NEW YORK STATE OF OPPORTUNITY. Department of Health

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Update on Medicaid Fee-for-Service (FFS) Pharmacy Billing Instructions for Coordination of Benefits (COB) Submission

Effective July 26, 2018, the Department will implement system enhancements to improve the submission of Medicaid FFS pharmacy claims when the patient has other third-party coverage. These changes are being made to ensure that all values in specified fields are recognized and function appropriately, other patient responsibility amounts are accepted and other third-party insurance billing is validated when the claim is not covered. This is an update to previous guidance on this topic issued in *the May 2014 Medicaid Update*.

Coordinating benefits ensures the correct party pays first. **Medicaid is always the payor of last resort; federal regulations require that all other available resources be used before Medicaid considers payment.** If there is a responsible third-party that should be paying for the patients' health benefits, such as a health insurance provider, the responsible third-party should pay first.

Medicaid pays the lesser of Patient Responsibility (PR) or the Medicaid fee, regardless of the Patient Responsibility Amount. For pharmacy, this rule applies to all PR, which includes deductible, co-insurance, copay and other patient responsibility.
The following list of values reported in field 308-C8 (Other Coverage Code) are considered acceptable. This field is used by the pharmacy to indicate whether the patient has other insurance coverage or is enrolled in a Medicare Managed Care Organization (MCO).

Valid entries for field 308-C8 are:

- 0 = Not Specified
- 1 = No Other Coverage Identified
- 2 = Other Coverage Exists, Payment Collected
- 3 = Other Coverage Exists, This Claim Not Covered
- 4 = Other Coverage Exists, Payment Not Collected

The following updates will be made to the specified values submitted in field 308-C8 when the Other Coverage Code of "3" is submitted. The following codes *will not* be accepted in NCPDP field 472-6E, 'Other Payer Reject Codes' and *will not* be allowed to be returned on a claim.

Invalid Entries for field 472-6E are:

- 75 (Prior Authorization Required)
- 39 (M/I Diagnosis Code)
- 76 (Plan Limitations Exceeded)
- 80 (Drug - Diagnosis Mismatch)
- 79 (Refill too Soon)
- 88 (DUR Reject Error)
- MR (Product Not on Formulary)

A pre-adjudication edit was developed for this field and will return the NCPDP Reject Code (DE 3988) '6E - M/I Other Payer Reject Code' if one of these values are used.

The Provider must work with the primary insurance to obtain coverage for the member. This could involve prior authorization requirements, appeal processes or changes to medications ordered to align with the primary plans formulary products, etc. If all attempts for coverage have been exhausted and coverage has not been granted from the primary insurer, the Department may consider the denial under special circumstances. The medication in question would still be subject to any editing requirements under the Medicaid FFS program.

Contact the eMedNY Call Center at (800) 343–9000 for questions regarding COB billing or any billing issue