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 27th, 2017, the Department will be implementing system enhancements to improve the submission of Medicaid FFS pharmacy claims when the patient has other third party coverage. These changes were 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 the payer of last resort. This means when a patient has other insurance or Medicare; federal regulations require that all available resources be used before Medicaid considers payment. If there is a responsible third party who should be paying for the patients' health benefits, for example a health insurance provider, that responsible third party should be paying 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 or not 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 “4” is submitted:

- Submission of Other Coverage Code "4" (Other Coverage Exists, Payment Not Collected). If the value code of "4" is submitted in field 308-C8 for situations where the prior payer did not make a payment, however PR- (Patient Responsibility Amount) is due the system **will enforce that a COB segment is submitted** and the amount reported in field 431-DV “Other Payer Amount Paid” is **not greater than zero**.

The following list of values have been updated and are recognized when reported via NCPDP D.0 in the COB segment, field 351-NP (Other Payer Patient Responsibility Amount Qualifier) when the Other Coverage Code of “4” is submitted. These values are considered as acceptable for payment when qualifying PR amounts are reported in field 352-NQ (Other Payer Patient Responsibility Amount) for claims involving third party liability (TPL) other insurance. All payments paid by any/all third parties, including Medicare, should be included on the claim.

Qualifier values Accepted- Field 351-NP:
Blank = Not Specified
01= Deductible
04= Amount reported from previous payer as Exceeding Periodic Benefit Maximum
05= Copay Amount
06= Patient Pay Amount
07= Coinsurance Amount
09= Health Plan Assistance Amount
12= Coverage Gap Amount

The following list of values reported in field 351-NP (Other Payer Patient Responsibility Amount Qualifier) will be considered as NOT acceptable for payment when the Other Coverage Code of “4” is submitted. If any of the following values are submitted, the claim will fail a Pre-adjudication edit NCPDP Reject code 536 (Other Payer - Patient Responsibility Amount Qualifier Value Not Supported).

Qualifier values Not Accepted - Field 351-NP:
02= Product/Selection/Brand Drug Amount
03= Sales Tax Amount
08= Product Selection/Non-Preferred Formulary Selection Amount
10= Provider Network Selection Amount
11= Product/Selection/Brand Non-Preferred Formulary Selection Amount
13= Processor Fee Amount

The Provider must work with the primary insurance to obtain coverage for the member. This could involve prior authorization requirements or changes to medications ordered to align with the primary plans formulary products, etc.

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