

Pharmacy Point of Sale- Cost Avoidance

Effective October 1 2004, pharmacy providers will be required to bill prescription claims to private third party insurance carriers for those beneficiaries covered by both Medicaid and other third party insurance.

MS Medicaid Electronic Billing Procedure for Cost Avoidance

A. **Beneficiaries whose data on file with Medicaid indicates other third party coverage OR beneficiaries whose data on file indicates no other coverage, but provider is aware of other insurance coverage:**

* Provider must report the beneficiary's other insurance to Medicaid. Follow steps under "B" below.

1. Pharmacy sends electronic claim to fiscal agent and it is rejected with NCPDP Reject Code "41" which will display the message, "Submit Bill to Other Processor or Primary Payer". The text of the rejection message (NCPDP Field # 504-F4) will also state the Third Party payer information including name, address and telephone number.
2. Pharmacy sends claim to Third Party Payer.
 - a. **Third Party Payer pays 100% of the Medicaid allowable charge-** Claim may be resubmitted to Medicaid but no payment will result.
 - b. **Third Party Payer pays less than 100% of the Medicaid allowable-** Claim should be resubmitted to Medicaid.
 - i. **Enter the total amount paid by Third Party Payer in the "TPL Amount Paid" Field** (NCPDP Field # 431-DV - 'Other Payer Amount Paid')
 - ii. **Enter '02' in 'Other Coverage Code' Field** (#308-C8- Other Coverage Exists- Payment Collected)
 - iii. **Submit claim to Medicaid fiscal agent for the full usual and customary amount. DO NOT SUBMIT COPAY AMOUNT ONLY.**
 - iv. Resulting payment will be Medicaid allowable minus TPL Amount Paid.

Example of claim submission to Medicaid **AFTER OTHER INSURANCE has been billed:**

- Claim Submitted to BCBS with a total submitted Charge of \$200.00 (Usual and Customary)
Blue Cross Blue Shield Pays Pharmacy \$100.00 and receipt states that Patient must pay \$100.00 Deductible.
- Submit Secondary claim to Medicaid –
 - i. Submit a **TOTAL Charge of \$200.00**

- ii. Enter a '02' in the "Other Coverage Code" field (NCPDP 308-C8)
 - iii. Enter \$100.00 in the 'TPL AMOUNT PAID' field (NCPDP 431-DV) DO not bill only the copay amount to Medicaid.
- c. **Third Party Payer sends back a \$0.00 Paid Amount*** (Rejection or Denial)
- *Valid Values for 'Other Payer Reject Codes' (Field # 472-6E) received from other insurance are:
 - 40= Pharmacy Not Contracted with Plan on Date of Service
 - 65= Patient is Not Covered
 - 67= Filled Before Coverage Effective
 - 68= Filled After Coverage Expired
 - 69= Filled After Coverage Terminated
 - 70= Product/Service Not Covered
 - 73= Refills are Not Covered
 - 76= Plan Limitations Exceeded
- i. **Enter \$0.00 in the 'TPL Amount Paid' Field 431-DV** (*this field is optional when Field #308-C8 'Other Coverage Code' = 01, 03 or 04*)
 - ii. In Field #**308-C8,'Other Coverage Code'** one of the following applicable values **should** be entered:
 - 01= No Other Coverage Exists** (Ex: Claim denies due to coverage expired)
 - 03= Other Coverage Exists-Claim Not Covered** (Ex: Claim denies due to non-coverage of drug by insurance and drug is covered by Medicaid)
 - 04= Other Coverage Exists-Payment Not Collected**

Examples:

- Beneficiary has insurance coverage (ex: 70-30), which requires the beneficiary to pay for the prescriptions, then the insurance company would reimburse the beneficiary a certain percentage of the claim.
- Pharmacy submits claim to other payer. The beneficiary must meet a deductible before benefits pay for pharmacy claims. The other payer applies the claim to the beneficiary's deductible for the other insurance. The provider then submits the usual and customary charge to Medicaid.
- Other insurance company is a mail order only company.
- Other insurance requires prior authorization for claim submitted. The prior authorization process should be initiated by the provider. Should the access of the beneficiary's prescription be delayed due to this process, the pharmacy may submit the claim to Medicaid. Once the prior authorization is acquired, the claim **must** be reversed then coordinated with the insurance carrier.

05=Managed Care Plan Denial – Not an acceptable value

06= Other Coverage Denied- Not Participating Provider (Ex: Beneficiary has insurance coverage but the pharmacy and/or prescriber is out of the insurance company's network.

07= Other Coverage Exists- Not in Effect on Date of Service

08= Billing for Copay - Not an acceptable value

- iii. Submit claim to Medicaid fiscal agent.
- iv. Claim will pay Medicaid Allowable.

B. Provider must report the beneficiaries' other insurance to Medicaid. Provider may report changes in beneficiaries' insurance coverage as follows:

- FAX information to: (601) 359-6294 (PREFERRED)
- CALL Third Party Recovery – Division of Medicaid – (601) 359-6095
- Email or mail form – Visit MS Medicaid Website – <http://www.medicaid.ms.gov/UpdateHealthInsuranceInformation.aspx>

Notes:

Pharmacy providers must keep explanation of benefits (EOB) from other insurance companies. These records must be available to Medicaid upon request.

If a beneficiary tells the provider that his/her insurance policy is no longer in effect, the policy never existed, or the policy is for something other than medical insurance, the provider should obtain a signed statement from the beneficiary which includes: the name of the insurance company, the policy number, and the ending date of coverage. The signed statement should be forwarded to the DOM Bureau of Third Party Recovery. Upon receipt of this information, the patient's statement will be researched and, if necessary, the third party resource file will be updated.

Remember, Medicaid is always the payer of last resort.

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