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Authorized Signature

Number: DMAP-IM-07-162

Issue Date: 11/14/2007

Topic: Medical Benefits

Subject: Provider announcement: Coordination of Benefits errors

Applies to (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> All DHS employees | <input type="checkbox"/> County Mental Health Directors |
| <input type="checkbox"/> Area Agencies on Aging | <input type="checkbox"/> Health Services |
| <input type="checkbox"/> Children, Adults and Families | <input type="checkbox"/> Seniors and People with Disabilities |
| <input type="checkbox"/> County DD Program Managers | <input checked="" type="checkbox"/> Other (please specify):
DMAP staff + Plans |

Message:

DMAP is mailing pharmacies the following message about Coordination of Benefits claims. Some providers' billing practices are producing costly errors for DHS.

If you have any questions about this information, contact:

Contact(s):	Debbie Bishop, DMAP Pharmacy Policy Analyst
Phone:	503-945-6291
E-mail:	Debbie.Bishop@state.or.us

Coordination of benefits (COB)

As you know, DMAP is the payer of last resort on claims for OHP clients who have other insurance coverage for prescription drugs. DHS and First Health have observed many errors on Point of Sale (POS) claims involving third party liability. Please review the rules and regulations surrounding these COB claims: OAR 410-120-1280 or 42 CFR 433.135 through 433.154. Audit results may soon oblige DHS to start recouping overpayments on COB claims.

COB billing procedure

As we informed pharmacies last April, DMAP will pay POS claims billed with Other Coverage Code 3 (“Other coverage exists, claim not covered”) when all of the following are true:

- ✦ A drug product is not covered by the beneficiary’s other insurance.
- ✦ DMAP covers the drug.
- ✦ The claim’s COB segment contains a valid Other Payer Reject Code (NCPDP Field 472-6E).

DMAP will reject claims with Other Coverage Code 3 that do not meet all of the criteria listed above (NCPDP Reject code 6E — “M/I other payer reject code”).

Common errors

A review of claims shows that some providers may be manipulating data in order to make their POS claims process by either adding or omitting pertinent information.

Some providers submit the same claim several times — entering the payment from the other insurance the first time, but after it’s rejected multiple times, they delete the other payment in order to get Medicaid to pay. This results in the provider receiving double payment – one from the third party and then full payment from DMAP. Please call for help* rather than knowingly entering incomplete or erroneous data.

Other providers are altering their usual and customary charges in an attempt to collect copayments or overriding prior authorization codes rather than seeking PA. These practices are also unacceptable.

Purposefully misusing or misrepresenting OCC coding in order to ensure transaction adjudication is inappropriate and could also be construed as fraudulent.

Note: Only fee-for-service claims go to DMAP. The department contracts with the OHP managed care plans to pay you the Medicaid portion of your claim for each of their OHP clients. After you bill the client’s plan, please do not resubmit the claim to DMAP.

*** Need Help?**

- ✦ If your POS claims do not process correctly, contact the First Health claims technical help desk at 800-884-7387. Your software may need adjustments.
- ✦ If you have questions about DMAP policy or billing practices, contact DMAP Provider Services at 800-336-6016 or dmap.providerservices@state.or.us.
- ✦ DMAP OARs are online at www.dhs.state.or.us/policy/healthplan/guides/main.html.

The following is the approved list of Oregon DHS Division of Medical Assistance Programs (DMAP) descriptions and acceptable values for third party liability (TPL) denials. These are to be used in claim processing for the Other Coverage field. DMAP will audit transactions to ensure policy is strictly followed and only the following approved **Other Coverage Codes (OCC)** are properly used in claims processing. Please submit any denial code received from the primary or secondary payer when submitting the claim to DMAP using an OCC override code.

1. No other valid pharmacy coverage in effect.

OCC 1 is for situations where the provider has confirmed that the patient does not have valid pharmacy coverage. Submit the claim with an OCC 1, along with a valid Other Payer Denial Date and Other Payer ID returned on the original claim to override the TPL denial.

2. An amount is collected from another payer.

OCC 2 is used when any positive amount of money is collected from another payer. Submit the claim with an OCC 2, the amount collected from the primary payer, along with the date the claim was adjudicated by the primary payer and the Other Payer ID to override the TPL denial.

3. Primary payer does not cover the specific drug being submitted.

OCC 3 is used when the primary payer does not cover the specific drug being submitted. Submit an OCC 3 and Other Payer ID along with a valid Other Payer Denial Date to override the TPL denial. OCC 3 is submitted only if the primary insurance carrier returned a NCPDP 70 - NDC Not Covered - denial. **If the primary carrier requires a Prior Authorization (NCPDP 75), the primary carrier's Prior Authorization procedures must be followed prior to submitting the claim to DMAP for secondary payment. If you receive other error codes, take action to resolve the problem (such as re-directing the recipient to a different pharmacy or contact the doctor's office). Use another OCC only if appropriate.**

4. Plan limitation exceeded

OCC 3 now also allows NCPDP Reject Codes of 3Y - Prior Authorization Denied and 76 - Plan Limitations Exceeded. The Plan Limitation Exceeded situation needs to have had an attempt at resolution, particularly if the plan limit is only a certain "days supply" quantity.

5. Recipient has yet to meet their primary payer's deductible.

OCC 4 - If the recipient has not met their primary payer's deductible, and the primary payer payment is zero, submit the claim with an OCC 4, a zero amount collected from the primary payer, the Other Payer ID, along with the date the claim was adjudicated by the primary payer to override the TPL denial.

6. Total cost of the claim is less than the patient's primary payer's co-payment.

OCC 4 - If the total cost of the claim is less than the patient's primary payer's co-payment and the adjudication of the claim by the primary payer resulted in zero payment, submit the claim with an OCC 4, a zero amount collected from the primary payer, the Other Payer ID, along with the date the claim was adjudicated by the primary payer for an override.

7. Recipient's primary insurance requires the patient to pay for medications.

OCC 4 - If the recipient's primary insurance requires the patient to pay for the medications at the time of dispensing and submit receipts for reimbursement submit the claim with an OCC 4, a zero amount collected from the primary payer, the Other Payer ID, along with the date of service in the other payer date field to override the TPL denial. In these cases, DMAP will be responsible for collecting the payment from the primary payer.

8. Patient's pharmacy coverage is not yet in effect for the date of service.

OCC 7 is reserved for situations where the provider has confirmed that the patient's pharmacy coverage is not yet in effect for the date of service on the claim. In this case, submitting the claim with an OCC 7, Other Payer ID, along with a valid Other Payer Denial Date will override the TPL denial.

PLEASE NOTE: You are not to collect primary co-pays or deductibles from OHP clients if the claim is for a covered DMAP service. Collect only DMAP co-pays (if applicable) from the clients.