

Date: January 14, 2009

Alert Number: 0048 — Revised

To: Pharmacy Providers

Re: Pharmacy Coordination of Benefits Clarifications

The following information applies to pharmacy providers who coordinate benefits for members with other insurance sources (e.g., commercial health insurance, Medicare Part B, Medicare Part D).

Members may be covered by multiple other insurance sources that are primary to BadgerCare Plus, Medicaid, SeniorCare, or Wisconsin Chronic Disease Program (WCDP). A claim must be submitted to each other insurance source before it is submitted to BadgerCare Plus, Medicaid, SeniorCare, and WCDP. Pharmacy providers are required to indicate coordination of benefits (COB) information for each other insurance source on claims submitted to BadgerCare Plus, Medicaid, SeniorCare, and WCDP. Providers may submit COB information for up to nine other insurance sources to BadgerCare Plus, Medicaid, SeniorCare, and WCDP. Claims submitted to BadgerCare Plus, Medicaid, SeniorCare, and WCDP should include the amount paid or the reason for denial by other insurance sources.

Claim Submission Requirements

When submitting claims for other insurance to ForwardHealth, providers are required to include specific COB information based on the results of the claim submission to other insurance sources. Some or all of the information below may be automatically populated by the pharmacy software; however, if the software does not automatically populate this information, pharmacy providers are required to enter the information before submitting the claim to ForwardHealth or WCDP.

If a service is covered by other insurance and payment is collected, providers are required to indicate a value of “2” in National Council for Prescription Drug Programs (NCPDP) field 308-C8 (Other Coverage Code) and information in the following NCPDP fields for each other insurance source:

- 338-5C (Other Payer Coverage Type).
- 340-7C (Other Payer ID).
- 339-6C (Other Payer ID Qualifier) with a value of “99”.
- 443-E8 (Other Payer Date) with the payment date, denial date, or the date the claim was submitted to other insurance sources.
- 431-DV (Other Payer Amount Paid) with amount paid by other insurance sources.

Informational — Revised

- 342-HC (Other Payer Amount Paid Qualifier) with a value of “08”.

If services are *not* covered by other insurance or if payment is not collected, providers are required to indicate the appropriate value (refer to the Attachment of this Alert) in NCPDP field 308-C8 (Other Coverage Code) and information in the following NCPDP fields for each other insurance source:

- 338-5C (Other Payer Coverage Type).
- 340-7C (Other Payer ID).
- 339-6C (Other Payer ID Qualifier) with a value of “99”.
- 443-E8 (Other Payer Date) with the payment date, denial date, or the date the claim was submitted to other insurance sources.
- 471-5E (Other Payer Reject Count) with the number of reject codes to follow.
- 472-6E (Other Payer Reject Code) with the error code provided by the other insurance source.

For more detailed information about required NCPDP fields, providers should refer to the Attachment and to the ForwardHealth Companion Document to HIPAA Implementation Guide: NCPDP 5.1, which is available in the Trading Partner area of the ForwardHealth Portal at www.forwardhealth.wi.gov/.

Providers may refer to the July 2008 *ForwardHealth Update* (2008-105), titled “ForwardHealth Announces Changes to Paper and Electronic Claims Submission for Pharmacy Services,” and the NCPDP companion document for fields required on claims when a member has other insurance. Providers should call their software vendors with questions about field titles.

Other Coverage Code

When a member has other insurance, providers are required to indicate the following in NCPDP field 308-8C (Other Coverage Code):

- 2 — Other Coverage Exists — Payment Collected.
- 3 — Other Coverage Exists — This Claim Not Covered.
- 4 — Other Coverage Exists — Payment Not Collected.
- 5 — Managed Care Plan Denial.
- 6 — Other Coverage Denied — Not a Participating Provider.
- 7 — Other Coverage Exists — Not in Effect at Time of Service.

Other Coverage Type

For the member’s other insurance, providers are required to indicate the following in NCPDP field 338-5C (Other Payer Coverage Type):

- 01 — for primary coverage.
- 02 — for secondary coverage.
- 03 — for tertiary coverage.
- 99 — for composite coverage.

Informational — Revised

For example, if a member is covered by Medicare Part D, commercial health insurance, and SeniorCare, when billing SeniorCare, “01” should be indicated on the claim for Medicare Part D and “02” should be indicated on the claim for commercial health insurance.

Other Payer ID

Providers are required to indicate either “PARTD,” “PARTB,” or “COMM” in NCPDP field 340-7C (Other Payer ID) when a member is covered by Medicare Part B, Medicare Part D, or commercial health insurance. The bank identification number (BIN) should *not* be indicated in this field.

Other Payer ID Qualifier

Other payer ID qualifier “99” must be indicated in NCPDP field 339-6C (Other Payer ID Qualifier) when a member is covered by Medicare Part B, Medicare Part D, or commercial health insurance. Claims submitted with blank fields or a different number will be denied.

Other Payer Date

The other payer date must be indicated in NCPDP field 443-E8 (Other Payer Date) with the payment date, denial date, or the date the claim was submitted to other insurance sources.

Other Payer Amount Paid Qualifier

The other payer amount paid qualifier must be indicated in NCPDP field 342-HC (Other Payer Amount Paid Qualifier) with a value of “08” when payment is collected from other insurance sources.

Other Payer Amount Paid

The sum of reimbursement from each insurance source must be indicated in NCPDP field 431-DV (Other Payer Amount Paid). Claims with negative dollar amounts indicated will be denied.

Other Payer Reject Code

The other payer’s error code received must be indicated in NCPDP field 472-6E (Other Payer Reject Code). This field or an other payer amount paid is required when an other payer ID is submitted.

Note: Other insurance sources will not provide a reject code when coverage exists and payment is *not* collected. Pharmacy software will not populate this field. Therefore, providers are required to enter the appropriate value before the claim is submitted to ForwardHealth or WCDP.

Special Claim Submission Requirements for Members Enrolled in Medicare Part D and SeniorCare or Wisconsin Chronic Disease Program

Pharmacy providers are required to submit claims for SeniorCare and WCDP members who are enrolled in a Medicare Part D Prescription Drug Plan (PDP) to the member’s PDP and other health insurance sources *before* claims are submitted to SeniorCare or WCDP. SeniorCare and WCDP are payers of last resort; WCDP is payer of last resort after BadgerCare Plus, Medicaid, and SeniorCare.

Informational — Revised

After a claim has been submitted to Medicare Part D, providers may need to change the processor control number (PCN) to WIPARTD before submitting the claim to SeniorCare or WCDP. (For SeniorCare, this policy applies for members enrolled in Level 2b and 3 only.) Claims received without WIPARTD indicated in NCPDP field 104-A4 (Processor Control Number) will be denied.

After a claim has been submitted to Medicare Part D for a member who has reached the “donut hole,” pharmacy providers may submit the claim to SeniorCare for the “donut hole” amount with PCN WIPARTD to account for the SeniorCare member’s spenddown or deductible amount. After a claim has been submitted to SeniorCare, ForwardHealth will send the pharmacy provider *and* the true out-of-pocket (TrOOP) facilitator a response that identifies whether the claim was reimbursed or denied.

To determine the specific PDP in which a member is enrolled, providers should first check with the member. If the member does not know the PDP in which he or she is enrolled, providers may send an online eligibility transaction through Medicare’s E1 query. If the E1 transaction does not return Medicare Part D plan information, providers may call the Medicare Pharmacy Hotline, available 24 hours a day, seven days a week, at (866) 835-7595. Providers may also call Provider Services at (800) 947-9627 to determine the PDP in which a member is enrolled.

ATTACHMENT

Common Coordination of Benefits Errors and Resolutions

The following are common coordination of benefits errors and the appropriate resolution for each error.

Explanation of Benefit Code	National Council for Prescription Drug Programs Reject Code	Description	Resolution
1227	6C	OTHER PAYER ID QUALIFIER INVALID FOR WI	NCPDP field 339-6C (Other Payer ID Qualifier) must equal 99.
0320, 1210	04	INVALID PCN	NCPDP field 104-A4 (Processor Control Number) must contain WIPARTD (Refer to special submission requirements information in the alert.)
0268	41	DRUG COVERED BY MEDICARE PART D (WCDP/SENIORCARE)	NCPDP field 340-7C (Other Payer ID) must equal PARTD AND fields 431-DV (Other Payer Amount Paid) or 472-6E (Other Payer Reject Code) must be present.
0278	41	RECIPIENT COVERED BY PRIVATE INSURANCE (PHARMACY)	NCPDP field 340-7C (Other Payer ID) must equal COMM AND fields 431-DV (Other Payer Amount Paid) or 472-6E (Other Payer Reject Code) must be present.
0545	41	DRUG COVERED BY MEDICARE - MEDICAID	BadgerCare Plus covers only Medicare Part D excluded drugs. Claims for all other drugs must be submitted to the member's Medicare Part D Prescription Drug Plan.
0010	41	INVALID MEDICARE DISCLAIMER	NCPDP field 340-7C (Other Payer ID) must equal PARTB AND fields 431-DV (Other Payer Amount Paid) or 472-6E (Other Payer Reject Code) must be present.