THIRD PARTY LIABILITY/COORDINATION OF BENEFITS

This section describes the Pharmacy Program's policy regarding beneficiaries who have other third party resources that can be applied to their pharmacy expenses.

Third Party Liability

Federal regulations and applicable state laws require that third party resources be used before Medicaid is billed, as Medicaid by law, is intended to be the payor of last resort. Third party liability (TPL) refers to those payment resources available from both private and public health insurance and from other liable sources, such as liability and casualty insurance, which can be applied toward the Medicaid beneficiary's medical and health expenses.

Coordination of Benefits

Providers are able to coordinate benefits or "split-bill" pharmacy claims through the Medicaid Point of Sale (POS) system. Providers must bill beneficiaries' primary insurance companies before billing Medicaid. Medicaid will reimburse providers for the beneficiary's responsibility of coinsurance, co-payments and/or deductibles with other insurance companies up to the maximum Medicaid allowed amount. This will be accomplished by Medicaid payment of the outstanding balance remaining after the payment by the primary payor has been deducted from the maximum Medicaid allowed amount. Medicaid co-payments should still be collected if applicable.

Pharmacy Providers' Roles

The provider should inquire if the beneficiary has private insurance coverage with prescription benefits. This information is entered in the beneficiary's profile of the pharmacy's software. When a pharmacy claim is filled, it is submitted to the primary insurance company(ies). The other payor's paid amount should be submitted on the pharmacy claim to Medicaid.

Pharmacy claims billed to Medicaid first, when drug coverage with another insurance company is noted on the beneficiary's resource file and with no indication that the applicable private insurance has been previously billed, will deny.

Providers may log into the Louisiana Medicaid website to view the Medicaid Eligibility Verification System (MEVS). Providers may view the beneficiary's other insurance company and Medicaid carrier code number.

Valid insurance coverage may differ from what is on the beneficiary's resource file. Pharmacy providers may enter the correct coverage and coordinate benefits. Providers may contact the Louisiana Department of Health's TPL Unit with updated traditional Medicare insurance coverage (see Appendix N for contact information).

Urgent TPL requests are defined as the inability of a beneficiary to have a prescription filled or the inability of a beneficiary to access immediate care because of the incorrect third party insurance coverage.

Urgent private insurance and Medicare Advantage Plan update requests for beneficiaries enrolled in a Healthy Louisiana plan for pharmacy and medical benefits must be submitted to the beneficiary's Healthy Louisiana plan.

Urgent private and urgent Medicare Advantage Plan update requests for beneficiaries whose Pharmacy benefit is paid by Fee-for-Service Medicaid (Legacy) must be submitted to Louisiana Department of Health's TPL contractor, HMS.

NOTE: See Appendix D, POS User Guide of this manual chapter for claim submission details.

Coordination of Benefits Exemptions

Certain conditions exist that are exempt from coordination of benefits and Medicaid is mandated to pay and chase claims. A pharmacy provider may override the coordination of benefits edit when:

1. A Medicaid beneficiary has court ordered medical child support;
2. Pharmacy claims are deemed preventative care for individuals under age 21; and
3. Pharmacy claims are deemed preventive care for pregnant women.

NOTE: Documentation of court ordered medical child support or preventative care on the hard copy prescription or in the pharmacy's electronic recordkeeping system by the pharmacist is required for the above circumstances.

Exemptions to Medicaid Program Restrictions

Certain restrictions will be by-passed. Claims that are coordinated with primary insurance companies will process without edits for:

1. Prior authorization for non-preferred drugs;
2. Four prescription monthly limit; and
3. Orlistat, excluding the age edit.

Claims for Beneficiaries with Multiple Insurance Coverage

Some beneficiaries have one or more insurance companies for prescription coverage. The pharmacy should coordinate payment with other insurance companies prior to billing Medicaid, as Medicaid is the payor of last resort.

Override Capabilities and Codes

Override capabilities exist to allow providers to process claims and receive payment when a beneficiary would be delayed in receiving their prescriptions.

NOTE: See Appendix D, POS User Guide of this manual chapter for detailed billing information.

The Pharmacy Program monitors pharmacy providers' usage of override codes. Corrective actions will be offered to better utilize the coordination of benefits process.

Override codes should be used under the following conditions:

1. No other coverage:
   a. Pharmacy submits claim to other insurance company. Claim denies due to coverage expired. Pharmacist inquires of beneficiary regarding other insurance coverage. Beneficiary does not have, or cannot supply the pharmacy with other insurance information; or

   b. Pharmacy submits claim to other insurance company. The other insurance company does not include a pharmacy benefit. Pharmacist asks beneficiary for other insurance coverage, but beneficiary has none.

2. Other coverage billed - Claim not covered: Pharmacy submits claim to other payor. The other payor denies the claim due to non-coverage of drug.

3. Other coverage exists - Payment not collected:
   a. Beneficiary has insurance coverage (ex. 80/20 insurance) which requires the beneficiary to pay for the prescriptions, then the insurance company would reimburse the beneficiary a certain percentage of the claim;

   b. Pharmacy submits claim to other payor. The beneficiary must meet a deductible before benefits pay for pharmacy claims. The other payor applies the claim to the beneficiary's deductible for the other insurance. The provider then submits the usual and customary charge to Medicaid;

   c. Beneficiary has court ordered medical child support;

   d. Preventative care for a beneficiary under the age of 21 or a woman who is pregnant;

   e. Pharmacy submits claim to other insurance company. The other insurance company is a mail-order only company;

f. Beneficiary has other insurance coverage. The pharmacy claim requires prior authorization from the other insurance. The prior authorization process shall be commenced by the provider. Should the access of the beneficiary's prescription be delayed due to the prior authorization process, the pharmacy may submit the claim to Medicaid with the above other coverage code. However, once the prior authorization is acquired, the claim must be reversed and coordinated with all insurance carriers with Medicaid as last payor; or

g. Beneficiary has insurance coverage, but the pharmacy and/or physician is out of the insurance company's network.