37.8 THIRD PARTY LIABILITY/COORDINATION OF BENEFITS

Overview

Introduction

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

In This Section

This Section contains:

37.8.1 THIRD PARTY LIABILITY (TPL)

Federal regulations and applicable state laws require that third party resources be used before Medicaid is billed. ***Third party*** 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 recipient's medical and health expenses.

37.8.2 COORDINATION OF BENEFITS (COB)

Federal law mandates that Medicaid is the payor of last resort. Providers are able to coordinate benefits or "split-bill" pharmacy claims through the Medicaid Point of Sale system. P roviders must bill recipients' primary insurance companies before billing Medicaid. M edicaid will reimburse providers for the recipient'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 usual and customary charge. Again the payment will be up to the maximum Medicaid allowed amount. Medicaid co-payments should still be collected if applicable.

37.8.3 PHARMACY PROVIDERS' ROLES

The provider should inquire of the recipient, if that recipient has private insurance coverage with prescription benefits. This information is entered in the patient's profile of the pharmacy's software. When a pharmacy claim is filled, it is submitted to the primary insurance company/companies. 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 recipient's resource file and with no indication that the applicable private insurance has been previously billed will deny.

Providers may log in www.lamedicaid.com to view the Medicaid Eligibility Verification System (MEVS). P roviders may view the recipient's other insurance company and Medicaid carrier code number.

Valid insurance coverage may differ from what is on the recipient's resource file. Pharmacy providers may enter the correct coverage and coordinate benefits. P roviders may contact the DHH TPL Unit at 225-342-8662 with updated **traditional Medicare** insurance coverage. Providers may contact Health Management Systems (HMS), the DHH TPL collections contractor, at 1-877-204-1324 with updated **private insurance or Medicare Advantage Plan** coverage. Also, providers may instruct recipients to contact their local Medicaid offices to update their insurance coverage.

Note: Refer to Appendix D POS User Guide for claim submission details.

37.8.4 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:

- A Medicaid recipient has court ordered medical child support;
- Pharmacy claims are deemed preventative care for ages under twenty-one; and
- Pharmacy claims are deemed preventive care for pregnant women.

Documentation of court ordered medical child support or preventative care on the hard copy prescription by the pharmacist is required for the above circumstances.

37.8.5 EXEMPTIONS TO MEDICAID PROGRAM RESTRICTIONS

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

- Prior Authorization for non-preferred drugs;
- Four prescription monthly limit; and
- Orlistat excluding the age edit.

37.8.6 CLAIMS FOR RECIPIENTS WITH MULTIPLE INSURANCE COVERAGE

Some recipients 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.

37.8.7 OVERRIDE CAPABILITIES AND CODES

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

Note: Refer to Appendix D, POS User Guide for detailed billing information.

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

The following are scenarios for usage of override codes:

- No other coverage
  - Pharmacy submits claim to other insurance company. Claim denies due to coverage expired. P harmacist inquires of recipient regarding other insurance coverage. Recipient does not have or cannot supply pharmacy with other insurance information.
  - Pharmacy submits claim to other insurance company. The other insurance company does not include a pharmacy benefit. Pharmacist asks recipient for other insurance coverage, but recipient has none.
- Other coverage billed - Claim not covered
  - Pharmacy submits claim to other payor. The other payor denies due to non-coverage of drug.
- Other coverage exists - Payment not collected
  - Recipient has insurance coverage (ex. 80-20 insurance) which requires the recipient to pay for the prescriptions then the insurance company would reimburse the recipient a certain percentage of the claim.
  - Pharmacy submits claim to other payor. The recipient must meet a deductible before benefits pay for pharmacy claims. T he other payor applies the claim to the recipient's deductible for the other insurance. The provider then submits the usual and customary charge to Medicaid.
  - Recipient has court ordered medical child support.
  - Preventative care for a recipient under the age of twenty-one or a woman who is pregnant.
  - Pharmacy submits claim to other insurance company. The other insurance company is a mail-order only company.

- Recipient 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 recipient'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.

- Recipient has insurance coverage but the pharmacy and/or physician is out of the insurance company's network.