MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Pharmacy 01-03

Issued: August 1, 2001

Subject: Pharmacy Coordination of Benefits

Effective: September 1, 2001

Programs Affected: Medicaid, Children's Special Health Care Services [CSHCS], State Medical Program [SMP]

As a reminder, pharmacies must bill other insurances, including Medicare, before billing Medicaid, CSHCS, and SMP. Claims processed on and after September 1, 2001 will be rejected when beneficiaries have other insurance codes of 90-95 [Medicare], 87 [Other Pharmacy Insurance], and 89 [Health Maintenance Organization Private Insurance] when other insurance payments are available and no report of other insurance adjudication is made. When these other insurance codes exist and the pharmaceutical product is covered by Medicare or the other insurance, the program will only reimburse over and above the amount paid by other insurance up to MDCH allowable fee screen. If reimbursement from the other insurance, including Medicare, exceeds the program's allowable fee screens, no additional monies will be paid.

When billing for a beneficiary who has Medicare and/or other insurance, the pharmacy must enter the appropriate NCPDP code based on the status of the other insurance. These codes are:

0 = Not Specified
1 = No other coverage identified.
2 = Other coverage exists, payment collected.
3 = Other coverage exists, this claim is not covered.
4 = Other coverage exists, payment not collected.

In the following situations, the pharmacy may override the edit by using one of the NCPDP codes stated above. For the specific situation stated below, the appropriate NCPDP override code follows in parenthesis.

- Medicare does not cover the pharmaceutical product for the beneficiary's condition. (3)
- The beneficiary indicates or the pharmacy is aware that the beneficiary no longer has the other insurance nor is in a commercial health maintenance organization (HMO) on the date the prescription is being dispensed. (1)
- The beneficiary's other insurance carrier requires the beneficiary to pre-pay for the drug. (4)
- The beneficiary is in a long-term care facility and the dispensing pharmacy is not a part of the insurance carrier's network. (4)
- The other insurance carrier only has mail order pharmacy coverage. (4)

In the following situations, the pharmacy may not override the edit:

- The beneficiary has other insurance and the pharmaceutical product is covered and would be paid to the pharmacy if the insurance carrier's rules (e.g. obtain prior authorization, use of a network pharmacy, or incorrect claim submission) had been followed.
- The other carrier requires a generic instead of the brand equivalent covered by the program. The pharmacy must bill the other insurance for the generic.
- The pharmacy is not part of a carrier's network and is not able to obtain authorization from the carrier to provide the drug. The pharmacy should instruct the beneficiary to have the prescription filled at a participating pharmacy. If the beneficiary is not familiar with the carrier's network, the pharmacy should instruct the beneficiary to contact their carrier for a list of network pharmacies.
- The beneficiary is required to pre-pay, but only because the pharmacy is not part of the carrier's network. The beneficiary should be instructed to have the prescription filled at a participating pharmacy.

For more information on the Department's policy regarding other insurance, refer to the Other Insurance Appendix of your Pharmacy manual. The pharmacy's charge must be the amount allowed by the other insurance. The claims must show the other insurance paid, including dispensing fee, and other insurance co-payment. In addition, the pharmacy is to use the formulary established by the beneficiary's carrier.

To assure that other insurances are being utilized, the MDCH will review post-payment reports and include other insurance payment in its audit structure.

For complete information on using the POS system for third party payments, refer to your First Health Services Claims Processing Manual, the FHSC web site [www.michigan.fhsc.com], or phone the FHSC Technical Call Center at 1-877–624-5204.

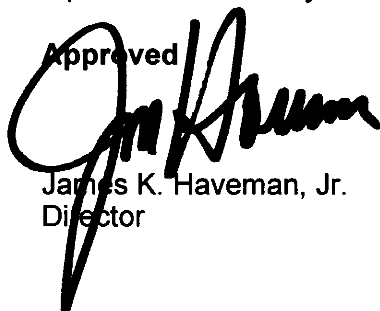
Manual Maintenance

Retain this bulletin for future reference.

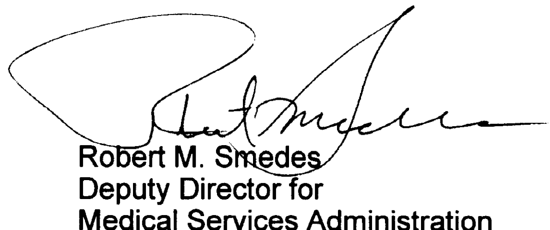
Questions

Any questions regarding this bulletin should be directed to: Provider Inquiry, Medical Services Administration, P.O. Box 30479, Lansing, Michigan 48909-7979, or e-mail at ProviderSupport@state.mi.us. When you submit an e-mail, be sure to include your name, affiliation, and a phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

Approved



James K. Haveman, Jr.
Director



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