



TEXAS HEALTH AND HUMAN SERVICES COMMISSION

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EXECUTIVE COMMISSIONER

July 1, 2009

**** Important Medicaid Information **** **Cost Avoidance Phase II Implements July 20, 2009**

Effective July 20, 2009, phase II of Cost Avoidance coordination-of-benefits (COB) for pharmacy claims will be implemented. This phase will include *all* Medicaid clients with other known insurance coverage (adults and children). Phase I of Cost Avoidance was implemented on January 20, 2009 and only included a limited number of adults age 21 and over.

The Texas Medicaid Vendor Drug Program (VDP) implemented this new process to ensure compliance with a regulation from the federal Centers for Medicare & Medicaid Services (CMS). Under federal rules, Medicaid agencies must be the payer of last resort. The cost avoidance model checks for other known insurance at the point of sale, preventing Medicaid from paying a claim until the pharmacy attempts to obtain payment from the client's third-party insurance.

In January, several interactive online training sessions were offered to pharmacists and other interested providers. An audio/visual training module and a PowerPoint presentation of the training session are available on the VDP website for those providers who were unable to attend or who would like to hear the information again. The information is available at: www.txvendordrug.com/costavoidance.html. The website also includes a list of frequently asked questions, as well as the procedure manual with payer sheets, and other helpful information regarding cost avoidance. Additionally, a quick reference guide to COB segment processing is included with this letter.

**** Remember ****

Any claim submitted for a client with other known insurance will be rejected at the point of sale, with the information needed for the pharmacy to bill the primary payer. If the pharmacy submits the claim to the primary payer and it is denied, the pharmacy should work with the primary payer and/or prescriber to address the denial reason. If the claim is not payable by the other insurer, Medicaid may pay the claim, depending on the reason for denial. If the third-party insurer requires a prior authorization (PA), pharmacies are asked to provide the doctor with contact information for the primary insurer's PA service, not the Medicaid PA-TEXAS service. Once a

pharmacy is aware of a Medicaid client's primary payer, it is recommended that they update their in-store files in order to bill the other insurer first for future prescriptions.

VDP will continue COB claim payments for clients with third-party insurance coverage (e.g. coverage for unmet deductible or co-pay). The pharmacy provider is to accept the combined payment from the other insurer(s) and Texas Medicaid as payment in full and may neither charge nor take other recourse against the client. Please refer to the VDP Pharmacy Provider Handbook - 4800 Limitations on Provider Charges to Recipients - on the VDP website at www.txvendordrug.com/about.html. Prescriptions reimbursable by Medicare Part D are **not** eligible for additional reimbursement through Medicaid.

COB claims paid by Texas Medicaid will count toward the prescription limit for those clients limited to three prescriptions per month. Medicaid recipients will continue to receive their medications, with no out-of-pocket expenses.

For inquiries specific to third-party insurance or payer information, contact Health Management Systems Texas Third Party Support Line at **1-866-389-5594**. Pharmacies should continue to contact the VDP Pharmacy Resolution Help Desk for general drug-related questions or claims adjudication inquiries.

Thank you for your prompt attention and cooperation with this effort. Your assistance and understanding ensures the continued success of the Texas Medicaid Vendor Drug Program.

Coordination of Benefits (COB) Reference Guide

When a claim is submitted to Texas Medicaid as the primary payer, the claim will be rejected with error code 41 (“Submit Bill To Other Processor or Primary Payer”) if the client has other insurance. The pharmacy will be provided with the third-party billing information needed for claims submission to the other payer (**Payer ID**, **Bank Identification Number [BIN]**, **Processor Control Number [PCN]**, **Group ID**, and **Cardholder ID**) in “Additional Message Information” (Field 526-FQ). If your software does not display the “Additional Message Information” field, you are strongly encouraged to contact your software provider.

The “Other Coverage Code” (Field 308-C8, in the Claim segment) must always be submitted. The acceptable values are:

- “2” = Other coverage exists – payment collected.
- “3” = Other coverage exists – this claim not covered.
- “4” = Other coverage exist – payment not collected.
- “6” = Other coverage denied – not a participating provider.

Example 1: Another payer has paid and returned an amount greater than \$0.00 in “Total Amount Paid” (Field 509-F9) and an amount greater than \$0.00 in “Patient Pay Amount” (Field 505-F5). The claim submitted to Texas Medicaid must include:

- “Other Coverage Code” (Field 308-C8) = “2” (Other coverage exists - payment collected), and
- The COB segment, which must include:

Field #	Field Name
111-AM	Segment Identification
337-4C	Coordination of Benefits/Other Payments Count
338-5C	Other Payer Coverage Type
339-6C	Other Payer ID Qualifier
340-7C	Other Payer ID
443-E8	Other Payer Date
341-HB	Other Payer Amount Paid Count
342-HC	Other Payer Amount Paid Qualifier
431-DV	Other Payer Amount Paid

Example 2: Another payer returns a reject response. The claim submitted to Texas Medicaid must include:

- “Other Coverage Code” (Field 308-C8) = “3” (Other coverage exists - this claim not covered) or “6” (Other coverage denied – not a participating provider), and
- The COB segment, which must include:

Field #	Field Name
111-AM	Segment Identification
337-4C	Coordination of Benefits/Other Payments Count
338-5C	Other Payer Coverage Type
339-6C	Other Payer ID Qualifier
340-7C	Other Payer ID
443-E8	Other Payer Date
471-5E	Other Payer Reject Count
472-6E	Other Payer Reject Code

Example 3: Another payer has returned a paid response and returned \$0.00 in “Total Amount Paid” (Field 509-F9), and an amount greater than \$0.00 in “Patient Pay Amount” (Field 505-F5). The claim submitted to Texas Medicaid must include:

- “Other Coverage Code” (Field 308-C8) = “4” (Other coverage exists - payment not collected), and
- The COB segment, which must include the same fields as shown in Example 1.

To learn more about COB processing, providers may consult our procedure manual and payer sheets on the Vendor Drug website located at: www.txvendordrug.com/about.html.