Third Party-Liability (TPL) Processing Educational Guide

COB General Instructions

COB Process

Louisiana Medicaid is always the payer of last resort. If a member has Third Party Liability (TPL), the claim must first be submitted to the other payers first.

If a claim is submitted for a member with existing TPL the pharmacy will receive a reject with **NCPDP reject code 41** – "**Submit Bill To Other Processor** or **Primary Payer**" as well as a supplemental message that includes any billing information we have for the primary payer, such as phone number, BIN, PCN, Group ID, and member ID.

COB processing requires that the Other Payer Amount Paid, Other Payer ID, Other Payer Date, and Other Payer Patient Responsibility be submitted on the claim to the plan. Pharmacy providers are asked to submit the TPL carrier code when coordinating claims for payment with a primary payer [LP1].

The following are values and claim dispositions based on pharmacist submission of standard NCPDP TPL codes. Where applicable, it has been noted which **Other Coverage Code** (NCPDP Field # 308-C8) should be used based on the error codes received from the primary

TPL Codes		
NCPDP Field #308-C8	**When to Use**	**Submission Requirements/Responses**
0 – Not Specified	OCC 0 is allowed; submit when Beneficiary does not have TPL. Used when No Other Coverage	Claim will reject with a 41 error if Beneficiary record has TPL. Claim should be submitted to the primary payer for payment.
2 – Exists Payment Collected	OCC 2 is accepted. Used when Other Coverage Exists Payment Collected.	Clam will process
3 – Exists Claim Not Covered	OCC 3 is accepted. Used when Other Coverage Billed – Claim Rejected	Claim will process but must be submitted with one of the reject codes listed in the OCC 3-Other Payer Reject Code list.

TPL Codes		
NCPDP Field #308-C8	**When to Use**	**Submission Requirements/Responses**
4 – Exists Payment Not Collected	OCC 4 is accepted. Used when Other Coverage Exists – No Payment Indicated	Claim will process
8 – Claim Billing for a Co-pay	OCC 8 is not accepted. Used when Claim Billing for Patient Financial Responsibility	Claim will reject

OCC 3 Reject Codes

COB claims will deny for Standard TPL when the pharmacy submits an OCC = 3 (Other Coverage Found Claim Not Covered) indicating the Other Payer denied the claim and the Other Payer Reject Code is not found in the below table. These claims will deny with *NCPDP EC 6E – M/I Other Payer Reject Code* with the supplemental message "*Other Payer Reject Code not allowed.*"

Reject Code	Reject Code Description
63	*Institutionalized Patient Product/Service Not Covered*
65	*Patient is Not Covered*
67	*Filled Before Coverage Effective*
69	*Filled After Coverage Terminated*
70	*Product/Service Not Covered*
71	*Prescriber ID is Not Covered*
A5	*Not Covered Under Part D Law*

Electronic Medicaid Eligibility Verification System (e-MEVS)

Providers can verify eligibility and service limits for a Medicaid recipient using the link below:

https://www.lamedicaid.com/account/login.aspx

The following table identifies the fields required for COB.

NCPDP Field Number	NCPDP Field Name	Value
308-C8	Other Coverage Code	0 = Not specified by patient 2= Other coverage exists/payment indicated 3= Other coverage billed - claim rejected 4= Other coverage exists - No payment indicated Required when submitting a claim for recipient who has other coverage.
337-4C	Coordination Of Benefits/Other Payments Count	Maximum count of 9
338-5C	Other Payer Coverage Type	
339-6C	Other Payer Id Qualifier	Required if Other Payer ID (340-7C) is used.
340-7C	Other Payer Id	Required if other insurance information is available for coordination of benefits.
443-E8	Other Payer Date	Required if identification of the Other Payer Date is necessary for claim/encounter adjudication.
341-HB	Other Payer Amount Paid Count	Maximum count of 9 Required if Other Payer Amount Paid Qualifier (342-HC) is used
342-HC	Other Payer Amount Paid Qualifier	07 - Drug Benefit 10 - Percentage Tax Required if Other Payer Amount Paid (431-DV) is used. **Note:** Submit total amount paid by the primary payer with a value of 07 (Drug Benefit) Submit sales tax paid by primary with a value of 10 (Percentage Tax)
431-DV	Other Payer Amount Paid	Required if other payer has approved payment for some/all the billing. Not used for patient financial responsibility, only billing. Not used for non-governmental agency programs if Other Payer-Patient Responsibility Amount (352-NQ) is submitted.