New York State EPIC Prescription Protection for Seniors Provider Bulletin

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SUBJECTS: **Coordination of Benefits – New Claim Edits**
- ✓ **Other Payer Denial Reasons**
- ✓ **Other Coverage Code**
- ✓ **Follow Part D Plan Formulary**

Most EPIC enrollees are also enrolled in a Medicare Part D or other drug plan, which is their primary drug plan. EPIC provides wraparound coverage for seniors with other drug coverage, helping them pay the out-of-pocket costs required by their primary plan. In addition to covering Part D deductibles and co-payments, including the coverage gap, EPIC also helps enrollees pay their monthly Part D premiums. In order to maximize the use of Part D and other primary coverage, the edits noted below will be added to the online EPIC claim system effective for prescriptions dispensed on or after **June 23, 2008**.

Other Payer Denial Reasons

New edit – EPIC will require valid Other Payer Reject Codes (field 472-6E) on all claims billed with an OCC of 3 (other coverage exists, claim not covered)
When EPIC is billed for a claim denied by the primary plan, all valid reject codes on the primary payer response must be included on the claim submitted to EPIC. This is already a required field in the EPIC payer specifications.

Other Coverage Code (OCC)

- ***New edit – EPIC will no longer accept claims with an OCC of 4 or 5***
  Claims covered by another payer, even if no payment was collected (e.g. deductible or coverage gap claims) should be billed with an OCC of 8 rather than an OCC of 4. For claims denied by a managed care plan, an OCC of 3 should be used instead of an OCC of 5. A description of all Other Coverage Codes is provided below.

- ***Reminder – OCC of 1 should only be used after an E1 transaction***
  EPIC denies a claim when Part D coverage exists but was not billed first. If your records show the senior has no other coverage or if the senior insists they do not have Part D coverage, before billing EPIC an eligibility transaction (E1) must be submitted to Medicare to retrieve the most up-to-date information available pertaining to the senior's enrollment in a Part D plan. For technical assistance with this transaction, please contact your software vendor or corporate office.

Follow Part D Plan Formulary

The prescriber needs to be consulted before billing EPIC for drugs not on the Part D plan formulary

When a Medicare Part D or other drug plan denies coverage of a drug, before billing EPIC, pharmacies are expected to consult with the prescriber about changing the prescription to a drug covered by the primary plan. If the prescriber states the drug is necessary and cannot be substituted, or if the prescriber could not be reached before the senior needs their medication, please document the consultation (or attempt) in your records and bill EPIC for the drug.

Other Coverage Codes

Description	OCC	When Used
Not specified	0	This code is used when the participant has no other coverage. However, if EPIC records indicate otherwise, an OCC of 1 will be required to override the EPIC denial edit for other coverage.
No other coverage identified	1	This code is used after an E1 transaction was completed and indicates that the participant does not currently have primary coverage other than NY EPIC
Other coverage exits, payment collected	2	DO NOT USE. Claim will deny. (Use OCC 8)
Other coverage exists, this claim not covered	3	This code is used when a claim is denied by the primary plan (other than for reasons indicated in OCC 6 and OCC 7), and the prescriber is consulted and says the specific drug is medically necessary. The other payer denial information must be included on the claim submitted to NY EPIC.
Other coverage exists, payment not collected	4	DO NOT USE. Claim will deny. (Use OCC 8)
Managed Care Plan Denial	5	DO NOT USE. Claim will deny. (Use OCC 3)
Other coverage denied, not a participating provider	6	This code is used when the primary payer denies a claim because the Provider is Non-Participating.
Other coverage exists, not in effect on date of service	7	This code is used when the primary payer denies a claim because the participant is not enrolled on the date of service submitted. This differs from OCC 1 in that there is or was coverage, but not in effect on that date.
Copay only billing	8	This code is used for any claim that is approved by the primary payer, including claims with no payment – e.g. deductible or coverage gap claims.