

Copay-Only Billing

B U S I N E S S R U L E S

Definition and purpose of copay-only billing

Copay-only claims allow the pharmacy to pass a primary payer's patient pay amount ("copay") to a secondary payer. The claim is assumed to be payable by the primary payer and the majority of the claim cost to have been the responsibility of the primary payer. The patient pay amount submitted on a copay-only claim, or the payable portion of that amount, is reimbursed to the pharmacy. The member, by having coverage through two or more health plans, is exempt from out-of-pocket charges.

Copay-only claim billings must be submitted as outlined in the NCPDP Telecommunication Version 5 Questions, Answers and Editorial Updates document.

Unique identifier for copay-only billing

For copay-only claims, the Claim Segment must include field 308-C8, Other Coverage Code, with a submitted value of '8' (Claim is billing for copay). The Other Coverage Code value of '8' triggers the copay-only processing logic.

The actual patient pay ("copay") dollar amount from the primary payer is submitted in the Pricing Segment, field 480-H9, Other Amount Claimed Submitted.

All mandatory and required fields and values needed for standard claim processing must be submitted on a copay-only billing, along with the following requirements.

- The Pricing Segment must include the primary payer's patient pay amount in the Other Amount Claimed Submitted field.
- The Quantity Dispensed and Days Supply are not expected on a copay-only claim and are ignored if submitted.
- No ingredient cost or dispensing fields are expected on the claim and are ignored if submitted.

Usage of the COB segment in copay-only billing

The COB segment is not submitted for copay-only billing. If the COB segment is submitted with an Other Coverage Code value of '8', the claim denies.

Edits performed on copay-only billing

Argus performs the following edits on a copay-only claim:

- The pharmacy must be eligible and valid for the plan.
- The member must be eligible and valid for the plan.
- The prescriber (if the plan has a prescriber edit in place) must be eligible and valid for the plan.
- The drug must be covered according to the member's plan benefit. If the drug on the copay-only claim is not covered by the member's plan benefits, the claim denies. (The plan has the option of authorizing the claim to override the non-covered drug.)
- Duplicate claim check logic is applied.

Exceptions for copay-only billings

The following processing logic does not apply to copay-only claims:

- The copay-only billing does not apply amounts to deductibles, calculate secondary plan copay/coinsurance amount or member pay difference.
- The claim does not have DUR edits applied, nor does it update the member's DUR record (without quantity submitted, there is not sufficient information to apply DUR).
- Because days supply is not submitted, the normal Refill Too Soon logic does not apply to copay-only claims.
- Denials normally generated when a member's eligibility file record is flagged as secondary coverage only is overridden for copay-only claims.

Maximum payable amounts for copay-only billing

Plans (particularly Medicaid) may wish to apply customer or client level maximum payable amounts. When those amounts are provided, the submitted copay is compared to the plan's allowed maximum payment amount and:

- If the submitted primary payer patient pay amount is greater than the plan allowed maximum, the payment to the pharmacy is reduced to the plan allowed amount.
- If the submitted primary payer patient pay amount is less than the plan allowed maximum amount, the submitted (lesser) amount is paid to the pharmacy.
- If the customer or customer client combination does not have a maximum payable amount indicated, the claim pays as submitted and the entire patient pay amount submitted is paid to the pharmacy.

In all cases, no additional dispense fee or incentives are paid to the pharmacy for a secondary claim submission.