



*Published by the  
N.J. Dept. of Human Services,  
Div. of Medical Assistance & Health Services  
& the N.J. Dept. of Health & Senior Services  
Div. of Senior Benefits and Utilization  
Management*

# Newsletter

Volume No. 19 No. 11

April 2009

**TO:** Providers of Pharmaceutical Services- **For Action**  
Health Maintenance Organizations – **For Information Only**

**SUBJECT:** **Other Insurance Claims**

**EFFECTIVE:** **Claims processed on or after July 1, 2009**

**PURPOSE:** To notify providers of pharmaceutical service of a decision by the Division of Medical Assistance and Health Services (DMAHS) and Department of Health and Senior Services (DHSS) to change secondary payment amounts for other insurance claims.

**BACKGROUND:** When other insurance pays a pharmacy claim, the other insurer is referred to as the “primary payer”. When the State pays a pharmacy claim after that same claim has been adjudicated by a primary payer, the State payment is referred to as a “secondary payment”.

With the exception of Medicare Part D claims, secondary payments for NJ FamilyCare (NJFC)/Medicaid Work First New Jersey (WFNJ)/General Assistance (GA) fee-for-service (FFS) and Pharmaceutical Assistance to the Aged and Disabled (PAAD)/Senior Gold (SG) claims are based on the difference between the primary payment amount and the Medicaid Allowed Amount. For Medicare Part D claims, secondary payments are currently limited to the Patient Paid Amount determined by the primary payer.

The purpose of this newsletter is to notify providers of pharmaceutical services of the limit for NJFC/Medicaid, WFNJ/GA and PAAD/SG program secondary payments for other insurance claims (non-Medicare Part D) which will be the Patient Payment Amount calculated by the primary payer.

**ACTION:** **Effective for claims processed on or after July 1, 2009,** secondary payments for NJFC/Medicaid, WFNJ/GA and PAAD, SG pharmacy claims shall be limited to the lower of the provider’s usual and customary charge; the difference between a primary insurance payment and the Medicaid Allowed Amount; or the Patient Paid Amount determined by the primary insurance payer. DMAHS/DHSS anticipates that the Patient Payment Amount will be the payment amount in most situations. This policy change does not apply to Medicare Part D claims, which are already limited to the Patient Paid Amount.

## **REQUIRED SOFTWARE CHANGES**

- In the NCPDP Pricing Segment, report the **Patient Paid Amount in Field 433DX**.
- In the NCPDP COB/Other Payment Segment, populate the **Other Payer ID Field 340-7C** with the appropriate value (see [www.njmmis.com](http://www.njmmis.com); Forms and Documents; Select “HIPAA” as the Topic).

**Error Code 2096, “Other Carrier Amount Meets or Exceeds Payable”** will deny claim payments when the Other Payer Amount Field, Field 431DV (COB/Other Payment Segment) is greater than ‘zero’ or the Other Coverage Code equals ‘08’ and the Patient Payment Amount (Field 433DX) is equal to ‘zero’.

If you have any questions concerning this Newsletter, please contact Unisys Provider Services at 1-800-776-6334.

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