

Other Coverage Codes (OCC)

Please see the following OCC billing instructions grid outlining the correct use of OCC codes when billing for members enrolled in Vermont’s publicly funded pharmacy programs. **Note that DVHA is no longer accepting OCC 8 (billing for co-pay). Please use OCC2 for claims with a payment from the patient’s primary insurer.**

OCCURRENCE	CORRECT OTHER COVERAGE CODE TO USE	<u>(PCN=VTM)</u> <u>Processing Policy Vermont Coverage Secondary to Alternate Insurance</u>	<u>(PCN= VTD)</u> Processing Policy Vermont Coverage Secondary to Medicare Part B and Part D
The primary insurance plan pays a portion of the claim.	2 = Other coverage exists, payment collected from primary insurance.	<u>Requires Submitted Patient Pay field and COB segment, detailing information on paid claim, including Other Payer ID and Other Payer Paid Amount. Claim will process based on Medicaid allowed amount.</u>	Requires Submitted Patient Pay field and COB segment, detailing information on paid claim, including Other Payer ID and Other Payer Paid Amount – claim will pay based on member cost share from PDP. Limitations: 1) OCC2 does not apply to full-benefit duals except in the event that the PDP makes a payment for a CMS Part D excluded drug (e.g. benzodiazepine). 2) Payment limited to \$6.30 for VPharm 100% LIS members.
The primary insurance rejects the claim.	3 = Other coverage exists, claim rejected by primary insurance.	<u>Only to be used for over-the-counter drugs. Claims submitted with an OCC = 3 will be subject to an edit to determine if drug is OTC; if so, the state will pay claim if all other state criteria is met. State would prefer Other Payer Reject Code, but field is not currently required.</u> <u>For non-OTC drugs: If the primary payer denies a claim because the drug requires a prior authorization or it is a non-formulary drug, then the primary carrier’s prior authorization procedures must be followed.</u>	Claims submitted with an OCC = 3 will be subject to an edit to determine if drug class is Excluded from Part D coverage by CMS or a covered OTC; if so, state will pay claim if all other state criteria is met. If product is not an Excluded Drug from CMS for Part D coverage or a covered OTC, state will reject claim. State would prefer Other Payer Reject Code, but field is not currently required. OCC=3 does not apply to Medicare Part B.

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<p>The primary insurance carrier processes the claim but does not make a payment because:</p> <ul style="list-style-type: none"> a) The member is in the Part D deductible period, b) The member is in the Part B deductible, or c) The payment is less than the patient's copayment 	<p>4 = Other coverage exists, payment not collected from primary.</p>	<p>Requires Submitted Patient Pay field and complete COB segment. Claim will pay based on Medicaid allowed amount.</p> <p>OCC = 4 is not to be used when the primary claim has been denied by the primary insurance plan because the drug requires a prior authorization or it is a non-formulary drug. These claims will be subject to recoupment.</p> <p>OCC = 4 may be used if the total cost of the claim is less than the copayment from the primary insurer, resulting in zero payment from the primary plan.</p>	<p>To be used when member is in deductible period and primary payer is not making payment on claim; requires Submitted Patient Pay field and complete COB segment. Claim will pay based on member cost share from PDP. Also used for Part B deductible.</p> <p>Limitations for OCC4: 1) Does not apply to Part D claims for full-benefit duals, and 2) Payment limited to \$6.30 for VPharm 100% LIS members.</p> <p>OCC = 4 is not to be used when the primary claim has been denied by the Part D Plan because the drug requires a prior authorization or it is a non-formulary or non-covered drug. These claims will be subject to recoupment.</p> <p>OCC = 4 may be used if the total cost of the claim is less than the copayment from the primary insurer, resulting in zero payment from the primary plan.</p>
<p>The primary insurance plan rejects the claim because coverage no longer exists.</p>	<p>7 = Other coverage exists, not in effect on Date of Service (DOS)</p>	<p>To be used if member's other coverage no longer exists; state will process claim.</p>	<p>Claim will reject.</p>