CHAPTER 6: BILLING AND PAYMENT

UNIT 6: COORDINATION OF BENEFITS

IN THIS UNIT

What Is My Service Area?

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**

The **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.

The **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.

The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

6.6 COORDINATION OF BENEFITS OVERVIEW

Introduction

Coordination of benefits (COB) applies when a patient is covered by two or more health insurance policies. Highmark employs several processes to ensure the services provided to our members are paid by the proper insurer and the reimbursement for these services does not exceed the actual charge.

Coordination of benefits defined

Coordination of benefits (COB) is the process of determining which of a member's benefit plans should assume primary, secondary, and tertiary (first, second, and third) financial responsibility for health care services.

COB allows patients to receive up to one hundred (100) percent of the cost of covered services while ensuring that no one collects more than the actual cost of the covered health expenses. When a member is covered by more than one health plan, one plan is determined to be primary and its benefits are applied to the claim first; reimbursement of the remaining balance is considered through the secondary policy, subject to benefit provisions.

Payment sources include Highmark plans as well as other commercial health care plans, automobile/liability insurers, and government programs such as Workers' Compensation and Medicare.

Workers compensation insurance

Workers compensation insurance covers medical treatment for work-related injuries or illnesses.

- Federal and state laws require employers to provide this coverage to their employees.
- Employees are entitled to full coverage for all employment-related health care expenses through their workers compensation insurance.
- Highmark is not liable to pay claims under these circumstances, unless workers' compensation benefits have been exhausted.

Automobile insurance

The following apply to coverage for medical treatment related to automobile accidents:

- Highmark may pay for covered services after the automobile insurance benefits are exhausted.
- The Pennsylvania Motor Vehicle Financial Responsibility Law requires anyone who registers a motor vehicle in the state to provide for specific levels of medical insurance coverage. The law mandates a minimum of $5,000 in medical benefit coverage must be available for each accident victim. The victim's motor vehicle accident insurance is always the primary payer for the treatment of injuries sustained in an automobile accident.

Continued on next page

6.6 COORDINATION OF BENEFITS OVERVIEW, Continued

Automobile insurance (continued)

- The law in Delaware mandates a minimum of $15,000 in Personal Injury Protection (PIP) coverage be available for each accident. PIP coverage is always primary in Delaware.
- Medical benefit coverage on motor vehicle insurance is not mandatory in West Virginia. However, if a member has medical benefits on their automobile policy, that coverage will be primary.

Note: Please be aware that automobile insurance laws can vary by state.

When Highmark is secondary

Highmark coverage is considered secondary in the situations listed below:

If…	Then…
Injuries are received in an automobile accident	Automobile insurance is primary
Injuries are received in a work-related illness or injury	Workers' Compensation Program is primary
Injury or illness occurs when another party is judged to be responsible	Liability insurance is primary

Subrogation

Subrogation is the contractual and equitable right of Highmark to recover any payments paid for health care expenses which were the result of injuries caused by another person or entity.

- Subrogation helps by crediting the member's benefit plan with the recovered monies and controls the cost the customer and his/her employer pay for health care.
- Examples of other party liability include: product liability, property negligence, auto accident caused by another party, or accidental injury on someone else's property.

Network providers must assist in our subrogation efforts by indicating an accident, the accident date, and the diagnosis on the claim.

Authorization requirements still apply

Please be aware that the authorization requirements for any Highmark benefit plan would still apply even if that benefit plan is secondary or tertiary for the services being reported.

Continued on next page

6.6 COORDINATION OF BENEFITS OVERVIEW, Continued

Right of recovery

If Highmark pays more for covered services than the applicable COB provision or that any other provision the member's contract requires, then we have the right to recover the excess from any person or entity to whom or for whom the payment was made. Recovery may be made through deductions and offsets from any pending and subsequent claims. Highmark's right of recovery includes, among other things, periods where a member's premiums were delinquent or the individual was otherwise ineligible for coverage.

6.6 DETERMINING ORDER OF COVERAGE

Introduction

When coordination of benefits is applied, the order of the member's benefit plans must first be determined:

- If the coverage is **primary**, it bears the majority of the financial responsibility for claim costs.
- If the coverage is **secondary**, it may contribute toward any remaining amounts after the primary benefit plan has paid.
- If the coverage is **tertiary**, it may contribute toward any remaining amounts after both the primary and secondary benefit plans have paid what they are liable to pay.

Determining the order of benefit payment requires applying certain standard rules to the member's situation. Most health insurance carriers, including Highmark, use the following rules to decide who is primary.

Member's own benefit plan

Typically, when a member has more than one benefit plan, the plan where the member is enrolled as the employee, or "subscriber," will be primary. A plan on which the individual is covered as a spouse or dependent is not primary, unless it is the only plan available.

Two active coverages

When a person is enrolled in two different plans, the plan that has provided coverage for the longer period of time will be primary.

Active over retiree/laid-off coverage

If a member has coverage as an active employee of one company and is also covered as a retiree or laid-off worker of another company, the benefit plan from his or her active employment is considered primary **in most cases**, while the benefit plan of the other company is considered secondary.

In some cases, however, one of the group contracts may not include this provision. Under these circumstances, the coverage that has been in force the longest is considered primary.

Dependent child

When both parents provide coverage for a dependent child, the plan of the parent whose date of birth (month and day) arrives earlier in the calendar year is the plan that pays first. The year of birth is not relevant. For example, if the mother's birthday is March 10 and the father's birthday is March 20, the mother's plan would pay first. This is known as the" birthday rule."

Continued on next page

6.6 DETERMINING ORDER OF COVERAGE, Continued

Dependent child (continued)

The birthday rule applies only under the following conditions:

- The parents are married; or
- The parents are living together, they are not married to each other or anyone else, and they are not separated from each other; or
- There is a court order for joint custody with no assigned financial responsibility.

If the parents are separated or divorced, then:

- The plan of the parent with whom the child lives pays first.
- The plan of the stepparent with whom the child lives pays second.
- The plan of the parent without custody pays third.
- A court order can establish a different order*

** When such a decree exists, it is documented in the parent's membership file. This information is not available in NaviNet® Eligibility and Benefits. Providers must call the Provider Service Center to check for this information.*

Quick Reference

6.6 COB PAYMENT METHODOLOGIES

When Highmark is primary

When Highmark is the primary coverage, the services are considered as though no other coverage is available. A health care professional who participates in our networks agrees to accept the program allowance as payment in full. The only amounts billable to the secondary insurance are for coinsurances, deductibles, amounts exceeding a maximum, and those charges denied as non-covered.

When Highmark is not primary

When not the primary payer, Highmark uses several methodologies when processing claims. These COB payment methodologies include:

- National Association of Insurance Commissioners (NAIC) Model
- Regular COB
- Hard non-duplication
- Soft non-duplication I
- Soft non-duplication II
- Regular Medicare COB
- Customized COB

NAIC Model COB Regulation

Highmark has adopted the National Association of Insurance Commissioners (NAIC) Model COB Regulation. This regulation is the most common methodology used for calculating a secondary payment in COB situations. This model applies to all commercial group products. While the majority of commercial business has been moved to the NAIC model, certain national accounts and larger regional accounts have the option to not participate in this methodology.

The NAIC model COB regulation applies to institutional claims, professional claims, and ancillary claims. It applies to all health care professionals and providers regardless of their participating status with Highmark. The Blue Cross Blue Shield Association supports the NAIC model COB regulation. This is a common industry standard and is consistent with most insurers.

Note: Highmark's senior products, Medicare Advantage products, direct pay products, and the Federal Employee Program (FEP) do not use the NAIC Model.

What Is My Service Area?

Pennsylvania NAIC Model

PA ONLY

With the Pennsylvania NAIC model, Highmark first determines the amount it would have paid as primary. As a secondary payer, Highmark will never pay more than it would have paid as primary. If the primary "Other Insurance" carrier has paid more than or equal to the original Highmark payment, no additional payment will be made.

Continued on next page

6.6 COB PAYMENT METHODOLOGIES, Continued

Pennsylvania NAIC Model (continued)

The Other Insurance primary payment is deducted from the original Highmark payment. This amount is then compared to the Other Insurance member liability. The lesser of the two amounts is paid at 100 percent reimbursement. The member always receives credit for the original Highmark deductible and coinsurance expenses.

With this method, when Medicare is primary, regular Medicare coordination of benefits would be applied.

What Is My Service Area?

Delaware and West Virginia NAIC Model

With the Delaware and West Virginia NAIC model, Highmark first determines the amount it would have paid as primary. As a secondary payer, Highmark will never pay more than it would have paid as primary.

Highmark compares their primary benefit to the "Other Insurance" member liability. Highmark will pay the member liability up to, but not more than, what the Highmark primary payment would have been.

Highmark will follow Delaware and West Virginia State regulations, unless an ASO groups requests something different.

Regular COB Model defined

With the Regular COB model, Highmark first determines the amount it would have paid as primary. As a secondary payer, Highmark will never pay more than it would have paid as primary.

Highmark compares their original allowance to the primary "Other Insurance" member liability. The lesser of the two amounts is considered for payment. Highmark will apply the member's group benefits, such as co-payments, coinsurance and deductibles, to any balances after the coordination of benefit methodology is applied.

With this method, when Medicare is primary, regular Medicare coordination of benefits would be applied.

Hard Non - Duplication COB Model

With the Hard Non-duplication COB model, Highmark first determines the amount it would have paid as primary. As a secondary payer, Highmark will never pay more than it would have paid as primary. If the primary "Other Insurance" carrier has paid more than or equal to the original Highmark payment, or there is no primary Other Insurance member liability, no additional payment will be made.

Continued on next page

6.6 COB PAYMENT METHODOLOGIES, Continued

Hard Non - Duplication COB Model (continued)

The Other Insurance primary payment is deducted from the original Highmark payment. This amount is then compared to the Other Insurance member liability. The lesser of the two amounts is paid at 100 percent reimbursement. The member always receives credit for the original Highmark deductible and coinsurance expenses.

With this method, when Medicare is primary, Medicare Hard Non-Duplication coordination of benefits would be applied. Highmark first determines the amount it would have paid as primary using the Medicare allowance. From here, the calculations remain the same as in the Hard Non-Duplication definition.

Note: This pertains to Blue on Blue or Blue on Commercial ONLY.

Soft Non - Duplication I COB Model

With the Soft Non-duplication I COB model, Highmark first determines the amount it would have paid as primary. As a secondary payer, Highmark will never pay more than it would have paid as primary. If the primary "Other Insurance" carrier has paid more than the original Highmark allowance, no additional payment will be made.

The Other Insurance primary payment is deducted from the original Highmark allowance. This amount is then compared to the Other Insurance member liability. The lesser of the two amounts is considered for payment. Highmark will apply their group benefits, such as co-payments, coinsurance and deductibles, to any balances after the coordination of benefit methodology is applied.

With this method, when Medicare is primary, regular Medicare coordination of benefits would be applied.

Note: This pertains to Blue on Blue or Blue on Commercial ONLY.

Soft Non - Duplication II COB Model

With the Soft Non-duplication II model, Highmark first determines the amount it would have paid as primary. As a secondary payer, Highmark will never pay more than it would have paid as primary. If the primary "Other Insurance" carrier has paid more than the original Highmark allowance, no additional payment will be made.

The Other Insurance primary payment is deducted from the original Highmark allowance. This amount is then compared to the original Highmark payment. The lesser of the two amounts is paid at 100 percent reimbursement, not to exceed the primary Other Insurance member liability. If the lesser of the two amounts is

Continued on next page

6.6 COB PAYMENT METHODOLOGIES, Continued

Soft Non - Duplication II COB Model (continued)

greater than the Other Insurance member liability, Highmark will pay the Other Insurance member liability at 100 percent reimbursement after any copayments are applied. The member always receives credit for the original Highmark deductible and coinsurance expenses. With this method, when Medicare is primary, regular Medicare coordination of benefits would be applied.

Note: This pertains to Blue on Blue or Blue on Commercial ONLY.

Regular Medicare COB Model

For Medicare participating providers or providers who are obligated to accept Medicare Assignment (MOM Legislation), when Medicare is primary, Highmark will coordinate benefits up to the Medicare allowance. Highmark will apply their group benefits, such as co-payments, coinsurance and deductibles, to any balances after the coordination of benefit methodology is applied.

Customized COB Model

Self-funded ("ASO") accounts may choose from any COB method option. Certain ASO Accounts may also be permitted to customize calculation methodologies. Custom COBs are methods considered to be outside of Highmark's regular COB method option.

COB Calculation Tip Sheet

TIP SHEET

In order to understand the different COB models outlined in this unit, click on the Tips Sheet icon to the left for a document that provides examples of the following types of COB calculations:

- **COB Calculation Example #1:** An example COB calculation that illustrates an insurance payment that is **greater** than what Highmark would have paid if Highmark was primary.
- **COB Calculation Example #2:** An example COB calculation that illustrates an insurance payment that is **less** than what Highmark would have paid if Highmark was primary.

Blue on Blue

In many cases, duplicate coverage occurs when both the primary coverage and the secondary coverage are provided through Highmark. In most "Blue on Blue" cases, the paid-in-full regulations do apply for health care professionals who participate with Highmark networks.

6.6 COB CLAIM SUBMISSION

Overview

When submitting COB claims to Highmark when it is the secondary payer, please include all relative information from the primary insurer, including member liability (e.g., copayment, coinsurance, and deductible).

When Highmark processes a COB claim as the secondary payer, your Explanation of Benefits (EOB) may or may not show the amount the primary insurer paid. The EOB will also show the member's liability. A network provider cannot balance bill the member when Highmark made payment as secondary payer except for any copayment, coinsurance, deductible, or non-covered service under the secondary policy.

How can providers assist with the process?

Health care providers can assist in the COB process by following these guidelines:

- When you file a COB claim, submit the claim to the primary carrier first.
- When Highmark is the secondary coverage, you must submit information about the primary insurer's claim payment and/or the denial of the claim to Highmark.
- When filing claims electronically, the nationally accepted electronic submission formats accommodate secondary claims submission.
- If you submit paper claim forms, you must also send us a copy of the other plan's Explanation of Benefits payment information.
- If both insurance companies make payments on a claim and the combined payments exceed your charge, notify Highmark Provider Services. Provider Services will investigate and advise if a refund is required.

Quick Reference

6.6 DUPLICATE PAYMENTS

When a duplicate payment is received

If you received a duplicate payment for a service, please follow these guidelines:

PENNSYLVANIA:	
Send refund checks for overpayments to:	Highmark Attn: Cashier P.O. Box 898820 Camp Hill, PA 17089-0150
To request a formal refund request for an offset...	Please call your regional Provider Service Center to initiate an offset.
DELAWARE:	
Send refund checks for overpayments to:	Highmark Blue Cross Blue Shield Delaware Attention: Treasury P.O. Box 1991 Wilmington, DE 19899-1991
To request a formal refund request for an offset...	Please contact Highmark Delaware's Provider Service Department.
WEST VIRGINIA:	
If you receive duplicate payment in a subrogation case, please send a written notice of duplicate payment to:	Highmark Blue Cross Blue Shield West Virginia Attention: Third Party Recoveries Department P.O. Box 1948 Parkersburg, WV 26102 **Fax** to: **304-424-0320**

Quick Reference

Member inquiries

If a member seeks advice on a duplicate payment, advise members to call the Highmark member service telephone number on the back of their identification cards for direction for their specific situation.

6.6 MEDICARE BENEFICIARIES

Introduction

When a member has Medicare and other insurance, there are certain rules that decide whether Medicare or the other insurance pays first.

Retiree coverage

Medicare is typically primary for retirees and their spouses since their coverage is not on the basis of current active employment. An employer group retiree health plan with Highmark would be the secondary coverage for the retiree and spouse.

Medicare is secondary payer for the working aged

The Tax Equity and Fiscal Responsibility Act (TEFRA) requires that employers of 20 or more people offer their working-aged employees and their spouses aged 65 and over the same employee group health plan offered to other employees.

Under the TEFRA law and subsequent legislation, the employee group health plan is the primary payer and Medicare is the secondary payer of claims for working-aged employees in employer group health plans with 20 or more full-time and/or part-time employees. This applies when a single employer with 20 or more employees (as determined by the IRS) sponsors or contributes to the employee group health plan; or multiple employers sponsor or contribute to the employee group health plan and at least one of them has 20 or more employees.

Please contact Highmark Provider Services to determine whether TEFRA applies.

Quick Reference

Active, retiree/laid-off, & Medicare coverage

If a member has coverage as an active employee of one company, coverage as a retiree or laid-off worker of another company, **and** Medicare coverage, either of the following scenarios could occur:

- If TEFRA applies, the active coverage is primary; Medicare is secondary; and the retiree coverage is tertiary.
- If TEFRA does not apply, Medicare is primary; the active coverage is secondary; and the retiree coverage is tertiary.

In the case of a husband and wife, it is possible that one may be actively employed while the other is retired, and one or both may also have Medicare coverage, in such a case, either of these scenarios could occur:

- If TEFRA applies, the active coverage is primary for both the husband and wife; Medicare is secondary; and the retiree/laid-off coverage is tertiary.
- If TEFRA does not apply, Medicare is primary for both the husband and the wife; the active coverage is secondary; and the retiree/laid-off coverage is tertiary.

If Medicare is not involved in this scenario, the husband and wife would each be primary under his or her own insurance.

Continued on next page

6.6 MEDICARE BENEFICIARIES, Continued

Medicare and persons with disabilities

The Omnibus Budget Reconciliation Act of 1993 (OBRA-93) is a federal law that enabled the government to raise additional revenues to help reduce the deficit and balance the federal budget. One of the provisions of OBRA-93 made Medicare the secondary payer for people who meet all of the following criteria:

1. Are under age 65;
2. Have Medicare coverage because of a disability other than permanent kidney failure; and
3. Are covered by a large group health plan (100 or more employees).

Those who can receive secondary Medicare coverage due to disability include:

- Disabled members who are covered by a large group health plan
- Disabled members who are the spouse of a person covered by a large group health plan
- Disabled child members with at least one parent covered by a large group health plan

End-stage renal disease (ESRD)

Under certain circumstances, Medicare benefits are available to persons under the age of 65 who have end-stage renal disease (ESRD). For members who have coverage under an employee group health plan, Medicare and the group plan have specific, time-dependent roles in paying for care related to ESRD. The table below outlines this coverage process:

If…	Then…
It is within the first three months after the Medicare application has been made...	Only the employee group health plan coverage will be available.
The application for Medicare has been finalized, and the coordination period begins...	The employee group health plan is primary; Medicare is secondary.
The coordination period ends...	Medicare is primary; the employee group health plan is secondary.
Member is no longer ESRD for 12 consecutive months; ***or***, the member is 36 months after a successful kidney transplant...	Medicare benefits end; only the employee group health plan will be available.

The waiting period is waived for ESRD members who undergo a kidney transplant within the first three months after applying for Medicare benefits. The same waiver is provided for members who participate in a course of self-dialysis training during the initial three-month period.

When a member's entitlement has ended and another course of dialysis and/or kidney transplant is needed, a new waiting period is <u>not required</u>.

Continued on next page

6.6 MEDICARE BENEFICIARIES, Continued

End-stage renal disease (ESRD) (continued)

Medicare will be the secondary payer for persons with ESRD who fall into one of the following categories:

- Members who are also covered under an employee group health plan
- Members who are the spouse of a person covered by a group health plan
- Child members with at least one parent covered by an employee group health plan

Who is primary?

The following table describes who is considered primary when a Medicare beneficiary also has group health coverage:

If…	Then…
The beneficiary has retiree insurance...	Medicare pays first.
The beneficiary is 65 or older, has group health plan coverage based on their own or their spouse's current employer, and the employer has **20 or more employees**...	The group health plan pays first.
The beneficiary is 65 or older, has group health plan coverage based on their own or their spouse's current employer, and the employer has **less than 20 employees**...	Medicare pays first.
The beneficiary is under 65 and disabled, has group health plan coverage based on their own or a family member's current employer, and the employer has **100 or more employees**...	The group health plan pays first.
The beneficiary is under 65 and disabled, has group health plan coverage based on their own or a family member's current employer, and the employer has **less than 100 employees...**	Medicare pays first.
The beneficiary has Medicare because of end-stage renal disease (ESRD)...	The group health plan will pay first for the first 30-month period after the beneficiary becomes eligible to enroll in Medicare. Medicare will then pay first after the initial 30-month period.

Note: In some cases, the employer may join with other employers or unions to forma multiple employer plan. If this happens only one of the employers or unions in the multiple employer plan is required to have the number of employees for a group health plan to pay first.

Continued on next page

6.6 MEDICARE BENEFICIARIES, Continued

Group coverage doesn't exist	If the employer group provides no coverage for particular services that are deemed to be medically appropriate (e.g., kidney transplant), then Medicare may pay for those services as the primary payer. This assumes that the medically appropriate service is covered under the Medicare program.

6.6 MEDICARE CROSSOVER

Overview

The Centers for Medicare & Medicaid Services (CMS) consolidated its claim crossover process under a special Coordination of Benefits Contractor (COBC) by means of the Coordination of Benefits Agreement. Under this program, the COBC automatically forwards Medicare claims to the secondary payer, eliminating the need to separately bill the secondary payer.

Crossover process

Blue Plans implemented the Medicare crossover consolidation process system-wide. This process provides an increased level of one-step billing for your Medicare primary claims, streamlines your claim submissions, and reduces your administrative costs.

The claims you submit to the Medicare carrier cross over to the Blue Plan only after the Medicare carrier or intermediary has processed them. The Medicare carrier or intermediary automatically advises the Blue Plan of Medicare's approved amount and payment for the billed services. Then, the Blue Plan determines its liability and makes payment to the provider. This one-step process means that you do not need to submit a separate claim and copy of the Explanation of Medicare Benefits (EOMB) statement to the Blue Plan after you receive the Medicare carrier's or intermediary's payment.

Some providers submit paper claims and EOMB statements for secondary payment unnecessarily. Sending a paper claim and EOMB statement for secondary payment, or having your billing agency resubmit automatically, does not speed up the reimbursement of secondary payments. Instead, this costs you money and creates confusion for members. It also increases the volume of claims handled by the secondary payer and can slow down all claims processing and delay payments.

Whether you submit electronic or paper claims, it is no longer necessary to send a separate claim and EOMB statement for the purpose of obtaining payment on a secondary claim.

If you have not yet received secondary payment from Highmark

Please allow at least thirty (30) days for the secondary claim to process. If you have not received notification of the processing of the secondary payment, please do not automatically submit another claim. Rather, you should check the claim status before resubmitting. To further streamline the claim submission process to save your practice time and money, consider revising the time frame for the automated resubmission cycle of your system to accommodate the processing times of these secondary claims.