

Section 8

Coordination of Benefits

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Section 8

Coordination of Benefits Processing

I. Introduction

Coordination of benefits (COB) is an activity that is performed in accordance with CDPHP contracts. The intent of this publication is to promote a better understanding of the entire process as it relates to your claims and CDPHP.

COB is a body of information that needs to be laid out in an understandable pattern. As the following steps begin to explore how COB is calculated by CDPHP, it should be understood that not every possible situation encountered within the COB arena can be explained here. Instead, the most frequent concerns will be addressed through the definition of key terms, the understanding of which carrier is really primary and an exploration of how a COB claim is ideally processed by CDPHP. **(Special Note: Whenever CDPHP is involved, the provider is only entitled to the copayment or other member liability at the time the services are rendered. If CDPHP is secondary, the provider must wait for the explanation of benefits (EOB) from the primary carrier first before billing CDPHP.)**

II. Definitions

COORDINATION OF BENEFITS:

Coordination of benefits is an activity undertaken by insurance carriers that is intended to **coordinate** actions between carriers to ensure that **benefits** are paid to the fullest extent possible, while at the same time minimizing duplication of payment.

PLAN:

A plan is the type of coverage with which coordination activities are allowed. Plan may include all group health insurance coverage (such as Metropolitan, Blue Cross and Blue Shield, No-fault, Workers' Compensation, and Medicare coverage). Plan may not include individual or family direct payment contracts, blanket school accident coverage or similar policies, or Medicaid.

PRIMARY PLAN:

The primary plan is one whose benefits must be determined first without taking the existence of any other plan into consideration.

SECONDARY PLAN:

The benefits of a secondary plan take into consideration the payment of the primary plan when determining its responsibility for coverage and payment.

When billing CDPHP as the secondary payer, submit a **duplicate claim with the total amount billed** (just as if CDPHP were the only insurance company) with the primary carrier's explanation of benefits (EOB) attached. Claims for members with Medicare as their primary insurance will automatically "crossover" from Medicare directly to CDPHP. The Medicare EOB will indicate that the claim was sent to CDPHP.

ALLOWABLE EXPENSE:

An allowable expense is the necessary, reasonable, and customary item of expense for health services when the item of expense is covered, at least in part, under any primary or secondary plan involved.

EXPLANATION OF BENEFITS:

An explanation of benefits or EOB is a description of the benefits covered by a specific insurance carrier after a claim has been filed. This form will normally outline the type of service rendered, the date of service, the physician's billed amount, the amount "recognized" by the other carrier, the amount applied toward deductible/coinsurance, the amount that is considered a non-covered service, and the amount paid by the carrier. A "complete" EOB provides all of this information, including the member's name and the primary payer's adjudication date for filing limit purposes.

III. Order of Benefits Determinations

When insurance carriers need to establish who is the primary and secondary plan for a particular situation the rules outlined by COB regulations will be followed. Within the industry, these rules are referred to as the order of benefit determination. They are outlined below.

1. The plan that does not adhere to New York State Insurance Department regulations or does not contain a COB clause within its contract always is considered primary.
2. The plan that covers the person as an employee or subscriber is **primary** before that of a plan that covers the person as a dependent.

Example: If the husband has a Blue Cross policy through his employer and lists the wife as a dependent but the wife has a CDPHP policy through her employer, Blue Cross always will be the primary insurance for the husband and CDPHP always will be primary for the wife.

3. For dependent children: If both parents list the child as a dependent on their insurance coverage, the plan of the parent whose birthday falls earlier in a calendar year is considered primary. The earlier birthday is determined by using only the month and day of birth.

Example: The father was born on April 16 and the mother was born on April 4. In this case, the mother's insurance plan would be considered primary for the listed dependent children, as her birthday falls earlier in the calendar year.

4. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child or children are determined in this order. In such cases where a court decree does not indicate financial responsibility from a parent or guardian for covered medical expenses, but does indicate joint custody, then the order of primary determination is based on the birthday rule.
 - a. First, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan or that parent has actual knowledge of those terms, the benefits of that plan are determined first;
 - b. Then, the plan of the parent with custody of the child (if dependent is eligible for coverage);
 - c. Then the plan of the spouse of the parent with custody of the child (if dependent is eligible for coverage);
 - d. Finally, the plan of the parent not having custody of the child.
5. The plan that covers a person who is neither laid off nor retired (employee or dependent of an active employee) is considered primary if none of the previous four rules applies.
6. If none of the above rules applies, then the plan that has been in effect the longest is considered primary.

The above order of benefit determination rules work well except in the cases where Medicare coverage may be involved. In the 1980s, Medicare established itself as a secondary payer to any existing full coverage employer group health plans (EGHP) whenever possible. Although certain circumstances such as employer group size, employee disability or end-stage renal disease may influence the following two statements, these **guidelines** should be used to initially decide whether Medicare is the potential primary plan for a particular person.

1. If a person is 65 years of age and older or entitled to Medicare due to disability **AND** is retired from active employment, Medicare will be the **primary** plan.
2. If a person is 65 years of age or older and is a) actively employed **OR**, b) is listed as a dependent of an actively employed person, and group size is 20 or more, Medicare will be the **secondary** plan. If the group size is 19 or less, Medicare is primary.
3. If a person has Medicare due to disability and is a) actively employed **OR**, b) is listed as a dependent of an actively employed person, and group size is 100 or more, Medicare will be the secondary plan. If the group size is 99 or less, Medicare is primary.

If there is confusion about whether Medicare is the primary or secondary plan for a particular person, CDPHP should be contacted so that it may use its resources to assist in clarifying the issue.

IV. COB and Claims Processing

The purpose of COB activities is to avoid paying twice for claims. CDPHP makes every attempt to gather information about members and the other health insurance coverage they may have available. Such data is collected from subscriber enrollment forms, provider claim forms, COB member questionnaires, member phone calls, other insurance company inquiries, and CDPHP provider phone calls.

The actual route followed by a potential COB claim through the CDPHP claims processing flow is dependent upon when information regarding the other insurance company becomes known to CDPHP.

1. The claim is reviewed by the claims examiner to ensure its completeness.
2. The claim is forwarded to data entry to be entered into the system.
3. **A. If the EOB is attached to the claim:**
 - a. The claim is systematically flagged and queued to one of the claims operations adjudicators.
 - b. Once the plan imposed edits are satisfied, the benefits are coordinated based on the member's line of business, and the claim is released to appear on the next available payment run.
 - c. If there is no indication of a COB record on file, the COB information is forwarded to the COB department for investigation and system update.
- B. If there is no EOB but there is active record:**
 - a. If Medicare or commercial carrier active COB record—Claims will deny “RPC” automatically for Medicare, commercial carrier, Select Plan, or Family Health Plus contracts. “RPC” = See secure provider site for other primary insurance carrier information.
 - b. If there is an active record for No-Fault, Workers’ Compensation, dual CDPHP coverage, or student coverage, claims will pend automatically until the claim is reviewed. Once reviewed, claim will either appropriately deny or pay.
4. The payment voucher is produced and sent to the provider. Claim may be left pending during an investigation.
 - a. Claim may deny if member does not respond to our inquiry for No-Fault, Worker’s Compensation, or Medicare coverage after a 45-day tracking period.
 - b. Claim will not deny if member does not respond to our inquiry within the 45-day tracking period if the other carrier is a commercial carrier. CDPHP will assume primary payment and continue to pursue the other commercial coverage.
 - c. If CDPHP has paid primary and evidence of other commercial coverage is confirmed retroactively, a letter is sent to the provider as notification that the other commercial carrier is primary. This will be tracked for 120 days before an adjustment is performed. If, after 120 days, no record of resubmission is received from the provider regarding the other commercial carrier EOB, CDPHP will perform an adjustment and take back their primary payment.
 - d. If CDPHP has paid primary and evidence of other coverage for No-Fault, Workers’ Compensation, or Medicare is confirmed retroactively, an immediate adjustment will be performed to take back primary payment made by CDPHP.

V. Hospital Payment Formulas

The amount owed on a claim by CDPHP is determined using the definition of allowable expense and the information that is contained on an EOB. **Note: OIC is an abbreviation for “Other Insurance Carrier.”**

It should be remembered that hospitals have the responsibility to collect any appropriate CDPHP copayments or deductibles directly from a member in a COB situation. Regardless of CDPHP being primary or secondary, any applicable copayments or deductibles will always be applied to payment calculations.

VI. Summary

Coordination of benefits (COB) is an activity undertaken by CDPHP and its providers to ensure that all insurance carriers are held to the appropriate level of payment responsibility and that the patient receives the highest level of health care benefits available. The ability of any one entity to accomplish this task is dependent upon the sharing of information between insurance companies, patients, and providers of health care. If any link fails to provide timely notice of pertinent information, then the entire process slows down.

Within the CDPHP processing of COB, the other insurance carrier’s EOB becomes the cornerstone. If CDPHP does not know what was paid or not paid by the primary carrier, benefits for which CDPHP is responsible may not be reimbursed at the appropriate level. And, since EOBs and/or other insurance information are critical to payment calculations they must be included with each claim form that is submitted by any provider. Attach the primary carrier’s EOB to the CMS 1500 or UB04 claim form and submit to CDPHP **within filing limits from the date of the primary EOB**, or the claim will be denied. CDPHP may recoup monies paid to the provider as the primary carrier when it is determined that another entity has/had the primary responsibility.

Although not all questions are answered or situations discussed within this document, it is hoped that this overview will assist everyone in their understanding of what happens within CDPHP during the processing of a COB claim. Each participating provider is still encouraged to call CDPHP with any specific questions he/she may have regarding a particular claim.

Coordination of Benefits Calculations

What is COB Credit Banking?

When a member is covered by more than one group health plan, a “savings bank” can be established using the amount saved by the secondary payer (CDPHP). The amount that is recorded as savings is stored in a “savings bank” in our system. It can then be used for payment of outstanding balances that may otherwise not be fully covered under the primary, or that may be excluded under the secondary payer. A counter record is created when the credit bank is activated for a member and the processed service results in the calculation of savings or a reimbursement of savings for that member.

For example:

A claim was processed and allowed by the primary carrier (NOT CDPHP). The claim comes to CDPHP for consideration. This claim would not be allowed by CDPHP. If the EX code placed on the claim has been specified to invoke the credit bank, and there is a balance in the member’s bank (created by savings from previous claims), the claim will be paid using credit bank funds.

Why do we need to calculate COB using this methodology?

There are two reasons for using this methodology. First, the CDPHP HMO contract (Section X, A) refers to this method for COB calculation. There is also a New York State Department of Insurance COB regulation defining that a secondary payer is required to pay up to the total “allowable expenses” of a claim, so long as the expense is covered, at least in part, by any of the primary plans involved.

Tracking COB

CDPHP will track the total savings and the total allowable expenses as compared to total benefits payable in the absence of COB on a calendar year basis. There will be no carryover for COB savings from one year to the next. Once the total expenses for the calendar year equal the total amount in the member’s “savings bank,” CDPHP is not obligated to pay as secondary payer any claims that are not covered by the contract.

Invoking the COB Credit Bank

The COB Credit Bank will be invoked based on the EX codes placed on the claim during adjudication. Specific EX codes have been flagged with “CBANK” keywords in the code set. When one of these EX codes is used to deny a claim, if there are funds in the member’s credit bank, the claim will be paid using those funds. When the credit bank is invoked and services are paid using funds from the COB “savings bank,” there will be no risk withhold, copayment, or coinsurance deducted from the payment. Also, no further savings are accumulated into the bank on a credit bank claim.

Lines of business involved:

This method of COB calculation will involve the HMO Commercial and the CDPHP UBI (Article 43) lines of business. The CDPHN groups are not involved at the present time.