# Chapter 6

## **Policies and Procedures**

# **Unit 1: Other Party Liability**

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#### 6.1 Coordination of Benefits

#### Overview

Highmark Blue Shield employs several processes to ensure the services provided to its members are paid by the proper insurer and the reimbursement for these services does not exceed the actual charge.

#### Definition – Coordination of Benefits

**Coordination Of Benefits** allows patients to receive up to 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 care 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.

#### Definition --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 Blue Shield is not liable to pay claims under these circumstances unless Worker's Compensation benefits have been exhausted.

# **Definition -- 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 members 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.



### 6.1 Coordination of Benefits, Continued

Definition – The Motor Vehicle Financial Responsibility Law The Motor Vehicle Financial Responsibility Law requires anyone who registers a motor vehicle in Pennsylvania 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.
- Highmark Blue Shield may pay for covered services after the automobile insurance benefits are exhausted.

Crossover Consolidation Process Automatically Submits Medicare Claims To Secondary Payer 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 COBS automatically forwards Medicare claims to the secondary payer, eliminating the need to separately bill the secondary payer.

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 crossover 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 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 claim processing, thereby delaying payments.



## 6.1 Coordination of Benefits, Continued

Crossover
Consolidation
Process
Automatically
Submits
Medicare
Claims To
Secondary
Payer,
continued

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.

Please allow at least 30 days for the secondary claim to process. If you haven't 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.



## 6.1 Frequently Asked Questions about COB

# When Does COB Apply?

When a patient is covered by two or more health insurance policies.

# Why Does COB Apply?

COB allows patients to receive up to 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 care 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.

# Who Pays First?

Most health insurance carriers, including Highmark Blue Shield, use the following rules to decide who is primary:

- 1. Typically, the plan where the patient is enrolled as the applicant (or employee) will pay first. The other plan, perhaps through a spouse, will provide secondary coverage.
- 2. 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. 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" and applies only when:

- 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.



## 6.1 Frequently Asked Questions about COB, Continued

# Who Pays First?, continued

3. When a person is enrolled in two different plans, the plan that has provided coverage for the longer period of time, will pay first. If that person is covered through an active employment plan and also through a retiree or laid off employee plan, the active employment plan pays first.

#### How Much Does Highmark Blue Shield Consider Primary?

When Highmark Blue Shield 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.

#### How Much Does Highmark Blue Shield Consider Secondary?

Highmark Blue Shield 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. Highmark Blue Shield's senior products, Medicare Advantage product, direct pay products and the Federal Employee Program are not included. While the majority of commercial business has been moved to the NAIC model, certain national accounts and larger regional accounts will had the option to not participate in this change.

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 Blue Shield. The Blue Cross Blue Shield Association supports the NAIC model COB regulation. This is a common industry standard and is consistent with most insurers.

Under the NAIC model COB regulation, Highmark Blue Shield's payment as secondary will be based on the difference between what the other insurer paid and what Highmark Blue Shield would have paid as primary. If the primary payment is less, Highmark Blue Shield will pay the difference.



## 6.1 Frequently Asked Questions about COB, Continued

How Much Does Highmark Blue Shield Consider Secondary? (continued) If the primary payment is greater or equal to the original approved amount, no additional payment will be made. In no case will Highmark Blue Shield, as secondary, pay more than it would have paid if it were primary. Below is an example of the NAIC model COB regulation:

Example	Charge	Blue Shield's Allowance	Primary Carrier's Payment	Blue Shield's Payment	Amount Provider Receives
1	\$100	\$50	\$60	-0-	\$60
2	\$100	\$50	\$20	\$30	\$50

Reminders For Submitting COB Claims:

When submitting COB claims to Highmark Blue Shield when it is the secondary payer, please include all relative information from the primary insurer, including member liability, for example, copayment, coinsurance, and deductible.

When Highmark Blue Shield 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 Blue Shield made payment as secondary payer except for any copayment, coinsurance, deductible or non-covered service under the secondary policy.

What Is Blue On Blue?

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



## 6.1 Frequently Asked Questions about COB, Continued

How Can Health Care Professionals Assist With The Process?

- When you file COB claims, submit the claims to the primary carrier first.
- When Highmark Blue Shield is the secondary coverage, you must submit information about the primary insurers' claim payment or denial with the claim to Highmark Blue Shield.
- 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 Blue Shield's or Blue Cross of Northeastern's Customer Service department at the phone numbers listed below. The Customer Service Department will investigate and advise if a refund is requested.

  What Region Am 1?

Central and Eastern PA Regions 1-866-731-8080

Northeastern PA Region
Blue Cross of Northeastern PA

BlueCare Traditional: 1-800-827-7117 BlueCare PPO: 1-866-262-5635

**Western PA Region** 1-866-763-3224, Option 1

