BlueCross BlueShield of Illinois

Blue Cross and Blue Shield of Illinois Provider Manual

HMO Coordination of Benefits Section

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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Introduction

When a member is covered under two or more group health insurance plans, the insurance carriers coordinate the claim payment process to insure benefits are not provided in excess of 100%. An example would be if a husband and wife had separate health insurance policies, the husband has a family policy with the HMO and the wife also has a family policy but with Blue Cross/Blue Shield or another commercial carrier. Each family member is covered by more than one group policy and it would be necessary to coordinate benefits.

Coordination of Benefits (COB) is generally not done with the following policy types:

- Medicaid (public aid)
- Champus
- Individual or Direct Pay policy (that have no COB provision)
- Automobile, Home or Property Owners policies
- Lodge policies such as Elks, Moose, Knights of Columbus, etc.
- Some student policies (some contain COB provisions, some do not)

Definitions

1. “This Plan” refers to Blue Cross Blue Shield of Illinois HMOs. If “This Plan” is the Primary Carrier for a member, then “This Plan” will provide its services and benefits in full regardless of the benefits available to the member from any “Other Plan”.

2. "Other Plan" refers to any Plan providing benefits or services for inpatient hospital or outpatient medical care. If “This Plan” is Secondary Carrier for a member, then “This Plan” will provide its benefits only after the Primary Carrier has paid for covered benefits. This is if all pertinent rules of the HMO were followed (e.g., services were performed or referred by the Primary Care Physician). The HMO will need a copy of the Primary Carrier’s Explanation of Benefits (EOB) in order to process all claims.

3. "Primary Carrier" refers to a Plan which, according to the "Order of Benefit Determination" provisions of Part B below, has primary responsibility of benefits.

4. "Secondary Carrier" refers to a Plan which, according to the "Order of Benefit Determination" provisions of Part B below, has secondary responsibility for the provision of benefits after the primary carrier determines its benefits.

Order of Benefit Determination

If the Other Plan does not provide for the coordination of its benefits with the benefits of This Plan, the Other Plan will always have primary responsibility for the provision of benefits before This Plan. Otherwise, the rules for establishing the order of benefit determination are:

1. A Plan which covers the Member other than as a Dependent shall have primary responsibility for the provision of benefits before a Plan which covers the Member as a Dependent.

2. When two Plans, from employer groups of 10 or more employees, cover the Member as a Dependent, the birthday rule applies:

    a) The policy of the Subscriber whose birth date (month/day) occurs earliest in the calendar year, will be primary.
    b) If both Subscribers have the same birth date, the Plan covering a Subscriber for the longer time is primary for the Member as Dependent.

3. When two Plans, from employer groups of less than 10 employees, cover the Member as a Dependent, the Plan which covers the Member as a Dependent of a male policyholder shall have primary responsibility over the Plan which covers the Member as a Dependent of a female policyholder. This is known as the gender rule.

4. When two Plans cover the Member as a Dependent, if one Plan has the birthday rule and the Other Plan has the gender rule, the gender rule prevails.

5. If the child's parents are separated or divorced and there is a court decree which establishes financial responsibility for the child's health care expenses, the contract which covers the child as a dependent of the parent who has this financial responsibility is considered the primary coverage. It is the obligation of the person claiming benefits to notify the Plan and, upon request, to provide a copy of such court decree.

    When the child's parents are separated or divorced and there is no such court decree, then the following rules will be used to determine payment responsibility:

    a) If the parent who has custody of the child has not remarried, then that parent's coverage is the primary coverage.
    b) If the parent with custody of the child has remarried, then the contract which covers the child as a dependent of the parent with custody is primary, followed by the contract which covers the child as a dependent of a stepparent and then the contract which covers the child as a dependent of the parent without custody.

COB with Medicare

The following requirements can be used as a guide when determining how to coordinate benefits for members with both the HMO and Medicare coverage:

When the HMO Is Primary and Medicare Is Secondary

Group health insurance (the HMO) is generally the primary payer if the member is:

- Age 65 or older and has coverage based on their own or their spouse's current employment
- Disabled and has coverage based on their own or the current employment of a family member

An employee can reject their employer's coverage and elect to have Medicare as primary.

Medicare is also the secondary payer in the following circumstances:

- The member is entitled to workers' compensation or to federal black lung benefits for an illness or injury.
- No-fault insurance or liability insurance is available as the primary payer.
- For the coordination period (18 or 30 months) if the member is a kidney dialysis patient and covered by an employer group health plan

When Medicare Is Primary Payer and the HMO Is Secondary

Medicare is generally the primary payer if the member is:

- Age 65 or older, employed or a retiree, and rejects the employer's coverage (the member then has no HMO coverage)
- A kidney dialysis patient with ESRD and has completed the coordination period

The IPA should bill Medicare on an assignment basis for those Part B services which they provide. The cost of IPA referral services, diagnostic procedures and supplies covered under Medicare are then reimbursed to the IPA.

Per the HMO Certificate language, in order for a member to be eligible for benefits, they must be actually enrolled in both Medicare Parts A and B.

If the member's Medicare policy includes a deductible, that portion should be considered for payment under the HMO coverage.

The IPA, at their discretion, may charge the member an office visit copayment when applicable for those members whose policies include an office visit copayment.

End Stage Renal Disease (ESRD)

The Balanced Budget Act of 1997 contains several provisions, one of which affects coverage for ESRD in dual coverage situations regarding private group health coverage and Medicare.

For periods between Feb. 1, 1990, and Feb. 1, 1996, the group health plan (HMO) is the primary coverage for ESRD for 18 months. This applies to services received up to, and including Aug. 5, 1997. For periods on or after Feb. 1, 1996, the primary coverage for group health plans is 30 months. This applies to services received on or after Aug. 6, 1997.

The HMO is primary and Medicare is secondary with respect to benefits payable on behalf of a member who is entitled to Medicare on the basis of ESRD for services furnished during a coordination period of 18 or 30 months, beginning with the first month of ESRD eligibility or entitlement. The ESRD Rule applies regardless of the number of employees or the employment status (i.e., retired).

Under the OBRA Act of 1993, further amendments were enacted to the Medicare Secondary Payer (MSP) laws:

As of Aug. 1993, the 18 or 30 month period during which the HMO is primary and Medicare is secondary will continue throughout the 18 or 30 month coordination period, even if the person becomes dually entitled to Medicare because of age, disability or other reasons.

Upon completion of the 18 or 30 month coordination period, Medicare will revert to primary payer status and will remain primary as long as dual entitlement exists.

Medicare remains the primary payer if the HMO was already the secondary payer for an individual entitled to Medicare on the basis of age or disability when the member became eligible for Medicare on the basis of ESRD.

Example: If Medicare's eligibility is based on disability or age 65 and older, and the member becomes ESRD entitled on or after Aug. 10, 1993, with the first month of dialysis, Medicare is the secondary payer for the next 18 months. If the member becomes ESRD entitled on or after April 25, 1995, on April 25, 1995 Medicare becomes primary for the remainder of the 18-month coordination period and will remain primary for as long as dual entitlement exists.

Changes to the OBRA Act of 1993 do not affect retirees or spouses of retirees if the 18-month coordination period ended before Aug. 1993.

Medicare Secondary Payer Demand Letter

The Medicare Secondary Payer Statute is a provision of the Social Security Act. It refers to those instances in which Medicare does not have the primary responsibility for paying the medical expenses of a Medicare beneficiary because the beneficiary is entitled to other coverage that should pay primary health benefits.

There are times when Health Care Financing Administration (HCFA) will send a Medicare Demand Letter if Medicare has paid claim as Medicare primary in error. This letter contains a summary data sheet, a payment record summary and the claims that are involved in the reimbursement to Medicare. This Demand Letter requires that the HMO reimburse Medicare in full for their expenses for the health care services that it paid as primary in error.

The HMO reviews the Medicare Demand Letter and verifies the eligibility, claim information and identifies the appropriate IPA. The HMO will send a Medicare Secondary Payment Request Letter to the IPA including a summary list of claims. The IPA will have five business days to respond to the request.

The IPA should complete the Summary Claims List first, indicating if the claim was group-approved or not group-approved. If a group-approved claim has not been previously paid by the IPA, no payment should be made based upon this review.

If the claim was group-approved, the IPA should indicate the amount paid, the check number, the date paid and to whom the payment was made on the form. If a partial payment was made, the IPA should indicate the reason (e.g., was paid due to contract agreement with the provider or it was paid as a secondary payer). If no payment was made, this should be documented.

If the IPA paid the claim as a primary payer (through capitation, contract agreement or payment in full), the HMO will not need to reimburse Medicare.

If the IPA paid the claim as a secondary payer or if the IPA has approved the claim but has not yet paid as the secondary payer, Medicare is reimbursed at the requested level. This amount will be deducted from the IPA's next capitation check. A Summary Notification Letter will be sent to the IPA confirming the capitation deduction.

IPA Steps for Handling COB Investigations

1. When members register, request other carrier information.

2. Determine which insurance carrier is primary for each member using the guidelines outlined in B above.

3. If the HMO is the Primary Carrier for the member, do not bill the other carrier for any HMO-covered services.

4. If the HMO is the Secondary Carrier for the member, process the necessary paperwork to bill the Primary Carrier for covered services. ***Do not bill the member. Do not require the member to bill the carrier.***

5. Money recovered through Coordination of Benefits is kept by the IPA. All cost savings or recoveries from COB investigations must be recorded and included on the financial statements of the IPA.

HMO Steps for Handling COB Investigations

1. The HMO Claims Department will automatically coordinate benefits on all claims when other carrier information is available.

2. Each IPA can assist the HMO's COB investigation of claims by providing other carrier information to the HMO Claims Department. It should be mailed to the attention of the Manager of Claims and marked "COB Information." It will be recorded permanently on the member's claim record.

   Likewise, the HMO Claims Department can share COB information with the IPA. Inquiries can be made by calling the customer service department number on the back of the Member's ID card.

3. If the HMO pays less than 50% of the inpatient charges because of coordination of benefits, no units will be charged to the IPA's Utilization Management Fund.

Worker's Compensation

The Illinois Workers Compensation Act provides that an insured employee has the right to obtain medical care for treatment of a work related injury. If the member chooses to seek services through the chosen IPA, the charges or equivalents for these services may be recouped through the employer's Worker's Compensation carrier.

The IPA must provide the services under the terms of the Medical Service Agreement. The member may not be denied service nor can any IPA Provider bill the member for services managed or authorized by the IPA that may be related to a Worker's Compensation injury. A Member can be questioned to determine whether the injury a) occurred at work or b) during the course of their work duties. Regular follow up by the IPA, via certified mail, is recommended to ensure reimbursement. Liens should not be issued for Worker's Compensation claims.

Right to Recovery

The IPA has the right to recovery after they have rendered services for an injury and the member attempts to collect payments by an action at law, settlement, or otherwise. Benefits provided must be for covered services under the Subscriber Certificate. The member may not be denied service nor can any IPA Provider bill the member for services managed or authorized by the IPA that may be related to a third party injury.

In the event of accidental injury outside of work or when some parties other than the employer or co-employees are responsible for the injury, there is a right to recovery of these monies from the responsible party (i.e. insurance carrier). A lien for medical or hospital treatment can be perfected against the third party and his or her insurance carrier. This must be perfected by the medical provider and not the HMO. No lien can be filed unless there is a claim or litigation pursued by the member. The member should not be pursued for any amount other than the applicable copayments, coinsurance and/or deductible.