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## Introduction

If a member has coverage with another plan that is primary to Medicare, the claim should be submitted for payment to that plan first. The amount payable by Blue Cross Medicare Advantage HMO will be governed by the amount paid by the primary plan and Medicare Secondary Payer law and policies.

## Definitions

1. “This Plan” means Blue Cross Medicare Advantage HMO. 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" means 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 Medicare HMO were followed (e.g., services were performed or referred by the Primary Care Physician). The Medicare HMO will need a copy of the primary carrier’s explanation of benefits (EOB) to process all claims.

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

4. "Secondary Carrier" means 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

These rules apply for employer or union group health plan coverage:

- If the enrollee has retiree coverage, Medicare pays first.
- If the enrollee's group health plan coverage is based on their or a family member's current employment, who pays first depends on their age, the size of the employer and whether they have Medicare based on age, disability or End Stage Renal Disease (ESRD):
    - If the enrollee is under 65 and disabled and the enrollee or their family member is still working, the enrollee's plan pays first if the employer has 100 or more employees, or at least one employer in a multiple employer plan has more than 100 employees.
    - If the enrollee is over 65 and the enrollee or their spouse is still working, the plan pays first if the employer has 20 or more employees, or at least one employer in a multiple employer plan has more than 20 employees.
- If the enrollee has Medicare because of ESRD, the enrollee's group health plan will pay first for the first 30 months after they become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans and/or Medigap have paid.

## 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 the Centers for Medicare & Medicaid Services (CMS) 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 Summary Claims Listing. The IPA will have five business days to respond to the request.

The IPA should complete the Summary Claims Listing first indicating if the claim was group approved or not group approved. If the IPA has not previously paid a group approved claim, 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 payer information 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.

## 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 employee chooses to use the services of the chosen IPA, the charges or equivalents for these services should be recouped through the employer's Workers' Compensation carrier. The IPA must provide the services under the terms of the Medical Service Agreement (MSA). The IPA must not bill the member. A member can be questioned to determine whether the injury a) occurred at work or b) during their work duties.

Regular follow up by the IPA, via certified mail, is recommended to ensure reimbursement. Liens should not be issued for Workers' 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.

In the event of accidental injury outside of work or when some party 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 insured, the responsible party and the responsible party's 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.

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