

## **Section 8**

### **Coordination of Benefits**

Providers must cooperate with and support coordination of benefits activities by HC Generations. In the event that there is a third party liability or third party coverage for an HC Generations Member, Providers agrees to identify and seek such payment before submitting claims to HC Generations.

#### **HC Generations is Primary**

If an HC Generations Member possesses health benefits coverage through another policy which is secondary to the Health Choice Generations under applicable coordination of benefits rules, including the Medicare secondary payer program, providers must accept payment from HC Generations for Covered Services as full payment for such services, except for applicable co-payments, coinsurance, or deductibles. Other than for co-payments, coinsurance, or deductibles under the applicable HC Generations Benefit Plan, Health Choice Generations Members must have no obligation for any fees, regardless of whether secondary insurance is available.

Nothing in this section is meant to prevent providers from receiving payment from any secondary payer.

#### **Claims involving third parties must be filed in accordance with the following:**

##### **HC Generations is Secondary.**

If a Health Choice Generations Member possesses health benefits coverage through another policy which is primary to HC Generations under applicable coordination of benefits rules, including the Medicare secondary payer program, or if a Health Choice Generations Member is entitled to payment under a worker's compensation policy or automobile insurance policy, providers must pursue payment from the primary payer consistent with the applicable State and Federal Law. In such event, Health Choice Generations' payment responsibility must be the difference between the primary payer's allowed reimbursement and the HC Generations allowed reimbursement.

Providers must include a complete copy of the other third- party carrier's explanation of benefits (EOB) or remittance advice (RA) when submitting a claim for the balance due under coordination of benefits. Such claim(s) for any balance due must be received by HC Generations within thirty (30) days from the date of remit from the primary carrier or six (6) months from date of service, whichever is less.

For HC Generations Members, payment will be based upon the HC Generations fee schedule, less the beneficiary co-insurance, co-payment, and applicable deductible. This will constitute payment in full to Providers.

In situations where Providers have not received notification from the primary payer, Providers may submit the claim without the EOB/EOMB and it must be received by HC Generations within the prescribed initial submission deadline of six (6) months. HC Generations will deny

the claim for failure to submit the EOB/EOMB thereby allowing the Providers to resubmit the claim with the EOB/EOMB within eighteen (18) months from the date of service.

**Motor Vehicle (MVA) or Work Related Injuries**

If a member requires services for an injury or condition resulting from circumstances involving a third party, (e.g., automobile accident or work related injuries) the provider must notify HC Generations at (480) 968-6866 or 1-800-322-8670.

Providers are required to furnish the following information:

- Name of provider
- Address of provider
- Name of patient
- Patient’s Health Choice Generations identification number
- Address of patient
- Date(s) of hospitalization and/or outpatient services
- Amount due for care of patient
- Date of accident
- County in which injuries were sustained
- Names, if known, of liable persons, firms, corporations, and insurance carriers claimed by the patient or patient’s legal representative to be liable for damages.

**Failure to meet the notice requirements may forfeit the provider’s right to reimbursement**

HC Generations third party liability administrators will coordinate and pursue collection from underinsured motorist insurance, third party liability insurance, and tortfeasors in cases of probable third party liability.

**For recipients and services covered by Medicare**

For recipients and services covered by Medicare, providers must bill Medicare first. When payment is received, providers may bill HC Generations for the coinsurance and deductible as shown on the Medicare EOMB. The coinsurance and deductible information is entered in Field 24K.

24		A	B	C	D	E	F	G	H	I	J
Date of Service FROM		TO	Place of Service	Type of Service	Procedures, Services or Supplies Explain Unusual Circumstances CPT/HCPCS Modifier	Diagnosis Code	Charges	Days or Units	EPST Family plan	EMG	Reserved for local use

- Providers should divide Field 24K with a diagonal or vertical line and report *coinsurance* to the *left* of the vertical line or *above* the diagonal line.
- Providers should report *deductible* to the *right* of the vertical line or *below* the diagonal line.

- If the deductible has been met, enter zero (Ø) for the deductible.
- If only the coinsurance amount is entered in Field 24K, the amount is treated as a TPL payment, resulting in incorrect reimbursement.

**Example 1:** Provider reports coinsurance of \$145 and deductible of \$100.

K
RESERVED FOR LOCAL USE
145.00
100.00

or

K
RESERVED FOR LOCAL USE
145.00
100.00

**Example 2:** Provider reports \$145.00 coinsurance and no deductible.

K
RESERVED FOR LOCAL USE
145.00
0

or

K
RESERVED FOR LOCAL USE
145.00
0

- If two amounts are reported without a line separating the amounts, the first amount will always be considered coinsurance and second amount will be treated as the deductible.

**Example 3:** Provider reports \$145.00 coinsurance and no deductible.

K
RESERVED FOR LOCAL USE
145.00
0

- For recipients and services covered by other third party payers, enter only the amount *paid*.

**Example 4:** Provider reports payment of \$105.00 from a third party payer.

K
RESERVED FOR LOCAL USE
105.00

- **Always** attach a copy of the Medicare or other insurer’s EOB to the claim.
- Providers must submit a separate Medicare EOMB with each claim form.

- If a provider submits multiple claims for a recipient but includes only one copy of the Medicare EOMB, the EOMB will be attached to the claim with highest coinsurance and deductible amount.
- The other claims in the package will be denied for lack of a Medicare EOMB.

**For recipients with Medicare coverage but the service is *not* covered by Medicare**

- If the recipient has Medicare coverage but the service is not covered by Medicare or the provider has received no reimbursement from Medicare, the provider should “zero fill” Field 24K and submit the claim within the appropriate time frame.
  - Leaving the field blank will cause the claim to be denied.
  - Zeros indicate that no payment was received.
  - If payment from Medicare or another third party is received after the provider has been reimbursed by HC Generations, the claim to HC Generations must be adjusted.

**Example 5:** Provider reports no payment received from Medicare.

K	<b>OR</b>	K	<b>OR</b>	K
RESERVED FOR LOCAL USE		RESERVED FOR LOCAL USE		RESERVED FOR LOCAL USE
0            0		0        0		0 0

**Example 6:** Provider reports no payment received from third party payer.

K
RESERVED FOR LOCAL USE
0

- If the service is a Medicare-covered service and the claim is denied by Medicare, the provider’s claim to HC Generations also will be denied unless the provider has obtained authorization from the HC Generations Prior Authorization Unit.

The Medicare EOMB may combine each individual line charge into a single charge for the entire claim and issue payment based on the total charges. The EOMB may not show a coinsurance amount for each billed charge.

For HC Generations to correctly process and reimburse claims, providers must follow these steps to prorate the total coinsurance amount and allocate it to each line of the claim:

- Divide the coinsurance amount by the total covered charges allowed by Medicare as shown

on the EOMB.

- Multiply the charges on each line by the percentage calculated in Step 1.
- Enter the prorated coinsurance amounts calculated in Step 2 on the CMS 1500.

**Example 7:** Provider submits a three-line claim to HC Generations.

Total covered charges allowed by Medicare	\$4,210.00
Medicare paid amount	\$3,368.00
Coinsurance	\$ 842.00

- Divide the coinsurance amount by the total covered charges allowed by Medicare

$$842.00 \div 4,210.00 = .20 \text{ Coinsurance is 20\% of total charges}$$

- Multiply the charges per line by the percentage calculated in Step 1.

Line	Billed charges X per cent	Prorated Coinsurance
1	2,900.00 X .20	580.00
2	270.00 X .20	54.00
3	1,040.00 X .20	208.00
Total	4,210.00 X .20	842.00

- Enter the amounts calculated in Step 2 on the corresponding lines of CMS 1500. If the deductible has been met, enter zero (Ø) on each line.

F	G	H	I	J	K	
CHARGES	DAYS OR UNITS	EPS DT Family Plan	EM G	COB	RESERVED FOR LOCAL USE	
290000	1		N	Y	580.00	0
27000	1		N	Y	54.00	0
104000	1		N	Y	208.00	0
28. TOTAL CHARGE	4210.00	29. AMOUNT PAID		30. BALANCE DUE	842.00	

- For other third party payers, perform the same calculations to the paid amount and enter only the prorated paid amount in Field 24 K.

**UB-92 CLAIMS WITH MEDICARE/OTHER INSURANCE**

When a provider finds it necessary to file a UB-92 claim with HC Generations for a recipient who also is covered by Medicare or other insurance, the provider must report Medicare and other insurance information on the claim to HC Generations.

For recipients and services covered by Medicare, providers must bill Medicare first. When payment is received, providers may bill HC Generations for the coinsurance and deductible as shown on the Medicare EOMB. Providers must attach a copy of the Medicare EOMB to the UB-92 claim.

- Medicare Part A
  - Report the Part A deductible and coinsurance (if applicable) amounts and appropriate value codes in Fields 39A and 40A.
  - Use value code A1 to indicate Part A deductible and A2 for Part A coinsurance.

**Example 8:** Provider reports Medicare Part A deductible of \$812 and no coinsurance.

	39	Value		40	Value Code		41	Value	
	Cod e	Code	Amount	Cod e	Code	Amount	Code Code Amount		
a	A1	812	00						
b									
c									
d									

- Medicare Part B - Inpatient
  - Report Medicare Part B as the payer and the Part B paid amount in Fields 50B and 54B.

**Example 9:** Provider reports Medicare Part B Inpatient payment of \$312.

50 Payer	51 Provider No.	52 Rel.	53 ASG Info Ben	54 payments	Prior	55 EST Amount Due
A						
B Medicare Part B				312	00	
C						

- Medicare Part B – Outpatient
  - Report the Part B deductible (if applicable) and coinsurance amounts and appropriate value codes in Fields 39B and 40B.

- Use value code B1 to indicate Part B deductible and B2 for Part B coinsurance.

**Example 10:** Provider reports outpatient Part B coinsurance of \$125.

	39 Code	Value Code Amount	40 Code	Value Code Amount	41 Code Code Amount	Value
a						
b	B2	125 00				
c						
d						

- Third party payers
  - Report the third party’s name and payment amount in Fields 50A and 54A or 50B and 54B.
  - Attach a copy of the insurer’s EOB to the UB-92 claim.

**Example 11:** Provider reports a third party payment of \$1,225.00.

50 Payer	51 Provider No.	52 Rel.	53 ASG Info Ben	54 payments	Prior	55 EST Amount Due
A XYZ Insurance				1,225	00	
B						
C						

Providers may not “zero fill” the Medicare fields on hospital inpatient and outpatient claims, dialysis facility claims, and hospice claims. If a claim is denied by Medicare, providers should submit documentation of the denial with the UB-92 claim to HC Generations.

**Nursing Facility Claims with Medicare/Other Insurance**

HC Generations is responsible for reimbursement of Medicare coinsurance minus any TPL payment, minus the recipient’s share of cost (SOC).

When a nursing facility submits a claim to Medicare Part A intermediaries BlueCross/BlueShield of Arizona and BlueCross/Blue-Shield of Texas (TrailBlazer Health Enterprises) for an HC Generations recipient who also is Medicare eligible, the claim is automatically crossed over to HC Generations when Medicare issues payment.

Nursing facilities should not submit claims to HC Generations for paid Medicare claims for dually eligible HC Generations recipients or QMB recipients. All Medicare crossover claims are identified on the provider’s remittance advice.

When a recipient has exhausted the Medicare benefit for nursing facility coverage, the nursing facility must submit a claim to HC Generations. The facility should “zero fill” the Medicare fields and submit the claim within the appropriate time frame. Leaving the fields blank will cause the claim to be denied. Zeros indicate that no payment was received.

**Example 12:** Provider reports no payment received from Medicare.  
Value Code A2 = Medicare Part A Coinsurance

	39	Value		40	Value Code			41	Value	
	Cod e	Code	Amount	Code	Code	Amount	Code	Code	Amount	
a	A2	00	00							
b										
c										
d										

If payment from Medicare or another third party payer is received later, the claim must be adjusted.

Denied and adjusted Medicare claims also are not automatically crossed over to HC Generations. These claims must be submitted to HC Generations within six months from the date of the Medicare EOB.

A copy of the Medicare EOB must accompany the claim to HC Generations. The claim must achieve clean claim status within 6 months of the date of the Medicare EOB or 60 days of the last adverse action by HC Generations, whichever is later, as long as the claim was initially submitted within 6 months from the date of service.

**Retroactive Posting of Medicare Eligibility**

Occasionally, HC Generations learns that a recipient is eligible for Medicare after payment has been made to the provider. When that happens, HC Generations recoups the money overpaid from future payments to the provider and advises the provider to bill Medicare.

HC Generations also has contracted with Public Consulting Group, Inc. to identify inpatient hospital claims that are overpaid due to the late posting of Medicare eligibility.

HC Generations has begun to systematically identify all members with retroactive Medicare posting for whom the agency has paid claims from both hospitals and other providers, without consideration of the potential Medicare payment. A report is reviewed monthly and allows HC Generations to recoup any overpayments from all provider types.

When HC Generations recoups, providers should bill Medicare and follow the procedure outlined earlier in this chapter.

