

COORDINATION OF BENEFITS

TIPS FOR REDUCING PAYMENT DELAYS AND IMPROVING ACCOUNTS RECEIVABLE

One of the major reasons for delays in claims processing is the need for information to support coordination of benefits. Coordination of benefits (COB) applies to a person who is covered by more than one health plan. The COB provision and regulations require that all health plans and other payers (e.g., Medicaid and Medicare) coordinate benefits to eliminate duplication of payment and assist patients to receive the maximum benefit to which they are entitled. By adhering to the COB provisions, the health plans and other payers can determine which plan will pay for a claim first. The health plan or payer obligated to pay a claim first is called the "primary" payer and the other plan or payer is termed "secondary". Together, the primary and secondary payers coordinate payments for services up to 100% of the covered charges at a rate consistent with the benefits. When information about all potential sources of coverage is not available to plans and payers, claims will generally be "pending" and remain unpaid until complete COB information is on file.

Top reasons for COB-related delays in payment include: (1) incomplete or inaccurate COB information on file with the plan or payer, and (2) failure to attach the Explanation of Benefits (EOB) from the primary payer when billing the secondary payer. In addition, one of the leading reasons for claim denials is failure to submit complete and clean claims. The following tips are designed to assist providers and their billing staff to reduce payment delays attributed to COB-related problems:

1. Ask All Patients About Secondary Insurance Coverage

Have an office procedure to collect and/or confirm primary and secondary insurance information at each visit. Ask patients to provide the following information about their spouse and/or dependents: social security number; birth date; group/policy number for other medical coverage (if applicable); and Medicare or Medicaid ID card (if applicable). Collect this information at the time the appointment is booked to allow time for your staff to confirm eligibility prior to the visit.

2. Know What Plans and Payers Need to Pay Claims

Although each plan and payer may have slightly different requirements, there are some requirements that are nearly universal. For example, nearly all plans require a copy of the EOB from the primary payer prior to paying a claim as the secondary payer. Most plans and payers publish their requirements and the information should be available in provider manuals, online, and by contacting provider representatives.

3. Determine Primary and Secondary Payers

It is important for providers to determine primary and secondary payers so that claims can be sent to the primary payer first. Some plans will be able to tell providers whether they are primary or secondary at the time the provider contacts the plan to verify eligibility. Typically, the following rules are used by plans and payers to determine the primary and secondary payer:

- a) The payer covering the patient as a subscriber will be the primary payer.
- b) If the patient is a dependent child, the payer whose subscriber has the earlier birthday in the calendar year will be the primary payer. This is known as the Birthday Rule.

4. Attach EOB from Primary Payer When Submitting Claim to Secondary

Secondary payers must have a copy of the Explanation of Benefits (EOB) provided by the primary payer to process and pay a claim. Make attaching an EOB to claims filed with secondary payers a part of your routine office procedure.

A SPECIAL CONSIDERATION FOR MEDICARE CLAIMS

Many health plans receive Medicare claims automatically when they are the secondary payer. In this case, the Explanation of Medicare Benefits (EOMB) will indicate that the claim has been automatically crossed over for secondary consideration. Providers should look for this indication on their EOMBs and should not submit a paper claim to the secondary payer. A paper claim submitted in this circumstance would be coded as a duplicate and rejected by the secondary payer.

A committee representing health plans and health care providers prepared this document. Organizations that participated in the development of this document include American Academy of Family Physicians, American College of Obstetricians and Gynecologists, American Academy of Dermatology Association, Bethesda Healthcare System, Piedmont Hospital, Group Health Incorporated, and Health Alliance Plan. The American Association of Health Plans and the Healthcare Financial Management Association convened the committee.