The Coordination of Benefits Process

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Objective

The goal of this training is to increase the understanding of the coordination of benefits (COB) process between other insurance plans and ForwardHealth.

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Agenda – The COB Process

- Verification of other insurance
- Billing other insurance
- Submitting claims to ForwardHealth

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The COB Process

- Providers verify other insurance coverage
  - Report other insurance coverage discrepancies
- Providers bill the other insurance carrier
  - Exhaust other commercial health insurance sources
  - Review outputs of other insurance processing:
    - Explanation of Benefits (EOB)
    - Remittance Advice (RA)
- Providers submit claims to ForwardHealth using the following:
  - Electronic submission
  - Paper claims and the Explanation of Medical Benefits (EOMB) form
  - Other insurance indicators

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Verifying Other Insurance Coverage

- Providers can access Wisconsin's Enrollment Verification System (EVS) to determine if a member has other health insurance coverage.
- Providers should refer to the Enrollment Verification User Guide on the Provider home page of the Portal for more information about accessing the EVS.

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Search Results

Member Information

Member ID	1110560117	Name	MARY R MEDICAID
Date of Birth	10/01/1938	County	Trempealeau
Medicare ID	391322563A	Address	DO NOT USE/CHANGE OSSEO WI, 54758

Confirm Member

Benefit Plan

Payer	Benefit Plan	Effective Date	End Date
MEDICAID	Medicaid (HPSA Recipient)	04/18/2016	04/18/2016
MEDICAID	Specified Low-income Medicare Beneficiary (HPSA Recipient)	04/18/2016	04/18/2016

Member's Medicaid Plan

Medicare

Coverage	Medicare Coverage Start Date	Medicare Coverage End Date
Medicare Part A	04/18/2016	04/18/2016
Medicare Part B	04/18/2016	04/18/2016

Patient Liability

Benefit Plan Group	Liability Amount	Effective Date	End Date
MEDICAID COST SHARE	$250.00	01/01/2011	12/31/2299

Nursing Home Level Of Care

Code	Description	Provider Id	Effective Date	End Date
ICF2	0192 - Intensive Care Facility - Level 2	1528093903	01/01/2011	12/31/2299

Other Commercial Health Insurance

Group Number		**Carrier Name**	HUMANA (M+C)
Policy Number	MB12459	**Carrier Telephone**	(800)448-6262
Policy Holder	MARY MEDICAID (SELF)	**Effective Date**	04/18/2016
PH Date Of Birth	10/01/1938	**End Date**	04/18/2016
PH Address	DO NOT USE/CHANGE OSSEO, WI 54758	**Coverage Code**	CHOICE

Member's Other Insurance

Reporting Other Insurance Coverage Discrepancies

- Providers are encouraged to report discrepancies to ForwardHealth by submitting the Other Coverage Discrepancy Report form, F-01159.
- Providers can also use the online tool available in their ForwardHealth Portal account to report discrepancies.
- Refer to the Reporting Discrepancies topic (#4942) for more information.

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Billing the Other Insurance Carrier

- Providers are required to exhaust commercial health insurance sources before submitting claims to ForwardHealth.
- Providers can determine if the service requires commercial health insurance billing by referencing the following topics:
  - Services Not Requiring Commercial Health Insurance Billing (#603)
  - Services Requiring Commercial Health Insurance Billing (#769)
  - Exhausting Commercial Health Insurance Sources topic (#596)

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Outputs of Other Insurance Processing

- An explanation of medical benefits (commonly referred to as an explanation of benefits [EOB] form) is a statement sent by a payer **to a member** summarizing the medical treatments and/or services that were paid to a provider on their behalf.

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Outputs of Other Insurance Processing (cont.)

- A remittance advice (RA) is a statement sent by a payer **to a provider** that explains the payment and any adjustments made to a payment during the adjudication of claims.
- RAs provide itemized claims processing decision information.
- A standardized claim adjustment reason code, known as a reason/remark code, is used by payers to communicate to a provider why a payment adjustment was made (i.e., why a claim or service line was paid differently than it was billed).

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Outputs of Other Insurance Processing (cont.)

- Some reason/remark codes may be referred to as American National Standards Institute (ANSI) codes.
- If there is no adjustment to a claim or service line, then there is no adjustment reason code.
- Providers are required to use the information from the commercial insurance RA when billing ForwardHealth.

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Primary Insurance Correct and Complete Claims

- A correct and complete claim is one that is processed without billing errors, provider network errors or member eligibility errors.
- In some instances, a correct and complete claim will be approved or allowed by the primary insurance, but still not be paid or only partially paid, because of the member's cost-sharing responsibility (e.g., deductible, co-payments, co-insurance).
- In some instances, a correct and complete claim will be denied or not allowed because a service is noncovered.
- All correct and complete claims that have been processed by commercial insurance should be submitted to ForwardHealth as the secondary payer to be considered for reimbursement.

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Primary Insurance Incorrect or Incomplete Claims

- If the provider failed to submit a correct and complete claim, the reason/remark code will indicate that the claim was denied due to billing errors. The claim must be corrected and re-submitted to the commercial insurer before submitting to ForwardHealth.
- If the reason/remark code indicates that the claim was denied due to missing the filing deadline or because the provider is out of network, the provider can submit an appeal to the commercial insurer. If the primary insurance reverses their decision, the provider can submit a claim to ForwardHealth with the updated remark code.
- Refer to the Claims for Services Denied by Commercial Health Insurance topic (#844) for more information.

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Submitting Claims to ForwardHealth for Secondary Payment

- The provider is required to demonstrate that a correct and complete claim was submitted to the commercial insurer before submitting a claim to ForwardHealth.
- When submitting a claim to ForwardHealth for secondary payment, the claim must:
  - be identical to the claim submitted to the primary payer (e.g., codes, modifiers, and units billed)
  - include the primary payer's processing information from the RA (payments, reason/remark codes)

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Submitting Electronic Claims to ForwardHealth

Providers may submit claims using the following electronic submission options:

- ForwardHealth Portal via Direct Data Entry (refer to the Portal Claims Functionality User Guide for detailed information about submitting other insurance via the Portal)
- 837 Health Care Claims for Electronic Data Interchange (EDI) (refer to the applicable trading partner companion guide on the Portal)
- Provider Electronic Solutions (PES) software (refer to the PES Manual on the Portal)
- National Council for Prescription Drug Programs (Refer to the Real-Time Claim Submission Requirements for Coordination of Benefits topic [#12877] for more detailed information)

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Submitting Paper Claims to ForwardHealth

- Providers are reminded to submit a complete and correct paper claim using the most current claim form i.e. 1500 version 02/12 or CMS 1450.
- An EOMB form must be included for each other payer when other insurance sources (e.g. commercial insurance, Medicare) are indicated on a paper claim or paper adjustment on professional and institutional claims.
- The EOMB Form:
  - was developed by ForwardHealth as a standard paper form to be used for paper claim submissions when COB is required.
  - can also be used as a "worksheet" resource to assist in entering reason/remark codes and other applicable information when an electronic submission method is used.
- Refer to the Explanation of Medical Benefits Form Requirement topic (#18497) for more information.

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Other Insurance Indicators

Other insurance indicators are used to report the following on claims:

- Full or partial payment was made by commercial health insurance.
- Claims were denied by commercial health insurance following submission of a correct and complete claim.
- Commercial health insurance exists, does not apply, or for some valid reason, the provider is unable to obtain such reimbursement by reasonable means.
- Refer to the Other Insurance Indicators topic (#605) for more information.

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Billing ForwardHealth Secondary to Commercial Insurance

The following summary includes the steps providers are required to take when billing ForwardHealth secondary to commercial health insurance:

- Verify other insurance coverage
- Bill the other insurance carrier, if required
- Submit claims to ForwardHealth

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Additional COB recorded trainings available

- General Concepts of Coordination of Benefits
- Other Coordination of Benefits Policy Reminders and Resources

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Thank You