Overview of the ForwardHealth Coordination of Benefits and the Commercial Insurance Process

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Objective

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

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Agenda (Part 1) – General Concepts of COB

o What is COB?

o What is third-party liability?

o What constitutes commercial health insurance?

o What does it mean to be the payer of last resort?

o What is provider-based billing?

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Agenda (Part 2) – The COB Process

o Verification of other insurance

o Billing other insurance

o Submitting claims to ForwardHealth

Agenda (Part 3) – Other COB Policy Reminders and Resources

o Payment of claims

o Non-reimbursable commercial health services

o Cost sharing

o Resources

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General Concepts of COB

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What is COB?

o COB is the process of determining which of two or more insurance sources will have the primary responsibility of processing and/or paying a claim, and the extent to which the other sources will contribute.

o The terms "primary payer" and "secondary payer" indicate the relative order in which insurance sources are responsible for paying a claim. (Refer to the Primary Payer/Secondary Payer topic (#255) for more information.)

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Why is the Purpose of COB?

o When a member has more than one insurance source, COB is intended to ensure that the total payments for a service from all of the member's insurance sources do not exceed 100 percent of the covered charges for that service.

What is Third-Party Liability (TPL)?

o TPL is the legal obligation of third parties to pay part or all of medical assistance expenditures.

o By law, all other available third-party resources must meet their legal obligation to pay claims before ForwardHealth pays for covered services provided to a member.

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What Constitutes Commercial Health Insurance?

o Commercial health insurance is any type of health care coverage not obtained from Medicare or ForwardHealth programs (e.g., Wisconsin Medicaid or BadgerCare Plus):

– It may be employer-sponsored or privately purchased.

– It may be provided on a fee-for-service basis or through a managed care plan.

– Health care coverage provided by Medicaid and BadgerCare Plus HMOs, although administered through commercial health insurance carriers, are not commercial health insurance.

o Refer to the Definition of Commercial Health Insurance topic (#601) in the Online Handbook for more information.

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What Does It Mean to be the Payer of Last Resort?

o The payer of last resort is an entity that pays for services only after other third parties have met their legal obligation to pay.
o Except for a few instances, ForwardHealth is the payer of last resort for any covered services.
o Providers are required to make a reasonable effort to exhaust all existing other health insurance sources before submitting claims to ForwardHealth.
o ForwardHealth utilizes a claims-editing mechanism to determine if a member has insurance that could be responsible for coverage of the services submitted.
o Refer to the Payer of Last Resort topic (#253) for more information.

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What is Provider-Based Billing?

o Provider-based billing is when ForwardHealth sends an invoice to the provider to recoup claims ForwardHealth has paid, that should have been paid by a third party.

o ForwardHealth sends a provider-based billing claim when other coverage is discovered or made retroactive after payment of a claim by ForwardHealth.

o Since ForwardHealth is a secondary payer to most other health insurance sources, providers are required to seek reimbursement from the primary payer when they receive the provider-based billing claim.

o Provider-based billing ensures providers receive maximum reimbursement from other health insurance sources before receiving reimbursement from ForwardHealth.

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The COB Process

The COB Process

o Providers verify other insurance coverage and report other insurance coverage discrepancies

o Providers bill the other insurance carrier(s):

– Exhaust other commercial health insurance sources

– Review results of other insurance processing:

- Explanation of Benefits (EOB)
- Remittance Advice (RA)

o Providers submit claims to ForwardHealth using the following:

– Electronic submission

– Paper claims and the Explanation of Medical Benefits (EOMB) form (F-01234)
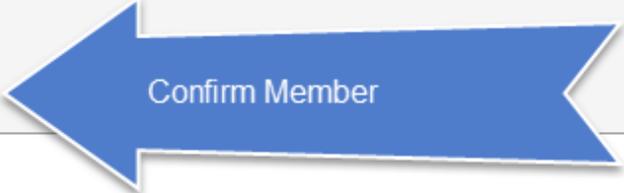
– Other insurance indicators

Verifying Other Insurance Coverage

o Providers can access Wisconsin's Enrollment Verification System (EVS) to determine if a member has other health insurance coverage.

o Providers should refer to the Enrollment Verification User Guide on the Provider home page of the Portal for more information about accessing the EVS.

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
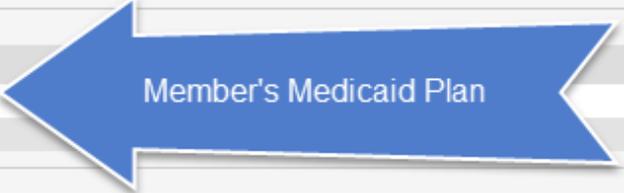
Member's Medicaid Plan

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	
Policy Number	MB12459
Policy Holder	MARY MEDICAID (SELF)
PH Date Of Birth	10/01/1938
PH Address	DO NOT USE/CHANGE OSSEO, WI 54758

Carrier Name	HUMANA (M+C)
Carrier Telephone	(800)448-6262
Effective Date	04/18/2016
End Date	04/18/2016
Coverage Code	CHOICE
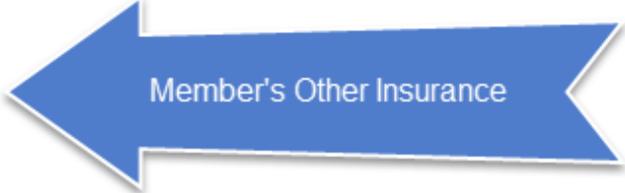
Member's Other Insurance

Reporting Other Insurance Coverage Discrepancies

o Providers are encouraged to report discrepancies to ForwardHealth by submitting the Other Coverage Discrepancy Report form, F-01159.

o Providers can also use the online tool available in their ForwardHealth Portal account to report discrepancies.

o Refer to the Reporting Discrepancies topic (#4942) for more information.

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Billing Other Commercial Health Insurance Sources

o Providers are required to exhaust commercial health insurance sources before submitting claims to ForwardHealth.

o Providers can determine if a service requires commercial health insurance billing by referencing the following topics in the Online Handbook:

– 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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Results of Other Insurance Processing

o An explanation of medical benefits (commonly referred to as an explanation of benefits form or EOB form) is a statement sent by a payer **to a member** summarizing the medical treatments and/or services for which payment was made to a provider on his or her behalf.

o 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.

o RAs provide itemized claims processing decision information.

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Results of Other Insurance Processing (cont.)

o 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).

o Some reason/remark codes may be referred to as American National Standards Institute (ANSI) codes.

o If there is no adjustment to a claim or service line, then there is no adjustment reason code.

o 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

o A correct and complete claim is one that is processed without billing errors, provider network errors or member eligibility errors.

o In some instances, a correct and complete claim will be approved or allowed by the primary insurance, but it will still not be paid or will only be partially paid because of the member's cost-sharing responsibility (e.g., deductible, co-payments, co-insurance).

o In some instances, a correct and complete claim will be denied or not allowed because a service is not covered.

o All correct and complete claims that have been processed by commercial health 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

o If a provider fails 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.

o 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 insurer reverses its decision, the provider can submit a claim to ForwardHealth with the updated remark code.

o Refer to the Claims for Services Denied by Commercial Health Insurance topic (#844) in the Online Handbook for more information.

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Submitting Claims to ForwardHealth for Secondary Payment

o Provider are required to demonstrate that a correct and complete claim was submitted to the commercial insurer before submitting a claim to ForwardHealth.

o When submitting a claim to ForwardHealth for secondary payment, providers must ensure the claim:

 – Is identical to the claim submitted to the primary payer (e.g., codes, modifiers, and units billed)

 – Includes 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:

o Direct Data Entry on the ForwardHealth Portal (refer to the Portal Claims Functionality User Guide for detailed information about submitting other insurance via the Portal)

o 837 Health Care Claim transactions for Electronic Data Interchange (EDI) (refer to the applicable trading partner companion guide on the Portal)

o Provider Electronic Solutions (PES) software (refer to the PES Manual on the Portal)

o Real-time pharmacy claims using National Council for Prescription Drug Programs values (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

o Providers are reminded to submit a complete and correct paper claim using the most current claim form i.e. 1500 Health Insurance Claim Form version 02/12 or Centers for Medicare and Medicaid Services (CMS) 1450 Form.

o An EOMB form must be included for each other payer when other health insurance sources (e.g. commercial insurance, Medicare) are indicated on a professional or institutional paper claim.

o The EOMB Form:

– Must be used with 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.

o Refer to the Explanation of Medical Benefits Form Requirement topic (#18497) in the Online Handbook for more information.

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Other Insurance Indicators

o 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.

o Refer to the Other Insurance Indicators topic (#605) in the Online Handbook for more information.

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Billing ForwardHealth as a Secondary Payer After Commercial Insurance

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

o Verify other insurance coverage.

o Bill the other insurance carrier, if applicable.

o Submit claims to ForwardHealth.

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Other COB Policy Reminders and Resources

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Payment of Claims

o Claim submission to ForwardHealth does not guarantee payment.

o Providers are required to meet all ForwardHealth requirements, including billing a member's other health insurance sources.

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Non-Reimbursable Services

o Providers are not reimbursed for the following:

– Services covered by a commercial health insurance plan, except for coinsurance, copayment, or deductible

– Services for which providers contract with a commercial health insurance plan to receive a capitation payment for services

o Refer to the Non-reimbursable Commercial Health Insurance Services topic (#604) in the Online Handbook for more information.

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Cost Sharing

o According to federal regulations, providers cannot hold a member or authorized person acting on behalf of the member, responsible for any commercial or Medicare cost-sharing amount such as coinsurance, copayment, or deductible, if the service is covered by both the primary payer and Wisconsin Medicaid.

o The provider should collect from the member **only** the ForwardHealth copayment amount indicated on the provider's RA.

o Refer to the Cost Sharing topic (#538) in the Online Handbook for more information.

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Resources

o Online Handbook at
  https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx

o Companion guides at
  *https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Account/
  StaticHTML.aspx?srcUrl=CompanionDocuments.htm*

o Provider Services at 800-947-9627

o Electronic Data Interchange helpdesk at 866-416-4979

o Portal helpdesk at 866-908-1363

o Professional Relations representatives

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Thank You