HIGHLINE MEDICAL SERVICES ORGANIZATION
CLAIMS PROCESSING POLICY/PROCEDURE

Title: Coordination of Benefits Apple Health	Policy Number:	
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Last Review Date: August 1, 2020 Dallas Person **, Director of Operations**

Policy
Apple Health is always the payer of last resort.

HMSO follows State WAC 284-51-230 and health plan requirements when adjudicating claims for a member who has other health insurance coverage (OHI). Prenatal Care, Preventative Pediatric Care, services covered under EPSDT, including Applied Behavior Analysis (ABA) treatment services, (if delegated) or coverage is through a parent whose obligation to pay support is enforced by the states' child enforcement agency are **always** initially allowed and recovery of the payment is immediately pursued.

Coordination of Benefits includes paying any applicable cost-sharing on behalf of a member up to the Medicaid allowed amount.

Provider agreements identify the provider's responsibilities regarding other health insurance including the provider's responsibility to identify other insurance coverage and pursue third party payment before submitting claims to HMSO.

Procedure
Benefits are coordinated as follows:
Commercial OHI: The member's Managed Medicaid coverage pays any copays or coinsurance owed by the member and any amounts payable under the Medicaid fee schedule if such payment is above the primary coverage payment amount.

Court-Ordered Medical Payments by an Absent Parent: When there is no OHI, the member's Managed Medicaid coverage pays as primary and pursues recovery from the absent parent.

Prenatal and Preventive Pediatric Care: Payment is **always** initially allowed and recovery of payment is immediately pursued. These types of services are identified by the diagnoses and CPT codes submitted by providers.

Monthly Reporting to Health Plan: HMSO recognizes its obligation to report members with OHI to the health plan as part of monthly reporting utilizing attachment 2 "COB Apple Health Monthly Report Form" or another mutually agreeable format. COB Cost Recovery (Pay and Pursue) is reported to the health plan on a quarterly basis.

Referral/authorization is not required when other health insurance is primary provided the primary carrier allowed the services.

Procedure
Identifying Other Health Insurance

HMSO identifies other health insurance when:

- A provider submits the other carriers EOP with a claim
- A provider submits a refund indicating HMSO paid as primary
- A provider contacts HMSO to report other health insurance

The other (primary) insurance carrier is then contacted to verify the effective eligibility date/s.

Once HMSO verifies an enrollee has OHI, the other health insurance is added to the member record in EZ Cap under "additional insurance" and a decision is made as to whether the OHI is primary or secondary. A COB record is added to the member record identifying the name of the other carrier, the policy holder's ID and DOB (if provided), the policy effective date and termination date (when applicable), the policy holder's gender and the member relationship to the subscriber.

Once the member record has been updated with OHI, the member's claims history, professional and institutional, is researched to determine whether or not HMSO made a primary payment to a provider during the OHI eligibility dates. If HMSO made a primary payment to the provider when the OHI was effective, the following steps are taken:

- All claim/s during the OHI eligibility period are researched to identify whether or not HMSO paid the claim as primary or the claim has already been coordinated with the primary carrier
- Qualifying claim/s that have not been coordinated with the primary carrier are flagged with a processing status of OHI.
- An automated notification letter is mailed to contracted providers the following day identifying OHI data when a claim is denied for third party coverage.
- The OHI processing status report is generated and worked by a Claims Adjudicator weekly.
- Claim payment is taken back. Remittance advice to providers indicates to "submit claim to primary carrier".

Claims Adjudication

When the member record is set to enable COB, EZ Cap sets a claim flag to alert the adjudicator to coordinate benefits. Each of these data elements is visible from within a claim during adjudication. The following steps are taken during claims adjudication:

Claim has a COB alert

Does claim have an EOB attached?

Yes: Process per attachment 3 "Washington COB Secondary Processing Workflow".

No: Review member record to determine whether the OHI has terminated.

- OHI is terminated for the claim's date of service
  - Continue processing; coordination of benefits is not applicable.

- OHI is in effect for the claim's date of service
  - Prenatal and Preventive Pediatric Care
    - Pay claim up to Medicaid allowed amount
    - Deny claims the primary payer denied because the provider or the enrollee did not follow the payer's payment or adjudication rules; (e.g., claims submission without required prior authorization or untimely claims filing), as long as there are no travel times/distance or access to care issues with use of an in-network provider with the primary carrier.
    - Add OHI processing status to initiate payment recovery
  - All Other Service
    - Pay claim at $0.00 and assign code 563 "Submit claim to Primary Carrier".
    - Terminate the member's primary insurance information in the system and pay as primary in certain exceptional situations; when a member's health information or location should not be communicated to the policyholder of the member's other coverage. When a member's OHI is terminated for this reason, expedite to Claims Manager for immediate action, examples:
      - Situations of domestic abuse
      - If the member has a protective order against the other coverage subscriber

Claim does not have a COB alert

Does claim have an EOB attached?

Yes: Process per attachment 3 "Washington COB Secondary Processing Workflow".
  - Make a copy of the EOB and forward to appropriate staff member to initiate OHI investigation
  - Once OHI investigation is complete, process as indicated above under ***"Identifying Other Health Insurance"*** to initiate recovery activity

No: Continue processing, COB not applicable

COB Savings

"COB savings" is the term used to describe the amount not paid out by the payer due to the other carrier's payment. COB savings accrue to the benefit of the member and are used to pay for services that would otherwise have been denied and resulting in member liability, i.e. non-covered services, benefit limitations, etc.

COB savings are tracked at the member level by creating a claim to provider 99998 "COB Savings", with service code "COB", DOS of the original claim and allowable equal to the savings amount. COB savings group to benefit tracking code 551 "COB Savings Applied".