



PROVIDER ALERT

Alert # 2-2003-04-08-HCYAB

Coordination of Benefits (COB) – HealthChoices Program

Community Care has received ongoing inquiries from providers on the confusion surrounding payment obligations on members who have a coexisting primary insurance carrier. It is important to note that the Commonwealth is currently reviewing its Third Party Liability/Coordination of Benefits (TPL/COB) rules. Changes may be made as early as May, 2003. Community Care will send out amendments to its TPL/COB procedures via a provider alert as soon as we are notified of changes.

Community Care, as a managed care organization for Medical Assistance dollars, has an obligation to the Pennsylvania Department of Public Welfare (DPW) for effective utilization of resources and for the quality of care and services provided by its participating providers. The goal of our Coordination of Benefits process is to hold the member harmless from out of pocket expenses, up to Community Care's fee schedule amount. Please find outlined below Community Care's process for managing member services when a primary insurance carrier exists:

- ◆ **Medical Assistance is always the insurance payor of last resort.** All other applicable insurance must be exhausted before Medical Assistance funds can be used to pay a claim.
- ◆ It is the responsibility of the provider to ensure that the primary insurance is contacted.
- ◆ Neither provider nor member may choose to use the secondary coverage before the primary coverage has been exhausted, or to avoid the requirements of the primary payor. This includes the member requirement to seek treatment with providers who are within the network of the primary insurance carrier. **Providers who are not part of the primary carrier's network should redirect the member in-network or seek out of network benefits with the primary carrier.**
- ◆ When the primary insurance is exhausted or a service is not covered, then Medical Assistance funds may be used.
- ◆ Primary insurance is considered to be fully satisfied, no secondary insurance indicated, when the contractually agreed upon rate is paid in full.
- ◆ If the primary payor issues a medical necessity denial, the provider must follow the denial procedures of the primary carrier and exhaust all Act 68 grievance levels to obtain payment. If the medical necessity denial of the primary carrier is upheld, Community Care must conduct a retrospective review of the clinical record to establish medical necessity against Community Care's standards. Please remember: Community Care's timely filing rules changed to 90 days on January 1, 2003. Service dates that have exceeded our 90 day timely filing limit due to following the Act 68 denial procedures of the primary insurance carrier will require special handling of claims. In these instances, the claim with copies of documentation on appeal decisions should be submitted for special handling at the following address:

Community Care Behavioral Health
One Chatham Center
112 Washington Place
Suite 700
Pittsburgh, PA 15219
Attention: Claims Department

- ◆ Community Care does pay for co-payments and deductibles for both Medicare and Commercial primary members. Payment responsibility determinations are explained below.

- ◆ Community Care will pay co-payments and deductibles up to, but not exceeding, the fee schedule or agreed upon service amount of the HealthChoices program. This includes money received from the primary payor on the claim as well as co-payments or deductibles collected.

Examples

Community Care's HealthChoices fee schedule rate for one hour of individual therapy is \$60. The provider bills the primary carrier \$100. The patient does not have a copay amount. The primary payor remits \$50 as per its fee schedule to the provider. Community Care would pay \$0.

Community Care's HealthChoices fee schedule rate for one hour of individual therapy is \$60. The provider bills the primary carrier \$100. The primary payor pays \$0 because the member has not yet satisfied his \$200 deductible for the year. The provider can obtain \$60 from Community Care.

Community Care's HealthChoices fee schedule rate for one hour of individual therapy is \$60. The provider charge to the primary payor is \$100. The patient has a \$20 co-payment responsibility. The primary payor remits \$30 (the \$50 payment less the \$20 co-payment that is the responsibility of the member). Community Care would pay \$20 to cover the copay/patient liability amount.

Community Care contracts with an inpatient psychiatric facility for \$550. The provider bills \$1500 to the primary carrier. The primary carrier pays \$1000. Community Care will make no additional payment since the paid amount of \$1000 exceeds the contracted rate with Community Care.

A Medicare patient has an 18-day stay on an inpatient unit. The hospital charge is \$1000 per day, Community Care approved reimbursement is \$550 per day; the Medicare approved rate is \$600 per day. Medicare is billed for \$18,000 (18 days at \$1000/day). Medicare denies 7 days because of lifetime max limits, pays for 11 days at \$600 x 11, less an \$840 deductible for a total payment of \$5760. Community Care would pay \$4,690, (\$550 x 7 denied days = \$3850 plus the Medicare deductible of \$840)

A Medicare patient has a 1-day stay on an inpatient unit. The hospital charge is \$1000 per day, Community Care approved reimbursement is \$550 per day; the Medicare reimbursement is \$600 per day. Medicare is billed for \$1,000 (1 day at \$1000/day). Medicare denies because of the Medicare deductible of \$840 was not met. Community Care would pay \$550, because the one-day rate is less than the Medicare deductible of \$840.

Clinical Notification Responsibilities

- ◆ For Inpatient services, Community Care must be notified of a member's inpatient admission within 48 hours when a primary insurance carrier is evident. A subsequent discharge review must be completed within 24 hours of discharge so an authorization can be entered into our system. The review must include accurate length of stay, date of follow-up appointment and diagnosis on five axes. This authorization will ensure payment for any co-insurance, deductibles, co-pays or balances between the primary carrier's approved amount and the maximum allowable on Community Care's HealthChoices fee schedule.

- ◆ For Outpatient services, Community Care must be notified of the initiation of outpatient services following the established outpatient authorization guidelines even when it is anticipated that Medical Assistance will be secondary to a primary insurer. This notification will ensure payment for any co-insurance, deductibles, co-pays or balances between the primary carrier's approved amount and the maximum allowable on Community Care's HealthChoices fee schedule.

Claims Completion Responsibilities

- ◆ Providers are required to always bill the primary insurance carrier before billing Community Care (except for those services exempt from COB – itemized below). Failure to bill the primary insurance carriers or third party liability payors first will result in a denial by Community Care.
- ◆ All claims for secondary insurance payment including co-pays, co-insurances and deductibles must be accompanied by an Explanation of Benefit (EOB) from the primary carrier.
- ◆ Please remember: Community Care's timely filing rules changed to 90 days on January 1, 2003. Providers must ensure that all claims be submitted within the 90 day timely filing rule to avoid possible claims denials.

In the event that a primary carrier does not process an EOB within the 90 days, Providers must ensure that all COB claims submissions are submitted within 30 days from the date of the Explanation of Benefit (EOB) from the primary insurance. Secondary claims will only be considered for processing with supporting documentation demonstrating that the primary insurance was billed within 90 days from the date of service and follow up with the primary insurance occurred every 60 days. In these instances, the secondary claim with a copy of your documented efforts to follow-up should be submitted for special handling at the following address:

Community Care Behavioral Health
One Chatham Center
112 Washington Place
Suite 700
Pittsburgh, PA 15219
Attention: Claims Department

Exceptional situations will be handled on a case-by-case basis. These situations can be reviewed by calling Community Care's claims department at 1-888-251-2224.

COB/Third Party Liability Exempt Services

Community Care contracts for certain services that are classified as exempt from primary insurance coverage. For these services, Community Care can be billed as a primary payor regardless of the presence of another insurance.

The list of exempt services is as follows:

Residential Treatment Facilities except for TRICARE
Halfway House Services
Intensive Case Management
Resource Coordination
School-Based Partial Hospitalization
BHRSCA (wraparound) Services

Family-based Mental Health
Telephone Crisis
Walk-in Crisis
Mobile Crisis
Respite Services
Methadone Maintenance
Clozaril Support Services
*Alternative services individually negotiated and contracted by Community Care

Community Care receives ongoing updates surrounding Coordination of Benefits and Third Party Liability procedures from the Department of Public Welfare. As updates are received, Community Care will provide updates to our contracted providers.

If you have further questions surrounding Community Care's Coordination of Benefit policy, please call the Claims Department at 1-888-251-2224. Thank you.