



Behavioral Health Rhode Island Provider Training

Coordination of Benefits

RI Provider Relations Team

2023



What is Coordination of Benefits (COB)?

Definition of COB

- “Coordination of Benefits” or “COB” means a provision establishing an order in which plans pay their claims and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

Types of COB

- Subrogation
- Third-party liability (TPL)
- Workers’ compensation
- Health Coverage

Understanding the Coordination of Benefits System

What is the COB Process?

- The first way that health insurance providers coordinate benefits is to determine which health insurance plan of the patient would be considered the primary plan and which health care plan of the patient would be considered the secondary plan.
- Once the covered patient's primary plan is determined, the benefits that the patient is eligible for under the primary plan must be given without assuming there is a secondary plan.
- The secondary health insurance plan, unlike the primary health insurance plan under the coordination of benefits, can take into consideration what health insurance benefits were provided to the patient in the primary health insurance plan. The remaining allowable health care costs due will then be considered for payment under the secondary health insurance plan.

Order of payment for reimbursement

Which Plan Pays First?

- If a plan coordinates benefits, its contract shall state the types of coverage that will be considered in applying the COB provision of that contract. Whether the contract uses the term “plan” or some other term such as “program,” the contractual definition may be no broader than the definition of “plan” in this subsection.
- Optum is the payer of last resort when one of its members is insured by another liability or health insurance plan. Providers can bill Optum as the secondary carrier after receiving an EOB or PRA from the primary carrier.

Order of Benefits

Determining which Plan pays first

- Each plan determines its order of benefits using the first of the following rules that apply:
 - Non-Dependent or Dependent
 - the plan that covers the person other than as a dependent, for example as an employee, member, subscriber, policyholder or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan
- Dependent Child Covered Under More Than One Plan
 - For a dependent child whose parents are married or are living together --- whether or not they have ever been married:
 - The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
 - If both parents have the same birthday, the plan that has covered the parent longest is the primary plan
 - For a dependent child whose parents are divorced or separated or are not living together, If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary --- whether or not they have ever been married

Coordination of Benefits Federal Programs

- If the person is a Medicare beneficiary and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 - Secondary to the plan covering the person as a dependent; and
 - Primary to the plan covering the person as other than a dependent (e.g., a retired employee)
- Medicaid is always the payor of last resort

Claim Submission requirements

- When filing a claim for a member with TPL or COB resources, providers must include:
 - ❖ The primary carrier's denial or payment code descriptions on the CMS 1500 or UB04 form, showing claim-processing results from the primary carrier
 - ❖ A copy of the primary carrier's EOB, denial notice, and benefits exhausted statement (including personal injury protection, if applicable)
 - ❖ The primary carrier's EOB must contain the check date or date the claim was finalized. An administrative denial from the primary carrier is not accepted as a reason for Optum to pay as a primary carrier.
 - ❖ When submitting a claims retraction request for a claim that a motor vehicle, workers' compensation, health, or other third-party insurer has paid, providers must include a copy of the primary carrier's EOB and, when applicable, a check.

Filing paper claims

01 Use an original 1500 Claim Form (no photocopies)

02 Type information to ensure legibility

03 Use a DSM-5 derived ICD-10 code for primary diagnosis
(Hint: the DSM-5 includes ICD codes along with the DSM diagnostic info)

04 Complete all required fields (including ICD indicator and NPI number)

Submitting Electronic Secondary or Tertiary Claims to UnitedHealthcare

Secondary or tertiary professional and institutional claims can be submitted electronically. This process is commonly referred to as eCOB (electronic Coordination of Benefits). If sending these types of claims correctly in an electronic format, the paper EOB is not needed by UnitedHealthcare.

Contact your software vendor or clearinghouse to determine the version you are using or to request upgrade for your Practice Management System or Hospital Information System.

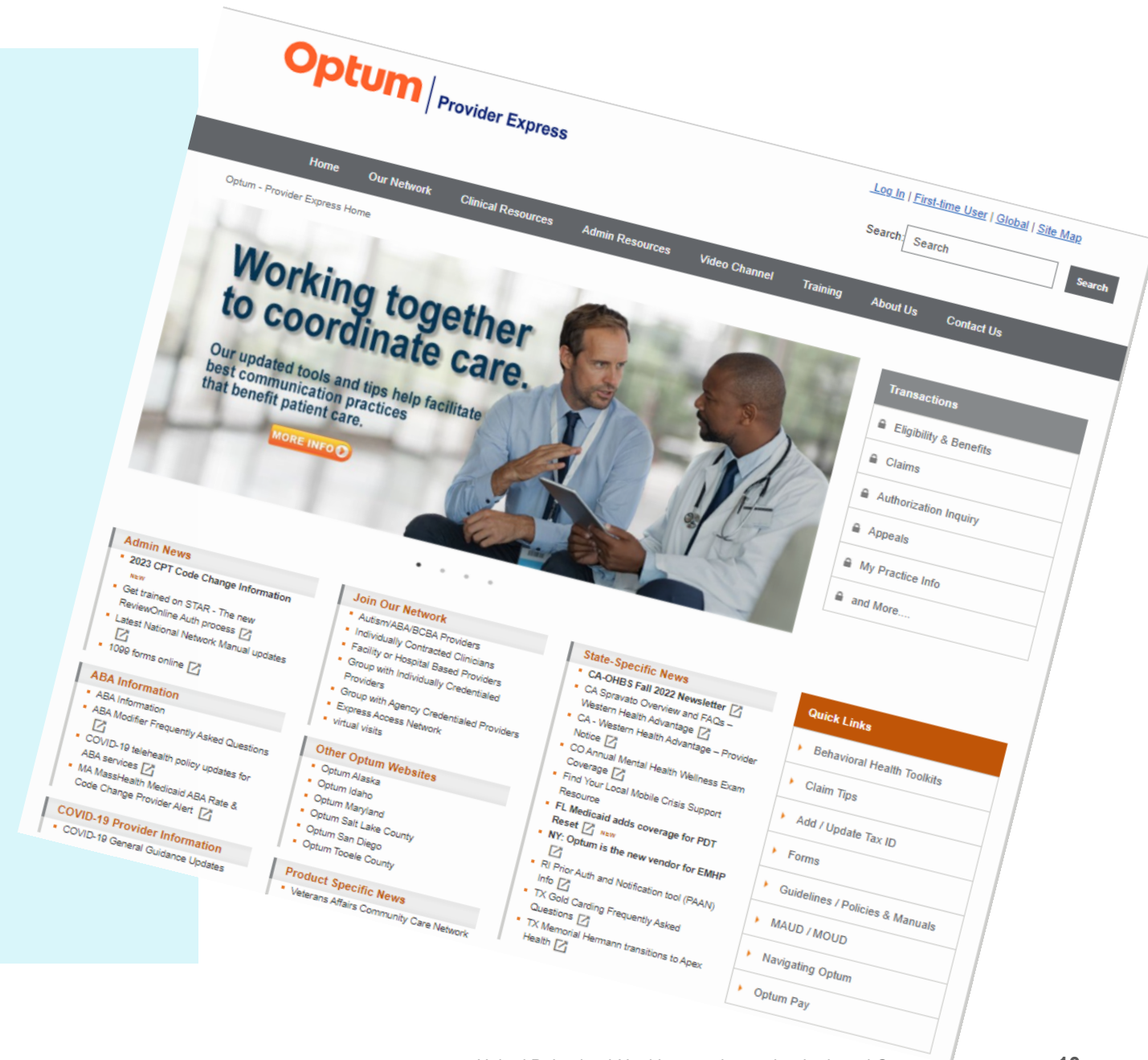
To learn more about submitting secondary/COB claims electronically to UnitedHealthcare, please consult your vendor, 837P/837I Implementation Guide, or refer our Companion Guides page for eCOB specifications.

Benefits of using Provider Express regularly

Provider Express offers many tools that make working with Optum quick and easy

Use the secure transactions to:

- Look up Member Eligibility / Benefits
- Request and view authorizations
- Submit claims
- Check claim status and submit claim adjustments
- Create a customized “My Patients” list
providerexpress.com



Reference materials

Need more information?

For more information see:

National Association of Insurance Carriers :
<http://www.naic.org/store/free/MDL-120.pdf>

Rhode Island 11-5 R.I. CODE R. §§ 48:1 to 48:10
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Q&A

NHPRI Optum Network Managers

Wendy Hamel Sherzer

Wendy.Hamel.sherzer@optum.com

Providence County

Aura Matos

Aura_Matos@optum.com

Bristol, Newport, Kent, & Washington County

UHC Optum Network Managers

Stacie Warner

Stacie.Warner@optum.com

Providence County

Christine Pellegrino-Celio

Christine.Pellegrino-Celio@optum.com

Bristol, Newport, Kent, & Washington County

Escalated Concerns

Robert (Bob) Wishtischin

Provider Relations, Director

robert.wishtischin@optum.com

Optum

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