Coordination of Benefits Reference Guide

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Definitions

**Coordination of Benefits (COB):** A procedure used to process health care payments when a person is covered by one or more insurers. Prior to submitting a claim to the Plan, providers must identify if any other payer has primary responsibility for payment of a claim.

**Co-Payment:** Part of the cost-sharing requirement for members in which a fixed monetary amount is paid for certain services/items received from the contractor’s providers.

**Cost Avoidance:** A method of paying claims in which the provider is not reimbursed until he/she has demonstrated that all available health insurance has been exhausted.

**Covered Services:** Those medically necessary health care services provided to members, the payment or indemnification of which is covered under Georgia Medicaid.

**Crossover:** The transfer of processed claim data from primary payer to Medicaid and/or WellCare of Georgia.

**Explanation of Payment (EOP):** A statement or summary sent to the provider from the payer detailing which items/services were paid or allowed.

**Medicaid Secondary:** The provider is billing Medicaid as the “payer of last resort”, acknowledging that any and all other insurance benefits have been pursued for payment prior to billing WellCare of Georgia.

**WellCare of Georgia Allowable:** Reimbursement rate outlined in the provider’s contract.
Coordination of Benefits

Coordination of Benefits (COB) is a provision used to establish the order in which health insurance plans pay claims when more than one plan exists, as well as the payment liability amount each payer has. COB is utilized to ensure that reimbursement for covered health care services does not exceed 100 percent of total allowed amounts.

Since by federal law, Medicaid is the “payer of last resort,” WellCare of Georgia (WellCare) will consider payment on a claim only after all other payers have been billed and their payment liability has been determined. Providers must exhaust all efforts to receive payment from other payers that have primary legal responsibility to pay the claim before billing WellCare and must demonstrate that all available health insurance has been exhausted. This includes exercising any and all appeal rights from the primary payer for denial, reduction or corrections of services. WellCare is not liable for payment of services denied to a provider because of the provider’s failure to follow the primary payer’s rules, guidelines or polices. The requirement of Cost Avoidance applies to all covered services with the exception of the services listed below that can be billed to WellCare as primary:

Claims for labor and delivery, including inpatient hospital care and postpartum care, prenatal services, preventive pediatric services, and services provided to a dependent covered by health insurance pursuant to a court order. For these services, WellCare shall ensure that services are provided without regard to insurance payment issues and must provide the service first. WellCare shall then coordinate with DCH or its agent to enable DCH to recover payment from the potentially liable third party.

If the patient has coverage with a primary payer and has secondary coverage with WellCare, this coverage does not relieve the patient from any cost-sharing responsibilities (deductible, coinsurance and/or co-payment) required by the primary payer. WellCare will pay the cost-sharing amounts up to the WellCare allowable for total reimbursement. WellCare’s liability for such cost-sharing amounts shall not exceed the amount WellCare would have paid under the provider’s contracted reimbursement.

**PLEASE NOTE:** If the primary payer pays an amount equal to or more than the WellCare Allowable, there is no additional reimbursement available from WellCare.

### EXAMPLE 1

| Provider billed charges: | 120.00 |
| WellCare Max Allowable: | 90.00 |
| Primary Payer Pays: | 80.00 |
| Difference: | 10.00 |
| Member’s Responsibility: | 10.00 |
| WellCare Pays: | 10.00 |

### EXAMPLE 2

| Provider billed charges: | 100.00 |
| WellCare Max Allowable: | 70.00 |
| Primary Payer Pays: | 80.00 |
| Difference: | (-)10.00 |
| Member’s Responsibility: | 20.00 |
| WellCare Pays: | 0.00 |
Basis of Reimbursement

Claims originally filed timely to the primary payer must be received by WellCare within 12 months from the month of service. We will make an exception if the primary payer’s appeal process has surpassed the WellCare timely filing period. Those claims will be reviewed by the WellCare Claims Processing department.

When COB is filed with a primary payer paid amount and the EOP shows a patient liability amount, WellCare will deduct the primary payer paid amount from the WellCare Allowable amount and compare the difference. If the difference between the WellCare Allowable and the primary payer paid amount is equal to or greater than the patient liability, the patient liability amount becomes the new WellCare Allowable and no additional payment above the patient liability will be reimbursed. Claims that “pay” at zero are considered paid claims, since the benefit has been reached.

When a COB claim is filed with a primary payer paid amount and the EOP attachments shows a patient liability amount, WellCare will deduct the primary paid amount from the WellCare Allowable and compare the difference. If the difference between the WellCare Allowable and the primary paid amount is equal to or greater than the patient liability, the patient liability amount becomes the new WellCare Allowable and will be used to complete the adjudication process. For example:

WellCare Allowable  75.00
Primary Paid Amount 35.00
Patient Liability 25.00

$75.00 (WellCare Allowable) minus $35.00 (Primary Paid Amount) = $40.00

Compare the $40.00 (difference between the WellCare Allowable and the Primary Paid Amount) to the $25.00 (patient liability). The $40.00 is greater than the $25.00 patient liability so the new WellCare Allowable becomes $25.00.

If the difference between the WellCare Allowable and the primary paid amount is less than the patient liability, then the WellCare Allowable will be used to complete the adjudication process. For example:

WellCare Allowable 75.00
Primary Paid Amount 35.00
Patient Liability 50.00

$75.00 (WellCare Allowable) minus $35.00 (Primary Paid Amount) = $40.00

Compare the $40.00 to the $50.00 (Patient Liability) and $40.00 will be used as the WellCare Allowable.

When the payment from another insurance carrier is less than the WellCare Allowable, we can pay up to the WellCare Allowable. The sum of the WellCare payment and the other payer payment(s) will not exceed the WellCare Allowable including co-payments.
When a provider is capitated with the primary payer and does not receive an EOP, the provider must submit the COB Notification Form, found here: https://georgia.wellcare.com/formsanddocuments/default, to WellCare in order to receive reimbursement for the deductible, coinsurance and/or co-payment amount. The COB Notification Form must be received by WellCare within 12 months from the month of service.

**Service or Benefit Not Covered by the Primary Payer**

When a service or benefit is not covered by the primary payer, but is a covered Medicaid service or benefit, we will process the claim as primary and payment shall not exceed the WellCare Allowable.

**Service or Benefit Denied by the Primary Payer**

Providers may not bill WellCare when the primary payer denied the submitted charges due to:

- A billing error on the part of the provider OR
- The provider’s failure to follow the primary payer’s rules, guidelines or polices

When billing WellCare as a secondary payer, the provider must follow the WellCare policies and procedures, including adherence to all policies/guidelines for authorizations of services. If your claim was denied by the primary payer, you must submit the EOP as validation of the denial; be sure that the EOP clearly shows the denial reason.

**EDI Submission of COB and COB Information – MOOP**

The Plan encourages providers to submit COB claims electronically through Electronic Data Interchange (EDI). All submitters that adjudicate claims for the Plan or have COB information from other payers are required to submit all the COB and Adjudication Loops as per the Coordination of Benefits 1.4.1 section within the 837 Professional and Institutional Implementation Guide.

The following are the required Loops and Segments needed to submit a compliant COB:

- Other Subscriber Information (2320) Loop
- Other Subscriber Name (2330A) Loop
- Line-Level Adjudication Information (2430) Loop
  - (CAS) Segments within this loop contain previously adjudicated information by another payer. These Claim Adjustments include, but not limited to: co-insurance, co-pays and deductibles. Please refer to the 5010 Implementation Guides for complete details.

**Billing Information**

For more info, contact your clearinghouse or email us at EDI-Master@wellcare.com. Submit paper claims (UB-04 and CMS 1500 Forms) to:

**WellCare of Georgia Health Plans, Inc.**

Attn: Georgia Claims Department

P.O. Box 31224

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