Coordination of Benefits (COB) Claims Submission Guide

Coordination of benefits applies to members who have coverage with more than one health care plan and helps to ensure that these members receive benefits while avoiding overpayment to the provider by either plan. By law, all other available third party resources hold a liability (third party liability or TPL) and must meet their legal obligation to pay claims before Medicaid pays for the care of an individual eligible for Medicaid. The primary carrier covers the first portion of the bill according to plan allowances, and the secondary carrier, or in this case, Medicaid, will cover any remaining allowable expenses. There are several factors that affect each COB claim:

- If an Explanation of Benefits (EOB) was received
- If the primary plan is Medicare or a commercial plan (another group health plan; not Medicare or Medicaid)
- The plan’s COB provision
- The provider’s participating status with both carriers
- The COB allowable
- The primary plan’s payment and the member’s liability

The most common COB provision, also referred to as “COB method”, is standard COB. With standard COB, the total amount paid by two or more health plans will not exceed 100% of the total allowable expense. The primary plan pays its normal benefit, while the secondary plan pays the difference between what the primary plan paid and the allowable expense, up to its normal benefit. Essentially, the total amount paid between both plans should not exceed 100% of the total allowable expense. See the example below for calculating standard COB. Also, as a reference, rate schedules are updated no less than annually and posted on www.magellanofvirginia.com under “For Provider”.

**This is an example of Standard COB, if the primary carrier is other than MEDICARE:**

- Billed = $200.00
- Primary Carrier Allowed = $75.00
- Primary Carrier Paid = $75.00
- Medicaid Allowed = $100.00
- Magellan will pay: $25.00 (difference between the amount paid by the primary carrier and the Medicaid Allowed)
- Pay up to the Medicaid allowance, minus TPL

COB Allowable – Other Insurance Carrier (OIC) Paid = Magellan payment

$100 – $75 = $25
If the primary carrier is MEDICARE:

All behavioral health claims where Medicare is primary and Medicaid is secondary are considered crossover claims and should be billed to Magellan for Magellan to pay as secondary to Medicare. Providers can refer to the 10/01/2014 Medicaid Memo, “Medicare Crossover Billing Instructions on Paper CMS 1500” for additional guidance.

There are times Medicare is primary, yet makes no payments. The following are examples and how the claims should be handled by Magellan:

- The Medicare member benefits are exhausted, per an attached Medicare Explanation of Benefits (EOB). The claim should be paid as if they had no Medicare.
- The rendered service is non-covered by Medicare, then Medicaid (Magellan) is considered the primary carrier. The provider must submit the Medicare EOB or letter (on agency letterhead) stating that Medicare does not cover the service for each impacted claim.
- The provider is not contracted for Medicare or does not qualify as a Medicare provider; then Medicaid (Magellan) is considered the primary carrier. The provider must submit the Medicare EOB or letter (on agency letterhead) stating that Medicare does not contract with their specific provider type or they are not contracted with Medicare for each impacted claim.
- For claims submitted on a UB-04 claim form and Medicare has paid $0.00 because of deductible/coinsurance, bill Magellan. DMAS (Magellan) cannot be billed as a crossover claim, since Medicare made no payment. For Behavioral health providers, billing behavioral health services with a psychiatric diagnosis; bill these claims to Magellan for processing. Include the Medicare EOB showing the paid amount was zero due to a deductible and/or coinsurance.

Co-Payments

If primary carrier is other than MEDICARE, and provider is billing MCO co-payments:

- NOTE: The primary carrier has to be a commercial managed care plan not one of the contracted Medicaid MCO plans or CCC MMP plans for the following rule to be followed.
- If MCO co-payment is $25.00 or less, and EOB does not need to be attached. Magellan will pay the full co-payment amount.
- If MCO co-payment is greater than $25.00, the primary carriers EOB must be attached and show the co-payment amount. Magellan will pay the MCO co-payment amount.

Authorization Requirements

Authorization requirements still apply.
**Timely Filing**
Claims must be submitted within 365 days of the provision of covered services. If a member has no COB information on file or has not updated the information in the past year, any claims submitted may be denied when first processed. If you have additional questions please call 1-800-424-4046 or submit questions online at www.Magellanofvirginia.com using the “contact us” link.

**Billing Magellan**
Providers are responsible for checking member coverage with another carrier to confirm coverage, any changes to coverage or if coverage has been terminated.

The following guidance outlines billing TPL claims to Magellan for any instance where the member has COB. This may apply to services such as behavioral therapy (procedure codes H0032 UA and H2033) and residential treatment.

**Clearinghouse/EDI**
When billing electronically, the required COB data elements may be gathered from the previous payer’s adjudication. Either claim line or claim level is accepted, with claim line level being the preferred method of submission. If both are submitted, line level must add up to the claim level.

The loop/segment information below provides the exact location of the COB data element in the 837I format:

<table>
<thead>
<tr>
<th>Loop 2430:</th>
<th>Segment Name</th>
<th>Element Name</th>
<th>Requirements/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SVD02</td>
<td></td>
<td>Paid Amount</td>
<td>Amount paid by the primary carrier. If you are not contracted with the primary carrier or the primary carrier does not cover the service billed, paid amount = 0</td>
</tr>
<tr>
<td>CAS</td>
<td></td>
<td>Claim Level Adjustment</td>
<td>Prior payers claim level adjustments. This segment is used if the payer in this loop has reported claim level adjustment information on the primary payers remittance advice. Use 109 adjustment reason code when not contracted with the primary carrier or the primary carrier does not cover the service billed.</td>
</tr>
<tr>
<td>DTP</td>
<td></td>
<td>Date Claim Paid</td>
<td>Service adjudication or payment date</td>
</tr>
<tr>
<td>AMT</td>
<td></td>
<td>Total Amount Billed</td>
<td>Total amount billed for patient responsibility</td>
</tr>
</tbody>
</table>
For any questions related to EDI billing, please contact Magellan’s EDI support at 1-800-450-7281 ext. 75890 or email EDISUpport@MagellanHealth.com

Claims Courier (Magellan Provider Website)
Magellan’s Claim Courier application is a web-based data entry application for providers submitting individual professional claims. Claims Courier allows the submission of COB information via the “Submit a Claim Online” function when there is a single primary carrier other than Medicaid. When there are multiple carriers, please refer to the paper claim instructions.

Enter COB in the “Patient/Insured Information” section of the claim:

Select “No” for the last question in this section “Is Magellan the primary carrier?” Click the box for “add other insurance” and enter the primary carrier information and hit “save”.

In the claim detail section, on the “Claim Line Information” tab, enter allowed and paid amounts. When the carrier does not cover the service, the paid amount = 0.00.

On the “Coordination of Benefits” tab, enter the amounts covered by each carrier other than Medicaid.

If the claim is not covered by the primary carrier, enter the total billed amount on the line “claim not covered by this payer/contractor”:

Once submitted, you will see the claim status update to “pend”. Once the claim has been processed and finalized, you will see a change in the claim status.

Paper
When billing on a CMS 1500 paper claim form, box 11d asks if there is another health benefit plan. If the answer is “yes”, boxes 9a-d are completed with the information of the other plan. If billing on the UB-04 paper claim form, box 50 allows any other health benefit plans to be listed.
When submitting paper claims, an **Explanation of Benefits (EOB) from the primary carrier is required with each claim**. If an EOB is not submitted, the claim will be denied requesting the explanation of benefits from the primary carrier. If you are not contracted with the primary carrier or the primary carrier does not cover the service, you do not need to submit to the primary carrier for a denial. You may submit a letter on company letterhead explaining the reason Magellan should treat the claim as primary for Medicaid. The letter must be dated within a year of the date of service for the claim in question. If submitting a letter, one must be submitted with each claim.

For questions regarding the information in this communication, please contact our customer service department at 1-800-424-4046 or use the “Contact Us” link on the Magellan of Virginia website.