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Optometry Coding & Billing Alert

Billing: Overcome Primary vs. Secondary Payer Woes With Answers to Your FAQs

Start with the basics and then move on to learning the intricacies.

When a patient is covered by two insurance companies, such as patients whose employer and spouse's employer both provide health benefits, claims processing can be confusing. Add in differing payer claims processes and patients who might not give you all the information you need, and primary and secondary payer cases can lead to reimbursement loss -- not to mention biller headaches.

You can maximize your practice's reimbursement and reduce the costs of administering claims for patients covered by more than one payer if you understand coordination of benefits (COB) and how both insurers are supposed to pay.

Take a look at these three questions -- with answers from the experts -- to get the scoop on what you need to do to ensure you're on the right track with multiple-payer billing situations.

1. What Does Coordination of Benefits Even Mean?

COB is a common clause in many health insurance policies. It specifies how the insurer will reimburse for services when more than one insurance plan is applied to a claim.

"Coordination of benefits exists when there are two policies in place (e.g.., one is the husband's employer policy and the other is the wife's employer policy)," says **Linda Huckaby, CMA (AAMA),** with Carolina Medical Rehabilitation in Greenville, S.C. "The primary policy pays, then the secondary coverage will review the claim paying any difference between what the primary insurance has paid and what the secondary coverage allows."

Which payer is primary and which is secondary is defined by the payers, explains coding, billing, and practice management consultant **Steven M. Verno, CMBS, CMSCS, CEMCS, CPM-MCS,** in Orlando, Fla. "An example is when Patient X has coverage through Aetna and Blue Cross. The determination as to whether Aetna is primary or Blue Cross is primary is between the two insurance companies, not the patient and not the provider of medical services."

Be aware: There may be some rare cases where a patient has two forms of healthcare coverage where both plans are deemed to be primary, Verno says.

2. How Does State Law Factor Into COB Rules?

COB rules can follow state law definition and state law requirements, Verno says. "For example, in Florida, you have Florida statute 627.4235.

But although COB rules can be governed by state law, and most insurers have COB rules in their contracts, many payers follow model rules developed by the National Association of Insurance Commissioners (NAIC).

"If the health benefits are not under state law jurisdiction, as defined by the Employee Retirement Income Security Act (ERISA), specifically 29 USC 18, 1144(a), then COB may come under Federal Regulation jurisdiction as defined in 29 CFR 2560-503-1," Verno explains. "Most payers follow state law and NAIC COB requirements."

3. How Do I Know Which Is the Primary Payer?

Under the NAIC rules, the plan that pays first is known as the primary plan; the one that pays second is known as the secondary plan. The primary plan must pay benefits as if the secondary insurer did not exist, Huckaby says. The

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secondary plan can only take into account what another plan paid when it is secondary to that plan.

How it works: "Normally the primary pays as primary without regard to any other coverage," Verno says. "The secondary should follow applicable COB laws, rules, or policies and pay the claim according to those laws and rules." Verno offers the following example from an AvMed HMO benefit manual: "When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full, or (2) a reduced amount which, when added to the benefits payable by the other coverage, will not exceed reasonable charges."

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