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Part B Insider (Multispecialty) Coding Alert

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.

In this first article of a two-part series, you'll learn the basics about billing two payers. Then, tune in next issue for part two, in which you'll learn more details about handling primary and secondary payer claims.

Take a look at these 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 (i.e., 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 (http://www.floir.com/siteDocuments/Fl_1st_Hlth_Plans_00_Rpt.pdf).

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?

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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 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.

4. Who Is Responsible For Knowing About Primary vs. Secondary?

There is no exact, easy answer to this question, but everyone should be aware of which insurance that patient has. Ideally, the patient should know but that is not usually the case, Huckaby says.

Everyone, provider, patient, and payer, has a responsibility to know, says Verno. The provider should know because they need to know who the claim is to be sent if the patient has covered health benefits. The medical biller who works for the provider should know for the same reason. The patient should know so that they seek care from doctors who are networked with their insurance plans, which may be outlined in their contract with the insurance company.

Your practice should be asking the patient for his insurance information before rendering services. Be sure to ask the patient if he has more than one plan. It is the responsibility of the practice to identify primary and secondary because billing done incorrectly slows the revenue flow, Huckaby adds. The payer will always have some clue as to primary and secondary, although sometimes that information is incorrect and requires assistance from the patient.

Best bet: Verify a patient's insurance coverage before you bill the service. Verification means checking the patient's insurance information to be sure that a patient belongs to the group you-re billing and that her group and member identification are correct. You should obtain this information prior to the patient's initial visit when possible.

If your practice verifies eligibility and benefits prior to an appointment, sometimes the insurance companies will indicate that other insurance coverage exists. That would let you know ahead of time that you should speak to the parent regarding the primary/secondary coverage.

Work faster: Take advantage of payer Web sites to make insurance verification less time-consuming. Find out which payers you deal with have verification Web sites, and sign up for them. Some clearinghouses also offer verification services.

Ask the patient: Have good patient registration and insurance forms to collect all the information you'll need. Make sure there is room for the patient to list a secondary payer. Ask front-desk personnel to look immediately at the form for any missing information. Also ask returning patients if their information has changed, and get a new copy of the insurance card(s).

5. What Does the Secondary Pay?

The secondary plan must determine the amount of benefits it would normally pay if no coordination existed and apply that amount to unpaid covered charges owed by the insured after any benefits have been paid by the primary payer. The payable amount must include deductibles coinsurance and copays owed by the insured. The secondary plan can use its own deductibles coinsurance and copays to determine the amount it would have paid had it been primary. It can apply only its own deductibles coinsurance and copays to the total allowable expenses not to the amount owed after payment by any primary plan.

The secondary plan has no obligation to pay for any services that it does not cover as a benefit. A practice should never expect reimbursement from the primary and secondary insurer to total more than the service charges. COB's purpose is to make sure insurance payments for patients with duplicate health insurance coverage do not exceed the cost of the services.

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When a secondary insurer acts on your claim, check the payer's COB clause to see if it followed its own rules. Ask the insurer's customer-service representative to explain its COB rules and request a copy in writing. A company's Web site may also offer COB handling explanations. Or ask patients for copies of their insurance policies.

6. How Should I Handle Payment Errors We Discover?

You are obligated to refund overpayments to payers regardless of primary-versus-secondary issues between the payers. Keeping an overpayment might be deemed to be fraud or a possible kickback Verno warns.

Stay compliant: Both the OIG's compliance guidance for physicians and its guidance for third-party billing companies address overpayment refunding. As a healthcare provider, you have a legal obligation to repay any discovered overpayments.

If you discover an overpayment, your practice should be prepared to refund one of the payers -- or sometimes the patient -- the money due.

Example: Let's say the patient has ABC and XYZ insurance, Verno says. ABC is supposed to pay 80 percent of the charges. The charge is $100. ABC pays $100. The provider's charges are paid in full but the provider knows that all ABC is required to pay is $80. The provider should follow the practice compliance plan by refunding the overpayment to whom the insurance designates is to receive the overpayment.

Pointer: Don't send refunds to payers until you have specific information on where to send the money. When you find out about an overpayment because of primary and secondary payer mix-ups, send a letter to the payer explaining the situation, and wait for them to tell you where to send the repayment check.

If a patient presents you with information on what she thinks is her primary insurance, and your practice finds out much later that it was her secondary insurance but you were paid, talk with the payer.

Ideally: Patients are responsible for being compliant, and they can get into trouble for insurance fraud by not following their insurance payers' rules. If the patient makes a mistake and gives the secondary payer as the primary, the insurance company will hopefully catch the error and then pay at the secondary rate.

Reality: Sometimes patients and payers make mistakes. If the secondary insurance paid the claims as a primary because it was unaware of other insurance and the practice also did not have any knowledge of the primary payer, then the practice is not held liable.

Be proactive: If you find out about the error -- for example, if the patient calls your office several months later and explains the situation -- you should call the payer and let it know of the error. Often the payer may not do anything because so much time has passed, or it may work directly with the patient to solve the problem.

Contact should be made with the overpaying insurance, first, to identify what happened to create the overpayment; then a refund should be initiated as per instructions from the insurance company, Huckaby explains.

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