Psychiatry Coding & Reimbursement Alert

Reimbursement Strategies: Lean On This Advice To Sort Out Primary Vs Secondary Payer Challenges

3 FAQs guide your way to smoother processing and improved reimbursement flow.

When a psychiatric patient is covered by two insurance companies, such as patients whose employer and spouse's employer both provide mental health benefits, claims processing can be confusing. And when you factor in insurer carve-outs that may limit payment for mental health services, you've added another layer of complexity to primary and secondary payer billing for psychiatric cases.

Best practice: You can ethically 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 first 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 [or more] 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.

For psychiatry claims, the process parallels other specialties in that the claim would be sent to primary insurance, and once the primary pays, "the payment is applied with any applicable adjustments" offers Verno. The claim is then "sent with the same codes to the secondary showing the balance due," he adds. "The secondary usually requires the EOB from the primary."

Bear in mind that for psychiatry, as for other specialties, specific carrier benefit policies may vary, so it's best to verify with payers.

2. Where do I find COB Rules?

Most insurers have COB rules in their contracts.Those 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). "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. Federal law also governs when Medicare and certain other federal health coverage is primary or secondary to other insurance.

Many payers also follow model rules developed by the National Association of Insurance Commissioners (NAIC). "Most payers follow state law and NAIC COB requirements," according to Verno.

So, to find a payer's COB rules, start with its contract(s). Beyond that, if you want know whether state law and regulations are in effect, contact the state insurance commissioner's office in your state. As noted, if state law does not apply, you will need to refer to the applicable federal regulations. To learn more about the NAIC COB requirements, you can visit the NAIC web site at www.naic.org

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.

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."