POLICY AND PROCEDURE

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COMMUNITY HEALTH CHOICE
COMMUNITY CARES

TITLE: COORDINATION OF BENEFITS

Department:	Operations - Claims	**Department Head:** (Name and Signature)	Mychelle Scott
Approval Date:	8/13/18	**Next Review Date:** (12 months from approval date)	August 2019
Compliance/Executive Approval:			
Name : Devona J Williams		**Date:** 8/14/18	

APPLIES TO: ☒ **MEDICAID** ☒ **CHIP/ CHIP P** ☒ **HEALTH INS MARKETPLACE** ☒ **OTHER**

☐ **STAR+PLUS** ☐ **D SNP** ☐ **MMP**

PURPOSE:
The purpose of this policy and procedure is to comply with federal and state regulatory requirements with respect to identification and coordination of benefits for covered services provided to Community Health Choice (Community) Enrollees.

POLICY:
Community administers benefits according to the Texas Insurance Code § 843.349 (e) and (f), and for Medicaid MCOs, chapter 42, section 433.139 of the Code of Federal Regulations(CFR) . Community is the payer of last resort when other insurance is in effect. When other primary insurance information is not identified, Community will pay all covered medical services. Upon notification that other primary insurance exists, Community shall employ all reasonable actions to pursue recovery of benefits paid as primary.

"Medicaid coverage is the payer of last resort, unless specifically prohibited under state or federal law, when coordinating benefits with all other insurance coverage. Coverage provided under Medicaid will pay benefits for covered services that remain unpaid after all other insurance coverage has been exhausted. . For in network providers, and Out-of-Network (OON) providers with written reimbursement arrangements with the MCO, the MCO must pay the unpaid balance for covered services up to contractually agreed upon rate. For OON providers with no written reimbursement arrangement, the MCO must pay the unpaid balance for covered services in accordance with HHSC's administrative rules regarding out-of-network payment (1 Texas Administrative Code §353.4). In both cases, the MCO must pay the difference between the reimbursed amount from the third party insurance and the MCO's negotiated rate or the required OON rate, as applicable."

Scenario	Response
Service is not covered by private insurance, but is covered by Medicaid.	Provider bills private insurance, receives Explanation of Benefits (EOB) denying coverage, then bills Medicaid MCO for the contractually agreed upon rate established between the provider and the Medicaid MCO.
Service is covered under both private insurance and Medicaid, but deductible has not been met.	Provider bills private insurance, receives EOB indicating deductible has not been met, then bills Medicaid MCO for the deductible up to the contractually agreed upon rate established between the provider and the Medicaid MCO.
Service is covered under both private insurance and Medicaid, and deductible has been met.	Provider bills private insurance, receives EOB and payment up to the agreed upon rate. The provider may then bill the Medicaid MCO *if* the private insurance reimbursement is *lower* than the contractually agreed upon rate established between the provider and the Medicaid MCO. The MCO must pay the difference between the reimbursement offered by private insurance and the agreed upon reimbursement offered by the Medicaid MCO.

DEFINITIONS:

Cost Avoidance means to avoid payment of claims when other insurance resources are available to the Enrollee.

Coordination of Benefits (COB) is when an Enrollee is covered by two or more health plans; benefits for these plans will be coordinated so that compensation does not exceed the maximum benefit.

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PROCEDURE:
Upon receipt of a claim, review the member file for COB information:

Responsible Party (Who)	Step	Action Taken (Does What)
Claims Examiner or Adjuster	(A)	If no other primary insurance exist, adjudicate the claim.
	(B)	If other primary insurance exist, and no primary explanation of benefits from the carrier is attached, deny the claim requesting the Other Carrier's explanation of benefits.
	(C)	If other primary insurance exists, and a primary explanation of benefits from the carrier is attached, pay up to the contractual allowable.

MONITORING:

Monthly validation of Health Management Systems (HMS) reports to ensure the members' records are updated in the QNXT system.

REPORTING:

Name of Report	Frequency of Report	Owner
Random Audit Report	Monthly	Claims Management team

ATTACHMENT(S):
None