Provider Notice 1.15

July 1, 2008

» ***Coordination of Benefits/TPL Billing Instructions***

In consultation with SRS and CMS guidance, KHS has developed new policies and procedures around coordination of benefits when a KHS eligible member has other primary insurance to Medicaid. KHS is instructing its Provider Network to adjust its billing practices to adhere to this new policy.

Effective with dates of service on and after July 1, 2008, when a KHS eligible member has other primary insurance to Medicaid, KHS will not require the member to seek services from a provider who is contracted with the primary insurer. If the KHS member receives services from a KHS provider who is not in the primary insurer network or a provider whose license type is not recognized by the primary insurer, the KHS provider should bill the primary insurance, obtain the appropriate denial and bill KHS for the services rendered. KHS will reimburse providers for covered services as secondary payer based upon the KHS allowed fee, less primary insurance payment.

1. BILLING via 837 FILE.
   No Explanation of Benefits (EOB) will be required to be submitted with the claim if submitted in an 837 file format. Amounts paid by the primary insurance must be reported in the required loops and segments per the 837 4010A1 Implementation Guide. In cases of denials, the amount paid should be entered as zero.

   a. Providers are required to retain the Explanation of Benefits from the primary insurance as evidence of filing with the primary insurance. Upon audit, if no EOB is available, the claim may be subject to recoupment.
   b. If claims are submitted with blank fields on the 837 file and KHS shows the member has primary insurance to Medicaid, KHS will deny/ reject the claim as needing to be submitted to the primary insurance. Amounts paid by the primary insurance must be reported in the required loops and segments per the 837 4010A1 Implementation Guide.

2. BILLING via PROVIDERCONNECT
   Due to the need to have primary insurer reason codes on denials/ payments, billing of COB claims is not allowed through ProviderConnect.

Changes will go into effect 30 days following the date of publication of Provider Notice.

3. BILLING PAPER CMS 1500 FORMS.
   Claims filed on a CMS 1500 will require the EOB to be attached to the claim.

   a. Where claims are submitted on the CMS 1500 without the EOB attached and KHS shows the member has primary insurance to Medicaid, KHS will deny the claim as needing to be submitted to the primary insurance.

4. Allowable Reimbursement Calculation:
   For covered services, KHS will reimburse providers as secondary payer based upon the following calculation: **KHS Fee Schedule Amount – Primary insurer payment = KHS payment.**

5. Under KHS contract, when payment is satisfied by the primary insurance, the provider is required to submit the claim for KHS encounter and fee for service tracking

While this new policy is effective for dates of services on and after July 1, 2008, if providers were denied payment on COB claims for missing EOB's, being out of primary network or non-recognized license type, for services prior to July 1, 2008, providers may resubmit the claims for reconsideration. Claims must be submitted in manners outlined in this policy. Claims will not be reconsidered solely for adjustments to the allowable reimbursement calculations.

KHS providers are reminded that they may not bill a member for covered services in which KHS denied payment, including COB activity, unless the member is on spenddown. If members have been billed, appropriate corrections to billings or refunds to members must be made.

Steve Richards, Chief Financial Officer