

Dual Coverage

Most health insurance contracts have a clause that allows the benefits of one policy to be coordinated with the benefits of other policies. This clause, referred to as *Coordination of Benefits (COB)*, prevents duplicate payment of health care services. The COB rules follow guidelines established by the National Association of Health Insurance Commissioners (NAIC). The following rules are sequential and the first one to apply is used, unless Medicare is involved. Medicare Secondary Payer rules take precedence over NAIC guidelines.

1. Non -Dependent / Dependent

a) The plan that covers the person other than as a dependent, for example as an employee, a member, a subscriber, or a retiree is primary. However if the person is a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act, Medicare is:

- (1) secondary to the plan covering the person as a dependent and
- (2) primary to the plan covering the person as other than a dependent (i.e., retired employee) then the order of the two plans is reversed.

2. Children covered under more than one plan, with the parents married or living together:

- a) The policy of the parent whose birthday (month and day) is earlier in the year is primary.
- b) If the parents share the same birthday (month and day), the policy with the earlier effective date is primary.

3. Children covered under more than one plan, with the parents divorced or living apart:

- a) The policy of the parent that the court has made responsible for health care insurance is primary.
- b) The policy of the parent who has custody of the children is primary.
- c) If the court has not placed responsibility on one parent to insure the children and the parents have joint custody, the policy of the parent whose birthday (month and day) is earlier in the year is primary.
 - (1) If the parents share the same birthday (month and day), the policy with the earlier effective date is primary.
- d) If the natural parent elects to have coverage under the policy of the step parent, we will consider the policy to be that of the natural parent.
- e) If the children are covered under three or more plans, coverage is determined in this order.
 - (1) The plan of the primary parent;
 - (2) The plan of the spouse of the primary parent;
 - (3) The plan of the secondary parent; and then
 - (4) The plan of the spouse of the secondary parent.

4. Active or inactive employee:

- a) The plan that covers the person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. The contract with the earlier effective date is primary.

5. Continuation Coverage (COBRA):

- a) If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the plan covering the person as an employee, a member, a subscriber, or a retiree (or as the retired person's dependent) is primary, and the continuation coverage is secondary.
- b) If the other plan does not have this rule, and if as a result, the plans do not agree on the order of benefits, this rule is ignored.

6. Longer or shorter length of coverage:

- a) If none of the above rules determine the order of benefits, the plan that covered the person as an employee, a subscriber, a member, or retiree is primary.

Reminders

- ◆ Claims with COB must be submitted to the primary carrier first.
- ◆ If there is a balance due after the primary carrier has processed the claim, **submit a copy of the claim and the corresponding explanation of benefits or remittance from the primary carrier.**
- ◆ Claims must be submitted within the filing limit required by each carrier. However in the case of COB, this period is calculated from the date the primary carrier processed the claim which is indicated on the explanation of benefits or remittance from the primary carrier.
- ◆ Managed Care Plan members must obtain referrals for services when the Managed Care Plan is not the primary carrier.
- ◆ Secondary payments are calculated based on the patient's liability after the primary carrier has considered the claim. Calculation of the secondary payment can vary from plan to plan.

Workers' Compensation

Workers' Compensation coverage is required of most employers for their employees. It provides coverage for injuries sustained during the course of employment or at an employer sponsored event. Most of the member contracts issued by BCBSRA contain the following Workers' Compensation exclusion:

"We will not provide benefits for any service for any injury, condition or disease if benefits are available to you under a Workers' Compensation Law or similar law. We will not provide benefits even if you do not claim the benefits you are entitled to receive under the Workers' Compensation Law. Also, we will not provide benefits even if you bring a lawsuit against the person who caused your injury or condition and even if you received money from that lawsuit and you have repaid the hospital and other medical expenses you received payment for under the Workers' Compensation Law or similar law. However, if you are covered under Workers' Compensation or a similar law and you request services covered under this Contract, the physician may provide the services and charge you for them at prevailing rates."

1. If the Workers' Compensation Board and/or carrier denies payment on services relating to a workers' compensation illness/injury, they may be billed to the patient's health insurance plan for consideration. A copy of the corresponding *Workers' Compensation Final Notice of Decision*, or any other corresponding documentation from the workers' compensation carrier, must be submitted with the claim within the filing limit required by the plan. When a case is denied by Workers' Compensation, the filing limit period is calculated from the date the decision was reached to deny the case.
2. If the Workers' Compensation Board has apportioned the compensation case stating that the workers' compensation carrier is liable for a percentage and the health insurance plan is liable for a percentage, the services may be billed to the patient's health insurance plan for consideration. A copy of the corresponding *Workers' Compensation Final Notice of Decision* must be submitted with the claim within the filing limit required by the plan. When a case is apportioned by the Workers' Compensation Board, the filing limit period is calculated from the date the decision was reached to apportion the case. In these cases, payment is calculated by applying the percentage determined by the Workers' Compensation Board to the applicable plan fee schedule (deductibles and copays may apply).
3. Managed Care Plan Members must obtain referrals for services when Workers' Compensation is involved.
4. When a patient has a work related injury/illness, it is important that the diagnoses billed indicate the specific body part being treated. When a generic diagnosis is billed, the claim will be denied for a more accurate diagnosis.

Motor Vehicle Accidents “No-Fault” Insurance

In states where No-Fault Automobile Insurance is mandated, it is primary to the patient's health insurance plan. Mandatory No-Fault benefits are determined based on where the patient resides, not the state in which the accident occurs. New York State residents are covered under the No-Fault carrier when the accident occurs in the United States, Canada or Puerto Rico.

Most of the member contracts issued by BCBSRA contain the following No-Fault Automobile Insurance exclusion:

“We will not provide benefits for any service for any injury, condition, or disease if benefits are available under your mandatory automobile no-fault coverage. We will not provide benefits even if you do not claim the benefits you are entitled to receive under mandatory automobile no-fault coverage. Also we will not provide benefits even if you bring a lawsuit against the person who caused your injury and even if you receive money from that law suit and have repaid the hospital and other medical expenses you received payment for under the mandatory automobile no-fault coverage. If you are covered under a Managed Care Organization (MCO) we will not pay for out-of-pocket network deductibles and co-insurance.”

1. Operators and riding passengers of motorcycles are not covered for medical services under a mandatory No-Fault policy. Claims may be submitted to the health insurance plan for consideration, with indication that the patient was the operator or passenger of a motorcycle.
2. Pedestrians hit by an automobile or motorcycle are covered by the No-Fault carrier that insures the automobile or motorcycle.
 - a) If No-Fault benefits are not available under the driver's automobile insurance carrier or the driver was uninsured, claims must be submitted to the pedestrian's automobile insurance carrier.
 - b) If the pedestrian does not have automobile insurance or if No-Fault benefits are not available under the pedestrian's automobile insurance carrier, claims must be submitted to the Motor Vehicle Accident Indemnification Corporation (MVAIC) for consideration.
3. Motor Vehicle Indemnification Corporation (MVAIC) benefits are available if the pedestrian/victim is:
 - a New York State resident and
 - Suffering from major injuries and
 - the victim of a hit and run or was hit by an uninsured automobile or motorcycle and
 - not covered under anyone else's No-Fault policy

In these cases, send claims to:

*Motor Vehicle Accident Indemnification Corporation
110 Williams Street
27th Floor
New York, NY 10038*

5. If the No-Fault carrier has denied payment of services relating to a motor vehicle accident or the services were applied to the No-Fault deductible, those charges may be billed to the patient's health insurance plan for consideration. A copy of the corresponding No-Fault carrier's denial must be submitted with the claim. Claims must be submitted within the filing limit required by the plan. This filing limit period is calculated from the date the No-Fault carrier denied the service.
6. If the No-Fault carrier has apportioned the No-Fault case stating that the No-Fault carrier is liable for a percentage and the health insurance plan is liable for a percentage, the services may be billed to the patient's health insurance plan for consideration. A copy of the corresponding No-Fault carrier's statement indicating the apportionment, and supporting documentation from the patient's personal physician agreeing with the No-Fault carrier's apportionment, must be submitted with the claim. Claims must be submitted within the filing limit required by the plan. This filing limit period is calculated from the date the No-Fault carrier apportioned the case. Payment is calculated by applying the percentage determined by the No-Fault carrier to the applicable fee schedule (deductibles and copays may apply).
7. Managed Care Plan Members must obtain referrals for services when No-Fault is involved.
8. When a patient has a No-Fault related injury, it is important the diagnoses billed indicate the specific body part being treated. When a generic diagnosis is billed, the claim will be denied for a more accurate diagnosis.