Administrative Simplification

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Best Practice Recommendation for

Exchanging Explanation of Payment Information between Providers and Health Plans (using 5010v transactions)

For use with ANSI ASC X12N 5010v
Health Care Claim (837)
Health Care Claim Payment/Advice (835)
Technical Report Type 3

Version 3.0

Version	
Issue Date	**Explanation**
02-22-10	Initial release
09-28-10	Notes to highlight that 837 will not contain payer's allowed amount
12-14-2011	Clarification for handling dual coverage by the same health plan (pg 8-9)
05-14-2015	Major revision

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Best Practice Recommendation

Exchanging EOP Information between Providers and Health Plans

Topic: Coordination of Benefits

NOTE: Issues related to liability and casualty coverage, e.g. accident, are outside the scope of this BPR

Goal: Speed up the turnaround of claims by non-primary payers while minimizing the provider work effort to do so.

Summary: *To speed up the processing of secondary, tertiary, etc. claims, providers should* ***include the EOP information on the 837 claim transaction****, instead of sending the paper Explanation of Payment.*

Including Explanation of Payment (EOP) information on the 837 claim transaction to non-primary payers will speed up the processing of that claim. Payers will not need to wait for the paper EOP and will not need to track down the previous payers to find out how much they paid.

Background:

Some patients receive insurance coverage from more than one health plan. In these situations, care providers submit multiple claims for the same service. The first claim is submitted to the health plan responsible for the primary coverage. That health plan will adjudicate the claim and respond to the provider with either an 835 Claim Payment/ Advice and/or a paper EOP voucher. The provider then submits a claim to the health plan responsible for secondary coverage, along with information about how the prior payer adjudicated the claim. Secondary payers need this information in order to adjudicate the claim. Tertiary payers have the same requirements as secondary payers.

In the interest of timely and accurate payment, providers should include EOP information on the 837 claims to non-primary payers. Submitting a paper EOP voucher along with an 837 claim adds administrative burden for the provider and adds a time delay before the health plan can process the claim. Not submitting any EOP information also adds a time delay as the health plan must track down the prior payer. Furthermore, if information from the prior payer cannot be obtained in a timely manner, the payer will inform the provider that additional information is required before the claim can be accurately paid.

Recommended Best Practices for Providers:

Best Practices start with a provider obtaining comprehensive coverage information from the patient. Since a patient's coverage information is likely to change over time, providers should ask each patient the following questions when they register for EVERY visit:

- What is the insurance coverage for this patient?
- Are there any other insurance coverage for this patient, e.g multiple employers, multiple responsible parties, etc.?

The following describes the practices that providers should follow when submitting 837 claims to non-primary payers.

***When** should claims be submitted to non-primary payers?*

837 claims should be submitted **sequentially** to the responsible health plans, one payer at a time, until all health plans that provide coverage to the patient have received a claim. The claim should be submitted to the secondary, the tertiary and subsequent payers in turn only after the prior payer has completed their processing of that claim. It is important that all contractual obligations and adjudication/processing errors with the prior payer be resolved, within the timelines established in statute or rule, before sending the claim to the subsequent payer.

How are Medicare claims different?

When Medicare is primary, the submission process is different. In most circumstances, Medicare will automatically crossover (i.e. forward) a claim to other supplemental coverage(s). Medicare may be aware of the other insurance coverage(s) and will use that information when forwarding claims. This information may or may not be the same as the 'other insurance' information that was supplied on the claim that was submitted.

You can identify that Medicare has forwarded the claim by RARC MA07 or MA18 on the 835 Claim Payment/Advice. The name of the carrier to which the claim was forwarded by Medicare will be in loop 2100 NM1-03 and NM1-01 = "TT".
You should ONLY submit claims to the secondary payor when Medicare has not indicated that they have forwarded the claim. This will prevent duplicate denials.

Note: Some payors may require you to wait 30 days from the Medicare adjudication date before submitting a subsequent claim to them, even if the Medicare crossover did not occur and that payer does not have the claim in their system.

***When** must EOP information be included on the 837 claims to secondary and tertiary payers?*

In coordination of benefits situations, EOP information must be included on **ALL** 837 claims sent to non-primary payers.

***If** a patient has multiple coverage from the same health plan, do I send one claim or two claims?*

Only one claim should be sent and the health plan will automatically process the claim as payer 'first' AND then as payer 'second' and will send the provider two corresponding 835 records. The 835 related to the first processing will use the 'TT' indicator (described in item "5" below in the section titled 'Recommended Best Practices for Health Plans'). If the 'TT' indicator is not received, the provider should send a second claim. The 835 related to the second processing will not use the 'TT' indicator.

By only sending one claim, the extra work of processing and reconciling duplicate claims will be eliminated. Remember, whenever you are in doubt about the status of a claim, always make a claim status inquiry rather then rebilling.

***Do** I still need to submit a claim if I don't expect any reimbursement from non-primary payers?*

Yes, ***unless indicated otherwise by a specific payer***. Claims should be submitted to EVERY SINGLE payer that provides coverage to the patient, even if the provider does not expect reimbursement from that payer. Submitting a claim to every payer will ensure that the patient receives their full benefits, as COB savings accrue to the member.

This claim will be reflected on an 835 Claim Payment/Advice from the non-primary payer as a zero payment (as described in item 4. example #2 under the section titled 'Recommended Best Practices for Health Plans')

***What** happens if a patient has coverage with multiple health plans, yet I receive denials from both of them because there is confusion over which plan is primary and which plan is secondary?*

Notify both health plans that the patient has coverage with them. Make sure that the health plans have complete and correct information about the patient's other coverage. Health plans have responsibility for solving this in a timely manner (as described in the section titled 'Recommended Best Practices for Health Plans')

Recommended Best Practices for Health Plans:

In those cases when a health plan learns of a possible COB order of liability conflict (i.e. multiple health plans believe they are primary or believe they are secondary), the health plan will:

1. Obtain the patient's other coverage information from the provider
2. Contact the other health plan and resolve the order of liability conflict within 5 business days of being notified of the conflict by the provider and obtaining comprehensive coverage information. (More than 5 business days may be required to resolve the conflict in situations where the patient has the required information, e.g. court orders, and this information is not in the possession of the health plan or provider.)
3. Document the resolution on the account so that future claims with the same criteria will process first time through. (Both health plans should do this.)
4. Notify the provider about the correct order of liability and instruct the provider to resubmit claims in accordance with this order of liability.