Section 9
Coordination of Benefits

General Rules to Follow

Some Alliance members have Other Health Coverage (OHC) in addition to their Alliance coverage. Specific rules govern how benefits must be coordinated in these cases. The Alliance is not liable for the cost of services for members with OHC who do not obtain the services in accordance with the rules of their primary insurance. If a member elects to seek services outside of the framework of his or her primary insurance, the member is responsible for the cost.

Other health coverage entities include but are not limited to:

- Commercial health insurance plans (individual and group policies).
- Prepaid health plans.
- Health Maintenance Organizations (HMOs).
- Employee benefit plans.
- Union plans.
- Tri-Care, Champ VA.
- Medicare, including Medicare Part D plans, Medicare supplemental plans and Medicare Advantage (Preferred Provider Organization [PPO] HMO, and fee-for-service) plans.

Other health insurance information should be verified on the Alliance Provider Portal prior to submission of claims. To coordinate benefits for a member who has active OHC coverage, providers must bill the primary insurance first. If there is any balance remaining after payment is received from the primary insurer, you should submit a claim to the Alliance along with an EOB from the primary payer. Claims for members with one or more than one policy will deny without the EOB from the primary carrier or proof that the member does not have OHC. For more information on coordination of benefits, see Policy 702-1750 - Coordination of Benefit Guidelines for Providers.

Medi-Cal

Federal and state laws require that all available health coverage be exhausted *before billing Medi-Cal.* Thus, when a Medi-Cal member has other health coverage, the Alliance becomes the *secondary payer*, with Medi-Cal always as the payer of last resort.

It is the responsibility of the provider to verify their patient's eligibility; this can be done on the Alliance provider website through the Provider Portal. If the member shows OHC or Medicare eligibility, the services rendered must be billed to the primary insurance first within the rules of the primary insurance. The claim is then sent to the Alliance with the primary insurer's explanation of benefits.

When an Alliance member's primary insurance has copayments and/or deductibles, the member cannot be asked to pay, as long as he/she is obtaining benefits within the rules of the primary insurance. The exception to this is the copayments a dual eligible member would have for his/her Medicare Part D drug plan. If the primary insurance covers the service, procedures that normally require prior authorization will not require it (with the exception of pharmacy services).

The Alliance bases billing limitations on the Medicare Explanation of Member Benefits (EOMB) or OHC Explanation of Benefits (EOB) date rather than the received date. Exceptions to the billing limit can be made if it is one of the reasons allowed by Medi-Cal for late billing. Please refer to the Delay Reason Code section of the Medi-Cal Provider Manuals for the exceptions to the billing limits allowed by Medi-Cal.

Medicare has the ability to reduce claims payment, often times in the form of a penalty. For Medicare/Medi-Cal crossover claims, the Alliance may coordinate payment based upon the amount the provider is eligible to receive from Medicare after these reductions are imposed, as is further discussed in Policy 600-1041 - Medicare and Coordination of Benefits Reimbursement.

Billing for Medi-Cal Members with Other Health Coverage

Claims that involve potential payment from another health insurance carrier are processed using a coordination of benefits methodology. Providers may bill Medi-Cal for the balance, including coinsurance and deductibles. California law limits Medi-Cal's reimbursement to an amount that, when combined with the primary's payment, should not exceed Medi-Cal's maximum allowed for similar services.

Hardcopy Crossover Claim Submission

To send a copy or an original claim, please confirm that your National Provider Identifier (NPI) number is on the claim. You may bill us in the same manner as you billed the primary insurer, using the same procedure codes and modifiers. It is essential that a code be given to indicate the place of service. Attach a full-page copy of the Explanation of Benefits (EOB) or Explanation of Medical Benefits (EOMB), not a partial page, with the primary insurer's reason code descriptions to each page of the claim. Please draw a line through all other patient names and identifying numbers on all pages.

Electronic Medicare Crossover Claims

The Alliance receives Medicare/Medi-Cal automatic crossover claims electronically for professional services only at this time. If you believe that your secondary claim was processed incorrectly, please contact our Claims Department at (800) 700-3874 ext.5503. Please do not submit hard copy Medicare claims if your Medicare claims have been submitted electronically to the Alliance, as it may prolong the processing time.

Coordination of Benefits for Medicare Non-Eligible Recipients

Medicare eligibility is received from the California Department of Health Care Services and cannot be changed by The Alliance. If providers receive an Identification of Overpayment notice stating their patient has Medicare, but the provider shows 'Member Not Eligible', the claim should still be billed to Medicare. The Alliance will only process claims as the primary payer with the EOMB showing Medicare Non-Eligible. Copies of Medicare cards or Common Working File (CWF) printouts are not acceptable documentation.

Medicare Retro Entitlement

The Alliance routinely conducts audits to identify patients with retroactive eligibility with Medicare or OHC. If the Alliance has paid as primary in error, the provider may receive an Identification of Overpayment notification. This letter will indicate the patient information as well as the primary payer name, if applicable. Claims paid as primary in error is an overpayment and should be returned to the Alliance. Providers should follow standard coordination of benefits guidelines and resubmit their claims as crossovers for processing.

If the Alliance finds a member has Retroactive Medicare Entitlement, providers should submit their claims to Medicare/CMS retro unit along with the following documents:

- A copy of the Remittance Advice or Identification of Overpayment notification from the Alliance indicating the date overpayment was requested or recouped;
- Documentation verifying that the beneficiary was retroactively entitled to Medicare before the date of the furnished service (i.e., the official letter to the beneficiary); and,

Additional information regarding Retroactive Medicare Entitlement can be found in the CMS Manual, Sections: 70.7.2 and 70.7.3.

Coordination of Benefits Examples

A claim is filed for $60.00. The Medi-Cal allowable amount is $32.00. Medicare paid $53.90. The Medi-Cal payment on this claim would be $0.00, not the difference of $6.10.

$32.90	Medi-Cal Allowed
53.90	Medicare Paid
$ 0.00	Medi-Cal Reimbursement

Patients with a SOC are not eligible for Medi-Cal coverage until they meet their SOC for the month of service. The provider should ask for or accept obligation from the patient for their Medi-Cal share of cost. Remember that when Medi-Cal pays for any portion of the service, the total reimbursement received for the service may not exceed the Medi-Cal allowable amount.

Example A

Provider's Charge	$250.00
Medicare Allows	200.00
Medicare Pays (80% of Medicare allowed amount of $200.00)	160.00
Medi-Cal Allowable	180.00
Difference	20.00
Share of Cost Collected	25.00
Medi-Cal would pay	$ 0.00

Example B	
Provider's Charge	$250.00
Medicare Allows	200.00
Medicare Pays (80% of Medicare allowed amount of $200.00)	160.00
Medi-Cal Allowable	190.00
Difference	30.00
Share of Cost Collected	25.00
Medi-Cal would pay	$ 5.00

Alliance Care IHSS

In most cases, when an Alliance Care IHSS member has other OHC the Alliance is the primary payer — the exception would be if the member is the primary subscriber and the policy was in effect before he/she became covered through the Alliance.

OHC includes but is not limited to:

- Commercial health insurance plans (individual and group policies).
- Prepaid health plans.
- Health Maintenance Organizations (HMOs).
- Employee benefit plans.
- Union plans.
- Tri-Care, Champ VA.
- Medicare, including Medicare supplemental plans and Medicare Advantage (PPO, HMO and fee-for-service) plans (Medicare would be primary only if the member has end-stage renal disease).

When an Alliance Care IHSS member also has OHC that is primary, s/he must treat the other insurance plan as the primary insurance company and access services under that company's rules of coverage.

Dual Coverage

Some of our Alliance Care IHSS members have dual coverage. They may have an employer or individual plan, Medicare or Medi-Cal. Alliance Care IHSS is a commercial health plan, so it is always primary over Medi-Cal and Medicare. In order for an Alliance Care IHSS member's OHC to be primary, the member would have to be the *primary subscriber* on the plan (rather than being a dependent) and must have been enrolled in the plan prior to the member becoming enrolled in Alliance Care IHSS.

For additional information on submitting claims for members with dual coverage, please see Section 10. Claims.

Alliance Members with Veterans Benefits

If the Alliance member is a Veteran and is eligible for Veterans Affairs (VA) health care benefits, he/she may choose to use VA services (hospitals, outpatient and other government clinics). A description of these services can be found at the VA website.

There are outpatient facilities in Capitola, Monterey, Atwater, Tulare and San Jose. There is a bus service through the VA for transportation to the Monterey, San Jose and Palo Alto facilities; the bus schedule can be found on the VA website. For inpatient facilities, contact VA Hospital in Palo Alto, which has an affiliation with Stanford or the VA Hospital in Fresno.

Members with VA benefits may use their own discretion in choosing whether to receive their care through the VA system or the Alliance — we cannot require or request that they do so but, if the member wishes, we will facilitate and coordinate their care.

Emergency Services for Veterans

Payment or reimbursement for emergency services for non-service-connected conditions in a facility other than a VA facility may be authorized under the "Millennium Bill Act." To be eligible for this authority, the veteran must satisfy *all* of the following conditions:

The emergency services must have been provided in a hospital emergency department or a similar facility that is known to provide emergency care to the public.The claim for payment or reimbursement for the initial evaluation and treatment must be for a condition of such a nature that a prudent layperson would have reasonably expected that delay in seeking immediate medical attention would have been hazardous to life or health.

This standard would be met in the presence of an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson with an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention would seriously jeopardize the health of the individual, would result in serious impairment to bodily functions, or cause serious dysfunction of any bodily organ or part.

If we receive a claim for emergency services for a member who is known to have VA benefits, the claim will be held until the facility has received payment (or formal denial) for qualified services, as described above. Once the VA has made determination, we will make a determination based on ongoing medical necessity, but will accept responsibility for coverage even when the member could have been transferred.

VA System Referrals

In certain circumstances, the VA contracts services in non-VA facilities. If we become aware of such a service resulting from a VA referral, we will determine whether the VA has accepted financial responsibility and, if so, issue a denial.

For more information on coordination of VA benefits, please see Policy 404-1703 - Alliance Members with Veteran's Benefits.