Coordination of Benefits

Overview

Members may be covered by multiple health plans. For example, they may have coverage through their employer and through their spouse’s employee benefits as well. Coordination of benefits (COB) provisions correlate all the applicable health plans to ensure reimbursement does not exceed 100% of the billed charges for the covered services. The provision rules determine one plan to be the primary insurer and its benefits are applied to the claim first. The secondary plan then pays the unpaid balance of the charges to the limit of its responsibility, and so on until all applicable plans have made payment.

Determining Coordination of Benefits

Ask the patient if their condition is work-related, the result of an auto accident, or the result of any other accident or injury. Ask the patient if they have coverage from more than one health benefit plan. Determine the Primary Payer by checking the patient’s Coverage and Benefits on Anthem Online Provider Services or by calling the appropriate Provider Services number.

Anthem as Primary Payer

When the Anthem plan is primary, Anthem will reimburse the full extent of covered medical services; i.e., the physician’s billed charge or the maximum allowable benefit (MAB), whichever is less. If a balance exists after Anthem’s reimbursement, the provider submits the unpaid balance to the secondary health plan.

Anthem as Secondary or Tertiary Payer

When the Anthem plan is not primary, the provider receives payment for covered services in conjunction with the primary plan so that reimbursement is no more than 100% of the covered charges or the Anthem MAB, whichever is less. If there is a balance after the primary plan has made payment and Anthem has reimbursed the MAB for the covered services, the provider submits the unpaid balance to the tertiary health plan if applicable.

- Submit 837 Coordination of Benefits claims electronically without an accompanying Explanation of Benefits (EOB), or
- Submit a paper claim form with the primary carrier EOB or Remittance Advice (RA) attached.
Workers’ Compensation

Anthem will not pay for services which are covered under State Workers’ Compensation Laws. Claims for a work-related injury or illness should be submitted through the member’s workers’ compensation carrier or employer. As some workers’ compensation cases take months or years to resolve, it is recommended that providers submit a claim to Anthem so that we have a record of receiving a claim within the filing time limit. It is important that the claim indicate that the services were work-related.

Claims determined to be work-related will be denied and the provider will be notified to file a claim through the applicable workers’ compensation carrier or the member’s employer. If Anthem inadvertently or mistakenly pays a claim on a work-related injury, Anthem will seek appropriate recoveries from providers who have been reimbursed for services.

If the member fails to submit a “First Report of Injury” form to their employer, Anthem will deny the claims and/or seek recoveries from the provider instructing the provider to bill the member directly.

Subrogation

Subrogation means that Anthem has the right to be reimbursed for the cost of benefits provided to a member who has been injured due to the negligence of another person. Claims for services that will potentially qualify as a subrogation claim should be submitted to Anthem directly. Based on the diagnosis submitted, a questionnaire will be sent to the member on a post-payment basis.

Providers may choose to seek reimbursement from the liable insurance carriers for noncovered charges, to include amounts over the contracted rate. The provider may do this by either instructing the member to submit those unreimbursed balances to the liable insurance carrier or submitting the unreimbursed balances to the liable insurance carrier directly. This practice is permitted provided the member is not held responsible for any amount over the contracted rate. (Note: This must be done in a timely manner or your claim for reimbursement from the liable carrier may be jeopardized.)
Auto Insurance Medical Payment Provisions

In accordance with New Hampshire state law, automobile insurance policies containing auto medical payments (Med Pay) provisions shall be considered primary, over health insurance plans, up to the policy limit, except where precluded by law.

Providers may opt to submit directly to the auto insurance carrier for services related to an auto accident. Once the Med Pay provision limits have been exceeded, providers can then submit subsequent claims to Anthem for reimbursement.

If Anthem is informed that the auto insurance carrier has directly reimbursed the member for accident related services, and adequate documentation cannot be supplied by the member to substantiate that reimbursement, Anthem will deny benefits and seek reimbursement from the provider instructing the provider to bill the member directly.

End Stage Renal Dialysis

For members who have Anthem and Medicare due to End Stage Renal Dialysis (ESRD), Medicare is the secondary payer during the coordination period. The coordination period is currently 30 months for individuals who are eligible or entitled to Medicare due to ESRD only. The start of the coordination period is the first day of the month of eligibility or entitlement to Medicare due to ESRD.