Other Party Liability helps coordinate your coverage.

Duplicate coverage, OPL exclusions, workers' compensation, auto no-fault, subrogation and pre-existing

BlueCross BlueShield Kansas

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bcbsks.com

This manual includes information on the following subjects regarding submitting claims and payment on claims for members that are covered under multiple plans.

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What is Other Party Liability?

Other Party Liability (OPL) determines whether services are eligible for coverage under another insurer. OPL then assigns primary liability with the correct carrier.

Every 18 months (12 months for FEP) Blue Cross and Blue Shield of Kansas verifies whether or not our members and/or their dependents have other group health insurance coverage. OPL also verifies if injuries and other certain conditions are eligible to be covered by workers' compensation or auto insurance.

This activity helps contain costs that affect rates paid by our members. OPL deals specifically with duplicate coverage (not Medicare or Medicaid), workers' compensation and no-fault auto.

Submitting a claim

When the member is covered under two different insurance carriers, a claim should be filed with both carriers. When two Blue Cross and Blue Shield of Kansas (Blue on Blue) group policies are involved, Blue Cross will coordinate these for you with one filing. The exception to this is in the event one of the two policies involved (grandfathered policies) doesn't coordinate, separate claims need to be filed. The claim filed to each policy should include information regarding the other carrier.

Timely filing

The reason for filing a claim with each carrier is to protect you from the possibility of a timely filing denial later. An example of such a case would be when a worker who has been injured on the job seeks treatment and advises you his claims will be paid by workers' compensation. Later, if the condition is found to be unrelated to the patient's employment, a denial could be received from the workers' compensation carrier or refunds could be requested on claims for which they have already paid.

If this takes place more than 15 months from the date of service, those claims which would have been eligible under the patient's Blue Cross and Blue Shield of Kansas policy by filing in a timely manner will be denied. Denials for not filing within the specified time period are a provider write-off. If those same claims had been filed with Blue Cross originally, we would have denied services as work related but would reprocess them for eligible benefits upon receipt of the denial letter.

BlueCard

Providers should file a secondary host[1] inter-plan teleprocessing services (ITS) claim to Blue Cross and Blue Shield of Kansas just as you would a claim for any Kansas Plan member. However, if the patient is covered under another Blue Plan membership and a Blue Cross Plan membership, a separate claim will need to be filed under each ID number. Inquiries regarding overpayments on claims paid by Blue Cross and Blue Shield of Kansas as the host plan that have resulted from payment made by another carrier should be directed to our customer service center at 785-291-4058. Do not direct these inquiries to OPL.

Avoiding delays

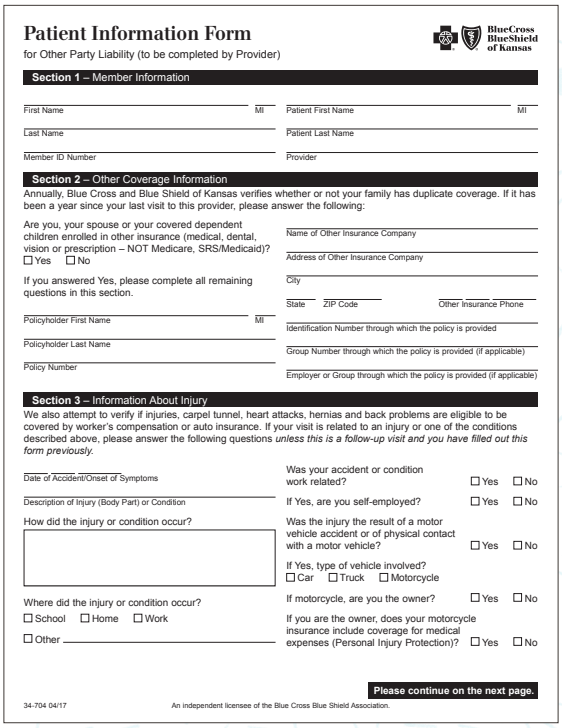
When investigation by OPL is necessary, it may delay the processing of your claims. To avoid this delay, you may choose to provide OPL with the information prior to or at the time of filing your claim. Providers may want be duplicate the OPL form and have patients fill out the questionnaire prior to receiving services. A form for providers to request a deduction of OPL related overpayments is also available. Both the OPL Questionnaire and the OPL Deduct Authorization form can be found on the Blue Cross website at: https://www.bcbsks.com/providers/professional/forms

Send or fax completed forms to:

Blue Cross and Blue Shield of Kansas
ATTN: OPL cc217C2
1133 SW Topeka Blvd
Topeka, KS 66629-0001

Fax to OPL at: 785-290-0771

In addition, there is another OPL form on the Blue Cross website for OPL patient information that can be completed and submitted online.



Patient Information Form
for Other Party Liability (to be completed by Provider)

BlueCross BlueShield of Kansas

Section 1 – Member Information

First Name MI
Last Name
Member ID Number

Patient First Name MI
Patient Last Name
Provider

Section 2 – Other Coverage Information

Annually, Blue Cross and Blue Shield of Kansas verifies whether or not your family has duplicate coverage. If it has been a year since your last visit to this provider, please answer the following:

Are you, your spouse or your covered dependent children enrolled in other insurance (medical, dental, vision or prescription – NOT Medicare, SRS/Medicaid)?
☐ Yes ☐ No

If you answered Yes, please complete all remaining questions in this section.

Policyholder First Name MI
Policyholder Last Name
Policy Number

Name of Other Insurance Company
Address of Other Insurance Company
City
State ZIP Code Other Insurance Phone
Identification Number through which the policy is provided
Group Number through which the policy is provided (if applicable)
Employer or Group through which the policy is provided (if applicable)

Section 3 – Information About Injury

We also attempt to verify if injuries, carpel tunnel, heart attacks, hernias and back problems are eligible to be covered by worker's compensation or auto insurance. If your visit is related to an injury or one of the conditions described above, please answer the following questions *unless this is a follow-up visit and you have filled out this form previously.*

Date of Accident/Onset of Symptoms
Description of Injury (Body Part) or Condition

How did the injury or condition occur?

Where did the injury or condition occur?
☐ School ☐ Home ☐ Work
☐ Other

Was your accident or condition work related? ☐ Yes ☐ No
If Yes, are you self-employed? ☐ Yes ☐ No
Was the injury the result of a motor vehicle accident or of physical contact with a motor vehicle? ☐ Yes ☐ No
If Yes, type of vehicle involved?
☐ Car ☐ Truck ☐ Motorcycle
If motorcycle, are you the owner? ☐ Yes ☐ No
If you are the owner, does your motorcycle insurance include coverage for medical expenses (Personal Injury Protection)? ☐ Yes ☐ No

Please continue on the next page.

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[1] Host is defined as a Blue Cross contracting facility/provider rendering services for a member of another Blue Plan.

Reconciling your account

To reconcile your patient's account after the secondary carrier has processed a claim, refer to the primary carrier's EOB, as well as that of the secondary carrier.

The following rules apply for provider reimbursement and when reconciling the patient account:

- If the member is not an FEP member or when the provider contracts with the primary carrier, the provider should accept the primary carrier's write-off. Then, determine the patient's responsibility by subtracting that provider write-off and the payments of the primary and secondary carriers from the total charge(s).
- If patient is an FEP member or when the provider does not contract with the primary carrier, the provider can determine the provider write-off by subtracting the lesser allowance of any carrier with whom the provider has a contracting arrangement from the total charge. Determine the patient's responsibility by subtracting provider write-off and the payments of the primary and secondary carriers from the total charge(s).
- When the patient responsibility after the primary carrier's payment is greater than our Blue Cross allowance, the provider must accept our Blue Cross write-off.

The Blue Cross remittance advice (RA) for secondary payments will show the amount paid on the secondary claim, the amount paid by the primary carrier, the amount of patient responsibility, and the total provider write-off after taking into consideration the benefits of both carriers. This eliminates the need to retrieve the primary carrier EOB for balancing patient accounts. Listed below are specific coding combinations on the RA that helps the provider to identify a claim involving OPL.

OPL code(s) on RA	Coding details
ARC = 23	Paid as secondary carrier.
ARC = 227; RMK = N179	Awaiting a response to an OPL questionnaire sent to the patient.
ARC = 22; RMK = MA04	The primary carrier must process first and an EOB is required.
ARC = 23; RMK = M43	The primary carrier's payment exceeds the amount payable under the patient's contract. No secondary payment is available.
ARC = 22; RMK = N48	The EOB does not match the claim.
ARC = 19; RMK = MA04	This service is due to a job-related illness or injury (workers' compensation applies).
ARC = 21; RMK = MA04	The service is due to a motor vehicle related accident (automobile insurance applies).
ARC = 23; RMK = MA04	The patient has accepted a financial settlement from another insurance carrier for this claim.

Duplicate coverage

Duplicate coverage applies when a patient is covered under more than one health insurance carrier. Benefits are coordinated by the secondary carrier to prevent duplicating payment for the same service made by the primary insurer.

Duplicate coverage is investigated on new health family contracts. Follow up investigations are conducted every 12 months for FEP, 18 months for all other policies. On those members who have indicated they have no duplicate coverage.

Other Party Liability will not delay claims for response to a routine duplicate coverage questionnaire. FEP policies, large dollar claims, member pay and third party payees are excluded.

When duplicate coverage exists, a claim should be filed to all carriers (except in the case of multiple Blue Cross and Blue Shield of Kansas policies, when only one is necessary). "Order of Benefit Determination" rules establish a patient's primary carrier. Once provided proof of primary payment, the secondary carrier will process balances still owed by the patient for eligible benefits. A copy of the actual primary EOB should be submitted as proof of primary payment, unless filing electronically. The electronic 837 claim format includes specific fields for reporting other insurance information. Claims must be filed to all carriers involved within the specified timely filing period of each.

Coordination of benefits

When payments for the same claim through multiple group health insurance companies exceed the total charge (or allowance if the provider is contracting), then benefits as secondary are reduced. The difference between what Blue Cross and Blue Shield of Kansas would have paid as primary and what we actually pay as secondary is coordination of benefits (COB) savings.

Savings in the accumulator may later be used when our payment as secondary combined with the primary payment is insufficient to meet the allowable expense. Those who elect to apply these savings to an accumulator within our claims system for that patient are all local contracts, Administrative Services Only (ASO), and out-of-area groups.

When appropriate, the claims system automatically draws any available savings to the point of exhausting savings or paying the amount for which the patient would have been responsible for otherwise; whichever occurs first. The process of adding to and borrowing from this accumulator is referred to as a Benefit Reserve and is applied to claims within the same benefit year.

Maintenance of benefits (MOB)

ASO and out-of-area groups may choose to apply maintenance of benefits (MOB) to dual coverage, rather than the standard coordination of benefits (COB) regulated by the NAIC and State Model. MOB does not apply the Benefit Reserve, nor does it ever allow the combined payments of carriers to exceed the allowable charge regardless of the provider's contracting status. In some instances, the group has elected to hold the combined payments to the amount payable by their policy as if they are the only insurance coverage available.

Groups currently using MOB include Great Plains Manufacturing (dental and Rx only) and FEP.

Rules in determining primary carrier

Blue Cross sometimes receive inquiries asking us which policy is the primary carrier for a patient and how we determine that information. The NAIC and State Model have set guidelines referred to as Order of Benefit Determination to help us determine where the primary payment responsibility lies when duplicate coverage exits. The most frequently used are:

- **Subscriber Rule** – When a patient is covered as the subscriber of one group health insurance plan and that same patient is covered as a spouse or dependent under another group health insurance plan, the plan covering the patient as the subscriber will be the primary carrier.
- **Birthday Rule** – When each parent covers the children on his/her own health insurance plan, then the parent who has a birthday occurring first in the year is primary for the children. For example, if the mother's birthday is in February and the father's birthday is in June, then the mother's plan becomes primary for the children due to her birthday occurring earlier in the year than the father's birthday. The age (year of birth) of each parent is not a factor.
- **Divorce (Legal Separation) Rules** – If a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage, then that parent's plan is primary. If the decree does not establish primary carrier, the parent with legal (not residential) custody will be primary. In the case of joint custody, the Birthday Rule is applied. In the case of remarriage, the benefits of the stepparent married to the primary natural parent will be determined before those of the other natural parent.
- **Retiree (or laid-off) Rule** – When the employee is insured on two group health contracts and one contract covers the person as a retired or laid-off employee and the other covers the person as an active employee, then the contract covering the person as an active employee will be considered primary. This rule will only be applied if both contracts follow the retiree/laid-off employee rule.
- **Consolidation Omnibus Budge Reconciliation Act of 1985 (COBRA) Rule** – A group providing continuous coverage as a COBRA policy will be deemed secondary to another covering that person as an active employee. As with the Retiree Rule, the insured must be the same on both policies.

- **Death resulting in remarriage Rule** – The group health plan for the natural parent is primary for the children and the plan of the stepparent is secondary.
- **Dumping Rule** – When one group does not contain a non-duplication of benefits clause, then that contract automatically becomes the primary carrier.
- **Athletic Rule** – When one group plan is a school athletic coverage only plan and the patient is covered under another health plan, then the other health plan will automatically become the primary carrier for that patient.
- **Birthmother Rule** – If a birthmother has group coverage separate from the adopting parents, the birthmother's group coverage will be considered primary. If the adopting parents have two (group) family memberships, normal Coordination of Benefits (COB) rules and regulations will apply.
- **Adoptions Rule** – If the birthmother has group coverage which extends to the child and because of the mandate for coverage of adopted children, then the child is also covered under the adopting parents' group coverage. Primary coverage will be determined by which group contract has been in effect the longest.
- **Single mother with newborn Rule** – Follow regular National Association of Insurance Commissioners (NAIC) guidelines for determining primary carrier for both the mother and the child.
- **Extension of Benefits (Senate Bill 23) Rule** – When an individual is an inpatient on the date his/her coverage changes from one plan to another, the preceding plan is required to extend coverage for that hospitalization for up to 31 days or the date of discharge, whichever occurs first. This law applies to insurers having a member residing in Kansas. Administrative Services Only (ASO) groups may opt out of applying this law.
- **Medicare and two group policies Rule** – Active employee policies are primary over Medicare polices. Medicare polices are primary over retiree policies. Therefore, in the case of a patient being covered under Medicare and 2 group polices and one of the group policies being a retiree policy, the order of coverage is as follows:
  - Primary – Active employee policy
  - Secondary – Medicare policy
  - Tertiary – Retiree policy

  NOTE: Where Medicare is for disability other than End Stage Renal Disease (ESRD) and the patient is enrolled in a small group not subject to the Omnibus Budget Reconciliation Act of 1986 (OBRA-86), then Medicare is primary over the group plans.
- **Longer Shorter Rule** – If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time will be considered primary.
- **Shared Payment (50/50) Rule** – If none of the preceding rules determine the primary plan, the allowable expenses shall be shared equally between the plans.

OPL exclusions

Blue Cross contracts contain an exclusion section which outlines conditions for which benefits will not be provided. Among these exclusions are workers' compensation and no-fault auto related services. As an exclusion (rather than coordination) of benefits, the payments made by the other insurer cannot be used toward satisfying any shared patient responsibility, such as deductible and coinsurance, imposed by the Blue Cross contract.

As stated previously under *Submitting a Claim*, it is still important to file with Blue Cross to avoid a timely filing problem in case services are later denied by the carrier first thought to be primary and/or responsible.

Workers' compensation

Workers' compensation insurance provides benefits when an employee suffers a job related injury or illness. Blue Cross and Blue Shield of Kansas excludes coverage for services covered (or required to be covered) under a workers' compensation law. If the employee receives services from an unauthorized provider, or enters into a settlement giving up their right to future medical benefits, related claims will not be eligible under their Blue Cross policy. A letter of denial or release from the workers' compensation carrier should be forwarded to us for reconsideration when applicable.

No-fault automobile insurance

Benefits will not be provided for services resulting from accidental bodily injuries due to a motor vehicle accident to the extent that the services are payable under any medical expense payment provision of any automobile insurance policy. The Kansas Automobile Reparations Act requires motor vehicle liability insurance policies to include Personal Injury Protection (PIP).

K.S.A 40-3109 identifies the injuries for which PIP coverage must be provided as injuries sustained in the U.S. or Canada while:

- Entering into a motor vehicle
- Alighting from a motor vehicle
- In the use of a motor vehicle
- In the operation of a motor vehicle
- In the maintenance of a motor vehicle

If the accident falls into one of the above categories, Blue Cross and Blue Shield of Kansas will deny the claims until the charges have been filed with the auto insurance carrier. Benefits will be considered according to the benefits of the Blue Cross contract after Blue Cross has received either a letter of denial from the auto carrier or a complete itemization of PIP payments after those maximum benefits have been exhausted. Services paid for by the auto carrier of the responsible party are not PIP and do not fall within this exclusion. Such payments are liability and fall within the category of subrogation.

Subrogation

Current state insurance laws do not permit routine subrogation in Kansas. Local contracts cannot add this rider. ASO and out-of-area groups, however, have the option of whether or not to attach the subrogation rider to their contracts. Subrogation is defined as "The substitution of one for another as creditor so that the new creditor succeeds to the former's rights or obligations." In short, subrogation is the recovery of payment because of a third party liability. Blue Cross handles those contracts with this rider on a pay and pursue basis. Recoveries and inquiries into and/or regarding subrogation are outsourced by Blue Cross and Blue Shield of Kansas to:

The Rawlings Company
One Eden Parkway
PO Box 49
LaGrange, KY 40031-0049

You may inquire as to whether a group has a subrogation rider through OPL.

Multiple carriers assuming primary payer responsibility

When there is more than one insurance company, Kansas state law and/or the Blue Cross member contract dictates which insurance carrier has the primary liability, however, there are some cases when State law or member contract is not a factor and more than one insurance company assume the primary responsibility. Examples include:

- Patient has a non-group contract and a group contract
- Patient has two non-group contracts
- Patient's Blue Cross contract does not include a subrogation provision that allows for the recovery of payment because of a third party liability.

When one of these (or similar) situations above exist and:

1. Blue Cross is paying on the claim and services were provided by a contracting provider, the provider will be required to accept the Blue Cross MAP as payment in full and hold the member harmless. Money in excess of the contracting provider allowance would belong to the patient/member.
2. Blue Cross does not allow the claim (services are non-covered); the Blue Cross allowance is not applicable. Payment, allowance and write-off issues would be between the other insurance carrier, the provider and the member.

Duplicate coverage OPL exclusions:
Workers compensation, auto no-fault,
subrogation, pre-existing

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