CHAPTER 7
REIMBURSEMENT & CLAIMS

- Fee for Service Reimbursement 41
- Claims Filing Procedures 41
- Status of Claims 43
- Timely Filing 44
- Remittance Advices 45
- Correction of Payment 46
- Systems Affecting Claims Payment 49
- Reimbursement Determinations 50
- Processing Tips 54
- Coordination of Benefits (COB) 59
- Tricare 62
Reimbursement & Claims

This section details Coventry’s reimbursement and claims process.

FEE FOR SERVICE REIMBURSEMENT

Fee for service reimbursement compensates the provider only for services rendered based on the CPT codes submitted. Physician allowances are set by CPT codes. When submitting claims, please include all applicable modifiers to ensure proper payment. Claims submitted to CHCDE should include your usual fee-for-services rendered by CPT code. Proper coding remains the responsibility of the billing provider. Fees charged for services provided to CHCDE members should be the same as those charged to non-CHCDE members for the same services.

CHCDE recognizes all valid American Medical Association (AMA) CPT codes ranging from 10000 to 99999 with the exception of unlisted procedures codes such as 69979 or 99199. Deleted codes are not considered valid for dates of services after the codes have been deleted. In addition, all modifiers listed in the AMA CPT manual are recognized and reimbursed according to industry standards. CHCDE also recognizes CMS Common Procedure Coding System (HCPCS) and will reimburse them in accordance to the CHCDE fee schedule.

Anesthesia services should be billed with base units for surgical anesthetics in accordance with the current editions of the American Society of Anesthesiologists Relative Value Guide (ASARVG) and Crosswalk. Services billed with CPT codes will be denied until submission with ASARVG codes.

Claims Filing Procedures

We encourage the submission of electronic claims. The Coventry Health Care of Coventry, Inc., Payor ID is 25130.

Providers should submit charges on an CMS 1500 Health Insurance Claim form (or UB04 if applicable) directly to the Claims Address listed on the Member’s Identification Card. Claims should be submitted within thirty (30) days from the date of service. CHCDE will not consider claims for payment submitted more than one hundred-eighty days (180) after the date of service.

Exceptions will be made for claims involving Coordination of Benefits (COB). Coordination of Benefits is the process of coordinating the payable benefits when the Member is covered by two or more group benefit plans. COB claims must be submitted within one hundred-eighty (180) days of the
primary insurer’s Explanation of Benefit (EOB) date and a copy of EOB must be attached to the claim if the COB is not billed electronically (refer to the COB section in this chapter).

Submit all claims for members with HMO, Point of Service, Open Access and Health Assurance (Coventry Health and Life PPO product) to:

Coventry Health Care, Inc.
P.O. Box 7713
London, KY 40742

Submit all Coventry Health Care Employee claims to:

Coventry Health Care, Inc.
P.O. Box 7712
London, KY 40742

Please submit claims on a standard CMS 1500 or UB04 form along with the following information:

**CMS 1500:**

- Rendering Provider (Box 31) proprietary ID number should be submitted in (Box 24J) on the shaded part of the first claim line. The accompanying qualifier in (Box 24I) is not used, so any value may be included.  
**Note:** CHCDE will only read one rendering provider ID per claim - not different provider IDs on separate claim lines.

- Rendering provider (Box 31) NPI number should be submitted in (Box 24J) on the lower, non-shaded section of the first claim line.  
**Note:** CHCDE will only read one rendering provider ID per claim - not different provider IDs on separate claim lines.

- The NPI number for the Facility where services are rendered (Box 32) should be submitted in (Box 32A) on the new form.

- The Billing provider (Box 33) NPI should be submitted in (Box 33A).

- The Billing Provider (Box 33) proprietary number (if applicable) should be submitted in (Box 33B).

**UB04**

Box 1  For the actual location services were preformed - Facility Name, Address and Telephone number. This information will only be captured if Box 2 is blank.

Box 2  Actual location for payment - Facility Pay-to Name and Address, P.O. Box addresses are to be sent in this box.

Box 3a  Patient Control Number (patient account number) no change

3b  Medical Record Number (Box 23)

Box 8a  Patient ID
This is the patient's unique ID which will be captured for claims adjudication. If it is blank, the data will be captured from the old (Box 60), which is insured ID on the UB04.

Box 8b Patient Name (UB04 (Box 12))

Box 9a,b,c,d Patient Address, City, State, Zip Code (UB04 (Box 13))

Box 29 Accident State (new field)
Not data captured

Box 39-41 Value Codes UB04 (Boxes 8, 9, and 10) were deleted. Data will now need to be sent as value codes. All value codes will now be captured.

The claim should be submitted with the following information included on the claim:

- Member Name and CHCDE ID Number;
- Name of Referring Physician;
- Dates of Service;
- ICD-9 diagnosis codes;
- CPT-4 procedure code with valid modifiers (as applicable);
- COB information;
- Operative report (as applicable); and
- Provider's Tax ID number, name, signature, credentials, and NPI

**STATUS OF CLAIMS**

You may check your claims via our interactive voice response system (IVR) or on-line via directProvider.com or Emdeon Office. You can also call the Customer Service department to check the status of claims. Our Customer Service department is available to answer any claim inquiries, Monday through Friday between 8 am to 5 pm ET. The Customer Service phone number is (800) 877-8423. For Coventry employees, please call (877) 843-1941.

CHCDE recommends that claims status inquiries not be made unless it has been at least 30 to 45 days since the date of submission. This will allow time for claim processing and mailing of the checks.

It is the responsibility of the Provider to maintain an updated record of their account receivables. CHCDE recommends that you check your account receivables monthly to determine if there are any outstanding claims. In the event that there are, you may check for receipt of your claims via our interactive voice response system (IVR) or on-line via directProvider.com or Emdeon Office. Providers should also contact Customer Service to determine if the claim was received. CHCDE will not be responsible for claims that were never received or for date of service that exceed the timely filing limit.
For Providers who submit claims electronically, reports are provided to provider after each submission detailing the claims that were sent and received. It is the provider’s responsibility to track this list to ensure that claims were received by CHCDE. CHCDE will not be responsible for claims that were never received when the date of service exceeds the timely filing limit and an EDI report showing acceptance of the claim is not present.

**TIMELY FILING**

CHCDE maintains mechanisms that encourage compliance with CHCDE policies and procedures to ensure timely submission of medical claims (“claims”). CHCDE recognizes that participating and non-participating providers may encounter timely filing claim denials from time to time, and therefore, maintains a system to coordinate review of all disputed timely filing of claim denials that providers bring to our attention.

Timely filing limitations for participating and non-participating providers are as follows:

- Original claim submission must be submitted within 180 days from date of service or date of discharge, unless otherwise specified in the contract. The date of discharge is applicable to both hospital and physician claims when the services are in a hospital setting.
- In the event that CHCDE is the secondary payor, the claim must be submitted to CHCDE within 180 days from the date of the Explanation of Benefits (EOB) from the primary payor.
- Corrected claims, including late charges and claim inquiries must be submitted within 90 days from the date of the denial or status of payment of the original claim.
- Providers have 365 days from the date of service to prove that their claims were submitted in a timely manner. No claim beyond 365 days from the date of service will be considered for proof of timely filing.
- If CHCDE is at fault for improper claims processing or provider has adequate proof that the claim was submitted timely, the claim will be reviewed up to 365 days from the initial date of service, and without the necessity of the provider to resubmit the claim and without regard to timely submission deadlines.

Providers may request a review of a timely filing denial through the Claim Inquiry process. The Customer Service Organization (CSO) will review the documentation of the specific claim in question and make a determination to deny or approve. If an approval is granted and all of the necessary elements listed above are documented, there is no need for senior manager level approval.

**Criteria to Override Timely Filing Limitations:**

**Electronic Submission**

For an override review to be initiated, the provider must submit hard copy or electronic copy of the acceptance report from the provider’s clearinghouse or Emdeon/Envoy that indicates the claim was accepted. When necessary, the CSO will run a claims report. If the CSO determines the original claim submission was rejected, the claim denial will be upheld and communicated to the provider via Explanation of Benefits.

**Claims Submitted via Paper**

For an override review to be initiated, the provider must submit a screen print from the provider’s database with documentation that indicates that the claim was generated and the
proper CHCDE address within timely filing limits. NOTE: You may be requested to provide additional information.

Supporting Documentation from the Provider should include:

1) A system print-out that indicates somewhere on the print-out that the claim was submitted to CHCDE;

2) Member name or ID number;

3) Date of service of the claim; and

4) Date the claim was filed to CHCDE

OR

A copy of the original CMS 1500 or UB-04 claims form that indicates the original date of submission.

OR

Documentation that the provider checked CHCDE’s Interactive Voice Response (“IVR”) phone line, Emdeon Office, directProvider.com, or called Customer Service for status of claim within the timely filing guidelines.

R E M I T T A N C E  A D V I C E S

It is the responsibility of the Provider to verify Remittance Advices (RA). If the Provider wishes to dispute a payment, the Provider must contact CHCDE within ninety (90) days of the check date. If the Provider does not notify CHCDE within ninety (90) days after the receipt of payment, payment is considered final.

Schedule of Payment

Checks for CHCDE are scheduled to run twice a week on Tuesdays and Fridays.

Method of Payment

Payments are made to the provider. The check sum includes payment for all services processed for that practice during the payment cycle. Should an RA include denied charges or payments requiring adjustment, an explanation of the denial or adjustment code will be given on the last page of the voucher.

How to Read your Remittance Advice

Here are detailed explanations of the fields on the remittance advice to aid you in reading your remittance advice.
CORRECTION OF PAYMENT

If you discover an underpayment in your claim, please notify our Customer Service department within ninety (90) days of the check date. Customer Service will review the claim. If a correction is needed, they will fix the claim and additional payment will be sent to you on a future remittance/check.

If we have overpaid you, CHCDE will correct the error by subtracting the overpayment from a future remittance/check and reissue the correct payment. Please notify us so that we can make the appropriate adjustments. Please do not return a check to CHCDE unless it is specifically requested. If a returned check is requested, please mail it to the following address:

Coventry Health Care of Delaware
Recoveries Department
120 East Kensinger Drive
Cranberry Twp, PA 16066

To send in a refund check, please send it to:

Delaware Plan-Refund
First Union National Bank
P.O. Box 8500-5438
Philadelphia, PA 19178

Providers with questions regarding a recovery appearing on a Remittance Advice should contact a Service Specialist in the Recovery Department at 877-588-0405.

Business Partner Agreements are maintained by Recovery Administration.

<table>
<thead>
<tr>
<th>Vendor Name</th>
<th>Recovery Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Active Recovery Vendor Contracts</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACS Recovery Services (formerly Primax Recoveries, Inc.)</td>
<td>COB</td>
<td>Effective 8/31/09 Coventry's COB agreement with ACS Recovery has transitioned to services covered under the Section 111 Proactive COB agreement with ACS Recovery Services. Please see refer to the details under ACS RS Proactive COB.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A coordination of benefits (COB) recovery occurs when ACS Recovery Services (formerly Primax Recoveries, Inc.) identifies other primary insurance that was not identified during the claim payment process and recovers overpayments made to providers or individuals. Sources of recovery include other commercial insurance, Medicare, End Stage Renal Disease, working aged and the disabled.</td>
</tr>
<tr>
<td>Vendor Name</td>
<td>Recovery Activity</td>
<td>Description</td>
</tr>
<tr>
<td>--------------------</td>
<td>----------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>AIM</td>
<td>Credit Balance</td>
<td>A credit balance is a positive balance in a patient's account, created when a payer remits more than the final billed amount or contractually agreed upon amount. Credit balances exist on the provider account as a recorded liability. AIM provides free book keeping to providers by coordinating refunds to the appropriate payer.</td>
</tr>
<tr>
<td>Arbor Health</td>
<td>Credit Balance</td>
<td>A credit balance is a positive balance in a patient's account, created when a payer remits more than the final billed amount or contractually agreed upon amount. Credit balances exist on the provider account as a recorded liability. Arbor provides free book keeping to providers by coordinating refunds to the appropriate payer.</td>
</tr>
<tr>
<td>CDR Associates</td>
<td>Credit Balance</td>
<td>A credit balance is a positive balance in a patient's account, created when a payer remits more than the final billed amount or contractually agreed upon amount. Credit balances exist on the provider account as a recorded liability. Accent provides free book keeping to providers by coordinating refunds to the appropriate payer.</td>
</tr>
<tr>
<td>Connolly Healthcare</td>
<td>DRG Audit Services</td>
<td>A DRG audit is a comprehensive medical record review that involves a review of the medical record documentation to validate the assignment of the principal and secondary diagnosis as well as the principal procedure code or CPT assignment. As part of this audit a coding validation is conducted to confirmation of the diagnosis code recorded by the provider and its relevance to the billed procedure code(s). These audit processes determine if the correct DRG was assigned. Connolly Healthcare is Coventry’s first pass DRG audit vendor for the Medicaid line of business. Connolly Healthcare is Coventry’s second pass DRG audit vendor for all other lines of business.</td>
</tr>
<tr>
<td>Connolly Healthcare</td>
<td>Data Mining</td>
<td>Data mining is the systematic retrospective review of paid medical and pharmacy claims using proprietary algorithms to identify overpaid claims. The use of data mining vendors acts to supplement Coventry’s internal data mining efforts. Connolly Healthcare is Coventry Corporate first pass data mining vendor and retains 120 days exclusivity to data mine for overpayments for each new monthly data set.</td>
</tr>
<tr>
<td>Dun and Bradstreet</td>
<td>Collections</td>
<td>Coventry has contracted with Dun and Bradstreet RMS (D&amp;B RMS) to pursue retro-terminated pharmacy recoveries and open payable provider collections.</td>
</tr>
<tr>
<td>Vendor Name</td>
<td>Recovery Activity</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>-------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Health Data Insights (HDI)</td>
<td>DRG Audit Services</td>
<td>A DRG audit is a comprehensive medical record review that involves a review of the medical record documentation to validate the assignment of the principal and secondary diagnosis as well as the principal procedure code or CPT assignment. As part of this audit a coding validation is conducted to confirmation of the diagnosis code recorded by the provider and its relevance to the billed procedure code(s). These audit processes determine if the correct DRG was assigned.</td>
</tr>
<tr>
<td>HRI</td>
<td>Provider Bill Audit</td>
<td>A Provider Bill Audit is an audit to determine whether all medical/clinical items or services appear on the provider’s bill and whether the provider’s medical/clinical documentation substantiate or support the bill.</td>
</tr>
<tr>
<td>Termed Recovery Vendor Contracts</td>
<td></td>
<td>Note: Termed Vendors May have contractual rights to retains cases/inventory in process</td>
</tr>
<tr>
<td>Accent</td>
<td>Credit Balance</td>
<td>A credit balance is a positive balance in a patient’s account, created when a payer remits more than the final billed amount or contractually agreed upon amount. Credit balances exist on the provider account as a recorded liability. Accent provides free book keeping to providers by coordinating refunds to the appropriate payer.</td>
</tr>
<tr>
<td>ACS Recovery Services (formerly Primax Recoveries, Inc.)</td>
<td>TPL</td>
<td>Third Party Liability exists for accident related medical care when another party is liable through Home Owner Insurance, Workers Compensation and Motor Vehicle Accident situations.</td>
</tr>
</tbody>
</table>

Coventry Health Care of Delaware, Inc.  
Revised: November 2011
<table>
<thead>
<tr>
<th>Vendor Name</th>
<th>Recovery Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIM Data Mining</td>
<td>Data Mining</td>
<td>Recoveries occur when ADM identifies a claim that was overpaid due to provider billing or claims processing errors.</td>
</tr>
<tr>
<td>CGI</td>
<td>DRG Audit and Validation</td>
<td>A DRG audit is a review of medical records for appropriate ICD9-CM coding and DRG assignment and payment.</td>
</tr>
<tr>
<td>End Game Strategy</td>
<td>Anesthesia Overpayments</td>
<td>End game is being piloted for HAPA WPA providers. Results of the pilot project will be evaluated for a potential 2005 Coventry wide implementation. Recoveries occur when End Game Strategy identifies a claim that was potentially overpaid for some of the following reasons: different anesthesia providers billing for the same service on the same date of service, the same anesthesia provider billing for the same service on the same date of service, the same anesthesia provider billing for different anesthesia services on the same date of service.</td>
</tr>
<tr>
<td>Health Compliance Associates</td>
<td>Data Mining</td>
<td>Recoveries occur when HCA identifies a unbundled claim that was overpaid due to provider billing and claim payment errors.</td>
</tr>
</tbody>
</table>

**Systems Affecting Claims Payment**

CHCDE utilizes a variety of systems and procedures in the claim review process. These systems may affect the payment of the claims. The systems noted below contain licensed or copyrighted material. Due to the licensing agreements and copyright laws, CHCDE cannot mass distribute the detailed logarithms, policies, or rules used in these systems. If you have specific questions, please direct them to Customer Service at (800) 833-7423.

**Healthcare Recoveries, Inc. (HRI)**

Proprietary databases are used to review claims with diagnosis codes that are appropriate for investigation of third party liability or worker’s compensation. HRI conducts investigation of claims and recovers on behalf of CHCDE.

**Special Investigative Unit (SIU)**

SIU provides comprehensive fraud and abuse detection services for CHCDE. These services include training claim’s staff on fraud detection and reporting, the prospective investigation of claims for potential abuse, and the ongoing monitoring of claims paid data to identify claims paid to “suspect” providers. Identification of “suspect” providers and other services are based on the SIU's proprietary
review protocol. Services include the validation of the tax identification number and licensures of providers from zip code areas where prior billing abuse has been widespread.

**MedCost Recovery Systems, Inc.**

Through electronic transfer of data, MedCost Recovery Systems employs proprietary logarithms to identify episodes of care that are aberrant. These records are audited against CHCDE hospital contracts, and if medical charts do not support the charges and services billed, recovery is initiated.

**Proprietary Claims Payment Guidelines**

In addition to the ClaimCheck System, CHCDE supplements its claims policies with proprietary claims payment guidelines. These guidelines are generally developed on a national level by the medical management staff at Coventry Health Care’s corporate headquarters and approved at the local CHCDE level prior to use. Examples of areas of care where proprietary claims payment guidelines exist include but are not limited to: chiropractic care, payment of supplies, and policies on the applicability of copayments.

**Reimbursement Determinations**

Whereas, the previous sections provides a description of systems affecting claims payment, this section is designed to provide some specific information about the types of rules applied to claims billed by providers to CHCDE.

The CHCDE schedule of allowances represents the maximum reimbursement amount for each covered service that corresponds to any given medical service code. The basis of determining valid medical service codes are from Current Procedural Terminology (CPT), HCFA Common Procedural Coding System (HCPCS), or National Drug Codes (NDC). For covered services represented by a single code, the maximum reimbursement amount is the allowance amount determined by CHCDE or the provider’s usual charge for the service, whichever is less. In many cases, CHCDE allowances are based upon measures of relative value such as Average Wholesale Price (AWP), the Federal Resource Based Relative Value Scale (RBRVS), American Society of Anesthesiologists (ASA) units, Medicare laboratory, and Durable Medical Equipment (DME) rates.

**Claim Check System**

This is an automated claims auditing system that verifies the clinical patterns of professional claims. CHCDE follows Correct Coding Initiative (Medicare) guidelines. It is integrated with our claims processing, IDX, and identifies inappropriate billing practices. ClaimCheck, helps to ensure that claims are paid correctly based on clinical patterns and is designed to prevent overpayment. Through the edit process, the system advises CHCDE’s claims processors when inappropriate billing occurs. ClaimCheck analyzes data and identifies and corrects all major types of inappropriate code irregularities. Specific CPT codes may be considered incidental to the major procedure performed on the patient. The use of modifiers, duplicate claims, assistant surgeon billing and the identification of possible cosmetic surgery are examples of claims issues evaluated by ClaimCheck. In addition, the age and sex appropriateness of a CPT code is considered. ClaimCheck is intended to consistently apply American Medical Association guidelines to all claims. Questions about ClaimCheck system edits on specific claims should be directed to Customer Service.

The following are the edits used by this software and medical notes must be submitted in the event any claim/s have denied for one of these edits:
● Medical Visit;
● Duplicate;
● Pre-operative;
● Post-Operative;
● Incidental;
● Mutually Exclusive;
● Assistant surgeon;
● Rebundling;
● New Visit;
● Multiple Surgical Reduction; and
● Invalid modifier/procedural code combination.

Please refer to your Remittance Advice to determine if medical records are necessary.

A listing of the most commonly seen modifiers for surgical claims and their meanings are:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>50</td>
<td>Bilateral Procedures</td>
</tr>
<tr>
<td>51</td>
<td>Multiple Procedures 50% cut back</td>
</tr>
<tr>
<td>57</td>
<td>Decision for Surgery</td>
</tr>
<tr>
<td>59</td>
<td>Distinct Procedural Service</td>
</tr>
<tr>
<td>62</td>
<td>Two Surgeons</td>
</tr>
<tr>
<td>80</td>
<td>Assistant Surgeon</td>
</tr>
<tr>
<td>82</td>
<td>Assistant Surgeon, when qualified resident surgeon is not</td>
</tr>
<tr>
<td>AS</td>
<td>Physician Assistant for surgery</td>
</tr>
</tbody>
</table>

**Multiple Surgery**

It is CHCDE’s policy to apply a payment reduction for many approved multiple surgical procedures. These surgeries (if approved) are paid at a rate of 100% of the approved amount for the primary procedure, and 50% of the approved amount for the second procedure. When
two or more different medical service codes are provided to the same patient (usually by the same provider on the same date of service) for covered surgical services provided in a single operative session reimbursement would be made at 100% of the allowance and 50% of the allowance amount for the second medical service code, and 50% of the allowance amount(s) for each subsequent procedure. All multiple surgery/procedural services are reviewed to determine primary versus secondary procedures.

**Bi-lateral and Multiple Bi-lateral Processing**

A bilateral procedure is a service that is performed on both sides at the same operative session. For example, a bilateral mastectomy is a mastectomy performed on both the left and right breast during the same session.

If any of the multiple surgeries are bilateral surgeries, reimbursement will be made at 150% as one payment amount, rank this with the remaining procedures, and apply the appropriate multiple surgery reductions.

**Incidental Surgery**

Incidental procedures are not reimbursed as separate charges when they are performed in conjunction with other surgical procedures. The following are a few examples of incidental procedures:

An incidental procedure is one that is performed at the same time as a more complex primary procedure that does not require significant, additional physician resources and/or is clinically integral to the performance of the primary procedure. When multiple medical service codes are billed in conjunction, some codes may be considered incidental to other codes and may not be considered toward the total allowance for the aggregation of billed codes. A code which is a subset of another code based on an objective interpretation of CPT verbiage will be considered incidental to the latter code. Codes which are “components” of “comprehensive” codes based on the CMS Correct Coding Initiative, will be considered incidental to the latter. In addition, CHCDE may also consider a code incidental to another if the incremental value of the former is less than one-fourth of its usual value when provided in combination with the latter. In many instances, this occurs when the lesser services do not pertain to different route of access, different organ systems, different pathological processes, or to multiple trauma.

- Procedures to create surgical entry (such as laparotomy)
- Incidental appendectomy
- Bilateral salpingo-oophorectomy when performed with a total hysterectomy

**Assistant Surgeon**

Assistant surgeon charges are indicated on a physician’s claim by an 80 (assistant surgeon) or an 82 (assistant surgeon when qualified resident unavailable). Physician Assistant (PA) services are indicated on a claim with an AS modifier. Minimum assistant surgeon is indicated with an 81 modifier and zero reimbursement is available for these services. Not all surgical procedures allow for an assistant surgeon. If the procedure **always allows** or **always denies** an assistant surgeon, the claim will be auto adjudicated through the CHCDE system.

Procedures that always deny can still be reviewed if the medical records/operative report is attached to the claim.
If the surgery may allow for an assistant based on the complexity of the patient’s condition and other factors, the claim will be reviewed if documentation such as an operative report is attached to the claim.

If the Assistant Surgeon is non participating their services must be pre-authorized.

**Age/Sex Restrictions**

Some services are allowed for only one sex (e.g., provider should not submit CPT code 58150 for a hysterectomy for a male patient). Some services are allowed only for certain age ranges (e.g. provider should not submit CPT code 43831 for a gastrostomy, neo-natal for feeding a 45 year old patient).

**Experimental/Investigational Services/Supplies/Drugs**

A health product service, supply or drug is deemed experimental/investigational by Coventry according to the following criteria following coverage eligibility criteria:

- Any drug not approved for use by the Food and Drug Administration (FDA); any drug that is classified as IND (Investigational New Drug) by the FDA; any drug requiring pre-authorization that is proposed for off-label prescribing.
- Any health product or service that is subject to Investigational Report Board (TRB) review or approval.
- Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II, or III as set forth by FDA regulations.
- Any health product or service that is considered not to have demonstrated value based on clinical evidence reported by peer-review medical literature and by generally recognized academic experts.

A drug, device, procedure, or other service will be experimental or investigational if CHCDE makes such a determination based upon criteria noted, unless otherwise noted in the Certificate of Coverage documents. Experimental or investigational services are not covered services.

**Global Processing**

For some medical services (in most instances surgical services), CHCDE will impose global surgery processing rules, wherein some services (in most instances evaluation and management services) are incidental to other services (in most instances procedural services) when provided with a defined time period and in conjunction with the procedural service. CHCDE follows CMS conventions regarding global designations and time periods for major and minor surgery.

**History Edits**

These edits apply to once-in-a-lifetime procedures, such as an appendectomy. These edits also apply to items such as drugs or supplies with monthly limits. History edits may also apply to certain
codes, which denote services for a specified time period such as weekly or monthly radiology or renal dialysis.

**Site of Service Payment Differential**

CHCDE uses differentials in its physician fee schedules to incorporate the site at which the service was performed as a basis for the allowable amount. The differential is intended to reflect the differences in practice expense between use and non-use of a physician office. For some services, a higher allowable fee schedule exists if the service is performed outside of a facility setting. Many services have no site-of-service differential based on the nature of the service.

**Medical Necessity**

Medical necessity is defined by CHCDE as the use of services or supplies as provided by a hospital, skilled nursing facility, physician, or other provider required to identify or treat a member’s illness or injury and which, as determined by CHCDE, are: (1) consistent with the symptoms or diagnosis and treatment of the member’s condition, disease, ailment or injury; (2) appropriate with regard to standards of good medical practice; (3) not solely for the convenience of the member, his/her participating physician, hospital, or other health care provider; and (4) the most appropriate supply or level of service which can safely be provided to the member. When specifically applied to an inpatient admission, it further means that the member's medical symptoms or condition requires that the diagnosis or treatment cannot be safely provided to the member in an outpatient setting. Services listed in the schedule of benefits are covered only if they are medically necessary.

**Modifiers**

CHCDE accepts most standard modifiers; however, some modifiers may require clinical review.

**Rebundling Claim Processing**

Procedure unbundling occurs when two or more procedures are used to describe a service when a single, more comprehensive procedure exists that more accurately describes the complete service performed by the provider. For some combinations of medical service codes, CHCDE will allow the allowance amount for the totally different service code while disallowing the billed medical service code. CHCDE refers to this as rebundling processing. Medical service codes to which billed services combine are usually a superset of the billed codes. An example would be a set of laboratory codes that are all contained within a single panel or multi-channel test. Less frequently, CHCDE will combine billed codes into a code which is not a superset of billed charges, but does represent the value of the combined medical services billed.

**Billing for Electronic Communication**

CHCDE does not allow billing of charges associated with telephone (such as 99371-99373), e-mail, or other electronic communications. These charges are not billable to CHCDE and are also not billable to the patient.

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**PROCESSING TIPS**

Allergy services include the following codes:

95115 - injection of antigen only, single injection
95117 - injection of antigen only, two or more (only use one unit)
95120 - injection of single antigen AND provision of antigen
95125 - injection of two or more antigens AND provision of antigen
95165 - provision of antigen (paid on a per dose basis)

<table>
<thead>
<tr>
<th>Code</th>
<th>Type of Service</th>
<th>Coverage Category</th>
<th>Disposition w/o Rider</th>
<th>Rider Necessary</th>
</tr>
</thead>
<tbody>
<tr>
<td>95115</td>
<td>injection</td>
<td>Allergy Injections</td>
<td>eligible</td>
<td>No</td>
</tr>
<tr>
<td>95117</td>
<td>injection</td>
<td>Allergy Injections</td>
<td>eligible</td>
<td>No</td>
</tr>
<tr>
<td>95120</td>
<td>provision and injection</td>
<td>Antigen and Serum</td>
<td>not covered</td>
<td>Yes</td>
</tr>
<tr>
<td>95125</td>
<td>provision and injection</td>
<td>Antigen and Serum</td>
<td>not covered</td>
<td>Yes</td>
</tr>
<tr>
<td>95165</td>
<td>provision</td>
<td>Antigen and Serum</td>
<td>not covered</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Members are responsible for paying their co-pay for the office visit to have the allergy injection service. If a provider is just providing the allergy serum (CPT 95165) to the patient and no other services are rendered, then the office co-pay will not apply.

**Covered Services Include:**

- Routine testing procedure to determine or evaluate the source of the allergy;
- Treatment and procedures to correct the allergy or render the member insensitive to an allergen, including the provision and administration of allergy serum;
- The cost of injections when performed by a member’s PCP or Specialist to whom the member is referred;
- Skin-testing only when performed by a participating allergist;
- The cost of serum; and
- Re-evaluation when performed by a participating allergist

**Anesthesia/CRNA**

Anesthesia related to surgery should be billed using the same location code as the surgery. For example, if surgery was done in-patient, the billing provider should use location 21, outpatient at a hospital, location 22 would be billed and if the surgical procedure was performed in a physician’s office, location 11 should be billed.

Anesthesia services are handled differently than other procedures, as the payment is determined by a specific formula:

- BASE + TIME x Dollars Per Unit
- The Dollars Per Unit amount is loaded into the system individually for each anesthesia provider.
• Units calculations – the system is set up to allow one (1) unit for every 15 minutes. If the time indicates 16 to 19 minutes the system will round down to one (1) unit. If the time indicates 20 to 29 minutes the system rounds up to two (2) units.

• The claim must indicate whether anesthesia services were provided by an anesthesiologist or a CRNA by using Anesthesia Modifiers.

• There are many different contractual agreements related to reimbursement of the CRNA. The modifiers AA, QK and QX are used to further define the provider of the anesthesia service.

• The AA Modifier represents an anesthesiologist performed the surgical anesthesia. The anesthesiologist is paid full base and time per contract.

• The QK Modifier represents the anesthesiologist supervision of two or more CRNAs. Base is reimbursed per contract, but time units are reduced to 1 unit is 30 minutes. No additional claims should be paid from the CRNA for the anesthesia.

• The QX Modifier represents a CRNA provided the service under medical direction by a physician. The CRNA is reimbursed base and time per contract as if the anesthesiologist did the case. No additional claims should be paid from the anesthesiologist for the anesthesia.

• The QZ Modifier is reimbursable at 100% of fee schedule subject to GMIS claim check edits.

• When a CRNA anesthesia claim is billed along with an anesthesiologist’s claim, with the same procedure for the same date of service, and both are PAR or NON-PAR, deny the CRNA claim with disposition code C36/535 INELIGIBLE – NOT A BILLABLE SERVICE.

NOTE: Some provider specific arrangements exist. Always refer to your providers specific contract for details.

Coding

“C” codes refer to the HCPCS code range C1000 through C9999. These codes are used under Medicare’s Prospective Payment System (PPS) for reporting purposes. These codes are to be used exclusively in billing by hospitals who have the Ambulatory Payment Classification (APC) procedure payment system included in their contract. Other instances of “C” codes being billed will be denied INAPPROPRIATE BILLING, NO MEMBER RESPONSIBILITY.

Invalid/Obsolete Codes

Providers are required to bill CHCDE with the correct information. Another area of billing where common errors are made is the diagnosis code. Often there is more than one diagnosis code to represent the patient’s condition, and the appropriate code(s) are not used. Example - If the provider intended to bill 255.4 as the diagnosis code and instead bills 255.04, the CHCDE claim system will not accept this diagnosis. We consider any diagnosis code the system does not accept to be an invalid diagnosis code and will be rejected for correct coding.

Unlisted Codes

You are encouraged to code a claim for processing; however, there are certain instances when there is no appropriate CPT or HCPC code for the procedure performed. In these instances you must submit medical records for review or write a justification explaining the procedure which was preformed and why there is no applicable code. An unlisted CPT or HCPCS code usually ends with “99” and should only be billed when no other CPT or HCPCS code can accurately describe the procedure or service performed. All
unlisted procedures require documentation for review. If there is no documentation attached, we will deny the unlisted procedure line requesting the medical records.

**Durable Medical Equipment**

Covered durable medical equipment and corrective appliances under $200.00** can be approved for purchase without referral for all products under Coventry’s Commercial lines of business.*

**Compression stockings regardless of amount requires an authorization.**

All rentals require authorization regardless of the dollar amount.

** $200.00 is per item or claim line billed amount

Rental vs. Purchase – claims must be submitted with the appropriate modifier indicating whether the item is being rented (RR) or purchased (NU).

Rental to purchase – when an item is being rented then purchased by the patient, Coventry will refer to the provider’s contract as to how many months rental will be applied toward the purchase. If there is no specific contract wording then all rentals will be applied towards the purchase price.

**Home Health Care**

Home Health Care requires prior authorization and can include any combination of the following services:

1. Professional medical care services deemed medically necessary for the member’s care and treatment;
2. Intermittent home care nursing services (other than private duty nursing services) by a registered nurse or licensed practical nurse;
3. Physical Therapy, Speech Therapy, Occupational Therapy and Respiratory Therapy services;
4. Nutritional education and counseling;
5. Part-time home health aide services (not including housekeeping or long term custodial care services);
6. Home care medical supplies when deemed medically necessary for the care and treatment of the member during the member’s home confinement; and/or
7. Administration of medicines, medical supplies, and dressings used by the health professionals in conjunction with services provided during Home Health Service visits

The following services are not covered:

1. Home health services determined not to be medically necessary;
2. Services for investigational and experimental purpose;
3. Mental health services performed incidentally to other skilled nursing services in the course of a single visit;
4. Non-skilled services rendered by nurses, Physical Therapy, Occupational Therapy, or Speech Pathologists;
5. Personal Care Aides (PCA);
6. Child Care;
7. Respite Care;
8. Meal preparation and housekeeping;
9. Services and medical supplies that are not medically necessary or appropriate;
10. Medical day care services; and
11. Non-referred or out of plan services
Newborn Coverage

Newborn children are added to the subscriber’s policy for the first 31 days regardless if the subscriber plans to continue coverage after the first month. This applies to all Full Risk policies and most ASO policies. It is the subscriber’s responsibility to submit an Enrollment Form to their employer to have continued coverage on the dependent.

The birth mother is required to be on a policy for the newborn to be added. As long as the newborn qualifies for coverage, coverage is allowed. If the mother (who isn’t on the Coventry policy) elects to carry coverage in addition to the father’s CHCDE coverage, normal order of benefits determination would apply.

For healthy, “normal” newborns, the initial inpatient services are covered without a separate authorization. If the benefit plan has deductible and co-insurance for inpatient services, this will be waived. However, a separate authorization is required for a newborn if the hospital is billing for NICU (Rev 174) or SPC Care Nursery (Rev 173) charges and the newborn is not a detained baby.

For sick newborns “detained baby” (requiring more than normal nursery care) a separate authorization is required. If the benefit plan has deductible and co-insurance for inpatient services, this will be applied.

Radiology

Radiology charges can be billed as professional, technical and global fees as represented by their respective modifiers.

Global radiology services should be billed without any type of modifier. This is when both the technical and professional components of the radiology procedure is done by the same provider.

Technical component modifier TC should be placed on a claim when you are providing the radiology service only and does not include the reading/interpretation of the service and are usually provided by a facility where the radiology procedure is performed.

Professional component modifier – 26 should be placed on a claim for the reading/interpretation of the radiology service. These services are usually for reading/interpretation of radiology services done inpatient, outpatient, emergency room or ambulatory surgery center.

MedSolutions

MedSolutions, Inc. administers the utilization management program for all outpatient MRI, MRA, CT and PET imaging studies and readings for all commercial and Medicaid Coventry plan participants. In addition, MedSolutions, Inc. administers the utilization management of nuclear cardiac studies for Coventry’s Medicaid (Diamond Plan) plan participants.
MedSolutions, Inc. will handle the authorization process and claims processing for all Office (POS 11), Outpatient (POS 22) and Ambulatory Surgery Center (POS 24) Claims.

CHCDE will maintain responsibility for Inpatient (POS 21) and Emergency Room (POS 23) Claims. In addition, claims billed with Observation Charges will be payable by CHCDE.

**COORDINATION OF BENEFITS (COB)**

**Coordination of Benefits (COB):** CHCDE does not require an authorization when the member has other primary insurance. Claims payment would be considered if the provider has followed the rules of the primary carrier. (i.e. authorization requirements, etc) In the case of In-Patient Hospitalization, notification is recommended. Method of integrating benefits payable under more than one health insurance plan so that the insured persons benefits from all sources do not exceed 100 percent of allowable medical expenses or eliminate incentives to contain costs.

**National Association of Insurance Commissioners (NAIC)** [www.naic.org](http://www.naic.org) is a national organization of state officials charged with regulating insurance. It has no official power but wields significant influence. NAIC was formed to provide national uniformity in insurance regulations. The implementation of these provisions:

- Prevents a person from profiting from excess health care coverage
- Eliminates duplicate payments
- Establishes a sequence of payment determination
- Results in important cost savings to the plan

**NAIC** has also developed a sequence of rules, which are outlined below, that are to be adhered to when determining the order of benefit determination for an insured individual. These rules identify which insurance carrier should pay as primary, secondary and so forth. When a carrier is identified as the "primary plan", that plan is then the first plan to make payment according to their individual plan provisions. The primary plan must pay or provide its benefits as if the secondary plan or plans did not exist. The "secondary plan" would then consider the bill for payment according to their plan provisions. However, the secondary plan will reduce its payment by the benefits paid or provided by the primary plan. In no event will the secondary plan ever pay more than what it would have paid as the primary plan. The order of benefit determination rules only applies to those plans that contain a COB provision. The group benefit plan that does not contain a COB provision in its documentation, is the benefit plan that would be considered the primary plan. Therefore, you would not need to refer the order of benefit determination rules.
Order of Benefit Determination Rules (Health Plan vs. Health Plan)

The following rules are NOT mutually exclusive. One rule can work in conjunction with another, or can override (or void) another rule. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

**Rule 1: Non-Dependent or Dependent**

The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree, is primary and the other plan that covers the person as a dependent is secondary.

**Rule 2: Dependent Child/Parents NOT Separated or Divorced**

When both parents elect to cover the children under their benefit plans, two rules are used to determine primary vs. secondary coverage for the dependent children:

1. Birthday Rule means the primary plan will be the plan of the parent whose birthday (month & day) falls FIRST in a calendar year. If both parents have the same birthday (month & day), benefit plan that covered the parent longer is primary.

2. Gender Rule means primary coverage is determined by the sex of the parent. The primary plan will be the plan of the male. The Gender Rule is the exception to the Birthday rule. If one or both of the plans contains the gender rule as a COB provision, the gender rule overrides the birthday rule when determining order of benefits payments. The male’s plan will always be primary.

**Rule 3: Dependent Child of Divorced or Separated Parents**

If a court decree is received and it states that one of the parents is financially responsible for the child’s health care expenses or health care coverage then that parent’s plan is primary. If the parent with financial responsibility has no coverage, but the parent’s spouse does, then the spouse’s plan is primary.

If no court decree exists the following would apply in order:

1. The plan of the custodial parent.
2. The plan of the spouse of the custodial parent.
3. The plan of the non-custodial parent.
4. The plan of the spouse of the non-custodial parent.

If a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage, use the birthday rule to determine the primary and secondary carrier.

**Rule 4: Active or Inactive Employee**

As a general rule, the plan that covers a person as an employee who is neither laid off nor retired is primary. This rule covers the situation where one individual is a subscriber covered under one policy as an active worker and a subscriber under another policy as a retired worker. If the member is the subscriber of a retiree policy and is a dependent under an active commercial policy, then the retiree policy will be primary.
However, there may be some Certificates of Coverage's that indicate that if there is an active policy and a retiree policy, the active policy always will be primary. Check your plans COC to identify which rule to use.

**Rule 5: Continuation Coverage/COBRA (Consolidation Omnibus Budget Reconciliation Act)**

If a person whose coverage is provided under COBRA and also is covered under another plan, the plan covering the person as an employee, member, subscriber, policyholder or retiree (or that person's dependent) is primary and the COBRA coverage is secondary. The COBRA coverage can continue if the new group plan contains any pre-existing condition limitation.

Under COBRA, an employer group health plan (fully-insured, self-funded and Federal plans with 20+ employees) ordinarily is defined as a plan that provides medical benefits for the employer's own employees and their dependents through insurance or otherwise (such as a trust, health maintenance organization, self-funded pay-as-you-go basis, reimbursement or combination of these).

**Rule 6: Longer or Shorter Length of Coverage**

If none of the preceding rules determine the order of benefits, the plan that covered the person for the longer period of time is primary. The length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force. If order of benefits still can't be determined the primary plan then the allowable expenses shall be shared equally between plans.

Here are a few examples of how to apply the Order of Determination rules previously described:

<table>
<thead>
<tr>
<th>IF</th>
<th>AND</th>
<th>THEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our subscriber is actively employed…</td>
<td>Our subscriber is actively employed with another company…</td>
<td>The company that has insured the member the longest will be the primary carrier.</td>
</tr>
<tr>
<td>Our subscriber is actively employed…</td>
<td>The spouse is also actively employed…</td>
<td>If a claim is on our subscriber:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. CHCDE is primary.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Spouse’s plan would be secondary.</td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If a claim is for the Spouse:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Spouse’s plan would be primary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. CHCDE would be secondary.</td>
</tr>
<tr>
<td>Both the subscriber and spouse are actively employed and are NOT divorced…</td>
<td>Both plans have the Birthday Rule and the claim is for their child(ren)…</td>
<td>The primary plan will be that of the parent who’s birthday comes first in the calendar year. <strong>Note:</strong> If they share the same month and day then whoever has been insured the longest will be the primary carrier.</td>
</tr>
<tr>
<td>IF</td>
<td>AND</td>
<td>THEN</td>
</tr>
<tr>
<td>----</td>
<td>-----</td>
<td>------</td>
</tr>
<tr>
<td>Both the subscriber and spouse are actively employed and are NOT divorced...</td>
<td>Only 1 plan has the Birthday Rule...</td>
<td>Then the plan of the male will be primary</td>
</tr>
<tr>
<td>The claim is for a step child for our subscriber member...</td>
<td>The natural parent has been determined by the court decree to carry insurance...</td>
<td>1. Natural parents insurance is primary 2. CHCDE would be secondary. <strong>Note:</strong> If the natural parent or the dependent spouse also has coverage for the dependent children then CHCDE may be tertiary - 3rd coverage.</td>
</tr>
<tr>
<td>A spouse is employed...</td>
<td>Has CHCDE insurance through their employer with but also is covered as a dependent with CHCDE...</td>
<td>1. Process the claim under their subscriber policy number 2. Then process the claim again to coordinate under their dependent policy number.</td>
</tr>
<tr>
<td>Our spouse is retired under age 65...</td>
<td>Goes somewhere else to work and is actively employed with insurance...</td>
<td>1. The active plan is primary. 2. CHCDE is secondary.</td>
</tr>
</tbody>
</table>

**Tricare**

Tricare is military insurance for active and retired military personnel.

1. If member is active in the military, Tricare is primary and the group plan is secondary.
2. If a member is retired from the military, Tricare is secondary and the group plan is primary.
3. If the active military person has coverage for his/her spouse and/or any children, then Tricare is **secondary** for any dependents on the policy.
# Order of Benefit Determination Rules (Medicare)

## MEDICARE COB DETERMINATION TABLE

<table>
<thead>
<tr>
<th>MEDICARE ELIGIBILITY SITUATION</th>
<th>ELIGIBILITY CONDITIONS</th>
<th>PRIMARY COVERAGE</th>
<th>COVERAGE SECONDARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 65+, retired, not actively working but has retiree group coverage</td>
<td></td>
<td>Medicare</td>
<td>Retiree Plan*</td>
</tr>
<tr>
<td>Age 65+ and actively working with employer group coverage (with or without Rx coverage)</td>
<td>If the group has 2 - 19 employees</td>
<td>Medicare</td>
<td>Employer Group Coverage*</td>
</tr>
<tr>
<td></td>
<td>If the group has exactly 20 or more employees</td>
<td>Employer Group Coverage</td>
<td>Medicare</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDICARE ELIGIBILITY SITUATION</th>
<th>ELIGIBILITY CONDITIONS</th>
<th>PRIMARY COVERAGE</th>
<th>COVERAGE SECONDARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65, disabled and actively working with employer group coverage (with or without Rx coverage)</td>
<td>Group has less than 100 employees</td>
<td>Medicare</td>
<td>Employer Group Coverage*</td>
</tr>
<tr>
<td></td>
<td>Group has exactly 100 or more employees</td>
<td>Employer Group Coverage</td>
<td>Medicare</td>
</tr>
<tr>
<td>Under 65, disabled dependent and covered by an actively working subscriber with active employer group coverage</td>
<td>Group has less than 100 employees</td>
<td>Medicare</td>
<td>Employer Group Coverage*</td>
</tr>
<tr>
<td></td>
<td>Group has exactly 100 or more employees</td>
<td>Employer Group Coverage*</td>
<td>Medicare</td>
</tr>
<tr>
<td>ESRD Diagnosis and actively working with employer group coverage</td>
<td>1st 30 months of eligibility</td>
<td>Employer Group Coverage</td>
<td>Medicare</td>
</tr>
<tr>
<td></td>
<td>After the 1st 30 months of eligibility</td>
<td>Medicare</td>
<td>Employer Group Coverage</td>
</tr>
</tbody>
</table>

**COB METHODS OF PROCESSING:**

**Benefits-Less-Benefits (BLB)** means if the primary carrier paid more than what we would have paid as the primary carrier, **WE PAY NOTHING.** If we would have paid more than the primary carrier paid, we pay the difference up to the primary carriers allowed amount. The best
way to interpret BLB is to think in terms of **Payment-Less-Payment**. The key factor is CHCDE payment amount will **not exceed 100% of the LESSER** of the two carriers allowed amount.

CHCDE uses BLB method for all self funded Delaware based employer groups and all employer groups outside the state of Delaware.

**Example 1:**

- Primary Allowed $90.00  
- Primary Payment $80.00  
- Member’s Co-pay $10.00  
- CHCDE Allowed $80.00  
- CHCDE Payment $70.00  
- Member’s Co-pay $10.00  

The lesser of the two allowables is $80.00, since the primary paid $80.00, CHCDE would pay nothing.

**Example 2:**

- Primary Allowed $80.00  
- Primary Payment $70.00  
- Member’s Copay $10.00  
- CHCDE Allowed $90.00  
- CHCDE Payment $80.00  
- Member’s Copay $10.00  

The lesser of the two allowables is $80.00, since the primary paid $70.00, CHCDE would pay $10.00.

**Traditional with Credit Banking (TCB)** means we pay the difference between our allowed amount and the primary carrier’s payment but never more than what we would have paid as the primary carrier. **COB Savings** are the amounts CHCDE would have paid for any claim if it had been primary LESS whatever amounts we actually paid as the secondary plan. This savings is reserved in credit banks. The credit bank is used when we makes a withdrawal to cover member expenses, such as co-pays, deductibles and co-insurances which are typically NOT paid when coordinating benefits.

CHCDE uses TCB method of processing for all fully insured Delaware based employer groups.

**Example:**

- Primary Allowed $1500.00  
- Primary Payment $1100.00  
- Member’s Coinsurance $400.00  
- CHCDE Allowed $1000.00  
- CHCDE Payment $900.00  
- Member’s Co-pay $100.00  

If CHCDE was primary, we would have paid $900.00; therefore, as secondary we are saving $900.00, which would be reserved in the member’s credit bank. However, the primary carrier is making the member responsible for $400.00 coinsurance. Since member has $900.00 in their credit bank, $400.00 can be withdrawn to cover the member’s responsibility, leaving the total savings at $500.00 in the credit bank for future use.

**NOTE:** We will only override and approve payment when monies are available in the Credit Bank.

**Medicare primary**- When paying as secondary to Medicare, we typically pay member’s responsibility on Medicare allowed services, with the exception of Pepco membership, which pays BLB.

**Example:**

- Medicare Allowed $1500.00  
- Medicare Payment $1100.00  
- Member’s Coinsurance $400.00  
- CHCDE Allowed $1000.00  
- CHCDE Payment $900.00  
- Member’s Co-pay $100.00  

Medicare is leaving member responsible for $400.00; therefore, CHCDE would pay $400.00.
Key Points:

- Denial/Reason Codes are needed for all primary denial, as CHCDE does not coordinate when member’s do not follow the rules of their primary carrier.
- CHCDE will pay the balance due indicated on the CMS1500/UB04 when it is less than the calculated approved amount.
- As the secondary payor, our pre-authorization guidelines do not apply. However, any services allowed by CHCDE as the primary carrier must follow our pre-authorization guidelines.
- Billed amounts on Explanation of Benefits and claim must be the same or CHCDE will deny.
- As the secondary carrier, our timely filing guidelines are applied from the Explanation of Benefits date and not the date of service.
- Our Claim Check edits are applied as the secondary carrier.
- Member can be balance billed for amounts not paid by either carrier.