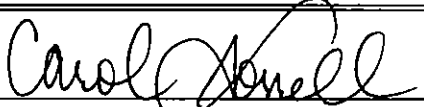
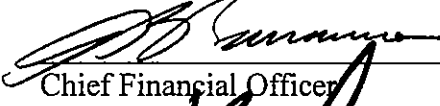



**KERN HEALTH SYSTEMS  
POLICIES AND PROCEDURES**

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SECTION: Claims		ISSUE DATE: July 1, 1998			
SUBJECT: Coordination of Benefits (COB)		EXTERNAL APPROVAL		DMC	DHS
					01-09-02
REVIEW DATE	10/00				
REVISION DATE	10/00				

Approved		Date	10/04/00
	Carol Sorrell, R.N. Chief Executive Officer		
Approved		Date	10/05/00
	Chief Financial Officer		
Approved		Date	9/6/00
	Claims Manager		

**POLICY:**

The Kern Health Systems Claims Department will make every effort to identify members that are covered under any other State or Federal Medical Care Program or under other contracted or legal entitlement including, but not limited to, a private group or indemnification program. Kern Health Systems Claims Department will make every effort to recover any monies paid for services provided to members prior to identifying such other coverage.

**PURPOSE:**

To avoid duplication of payment to providers for members that are covered under any other State or Federal Medical Care Program or under any other contractual or legal entitlement including, but not limited to, a private group or indemnification Program, and to seek reimbursement for any expenses paid for members prior to identifying such other coverage.

**PROCEDURE:**

**KERN HEALTH SYSTEMS  
POLICIES AND PROCEDURES**

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**1.0 IDENTIFICATION OF OTHER INSURANCE**

The Kern Health Systems Claims Department identifies member that are covered under any other program using the following sources:

- A. Enrollment information received from the Department of Health Services (DHS) and Managed Risk Medical Insurance Board (MRMIB)
- B. Information received from the Provider on the claim form or during the authorization process
- C. Information received from the member
- D. Receipt of reimbursement from provider

KHS personnel document the other coverage information in the member's eligibility file in the KHS information system. Claims staff use this file in claims processing to identify other insurance coverage.

**2.0 REIMBURSEMENT**

If the member has other medical coverage, the provider must file the claim with the other primary insurance carrier before filing with KHS. Upon receipt of partial payment or denial from the other carrier, the provider should submit the claim to KHS along with documentation of payment or denial from the primary carrier. The Claims Department requires a copy of the other Plan's payment determination prior to releasing payment to a provider for those members covered by another Plan.

KHS secondary payment for eligible services is limited to the maximum that KHS would compensate providers as specified in the provider's contract. The primary and secondary payments may not add up to more than 100% of eligible charges.

**2.1 Utilization Management Review Requirements**

If Kern Health Systems' liability is zero after the primary carrier has made payment, it is not necessary to refer claims to Utilization Management for authorization. However, if there is a payment due on a claim, an authorization is necessary for services that require Authorization.

The Utilization Management Department conducts pre-certification and concurrence review for all KHS Plan member hospitalizations regardless of the existence of other coverage including Medicare.

**3.0 COST AVOIDANCE**

KHS does not pay claims for services provided to a Member whose Medi-Cal eligibility record indicates either third party coverage, designated by the Other Health Coverage (OHC) code, or Medicare coverage without proof that the provider has first exhausted all other sources of

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POLICIES AND PROCEDURES**

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payment.

An exception to this guideline exists for services and OHC codes which request post-payment recovery. Proof of third party billing is not required prior to payment for services provided to Members with OHC codes A, M, X, Y or Z.

The Claims Department does not attempt recovery in circumstances involving Casualty Insurance, Tort Liability, or Workers' Compensation awards to plan members. Circumstances which may result in Casualty Insurance payments, Tort Liability payments, or Worker's Compensation awards are reported, in writing, to DHS or MRMIB as appropriate within 10 (ten) calendar days after discovery by Kern Health Systems.

#### **4.0 POST-PAYMENT RECOVERY**

##### **4.1 Situations which Require Post-Payment Recovery**

KHS pays the provider's claim and seeks to recover the cost of the claim from the third party in the following circumstances:

- A. For services provided to Medi-Cal Members with OHC codes A, M, X, Y, OR Z
- B. For Medi-Cal services defined by DHS as prenatal or preventive pediatric services
- C. In child-support enforcement cases, identifiable by KHS. If sufficient information is not available to determine whether or not the OHC coverage is the result of a child support enforcement case, KHS follows the procedures for Cost Avoidance.

##### **4.2 Identification of Other Insurance Coverage after Initial Payment**

If a payment was made prior to identifying another Plan, the Claims Department seeks reimbursement from the provider or other Plan.

#### **5.0 CLAIMS PAYMENT WITH OTHER INSURANCE**

Whenever a claim is received and other insurance is indicated the following steps are taken:

- A. If the claim is received without an Explanation of Benefits (EOB) from the third party, the claim is denied (except for services and OHC codes listed above in Post-Payment Recovery guidelines).
- B. If the claim is received and an EOB is attached from the third party, the following steps are taken to adjudicate the claim:
  - (i) If the provider accepts the OHC payment as "payment in full" KHS does not pay the balance of the provider's bill.
  - (ii) If a claim is received from a member who has other coverage through an HMO or PPO and charges were denied because a contracting provider or facility within their network was not used, the claim is denied.
  - (iii) If the provider accepts the OHC payment as "payment in full" and all of the OHC allowable amount was applied to the deductible, the lesser of the allowable

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amounts between KHS and the OHC is used to determine payment. Payment is calculated based on the lesser of the allowed amounts minus any applicable withhold. This is true for Medicare, when they accept payment in full, as well as any other OHC who accepts payment in full.

- (iv) If the EOB indicates the member is responsible for the balance of the allowable amount, payment is based on KHS' allowable amount minus any amount paid by the OHC (COB amount). If the EOB attached indicates that the total allowed charges was applied to the member's OHC deductible, Kern Family Health Care pays the claim based on KHS' allowable amount minus any applicable withhold.
- (v) If the OHC has denied payment, an EOB with the explanation must be submitted. If the service is a KHS covered procedure, payment is made based on KHS' allowable amount withhold. If the OHC has denied payment pending additional information, no payment is issued by KHS until a final denial has been indicated on the EOB.

## **6.0 REPORTING REQUIREMENTS**

### **6.1 Medi-Cal Product**

KHS submits monthly reports to DHS, in a format prescribed by DHS, displaying claims counts and dollar amounts of costs avoided and the amount of Post-Payment Recoveries by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of account. (See Attachment A). Reports are sent to the following address:

Department of Health Services  
Third Party Liability Branch  
Cost Avoidance Unit  
P.O. Box 2471  
Sacramento, CA 95812-2471

When KHS identifies OHC unknown to DHS, KHS reports this information to DHS within ten (10) days of discovery in a automated format as prescribed by DHS. This information is also sent to the DHS Third Party Liability Branch, Cost Avoidance Unit.

## **7.0 INITIATING DISENROLLMENT FOR MEDI-CAL MEMBERS**

KHS initiates disenrollment with DHS for all members whose eligibility record indicates OHC codes K, C, P, or F within three (3) working days of discovery. See KHS Policy and Procedure #5.04 – Disenrollment of Medi-Cal Members for details.

Until the member is disenrolled, KHS practices cost avoidance or seeks post-payment recovery as specified in Sections 3.0 and 4.0 of this policy.

COORDINATION OF BENEFIT SAVINGS

DATE: JUNE 2000

ADJ	DOCUMENT	POS	PROVIDER	MEMBER	FIN UPD	REQ AVAIL	MAX AMP	COB AVAIL	WITHD AMT	PRPAY AMT	SAVED AMT
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