

Chapter 9. Third Party Liability and Recoveries

9.1	Coordination of Benefits (“COB”)	3
9.1.1	Applicability	3
9.1.2	Determining Other Coverage	3
9.1.3	Order of Benefit Determination	4
9.1.4	Payments to Other Plans	6
9.1.5	Medicare Coordination	6
9.2	Workers’ Compensation	6
9.3	Right of Recovery	7
9.4	Subrogation and Right of Reimbursement	7

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9.1 Coordination of Benefits (“COB”)

9.1.1 Applicability

Coordination of Benefits (“COB”) applies when a member is covered by more than one benefit plan, contract or program for the same expenses. The purpose of COB is to ensure that the member receives his/her benefits but that duplicate payments are not made. Generally, COB is calculated using Mountain State’s contract allowance subject to member benefits.

The member’s Mountain State contract will usually contain a COB provision. If there is a conflict between this provision and this *Provider Manual*, the COB provision in the member’s contract controls.

Generally, Mountain State will coordinate group benefits with other group plans and contracts providing healthcare benefits or services. This includes, but is not limited to, employer-sponsored plans, union welfare plans, multi-employer plans, other Blue Cross or Blue Shield plans, health maintenance organizations, group practices or other prepayment arrangements. COB may also be applied to medical benefits coverage in group, group-type and individual automobile “no fault” and traditional “fault” type insurance contracts. Mountain State will not coordinate benefits where the other coverage is an individual or family insurance contract (other than noted in the preceding sentence), group or group-type hospital indemnity benefits of \$100 per day or less, school accident type coverage, Medicaid, or TRICARE.

9.1.2 Determining Other Coverage

Mountain State attempts to determine whether a member has other coverage by several means. These include requesting information at the time of enrollment, periodically sending questionnaires to the member asking about other coverage, and requiring the members to notify Mountain State if they obtain or change other coverage.

Mountain State will coordinate benefits to the extent that we are informed of other coverage by the member, a provider, or some other person or organization. However, Mountain State is not required under its policies to make an independent determination of whether and to what extent a person is covered under another plan or program before processing a claim. If we pay a claim as primary, and later receive information that the member has other coverage and that we should have paid as secondary, we may retroactively adjust the claim.

The provider should conduct an inquiry of what sources of coverage a patient may have. It is the provider's responsibility to ensure that claims are filed timely with Mountain State and any other plans or programs that may afford primary or secondary coverage.

9.1.3 Order of Benefit Determination

If there is a COB provision in the member's contract, it will determine the order in which benefits are paid. Self-funded groups administered by Mountain State and BlueCard® claims may differ in their coordination rules. Generally, COB is calculated using Mountain State's contract allowance subject to member benefits.

For group contracts insured by Mountain State, the order of benefits will be determined in accordance with the COB rules promulgated by the West Virginia Insurance Commissioner, set out at 114 C.S.R. §114-28-1 et seq. For these insured contracts, when Mountain State is primary, we will pay benefits for covered services without regard to the member's coverage under another plan. When Mountain State is secondary, the benefits payable may be reduced.

The following rules will apply in determining the order of benefits under Mountain State insured group contracts:

- **No COB Provision.** A plan that does not include a coordination of benefits provision may not take the benefits of another plan into account when it determines its benefits. There is one exception: a contract holder's coverage that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder.
- **Employee/Member v. Dependent.** The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent.
- **Dependent Child/Parents Not Separated or Divorced.** The rules for the order of benefits for a dependent child when the parents are not separated or divorced are as follows:
 - a. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;
 - b. If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time; and
 - c. The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born.

- **Dependent Child/Separated or Divorced Parents.** If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - a. First, the plan of the parent with custody of the child;
 - b. Then, the plan of the spouse of the parent with the custody of the child; and
 - c. Finally, the plan of the parent not having custody of the child.
 - d. If the specific terms of a court decree state that one of the parents is responsible for the healthcare expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
 - e. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above under “Dependent Child/Parents Not Separated or Divorced.”
- **Active/Inactive Employee.** The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter term.
 - a. To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended.
 - b. The start of a new plan does not include:
 - A. A change in the amount or scope of a plan's benefits;
 - B. A change in the entity which pays, provides or administers the plan's benefits; or
 - C. A change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

The claimant's length of time covered under a plan is measured from the claimant's first date of coverage under that plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to

determine the length of time the claimant's coverage under the present plan has been in force.

9.1.4 Payments to Other Plans

If payment is made under another plan which should have been made by Mountain State under the applicable COB provision, then Mountain State may pay this amount to the plan which made the original payment. Such payment is treated as a benefit paid under the member's contract and Mountain State is discharged from any further liability.

If you have questions about COB, contact the Customer Service number on the back of the member's ID Card.

9.1.5 Medicare Coordination

Mountain State will coordinate with Medicare in accordance with applicable federal law and Medicare Secondary Payor rules. Generally, Medicare is secondary to group coverage under the following conditions:

- **Working Aged.** Group health plans of employers that employ more than 20 employees and that cover Medicare beneficiaries age 65 or older who are covered under the plan by virtue of the individual's current employment status or the current employment status of a spouse of any age.
 - **End Stage Renal Disease ("ESRD").** Group health plans throughout the first 18 months of ESRD – based on Medicare eligibility or entitlement.
 - **Disability.** Large group health plans (those with at least 100 employees) that cover Medicare beneficiaries who are under age 65, entitled to Medicare on the basis of disability, and covered under the plan by virtue of the individual's or a family member's current employment status with an employer.
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9.2 Workers' Compensation

Services and supplies resulting from an illness or injury that occurs in the course of employment are generally exclusions in the member's contract and are not reimbursable by Mountain State. These claims should be billed to the appropriate state or federal workers' compensation program. Network providers are required to inquire from a member as to whether an injury or illness resulted through the course of employment and ensure that claims are timely filed with Workers' Compensation and Mountain State. It is generally illegal for a provider to knowingly seek payment in excess of the workers' compensation rates. If for any reason the appropriate

workers' compensation program denies the claim it may be appealed to Mountain State for payment. Claims to Mountain State shall include the proper occurrence codes, condition codes, and any denials made from a Workers' Compensation program.

In the event a Workers' Compensation claim is identified, adjustments may be needed to correct an over or under payment. The adjustment reason will appear on the Remittance Advice or Provider EOB to explain the disposition of the claim.

For more information on Workers' Compensation, please call 1-800-989-9675.

9.3 Right of Recovery

If Mountain State pays more for covered services than the applicable COB provision or any other provision in the member's contract requires, then we have the right to recover the excess from any person or entity to whom or for whom the payment was made. Recovery may be made through deductions and offsets from any pending and subsequent claims. Mountain State's right of recovery includes, among other things, periods where a member's premiums were delinquent or the individual was otherwise ineligible for coverage.

9.4 Subrogation and Right of Reimbursement

To the extent Mountain State pays medical or other expenses for a member, it may have the right to be reimbursed for those expenses from any recovery that member may obtain from and against a responsible third party ("Responsible Party"), including the member's own insurance company. Subrogation and Right of Reimbursement provisions (hereinafter "Subrogation") are contained in the member's contract and the specific terms may vary. Responsible Parties generally include, among others, individuals, business entities, automobile insurers, malpractice carriers and homeowner's coverage.

If a Subrogation situation arises, Mountain State will pay all related claims in accordance with our contractual obligations under the terms of the contract. However, all payments made in a Subrogation situation are conditional and may be recovered directly from a Responsible Party or from the member when the member recovers money from a Responsible Party – sometimes months or years after the incident. Mountain State's right of Subrogation entitles it to recover money paid to a member or on behalf of a member.

Often, another payor or an attorney will send payment directly to a treating provider. This does not relieve a network provider from its obligations under its provider

agreement with Mountain State, including payment rates and hold harmless provisions. If you receive duplicate payment in a Subrogation case, please send a written notice of duplicate payment to:

Mountain State Blue Cross Blue Shield
Attention: Third Party Recoveries Department
P.O. Box 1948
Parkersburg, WV 26102
or by fax to 304-424-0320.

Include copies of documentation such as duplicate checks, Explanation of Benefits, etc. from a Responsible Party.

Network providers must assist in our Subrogation efforts by indicating an accident, the accident date and the diagnosis on the claim form. In the event a network provider receives information regarding an accident after submission of a claim, please contact the Third Party Recoveries Department at the telephone number listed below.

For more information on Subrogation, third-party liability insurers and automobile related accidents, call the Third Party Recoveries Department at 1-800-989-9675.