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| Policy: | MA.3103 |
| Title: | **Claims Coordination of Benefits** |
| Department: | Claims Administration |
| Section: | Not Applicable |
| *CEO Approval*: | */s/ Michael Hunn 02/21/2025* |
| Effective Date: | 08/01/2005 |
| Revised Date: | 02/01/2025 |
| Applicable to: | ☐ Medi-Cal<br>☒ OneCare<br>☐ PACE<br>☐ Administrative |

## I. PURPOSE

This policy establishes a process for payment of services rendered to a Member who is covered under Medi-Cal or any Other Health Coverage (OHC).

## II. POLICY

A. CalOptima Health shall identify payers that are primary and secondary to OneCare, determine amounts payable, and coordinate benefits for Members with OHC in accordance with the terms and conditions set forth in this Policy.

B. CalOptima Health shall ensure that a Member exhausts supplemental benefits prior to or concurrent with authorization of or referral for Medi-Cal benefits, in accordance with CalOptima Health Policy MA.6026: Coordination of Care, Medi-Cal Covered Services for OneCare.

C. If a Member is covered under Medi-Cal, CalOptima Health shall:

1. Be the primary payer for Covered Services rendered to such Member;

2. Adjudicate a claim based on amounts allowed by OneCare; and

3. Apply Coordination of Benefits (COB) in accordance with OneCare benefit limits.

D. If a Member is covered under OHC that is not Medi-Cal, CalOptima Health shall:

1. Be the secondary payer for Covered Services rendered to such Member;

2. Adjudicate a claim based on amounts allowed by OneCare, or the primary payer, whichever is less; and

3. Pay for services not covered by the OHC if:

a. Such services are Covered Services when OneCare is the primary payer; and

b. The Provider submits the claim with a denial letter, or Explanation of Benefits (EOB), from the OHC.

E. CalOptima Health shall base the COB claim determination period on the period of time that the Member is enrolled in OneCare. If the Member is not enrolled in OneCare on the date of service, COB rules for claims for services rendered on the date of service shall not apply.

F. CalOptima Health shall have the right to obtain and release COB information and may do so without the Member's, or his or her authorized representative's, consent. Members shall provide an insurer with any information needed to make COB determinations and to pay claims.

G. Cost Avoided Other Coverage

1. CalOptima Health shall not consider services rendered to a Member with OHC within the OHC scope of coverage unless such OHC makes payment as appropriate or denies such claim as non-covered benefits.

2. In the absence of proof of payment, or denial of benefits, the OHC shall certify that the policy had terminated, and the Member was no longer eligible at the time the services were rendered.

H. CalOptima Health has the right to recover and demand refunds from Providers for the value of Covered Services if such Member is fully, or partially, covered for the same service under any commercial, state or federal medical care program, or under contractual or legal entitlement including, but not limited to, a private group or indemnification program in accordance with CalOptima Health Policy MA.3105: Medicare Secondary Payer.

## III. PROCEDURE

A. CalOptima Health shall use indicators to assess a claim for possible OHC including, but not limited to, the following:

1. Claim forms (CMS1500, UB04, and EDI 837P/837I) or Provider billings, in accordance with CalOptima Health policy;

2. Operations system: CalOptima Health or FACETS™;

3. Health plan carrier codes;

4. Medi-Cal eligibility codes;

5. Health Network;

6. Health plan carrier code;

7. Other insurance information included in the CalOptima Health Member eligibility files;

8. Automated Eligibility Verification System (AEVS);

9. Explanation of Benefits (EOB), or explanation of payments (EOP), to a Provider from another insurance payer;

10. Medicare Secondary Payer (MSP) File provided by CMS; and

11. Notification from Member.

B. COB Claim Process

1. CalOptima Health shall review the submitted claim form for indication of OHC. The review shall include, but not be limited to, the following:

    a. The existence of OHC within the claim: Universal claim forms (CMS1500, UB04, or EDI 837P/837I) used by Providers usually indicate the type of coverage and the insurance carrier and may provide the group plan name and number;

    b. The bill is paid in part, or full: An attachment to the claim submitted as evidence or the EOB may indicate that OHC has already provided benefits;

    c. The spouse is employed: If the Member's spouse is employed, he or she may be covered under the spouse's employer health plan;

    d. The Member is covered by other plans that provide benefits or services: Claim forms usually request the type of coverage, the name of the insurance carrier, and the group number;

    e. The Member has a former employer included on the claim form: This may indicate that the Member is receiving coverage as a retiree under the former employer's group health plan;

    f. The claim form indicates that the Member is covered under a state or federal health insurance continuation program within the claim form: This may indicate coverage under a former employer's group health plan (i.e., COBRA);

    g. The claim is the result of an accident: This may indicate that the medical expenses are covered by a third-party liability carrier such as auto insurance, or a homeowner's policy;

    h. The bills are submitted as photocopies: This may indicate that the original bills were sent to OHC for payment;

    i. Copies of the other carrier's evidence or Explanation of Benefits (EOB), or payment, are submitted instead of the Provider's itemized bill: This usually indicates that the Member has OHC; and

    j. The system identifies health plan carrier codes as evidence of OHC: If available, the operations system shall flag the claim for identification of OHC.

2. If a CalOptima Health claims examiner identifies indication of OHC, he or she shall pend the claim in accordance with CalOptima Health Policy MA.3101: Claims Processing.

3. CalOptima Health shall record information received regarding a Member's OHC in the Member's claim file, or history, to avoid future repeated requests. To reflect a system update, CalOptima Health shall gather and report information to the OneCare Customer Service Department.

4. If CalOptima Health receives a COB claim without proof of disposition, or rejection letter from the primary payer, it shall process the claim as a non-clean claim in accordance with CalOptima Health Policy MA.3101: Claims Processing.

## IV. ATTACHMENT(S)

A. Claim Form CMS1500
B. Claim Form UB04

## V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Policy MA.3101: Claims Processing
C. CalOptima Health Policy MA.3105: Medicare Secondary Payer
D. CalOptima Health Policy MA.6026: Coordination of Care, Medi-Cal Covered Services for OneCare
E. Medicare Secondary Payer Manual - Issued 01/04/2024
F. Medicare Managed Care Manual, Chapter 4: Benefits and Beneficiary Protections - Issued 04/22/2016
G. Title 42, Code of Federal Regulations (C.F.R), §422.108

## VI. REGULATORY AGENCY APPROVAL(S)

None to Date

## VII. BOARD ACTION(S)

None to Date

## VIII. REVISION HISTORY

| Action | Date | Policy | Title | Program(s) |
|---|---|---|---|---|
| Effective | 08/01/2005 | MA.3103 | Claims Coordination of Benefits | OneCare |
| Revised | 01/01/2008 | MA.3103 | Claims Coordination of Benefits | OneCare |
| Revised | 01/01/2010 | MA.3103 | Claims Coordination of Benefits | OneCare |
| Revised | 01/01/2017 | MA.3103 | Claims Coordination of Benefits | OneCare |
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| Revised | 02/01/2025 | MA.3103 | Claims Coordination of Benefits | OneCare |

## IX. GLOSSARY

| Term | Definition |
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| Covered Services | Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. |
| Explanation of Benefits (EOB) | An ad hoc communication that provides Members with clear and timely information about their medical claims to support informed decisions about their healthcare options. |
| Health Network | A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network. |
| Medicare Secondary Payer (MSP) | The term generally used when the Medicare program does not have primary payment responsibility. |
| Member | A beneficiary enrolled in the CalOptima Health OneCare program. |
| Other Health Coverage (OHC) | Evidence of health coverage other than OneCare including, but not necessarily limited to:<br><br>1. The CalOptima Health Medi-Cal program;<br>2. Group health plans;<br>3. Federal Employee Health Benefits Program (FEHB);<br>4. Military coverage, including TRICARE;<br>5. Worker's Compensation;<br>6. Personal Injury Liability compensation;<br>7. Black Lung federal coverage;<br>8. Indian Health Service;<br>9. Federally qualified health centers (FQHC);<br>10. Rural health centers (RHC); and/or<br>11. Other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of Covered Part D Drugs on behalf of Part D eligible individuals as the Centers for Medicare & Medicaid Services (CMS) may specify. |
| Provider | Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B. |