# Coordination of Benefits Policy

Applies to the following Tufts Health Plan products:

☒ Tufts Health Plan Commercial (including Tufts Health Freedom Plan)

☒ Tufts Medicare Preferred HMO

☒ Tufts Health Plan Senior Care Options (SCO) products

Applies to the following Tufts Health Public Plans products:

☒ Tufts Health Direct – Health Connector

☐ Tufts Health Together – A MassHealth MCO Plan and Accountable Care Partnership Plans

☐ Tufts Health Unify – OneCare Plan

☐ Tufts Health RITogether – A RI Medicaid Plan

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The following payment policy applies to Tufts Health Plan contracting providers.

In addition to the specific information contained in this policy, providers must adhere to the information outlined in the Professional Services and Facilities Payment Policy.

**Note:** Audit and disclaimer information is located at the end of this document.

## POLICY

Coordination of Benefits (COB) applies to members who are covered by more than one health insurance plan. Hospitals and providers affiliated with Tufts Health Plan are required to advise Tufts Health Plan of information they have concerning other insurance coverage. Tufts Health Plan follows applicable laws and regulations to determine which plan has the primary obligation to provide benefits.

Tufts Health Plan's Coordination of Benefits (COB) program prevents duplication of payment for the same health care services. Tufts Health Plan will coordinate benefits payable for covered services with benefits payable by other plans, consistent with applicable state law, as described below. Tufts Health Plan will divert bills for service when evidence supports that Tufts Health plan is not the primary payer responsible for the services.

**Note:** Tufts Health Plan coordinates benefits pursuant to CMS Medicare Secondary statutory provisions.

### Coordination of Benefit Rules for Commercial Products

If only one of a member's plans has a COB rule, the plan with no rules is considered the primary plan. If one of the plans has rules permitted by law and the other does not, the latter plan is considered the primary plan.

The following applies to all plans with COB rules that are consistent with applicable state and federal laws and regulations:

| Rule | Description |
|---|---|
| Employee/Dependent | The plan that covers a member as an employee or subscriber is primary to the plan that covers the member as a dependent |
| Birthday | If two or more plans cover a dependent child, the primary plan is that of the parent whose birth date (month and day, not year) occurs earlier in the calendar year. If parents share a birth date, the primary plan is the plan of the parent whose coverage has the earlier effective date |
| Children of Separated or Divorced Parents | If two or more plans cover a dependent child of divorced or separated parents, the order of payment is as follows:<br>▪ Plan of the custodial parent<br>▪ Plan of the custodial parent's spouse<br>▪ Plan of the noncustodial parent |

| Rule | Description |
|---|---|
| Court Decree | There may be a court decree stating that one of the divorced or separated parents is responsible for the child's health care. If so, and if that plan has actual knowledge of the terms of the court decree, that plan is primary. In cases of joint custody without specific terms regarding health care, the birthday rule applies. |
| Active/Inactive | The plan that covers an employee or employee's dependent who is not laid-off or retired is primary to the plan that covers the member as a laid-off or retired employee. If the other plan does not share this rule, this rule is ignored. |
| Longer/Shorter | If none of the above rules apply, the primary plan is the plan that has covered the member longer. |

## GENERAL BENEFIT INFORMATION

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider website or by contacting Provider Services.

### Subrogation

Subrogation is a liability recovery activity in which medical costs that are the result of actions or omissions of a third party are recovered from the third party (and/or his/her insurer).

Tufts Health Plan has outsourced subrogation recovery services to the Rawlings Company in Louisville, Kentucky. Providers may receive correspondence from Rawlings related to duplicate claim payments (e.g., Tufts Health Plan and a motor vehicle carrier). Inquiries relating to correspondence received by the provider must be directed to The Rawlings Company. Contact Provider Services for additional information.

### Motor Vehicle Accidents

Tufts Health Plan coordinates with auto insurance coverage, including personal injury protection (PIP) and/or Medical Payment (MedPay) on claims for services rendered as a result of a motor vehicle accident (MVA). Refer to the Commercial Provider Manual, Senior Products Provider Manual or Tufts Health Public Plans Provider Manual for additional information.

## REFERRAL/AUTHORIZATION/NOTIFICATION REQUIREMENTS

Certain procedures, items and/or services may require prior authorization with the Tufts Health Plan Precertification Operations Department. Requirements for prior authorization include timely inpatient notification and submission of all required documentation. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained.

Whether Tufts Health Plan is the primary, secondary, or tertiary insurer, all applicable referral and authorization procedures must be followed to receive benefits.

## BILLING INSTRUCTIONS

Unless otherwise stated, Tufts Health Plan follows AMA coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers and their usage. For more information refer to the Professional Services and Facilities Payment Policy.

**When Tufts Health Plan is the primary insurer:**

- Refer to the applicable Provider Manuals for claims submission information Commercial, Senior Products and Tufts Health Public Plans (for Tufts Health Direct)

**Multiple insurance carriers:**

In the instance there are multiple insurance carriers, the filing deadline for claims submission is as follows:

- 90 days for Commercial products from the date of the primary insurer’s EOB
- 60 days for Tufts Medicare Preferred HMO, Tufts Health Plan SCO and Tufts Health Direct from the date of the primary insurer’s EOB

Providers must submit the EOB from the primary insurer with the claim when Tufts Health Plan is the secondary payer.

**When Tufts Health Plan is the secondary insurer:**

- Do not take a cost-sharing amount up front. Submit the claim to the primary insurer, then submit with the primary insurer's EOB to the secondary plan (Tufts Health Plan). If a cost-sharing amount is still due, it will appear on the EOP at the time of payment and you can then bill the member.
- Tufts Health Plan Medicare Complement and Medicare Supplement Plans must be submitted with a Medicare EOB.
- For paper claim submissions, carefully circle or asterisk the member's name on the EOB. Do not highlight the information. Highlighting causes the data to be blacked out in the scanning process.
- If submitting electronically, the primary insurer payment information must be submitted in Loops 2320, 2330 and 2430.

**Tufts Health Plan members covered by two Tufts Health Plan policies**

When a member has two active Tufts Health Plan policies, one will be considered primary and one will be considered secondary and the Coordination of Benefit Rules outlined above will be followed.

The first claim should be submitted under the primary policy number for consideration. When the Tufts Health Plan explanation of payment (EOP) has been received and the member has a cost-share due, submit a new claim with the secondary Tufts Health Plan policy number. Attach the EOP to the claim and submit it as an original submission.

**Adjustments**

When submitting a COB claim for an adjustment, do not send in a new claim. Send a copy of the Tufts Health Plan EOP with the primary insurer's EOB and the original claim will be adjusted accordingly. Clearly mark "COB adjustments" on the envelope.

**Filing Deadline Disputes**

Submit a copy of the Tufts Health Plan EOP with the original EOB from the primary insurer to the correct address as outlined in the Request for Claim Review Form Mailing Instructions. Refer to the applicable Provider Payment Dispute Policy for Commercial, Senior Products or Tufts Health Public Plans (for Tufts Health Direct) for more information.

**Claim Retractions**

In the event Tufts Health Plan determines that a member's Tufts Health Plan coverage is the secondary coverage after a claim has processed with Tufts Health Plan as the primary coverage, a retraction of that claim payment may occur. The claim must be billed to the primary insurer and resubmitted to Tufts Health Plan with the primary insurer's EOB.

**Medicare COB**
Refer to the grid below to determine the primary payer when a member is eligible for Medicare coverage. For more information, refer to CMS' Who Pays First grid.

| Scenario | | Primary Payer | Secondary Payer |
|---|---|---|---|
| Have Medicare and Medicaid coverage | | Medicare[1] | Medicaid |
| • At least 65 years old<br>• Covered by an employer group health plan[2] because you or your spouse is still working | | employer group health plan (if employer has 20+ employees) | Medicare |
| | | Medicare (if employer has <20 employees) | employer group health plan |
| • At least 65 years old<br>• Have an employer group health plan through Tufts Health Plan after you retire | | Medicare | employer group health plan (Tufts Health Plan) |
| • Disabled<br>• Covered by either a large group health plan from Tufts Health Plan **or** covered under a spouse or family member who is working | | employer group plan (if employer has 100+ employees) | Medicare |
| | | Medicare (if employer has <100 employees) | employer group plan |
| Have End-Stage Renal Disease (ESRD) | Months 1-30 | employer group plan | Medicare |
| | Months 31+ | Medicare | employer group plan |
| • Are 65 or over **OR** under 65 and disabled (other than by ESRD) and covered by either COBRA coverage or retiree group health plan coverage | | Medicare | COBRA or employer group plan |
| Have Medicare and individual commercial coverage | | Medicare | Individual commercial coverage |

## COMPENSATION/REIMBURSEMENT INFORMATION

Providers are compensated according to the applicable contracted rates, regardless of the address where the service is rendered. For additional information, refer to the Professional Services and Facilities Payment Policy.

## ADDITIONAL RESOURCES

- Commercial Provider Manual
- Senior Products Provider Manual
- Tufts Health Public Plans Provider Manual
- Motor Vehicle Accident Payment Policy
- Provider Payment Dispute Policy (Commercial)
- Provider Payment Dispute Policy (Senior Products)
- Provider Payment Dispute Policy (Public Plans)

## DOCUMENT HISTORY

- January 2020: Reviewed by committee; added Tufts Health Plan SCO; clarified existing COB processes
- September 2019: Added Tufts Health Direct; added boiler plate language
- May 2019: Removed references to Claims Submission Policy (retired)
- August 2018: Clarified existing COB processes
- June 2018: Template updates

## AUDIT AND DISCLAIMER INFORMATION

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that an

[1] If the member is a Tufts Medicare Preferred HMO or Tufts Health Plan SCO member, Tufts Health plan is Medicare.
[2] If the member is a Tufts Health Plan Commercial member (including Tufts Medical Complement, Medicare Supplement and Tufts Health Direct), Tufts Health Plan is considered the employer group plan.

office/facility did not comply with this payment policy, Tufts Health Plan will expect the office/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan's audit policies, refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan fully insured products, as identified in the checkboxes on the first page, and to CareLink℠ for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna's provider agreements with respect to CareLink members. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan) or to self-insured plans which coordinate benefits based on the plan benefit document. Tufts Health Plan reserves the right to amend a payment policy at its discretion.