Coordination of Benefits FAQ For Providers

Q: What is Coordination of Benefits?

A: If a person is covered under more than one health insurance policy, coordination of benefits is the process of informing each insurance policy about the existence of the other. This must be done by the policy holder(s). A healthcare provider cannot do this.

Q: Why is this important?

A: The insurance companies will determine which policy is the primary policy and which one is the secondary policy. This will determine the order in which they pay out on claims.

Q: How is it determined which insurance is primary and which is secondary?

A: There are many different factors that determine the order in which insurance companies pay.

- Medicaid is always the payor of last resort – all other insurance companies must process the claim before Medicaid will consider it for reimbursement.
- In most cases, Tricare will be the secondary payor. If the patient has both Tricare and Medicaid, Tricare is the primary payor.
- The **"Birthday Rule"** normally determines which policy is primary and which is secondary. The health plan of the subscriber with the date of birth that comes first in the calendar year is designated as primary. The birth year is not a factor in this rule – only the month and day of birth.
    - If both parents have the same birthday, the primary coverage is the oldest policy (one that has been active the longest).
    - When regular coverage and COBRA coverage are at play, regular coverage is primary.
    - In divorce cases where the custodial parent has not remarried, the custodial parent's plan is primary and the non-custodial parent's policy is secondary. If one parent has a group policy and the other has an individual plan, the group plan becomes the primary insurance.
- In divorce cases where the custodial parent has remarried, the custodial parent's policy is primary and the stepparent's coverage is secondary. The non-custodial parent's coverage would be tertiary.
- State laws and court orders may supersede the Birthday Rule.

Q: What should I do as a healthcare provider if my patient/client has more than one insurance policy?

A: Here are the procedures you should follow as a healthcare provider:

- Always collect information for both policies (make sure your intake forms include the option for patients to enter a secondary policy). You should get the policy ID #, group #, subscriber name and date of birth for each policy. You should also make a copy of the front and back of each insurance card.
- Verify benefits for both policies by calling each payor. Inquire with each payor if they are the primary or secondary policy. If they state they are primary, ask if they show any secondary coverage.
- ***If both payors state they are primary or show that they are the only payor, have the member update their "coordination of benefits" information with both payors. THIS IS VERY IMPORTANT - CLAIMS WILL NOT PAY CORRECTLY IF THEY DO NOT DO THIS STEP.***
- Obtain pre-authorization (if required) from both payors. If a payor states no authorization is required, be sure you get a call reference # you can refer back to if that information ends up being incorrect.
- Render services and bill the patient's primary insurance policy.
- Once the primary insurance processes and issues an EOB (explanation of benefits), submit the claim to the secondary insurance with a copy of the primary insurance EOB. You will submit everything exactly the same as you did to the primary insurance – same billed amount, same dates of service, same # of units.