COORDINATION OF BENEFITS

1. Federal and state regulations require Medicaid to be the payer of last resort.

2. Providers are required to collect all first- and third-party funds before submitting Medicaid claims to Partners for reimbursement.

3. Third-party payers are any other funding sources that can be billed to pay for the services provided to the consumer. This can include worker's compensation, disability insurance or other health insurance.

4. Third-party payers, including Medicare and private health insurance carriers, must process the claim before Partners processes a Medicaid claim.

5. Providers must report any payments or denial reasons from third-party payers on Medicaid claims filed with Partners. Medicaid claims submitted without third-party information will be denied.

6. Partners pays Coordination of Benefit claims according to the "lesser of" methodology. If the Medicaid allowed amount is more than the third-party payment, Partners will pay the difference up to the contracted allowed amount. If the other insurance payment is greater than the Partners contracted amount, no additional amount will be paid.

7. Partners will not pay for any service that could have been paid for by Medicare or other private insurance plans had the beneficiary or provider complied with the plan's requirements. Examples of common private plan non-compliance denials include, but are not limited to:

- Failure to get an authorization referral from a primary care physician.

- The provider is a “Non-participating provider” in the first and/or third-party plan.

- Failure to obtain prior approval.

8. Partners will not reimburse providers for covered services provided by clinicians who are non-paneled or not enrolled under the recipient's third-party coverage plans.

9. If the provider is not enrolled or have paneled staff with the primary payer, the provider should refer the consumer to an eligible provider of third-party covered services.

10. First-party payers are the clients/consumer or their guarantors.

* Partners BHM applies the same guidelines when processing claims for State funded services.
* Providers are not required to bill Medicare/TPL for service codes that are listed on the current bypass list.

Program Integrity –Billing Requirements

Partners is committed to protecting taxpayer and trust fund dollars, while also protecting the consumer's access to care. It is important that program integrity efforts extend beyond dollars and health care costs alone. It is fundamentally about protecting the beneficiaries and ensuring we have the resources to provide for their care.

The goal of Partners Program Integrity Department is to correct behaviors in need of change and prevent future inappropriate billing. It is our priority to minimize potential future losses to the Medicaid and State Trust Fund through targeted claims reviews while using resources efficiently and treating providers and consumers fairly. Please review the following information to ensure that you are properly billing for services delivered.

Clinical Coverage Policy 8C: Coordination of Benefits, states that *"Any provider who serves dually eligible beneficiaries (i.e., Medicaid and Medicare or other insurance carriers) shall be enrolled as a participating provider with each of the identified insurance carriers in order to be reimbursed."*

Partners BHM Claims Adjudication Policy states that *"Claims with Coordination of Benefits (COB) should be submitted within 180 days of service and include the COB information on the claim."* If the consumer is currently enrolled in the Partners AlphaMCS system and obtains third party coverage, or the provider is made aware of other third party coverage, it is the provider's responsibility to ensure this information is added to the system.

On March 28, 2003, the US Department of Health and Human Services and the Centers for Medicare and Medicaid Services released Program Memorandum Intermediaries/Carriers Transmittal AB-03-037 Subject: Provider Education Article: Medicare Payments for Part B Mental Health Services, which states: *"Medicare recognizes the following providers who are eligible under Part B to furnish diagnostic and/or therapeutic treatment for mental, psychoneurotic, and personality disorders. Those professionals are as follows:*

- Physicians (MD) and Doctors of Osteopathy (DO); particularly
- Psychiatrist;

- Clinical Psychologist (CP);
- Clinical Social Workers (CSW);
- Clinical Nurse Specialists (CNS);
- Nurse Practitioners (NP);
- Physician Assistants (PA);
- Certified Nurse-Midwives (CNM) and
- Independently Practicing Psychologist (IPP).

All services provided to Medicare patients must be furnished by practitioners who by virtue of their specific State licensure certification and training are professionally qualified to provide medically necessary services; and who are impaneled with Medicare, have the right to bill directly and collect and retain the fee for their services."

If you have questions, please contact Partners' Program Integrity Department by email at **ProgramIntegrity@partnersbhm.org**, or call **1-877-864-1454** and ask to speak to a member of the Program Integrity Department.