KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Coordination of Benefits				POLICY #: 6.08-P	
DEPARTMENT: Claims					
Effective Date: 10/2000	Review/Revised Date: 5/23/2023	DMHC		PAC COMMITTEE	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
Emily Duran
Chief Executive Officer

_____ Date _____
Chief Financial Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Director of Utilization Management

_____ Date _____
Director of Claims

POLICY:
The Kern Health Systems (KHS) Claims Department will make every effort to identify members that are covered under any other State or Federal Medical Care Program or under other contracted or legal entitlement including, but not limited to, a private group or indemnification program. Kern Health Systems Claims Department will make every effort to recover any monies paid for services provided to members prior to identifying such other coverage.

PROCEDURES:

1.0 IDENTIFICATION OF OTHER INSURANCE

The Kern Health Systems Claims Department identifies members that are covered under any other program using the following sources:

A. Enrollment information received from the Department of Health Care Services

(DHCS)

B. Information received from the Provider on the claim form or during the authorization process
C. Information received from the member
D. Receipt of reimbursement from provider

KHS personnel document the other coverage information in the member's eligibility file in the KHS information system. Claims staff use this file in claims processing to identify other insurance coverage.

2.0 REIMBURSEMENT

If the member has other medical coverage, the provider must file the claim with the other primary insurance carrier before filing with KHS. Upon receipt of partial payment or denial from the other carrier, the provider should submit the claim to KHS along with documentation of payment or denial from the primary carrier. The Claims Department requires a copy of the other Plan's payment determination prior to releasing payment to a provider for those members covered by another Plan.

KHS secondary payment for eligible services is limited to the maximum that KHS would compensate providers as specified in the provider's contract. The primary and secondary payments may not add up to more than 100% of eligible charges.

KHS will adopt the Medicare allowable and pay full coinsurance and deductible for Long Term Care and Dialysis services. KHS may adopt the Medicare allowable in other cases when there is no established allowable found under Medi-Cal such as newly established codes not yet adopted by Medi-Cal. KHS will also adopt the Medicare allowable when it is lower that the contracted rate determined for the claim payment as a whole.

2.1 Utilization Management Review Requirements

If Kern Health Systems' liability is zero after the primary carrier has made payment, it is not necessary to refer claims to Utilization Management for authorization. However, if there is a payment due on a claim, an authorization is necessary for services that require Authorization.

The Utilization Management Department conducts pre-certification and concurrence review for all KHS Plan member hospitalizations regardless of the existence of other coverage including Medicare.

3.0 COST AVOIDANCE

KHS will not process claims for a Member whose Medi-Cal Eligibility Record indicates OHC, other than a code of A or N, unless the Provider presents proof that all sources of payment have been exhausted, or the provided service meets the requirement for billing Medi-Cal directly. Acceptable forms of proof that all sources of payment have been exhausted include a denial letter from the OHC for the service, an explanation of benefits indicating that the service is not covered by the OHC, or documentation that the Provider has billed the OHC and received no response for 90 days.

The Claims Department does not attempt recovery in circumstances involving Casualty Insurance, Tort Liability, or Workers' Compensation awards to plan members. Circumstances which may result in Casualty Insurance payments, Tort Liability payments, or Worker's Compensation awards are reported, in writing, to DHCS as appropriate within 10 (ten) calendar days after discovery by Kern Health Systems.

4.0 POST-PAYMENT RECOVERY

4.1 Situations which Require Post-Payment Recovery

A. KHS will engage in post-payment recovery if OHC is discovered retroactively, or the Member had an OHC indicator code of A on their Medi-Cal Eligibility Record at the time of service.

B. For the purpose of post-payment recovery, the reasonable value of the services is the average payment the MCP pays for similar services in the particular service area, but in no event less than the Medi-Cal fee-for-service payment rate for the services rendered.

C. When KHS initiates and complete post-payment recovery within 12 months from the date of payment of a service we will retain all monies recovered.

D. When KHS initiates an active repayment plan with Providers or carriers that is agreed upon prior to, and extends beyond 12 months from the date of payment of a service, KHS will retain the recovered monies.

E. An active repayment plan is considered active if the Provider or carrier has agreed to repay the liability but has not yet paid the full amount.

F. Beginning April 1, 2021, KHS will submit detailed information regarding their recoveries to DHCS on a monthly report utilizing DHCS' Secure File Transfer Protocol no later than the 15th of each month (See Appendix B for the specifics regarding the file format, required data elements, and other submission requirements).

G. On a monthly basis, KHS will report all recovered OHC monies that are 13 months or older from the date of payment of a service to DHCS utilizing the monthly report (Appendix B). ALL PLAN LETTER 22-027 Page 5

H. Beginning March 1, 2023, KHS will include the check or electronic fund transfer (EFT) control number under row "V", field name "Filer" for all related Transaction Control Numbers on the monthly Appendix B report. KHS is not required and will not reproduce retroactive check information prior to 3/1/23.

I. KHS will remit warrants, payable to DHCS, for all recovered monies that are 13 months or older from the date of payment of a service, unless the payment meets the criteria of an active repayment plan, to the following address: Bank of America P.O. Box 742635 Los Angeles, CA 90074-2635

4.2 Identification of Other Insurance Coverage after Initial Payment

If a payment was made prior to identifying another Plan, the Claims Department seeks reimbursement from the provider or other Plan.

5.0 CLAIMS PAYMENT WITH OTHER INSURANCE

Whenever a claim is received, and other insurance is indicated the following steps are taken:

A. If the claim is received without an Explanation of Benefits (EOB) from the third party, the claim is denied (except for services and OHC codes listed above in Post-Payment Recovery guidelines).

B. If the claim is received and an EOB is attached from the third party, the following steps are taken to adjudicate the claim:

1. If the provider accepts the OHC payment as "payment in full" KHS does not pay the balance of the provider's bill.
2. If a claim is received from a member who has other coverage through an HMO or PPO and charges were denied because a contracting provider or facility within their network was not used, the claim is denied.
3. If the provider accepts the OHC payment as "payment in full" and the entire OHC allowable amount was applied to the deductible, the lesser of the allowable amounts between KHS and the OHC is used to determine payment. Payment is calculated based on the lesser of the allowed amounts minus any applicable withhold. With the exceptions of Long Term Care and Dialysis, this is true for Medicare, when they accept payment in full, as well as any other OHC who accepts payment in full.
4. If the EOB indicates the member is responsible for the balance of the allowable amount, payment is based on KHS' allowable amount minus any amount paid by the OHC (COB amount). If the EOB attached indicates that the total allowed charges was applied to the member's OHC deductible, Kern Family Health Care pays the claim based on KHS' allowable amount minus any applicable withhold.
5. If the OHC has denied payment, an EOB with the explanation must be submitted. If the service is a KHS covered procedure, payment is made based on KHS' allowable amount withhold. If the OHC has denied payment pending additional information, no payment is issued by KHS until a final denial has been indicated on the EOB.

6.0 REPORTING REQUIREMENTS

6.1 Medi-Cal Product

KHS reports new OHC information not found on the Medi-Cal Eligibility Record or OHC information that is different from what is found on the Medi-Cal Eligibility Record to DHCS within ten (10) calendar days of discovery. KHS will report this OHC information to DHCS by either:

A. Completing and submitting an OHC Removal or Addition form; or
B. Reporting OHC information to DHCS in batch updates. Batch updates regarding OHC information are processed by DHCS on a weekly basis. MCPs can contact their Managed Care Operations Division (MCOD) Contract Manager for more information regarding this process. (See Attachment A).

Beginning January 1, 2022, KHS will include OHC information in their notification to the Provider when a claim is denied due to the presence of OHC. OHC information includes, but is not limited to, the name of the OHC Provider and contact or billing information. Prior to January 1, 2022, KHS may direct Providers to access the necessary Member OHC information utilizing the Automated Eligibility Verification System at (800) 427-1295, or the Medi-Cal Online Eligibility Portal. Information pertaining to OHC carriers can be found in the Health and Human Services Open Data Portal.

6.2 Third Party Liability

When KHS identifies OHC unknown to DHCS for Third Party Liability for possible accidents and/or injuries, KHS reports this information to DHCS within ten (10) days of discovery in an automated format as prescribed by DHCS. Information is submitted electronically to:

http;//www.dhcs.ca.gov/services/pages/TPLRD_PI_OnlineForms/aspx
(See Attachment B).

ATTACHMENTS:

- Attachment A: Other Health Coverage Change Request
- Attachment B: Managed Care Report

REFERENCE:

Revision 2023-03: Policy revised by Director of Claims to comply with DHCS APL 22-027, DHCS Approved 4/5/2023. **Revision 2016-12:** Policy revised by Director of Claims to remove MHC language from policy due to new core system. Section for disenrollment removed based on OHC codes. **Revision 2014-03:** Revisions made in section 2.0 "Reimbursement" as requested by the Director of Claims. Removed references to Healthy Families. **Revision 2012-12:** Policy updated by Director of Claims and Claims Supervisor. Includes changes to reporting processes and updated attachments.

BENEFICIARY INFORMATION					**INSURANCE CARRIER INFORMATION**							**POLICY HOLDER INFORMATION**			**POLICY INFORMATION**			**SCOPE OF COVERAGE**									**GROUP INFORMATION**
Medi-Cal Client Index No. (CIN#) **9 digits**	Date of Birth **8 digits**	Last Name **20 digits**	First Name **15 digits**	Middle Initial **1 digit**	Carrier Code **4 digits**	Carrier Name **30 digits**	Address Line 1 **50 digits**	City **23 digits**	State **2 digits**	Zip **5 digits**	Zip Plus 4 **4 digits**	Last Name 20 digits	First Name **15 digits**	Middle Initial **1 digit**	Policy Number **30 digits**	Effective Start Date **8 digits**	End Date **8 digits**	Out-patient **Valid Value "O"**	In-patient **Valid Value "I"**	Physicians **Valid Value "M"**	LTC **Valid Value "L"**	Pharmacy Valid Value "P"	Dental **Valid Value "D"**	Vision **Valid Value "V"**		Group Employer Name **30 digits**

Managed Care Report

Entry Date From 5/1/12 Entry Date to 5/15/12

MCP Number	CIN Number	Last Name	First Name	Date Of Birth	Service From	Service To	Request
201 - Managed Care Name	cXXXXXXXXX	Test	Test	12/12/2011	12/31/2011	5/14/2012	2nd Request
201 - Managed Care Name	cXXXXXXXXX	Test	Test	8/1/2011	8/15/2011	5/14/2012	3rd Request
201 - Managed Care Name	cXXXXXXX	Test	Test	10/19/2011	10/19/2011	5/14/2012	1st Request