

Administrative Simplification
Policy Guidelines

Simplification Area: Claims Processing – Paper Reduction

Topic: Incorporate Explanation of Benefits (EOB) Information on Electronic Claims

Objective: Reduce Administrative Overhead and Delays in Processing Claims

When these guidelines are followed by providers, a health plan will be able to process secondary claims in a timely manner with no supporting EOB documentation, as long as the primary payer is a commercial health plan, i.e. not Medicare, and the secondary claim is submitted electronically.

Expected Impact: *Hospitals & Practitioners* – 12-80 hours per month of practitioners staff time and 20-80 hours per month of hospital staff time are typically required to appropriately match and submit paper EOBs with corresponding electronic claims. And, since the entire transaction cannot be electronic, payment turnaround typically requires an additional 17 days.

Health Plans – Processing paper EOBs for secondary claims typically requires 100-200 hours per month.

Synopsis:

Participating health plans will not require providers to submit paper EOBs with electronic secondary claims, as long as the:

- Primary payer is a commercial insurance company, i.e. it is not Medicare
- Necessary EOB information is included on the electronic claim.

The following health plans will also accept UB-04 and CMS 1500 *paper claims* without a paper EOB if these guidelines are followed in completing the paper claim.

- Aetna
- Group Health Cooperative (GHC)

Background:

Some patients receive insurance coverage from more than one health plan. In these situations, care providers submit multiple claims for the same service. The first claim is submitted to the health plan responsible for the primary coverage. That health plan will

adjudicate the claim and respond to the provider with an Explanation of Benefits (EOB). The provider then submits a claim to the health plan responsible for secondary coverage, along with a copy of the EOB. Submitting a paper EOB adds administrative burden for the provider and adds a time delay before the health plan can process the electronic claim.

In the interest of eliminating the burden and the time delays associated with processing paper EOBs, participating health plans will not require providers to submit paper EOBs with electronic secondary claims, as long as the:

- Primary payer is a commercial insurance company, i.e. it is not Medicare. For more specific Medicare information, see the section below titled 'How are Medicare claims different?'
- Necessary EOB information is included on the electronic claim

Guidelines:

The following guidelines describe how EOB information should be included on HIPAA 837 secondary electronic claims.

Why does EOB information need to be included on the claim?

Secondary health plans need to know the amount paid on a claim by the primary health plan. The secondary payor will subtract the amount paid by the primary health plan from their allowed amount and pay the difference. They also need to know who the primary health plan is, so that any detail questions about deductibles, line items, etc. can be answered.

When must EOB information be included on the claim?

EOB information must be included on ALL electronic claims sent to a health plan as a 'secondary' payer, unless a paper EOB is submitted. EOB information must be included even if the primary payer remitted an amount of \$0.00.

What EOB information should be included on the claim and where should it be placed?

The following EOB information from the primary health plan(s) must be contained on the claim if a paper EOB is not submitted. *Otherwise the claim may be denied.*

EOB Information	UB-04 fields	CMS 1500 fields	837 fields
Payer Name	50 a, b & c	9d	Loop 2330B: <ul style="list-style-type: none"> • NM101= 'PR' • NM102 = '2' • NM103 is Payer Name Information • NM108 = 'PI' • NM109 is payer identification information (the entered value is unimportant as it won't be used by the health plan)
Other Insured Name	58 a, b, & c	9	Loop 2330A: <ul style="list-style-type: none"> • NM101= 'IL' • NM102= '1' or '2' • NM103-105 is Other Insurance Name Information
Other Insured Number	60 a, b & c	9a	Loop 2330A: <ul style="list-style-type: none"> • NM108 = 'MI' • NM109 is Identifying Number
Amount Paid by Primary Payer ^{*1}	54 a, b & c	29	For professional claims: Loop 2320—COB Payer Paid Amount <ul style="list-style-type: none"> • AMT01 = 'D' • AMT02 is Amount Paid For institutional claims: Loop 2320 --COB Payer Prior Payment <ul style="list-style-type: none"> • AMT01 = 'C4' • AMT02 is Amount Paid
Zero Payment Indicator ^{*2}	'COB-Z' in 80	'COB-Z' in 19	Loop 2300 Segment NTE <ul style="list-style-type: none"> • NTE01='ADD', • NTE02 = 'COB-Z' or information about the \$0.00 payment contained on the paper EOB.

^{*1} The 'Amount Paid by Primary Payer' field should only contain the amount paid by the payer, excluding the contract adjustment. (If the coverage from the primary payer is a capitated product, the amount paid will be considered to be equivalent to a fee for service amount. This secondary claim will be processed as all other Coordination of Benefit claims.) Using this field for the amount paid by the patient, such as copay amount or patient responsibility amount, will slow down the adjudication process. When a health plan sees an amount in that field that appears to be a co-pay amount, e.g. \$10 or \$15, the claim will be pended until the other payer can be contacted to confirm that the amount was paid by them.

*2 The 'Zero Payment Indicator' is only required when the primary payer was billed and remitted \$0.00. (An example of this situation is when the patient's deductible has not been met.)

How are Medicare claims different?

GHC has a Medicare Plus Choice contract with the Center for Medicare and Medicaid Services (CMS). Under the terms of that contract, GHC-Medicare member primary claims (both institutional and professional) must be submitted to GHC for payment as Medicare. Once GHC has made the Medicare primary payment, the claims are automatically adjudicated by GHC for any secondary payments that are due under the member's secondary contract. It is not necessary for providers to submit Medicare secondary claims to GHC.

Medicare claims are handled differently by other commercial health plans. The following is a list of important considerations that affect the billing process. *It is important to note that Medicare Part A and Part B balance are handled differently by health plan.* For more specific information about how Medicare Part A and Part B balances are handled, contact the health plan directly.

1. Medicare is notified of secondary supplemental coverage for a patient, typically by the health plan that is providing that coverage to the patient.
2. Care providers will submit Medicare claims to Medicare.
3. For Medicare Part B balances (professional claims), Medicare will pay the care provider the amount that it determines to be due from Medicare. For patients who have a secondary supplemental policy with one of the above health plans, Medicare will notify that health plan of balances owing. This notification is typically called a crossover. In the case of crossovers, the health plan will pay in accordance with the benefits in the patient's supplemental policy. It is not necessary for the care provider to submit a secondary claim or an EOB from Medicare.
4. For Medicare Part A balances (institutional claims), Medicare will pay the care provider the amount that they determine to be due from Medicare. ***For some health plans***, Medicare will send Part A crossovers for unpaid balances to the health plan with which a patient has a secondary supplemental policy. In these situations, the health plan will pay in accordance with the benefits in the patient's supplemental policy. It is not necessary for the care provider to submit a secondary claim or an EOB from Medicare. *(Care providers should check with the health plan to determine if they receive Part A crossovers for their facilities.)*

If Medicare does not send Part A crossovers for unpaid balances to the above health plan, the care provider has the responsibility of sending a secondary claim to the responsible health plan. When this situation occurs, Regence will accept secondary claims with Medicare Part A balances without a paper EOB, as long as the EOB

information is on the claim and the claim is submitted electronically. First Choice, Premera and the Uniform Medical Plan require a paper EOB containing Medicare payment information to be submitted with the secondary claim.

For all crossover situations, the care provider should look at the Medicare Remittance Notice to determine if they need to send in a claim to the secondary Health Plan. If Medicare sends a crossover, a message indicating such will be displayed on the Medicare Remittance Notice. This is usually reliable, although not fail safe.

What are other processing considerations?

If the member has not informed the health plan that benefits need to be coordinated with a primary payer, the processing of the secondary claim may require additional time so that the health plan can get the required information from the member.

To streamline claims processing, the participating health plans (when acting as the secondary payer) will typically calculate their payment amount only using the 'Amount Paid by the Primary Payer', as submitted on the provider claim. However, there may be circumstances when the health plan contacts the primary payer for additional information.

Providers will need to verify that their system vendors and/or clearinghouses are able to send these fields on the electronic claim. Otherwise the providers will need to continue to send the paper EOB.

EDI Contacts

For questions about submitting HIPAA-EDI transactions, the health plan can be contacted using the numbers posted in the Forum's Contact Directory at <http://www.wahealthcareforum.org/healthplaninfo/contact/index.htm>. The path is Operational Questions / HIPAA-EDI transactions.