REIMBURSEMENT POLICY STATEMENT
Georgia Medicaid

Policy Name & Number	Date Effective
Coordination of Benefits-GA MCD-PY-1344	03/01/2025
Policy Type	
REIMBURSEMENT	

Reimbursement Policies prepared by CareSource and its affiliates are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.
CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject
Coordination of Benefits

B. Background
The purpose of this guideline is to define the order of coverage and how CareSource will coordinate benefit payments as the secondary payer.

CareSource coordinate payment for covered services in accordance with the terms of a member's benefit plan, applicable state and federal laws, and applicable Centers for Medicare & Medicaid Services (CMS) guidance. If CareSource is not the primary carrier, providers bill the primary carrier for all services provided before submitting claims to CareSource. Any balance due after receipt of payment from the primary carrier should be submitted to CareSource for consideration. The claim must include information verifying the services billed and the payment amount received from the primary carrier.

C. Definitions
- **CareSource Provider Agreement** – The contract between the provider and CareSource for the provision of services by providers to individuals enrolled with the plan, including but not limited to contracts titled "Provider Agreement" and "Group Practice Services Agreement."
- **Coordination of Benefits (COB)** – The process of determining which health plan or insurance policy will pay first and/or determining the payment obligations of each health plan, medical insurance policy, or third party resource when 2 or more health plans, insurance policies, or third party resources cover the same benefits for CareSource members.
- **Explanation of Payment (EOP)** – A detailed explanation of payment or denial of a claim by an insurance carrier.
- **Primary Carrier** – The insurance carrier that has been determined to be responsible for primary payment.

D. Policy
I. Submitted claims must include the total amount billed, total amount paid by primary carrier, and balance due along with a valid provider signature. Any balance due after receipt of payment from the primary carrier should be submitted to CareSource for consideration, and the claim must include information verifying the payment amount received from the primary plan.

II. COB Guidelines
A. When CareSource coordinates benefits with the primary carrier, reimbursement will be made according to the Medicaid contracted maximum allowable minus any payment made by the primary carrier. Any items or services for which another carrier's reimbursement amount is equal to or greater than the Medicaid contracted maximum allowable amount will be paid at zero. Claims that "pay" at zero are considered to be paid claims, not denied claims.

B. When the payment from another insurance carrier is less than the Medicaid contracted amount, CareSource will pay up to the Medicaid contracted total allowed amount. The sum of the payments will not exceed the Medicaid contracted maximum allowable amount as indicated in the CareSource Provider Agreement.

Example 1: Charged Amount $100.00

Carrier	Allowed	Co-pay	Deductible	Co-Insurance	Paid
Primary Insurance	$50.00	$10.00	$0	$0	$40.00
CareSource	$35.00				$0.00

Summary: In this example, since the primary carrier paid amount of $40.00 is ≥ to the Medicaid contracted allowed amount of $35.00, then CareSource pays zero, as indicated in the CareSource Provider Agreement.

Example 2: Charged Amount $100.00

Carrier	Allowed	Co-pay	Deductible	Co-Insurance	Paid
Primary Insurance	$80.00	$50.00	$0	$0	$30.00
CareSource	$40.00				$10.00

Summary: In this example, subtract the primary paid amount of $30.00 from the Medicaid contracted allowed amount of $40.00. CareSource will pay $10.00, as indicated in the CareSource Provider Agreement.

Example 3: Charged Amount $200.00

Carrier	Allowed	Co-pay	Deductible	Co-Insurance	Paid
Primary Insurance	$200.00	$0	$200.00	$0	$0.00
CareSource	$125.00				$125.00

Summary: In this example, subtract the primary paid amount of $0 from the Medicaid contracted allowed amount of $125.00. CareSource will pay $125.00, which is the total allowed amount as indicated in the CareSource Provider Agreement.

Example 4: Charged Amount $200.00

Carrier	Allowed	Co-pay	Deductible	Co-Insurance	Paid
Primary Insurance	$150.00	$0	$100.00	$40.00	$10.00
CareSource	$125.00				$115.00

The REIMBURSEMENT Policy Statement detailed above has received due consideration as defined in the REIMBURSEMENT Policy Statement Policy and is approved.

Summary: In this example, subtract the primary paid amount of $10.00 from the Medicaid contracted allowed amount of $125.00. CareSource will pay $115.00, as indicated in the CareSource Provider Agreement.

Example 5: Charged Amount $200.00

Carrier	Allowed	Co-pay	Deductible	Co-Insurance	Paid
Primary Insurance	$150.00	$30.00	$100.00	$0	$20.00
CareSource	$200.00				$180.00

Summary: In this example, subtract the primary paid amount of $20.00 from the Medicaid contracted allowed amount of $200.00. CareSource will pay $180.00, as indicated in the CareSource Provider Agreement.

C. Non-Contracted Providers
When the payment from another insurance carrier is less than the CareSource Medicaid non-participating reimbursement rate, the sum of the payments will not exceed the CareSource Medicaid non-participating reimbursement rate.

III. COB Timely Filing Guidelines
A. If a provider is aware that a member has primary coverage, the provider should submit a copy of the primary payers EOP along with the claim to CareSource within the claims timely filing period.
1. If CareSource receives a claim for a member that we have identified as having other coverage and a primary payer EOP was not submitted with the claim(s), CareSource will deny the claim(s) requesting the required COB information.
2. If a claim is denied for COB information needed, the provider must submit the primary payers EOP. If the initial timely filing period has elapsed, the EOP must be submitted to CareSource within 90 days from the primary payers EOP date.

B. If a provider has information that the primary payers policy has terminated or was not in effect during the date of service for the claim(s), the provider must notify CareSource of the dispute within the original timely filing period or within 90 days of the provider's actual receipt of the primary payer's EOP date, whichever is greater.

C. If the dispute is received within the original timely filing period:
1. CareSource will confirm whether or not the primary payer was in effect during the date of service. If the policy was **NOT** in effect, CareSource will process the claim(s) that are within the original timely filing period or 90 days of the provider's actual receipt of the payer's EOP date.
2. If the policy was in effect, the claim will remain denied for lack of primary payer's EOP.

D. If the provider does not notify CareSource of the dispute within the original timely filing period or if the provider does not submit the primary payer's EOP within 90

days of the provider's actual receipt of the primary payer's EOP date, the claim will re-deny as not being timely filed.

IV. COB Claim Submission to CareSource
   A. CareSource follows The Health Insurance Portability and Accountability Act (HIPAA) guidelines and accepts industry standard codes. It is imperative that claims are filed with the same codes that the primary payer presented on the EOB to ensure that claims are processed correctly. Claim(s) will be denied if there is a mismatch between the codes on the received claim and the primary payers EOP.
   B. CareSource applies standard claim adjustment codes.
   C. Claim Adjustment Group Codes are as follows:
      1. CO – Contractual Obligation
      2. OA – Other Adjustment
      3. PI – Payer Initiated Reductions or
      4. PR – Patient Responsibility
   D. When filing claims with patient's responsibility, the following Claim Adjustment Reason Codes should be used:
      1. PR1 – Deductible
      2. PR2 – Coinsurance or
      3. PR3 – Copayment
   E. When filing claims with contractual obligation, please use Adjustment Group Code "CO". Contractual obligation can be communicated on the primary payer's EOB with several different codes. Use the code reflected on the primary payer's EOB. Some examples of these codes are: 24, 45, 222, P24, P25, and 26. The same process should be followed when using Adjustment Group Code "OA" Other Adjustment.

V. Denied COB Claims
   A. Denied COB claims will be automatically adjusted when primary insurance has been updated retroactively to show coverage was terminated at the time of service AND the claim was denied for COB within 90 days of CareSource receiving the notification.
   B. Denied COB claims will NOT be automatically adjusted if the updated coverage information was received after 90 days from the denial for COB information. In this case, the provider must request claim adjustment within the original timely filing period or within 90 days from the date of the EOP denial, whichever is greater. Although CareSource is implementing this COB Adjustment Policy, it is still the provider's responsibility to review their accounts and submit COB claims in a timely manner for payment.

VI. Disputes for Denied COB Claims
   A If a provider has information that the primary carrier's policy has terminated or was not in effect during the date of service for the claim(s), the provider must notify CareSource of the dispute within the original timely filing period or within 90

days of the original denial date or 90 days from the primary carriers EOP date, whichever is greater. If the dispute is received within the original timely filing period or within 90 days of the original denial date:

B. CareSource will confirm whether or not the primary coverage was in effect during the date of service. If the policy was **NOT** in effect, CareSource will process the claim(s) that are within the original timely filing period. If the initial timely filing period has elapsed, then CareSource will process the claims that are within 90 days of the original denial. If the policy was in effect, the claim will remain denied for needing primary carrier's EOP. If the provider does not notify CareSource of the dispute within the original timely filing period within 90 days of the CareSource denial or if the provider does not submit the primary carrier's EOP within 90 days of the primary carrier's EOP date, the claim will re-deny as not being filed timely.

E. Conditions of Coverage

Reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, if applicable. Please refer to the individual fee schedule for appropriate codes.

F. Related Policies/Rules

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	10/13/2021	New policy. Approved at PGC
Date Revised	11/30/2022 10/09/2024	Editorial and reference updates only. Periodic review. Updated references. Approved at Committee.
Date Effective	03/01/2025	
Date Archived		

H. References

1. Georgia Department of Community Health. Medicaid/PeachCare for Kids Provider Billing Manual. Accessed October 1. 2024. ww.mmis.georgia.gov
2. CareSource Georgia Medicaid Provider Manual (May 2023). Accessed October 1. 2024. www.caresource.com

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