



National MMIS HIPAA Conference

Coordination of Benefits

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Presented by:

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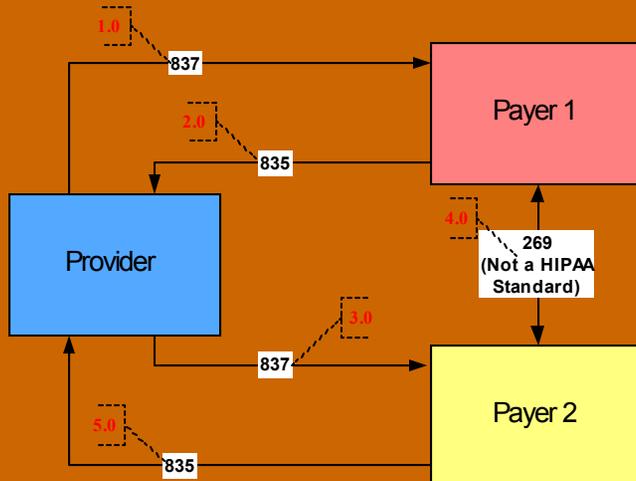
CMS



HIPAA's Two Models of COB

Model 1

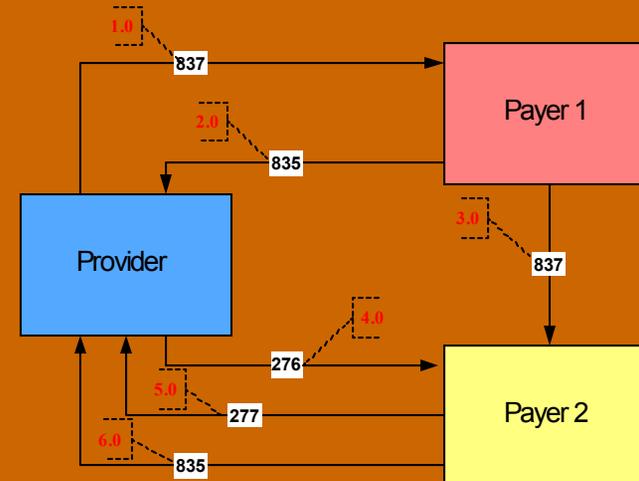
Provider-to-Payer-to-Provider



1. Provider sends 837 claim to Payer 1
2. Payer 1 sends 835 remittance to Provider with other carrier information blank
3. Provider sends 837 COB claim to Payer 2
4. Payer 2 sends 269 COB payment verification to Payer 1 (not a HIPAA transaction)
5. Payer 2 sends 835 remittance to Provider

Model 2

Provider-to-Payer-to-Payer



1. Provider sends 837 claim to Payer 1
2. Payer 1 sends 835 remittance to Provider with Payer 2 shown as other carrier
3. Payer 1 sends 837 COB claim to Payer 2
4. Provider sends 276 claim status request to Payer 2
5. Payer 2 sends 277 claims status response to Provider
6. Payer 2 sends 835 remittance to Provider



Transactions Included in the Flow

- 837 or NCPDP Claim
- 835 Payment & Remittance
- 837 Coordination of Benefit Claim
- 269 Benefit Verification Request & Response
- (not a HIPAA standard)
- 276/277 Claim Status Request & Response



Benefits

- ✓ Automates the most expensive paper claim transaction—labor intensive
- ✓ Potential to reduce fraud
- ✓ Moves the industry further toward 100% EDI



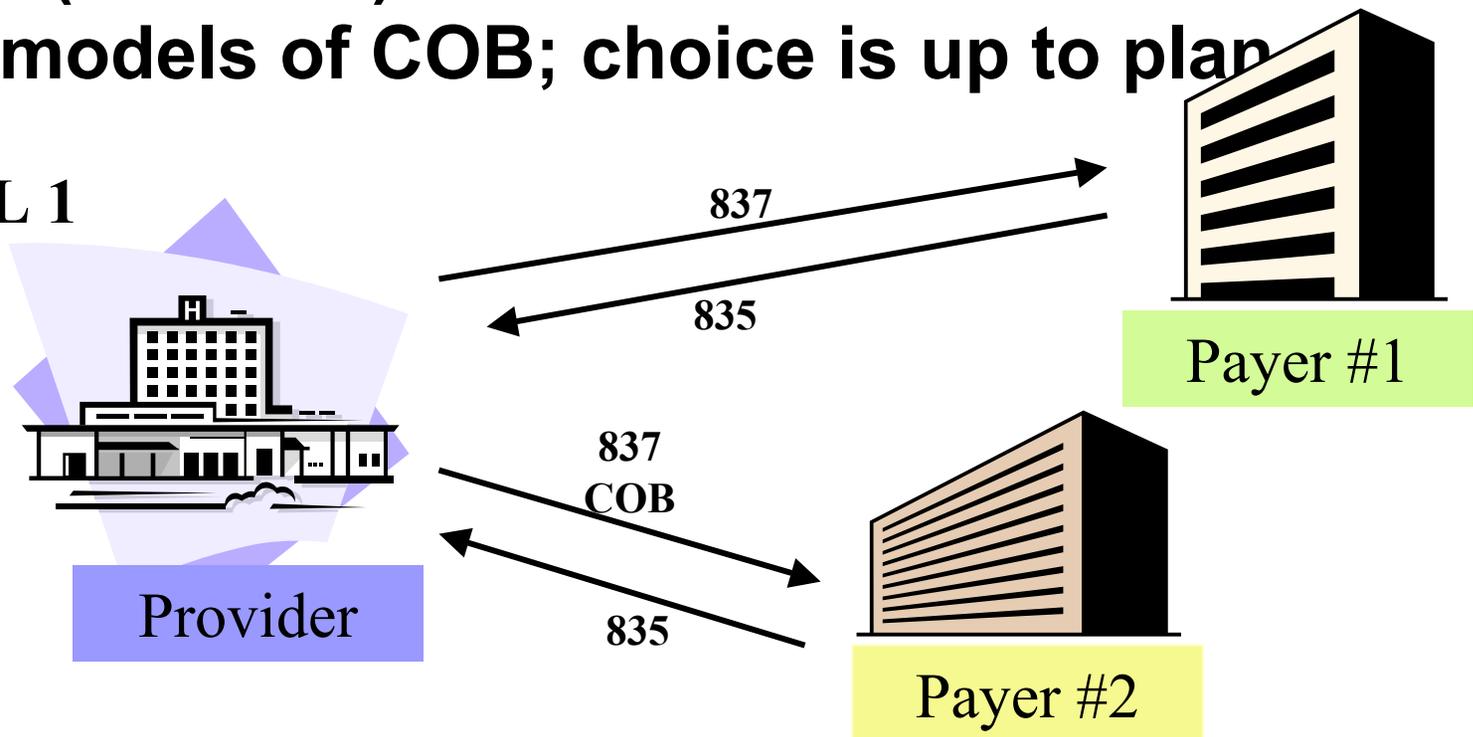
Challenges of Implementation

- Detailed trading partner agreements for Model 2
- Managing a two model system
- No mandated standard method for verification of benefits (X269)
- Potential issues surrounding legal liability

Coordination of Benefits

- Batch transaction that facilitates supplemental (secondary) insurance billing
- Requires benefit detail from the primary payer (835 data)
- Two models of COB; choice is up to plan

MODEL 1



Coordination of Benefits

MODEL 2

