ADMINISTRATIVE POLICY STATEMENT
Michigan Medicaid

Policy Name & Number	Date Effective
Coordination of Benefits-MI MCD-AD-1370	06/01/2024
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy 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 Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement 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.

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
Federal regulations require that all identifiable financial resources be utilized prior to the expenditure of Medicaid funds for most health care services provided to Medicaid beneficiaries. Coordination of benefits (COB) is the method used to designate the order in which multiple carriers are responsible for benefit payments, which prevents duplication of payments. Providers must utilize other payment sources to the fullest extent prior to filing a claim with HAP CareSource. The terms "third party liability" and "other insurance" are used interchangeably to mean any source, other than Medicaid, that has a financial obligation for health care coverage. If other insurance resources are not exhausted and the provider was aware of other insurance coverage, billing Medicaid may be considered fraud under the False Claim Act.

C. Definitions
- **Coordination of Benefits (COB)** – The method used to determine which insurance plan has the primary payment responsibility, and the extent to which the other plans will contribute when an individual is covered by more than one plan.
- **Third party liability (TPL)** – Insurance plan or carrier (eg, individual, group, employer-related, self-insured, or self-funded plan), commercial carrier (eg, automobile insurance and workers' compensation), or program (eg, Medicare) that has liability for all or part of a beneficiary's medical coverage.

D. Policy
I. HAP CareSource follows the *Michigan Medicaid Provider Manual* for coordination of benefits.
   A. Medicaid is the payer of last resort.
   B. Providers should always determine if the member has other insurance coverage at the time of service. If other insurance coverage is identified that is not listed in the eligibility response, the provider must use that other insurance first.
   C. Providers must report all other insurance or liability coverage using all other payment resources before submitting a claim to HAP CareSource.
   D. An explanation of payment or explanation of benefits from the primary carrier must accompany the claim to coordinate benefits.
   E. Professional, facility, and ancillary services not covered by the primary insurance carrier and billed to HAP CareSource must comply with the authorization requirements to be reimbursed. See the Referrals and Authorizations section in the provider manual.

II. General Billing Guidelines
   A. Billing Medicaid prior to exhausting other insurance resources may be considered fraud under the Medicaid False Claim Act if the provider is aware that the beneficiary had other insurance coverage for the services rendered.

B. The provider should bill the other resource first. Once payment has been received, the provider may bill Medicaid. The Medicaid claim must include the payment amount received from the other resource.
C. If payments are made by another insurance carrier, the amount paid, whether it is paid to the provider or the beneficiary, must be reflected on the claim. It is the provider's responsibility to obtain the payment from the beneficiary if the other insurance pays the beneficiary directly. It is acceptable to bill the beneficiary in this situation.
D. In cases where the provider renders a service and the carrier indicates it does not cover that specific service, the provider needs only to bill the carrier once for the service and keep a copy of the denial in the beneficiary's file.

III. Other payers
If covered by other sources (ie, automobile insurance, workers compensation claims, and court-ordered medical support, Medicare), additional guidance for filling claims and billing can be located in the *Michigan Medicaid Provider Manual*, Coordination of Benefits chapter for All Providers.

IV. Medicaid Liability
A. As a condition of Medicaid eligibility, payers must reimburse HAP CareSource if another resource is identified for reimbursement.
B. HAP CareSource does not pay for services denied by Medicare or other insurance plans due to noncompliance with Medicare or other insurance plan requirements. Common noncompliance denials include, but are not limited to:
1. Failure to obtain a referral from a participating primary care provider (PCP), a second opinion, or a prior authorization, if required.
2. Failure to be seen by a participating provider or in a participating place of service.

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	09/27/2023	New policy. Approved at Committee.
Date Revised	03/13/2024	Annual review. Updated references. Approved at Committee.
Date Effective	06/01/2024	
Date Archived		

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

H. References

1. False Claims Act, 31 U.S.C. §§ 3729-3733 (2023).
2. *Medicaid Provider Manual: Coordination of Benefits*. Michigan Dept of Health and Human Services; 2023. Accessed September 1, 2023. www.mdch.state.mi.us
3. The Coordination of Benefits Act, Act 64 of 1984, MICH. COMP. LAWS §§ 550.251-233 (2023).
4. The Medicaid False Claim Act, Act 72 of 1977, MICH. COMP. LAWS §§ 400.601-615 (2023).