



Other Party Liability/Ridered Condition/ Waiting Periods

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I. What is OPL

OTHER PARTY LIABILITY (OPL) is the area within Blue Cross and Blue Shield of Kansas which determines whether services are eligible for coverage under another insurer. OPL then place primary liability with the correct carrier.

Annually, we verify whether or not our members and/or their family members have other group health insurance coverage. OPL also verifies if injuries and other certain conditions are eligible to be covered by worker's compensation or auto insurance.

This activity helps contain costs that affect rates paid by our members. OPL deals specifically with duplicate coverage (not Medicare or Medicaid), worker's compensation and no-fault auto.

II. Submitting the Claim

(See the [ITS section](#) for details on filing Host claims as secondary.)

When you are aware of another insurance carrier, a claim should be filed with both carriers; except when two Blue and Cross Blue Shield of Kansas group* policies are involved (we will coordinate these for you with one filing). The claim filed to each policy should include information regarding the other carrier.

**if one or both policies are non-group, you must file under each ID# separately.*

When an Explanation of Benefits (EOB) is received from the first or primary carrier, it should be sent to the secondary carrier's OPL department. It should NOT be re-filed with another claim form. This could cause the EOB to be misdirected, possibly resulting in a denial for submitting a duplicate claim. The same procedure applies to denial letters. In all cases, be sure to include the member's ID# for the carrier to which you are sending the information.

III. Timely Filing:

The reason for filing a claim with each carrier is to protect you from the possibility of a timely filing denial later. An example of such a case would be when a worker who has been injured on the job seeks treatment and advises you his claims will be paid by the worker's compensation. Later, if the condition is found to be unrelated to the patient's employment, a denial could be received from the worker's compensation carrier or refunds could be requested on claims for which they have already paid.

If this takes place more than 15 months from the date of service, those claims which would have been eligible under the patient's Blue Cross and Blue Shield of Kansas policy by filing in a timely manner, will be denied. Denials for not filing within the specified time period are a provider write-off. Had those same claims been filed with us originally, BCBSKS would have denied services as work related but would reprocess them for eligible benefits upon receipt of the denial letter.

IV. BlueCard (ITS):

File a 'secondary' Host* ITS claim to Blue Cross and Blue Shield of Kansas as you would a claim for any Kansas Plan member. However, if the patient is covered under another Blue Plan membership and a Kansas Plan membership, a separate claim will need to be filed under each ID#. Inquiries regarding overpayments on claims paid by Blue Cross and Blue Shield of Kansas as the Host Plan that have resulted from payment made by another carrier should be directed to our Customer Service Center at (785) 291-4058. Do not direct these inquiries to the OPL department.

*Host is defined as *A BCBSKS contracting facility/provider rendering services for a member of another Blue Plan.*

V. Avoiding Delays:

When investigation by OPL is necessary, it may delay the processing of your claims. If you wish to avoid this delay, you may choose to provide OPL with the information prior to or at the time of filing your claim. A copy of our OPL questionnaire can be found on the Web at www.bcbsks.com and may be duplicated for your use, should you decide to have your patients fill out the questionnaire prior to receiving care. A form for your use in requesting a deduct of OPL related overpayments is also provided on the Web at www.bcbsks.com. Mail or fax completed forms to the OPL department at.

Attn: OPL cc217D5
Blue Cross and Blue Shield of Kansas
1133 SW Topeka Blvd
Topeka, KS 66629-0001
Fax to OPL at: (785) 291-8981

BCBSKS changed our investigation procedures for duplicate coverage from "pursue and pay" to "pay and pursue" January 1, 2008.

This means:

- Faster payment of provider claims.
- BCBSKS will ask our members for information about duplicate after the claim(s) is paid.
- If we find out later that we paid as primary in error, claims will be adjusted.

This change does not apply to:

- Pay subscriber claims.
- Federal employee program claims.
- Large dollar claims (inpatient \$50,000, outpatient \$20,000)
- Worker's compensation or no fault auto cases.

Many providers obtain OPL information from BCBSKS members when services are provided. BCBSKS encourages you to continue to do so.

VI. Reconciling Your Account:

To reconcile your patient's account after the secondary carrier has processed a claim, refer to the primary carrier's Explanation of Benefits (EOB) as well as that of the secondary carrier. Determine your write-off by subtracting the lesser allowance of any carrier with whom you have a contracting arrangement from the total charge. Determine the patient's responsibility by subtracting your write-off and the payments of the primary and secondary carriers from the total charge.

The BCBSKS remittance advice (RA) for secondary payments will show, not only the amount paid on the secondary claim, but also the total amount paid by the primary carrier, the total amount of patient responsibility, and the total provider write-off after taking into consideration the benefits of both carriers. This eliminates the need to retrieve the primary carrier EOB for balancing patient accounts. There are specific coding combinations on the RA that helps the provider identify a claim involving OPL.

- The CNTR column = OP
- Paid as secondary carrier – ARC 23
- Awaiting a response to an OPL questionnaire sent to the patient = ARC = 227, RMK = N179
- The primary carrier must process first and an EOB is required = ARC = 22, RMK = MA04
- The primary carrier's payment exceeds the amount payable under the patient's contract. No secondary payment is available on this column = ARC 23, RMK = M43
- The EOB does not match the claim = ARC 22, RMK = N48
- This services is due to a job-related illness or injury by Workman's Compensation = ARC = 19, RMK = MA04
- This service is motor vehicle related = ARC 21, RMK = MA04
- The patient has accepted a financial settlement from another insurance carrier for this claim = ARC 23, RMK = MA04

VII. DUPLICATE COVERAGE

Other party liability (OPL) coordinates benefits with other *group policies by following the portions of the NAIC Coordination of Benefits Model Regulation adopted by the State of Kansas, (K.A.R. 40-4-34) and regulated by the Kansas Insurance Department.

A. Coordination of Benefits (COB):

When payments for the same claim through multiple *group health insurance companies exceed the total charge (or allowance if the provider is contracting), then benefits as secondary are reduced. The difference between what Blue Cross and Blue Shield of Kansas would have paid as primary and what we actually pay as secondary is COB savings.

All local contracts, and those Administrative Services Only (ASO) self-insured groups and out-of-area groups who elect to do so, apply these savings to an 'accumulator' within our claims system for that patient. Savings in the accumulator

may later be used when our payment as secondary combined with the primary payment is insufficient to meet the allowable expense.

When appropriate, the claims system automatically draws any available savings to the point of exhausting savings or paying the amount for which the patient would have been responsible otherwise, whichever occurs first. The process of adding to and borrowing from this accumulator is referred to as a 'Benefit Determination Period' and is applied to claims WITHIN THE SAME BENEFIT YEAR.

* The group number of most BCBSKS non-group policies begins with "M" or "08". These policies do not coordinate benefits and will process to the maximum allowable expense under the contract. Credit balances may be sent to the patient. However, if another carrier is involved please check with them first.

B. Maintenance of Benefits (MOB):

ASO and out-of area groups may choose to apply Maintenance of Benefits (MOB) to dual coverage, rather than the standard Coordination of Benefits regulated by the NAIC and State Model. MOB does not apply the Benefit Determination Period, nor does it ever allow the combined payments of carriers to exceed the allowable charge regardless of the provider's contracting status. In some instances, the group has elected to hold the combined payments to the amount payable by their policy were it the only insurance coverage available.

(Groups currently using MOB as of August 1, 2009: OneOK, Great Plains Manufacturing dental and RX only, and FEP)

C. Determining Primary Carrier

We sometimes receive inquiries asking us which policy is the primary carrier for a patient and how we determine that information. The NAIC and State Model have set forth guidelines referred to as ORDER OF BENEFIT DETERMINATION to help us determine where the primary payment responsibility lies when duplicate coverage exists. The most frequently used are:

1. Member Rule:

When a patient has coverage as the member of one group health insurance contract and is covered as spouse or dependent under another, the contract covering the patient as the member is primary carrier.

2. Birthday Rule:

When each parent carries his/her own group health insurance contract on the children, the parent who has a birthday occurring earlier in the year is primary for the children. Age (year of birth) is not a factor. If one of the insurance carriers does not follow the 'Birthday Rule,' the 'Gender Rule' will be applied.

3. Gender Rule:

When each parent carries his/her own group health insurance contract on the children and one or both of those contracts does not follow the 'Birthday Rule,' the father is automatically primary for the children.

4. Divorce (legal separation) rules:

a) If a court decree establishes a parent as responsible for the children's medical expenses, that parent will be primary.

b) If the decree does not establish primary carrier, the parent with legal (not residential) custody will be primary.

c) In the case of joint custody, the 'Birthday Rule' is applied.

d) In the case of remarriage: once the primary natural parent has been determined, the step-parent married to the primary parent would be considered secondary carrier. Benefits of that step-parent will be determined before those of the other natural parent who would be considered tertiary (third) carrier.

D. Other COB Rules

1. Retiree (or laid-off) Rule:

If the member under both coverages is the same person, a group covering that person as an active employee shall be determined primary carrier to any other covering that person as a retired employee. If one or both of those policies does not follow the 'Retiree Rule,' the 'Longer Shorter Rule' will be applied.

2. Consolidation Omnibus Budget Reconciliation Act of 1985 (COBRA) Rule:

A group providing continuous coverage as a COBRA policy will be determined as secondary to another covering that person as an active employee. Like the 'Retiree Rule,' the member must be the same on both policies and the 'Effective Date Rule' is applied if either of the policies does not follow the COBRA Rule.

3. Death Resulting in Remarriage:

The natural parent is primary for the children and the step-parent is secondary.

4. Dumping Rule:

When one group does not contain a non-duplication of benefits clause, that contract automatically becomes the primary carrier.

5. Athletic Rule:

When one group is school athletic coverage only, the other will automatically become primary carrier for that patient.

6. Longer Shorter Rule:

If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is primary.

7. Shared Payment (50/50 Rule:

If none of the preceding rules determines the primary plan, the allowable expenses shall be shared equally between the plans.

E. OPL Exclusions

1. Exclusion vs. Coordination

Blue Cross and Blue Shield of Kansas contracts contain an EXCLUSION section which outlines conditions for which benefits will not be provided. Among these exclusions are Worker's Compensation and No-Fault Auto related services. As an exclusion (vs. a coordination) of benefits, the payments made by the other insurer cannot be used toward satisfying any shared patient responsibility, such as deductible and coinsurance, imposed by the Blue Cross and Blue Shield of Kansas contract. As stated previously under "Submitting the Claim", it is still important to file with Blue Cross and Blue Shield of Kansas to avoid a timely filing problem in case services are later denied by the carrier first thought to be responsible.

VIII. Worker's Compensation

Services provided as the result of work related injury or illness will not be covered by BCBSKS when the patient is covered (or required to be covered) by worker's compensation law. If the patient accepts a settlement giving up the right to future medical payment, BCBSKS will not pay for services that would have been payable by the worker's compensation carrier except for that settlement. In addition, if the worker's compensation program limits benefits if other than specific health care providers are used, BCBSKS will not pay balances of charges from such non-specified providers. Self-employed persons and others exempt from the Worker's Compensation Act will not be subject to this exclusion.

IX. No-Fault Auto

Benefits will not be provided for services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent such services are payable under any medical expense payment provision* of any automobile insurance policy. The Kansas Automobile Reparations Act requires motor vehicle liability insurance policies to include Personal Injury Protection (PIP). K.S.A. 40-3109 identifies the injuries for which PIP coverage must be provided as injuries sustained in the US or Canada while: 1) entering into, 2) alighting from, 3) in the use of, 4) in the operation of, or 5) in the maintenance of a motor vehicle. If the

accident falls into one of these categories, Blue Cross and Blue Shield of Kansas will deny the claims until the charges have been filed with the auto insurance carrier. Benefits will be considered according to the benefits of our contract after we have received either a letter of denial from the auto carrier or a complete itemization of PIP payments after those maximum benefits have been exhausted. Services paid for by the auto carrier of the responsible party are not PIP and do not fall within this exclusion. Such payments are liability and fall within the category of subrogation.

** Commonly known as No-Fault, Personal Injury Protection (PIP), Excess Medical or by any other terminology used by the automobile insurance carrier.*

X. SUBROGATION

Current state insurance laws do not permit routine subrogation in Kansas. Local contracts cannot add this rider. ASO and out-of-area groups, however, have the option of whether or not to attach the Subrogation rider to their contracts. Subrogation is defined as "The substitution of one for another as creditor so that the new creditor succeeds to the former's rights or obligations." In short, subrogation is the recovery of payment because of a third party liability. BCBSKS handles those contracts with this rider on a pay & pursue basis. Recoveries, as well as inquiries into and/or regarding subrogation, are outsourced by Blue Cross and Blue Shield of Kansas to:

Rawlings Co., LLC
1700 Waterfront Plaza
325 W. Main Street
PO Box 740027
Louisville, KY 40202-7427
(502) 587-1279
(800) 928-1279

You may inquire as to whether a group has a subrogation rider through the OPL department.

XI. Multiple Insurance Carriers Assuming Primary Responsibility

As illustrated in this section of the Institutional Provider Manual, when there's more than one insurance company, Kansas state law and/or the BCBSKS member contract dictates which insurance carrier has the primary liability.

There are however some cases when State law or member contract is not a factor and more than one insurance company assumes the primary responsibility. Examples would include:

- the patient has a non-group contract and a group contract;
- the patient has two non-group contracts; or

- the patient's BCBSKS contract does not include a subrogation provision that allows for the recovery of payment because of a third party liability.

When one of these (or similar) situations exist:

1. If BCBSKS is paying on the claim AND services were provided by a contracting provider, the provider will be required to accept the BCBSKS MAP as payment in full and hold the member harmless. Money in excess of the contracting provider allowance would belong to the patient/member.
2. If BCBSKS does NOT allow the claim (services are non-covered), the BCBSKS allowance is not applicable. Payment, allowance and write-off issues would be between the other insurance carrier, provider and the member.

XII. Ridered Condition

A ridered condition (restricted condition) is an illness or condition for which **any type of treatment or care is EXCLUDED** from otherwise eligible BCBSKS benefits. The provisions of a rider are stated specifically on a separate document that is attached to the member's contract.

A health condition restriction rider is most commonly associated with individual/direct enrolled memberships. A ridered condition could be for two years, five years or permanent.

XIII. Waiting Periods

A waiting period is the period of time between the effective date of the membership and the date when services or benefits are available.

A membership may include the standard five (5) condition waiting period or a pre-existing waiting period.

A. STANDARD FIVE (5) CONDITION WAITING PERIOD

The standard five (5) conditions waiting period are:

- 1) Tonsillectomy and Adenoidectomy
- 2) Obstetrical Services
- 3) Treatment for Tumors or Growths
- 4) Treatment for Hernia
- 5) Treatment for Conditions of Gall Bladder, Rectum, or Genito-Urinary Tract

These waiting periods are most commonly applicable to direct enrolled non-group members whose enrollment with Blue Cross and Blue Shield of Kansas, Inc. includes the completion of a Statement of Health Application.

B. PRE-EXISTING WAITING PERIOD

A “pre-existing condition” is a condition, including related conditions, for which diagnosis, treatment or advice was sought or received in ninety (90) days* prior to the effective date of coverage.

***Note:** 90 days is the most common time frame, but could vary.

“Condition” includes not only a condition itself but also symptoms of such condition. The waiting period, exclusion, or other limitation also applies to conditions related to the “pre-existing condition”, complications of the “pre-existing condition”, and conditions having symptoms of the condition for which the member asked or received evaluation, diagnosis, or medical treatment.

The term “medical treatment” includes both active treatment and passive forms of treatment, such as following a diet recommended by a doctor for a condition or taking medications for a condition.

A pre-existing waiting period most commonly will extend for 240 or 270 days. Some groups, however, do extend the waiting period for longer time periods.

Pre-existing waiting periods (which are not necessarily part of all group coverage) could apply if:

- The insured did not enroll at their first opportunity (the waiting period would then apply to every person covered by the membership)
- If a change from single to family is not made at their first opportunity.