

Medicare Beneficiaries

Generally, Medicare beneficiaries who also have Regence BlueShield coverage will have a “Medicare Medigap” or “Medicare supplement” policy that pays secondary to Medicare. However, employed persons age 65 and over and their eligible dependents age 65 and over may be covered first by their employer’s healthcare plan and second by Medicare.

Federal law (TEFRA) requires that employers with 20 or more employees offer employees age 65 and older the same health care plan that is offered to younger employees and their families. In these cases, the employer plan will pay primary to Medicare and you should bill us in the same manner that you do for any BlueShield member. After we have processed the claim, Medicare should be billed for unpaid amounts that are the member's responsibility.

If the member is covered by Medicare and a BlueShield Medicare Medigap or supplement plan or a BlueShield individual or group plan with less than 20 employees or on a retiree plan, you must submit the charges to Medicare first for payment.

If you submit claims to Medicare you will receive a remittance notice. Your Medicare remittance notice will indicate if a claim has been forwarded electronically, to Regence BlueShield. This happens when the patient has a Medigap or supplemental coverage with a health plan. To see if this occurred, look on the remittance notice. The same line that contains the patient's name will also display the code 'MA18' ("The claim information is also being forwarded to the patient's supplemental insurer."); the name of the health plan Medicare forwarded the claim to is indicated at the bottom lower left section of that beneficiary's payment information on the Remittance Advice.

If your claim was forwarded on, please allow four full weeks for processing, from the date of receiving your remittance from Medicare. If processing is not received by that time, or if the 'MA18' message does not appear on your remittance advice, please submit the claim with either a copy of the remittance notice or an Explanation of Medicare Benefits (EOMB) attached to Regence BlueShield for processing.

Note: Medicare will not forward any claims that were either paid in full or totally disallowed by Medicare. Those claims must be submitted with the remittance or EOMB for supplemental processing. Also note that if a procedure code is not HIPAA compliant, Medicare may still process and/or pay on the claim but will not forward on to the secondary carrier, even though the Remittance Advice states that it was forwarded. GHI, the clearing house for COBA claims, notifies the Medicare carrier of this error, and they, in turn, are supposed to notify the providers, but this often does not occur.

Regence BlueShield claims secondary to Medicare claims are usually paid within three to four weeks of Medicare’s payment. If a payment is not received within 30 days, call provider customer service at **1 (800) 322-1737** to verify the claim status.

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If you are uncertain as to whether Medicare is primary or secondary, you may:

- ask the member to check with his or her employer
- you may bill us in the usual manner. If we are not primary, we will notify you that Medicare must be billed first.
- you may call Regence BlueShield at 1-800-322-1737
- you may call Medicare COBC at 1-800-999-1118

Carve outs-(now termed “Supplemental” by CMS)

Medicare beneficiaries may have a Regence BlueShield group contract secondary to Medicare. All charges not paid by Medicare are considered for payment. These include:

- Charges applied to the Medicare deductible
- All balances after Medicare payment (unassigned claims)
- Charges excluded by Medicare
- The 20% coinsurance on assigned claims

Cobra and Medicare

If an individual has Medicare and elects COBRA coverage, both coverage's are allowed. If an individual has COBRA coverage and subsequently becomes entitled to either Medicare Part A or Part B, the COBRA coverage terminates on the date that Medicare becomes effective.

Note: *If Medicare is in effect and COBRA is elected, Medicare is normally primary even if group is TEFRA or OBRA eligible (the exception is ESRD).*

Omnibus Budget Reconciliation Act of 1986 (OBRA)

Persons under 65 who are covered by Medicare because of disability or end stage renal disease may also be covered through an employer plan as an employee or dependent.

- A person who has Medicare due to disability and is covered as either a subscriber or dependent by an employer group health plan that has 100 or more employees, is OBRA eligible
 - The group plan is primary over Medicare
- A person who has Medicare due to disability and is covered as either a subscriber or dependent by an employer group health plan that has less than 100 employees, is not OBRA eligible
 - Medicare is primary over the group plan
- A person who has Medicare due to End Stage Renal Disease and is covered by a Group Employer Plan is normally considered Employer Group Plan Primary for the first 30 months. Once the 30 months EPGH period is met, Medicare becomes primary payer, with the Employer plan becoming secondary.

Regence Regence MedAdvantage

Please visit www.wa.regence.com/provider/medadvantage for more information on our members who have Regence Regence MedAdvantage coverage.