Coordinating VSP Benefits on Claims in eClaim

This job aid provides instructions for Eyefinity.com users to coordinate benefits on VSP claims using the modern eClaim.

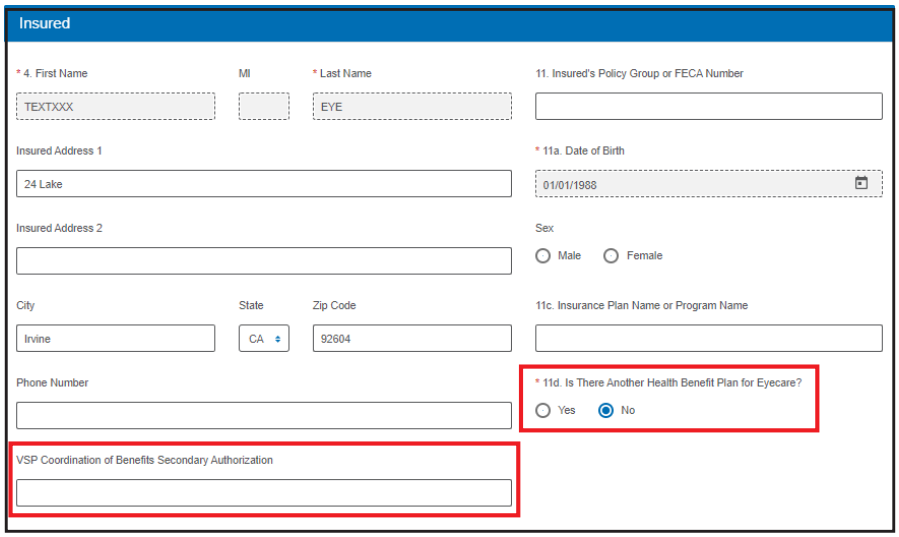
- Coordinating Benefits When VSP is the Primary & Secondary Carrier
- Coordinating Benefits When VSP is the Secondary Carrier

Coordinating Benefits When VSP is the Primary & Secondary Carrier

For more information on recording information on and submitting claims, see Submitting Exam-Only VSP Claims Using eClaim and Submitting Eyeglass and Contact Lens VSP Claims Using eClaim.

1. Obtain a VSP authorization for the patient's primary insurance plan and secondary insurance plan. For more information, see Authorizing VSP Benefits Using eClaim.
2. Click **View CMS 1500 Form** or return to the eClaim home page and type the authorization number for the patient's primary insurance plan from step 1 in the **Enter Authorization #** text box and click **Search**.
3. Record the services performed, calculate the HCPCS codes, and type the full usual and customary cost (i.e., the cost the patient would pay without insurance) of the patient's services in the **24f. Charges** text boxes.
4. Type the amount the patient has already paid in the **29. Paid** text box below the charges.

5. Indicate the VSP secondary benefits by recording information in the **Insured** section:
   a. Select **No** for box **11d**.
   b. Type the secondary VSP benefit authorization number in the **VSP Coordination of Benefits Secondary Authorization** text box.



6. Record any other required information on the claim.
7. When you are ready to send the claim to VSP, verify that all of the information on it is correct and then click **Submit Claim** in bottom command bar.

Coordinating Benefits When VSP is the Secondary Carrier

Follow the instructions below if the patient has a health or vision plan or Medicare as their primary insurance carrier and VSP as their secondary insurance carrier.

When a patient has a non-VSP primary insurance carrier and VSP as their secondary insurance carrier, you can now coordinate benefits in a single claim submission using both the patient's routine and medical eyecare plans. This new feature allows you to maximize the patient's VSP benefits.

EXAMPLE	If the patient's primary insurance carrier is Medicare, obtain an authorization for both the patient's Primary EyeCare or Diabetic Eyecare Plus plan and routine services. Submit the claim on the patient's Primary EyeCare or Diabetic Eyecare Plus authorization for the non-covered portion of the medical eye exam and type the patient's routine exam authorization number in the VSP Coordination of Benefits Secondary VSR text box to pick up the patient's noncovered refraction.

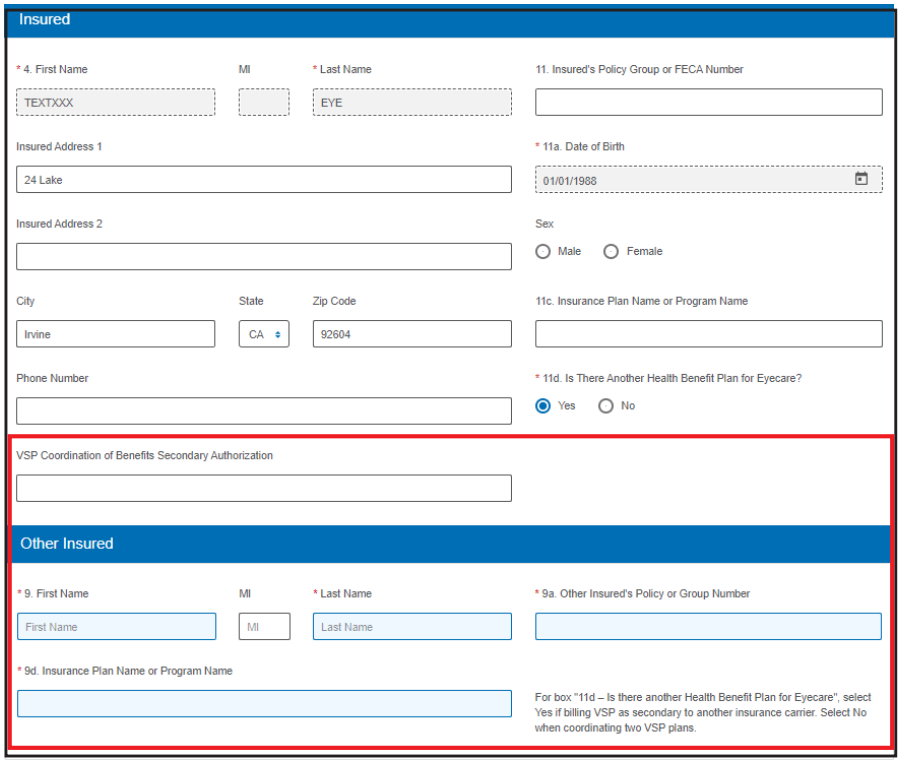
1. Submit an insurance claim to the patient's primary insurance carrier.
2. Wait to receive an explanation of payment (EOP) from the primary insurance carrier.

3. Obtain a backdated (using the original date of service) standard VSP authorization for the services to be coordinated. For more information, see Authorizing VSP Benefits Using eClaim.
4. Click **Continue to CMS 1500** or return to the eClaim home page and type the authorization number for the patient's secondary insurance (VSP) plan from step 3 in the **Enter Authorization #** text box and click **Go**.
5. Record the services performed.

NOTES	
	• Ensure that the exam, refraction, and/or materials information that you record on the secondary insurance claim matches the information that you recorded on the primary insurance claim. • You do not need to record any invoice details after you record the services performed.

6. Navigate or scroll to the **Insured** section and record the following information:
   a. Select **Yes** in box **11d**.
   b. Optionally, if you are coordinating benefits using more than one VSP plan (i.e., medication and routine; employee and spouse), type the additional VSP authorization number in the **VSP Coordination of Benefits Secondary Authorization** text box. Leave this field blank if you are coordinating only one VSP plan.
   c. Type the first and last name of the insured person on the patient's primary insurance plan in box **9**.
   d. Type "NA" in box **9a**.

e. Type the patient's primary insurance plan name in box **9d**.



7. Scroll up to the **Services** section and enter the procedure codes to match the EOP from the primary insurance carrier.
8. Complete the COB fields in the **Services** section:
   a. In the **Other Ins Allowed** text box, record the maximum amount allowed for the service by the other insurance, as indicated on the EOP.
   b. In the **Other Ins Paid** text box, record the amount paid for the service by the other insurance, as indicated on the EOP.
   c. In the **Other Ins Pat Resp** text box, record the remaining balance the patient is responsible to pay for the service by the other insurance, as indicated on the EOP.

NOTE	If VSP is the tertiary insurance carrier, do not break down primary and secondary insurance carrier payments. Instead, record the allowed amount from the primary EOP and the combined paid amounts from the primary and secondary EOPs along with the patient's final out-of-pocket expense.

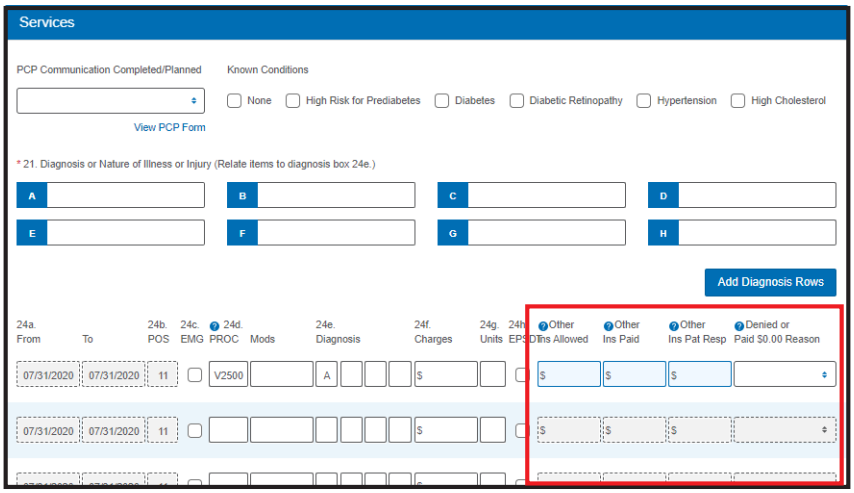
d. In the **Denied or Paid $0.00 Reason** drop-down menu, select the reason the primary EOP indicated that the claim was denied or paid $0.00.

NOTE

Why? When the primary insurance did not make payment on a claim or claim line, the reason code provided (either on an EOB or in the drop down menu for electronic claims) determines if VSP assumes primary or secondary on the claim or claim line. This affects the payment made to the provider and the patient's out of pocket expense.

- If the primary does not make payment because the allowed amount was applied to the deductible, then VSP is secondary and the payment amount is the secondary COB allowance. The remaining would be patient responsibility.
- If the primary does not make a payment because the service is non covered or the patient is not covered under the insurance, then VSP is the primary and the payment amount is the doctor filed fee for the service. The patient's responsibility is the plan copay.

Select this option…	When the Primary EOP indicates…
Not Covered	The claim was denied due to the patient not being covered on the date of service or services billed not being covered by the primary insurance.
Deductible	The service was applied to the deductible and paid $0.
Max Allowance Met	The maximum allowance was met and paid $0.
Bundled Service	The payment for this service is included in the reimbursement of another service/procedure billed.
Timely Filing	The claim was denied due to untimely filing.
Capitation	The claim was denied due to capitation.



NOTE	Click the blue question mark icons to see descriptions of how the information entered in each field is used.

9. Type the amount already paid by the primary insurance carrier (not the amount due from the patient) in the **29. Paid** text box below the charges.
10. Scroll to the **Additional Information** section and type "Secondary COB claim" in the **19. Additional Claim Information** text box.
11. If you need a copy of the claim with the COB details, click **Print** in the top navigation bar.

NOTE	The COB details on the claim will not be available in the CMS Report or Service Report and you will not be able to view them after you submit the claim.

12. When you are ready to send the claim to VSP, verify that all of the information on it is correct and then click **Submit Claim** in the bottom command bar.