Dynamic Chiropractic

Billing Secondary Insurance

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Q: I am confused on how to bill a secondary insurance. Is there an official way to bill secondary carriers?

A: Billing a secondary insurance is not very different from billing a primary insurance, but there are some specific steps to follow and rules to understand. A secondary insurance is an additional insurance plan (often, both husband and wife work and have separate plans from their respective jobs that cover their spouse as well) that will make an additional payment after the primary insurance has paid. In many instances, a secondary insurance will pay most, if not all, of the balance left over from the primary, leaving little out-of-pocket expense. This type of coverage certainly makes it financially easier for a patient to complete a treatment plan, and makes money not as big a factor in their choice of care.

The first step in billing a secondary insurance is simply billing the primary insurance as you normally would. Once you receive payment from the primary, you can then bill the secondary. For the secondary, create a new billing with the secondary insurance information and attach a copy of the explanation of benefits (EOB) from the primary carrier. The secondary will then process the claim based on the balances owed by the patient from the primary. I am aware of offices that will bill a secondary with a copy of the original claim and a copy of the EOB from the primary carrier, and have not had any problems with payment from the secondary. Although I do not recommend that procedure, I can attest that offices have success getting payment from the secondary with it.

One issue that often is overlooked is how much the secondary will pay. Of course, this is based on any contracts your office may have as a provider for the primary or secondary insurance. If you have no membership or contract with the primary carrier, the secondary simply will recognize any amount balanced or not paid by the primary. What often is not understood is that when we are members and there are reductions in the fees by the primary, the secondary will only owe based on what the primary contract allows to be collected from the patient. Therefore, a secondary policy always is equivalent to the patient in the sense that it owes only what the patient owes per the primary contract.

For example, if your bill was for $50, and the primary insurance pays $25, and the patient (per your contract with the carrier) owes a $10 co-pay, the secondary carrier is only responsible for $10, with $15 being written off as a contractual reduction. On the other hand, if you are not a member and bill $50 and the primary pays $25, the patient balance would be $25. Therefore, the secondary carrier would owe based on the $25 balance.

Medicare is the one carrier that will submit claims for participating providers automatically to the secondary insurance on your behalf. For this, you simply add the secondary insurance information in blocks 9a-d. Nonparticipating Medicare providers do not, by contract, get this benefit, but I have found that in many cases, Medicare still will submit to the secondary as a benefit to the Medicare patient. However, they are not obligated to do so.