ADA Guidance on Coordination of Benefits

Coordination of Benefits takes place when a patient is entitled to benefits from more than one dental plan. Plans will coordinate the benefits to eliminate over-insurance or duplication of benefits.

General Coordination of Benefits Rules

It is important to note that only group (employer) plans are required to coordinate. So if one of the policies covering your patient is an individual policy, then it does not coordinate.

Employee/Main Policyholder - When both plans have COB provisions, the plan in which the patient is enrolled as an employee or as the main policyholder is primary. The plan in which the patient is enrolled as a dependent would be secondary.

Current Employment – When an employed patient has coverage through an employer that plan is primary over a COBRA or a retiree plan.

More than One Employer Plan – When a patient has plans provided by more than one employer, the plan that has covered the patient the longest is primary. A change in the dental plan carrier does not change the length of coverage time for the patient.

Dependent Children - The typical rules for dependents of parents with overlapping coverage rely on the birthday rule, that is, the parent with the earliest birthday in a calendar year is primary. In the case of divorced/ separated parents, the court's decree would take precedence.

Medical/Dental Plan – When a patient has coverage under both a medical and dental plan, the medical plan is primary.

Additional information regarding coordination of benefits that may be helpful follows.

Types of Coordination of Benefits

Many factors determine how COB is handled including state laws, processing policies of the carriers involved, contract laws, fully insured versus self-funded plans and types of COB utilized. There are several different types of COB that plans may use. A brief description of some of the more common methods follows.

Traditional - Traditional coordination of benefits allows the beneficiary to receive up to 100 percent of expenses from a combination of the primary and secondary plans.

Maintenance of Benefits - Maintenance of benefits (MOB) reduces covered charges by the amount the primary plan has paid, and then applies the plan deductible and co-insurance criteria. Consequently, the plan pays less than it would under a traditional COB arrangement, and the beneficiary is typically left with some cost sharing.

Carve out - Carve out is a coordination method which first calculates the normal plan benefits that would be paid, then reduces this amount by the amount paid by the primary plan.

Nonduplication COB - In the case of nonduplication COB, if the primary carrier paid the same or more than what the secondary carrier would have paid if it had been primary, then the secondary carrier is not responsible for any payment at all. Nonduplication is typically used in self-funded dental plans. A self-funded dental plan is a plan in which the plan sponsor bears the entire risk of utilization.

Self-funded plans are exempt from state insurance statutes and are generally governed by federal legislation known as the Employee Retirement Income Security Act (ERISA). In 2012,

49% of people with a dental benefit had a self-funded plan.[1] It is important that dental offices understand that not all patients will have a dental plan that is subject to your state's COB laws. ADA policy opposes nonduplication provisions and at least one state, California, has enacted legislation prohibiting such provisions.

Network Plan Write-Offs

The difference between the dentist's full fee and the sum of all dental benefit plan payments and patient payments is the amount of the write-off. Write-offs should not be posted until all plans have paid accordingly. If a write-off is posted after the primary pays and then posted again based on the secondary payment, it is possible the dental office may incorrectly apply a credit to the patients' balance. Remember to always submit your full fee on the dental claim form.

Medicaid, Medicare and Coordination of Benefits

By law, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid.[2] Thus, Medicaid is typically secondary to any other benefit plan.

In cases that involve a patient presenting with a retiree plan, Medicare and the patient has coverage on a spouse's plan, generally any dependent coverage pays first, Medicare pays second and any non-dependent coverage (e.g. retiree coverage) pays third.[3]

National Association of Insurance Commissioners (NAIC)

The NAIC has drafted model regulation on coordination of benefits and recommends that states pass similar legislation so that benefits can be coordinated uniformly across states. The ADA supports this also and recommends that state dental association's attempt to pass similar legislation. The NAIC model regulation can be found at: http://www.naic.org/store/free/MDL-120.pdf

Affordable Care Act and its Impact on COB

Contrary to many myths, the Affordable Care Act did little to address claims submission and coordination of benefits (COB) arising from dental benefits embedded in medical plans and sold through the Federal and State Marketplaces. Thus, coordination of benefits and claims submission is handled the same as it was prior to the implementation of the Affordable Care Act.

The following information should help dental offices navigating the COB maze in the context of the ACA.

Billing to Medical Plans

Dentists will continue to submit the dental claim form along with Current Dental Terminology (CDT) codes to these plans. Even though the covered benefits are not necessarily the same as regular dental plans, the claims process remains the same.

Coordination of Benefits

For routine dental billing to two medical plans with embedded dental benefits, billing will be no different than it is now and any coordination should be attempted in the usual way (a determination of who the

[1] NADP Purchaser Behavior Survey, September 2011

[2] Accessed from: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/TPL-COB-Page.html

[3] Model Regulation Service - October 2013, Coordination of Benefits Model Regulation, National Association of Insurance Commissioners, pg. 8.

primary payer is and then a copy of the explanation of benefits (EOB) statement submitted with the claim to the secondary payer).

How is the primary coverage determined between a medical plan and a stand-alone dental plan? The usual primary coverage determination rules would apply. In California, Exchange contracts call for the embedded dental plan to always be primary and the standalone plan to pay secondary – this may vary by state. Keep in mind that some embedded plans may utilize a closed panel network meaning that benefits will only be paid if services are provided by a network provider. In this case and if the closed panel plan was primary, the secondary would basically provide coverage as though it were primary.

As in the past, it is strongly recommended that the dental office (assuming the office files claims on behalf of the patient) verify primary/secondary coverage by calling the customer service number on the patient's identification card. If a dental office cannot determine which plan is primary, a call to the state insurance commissioner's office could be made to determine primary versus secondary.

Contracting with Medical Plans

Medical plans with embedded dental benefits have indicated that they will not require dentists to be credentialed under the medical plan(s). Fees are determined by the dental plan and if a dentist is under contract with the plan, then contracted dental fees apply. If the dental office has questions regarding participating provider status, it is recommended that the office call the plan's professional services department to obtain that information. Contact information for these departments can be found on the patient's identification card.

Current ADA Policy on Coordination of Benefits

Guidelines on Coordination of Benefits for Group Dental Plans (*Trans.*1996:685; 2009:423)

When a patient has coverage under two or more group dental plans the following rules should apply:

a. The coverage from those plans should be coordinated so that the patient receives the maximum allowable benefit from each plan.

b. The aggregate benefit should be more than that offered by any of the plans individually, allowing duplication of benefits up to the full fee for the dental services received.

Summary

Navigating the path of coordination of benefits can be a frustrating and time consuming endeavor for dental offices trying to settle accounts for patients with more than one dental benefits plan. In addition, state laws and regulations often mandate coordination of benefits. If after the claim payment has been made and it appears to have been incorrectly adjudicated it is recommended that the claim determination be appealed and if necessary the state insurance commissioner's office be contacted for assistance. This information along with state specific information on coordination of benefits, can be found by visiting the *member's only* resource, Center for Professional Success website (success.ada.org) or you may call ADA staff at 800-621-8099 for further assistance.