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TOP 10 CLAIM CONCERNS: ADA, NADP SHARE VIEWS ON DENTISTS' CONCERNS

The ADA Council on Dental Benefit Programs continually receives and addresses a variety of dental claim submission and adjudication questions from member dentists and practice staff. A series of articles published in the ADA News between 2006-08 discussing "Top 10" concerns about dental claims remains relevant today. The articles included perspectives from ADA members, National Association of Dental Plan members and the Council on Dental Benefit Programs.

COORDINATION OF BENEFITS

Dentist Perspective

The ADA policy is based on a simple premise, the patient should get the maximum allowable benefit from each plan. I n total the benefit should be more than that offered by any of the plans individually, but not such that the patient receives more than the total charges for the dental services received.

Increasingly, the ADA receives calls from dentists that indicate the secondary carrier refused any additional payment because it had the same benefit level as the primary carrier. These calls refer to a non-duplication provision in the policy. This provision seems unfair to the patient that paid two premiums for coverage but received no benefit from the second premium. ADA policy opposes non-duplication provisions and at least one state, California, has enacted legislation prohibiting such provisions.

It is also hard to find a consistent pattern in which carrier is primary and secondary. This is something the dentist has to determine because the secondary carrier requires an EOB from the primary carrier to process a claim. How can dentists get a consistent picture of who to go to first? ADA policy outlines the following steps in determining a primary carrier.

Dental benefits industry perspective

COB is regulated for group carriers licensed by the state, so it is largely standardized. The exceptions are for employer-sponsored and collectively bargained (labor union) plans.

ADA policy guidelines on COB are largely consistent with the most common state laws on COB. There are three main issues raised in the questions most often posed to the ADA about application of COB regulations – which carrier is primary, what fee governs the payment from the carriers and what does the dentist charge the patient? For state regulated carriers, state insurance regulations and contract law determine how these issues are handled. What follows is an overview of the National Association of Insurance Commissioner's Model Law on COB; most state laws follow this model.

Who pays first? Who pays second?
First, only group carriers are required to coordinate. So if one of the policies covering your patient is an individual policy, then it does not coordinate. Also if one of the group carriers is an employer-sponsored plan or a collectively bargained plan, it may set its own policy for coordination. Often employer sponsored plans have a non-duplication provision which states that the employer will not pay for benefits that are reimbursed by other insurance. This provision has been included in the calculation of the premium for these policies.

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- The plan covering the patient, other than as a dependent, is the primary plan.
- When both plans cover the patient as a dependent child, the plan of the parent whose birthday occurs first in a calendar year should be considered as primary.
- When a determination cannot be made in accordance with the above, the plan that has covered the patient for the longer time should be considered as primary.
- When one of the plans is a medical plan and the other is a dental plan, and a determination cannot be made in accordance with the above, the medical plan should be considered as primary.

There is also confusion when the carriers covering a patient provide different types of coverage—a capitation plan, a reduced fee plan and a full fee plan. Which fee is the charge to the patient based on? ADA policy states that dental offices should submit their usual fee, defined by ADA policy as "the fee which an individual dentist most frequently charges for a specific dental procedure," to a dental benefit plan. The benefit plan will adjudicate the claim based on its allowed fee schedules.

The Council on Dental Benefit Programs believes that if COB were standardized, dentists could better estimate the appropriate reimbursement.

When carriers are licensed by the state, like most dental carriers, state COB regulations provide guidelines by which the primary carrier and secondary carrier(s) are determined. Basically this guideline follows who is insured and how they are insured.

For dependent children, some states use the gender rule rather than the birthday rule, which makes the father's coverage primary. Check your state law before submitting claims for children. When there is a disagreement between carriers as to which rule applies, the gender rule is often used.

What is paid by the carrier: Allowable expenses

Once it is determined which company is the primary carrier and which company is the secondary carrier, claims can be processed. The primary carrier pays the claims as if there is no other insurance involved. The COB law requires the secondary carrier to calculate what the benefit would have been for the claim if there were no other carrier involved, but allows the secondary carrier to deduct the amount paid on the claim by the primary carrier from its payment. The secondary carrier then pays the claim up to 100 percent of the allowable expense if the benefit contained in the policy is great enough. So, if the dentist's charge for a procedure is $100, but the allowable expense is $80, the claim will be paid based on $80 being the maximum that can be paid.

There are two exceptions to this general rule. First, if the primary carrier is a dental health maintenance organization and the patient does not use a DHMO provider, the secondary carrier must pay the claim as if it were a primary carrier. As well, self-funded and collectively bargained employer groups operate under federal law and do not have to follow state COB laws. These groups often utilize non-duplication provisions to lower premiums. These provisions provide that the

insurer will not pay for benefits that are reimbursed by other insurance. Where these provisions are present in the patient's policy, there may not be any payment from the secondary carrier.

An allowable expense is defined as the usual and customary or maximum allowable expense for the dental service when the item is covered at least in part under any of the plans involved. When a covered person is covered by two or more carriers which determine benefits on the basis of usual and customary fees or maximum allowable expense, any amount in excess of the highest usual and customary or maximum allowable is not an allowable expense. When a covered person is covered by two or more carriers, which determine benefits on the basis of contracted fees, any fee in excess of the highest contracted fee is not an allowable expense.

What to charge the patient?
Coordination of benefits can be a win-win for both patients and dental practices. Patients with more than one dental benefits program from state licensed carriers are likely to visit their dentists more frequently, knowing all or at least a large majority of treatment costs will be covered by the combination of two programs. Out-of-pocket expenses for more complex and expensive procedures are reduced or sometimes even eliminated. And dental practices can receive payment in full for all treatment rendered when reimbursement from both plans is settled.

However, COB can be complicated and time consuming for both dental practices and insurance carriers. Based on inquiries to the ADA, one of the most confusing steps in a COB situation is: "What to charge the patient?" To begin, here are two general guidelines to determine what to charge the patient:

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	(1) Regardless of the COB situation, always submit the fees charged to the patient as submitted charges on claim forms. (Note: Discount plans are not subject to COB laws and regulations as they are not insurance products.) If this is not the usual fee but is discounted, include a statement regarding the discount provided. When processing the claims, the plan administrators will apply plan allowances. (2) The participating network contractual relationship with the patient's primary plan determines the amount that can be collected from the patient. If the primary carrier has no participating network contract with your office, and the secondary carrier does, then the network relationship with the secondary carrier determines the charges to the patient.