Billing Paper

American Association of Oral and Maxillofacial Surgeons

# Coordination of Benefits

## I. INTRODUCTION

The OMS has just removed 17-year-old Susan Smith's third molars. While Susan's surgery is covered by her parents' insurance, each parent has their own individual insurance plan. Does the staff understand the intricacies of coordination of benefits (COB), and how it is governed by state insurance laws?

Coordination of benefits exists to prevent over-payments and/or duplication of benefits when a patient is covered by more than one medical or dental plan. One carrier is designated as the primary carrier, and the secondary carrier calculates remaining costs not covered by the primary carrier. Coordination of benefits can be confusing, especially when it involves medical and dental benefits. Therefore, the OMS and their professional staff should become familiar with how their state's insurance laws address coordination of benefits. Working with a practice attorney or state insurance commissioner to clarify the intent of state laws will help address discrepancies with coordination of medical and dental benefits.

## II. COORDINATION OF BENEFITS

Without the existence of the Coordination of Benefits process, fraudulent or abusive billing practices – such as "double dipping" or "double billing" two or more insurance plans at the same time for full payment – may occur. Whether inadvertent or intentional, these occurrences could result in financial penalties and/or void any provider participation agreement if an overpayment to the carrier is not handled in a timely manner. In some cases, the provider may be excluded from federal programs, such as Medicare and Medicaid, as well as many commercial payers.

Because insurance plan contracts are between the carrier and the patient, some believe it is the patient's responsibility to determine the correct order of claim submission. While the policy holder (who may or may not be the patient) should know which plan is primary and which is secondary, this may not always be the case. Therefore, to assure prompt and proper payment, the OMS office should work with the insured to verify the order in which the claims should be submitted. This also is known as primary and secondary adjudication responsibility.

### General COB Considerations

For actively employed patients, the employer-sponsored plan is typically the primary payer. Self-funded plans may have limited or no COB provisions, and individually purchased policies often do not coordinate with other coverage. Whether these plans are HMOs or PPOs, and whether the doctor is in-network or out-of-network, can further complicate the COB process.

Employer group health plans typically coordinate benefits when a patient is covered by more than one plan. In general, if a patient is the primary policyholder on one plan and a dependent on another, the plan where the patient is the policyholder is considered primary, and the other plan is secondary. COBRA or retiree coverage is generally secondary to active employer-sponsored insurance. Liability insurance, such as workers' compensation, always pays before health insurance. If a patient has coverage through both an active employer plan and a retiree plan or COBRA, the active employer plan is primary. When a patient is covered under two active employer plans, the plan that has provided coverage for the longest period is usually primary. Medicaid is typically the payer of last resort and only pays after all other insurance plans have fulfilled their obligations. For retired patients covered under a spouse's plan, employers with 20 or more employees generally keep the employer plan as primary over Medicare. For employers with fewer than 20 employees, Medicare becomes the primary payer.

Medicare, Medicaid, TRICARE and some group employer plans may automatically coordinate benefits, but other plans – such as indemnity plans and plans purchased through state exchanges or on an individual basis – typically do not. Additional guidance on handling COB can be found on the CMS website at CMS.gov/Medicare/Coordination-Benefits-Recovery/Overview/Secondary-Payer and CMS.gov/Medicare/Coordination-Benefits-Recovery/Overview/Coordination-Benefits.

For dependent coverage, when a patient is a dependent of two insured parents, each with their own medical and/or dental plan, the Birthday Rule generally determines which plan is primary. Under this rule, the parent whose birthday (month and day, not year) falls earlier in the calendar year provides the primary coverage. For example, if Susan Smith's mother was born April 5 and her father Oct. 20, her mother's plan would be primary. If neither plan follows the Birthday Rule, some plans may apply the Gender Rule, which designates the father's plan as primary; however, this rule is largely outdated and rarely used.

If the parents are divorced, the court decree or parenting agreement should specify which parent's insurance is billed first. If the decree states joint custody without assigning responsibility for healthcare expenses, the standard order of benefit determination rules may apply. It is important that the OMS practice does not make this determination independently but follows the instructions in the legal documents. Court orders or state laws always supersede the Birthday Rule, Gender Rule or any other standard coordination of benefits guidelines.

The National Association of Insurance Commissioners (NAIC) has developed Coordination of Benefits model regulation which is aimed at establishing a uniform order of benefit determination under which plans pay claims. According to NAIC, when a person is covered by multiple plans, the primary plan pays benefits as if no other coverage exists, and secondary plans calculate their payments based on the primary plan's benefits and allowable expenses. If a plan does not follow the NAIC order of benefit determination rules, it is considered the primary plan unless both plans agree otherwise. It should be noted, however, that only some carriers abide by these guidelines.

Under the Affordable Care Act, pediatric dental coverage is an essential health benefit and must be offered on state and federal exchanges, either embedded in a medical plan or as a standalone dental plan. While consumers are not required to purchase dental coverage in most states, they must be given the option. Many carriers embed dental benefits in medical plans, though standalone dental plans are also common, and rules vary by state. For example, California directs embedded dental coverage to be primary and standalone dental coverage to be secondary. Coordination of benefits is intended to be automated but often requires manual processing.

Furthermore, some embedded plans or even standalone plans may utilize a closed panel provider network in which benefits will only be paid if services are rendered by a network provider. If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan may pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

Because state laws and provider contracts vary, each oral and maxillofacial surgery practice should be familiar with state insurance laws and payer policies related to coordination of benefits. There is no official rule of thumb when determining which to bill first if neither the medical plan nor dental plan has a coordination of benefits clause and if there is no direction from state insurance laws. If neither plan says it will coordinate or agree to be secondary, the nature of the patient's condition may be the determining factor. For example, a jaw fracture may typically be billed only to medical, while a biopsy may be billed to dental and/or medical. In this instance, billing medical first may be appropriate. In the case of the biopsy, it is important to consider whether the deductible has been met and the copayment (if medical) is billed first. If dental is chosen, the office should verify that the dental benefit has not been maximized. According to the Office of Inspector General, simultaneously filing claims to either dental and medical carriers, two dental plans or a combination of these scenarios – while tempting – is not appropriate and is referred to as double-billing and considered fraudulent. Generally, write-offs should not be posted until all plans have paid their portion. If a write-off is posted after payment is received from the primary and then posted again based on the secondary payment, it is possible the practice may incorrectly apply a credit to the patient's account.

If an overpayment is made (i.e., the office collects more money than was billed), it is important to understand that the OMS practice is not entitled to more than the OMS's standard fee or what is contractually allowed. Every attempt should be made to work with the insurance companies

involved to determine how to handle the overpayment or refund. Provider contracts may outline the handling of overpayments as well as timelines in which overpayments must be returned. Some may indicate that the doctor may accept reimbursement exceeding the contractual allowed amount if the overpayment is received by another insurance plan, while others may strictly prohibit collecting more than the contractual allowed amount. If the contract does not specify and the insurance plan refuses to accept the refund, it may be best to return the money to the responsible party, parent or patient, regardless of participation status. Although, AAOMS strongly recommends consulting with a practice consultant or an attorney for advice on the proper handling of overpayments. When returning overpayments to either a carrier or a patient, detailed timelines, correspondence – including any attempt to seek direction from a carrier – should be carefully documented and include all facts before reimbursing the primary beneficiary.

Additional COB resources are available on the AAOMS website, including Coordinating Your Patient's Benefits, Post-payment Audits and Refund Requests and the Health Policy Perspectives column in the July/August 2025 edition of *AAOMS Today*.



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