Breaking down double billing and coordinating

Coordination of benefits (COB) can be a confusing topic and oftentimes leaves OMSs and their staff without a definitive answer as to how to proceed with filing claims.

COB is the practice of determining (or coordinating) the order of insurance benefits when a patient is entitled to benefits from more than one insurance plan. COB determines the respective payment responsibilities for each plan and ensures the amount paid does not exceed 100 percent of the doctor's charges or contracted allowed amounts to avoid duplicate or over payments.

Determining COB may be a daunting task, especially when both dental and medical benefits are involved. Because state laws and provider contracts vary, each OMS practice should be familiar with state insurance laws and payer policies related to COB. No official rule determines which insurer to bill first when no direction from state insurance laws is given or if neither the medical plan nor the dental plan has a COB clause. Therefore, OMS offices need to treat each plan individually and confirm with each payer its particular COB processes and policies.

'Double billing'

Without the existence of COB guidelines, fraudulent or abusive billing practices – such as "double dipping" or "double billing" – may occur. Duplicate billing occurs when more than one claim for the same service is submitted, or the claim is submitted to more than one primary payer at the same time.

Although duplicate billing can occur due to simple error, intentional duplicate billing can create liability under criminal, civil or administrative law, particularly if an overpayment is not refunded in a timely manner. It also can lead to termination of a provider participation agreement. To avoid duplicate billing, it is important to determine which payer is primary and secondary, and file claims according to payer guidance.

Because the type of insurance benefits offered or selected 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 policyholder – 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 the claims should be submitted. This also is known as primary and secondary adjudication responsibility.

General COB rules

- **Employee or main policyholder:** Plan is designated as the primary insurance.
- **Patient enrolled as a dependent:** Plan is deemed secondary.
- **Patient with more than one employer:** Plan that has covered the patient the longest is primary. Note: A change in carrier does not change this rule.
- **Dependent children:** The Birthday Rule typically determines which plan is primary. The Birthday Rule

benefits with more than one payer

identifies the primary insurer as the parent whose birthday (month and day) falls first in the calendar year. *Example:* The father of a patient was born April 5, 1967, and the mother was born August 22, 1963. According to the Birthday Rule, the father's insurance would be primary.

Some insurance payers may not follow the Birthday Rule and instead follow the Gender Rule, which declares the father's insurance company as primary. If the parents are divorced, the divorce agreement or court decree supersedes any birthday, gender or state law. If both parents have medical and dental coverage, the same rules apply: one parent at a time.

What some plans do

Medicare, Medicaid, TRICARE and some group employer plans may automatically coordinate benefits, but other plans – such as indemnity plans, or plans purchased through the state exchanges or on an individual basis – typically do not. Guidance can be found on the CMS webpages for Medicare Secondary Payer and Coordination of Benefits and Recovery Overview.

Moreover, with the passage of the Affordable Care Act and implementation of state insurance exchanges, "essential benefits" – such as dental coverage for children – must be offered by plans in the exchange. While not required to be purchased in all states, dental benefits must be offered to the purchaser as an option to include.

Standalone and embedded plans

More plans are beginning to offer standalone dental plans, but it is not uncommon for the carrier to embed dental benefits into a medical plan. In California, for example, insurance exchange contracts consider the embedded dental plan to always be primary and the standalone dental plan to be secondary.

Some embedded plans or even standalone plans may use a closed panel provider network where benefits will be paid only 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 patient uses a non-panel provider, except for emergency services or authorized referrals paid or provided by the primary plan.

Patient's condition

If neither plan coordinating benefits agrees to be secondary, the nature of the patient's condition may be the determining factor. For example, a jaw fracture would typically be billed only to a medical carrier, while a biopsy may be billed to a dental and/or medical carrier. 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 the medical carrier is billed first. If the choice is to bill the dental carrier first, verify the dental benefit has not been maximized.

Overpayment

If an overpayment is made to the practice, the plans likely did not coordinate benefits. Every attempt should be made to work with the insurance companies involved to determine how to handle the overpayment or refund. Provider contracts also may dictate the handling of overpayments. Some contracts are written so the doctor may accept reimbursement exceeding the contractual allowed amount if the overpayment is received from another insurance plan, while others may strictly prohibit collecting more than the contractually allowed amount.

A practice consultant or an attorney can provide guidance on properly handling overpayments. When returning overpayments to a carrier or a patient, detailed timelines and correspondence – including any attempt to seek direction from a carrier – should be carefully documented before issuing the reimbursement. ■