

How to effectively manage coordination of

The process of coordination of benefits (COB) exists to prevent overpayments and duplication of benefits when a patient is covered by more than one medical or dental plan. Medical and dental insurance often have distinct rules that may not align. Also, factors such as the surgeon's participation status, state insurance laws and the type of benefits purchased can complicate coordination.

General coordination of benefits rules

When managing COB and navigating various scenarios, consider these key points:

- **Overpayment prevention:** COB ensures the total payment from all plans does not exceed the actual cost of services, avoiding duplication or overpayment.
- **Dependent children coverage:** When both parents provide coverage, the "birthday rule" assigns the plan of the parent whose birthday occurs first in the year as primary. For divorced or separated parents, the custodial parent's plan is usually primary unless a court order dictates otherwise.
- **Employer-sponsored vs. individually purchased coverage:** For actively employed patients, their employer-sponsored plan is typically primary. Self-funded plans may have limited or no COB provisions, and individually purchased policies often do not coordinate with others. Whether these plans are HMOs or PPOs and whether the doctor is in network or out-network may further complicate the COB process. For retired patients covered under a spouse's plan:
 - *Employers with 20+ employees:* The employer plan remains primary over Medicare.
 - *Employers with fewer than 20 employees:* Medicare becomes the primary payer.
- **Medicaid as payer of last resort:** Medicaid only pays after all other insurance plans have fulfilled their obligations.
- **Other scenarios:** COBRA or retiree coverage is generally secondary to active employer-sponsored insurance. Liability insurance, such as workers' compensation, always pays before health insurance.

- **State-specific rules:** Thirty-three states have coordination of benefit laws, but only Nevada addresses coordination between medical and dental benefits. Some state laws may mandate that plans without COB provisions act as the primary insurer or set timelines for recouping overpayments.

COB best practices

Efficient and accurate COB in a healthcare setting involves the following best practices:

- **Collect accurate information:** Obtain detailed insurance information from the patient, including all the names of all medical and dental benefit plans and the order of benefits (primary, secondary, tertiary, etc.).
- **Verify and confirm benefits:** If available, use online portals or real-time systems to confirm eligibility, coverage, co-pays, deductibles and pre-authorization requirements. If these tools are not available or the information provided lacks granularity, contact insurers directly for details on overlapping medical and dental coverage, exclusions or carve-out provisions.
- **Educate staff:** Train office staff on COB procedures, coverage overlaps and managed care contract terms. This helps staff guide patients on expected costs and manage contract adjustments or refunds efficiently.
- **Follow proper order of benefits:** Submit claims to the correct insurer first to avoid overpayments or denials. When plans lack coordination, the nature of the condition may determine the primary payer. For instance, a jaw fracture typically falls under medical coverage, whereas a biopsy may be billed to both medical and dental; if the plans do not coordinate, billing medical first may be appropriate.
- **Contract adjustments and overpayments:** Managed care contracts often restrict doctors from collecting more than the payer's allowed amount specified in the agreement. Overpayments may occur if a surgeon is contracted with multiple plans and the plans do not coordinate. The total to which the surgeon is entitled may default to the lesser of the contracted rates unless the contract explicitly permits payment above the allowed amount from a different insurer.



benefits to prevent overpayment and errors

Mismanagement of these adjustments can result in accusations of fraud or violation of contract terms. To address this, providers' contracts may outline refund protocols and timelines. It is essential to know contract terms and the payer's overpayment processes and thoroughly document all interactions, timelines and attempts to obtain payer instructions before issuing refunds.



Common COB mistakes

Be mindful of these common pitfalls to ensure accurate billing in the COB process:

- **Failing to verify insurers:** Not confirming the primary insurer can lead to claim denials or delays.
- **Double dipping:** Sending claims to primary and secondary insurers at the same time can be considered fraudulent and can lead to denial of claims, cancellation of policies, repayment demands, hefty fines or even criminal charges.
- **Submitting claims out of order:** Sending claims to the secondary insurer before the primary insurer processes the claims may result in rejection or complications.
- **Overlooking plan exclusions:** Skipping a review of coverage details can cause misunderstandings about what each plan covers.
- **Neglecting preauthorization:** Failing to secure required prior approvals can lead to claim denials.
- **Using incorrect codes:** Inaccurate or incomplete procedure coding can lead to claim delays, denials or underpayments. Ensure codes submitted accurately and appropriately reflect the services provided.
- **Assuming automatic coordination:** Do not assume medical and dental plans will automatically coordinate benefits. Clarify responsibilities with insurers proactively.
- **Ignoring documentation requirements:** Provide all necessary documents to payers, such as an operative report or narrative when applicable, or provide the

explanation of benefits (EOB) to secondary payers to avoid slowing down claims.

- **Skipping communication:** Failure to contact insurers for clarification on complex cases – like overlapping medical and dental coverage – can lead to errors or missed benefits.
- **Not educating patients:** Patients often misunderstand their benefits, resulting in confusion over out-of-pocket costs. Clear communication helps prevent surprises.
- **Lacking a standard workflow:** Practices without a defined process for verifying eligibility, submitting claims and managing COB are more prone to errors and inefficiencies.

For additional resources, refer to the Coordination of Benefits Billing paper at [AAOMS.org/publications/position-papers/coding-billing-papers](https://www.aaoms.org/publications/position-papers/coding-billing-papers) and the webpage [Coordinating Your Patient's Benefits at AAOMS.org/practice/practice-management/coding-reimbursement/reimbursement](https://www.aaoms.org/practice/practice-management/coding-reimbursement/reimbursement). ■