DELTA DENTAL®

Coordination of Benefits

How to proceed when your patients are covered under more than one dental plan.

What is Coordination of Benefits (COB)?

Coordination of Benefits occurs when a patient has dental coverage under two plans, and the coverage from both plans is coordinated so that the patient receives the maximum allowable benefits under each one. The combined benefit should not exceed the submitted charges for the completed dental services.

Determining which plan is primary

- Subscribers are always primary for themselves.
- If the spouse has coverage, they are secondary on the subscriber's coverage and primary for themselves.
- The children's coverage is based on the Birthday Rule. The Birthday Rule is defined as the parent whose birthday (month and day) falls first in the year (not necessarily the oldest parent). The plan of the parent whose birthday is first in the year is primary for the child(ren). If both parents have the same month and day of birth, then the plan in effect the longest is considered the primary plan.
- Court orders may override the above rules regarding which parent is primary for the child(ren).

How do I submit my claims?

- Submit the claim with your full fee (regular office fee) to the primary carrier. After you receive the Explanation of Benefits (EOB) from the first carrier, submit the claim to the secondary carrier (again with your full fee) with a copy of the EOB from the primary carrier.
- After you receive the EOB from the secondary carrier, then and only then, should you determine the patient balance and/or write off.

Things to remember

- Do not determine an adjustment until after you receive the secondary EOB. The secondary payment may cover all or part of the adjustment.
- Not all COB will result in your office receiving the maximum plan allowance or your submitted fee (whichever is less). Therefore, you still may have to make an adjustment (take a write off).

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Calculating the Patient Balance/ Write Off

It can be confusing trying to determine the patient balance and/or write off in a COB situation. To help you figure that out, the following information is from an edition of Insurance Solutions Newsletter that many offices have found helpful.

When submitting a claim for a patient with more than one dental plan, the dentist should always bill his or her full fees and have the carriers determine their payable benefits. If the primary plan is a PPO or a reduced fee schedule plan and the secondary is a traditional plan, the secondary plan may limit the allowable fee to the PPO plan's fee. However, many traditional plans coordinate up to their full allowable fees even when coordinating with a PPO or a reduced fee schedule plan. Through Coordination of Benefits, the provider can potentially collect more than his or her lowest contracted fee. If, however, the claim is not paid in full between the two carriers, the most the dental office can balance bill the patient is the unpaid amount up to the lowest contracted fee. This is the case regardless of whether the plan with the lowest contracted fee is primary or secondary.

The following instructions show how to calculate the write off if a provider is contracted with one or more dental plans:

1. Ignore the write off information on both EOBs.

2. Enter the information below:
   A. What is the dentist's full fee submitted on the claim(s)? $_____
   B. What is the lowest contracted fee? $_____
   C. What is the total amount paid by both plans? $_____

3. If C is more than B:
The patient owes nothing. A contracted dentist must write off the difference between A and C (A minus C = dentist's write off).

4. If C is less than B:
The patient owes the difference between B and C (B minus C = patient responsibility). A contracted dentist must write off the difference between A and B. (A minus B = contracted dentist's write off)

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