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"A prisoner set free!"

Be Paid, Protected, and Prosperous

When is the last time you ran a report of all patient accounts with credit balances? If you can't remember how long it has been, you may be in for quite a shock if you are a participating provider for one or more dental plans. Participating providers often write off too much money when patients have multiple insurance plans.

Running a report of accounts with credit balances can be a quick way to determine if you are writing off too much money. If you notice that a significant number of credit-balance accounts have multiple insurance plans, pull the EOBs for these accounts and recalculate the write-off using the formula at the end of this article. If you determine that money was written off in error, then reverse part or all of the write-off.

If you routinely send refund checks to patients with credit balances, your credit balance report will not reveal the problem. Instead, you will need to review the accounts of patients with multiple plans to see if insurance write-offs have created credit balances at some point. If so, you may be calculating write-offs incorrectly. This could be costing your practice thousands of dollars each year if you participate in several dental insurance networks.

Writing off too much money is a significant problem for participating providers all around the country. Unfortunately, some patients actually make money on their dentistry, which is not the goal of coordination of benefits. All too often, a staff member posts a write-off based on the amount specified on the contracted primary plan's EOB, the secondary coordinates up to the dentist's full fee (which creates a credit on the patient's account), and the dental practice then sends an overpayment refund check to the patient. These patients, of course, are thrilled to receive what is actually the dentist's money.

When calculating patient responsibility and provider write-offs, keep the following in mind:

1. Never take a write-off until all insurance/benefit plans have paid.
2. Do not trust the write-off information on EOBs. Do your own math.
3. Patients are never responsible for more than their lowest contracted fee for covered services (plus any noncovered services) minus what both/all plans have paid.
4. Participating dentists can accept up to their full fee from multiple insurance plans if that is how a secondary plan calculates its payment responsibility (even though patients are only responsible for the lowest contracted fee).

Note: It can be difficult to predict how much the secondary dental plan will pay because some coordinate up to the dentist's full fee, some coordinate up to the primary plan's allowable fee, and some coordinate up to the highest allowable fee.

5. As a general rule, patients should not make money on their dentistry.

Note: An exception may occur when a patient has an individual dental plan such as AFLAC, which does not coordinate benefits. Group plans typically do not coordinate benefits with individual plans. If this is the case, AFLAC is considered a supplemental dental plan and any overpayment by AFLAC goes to the patient. However, some group plans now coordinate with individual plans. When this is the case, AFLAC is considered primary because it does not coordinate benefits. If the AFLAC payment combined with the secondary plan's payment totals more than the dentist's full fee, then the overpayment should be returned to the secondary plan, not the patient.

Why don't all dental plans coordinate benefits the same?

The reason carriers vary in how they coordinate benefits is because there is no single set of rules that regulate all dental plans. Some dental plans are regulated by state insurance laws, while others are regulated by the U.S. Department of Labor under the Employee Retirement and Income Security Act (ERISA).

State Insurance Regulations:

State insurance laws only regulate fully insured indemnity dental plans (i.e., the insurance company is at-risk for the cost of claims) that are sold in that particular state. State laws often define how much time a fully insured plan has to pay a claim, the limitations for requesting a refund, and the fee that must be considered when coordinating benefits. These laws vary widely from state to state. To understand why it is so difficult to anticipate how much the secondary carrier will pay, consider the following:

- Some states require dental plans to coordinate up to the dentist's full fee,
- Some states require plans to coordinate up to the primary plan's allowable fee,
- Some states require plans to coordinate up to the highest allowable fee,
- Some states have no coordination of benefits (COB) regulations,
- Some states only require coordination between group dental plans, and
- Some states require coordination between group and individual plans.

ERISA Regulations:

ERISA regulates self-funded dental plans (the employer is at-risk for the cost of claims). However, ERISA has no COB requirements and leaves it up to the dental plans to fight it out (and sometimes they do). Because there are no COB requirements, self-funded dental plans often follow their local COB laws, which, as you can see above, vary widely from state to state.

The Bottom Line:

Patients are responsible for your full fee unless you are obligated to honor a reduced fee as part of a dental network. Network patients are only responsible for their lowest contracted fee even though you may accept up to your full fee if that is how the secondary plan coordinates benefits. When a patient has multiple plans, never post a write-off until all plans have paid, and never trust the write-off information on the EOB.