Information for Providers: Dental Insurance Plans and Coordination of Benefits

Common Types of Dental Insurance Plans

Indemnity Plan - Patients receive treatment from their dentist on a fee-for-service basis, and a claim is submitted and reimbursed based on services performed. The levels of coverage on this type of plan are commonly set at 100% for preventative, 80% for restorative and 50% for major dental services. Limitations for coverage under this type of plan are annual maximums and deductibles. Patients can usually choose their provider.

Capitation Plan (Dental DHMO's) - An arrangement between a dentist and a DHMO carrier in which the dentist contracts to provide dental services to members. The dentist is paid a monthly fee based on patients who have selected him or her. In return, the dentist provides any needed dental services for the patient during the contracted time frame. There will be plan requirements and allowances that determine procedures allowed. The network of dental providers for this type of plan can be smaller and limited.

Preferred Provider Organization (PPO) – Participation in this type of plan requires a dentist to sign a contract with the plan and agree to the contractual requirements, which generally involves a significant fee reduction for services performed and limitations on covered services. Patients with this type of plan do not always NEED to see a PPO contracted dentist, but they often experience lower benefits or higher deductibles should they choose to go "out of network". This type of plan will also be subject to annual maximums, deductibles and varied coverage levels for services.

Coordination of Benefits between Primary and Secondary Insurance

In Minnesota, there is state guidance on the coordination of insurance benefits between primary and secondary insurance payers. Per Minnesota Statutes **4685.0915 COORDINATION OF BENEFITS; PROCEDURES:** The primary plan must pay or provide its benefits as if the secondary plan or plans do not exist. This applies to plans without a coordination provision.

Are there exceptions? Plans can have different coordination provisions; self-insured plans have different arrangements and some plans will have a non-duplication benefit clause. In non-duplication situations, the secondary may not pay any additional amounts if the primary paid the allowed percentage.

Non- Duplication of Benefits Example
Primary insurance allowed and paid 50% of charges; secondary insurance also would allow 50% for service, but, under a non- duplication provision, no additional payments are made.

How do you determine how much (if any) the patient owes for the bill? Historically, the ADA, in coordination with the National Association of Insurance Commissioners, has provided guidance on this subject (see references).

In an example of a contracted dentist providing services to a patient with a PPO type of plan for primary coverage, the PPO fee will be the dentist's fee for the services performed. The secondary plan will consider coverage based on the difference between the primary plan's allowed fee and what the primary paid toward the service. If a full-fee indemnity plan is primary and the PPO plan is secondary, the primary plan should pay its allowed amount for the service and the

secondary discount plan should pay the lesser of its allowed benefit or the balance of the full fee.

Coordinating benefits between capitation and indemnity plans can be tricky for providers. The ADA has also issued guidance in these situations (see references) For instance, when the capitation plan is primary, payments to the dentist remain at the usual benefit. As a secondary carrier, the indemnity plan should pay for any copayments up to its allowable benefit.

If the indemnity plan is the primary plan, it should pay accordingly and the capitation plan would be secondary and responsible for benefits up to the contracted amount with the capitated provider. If a dentist is not participating in the capitation plan, the indemnity plan would pay as normal and the capitation plan would pay an out of network benefit if applicable. Sometimes the patient will not receive additional benefit if they have services by a non-DHMO provider.

Important Points to Consider:

There is no single set of rules that apply to all COB situations. A dentist should not have write offs and payments that exceed 100% in coordination of benefit situations. Adjustments may need to be calculated. You cannot always rely on the Explanation of Benefits to reveal the correct write off amount.

Please feel free to call the MDA with questions on dental insurance: Bridgett Anderson at 612-767-4256. Also, the American Dental Association Dental Benefit Information Service 1-800-621-8099 can provide guidance and more information.

References

[1]ADA/NADP Share Views on Coordination of Benefits
ADA Dental Benefit Plan Models http://www.ada.org/6261.aspx