Regence

Dental Manual

A Dental Administrative Guide

2025

This publication is subject to periodical revisions and additions. Future inserts will be sent to you if necessary. For questions about these materials, please contact your network manager.

Dear Participating Dental Provider:

We are excited to provide you with the Regence BlueShield of Idaho (“Regence”) *Dental Manual*, an administrative guide to assist you and your staff in servicing our Members.

This *Dental Manual*, along with the *CDT Dental Procedure Guidelines*, provide a comprehensive, single-reference source for many of the policies and procedures necessary to support your practice when doing business with us. The *Dental Manual* is an accompaniment to your Participating Dental Agreement, which provides comprehensive details regarding the terms of your Participating Dental Agreement. Both the *Dental Manual* and the *CDT Dental Procedure Guidelines* are located on our website at **regencedental.com**.

Your dedicated network manager is available to assist you with any questions you have relating to your Agreement, the *Dental Manual* or the *CDT Dental Procedure Guidelines*.

Thank you for the role you and your staff play in providing a positive experience for our Members who are seeking solutions for their dental health. From time to time, you can expect to see updates to this *Dental Manual* to keep you apprised of changes and additional information as it becomes available. If you have any suggestions for what you would like to see included in the *Dental Manual*, please email our Provider Relations team at **DentalProviderRelations@regencedental.com**.

We appreciate the quality service you provide our Members and look forward to continuing our relationship with you and your staff.

Sincerely,

Vice President Provider Networks

Table of Contents

Section 1: Definitions

The definitions of capitalized terms that are not otherwise defined in the body of the Agreement are set forth in this section of the *Dental Manual*.

Appeal	The process used to review an adverse determination. The process may also be known as a request for reconsideration of an adverse determination.
Billed Charges	The amount you bill for a specific dental service or procedure(s).
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the Department of Health and Human Services responsible for the administration of Medicare. CMS language may be different than conventional insurance contracts.
Clean Claim	A claim for Covered Services that is submitted for adjudication in accordance with applicable terms and conditions of this *Dental Manual*. A claim is considered clean when it requires no further information, adjustment, or alteration in order to be processed and paid by the Responsible Payor.
Coordination of Benefits (COB)	The determination of which Responsible Payors have primary and secondary responsibilities for paying for Covered Services in accordance with the rules set forth in the Member Contract when that Member is eligible for Covered Services from more than one Responsible Payor, including from a governmental or self-funded Responsible Payor.
Cost-Share	Any and all charges that a Participating Dental Provider may collect directly from a Member in accordance with the terms of the Member Contract which includes Copayments, Deductibles, or Coinsurance.
Covered Services	Dental services and supplies for which benefits are provided under a Member Contract.
Dental Benefits	Those covered dental services and supplies, together with exclusions and limitations, as set forth in the applicable Member Contract.
Dental Manual	This document, which sets forth the policies, procedures, and requirements applicable to Participating Dental Providers providing dental services to Members.
Dependent	A Member who is eligible and enrolled in a Member Contract based upon his or her relationship with a Subscriber.
Emergency Dental Care	Dental services necessary to treat a sudden onset and severity of a dental condition that leads to an immediate dental procedure to relieve pain or eliminate infection.
EOB	Explanation of benefits.
Grievance	Dissatisfaction from or on the behalf of an enrollee or dental service provider about any action taken by Regence.
HIPAA	The Health Insurance Portability and Accountability Act of 1996 and its implementing regulations.
Insured	Each individual covered under a Member Contract.
Late Claim	The submission of a claim for Covered Services to Regence, more than 90 days (three months) from the date of service or the completion of a course of treatment. Regence

	may deny a Late Claim unless it determines, at its discretion, that there was good cause for the delay in submitting that claim.
Medicare Advantage (MA) Plan	Regence, a Medicare Advantage Organization offering Medicare Advantage programs through a MA contract.
Member Payments	Any and all charges that a dentist may collect directly from a Member in accordance with the terms of the Member Contract which include Copayments, Deductibles or Coinsurance.
National Provider Identifier (NPI)	The government-issued, 10-digit identification number for individual health care providers and entities.
Non-Reimbursable Services	Services that would have been Covered Services but for the fact that the Participating Dental Provider: 1. Rendered services that were not necessary and appropriate; or 2. Failed to comply with applicable requirements of the *Dental Manual* in connection with the provision of such services; or 3. Failed to submit a claim for such services within the submission deadlines established by the applicable *Dental Manual*.
Participating Dental Agreement	The document that defines the contractual rights and obligations between you as a Participating Dental Provider and Regence for your participation in the Participating Dental Network which is made up of your standard contract.
Participating Dental Providers	Those Dental Providers who meet minimum participation standards as set forth in this Agreement, have been credentialed under Regence's credentialing policies and have signed a Participating Dental Provider Agreement with Regence.
Participating Dental Network	The Regence dental network dental provider contracts with.
Practitioner Credentialing Application	The form that a dentist has completed setting forth requested information concerning his or her professional qualifications, experience, and other relevant credentialing information.
Provider Network	The group of Participating Dental Providers who contract with Regence to render Covered Services to Members.
Plan	A Regence Dental Plan.
Pre-authorization	A Participating Dental Provider's submission of information to the Responsible Payor prior to rendering services, for advanced written approval for planned services for medically necessary treatment. Pre-authorization is subject to: • the accuracy and completeness of the Participating Dental Provider's submission of information, • Medical Necessity, • the Member's eligibility at the time services are rendered, • the Responsible Payor's allowed payment for such services, and • the terms of the Member Contract at the time services are rendered.
Predetermination	A Predetermination of benefits is a request for services submitted by a Participating Dental Provider to the Responsible Payor prior to rendering those services to determine if they are Covered Services. In addition, the Responsible Payor will also

	determine whether any Dental Allowable Amount, Copayment, Coinsurance and Deductible apply. A Predetermination of benefits is not a commitment and does not create any obligation to pay any amount for services rendered. A Predetermination is subject to: 1. the accuracy and completeness of the Participating Dental Provider's submission of information, such services being necessary and appropriate, 2. the Member's eligibility at the time services are rendered, 3. the Responsible Payor's allowed payment for such services, and 4. the terms of the Member's Contract at the time services are rendered.
Responsible Payor	The Plan responsible for paying benefits for Covered Services rendered to a Member.
State	The State of Idaho.
Subscriber	A Member who is eligible and enrolled in a Member Contract as an individual or as an employee or primary Member of an account.
Unbundling of Procedures	The "unbundling" of charges has been recognized on a national level as a contributing factor to the increasing cost of health care. Examples of unbundling include the use of more than one procedure code to bill for a procedure that can be adequately described by a lesser number of codes, filing for services that are an integral part of a procedure, and filing for procedures (such as "sterilization," services, or supplies) that are required in rendering dental services. When these and other unbundled claims are identified, partial denials of payment or refund request will result.
Utilization Management Program	The review process used to evaluate if services rendered to Members are necessary and appropriate.

Section 2: Contact Information

At Regence, one of our most important goals is to nurture a relationship with you defined by mutual respect and responsiveness. Please do not hesitate to contact us with any questions.

Claims and Customer Service Contact Information

Plan	Schedule of Allowances	Customer Service	Claims Address
Regence	Participating Fee Schedule	1(800)253-0838	Regence P.O. Box 1106 Lewiston, ID 83501-1106
Medicare Advantage	Medicare Advantage Fee Schedule	1(800)253-0838	Regence P.O. Box 1827 Medford, OR 97501
Federal Employee Program	FEP Fee Schedule	1(877)668-4656	Regence FEP P.O. Box 857 Lewiston, ID 83501-0857

Your Network Manager

As a Participating Dental Provider, you have a dedicated network manager available to provide support. Please do not hesitate to contact us with any questions about your Agreement by contacting our team at **DentalProviderRelations@regencedental.com**. The network manager for your territory will respond to you.

Section 3: Participating Dental Provider’s Responsibilities

Participating Dental Provider’s Responsibilities

As a Participating Dental Provider, you are solely responsible for making treatment recommendations and decisions for your Members. You are also responsible for ensuring that all claims you submit are accurate, complete and adhere to the claims filing and coding policies of Regence.

Regence's Responsibilities

Regence will not interfere with your judgment with respect to a Member’s treatment or the Participating Dental Provider/Member relationship. However, we do reserve the authority to make eligibility and coverage determinations and to make claims-processing decisions that may include re-bundling or down-coding. You can find additional information on claim edits in the *CDT Guide* at the end of this *Dental Manual*.

Section 4: Working with Regence

What We Offer You

At Regence, we are committed to helping you provide the best care to our Members and manage a successful business practice. We have built a reputation based on trust and excellent customer service, the same qualities you deliver to our Members. We offer:

- Fast, reliable, and direct electronic claims-processing.
- Dedicated provider network managers.
- Competitive reimbursement rates driven by the market.
- Online *Dental Manual* to assist providers with basic questions.
- The Regence Participating Dental network and the Regence Medicare Advantage Dental network.
- A listing in our online provider directory, which Members can use to search for providers by location, specialty, gender, or language. Visit the directory at **regencedental.com**.

Section 5: Conditions of Participation in Our Networks

Conditions of Participation

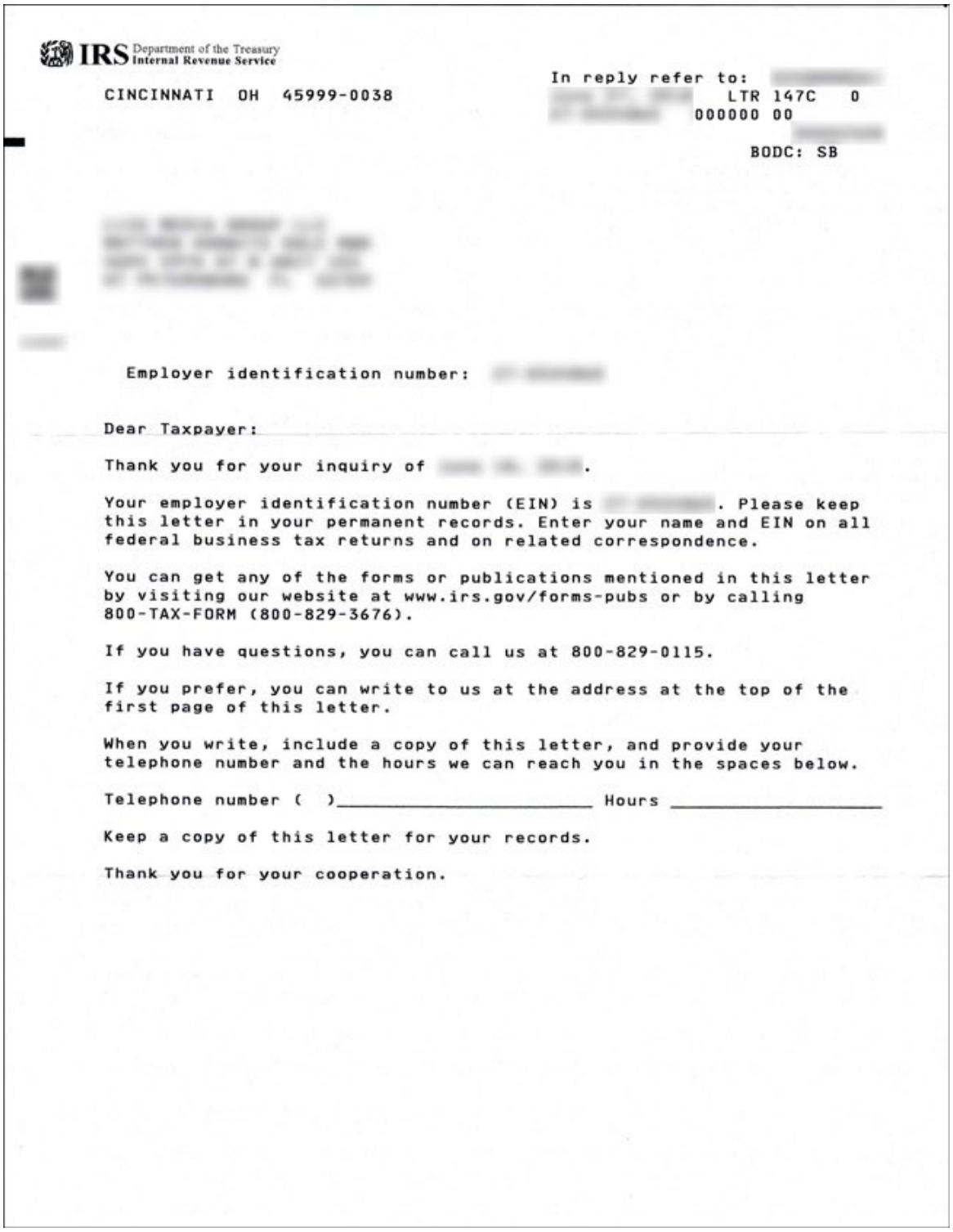
To participate in the Regence dental networks, each dental professional must meet the standards, requirements, and contractual conditions described below:

General Conditions	• You must complete a Practitioner Credentialing Application with supporting documentation. • You must include an IRS letter that lists the name that is registered to the tax ID number. (Examples below) • Sign the Participating Dental Agreement and continuously comply with all its terms and conditions. • You must cooperate with any third-party claims administrator or network administrator engaged by Regence.
Standards	• You must be licensed in Idaho. If you practice in a state other than Idaho, you must comply with the license requirements of the state where you are located and where services are rendered to Members. • You must maintain individual liability insurance in the amounts of $1,000,000 per occurrence and $3,000,000 in aggregate to insure you against any claim for damages arising by reason of personal injury or death caused directly or indirectly by you. • DEA (Drug Enforcement Administration) and CDS (Controlled Dangerous Substances) eligible dentists who do not have an active DEA certificate will provide a DEA waiver indicating the reason for the waiver and provide a designated practitioner to write on their behalf. The alternate prescriber may be an individual or a practice but must be identified by name and NPI. • The Idaho providers who hold an Idaho DEA certificate must be registered with the Idaho prescription drug monitoring program. Prescription drug monitoring program (PDMP) is an electronic database of all the controlled prescriptions dispensed at Idaho pharmacies, mail-order pharmacies delivered into Idaho, and other dispensaries, such as a veterinary or medical clinic. Under the law, a prescriber may designate someone in the facility to be that prescriber's delegate for checking the prescription drug monitoring program database once that delegate has also registered. Regence requires contracted providers in Idaho to register and encourages use of the Idaho prescription drug monitoring program.
Requirements	• You must achieve a satisfactory review from the Idaho State Board of Dental Examiners.
Contractual Conditions	• You shall notify Regence of your intent to terminate or alter your participation. Furthermore, any individual provider wishing to join an existing group practice shall notify Regence.

	• To the extent that services that otherwise meet the requirement of the Agreement are rendered by a dentist not located in Idaho, the statutory and regulatory requirements of that state that are equivalent to these Contractual Conditions shall be complied with to the satisfaction of Regence. • Excluded Persons. Participating Dental Providers represent and certifies that neither it, nor its Affiliated Parties or Downstream Entities have been suspended or excluded from participation in the Medicare program or any other federal health care program (as defined in 42 U.S.C. § 1320a-7b(f)). Participating Dental Providers shall check appropriate databases regularly, but no less than monthly and upon hiring and subcontracting, to determine whether any Affiliated Party or Downstream Entity has been suspended or excluded from participation in the Medicare program or any other federal health care program. Databases include the U.S. Department of Health and Human Services ("HHS") Office of Inspector General List of Excluded Individuals/Entities (**http://exclusions.oig.hhs.gov**) and the General Services Administration's System for Award Management (**http://www.sam.gov/portal**). Participating Dental Providers shall notify Regence immediately in writing if Participating Dental Providers, an Affiliated Party, or any Downstream Entity is suspended or excluded from the Medicare program, or any other federal program monitored as described in this Section. Participating Dental Providers shall prohibit any Affiliated Party or Downstream Entity that appears on any of the above-listed databases or who has opted out of Medicare from doing any work directly or indirectly related to the delivery or administration of Covered Services to Medicare Advantage Members. Regence reserves the right to require any Participating Dental Providers to demonstrate compliance with this provision upon reasonable request.

Examples of IRS Tax Letter Required by Regence

For verification, Regence will accept a tax coupon or letter from the Department of Treasury (IRS) 147C or CP 575C. See the following examples of an IRS letter:



IRS Department of the Treasury
Internal Revenue Service

CINCINNATI OH 45999-0038

In reply refer to:
LTR 147C 0
000000 00

BODC: SB

Employer identification number:

Dear Taxpayer:

Thank you for your inquiry of .

Your employer identification number (EIN) is . Please keep this letter in your permanent records. Enter your name and EIN on all federal business tax returns and on related correspondence.

You can get any of the forms or publications mentioned in this letter by visiting our website at www.irs.gov/forms-pubs or by calling 800-TAX-FORM (800-829-3676).

If you have questions, you can call us at 800-829-0115.

If you prefer, you can write to us at the address at the top of the first page of this letter.

When you write, include a copy of this letter, and provide your telephone number and the hours we can reach you in the spaces below.

Telephone number ( )_____ Hours _____

Keep a copy of this letter for your records.

Thank you for your cooperation.

IRS DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
CINCINNATI OH 45999-0023

Date of this notice:

Employer Identification Number:

Form: SS-4

Number of this notice: CP 575 G

For assistance you may call us at:
1-800-829-4933

IF YOU WRITE, ATTACH THE
STUB AT THE END OF THIS NOTICE.

WE ASSIGNED YOU AN EMPLOYER IDENTIFICATION NUMBER

Thank you for applying for an Employer Identification Number (EIN). We assigned you EIN . This EIN will identify you, your business accounts, tax returns, and documents, even if you have no employees. Please keep this notice in your permanent records.

When filing tax documents, payments, and related correspondence, it is very important that you use your EIN and complete name and address exactly as shown above. Any variation may cause a delay in processing, result in incorrect information in your account, or even cause you to be assigned more than one EIN. If the information is not correct as shown above, please make the correction using the attached tear off stub and return it to us.

A limited liability company (LLC) may file Form 8832, *Entity Classification Election*, and elect to be classified as an association taxable as a corporation. If the LLC is eligible to be treated as a corporation that meets certain tests and it will be electing S corporation status, it must timely file Form 2553, *Election by a Small Business Corporation*. The LLC will be treated as a corporation as of the effective date of the S corporation election and does not need to file Form 8832.

To obtain tax forms and publications, including those referenced in this notice, visit our Web site at www.irs.gov. If you do not have access to the Internet, call 1-800-829-3676 (TTY/TDD 1-800-829-4059) or visit your local IRS office.

IMPORTANT REMINDERS:

* Keep a copy of this notice in your permanent records. **This notice is issued only one time and the IRS will not be able to generate a duplicate copy for you.** You may give a copy of this document to anyone asking for proof of your EIN.
* Use this EIN and your name exactly as they appear at the top of this notice on all your federal tax forms.
* Refer to this EIN on your tax-related correspondence and documents.

If you have questions about your EIN, you can call us at the phone number or write to us at the address shown at the top of this notice. If you write, please tear off the stub at the bottom of this notice and send it along with your letter. If you do not need to write us, do not complete and return the stub.

Your name control associated with this EIN is CAME. You will need to provide this information, along with your EIN, if you file your returns electronically.

Thank you for your cooperation.

Effective Date Policy

For newly credentialed or existing providers requesting a new agreement, the participation effective date is based on a complete and approved provider package, which includes, but is not limited to: completed application, approved credentialing, completed and approved contract and complete provider profile. Effective date of participation is determined by the date of the complete, approved provider package.

Participation effective date

Agreement Type	Completion Date	Effective Date of Participation
Newly credentialed or existing providers requesting a new Agreement	Complete provider package approved between the 1st and 15th of the month. Example: Complete provider package approved 01/05/2025	Please refer to the Effective Date Calendar below for additional information
	Complete provider package approved between the 16th and the end of the month. Example: Complete provider package approved 01/20/2025	Please refer to the Effective Date Calendar below for additional information
Newly credentialed providers joining an existing Agreement		Date the complete credentialing application is received, or the date requested on the credentialing application, whichever is later. An application is determined to be complete as part of the credentialing approval process.
Existing credentialed provider joining an existing Agreement	Notification of joining Agreement received between the 1st and 15th of the month. Example: Agreement notification received 08/05/2025	1st of the month following notification of joining Agreement. Example: Effective date 09/01/2025
	Notification of joining Agreement received between the 16th and end of the month. Example: Agreement notification received 08/20/2025	15th of the month following notification of joining Agreement. Example: Effective date 09/15/2025

Effective Date Calendar

Complete provider package approved:	Contract Effective Date:
January 1-15	February 15
January 16-31	March 1
February 1-15	March 15
February 16-28	April 1
March 1-15	April 15
March 16-31	May 1
April 1-15	May 15
April 16-30	June 1
May 1-15	June 15
May 16-31	July 1
June 1-15	July 15
June 16-30	August 1
July 1-15	August 15
July 16-31	September 1
August 1-15	September 15
August 16-31	October 1
September 1-15	October 15
September 16-30	November 1
October 1-15	November 15
October 16-31	December 1
November 1-15	December 15
November 16-30	January 1
December 1-15	January 15
December 16-31	February 1

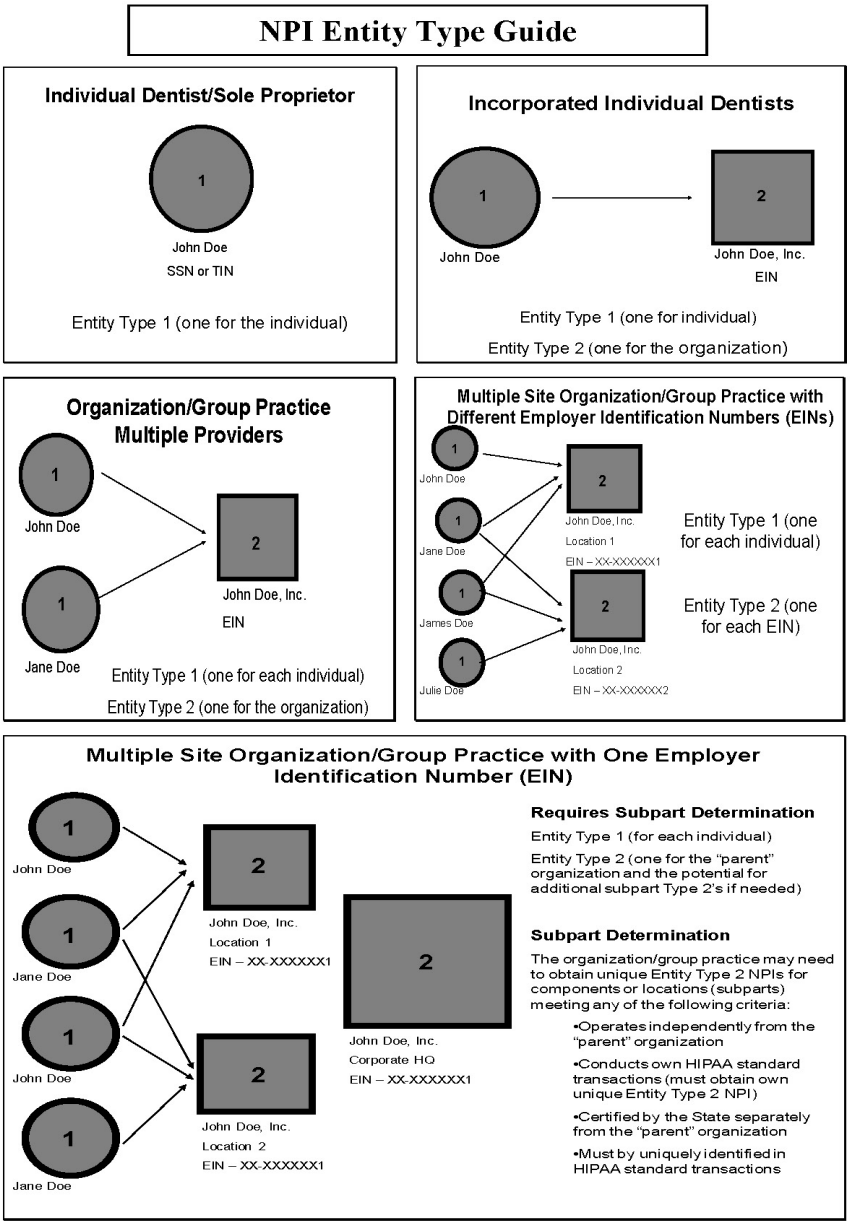
***Please note:** For newly credentialed or existing providers requesting a new agreement, the participation effective date is based on a complete and approved provider package, which includes, but is not limited to: completed application, approved credentialing, completed and approved contract and complete provider profile.

Section 6: National Provider Identifier (NPI)

Overview

The National Provider Identifier (NPI) is a government-issued, 10-digit identification number for individual health care providers and organizations. The numbers are randomly assigned and contain no coded information about the individual or organization. The NPI will never expire, and your individual NPI will remain the same even if you change jobs or locations.

All dental professionals are required by federal law to obtain an NPI. Regence requires each Participating Dental Provider to have an NPI regardless of whether they submit claims electronically. We encourage you to obtain an NPI as soon as possible; getting your NPI now will help eliminate issues with claims administration.



How to Apply for and Use an NPI

You can apply for an NPI at no charge through CMS' National Plan and Provider Enumeration System website at **nppes.cms.hhs.gov**.

You can choose to either:

1) Apply online and receive your NPI via email in one to five business days or
2) Download a printable application and submit by mail; processing takes about 20 business days.

Once you have received an NPI, email a copy of your confirmation to our Dental Provider Relations team at **DentalProviderRelations@regencedental.com** and we will update your provider record. If you have questions about NPI, contact your network manager.

Section 7: Filing Provider or Practice Changes

Occasionally, you may need to submit changes to Regence concerning relocation, adding, or changing an employer identification number (EIN) or tax identification number (TIN), adding or terminating an associate or closing a location. To make changes, forms can be found on our website at **regencedental.com**. For assistance, please contact us at **DentalProviderRelations@regencedental.com**.

Changes Requiring Notification

Changes to your practice that require notification include:

- Adding dentists to your practice
- Additional offices
- Change of practice name
- Changes to telephone and fax numbers
- Providers leaving the practice
- Relocation
- Retirement/death of provider
- Transfer of ownership (TIN change)

Changes to your status that require immediate written notification include:

- Accreditation
- Certification
- License to practice dentistry suspended or revoked
- Malpractice or an act of professional misconduct as found by a court or arbitrator
- Participation
- Professional liability or malpractice insurance changed or revoked
- Qualification

Submitting Changes

For guidance on how to notify us, please consult the table below:

Type of Change	Method of Submission
Relocation, contact information (telephone, fax, etc.), adding additional practice locations	*Provider Information Update Form*
Employer Identification Number (EIN) or Taxpayer Identification Number (TIN)	*Provider Information Update Form*. A new agreement is required to be signed for network participation for the new TIN. Also include a copy of a letter from the IRS (CP 575 or 147c).
Associate dentist/orthodontist who has left your practice	*Provider Information Update Form*
Add a new associate dentist/orthodontist to your practice	Submit a credentialing application if the provider is not credentialed or submit a *Provider Information Update Form* for existing providers.
Termination of participation requires 120 days advance written notification	Send a letter of termination on your practice letterhead with a provider's signature, include the Dentist's name, practice address, TIN and network you are terming via email to **DentalProviderRelations@regencedental.com**

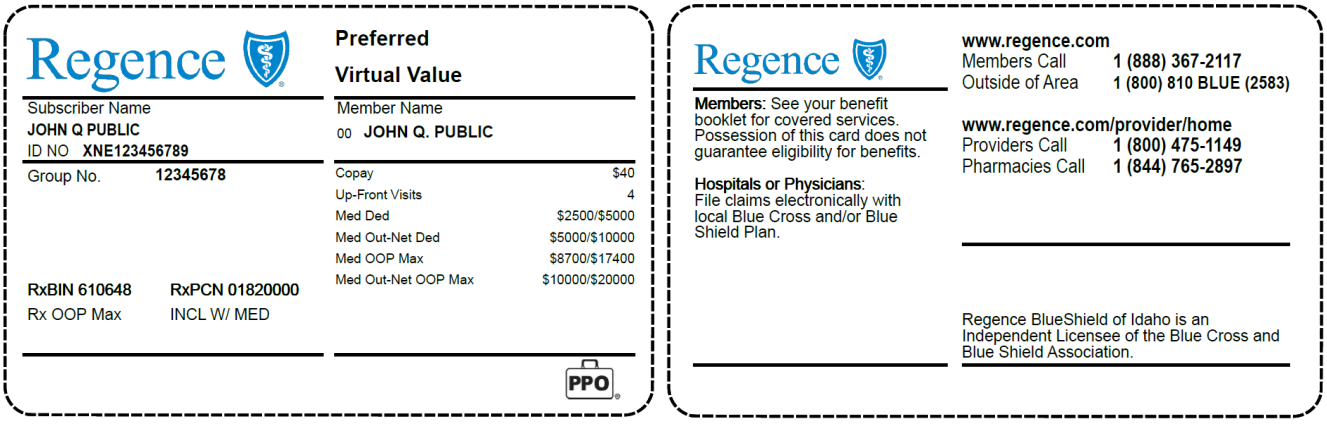
Section 8: Dental Plans and Benefits

The following is an overview of the dental plans offered by or administered by Regence.

Dental Plans Offered or Administered by Regence

Plan/ Program	Responsible Payor	Claim Type	Payment Supported by	Provider Customer Service
Expressions	Regence	Dental	Regence	Dental Claims customer service
Medicare Advantage	Regence	Dental	Regence	Dental Claims customer service
FEP	FEP program	Dental	FEP program	FEP customer service

Sample Card



Important note: We use assigned Subscriber identification numbers in place of Social Security numbers. Be sure to use the Member's current identification number when submitting claims to avoid delays in payment.

Section 9: Medicare Advantage

Regence offers the following Member Contracts for its Medicare Advantage Members to choose from during the open enrollment period.

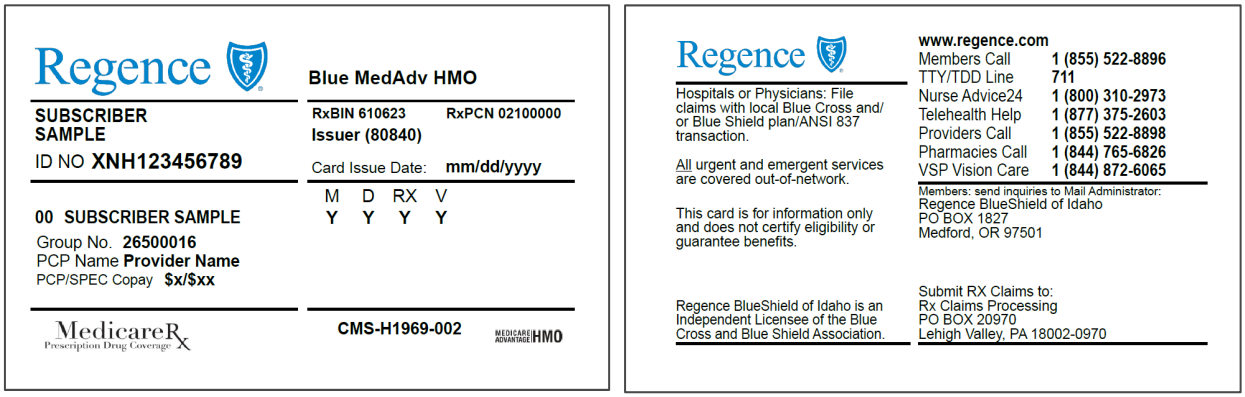
- Medicare Advantage HMO
- Medicare Advantage PPO

These Medicare Advantage Member Contracts cover a limited number of dental services. Any dental service not covered by the Member Contract may be billed at your usual and customary charge. This does not include procedures that would otherwise be covered but are denied due to frequency limitations having been met. **For dental services not covered by the Member Contract, please notify the Member in writing before services are rendered.**

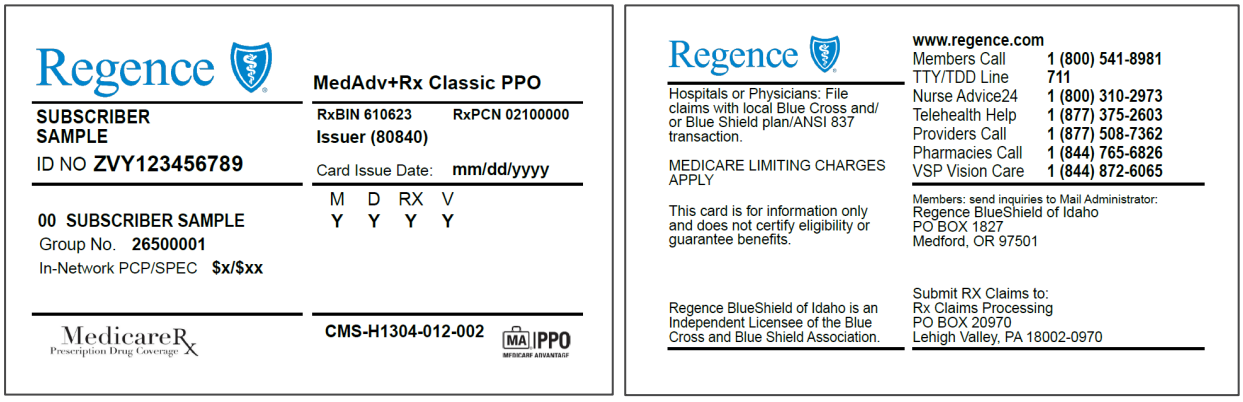
Please be sure to verify eligibility and benefits for all Medicare Advantage Members before rendering services.

Following are samples of ID Cards.

BlueMedAdv HMO Member Sample ID Cards



MedAdv+Rx Classic PPO



For Regence eligibility, benefits and claims information visit **availity.com** to access online services or contact the Provider Contact Center at 1(800)253-0838. Information on Medicare compliance, including training, can be found on **regence.com**.

Medicare Advantage dental reimbursement

Effective **January 1, 2023**, the reimbursement schedule amounts for covered services provided to Medicare Advantage members by dental provider shall be based upon a hierarchy determined by your network participation status in the following networks:

- United Concordia Dental
- DenteMax
- Regence Participating Dental

Effective **January 1, 2025**, claims with dates of service on or after January 1, 2025, will be reimbursed using the new fee schedule. The new hierarchy is as follows:

- Regence 2025 Medicare Advantage fee schedule
- United Concordia Dental
- DenteMax

Accessing 2025 Medicare Advantage fee schedule

You can view the Regence Medicare Advantage Dental Reimbursement Rates on Availity Essentials at **availity.com**: Claims & Payments>Fee Schedule Listing. Not all plans will have the same benefits, so it is important for you to verify member eligibility and benefits on Availity Essentials: Patient Registration>Eligibility and Benefits Inquiry.

Regence reserves the right to enter into additional agreements to rent or otherwise gain access to other provider networks in which dental providers may participate. Regence shall place any additional networks within the list above or modify it by providing at least 60 days' advance notice.

For the Regence Participating Dental fee schedule please visit Availity Essentials. For questions related to your participating agreement with United Concordia or DenteMax, please contact them directly using the online services provided.

- Visit the United Concordia Dental website or call 1(800)307-8514.
- Complete the DenteMax online request form.

Medicare Advantage compliance training

Below are links to annual general and specialized Medicare compliance training. These courses are available to all persons involved in the administration or delivery of MA Program benefits. Providers are advised to complete the training and to email Certificates of Completion to dentalproviderrelations@regencedental.com.

Combating Medicare Parts C and D Fraud, Waste and Abuse

https://www.cms.gov/Outreach-and-Education/MLN/WBT/MLN3995723-MLNPartsCD/FWA/story.html

Part C Organization Determinations, Appeals, and Grievances

https://www.cms.gov/Outreach-and-Education/MLN/WBT/PartCOrganizationDetermination/story.html

Part D Coverage Determinations, Appeals, and Grievances

https://www.cms.gov/Outreach-and-Education/MLN/WBT/PartDDeterminations/story.html

Section 10: Dental4Health℠ (D4H)

Dental4Health℠ (D4H)

The oral health of your patients can have a big impact on their overall health, especially if they've been diagnosed with certain medical conditions. For members with medical and dental plans with Regence, we're able to review their medical claims to identify and automatically enroll those with qualifying health conditions (listed in the grid below) that benefit from additional dental care. We conduct outreach and education to make sure our members are aware of the positive impacts preventive and/ or periodontal dental services have on their total well-being.

Eligible medical conditions	Two additional cleanings or periodontal maintenance visits, enhanced cleaning to remove excess plaque buildup, and:	
	Periodontal scaling covered 100%	Oral health screenings; fluoride treatments
Chronic obstructive pulmonary disease	✓	
Coronary artery disease	✓	
Diabetes	✓	
End-stage renal disease	✓	
Metabolic syndrome	✓	
Oral, head, and neck cancers		✓
Pregnancy	✓	
Sjögren's syndrome		✓
Stroke	✓	

Your Partnership with Regence

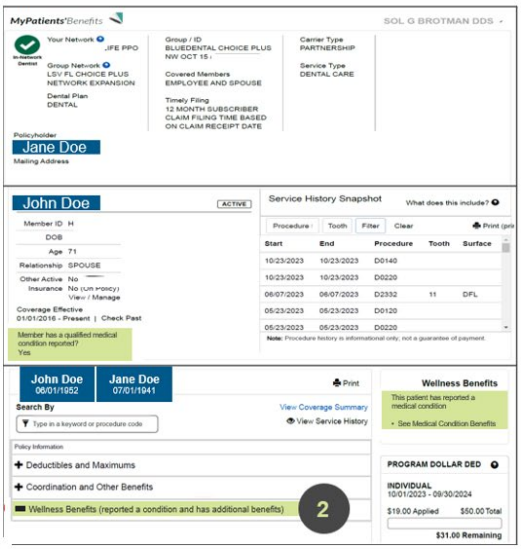
Our Dental4Health[SM] program allows us to combine expertise in all disciplines of comprehensive care. By partnering with Regence, you can help your patients who have medical conditions that might benefit the most from preventive dental care. Through Dental4Health[SM], you can:

- Help your patients achieve better overall health
- Increase your revenue by providing additional services
- Easily identify patients who are enrolled in the program, so they can take advantage of enhanced dental benefits.
    - By logging into MyPatients'Benefits providers can quickly identify if a patient has a reported medical condition, wellness benefits and coverage (see The Provider Experience below)

The Provider Experience

We empower providers with information about patients' eligible condition(s), benefits and program treatment protocols through a convenient online portal

1. Medical Condition Flags
2. Extra Wellness Benefits
3. Medical Conditions



Coverage %							
Procedure		Covered	Allowance	or Copay $	Limitation	Applied to Deductible	Applied to Maximum
D0431	Adjunctive Prediag Test >	Yes	$30.00	100%	1 Per 6 Months ~ OC, HNC, SjS Medical Conditions	No	No
D1110	Prophylaxis Adult >	Yes	$85.00	100%	In Network~ DM, CAD, CVA, PG, OC, HNC, SjS, ESRD, COPD, MetS Medical Conditions | 4 Per Benefit Period Total ~ DM, CAD, CVA, PG, OC, HNC, SjS, ESRD, COPD, MetS Medical Conditions	No	No

3

Enhanced dental benefits at no additional cost

We've made it easier financially for your patients to take advantage of the program:

- No waiting periods
- Services do not count toward the calendar year maximum (CYM)
- There are no deductibles, copayments or coinsurance; paid at 100% when visiting a participating provider.

How do my patients enroll?

Members who have medical and dental plans through Regence and a qualifying medical condition are auto-enrolled in the program. Members who have only a dental policy with Regence must self-enroll. If your patient qualifies and needs to self-enroll, they can download the attestation form located https://regencedental.com/members/oral-and-overall-health, by entering their zip code and county. Once you have identified members who are enrolled, we encourage setting up their four prophy recalls.

For more information about the impact oral health has on the qualifying conditions, please visit: https://regencedental.com/members/oral-and-overall-health

Eligible Dental4Health℠ plan types as of January 1, 2025

January 1, 2025, eligible Dental4Health plan types	
Plan	Eligible?
Fully insured non-ACA group	Yes
Fully insured ACA small group pediatric	Yes[1]
Self-funded group (opt-in)	Yes
Individual ACA pediatric	No
Individual non-ACA	No
Medicare Advantage (Individual and EGWP)	No
MediGap	No

[1]Program coverage and benefits for ACA Small Group pediatric dental plans may vary according to each state's benchmark ACA plan. For details, contact Dana Kovaleski.

Section 11: Member Information

Verifying Member Eligibility, Benefits and Claim Status

You can obtain Member eligibility, benefits, claims status, maximums, deductibles, service history, allowance information, procedure code information, and orthodontic information via:

- **Availity Essentials:** Participating Dental Providers can access Member information on Availity Essentials to obtain immediate, up-to-the-minute access to Member information 24 hours a day, 7 days a week.
- **Interactive Voice Response (IVR) System:** Our Customer Service IVR System offers Participating Dental Providers and most Subscribers access to information stored in records and the capability of finalizing Predeterminations for payment via the telephone. This automated system requires a touch-tone telephone and provides an immediate response. **You can choose to listen to the information or, in most instances, request the information by fax**. The IVR system is available to respond to your inquiries 24 hours a day, 7 days a week, except when our databases are undergoing scheduled maintenance.

Confidentiality of Member Information

The privacy rule enacted as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) has strengthened the protections already in place at Regence to safeguard our Members' protected health information (PHI). Since the privacy rule applies to Responsible Payors and providers, Regence shares with you the responsibility of protecting privacy. Please see Section VIII of your Agreement for reference to your commitments regarding Member records and PHI confidentiality.

The HIPAA privacy rule allows for Regence to share PHI with other parties without Members' authorization under certain circumstances, including when we have a business relationship with the third-party and to the extent we need to share the information to support treatment, payment or health care operations, as defined by the privacy rule. If you have questions about the privacy rule, seek advice from your attorney or business counselor.

We are sensitive to concerns about confidentiality and will take every precaution to protect the privacy of your Members' dental records, including validating your provider information when you call us. As your Agreement with Regence states, we may require access to or copies of Members' dental records. Our Members' health plans and insurance policies advise Members of our right to assess and handle their records to support treatment, payment, and health care operations.

Section 12: Predeterminations and Claims

Predeterminations

Download the most current ADA claim form at www.adacatalog.org. To order a hard copy, contact your dental office supplier or software administrator or call the ADA at 1(800)947-4746.

Overview

A Predetermination is a written request by a Participating Dental Provider for verification of benefits prior to rendering services. This request helps us determine how we will process a claim based on a Member's benefits. A Predetermination is not a guarantee of payment but is designed to determine:

- If a service is covered under the Member Contract.
- If the procedure meets our utilization review guidelines and dental policy.
- If any time limitations apply on a procedure.
- The projected estimated payment for the procedure.

Although not required, we recommend you submit a Predetermination for prosthetics and crowns, inlay/onlay restorations, and periodontal services totaling more than $500 in allowable expenses. Note: FEP does not perform dental Predeterminations.

We process a Predetermination as if it were an actual claim and respond via a pre-treatment estimate. You and the Member will be notified of all approvals and denials.

How to Submit a Predetermination

Complete the most current version of the *ADA Dental Claim Form* as if you were submitting an actual claim for services. Do not enter a date of service on the claim. Remember to:

- Enter an X in Box 1 of the claim form next to "Request for Predetermination/Pre-authorization."
- List only the services to be included in the Predetermination.
- Send the Predetermination electronically.

Completing a Dental Claim Form

Please follow the instructions below to complete the most current *ADA Dental Claim Form*, which you can find on the ADA website or in the most current *ADA Practical Guide to Dental Procedure Codes*. A sample form follows these instructions.

Header Information (blocks 1 and 2)

- 1: Enter an X in the appropriate box to indicate if this claim is a pre-treatment estimate or a claim for actual services rendered.
- 2: Predetermination/Pre-authorization Number is not required.

Other Coverage (blocks 4-11) refers to the possible existence of other medical or dental insurance policies, relevant for Coordination of Benefits.

Policyholder/Subscriber Information (blocks 12-17) documents information about the Insured person (Subscriber), who may or may not be the Member.

Member Information (blocks 18-23) refers to the Member receiving services or treatment.

Record of Services Provided (blocks 24-35) regards the treatment performed or proposed. For a Predetermination of benefits, complete this area in the same way as for an actual service, but omit the date of service. Ten lines are available for reporting.

Authorizations (blocks 36 and 37) are where the Member or Subscriber signs to provide consent for treatment and authorization for direct payment.

Ancillary Claim/Treatment Information (blocks 38-47) asks for additional information regarding the claim and the Member's prior dental history. Some of these questions may be left blank if the service is not orthodontic or prosthetic.

Billing Dentist or Dental Entity (blocks 48-52A) provides information on the dental professionals or group/corporation responsible for billing and receiving payment, which may or may not be the treating dentist. *Block 49 is specific to reporting the associated National Provider Identifier (NPI).*

Treating Dentist and Treatment Location Information (blocks 53-56A) asks for information specific to the provider. Block 54 asks for the treating dentist's NPI. To obtain an NPI, visit the Centers for Medicare & Medicaid Services' National Plan and Provider Enumeration System (NPPES) website at **nppes.cms.hhs.gov/NPPES/Welcome.do**. *You must submit all claims with your NPI information.*

Billing with a National Provider Identifier (NPI)
If you have a Type 1 NPI (Sole Proprietor), submit your claim using the Type 1 NPI in blocks 49 and 54. If you have a Type 2 NPI (Professional Corporation, Limited Liability Corporation or Incorporated—PA, PC, LLC or INC), submit your claim using the Type 2 NPI in block 49 and the rendering provider's NPI (Type 1) in block 54.

Sample Claim Form

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F ☐U | 8. Policyholder/Subscriber ID (Assigned by Plan)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F ☐U | 15. Policyholder/Subscriber ID (Assigned by Plan)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐M ☐F ☐U | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ C _____ B _____ D _____

31a. Other Fee(s)
32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) - | 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID

J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J430D)

To reorder call 800.947.4746 or go online at ADAcatalog.org

Section 13: Coordination of Benefits (COB)

Determining the Primary Responsible Payor

The following rules applicable shall be used by Regence to determine the primary Responsible Payor.

1. The plan that covers the person as an employee or Member, other than as a Dependent, is determined to be primary before the dental plan that covers the person as a Dependent.

   However, if the person is also a Medicare beneficiary, Medicare is secondary to the dental plan covering the person as a Dependent of an active employee. The order in which Dental Benefits are payable will be determined as follows:

   Responsible Payor #1: Dental Benefits of a plan that covers a person as an employee, primary Member or Subscriber.
   Responsible Payor #2: Dental Benefits of a plan of an active employee that covers a person as a Dependent.
   Responsible Payor #3: Medicare benefits.

2. When two or more dental plans cover the same child as a Dependent of different parents:
   a. The Dental Benefits of the plan of the parent whose birthday month and day, excluding the year of birth, falls earlier in a year should be applied before the dental plan benefits of the parent whose birthday month and day, excluding the year of birth, falls later in the year; but
   b. If both parents have the same birthday, the Dental Benefits of the plan that has covered the parent for the longest are determined before those of the plan that has covered the parent for the shorter period of time.

   However, if one of the plans does not have a provision that is based on the birthday of the parent, but instead on the gender, this results in each plan determining its benefits before the other, and the plan that does not have a provision based on a birthday will determine the order of Dental Benefits.

3. If two or more dental plans cover a Dependent child of divorced or separated parents, Dental Benefits for the child are determined in this order:

   Responsible Payor #1: the plan of the parent with custody of the child.
   Responsible Payor #2: the plan of the spouse of the parent with custody of the child.
   Responsible Payor #3: the plan of the parent not having custody of the child.

   However, if the specific terms of a court decree make one parent financially responsible for the dental care expenses of the child, and if the entity obliged to pay or provide the Dental Benefits of the dental plan of that parent has actual knowledge of those terms, the Dental Benefits of that plan are determined first. This does not apply with respect to any claim determination period or dental plan year during which any Dental Benefits are actually paid or provided before that entity has the actual knowledge.

4. The Dental Benefits of a dental plan that covers a person as an employee other than as a laid-off or retired employee, or as a Dependent of such a person, are determined before those of a dental plan that covers that person as a laid off or retired employee or as a Dependent of such a person. If the other dental plan is not subject to this rule, and if, as a result, the dental plans do not agree on the order of Dental Benefits, this paragraph shall not apply.

5. If an individual is covered under a COBRA continuation plan and also under another group dental plan, the following order of benefits applies:

   Responsible Payor #1: The dental plan which covers the person as an employee or as the employee's Dependent.

Responsible Payor #2: The coverage purchased under the dental plan covering the person as a former employee, or as the former employee's Dependent provided according to the provisions of COBRA.

6. FEP follows NAIC guidelines for determining primary.

If none of the above rules determines the order of Dental Benefits, the Dental Benefits of the plan that has covered the employee, Member or Insured the longest period of time are determined before those of the other dental plan.

Coordination of Benefits Shall not be Permitted Against the Following Types of Policies

1. Indemnity
2. Excess insurance
3. Specified illness or accident
4. Medicare supplement
5. We do not coordinate with State plans (Medicaid)

Determining Your Member's Liability in a COB Situation

If the Regence plan is the secondary plan in accordance with the order of benefits determination rules outlined above, the benefits of the plan will be reduced when the sum of:

1. The benefits that would be payable for the allowable expense under Regence in the absence of this COB provision; and
2. The benefits that would be payable for the allowable expense under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of Regence will be reduced so that its benefits and the benefits payable under the other plans do not total more than those allowable expenses.

When the benefits of Regence are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of the Plan.

Helpful Tips

In situations where you believe your Member may be covered by more than one Responsible Payor, the following hints may help you manage the claim more efficiently:

- Determine your Member's primary Responsible Payor and submit the claim to that Responsible Payor first.
- Submit the primary Responsible Payor's Explanation of Benefits (EOB) to the secondary Responsible Payor (even if both Responsible Payors are Blue Cross Blue Shield plans).
- Always calculate your Member's liability by claim line rather than by using the total claim payment amount, waiting until all insurance payments have been made.
- Remember that the secondary Responsible Payor's EOB may not correctly reflect the Member's balance and that the Member's liability may be affected by contracts that you hold with the primary carrier.

Section 14: Reimbursement

Overview

Regence will always reimburse claim payments for covered Members directly to the Participating Dental Provider.

Services That Are Not Covered

In accordance with the Regence agreement, Participating Dental Providers agree to accept as payment in full the lesser of either their Billed Charges or the Dental Allowable Amount for dental services provided under the applicable dental program, less any applicable Member Cost-Share. You may not bill the Member for the difference between the allowed amount and your Billed Charges, except in these instances:

- ***The procedure is non-covered.*** If a service is not considered an eligible service under the Member's benefit plan (i.e., it is not listed on the fee schedule of allowances), you can collect your fees. You should verify with Regence that services are covered; for any that are non-covered, please inform the Members that they will be responsible for your Billed Charges. Please note that your Participating Dental Agreement imposes additional conditions on billing of Members for any services that are not Necessary Dental Care or which are experimental/investigational, including the requirement to first obtain a written waiver of informed consent in advance from the Member.
- ***A Member has exhausted their annual maximum benefit and any roll-over benefit, if applicable.*** In this instance, you can collect your full fee (subject only to the Participating Dental Agreement's preconditions for billing of any services that are not Necessary Dental Care or experimental/investigational). Please verify that the Member has exhausted all benefits and inform them of their responsibility for your actual charge.

Here is an example of how we calculate the Member's Cost-Share for a Non-Reimbursable Service:

Procedure Code	Your Charge	Coverage Level	Allowed Amount	Member Cost-Share
D0460	$50	0%	$0	$50

Coinsurance

If the Member's dental plan covers a procedure at less than 100%, the Member is responsible for the difference between what we pay and the allowed amount, as shown in this example:

Procedure Code	Benefit Type	Coverage Level	Allowed Amount	Member's Coinsurance
D2150	Basic	80%	$100	$100 x 20% = $20

The Member's Coinsurance is based on a percentage of your Regence applicable Dental Allowable Amount and the Member's benefit structure. The Member is responsible for all Non-Reimbursable Services. You can collect the Member's Coinsurance at the time of the visit or bill the Member after you receive payment from us.

Deductibles

Generally, the Deductible applies annually with a per-Member amount that cannot exceed a family total maximum for the benefit period. Any Member Cost-Share that applies toward the Deductible shall be based upon the provider's usual charge or the Dental Allowable Amount, whichever is less, as shown in this example:

Member's Yearly Deductible	Your Charge	Allowed Amount	Member Cost-Share Applied Toward Deductible
$50	$30	$25	$25

Common Reasons for Non-Payment

To familiarize yourself with Regence's reimbursement requirements, please refer to the list below of messages commonly found on dental remittances to explain non-payment:

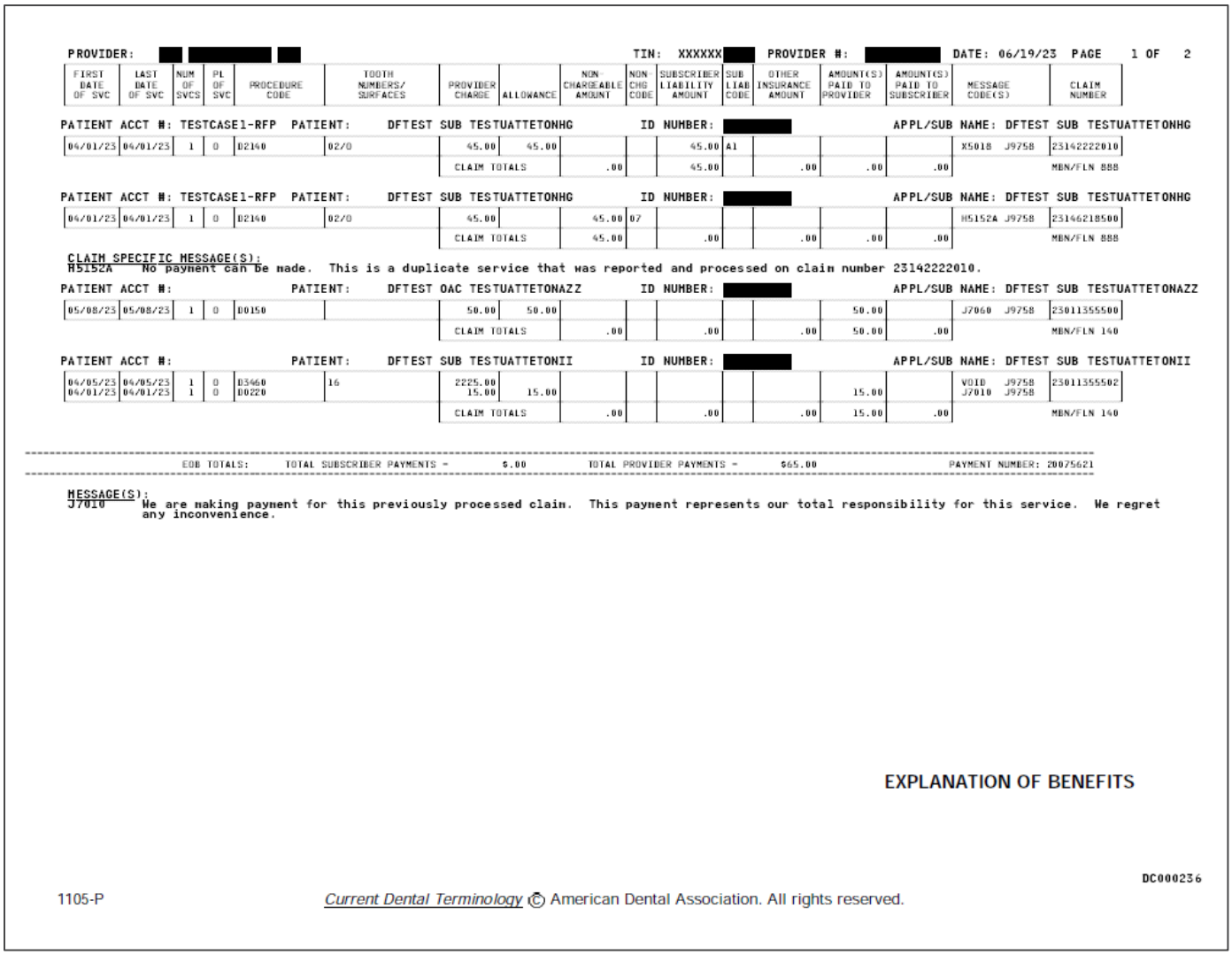
- No payment can be made. The reported procedure is covered once in a 3-year period. Benefits have been provided previously for a similar service within this time period.
- No payment can be made. The Member's coverage does not provide for this service.
- No payment can be made. The reported service is covered twice in a contract year period.
- No payment can be made. The maximum benefit amount available under the Member's coverage has been paid. **IF THIS HAS OCCURRED, YOU MAY BALANCE BILL THE MEMBER.**
- No payment can be made. An incomplete dental claim has been received in our office. Please submit a *Dental Claim Form* with the tooth number(s) for the procedure(s) reported, include x-ray(s), periodontal charting and any narrative if required.
- This Member cannot be identified from the identification number reported above. Please verify the name and number shown on the ID card. If the Member is covered, please resubmit the claim.
- No payment can be made. This service is subject to a waiting period as required under the Member's coverage.
- The maximum allowance for bitewing radiographs (x-rays) has been paid.

If you have any questions about your remittance, please call the Provider Contact Center at 1(800)253-0838, Monday through Friday, from 6:00 a.m. to 5:00 p.m. PT.

How to Access the Regence Dental Fee Schedules

Fee schedule information can be found on the dental provider page under Provider Tools & Resources>Plan Information and Documents at **regencedental.com**. For FEP fee schedules, call the FEP Customer Service Center at 1(877)668-4651. If you have questions about a fee schedule, please contact your network manager, indicating the Plan name.

Sample Dental EOB



PROVIDER: [redacted] TIN: XXXXXX[redacted] PROVIDER #: [redacted] DATE: 06/19/23 PAGE 1 OF 2

FIRST DATE OF SVC	LAST DATE OF SVC	NUM OF SVCS	PL OF SVC	PROCEDURE CODE	TOOTH NUMBERS/ SURFACES	PROVIDER CHARGE	ALLOWANCE	NON-CHARGEABLE AMOUNT	NON CHG CODE	SUBSCRIBER LIABILITY AMOUNT	SUB LIAB CODE	OTHER INSURANCE AMOUNT	AMOUNT(S) PAID TO PROVIDER	AMOUNT(S) PAID TO SUBSCRIBER	MESSAGE CODE(S)	CLAIM NUMBER
PATIENT ACCT #: TESTCASE1-RFP PATIENT: DFTEST SUB TESTUATTETONHG ID NUMBER: [redacted] APPL/SUB NAME: DFTEST SUB TESTUATTETONHG																
04/01/23	04/01/23	1	0	D2140	02/O	45.00	45.00			45.00	A1				X5018 J9758	23142222010
						CLAIM TOTALS		.00		45.00		.00	.00	.00		MBN/FLN 888
PATIENT ACCT #: TESTCASE1-RFP PATIENT: DFTEST SUB TESTUATTETONHG ID NUMBER: [redacted] APPL/SUB NAME: DFTEST SUB TESTUATTETONHG																
04/01/23	04/01/23	1	0	D2140	02/O	45.00		45.00	07						H5152A J9758	23146218500
						CLAIM TOTALS		45.00		.00		.00	.00	.00		MBN/FLN 888

CLAIM SPECIFIC MESSAGE(S):
H5152A No payment can be made. This is a duplicate service that was reported and processed on claim number 23142222010.

PATIENT ACCT #: PATIENT: DFTEST OAC TESTUATTETONAZZ ID NUMBER: [redacted] APPL/SUB NAME: DFTEST SUB TESTUATTETONAZZ																
05/08/23	05/08/23	1	0	D0150		50.00	50.00						50.00		J7060 J9758	23011355500
						CLAIM TOTALS		.00		.00		.00	50.00	.00		MBN/FLN 140
PATIENT ACCT #: PATIENT: DFTEST SUB TESTUATTETONII ID NUMBER: [redacted] APPL/SUB NAME: DFTEST SUB TESTUATTETONII																
04/05/23	04/05/23	1	0	D3460	16	2225.00									VOID J9758	23011355502
04/01/23	04/01/23	1	0	D0220		15.00	15.00						15.00		J7010 J9758	
						CLAIM TOTALS		.00		.00		.00	15.00	.00		MBN/FLN 140

EOB TOTALS: TOTAL SUBSCRIBER PAYMENTS = $.00 TOTAL PROVIDER PAYMENTS = $65.00 PAYMENT NUMBER: 20075621

MESSAGE(S):
J7010 We are making payment for this previously processed claim. This payment represents our total responsibility for this service. We regret any inconvenience.

EXPLANATION OF BENEFITS

DC000236

1105-P *Current Dental Terminology* © American Dental Association. All rights reserved.

Section 15: Handling Overpayment Requests

Overview

Occasionally, Regence may overpay a dental claim. Some reasons for overpayment include:

- Processing under an incorrect procedure code;
- Paying a claim for a Member who is not a patient of record with the provider's office; or
- Paying a claim without coordinating benefits.

In these circumstances, we are required to correct the action and issue a request for refund (invoice) to the provider, which includes information needed for the provider to refund the Responsible Payor for the overpayment.

This section does not apply to FEP overpayments. If you discover an overpayment, please call the Provider Contact Center at 1(800)253-0838, Monday through Friday, from 6:00 a.m. to 5:00 p.m. PST.

If You Receive a Request for Refund

If you receive a letter requesting a refund, please:

- Make a copy of the letter and include it with your refund.
- **Make the check payable to REGENCE BLUESHIELD OF IDAHO.**
- To ensure prompt and accurate posting, send your payment within fifteen (15) days of receipt to the address listed on the letter.

Please note: If payment is not received by the invoice due date, the Responsible Payor will collect the money by deducting the overpaid amount from future payments made to you by the Responsible Payor. This is called an offset. These payments may be deducted from different claims for claimants other than those who incurred the overpayment.

If You Discover an Overpayment

If you discover that Regence has overpaid you, please call the Provider Contact Center at 1(800)253-0838 and provide the amount of the claim, the claim number, and the Member ID number. The representative will confirm the overpayment and, if necessary, have a request for refund mailed to your office. After that, you may do one of the following:

- Cash the check and wait for the request for refund letter, then follow the steps above for "If You Receive a Request for Refund."
- Return the check. To ensure we credit the refund to the appropriate account, we recommend that you wait for the request for refund letter to arrive and attach it to the check you are returning.

Section 16: Orthodontic Services

Orthodontic Claim Submission Guidelines

Orthodontia is a separate benefit from other dental services. Check the Member's benefits to determine whether it is a covered service. Orthodontia for periodontal reasons is covered only if the Member has orthodontic benefits. Please access Availity Essentials prior to treatment to determine if your Member has orthodontic benefits.

Note: Orthodontia services do not have a fee schedule. Members with an orthodontic benefit have a dollar benefit maximum. This information, if applicable, is available in an Eligibility and Benefits Inquiry on Availity Essentials.

Traditional Orthodontic Treatment Calculation

- Treatment Liability will be Calculated Based on the Member's Benefit Plan
- Treatment Payment Schedule:
    - One Initial Payment will be Calculated at 25% of the Treatment Liability Upon Banding
    - Equal Interim Payments will be Calculated on a Quarterly Basis Throughout the Treatment
    - Treatment Plans Calculated with a Total Liability of $1000 or Less will be Paid in One Lump Sum Payment

Traditional Orthodontic Treatment in Progress

Treatment in progress includes scenarios where new group business has members in active treatment prior to coverage; a member picks up coverage after treatment began; or when a member changes their provider mid-treatment. This scenario will not result in an initial payment. Instead, the case will be initiated with scheduled installments spread evenly over the remainder of the treatment plan.

Handling traditional ortho treatment in progress:

- Require providers to submit a new claim with treatment plan information. With this option, we will prorate payment by comparing the banding date to the effective date of coverage and remaining length of treatment.

Submit claims electronically using valid orthodontic codes along with the following information in the Claims Notes or Remarks section:

- Banding date
- Total treatment charge
- Monthly payment amount
- Estimated length of treatment
- Initial banding fee or down payment
- Orthodontic treatment that started before the Member's effective date with Regence will be reimbursed in proportion to the time remaining in treatment.

Example: If a Member's effective date with Regence is in the 6th month of a 24-month course of treatment, payment will be prorated to the 18 months in which they became eligible. This payment, when combined with any payment made by a previous insurance carrier, cannot exceed the total billed amount.

Note: Orthodontia benefits for some groups are structured to pay for periodic treatment visits, as indicated in the Member's benefits. If you are not able to submit electronic claims for periodic treatments and the payment received for your initial claim is not equal to the amount of the Member's available orthodontia benefit, please submit monthly or quarterly visit claims until benefits are exhausted. The last claim for treatment must indicate the date that the Member was de-banded.

Section 17: General Policies and Procedures

Quality and Utilization Review

While we continue to conduct utilization reviews on submitted claims, as a Participating Dental Provider we no longer require submission of radiographs or periodontal charting, except in specific cases or unless requested by the Plan.

From time to time, we may request that your practice participate in Utilization Management Programs that may include an onsite review of facilities, onsite review of dental records, providing copies of Member dental records, audit of dental records, dental care evaluation studies, practice pattern studies and/or analysis based on claims data.

Necessary Dental Care

Our Member Contract or guide to benefits specify that all dental care—including services, procedures, supplies, and appliances–must be “necessary and appropriate to diagnose or treat (the) dental condition.” Necessary and appropriate care must meet these criteria:

- The care must address the prevention, diagnosis and/or treatment of oral disease, decayed or fractured teeth, or a supporting structure weakened by disease (including periodontal, endodontic and related diseases);
- The care must be furnished in accordance with standards of good dental practice;
- The care must be provided in the most appropriate site and at the most appropriate level of services based upon the Member’s condition;
- The care must not be provided solely to improve a Member’s condition beyond normal variation in individual development and aging, including improving physical appearance that is within normal individual variation;
- The care must be as beneficial as any established alternative; and
- The care must not be solely for the Member’s or dentist’s convenience.

Section 18: Appeals and Grievances

If we deny payment of a claim, you have the right to request an Appeal. The Appeal must be in writing and received by Regence within a specific time period of the denial, depending on the Member's plan. We will immediately acknowledge the Appeal and respond in writing within a specific period, depending on the Member's plan. You may request an expedited Appeal if you feel that any delay would prevent a Member from receiving urgently needed services. Appeal information can be submitted using the *Provider Appeal Form*, located on the **regence.com** website.

Commercial Plan (excluding FEP and Medicare Advantage) Appeals must be mailed to:
Dental Customer Service
Appeals
P.O. Box 69437
Harrisburg, PA 17106-9437

Federal Employee Program (FEP) Appeals must be mailed to:
Regence - FEP
P.O. Box 1388
Lewiston, ID 83501-9998

The following information must be submitted with the *Provider Appeal Form* or the written description of the issue(s) on Appeal:

i. A detailed description of the disputed issue(s);
ii. The basis for disagreement with the decision; and
iii. All evidence and documentation supporting your position.

Medicare Advantage Appeals must be mailed to:
Medicare Advantage/Medicare Part D
Appeals and Grievance B32AG
PO Box 1827
Medford, OR 97501

The following information must be submitted with the *Provider Appeal Form* or the written description of the issue(s) on Appeal:

i. A detailed description of the disputed issue(s);
ii. The basis for disagreement with the decision; and
iii. All evidence and documentation supporting your position.

Invalid Appeals

Examples of invalid Appeals where an Appeal should not be initiated:

- Claim was processed incorrectly.
- Issue qualifies for an exception (for example, due diligence or a misquote).
- Claim is not clean.
- Exception payment request.

Who Can Receive the Appeal Determination

The following may receive an Appeal determination:

- The treating provider
- The Member (the Member who received or will receive services)

- The parents of a minor child of an intact family
- The Member's authorized representative—requires a valid disclosure authorization from the Member.

Definitions

Adverse Determination (Appeal): For the purpose of the Provider appeal process, adverse determination means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of any of the following:

a. Application of utilization review;
b. Determination that a treatment is not Medically Necessary; or
c. Denials related to upcoding;
d. Application of a Current Procedural Terminology (CPT®) modifier, and/or other reassignment of a code by us to patient specific factual situations, including the appropriate payment when two or more CPT Codes are billed together, or
e. Whether a payment enhancing modifier is appropriate

Appeal Record: Includes all information which was relied upon in making the payment determination; or was submitted, considered, or generated in the course of making the payment determination, whether or not such document, record, or other information was relied upon in making the payment determination; or demonstrates compliance with our claims procedures, administrative processes and safeguards; or constitutes a statement of policy or guidance with respect to the payment determination.

Claims: A Provider's request for payment submitted in the usual course of business between the Provider and us.

Dispute: For the purpose of the Provider dispute process, dispute means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of any of the following:

a. Failure to secure Preauthorization
b. Determination that records do not support billing
c. Any other dispute that does not meet the definition of Adverse Determination outlined in the Definitions

External Review: Review of an Adverse Determination Appeal submitted to the External Review Organization with which we have contracted to provide these review services by a provider in compliance with the terms of the Adverse Determination Appeal Process.

External Review Organization ("ERO"): An independent organization employing providers and other medically qualified individuals or experts, which acts as the decision maker for External Reviews, through an independent contractor relationship with us.

"Our" or "We": References to our or we mean Regence or the Company.

Provider: Provider means provider, practitioner, clinic, dental provider, or other health care professional as defined in the Agreement.

Provider Appeal: Formal request from a contracted Provider to reconsider an Adverse Determination when the Provider is at financial risk for the services.

"You" or "Your": References to you or your mean Provider as defined in the Agreement.

Provider Adverse Determination Appeal and Dispute Process

Applicability. Our Provider Adverse Determination Appeal and Dispute Process will apply when the Provider is at financial risk for the cost of the claim. The member appeal process will apply when the member is or may be at financial risk for the cost of the claim.

The following are not eligible under the Adverse Determination Appeal or Dispute Process:

a. Appeals made by non-contracted providers. Appeals by non-contracted providers may be eligible for the member appeal process.
b. The member has filed suit under Section 502 of ERISA or other suit for denial of the health care services or supplies regarding an Adverse Determination.

Process for Submission of all levels of Adverse Determination Provider Appeals or Disputes

Use the *Provider Appeal Form*, which can be found on our provider website at **regencedental.com**.

The completed appeal form or a written description of the issue(s) on the appeal may be submitted via the electronic portal, or the mailing address or fax number listed in the Adverse Determination Provider Appeals or Disputes section on the Contact Us page of the Provider Web Site.

The following information must be submitted with the *Provider Appeal Form* or the written description of the issue(s) on appeal:

- A detailed description of the disputed issue(s);
- The basis for disagreement with the decision; and
- All evidence and documentation supporting your position.

Provider First Level (Internal) Appeals and Disputes

Timeframes

An internal level adverse determination Appeal or dispute for our Members must be submitted in writing within the following timeframes:

- Idaho providers located in Idaho: Within 12 months after payment of the claim or notice that the claim was denied. Regence BlueShield of Idaho providers located in either Asotin or Garfield counties in Washington: Within 24 months after payment of the claim or notice that the claim was denied or within 30 months for claims subject to Coordination of Benefits.

If a Provider wishes to appeal a refund request initiated by us, you can submit an Appeal within the same timeframe as listed above. Note: The timeframe begins when the written request for refund is sent to the Provider.

Failure to request review with all applicable documentation within the stated time period will preclude the right to appeal and may jeopardize the right to contest the decision in any forum.

Level One Internal Appeal and Dispute Review Provisions

The individual reviewing the issues(s) of the appeal/dispute will meet the following criteria:

i. Is not an individual who made or consulted in the initial determination;
ii. Is not a subordinate of an individual involved in the initial determination.

If your appeal/dispute determination is unfavorable in whole or in part, we will communicate a written decision on an Internal Review of an Adverse Determination Appeal within thirty (30) calendar days of our receipt of all

documentation reasonably needed to make the determination. A description of the External Review option will be supplied with the written decision, including the time limit for requesting External Review.

Additionally, for unfavorable determinations in whole or in part, you have the option to seek a Level Two appeal/dispute. A description of the Level Two Review option will be supplied, including the time limit for requesting a Level Two Review which is ninety (90) calendar days after the written Internal Review determination.

Provider Second Level (Internal) Appeals and Disputes

Level Two Disputes (Internal Review)

a. If the initial determination is upheld through the Internal Review process, the option to seek a second level Internal Review of the determination will be made available for Disputes.

b. Prerequisites for a Level Two Disputes (Internal) Review:

    i. The Level One Internal Review process must be exhausted before requesting a Level Two Internal Review.
    ii. Provider must submit a written notice to us within ninety (90) calendar days from the date of the Level One Internal Review Determination Letter.
    iii. The appeal meets the definition of a Dispute as described in the Definitions listed above. These disputes include:
        1. Failure to secure Preauthorization
        2. Failure to notify of Inpatient Admission
        3. Determination that services are related to a Hospital Acquired Condition
        4. Determination that records do not support billing during a Line Item Audit
    iv. Any other dispute that does not meet the definition of Adverse Determination outlined in the Definitions listed above.
    v. Only one Level Two review is available. If a Provider utilizes a second external level review process outlined above, a second internal review will not be made available.

Level Two Dispute (Internal) Review Provisions

a. The individual reviewing the issue(s) on appeal will meet the following criteria:
    i. Is not an individual who made or consulted in the initial determination;
    ii. Is not a subordinate of an individual involved in the initial determination.
b. If your appeal determination is unfavorable in whole or in part, we will communicate a written decision on a Second Level Internal Review of the Dispute within thirty (30) calendar days of our receipt of all documentation reasonably needed to make the determination. This is the final level of internal dispute review process.

The Provider has the option to request an in-person meeting. If no request for an in-person meeting is made, the process for review outlined above will proceed without one. If an in-person meeting is requested, the meeting will be held within forty-five (45) calendar days of the written request. If your appeal determination is unfavorable in whole or in part, we will communicate a written decision on a Second Level Internal Review of the Dispute within thirty (30) calendar days of the in-person meeting. This is the final level of internal dispute review process.

Level Two Adverse Determination Appeals (External Review)

If the initial determination is upheld through the Internal Review process, the option to seek External Review of the determination will be made available for Adverse Determination Appeals.

Prerequisites for Level Two Adverse Determination Appeals (External Review)

The Level One Internal Review process must be exhausted before requesting a Level Two External Review of the determination unless both we and the Provider agree in writing to forego the Internal Review process and proceed directly to External Review.

A Provider who chooses External Review will submit a written notice to us within ninety (90) calendar days from the date of the Internal Review Determination.

The appeal meets the definition of Adverse Determination as described in the Definitions listed above.

Level Two Adverse Determination Appeals (External Review) Provisions

An Adverse Determination Appeal may be submitted for External Review. The request for External Review is at the option of the Provider, who may instead choose any other dispute resolution allowed by the Agreement.

The Adverse Determination Appeal must be submitted to us in writing. The *Administrative Manual* and the *Provider Appeal Form* provides detailed contact information.

We will forward Adverse Determination Appeals that meet the prerequisites as listed above to a designated External Review Organization.

The Provider shall pay a filing fee of $50.00 for each Adverse Determination Appeal.

i. We shall notify you that the filing fee is due;
ii. Payment must be submitted before the External Review begins; provided, however, that you shall be entitled to a refund of such payment in the event that you prevail in the External Review process.
iii. You shall submit the filing fee within sixty (60) calendar days of notice from us that filing fee is due or the External Review request will be closed.

Upon receipt of a timely filing fee, we will provide to the External Review Organization the Appeal Record.

The External Review Organization will process the Adverse Determination Appeal and notify you and us of its recommendation within thirty (30) calendar days of receipt of the filing fee.

In the event that the External Review decision requires payment by us, such payment shall be initiated within fifteen (15) calendar days after we received notice of the determination.

Special Investigations Unit Appeal Process

The Special Investigations Unit Appeal Process is intended to give you an opportunity to request reconsideration of audit findings issued by our Special Investigations Unit Department and to ensure we have reviewed all information relevant to the audit findings. Please note that contract terminations resulting from audit findings must follow the Provider Contract Termination Appeal Process.

Level One Appeal. Upon receipt of our audit findings, you have forty-five (45) business days to review and dispute these findings before the audit becomes final. In order to appeal the findings, you must submit a written request for appeal. You will be given the address for where to send your request.

The request must be received by us within forty-five (45) business days of your receipt of the audit findings and must include, at a minimum, the following:

a. A detailed statement of the issue(s) in dispute;
b. At the election of the Provider, notification of a request for a meeting with the person(s) reviewing the issue(s) in dispute;
c. Any documents which the Provider contends supports your position
(Exception: Please note that all documentation required to justify your billing, including but not limited to chart notes, must be present in your files at the time of an audit. Additions to file documentation and/or the production of files that were not made available to us at the time of an audit will not be considered in connection with an appeal involving adverse audit findings. We will, however, consider your explanation as to why the documentation was not present at the time of the audit.)

If we do not receive such a request for appeal within forty-five (45) business days of your receipt of the audit findings, the findings will be final.

The Level One Appeal decision will be made by a manager of our Special Investigations Unit, and our other Regence representatives, as determined by the manager. At the discretion of the manager, one of our Medical Directors may be consulted prior to the final decision. A meeting, prior to the review of your request for reconsideration, can be arranged either at your office, at our office, or by telephone, as mutually convenient. You must request this meeting when submitting your request for appeal. At the meeting, you may appear in person and may be accompanied by an attorney or other representative. The purpose of this meeting is to give you an opportunity to present your position prior to the appeal determination.

If additional documentation to reach a decision is needed, the additional documentation must be submitted within twenty (20) calendar days of the date of our written request for information, unless your written request for a reasonable extension of time is granted. If the requested documentation is received on time, it will be included in the request for appeal.

If the documentation is not received on time, the appeal will continue and a decision will be made based on the information originally submitted.

During the period of time in which we are waiting for additional information, the appeal decision time frame is suspended until the information is received or the time to respond to the request has expired. You will be sent written notice of the decision within forty-five (45) business days following the meeting or, if no such meeting was requested, within forty-five (45) business days of our receipt of the Level One Appeal.

The decision on a Level One Appeal is deemed final forty-five (45) business days after your receipt of our decision, unless a timely written request for a Level Two Appeal is received.

Level Two Appeal. If you are not satisfied with the decision made following the first request for appeal, you may request a second appeal of the audit findings. The written request for a Level Two Appeal and any supporting information, must be received by us within forty-five (45) business days of your receipt of our decision. The address where to send your request will be included in our response to your Level One Appeal.

Level Two Appeals are categorized as either a clinical dispute or a non-clinical dispute. For clinical disputes, a Medical Director review will be held no more than forty-five (45) business days following receipt of the request, not including the time in which we are waiting for additional information from you. The review will be conducted by a Medical Director who was not involved in an earlier review of the audit findings.

For non-clinical (administrative/contractual) disputes, a decision will be made by a manager of the Special Investigations Unit not involved in an earlier review of the audit findings, and/or other Regence representatives, as deemed by the manager.

If additional documentation is needed to reach a decision, the additional documentation must be submitted within twenty (20) calendar days of the date of our written request for information, unless your written request for a reasonable extension of time is granted.

a. If the requested documentation is received on time, it will be included in the request for appeal.
b. If the documentation is not received on time, the appeal will continue and a decision will be made based on the information originally submitted.

During the period of time in which we are waiting for additional information, the forty-five (45) business day clock is suspended until the information is received or the time to respond to the request has expired.

You will be sent written notice of the decision within forty-five (45) business days following the Medical Director review, for a clinical dispute, or forty-five (45) business days following receipt of the Level Two appeal, for a non- clinical dispute.

The Level Two Appeal is the final step in the Special Investigations Unit Appeal Process. Once a decision has been made, the Special Investigations Unit Appeal Process has been completed and the decision shall be deemed final. If you are not satisfied with our decision after completing the Special Investigations Unit Appeal Process and want to continue to dispute the issue(s), you must initiate the appropriate process(es) as outlined in your Provider contract.

Section 19: Provider Contract and Credentialing Termination Appeals

A contracted Participating Dental Provider may initiate an Appeal of a contract termination decision made by A contracted Participating Dental Provider may initiate an Appeal of a contract termination decision made by Regence through the provider contract termination Appeal process.

You may also Appeal the decision of a denied credentialing application decision made by the dental credentialing committee by submitting a written notice of Appeal and any relevant material you feel pertinent to the decision.

To request an Appeal, you must send a written request to the Dental Provider Relations team at the address listed below within thirty (30) business days of receipt of the termination notification.

Level One

To request an Appeal, you must send a written request to the Dental Provider Relations team at the address listed below within thirty (30) business days of receipt of the termination notification.

By mail:
Provider Contract or Credentialing Termination Appeal
Attention: Provider Relations
P.O. Box 45132
Jacksonville, FL 32232-9902

The following information must be submitted with the *Provider Appeal Form* or the written description of the issue(s) on Appeal:

i. A detailed description of the disputed issue(s);
ii. The basis for disagreement with the decision; and
iii. All evidence and documentation supporting your position.
iv. Your requested outcome

Upon receipt of the Level One Appeal request, we will send you an acknowledgement letter within fifteen (15) business days. The Level One Appeal Panel is comprised of at least three (3) individuals that have not been directly involved in the Credentialing Committee or termination decision and have the appropriate level of knowledge and training to understand the issues presented. At least one panel member must be a participating provider. Level One Appeals meetings are held on a bi-monthly basis. Your appeal will be scheduled for review at the next available Level One Appeal Panel meeting, subject to the time your appeal request and any additional information are received and the volume of appeals being reviewed by the panel. If additional information is requested, it must be submitted within fifteen (15) business days of the date of the written request for information, unless a written request for a reasonable extension of time is granted.

a. If the information is not received on time, a decision will be made at the next Level One Appeal panel meeting, based on the limited information available.
b. If the additional information is received on time, the new information will be taken into consideration at the next Level One Appeal panel meeting.

Information not submitted within the time limit will not be considered for the Level One Appeal, unless otherwise allowed by the Level One Appeal Panel. You will receive a written determination within ten (10) business days of the Level One Appeal panel decision. The Level One Appeal decision is deemed final on the

thirtieth (30th) business day after you receive it, unless a written request for a Level Two Appeal is received timely.

Level Two

"In-Person Hearing". If you are not satisfied with the results of the Level One Appeal, you may submit a written request to the Credentialing Department, at the address listed on the Contact Us page on the provider website, for a Level Two Appeal, "in-person hearing" no later than thirty (30) business days after your receipt of the Level One Appeal decision.

The Level Two Appeal Panel is comprised of at least three (3) individuals that have not been directly involved in the Level One Appeal, the Credentialing Committee or the termination decision and have the appropriate level of knowledge and training to understand the issues presented. At least one panel member must be a participating provider.

The request for a Level Two Appeal must identify in detail the following:

a. All issues on which you request re-evaluation

b. Information not previously submitted to the Level One Appeal panel, if any

   (Exception: We expect all documentation required to justify your billing, including, but not limited to, chart notes, to be present in your files at the time of an audit. Additions to file documentation or the production of files that were not made available to us at the time of an audit will not be considered in connection with an appeal involving adverse audit findings. We will, however, consider your explanation as to why the documentation was not present at the time of the audit.)

c. Your requested outcome

   The hearing is generally completed within two (2) hours and will be scheduled for two (2) hours, unless you notify us when requesting your Level Two Appeal that additional time is needed. We will make our best efforts to accommodate reasonable requests for additional time, as long as we are notified when you request the Level Two Appeal.

Upon receipt of the Level Two Appeal request, we will send you an acknowledgement letter within fifteen (15) business days.

Level Two Appeals meetings are scheduled upon request. We will make our best efforts to provide proposed times and dates within sixty (60) business days of the Company's receipt of your Level Two Appeal request. Once you have been provided the proposed times and dates you will have five (5) business days to notify us of your preferred time and date for the Level Two Appeal hearing. If you fail to notify us of your preferred time and date for the Level Two Appeal hearing within five (5) business days of receiving the proposed times and dates, the hearing will be set on one of the proposed times and dates.

Prior to the Level Two Appeal hearing, you will receive a "Notice of Hearing". The "Notice of Hearing" will indicate the following:

a. Date of the hearing
b. Time of the hearing

c. Location of the hearing
d. Names of the members of the Level Two Appeal panel
e. Reasons for the adverse action
f. Names of witnesses who will testify on our behalf at the hearing
g. Your rights at the hearing

At the hearing, you have the following rights:

a. To have representation by an attorney or other person of your choice
b. To have a court reporter make a record of the proceedings at an additional cost to you. Costs associated with the court reporter must be paid by you prior to receiving a copy of the transcript
c. To call witnesses and to examine/cross-examine witnesses
d. To present relevant evidence (as determined by the panel)
e. To submit a written statement at the close of the hearing

Approximately thirty (30) calendar days before the scheduled date of the hearing, a Level Two Appeal binder will be sent to you or your representative. The binder will include, among other things, the documentation reviewed by the Credentialing Committee initially and at the Level One Appeal, as well as any documentation submitted by you. If you wish to submit additional information to further supplement the Level Two Appeal binder, this information, as well as a list of witnesses that you plan to call, examine, and cross examine at the hearing, must be received no later than fourteen (14) calendar days prior to the hearing date. Unless otherwise allowed by the Level Two Appeal panel, documentation and witnesses not submitted at least fourteen (14) calendar days prior to the hearing date will not be considered by the Level Two Appeal panel and should not be brought to the hearing for the panel's consideration. The only exception is that you may submit a written statement at the close of the hearing.

If the Level Two Appeal binder is later supplemented with new or revised information prior to the hearing, you will receive copies of the new or revised material as soon as practicable before the scheduled date of the hearing. After the Level Two Appeal binder has been finalized, it will be forwarded to the Level Two Appeal panel for review prior to the hearing. Neither you nor we may supplement the binder within thirteen (13) calendar days prior to the hearing, unless a written request for an exception is approved by the Chair of the Level Two Appeal panel.

You will receive written notification of the Level Two Appeal decision within fifteen (15) business days of the hearing. If the Level Two Appeal panel cannot reach a decision within fifteen (15) business days, or if additional information is needed to reach a decision, you will be informed of any additional information needed and a new date by which the decision will be made.

Decisions of the Level Two Appeal panel related to contract terminations are deemed final. Once a decision has been made by the Level Two Appeal panel, you have completed the Provider Contract Termination Appeals process. If you are not satisfied with our decision after completing the Provider Contract Termination Appeal process and want to continue to dispute the issue(s), you must initiate the appropriate process(es) as outlined in your provider contract.

Additional Information Regarding the Provider Contract Termination Appeals Process

Provider Status During a Contract Termination Appeal

You will continue as a Participating Dental Provider; however, you will be temporarily removed from all provider directories and any pending action by us is put in abeyance until the Appeal is resolved and a final decision is made. If, however, the basis for the termination decision relates to the health, safety or welfare of our Members, or if we have exercised our right to immediately terminate the provider contract for reasons allowed by the provider contract, your participation status will be terminated for the duration of the Appeal process and reinstated only if you prevail during the provider contract termination Appeal process.

The Data Bank Reportable Actions

We are required by law to report certain adverse actions or decisions against you to the data bank. If our termination decision stands, either by virtue of you choosing not to Appeal or if the decision is upheld by the Appeals panel, we may be obligated to report this termination to the data bank, as applicable. You may not “self-term” to avoid being reported to the data bank. Additional information on these reporting requirements is available on the data bank website, at **npdb.hrsa.gov**.

Section 20: Federal Employee Program (FEP)

Overview

The Federal Employee Program (FEP) is a nationwide federal employee program. Claims and customer service functions are administered through Regence. The FEP membership card is identified by the following enrollment codes:

Note: Blue Focus does not have Dental Benefits, but providers may see these enrollment codes on member ID cards.

ID Card Enrollment Code	Member's Plan
104	Standard Option Individual Policy
105	Standard Option Family Policy
106	Standard Option Self Plus One
111	Basic Option Individual Policy
112	Basic Option Family Policy
113	Basic Option Self Plus One

Participating Dental Providers should always verify Member eligibility first by going to Availity Essentials or the IVR. If the information is not available on Availity Essentials or IVR, you can call the FEP Customer Service Center at 1(877)668-4651.

Regence BlueShield of Idaho is responsible for servicing and recruiting the Participating Dental Network for FEP, and for ensuring the accuracy of the online provider directory and the provider file used for claims processing.

Participating Dental Providers must provide care to Members of both the FEP Basic Option and Standard Option plans. You can determine which plan a Member has by looking at the ID card (see samples on the following page). The card will have a unique ID number beginning with an "R" to indicate FEP, as well as one of the enrollment codes listed above.

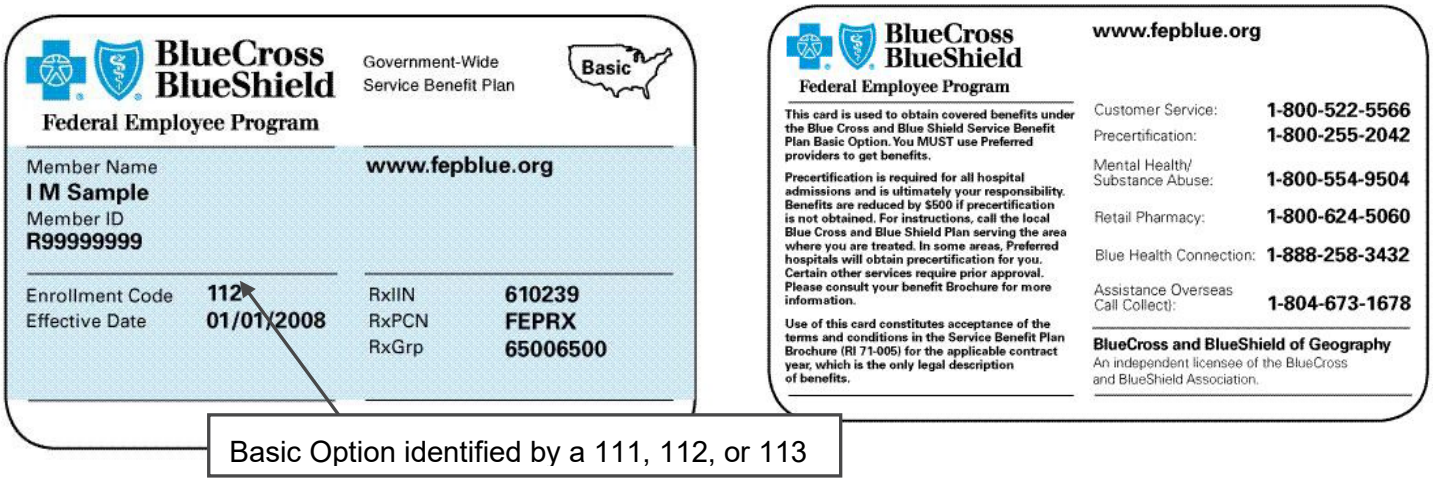
Highlights of Basic and Standard Options

Note: FEP refers nationally to the established allowance for a procedure (the amount you agree to accept as payment in full) as the maximum allowable charge (MAC).

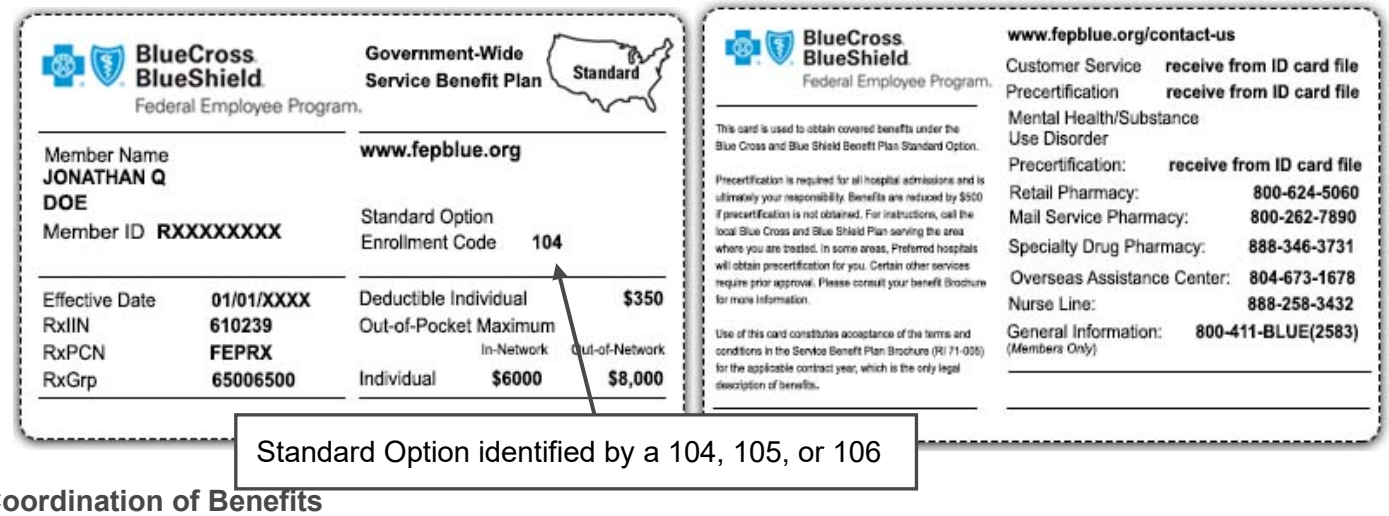
Features of Basic and Standard Options

- The Basic and Standard Options have separate lists of Covered Services.
- For procedures on both lists, the MAC is the same.
- For procedures not covered under either option, you may charge your usual fee.
- Neither plan requires payment of a Deductible.
- You can obtain a benefit brochure through **fepblue.org**
- The Customer Service for both options is: 1(877)668-4651
- For prior approval requirements, please visit **regence.com**

Basic Option



Standard Option



Coordination of Benefits

As explained in the Coordination of Benefits (COB) section, COB involves two or more Responsible Payors working together to share the cost of health care expenses, with one plan identified as primary (this plan pays first) and the other plan as secondary (this plan pays second). COB allows Responsible Payors to help manage the cost of health care by avoiding payment of more than the total reasonable expenses incurred.

When FEP is the secondary Responsible Payor, we will adhere to these guidelines:

- We will pay the difference between the primary Responsible Payor's payment and the lower of the MAC allowance or the dentist's charge.
- If the primary Responsible Payor's payment is equal to or greater than the MAC allowance, FEP will not owe a payment. If the primary Responsible Payor's payment is less than our allowance, we will coordinate and process up to the fee schedule not to exceed the MAC.

Whether FEP is the primary or secondary Responsible Payor, you may not bill Members for the difference between your charges and the MAC. Whenever you bill the secondary plan, always attach a copy of the primary Responsible Payor's EOB.

How to File a Claim

When filing claims for FEP Basic and Standard plan Members, please do the following:

- Include the policy Subscriber's ID number—an R followed by eight digits—in block 15 of the 2012 ADA claim form.
- Electronic claim submission is required for FEP. Claims can be billed through the vendor or Availity Essentials. Register for Availity Essentials access.
- Include the Member's ID number, not the Social Security number (the SSN is longer than the ID number).

FEP Reimbursement

Please see the tables below for examples of services covered under the Standard Option and Basic Option.

- The Standard Option codes listed are those reimbursed by the plan. You can bill Standard Option Members up to your MAC less the Standard Option Fee Schedule.
- You can bill Basic Option Members the $30 Copayment for Covered Services and your charge for any services not covered under the Basic Option.
- Please note age limits: Patients are considered children up to age 13; ages 13 and older are considered adults.

ADA Code	Narrative	Standard Option	
		Up to Age 13	Age 13+
CLINICAL ORAL EVALUATIONS			
D0120	Periodic oral evaluation*[1]		
D0140	Limited oral evaluation[1]		
D0150	Comprehensive oral evaluation[1]		
RADIOGRAPHS			
D0210	Intraoral complete series (seven or more films, including bitewings)[2]		

* Limited to two per person per calendar year
[1] Basic Option benefits limited to a combined total of two evaluations per person per calendar year for D0120 & D0150
[2] Basic Option benefits limited to one series every five years for D0210

ADA Code	Narrative	Standard Option	
		Up to Age 13	Age 13+
PALLIATIVE TREATMENT			
D9110	Palliative (emergency) treatment of dental pain – minor procedure		
D2940	Sedative filling		
PREVENTIVE			
D1110	Prophylaxis – adult	N/A	

D1120	Prophylaxis – child		
D1206	Topical application of fluoride varnish		
D1208	Topical application of fluoride – excluding varnish		
D1351	Sealant – per tooth, first and second molar only (*once per tooth for children up to age 16)* FOR BASIC OPTION ONLY		
D1352	Preventive Resin Restoration in a Moderate to High Caries Risk Member – Permanent Tooth – Children ages 0-15		

Reconsideration of an FEP Claim

Step 1 To request reconsideration of a claim decision you must:

a) Write to the local plan within 6 months from the date of the decision; and
b) Send your request to the address shown on your explanation of benefits (EOB) form for the local plan that processed the claim; and
c) Include a statement about why you believe the initial decision was wrong, based on specific benefit provisions; and
d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, dental records, and EOB forms.

The local plan will provide you, in a timely manner, with any new or additional evidence considered, relied upon, or generated at its direction in connection with the claim and any new rationale for the claim decision. The local plan will provide you with this information sufficiently in advance of the date that it is required of the reconsideration decision to allow you a reasonable opportunity to respond before that date. However, the local plan's failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate its decision on reconsideration.

Step 2 In the case of a post-service claim, the local plan has 30 days from the date they receive your request to:

a) Pay the claim or
b) Write to you and maintain its denial or
c) Ask you or your Member for more information.

You or your Member must send the information so that we receive it within 60 days of our request. The local plan will then decide within 30 more days.

If the local plan does not receive the information within 60 days, a decision will be made within 30 days of the date the information was due.

The decision will be based upon the information already on file. The local plan will provide a written response regarding its decision.

Section 21: Administrative Services Only (ASO) and Regence Group Administrators (RGA)

Administrative Services Only (ASO)

Regence administers medical, dental and prescription benefits for self-funded group plans, in addition to fully insured individual and group plans. Self-funded groups establish their own benefits and Regence is the third-party administrator that provides administrative services for their benefit plans. Due to this, self-funded groups customize their plans and may not be subject to Regence's administrative guidelines. We have a dedicated service center that administers benefits for all self-funded groups in Regence's service area.

Identifying Members

The back of the Member ID card will include two key pieces of information to help you identify ASO Members:

- A disclaimer explaining that Regence provides administrative services is in the lower left corner on the back of their Member ID card. The disclaimer states that "Regence provides administrative claims payment services only and does not assume any financial risk or claims."
- The Provider Contact Center number listed on the back of the card will be 1(866)227-0913 for the ASO Service Center.

Obtaining Pre-authorization

View our Pre-authorization lists and requirements. Our lists indicate which services are Pre-authorized by us and which are administered by one of our partners.

If Pre-authorization is required by Regence, submit requests using the Electronic Authorization application on Availity Essentials.

Verifying Eligibility, Benefits and Claims Information

We require physicians, dentists, other health care professionals and facilities to use Availity Essentials to access eligibility, benefits and claims-related information, such as payment details and vouchers. Some self-funded groups utilize month-to-month eligibility. Availity Essentials will refer you to our Provider Contact Center if the Member is on a month-to-month eligibility plan.

Submitting Claims

Claims for ASO Members should be submitted to us electronically, along with your other Regence Members.

Receiving Vouchers and Payment

Receive your payment vouchers electronically via an ANSI 835 transaction. View vouchers online using the remittance viewer on Availity Essentials.

Questions

If you have questions, please contact our Provider Contact Center at 1(866)227-0913.

Regence Group Administrators (RGA)

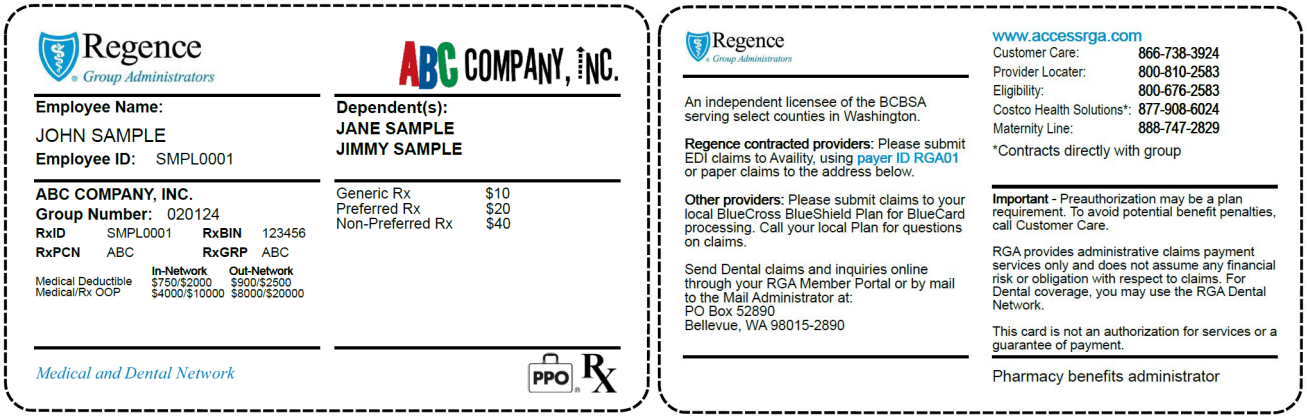
Regence Group Administrators (RGA) provides third-party administrative services to self-funded employer groups. RGA's self-funded employer group Members may utilize our Participating Dental Networks.

Members may live in or travel to our service area and seek services from you.

Identifying RGA Members

The front of the Member ID card includes the:

- RGA logo or
- National Account BlueCross BlueShield logo



Obtaining Pre-authorization, Eligibility, Claims Status or Answers to Other Inquires

Obtain this information by:

- Using RGA's secure Provider Services Portal.
- Contacting RGA's Customer Service department at 1(866) 738-3924.

Notes:

- Access RGA Member information on Availity Essentials.
- Select "Regence Group Administrators" to submit eligibility and claim status inquires.
- **Availity Essentials Payer ID for Regence Group Administrators**:
  - Use **RGA01** when submitting 270 and 276 transactions to Availity Essentials
- Please contact RGA to obtain Pre-authorization information for RGA Members. RGA employer group's Pre-authorization requirements differ from Regence's requirements. Self-funded plans typically have more stringent authorization requirements than those for fully Insured health plans.

Submitting Claims to RGA

Submit claims to RGA electronically or via paper.

- **Electronically**: Submit claims directly on Availity Essentials with Payer Identification Code ID RGA01.
- **Mail:** Regence Group Administrators, P.O. Box 52890, Bellevue, WA 98015-2890.
- The claim should include the prefix and the Subscriber number listed on the Member's ID card.
- Do not submit RGA claims to Regence. RGA claims that are submitted incorrectly to Regence will be returned with instructions to resubmit to the correct payer.

Receiving Vouchers and Payment

Vouchers and reimbursement checks will be sent by RGA. Claims information and vouchers for your RGA Members are available on Availity Essentials.

Provider vouchers and Member Explanation of Benefits (EOBs) will include a message code and description. As indicated in your provider agreement with Regence, you will need to hold the Member harmless (write-off) the amount indicated on the voucher when these message codes appear.

Payment Information

We generate weekly remittance advices to our Participating Dental Providers for claims that have been processed. Benefits are not assignable; you will receive direct payment even if your Member signs an assignment authorization. Corresponding to the claims listed on your remittance advice, each Member receives an explanation of payment notice outlining balances for which they are responsible.

View or download your remittance advices on Availity Essentials: Claims & Payments>Remittance Viewer or by enrolling to receive ANSI 835 electronic remittance advices (835 ERA) on Availity Essentials: My Providers>Enrollments Center>Transaction Enrollment.

Remittance advices contain information on how we processed your claims. A single payment may be generated to clinics with separate remittance advices for each provider within the practice.

Remittance advices include:

- Line-by-line breakdowns
- Specific error messages
- Boxes around the headers for each amount
- Codes billed by line item and then, if applicable, the code(s) bundled into them

Claims for your Members are reported on a payment voucher and generated weekly. They are sorted by clinic, then alphabetically by provider. Each claims section is sorted by product, then claim type (original or adjusted). Within each section, claims are sorted by network, Member name and claim number. The main pages include original claims followed by adjusted claims that do not have an amount to be recovered.

View our message codes for additional information about how we processed a claim.

Appeals

- Initial provider disputes and Appeals can be submitted by mail or fax:
  - **Mail**: Regence Group Administrators, Attn: Appeals, PO Box 52730, Bellevue, WA 98015-2730
  - **Fax**: Regence Group Administrators, Attn: Appeals 855-462-8875
- For inquiries regarding status of an Appeal, providers can email RGA directly.

Contact RGA

- Phone: 1(866)738-3924
- Access RGA's secure Provider Services Portal

Section 22: Technology Solutions

Common Terms

The following terms are important to know when using our technology solutions:

Clearinghouse	The entity that connects your office and the insurance carrier for electronic billing
Electronic Data Interchange (EDI)	The transmission of data from one computer to another
Electronic attachment	Any clinical documentation requested by the insurer to support your claim
Practice management software	The software program that allows you to manage your practice; often includes electronic-claims capability

Electronic Claims Submission

Technology can help you spend less time on paperwork and other administrative tasks, so you can spend more time caring for your Members. Regence offers technology solutions to help you and your staff do business with us more efficiently by:

- Improving claim payment time and office cash flow;
- Reducing claim errors; and
- Increasing productivity and efficiency by reducing time spent on billing and benefit inquiries.

Electronic Claims Filing Information

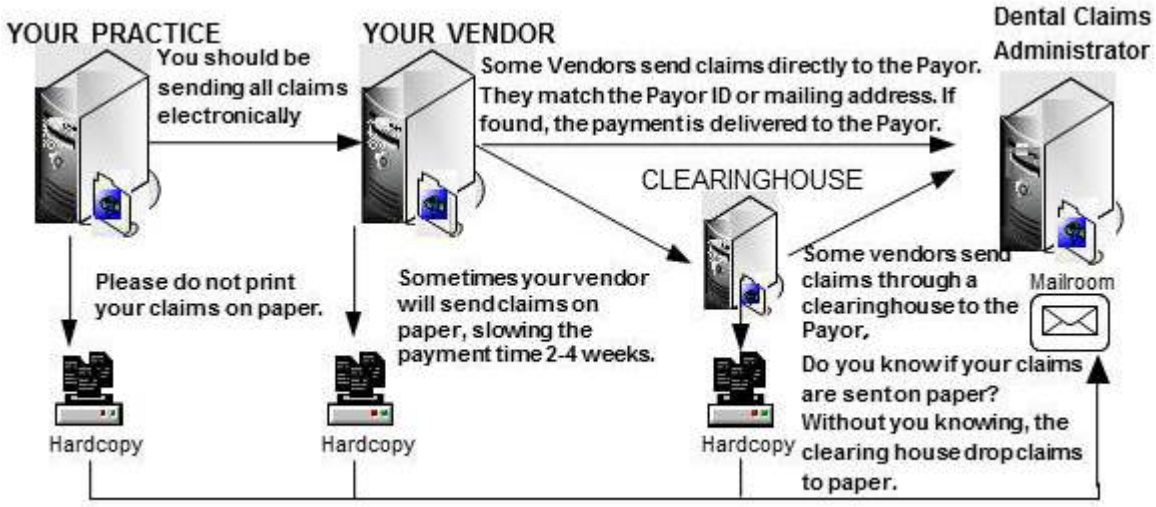
Claims are required to be submitted electronically. The advantages are listed above. One important advantage is that your vendor automatically corrects electronic claims prior to reaching us, so they are more likely to process without delay. You will receive a report confirming that your vendor did or did not receive each claim.

To get started, you will need:

- A computer with a modem and a printer
- Internet access
- Practice management or EDI-enabling software
- Notification to your software vendor of your provider billing number
- Know if your vendor is sending paper claims
- Know if your vendor's clearinghouse choice is sending claims on paper
- Ask your vendor what percentage of your claims is sent to the Responsible Payor electronically

Electronic Claims Illustration

The graphic illustrates how information flows among the entities involved in electronic claims submission.



Customer Support

If you have questions about filing claims electronically, please call our Technology Support Center at 1(800)253-0838, Monday through Friday, between 6:00 a.m. and 5:00 p.m. PST.

Self-Service Tools

Self-Service Tools and services are available to Regence Participating Dental Providers through our dental website. Registered users will have access to all of the following online services 24 hours a day, 7 days a week. To register for any of these online services, visit **regencedental.com**. From there, you will be directed to click on the Tools and Resources link, then click on Online Services, and finally, click Register. This will take you to Availity Essentials, where you will enter your information to register. Once you have completed the registration form, you will have a secure user ID and password, which will provide access to the tools on the following matrix.

Tool Service	What	How
MY PATIENTS' BENEFITS	Provides direct, up-to-the minute access to Member information and offers dental offices the ability to check Member eligibility and the status of Members' claims online for free.	**To verify Member eligibility and claim status:** • Go to **regencedental.com**. After being redirected to Availity Essentials, click on the **For Dentists** link, and then click on the **My Patients' Benefits** link. • Enter the required provider and Member information and click **Retrieve**. The Eligibility information for the Member is displayed. • To check the Claim Status for a Member, perform the same steps as above and click on the **Claim Status** tab. Select a date range and hit **Retrieve**.
PROVIDER CHECK INFORMATION	This online feature allows dental professionals to view check summaries, check detail and check-related claims for a selected date range.	• Go to **regencedental.com**. After being redirected to Availity Essentials, click on the **For Dentists** link. • Click on the **Reimbursements** link where you will be asked to enter a date range for a review of payments made to your office.

HIPAA ELIGIBILITY AND CLAIM STATUS TRANSACTIONS USING A CLEARINGHOUSE /VENDOR	Dental offices work with a multitude of Responsible Payors, and it can be difficult to determine which systems are compatible with every carrier. To make verifying eligibility and checking claim status easier for dental offices, we work with numerous clearinghouses and software vendors who can provide the ability for dental offices to perform these electronic transactions with all Responsible Payors using just one system.	Contact your software vendor to find out how you can perform these transactions through your practice management software.

Interactive Voice Response (IVR) System

Our interactive voice response (IVR) system offers physicians, dentists, other health care professionals, facilities, and their staff quick and easy access to Member information via phone. IVR is available 24 hours a day, seven days a week.

When calling our Provider Contact Center at 1(800)253-0838, use the phone prompts below to access IVR:

If the Member is a Regence Member, press 1 and select:

1. For questions regarding dental
2. For prescription Pre-authorization questions
3. For claims or eligibility information, not including Pre-authorization
4. For questions regarding mental health, chemical dependency, and/or hemophilia medication

If you do not select one of the above options, you will be placed in the general Provider Contact Center queue.

If the Member is not a Regence Member, press 2

Note: IVR does not include the following:

- Benefits
- Eligibility (for dental and vision)
- Medicare Advantage
- BlueCard
- Blue Cross Blue Shield Federal Employee Program® (BCBS FEP®)

The information available via IVR is also available online through Availity Essentials.

Options

Use your phone keypad to enter the touch-tone options or speak the voice option listed below.

Note: Information about multiple Members or multiple providers can be obtained in a single session. When checking multiple Members or using more than one tax ID number, the prompting options and order of options will change. Please listen carefully to the touch-tone or voice options.

Type of inquiry	Touch-tone option	Voice option	Information required
Claim status	1	Claims	• Provider tax ID • Member ID number • Member's date of birth • Date of service or date range of claim

Section 23: Medical Billing for Dental Offices

Medical Claims Billed by Dental Offices

Dental offices performing procedures not on or contiguous to a tooth must report the service on a medical claim form, with CPT codes. These codes must be reported with the appropriate ICD-10 diagnosis codes.

ICD-10 Coding Resources

ICD-10 CM and PCS medical billing codes may be helpful when submitting medical claims that require ICD-10 coding.

The following illustrates some common examples of services that should be billed as a medical benefit. This list is not all-inclusive and should be used as a reference only.

Sleep Apnea

- HCPCS E0486 Oral device/appliance used to reduce upper airway collapsibility, adjustable or nonadjustable, custom fabricated, includes fitting and adjustment.

TMJ

- CPT 21085 Impression and custom preparation; oral surgical splint (should not be used without surgery intervention)
- CPT 21089 Impression and custom preparation; unlisted maxillofacial prosthetic procedure (used to report mandibular repositioning devices where surgery is not part of the treatment plan for splint placement)

Implants

- CPT 21248 Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial
- CPT 21249 Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete

Biopsy

- CPT 40490 Biopsy of lip
- CPT 40808 Biopsy, vestibule of mouth

Other

- CPT 41899 Unlisted procedure, dentoalveolar structures can be used for extractions, crowns, build ups, root canals, dentures, or other procedures not separately identified with a CPT or HCPCS code.
- Note: Include the corresponding CDT code in the 2400 Loop, in the SV1 segment (professional service) and the SV101-7 (description) of the electronic medical claim.

Submit Diagnosis Codes on Dental Claims

We require diagnosis codes on certain dental claims to support expanded dental care benefits for Members with such conditions as heart disease, diabetes, or pregnancy. Diagnostic codes will identify why a procedure was performed and the associated disease, illness symptom or disorder.

We encourage you to begin including diagnosis codes when submitting dental claims to us as soon as possible. You can submit dental claims using the online claims submission tool on Availity Essentials: Claims & Payment>Dental Claim. You can submit up to four diagnosis codes in the record of services provided section.

Availity Essentials also includes training on how to submit a dental claim: Help & Training>Find Help>Claim Submission>Dental Claims>Submitting Dental Claims.