

Dental Provider Manual



Regence
BlueShield
of Idaho

An Independent Licensee of the Blue Cross
and Blue Shield Association

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Introduction

In 1946, twenty-seven physicians of the North Idaho Medical Society met to lay the foundation for what would become Idaho's premier prepaid medical service plan. With contributions of \$100 from each of the doctors, the North Idaho District Medical Service Bureau (now Regence BlueShield of Idaho) was incorporated on February 20.

Today, Regence BlueShield of Idaho finances health care for more than 300,000 members through traditional and managed care benefit plans and administrative service agreements in its service area which includes the state of Idaho and Asotin and Garfield counties in Washington. It is a mutual health insurance company and holds a certificate of authority to operate a managed care organization throughout the state of Idaho.

As compared with other Blue Shield and Blue Cross plans, Regence BlueShield of Idaho's operating cost is historically among the lowest in the nation. For example, 93 cents of every net premium income dollar is returned to members in the form of claims benefit payments.

Regence BlueShield of Idaho is headquartered in Lewiston, employs over 500 individuals and maintains offices in Boise, Coeur d'Alene, Pocatello and Twin Falls. It is an affiliate of The Regence Group that consists of four Blue Shield and/or Blue Cross plans located in four states: Idaho, Oregon, Washington and Utah. Our financially stable, customer-oriented companies are the backbone of the region's health insurance industry.

Regence BlueShield of Idaho is an independent licensee of the Blue Cross and Blue Shield Association, an association of 55 independent, locally operated Blue Shield and/or Blue Cross companies.

Definition of Terms

Accidental Injury - A dental accidental injury involves damage to the natural, sound and healthy tooth or tooth structure.

American Dental Association (ADA) - Office Headquarters: 211 East Chicago Avenue, Chicago, Illinois 60611. The telephone number is (312) 440-2500.

Approved Payment Amount - The amount which Regence BlueShield of Idaho has approved as full payment for a covered service.

Benefit - A service for which payment is allowed.

Benefit Year - A twelve month period which begins on the date the plan coverage becomes effective (i.e., May 1st of the current year through April 30th of the following year).

Calendar Year - A twelve month period beginning January 1st and ending December 31st each year.

Claim - A request for payment for services provided. Claims may be submitted electronically or on a current, universal ADA-approved claim form.

Coding - Current Dental Terminology, Fourth Edition (CDT-4) - the ADA approved dental coding system.

Coinsurance - A means of sharing the cost of dental services between the dental plan and an enrollee in which the enrollee pays a fixed percentage of the payment. For example, the dental plan would pay 80 percent and the enrollee would be responsible for 20 percent of the allowable amount.

Contractual Adjustment - The dollar amount that exceeds the Regence BlueShield of Idaho maximum allowable that the provider has agreed to absorb and for which the patient will not be held responsible.

Coordination of Benefits (COB) - A system which permits enrollees to receive benefits from all dental plans under which they have coverage while assuring that the total, combined payment from the plans is not more than the total charge for the service.

Coverage - The specific benefits offered to an enrollee under a dental plan.

Covered Service - Dental services and supplies for which benefits are provided under an enrollee contract.

Deductible - An out-of-pocket expense which an enrollee must pay before a dental plan's payment for covered services begins. For example, the enrollee might be responsible for the first \$50 (or other set deductible dollar amount) for covered services during the benefit year.

Dental Necessity - Necessary dental care is defined in enrollee contracts as necessary dental care (or some substantially equivalent term). Generally, enrollee contracts define necessary dental care as follows:

- It is the appropriate type, level, amount, and frequency of care necessary to treat a dental condition or injury that is harmful to the health of an enrollee;
- It is the least costly appropriate treatment and location that can be used safely to treat the enrollee's condition;
- It is consistent with widely accepted standards of practice;
- It could not have been omitted without adversely affecting the enrollee's condition or quality of care; and
- It is not primarily for the convenience of the enrollee, the dental provider, or any other person.

Dependent - A husband, wife, or child of an enrollee who is covered under the enrollee's benefit contract.

Dual Coverage - Coverage under two different Regence BlueShield of Idaho dental benefit policies.

Electronic Claims - Submitting claims electronically via a software system and a telecommunications device.

Enrollee - A person eligible to receive benefits under an enrollee contract.

Enrollee Contract - A contract or plan, underwritten or administered by Regence BlueShield of Idaho or other payor, entitling enrollees to receive benefits for the services of participating dental providers.

Excluded Service - A service which is not covered by an enrollee's benefit plan.

Explanation of Benefits/Explanation of Claims Processing - A statement sent to an enrollee by the dental plan which explains the action taken on a claim and gives information about any payment which has been made.

Fee-For-Service - A type of benefit plan which reimburses the provider based on the individual procedure(s) performed.

Group - The employer, union, association, or other organization which provides dental benefits for an enrollee.

Group Number - The number used to identify the employer or group which provides dental benefits for an enrollee.

Hold Harmless - The difference between the provider's charge and the plan maximum allowable for which the enrollee cannot be held responsible.

Identification Number - The number used to identify the enrollee; generally the enrollee's social security number. Regence BlueShield of Idaho members typically have a six digit identification number separate from their social security number.

Maintenance of Benefits (MOB) - A provision which limits what the plan will pay when it is in the secondary position so that the total benefit available under all plans does not exceed the highest benefit level between the plans.

Maximum Allowable Amount - The maximum dollar amount which Regence BlueShield of Idaho and the enrollee will pay for covered services.

Participating Provider - A dental provider who has signed a Participating Dental Provider Agreement with Regence BlueShield of Idaho.

Payment Rule - A rule adopted by Regence BlueShield of Idaho which describes policy used in determining payment.

Predetermination/Estimate of Benefits - An informational service Regence BlueShield of Idaho provides to determine whether or not the proposed service is a benefit of the contract prior to the delivery of services. It will also indicate whether the enrollee is eligible for benefits on the date the predetermination is completed, the amount that will be allowed, and whether Regence BlueShield of Idaho will consider the services to be necessary.

Primary Plan - The dental plan which has first responsibility to pay benefits when an enrollee is covered by more than one dental plan.

Provider - A licensed professional who provides dental care.

Regence BlueShield of Idaho Provider Number - A number assigned by Regence BlueShield of Idaho to identify a dental provider.

Secondary Plan - An additional dental plan which may cover dental expenses after the primary plan has made payment for an enrollee.

Tax Identification Number (TIN) - The number the provider uses to report earnings to the Internal Revenue Service.

Utilization Management - A mechanism designed to assure that enrollees receive dental services that are efficiently and cost-effectively delivered.

Voucher - A statement sent to a provider by Regence BlueShield of Idaho which explains action taken on claims and gives information on the accompanying payment. This form may also be called a payment remittance advice.

Who To Contact

Customer Service

Call Customer Service to Verify:

- Patient eligibility and effective date of coverage
- Specific information about your patient's benefits
- How to correctly file a claim
- Claim(s) status
- Payment amounts, hold harmless adjustments, and/or to request reconsideration of payment
- How dental, administrative, or payment policies were applied on specific claims

Benefit Information by Telephone

It is important to understand that this service is not designed to guarantee payment before you submit a claim. We provide you with the information available at the time; however, we cannot guarantee it will still be accurate when your claim is processed. For example:

- We can tell you that your patient appears to be eligible at the time of the call but we cannot prevent an employer from retroactively canceling your patient's coverage.
- We can tell you the available benefits at the time of your call; however, we cannot guarantee which benefits remain at the time your claim is processed.

Professional and Provider Relations

Call Your Provider Relations Representative To:

- Discuss the terms of your Participating Provider Agreement
- Review dental, administrative, or payment policies
- Request a personal visit to your office to discuss issues or problems or to assist with training office staff

Regence BlueShield of Idaho Telephone Directory

Customer Service:

..... (208) 746-2671
..... (800) 632-2022

Professional and Provider Relations:

..... 1 (866) 731-1330

Federal Employee Program (North Idaho only):

..... (208) 798-2035
..... (800) 732-1209

Regence Life and Health Insurance Company:

..... (800) 621-3330

Change of Address, Tax Identification Numbers, Etc.

For address changes, please send in writing to Regence BlueShield of Idaho, attention Professional and Provider Relations, or fax to (208) 798-2046.

Reporting Fraud and Abuse:

..... (800) 323-1693

Reporting suspected fraud and abuse; caller identity not required

Federal Employee Program Fraud and Abuse Hotline:

..... (800) 798-2038

Provider Contracts

Participating With Regence BlueShield of Idaho

As a participating provider with Regence BlueShield of Idaho, you have signed a Participating Dental Provider Agreement. You may choose to file a copy of your signed agreement following this page.

Advantages of Participation:

- Participating Providers are assured of direct, prompt, predictable payment.
- You are listed in the Regence BlueShield of Idaho Dental Participating Provider Directory.
- Claim payments are made to you on a weekly basis.
- Your patients' out of pocket expenses may be reduced when they seek dental care from a participating provider.
- Provider Relations staff are available by phone and in person to assist you and your staff.

Participating Providers Agree To:


- Accept Regence BlueShield of Idaho maximum allowable amounts as payment in full for covered services. Your patient is responsible only for coinsurance and deductible amounts and for services which are not covered by their benefit contract. Refer to the reimbursement section for more information.
- Bill Regence BlueShield of Idaho directly for services rendered. Patients should not be asked to bill Regence BlueShield of Idaho.
- Provide Regence BlueShield of Idaho with copies of enrollee's records (including x-rays) at no charge when Regence BlueShield of Idaho needs such records to make a claim determination, to perform utilization management or quality assurance activities, or to review the dental provider's billing practices. The dental provider will maintain records necessary to document the services for those claims submitted to Regence BlueShield of Idaho.
- Include provider number issued by Regence BlueShield of Idaho on all claims submitted to Regence BlueShield of Idaho.
- Maintain dental license, without restriction, to provide dental services. The dental provider will inform Regence BlueShield of Idaho within five (5) business days if disciplinary action of any kind is taken against the dental provider, if the dental provider is charged with a felony, convicted of a crime, or if a malpractice judgment is entered against the provider.
- Maintain adequate general comprehensive liability and professional liability coverage (\$1,000,000 individual, \$3,000,000 aggregate), and will provide a copy of the declarations page of the policy to Regence BlueShield of Idaho upon request.

- Provide covered dental services to Regence BlueShield of Idaho enrollees where such services are necessary and the dental provider is qualified to provide such services. In providing such services, the dental provider will meet the same standards of professional care that characterize the dental provider's services to non-enrollees.
- Willingness to abide by Regence BlueShield of Idaho dental policy guidelines as pertains to the determination of claims for Regence BlueShield of Idaho members.
- Willingness to bill Regence BlueShield of Idaho promptly for covered services (within 12 months of the date of service).
- Willingness to submit claims on the most current edition of the American Dental Association (ADA) standard claim form or electronically using the most current ADA procedure codes to report services.
- Willingness to refer to participating dental providers whenever possible.


Identifying Enrollees

Members are provided with an identification card when their coverage through Regence BlueShield of Idaho becomes effective. However, not all members with cards will have dental coverage. The identification card is neither an authorization for service or a guarantee of payment. We suggest you call the Regence BlueShield of Idaho Customer Service Department at 1-800-632-2022 or (208) 746-2671 to verify eligibility and benefits.

Sample Identification Cards

 **Regence
BlueShield
of Idaho**

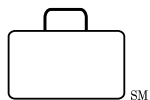
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 SM

ID No. **XNA 012345679** Group **ABC COMPANY**
Group No. **15000000** Plan **611**

Members
00 JANE M DOE
01 DEBBIE S DOE
02 TIMOTHY M DOE
03 JOHN A DOE

**COPAY OV \$15 ER/UC \$100/\$40 IP \$150/\$200
OP \$20**



- BlueCard

Filing Claims

Bill Directly

As a Participating Provider, you have agreed to bill Regence BlueShield of Idaho directly for services provided to your patients.

Using Your Regence BlueShield of Idaho Provider Number/Tax Identification Number

In order for your claim to be processed, each claim must include your Regence BlueShield of Idaho provider number. If you do not include this number or include the wrong number, your claim will be denied. Your tax identification number (T.I.N.) is used for income reporting purposes. If you are unsure of your provider number, check your payment voucher or call Customer Service or Provider Relations for assistance.

Offices With Multiple Dentists

Please submit claims using the name of the dentist who provided the service, rather than the name of the dentist who owns the practice. If you are participating with Regence BlueShield of Idaho and have additional dentists in your office who are paid as employees, please call us. Your Professional and Provider Relations Representative will assist you by setting up provider file records appropriately.

Claim Forms

All dental providers must submit claims using the current American Dental Association (ADA) standard claim form, unless submitting electronically. American Dental Association claim forms may be ordered from:

**American Dental Association
Department of Salable Materials
211 East Chicago Avenue
Chicago, Illinois 60611
(800) 947-4746**

Claims submitted more than twelve months after the service date generally will not be paid by Regence BlueShield of Idaho and may not be billed to the enrollee.

Please clearly label any reports or x-rays with the patient's name and identification number as well as the provider name and address and attach securely to the claim form.

Claim Form Explanation

This form is divided into two parts. The upper portion is for information concerning the patient and the member. The lower portion is for information regarding the services rendered by your office.

Listed below is a description of the information which should be contained in each block of the standard dental claim form. An example of the standard dental claim form follows. The blocks indicated with an asterisk (*) are required. If this information is not included, it may take longer to process your claim or it may be returned to you.

- * Block 1: **DENTIST'S PRETREATMENT ESTIMATE OR STATEMENT OF ACTUAL SERVICES, EPSDT/TITLE XIX**
By checking the appropriate box, the form will be processed more quickly and with less chance of error.
- * Block 2: **PREDETERMINATION/PRIOR AUTHORIZATION NUMBER**
Include appropriate information for government funded benefit programs as necessary.
- Block 3: **CARRIER NAME AND ADDRESS**
The name and address of the carrier where the claim is to be sent. On carrier-supplied claim forms, this information ordinarily will be preprinted at the top of the form.
- * Block 4: **IS PATIENT COVERED BY ANOTHER DENTAL PLAN OR IS PATIENT COVERED BY A MEDICAL PLAN?**
This is to determine multiple coverage. The information contained in items 5-11 is very important in order to determine which other carriers, if any, have primary liability for treatment provided.
- * Block 5: **SUBSCRIBER NAME (IF DIFFERENT FROM PATIENT'S)**
- * Block 6: **DATE OF BIRTH (MM/DD/CCYY)**
Refers to employee in # 5.
- * Block 7: **GENDER**
Refers to # 5.
- * Block 8: **SUBSCRIBER IDENTIFIER (SSN # or ID #)**
Refers to employee in # 5.
- * Block 9: **GROUP NUMBER**
Refers to #11.
- * Block 10: **RELATIONSHIP TO PRIMARY SUBSCRIBER**
Refers to employee in # 5.
- * Block 11: **NAME AND ADDRESS OF CARRIER(S)**
Refers to carrier(s) in #4.

- Block 12: **SUBSCRIBER NAME AND ADDRESS**
Refers to the insured person and is not necessarily the patient.
- Block 13: **SUBSCRIBER DATE OF BIRTH (MM/DD/CCYY)**
Very important for determination of coordination of benefits.
- Block 14: **GENDER**
Refers to # 5.
- * Block 15: **SUBSCRIBER IDENTIFIER (SSN # or ID #)**
The employee's social security number (SSN) is commonly used for an identification number, but some plans use an identification number that is different from the SSN.
- * Block 16: **GROUP NUMBER**
Refers to contract policy number assigned to the employer group.
- Block 17: **EMPLOYER (COMPANY) NAME**
Refers to employer of person in #12.
- Block 18: **RELATIONSHIP TO SUBSCRIBER**
Employee refers to the insured person and his or her relationship to the patient. This relationship sometimes affects the patient's eligibility, as well as level of benefits available.
- * Block 19: **STUDENT STATUS**
Eligibility of the dependent patient may be affected if the patient is over a certain age (specified in the benefits policy) and is still a full-time student.
- * Block 20: **PATIENT NAME**
This should be completed in full for proper identification purposes.
- * Block 21: **PATIENT BIRTHDATE**
Very important for determination of eligibility.
- * Block 22: **GENDER**
Refers to # 20.
- * Block 23: **PATIENT ID/ACCOUNT #**
Assigned by dentist.
- Block 24: **PROCEDURE DATE (MM/DD/CCYY)**
Self explanatory.
- * Block 25: **AREA OF ORAL CAVITY**
Self explanatory.
- * Block 26: **TOOTH SYSTEM**
Self explanatory.

- * Block 27: **TOOTH NUMBER(S) OR LETTER(S)**
Self explanatory.
- * Block 28: **TOOTH SURFACE**
Self explanatory.
- * Block 29: **PROCEDURE CODE**
Self explanatory.
- Block 30: **DESCRIPTION**
Self explanatory.
- * Block 31: **FEE**
Self explanatory.
- * Block 32: **OTHER FEE(S)**
Self explanatory.
- * Block 33: **TOTAL FEE CHARGED**
Sum of the fees for each procedure.
- * Block 34: **IDENTIFY MISSING TEETH WITH “X”**
Self explanatory.
- * Block 35: **REMARKS**
Use to indicate any information which you feel may be helpful in determining the benefits for the treatment. If space is inadequate, attach a separate page.
- * Block 36: **PATIENT SIGNATURE**
The patient is defined as an individual who has established a professional relationship with a dentist for the delivery of dental health care. For matters relating to communication of information and consent, this term includes the patient’s parent, caretaker, guardian, or other individual as appropriate under state law and the circumstances of the case.
- * Block 37: **SUBSCRIBER**
This block must be completed if the patient and/or the dentist wish to have benefits paid directly to the provider. This is an authorization of payment and does not constitute an assignment of benefits. It does not create a contractual relationship between the dentist and the payer.
- * Block 38: **PLACE OF TREATMENT**
Depending on where treatment is rendered, medical and/or hospital coverage (including dental benefits) may be applied. ECF stands for “extended care facility.”
- Block 39: **NUMBER OF ENCLOSURES (00-99)**
Radiograph, Oral Image or Model(s) indicates whether diagnostic materials were submitted. Assists in return of proper number of materials to dentist. (For specific requirements regarding x-ray requirements, please refer to page 20.)

- Block 40: **IS TREATMENT FOR ORTHODONTICS**
Self explanatory.
- Block 41: **DATE APPLIANCE PLACED (MM/DD/CCYY)**
Refers to # 40.
- Block 42: **MONTHS OF TREATMENT REMAINING**
Refers to # 40.
- * Block 43: **REPLACEMENT OF PROSTHESIS**
Most dental contracts have specific limitations on replacement of dentures, partials, crowns, and bridges. This is used to determine eligibility.
- Block 44: **DATE OF PRIOR PLACEMENT**
Indicate date of prior placement, if applicable.
- Block 45: **IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS / INJURY, AUTO ACCIDENT, OR OTHER ACCIDENT**
Refers to possible application of Workers' Compensation, which would alter coverage available and carrier involved. Important for coordination of benefits and accurate claims processing. Will affect reimbursement in no-fault auto cases. Indicates whether another party's insurance may be responsible. Also important for coordination of benefits.
- Block 46: **DATE OF ACCIDENT (MM/DD/CCYY)**
Refers to # 45.
- Block 47: **AUTO ACCIDENT STATE**
Refers to # 46.
- * Block 48: **NAME OF BILLING DENTIST, OR DENTAL ENTITY, ADDRESS WHERE PAYMENT SHOULD BE REMITTED**
The individual dentist's name or the name of the group practice/corporation responsible for billing. This may differ from the actual treating dentist's name. This is the name that should appear on any payments or correspondence that will be remitted to the billing dentist.
- * Block 49: **PROVIDER IDENTIFICATION NUMBER**
Insert your Regence BlueShield of Idaho provider identification number.
- * Block 50: **DENTIST'S LICENSE NUMBER**
This is the license number of the billing dentist. This may differ from that of the treating dentist, which appears in the Dentist's signature block at the bottom of the form.
- * Block 51: **DENTIST'S SOCIAL SECURITY NUMBER OR T.I.N.**
Refers to dentist or dental entity in # 21. Report the corporation T.I.N. if the billing dentist is incorporated. If the billing entity is a group practice, clinic, etc., the entity's T.I.N. should be entered.

* Block 52: **DENTIST'S PHONE NUMBER**

Self explanatory. Include area code.

* Block 53: **DENTIST'S SIGNATURE**

The treating dentist's signature and license number.

Block 54: **PROVIDER IDENTIFICATION NUMBER**

Insert your Regence BlueShield of Idaho provider identification number.

Block 55: **LICENSE NUMBER**

Refers to # 53.

* Block 56: **ADDRESS WHERE TREATMENT WAS PERFORMED**

Complete this section if the treatment was performed at a different location than indicated in #22 and #23.

Block 57: **PHONE NUMBER**

Refers to # 56.

* Block 58: **TREATING PROVIDER SPECIALTY**

Refers to # 53.

Where to Send Claims Forms

Send claims to:

**Regence BlueShield of Idaho
PO Box 31603
Salt Lake City, UT 84131-0603**

Claims for Regence Life and Health members send to:

**Regence Life and Health Insurance Company
P.O. Box 1071
Portland, Oregon 97207-1071**

Coding

Claims must be coded with current, ADA-approved procedure codes in order to be processed. Claims which are not coded correctly will be denied to rebill appropriately.

Please note: If a miscellaneous code is used, please include a full narrative description.

The American Dental Association (ADA) has compiled dental procedure codes into a Current Dental Terminology (CDT)–4th Edition User Manual. This manual may be ordered from:

**American Dental Association
Department of Salable Materials
211 East Chicago Avenue
Chicago, Illinois 60611
(800) 947-4746**

Reimbursement

Understanding Your Voucher

Payment vouchers, which explain payment for services provided to your patients, are sent to providers weekly. If payment is due from Regence BlueShield of Idaho, a check will be included with the voucher. Corresponding to the claims listed on your payment voucher, each patient receives an Explanation of Benefits notice outlining balances for which they are responsible.



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Provider Remittance Statement

THIS IS NOT A BILL

JOHN Q. PHYSICIAN
CHECK NO. 1234567891

ID No. 000012345678
TIN 198765432

Date 1/1/2003
VOUCHER NO 123456789012345

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Patient Name ID No./Group No. Acct. No. Claim No.	Dates of Service From-To	Proc-Code Modifier	Units	Total Charge	Contractual Adjustment	Paid By Other Insurance	Risk Withhold	Patient Responsibility				Payment to Provider	Msg Code
								Deductible	Copay/Coinsurance	Non-Covered	Total		
FOLLOWING CLAIMS FOR Dental Product FOR PHYSICIAN, JOHN Q.													
DOE, JANE A. ADDITIONAL MESSAGE CODES 987654321 NOT SENT 0000123401000	01/01/03 35	D1111111	1	500.00	0.00	0.00	0.00	0.00	0.00	500.00	500.00	0.00	88
CLAIM TOTAL				500.00	0.00	0.00	0.00	0.00	0.00	500.00	500.00	0.00	
TOTAL CLAIMS PAID FOR Dental Product FOR PHYSICIAN, JOHN Q.												0.00	



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PROVIDER REMITTANCE STATEMENT
THIS IS NOT A BILL

JOHN Q. PHYSICIAN
CHECK NO. 1234567891

ID No. 000012345678
TIN 198765432

Date 1/1/2003
VOUCHER NO 123456789012345

Page 1

PAYMENT SUMMARY			
PROVIDER NAME	PROVIDER ID	TOTAL BILLED	TOTAL PAYMENT
PHYSICIAN, JOHN Q	000012345678	500.00	0.00
VOUCHER TOTALS		500.00	0.00
MESSAGE CODE	EXPLANATION		
88	Adjustment amount represents collection against receivable created in prior overpayment		
35	Benefit maximum has been reached		

FORM RIV04D (Rev - 6/02)

Hold Harmless Requirement

As a Participating Provider you have agreed to accept our maximum allowable amount as payment in full for covered services when treating a Regence BlueShield of Idaho member. This means you may charge your patients only for deductibles, copayments, coinsurance and for non-covered services. You must hold harmless or write-off any balances exceeding the maximum allowable as shown in the examples below.

Example #1: 100% Benefit

	Billed Charge	Maximum Allowable Adjustment	Hold Harmless
D0150	\$43.00	\$42.00	\$1.00
D1110	\$55.00	\$51.00	\$4.00
D0274	\$33.00	\$30.00	\$3.00

Example #2: 80% Benefit

	Billed Charge	Maximum Allowable Amount	Paid Responsibility	Patient Adjustment	Hold Harmless
D2150	\$82.00	\$79.00	\$63.20	\$15.80	\$3.00
D2330	\$80.00	\$75.00	\$60.00	\$15.00	\$5.00

The hold harmless adjustments are the total amount your office will be asked to write off and not charge the patient when your charges exceed the maximum allowable amount. Hold harmless adjustments are indicated on your payment voucher.

Charges which are considered incidental to, or inclusive of, another procedure will be denied and subject to the hold harmless requirement.

Overpayments and Refunds

Whenever an adjustment is made to a previously processed claim, there will be an entry on a subsequent payment voucher reversing the paid claim. The reversal will be identical to the original claim, except for the minus signs beside the payment amounts.

Another entry will be made below the reversal, showing the amount that should have been paid on the claim.

If the combination of both entries results in a negative dollar amount, this will be subtracted from the total amount paid on the voucher.

In order to keep correct office records, the adjustment must be posted to the patient's account whose claim created the deduction. All other payments on the voucher must be posted as such to the appropriate patient's account. Under no circumstances should paid accounts be modified to compensate for out of balance deposits.

If your practice management system does not provide a mechanism for balancing insurance adjustments against deposits, you may wish to write a check back to the office out of your general account for the amount of the adjustment, identifying "Regence BlueShield of Idaho fund" and then deposit it with your Regence BlueShield of Idaho voucher check so the deposit will balance. Offices have told us this is a method they developed that requires no more steps than if they were actually writing the refund check to Regence BlueShield of Idaho. However, we suggest you check with your accountant and/or software support representative for their recommendation as there may be tax ramifications due to the need for adjustments to offset fee income.

Request for Reconsideration of Benefit Administration

If you disagree with a claim determination made by Regence BlueShield of Idaho, you may request reconsideration of our decision. (Reconsideration does not extend to a review of maximum allowables.) To do so, you must submit an appeal to Regence BlueShield of Idaho within 90 days of receiving payment or notification of Regence BlueShield of Idaho's claim determination. The appeal must be in writing, must identify the determination with which you disagree, and must state the basis for the appeal. Regence BlueShield of Idaho will respond within 60 days of receiving the appeal. If the dentist desires, they may be heard in person. Please see section 7.1 of your Participating Dental Provider Agreement for more specific information.

Coordination of Benefits/Maintenance of Benefits

Coordination of Benefits (COB) is a method of applying benefits from two or more dental plans which assures that the total, combined payment from the plans is not more than the total charge for the service.

Maintenance of Benefits (MOB) is another method of coordinating dual coverage. This provision limits what the plan will pay when it is in the secondary position so that the total benefit available under all plans does not exceed the highest benefit level between the plans.

When your patient has coverage with two or more dental plans, one plan is considered the primary plan and "pays first." The other plan is considered the secondary plan. The combined payments provided by the primary and secondary plans cannot exceed the total charges.

Coverage Under More Than One Dental Plan

When your patient has coverage under more than one plan, file the claims with the primary plan for processing. Upon receipt of payment from the primary plan, submit a fully itemized claim along with the primary plan's explanation of benefits to the secondary plan.

When your patient is covered by more than one Regence BlueShield of Idaho plan, you only need to file one claim with Regence BlueShield of Idaho. Be sure to list both member identification numbers on the claim. The claim will be processed under the primary plan first and then any remaining balance will be considered under the secondary plan.

Benefit Guidelines

How And When To Submit X-Rays/Documentation

Occasionally additional information (x-rays, narratives, chart notes, etc.) may be required to determine dental necessity and dental benefits according to the group's dental policy. The following is a list of procedures that require additional information to process claims.

Procedure	Description	Notes
D2510-D2530	Inlays-metallic	Requires pretreatment x-rays and/or photo
D2610-D2630	Inlays-porcelain/ceramic	Requires pretreatment x-rays and/or photo
D2650-D2652	Inlays-composite/resin	Requires pretreatment x-rays and/or photo
D2710-D2799	Crowns	Pretreatment x-rays required
D2950	Build-up	Requires pretreatment X-ray and/or photo
D2960-D2962	Veneers	Requires pretreatment x-rays and/or photo
D6210-D6792	Fixed partial dentures #6-11 and #22-27	Pretreatment x-rays required for anterior teeth
D9220-D9221	General Anesthesia IV sedation	Anesthesia or IV sedation billed in conjunction with extractions other than multiple partial or complete bony extractions requires x-rays and narrative to support dental necessity of anesthesia.
Miscellaneous/By Report Procedures		Any procedure that is listed as "by report" or any procedure not described in the CDT-4 book requires a narrative. Submit an x-ray/photo if it supports the narrative.

Pre-treatment x-rays should be of diagnostic quality. Please label duplicate or panorex x-rays "right" and "left". Also, please label x-rays with the date of the x-ray, patient's name and dentist's name and address. Unless otherwise noted, x-rays will be returned to the dental office. In some instances, additional information may be requested on procedures other than those referred to above.

Orthodontia Billing Guidelines

Orthodontia is a separate benefit. Not all policies cover orthodontia services. When submitting orthodontic claims, include the following information:

- Treatment start date
- Estimated length of treatment
- Total treatment charge
- Initial down payment
- Monthly payment amount

Claims must be submitted with the itemized monthly charges to obtain payment.

Alternative Procedures

Benefits will be provided for the least costly procedure when optional techniques of treatments are available. We recommend that treatment options are reviewed with the patient prior to rendering services.

For example, some dental policies allow only amalgam restorations for posterior teeth. When your office elects to do a composite restoration, Regence BlueShield of Idaho will reimburse at the maximum allowable for an amalgam only. However, the difference between the amalgam maximum allowable and the composite maximum allowable (or the billed amount, whichever is less) will be the patient's responsibility along with any co-insurance due.

Complications

A narrative describing any extenuating or unusual circumstances should accompany claim forms for charges in excess of your usual charge. The claim and narrative are referred to the Dental Consultant for review.

Estimate of Benefits / Predetermination

Pretreatment estimates provide benefit information and allowed amounts under the insured's policy, allowing both the patient and the provider to know estimated coverage prior to treatment.

PRETREATMENT ESTIMATES ARE NOT A GUARANTEE OF PAYMENT. Pretreatment estimates are approved subject to benefits, eligibility and maximum allowables in effect on the actual date of service. Please refer to How And When To Submit X-Rays / Documentation section of this manual to determine what information is needed to determine benefits.

Injury/Medical Dental Claims

Claims submitted for dental injuries or for medical conditions need to include description of how and when injury occurred and also medical diagnosis. In some instances, coverage may be provided under the patient's medical policy for injury or medical claims.

Charges That May Not Be Billed to Regence BlueShield of Idaho or to the Patient

- Charges for periodontal charting
- Charges for local or regional anesthetic in addition to an operative procedure
- Charges for submission of x-rays
- Charges for Provider write-off/contractual

Federal Employee Program (FEP)

How to Reach the Blue Cross and Blue Shield Plan Benefit

Federal employees are covered under the Blue Cross and Blue Shield Service Benefit Plan, also known as the Federal Employee Program (FEP). Please direct all telephone inquiries about your patients who are covered under this program to 1-800-732-1209. The mailing address for northern Idaho FEP dental claims and correspondence is:

**Regence BlueShield of Idaho
PO Box 31603
Salt Lake City, UT 84131-0603**

Preferred dentists are reimbursed directly and have agreed to accept a maximum allowable reimbursement for services rendered to federal employees with this coverage.

All covered dental procedures are listed in the employee's Blue Cross and Blue Shield Benefit Plan brochure. The only exception is impacted extractions which are covered under the medical portion of the contract.

Patients should identify themselves as covered under this program by presenting a Blue Cross and Blue Shield FEP identification card. See the Identifying Enrollees section of this manual.

All claims must be transmitted by Regence BlueShield of Idaho to the FEP national headquarters in Washington, D.C. for verification of eligibility and allowed benefits. Regence BlueShield of Idaho cannot process the claim until it is approved. Because of this requirement, we encourage you to submit claims for FEP enrollees promptly.

Tip: All corrections to billing, other carrier (secondary insurance) information and any other changes in information must be submitted in writing. Only a member may verbally notify the customer service department if they do not have insurance coverage through any other carrier. Please be sure to indicate Blue Cross Blue Shield and the member's ID number (the "R" number followed by eight numerical digits) on all of your correspondence to ensure that your information goes directly to this department.