

REIMBURSEMENT

Understanding Your Payment Voucher

Payments will be accompanied by a payment voucher that contains information about how your patients' claims were processed. The voucher, also known as the explanation of Claims Processed (EOCP) or remittance advice, is sent to participating dental providers weekly. Clinics may receive a single check with separate vouchers for each dental care professional within the practice. If payment is due from Regence, 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.

PATIENT NAME PROCEDURE CODE		IDENTIFICATION NUMBER	CLAIM NUMBER	DATES OF SERVICE	TOTAL CHARGES	ADJUSTMENTS	ALLOWED CHARGES	DEDUCTIBLE + CO-INS + OTHER INS	PATIENT BALANCE	TOTAL PAID
<p>INS: John U Public XNA951777819 GROUP: 951777819 CUST SVC: (503) 225-6619 / 1 800 722-5086 PAT ACCT: UNKNOWN</p> <p>SELF 604229222 020106 020106 211.00 1.00 210.00 .00 42.00 168.00 **</p> <p>00150-DIAGNOSTIC 49.00 .00 49.00 .00 9.80 39.20</p> <p>00210-DIAGNOSTIC 89.00 .00 89.00 .00 17.80 71.20</p> <p>01110-FREVENTIVE 73.00 1.00 * 72.00 .00 14.40 57.60</p> <p>*HOLD HARMLESS ADJUSTMENT. DO NOT BILL THE PATIENT FOR \$ 1.00 -CHARGES EXCEED OUR FEE SCHEDULE OR MAXIMUM ALLOWABLE AMOUNT</p>										
<p>INS: Jan P Public XNA951777819 GROUP: 951777819 CUST SVC: (503) 225-6619 / 1 800 722-5086 PAT ACCT: UNKNOWN</p> <p>604824442 021406 021406 64.00 .00 64.00 50.00 52.80 11.20 **</p> <p>00140-DIAGNOSTIC 47.00 .00 47.00 47.00 47.00 .00</p> <p>00220-DIAGNOSTIC 17.00 .00 17.00 3.00 5.80 11.20</p>										

Hold Harmless Adjustment

As a participating dental provider you have agreed to accept our maximum allowable charge (MAC) as payment in full for covered services when treating a Regence 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

Code	Billed Charge	Maximum Allowable	Hold Harmless Adjustment
D0150	\$22.00	\$20.00	\$2.00
D1110	\$45.00	\$42.85	\$2.15
D0274	\$25.00	\$22.50	\$2.50

Example #2: 80% Benefit

Code	Billed Charge	Maximum Allowable	Paid Provider	Patient Responsibility	Hold Harmless
D2150	\$55.00	\$53.56	\$42.85	\$10.71	\$1.44
D2330	\$60.00	\$55.43	\$44.34	\$11.09	\$4.57

Example #3: 100% Benefit After Copay

Code	Billed Charge	Maximum Allowable	Copay	We Owe	Patient Responsibility	Hold Harmless
D0140	\$35.00	\$34.41	\$20.00	\$14.41	\$20.00	\$0.59
D0274	\$25.00	\$22.95	\$00.00	\$22.95	\$00.00	\$2.05

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 MAC. Hold Harmless adjustments are indicated on your payment voucher under the heading "Adjustments", the fee will have an asterisk next to the dollar amount. Charges that are considered incidental to, or inclusive of another procedure, will be denied and subject to the Hold Harmless requirement.

Overpayments and Refunds

If you receive an overpayment on a claim, or a payment for someone else's patient, please send a copy of the voucher with the incorrect payment noted, an explanation of the error and a check for the amount of the error to :

Regence BlueCross BlueShield of Oregon
Attention: Cash Control – Mail Station C2C
PO Box 1271
Portland, OR 97207-1271

An adjustment for the error should appear on a subsequent payment voucher once the correction has been made. If you prefer, you may contact Customer Service to discuss the error and arrange the necessary corrections. Their phone number(s) can be found in the Who To Contact section of this manual.

If the adjustment results in a negative dollar amount, an overpayment letter will be sent requesting return of the funds. If the funds requested are not received within 45-days, a credit of this amount will be posted against your account. In order to keep correct office records, the adjustment must be posted to your 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 your office out of your general account for the amount of the adjustment.

Identify this check as a “Regence BlueCross BlueShield of Oregon refund” and then deposit it with your Regence voucher check so the deposit will balance. Office managers who developed this method say it requires no more steps than if they were actually writing the refund check to Regence . However, we suggest you check with your accountant and/or software support representative for their recommendations, as there may be tax ramifications due to the need for adjustments to offset fee income.

Coordination of Benefits/Maintenance of Benefits

Coordination of Benefits (COB)

Coordination of Benefits (COB) is a method of applying benefits from two or more dental plans to ensure that the combined payment from both plans is not more than the total charge for the service. 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 or exceed what the patient would owe if he/she had only one insurance plan.

For example: Jane Smith has double coverage, with Regence as her secondary carrier. Jane receives services totaling \$150. Her primary plan is an 80/20 plan, and the primary plan allows \$120 for these services. The primary plan would pay \$96 (80%), leaving a patient responsibility of \$24 (20%). Under the Coordination of Benefits provision, if the secondary payer (Regence) also allows \$120 for the services, we would pay the full \$24 the patient owes.

If, however, Regence only allows \$100 for these services, we would only pay \$4. (\$100 allowable minus \$96 paid by the primary carrier equals \$4.) The provider would write-off the remaining \$20 because he has contracted to hold the member harmless for amounts over our maximum allowable.

Maintenance of Benefits (MOB)

Maintenance of Benefits (MOB) is another method of coordinating dual coverage. This provision limits what the secondary plan will pay so that the total benefit available under all plans does not exceed the Regence benefit maximum.

Using the same example, change Jane’s Regence Plan to a Maintenance of Benefits 80/20 plan. Her primary plan is still an 80/20 plan, allowing \$120 for her services, and has paid \$96 (80%). If Regence also allowed \$120 for the same services, we would have paid \$102 (85%). Because the primary plan already paid \$96, we would pay the additional \$6 to bring payment up to the 85% of the allowed amount. Jane would then be responsible to pay the remaining \$18 (15%) of the allowed amount.

If, however, Regence only allowed \$100 on these services, we would make no further payment because the primary plan had already paid more than the 85% we would have paid if we were primary. Jane would be responsible to pay \$24 (20%).

Coverage Under More Than One Dental Plan

When your patient has coverage under more than one plan, file your claims with the primary plan first for processing. Upon receipt of payment from the primary plan, submit a fully itemized claim along with the Primary Plan's Explanation of Benefits (EOB) to the secondary plan. If the claim for secondary payment is received without the primary plan's EOB, the claim will be denied for this information.

When your patient is covered by more than one Regence plan, you need only file one claim with Regence. Be sure to list the identification numbers for both plans on the claim, using the appropriate primary/secondary positions. The claim will be processed under the primary plan first, then any remaining balance will be considered under the secondary plan. The exception to this is if the Federal Employee Program is one of the plans. Claims do not automatically "cross-over" to or from FEP. If you are uncertain as to which plan is primary (i.e., a child has coverage under the plans of both parents), please call our Customer Service Department for assistance.