

# PROVIDER AGREEMENTS

## Participating with Regence

As a participating Regence dental provider, you have signed a Participating Dental Provider Agreement, or are a provider in a clinic setting that has signed a Participating Dental Group Agreement.

### **Benefits of Participation**

- Participating dental providers are assured of direct, prompt, predictable payment on a weekly basis.
- You are listed in the Regence Participating Dental Directory.
- Your patient's out-of-pocket expenses may be reduced when they seek dental care from a participating provider.
- Dental Relations representatives are available by phone and in person to assist you and your office personnel.

### Participating Dental Providers agree to:

- accept Regence maximum allowable amounts as payment in full for covered services. Your patient is responsible only for copayments, coinsurance and deductible amounts and for services that are not covered by their benefit contract. Refer to the Reimbursement section for more information.
- bill Regence directly for services rendered. Patients should not be asked to submit their own claims to Regence.
- bill Regence promptly for covered services (within 12 months of the date of service).
- provide Regence with copies of members' records (including x-rays), at no charge, when Regence needs such records to make a claim determination. The dentist will maintain records necessary to document the services for those claims submitted to us.
- maintain a current dental license without restriction, to provide dental services. The dental provider will inform Regence within (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 provide a copy of the declarations page of the policy to Regence upon request.
- abide by Regence dental policy guidelines as it pertains to the determination of claims for Regence members.
- provide covered dental services to Regence members 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 providers' services to non-members.
- submit claims on the most current edition of the American Dental Association (ADA) standard claim form or electronically, using the most current CDT procedure codes to report services rendered.

### **Confidentiality Requirements**

As a Regence dental provider, it is your responsibility to abide by all applicable provisions of the law concerning the confidentiality of patient information and records. Regence members are informed through member materials of our commitment to protecting the confidentiality of their information and records. The following is Regence policy regarding patient confidentiality.

### **Right to Approve Release of Information**

Disclosure outside of Regence is permitted only when necessary to perform functions related to providing coverage and/or when otherwise allowed by law. Subject to certain exceptions, Oregon law requires insurers to obtain a written authorization from the member or their representative before disclosing personal information.

### **Routine Consent**

By signing the enrollment form, members are authorizing Regence BCBSO to obtain health information about them and their dependents as necessary:

- To determine eligibility for coverage.
- To pre-authorize or process claims for benefits.
- To perform provider credentialing, utilization management, or quality assurance reviews.
- To conduct audits

### **Access to Records**

Members have the right to obtain and inspect a copy of their personal information for as long as our business associates or we maintain it. Members can submit a request in writing identifying the information requested. Requests should be sent to the address on the identification card.

### **Use of Measurement Data**

Regence collects and analyzes claim information to perform care management, case management and other clinical activities. The data is used to identify areas of improvement for the care and service members receive.

### **Protection of Privacy**

Our staff is committed to assuring personal information is kept confidential. Only Regence and employees who need information in order to do their jobs (e.g. process claims) may access member information. In addition, Regence requires

persons and entities with whom it contracts to maintain the confidentiality of our members' health information.

### **Members Unable to Give Consent**

There are situations when a member cannot give an authorization for the release of information. An adult or emancipated minor who is legally authorized to act on behalf of an individual for health care decisions can act as a legal representative. If not already on file, Regence will request proof of the members' legal representative.

### **Information and Employers**

We will not disclose personal information to any employer, union or other entity that sponsors the group health plan without the individual's authorization. Only minimum necessary patient de-identified information may be released as long as the employer signs a privacy protection agreement with us.

## **Provider Appeal Procedures**

### **Informal Resolution of a Dispute**

If a dental provider feels that a claim has been paid incorrectly or improperly denied, the dental provider may contact a Regence customer service representative or a dental relations representative to investigate their concern and provide oral information so that Regence can review the determination. A majority of such disputes can be resolved informally. If the representative is unable to satisfactorily resolve the claim dispute and the dental provider wishes to proceed further, the dental provider may initiate the Billing Dispute Process.

**Note:** *In most cases where the provider wishes to appeal a matter in which a member has an interest, the **Member Appeals** process must be used. Please refer to the Member Appeals section beginning on page D-5 for additional information.*

### **Billing Dispute Process**

If you feel a claim has been paid incorrectly or improperly denied, please initiate the billing dispute process by submitting a written request via regular mail to your dental relations representative or to the following address:

**Regence BlueCross BlueShield of Oregon  
Attn: Dental Services – Billing Dispute  
PO Box 1271, M/S E7F  
Portland, OR 97207**

Please send all pertinent information, including copies of original payment vouchers and other documents that will help us investigate the claim in question. To ensure that the documents are handled appropriately, please include "billing dispute" on all documents submitted. After we review the information, we will

make our decision within sixty (60) days of the complaint. If you disagree with our decision, you may invoke the Internal Provider Appeal Process as set forth below.

### **Internal Provider Appeal Process**

If your dispute regarding any Company action or determination cannot be resolved through communications with provider customer service or your dental relations representative, you may utilize the internal provider appeals process. This formal process is used to adjudicate disputes between providers and Regence. You must exhaust the internal provider appeals process before seeking arbitration or mediation, as set forth in your participating provider agreement with Regence. As a reminder, claims adjudication issues must go through the billing dispute process set forth above before proceeding to the internal provider appeals process.

To initiate the internal provider appeals process, you must mail a request for an internal providers appeal hearing to us at the following address:

**Regence BlueCross BlueShield of Oregon  
Attn: Dental Services – Appeals  
PO Box 1271, M/S E7F  
Portland, OR 97207**

We must receive the written request no later than thirty (30) days after you have been notified in writing of the determination of the billing dispute or the determination of the billing dispute will be deemed final. Any additional documentation or information that you desire to be reviewed at the internal appeals hearing should be enclosed with the request for a hearing. You should also specify whether you would like the matter heard as a conference call or as an “in person” meeting. We shall schedule the appeals hearing for a date not later than thirty (30) days after receipt of the written request. The appeals hearing will generally be completed within one hour and shall not exceed four hours. You and Regence may be represented at the appeals hearing by legal counsel. The appeals committee shall render a decision within fifteen (15) days after the hearing unless additional information is needed to reach a final decision. In such case, you will be notified of the delay and/or given a description of the additional information requested. A new date will be established by which the decision will be made. The appeals hearing is the final step in the internal provider appeals process. Once a decision has been made by the appeals committee, you have completed the internal provider appeals process.

## Additional Information Regarding the Internal Provider Appeals Process

### **Failure to Timely Appeal**

If you fail to submit a complete and timely appeal, you will be deemed to have accepted the Regence's last determination of the issues raised by you and to have waived all further internal, external, judicial or arbitral process regarding the issues.

### **Provider Status During Appeal Process**

Generally, on receipt of an appeal meeting the criteria set forth herein, you will continue in your prior status, and any pending action by Regence 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 safety or welfare of our members, the status of your license, or if we have exercised our right to immediately terminate as set forth in your contract, your participating status may be suspended for the duration of the appeals process.

***Effect of Appeals Process:** This process is not intended to create any substantive rights for you or to guarantee participation with Regence. Just as you remain free to choose not to contract with Regence, Regence is free to decide whether to enter into or maintain a contract with a provider.*

## Member Grievance and Appeal Procedures

These procedures are designed to keep lines of communication open and to provide an opportunity for mutual understanding among our members, providers and facilities and Regence. Complaints, grievances and appeals from members are promptly directed to appropriate individuals within Regence so action can be taken quickly, and on an informal basis, if possible. The member appeal process outlined below not only meets rigorous regulatory and quality standards but is designed to administer a fast and fair system for our members.

If Regence members have concerns regarding a decision, action or statement by a provider or facility, we encourage members to discuss their concern with the individual or facility involved. If the member remains dissatisfied after this discussion, they are guaranteed the right to file a complaint, grievance or an appeal. As a participating provider or facility, it is your responsibility to respond to requests for dental records and other sources of documentation **within seven days** of our request. This timeline is to ensure the member receives a timely response to their health-care needs.

**Complaints** are defined as oral expressions of dissatisfaction.

**Grievances** are defined as written expressions of dissatisfaction.

**Appeals** are written or oral requests from a member or, if authorized by the member, the member's representative, to change a previous decision made by Regence concerning:

- Access to health-care benefits, including adverse determinations made pursuant to utilization review
- Claims payment, handling or reimbursement for health-care services
- Matters pertaining to the contractual relationship between a member and the Plan
- Other matters as specifically required by state law or regulation

**Member Representative** is any authorized representative of the member, as designated in writing by the member on an "Authorization Form", e.g., relative, attorney or provider. At any time, the member may obtain a member representative to file a grievance or appeal on their behalf. A signed authorization from the member must be obtained before processing the issue. **Please note:** For expedited appeals only, a health-care professional with knowledge of the member's condition is recognized as the member's representative, and no "Authorization Form" is needed.

### **Oregon and Washington Member Grievance and Appeal Process**

Regence BCBSO members are entitled to three levels of review. At any time during the process, Oregon-based members may file a complaint with the Department of Consumer and Business Services:

Oregon Insurance Division; Consumer Protection Unit  
350 Winter Street NE, Room 440-2  
Salem, OR 97310  
[www.cbs.state.or.us/external/ins](http://www.cbs.state.or.us/external/ins)

#### **Level One – Grievance**

Filing a grievance is the first level of review. Members have the right to voice their complaint orally or in writing within 180 days of receipt of the written notification of the decision. If a member chooses to file a grievance orally, Customer Service will provide assistance to the member by accepting information about the member's grievance over the phone. This information will be documented and read back to the member to ensure accuracy.

The grievance coordinator will acknowledge receipt of the complaint and advise the member of all member rights and gather the necessary information to thoroughly investigate the substance of the issue. Upon completion of the review, the grievance coordinator will send a written response to the member. Grievances involving pre-service issues are responded to within 14 calendar days; investigational issues are responded to within 20 working days; and post-

service issues are responded to within 30 calendar days.

If the decision is not in the member's favor, we will let the member know they have a right to file an appeal.

### **Level Two – Internal Appeal**

The member or member representative may file an appeal. If the appeal involves a clinical issue, the member or member's representative may appear before the panel at this level of review. The appeal coordinator acknowledges the receipt of the appeal by the 5<sup>th</sup> day. The acknowledgement must be in writing and must state all member rights. Documentation is compiled by the coordinator then presented to an internal appeal panel. The panel is comprised of three voting members not previously involved with the case. The medical director shall, if not appropriately qualified to review the case in a particular procedure, consult with an outside practitioner in the same or similar specialty of the medical procedure or condition involved as part of the review. A written response is sent to the member in:

- Fourteen (14) days for pre-service issues
- Twenty (20) working days for investigational procedures
- Thirty (30) days for all other appeals

If the decision is not in the member's favor, the member is informed of the next level of appeal and again informed of their rights to file a complaint with the Oregon Insurance Division. For clinical issues, the member is informed of the right to file the appeal with an Independent Review Organization (IRO) within 180 days. For all other non-clinical issues, the member is informed of their right to file a final appeal to be considered by another internal three-member panel.

### **Level Three Appeals**

#### ***External Appeal with an Independent Review Organization (IRO)***

The appeal is filed and acknowledged within five days. The coordinator requests regulator appointment of the IRO within 2 business days. All documentation, including a written summary of the facts, is delivered to the IRO within 6 business days. The IRO is unbiased, independent and not controlled by the Plan. The member receives a written response from the IRO within 30 days of the Plan's receipt of the member's appeal.

#### ***Level Three Internal Appeal – Oregon***

All benefit administration appeals are handled through a third level internal review panel. The member or their representative has the right to appear in person at this level of review. Documentation is compiled by the appeal coordinator and presented to an internal appeal panel. The panel is comprised of representatives not involved in the previous, or first-level, appeal. A decision is made within five days. The written response is sent to the member within 14 days

for pre-service appeals or 30 days for post-service appeals. Our response will remind the member that they may also file a complaint with the Oregon Insurance Division.

### **Expedited Appeals**

A Regence BCBSO member may request an expedited appeal if

- The member or member's provider reasonably believes that denying a pre-service issue could jeopardize the member's life, health or ability to regain maximum function, or
- a provider with knowledge of the member's medical condition reasonably believes that denying a pre-service issue could subject the member to severe pain that cannot be adequately managed without the disputed care or treatment.

The member, their representative or the provider may request an expedited appeal either verbally or in writing. **Please note:** For expedited appeals only, a health-care professional with knowledge of a member's medical condition is recognized as the member's representative and no "Authorization Form" is needed.

Expedited appeals are responded to within 72 hours by certified mail. Expedited requests can also be presented in person, by telephone or by FAX.

Providers cannot file an expedited appeal request on their own behalf for "termination of care." All verbal requests must be documented and read back to the requester.

As a participating provider, you can minimize the complaints and appeals by:

- Being knowledgeable about covered and non-covered services. If you authorize Medicare members to receive non-covered services and the members have not been informed that they are liable for the cost of such services, the Plan is liable for the cost of the service.
- Service cannot be denied retroactively for a service you order based upon a determination that the service exceeds Medicare Limits. The only exceptions are the presence of written evidence that the service is not covered unless further action is taken by the member in cases where the member should be expected to know that the services were not covered.
- If you provider or direct a beneficiary to receive a covered Medicare service without following Plan procedures, the Plan must cover the service. The Plan cannot penalize a beneficiary who has already received a service is your referral was improper or the referral specialist delivered the service without the necessary authorization.
- Acknowledging and upholding member's right to complaints, grievances and appeals.
- Explaining these rights to members who contact you to express a concern

- or dissatisfaction.
- Assisting Regence in timely resolution by submitting requested records or input within seven days of the request.