

Payment

An allowable fee, or allowance, is determined for each service and supply you provide to Regence members. This allowance can vary with the type of benefits the member has and with the type of provider agreement(s) you have signed (e.g., professional or facility).

Professional Reimbursement

Relative value units and conversion factors

Most professional allowances are calculated by multiplying resource-based relative value scale (RBRVS) relative value units (RVUs) by contracted conversion factors assigned to procedure codes. The most commonly-used RVUs are published annually by the Centers for Medicare & Medicaid Services (CMS) in the *Federal Register*, although Regence may also use RVUs published by *St. Anthony's* in the absence of CMS RVUs. Conversion factors are assigned to procedure code ranges by Regence and are reviewed periodically.

Site of service reimbursement methodology

Site of service refers to the method of calculating reimbursement for services based on the setting in which they were provided. Services that can be provided both in office and facility settings will have both facility and non-facility RVUs listed in the *Federal Register*. In general, reimbursement calculations for office-based services are made using non-facility RVUs, and for facility-based services using facility RVUs. If only one RVU is listed (e.g., facility or non-facility), that RVU will be used to calculate reimbursement regardless of treatment setting.

Calculating fees using RVUs and conversion factors

The table below illustrates how to calculate allowances using *Federal Register* RVUs.

1. Find the procedure code in the *Federal Register* and note the RVUs in the *Transitional Facility and/or Non-Facility Total* column.
2. Conversion factor: In this example, we used \$50.
3. Multiply the total RVUs by your conversion factor to determine your allowance.

Calculating a Maximum Allowable Fee:	CPT 99213	CPT 44950
1. Locate total RVUs	(NonFacility) 1.50	(Facility) 10.00
2. Multiply by your conversion factor	X \$50.00	X \$50.00
3. The result is your allowance	\$75.00	\$500.00

The current *Federal Register* may be purchased online through the Government Printing Office at bookstore.gpo.gov.

Other reimbursement methods

Not all procedure codes have RVUs published in the *Federal Register* or *St. Anthony's*. In these cases, allowances are administratively set by Regence using various methods. These include using published fee schedules, such as those used to calculate Medicare payment for laboratory procedures or durable medical equipment. Your provider consultant can discuss how specific allowances are determined.

National Correct Coding Initiative (NCCI)

The administrative policies and guidelines that we use to review and pay claims are important and integral to the relationship we share with our participating providers. When establishing our policies, we attempt to adopt widely accepted community policies and standards when they are available and supportable. In keeping with this, Regence BlueShield uses CMS' National Correct Coding Initiative (NCCI) edit data with our claims processing system. In addition, Regence BlueShield has identified code edits to supplement NCCI.

Correct coding edits identify component service codes that are inappropriately reported as separate and distinct services from the comprehensive code. In comprehensive and component codes edits, the comprehensive code will be reimbursed to contract benefits and the component code will be considered included in the comprehensive code.

Our CCE is updated quarterly (January, April, July and October) and is available on our *Provider Web Site* in the Claims & Billing section, under Coding Toolkit. Coding changes occurring in the updates are effective for dates of service on or after the installation date and no claims will be adjusted retrospectively.

AdminaStar Federal, Inc. (a subcontractor of Reliance Safeguard Solutions) develops and refines CCI, coordinates the receipt of comments, the prioritization of issues, the review and research of previous actions and the discussion with CMS about the concerns. AdminaStar Federal, Inc. accepts written comments via mail or fax at:

National Correct Coding Initiative
AdminaStar Federal, Inc.
Attn: Niles R. Rosen, MD or Linda Dietz, RHIA, CCS, CCS-P
P.O. Box 50469
Indianapolis, IN 46250-0469

Fax: 1 (317) 841-4600

Correct Coding Edits (CCE)

Correct coding edits identify component service codes that are inappropriately reported as separate and distinct services from the comprehensive code. In comprehensive and component codes edits, the comprehensive code will be reimbursed to contract benefits and the component code will be considered included in the comprehensive code. Our member-base is broader and more diverse than the Medicare membership base and because of this, we have implemented additional edits to supplement what is available through the CCI software. All supplemental edits are based on guidelines published in the AMA CPT manual or by CMS in their various publications.

Regence BlueShield implements correct coding edits on a quarterly basis. Coding changes occurring in the updates are effective for dates of service on or after the installation date and no claims will be adjusted retrospectively.

All lines of business, including BlueCard ITS Host and FEP claims, except Medicare, will use CCE. CCI logic will apply first, then supplemental CCE edit logic will apply when a claim is being adjudicated.

Our CCE is available on our *Provider Web Site* in the Claims & Billing section, under Coding Toolkit. In addition to viewing the edits, you are able to provide feedback from within the site at **Clinical Editing Issues@regence.com**, or you can write to:

**Regence BlueShield
P.O. Box 21267- M/S-S531
Seattle, WA 98111-3267**

If you have a specific question or concern regarding a specific claim, please follow the provider billing dispute and medical necessity/investigational procedure determination appeal process outlined in the *Appeals* section of this manual.

Hold Harmless

Participating physicians and other health care professionals have agreed to accept our allowable fee as payment in full for covered services and supplies, whether paid by Regence, our member, or another payer. This means you may only charge Regence members for deductible, coinsurance, copayments and non-covered services. You must write-off (or 'hold the member harmless') for other amounts as shown below. These write-offs are also known as contractual adjustments. Please refer to your agreement for detailed information.

- **Charges above Maximum Allowable Fee:** You must hold harmless any amount of your charge that is over the allowance. For example, if you charge \$45.00 for a service with a \$43.00 allowance, you must not charge the member for the \$2.00 difference.
- **Charges denied due to investigational, medical or reimbursement policies:** You must hold harmless any amount deemed a provider write-off based on Regence medical or reimbursement policies, including services or supplies determined not medically necessary. Changes in policy are normally sent via provider newsletters or bulletins, letters from the Medical Director or company officer, or amendments to your agreement.

Determining Member Responsibility

Your payment vouchers display amounts you may bill to your members under the 'Patient Responsibility' column. In general, charges for non-covered services do not need to be written off and can be billed to the member. In some cases, the member cannot be billed unless they signed a non-covered member consent form acknowledging financial liability for the charges before the services or supplies were provided. A sample member consent form listing key elements that must be included for non-covered services follows on the next page. A non-covered member consent form, such as the sample form shown, should be used for all Regence patients, including Regence MedAdvantage patients.

Sample Non-Covered Services Member Consent Form

This sample may be used as a guideline when developing a member consent form. Please consult with your legal counsel before adopting this format.

NON-COVERED SERVICES MEMBER CONSENT FORM

I, _____ (list patient name and member number), understand that the services and/or supplies listed below may not be considered eligible for benefits (e.g., services and/or supplies may be determined to be not medically necessary, non-covered or investigational) by _____ (health insurer). I understand that my health insurance coverage has certain restrictions and limitations, such as authorization requirements, and non-covered services and/or supplies. Since I have chosen to obtain the services and/or supplies listed below, I agree to be financially responsible for any and all related charges, if they are not covered by my insurance.

Services/Supplies Requested

Condition/Diagnosis

Approximate Cost of Service

Date

of Service

Member or Legal Guardian Signature

Member Identification Number

Date

Witness Signature

Date

Receiving Payment

As a participating physician, other health care professional or facility, you will receive a direct remittance advice weekly from Regence BlueShield for claims you have submitted. Benefits are not assignable; you will receive direct payment even if your patient signs an assignment authorization.

Provider Remittance Statements (Payment Vouchers)

Regence BlueShield's *Provider Remittance Statement* contains information on how we processed your claims, and is commonly referred to as a "voucher" or "payment voucher." Clinics may receive a single check with separate vouchers for each provider within the practice.

Samples of Participating, Regence MedAdvantage, Innova®, Engage®, ActivateSM and HAS Healthplan 2.0SM vouchers are shown on the following pages; these samples are not all-inclusive. The format and content may differ greatly with some products, groups, and wholly owned administrators such as Healthcare Management Administrators, Inc. (HMA). Voucher questions should be directed to Customer Service at the numbers listed in the Contact Us section of our *Provider Web Site*.

Adjustments

Asterisked (*) amounts in the non-covered charges and adjustments field are to be written off by the physician and other health care professional and cannot be billed to the patient. The adjustment reason is noted with an asterisk (*) below the service's description. The most common reasons are:

- **Hold Harmless Adjustment:** Charge exceeds the Maximum Allowable Fee.
- **Fee Adjusted According to Administrative Policy/Hold Harmless Adjustment:**
These adjustments may be due to administrative, medical or reimbursement policies.

Non-Covered Charges

Amounts in the non-covered charges and adjustments field not followed by an asterisk are non-covered charges. These do not need to be written-off by the provider and can normally be billed to the patient.

Message Codes

Message codes are used to provide additional information about how we have processed a claim. Our message codes lists are available in the Claims & Billing section of our *Provider Web Site*.

Appealing Reimbursement and Medical Policy Determinations

If you disagree with a decision regarding reimbursement, care management or medical policy, resubmit the claim with additional clarifying information, such as history and physical, operative report or narrative of unusual considerations that support the medical necessity of the service. If the determination is not reversed in this claims review or if you disagree with the subsequent determination, you may wish to use the appeals process. Refer to the *Appeals* section of this manual for detailed information.

Payment Vouchers

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


Regular Voucher Sample

Regular vouchers are sent to participating providers for their patients covered under Regence BlueShield traditional (also called indemnity) plans. Brief explanations of each field are listed on the page following this voucher sample.

Note: A Pending Claims Report, which lists claims, that are being investigated for waiting periods, coordination of benefits or third party liability information, may be included on your payment voucher. The report lists claims that we have had for 30 days or more. Claims delayed for other reasons do not appear on this report.

Fields and definitions

1. Tax identification number and rider number
2. Check number of enclosed check
3. Members name, multiple members can appear on one voucher
4. Dates of service for that member
5. Procedure codes for services rendered
6. Line by line charges for services rendered
7. Amount contractually disallowed or provider write off
8. Amount allowed for procedure
9. Amount member is responsible for or other insurance
10. Amount Regence BlueShield paid on procedures/service
11. Message codes are used to provide additional information about how the claim was processed. Our message codes lists are available in the Claims & Billing section of our *Provider Web Site*
12. Total amount, per claim, for each of the following:
 - Charge disallowed
 - Member responsibility
 - Amount paid
13. Member identification number

		1400 North Avenue # P.O. Box 11227 Grand Rapids, MI 49511 616 776 4773		PAYMENT VOUCHER		DATE 11/13/02				PAGE 1	
999999999 AN1111 ASSOCIATES IN FAMILY MEDICINE				CHECK NUMBER 6592175							
SUBSCRIBER NAME	SSN#	ACCOUNT NO.	CHARGE	CONTRACTUAL ALLOWANCE/DISALLOWED	ALLOWED	PAT.RESP/ OTHER INS.	PAID	MSG CODES			
PATIENT NAME	BRANCH	DEP.NO.	CLAIM NO.								
DATES OF SERVICE	LGTL#	T/S	PROCEDURE	U/C	DISP						
Member					00892201						
	FEP	01	0230680734850								
09/27-09/27/02	01	99214		1	1	10200	2520	7680	00	1536	303310
09/27-09/27/02	08	G0001		1		600	500	300	00	00	038303310
09/27-09/27/02	08	85024		1		2200	1030	1170	00	00	038303310
09/27-09/27/02	08	84443		1		2800	479	2321	00	00	038303310
09/27-09/27/02	08	85651		1		1100	609	491	00	00	038303310
09/27-09/27/02	08	84550		1		1100	572	528	00	00	038303310
			CLAIM TOTAL			18200	5710	12490	00	1536	
Member					00892201						
	FEP	01	0230680734960								
09/27-09/27/02	08	81003		1	1	1000	690	310	00	00	303310
09/27-09/27/02	08	80048		1		1400	728	672	00	00	303310
			CLAIM TOTAL			2400	1418	982	00	00	
Member					02779902						
	FEP	00	0230685735070								
09/06-09/06/02	08	Q0091		1	1	3800	65	3735	00	747	303310
09/06-09/06/02	01	G0101		1		4900	882	4018	00	4018	610
			CLAIM TOTAL			8700	947	7753	00	4765	
			VOUCHER TOTAL			29300	8075	21225	00	6301	
			CHECK TOTAL						00	6301	
038 - MAXIMUM BENEFITS PAID BY MEDICARE-MEMBER NOT RESPONSIBLE.											

Regence MedAdvantage Payment Voucher Sample

Payments for all members enrolled in a Medicare Advantage plan like Regence MedAdvantage will be sent to participating physicians, other health care professionals or facilities accompanied by the *Claim Voucher Statement* on a regular basis. All vouchers will have the Regence BlueShield name and logo in the upper left corner. Below is an explanation of the key information provided on this claim voucher. A sample of the *Claim Voucher Statement* follows.

Section A

- Professional Provider or Facility's name
- Regence BlueShield provider identification number
- NPI number
- Product name
- Voucher page number
- Date of check that accompanies this voucher

Section B

- Patient's name
- Member number
- Patient's account number (if one was submitted on the claim)
- Member's group number
- Claim number

Section C

- CPT, CDT, or HCPCS codes billed
- Written description of the service
- First and last dates of service
- Total charge for the service
- Fee adjustment or the amount not covered by the member's plan. The member may not be held responsible for this amount
- Amount paid by another carrier
- Amount of patient responsibility. This amount includes copayment, coinsurance, deductible or any non-covered services
- The reason code explaining how this particular claim was processed. Refer to the last page of the voucher for descriptions
- Amount paid by Regence BlueShield

Section D

- Claim voucher totals

Section E

- Description of reason codes entered in the reason code column in Section C

Sample Regence MedAdvantage Voucher

CLAIM VOUCHER STATEMENT

PAGE 1

(A) JANE DOCTOR, MD
1234 SW MAIN ST.
ANYTOWN, USA 99999

REFERENCE NUMBER 0066778899

DATE 06/15/05

REGENGE MEDADVANTAGE

PATIENT NAME TYPE OF SERVICE	SERVICE DATE	GROSS CHARGES	FEE ADJUSTMENT	PAID BY OTHERS	PATIENT RESPONSIBILITY		REASON CODE	BENEFITS PAID
					DEDUCTIBLE	COPAY/OTHER		
(B) JOHN SMITH	MEM #: ZVY921023189	148.00	PAT ID: 000196C15		GRP #: 550500000		CLM # 01234567890	
(C) 99214 E/M DETAILED VISIT	06/01/05	148.00	51.64	.00	.00	5.00		91.36
** CLAIM TOTALS **		148.00	51.64	.00	.00	5.00		91.36
JOHN SMITH	MEM #: ZVY921023189	120.00	PAT ID: 000196C15		GRP #: 550500000		CLM # 01235679120	
99217 OBSERV CARE DISCHARGE	06/03/05	120.00	**** CLAIM PENDING ****	.00	.00	.00	402	.00
** CLAIM TOTALS **		120.00	.00	.00	.00	.00		.00
(D) *** VOUCHER TOTALS ***		268.00	51.64	.00	.00	5.00		91.36

FORM 4414 - From 14/05b

BlueCard[®], Innova, Engage, Activate and HSA Healthplan 2.0 Vouchers

The easy-to-read vouchers for these members include:

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

A guide for reading the new *Claim Vouchers* and summaries is included on the following pages. More detailed information is available in our *Guide to Claim Vouchers* for these products, available in the Educational Tools section of our *Provider Web Site* under Self-paced.

Summary of Adjusted Claims to be Recovered

When an adjustment is made, it will show as a negative payment on the voucher and include the previous voucher date. The negative amount is not actually subtracted from our payment at that time. If applicable, a refund request will be sent under separate cover.

COMPANY LOGO, ADDRESS

Check cut to: MEDICAL CLINIC
1234 MAIN ST
HOMETOWN, USA 12345

Provider ID: 100100100
NPI No: 0101010101
Check No: 0000000000

Customer Service Phone No: 1 (XXX) XXX-XXXX

Date: MM/DD/CCYY
Voucher No: 11M00000000####

SUMMARY OF ADJUSTED CLAIMS TO BE RECOVERED

These adjusted claims were not deducted from this voucher. A future voucher may reflect the take back of dollars.

Product Name ADJUSTMENTS

Date of Service		Proc. Code Modifier	Units	Billed Amount	Allowed Amount	Contractual Adjustment	Paid By Others	Risk Withhold	Patient Responsibility					Amount Paid	Msg Code
From	Through								Deductible	Copay	Coinsurance	Non Covered	COB Amount		

Patient Name: JOANNE DOE Insured Name: JOANNE DOE Group No: 77777777 Claim No: X200000000007
 Pat Acct No: 1111111111 Subscriber ID No: XXX111111111 Del Prov: JOHN SMITH
 Previous Voucher Date: 08/18/09 Network ID: Network Name

07/06/09	07/06/09	99212	1	-100.00	-60.60	-39.40							-18.18			-18.18	-42.43	
07/06/09	07/06/09	80050	1	-90.00	-61.97	-37.03							-18.59			-18.59	-43.38	
Previous Claim Total				-190.00	-122.57	-76.43							-36.77			-36.77	-85.80	6.2H
REFUND DUE																	43.48	

Patient Name: JOANNE DOE Insured Name: JOANNE DOE Group No: 77777777 Claim No: X200000000008
 Pat Acct No: 1111111111 Subscriber ID No: XXX111111111 Del Prov: JOHN SMITH
 Current Network ID: Network Name

07/06/09	07/06/09	99212	1	100.00	60.60	39.40							18.18			18.18	42.42	PXN
07/06/09	07/06/09	80050	1	99.00													0.00	G94
Adjusted Claim Total				199.00	60.60	39.40							18.18			18.18	42.42	
INTEREST																		

Total Product Name ADJUSTED CLAIMS

Billed Amount	Allowed Amount	Contractual Adjustment	Paid By Others	Risk Withhold	Amount Paid	Interest Paid	Refund Due	Amount(-) Prev Paid
199.00	60.60	39.40			42.42		43.48	42.42

Payment Summary and Summary of Payment Reductions

This section lists current payments amounts as well as any payments that are being recovered on this voucher from a previous adjustment.

COMPANY LOGO, ADDRESS

Check cut to: MEDICAL CLINIC
1234 MAIN ST
HOMETOWN, USA 12345

Provider ID: 100100100
NPI No: 0101010101
Check No: 0000000000

Customer Service Phone No: 1 (XXX) XXX-XXXX

Date: MM/DD/CCYY
Voucher No: 11M00000000####

PAYMENT SUMMARY

VOUCHER TOTAL	AMOUNT PREVIOUSLY PAID	AMOUNT RECOVERED THIS VOUCHER	TOTAL INTEREST	CHECK AMOUNT	CHECK DATE
1642.01	64.00	50.00	10.00	1538.01	02/04/2009

SUMMARY OF PAYMENT REDUCTIONS

Provider No.	Patient Account No.	Claim No.	Original Refund Amount	Amount Previously Recovered	Amount Recovered this Voucher	Balance Remaining	Original Voucher Date	Message Code
1001001001111	1231231231	E20000000010	50.00	0.00	50.00	0.00	08/07/2009	PSS

Total Amount Recovered This Voucher	Total Overpayment Balance Remaining
50.00	0.00

ITS Processed to preferred provider plan benefits.
PXN Pricing is based on maximum allowance for the service billed by this provider.
E20 An additional or corrected claim has been received. The original claim will be adjusted/reprocessed according to the member's benefit plan.
PSS Pricing is based on maximum allowance for the service billed by this provider.

Pended Claims Summary

This section provides information about claims we have received but have not processed because additional information or further review is required (e.g., coordination of benefits information, an accident report or medical records). You can check the status of pended claims on the Provider Center.

COMPANY LOGO, ADDRESS

Check cut to: MEDICAL CLINIC
1234 MAIN ST
HOMETOWN, USA 12345

Provider ID: 100100100
NPI No: 0101010101
Check No: 0000000000

Customer Service Phone No: 1 (XXX) XXX-XXXX

Date: MM/DD/CCYY
Voucher No: 11M00000000####

PENDED CLAIMS SUMMARY

Date of Service		Proc. Code Modifier	Units	Billed Amount	Pend Code	Claim Pend Reason
From	Through					
Patient Name: JUNE DOE Insured Name: JUNE DOE Group No: 0123456 Claim No: X200000000012 Pat Acct No: 222222222 Subscriber ID No: 123123123 Del Prov: JANE SMITH						
08/25/09	08/25/09	99212	1	100.00		
Claim Total				100.00	PEND	Possible pre-existing condition. We will request additional information from originating or other provider if needed.
Patient Name: JACK DOE Insured Name: JACK DOE Group No: 1234567 Claim No: X200000000013 Pat Acct No: 122222222 Subscriber ID No: 321321321 Del Prov: JANE SMITH						
08/25/09	08/25/09	84443	1	25.00		
Claim Total				25.00	CA14	This claim has been forwarded to a designated claims analyst for COB investigation.

Sample Activate Member Choice Account Payment

COMPANY LOGO, ADDRESS

Customer Service Phone No.: 1 (800) 111-2222

Check cut to: MEDICAL CENTER
1234 MAIN ST
HOMETOWN USA 12345

Provider ID: 100100100
NPI NO: 0101010101
Check NO: 00000101

Date: 07/01/2008
Voucher No: I1M0000000000001

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CLAIM VOUCHER

Medical Plan 1 Claims

Date of Service		Proc. Code Modifier	Units	Billed Amount	Allowed Amount	Contractual Adjustment	Paid By Others	Risk Withhold	Amount Paid	Patient Responsibility					Interest Paid	Msg. Codes
From	Through									Deductible	Copy	Coinsurance	Non Covered	Total		
Patient Name: JOHN DOE		Insured Name: JOHN DOE					Group # 8888888					Claim # M00000000001				
Patient Acct# 22222222		ID# 111111111					Medical Plan 1					Del Prov: JANE SMITH				
		Original Claim 100000000001										A B				
05/01/08	05/01/08	MCAA	1	\$50.00	\$50.00				\$50.00							ZM0
Current Claim Total				\$50.00	\$50.00				\$50.00							

Total Medical Plan 1 Claims

Billed Amount	Allowed Amount	Contract. Adjustment	Paid By Others	Risk Withhold	Amount Paid	Interest Paid	Balance Forward	Amount(-) Prev. Paid
\$50.00	\$50.00				\$50.00			

COMPANY LOGO, ADDRESS

Customer Service Phone No.:

Check cut to: MEDICAL CENTER
1234 MAIN ST
HOMETOWN USA 12345

Provider ID : 100100100
NPI NO: 0101010101
Check NO: 00000101

Date: 07/01/2008
Voucher No: I1M0000000000001

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PAYMENT SUMMARY

VOUCHER TOTAL	AMOUNT PREVIOUSLY PAID	AMOUNT RECOVERED THIS VOUCHER	TOTAL BALANCE FORWARD	TOTAL INTEREST	CHECK AMOUNT	CHECK DATE
\$50.00					\$50.00	07/2/2008

C ZM0 This is a Members Choice Account payment.

Note: Only items that differ from Innova, Engage and HSA Healthplan 2.0 vouchers are listed below.

Item A

- Claim number begins with an M

Item B

- The message code is ZMO

Item C

- Explanation of ZMO message code

Additional Information

For more information

Please refer to the *Filing Claims* section for detailed information on claim submission, direct and timely billing, and prompt pay regulations.

Payment Errors

If you receive an overpayment on a claim, or a payment for someone else's patient, please complete the *Overpayment/Voucher Deduction Request* form that is found on our *Provider Web Site* in the Claims & Billing section, under Forms or 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 the applicable address listed below:

Regence BlueShield Attention: Mail Stop S620 P.O. Box 21267 Seattle, WA 98111-3267
Regence BlueShield – Boeing Claims Attention: Mail Stop BU221 P.O. Box 91015 Seattle, WA 98111-9115
Regence BlueShield – FEP Claims Attention: Mail Stop BR480 P.O. Box 21709 Seattle, WA 98111-3709

An adjustment for the error should appear on a subsequent payment voucher once the correction has been made.

Regence will occasionally recoup payments due to a duplicate or adjusted claim. We will not initiate overpayment recovery efforts more than 18 months after a claim is paid. However, no time limit shall apply to the initiation of overpayment recovery efforts based on the following criteria:

- Reasonable belief of fraud or other intentional misconduct; or
- Required by a Self-Insured Plan; or
- Required by a state or federal government program.

If Regence identifies that an overpayment has been made to your office, we will notify you and request payment be made within 30 days. If you disagree with the overpayment

refund request, you must initiate a formal appeal in writing within thirty (30) days from receipt of the overpayment refund request. If an appeal is not initiated within this thirty (30) day period, Regence may deduct the overpayment from future payments due to you if the overpayment has not been returned.

How to Appeal Payment Determinations

If you disagree with how a claim was processed, please contact Customer Service. If the determination is not reversed or if you disagree with the subsequent determination, you may wish to use the appeals process. Please refer to the *Appeals* section for detailed information.

Practitioner/Provider Audits

Regence BlueShield audits the billing of its participating physicians and other health care professionals. While many of our audits are to determine whether we have been appropriately billed, we also audit to determine:

- Accuracy of claims submitted
- Coverage of services
- Medical necessity
- Proper utilization
- Appropriateness of services

Audits are also done in the case of abusive billing practices or to determine the possibility of fraud. For examples of fraudulent, abusive or inappropriate billing practices, refer to the *Fraud and Abuse* section of this manual. Trained auditors review all areas of medical services, including physicians, practitioners, laboratories, pharmacies, durable medical equipment and supplies, hospitals and ancillary health-care providers. All audits comply with the laws, statutes and regulations pertaining to the confidentiality of member records. Information is not disclosed, except to accomplish the audit or report findings/conclusions where appropriate and necessary.

Audits are conducted in the offices of our providers and occur at a mutually agreed date and time within the timeframe specified in your agreement with Regence BlueShield.

In the event of an audit, please allow sufficient space within your office to review records and copy those records relevant to the scope of the audit. The audit may include charges to members not covered by agreements with Regence BlueShield. However, the physician/practitioner may obscure or remove these names from the billing records being audited.

Copies of relevant records may be removed from your office for the purpose of comparison with claims that have been submitted to Regence BlueShield. Our staff will conduct this review at our offices. We will protect the confidential nature of the member

records. We will destroy all copies of documentation acquired from an external audit review in a manner that will protect the integrity of confidential information and abide by all laws, statutes and regulatory requirements concerning the protection of confidential medical healthcare information once the audit file is closed and the need to retain any such information no longer exists. Regence BlueShield, as a responsible health care services contractor, is obligated to ensure the integrity of claims submittal and its reimbursement system. Therefore, it is our policy to exercise our contractual ability to audit documentation in support of claims submitted on behalf of our members.

Additional audit provision information is available in your Regence BlueShield agreement.

Procedures Not Covered

The conditions or procedures listed below are excluded under most Regence BlueShield contracts. However, some contracts do cover these, so the member should check his or her benefits booklet. **This is not a complete list.** Please contact provider customer service at **1 (800) 322-1737** to verify eligibility and benefits.

- Acupuncture, except as specifically provided in the Acupuncture and Chemical Dependency benefits
- Drug or chemical substance addiction or abuse, unless otherwise specified
- Conditions related to acts of war or military service
- Counseling services that are undocumented at the member's request, pursuant to WAC 246- 810-035
- Hospitalization for diagnostic purposes when not medically necessary
- Treatment related to the inability to conceive; artificial means of conception; fertility drugs; however, pregnancy resulting from such treatment will be covered
- Injuries related to semi-professional or professional athletics, including practice
- Surgery, treatment, program or supplies that are intended to result in weight reduction, regardless of diagnosis
- Cosmetic surgery unless related to illness or injury occurring while covered, for reconstructive breast surgery following mastectomies and for congenital anomalies
- Treatment or surgery for sexual dysfunction/impotence or transsexualism
- Treatment for malocclusion or other abnormalities of the jaw, including service for myofascial pain syndrome or any related appliances unless coverage is specifically provided for temporomandibular joint disorders
- Benefits excluded to the extent covered under any automobile medical, personal injury protection, automobile no-fault, automobile uninsured or underinsured motorist, homeowner or commercial premises, medical or similar insurance
- Investigational services or supplies
- Charges that in the absence of coverage there would be no obligation to pay
- Marital and family counseling

- Physical or psychiatric examinations or psychological testing for the purpose of obtaining or continuing employment, licensure, legal proceedings, insurance, school admission or sports activity.

Regence BlueShield will not pay for services that are not covered under the member's health plan or for services that do not meet the requirements outlined in this manual, the Practitioner Agreement or any other Regence BlueShield communication or publication.

Responsibilities of all Participating Providers

Each participating physician or other health care professional has entered into an agreement with Regence BlueShield. This agreement contains important information about your responsibilities as a Regence BlueShield participating provider. If you have any questions about your responsibilities, please contact our Provider Network Management department at **1 (800) 562-2156**.

Participating providers have agreed, at minimum, to:

- Notify our Provider Network Management department in writing at least 60 days prior to limiting or closing their practice to members.
- Provide services during normal business hours with 24 hour, 7-day-a-week emergency coverage.
- Refer members only to participating providers unless one is not available.
- Submit claims and encounter data for services provided to members.
- Accept the Medicaid reimbursement made by Regence BlueShield, or Regence BlueShield's reimbursement, as payment in full for covered services rendered to Healthy Options members.
- Accept our reimbursement as payment in full for covered service rendered to eligible members. The provider cannot seek additional reimbursement from the member for covered services.
- Provide consultation to other participating practitioners as reasonably requested.
- Maintain all required licenses, certifications, credentials and liability insurance, as defined by Regence BlueShield's credentialing program policies and procedures.
- Comply with Regence BlueShield's quality improvement, credentialing and utilization management programs, policies and procedures.
- Allow onsite reviews and medical record reviews by Regence BlueShield upon reasonable notice.
- Maintain confidentiality of Regence BlueShield's proprietary information.

Please refer to your agreement for more complete information about your responsibilities. The above list is a summary of some of your responsibilities for reminder purposes only. It is not intended to replace or redefine the responsibilities in your agreement.

Overpayment Recovery

If you receive an overpayment on a claim or a payment for someone else's patient, or if Regence discovers a claim has been overpaid due to a duplicate or adjusted claim, an overpayment recovery may be initiated.

Overpayment Recovery/Refunds

On January 1, 2006, the state house bill 'Overpayment Recovery Practices' went into effect. This law requires prior written notification when a recoupment is requested by the health plan or the provider. The law allows 24 months to request a recoupment or additional payment; 30 months for a coordination of benefits (COB) recoupment or additional payment. However, due to requirements of the Thomas/Love class action settlement, effective January 1, 2008, we have limited the time period that we can request reimbursement to 18 months after the date the provider receives payment for the claim (except in the case of fraud). This change does not affect the time periods that a provider has to request recoupment or additional payment.

Exceptions:

- Recoupment requests for Medicare, Medicare Supplement and Healthy Options members will continue to follow our current automatic deduction process for refunds. Only providers who received the Addendum Regarding Settlement of the Thomas/Love Provider Litigation will have the benefit of the 18 month recoupment period described above.
- Hospitals, laboratories, durable medical equipment (DME) and/or home medical equipment (HME) providers are excluded and will continue to follow our automatic deduction process for refunds.
- Credit and refund adjustments for certain products and the providers mentioned above, are automatically processed by our claims system. These transactions are reflected on your voucher.

We will notify applicable providers in writing, via the *Pending Claims Report* of an impending recoupment. The pending recoupment is identified by the claim number(s); the dollar amount and the reason why we are recouping the funds.

Recoupment requests for special circumstances, COB and other party liability (OPL) claims will continue to be requested via written notification, they will also appear on the *Pending Claims Report*. For easy identification and to expedite the current process, the recoupment request letters for COB, OPL and special circumstances will be mailed to your office in a bright goldenrod envelope.

Once you have been notified of the recoupment, your office will have 30 days to respond. To expedite the refund process, please respond immediately. If we have not received a response after 30 days, the recoupment will be released and automatically deducted on a future remittance advice.

If additional time is needed to refund the amount due, contact us using one of the following methods:

- Complete our online *Overpayment/Voucher Deduction Request* form available on our *Provider Web Site* in the Provider Library section, under Forms:
- Fax the *Pending Claims Report* to our refund department. Indicate "OK to finalize" for each claim awaiting recoupment notification. If you need additional time, use the other options listed to make payment arrangements.

If you have a question regarding the original claim related to the refund request, you can also use the Provider Center to view a remittance advice or check the claim status.

Time limits for adjustments, deductions and/or refunds

The following time limitations apply to adjustments deductions or refunds:

- Deductions or refunds due to Medicare's processing or eligibility may be requested in the same manner and for the same periods as Medicare.
- A request from a practitioner for additional payment or to adjust a claim must be submitted within 12 months from the date of service.
- A deduction that is unrelated to any legal processes can occur for up to 12 months from the last date we processed or reviewed the claim.

Exceptions to the limitations above:

- If the deduction is requested or approved by the provider
- Payment was made to the incorrect provider
- The claim was paid for the wrong member
- The claim is part of a legal investigation or medical review audit
- There is coordination of benefits or other party liability considerations

If any of these exceptions apply, we may request a refund regardless of the claim processing date or date of service.

Waiting Periods

A preexisting condition is defined as a condition for which medical advice was given, or for which a health care provider recommended or provided treatment within a period of time before the effective date of coverage under the plan.

- For group plans, maternity benefits are not subject to the preexisting condition waiting periods.
- For Individual plans, prenatal care is not subject to the preexisting condition waiting period.
- The transplant waiting period is six months for standard group plans and 12 months for individual plans

- The preexisting condition waiting period for group plans will vary from three to nine months depending on the plan.
- Individual products have a nine month waiting period for treatment of preexisting conditions.

Members are allowed to credit the amount of time they were continuously covered under their immediately preceding health plan against the preexisting condition waiting period of their current plan.

If a claim was paid that was related to a preexisting condition, the payment will not constitute a waiver of this exclusion for that claim or for any subsequent claim if it is determined that the condition was preexisting.