Dentalupdate
MARCH 2018

BlueCross BlueShield Nebraska

BLUE CROSS AND BLUE SHIELD OF NEBRASKA DENTAL NEWSLETTER

nebraskablue.com

The **Dental Update** is a provider newsletter that contains up-to-date information about Blue Cross and Blue Shield of Nebraska (BCBSNE) for health care providers. It is published by the Health Network Management Services Department (HNS).

If you are a contracting BCBSNE health care provider, this newsletter serves as an amendment to your agreement and affects your contractual relationship with us. You are encouraged to file every issue of the Dental Update within your BCBSNE Policies and Procedures manual and reference it often. You may also view the current manual in the Provider section at nebraskablue.com.

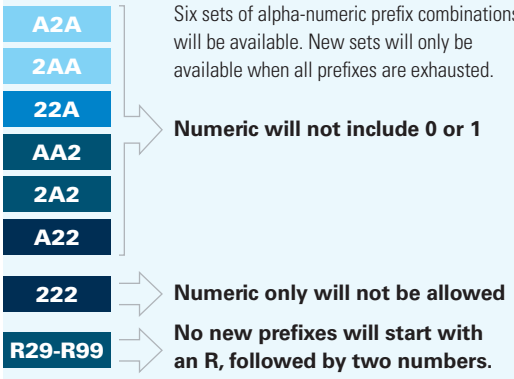
As a service for Blue Cross and Blue Shield members, we also send this newsletter to non-participating Nebraska providers.

We also publish each issue online in the Provider section at **nebraskablue.com**

For permission to reprint material published in the Dental Update, email Brooke Ossenkop, at brooke.ossenkop@nebraskablue.com

Alpha-numeric prefixes coming in 2018

Prefix Combinations



The graphic is showing prefix combination options and guidelines.

BCBSNE member ID numbers currently begin with a three-character alpha prefix. Beginning in 2018, we will introduce alpha-numeric prefixes to our member ID cards.

Please review all software programs you use and work with your vendors to ensure all can facilitate ID numbers containing alpha-numeric prefixes. If you are confident that your systems can process alpha-numeric prefixes, no further action is needed. If you have questions about the ability of your software or that of your vendors to process ID numbers which contain alpha numeric prefixes, please work with your IT team and your vendors for resolution. If you have questions about a rejected claim, contact EDIsupport@nebraskablue.com.

Please don't bill CPT D0290 for dental procedures

Dental code D0290 was termed effective 12-31-16. We did not terminate the code in our processing systems prior to the creation of the 2017/2018 fee schedule. Therefore, when the fee schedules were created, a rate was published for this code. It should not have been on the schedule as it is termed and was not reinstated.

In this issue → Click on the headline to jump to the article.

Updated 2018 ADA codes

There have been several updates to the American Dental Association codes for 2018. Below are the updated codes with descriptions.

Important Notes:

- CDT coding and nomenclature are the copyright and trademark of the ADA; all rights reserved.
- There are important differences between BCBSNE's plan benefits and processing policies and the descriptors found in the CDT code.
- Not all codes listed are necessarily covered services. Those listed below are provided as updates not covered services.
- Please check member's benefits to determine what services are covered.

Deleted codes:

D5510 – Repair broken complete denture base

D5610 – Repair resin denture base

D5620 – Repair cast framework

New/Added codes:

D0411 – HvA1c in-office point of service testing

D5511 – Repair broken complete denture base, mandibular

D5512 – Repair broken complete denture base, maxillary

D5611 – Repair resin partial denture base, mandibular

D5612 – Repair resin partial denture base, maxillary

D5621 – Repair cast partial framework, mandibular

D5622 – Repair cast partial framework, maxillary

D6096 – Remove broken implant retaining screw

D6118 – Implant/abutment supported interim fixed denture for edentulous arch-mandibular

D6119 – Implant/abutment supported interim fixed denture for edentulous arch-maxillary

D7296 – Corticotomy-one to three teeth or tooth spaces, per quadrant

D7297 – Corticotomy-four or more teeth or tooth spaces, per quadrant

D7979 – Non-surgical sialolithotomy

D8695 – Removal of fixed orthodontic appliances for reasons other than completion of treatment

D9222 – Deep sedation/general anesthesia-first 15 minutes

D9239 – Intravenous moderate (conscious) sedation/analgesia-first 15 minutes

D9995 – Teledentistry-synchronous; real-time encounter

D9996 – Teledentistry-asynchronous: information stored and forwarded to dentist for subsequent review

For ADA frequently asked questions, visit ADA Center for Professional Success™ or visit ADA's website for additional information.

Where to submit the dental claims

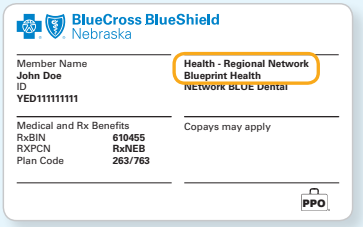
When determining where to submit the dental claims please make sure to check both the front and back of the member's ID card. When a patient has BCBSNE most of the time the claims will come to BCBSNE, but in the instance the Dental coverage is with a different carrier the information can be on the back of the ID card. It's important to make sure you submit the claim to the correct plan so there are no delays in processing and payment of the claim.

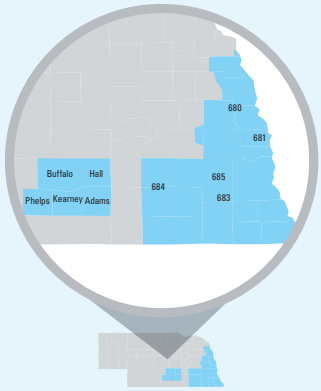
Do you have any patients that are employees of Hornady Manufacturing?

We have found there is some confusion on who is the payer for the dental claims for these patients and who the claims should be submitted to. We are working with you, our valued providers, the employer group and Blue Cross and Blue Shield of South Carolina (BCBSSC) to ensure we are all following the correct process regarding network status and where to submit the claims. All dental claims for your patients that are employees of Hornady Manufacturing need to be submitted to BCBSSC. If you are a participating provider with the Dental Grid you will be considered participating for these patients.

If a dental service needs to be submitted for payment on the patient's medical plan, then that claim should be submitted to Blue Cross and Blue Shield of Nebraska. Once the remit is received from the medical claim, you will submit a claim with that remit to BCBSSC for processing through the dental plan.

Sample ID Card





In-network service available
680, 681, 683, 684, 685 as well as Adams, Buffalo, Hall, Kearney and Phelps counties

New ID card – Blueprint Health network

NEW – for groups of 50+ employees! Blue Cross and Blue Shield of Nebraska is pleased to offer Blueprint Health. This new regional network is available to fully insured and self-funded large groups with 50+ employees, starting Jan. 1, 2018. It features CHI Health providers and facilities in Nebraska and contiguous counties in Iowa, as well as other providers. Dental providers that are participating in the Dental Grid are considered participating for members who have the Blueprint Health Network.

Blueprint Health is for groups that are headquartered in the Omaha/Lincoln and surrounding communities in ZIP codes 680, 681, 683, 684 and 685, as well as Adams, Buffalo, Hall, Kearney and Phelps counties.

Some of the key hospitals and health care providers include:

- Affiliated physicians and clinics
- Alegent Creighton Health Services
- Boys Town National Research Hospital
- CHI Health Creighton University Medical Center – Bergan Mercy
- CHI Health Good Samaritan
- CHI Health Immanuel
- CHI Health Lakeside
- CHI Health Mercy Council Bluffs
- CHI Health Midlands
- CHI Health Nebraska Heart
- CHI Health Plainview
- CHI Health Richard Young
- CHI Health Schuyler
- CHI Health St. Elizabeth
- CHI Health St. Francis
- CHI Health St. Mary's
- Children's Hospital
- Children's Physicians
- Creighton St. Joseph Regional Health
- Lasting Hope Recovery Center
- Nebraska Spine Hospital LLC
- Secure Care Providers

To see all providers in this network, visit nebraskablue.com/find-a-doctor/provider-directories

Note: This listing is subject to change without prior notice.

Best practices for checking claims status

PHONE

The Intelligent Voice Recognition (IVR) system provides claims status details, such as denied claims with the remit date or claim returned status. To use the system, you will need your NPI number, tax ID, patient's date of birth and patient's identification number.

ONLINE

Nebraskablue.com/contact: Requests for claims information that cannot be obtained via the IVR system should be submitted via **nebraskablue.com/contact**. Click on the Check a Claim Status link and complete and submit the form. Inquiries will be answered within five business days.

- Claim status questions submitted via **nebraskablue.com/contact** within 30 days of the claims submission will not be addressed unless the claims have already been adjudicated. Please use the IVR system for claim status on claims under 30 days.
- Please allow 60 days before submitting an inquiry on a reconsideration or an appeal to allow time for processing. Requests submitted via **nebraskablue.com/contact** within 60 days of the request will not be addressed.
- **Please note:** Claims, appeals and reconsiderations for out-of-area Blue Cross and Blue Shield Plan members may take more than 60 days due to coordination with other Blues Plans.

When submitting the Reconsideration/Appeal form, do you know which box to check?

Please remember when submitting the Appeal/Reconsideration Request form that checking the wrong box or checking both boxes **will** result in a delay in the handling of your request.

☑ RECONSIDERATIONS

Check this box to request BCBSNE review a claim with additional information/documentation that was not previously provided.

A **RECONSIDERATION** request is most commonly submitted for:

- Timely filing denials
- Coordination of Benefits denials or conflicts
- Worker's Compensation denials
- Medical documentation to support coding denial, such as the use of modifiers -25 or -59
- Pricing issues

☑ APPEAL

To request that BCBSNE review a claim with a disposition that the member or provider disagrees with based on the information already provided.

An **APPEAL** request is submitted for:

- Medical necessity denials
- Investigational denials
- Experimental denials
- Medical policy denials

Additional information on filing the Appeal/Reconsideration Request form can be found in the Policies and Procedures Manual at **nebraskablue.com/providers**. Click on Policies and Procedures in the left hand menu and select Download Manual under the headline NEtwork BLUE.

Reminder for timely filing

Please remember that the timely filing limit for BCBSNE is 180 days from the date of service. As a network provider you are obligated to file the claim to BCBSNE within the 180-day limit. If the claim is not submitted within 180 days from the date of service, no reimbursement will be made and the member cannot be held liable. Always make sure to ask for a current member ID card.

Note: If a claim is incomplete and is returned for "lack of information," you will need to submit a new claim (bill type XX1) with in the timely filing limit in order for the claim to be processed.

Tips for billing medical services

- File medical services on a HCFA 1500 form
- ICD-10 DX codes must be on the claim form

Common ICD-10 Medical Diagnosis codes

- SO1.512A – Laceration without foreign body of oral cavity
- SO2.5 – Fracture of tooth
- K00.5 – Disturbances in tooth eruption
- K01.0 – Embedded tooth
- K01.1 – Impacted tooth
- G47.30 – Sleep Apnea
- M26.60 – TMG

Full instructions on how to file medical claims are in the Dental Policies and procedures manual under "Filing for Medical Services."

Locum tenens

A locum tenens is a person who is temporarily fulfilling the duties and responsibilities of a particular office in the absence of the appointed holder of that office. Locum tenens are used for a practitioner who substitutes for another practitioner. When a locum tenens is used, services should be billed under the practitioner who is temporarily absent.

The contracting status of the dentist/practitioner under whose name the services are being billed will be used for claim payment. Payment for a locum tenens will only be made if there is an actual substitution for an in-network provider. If the substitution lasts for more than 90 days, then the practitioner filling in should be credentialed. A locum tenens is **not** a new permanent dentist or a dentist going through credentialing.