Dentalupdate

SPRING 2019

BlueCross BlueShield Nebraska

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 Loraine Miller, at Loraine.Miller@nebraskablue.com

What's New

A special announcement to our providers

BCBSNE values you and your staff. We also appreciate your ongoing efforts to provide care and answers to your patients, who are also our customers. We recognize the need to improve your service experience with us.

That's why we are pleased to announce that as of Wednesday, April 3, 2019, you are once again able to call our Customer Service team for any claim, reconsideration or appeal items that you have not been able to resolve via self-service. We understand your need for interaction with our team and the value this brings. We look forward to helping you.

Provider Customer Service hours

7:30 a.m. - 5 p.m. CT
Monday - Friday
800-635-0579

In order to give the best service possible to all our providers and minimize wait times, up to 20 ID numbers can be taken per call.

Self-service information, including the Interactive Voice Response (IVR) and other provider resources, are available at www.nebraskablue.com/providers.

In addition to the above, online inquiries to Customer Service may be submitted any time at www.nebraskablue.com/Providers/Eligibility-and-Claims under 'Check Claims Status'. Our standard response time is three business days.

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BCBSNE and FEP transition to new platforms

BCBSNE is in the process of transitioning to a new claims processing system called HealthRules. This platform uses advanced technology to improve efficiencies of our claims and enrollment administration.

Our changeover to HealthRules will be gradual. Starting Jan. 1, 2019, we moved our employee and retiree plans to the new platform. We will move our remaining business to HealthRules throughout 2019 and into early 2020.

FEP transition

Claims processing for the Federal Employee Program (FEP) transitioned to CareFirst on Jan. 1, 2019. Like HealthRules, the number of members moving to CareFirst will start small and increase throughout the year.

Throughout this transition, we are focused on minimizing disruption. The following page shows an overview of what you can expect with the move to HealthRules and CareFirst:

story continues >

ID cards/Plan code

- BCBSNE members will receive new ID cards when their plans transition to the new system.
  - The volume of patients with new ID cards will increase as the year progresses.
  - Please note, some prefixes on the new ID cards may change.
  - Please ensure your office makes copies of the new cards, so you may file claims using the correct ID number.
- You may see a new plan code on ID cards: 259/759.
  - This new plan code identifies members that have already transitioned to HealthRules.
  - Note: You will still see ID cards with the current plan codes (263/763). These are members that have not transitioned yet.
  - Plan codes may be referenced in the Policies and Procedures manuals as well as future newsletters. Please be sure to note this information to determine if the message applies to your patient.

Updated payment cycle information

Plan code	Payment and remit disbursement
ALL PLANS	Tuesday and last business day of the month

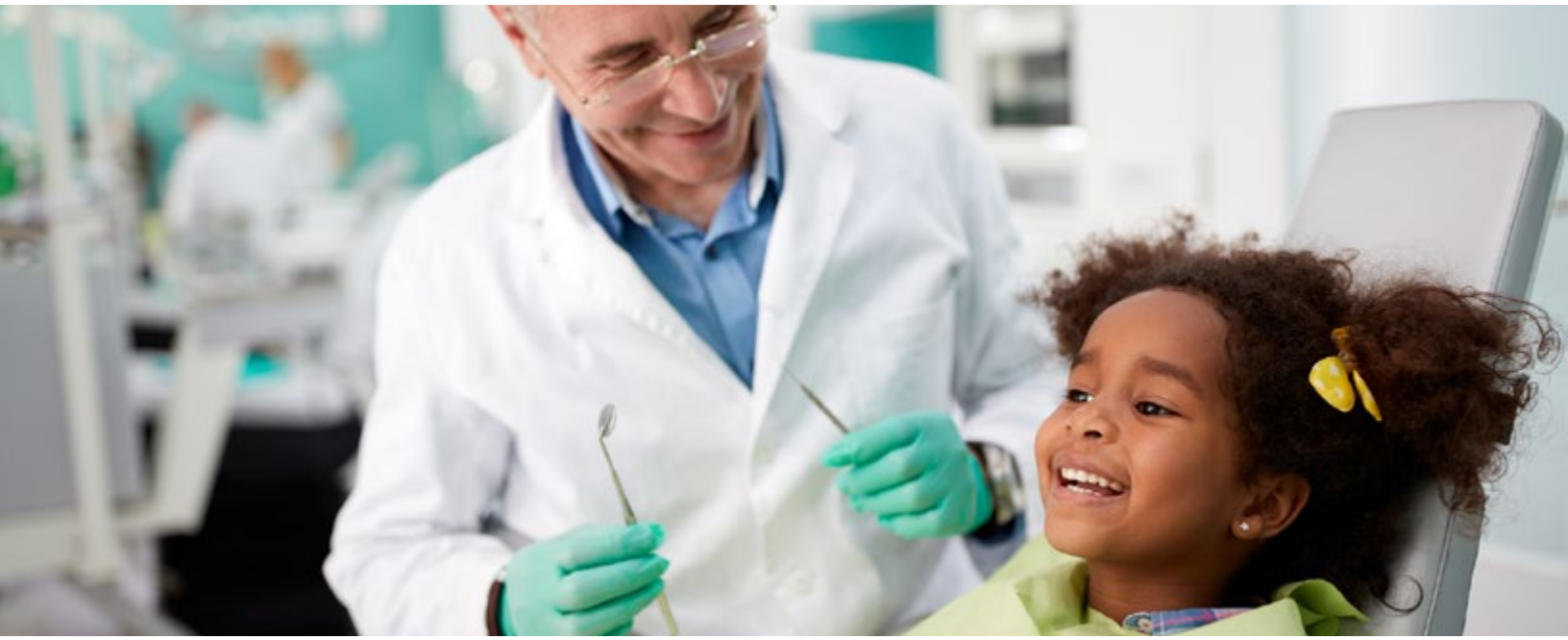
Remittance advice for HealthRules plan code 259/759

- A remit will be sent for every completed payment cycle. It is possible providers may receive multiple remits on the same day and/or multiple remits in the same week.
- The remittance advice for these members will have a different look.
- Tips on how to read the paper remittance advice can be found on our website under Happening Now.

Offsetting

- Claims processed on HealthRules that result in a refund will offset partial amounts, if necessary, until the full amount is collected. We strongly recommend you allow offsetting; however, the 30-day window to return a check is still in place.
  - **Note:** For additional information on our current offsetting policy, please consult the Policies and Procedures Manual on nebraskablue.com/providers.
- HealthRules will offset dental claims.
  - **Note:** For more information about our offsetting policy for dental providers please see the Dental Policies and Procedures manual on nebraskablue.com/provider.
- FEP will take immediate offsetting on CareFirst only.
  - **Note:** FEP claims may only be offset by other FEP claims.

Reminders



Claim Form

To expedite claims payment, always use the American Dental Association 2012 dental claim form. To obtain copies of the form, visit www.adacatalog.org or call **(800) 947-4746**.

Filing for medical services

Medical services provided by dentists must be submitted with the appropriate CDT code on a HCFA 1500 form. Billing with a CPT code of 41899 (unlisted procedure, dentoalveolar structures) is not appropriate and claims will be returned.

For more information, please refer to "Filing for Medical Services" in the Dental Policies and Procedures Manual

Electronic claims – line limits

There is no minimum or maximum number of claims that can be submitted electronically. However, there is a maximum number of service lines that may be submitted per claim. Dental claim forms (837D) have a maximum of 32 lines per claim.

Timely filing

Our Dental Policies and Procedures Manual states that providers agree to file claims within 120 days after the date a service is delivered to the covered person. If a claim for a covered person is not filed originally within the timeframe and in compliance with BCBSNE's Policies and Procedures, no benefits will be paid, and the provider agrees that no payment will be pursued from a covered person for any service not submitted in compliance with these terms. No adjustments or revisions to timely filed claims made by the provider will be accepted more than 12 months from the last date of payment by BCBSNE and, in such a case, all liability will be the sole responsibility of provider.

This means that any deductible or coinsurance collected from the member should be refunded to them. The member is not getting credited for the deductible or coinsurance that they have paid, which will influence other timely submitted claims.