Policies and Procedures

A Manual for Dental Professionals

Updated 05.29.2020

The content of this manual is subject to change. Please visit Blue Cross and Blue Shield of Nebraska online at https://www.nebraskablue.com/Providers/Policies-and-Procedures for the most current version.

Dear Dental Professional,

This manual is dedicated to keeping you and your staff informed regarding our operational policies and procedures at Blue Cross and Blue Shield of Nebraska (BCBSNE).

The contents of this manual are contractually binding for compliance based on your provider agreement with BCBSNE. Therefore, it is important for you to familiarize yourself with the information provided and have it readily available as a reference.

For your convenience, this manual is available in the Providers section at NebraskaBlue.com/Providers/Policies-and-Procedures. The online version of the manual contains the most current information.

If you have any suggestions as to how we can improve this manual as a comprehensive resource for you, please let us know.

Sincerely,

Jeni Alm, Vice President
Health Network Services

Preface

Participating health care professionals agree to follow the Policies and Procedures Manual as part of their Agreement with BCBSNE.

When there is a discrepancy between the terminology in this manual and covered person contract language, the specific contract language will prevail.

The information in this manual is subject to change. There may be deletions and additions published periodically, each with its own effective date. We encourage you to use the most current version of the manual by visiting NebraskaBlue.com and clicking on “Providers” and then “Policies and Procedures” in the left column.

Revisions are often published in our provider newsletter, *Provider UPDATE*, and in direct mailings to your office. Newsletters can also be viewed at NebraskaBlue.com by clicking on “Providers,” then “Newsletters” in the left column. To receive an email each time we post a new issue of the newsletter on the provider website, click on “Sign up today for a newsletter.”

This is general information that applies to many, but not all, employer group contracts. Employer groups can and do request variations of benefit coverage. The information in this manual should not be considered all-inclusive.

Health care professionals can call **(800) 635-0579**, our toll-free interactive voice response system, to answer questions about BCBSNE benefit coverage.

About Blue Cross and Blue Shield of Nebraska

Who We Are

BCBSNE is a member of the Blue Cross and Blue Shield Association (BCBSA), an association of independent Blue Cross and/or Blue Shield (BCBS/Blue) Plans. BCBSNE is an independent mutual insurance company licensed by the State of Nebraska.

BCBSNE has done business in Nebraska for more than 80 years. We work jointly with network health care professionals in providing the best health care possible to our customers.

Financial Stability

Although the BCBSA does not act as a guarantor of each Blue Plan's financial obligations, all Plans are subject to uniform financial standards established by the Association. These standards are intended to foster a system in which each Plan maintains adequate resources to meet its obligations to its customers. BCBSNE monitors financial and operational performance in several ways.

Business leaders, consumers and health care professionals across the state sit on our board of directors. The board sets standards for operations and financial performance. Such standards include the amount of operating reserves we maintain. Reserves are funds that are set aside over and above dollars needed to pay claims and run the business.

The board also establishes and monitors all policies governing the conduct of our employees, officers and directors. These policies ensure that the corporation operates ethically and within the laws and regulations prescribed for us.

Our Mission

BCBSNE exists to lead the way in supporting patient-focused care.

Advertising Policy

As a NEtwork BLUE Dental contracted health care provider, you are permitted to mention your BCBSNE network affiliation(s) in any electronic or print advertising or promotional materials, such as telephone directories, websites and brochures *with prior approval.*

As a health care provider, you are NOT permitted to use the BCBS symbols at any time. Please refer to the following guideline when requesting approval.

- You are required to submit your print-ready copy for review and approval to:

  Blue Cross and Blue Shield of Nebraska
  Public Relations and Corporate Communications Department
  P.O. Box 3248
  Omaha, NE 68180-0001
  Email: BMR@NebraskaBlue.com

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Different Needs Created Different Blues

Many "Blue" terms are used to describe the different programs and products of Blue Cross and Blue Shield designed to meet your needs and those of our members.

Each program/product is unique in its focus and because it carries the term "Blue," you can be assured that it supports our mission to deliver the health and wellness solutions people value most.

Benefits of Participation

Claim Information

NEtwork BLUE Dental providers can access the interactive voice response system at **800-635-0579**, for access to dental benefits for covered BCBSNE members. Providers who have not signed an agreement with BCBSNE are not able to access benefit information telephonically.

Direct Payment

As a NEtwork BLUE Dental provider for BCBSNE, you will receive direct payment for covered services in accordance to your provider agreement(s).

Notification of Disposition
You always know when a claim is paid, how much is paid and what the patient's liability is because you receive our remittance advice. Only NEtwork BLUE Dental providers routinely receive this information.

Patient Base
We actively promote our health care professionals and facilities. Provider access information is continually updated on local, national and group websites for customers to review when selecting. Up-to-date provider directories are available to our customers at NebraskaBlue.com/Find-a-Doctor. Members who obtain covered services from network providers have lower out-of-pocket expenses and receive the highest level of benefits.

Confidence
You can rely on our excellent reputation in the industry and the community. We've done business in Nebraska for more than 80 years. Our dental consultants and physician reviewers who help develop our policies are also BCBSNE network providers. We work jointly with our health care professionals in providing the best health care possible to our customers.

NEtwork BLUE Dental

What is NEtwork BLUE Dental?
NEtwork BLUE Dental is a Preferred Provider Organization (PPO) with an established dental panel. The term "NEtwork BLUE Dental" dentist is used to refer to a dentist who has signed an agreement and been approved to participate in BCBSNE's PPO dental network. Depending on the member's benefit plan, services provided by a non-PPO provider may be reduced or denied.

How to Participate?
To participate in the NEtwork BLUE Dental network, complete the credentialing process and sign an agreement with BCBSNE. All applicants must go through the credentialing process and satisfy all requirements prior to being accepted into the PPO network. By signing the Agreement, you consent to participate at all practice locations in Nebraska. As a network provider, you have agreed to file all claims, dental or medical, to BCBSNE for any covered benefit provided to our members and to accept our payment as payment in full.

To request an agreement and an application, please visit our Credentialing page at NebraskaBlue.com/Providers/Credentialing or call or email the following:

Phone: 877-435-7258 or **402-982-7711**
Fax: 402-343-3455
Email: CredentialingRequests@NebraskaBlue.com

How do I know if I've been accepted into NEtwork BLUE Dental?

Dentists whose applications have been approved for participation will be notified in writing. The letter will include a BCBSNE-assigned provider identification number (PIN). The PIN is specifically assigned to the tax identification number (TIN) submitted in the application.

Adding or Changing Practice Locations

If a dentist is already in our network and is merely adding another practice location OR if the contracting dentist is changing from one TIN to another, they need to complete an Extend/Transfer form. The form requires the practitioner's signature and is available at NebraskaBlue.com/Providers/Find-a-Form.

Transfer is used when the dentist will no longer be at their current practice location.

Extend is used when the dentist is adding a new practice location under a different TIN. The TIN that should be listed at the top of the form is the one tied to the current practice location and existing BCBSNE provider agreement. The rest of the information on the form should be related to the new location. Please note that BCBSNE provider numbers are tied to a specific TIN. The provider will be getting a new/additional BCBSNE Provider Number. All NEtwork BLUE Dental providers' Nebraska locations are required to participate.

Tax Identification Number (TIN) – Multiple Locations

As a network provider, you have agreed to file all claims to BCBSNE for any covered benefit provided to our members and to accept our payment as payment in full. If an office has multiple locations with multiple billing addresses, the provider will need to designate one payee location. BCBSNE policy is that all payment will go to one location since the offices share the same TIN.

National Provider Identifier (NPI)

The Administrative Simplification provisions of the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* mandated the adoption of standard unique identifiers for health care providers. As a result, the Centers for Medicare & Medicaid Services (CMS) developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers. BCBSNE also requires providers to use an NPI number when submitting claims.

Providers can apply for NPIs in one of three ways:

- For the fastest receipt of NPIs, use the web-based application process. Simply log onto the National Plan and Provider Enumeration System (NPPES) at https://nppes.cms.hhs.gov and apply online.
- Obtain a paper copy of the NPI Application/Update Form in any of these ways:
  - Phone: **800-465-3203** or **TTY 800-692-2326**
  - Email: customerservice@npienumerator.com
  - Mail:
    NPI Enumerator
    P.O. Box 6059

Fargo, ND 58108-6059

You File, So Patients Don't Have To

We encourage you to remind your patients that YOU file the claims for the services they receive. If the patient is given a copy of the charges, please annotate the copy: "For your records only. We file your Blue Cross and Blue Shield of Nebraska insurance claim."

Submitting claims for your services directly to us is not only a benefit to your patient, but also a benefit to you because:

- You have all the required information in the patient's file to complete a valid claim.
- Your expertise in completing insurance claims means you complete claims correctly at the time of submission.
- You control the accuracy of the information used to calculate benefits for your services.
- Patient submitted claims are often the cause of incorrect payments and payments to the wrong office.

A verbal reminder may also help the patient to understand that this is one of the services you provide as part of your agreement with us.

Sliding Fee Schedules

BCBSNE providers must be consistent in the amount they charge for their services. If you use a sliding fee scale for your disadvantaged clients, you must also apply this sliding fee scale to your BCBSNE covered members and bill that amount to BCBSNE.

Waiver of Coinsurance

BCBSNE strongly recommends collection of coinsurance at the time of service. The routine waiver of coinsurance may represent a breach of contract with BCBSNE.

Routine waiver of coinsurance is unlawful because it results in false claims, violations of the anti-kickback statute and excessive utilization of items and services. In addition to being unlawful, the waiver of coinsurance discourages patients from using health care services responsibly by removing the economic obligation of receiving care, which, in turn, indirectly raises the cost of health care to other covered persons.

Medical Records

NEtwork BLUE Dental professionals agree to submit medical records requested by BCBSNE in a timely manner at no cost to the covered person or to BCBSNE. BCBSNE members have consented to release medical records to us. An additional release is not required. All information resulting from the review is confidential.

Onsite Review

BCBSNE may designate an Onsite Review Coordinator to examine quality of care at an office where any issues of safety, privacy or environment have been brought to our

attention. An assessment will be made by the Coordinator and a summary of findings will be provided to the dental provider. If corrective action is deemed necessary, a repeat visit will be scheduled.

Responsibilities

NEtwork BLUE Dental Professionals must:

- Refer patients only to NEtwork BLUE medical specialists and other NEtwork BLUE health care providers. ***Except under circumstances identified in the agreement***.
- Arrange vacation and call coverage to be provided by a NEtwork BLUE Dental provider.
- Following these terms ensures the lowest out-of-pocket expense to the patient.

Billing

BCBSNE billing guidelines must be followed for all claims submitted. Refer to Policy and Coding and Claim Filing sections for more details.

- Bill your usual charge.
- Don't prepare claims using the fees on the reimbursement schedule as your charge.
- Don't reduce the office visit charge by any coinsurance that applies.

Payment

NEtwork BLUE Dental providers agree to accept our reimbursement as payment in full, except for the following amounts when applicable:

- Deductible
- Coinsurance
- Charges for services and supplies which are not covered in the member's contract and are not provider liability.

The reimbursement amount you receive may differ slightly from the contractual reimbursement amount due to system rounding.

NOTE: The member is not responsible for noncovered charges for services and supplies that are deemed not medically necessary by BCBSNE. However, on an exception basis, if prior to the services being provided, you have advised the member of this fact, in writing, and the member has agreed, in writing, to be responsible for payment, you may bill the patient. This may not be standard practice.

NOTE: Charges for noncovered services as well as any deductible and coinsurance on covered services may be collected at the time of service.

Not Medically Necessary Reimbursement

Contracting providers are not reimbursed by BCBSNE for services which are determined to be Not Medically Necessary. Under the contracting provider's agreement, the member cannot be charged for services determined to be Not Medically Necessary unless:

- Arrangements were made prior to the services;
- They have been advised in writing; and
- They have agreed in writing to be responsible for payment.

Use of the above practice must be limited to a specific instance and not done as a usual practice.

Reimbursement Schedules

NEtwork BLUE Dental professionals are reimbursed according to a NEtwork BLUE Dental Reimbursement Schedule for services provided to members with dental PPO coverage. Each year, the reimbursement schedule is reviewed and adjusted as needed. The schedule is mailed at least 30 days in advance of the implementation of that year's fees. The 30-day comment period gives you an opportunity to review and discuss the fee schedule with your Provider Executive.

Covered services not listed on the NEtwork BLUE Dental Reimbursement Schedule are reimbursed according to an amount set by BCBSNE. The Reimbursement Schedule displays all services and reimbursement amounts but does not dictate a covered service.

Termination and Appeals

NEtwork BLUE Dental Agreements between a dental professional and BCBSNE includes information about terminating the agreement by either party.

In accordance with Nebraska Revised Statutes 44-4101 et. seq., BCBSNE provides the opportunity for a provider to appeal a termination of his/her provider agreement. The provider must request an appeal of a contract termination in writing within 30 days of receiving notification of termination of the agreement.

When such appeal is requested, BCBSNE will furnish written notice of the date and time of the hearing which will be held at BCBSNE's offices. This notice will contain a statement of the standards or criteria on which the decision was based. The provider will be given an opportunity to appear personally at the hearing and to present additional information. If the provider disagrees with the decision made at this hearing, a further appeal is permitted to a three-person appeal committee.

A second appeal also must be requested in writing. BCBSNE will furnish written notice of the date, time and place of the hearing. This hearing must take place within a reasonable period after the request for appeal.

The appeal committee for this hearing will consist of one person selected by each party to the appeal and one person mutually agreeable to both parties. Each party will pay costs for the person it selected and share the costs of the third. Costs shall not be recoverable.

Prior to the effective date of any termination, the provider can enter and complete a corrective action plan which is approved by BCBSNE.

Exception: There is no corrective action plan available for cases of fraud or imminent harm to patient health or when the provider's ability to provide services has been restricted by an action, including probation or any compliance agreements, by the Department of Health or other governmental agency.

Hearings are not open to the public and are not subject to formal rules of evidence. Either party may present material evidence or testimony as may be necessary to resolve the dispute. The statute does not provide for immunity of the proceedings. In both instances, a timely decision shall be made and communicated as appropriate.

Members with NEtwork BLUE Dental Coverage

Identification

The patient's BCBSNE member ID card, including both the front and back sides, lists special instructions about where to file claims and what numbers to call for information and precertification.

You should photocopy the front and back of the patient's current ID card **on every visit** to assist in correct matching for coverage. New ID cards are issued for a variety of reasons, so it is imperative that the most current information on the card be used when submitting claims.

Federal Employee Program (FEP) Requirements

General FEHB overview

Federal employees who are enrolled in a medical plan offered through the Federal Employee Health Benefits Program (FEHB) may have a plan that includes dental benefits. When this is the case, file your dental claim to the FEHB carrier first. * This coverage is primary to any coverage the patient has through a supplemental Federal Employee Dental and Vision Insurance Program (FEDVIP) dental plan (see FEDVIP section below).

*Other coordination of benefits (COB) rules may apply if the federal employee or a covered family member has other non-FEDVIP medical and/or dental coverage. Follow your normal procedures for verifying which group or individual dental plan is primary in these situations.

Plans available in Nebraska
To view plans available to federal employees living in Nebraska, visit the Office of Personnel Management's website.

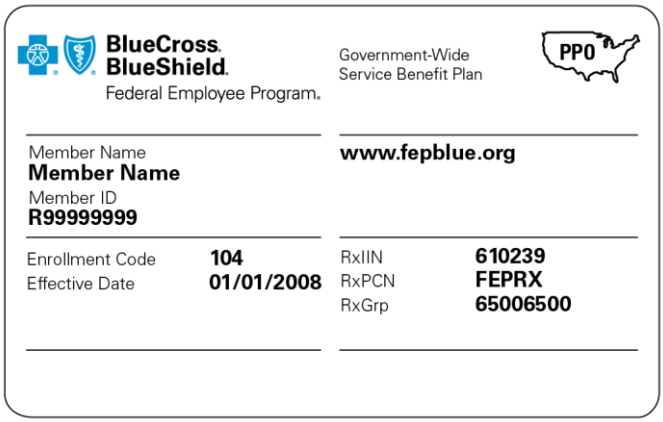
The Blue Cross and Blue Shield FEP Service Benefit Plan

ID cards
FEP Service Benefit Plan member ID cards do NOT list the names of all eligible dependents on the card. This would be cost-prohibitive because the SBP insures more than 6 million federal employees and family members nationwide. To verify eligibility, call the Blue Plan in the state where services will be rendered.

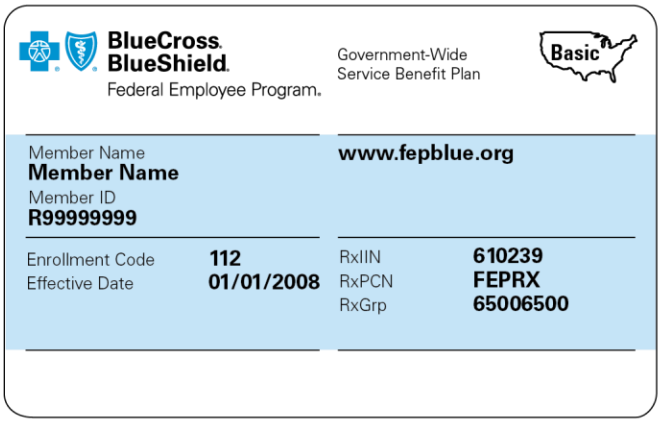
For services rendered in Nebraska, you may use GABBI (preferred method) or call the FEP Customer Service department at **800-223-5584** or **402-390-1879** in the Omaha area. Dental GRID providers are subject to the terms and conditions of their Dental GRID contract. Enrolled children are covered up to age 26.

Here are examples of the FEP SBP member ID cards.

Standard Option ID Card
Enrollment codes 104, 105 and 106



Basic Option ID Card
Enrollment codes 111, 112 and 113



Standard Option and Basic Option Dental Benefits
Click here to access the 2015 Service Benefit Plan brochure. Dental benefits are listed in Section 5(g) Dental Benefits.

It is important to note the FEP Service Benefit Plan is a medical plan and includes very limited dental benefits. Members do not pay any additional premiums for this coverage.

When the Service Benefit Plan is primary, file the claim to the correct Blue Plan using the rules above and using the member ID number listed on the FEP Service Benefit Plan member ID card.

Standard Option:
Members enrolled in the SBP Standard Option are entitled to the benefits listed in the Standard Option benefits section whether the dental provider participates in Dental GRID.

The amounts listed in the “we pay” columns are the amounts BCBS will pay you if you are a GRID provider. *You may collect* up to your GRID fee schedule allowance.

Basic Option:
Members enrolled in the SBP Basic Option are entitled to the benefits listed in the Basic Option benefits section AND the dental provider is a Dental GRID provider. Basic Option members do not have out of network benefits.

If services are covered, BCBS will pay you; the member owes the copay listed in the “you pay” column.

Federal Employee Dental Insurance Plans:
Federal employees who are eligible to enroll in the FEHB Program (health insurance plans) are also eligible to enroll in the Federal Employee Dental and Vision Insurance Program (FEDVIP). FEDVIP Plans are always secondary to FEHB coverage, whether the member is enrolled in the Service Benefit Plan (FEP) or one of the other plans available.

To view the plans available to members in Nebraska, click here.

Eligible dependent children are covered up to age 22.

FEP BlueDental
Blue Cross and Blue Shield offers one supplemental dental plan: The FEP BlueDental plan, administered by Blue Cross and Blue Shield of Minnesota. In most cases, when the member has coverage under the FEP Service Benefit Plan and FEP BlueDental coverage, claims will automatically cross over from the FEP Service Benefit Plan to FEP BlueDental for processing. Claims will not cross over when another carrier (non-Blue) plan is involved.

Click here to view the 2015 FEP BlueDental brochure.

To verify enrollment, or if you have questions about coverage or a claim payment, you must contact FEP BlueDental at **800-504-2582**. BCBSNE does not have access to claims payment or enrollment information for FEP BlueDental members.

The dentist must promptly inform BCBSNE of any event which may adversely reflect upon professional competence, ethics and other qualifications as a NEtwork BLUE Dental provider in accordance with the NEtwork BLUE Dental Provider Agreement.

The dentist agrees to complete treatment in progress and accept BCBSNE reimbursement for that case if he or she terminates participation as a NEtwork BLUE dentist.

When FEP is the secondary payer, the dental claim must be filed to the primary carrier first.

A participating NEtwork BLUE dentist has agreed to accept the NEtwork BLUE Dental allowable as payment in full for an FEP patient. Therefore, the dentist needs to collect the difference between the amount paid by FEP and the PPO amount or their charge, whichever is less.

Coordination of Benefits

The Coordination of Benefits (COB) provision in a covered person's group contract is designed to prevent duplicate benefit payments when a patient has two or more health or dental insurance plans providing coverage. Even if you do not contract with other insurance payer(s), if BCBSNE is secondary we will need the primary insurance's explanation of benefits (EOB)/remit in order to process the claim.

Primary BCBS/Secondary Other Payer– Contracting provider must file claim to BCBS; filing to secondary is optional based on office policy

Primary XYZ/Secondary BCBS – Primary claim filing based on office policy and provider must submit primary EOB/remit to BCBS

Primary BCBS/Secondary BCBS – Contracting provider must file both primary and secondary claims to BCBS

COB rules dictate which payer is primary. When BCBSNE is the primary payer, benefits are determined as if no other plan provided coverage. When BCBSNE is the secondary payer, benefits are determined after the primary plan has decided its benefit amount. As the secondary payer, BCBSNE may reduce benefits due to the primary plan benefit responsibility.

Payment will not be made for any amount for which the covered person is contractually held harmless by either the primary or secondary plan. Payment shall not exceed the amount paid under BCBSNE, had it been primary.

Most group health plans follow the most current National Association Insurance Commission (NAIC) COB model regulations when determining the order of benefits. The NAIC Coordination of Benefits model regulations dealing with "Order of Benefits Determination" sets forth six rules for determining the order of benefits between plans.

Most plans follow the "birthday rule" to determine which parent's plan is primary for children. The plan covering the parent whose birthday falls earlier in the year is considered the primary payer. "Birthday" refers only to the month and day in the calendar year – not the year of birth. If the parents share the same birthday, the primary plan which has been in effect for the longest time.

There are exceptions in the case of parents that are separated/divorced. Unless specifically stated in the decree, the primary plan is determined in the following order:

1. The plan covering the custodial parent;
2. The plan covering the custodial parent's spouse;
3. The plan covering the non-custodial parent; and then
4. The plan covering the non-custodial parent's spouse.

However, in the event that we have actual knowledge that a divorce decree or a child support order requires one parent to be responsible for health care expenses, the Primary Plan will be the Plan provided by that parent.

For questions regarding other COB rules, please contact the BCBSNE COB department at **402-390-1840** or **800-462-2924**.

Electronic Claim Filing and Funds Transfer

Electronic Claims Submission

Electronic submission is the preferred method of filing claims for professional services. Benefits of electronic claim submission include:

- Lower operating costs. You will spend fewer dollars for clerical work and postage. Most electronic claims are submitted in less than 60 seconds.
- Greater control over claim data. Electronic claim submission is a more efficient way to submit claims and will lead to a faster, more accurate payment.
- When all necessary information is submitted electronically, fewer claims will be returned for missing or incorrect information.

Our NEBLUE*connect* Account Managers can tell you about the hardware and software that make electronic claim submission possible and can show you how electronic claims processing has helped offices like yours.

For more information, go to NebraskaBlue.com and click on “Providers,” then “NEBLUEConnect” in the left-hand column.

Electronic Funds Transfer

To inquire about having funds electronically deposited into your bank account, please visit NebraskaBlue.com/Providers/Find-a-Form or contact:

BCBSNE Health Network Services
PO Box 3248
Omaha, NE 68180-0001
Fax: 402-343-3455
Email: ProviderServicesOperationsSupport@NebraskaBlue.com

Policy and Coding

Our goal is to provide you with information that encourages consistent, uniform billing practices among Nebraska dental professionals. Our intent is to provide correct reimbursement for services provided.

This section is designed to clarify our medical policies and clarify coding guidelines that relate to those policies. This is a guide, not an all-inclusive policy. You will read about changes to these policies in our provider newsletter or in direct mailings to your office.

Covered services and benefits vary considerably within the various contracts administered by BCBSNE. In all cases, we follow the specific covered person's contract provision.

The following Policy and Coding section is an alphabetic listing of common medical policies and coding guidelines that apply to BCBSNE claim processing.

Adult vs. Child Codes

Submit adult procedure codes for those patients with adult dentition or if child is 12 years of age or older.

Ambulatory Surgery (See "Surgery") Anesthesia Billing Situations

IV sedation, nitrous oxide, local anesthesia, blocks and conscious sedation are contract exclusions unless a member or group contract is endorsed to add such benefits. General anesthesia is only payable when medical necessity criteria are met or if used for the removal of impacted teeth.

- **D9241** – intravenous conscious sedation/analgesia – first 30 minutes
- **D9242** – intravenous conscious sedation/analgesia – each additional 15 minutes

Arestin Toothpaste

If using Arestin toothpaste when doing perioscaling and root planing, bill the toothpaste separately with D4381, one unit per tooth. If sending Arestin home with the patient, code as D9630.

Bridges

Correct abutment and pontic description are required.

Bridge Repair

Tooth numbers and description of repair are required.

Cash Discounts

If a cash discount is offered to any patient, it must be extended to BCBS patients. The discounted amount must be the amount billed on the claim. If a BCBS member requests a claim be filed for a noncovered service, the provider must file the claim.

CDT

To report treatment, use the American Dental Association's (ADA) Code on Dental Procedures and Nomenclature (CDT). The CDT is revised periodically by the ADA. When codes are added or deleted by the ADA, BCBSNEs change our claim processing system

accordingly. Use only the codes listed in the most current version of CDT when reporting services to us. Claims with codes NOT in the current CDT will be invalid for processing and returned.

The latest revision of CDT is available through:

American Dental Association
Department of Saleable Materials
211 East Chicago Avenue
Chicago, IL 60611-2616

CDT-Coding

Please reference American Dental Association Council on Dental Care Programs Current Dental Terminology Revised CDT.

Claim Filing Limit **(See "Timely Filing")**

Coding

Use the code that best describes the service performed. Many codes in CDT are accompanied by additional information or explanations to help clarify the best use of each number.

Common Errors Causing Claims to be Returned

- The tooth number, surface and procedure listed are not compatible
- Claims are submitted without procedure codes
- Procedure codes require units, teeth or surface information that is not given; for example, Tooth 15 billed with code D2330 or Tooth 18 billed with an "O" surface
- Accident care does not include the accident date and description of the accident
- Procedure codes are invalid or outdated

Crown Buildups

The charge for all pins must be included in the total fee.

Crown Repairs

A narrative explaining type of repair is required.

D61

When posting from the Remittance Advice, if Code D61 is in the "Notes" column, the amount above the Maximum Benefit Amount is to be written off.

Dental Plan Code Directory

Once the dentist has received the Dental Plan Code from our telephonic benefits inquiry line or Customer Service, the Dental Plan Code Directory may be used for coverage

information. This document can be found in the “Providers” section at NebraskaBlue.com, under “Policies and Procedures.”

Documentation

General Principles of Medical Record Documentation
The principles of documentation listed below are applicable to all types of services in all settings.

1. Must be complete and legible.

2. Each patient encounter record should include:

    - Reason for the encounter and relevant history, physical examination findings, prior diagnostic test results;
    - Assessment, clinical impression, or diagnosis;
    - Plan for care; and
    - Date and legible identity of the observer.

3. The rationale for ordering diagnostic and other ancillary services must be documented.

4. Appropriate health risk factors should be identified.

5. The patient’s progress, response to and changes in treatment, and revision of diagnosis must be documented.

6. The CDT codes reported on the claim form must be supported by the documentation in the medical record.

Tips to Remember

1. Documentation should be complete and accurate before the claim is submitted.

2. Accurate documentation in the medical record enables:

    - The dentist and other health care professionals to evaluate and plan the patient’s immediate treatment, and to monitor his/her health care over time

    - Communications and continuity of care among dentists and other health care professionals involved in the patient’s care

    - Accurate and timely claims review and payment

    - Appropriate utilization review and quality of care evaluations

- An appropriate documented dental record, reducing frustration associated with claims processing and serving as a legal document to verify the care provided, if necessary

3. All documentation in the medical record must be patient specific. Cloning of documentation which fails to take into account patient specific variations will be considered a misrepresentation of the medical necessity requirement for coverage of services.

Gingivectomy

Use correct code for either single tooth or quadrant.

Immediate Family

Contracting providers may not bill BCBSNE for health care services rendered to themselves or their immediate family members, or designate themselves as a primary care physician, for any purpose, for themselves or their immediate family members. An "immediate family member" is defined as: (i) current spouse; (ii) eligible domestic partner; (iii) parents and step-parents of the provider or the provider's spouse or domestic partner; (iv)children and grandchildren (biological, adopted or other legally placed children) of the provider and/or the provider's spouse or domestic partner; and (v) siblings (including biological, adopted, step, half or other legally placed children) of the provider or the provider's spouse or domestic partner.

BCBSNE will not process any claims for services, nor make payment for any claims for services, rendered by a contracting provider to him/herself, or to his/her immediate family members. In the event BCBSNE determines that a benefit was paid in error, BCBSNE has the right to request and receive a refund of the payment from the contracting provider. BCBSNE does not expect to receive claims for these services and will not make payment on claims submitted for services rendered by or for immediate family. Should it be determined that a benefit has been paid in error, BCBSNE will request a refund of the original payment.

Incision and Drainage of Abscess (Soft Tissue)

The tooth number is required for Procedure 7510.

Impacted Teeth

Specific procedure codes are payable on the medical side if the member's contract contains the verbiage "evaluation and treatment" of impacted teeth. Otherwise, these codes are an exclusion under the medical plan. These codes are only payable under dental benefits if the member has orthodontic coverage.

Laboratory Fees for Crown & Bridge Services

Lab fees should be included in the charge for the crown and bridge, not billed separately.

Locum Tenens

A Locum tenens (Latin: “holding the place,” i.e., “placeholder”) is a person who is temporarily fulfilling the duties and responsibilities of an office in the absence of the appointed holder of that office.

When a locum tenens is used, services should be billed under the dentist who is temporarily gone. The contracting status of the dentist under whose name the services are being billed will be used for claim payment. If the substitution lasts for more than 90 days, then the dentist filling in should be credentialed.

A locum tenens is not a new permanent dentist or a dentist going through credentialing.

Medical Records **(also see “Documentation”)**

Any additional information which is reasonably necessary to determine benefits and to verify performance under the Provider’s Agreement shall be provided without charge and in a timely manner.

Note: If a member is applying for coverage (not already covered) and medical records are requested, providers can charge the member for sending medical records to BCBSNE.

Filing for Medical Services

You must use the CMS 1500 Claim Form when billing for services covered under the patient’s medical benefit plan. As a network provider, you have agreed to file all claims, dental or medical, to BCBSNE for any covered benefit provided to our members and to accept our payment as payment in full.

Guidelines for completing the CMS 1500 form are in the NEtwork BLUE Policies and Procedures Manual. This manual can be found at NebraskaBlue.com/Providers/Policies-and-Procedures. Handwritten, legible CMS 1500 claims are acceptable. Covered medical services are subject to the same in-network fee schedule reimbursement and provider responsibilities as dental services in accordance with the dental provider’s Network Blue agreement.

Guidelines for oral appliances for sleep apnea treatment

BCBSNE medical policy for treatment of obstructive sleep apnea (OSA) includes an oral appliance, among other alternatives. Treatment of sleep apnea must be preauthorized for BCBSNE members or the claim will be denied as provider liability. Because dentists are best qualified for evaluating a patient’s suitability for the mouthpiece and making the dental impressions, BCBSNE regulates the coding guidelines that dentists are to bill for the oral appliance. As with any medical service rendered by a dentist, BCBSNE expects only CDT Dental Procedure Codes on the NEtwork BLUE dental fee schedule to be billed on the medical claim. The two charges dentists can bill for the oral appliance for sleep apnea are:

D0150 Comprehensive Oral Evaluation—new or established patient

E0486 NU Oral device/appliance used to reduce upper airway collapsibility, adjustable or nonadjustable, custom fabricated, includes fitting and adjustment. (Due to the fact that there is no CDT code on the dentist fee schedule that accurately describes the oral appliance, dentists must use the HCPCS code E0486.)

The NU modifier is required, or the claim will be returned. The prefabricated appliance E0485 is not payable.

The medical policy for sleep apnea treatment is VIII.8 “Medical Management for Obstructive Sleep Apnea” available at MedicalPolicy.NebraskaBlue.com/home. Note that a preauthorization may be submitted from the Medical Policy tool. No preauthorization on file will cause the medical claim to deny provider liability.

Common ICD-10 Medical Diagnosis
SØ1.512A Laceration without foreign body of oral cavity
SØ2.5 Fracture of Tooth
K00.6 Disturbances in Tooth Eruption
K01.0 Embedded Tooth
K01.1 Impacted Tooth
G47.30 Sleep Apnea
M26.60 TMJ

Miscellaneous Codes
Use miscellaneous codes as appropriate

Multiple Bitewings
When multiple bitewings are taken on the same day, the procedure codes used must match the number of bitewings taken.

Multiple Extractions
The first extraction should be coded D7140 and each additional extraction D7140.

Noncovered Services
If a BCBS member requests a claim be filed for a noncovered service, the provider must file the claim. Office visits, lab and X-rays are not payable when billed on the same day as a noncovered service.

Office Visits
Office visits (99201-99215) are payable when billed on the same day with a covered service. Dental consult visits may be payable regardless of other services provided on the same date of service.

Orthodontics/Invisalign

The initial banding charge should be up to one-third of the total charge. After the initial banding, provider may bill monthly or quarterly (three-month increments) for the remainder of treatment, until the benefit is exhausted. Billing may be submitted monthly at the first of the month, regardless of whether the patient was seen on that date, or quarterly, with the three months listed under the line charge or in the comments field.

Reimbursement for other Orthodontic Treatments will be the same as regular orthodontics. Invisalign is a mode of treating orthodontics; therefore, this policy applies to Invisalign orthodontics also.

Oximetry

Regardless of what other charges are billed, pulse oximetry will be denied as a noncovered service.

Pathology

The fee for pathology is not payable under a member's dental benefits but may be considered under medical.

Panorex and Full Mouth X-Rays

Either one panorex or one full mouth X-ray is allowed every 3 years (unless a group amends for longer). If both are billed on the same day, BCBSNE will only pay for one of them.

Periapical X-rays

When multiple periapical X-rays are taken on the same day, the first X-ray should be coded separately using Procedure Code D0220 with the charge. Additional X-rays should be coded together using Procedure Code D0230 with the total charge and number of X-rays indicated in the description. Do not lump all charges under D0220.

Periodontal Scaling and Root Planning - per quadrant

Procedure Code D4341 is a per quadrant code. Code once and specify tooth numbers appropriately.

Periodontal Services

Tooth numbers are required for all periodontal procedures, except D4910.

Physical Presence

Physical presence means you have a brick and mortar location, which must be a street location, not a P.O. Box.

Pretreatment Estimates

Additional services to pretreatments must be submitted on a separate claim form; they may not be submitted on the pretreatment claim form.

Prophylaxis
Use Code D1120 (Prophylaxis Child) or Code D1110 (Prophylaxis Adult) only when a cleaning is done without application of fluoride. Use Code D1208 for fluoride application only.

If during a prophylaxis visit is it determined another service is needed (e.g., periodontal scaling and root planning) complete the procedure(s) and reschedule the prophylaxis, if possible. You may also schedule the procedure(s) and complete the prophylaxis, but the prophylaxis and procedure(s) cannot be billed on the same day.

Replacement Bridge
Tooth numbers are required.

Replacement Inlays and Crowns, Pins and Sedative Fillings
The tooth number is required.

Root Canal – Retreatment
A statement explaining need for procedure, date of previous root canal, and X-ray is required.

Staged Procedure/Contract Terminated
Some member contracts may allow benefits after termination of the contract for certain procedures already begun. This may include root canal therapy, crowns, bridges, inlays, onlays, dentures and orthodontia, payable for a period not to exceed 30 days. Reimbursement is based on the preparation date.

Superbills
Superbills are not an acceptable claim form.

Supernumerary Teeth
X-rays and tooth numbers are required.

Temporary Crowns
Always indicate whether a temporary crown (Procedure D2970) is accident related or not. When accident-related, a preoperative X-ray is required. Accident information should be listed in Box 26.

Temporary Dentures and Partials
Always use the correct ADA procedure code. Tooth numbers should be listed for partials.

Tooth Number

Use the American Dental Association (ADA) numbering system to identify the site of each service.

Unlisted Procedure or Service

Unlisted procedure codes have been designated to report services or procedures that are not found in the CPT or CDT manual. These codes usually end in the number 99.

Any procedure not accurately described in CDT should be reported using the appropriate unspecified (D9999) code with a narrative description by report.

When an unlisted procedure code is submitted, the claim cannot be reviewed without a description of the service. Documentation such as visit or operative notes clearly detailing the service provided should be submitted with the claim.

Waiver of Coinsurance

BCBSNE recommends collection of coinsurance at the time of service. Providers, practitioners or suppliers who waive coinsurance are misstating their actual charge. The waiver of coinsurance may represent a breach of contract with BCBSNE. The Plan will base its calculation on the fees charged.

X-Rays

X-rays should only be submitted in the following situations:

- Anterior crowns
- Multiple restorations of same teeth
- Extensive anterior restorations
- Accidents when the services are crowns, root canals, fractures, posterior teeth repair, orthodontic services or implants
- Veneers for Procedure Codes
- Impactions other than wisdom teeth.

Claim Reporting

Paper Claim Submission

Paper claims are entered into our claim processing system by transforming information on paper claims to an electronic format. If the claim cannot be entered electronically, it is delayed for research and entered manually by an auditor.

To expedite claims payment, always obtain form copies from the ADA by calling **800**-**947-4746** or visiting www.adacatalog.org.

- Claims must be submitted on 2012 or newer forms;
- Claims submitted on forms older than 2012 will be returned.

The BCBSNE member or FEP member ID **MUST** be populated on Form Locator 15 on the 2016 Dental Claim Form and newer forms. (When the BCBSNE member or FEP member ID isn't added to that section, it could delay processing of the claim.)

Electronic entered claims go into our processing system more quickly and more accurately than paper claims that have to be manually entered.

Please mail your claims to:

Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, NE 68180-0001

Paper Claim Success

To ensure that your paper claims receive the benefits of automated entry:

- Text must be typed and legible.
- Keep all text inside the lines.
- Text must be dark.
- Dates must be numeric and six digits (mmddyy).
- Don't use nicknames or, e.g., "Baby Girl" or "Baby Boy" as the patient's name. The TIN on the claim must match the information on BCBSNE's provider file.

Coding

BCBSNE has adopted the ADA's code descriptions, which is a national standard for reporting dental procedures. To purchase the most current ADA catalog, visit www.adacatalog.org or call **800-947-4746**.

Dental Claim Filing

The appropriate box must be marked to indicate if the information provided is a pretreatment estimate or for services rendered.

CMS 1500 Claim Filing

The CMS 1500 must be used when the services are for care, which is a benefit under medical surgical benefits. Guidelines for completing the CMS 1500 form are in the Policy and Procedure Manual, in Section 10 of the for Physicians. A mock-up CMS 1500 claim with medical services is available for viewing **here**. A blank copy of the CMS 1500 that you can print for claim submission is available **here**. Handwritten, legible claims are acceptable.

SPECIAL NOTE:

When filing with dental codes on a CMS 1500, a "D" must be in the first position of the dental code. Tooth numbers and descriptions for supplies must be included on the claim. In complete information will cause the claim to be returned.

Timely Filings Restrictions

Time Limit for Filing or Adjusting a Claim
The provider agrees to file claims within 120 days after the date on which the service is delivered to the member. If a claim for a member is not filed originally within the timeframe and in compliance with BCBSNE's Policies and Procedures, no benefits will be paid, and 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 the 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 claims.

Remittance Advice

NEtwork BLUE Dental providers receive direct payment from BCBSNE. Direct payment and claim information assist patient accounting activities because:

- A remittance advice is generated when the claim is processed and mailed on a weekly basis.
- Claims payment is mailed with the remittance advice unless electronic funds transfer is requested.
- The subscriber and NEtwork BLUE Dental providers are notified of the processed claim status at the same time.
- Payment information is detailed for each claim on the remittance advice.
- Deductible, coinsurance, and noncovered charges are identified. A denial explanation is given for all amounts not covered.
- Any amount that is the provider's responsibility to write off is specifically identified.
- If a patient account number is submitted on a claim, that number is included on the remittance advice.
- Adjustment claims are clearly identified

The following codes are listed on your remittance advice and reflect the type of service provided.

Code BCBSNE Definition
200 .....Surgery
2M0 .....Oral Surgery
400 .....Anesthesia
500 .....Nuclear Medicine/Ultrasound, X-rays
600 .....Medical Care

OTHER HEALTH SERVICES

9D0.....Dental Care
013.....Dental EOBs

Claim Adjustment and Remittance Advice Codes

Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) communicate why a claim or service line was paid differently than it was billed. If there is no adjustment to a claim/line, then there is no adjustment reason code. Each code identifies a specific message.

The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers. The CARC list is maintained by a national Code Maintenance Committee. Click here to access the complete listing and description of these codes.

Corrected Professional Claims Require Appeal / Reconsideration Request Form

If the information on a processed claim is subsequently found to be incorrect, a reconsideration form and corrected claim must be submitted in order for an original claim to be considered for adjustment.

Before attaching the Appeal/Reconsideration Request Form to your corrected claim, be sure you have filled out the form completely and legibly.

In the section titled, “Reconsideration” (Column B), mark the box that clearly identifies the error that was made on the original claim, i.e., incorrect CPT code, incorrect ICD-10 code, incorrect POS, etc.

Failure to submit your corrected claim with an Appeal/Reconsideration Request Form attached will result in our inability to respond to any status inquiries since the corrected claim was not submitted as a claim reconsideration.

Attaching the Appeal/Reconsideration Request Form will also ensure that your corrected claim is not denied as a duplicate claim submission. This form and others are available at NebraskaBlue.com/Providers/Find-a-Form.

Refunds

NEtwork BLUE dental providers agree to notify and refund to BCBSNE all amounts paid in error. In the event of overpayment, duplicate payment or other payment of an amount in excess of the amount to which the dentist is entitled, BCBSNE may, in addition to any other remedy, recover the same by way of offsetting the amounts overpaid against current and future amounts due and/or seek refund of the amount in controversy from the dentist.

Send refunds along with a Check Return Form:

Blue Cross Blue Shield of Nebraska
Accounting Department

PO Box 3248
Omaha, NE 68180-0001

Upon request by the covered person, the dentist agrees to refund to the covered person any amount paid to the dentist by the covered person for covered services which is in excess of the amounts for noncovered services, deductible and coinsurance. The Check Return form is available at NebraskaBlue.com/Providers/Find-a-Form.

Call **877-888-2374** to advise BCBSNE of an overpayment or to respond to a refund request.

Pretreatment Estimates and Preauthorization

What is the difference between a pretreatment estimate and a preauthorization?

A pretreatment estimate is a request for approval of **dental** benefits prior to the service. A preauthorization is a written request for approval of **medical** benefits prior to the performance of certain services which require a medical decision.

Pretreatment Estimates

A pretreatment estimate needs to be submitted to BCBSNE only when the total fees for the treatment plan exceed $500.00, excluding examinations, prophylaxis, radiographs, oral surgery and emergency treatment. Services not included on the pretreatment form should be filed separately.

Preoperative X-rays should be sent with the pretreatment estimate only for anterior crowns, abutments with A/B coverage, multiple restorations (same tooth) and accident related care. In all other cases, BCBSNE will request them on an as needed basis. When a pretreatment estimate is not required because the fees will be under $500.00, submit the Xrays with the actual claim for crowns, bridges and accident care. These X-rays will be returned to the dentist's office shortly after processing is completed.

Pretreatment estimates are only valid for six months.

Pretreatment estimates are not required or processed for Federal Employee Program (FEP) members. Requests received for pretreatment estimates for FEP members will be returned to the provider advising pretreatment estimates are not provided. The provider will be requested to submit the claim when the services are provided.

Preauthorization

Preauthorization is based on the terms of the covered person's contract and is based on the information submitted to BCBSNE. Preauthorization guidelines apply whether BCBSNE is primary or secondary payer to Medicare or to other third-party payers.

Services Exempt from Preauthorization

If the patient is age 8 and under or developmentally disabled and receiving dental anesthesia, no preauthorization is required.

Investigative Procedures

Any time there is a question whether a procedure or service is covered by BCBSNE, the provider should first search for that procedure/service in the BCBSNE Medical Policy manual, available at NebraskaBlue.com/Providers/Find-a-Form.

If a policy is not listed for that procedure or if the provider is not certain the member's condition meets the coverage guidelines, the care should be preauthorized.

The preauthorization form is available at NebraskaBlue.com/Providers/Find-a-Form.

If a procedure is determined to be investigative and, therefore, not covered, the provider is strongly encouraged to inform the member of that fact prior to the service or procedure being performed. Such advisement should note that payment for investigative services, procedures or related expenses is the patient's responsibility. Any written or verbal notification should be documented in the patient's medical record. If the member still desires to have the procedure or service done, the provider is strongly encouraged to make the member aware of the approximate cost.

Time Lines

Preauthorizations that are not urgent will be processed within 15 calendar days of receipt, unless an extension is needed to obtain necessary information. If information is requested, the claimant/provider may be given not less than 45 calendar days from receipt of notice to submit the specified information. A preauthorization determination will be made within 15 calendar days of receipt of the information or the end of the extension period.

In the case of an urgent preauthorization, the claimant/provider will be notified of the decision (whether adverse or not), not later than 72 hours after receipt of the preauthorization, unless further information is needed. If additional information is necessary, the claimant/provider may be afforded not less than 48 hours from the date of the request to provide the specified information. Notification of the decision will be provided within 48 hours of receipt of the specified information or the end of the period allowed to provide the information.

Time Limitations

The authorization may be effective for a limited period. Most are good for six months. The written request must indicate the name of the patient and the covered person's BCBSNE member ID number, including alpha prefix.

No Payment Guarantee

Approval is based on the terms of the contract in effect on the date services are received. Changes in the patient's coverage for any reason, including eligibility, benefit revisions or contractual maximums, may affect this approval.

Appeal Overview

All BCBSNE contracts adhere to the applicable state and/or federal guidelines governing appeals. Appeals are performed by nurses and/or physicians who were not previously involved in the review or appeal process. When requesting an appeal, it is important to submit all relevant information that may assist in conducting the appeal.

Expedited Appeal

An expedited appeal is a request to review a second level reviewer (SLR) noncertification determination. It is offered to the attending dental provider/other ordering provider, patient/member and facility when a determination is made not to certify services and the situation meets one or more of the following requirements defined by BCBSNE:

a. The service is imminent or ongoing.

b. A delay in decision making might seriously jeopardize the life or health of the patient/member or their ability to regain maximum function.

First Level of Appeal

The first level of appeal may be expedited or non-expedited and should be submitted in writing.

Providers are encouraged to use the Appeal/Reconsideration form found at NebraskaBlue.com/Providers/Find-a-Form.

For most groups covered by BCBSNE, the timeframe for requesting a first level appeal is six (6) months from the initial denial of benefits. The following information will assist the attending dental provider in requesting an appeal. A written request for an appeal may be faxed to **402-548-4684** or **888-492-4944**; or it may be mailed to:

Appeals Department
Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, NE 68180-0001

The laws and regulations governing appeals do not allow the plan to delay or postpone an appeal decision if additional information is requested but not received. For an expedited first-level appeal, a determination will be made within 72 hours of the request for the appeal. If additional information was requested but not received, the appeal decision will be made

based on the information available. For a non-expedited first-level appeal, a decision will be made on either the 15th working day or 30th calendar day (depending upon the group's contract) from receipt of the appeal request.

The attending dental provider will be notified of the appeal determination within 72 hours of the request for the appeal when care is expedited. Written notification of the appeal determination will be sent for expedited and non-expedited appeal determinations.

Second Level of Appeal (if applicable)

A second level of appeal is available when the first level of appeal results in a denial of benefits. Most groups covered by BCBSNE allow 60 days from the first level appeal denial to request the second level appeal. There are different second level appeal processes. The denial of benefits letter following the first level of appeal will provide the necessary information and the process to use to request a second level of appeal.

The second level appeal request must also be in writing. Additional information not included in the first appeal may be submitted. A written request for an appeal may be faxed to **402-548-4684** or **888-492-4944**; or it may be mailed to:

Appeals Department
Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, NE 68180-0001

If the second-level appeal results in a denial of benefits, then BCBSNE's appeal process has been exhausted and no further appeals are available.

Denial Upheld on Appeal

When a denial is upheld on first- or second-level appeal, the attending dental provider has the right to request in writing:

- A copy of the rule, guideline, protocol or other criterion that was relied upon in making the decision (if applicable); and

- An explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances (if the denial is based on medical necessity, experimental treatment or similar exclusion or limit).

Subrogation and Worker's Compensation

Subrogation

The dental/health plans underwritten and/or administered by BCBSNE have a contractual right to recover amounts paid as a result of an injury/illness caused by a third party. This priority lien of the dental/health plan on proceeds paid by a third party applies whether or not the covered person has been fully compensated. The dental/health plans also may have a contractual right of reimbursement from other proceeds to the extent benefits were also paid under the health plan for the same illness or injury.

What is a subrogation or right of reimbursement term in a member contract?
Subrogation is the right of a person to assume a legal claim of another or the right of a person who has paid a liability or obligation of another to be indemnified by that person. A right of reimbursement is a contractual term granting one party to a contract the right to obtain reimbursement from the other party to the contract under certain circumstances. All member contracts of insurance with BCBSNE and all dental/health plans administered by BCBSNE contain subrogation and right of reimbursement provisions.

Before Sending in an Accident Claim
As a network provider, you have agreed to file all claims to BCBSNE for any covered benefit provided to our members and to accept our payment as payment in full.

If a covered benefit involves claims that are a result of an accident or illness caused by a third party, you must file a claim including accident information to BCBSNE. We will provide benefits according to the member's contract and supply payment to the provider of service pursuant to our agreement with them.

Our Subrogation department will begin the necessary procedures to recover paid amounts from the covered person or third-party payer, which will not exceed the amount we paid in benefits.

If you are notified of an injury or accident after filing claims to BCBSNE and have not included the accident information on the claim, you should notify our Subrogation department immediately at **402-390-1847** or **800-662-3554**.

How are BCBSNE members affected by subrogation and right of reimbursement?
Members receive benefits under contacts or dental/health plans that include an obligation to reimburse BCBSNE or the health plan if another party is responsible for payment or if the member is pursuing payment from another source and when certain conditions are met. BCBSNE enforces the terms of the contract or dental/health plan and pursues recoveries through its Subrogation department. The contract or dental/health plan language in place at the time of the accident will determine the rights and obligations of the parties.

How are BCBSNE providers affected by subrogation and right of reimbursement?
In general, dentists are not affected by subrogation or right of reimbursement. In certain circumstances, there may be two insurers potentially responsible for payment: the member's auto insurer or a third party's auto insurer, and BCBSNE. When more than one insurer is responsible for payment, dentists must file claims for all service to both insurers. Some BCBSNE member contracts have COB language in them, requiring us to coordinate benefits with the individual auto carriers.

In some cases, someone other than BCBSNE will make payment directly to the dentist and the dentist may have received payment from BCBSNE, as well. If you receive a payment from two sources, the BCBSNE provider agreements indicate that you should return the overpayment to BCBSNE. Even if the payment received from the third party is less than the BCBSNE payment, you must send the amount of the third-party payment to BCBSNE.

In all cases, BCBSNE will follow the member contract or health plan when processing claims and payments from other sources. In no circumstance should providers send an overpayment to the other insurer or the member without direction from our Subrogation department.

For questions, please call the BCBSNE Subrogation department **800-662-3554** or **402-390-1847**.

Workers' Compensation

The health plans underwritten and/or administered by BCBSNE exclude services related to injuries or illnesses related to employment. These provisions apply whether or not the covered person asserts rights to or waives workers' compensation coverage. Please send a copy of the First Injury Report, as this enables us to process claims accurately and reduces the likelihood that future refunds or adjustments will have to be made.

For questions, please call **800-821-4786** or **402-398-3615**.

Noncovered Services

BCBSNE's member contracts do not provide benefits for the following Noncovered Services or for amounts above Allowable Charges for Covered Services.

Noncovered Services include but are not limited to any service for, or related to:

1. Services not covered by this Contract.
2. Services determined by BCBSNE to be not Medically Necessary.
3. Services considered by BCBSNE to be Investigative, or for any directly related Services.

Noncovered Services

Services must be performed by a licensed dentist. Teeth cleaning may be performed by a licensed dental hygienist. Please reference exclusions and limitations that apply to the BCBSNE Dental Plan. A complete list may be found in the Master Group Dental Contract.

Noncovered Services Provided

1. Services provided to or for:

    a. Any dependent of a Subscriber who has a Single Membership, except as specified in this Contract for newborn or adopted children.
    b. Any person who does not qualify as an Eligible Dependent.
    c. Any Covered Person before his or her effective date of coverage, or after the effective date of cancellation or termination of coverage.
    d. Any Covered Person for any Pre-existing Condition for which coverage is not available because of any Contract Waiting Periods.

2. Services for Illness or Injury related to military service.

Noncovered Charges for Services

1. Charges made for filling out claim forms or furnishing any records or information or special charges such as dispensing fees, admission charges, dental provider's charge for hospital discharge services, after-hours charges over and above the routine charge, administrative fees, technical support or utilization review charges normally considered to be within the charge for a service.

2. Charges received when there is inadequate documentation that a service was provided.

3. Services available at government expense, except as follows: If payment is required by state or federal law, the obligation to provide benefits will be reduced by the amount of payments a Covered Person is eligible for under such program (except Medicaid).

    With respect to persons entitled to Medicare Part A and eligible for Part B benefits, the obligation to provide benefits will be reduced by the amount of payment or benefits such person receives from Medicare. This provision will not apply if the Covered Person is still actively at work or is an Eligible Dependent of a Subscriber who is actively at work and has elected the BCBSNE Contract as primary, unless otherwise provided by federal law. Services provided for renal dialysis and kidney transplant Services also will be provided pursuant to federal law.

4. Services for which there is no legal obligation to pay.

5. Services arising from or in the course of employment, whether the Covered Person fails to assert or waives his or her rights to Workers' Compensation or Employers'

Liability Law. This includes Services determined to be work-related under Workers' Compensation laws or under a Workers' Compensation Managed Care Plan, but which are not payable because of noncompliance with such law or Plan.

6. Charges for Services provided by a person who is a member of the Covered Person's immediate family by blood, marriage or adoption.

7. Charges for Services by a health care provider which are not within the scope of practice of such provider; or charges by a non-Approved Provider.

8. Charges in excess of the Contracted Amount or the Reasonable Allowance.

9. Charges made separately for Services when they are considered to be included within the charge for a total Service payable under this Contract or if the charge is payable to another provider.

   EXCEPTION: If such charges are made separately when they are included within the charge for a total service performed by a BCBSNE Participating or NEtwork BLUE Dental Provider, then this amount is not the Covered Person's liability.

10. Charges made pursuant to a Covered Person's engagement in an illegal occupation or his or her commission of or attempt to commit a felony.

11. Interest and sales or other taxes or surcharges on Covered Services, drugs, supplies or Home Medical Equipment, other than those surcharges or assessments made directly upon employers or third-party payers, will not be covered.

Terms and Abbreviations

Agreement
Refers to the legal Agreement(s) between BCBSNE and the health care professional, facility or other provider. This document, and any attachments or addenda including the Provider's Application, the Reimbursement Schedule, these BCBSNE Policies and Procedures, and such other documents and modifications as may be made pursuant to the Agreement.

Approved Provider
A licensed practitioner of the healing arts who provides Covered Services within the scope of his or her license or a licensed or certified facility or other health care provider, payable according to the terms of the member/subscriber contract, Nebraska law or the direction of the BCBSNE Board of Directors.

BCBSNE
Blue Cross and Blue Shield of Nebraska

Billed Charge
Dentists should bill their charge, not the Blue Cross allowable for the services.

Blue Cross and Blue Shield Association (BCBSA)
National association of independent Blue Cross and/or Blue Shield (BCBS/Blue) Plans.

CDT
Current Dental Terminology (CDT) is a book published and updated by the American Dental Association (ADA). CDT codes should be used for reporting dental services (except for some oral surgery procedures coded with CPT). The procedure code that best describes the services provided is required on claims.

Charge
The amount per service or supply regularly established by the Provider and is billed to the patient.

Clean Claim
Claims submitted by the Provider which are accurately completed, submitted in the prescribed manner and contain all information specified by BCBSNE and which do not require further information for processing, from either the Provider, Covered Person or any other party. Information shall be provided by Provider on a valid ADA Claim Form (2006 version or newer) or an equivalent electronic form that contains the following: Covered Person's name, date of birth and BCBSNE member identification number; provider's name, address, TIN and all applicable NPI numbers; date of service or purchase; valid tooth number and, if applicable, valid tooth surfaces; diagnosis narrative or procedure narrative; and diagnosis code(s).

Charges for services must be submitted in compliance with BCBSNE's Policies and Procedures and no additional information shall be needed in order to resolve one or more issues concerning coverage, eligibility, coordination of benefits, subrogation, determination of medical necessity, the use of unlisted procedural codes, or reasonable belief supported by specific information that the claim has been submitted fraudulently.

CMS 1500
The form originally developed by the Health Care Financing Association (HCFA) for submitting Medicare Part B claims. Other third-party payers also use the form. CMS 1500 12-90 is the most recent revision of the form and it is the paper claim format requested by BCBSNE.

Coinsurance
The percentage of the Contracted Amount which the Covered Person must pay after the application of the Deductible. The Contracted Amount for a Covered Service provided by

the Provider or another provider is the lesser of the billed Charges or the Contracted Amount on the Reimbursement Schedule.

Content of Service
Refers to specific services and/or procedures, supplies and materials that are considered by BCBSNE to be an integral part of previous or concomitant services or procedures, or all inclusive, to the extent that separate reimbursement is not recognized by BCBSNE.

Contracted Amount
The payment mutually agreed to by BCBSNE and the Provider, for services and supplies received by a Covered Person and documented in the Reimbursement Schedule.

Contract or Plan
An insurance contract, administrative services agreement or health benefit plan outlining the Covered Services, benefits allowed for those Covered Services and other related topics. The Contract or Plan includes any endorsements, the Master Group Application, subgroup applications, addenda and individual enrollment forms of subscribers, and any health plan documents designated or qualified as such under applicable federal or state law.

Coordination of Benefits
Provisions and procedures used by insurers to avoid duplicate payment of benefits by more than one insurance policy.

Copayment
A portion of the Contracted Amount paid by the Covered Person to the Provider each time a service is rendered and set by the terms of the Contract or Plan.

Cosmetic
Any services provided to improve the patient's physical appearance, from which no significant improvement in physiologic function can be expected, regardless of emotional or psychological factors.

Covered Charge
That part of a charge for which benefits would be provided under the terms of the Contract except for any Coinsurance and Deductible amount.

Covered Person
Any person entitled to benefits for Covered Services pursuant to a contract or health coverage underwritten or administered by BCBSNE or any Plan Sponsor utilizing the NEtwork BLUE Dental product.

Covered Services
Those dental or surgical services provided to Covered Persons for which benefits are payable under a Contract or Plan underwritten or administered by BCBSNE.

Deductible
An amount which the Covered Person must pay each calendar year for Covered Services before benefits are payable.

NEtwork BLUE Dental
The dental care Services product offered for sale by BCBSNE and supported by a network of dental care providers choosing to participate.

NEtwork BLUE Dental Provider (or Preferred Provider)
Any licensed hospital, practitioner of the healing arts or qualified provider of health care services, supplies or home medical equipment who has contracted to provide Covered Services to Covered Persons as a part of the NEtwork BLUE Dental provider network.

Eligibility Waiting Period
Applicable to new Members only, the period between the first day of employment and the first date of coverage under the group or individual applicant Contract.

Eligible Dependent

1. The spouse of the Member unless the marriage has been ended by a legal, effective decree of dissolution, divorce or separation.

2. Unmarried children 18 years of age or less who are dependent on the Member for support and maintenance. A child is dependent so long as he or she:

    - Lives with the Member, or
    - Is provided financial support (voluntarily or by order of the court), or
    - Is provided health coverage by order of the court.

    "Child" means a grandchild who lives with the member in a regular child-parent relationship, a stepchild, adopted child or a child under a legal guardianship, but does not include a foster child.

3. Unmarried children/students, 23 years of age or less, for whom the Member provides support and who are in full-time attendance at an educational institution which has a curriculum, faculty and student body in attendance. Coverage will continue during normal school vacation periods.

4. Reaching age 19, or, if a full-time student, age 24, will not end the covered child's coverage under this contract as long as the child is, and remains, both:

    - Incapable of self-sustaining employment, or returning to school as a full-time student, by reason of mental or physical handicap; and
    - Dependent upon the Employee/Member for support and maintenance.

Employee
An individual hired by an Employer or an association who enrolls for health coverage under this Contract and is named on an identification card issued pursuant to this Contract. Enrolled employee is referred to as a Member.

Employee/Spouse Membership
This option provides benefits for covered services provided to the Employee/Member and their spouse.

Employer
A Group Applicant who signs a master group application for health coverage on behalf of its Employees.

Endorsement
A provision which expands or modifies a member contract.

Explanation of Benefits (EOB)
The BCBSNE notice which informs the Covered Person of the benefits allowed on a specific claim. The EOB reports a breakdown of charges, our payment and the Covered Person's liability; Coinsurance, Deductible and noncovered amounts.

Family Membership
Membership option providing benefits for Covered Services provided to the subscribing Member and his or her Eligible Dependents.

Federal Employee Program (FEP)
The largest nationally underwritten group covering employees of the federal government and their dependents. FEP members have an identification number that starts with the single alpha prefix "R".

Group Applicant
The Employer or association making application for health or dental coverage under a contract.

HCPCS (Healthcare Common Procedure Coding System)
Medicare's National Level II codes is a 5-digit alpha-numeric system. This system of coding is an expansion of the CPT coding structure and includes coding for ambulance, home medical equipment, injectables, etc., which are not available with CPT coding.

Hospital
An institution or facility licensed by the state of Nebraska or the state in which it is located, which provides medical and surgical diagnostic and treatment services with 24-hour-per-day nursing services, to two or more unrelated persons with an Illness, Injury or pregnancy, under the supervision of a staff of physicians licensed to practice medicine and surgery.

Illness
A condition which deviates from or disrupts normal bodily functions or body tissues in an abnormal way and is manifested by a characteristic set of signs or symptoms.

Injury
Physical harm or damage inflicted to the body from an external force.

Inpatient
A patient admitted to a Hospital or other facility for bed occupancy to receive services consisting of active medical and nursing care to treat conditions requiring continuous nursing intervention of such an intensity that it cannot be safely or effectively provided in any other setting.

Investigative
Describing a technology, a drug, biological product, device, diagnostic, treatment or procedure if it has not been Scientifically Validated pursuant to all of the factors set forth below:

- Technologies, drugs, biological products, devices and diagnostics must have final approval from the appropriate government regulatory bodies. A drug or biological product must have final approval from the Food and Drug Administration (FDA). A device must have final approval from FDA for those specific indications and methods of use that are being evaluated. FDA or other governmental approval is only one of the factors necessary to determine Scientific Validity.

- Evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

- The evidence should demonstrate that the technology can measure or alter the physiological changes related to a disease, injury, illness or condition. In addition, there should be evidence based on established medical facts that such measurement or alteration improves the health outcomes.

- Opinions and evaluations by national medical associations, consensus panels or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence and rationale. Our evidence ~~includes, but~~includes but is not limited to: Blue Cross and Blue Shield Association Technology Evaluation Center technology evaluations, Hayes Directory of New Medical Technologies' Status, Centers for Medicare and Medicaid Services (CMS) Technology Assessments and United States Food and Drug Administration (FDA) approvals.

- The technology must improve the net health outcome. The technology must improve the net health outcome as much as or more than established alternatives. The improvement must be attainable outside the investigational settings.

BCBSNE, or applicable Plan Sponsor or Administrator, will determine whether a technology is Investigative. BCBSNE shall post those technologies that it has previously determined to be Investigative and shall make such determinations available on its website. The absence of a medical policy on a particular matter shall not prohibit BCBSNE or the applicable Plan Sponsor or Administrator from concluding that a matter is Investigative.

Licensure
Permission to engage in a health profession which would otherwise be unlawful in the state where services are performed, and which is granted to individuals who meet prerequisite qualifications. Licensure protects a given scope of practice and the title.

Medicaid
Grants to states for Medical Assistance Programs, Title XIX of the Social Security Act, as amended.

Medically Necessary or Medical Necessity
Dental care services ordered by a treating provider exercising prudent clinical judgment, provided to a Covered Person for the purposes of prevention, evaluation, diagnosis or treatment of that Covered Person's illness or injury, that are:

- Consistent with the prevailing professionally recognized standards of dental practice, and known to be effective in improving health care outcomes for the condition for which it is recommended or prescribed. Effectiveness will be determined by validation based upon scientific evidence, professional standards and consideration of expert opinion;

- Clinically appropriate in terms of type, frequency, extent, site and duration for the prevention, diagnosis or treatment of the Covered Person's Illness, Injury or pregnancy. The most appropriate setting and the most appropriate level of Service is that setting and that level of Service, which is the most cost-effective considering the potential benefits and harms to the patient. When this test is applied to inpatient care, the Covered Person's medical symptoms and conditions must require that treatment cannot be safely provided in a less intensive medical setting;

- Not more costly than alternative interventions, including no intervention, and are at least as likely to produce equivalent therapeutic or diagnostic results as to the prevention, diagnosis or treatment of the Covered Person’s Illness, Injury or pregnancy, without adversely affecting their medical condition;

- Not provided primarily for the convenience of the Covered Person, Provider, Covered Person's family, or any other person or health care provider; and

- Not considered unnecessarily repetitive when performed in combination with other prevention, evaluation, diagnosis or treatment procedures.

BCBSNE or applicable Plan Sponsor or Administrator will determine whether Services are Medically Necessary. Services will not automatically be considered Medically Necessary because they have been ordered or provided by a treating Provider.

Member
A person named on an identification card issued pursuant to a Member, group or individual Contract. Enrolled Employee is referred to as a Member.

Network Provider
Providers, group practices of Providers, mid-level professionals employed by or supervised by such Providers, and other dental care or affiliated providers that have entered into an agreement with BCBSNE and have met all BCBSNE credentialing standards.

Non-Covered Services
Services for which benefits are not provided under the Covered Person's contract.

Participating Provider
Provider who has completed the BCBSNE credentialing requirements and agreed to the terms of a Provider Agreement to participate in BCBSNE's NEtwork BLUE Dental Provider Networks.

Physician
Any person holding a license who is duly authorized to practice medicine, practice surgery and prescribe drugs.

Blue Plan
An individual organization participating in the BCBSA.

Plan Sponsor or Administrator
The employer in the case of an employee benefit plan using the NEtwork BLUE Dental product as an employee benefit plan, a customer purchasing a NEtwork BLUE Dental benefit contract, and/or BCBSNE or an applicable insurer or third-party administrator who underwrites or administers a NEtwork BLUE Dental benefit plan or Contract.

Policies and Procedures
Document published by BCBSNE and setting forth the billing, payment, utilization management, certain medical policies and other administrative guidelines under this Agreement. These manuals are updated by BCBSNE from time to time by the *Provider Update* newsletter and, where applicable, under the Modification terms of this Agreement. The Policies and Procedures Manuals are published at NebraskaBlue.com.

Preauthorization
Preauthorization of benefits is prior written approval of benefits for certain services such as organ transplants, subsequent purchases of home medical equipment, physical rehabilitation and other services specified under the contract. This preauthorization is based on the terms of the benefits Contract and on the information submitted to BCBSNE.

Preauthorization may be effective for a limited period of time. The Covered Person should encourage the Provider to request preauthorization in order to determine whether benefits for certain services are payable.

Preferred Provider Organization (PPO)
A panel of hospitals, physicians and other health care Providers who belong to a network of Preferred Providers, which agrees to more effectively manage health care costs.

Reimbursement Schedule
The schedule of reimbursement fees attached to this Agreement evidencing the Contracted Amount agreed to as payment in full for the identified Service(s) on the schedule.

Remittance Advice (RA)
The BCBSNE claim payment report for participating hospitals, physicians and other providers of health care services. The RA is a record of how payment was made: Total Charges, Covered Person's Liability, Provider Liability and BCBSNE Payment.

Scientifically Validated
Describing technology, a drug, biological product, device, diagnostic, treatment or procedure that meets all the factors set forth below:

- Technologies, drugs, biological products, devices and diagnostics must have final approval from the appropriate government regulatory bodies. A drug or biological product must have final approval from the Food and Drug Administration (FDA). A device must have final approval from FDA for those specific indications and methods of use that is being evaluated. FDA or other governmental approval is only one of the factors necessary to determine Scientific Validity.

- The Scientific Evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

- The evidence should demonstrate that the technology can measure or alter the physiological changes related to a disease, injury, illness or condition. In addition, there should be evidence based on established medical facts that such measurement or alteration improves the health outcomes.

- Opinions and evaluations by national medical associations, consensus panels or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence and rationale. Our evidence includes but is not limited to: Blue Cross and Blue Shield Association Technology Evaluation Center technology evaluations, Hayes Directory of New Medical Technologies' Status, Centers for Medicare and Medicaid Services (CMS) Technology Assessments and United States FDA approvals.

- The technology must improve the net health outcome. The technology must improve the net health outcome as much as or more than established alternatives. The improvement must be attainable outside the investigational settings.

BCBSNE, or applicable Plan Sponsor or Administrator, will determine whether a technology is Scientifically Validated. BCBSNE shall post those technologies that it has previously determined to be investigative and shall make such determinations available on its website. The absence of a medical policy on a particular matter shall not prohibit BCBSNE or the applicable Plan Sponsor or Administrator from concluding that a matter is Scientifically Validated. (See also “Investigative.”)

Single Membership
Membership option providing benefits for Covered Services provided to the Member only.

Single Parent Membership
Membership option providing benefits for Covered Services provided to the Member and his or her Eligible Dependent children, but not a spouse.

Subrogation
Subrogation is our right to recover benefits paid for Covered Services as the result of an Injury or Illness which was caused by a third party. We also assert a contractual right of recovery to collect proceeds recovered from a third party. Subrogation and the contractual right of recovery are prior liens against any proceeds recovered by the Covered Person.

Claims will be paid according to the Covered Person’s Contract, then BCBSNE will seek reimbursement from the other party. The recovery amount will not exceed the amount we paid in benefits.

Supervision
The ready availability of the Provider for consultation and direction of the activities of any other provider who is providing dental services within his/her defined scope of practice.

Tax Identification (ID) Number (TIN)
The number you use to file income tax with the IRS.

Third-Party Payer
A company, organization, insurer or government agency which makes payment for health care services received by a patient, including Blue Plans, commercial insurance companies, Medicare, Medicaid, HMOs and PPOs. The patient and the Provider of service are the first two parties to the delivery of health care services; the insurer becomes the third party.

Utilization Review
The evaluation by BCBSNE, or persons designated by BCBSNE, of the use of a medical, diagnostic or surgical procedure or Service, the utilization of medical supplies, drugs or home medical equipment compared with established criteria in order to determine benefits. Benefits may be excluded for services, procedures, supplies, drugs or home medical equipment found to be not Medically Necessary.

Waiting Period
The period during which no benefit payment will be made for services provided to a Covered Person for a pre-existing condition.

Workers' Compensation
The Nebraska Workers' Compensation laws are designed to provide certain benefits to employees who

1. Sustain injury or contract occupational disease,
2. Arising out of an in the course of their employment, and
3. Are not willfully negligent at the time of their injury.

The Nebraska Worker's Compensation Act applies to most employers in Nebraska; however, some exceptions include employers of farm or ranch laborers and domestic workers, independent contracts and nonincorporated business owners.

Resources and How to Contact Us

Online Email Inquiry
Go to NebraskaBlue.com/Providers/Eligibility-and-Claims

For questions about:	Call or email:

Eligibility Claim Status	**800-635-0579** Monday – Friday: 7:30 a.m. to 4:30 p.m. Please have the following information ready when you call: • The BCBSNE-assigned provider ID number of the specific provider of service • Cardholder's member ID number • Cardholder's name • Patient date of birth
To verify Federal Employee Program (FEP) Membership (FEP members can be identified by the number on the ID card which begins with the single alpha character "R.")	**FEP Customer Service** at: **402-390-1879** **800-223-5584** Monday – Wednesday, Friday: 8 a.m. to 4:30 p.m. (CST), Thursday - 9 a.m. to 4:30 p.m.
• Your BCBSNE provider agreement • Reimbursement issues • To request a visit	NebraskaBlue.com/Providers/Provider-Contacts

For questions about:	Call or email:
• Electronic funds transfer • To report a change in your Medicare number or TIN	**Health Network Administration** at: **800-821-4787**, option 4 HealthNetworkRequests@nebraskablue.com
• An application for a new dentist • Professional office billing information changes (change of address, TIN) • Copy of your agreement	**Health Network Administration** at: **800-821-4787**, option 2 HealthNnetworkRequests@NebraskaBlue.com
Provider Update newsletters and manuals	NebraskaBlue.com/Providers/Alerts-and-Updates

Online References

The following information is available on our website, NebraskaBlue.com, under the "Providers" section in the upper navigation:

- Forms for Providers
- Credentialing information and applications
- Dental Benefits by Plan Code Documentation under Policies and Procedures
- Provider Library of materials