Dental Update

FALL 2012

NEBRASKA

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

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

Each issue is also published online in the Provider section at **nebraskablue.com**.

For permission to reprint material published in the Dental Update, email the editor, Kimberly Vavra, at **kimberly.vavra@nebraskablue.com**.

Introducing DentalEssentials

Dental Coverage for Individuals and Families

Blue Cross and Blue Shield of Nebraska (BCBSNE) is excited to announce our new Individual dental product, DentalEssentials.

DentalEssentials coverage is available for individuals and families with four coverage options that meet a variety of coverage needs and budgets:

Dental Essentials								
	Option 1		Option 2		Option 3		Option 4	
Deductible	$50 per person per calendar year		$50 per person per calendar year		$50 per person per calendar year		$50 per person per calendar year	
Annual Benefit Maximum	$1,000 per person per calendar year		$1,000 per person per calendar year		$1,000 per person per calendar year		$1,000 per person per calendar year	
Coinsurance	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Coverage A services	0% (deductible waived in-network)	20%	0% (deductible waived in-network)	20%	0% (deductible waived)		0% (deductible waived)	
Coverage B services (6 Month Waiting Period*)	20%	30%	20%	30%	20%		20%	
Coverage C Services (12 Month Waiting Period)	50%	50%	N/A	N/A	50%		N/A	

*Waived for seniors purchasing a BlueSenior Classic Medicare Supplement plan at the same time as a DentalEssentials plan.

Please note: DentalEssentials does not cover services for orthodontic dentistry.

Coinsurance is based on the allowable charge for a covered service. Generally, the allowable charge for covered services by in-network providers will be the contract amount. The allowable charge for covered services by out-of-network providers will be based on the contracted amount for Nebraska providers or an amount determined by the on-site plan for out-of-area providers.

Members with DentalEssentials coverage will receive in-network benefits when they use dentists in our Dental GRID network, located in Nebraska and throughout the nation.

Dental GRID is a provider network of multiple Blue Cross and Blue Shield (BCBS) plans that, when combined, offers members one of the largest PPO dental networks in the nation. In turn, patients are provided with lower out-of-pocket costs and greater access to participating dentists.

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(DentalEssentials continued)

As part of the Dental GRID, in-network providers have agreed to accept our benefit payment for covered services as payment in full, except for any deductible or coinsurance amounts and charges for noncovered services, which are the member's responsibility.

Dental GRID providers, under the contract terms with BCBSNE, can't bill members for amounts over our benefit allowance. Out-of-network providers can bill patients for amounts in excess of the amount payable under the contract.

Covered Services

COVERAGE A
Preventive and Diagnostic Dentistry

Under Coverage A, benefits are available for (but not limited to) the following covered services:

- Two comprehensive and/or periodic oral examinations per calendar year
- Consultations with a dental consultant
- Two prophylaxis, including cleaning, scaling and polishing of teeth per calendar year
- Two topical fluoride applications per calendar year*
- Dental x-rays**
  - One full mouth or panorex series of x-rays in any period of three consecutive calendar years
  - One set of four supplemental bitewing x-rays in a calendar year
- Sealants, but not more than once every four calendar years*
- Space maintainers*

* *Coverage available for dependents under the age of 16 only*
** *X-rays related to services provided under a different coverage classification are excluded under Coverage A benefits*

COVERAGE B
Maintenance and Simple Restorative Dentistry and Oral Surgery

Under Coverage B, benefits are available for (but not limited to) the following covered services:

Oral surgery consisting of:
- Simple and impacted extractions (extractions for orthodontia services are excluded)
- Removal of dental cysts and tumors

Other services:
- General anesthesia
- Restorations of silver and/or composite materials
- Palliative treatment
- Problem focused and/or emergency oral examinations

COVERAGE C
Complex Restorative Dentistry, Periodontic and Endodontics

Under Coverage C, benefits are available for (but not limited to) the following covered services:

- Crowns
- Installation of permanent bridges
- Dentures – full and partial
- Denture adjustments
- Repair of dentures, bridges, crowns and cast restorations
- Core buildup

Periodontic services consisting of:
- Up to four periodontic cleanings per calendar year
- Gingivectomy
- Gingival curettage
- Osseous surgery
- Treatment of acute infection and oral lesions

Endodontic services consisting of:
- Pulp cap
- Vital pulpotomy
- Root canals (includes treatment plan, clinical procedures and follow-up care)
- Apical curettage

(continued on next page)

(DentalEssentials continued)

Waiting Periods

- Benefits for Coverage B services are subject to a six-month waiting period.*
- Benefits for Coverage C services are subject to a 12-month waiting period.

* *As a special consideration for Medicare-qualified Nebraskans, this waiting period is waived for individuals purchasing DentalEssentials and a BlueSenior Classic Medicare Supplement plan at the same time.*

Calendar Year Deductible

The deductible must be met each calendar year by each covered person.

Coinsurance and Calendar Year Maximum

After members have met the calendar year deductible, they're responsible for paying a certain percentage of covered charges (called "coinsurance"). Covered services will be available at the applicable coinsurance percentage until the calendar year maximum is met. Once the calendar year maximum is met, coverage for additional services will not be available for remainder of the calendar year.

For all DentalEssentials options, services listed under Coverages A, B and C accumulate towards one combined calendar year maximum.

Noncovered Services

The noncovered services below are only a partial listing of the limitations and exclusions that apply to DentalEssentials coverage. Benefits are not available for the following:

- Services not covered by the contract
- Services for orthodontic dentistry
- Services for treatment of Temporomandibular (jaw) joint
- Services with respect to congenital malformations (including, but not limited to missing teeth) or primarily for cosmetic or aesthetic purposes
- Replacement of the third molars with prostheses
- Implants or any procedure associated with the preparation for, maintenance of or placement or removal of implants
- Services considered to be investigative, not medically necessary, experimental, cosmetic or obsolete
- Injectable drugs or drugs dispensed in a provider's office
- Charges for services provided by a hospital, ambulatory surgical facility or any other facility charge

For more information on rates and coverage for DentalEssentials, please call (888) 926-5397.

BlueBoard

Policies and Procedures Reminder

As a participating dental care provider with the Dental GRID/Dental GRID+, you must follow all applicable BCBSNE policies and procedures as incorporated terms of your Agreement and those applicable to the Plan or Contract of the Covered Person. As a dental care provider, you agree to provide appropriate information to your employees, agents and representatives consistent with this commitment.

BCBSNE will publish policies and procedures applicable to dental care providers and provide access to BCBSNE's Health Network Services Consultants to assist in the provision of information about BCBSNE's policies and procedures. BCBSNE may update and revise provisions of the Policies and Procedure Manual by providing 30-days' notice to dental care providers prior to the effective date of any revision and BCBSNE may accomplish the notice of such changes through publication of our "Update" newsletter or other means.

BCBSNE Teams with CAQH for Credentialing

BCBSNE has partnered with the Council for Affordable Quality Healthcare (CAQH) to streamline the credentialing process and allowing non-participating providers to fill out a single online application to save time and paperwork.

To begin the credentialing process, simply complete and return our electronic "Request to Participate" form located under "Credentialing" on the Provider section of our website at **www.nebraskablue.com**.

If you are not currently enrolled in CAQH, you will be contacted directly by the organization with your next steps. If you are already enrolled in the CAQH credentialing initiative, we will attempt to retrieve your digital application as soon as we receive your Request to Participate. Please be sure to set BCBSNE as an authorized entity to access your CAQH information.

(BlueBoard continued)

Faxed Claims No Longer Accepted as of October 1, 2012

Due to the inefficiency of receiving reimbursement claims submitted through multiple fax numbers and the difficulty in handling claims by fax, BCBSNE is no longer accepting faxed claims as of October 1, 2012.

Any reimbursement claims sent by fax will be returned with directions to submit the claim electronically or by mail. We encourage all providers to submit claims electronically as it is the most efficient method for claims handling and adjudication.

If you need assistance with electronic submissions, please contact our EDI Team at **EDISupport@nebraskablue.com** or (888) 233-8351.

Paper claims are acceptable if complete, accurate and legible. These claims must be sent to:

BCBSNE
ATTN: NEW CLAIMS AREA
P. O. BOX 3248, Omaha, NE 68180-0001

Duplicate Claims Submission May Delay Processing

If you have submitted a claim for payment, please do not file duplicate claims. The submission of duplicate claims may actually delay the processing of the original claim. Please allow 15-20 business days before contacting Customer Service about any previously submitted claims.

NPI and Tax Identification Numbers Needed on Claim Forms

Having complete and accurate information on claim forms will expedite our claim processing time and minimize the number of claims being returned for clarification. To ensure claim accuracy, please refer to the following guidelines:

- **Box 49** must include the Type 2/Clinic National Provider Identifier (NPI). Not all offices have a Type 2/Clinic NPI. If your office doesn't have a Type 2/Clinic NPI, please leave this box blank.
- **Box 51** must include the office Tax Identification Number (TIN) that has been provided to BCBSNE and is on file.
- **Box 53** must include the treating Dentist's name.
- **Box 54** must include the treating dentist's Type 1/Individual NPI. Every dentist must have an individual NPI.

Billing For Orthodontic Services

All claims for orthodontics must be broken down with the initial banding allowance and then subsequent monthly bills for adjustments.

For Invisalign services, the initial banding is when your office inserts the first tray.

Recontracting and Recredentialing – How They Differ

To minimize any confusion, we want to clarify that the **recredentialing** process is separate from the **recontracting** process.

For example, in 2011, BCBSNE **recontracted** our entire Dental network. Dental PPO providers were asked to sign a new Dental GRID agreement to continue their participation in our Dental PPO network.

After the initial credentialing process and acceptance as a PPO Dental provider, you received your PPO effective date with BCBSNE.

Recredentialing for PPO providers begins with BCBSNE establishing a date for a three-year recredentialing cycle. This cycle assists us with keeping our dental providers' information, such as your license and insurance information, current.

In addition, records need to be billed using the individual codes for the services that are provided. Please do not bill as a lump sum for records. All orthodontic services, including Invisalign or standard orthodontics, must be billed in this format. The BCBSNE standard dental contract does not allow these services to be paid as a lump sum.

General Anesthesia Guides for Dental Services

If a member has coverage for general anesthesia under their dental contracts, the anesthesia is payable if surgical extractions are being performed (D7220-D7241).

For claims where the procedures being performed are NOT surgical extractions, the following medical necessity guidelines for general anesthesia must be met:

1. The patient is a child, age eight and under
2. Procedure is for treatment of an acute infection
3. Patient is having extractions in three or four quadrants
4. Patient is having Alveoloplasty

All other reasons for general anesthesia, including extreme apprehension, will be reviewed under individual consideration by a BCBSNE Dental Consultant.

Please note that the dentist must have a license to perform the anesthesia service. If the dental service being performed is not payable, the anesthesia service will also not be payable. Please remember, CPT Codes 99144 and 99145 are only payable when performed by a Certified Registered Nurse Anesthetist (CRNA) or Anesthesiologist (MD).

FEP Standard Option Dental Benefits

Fee schedule and maximum allowable charges

Please note: The FEP Dental Benefits for 2013 have not changed.

ADA Code	Dental Service	Fee Schedule Amount Up to Age 13	FEP Fee Schedule Amount Age 13 and Over	MAC Amount
120	Periodic oral evaluation	$ 12	$ 8	$ 29.00
140	Limited oral evaluation	14	9	42.41
150	Comprehensive oral evaluation	14	9	45.73
160	Detailed and extensive oral evaluation	14	9	–
210	Intraoral–complete series	36	22	76.76
220	Intraoral–periapical–first film	7	5	16.88
230	Intraoral–periapical–each additional film	4	3	15.48
240	Intraoral–occlusal film	12	7	21.21
250	Extraoral–first film	16	10	26.26
260	Extraoral–each additional film	6	4	14.14
270	Bitewing–single film	9	6	16.18
272	Bitewings–two films	14	9	26.26
274	Bitewings–four films	19	12	35.35
277	Bitewings–vertical	12	7	66.83
290	Posterior-anterior or lateral skull and facial bone survey film	45	28	76.76
330	Panoramic film	36	23	69.65
460	Pulp vitality tests	11	7	31.31
9110	Palliative (emergency) treatment of dental pain–minor procedure	24	15	59.80
2940	Sedative filling	24	15	62.62
1110	Prophylaxis–adult*	–	16	54.00
1120	Prophylaxis–child*	22	14	37.37
1203	Topical application of fluoride prophylaxis not included–child	13	8	24.24
1204	Topical application of fluoride (prophylaxis not included)–adult	–	8	23.23
1510	Space maintainer–fixed–unilateral	94	59	218.09
1515	Space maintainer–fixed–bilateral	139	87	370.67
1520	Space maintainer–removable–unilateral	94	59	317.14
1525	Space maintainer–removable–bilateral	139	87	180.79
1550	Recementation of space maintainer	22	14	43.62
2140	Amalgam–one surface, permanent	25	16	77.39
2150	Amalgam–two surfaces, permanent	37	23	94.27
2160	Amalgam–three surfaces, permanent	50	31	113.26
2161	Amalgam–four or more surfaces, permanent	56	35	132.96
2330	Resin–one surface, anterior	25	16	86.53
2331	Resin–two surfaces, anterior	37	23	106.93

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FEP Standard Option Dental Benefits (cont.)

Fee schedule and maximum allowable charges

ADA Code	Dental Service	Fee Schedule Amount Up to Age 13	FEP Fee Schedule Amount Age 13 and Over	MAC Amount
2332	Resin–three surfaces, anterior	$ 50	$ 31	$ 146.45
2335	Resin–four or more surfaces or involving incisal angle (anterior)	56	35	157.58
2391	Resin–based composite, one surface, posterior	25	16	106.05
2392	Resin–based composite, two surfaces, posterior	37	23	146.45
2393	Resin–based composite, three surfaces, posterior	50	31	181.80
2394	Resin–based composite, four or more surfaces, posterior	50	31	217.15
2510	Inlay–metallic–one surface	25	16	253.51
2520	Inlay–metallic–two surfaces	37	23	460.56
2530	Inlay–metallic–three or more surfaces	50	31	557.52
2610	Inlay–porcelain/ceramic–one surface	25	16	306.03
2620	Inlay–porcelain/ceramic–two surfaces	37	23	490.86
2630	Inlay–porcelain/ceramic–three or more surfaces	50	31	515.10
2650	Inlay–composite/resin–one surface	25	16	227.25
2651	Inlay–composite/resin–two surfaces	37	23	335.32
2652	Inlay–composite/resin–three or more surfaces	50	31	497.93
2951	Pin Retention–per tooth, in addition to restoration	13	8	30.30
7140	Extraction, erupted tooth or exposed root	30	19	98.49
7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	43	27	161.81
7250	Surgical removal of residual tooth roots (cutting procedure)	71	45	170.95
9220	General Anesthesia in connection with covered extractions	43	27	299.97

*Limited to two per person per calendar year

Not Covered – Any service not specifically listed above.

Fee Schedule Amount – The amount Standard Option pays toward a covered dental service.

MAC (Maximum Allowable Charge) – The maximum amount NEtwork BLUE dentists will charge for a covered dental service. This MAC may be updated periodically and is subject to change. When care is provided by a NEtwork BLUE dentist, the member owes the difference between the FEP fee schedule amount and the MAC (Maximum Allowable Charge).

Benefits for general anesthesia in connection with covered extractions (D9220 + D9221 combined) are available up to the Maximum Allowable Charge (MAC) amount according to age. Up to age 13 the MAC amount is $43. Age 13 and over, the MAC amount is $27.

Guidelines for Dental Claims that May Require a Diagnosis Code

Claims received that do not have a diagnosis listed must be coded with one of the following codes:

V72.2 General (Routine) Dentistry Services
873.69 Accident-Related Services
520.6 Used for all other procedures, including Extractions, Impactions, Oral Surgery, Office Visits, and X-Ray

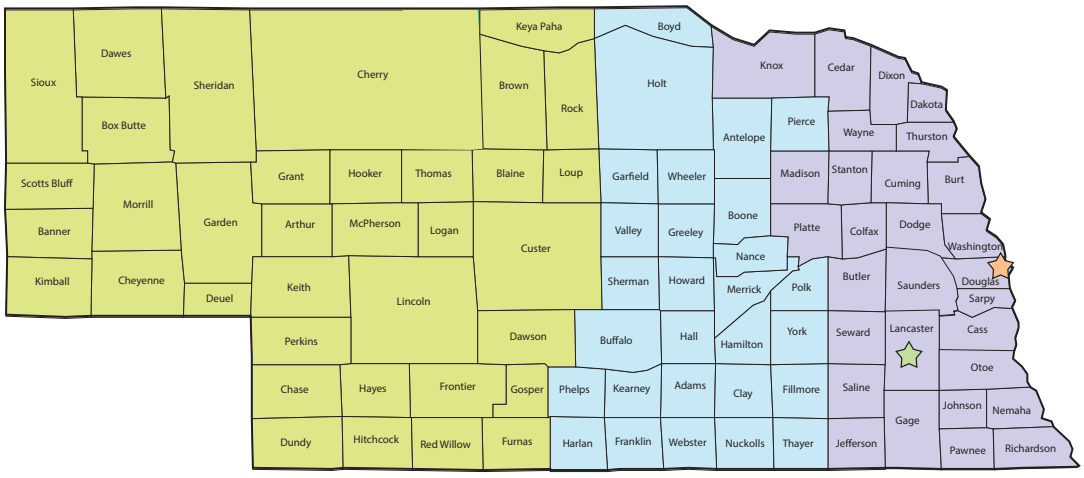
Refer to the codes below to determine if the diagnosis is considered medical or dental:

520.0	Medical	**520.5**	Dental
520.1	Dental	**520.6**	Medical or Dental*
520.2	Medical	**520.7**	Medical or Dental**
520.3	Dental	**520.8**	Dental
520.4	Dental	**520.9**	Dental

* *520.6 - Can be either medical or dental depending on whether a payable service is billed or if the provider indicates that services were due to embedded or impacted teeth. This diagnosis code requires confirmation of impacted or erupted teeth. If submitting a paper claim on the CMS 1500, this information may be noted in Box 19. If submitting electronically on a professional claim (837P), please insert your note into the 2400 NTE segment. The NTE –Line Note segment needs to be used with an ADD qualifier in the 2400 loop.*

** *520.7 - Teething syndrome is considered dental unless billed by an MD. If a claim is received with office visits and x-rays with no diagnosis, or the claim does not clearly state embedded or impacted teeth, the claim will be returned to verify if the charges are an allowable medical service. Once it has been verified that these are a medical service, send the claim to Dental for processing if dental coverage exists.*

Dental Health Network Consultants



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