Dental Update

SPRING 2016

BlueCross BlueShield Nebraska

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Who's Responsible for Re-credentialing? You Are!

All BCBSNE professional providers must go through a re-credentialing cycle every three years. It is a requirement to re-attest a provider's good standing with a state license, valid insurance and other touch points that were required for initial acceptance into the network. **Lack of response to the re-credentialing requests will ultimately result in a provider being terminated from the NEtwork BLUE PPO network.**

When a provider's re-credentialing is due, BCBSNE's online credentialing partner, CAQH, makes contact by email notifying the provider that they need to visit the CAQH re-credentialing portal either to complete the online application or, if the provider has completed the CAQH application, to update the application and attest to it. **Please consider any communications from CAQH to be delegated by BCBSNE.**

CAQH makes no distinction between initial credentialing and re-credentialing. Acquiring a completed application is CAQH's main role. Once the application and the attestation are complete, CAQH will notify BCBSNE via a weekly roster that the provider has satisfied the application process. If you or other office staff take delivery of a re-credentialing request, do not delay. Please take the requested action to involve the provider or your facility's credentialing representative.

VERY IMPORTANT: The application cannot be rostered to BCBSNE until you receive notification from CAQH stating your application is complete.

Review page 3 of the "Provider & Practice Administrator Quick Reference Guide" for the steps and list of items you will need to complete the re-credentialing process.

In this issue

Click on one of the headlines below to go directly to the article you wish to view.

Who's Responsible for Re-credentialing? You Are!	1
Digital Copies of X-Rays	2
CDT Code Updates	2-3
Federal Employee Program Dental Benefits Fee Schedule	3-4
BlueBoard: Wait to Bill Again	4
BlueBoard: Fee Change Notification	4
BlueBoard: Filing Medical Claims	4

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 also offers important details about BlueCard providers and the Federal Employee Program. It is published by the Health Network Services (HNS) Department and the Marketing Department.

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

As a service for Blue Cross and Blue Shield members, we also make this newsletter available to nonparticipating Nebraska providers. We also publish each issue online in the Provider section at: **nebraskablue.com.**

For permission to reprint material published in the Dental Update or to request a printed copy, e-mail the editor, Elizabeth Darling, at: **elizabeth.darling@nebraskablue.com.**

If you would like to receive an e-mail each time a new issue of this newsletter is posted on the website, go to **bit.ly/updatenewslettersignup**. You can view the newsletter and request online notifications of special announcements about workshops, resources, and other information from BCBSNE.

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Digital Copies of X-Rays

When sending or attaching X-rays to a dental claim, please submit a digital copy rather than the physical X-ray copy, if possible. BCBSNE cannot accept X-rays as an electronic attachment. Additionally, digital copies are clearer and easier to scan than physical copies.

As a reminder, X-rays are needed ONLY for the following services:

- Anterior crowns or veneers
- Crowns placed and the patient has preventative and restorative coverage only
- Multiple restorations on the same tooth

We do NOT need X-rays for posterior teeth except as listed here.

Periapicals should be placed inside an X-ray envelope with the patient's name, dentist's name and the dentist's address.

Panographs should identify the patient's and the dentist's names as well as the dentist's address.

Please do not include X-rays for any other services. Should we require X-rays to review any procedures not mentioned in this article, we will request them once the claim is filed.

CDT Code Updates

The American Dental Association (ADA) added 19 new CDT codes and deleted eight CDT codes for 2016. The codes below in blue are new and the codes in red have been deleted. For information on the CDT code nomenclature, please refer to the CDT 2016 Help Guide and Training Manual or search "CDT" at http://www.ada.org.

CDT Code	Dental Service
D0251	Extra-oral posterior dental radiographic image
D0422	Collection and preparation of genetic sample material for laboratory analysis and report
D0423	Genetic test for susceptibility to diseases – specimen analysis
D0260	Extraoral-each additional radiographic image
D0421	Genetic test for susceptibility to oral diseases
D1354	Interim caries arresting medicament application
D2970	Temporary crown
D4283	Autogenous connective tissue graft procedure—each additional contiguous tooth, implant or edentulous tooth position in same graft site
D4285	Non-autogenous connective tissue graft procedure-each additional contiguous tooth, implant, or edentulous tooth
D5221	Immediate maxillary partial denture-resin base
D5222	Immediate mandibular partial denture-resin base
D5223	Immediate maxillary partial denture-cast metal framework with resin denture bases
D5224	Immediate mandibular partial denture-cast metal framework with resin denture bases
D7881	Occlusal orthotic device adjustment
D8681	Removable orthodontic retainer adjustment
D9223	Deep sedation/general anesthesia—each 15 minute increment
D9243	Intravenous moderate (conscious) sedation/analgesia—each 15 minute increment
D9932	Cleaning and inspection of removable complete denture, maxillary
D9933	Cleaning and inspection of removable complete denture, mandibular
D9934	Cleaning and inspection of removable partial denture, maxillary
D9935	Cleaning and inspection of removable partial denture, mandibular

(continued)

CDT Code	Dental Service
D9943	Occlusal guard adjustment
D9220	Deep sedation/general anesthesia—first 30 minutes
D9221	Deep sedation/general anesthesia—each additional 15 minutes
D9241	Intravenous moderate (conscious) sedation/analgesia—first 30 minutes
D9242	Intravenous moderate (conscious) sedation/analgesia—each additional 15 minutes
D9931	Cleaning and inspection of a removable appliance

Federal Employee Program Dental Benefits

Covered Codes for Service Benefit Plan Dental Effective Jan. 1, 2016:

ADA Code	Dental Service	Amount FEP Pays Up to Age 13 (Standard Option)	Amount FEP Pays Age 13 and Over (Standard Option)	Fee Schedule Amount
120	Periodic oral evaluation*	$12	$8	$28.40
140	Limited oral evaluation	14	9	42.21
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 and subsequent films	16	10	26.26
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	66.86
9110	Palliative (emergency) treatment of dental pain--minor procedure	24	15	59.80
2940	Sedative filling	24	15	62.62
1110	Prophylaxis--adult*	--	16	55.08
1120	Prophylaxis--child*	22	14	36.90
1206	Topical application varnish	13	8	33.56
1208	Topical application of fluoride	13	8	24.24
1351	Sealant, per tooth, first and second molars only (once per tooth for children up to age 16 only)	N/A	N/A	33.33

**Limited to two per person per calendar year*
***Limited to two per person per calendar year (Basic Option only)*

(Federal Employee Program Dental Benefits, continued from page 3)

Fee Schedule Amount The maximum amount GRID/GRID + dentists will charge for a covered dental service. This amount may be updated periodically and is subject to change. When care is provided by a GRID/GRID + dentist, the member owes the difference between the amount FEP pays and the Fee Schedule Amount (for Standard Option members).

For Basic Option members who see a PPO dentist, FEP will pay up to the Fee Schedule Amount on covered services after assessing a $30 copay per visit. Services by a non-PPO dentist are not covered. Covered X-rays listed in the chart are limited to four bitewing images per calendar year per member and one intraoral-complete series every three calendar years.

Benefits are subject to change yearly. Please refer to your Dental Update newsletter for changes. Not all services in the chart are covered under both FEP options. Services not highlighted in the chart are covered under both options. Services highlighted in green are covered for Standard Option members only. Services highlighted in blue are covered for Basic Option members only.

We also provide benefits for services, supplies, or appliances for dental care necessary to promptly repair injury to sound natural teeth required as a result of, and directly related to, an accidental injury (injuries to the teeth while eating are not considered accidental injuries). Payment amounts and the list of covered codes may differ to those listed in the chart. Call the Federal Employee Program Customer Service Department if you have questions about benefits or reimbursement for services used to treat an accidental injury.

Not covered-Any service not specifically listed in the chart.

BlueBoard

Wait to Bill Again

BBCBSNE receives many dental claims that are being rebilled on a weekly basis. Please allow us 30 days to process your clean claim before checking claims status or rebilling the same claim. Billing a claim multiple times creates duplicate denials and extra effort for both your office and BCBSNE.

Fee Change Notification

BCBSNE no longer requests fee change notices from NEtwork BLUE dentists. If you change your billed charges, it will be reflected on submitted claims and we will capture the data accordingly.

Filing Medical Claims

Previously, BCBSNE could process medical services billed on either the ADA form or the CMS 1500 form, depending on the member's benefits. Due to HIPAA requirements, we are restricted from converting a submitted dental claim into a medical claim. Therefore, if you get a returned or denied claim requesting that you resubmit it as medical, then you will need to follow the directions for completing the CMS 1500 claim form. The Dental Policies and Procedures manual contains a sample medical claim as well as a blank copy of the 1500 claim form that you can print and use for submission.

Visit the Policies and Procedures page on our website and select "View Dental Policies." Review "CMS 1500 Claim Filing" under Section 7. The data on the claim is very similar to what you populate on a dental claim form with one additional requirement—a diagnosis code. We recommend that you use D-codes for procedures, rather than medical CPT codes.

The most common ICD10 codes for medical claims filing include:

SØ1.512A Laceration without foreign body of oral cavity
SØ2.5XXA Fracture of Tooth (initial encounter)
KØØ.6 Disturbances in Tooth Eruption
KØ1.Ø Embedded Tooth
KØ1.1 Impacted Tooth
G47.3Ø Sleep Apnea
M26.6Ø TMJ