Dental Update

SPRING 2015

NEBRASKA

GO PAPERLESS! Register to receive this newsletter electronically: nebraskablue.com/providers/newsletters

nebraskablue.com

PARTNERING WITH YOU FOR A HEALTHIER NEBRASKA

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

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

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

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

Dental Network Name Change

Effective June 1, 2015, the name of Blue Cross and Blue Shield of Nebraska's dental network will be adjusted to "NEtwork BLUE Dental." Per a communication sent in late February, an addendum was sent to appropriately identify and establish our local dental provider network's name change from "Dental GRID" to "NEtwork BLUE Dental."

Please note: No other terms of our dental agreement have changed as part of this addendum, and claim filing is not impacted. Our Policies and Procedures manuals will be revised accordingly. Member ID cards will be revised and reissued throughout 2015, displaying "NEtwork BLUE Dental" on the front of the card and "GRID/GRID+" on the back of the card.

As a reminder, Dental GRID is a network of the GRID Dental Corporation, an independent company that provides dental network services to participating Blue Cross and Blue Shield plans, including BCBSNE. Your agreement with us is as a participating provider within the NEtwork BLUE Dental network, which in turn is the local network participating in Dental GRID.

Reminder: Always ask to see the member's ID card at the time of service and if they are presenting the most current card. Doing so will help ensure the member's information is up-to-date.

Save the Date: National Walk at Lunch Day on April 29

Make a pledge to walk at lunch for 30 minutes!

Mark your calendars for BCBSNE's Ninth Annual National Walk at Lunch Day on April 29, 2015.

Join thousands of Nebraskans from across the state in this fun event. Visit **nebraskablue.com/walk** for more information or to register.

Providers Are Responsible for Recredentialing

All BCBSNE professional providers are required to undergo recredentialing every three years. The purpose of the recredentialing process is to re-attest a provider's good standing with state license, valid insurance and other touch points that were required for initial acceptance into the network. If you or other members of your office staff receive a re-credentialing request, do not delay taking the requested action.

A lack of response to our recredentialing requests may result in a provider being terminated from the BCBSNE PPO network. If the provider does not respond to the re-credentialing request after one month, BCBSNE will send a reminder letter. If the request goes unanswered after two months, a third and final certified letter will be sent to the provider advising that they will be terminated from the BCBSNE network if they do not respond within two weeks. If termination occurs, the provider will experience an in-network status lapse and will have to credential as a new provider.

When a provider's recredentialing is due, BCBSNE's online credentialing partner, the Council for Affordable Quality Healthcare (CAQH), notifies the provider that they need to visit **upd.caqh.org/OAS** to either complete the online application or update the application and attest it (if the provider has previously completed the CAQH application). Any communications from CAQH are delegated through BCBSNE. CAQH makes no distinction between initial credentialing and re-credentialing, as monitoring the application completion process is CAQH's main role. Once the application and/or attestation are complete, CAQH will notify BCBSNE via a weekly roster that the provider has satisfied the application process.

For information on the steps and list of items you will need to complete the re-credentialing process, refer to page 3 of the CAQH Universal Provider Datasource's Quick Reference Guide at **bit.ly/10v7u2O**.

It is important to note that the application is not complete until you have been officially notified by CAQH. For CAQH questions, call **(888) 599-1771** or email **caqh.uphelp@acsgs.com**, from 8 a.m. – 10 p.m. (CST) Monday through Thursday, and Friday from 8 a.m. to 8 p.m. (CST).

For additional information on BCBSNE's recredentialing process and helpful tools, visit the Credentialing page at **nebraskablue.com/providers**, and be sure to review the CAQH credentialing steps within the "How It All Fits Together" section. For credentialing status questions, please contact our Provider Solutions team at **(877) 435-7258, (402) 982-7711** or **ProviderSolutions@nebraskablue.com**.

Provider Solutions Is Ready to Assist You

BCBSNE's Provider Solutions Team is available to serve our community of providers. The team services and triages inquires that cannot be otherwise resolved with Customer Service.

The team, which consists of members from our Health Network Services, Credentialing and Electronic Data Interchange departments, handles the following inquiries:

- Credentialing and application status
- Provider agreement inquiries
- Reimbursements and fee schedules
- Billing and coding
- EDI
- Request Electronic Funds Transfer/ Electronic Remittance Advice
- Escalated claim issues
- Change of name, location, tax identification number, NPI, etc.

It is important to note that our Health Network Consultants are still available to assist you with provider agreement education and contract questions. Customer Service will continue to assist all members and providers with Customer Service-related issues including, but not limited to, all claims issues including coding, BCBSNE member benefits and eligibility, questions regarding medical policy, precertification/preauthorization and/or appeals and plan-to-plan calls to resolve BlueCard claims issues.

You can contact the team at **(877) 435-7258**, (**402) 982-7711** or **ProviderSolutions@nebraskablue.com**, from 8 a.m. - 4 p.m. (CST), Monday - Friday.

BlueBoard

At Your Service: Your Health Network Dental Consultant

Charlie Kennedy
Phone: 402-982-7638
Fax: 402-398-3875
Email: charlie.kennedy@nebraskablue.com

Department of Corrections Adds Benefits

The Department of Corrections now covers dental services , effective for dates of service on or after October 1, 2014.

The alpha prefix for this group is YEF. Providers must submit claims to BCBSNE for adjudication and reimbursement.

Mobile ID Cards Now Available

BCBSNE now offers members the convenience of a digital ID card. To access the ID card, members will log in to myblue, our self-service website at **mynebraskablue.com**. Once they have logged in, they can access an image of the front and back of their card and email it directly from their mobile device to your office staff. Please note that members will still continue to receive printed ID cards.

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. Additionally, 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.

Benefit Letter Requests No Longer Accepted

Effective immediately, Customer Service no longer accepts dental benefit letter requests from both in-state or out-of-state providers. If needed, our Customer Service representatives are available to provide benefits information via phone.

Dental Policies and Procedures Available Online

Stay up-to-date on the latest dental policies and procedures by reviewing our online manual!

To access the latest version of the manual, click on the "View Dental Policies" link on the "Policies and Procedures" page at **nebraskablue.com/providers**.

BlueBoard (continued)
Claim Filing Updates and Reminders

The following updates and reminders are meant to serve as guidance when filing BCBSNE claims. Submitting clean and accurate claims allow for faster processing and less provider and member abrasion.

Timely Filing Limits

In order to comply with timely filing limits, all claims must be submitted by the provider or covered person within 180 days of the date of service. If a claim for a covered person is not filed originally within 180 days of the date of service (or the time limit set forth in the applicable provider agreement, Master Group Application or Summary Plan Description) and in compliance with BCBSNE's Policies and Procedures, no benefits will be paid, and GRID/GRID+ providers agree that no payment will be pursued from the covered person.

If a copay is collected from our member at the time of service and the claim is denied for timely filing, the copay does not need to be refunded to the member. Conversely, if monies for the deductible or coinsurance are collected at the time of service from our member and the claim is denied for timely filing, one or both must be refunded to our member as they are calculated on allowed amounts and subject to the timely filing denial. Adjustments or revisions to timely filed claims may be made within 12 months from the date of service. No adjustments or revisions to timely filed claims will be accepted more than 12 months from the date of service.

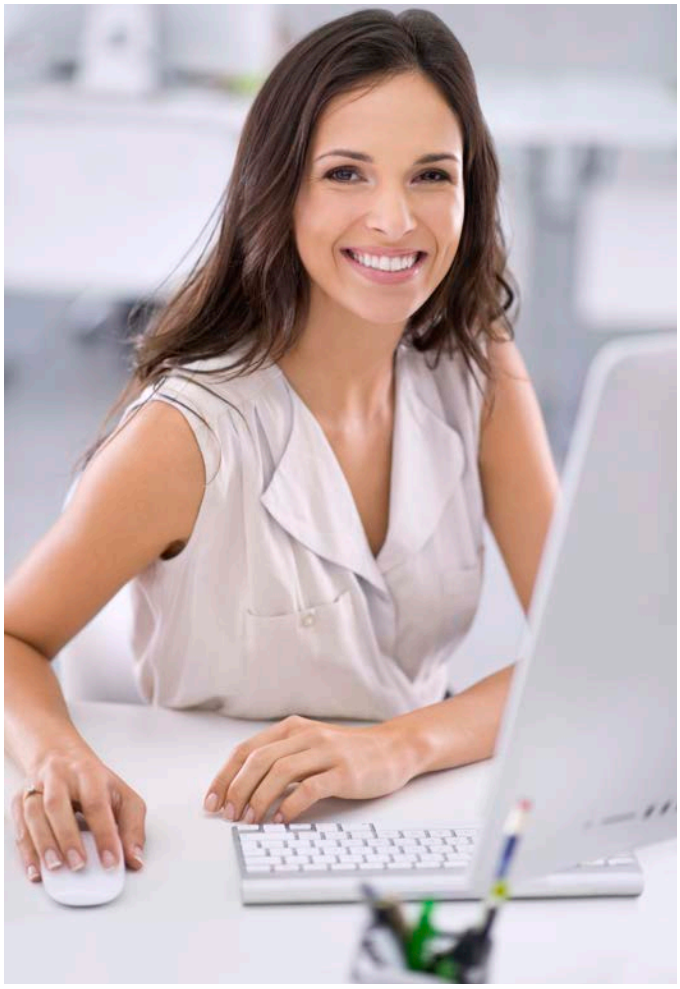
If a claim submission is rejected due to incorrect or invalid information, it is the provider's responsibility to make the necessary corrections and resubmit the claim within the timely filing period. BCBSNE does not consider a rejected claim as proof of timely filing but will reconsider a claim listed on a BCBSNE accepted claim report if the claim shows no errors, but was not processed.

Gender Edit Added to Claims Processing

Please note that **Box 7** (gender of patient) must be completed correctly when filing claims electronically or completing a paper American Dental Association Dental Claim Form. BCBSNE has added an edit that will reject the claim when the selected gender conflicts with our membership files. As a result, the claim will be returned, requesting that a corrected claim be submitted with the appropriate gender information.

Include Your National Provider Identifier on Claim Submissions

When completing the paper ADA Dental Claim Form or when filing an electronic claim as the treating dentist, it is important to indicate your individual National Provider Identifier in **Box 54** of the claim form. If the dental practice has a **clinic NPI**, this number should be noted in **Box 49** of the ADA Dental Claim Form. It is imperative to remember that the individual or the treating Dentist NPI should **not** be noted in Box 49, only the clinic NPI.



BlueBoard (continued)

Top Five Claims Issues

BCBSNE has identified the following issues when processing electronic and paper claims.

When preparing to file claims for your patients, your awareness of these issues is greatly appreciated as it will help decrease the amount of claims that we reject and return to providers.

Issue #1 – Duplicate Claims

If you have already submitted a claim for payment, please do not file duplicate claims, as duplicate claims may actually delay the processing of the original claim. **Due to an increase in our Dental membership, there has been an impact on the timeliness of claim processing**. As a result, we request that you do not resubmit any dental claims for benefit consideration until 45 days after the initial submission.

Secondary coverage note: When the member has both primary and secondary insurance through BCBSNE, it is not necessary to send claims for both ID numbers.

Issue #2 – Claims Submitted with Social Security Numbers

For the protection of our members' privacy, BCBSNE does not accept Social Security numbers on claim forms. Claims submitted with Social Security numbers in place of the actual member ID will be returned for the proper identification number. Always list the member's subscriber ID number.

Issue #3 – No Blue Cross ID Number(s) Listed OR Old ID Number Used

Always ask to see the member's ID card at the time of service. Use the ID number listed on the front of the card when completing the member's claim.

Issue #4 – ID Numbers Don't Show on Claim

When completing a claim form, be sure to put the ID number in the designated fields on the claim form. Doing so will ensure our scanners easily pick up the ID number. Otherwise, the ID will not be visible and the claim will be rejected and returned.

Issue #5 – Sending Too Much Information

For example, we have recently noticed that X-rays have been submitted for reasons other than the service needed. Claims for services such as crown and veneers on anterior teeth should be submitted with X-rays, unless the claim was previously pre-authorized.

All of these outlined issues can cause claims processing delays, in addition to claims being returned multiple times. As a result, this causes both member and provider abrasion.

Our claims team strives to process all claims accurately and in a timely manner. Providing correct information in the appropriate format will allow to us continue to achieve this goal, while preventing any member concern and appropriately reimbursing our dental providers for services rendered.

(continued on page 6)

BlueBoard (continued)

Claim Filing Guidelines for CMS 1500 Forms

Providers must use the CMS 1500 Claim Form for dental services deemed payable under the member's medical benefit plan or services related to an injury.

Please note the following regarding CMS 1500 claim filing:

- Dental claims **cannot** be submitted on a medical claim form, unless the claim is injury-related.
- The date of injury and diagnosis codes that best describe the services need to be provided.
- A medical CPT code can be used, if applicable (rather than the dental CPT code).

An example of a CMS 1500 claim with medical services is available for viewing online at **http://bit.ly/1B6gvhV**. A blank copy of the CMS 1500 that can be printed for claim submission is available at **http://bit.ly/1Gmm5gd**. Handwritten, legible CMS 1500 claims are accepted as well.

FEP 2015 Standard Option Fee Schedule

The following chart provides information on FEP Standard Option dental benefits for 2015. Fee schedule amounts and Maximum Allowable Charge information are listed below.

Also note:

Not Covered – Any service not specifically listed below.
Fee Schedule Amount – The amount Standard Option pays toward a covered dental service.
MAC – The maximum amount GRID/GRID+ 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 GRID/GRID+ dentist, the member owes the difference between the FEP fee schedule amount and the MAC.
Benefits for general anesthesia in connection with covered extractions (D9220 + D9221 combined) are available up to the Maximum Allowable Charge amount according to age. Up to age 13, the MAC amount is $43. Age 13 and over the MAC amount is $27.

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	$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 film	16	10	26.26
260	Extraoral–each additional film	6	4	19.72
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

(continued on page 7)

(continued)

ADA Code	Dental Service	Fee Schedule Amount Up to Age 13	FEP Fee Schedule Amount Age 13 and Over	MAC Amount
290	Posterior–anterior or lateral skull and facial bone survey film	45	28	76.76
330	Panoramic film	$36	$23	$66.86
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	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
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	323.87
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
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	101.81
2392	Resin–based composite, two surfaces, posterior	37	23	143.40
2393	Resin–based composite, three surfaces, posterior	50	31	174.53
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	445.43
2620	Inlay–porcelain/ceramic–two surfaces	37	23	490.86
2630	Inlay–porcelain/ceramic–three or more surfaces	50	31	586.95
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*

NEBRASKA
Blue Cross and Blue Shield of Nebraska is an Independent Licensee of the Blue Cross and Blue Shield Association.

P.O. Box 3248 • Omaha, NE 68180-0001

Address Service Requested

PRESORTED
STANDARD
U.S. POSTAGE
PAID
OMAHA, NE
No. 222

If you would like to receive an e-mail each time a new issue of this newsletter is posted on the website, please go to **nebraskablue.com** and click on the Providers button. In the left column, click the Newsletters button. You can view the newsletter and request online notifications of special announcements about workshops, resources, and other information from BCBSNE.

In this issue