2022 Dental Billers Workshop

BlueCross BlueShield Kansas

What can your Rep do for you?

- Insurance billing education
- CAP mailing
- Policy Memos
- Dental Medical Policies
- Documentation
- Coding
- Claim Submission Tips
- Availity
- Training

Contracting

- 2023 CAP contract
- Quality-Based Reimbursement Program (QBRP)
- Policy Memo changes
- Value in contracting

Member Services

- Dental Benefits
- Availity
- Dental GRID

Claim Tips, Miscellaneous

- Claim submission reminders
- Dental Manual review

Value in Contracting

- **Local member contracts** structured to allow charges up to 100 percent of the MAP for participating CAP providers
- Opportunity to Earn **Quality-Based Reimbursement**.
- **Direct Payment** from BCBSKS
- **Detailed Claim-payment** information provided to you and the member
- **Electronic Remittance Advice**
- **Dental Seminars**
- **Provider name listed in directory of providers** in service area
- **Website** and self-service access
- **Access** to Provider Network Services

CAP – Competitive Allowance Program

- Annual Contract Update
- Provider Contract is Perpetual
- Approved by Board of Directors at BCBSKS
- Emailed towards the end of July
- Quality Based Reimbursement Program (QBRP)
- Policy Memo

2023 Reimbursement

- Aligned to continue RVU-based pricing
- QBRP incentives
- Rural Access Incentive
- Increase lower-valued codes
- Maintaining allowances for higher-valued codes

Quality-Based Reimbursement Program (QBRP)

- Applies to all eligible dental providers
  - BCBSKS CAP
  - Dental PPO
  - Solutions
- Prerequisite: Conduct business electronically
  - File claims electronically
  - Sign up for electronic newsletters
  - Stop receiving paper remits
  - Must be in good standing with BCBSKS

QBRP – Groups 1 and 2

- Applies to all eligible dental providers.
- Group 1 (ESS & EPM): Applies to all eligible CDT and CPT codes except clinical lab and pharmaceutical services.
- Group 2 (PRD): Applies to all eligible CDT codes except clinical lab and pharmaceutical services.

QBRP – Group 1

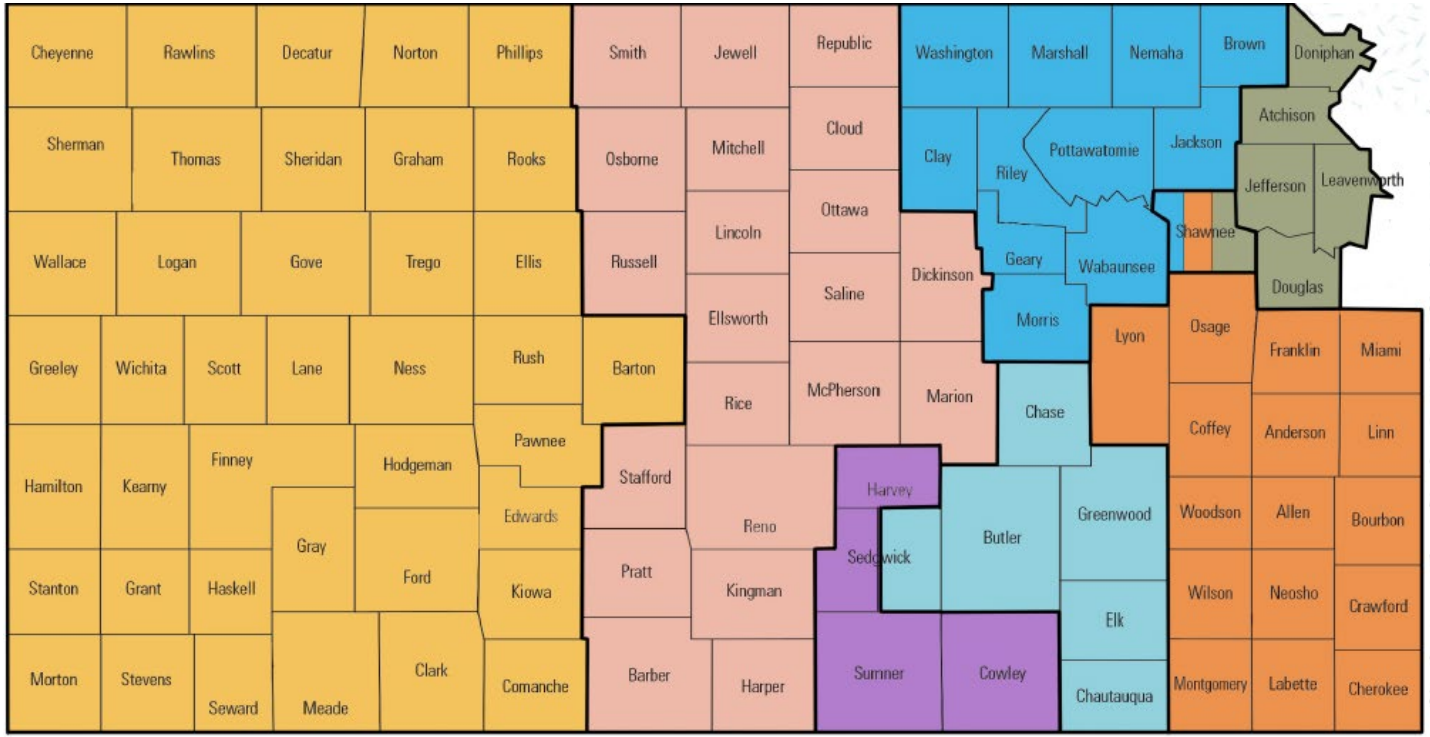
- Electronic Self-Service (ES3 and ES2)
    - ES3 – 2.0 percent (96 percent or greater)
    - ES2 – 1.0 percent (86 to 95 percent)
- Electronic Provider Message Board (EPM)
    - EPM – 1.0 percent

QBRP – Group 2

- Provider Portal Information (PRD) – 2.0 percent
  - Must verify provider information every 90 days
  - During the designated time periods outlined in CAP
  - At the group level and individual provider level for all providers tied to your group contract.

Rural Access Counties

- Blue Cross is sensitive to the challenges experienced in rural Kansas regarding access to dental care and recruitment of dentists.
- Blue Cross will continue to increase base allowances 5 percent for services performed by dentists (CDT codes) in counties with a population of 13,000 or less.



MD, DO, DPM, DC, DDS, PA, APRN, CRNA, LSCSW, PHD, OD, OOD, OSAF, CCC-SLP (speech), OTR, RPT

- Gwen Nelson - Topeka - Rep. Code C
- Jennifer Falk - Topeka - Rep. Code Z
- Darin Fieger - Topeka - Rep. Code D
- Jennie Fellers-Morgan - Hays - Rep. Code R
- Patrick Romm - Hutchinson - Rep. Code K
- Vickie Kloxin - Wichita - Rep. Code M
- Kyle Abbott - Wichita - Rep. Code R

Pharmacy and Infusion Therapy

Ken Mishler, PharmD, MBA - Topeka - Rep. Code B

CCC-A (AUD), Hearing Aid Dispenser (HAD), HME, Orthotists, Private Duty Nurses, Prosthetists, Sleep Labs (SLAB), AMB, ABA

Heather Schultz - Topeka - Rep. Code V

2023 Policy Memo – Dental

- Retrospective Claim Review
    - 120 days from date of Remittance Advice
- Appeals – only "Not Medical Necessary" denials
    - 1st Level: Written notification within 60 days from Retrospective Review Determination
    - 2nd Level: Written request within 60 days from 1st Level Appeal

Content of Service

- Local Anesthesia
- Impressions for Prosthetics
- Materials/ Supplies
- Suture Removal
- Postoperative Care
- Sedative Base content to Amalgam or Composite Restoration

Non-covered Services

- Professional services are not reimbursed when provided to an immediate family member – spouse, children, parents, siblings, or legal guardian of the person who received the service (or themselves).
- There are several categories of service and procedures that may be considered non-covered services for various reasons. These denials are billable to the member.

Limited Patient Waiver

- Situations when a Waiver should be Obtained
  - Medical Necessity Denials
  - Utilization Denials
  - Patient-Requested Services
  - Experimental / Investigational Procedures
  - Deluxe Services (Gold crowns, diamond caps, etc.)
- Waiver should NOT be used
  - Services considered Content of Service
  - Amounts over MAP: cannot be used to bill the patient the difference between the provider charge and the allowed amount.

Limited Patient Waiver Cont.

- Requirements of the Waiver
    - Signed Before Receipt of Service
    - Patient Specific
    - Procedure Specific
    - Date of Service Specific
    - Dollar Amount
    - Retained in the patient's file at the provider's place of business
    - Presented on an individual basis to patients. No "blanket" waivers.
- Use Modifier -GA for all claims
- NOTE: If the waiver is not signed before the service being rendered, the service is considered a contracting provider write-off.

Limited Patient Waiver

BlueCross BlueShield of Kansas

Section 1 – Patient Information

First Name _____ MI _____ Provider Name _____

Last Name _____ Suffix _____ Provider Address _____

Identification Number _____ City _____

Provider NPI _____ State _____ ZIP Code _____ +4 _____

The provider must document in the patient record the discussion with the patient regarding the following service(s):

_____ _____

Section 2 – Notice of Personal Financial Obligation (Please read before signing)

I have been informed and do understand that the charge(s) for _____
Nomenclature/Procedure Code/Appliance

provided to me on ____ ____ _____ **will not be covered** because Blue Cross and Blue Shield of Kansas (BCBSKS) considers this service to be:

- ☐ Not medically necessary
- ☐ Deluxe features (applicable to deluxe orthopedic or prosthetic appliances as specified in the member contract) – the allowance for standard item(s) will be applied to the deluxe item(s)
- ☐ Patient demanded services
- ☐ Utilization denials
- ☐ Experimental or investigational

It is my wish to have this service(s) performed even though it will not be paid by BCBSKS.

I understand that I will be held personally responsible for approximately $_____. This amount is an approximation only, based on the service(s) scheduled to be provided.

Options: Check only one box. We cannot choose for you.

- ☐ **Option 1:** I want the service listed above. I also want the provider to bill my insurance for the service provided so that a determination of coverage can be made by my carrier.
- ☐ **Option 2:** I want the service listed above, but do not want the provider to bill my insurance. I understand that I am responsible for the charge and have no appeal rights if the claim is not processed through my insurance.

Acknowledgment of personal financial obligation applies to charge(s) for service(s) specified above when performed by this or another provider(s).

I further understand any additional service(s) could affect the amount of my financial responsibility.

Your signature required _____ _____ _____
Patient (Signature of parent/guardian if other than patient) Date Signed

I, _____ (witness name), did personally observe and do certify the person who signed above did read this notice and did affix their signature in my presence.

Your signature required _____ _____ _____
Witness Date Signed

Documentation

- Abbreviations – Have a Legend
- Must be legible in readability and content
- Diagnosis and Dx Code, when appropriate
- Electronic vs Hand-Written Signature
- BCBSKS requests for medical records
    - Must be provided at no charge
    - Must be submitted within the time frame specified by BCBSKS.

Uniform Charging

- What constitutes a provider's usual charge?
    - A discount to every patient without health insurance would be considered the "usual charge," and you must bill BCBSKS the same amount.
- Concierge/Club Services are not to be offered to BCBSKS members
- Are discounts acceptable?
    - **Yes, if** they are based upon an individual patient's situation
    - Cash discounts are not allowed
    - Community mental health centers and county health departments are allowed to use a sliding scale due to agency regulations
    - Only collect deductible, co-payment, co-insurance, or non-covered services at the time of service

Non-contracting provider

- When a contracting provider uses a non-contracting provider (either in or out-of-state) to perform one or more professional services, the contracting provider who ordered the service(s) must bill BCBSKS for all services rendered by the non-contracting provider.
- The contracting provider will be required to ensure the member is held harmless
- If a member requests referral to a non-contracting provider, a signed statement of financial obligation should be on file with the referring provider

Locum Tenens Provider

- BCBSKS allows use of a Locum Tenens
  - Provider must be same type of a provider for whom the locum is substituting for.
  - Locum Tenens must be contracting provider with BCBSKS.
  - No longer than a continuous period of 60 days
  - Billing: use NPI of the provider for whom the locum tenens is substituting. Add Q6 modifier.
  - Can not use Locum Tenens for a deceased provider.

Claims Filing

- Timely Filing – Blue Cross has a timely filing period of 15 months from the date of service.
- Modifiers Blue Cross accepts:
    - Modifier 22
    - GA Modifier
- Dental vs. Medical – Services that fall under a patient's medical benefit are to be filed on a current ADA J430D form.

BlueCard Claims Filing

- Out-of-state Blue Cross and Blue Shield member services that fall under the member's dental policy should be submitted directly to the member's home plan. This information is located on the back of the ID card.
- BlueCard Claims (Out-of-state Blue Cross and Blue Shield) is only for services that fall under a member's medical policy. These claims should be submitted to BCBSKS.

National Dental GRID and GRID+

- BCBSKS has teamed with other Blue Plans to form the GRID Dental Corporation.
- Dental GRID and Dental GRID+ enable patients to see in-network providers outside their plan area.
- ID card
    - GRID
    - GRID+

Claims Filing Hints

- Corrected Claim
    - Box 35: Indicate Resubmission Code 7 and original claim #
- Void Claim
    - Box 35: Indicate Resubmission Code 8 and original claim #
- Accident Claim
    - Box 29a: Diagnosis Pointer
    - Box 34: AB to indicate ICD-10 code
    - Box 34a: ICD-10 code (Accident code must be primary)
    - Box 45: Complete appropriate box for accident type
    - Box 46: Accident date

Remittance Advice (RA)

- More than one claim and patient per RA.
- Claim Control Number
    - Example: 202200500001
        - 20 – paper claim
        - 22 – received in 2022
        - 005 – received on 5th of January
        - 0001 – first claim in the sequence

Remittance Advice (RA) Cont.

- Commonly Used Remark Codes for Dental Services
  - https://x12.org/codes
- Health Care Code Lists
  - Claim Adjustment Reason Codes (CARC)
  - Remittance Advice Remark Codes (RARC)

Electronic Funds Transfer (EFT)

- Mandatory soon
- Quicker access to payments by eliminating postal service transit delays
- Reduces the clinic's hands-on check processing efforts
- Sign up in Blue Access under Resources tab/Forms
- Funds transferred will match the Remittance Advice total payment amount.

Credentialing

- Blue Cross credentials all dentists in the CAP network based on the URAC Health Plan Credentialing Standards.
- Blue Cross utilizes CAQH for professional and demographic information for network providers.
- CAQH website www.caqh.org.

Provider Add/Term/Address Change

- Provider Change Request Form
    - https://www.bcbsks.com/documents/provider-information-change-form-15-141-2022-04-19
- Provider Network Enrollment Request Form
    - https://www.bcbsks.com/documents/provider-network-enrollment-request-15-481-2021-11-23
- Initiate request at least 60 days before start date
- BCBSKS does NOT backdate the contract effective date because of URAC requirements
- CAQH must be current
- BCBSKS Credentialing Program
    - https://www.bcbsks.com/providers/professional/publications/credentialing-information

Dental Benefit Programs

Verify benefits via Availity

- Comprehensive Dental
- Share Pay Dental
- Building Block Dental
- BlueCare Dental
- Voluntary Dental
- ACA Pediatric Dental Benefits

General Exclusions

- Non-intravenous conscious sedation
- Cosmetic services
- Patient education services
- Hospital calls or consultations
- Bone graft for alveolar ridge augmentation
- Occlusal adjustments
- Mandible staple bone plate procedures
- Acid etching
- Services done in conjunction with a non-covered Service

Federal Employee Program (FEP)

- FEP has three dental plan options:
  - Basic
  - Standard
  - Blue Cross Blue Shield FEP Dental

Blue Cross and Blue Shield FEP Dental

- Part of the GRID+ network
- For patients with FEP Medical, submit claims to the address on the back of the medical ID card
- For patients without FEP Medical, submit claims to:
    - BCBS FEP Dental Claims
      PO Box 75
      Minneapolis, MN 55440-0075
- Contact Information:
    - www.bcbsfepdental.com
    - CSC 855-504-BLUE(2583)

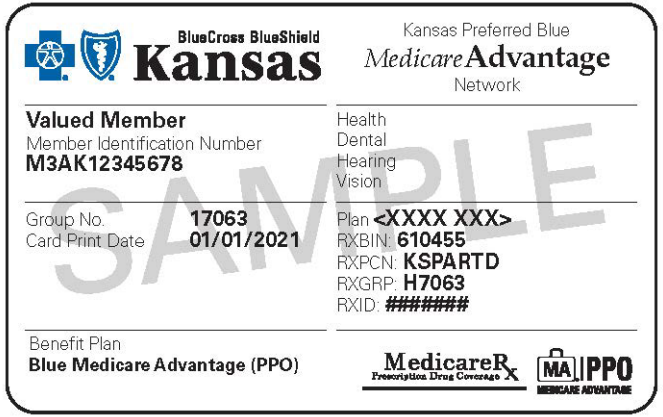
BCBSKS Medicare Advantage Dental

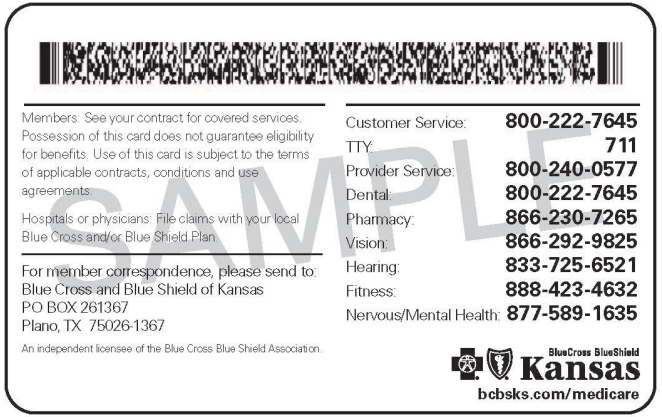
- BCBSKS Medicare Advantage PPO has contracted with Dominion National
- Basic Preventive Dental Care is covered
- Additional comprehensive and supplemental coverage may be added
- Benefits are paid the CAP Allowance for MA—not the DPPO rates

BCBSKS Medicare Advantage Dental - Claims

- Submit electronic claims to ASK using BCBSKS payor id 47163
- Paper claims submit direct to Dominion National at the following address:
    - BCBSKS
      P.O. Box 1126
      Elk Grove Village, IL 60009

BCBSKS Medicare Advantage Member ID Card





Provider Services: 800-240-0577

Dental Coverage Summary

- Table lists
  - CDT code
  - Policy Name
  - Accident Rider
  - Associated medical policies

Availity/BlueAccess – BCBSKS

- Eligibility and Benefits
- Claim Status
- Blue Access (BCBSKS Secure Section)
  - Patient ID Search
  - Provider Information: Rolling 90-day Attestation
  - Business Associate Agreement (BAA): Complete annually
  - Message Portal
  - View / Print Remits
  - QBRP Earned Report
  - Resources
  - Dental Manuals and forms
  - EFT Sign-up

Other Party Liability (OPL)

- Duplicate coverage from another insurance policy.
- Workers' Compensation
- Personal Injury Protection (PIP) (auto no-fault coverage)
- Claims Filing
- Coordination of Benefits (COB)
- Group vs Non-group
- Pay and/or Pursue

Dental Procedure Codes

- Diagnostic Procedures (D0100-D0999)
- Clinical Oral Evaluations (D0120-D0180)
    - Must be performed by a licensed dentist.
    - Content of service of palliative treatment, prosthetic or orthodontic adjustments on same date of service as an oral surgical procedure.
    - D0171 – Re-evaluations (postoperative office visit) are content of service of the primary procedure.

Dental Procedure Codes Cont.

- Diagnostic Procedures (D0100-D0999)
  - Diagnostic Imaging (D0210-D0395)
    - When submitting films/x-rays,
      - Send originals
      - Dated
      - Contain patient's name, ID number, and date of birth
      - Contain name of the provider
      - Checkmark should be placed in Box 39 of claim form
  - Blue Cross does not accept faxed images

Dental Procedure Codes Cont.

- Diagnostic Procedures (D0100-D0999)
  - Diagnostic Imaging (D0210-D0395)
    - D0330 Panoramic image is generally considered medically necessary once every three-to-five years.
    - D0350-D0351 Photographic images are denied content of service.
    - Films are required for crowns for multiple teeth (six or more).
    - Films are required for crowns for any front tooth.
    - Films are required when requesting pre-determinations on primary teeth.

Dental Procedure Codes Cont.

- Diagnostic Procedures (D0100-D0999)
  - Test and Exams (D0415-D0470)
    - D0422-D0423 Genetic sampling codes are non-covered
    - D0425 Caries susceptibility tests are non-covered
    - D0460 Pulp vitality test is covered as a diagnostic tool
    - D0470 is content of service except when used with a TMJ diagnosis

Dental Procedure Codes Cont.

- Diagnostic Procedures (D0100-D0999)
    - Oral Pathology Laboratory (D0472-D0999)
        - No benefits under dental contract

Dental Procedure Codes Cont.

- Preventive (D1000-D1999)
    - Dental Prophylaxis (D1110 & D1120)
    - Topical Fluoride Treatment (D1206 & D1208)
    - Space Maintenance - Passive Appliances (D1510 – D1575)
    - Other preventive services (D1310 – D1353)

Dental Procedure Codes Cont.

- Restorative Procedures (D2000-D2999)
    - Crowns (D2710 – D2799)
    - Inlay/Onlay Restorations (D2510 – D2664)
    - Restorations (D2140- D2430)
    - Other Restorative Services (D2990 – D2983)

Dental Procedure Codes Cont.

- Endodontic Procedures (D3000-D3999)
    - Medical Policy – Cone Beam D0364
    - Trauma cases must include ICD-10 specific diagnosis
    - Palliative treatment

Dental Procedure Codes Cont.

- Periodontal Procedures (D4000-D4999)
    - Surgical Services (D4210- D4381)
    - Nonsurgical Periodontal Service (D4320 – D4321)
    - Medical Policy – Periodontal Soft Tissue Grafting

Dental Procedure Codes Cont.

- Prosthodontics – Removable (D5000-D5899)
    - Dentures (D5110 – D5286)
    - Adjustment (D5410 – D5422)
    - Denture Rebase and Reline Procedures (D5710 – D5761)

Dental Procedure Codes Cont.

- Maxillofacial Prosthetics (D5900-D5999)
    - May be covered under member's medical benefits
    - Not covered under dental benefits
- Implant Services (D6000-D6199)
    - May be covered under the medical or dental policy

Dental Procedure Codes Cont.

- Prosthodontics – Fixed D6200-D6999)
- Oral and Maxillofacial Surgery (D7000-D7999)
    - Services may be covered under member's medical benefits.
- Bio-type material (Platelet Rich Plasma System) – content of the extraction

Dental Procedure Codes Cont.

- Orthodontics (D8000-D8999)
  - Covered Services
    - Diagnosis of condition (D8660)
    - Active treatment
      - Down payment or full Orthodontic Care (D8070, D8080, and D8090)
      - Periodic Payment (D8670)
    - Retention treatment (D8680)
  - Accident-related? Complete appropriate boxes of the claim form

Dental Procedure Codes Cont.

- Adjunctive General Services (D9000-D9999)
    - Unclassified Treatment (D9110 – D9130)
    - Anesthesia
        - Deep/general sedation (D9222-99223)
        - Inhalation of nitrous oxide/analgesia anxiolysis (D9230)
        - General anesthesia (CPT) codes
        - Drugs
        - Miscellaneous Services

Sleep Apnea Appliances

- Must use and in-network sleep lab
    - If non-contracting lab is used, member held harmless
    - Policy Memo 1, Section XIV
- Use HCPC code E0486 only
    - Includes appliance, fitting, & adjustment of appliance
    - Do not use D-codes for appliance, fitting, or adjustment
- Cannot bill member for the difference between the charge and the MAP—not eligible to be a waivered service.

Coding Tips

- Front teeth knocked out because of an accident will deny unless pre-accident x-rays accompany the claim.
- Claims for family members are considered non-covered and should not be billed.
- Pano's and full-mouth x-rays are not covered on the same day of service.

Questions?