2025 Dental Billers Workshop

BlueCross BlueShield Kansas

Agenda

Contracting

Provider services

Claim tips / miscellaneous

ASK-EDI

Lucky Strikes

Important Contact Information

Customer Service	Medicare Advantage Customer Service	Provider Network Enrollment
• 800-432-3990/ 785-291-4180 • csc@bcbsks.com	• 800-240-0577	• 800-432-3587/ 785-291-4135 • Prof.relations@bcbsks.com

Ask EDI	FEP Dental	Availity Essentials
• 800-472-6481 • askedi@ask-edi.com	• 855-504-BLUE (2583)	• 800-282-4548

Value in Contracting

- Opportunity to earn additional revenue through the Quality Based Reimbursement Program (QBRP)
- Direct payment from BCBSKS
- Claim payment information provided to you and the member
- Electronic Remittance Advice (ERA)
- Dental workshops
- Provider name listed in the directory
- Self-service tools accessible through Availity Essentials

Competitive Allowance Program (CAP)

- Annual contract update
- Provider contract is perpetual
- Approved by Board of Directors at BCBSKS
- Published/emailed August 1
- Quality Based Reimbursement Program (QBRP)
- Policy Memo Summary of Changes

2025 Reimbursement

- Aligned to continue RVU-based pricing
- Increase lower valued codes
- Maintain allowances for higher valued codes
- QBRP incentives
- Rural access incentive

Quality Based Reimbursement Program (QBRP)

Prerequisites:

- File claims electronically
- Sign up for electronic newsletters
- Receive remittances electronically/turn off paper
- Must be in good standing with BCBSKS

Applies to all eligible dental providers:

- BCBSKS CAP
- Dental PPO
- BCBSKS BlueCare Exclusive Provider Organization (EPO)

Does not apply to:

- Medicare Advantage (MA)
- FEP Blue Standard and FEP Blue Basic

QBRP – Groups 1 and 2

Group 1 (ESS & EPM): Applies to all eligible CDT and CPT codes Clinical lab and pharmaceutical services are excluded	
Electronic Self-service (ESS)	**ES3 – 2% (96% or greater)**
	ES2 – 1% (86% to 95%)
Electronic Provider Message Board (EPM)	**EPM – 1%**
Group 2 (PRD): Applies to all eligible CDT codes Clinical lab and pharmaceutical services are excluded	
Provider Portal Information (PRD)	**PRD – 3%**
Attest during each qualifying period outlined in CAP	
Individual provider level for all providers tied to the group contract	
Consolidated Appropriations Act (CAA)	Rolling 90-day attestation requirement
	Group and individual attestations are required

2026 Policy Memo Summary of Changes

Policy Memo Summary of updates can be found on our website

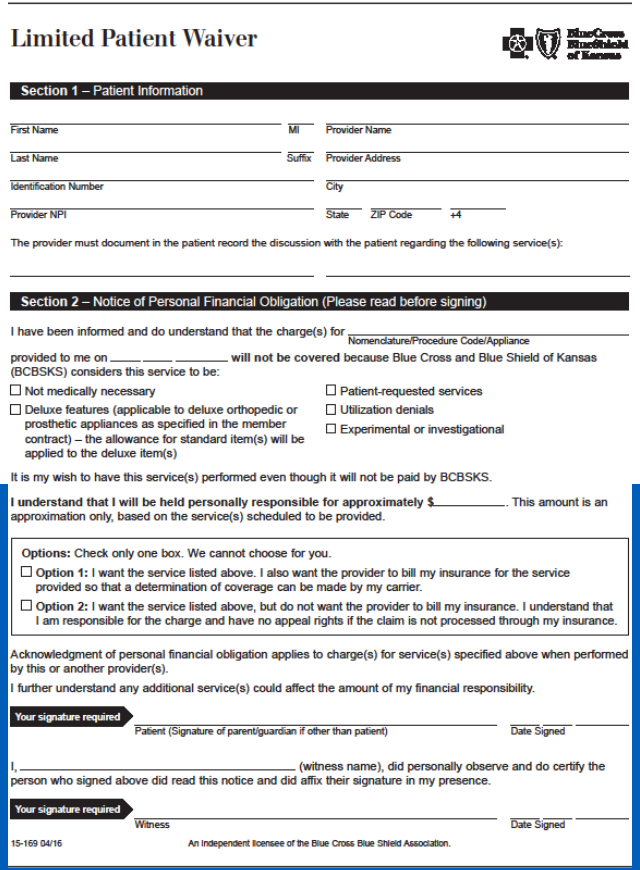
- Policy Memo No. 1
  - SECTION II. Retrospective Claim Reviews/Corrected Claim
  - SECTION IV. Utilization Review and Medical Necessity
  - SECTION X. Waiver Form
  - SECTION XI. Medical Records
  - SECTION X. Adverse Events

Content of Service

- Local anesthesia
- Impressions for prosthetics
- Materials and/or 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
    - Legal guardian of the person who received the service
    - Themselves
- There are several categories of services and procedures that are considered non-covered per member contract language.
    - These denials are billable to the member.



Limited Patient Waiver

Blue Cross Blue Shield 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-requested 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

15-169 04/16 An Independent licensee of the Blue Cross Blue Shield Association.

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.)

When not to use a waiver:

- Services considered content of service
- Balance billing: cannot be used to bill the patient the difference between the provider charge and the allowed amount (contractual obligation) – excluding deluxe services

Limited Patient Waiver cont.

Requirements of the waiver:

- Signed before services are started or rendered
- 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 (blanket waivers are not permitted)

Use modifier GA

Break

Documentation

- Abbreviations – must have a legend
- Must be legible
- Diagnosis and diagnosis 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 is considered the usual charge.
- Required to bill BCBSKS the same amount as the self-pay amount.

Are discounts acceptable?

- Yes, only if based upon an individual patient's situation and is documented as such
- Cash discounts are NOT allowed
- Collect only deductible, coinsurance, copay, or non-covered amounts at the time of service

Concierge/club services are not to be offered to BCBSKS members

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 financially 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 in the following situations:
    - Provider and substituting locum must be the same provider type
    - Locum tenens must be license in Kansas
    - Coverage can last no longer than a continuous 60-day period
- Billing:
    - Use the NPI of the provider for whom the locum tenens is substituting
    - Modifier Q6 is required
- Cannot use locum tenens coverage:
    - For a deceased provider
    - Cannot be used as credentialing substitute

Adverse Events

- The following adverse events are not billable to BCBSKS:
    - Surgery/procedure on the wrong tooth
    - Surgery/procedure on the wrong patient
    - Wrong surgery/procedure on a patient
- When one of these adverse events occurs:
    - No payment will be made to the provider for that error or the correction of that error
    - Patient shall be held financially harmless and may not be billed for the adverse event
    - Provider shall refund payments to BCBSKS made for an adverse event if a claim is filed in error

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 of their plan area
- Member ID cards
    - GRID = Dental PPO Maximum Allowable Payment (MAP)
    - GRID+ = BCBSKS MAP
- Troubleshooting
    - Active license
    - NPI change
    - EIN change
    - Contract status change

Claims Filing

- BCBSKS has a timely filing period of 15 months from the date of service
- Dental vs. Medical:
    - Services that fall under a patient's medical benefit can be filed on a current ADA J430C or CMS-1500 claim form
- BlueCard Claims (out of state BCBS members)
    - Out of state BCBS member services that fall under the member's dental policy should be submitted to the member's Home Plan
    - Out of state BCBS member services that fall under a member's medical policy should be submitted to BCBSKS
- Modifiers BCBSKS accepts:
    - GA modifier – waiver on file
    - Q6 – locum tenens provider used

Claims Filing Hints

Accident claims:

- 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

Corrected claim

- Box 35: Indicate resubmission code 7 and the original claim number

Void claim:

- Box 35: Indicate resubmission code 8 and the original claim number

Availity Essentials

Contact Availity Essentials for

- Registration (www.Availity.com)
- Password issues
- Changes/updates to Availity provider profile
    - TIN or NPI changes
    - Name or address changes
- Questions regarding other payers

Contact phone number:

- 1-800-Availity

Availity/Blue Access – BCBSKS

- Eligibility and benefits
- Claim status
- Blue Access (BCBSKS Provider Secure Section)
  - Patient ID search
  - Update/maintain provider information: 90-day attestation
  - Business Associate Agreement (BAA)
  - View/print remits
  - QBRP Earned Report
  - Message board
- Resources
  - Dental Manual
  - Coverage Summary
  - Dental newsletters
  - EFT form (enroll, change, term)

Remittance Advice

Claim Control Number breakdown

Example: 252400500001	
25	Electronic claim
24	Year received
005	Received on Jan. 5
0001	First claim in the sequence

Commonly used remark codes for dental services can be found at:

- https://x12/org/codes

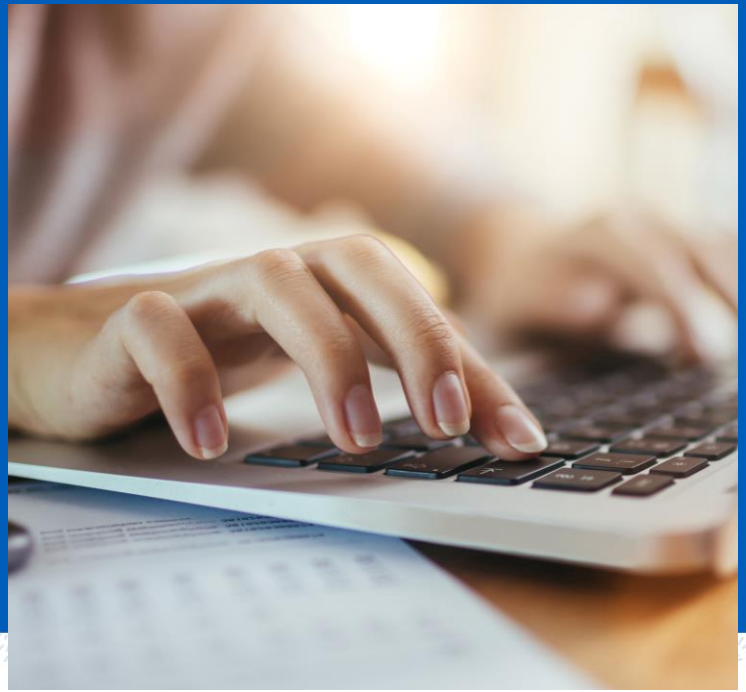
Healthcare code lists:

- Claim Adjustment Reason Codes (CARC)
- Remittance Advice Remark Codes (RARC)

Electronic Funds Transfer (EFT)

- Quicker access to payments by eliminating postal service transit delays
- Reduces the clinic's manual check processing efforts
- Sign up in Blue Access in *Forms* under the *Resources* tab
- Funds transferred will match the Remittance Advice (RA) total payment amount

Credentialing



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

Provider Add/Term/Address Change

- Provider Network Enrollment Request Form
    - Initiate request as soon as you become aware the provider is joining the group
    - Provider must have:
        - Current Kansas license
        - NPI
        - Certificate of liability insurance for Kansas services
    - CAQH must be current
- BCBSKS credentialing program
- BCBSKS does NOT backdate contract effective dates due to URAC requirements
- Provider Change of Information form (for terms and changes)

Break

General Exclusions

- Non-intravenous conscious sedation
- Cosmetic 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 dental plan options:

- FEP Blue Basic
- FEP Blue Standard
- FEP Blue Focus
- Blue Cross and Blue Shield FEP Dental

Blue Cross Blue Shield FEP Dental

- Part of the GRID+ network
- For patients without FEP medical, submit predeterminations and claims to:
    - BCBS FEP Dental Claims

      PO Box 75

      Minneapolis, MN 55440-0075
- For patients with FEP medical, submit claims to BCBSKS and we will coordinate with BCBSMN

Contact Information

www.bcbsfepdental.com

855-504-BLUE (2583)

Dental Coverage Summary

Table Includes					
CDT code	Policy name	Accident rider	Waiting periods	Associated medical policies	Coverage hints

Other Party Liability (OPL)

- Duplicate coverage from another insurance policy
- Workers' compensation
- Personal Injury Protection (PIP)
    - Auto no-fault coverage
- Coordination of Benefits (COB)
    - Orthodontics
- Group vs. non-group

Oral Sleep Apnea Appliances

Must use an in-network sleep lab

- If non-contracting lab is used, member must be held financially harmless
- Dental Policy Memo, section XIV

Use HCPCS code E0486 only – bundled/global code

- Includes appliance, fitting and adjustment of appliance
- Includes x-rays, AM aligners and impressions
- Includes 42-day global period for follow-up exams
- Do not use CDT codes for appliance, fitting or adjustments

- **Waiver is not applicable for sleep apnea services/appliances**
- **Cannot bill the member for the provider write-off amount (contractual obligation)**
- **Initial E/M should never be higher than level 3**
- **Follow up visits after the first 42 days global period are allowed if medically necessary**

TMJ Appliances

Occlusal orthotic device for diagnosis of TMJ

- D7880 (occlusal orthotic device, by report)
    - Includes device, impressions, treatment planning, fitting and subsequent adjustments within the first two weeks of placement
- Initial evaluation (low level)
- Imaging/diagnostic services (subject to medical necessity)

Follow up (after the first two weeks of placement)

- Subject to medical necessity (should be documented in the record)
- D0140 (limited exam, problem focused) for TMJ management with no adjustment
- D7881 (occlusal device adjustment) for TMJ management with adjustment

TMJ Appliances Cont.

Non-billable services

- CPT 97763 should not be billed for TMJ appliance adjustment.
- Pre-planned follow-up visits with no patient chief complaint are not billable.
- Orthodontic treatment/devices used for the purpose of moving teeth are considered “experimental/investigational” for a diagnosis of TMJ. They should never be billed using TMJ occlusal orthotic device codes.

Medical policy for TMJ

- https://www.bcbsks.com/medical-policies/temporomandibular-joint-tmj-disorder

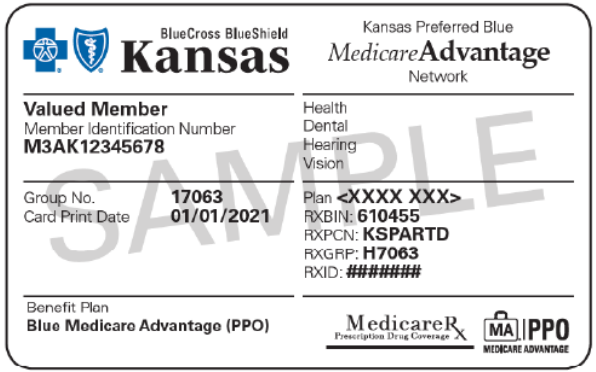
Lucky Strikes

- Orthodontic billing
- Cone beam imaging (CBT)
    - https://www.bcbsks.com/medical-policies/cone-beam-computed-tomography-cbct
- Front teeth knocked out because of an accident
    - Will deny unless pre-accident x-rays accompany the claim
- Panos and full mouth x-rays are not covered on the same date of service

Blue Medicare Advantage Dental

Kansas Blue Medicare Advantage (MA) Dental Network

- Same CAP allowances (fee schedule)
- No PPO reduction
- Serve Kansans through all stages of their lives
- Simple opt-in process



2025 MA Dental Coverage

Embedded preventive + minor comprehensive services on all plans

Blue Medicare Advantage plans include the following embedded routine dental coverage:

Preventive Dental Services	Comprehensive Dental Services
Routine cleanings (up to two every year)	Restorative
Bitewing x-rays (up to two every year)	Endodontics
Oral exams (up to two every year)	Periodontics
	Extractions
	Prosthodontics and oral/maxillofacial services

Reference Evidence of Coverage, Availity, or contact customer service for additional detail on covered comprehensive services / limitations.

MA Claims and contracts

Electronic Claim Submission:

Send electronic claims to ASK-EDI using BCBSKS payor ID 47163

Paper Claim Submission – Mail to:

Dominion National ATTN: BCBSKS
PO Box 211424
Eagan, MN 55121

Who to contact?

MA provider services at 800-240-0577

BlueMA Dental Member Eligibility and Benefit Inquiries

SUBMIT AN INQUIRY
Once logged into Availity:

1. Select **Payor Spaces**

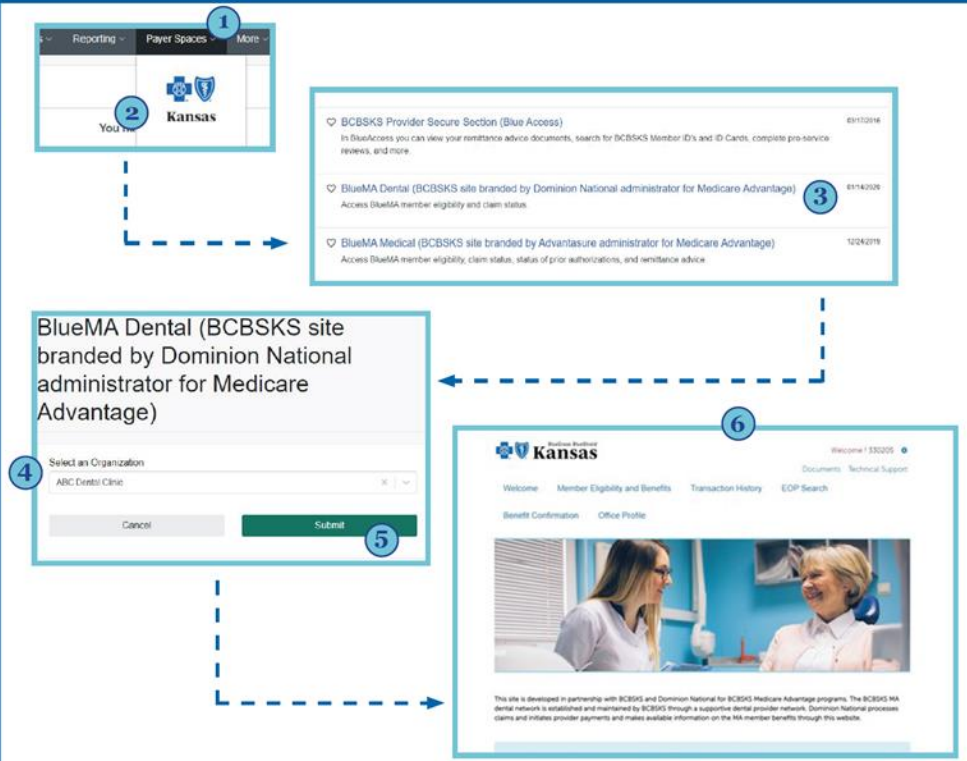
2. Select **Blue Cross and Blue Shield of Kansas**

3. Select **BlueMA Dental (BCBSKS site branded by Dominion National administrator for Medicare Advantage)**

4. Select **Organization** from drop-down menu

5. Select **Submit**

6. You have arrived at the Dominion National sef-service portal



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BlueMA Member Eligibility & Benefits Inquiry

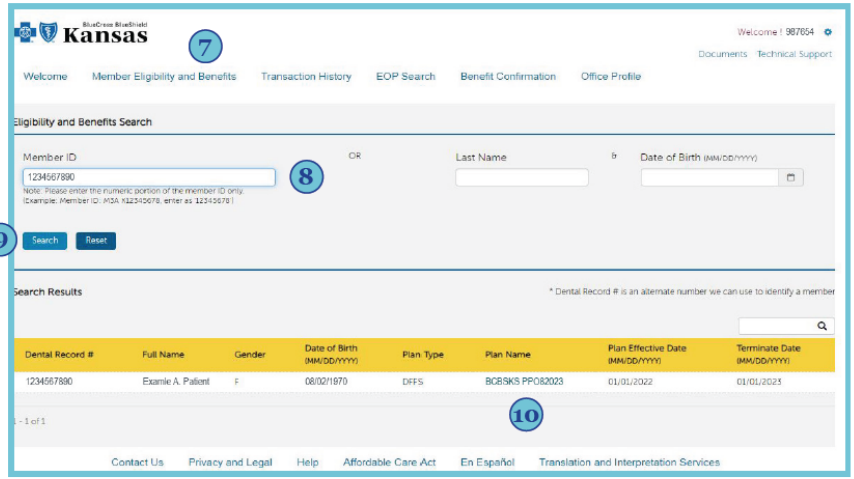
Member Eligibility & Benefits

7. Select **Member Eligibility and Benefits** header

8. Enter **Member ID or Last Name & Date of Birth** (search by numeric portion of the member ID only)

9. Select **Search**

10. Select the **Plan Name displayed** and member beneift details will open



BlueCross BlueShield Kansas

BlueMA Benefit Confirmation Inquiry

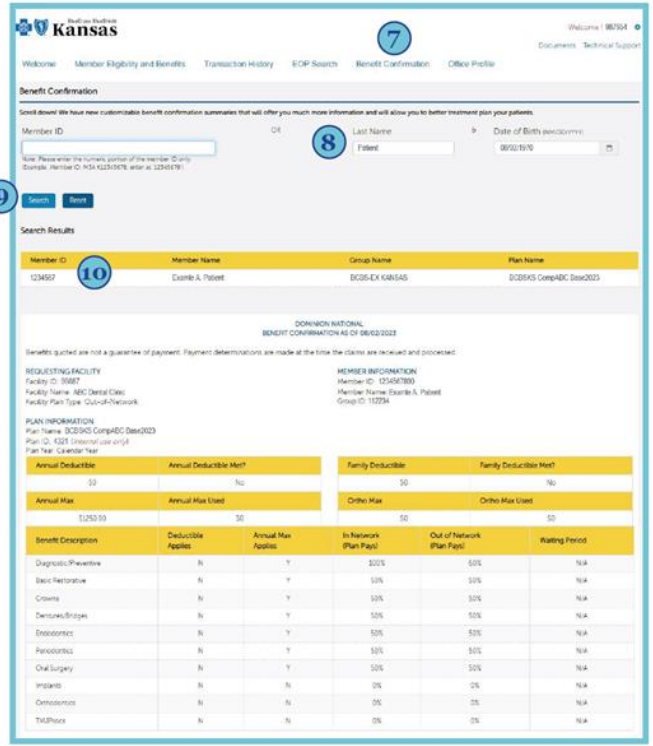
Benefit Confirmation

7. Select **Benefit Confirmation** header

8. Enter **Last Name & Date of Birth**

9. Select **Search**

10. Select the **Member ID number displayed** and benefit details will appear at the bottom of the page



BlueCross BlueShield Kansas

Thank you for being a BCBSKS contracting provider

Questions?

bcbsks.com

Provider Network Solutions

Provider Relations