Blue Cross Blue Shield of Michigan Dental Provider Manual

Rev. 12/2023

I. Introduction to Blue Dental

Our history

Since 1976, Blue Cross Blue Shield of Michigan has had dental coverage available as a benefit. This guide will assist dentists with billing and documentation. We pay for necessary dental services provided to our eligible members if all coverage, contract and provider requirements are met.

PPO (in-network) vs. non-PPO (out-of-network) dentists

We pay for covered services provided by both PPO (in-network) and non-PPO (out-of-network) providers. We have provided information about participating with us below.

II. Provider participation

Overview

Our payment for dental services is based on the parameters of the dental plan chosen by the group or member and by the dentist's participation status with Blue Cross Blue Shield of Michigan. Dentists can participate with us by signing a contract with one of the networks in the Blue Dental PPO network or on a per-claim basis. They can confirm their participation status on www.mibluedentist.com or by calling dental servicing at 1-888-826-8152.

Blue Cross uses three main vendors to help us administer our business:

1. DentaQuest provides administrative support for our claims processing.
2. United Concordia Company Inc. is our primary network partner and network administrator of the Blue Dental PPO network. UCCI is responsible for credentialing and network data maintenance.
3. DenteMax is our network partner for Medicare Advantage and Federal Employee Program plans.

Blue Cross offers several different networks for providers like you to join. We have:

Tier 1 contracted PPO networks

- Blue Dental PPO
- Medicare and BCN Advantage (Medicare Plus Blue PPO & BCN Advantage)
- Federal Employee Program®

Tier 2 per-claim arrangement

Per-claim (also known as Blue Par Select) participation for dentists who want the option to accept Blue Cross reimbursement claim by claim.

We believe there are advantages to joining our Tier 1 network or Tier 2 per-claim arrangement:

- You will be listed on our Find a Dentist tool if you are a Tier 1 provider or if you are a Tier 2 provider who has participated with us 100% of the time within the last rolling 12 months. The tool is for employers and individuals who have purchased our dental plans. This makes it easier for our members and your potential future patients to find a dentist in their area.
- Members are shopping for savings. If you participate with us, members have the peace of mind knowing you won't bill them for the difference between the billed amount and the Blue Cross approved amount for each procedure.

Blue Dental PPO

United Concordia Company Inc. is Blue Cross' primary network administrator for the Blue Dental PPO network. The Blue Dental PPO network is a unique combination of several dental networks partnered with UCCI.

If you would like to join our Tier 1 Blue Dental PPO network, you must meet the requirements established by UCCI and go through the credentialing process. For more information or to request an application, call them at 1-800-307-8514.

The Blue Dental PPO network is used for commercial, individual and Medicare supplement/Medigap plans.

Federal Employee Program and Medicare Advantage plans (Medicare Plus Blue PPO and BCN Advantage)

DenteMax manages our dental networks for our Federal Employee Program and Medicare Advantage plans. To join the network for these plans, call DenteMax at 1-800-752-1547 or go to www.dentemax.com/dentists.

Payment

Our payment is based on the class or level of service in the member's benefit plan. For more information on the classes of dental services, see *Section V. What's covered: General information*.

Dentists who belong to the networks referenced above participate on all claims and agree to accept the contracted fee schedules of these networks. They also have access to exclusive savings on various dental practice products and services with respected industry leaders. Go to www.UnitedConcordia.com/dental-insurance/dentist/discounts/ for more information.

Participation requirements

Participation in our dental programs means you will follow the requirements below when billing us for services provided to our members. These requirements apply whether you are in the Blue Dental PPO (Commercial and Medicare Supplement) network, the Federal Employee Program network, the Blue Cross Medicare Advantage network or you choose to participate on a per-claim basis.

You're required to:

- Submit claims in accordance with the terms of the member's contract, published billing guidelines and applicable laws.
- Prepare and maintain all appropriate records for members receiving services and prepare, keep and maintain records in accordance with our existing record-keeping and documentation requirements.
- Release information and records to us or our designee that include, but aren't limited to, copies of treatment records, duplicate X-rays and other documents relative to the care and treatment of our members as needed for prospective and retrospective reviews.
- Follow our policies and procedures regarding prepayment and utilization reviews and quality assessment or other programs established by us.
- Allow us or our designee access to your premises to review, photocopy and audit your records for Blue Cross plan members.
- Require your designated billing agent to follow the requirements above.

If you have the member assign their benefits to you and sign box 37 on the ADA claim form, you are participating on the claim. Complete billing instructions are in *Section IX. Claims – Filing*.

If the patient elects to have services performed that are other than those allowed by Blue Cross, be sure to get the patient's signature of agreement for your records.
Our payment to the dentist or member is the lesser of submitted charges or our maximum allowed amount. Participating Tier 1 and Tier 2 dentists can bill members for:

- Applicable deductibles and coinsurance

- Amounts exceeding benefit maximums
- Member-authorized alternate treatments
- Noncovered services

Additional requirements for non-PPO dentists

Non-PPO dentists can participate with Blue Cross on a per-claim basis. The back of our checks (or EFT assignment) outline per-claim participation agreement terms. We pay Tier 2 participating non-PPO (out-of-network) dentists directly. Per-claim participation is also known as our Blue Par Select™ arrangement.

To participate on a claim as a Tier 2 dentist, simply submit the claim (through the provider portal, mail, or clearinghouse) indicating that Blue Cross should pay you directly for covered services. No additional paperwork is required to be setup with Blue Cross as a per-claim participating, Tier 2, dentist. For claim submission information, please see here.

When you choose to participate on a per-claim basis:

- Have the patient assign benefits to you, either by signing the form you provide to new patients or by signing the current American Dental Association claim form under Box 37.
    - Either way, Box 37 must be signed if you want to participate with us on the claim and have the checks sent to your office.
- We will send payment directly to you.
- You may not bill the patient for charges that exceed our approved amount for covered services.
- You agree to accept our payment as full reimbursement, except for any coinsurance, deductibles or charges for elective services (such as cosmetic procedures) the member selects.
- This is our per-claim arrangement with you as a provider and serves as our agreement for billing our members.

When you receive the payments, you'll see the following language on the checks:

FOR PROVIDERS ONLY (Does not apply to member payments) I agree that receipt of BCBSM's payment constitutes my agreement to accept it as full payment for these services and to bill the subscriber only for applicable copayments and deductibles. I also agree to comply with all BCBSM's policies and agree to permit BCBSM access to all records pertaining to this patient for audit purposes. I understand that if I fail to comply with these policies, BCBSM reserves the right to send payment directly to the member for any and all future claims.

Your participation decision is final for each claim. Once a claim has been submitted and processed, you can't resubmit the claim to change the payment direction for the services billed.

How you participate with us determines where we send the payment:

- If you choose to participate on a per-claim basis, you get paid directly from Blue Cross. Your portion of payment is based on approved fees for participation.
- If you are a nonparticipating dentist, we pay the patient directly.

Choosing not to participate

If you're not participating at all with Blue Cross, tell the patient before providing services and follow these steps:

- The patient pays for the services provided.
- You may bill the patient for charges that exceed our approved amount.
- Leave Box 37 on the current American Dental Association claim form blank or, if you are submitting a claim on the provider portal, make sure you select "Pay member" designation.
- Once we receive the claims from you, we pay the patient directly for covered services received up to our approved amount or your charge, whichever is less.

Changes to your personal information

In-network providers

Promptly notify your contracted network and Blue Cross of changes to your specialty, board certification status, federal tax ID, telephone number or address by contacting them directly.

Out-of-network providers

Promptly notify us of changes to your specialty, board certification status, federal tax ID, telephone number or address by calling 1-888-826-8152. Alternately, you can fill out a Provider Update Form at dentaquest.com/content/dam/dentaquest/en/providers/resources/standard-updates-form.pdf, email it to Standardupdates@greatdentalplans.com or fax it to 262-241-4077.

Medical-surgical services

When you use the CMS-1500 claim to bill for medical-surgical services, you can participate on a per-claim basis. If the dentist doesn't have a medical PIN, we'll pay the subscriber.

Departicipation

We have the right to end a dentist's participation with us. When this occurs, we send payment for subsequent dental services to the member. Departicipation may occur for any of the following (but isn't limited to these) reasons:

If providers:

- Have any felony conviction or misdemeanor involving Blue Cross Blue Shield of Michigan, Medicare, Medicaid or other health care insurers
- Have terminated or suspended licensure, certification, registration or accreditation in Michigan
- Continue to be noncompliant in their reporting after documented notification
- Continue to bill Blue Dental patients amounts in excess of deductibles, coinsurance, alternate benefits or benefit maximums after notification
- Fail to document dental-medical necessity on 50% or more of the services billed to us upon an audit
- Prescribe or dispense controlled substances for other than therapeutic reasons
- Demonstrate a pattern of billing for services that aren't provided or aren't medically or dentally necessary
- Refuse access to records that are deemed essential for us to determine our liability
- Entice patients to receive services through the use of work slips, prescriptions or money

- Advertise free services, then bill us for additional services that aren't medically or dentally necessary
- Owe Blue Cross refunds in excess of $100,000
- Violate local, state or federal regulations, laws or codes

Applicable laws

The laws that may affect you with respect to your dental practice are:

Law	Description
The Health Care False Claims Act of 1984	Pertains to fraudulent acts against third-party insurers
The Truth-in-Lending Law	Identifies the possession of a stolen Blue Cross identification card as a crime

To ensure compliance with these laws, we suggest you:

- Report only services you have personally performed or directly supervised.
- Report services under the tax ID assigned to you. Never let another dentist use your individual tax ID.
- If you are in a group practice, don't allow any dentist not listed under your group tax ID to submit claims.
- Include the patient's name and the location and date of service on each claim.
- Check a patient's personal identification when checking a new patient's Blue Cross member ID card.

III. Eligibility and coverage

The identification card

All Blue Cross members have identification cards. However, the ID card alone isn't a guarantee [illegible]nt has dental benefits, because not all Blue Cross plans provide dental coverage.

- The ID card contains the name of the contract holder, called the subscriber. Family members included on the subscriber's contract are also eligible to receive covered services. The card also contains the enrollee ID. Don't use the three alphanumeric characters at the beginning of the ID number when making inquiries.
- You must use the 9-digit enrollee ID (again, do not use the three alphanumeric characters at the beginning of the ID number) and the member's date of birth to verify eligibility. The member's Social Security number can't be used to verify eligibility.
- A Blue Dental logo identifier is included on the ID card for most members who have dental coverage. The back of the ID card will include subscriber and provider dental inquiry phone numbers.

Verifying member eligibility

We have two options for verifying your patient's eligibility and checking available dental benefits: our provider web portal or our interactive voice response customer service system.

Provider web portal:

We encourage all dental providers to use our provider portal for easy access to claims and member eligibility information.

You must register for an account with your TIN, NPI and office ZIP code. The provider web portal will guide you

through the registration process. A user ID and password are automatically assigned once you have completed the online registration process. Only one ID and password are needed for a TIN. All users at your practice sign in under the same user ID and password.

To sign up for access to the provider web portal

1. Go to http://provideraccess.dentaquest.com.
2. Begin the self-registration process by clicking on ***"I don't have an account yet."***
3. Dentists must first be enrolled with Blue Cross before they can submit claims for payment and receive information from our provider portal about claims or member eligibility.

Use the provider web portal online access to:

- Verify Blue Dental member eligibility.
- Check member benefits.
- Submit claims.
- Submit prior authorization requests.
- View explanation of benefits.

The provider portal provides HIPAA compliant transactions. There's no special software needed; simply log in to http://provideraccess.dentaquest.com to get started. All Blue Cross member transactions are free of charge for providers.

Don't have an NPI number yet?

Apply today by using one of the following options: Email: customerservice@npienumerator.com Call: 1-800-465-3203; NPI TTY: 1-800-692-2326

Mail: NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059

Interactive voice response customer service systems

- For Medicare Advantage program patients, call 1-844-876-7917.
- For Federal Employee program patients, call 1-800-840-4505.
- For all other customer service inquiries, call 1-888-826-8152.

If your question can't be answered by the system, you connect to a customer service representative. Contacting Dental Inquiry may help with questions about eligibility, benefits, coinsurance, deductibles and claim status.

Member coverage guidelines

Blue Cross dental coverage varies by contract. If there is a difference between what is described in this guide and what is stated in the member's contract, the information in the contract applies.

For each member (your patient), we pay up to a maximum dollar limit for covered services each benefit year, which isn't always based upon a calendar year. Payments for all covered services are subject to the member's benefit year maximum or lifetime maximum. To be payable, dental services must meet these criteria:

- Services must be considered dentally necessary according to generally accepted standards of care and patterns of dental practice.
- Covered services must follow the member's contract terms.

- Prerequisites we apply to general claims processing must be satisfied (such as eligibility, benefit renewal restrictions and age limitations).

A member may have significant financial liability for certain dental treatments. Please review and discuss the types of services available with the member prior to treatment so the member is aware of his or her responsibility for part or all of the cost. Some dental services may not be approved based on dental criteria or the member's Blue Dental plan. However, alternative services may be payable. For example, we may pay for amalgam or resin restorations rather than crowns or inlays.

Our dental programs

Blue Dental Commercial

Benefits vary by member's contract for both employer sponsored and individual commercial plans. Please check the portal before accepting or declining their eligibility for care. Blue Dental commercial plans use our Tier 1 Blue Dental PPO network.

Medicare Supplement plans (also known as Medigap)

Medicare supplement plans (Medigap) are sold as an addition to Original Medicare. These plans help pay for costs that Original Medicare doesn't cover, like deductibles, copays and coinsurance.

Blue Cross Medicare supplement members have the option to purchase a separate *Dental Vision Hearing (DVH) Package. Dental services included in the DVH package* are cleanings, X-rays, fluoride, brush biopsies, root canals, crowns and simple extractions.

This plan has in-network and out-of-network coverage. Our Blue Dental PPO network is used for this product (*the same network as the commercial plans*). Please check the provider portal to confirm the plan and member eligibility.

Exclusive provider organization, or EPO

Members with an EPO plan must see an in-network dentist in order to receive coverage. If you aren't in our PPO network the EPO plan member will be responsible for all charges.

Medicare Advantage

Effective January 1, 2023, both Medicare Plus Blue PPO and BCN Advantage plans have the same dental services included in their plan. Members can also purchase extra coverage called Optional Supplemental Benefits (also known as a buy-up).

All Medicare Plus Blue PPO plans have in and out of network coverage. All BCN Advantage plans have in and out of network coverage except for the specific plans called Connected Care and Local.

For in-network coverage, Medicare Advantage uses the *Medicare Advantage network*. Please check the provider portal for member eligibility.

For more information about Medicare Advantage terms and conditions through Blue Cross, please refer to the Medicare Advantage information at www.bcbsm.com/ma.

1. Medicare Plus Blue PPOSM

Services included in the Medicare Advantage plans include:

- Two oral exams every year
- Two routine cleanings every year
- One set of bitewing X-rays (up to four) or up to six periapical films (not both) once every two years

- Fluoride
- Fillings
- Crowns and crown repairs
- Root canals
- Deep cleaning
- Extractions
- Oral Surgery

Services included in the buy-up package (Optional Supplemental Benefits) include:

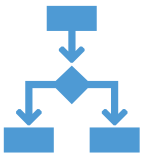
- Onlays
- Periodontics
- Dentures and Bridges *(including adjustments, repairs, relines and rebase)*
- Implants
- Anesthesia

Federal Employee Program Dental

We administer two dental plan options for federal government employees – the basic option and the standard option.

The basic option plan provides benefits only when the member receives services from a DenteMax network provider, the PPO dental network Blue Cross uses to service FEP members. Standard option members can seek treatment from any licensed dentist. The payment amount is based upon a set fee schedule, and dentists can bill the member for the balance owed.

Coordination of benefits



If a Blue Cross member is also covered under another group dental plan, we'll coordinate benefits. COB determines the payable amounts and the order in which services or treatments should be paid. The amounts paid by the plans won't exceed 100% of the total expenses.

In most cases, we ask subscribers if they have any coverage under another group plan before we pay claims. We need to know whether Blue Cross is the primary or the secondary payer. The primary plan pays benefits first.

The information in this section provides our standard procedure for processing COB claims. Some groups may elect a different process.

In COB cases, we review prior authorization requests only when we are the patient's primary insurer. If another insurer is primary, we can't determine our payment because it's based on the primary insurer's actual payment amount.

We won't process a pre-determination request pending the other insurer's payment. (See Coordination of benefits, or COB, for more information.)

General COB rules:

- The plan covering the patient as an active employee or retiree provides benefits before the plan covering the patient as a dependent. For example, if your patient has Blue Cross coverage through his or her employer and is also covered by another plan as part of the spouse's coverage, Blue Cross is the primary plan. The other plan considers additional payment after we've made our payment.

- If your patient has two Blue Cross plans, one as an active employee and one as a retiree, the active employee plan is primary.
- If a patient has two active plans, the plan where the patient has been employed the longest is primary.

When there are dependent children:

If…	Then…
The parents have separate health plans and are married or living together.	The plan of the parent whose birthday falls earlier in the calendar year covers the children first.
The parents are divorced, separated or not living together.	Ask if there is a court order specifying who has primary responsibility for children. If no court order exists, the custodial parent is primary.

Overview of how COB works:

1. Once you receive all coverage information for a patient, determine the primary and secondary payers. Since the primary payer considers a claim first and pays the full amount allowed by the subscriber's contract, bill the primary payer first. Treat this claim as you do other claims. If we're the primary plan, we'll process the claim as usual.
2. If there's a balance after the primary plan has paid, send the secondary plan a secondary balance claim. Attach a copy of the voucher with information on how much you received from the primary plan. The combined payments of both primary and secondary carriers won't exceed the maximum allowed amount for services.
3. When you submit a claim under one Blue Cross contract and our records also show coverage under another Blue Cross contract, we first pay under the primary contract. At that point, we consider payment as the secondary payer under the secondary contract. See COB billing guidelines in section **IX. Claims filing**.

IV. Predetermination

Pre-Determination, is the review of a member's coverage before treatment begins to determine probable Blue Cross payment.

Prior authorization results don't imply any judgment on how beneficial or desirable a given service may be. They reflect only our determination of what's payable under the terms of your patient's contract. The prior authorization process is voluntary and doesn't guarantee payment.

Predetermination:

- Allows you to know in advance whether a proposed service is covered
- Allows your patients to know their financial liability in advance (not applicable to Medicare Advantage plans)
- Allows your patients to make an informed decision before service starts

You may submit a request for predetermination:

- For costly non-urgent services
- For complex procedures such as crowns, onlays, veneers, bridges or complete or partial dentures
- If you or the patient want a payment determination in advance

- If the need for treatment isn't evident in preoperative X-rays (the dental condition can be seen during examination but isn't visible on an X-ray). Note: In such a case, if treatment isn't approved in advance, we may reduce our payment or approve an alternate treatment

Predetermination isn't necessary in these cases:

- Services costing less than $200
- Routine oral exams
- Cleanings (prophylaxes)
- Fluoride treatment
- X-rays
- Routine extractions and fillings
- Root canal treatment

To request predetermination:

1. Submit a 2006 or newer ADA claim form by mail or electronically. Make sure to mark the "Dentist's pretreatment estimate" box in field 1 with an "X" if submitting paper claims.
2. Mail the claim with the treatment plan to:

   Blue Cross Blue Shield of Michigan
   P.O. Box 49
   Detroit, MI 48231
3. **If we request X-rays,** send the predetermination request and duplicate (or digital X-rays. Don't send original X-rays. Refer to section **VI. What's Covered: Frequently** used procedures to verify dental records required for submission. Use the following procedure when mailing copies of the X-rays:
   a. Mount full mouth X-rays.
   b. Label the X-rays with the following information:
      i. Patient's name
      ii. Contract number
      iii. Date X-rays were taken
      iv. "Left" or "right"
      v. Dentist's name and address
      vi. Dentist's tax identification number
   c. Place the X-rays in a secure radiographic mount or coin envelope. If there are multiple claims with X-rays, place X-rays corresponding with each claim in separate coin envelopes.
4. Mail the claim with the X-rays to:

   Blue Cross Blue Shield of Michigan
   P.O. Box 49
   Detroit, MI 48231

Blue Cross policy isn't to return X-rays to your office. Any X-rays you send us will be destroyed after they are imaged to become part of the permanent claim record. As per American Dental Association guidelines, you should keep original X-rays and send duplicates for procedures if we request them.

Payment determination

If…	Then…
The proposed procedure is a benefit and is the only possible treatment according to accepted standards of dental practice and meets medical necessity criteria.	We'll approve payment for the procedure.
The proposed procedure isn't the only possible treatment.	We'll approve the payment amount of the least costly treatment.
The patient decides to have the more costly procedure when there is more than one possible treatment.	The patient is responsible for the non-covered amount.
We don't approve any payment for the proposed procedure.	The patient may still decide to have the procedure and accept full responsibility for the entire payment.
The patient's dental coverage expires before services are performed.	There will be no payment because the contract is no longer in effect.
The patient's annual or lifetime maximum dental benefits are exhausted before the predetermined services are performed and billed.	Our payment, if any, may be different from what's originally determined.

Additional pre-determination procedures

If the information we received from you isn't clear or something is missing, you'll receive the appropriate rejection notice asking for additional information.

Blue Cross will send you and the patient a letter showing our prior authorization decision and estimated payment amount. Note: Medicare Advantage predeterminations don't explain estimated costs, they only indicate if a service is covered or not covered.

Predetermination approval notices are valid for 365 days from the date of issue. If the services aren't completed during that time, request predetermination again if you still want a determination before you perform the service.

The current and correct ADA dental claim form can be used to submit both completed services and prior authorization of treatment plans. However, don't include services for prior authorization and completed services on the same form.

Billing guidelines for pre-determination services

It's important to verify the member's current ID using the most recent Blue Cross ID card. The member may have been issued a new plan number and new ID card since the original issue date of the prior authorization. Don't use the member's Social Security number on the claim.

When you send the ADA claim form for payment, we'll recheck the procedures to determine if time, frequency and benefit maximum limits or other conditions and requirements of the member's contract have been met. Also, there may be a situation — such as an audit — where a treatment plan submitted for predetermination was approved, but we determine later that it didn't meet Blue Cross criteria. If that occurs, Blue Cross can recover the amount paid for services up to two years from the payment date. In cases involving fraud, there is no time limit for payment recovery.

If you don't receive a payment or notice of nonpayment within 45 days of filing the claim, call:

Blue Dental customer service at 1-888-826-8152 Medicare Advantage at 1-844-876-7917.
Federal Employee Program at 1-855-504-2583 Healthy Kids Dental at 1-855-504-2583

V. What's covered: General information

In this section, we describe the services covered under our dental plans. To be payable, services must be:

- Covered and available under the patient's dental plan on the day of the service
- Considered dentally necessary and appropriate according to generally accepted standards of care and patterns of dental practice
- Billed on the date of tooth preparation for cast restorations (such as crowns) and fixed prosthetics (bridges), and on the date of the final impression for removable prosthetics (dentures)
- Billed on the date the tooth was opened for root canal procedures

Dentists should be aware they have an ethical and legal obligation to refund fees for services that are paid in advance but not completed.

A service must be dentally necessary and appropriate according to generally accepted standards and patterns of dental practice to be covered. Dental necessity is determined by dental consultants acting on behalf of Blue Cross, based on developed criteria and guidelines.

- The covered service is accepted as necessary and appropriate for the patient's condition. It isn't mainly for the convenience of the member or dentist.
- Covered services are subject to certain restrictions based on:
  - Policies consistent with generally accepted standards of dental practice
  - Those specific contracts that only pay for the least expensive acceptable treatment
- In the case of diagnostic testing, the results are essential to and are used in diagnosis or management of the patient's condition.

Note: In the absence of established criteria, dental necessity will be determined according to accepted standards and practices by dentists acting on behalf of Blue Cross or the Blue Cross dental director.

Payment guidelines

We pay a percentage or the entire approved fee for covered services, based on the group's contract and subject to benefit period or lifetime maximum limitations. Our approved amount is either the dentist's charge or our approved amount, whichever is less.

Limitations on dental benefits exist because the member's employer determines:

- The member's benefit plan
- The services to be covered, benefit levels, frequencies, time limits and special processing policies

Also, covered services are restricted because of contracts that call for the least expensive, acceptable treatment. We pay for services based on what's specified in the member's contract.

Because of benefit limitations, it's important to predetermine services when you have questions about applicable benefits, benefit levels, time limits or frequencies. (See section **IV. Predetermination**.)

Please refer to section **VI. What's Covered**: Frequently used procedures to verify dental records required for submission. If requested records aren't submitted, you'll receive a nonpayment message asking you to resubmit with the required records.

For payment consideration, send a new claim, X-rays and other supporting documentation to:

Blue Cross Blue Shield of Michigan
P.O. Box 49
Detroit, MI 48231

Your X-rays and photographs won't be returned. Please send duplicate copies of documentation when required for certain services. As per American Dental Association guidelines, original X-rays and other documentation should remain in your office.

Procedures covered under a patient's medical plan aren't payable under the patient's Blue Dental plan. For specific dental services payable under the medical-surgical benefit, see section VII. If the procedure submitted can be covered under the member's medical plan, you'll receive a processing policy non-payment message code 2390 or 2399.

2390 – this procedure(s) is covered under the patient's medical plan and has been forwarded to the appropriate medical department at BCBSM for processing

2399 – this procedure(s) has been denied. It is not covered under your dental plan. Please submit this procedure to your medical plan for possible coverage.

Classes of services

There are four basic categories or classes of dental services. Employers purchase dental benefits according to the procedures assigned to each class. The classes define the types of services available in a member's contract.

Particular services may be added to the classes of services. For example, a group may request that some diagnostic services be covered under ***Class II*** or that major restorative services be covered under ***Class III***. This is called reclassification.

The benefit information on the following pages is organized according to standard classes of dental services.

Class I	Diagnostic & Preventive	Diagnostic, preventive, emergency and palliative services*
Class II	Basic	Restorative services* Endodontic services* Periodontic services* Basic prosthodontic services* (adjustments and repairs of bridges and relining of dentures and bridges)
Class III	Major	Prosthodontic services (construction and replacement of dentures and bridges) Implants
Class IV	Orthodontic	Orthodontic services

**These services are contract-specific and can be reclassified.*

Note: Even when services, treatments and procedures meet the requirements of the classes of dental services, they're payable only if they're covered and available under the patient's contract.

Class I — Diagnostic services: examinations, X-rays and tests

Diagnostic services are those performed by a dentist to note the extent of dental disease or injury and to determine the treatment required. Diagnostic services include examinations, X-rays and tests. Below are lists explaining covered and non-covered exams, X-rays and tests.

Covered examinations

- Clinical oral examinations and evaluations for the purpose of routine checkup, specialized treatment or emergency
- Periodic oral evaluations, usually two times per benefit year
- A comprehensive evaluation once per dentist or dental office every five years. Additional examinations or evaluations are considered periodic and are paid as such
- Problem-focused oral evaluations for the diagnosis of an emergency condition. Miscellaneous tests, such as pulp tests, are considered part of the examination
- Consultations by a second dentist

Covered X-rays

- A set of bitewing X-rays (a maximum of four films) two times per benefit year*
- A full-mouth series of radiographs that includes bitewings and 10 or more periapical films taken on the same day, once in a 60-month period.* A panoramic X-ray with or without bitewings is considered a full-mouth series
- A pedodontic full-mouth series that includes two bitewings and up to six periapical films

Non-covered X-rays

- More than one full-mouth radiographic series or panoramic film in a 60-month period*
- Posterior, anterior or lateral skull and facial bone survey films or cone beam CT scans
- Temporomandibular joint film and arthrograms
- Duplication of X-rays for administrative or other purposes
- X-rays that aren't of diagnostic quality

Covered tests

- Pulp tests, once per visit, no matter how many teeth are evaluated when done with no other services
- Diagnostic study models once in a 60-month period per dentist
- Brush biopsy

Non-covered tests

- Pulp tests done as part of an examination or evaluation
- Sialography
- Imaging of any type
- Bacteriologic studies for determination of pathologic agents
- Diagnostic photographs*
- Histopathologic examination
- Mounted case analysis

**Contract-specific benefit*

Class I — Preventive services: cleanings, fluoride treatments, sealants and space maintainers

Preventive services are performed by a dentist or a licensed dental hygienist, under the supervision of a dentist, to prevent oral disease or to stop the progression of disease already present. Preventive services include:

- Dental prophylaxes (cleanings)
- Fluoride treatments
- Sealants
- Space maintainers

Prophylaxes

These cleanings are covered with some limitations:

- Prophylaxes to remove plaque, calculus and stains from exposed and non-exposed tooth surfaces by scaling and polishing are usually covered twice in a benefit year.
- A third or fourth prophylaxis in a benefit year — if the group has purchased a special rider to cover it — following any of these four procedures:
    - Gingivectomy or gingivoplasty, per quadrant
    - Gingival flap procedure, including root planing, per quadrant
    - Osseous surgery, including flap entry and closure, per quadrant
    - Periodontal scaling and root planing, per quadrant

For billing purposes, members 11 years old and younger are considered children.

Fluoride treatments

Fluoride treatments are payable but must be necessary and appropriate according to accepted dental standards. Age and frequency limitations for fluoride treatments are contract-specific.

Sealants

Sealants are applied to tooth enamel to prevent decay.

Covered sealants

- Tooth must be free of restorations
- On first and second permanent molars only
- For patients through the age of 19*
- Once every three years on designated teeth
- On the occlusal, buccal and lingual surfaces of teeth
- Only one sealant per tooth, regardless of the number of surfaces

**Contract specific*

Non-covered sealants

- Sealants as restorations (amalgams, composites or resins)
- Preventive or plaque-control programs with or without microbial testing, dietary counseling and associated products such as an electric toothbrush or mechanical rinsing device
- Sealant on primary teeth
- Sealants on permanent teeth other than first and second molars

Space maintainers

Space maintainers prevent teeth from moving into space left by a lost primary tooth. They are classified as either fixed or removable.

Covered space maintainer services

- For posterior primary teeth only
- Only one per quadrant
- Recementation three times per quadrant per lifetime

Non-covered space maintainer services

- For primary anterior teeth
- Done in conjunction with orthodontic treatment
- Replacement of damaged, lost or stolen appliances

Class I — Emergency palliative treatment

Emergency palliative treatment is emergency treatment for temporary relief of dental pain or discomfort and may not constitute a permanent cure. We pay for pain treatment:

- On a per-visit basis, once on the same day
- If there is documentation of diagnosis, necessity and treatment provided
- For minor procedures when no other treatment, except for limited X-rays, is provided on the same date of service

Class II — Restorative services: fillings

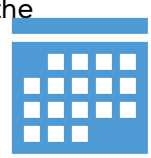
Restorative fillings are services provided to restore teeth with amalgam, resin-based composite or similar filling materials.

Covered fillings

- Amalgam, resin-based composite or similar filling material to restore decayed or fractured teeth
- Only one time per tooth per surface within 12 months for primary teeth and 24 months* for permanent teeth regardless of the number or combinations of restorations placed
- Resin-based composites* for posterior teeth
- Restorations involving the proximal, occlusal, buccal, lingual or incisal surfaces on the same tooth are considered connected for payment purposes
- Completed restorations

**Contract-specific benefit*

Note: We don't pay for occlusal adjustment of restorations within 90 days following placement of the restoration.



Non-covered fillings

- Gold foils
- One, two, three (or more) surface metallic inlays except under very limited circumstances
- One, two, three (or more) surface porcelain or ceramic inlays except under very limited circumstances
- Two-surface metallic porcelain or ceramic onlays except under very limited circumstances The above-stated gold foils, inlays and onlays are paid as similar-surface, resin-based composite or amalgams. The patient is responsible for the difference between your charge and our approved amount for the resin-based composite or amalgam. (See section **IV** for predetermination requirements.)

Non-payable fillings

- Restorations done for any purpose other than for missing tooth structure or decay, such as:
  - Eliminate stained craze lines, developmental grooves, abrasion, attrition or erosion (chemical or mechanical)
  - Close a space
- Restorations to strengthen a tooth or prevent a future problem
- Placement or replacement of fillings for cosmetic reasons
- Procedures to correct congenital or developmental malformations, lack of tooth enamel and tooth discoloration
- Services that are considered part of the restorative procedure: pulp caps, etching, bonding agents, bases, liners, local anesthesia, temporary restorations, polishing, preparation, supplies, caries removal agents and infection control
- Preventive resin restorative fillings when the restoration doesn't extend into the dentin
- Sealants used as or billed as restorative fillings

Class II — Restorative services: substructures

Restorative substructures are provided for permanent teeth when there is insufficient tooth strength and retention for the crown procedure.

Restorative services covered with limitations

- Substructures are payable only for permanent teeth. Substructure types are cores (including pins), prefabricated posts and cores, and cast posts and cores.
- Only one type of substructure per tooth is payable in a 60-month period.*

Non-covered restorative services

- Substructures on primary teeth, or with inlays and onlays, ¾ crowns and veneers
- Multiple posts in the same tooth

Limitations on post and cores

- Recementation is payable three times per tooth per benefit year.
- Recementation is included in the substructure fee for the first six months following delivery of the substructure.

**Contract-specific benefit*

Class II — Restorative services: crowns, onlays and veneers

Crowns, onlays and veneers are metallic, resin or porcelain restorations used to restore the teeth. We cover these services:

- Only when, due to extensive decay or missing tooth structure, the tooth can't be restored using direct restoration materials such as amalgam or resin-based composites. If loss of tooth structure isn't deemed sufficient to warrant these services, alternate benefits may be allowed
- Veneers are payable on teeth #6–11 and #22–27 only
- Cast restorations for permanent teeth or retained primary teeth with no permanent successors and adequate root structure remaining
- Cast restorations for patients 12 or older if root apices are fully developed and closed
- If dentally necessary, replacement of cast restorations once in a 60-month period*
- If dentally necessary, replacement of a stainless-steel crown or prefabricated resin crown once in a 12-month period
- Only completed restorations, the date of the final impression is the date of service
- Recementation of onlays, veneers and crowns six months after initial placement

**Contract-specific benefit*

Limitations on crowns, onlays and veneers

- Recementation is payable three times per tooth, per benefit year.
- Recementation is included in the cast restoration fee for the first six months following delivery of the restoration.

Non-covered restorative services

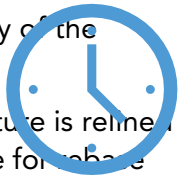
- Replacement of tooth structure due to stained craze lines or developmental grooves
- Crowns for abrasion, attrition or erosion (mechanical or chemical)
- Crowns to change vertical dimension
- Crowns to close spaces
- Crowns to correct periodontal conditions
- Onlays unless at least one cusp is completely overlaid (covered or hooded)
- Placement or replacement of fillings or cast restorations for cosmetic reasons
- Fees for services considered part of the restorative procedure, such as etching, bases, liners, local anesthesia, temporary restoration, polishing, preparation, supplies, caries removal agents and infection control
- Procedures to correct congenital or developmental malformations such as cleft palate, upper and lower jaw malformations, lack of tooth enamel and tooth discoloration
- Fitting a crown to a partial denture clasp
- Routine placement of a temporary restoration following tooth preparation for a crown or bridge
- Services or supplies that are cosmetic in nature, including charges for bonding or laminate (labial) veneers in the absence of decay or fracture, and vital or nonvital tooth bleaching for one tooth or the entire mouth
- Replacement of lost, missing or stolen onlays, veneers or crowns

Class II – Adjustments, repairs, relines, tissue conditioning

Adjustment and repair of bridges and dentures

- Adjustments for the bridge or denture (complete or partial) if six months have elapsed since delivery of the appliance
- Recementation of a fixed bridge if six months have elapsed since initial placement
- Repair and adjustment of partial or complete dentures within a 12-month period can't exceed one-half of our allowed amount for a new partial or complete denture

Relines



- Relining or rebasing of partial or complete dentures if six months have elapsed since delivery of the dentures
- Denture relines and rebases one time per arch every 36-month period. If an immediate denture is relined or rebased within one year of placement, the denture is considered permanent. It is eligible for rebase or reline in 36 months, or replacement in 60 months

Tissue conditioning

- Tissue conditioning one time per arch every 36-month period

Class II — Endodontic services

Endodontic services pertain to treatment of diseases of the tooth pulp and apical structure. Below is a list of payable services:

Covered endodontic services:

- Vital pulpotomy for primary teeth
- Root canal treatment for permanent teeth
- Root canal treatment for primary teeth if full root formation is present and there is no permanent successor for the primary tooth
- Root canal treatment for a tooth involving one or more canals once per lifetime
- Root canal retreatment 12 months after the original placement and only once per tooth per lifetime
- Apical surgery on permanent teeth

Note: Biopsies aren't payable as a separate benefit under the dental plans.

Non-covered endodontic services:

- Root canals treated using the Sargenti method
- Root canal retreatment for primary teeth, unless no permanent tooth formed, and adequate crown root ratio available
- Pulpotomies or pulpectomies on permanent teeth
- Endodontic implants (a contract-specific benefit)
- Special instrumentation, microscopic examination or surgical techniques

Class II — Periodontic services: treatments, surgery, adjustments, appliances

Periodontic services pertain to treatment of diseases involving the gums, soft tissues and bone that surround and support the teeth.

Covered periodontic treatments

- Scaling and root planing are payable once per quadrant in a 24-month period on patients 12 or older who have evidence of crestal bone loss and root surface calculus.
- Periodontal maintenance procedures must have a history of periodontal surgical services or scaling and root planing. If there is no Blue Cross periodontal surgical history, complete and submit a status inquiry claim to us, including documentation of past periodontal surgery or scaling and root planing and a full-mouth periodontal charting.

Non-covered periodontic treatments

- Chemotherapeutic irrigation
- Home fluoride trays and products
- Prophylaxis and periodontal maintenance procedure done on the same date or within 60 days of the periodontal surgical procedures or periodontal scaling and root planing

Covered periodontal surgical procedures

- Periodontal surgical services per designated quadrant once in a 36-month period
- Various types of periodontal surgical services when documentation of need is submitted with the claim. (Dental procedures appear in Appendix A, Dental Procedure Codes Charts)
- When more than one periodontal surgical procedure is done on the same date of service, the less difficult surgical procedures are considered part of the more difficult procedure
- Bone replacement grafts when done on the same date of service as periodontal surgery

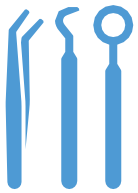
Non-covered periodontal surgical procedures

- Intracoronal and extracoronal provisional splinting
- Services or supplies related to periodontal splitting
- Surgical barrier for guided tissue regeneration
- Bone grafts for the placement or repair of implants or after tooth extractions
- Grafting of tissue outside the mouth to oral tissue
- Charges to stabilize the teeth or to correct the vertical dimension

Covered adjustments

- Occlusal adjustment through selective grinding of tooth structure
- Limited occlusal adjustments up to five times in a 60-month period
- Limited occlusal adjustment once in a six-month period

Non-covered adjustments



- Full mouth occlusal adjustment
- Charges associated with full mouth occlusal adjustment

Non-covered services

- TMJ (temporomandibular joint) appliances
- Replacement of missing, lost or stolen appliances

Class II — Oral surgery services

Oral surgery consists of surgical procedures performed to treat diseases, injuries or defects of the mouth and jaws. These services are payable:

Covered simple extractions and surgical extractions

- Extractions of permanent or primary teeth as simple extractions. Surgical extractions of primary teeth are individually reviewed for consideration
- Alveoloplasty (smoothing of bone) needed in preparation for dentures
- Drainage of intraoral soft tissue or facial spaces of the mouth or surrounding tissues

Non-covered surgical services

- Surgical procedures to correct congenital or developmental malformations such as cleft palate or upper and lower jaw malformations
- Tooth transplantation
- Uncovering of implants
- Diagnostic services, reversible and irreversible treatment related to the treatment of jaw joint disorders (TMJ)
- Biopsy on the same day as, or in conjunction with, endodontics, periodontics or extractions of all types is included in the allowed amount for the procedure and is not payable as a separate benefit
- Excisional biopsy of hard or soft tissue

Oral surgery services aren't payable under medical benefits if they're payable under the Blue Cross dental benefit.

Class II — Adjunctive general services

Adjunctive general services are miscellaneous services provided in connection with dental care. These services are covered as follows:

Covered adjunctive general services

- General anesthesia or IV sedation is payable when medically necessary. To determine medical necessity, one of the following criteria must be met:
  - Significant cellulitis or swelling and the associated inability to open the mouth fully doesn't allow the use of local anesthesia at the site of the injection.
  - Treatment is for bilateral alveolectomy, bilateral alveoloplasty, bilateral surgical exposures or bilateral tori.
  - Six or more teeth in various quadrants are removed on the same date of service.

- Two or more impacted teeth are removed on the same date of service.
- Four third molars are removed on the same date of service.
- Patient is medically impaired or compromised.
- Patient is allergic to local anesthesia.
- Patient is younger than age seven.

- Dentists must provide the reason general anesthesia or IV sedation was needed and a description of the services that were performed.
- Professional consultations are only payable for a second opinion to a dentist or office not rendering any treatment for the patient. The examination or evaluation is applied to the allowable number of examinations or evaluations.
- Professional visits are payable when no other treatment is rendered at the same visit. Visits are applied to the allowable number of examinations or evaluations.
- House calls and hospital calls are payable. All calls are applied to the allowable number of examinations or evaluations.
- Antibiotic injections are payable when submitted with documentation supporting their need and the type of antibiotic used.
- Bite guards/occlusal guards are payable if need is documented, explaining the signs and symptoms supporting the treatment.

Non-covered adjunctive general services

- Drugs and medications dispensed or not dispensed by the dentist, and those available without prescription or used in connection with medical or non-covered services
- Prophylactic antibiotics or behavior management premedication
- Supplies and materials used for infection control, which are included in the fee for the service
- Bleaching trays and bleaching agents
- Fees for special monitoring equipment used in conjunction with general anesthesia or IV sedation

Class III — Prosthodontic services: Implants, bridges and dentures

Prosthodontic services consist of implants and the construction or replacement of bridges and dentures, either complete or partial.

Covered prosthodontic services

- Complete dentures
- Removable partial dentures for patients ages 16 and older
- Overdentures
- Implants for patients ages 16 and older and done on permanent teeth only
- Interim partial dentures to replace recently extracted anterior teeth, #6-11 and #22-27 only
- Fixed bridges, including abutment crowns and pontics (artificial tooth or teeth) for patients 16 or older, if apices of abutment teeth are fully developed and closed
- A partial denture when anterior bridges and the partial denture replacing posterior teeth are done in the same arch
- Replacement of fixed bridgework once in a 60-month period, if necessary
- Replacement of complete or partial removable dentures once in a 60-month period, if necessary

Due to the pattern of missing teeth, a removable partial denture may be approved as an alternate benefit to a fixed bridge. If the patient elects the fixed bridge, he or she may be responsible for the difference between your charge and our approved amount for the partial denture. (See section II for per-claim participation and section **IV** for predetermination requirements.)

Non-covered prosthodontic services

- Temporary partial dentures, temporary complete dentures or fixed bridges, which are considered part of the overall treatment
- Implants on teeth #1, 16, 17 and 32
- Immediate flipper or temporary partial denture to replace bicuspid and molar teeth
- Personalization or characterization of dentures
- Replacement of lost, missing or stolen prosthetic appliances such as crowns, bridges, implant prostheses, partial or complete dentures
- Spare partial or complete denture or other duplicate appliance
- Precision attachments
- Overdenture attachments or retainer bars
- Related implant services. This includes maintenance of tissues surrounding the implants*

**Contract-specific benefit*

Class IV — Orthodontic services

Orthodontic services consist of evaluating and treating patients with tooth and arch discrepancies or malocclusions. Benefits are available for:

- Limited orthodontic treatment
- Preventive and interceptive orthodontic treatment
- Comprehensive orthodontic treatment and post-treatment supervision

Covered orthodontic services

- Initial orthodontic examination or evaluation is covered once per dentist or dental office per lifetime. For frequency and time limits, see **Class I — Diagnostic services for clinical oral examinations**.*
- Case models (diagnostic casts) are payable once every five years. This is a **Class I** benefit and comes out of a benefit year maximum. The code can be paid to any provider, orthodontist or not, and isn't linked to orthodontic treatment only.
- Cephalometric X-rays are a **Class IV** benefit and payable once every five years.*
- Diagnostic photographs for orthodontic purposes are a **Class IV** benefit and covered once every 60 months.*
- Diagnostics, such as examinations, X-rays, and models, may be covered under the patient's yearly maximum instead of the patient's orthodontic lifetime maximum.*

Note: When banding is completed, use a 2006 or newer ADA claim form to bill us.

Covered orthodontic services with limitations

- Orthodontic coverage is usually terminated at the end of the day of the covered member's 19th birthday.
    - If treatment begins before the covered member's 19th birthday, coverage can continue after the member reaches age 19, regardless of the age limitation, as long as he or she is listed on the contract.*
    - Adult coverage for persons over 19 may be a contract benefit if the employer has purchased a specific rider for it.*
- Maxillary and mandibular retention appliances are payable once per lifetime.
- Retention appliances and retainers following active orthodontic treatment are payable.
- Transseptal fiberotomy is payable only for permanent teeth if it follows active orthodontic treatment.
- Repair of damaged orthodontic appliances.

Non-covered orthodontic services

- Routine monthly examinations or evaluations. These are included in the payment made on the comprehensive orthodontic treatment code
- Replacement of a lost, missing or stolen orthodontic appliance
    - Diagnostic services, reversible and irreversible treatment related to the treatment of jaw joint disorders

**Contract-specific benefit*

Inclusive dental services

Inclusive dental services are services that aren't payable separately but are included in our payment for a related service.

Inclusive services for restorations

- Bases, liners and varnishes are included in the restoration fee.
- Occlusal adjustment or correction of the occlusion within six months of placement of any restoration is included in the fee for the restoration. Examples of restorations are amalgam, resin-based composite, inlay or onlay, crown, bridge and substructure.
- All amalgam or composite restorations done on the same tooth on the same date of service are considered touching for payment purposes.
- Duplicate amalgam or resin-based composite surfaces billed during the time limit specified in the patient's contract aren't paid separately regardless of the number of restorations or combination of surfaces placed.
    - **Example:** If a distal occlusal and mesial occlusal restoration are billed for the same tooth within the specified time limit, only one occlusal surface is payable. The fee for the remaining occlusal surface is included in the first payment.
- Direct and indirect pulp caps are included in the final restoration allowance.

Covered services for substructures:

Only one type of substructure or substructure combination will be paid per tooth within the same time limit, and only one post will be payable per tooth. Blue Cross doesn't cover multiple posts in the same tooth.
Below are substructure and substructure combinations:

- Core with or without pins
- Prefabricated post and core
- Cast post and core

The fee for the crown, onlay, veneer or bridge includes all adjunctive services such as:

- Impressions
- Laboratory fabrication fees
- Models
- Temporary filling or crown
- Recementation of temporary crowns
- Adjustment of the occlusion
- Mounting the case
- Crown under survey or to fit an existing partial denture

Covered services for prosthodontics

Occlusal adjustments following the delivery of a partial denture or full denture are included in the denture allowance for the first six months following delivery.

The fee for a partial or full denture includes all adjunctive services, such as:

- Impressions
- Models
- Individual trays
- Adjustment of the occlusion
- Mounting the case
- Delivery of the partial or full denture
- All tests and the recording of the test findings needed to evaluate the patient's oral health are included in the examination or evaluation

Covered periodontal services

- Periodontal pocket charting is included in related periodontal services.
- Periodontal maintenance services, root planing and scaling, flap and osseous surgery include the prophylaxis.

Covered endodontic services

- One periapical X-ray is payable on the same day as endodontic treatment. All other X-rays, including completion and final-fill X-rays taken during a root canal treatment, are included in the allowance for completed root canal service.
- Opening of the tooth, obturation with debridement, final seal and related incision and drainage services are included in the allowance for the completed root canal service.
- Curettage, apicoectomy and apicoectomy with retrograde filling include taking a biopsy sample and services using microsurgery techniques.

You can't bill separately for services that are included in the fee for a related service.

Non-covered services

We don't cover the following services or items under any of our contracts and won't pay for them if billed to us:

- Services that are covered by hospital, surgical, medical and prescription drug coverage; for example, surgery, anesthesia and diagnostic services
- Services or supplies covered by workers' compensation laws
- Supplies or services provided to the patient free of charge by any federal, state, local, foreign or other government agency, except where this exclusion is prohibited by law
- Services received at a medical or dental clinic provided or maintained by an employer
- Services provided by a student of a dental or medical school (unless the student is in a graduate program and has a state license to practice dentistry)
- Services for dental disease or injuries resulting from declared or undeclared acts of war
- Treatment by someone other than a dentist, except for scaling or cleaning of teeth, topical application of fluoride and placement of sealants performed by a licensed dental hygienist who is under the supervision and guidance of a dentist
- Services or supplies for which no charge is made that the patient is legally obligated to pay or for which no charge would be made in the absence of dental coverage
- Services that began or were provided before the effective date of coverage. This exclusion does not apply to orthodontic treatment in progress
- Services provided after coverage ends, except in this situation: The patient begins a dental procedure, and final impressions have been completed for the crown, bridge, partial or full denture before coverage ends. To be payable, installation, delivery or completion of the final product or procedure must be accomplished within 60 days after the coverage termination date
- Charges for failure to keep a scheduled appointment with the dentist or hygienist
- Charges for completing a dental claim or other forms
- Treatment, drugs or services that are experimental, investigational or that do not meet the profession's standard of care
- Services or supplies that are not necessary according to accepted standards of dental practice, are not needed for diagnosis or treatment of a dental disease or injury or have not been recommended or approved by the attending dentist
- Facility fees or hospital charges for treating a patient at the hospital, inpatient or outpatient facility

- Oral medications, topically applied antibiotics, antibiotic impregnated fibers, nonantibiotic injections, emergency prescriptions and other drugs
- Premedication, local anesthetic and analgesia when billed as a separate service
- Services provided for infection control and barrier techniques
- Mouth guards or trays for the delivery of home-applied preparations, such as fluoride or bleaching agents
- Desensitizing medications
- Full charges for the costliest course of treatment when there are two or more methods of treating a particular dental condition

Note: We make an allowance for the less expensive course of treatment or service and don't interfere with the dentist-patient relationship. You can apply any allowed payments toward the treatment that you and the patient agree on.

- Full-mouth reconstruction to change the occlusion or vertical dimension
- Obturator used to correct a congenital malformation, such as a cleft palate
- Surgery, appliances or procedures to correct congenital or developmental malformations such as cleft palate, upper and lower jaw malformations, lack of tooth enamel and tooth discoloration

Note: If a service isn't completed or delivered (such as a crown, fixed partial denture or full denture), payment for that completed service must be returned to Blue Cross.

VI. How to determine what's covered – frequently used procedures

This part provides coverage guidelines for many frequently used procedures included in the *ADA Common Dental Terminology*. The guidelines can help you determine your patient's dental benefits and decide on a course of treatment and a method of payment before treatment begins.

You may request predetermination before:

- Performing non-urgent services that cost more than $200
- Beginning complex services such as crowns, onlays, veneers, bridges, or complete or partial dentures

See section **IV** for predetermination details.

Be sure to retain information in your patient's permanent dental treatment record about diagnosis and treatment. This information should include, but isn't limited to, X-rays, baseline notations, medical history, written narrative and operative notes, and should be available if requested for dental necessity review.

The procedures are arranged below alphabetically for easy reference. Procedures submitted for payment are subject to our benefit and utilization review.

Note: In the procedures listed below, photographs or models retained as additional documentation shouldn't be considered replacements for X-rays.

Behavior management, by report

Behavior management is in addition to other treatment provided.

Criteria:

- Patient is 6 or younger.
- Patient is medically impaired or compromised.

Limitations:

- Sedation and monitoring of patient are included in the service.

Dental records needed:

- Narrative regarding the need for behavior management
- Treatment plan for services if submitting a prior authorization
- Operative notes for completed services that include behavior management services on the same date as other services

Bone replacement grafts (first site and each additional site in a quadrant)

Involves the use of osseous autografts, osseous allografts or non-osseous grafts to stimulate bone formation or periodontal regeneration when the disease process has led to a deformity of the bone

Criteria:

- Teeth must be permanent.
- Crestal bone level should be greater than 2 mm below the CEJ.
- There should be vertical and horizontal bone loss with bony pockets.
- Charting should show probing depths of 5 mm or greater.

Limitations:

- Must be done on the same date as osseous or flap surgery
- Payable once per tooth in a 36-month period
- Not payable in conjunction with extractions, implants or implant-related services
- Not payable for periapical or periradicular surgical sites

Dental records needed:

- Currently dated periapical X-rays of quadrant
- Indicated tooth number
- Currently dated periodontal charting
- Documentation to support the service

Clinical crown lengthening – hard tissue

A procedure in which bone is removed surgically to allow a restorative procedure or a crown to be placed when little or no tooth structure is exposed in the oral cavity.

Criteria:

- Teeth must be permanent and restorable.
- Teeth prognosis must be favorable.
- The remaining root structure must be greater than half the anatomical root length.

Limitations:

- Payable once per tooth
- Not payable on the same day as any other restorative, prosthetic or endodontic procedure performed on the same tooth
- Not payable solely for soft tissue removal; must include bone removal

Dental records needed:

- Currently dated periapical X-rays of tooth
- Documentation to support the service

Cores and posts (substructures)

These are provided for permanent teeth when there is insufficient retention for the crown procedure.

Criteria:

- Teeth must be permanent and restorable.
- The surrounding bone must be midroot or better with no furcation involvement.
- The missing tooth structure must be due to one or a combination of the following:
  - Decay
  - Fractured off cusp or wall
  - Missing structure due to previous restoration
- At least 35% of the prepared tooth for the crown must be core material.

Limitations:

- Only one substructure type per tooth is covered in any benefit period.*
- Substructures aren't payable with inlays, onlays, ¾ crowns and veneers.
- Time and age limitations may apply.

**Contract-specific benefit*

Dental records needed:

- For all teeth: currently dated preoperative X-ray
- For all endodontically treated teeth: current periapical x-ray
- For third molars: current periapical and bitewing X-ray showing occlusion

Crown and fixed partial dental repair, by report

This procedure includes the removal of the crown or fixed bridgework to repair broken-off porcelain or resin composite. This procedure can also be used to repair a hole through the crown or repair the margin adaptation to the tooth surface — payable as a single-surface restoration. In case of crown and bridgework, it can be used to repair a fractured connector joint.

Criteria:

- Teeth must be permanent.
- Documentation should show:
  - A need for repair

    - Dental caries at the margin
    - Fractured connector joint
- The repair must have an acceptable prognosis.

Limitations:

- This procedure isn't payable:
    - On primary teeth
    - For patients 11 years of age or younger
    - For replacement of crown or bridge when lost, missing or stolen
    - For repair of temporary crown or temporary bridge

Dental records needed:

- Narrative describing necessity for procedure
- Laboratory bill that justifies expense of laboratory porcelain repair to crown or bridge
- Currently dated X-rays showing damage to crown or bridge

General anesthesia and intravenous sedation

General anesthesia: A state of unconsciousness and insusceptibility to pain; may be produced by inhalation or intravenous injection of anesthetic agents

Intravenous sedation: A state of altered consciousness in which reflex action remains operable; administered by injection of an anesthetic agent through a vein

Criteria:

- Significant cellulitis or swelling and the associated inability to open the mouth fully doesn't allow the use of local anesthesia at the site of the injection.
- Treatment is for bilateral alveolectomy, bilateral alveoloplasty, bilateral surgical exposures or bilateral tori.
- Six or more teeth in various quadrants are removed on the same date of service.
- Two or more impacted teeth are removed on the same date of service.
- Four third molars are removed on the same date of service.
- Patient is medically impaired or compromised.
- Patient is allergic to local anesthesia.
- Patient is 6 years of age or younger.

Limitations: This procedure isn't payable unless one of the above criteria is met. There is a frequency limitation maximum of five units.

Dental records needed:

- Reason for necessity for general anesthesia
- Description of services provided

Gingivectomy or gingivoplasty per quadrant

These are surgical procedures to remove soft tissue for the elimination of gingival enlargements, per quadrant or tooth.

Criteria:

- Teeth must be permanent.
- Bone height and contours must be acceptable, provided no previous periodontal surgery is performed.*
- Sufficient attached gingiva must be present to allow physiological contouring during surgery.

Limitations:

- Payable once per quadrant* depending on previous periodontal history.
- When more than one periodontal surgical procedure is done on the same date of service, the less difficult surgical procedures are considered part of the more difficult procedure.
- Not payable if done with any restorative procedure on the same date of service.

Dental records needed:

- Currently dated periapical X-rays of tooth or quadrant
- Indicated tooth number or quadrant
- Currently dated periodontal charting
- Documentation to support the service

**Contract-specific benefit*

Incision and drainage of abscess, intraoral soft tissue

Involves an incision through the oral mucosa and dissection may extend into fascial spaces.

Criteria:

- Drainage of purulent material by incision through the oral mucosa is covered with or without drain placement.
- If the procedure is done in conjunction with a root canal, report as D3221*, Pulpal debridement, primary and permanent teeth.

**Contract-specific benefit*

Limitations:

- Not payable on the same date, same tooth or quadrant as endodontic, periodontic or other oral surgical procedures.
- If same provider completes the root canal treatment, the D3221 is included in the fee for the completed root canal.

Dental records needed:

- Narrative or postsurgical notes
- Record indicating patient was placed on antibiotics, if applicable

Occlusal adjustment, limited

Equilibration of the teeth to create harmonious contact relationships between the maxillary and mandibular teeth.

Criteria:

- One or more of these symptoms must be present:
  - Mobility
  - Fremitus
  - Sore teeth
  - Bruxism
  - Pathological migration
  - Food impaction

Limitations:

- Only one limited occlusal adjustment is payable in a six-month period.
- Only five limited occlusal adjustments are payable in a 60-month period.*
- Procedure isn't payable within six months following restorative or prosthodontic services.

Dental records needed:

- Narrative describing the need for occlusal adjustment and identifying the teeth that were adjusted

Occlusal guards

Removable dental appliances designed to minimize the effects of bruxism (grinding) and other occlusal factors that cause destruction to the tooth or periodontium.

Criteria:

- Covered for adult dentition only
- One or more of these symptoms must be present:
  - Mobility
  - Bruxism
  - Fremitus
  - Pathological migration
  - Sore teeth
  - Severe attrition
- Appliance must oppose natural dentition

Limitations:

- Not payable if the patient has an upper or lower denture.
- Not payable for patients with mixed dentition.
- Not payable for the sole treatment of temporomandibular joint dysfunction.
- Not payable if used as an athletic mouthguard.
- Limitations for occlusal guards are contract-specific.

Dental records needed:

- Narrative describing the signs and symptoms

Osseous surgery (including flap and entry, and closure)

This is performed to modify the bony support of the teeth by reshaping the alveolar process to achieve a more physiologic form. This procedure may include removal of supporting bone (ostectomy) or non- supporting bone.

Criteria:

- Teeth must be permanent.
- Crestal bone level should be greater than 2 mm below the CEJ.
- There should be vertical and horizontal bone loss with evidence of bony pockets.
- Charting should show probing depths of 5 mm or greater.

Limitations:

- Payable once per quadrant.*
- Not payable with implant or implant-related services.
- When more than one periodontal surgical procedure is done on the same date of service, the less difficult surgical procedures are considered part of the more difficult procedure.

**Contract-specific benefit*

Dental records needed:

- Currently dated periapical X-rays of quadrant
- Identified quadrant
- Currently dated periodontal charting
- Documentation to support the service

Periodontal scaling and root planing

Performed as therapeutic, rather than prophylactic, treatment for patients with periodontal disease. It may be defined as a conservative mode of periodontal treatment, involving judicious and thorough planing of the roots to remove cementum and dentin roughness, calculus and debris. It may also be the first phase of a more comprehensive periodontal treatment.

Criteria:

- Teeth must be permanent.
- Crestal bone level should be greater than 2 mm below the cementoenamel junction, or CEJ.
- Vertical and horizontal bone loss is present with the start of bony pockets.
- Calculus deposits are visible on cementum surface.

Limitations:

- Payable once per quadrant in a 24-month period on patients ages 12 and older.
- Post-treatment follow-up and evaluation of the treated area are included in the allowance for completed service.
- When more than one periodontal surgical procedure is done on the same date of service, the less difficult surgical procedures are considered part of the more difficult procedure.

Dental records needed:

- Currently dated bitewing X-rays
- Currently dated periodontal charting
- Narrative to support the service

NOTE: For patients with calculus supragingival or subgingival, but not on the cementum, and without radiographic loss of bone, but able to be periodontally probed and periodontally assessed, consider the ADA's newer code, D4346 as one of your periodontal treatment options. A debridement (D4355) indicates that a periodontal assessment can't be made due to interferences, such as large amounts of calculus inhibiting the ability to periodontally probe.

Pontics

These are artificial teeth used to replace missing teeth. They are supported by adjacent teeth.

Criteria:

- Covered for teeth #2 to 15 and #18 to 31.
- Space for the pontic must be at least 4 mm.
- Patient must be at least age 16.

Limitations:

- Due to the pattern of missing teeth or periodontal involvement, a removable partial denture may be allowed as an alternate benefit.
- Payable once in a 60-month period, per tooth.

Dental records needed:

- Currently dated preoperative full mouth X-rays of missing and abutment teeth
- Current periapical X-rays of abutment teeth if full-mouth X-rays are more than 18 months old

Prosthetics: Abutment or implant-supported crowns

Single-crown restorations that are retained, supported and stabilized by an abutment or an implant — may be screw-retained or cemented. May also be a retainer for a fixed partial denture that gains retention, support and stability from an abutment or an implant — may be screw-retained or cemented.

Criteria:

- Implant must have adequate bone support.
- Bone level must be mid-root or better surrounding the implant.
- Patient must be at least age 16.

Limitations:

- Payable for:
  - Permanent teeth numbers 2 to 15 and 18 to 31
  - Payable once in a 60-month period per implant
- Not payable for:
  - Primary teeth
- We may approve a removable partial denture as an alternate benefit in place of an implant-supported bridge if:

- Multiple teeth are missing on the opposite side of the arch from the implant-supported bridge.
- The remaining natural teeth in the arch show a pattern of periodontal involvement.
- Fixed prosthetics must be a part of the member's benefit plan
- Service is payable once in a 60-month period per tooth.

Dental records needed:

- Currently dated preoperative full-mouth X-rays of missing and abutment teeth
- Current periapical X-rays of abutment teeth if full-mouth X-rays are more than 18 months old

Prosthodontic retainers: crowns, inlays and onlays

Porcelain, ceramic and cast restorations used to support pontics for fixed partial dentures or as abutments for removable partial dentures.

Criteria:

- Patient must be age 16 or older, and the tooth must be permanent with apices fully developed and closed.
- Tooth must be restorable.
- Tooth used as an abutment must be adequate to support the bridge.
- There must be midroot or better bone level with no furcation involvement.
- Tooth must be vital or appropriately treated.

Limitations:

- Payable once in a 60-month period, per tooth.

Dental records needed:

- Currently dated preoperative full-mouth X-rays of missing and abutment teeth
- For third molars: current periapical and bitewing X-rays showing occlusion

Restorative crowns

Porcelain/ceramic, resin and cast restorations that are used when tooth structure is lost to such an extent that it can't be restored with a composite, amalgam or similar type of restoration

Criteria:

- Patient must be age 12 or older, and the tooth must be permanent with apices fully developed and closed.
- Deciduous teeth may be covered if documentation indicates there is adequate root structure and no permanent successor.
- Tooth must be restorable.
- There must be midroot bone level with no furcation involvement.
- A minimum of one-half of the clinical crown must be missing due to one, or a combination, of the following:
  - Decay
  - Loss of tooth structure, such as a cusp or wall
  - Missing structure replaced by a previous restoration

If the tooth doesn't meet the criteria above and the tooth is submitted for a crown as cracked or cracked tooth syndrome, include documentation of signs and symptoms. Examples: occlusal adjustments, history of pain and previous treatment.

Limitations:

- Restorative crown isn't payable as an implant crown or abutment.
- Crowns aren't payable for cosmetic reasons.
- If loss of tooth structure doesn't meet the criteria, alternate benefits may be allowed.
- Time limitations are contract-specific.
- Crowns aren't payable due to attrition, abrasion or erosion.

Dental records needed:

- Currently dated preoperative X-rays
- For third molars: current periapical and bitewing X-rays showing occlusion

Restorative veneers, inlays and onlays

Porcelain/ceramic, resin and cast restorations that are used when tooth structure is lost to such an extent that it can't be restored with a composite, amalgam or similar type of restoration

Criteria:

- Patient must be age 12 or older, and the tooth must be permanent with apices fully developed and closed.
- Deciduous teeth may be covered if documentation indicates there is adequate root structure and no permanent successor (onlays only).
- Tooth must be restorable.
- There must be midroot bone level with no furcation involvement
- A minimum of one-half of the clinical crown must be missing due to one, or a combination, of the following:
    - Decay
    - Loss of tooth structure such as a cusp or wall
    - Missing structure replaced by a previous restoration
    - Veneers are payable only on teeth numbers 6 to 11 and 22 to 27

If the tooth doesn't meet the criteria above, such as in a cracked tooth syndrome, include documentation of signs and symptoms. Examples: occlusal adjustments, history of pain and previous treatment.

Limitations:

- Onlays and veneers aren't payable for cosmetic reasons.
- Onlays aren't payable unless at least one cusp is completely overlaid (covered or hooded).
- Two surface onlays aren't a benefit.
- Inlays aren't a benefit except under very limited circumstances (example, to replace an existing inlay or used as an abutment for a fixed bridge).
- If loss of tooth structure doesn't meet criteria, alternate benefits may be allowed.
- Time limitations are contract-specific.

Dental records needed:

- For third molars: current periapical and bitewing X-rays showing occlusion

VII. What's covered: Dental services payable under the medical-surgical benefit

We explain the criteria for coverage of dental services that are payable under the medical-surgical benefit in this section.

In general, services payable under the dental program aren't payable under medical coverage. Dental services – treatment of the teeth and supporting structures – are covered by the design of the member's benefit. Also, dental services don't become eligible for medical coverage merely by virtue of their being performed prior to a covered medical-surgical service or as a result of a medical treatment or a medical condition or deficiencies in dental benefit coverage.

You can check your patient's medical coverage online by calling Provider Inquiry at:

Phone inquiries from anywhere inside or outside of Michigan	24/7 access	Hours of operation to reach a Provider Inquiry representative
All Blue Cross Blue Shield of Michigan members (except employees)	1-800-344-8525	Monday – Friday 8:30 a.m. to noon; 1 p.m. to 5 p.m.
Blue Cross Blue Shield of Michigan employees (only)	1-877-258-0167	Monday – Friday 8:30 a.m. to noon; 1 p.m. to 5 p.m.

For dental services billed under the medical-surgical benefit, when palliative treatment and surgery for the same condition are performed on the same day by the same physician or dentist, the palliative treatment isn't payable.

Billing on a CMS-1500

Medical-surgical services

When you use the CMS-1500 claim to bill for medical-surgical services, you can participate on a per-claim basis. If the dentist doesn't have a medical PIN, we'll pay the subscriber.

Use the CMS-1500 claim (08/05 version) to bill for dental services under the medical-surgical benefit. Blue Cross will accept only this version of the CMS-1500 form for claims processing.

Please keep the following tips in mind when completing this form:

- Use an X to mark a required box.
- Use the upper-right corner to describe:
  - Unusual circumstances
  - Any attachments to the claim
- If you don't have anything to enter in a particular field, leave it blank.
- If there are no line-by-line instructions for a particular field, leave it blank.

For additional information, refer to the National Uniform Claim Committee's Instruction Manual at https://nucc.org.

Send completed CMS-1500 claims to:

Professional Claims
Blue Cross Blue Shield of Michigan
P.O. Box 2500
Detroit, MI 48231-2500

Below, we identify dental procedures billable under the medical-surgical benefit and our coverage guidelines for them.

Accidental dental injury

Accidental dental injury is defined as an external force to the lower half of the face or jaw that damages or breaks the teeth, periodontal structures or bone. Damage to the mouth by self-inflicted external force or chewing isn't covered.

Guidelines for emergency dental treatment:

- Emergency treatment should be completed within 24 hours following the trauma to relieve the patient of pain and discomfort.
- Subsequent related accidental dental injury treatment services should be performed as soon as possible, and the clinical record should document any circumstances resulting in delay of treatment.
- All treatment must be completed within six months of the date of accident.

The medical-surgical benefit may cover the following accidental dental services:

- Services routinely covered under our dental plan
- Emergency care
- Treatment to restore or repair accident-related damaged or broken sound natural teeth, previously restored natural teeth and supporting dentoalveolar structures while the patient is covered by the plan, and only if coverage by the plan has been continuous since the date of the accidental injury

Patients with damaged, previously placed implant-supported structures may receive accidental dental coverage for repairs that involve non-implant supported fixed or removable dental treatment (for example, dentures, bridge, etc.).

The following dental services aren't covered under the accidental dental injury benefit:

- Treatment not completed within six months of the accidental injury
- Replacement or retreatment services already paid under the accident benefit
- Dental conditions in other areas of the mouth (for example, missing or decayed teeth or extractions) untreated prior to the accident
- Services to treat temporomandibular joint disorder
- Any type of implant procedure, including surgery and grafts, fixtures, prostheses or maintenance, unless the group has specific coverage
- Any type of repair procedure of previously placed implants, superstructure or restorations, including surgery and grafts, fixtures, prothesis or maintenance
- Procedures covered under the member's medical benefit
- Services that don't meet our medical and dental guidelines

These payment guidelines apply to services related to accident injuries:

- The maximum payment for a procedure is the lesser of the provider's fee or our maximum allowance.
- Per-claim participation applies.
- If dentist doesn't have a medical PIN, the payment direction is to the subscriber.
- Claims processing is based on the date the service was provided.
- We don't pay for services performed as part of another procedure, payment for which is inclusive of those services.
- Payments for accidental injury cases aren't subject to annual, lifetime or incident dental maximums accumulated before the accident. However, dental services covered under the accidental dental injury benefit may become part of the member's history, are used for future time limits and frequencies, and are subject to the member's medical deductibles and copayments.
- Only services related to the accident should be billed under medical. Non-accidental services should be billed to dental.

Future or replacement services are subject to normal time limits, frequencies and annual maximums specified in the dental contract. Such services aren't automatically related to the accident.

Please follow these billing guidelines:

1) Complete a CMS-1500 claim form. Make sure to check either YES or NO in field 27 (ACCEPT ASSIGNMENT). If the dentist doesn't have a medical PIN, we'll pay the subscriber.
2) Attach the following information to the claim:
    a) X-rays
    b) Description of the accident, such as:
        i. Police accident report
        ii. Hospital or emergency room dismissal report
        iii. Member's dental and medical records related to the accident
        iv. Other reports or documents the member believes are appropriate
3) Post-accident dental information such as:
        i. Duplicate dated full-mouth X-rays or other X-rays
        ii. Detailed narrative
        iii. Copy of treatment notes
        iv. Duplicate oral photographs or other pictures
        v. Diagnostic casts (study models)
4) Other documents the provider believes will assist in determining the member's benefits following the accident

1) Send the claim and attachments to Professional Claims at:

Blue Cross Blue Shield of Michigan Professional Claims
P.O Box 2500
Detroit MI, 48231-2500

Anesthesia and facility charges

Billable and payable under the medical-surgical program in conjunction with billable procedures on the teeth and supporting structures only when medically necessary and performed in the hospital setting by a provider other than the provider performing the dental services. This benefit doesn't reimburse for any dental services provided.

Consider these factors to determine coverage for anesthesia:

- Payable for children ages 6 and under (that is, through the end of the sixth year).
- For older patients, consider the extent of procedures required. At a minimum, the patient should require:
  - A total of six or more teeth to be extracted
  - Other procedures that must be performed in two or more quadrants of the mouth on the same date of service
- One of the following conditions should also exist:
  - A concurrent hazardous medical condition that creates a documented medical necessity to safeguard the life of the patient must exist to perform the procedure in a facility under general anesthesia or sedation (for example, labile hypertension with three or more antihypertensives, severe cerebral palsy, severe autism). Chronic stable medical conditions and situational anxiety are not considered a concurrent hazardous medical condition under these criteria
  - Significant cellulitis or swelling and associated trismus that doesn't allow the use of local anesthesia
  - Extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised

Documentation is required to support a claim or pre-determination request for coverage of general anesthesia or intravenous sedation for procedures on the teeth or supporting structures.

It must include:

- Patient name and address
- Patient contract and group numbers
- Patient date of birth
- Anesthesia provider's (MD, DO, DDS or CRNA) name and address
- Location where services are being provided
- Referring dentist's name and address
- Primary and all pertinent secondary diagnoses with dates of onset. Diagnoses must be recognized ICD-9CM or ICD-10-CM diagnoses and codes
- Documentation from the patient's primary care provider of the medical conditions that place the patient at high risk for treatment in the office setting and recommend general anesthesia or intravenous sedation in the outpatient setting
- A copy of the dental clinical record that details the treatment encounters with the patient
- A copy of the anesthesia record

Clinical notes should follow the CMS guidelines for evaluation and management services.

For the current version (08-05) of the CMS-1500 claim and instructions, go to the "Claims" chapter in the "Anesthesiology" or "MD-DO" online manuals available on Availity under BCBSM Provider Publications and Resources.

The anesthesia record documentation must clearly describe the portion (amount of time) of the anesthesia services directly provided by the anesthesiologist or dentist as distinct from the portion directly provided by a certified registered nurse anesthetist. Submit a copy of the anesthesia record and documentation when you file a claim for the anesthesia services.

Using the CMS-1500 claim, bill:

- Facility and anesthesia services with the appropriate CPT code
- The surgical procedures under the corresponding ICD-9CM or ICD-10-CM and CPT codes with appropriate anesthesia modifiers
- The dental services performed should be billed to the subscriber's dental benefits carrier. Dental benefits aren't payable under the medical-surgical benefit

Include a copy of the anesthesia record and required documentation along with a record of the time (in hours and minutes), including modifiers, with the claim.

Note: If the same provider performs both the dental surgery and anesthesia, we'll include the anesthesia in the dental surgical procedure that you bill.

Biopsies

Excision of oral soft tissue and bony lesions are billable under the medical-surgical benefit. Documentation must include, but isn't limited to, the clinical record and pathology report.

Guidelines for cyst biopsy

- When associated with extractions, endodontic or periodontal treatment, radicular cyst and periapical curettage and soft tissue biopsies are included in the allowed amount for the procedure and aren't covered as a separate benefit under the dental benefit or the medical-surgical benefit.
- When a cyst is primary or otherwise associated with teeth (for example, a dentigerous cyst), biopsy is payable under the medical-surgical benefit.
- Documentation (pathology reports, diagnostic copy of imaging) is required.

Guidelines for the oral brush biopsy

- Procurement of the transepithelial cells (oral brush biopsy) is billed to dental with ADA dental code D7288.
- The professional component, such as pathologist's services for determining the histopathological diagnosis, is payable from medical with the appropriate CPT and ICD-9CM or ICD-10-CM codes.

Dental services provided in the hospital setting

We pay for dental services provided in the hospital setting when a member is admitted to the hospital as an inpatient, with a medical condition that is being negatively impacted by a dental condition and treating the dental condition is intended to improve the medical condition to facilitate discharge from the hospital.

- Patient stays of less than 24 hours are considered outpatient services.
- Patient stays of 24 hours or more are considered inpatient services.

Note: Usually, dentoalveolar surgical procedures can be performed in an office setting.

Extractions

Most extractions are covered under the dental benefit. However, prophylactic extractions are payable under the medical-surgical benefit to prevent future complications when the patient has a documented concurrent hazardous medical condition that requires prophylactic extractions, as follows:

- Cancer of the head and neck region requires extractions prior to radiation therapy.
- Extraction of teeth is required immediately prior to transplant surgery.
- Cardiac surgery such as artificial cardiac valve replacement necessitates extraction of teeth prior to the surgery.
- Extractions provided in a hospital setting for a member admitted in-patient with a medical condition negatively impacted by a dental condition, and treating the dental condition by extraction of the teeth is intended to improve the medical condition to facilitate discharge.
- Documentation must include the treating physician's statement supporting the indication for dental extraction.

If those criteria are met, bill the extractions under the dentist's medical PIN. Extractions eligible under the medical-surgical benefit require pre-determination. Send requests to:

> Blue Cross Blue Shield of Michigan Provider Inquiry — Mail Code 0450 600 E. Lafayette Blvd.
> Detroit, MI 48226-2998

Guidelines for alveoloplasty

- Covered under dental, not under the medical-surgical benefit
- Covered and included in the fee for the extractions performed if performed with extractions in a hospital setting
- Payable reconstruction of the mandible with dental implants
- Billed using the CMS-1500 claim and attach documentation

Implants

Some groups cover mandibular reconstruction with endosteal implants that are "fully approved" (that is, not provisionally approved) by the American Dental Association when performed on or after the effective date of benefit coverage.

Use CPT code *21249 (reconstruction of mandible, endosteal (for example, blade, cylinder); complete, that is inclusive of all implants placed).

Note: CPT code *21249 is inclusive of all implant services and implants placed and can't be billed multiple times.

Examples of payable conditions include implants following ablative tumor surgery or severe atrophy of the mandibular arch. To be covered, implants must meet the criteria below. Coverage is only for placement surgery of implant substructure for two or more implants.

- There are no medical or dental contraindications to treatment.
- More conservative treatment hasn't been successful.
- Documentation, as indicated in the guidelines, includes the functional problems associated with the mandibular deformity.

- Totally edentulous mandible must have less than 20 mm in radiographic height from the inferior border to the crest of the ridge in the mandibular symphysis region.

Coverage is limited to surgery for the placement of the implant substructure, which includes:

- Surgical placement of the device
- Uncovering the implant at a later date
- Cost of the implant cylinders, which is included in the surgical allowance for the service

CPT code *21248 isn't payable for Blue Cross groups unless the group has specific contract coverage. Single endosteal implants may be payable for certain groups under the dental program. The placement coverage for endosteal implants in the dental program includes both ADA- and FDA-approved implants.

We don't cover:

- Maxillary implants, peri-implant bone grafts, bone grafts in preparation for implants (including socket preservation), ridge augmentation, sinus lifts, soft tissue grafts and dental implant related surgical services including removal of dental implants, which aren't medical-surgical benefits
- Dental implants that aren't "fully approved" by the ADA and FDA and don't meet the medical criteria above
- Charges for implant mesostructure, superstructure, attachments, connecting devices, prostheses or maintenance

Submit documentation with pre-determination requests and claims, including:

- Purpose of the procedure and documentation that medical criteria are met
- Radiographic evidence (panoramic or lateral cephalometric film)
- The setting in which the procedure will be or has been performed and the implant system
- Other information that you or we consider pertinent to our payment determination
- Submit this information to the address given under Extractions.

Orthotic appliance for sleep apnea

Oral orthotic appliances for sleep apnea are billable under the medical-surgical benefit when medically necessary. "Snoring" isn't considered a medically necessary diagnosis. Coverage is limited to and includes impressions, fabrication, materials, and all subsequent adjustments (orthotic check-out) and repairs. There is no benefit coverage for any screening tests, for example, questionnaire, sleep study, pulse oximetry, rhinometry, laryngometry and pharyngometry by the dentist.

All the following must be present to bill for oral orthotic treatment of sleep apnea:

- Symptoms and signs of obstructive sleep apnea
- Polysomnography demonstrating obstructive sleep apnea. This is defined as documented respiratory disturbance index of five or more obstructive events per hour of sleep followed by arousal, awakenings or a reduction of oxygen saturation of 4% or greater. At least two hours of sleep must be documented during the overnight recording. All sleep testing must be interpreted by board certified sleep medicine physicians

Physician and technician requirements for sleep studies and polysomnography testing:

- The physician performing the service must meet one of the following:
  - The physician is a diplomate of the American Board of Sleep Medicine, pulmonologist, neurologist or has a sleep certification issued by one of the following boards:
    - American Board of Internal Medicine
    - American Board of Family Medicine
    - American Board of Pediatrics
    - American Board of Psychiatry and Neurology
    - American Board of Otolaryngology
  - The physician is an active staff member of a sleep center or laboratory accredited by the American Academy of Sleep Medicine or the Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations)
- Technician credentials:
  - Board of Registered Polysomnographic Technologists
  - Registered Polysomnographic Technologist
  - National Board for Respiratory Care
  - Certified Pulmonary Function Technologist
  - Registered Pulmonary Function Technologist
  - Certified Respiratory Therapist
  - Registered Respiratory Therapist
  - Board of Registered Polysomnographic Technologists
  - Registered Polysomnographic Technologist
- Subjective complaints or laboratory evidence of excessive daytime sleepiness or a comorbidity associated with sleep apnea (such as systemic hypertension, cardiovascular disease, impaired cognition); one of the following must be present:
  - Refusal of CPAP
  - Failure of a three-month trial of CPAP

When billing, use the CMS-1500 claim form and bill oral orthotic for treatment of obstructive sleep apnea with only these HCPCS codes:

- **E0485** — Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, prefabricated, includes fitting, training and adjustment
- **E0486** — Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated, includes fitting, training and adjustment. Be sure to include the corresponding ICD-9CM or ICD-10-CM diagnosis code.

Prosthetic appliances

Maxillofacial prosthetic appliances are devices used to replace oral or maxillofacial anatomical deficiencies. They're payable if the subscriber has prosthetics and orthotics coverage. For a list of procedure codes, refer to the American Medical Association's Physician's Current Procedural Terminology manual under "Prosthesis."

To be covered, the prosthetic appliance must replace all or part of an oral or maxillofacial deficiency.

Here are billing guidelines:

- Enclose all applicable documentation with the claim, including operative and pathological reports and clinical notes.
- Submit a CMS-1500 claim with the appropriate CPT code.
- Be sure to include the corresponding ICD-9CM or ICD-10-CM diagnosis code.

We don't cover:

- Dental appliances, such as full or partial dentures, bridges
- Experimental or investigational services or devices
- Orthodontic appliances
- Routine periodic maintenance of dental and orthodontic appliances

Temporomandibular joint dysfunction, or TMJ, treatment

Overview — Temporomandibular joint disorders affect the temporomandibular joint. The TMJ is located in front of the ear where the skull and lower jaw (mandible) articulate. The TMJ allows the mandible to move and function. The etiology of TMD may be developmental or acquired, and may include multifactorial etiologies such as trauma, intracapsular abnormalities, and associated muscular dysharmony or parafunctional activity of the jaws.

The American Dental Association Council on Dental Care Programs has recommended that treatment of the TMJ and jaw joint disorders not be classified as solely medical or dental. Blue Cross has adopted this position and considers some treatment of TMD under the medical-surgical program benefit and others under the dental program benefit.

Benefits — Benefits for TMD treatment are contract-specific. You can determine whether the patient's coverage includes TMD benefits prior to treatment by calling CAREN at 1-800-482-4047 or by checking the patient's benefits online through web-DENIS.

Benefits for treatment of bruxism with an occlusal guard is the only TMD-related service covered under the Blue Cross dental program. Refer to "Occlusal guards" in section VI for guidelines and criteria. Irreversible and related services to treat TMD aren't a benefit under the dental program.

Benefits for TMD or jaw-joint disorder treatment are limited to diagnostic services including simple physical examination, limited imaging services, symptom-management services such as reversible appliance therapy, physical medicine, medications, injections and surgery directly on the jaw joint.

Billing guidelines — Don't bill the dental program for a bruxism appliance and the medical — surgical program for TMD services on the same patient. Determine which problem is primary (based on the clinical documentation) and submit the claim appropriately — see the chart below. Billing both the dental and medical-surgical programs for bruxism and TMD is considered inappropriate and is subject to retrospective review and recovery.

Treatment	Covered under
Reversible treatment — Treatment of the jaw joint and masticatory musculature that isn't intended to affect a permanent alteration of the bite (occlusion). Reversible treatment is directed at managing symptoms. It can include, but isn't limited to, physical medicine, medications or reversible appliance therapy (occlusal orthotic).	Medical-surgical program
Surgical treatment — Surgery that is directly on the temporomandibular joint and that is intended to treat intracapsular disorders. This can include arthrocentesis, arthroplasty and condylotomy.	Medical-surgical program
Bruxism — A habitual parafunctional grinding of the teeth that may include pain irradiating around the TMJ. Treatment of bruxism is intended to prevent damage to the teeth and their supporting structures.	Dental program
Irreversible treatment — Treatment of the mouth, teeth or jaw that is intended to effect a permanent change in the positioning of the jaws or permanent alteration of the vertical dimension. It includes, but isn't limited to, bridges, crowns, inlays, dental restorations, occlusal equilibration, orthognathic surgery, and orthodontics including appliances that allow tooth movement.	Not a benefit under either program for treatment of TMD

TMJ and other jaw joint disorder coverage are subject to the specific provisions of the subscriber's contract, including deductibles and copayments. The following TMJ and other jaw joint disorder procedures are payable benefits for those subscribers who have coverage.

- Arthrocentesis
- Magnetic resonance imaging
- Medications
- Office visits
- Physical medicine — Refer to the BCBSM Guide for Providers of Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services available on web-DENIS for coverage and documentation guidelines, covered and non-covered services as they relate to TMD dysfunction
- Reversible appliance therapy (mandibular orthotic repositioning appliance)
- Surgery directly to the jaw joint
- Other imaging (except routine screening X-rays)

Physical therapy

Physical therapy procedures are payable to dental providers (dentists, non-oral and oral surgeons, specialties 19 and 97) for the treatment of TMD provided it's a covered benefit. The procedure codes and diagnoses in the charts below are applicable for TMD treatment.

Procedure Code*	Description
97001	Physical therapy evaluation
97002	Physical therapy reevaluation
97010	Application of a modality to one or more areas; hot or cold packs
97014	Electrical stimulation (unattended)
97024	Diathermy (e.g., microwave)
97026	Infrared
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
97033	Iontophoresis, each 15 minutes
97035	Ultrasound, each 15 minutes
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

Diagnosis Code	Description
524.6	Temporomandibular joint disorders, unspecified
524.61	Adhesions and ankylosis (bony or fibrous)
524.62t	Arthralgia of temporomandibular joint
524.63	Articular disc disorder (reducing or non-reducing)

Dental providers must perform the physical therapy themselves, have it performed by a registered physical therapist in the office or refer the patient to a physical therapy office where a registered therapist performs the therapy. Physical therapy provided by physical therapy assistants or any other individual working in the dentist's office won't be eligible for Blue Cross reimbursement, except when the assistant is directly supervised by a registered physical therapist.

Imaging

Radiography of the temporomandibular joint structures is prescribed primarily when documented clinical examination suggests some form of joint pathology. The following diagnostic imaging procedures are medically appropriate in the diagnosis of TMJ dysfunction:

- Tomograms
- Arthrograms
- CT scan or MRI (generally CT scans and MRIs are reserved for pre-surgical evaluations)
- Cephalograms (X-rays of jaws and skull)

- Panoramic (X-rays of maxilla and mandible)

Other transcranial radiography of the TMJ has a limited screening purpose due to image distortion of the bony articulator structures and superimposition of other structures and is not considered medically appropriate. Full mouth periapical X-rays are not considered medically appropriate.

Documentation

Your patient's treatment record must contain the evaluation and management documentation that supports your claim for payment or pre-determination.

Use the most current Evaluation and Management Services, or E&M, Guide on the CMS website. Note that time spent with the patient isn't a criterion for the documentation and is only a guide. The documentation must reflect the E&M guidelines for each visit.

For all physical therapy services, refer to the BCBSM Guide for Providers of Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services available on web-DENIS for specific documentation guidelines necessary to bill physical therapy services. All these specific guidelines and criteria must be met to successfully bill for these procedures and services.

Billing for reversible appliance

All medical doctors, doctors of osteopathic medicine, oral surgeons and other dentists billing under medical coverage should use only procedure code S8262 to bill for the reversible appliance used for treatment of temporomandibular joint dysfunction.

- The TMD reversible appliance treatment encompasses the impressions, models, fabrication, insertion and all adjustments of the appliance.
- The TMD reversible appliance is payable once per lifetime. Temporary and prophylactic appliances aren't separately billable.
- Do not bill the TMD reversible appliance with procedure codes *21085, *21299, *21485, *21110, D7880, *20999 or D9940.
- Report the TMD reversible appliance on the CMS-1500 form only, not on a dental claim form.
- Use AMA CPT coding, and not ADA CDT codes on the CMS-1500 form.
- Report the related ICD-9CM or ICD-10-CM diagnosis where indicated.
- The correct type of service is G; indicate it in field 24C, Type of Service.
- Check either YES or NO in field 27, ACCEPT ASSIGNMENT.
- Send any X-rays, exam records or other documentation that substantiate the need for a TMD reversible appliance.
- Note: Code S8262 can't be billed electronically.

Non-covered services

Irreversible treatments for TMJ dysfunction aren't covered under any Blue Cross dental or medical programs, with the exception of surgery directly on the jaw joint for the treatment of documented intra-articular disorders. New materials and treatments that are considered experimental or investigative are excluded.

The following diagnostic procedures aren't covered for the treatment of TMD unless the patient has specified contract coverage for the procedure:

- Surface EMG
- Nasal function studies
- Laryngeal function studies
- Joint vibration studies
- Structural/posture analysis
- Cone beam CT
- Kinesiography or thermography
- Neuromuscular junction testing
- Somatosensory testing
- Transcranial or lateral skull X-rays
- Sonogram (ultrasonic Doppler auscultation)
- Intra-oral or gothic-arch tracing (intended to demonstrate deviations in the positioning of the jaws that are associated with TMJ dysfunction)
- Muscle testing
- Standard dental radiographic procedures
- Range of motion measurements
- Computerized mandibular scan
- Condylar position indication
- Hinge axis location and recording
- Diagnostic models or set-up
- Psychological testing

The following non-surgical treatments are not covered for the treatment of TMD:

- Biofeedback
- Orthodontic services
- Dental restorations and prosthesis
- Devices promoted to maintain joint range of motion and to develop muscles involved in jaw function (except as an adjunct to post-surgical management)

The bruxism appliance (D9940) isn't covered for treatment when TMD is the primary diagnosis. The following surgical treatments aren't covered for the treatment of TMD:

- Arthroscopy of the TMJ for purely diagnostic purposes
- Orthognathic surgery
- Endosteal implants

Other services

Tori and exostoses removal are group-specific benefits and may be payable under the dental or the medical/surgical coverage. Check web-DENIS or call CAREN or Provider Inquiry to verify if a patient has this benefit.

These services aren't covered under the medical/surgical benefit:

- Alveoloplasties
- Endodontic treatment
- Periodontal treatment
- Orthodontic treatment

VIII. Blue Cross Complete – Dental

Blue Cross Complete members who are covered by the Healthy Michigan Plan have some dental care coverage through Blue Cross Complete. Dental exams, cleanings and extractions are covered. Members get dental care through Blue Cross Complete's network of dental providers.

Note: Members can locate a dentist by calling Blue Cross Complete's Dental Customer Service at 1-844-320-8465. TTY users should call 711. The business hours for Dental Customer Service are 9 a.m. to 5 p.m. Monday through Thursday and 9 a.m. to 3:30 p.m. Friday.

For Blue Cross Complete members who aren't covered by the Healthy Michigan Plan, the State of Michigan's Medicaid program pays for emergency, diagnostic, preventive and therapeutic services for dental disease that, if left untreated, would result in acute dental problems or cause irreversible damage to teeth and supportive structures.

Note: For these members, routine dental exams, cleanings, fillings, dentures and other non-emergency dental services aren't a covered Blue Cross Complete benefit.

IX. Claims – Filing

You or your billing service may submit dental claims electronically through a clearinghouse, through the provider portal or on paper. This part provides paper-claim billing guidelines and instructions.

If you're filing claims electronically, please refer to the instructions provided by your software vendor. We accept X-rays, written records and other attachments to your electronic claims through National Electronic Attachment.

See specific sections of this manual for the following:

- Orthodontic paper claims filing information in section IX
- Guidelines for medical-surgical services billed on the CMS-1500 claim in section X
- Guidelines for submitting claims for prior authorization in section IV

File claims within 24 months of the date of service (except for the Federal Employee Program). Medicare claims have a one-year filing limitation. If you have claims older than 24 months that were previously submitted but not resolved, submit an appeal. Include the appropriate documentation supporting the reason for the filing delay.

For FEP, submit claims no later than December 31 of the calendar year after the year in which the covered service was provided.

Electronic and internet claims filing

Blue Cross offers dentists the option to file claims electronically or via the provider portal. Both methods of filing claims are quicker and more cost-effective than submitting paper, and payment is faster.

Blue Cross uses DentaQuest's provider portal as a web-based inquiry system. DentaQuest's provider portal provides HIPAA compliant transactions. There's no special software needed; simply log on to **http://provideraccess.dentaquest.com** to get started. You will need to request an access code. All Blue Cross member transactions are free of charge for contracted providers.

For electronic billing information, call our Electronic Data Interchange department at 1-800-542-0945.

Blue Cross accepts electronic attachments to claims. Contact National Electronic Attachment to register for software, installation and training to help dental offices get started sending X-rays and other attachments electronically. Call NEA at **1-800-782-5150**, option 2, email **sales@nea-fast.com** or go to **https://nea-fast.com/install/**.

Paper claims filing — ADA form

To bill dental services on paper, properly fill out the current and correct American Dental Association form. Report all the information we need so we can process your claim promptly and accurately. We accept claims only on the 2006 or newer ADA form. Blue Cross doesn't supply ADA forms. Order them directly from the ADA at www.adacatalog.org or call **1-800-947-4746**.

These services must be billed on paper:

- Coordination of benefits claims when we are the secondary payer (unless submitted as an attachment through NEA)
- Claims with medical codes – Use form CMS1500
- Accidental dental injury claims – Use form CMS1500

We'll review your claim on the initial submission based on the patient's utilization history. However, certain services may require submission of documentation and X-rays to support the treatment. If we require an X-ray or documentation, we'll notify you with a processing policy nonpayment code.

Enrolling with NEA allows you to submit documentation electronically, if requested. You can also send photographs (if available), periodontal charting and explanations of the circumstances that make the procedure necessary. However, this information doesn't replace required X-rays.

Key points to remember when filling out the ADA paper claim:

Do	Don't
• Use black ink and type entries in capital letters inside the boxes. • Fill in all fields that pertain to the claim. • Use the patient's and subscriber's legal names. • Enter the Blue Cross subscriber ID number as it appears on the patient's ID card. Do not include the alphanumeric characters before the numbers. Only use the numbers. • Itemize all services.	• Handwrite, send photocopied claims, use paper clips or tape. • Use script, slanted or italicized type or special characters, such as, @ or #. • Use nicknames or titles, such as Mr. and Mrs. • Combine prior authorization services and completed services to be processed for payment on the same form. • Send the patient bill or payment receipt.

Claim instructions

The American Dental Association provides step-by-step instructions to help complete dental claims. Please go to the following link for up-to-date guidance: **https://ada.org/en/publications/cdt/ada-dental-claim-form**

Submit completed paper claims and supporting documentation to the appropriate address as outlined in the chart below:

Type of claim	Address
Initial claims, except FEP	Blue Cross Blue Shield of Michigan P.O. Box 49 Detroit, MI 48231
Medicare Advantage claims	Blue Cross Blue Shield of Michigan P.O. Box 49 Detroit, MI 48231
FEP claims	Federal Employee Program Blue Cross Blue Shield of Michigan P.O. Box 2599 Detroit, MI 48231-2599
Accidental dental injury claims, send a CMS-1500 form	Blue Cross Blue Shield of Michigan P.O. Box 2500 Detroit, MI 48231-2500

Billing and payment of dental procedures that apply payment toward medical out-of-pocket cost

Some members may have medical benefit plans that apply payment for certain dental procedures to their medical out-of-pocket cost. When claims are submitted that include certain dental procedures for these members, they will be processed by both DentaQuest and Blue Cross. This circumstance results in two separate payments. In these instances, the provider is still required to submit the claims on the proper ADA claim forms, not on medical CMS claim forms.

DentaQuest will initially receive the claim. They will process the portion of the claim that contains services covered by the member's dental plan then forward the claim to Blue Cross for processing of the remaining non-medical dental procedures that are covered under the member's medical out-of-pocket cost.

You will receive payment and an EOB from DentaQuest. The EOB will indicate which services were sent to Blue Cross for processing. It will specifically state the following: "This procedure(s) is covered under the member's medical plan and has been forwarded to the appropriate medical department at Blue Cross Blue Shield of Michigan for processing." You will also receive payment and a voucher from Blue Cross.

In the circumstance of billing and receiving payment for members with dental applied toward payment of medical out-of-pocket cost, you don't need to take any special action. Simply wait for receipt of the voucher and check from Blue Cross. Don't bill the member for the remainder of the claim. If you have questions or concerns about either portion of the claim, contact either DentaQuest or Blue Cross as instructed on the EOB or payment voucher.

Coordination of benefits billing guidelines

If a member is covered under another group health plan, benefits are coordinated. The primary plan pays benefits first. For additional COB information, see section III. If you're billing us as the primary payer:

- Treat this claim as you do other claims. See preceding billing instructions.
- Mark "*Yes*" in the "*Other Dental*" field and indicate the other carrier.

- Keep a copy of our payment voucher. You will need this to bill the secondary payer if there's a balance after we have paid.

We will process the claim as usual.

If we are the secondary payer, bill us on a paper ADA claim form after receiving a payment or a nonpayment notice from the primary payer. Refer to the preceding billing instructions. However, please note the following:

- In the "*Fee*" column, enter the full charge – not the balance still owed – for the service.
- Make sure to attach a copy of the primary payer's voucher to the claim.

There are two ways to pay the secondary balance, and we use whichever applies:

1. We pay our approved amount minus the amount paid by the primary payer. Our payment will never exceed our approved amount for the procedure.

   See the example below:

   Example

Dentist's charge for a crown:	$800
Primary payer's approved amount:	700
Primary payer's payment amount:	560
Blue Cross' approved amount for a crown:	650
The secondary balance we will pay:	$90

   Calculation: $650 (our approved amount) minus $560 (the primary payer's payment) equals $90.

2. If the dentist's charge is less than our approved amount, we pay the difference between the dentist's charge and the amount paid by the primary payer.

   Example

Dentist's charge for a crown:	$600
Primary payer's approved amount:	700
Primary payer's payment amount:	560
Blue Cross' approved amount for a crown:	650
The secondary balance we will pay:	$40

   Calculation: $600 (the dentist's charge, which is less than our approved amount) minus $560 (the primary payer's payment) equals **$40**.

The combined payments of both payers can't exceed the charge for the service provided.

Here are some guidelines:

If…	Then…
We are the primary and secondary payers (that is, there are two Blue Cross contracts).	Our payment under the secondary contract won't exceed what is payable. Submit the secondary claim to us with the primary payment voucher attached.
We incorrectly pay as the primary plan instead of the secondary plan.	Please return the payment amount.
You receive an incorrect payment or a nonpayment notice.	Resubmit the claim as a status inquiry claim. Indicate the reason for resubmission.
The member has coverage under more than two dental carriers.	You can't bill for payment in excess of your charge for your services.

Claims follow-up — status inquiries

To find the status of a claim or to resolve claim issues or disagree with a payment or nonpayment, please use DentaQuest's Provider Portal or call Blue Cross Customer Service 1-888-826-8152.

For Medicare Advantage customer service, claim and payment status, patient eligibility and benefits, and frequency limitations, use DentaQuest's Provider Portal or call 1-844-876-7917 Monday through Friday from 8 a.m. to 5 p.m. Eastern time.

Note: Payment of claims is subject to contract limitations.

Payment of interest on claims

We automatically pay interest on eligible claims that take more than 45 days to process.

By "eligible claim," we mean:

- It's for services provided.
- It's a clean claim (see below).
- Payment is directed to the provider or subscriber.

Depending on which group the member belongs to, the interest payment will either appear on your check voucher as an additional item, or we'll issue a separate check for the interest payment the following week.

When we receive claims that aren't submitted with the required information, we send a denial notice to you indicating what information is missing. You can resubmit the claim on a 2006 or newer ADA claim form with the requested documentation.

Once all required information is submitted, the claim is considered clean.

X. Claims – Filing orthodontic claims

Blue Cross processes and pays orthodontic claims according to the member's contract benefits. All orthodontic services can be submitted either on paper or electronically. Please read options below carefully to make sure you use the correct code for either:

- Comprehensive treatment (D8080)
- Treatment in Progress (D8999)

Blue Cross pays for orthodontic treatment in one payment. When we process your total treatment claim, we'll pay up to the member's lifetime maximum, minus applicable coinsurance and deductibles. The payment can't be more than the coinsurance of our approved amount.

Use a current ADA claim form, the provider portal or submit electronically when submitting for orthodontic services.

To file an initial claim for orthodontic treatment:

- Bill the date of service, orthodontic treatment code and the total fee on one line.
- Always itemize diagnostics and bill them separately from the total orthodontic treatment.
- For appropriate orthodontic case codes to report, see information later in this section.

Important notes:

- The above payment process doesn't apply to orthodontic cases in progress, or to patients who obtain Blue Cross orthodontic coverage after treatment begins.

- Since orthodontic treatment is paid for in one payment, don't bill for periodic orthodontic treatment visits - D8670. Use code D8999 instead, for continuation of care ortho cases.
- See below for an example claim before sending in claim.

Please complete the following fields on the current ADA form as requested by Blue Cross. Fill out the remainder as indicated at ada.org.

Field	What to do
1. Dentist's pretreatment estimate; dentist's statement of actual service	Mark the appropriate box.
24. Procedure code (first line)	Enter the CDT code that best describes your orthodontic treatment plan for the patient.
30. Description (first line)	Enter a description of the services provided.
31. Fee (first line)	Enter the total case fee. Don't include fees for diagnostic procedures in the total case fee — list diagnostic codes and fees separately.

Additional guidelines for orthodontic cases

If a patient changes insurance with a new orthodontic benefit amount or continues treatment with a new dentist or orthodontist, use code D8999 as directed below.

You may bill for orthodontic cases in progress or for patients who obtain Blue Cross orthodontic coverage after treatment begins. An example ortho claims form is provided here for guidance when a continuation of care claim is needed for ortho treatment with a new provider or new insurance carrier.

To do so, please submit the following information:

- Paper claims using the current ADA form For Example:
- In field 1 of the Record of Services Provided section, enter the banding procedure code, the total treatment fee and the date of service.
- In field 2, enter procedure code D8999, the date the member's BCBSM coverage became effective and the lump sum fee for the monthly visits remaining in the treatment plan.
- In field 35, under remarks, enter the treatment code used, the monthly fee and the months of treatment remaining.
- Electronic claims
- Submit an 837 transaction with procedure code D8999.
- Include a note at the claim or service level that the claim is for remaining benefits due to a carrier or provider change.
- Provide the total fee, the monthly fee and the months of treatment remaining.

Blue Cross will pay the remaining benefits, minus any applicable deductible or coinsurance, up to the member's lifetime benefit maximum.

Other guidelines: terminated services, underpayment or over payment

- If you have terminated services, please submit an inquiry advising us of the date treatment stopped.
- If we underpay you, complete and submit an inquiry claim using a 2006 or newer ADA claim, and we'll review each case for special consideration.

- Indicate the reason for the further payment consideration and the revised total fee in the "Remarks" field.
- Attach your written notice of continuation of treatment to the claim.

- If you receive an overpayment or a payment in error, please send us a refund:
  - Write a check in the amount of the incorrect payment.
  - In the lower left corner of the check, write the:
    - Patient's name and contract number
    - Service date
    - Claim document number
  - Write a note of explanation.
  - Attach the EOB and note to the check and send it all to: Blue Cross Blue Shield of Michigan
    P.O. Box 49
    Detroit, MI 48231

XI. Reprocessing, Recovering and Offsetting Claims

Blue Cross Blue Shield of Michigan has the right to reprocess claims and recover or offset claim payments made in error, regardless of the cause of the error, within 18 months from the date of payment. In the instance of dental provider fraud or misrepresentation, the 18-month limitation will not apply.

XII. Claims – Documentation

Supporting documentation is sometimes necessary when you submit claims. It helps us determine benefits for your patient. For example, in the "Remarks" section of the claim or on a separate sheet of paper, you can note additional facts about the case you're reporting.

It's important that you maintain sufficient documentation in a member's dental records. For documentation guidelines, refer to the Frequently Used Procedures section of this manual, as well as Appendix A.

Only send duplicates as X-rays aren't returned. Here are examples of documents that support the need for treatment:

- Visual findings that aren't apparent on the patient's X-ray
- Periodontal charting
- Test results that are recorded in the dental chart
- History of trauma or accident
- Medical history or complications, if applicable
- Copy of patient's treatment record, documenting a specific problem

Once we receive this documentation, we'll verify the treatment and procedures you billed were actually performed. We may seek recovery of our payment if your records and clinical notes don't support the need for treatment or treatment was never completed.

Record return policy and e-attachments

- Blue Cross doesn't return X-rays or photographs to your office. X-rays and photographs will be destroyed after they are imaged and become part of the permanent claim record. We urge you to send duplicates when X-rays are requested.
- Blue Cross accepts attachments to electronic claims. Call National Electronic Attachment at 1-800-782-5150, option 2, or e-mail sales@nea-fast.com for registration information.

Supporting documentation guidelines

Dental records are legal documents and, therefore, must be clear and complete.

- When filling out charts:
  - Use black ink.
  - Write clearly.
  - Include the patient's name on every page.
  - Date all entries.
- All dentists in the office must sign the chart as follows:
  - The dentist or hygienist who provided the service initials all entries.
  - If different dentists provided different services on the same day, each one initials his or her particular treatment entry.
  - If you advise the patient of alternative treatments, chart them and have the patient sign the chart.
- If you make an error on the chart:
  - Delete a mistake with a single slash through it.
  - Initial the error before the correct entry is made.
  - Don't erase or use correction fluid on an incorrect entry.

Recommended components for documenting each type of oral evaluation include but aren't limited to:

Type of evaluation	Recommended documentation components
Initial evaluation	• Patient's medical and dental health status with assessment • Extraoral and intraoral soft-tissue evaluation with recording of findings • Case diagnosis and treatment planning • Oral condition and periodontal findings with charting • Baseline findings • Oral cancer exam
Periodic evaluation	• Notes about any changes in the patient's medical and dental health status, extraoral and intraoral hard and soft tissues, oral condition and periodontal status • Dentist's review and updated treatment plan
Problem-focused (emergency) evaluation	• Patient's medical and dental health status with assessment • Reason for referral or patient's chief complaint • Dentist's findings and diagnosis • Dentist's treatment recommendations

Treatment documentation guidelines

Describe in writing the entire treatment provided.

Include:

- The type and amount of anesthetic used
- The correct tooth number, quadrant, arch or area
- A complete description of service, including the diagnosis made that warrants treatment
- All materials used
- Any special reason for service (for example, trauma to the face). For accuracy, make the entry as soon as possible after the service
- Make a new clinical note or addendum to the original. Keep a copy of the original note.

Submitting X-rays

We request you only submit copied X-rays or submit them electronically. X-rays submitted with a paper claim won't be returned to your office.

To enroll in our e-attachment program and submit X-rays electronically, visit **https://reg.nea-fast.com/** or call National Electronic Attachments at **1-800-782-5150**, option **2**.

XIII. Service level reviews

We established cost management and quality assurance programs to promote dental care that meets the quality and standard of care for the community and the dental profession.

We work closely with dentists to ensure:

- Services paid are appropriate and dentally necessary.
- Services are actually provided and billed correctly.
- Services are performed within usual practice patterns in the dental community.

Our dental claims review is a full review of select dental procedures after services are provided, but prior to payment, to determine whether the services meet our criteria for coverage or are covered under the patient's contract.

Peer-to-peer review allows dentists to speak with a dental consultant to impartially review and resolve issues related to dental treatment.

They may pertain to:

- Unpaid services related to clinical discrepancies
- Quality of care
- Appropriateness of treatment

Peer reviews can be requested on the portal or in writing. All peer reviews should be clinical in nature. Administrative concerns should be addressed through the Customer Service line.

Prepayment utilization review

Prepayment utilization review is a process to determine our appropriate liability for covered health care services prior to payment. Placing a provider on PPUR requires the approval of our Audit and Investigations subcommittee. We individually consider each recommendation.

We may recommend dentists, physicians, other health care providers and specific procedures for PPUR for one or more reasons, which include, but aren't limited to:

- A provider is under investigation or review for possible improprieties, which involve:
  - Blue Cross, Medicare, Medicaid and other health care or insurance carriers
  - Prescribing and dispensing controlled substances for other than therapeutic reasons
  - Inducing patients to receive services through the use of work slips, prescriptions or money
- A provider is under investigation or review by a regulatory board or agency involving the termination or suspension of licensure, certification, registration, certificate of need or accreditation.
- A provider demonstrates noncompliance with our policies, guidelines and procedures. Examples include, but aren't limited to:
  - Billing for services other than what's provided
  - Refusing access to records that are essential to determine our liability
  - Failure to maintain satisfactory documentation to support billings
- A provider fails to document the dental or medical necessity of 50% or more of the services billed to us following a final audit determination.
- A provider overutilizes or inappropriately bills a procedure or set of procedures to us.
- A provider is or has been departicipated.

Financial investigations

We recognize your commitment to high-quality dental care. You and your professional organizations have high ethical standards. We ask that you share our concern about the few dentists who abuse the health care system, and we ask that you work with us to eliminate fraud and inappropriate use of services.

Improper billing by even a few dentists can threaten the resources available for health care. Our Corporate and Financial Investigations department follows up on reports of improper billing and, if improper activity is substantiated, refers information for possible legal action.

We review information, from many sources, to determine when an investigation is necessary. We handle any information we receive confidentially.

We identify and actively pursue tips provided on our antifraud hotline. If you suspect fraudulent activity against Blue Cross, please call our antifraud hotline at 1-844-STOP-FWA.

XIV. Provider appeals

In this section, we discuss the appeal process for individual claim disputes.

The appeal process usually starts 30 days after one of the following occurs:

- You complete routine inquiry procedures (telephone or written).
- You receive an audit determination.

Appeal process-at-a-glance

The chart below summarizes the appeal steps and time frames that DentaQuest will follow acting on behalf of Blue Cross.

Steps	Time frame
1. Provider submits written complaint or request for reconsideration of Blue Cross' adverse determination.	Within 180 days of receiving written response to routine inquiry or audit determination
2. Blue Cross sends results of review.	Within 30 days of receiving provider request
3. If still no satisfactory result, provider requests peer-to-peer review.	Within 60 days of receiving review results

Appeal process in detail

You have the right to appeal the results of an individual claim determination or an audit. After an appeal, if you agree with or choose not to dispute the reviewer's findings, we'll make the recommended adjustment to the claim or claims in question.

Written complaint or request for reconsideration review

For individual claim disputes: Within 180 days of receiving our determination, send your written complaint or request for reconsideration review to the address given in your letter:

Blue Cross Blue Shield of Michigan Attention: Appeals
P.O. Box 49

Detroit, MI 48231

In your request, include:

- Area of dispute
- Reason for disagreement
- Any additional supportive documentation
- Copies of dental records (if not previously submitted)

Within 30 days of receiving your complaint or reconsideration review request, we'll send you the results of our review in writing or an explanation concerning your complaint. If still no satisfactory result, provider requests peer-to-peer review if clinical in nature. Or, follow the instructions on the appeal determination for further options if not clinical in nature.

XV. Appendix A — Dental procedure code

- The American Dental Association provides updated code information each year. That information can be found in the latest edition of the ADA CDT code books. Please see the latest edition of the CDT code books for guidance on code selection. ADA CDT- 2023 (copyright 2023 by the American Dental Association; all rights reserved) procedure codes that may be covered under our dental programs — services, time and age limitations are subject to the member's contract. If you have benefit questions, call the Dental Inquiry line at 1-888-826-8152. See section III for phone numbers
- Procedures that may be reviewed for benefit coverage by our team of dental professionals, and other information about a specific procedure code that may be a contract-specific benefit
- Procedures requiring a tooth number, tooth surface, root, quadrant or arch designation

For detailed procedure code descriptors, refer to the current CDT manual. You can order it from the ADA at 1-800-947-4746. For services performed on or after January 1, 2023, refer to the ADA's copyrighted CDT 2023 dental terminology manual. Dental procedures don't require X-rays and supporting documentation or narrative when billing the initial claim, so please don't send X-rays to Blue Cross unless we request them.

XVI. Appendix B – Medicare FAQs

Medicare Plus Blue PPO

Question	Answer
Is coordination of benefits required?	Yes. The group coverage is primary and Medicare coverage is secondary.
How long is the Medicare Advantage PPO contract through Blue Cross in effect?	The initial term of the contract ended December 31, 2010; Blue Cross is no longer accepting dentists into the Medicare Advantage PPO network. Existing contracts will automatically renew for successive one-year periods unless terminated by either party. Once the contract is terminated, a dentist can't rejoin.
Will I be able to see the members as an out-of- network dentist?	Yes.
I have an "opt-out" agreement with Medicare; can I still provide dental services for Medicare Advantage patients?	No, because the Medicare "opt-out" applies to both medical and dental services. Blue Cross can't reimburse either you or the member for services.
How do I verify my "opt-out" status with Medicare?	You may verify your status online at www.wpsgha.com. Search for "Opting Out of Medicare". This gives you a list of documents to help you.
How can I obtain more information about the Medicare Plus Blue PPO plan through Blue Cross?	More information can be obtained on our website: http://provideraccess.dentaquest.com
Where can I go for MAPPO benefit information, patient eligibility, electronic claims submission, communications, claim and payment status?	For provider registration go to: http://provideraccess.dentaquest.com For website access go to: http://provideraccess.dentaquest.com For assistance, call 844-876-7917
Where can I go for MAPPO provider service, claim and payment status, patient eligibility and benefits, frequency and limitations?	1-844-876-7917 Monday through Friday 8 a.m. to 5 p.m. Eastern time Automated information is available 24/7.
How do I submit paper claims?	Blue Cross Blue Shield of Michigan P.O. Box 49 Detroit, MI 48231
How do I submit electronic claims?	Please work with your clearinghouse to submit claims electronically. Payor ID is BBMDQ.
How do I submit attachments (X-rays/files?	**https://vynedental.com/**800-782-5150

BCN Advantage

Question	Answer
Will I be able to see the members as an out-of-network dentist?	Yes, based on the purchased plan.
How can I obtain more information about BCN Advantage?	For more information, visit our website: http://www.bcbsm.com/providers/help. Choose Medicare Advantage from the drop down.
Where can I go for BCN Advantage benefit information, patient eligibility, electronic claims submission, communications, claim and payment status?	For provider registration, go to: http://dentaquest.com/selfreg/bcbsm For website access go to: http://onlineservices.bcbsm-dental.com for assistance, call 1-844-876-7917
Where can I go for BCN Advantage provider service, claim and payment status, patient eligibility and benefits, frequency and limitations?	1-844-876-7917 Monday through Friday 8 a.m. to 5 p.m. Eastern time Automated information is available 24/7
How do I submit paper claims?	Blue Cross Blue Shield of Michigan P.O. Box 49 Detroit, MI 48231
How do I submit electronic claims?	Please work with your clearinghouse to submit claims electronically Payor ID is BBMDQ
How do I submit attachments (X-rays and files)?	**https://vynedental.com/** 1-800-782-5150

XVII. Appendix C – Medicaid FAQs

Healthy Kids Dental

Question	Answer
How do I contact someone about Healthy Kids Dental?	**Phone:** 1-844-876-7917 **Mail:** BCBSM P.O. Box 491 Milwaukee, WI 53201-0491

XVIII. Other Resources

Resource	Contents	How to order
Dental Care News, our quarterly newsletter for dentists	Billing tips and policy changes from BCBSM	Email request to Lknowles@bcbsm.com .
CDT- 2023 manual	Dental procedures, codes and nomenclature, glossary of dental terms, ADA dental claim form	Call the American Dental Association at 1-800-947-4746 or visit www.ada.org.
CPT and ICD-9CM or ICD-10-CM manuals	Medical procedure and diagnosis codes	Call the American Medical Association at 1-800-621-8335 or visit www.amabookstore.com.