

## DENTAL CARE

Dental care includes items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth. Structures directly supporting the teeth mean the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum of the teeth, and alveolar process.

## ORIGINAL MEDICARE<sup>1</sup>

Original Medicare will pay for dental services that are an integral part either of a covered procedure (e.g., reconstruction of the jaw following accidental injury), or for extractions done in preparation for radiation treatment for neoplastic diseases involving the jaw. Medicare will also make payment for oral examinations, but not treatment, preceding kidney transplantation or heart valve replacement, under certain circumstances. Such examination would be covered under Part A if performed by a dentist on the hospital's staff or under Part B if performed by a physician.

### Statutory dental exclusion

Section 1862 (a)(12) of the Social Security Act states, "where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under Part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his or her underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services."

### Services excluded under Part B

The following two categories of services are excluded from coverage:

- A primary service (regardless of cause or complexity) provided for the care, treatment, removal, or replacement of teeth or structures directly supporting teeth, e.g., preparation of the mouth for dentures, removal of diseased teeth in an infected jaw.
- A secondary service that is related to the teeth or structures directly supporting the teeth unless it is incident to and an integral part of a covered primary service that is necessary to treat a non-dental condition (e.g., tumor removal) and it is performed at the same time as the covered primary service and by the same physician or dentist. In those cases in which these requirements are met and the secondary services are covered, the Medicare payment amount should not include the cost of dental appliances, such as dentures, even though the covered service resulted in the need for the teeth to be replaced, the cost of preparing the mouth for dentures, or the cost of directly repairing teeth or structures directly supporting teeth (e.g., alveolar process).

### Exceptions to services excluded:

- The extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease.
- An oral or dental examination performed on an inpatient basis as part of comprehensive workup prior to renal transplant surgery or performed in a rural health clinic and federal qualified health center prior to a heart valve replacement.

<sup>1</sup> Medicare dental coverage overview – <http://www.cms.hhs.gov/MedicareDentalCoverage/>

# MEDICARE ADVANTAGE

Coverage for dental care that is considered preventive services is provided to members under select Medicare Advantage private fee-for-service plans. Since Original Medicare does not cover these services, the scope of benefit, reimbursement methodology and member cost-sharing are determined by the individual group plan.

## Conditions for payment

BCBSM Medicare Advantage private fee-for-service plans use the Centers for Medicare & Medicaid Services deemed provider concept for this benefit. The table below specifies payment conditions for dental care:

Conditions for payment	
Eligible provider	Dentist
Deemed provider	See terms and conditions on <a href="http://bcbsm.com/ma">bcbsm.com/ma</a> <sup>2</sup>
Payable locations	No restrictions
Frequency	<ul style="list-style-type: none"><li>• Periodic (routine) oral evaluation (one per calendar year)</li><li>• Bitewing X-rays (one set – up to 4 X-rays per set, per calendar year)</li><li>• Adult prophylaxis (one cleaning per calendar year)</li></ul>
CDT codes	D0120, D0270, D0272, D0273, D0274, D1110
Diagnosis restrictions	No restrictions
Age restrictions	No restrictions

## Reimbursement

The maximum payment amount for dental care benefit is based on the approved fees that have been established. The fee schedule is available in a separate document, [BCBSM Medicare Advantage – Additional Benefits Fee Schedule](#).

The provider will be paid the lesser of the approved amount or the provider's charge. This represents payment in full and providers are not allowed to balance bill the member the difference between the approved amount and the charge.

## Member cost-sharing

- The member cost-sharing responsibilities do not apply to dental care.
- If the member elects to receive a noncovered service, he or she is responsible for the entire charge associated with the noncovered service.

The chart below identifies members under the individual group plan with dental care coverage:

Group name and number		
Medicare Plus Blue	Option A	53910
Medicare Plus Blue	Option B	53921
Medicare Plus Blue	Option C	53901
Medicare Plus Blue	Option D	53903

## Billing instructions

1. Bill services on 2006 or 2002, 2004 American Dental Association claim form.
2. Submit claims to:  
Blue Cross Blue Shield of Michigan  
P.O. Box 49  
Detroit, MI 48231-0049
3. To submit claims electronically contact:  
Electronic Data Interchange  
Telephone number: 800-542-0945

<sup>2</sup> 2009 Terms & Conditions – <http://www.bcbsm.com/ma/>