Dental Care
Applies to:

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

☒ Medicare Plus Blue℠ PPO ☐ Medicare Plus Blue℠ Group PPO ☐ Both

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 gingiva, dentogingival junction, periodontal membrane, cementum of the teeth and alveolar process.

Original Medicare

Original Medicare will pay for dental services that are an integral part either of a covered procedure, such as reconstruction of the jaw following accidental injury, or for extractions done in preparation for radiation treatment for neoplastic diseases involving the jaw. Original Medicare will also make payment for oral examinations, but not treatment, preceding kidney transplantation or heart valve replacement, under certain circumstances. Such an 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 federal Social Security Act prohibits payment under Medicare Parts A and B for expenses incurred by a Medicare member "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

These two categories of services are excluded from coverage under Medicare Part B:

- A primary service, regardless of cause or complexity, provided for the care, treatment, removal or replacement of teeth or structures directly supporting teeth, such as preparation of the mouth for dentures or removal of diseased teeth in an infected jaw.
- A secondary service related to the teeth or structures directly supporting the teeth unless it's incident to and an integral part of a covered primary service necessary to treat a non-dental condition, such as tumor removal.
  - This service must be 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, such as alveolar process.

Exceptions to excluded services

- 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 federally qualified health center prior to a heart valve replacement.

Medicare Plus Blue℠ PPO enhanced benefit

Medicare Plus Blue℠ PPO is a Medicare Advantage plan that provides at least the same level of benefit coverage as Original Medicare (Part A and Part B) and may provide enhanced benefits beyond the scope of Original Medicare within a single health care plan. This flexibility allows Blue Cross to offer enriched plans by using Original Medicare as the base program and adding desired benefit options.

Coverage for preventive dental care is provided to members under select individual Medicare Plus Blue PPO plans. Because Original Medicare doesn't cover preventive dental care, the scope of benefit, reimbursement methodology, maximum allowed payment amounts, and member cost sharing are determined by Blue Cross.

Conditions for payment

This table below specifies payment conditions for dental care.

Conditions for payment	
Eligible provider	Dentist
Payable location	No restrictions
Frequency	Based on Individual plan option
CPT codes	D0120, D0140, D0150, D0160, D1110, D1120, D0220, D0230, D0270, D0272, D0273, D0274, D4346, D4910
Diagnosis restrictions	No restrictions
Age restrictions	

Reimbursement

Medicare Plus Blue PPO plan's maximum payment amount for dental care is available on our provider website, **bcbsm.com/providers/help/faqs/medicare-advantage/provider-toolkit/enhanced-benefits.html** in the MA enhanced benefits fee schedule. The provider will be paid the lesser of the approved amount or the provider's charge minus the member's share of the cost. This represents payment in full and providers aren't allowed to balance bill the member the difference between the allowed amount and the charge. Members who chose to use an out-of-network provider will be responsible for any amount that is greater than the Blue Cross allowed amount.

Member cost sharing (enhanced benefit)

- Medicare Plus Blue PPO members' cost sharing responsibilities don't apply to dental care for in-network providers.
- Medicare Plus Blue PPO members have a 50 percent cost-sharing responsibility applied for out-of-network providers. Cost sharing refers to a flat-dollar copayment, a percentage coinsurance or a deductible. Members who chose to use an out-of-network provider will be responsible for any amount that is greater than the Blue Cross allowed amount.
- If the member elects to receive a noncovered service, he or she is responsible for the entire charge associated with the that service.
- Cost sharing amounts incurred by the member under this benefit don't count toward the health plan deductible or the combined maximum out-of-pocket limit as listed in the *Evidence of Coverage* document.

Dental buy-up – optional supplemental

This plan offers some extra benefits that aren't covered by Original Medicare and not included in the enhanced benefits package. These extra benefits are called "optional supplemental benefits." If a member chooses these optional supplemental benefits, they must sign up for them and may have to pay an additional premium. The optional supplemental benefits described are subject to the same appeals process as any other benefits.

Optional supplemental benefits are offered uniformly to all enrollees. Enrollees may choose to pay an additional premium to receive coverage under the optional supplemental benefit. The optional supplemental benefit is paid for directly by the enrollee or on behalf of the enrollee through an additional premium and cost sharing.

Conditions for payment		
Eligible provider	Dentist	
Payable location	No restrictions	
Frequency	**Fluoride** – 1 calendar year **Amalgam/resin filing** – 1 time per tooth per surface every 48 months **Root canal** – Once per lifetime per tooth **Crowns** – One time per tooth every 84 months	Essential plan buy-up will include: 2 routine exams, 2 cleanings, & X-rays - 1 set of up to 4 bitewings or 6 periapical (not both) every 2 calendar years
CPT codes	D1206, D1208, D2140 through D2335, D2391 through D2394, D3310 through D3330, D7140, D2980, D2710-D2794	
Diagnosis restrictions	No resrictions	
Age restrictions		

Member cost sharing (optional supplemental)

Essential plan

Comprehensive dental — $2500 allowance (combined in and out); no waiting period; no deductible

In network	Out of network
Routine exams, cleaning, X-rays: no deductible, $0 copay	Routine exams, cleaning, X-rays: no deductible, 50% coinsurance
Class I 0% coinsurance - fluoride	Class I 50% coinsurance - fluoride
Class II and III - 25% coinsurance – amalgam and resin fillings, root canals, simple extractions, crown repairs, crowns	Class II and III- 50% coinsurance - amalgam and resin fillings, root canals, simple extractions, crown repairs, crowns

Vitality, Signature and Assure plans

Comprehensive dental — $2500 allowance (combined in and out); no waiting period; no deductible

In network	Out of network
Class I 0% coinsurance - fluoride	Class I 50% coinsurance - fluoride
Class II and III 25% coinsurance – amalgam and resin fillings, root canals, simple extractions, crown repairs, crowns	Class II and III - 50% coinsurance - amalgam and resin fillings, root canals, simple extractions, crown repairs, crowns

To verify benefits and cost sharing, providers may utilize the online services website. To register, visit **http://dentequest.com/selfreg/bcbsm***. After the provider has registered, go to **http://onlineservices.bcbsm-dental.com*** or call 1-844-876-7917.

*Blue Cross Blue Shield of Michigan and Blue Care Network do not own or control this website.

Billing instructions for providers

1. Bill services on the 2012 American Dental Association claim form.
2. Report your national provider identifier and taxpayer identification number on all claims.
3. To submit claims electronically contact, please work with your clearinghouse.

DentaQuest Payor ID is BBMDQ

Send paper claims to:

Blue Cross Blue Shield of Michigan
P.O. Box 491
Milwaukee, WI 53201

Revision history

Policy number: MAPPO 1006

Reviewed: 07/17/2018, 08/15/2016

Revised: 10/05/2018, 08/22/2016, 08/14/2015, 2012

10/05/2018: Updated policy to add Dental Buy-Up Optional Supplemental coverage

08/22/2016: Removed reference to ICD-9/ICD10 transition, added bullet indicating cost shares for this benefit do not apply to the combined maximum out of pocket amount.

08/14/2015: Updated formatting and billing instructions, removed reference to CAREN, added revision history section, updated web links.