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Dental Care NEWS



Use only CDT-3 codes effective Oct. 14, 2002

CDT-2 codes will be rejected

Effective for service dates of Oct. 14, 2002 and later, Blue Cross Blue Shield of Michigan will accept only CDT-3 codes on dental claims.

Claims with CDT-2 codes or BCBSM-specific (also known as "local") codes will be rejected, and billers will be asked to resubmit claims with the appropriate CDT-3 codes. This is a change from our current practice of accepting either CDT-2 or CDT-3 codes.

Our transition to processing only CDT-3 codes is consistent with the standards for medical code sets required by HIPAA, the Health Insurance Portability and Accountability Act of 1996.

Many dental plans already accept only CDT-3 codes. "The Blues' move to CDT-3 codes will enable dentists to bill us the same way they bill other carriers, improving efficiency and simplifying the billing process," says Peggy Anthony, director of Dental Program Administration for the Blues.



CDT-3 codes can be found in *Current Dental Terminology, Version 2000*, a resource maintained and distributed by the American Dental Association. This resource is available in hard copy and CD-ROM. You may call 1-800-947-4746 for ordering information. ♡

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Focused review moves into second year

May 1, 2002 marked the one-year anniversary of BCBSM's dental focused review program. We would like to thank the 400 dentists involved in reviews for their cooperation.

We are pleased to report that approximately 98 percent of the 30,000 services reviewed were approved. Billing of aberrant codes (where a provider's utilization rate is at least two standard deviations greater than the peer group norm) decreased by 37 percent.

We recently notified 375 providers of their selection for the program this year, May 1, 2002 – April 30, 2003. Just like last year, these providers were selected randomly by computer or by comparing their practice patterns with those of their peers. Only 15 of the providers selected for 2001-2002 will continue on focused review for 2002-2003.

"BCBSM is very pleased with the overall results of our focused review program," says Carl Stoel, DDS, BCBSM dental consultant. "Provider compliance to BCBSM criteria and guidelines is something we are proud to pass along to our valued customers. Cooperation with the focused review program is very important, and it adds to the success of timely and efficient claims review processing and payments."

BCBSM reminds all dentists that certain services require X-rays and supporting narratives. For a list of these services, please see the April 2002 *Dental Care News* article "Some documentation requirements change." ♡

DenteMax phone number corrected

In our last issue we inadvertently published an incorrect phone number for DenteMax. Any dentist who is interested in becoming a DenteMax provider should call 1-800-752-1547.

We apologize for any inconvenience this may have caused. ♡

THE NEXT ISSUE: OCT. 2002

New payment methodology for orthodontic services effective Oct. 14, 2002

As announced on page one, BCBSM will accept only standard American Dental Association CDT-3 codes on claims for dental services, effective for dates of service Oct. 14, 2002 and later. The BCBSM-specific or "local" codes we currently use to process



orthodontic diagnostic and initial banding services will no longer be accepted. Because our payment for these services is based on

local codes, we developed a new payment methodology based on CDT-3 codes.

The new payment methodology is this:

Diagnostic services

Local code to delete	Description	Replacement CDT-3 code	Processing rules
88805	Exam	D0150	Class I
88815	Panoramic film	D0330	Class I or Class II*
88825	Diagnostic casts	D0470	Class I or Class II*
88820	Cephalometric film	D0340	Class IV**
88830	Photos	D0350	Class IV**
88880	Occlusal adjustment	D9951	Class I or Class II*

* Classifications are contract-specific.

** Payable only if the patient has orthodontic benefits; therefore, payable as Class IV.

Initial orthodontic treatment

Our initial payment, at the beginning of orthodontic treatment, will be 30 percent of our fee for the CDT-3 treatment procedure code reported OR the provider's charge, whichever is less, minus the patient's copay. The remaining balance will go toward payment for monthly visits.

Example:

- Provider charge for orthodontic treatment procedure code is \$5,000.
- Provider charge for orthodontic monthly visit code is \$140.

- BCBSM fee for CDT-3 orthodontic treatment procedure code is \$4,200.
- Member's lifetime maximum is \$1,500 and the copay is 50 percent.

Payment calculation:

- Thirty percent of \$4,200 is \$1,260. BCBSM's initial payment to the provider is 50 percent of \$1,260, or \$630.
- \$4,200 minus \$1,260 is \$2,940, which will be divided by the provider's monthly charge to determine the number of monthly visits to be automated. In this example, \$2,940 is divided by \$140, which equates to 21 monthly visits.

Note: The dollar amounts in this example are for demonstration purposes only. Member lifetime maximums and copay amounts are contract-specific.

The new payment methodology applies to the following CDT-3 procedure codes:

ADA Code	Explanation
Limited orthodontic treatment	
D8010	Limited orthodontic treatment of the primary dentition
D8020	Limited orthodontic treatment of the transitional dentition
D8030	Limited orthodontic treatment of the adolescent dentition
D8040	Limited orthodontic treatment of the adult dentition
Interceptive orthodontic treatment	
D8050	Interceptive orthodontic treatment of the primary dentition
D8060	Interceptive orthodontic treatment of the transitional dentition
Comprehensive orthodontic treatment	
D8070	Comprehensive orthodontic treatment of the transitional dentition
D8080	Comprehensive orthodontic treatment of the adolescent dentition
D8090	Comprehensive orthodontic treatment of the adult dentition

Please watch for more information on dental code changes in future issues of *Dental Care News*. 🍏

Questions about your patient's benefits and eligibility?

Call **CAREN+** at **1-800-482-4047** for the answer!

Newsbites

Holiday Closings

BCBSM will be closed:

- July 4 and 5 for Independence Day
- Sept. 2 for Labor Day 🍏

MiChild dental benefits explained

MiChild is the State of Michigan program that provides comprehensive medical and dental services to uninsured children of low-income working families. Benefits are determined by the state. BCBSM offers both health and dental plans to these members.

The MiChild BCBSM Traditional Plus Dental program covers 100 percent of basic preventive and diagnostic services with a \$600 annual benefit maximum when services are provided by BCBSM participating providers. Covered dental benefits include:

- Two exams, cleanings and fluoride treatments per benefit year
- Bitewing X-rays once per benefit year
- Dental sealants on permanent first and second molars
- Fillings
- Space maintainers for children under age 15
- Stainless steel crowns
- Pulpotomy for primary teeth
- Simple extractions

Oral surgery is covered under the medical plan instead of the dental plan.

MiChild members have identification cards with group number 31295. For specific information on a MiChild patient, please call CAREN+ at 1-800-482-4047. 🗣️

Help us provide oral surgery care for MiChild members

The MiChild BCBSM PPO program covers 100 percent of the approved medical benefit amount for in-network oral surgery procedures. BCBSM reimburses PPO and participating oral surgeons for covered services at the BCBSM TRUST (The Responsible Use System of Treatment) or Traditional allowed amounts. Covered medical benefits include:

- Removal of impacted teeth or roots
- Treatment of cysts and jaw fractures
- Apicoectomy
- Other surgery of gum and mouth tissues

MiChild members come from low-income families who cannot afford additional expenses for oral surgery. To eliminate their expenses for out-of-network services provided by nonparticipating providers, we encourage oral surgeons to:

- Participate with BCBSM on a per-claim basis, or
- Become a BCBSM PPO participating provider by calling Provider Registration at 1-800-822-2761.

BCBSM is committed to ensuring that MiChild members have access to high-quality, affordable dental care. We look forward to working with you in this effort.

For more billing information, please call Provider Inquiry:

Your area code	Provider Inquiry number
248, 313, 517, 586, 734, 810 or 989	1-800-482-5141
231 or 616	1-800-531-2583
906	1-800-517-4441

Use care when submitting these procedure codes

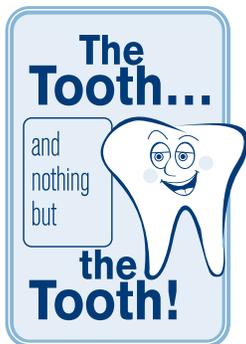
You can reduce the likelihood of claim rejections by submitting appropriate American Dental Association CDT-3 procedure codes for the services below. We're offering the following information to help you bill these claims correctly.

- **Procedure code D2335 is payable only when you submit four or more surfaces.** This code will not be paid when only the incisal angle, or "I" surface, is reported. When fewer than four surfaces are submitted, our system converts the code to the appropriate procedure code.

Code	Description
D2330	Resin, one surface, anterior
D2331	Resin, two surfaces, anterior
D2332	Resin, three surfaces, anterior
D2335	Resin, four or more surfaces, or involving incisal angle (anterior)

If the incisal angle of the tooth is being restored, please list all surfaces involved in the restoration. According to the ADA's CDT-3 descriptor, the incisal angle is one of the angles formed by the junction of the incisal and the mesial, or distal, surface of an anterior tooth.

- **Procedure codes for veneers — D2960, D2961 and D2962 — are payable when decay or fracture is evident to the extent the tooth cannot be restored with a composite or resin filling.** Documentation and X-rays are required for these procedures, and veneers are subject to medical necessity guidelines. Veneers are not payable for cosmetic reasons.
- **BCBSM will enforce the benefit criteria policy for procedure code D4341, scaling and root planing.** As stated in the BCBSM *Guide for Dental Care Providers*, billing for D4341 "requires multiple office visits with a maximum of two quadrants per visit." Any quadrant(s) billed beyond the maximum two per visit will be rejected. Individual consideration will be given when more than two quadrants per visit are required and supporting documentation is submitted with the claim.
- **Crown restorations on dental implants should be reported with D6000-series codes.** When you submit a claim for implant abutment supported crowns or implant supported crowns or retainers, you must report the appropriate CDT-3 codes — D6058 through D6077. These procedures are Class III benefits, but many providers incorrectly bill them as Class II benefits, using regular D2000-series crown codes. To achieve uniformity and consistency in accurately reporting the dental procedure, you must report the specific code for the service you actually performed.
- **The appropriate D6000 series codes are required when you report treatment services for fixed partial denture retainers (bridgework).** The CDT-3 D2000 series codes for crowns and onlays are for single restorations and are not to be used when reporting fixed partial denture retainers. Report CDT-3 codes D6519 through D6792 when billing for these retainers. "Bridgework" is a Class III dental benefit that must be reported accurately for appropriate benefit determination. 🗣️



The Tooth... and nothing but the Tooth! is our regular feature that will answer your questions on topics of interest to you.

Q. How will the new HIPAA regulations impact my dental office?

A. Effective Oct. 14, 2002, BCBSM will accept only CDT-3 codes on claims. Claims submitted with codes other than CDT-3 will be rejected and returned to you. Although you may be aware that President Bush granted a one-year extension to HIPAA regulations that address coding and electronic transactions, BCBSM has decided to proceed with its plan to be compliant by Oct. 14, 2002. Please see related article, "Use only CDT-3 codes effective Oct. 14, 2002," for more information on other HIPAA-related changes.

Do you have a question for our newsletter? Send your questions to Dental Care News Editor Jim Matuszak by e-mail at jmatuszak@bcbsm.com or fax at (313) 225-7709 before Aug. 15 so they may be considered for publication in the October 2002 issue. ♥

Inci-dental-ly...

It's easy to order the *Guide for Dental Care Providers* or to be put on our mailing list for *Dental Care News*. On your office letterhead, tell us how many provider manuals or newsletters you need.

Have you moved to a new office? Just give us your name and new address, along with the old address.

Please fax this information to our database administrator at:

 (313) 225-7709

Or mail it to:

 Database Administrator
 Provider Communications – **Mail Code 2123**
 Blue Cross Blue Shield of Michigan
 600 E. Lafayette Blvd.
 Detroit, MI 48226-2998 ♥

Continuing Medical, Dental Education seminars

Tuesday, Aug. 20

Topic: AIDS Update: Worldwide Issues in the Diagnosis and Treatment of AIDS across the Age Spectrum
 Speaker: Sandro Cinti, MD
 Time: Registration and hors d'oeuvres at 5:30 p.m.
 Program 6 to 8 p.m.

Registration
 Deadline: Aug. 13, 2002

Wednesday, Sept. 25

Topic: Enhanced Smoking Cessation in Your Medical Practice
 Speaker: William Wadland, MD
 Time: Registration and hors d'oeuvres at 5:30 p.m.
 Program 6 to 8 p.m.

Registration
 Deadline: Sept. 16, 2002

Thursday, Oct. 24

Topic: Adverse Effects and Interactions of Dental Drugs
 Speaker: W. Choong Foong, PhD
 Associate Professor, University of Detroit-Mercy
 Time: Registration and hors d'oeuvres at 5:30 p.m.
 Program 6 to 8 p.m.

Registration
 Deadline: Oct. 14, 2002

All seminars are held in the BCBSM Metro Service Center Auditorium, 27000 W. 11 Mile Road, Southfield, and are free to participating BCBSM providers.

You can register for the seminars by calling the Department of Health Care Education hot line at 1-800-921-8980 or on the Web at www.bcbsm.com/providers/cme.shtml.

For more information about the seminars or directions, please call (313) 225-0163.

BCBSM is approved by the Academy of General Dentistry as a provider of continuing dental education. ♥

Dental Care News

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