Blue Cross Blue Shield of Michigan
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Dental Care NEWS

OCT. 2003 **IN THIS ISSUE:**

THE NEXT ISSUE: JAN. 2004

BCBSM accepts CDT-4 codes Oct. 16

Effective Oct. 16, 2003, BCBSM will accept American Dental Association CDT-4 procedure codes for all services.

Please refer to the ADA's CDT-4 *Current Dental Terminology*, which contains the *Code on Dental Procedure and Nomenclature*. The *Code* has been designated as the national standard for reporting dental services by the federal government under the Health Insurance Portability and Accountability Act of 1996.

Do not refer to the BCBSM *Guide for Dental Care Providers* for CDT-4 codes. We are updating the *Guide* with the new codes.

When billing a CDT-4 code, please report all five digits, including the "D."

Example: D1110 — **correct**

01110 – 1110 — **incorrect**

Below are highlights of new codes with particular significance:

- With CDT-4, there are no longer any primary resin-based composite or amalgam restorative codes.
  - Report codes D2140, D2150, D2160 and D2161 for all primary and permanent teeth for amalgam restorations.
  - Use new codes D2391, D2392, D2393 and D2394 for resin-based posterior composite restorations on both primary and permanent teeth.
- Codes for periodontal surgical services such as gingivectomy/gingivoplasty, gingival flap procedure, osseous surgery and scaling/root planing are reported based on the number of teeth treated per quadrant.
  - Report codes D4210, D4240, D4260 or D4341 if there are four or more contiguous teeth or bounded teeth spaces per quadrant.
  - Report codes D4211, D4241, D4261 or D4342 if there are one to three teeth per quadrant.
  - Please note that the code for "four or more teeth" and the code for "one to three teeth" cannot be billed for the same quadrant for the same date of service, or within the same benefit period.
- When billing nonsurgical extractions, report code D7111 for coronal remnants — deciduous tooth or D7140 for extraction, erupted tooth or exposed root.

More new codes have been added since CDT-3, as well as revisions to the code nomenclature for existing codes. The CDT-4 handbook contains more information on the new codes. To order your book, call the ADA at 1-800-947-4746.

Please continue to use the ADA version 2000 form to bill your paper claims.

CDT-4 codes *continued on page 4*

Dentists can help reduce patients' tobacco use

Do you have a patient who wants to stop using tobacco? It's never too late to help them. Studies show that people who use tobacco all their lives can reverse some of the damage.

Blue Cross Blue Shield of Michigan and Blue Care Network have developed a *Tobacco Toolkit* to help you discuss tobacco risks with your patients who smoke or chew it. The toolkit contains information you can share with your patients who are interested in quitting tobacco use, as well as resources for you to use when assisting them.

Tobacco prevention and cessation is one of the Blues' social missions. We want to get the word out to those, like you, who can make a difference, so we are offering the toolkit at no cost to you.

Enclosed with your October *Dental Care News* is a letter with instructions on ordering the toolkit. Through targeted approaches like this, we can work together to help your patients.

HIPAA format number corrected

In our last issue, we inadvertently published an incorrect dental claims version in the story titled "Important EDI format changes announced." The correct HIPAA version number is **4010X097A1**.

We apologize for any inconvenience this may have caused.

Resubmitted claims, status inquiries, appeals clarified

We would like to clarify the steps you should take for resubmitting claims, submitting status inquiries and appealing a status inquiry response.

Resubmitted claims

When your claim is rejected for missing information (such as an invalid procedure code or missing tooth number), please submit a new claim with the missing information. Do not submit the new claim as a status inquiry. Send the resubmitted claim to the same address as the original claim.

Status inquiries

You should submit a status inquiry when you do not understand or do not agree with a claim payment or rejection. To submit a status inquiry:

- Write the words "Status Inquiry" in **bold** letters at the top of the claim
- Include the following additional information with the claim:
  - A detailed description of the issue surrounding the payment or nonpayment of the submitted claim
  - Supporting information not previously submitted with the claim
  - Document number of the claim in question
- Send the status inquiry to the appropriate address below:

FEP claims:	Non-FEP claims:
Federal Employee Program – **MC 1601** Blue Cross Blue Shield of Michigan P.O. Box 2599 Detroit, MI 48231-2599	Blue Cross Blue Shield of Michigan P.O. Box 49 Detroit, MI 48231-0049

Appeals

If you submit a status inquiry and receive a nonpayment code 048 or X758 in response, your next step is the appeal process. Follow the directions in the appeals letter that you receive with the rejection. Please do **not** resubmit this claim as a status inquiry.

For additional information on resubmitted claims, status inquiries and appeals, please refer to your BCBSM *Guide for Dental Care Providers*.

Billing reminders

Follow these tips when submitting claims

We've received many dental claims recently with missing, improper or incomplete information and were unable to process them correctly. Here are some tips to remember when filing your claims so they can be processed quickly and accurately.

Use patients' proper names

Please use your patient's proper first name — not a nickname — when completing claims. Examples of proper names include Theodore (not Ted) or Susan (not Sue).

Using nicknames instead of proper names may cause claims to reject for invalid member names, and delay payment of your claims.

Include subscriber address on claims

Remember to enter the subscriber's current address on every claim you submit. Claims received without addresses may be delayed due to incomplete information.

Be aware of provider address limits

Our claim system has a limited number of characters for the provider address field. In cases where provider address information exceeds this available space, a crucial piece of your address may not print on your check, and the check may never find its way to you.

Here are some ways to ensure your address will fit on your check:

- If you have a post office box and a street address, please enter on your claim only the address where you want the check mailed (either the street address **or** the P.O. Box, but not both).
- Abbreviate wherever possible. Common abbreviations include:
  - Street = St
  - Boulevard = Blvd
  - Highway = Hwy
  - North, South, East, West = N, S, E, W
  - Avenue = Ave
  - Road = Rd
  - Route = Rte
  - Drive = Dr

Use TIN correctly

To ensure prompt claims payment, remember to include your Tax Identification Number or Social Security number, as registered with BCBSM. Enter either number in field 45 of the ADA version 2000 claim.

If you have multiple billing addresses assigned to your TIN, enter the appropriate BCBSM group Provider Identification Number in field 44 of the ADA version 2000 claim form. This will ensure that payment is sent to the correct address.

For more information regarding the TIN, please see Chapter 6 of the BCBSM *Guide for Dental Care Providers*.

Continuing education seminars

Thursday, Oct. 23

Topic: Medical Perspectives of Cardiovascular Disease

Speaker: Dorothy Kahkonen, MD
Division Head, Endocrinology and Metabolism,
Henry Ford Health System

Time: Registration 5:30 p.m.
Program 6 – 8:15 p.m.

Registration Deadline: Oct. 17

Thursday, Jan. 15, 2004

Topic: Eating Disorders: How to Develop Effective Relationships

Speaker: Mary Franzen Clark, EdD
Michigan Limited License Psychologist
Alpha Psychological Services, PC

Time: Registration 5:30 p.m.
Program 6 – 8:15 p.m.

Registration Deadline: Jan. 5, 2004

The 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 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 or directions, please call (313) 225-6398 or go to **www.bcbsm.com/directories/maps/mapsearch.html**.

BCBSM is approved by the Academy of General Dentistry as a provider of continuing dental education, AGD sponsor 83104.

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 CD-ROM 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:

FAX (313) 225-7709

Or mail it to:

Database Administrator
Provider Communications – **Mail Code J523**
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

Submit predetermination for coverage information

Predetermination provides you and our member with information about whether a procedure will be covered, how much BCBSM will approve, time or frequency limits and whether an alternative course of treatment is available before the service is performed.

Certain procedures require review to determine dental necessity, and the treatment plan for these procedures may also be submitted for predetermination. You can submit predetermination claims electronically or on paper.

The predetermination process is **voluntary**; however, it does **not** guarantee payment. If we recommend an alternative treatment, the most we will pay is our approved amount for the recommended procedure. The member may select another treatment plan, and the amount we approve for the recommended procedure can be applied to the treatment plan chosen; however, the member will be responsible for any difference between our payment for the alternative procedure and the provider's charge for the treatment that was selected.

When you return the predetermination form to BCBSM for payment, the procedures will be rechecked to determine if time and frequency limits or other conditions and requirements of the member's contract have been met. An approved predetermination is valid for 24 months. If the procedure has not been completed within that time, you can submit a new predetermination if you and the member want to verify current coverage for the procedure.

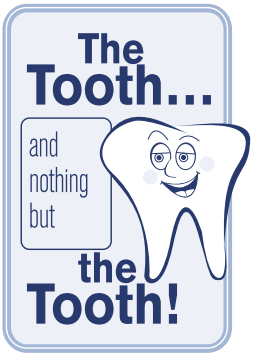
There may be situations — such as an audit — where a treatment plan submitted for predetermination was approved, but we determined later that it did not meet BCBSM criteria. If that occurs, BCBSM can recover the amount paid for services up to two years from the payment date. In cases involving fraud, there is no time limit for payment recovery.

For more information about predetermination, please refer to the BCBSM *Guide for Dental Care Providers*.

Newsbites

BCBSM will be closed:

- Nov. 27 and 28 (Thanksgiving)
- Dec. 24 – 26 (Christmas)
- Jan. 1, 2004 (New Year's Day)



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

Q: Is an adult prophylaxis or periodontal maintenance procedure payable for the same date of service as periodontal procedure D4341 or D4342?

A: BCBSM benefit guidelines state that adult prophylaxis, procedure code D1110, and periodontal maintenance, procedure code D4910, are not payable when the more difficult periodontal procedure D4341 or D4342 is billed for the same date of service. D1110 or D4910 is considered part of the more difficult D4341 or D4342 when performed on the same day, and included in the payment for D4341 or D4342.

Do you have a question for our newsletter? Send your questions to Jim Matuszak, Dental Care News *editor, by e-mail at jmatuszak@bcbsm.com, or fax at (313) 225-7709, before Nov. 15 so they may be considered for publication in the January 2004 issue.*

CDT-4 codes

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Finally, remember that the potential for claims processing delays exists whenever new codes are implemented. During this transition BCBSM will process your claims as quickly and efficiently as possible.

Billing CDT-4 codes electronically

HIPAA also has uniform billing guidelines for submitting claims electronically. These guidelines include use of numeric international standard codes for reporting areas of the oral cavity. Maxillary and mandibular areas and quadrants must be reported in the "Oral Cavity Designation Code" field of the electronic claim.

When billing electronic claims, you can no longer place alpha-character quadrant codes in the tooth number field. However, you can continue to do so on the ADA version 2000 paper form.

There are other electronic billing guidelines that you are required to follow to ensure compliance with HIPAA regulations. Please contact your EDI software vendor for more information.

Audit tips

Billing for cores, crown lengthening clarified

Our auditors have found that providers are confused when billing for crown buildups and coding for clinical crown lengthening. We hope the following information will help you avoid mistakes when filing claims for these procedures in the future.

Billing for cores

When a tooth exhibits insufficient strength and retention for crown placement, the anatomical crown requires building up. In these cases, you should use procedure code D2950 (crown buildup/core) to bill this procedure. BCBSM will pay for code D2950 when the buildup procedure and crown procedure are performed independently.

Procedures involving only fillers to eliminate any undercut, box form, or concave irregularity in the preparation should not be billed with code D2950. A core that is cast or milled as part of the crown, 3/4 crown or onlay, is not payable as a separate benefit.

Payment policy for crown lengthening

Procedure code D4249 (crown lengthening) is not a covered benefit if it's performed on the same day as any other restorative, prosthetic or endodontic service. Crown lengthening includes the use of a surgical flap, bone removal, and may involve an area larger than one tooth. This procedure requires a healing period prior to crown preparation or any other treatment.

BCBSM's policy on payment for soft tissue management using procedure codes D4210 or D4211 (including the electrosurging or trimming of hyperplastic gingival tissue) is different from crown lengthening. Soft tissue management is considered part of the restorative service. A separate fee is not allowed for this type of procedure.

BCBSM's policy on crown lengthening follows the definition found in the American Dental Association's CDT-4 manual. Billing of crown lengthening to BCBSM is subject to retrospective audit.

Blue Cross Blue Shield of Michigan

Dental Care News

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