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Dental Care NEWS



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Revised dental manual coming soon

A new *Guide for Dental Care Providers* CD-ROM will soon be coming your way. The revised guide will include our billing guidelines for CDT-4 codes, as well as updated information including the important changes below.

Definition of "core" clarified

BCBSM's requirements for payment of core build-ups (American Dental Association CDT-4 code D2950) seem unclear to many providers.

BCBSM based its guidelines on the ADA CDT definition of a core. The definition states that a core is the build-up of the anatomical crown when there is insufficient tooth strength and retention for the crown procedure.

Cores are payable only if at least 35 percent of the prepared tooth for the crown restoration consists of the core material. This means that a substantial amount of tooth structure must be lost due to decay, fracture or old, faulty restorations. For example, the loss of a single cusp on a molar tooth typically would not qualify for a core.

Another situation that would not qualify is the removal of a typically sized faulty MOD amalgam prior to the crown preparation.

Cores are not payable for the block-out of undercuts, nor are they payable separate from the post and core codes, D2952 and D2954, or as a single unit attached to the crown.

EDI telephone numbers updated

Page 6a-3 of the *Guide for Dental Care Providers* will be updated to reflect the following changes and corrections to telephone numbers:

For electronic billing information, call our Electronic Data Interchange department:

(248) 486-2292

(This number has changed from 486-2445.)

For the software package that allows direct connection to us, call Electronic Services Technologies:

(313) 341-1821

(The number listed in the current *Guide*, 1-800-274-8374, is incorrect; we apologize for the error.)

Follow these guidelines for billing dental services under medical-surgical benefits

For dental services payable under Blues medical-surgical benefits, you must:

- Use the CMS-1500 (Centers for Medicare & Medicaid Services) claim form or, if submitting electronically, submit in the ASC X12N Professional 837 format.
- Have a BCBSM medical provider identification number.

The following dental services may be covered under medical-surgical benefits:

- Biopsy of oral soft and hard tissue
- Vestibuloplasty
- Surgical excisions of soft tissue and intra-osseous lesions
- Treatment of simple and compound bony fractures
- Temporomandibular joint dysfunction

- General anesthesia and intravenous sedation that is medically necessary and performed in the hospital setting by a provider other than the surgeon
- Orthotic devices for the treatment of obstructive sleep apnea (see related story on pg. 3)
- Tori and exostoses, which are group specific benefits — please call CAREN+ for details

Services excluded and **not covered** under medical-surgical benefits include the following:

- Oral brush biopsy collection sample
- Extractions, including surgical and impactions
- Alveoplasties

Guidelines continued on page 4

Your rights, obligations when participating on a claim

When you treat patients with BCBSM Traditional or Traditional Plus coverage, you have the option to participate on the claim unless you are enrolled in the DenteMax network. We would like to remind you about your rights and obligations when participating.

What is per-claim participation?

Per-claim participation is choosing to participate or not on a per-claim basis. The back of our payment and nonpayment vouchers, under the heading "Dentist/Provider's Certification" contains the per-claim participation agreement.

If you participate

- Under Michigan Public Act 350, if you choose to participate per claim, we send you our payment directly and you are considered "participating."
- You agree to accept our payment in full. When you accept payment in full, you do not have the right to "balance bill" the patient; that is, you cannot bill the patient for the difference between our payment and your charges.
- You can bill members for:
 - Applicable deductibles and copayments
 - Amounts exceeding the yearly benefit maximum
 - Member-authorized alternate treatments

If you're not participating

If you decide not to participate on a claim:

- You must tell the patient you're not participating before providing services.

- The patient has to pay for the services provided.
- We will pay the patient directly for covered services received.
- You will not receive a notification voucher.
- You may "balance bill" the patient for charges that exceed our approved amount.

Participation decision is final

Your participation decision is final for each claim. Once a claim has been submitted and processed, you cannot resubmit the claim to change the payment direction for the services billed. More information is available in chapter 2 of the *Guide for Dental Care Providers*.

DenteMax network

Participation in the Traditional Plus, Community, Exclusive, Personal and FEP Dental plans is by contract if you are enrolled in the DenteMax network. This means that DenteMax network providers participate on all claims.

Michigan and non-Michigan dentists who are in the DenteMax network agree to accept our benefit guidelines and the DenteMax contractual fee schedule, which is updated annually. We pay network dentists directly.

Note: If you participate, ask the subscriber to sign in field 41 of the American Dental Association version 2000 claim. Otherwise, leave this field blank. Complete participation guidelines are in part 2 of the *Guide for Dental Care Providers*, and complete billing instructions are in part 6a of the *Guide*. ♥

Billing reminders

Use proper letter codes to maintain root history

We wanted to let you know that BCBSM requires a root letter for processing apicoectomy or periradicular surgery and retrograde fillings.

Our claims processing system looks for a specific root for maintaining proper history for all teeth, including those teeth with multiple roots. Please use the following letter codes:

- B – buccal
- M – mesial
- D – distal
- L – lingual

For designating anterior teeth roots 6-11 and 22-27, please use letter code "B" (buccal) in the tooth surface field.

Be aware of ADA change to tooth numbering

The American Dental Association has changed the tooth numbering sequence for supernumerary teeth. This change will affect the way that you complete your BCBSM claims.

For permanent teeth, the designated tooth number is the permanent tooth number plus 50. For example:

- The correct tooth number for a supernumerary tooth adjacent to the upper right third molar would be 51 (tooth number 1 + 50).
- The correct tooth number for permanent tooth number 32 would be 82 (tooth number 32 + 50).

When coding for a primary supernumerary tooth, use the proper code for a supernumerary tooth area plus the letter "S." For example:

- The proper code for the area of primary tooth A would be AS.
- The proper code for tooth area T would be TS.

When reporting supernumerary teeth, please include the new tooth designations in the tooth number field on the claim. ♥

Continuing education seminars

Thursday, Jan. 15

Topic: Eating Disorders: How to Build Effective Patient Relationships

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

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

Registration
deadline: Jan. 10, 2004

Thursday, Feb. 19

Topic: The Role of Nutrition and Nutraceuticals in the Prevention and Treatment of Chronic Disease, 2004

Speaker: Pamela W. Smith, MD, MPH

Time: Registration — 5:30 p.m.
Program — 6 to 9:15 p.m.

Registration
deadline: Feb. 12, 2004

Wednesday, March 10

Topic: Recognition and Treatment of Anxiety Disorders in the Primary Care Setting

Speaker: Calmeze Dudley, MD

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

Registration
deadline: March 3, 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 logging onto 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.shtml.

Special note: The Michigan Health and Safety conference will be held on April 14 and 15 at the Ford Conference and Event Center in Dearborn, Mich. More information will be available in the April 2004 issue of *Dental Care News*. You can also keep updated on conference information by logging on to the Michigan Health and Safety Coalition Web site at www.mihealthandsafety.org.

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

Follow these guidelines when billing obstructive sleep apnea orthotics

Here are some helpful guidelines to aid you in billing oral orthotics for the treatment of obstructive sleep apnea.

General coverage guidelines

- These orthotics are payable under medical-surgical benefits only when they are medically necessary.
- "Snoring" is not considered a medically necessary diagnosis.
- Coverage is limited to and includes impressions, fabrication, materials, subsequent adjustments and repairs.

Documentation requirements

All of the following must be present in order to bill for oral orthotic treatment of obstructive 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 percent or greater. At least two hours of sleep must be documented during the overnight recording.
- Subjective complaints or laboratory evidence of excessive daytime sleepiness or a comorbidity associated with sleep apnea (for example, systemic hypertension, cardiovascular disease, impaired cognition, etc.)
- One of the following must be present:
 - Refusal of continuous positive airway pressure system, or CPAP
 - Failure of a three-month trial of CPAP

Billing guidelines

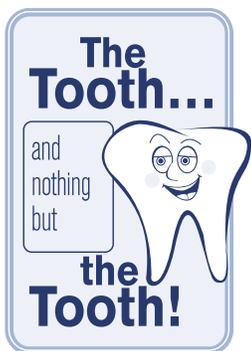
When billing, use the CMS-1500 claim and bill oral orthotic for treatment of obstructive sleep apnea with procedure code S8260. Be sure to include the corresponding ICD-9-CM diagnosis code. ♡



Newsbites

BCBSM will be closed:

- Jan. 1–2 (New Year's holidays)
- Jan. 19 (Martin Luther King Day) ♡



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

Q. What is BCBSM's registration policy for offices with multiple dentists using the same federal tax identification number or common BCBSM-assigned PIN?

A. You should report treatment services to BCBSM under your personal Social Security number or your federal tax ID unless you are in a group practice. Dentists who are not listed under your group tax ID or common BCBSM-assigned PIN cannot use your number to bill BCBSM for services rendered. BCBSM requires that you register all dentists using a common BCBSM PIN or federal tax ID.

Please notify us of additions or deletions to your group practice, changes to your specialty, board-certification status, federal tax ID number, telephone or address (either office or payment location). You can send changes to:

Provider Enrollment and Data Management —
Mail Code B443
 Blue Cross Blue Shield of Michigan
 600 E. Lafayette Blvd.
 Detroit MI 48226-2998

Do you have a question for our newsletter? Send your questions to Rob Sawalski, Dental Care News editor, by e-mail at rsawalski@bcbsm.com, or fax at (313) 225-7709, before Feb. 13 so they may be considered for publication in the April 2004 issue. ♡

Remember to use 5-digit CDT-4 codes

BCBSM implemented all CDT-4 codes Oct. 16, 2003. We have been seeing some submission errors and would like to remind you that in order to correctly report a procedure code, you now must use the letter "D" followed by four numbers.

Also, we discovered that our system incorrectly rejected codes for some groups. If you receive a rejection code NP069, NP105 or NP108 with a valid CDT-4 procedure code for a date of service after Oct. 16, 2003, please resubmit a new clean claim — not a status inquiry — for faster processing. We apologize for the inconvenience. ♡

Guidelines continued from page 1

- Endodontic treatment services
- Periodontic treatment services

When you use the CMS-1500 claim to bill for medical-surgical services, you can participate on a per-claim basis.

Please see chapter 5c of the *Guide for Dental Care Providers* for coverage guidelines for specific procedures. For instructions on how to complete a CMS-1500 claim, see the *Guide for Physicians and Medical Assistants, Volume 1*. To order the manual, send your request to:

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

Fax number: (313) 225-7709 ♡

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:

 (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 ♡

Questions about your patient's benefits and eligibility?

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



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