NEWS dental care

Share the "News" with your office!
Please read, check your box, and pass it on!

- ❑ Receptionist
- ❑ Doctor
- ❑ Office Manager
- ❑ Biller
- ❑ Hygienist

Communicate your NPIs to us

Soon, all health care providers need to begin using their national provider identifiers for HIPAA standard transactions. We hope that you have taken the time to obtain your NPI.

If you have your NPI, please communicate it to BCBSM so there will be no delay in claim processing. We offer two ways to report your NPI to us:

- Submit your NPI information on the Excel® templates available on **bcbsm.com**. The templates come with instructions and can be downloaded. All you have to do is select the form that is appropriate for you: save a copy on your computer, fill it out, and e-mail the completed form to the address provided.

  Go to **bcbsm.com**, click on the *I am a Provider* tab, and under the *News & Updates* section click on *NPI – Get it, report it, register it.*

- Fill out the appropriate paper NPI submission form included with this edition of *Dental Care News*: one for individuals and one for groups. We've provided instructions for filling out the form. You can fax it to BCBSM Provider Enrollment and Data Management at 866-504-0449 or mail it in an envelope to the address listed in the letter.

If you haven't received your NPI, we urge you to apply as quickly as possible. For instructions, visit **cms.hhs.gov/NationalProvIdentStand***.

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JANUARY 2008

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Blue Cross Blue Shield of Michigan

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

Hello, doctor: Do you participate with BCBSM?

A new year often brings changes to your patients' dental coverage, and changes mean calls and questions. When patients ask if you participate with BCBSM, please remember:

- If you accept payment from BCBSM, the answer is "yes."
- If you are a DenteMax PPO provider, the answer is always "yes."

Making the *link*

New medical plan offers head-to-toe coverage

A new BCBSM health plan option features coverage to treat the whole body. Healthy Blue Incentives℠ rewards members who make a commitment to better health with lower copays and deductibles.

Even better, groups with no dental coverage can now encourage their employees to take health care a step further. This plan allows groups to provide benefits for the following basic dental services:

- One yearly dental exam
- A set (up to four) of bitewing X-rays once per calendar year
- One routine dental prophylaxis per calendar year

As a dental professional, you know that research continues to demonstrate the impact of good oral health on overall health. By offering products that include dental coverage, BCBSM is doing its part to make better dental care both affordable and available for its customers.

Billing Reminders

Only bill exams performed by dentists

Please be aware that an exam code can only be billed to BCBSM when a dentist performs the procedure. If a patient is seen by the dental hygienist for a prophylaxis and the dentist does not handle the exam, it should not be billed. A dental hygienist cannot legally perform an exam.

Check contract number on electronic claims

Please take a moment to ensure that electronic claims contain the correct contract number in the field that follows the subscriber's last name. Claims submitted with incorrect patient information (i.e., wrong contract number, different last name, nickname) will be rejected with nonpayment code NP006.

Send X-rays on request

Please **do not send X-rays** to us unless we request them.

You should send X-rays and other documentation **only** in response to nonpayment messages 045, 125, 419, B485, X426 and X509. For paper claims, these messages instruct you to submit a new claim with X-rays and documentation to the following address:

Blue Cross Blue Shield of Michigan
P.O. Box 1633
Detroit, MI 48231-1633

Please note that all X-rays, including those submitted with status inquiries and coordination of benefits claims, must be sent to P.O. Box 1633. **X-rays or documentation sent to P.O. Box 0049 will be destroyed.** Electronic submitters can send X-rays or other documentation, if requested, via the National Electronic Attachment *Fast*Attach™ program. (See story to the right.)

Sign up with NEA by Feb. 29 to save money

Registration half-off; first 2 months free

Are you looking for an easy, effective and inexpensive way to process your dental claim attachments? For about 67 cents a day, you can transmit an unlimited number of attachments via the Internet using National Electronic Attachment.

NEA's *Fast*Attach™ system allows dentists to electronically transmit X-rays, explanations of benefits, periodontal charts, intra-oral pictures and narratives to more than 260 payers.

To join thousands of dentists using this system, visit NEA's Web site at **welcometonea.com*** and enter "BCBSMNWS" in the promotion code box. This special offer, sponsored by NEA and BCBSM, provides 50 percent off the regularly priced $200 registration fee, plus two **free** months of service. Registration includes software, installation, training and unlimited telephone support.

For more information, call 800-782-5150, ext. 2. This offer expires Feb. 29, 2008.

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Include these details when billing orthodontic cases in progress

You may bill for orthodontic cases in progress or for patients who obtain BCBSM orthodontic coverage after treatment begins.

To do so, please submit the following information.

Paper claims using the 2006 or 2002, 2004 American Dental Association form

- In field 1 of the *Record of Services Provided* section, enter the banding procedure code, the total treatment fee and the date of service.
- In field 2, enter procedure code D8999, the date the member's BCBSM coverage became effective and the lump sum fee for the monthly visits remaining in the treatment plan.
- In field 35, *Remarks*, note the monthly fee and the months of treatment remaining.

Electronic claims

- Submit an 837 transaction with procedure code D8999.
- Include a note at the claim or service level that the claim is for remaining benefits due to a carrier change. Also provide the total fee, the monthly fee and the months of treatment remaining.

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	12-1-06					D8080		4 200 00
2	6-1-07					D8999		750 00
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION — Permanent: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 / 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 — Primary: A B C D E F G H I J / T S R Q P O N M L K — 32. Other Fee(s) — 34. (Place an "X" on each missing tooth) — 33. Total Fee

35. Remarks: INS. EFFEC. 6-1-07; $150 WITH 5 MONTHS REMAINING. (10 MONTHS TOTAL)

BCBSM will pay the remaining benefits, minus any applicable deductible or copay, up to the member's lifetime benefit maximum.

Dental services may qualify for payment as medical-surgical benefit

BCBSM dental programs are intended to cover treatment of the teeth and supporting structures. These services, in general, are payable as part of a member's dental benefits but **not** as medical-surgical benefits.

However, dental services **may** qualify for payment as medical-surgical benefits if:

- They are part of the member's benefit design and certain criteria are met.
- A member is admitted to the hospital as an inpatient with a medical problem that is being negatively impacted by a dental condition — and treatment of the dental condition is intended to improve the medical condition.
- The member has MIChild BCBSM PPO medical benefits that cover the following dental procedures:
  - Surgical extractions (D7210, D7220, D7230, D7240, D7250)
  - General anesthesia and sedation administered by the surgeon (D9220, D9221, D9241, D9242)
  - Apicoectomy (D3410)

  Please note: For MIChild members, these services will not be paid if submitted using medical procedure codes *48199, *00170 or *99143-*99148.

DENTAL SERVICES MAY BE MEDICAL BENEFIT
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DENTAL SERVICES MAY BE MEDICAL BENEFIT *continued from page 3*

- A patient requires prophylactic extractions before an organ transplant, cardiac valve surgery or ionizing radiation (5,000 cGy or more) that involves the jaws.
- They are part of the accidental dental injury benefit. This benefit applies when a patient experiences an external force to the lower half of the face or jaw that damages or breaks the teeth, periodontal structures or bone (other than by self-inflicted external force or chewing).

Facility charges are part of the medical-surgical benefit when associated with dental procedures if circumstances prevent the dental procedures from being performed in an office setting. These circumstances include:

- A member is an inpatient with a medical problem and the medical problem is being impacted negatively by the dental problem. Treatment of the patient's dental issue is intended to help improve his or her medical condition.
- A patient requires dental services and meets the anesthesia criteria for outpatient general anesthesia. (See below.)

Anesthesia services are billable and payable to the anesthesiologist or certified registered nurse anesthetist under the medical-surgical benefit — in conjunction with billable procedures on the teeth and supporting structures — when those services are medically necessary and performed in a hospital setting. In such cases, the anesthesiologist or CRNA would submit procedure code *00170 (anesthesia for intraoral procedures, including biopsy).

Coverage for anesthesia can be determined by using the following criteria:

- The patient is a child younger than 7.
- For older patients, coverage depends on the extent of procedures required. At a minimum, the patient should require a total of six or more teeth extracted or other procedures that must be performed in two or more quadrants of the mouth on the same date of service.
- One of the following conditions should also exist:
  - A concurrent hazardous medical condition that creates a documented medical necessity to perform the procedure in a facility under general anesthesia or sedation (for example, severe cerebral palsy, labile hypertension with three or more antihypertensives or when certain mental health conditions are present)
  - Significant cellulitis or swelling and associated trismus that does not allow the use of local anesthesia
  - Extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised

Anesthesia charges are considered a medical-surgical benefit when the procedure code performed is **not** in CPT Appendix G and when modifier 59 is indicated with procedure codes *99143-*99145. Procedure code *41899 and "D" codes are not payable in association with *99143-*99148 unless the patient has certificate coverage.

Anesthesia charges are payable under the MIChild benefit through the medical-surgical program using CDT codes D9220, D9221, D9241 and D9242 when the approved CDT oral surgery treatment codes are used.

NEWS bites

- Some BCBSM payment vouchers include a message to call 877-BLUE-WEB (258-3932) for information about gaining access to web-DENIS, our online inquiry tool. Please note that this number **only** provides information about web-DENIS. You should continue to call Provider Inquiry with questions about processing dental claims.
- Please update the following on the *Contact Information for Dental Providers* sent to you with the October 2007 issue of *Dental Care News*. Under No. 2, "I have claims-related issues," the phone number for FEP cases (inquiries) should be **800-482-3600**.
- BCBSM will be closed:
  - Jan. 21 (Martin Luther King Jr. Day)
  - March 21 (Good Friday)

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