# The Blue Book℠
## Dental e-Manual

A guide for dental care providers

An independent licensee of the Blue Cross and Blue Shield Association. ® Mark of the Blue Cross and Blue Shield Association. SM Mark of Blue Cross and Blue Shield of North Carolina.

Visit us at **bcbsnc.com** | **bcbsnc-dental.com**

BlueCross BlueShield of North Carolina

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To view pdf documents, you will need Adobe Acrobat Reader.

If you do not already have Adobe Acrobat Reader, Adobe makes access available from their website at: ***www.adobe.com/products/acrobat/readstep2.html***.

# The Blue Book℠
## Dental e-Manual

**Nothing in this e-manual is intended or should be understood to modify the requirements, limitations and/or exclusions in the BCBSNC member's policy.**

**Note:** In the event of any inconsistency between information contained in this e-manual and the Dental Network Participation Agreement between your dental care practice and Blue Cross and Blue Shield of North Carolina (BCBSNC), the terms of such agreement shall govern. Also, please note that BCBSNC and other Blue Cross and/or Blue Shield Plans may provide available information concerning an individual's status, eligibility for benefits and/or level of benefits. The receipt of such information shall in no event be deemed to be a promise or guarantee of payment, nor shall the receipt of such information be deemed to be a promise or guarantee of eligibility of any such individual to receive benefits. Further, an individual's possession of a BCBSNC identification card in no way creates, nor serves to verify an individual's status or eligibility to receive benefits. In addition, all payments are subject to the terms of the contract under which the individual is eligible to receive benefits. For the purposes of this e-manual: insured, policyholder, participant, patient, member, enrollee, subscriber and covered person are terms used to refer to a person who is entitled to receive benefits underwritten or administered by BCBSNC, however such person may be referred to or described in said policy.

BCBSNC may provide notices of updates to the dental e-manual and updates to dental policies and procedures generally by posting them on ***bcbsnc.com***. More information regarding such electronic notices is set out in the dental e-manual.

# What's New!

## Important dental information for 2015

### Medically Necessary Orthodontia

Pediatric Oral Health coverage including Medically Necessary Orthodontia service is one (1) of the Affordable Care Act's ten (10) categories of essential health benefits required on qualified health plans. Effective December 1, 2014, Medically Necessary Orthodontia services require Prior Plan Approval (PPA) from Blue Cross Blue Shield of North Carolina (BCBSNC). See Orthodontia Care chapter (**Chapter 9**) of this e-manual for more details.

### Reminders:

- **As of July 1st, 2015, we require the use of the 2012 ADA Claim form when submitting dental claims for payments.**
- Effective fourth (4th) quarter 2014, BCBSNC added a dental newsletter to keep providers informed, dental providers that join our email registry get the latest BCBSNC dental news delivered directly to their inbox. News articles are also available on the Web at ***bcbsnc.com/content/providers/news-and-information/dental-blue-news.htm***. Please check the website periodically for updates.

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Chapter 1

# Introduction

## 1.1 About The Blue Book℠ Dental e-Manual

Blue Cross and Blue Shield of North Carolina (BCBSNC) is pleased to provide you with The Blue Book℠ Dental e-Manual (e-manual) for dental care providers. This e-manual has been designed to make sure that you and your office staff have the information necessary to effectively administer BCBSNC dental products. This e-manual contains information that dental providers need in order to administer BCBSNC dental care programs efficiently and understand policies and procedures used in the management of the BCBSNC member's dental benefits.

The e-manual is intended as a supplement to the Dental Network Participation Agreement "Agreement" between you the dental provider and Blue Cross and Blue Shield of North Carolina (BCBSNC). The agreement is the primary document controlling the relationship between participating dental providers and BCBSNC. Nothing contained in this e-manual is intended to amend, revoke, contradict or otherwise alter the terms and conditions of the agreement. BCBSNC policies and procedures will change periodically, and pursuant to the terms of your agreement, dental providers will be deemed to receive electronic notification of such changes when BCBSNC posts new or amended policies and procedures in this e-manual or in another applicable section of ***bcbsnc.com***.

We thank you for your participation in the BCBSNC dental network, as we continue our efforts to help our members improve the quality of their health and dental care.

## 1.2 The Blue Book℠ Dental e-Manual available online

To access the e-manual online, please visit us on the Web at ***bcbsnc.com***, click on the "Providers" page, and then click on the hyperlink for the e-manual. You must have Acrobat Reader on your computer to download the e-manual. If you are unable to download The Blue Book℠ Dental e-Manual and you would like a copy, please contact your BCBSNC Network Management representative.

## 1.3 Additional references

This e-manual is your main source of information for how to administer BCBSNC dental products. If you cannot find specific information in this e-manual, the following additional resources are available to assist:

- Your Dental Network Participation Agreement
- BCBSNC's dental website (for dental providers) at ***bcbsnc-dental.com***
- BCBSNC's website for providers (not exclusively dental) at ***bcbsnc.com/content/providers/***
- **Blue *e***℠ at ***providers.bcbsnc.com/providers/login.faces***
- Customer service
- Your Network Management representative

Telephone numbers for contacting customer service and Network Management, as well as, information for accessing **Blue *e***℠ are located in **Chapter 2** of this e-manual.

Thank you for your participation and for providing dental care to our BCBSNC members.

Chapter 2

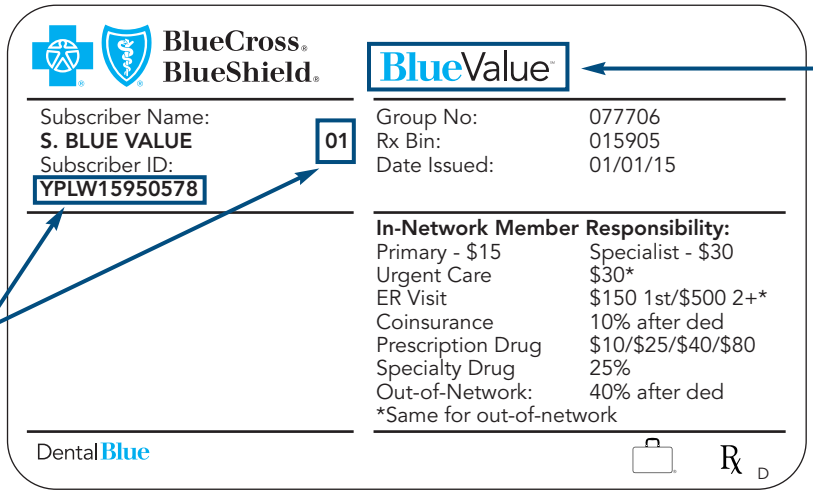
# Contact information and general administration

## 2.1 Contact and general claim information

Patients may arrive at your office and present varying types of BCBSNC member identification cards. This is because members can enroll in BCBSNC health care plans and add dental coverage as an option. Members can also select a dental plan as a stand alone coverage choice. Subsequently, a member may have an identification card for a dental coverage only plan that displays the name and logo of the dental product prominently in the upper right corner, on the front of the member's identification card. Or, if a member has health and dental coverage, the name and logo of the health care coverage plan will be displayed in the upper right corner and the dental product's name and logo will typically be printed in the lower left corner. Please reference **Chapter 2** for additional sample images of member identification cards.

### Dental Blue® for Groups – group dental plan

Front of card

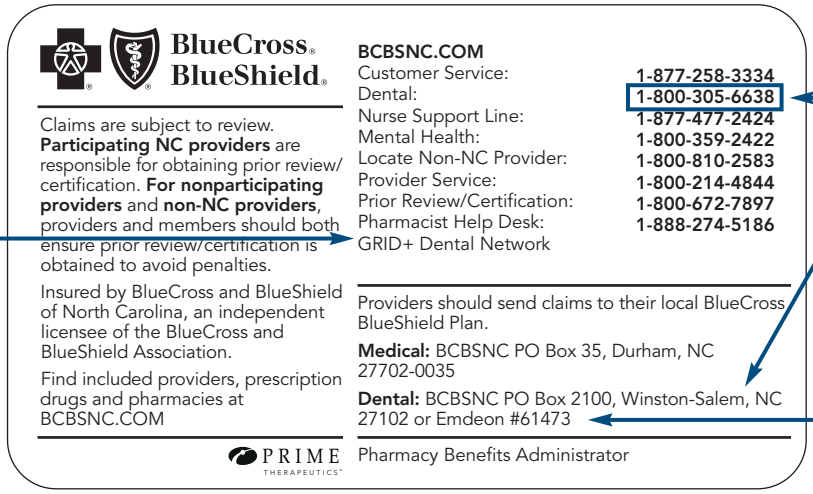



Always file claims for services with the patient's complete identification number, which includes both numbers and letters.

Example – **YPLW15950578 01**

This card is of a BlueValue℠ member's identification card. BlueValue℠ is the name of 1 of several health care products offered by BCBSNC.

Back of card




GRID+ logo identifies that a member is participating in the GRID+ dental network (see **Chapter 6** for additional information)

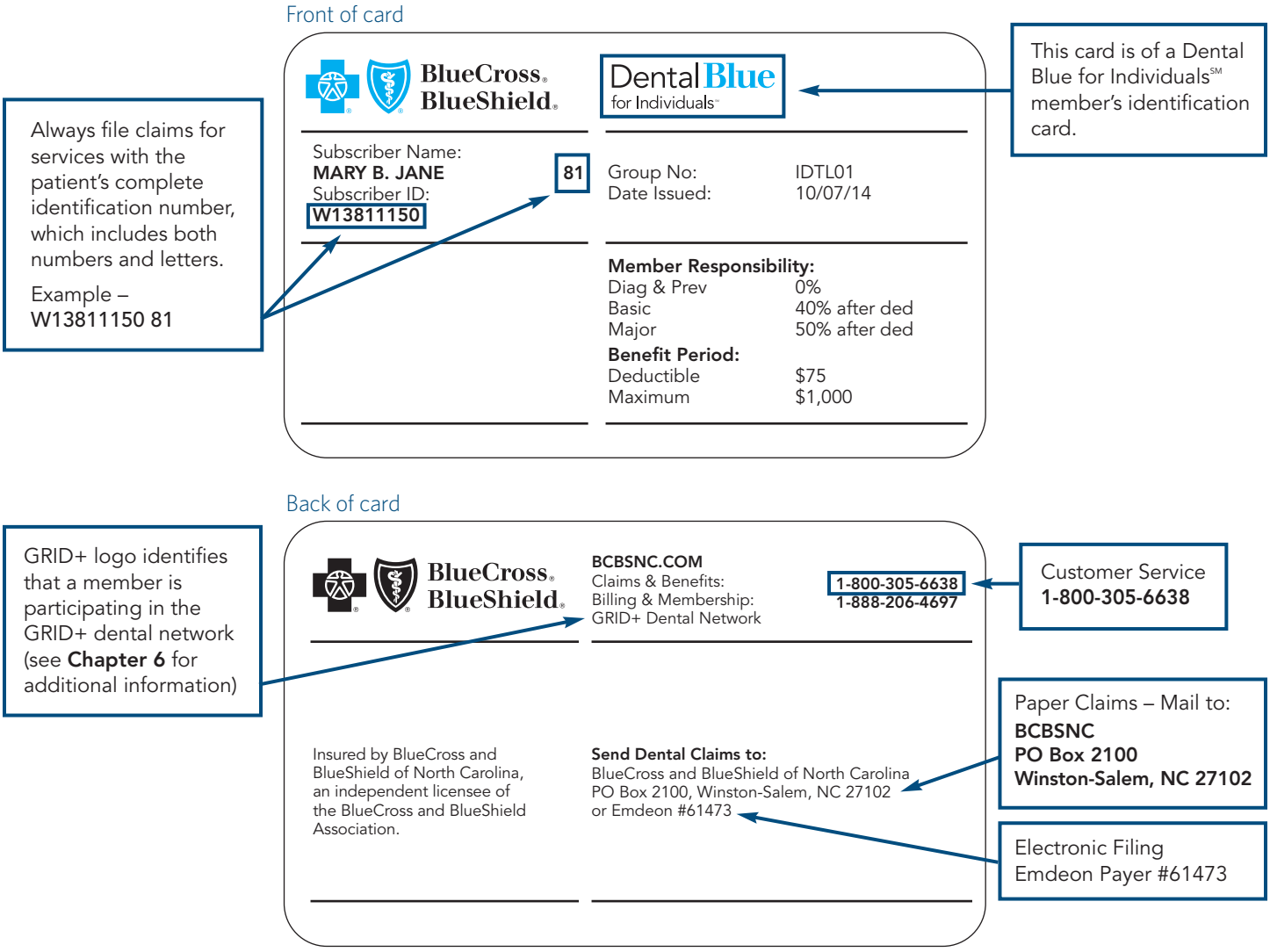
Customer Service **1-800-305-6638**

Paper Claims – Mail to:
**BCBSNC**
**PO Box 2100**
**Winston-Salem, NC 27102**

Electronic Filing Emdeon Payer #61473

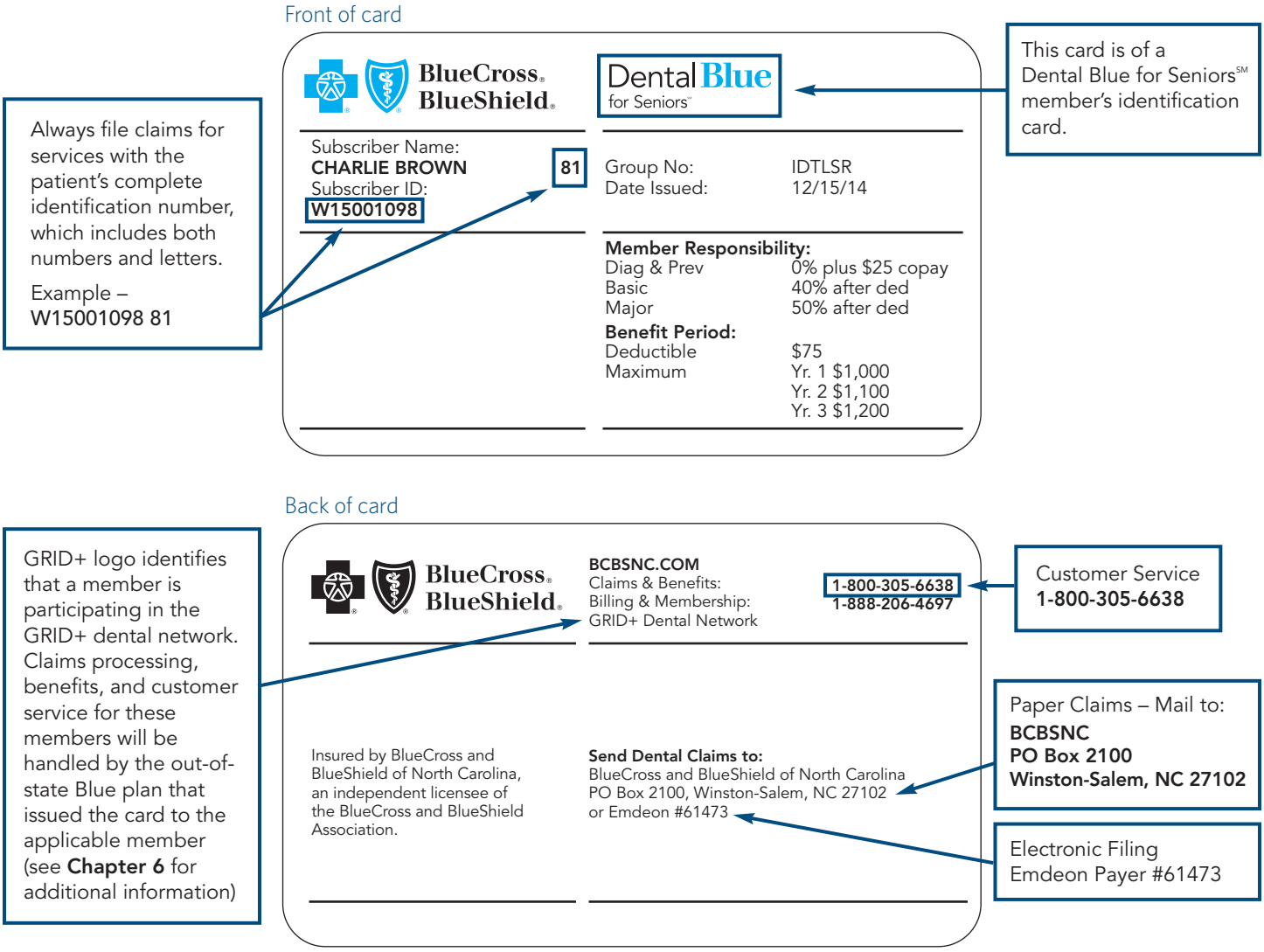
| Customer service | 1-800-305-6638 |
|---|---|
| **Claims** | |
| Electronically Filing | **Emdeon Payer Number 61473** |
| Paper Filing | **Mail to:** **Blue Cross and Blue Shield of North Carolina**<br>**PO Box 2100**<br>**Winston-Salem, NC 27102** |
| **Websites** | *bcbsnc-dental.com*<br>*bcbsnc.com/plans/dentalblue/* |

## DentalBlue for Individuals℠




| Customer service | 1-800-305-6638 |
|---|---|
| **Claims** | |
| Electronically Filing | **Emdeon Payer Number 61473** |
| Paper Filing | **Mail to:** **Blue Cross and Blue Shield of North Carolina**<br>**PO Box 2100**<br>**Winston-Salem, NC 27102** |
| **Websites** | *bcbsnc-dental.com*<br>*bcbsnc.com/plans/dentalblue/*<br>*providers.bcbsnc.com/providers/login.faces* |

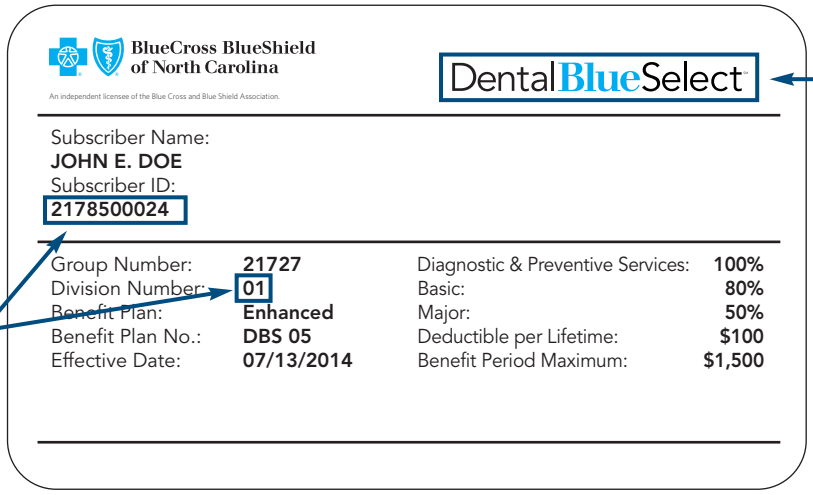
## DentalBlue for Seniors℠




| Customer service | 1-800-305-6638 |
|---|---|
| **Claims** | |
| Electronically Filing | **Emdeon Payer Number 61473** |
| Paper Filing | **Mail to:** **Blue Cross and Blue Shield of North Carolina**<br>**PO Box 2100**<br>**Winston-Salem, NC 27102** |
| **Websites** | *bcbsnc-dental.com*<br>*bcbsnc.com/plans/dentalblue/*<br>*providers.bcbsnc.com/providers/login.faces* |

## DentalBlue Select℠ – voluntary group dental plan

Front of card

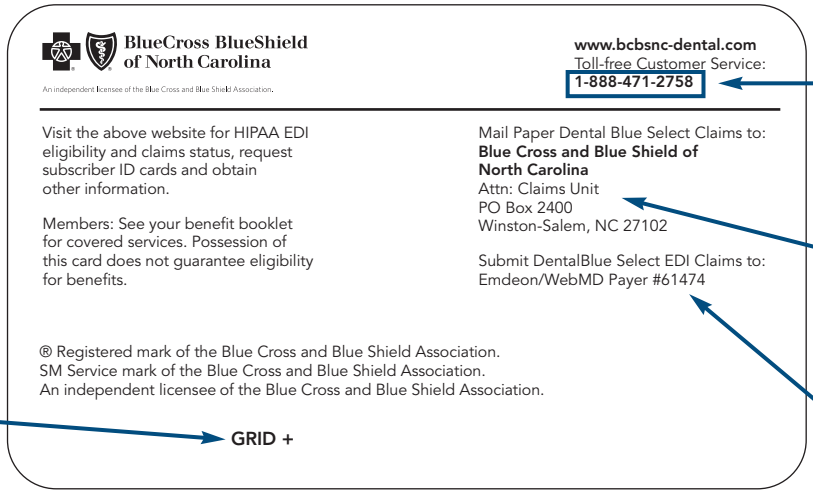



This card is of a DentalBlue Select℠ identification card.

Always file claims for services that include the patient's complete identification number, which includes both numbers and letters.

Example – 2178500024 01

Back of card




Customer Service **1-888-471-2758**

Paper Claims – Mail to:
**BCBSNC CLAIMS UNIT**
**PO Box 2400**
**Winston-Salem, NC 27102**

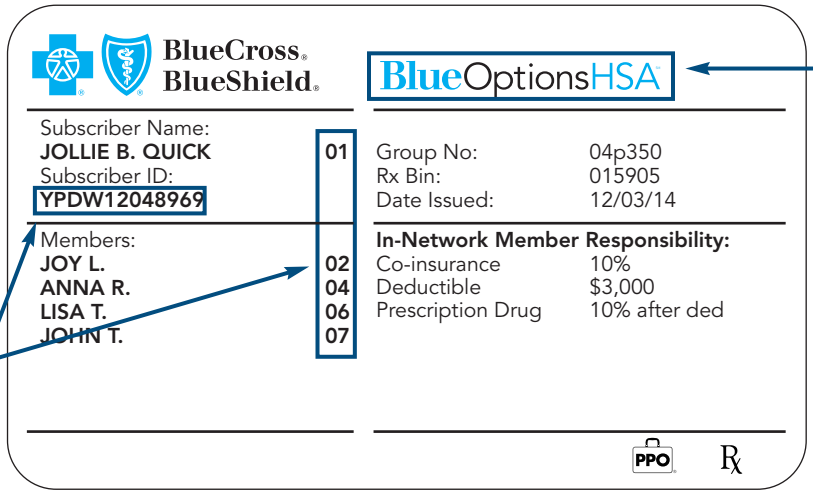
Electronic Filing
Emdeon Payer #61474

GRID+ logo identifies that a member is participating in the GRID+ dental network (see **Chapter 6** for additional information)

| Customer service | 1-888-471-2738 |
|---|---|
| **Claims** | |
| Electronically Filing | **Emdeon Payer Number 61474** |
| Paper Filing | **Mail to:** **Blue Cross and Blue Shield of North Carolina**<br>**PO Box 2400**<br>**Winston-Salem, NC 27102-2400** |
| **Website** | *bcbsnc.com/content/providers/dental/blue-book-dental.htm*<br>*providers.bcbsnc.com/providers/login.faces* |

## Dental Services under Medical/Pediatric Oral Health

Front of card



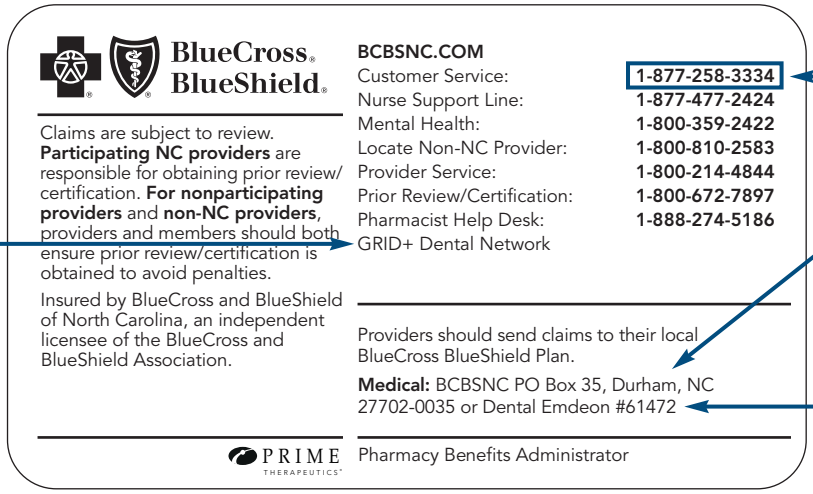

Always file claims for services that include the patient's complete identification number, which includes both numbers and letters.

For filing a claim for Joy L, use – YPDW12048969 02

This card is of a Blue Options℠ member's identification card. Blue Options℠ is the name of 1 of several health care products offered by BCBSNC.

pediatric dental is part of medical and should be billed to medical versus dental using the 2012 ADA claim form

Back of card




GRID+ logo identifies that a member is participating in the GRID+ dental network (see **Chapter 6** for additional information)

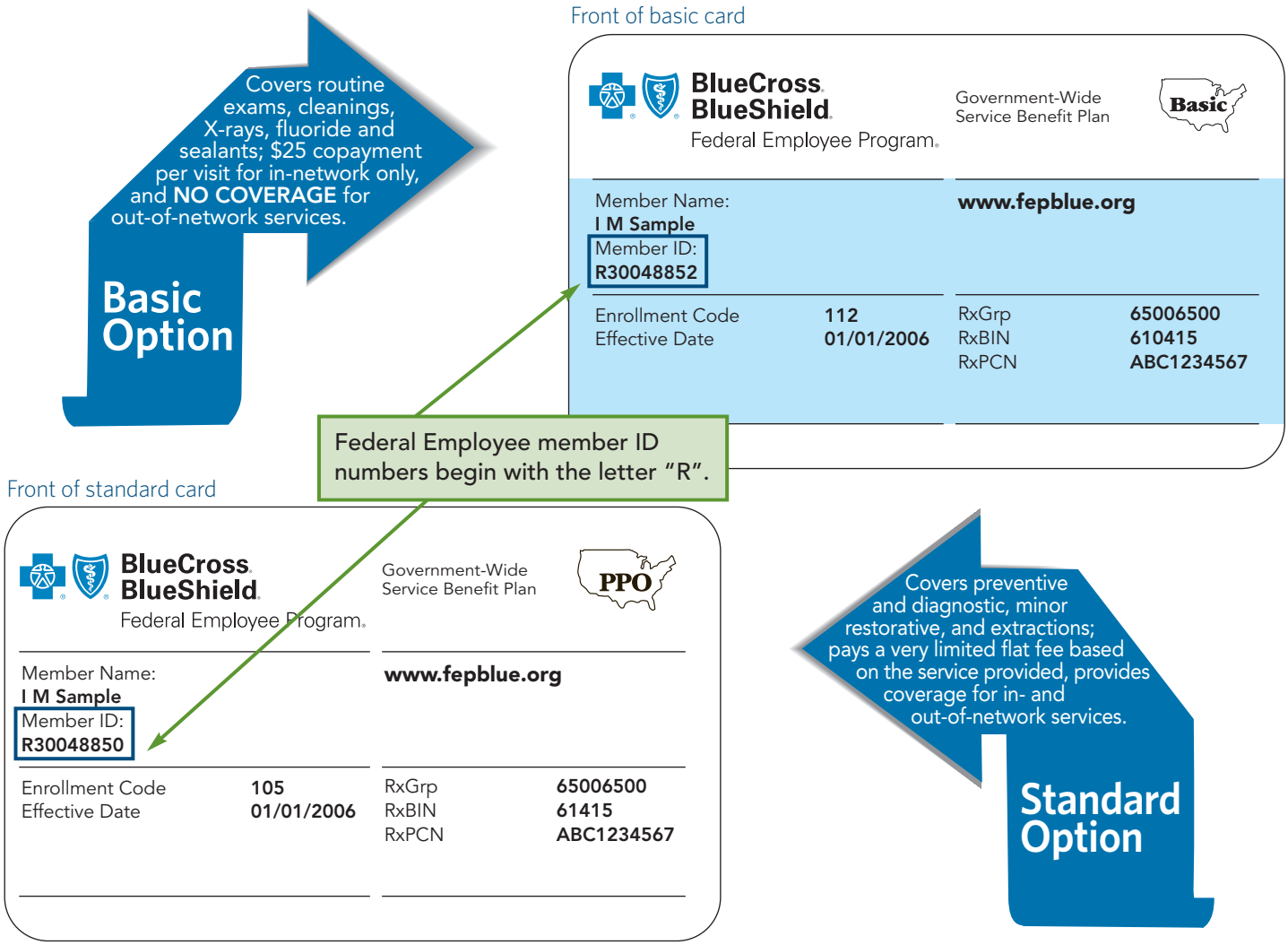
Customer Service **1-877-258-3334**

Paper Claims – Mail to:
**BCBSNC Claims**
**PO Box 35**
**Durham, NC 27702-0035**

Electronic Filing
Emdeon Payer #61472

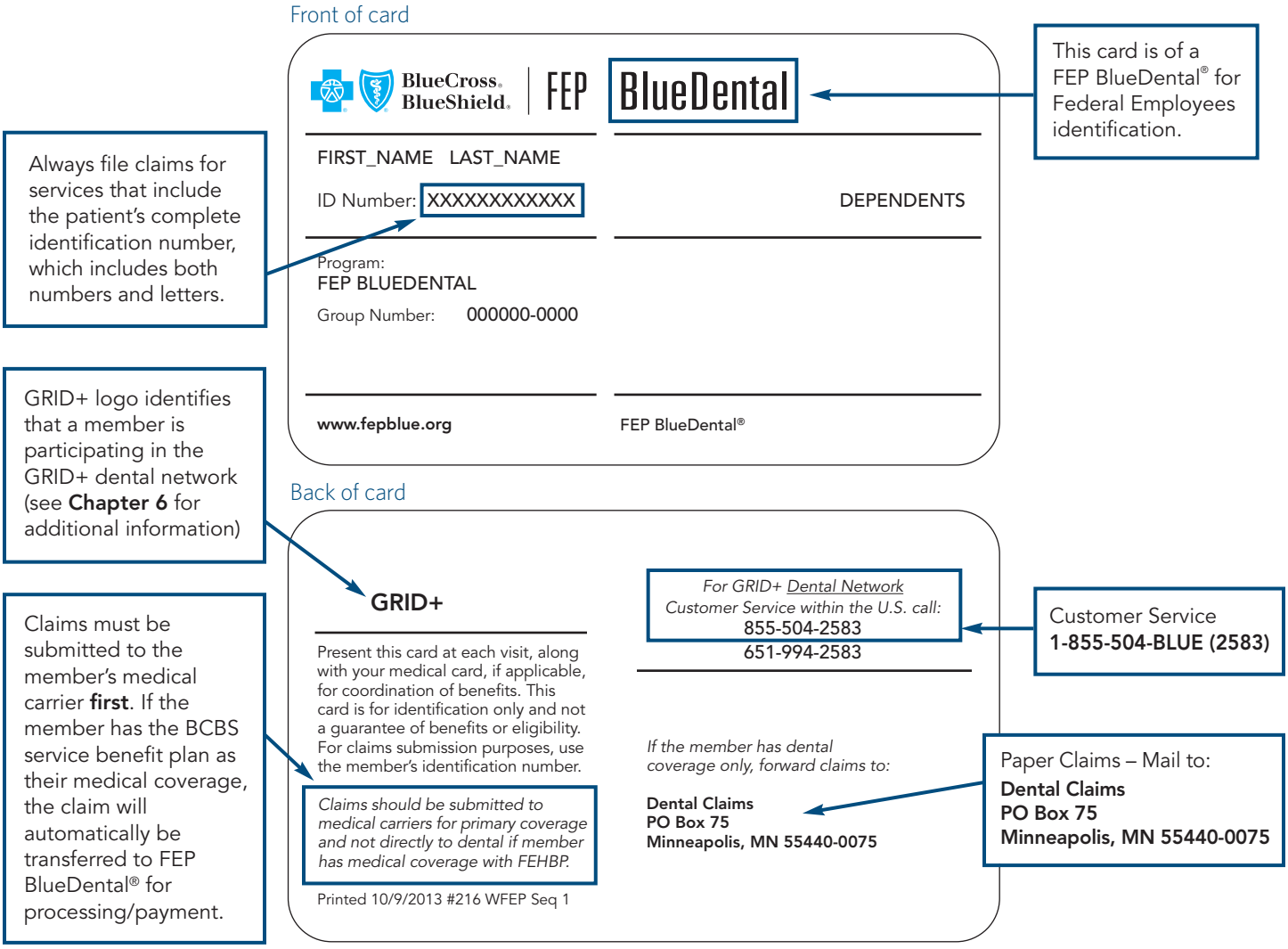
| Customer service | 1-877-258-3334 |
|---|---|
| **Claims** | |
| Electronically Filing | **Emdeon Payer Number 61472** |
| Paper Filing<br>***All claims must be submitted on the most current 2012 ADA claim form** | **Mail to:** Blue Cross and Blue Shield of North Carolina<br>PO Box 35<br>Durham, NC 27702-0035 |
| **Website** | *bcbsnc.com/content/providers/dental/blue-book-dental.htm*<br>*providers.bcbsnc.com/providers/login.faces* |

## Federal Employee Health Benefit Plan (BCBS medical coverage includes some dental benefits)




| Customer service | 1-800-222-4739 |
|---|---|
| **Claims**<br>**Dental claims** covered under Federal Employee Health Benefit Plan (FEHBP) filed with CDT codes on 2012 ADA form | **Emdeon Payer Number 61472 (electronic filing)**<br>**Mail claims to: Blue Cross and Blue Shield of North Carolina**<br>**PO Box 35**<br>**Durham, NC 27702-0035** |
| **Medical claims** (medical/accident/ TMJ filed with CPT codes) | Enrollment for electronic medical claims available through the Web at *bcbsnc.com/content/providers/edi/* |
| **Websites** | *bcbsnc.com/content/providers/index.htm*<br>*providers.bcbsnc.com/providers/login.faces* |

## FEP BlueDental®



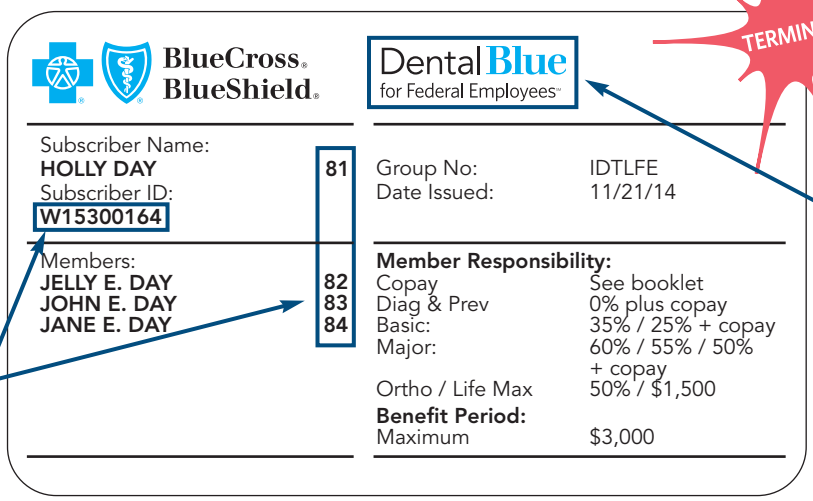

| Customer service | 1-855-504-BLUE (2583) |
|---|---|
| **Claims**<br>FEP BlueDental® Claims | **Mail claims to:** PO Box 75<br>Minneapolis, MN 55440-0075 |
| **Websites** | *bcbsnc.com/content/providers/index.htm*<br>*providers.bcbsnc.com/providers/login.faces* |

Important Note: FEP BlueDental® dental claims must be submitted to the member's medical carrier **first** using the 2012 ADA claim form. If the member has the BCBS service benefit plan as their medical coverage, the claim will automatically be transferred on a 2012 ADA claim form to FEP BlueDental® for processing/payment. If the member has coverage other than a Federal Employee Health Benefits Plan, a copy of the EOB is needed and must be submitted to the address below for processing:

**FEP BlueDental® Claims**
**PO Box 75**
**Minneapolis, MN 55440-0075**

## DentalBlue® for Federal Employees℠ *

Front of card

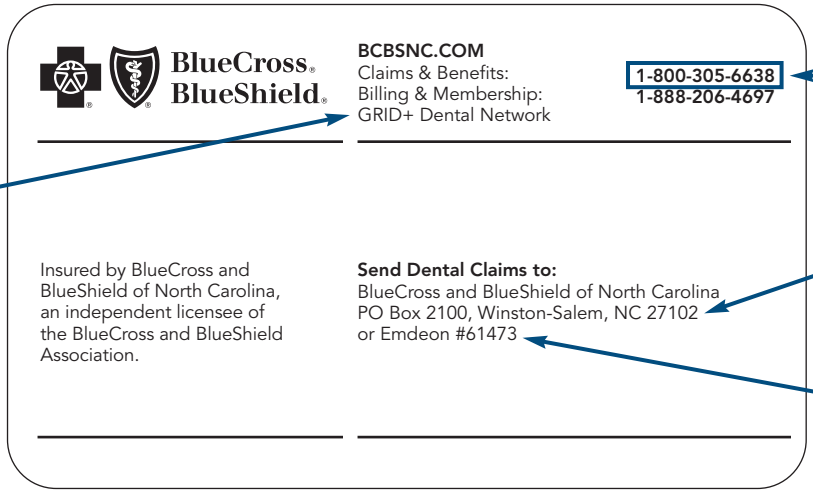



TERMING

Always file claims for services that include the patient's complete identification number, which includes both numbers and letters.

This card is of a DentalBlue® for Federal Employees℠ identification card.

Back of card




GRID+ logo identifies that a member is participating in the GRID+ dental network (see **Chapter 6** for additional information)

Customer Service **1-800-305-6638**

Paper Claims – Mail to:
**BCBSNC Claims**
**PO Box 2100**
**Winston-Salem, NC 27102**

Electronic Filing
Emdeon Payer #61473

| Customer service | 1-800-305-6638 |
|---|---|
| **Claims** | |
| Electronically Filing | **Emdeon Payer Number 61473** |
| Paper Filing | **Mail to:** Blue Cross and Blue Shield of North Carolina<br>PO Box 2100<br>Winston-Salem, NC 27102 |
| ***All claims must be submitted on the most current 2012 ADA claim form** | |
| **Websites** | *bcbsnc.com/content/providers/index.htm*<br>*providers.bcbsnc.com/providers/login.faces* |

*** This plan will term as of December 31, 2015.**

## 2.2 Eligibility, benefit verification and claim status

Dental providers and their staff can review eligibility and benefits for BCBSNC members enrolled in **Dental Blue® for Groups**, **Dental Blue for Individuals**℠, **Dental Blue for Seniors**℠ and **Dental Blue® for Federal Employees (terming 12/31/2015)**:

- **Phone** – Providers who contact Dental Blue® customer service at **1-800-305-6638** can receive a maximum of three (3) Verification of Benefits (VOB) at a time.
- **Website** – ***bcbsnc-dental.com*** includes the added feature of displaying benefit accumulator amounts, helping dental providers to see what amounts have been applied to a patient's dental deductible and coinsurance during the course of a benefit plan year.
- **Fax** – BCBSNC Dental Blue® offers a faxback feature for providers seeking Verification of Benefits (VOBs). Providers may contact BCBSNC Dental Blue® customer service to request VOBs. An unlimited amount of VOBs can be faxed to providers when requesting VOBs prior to rendering dental services. Call **1-800-305-6638** and select the faxback option to request VOBs.

Verification of care eligibility and benefits for members enrolled in **medical policy plans with dental procedures**, **pediatric dental**, and **FEP dental**, can be obtained in one (1) of the following ways:

- **Phone** – Providers may call to verify eligibility and benefits:
  - ‡ **Pediatric Dental / Dental Services under a Medical Plan** – Call the customer service number on member's ID card
  - ‡ **Federal Employee Health Benefit Plan (FEHBP)** – Call **1-800-222-4739** for dental claims filed with CPT codes on 2012 ADA form

**Website** – **Blue *e***℠ is a secure, internet-based application, for verification of membership and eligibility from the convenience of your internet browser. BCBSNC offers this service free-of-charge to BCBSNC dental providers. Providers can easily register for **Blue *e***℠ online. **Blue *e***℠ can be used to find dental claim status for claims submitted for policies with the PO Box 35, Durham NC filing address, listed on the patient's ID card.

Dental providers not currently registered to use **Blue *e***℠, can register online at ***providers.bcbsnc.com/providers/login.faces***. Providers with questions about enrolling as a **Blue *e***℠ user or how to use **Blue *e***℠ transactions can contact BCBSNC's eSolutions HelpDesk at **1-888-333-8594** or you can email us at ***Bluee.HelpDesk@bcbsnc.com***.

## 2.3 ACS Benefit Services, Inc. (ACS)

BCBSNC utilizes the services of ACS Benefit Services, Inc. (ACS), for the administration of customer service and claims processing for the BCBSNC dental products. ACS claims system allows ACS to process claims accurately because their processing systems are customized for each dental plan's benefit structure, down to the code and tooth number level. Most claims are processed as EDI (electronic data interchange) claims for increased efficiency.

ACS acts on behalf of BCBSNC to administer:

- Dental claims processing
- Eligibility and benefit verification
- Customer service
- Pre-treatment
- Reconsideration first level appeals for claim denials

## 2.4 BCBSNC dental customer service

The BCBSNC dental customer service office can be reached toll-free during the hours of operation, Monday through Friday from 8:00 a.m. to 6:00 p.m., Eastern Standard Time. Calls received outside these hours are handled by the BCBSNC Dental Blue® integrated voice response (IVR) system. The IVR allows callers with a touch-tone phone to access benefit plan information via a series of voice prompts. When calling dental customer service, please use the customer service phone number assigned to the patient's dental coverage plan type. Customer service numbers are printed on the back of BCBSNC member's identification cards and are additionally located within this chapter.

## 2.5 BCBSNC enhanced Web-based services

BCBSNC offers Web-based services to assist dental providers with the many administrative functions associated with arranging patient care and subsequent claim submission and claims reconciliation. These services are available by accessing ***bcbsnc-dental.com***.

- Standard services include:
  - ‡ Member/eligibility check
  - ‡ Member claim history (claim history for dental services provided by your practice to your patients)
  - ‡ Pre-treatment/authorization submission
  - ‡ Review pre-treatment/authorization service requirements (if x-rays and/or treatment plans are required these requirements will be noted)
  - ‡ Upload required documents using national electronic attachment (NEA) (e.g. X-ray images, perio-charting, ortho contracts, etc.)
  - ‡ Check claim status
  - ‡ Check pre-treatment status

The ***bcbsnc-dental.com*** website access requires registration. To register please call BCBSNC dental customer service at **1-800-305-6638** and request to speak with Provider Web Services.

Providers with questions about Web-based transaction registration or providers experiencing website difficulty can contact Provider Web Services by calling **1-800-305-6638**.

## 2.6 NEA FastAttach™ and *Fast*Look

Dental providers can send electronic attachments using the NEA (National Electronic Attachment Inc.) offered services of FastAttach.™ FastAttach™ enables dental providers to transmit attachments (i.e. X-rays, lab reports, perio-charts) in support of electronic claims to dental insurance payers using the internet. Attachments can also be stored for providers who request storage services. Additional information about NEA FastAttach™ can be found in **Section 7.5** of this e-manual.

## 2.7 BCBSNC Network Management

Your Network Management field office is responsible for developing and supporting relationships with participating dental providers and their staff. Network Management staff is dedicated to serve as a liaison between you and BCBSNC. Network Management staff is available to assist your practice with the following:

- Enrollment/contracting with BCBSNC
- Questions regarding BCBSNC contracts, policies and procedures
- Changes to your organization including:
  - ‡ Opening/closing locations
  - ‡ Change in name or ownership
  - ‡ Change in tax ID number, address or phone number
  - ‡ Merging with another group
  - ‡ Adding or removing a provider

**Stay Informed!**

Blue Cross and Blue Shield of North Carolina is committed to informing dental providers participating in our dental network about recent dental-related updates, new dental products and programs, and other relevant BCBSNC news.

**Email updates**
Join our **email registry** to get the latest dental news from BCBSNC delivered right to your inbox.

**Dental Blue® news**
Visit our **Dental Blue® News** page to stay up-to-date with the latest news and information for dental providers.

## 2.8 BCBSNC Network Management contact information

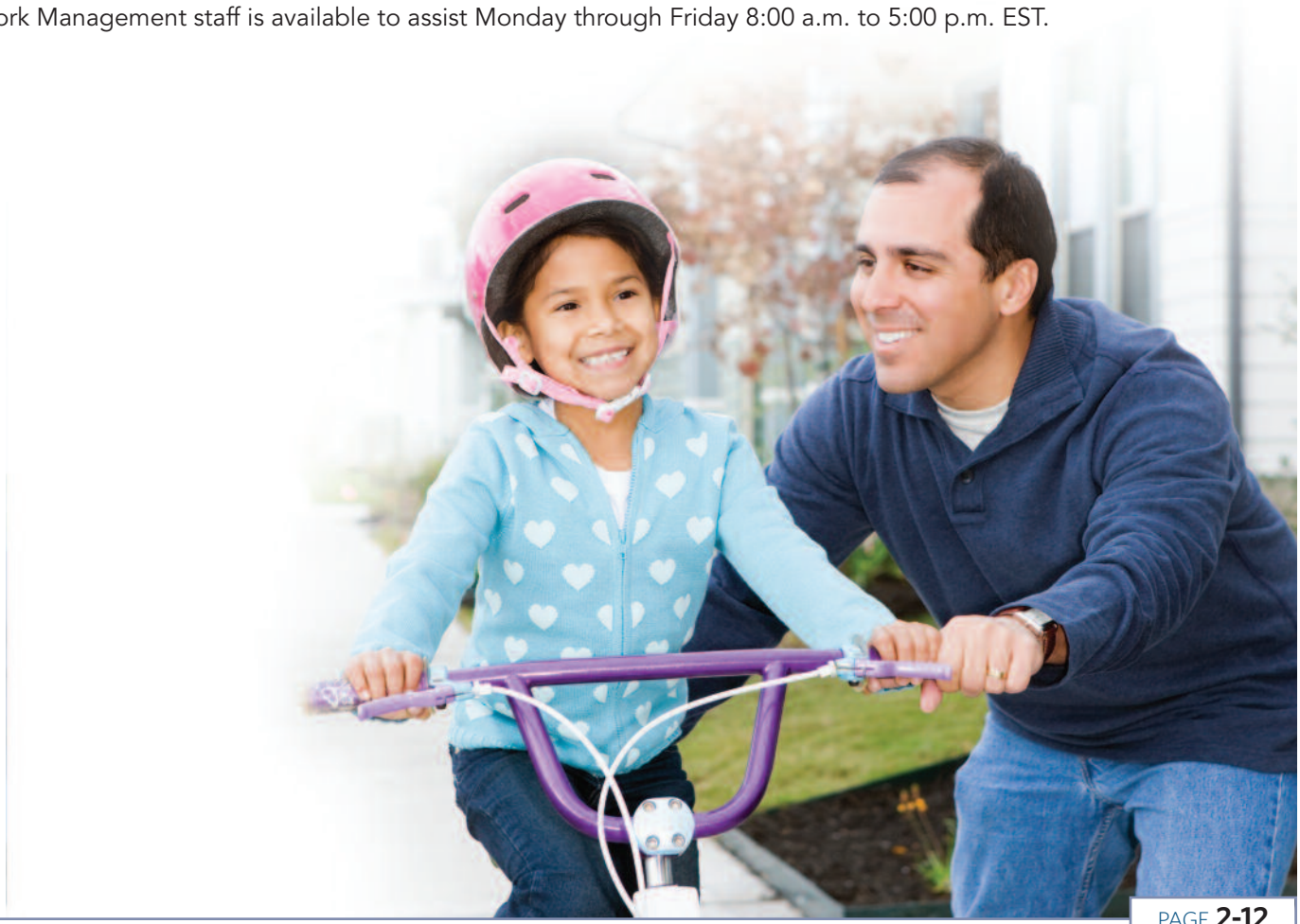
### General inquiries

| Phone / Fax / Email | Address | On the Web |
|---|---|---|
| **1-800-777-1643**<br>**919-765-4349** (FAX)<br>*NMSpecialist@bcbsnc.com* | **PO Box 2291**<br>**Durham, NC 27702-2291** | *bcbsnc.com*<br>*bcbsnc.com/content/providers/dental-providers/join-network.htm*<br>*bcbsnc.com/content/providers/dental/blue-book-dental.htm* |

### Dental provider enrollment

| Phone / Fax / Email | Address | On the Web |
|---|---|---|
| **1-800-909-3385** (Phone)<br>**919-765-3888** (FAX)<br>*dentalcontracts@bcbsnc.com* | **Attention:**<br>**Dental Blue® Contracting**<br>**PO Box 2291**<br>**Durham, NC 27702-2291** | *bcbsnc.com/content/providers/dental-providers/join-network.htm*<br>*bcbsnc.com/content/providers/dental/blue-book-dental.htm* |

Network Management staff is available to assist Monday through Friday 8:00 a.m. to 5:00 p.m. EST.



Chapter 3

# Dental provider demographics

## 3.1 Dental provider demographics

BCBSNC maintains an online provider directory listing addresses, phone numbers and current rosters of providers at a participating practice, so that our members can quickly locate dental care providers and health care providers to schedule appointments. Our ability to successfully direct members to you for their dental care depends on the accuracy of the information we have on file for your dental practice. We encourage you to visit the "Find a Dentist page" located on the BCBSNC website at ***bcbsnc.com*** to validate your dental care business information.

If you find that your dental practices information needs to be updated, please let us know by contacting a BCBSNC Network Management representative or complete and return a provider demographic form that can be accessed from the "Dental Providers" tab on our website at ***bcbsnc.com/content/providers/index.htm***. Providers can email the completed form to ***provider.addressupdates@bcbsnc.com*** or fax to BCBSNC at **1-919-287-8884**.

Please note that having accurate mailing information on file for your practice also ensures you receive claims payments and other important correspondence in a timely manner from BCBSNC.

## Sample of the provider demographic form

Access the form at ***bcbsnc.com/assets/providers/public/pdfs/Provider_Update.pdf***.

BlueCross BlueShield of North Carolina

An independent licensee of the Blue Cross and Blue Shield Association

(Internal Use Only)

Verified by: _____

Date: _____

County Code: _____

### New/Updated Information

**Name of Practice:** _____

**Tax Identification Number (TIN)** _____

**National Provider Identifier (NPI)** _____

**Inbound NPI (Type I)** _____

**Outbound NPI (Type II)** _____

**Billing/Remit Address/Phone #** (Address where provider receives checks, billing information and billing correspondence):

_____

_____

**Physical and Mailing/Correspondence Address is the same as Billing?** _____ **Yes** _____ **No**

**If not, please complete the following:**

**Physical Address** (Street address of facility where services are rendered [actual office location]):

_____

_____

**Mailing/Correspondence Address/Phone #** (Address where provider receives general mail if different from billing address):

_____

_____

**Notice Contact Address** (Name or title and address of the person to whom contractual notices and other communications regarding the provider agreement with BCBSNC must be sent. Please indicate if the mailing address for US Mail is different from the courier/hand delivery address:

_____

**Telephone Number for Patients Use:** _____

**Fax Number for BCBSNC and/or Blue Medicare Use:** _____

**Practice E-Mail Address:** _____
(Allows us to quickly disseminate important information to provider practices)

**Effective Date of Change:** _____

_____ _____

**Signature of Physician, Practice Manager, or Authorized Representative** **Date**

Revised 09/2011

*The back of this sample form is continued on the following page.*

# Sample of the provider demographic form (continued)

Access the form at ***bcbsnc.com/assets/providers/public/pdfs/Provider_Update.pdf***.

### General Updates:

Practice Manager/Physician may download this form and e-mail to BCBSNC at ***Provider.AddressUpdts@bcbsnc.com*** or **FAX** to BCBSNC **919-287-8884**.

### Contractual Notice Updates:

Only persons authorized to update or amend your provider agreement with us may update the Notice Contact address, as this is a contractual requirement. Please email contractual notice updates to Network Management at ***NetworkManagementProviderNot@bcbsnc.com*** or **FAX** form to Network Management Operations **919-765-4349**.

==========

If you have new physicians join your practice, please visit our website at ***bcbsnc.com*** to obtain an individual application to enroll the new provider's NPI and to obtain a credentialing application and instructions for credentialing if the provider has not been credentialed by Blue Cross and Blue Shield of North Carolina. If you have questions, please contact your regional field office representative.

#### Provider Demographic Form

It is a participating provider's/group's contractual obligation to notify Blue Cross and Blue Shield of North Carolina (BCBSNC) of any change in demographic information and addition and/or deletion of any providers to your staff. This is critical to ensure BCBSNC and Blue Medicare HMO and Blue Medicare PPO members can access care through your practice by displaying the correct demographic information in the Provider Directory.

#### Notice Contact – What is it?

**For non-Medicare provider agreements,** the Notice Contact is the name or title and address that you and BCBSNC are required to use to send certain notices regarding your provider agreement. This address is the "Notice Contact" listed in your agreement with us. Some notices must be sent in writing. Other notices may be sent electronically. See your provider agreement and the provider manual for more details. The "Notice Contact" may be different from your billing address and physical address.

#### Required Information:

Your Commercial agreement with us must contain a "Notice Contact" provision listing the name or title and address of the person to whom contractual notices and other communications regarding our agreement shall be sent.

#### Notice Contact Updates:

It is a participating provider's/group's contractual obligation to notify BCBSNC of any change to the Notice Contact. You may update the Notice Contact identified in your agreement with us by filling out this form and sending it to us. We accept e-mails, faxes, or hard copies. Only persons authorized to update or amend your provider agreement with us may complete this form, as this is a contractual requirement. Please utilize this form when reporting changes.

Revised 09/2011

Chapter 4

# Dental benefit plans

## 4.1 Dental Blue® products

Blue Cross and Blue Shield of North Carolina (BCBSNC) offers a dental benefit plan for individuals and a choice of dental plan products for groups:

- Dental Blue for Individuals℠ – a consumer driven dental plan for individuals and their eligible dependents.
- Dental Blue for Seniors℠ – a consumer dental product for individuals and their spouse age sixty-five (65) and older.
- Dental Blue® for group – offers employers the freedom to customize a plan to meet the needs of employees, customizing plans from a choice of available benefit options.
- Dental Blue Select℠ – a competitive voluntary dental plan. Employers have a choice of Standard, Complete or Enhanced dental plans.
- Dental Blue® for Federal employees – a BCBSNC product offering flexibility and choice, intended to complement the policy offered to Federal employees and retirees of the Federal government. See **Chapter 5**, **Section 5.6**, for additional information about this product.

In addition to the dental benefit plans for groups and individuals, BCBSNC medical plans offer limited dental benefits where applicable. Pediatric Oral Health benefits were also added to BCBSNC health plans as mandated under the Affordable Care Act. Please reference **Section 4.7** of this e-manual for additional information regarding Pediatric Dental services covered under BCBSNC medical plans.

## 4.2 Member identification cards

BCBSNC members enrolled with dental coverage receive identification cards from BCBSNC that display the name of the subscriber, as well as, the names of his or her eligible dependents. Providers are responsible for verifying that members are eligible for benefit coverage at the time services are rendered and for determining if patients have other dental coverage.

It's important to note that an identification card, in itself, does not guarantee that a person is currently enrolled in a BCBSNC dental plan. Whether from speaking with BCBSNC customer service, obtaining member information using **Blue *e***℠ or from the website ***bcbsnc-dental.com***, information about benefits and eligibility is accurate at the time it's provided.

Coverage and payment decisions pertaining to eligibility are made according to the member's policy and current eligibility information when a claim is received, as of the date services were rendered. Eligibility responses provided by customer service, **Blue *e***℠ and/or the website ***bcbsnc-dental.com*** do not guarantee coverage, eligibility or payment. Sample member identification card images can be found in this chapter (**Chapter 4**) and in **Chapter 2**.

BCBSNC **strongly** recommends that a patient's chart be updated with a photocopy of the patient's most current member identification card, each time a patient is seen in your office. The updated copy of the member's card will help ensure that the needed member identifying information is accurately recorded for reporting on the next claim submission.

Dental Blue®

## 4.3 Dental Blue® for group

Dental Blue® for group is a group dental plan available to employees through their employer. Employers may contribute any amount towards the premium costs. Dental Blue® for group is underwritten by Blue Cross and Blue Shield of North Carolina (BCBSNC).

Dental Blue® for group offers employer groups a choice of standard and non-standard plans that include a choice of deductibles and annual maximums.

**Important:** BCBSNC also offers a voluntary dental product called Dental Blue Select℠. Please refer to the BCBSNC Dental Blue Select℠ benefits information contained on the following pages of this e-manual for benefits information about the BCBSNC voluntary group dental plan.

### 4.3.1 Benefit period

The twelve (12) month benefit period is for a contract year, beginning with the group's effective date.

### 4.3.2 Waiting period

The following waiting period time limits only apply to those members who have waiting periods. This information does not apply to groups and/or members who do not have waiting periods.

| Category | Standard plan | Late enrollment | Non-standard plans |
|---|---|---|---|
| Preventive | None | None | Non-standard plans may offer varying waiting periods for member's eligibility for services. Dental providers are encouraged to verify a member's benefits and eligibility in advance of providing services. |
| Basic | None | 12 months | |
| Major | None or 12 months | 12 or 24 months | |
| Orthodontia | None or 12 months | 12 or 24 months | |

Please note that depending on employer groups, waiting periods may be waived or extended for late enrollees.

### 4.3.3 Benefit categories

There are four (4) benefit categories of dental services:

1) Diagnostic and preventive
2) Basic
3) Major
4) Orthodontia (available as a separate rider)

## Benefit overview

The following overview of benefits is offered as an example of group dental benefit options; however, this is not a guarantee of member's benefits, eligibility or plan coverage. Please verify a member's actual eligibility and benefits prior to providing dental care services.

**Note:** Amounts reflected below are member liability. The information provided herein is for informational purposes. Benefits may vary based on benefit plan. Please see member's benefit booklet for a complete listing of benefits available.

| Dental Blue® for group | Standard plan benefits* - member responsibility |
|---|---|
| **Coinsurance** | **Coinsurance** |
| Preventive services | No charge |
| Basic services | 20% |
| Major services | 50% |
| Ortho | 50% |
| **Deductibles and maximums** | **Deductibles and maximums** |
| Individual deductible (applies to basic and major services) | $25 / $50 / $75 |
| Family deductible options (applies to basic and major services) | 3 times individual |
| Individual benefit maximum options (applies to diagnostic and preventive, basic and major services) | $750 / $2,500 |
| Lifetime maximum for orthodontia | $750 / $2,000 |
| Prior coverage credit | Credit given for continuous prior dental coverage |
| **Available benefits** | **Available benefits** |
| Preventive and diagnostic | Oral exams and teeth cleanings<br>Bitewing X-ray<br>Full mouth X-ray<br>Fluoride treatment<br>Sealants<br>Space maintainers |

Continued on the following page.

| Dental Blue® for group | Standard plan benefits* - member responsibility |
|---|---|
| Basic | Simple restorative services (fillings)<br>Simple teeth removal<br>Oral surgery<br>Endodontics and periodontics**<br>Stainless steel crowns |

| Available benefits | Available benefits |
|---|---|
| Major | Endodontics and periodontics**<br>Crowns, inlays, onlays<br>Bridges<br>Dentures<br>Implants (optional) |
| Orthodontics | Children under 19***<br>No deductible |

* Non-standard plans may offer varying benefits as selected by employers. Dental providers are encouraged to verify a member's benefits and eligibility in advance of providing services.

** Endodontics and periodontics may be considered either basic services or major services, depending on benefit categorization as elected by an employer group.

*** Standard plans may cover orthodontics on adults for medium or large groups.

**Frequency/age restrictions and other exclusions may apply – see benefits defined online or call customer service for details.**

# Dental Blue Select℠

## 4.4 Dental Blue Select℠ for group (a voluntary group product)

Dental Blue Select℠ for group is a competitive voluntary dental plan.

Dental Blue Select℠ offers employer groups a choice of three (3) benefit plans:

1) Dental Blue Select℠ Standard – basic services at a low cost
2) Dental Blue Select℠ Complete – covers all dental needs at a reasonable price, orthodontia optional
3) Dental Blue Select℠ Enhanced – premium services at great value, orthodontia optional

### 4.4.1 Benefit period

The twelve (12) month benefit period is for a contract year, beginning with the group's effective date.

### 4.4.2 Waiting period

The following waiting period time limits only apply to those members who have waiting periods. This information does not apply to groups and/or members who do not have waiting periods.

| Category | Dental Blue Select℠ Standard | Dental Blue Select℠ Complete | Dental Blue Select℠ Enhanced |
|---|---|---|---|
| Preventive | None | None | None |
| Basic | 6 months | 6 months | None |
| Major | 12 months | 12 months | 12 months |
| Orthodontia (optional) | NA | 12 months<br>when benefits apply | 12 months<br>when benefits apply |

### 4.4.3 Benefit categories

There are four (4) benefit categories of dental services:

1) Diagnostic and preventive
2) Basic
3) Major
4) Orthodontia (available as a complete or enhanced option)

## Benefit overview

The following overview of benefits is offered as an example of a group's dental benefit options; however, this is not a guarantee of member's benefits, eligibility or plan coverage. Please verify a member's actual eligibility and benefits prior to providing dental care services.

**Note:** Amounts reflected below are member liability. The information provided herein is for informational purposes. Benefits may vary based on benefit plan. Please see member's benefit booklet for a complete listing of benefits available.

| | Member responsibility | | |
|---|---|---|---|
| | Dental Blue Select℠ Standard | Dental Blue Select℠ Complete | Dental Blue Select℠ Enhanced |
| **Coinsurance** | | | |
| Preventive services | 0%* | 0%* | 0%* |
| Basic services | 20% | 20% | 20% |
| Major services | 50% | 50% | 50% |
| Ortho | NA | 50% (optional) | 50% (optional) |
| **Deductibles and maximums** | | | |
| Individual deductible (applies to diagnostic and preventive, basic and major services) | $100 lifetime per member | $100 lifetime per member | $100 lifetime per member |
| Family deductible | NA – each family member satisfies an individual deductible | NA – each family member satisfies an individual deductible | NA – each family member satisfies an individual deductible |
| Individual annual maximum options (applies to diagnostic and preventive, basic and major services) | $1,000 | $1,000 or $1,500 | $1,000 or $1,500 |
| Lifetime maximum for orthodontia | NA | $1,000 or $1,500 (optional coverage) | $1,000 or $1,500 (optional coverage) |
| Prior coverage credit | No | Yes | Yes |

Continued on the following page.

| | Member responsibility | | |
|---|---|---|---|
| | Dental Blue Select℠ Standard | Dental Blue Select℠ Complete | Dental Blue Select℠ Enhanced |
| **Available benefits** | | | |
| Preventive and diagnostic | Oral exams, teeth cleanings (1 per benefit period)<br>Bitewing X-ray (maximum of 4 films per benefit period)<br>Fluoride treatment (2 per period)<br>Sealants (age 6-15) | Oral exams, teeth cleanings (2 per benefit period)<br>Bitewing X-ray<br>Fluoride treatment<br>Sealants (age 6-15) | Oral exams, teeth cleanings (2 per benefit period)<br>Bitewing X-ray<br>Fluoride treatment<br>Sealants (age 6-15) |
| Basic | Simple restorative services (fillings)<br>Simple teeth removal | Simple restorative services (fillings)<br>Simple teeth removal | Simple restorative services (fillings)<br>Simple teeth removal<br>Intraoral/periapical X-ray<br>Panorex or full mouth X-ray (1 per 36 months)<br>Endodontics<br>Periodontics |
| Major | Endodontics<br>Periodontics<br>Oral surgery<br>Space maintainers<br>Intraoral/periapical X-ray<br>Panorex or full mouth X-ray (1 per 36 months) | Root of teeth X-ray<br>Panorex or full mouth X-ray (1 per 36 months)<br>Endodontics<br>Periodontics<br>Oral surgery<br>Space maintainers<br>Crowns, inlays, onlays | Oral Surgery<br>Space maintainers<br>Crowns, inlays, onlays<br>Dental implants<br>Prosthodontics (bridges, dentures) |
| Orthodontics (optional) | Not available | Children under 19<br>No deductible | Children under 19<br>No deductible |

* Dental providers are encouraged to verify a member's benefits and eligibility in advance of providing services.

Dental Blue
for Individuals℠

## 4.5 Dental Blue for Individuals℠

Dental Blue for Individuals℠ is a consumer dental product for individuals and their eligible dependents. Member's checkups and cleanings are covered twice per benefit period and member pays no deductible for checkups or diagnostic and preventive services.

### 4.5.1 Eligibility

North Carolina residents under age sixty-five (65) and their dependents are eligible. An eligible dependent is defined as a spouse or an unmarried child until age twenty-six (26). A child who is a North Carolina resident may have an individual policy in their name. A person is ineligible for Dental Blue for Individuals℠ if they have cancelled a previous Dental Blue for Individuals℠ policy within the past twelve (12) months.

### 4.5.2 Waiting period

The following waiting period time limits only apply to those members who have waiting periods. This information does not apply to groups and/or members who do not have waiting periods.

| Category | Standard plan | Non-standard plans |
|---|---|---|
| Preventive | None | Members who can demonstrate prior proof of dental coverage may have waiting periods waived if they have a statement from another carrier showing consecutive dental coverage. However, waiting periods will not be waived if more than sixty-three (63) days have passed between the termination of the prior coverage and the effective date of the current coverage. |
| Basic | 6 months | |
| Major | 12 months | |
| Orthodontia | NA | |

### 4.5.3 Benefit categories

There are three (3) benefit categories of dental services:

1) Diagnostic and preventive
2) Basic
3) Major

(Orthodontic coverage is not available on the Dental Blue for Individuals℠ plan)

## Benefit overview

The following overview of benefits is offered as an example of a member's dental benefit options; however, this is not a guarantee of benefits, eligibility or plan coverage. Please verify a member's actual eligibility and benefits prior to providing dental care services.

**Note:** Amounts reflected below are member liability. The information provided herein is for informational purposes. Benefits may vary based on benefit plan. Please see member's benefit booklet for a complete listing of benefits available.

| Dental Blue for Individuals℠ | Plan benefits – member responsibility |
|---|---|
| **Coinsurance** | **Coinsurance** |
| Preventive services | 0% |
| Basic services | 40%, subject to deductible and 6 month waiting period |
| Major services | 50%, subject to deductible and 12 month waiting period |
| Ortho | NA |
| **Deductibles and maximums** | **Deductibles and maximums** |
| Individual deductible (applies to basic and major services) | $75 per member annual |
| Individual annual maximum (applies to all services) | $1,000 |
| Prior coverage credit | Yes, waived or reduced by number of months of prior coverage |
| **Available benefits** | **Available benefits** |
| Preventive and diagnostic | Oral exams and teeth cleanings<br>Bitewing X-ray<br>Full mouth X-ray<br>Fluoride treatment<br>Sealants<br>Space maintainers |
| Basic | Simple restorative services (fillings)<br>Simple teeth removal<br>Oral surgery<br>Endodontics<br>Stainless steel crowns |

Continued on the following page.

| Dental Blue for Individuals℠ | |
|---|---|
| **Available benefits (continued)** | **Available benefits (continued)** |
| Major | Periodontics<br>Crowns, inlays, onlays<br>Bridges<br>Dentures |
| Orthodontics | NA |

Dental Blue for Seniors℠

## 4.6 Dental Blue for Seniors℠

Dental Blue for Seniors℠ is a consumer dental product for individuals and their spouse, age sixty-five (65) and older. All membership and billing administration is provided by BCBSNC. ACS Benefits Services, Inc., administers all claims and customer service fundamentals on behalf of BCBSNC.

### 4.6.1 Eligibility

North Carolina residents and their spouse, age sixty-five (65) or older, are eligible. An eligible dependent is defined as a spouse. A child who is a North Carolina resident may have an individual policy in their name. A person is ineligible for Dental Blue for Seniors℠ if they have cancelled a previous Dental Blue for Seniors℠ policy within the past twelve (12) months.

### 4.6.2 Waiting period

The following waiting period time limits only apply to those members who have waiting periods. This information does not apply to members who do not have waiting periods.

| Category | Standard plan | Requirement |
|---|---|---|
| Preventive | None | Members who can demonstrate prior proof of dental coverage may have waiting periods waived if they have a statement from another carrier showing consecutive dental coverage. However, waiting periods will not be waived if more than sixty-three (63) days have passed between the termination of the prior coverage and the effective date of the current coverage. |
| Basic | 6 months | |
| Major | 12 months | |
| Orthodontia | NA | |

### 4.6.3 Benefit overview

The following overview of benefits is offered as an example of a member's dental benefit options; however, this is not a guarantee of benefits, eligibility or plan coverage. Please verify a member's actual eligibility and benefits prior to providing dental care services.

**Note:** Amounts reflected below are member liability. The information provided herein is for informational purposes. Benefits may vary based on benefit plan. Please see member's benefit booklet for a complete listing of benefits available.

| Dental Blue for Seniors℠ | Plan benefits – member responsibility |
|---|---|
| **Coinsurance** | **Coinsurance** |
| Preventive services | 0%, after $25 copay, no subject to deductible or waiting period limitations |
| Basic services | 40%, subject to deductible, and 6 month waiting period |
| Major services | 50%, subject to deductible, and 12 month waiting period |
| Ortho | NA |
| **Deductibles and maximums** | **Deductibles and maximums** |
| Individual deductible (applies to basic and major services) | $75 per member annual |
| Individual annual maximum (applies to all services) | Year 1 $1,000 / Year 2 $1,100 / Year 3 and after $1,200 |
| Prior coverage credit | Yes, waived or reduced by number of months of prior coverage |
| **Available benefits** | **Available benefits** |
| Preventive and diagnostic | Oral exams, teeth cleanings<br>Bitewing X-ray<br>Full mouth X-ray |
| Basic | Simple restorative services (fillings)<br>Simple teeth removal |
| Major | Oral surgery<br>Endodontics<br>Periodontics<br>Crowns, inlays, onlays<br>Bridges<br>Dentures |
| Orthodontics | NA |

## 4.7 Medical plans with dental benefits / Pediatric Oral Health

BCBSNC medical plans offer limited dental benefits were applicable. Effective January 1, 2014, Pediatric Oral Health benefits were also added to BCBSNC health plans as mandated under the Affordable Care Act, effective January 1, 2014, the Affordable Health Care Act (ACA) mandate made Pediatric Oral Health (Pediatric Dental) benefits available to children up to age nineteen (19). Pediatric Dental benefit is an essential health benefit for all BCBSNC ACA compliant plans for fully insured small groups and non-grandfathered individual plans.

Pediatric Dental benefits offer a full range of dental services including preventive, basic, major and medically necessary orthodontia services covered under a small group or a non-grandfathered individual medical policy with BCBSNC. Prior approval is required for medically necessary orthodontia covered under Pediatric Oral Health.

Members covered under BCBSNC medical plan with Pediatric Dental benefits may visit a dental network provider or an out-of-network provider for dental services. If you choose to visit a network dentist you may save on your out-of-pocket cost.

A participating dentist rendering dental care to a member with Pediatric Dental benefits must submit claims using the 2012 ADA claim form to BCBSNC medical plan first for reimbursement. The member's medical plan is considered primary. Once the claim is processed and payment issued, the provider or member may submit a claim to the member's dental carrier for reimbursement. BCBSNC dental plan will always be considered secondary to the member's medical plan for Pediatric Dental services.

### 4.7.1 Member eligibility, benefits and claim status

Dental providers may contact medical customer service at the phone number listed on the back of the member's ID card to verify eligibility, benefits and claims status for Pediatric Dental services. Providers may also verify benefits by visiting the **Blue e**℠ website available to providers.

Dental providers can identify a member under age nineteen (19) with Pediatric Dental by viewing the back of the member's medical ID card. **If Emdeon Dental Payer ID #61472 appears under the medical mailing address, then the member has Pediatric Dental benefits.** The claim should be submitted to either Emdeon #61472 or the medical mailing address.

**Blue Cross and Blue Shield of North Carolina**
**PO Box 35**
**Durham, NC 27702-0035**

### 4.7.2 Benefit overview

| | Member responsibility | |
|---|---|---|
| **Covered services** | **In-network** | **Out-of-network** |
| Preventive and diagnostic | $25 copay per visit | $50 copay per visit |
| Basic and major | 20% after medical deductible | 40% after medical deductible |
| Medically necessary orthodontia (subject to a 12 month waiting period)*<br>Prior Plan Approval (PPA) is required | 20% after medical deductible | 40% after medical deductible |

*Waiting period for medically necessary orthodontia must be satisfied.

| Pediatric Dental services covered under medical | |
|---|---|
| **Benefits category** | **Available benefits** |
| Preventive and diagnostic | Oral exams and teeth cleanings<br>Bitewing X-rays<br>Full mouth X-ray<br>Fluoride treatment<br>Sealants<br>Space maintainers |
| Basic and major | Simple restorative services (fillings)<br>Simple teeth removal<br>Oral surgery<br>Endodontics and periodontics<br>Crowns, inlays, onlays<br>Bridges<br>Dentures<br>Implants |
| Orthodontics | Medically necessary, prior approval required* |

*Criteria for medical necessity and prior approval process will be posted as an addendum to the Dental e-Manual.
**Providers are reminded to always verify a member's actual benefits and eligibility.**

## 4.8 Benefit exclusions and limitations

Below is a partial list of exclusions/limitations. Please refer to **Chapter 7** for a complete list of exclusions/limitations (general limitations). Additionally, the member booklet can be referenced for final determination of exclusions/limitations. Providers are reminded to always verify a member's benefits and eligibility prior to rendering a service.

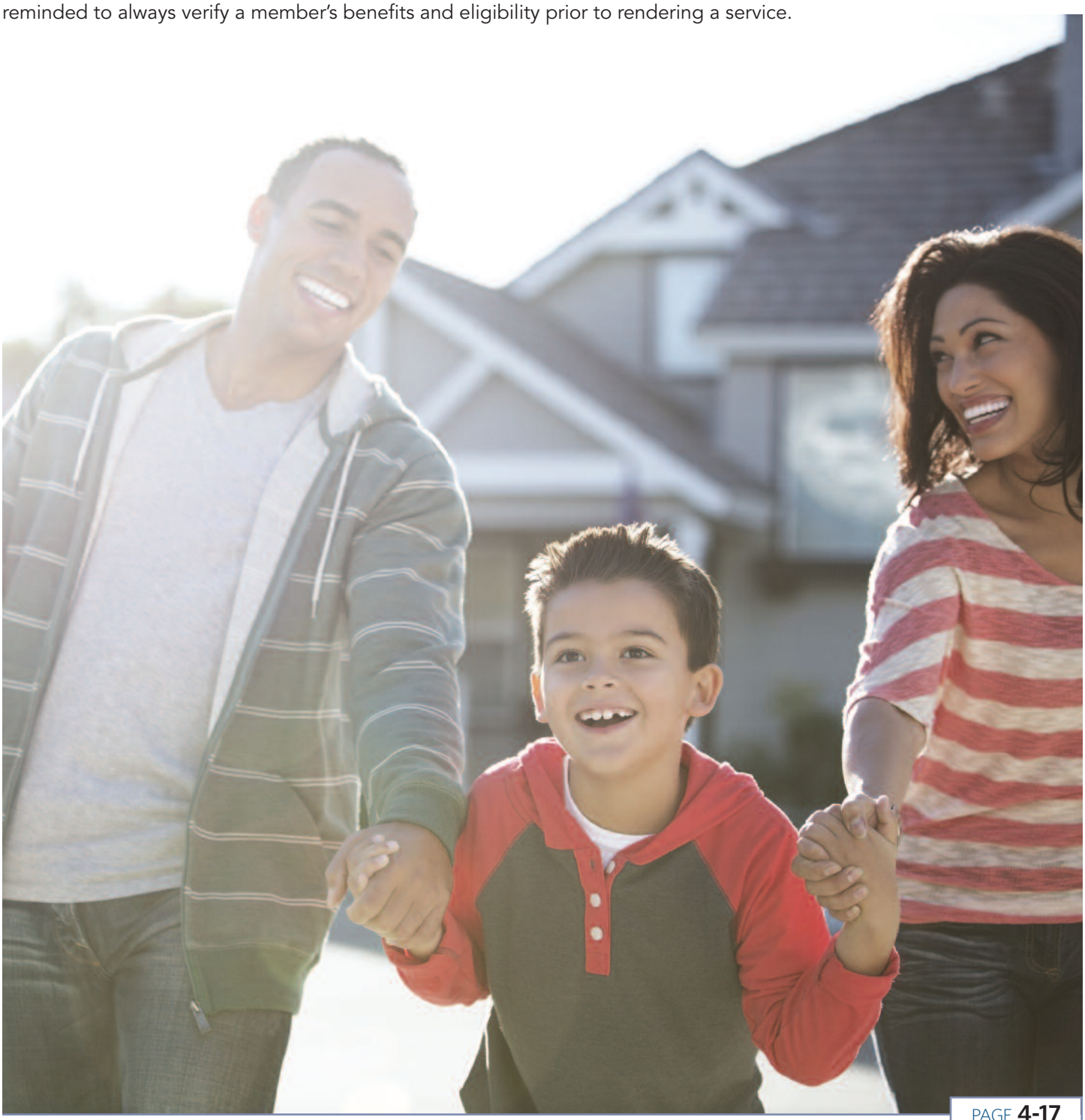
Services, supplies and drugs that are typically not covered under a member's dental benefit coverage unless written into a policy by an employer group:

- Not clinically necessary
- Investigational in nature or obsolete, including any service, drugs, procedure or treatment directly related to an investigational treatment
- Procedures that are considered to be experimental, including pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics
- Drugs or medications, obtainable with or without a prescription unless they are dispensed and utilized in the dental office during the patient visit
- Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue
- Not prescribed or performed by or upon the direction of a dentist or other provider.
- For any condition, disease, illness or injury that occurs in the course of employment, if the employee, employer or carrier is liable or responsible (1) according to a final adjudication of the claim under a state's workers' compensation laws, or (2) by an order of a state Industrial Commission or other applicable regulatory agency approving a settlement agreement.
- Received prior to the member's effective date.
- Received on or after the coverage termination date, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination.
- For telephone consultations, charges for failure to keep a scheduled visit, charges for completion of a claim form, charges for obtaining dental records, and late payment charges.
- Incurred more than eighteen (18) months prior to the member's submission of a claim to BCBSNC, except in the absence of legal capacity of the member.
- For any services that would not be necessary if a non-covered service had not been received, except for emergency services in the case of an emergency.
- For benefits that are provided by any governmental unit except as required by law.
- For services that are ordered by a court that are otherwise excluded from benefits under this dental benefit plan.
- For care that the provider cannot legally provide or legally charge or is outside the scope of license or certification.
- Provided and billed by a licensed dental care professional who is in training.
- Available to a member without charge.
- For care given to a member by a provider who is in a member's immediate family.
- For any condition suffered as a result of any act of war or while on active or reserve military duty.
- In excess of the allowed amount.
- For oral orthotic devices, palatal expanders and orthodontics except as specifically covered by a member's dental benefit plan.
- Dental services provided in a hospital, except when a hazardous condition exists at the same time or covered oral surgery services are required at the same time as a result of a bodily injury.
- Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group.
- Hypnosis except when used for control of acute or chronic pain.
- Acupuncture and acupressure.
- Surgery for psychological or emotional reasons.
- Travel, whether or not recommended or prescribed by a doctor or other licensed dental care professional, except as specifically covered by a member's dental benefit plan.

- Heating pads, hot water bottles, ice packs and personal hygiene and convenience items such as, but not limited to, devices and equipment used for environmental control.
- Devices and equipment used for environmental accommodation requiring vehicle and/or building modifications such as, but not limited to, chair lifts, stair lifts, home elevators, and ramps.
- For services primarily for educational purposes including, but not limited to, books, tapes, pamphlets, seminars, classroom, Web or computer programs, individual or group instruction and counseling, except as specifically covered by your dental benefit plan.
- For any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or persons are eligible for coverage under Title XVIII of the Social Security Act of 1965, including amendments, except as otherwise provided by Federal law.
- For conditions that Federal, state or local law requires to be treated in a public facility.
- For vitamins, food supplements or replacements, nutritional or dietary supplements, formulas or special foods of any kind.
- Dental procedures performed solely for cosmetic or aesthetic reasons, except when dental procedures are performed in order to restore normal function to minor children with congenital defects and anomalies.
- Dental procedures not directly associated with dental disease.
- Procedures not performed in a dental setting.
- Treatment of malignant or benign neoplasms, cysts, or other pathology, except excisional removal. Treatment of congenital malformations or hard or soft tissue, including excision. Hard or soft tissue biopsies of neoplasms, cysts, or hard or soft tissue growth or unknown cellular makeup are not excluded.
- Replacement of complete or partial dentures, fixed bridgework or crowns within eight (8) years of initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.
- Services related to the temporomandibular joint (TMJ), either bilateral or unilateral.
- Expenses for dental procedures begun prior to the member's eligibility with the Plan.
- Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
- Attachments to conventional removable prostheses or fixed bridgework, including semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
- Procedures related to the reconstruction of a patient's correct vertical dimension or occlusion (VDO).
- Denture relines for complete or partial conventional dentures are not covered for six (6) months following the insertion of prosthesis. Tissue conditioning and soft and hard relines for immediate full and partial dentures are not covered for six (6) months after insertion of the full or partial denture. After the specified waiting period, relines are covered once every twelve (12) months.
- One hard tissue periodontal surgery and one soft tissue periodontal surgery per surgical area are covered within a three (3) year period. This includes gingivectory, gingivoplasty, gingival curettage (with or without flap procedure), osseous surgery, pedicle grafts, and free soft tissue grafts.
- Osseous grafts, with or without resorbable or non-resorbable GTR membrane placement, are covered once every thirty-six (36) months per quadrant or surgical site.
- Clinical situations that can be effectively treated by a more cost-effective, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.
- Services for incision and drainage if the involved abscessed tooth is removed on the same date of service.
- Full mouth debridement is limited to once every five (5) years.
- Occlusal guards for any purpose other than control of habitual grinding.
- Placement of fixed bridgework solely for the purpose of achieving periodontal stability.

- Implants (except as specifically covered).
- Orthodontia services (except as specifically covered).
- Any dental services not specifically listed as a covered service.

**Note:** This is a partial list of exclusions/limitations. Please refer to **Chapter 7** for a complete listing (general limitations). Additionally, the member booklet can be referenced for final determination of exclusions/limitations. Providers are reminded to always verify a member's benefits and eligibility prior to rendering a service.



Chapter 5

# Federal plans with dental benefits

## 5.1 Federal Employees Health Benefit Plan (FEHBP)

The Blue Cross and Blue Shield Association (BCBSA) contracts with the United States Office of Personnel Management on behalf of the independent Blue Cross and Blue Shield Plans to provide health care coverage (including certain dental services) to Federal employees, postal employees and retirees who choose to enroll in one of two service benefits plan options - standard option and basic option.

## 5.2 Eligibility

Benefits are available to Federal employees who have elected coverage, retirees and their surviving spouses, family members, former spouses, Federal employee reservists who are on leave and certain members qualifying for temporary continuation of coverage. Please visit the United States Office of Personnel Management website for detailed descriptions about eligibility requirements: ***www.opm.gov***.

## 5.3 Benefit overview

The following overview of benefits is offered as an example of benefits available to Federal employees under their medical plan; however, this is not a guarantee of benefits, eligibility or plan coverage. Please verify a member's actual eligibility and benefits prior to providing dental care services.

### Standard option

Under the standard option plan a member's dental benefits will typically cover the billed charges for the following services, up to the amounts shown per service, as listed in the following chart. Members enrolled in the standard option have no deductibles, copayments, or coinsurance amounts. **When members use preferred dentists they pay the difference between the amounts listed in the below chart and the dental provider's contractual allowance with BCBSNC.**

| Available benefits | Benefit to age 13 | Benefit for age 13 and over |
|---|---|---|
| **Clinical oral evaluations** | | |
| Periodic oral evaluation (limited to 2 per person per calendar year) | $12 | $8 |
| Limited oral evaluation | $14 | $9 |
| Comprehensive oral evaluation | $14 | $9 |
| Detailed and extensive oral evaluation | $14 | $9 |
| **Radiographs** | | |
| Intraoral complete series | $36 | $22 |
| Intraoral periapical first film | $7 | $5 |
| Intraoral periapical each additional film | $4 | $3 |
| Intraoral occlusal film | $12 | $7 |

Continued on the following page.

| Available benefits | Benefit to age 13 | Benefit for age 13 and over |
|---|---|---|
| **Radiographs (continued)** | | |
| Intraoral first film | $16 | $10 |
| Intraoral each additional film | $6 | $4 |
| Bitewing – 1 film | $9 | $6 |
| Bitewings – 2 films | $14 | $9 |
| Bitewings – 4 films | $19 | $12 |
| Bitewings – vertical | $12 | $7 |
| Posterior-anterior or lateral skull and facial bone survey film | $45 | $28 |
| Panoramic film | $36 | $23 |
| **Tests and laboratory exams** | | |
| Pulp vitality tests | $11 | $7 |
| **Palliative treatment** | | |
| Palliative (emergency) treatment of dental plan – minor procedure | $24 | $15 |
| Sedative filling | $24 | $15 |
| **Preventive** | | |
| Prophylaxis – adult* | $0 | $16 |
| Prophylaxis – child* | $22 | $14 |
| Topical application of fluoride (prophylaxis not included) – child | $13 | $8 |
| Topical application of fluoride (prophylaxis not included) – adult | $0 | $8 |

*Limited to 2 per person per calendar year

| Space maintenance (passive appliances) | | |
|---|---|---|
| Space maintainer – fixed – unilateral | $94 | $59 |
| Space maintainer – fixed – bilateral | $139 | $87 |
| Space maintainer – removable – unilateral | $94 | $59 |

Continued on the following page.

| Available benefits | Benefit to age 13 | Benefit for age 13 and over |
|---|---|---|
| **Space maintenance (passive appliances) (continued)** | | |
| Space maintainer – removable – bilateral | $139 | $87 |
| Recementation of space maintainer | $22 | $14 |
| **Amalgam restorations (including polishing)** | | |
| Amalgam – 1 surface, primary or permanent | $25 | $16 |
| Amalgam – 2 surfaces, primary or permanent | $37 | $23 |
| Amalgam – 3 surfaces, primary or permanent | $50 | $31 |
| Amalgam – 4 or more surfaces, primary or permanent | $56 | $35 |
| **Resin restorations** | | |
| Resin – 1 surface, anterior | $25 | $16 |
| Resin – 2 surfaces, anterior | $37 | $23 |
| Resin – 3 surfaces, anterior | $50 | $31 |
| Resin – 4 or more surfaces or involving incisal angle (anterior) | $56 | $35 |
| Resin-based composite – 1 surface, posterior | $25 | $16 |
| Resin-based composite – 2 surfaces, posterior | $37 | $23 |
| Resin-based composite – 1 surface, posterior | $25 | $16 |
| Resin-based composite – 3 surfaces, posterior | $50 | $31 |
| Resin-based composite – 4 or more surfaces, posterior | $50 | $31 |

Continued on the following page.

| Available benefits | Benefit to age 13 | Benefit for age 13 and over |
|---|---|---|
| **Inlay restorations** | | |
| Inlay – metallic – 1 surface | $25 | $16 |
| Inlay – metallic – 2 surfaces | $37 | $23 |
| Inlay – metallic – 3 or more surfaces | $50 | $31 |
| Inlay – porcelain/ceramic – 1 surface | $25 | $16 |
| Inlay – porcelain/ceramic – 2 surfaces | $37 | $23 |
| Inlay – porcelain/ceramic – 3 or more surfaces | $50 | $31 |
| Inlay – composite/resin – 1 surface | $25 | $16 |
| Inlay – composite/resin – 2 surfaces | $37 | $23 |
| Inlay – composite/resin – 3 or more surfaces | $50 | $31 |
| **Other restorative services** | | |
| Pin retention – per tooth, in addition to restoration | $13 | $8 |
| **Extractions – includes local anesthesia and routine post-operative care** | | |
| Extraction, erupted tooth or exposed root | $30 | $19 |
| Surgical removal or erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth | $43 | $27 |
| Surgical removal of residual tooth roots (cutting procedure) | $71 | $45 |
| General anesthesia in connection with covered extractions | $43 | $27 |

## Basic option

Under the medical basic option plan benefits are available for the following listed services. Members pay a $25 copayment for each evaluation; the benefit plan typically pays any remaining balance up to the dental provider's contracted allowable with BCBSNC. This is a complete list (except for accidental injury) of dental services and benefits covered under the medical basic option plan. **Members must use a preferred dentist in order to receive benefits.**

| Available benefits | Plan pays | Member pays |
|---|---|---|
| **Clinical oral evaluations** | | |
| Periodic oral evaluation (limited to 2 per person per calendar year) | Charges in excess of $25 copayment (up to the preferred dental provider's contractual allowable) | $25 copayment per evaluation when services received from a preferred dental provider |
| Limited oral evaluation | | |
| Comprehensive oral evaluation | | |
| Detailed and extensive oral evaluation | | |
| **Radiographs** | | |
| Intraoral – complete series including bitewings (limited to 1 complete series every 3 years) | Charges in excess of $25 copayment (up to the preferred dental provider's contractual allowable) | $25 copayment per evaluation when services received from a preferred dental provider |
| Bitewing – 1 film* | | |
| Bitewings – 2 films* | | |
| Bitewings – 4 films* | | |
| Bitewings – vertical | | |
| **Preventive** | | |
| Prophylaxis – adult | Charges in excess of $25 copayment (up to the preferred dental provider's contractual allowable) | $25 copayment per evaluation when services received from a preferred dental provider |
| Prophylaxis – child | | |
| Topical application of fluoride (prophylaxis not included) – child (up to 2 per calendar year) | | |
| Sealant – per tooth, first and second molars only (once per tooth for children up to age 16 only) | | |

*Benefits are limited to a combined total of 4 films per person per calendar year

| Accidental injury | Standard option | Basic option |
|---|---|---|
| Benefits are available for services, supplies and appliances for dental care necessary to promptly repair injury to sound natural teeth, as required as a result of, and directly related to, an accidental injury.<br><br>**Notes:** An accidental injury is an injury caused by an external force or element such as a blow or fall and that requires immediate attention (injury to teeth while eating is not considered an accidental injury).<br><br>A sound natural tooth is a tooth that is whole or properly restored (restoration with amalgams only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this benefit, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth. | Benefit pays 85% of the contractual allowance when services are provided by a preferred dental provider (calendar year deductible applies).<br><br>**Note:** Benefits for accident related services are first applied based on dental benefits available. Accidental injury benefits are then applied based on any remaining balances for those services. | Member pays $100 copayment per performing surgeon<br><br>**Note:** All follow-up care must be performed by a preferred provider to be eligible for benefits. |

*Benefits are limited to a combined total of 4 films per person per calendar year

## 5.4 Additional online information

Additional dental benefits information is available from the service benefit plan handbook, which may be accessed on the Web at ***fepblue.org/benefitplans***

To learn more about the Federal Employees Program, dental providers can visit the following websites:

- BCBSNC Federal Employees Program: ***bcbsnc.com/content/fep/index.htm***
- Federal Employees Program: ***fepbluedental.com***
- U.S. Office of Personnel Management: ***www.opm.gov/insure***

## 5.5 FEP BlueDental®

Effective January 1, 2014, BCBSNC participates in the Federal Employee Dental and Vision Insurance Program (FEDVIP) offering dental benefits. BCBSNC is one of many carriers available to Federal employees and retirees. Enrollees of the FEDVIP dental plan have a full range of dental benefits, including preventive, basic, major and orthodontia services. The FEDVIP dental plan, known as **FEP BlueDental®**, offers a choice of two (2) plan options (high plan and standard plan). FEP BlueDental® is a dental benefit program sanctioned by the Federal government for Federal employees and retirees. The benefits defined below are specific to Federal employees and retirees who purchase a standalone dental plan.

| FEP BlueDental® | |
|---|---|
| Customer service | **1-855-504-BLUE (2583)** |
| FEP BlueDental® Claims | **PO Box 75**<br>**Minneapolis, MN 55440-0075** |
| Website | ***fepbluedental.com*** |

| FEP BlueDental® | Standard | | High option | |
|---|---|---|---|---|
| | In-network | Out-of-network | In-network | Out-of-network |
| **Coinsurance** | | | | |
| Preventive services | **100%** | 60% | **100%** | 90% |
| Basic services | **55%** | 40% | **70%** | 60% |
| Major services | **35%** | 20% | **50%** | 40% |
| Orthodontics | **50%** | 50% | **50%** | 50% |
| **Deductibles and maximums** | | | | |
| Individual annual maximum options (applies to diagnostic and preventive, basic and major services) | **$0** | $75 | **$0** | $50 |
| Lifetime maximum for orthodontics | **$2,000** | $1,000 | **$3,500** | $3,500 |
| Non-orthodontic annual maximum per person | **$1,500** | $750 | **$10,000** | $10,000 |

Continued on the following page.

## Available benefits

| | |
|---|---|
| Preventive and diagnostic | Oral exams, teeth cleanings<br>Bitewing X-ray<br>Fluoride treatment<br>Sealants |
| Basic | Simple restorative services (fillings)<br>Simple teeth removal<br>Periodontal scaling<br>Oral surgery |
| Major | Endodontics<br>Periodontics<br>Onlays, crowns, dental implants<br>Prosthodontics (bridges, dentures) |
| Orthodontics | Covers adult and children |

## Dental waiting periods

| | |
|---|---|
| Diagnostic and preventive services | None |
| Basic services | None |
| Major services | None |
| Orthodontics | 12 months |

## 5.5.1 Exclusions and limitations

The exclusions list applies to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is necessary for the prevention, diagnosis, care, or treatment of a covered condition. Please reference Section 7.35 of this e-manual for important information regarding non-covered services.**

The following services are not covered:

- Services and treatment not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, we will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law;
- Services and treatment which are experimental or investigational;
- Services and treatment which are for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation.
- Services and treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, VA hospital or similar person or group;
- Services and treatment performed prior to your effective date of coverage;
- Services and treatment incurred after the termination date of your coverage unless otherwise indicated;
- Services and treatment which are not dentally necessary or which do not meet generally accepted standards of dental practice.
- Services and treatment resulting from your failure to comply with professionally prescribed treatment;
- Telephone consultations;
- Any charges for failure to keep a scheduled appointment;
- Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD);
- Services or treatment provided as a result of intentionally self-inflicted injury or illness;
- Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- Office infection control charges;
- Charges for copies of your records, charts or X-rays, or any costs associated with forwarding/mailing copies of your records, charts or X-rays;
- State or territorial taxes on dental services performed;
- Those submitted by a dentist, which is for the same services performed on the same date for the same member by another dentist;
- Those provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
- Those for which the member would have no obligation to pay in the absence of this or any similar coverage.
- Those which are for specialized procedures and techniques;
- Those performed by a dentist who is compensated by a facility for similar covered services performed for members;
- Duplicate, provisional and temporary devices, appliances, and services;
- Plaque control programs, oral hygiene instruction, and dietary instructions;
- Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.
- Gold foil restorations;

- Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan;
- Treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
- Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
- Charges by the provider for completing dental forms;
- Adjustment of a denture or bridgework which is made within six (6) months after installation by the same dentist who installed it;
- Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;
- Cone Beam Imaging and Cone Beam MRI procedures;
- Sealants for teeth other than permanent molars;
- Precision attachments, personalization, precious metal bases and other specialized techniques;
- Replacement of dentures that have been lost, stolen or misplaced;
- Orthodontic services provided to a member who has not met the twelve (12) month waiting period requirement;
- Repair of damaged orthodontic appliances;
- Replacement of lost or missing appliances;
- Fabrication of athletic mouth guard;
- Internal and external bleaching;
- Nitrous oxide;
- Oral sedation;
- Topical medicament center;
- Bone grafts when done in connection with extractions, apicoectomies or non-covered/ non-eligible implants;
- When two (2) or more services are submitted and the services are considered part of the same service to one another the Plan will pay the most comprehensive service (the service that includes the other non-benefited service) as determined buy FEP BlueDental®.
- When two (2) or more services are submitted on the same day and the services are considered mutually exclusive (when one [1] service contradicts the need for the other service), the Plan will pay for the service that represents the final treatment as determined by this Plan.
- All out-of-network services listed in **Chapter 5** are subject to the maximum allowable amount as defined by FEP BlueDental®. The member is responsible for all remaining charges that exceed the allowable maximum.

## 5.6 Dental Blue® for Federal employees

Dental Blue® for Federal employees offers flexibility and freedom: a choice of plan options (standard and basic) and the ability to choose any licensed dentist. Dental Blue® for Federal employees is not part of the covered benefits of any other BCBSNC health plans. It must be purchased separately.

This dental product, offered by BCBSNC, is intended to complement the policy offered to Federal employees and retirees by the Federal government. This dental product is not approved, endorsed or accredited by the Federal government, and it is in no way connected to the Federal government or to the U.S. Office of Personnel Management.

Dental Blue® for Federal employees is no longer available to new enrollees as of January 1, 2014.

### 5.6.1 What's covered

| | Plan benefits | |
|---|---|---|
| | Standard option | Basic option |
| **Type of coverage** | | |
| Preventive services<br>**Standard option**<br>Routine oral exams and cleanings<br>Bitewing X-rays<br>Pulp testing<br>Fluoride treatment (for those under the age of 19)<br>Palliative emergency treatment<br>Emergency oral examinations<br>Sealants and other preventive services<br>**Standard and basic options**<br>Space maintainers (for those under the age of 13) and other preventive services | You pay 0% (plus applicable copayment[1]). | Routine services such as checkups, cleanings, and X-rays are not covered. You pay 0% on some diagnostic and preventive services such as palliative treatments, consultations, space maintainers and pulp testing. |
| Basic services<br>Fillings<br>Simple extractions<br>Oral surgery<br>Other basic services | You pay 35% (plus applicable copayment[1]) in Year 1 with no deductible and no waiting periods.[2]<br>In Year 2 and after, you pay 25% (plus applicable copayment[1]). | You pay 35% in Year 1 with no deductible and no waiting periods.[2]<br>In Year 2 and after, you pay 25%. |

Continued on the following page.

| | Plan benefits | |
|---|---|---|
| | Standard option | Basic option |
| **Type of coverage (continued)** | | |
| Major services<br>Gingival curettage<br>Gingivectomy and gingivoplasty<br>Endodontics (root canals)<br>Periodontal maintenance<br>Inlays and onlays (once every 8 years)<br>Crowns, bridges, dentures, implants and other major services | You pay 60% (plus applicable copayment[1]) in Year 1 with no deductible and no waiting periods.[2]<br>In Year 2 you pay 55% (plus applicable copayment[1]) and in Year 3 and after you pay 50% (plus applicable copayment[1]). | You pay 60% in Year 1 with no deductible and no waiting periods.[2]<br>In Year 2 you pay 55%, and in Year 3 and after you pay 50%. |
| Orthodontic services<br>Orthodontic services (members under age 19 only) | There is a 24-month waiting period before coverage begins. Once coverage begins you pay 50% with no deductibles and no copayment amounts. There is a $1,500 lifetime maximum per individual. | There is a 24-month waiting period before coverage begins. Once coverage begins you pay 50% with no deductibles and no copayment amounts. There is a $1,500 lifetime maximum per individual. |
| Annual maximum, all services (except orthodontia) | $3,000 | $2,500 |

## 5.6.2 Waiting periods

| Waiting periods | |
|---|---|
| Diagnostic and preventive services | None |
| Basic services | None |
| Major services | None |
| Orthodontia | 24 months |

## Chapter 6

# GRID+

## 6.1 The National **GRID+** Dental Network

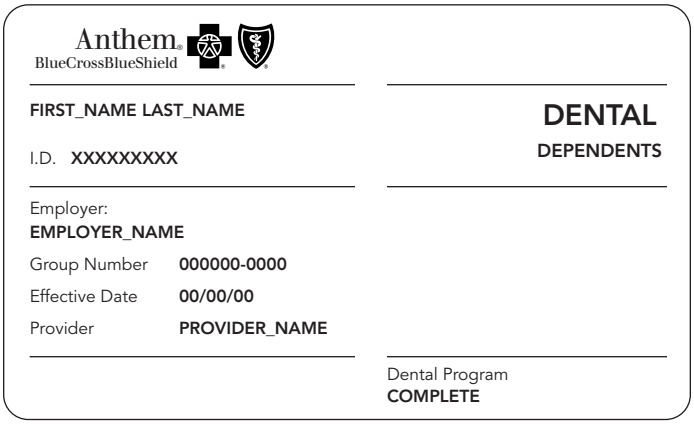
The National **GRID+** Dental Network, administered by the GRID Dental Corporation (GDC)*, is a national dental network and includes many of the nation's Blue plans. In addition, the **GRID+** coordinates access to networks wherever local Blue plans do not participate.

## 6.2 Participation in the **GRID+** network

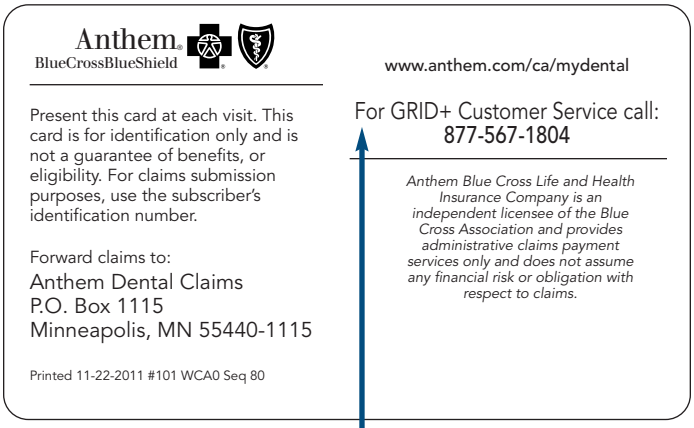
The following applies to dental providers participating with BCBSNC dental network.

- Providers participating with the BCBSNC dental network are automatically included as a participating provider in the **GRID+** network.
- When members of other Blue plans are in North Carolina and searching for a participating dental provider, your practice will appear in the provider directory. This may assist you in growing your practice, should those members choose you as their dental provider.
- In order to verify that a member of an out-of-state Blue plan qualifies as a "member" under your agreement, look for a "**GRID+**" indicator on the member's Blue Cross and/or Blue Shield branded card or on the notification of payment. Claims processing, benefits, and customer service for these members will be handled by the out-of-state Blue plan that issued the card to the applicable member. Providers should reference the information on the back of the identification card.

Front of card




Back of card




Identifying that a member is participating in the **GRID+** Dental Network.

## 6.3 Reimbursement

As a North Carolina participating provider, regardless of whether the patient is a BCBSNC member or a member of another participating plan, the fee schedule contracted under the BCBSNC agreement applies.

*GRID Dental Corporation is a separate company that provides access to dental networks and services on behalf of BCBSNC.

Chapter 7

# Claims administration, billing and reimbursement

## 7.1 Administration of dental claims

With the implementation of the ACA mandated Pediatric Oral Health benefits, the processing of dental claims have become more complex. The following is a general guideline for dental claims processing:

- Dental benefits such as preventive, basic or major care are typically covered under a member's dental benefit. BCBSNC utilizes the services of ACS Benefit Services, Inc. for the administration of claims for services covered under a member's supplemental dental policy.
- Services such as Pediatric Oral Health benefits, medically necessary orthodontia or medically necessary dental reconstructive services are typically covered under the member's BCBSNC medical benefit. BCBSNC administers benefits for dental services covered under a member's medical plan.
- Dental services covered under the Federal Employee Benefit Health Plan are handled through BCBSNC.

**Note:** Claims administration for the Federal Employee Program is handled through BCBSNC for both dental and medical services.

### 7.1.1 ACS Benefit Services, Inc. (ACS) – dental claims for services covered under a supplemental dental policy.

BCBSNC utilizes the services of our wholly owned subsidiary ACS Benefit Services, Inc. (ACS), for the administration of customer service and claims processing for BCBSNC dental products. ACS is a third party administrator of self-funded medical and dental benefit plans. ACS has developed an advanced claims system for servicing the BCBSNC dental products, which allows ACS to process claims with extreme accuracy because benefits processing can be tailored for each employer group. ACS as our administrator for BCBSNC dental products maintains procedures, policies and guidelines for dental providers transacting dental business. This e-manual acts as a supplement to those procedures, policies and guidelines as determined by BCBSNC. In the event there is a discrepancy, BCBSNC rules and guidelines administered by ACS will supersede this e-manual.

### 7.1.2 Dental claims for services covered under a medical benefit/Pediatric Oral Health benefit

Effective January 1, 2014, dental provider contracts apply to medical services. BCBSNC under our health benefit plans provide benefits for services provided by a duly licensed doctor, doctor of dental surgery or doctor of dental medicine for diagnostic, therapeutic or surgical procedures, including oral surgery involving bones or joints of the jaw, when the procedure or dental treatment is related to one of the following conditions:

- Accidental injury of the sound teeth, jaw, cheeks, lips, tongue, roof and floor of the mouth
- Congenital deformity, including cleft lip and cleft palate
- Removal of tumors, cysts which are not related to teeth or associate dental procedures
- Tumors cysts exostoses for reasons other than for preparation for dentures

In addition, ACA mandated "Pediatric Oral Health Benefits" such as diagnostic and preventive, basic, major and medically necessary orthodontia are covered under the medical plan for certain members. If the patient does not have a BCBSNC medical benefit plan, submit Pediatric Oral Health electronic claims to Emdeon payer #61472.

BCBSNC administers these benefits through our advanced claims payment system. BCBSNC rules and guidelines will supersede this e-manual. Providers are encouraged to access the BCBSNC website ***bcbsnc.com*** to obtain copies of the procedures, policies and guidelines.

### 7.1.3 Medical vs dental

The table below provides further clarification regarding dental services covered under a member's BCBSNC supplemental dental policy and dental services covered under a member's BCBSNC medical policy.

| Dental | Medical | Pediatric Oral Health benefit |
|---|---|---|
| Dental procedures must be submitted using the ADA 2012 dental claim form | Medical procedures should be submitted using a HCFA-1500 medical claim form | Providers can submit an ADA 2012 claim form or HCFA-1500 medical claim form |
| Contact the toll-free number on the back of the member's dental ID card for questions relating to dental benefits. | Contact the toll-free number on the back of the member's medical ID card for questions relating to medical benefits. | Contact the customer service number on the back of the ID card for medical benefits. |

**Important note:** Providers should always verify a member's individual benefits and coverage prior to rendering any dental service. The presentation of BCBSNC identification cards should not serve as a method for verifying a member's status or eligibility to receive dental benefits. In addition, all payments are subject to the terms of the contract under which the individual is eligible to receive benefits.

## 7.2 BCBSNC dental claims submission

BCBSNC accepts dental claims in the following formats: EDI (electronic data interchange) submissions via the Emdeon clearing house and paper claims.

**Emdeon is the preferred and most efficient method.**

An interactive paper claim form is available online. Using the ***bcbsnc-dental.com*** site, register and log in as a provider. (Refer to **Chapter 2** for instructions on registration.) You will then have access to the appropriate dental claim form for each of the dental products which include the correct mailing address.

## 7.3 National Provider Identifiers

BCBSNC requires that all electronically transmitted claims include billing and rendering NPI (national provider identifier) numbers. Providers with a Group NPI should list the Group NPI in box 49 of the claim form and the Individual NPI in box 54 (rendering provider). The Individual NPI will apply to box 49 and 54 for solo providers.

## 7.4 Emdeon clearing house

Dental providers are encouraged to submit their claims via Emdeon. Claims are received by BCBSNC through separate Emdeon payer numbers that identify product lines. Submitting claims using an incorrect payer ID number will delay processing. Always refer to the member's BCBSNC ID card to properly identify the correct plan and the correct Emdeon payer ID number:

- 61472 – Federal employees/Pediatric Oral Health/medical-dental claims
- 61473 – BCBSNC Dental Blue® for Group/Individual/Senior plans and Dental Blue® for Federal employees
- 61474 – BCBSNC Dental Blue Select℠ (group enrollment only)

## 7.5 NEA FastAttach™ and *Fast*Look

Dental providers can send electronic attachments using FastAttach™, made available from National Electronic Attachment Inc. (NEA). FastAttach™ enables dental providers to transmit electronic attachments in support of electronic claims via the internet. Attachments can also be stored for providers requesting the service. Attachments include: X-rays, lab reports, EOBs, narratives, OP reports, dental notes, perio-charts and most other documents required to process a claim.

Dental providers can receive additional information about FastAttach™ services and/or sign up for FastAttach™ by calling **1-800-782-5150**, **option 2** or by visiting NEA on the Web at ***www.nea-fast.com***. If signing up for FastAttach™ use, enter the promotional code of **BCBSNCZ1M** to receive special promotional information. Please note this is a promotional rate and subject to expiration.

Additionally, NEA offers the *Fast*Look system, which gives providers one central site to view the attachment requirements for multiple payers (BCBSNC), as well as, other dental care payers. Using *Fast*Look dental care providers can search by payer name and procedure code to determine what, or if any, attachments need to be sent to a member's payer plan. For more information about the *Fast*Look system, please visit *Fast*Look on the Web at ***www.welcometonea.com*** or call **1-800-782-5150**, **ext #2**.

Please note that costs and/or fees can be associated with the use of FastAttach™ and/or the *Fast*Look systems. Dental providers enrolling for use of the NEA offered applications assume all associated expenses. See **Chapter 11** for specific details.

## 7.6 Paper claims

Claims for dental services must be submitted on the 2012 version of the American Dental Association (ADA) claim form. 2012 ADA claim forms may be purchased from a vendor or directly from the ADA by calling **1-800-947-4746** or visiting ADA on the Web at ***www.ada.org***. Additionally, dental providers may download copies of the current pre-addressed and approved ADA forms from ***bcbsnc-dental.com***.

## 7.7 Claim form completion

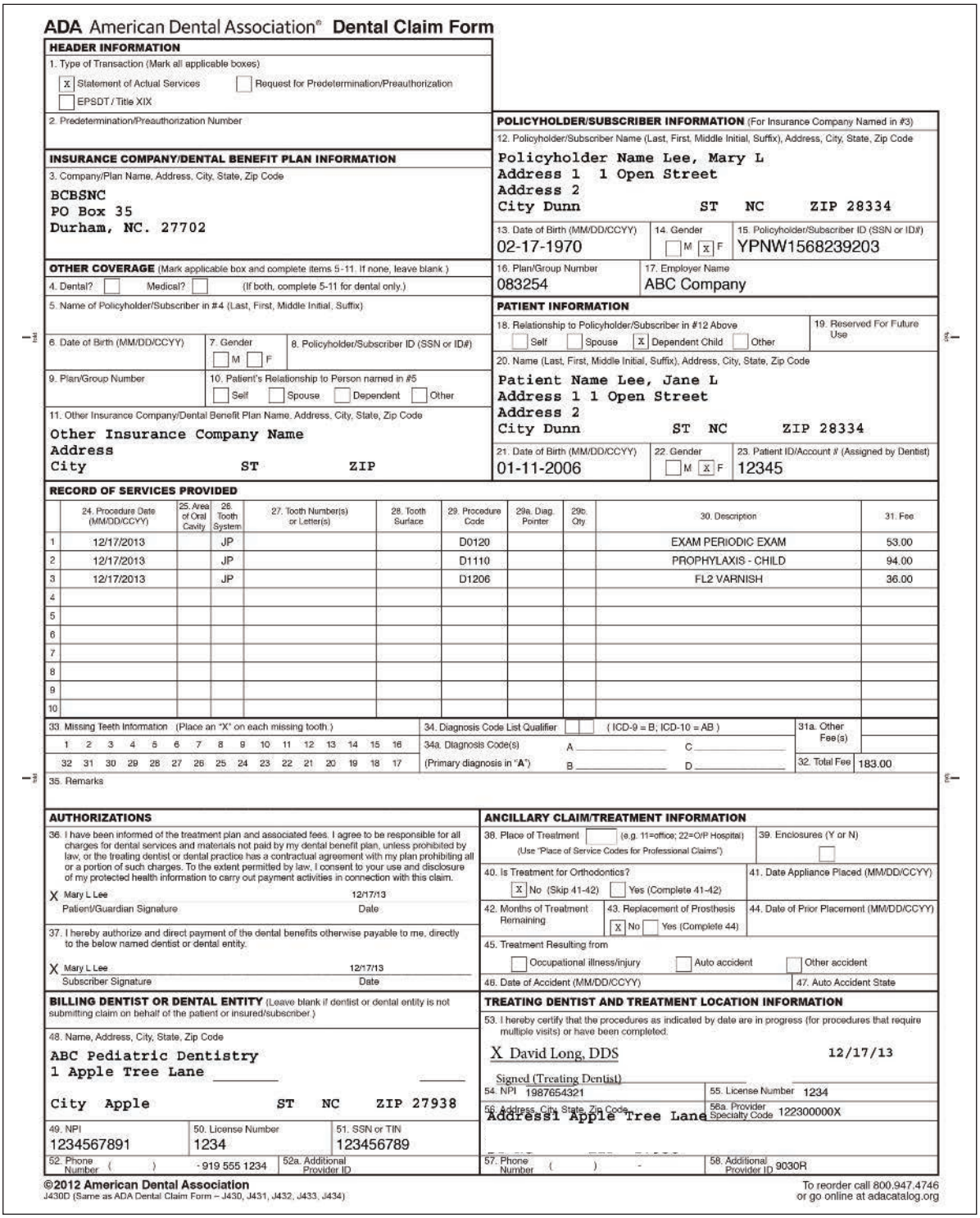
Dental claim forms must be submitted with all required fields complete, using acceptable data and coding sets needed to complete processing of a claim (please note that additional information may be requested). Claim submissions should report all rendered services and include procedure codes from the most current ADA Current Dental Terminology (CDT) user's manual.

All participating dental providers must submit claims within one hundred and eighty (180) days from the date of completion of the dental treatment. Below is a summary (not all-inclusive) of what's needed to comply with claims submission requirements:

- Use of the 2012 version of the American Dental Association (ADA) claim form is required. Complete by following the 2012 ADA claim form instructions.
- Essential data elements must be completed (essential data elements include, but are not limited to, place of service codes and procedure codes).
- Claims must be completed using the ADA standard code set. Claims missing an essential data element or listing inappropriate code sets, or are otherwise illegible, will be returned.
- Include necessary supporting documentation (i.e., X-rays and dental provider notes).
- Claim forms must include the member's name and ID number (including alpha prefix and suffix) and patient's date of birth.
- The dental provider's identifying information and the location where service was provided must be clearly identified on the claim form.
- A date of service must be provided on the claim form for each service line submitted.
- Each separate (individual calendar date) of service must be submitted as a single claim. Individual claims may not span dates of service with the exception of certain orthodontia services.
- List all quadrants, tooth numbers and surfaces for dental codes that necessitate identification (extractions, root canals, amalgams and resin fillings). Failure to provide tooth and surface identification codes can result in the delay or denial of claims payment.

## 7.8 Sample 2012 ADA claim form and completion instructions

Visit the American Dental Association website at:
***www.ada.org/~/media/ADA/Member%20Center/FIles/ada_dental_claim_form_completion_instructions_2012.ashx***
for comprehensive completion instructions for the 2012 ADA claim form.



**ADA American Dental Association® Dental Claim Form**

**HEADER INFORMATION**

1. Type of Transaction (Mark all applicable boxes)
[X] Statement of Actual Services [ ] Request for Predetermination/Preauthorization
[ ] EPSDT / Title XIX

2. Predetermination/Preauthorization Number

**INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION**

3. Company/Plan Name, Address, City, State, Zip Code
BCBSNC
PO Box 35
Durham, NC. 27702

**OTHER COVERAGE** (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender [ ] M [ ] F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code
Other Insurance Company Name
Address
City ST ZIP

**POLICYHOLDER/SUBSCRIBER INFORMATION** (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Policyholder Name Lee, Mary L
Address 1 1 Open Street
Address 2
City Dunn ST NC ZIP 28334

13. Date of Birth (MM/DD/CCYY): 02-17-1970 | 14. Gender [ ] M [X] F | 15. Policyholder/Subscriber ID (SSN or ID#): YPNW1568239203

16. Plan/Group Number: 083254 | 17. Employer Name: ABC Company

**PATIENT INFORMATION**

18. Relationship to Policyholder/Subscriber in #12 Above [ ] Self [ ] Spouse [X] Dependent Child [ ] Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Patient Name Lee, Jane L
Address 1 1 Open Street
Address 2
City Dunn ST NC ZIP 28334

21. Date of Birth (MM/DD/CCYY): 01-11-2006 | 22. Gender [ ] M [X] F | 23. Patient ID/Account # (Assigned by Dentist): 12345

**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 | 29a. Diag. Pointer | 29b. Qty | 30. Description | 31. Fee |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 12/17/2013 | | JP | | | D0120 | | | EXAM PERIODIC EXAM | 53.00 |
| 2 | 12/17/2013 | | JP | | | D1110 | | | PROPHYLAXIS - CHILD | 94.00 |
| 3 | 12/17/2013 | | JP | | | D1206 | | | FL2 VARNISH | 36.00 |
| 4 | | | | | | | | | | |
| 5 | | | | | | | | | | |
| 6 | | | | | | | | | | |
| 7 | | | | | | | | | | |
| 8 | | | | | | | | | | |
| 9 | | | | | | | | | | |
| 10 | | | | | | | | | | |

33. Missing Teeth Information (Place an "X" on each missing tooth.)
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

34. Diagnosis Code List Qualifier [ ] [ ] (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____

31a. Other Fee(s)
32. Total Fee: 183.00

35. Remarks

**AUTHORIZATIONS**

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.
X Mary L Lee — Patient/Guardian Signature — 12/17/13 Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.
X Mary L Lee — Subscriber Signature — 12/17/13 Date

**BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
ABC Pediatric Dentistry
1 Apple Tree Lane
City Apple ST NC ZIP 27938

49. NPI: 1234567891 | 50. License Number: 1234 | 51. SSN or TIN: 123456789

52. Phone Number: ( ) - 919 555 1234 | 52a. Additional Provider ID

**ANCILLARY CLAIM/TREATMENT INFORMATION**

38. Place of Treatment [ ] (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) [ ]

40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining | 43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

**TREATING DENTIST AND TREATMENT LOCATION INFORMATION**

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X David Long, DDS — Signed (Treating Dentist) — 12/17/13

54. NPI: 1987654321 | 55. License Number: 1234

56. Address, City, State, Zip Code: Address1 Apple Tree Lane | 56a. Provider Specialty Code: 122300000X

57. Phone Number: ( ) - | 58. Additional Provider ID: 9030R

©2012 American Dental Association
J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)
To reorder call 800.947.4746 or go online at adacatalog.org

# Sample 2012 ADA claim form and completion instructions (continued)

**ADA** American Dental Association®
America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

**GENERAL INSTRUCTIONS**

A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.

B. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.

C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.

D. All dates must include the four-digit year.

E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

**COORDINATION OF BENEFITS (COB)**

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35). There are additional detailed completion instructions in the CDT manual.

**DIAGNOSIS CODING**

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)

Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)

Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

**PLACE OF TREATMENT**

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at "www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf"

**PROVIDER SPECIALTY**

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

| Category / Description Code | Code |
|---|---|
| **Dentist**<br>A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license. | 122300000X |
| **General Practice** | 1223G0001X |
| **Dental Specialty** (see following list) | Various |
| Dental Public Health | 1223D0001X |
| Endodontics | 1223E0200X |
| Orthodontics | 1223X0400X |
| Pediatric Dentistry | 1223P0221X |
| Periodontics | 1223P0300X |
| Prosthodontics | 1223P0700X |
| Oral & Maxillofacial Pathology | 1223P0106X |
| Oral & Maxillofacial Radiology | 1223D0008X |
| Oral & Maxillofacial Surgery | 1223S0112X |

Provider taxonomy codes listed above are a subset of the full code set that is posted at "www.wpc-edi.com/codes/taxonomy"

## 7.9 Claim form – common errors

**Always remember to verify member's current eligibility and benefits prior to providing any dental services**

| | | |
|---|---|---|
| 1 Box 3 | Company/Plan Name, Address, City, State, and Zip Code: | **This box is always completed.** Enter the information for the insurance company or dental benefit plan. If the patient is covered by more than 1 plan, enter the primary insurance company information here for the initial claim submission.<br>• If the patient is covered by more than 1 plan, enter the primary insurance company information here for the initial claim submission.<br>• When submitting a separate claim to the secondary carrier, place the secondary carrier's company/plan name and address information here. |

**Federal Employee Health Benefit Plan (medical coverage including limited dental benefits) or Pediatric Dental or Dental Services under Medical**

- **Blue Cross and Blue Shield of North Carolina**
  **PO Box 35**
  **Durham, NC 27702-0035**

**Dental Blue for GROUPS, INDIVIDUALS, and SENIORS**

- **Blue Cross and Blue Shield of North Carolina**
  **Dental Blue Claims Unit**
  **PO Box 2100**
  **Winston-Salem, NC 27102-2400**

**Dental Blue SELECT:**

- **Blue Cross and Blue Shield of North Carolina**
  **Dental Blue Select Claims Unit**
  **PO Box 2400**
  **Winston-Salem, NC 27102-2400**

**FEP BlueDental/FEDVIP**

- **FEP BlueDental Claims**
  **PO Box 75**
  **Minneapolis, MN 55440-0075**

| | | |
|---|---|---|
| 2 Box 4 | Other Dental or Medical Coverage? | Mark the box after "Dental?" or "Medical?" whenever a patient has coverage under any other dental or medical plan, without regard to whether the dentist or the patient will be submitting a claim to collect benefits under the other coverage.<br>• Leave blank when the dentist is not aware of any other coverage(s).<br>• When either box is marked, complete Items 5 through 11 in the "Other Coverage" section for the applicable benefit plan.<br>• If both Dental and Medical are marked, enter information about the dental benefit plan in Items 5 through 11. |
| Box 5 | Name of Policyholder/ Subscriber with Other Coverage Indicated in #4 (Last, First, Middle Initial, Suffix): | If the patient has other coverage through a spouse, domestic partner or, if a child, through both parents, the name of the person who has the other coverage is reported here. |

Continued on the following page.

| | | |
|---|---|---|
| Box 6 | Date of Birth (MM/DD/CCYY): | Enter the date of birth of the person listed in Box #5. The date must be entered with 2 digits each for the month and day, and 4 digits for the year of birth. |
| Box 7 | Gender: | Mark the gender of the person who is listed in Box #5. Mark "M" for Male and "F" for Female as applicable. |
| Box 8 | Policyholder/Subscriber Identifier (SSN or ID#): | Enter the social security number or the identifier number of the person who is listed in Box #5. The identifier number is a number assigned by the payer/insurance company to this individual. |
| Box 9 | Plan/Group Number: | Enter the group plan or policy number of the person identified in Box #5. |
| Box 10 | Patient's Relationship to Person Named in Box #5: | Mark the patient's relationship to the other insured named in Box #5. |
| Box 11 | Other Insurance Company/ Dental Benefit Plan Name, Address, City, State, Zip Code: | Enter the complete information of the additional payer, benefit plan or entity for the insured named in Box #5. |

| | | |
|---|---|---|
| 3 Box 12 | Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code: | Enter the complete name, address and zip code of the policyholder/ subscriber with coverage from the company/plan named in Box #3. |
| Box 13 | Date of Birth (MM/DD/CCYY): | A total of 8 digits are required in this field; 2 for the month, 2 for the day of the month, and 4 for the year. |
| Box 14 | Gender: | This applies to the primary insured, which may or may not be the patient. Mark "M" for Male and "F" for Female. |
| Box 15 | Policyholder/Subscriber Identifier (SSN or ID#): | Enter the unique identifying number assigned to the person named in Box #12, ***EXCEPT*** when the patient is a spouse, dependent child or other. In this case you will enter the prefix (letters), numbers including the last 2 digits of the spouse, dependent child or other:<br>• For example: ***YPLW11595057801-01 (dependent child or spouse) YPLW11595057801-02 (another dependent child).*** This information is on their identification card. |
| Box 16 | Plan/Group Number: | Enter the policyholder/subscriber's group plan/policy number. |
| Box 17 | Employer Name: | If applicable, enter the name of the policyholder/subscriber's employer. |

Continued on the following page.

| | | |
|---|---|---|
| 4 Box 18 | Relationship to Policyholder/ Subscriber in #12 Above: | Mark the relationship of the patient to the person identified in Box #12 who has the primary insurance coverage. The relationship between the insured and the patient may affect the patient's eligibility or benefits available. **If the patient is also the primary insured, mark the box titled "Self" and skip to Box #23.** |
| Box 19 | Reserved for Future Use: | Leave blank and skip to Box #20. (Box #19 was previously used to report "Student Status"). |
| Box 20 | Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code: | Enter the complete name, address and zip code of the patient. |
| Box 21 | Date of Birth (MM/DD/CCYY): | A total of 8 digits are required in this field; 2 for the month, 2 for the day of the month, and 4 for the year of birth of the patient. |
| Box 22 | Gender: | This applies to the patient. Mark "M" for Male or "F" for Female. |
| Box 23 | Patient ID/Account #: | Enter if the dentist's office has assigned a number to identify the patient. |

| | | |
|---|---|---|
| 5 Box 39 | Number of Enclosures (00 to 99): | Enter a "**Y**" or "**N**" to indicate whether or not there are enclosures of any type included with the claim submission (e.g., radiographs, oral images, models) |
| Box 40 | Is Treatment for Orthodontics? | **If no, skip to Box #43**. If yes, answer Boxes 41 and 42. |
| Box 41 | Date Appliance Placed (MM/DD/CCYY): | Indicate the date an orthodontic appliance was placed. This information should also be reported in this section for subsequent orthodontic visits. |
| Box 42 | Months of Treatment: | Enter the total number of months required to complete the orthodontic treatment. (Note: This is the total number of months from the beginning to the end of the treatment plan. Some versions of the paper claim form incorrectly include the word "Remaining" at the end of this data element's name). |

Continued on the following page.

| | | |
|---|---|---|
| Box 43 | Replacement of Prosthesis? | This box applies to crowns and all fixed removable prostheses (e.g., bridges and dentures). Please review the following 3 situations in order to determine how to complete this item.<br>a) If the claim does not involve a prosthetic restoration mark "NO" and proceed to Box 45.<br>b) If the claim is for the initial placement of a crown, or a fixed or removable prosthesis, mark "NO" and proceed to Box 45.<br>c) If the patient has previously had these teeth replaced by a crown, or a fixed or removable prosthesis, or the claim is to replace an existing crown, mark the "YES" field and complete Box 44. |
| Box 44 | Date of Prior Placement (MM/DD/CCYY): | Complete if the answer to Box #43 was "YES". |
| Box 45 | Treatment Resulting From: | If the dental treatment listed on the claim was provided as a result of an accident or injury, mark the appropriate box in this item, and proceed to Boxes #46 and #47. **If the services you are providing are not the result of an accident, this Box does not apply; skip to Box #48.** |
| Box 46 | Date of Accident (MM/DD/CCYY): | Enter the date on which the accident noted in Box #45 occurred. Otherwise, leave blank. |
| Box 47 | Auto Accident State: | Enter the state in which the accident noted in Box #45 occurred. Otherwise, leave blank. |

| | | |
|---|---|---|
| 6 | The "Billing Dentist" or "Dental Entity" section provides information on the individual dentist's name, the name of the practitioner providing care within the scope of their state licensure, or the name of the group practice/corporation that is responsible for billing and other pertinent information. Depending on the business relationship of the practice and the treating dentist, the information provided in this section may not be the treating dentist. | |
| Box 48 | Name, Address, City, State, Zip Code: | Enter the name and complete address of a dentist or the dental entity (corporation, group, etc.). |

| | | |
|---|---|---|
| 7<br>Box 49 | NPI (National Provider Identifier): | Enter the appropriate NPI type for the billing entity. A Type 2 NPI is entered when the claim is being submitted by an incorporated individual, group practice or similar legally recognized entity. Unincorporated practices may enter the individual practitioners Type 1 NPI. |

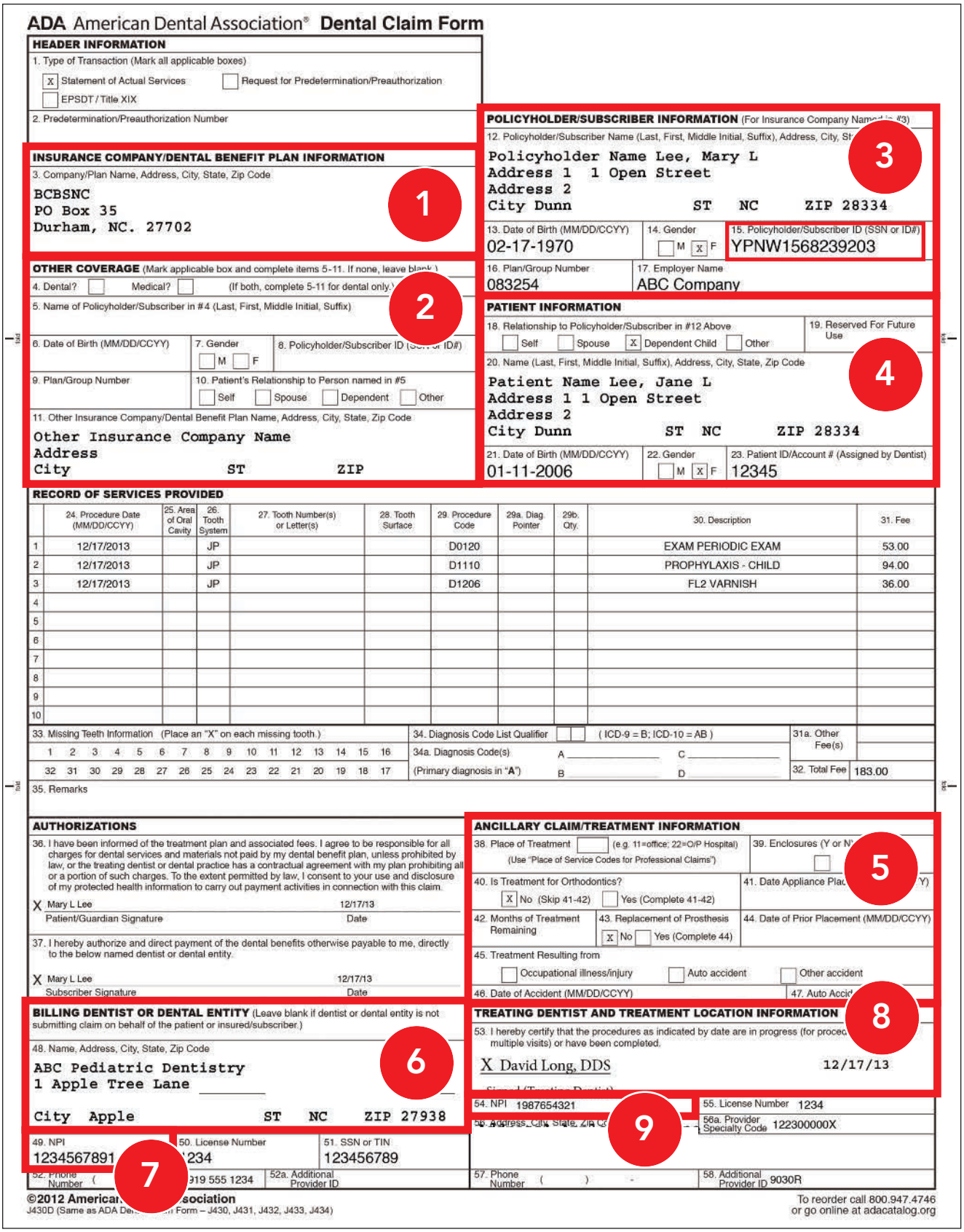
***NOTE: The NPI is an identifier assigned by the Federal government to all providers considered to be HIPAA covered entities. Dentists who are not covered entities may elect to obtain an NPI at their discretion, or may be enumerated if required by a participating provider agreement with a third-party payer, or applicable state law/regulation.***

Continued on the following page.

**An NPI is unique to an individual dentist or dental entity, and has no intrinsic meaning. There are 2 types of NPI available to dentists and dental practices:**

- **Type 1 Individual Provider - All individual dentists are eligible to apply for Type 1 NPIs, regardless of whether they are covered by HIPAA.**
- **Type 2 Organization Provider - A health care provider that is an organization, such as a group practice or corporation. Individual dentists who are incorporated may enumerate as Type 2 providers, in addition to being enumerated as a Type 1. All incorporated dental practices and group practices are eligible for enumeration as Type 2 providers.**

| | | |
|---|---|---|
| **8** Box 53 | Certification: | **Signature of the treating or rendering dentist** and the date the form is signed. This is the dentist who performed, or is in the process of performing, procedures, indicated by date, for the patient. If the claim form is being used to obtain a pre-estimate or pre-authorization, it is not necessary for the dentist to sign the form. ***Claim forms prepared by the dentist's practice management software may insert the treating dentist's printed name in this item.*** |
| **9** Box 54 | NPI (National Provider Identifier): | Enter the treating dentist's Type 1 – Individual Provider NPI in Box # 54. (See Box #49 for more NPI information.) |



ADA American Dental Association® **Dental Claim Form**

**HEADER INFORMATION**

1. Type of Transaction (Mark all applicable boxes)
[X] Statement of Actual Services [ ] Request for Predetermination/Preauthorization
[ ] EPSDT / Title XIX

2. Predetermination/Preauthorization Number

**INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION**

3. Company/Plan Name, Address, City, State, Zip Code

BCBSNC
PO Box 35
Durham, NC. 27702

1

**OTHER COVERAGE** (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)

2

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender [ ] M [ ] F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

Other Insurance Company Name
Address
City ST ZIP

**POLICYHOLDER/SUBSCRIBER INFORMATION** (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, St

Policyholder Name Lee, Mary L
Address 1 1 Open Street
Address 2
City Dunn ST NC ZIP 28334

3

13. Date of Birth (MM/DD/CCYY): 02-17-1970 | 14. Gender [ ] M [X] F | 15. Policyholder/Subscriber ID (SSN or ID#): YPNW1568239203

16. Plan/Group Number: 083254 | 17. Employer Name: ABC Company

**PATIENT INFORMATION**

18. Relationship to Policyholder/Subscriber in #12 Above [ ] Self [ ] Spouse [X] Dependent Child [ ] Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

Patient Name Lee, Jane L
Address 1 1 Open Street
Address 2
City Dunn ST NC ZIP 28334

4

21. Date of Birth (MM/DD/CCYY): 01-11-2006 | 22. Gender [ ] M [X] F | 23. Patient ID/Account # (Assigned by Dentist): 12345

**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 | 29a. Diag. Pointer | 29b. Qty. | 30. Description | 31. Fee |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 12/17/2013 | | JP | | | D0120 | | | EXAM PERIODIC EXAM | 53.00 |
| 2 | 12/17/2013 | | JP | | | D1110 | | | PROPHYLAXIS - CHILD | 94.00 |
| 3 | 12/17/2013 | | JP | | | D1206 | | | FL2 VARNISH | 36.00 |
| 4 | | | | | | | | | | |
| 5 | | | | | | | | | | |
| 6 | | | | | | | | | | |
| 7 | | | | | | | | | | |
| 8 | | | | | | | | | | |
| 9 | | | | | | | | | | |
| 10 | | | | | | | | | | |

33. Missing Teeth Information (Place an "X" on each missing tooth.)
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

34. Diagnosis Code List Qualifier [ ] [ ] ( ICD-9 = B; ICD-10 = AB )
34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____

31a. Other Fee(s)
32. Total Fee: 183.00

35. Remarks

**AUTHORIZATIONS**

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Mary L Lee — Patient/Guardian Signature — 12/17/13 — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Mary L Lee — Subscriber Signature — 12/17/13 — Date

**ANCILLARY CLAIM/TREATMENT INFORMATION**

38. Place of Treatment [ ] (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) [ ]

5

40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)
41. Date Appliance Pla... (Y)

42. Months of Treatment Remaining
43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accid...

**BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

ABC Pediatric Dentistry
1 Apple Tree Lane
City Apple ST NC ZIP 27938

6

**TREATING DENTIST AND TREATMENT LOCATION INFORMATION**

8

53. I hereby certify that the procedures as indicated by date are in progress (for proced... multiple visits) or have been completed.

X David Long, DDS — 12/17/13

54. NPI 1987654321
55. License Number 1234
56. Address, City, State, ZIP Co...
56a. Provider Specialty Code 122300000X

9

49. NPI 1234567891
50. License Number ...234
51. SSN or TIN 123456789

7

52. Phone Number ( ...)919 555 1234
52a. Additional Provider ID
57. Phone Number ( )
58. Additional Provider ID 9030R

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J430D (Same as ADA De... Form – J430, J431, J432, J433, J434)
To reorder call 800.947.4746 or go online at adacatalog.org

## 7.10 Required identifying information

- Member's name, BCBSNC identification number (including alpha prefix and suffix) and date of birth must be listed on all claims submitted. If the member's identification number is missing or miscoded on the claim form, the patient cannot be identified. This could result in the claim being returned to the submitting provider's office, causing a delay in payment. The member's ID is located on the member's BCBSNC identification card. (Do not use "nick names" when submitting claims.)
- **The rendering and billing office must be clearly identified on the claim.** Please include a typed dentist (practice) name, NPI and tax identification number for both the rendering provider and the billing entity. The provider name, tax ID and billing address must match the provider's contract with BCBSNC.

  **Note:** Providers with a Group NPI number should list the Group NPI number in field forty-nine (49) and the individual NPI number in box fifty-four (54) (rendering provider). The individual NPI will apply to box forty-nine (49) and fifty-four (54) for solo providers.
- The date of service must be provided on the claim form for each service line submitted.
- Use approved ADA dental codes as published in the current CDT book.
- Claims must be submitted within one hundred and eighty (180) days of the date of service.
- List all quadrants, tooth numbers and surfaces for dental codes that necessitate identification (extractions, root canals, amalgams and resin fillings). Failure to provide tooth and surface identification codes can result in the delay or denial of claim payment.

**Note:** The Blue Book℠ Provider eManual, available at ***bcbsnc.com/content/providers/blue-book.htm***, offers additional information about medical/dental and pediatric billing.

## 7.11 Documentation, treatment plans, charting and X-rays

Please send only copies of X-rays or readable images. X-rays will not be returned.

**Dental providers can send electronic attachments using FastAttach™ available on the Web at *www.edsedi.com/NEA.aspx*.**

For a listing of CDT specific codes and corresponding documentation that can be accepted by NEA for transmission per BCBSNC coverage plan type, please see **Chapter 11** of this e-manual.

## 7.12 Postage

Affix the proper postage when mailing bulk documentation to BCBSNC. BCBSNC does not accept postage due mail. This mail will be returned to the sender and will result in delay of processing and payment.

## 7.13 Timely filing of claims

To be eligible for payment, claims must be received no later than one hundred and eighty (180) days of the date of service. Participating dental providers may not collect, or attempt to collect payment from BCBSNC members for any claim that was not submitted within the one hundred and eighty (180) day time period.

## 7.14 Dental coding terminology, dental procedures and nomenclature

Dental providers should report services using codes found in the most current edition of the Current Dental Terminology (CDT) manual. The CDT manual is published by the American Dental Association (ADA) for reporting services for treatment. The existence of a procedure code does not guarantee coverage; the benefit is determined based on the member's contract. The CDT manual can be purchased directly from the ADA by calling **1-800-947-4746** or by accessing their website at ***www.ada.org***.

### 7.14.1 Deletion of ADA codes

Once the ADA deletes codes, we will no longer accept the codes as of the effective date of the deletion. Submitted claims will be rejected or returned to the provider's office.

## 7.15 Dental claims processing

In an effort to process claims accurately and consistently, ACS as our claims processing administrator has developed processing standards that represent current community standards of dental care and are derived through consultation with dental practices, academic communities and current scientific literature. These standards are supported by system edits designed to adjudicate claims efficiently and accurately based on the member's contract. These edits use the most cost-effective, clinically appropriate claim reimbursement, based on clinical standards and contractual limitations.

## 7.16 Mutually exclusive edits

Mutually exclusive edits are designed to identify the billing for two (2) or more procedures that by dental care standards would not usually be billed for the same patient, on the same date of service.

| Procedure code | Description | Limitations and exclusions |
|---|---|---|
| 0120, 0140, 0145, 0150, 0171, 0180 | **Oral Evaluations** | 2 or more of these codes should not be submitted on the same date of service |
| 0220, 0230 | **X-rays** | No coverage if submitted with a code of 0330 |
| 1110 | **Prophylaxis** | No coverage if submitted on same DOS, same tooth or quadrant as a crown exposure, gingival flap procedure, crown lengthening, osseous surgery, bone grafts, biologic materials, guided tissue regeneration, debridement |
| 2960, 2961, 2962 | **Veneers** | No coverage if there is a history of 27xx or 67xx on the same tooth |
| 3310, 3320, 3330, 3346, 3347, 3348, 3332 | **Root canals and retreatments** | No coverage if same date as an extraction of the same tooth |
| 3331 | **Root canal obstruction** | No coverage when submitted on the same date as a root canal therapy or root canal retreatment |
| 3346, 3347, 3348 | **Root canal retreatments** | No coverage for root canal retreatment when submitted with an apicoectomy |
| 4270, 4273, 4275, 4276, 4277, 4278 | **Soft tissue grafts** | No coverage if submitted with 7340, 7350, 7955, 7963 on the same tooth or the same area |
| 4341, 4342 | **Scaling and root planning** | No coverage when submitted on same DOS, same tooth or quadrant as a crown exposure, gingival flap procedure, crown lengthening, osseous surgery, bone grafts, biologic materials, guided tissue regeneration, debridement |

Continued on the following page.

| Procedure code | Description | Limitations and exclusions |
|---|---|---|
| 4381 | **Antimicrobial agent** | No coverage when submitted on the same date of service as periodontal surgery |
| 7140 | **Non-surgical extraction** | No coverage if submitted on same tooth, same DOS with root amputation, endosseous implant, hemisection, or coronectomy |
| 7310, 7311 | **Alveoloplasty** | No coverage if submitted on same date of service and same area as 7111 or 7220-7251 |
| 7960, 7963 | **Frenulectomy and frenuloplasty** | No coverage if submitted with soft tissue grafts in same area, same date of service |

**Note:** This list, while meant to be comprehensive, may not list every procedure.

## 7.17 Unbundling / bundling edits

Unbundling occurs when two or more procedures are used to describe a service for which a single, more comprehensive procedure exists that more accurately describes the complete service performed.

### 7.17.1 Unbundling

Unbundled procedures will be re-bundled to the correct CDT procedure.

| Procedure code | Description | Limitations and exclusions |
|---|---|---|
| 4240, 4241 | **Gingival flap procedure** | No coverage if performed on the same date/same area as 3410, 3421, 3425, 3426, 3450, 3920, 4230, 4231, 4249, 4260, 4261, 4274, 60xx, 7140, 7210, 7220, 7230, 7240, 7241, 7250, 7251, 7350, 7471, 7473, 7485, 7970, 7971, 7972 |
| 4260, 4261 | **Osseous surgery** | No coverage if performed on same date of service, same area as implants, extractions, excision, or surgical reduction |
| 7485 | **Surgical reduction of osseous tuberosity** | No coverage if submitted with osseous surgery |
| 7970, 7971, 7972 | **Excision of hyperplastic tissue or pericoronal gingiva and reduction of fibrous tuberosity** | No coverage if submitted on the same date of service and area as a restoration, crown, veneer, gingivectomy, crown exposure, gingival flap, crown lengthening, osseous surgery, wedge, implants, extractions, removal of root, or coronectomy |

**Note:** This list, while meant to be comprehensive, may not list every procedure.

### 7.17.2 Bundled procedures

Restorative services performed on the same tooth/same day are combined into the code with the highest number of services due to benefit restrictions. Please refer to the dental claims processing section (**Section 7.14**) for more information.

| Procedure code | Description |
|---|---|
| 2140 | Amalgam restorations – 1 surface, permanent |
| 2150 | Amalgam restorations – 2 surfaces, permanent |
| 2160 | Amalgam restorations – 3 surfaces, permanent |
| 2161 | Amalgam restorations – 4 or more surfaces, permanent |
| 2330 | Resin-based composite restorations – 1 surface, anterior |
| 2331 | Resin-based composite restorations – 2 surfaces, anterior |
| 2332 | Resin-based composite restorations – 3 surfaces, anterior |
| 2335 | Resin-based composite restorations – 4 or more surfaces or involving incisal angle (anterior) |
| 2390 | Resin-based composite crown, anterior |
| 2391 | Resin-based composite – 1 surface, posterior |
| 2392 | Resin-based composite – 2 surfaces, posterior |
| 2393 | Resin-based composite – 3 surfaces, posterior |
| 2394 | Resin-based composite – 4 or more surfaces, posterior |

**Note:** This list, while meant to be comprehensive, may not list every procedure.

## 7.18 Incidental and integral

Incidental and integral services are defined as procedures carried out at the same time as a primary procedure, which are clinically integral/necessary to the performance of the primary procedure. Additional reimbursement is not provided for incidental procedures, as they are included in the allowance for the primary procedure.

| Procedure code | Description | Limitations and exclusions |
|---|---|---|
| 0210 to 0290 | **X-rays** | No coverage if submitted on the same claim as 9430 and 9440 |
| 9120 | **Fixed partial denture sectioning** | No coverage if submitted with a 7140 or 7210 |

**Note:** This list, while meant to be comprehensive, may not list every procedure.

## 7.19 Alternate benefits

Clinical situations that can be effectively treated by a more cost-effective, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure. Please refer to the benefit exclusions and limitations section (dental benefits chapter) for additional information.

| Procedure code | Description | Dental limitations and adjudication |
|---|---|---|
| 2331 (DL, DB, DF, ML, MB, MF surfaces only - in any order) | Anterior Composites | Coverage is restricted for a two-surface anterior proximal restoration to an alternate benefit of a one (1) surface restoration when there is only an access surface for the lingual or facial (only the decayed proximal surface is benefited). |
| 2332 (MFL, MBL, DFL, DBL surfaces only - in any order) | Anterior Composites | Coverage is restricted for a three-surface anterior proximal restoration to an alternate benefit of a one (1) surface restoration when there is only an access surface for the lingual or facial (only the decayed proximal surface is benefited). |

The procedures listed below will be reimbursed at the restoration level of noble metal procedure:

| Procedure code | Description |
|---|---|
| 2140 | Amalgam restorations – 1 surface, permanent |
| 2150 | Amalgam restorations – 2 surfaces, permanent |
| 2160 | Amalgam restorations – 3 surfaces, permanent |
| 2161 | Amalgam restorations – 4 or more surfaces, permanent |
| 2330 | Resin-based composite restorations – 1 surface, anterior |
| 2331 | Resin-based composite restorations – 2 surfaces, anterior |
| 2332 | Resin-based composite restorations – 3 surfaces, anterior |
| 2335 | Resin-based composite restorations – 4 or more surfaces or involving incisal angle (anterior) |
| 2390 | Resin-based composite crown, anterior |
| 2391 | Resin-based composite – 1 surface, posterior |
| 2392 | Resin-based composite – 2 surfaces, posterior |
| 2393 | Resin-based composite – 3 surfaces, posterior |
| 2394 | Resin-based composite – 4 or more surfaces, posterior |
| 2410 | Gold foil restorations – 1 surface |
| 2420 | Gold foil restorations – 2 surfaces |
| 2430 | Gold foil – 3 surfaces |
| 2510 | Inlay restorations – metallic – 1 surface |
| 2520 | Inlay restorations – metallic – 2 surfaces |

Continued on the following page.

| Procedure code | Description |
|---|---|
| 2530 | Inlay restorations – metallic – 3 surfaces |
| 2542 | Onlay – metallic – 2 surfaces |
| 2543 | Onlay restoration – metallic – 3 surfaces |
| 2544 | Onlay restoration – metallic – 4 or more surfaces |
| 2720 | Crown restorations – resin with high noble metal |
| 2750 | Crown restorations – porcelain fused to high noble metal |
| 2780 | Crown restorations – 3/4 cast high noble metal |
| 2790 | Crown restorations – full cast high noble metal |
| 6059 | Abutment supported porcelain fused to metal crown (high noble metal) |
| 6062 | Abutment supported cast metal crown (high noble metal) |
| 6072 | Abutment supported retainer for cast metal FPD (high noble metal) |
| 6210 | Fixed partial denture pontic – cast high noble metal |
| 6240 | Fixed partial denture pontic – porcelain fused to high noble metal |
| 6250 | Fixed partial denture pontic – resin with high noble metal |
| 6610 | Onlay – cast high noble metal – 2 surfaces |
| 6611 | Onlay – cast high noble metal – 3 or more surfaces |
| 6720 | Fixed partial denture retainer – crown – resin with high noble metal |
| 6750 | Fixed partial denture retainer – crown – porcelain fused to high noble metal |
| 6780 | Fixed partial denture retainer – crown – 3/4 cast high noble metal |
| 6790 | Fixed partial denture retainer – crown – full cast high noble metal |

**Note:** This list, while meant to be comprehensive, may not list every procedure.

## 7.20 Other reimbursement limitations

| Procedure code | Description | Dental limitations and adjudication in addition to benefit restrictions |
|---|---|---|
| 2932 | **Prefabricated resin crown** | Anterior primary teeth only |
| 2933 | **Prefabricated stainless steel crown with resin window** | Anterior primary teeth only |
| 2934 | **Prefabricated esthetic coated stainless steel crown – primary tooth** | Anterior primary teeth only |
| 2950 | **Core build-up, including any pins** | May not be billed in addition to 02140-02161 or 02330-02394 within 3 years |
| 4381 | **Localized delivery of chemotherapeutic agents via controlled release vehicle into diseased crevicular tissue, per tooth** | Must have history of 04341 performed in the same tooth range, once per site per 24 months |
| 5860 | **Overdenture – complete, by report** | Reimbursed at the level of complete dentures and included in frequency limitation of once per 8 years |
| 5861 | **Overdenture – partial, by report** | Reimbursed at the level of partial dentures and included in frequency limitation of once per 8 years |
| 5410 | **Adjust complete denture – maxillary** | No benefits within the first 12 months after insertion, maximum of 2 adjustments per year |
| 5411 | **Adjust complete denture – mandibular** | No benefits within the first 12 months after insertion, maximum of 2 adjustments per year |
| 5421 | **Adjust partial denture – maxillary** | No benefits within the first 12 months after insertion, maximum of 2 adjustments per year |
| 5422 | **Adjust partial denture – mandibular** | No benefits within the first 12 months after insertion, maximum of 2 adjustments per year |
| 5670 | **Replace all teeth and acrylic on cast metal framework, maxillary** | Included in frequency limitation of complete and partial dentures, once per 8 years |
| 5671 | **Replace all teeth and acrylic on cast metal framework, mandibular** | Included in frequency limitation of complete and partial dentures, once per 8 years |
| 7510 | **Incision/drain abscess – intraoral** | If the tooth is removed, then this procedure is considered incidental |

Continued on the following page.

| Procedure code | Description | Dental limitations and adjudication in addition to benefit restrictions |
|---|---|---|
| 7511 | **Incision/drain abscess – intraoral soft tissue** | If the tooth is removed, then this procedure is considered incidental |
| 9440 | **Office visit – after regularly scheduled hours** | Cannot be submitted on the same day as a problem – focused exam |
| 9942 | **Repair and/or reline of occlusion guard** | Allowed only once per year after 12 months from receipt of guard |
| 9950 | **Occlusion analysis – mounted case** | Once per 5 years |
| 9951 | **Occlusal adjustment – limited** | Once every 24 months, cannot be billed with 09952 or 09971 |
| 9952 | **Occlusal adjustment – complete** | Once per 5 years, cannot be billed with 09951 or 09971 |

**Note:** This list, while meant to be comprehensive, may not list every procedure.

## 7.21 Follow-up care

Procedures should be performed based on dental necessity and as appropriate in the diagnosis, treatment and care of the member's condition. Treatment rendered for the following is not eligible for benefits:

- Cosmetic reasons
- Member convenience
- Services not meeting standards of care

Additionally, the following limitations and exclusions apply for post-operative visits for periodontal and oral surgery:

| Procedure code | Description | Limitations and exclusions |
|---|---|---|
| 0120, 0140, 0170 | Oral evaluations | No coverage if evidence that a post-op for periodontal or oral surgery is being billed as an oral evaluation |
| 9430, 9440 | Office visit for observation | No coverage if evidence that a post-op for periodontal or oral surgery is being billed as an oral evaluation |

*This list, while meant to be comprehensive, may not list every procedure.

## 7.22 Standard dental benefits limitations

The table below provides a general overview of standard dental benefits limitations. It is important to remember that benefit allowances are subject to the terms and limitations of the member's eligibility and benefits at the time a service is provided. Providers are encouraged to always verify a member's benefits and eligibility in advance of providing services.

| Benefits | Standard dental benefit limitations |
|---|---|
| Oral evaluations<br>• periodic, limited, detailed or problem focused comprehensive oral or periodontal | twice per benefit period<br>limit one per provider |
| Consultations | twice each benefit period |
| Cleaning<br>• prophylaxis, including scaling and polishing above the gum line | twice each benefit period |
| X-rays<br>• full mouth or panoramic<br>• supplemental bitewings – X-rays showing the back teeth/periapical and occlusal X-ray of a tooth<br>• vertical bitewings, associated with periodontics<br>• extraoral | limited to members ages 6 and older<br>limited to once every 3 years<br><br>maximum of 4 films per benefit period<br>limit of 1 set per benefit period |
| Pulp-testing<br>• evaluation of tooth nerve, regardless of the number of teeth tested | 2 films per benefit period |
| Topical fluoride, up to age 18 | limited to 1 charge per visit |
| Palliative emergency treatment for relief of pain only | twice per benefit period |
| Sealants for first and second permanent molars | twice per benefit period<br>for members 6 through 15<br>one reapplication per tooth every 5 years |
| Space maintainers | limited to dependents through age 15 |
| Periodontal maintenance following active periodontal therapy | twice each benefit period |
| Routine fillings to restore diseased teeth<br>• Composite<br>• Amalgam | limit of 1 restoration per tooth every 2 years, unless new decay appears |

Continued on the following page.

| Benefits | Standard dental benefit limitations |
|---|---|
| Stainless steel crowns<br>• primary posterior<br>• primary anterior<br>• permanent | <br>one per tooth per lifetime<br>one per tooth every three years<br>one per tooth every 8 years |
| Endodontics<br>• endodontic therapy | one per tooth/root per lifetime<br>once per lifetime after 12 months from initial treatment |
| Occlusal guard, for treatment of bruxism only | once every 5 years |
| Denture relining done more than 6 months after the initial insertion | once every 2 years |
| Crown, partial and complete denture repairs and addition of teeth to existing partial dentures | limited to repairs or adjustments done after 12 months following the initial insertion |
| Rebasing of complete and partial dentures done more than 5 years after the initial insertion | once every 5 years |
| Replacement of broken teeth on partial or complete denture | once per tooth every 3 years |
| Periodontics | once per tooth every 3 years per site or quadrant |
| Crown lengthening<br>• reshaping the bone around the teeth to allow for proper prosthetic preparation | once per tooth every 3 years per site or quadrant |
| Root planing and periodontal scaling<br>• scraping to remove mineralized deposits and smooth rough, infected root surfaces | once per quadrant every 3 years |
| Full mouth debridement | once every 5 years |
| Provisional splinting | once every 3 years |
| Periodontal maintenance following active periodontal therapy | twice each benefit period |
| Inlays, onlays, crowns, covered only when a filling cannot restore the tooth | 1 restoration per tooth every 8 years |
| Complete, fixed, removable partial dentures | once every 8 years, no additional allowances for over-dentures or customized dentures |
| Tissue conditioning done more than 6 months after initial insertion or rebasing or relining | once per 12 months per prosthesis |

Continued on the following page.

| Benefits | Standard dental benefit limitations |
|---|---|
| Complex oral surgery | |
| • oroantral fistula closure/closure of sinus perforation/surgical access of unerupted tooth/ process to aid eruption | once per tooth |
| • transseptal fiberotomy | once per tooth |
| • alveoloplasty/vestibuloplasty/removal of exostosis/excision of hyperplastice tissue or pericoronal gingival | once per site every 3 years |
| • incision and drainage of intraoral abscess | once per site every 3 years |
| • frenulectomy | once per site per lifetime |

## 7.23 General criteria

Procedures should be performed based on dental necessity and as appropriate in the diagnosis, treatment and care of the member's condition. Treatment rendered for cosmetic reasons, member convenience or services that do not meet standards of care are not eligible for benefits. See page 7-24, **Section 7.35**.

## 7.24 Utilization management review – P&R Dental Strategies, Inc.

P&R Dental Strategies, Inc. is an industry leader in dental utilization management services that offers a comprehensive set of solutions to support the business needs of dental benefit payers. BCBSNC has entered into an agreement with P&R Dental Strategies, Inc. to facilitate utilization management and review services for our dental programs.

Although P&R Dental Strategies, Inc. is based in New York, dentists who are reviewing the claims are licensed in North Carolina. If you receive a letter requiring additional information, please send the information directly to P&R Dental Strategies, Inc. at the address on the letter. Sending it to the normal claims address will delay the review.

**Note:** BCBSNC's agreement with P&R Dental Strategies, Inc. does not impact claims processed under a member's medical benefit.

## 7.25 Dental (CDT) accidental procedure codes

Claims coded with (CDT) accidental procedure codes are processed under the member's medical coverage instead of their dental coverage. Oral surgical services and services rendered as a result of an accidental injury must be reported on the most current version of the American Dental Association (ADA) claim form. Services not covered under the dental plan should be submitted to the member's medical plan using a CMS-1500 claim form.

## 7.26 Dental-medical claims CPT/HCPC

Claims for "dental-medical" (dental related services that fall under a patient's medical benefit), such as accidental injury and/or TMJ services, should be filed to BCBSNC (or the patient's medical benefit carrier) using the most current version of the CMS-1500 claim form. Essential data elements must be completed.

Essential data elements include, but are not limited to, place of service codes and procedure codes (including modifiers if applicable). Claims must be completed using CPT and/or HCPC standard code sets. Claims missing an essential data element or that use an inappropriate code or are otherwise illegible will be returned.

BCBSNC accepts medical service claims when filed using the CMS-1500 paper claim form and when filed electronically. If sending a paper claim form to BCBSNC, please submit to the medical claims address listed on the member's BCBSNC identification card. Providers electing to transmit claims electronically for medical services can obtain resources and required forms on the BCBSNC electronic solutions website located at ***bcbsnc.com/content/providers/edi/bluee/signingup.htm***.

Please note that all electronic senders of claims for medical services will need to sign and submit a Blue Cross and Blue Shield of North Carolina trading partner agreement and an electronic connectivity request form or a **Blue *e***℠ interactive network agreement available from the BCBSNC website located at ***bcbsnc.com/content/providers/edi/bluee/signingup.htm***.

If you are signed up for **Blue *e***℠ and need to add users to your account, visit us at ***bcbsnc.com/content/providers/edi/bluee/add.htm***.

## 7.27 Accidental injuries, Pediatric Oral Health and dental-medical for out-of-state members

BCBSNC can accept claims for Blue Cross and/or Blue Shield member's having medical benefits coverage from a Blue Cross and/or Blue Shield plan other than BCBSNC, when services are provided for accidental injuries or other services that qualify under the out-of-state member's medical benefit plan.

- Send claims for "dental-medical" services provided to out-of-state Blue Cross and/or Blue Shield Plan members to:

  **Blue Cross Blue Shield of North Carolina**
  **PO Box 35**
  **Durham, NC 27702**

  Questions about claims filed for out-of-state members should be placed by calling **1-800-487-5522**. Dental providers can also verify an out-of-state Blue Cross and/or Blue Shield plan member's medical eligibility or benefits by calling **1-800-676-BLUE (2583)**.
- The Pediatric Oral Health process dictates that claims are processed by the specific plan and does not flow through the current IPP process.

## 7.28 Payment guidelines

Providers are notified of payment determination via messages contained on the notification of benefit (NOB). For example, a message will appear when services that are considered incidental to the primary service are not eligible for separate reimbursement.

## 7.29 Payment for covered services only

Participating dental providers are eligible for payment, only when, the services provided are clinically necessary and covered as part of the member's benefit plan. The issuance of the member's benefit payment amount is considered payment in full, with the exception of any applicable deductible, coinsurance, and/or copayment amounts.

## 7.30 Appeals and review of benefit determinations

Please contact BCBSNC Dental Blue® customer service for assistance with making a request for appeal or benefit determination review. Please use the call center appropriate for the member's benefit coverage type as outlined in **Chapter 2** of this e-manual.

## 7.31 Billing BCBSNC members

Participating providers agree not to bill members for services until after receipt of the BCBSNC issued notification of benefits, except for member's copayments. Member's copayment amounts, when applicable, are listed on the member's BCBSNC identification card. However, dental providers may bill BCBSNC members prior to the receipt of the Notification of Benefits (NOB) for services verified in advance as non-covered. Any amounts that both you and the member agree were collected erroneously for any reason must be refunded to the member within forty-five (45) days of the receipt of the NOB or your discovery of the error.

## 7.32 Payment options

BCBSNC offers two (2) available payment options to participating providers. Please see the table below for details regarding QuicRemit and electronic funds transfer payment options.

**BCBSNC dental payment options**

| Option | Summary | Details |
|---|---|---|
| **QuicRemit** | A fax is sent to your office containing a virtual MasterCard with a number unique to your payment transaction. You will receive a detailed explanation of payment in the fax along with the card number. | • The amount of credit is for the total due for claims processed during that cycle for all BCBSNC Dental Blue® and Dental Blue Select™ members.<br>• Normal MasterCard debit transaction fees apply. This normally ranges from 2-4% of total payments based on the agreement between your office and your card vendor.<br>• Payments are received 2-5 days earlier than paper checks since there are no print and mail delays.<br>• If the card transaction is not processed within 30 days, the virtual MasterCard debit transaction will be voided and a paper check will automatically be sent to your office.<br>• You can "opt out" of this payment option at any time by calling BCBSNC at **1-800-305-6638**. If you "opt out", all future payments will be delivered via EFT.<br>• If you have employees processing payments from remote locations, this may not be a viable option since they would need access to the credit card terminal. |
| **EFT / ACH** | Your office receives payment via electronic funds transfer (EFT) when you provide your banking account information. View the "Authorization and Guarantee Agreement" form at ***bcbsnc-dental.com/dbs_doclib/Echo%20ACH%20form.pdf*** | • Normal banking transaction fees apply.<br>• Payments are received 2-5 days earlier than paper checks since there are no print and email delays.<br>• Payment information delivered via secure website with email notification of new data available. |

**Important note:** **Members receive payments directly when services are rendered by a non-participating provider.**

## 7.33 Amounts billable to members

Providers may collect any applicable copayments at the time service is rendered. Any applicable coinsurance and/or deductible amounts may be collected from BCBSNC members only after receipt of the notification of benefits. Amounts for non-covered services may only be collected if they meet the criteria outlined in the instructions for the hold harmless provision as contained this e-manual. Any amounts collected erroneously by a dental care provider, from a member, for any reason, shall be refunded to the member within forty-five (45) days of the error being identified.

## 7.34 Amounts not billable to members

Participating providers may not collect any payments from members for covered services, except for any applicable copayment, coinsurance and deductible amounts. Participating providers may not balance bill BCBSNC members for the difference between billed charges and the amount allowed on the notification of benefits for a processed claim. Any differences between a dental provider's charges and the allowed amount are considered contractual adjustments and are not billable to members. Participating providers may not seek payment from either members or BCBSNC if a proper claim has not been submitted to BCBSNC within one hundred and eighty (180) days of the date a service is rendered. Participating providers charging fees for administrative services, such as paper work completion or furnishing clinical records may not bill BCBSNC members for these fees.

## 7.35 Billing members for non-covered services

Sometimes a dental provider may be asked by a member to provide services that are not covered by the member's benefit plan. Only under the following conditions may the provider bill the member for such services:

- The provider informs the member in advance of providing the service, in a written notification, that the specific service might not be covered.
- The member signs a written acknowledgment that he/she received such notification prior to receiving the specific service at issue. That notification must inform the member that the particular service at issue may not be covered.
- The member also acknowledges in advance and in writing that he/she has chosen to have the service at issue and if it is indeed not covered, the member is responsible for the expense and will pay the dental provider directly.
- The written notice regarding a particular service must be specific, defining the exact treatment of care being provided to the member. It is not acceptable to use a generic release form with a general statement regarding member's obligations to pay for non-covered services.

## 7.36 Coordination of benefits

When a member is covered by more than one (1) coverage plan, one plan must be designated as primary and the other as secondary. Coordination of benefits (COB) logic is used to determine which plan pays first on the claim.

If BCBSNC is primary and another insurance plan is secondary, use the following guidelines:

- Any prior approval and/or certification requirements must be followed according to the member's BCBSNC plan.
- File a claim first with BCBSNC. The secondary plan may be billed any copayment, coinsurance and/or deductible amounts and for services not covered under the BCBSNC member's benefit plan.

If BCBSNC is secondary, use the following guidelines:

- Any prior approval and/or certification requirements must be followed according to the member's BCBSNC plan.
- File a claim with the primary plan first, after the primary plan pays its benefits, then file the secondary claim along with the primary payment information to BCBSNC.

BCBSNC and our member's combined liability are limited to the BCBSNC contractual allowed amount. The contract between the provider and BCBSNC allows that benefits will be coordinated up to the contractual allowance. Disallowed amounts and/or services cannot be billed to the member.

Pediatric Oral Health benefits covered under the health plan will always be considered primary. Stand-alone dental will be considered secondary. Coordination of benefits rules will apply.

## 7.37 Hold harmless provision

Providers agree not to bill or otherwise hold members, BCBSNC or any third party responsible for payment for services and/or supplies provided to members, which are determined not to be clinically necessary and/or not eligible under the member's benefit plan, except when the following conditions shall have been met:

- The dental provider obtained prior authorization or certification in advance of providing the specific services and/or supplies to the member – and/or – the dental provider gave specific written notification to the member in advance of providing the non-medically necessary services or other non-covered services, explaining that such service might not be covered under the member's benefit plan; and the member signed a written authorization stating that:
  - ‡ The member received from the provider notification that the specific services and/or supplies may not be covered by his or her benefit plan.
  - ‡ The member received the notification prior to receiving the specific services and/or supplies.
  - ‡ The notification informed the member that the particular services and/or supplies, if not covered by member's benefit plan, are provided at the member's own expense, if the member elects to receive the specific services and/or supplies.
  - ‡ The provider obtained the member's written authorization prior to rendering the specific services and/or supplies.
  - ‡ The member's authorization includes that such services and/or supplies may not be covered by his or her benefit plan and the member agrees to pay for such services and/or supplies apart from his or her benefit plan.
  - ‡ The member's authorization specifies that the member elects to receive such services and/or supplies at the member's own expense and the provider has obtained the member's written authorization.
  - ‡ The notification by the provider and the authorization by the member, as set forth in the agreement, shall be given regarding a particular service at issue in the specific treatment of a member and not as a matter of general or standard procedure in all cases.

Dental providers agree to provide BCBSNC and/or ACS with a copy of any and all such written authorizations upon request.

Please refer to your dental care practice's contractual agreement with BCBSNC to review the hold harmless provision and how the provision applies. If you have questions regarding the hold harmless provision, please contact your regional BCBSNC Network Management representative.

Chapter 8

# Pre-treatment estimates and prior approval

## 8.1 Pre-treatment estimate of benefits

A pre-estimate of benefits is a request made prior to a procedure being performed, to verify benefits and clinical appropriateness of a procedure. This allows both the dental care provider and the patient to make an informed decision of potential coverage for a given procedure in advance.

When the charges from a dentist for a proposed course of treatment are expected to be over $250, a pre-treatment estimate of benefits is **strongly recommended** before any services are performed. The member or the dentist can make a request for a pre-treatment estimate of benefits (however, certain procedural and dental necessity information will most often be needed from the dental provider rendering care). Once received, the information will be reviewed and a pre-treatment estimate of benefits will be provided.

When requesting a pre-estimate of benefits, please send a written request along with any supporting documentation to the claims mailing address that's listed on the member's identification card, or use the claims mailing information located in **Chapter 2** of this e-manual.

Pre-treatment requests for a specific diagnosis or procedure must be submitted in writing. This chart provides information regarding required documentation needed before a pre-treatment estimate of benefits can be determined:

| Description | Information required for claims processing |
|---|---|
| **Single unit fixed restorations** | |
| Crowns<br>Build-ups<br>Post and cores | Pre-operative X-ray(s) |
| **Periodontics** | |
| Root planning and osseous surgery | Pre-operative X-ray(s)<br>Periodontal charting |
| **Multiple unit fixed restorations** | |
| Abutments<br>Pontics | Pre-operative X-rays (full arch) |
| **Endodontics** | |
| Conventional endodontics on permanent teeth and re-treatments | Pre- and post-operative X-rays |
| **Oral surgery** | |
| Surgical extractions<br>Impactions | Pre-operative X-rays |
| **Anesthesia** | |
| General IV sedation | Type, duration of agent |

**Note:** **Pre-treatment estimates are not available for Pediatric Oral Health benefits covered under medical.**

## 8.2 Prior plan approval

Prior approval (also referred to as prior review and prior authorization) is the process by which BCBSNC reviews the provision of certain "dental-medical" services (dental services paid under a member's medical benefit, such as, TMJ, accidental injury or medically necessary orthodontia covered under Pediatric Oral Health) against health care management guidelines prior to the services being provided.

Reviews are done to confirm the following:

- Member eligibility
- Benefit coverage
- Compliance with BCBSNC corporate medical policy regarding medical necessity
- Appropriateness of setting
- Requirements for utilization of in-network and out-of-network facilities and/or providers

It's important for in-network providers to remember that hold harmless is a contractual agreement between BCBSNC and participating providers. The agreement states that the provider may not balance bill a member for services or supplies that were not prior authorized or certified in advance by BCBSNC and/or deemed not medically necessary by BCBSNC. Members are not to be held responsible for any failure to obtain PPA.

If a request for PPA is submitted and not approved for medical necessity, and the member elects to continue with the service, then you would need to have the member sign a waiver that they are aware of the denial of services and responsible for the cost.

When a BCBSNC member seeks care from a dental provider that is nonparticipating with BCBSNC, the care will be reimbursed at the lower benefit level, with the member having liability for a higher out-of-pocket expense. The member is responsible for making sure that the PPA is obtained.

### 8.2.1 Submitting a request

Requests for prior plan approval can be submitted to BCBSNC's Care Management and Operations department in one (1) of the following ways:

- **Call 1-800-672-7897** Monday- Friday, 8:00 am – 5:00 pm
- **Fax** clinical information to: **1-800-571-7942**
- **Mail** clinical information to:
  **Blue Cross and Blue Shield of North Carolina**
  **Attention: Care Management and Operations**
  **PO Box 2291**
  **Durham, NC 27702-2291**

Include the following information when submitting a request:

- Practice name and BCBSNC provider number
- Contact name, phone number, and fax number
- Patient's name, BCBSNC member ID number, and date of birth
- Attending physician's name, BCBSNC provider number, and phone number
- Treatment setting – i.e., physician's/provider's office
- Expected dates of service

- Description of diagnosis and diagnosis codes
- Description of procedure and applicable codes
- Clinical information, including history and physical, treatment plan, and orthodontic contract

If all clinical information is submitted with the request, then BCBSNC has three (3) business days to return a decision. If the nurses or medical directors need additional information, then the process can take up to fifteen (15) calendar days. A letter will be faxed to you with the determination.

The BCBSNC corporate medical policy for Pediatric Orthodontics includes documentation requirements, along with guidelines for coverage. Dental providers can access the policy at ***bcbsnc.com/content/services/medical-policy/index.htm***.

### 8.2.2 Peer to peer review

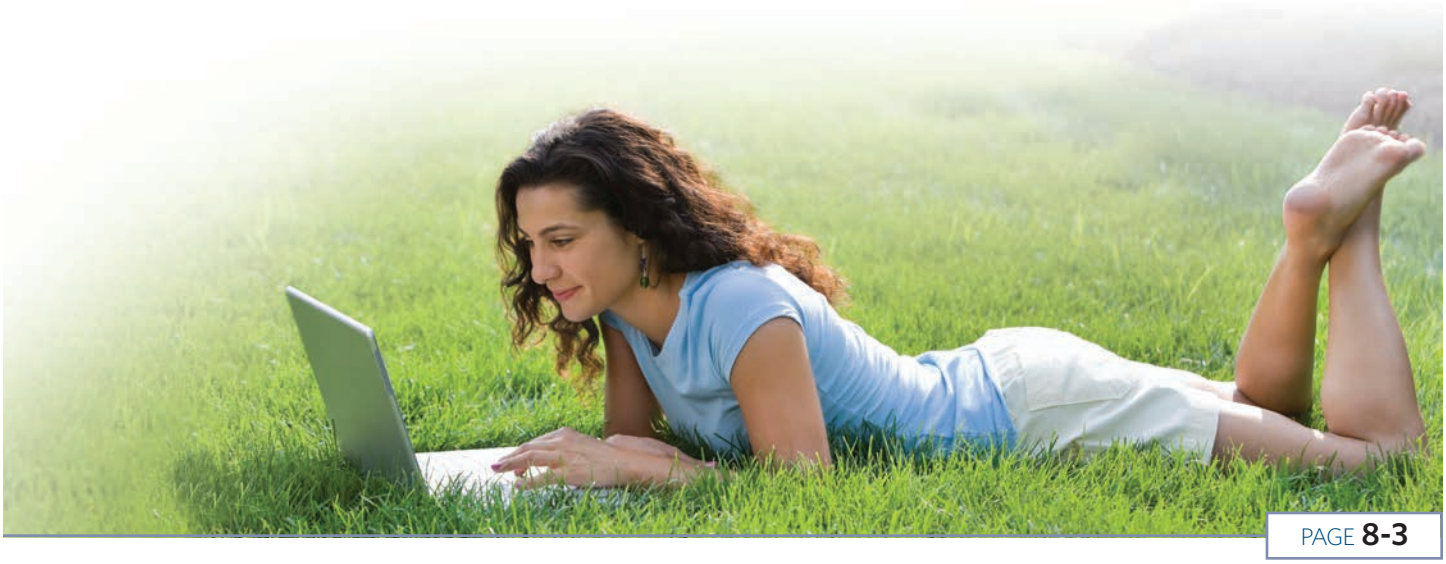
BCBSNC medical directors are available to discuss clinical problems and benefit issues with network providers, particularly where there are issues that complicate the management of the patient's condition. If you have questions about a certification request, you may request to speak directly to a medical director by calling **1-800-672-7897**, extension **51019**. The purpose of the peer to peer discussion is to give the requesting physicians an opportunity to discuss the clinical details of a requested service. A peer to peer review may also be requested by a BCBSNC medical director in order to obtain more clinical information from an attending physician before making a final determination.

### 8.2.3 Reconsideration review

BCBSNC offers a provider courtesy review for denied services. This is separate from the appeals process and is done if there is relevant information that was not previously submitted. This must be requested within one hunderd and eighty (180) days from the date of the adverse benefit determination letter. Dental providers can submit this information by calling or faxing to the same numbers for Care Management and Operations (see **Section 8.2.1**, **Submitting a request**).

### 8.2.4 Appeals for medical necessity denials

Appeals for cases that are deemed not medically necessary by BCBSNC, and are pre-service, are member appeals. Member appeals must be initiated by the member. Providers can initiate an appeal on the member's behalf only with a signed member consent form. Member benefit notification letters will include instructions for members on how to file an appeal for medical necessity denials. Post-service appeals are provider appeals, and can continue to be submitted by providers. To find out more about BCBSNC appeals and grievance procedures, please refer to **Chapter 12** of this e-manual.



Chapter 9

# Orthodontic care

## 9.1 Orthodontic care

**Available to members covered under Dental Blue® for Groups and Dental Blue Select℠ voluntary plans (orthodontic benefits are not available on individual plans).**

When applicable, benefits for a comprehensive orthodontic treatment are covered for all eligible members through age eighteen (18). Non-standard plans may cover orthodontics on adults. The following are covered services that are typically considered part of the comprehensive orthodontic care (but only if the group has purchased the orthodontic rider):

- Diagnosis, including the examination, study models, radiographs, and other aids needed to define a specific problem.
- Appliances or devices worn during the course of treatment. Coverage includes the design, making, placement and adjustment of the device. Benefits are not provided to repair or replace an appliance.

## 9.2 Medically necessary orthodontia

The ACA requires that ten (10) essential health benefits are included on every qualified health plan. One (1) of those essential benefits is pediatric dental coverage. Included in the pediatric dental essential health benefit is the coverage of orthodontia when it is medically necessary. BCBSNC will administer this benefit as follows:

- Covered members under the age of nineteen (19) – the benefit ends on the member's nineteenth (19th) birthday.
- Twelve (12) month waiting period for the member to be eligible for this coverage, beginning on the member's plan effective date. For example, if a member's plan began on **1/1/2014**, then that member would be eligible for their orthodontia coverage on **1/1/2015**.
- Codes (D8010, D8020, D8030, D8040, D8050, D8060, D8070, D8080, D8090, D8210, D8220, D8660, D8670, D8680, D8690, and D8999) will be added to BCBSNC's prior plan approval list, which can be found at ***bcbsnc.com/content/providers/ppa/services.htm***. This list is updated quarterly. Please reference **Chapter 8** for additional information related to prior plan approval.

### 9.2.1 Claims

Since medical necessary orthodontia is a medical benefit, there are a few changes to how claims are filed:

- Please be sure to use the 2012 ADA claims form with the appropriate CDT codes.
- Include the diagnosis code(s) for the patient on the 2012 ADA claims form.

| | | | | |
|---|---|---|---|---|
| 34. Diagnosis Code List Qualifier | | | (ICD-9 = B; ICD-10 = AB) | |
| 34a. Diagnosis Code(s) | A | | C | |
| (Primary diagnosis in "A") | B | | D | |

- Please include a copy of the completed orthodontic contract/treatment plan with the claim.

- Address for medical claims:
  **Blue Cross and Blue Shield of North Carolina**
  **PO Box 35**
  **Durham, NC 27702-0035**
- Emdeon Number for medical claims: **61472**
- After your PPA is approved, you will need to submit a claim each time service is rendered in order to be reimbursed. You will not be receiving a payment in total upfront.

## 9.3 Notes on orthodontic claims

- The dental provider must submit a complete treatment plan.
- Initial fee/down payment (date braces are placed)
- Number of treatment months
- Monthly fee
- File orthodontic claims on a monthly basis
- Phase I treatment is minor orthodontic treatment and can be paid in one total fee when treatment begins. Phase II treatment is comprehensive orthodontics and is divided into multiple payments. The first benefit payment is 50% of your initial payment, but no more than half of the **lifetime maximum** for orthodontics. This is followed by monthly coinsurance payments based on the existing treatment plan, up to the **lifetime maximum** for orthodontics. In order for benefits to continue throughout the treatment plan, this dental benefit plan must remain in effect, the **member** must remain enrolled in the plan, and the **member's** orthodontic **lifetime maximum** must not be met.
- Liability for orthodontic treatments should be assumed with the effective date of coverage, even if the braces were in place prior to coverage. Coverage is available from the effective date forward but only for the remaining time and fees (even if only a part of a member's lifetime orthodontic benefits are used).

Chapter 10

# Provider certification

## 10.1 Provider certification

BCBSNC electronically submits annual payment information to the IRS. An IRS form W-9 is required to be submitted as requested for the registration process, or when you file your first claim with BCBSNC, or as the result of an IRS action due to a CP2100 report. Failure to provide a W-9 or certified W-9 when requested, may result in an IRS required withhold of payment. Dental providers may also find it necessary to re-file an IRS form W-9 to reflect changes in a practice as recommended by a tax accountant.

BCBSNC participates in the IRS tax identification number (TIN) matching service to verify provider certification. A description of the matching services is available on the Web at ***www.irs.gov***. BCBSNC utilizes the matching service to validate IRS forms W-9 submitted by dental providers. The tax name and TIN, either an employer identification number (EIN) or social security number (SSN), submitted on the IRS form W-9 must match the IRS records.

## 10.2 Credentialing and re-credentialing

BCBSNC credentials all practitioners of care applying for membership in the network(s) and re-credentials any applicable contracted practitioner every three (3) years. Practitioners of care that are required to be credentialed and re-credentialed include both doctors of dental surgery (DDS) and doctors of dental medicine (DMD).

Guidelines are followed for all providers applying for participation in the BCBSNC networks. These guidelines have been adopted by BCBSNC and adhere to the guidelines established by the National Committee for Quality Assurance (NCQA) and the North Carolina Department of Insurance (NCDOI). NCQA is responsible for accrediting managed care organizations (MCO's) using specific standards for credentialing, quality management, utilization management, member rights and responsibilities, preventive care, and medical records. The NCDOI is the regulatory body for the state of North Carolina for managed care organizations.

BCBSNC makes best efforts to process and complete all credentialing and re-credentialing applications within sixty (60) days of receipt of a completed application. For further information about the credentialing and/or re-credentialing process and to download forms and applications, please visit the "Providers Applying for Credentialing" page located at ***bcbsnc.com/content/providers/dental-providers/join-network.htm***.

Additional forms required by Network Management when enrolling in the BCBSNC network:

- Individual provider number application and/or group provider number application
- Substitute W-9 form*

*Available for download at ***bcbsnc.com/content/providers/dental-providers/join-network.htm***.

Chapter 11

# NEA accepted codes for FastAttach™

## 11.1 NEA accepted codes for FastAttach™

The following listing of CDT codes has been compiled for dental providers for use when sending electronic attachments using FastAttach™ (when supplying the needed supporting documentation with electronic claims). This chart has been designed to help dental providers distinguish the appropriate documentation accepted by NEA for transmission, based on CDT code submission and BCBSNC coverage plan.

Please note that the below chart has been designed as a guide but is not intended to be all inclusive. The absence of a code or attachment type does not preclude our requesting that other or additional information be provided, if needed to properly administer a member's dental benefits. Additionally, inclusion of a code does not guarantee payment or a member's eligibility for benefits. This listing is subject to change.

Dental care providers can view the attachment requirements for BCBSNC, as well as, other dental care payers when using NEA *Fast*Look.

| | NEA accepted CDT codes | Dental Blue® for Groups | Dental Blue Select℠ | Dental Blue for Individuals℠ |
|---|---|---|---|---|
| CDT code | Description | Attachments | | |
| D0160 | Detailed and extensive oral evaluation – problem focused by report | Narrative | Narrative | Narrative |
| D0170 | Re-evaluation – limited problem focused (established patient – not post-op) | Narrative | Narrative | Narrative |
| D0999 | Unspecified diagnostic procedure by report | Narrative | Narrative | Narrative |
| D1510 | Space maintainer – fixed – unilateral | Narrative if submitted on permanent teeth or if under 4 years of age | Narrative if submitted on permanent teeth or if under 4 years of age | Narrative if submitted on permanent teeth or if under 4 years of age |
| D1515 | Space maintainer – fixed – bilateral | Narrative if submitted on permanent teeth or if under 4 years of age | Narrative if submitted on permanent teeth or if under 4 years of age | Narrative if submitted on permanent teeth or if under 4 years of age |
| D1520 | Space maintainer – removable unilateral | Narrative if submitted on permanent teeth or if under 4 years of age | Narrative if submitted on permanent teeth or if under 4 years of age | Narrative if submitted on permanent teeth or if under 4 years of age |
| D1525 | Space maintainer – removable bilateral | Narrative if submitted on permanent teeth or if under 4 years of age | Report | Report |

Continued on the following page.

| | NEA accepted CDT codes | Dental Blue® for Groups | Dental Blue Select℠ | Dental Blue for Individuals℠ |
|---|---|---|---|---|
| CDT code | Description | Attachments | | |
| D2542 | Onlay – metallic – 2 surfaces | Pre-op X-rays | | Pre-op X-rays |
| D2543 | Onlay – metallic – 3 surfaces | Pre-op X-rays | | Pre-op X-rays |
| D2544 | Onlay – metallic – 4/more surfaces | Pre-op X-rays | | Pre-op X-rays |
| D2642 | Onlay – porcelain/ceramic – 2 surfaces | Pre-op X-rays | | Pre-op X-rays |
| D2643 | Onlay – porcelain/ceramic – 3 surfaces | Pre-op X-rays | | Pre-op X-rays |
| D2644 | Onlay – porcelain/ceramic – 4/more surfaces | Pre-op X-rays | | Pre-op X-rays |
| D2662 | Onlay – resin-based composite/resin – 2 surfaces | Pre-op X-rays | | Pre-op X-rays |
| D2663 | Onlay – resin-based composite/resin – 3 surfaces | Pre-op X-rays | | Pre-op X-rays |
| D2664 | Onlay – resin-based composite/resin – 4/more surfaces | Pre-op X-rays | | Pre-op X-rays |
| D2710 | Crown – resin-based composite (indirect) | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date |
| D2712 | Crown – 3/4 resin-based composite (indirect) | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date |
| D2720 | Crown – resin with high noble metal | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date |
| D2721 | Crown – resin with predominantly base metal | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date |
| D2722 | Crown – resin with noble metal | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date |
| D2740 | Crown – porcelain/ceramic substrate | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date |

Continued on the following page.

| | NEA accepted CDT codes | Dental Blue® for Groups | Dental Blue Select℠ | Dental Blue for Individuals℠ |
|---|---|---|---|---|
| CDT code | Description | Attachments | | |
| D2750 | Crown – porcelain fused to high noble metal | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date |
| D2751 | Crown – porcelain fused to predominantly base metal | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date |
| D2752 | Crown – porcelain fused to noble metal | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date |
| D2780 | Crown – 3/4 cast high noble metal | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date |
| D2781 | Crown – 3/4 cast predominantly base metal | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date |
| D2782 | Crown – 3/4 cast noble metal | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date |
| D2783 | Crown – 3/4 porcelain/ceramic | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date |
| D2790 | Crown – full cast high noble metal | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date |
| D2791 | Crown – full cast predominantly base metal | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date |
| D2792 | Crown – full cast noble metal | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date |
| D2794 | Crown – titanium | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date |

Continued on the following page.

| | NEA accepted CDT codes | Dental Blue® for Groups | Dental Blue Select℠ | Dental Blue for Individuals℠ |
|---|---|---|---|---|
| CDT code | Description | Attachments | | |
| D2950 | Core buildup including any pins | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date |
| D2952 | Post and core in addition to crown – indirectly fabricated | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date |
| D2953 | Each additional indirectly fabricated post – same tooth | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date |
| D2954 | Prefabricated post and core in add to crown | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date |
| D2957 | Each additional prefabricated post – same tooth | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date |
| D2960 | Labial veneer (resin laminate) – chair side | Pre-op X-rays and narrative | Pre-op X-rays and narrative | Pre-op X-rays and narrative |
| D2961 | Labial veneer (resin laminate) – lab | Pre-op X-rays and narrative | Pre-op X-rays and narrative | Pre-op X-rays and narrative |
| D2962 | Labial veneer (porcelain laminate) – lab | Pre-op X-rays and narrative | Pre-op X-rays and narrative | Pre-op X-rays and narrative |
| D2980 | Crown repair by report | Narrative and replacement date of crown | Narrative and replacement date of crown | Narrative and replacement date of crown |
| D3310 | Anterior (excluding final restoration) (root canal) | Pre-op X-rays, post-op X-rays | Pre-op X-rays, post-op X-rays | Pre-op X-rays, post-op X-rays |
| D3320 | Bicuspid (excluding final restoration) (root canal) | Pre-op X-rays, post-op X-rays | Pre-op X-rays, post-op X-rays | Pre-op X-rays, post-op X-rays |
| D3330 | Molar (excluding final restoration) (root canal) | Pre-op X-rays, post-op X-rays | Pre-op X-rays, post-op X-rays | Pre-op X-rays, post-op X-rays |
| D3331 | Treatment root canal obstruction – non-surgical access | Narrative | Narrative | Narrative |
| D3332 | Incomplete endodontic therapy – inoperative/fractured tooth | Narrative | Narrative | Narrative |

Continued on the following page.

| | NEA accepted CDT codes | Dental Blue® for Groups | Dental Blue Select℠ | Dental Blue for Individuals℠ |
|---|---|---|---|---|
| CDT code | Description | Attachments | | |
| D3333 | Internal root repair – perforation defects | Narrative | Narrative | Narrative |
| D3346 | Retreatment preventive root canal therapy – anterior | Pre/post-op X-rays and date of original root canal | Pre/post-op X-rays and date of original root canal | Pre/post-op X-rays and date of original root canal |
| D3347 | Retreatment preventive root canal therapy – bicuspid | Pre/post-op X-rays and date of original root canal | Pre/post-op X-rays and date of original root canal | Pre/post-op X-rays and date of original root canal |
| D3348 | Retreatment preventive root canal therapy – molar | Pre/post-op X-rays and date of original root canal | Pre/post-op X-rays and date of original root canal | Pre/post-op X-rays and date of original root canal |
| D3410 | Apicoectomy/periradicular surgery – anterior | Pre-op and post-op X-rays required – also date of original root canal | Pre-op and post-op X-rays required – also date of original root canal | Pre-op and post-op X-rays required – also date of original root canal |
| D3421 | Apicoectomy/periradicular surgery – bicusp (1st root) | Pre-op and post-op X-rays required – also date of original root canal | Pre-op and post-op X-rays required – also date of original root canal | Pre-op and post-op X-rays required – also date of original root canal |
| D3425 | Apicoectomy/periradicular surgery – molar (1st root) | Pre-op and post-op X-rays required – also date of original root canal | Pre-op and post-op X-rays required – also date of original root canal | Pre-op and post-op X-rays required – also date of original root canal |
| D3426 | Apicoectomy/periradicular surgery – bicusp (each additional root) | Pre-op and post-op X-rays required – also date of original root canal | Pre-op and post-op X-rays required – also date of original root canal | Pre-op and post-op X-rays required – also date of original root canal |
| D3430 | Retrograde filling – per root | Pre-op and post-op X-rays required – also date of original root canal | Pre-op and post-op X-rays required – also date of original root canal | Pre-op and post-op X-rays required – also date of original root canal |
| D3999 | Unspecified endodontic procedure by report | Narrative | Narrative | Narrative |

Continued on the following page.

| | NEA accepted CDT codes | Dental Blue® for Groups | Dental Blue Select℠ | Dental Blue for Individuals℠ |
|---|---|---|---|---|
| CDT code | Description | Attachments | | |
| D4249 | Clinical crown lengthening – hard tissue | Pre-op X-rays required | | Narrative |
| D4260 | Osseous surgery (including flap entry and close) – per quadrant | Pre-op X-rays and recent perio charting required | | Pre-op X-rays and recent perio charting required |
| D4261 | Osseous surgery (including flap entry and closure) 1-3 teeth | Pre-op X-rays and recent perio charting required | | Pre-op X-rays and recent perio charting required |
| D4263 | Bone replacement graft – first site in quadrant | Narrative | | Pre-op X-rays and recent perio charting required – Narrative |
| D4264 | Bone replacement graft – each additional site in quadrant | Narrative | | Narrative |
| D4265 | Biologic materials / soft and osseous tissue regeneration | Narrative | | Narrative |
| D4266 | Guided tissue regeneration – resorbable barrier per site | Narrative | | Narrative |
| D4267 | Guided tissue regeneration – non-resorbable barrier per site | Narrative | | Narrative |
| D4341 | Periodontal scaling and root planing per quadrant | Pre-op X-rays and recent perio charting required | Pre-op X-rays and recent perio charting required | Pre-op X-rays and recent perio charting required |
| D4342 | Periodontal scaling/root planing/1-3 teeth per quadrant | Pre-op X-rays and recent perio charting required | Pre-op X-rays and recent perio charting required | Pre-op X-rays and recent perio charting required |
| D4381 | Localize delivery antimicrobial agents per tooth by report | Narrative | Narrative | Narrative |
| D5110 | Complete denture – Maxillary | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |

Continued on the following page.

| | NEA accepted CDT codes | Dental Blue® for Groups | Dental Blue Select℠ | Dental Blue for Individuals℠ |
|---|---|---|---|---|
| CDT code | Description | Attachments | | |
| D5120 | Complete denture – mandibular | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D5130 | Immediate denture – maxillary | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D5140 | Immediate denture – mandibular | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D5211 | Maxillary part denture – resin base (includes clasp – rest) | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D5212 | Mandibular part denture – resin base (includes clasp – rest) | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D5213 | Maxillary part denture – cast metal frame with resin base | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D5214 | Mandibular part denture – cast metal frame with resin base | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D5225 | Maxillary partial denture – flexible base | Pre-op and panoramic X-rays | Pre-op panoramic X-rays required for initial placement date | Pre-op and panoramic X-rays |
| D5226 | Mandibular partial denture – flexible base | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |

Continued on the following page.

| | NEA accepted CDT codes | Dental Blue® for Groups | Dental Blue Select℠ | Dental Blue for Individuals℠ |
|---|---|---|---|---|
| CDT code | Description | Attachments | | |
| D5860 | Overdenture – complete by report | Narrative and initial placement date | Narrative and initial placement date | Narrative and initial placement date |
| D5861 | Overdenture – part by report | Narrative and initial placement date | Narrative and initial placement date | Narrative and initial placement date |
| D5999 | Unspecified maxillofacial prosthetic by report | Narrative | Narrative | Narrative |
| D6010 | Surgical placement – implant body – endosteal implant | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date |
| D6012 | Surgical placement interim implant body – endosteal | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date |
| D6040 | Surgical placement – eposteal implant | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date |
| D6050 | Surgical placement – transosteal implant | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date | Pre-op X-rays and initial placement date |
| D6053 | Implant/abutment removable denture complete arch | Initial placement date | Initial placement date | Initial placement date |
| D6054 | Implant/abutment removable denture partial arch | Initial placement date | Initial placement date | Initial placement date |
| D6055 | Dental implant supported connecting bar | Initial placement date | Initial placement date | Initial placement date |
| D6056 | Prefabricated abutment – includes placement | Initial placement date | Initial placement date | Initial placement date |
| D6057 | Custom abutment – includes placement | Initial placement date | Initial placement date | Initial placement date |
| D6058 | Abutment supported porcelain/ceramic crown | Initial placement date | Initial placement date | Initial placement date |
| D6059 | Abutment support porcelain fused metal crown (high noble metal) | Initial placement date | Initial placement date | Initial placement date |

Continued on the following page.

| | NEA accepted CDT codes | Dental Blue® for Groups | Dental Blue Select℠ | Dental Blue for Individuals℠ |
|---|---|---|---|---|
| CDT code | Description | Attachments | | |
| D6060 | Abutment support porcelain fused metal crown (base metal) | Initial placement date | Initial placement date | Initial placement date |
| D6061 | Abutment support porcelain fused metal crown (noble metal) | Initial placement date | Initial placement date | Initial placement date |
| D6062 | Abutment supported cast metal crown (high noble metal) | Initial placement date | Initial placement date | Initial placement date |
| D6063 | Abutment supported cast metal crown (base metal) | Initial placement date | Initial placement date | Initial placement date |
| D6064 | Abutment supported cast metal crown (noble metal) | Initial placement date | Initial placement date | Initial placement date |
| D6065 | Implant supported porcelain/ceramic crown | Initial placement date | Initial placement date | Initial placement date |
| D6066 | Implant supported porcelain fused to metal crown | Initial placement date | Initial placement date | Initial placement date |
| D6067 | Implant supported metal crown | Initial placement date | Initial placement date | Initial placement date |
| D6068 | Abutment supported retainer – porcelain/ ceramic FPD | Initial placement date | Initial placement date | Initial placement date |
| D6069 | Abutment supported retainer – porcelain fused metal FPD (high noble) | Initial placement date | Initial placement date | Initial placement date |
| D6070 | Abutment supported retainer – porcelain fused metal FPD | Initial placement date | Initial placement date | Initial placement date |
| D6071 | Abutment supported retainer – porcelain fused metal FPD (noble metal) | Initial placement date | Initial placement date | Initial placement date |
| D6072 | Abutment supported retainer – cast metal FPD (high noble) | Initial placement date | Initial placement date | Initial placement date |
| D6073 | Abutment supported retainer – cast metal FPD (base metal) | Initial placement date | Initial placement date | Initial placement date |
| D6074 | Abutment supported retainer – cast metal FPD – (noble metal) | Initial placement date | Initial placement date | Initial placement date |
| D6075 | Implant supported retainer – ceramic FPD | Initial placement date | Initial placement date | Initial placement date |

Continued on the following page.

| | NEA accepted CDT codes | Dental Blue® for Groups | Dental Blue Select℠ | Dental Blue for Individuals℠ |
|---|---|---|---|---|
| CDT code | Description | Attachments | | |
| D6076 | Implant supported retainer – porcelain fused metal FPD | Initial placement date | Initial placement date | Initial placement date |
| D6077 | Implant supported retainer – cast metal FPD | Initial placement date | Initial placement date | Initial placement date |
| D6078 | Implant/Abutment supported fixed denture – complete endent arch | Initial placement date | Initial placement date | Initial placement date |
| D6079 | Implant/Abutment supported fixed denture – partial endent arch | Initial placement date | Initial placement date | Initial placement date |
| D6080 | Implant maintenance procedure include remove – clean – reinsert | Initial placement date | Initial placement date | Initial placement date |
| D6090 | Repair implant supported prosthesis by report | Pre-op X-ray | Pre-op X-ray | Pre-op X-ray |
| D6095 | Repair implant abutment by report | Pre-op X-ray | Pre-op X-ray | Pre-op X-ray |
| D6100 | Implant removal | Pre-op X-ray and initial placement date | Pre-op X-ray and initial placement date | Pre-op X-ray and initial placement date |
| D6190 | Radiographic/surgical implant index, by report | Pre-op X-ray and narrative and initial placement date | Pre-op X-ray and narrative and initial placement date | Pre-op X-ray and narrative and initial placement date |
| D6199 | Unspecified implant procedure by report | Pre-op X-ray and narrative and initial placement date | Pre-op X-ray and narrative and initial placement date | Pre-op X-ray and narrative and initial placement date |
| D6205 | Pontic – indirect resin-based composite | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6210 | Pontic – cast high noble metal | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6211 | Pontic – cast predominantly base metal | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |

Continued on the following page.

| | NEA accepted CDT codes | Dental Blue® for Groups | Dental Blue Select℠ | Dental Blue for Individuals℠ |
|---|---|---|---|---|
| CDT code | Description | Attachments | | |
| D6212 | Pontic – cast noble metal | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6214 | Pontic – titanium | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6240 | Pontic – porcelain fused to high noble metal | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6241 | Pontic – porcelain fused to predominantly base metal | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6242 | Pontic – porcelain fused to noble metal | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6245 | Pontic – porcelain/ceramic | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6250 | Pontic – resin with high noble metal | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6251 | Pontic – resin with predominantly base metal | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6252 | Pontic – resin with noble metal | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |

Continued on the following page.

| | NEA accepted CDT codes | Dental Blue® for Groups | Dental Blue Select℠ | Dental Blue for Individuals℠ |
|---|---|---|---|---|
| CDT code | Description | Attachments | | |
| D6545 | Retainer – cast metal for resin bonded fix prosthetic | Panoramic X-rays and initial placement date | Panoramic X-rays and initial placement date | Panoramic X-rays and initial placement date |
| D6548 | Retainer – porcelain/ceramic – resin bond fix prosthetic | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6601 | Inlay – porcelain/ceramic – 3 or more services | Panoramic X-rays and initial placement date | Panoramic X-rays and initial placement date | Panoramic X-rays and initial placement date |
| D6602 | Inlay – cast high noble metal – 2 surfaces | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6603 | Inlay – cast high noble metal – 3 or more surfaces | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6604 | Inlay – cast predominantly base metal – 2 surfaces | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6605 | Inlay – cast predominantly base metal – 3 or more surfaces | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6606 | Inlay – cast noble metal – 2 surfaces | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6607 | Inlay – cast noble metal – 3 or more surfaces | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6608 | Onlay – porcelain/ceramic – 2 surfaces | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |

Continued on the following page.

| | NEA accepted CDT codes | Dental Blue® for Groups | Dental Blue Select℠ | Dental Blue for Individuals℠ |
|---|---|---|---|---|
| CDT code | Description | Attachments | | |
| D6609 | Onlay – porcelain/ceramic – 3 or more surfaces | Pre-op panoramic X-rays required for initial placement date | | Pre-op panoramic X-rays required for initial placement date |
| D6610 | Onlay – cast high noble metal – 2 surfaces | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6611 | Onlay – cast high noble metal – 3 or more surfaces | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6612 | Onlay – cast predominantly base metal – 2 surfaces | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6613 | Onlay – cast predominantly base metal – 3 or more surfaces | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6614 | Onlay – cast noble metal – 2 surfaces | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6615 | Onlay – cast noble metal – 3 or more surfaces | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6634 | Onlay – titanium | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6710 | Crown – indirect resin-based composite | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |

Continued on the following page.

| | NEA accepted CDT codes | Dental Blue® for Groups | Dental Blue Select℠ | Dental Blue for Individuals℠ |
|---|---|---|---|---|
| CDT code | Description | Attachments | | |
| D6720 | Crown – resin with high noble metal | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6721 | Crown – resin with predominantly base metal | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6722 | Crown – resin with noble metal | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6740 | Crown – porcelain/ceramic | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6750 | Crown – porcelain fused to high noble metal | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6751 | Crown – porcelain fused to predominantly base metal | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6752 | Crown – porcelain fused to noble metal | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6780 | Crown – 3/4 cast high noble metal | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6781 | Crown – 3/4 cast predominantly based metal | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |

Continued on the following page.

| | NEA accepted CDT codes | Dental Blue® for Groups | Dental Blue Select℠ | Dental Blue for Individuals℠ |
|---|---|---|---|---|
| CDT code | Description | Attachments | | |
| D6782 | Crown – 3/4 cast noble metal | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6783 | Crown – 3/4 porcelain/ceramic | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6790 | Crown – full cast high noble metal | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6791 | Crown – full cast predominantly base metal | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6792 | Crown – full cast noble metal | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6793 | Provisional retainer crown | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6794 | Crown – titanium | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date | Pre-op panoramic X-rays required for initial placement date |
| D6973 | Core build up for retainer including any pins | Panoramic X-rays and initial placement date | | Panoramic X-rays and initial placement date |
| D6976 | Each additional indirectly fabricated post – same tooth | Narrative | Narrative | Narrative |
| D6977 | Each additional prefabricated post – same tooth | Narrative | Narrative | Narrative |

Continued on the following page.

| | NEA accepted CDT codes | Dental Blue® for Groups | Dental Blue Select℠ | Dental Blue for Individuals℠ |
|---|---|---|---|---|
| CDT code | Description | Attachments | | |
| D6980 | Fixed partial denture repair BR | Narrative and initial placement date | Narrative and initial placement date | Narrative and initial placement date |
| D6999 | Unspecified fix prosthodontic procedure | Narrative | Narrative | Narrative |
| D7220 | Remove impacted tooth – soft tissue | Pre-op X-rays | Pre-op X-rays | Pre-op X-rays |
| D7230 | Remove impacted tooth – part boney | Pre-op X-rays | Pre-op X-rays | Pre-op X-rays |
| D7240 | Remove impacted tooth – complete boney | Pre-op X-rays | Pre-op X-rays | Pre-op X-rays |
| D7241 | Remove impacted tooth – complete boney with unusual complications | Pre-op X-rays | Pre-op X-rays | Pre-op X-rays |
| D7250 | Surgery remove residual tooth roots (cutting procedure) | Pre-op X-rays | Pre-op X-rays | Pre-op X-rays |
| D7290 | Surgical repositioning teeth | Narrative | Narrative | Narrative |
| D7291 | Transseptal fiberotomy by report | Narrative | Narrative | Narrative |
| D7960 | Frenulectomy (Frenectomy/Frenotomy) – separate procedure | Narrative | | Narrative |
| D7963 | Frenuloplasty | Narrative | | Narrative |
| D7995 | Synthetic graft – mandibular/facial bones by report | Narrative | | Narrative |
| D7999 | Unspecified oral surgery procedure by report | Narrative | | Narrative |
| D8999 | Unspecified orthodontic procedure by report | Narrative | Narrative | Narrative |
| D9310 | Consultation (diagnostic service by non-treating practitioner) | Narrative | Narrative | Narrative |
| D9410 | House/extended care facility call | Narrative | Narrative | Narrative |
| D9930 | TX complications (post-surgery) – unusual circumstances by report | Narrative | Narrative | Narrative |
| D9940 | Occlusal guard by report | Narrative | Narrative | Narrative |
| D9999 | Unspecified diagnostic procedure | Narrative | Narrative | Narrative |

Chapter 12

# Appeal and grievance procedures

## 12.1 Member appeal and grievance process

In accordance with state law and in response to heightened concerns about member privacy and the confidentiality of medical information. BCBSNC requires the **member's written authorization** in order for a third party, including the member's provider, to pursue an appeal or grievance on the member's behalf. The appeal and grievance processes are available to address member concerns about:

- Adverse medical necessity decisions (non-certifications)
- BCBSNC decisions related to the availability, delivery or quality of dental care
- Claims payment, handling, or reimbursement
- The relationship between BCBSNC and the member

Member appeals must be requested within one hundred and eighty (180) days of the adverse benefit determination letter. Member appeals have a thirty (30) day turnaround time once they are received by BCBSNC. There are expedited processes if a situation is urgent. Benefit notification letters will have instructions for how members can file an appeal. In order for you, the provider, to represent the member in a level I member appeal, a **written authorization** must be obtained from the member. The member may obtain the member appeal representation authorization form by calling the customer service phone number located on the back of their ID card or the member can download a copy at ***bcbsnc.com***. A copy of the member representation authorization form is included in this section of the Dental e-Manual. Requests for review should also include all pertinent dental records information, not previously supplied to BCBSNC. Member authorization must be received by BCBSNC for a specific issue. A blanket authorization statement for appeal cannot be used. A signed authorization will remain valid until the particular issue is resolved or until authorization is rescinded by the member. Providers should submit documents for a level I appeal along with the appeal representation form to the following address:

**Blue Cross and Blue Shield of North Carolina**
**Level I – Dental Member Appeals**
**PO Box 2100**
**Winston-Salem, NC 27102-2100**

## 12.2 Member grievance policy

Occasionally, BCBSNC receives complaints from members about a provider or their staff regarding quality of care issues. In order to appropriately respond to our members, BCBSNC may ask you to review and provide a written response to such cases. You are required to cooperate with BCBSNC member grievance policies and must respond to BCBSNC direct inquiries within the timeframe specified in each request. This will ensure the best service to our mutual customer, our member/your patient.

### 12.2.1 Level I provider appeals

Level I provider appeals consist of retrospective reviews and do not require a member signed authorization. A post-service level I provider appeals of claims is performed based on your belief that a claim has been denied or adjudicated incorrectly. The provider appeal process is separate from BCBSNC's member rights and appeals process. If at any time the member files an appeal during a provider appeal, the member's appeal supersedes the provider appeal. Providers may not appeal items related to member benefit or contractual issues. If you believe a claim has been denied or adjudicated incorrectly, you may initiate a request for review by submitting a written request for appeal. To request a claim review regarding a processed claim related to:

- Coding, bundling, or fees
- Medical necessity

Providers will have ninety (90) calendar days from the adjudication date to submit the level I billing/coding dispute. Providers will have ninety (90) calendar days from the adjudication date to submit the level I clinical necessity provider appeal.

**Blue Cross and Blue Shield of North Carolina**
**Level I – Dental Member Appeals**
**PO Box 2100**
**Winston-Salem, NC 27102-2100**

## 12.2.2 Level II post-service provider appeals

Level II post-service provider appeals are available to dentist and will be performed by an independent review organization. Dental providers may file a level II post-service provider appeal for clinical necessity or billing disputes with MES Solutions, an independent review organization. There is a filing fee associated with all requests for a level II post-service provider appeal.

## 12.2.3 Process for submitting a post-service level II provider appeal

The level II post-service provider appeal request should clearly identify the issue that is in dispute and rationale for the appeal. Demographic information including subscriber name, patient name, patient BCBSNC ID number, provider name, and provider ID number should also be included with any request for appeal. Level II post-service provider appeals require a filing fee to be submitted before the review can begin. Providers may reduce administrative cost associated with records submission by first verifying that the record document information is consistent with BCBSNC dental policy, payment policy and clinical edit clarification guidelines.

A dental provider may file a level II post-service provider appeal if an adverse determination was given on a level I post-service provider appeal billing dispute or clinical necessity denial, as described below:

## 12.2.4 Level II post-service provider appeal for billing disputes

The BCBSNC billing dispute resolution process is available to resolve disputes over the application of coding and payment rules and methodologies to specific patients. Dental providers must submit a written request for level II post-service provider billing dispute appeal within ninety (90) calendar days of the date of the level I post-service provider appeal denial letter.

Dental providers must exhaust BCBSNC level I post-service provider appeal process before submitting a level II post-service provider appeal. You may access BCBSNC's dental policy at: ***bcbsnc.com/content/providers/index.htm***. Dental providers should contact MES Solutions directly to submit a level II post-service provider appeal for medical necessity.

Mailing address:

**MES Solutions**
**100 Morse Street**
**Norwood, MA 02062**
**Phone: 800-437-8583**
**Fax: 888-868-2087**
***www.mesgroup.com***

| Billing dispute | |
|---|---|
| **Amount of dispute** | **Filing fee calculation** |
| $1,000 or less | Filing fee shall be equal to $50 |
| Greater than $1,000 | Filing fee shall be equal to $250 |

| Medically necessary dispute | |
|---|---|
| **Amount of dispute** | **Filing fee calculation** |
| $1,000 or less | Filing fee shall be equal to $50 |
| Greater than $1,000 | Filing fee shall be equal to $250 |

**Note:** For level II post-service provider appeals related to billing disputes, the disputed amount must exceed $500. In instances where the disputed amount is less than $500, the dental provider may submit similar disputes to the independent review organization within one (1) year of the original submission date. If the dental provider intends to submit additional similar disputes during the year, the dentist must contact the billing dispute reviewer to notify that additional similar submissions will be sent. If the one (1) year lapses and the disputes submitted are not in excess of $500 in the aggregate, the original dispute will be dismissed. The filing fee will be refunded in the event that the dental provider prevails in the level II post-service appeal process.

## 12.3 Provider resources

The provider website contains a form for requesting provider appeal reviews regarding coding, bundling, fees, clinical necessity. This form is located at ***bcbsnc.com/content/providers/appeals/LevelIIProviderAppeals.htm***. BCBSNC provides resources that are readily available which may provide immediate resolution to questions for how a particular claim was considered. Your BCBSNC notification of payment (NOP) and explanation of payment (EOP) provide a detailed summary of how a claim was adjudicated. The secured website ***bcbsnc-dental.com***, accessed via the internet, allows you to search from your desktop: status of submitted claims, including payment amounts, member responsibility, and deductible amounts.

## 12.3.1 Sample medical member appeal representative authorization (members under 65)

BlueCross BlueShield of North Carolina

Date:

Name
Address
City, State, Zip

Patient:

Date of Birth:

Date(s) of Service:

Provider:

Reference Inquiry:

Regarding:

I have given my permission for _____ to represent me, and act on my behalf

regarding the above-referenced denial for the following services:_____ .

_____

I authorize Blue Cross and Blue Shield of North Carolina (BCBSNC) to release any of my protected health information (PHI) to my representative named above for the purpose of resolving my appeal.

I understand that I may revoke this authorization at any time by mailing a written notice to BCBSNC at the address below. I understand that revoking this authorization will not affect my action that BCBSNC has taken prior to receiving my notice of revocation.

I further understand that BCBSNC will not condition the provision of my health plan benefits because of this authorization.

I further understand that the person(s) that I have given permission to receive my PHI may not be subject to Federal health information privacy laws and that they may disclose my information and it may no longer be protected by Federal health information privacy laws.

This authorization will expire upon resolution of this appeal.

Thank you,

_____

Member Signature Date

Chapter 13

# Glossary

The following abbreviated glossary of terms contains common terminology used in the descriptions of BCBSNC products and procedures. Terminology specific to dental procedures can be referenced by accessing the ADA Glossary of Dental Terms available on the American Dental Association's website located at: ***www.ada.org/en/publications/cdt/glossary-of-dental-clinical-and-administrative-ter***.

**Administrative costs** - the costs assumed by a health and dental care plan for administrative services, such as claims processing, billing and overhead costs.

**Administrative services only "ASO"** - an account that assumes full claims liability (self-insured) for funding the dental and/or health benefits contract with a third party (such as BCBSNC) providing all or a portion of the administrative services that would be available under a regular health and/or dental plan. Because the service company assumes no liability for coverage, claim reserves normally are not required.

**Allowable charge/amount** - the maximum amount to be reimbursed to a provider as negotiated.

**Allowed amount** - the charge that BCBSNC (or contracted vendor) determines is reasonable for covered services provided to a member. This may be established in accordance with an agreement between the dental provider and BCBSNC.

**Alpha prefix** - a letter code that precedes a member's identification number.

**BCBS** - Blue Cross and Blue Shield (BCBS) is used to refer to national association programs.

**Beneficiary** - a person who is eligible to receive insurance benefits (includes member, dependent and subscriber).

**Benefit booklet** - The document that contains a general explanation of the member's benefits.

**Benefits package** - services an insurer, government agency or dental plan offers to a group or individual under the terms of a contract. The components that make up a product's dental benefit plan (e.g., deductible, out-of-pocket limit, lifetime maximum, etc.).

**Benefit period** - the period of time, usually twelve (12) months as stated in the group or individual contract, during which charges for covered services provided to a member must be incurred in order to be eligible for payment by BCBSNC (or our vendor). A charge shall be considered incurred on the date the service or supply was provided to a member.

**Billed charge** - the amount a dental provider bills a patient for a particular dental service or procedure. This is referred to as actual charge or public charge.

**Billing** - (a) an itemized account of subscriber dues owed to the Plan by a group or subscriber; (b) an itemized account of services rendered by a dental provider or supplier.

**Birthday rule** - a process under coordination of benefits clauses in a contract that determines which patient's coverage pays first when a dependent child has dental insurance coverage through both parents. This rule states that the parent whose birthday falls first during the calendar year is primary (his or her coverage pays first).

**BlueCard®** - a collection of programs and policies that enable members to receive services while traveling or living in another Plan's service area.

**Calendar year** - the period of time beginning January 1 and ending December 31 of a given year.

**Claim** - a request for retrospective payment by a member or, on his/her behalf, by the provider for services or supplies rendered. Each document or request for payment should be counted as one claim.

**Coinsurance** - the sharing of charges by BCBSNC and the member for covered services received by a member, usually stated as a percentage of the allowed amount.

**Coinsurance maximum** - the maximum amount of coinsurance that a member is obligated to pay for covered services per calendar year/benefit period.

**Copayment** - the fixed-dollar amount which is due and payable by the member at the time a covered service is provided.

**Coordination of benefits (COB)** - a method of determining the primary payment source when a person is covered under more than one (1) program.

**Coverage** - benefits available to eligible members.

**Covered service(s)** - a service, drug, supply or equipment specified in a member's benefit booklet for which members are entitled to benefits in accordance with the terms and conditions of their dental benefit plan.

**Dependent** - a member other than the subscriber, who is eligible for dental insurance through a spouse's, parent's or other family member's policy.

**Dependent child(ren)** - the covered child(ren) of a subscriber, spouse or domestic partner up the maximum dependent age, as specified in the subscriber's policy.

**Empty suitcase** - an ID card logo that indicates away from home care coverage that is administered through the BlueCard® system.

**Exclusions** - specific conditions or services listed in the dental benefit plan for which benefits are not available.

**Explanation of benefits (EOB)** - a statement to the subscriber that explains the action taken on each claim.

**Family deductible** - a deductible that is satisfied by either the combined expenses of all family members or a certain number of family members.

**Group** - an employer or other entity that has entered into a contract for dental care and/or administration of benefits for its eligible members.

**Group administrator** - a representative of the group designated to assist with member enrollment and provide information to subscribers and members concerning the dental benefit plan.

**Group contract** - the agreement between BCBSNC and the group. It includes the master group contract, the benefit booklet(s) and any exhibits or endorsements, the group enrollment application and dental questionnaire when applicable.

**Dental benefit plan** - the evidence of coverage issued to a group or individual by us or other Blue Cross and/or Blue Shield plans that describes the scope of covered services and establishes the level of benefits payable, on an insured or administered basis, for such services rendered to members.

**HIPAA** - Health Insurance Portability and Accountability Act - calls for enhancements to administrative processes that standardize and simplify the administrative processes undertaken by providers, clearinghouses, health plans and employer groups.

**Hold harmless** - a contract provision whereby providers agree not to charge members more than the allowable charges for covered services and not to charge members for non-covered services. The subscriber's only liability would be the deductible, coinsurance, and/or copayment.

**Home plan** - the Blue Cross and/or Blue Shield plan that carries the member's contract when the member receives services out-of-area.

**Host plan** - a Blue Cross and/or Blue Shield plan participating in the (inter-plan service) benefit bank that provides payment for dental care to a subscriber of another Blue Cross and/or Blue Shield Plan (home). BCBSNC serves as the host plan in the BlueCard® program.

**In-network** - refers to participating dental providers.

**Inquiry** - a request for information, action or a document from a subscriber, provider, account, another plan or the general public. Inquiries may be received in any area within a plan office.

**Investigational (experimental)** - the use of a service or supply, including but not limited to treatment, procedure, equipment, drug or device that BCBSNC does not recognize as standard dental or medical care of the condition, disease, illness or injury being treated. The following criteria are the basis for BCBSNC's determination that a service or supply is investigational:

- Services or supplies requiring Federal or other governmental body approval, such as drugs and devices that do not have unrestricted market approval from the Food and Drug Administration (FDA) for final approval from any other governmental regulatory body for use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.
- There is insufficient or inconclusive scientific evidence in peer-reviewed medical or dental literature to permit BCBSNC's evaluation of the therapeutic value of the service or supply.
- There is inconclusive evidence that the service or supply has a beneficial effect on dental health outcomes.
- The service or supply under consideration is not as beneficial as other established alternatives.
- There is insufficient information or inconclusive scientific evidence that, when utilized in a non-investigational setting, the service or supply has a beneficial effect on dental health outcomes and is as beneficial as any established alternatives.

**Lifetime maximum** - the maximum amount of covered services that will be provided to a member while they have coverage under a dental benefit plan or any prior dental benefit plan sponsored by the group in any member's lifetime.

**Medical necessity** - medical services or procedures that are considered reasonable, appropriate and necessary based on clinical standards of care.

**Member** - a subscriber or dependent, whose enrollment application and change form has been accepted and approved by BCBSNC as eligible for coverage benefits.

**Notification of benefits (NOB)** - a statement to the provider that explains the action taken on each claim.

**Primary payer** - when a member is covered by more than one (1) insurance carrier, the primary payer is the carrier responsible for providing benefits before any other insurer makes payment.

**Retrospective review** - a manner of judging dental necessity and appropriate billing practices for services that have already been rendered.

**Secondary payer** - when a member is covered by more than one (1) insurance carrier, the secondary payer is the carrier responsible for providing benefits after the primary payer has provided benefits.

**Subrogation** - the substitution of one person for another who has a legal claim or right.

**Underwriting** - the process by which an insurer determines if, and on what basis, an application for insurance will be accepted.

**IVR** - the IVR system is a voice response front end application that allows callers to access member's benefits information and check eligibility, claims and payment status for individual accounts.

**Workers' compensation** - insurance against liability imposed on certain employers to pay benefits and furnish care to employees injured on the job, and to pay benefits to dependents of employees killed in the course of or in circumstances arising from their employment.

# The Blue Book℠
## Dental e-Manual

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