2024 Participating Dental Provider

ADMINISTRATIVE MANUAL

Blue Cross Blue Shield of Rhode Island

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CHAPTER 1 – INTRODUCTION

Welcome to Blue Cross & Blue Shield of Rhode Island's
Blue Cross Dental

We created this manual for dentists and their office managers in the Blue Cross & Blue Shield of Rhode Island (BCBSRI) dental network. You will find a broad range of topics in this document, such as key contacts and an overview of the dental provider services offered by BCBSRI. In addition to this manual, our website, bcbsri.com, offers access to even more dental provider resources. We hope you find these tools to be valuable in helping you provide important, high-quality care to our members.

The intent of this manual is to help facilitate your interactions with our company. We believe that our dental provider community is vital to achieving our corporate vision: To improve the quality of life of our customers and of the people of Rhode Island by improving their health.

About Blue Cross Dental

BCBSRI has been the state's leading health plan since 1939 and has administered dental benefits for over 40 years. In 1993, the current Blue Cross Dental plan was created and now services an ever-growing membership, the majority of whom reside in Rhode Island.

Our Mission
To improve our members' health and peace of mind by facilitating their access to affordable, high-quality healthcare.

Toward that end we shall:

- Make high-quality health and dental insurance available to a comprehensive range of consumers, including business owners, employees, and self-paying individuals
- Assist and support healthcare initiatives for individuals without healthcare insurance
- Contribute to the improvement of medical, dental, and preventive services delivered in Rhode Island
- Promote a coherent, integrated, and efficient statewide healthcare system that meets the needs of all Rhode Islanders
- Ensure that BCBSRI is financially viable and maintains the resources and stability necessary to accomplish our mission

Mouth-Body Wellness

At BCBSRI, we recognize the impact that good oral health can have on improving overall health. As a health and wellness partner, we stand by our commitment to improve overall health and with that in mind, we developed the following programs to keep our members healthier.

Total Health Solutions

The Total Health Solutions Program provides our members* with non-surgical periodontal benefits when the have the following medical conditions:

- Diabetes
- Coronary artery disease
- Cardiovascular disease
- Stroke
- Oral, head & neck cancers
- Rheumatoid Arthritis
- Lupus
- Sjogren's disease
- Organ transplant

Members with these conditions will receive the following services at no cost:

- Non-surgical periodontal services (D4341, D4342, D4346): 1 service per quadrant, every 36 months
- Periodontal maintenance (D4910): 2 visits per calendar year with evidence of periodontal treatment

*Some self-funded commercial group plans may opt out of the Total Health Solutions benefit. Medicare Advantage plans automatically include periodontal services at 100% beginning on January 1, 2024, however, non-surgical periodontal services provided to members diagnosed with coronary artery disease or diabetes is not applied towards the members' calendar year maximum.

Maternal health

Members who are expecting are eligible for one additional cleaning during their pregnancy in addition to the two cleanings provided per plan year.

CHAPTER 2 – KEY CONTACTS AND RESOURCES

Key Contacts for Dental Offices

Blue Cross Dental (BCD) is committed to maintaining open lines of communication with all participating dentists. We will direct inquiries to the most appropriate resource as quickly and efficiently as possible to avoid disruption to your business.

There are two primary contact resources available to dentists and their office staff:

1. www.unitedconcordia.com*
2. Dental Provider Call Center

Directly contacting the appropriate resource will save you time and will enable us to respond more quickly. Additionally, our Provider Relations Representatives are available to help with issues that require more than a phone call or letter.

*United Concordia Dental (UCD) performs claims processing and customer service functions for BCD. Your patients with BCD coverage remain members of Blue Cross & Blue Shield of Rhode Island (BCBSRI). Additionally, you do not need to become a participating provider with UCD; your participation with BCBSRI qualifies you as in-network for BCD members.

For member eligibility, benefits & claims inquiries
www.unitedconcordia.com
Dental Provider Call Center: (401) 453-4700; or 1-800-831-2400
Hours: Monday - Friday, 8:00 a.m. - 8:00 p.m.

For complaints and grievances
Dental Provider Call Center: (401) 453-4700; or 1-800-831-2400
Hours: Monday - Friday, 8:00 a.m. - 8:00 p.m.

For credentialing or recredentialing
Fax: (401) 459-1369
Status of a credentialing and/or re-credentialing application
Hours: Monday - Friday, 8:00 a.m. - 4:30 p.m.

For Blue Cross Dental specific information and requirements
www.bcbsri.com/providers/dental

For Blue Cross Dental Provider Relations
Email: ProviderRelations@BCBSRI.org
Provider education, responsibilities, policies and procedures
Hours: Monday - Friday, 8:00 a.m. - 4:30 p.m

Communication Channels

The primary source of information for updates and policy changes is our newsletter ***Dental Connection.***

Dental Connection is published to communicate important topics to our network of dentists:

- Updates on administrative or operational policies/procedures/changes
- Benefits and claims information
- State and federal regulatory guidelines
- Information on corporate initiatives
- Articles of interest to dentists and dental staff

CHAPTER 3 – ORGANIZATIONAL STRUCTURE

Organizational Structure and Committees

The corporate structure of Blue Cross Dental is designed to help us work most effectively with you in meeting the following objectives:

- Maintain access to care through our dental network
- Ensure that all dentists meet our credentialing standards
- Monitor network performance against measurable standards
- Identify areas of potential improvement at corporate, network, and individual levels

To ensure that these objectives are met, the Dental Consultant, also a dentist, monitors the program. BCBSRI's Director of Product Strategy & Development and the Specialty Products & Services Manager also maintain oversight of the dental program.

Committees

The Dental Constituency Advisory Committee and the Provider Credentialing Committee are the two key committees that contribute valuable information and assist in our efforts to facilitate close working relationships with our participating dentist network.

Dental Constituency Advisory Committee (DCAC)

Purpose: To provide valuable input and expertise to BCD from the dentist's perspective. The DCAC is instructed to:

- Enhance communication with community dentists
- Serve as a forum for presenting and soliciting input for new or changing policies and procedures
- Review existing corporate policies and dental treatment guidelines
- Discuss new trends and technologies
- Provide information to committee members regarding corporate initiatives
- Serve as a liaison to their respective dental societies or associations
- Review and provide written input on dental necessity guidelines and policies

Composition: The membership includes a minimum of six Rhode Island licensed and practicing dentists (may be participating or non-participating with the BCD network) and …

- Director, Product Strategy & Development
- Manager, Specialty Products & Services
- Dental Consultant

Provider Credentialing Committee

Purpose and Objectives

- To ensure that providers (physicians, mid-level providers, allied health providers, dentists, behavioral health specialists, etc.) who wish to participate in the BCBSRI provider network have appropriate qualifications and meet credentialing requirements as set forth in the BCBSRI Credentialing Policies and Procedures.
- To review credentials, changes to practice, and appropriate regulatory, legal, or disciplinary information for contracted providers during the recredentialing process and determine whether the provider should continue to participate in the BCBSRI network.
- To ensure that Health Delivery Organizations (HDOs) wishing to participate in the BCBSRI network meet contracting requirements, including a quality assessment, as set forth in BCBSRI's policies and practices.

Composition: The Credentialing Committee membership includes:

- BCBSRI medical director
- BCBSRI credentialing operations analyst
- BCBSRI director of provider relations
- Additional BCBSRI physician reviewers, including other medical directors
- At least six additional community-based providers, including PCPs, specialist providers, and behavioral health professionals. All providers must participate in the BCBSRI network.
- BCBSRI Quality Management representative
- Representatives from the BCBSRI credentialing department and other individuals (staff, individuals involved in delegated arrangements, and others) are invited to attend committee meetings as determined by the Provider Credentialing Committee.

BCBSRI Dental Networks

As a participating dentist with BCBSRI, you agree to participate with all dental plans offered by BCBSRI, including members with supplemental dental coverage as part of a BCBSRI Medicare Advantage plan.

Additionally, BCBSRI participating dentists are considered part of the Blue Cross & Blue Shield of Massachusetts (BCBSMA) network and agree to accept BCBSRI allowances when treating a BCBSMA member.

When presented with a BCBSMA member identification card, please contact BCBSMA directly to determine member eligibility and benefit information. The number is **1-800-882-1178, option #3.** You should submit a claim directly to BCBSMA for payment at the following address, specifying pre-service or post-service:

BCBSMA Provider Claims P.O. Box 986005 Boston, MA 02298	or	BCBSMA Pre-Treatment Estimates P.O. Box 986005 Boston, MA 02298

Blue Cross Dental members may utilize a national network–the United Concordia Advantage 2.0 network–for access to participating dental offices nationwide.

National Dental GRID

In January 2016, BCBSRI joined the National Dental GRID for our federal employees who choose their stand-alone dental coverage, FEP Blue Dental, with us. FEP Blue members have access to the GRID's nationwide dental network. As a participating dentist with BCBSRI, you are automatically included in the National Dental GRID network. If you're not sure if you participate in the National Dental GRID network, or you do not wish to be included in this network, please contact ProviderRelations@BCBSRI.org.

In addition to federal employees, there are several other commercial dental plans that use the GRID as their network–including Anthem and Blue Cross & Blue Shield of Vermont. Services provided to GRID members are reimbursed according to the Blue Cross & Blue Shield of Rhode Island dental fee schedule.

To access eligibility and benefits information for patients with coverage other than BCBSRI or BCBSMA, contact the customer service number located on the back of the member's ID card.

CHAPTER 4 – DENTIST RIGHTS AND RESPONSIBILITIES

Dentist Rights and Responsibilities

As a BCBSRI dentist, you understand how important it is to be aware of the various clinical and administrative aspects of network participation. We expect all dentists to:

- Provide covered benefits in a manner consistent with professionally recognized standards of care
- Provide professional services in a manner that complies with all laws and requirements, including Title VI of the Civil Rights Act of 1975, the Americans with Disabilities Act, and all other laws applicable to the receipt of federal funds
- Know and observe the policies and procedures in accordance with Blue Cross Dental treatment guidelines

BCBSRI Confidentiality Statement

BCBSRI employees and agents will protect the privacy and confidentiality of our members' healthcare information. We will maintain, use, and disclose confidential health information as permitted or required by applicable state and federal laws, such as the Rhode Island Confidentiality of Health Care Communications and Information Act, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996. We will have in place administrative, technical, and physical safeguards to protect the privacy and security of our members' health information.

Protected health information is information that relates to an individual's past, present, or future physical or mental health or condition, or the past, present, or future payment for the provision of healthcare to an individual, including demographic information, received from or on behalf of a healthcare provider, health plan, clearinghouse, or employer, that either identifies the individual or could be used to identify the individual. It includes such information contained in any form or medium (electronic, paper, oral, etc.).

BCBSRI Employee Access

All BCBSRI employees are trained in confidentiality and our privacy and security policies and procedures upon hire and are required to read and sign a confidentiality statement upon hire and then yearly thereafter. To further protect the privacy of our members' health information, employees' access to health information is limited to only that information that they need to do their job. Any employee who violates the confidentiality policy will be subject to disciplinary action.

Member Access

BCBSRI members have the right to access their own health information/records and the right to request an amendment of their health information in accordance with the Rhode Island Confidentiality of Health Care Communications and Information Act. Our Notice of Privacy Practices describes additional rights in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 privacy provisions.

Participating Dentist Sites

BCBSRI dentists are responsible for maintaining the privacy, confidentiality, and security of their patients' health information in accordance with applicable state and federal laws. Dental records must be in a secure area with access limited to authorized personnel only. Effective record-keeping practices must be in place to protect the integrity and privacy of their patients' health information.

Physical Accessibility

All practice sites must comply with the specifications of the Americans with Disabilities Act (unless qualified for exceptions according to the law), including:

- The building must have a wheelchair ramp or suitable alternative, such as assistance provided by the office staff
- A building of two or more stories must have an elevator or wheelchair lift.
- The building must have designated handicapped parking
- Bathrooms must be handicapped-accessible, or alternative access must be available
- The waiting area must have adequate space

Site Safety

The practice site must be designed, constructed, equipped, and maintained in a manner that provides for the physical safety of patients, visitors, and staff.

The site must be:

- Identified as a professional/dental building; if not, the staff must identify it as being unmarked when members call for appointments
- Well lit, with visible exit sign(s)
- Structurally sound

The site must have:

- Readily available equipment/supplies for performing services
- Secure stairways with railings
- A lit parking lot (if the office keeps evening hours)
- Active infection control practices
- A written safety hazard policy (or one that the staff can communicate verbally)

Medication Safety

Medications must be safely stored to protect unauthorized access. Here are some medication safety practices that must be followed:

- Prescription pads and sample drugs must be kept in locked storage, with access granted to authorized personnel only
- A Controlled Drug/Substance (CDS) and/or Drug Enforcement Agency (DEA) certificate must be available upon request
- Medications and biologicals requiring refrigeration must be stored separately from food or lab specimens
- All sample drugs must be destroyed by their expiration date

- Oral and topical medications must be stored separately
- Needles and syringes must be stored in a secure area away from patient access (if stored in cabinets in exam areas, cabinets must be locked)
- There must be a written policy and procedure for the storage and dispensing of medications and handling of patient requests on prescriptions (or one that the staff can communicate verbally)

Dental Records

A dental record must be created for every patient treated or seen by the dentist. Records are confidential and must be securely stored with safeguards in place to prevent unauthorized or inadvertent use or disclosure of the information. Treatment records must be retained in accordance with generally accepted standards and applicable laws and regulations.

Release of Records

BCBSRI/BCD may request a member's dental records for administrative reasons such as the evaluation of quality of care, utilization of services, payment of claims, and resolution of disputes related to dental services. Information may be required to respond to regulatory requests, to provide to third-party insurers for adjudication of claims, or for peer review such as for use in credentialing or in quality improvement activities. When we request information for these purposes, or for other purposes that are part of our healthcare operations, these disclosures are permitted by HIPAA and a written authorization from the patient(s) is not needed.

The documentation of the release of your patients' treatment records must be maintained. Written authorization to release health information is not required when forwarding information to referring dentists or specialists, or for other treatment-related purposes. However, if you need the records of a new patient, or you must forward the records of a patient who has left your care, we recommend that you obtain written permission from the member.

Procedures and Charges for Treatment Records

We will only request the minimum amount of information needed for a specific purpose. Dentists or dental staff members do not need a written authorization from patients to release information to us. When submitting documentation, we recommend the following:

- Take measures to ensure that the information will be delivered directly to BCBSRI/BCD
- Do not fax documents (except in emergency situations) due to confidentiality and security issues
- Do not submit charges to BCBSRI/ BCD for costs incurred when releasing records; we do not reimburse for the release of records

Upon written request, Rhode Island dentists are required to provide a patient's dental records. While BCD will not reimburse providers, the Rhode Island Department of Health regulations state that providers may charge patients "a reasonable fee for the expense of providing a patient's dental record, not to exceed cost."

Transfer of Treatment Records
Dentists are responsible for transferring a member's treatment records when the member transfers to another dentist. The transfer of treatment records must be done in a timely manner to avoid any disruption in the member's care.

Reporting

Providers should report all practice changes by completing the appropriate forms and sending them to BCBSRI so we can make the necessary updates. A Practitioner Change Form and Substitute W-9 Form are available in the Provider section of bcbsri.com. Also, it is essential that we have your current email address so we can send your practice important information. Please complete the Email Address Update Form and send it to ProvDB@bcbsri.org or fax to 401-459- 2099.

Quarterly validation

BCBSRI is committed to ensuring that the information included in our Find a Dentist tool is accurate and up to date. As of January 1, 2022, participating providers are required to review and attest to their provider data each quarter per the Consolidated Appropriations Act. Providers who fail to do so will be removed from the BCBSRI provider directory/Find a Dentist tool.

Providers will receive quarterly notifications of this requirement, a reminder if 60 days into the quarter an attestation has not been received and notice if they fail to attest and are removed from the directory. When you receive these communications, please review, and make needed updates via our Provider Portal at bcbsri.com. It is important to review all locations to confirm if the location is where a patient can make an appointment to see the provider and whether the provider is accepting new patients; CMS requires this information.

Please make appropriate changes, check the attestation box, and submit your record to us as soon as possible. Even if the information is accurate, we need you to attest that your data has been reviewed and is accurate. Send any questions about our verification efforts to ProviderDirectory@bcbsri.org.

While some practice changes do not affect the continuity or coordination of member care, we ask that you notify us of any changes to your practice as soon as you are aware of them, or at least 30 days in advance. This will allow us to update our systems and to provide members with the most complete, up-to-date information available.

Credentialing and Recredentialing

Requirements[1]

Only those dentists who meet BCBSRI's credentialing/recredentialing requirements are

eligible to participate in the network. As a participating dentist, or a dentist applying for participation, you are required to supply us with the information needed to review and verify your credentials. Notification of completion of the credentialing/recredentialing process and verification of participation in the BCBSRI dental network is mailed directly to the dentist.

In addition to completing a comprehensive application, all dentists must supply evidence of the following:

- A detailed work history for the preceding five years (initial applicants only)
- Board certification, if indicated on the application, as applicable
- Current unrestricted professional license in state where practicing and acceptable license history
- Current Unrestricted Federal Drug Enforcement Agency (DEA) certificate when applicable
- Proof of adequate professional liability insurance and acceptable history of malpractice claims experience

[1] The BCBSRI service area includes the Massachusetts and Connecticut contiguous counties that border Rhode Island. In accordance with the reciprocal agreement between Blue Cross Blue Shield of Massachusetts (BCBSMA) and BCBSRI, no new dental offices in Massachusetts, within or outside of the respective counties, are allowed to join BCBSRI. If these Massachusetts offices become participating with BCBSMA, they will be part of our Coast-to-Coast dental network.

NPI Requirement

Every dentist is required to obtain an Individual NPI, "NPI-Type 1." Depending upon your practice structure, you may also need an Organizational NPI, "NPI-Type 2." Independent (sole dentist) practices can obtain a NPI-Type 2, but it is not required. Group (multiple dentist) practices are required to obtain a NPI-Type 2 under the taxable entity (Tax ID).

- NPI-Type 1 – Issued to individual dentist
- NPI-Type 2 – Issued to group dental practice

When completing a claim form:

- *Independent (sole dentist) practice, no NPI-Type 2* – Submit your **NPI-Type 1** for **both** your "rendering" and "billing" NPI (payment purposes), (Boxes 49 and 54 ADA 2019 Dental Claim Form).
- *Independent (sole dentist) practice, with NPI-Type 2* – Submit your **NPI-Type 1 for "rendering,"** (Box 54 ADA 2019 Dental Claim Form) and your **NPI-Type 2 for "billing,"** (Box 49 ADA 2019 Dental Claim Form).
- *Group (multiple dentist) practice* – Submit the rendering dentist's **NPI-Type 1 for "rendering,"** (Box 54 ADA 2019 Dental Claim Form) and the group's **NPI-Type 2 for "billing"** (Box 49 ADA 2019 Dental Claim Form).

How to Obtain Your NPI

The Centers for Medicare and Medicaid Services (CMS) has contracted with Fox Systems to serve as the National Plan and Provider Enumeration System (NPPES). You

may request your NPI via the following methods:

By phone: 1-800-465-3203 (NPI Toll-Free) 1-800-692-2326 (NPI TTY)
By email: customerservice@npienumerator.com
Online: nppes.cms.hhs.gov
By mail: NPI Enumerator, P.O. Box 6059, Fargo, ND 58108-6059

Dentists' Right to Review Information

Dentists have the right to review information we obtain to evaluate their credentialing application and to contact us to be informed of the status of the application. Dentists may contact the Blue Cross Dental Provider Call Center at (401) 453-4700 or 1-800-831-2400 to inquire about the status of an application.

Dentists have the right to review information obtained from any outside primary sources (e.g., malpractice insurance carriers, state licensing boards, etc.). This policy does not require us to allow providers to review references, recommendations, or other information that is peer-review protected.

In addition, BCBSRI will notify you if credentialing information obtained from other sources varies from the information provided on the application. BCBSRI is not required to reveal the source of information if it is not obtained to meet credentialing verification requirements, or if disclosure is prohibited by law. Lastly, dentists have the right to correct erroneous information submitted by another source.

Initial Application Process

Dentists may obtain a ***Provider Participation/Application*** via BCBSRI.com. Under the Provider tab you will find the selection "Become a Participating Provider." As a general rule, it is best to submit new applications at least two to three months prior to a new dentist's commencement of employment. After we receive and verify the required documentation, the dentist's credentialing file is presented to the Credentials Committee for approval/denial of network participation. Once approved, you may expect written confirmation of your participating status within 30 to 45 days. Your data is loaded into our system during this period, and all claims are processed as participating based on your credentialed approval date.

Recredentialing Process

Dentists are recredentialed every three years. Approximately six months prior to a dentist's scheduled recredentialing date, we mail the required recredentialing paperwork to the dentist. Included in the packet are instructions on how to complete and submit all required paperwork to facilitate the recredentialing process. After we receive and verify the returned documentation, the dentist's credentialing file is presented to the Credentials Committee for approval/denial of continued network participation.

Notification

Approved dentists are notified by mail. First-time dentist applicants who have been approved receive a welcome letter containing helpful information.

The committee sends a certified letter of notification to any dentist who has been denied initial or continued participation. The letter will outline the reasons for the denial or termination and explain how the dentist may appeal the decision if he or she wishes.

Currently, some dental practices considered "participating offices" employ dentists who are both participating and non-participating with BCBSRI. If your office has dentists who are non-participating, please follow these guidelines:

- Dental practices may have both participating and non-participating dentists employed and linked to the same Tax Identification Number (TIN) for claims processing purposes. Participating status [and **assignment of benefit (AOB) rights**] will dictate payment direction appropriately to either the business entity or the member.
- Dental practices with both participating and non-participating dentists are required to verbally notify BCBSRI members, prior to treatment, that they may be balance-billed for services rendered by a non-participating dentist.

Payment Rules:

- Participating dentists receive payments directly from BCBSRI.
- Non-participating dentists may receive direct payments from BCBSRI if they have AOB rights, in accordance with the AOB Law, Section 1, Chapter 27-18 of the General Laws enacted by the Rhode Island General Assembly July 2, 2004.
- Payments for claims from non-participating dentists (who do not have AOB rights) will be sent to BCBSRI members.

CHAPTER 5 – BENEFIT PLANS

Benefit Plan Offerings

BCBSRI offers a variety of dental plans to our members, including Blue Cross Dental, Dental Direct, BlueCHiP for Medicare, and Federal Employee Program. **To confirm that a patient has dental coverage, look for the toothbrush in the upper right-hand corner of the member's BCBSRI ID card.**

We encourage you to verify eligibility and check your patients' specific benefit information each time you see a BCBSRI member. You can access this information at www.unitedconcordia.com 24 hours a day, seven days a week, or you can contact us at (401) 453-4700 or 1-800-831-2400, Monday through Friday, 8:00 a.m. to 8:00 p.m.

Blue Cross Dental

These plans offer employee groups numerous choices for dental benefits, from basic care to full coverage to meet the varying needs and requests of our customers. Many combinations of benefits, deductibles, and coinsurances are available.

Dental Direct

BCBSRI offers four individual dental plans (Basic, Standard, Plus & Elite) providing members with varying levels of quality dental coverage at affordable rates.* These comprehensive and voluntary dental plans are available exclusively to Rhode Island residents. Members are not required to have an association membership or Blue Cross medical coverage to be eligible for our Dental Direct plans.

* In some cases, there is a 12-month waiting period for major restorative procedures.

If you would like to request Dental Direct brochures to display in your office, please email ProviderRelations@BCBSRI.org with your office name and address, as well as the quantity, and we will mail these directly to you.

BlueCHiP for Medicare

BlueCHiP for Medicare offers individual Medicare members and Medicare retiree group members access to dental benefits. Please check individual member benefits for specific coverage information.

BlueRI for Duals (D-SNP)

A BlueCHiP for Medicare Advantage plan available to Rhode Islanders who qualify for both Medicare and Medicaid. Dentists who participate with BCBSRI are considered in network for these members. Participation with Medicaid is not required to see these members.

BlueRI for Duals (D-SNP) Annual Training Requirement

BCBSRI requires all participating providers to annually attest to our D-SNP overview. The overview provides information on the care management interaction and the

additional social services available to members of the BlueRI for Duals plan.

The D-SNP overview presentation and subsequent attestation form can be independently accessed at any time by visiting the D-SNP page from the Provider section on BCBSRI.com. Annual attestation must be submitted each year by March 31st.

Federal Employee Program

The Federal Employee Program (FEP) is administered by BCBSRI for all federal employees in Rhode Island. Members of this program are offered a choice of two dental plans: **Basic** or **Standard**. The following is a general description of each plan, how they differ, and what your office needs to know regarding reimbursement:

- ***Basic*** – Under the Basic option, a member must receive treatment from a dentist that participates in the **FEP Preferred Network** to be eligible for coverage. A Preferred Network dentist participates with BCBSRI and has signed a separate FEP Preferred Network participating agreement. Preferred dentists agree to accept a discounted allowance, the *maximum allowable charge*, as payment in full for all covered services (no balance billing to the patient).
- ***Standard*** – Under the Standard option, a member may choose to receive treatment by any dentist, whether participating or not. Benefits are paid according to a specific fee schedule of allowances. If a Preferred Network dentist is used, the patient is only responsible for the difference between the fee schedule amount paid and the maximum allowable charge.

Questions about participating status in the FEP Preferred Network can be directed to ProviderRelations@BCBSRI.org.

Claims for the FEP should be submitted to the address on the member's identification card. Additionally, all eligibility, benefit and claims inquiries should be directed to the contact information on the member's identification card.

FEP Blue Dental federal employees have medical coverage (FEP), which includes minimal dental benefits. In addition to their medical coverage, these federal employees have a variety of insurance carriers from which they can select additional comprehensive dental benefits. BCBSRI is pleased to offer this plan, called "FEP Blue Dental." FEP Blue Dental uses a nationwide dental network called the National Dental GRID.

The GRID allows members from FEP Blue Dental and other Blue Cross & Blue Shield commercial plans that participate in the National Dental Grid, to get services in the BCD network. Your services are reimbursed at the **Blue Cross Dental of Rhode Island reimbursement levels**.

Claims for FEP Blue Dental should be remitted to the address on the member's identification card.

CHAPTER 6 – CLAIMS ADMINISTRATION[2]

BCBSRI network dentists agree to submit claims on behalf of our members and to accept our allowance of fees as payment in full, based on the benefit plan design. Participating dentists collect the coinsurance and deductible amounts specified by a member's plan, and applicable charges for services that are not covered. Additionally, reimbursement for services performed after the member has reached the annual maximum of their coverage may be made up to the dentist's charge.

Payment is sent directly to your office as a participating BCBSRI dentist, not to the patient. Your name and office location are listed in the *Blue Cross Dental Provider Directory* by any member looking for a participating dentist.

Deductibles, Coinsurances, and Annual Maximums

When a coinsurance or deductible is due from the patient, your office may collect the specified amount directly from the member. We ask that you observe the following:

- ***Deductibles*** – These fixed dollar amounts are applied to the services received during a period of time, usually a calendar year. BCBSRI tracks the accumulated deductible for each member. You may collect the deductible at the time of service if you verify the member's eligibility, benefit, and deductible information prior to the time of service.
- ***Coinsurances*** – A percentage of the allowable fee for a specific service, coinsurance may vary depending on the member's plan. As it is the patient's financial responsibility, you may collect the coinsurance at the time of service (except for those members covered by one of our BlueCHiP for Medicare plans) if you know the appropriate coinsurance percentage for that member's plan, as well as the allowable amount for the service(s) rendered.
- ***Annual maximums*** – Once a member has reached the yearly maximum of his or her plan (the BCBSRI fee allowance for each service counts toward this maximum amount), the dentist may bill the patient up to the charge for additional services within the coverage period.

"Hold Harmless" Provisions

Your contract with BCBSRI expressly states that you may not bill, charge, or collect a deposit from; seek compensation, remuneration, or reimbursement from; or have any recourse against a member (or person acting on the member's behalf) for services covered by the member's benefit plan. This provision does not apply to coinsurance and/or deductible amounts, or charges for services not covered by the member's benefit plan or more than the annual/lifetime maximums. These are the full responsibility of the member.

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[2] *Claim processing is administered by United Concordia Dental.*

Billing the Patient

When a patient's coverage pays less than 100% of the Blue Cross Dental allowance (e.g., 80%, 50%, etc.), the patient is responsible for the remainder of the Blue Cross Dental allowance, referred to as the "coinsurance" amount. Participating dentists have agreed to charge for and make reasonable efforts to collect the coinsurance and deductible amounts from BCBSRI members. Dental plans designed with deductibles and coinsurances present patients with a financial stake in the treatment they receive and contribute to the control of premium costs.

Payments to Dentists

An Explanation of Benefits (EOB) is sent to each dentist for all claims processed within a processing period, accompanied by a check for the total amount payable for those claims. You may also view your EOB under Payments and EOBs on the provider portal at unitedconcordia.com.

Predeterminations are issued, providing your office with an estimate of payment for planned services, and are valid up to one year from the date of issue. The predetermination is not a guarantee of payment and reflects the member's eligibility, deductibles, benefit coverage, and annual maximum at the time the predetermination is processed. The patient is responsible for payment if the member's contract is canceled, benefits are changed, additional services are rendered, or if the annual dollar maximum is reached by the time services are completed.

Coordination/Non-Duplication of Benefits

Many individuals enrolled in BCBSRI dental plans have additional coverage through their spouse or parents. Standardized, industry-wide rules have been established for determining the order of financial responsibility when multiple plans cover the same services. BCBSRI is responsible for coordinating the appropriate payment of benefits for our members, and we adhere to industry rules and guidelines in doing so.

As a BCBSRI participating dentist, you are required to:

- Provide any information necessary for collection and coordination of benefits (COB) when a member has other dental insurance coverage
- Comply with BCBSRI's COB and duplicate coverage provisions
- Assign to BCBSRI all payments owed by or received from another payer for services you have rendered to BCBSRI members

Role of the Dentist's Office

The dentist's office is not responsible for determining the order of benefit payment from the multiple dental plans of a patient or coordinating the order of payment. We assume full responsibility for COB activities.

We do require the office's cooperation as we work to accomplish COB. We need the office to supply us with requested information and abide by our COB rules. To determine

whether a member has other coverage, the office should ask the member when he or she first comes in for an appointment. The information should be updated at least once a year or preferably at every service date.

The following brief overview of the basic COB rules may help offices determine payment priority and streamline their own bookkeeping and billing efforts. When more than two plans are involved, or when there are complex relationships among employee, subscribers, and multiple dependents, the process can become quite complicated. In these instances, it is helpful to contact all involved carriers before submitting claims.

Coordination of Benefits

When members are covered by more than one group insurer, their BCBSRI benefits are coordinated with those of the other insurer(s), so that the total amount paid does not exceed the cost of those services.

Procedures

1. **Collect applicable coinsurances and/or deductibles.**
   These amounts are collected the same way, regardless of whether BCBSRI is the primary or secondary carrier.
2. **Submit the claim for services to BCBSRI.**
   When submitting the claim, be sure to identify any additional coverage the member may have.

If you can identify BCBSRI as the secondary carrier, you may postpone submitting the claim until the other carrier has paid benefits. In this case, please submit a copy of the other carrier's Explanation of Benefits with your claim.

If BCBSRI is clearly the primary carrier, bill the other carrier after receiving our Explanation of Benefits.

If you cannot identify which plan is primary, call the Blue Cross Dental Provider Call Center at (401) 453-4700 or 1-800-831-2400 for assistance.

Filing Claims with Blue Cross Dental

We require that all dentists use the most current version of the American Dental Association (ADA) claim form. This form has appropriate fields for your NPI(s), as well as other practice/dentist identifiers, and required patient and service information. Your software vendor should be able to provide this form, or a comparable format that will accommodate your NPI(s). Paper forms can be ordered from the ADA by calling 1-800-947-4746, or visiting www.adacatalog.org.

We encourage electronic claim submission and accept electronic attachments using NEA or Tesia. To be considered for payment, claims must be submitted within 12 months of the date of service and cannot be charged to the patient if the office fails to submit within this time frame.

Claims for services are paid upon completion date. In the case of multistage procedures, the completion date is the date the specific treatment is final (e.g., crown insertion date, final fill date for root canals, delivery date for removable prosthetics). Specific plans do not cover procedures that were started prior to the member's coverage eligibility. For instance, if a crown preparation was done prior to the member having coverage, but the crown was inserted after coverage commenced, the plan would not cover the crown. Additionally, some plans have waiting periods for procedures such as crowns. These waiting periods may vary but are most commonly 12 months from the original eligibility date. Members receive this information with their benefit packages, but we suggest that your office confirm coverage and limitations through bcbsri.com.

Predeterminations

Blue Cross Dental does not require predeterminations for any services. However, we strongly recommend submitting a predetermination if the services total $400 or more. A predetermination will provide the following information:

- Amount of payment allowed according to the member's contract and our reimbursement and utilization review policies
- Amount of payment that is the patient's responsibility
- Benefits that the patient is eligible for at the time the predetermination is processed

Predeterminations are an estimate, **not a guarantee of payment**. The payment amounts on the predetermination are based on the member's eligibility, contractual limitations, and benefit dollars that are valid at the time the predetermination is processed. Actual reimbursement may vary from this estimate if any of the determining factors above have changed at the time the claim for payment is processed.

We highly recommend that you use the returned predetermination form for submission of your claim for payment once the service is complete. By entering the date of service in the appropriate field on your returned predetermination form, the claim for payment is complete and will expedite processing of the claim.

Predeterminations are valid for 12 months from date of issue. We recommend that you submit a new predetermination if this period has elapsed, and the service was not performed.

Required Information

To ensure prompt payment, complete all mandatory fields on the claim form, including, but not limited to:

- Personal information that identifies the member as a subscriber or dependent of a subscriber, and other pertinent data including the member identification number
- Coverage information, including the member's specific plan; coverage from other carriers; and any information that can help identify whether another party is financially liable for the charges
- Identifying rendering dentist information (Type 1 NPI)
- Signature (written/typed) of treating dentist

- Billing identification/location information (Type 1 NPI for single practitioners, Type 2 NPI for group practices)
- Tax identification number (TIN, EIN, or SSN)
- Appropriate CDT procedure codes
- Dates of service (completion dates) on payment claims
- Appropriate treatment site/area for service
- Charge for the service(s)

When the required information is not included, the claim will be returned for omitted documentation/information. This may include a request for clinical documentation as necessary to complete utilization reviews. A new claim with correct and complete information must be submitted for appropriate processing.

Clean Claims

A clean claim is a claim for payment of healthcare services that is submitted via acceptable claim forms or electronic formats with all required fields completed with accurate and complete information in accordance with the insurer's requirements.

A claim is considered "clean" if the following conditions are met:

1. The services must be eligible, provided by an eligible provider, and provided to a person covered by the insurer.
2. The claim has no material defect or impropriety, including, but not limited to, any lack of required substantiating documentation or incorrect coding.
3. There is no dispute regarding the amount claimed.
4. The payer has no reason to believe that the claim was submitted fraudulently or there is no material misrepresentation.
5. The claim does not require special treatment or review that would prevent the timely payment of the claim.
6. The claim does not require coordination of benefits, subrogation, or other third-party liability.
7. Services must be incurred during a time where the premium is not delinquent. (Due to Federal Regulation, this condition does not apply to BlueCHiP for Medicare members.)

If you have questions about whether your claims meet all the conditions of a "clean claim," you may contact the Blue Cross Dental Provider Call Center at (401) 453-4700 or 1-800-831-2400.

Procedures

1. Complete the dental claim form (ADA 2019, 2012 or 2006).
2. Submit the form to Blue Cross Dental.

To be considered for benefit payment, you must submit a clean claim within 12 months (one year) of the date of service (completion). Claims submitted after the time limit will be denied. Please remember that in accordance with your participating provider

agreement, you may not bill patients for services that were denied because you did not meet timely filing requirements. Please submit claims to:

Blue Cross Dental Claims Administrator
P.O. Box 69427
Harrisburg, PA 17106-9427

Claims for FEP and FEP Blue Dental members should **not** be submitted to the Harrisburg, PA address. The correct submission address is on the member's most recent identification card.

Allowable Fees

Dentists are required to accept, as payment in full, the amount allowed by BCBSRI for covered services, less any applicable deductible or coinsurance collected from the member at the time of service. Disputed payments will be reconsidered upon request.

Payment Forms and Claims Checks

A Remittance Advice form is sent to each provider for all claims processed within a processing period, accompanied by a check for the total amount payable for those claims. BCBSRI's standard for claims payment is within 30 days of receiving a clean claim and settlements are currently paid weekly.

Payment Errors

BCBSRI has the right to recover any payments, from providers, made in error. In turn, dentists have the right to have payment determinations reconsidered and adjustments made when appropriate.

If BCBSRI has overcompensated a provider for services rendered in error, we have the right to recover the overpayment amount. When an adjustment is processed, a letter notifying the dental office of the reason for the adjustment will be sent giving the dentist the option of remitting a payment to offset the adjustment. If payment is not remitted within 60 days, it will automatically be retracted from the first settlement after the 60-day period.

If BCBSRI has not compensated a provider in full for services rendered, a payment adjustment will be made. If you have received payment from the member and we later reimburse you for the service, you must reimburse the member the amount that he or she paid.

Overpayment recoveries and underpayment adjustments will be itemized on your next settlement. All over/underpayment adjustments are reflected in the Provider Settlement.

Appeals of Payment Determinations

You are entitled to reconsideration of any claims payment that you believe is inaccurate or does not reflect an appropriate allowance for the services rendered. Administrative appeals are handled by the Dental Claims Department and must be submitted within 180 days of the mailing date of the settlement notice. Resolution to the administrative appeal will be made within 60 business days of receipt of all necessary information related to the

appeal. (See Appeals section in this chapter on page 25.)

Utilization Review

As part of our Quality Assurance Program (QAP), Blue Cross Dental conducts utilization review and utilization management. There are no financial incentives for BCBSRI or for individuals conducting utilization review for issuing denials of services. Our utilization management procedures are in place to ensure that our members receive appropriate quality of care and services.

Dental Necessity

BCBSRI bases all review determinations on evidence that services demonstrate dental necessity and are appropriate to ensure high-quality care for our members. Claims recommended for dental consultant review include procedures in the categories of endodontics, oral surgery, periodontics, prosthodontics, onlays, crowns, and implants. Processing policies are documented in the *Blue Cross Dental Treatment Guidelines.* General policy pages from this document may be found in the Appendix of this manual.

Definitions

Dental necessity – The use of services or supplies as provided by a dentist required to identify or treat a member's dental or oral health condition must be:

- Consistent with the symptoms or diagnosis and effective treatment of the member's oral condition, disease, or injury for which it is prescribed or performed
- Appropriate with regard to generally accepted standards of dental practice within the dental community
- The most appropriate level of service that can safely be provided to the member

Claim denial (patient responsibility) – The patient is responsible for the payment if:

- The service/treatment is not contractually covered (a non-covered benefit).
- The services are deemed to be cosmetic or a specialized technique.
- The member's annual maximum has been reached. Additional services within that year of coverage are the patient's responsibility, up to the dentist's charges.
- The service is completed after the patient's coverage has terminated (in some cases, procedures were started prior to coverage).

Claim denial (provider responsibility) – The dentist cannot charge the patient for a denied procedure/service if:

- The office does not file claims within the timely filing guidelines (within one year from date of service).
- The service is considered to be part of a comprehensive procedure/treatment (e.g., sterilization procedures, supplies, local anesthetic, etc., are considered part of the overall dental treatment).

Claim disallow (no payment, no liability determined) – The dentist cannot charge the patient at this point in the claims processing procedure due to:

- Incomplete or inaccurate claim information was received.
- Necessary clinical documentation was not received with the claim.

Notification of Rights to Review

Blue Cross Dental

RIGHTS TO REVIEW

Claims are recognized for utilization review and evaluated by a licensed dentist, who renders clinical decisions on predeterminations, payment claims and appeal cases. Determinations are based on criteria in the Blue Cross Blue Shield Guidelines. Services must meet the standards for quality care to qualify for reimbursement. If a service is not approved on a predetermination, a notification of the adverse determination will be sent to the subscriber and dentist within 15 calendar days of receipt of all necessary information. On post-service claims, if a procedure does not qualify for benefit payment, notification of the adverse determination will be sent to the subscriber and dentist within 30 calendar days of receipt of all necessary information. You have the right to request, free of charge, all records to your claim, including clinical criteria on which the denial was based.

RECONSIDERATION: Applicable only to members with employer group coverage

A dentist and/or subscriber may request a reconsideration of an adverse determination by requesting reconsideration in writing from Blue Cross Dental within 180 calendar days of receipt of the original adverse decision. The request, with any additional clinical documentation, should be sent to: Dental Appeals, P.O. Box 69420 Harrisburg, PA 17106-9420. You will be notified of the decision within 15 calendar days of receipt of your request. If the reconsideration is denied, you have the right to an appeal. You have 45 days after receiving the reconsideration denial letter to request an appeal.

APPEAL: Applicable to members with employer group coverage and individual coverage

If you have individual coverage, a dentist and/or subscriber may file an appeal of an adverse determination by requesting an appeal in writing from Blue Cross Dental within 180 calendar days of receipt of the adverse decision. You will be notified of the result of your appeal within 15 calendar days of receipt of your request.

If you have employer group coverage, a dentist and/or subscriber may file an appeal of an adverse reconsideration within 45 days of receiving notice of the denial of the reconsideration. You may inspect your file and add additional information prior to our review. You may inspect your file and add additional information prior to our review. You will be notified of the result of your appeal within 15 calendar days of the receipt of your request.

The request, with any additional clinical documentation, should be sent to: Dental Appeals, P.O. Box 69420 Harrisburg, PA 17106-9420. If the decision on the appeal is adverse, you will receive notification and have the right to file for an external appeal.

EXTERNAL APPEAL

A dentist and/or subscriber may request a review to be conducted by an approved, independent review organization (IRO) disputing the outcome of the internal reviews by the Blue Cross Dental. The appellant must submit a written request and explain the reason for your disagreement with our decision within four (4) months of the appeal adverse determination. Members are not required to bear any costs when requesting a case be sent for external review to an IRO. Blue Cross Dental will forward your letter and the entire case file to IRO. Upon receipt of the necessary information, the IRO will notify you and Blue Cross Dental of the outcome within 10 calendar days, or 72 hours for an expedited appeal. If the IRO overturns our decision, we will authorize or pay for the services in question.

OTHER RESOURCES

Other resources to help you:

- If you receive your insurance through your employer, the Employee Benefits Security Administration can be reached at 1-866-444-EBSA (3272)
- Rhode Island Insurance Resource, Education, and Assistance Consumer Helpline (RI REACH) 1-855-747-3224

If you have a question regarding the initiation of a reconsideration or an appeal, please call Dental Customer Service at 401-453-4700 or 1-800-831-2400.

If you have a question regarding the initiation of an appeal, please call Blue Cross Dental Customer Service at (401) 453-4700 or 1-800-831-2400.

Administrative Appeals & Complaints

Administrative Appeals

An administrative appeal is a verbal or written request for reconsideration of a full or partial denial of payment due to:

- Services submitted that were non-covered or limited under the terms of the member's Blue Cross Dental coverage
- A member or dentist not following Blue Cross Dental administrative procedures

Provider Settlements and customer Explanation of Benefits include a message stating that all appeals must be initiated within 180 days of the mailing date of the original adverse notification. A response to an administrative appeal will be completed within 30 business days of receipt of all necessary information related to the appeal.

Complaints

A quality of care complaint is specific to a member's dissatisfaction with the provider, provider staff, facility, or direct experience with the dental office. The complaint can be a verbal or written application expressing dissatisfaction made by a member or provider, a member's beneficiary, legal representative, parent, designated advocate/representative, or legal guardian, to review an actual or alleged circumstance that gives the member or provider cause for protest. A complaint is not an appeal, an inquiry or a

misunderstanding, or problem of misinformation that is resolved promptly by clarifying the related issues or providing appropriate information to the satisfaction of the member or dentist. Complaints must be submitted within 180 days of the incident date and resolved within 30 business days of receipt of all necessary information related to the complaint.

CHAPTER 7 – QUALITY MANAGEMENT & IMPROVEMENT

QMI Program Overview

Blue Cross Dental's Quality Management & Improvement (QMI) Program, based on an annual evaluation of our members' needs, helps us to implement activities that will improve overall quality of care and service.

This program addresses the following issues:

- Access to care and service
- Improvements in administrative and clinical processes used to deliver care
- Mechanisms for identifying and resolving quality of care concerns
- Mechanisms for ensuring that network dentists meet standards and requirements set forth by state and federal agencies and accrediting organizations

The strategy of our QMI Program is to coordinate a multidisciplinary approach to monitoring, measuring, assessing, and improving the care and administrative services provided to members. We view this as the responsibility of each area of the company that impacts the dental program. Our efforts are focused on continuous, incremental improvements that lead to optimal outcomes that exemplify a high standard of practice in the community, minimize member and organizational risk, and are cost-effective. By improving the care and services our members receive, we hope to positively influence the dental health and total wellness of our community.

Goals and Objectives:

- Assure member and dentist privacy and confidentiality
- Objectively and systematically monitor and evaluate the quality and appropriateness of care delivered to members in accordance with state and federal regulatory agencies and accrediting bodies
- Provide a mechanism for resolving quality of care concerns
- Ensure that all participating dentists are credentialed and recredentialed within the standards and requirements set forth by state and federal agencies and accrediting organizations

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