



2016 Participating Dental Provider Administrative Manual

It takes a team



**Blue Cross
Blue Shield**
of Rhode Island

PARTICIPATING DENTIST ADMINISTRATIVE MANUAL

TABLE OF CONTENTS

Chapter 1 Introduction	Page 2
Chapter 2 Key Contacts and Resources	Page 4
Chapter 3 Organizational Structure	Page 6
Chapter 4 Dentist Rights and Responsibilities	Page 8
Chapter 5 Benefit Plans	Page 15
Chapter 6 Claims Administration	Page 17
Chapter 7 Quality Management and Improvement	Page 27
Appendices	Page 28

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

Our mission is to provide our members with peace of mind and improved health by representing them in their pursuit of affordable, high-quality healthcare.

Toward that end we shall:

- Make high-quality health 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

The Mouth–Body Connection

At Blue Cross Dental, we recognize the impact that good oral health can have on improving overall health. As our members' health and wellness partner, we offer a variety of information and programs aimed at improving their oral and, ultimately, their systemic health.

Being both a medical and dental carrier puts BCBSRI in an optimal position to implement programs and benefits based on new findings about the mouth-body connection. Our combination of systems and health management expertise allows us to identify, outreach to, and educate members with chronic health conditions about the importance of their oral health to their overall health. We strive to emphasize the tremendous impact that you, a BCBSRI network dentist, have on our members' overall health.

Here are examples of programs we currently have in place that emphasize the mouth-body connection:

- *Cleaning coupon for pregnant members* – In July 2007, BCBSRI introduced the “cleaning coupon,” which provides a complimentary third prophylaxis in a calendar year for any pregnant member with dental coverage through BCBSRI. The coupon must be used during the term of the pregnancy and does not count toward the member's annual dollar maximum. We hope this outreach to qualifying expectant mothers will contribute to reducing the number of premature, low birth weight babies.
- *Diabetes outreach* – In the spring of 2008, we outreached to members with diabetes who had medical and dental coverage through BCBSRI who had not received regular dental care. We educated this group on the importance of a healthy mouth relative to managing their diabetic condition.
- *Coronary Artery Disease (CAD) outreach* – In 2008, in conjunction with our diabetic outreach, we identified medical/dental members who had been diagnosed with CAD but had not seen a dentist for preventive care. We outreached to these members with information regarding the possible link between good oral health and heart disease.

BCBSRI is committed to educating our members achieve optimal health by providing these types of targeted outreach in addition to our comprehensive benefits and wellness programs. By providing outstanding dental care and guidance, you can help lead our members to better oral health, and in turn, better overall health.

CHAPTER 2 – KEY CONTACTS AND RESOURCES

Key Contacts for Dental Offices

Blue Cross Dental 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 offer assistance with issues that require more than a phone call or letter.

*United Concordia Dental (UCD) performs claims processing and customer service functions for Blue Cross Dental. Your patients with Blue Cross Dental 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 Blue Cross Dental members.

For specific inquiries, you can contact one of the following resources directly:

For member eligibility and benefits

- www.unitedconcordia.com
- Blue Cross Dental Provider Call Center
 - (401) 453-4700 or
 - 1-800-831-2400

For Blue Cross Dental specific information and messages

- www.bcbsri.com/providers/dental

For claims inquiries

- www.unitedconcordia.com
- Blue Cross Dental Provider Call Center
 - (401) 453-4700
 - 1-800-831-2400

For policies and procedures, complaints, and grievances

- Blue Cross Dental Provider Call Center
 - (401) 453-4700
 - 1-800-831-2400

PARTICIPATING DENTIST ADMINISTRATIVE MANUAL

For credentialing or recredentialing

- www.bcbsri.com/
- Blue Cross Dental Provider Call Center
 - (401) 453-4700
 - 1-800-831-2400

Hours of Operation

United Concordia

www.unitedconcordia.com is available 24 hours/7 days a week.

Blue Cross Dental Provider Call Center

Monday through Friday,
8:00 a.m. – 8:00 p.m.

Communication Channels

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

Dental CONNECTION is published as important topic areas need to be communicated to our network of dentists. This publication may include:

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 Executive Director of Blue Cross Dental is a dentist who monitors the program. BCBSRI’s Chief Medical Officer and Senior Vice President also maintains oversight of the Dental Program.

Professional Advisory Committees play an important part in our effort to gain input and expertise from our network of practitioners.

BCBSRI Dental Networks

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

BCBSRI-participating dentists may treat patients with Blue Cross and Blue Shield of Massachusetts (BCBSMA) coverage. 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	or	BCBSMA
Provider Claims		Pre-Treatment Estimates
PO Box 986005		PO Box 986005
Boston, MA 02298		Boston, MA 02298

As a participating dentist with BCBSRI, you are part of the BCBSMA network, and agree to accept BCBSRI allowances when treating a BCBSMA member. These patients may be billed for non-covered services, copayments, deductibles, and amounts in excess of any annual/lifetime maximums.

Committees

The Credentials Committee and the Dental Constituency Advisory 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.

Credentials Committee

Purpose – To ensure that all dentists wishing to participate in the BCBSRI network meet specific criteria in accordance with credentialing requirements. Thereafter, our participating dentists are recredentialed every three years.

Composition – The membership includes:

A minimum of five participating community-based practitioners (voting members)

- Executive Director, Blue Cross Dental (non-voting member)
- Associate Chief Medical Officer, BCBSRI (voting member)
- Manager, Health Operations, BCBSRI or designee (non-voting member)

Dental Constituency Advisory Committee (DCAC)

Purpose – To provide valuable input and expertise to Blue Cross Dental from the dentists' perspective. The DCAC is charged with the following responsibilities and purposes:

- 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 BCBSRI dental network)

- Executive Director, Blue Cross Dental
- Dental Program Administrator
- Provider Relations Representative

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

PARTICIPATING DENTIST ADMINISTRATIVE MANUAL

- 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/Blue Cross Dental 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/Blue Cross Dental
- Do not fax documents (except in emergency situations) due to confidentiality and security issues
- Do not submit charges to BCBSRI/Blue Cross Dental 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 Blue Cross Dental 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

It is important that our information on dentists/dental practices is accurate and up-to-date. Therefore, participating dentists are required to inform BCBSRI of any changes affecting member access to care and services. **Please contact us immediately if:**

- **You change your office address**
- **You have a new associate join your practice**
- **A dentist leaves the practice**

Please report changes via email to provdb@bcbsri.org or via fax (401) 459-2099.

Practice Changes to Report

BCBSRI has established standards for geographic access by members to dentists; a relocation may affect member accessibility.

All practice changes should be reported by completing the appropriate forms and sending them to Blue Cross Dental so that the necessary updates can be made. For your convenience, a ***Practitioner Change Form*** and ***Substitute W-9 Form*** are included in Appendix C and are also available on the Provider page under Forms on BCBSRI.com.

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

Requirements¹

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

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.

PARTICIPATING DENTIST ADMINISTRATIVE MANUAL

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

NPI Requirement

As part of the credentialing process, all eligible dentists are required to supply their National Provider Identifier (NPIs). The following information provides background on the NPI requirement, as well as how to obtain one and send it to us.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires the adoption of a standard unique identifier for all healthcare providers. The National Provider Identifier (NPI) Final Rule, issued January 23, 2004, adopted the NPI as that standard. The NPI is a **10-digit numeric identifier** that will be used to replace all previous healthcare provider identifiers.

Every dentist will need an Individual NPI, “NPI-Type 1.” Depending upon your practice structure, you may also need an Organizational NPI, “NPI-Type 2.” If you have individual dentists who are working under one taxable entity (one TIN), each individual practitioner will need an NPI-Type 1, and the taxable entity will require an NPI-Type 2.

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

When completing a claim form:

- *Practice as an individual provider* – You use your **NPI-Type 1** for **both** your “rendering” and “billing” NPI (payment purposes), (Boxes 49 and 54 ADA 2006 Dental Claim Form).
- *Practice with a group of dentists* – Each individual would use an **NPI-Type 1 for “rendering,”** (Box 54 ADA 2006 Dental Claim Form) and the group would use the **NPI-Type 2 for “billing”** (Box 49 ADA 2006 Dental Claim Form).

PARTICIPATING DENTIST ADMINISTRATIVE MANUAL

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 e-mail: customerservice@npienumerator.com

Online: nppes.cms.hhs.gov

By mail: NPI Enumerator, P.O. Box 6059, Fargo, ND 58108-6059

Please send your NPI directly to BCBSRI. Once you receive your NPI(s), please fax the confirmation letter/e-mail you received from NPPES, along with your name, to (401) 459-2099.

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 recredentialled every three years. Approximately six months prior to a dentist's scheduled recredentialing date, we mail, to the dentist, the required recredentialing paperwork. Included in the packet are instructions on how to

PARTICIPATING DENTIST ADMINISTRATIVE MANUAL

complete and submit all of the 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 the 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 on 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 co-insurances are available.

Dental Direct

This comprehensive and voluntary dental plan is available exclusively to Rhode Island residents who do not have other dental coverage. Dental Direct is a unique offering to this population because they are not required to have an association membership, or Blue Cross medical coverage, to be eligible for Dental Direct.

Dental Direct currently offers four different plan designs including coverage for preventive, minor, and major restorative services. There is a 12-month waiting period for major restorative procedures.

If you would like to offer this valuable dental plan directly to your patients who currently have no dental coverage, please contact Blue Cross & Blue Shield of Rhode Island at (401) 459-5550 or 1-855-690-2583. Additionally, you can email us at dentalbrochures@bcsri.org and we will be happy to provide you with a supply of Dental Direct brochures to offer your patients.

BlueCHiP for Medicare

BlueCHiP for Medicare offers retiree group members in Group Preferred and Group Preferred Unlimited preventive and comprehensive dental benefits. Please check individual member benefits for specific coverage information.

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:

PARTICIPATING DENTIST ADMINISTRATIVE MANUAL

- **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.

There is a separate contract for dentists to participate in the FEP.

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

FedVIP

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 "FedVIP Dental." FedVIP uses a nationwide dental network called the National Dental GRID.

The GRID allows members from FedVIP Dental and other Blue Cross plans to get services in the Blue Cross Dental network. Your services are reimbursed at the **Blue Cross Dental of Rhode Island reimbursement levels**.

Claims for FedVIP should be remitted to the address on the member's identification card.

CHAPTER 6 – CLAIMS ADMINISTRATION²

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*, as well as on www.unitedconcordia.com for access 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 as long as 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) as long as 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 particular plan (the BCBSRI fee allowance for each service counts toward this maximum amount), the dentist may bill the patient up to 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 in excess of the annual/lifetime maximums. These are the full responsibility of the member.

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 to employers.

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. If you are registered on unitedconcordia.com, you may also view your EOB under Payments and EOB's after logging on.

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

PARTICIPATING DENTIST ADMINISTRATIVE MANUAL

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 2006 or 2012 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.

PARTICIPATING DENTIST ADMINISTRATIVE MANUAL

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 it 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 time 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

PARTICIPATING DENTIST ADMINISTRATIVE MANUAL

- 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 or not 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 2006 or 2012).
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

PARTICIPATING DENTIST ADMINISTRATIVE MANUAL

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 FedVIP 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.

National Provider Identifier (NPI)

Effective October 1, 2008, all electronic and paper claims (dental and medical) are required to be submitted with the dentist's NPI(s).

Definitions of Provider Identifiers

NPI-Type 1 (Individual) – If you are an individual dentist, you need an NPI-Type 1. Your NPI-Type 1 is not specific to a location or specialty. Regardless of where you perform a service or what type of service it is, as an individual, you will use your NPI-Type 1. An individual dentist who is not part of an incorporated or group practice will *only* use his or her NPI-Type 1 for filing claims. On the ADA 2006 Dental Claim Form, the NPI-Type 1 should be used in both *Billing Dentist or Dental Entity* (Field 49) and the *Rendering/Treating Dentist* (Field 54). A dentist who works in a group or incorporated practice will follow claim filing steps outlined in the NPI-Type 2 (Organizational) section below.

NPI-Type 2 (Organizational) – If you are a practice that provides healthcare services using employees or contractors, you need an NPI-Type 2. The NPI-Type 2 is used by incorporated entities (e.g., group practices, clinics, LLCs, or similar organizations). If you are a dentist practicing in an organization that has an NPI-Type 2, submit your claims using your NPI-Type 1 (individual) in *Rendering/Treating Dentist* (Field 54) on the ADA 2006 Dental Claim Form, and place the organizational NPI-Type 2 in the *Billing Dentist or Dental Entity* (Field 49).

PARTICIPATING DENTIST ADMINISTRATIVE MANUAL

BCBSRI (Legacy) Identifiers – Your NPI(s) replaces all other previously assigned provider identifiers, also known as Legacy numbers (BCBSRI numbers). **BCBSRI no longer accepts any Legacy identifier on claims—medical or dental—submitted electronically or on paper.**

Tax Identification Number – Your NPI, regardless of whether it is an NPI-Type 1 or NPI Type 2, will **not** replace your Tax Identification Number (TIN, EIN, or SSN). The Tax Identification Number will continue to be reported for tax purposes as required.

Drug Enforcement Agency (DEA) Number – Your NPI will **not** replace your DEA number when the number is required to be used for regulatory purposes.

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, in error, overcompensated a provider for services rendered, 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 to 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 Dental Treatment 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 business 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 business days of receipt of all necessary information.

FIRST APPEAL

A dentist and/or subscriber may appeal 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**. Appellants are notified of the Dental Consultant's appeal decision within 15 business days of receipt of all necessary information. If the service(s) is/are approved, you will be notified. If adverse, you will receive notification and have the right to a second internal appeal. (If verbal notice is given to the dentist within the 15 business days, written notice may be given within 21 business days of receipt of all necessary information to conduct the review.) Note: First-level appeal reviews are conducted by a licensed practitioner with the same licensure status as the treating dentist.

SECOND APPEAL

A dentist and/or subscriber may appeal a first-level appeal adverse determination by requesting reconsideration in writing from Blue Cross Dental within 180 calendar days of receipt of the first appeal adverse decision. The request, with any additional clinical documentation, should be sent to: **Dental Appeals, P.O. Box 69420 Harrisburg, PA 17106-9420**. Upon request, at any time prior to the Dental Consultant's final decision on a second-level appeal, the appellant may inspect and add information to the case file. Appellants are notified of the Dental Consultant's appeal decision within 15 business days of receipt of all necessary information. If the service(s) is/are approved, you will be notified. If adverse, you will receive notification and have the right to file for an external appeal. (If verbal notice is given to the dentist within the 15 business days, written notice may be given within 21 business days of receipt of all necessary information to conduct the review.) Note: Second-level appeal reviews are conducted by a licensed practitioner with the same licensure status/specialty as the treating dentist.

EXTERNAL APPEAL

A dentist and/or subscriber may request a review to be conducted by an approved, independent external review organization disputing the outcome of the internal reviews by the Blue Cross Dental Consultants. External review is a voluntary level of review and cannot preclude a member or dentist from filing suit. The appellant must submit a written request, all pertinent clinical documentation, and a check for one-half (50%) of the cost of the external review within 60 days of the second appeal adverse determination. Blue Cross Dental will forward its one-half (50%) of the cost of review and the entire case file to the external review agency within five business days of receipt of the request as described above. The external agency will notify you and Blue Cross Dental of the outcome within 10 business days. Should the

PARTICIPATING DENTIST ADMINISTRATIVE MANUAL

external review result in an overturned decision, you will be reimbursed the other half of the review fee within 60 days of the date of the decision. A check in the amount of \$288.40 (your portion of the review fee) made payable to MAXIMUS Federal Services, Inc. must be included with your request for review.

OTHER RESOURCES

For questions about your rights, this notice, or for assistance, you can contact the State Department of Insurance at (401) 462-9500, or if you receive your insurance through your employer the Employee Benefits Security Administration at 1-866-444-EBSA (3272). Additionally, the Rhode Island Consumer Assistance Program can help you file your appeal. Contact them at 1-855-747-3224.

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 their 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

PARTICIPATING DENTIST ADMINISTRATIVE MANUAL

APPENDICES

- Appendix A** General Policy Guidelines: from the *Blue Cross Dental Treatment Guidelines*
- Appendix B** Dental Plan General Exclusions
- Appendix C** Provider Change Form
- Appendix D** W-9 Form

Appendix A

General Policy Guidelines: from the Blue Cross Dental Treatment Guidelines

This manual contains a general overview of common treatment guidelines. For comprehensive policy guidelines, please visit bcbsri.com/providers/dental. All codes are not covered procedures, and the group account is responsible for choosing the specific benefit coverage.

Definition of Terms

- Denied - Not Covered – Dentist **CAN** bill patient
- Denied - Not Allowed – Dentist **CANNOT** bill patient
- Group Specific – Indicates that the processing policy applied to the specific procedure is determined by the terms of the subscriber’s contract. Limitations specified in the subscriber contract dictate how/if a benefit is covered and paid.

Each section of the Blue Cross Dental Treatment Guidelines contains a “General Policies” description for the procedures in that specific code set. Processing policies and contractual limitations are included in the descriptions, as well as any “bundled” procedures.

Blue Cross Dental recommends a predetermination for treatment plans in excess of \$400. For all dentists, including providers in our Providers Off Review Program, the following procedures are reviewed by the Dental Consultants and require appropriate documentation as listed below:

Implant procedures – Preoperative X-rays (predeterminations) and postoperative X-rays (payment claims)

Unspecified procedures – Detailed narrative; preoperative and/or postoperative X-rays, photos if applicable/available (clinical documentation demonstrating the necessity for the treatment)

Procedures submitted with a “Request for Review” – Preoperative X-rays for major restorative surgery, oral surgery, periodontal surgery procedures; postoperative X-rays for endodontic procedures; narrative for details of any complicated or unusual circumstances related to the service

Submissions for individual consideration (IC) by the Dental Consultant – Detailed narrative; preoperative and/or postoperative X-rays, photos (clinical documentation demonstrating the necessity for the treatment)

All claim submissions are subject to post-payment review. Blue Cross Dental does not conduct random audits of dental offices. However, Blue Cross Dental reserves the right to impose review requirements on a participating dentist if internal audits indicate the need for reviews.

DIAGNOSTIC

Procedure Codes D0100 - D0999

General Policies

Clinical Oral Evaluations

Most groups cover one (1) examination per 12 months and do not include a benefit for an exam performed by a specialist. However, some group contracts may vary and include coverage for any or all of the following:

- Two (2) exams in a calendar year
- Specific coverage for emergency exams (code D0140)
- Exams performed by a specialist

Radiographs/Diagnostic Imaging (Including Interpretation)

A full-mouth series of X-rays (FMX – code D0210) includes ten (10) or more periapical films and a set of bitewing X-rays. Most groups cover a FMX **or** a panoramic film once in 60 months. However, some groups vary in their time limitations for these services, allowing either an FMX **or** panorex once in 24 months, 36 months, etc. The specific subscriber coverage should be checked for the applicable time limitation. In all cases, the need for full mouth radiographs should be determined by the patient's oral condition, rather than the contract benefit.

A maximum of four (4) periapical X-rays are payable in a 12-month period. Most contracts allow for one set of bitewings in a calendar year.

Diagnostic casts are considered part of the comprehensive procedure when performed in conjunction with restorative, prosthetic, or orthodontic treatments.

Documentation Requirements

Generally, there are no clinical documentation requirements for the services in this category. However, we recommend a detailed narrative for any unspecified procedures, complicated or unusual services, or specific circumstances that might impact a payment determination.

PREVENTIVE

Procedure Codes D1110 - D1555

General Policies

Dental Prophylaxis

Most groups cover two (2) dental prophylaxis per 12 months. A patient is considered eligible for a child prophylaxis up to his or her 13th birthday. A prophylaxis is considered integral when performed on the same day, or within 45 days, by the same dentist, as two or more limited sites, or one or more quadrants of scaling and root planing.

Fluoride

Fluoride treatments are paid as a separate procedure, although almost always performed in conjunction with dental prophylaxis. Benefits are contract specific, but most groups allow benefits for one (1) topical fluoride application per 12 months. The benefit is limited to patients under 19 years of age.

Sealants

Benefits for this service are contract specific for sealants on their permanent molars. Benefits for the replacement of sealants have a three-year time limitation.

Space Maintainers

Space maintainers are a covered benefit for patients through age 13. Blue Cross Dental will benefit one (1) re-cementation of a space maintainer in a six-month period, per dentist/dental office for patients through age 13. The removal of a space maintainer will be benefited if the removal is performed by a different dentist/dental office that placed the space maintainer. If performed by the same dentist/dental office than placed the appliance, the patient cannot be charged for the removal. The removal is considered part of the overall procedure in this case.

Documentation Requirements

Generally, there are no clinical documentation requirements for the services in this category. However, we recommend a detailed narrative for any unspecified procedures, complicated or unusual services, or specific circumstances that might impact a payment determination.

RESTORATIVE

Procedure Codes D2000 – D2999

General Policies

Local anesthesia is considered to be part of restorative procedures.

Restorative codes apply to both primary and permanent dentitions.

Tooth preparation, all adhesives (including bonding agents), liners, and bases are included as part of the restoration. If pins are used, they should be reported separately.

Specialized Procedures

Specialized procedures are considered non-covered by Blue Cross Dental and are a patient-pay responsibility. These services are to be performed with the consent of the patient prior to initiation of treatment. Documentation of the patient's acceptance of the treatment plan and payment responsibility is recommended. A porcelain labial margin (porcelain butt joint) is an example of a specialized restorative procedure.

Fillings

Resin-based composite refers to a broad category of materials including, but not limited to, composites. This may include bonded composite, light-cured composite, etc. Tooth preparation, acid etching, adhesives (bonding agents), liners, and bases are included as part of the restoration. Glass ionomers, when used as restoration, should be reported with these codes. If pins are used, they should be reported separately.

Multiple restorations on one tooth will be paid as a single filling. Benefits for the replacement of an existing amalgam/composite restoration are only payable if at least 24 months have passed since the existing amalgam was placed *by the same dentist*.

Benefits for composite resin restorations on bicuspid or molar teeth will be based upon the benefit for the corresponding amalgam restoration with the patient responsible for any difference in cost up to the dentist's charge.

Inlays and Onlays

An inlay is an alternative restoration to a conventional filling to treat carious or fractured areas of a tooth. If a patient elects to have an inlay placed, the patient must understand prior to treatment that the coverage will only pay up to the allowance for an amalgam (posterior teeth) or composite (anterior teeth) and the difference in cost for the inlay will be the patient's responsibility up to the dentist's charge.

Onlays, while a more conservative treatment than a full crown, are most commonly used on posterior teeth. Teeth must meet the criteria for full crown coverage in order to qualify for an onlay and must involve three surfaces. Patients should be advised of the out-of-pocket expense prior to treatment. There is a five-year replacement limitation for

PARTICIPATING DENTIST ADMINISTRATIVE MANUAL

onlays; generally, either benefits for an onlay **or** a crown per tooth are allowed in a five-year period. If an onlay requires replacement with a full crown within the five-year period, Blue Cross Dental will consider payment of the difference between the current allowance for a crown and the amount Blue Cross Dental originally paid for the onlay. The patient is responsible for the difference in payment, up to the dentist's charge.

Crowns

Blue Cross Dental recommends that the most conservative treatment should be attempted to restore a tooth. Crowns are covered when a tooth is decayed or fractured to the degree that an amalgam or composite filling is inadequate to restore the tooth. A tooth must have a sound endodontic and periodontic prognosis to be considered eligible for crown coverage. Cementation/insertion date (delivered to the mouth) is considered the completion date for a crown and benefits are payable for that date of service (not prep date).

There is a five-year time limitation for replacement of a crown and/or other major restorative procedures and are available for members age 14 and older. Models, temporary crowns, and final X-rays are considered part of the overall major restorative procedure.

The benefit for a crown includes preparation, impressions, insertion, and postoperative care. If a crown is placed within 30 days of a filling on the same tooth (same dentist/dental office), the allowance for the filling is considered a core buildup and is deducted from the allowance for the crown.

Recementation of a crown within 12 months of delivery of a crown (same dentist) is considered part of the comprehensive procedure and is "denied – not allowed"; the patient cannot be charged unless there is indication of root canal treatment or accident. It is then covered once per 36 months thereafter.

Generally, crowns are allowed only on permanent teeth. In the case of a retained deciduous tooth, without a permanent successor, consideration for a crown is given if the tooth has sufficient periodontal support. I.C. review by the Dental Consultant is required.

If the loss of tooth structure is due to attrition, erosion, and/or abrasion, a restoration will be denied as a contractual limitation and is not a covered benefit. Placement of a crown on a "peg lateral" is considered cosmetic, and therefore not a covered benefit (unless lateral is fractured or broken down by decay per the guidelines).

Crazed lines do not qualify as a "crack" in a tooth. If a tooth has been diagnosed with "cracked tooth syndrome," appropriate documentation must be submitted to demonstrate that the tooth is symptomatic. (Blue Cross Dental recommends submitting a detailed narrative and/or treatment chart denoting a history of symptoms.)

PARTICIPATING DENTIST ADMINISTRATIVE MANUAL

Temporary Crowns

A temporary crown is considered part of the permanent crown procedure and is not a covered benefit. No additional charge can be made to Blue Cross Dental or to the patient.

Provisional Crowns

If a patient is treated with a temporary crown (or bridge) intended for an extended period of time (i.e., six months or longer), the treatment is considered “provisional.” A provisional crown is not a covered procedure and is a patient responsibility. The procedure is considered “provisional” if the following circumstances exist:

- Patient is undergoing extensive periodontal treatment that will require several months for healing and to measure the success of the treatment
- Patient is having orthodontic treatment in conjunction with crown/bridge procedures
- Patient is undergoing extensive prosthodontic work

Core Build-Ups

A core build-up provides a foundation upon which a crown will be fabricated. A tooth is deemed in need of a core build-up if it requires the replacement of missing tooth structure for the purpose of obtaining adequate resistance and retention for the crown. If the purpose of the restoration involves pulpal insulation, undercut elimination, cast bulk reduction, box formation or concave irregularity in the preparation, or for any other purposes than obtaining adequate retention, the replacement of tooth structure should not be considered a core build-up.

A radiograph that exhibits a large restoration mesial-distal with substantial depth, or a photo displaying a wide restoration with little supporting tooth structure buccal-lingual, validates the need for a core build-up. A build-up in conjunction with an onlay is allowed if deemed necessary based on the criteria.

A core build-up is a benefit once in a five-year period. If, within the five years, the same tooth requires endodontic treatment, the post and core is not covered and is member liability.

Post and Cores

A post and core is used as a foundation to support a crown on an endodontically treated tooth. Post and cores are a benefit once in a five-year period. A cast post and core will be given the alternate benefit of a pre-fabricated post and core. If a tooth is deemed to have a poor endodontic prognosis, (inadequate fill, apical pathology, quality of care issue), the post and core may be denied, and a request made to the dentist to explain the prognosis of the tooth. The tooth may require retreatment, if found to be necessary, prior to payment approval.

If a review is conducted, the following clinical documentation is required:

We recommend a detailed narrative for any unspecified procedures, complicated, or unusual services, or specific circumstances that might impact a payment determination.

Procedures

Documentation recommended for crowns, onlays, core build-ups, and post and cores include:

- Current preoperative periapical X-ray of diagnostic quality
- If tooth has undergone endodontic treatment, the X-ray must be an endo postoperative film showing the entire tooth, including the apex
- A detailed narrative is recommended for complicated or unusual circumstances, or instances where the problem with the tooth is not indicated by the X-ray, (e.g., cracked tooth syndrome)
- Date of prior placement, when applicable

If a claim is submitted for a specialized procedure, please include the following as a separate line item on the claim:

- The applicable service code, or the applicable “unspecified” code (e.g., 2999, 5999, 7999)
- The description of the service (e.g., porcelain butt joint)
- The charge for the specialized procedure

ENDODONTICS

Procedure Codes D3000 – D3999

General Policies

Local anesthesia is considered to be part of endodontic procedures.

Specialized Procedures

Specialized procedures are considered non-covered by Blue Cross Dental and are a patient-pay responsibility. These services are to be performed with the consent of the patient prior to initiation of treatment. Documentation of the patient’s acceptance of the treatment plan and payment responsibility is recommended.

Pulp Capping

Pulp caps are considered part of a final restoration and are not separately billable.

Pulpotomy

Therapeutic pulpotomy is performed on primary or permanent teeth with the goal to maintain the vitality of the tooth. This procedure involves the removal of pulp tissues from the chamber/coronal area, with no instrumentation of the canals, and is a very effective measure in relieving pain. While the intention is to maintain the vitality of the tooth, a root canal may be required at a later date. Pulpotomy is not covered on permanent teeth unless there is an indication of an emergency, in which case it will be paid as palliative treatment. Pulpotomies performed on the same day as primary root canal treatment are considered part of the root canal procedure.

PARTICIPATING DENTIST ADMINISTRATIVE MANUAL

Pulpal debridement is performed to relieve acute pain prior to conventional root canal therapy. If performed on the same date of service as a root canal or palliative treatment on the same tooth by the same dentist/dental office, it is considered part of the root canal procedure.

Root Canal Therapy

Root canals are limited to one per tooth per lifetime, unless a retreatment is required and performed by a different dentist within five years. When the same dentist performs a retreatment within 12 months, the procedure will be subject to a dental consultant review, regardless of participating status.

If palliative treatment or a pulpotomy is performed within three months of the root canal by the same dentist/dental office, allowances made for the services are deducted from the allowance for the root canal. If a root canal is performed to accommodate an overdenture, it is considered a noncovered procedure.

Root canal therapy benefits include ancillary clinical procedures, including palliative treatment, pulp testing, pulpotomy, X-rays related to the treatment, local anesthetic, completion of the endodontic fill, and routine follow-up care. The final restoration is a separate benefit.

The periodontal prognosis of a tooth should be considered prior to performing a root canal. The Dental Consultant will review the overall prognosis of the tooth.

Treatment of root canal obstruction is considered a component of the root canal therapy in most cases. The exception is when the removal the obstruction is the only procedure performed (e.g., specialist removing object for the general dentist).

Internal root repair of perforation defects that occur during an attempted root canal, or are an operator error, are considered part of the comprehensive procedure performed. However, a natural resorptive defect addressed with a recalcification treatment, may be considered a separate, definitive treatment.

Apexification is performed on immature permanent teeth for members under the age of 15 to induce closure or further development of the root. Apicoectomies and retrograde treatments should exhibit similar healing to a standard root canal. Periapical lesions (even large ones) should be expected to heal within 6 to 12 months, if not sooner. Minimal scar tissue is usually present. Apicoectomies will not be allowed within 30 days following root canal treatment. Payment is based on the number of roots per tooth and are not eligible on anterior teeth. Apical curettage is considered integral to the apicoectomy procedure.

Root Amputations

Root amputations are performed to preserve a multi-rooted tooth that has an untreatable defect on one of the roots. Benefits include all preoperative and postoperative care, local anesthesia, and X-rays for permanent, posterior teeth. Limited to one root amputation per

tooth. If a root amputation is performed on the same day as a hemisection, it is considered part of the hemisection procedure.

Hemisection

Hemisections are performed on permanent posterior teeth (multi-rooted) only to preserve part of a tooth that has untreatable periodontal lesions. With the prevalence of implants in current dentistry, this procedure is performed less frequently. Limited to once per tooth. Prosthodontics to replace the missing portion of the tooth are not covered.

If a review is conducted, the following clinical documentation is required:

We recommend a detailed narrative for any unspecified procedures, complicated or unusual services, or specific circumstances that might impact a payment determination.

Procedures:

Documentation recommended for root canals, endodontic retreatments, apicoectomies, apexification, root amputations, and hemisections include:

- Current preoperative and postoperative periapical X-ray of diagnostic quality
- If tooth has undergone endodontic treatment, the X-ray must be an endo postoperative film showing the entire tooth, including the apex

PERIODONTICS

Procedure Codes D4000 - D4999

General Policies

Local anesthesia is considered to be part of the periodontal procedures.

Surgical services include routine postoperative care.

Gingivectomy

One treatment per site/area in a 36-month period is covered. If performed within three years of (same treatment site) as guided tissue regeneration, scaling and root planing, osseous surgery, or flap surgery, no separate allowance will be made. Claim will be denied if gingivectomy is performed on the same date of service (same treatment site) as extraction, surgical endodontic or periodontal procedures or oral surgical procedures and the dentist cannot charge the patient for the difference.

Periodontal Scaling and Root Planing

Periodontal scaling and root planing are covered once per quadrant in a 36-month period. When performed within 45 days of a prophylaxis, the prophylaxis will be considered integral. When performed on the same date of service as a periodontal surgical procedure (e.g., osseous surgery, flap surgery), periodontal scaling and root planing will be considered part of the more comprehensive procedure and are not paid separately and cannot be charged to the patient.

PARTICIPATING DENTIST ADMINISTRATIVE MANUAL

Periodontal Maintenance

At least one of the following procedures must be in patient's history to qualify for periodontal maintenance: osseous surgery, gingivectomy/gingivoplasty by quadrant, flap procedures, tissue grafts, root planing and scaling. Periodontal maintenance will be considered integral to scaling and root planing or surgical periodontal procedures on same day, same dentist.

Flap Procedures

Flap procedures are covered once per quadrant in a 36-month period. When performed within three years in the same treatment site as surgical periodontal procedures or scaling and root planing, flap procedures will not be covered.

Tissue Grafts

Tissue grafts in the same treatment site are covered once in a 36-month period.

If a review is conducted, the following clinical documentation is required:

We recommend a detailed narrative for any unspecified procedures, complicated or unusual services, or specific circumstances that might impact a payment determination.

Periodontal charting is required clinical documentation for many periodontal services.

The following constitutes acceptable periodontal charting for reviews:

- Current charting (documented not more than one year prior to the date of service of the treatment or predetermination submission date)
- Date of charting and name of patient on the periodontal chart/form
- Pocket depths of 4mm (or more) recorded for each tooth
- Six pocket depths per tooth

Documentation Required for Procedures

Gingivectomy (4 or more teeth per quad) – Periodontal charting, narrative

Crown lengthening – Periodontal charting and preoperative X-ray

Flap and osseous surgeries – Periodontal charting and X-rays of the treatment area; narrative for complicated services

Periodontal scaling and root planing – Periodontal charting

Guided tissue regeneration and surgical revision – Periodontal charting and narrative

Soft tissue grafts – Amount (mm) of attached gingival present at treatment site(s)

Periodontal maintenance – Documentation of previous surgical periodontal procedures and/or previous periodontal maintenance services

PROSTHODONTICS (removable)

Procedure Codes D5000 - D5899

General Policies

Specialized Procedures

Specialized procedures are considered non-covered by Blue Cross Dental and are a patient-pay responsibility. These services are to be performed with the consent of the patient prior to initiation of treatment. Documentation of the patient's acceptance of the treatment plan and payment responsibility is recommended.

Dentures (Complete & Partial)

Benefits for complete or partial dentures include adjustments, reline/rebase, or repair for six months following delivery of the denture to the patient, and are limited to one denture (partial or full) per arch in a five-year period.

Dentures (Immediate)

Benefits for immediate dentures include limited post-delivery care. Reline/rebase of the immediate denture is a benefit (after healing has occurred). Benefits are limited to a complete or an immediate denture, per arch, in a five-year period.

Overdentures

Overdentures are limited to one per arch, per five-year period.

Adjustments and Repairs

Adjustments and repairs to complete/partial dentures within six months of delivery are considered part of the initial placement and not billable to the patient. After the six-month period, one adjustment or repair, per arch, will be allowed per 36 months.

The Replacement of all teeth and acrylic on a cast base is limited to once per five-year period. Payment for this service or another denture within five years precludes payment for replacement of all teeth.

If a review is conducted, the following clinical documentation is required:

We recommend a detailed narrative for any unspecified procedures, complicated or unusual services, or specific circumstances that might impact a payment determination.

IMPLANT SERVICES

Procedure Codes D6000 – D6199

General Policies

Implant services are not a covered benefit unless specified in the group contract.

If a group purchases an Implant Rider, there is a \$3,500 lifetime maximum benefit for implant services. Services are subject to Dental Consultant review for all dentists.

Plans with prosthodontic coverage may include benefits for single-tooth implants only. These benefits are allowed in cases where only one natural tooth requires replacement and is an alternative treatment plan to a three-unit bridge.

Crowns over implants are covered if the contract includes prosthodontic coverage and should be submitted with the appropriate implant crown code(s) (e.g., D6058, D6059).

For implant reviews, the following clinical documentation is required:

Predeterminations – Preoperative X-ray demonstrating periodontal condition of the treatment site; narrative if bone graft is required and planned treatment.

Claims for payment – Postoperative X-ray demonstrating successful placement of the implant; narrative if there are any special circumstances related to the service.

PROSTHODONTICS (fixed)

Procedure Codes D6200 – D6999

General Policies

Prosthodontics are covered if specified in the group contract.

No replacement of teeth beyond the normal complement of teeth is allowed. Benefits for a fixed bridge are applicable in one calendar year, individual units of the bridge may not cross over multiple calendar years and are payable upon insertion/delivery of the fixed bridge.

Criteria for an abutment includes having a healthy periodontal and endodontic prognosis. A bridge, and each unit of the bridge, has a five-year limitation for replacement.

Recementation of a bridge is a covered benefit if performed more than 12 months after the insertion date (by the same dentist) unless there is indication of root canal treatment or an accident. Thereafter, it is covered once per 36 months.

If a review is conducted, the following clinical documentation is required:

Preoperative periapical X-rays of the entire treatment site and a detailed narrative, if there are any special circumstances related to the service.

ORAL AND MAXILLOFACIAL SURGERY

Procedure Codes D7000 – D7999

General Policies

Surgical extractions and removal of impacted teeth are benefits based upon the anatomical positioning of the treatment site. Placing a suture at the extraction site is not, in itself, indicative of a surgical extraction. Our guidelines for each specific extraction/impaction procedure code are in accordance with the CDT descriptors.

One hour of general anesthesia and IV sedation is a covered benefit with specified oral surgery

procedures. Local anesthesia, elevation of the flap, bone removal, sectioning of tooth, removal of the tooth structure, closure and suturing (if required), suture removal, and routine postoperative care are included in the surgical extraction or removal of an impacted tooth. Treatment for dry sockets is considered postoperative care and is included in the fee for the surgical procedure.

Third molar partial and complete bony impaction removal is not routinely covered for members under the age of 15 or over 30. Should special consideration be requested, radiographs and rationale/symptoms are required for review.

If an attempt to extract a tooth fails, it is not considered a completed procedure and should not be submitted for benefits. The entire tooth must be extracted to be considered for benefits.

Removal of residual roots (root is encased in bone) requires incision of the gingiva and bone, and is most often the result of trauma or extensive caries. If this procedure is performed by the same dentist who extracted the tooth, it is considered part of the extraction.

If a review is conducted, the following clinical documentation is required:

Preoperative periapical X-rays of the entire treatment site and a detailed narrative if there are any special circumstances related to the service.

ORTHODONTICS

Procedure Codes D8000 – D8999

General Policies

Dependents up to the age of 19 are eligible for orthodontic benefits if the specific contract includes orthodontic coverage. Coverage continues until December 31st in the year of the member's 19th birthday, and is subject to a separate lifetime orthodontic maximum allowance. Adult orthodontic coverage is available, but is group specific and not part of the common orthodontic benefits.

Our payments end when the benefit is exhausted, the dentist notifies BCBSRI that treatment has been terminated, or another event occurs that terminates payment (e.g., change in benefit, member eligibility)

In cases of a member becoming active with Blue Cross Dental during orthodontic treatment without previous coverage, the payments are calculated as follows:

- Benefits are based on the calculation for the remainder of the months in the treatment plan
- The months of treatment prior to the member's effective date are not covered

If a member has started orthodontic treatment with coverage by another carrier and the group is acquired by BCBSRI, the benefit maximum for orthodontic services is usually carried over from the previous insurer. *Example:* Previous insurer has paid \$900 towards orthodontic services, and BCBSRI has a lifetime maximum limit for orthodontics of \$1,200. BCBSRI will pay an additional \$300 towards the orthodontic treatment.

The fee for orthodontic treatment includes the diagnostic procedures, appliances, and post-treatment stabilization. If diagnostic procedures are performed with the intention of undergoing orthodontic treatment, the procedures (exam, panorex, cephalometric film, diagnostic casts, photographs, etc.) are included in the orthodontic fees. If, after the diagnostic procedures are performed, the member chooses to forego orthodontic treatment, benefits will be paid in accordance with the member's specific contract limitations.

Orthodontics covered as part of qualified Affordable Care Act plans are subject to medical necessity guidelines.

Services will not be covered when the dentition contains any more primary teeth than the primary second molars.

In addition: One of the following criteria must be met for services to be covered under this benefit:

- Maxillary/Mandibular incisor relationship: Overjet of 9 mm or more with impingement where the lower incisors are impinging the palate.

PARTICIPATING DENTIST ADMINISTRATIVE MANUAL

- Anterior crossbite equal to or greater than 5mm (short term, interceptive therapy covered only)
- Anterior open bite (canine to canine)
- More than one impacted permanent tooth when the dentition contains no more primary teeth than the primary second molars
- Posterior-unilateral crossbite involving three or more adjacent, permanent teeth, one of which must be a molar (no eruption/dentition requirements for this qualifier)
- Cleft palate deformities submitted by the surgical team
- Treatment for skeletal deformities will be considered on an individual basis and must be submitted by the surgical team

Required Documentation for review:

- Extra-oral photos – including frontal and profile
- 5 Intra-oral photos – R/L buccal, U/L occlusal, and front incisor view
- Panoramic film
- Lateral cephalometric film
- Frontal cephalometric film (for surgical cases)
- Consultation report with diagnosis and treatment plan

ADJUNCTIVE GENERAL SERVICES

Procedure Codes D9000 – D9999

General Policies

Palliative treatment is considered a separate procedure for the treatment of dental pain when no other definitive treatment is rendered to the treatment site. It is commonly used for examination and diagnosis on an emergency basis.

Local anesthesia is considered part of dental procedures. Benefits for sedation and general anesthesia are allowed only when rendered in conjunction with specific oral surgical procedures.

Analgesia (nitrous oxide) is not a covered benefit and is billable to the patient, up to the dentist's charge.

Appendix B

Dental Plan General Exclusions

Unless specified in the member's contract, the following are not covered:

- A service for which a charge would not have been made in the absence of dental insurance
- Services rendered by someone other than a licensed dentist or licensed dental hygienist operating within applicable laws and regulations
- Dental procedures that are not dentally necessary or do not meet the standards for quality care in accordance with the *Blue Cross Dental Treatment Guidelines*
- Dental procedures that are not listed as covered services
- Services performed primarily for cosmetic purposes
- A procedure, service, supply, or appliance provided to increase vertical dimension of the teeth or restore occlusion
- Restorations required due to attrition, abrasion, or erosion
- Treatment of temporomandibular joint (TMJ) disorders, including diagnosis, appliances, or surgical intervention
- Occlusal guards, athletic mouthguards
- Infection control, personal supplies (including toothbrushes, floss, etc.), oral hygiene instruction
- Administrative charges for broken appointments, completion of claim forms, reproduction or copies of treatment records, or professional advice over the telephone/Internet
- Replacement of lost or stolen appliances
- General anesthesia and intravenous sedation, unless rendered in conjunction with specified covered oral surgical procedures or if administered by anyone other than a licensed dentist
- Temporary or provisional procedures
- Bone grafts (per contract)
- Prescription drugs
- Services rendered prior to the effective date of the subscriber agreement
- Splinting and other stabilization treatments
- Services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trustee, or similar group or person
- Exams performed by a specialist; consultations (per contract)
- Charges made by a hospital, ambulatory surgical center, or similar facility
- Services related to occupational injury
- If more than one dentist is involved in a single procedure, Blue Cross Dental will not be responsible for more than the allowance made for the treatment when performed by one dentist
- Procedures or services considered experimental and/or investigational, or research studies related to dental treatments

PARTICIPATING DENTIST ADMINISTRATIVE MANUAL

- Dental services rendered after a patient has exceeded any contractual limitations, (e.g., annual/lifetime maximum, frequency limitations on specific procedures), or for services that are denied/reduced in accordance with processing policies or Dental Consultant review
- Any services provided by a person who is a member of your household or the cost of any care provided by one of your relatives (by blood, marriage, or adoption)

Waiting Periods

Some dental plans impose a “waiting period,” requiring members to wait for a certain time period for specific procedures to be performed. Waiting periods are noted with the member’s benefits.

Appendix C



Practitioner Change Form

DIRECTIONS: Please check all that apply and fill in sections as directed.

Tax ID Change – Complete Sections 1 and 2. **Attach a completed W-9 form.**

Change in Practice Information

- **Mailing and/or payment address for existing office** – Complete Sections 1 and 2.
- **Closing existing site, opening new site or joining existing practice** – Complete Sections 1, 2, 3A, and 3B.
- **Change in office hours, covering physicians and accepting/not accepting new patients** – Complete Sections 1, 3A, and 3B.

NOTE: If you are adding a new practice location in another state, please provide us with a copy of your license and federal DEA to practice in that state.

When completed, please fax the required documentation to (401) 459-1774 or (401) 459-2099, or mail it to:

Provider Information Management and Operations
 Blue Cross & Blue Shield of Rhode Island
 500 Exchange Street, Providence, RI 02903

If you have any questions regarding this form, please call The Physician and Provider Service Center at (401) 274-4848 or 1-800-230-9050.

Section 1 – General Information

Practitioner name: _____ Date: _____

Degree: _____ Date of birth: _____

Name and title of person completing form: _____

E-mail address: _____ Phone number: _____

National Provider Identifier(s)

NPI Type 1: _____ Tax ID number: _____

NPI Type 2: _____ Tax ID number: _____

Primary specialty: _____

Secondary specialty: _____

Do you speak a foreign language fluently? Yes No

Please list all languages spoken: _____

Description of requested change: _____

Section 2 – Mailing and/or Payment Address Change

New Mailing Address

Effective date of change: _____

Street: _____

City: _____ State: _____ ZIP: _____

Old Mailing Address

Street: _____ Phone: _____ Fax: _____

City: _____ State: _____ ZIP: _____

New Payment Address

Effective date of change: _____

Street: _____

City: _____ State: _____ ZIP: _____

Old Payment Address

Street: _____ Phone: _____ Fax: _____

City: _____ State: _____ ZIP: _____

PARTICIPATING DENTIST ADMINISTRATIVE MANUAL

Section 3A – Change in Practice Information

IMPORTANT: Please attach W-9 form

A CLOSING / ADDING ADDITIONAL SITES

If this information requires a change in your practice(s) hours, covering physicians, and whether you are accepting/not accepting new patients, please also complete Section 3B on the next page.

Old Office

Name of Group/Clinic: _____
 Name of Group/Clinic Manager: _____
 Street: _____
 City: _____ State: _____ ZIP: _____
 Phone: (____) _____
 Business E-mail: _____
 Date practice closed (if applicable): _____

New Office #1 (Primary Office)

Effective date of change: _____
 Name of Group/Clinic: _____
 Name of Group/Clinic Manager: _____
 Street: _____
 City: _____ State: _____ ZIP: _____
 Phone: (____) _____
 Fax (____) _____
 Business E-mail: _____
Payment Address
 Street: _____
 City: _____ State: _____ ZIP: _____
 Phone: (____) _____
 Fax (____) _____
 Tax ID Number: _____ - _____ - _____
 Type 2 NPI: _____

Mailing Address

Street: _____
 City: _____ State: _____ ZIP: _____

Is this office handicapped accessible? Yes No
Is it equipped with TDD equipment for the hearing impaired? Yes No
Do any of your staff members speak a foreign language fluently? Yes No
 Please list all languages spoken: _____

COMMENTS _____

New Office #2

Effective date of change: _____
 Name of Group/Clinic: _____
 Name of Group/Clinic Manager: _____
 Street: _____
 City: _____ State: _____ ZIP: _____
 Phone: (____) _____
 Fax (____) _____
 Business E-mail: _____
Payment Address Same as Primary Office Information
 Street: _____
 City: _____ State: _____ ZIP: _____
 Phone: (____) _____
 Fax (____) _____
 Tax ID Number: _____ - _____ - _____
 Type 2 NPI: _____

Mailing Address

Street: _____
 City: _____ State: _____ ZIP: _____

Is this office handicapped accessible? Yes No
Is it equipped with TDD equipment for the hearing impaired? Yes No
Do any of your staff members speak a foreign language fluently? Yes No
 Please list all languages spoken: _____

New Office #3

Effective date of change: _____
 Name of Group/Clinic: _____
 Name of Group/Clinic Manager: _____
 Street: _____
 City: _____ State: _____ ZIP: _____
 Phone: (____) _____
 Fax (____) _____
 Business E-mail: _____
Payment Address Same as Primary Office Information
 Street: _____
 City: _____ State: _____ ZIP: _____
 Phone: (____) _____
 Fax (____) _____
 Tax ID Number: _____ - _____ - _____
 Type 2 NPI: _____

Mailing Address

Street: _____
 City: _____ State: _____ ZIP: _____

Is this office handicapped accessible? Yes No
Is it equipped with TDD equipment for the hearing impaired? Yes No
Do any of your staff members speak a foreign language fluently? Yes No
 Please list all languages spoken: _____

PARTICIPATING DENTIST ADMINISTRATIVE MANUAL

Section 3B – Change in Practice Information

B GENERAL INFORMATION

Practice Information

What is the average waiting time to obtain an appointment? (Please respond with a specific waiting time. "PRN" is not acceptable.)

Initial visits will be provided within _____ weeks.

Symptomatic/non-urgent visits will be provided within _____ weeks.

Urgent visits will be provided within _____ hours.

Are you accepting new patients? Yes No

Which age groups do you treat? All ages 0-13 years 14-18 years 19-65 years 65+ years

New Office Hours Please indicate office hours at each location. (e.g., 9:00 a.m. – 5:00 p.m.)

Location	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Office #1							
Office #2							
Office #3							

Changes in Covering Physicians/Associates

Please list current partners/associates in your practice and physicians/providers who cover for you, with their respective specialties.

If more than four practitioners, please use additional sheets.

Collaborative agreements and requirements are required for nurse practitioners, physician's assistants, nurse midwives, and clinical nurse specialists with prescriptive privileges.

NAME	DEGREE	SPECIALTY	PARTNER	COVERING	BOTH
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are you available, or do you have available coverage, 24 hours per day, seven days per week? Yes No

How do you provide this coverage? (Please check)

- Answering Service Answering machine (with pager or call phone number)
 Call Forwarding Cell Phone Home Phone

Appendix D

Substitute Form W-9

Request for Taxpayer Identification Number and Certification

Federal regulations require BCBSRI to obtain and report accurate Taxpayer Identification Numbers (TIN) on payees of certain types of payment we make. This information is reported each year to the Internal Revenue Service on Form 1099. If you do not provide us with this information, your payments may be subject to 28% federal income tax backup withholding. Failure to furnish your correct TIN to us may also be subject to a \$50 penalty imposed by the Internal Revenue Service under Section 6723.

Please provide the information requested on the bottom of this form and return it to us within 30 days in the enclosed envelope. Enter your TIN in the appropriate box. The TIN provided must match the name given on Part I to avoid backup withholding.

If Applicable, Name of Practitioner: _____

PART I - TAXPAYER IDENTIFICATION NUMBER (TIN)

Social Security Number - -
OR
Employer Identification Number -

TYPE OF TAXPAYER (Check appropriate box)

<input type="checkbox"/>	Individual / Sole Proprietor. (Please provide S.S.N.)
<input type="checkbox"/>	Corporation
<input type="checkbox"/>	Partnership
<input type="checkbox"/>	Limited Liability Company. Enter tax classification _____
<input type="checkbox"/>	Other (Specify) _____
<input type="checkbox"/>	Exempt payee

NAME/ADDRESS: (Please print or type.)

Name (as shown on your income tax return)		
Business Name (if different from above)		
Address (number, street, apt. or suite no.)		
City	State	Zip Code (9 digit)

PART II - CERTIFICATION

- I certify under penalty of perjury that:
- 1 The Tax Identification Number I have provided is correct.
 - 2 I am not subject to backup withholding.
 - 3 I am a U.S. person (including a U.S. resident alien).

Person completing this form/Title (Please print)	Date
Tax correspondence address:	Telephone No. () -
City	State Zip Code

Form W-9 (Rev. January 2012)

500 Exchange Street Providence, RI 02903-3279

Requiere un equipo  **Blue Cross
Blue Shield**
of Rhode Island

500 Exchange Street • Providence, RI 02903-2699

Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

04/16 BCD-46252