Blue Impressions [STAY CONNECTED]

CareFirst Family of health care plans

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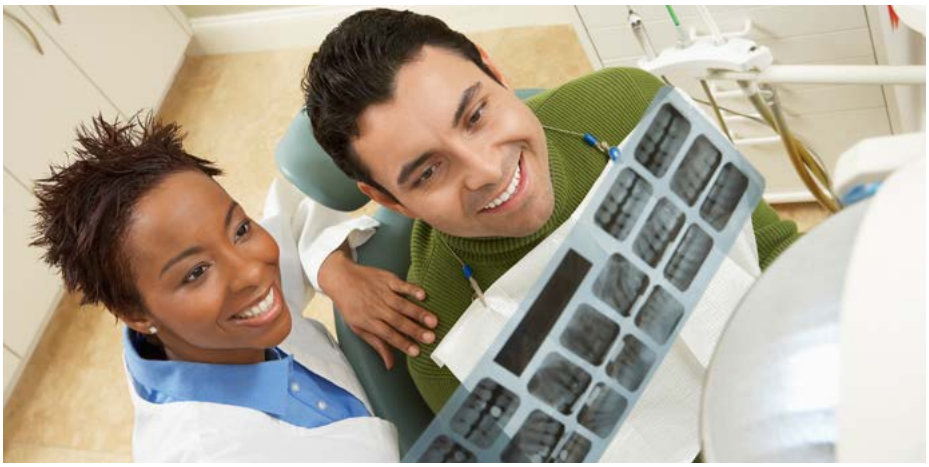

Federal Employee Program Benefits Update for 2016

Dental providers who participate in the Federal Employee Program (FEP) Preferred Provider Organization (PPO) network and who see members holding FEP medical coverage will experience changes in coverage plans for 2016, including:

- Under the Basic Option: A higher member copay ($30 instead of $25). FEP Dental Benefit Copay information is available in this chart.
- Under the Standard and Basic Options: The addition of a new coverage option for policyholders, as indicated by new enrollment codes:

ENROLLMENT TYPE	STANDARD BENEFIT OPTION	BASIC BENEFIT OPTION
Self Only	104	111
Self and Family	105	112
Self plus One	106	113

- Under the Standard and Basic Options: Coverage for dental benefits is now limited to coverage for clinical oral evaluations, limited diagnostic imaging, palliative treatment and preventive procedures. All services not listed in the member's schedule of benefits are not covered and, therefore, are billable to the member.

Please contact FEP Customer Service with any questions.

FEP members enrolled in *both* medical coverage and the FEP BlueDental plan should always consider their medical coverage primary. Claims for members who enroll in both the FEP Service Benefit Medical Plan and FEP BlueDental should always be sent to the FEP Service Benefit medical plan first, for primary consideration, and are automatically routed to FEP BlueDental for secondary coverage consideration.

Holiday Closings

CareFirst BlueCross BlueShield, CareFirst BlueChoice and The Dental Network will be closed on the following date:

- Monday, May 30 – Memorial Day

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WHAT'S HAPPENING

Affordable Care Act Plans: Pediatric Orthodontic Case Submission: Tips for Success

The pediatric dental orthodontic benefit within Affordable Care Act (ACA) plans requires pre-authorization for medical necessity. Often, incorrect submission of pediatric orthodontic cases results in delay or return of claims. To help successfully submit your cases for review, keep the following information in mind:

- Orthodontic cases are considered on a Pre-Treatment Estimate (PTE) basis only; starting a case before obtaining pre-authorization will result in an automatic denial. The only exceptions to this rule will pertain to transfers and continuation of care cases, which require original records or prior Medicaid approval form and date of banding as documentation of prior benefit authorization.
- Always verify a member's eligibility prior to taking records and requesting pre-authorization. Lack of active coverage eligibility will also prevent reimbursement for records.
- Only comprehensive cases are covered (Current Dental Terminology (CDT) D8070, D8080, D8090).
- Limited (CDT D8010 – D8040), interceptive (CDT D8050 – D8060) and minor treatment (CDT D8210 – D8220) cases are not covered.
- Pediatric benefits discontinue at the end of the calendar year of the patient's 19th birthday.
- Submit all required case records with a completed American Dental Association claim form with the procedure code and the number of months in treatment (transfer and continuation cases). Check the box for dentist's PTE and leave the date of service blank.
- The following documentation must be submitted with the pre-authorization request: panoramic images, diagnostic study models (trimmed) with wax bites or digital models, cephalometric images with measurements, intra- and extra-oral, photos and clinical summary with diagnosis and treatment plan, and the scoring tool required by your state. Maryland and the District of Columbia use the Handicapping Labio-Lingual Deviation Index; Virginia uses the Salzmann Index. These forms can be downloaded at www.carefirst.com/providerforms, under Dental.
- Label any stone models with patient name, office name and impression date, and package the models so that they do not break in transit.
- Electronic (digital) records may be provided in lieu of paper. For information on submitting electronic records, visit www.carefirst.com/dentaledi.

Requests for ACA plan pre-authorization for comprehensive pediatric orthodontic services should be mailed to:

Dental Director Orthodontic Review
CareFirst BlueCross BlueShield
1501 S. Clinton St. Mail Stop: CT09-09
Baltimore, MD 21224

CareFirst Selected to Provide Montgomery County Public Schools Employee Dental Coverage

CareFirst was selected to provide dental Preferred Provider Organization coverage for Montgomery County Public Schools active and retired personnel, effective Jan. 1.

If your office has any questions about patient eligibility, claim status or benefits, our Customer Care Tools (CareFirst Direct and CareFirst on Call) are great resources for you and your staff.

WHAT'S HAPPENING

Federal Employee Program Maximum Allowable Charge to include Current Dental Terminology Changes for 2016

Effective Jan. 1, the Federal Employee Program updated their Maximum Allowable Charge (MAC) schedule to include Current Dental Terminology changes made to the Diagnostic Image Capture with Interpretation – extra-oral. FEP will release payment to you for *each* extra-oral image provided under the Standard Option at either $16 or $10 (depending on patient age). You will collect payment from your patients as indicated on this chart.

IN CASE YOU MISSED IT

In Case You Missed It

Are you receiving email updates from CareFirst? Hopefully, you are.

We send news about your participation with CareFirst, upcoming events and other updates. In case you missed it, click on the icon to check it out.

If you or others in your practice aren't receiving email updates from CareFirst, register to receive them now at www.carefirst.com/stayconnected. Remember to select "Dental" as your area of practice.

Stay Connected

How Are We Doing?

Your feedback is requested. Tell us what you liked about this issue – or offer a suggestion for something we could do better. You can reach us at newsletter.editor@carefirst.com.

CLAIMS AND BILLING

Completion (Delivery) Dates to be used for Claims Processing

We understand that you may experience cases where multiple visits are necessary in order to complete certain procedures. In these cases, **CareFirst provides the benefits available under the member's contract only upon completion of treatment**. Dental procedures that require multiple visits (crowns, fixed and removable dentures, etc.) should be billed at the completion of the service or delivery of the prosthetic device. For crown restorations, the completion date is cementation or seat date.

Reminder: How to Use Pre-Treatment Estimates and Estimates of Eligible Benefits Correctly

- A Pre-Treatment Estimate (PTE) or Estimate of Eligible Benefits (EEB) is always recommended for high cost, complex procedures such as implants, fixed prostheses and periodontal surgeries.
- If you have a PTE/EEB in your possession, you should not submit a new claim form with the EEB or in place of the EEB unless the treatment plan has changed.
- Date the completed procedures listed on the EEB and sign the EEB form, then submit it to CareFirst for payment.
- PTE/EEB submissions or requests are reviewed and a decision is made within two days of receipt, provided the request is accompanied by the required clinical documentation. Usually, the PTE/EEB is processed within 10 - 15 days of the review decision.
  - Sending duplicate EEBs, or submitting a claim with the dated and signed EEB or a new claim form with the same services will significantly delay processing your requests and may trigger a repeat and unnecessary request for information and review.
- The EEB/PTE is valid for 180 days.

CLAIMS AND BILLING

When Are Dental Services Covered Under Medical Plans?

Generally, dental services are not covered under medical plans. Coverage may vary based upon the medical plan's specific contract language regarding exceptions, services covered and exclusions.

Three examples of situations where dental may be covered are outlined below.

Accidental Injury

Dental services may be covered when both:

- The injury is caused by an external force such as blunt trauma due to a fall or sports accident. (Breaking a tooth while biting or chewing is not a covered dental expense under medical plans.)
- The tooth or teeth injured in the accident are sound natural teeth. A sound natural tooth is one that has no evidence of prior or current disease or injury including periodontal disease, prior endodontic treatment, prior major restoration (crown, bridge). A tooth with a conservative amalgam or composite-resin filling absent recurrent caries is considered a sound natural tooth.

Implants and orthodontics are listed under the medical exclusions, with very limited exceptions. Generally, treatment must commence within six months of an accidental injury for medical benefit consideration.

When billing the patient's medical plan for dental services, you can expect to provide the following documentation:

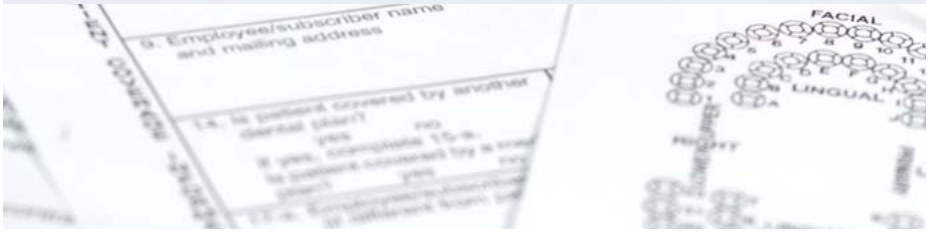
- Pre-accident dental records,
- Date of accidental injury,
- Emergency room report,
- Police report,
- Current records including letter of medical necessity, progress notes, treatment plan, diagnostic imaging, and
- Other records that may be required depending upon the nature of the claim.

Radical Surgery, Radiation Therapy

Dental services may also be eligible for medical benefit consideration when teeth are removed due to involvement within a tumor and included in the excision of the tumor (i.e. squamous cell carcinoma). Additionally, radiation therapy to the neck or jaw that causes dental complications may be considered for dental medical benefits.

Cleft Palate

Cleft palate repair and rehabilitation cases are generally eligible for medically necessary surgical and dental benefits, including orthodontics and implants.



CODING CORNER

Coding Corner

D7953 bone replacement graft for ridge preservation: Routine grafting of extraction sites (D7953 with or without D4266, D4267) is considered not medically necessary by CareFirst. Grafting of extraction sites will be considered, however, for benefit allowance when the buccal or lingual alveolar plate is fractured; there is a significant amount of bone destruction at the site due to cyst or abscess (>0.5cm) or other reason removal of the specific tooth is expected to result in a significant defect or fenestration which is not expected to heal without the graft or will heal leaving a major defect in the jaw. Radiographs of the site are required. Rationale for the graft and photos are helpful for an accurate benefit determination.

D7953 must not be reported when osseous grafting is done at the time of implant placement. D6104 is the correct code for bone grafting in conjunction with implant placement.

CODING CORNER

Reminder: American Dental Association Current Dental Terminology Changes for 2016

Regional dental provider fee schedules have been updated with the Current Dental Terminology (CDT) 2016 revisions. Notable changes include those outlined below:

	AMERICAN DENTAL ASSOCIATION NOMENCLATURE	NOTE
DELETIONS	D0260, D0421, D2970, D9220, D9221, D9241, D9242, D9931	**Deleted codes will be available for claims processing until 3/31/2016. After that, any claims containing deleted codes will be returned for correction.**
ADDITIONS	D0251, D0422, D0423, D1354, D4283, D4285, D5221, D5222, D5223, D5224, D7881, D8681, D9243, D9932, D9933, D9934, D9935, D9943	**D4283: Non-autogenous connective tissue graft procedure:** Used in conjunction with D4273 when more than one tooth position in the same graft site is involved. CareFirst considers two contiguous grafts as a single site. **D4285: Non-autogenous connective tissue graft procedure:** Used in conjunction with D4275 when more than one tooth position in the same graft site is involved. CareFirst considers two contiguous grafts as a single site.
REPLACEMENT	D9223 (replacing D9220, D9221)	**D9223 (deep sedation/general anesthesia – 15 minutes)** is reported in 15 minute intervals beginning when the anesthetic agent is administered by the doctor and continues only when the doctor is in continuous attendance. Anesthesia services are considered completed when the patient may be left safely under the observation of other trained personnel and the doctor may safely leave the room. Recovery time is not included, but is incidental to this service.
REPLACEMENT	D9243 (replacing D9241, D9242)	**D9243 (intravenous moderate (conscious) sedation/analgesia)** is reported in 15 minute intervals beginning when the anesthetic agent is administered by the doctor and continues only when the doctor is in continuous attendance. Anesthesia services are considered completed when the patient may be left safely under the observation of other trained personnel and the doctor may safely leave the room. Recovery time is not included, but is incidental to this service.

For more information about these codes and their benefits, view Coding Corner from our last issue.

DENTAL DIRECTOR
Robert S. Laurenzano, DMD, FAGD

EDITOR
Tara Wagner

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