CareFirst

Family of health care plans

DENTAL

PROVIDER MANUAL

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Chapter 4: Claims, Billing and Payments

Introduction to Claims Submission

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) supports electronic claims submission and automatic posting of remittance advice and electronic funds transfer. We strongly encourage providers to complete the "electronic round trip." Electronic transactions help facilitate streamlined claims submission, reconciliation and direct deposit of funds to your bank accounts. This section of the manual explains our claims submission requirements, how to follow up on claims and how to appeal claims when necessary.

Provider Self Service

CareFirst encourages the use of self-service channels for routine matters, such as eligibility, benefits or claims information. This helps free up resources to telephonically address matters requiring special handling.

Today, most of all telephone inquiries to customer service are for routine matters. We are moving our support for these simple, direct and factual queries to electronic channels and discouraging calls for these purposes.

When calling our service lines, you will be directed to a self-service channel to address your inquiry more quickly. Queries about the most common causes of calls will be answered in seconds through self-service technology. If you use one of our call centers for these simple inquiries, expect a longer wait time than you have in the past, since we are redirecting our service staff toward more complex issues and away from simpler inquiries.

CareFirst Direct

CareFirst Direct is a convenient tool available at carefirst.com/provider that gives you fast access to the information you need. With CareFirst Direct, you can:

- Make inquiries on your own time
- Avoid time consuming phone calls
- Verify eligibility and benefits
- Check claim status

It is important to designate one person to manage all users for the entire practice. This person is responsible for maintaining access for all others in the office. They must also remember to revoke access to users who no longer have access to CareFirst Direct. This person is also responsible for granting access to your billing service or agent.

You can set up a CareFirst Direct account for each tax identification number (TIN) used in your practice. When obtaining eligibility and benefits or claim status information, have the patient's date of birth and member ID number available. For claim inquiries, log in using the same TIN the claim was submitted under. You can find user guides for CareFirst Direct by going to carefirst.com/portaluserguides.

CareFirst on Call

CareFirst on Call is an Interactive Voice Response (IVR) system that allows providers to retrieve CareFirst member eligibility, benefits, deductibles, maximums, claim status and authorization status. Callers may use the telephone keypad input to interact with CareFirst on Call. The system has the capability to provide this information via fax for those who prefer printed documentation.

The system is available 24 hours a day, seven days a week (with periodic outages for system maintenance). CareFirst maintains a record of each IVR interaction to enable the retrieval of historic inquiries in case of questions regarding information received.

You can find more information about CareFirst on Call by going to carefirst.com/providerguides.

Basic Claim Submission Requirements

Reporting Current Dental Terminology (CDT®)

Use the most current edition of the CDT, published by the American Dental Association® (ADA), to report services for treatment. The CDT manual can be purchased directly from the ADA by calling 800-947-4746 or visiting www.ada.org.

Note: The existence of a procedure code does not guarantee coverage; the benefit is determined based on the member's contract.

Timely Filing of Claims

Note: To be considered for payment, claims must be submitted within 365 days from the date of service.

A member cannot be billed by a provider for failure to submit a claim to CareFirst within the guidelines listed above.

Reconsideration

Claims submitted beyond the timely filing limits are generally rejected for not meeting these guidelines. If your claim is rejected but you have proof that the claim was submitted to CareFirst within the guidelines, you may request processing reconsideration.

Timely filing reconsideration requests must be received within six months of the provider receiving the original rejection notification Notice of Payment (NOP) or Electronic Remittance Advice (ERA). Requests received after six months will not be accepted and the charges may not be billed to the member.

Documentation is necessary to prove the claim was submitted within the timely filing guidelines.

- **For electronic claims:** A confirmation is needed from the vendor/clearinghouse that CareFirst successfully accepted the claim. Error records are not acceptable documentation.
- **For paper claims:** A screenshot from the provider's software indicating the original bill creation date along with a duplicate of the clean claim or a duplicate of the originally submitted clean claim with the signature date in field 12, indicating the original bill creation date.

Electronic Capabilities

CareFirst encourages all providers to take advantage of the benefits of utilizing electronic capabilities to improve claims submission, expedite adjudication, receive remittance advices and payments faster and more. CareFirst offers the following Electronic Data Interchange (EDI) services through our trading partners:

- 837D – Dental Claims
- 835 – Electronic Remittance Advice
- 277CA – Payer Acceptance Report
- 270 – Eligibility Inquiry
- 276 – Claim Status

Electronic Claims (837D)

Electronic submission will help your practice save time, money and eliminate incomplete submissions, resulting in faster claims adjudication.

We urge you to submit claims electronically whenever possible, including for the following types of claims:

- Initial
- Corrected
- Pre-Treatment Estimates (PTEs)

Your billing and rendering National Provider Identifier (NPI) are required on all claim submissions.

Electronic Remittance Advice (ERA – 835)

Payment vouchers can be delivered by your trading partner through an ERA - 835. The ERA - 835 includes the payment details, Health Insurance Portability and Accountability Act (HIPAA) adjustment reason codes and HIPAA remark codes necessary for you to reconcile your patient accounts. Receiving payment information electronically allows you to realize claim resolution faster and save money. You can review remittance details on CareFirst Direct, as well as within your practice management system through your trading partner.

Electronic fund transfer

If you are receiving an ERA - 835, you can also take advantage of Electronic Fund Transfer (EFT). By enrolling to receive payments through EFT, you reduce paperwork and get paid faster with secure direct deposits from CareFirst. These are the preferred trading partners who offer EFT services.

Payer Acceptance Report (277CA)

Payer Acceptance Report (277CA) is returned by CareFirst the same day claims are received from the trading partner. This report will confirm which claims were accepted for adjudication and which claims were rejected. Claims that have been rejected with errors should be corrected and resubmitted. This report can be used with the CareFirst document control number as documentation for timely filing, if needed.

Eligibility Inquiry (270)

Eligibility Inquiry (270) can be used to obtain eligibility and benefits information for patients. The provider billing NPI should be used when submitting these inquiries.

Claim Status (276)

Claim Status (276) can be used to request claim status information through your trading partner. Please wait at least 48 hours after submitting a claim to request the status.

Questions?

For more information on all of the electronic capabilities, claims submission, companion guides, frequently asked questions and more, contact your trading partner.

Paper Claims Submission Process

Paper claims should be submitted as an exception. CareFirst encourages all providers to take advantage of the benefits of utilizing electronic claim submission. When paper claims are received, they are scanned, and a digitized version of the claim is produced and stored electronically. Successful imaging of the claim depends on print darkness. To help ensure your claim is accurately processed, please make sure the print is dark and legible.

Incomplete claims create unnecessary processing and payment delays. The fields listed below must be completed on all ADA claim forms. For dental services that are eligible for benefits under the patient's medical policy, please complete all required field below on a CMS-1500 claim form and submit to CareFirst. Claims missing or containing invalid information in any of the fields below will be returned.

Field name	Version 2019 ADA Claim Form Box	CMS-1500 box (Medical Only)
Insured ID Number	15	1a
Patient Name	12	2
Patient Date of Birth	13	3
CDT Code	29	n/a
ICD-10 Diagnosis	n/a	21
Dates of Service	24	24a
Place of Service, Facility Code	38	24b

Procedure Code/Revenue Code	29	24d
Charge	31	24f
Days of Units	41-42 (for orthodontia)	24g
Rendering National Provider Identifier	54	24j
Federal Tax ID	51	25
Signature of provider	53	31
Billing NPI	49	33a

Note: The three-digit prefix must be included if present on the member's ID card. FEP member numbers do not have a three-digit prefix but begin with an R and have eight numeric digits.

Claims must be submitted:

- On the most current 2019 © American Dental Association claim form. Instructions are available at www.ada.org. All information must fit properly in the blocks provided.
- Using the most current edition of the CDT, published by the ADA, to report services for treatment. **Note:** the existence of a procedure code does not guarantee coverage; the benefit is determined based on the member's contract.
- Using a membership ID number only. Social Security numbers will not be accepted in place of a membership ID number. Claims will be returned if the Social Security number is used as a membership ID number
- With your office's actual charges by procedure.

Pre-Treatment Estimate Submission Process

Dental providers and/or members who wish to obtain clinical review for dental treatment prior to services being rendered may request a Pre-Treatment Estimate (PTE). CareFirst strongly encourages providers to submit PTEs and required attachments electronically through your clearinghouse and NEA. PTEs submitted by hard copy should be submitted on a completed ADA claim form. Check the box for "Dentist's pre-treatment estimate" and leave the date of service blank. Include the following:

- ADA CDT procedure code(s)

- Appropriate supporting documentation for the service(s) to be rendered (see Reference Guide for Required Attachments). Providers with electronic capabilities are encouraged to submit attachments via one of our preferred trading partners.

This PTE process is an optional service limited to procedures which are subject to Utilization Review and listed in the Reference Guide for Required Attachments. The PTE provides a clinical review of a proposed treatment plan and is not a guarantee of payment or a prior authorization.

In the PTE process, benefits will be considered based on current eligibility and clinical guidelines. Providers will be notified on the Estimate of Eligible Benefits (EEB) form indicating approval or denial. Upon completion of treatment, the EEB form should be used to request reimbursement by completing the date of service, signing, and submitting the EEB to the appropriate claim submission address indicated on the form. Resubmission of supporting documentation is not necessary when submitting for reimbursement. Payment will be considered based on the following conditions:

- PTE was issued less than 270 days prior to the date service was completed.
- Member was eligible on the date service was completed.
- Frequency and annual maximums have not been exceeded.
- Service must be a covered benefit at the time service was rendered.
- Services rendered are consistent with those indicated on the PTE.

Note: If pre-treatment approval was granted on the EEB form, submit the EEB for completed services. Claims submitted on an ADA claim form for services that have been approved via the EEB process will automatically generate a request for supporting documentation.

Providers and/or members who choose not to request a PTE must continue to submit claims with the required attachments (radiographs, periodontal charting, etc.) for services requiring clinical documentation. You can check CareFirst Direct or CareFirst on Call to verify if the claim has been received by CareFirst.

Dental Reference Guide for Required Attachments

As part of our Utilization Management Program, you are required to submit supporting documentation for select dental procedures. The Dental Reference Guide for Required Attachments is updated on an annual basis, and lists by category of service, the procedure codes and the specific documentation required for submission with the claim.

Note: The requirements for attachments and documentation apply to all procedure codes within the range noted.

Notice of Payment

Participating providers are reimbursed by CareFirst for covered services rendered to CareFirst members. An NOP or ERA is available for each voucher and enables providers to identify members and the claims processed for services rendered to those members. A check may not be issued if there is no payment or if money has been recouped by CareFirst because of an adjudication.

Claims Overpayments

If an overpayment from CareFirst is discovered, the provider should not return the check. This causes a delay in the payment and the initial check must be voided. In such a situation, the provider should contact Provider Services or submit a claim inquiry on CareFirst Direct to initiate an adjudication. The claim(s) will be reprocessed, and a new check will be issued.

Effective Follow-Up on Claims

To follow-up on claims submitted more than 30 days ago, you can check CareFirst Direct or CareFirst on Call to determine the claim status.

Do **not** resubmit claims without checking CareFirst Direct or CareFirst on Call first. Submitting a duplicate claim already in process will generate a rejection and cause a backlog of unnecessary claims to be processed.

Step-by-Step Instructions for Effective Follow-Up

Claim status

The most effective way to accomplish follow-up on submitted claims is to access CareFirst Direct or CareFirst on Call. If there is no record of the claim, the claim must be resubmitted.

If the claim has been pending in the system for less than 30 days, wait until 30 days have elapsed from the processing date given on CareFirst Direct or CareFirst on Call. If processing has not been completed after 30 days, the preferred method for submitting an inquiry is electronically through CareFirst Direct's "Submit a Claim Inquiry" function.

Large volume of unpaid claims

- Please be sure that all NOPs or ERAs have been posted.
- Use CareFirst Direct or CareFirst on Call to verify receipt and status of claims.
- If you still have questions, please contact the appropriate customer service unit for assistance.

Corrected Claims, Inquiries and Appeals

What is a Corrected Claim?

A corrected claim is a replacement of a previously submitted claim (e.g., changes or corrections to charges, clinical or procedure codes, dates of service, member information, etc.). A corrected claim is not an inquiry or appeal.

How do I Submit a Corrected Claim?

Corrected claims should be submitted electronically to save time, money and help expedite claims processing. Dental providers should submit corrected claims in the HIPAA transaction 837D and indicate "corrected claim" in the Remarks section of the submission.

We urge you to submit all claims electronically. However, if you do not have electronic claim submission capabilities, you can submit them on paper.

If submitting a paper 2019 © ADA Claim Form, "Corrected Claim" must be written at the Remarks section of the claim form.

Paper claims should be mailed to the appropriate claim address for the member. This address is located on the back of the membership ID card. Mail these claims to the correspondence address.

For electronic and paper claims submission, please allow 30 days for reprocessing prior to checking your claim status on CareFirst Direct or the CareFirst On Call.

What is an Inquiry?

An inquiry is an informal request to review or explain why a claim was processed or paid a certain way. It could pertain to authorizations, correct frequency, accumulation calculations, rejections or automatic denial determinations, or clinical records, procedure/code errors. Before sending an inquiry, consider submitting a corrected claim.

The preferred method for submitting an inquiry is electronically through CareFirst Direct using the "Submit a Claims Inquiry" function. When you cannot use CareFirst Direct, contact the appropriate provider services area to file a claims inquiry.

What is an Appeal?

An appeal is a formal written request to CareFirst for reconsideration of a medical or contractual adverse decision. When CareFirst processes a claim and rejects it due to medical necessity or an adverse decision, providers may appeal the rejection in writing within 180 days from the Explanation of Benefits (EOB) or adverse decision. Appeals must be submitted in a letter on the provider's office letterhead.

Providers may appeal an adverse benefit determination based on medical necessity, appropriateness, or a decision to deny experimental/investigational or cosmetic procedures. The appeal letter must describe the reason(s) for the appeal and the clinical justification/rationale for the request.

Please include the following information on the letter:

- Patient's first and last name
- Identification number
- Claim number
- Admission and discharge dates (if applicable) or date(s) of service
- A copy of the original claim or EOB denial information and/or denial letter/notice
- Supporting clinical notes or clinical records including lab reports, X-rays, treatment plans, progress notes, etc.

Dental Providers
Mail Administrator
P.O. Box 14114
Lexington, KY 40512-4114

All appeal decisions are answered in writing. The appeal will be reviewed by a dentist or an appropriate practitioner who was not involved in the initial denial. Please allow 30 days for a response to an appeal.

Appeal resolution

Once the internal appeal process is complete, you will receive a written decision that will include the following information:

- The specific reason for the appeal decision.
- A reference to the specific benefit provision, guideline protocol or other criteria on which the decision was based.

Visit carefirst.com/inquiriesandappeals for more information.

Coordination with Other Payers/Other Party Liability

Subrogation

Subrogation refers to the right of CareFirst to recover payments made on behalf of a member whose illness, condition or injury was caused by the negligence or wrongdoing of another party. Such action will not affect the submission or processing of claims, and all provisions of the participating provider agreement will apply.

Personal Injury Protection – No Fault Automobile Insurance

Personal Injury Protection (PIP) is an automobile insurance provision that covers medical expenses and lost wages experienced by the insured or passengers as a result of an automobile accident. PIP may be required by automobile insurance laws to provide benefits for accident related expenses without determination of fault. PIP is a law in Maryland and does not include D.C. or Virginia. While Maryland law requires this coverage for passengers and family members under the age of 16, many insured members choose to continue to carry other passengers under this provision in their automobile insurance contracts.

CareFirst benefit contracts may contain a provision that requires coordination with PIP and may only provide benefits for covered medical expenses not reimbursed by the automobile insurer. A copy of the record of payment from the automobile insurer must be attached to the claim form submitted to CareFirst for any additional payment due.

Workers' Compensation

Health benefit programs administered by CareFirst exclude benefits for services or supplies for injuries/illnesses arising out of or in the course of employment to the extent that the member obtained or could have obtained benefits under a Workers' Compensation Act, or similar law. If CareFirst benefits are inadvertently or mistakenly paid despite this exclusion, CareFirst will exercise its right to recover its payments.

Workers' compensation replaces health insurance. A participating provider cannot balance bill CareFirst or the member for any amount not covered under workers' compensation unless it is determined that the charges are non-compensable under workers' compensation. If workers' compensation determines

that the charges are non-compensable, attach a copy of the denial from the workers' compensation carrier to the claim.

Under the Maryland Workers' Compensation Act, certain businesses may elect to waive coverage. Verification from the subscriber of this waiver may be required by CareFirst in order to process claims.

Coordination of Benefits

Coordination of Benefits (COB) is a cost-containment provision included in most group and member contracts and is designed to avoid duplicate payment for covered services. COB is applied whenever a member covered under a CareFirst contract is also eligible for health insurance benefits through another insurance company or Medicare.

CareFirst uses the Standard method of processing COB for all plans, which states that we will coordinate claims up to the highest allowed benefits of the two coverages. The liability of CareFirst as the secondary carrier will never exceed the highest allowed benefit between the two coordinating coverages, and CareFirst's payment as secondary carrier will never exceed what we would have paid as primary. The standard provision in a member's contract considers the amount paid by the primary carrier and our Allowed Benefit (AB). If the amount of the primary carrier's payment exceeds or equals the AB, we pay nothing.

If CareFirst is the primary carrier, benefits are provided as stipulated in the member's contract.

Note: The member may be billed for any deductible, coinsurance, non-covered services or services for which benefits have been exhausted. These charges may then be submitted to the secondary carrier for consideration. Group contracts may stipulate different methods of benefits coordination, but generally, CareFirst's standard method of providing secondary benefits for covered services is the lesser of:

- The balance remaining up to the provider's full charge; or
- The amount CareFirst would have paid as primary, minus the other carrier's payment (i.e., the combined primary and secondary payments will not exceed CareFirst allowance for the service.)

The participating provider cannot balance bill the member if the primary carrier and our reimbursement does not equal the total billed charges. The participating provider can only bill for claims that are rejected as non-covered or over maximum and for any deductibles and coinsurance. If the primary carrier appropriately denies benefits for rendered services, we automatically become the primary carrier for covered services.

Note: Providers may submit primary COBs electronically or via hard copy to our claims mailing address.

Coordination of benefits with Affordable Care Act (ACA) pediatric dental coverage

When a CareFirst member has a medical plan, is eligible for embedded pediatric dental coverage, and is also covered under a CareFirst Employer Group dental plan, the embedded pediatric coverage will always be primary for the member.

Coordination of benefits with DHMO policies

When coordinating between an indemnity and a capitation dental plan, the following rules apply:

- When the capitation plan is primary, the capitation copayments to the treating dentist remain the capitation plan's usual care. The indemnity plan should pay benefits for the patient's copayment up to the indemnity plan's allowable benefit.
- When the indemnity plan is primary, and treatment is received from a participating capitation provider, the indemnity plan should pay its allowable benefit. The capitation payments to the dentist are the secondary coverage since they constitute care up to the capitation plan's allowable amount.

Note: DHMO providers may only bill the secondary carrier the member's copayments

When coordinating benefits between two capitation plans, the following rules apply:

- **Primary General Dentist (PGD):** For a case in which the PGD participates with both capitation plans, the patient should be charged in accordance with the lesser of the two copayment schedules. This rule applies regardless of whether the two capitation plans are administered by the same managed care company or by two different managed care companies. If the PGD only participates with one of the capitation plans, the PGD has no choice but to charge in accordance with the capitation plan in which he/she participates.
- **Specialist:** For a case in which the specialist participates with both of the capitation plans and both of the capitation plans are administered by the same managed care company, the patient should be charged in accordance with the lesser of the two copayment schedules and the specialist should submit a claim for additional payment (if applicable) in accordance with the guidelines set forth by the capitation plan.

  For a case in which the specialist participates with both of the capitation plans and the capitation plans are NOT administered by the same managed care company, the patient should be charged in accordance with the plan that has been determined as the primary plan. The specialist should submit a claim for additional payment (if applicable) in accordance with the guidelines set forth by the primary plan. When the specialist submits a claim for additional payment (if applicable) to the secondary plan, the claim must include an EOB from the primary plan. If the secondary plan is a CareFirst DHMO plan, there will not be any additional payment to the specialist if the combined payment from the patient and the primary plan to the specialist is equal to or greater than the amount guaranteed to the specialist by the DHMO.

Orthodontia

CareFirst does not coordinate coverage for orthodontia. When members have dual dental CareFirst coverage whereby both plans include orthodontic benefits, CareFirst will process orthodontic claims under both plans simultaneously; there is no primary or secondary carrier in cases of orthodontia under CareFirst policies.

Dental Benefits Covered Under Medical Policies

Most of the time CareFirst processes dental-related services under a patient's dental plan. However, there are a few cases where the patient's benefit is processed under their medical plan. There are three major service types that fall under this category:

- **Complex Oral Surgery**, defined by CareFirst as medically necessary procedures intended but not limited to:
  - Attain functional capacity;
  - Correct a congenital anomaly;
  - Reduce a dislocation;
  - Repair a fracture;
  - Excise tumors, non-odontogenic cysts or exostoses; or
  - Drain abscesses involving cellulitis and are performed on the lips, tongue, roof, and floor of the mouth, sinuses, salivary glands or ducts and jaws.
- **Accidental Injury**, defined by CareFirst as dental services needed as a result of accidental bodily injury (except for accidents caused by biting or chewing), occurring on or after the patient's effective date of coverage, to the mouth, jaws, cheeks, lips, tongue, roof and floor of the mouth.
- **Temporomandibular Joint Disfunction**, when the patient's benefits allow and after the case is reviewed.

In these cases, claims must be:

- Reported using the CMS-1500 claim form, version 02/12, and the applicable AMA Current Procedural Terminology (CPT®) and ICD-10 diagnosis code.
- Submitted to the appropriate medical claims processing area for Prior Authorization when required.
- Submitted with a narrative and itemization of the CDT codes rendered.
- Processed under the patient's medical coverage instead of their dental coverage.