CareFirst
Family of health care plans

Dental Claims Submission

This manual provides information for CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and The Dental Network (CareFirst) Dental providers.

Per the terms of the Participating Agreement, all providers are required to adhere to all policies and procedures contained in this manual, as applicable. If we make any administrative or procedural changes, we will update the information in this manual and notify you through **email** and **BlueImpressions**, our online Dental provider newsletter.

Specific requirements of a member's dental benefits vary and may differ from the general procedures outlined in this manual. If you have questions regarding a member's eligibility, benefits or claims status information, we encourage you to use one of our self-service channels **CareFirst Direct** or **CareFirst on Call**. Through these channels, simple questions can be answered quickly.

Submission Guidelines

Timely Filing of Claims

Dental claims must be submitted within 365 days after the date of service. A member cannot be billed by a participating provider for failure to submit a claim to CareFirst within the 365 day timeframe.

Claims Filing

CareFirst strongly encourages providers to submit claims, pre-treatment estimates, and required attachments electronically. CareFirst's dental payer code is 00580. CareFirst only requires supporting documentation for certain **procedures**. These documents can be submitted via **National Electronic Attachment** (NEA). Please include the NEA document number in the Remarks section on the ADA claim form and submit by mail if necessary. Secondary Coordination of Benefits (COB) should not be submitted electronically.

If you do not currently submit claims electronically, contact one of our preferred clearinghouses:

- Change Healthcare at 888-255-7293
- Tesia Clearinghouse, LLC at 866-712-9584
- Dental Xchange at 800-576-6412

CareFirst has enhanced its electronic claims submission for dental providers, thereby simplifying the method for processing claims and sending payments to dentists.

New electronic capabilities include:

- Electric Funds Transfer (EFT) allows providers to receive payments electronically. A clearinghouse manages provider enrollment and validation date
- Electronic Remittance Advice (ERA) is equivalent to the Notice of Payment. Some clearinghouses auto-post the ERA and EFT to the patient's account using the providers Practice Management System

Visit **carefirst.com/dentaledi** to learn more about electronic claims submission.

Providers without electronic capabilities may submit claims and supporting documentation to the appropriate processing area. See **Dental Claims and Service Reference Guide**.

Dental Procedures and Nomenclature

Use the most current edition of the Current Dental Terminology (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 **ada.org**. Note: The existence of a procedure code does not guarantee coverage; the benefit is determined based on the member's contract.

Completing a Claim Form

- Use the most current **2012©American Dental Association** claim form and instructions available at **ada.org**
- Report completed services using the procedure codes from the most recent ADA Current Dental Terminology® (CDT) Reference Manual
- Essential data elements must be completed, including patient name, patient date of birth, valid membership ID number, provider tax identification number, signature of dentist or signature on file, valid CDT® procedure codes, teeth numbers and locations if applicable, and procedure charges
- 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 identification number
- Providers submitting claims for all plans should always submit their claims with their actual office charges by procedure

Claims received without the essential data elements may be returned to the provider of care for corrections.

Pre-Treatment Estimates (PTE)

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 American Dental Association® (ADA) claim form. Check the box for "Dentist's pre-treatment estimate" and leave the date of service blank. Include the following:

- ADA Current Dental Terminology® (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 National Electronic Attachment (NEA). Please include the NEA document number in the Remarks section on the ADA claim form if you submit by mail. For more information, contact NEA at 800-782-5150 and select option 2

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 pre-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 the 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 received 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 pre-treatment estimate (PTE) must continue to submit claims with the **required attachments** (radiographs, periodontal charting, etc.) for services requiring clinical documentation.

DHMO Claims

Claims are not required of network general dentists as providers are reimbursed capitation and collect copayments from the member. However, providers may be reimbursed a supplemental payment for certain plans/procedures as indicated on the Member Copayment Schedule.

If your office submits claims by mail, providers are required to submit the most current version of the **2012© American Dental Association** claim form. Whether claims are submitted electronically or by mail, all essential data elements must be completed in order for claims to be processed.

Specialty providers who may be eligible to receive supplemental payments for specific procedures will be paid upon receipt of a submitted claim..

Oral Surgery and Accidental Injury

Oral surgical services and services rendered as a result of an accidental injury must be reported using the CMS-1500 claim form, version 02/12, and the applicable American Medical Association (AMA) Current Procedural Terminology (CPT) or HCPCS Dental (CDT) procedure code(s). Claims should be submitted to the appropriate **medical claims processing** area. These claims will be processed under the member's medical coverage instead of their dental coverage.

Dental Reference Guide for Required Attachments

As part of our Utilization Management Program, the submission of supporting documentation for select dental procedures is required. The **Dental Reference Guide for Required Attachments** lists by category of service, the procedure codes and the specific documentation required for submission with the claim.

Whether claims are submitted electronically or by mail, all essential data elements must be completed in order for claims to be processed. The ADA Dental Claim Form provides a common format for reporting dental services to a patient's dental benefit plan. The current version is 2012© American Dental Association.

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

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