INDEMNITY AND PREFERRED PROVIDER ARRANGEMENT (PPA) ADMINISTRATIVE POLICY HANDBOOK

for
Dental Providers

MASSACHUSETTS

2024

ABOUT THESE ADMINISTRATIVE POLICIES

Thank you for participating with Blue Cross Blue Shield of Massachusetts. These Administrative Policies—also referred to as Rules and Regulations of the Corporation—apply to all dentists participating in Blue Cross Blue Shield of Massachusetts Dental Indemnity Plans and our dental Preferred Provider Arrangement (PPA) plans.

We may update these policies periodically. When we do, we will notify you in accordance with the notice requirement outlined in your dental provider contract. In addition to these policies, you are also governed by:

- Your Agreement with us, including all relevant terms relating to members and accounts.
- Applicable Division of Insurance (DOI)-approved documents regarding methods of compensating participating Indemnity and credentialed network PPA dental providers, as well as documents covering the interpretation and administration of such compensation methods.
- Network PPA dentists only: the Plan requires that participating providers complete a re-credentialing application every two years during the month of their birth.

Key terms

- Throughout this manual, we refer to Blue Cross Blue Shield of Massachusetts as “we,” “us,” or “the Plan.”
- A “participating provider” is one who is credentialed and/or contracted with Blue Cross Blue Shield of Massachusetts.

ACCURATE PROVIDER DIRECTORIES MATTER TO US ALL

Many of our members are finding that the directory listing for a provider is not correct: the office location has changed; the member is not able to schedule an appointment with the provider at the location listed (covering only, hospitalist, etc.); the phone number to schedule an appointment is wrong; the provider is not accepting new patients; or the doctor no longer accepts the insurance.

You are contractually required to keep your directory data current because patients rely on it for accurate information about you and your practice. We depend on you to routinely validate the information we have for you in our online directory, Find a Doctor & Estimate Costs. You are required to provide us with a 90 day written notification in these situations:

Changes to your practice	Changes to your status
• Transferring of ownership • Changing of practice name • Moving • Adding and/or removing dentists to your practice	• Licensure • Accreditation • Certification • Qualification • Participation

If you need to make changes, or have questions, please call Dental Network Management at **1-800-882-1178**, option **4**, or email Dentalnetworkrequest@bcbsma.com.

MEMBER BENEFITS

We reimburse participating providers for covered services that they provide to our members. Services are covered if the member's subscriber certificate or summary plan description includes them as a covered benefit and if they meet medical and dental necessity criteria. Our members receive a Subscriber Certificate or summary plan description explaining their covered benefits. All benefits are subject to medical and dental necessity criteria.

We do not cover treatments (services, procedures, supplies, drugs, and durable medical equipment) that we consider experimental or investigational. To access our *CDT Dental Procedure Guidelines and Submission Requirements*, log in to Provider Central at **bluecrossma.com/provider**. Click on **Office Resources**>**Policies & Guidelines> Provider Manuals**>**CDT Guidelines**, or call Dental Network Management at **1-800-882-1178, option 4**.

An employer can choose a different coverage level for each benefit group (preventive, basic, major, and orthodonic services). There is an annual benefit maximum per covered member and a separate lifetime maximum for orthodontics, if covered. An employer may include a per-individual deductible, not exceeding a pre-set family deductible, per calendar year.

Please also see the section titled **Affordable Care Act pediatric essential dental coverage provided in addition to certain medical plans**.

REIMBURSEMENT FOR DENTAL BLUE PLAN MEMBERS

Our Maximum Allowable Charge uses a market-driven methodology that reflects actual charges of all dental practices in Massachusetts. We reimburse specialists at least 110% of the general dentist reimbursement levels for specific procedures that apply to each area of specialty.

We review our fee schedule each year and evaluate our Maximum Allowable Charge amount by location and specialty using the most current market-driven data available at the time of the review. As a Dental Blue dentist, you agree to accept the Maximum Allowable Charge for your location and specialty as payment in full. We base reimbursement on the lower of these amounts:

- Your submitted charge for a particular procedure
- The maximum allowable amount for your location and specialty

In most instances, we will pay you directly for covered services that you provide to our members. Massachusetts General law, Chapter 176B, Section 7 regulates our payments for services rendered by participating dentists. Under this law, for covered services, Dental Blue participating dentists may not:

- Collect any balance above the Maximum Allowable Charge from a Dental Blue member
- Bill your patient for the difference between our allowed amount and your charge for covered services

Our Provider Detail Advisory (PDA) will give you detailed information enabling you to correctly bill your patient for co-insurance, deductibles, and any copayments. (For more information about the PDA, see the section titled **Payment and Correspondence**).

REIMBURSEMENT FOR DENTAL BLUE PPO PLAN MEMBERS

We set the PPO fee schedule using a market-driven methodology that reflects actual charges of all dental practices in Massachusetts, and review the fee schedule annually. Dental Blue PPO dentists agree to accept our PPO fee schedule amount as full payment and agree not to bill the patient above this amount. The presence of any procedure on the PPO fee schedule does not imply that it is a covered service.

As a Dental Blue PPO dentist, you agree to accept the PPO fee schedule as payment in full. We base reimbursement on the lower of these amounts:

- Your submitted charge for a particular procedure
- The maximum PPO fee schedule

In most instances, we will pay you directly for covered services that you provide to our members. Under Massachusetts law, for covered services, Dental Blue PPA credentialed network dentists may not:

- Collect any balance above the Maximum Allowable Charge from a Dental Blue member
- Bill your patient for the difference between the PPO fee schedule and your charge for covered services

Our Provider Detail Advisory (PDA) gives detailed information so you can correctly bill your patient for any co-insurance, deductibles, and copayments (see **Payment and Correspondence** for more information.)

When you can collect payment from the patient

You can collect copayments at the date of service. For co-insurance and deductibles, please wait until the claim has adjudicated.

The table below shows what you can bill the member for services. This applies to **all** benefit limits for any services that are covered, including:

- Annual maximums (calendar year and plan year) and orthodontic lifetime maximums
- Time limits
- Frequencies

When the member receives	You may bill the member
Covered services after meeting their benefit limits	Up to your contracted fee schedule amount
Non-covered services, has not satisfied a waiting period, or is outside their eligible coverage period	Up to your charges

Non-covered and alternate benefits

If the procedure is	Then
Non-covered	• You can collect your total charge for the treatment. • Please be sure to verify if a service is covered under your patient's benefit plan and, if not, notify your patient prior to treatment that he or she will be responsible for your total charge.
Covered as an "alternate benefit." *Examples:* an amalgam filling allowance toward the cost of a metallic, porcelain, or composite resin inlay.	We provide the benefit of a comparable service and notify you and your patient that they are responsible for the balance up to the allowed amount.

HOW TO SUBMIT DENTAL CLAIMS

Signature waiver

Your application may have included a Signature Waiver form that allows you to waive the requirement that you personally sign each claim. Regardless, you are personally responsible for each claim submitted on your behalf.

Claim form

Please include your established fee for the services performed in the appropriate space of the 2019 version of the American Dental Association (ADA)-approved claim form. When the billing provider's National Provider Identifier (NPI) differs from the servicing provider's NPI, your claim form must include both the billing NPI (block 49) and the servicing provider's NPI (block 54).

Claim submission

Your Agreement explains the filing limit for Dental Blue and PPA claims. We reserve the right to accept Dental Blue and PPA claims up to one year from the date of service.

To submit your claim via:	Here's how to get started:
Direct connection (electronic data interchange, or EDI)	Log in to Provider Central at **bluecrossma.com/provider** and select **eTools>Direct Connection**.
Electronic technologies	Use Dental Connect for Providers, our exclusive gateway for electronic transactions. To get started, contact Change Healthcare at **1-866-777-0713** or visit **dental.changehealthcare.com/DPS/securelogin.aspx**.
Mail (paper claims)	Complete the ADA dental claim form (2019) and send it to: Blue Cross Blue Shield of Massachusetts Process ControlP.O. Box 986005 Boston, MA 02298

Filing claims more than one year after the date of service

We will deny claims received more than one year from the date of service unless you submit them with another insurer's Explanation of Benefits (EOB). The other insurer's EOB must be dated within one year of the Blue Cross Blue Shield of Massachusetts claim receipt date. For these claims, please send your paper claim with the corresponding EOB attached to:

Blue Cross Blue Shield of Massachusetts
Process Control
P.O. Box 986005
Boston, MA 02298

Billing for members of a provider group

Dental providers who bill through a group entity may, at any time, terminate the group's authorization to receive payments for their services from Blue Cross Blue Shield of Massachusetts. If you submit claims to us through a group, or receive Blue Cross Blue Shield of Massachusetts payments through a group, you will continue to be personally responsible for all claims submitted in your name by the group.

Each member of the group who submits claims to us must participate with Blue Cross Blue Shield of Massachusetts. The group also must obtain a tax identification number and a Type 2 National Provider Identification (NPI) number specific to that group.

You must notify us of any change in your practice within 90 days of the change (Affordable Care Act requirement). Any change will become effective 90 days from provider notification receipt. Please provide any such notice to:

Blue Cross Blue Shield of Massachusetts
Dental Network Management, Mail Stop 03/03
25 Technology Place
Hingham, MA 02043

Dental Blue providers billing for members of other Blue Cross Blue Shield Plans

We offer dental services to members of other Blue Cross Blue Shield Plans through a nationwide dental network called the nationwide network. You and your practice are considered "in-network" for members of participating out-of-state Blue plans, unless you opt-out as described below. You are reimbursed at your Blue Cross Blue Shield of Massachusetts Dental Blue contracted rate for dental services you provide to members who use the nationwide network, including federal employees living in Massachusetts.

- **Use the same claim submission process and submit to the *member's Plan*.** This information is listed on the member's identification card.
- **You don't need to take any action to participate.** You do not need to do anything to participate in the nationwide network since you already participate in Dental Blue.

Dental Blue providers billing for members of other Blue Cross Blue Shield Plans, *continued*

Opting out of participation in the nationwide network (GRID) will not affect your participation in the local Dental Blue networks. To opt out of participation in the network leasing arrangement, you must let us know in writing no later than October 1st of any calendar year for a January 1st of the following year effective date. Send your written notification to:

Director, Dental Network Management
Blue Cross Blue Shield of Massachusetts
25 Technology Place M/S 03/03
Hingham, MA 02043

PPA providers billing for members of other Blue Cross Blue Shield Plans

We offer members access to a national network of credentialed network dentists located outside of Massachusetts. Blue Cross Blue Shield of Massachusetts has entered into an agreement with a national network of providers to increase geographic access to care for our members who reside or travel outside of Massachusetts. If you currently provide care for a patient from outside of Massachusetts, please continue to handle claims for their care as you have in the past.

For additional detailed information on services provided to out-of-area members, please refer to your Blue Cross Blue Shield of Massachusetts Dental Professional and Oral & Maxillofacial Surgery Agreement.

Billing for FEP Dental Blue

The Blue Cross and Blue Shield Association (BCBSA) has partnered with the GRID Dental Corporation (GDC) to administer FEP BlueDental. This plan is available across the United States to federal and postal employees and retirees through the Federal Employee Dental and Vision Insurance Program (FEDVIP), which is administered by the Office of Personnel Management (OPM). See your Dental *Blue Book*, Section 9: Federal Employees Program, for more information.

Billing for services performed by dental auxiliary personnel

An individual provider, professional corporation, or group practice may bill us for appropriately supervised, delegated outpatient services performed by licensed dental auxiliary personnel (i.e., dental hygienists, assistants, etc.) in accordance with the Rules and Regulations of the Board of Registration in Dentistry CMR 234-2.00.

Billing for covered services furnished to immediate family members

We will not reimburse you for any services when furnished to a member of your immediate family, including, but not limited to, the following:

- spouse or domestic partner
- parent, step-parent, father- or mother-in-law
- child, step-child, daughter- or son-in-law
- brother or sister (by birth or adoption), step-brother or step-sister, brother- or sister-in-law
- grandparent or grandchild

For the purposes of this exclusion, the immediate family members listed above will still be considered immediate family after the marriage that created the relationship is ended (by divorce or death).

DENTAL QUALITY ASSURANCE PROGRAM

Our Dental Quality Assurance Program begins by comparing submitted claims or pretreatment estimates against the most current *CDT Procedure Guidelines and Submission Requirements*. These guidelines tie the treatment rendered or requested to the CDT codes we currently use to determine appropriateness of the actual or proposed procedures. Additionally, our Inter-specialty Dental Advisory Committee helps to set clinical policy against which treatment appropriateness is measured.

Dental consultants (licensed general dentists and specialists in Massachusetts) review claims for appropriateness of treatment based on submitted radiographs, narratives, periodontal charting, photographs, and the dental claim. Consultants will call the provider's office for additional information or claim determination, if indicated, to expedite the claim review process. This feedback will assist you in future claims submission and help you to understand the reasoning behind a claim's denial. The Clinical Dental Director oversees this Program.

PAYMENT AND CORRESPONDENCE

When we receive your claim form, we will pay you for covered services, notify you of the reason for non-payment, or tell you what additional information we need to process the claim. For covered claims, you will receive payment within 45 days of our receipt of your completed claim. We provide two reports to help you track your claims when paid through Payspan Electronic Funds Transfer (EFT), the Provider Payment Advisory and the Provider Detail Advisory.

Provider Payment Advisory (PPA)

The PPA summarizes all of the claims included with the payment, including the member name, ID number, claim number, amount paid, and member balance. The bottom portion is your check.

Provider Detail Advisory (PDA)

The PDA details each claim, including member name, ID number, claim number, date of service, tooth identification, procedure code, submitted charge, allowed amount, member deductible, member co-insurance, paid amount, provider adjustment amount, member balance, and line message code. The PDA will:

- Help you understand why we paid or rejected a claim in a certain way
- Explain how we processed a Pre-treatment Estimate (PTE)
- Show why we have deducted money from your payment
- List costs you can collect from the patient – including co-insurance, deductibles – and non-covered charges

Pre-treatment Estimate

The pre-treatment estimate contains the same information as the PDA except that the “date of service” column is blank. The disclaimer message printed on the form states that this document is not a guarantee of payment.

Notifications

When notifications are sent by mail, the provider will receive the following documents:

- **Provider Dental Voucher**. Details each claim, including member name, ID number, claim number, date of service, tooth identification, procedure code, submitted charge, allowed amount, member deductible, member co-insurance, paid amount, provider adjustment amount, member balance, and line message code.
- **Pre-treatment Estimate**. The pre-treatment estimate contains the same information as the Provider Dental Voucher except that the “date of service” column is blank. The disclaimer message printed on the form states that this document is not a guarantee of payment.

Timeliness of payment

Within forty-five (45) days of when we receive a completed claim form, we will do one of the following:

- Reimburse you for covered services provided
- Notify you of the reason for non-payment
- Notify you of additional information or documentation necessary to complete the claim form

In addition to any reimbursement for covered services, if we fail to comply with the timeliness of payment section of your Agreement, we will pay interest on the covered services as required by applicable law. This does not apply to claims being investigated for fraud or other suspected wrongdoing.

Online payment and remittance (Payspan Health)

Blue Cross Blue Shield of Massachusetts pays participating providers through a secure online direct deposit into their business bank account. You must register with our vendor Payspan®, Inc., to begin receiving your e-payment. You will also use their system, Payspan Health, to view payment advisories online.

Our Quick Start guide explains:

- Payspan registration
- Bank deposit notification
- Finding Provider Payment Advisories
- Finding Provider Detail Advisories
- Bank statement reconciliation

There is no cost to use Payspan Health for members of Blue Cross Blue Shield of Massachusetts. To learn more about online payments and remittances, please log in to Provider Central at bluecrossma.com/provider and go to **eTools>Payspan**. To register, go to Payspanhealth.com and click **Register**.

APPEALS AND CLAIM REVIEWS

Appeals

You can request an appeal for a claim that has been denied because we have determined that a procedure does not meet our criteria for necessity and appropriateness of treatment. Appeals will be reviewed by a different dental consultant than the one who denied your original claim. If the denied procedure meets the criteria for appeal, either the letter or Dental Provider Advisory message you receive will outline how to appeal the procedure and the documentation required for re-review. To expedite the processing of your claim, please send your appeals with appropriate documentation to:

Blue Cross and Blue Shield of Massachusetts
Process Control
P.O. Box 986005
Boston, MA 02298

If you have additional questions about a denial, please call the Dental Provider Services at **1-800-882-1178, option 3**.

Claim reviews

You can request a claim review for the denial of a claim based on patient eligibility, benefits, or claim adjustments. To request a claim review, please call the Dental Provider Services at **1-800-882-1178, option 3**. We may ask you for a copy of your PPA or PDA with any additional paperwork that will help us to review the claim. Please send these to:

Blue Cross Blue Shield of Massachusetts
Process Control
P.O. Box 986005
Boston, MA 02298

Appealing adverse decisions resulting in changes in contractual privileges

We will provide due process for adverse decisions resulting in a change of contractual privileges for credentialed dentists who contract directly with us.

- We will notify the dentist in writing of any proposed change in contractual privileges with reasons for the proposed actions or immediate action.
- The dentist will have the opportunity to appeal the proposed actions.
- The appeal, if requested, will be completed before the implementation of the proposed actions, except in cases where we have reason to suspect that there is immediate danger to a patient. In such cases, we will notify the applicable regulatory agencies immediately and take appropriate action to protect our members.
- We will maintain an internal appeal process with reasonable time limits for resolving such appeals.
- The dentist may waive due process by putting the request in writing. We do not require dentists to waive their rights to appeal as a condition of their contract.

All appeal materials are considered confidential.

Member grievances

Members of all our plans have the right to appeal any decision regarding any aspect or action we take that relates to the member, including but not limited to: review of adverse determinations regarding scope of coverage, denial of services, quality of care, and administrative operations. We provide each member with information on how to initiate the appeal process. Along with the provider appeals process described above, providers and facility representatives may appeal concurrent issues for inpatients via the Member Grievance process by calling **1-800-472-2689**. These appeals do not require formal appointment by the member.

OUR RIGHT TO REVIEW DOCUMENTS

To comply with fraud and abuse regulations, utilization review requirements, quality assessment or improvement activities, and other health care operations, we have the right to review your documentation to determine the propriety and accuracy of claim submission and payments. We ask that you promptly send us requested photocopies or electronic files and allow us direct inspection of original documents, at no expense to us, upon our request. Supporting documents and information may include, among others:

- Our members' dental records
- Your billing records and policies
- Administrative and scheduling records
- Dental care policies

You must also give us access to employees or agents necessary to help us understand such supporting documents and information and your general billing practices.

We also have the right to inspect your professional premises during usual office hours upon giving you reasonable notice. We will require immediate access when it is needed to prevent imminent harm to us or our members. We also ask for your cooperation to ensure compliance with state and federal privacy laws and regulations.

If you willfully or knowingly fail to supply the documents or information promptly after we request them, we may delay payment or processing of your claims until you supply the documents, or we may retract payments made for the requested claims. If we have reasonable belief that you have submitted unreasonable, improper, or fraudulent payment claims to us, we may place your claims on "stop process" pending resolution of our inquiry into such claims.

AFFORDABLE CARE ACT PEDIATRIC ESSENTIAL HEALTH BENEFITS PROVIDED IN ADDITION TO CERTAIN MEDICAL PLANS

Under the Affordable Care Act, small group and individual medical plans provide additional coverage for Pediatric Essential Health benefits for children ages 0 through 19. You must be participating with Blue Cross Blue Shield of Massachusetts through the Dental Blue indemnity or Dental Blue PPO network to provide Pediatric Dental Essential Health Benefits (EHBs) under this additional coverage to the member's medical plan.

- Type 1 Services: Preventive and diagnostic services, including oral exams, X-rays, and routine dental care
- Type 2 Services: Basic restorative services, including fillings, root canals, stainless steel crowns, periodontal care, oral surgery, and dental prosthetic maintenance
- Type 3 Services: Major restorative services, including tooth replacement and crowns, and occlusal guards.
- Medically necessary orthodontic care that has been prior-authorized for qualified members (*limited to repair of cleft lip and palate or other severe facial birth defects or injury for which the function of speech, swallowing, or chewing shall be restored).*

The member's dental benefit maximums do not apply for EHB dental services processed under this additional coverage to the member's medical plan The member will have a separate maximum out-of-pocket benefit for pediatric dental benefits; after these are met, coverage for pediatric dental benefits will be at 100%.

Because these benefits are covered in addition to the member's medical plan, members with these EHBs will have a Blue Cross Blue Shield of Massachusetts medical ID card. Members who also have dental benefits will also have a Dental Blue ID card; in most cases, both cards will have the same ID number with a different prefix.

NOTICE OF GOVERNMENT ENFORCEMENT ACTIONS

You must promptly notify our Fraud Investigation and Prevention Unit of any action—whether civil, criminal, or administrative in nature—taken against you by any federal or state agency. Reportable actions include those that:

- Require you to pay any reimbursement, fines, or other monetary penalties to a government agency
- Suspend or debar you from governmental health care programs
- Impose care-based remedial obligations, a compliance agreement, or any other kind of remedial obligation upon you

To comply with this requirement, you may provide us with an explanation of whether you believe that the action affects your claims or our members. Please submit any notice of Government Enforcement Actions to:

Director, Fraud Investigation and Prevention
101 Huntington Avenue, MS 01/18
Suite 1300
Boston, MA 02199-3326
Fraud Hotline: **1-800-992-4100**

HOW WE COMMUNICATE WITH YOU

Our secure provider website, Provider Central, is designed to:

- Streamline your interactions with us by reducing the need to call for information
- Reduce paperwork
- Provide personalized communication based on your dental specialty

Our website allows you to:

- Access member eligibility, copayments, and other benefit information instantly by signing up for *ConnectCenter* (for oral surgeons) or via *Dental Connect* for all other Dental Specialties
- View and print your Dental Blue fee schedule, Dental *Blue Book,* and *CDT Guidelines*
- Download forms and receive *News Alerts*, news, and other updates via email
- Look up information about our medical and dental plans
- Use the "Find a Doctor" feature to find a network provider for patient referrals or look up the national provider identifier (NPI) of other providers

Participating providers are generally required to register; visit bluecrossma.com/provider and click on **Register**. For assistance with registration, you can:

- Email **providercentral@bcbsma.com**
- Call your Dental Network Manager at **1-800-882-1178, option 4**

The account administrator must complete the simple, two-part registration process before the entire office can begin using the site. We recommend that you select a minimum of two administrators from your office.

HOW TO CONTACT US

If you have questions or concerns, please feel free to contact us at the appropriate number below:

For:	Please contact us at:
Claim-related issues	Dental Provider Service: **1-800-882-1178**, **option 3** (8:30 a.m. to 4:30 p.m.)
Contracting, adding new dentists, changing address, joining our networks, or non-claim-related issues	Dental Network Management: **1-800-882-1178, option 4**
Resources to help you care for our members	Our Provider Central website at: bluecrossma.com/provider

Document History

Date	Section	History
1/20/2021	Member benefits	Added paragraph on pediatric health benefits
1/20/2021	Throughout	Clarified that current ADA claim form is the 2021 form.
1/20/2021	Throughout	Clarified that paper claims should be addressed to “process control”
1/20/2021	Billing for out-of-area members	Deleted this section per new agreement with our national dental network.
1/20/2021	Payment and correspondence	Added notation that reports are provided when providers use PaySpan EFT.
1/20/2021	PPO providers: Added section on Pediatric dental benefits covered under the member’s medical benefit	Updated information to clarify throughout and remove reference to a 24-month waiting period for medically necessary orthodontia.
1/20/2021	Online payment and remittance	Updated information for signing up for PaySpan
1/20/2021	Our right to review documents and notice of government enforcement actions	Reorganized
12/4/2022	Throughout	Updated addresses & format; minor edit to Member Benefit section.
12/1/2023	How to submit dental claims	Updated current claim form name from 2012 to 2019
12/1/23	Throughout	Minor edits for clarification