2026

BLUE BOOK

A dental reference guide

MASSACHUSETTS

440255 (1/26)

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Section 1 Our dental networks, plans, and benefits

Dental Blue is our traditional broad access fee-for-service network. For this network, reimbursement is based on the contracted regional maximum allowable fee schedule. 93% of Massachusetts licensed dentists participate in our Dental Blue Network.

Dental Blue PPO is our fully credentialed preferred provider organization network. We reimburse providers based on the discounted contracted fee schedule. PPO members have the least out-of-pocket expenses when they see a participating PPO network provider.

Dental Blue Nationwide Network is a partnership with our sister Blues plans referred to as The GRID Plus. The GRID Plus links together participating Blue Cross Blue Shield plans' dental networks in a comprehensive national network.

For a description of our dental products and network, visit our website, bluecrossma.com/provider, and go to **Patient Resources>Plans & Products>Product Overview**.

Our dental benefit designs

Our dental plans categorize dental procedures into four benefit groups shown on the following page.

Coverage for services in each benefit group adheres to our dental policy, which includes limitations and guidelines related to:

- Frequency (how often a service is performed)
- Age (specified age qualifications)
- Utilization
- Waiting periods

You can learn about the frequency limitations, age restrictions, utilization guidelines, and waiting periods for each code by using our CDT Dental Procedure Code Lookup tool or by referring to our *CDT Dental Procedure Guidelines and Submission Requirements*. These resources note that for some Affordable Care Act-compliant plans, the coverage differs between pediatric and adult benefits. For details, call Dental Provider Services at **1-800-882-1178**, option **3**.

Annual maximum: Members receive an annual maximum to use toward dental services each year. After members exhaust their annual maximum and any additional accumulated maximum rollover benefit, they are responsible for payment up to your contracted allowable amount for covered services.

Deductible amount: Your patient's plan may include an annual deductible. Deductibles are limited to each individual patient, not to exceed the overall family deductible.

Lifetime maximum: Orthodontic coverage typically has a lifetime maximum. When patients have met their lifetime maximum, they are responsible for payment up to the contracted allowable amount for covered orthodontic services. Please use our CDT Dental Procedure Code Lookup tool to review submission requirements for orthodontic codes. You can also review our *CDT Dental Procedure Guidelines and Submission Requirements*. Both can be found on Provider Central by going to **Office Resources > Billing & Reimbursement > CDT Dental Procedure Code Lookup**.

Our dental benefit designs, *continued*
Coverage may vary due to employer group customization.

Preventive (Group 1)	Basic (Group 2)	Major (Group 3)	Orthodontic
Diagnostic • One complete initial oral exam, including initial dental history & charting of the teeth & supporting structures • Evaluation – problem-focused (emergency exam) • Periodic or routine oral evaluation • Single tooth radiographs • Bitewing radiographs • Full mouth radiographs, seven or more films, or panoramic radiographs with bitewing radiographs • Study models and casts used in planning treatment **Preventive** • Routine cleaning, scaling, polishing • Fluoride treatment • Space maintainers • Sealants applied to permanent molars and pre-molar surfaces	**Restorative** • Amalgam restorations • Composite resin restorations on all teeth • Sedative restorations • Pin retention for restorations • Stainless steel crowns on primary teeth and first permanent molars **Oral surgery** • Tooth extractions • Root removal • Biopsies **Periodontic** • Periodontal scaling and root planing • Periodontal surgery (soft tissue and osseous surgery) • Periodontal maintenance following active periodontal therapy **Endodontics** • Root canal retreatment • Root canal therapy on permanent teeth • Therapeutic pulpotomy • Endodontic surgery **Prosthetic maintenance** • Repair of partial or complete dentures, crowns, and bridges • Repair or replacement of teeth on existing complete or partial denture • Rebase or reline dentures • Re-cementing or crowns, inlays, onlays, and fixed bridge work **Other services** • Services to treat root sensitivity • General anesthesia • Emergency dental treatment • Occlusal adjustments	**Prosthodontics** • Complete or partial dentures • Fixed bridges • Replacement of dentures and bridges • Adding teeth to an existing partial or full denture • Temporary partial dentures to replace any of the six upper or lower anterior teeth **Major restorative** • Crowns; metallic, resin and porcelain onlays • Replacement of crowns and onlays • Post and core, crown build-up, implant abutments • Implant crowns • Implant fixtures	**Orthodontics** • Complete orthodontic exam • Cephalometric radiograph • Comprehensive or limited active orthodontic treatment including appliances

Section 1 Our dental networks, plans, and benefits

Employer coverage customization

Employers can choose specific coverage levels for benefits, annual maximum, deductible, and lifetime orthodontic maximum for their employees. For example, a benefit selection could look like:

Benefit group	Level of coverage (example)
Group 1 Preventive/diagnostic	100%
Group 2 Basic	80%
Group 3 Major restorative	50%
Orthodontic	100%; $1,500 lifetime maximum

Employer accounts can also choose additional benefit options. We recommend that you check eligibility and benefits (see Section 8, Technology Solutions) before providing services since some of our employer accounts may customize their benefits.

Accumulated maximum rollover benefit

All small group dental plans include an accumulated maximum rollover benefit, which lets each member roll over a certain dollar amount of their unused annual dental benefits for use in a future year when the member meets certain criteria. Larger employer accounts may also select this benefit. Rollover funds are available 90 days after plan renewal. You can determine if a member has rollover benefits by calling our Dental Provider Services team to verify benefits at **1-800-882-1178**, option **3**.

If the member's dental plan's annual maximum benefit amount is	And if the member's claims don't exceed this amount for the benefit period	Then we will roll over this amount for the member to use next year and beyond	Rollover totals will be capped at this amount*
$500-$749	$200	$150	$500
$750-$999	$300	$200	$500
$1,000-$1,249	$500	$350	$1,000
$1,250-$1,499	$600	$450	$1,250
$1,500-$1,999	$700	$500	$1,250
$2,000-$2,499	$800	$600	$1,500
$2,500-$2,999	$900	$700	$1,500
$3,000 or more	$1,000	$750	$1,500

* This is not a Flexible Savings Account (FSA). The amount reflects the member's benefit maximum for a given year.

Section 1 Our dental networks, plans, and benefits

Enhanced Dental Benefits

To promote total health, we offer Enhanced Dental Benefits for members with the qualifying medical conditions shown below who may benefit from increased oral care. The services shown in the chart below are not subject to the member's deductible, coinsurance, or annual maximum when provided by a network dentist. There is no additional cost to receive these extra benefits.

Enhanced dental benefits for all members

Condition	One cleaning or periodontal mainenance[1] visit (four per calendar year*)	Periodontal scaling once per quadrant every 24 months*	Oral cancer screening two per calendar year	Fluoride treatment four per calendar year
Coronary artery disease	√	√		
Diabetes	√	√		
Developmental and/or intellectual disabilities[2]	√		√	√
Mental health conditions[2]	√		√	√
Oral cancer	√		√	√
Pregnancy[2]	√	√		
Sjögren's syndrome	√		√	√
Stroke	√	√		

1. Available on plans that offer periodontal benefits. There must be at least three months between a periodontal maintenance cleaning and any other cleanings covered under your dental plan, including these Enhanced Dental Benefits.
2. Self-enrollment is required.

Section 1 Our dental networks, plans, and benefits

How we identify and enroll members in Enhanced Dental Benefits

If the member has one of these conditions	With Dental Blue AND Blue Cross of Massachusetts health insurance	With Dental Blue and other health insurance
• Diabetes • Coronary artery disease • Oral cancer • Stroke • Sjögren's syndrome	We will automatically enroll them in Enhanced Dental Benefits.	The member must ask their physician to complete an Enhanced Dental Benefits Enrollment Form for them.
• Intellectual and/or developmental disabilities • Mental health condition • Pregnancy	The member must ask their physician to complete an Enhanced Dental Benefits Enrollment Form so we can determine eligibility.	

The enrollment forms can be found on our website at **Clinical Resources > Clinical Programs & Information > Oral & Overall Health.**

To determine if a member is eligible for the Enhanced Dental Benefits program, call the Dental Provider Services team at **1-800-882-1178**, option **3**.

Dental benefits for children under age 13

For our large group accounts, we provide 100% coverage for members under age 13 for covered preventive, basic, and major dental services up to the annual maximum. This does not apply to orthodontic benefits and the Table of Allowance still applies for members who have a Dental Blue Value Plan. Some accounts may opt out of this benefit, so please be sure to verify eligibility and benefits before providing services.

Coverage for dental services under medical plan

In accordance with the subscriber certificate, we do **not typically** cover dental services under the medical benefit, with the following exceptions:

- Cleft lip and/or cleft palate for members under age 18. For billing details, refer to our *Billing Guidelines for Cleft Lip and/or Cleft Palate* by logging on to our website and selecting **Office Resources> Billing & Reimbursement>Billing Guidelines & Resources**.
- Certain services related to accidents.

Dental services are not covered under the medical benefit even if a dental condition is caused by a covered medical condition or the result of treatment for a covered medical condition.

We do not cover the following services under most members' medical benefit plans unless the account has customized the benefit:

- Removal of fully or partially impacted teeth
- Removal of multiple erupted teeth

To check for eligibility and benefits, please call the Dental Provider Services team at **1-800-882-1178**, option **3**.

Section 1 Our dental networks, plans, and benefits

Pediatric dental benefits offered through our medical plans

Our individual and small group (under 50 employees) medical plans sold outside of the Dental Exchange cover pediatric dental benefits for children up to age 19, as required under the Patient Protection and Affordable Care Act (ACA). The pediatric dental benefits mirror the CHIP dental benefit plan offered in Massachusetts.

An example of how we will reimburse for services provided to eligible members is shown below:

Benefit group	Level of coverage (example)
Group 1 Preventive/diagnostic	100%
Group 2 Basic restorative	75%
Group 3 Major restorative	50%
Orthodontic (medically necessary)*	50%

* *Prior authorization is required. Refer to section 4 (Orthodontic services) for requirements and billing guidelines.*

There is no benefit maximum for services provided under the Pediatric Essential dental benefits but members typically have a deductible and year maximum out-of-pocket. We recommend that you check benefits and eligibility prior to rendering services.

The current deductible and maximum out-of-pocket for Pediatric Essential dental benefits are:

- **Annual deductible:** $50 per *member* (no more than $150 for three or more members who are eligible for pediatric essential dental benefits and who are enrolled under the same family membership)
- **Annual out-of-pocket maximum:** $350 per *member* (no more than $700 for two or more members who are eligible for pediatric essential dental benefits and who are enrolled under the same family membership)

For more information, refer to our *Pediatric Essential Health Benefits Guidelines and Submission Requirements*, which you can find by logging in to our website and selecting **Office Resources > Policies & Guidelines > Provider Manuals**.

Medicare Advantage: HMO and PPO plans

We offer Medicare HMO Blue® and Medicare PPO Blue for the Medicare-eligible community. Members receive coverage under their medical contract for dental services. These plans are available to Medicare beneficiaries residing in all Massachusetts counties except Berkshire, Dukes, and Nantucket. In addition, Medicare PPO Blue is available to employer group members residing anywhere in the United States.

Some Medicare Advantage plans offer limited preventive and diagnostic dental services while some plans include preventive, basic, and major services. To verify benefits, call Dental Provider Services at **1-800-882-1178**, option **3**. Please refer to Section 5, Reimbursement, for more information.

Medicare HMO Blue. (Prefix XXC) You must be Medicare-eligible and contracted with Medicare HMO Blue to provide care to Medicare HMO Blue members. With the exception of the Medicare HMO BlueFlexRx, these are the only members who can receive covered services out-of-network.

Medicare PPO Blue. (Prefix XXU) You can provide covered services to Medicare PPO Blue members whether or not you are contracted with Medicare PPO Blue. However, members have lower cost-sharing when they receive care from Medicare PPO Blue providers.

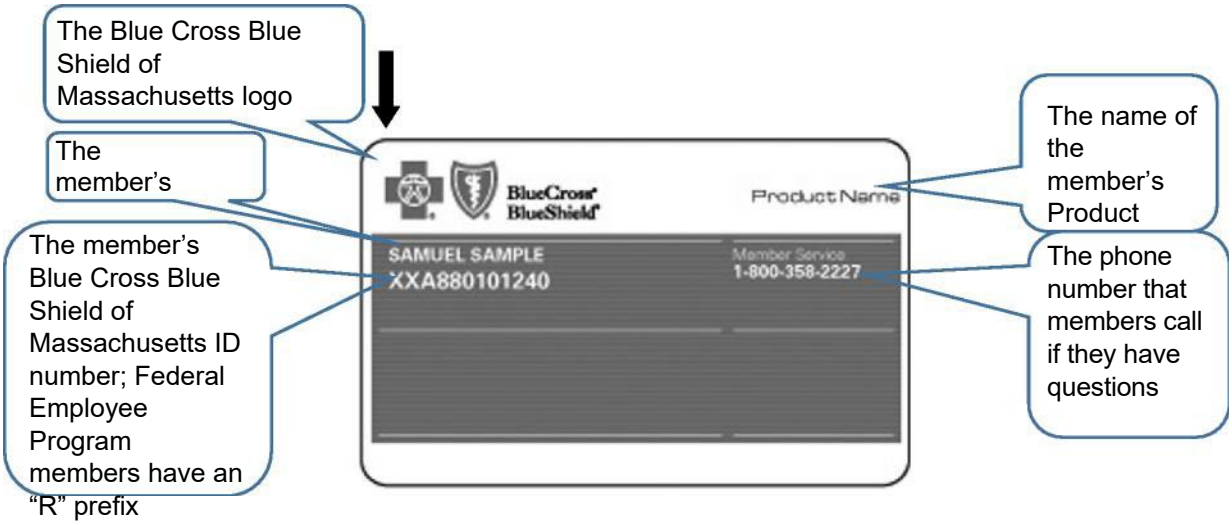
Section 2 Member Information

Sample member ID card

While our member ID cards differ from plan to plan, all cards include the information needed to submit claims to us, as shown in the illustration below: the subscriber's name, alpha-numeric ID, and plan name.

Please verify eligibility and benefits before rendering services. Patients may call the telephone number on the front of their ID card to speak to a Member Service representative if they have questions regarding their eligibility or benefits.

We use subscriber identification numbers in place of Social Security numbers. **Please be sure to use your patient's current identification number when submitting claims to avoid payment delays.**



Verifying member eligibility, benefits, and claim status

You can obtain patient eligibility, benefit descriptions, and claim status information by calling our Dental Provider Services team at **1-800-882-1178**, option **3**.

Co-insurance is the member's share of the allowed amount for covered services, expressed as a percentage. When a patient's plan covers a procedure at less than 100%, the member is responsible for the difference between our payment and the allowed amount.

The patient's co-insurance is based on the following, whichever is lower:

- Your fee or the maximum allowable charge for your location and specialty; or
- Your Dental Blue PPO fee schedule and your patient's benefit structure.

The Provider Detail Advisory (PDA) will display your patient's co-insurance (see Section 7). You may bill the patient after you receive payment from us.

Co-insurance, *continued*

The following table shows an example of how we calculate the member's co-insurance:

Procedure code	Benefit group	Coverage level	Allowed amount	Member's co-insurance
D2150	2	80%	$100	$100 x .2 = $20

Deductibles

Covered services may be subject to a deductible, which is an amount of money a patient is responsible for paying before benefits are provided. Generally, the deductible is collected annually, with a per-member amount that cannot exceed a family total maximum for the year. The deductible is based on your fee or the Maximum Allowable Charge, whichever is less. You can collect a patient's deductible ***after*** we've processed the claim and sent your Dental Provider Detail Advisory (PDA) and Dental Provider Payment Advisory (PPA).

Copayments

Copayments are set dollar amounts for which the member is responsible at the time of service. They are considered part of your total reimbursement and will be reflected on your payment advisory. You may collect copayments at the time of service.

When you can collect payment from the member

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

You may only charge the member up to the fee schedule amount beyond the benefit maximum in that calendar year for additional services **that would otherwise be covered**. 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 or • Has not satisfied a waiting period or • Is outside their eligible coverage period	Up to your charges

Non-covered services. If a service is not covered under your patient's benefit plan, 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 covered, notify your patient in writing that they will be responsible for your total charge prior to rendering the service to them.

When you can collect payment from the member, *continued*

For Medicare Advantage members. Before you render services to a Medicare Advantage member that you believe are non-covered, you must first submit an Inquiry or a Pre-service Organization Determination Request to determine if the services are covered under their Medicare Advantage Plan. We will respond to the Inquiry or Request. This response will serve as notice to the member about their benefits and obligations. See Appendix B to learn more about Medicare Advantage policies.

Services covered as an "alternate benefit." Some procedures are covered under your member's benefit plan as an "alternate benefit," such as an amalgam restoration allowance toward the cost of a metallic, porcelain, composite resin inlay, or composite resin restoration. In this case, we provide the benefit of a comparable service and notify you and your patient that they are responsible for the balance up to the plan allowable for the benefit.

What is a pre-treatment estimate (PTE)?

A pre-treatment estimate tells how we will process a claim based on the member's benefits at the time of processing. A pre-treatment estimate is not a guarantee of payment. It is designed to determine:

- Whether a service is a covered benefit under the member's plan
- Whether the procedure meets our utilization review guidelines and dental policy
- Whether there are any time limits on a procedure
- What the projected estimated payment will be for the procedure

We recommend that you submit a pre-treatment estimate for any services or combination of services exceeding $250.

For Medicare Advantage members. Pre-Treatment Estimates are classified as Inquiries. You may submit an Inquiry for Medicare Advantage members, but the purpose of the Pre-treatment Estimate/Inquiry is to understand the members benefits and estimated out-of-pocket costs. It is not a decision or authorization of coverage. If a utilization review or policy review is required or if you require a coverage decision to be made, you must submit a Pre-service Organization Determination Request. See Appendix B for more details.

How to submit a pre-treatment estimate (PTE)

Electronic submission: Use your practice management system to submit pre-treatment estimates electronically through your clearinghouse. The **payer ID** for Blue Cross Blue Shield of Massachusetts is **CBMA1**.

Paper claim submission: Complete the ***ADA Dental Claim Form* (2024)** as if you were submitting an actual claim for services. Be sure to:

- Enter an "X" in box 1 of the claim form next to "Requests for Predetermination/Preauthorization"
- List only the services to be included in the PTE for each line
- Do **NOT** list a date of service
- Enter the total charges in box 32.

How to submit a pre-treatment estimate (PTE), *continued*

Mail the paper pre-treatment estimate request to:

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

We do not process coordination of benefits on pre-treatment estimates.

- Rollover benefits may apply to pre-treatment estimates when annual maximum rollover dollars are available.
- We cannot accept pre-treatment estimates for Federal Employee Program (FEP) members covered under their medical benefit. FEP members can be identified by an ID number starts with "R." Verify if the member has Blue Cross Blue Shield FEP Dental under the GRID national network.
- Massachusetts-participating dentists: Do NOT submit attachments and documentation unless we request them. We will not return radiographs or attachments that you send to us.

How we respond to pre-treatment estimate requests

Our Utilization Management team, which includes licensed practicing dentists and hygienists, reviews pre-treatment estimate requests. **We will let you know** if documentation is required to process your pre-treatment estimate. For Medicare Advantage members, we'll let you know whether you need to submit a Pre-Service Organization Determination Request. We respond via the Pre-treatment Estimate Form and notify both you and your patient of approvals or denials.

Predetermination is not a guarantee of benefits. It is a response to your inquiry for dental coverage. For example, predetermination does not consider any coordination of benefits. We calculate pre-treatment estimates using current available benefits, patient's eligibility, and waiting periods. Estimates are subject to change when the claim is submitted for payment, based upon remaining benefits available and eligibility at the time services are completed. You must submit a new claim after providing the service to the member.

Claim submission

Submit all claims within 365 days of treatment. Claims submitted after that timeframe will be denied for being over the timely filing limit.

If you	You can submit a claim
Previously submitted a pre-treatment estimate request	• Electronically for services which were previously authorized and have been completed. • By paper, send the 2024 ADA form to: Process Control Blue Cross Blue Shield of Massachusetts P.O. Box 986005 Boston, MA 02298 Do not add the date of service to your pre-treatment estimate and resubmit it. You must submit a new claim.
Did not previously submit a pre-treatment estimate request	• Electronically using your practice management system. • By paper, send the 2024 ADA form to the address listed above.

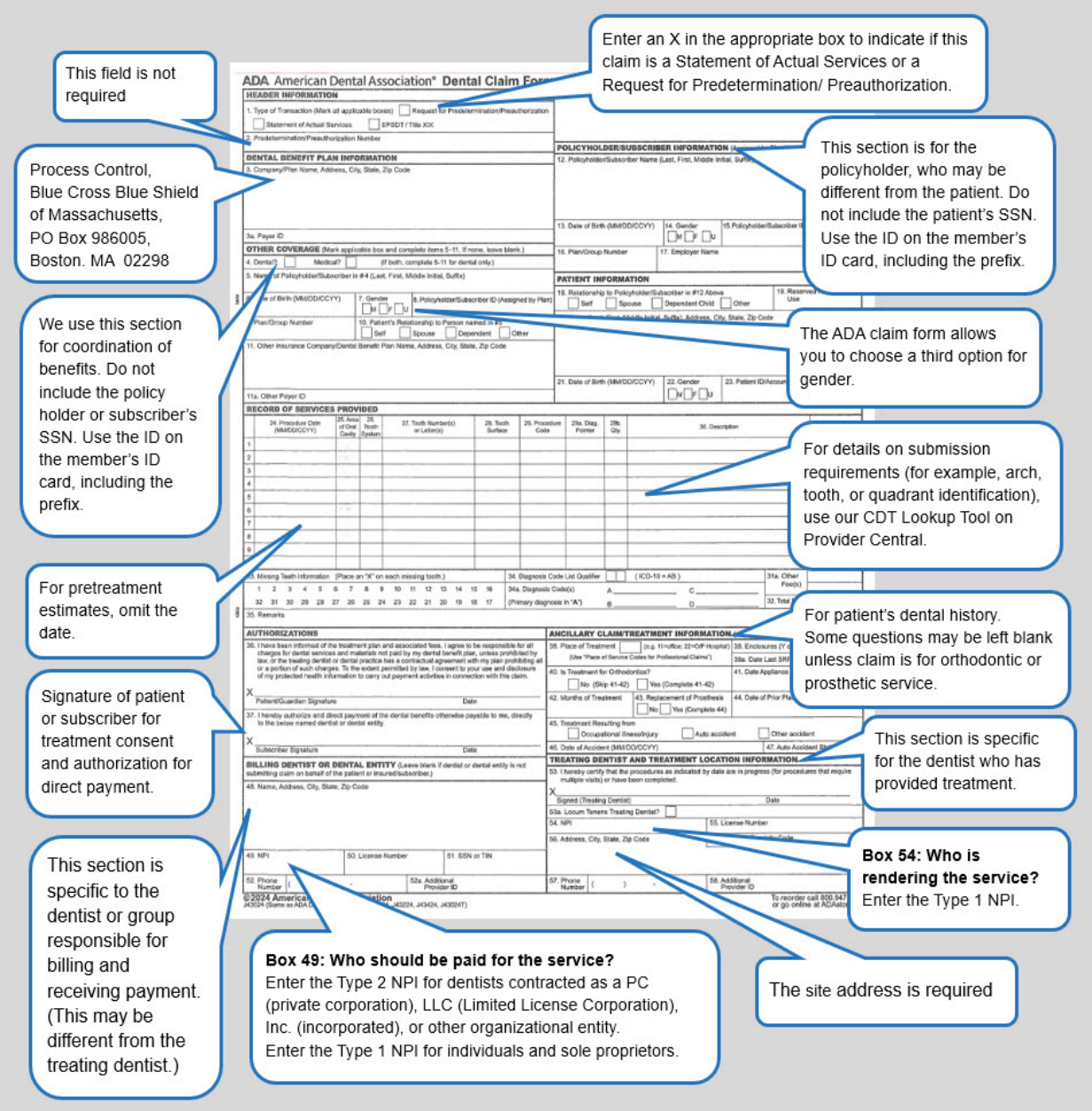
Section 3 Pretreatment estimates and claims

Benefits of submitting claims electronically

Submitting claims electronically will save you time and money so you can spend more time doing what you do best – caring for your patients. Electronic claim submission offers improved claim payment time, reduced claim errors, and increased productivity and efficiency. To get started with electronic claim submission, see Section 8, Technology solutions.

Completing a paper dental claim form

We recommend using the 2024 ADA claim form although we still accept previous versions at this time. If your office submits paper claims, you can order the new form through your dental office supply or through the ADA at **1-800-947-4746** or ada.org.



Section 3 Pretreatment estimates and claims

Dental claim submission guidelines using the 2024 ADA claim form

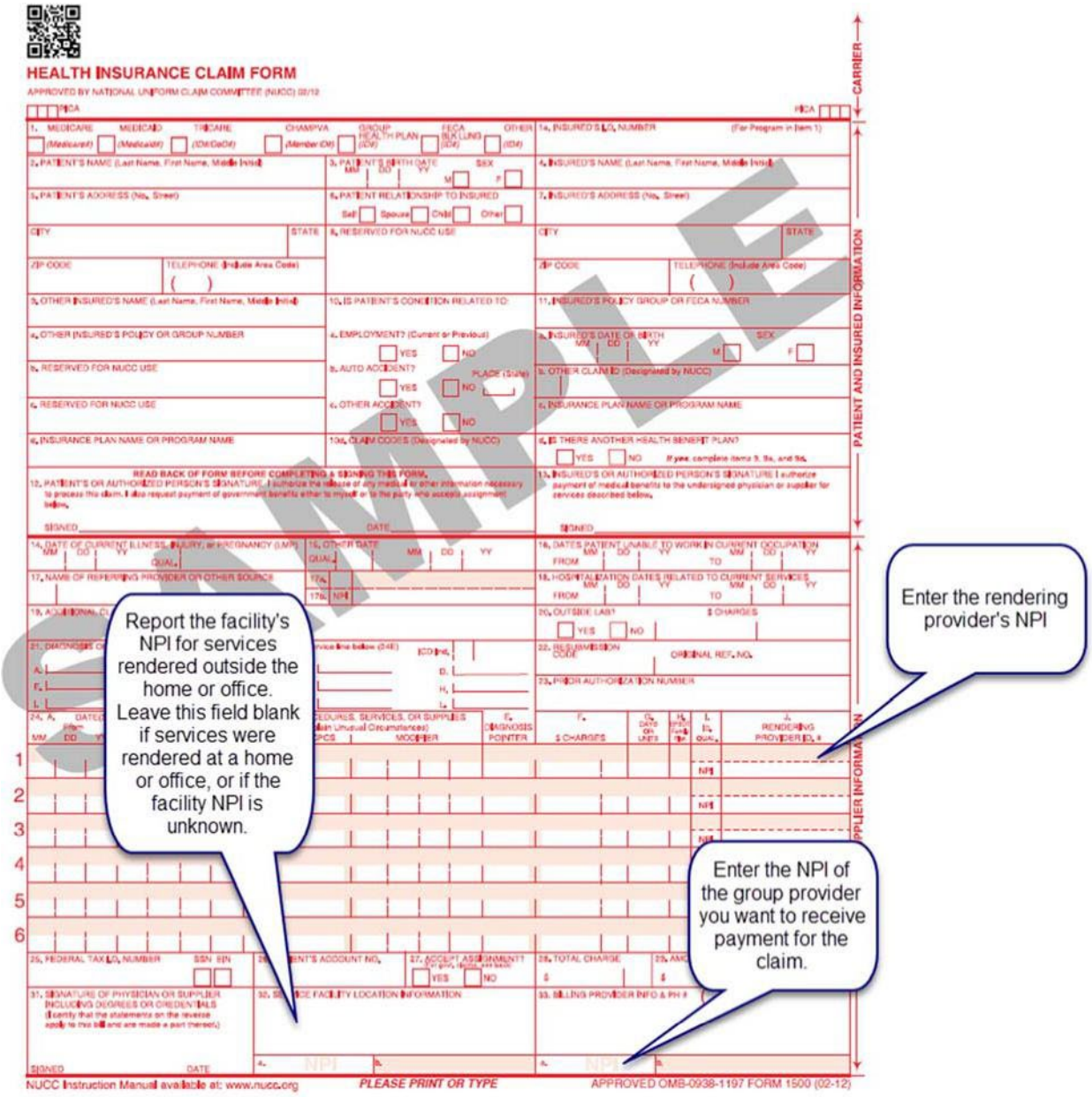
If you have this type of NPI	Submit paper claims using	Submit electronic claims using
Type 1 NPI (Individual and sole proprietor)	The Type 1 NPI in **box 49 & 54** of the 2024 ADA Claim Form	The Type 1 NPI in the billing provider section **(boxes 49 and 54)**.
Type 2 NPI (organizational) dentists contracted as one of the following: • PC (Private Corporation) • LLC (Limited License Corp) • Inc (Incorporated) • PLLC (Professional Limited Liability Company) • any other organizational entity	The organization's Type 2 NPI in **box 49** of the 2024 ADA claim form and The individual provider's Type 1 NPI **in box 54**.	The organization's Type 2 NPI in the Billing Dentist or Dental Entity provider section **(box 49)** and The individual provider's Type 1 NPI in the Treating Dentist and Treatment Location section **(box 54)**.

Ensure your practice management software vendor has the correct billing information as described above and verify with your clearinghouse that information matches.

Section 3 Pretreatment estimates and claims

Claim submissions (oral & maxillofacial surgeons)

For medical claims submitted using the red 1500 Claim Form (02/12 version), please be sure to enter the NPIs as shown below:



Ensure your practice management software vendor has the correct billing information as described above and verify with your clearinghouse that information matches.

Section 3 Pretreatment estimates and claims

How to check claim status

To check a claim's status:

- Use your practice management software tools.
- Call Dental Provider Services at **1-800-882-1178**. Select **option 3**, then **option 2**.

Oral and maxillofacial surgeons can use ConnectCenter via Provider Central to check the status of medical claims.

Coordination of benefits

Please be sure to ask your patients if they have another plan that may provide them with additional dental benefits. This is important because when a member has more than one insurer covering their health care costs, the insurers need to coordinate payment. The primary insurer must process the claim first. The claim is then submitted to a secondary or tertiary insurer with the explanation of benefits from the primary insurer. This is called "coordination of benefits."

To coordinate coverage, we need the other insurer's information, even if family members are covered by two different Blue Cross Blue Shield of Massachusetts policies. To avoid overpayments, obtain other possible insurance information in advance from your patient. Then, follow these general guidelines:

1. Determine the patient's **primary** payer so you can submit the claim.

If your patient	Then
Is the subscriber on the plan	The subscriber's plan is primary.
Has two plans	The plan that has been in effect longest is primary if both policies are active employer group policies or both retiree policies. Otherwise, active policies are primary over retiree or COBRA plans.
Is a dependent *over* age 19 with parents/guardians that are married or living together	The "birthday rule" applies. The parent or guardian whose birthday falls first in the calendar year is primary.
Is a dependent *under* the age of 19 who is covered under the Essential Health Benefits for pediatric dental	Their *medical* plan is primary.
If the member has both Dental Blue 65 and Medicare Advantage	The Medicare Advantage plan is primary *if the specific services are covered under both plans*.

2. Determine Medicare Advantage and Dental Blue 65 liability
    - If the Dental Blue 65 plan makes a payment as secondary, take the patient's liability from the primary Medicare Explanation of Benefits and subtract the Dental Blue 65 provider payment. This would equal the members total liability for that procedure/line. **For example**, if Medicare left a member liability of $130.84, and the Dental Blue 65 plan paid $15.42 as the secondary payer, the member's liability would be $115.42 (Medicare liability – Dental Blue 65 payment = Total member liability).

- Dental coordination of benefits differs from non-dental. The secondary Explanation of Benefits may not reflect accurate patient and provider liability.

  To determine the provider's liability, the provider would take their charge, and subtract the primary payment, the secondary Dental Blue 65 payment, and the subscriber's liability. That would equal their write-off.

3. Submit the primary payer's Explanation of Benefits (EOB) to the **secondary** payer.
   - When completing a dental claim form, be sure to complete the section that asks whether your patient is covered by another insurance carrier.
   - Remember that the secondary payer's EOB may not correctly reflect the patient balance, and that your patient's liability may be affected by contracts that you hold with the primary carrier. (This process is known as standard Coordination of Benefits.)
   - When the member has both medical and dental benefits, the medical plan will always be the primary payer. Please submit a claim to the medical plan first and then submit the claim with the medical explanation of benefits to the dental plan.
   - When the member has both medical and dental benefits with us as the secondary payer, we will not pay more than the remaining member balance reflected on the primary plan's EOB/Provider Detail Advisory.

Coordination of benefits, *continued*

We cannot accept a pre-treatment estimate from the primary carrier. This must be a clearly identified EOB.

Do not bill for coordination of benefits to collect any "adjusted" fee amount your office may have incurred. You can submit for coordination of benefits only when the member has a liability. **You may not bill** for coordination of benefits to collect any "adjusted" fee amount your office may have incurred.

If the medical insurance is primary, the payment will be based on member liability. If the dental insurance is primary insurance, the payment is determined by the secondary balance.

Important: Patients should contact our member service area if any of the following scenarios apply:

- The patient and spouse have separate insurance through each employer
- A patient's child has an insurance plan through his/her school and also through you or an employer
- A patient's child has multiple plans as the result of a divorce situation or custody arrangement
- A patient or other family member has potential coverage through Medicare

Billing requirements for coordination of benefit claims

You must complete the following fields on the ADA Dental claim form (2024):

- The primary insurer's name and address
- For electronic submissions: The amount paid by the primary insurer at the claim's line level detail (if the primary insurer paid the claim) or the reject reason at the line level detail (if the primary insurer denied the claim). Submitting an EOB is not considered line level detail. We only process line-by-line adjudication
- The insured member's ID number
- The amount paid by the primary insurer at the claim's line level (if the primary insurer paid the claim) or the reject reason at the line level (if the primary insurer denied the claim)
- Include a copy of the other insurer's EOB. Do not attach pre-treatment estimates when submitting your COB claim. We only accept EOBs. When submitting electronic attachments, include the Electronic Attachment number in the comments section of the claim.

For more information about coordination of benefits, please go to our Provider Central website and click on **Office Resources>Billing & Reimbursement > Coordination of Benefits**. That page includes a link to our Member Fact Sheet about Coordination of Benefits.

Section 4 Orthodontic services

Billing for preliminary work-up appointment (records)

For preliminary work-up (records) appointments, submit claims with separate lines for each service performed. This maximizes the member's orthodontic benefit since the services shown below (except cephalometric films) will be deducted from the member's annual dental benefit instead of their orthodontic benefit.

When orthodontic pretreatment estimates are requested, the estimates reflect the patient's remaining lifetime maximum.

CDT code	Narrative
D0150	Comprehensive oral evaluation
D0210	Intraoral complete series
D0330	Panoramic film

CDT code	Narrative
D0340	Cephalometric film
D0350	Oral facial images
D0470	Diagnostic casts

Orthodontic benefit categories

Term	Definition	Example
Limited orthodontic treatment	Orthodontic treatment using any therapeutic modality with a limited objective or scale of treatment. Treatment may occur in any state of dental development or dentition.	Treatment in one arch only to correct crowding, partial treatment to open or close spaces, or uprighting a tooth for a bridge, implant or partial.
Comprehensive orthodontic treatment	Multiple phases of treatment provided at different stages of dentofacial development.	Treatment may utilize fixed and/or removable orthodontic appliances to address comprehensive functional or anatomic dentofacial and craniofacial relationships.

How to submit the orthodontic treatment claim

Submit *all* orthodontic claims electronically. Include the following information on **all** orthodontic claims, including initial submissions of comprehensive cases and take-over cases.

If you must submit a paper 2024 ADA claim form, please note that:

- Routine orthodontic claims do not require attachments.
- If coordination of benefits is necessary, complete Sections 4-11, Other Coverage, and attach the Explanation of Benefits from any primary insurance along with line level payment details from the other carrier.
- On the primary EOB, include the patient's other insurance orthodontia lifetime maximum
- Be sure to complete all of the following boxes for both a full comprehensive case or take-over case:

Box	Data
29	Appropriate CDT procedure code
32	Total case fee
36 & 37	Assignment of benefits

Box	Data
41	Appliance placement date (banding date)
40	Is treatment for orthodontics?
42	Number of months of treatment

All orthodontic treatment should be performed by a licensed dentist or supervised staff acting within their scope of practice, including an initial clinical evaluation of the patient to establish need and develop a treatment plan.

Section 4 Orthodontic services

Billing and reimbursement

For all cases, be sure to submit the fields mentioned above.

To bill for	Include this information	And payment will be
Full comprehensive case for patients whose comprehensive treatment started after their orthodontic benefits became effective	• CDT procedure code • Total treatment charge • Box 41: Initial banding date (even if you didn't start the treatment) • Box 42: Total length of treatment/ treatment plan	Initial down-payment will be 50% of the patient's orthodontic benefit maximum for covered services less any member cost share. We will pay the rest in monthly installments until treatment plan is complete, or benefits are exhausted.*
Full comprehensive case for patients whose treatment began prior to their orthodontic benefits becoming effective	• CDT procedure code • Box 24: Procedure date -- use the date ortho became effective • Box 35: State "work in progress" • Box 41: Initial banding date (even if you didn't start the treatment) • Box 42: Total length of treatment/ treatment plan	Monthly payment will begin with the first date of service in your practice. It will include the monthly orthodontic reimbursement minus any member cost-share, up to the patient's lifetime maximum or end of treatment (whichever comes first).*
Full comprehensive case for patients whose treatment began in another office and you are completing treatment	• CDT procedure code • Box 35: Write "takeover case" • Box 41: Initial banding date (even if you didn't start the treatment) • Box 42: Total length of treatment/ treatment plan • Use takeover date as procedure date	Monthly payments will be made on the first date of service in your practice. It will include orthodontic reimbursement minus any member cost share, up to the patient's lifetime maximum or end of treatment (whichever comes first).*
Full comprehensive case for continuation of care *Continuation of care not covered for ACA medically necessary cases	• CDT procedure code with full case fee (with original banding date) • For each additional month you are billing in excess of the original treatment plan, you should submit additional charges as necessary Box 35: Write "Continuation of treatment" • Box 41: Original banding date • Box 42: Indicate total length of treatment/ treatment plan	Any additional payment will follow the next month from your last date of service provided benefits are available.

Section 4 Orthodontic services

To bill for	Include this information	And payment will be
Limited and minor treatment	• CDT procedure code • Total treatment charge	Blue Cross pays out limited orthodontia as a one-time payment and we do not accept "take over/work in progress" cases for limited orthodontia. If the patient started limited orthodontia services while the plan was • Active: we would issue a one-time payment. • Not active: we would not provide reimbursement.
Comprehensive ACA medically necessary case **Note:** Not applicable for ACA Medically necessary cases	• **Prior authorization is required** (see following page) • CDT procedure code • Total treatment charge	Initial payment will be 25% down-payment of the allowable benefit minus any annual member cost-share. Balance will be paid monthly until treatment plan is complete.

To receive our reimbursement, you must register for Electronic Funds Transfer through Payspan, Inc. (see Section 8, Technology solutions, for more information). You do not need to submit a second claim; we will automatically pay you.

Section 4 Orthodontic services

Eligibility for medically necessary orthodontic benefit

As part of the prior authorization process for medically necessary orthodontia services for patients under age 19, we may ask you to submit documentation supporting that the patient has:

- A severe and handicapping malocclusion or misalignment of teeth as defined by Handicapping Labio-Lingual Deviations (HLD) index score of 22
- An autoqualifier that we have reviewed and approved for automatic coverage.

If the member does not qualify by these criteria, please submit a rationale that explains the emotional, behavioral, or nutritional necessity for coverage. A clinician in the field where the exception is being sought should provide written support of this narrative.

Only participating orthodontists can perform medically necessary orthodontic services. We will only pay claims that have approved prior authorizations. We will only authorize new cases; there is no benefit for takeover cases.

Approved prior authorizations for medically necessary orthodontic cases are valid for one year from the date of approval. You must submit a new request if you begin treatment *after* this time period has elapsed. In addition, the prior authorization will only display the maximum out-of-pocket cost for that patient based on the current calendar year.

Prior authorization for medically necessary services

To request prior authorization for	Please
Medically necessary orthodontic services	1. Submit the services requested on a dental claim form with the pre-treatment estimate box checked. 2. Include the appropriate documentation for review of Comprehensive Orthodontic Cases (D8080, D8091) including the pre-treatment claim form, HLD Index Form, orthodontic prior authorization form, cephalometric and panoramic images, and photographic prints showing lateral, occlusal, and frontal views for comprehensive orthodontic cases. A letter of medical necessity can also be submitted for review with the necessary supporting documentation. 3. Include appropriate documentation for review of Limited Orthodontic cases (D8010, D8020) including the pre-treatment claim form, orthodontic prior authorization form, and photographic prints. 4. Send the prior authorization request electronically, if possible. If your pretreatment estimate has been approved, you can consider this to be your approved prior authorization.
Occlusal guards	1. Submit the services requested on a dental claim form with the pre-treatment estimate box checked. 2. Submit a narrative stating the necessity and appropriateness of an occlusal guard for prior authorization of this service. Do not enter a date of service on the claim. 3. Remember to enter an “X” in Box 1 of the claim form next to “Request for Pre-determination/Pre-authorization.” List the services to be included in the prior authorization. 4. Send the prior authorization request electronically, if possible. If your pretreatment estimate has been approved, you can consider this to be your approved prior authorization.

Section 4 Orthodontic services

Photographic print requirements for medically necessary orthodontia

When submitting photographic prints for medically necessary orthodontic services, please be sure to mount the print and indicate the provider and patient names and the date.

- **Facial view.** Be sure patient's face is clearly discernible.
- **Lateral views.** Take views with sufficient soft tissue retraction to expose the buccal dentition, and as close to ninety degrees to the plane of the buccal dentition as possible (use of mirror may be necessary). The use of a pediatric-size lip retractor facilitates sufficient soft tissue retraction. Photographs should allow evaluation of the antero-posterior relationship.
- **Occlusal view.** Take occlusal view with a mirror and retract so that the soft tissue of the lower lip does not cover the lower incisors. Try to include as many teeth as possible. Please measure the clinical widths of the maxillary and mandibular right central incisors and enter the measurements on the HLD Record Form.
- **Panoramic radiographic image.** All teeth must be clearly visible. For limited medically necessary orthodontics, radiographic images are not required.

We cannot authorize cases without complete information. We will return orthodontic records to the provider if submitted by mail with a self-addressed, stamped return envelope.

Section 5 Reimbursement

How we determine reimbursement

Use this chart to see which fee schedule we use to determine your reimbursement * Please note that each plan may have unique or non-standard benefits.

	And the provider participates in				
If the member belongs to	**Medicare Advantage**	**Dental Blue**	**Dental Blue PPO®**	**Dental Blue National Network**	**Then payment is based on the**
Dental Blue		√		√	Indemnity Regional Fee Schedule
Dental Blue PPO		√	√	√	Dental Blue PPO Fee Schedule
Dental Blue Select **Dental Blue Preventive** **Dental Blue Freedom** **Dental Blue Value** **Teamsters**		√	√	√	Dental Blue PPO Fee Schedule Indemnity Regional Fee Schedule if participating in Dental Blue only
Medicare HMO Blue℠ FlexRx*	√	√			Medicare Advantage HMO/PPO Fee Schedule If provider only participates in Dental Blue: Dental Blue Indemnity Regional fee schedule
Medicare HMO Blue℠ SaverRx **Medicare HMO Blue℠ ValueRx** **Medicare HMO Blue℠ PlusRx**	√				Medicare Advantage HMO/PPO Blue Fee Schedule. Patient only has coverage if they see a Medicare HMO contracted provider
Medicare PPO Blue EssentialRx* **Medicare PPO Blue ValueRx*** **Medicare PPO Blue PlusRx*** **Medicare PPO Blue Freedom Rx**	√	√			If Medicare Advantage provider: Medicare Advantage HMO/PPO Blue Fee Schedule If provider only participates in Dental Blue: Dental Blue Indemnity Regional fee schedule
Dental Blue® 65 Basic **Dental Blue® 65 Premier** **Dental Blue 65 Preventive**		√		√	Dental Blue Indemnity Regional Fee Schedule

Section 5 Reimbursement

How to obtain fee schedules

Your Dental Blue and Dental Blue PPO fee schedules are only available by logging into our Provider Central website and selecting **Office Resources>Billing & Reimbursement>Fee Schedules**. We will not mail or send them.

Out-of-state providers should contact your local Blue Cross plan for your fee schedules.

Electronic Funds Transfer

Our standard method of reimbursement is Electronic Funds Transfer (EFT), which we offer through Payspan, Inc. at no charge to you. See Section 8, Technology solutions, for more information about the benefits of using Payspan.

Reports to help you track claims

When you are paid electronically, we provide two reports to help you track your claims:

Dental Provider Payment Advisory (PPA). The top of the PPA summarizes all of the claims that are included with the payment, including the member's name, ID number, claim number, amount paid, and member balance. For providers who do not use EFT, the bottom portion is your check.

Dental Provider Detail Advisory (PDA). The PDA gives the detail for each claim, including the member's name, ID number, claim number, date of service, tooth identification, tooth surfaces, procedure code, submitted charge, allowed amount, member deductible, member co-insurance, paid amount, provider adjustment amount, member balance, and line message code. You will find the PDA particularly helpful in many ways. It will:

- Help you understand why we paid or rejected a claim in a certain way
- Explain how we processed a Pre-treatment Estimate
- Show why we have deducted money from your payment
- List the dollar amount you should collect from your patient including co-insurance, deductible, and non-covered charges.

Providers who are paid via check will receive the check with their ***Provider Dental Voucher.***

Section 6 Appeals and claim reviews

How to appeal a denied claim

Claims must meet the criteria for necessary and appropriate treatment as outlined in our CDT Dental Procedure Code Lookup tool or the most current version of our *CDT Dental Procedure Guidelines and Submission Requirements*. If your claim does not meet the criteria, you can request an appeal within one year from the date of service. Please note: we changed the timeframe to submit appeals, replacement claims, and corrected claims as of October 1, 2025 for medical claims. There is no change to the one-year timeframe for dental claims.

If the denied procedure(s) meets the criteria for appeal, either the denial letter or the PDA message you received outlines how to appeal the procedure and what documentation is required for re-review. Please provide the reason for appeal and any applicable documentation to support your request.

For Medicare Advantage members, please see Appendix B for submitting an appeal on behalf of a Medicare Advantage Member.

Pretreatment estimates cannot be appealed. You will need to resubmit pretreatment estimates with applicable documentation for consideration.

How to submit an appeal

Please send all appeals using the Request for Dental Claim Review Form with appropriate documentation to:

Process Control
Blue Cross Blue Shield of Massachusetts
P.O. Box 986010
Boston, MA 02298

If you have additional questions about a denial, please call Dental Provider Services, Monday-Friday, 8:30 a.m. – 4:30 p.m. (EST), at **1-800-882-1178**, option **3.**

How to request a claim review

To request a claim review for the denial of a claim based on patient eligibility, benefits, or claim adjustments, please call Dental Provider Services at **1-800-882-1178,** option **3**. We may ask you for a copy of your Dental Provider Payment Advisory (PPA) or Dental Provider Detail Advisory (PDA) with any additional documentation that will support your request. Please send the Request for Dental Claim Review Form with appropriate documentation to:

Process Control
Blue Cross Blue Shield of Massachusetts
P.O. Box 986010
Boston, MA 02298

Section 6 Appeals and claim reviews

Overpayments

If an overpayment was made to you, this is how you or we should proceed:

If	Then
You determine that Blue Cross Blue Shield of Massachusetts has overpaid you	Call Dental Provider Services at **1-800-882-1178,** option **3.** Please have the amount, claim number, and the patient's ID number available.
We determine that we made an overpayment to you	We'll send you notice of the retraction of the overpayment with an invoice. We request payment within 30 days. Your Provider Detail Advisory (PDA) indicates which claims were paid in error and should be included with your payment. Please copy the invoice and indicate the payment amount. Enclose a check or money order and forward it, along with the invoice, to: Blue Cross Blue Shield of Massachusetts P.O. Box 223934 Pittsburgh, PA 15251
You disagree with a request for refund of an overpayment	Call Dental Provider Services at **1-800-882-1178**, option **3**. Please have the invoice, claim number, and patient's ID number available and the reason you are disputing the refund request. You will be instructed on how to appeal.

If we do not receive payment by the due date on the invoice

If we do not receive payment by the date indicated on the invoice, we will deduct the money from future payments. This is called an "offset." We will send you a PPA that will show an "Account Receivable Applied."

When your PPA does not match your reimbursement check

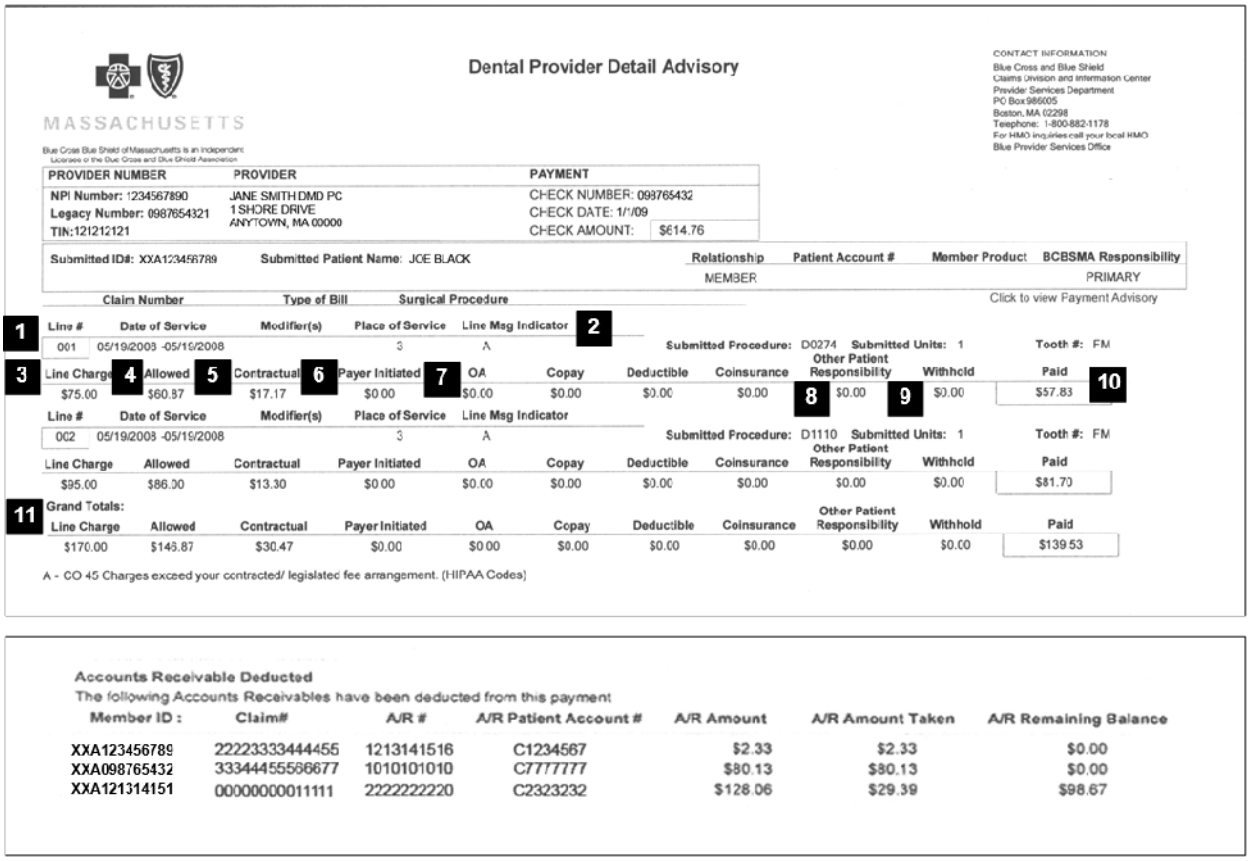
If the check amount is less than the total dollar amount on the Dental Provider Payment Advisory, the following may apply:

- We applied the money from that check to an outstanding balance ("accounts receivable," A/R), or
- The service was a pre-treatment estimate, so there is no actual claim payment.

See the example of a Dental Provider Payment Advisory (PPA) with an "A/R" on the next page. If you have questions about an invoice you received or how to interpret a Dental Provider Payment Advisory PPA, please call Dental Provider Services at **1-800-882-1178**, option **3**.

Section 6 Appeals and claim reviews

Sample Payspan provider detail advisory with accounts receivable (web)



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Dental Provider Detail Advisory

CONTACT INFORMATION
Blue Cross and Blue Shield
Claims Division and Information Center
Provider Services Department
PO Box 986005
Boston, MA 02298
Telephone: 1-800-882-1178
For HMO inquiries call your local HMO
Blue Provider Services Office

PROVIDER NUMBER	PROVIDER	PAYMENT
NPI Number: 1234567890 Legacy Number: 0987654321 TIN:121212121	JANE SMITH DMD PC 1 SHORE DRIVE ANYTOWN, MA 00000	CHECK NUMBER: 098765432 CHECK DATE: 1/1/09 CHECK AMOUNT: $614.76

Submitted ID#: XXA123456789 Submitted Patient Name: JOE BLACK

Relationship	Patient Account #	Member Product	BCBSMA Responsibility
MEMBER			PRIMARY

Claim Number Type of Bill Surgical Procedure

Click to view Payment Advisory

1 Line #	Date of Service	Modifier(s)	Place of Service	Line Msg Indicator 2
001	05/19/2003 -05/19/2008		3	A

Submitted Procedure: D0274 Submitted Units: 1 Tooth #: FM

3 Line Charge	4 Allowed	5 Contractual	6 Payer Initiated	7 OA	Copay	Deductible	Coinsurance	Other Patient Responsibility 8	Withheld 9	Paid 10
$75.00	$60.87	$17.17	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$57.83

Line #	Date of Service	Modifier(s)	Place of Service	Line Msg Indicator
002	05/19/2003 -05/19/2008		3	A

Submitted Procedure: D1110 Submitted Units: 1 Tooth #: FM

Line Charge	Allowed	Contractual	Payer Initiated	OA	Copay	Deductible	Coinsurance	Other Patient Responsibility	Withheld	Paid
$95.00	$86.30	$13.30	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$81.70

11 Grand Totals: Line Charge	Allowed	Contractual	Payer Initiated	OA	Copay	Deductible	Coinsurance	Other Patient Responsibility	Withhold	Paid
$170.00	$146.87	$30.47	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$139.53

A - CO 45 Charges exceed your contracted/ legislated fee arrangement. (HIPAA Codes)

Accounts Receivable Deducted

The following Accounts Receivables have been deducted from this payment

Member ID :	Claim#	A/R #	A/R Patient Account #	A/R Amount	A/R Amount Taken	A/R Remaining Balance
XXA123456789	22223333444455	1213141516	C1234567	$2.33	$2.33	$0.00
XXA098765432	33344455566677	1010101010	C7777777	$80.13	$80.13	$0.00
XXA121314151	00000000011111	2222222220	C2323232	$128.06	$29.39	$98.67

1. **Line #.** Identifies the sequence in which procedures are adjudicated on the claim.
2. **Line msg indicator.** Service disallowed or denial message code. Description of code appears at the end of the member's section.
3. **Line charge.** Charge for each procedure code.
4. **Allowed.** Dollar amount on which the applicable plan bases payment.
5. **Contractual.** The amount adjusted in this field is not the patient's responsibility under any circumstances due to either a contractual obligation between the provider and the payer, or a regulatory requirement.
6. **Payer initiated.** The amount in this field is not the responsibility of the patient.
7. **OA.** Indicates whether other insurance is allowed. This will be used when no other category is appropriate. Refer to Adjustment Reason Code/Remark Code fields. If a patient has reached the benefit maximum, or is not eligible for the service due to frequency limitations, this column lists the provider adjustment.
8. **Other patient responsibility.** Contains any dollar amounts the member owes outside of deductibles and coinsurance.
9. **Withhold.** Additional money withheld per provider's contractual agreements.
10. **Paid.** Amount paid for each line of claim. Total appears at the end of each member record.
11. **Grand total.** Combines all totals into a final adjudication for the entire claim.

Section 7 Federal Employee Program

Federal Employee Program plans

The Service Benefit Plan (commonly referred to as the Federal Employee Program or "FEP"), has more than 120,000 federal and postal employees enrolled in Massachusetts. You can find more information about Blue Cross Blue Shield FEP Dental at: bcbsfepdental.com or fepblue.org.

The following are plans available to federal employees and dependents. Dental Blue-participating dentists are designated as "preferred dentists" for FEP members.

Members of this plan	Can receive dental care from	And have coverage for
FEP Blue Basic®	Only Dental Blue-participating dentists. No benefits for non-network providers (some limited exceptions for emergencies)	Preventive dental care (exams, cleanings, intraoral X-rays (one complete series every three years), and sealants for children up to age 16.)
FEP Blue Standard®	Any dentist (Dental Blue, Dental Blue PPO, and non-participating dentists)	Includes preventive dental benefits
FEP Blue Focus®	This plan does not include dental benefits.	

Federal Employee Program ("Medical Plans") ID numbers

FEP members have ID numbers that begin with an "**R**." In addition to the unique ID number, the ID card identifies the member's plan by using the following codes:

This enrollment code indicates that the member belongs to	
33D	Standard Option Self Only (PSHB)
33E	Standard Option Self & Family (PSHB)
33F	Standard Option Self + One (PSHB)
33A	Basic Option Self Only (PSHB)
33B	Basic Option Self & Family (PSHB)
33C	Basic Option Self + One (PSHB)
104	Standard Option Self Only (FEHB)
105	Standard Option Self & Family (FEHB)
106	Standard Option Self + One (FEHB)
111	Basic Option Self Only (FEHB)
112	Basic Option Self & Family (FEHB)
113	Basic Option Self + One (FEHB)

Section 7 Federal Employee Program

Claim submission

Please be sure to include the alpha prefix and the ID number on your claims for Federal Employee Program members.

If you are not billing electronically, please submit claims for Federal Employee Program members (Standard Option and Basic Option) to:

Process Control – Attention FEP
Blue Cross Blue Shield of Massachusetts
P.O. 986005
Boston, MA 02298

Provider Services

For questions regarding the Federal Employee Program or your patient's claims, please call **1-800-882-1156** or write to us at:

Blue Cross Blue Shield of Massachusetts
FEP
P.O. Box 986005
Boston MA 02298

Provider Payment Advisories

We will send you a Provider Payment Advisory (PPA) and Provider Detail Advisory with our payment explaining how we processed your claim under the Standard Option or Basic Option.

Determining reimbursement

This table explains how we reimburse participating Dental Blue dentists for services provided to Federal Employee Program members:

If your patient is covered under:	And you are a Dental Blue dentist, we'll pay you the:	And you can bill your patient for:
Standard Option only	Standard Option fee schedule amount	The difference between the maximum allowable charge and any payments we make to you.
Basic Option only	Dental Blue Maximum Allowable Charge less the applicable copayment	A copayment up to the oral evaluation allowance, whichever is less.

You may not bill members for amounts more than the Maximum Allowable Charge for your region and specialty for any covered service. Members' co-insurance and copayments are included within the allowed amount.

Section 7 Federal Employee Program

When a patient has Standard Option *only*

The example below shows how we pay a Dental Blue dentist for CDT code D0120 and D1120 when a patient is covered by Standard Option *only.* The Maximum Allowable Charge is based on the dental provider's specialty and region. The following example uses random dollar amounts.

Step	Process	Example	Comments
1.	Use the Dental Blue fee schedule to determine our maximum allowed charge for the CDT code.	D0120 = $35.86 D1120 = $65.00	As an in-network provider, you agree to accept this amount as full payment.
2.	Use the Standard Option fee schedule to determine payment due from the Standard Option.	D0120 = $5.86 D1120 = $22.00	This is the amount you will receive from us.
3.	Determine what your patient must pay (Step 1 – Step 2).	D0120 = $27.86 D1120 = $43.00	You can bill the patient up to this amount.

When a patient has Basic Option *only*

You can bill **Basic Option** members the $35 copayment for covered services and your charge for any services not covered under the Basic Option. The Basic Option copayment is waived for dental care rendered to members with primary Medicare Part B.

Reimbursement for Federal Employee Program Members

The tables below identify services covered under the Federal Employee Program Standard Option and Basic Option. The **Standard Option** allowances listed are those reimbursed by the plan. Basic Option benefits are shaded and are only covered when rendered by a Dental Blue provider.

For Basic Option, please also note that:

- For D0120 and D0150, the benefit limit is a combined total of two evaluations per person per calendar year
- For D1110 and D1120, the benefit limit is a combined total of two visits per person per calendar year
- For D0210, the benefit is limited to one series every three years
- D1206 topical application fluoride varnish is covered for all ages
- Dental diagnostic imaging benefits are limited to an intraoral complete series.

Section 7 Federal Employee Program

Standard Option dental benefits

CDT Code	Narrative	Up to age 13	Age 13+
CLINICAL ORAL EVALUATIONS			
D0120	Periodic oral evaluation (up to two per person per calendar year)	$12	$8
D0140	Limited oral evaluation	$14	$9
D0150	Comprehensive oral evaluation	$14	$9
D0160	Detailed and extensive oral evaluation	$14	$9
DIAGNOSTIC IMAGING			
D0210	Intraoral - complete series	$36	$22
PALLIATIVE TREATMENT			
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$24	$15
D2940	Protective restorative	$24	$15
PREVENTIVE			
D1110	Prophylaxis - adult	N/A	$16
D1120	Prophylaxis - child	$22	$14
D1206	Topical application of fluoride or fluoride varnish (up to two per person per year)	$13	$8
Not covered: Any service not specifically listed above		Nothing	Nothing

Section 7 Federal Employee Program

Basic Option dental benefits

CDT code	Narrative	Payment/member responsibility
Clinical oral evaluations		
D0120	Periodic oral evaluation*	Dental Blue Indemnity allowable fee minus member $35 copayment
D0140	Limited oral evaluation	
D0150	Comprehensive oral evaluation*	
Diagnostic imaging		
D0210	Intraoral - complete series including bitewings (limited to one complete series every three years)	Dental Blue Indemnity allowable fee minus member $35 copayment
Preventive		
D1110	Prophylaxis – adult (up to two per calendar year)	Dental Blue Indemnity allowable fee minus member $35 copayment
D1120	Prophylaxis – child (up to two per calendar year)	
D1206	Topical application of fluoride or fluoride varnish (up to two per calendar year)**	
D1351	Sealant – per tooth, first and second molars only (once per tooth for children up to age 16 only)	
Any service not listed above		Member is responsible for all charges

* Benefits are limited to a combined total of two evaluations per person per calendar year.

** Preventive dental care benefits for the topical application of fluoride or fluoride varnish are limited to up to two services per person per calendar year, limited to children only.

Blue Cross Blue Shield FEP Dental

Blue Cross Blue Shield FEP Dental is a supplemental dental plan available to federal and postal employees and retirees. Blue Cross Blue Shield FEP Dental members can use GRID+ participating providers for in-network care. Dentists who participated in the Dental Blue network will have access to Blue Cross Blue Shield FEP Dental members.

Blue Cross Blue Shield FEP Dental reimbursement is based on your applicable Dental Blue fee schedule.

Blue Cross Blue Shield FEP Dental have two options while choosing benefits during open enrollment, High Option or the Standard Option, as shown in the following charts. To verify benefits, please call **1-855-504-2583** or visit bcbsfepdental.com.

Section 7 Federal Employee Program

Blue Cross Blue Shield FEP Dental benefits

High Option benefits	In-network member responsibility	Out-of-network member responsibility
Class A (Basic) services – preventive and diagnostic	0%	10%
Class B (Intermediate) services* – includes minor restorative services	30%	40%
Class C (Major) services* – includes major restorative, endodontic, and prosthodontic services	50%	60%
Class A, B, and C services are provided with an **unlimited** annual maximum benefit for in-network benefits, $3,000 for out-of-network benefits, and a $50 deductible for out-of-network services per calendar year.		
Class D services – orthodontic** $3,500 lifetime maximum for in- and out-of-network	50%	50% of the out-of-network allowed amount
Standard Option benefits	**In-network**	**Out-of-network**
Class A (Basic) services – preventive and diagnostic	0%	40%
Class B (Intermediate) services* – includes minor restorative services	45%	60%
Class C (Major) services* – includes major restorative, endodontic, and prosthodontic services	65%	80%
Class A, B, and C services are subject to a $1,500 annual maximum benefit for in-network benefits, $750 for out-of-network benefits, and a $75 deductible for out-of-network services per calendar year.		
Class D services – orthodontic** $2,500 Lifetime Maximum for in-network, or $1,250 lifetime maximum for out-of-network	50%	50%

* Class B and C services – For both High Option and Standard Option, services are covered at 100% for children age 13 and under when visiting an in-network dentist.

** Class D services – Both the High Option and Standard Option do not have an orthodontic waiting period.

FEP BlueDental member ID cards

The member's card has the FEP BlueDental logo with the claims' submission address and customer service number to verify benefits. On the back upper left corner of the member's ID Card, you'll see GRID+, which indicates the use of the GRID+ network.

The ID card is for identification ONLY. To verify coverage for the date of service, call the FEP BlueDental Customer Service Department at **1-855-504-2583**.

Because the member's medical plan is the primary carrier, you must ask for the member's medical ID card in addition to their FEP BlueDental ID Card.

Section 7 Federal Employee Program

Claim submission

Accurate claims submission results in faster payment. To ensure timely claims payment, please check that your claims include the following complete, accurate information:

- Treating dentist NPI, license number, and provider specialty code
- Billing dentist NPI and Tax Identification Number (TIN)
- Patient's birth date
- Patient's relationship to the member
- Member's birth date
- Member's identification number
- Member/patient's signature
- Current ADA procedure code(s)
- Fee for treatment
- Treatment date(s)
- Tooth number, surface, and quadrant if applicable
- Treating dentist's signature

Pre-treatment estimates

FEP BlueDental recommends that you submit a pre-treatment estimate request before treatment for extensive oral surgery, periodontics, endodontics, major restorative, prosthodontic, and orthodontic services. You and the member will receive an explanation of benefits that indicates if procedures are covered, and that estimates what will be paid for those services.

The estimated Maximum Allowable Amount is based on the member's current eligibility and contract benefits in effect at the time of the completed services. Submission of other claims or changes in eligibility or the contract may alter the final payment. A pre-treatment estimate is not a guarantee of benefits.

When submitting pre-treatment estimates for a member of FEP BlueDental, use the member's FEP BlueDental ID number and submit pre-treatment estimates to:

FEP BlueDental
P.O. Box 75
Minneapolis, MN 55440-0075

Do not submit radiographs with pre-treatment estimate requests; FEP BlueDental may request this documentation after treatment through our program that monitors dentist utilization patterns after payment.

Only submit cosmetic service claims if the member requests it

Cosmetic dental services **are not** covered by the plan. If you provide cosmetic services to a member, you do not need to submit a claim to FEP BlueDental. If you wish to submit a claim to show the member that the service is not covered, submit a claim directly to:

FEP BlueDental Claims
P.O. Box 75
Minneapolis, MN, 55440-0075

Section 7 Federal Employee Program

Coordination of benefits

The member's medical coverage is **always** primary (if there is embedded dental coverage) and FEP BlueDental is secondary. Submit all claims to the primary medical plan first. Refer to the back of the member's medical ID card for submission. Pre-estimates of benefits can be submitted directly to FEP BlueDental. Upon completion of the dental care, submit the claim to the primary medical plan.

FEP Standard Option or Basic Option medical member. Submit claims to the local Blue Cross plan. Primary payment will be sent to you, then FEP Medical will forward the claim, along with the primary payment amount, to FEP BlueDental. The primary benefit will be coordinated on the claim received from the medical carrier. FEP BlueDental will send you the secondary payment.

Non-Blue Cross Blue Shield medical member. Submit claims to the other medical carrier (if there is embedded dental). After you receive payment from the primary payer, submit claims and primary remittance to FEP BlueDental for secondary coordination of benefits payment. Please hold secondary claim submission until you have received primary payment and remittance from the other medical plan.

If primary submission is to FEP Standard Option or Basic Option medical. Federal member identification numbers (ID) for FEP Medical begin with an "R" followed by eight digits (example: R12345678). If you do not use the correct ID format for FEP medical, claims may reject. Follow all claim form instructions for the proper placement of the member ID.

Reconsiderations – claim dispute

If you and your FEP BlueDental patient disagree with the way dental services were processed, your FEP BlueDental patient may submit a reconsideration request. (Refer to the member's FEP BlueDental brochure.) Send reconsiderations or claim disputes to:

FEP BlueDental Claims Appeals
P. O. Box 551
Minneapolis, MN 55440-0551

Provider Services

Call Customer Service at **1-855-504-2583**. Submit claims to:

FEP BlueDental Claims
P.O. Box 75
Minneapolis, MN 55440-0075

Section 8 Technology Solutions

Provider Central

Provider Central is our secure website for Massachusetts participating providers that gives easy access to all the tools you need to do business with us. When you log into the Provider Central website you will find:

- The fee schedules specific to your practice
- Access to the technologies we offer to make doing business with us easier, including Payspan, ConnectCenter (for Oral and Maxillofacial surgeons), and our CDT look-up tool
- Links to all our policies and guidelines, including *CDT Dental Procedure Guidelines and Submission Requirements* and *Pediatric Essential Health Benefits Guidelines and Submission Requirements*
- Important contractual news, articles, and clinical news

Out-of-state providers can access news and policy information on the non-secure side of our website without logging in.

Electronic claim submission

We require all health care providers to submit claims electronically. Submitting claims electronically benefits you by:

- Reducing administrative costs and paperwork for your office
- Improving accuracy of billing and posting information, including itemized Coordination of Benefits at the claims line level
- Increasing security for protected information
- Improving cash flow
- Speeding claims processing

Check with your practice management software vendor to confirm that they can accommodate electronic billing and attachments if necessary.

Electronic attachments

Through our collaboration with Vyne Dental, you can submit any requested radiographs, periodontal charting, intra-oral images, narratives, and EOBs electronically through Vyne Dental's HIPAA-compliant, secure, FastAttach® website. FastAttach accelerates claim processing and eliminates the cost and time involved in duplicating and mailing radiographs and other attachments. FastAttach can:

- Acquire radiographs and other images from multiple sources
- Offer image enhancement
- Transfer claim information, eliminating duplicate data entry
- Provide a tracking number

To learn about the technical requirements for submitting electronic attachments and to enroll, call Vyne Dental at **1-800-782-5150**, ext. **1**, or go to vynedental.com.

Section 8 Technology Solutions

Electronic funds transfer (EFT) with Payspan

To receive payment from us, you must register for Electronic Funds Transfer (EFT) through Payspan, Inc. Payspan offers secure direct deposit of your organization's payments for services and allows you to:

- Receive your payments faster, using secure electronic funds transfer (EFT) directly into your business account
- Verify the weekly status of your EFT
- Access claim and payment data 24/7
- View, print, and search Dental Provider Payment Advisories (PPAs) and Dental Provider Detail Advisories (PDAs)
- Obtain account receivable information
- Customize reports for your office
- Set up multiple business accounts
- Simplify secondary submission with patient specific Dental Provider Payment Advisory (PDA)

To get started using Payspan, log on to payspanhealth.com/nps.

If you are registering for Payspan as a	Then
New group	You will receive your registration code and PIN (provider identification number) in your welcome letter
Existing practice	Request a new registration code and PIN by going to: payspanhealth.com/RequestRegCode/

CDT Dental Procedure Code Lookup tool

You can use our simple online CDT Dental Procedure Code Lookup tool for as many codes as needed, saving you time, just by selecting your patient's plan name. You can access the tool 24/7 on Provider Central by going to: **Office Resources > Billing & Reimbursement > CDT Dental Procedure Code Lookup**.

Section 9 Who do I contact?

To	Contact	At
• Add a new provider • Make practice changes • Learn about Enhanced Dental Benefits Program	Dental Network Management Out-of-state providers call your local Blue Cross plan	For Massachusetts providers: **1-800-882-1178**, option **4** **South Shore / Cape Cod Region** select **1** **North Shore / New Hampshire** select **2** **Boston / Metro West /** select **3** **Central and western Massachusetts/ Dental Schools** select **4** Email: DentalNetworkRequest@bcbsma.com
Verify member eligibility for members of this plan:		
• Medex®'	Medex®' Core Plus Dental Benefit	Phone: **1-800-882-2060**, option **5**
• Commercial dental (for dental services) • Pediatric dental benefits (for ACA-compliant medical plans)	Dental Provider Services	Phone: **1-800-882-1178**, option **3**
• Commercial dental or OMS providers (for medical services)	Medical Provider Services	Phone: **1-800-882-2060**
• FEP Massachusetts	FEP	Phone: **1-800-882-1156**
• FEP GRID/GRID+ (other Blue plans)	Blue Cross Blue Shield FEP Dental	Phone: **1-855-504- 2583** Mail: Blue Cross Blue Shield FEP Dental P.O. Box 75 Minneapolis, MN 55440-0075
• Blue Cross of Massachusetts employees	Employee provider services	Phone: **1-800-238-6616**
File a grievance for Medicare Advantage members	Medicare Advantage	Phone: **1-800-200-4255** Fax: **1-617-246-8506** Email: MedicareAdvantageRXAppeals@bcbsma.com Mail: Blue Cross Blue Shield of Massachusetts Medicare Advantage Appeals Coordinator P.O. Box 55007 Boston, MA 02205
File a written appeal on behalf of a Medicare Advantage member	Medicare Advantage	Mail: Blue Cross Blue Shield of Massachusetts Medicare Advantage Appeals Coordinator P.O. Box 55007 Boston, MA 02205 Email: MedicareAdvantageRXAppeals@bcbsma.com Fax: **1-617-246-8506**
Check eligibility and claim status	Dental Provider Service	Phone: **1-800-882-1178**, option **3**
Coordinate benefits with another insurer	Coordination of Benefits	Phone: **1-888-799-1888**
Set up and use Electronic Funds Transfer	Payspan	Phone: **1-877-331-7154** Web: providersupport@payspanhealth.com

Section 9 Who do I contact?

To	Contact	At
Submit electronic attachments	Vyne Dental	Phone: **1-800-782-5150, Ext 1** Web: vynedental.com
Help getting started with Provider Central or EDI	Provider Central Helpdesk	Phone: **1-800-771-4097** Web: bluecrossma.com/provider
Order ADA claim forms	American Dental Association	Phone: **1-800-947-4746** Web: ada.org
Report fraud	Fraud Hotline	Phone: **1-800-992-4100**
Find member resources	Blue Cross of Massachusetts	Web: bluecrossma.org

Appendix A Conditions of participation

This section applies only to Massachusetts-contracted participating providers.

Dental Blue conditions of participation

To participate in the Blue Cross and Blue Shield of Massachusetts Dental Blue network, each dentist must:

- Complete a dentist's application
- Complete a W-9 form
- Sign a Blue Cross Blue Shield of Massachusetts Dental and Professional Oral & Maxillofacial Surgery Agreement
- Register with Payspan, Inc. for Electronic Funds Transfer (EFT). Payspan lets you receive secure, direct reimbursement from us and view your Dental Provider Payment Advisory (PPA) and Dental Provider Detail Advisory (PDA). This is our standard method of reimbursement. (See Section 8, Technology, for more information about how to get started with Payspan.)

Standards, requirements, and contractual conditions

Participating dentists must also meet the standards, requirements, and contractual conditions described below.

Standard. The dentist must be licensed in Massachusetts pursuant to G.L.c. 112. A dentist who practices in a state other than Massachusetts must comply with the license requirements of the state where the dentist is located and provides services to members.

Requirements. The dentist must achieve a satisfactory review from the appropriate state board.

Contractual conditions.

1. If the dentist belongs to a group practice, full group participation is required. The dentist shall notify Blue Cross and Blue Shield of Massachusetts, Inc. of the intent of any individual provider in his or her group practice (organization) to terminate, extend, or alter his or her participation in the group practice. Furthermore, any individual provider wishing to join an existing group practice shall notify Blue Cross and Blue Shield of Massachusetts, Inc. within 90 days.

2. When a dentist located outside of Massachusetts renders services that otherwise meet Blue Cross and Blue Shield of Massachusetts, Inc. requirements, the dentist shall comply with the equivalent statutory and regulatory requirements of that state to Blue Cross Blue Shield of Massachusetts' satisfaction.

Appendix A Conditions of participation

Notification requirements for our Dental Blue Network

You are required to provide us with 90-day written notification in these situations:

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

For questions on making changes to your practice, please call Dental Network Management at **1-800-882-1178**, option **4**, or email: DentalNetworkRequest@bcbsma.com

Your Agreement shall remain in effect until terminated in one of the following ways:

1. **With cause.** These are terminations due to situations including, but not limited to: material breach, fraud, misrepresentation, and loss, limitation or suspension of licensure. Our termination may occur at any time with written notice to the provider. The practice or dentist shall conspicuously post a notice or notify members that the dentist is no longer a participating provider of the plan.
2. **Without cause.** These terminations require the dentist to provide us with 90-day written notice.

Dental Blue PPO and Medicare Advantage plans conditions of participation

To participate in Dental Blue PPO and Medicare Advantage* plans, each dentist must:

- Complete a dentist's application. The application includes an attestation to the accuracy of the application; malpractice information; statements regarding the dentist's lack of impairment to clinical practice; history of loss of license, felony conviction, or limitation to practice; and information about your practice characteristics.
- Complete a W-9 form.
- Provide the required credentials and successfully complete the credentialing process.
- Complete a Blue Cross Blue Shield of Massachusetts Dental Professional and Oral & Maxillofacial Surgery Agreement that includes PPA Products and/or Medicare Advantage Products, with associated attachments.

* The provider must be Medicare-eligible to participate with our Medicare Advantage Plans and indicate this as directed on the dental provider application form.

Participating dentists must also meet the standards, requirements, and contractual conditions described below.

Credentialing standards. The dentist must be licensed in Massachusetts pursuant to G.L.c. 112.

Requirements. The dentist must:

1. Achieve a satisfactory review of National Practitioners Data Bank (NPDB).
2. Achieve a satisfactory review of the Board of Registration in Dentistry with respect to sanctions, restrictions, and/or limitations in practice. A Blue Cross associate will review the information provided by the Board of Registration in Dentistry.
3. Successfully complete requirements for postgraduate training (specialty dentists only). Validation of successful completion is required.

Appendix A Conditions of participation

Dental Blue PPO and Medicare Advantage Plans conditions of participation, *continued*

Standard. The dentist must maintain appointment hours that are sufficient and convenient to service members at all times and must provide or arrange for 24 hour-a-day emergency and on-call services at their own expense.

Requirement. The dentist must submit a schedule of office hours, indicating a minimum of 12 clinical office hours per week or attest that they engage in sufficient clinical activity to maintain competency and provide appropriate member access.

Standard. The dentist must demonstrate clinical proficiency and a stable history of clinical practice.

Requirement. The dentist must:

1) Supply a curriculum vitae or complete work history spanning ten years in month/year format. They must include a written explanation of gaps of six months or greater.
2) Achieve a satisfactory review of malpractice history.
3) Supply a copy of a current/valid and unrestricted Federal Drug Enforcement Agency (DEA) certificate (excludes orthodontic specialists).

Note: If the new provider's DEA has not been released at the time of application, we will allow another participating dentist to prescribe on their behalf. This should be submitted in writing on office letterhead indicating the name and NPI of the prescribing dentist.

Standard. The dentist must maintain individual liability insurance in amounts of $1 million per occurrence/$3 million aggregate, to insure the dentist against any claim(s) for damages arising by reason of personal injury or death caused directly or indirectly by the dentist.

Requirement. A copy of the current declaration page must be submitted to us detailing coverage amounts. This can be attested to in the application or the declarations page.

Recredentialing

Credentialed dental providers must recredential every two years during the month of their birthday. A recredentialing packet will be sent to the practice as the due date approaches.

Information on our dental credentialing and recredentialing standards can be found by logging onto our website and going to **Office Resources > Enrollment > Credentialing & Recredentialing.**

Changes to your practice

You must notify us of any changes to your practice (adding or removing a provider, adding or closing a practice location, changing a TIN, or adding a new product).

To provide notice, please call Dental Network Management at **1-800-882-1178**, option **4**, or send an email to: DentalNetworkRequest@bcbsma.com.

See more information on our website by going to **Office Resources > Enrollment > Maintaining & Changing Status.**

Appendix B Medicare Advantage policies

This section applies only to Massachusetts-contracted participating providers.

These policies and procedures comply with the Centers for Medicare & Medicaid Services' (CMS') revised regulations for managed care organizations offering Medicare Advantage plans.

Inquiries

Members and providers can request inquiries to obtain information about coverage and benefits. An inquiry is not a grievance, organization or coverage determination request or an appeal. You can verify members eligibility, benefits and claim status as described in section 2, "How to Submit Pre-treatment Estimates."

Pre-Service Organization (Coverage) Determination Requests

A Pre-Service organization determination is a decision (approval or denial) made by the plan, on a request for coverage (provision) of an item, service, or drug.

We will process (inclusive of notification) Pre-service Organization Determination Requests within 7 calendar days (our standard timeframe). We will process (inclusive of notification) a request within an expedited timeframe of 72 hours if the request is expedited because the provider or documentation indicates that applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

If the request is denied, the member, provider on the member's behalf, or other designated party may request an appeal of the decision as described below.

Member appeals and grievances

Members of all our plans, including Medicare Advantage plans, have the right to appeal any decision regarding payment for services. Each member is provided with information on how to initiate the appeal process. We are also required to inform all Medicare Advantage providers of the member appeal process.

Member grievances

Grievance means any complaint or dispute, other than one that constitutes an organization determination, expressing dissatisfaction with any aspect of a Medicare Advantage organization's or provider's operations, activities, or behavior, regardless of whether remedial action is requested.

How members file a grievance

Medicare Advantage members can file a formal grievance in writing, by calling our Medicare Advantage service center at **1-800-200-4255**, or by sending a letter no later than 60 days after the event or incident. We will notify the member of our decision within 30 days of when we receive the grievance. Our decision is final.

Blue Cross Blue Shield of Massachusetts
Medicare Advantage Grievance Coordinator
P.O. Box 55007
Boston, MA 02205
Email: MedicareAdvantageRXAppeals@bcbsma.com
Fax: **1-617-246-8506**

Appendix B Medicare Advantage policies

Medicare Advantage appeals process

Medicare Advantage plan members, or you as a provider representing the member, can appeal any decision regarding our denial of payment or our failure to approve or provide services they believe are covered by Medicare. Appeals must be received within 65 calendar days of the denial notice, unless a good cause exception is granted.

We will process (inclusive of notification) appeals according to these timeframes:

- Standard (non-expedited) Pre-Service appeal – within 30 calendar days
- Expedited Pre-Service appeal – within 72 hours
- Payment/Claim appeal – within 60 days

If the appeal is denied, the case will be automatically sent to the Medicare Independent Review Entity (IRE) for further review.

Who can appeal?

An appeal can be requested verbally (expedited appeals only) or in writing by the member, the provider acting on the member's behalf, the legal guardian with power of attorney, or the person designated with power of attorney to make medical decisions member's behalf. We automatically expedite provider-initiated or provider-supported appeals.

Role of providers in appeal process

To comply with the 72-consecutive-hour requirement for expedited appeals, we need your cooperation in responding within 24 hours to medical record requests. We will clearly identify which requests are for expedited appeals. CMS will not accept delays in transferring medical record information between the health plan and participating providers as reason for extending the 72-consecutive-hour timeframe.

How to request an appeal

To support or request an appeal verbally, please call our Medicare Advantage service center at **1-800-200-4255**. To send appeals in writing, please mail them to:

Blue Cross Blue Shield of Massachusetts
Medicare Advantage Appeals Coordinator
P.O. Box 55007
Boston, MA 02205
Email: MedicareAdvantageRXAppeals@bcbsma.com
Fax: **1-617-246-8506**

Appendix B Medicare Advantage policies

Appeals of contractual privileges

Credentialed dentists who contract directly with Blue Cross Blue Shield of Massachusetts shall be provided due process for adverse decisions resulting in a change of contractual privileges.

This process will include the following:

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

All appeal materials are considered confidential.

For questions on the appeals process, please call Dental Network Management at **1-800-882-1178**, option **4**. Or write to:

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

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