



Dental Claims Imaging

Effective August 15, 2005

Special Interest Articles:

- Special tips on submitting corrected bills, reconsiderations and multi-page claims
- What to do if a paper claim is returned

Individual Highlights:

Required Elements	2
Specific Claim Form Guidelines	2-4
Corrected Bills	4
Optical Scanning Tips	5
If a Claim is Returned	5
Sample Returned Claim	6

Imaging and Scanning System Improves Service

BlueCross BlueShield of Tennessee implemented new data collection and imaging technology for paper claims with three basic goals in mind:

- Quicker claims processing
- Increased claims payment accuracy
- Enhanced customer service

Since we introduced this technology for medical and hospital claims these goals have been realized. We are now pleased to announce this technology will be applied to standard dental claim forms beginning August 15, 2005.

This updated Optical Character Recognition (OCR) software allows us to scan paper dental claims into our processing systems within one day of receipt while creating a permanent image of the claim.

These images will be used by claim

processors and customer service representatives to finalize claims and answer questions.

In most cases, filing claims in a scannable format will require very few changes to your billing procedures but making those few changes will improve the service we can provide you.

To assist you in filing claim forms in a scannable format, we have included guidelines on the types of dental claim forms that are appropriate for scanning as well as tips on completing required fields.

By following these guidelines, you can help reduce the time required to enter your Federal Employee Program (FEP) and Preferred Dental claims into our system and ensure that you receive accurate, timely claim payments.

Paper Forms Targeted for Scanning

Dentists who are not currently using one of the forms listed here are encouraged to update their systems to take advantage of improved claims processing.

BlueCross BlueShield of Tennessee will scan the following dental claim forms:

- American Dental Association (ADA) 2002
- American Dental Association (ADA) 1999 Version 2000
- American Dental Association (ADA) 1999
- American Dental Association (ADA) 1994

- American Dental Association (ADA) 1990
- DEN-119 (Preferred Dental)
- Dentech 2000
- Dentrix 2000 #2
- Easy Dental 1997-99

Other form types may be considered at a later date.

We will continue to accept other paper dental claim forms, however, they will be manually keyed into our processing systems. These claims will not benefit from the automation allowed through scanning.

Required Elements for Paper Dental Claims

Claim forms should be filled out completely with special attention given to the critical fields listed here. If the format or data on the following fields is not valid, the claim will be returned to the provider for correction and resubmission.

- Patient Name
- Patient Date of Birth
- Subscriber Identification Number
- Date of Service
- Procedure Code
- Charges
- Total Charges
- Tooth Number (*as appropriate*)
- Tooth Surface (*as appropriate*)
- Area of Oral Cavity (*as appropriate*)
- Tax Identification Number
- Signature of Treating Dentist

Note: The requirement of these data elements is not a change. These fields are currently required to process dental claims.

Specific Claim Form Guidelines

Actual Service vs. Pre-treatment

- Send claims for actual services on a separate claim form from pre-treatment requests. When actual services and pre-treatment requests are sent on the same claim, the form must be manually split, which slows down the claim payment process.
- Actual Services box checked - Include dates of service for all line items or the claim will be returned for correction.
- Pre-treatment box checked - Do not include dates of service or the claim will be returned for correction.

Patient Name

Follow the guidelines on the claim form. Some forms request the entire name in one field. Other forms provide separate fields for the First Name and Last Name.

- If the form asks for the Patient Name (Last, First, Middle Initial) in one field, provide the name using commas to separate the last name and first name. Example: HALL, CHRIS B.
- Patients with dual last names should use a hyphen between names. Example: JONES-HALL.

Patient Date of Birth

Date of Service

Dates should be submitted as follows:

MMDDCCYY

MM = month (01-12)

DD = day (01-31)

CCYY = year (0000-9999)

- Include leading zeros in the date fields, when appropriate. Example: **0**1122005, instead of 1122005
- Some paper dental forms will only allow a 2-digit year in the date of service. In these cases, use the format MMDDYY.

Example: 010105

- When sending a predetermination, do not include a date of service.

Subscriber Identification Number

Use the number **exactly** as it is listed on the member's BlueCross BlueShield of Tennessee identification card.

- BlueCross BlueShield of Tennessee began phasing in **non**-Social Security Number (SSN) identification numbers in 2004 to help protect member privacy. Some claim form fields may request the Subscriber's Social Security

Specific Claim Form Guidelines (Cont'd)

Subscriber Identification Number (cont'd)

Number. Because we moved to non-SSN identification numbers, we may not be able to identify the member by the SSN.

This is particularly true for new groups where we cannot require they provide their SSN.

- When submitting the subscriber ID number, do not include data in front of the ID number, such as ID#, SSN or #. The imaging equipment will read this extra data as part of the number, which may result in a rejection.

Procedure Code

- Use the appropriate CDT code for the date of service.
- Every line item with a charge must include a valid procedure code.
- A description or narrative is required when an unspecified code (999) is used.

Charges

Total Charge

- Do not include decimal points in the charges. Example: Submit 409 50 instead of 409.50.
- Submit 00 at the end of charges, when appropriate. Example: Submit 409 00 instead of 409.
- The sum of the line charges must equal the total charge.
- On multi-page claims, the total charge should only be listed on the last page.

Tooth Number

Follow American Dental Association (ADA) guidelines.

- Enter tooth number when the procedure directly involves a tooth or range of teeth.
 - When filing for consecutive teeth, use a "-". Example: 1-3 (Indicates procedure involved consecutive tooth numbers 1, 2, and 3).
 - When filing for teeth that are not connected, use a comma. Example: 1, 3, 4 (Indicates procedure involved tooth numbers 1, 3, and 4).

Tooth Surface

Follow American Dental Association (ADA) guidelines.

- Enter tooth surface when the procedure involves one or more tooth surfaces.

Area of Oral Cavity

Follow American Dental Association (ADA) guidelines.

- Enter oral cavity when:
 - procedure relates to area of oral cavity;
 - procedure does not require tooth or range of teeth; and
 - procedure code description does not include specific area of oral cavity.

Is Treatment for Orthodontics

It is important to indicate if the claim is for orthodontic services by using the appropriate box. Orthodontic claims will be reviewed manually to ensure appropriate reimbursement.

Treatment Resulting from Accident

Indicate in the appropriate box on the claim form if the treatment was provided due to an accident. Member benefits may be applied differently when services result due to an accident.

Provider Identification Number

Tax Identification Number

- The provider's tax ID number is required to identify the provider for payment. To speed up claims processing, the **individual** BlueCross BlueShield of Tennessee provider number should also be submitted.
 - Tax identification numbers are often tied to multiple provider numbers. When the provider number is not included on the claim, the list of providers tied to the tax ID must be manually checked against the provider's name or signature on the claim.
- When submitting the provider number and tax ID, do not include data in front of the number, such as ID#, PIN#, BCBS# or #. The imaging equipment will read this extra data as part of the number, which may result in a rejection.

Specific Claim Form Guidelines (Cont'd)

Provider Identification Number

Tax Identification Number (cont'd)

- Dentists who are currently using a claim form that does not include a specific field for the provider number should consider changing to a scannable form type that allows the provider number:
 - ADA 2002
 - ADA 1999 Version 2000
 - ADA 1999
 - ADA 1994
 - Dentech 2000
 - Dentrix 2000 #2
 - Easy Dental 1997-99

Dentists can locate their assigned BlueCross BlueShield of Tennessee provider number in the top right-hand corner of the dental remittance advice.

Some dental practices choose to obtain a group provider number for payment purposes. In these cases the remittance advice will reflect the group provider number. Note: This group number is used to report payments and should **not** be used when submitting claims.

If there is a question on the individual provider number, dentists may contact Dental Customer Service at 1-800-523-1478 or the local BlueCross BlueShield of Tennessee Provider Relations office at one of the numbers below.

<u>Regional Office</u>	<u>Telephone Number</u>
Chattanooga	(423) 755-6307
Jackson	(731) 664-4127
Johnson City	(423) 854-6036
Knoxville	(865) 588-4644
Memphis	(901) 544-2399
Nashville	(615) 386-8630

Corrected Bills – Use the Remarks Field

A claim that has been processed (you received a Remittance Advice with this claim) and was paid incorrectly due to an error or omission on the claim may be refiled as a corrected bill.

- A true corrected bill includes additional or changed dates of service, codes, units, and/or charges that were not filed on the original claim.
- Write or type "CORRECTED BILL" in black ink in the Remarks section of the claim form.

Reconsiderations – Use the Remarks Field

- Write or type "RECONSIDERATION" in black ink in the Remarks field of the claim form to identify the claim as a reconsideration.
- Staple correspondence related to the reconsideration to the **TOP** of the claim form. If the claim form is left on top of the packet, it will be considered a claim submission and processed accordingly, which could result in a duplicate claim rejection.

Multi-Page Claims

- Place the total amount only on the last page of the claim. The total on the last page should reflect the sum of the line items for all pages.
- If the sum of the line items does not match the total shown on the last page of the claim, the claim will be returned.
- On each page (except the last page which has the total charge), the words "Continued," "Continued on next page" or "Page X of X" should be indicated on the last line item or within the total charge field.
- Each multi-page claim should be stapled as one claim. This will help us identify it as a multi-page claim.
- Do not staple several multi-page claims together as one.

Submitting X-rays

- X-rays should only be submitted when required. The procedure codes that require X-rays are listed in our Clinical Criteria and Documentation Requirements on our Web site at <http://www.bcbst.com/providers/dental-booklet.pdf> or in the *Commercial Provider Administration Manual* mailed on CD-ROM to participating dentists each quarter.
- Sending X-rays when they are not required will slow down the claims process.
- Insert the X-ray into an appropriate envelope/holder and staple to the top of the claim form.
- If no enclosures (X-rays, oral images, or models) are enclosed with the claim, it is not necessary to include a "00" in the X-ray, oral image or model boxes.

Optical Scanning Tips

Do:

- Use one basic print style on the claim.
- Align data within the appropriate blocks on the claim.
- Use upper case (capital letters) if possible.
- Choose inkjet printers over dot matrix printers. If using a dot matrix printer, change ribbons when they show signs of wear.

Don't:

- Stamp or handwrite notes on printed claims (with the exception of the Remarks field for Corrected Bills or Reconsiderations). Note: Dentists may continue to send claims that are completely handwritten but these claims will be manually processed.
- Include extra data in a field. Example: If the field asks for City only, do not include State and Zip in this field as well.
- Add stickers or labels to the claim form.
- Use red ink. The scanning equipment ignores information in red.
- Alter a claim with "white-out" or by marking through information.

If a Claim is Returned

A claim that does not conform to the billing guidelines will be returned to you. These claims have **not** been processed and are referred to as incomplete claims.

- When an incomplete claim is returned, providers will receive a black and white copy of the claim submitted with the error(s) listed in the top right-hand corner of the claim form. The claim can list up to three errors.
- This claim copy returned to you may not look exactly like the claim form you originally submitted. Because we receive more than 90 different types of dental claim forms, we chose to generate one type of claim form for returned claims. It should contain the same data you submitted.

- The returned claim will include a 12-digit Electronic Claim Tracking Number or ECTN listed at the top of the claim by the error messages. If you have question on the errors, you can contact Dental Customer Service at one of the numbers listed below. The Customer Service Representative can view the claim by using the ECTN number.

Federal Employee Program: 1-800-572-1003
Preferred Dental: 1-800-523-1478

- Fields that include narrative text or signatures will be displayed as follows on returned claims:
 - The Remarks field will list "See Original Image for Remarks" if information was submitted in this field on the original claim. If no information was submitted, it will be blank.
 - The Treating Dentist Signature field will state "Signature On File" if a signature was present on the original claim. If no signature was present, it will be blank.
 - The Patient Authorization Signature fields will also state "Signature On File" if these fields were completed on the original claim. If no information was provided, it will be blank.
- The provider should correct the claim error(s) and resubmit the claim as a new claim, on a new claim form. Do not write or stamp "Corrected Claim" on the new claim.
- Since incomplete returned claims have not been processed (you have not received a Remittance Advice for these claims), the claim will **not** be denied "duplicate" when resubmitted.
- Images of all rejected and accepted claims will be maintained at BlueCross BlueShield of Tennessee for reference.

A sample returned claim follows on the next page.

Sample Returned Claim

Error Messages

Up to 3 error messages may be displayed on a claim returned for correction.

Electronic Claim Tracking Number (ECTN)

Use this number to identify the claim when calling Customer Service for assistance.

DENTAL CLAIM **CONFIDENTIAL** 03156R000000

ADA Dental Claim Form

EA037A PROVIDER SIGNATURE BLANK (OCR)
PRV000 PROVIDER TIN MISSING (OCR)

1. Type of Transaction (Check all applicable boxes)
 Statement of Actual Services - CR - Request for Preauthorization (Preauth/Preauth)
 RFDOT/Title XXX

2. Provider/Subscriber/Prescription Number

PRIMARY SUBSCRIBER INFORMATION
12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
 HALL CHRIS B
 123 MAIN STREET
 SOMEWHERE TN 37000
13. Date of Birth (MM/DD/YYYY) **14. Gender** **15. Subscriber Member ID# (M or CR)**
 07/01/1958 M 123894567

16. Plan/Group Number **17. Employer Name**
 86776

OTHER COVERAGE
4. Other Dental or Medical Coverage? No (Step 5-11) Yes (Complete 5-11)

5. Subscriber Name (Last, First, Middle Initial, Suffix)
 HALL CHRIS B
6. Date of Birth (MM/DD/YYYY) **7. Gender** **8. Subscriber Member ID# (M or CR)**
 07/01/1958 M 123894567

9. Plan/Group Number **10. Relationship to Primary Subscriber (Check applicable box)**
 TEC112233449 Self Spouse Dependent Other

11. Other Coverage Name, Address, City, State, Zip Code
 OTHER BCBST

PATIENT INFORMATION
18. Relationship to Primary Subscriber (Check applicable box) **19. Patient Status**
 Self Spouse Dependent Child Other PFS PFS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
 HALL MARY A
21. Date of Birth (MM/DD/YYYY) **22. Gender** **23. Patient ID/Member ID (Assigned by Dentist)**
 08/06/1959 M 123456789

RECORD OF SERVICES PROVIDED

24. Procedure Code (AA000000)	25. Area of One Tooth	25. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
01/13/2005	01	01	30	DOU	00220		1000
01/13/2005	02	01	30	DOL	D2750		1000
01/13/2005	03	01	30		D2750		1000
01/13/2005	04	01	30		D2750		1000
01/13/2005	01	02	30		D2750		1000
01/13/2005	02	02	30		D2750		1000
01/13/2005	03	02	30		D2750		1000
01/13/2005	04	02	30		D2750		1000
01/13/2005	01	03	30		D2750		1000

MISSING TEETH INFORMATION

24. Place an 'X' on each missing tooth																25. Other Teeth											
																25. Other Teeth											
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J	25. Other Teeth	
X																										9000	

26. Remarks
 Y

26. Remarks
 X

27. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.
SIGNATURE ON FILE
 Date

28. Billing Dentist or Dental Entity (Name block if dental or dental entity is not submitting claim as detail of the patient or insured/subscriber)
29. Name, Address, City, State, Zip Code
 WILLIAM Q
 987 PHYSICIAN DRIVE
 SOMEWHERE TN 37000
30. Provider ID **31. License Number** **32. SSN or TIN**
 0020214

33. Place of Treatment (Check applicable box) **34. Number of Enclosures (25 to 32, exclude 2)**
 Provider's Office Hospital EOP Other Radiograph Graminical

40. Is Treatment for Orthodontics? **41. Date Appliance Placed (MM/DD/YYYY)**
 No (EAO 41-43) Yes (Complete 41-43)

42. Months of Treatment Remaining **43. Replacement of Prosthesis?** **44. Date Prior Placement (MM/DD/YYYY)**
 No Yes (Complete 43)

45. Treatment Resulting from (Check applicable box) **46. Date of Accident (MM/DD/YYYY)** **47. Auto Accident Date**
 Occupational/Injury Auto accident Other accident

TREATING DENTIST AND TREATMENT LOCATION INFORMATION
48. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees (have changed and found to reflect) for these procedures.
49. Signed (Treating Dentist) **50. Date**
 Signature of Treating Dentist was missing from the claim resulting in an error.
51. Provider ID **52. License Number**
 0020214
53. Address, City, State, Zip Code
54. Phone Number **55. Treating Provider Specialty**

Provider Tax Identification Number (TIN) was missing from the claim resulting in an error.

Signature of Treating Dentist was missing from the claim resulting in an error.