Most of you have heard about the Affordable Care Act (ACA).

The ACA requires that ten essential health benefits are included on every qualified health plan. One of those essential benefits is pediatric dental coverage. Included in the pediatric dental essential health benefit is the coverage of orthodontia when it is medically necessary. Blue Cross and Blue Shield of North Carolina (BCBSNC) has decided to administer this benefit as follows:

- Covered members under the age of 19 – the benefit ends on the member's 19th birthday.
- Twelve (12) month waiting period for the member to be eligible for this coverage, beginning on the member's plan effective date. For example, if a member's plan began on **1/1/2014**, then that member would be eligible for their orthodontia coverage on **1/1/2015.**
- Codes (D8010, D8020, D8030, D8040, D8050, D8060, D8070, D8080, D8090, D8210, D8220, D8660, D8670, D8680, D8690, and D8999) will be added to BCBSNC's prior plan approval list, which can be found at http://www.bcbsnc.com/content/providers/ppa/services.htm. This list is updated quarterly. These codes are scheduled to be added on the October 2014 list.
- Requests for these services can be submitted to BCBSNC for review beginning **December 1, 2014**.

How do I submit a PPA request?

Call 1-800-672-7897 Monday- Friday, 8 AM - 5 PM

Fax clinical information to: 1-800-571-7942

Mail clinical information to:
Blue Cross and Blue Shield of North Carolina
Attention: Care Management and Operations
PO Box 2291
Durham, NC 27702-2291

Please provide the following information when submitting a request:

- ✔ **Practice name and BCBSNC provider number**
- ✔ **Contact name, phone number, and fax number**
- ✔ **Patient's name, BCBSNC member ID number, and date of birth**
- ✔ **Attending physician's name, BCBSNC provider number, and phone number**
- ✔ **Treatment setting - i.e., physician's/provider's office**
- ✔ **Expected dates of service**
- ✔ **Description of diagnosis and diagnosis codes**
- ✔ **Description of procedure and applicable codes**
- ✔ **Clinical information, including history and physical, treatment plan, and orthodontic contract**

When will I have a decision back from BCBSNC?

If all clinical information is submitted with the request, then BCBSNC has 3 business days to return a decision. If the nurses or medical directors need more information from you, then the process can take up to 15 calendar days. A letter will be faxed to you with the determination.

How do I know what clinical information is needed?

The BCBSNC corporate medical policy for Pediatric Orthodontics can be found at https://www.bcbsnc.com/content/services/medical-policy/index.htm. Documentation requirements, along with guidelines for coverage, are included in this policy.

What if I want to discuss a case with a BCBSNC medical director?

BCBSNC medical directors are available to discuss clinical problems and benefit issues with network providers, particularly where there are issues that complicate the management of the patient's condition. If you have questions about a certification request, you may request to speak directly to a medical director by calling 1-800-672-7897, extension 51019. The purpose of the peer-to-peer discussion is to give the requesting physicians an opportunity to discuss the clinical details of a requested service. A peer-to-peer review may also be requested by a BCBSNC medical director in order to obtain more clinical information from an attending physician before making a final determination.

Is there an option for reconsideration of a denial?

Yes. BCBSNC does offer a provider courtesy review for denied services. This is separate from the Appeals process and is done if there is relevant information that was not previously submitted. This must be requested within 180 days from the date of the adverse benefit determination letter. You can submit this information by calling or faxing to the same numbers for Care Management and Operations.

What if I do not get prior plan approval before filing a claim?

For in-network providers, hold harmless is a contractual agreement between BCBSNC and participating providers. This agreement states that the provider may not balance bill a member for services or supplies that were not prior authorized or certified in advance by BCBSNC and/or deemed not medically necessary by BCBSNC. Members are not to be held responsible for any failure to obtain PPA.

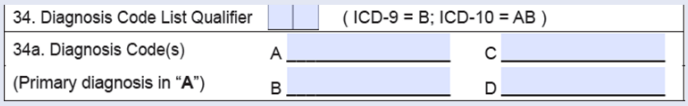
If a request for PPA is submitted and **not** approved for medical necessity, and the member elects to continue with the service, then you would need to have the member sign a waiver that they are aware of the denial of services and responsible for the cost.

If you are non-participating with BCBSNC, the care will be reimbursed at the lower benefit level, with the member having liability for a higher out-of-pocket expense. The member is responsible making sure that you are requesting for PPA.

Claims

There are a few changes to how to file these claims, since this is a **medical** benefit.

- Please be sure to use the 2012 ADA claims form with the appropriate CDT codes.
- Include the diagnosis code(s) for the patient on the 2012 ADA claims form.



- Please include a copy of the completed orthodontic contract/treatment plan with the claim.
- Address for medical claims:
  Blue Cross and Blue Shield of North Carolina
  PO Box 35
  Durham, NC 27702-0035
- Emdeon Number for medical claims: **61472**
- After your PPA is approved, you will need to submit a claim each time service is rendered in order to be reimbursed. You will not be receiving a payment in total upfront.

Appeals

Post-service/claims appeals are provider appeals, and can continue to be submitted by providers.

Appeals for cases that are deemed not medically necessary by BCBSNC, and are pre-service are **Member** appeals. These must be initiated by the member. They can be initiated by you on the member's behalf only **with a signed member consent form**. Benefit notification letters will have instructions for how members can file an appeal for medical necessity denials.

Member appeals must be requested within 180 days of the adverse benefit determination letter.

Member appeals have a 30 day turnaround time once they are received by BCBSNC.

There are expedited processes if a situation is urgent.

***Please note: There will be an update to the BCBSNC Dental Provider Manual with this information. Please refer to the medical Provider Blue Book for details on this information until the update to the dental manual occurs. http://www.bcbsnc.com/content/providers/blue-book.htm**