COMMONLY ASKED QUESTIONS

Table of Contents	

GENERAL	
Are pre-authorizations required?	They are not required; however, they are suggested for services over $300.
How long is a pre-authorization valid?	They are valid through the end of the benefit period or when the policy changes, whichever comes first.
Will the x-rays I submitted with a claim be returned?	No. We advise you send us a duplicate or copies of current/dated images that are of diagnostic quality. All images must be of diagnostic quality, labeled including L or R as applicable and contain appropriate landmarks views.
Is there an Alternate Benefit Provision?	The Alternate Benefit Provision applies when there are two or more clinically acceptable ways to treat a dental condition and both procedures are covered. In these cases, the benefit is based on the treatment that is more cost effective and produces a professionally acceptable result. The patient may use the payment towards the treatment of their choice; however, it may result in a higher out-of-pocket expense. If the patient chooses the more costly service, their financial responsibility is reflective of: • the patient charge for the less costly service • the difference in fees between the more costly service and the less costly service When an alternate benefit is applied, it is not meant to dictate treatment, question professional judgment, or interfere with doctor-patient relationships. The ultimate decision on treatment is up to the dentist and the patient. The Alternate Benefit Provision provides a range of treatment options established by the dental benefit contract
Is there a Missing Tooth Provision?	Use the Procedure Code Lookup field and search for procedure codes that are used to replace a missing tooth. If there is a missing tooth provision on the policy, the message ***missing tooth provision*** is displayed in the Other Limitations field.
Do you cover sedation services?	Sedation services D9222, D9223, D9239, D9243 and D9248 are covered, and subject to Professional Review and require medical necessity.

**Subject to Benefit Coverage

CLAIM PROCESSING	
What is the payer identification number?	**BCBSIL:** 00621 **BCBSMT:** 00751 **BCBSNM:** 00790 **BCBSOK:** 00840 **BCBSTX:** 84980 **Dearborn Group:** DNOA1 **Medicare Plans:** Medicare Advantage claims must be filled with a Payer ID that is unique to the Medicare Advantage product. Please contact your clearinghouse to obtain that Payer ID.
Do you accept assignment of benefits?	We accept assignment. We make the payment to the payee designated on the claim submission.
Do you accept signature on file?	We accept signature on file. We make the payment to the payee designated on the claim submission.
Do you accept electronic claims and electronic attachments?	We accept electronic claims; however, electronic attachments must be submitted through National Electronic Attachment (NEA).

DIAGNOSTIC SERVICES	
If a bitewing image and a panoramic image are taken on the same day, will it converts to a Complete Series (D0210)?	No. Our policy is to process the claim as submitted; however, claim payments may be limited to patient eligibility and frequency limitations according to a member's benefit plan provisions.
How many images make up a Complete Series (D0210)?	A Complete Series (D0210) usually consists of 14-22 periapical and posterior bitewing images.

BASIC SERVICES	
Are composite resin fillings covered on all teeth?	Yes. Composite resin fillings are a covered benefit on all teeth; however, alternate benefit provisions may apply.

**Subject to Benefit Coverage

PERIODONTICS	
<u>For new periodontal patients</u>: Please include current periodontal charting and x-rays when submitting claims or pre-estimates for periodontal services for patients without established periodontal history.	
What codes are valid for periodontal history?	D4210, D4211, D4240, D4241, D4260, D4261, D4341, D4342
What time frame is required between periodontal therapy and periodontal maintenance (D4910)?	Each patient's periodontal condition is unique; however, 4-6 weeks is a general guideline. A reasonable period of time is expected to elapse following periodontal therapy to allow for proper re-evaluation of the patient prior to initiating maintenance treatment.
Do you allow periodontal scaling and root planning (D4342) to be performed on all four quadrants on the same day?	Full mouth periodontal scaling and root planning can be performed on the same day when clinically appropriate and necessary.
What time frame is required between periodontal therapy and D4381?	The D4381 is not generally a covered benefit except in well documented refractory cases where an isolated tooth or limited teeth are involved. Re-evaluation following periodontal therapy must be well documented. (A period of at least 4-6 weeks elapsed following active periodontal therapy.)
Are benefits paid for D4381 by site or by tooth?	D4381 is a per tooth code which is based on the CDT descriptor.
Do you cover Full Mouth Debridement (D4355)?	Full Mouth Debridement is covered, subject to contract limitations. Full Mouth Debridement is not to be completed on the same day as a comprehensive evaluation.
Do you cover Scaling in the Presence of Generalized Inflammation (D4346)?	Scaling in the Presence of Generalized Inflammation is covered, subject to contract limitations, and should not be reported in conjunction with routine cleanings, scaling and root planning, or full mouth debridement.
Are bone grafts covered?	Bone grafts may be a covered benefit in instances where the graft is placed for certain clinical conditions and submitted with supporting documentations, i.e. 3 wall bony defects or implant placement.

MAJOR SERVICES	
Do you pay on prep or seat date?	We pay on seat date; however, certain employer groups may have exceptions to this rule and pay on prep date.
Are crowns subject to an alternate benefit?	Use the Procedure Code Lookup field and search for a code associated with a crown. Crown, bridge, and other prosthodontic procedures may be subject to Alternate Benefit Provision. Also, ***procedures may be subject to Professional Review***

**Subject to Benefit Coverage

ORTHODONTIA	
Do you cover treatment in progress?	Please submit the full treatment plan including the down payment amount, banding date, and total number of treatment months. We will prorate based on the effective date of our policy for eligible patients.
Is Invisalign® covered under orthodontia?	Yes. It is covered under orthodontia for eligible patients.
Do you cover at-home or DIY treatment for orthodontics?	No. DIY orthodontic treatments, or any other at-home treatment services, are not covered by our dental plans. We do not cover dental services unless administered and performed by a licensed dental professional.
How are records covered for orthodontia?	If preventive or diagnostic procedures for orthodontic records are performed on an eligible patient, then these services are processed under the orthodontia benefit. They do not count against the preventive frequencies.
How do you cover the down payment for orthodontia?	The down payment for orthodontia is covered at the same percentage as other orthodontic services for eligible patients.
Are payments made automatically for orthodontic treatment?	No. Payments are issued upon claim submission. You may submit claims monthly or quarterly.
Submitting for Pre-Estimate, what is required?	Required information for orthodontic Pre-Estimates: • Banding Date (not needed for pre-estimates) • Total treatment fee • Down payment amount (required even when the amount is $0) • ADA Code (D8010 - D8090) • Length of treatment

These questions represent questions commonly asked of our Customer Advocates. Some questions may require additional research of the policy to provide the most accurate answer.

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