

2020 Dental Reference Manual



Updated April 2020



BlueShield
of Northeastern New York

Dental Reference Manual

Section 1 — Introduction	3
Section 2 — Credentialing/Recredentialing Program	5
Section 3 — Preauthorization/Predetermination of Benefits	19
Section 4 — Corporate Medical Protocols	21
Section 5 — Dental Product Information	22
Section 6 — Claims and Billing	29
Section 7 — Provider Reimbursement and Fee Schedules	40
Section 8 — Member Information	41
Appendix	54

Section 1 — Introduction

Overview

For your convenience, we have developed this *Dental Reference Manual*, which includes all the information you will need regarding:

- Dental products we offer
- Services we provide
- Claims information
- Provider reimbursement

We hope you find this manual to be a helpful reference tool.

Our Vision: To be the preferred health care plan for our communities.

Our Mission: To develop and provide innovative and cost-effective health care delivery solutions to support the needs of our members, stakeholders, and communities.

BlueShield of Northeastern New York is dedicated to providing members with quality dental care that is cost-effective and easy to access.

Provider Network Management and Operations Department

Our Provider Network Management and Operations Department is your primary link with BlueShield. Our commitment to partnering with our participating providers is vital to providing quality coverage for our members.

Our provider website at bsneny.com/provider includes a variety of content, such as:

- Dental Reference Manual
- Provider and Facility Reference Manual
- Chiropractic Reference Manual
- Quarterly newsletters (articles regarding product information, coding and billing guidelines, policy changes, etc.)
- Stat bulletins (provider communications addressing urgent issues; distributed as needed)
- Corporate medical protocols (guidelines providing clinically significant information about medical treatment and administrative policies)

For additional information on the services available to providers, please contact our Provider Network Management and Operations Department at (518) 220-5601.

Provider Service Centers

Our provider service representatives are trained to assist you with:

- Answers to benefit questions
- Claim status
- Adjustment requests

Please refer to the Provider Telephone and Website Reference Guide for phone numbers.

Provider Telephone and Website Reference Guide

Provider Service	1-800-444-4552 or 1-518-220-5620 (Managed Care and Traditional/Indemnity) 1-877-327-1395 (Government Programs)
Provider Network Management and Operations	(518) 220-5601
Provider Website	bsneny.com/provider

Section 2 — Credentialing/Recredentialing Program

Introduction

The Practitioner Credentialing and Recredentialing Programs address the selection and retention of practitioners for participation in the BlueShield of Northeastern New York network. We use consistent, clear objectives for the credentialing and recredentialing of participating practitioners.

The practitioners to whom this program applies include physicians (MD, DO), oral surgeons and dentists (DDS, DMD), acting within the scope of their licenses, practicing in the outpatient setting. Further, this program applies to the credentialing and recredentialing of individual practitioners, organized medical group practices, and practitioners participating in subcontracted networks.

The procedures established herein are to be implemented for BlueShield where permitted by state laws and regulatory requirements and by existing contractual arrangements.

The decision to accept or retain a practitioner is based on the information available, including but not limited to the information gathered through a completed practitioner application, the re-evaluation process, and the verification of all collected information. This process takes place every thirty-six (36) months.

BlueShield does not discriminate against health care professionals who serve high-risk populations, or who specialize in the treatment of costly conditions, and/or provide certain services (i.e., abortions, HIV care). The provider credentialing and recredentialing process is conducted in a non-discriminatory manner, without regard for: race, color, religion, sex, national origin, age, marital status, sexual orientation, and veteran status.

Periodic audits of in-process, denied, and approved credentialing files will be conducted to ensure that practitioners were not discriminated against. A spreadsheet will be maintained for audit purposes. In addition, BlueShield will conduct periodic audits of practitioner complaints to determine if there are complaints alleging discrimination; maintain a heterogeneous credentials committee, and require those responsible for credentialing decisions to sign an affirmative statement to make decisions in a nondiscriminatory manner.

Medicaid Integrity/Disclosure of Ownership

The Medicaid Managed Care/Family Health Plus Plan Model Contract (18.9 (c)) indicates that the contractor requires all network providers to monitor staff and employees against the stated exclusion list (List of Excluded Individuals and Entities and the Restricted, Terminated or Excluded Individuals or Entities List) and report any exclusions to the contractor on a monthly basis.

Also, in accordance with federal regulations (Section 42 CFR 455.106) and the Medicaid Managed Care/Family Health Plus Plan Model Contract (18.12 (b)), the managed care health plan/contractor requires providers to disclose health care-related criminal conviction information from all parties affiliated with the provider. Upon entering into an initial agreement or renewal of any agreement between the managed care health plan/contractor and its providers, the managed care health plan/contractor must disclose to the SDOH Division of Health Plan Contracting and Oversight in 20 working days of the disclosure date any conviction of a criminal offense related to that provider or provider's managing employee involvement in any program

under Medicare, Medicaid, or Title XX services program (block grant programs).

As per federal regulation 42 CFR 455.104 and Medicaid Managed Care/Family Health Plus Plan Model Contract 18.6 (b), BlueShield requires that participating providers disclose complete ownership, control, and relationship information upon submitting application, executing the provider agreement, and within 35 days after any change in ownership. In accordance with federal regulation 42 CFR 455.105 and the Medicaid Managed Care/Family Health Plus Plan Model Contract 18.6 (c), and as cited in the Participating Provider Agreement within 35 days of the date of a request by the SDOH, OMIG, or DHHS, the managed care organization/contractor will require from any subcontractor disclosure of ownership, with whom an individual network provider has had a business transaction totaling more than \$25,000 during the 12-month period ending on the date of request.

A *Disclosure of Ownership Form* must be completed as part of the credentialing process to ensure compliance with the above-referenced program requirements. BlueShield requires that such providers not employ or contract with any employee, subcontractor, or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

The Disclosure of Ownership Form is located on our website under *Tools & Resources > Forms*.

When credentialing and recredentialing criteria for participation, the practitioner:

- Must hold a current valid license to practice in New York State and/or the state where the practitioner practices.
- Must have completed appropriate training for his/her profession.
- Effective July 1, 2007, BlueShield requires all new physician practitioners other than those who have completed their training within the previous five years to be board-certified in their specialty. This requirement also applies to practitioners who leave the panel and reapply at a future date.

For physicians who have completed their training within five years prior to their seeking participation with BlueShield, a certificate from an accredited training program will be required. These physicians must submit documentation of board certification within five years following completion of their training. Failure to do so will result in termination of the practitioner.

For physicians who have completed their training more than five years prior to their seeking participation with BlueShield, accreditation by a specialty board recognized by the American Osteopathic Association (AOA), the American Board of Medical Specialties (ABMS), or the Royal College of Physicians and Surgeons of Canada (RCPSC) is required.

Board certification exceptions may be granted to physician practitioners under the following conditions:

- If there is a demonstrated access issue (e.g., rural area), individual consideration may be given by the plan medical director or designee.
- BlueShield recognizes that some applicants may not meet the board certification standards, yet they possess extraordinary credentials and potentially unique abilities worthy of consideration. Circumstances of this nature will be reviewed for consideration by the plan medical director or designee.

- Physicians who are not board-certified on July 1, 2007, but were participating prior to July 1, 2002, are considered “grandfathered” and are not required to be board certified. If the board certification is obtained, the physician will lose grandfather designation.
- Physicians that are currently board certified, or obtain their board certification after July 1, 2007 but fail to recertify, will have two years to retake and obtain their board certification. Physicians will be notified in writing regarding this process.
- Physicians who are board certified in both general and sub-specialty boards must maintain both board certifications unless they attest that at least 75 percent of their practice is either general practice or in their specialty. In this situation, they will only be required to maintain board certification pertinent to their activities that represent 75 percent of their practice.
- Physicians who are requesting both a primary and secondary specialty must be board-certified in both their primary specialty and secondary specialty, or have a Certificate of Additional Qualification (CAQ) for their secondary specialty. If a CAQ does not exist in the secondary specialty, fellowship training is required.
 - Must hold a current federal or state Drug Enforcement Agency (DEA) certificate, if applicable.
 - Must hold current malpractice coverage to meet BlueShield and any state or federal requirements.
 - Must demonstrate a malpractice claims history acceptable to the Credentials Committee.
 - Must demonstrate an appropriate history of employment, clinical practice and hospital privileges for previous five years, or recent completion of training.
 - Must demonstrate sanction free status by federal, state, and local authorities, including each jurisdiction in which the practitioner practices or previously practiced. Providers who are sanctioned by the New York State Medicaid Program will be excluded from participation in BlueShield’s Medicaid/FHP/CHP panels. Providers who are sanctioned by the Medicare program will be excluded from participation in all government program panels.
 - Must demonstrate coverage arrangements, satisfactory on-site review results and medical record review results acceptable to the Credentials Committee, if applicable.
 - Must be free from any health problem that is likely to affect his/her ability to perform appropriate medical or professional duties with or without accommodation.
 - Must cooperate in utilization management and quality management activities and adhere to all policies, procedures and protocols as designated by BlueShield.
 - Allergists are required to be board certified by the American Board of Allergy and Immunology.
 - Podiatrists are required to be board-qualified or board-certified by the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedic and Primary Podiatric Medicine.
 - Must have unrestricted hospital privileges in the primary admitting hospital. If the physician does not have hospital privileges, the physician must have a formal agreement with a participating practitioner, who does have hospital privileges in the same specialty according to "telephone 24 hour access to care" policy and procedure. Hospital privileges are not required for general dentistry.
 - If a training facility has residents providing medical services to BlueShield members, the resident may bill for the services rendered under the supervising physician provider number, as long as the supervising physician is a participating provider with BlueShield. The supervising physician is required to review and sign off on the medical records within 72 hours of the resident rendering the care.
 - Completed and attested *Disclosure of Ownership* form.

Specialist Physician

The physician must have successfully completed postgraduate training in the specialty the practitioner wishes to practice as. A specialist physician must obtain 50 CME credits in the specialty, per year, or corresponding specialty recognition award for continuing medical education.

Credentialing Overview

The purpose of the selection process is to include only those practitioners who meet the established credentialing criteria.

All applications are reviewed by the medical director or designee. The credentials, when complete, are presented to the Credentials Committee that is under the direction of the BlueShield medical director. The committee meets at a minimum of four times per year, and is attended by other appropriate personnel to include but not limited to representatives from Quality Management and Provider Relations and Contracting, along with physicians from the community.

The chief medical officer makes the final determination for participation.

Credentialing criteria are developed for each type of health care professional who participates with BlueShield Managed Care product(s). These criteria are developed and approved by the Credentials Committee. Criteria include specific requirements relative to each specialty.

The goal of the credentialing process is to ensure that the members of BlueShield will be cared for by qualified practitioners in appropriate settings.

Universal Credentialing Electronic Application

BlueShield now requires providers to enter their credentialing/recredentialing information (free of charge) into a single, uniform online application. This application meets the credentialing needs of health plans, hospitals, and other health care organizations. The CAQH ProView™ provider data-collection service streamlines the initial application and recredentialing processes, reduces provider administrative burdens and costs, and offers health plans and networks real-time access to reliable provider information for claims processing, quality assurance and member services, such as directories and referrals.

Providers submit data through CAQH ProView to a secure, state-of-the-art data center. Providers then authorize health plans and other organizations to access the information. Periodic provider updates help ensure that the information is always current.

CAQH ProView is supported by the American Medical Association, the American Academy of Family Physicians, the American College of Physicians, America's Health Insurance Plans, the Medical Group Management Association, the National Association of Medical Staff Services and other provider organizations, and recognized by a number of state legislators and insurance commissioners. The newest version of the CAQH ProView application meets all related URAC, National Committee for Quality Assurance and the Joint Commission standards.

Providers are required to enter their credentialing data with CAQH ProView through the CAQH ProView website at upd.caqh.org. Once this application is complete, providers must allow BlueShield to view this information by choosing this option at the completion of the application.

For more information, or if there are additional questions, you may contact the Provider Enrollment Department at 1-800-666-4627.

Credentialing Process

Application for Dental Provider Participation

Instructions for enrolling as a participating provider can be found on our website at bsneny.com/content/nenypvider/joinournetwork.html.

Initial Credentialing

Providers can enroll into our health plan by filling out the Universal Credentialing Application with CAQH ProView, the Council for Affordable Quality Healthcare.

How it Works

To access the Universal Provider Datasource® go to upd.caqh.org and:

- Log on with your user name and password
- Enter your CAQH provider ID (if unknown, call CAQH at 1-888-599-1771)
- Enter or update your information
- Authorize BlueShield access to your information electronically
- If you do not have a CAQH application, refer to the 'First Time Here' information and click *Register Now*
- Complete this form and return it to the fax number on the form

After you have completed the CAQH application, contact our Provider Enrollment Department at 1-800-666-4627.

A Participating Provider Agreement, Disclosure of Ownership form, and instructions will be sent by the Provider Enrollment Department to the practitioner if the panel the practitioner is seeking participation in is open. Should a prospective practitioner request an application for a specialty in which the panel is closed, the practitioner may submit a letter of interest. These letters are kept on file until such time that the panel is reopened to that specialty. All appropriate practitioners operating in the service area are contacted when the panel is reopened in a requested specialty.

The application will be processed if complete information is provided on the CAQH application. If the information supplied on the application is incomplete, the application processor is responsible for contacting the applicant, initially by phone, to obtain details and documentation, as appropriate. Information will be deemed incomplete if information or documentation requested on the application is not provided, if responses provided require further explanation, if details related to affirmative answers to disclosure questions are not provided, or if any documents have expired prior to making a decision to accept or not to accept an applicant.

Upon receipt of a signed provider agreement, *Disclosure of Ownership* form, and complete CAQH application:

1. The credentialing specialist reviews the application for completeness.
2. The applicant is notified if any additional information is needed.
3. Primary source verification of specified credentialing criteria documentation will be initiated by the credentialing specialist.

4. The credentialing specialist will also verify if the provider has elected to opt-out of Medicare, as well as verify that the provider is not excluded from participation with Medicaid Managed Care or Medicare.
5. The completion of an application does not guarantee acceptance into the BlueShield panel. **The prospective practitioner may not make any appointments, see any patients, or be covering (on-call) for any participating providers, until they have been notified by BlueShield that they have been approved for participation.** For legal reasons, BlueShield does not backdate any effective date.
6. BlueShield reserves the right to deny participation to any practitioner that is an employee or an independent practitioner of a direct competitor.

If there is a substantial difference between the information provided by the practitioner and primary source verification, the practitioner will be notified and required to provide documentation prior to their credentials being presented to the Credentials Committee.

Upon receipt of all relevant documents, the credentials are reviewed by the medical director or designee. The medical director or designee will make the final determination regarding participation for level 1 practitioners. All level 2 or level 3 practitioners will be individually presented to the Credentialing Committee. The practitioner is notified in writing of the final decision.

The applicant will be provided with materials and appropriate office staff training by the Provider Practice Consultant upon acceptance into BlueShield.

Timetable

A new provider application may be processed within 60 days. Clean applications are processed more quickly.

An application is considered clean if:

- The CAQH/application is filled out accurately and has been attested to within 180 days of filing the application.
- All related credentialing documents are attached and current.
- The application is in compliance with all the BlueShield of Northeastern New York credentialing policies and procedures.
- Primary source verification is successfully completed by BlueShield credentialing specialists.
- The credentialing medical director has signified approval of the application.
- Provider information has been successfully updated in the claims processing system.

New provider applications that do not meet our established credentialing criteria will have the deficiencies noted and will require further intervention by the provider enrollment staff. These applications will require additional time to process, however, they will be completed as quickly as possible.

The credentialing process will be completed within 60 days from the receipt of a completed application. A notice is sent to the provider that informs them as to whether they are credentialed, whether additional time is needed, or that their application is denied.

After review and approval by the Credentials Committee, the credentialing specialist forwards the provider's approved credentialing file to the appropriate provider enrollment staff for entry

into the provider system. This entry generates a welcome letter, which contains the effective date of participation, the provider number, and a copy of the executed contract.

Recredentialing Overview

Collection of Information

The objective of the Recredentialing Program is to ensure the retention of practitioners who have the same qualifications that are required for initial participation under the Practitioner Credentialing Program. The information provided will be evaluated in accordance with the practitioner credentialing criteria.

The decision to retain or not retain a participating practitioner is based on the totality of information available, including, but not limited to the information gathered through the recredentialing process and verified as complete by the Credentials Committee. The information gathered is treated in a confidential manner and the disclosure of such information will be limited to those parties who have an appropriate reason to have access to the information. Review of information to evaluate continued participation of practitioners is ongoing and periodic.

All recredentialing information is reviewed by the medical director or designee. The recredentialing materials, when complete, are presented to the Credentials Committee. The Credentials Committee makes the final decision regarding continued participation.

Recredentialing criteria are developed for each type of health care professional who participates with BlueShield. These criteria are developed and adopted by the Credentials Committee. Criteria include specific requirements relative to each specialty.

Recredentialing Process

As a participating provider, you will be recredentialled at a minimum of every three years.

Your CAQH ProView application must be updated for the recredentialing process to be completed. Sixty days prior to your recredentialing due date, the credentialing specialist will review CAQH ProView to validate that the attestation date is within six months of the recredentialing due date. If the provider has failed to update their CAQH information, they will be contacted by the credentialing specialist.

A critical component of recredentialing includes the evaluation of the applicable information obtained through the following sources as applicable:

- Quality reviews
- On-site reviews, as applicable
- Medical records reviews, as applicable
- Utilization data
- Member satisfaction surveys
- Member complaints
- Adherence to the policies and procedures of BlueShield
- Verification of renewal of credentials with expiration dates

Credentials that expire include:

- State license/registration to include sanction status

- DEA certificate
- Malpractice coverage
- Board certification, where applicable
- Medicare/Medicaid sanction status
- Medicare opt-out status

Proof of renewal of these documents is required upon recredentialing from primary sources for participating practitioners, and as a component of the recredentialing profile. Copies of documents may be requested from participating practitioners through the use of the cover letter, which accompanies the recredentialing profile. Documents may also be obtained directly from the CAQH application.

Recredentialing on CAQH ProView

- Practitioners will be required to complete the recredentialing process, at a minimum, on a triennial basis (at least every 36 months). Providers must regularly update their CAQH ProView application for the recredentialing process to be completed timely.
- An updated list of hospitals in which the practitioner has privileges must be obtained. If a hospital listed on the initial Application or a prior Update as one in which the practitioner had privileges does not appear on this updated list of hospitals, the Provider Relations and Contracting staff must investigate reasons for the change. If a practitioner's hospital privileges have clinical restrictions, this information will be evaluated by the Credentials Committee.
- If at the time of credentialing the physician was, according to the American Board of Medical Specialists, a board candidate in the specialty in which he/she practices, then he/she is strongly encouraged to have achieved board certification within the five-year period following completion of his/her residency. Physicians approved prior to the effective date of this policy are not subject to this qualification.
- Office practice information must also be updated as part of the practitioner re-evaluation process, then reviewed to confirm continued adequacy of practice coverage arrangements and access.
- As in the application for practitioner participation, the information requested pertains to, but is not limited to, hospital privileges, professional disciplinary actions, license suspension or revocation (whether or not stayed), malpractice history, the physical/mental health of the practitioner, and chemical dependency/substance abuse history. As in the Credentialing Program, any practitioner who answers affirmatively to any of the disclosure questions, and who does not provide adequate information regarding the matter, must be contacted to obtain details and documentation.
- Recredentialing of any practitioner who answers affirmatively to any disclosure question is subject to review by the Credentials Committee.
- Providers that are sanctioned by the NYS Medicaid Program will be removed from participation in the BlueShield Medicaid/CHP/FHP panels. Providers that are sanctioned by the Medicare Program will be removed from participation in all government program panels. The CAQH ProView application must be signed and dated by the practitioner to be considered complete.

Ongoing Re-evaluation

Each practitioner's performance as a participating practitioner will be monitored on an individual basis. Each physician must comply with the requirements under contractual obligations with BlueShield. Data will be maintained in the Internal Performance Evaluation Directory and

incorporated as it becomes available. This information will be reviewed by the Credentials Committee for the purpose of practitioner recredentialing.

1. Clinical measures - sources of information may include, but are not limited to utilization management reports, medical record reviews, and focused quality of care reviews.
2. Service measures - sources of information may include, but are not limited to information from grievances filed, member complaints, feedback regarding PCP changes, and member satisfaction surveys.

Administration of Ongoing Review

A practitioner's profile will accumulate continuously as data becomes available. The data will be incorporated in each participating practitioner's credentialing file. In addition, it may be captured in a report card that summarizes number and type of occurrence (e.g., grievances and complaints, results of medical record reviews and quality of care reviews).

Timetable

Applicable physicians and health care professionals will be reviewed, at a minimum, on a 36 month recredentialing cycle. BlueShield may require participating practitioners to be recredentialed more frequently at the recommendation of the Medical Director, Credentials Committee or the Quality Improvement Committee or any other internal source.

Rights of the Practitioner: to Review Credentialing/Recredentialing Information

BlueShield is committed to maintaining accurate information and ensuring that providers are informed in the event that Credentialing information obtained from other sources varies substantially from the information obtained from the practitioner.

The practitioner has the right to:

- Review the information submitted in support of their credentialing application
- Correct erroneous information
- Receive the status of their credentialing/recredentialing application, upon request

If there is information substantially different from information submitted by the practitioner, the practitioner will be notified by certified letter of the discrepancy and asked to respond within fifteen (15) business days. If no correction is received in the allotted time, information received from the primary source will be considered to be correct and any decisions will be based on the primary source information.

Special consideration criteria and termination criteria

These guidelines are based on the New York State Public Health Law Article 44, New York State Department of Health Chapter 98, Health Care Quality Improvement Act and National Committee of Quality Assurance Standards. They were reviewed by our Physician Credential Committee and accepted.

A practitioner (physician or non-physician) may not be terminated solely for the following reasons:

1. If the practitioner advocated on behalf of an enrollee
2. Filed a complaint against BlueShield
3. Appealed a decision of BlueShield
4. Provided information or filed a report pursuant to PHL-4406-C regarding prohibitions of the plan(s)

5. Requested a hearing or review

Corrective Action

Responsibility for decisions regarding special consideration rests with the medical director or designee.

The medical director may take the following actions with individual practitioners or providers to assure quality of care and service to members and/or subscribers through integrated review and evaluation mechanisms that are efficient and effective in resolving instances of substandard care or patient care outside the accepted professional practice:

1. Direct consultation and education with the practitioner under review
2. Probationary status
3. Hold all payment of claims
4. Conduct focused review of ambulatory or hospital care
5. Suspend or terminate the practitioners' agreement (see Termination/Suspension)

The medical director or designee will notify the practitioner of his decision and the basis thereof, in writing. If remedial action is taken, the medical director or designee will encourage improved quality care and competence through education. BlueShield will work closely with the practitioner to educate and assist the practitioner in achieving compliance with BlueShield standards. Based on the decision of the medical director or designee, BlueShield will re-evaluate the practitioner's performance at predetermined times with regard to the identified concerns.

Suspension

A practitioner may be suspended from BlueShield network(s) for the following reasons:

1. BlueShield obtains information that it determines indicates the practitioner may cause, or is causing imminent harm to a member.
2. BlueShield obtains information that it determines indicates there are professional conduct or competence concerns that affect or could adversely affect the health or welfare of a member.
3. For any other reason that BlueShield determines, in its sole judgment, is appropriate under the circumstances.

Termination

In accordance with Public Health Laws 4406-d, BlueShield offers specific rights to a provider if it becomes necessary to terminate his or her provider agreement.

Responsibility for decisions with regard to termination rests with the medical director or designee. When circumstances are of such a nature that prompt and immediate action is necessary to maintain minimum quality standards of BlueShield and/or if the practitioner poses an imminent danger to BlueShield members, the medical director or designee has the authority to terminate the practitioner agreement immediately, subject to appeal.

The medical director or designee will initiate action under the following circumstances:

1. When it appears to the medical director or designee that the participating practitioner is engaging in conduct that is outside the professional standard of care.
2. The participating practitioner is about to or has lost his ability to practice medicine in the State of New York or any other state, whether through revocation or suspension of license,

whether or not stayed, through physical, mental disability or conviction of a crime or surrender of license or inactivation of license.

3. The participating practitioner fails to comply with BlueShield policies, procedures, rules, regulations, terms and conditions of the Practitioner Agreement.
4. The participating practitioner is noncompliant with recredentialing, quality initiatives, quality assurance, peer review, record-sharing, utilization review, continuing education and other programs that may be established by BlueShield.
5. If a practitioner submits claims that are of fraudulent nature.
6. For any other reason, which BlueShield determines, in its sole judgment, is appropriate under the circumstances.

Appeal

Once a practitioner is identified for termination, a letter is delivered by certified mail to the practitioner.

The Notice of Termination will include information advising of the following rights:

- An explanation of the reason for the termination will be provided.
- The practitioner may request a hearing before a panel of three people appointed by BlueShield. At least one-third of the panel will consist of clinical peer in the same or similar specialty.
- The request for the hearing must be made within thirty-five (35) days from the date the notice was provided.
- The hearing will be held within thirty (30) days of BlueShield's receipt of a request for a hearing.
- The practitioner will receive the written decision of the panel within twenty (20) calendar days of its decision. The panel will determine whether the practitioner should be reinstated with or without conditions or whether his/her participating agreement should be terminated.
- If the practitioner is terminated, he or she is not eligible to reapply for participation unless BlueShield determines there has been a substantial change in information and it has been at least twelve (12) months since the termination.

A hearing is not available if a practitioner is being terminated for one of the following reasons:

1. There has been a final disciplinary action by a state licensing board or other governmental agency that impairs the provider's ability to practice.
2. A determination of fraud on the part of the practitioner.
3. The corporation obtains information that, in its sole judgment, it determines the practitioner may cause or is causing imminent harm to BlueShield members.

Non-renewal

The practitioner or BlueShield may exercise a right of non-renewal of his or her participating agreement, either at the end of the period noted in the contract, or with sixty (60) days' notice, each January 1, occurring after the contract has been in effect at least one (1) year.

Other Guidelines

Fraud, Waste, and Abuse (Medicare and Medicaid)

Your contract with us requires you to comply with specific policies to detect and prevent fraud, waste, and abuse.

Per state and federal regulations, as noted in the *New York State Department of Health Standard Clauses for Managed Care Provider/IPA Contracts* in your Agreement, you must send us details on the following items:

- Disclose to the plan the identity of any person affiliated with the provider (owner/person with control interest, agent or managing employee) who has been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid or Title XX services programs. Monitor your managing employees and agents monthly against the following websites:
 - Office of the Medicaid Inspector General (OMIG) at **omig.ny.gov**.
 - List of Excluded Individual and Entities - Office of Inspector General (OIG) at **exclusions.oig.hhs.gov**
 - System for Award Management (SAM) at **sam.gov**
- Report to us monthly any individuals that were found to be on the exclusions list(s).
- Upon request made by the New York State Department of Health (NYSDOH), Office of Medicaid Inspector General (OMIG), or Department of Health and Human Services (DHHS), you must obtain ownership information from any subcontractor with whom you had a transaction totaling more than \$25,000 during the 12-month period ending on the date of the request.
 - You must send a copy of the information to us within 35 days of such request.

You are also obligated to:

- Disclose complete ownership, control, and relationship information. In accordance with state and federal regulation, we are required to obtain a Disclosure of Ownership and Control form from contracted providers rendering services to our members.
- Maintain and make available, upon request and at no charge, records related to monthly monitoring and reporting of criminal convictions and exclusions.

The Disclosure of Ownership and Control Forms for Facility and Practitioner are located on our website at bsneny.com/content/nenypvider/tools-resources/forms.html.

Non-discrimination Policy

Participating dental providers have a policy and procedure in place and agree not to differentiate or discriminate against members in the delivery of health care services based on, (to include, but not limited to) race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

Provider Directory Data Accuracy

Effective January 1, 2016, the Centers for Medicare & Medicaid Services (CMS) began enforcing regulations about changes in the Medicare program regarding accurate provider directory information.

As a participant in the Medicare program, BlueShield of Northeastern New York is required to adhere to CMS regulations, including displaying provider practice information in our provider directories and the *Find a Doctor* search tool on our website.

If your contact information is not accurate, our members could have difficulty scheduling appointments and receiving medical services from you; therefore, we will be contacting you on

a quarterly basis to validate your contact information.

The following information will be verified:

- Practitioners at all locations
- Specialties
- If you have capacity to accept new patients
- Street address
- Phone number
- Any changes that affect your availability to schedule patient appointments

Please review your current information at

bsneny.com/content/nenyhome/toolsandresources/find-a-doctor.html and ensure that it is accurate.

If you need to make any changes, please provide them via the Provider Demographic Change Form located on our website under *Tools & Resources > Forms*.

Changes in Status

Providers are contractually obligated to notify BlueShield promptly in writing if there are any changes to their practice. Please refer to your Participating Dental Agreement. Dental providers must notify BlueShield within thirty (30) days if and when any of the information submitted in the most recent application changes. If a provider is no longer participating and wishes to be reinstated, that provider must reapply and go through the full credentialing process if the break in participation is thirty (30) days or more. The Credentialing Committee must review all credentials and make a final determination prior to the provider's re-entry into the network. At the end of this section is a change of address form, which can be used to notify us when your office location changes (open/close, addition), or when an update for a tax identification number is needed. Dental providers are also required to notify their BlueShield patients, within seventy-two (72) hours, of any changes in office hours, location, and/or phone number. BlueShield will complete your demographic update request within thirty (30) days of receipt.

Medical Records, Information, and Confidentiality Policies

BlueShield is entitled to receive from any provider who renders service to a member all information reasonably related to the terms of their contracted agreement. Subject to applicable confidentiality requirements, members authorize any provider rendering service to disclose all facts pertaining to such member's care and treatment rendered to such member by the provider and to permit copying of such reports and records by the health plan. This authorization is obtained during the member's enrollment.

Confidentiality

BlueShield will preserve the confidentiality of the member's health and medical records consistent with the requirements of applicable New York State and federal law.

BlueShield's confidentiality policy expects that the providers will maintain confidentiality of all materials and records that are proprietary to BlueShield or are used in connection with BlueShield's credentialing, reimbursement, quality assurance or other peer review programs, in accordance with the terms of the physician's application form and contract with BlueShield and the requirements of state or federal law.

Records

BlueShield keeps records of all members, but will not be liable for any obligation dependent upon information from the group or members prior to its receipt in a form satisfactory to the health plan. If BlueShield has not acted to its prejudice by relying on incorrect information furnished by the group or members, such information may be corrected.

Provider Education and Support

BlueShield provides notification to the provider community through the publication of the *Provider and Facility Reference Manual*, quarterly newsletters, stat bulletins, and protocols, all available on our provider website.

For more information, or if there are additional questions, you may contact the Provider Enrollment Department at 1-800-666-4627.

Section 3 — Preauthorization/Predetermination of Benefits

Large Group Dental Products

BlueShield of Northeastern New York does not require preauthorization for dental services; however, dental providers may submit a request for predetermination of dental benefits.

Predetermination is a confirmation of benefits available according to the terms of the member's dental contract. We encourage you to submit a treatment plan before you begin any major work. This avoids any misunderstanding regarding the extent of dental coverage under the dental contract.

To obtain predetermination of benefits:

- Complete and submit a dental claim form leaving the date of service blank.
- You are *not* required to submit x-rays with predetermination or claims; we will request X-rays, if necessary.

You will receive a notification of coverage available under the member's contract.

When all services have been completed, you may submit a claim form for payment indicating the date of completion and the doctor's signature.

If a minor change is made to the treatment plan after it has been approved, please indicate the change when submitting the claim for payment. Major changes to a treatment plan will require a new predetermination.

Please note: Changes in the member's contract, changes to the description of services rendered, or termination of the patient's contract may affect the final claim payment.

Small Group and Individual Stand Alone Dental Products

Children - to age 19 years

Medically Necessary Orthodontia

BlueShield dental plans cover medically necessary orthodontics for children under the age of 19 as specified by the Affordable Care Act (ACA). Preauthorization and medical necessity review is required for these services to be covered. Dentists should submit a predetermination first - on paper or electronically. Be sure to submit a letter of medical necessity and supporting documentation along with the predetermination. This request will be reviewed for medical necessity and approved or denied by our Utilization Management (UM) department. If approved, a letter will be sent out to the provider and member indicating approval or denial. In addition, a call will be made to the provider by our UM department. If the procedure(s) are approved, then the dentist may submit claims.

Medically necessary orthodontia is defined as follows:

Orthodontics used to help restore oral structures to health and function and to treat serious medical conditions such as: cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.

Procedures include but are not limited to:

- Rapid palatal expansion (RPE)
- Placement of component parts (e.g., brackets, bands)
- Interceptive orthodontic treatment
- Comprehensive orthodontic treatment (during which orthodontic appliances are placed for active treatment and periodically adjusted)
- Removable appliance therapy
- Orthodontic retention (removal of appliances, construction and placement of retainers)

All Dental Products

Temporomandibular Joint Dysfunction/Sleep Apnea

If you are a provider of services associated with temporomandibular joint dysfunction (TMJ), or sleep apnea oral devices, please be aware that these services are not included in the dental benefit, but can be considered under the member's medical contract.

1. These services may require preauthorization. Contact Provider Service to verify the patient's benefit requirements before providing these services.
2. Claims must be submitted on a medical claim form along with the appropriate Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes.

Section 4 — Corporate Medical Protocols

BlueShield publishes Corporate Medical Protocols to give participating providers a concise overview of medical necessity criteria utilized to determine coverage of services rendered. The Corporate Medical Protocols also identify and explain services that are investigational or experimental. BlueShield reviews and re-evaluates the Corporate Medical Protocols at least annually and more frequently as new information emerges that affects them. A cover letter describing the changes to the Corporate Medical Protocols is included thirty (30) days in advance of their effective date in our quarterly provider newsletter, *Network News and Updates*.

Updated protocols and cover letters are available to providers on our website.

The Corporate Medical Protocols provide clinically significant information about medical treatment that, if not adhered to, may affect the payment a provider receives. When a service is denied because it does not meet the medical necessity criteria contained within the protocol or the preauthorization requirement is not adhered to, the member is held harmless and cannot be billed. Payment for covered services is always subject to individual contract limitation and member eligibility at the time the services are rendered.

Our written process for evaluating and implementing the Corporate Medical Protocols meets NCQA standard UM 10: Evaluation of New Technology.

Medical Policy Change Request Process

BlueShield provides an established process for participating providers who disagree with our current position regarding a specific medical treatment or technology. The medical policy process is designed to eliminate undue influence resulting in an unbiased determination.

Reconsideration of our corporate position will be made if/when published, peer-reviewed scientific literature supporting its efficacy becomes available.

The Medical Policy Change Request Form can be located on our provider website. Go to *Tools & Resources > Forms > Patient Care Forms*.

The form should be completed in full and submitted to the appropriate Provider Practice Consultant.

Section 5 — Dental Product Information

General Information

BlueShield offers a wide variety of dental plans.

Federal Employees Program (FEP)

FEP has an established list of covered procedure codes for dental services. As a participating dental provider, you are considered preferred with the dental line of business for FEP members. The FEP dental program is considered a dental indemnity product.

Federal members have the prefix 'R' on their ID card. The FEP program has a reimbursement schedule called the maximum allowable charge (MAC). As a preferred dental provider, you agree to accept the MAC along with the member's liability as payment in full.

For non-covered services rendered to FEP members, vouchers may only show the member's first name, this is a result of the federal government complying with HIPAA regulations. For benefit or claim information, please contact Federal Employee Customer Service at 1-800-234-6008.

General Enrollment Medicare Advantage (Freedom HMO, Senior Blue HMO and Forever Blue PPO)

All Medicare Advantage plans have coverage under the Original Medical guidelines for certain services. All Medicare Advantage members also have coverage for certain preventive services under their plan.

Coverage includes:

Routine cleaning and oral exam — twice per year

- Cleaning: D1110
- Exams: D0120, D0150, D0180, D0190

X-rays — four bitewings **or** one full-mouth X-ray per year

- Bitewings: D0270, D0272, D0273, D0274
- X-rays (full mouth): D0330

Members can also opt to purchase one of two Optional Supplemental Dental plans, which include services other than preventive (diagnostic and restorative services). There is no Medicare Advantage dental network; therefore, a member can see any dentist. Members should pay for services in full upfront, and submit their itemized bill (including procedure codes) and reimbursement form to BlueShield in order to be reimbursed directly, minus any member responsibility. You can verify if the member has any of these plans by calling provider service.

Employer Group Waiver Plan (EGWP) Medicare Advantage (Senior Blue HMO and Forever Blue PPO)

All Medicare Advantage plans have coverage under the Original Medicare guidelines for certain services. Most EGWP plans offer additional dental coverage in the form of a dental allowance that can be used towards any non-Medicare covered dental service. There is no Medicare Advantage dental network; therefore, a member can see any dentist. Members should pay for services in full upfront, and submit their itemized bill (including procedure codes) and reimbursement form to BlueShield in order to be reimbursed the allowance amount directly.

Small Group and Individual Stand-Alone Dental Products

BlueShield offers dental plans both on the New York State of Health exchange and directly to individuals and small employer groups. Blue Pediatric Dental provides pediatric coverage only for children up to age 19 years. Adult/family plans (Blue Value Dental 1, 2 and 3) provide coverage for families including spouses/domestic partner, adult dependents 19 to 26 years) and children. Please note that these plans may be purchased with a medical benefit or alone.

- The dental network for these products is the Dental PPO network. As a participating provider, you will be paid at 100% of the PPO fee schedule and are not permitted to balance bill the member.
- The member may have a separate dental ID card or an ID card with medical and dental plans indicated on it. The ID card will have a line with "Dental" or will list out the dental product name.
- The plans have four levels of coverage:
 - Class Type I - Preventive and diagnostics (e.g. exams and cleanings, X-rays)
 - Class Type II - Basic restorative (e.g. fillings, simple extractions, oral surgery)
 - Class Type III - Major restorative (e.g. dentures, bridges, crowns)
 - Class Type IV - Orthodontia
- On all dental plans, preventive and diagnostic services (Class I) are not subject to deductible, as applicable. Member cost sharing on Major services (Class III) is 50% coinsurance on the allowed amount. Cost sharing on Basic Restorative (Class II) varies by plan design, but is typically either 20% coinsurance or 50% coinsurance.
- Pediatric dental benefits are not subject to any deductibles. Most pediatric benefits are subject to an out-of-pocket maximum for one child and one for two or more children. Once that maximum is reached in cost-sharing, services will be paid at 100% of our PPO fee schedule with no member cost-sharing.
- There is a deductible on Class II and III services for adults enrolled in Blue Value Dental plans. The deductible amount is single/family with the family amount equal to three times the single. No one individual can exceed the single deductible amount. All adult dental benefits (age 19 years and older) are subject to an annual benefit maximum which is the maximum amount BlueShield will pay out for covered services. This applies to all covered adult benefits with the exception of cosmetic orthodontia (routine braces) as applicable. Annual benefit maximums vary by plan.
- Our dental plans cover the pediatric essential health benefits for children up to age 19 years as required by the ACA. All plans cover medically necessary orthodontics for children as required by the ACA. This benefit, as outlined below, is subject to preauthorization and medical necessity review by our Utilization Management Department. Any cost sharing on this benefit accumulates to the out-of-pocket maximum. Please refer to the Orthodontic Review section.

Plans may cover cosmetic orthodontics (routine braces) for children and adults. These benefits are subject to a **lifetime maximum per person**. Please refer to the Orthodontic Review section. Refer to the provider website for summaries of these benefits. To verify benefits, log in and go to bsneny.com/provider/dental-benefits-lookup or call Provider Service.

Quick Reference: Small Group and Individual Stand Alone Dental Products

Benefit	Blue Pediatric Dental	Blue Value Dental plans	Additional Information
Coverage	Children to age 19 (end of the month)	Families - children, adults and adult dependents (19 to 26 - end of the month)	Blue Pediatric Dental benefits are included in all Blue Value Dental plans.
Deductible (adult benefits)	Not applicable	\$50 per member/\$150 family maximum	After member has met deductible, no further deductibles apply. Family is capped at 3 times single.
Out-of-pocket Maximum (pediatric benefits)	\$350 – one child \$700 – two or more children	Not applicable	Maximum member cost-sharing. Embedded for two or more children*.
Annual benefit maximum (adult benefits)	Not applicable	\$750 - \$1,500 (varies by plan)	Maximum carrier payment in allowed amount for adult benefits.
Orthodontics Lifetime Maximum (pediatric and adult)	Not applicable	\$1,000 per member per person - applies to adults and children	Applies to Blue Value Dental 3 only.
Preventive/diagnostic	No deductible \$20 copayment/visit	No deductible \$0 copayment/visit	
Basic restorative	No deductible 50% coinsurance	Deductible 20% - 50% coinsurance (varies by plan)	
Major restorative	No deductible 50% coinsurance	Deductible, then 50% coinsurance	
Orthodontics	No deductible 50% coinsurance for medically necessary orthodontics, subject to out-of-pocket maximum	Blue Value Dental 3 only - No deductible 50% coinsurance for pediatric and adult cosmetic orthodontics up to lifetime maximum	Medically necessary orthodontics for children is covered in all plans. Predetermination and documentation required.

*For two or more children, the out-of-pocket maximum is embedded as follows: after one child has met \$350 maximum, there is no further cost-sharing for that child. After two or more children have reached \$700 maximum, there is no further cost-sharing for covered services.

Orthodontic Review
Small Group and Individual Stand Alone Dental Products
Children - to age 19 years

Medically Necessary Orthodontia

BlueShield dental plans cover medically necessary orthodontics for children under the age of 19 as specified by the ACA. Dentists should submit a predetermination first, either electronically or via paper. **Be sure to submit a letter of medical necessity and supporting documentation along with the predetermination request.** This request will be reviewed for medical necessity and approved or denied by our Utilization Management (UM) department. A letter will be sent to the provider and the member indicating approval or denial. In addition, a call will be made to the provider by our UM department. If the procedure(s) are approved, then the participating dentist may submit claims.

Medically necessary orthodontia is defined as follows:

- Orthodontics used to help restore oral structures to health and function and to treat serious medical conditions, such as cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.

Procedures include but are not limited to:

- Rapid palatal expansion (RPE)
- Placement of component parts (e.g., brackets, bands)
- Interceptive orthodontic treatment
- Comprehensive orthodontic treatment (during which orthodontic appliances are placed for active treatment and periodically adjusted)
- Removable appliance therapy
- Orthodontic retention (removal of appliances, construction and placement of retainers)

Payment

This benefit has a 50% coinsurance and is subject to an out-of-pocket maximum for the child or children. After the child or children receiving treatment have met the out-of-pocket maximum, no additional coinsurance will be collected.

Medically necessary orthodontics will be paid by us minus the member coinsurance.

Cosmetic Orthodontia (Routine braces)

Children and Adults - only for Blue Value Dental 3

Dentists should submit a pre-determination or a claim for cosmetic orthodontics. Not all our plans cover this benefit, so the dentist's office should contact us to determine eligibility and coverage. If there is any question on whether the service is for medical necessity orthodontia for a child under the age of 19, please refer to *Orthodontic Review for Medically Necessary Orthodontia*.

To verify orthodontic benefits, log in and go to bsneny.com/provider/dental-benefits-lookup or call Provider Service to confirm that the member has a cosmetic orthodontic benefit.

Payment

Orthodontic treatment plans should contain a complete description of the orthodontic treatment to be done, **including the appliance and placement charge**, as well as the total estimated cost of treatment and the total estimated treatment time.

If you request a predetermination it should **include all charges including the appliance and placement charge**. No separate payments will be made for items not listed on the predetermination and will be denied inclusive of the monthly payments.

If a member’s contract has a 50% benefit, the benefit is based on the approved total charge, not a fee schedule. Payments are determined by the number of months the plan is for. The payments are determined on total charged amounts on an approved predetermination submitted by the provider.

Cosmetic orthodontics (braces), when covered, are subject to a lifetime maximum. After the lifetime maximum is paid by us, no additional benefits are available.

Large Group Experience-Rated and Self-Insured Dental Products

Dental Product Summary BlueShield of Northeastern New York Large Employer Group - Experience-rated, Community-rated, Self-insured					
Reimbursement Information	Dental PPO	Dental (Voluntary) 1014/1098	Traditional Dental (Plus) 1015/1098	Indemnity Dental 1016/1098	HMO 100/200 Series Dental Rider
Fee schedule	Dental PPO	Traditional Dental	Traditional Dental	Traditional Dental	Traditional Dental
Who receives payment for services					
Participating provider	Provider	Provider	Provider	Provider	Provider
Non-participating provider	Subscriber or provider	Subscriber	Subscriber	Subscriber	Non-par = not eligible

Dental Plus (Traditional Dental)

- Dental Plus fee schedule
- Deductibles may apply to all services except diagnostic and preventive
- Participating providers may not balance bill with the exception of orthodontics
- Non-participating providers may balance bill the difference between charges and fee schedule
- \$1,000 per member per year maximum applies to all services, except orthodontic
- \$1,000 lifetime member maximum applies for orthodontic

Members cannot be billed for withhold or variance amounts (difference between participating provider charge and allowance), with the exception of orthodontics.

Allowances	
Preventive and diagnostic	100%
Sealants and space maintainers, restorative, periodontics, endodontics and oral surgery	80%
Prosthodontics	50%
Orthodontics (if covered)	50%

Dental PPO

The dental network for these products is the Dental PPO network. Participating providers are not permitted to balance bill the member, except for orthodontics.

There are four levels of coverage:

- Class Type I - Preventive and diagnostics (e.g., exams and cleanings)
- Class Type II - Basic restorative (e.g., fillings, simple extractions)
- Class Type III - Major restorative (e.g., dentures, bridges, crowns)
- Class Type IV - Orthodontia

Deductible, annual maximum and lifetime maximum options are available.

A deductible will apply to all levels of coverage, **except preventive and diagnostic**, on those plans that have them. The annual maximum applies to all levels of coverage **except orthodontia**.

The lifetime maximum **only** applies to orthodontia services. The deductible is single/family with the family amount equal to three times the single. No one individual can exceed the single deductible amount.

Various options are available for dependent/student, deductible, annual maximum, lifetime maximum and orthodontia coverage.

To identify members with the Dental PPO, our identification cards will indicate “Dental” or “Dental PPO.”

To confirm member eligibility, go to wnyhealthnet.org or call Provider Service.

HMO 200 Plus Series, ZWX prefix

These members have an added benefit on their medical contract for one annual dental exam and cleaning, if they have no other dental riders. You are considered a participating dental provider for these members. Collect the specialist copay indicated on the member’s ID card.

Orthodontic Services

To verify orthodontic benefits, log in and go to bsneny.com/provider/dental-benefits-lookup or call Provider Service. Confirm if the member has an annual or lifetime maximum for orthodontic services.

Orthodontic treatment plans should contain a complete description of the orthodontic treatment

to be done, **including the appliance and placement charge**, as well as the total estimated cost of treatment and the total estimated treatment time.

If you request a predetermination it should include all charges **including the appliance and placement charge**. No separate payments will be made for items not listed on the predetermination and will be denied inclusive of the monthly payments. If a member's contract has a 50% benefit, the benefit is based on the approved total charge, not a fee schedule. Payments are determined by the number of months the plan is for.

The payments are determined on total charged amounts on an approved predetermination submitted by the provider.

Example:

- The member's contract has a 50% orthodontic benefit with a \$1,000 yearly limit
- The total charges for all services (including placement and appliances) is \$2,500
- The predetermination is for valid for twelve (12) months
- The \$2,500 is approved, then divided by the 50% benefit ($\$2,500 \times 50\% = \$1,250$)
- BlueShield will pay the yearly maximum of \$1,000. The member's responsibility is \$1,500 ($\$1,250 + \$250 = \$1,500$)

Monthly payments would be \$208.33 as follows:

- 50% payment from BlueShield to the provider at \$104.16, per month, over 12 months, until the yearly maximum is paid
- 50% or \$104.16 per month from the member (as well as any other balance after the maximum is met)

If there is no yearly maximum on the contract, BlueShield would pay \$1,250 in payments over the twelve (12) months and the member would pay \$1,250 over twelve (12) months for a total to the provider of \$2,500.

BlueCard Members

Claims for services provided to members of other BlueCross and/or BlueShield Plans should always be submitted directly to the home plan, not to BlueShield of Northeastern New York.

Section 6 — Claims and Billing

Billing Guidelines for Dental Cone Beam Computed Tomography

- Current Dental Terminology (CDT) procedure codes D0364 - D0391 are the most accurate codes for dental cone beam imaging.
- Dental procedures for patients who do not have dental coverage or have a limited yearly dental maximum should not be billed as medical procedures.
- Dental procedures should only be billed as medical procedures when there is a documented medical condition in the patient's record to warrant the procedure.
- Dental claims that are billed inappropriately will be subject to audit and/or denial.

Electronic Billing

Electronic claim submission is an easy way to minimize the amount of time it takes your claim to reach and be processed by the health plan. Submitting claims electronically will also save you money by reducing what you spend on orders for paper claims and high postage fees.

BlueShield contracted with Administrative Services of Kansas, Inc. (ASK) to be our vendor for this service. ASK will receive all provider claims submissions and will perform any necessary edits to ensure the claims meet all regulatory and contract requirements. The claims will then be transferred to the health plan for adjudication and payment.

ASK was selected because of their experience and credibility in the Electronic Data Interface (EDI) marketplace. We have chosen this company to be our partner in achieving the electronic transaction component of HIPAA.

As of October 1, 2009, BlueShield requires all dental claims to be submitted electronically. Please contact your vendor to coordinate electronic transactions.

Enrolling with ASK

To obtain information on or sign up for Electronic Claims Submission with ASK, please visit their website, located on the Internet at ask-edi.com. Click "Getting Started" on the menu bar.

Please fill out the online form completely to register and click 'Submit'.

If you would like to contact ASK by phone, please call their toll free number at 1-800-472-6481; press option 1 for New York Customers and select option 1 again to connect to an EDI Helpdesk specialist.

Click the 'Resource Center' tab for:

- Payer News
- General Information
- CAQH-CORE Operating Rules

Acceptable Claim Formats

ASK accepts and edits electronic claims submissions using the following formats:

- ANSI X12 837D 5010 based on the HIPAA Implementation Guides (Dental)
- ANSI X12 837P 5010 based on the HIPAA Implementation Guides (Professional)

Providers receive a clearinghouse response report for each electronic submission that indicates:

- Whether we have received the file
- The number of claims submitted successfully
- The data fields that need to be corrected before electronically resubmitting a claim returned for edit errors

Other Payer Claims Routing

When you enroll with ASK, you will be offered a one-year free trial membership to ASK's commercial clearinghouse, EDI Midwest. This offer provides you with the option of clearing other payers' claims through ASK. EDI Midwest routes claims to 800 payers around the nation.

EDI Midwest will only accept claims that can be sent to their final destination electronically. Your ASK EDI account representative can give you more detailed information about EDI Midwest at the time you enroll with ASK. You can contact ASK directly at 1-800-472-6481.

If you elect not to use the services of EDI Midwest, please make arrangements with your current clearinghouse vendor or submitter to have non-BlueShield claims submitted directly to the appropriate payer.

We will continue to process claims destined for our vendors and all of our lines of business, including NASCO, Non Direct-Bill ITS/BlueCard, Wellpoint and Federal Employee Program (FEP).

We will also accept electronic claims if you are connected with the vendors Change HealthCare Dental or Tesia-PCI Corporation. Change HealthCare can be contacted at 1-866-369-8805. Tesia can be contacted at 1-800-724-7240.

Effective August 1, 2009, all participating providers **are required** to view their vouchers on line by registering with **PaySpan Health**. Providers have the option to sign up for electronic funds transfer. **There is no cost for this service**. To sign up, go to **payspanhealth.com** and enter the assigned registration code.

Non-Electronic/Paper Claim Forms

Effective December 1, 2018, BlueShield of Northeastern New York will accept only the 2012 version of the American Dental Association (ADA) dental claim form.

Non-electronic claims should be submitted using the approved 2012 ADA dental claim form. Please note that all required fields of the claim form must be completed, or the claim may be returned for additional information.

These forms can be purchased from your forms vendor. To ensure accurate claims processing, National Provider Identifier (NPI) and Tax ID numbers must appear on the claim form.

We accept Red Dental claim forms or black and white ADA standard claim forms. Please see the sample 2012 ADA dental claim form and the instructions for its use, including the required

fields in the [appendix](#) of this manual.

Claim Submission Tips:

- Use the 2012 version of the American Dental Association (ADA) dental claim form
- Check your printer to ensure that the ink is dark
- Do not highlight data on the claim form
- Check your printer to ensure it will print within the fields on the dental claim form
- If the information submitted is incorrect or missing, we may generate a letter asking you to resubmit the claim with the correct information
- The use of any outdated claim forms may delay processing
- Claims must be submitted with valid Current Dental Terminology (CDT) procedure codes, which begin with a "D." The ADA publishes CDT codes every other year; to obtain your CDT reference manual, contact the ADA or call your local vendor
- As of July, 2001, BlueShield no longer requires X-rays to be included with pre-treatment estimates and claims; if additional information is needed, we will contact you directly
- The three-letter prefix and the two-digit suffix, along with the member's identification number, is required (e.g., ZWL12345678901)
- Infection control charges - infection control is an integral part of doing business, and is therefore considered an overhead cost, which cannot be billed to our members.

Professional Courtesy - No reimbursement will be provided to a provider billing for professional services rendered to his/her immediate family, regardless of whether the family member has coverage under a BlueShield contract. Immediate family is defined as the provider's spouse, children, parents and siblings. BlueShield will not reimburse for services that would normally have been furnished without charge.

Mail all claims to:

BlueShield of Northeastern New York
PO Box 80
Buffalo, New York 14240-0080

Federal Employee Program (FEP)

BlueShield of Northeastern New York
Attention: FEP Department
PO Box 80
Buffalo, New York 14240-0080

Important Information Regarding Blue Card Members

Claims for services provided to members of other BlueCross and/or BlueShield plans should always be submitted directly to the home plan, **not** to BlueShield of Northeastern New York.

How to Identify Members

Member ID cards - When a Blue plan member arrives at your office, be sure to ask for their current membership identification card. The main identifier for out-of-area members is the alpha prefix.

Important facts:

- A correct member ID number includes the alpha prefix (first three positions) and all subsequent characters, up to 17 positions total.
- The alpha prefix on a member's ID must be three characters.
- Some member ID numbers may include alphabetic characters in other positions following the alpha prefix; others may be fewer than 17 positions.
- Do not add/delete characters or numbers within the member ID.
- Do not change the sequence of the characters following the alpha prefix.
- Members who are part of the Federal Employee Program (FEP) will have the letter 'R' in front of their member ID number. Claims for these members should also be filed with the local/host plan.

Alpha Prefix

The three-character alpha prefix, at the beginning of the member's identification number, is the key element used to identify and correctly route claims. The alpha prefix identifies the Blue Plan to which the member belongs. It is critical for confirming a patient's membership and coverage. To ensure accurate claim processing, it is critical to capture all ID card data. If the information is not captured correctly, you may experience a delay with the claim processing. Please make copies of the front and back of the ID card, and pass this key information to your billing staff. Do not make up alpha prefixes.

Do not assume that the member's ID number is the social security number. Use of the social security number on ID cards was phased out January 1, 2006.

Timely Filing

All claims must be submitted to BlueShield within one hundred and twenty (120) days from the date of service. Claims that are submitted after one hundred and twenty (120) days will be denied. The calculation begins from the date of service, discharge date or last date of treatment up to one hundred and twenty (120) days, which includes weekends. Do not delay the billing of a claim for any reason. If a claim denies for timely filing and you have previously submitted the claim within one hundred and twenty (120) days, resubmit the claim and denial with your appeal. Listed below are the guidelines for submitting appeals.

Timely filing does not apply to:

- National accounts
- Workers compensation

Claims must be submitted within one hundred and twenty (120) days from the date of service for all services **except** the following:

- Endodontic therapy and retreatment
- Apexification/recalcification procedures
- Comprehensive and periodic orthodontic treatment

Claims for these procedures must be submitted **within) one hundred and twenty (120) days of completion** of the above continuous service(s).

Submitting Appeals

Submit all timely filing appeal requests in writing, stating the reason for the delay of submission beyond one hundred and twenty (120) days. The claims you are appealing must be on a paper claim form and attached to your appeal. Please keep copies of the information you send for ease in identifying claims that will be approved/denied.

Electronically Submitted Claims

For electronic claims that have not been processed, please submit one of the following reports with your appeal request and claim(s):

- Deleted Claim Edit Report
- Clearinghouse response files

If you would prefer to receive these reports instead of your vendor, please contact ASK at 1-800-472- 6481.

If you are using the electronic response file to do automatic posting of errors or claims accepted, the following information needs to be included on the report you send to us:

- Error record
- Record sequence
- Error code
- Clearinghouse messages
- Error field
- Error description

Continue to balance your submission counts to those on the Clearinghouse Response file. If a discrepancy exists between the counts, notify ASK's Help Desk immediately. The Clearinghouse Response file will be the only notification you will receive about a claim deleted in the transmission.

If you currently do not receive any of the above reports or experience discrepancies on claim counts, contact ASK at 1-800-472- 6481.

Clearinghouse Rejections

If a claim rejects in the clearinghouse (i.e., invalid member identification number), submit your deleted claim edit report and claim with your appeal.

Coordination of Benefits (COB)

If an insurance carrier other than BlueShield is the primary carrier, the provider must submit the other carrier's payment voucher and claim within one hundred and twenty (120) days of the payment from the other carrier. COB claims can be submitted using the electronic format of 837I or 837P. Providers do not need to submit the other carrier explanation of benefits (EOB) if all of the information is submitted on the 837.

If a provider is receiving an 835 (electronic remittance), they may or may not have a paper voucher or EOB to submit to BlueShield. The information received on the 835 should be incorporated into the secondary fields on the 837.

Incorrect Insurance Information

If the member provided incorrect insurance information, the denial notice from the other carrier must be submitted with the original claim within one hundred and twenty (120) days of the other carrier's denial.

No Coverage

If a participating provider, in dealing with a patient finds that he/she has no insurance, the member should be asked to sign and date a patient responsibility form or waiver. A provider may seek payment from the patient for any services provided.

If the member realizes that he or she has BlueShield coverage after a provider has billed the member and the claim is beyond the three month timely filing limit, the provider should submit the signed waiver/patient responsibility form and claim with your appeal. Do not re-bill the member.

If you do not have a signed waiver, submit copies of billing statements with your claim(s) and appeal that indicates that you have billed the member who has now advised you that he/she has BlueShield insurance.

Member Held Harmless

Participating providers are responsible to abide by the stipulations of the BlueShield provider agreements. In cases where services were not billed to us within the timely filing limits, you cannot bill the member directly. The member is to be held harmless. The reimbursement issue is between you as a participating provider and us as the insurer. You may file the claim late with a request to waive the limit with an explanation. Upon review of your appeal, approval or denial will be determined; however, at no time is the member to be held responsible.

Filing Requirements for Members and Non-Participating Providers

Dental claims submitted by members or non-participating providers (for traditional and approved services through our managed care contracts) must be submitted within two years. If claims, requests for adjustments, appeals or claim reviews are submitted by the member or a non-participating provider beyond the two year time frame, the claim will be denied. The non-participating provider can bill the member for these denied claims.

Claim Adjustment Policy

Effective January 1, 2005, BlueShield of Northeastern New York implemented a standard claim adjustment policy for all providers, with the exception of those whose current agreements include such a provision.

Standard Claim Adjustment Policy

BlueShield will accept claim adjustment requests up to one hundred and eighty (180) days from the end of the calendar year in which the claim in question was adjudicated. Adjustment requests received after that time frame has expired will not be recognized.

The *Provider Claim Inquiry Form* should be used to submit provider inquiries and adjustment requests for all BlueShield lines of business.

Adjustment requests should be submitted within one hundred and eighty (180) days from the end of the calendar year in which the claim in question was adjudicated. The form and

instructions for its use are available at bsneny.com.

Additionally, BlueShield will not engage in any retroactive claim adjustment activities after the 180-day timeframe has expired for paid claims.

Exclusions to this policy

- Claims investigated as part of an internal audit for fraud are exempt from this policy and are subject to payment recovery.
- Coordination of Benefits (COB) and Other Party Liability (OPL) situations are exempt from this policy. Consideration of claims/adjustments will be based on current COB/OPL timely filing guidelines. In the case of No Fault and Other Insurance situations, submissions and adjustment requests must be received within one hundred and twenty (120) days of the other carrier's process date. Claims that are related to workers' compensation are not subject to timely filing limitations.

New York State Prompt Pay Interest

Prompt pay interest exceeding \$1.99 per claim is generated on a daily basis for claims not processed within forty-five (45) days of BlueShield's receipt of the claim. Checks and wire payments are issued more frequently than the weekly cycle to ensure that prompt pay requirements are met. Any interest paid appears under the "Interest Paid" column on your payment voucher.

Claims submitted for adjustment due to errors caused by BlueShield processing receive prompt pay interest.

The following are excluded from prompt pay interest:

- Administrative services only (ASO) and administrative services for national accounts (NSO) contracts
- Federal Employee Plan (FEP) contracts
- Services rendered by out-of-state providers
- Senior Blue claims from non-participating providers
- National accounts when an out-of-state plan is the control plan
- BlueCard® claims for members from plans outside New York State, home and host

Coordination of Benefits (COB)

Coordination of benefits applies to members who have more than one group health insurance contract. BlueShield coordinates benefit payments with other carriers to ensure members receive all of the benefits to which they are entitled and to prevent duplicate payments. Other insurance information should be verified each time that a patient visits your office.

Primacy

When a patient is covered by two or more health insurance plans, one plan is determined to be primary and its benefits are applied to the claim. The following rules apply when determining which carrier is primary:

- If one policy does not have a COB provision, then it is primary.
- If the patient is covered by one policy as the employee and by another policy as a dependent, the policy that covers the patient as an employee is primary.

- The primary policy for children is the policy of the parent whose birthday (month and day) occurs earliest in the year; if both parents have the same birthday, the oldest policy is primary.
- When there is more than one insurance policy and the parents are divorced or separated, the rules of primacy vary depending on the court decision.
- If the patient is the policyholder and covered by one of the policies as an active employee, is neither laid off nor retired, and also covered by another policy as a laid off or retired employee, the policy covering the patient as an active employee is primary.
- If none of the above applies, then the policy that has covered the patient for the longest time is primary.

Submitting Claims for Secondary Reimbursement

Claims must be submitted electronically on the 837D or 837P, or on paper, using a current ADA dental claim form. All line items billed to the primary carrier should be submitted on the secondary claim.

Attach a copy of the primary carrier's Explanation of Benefits Statement and indicate balance due. The balance due is the amount to be considered by BlueShield or the patient's responsibility.

Attach a copy of the primary carrier's Explanation of Benefits Statement. Claims submitted on paper without the Explanation of Benefits Statement will be rejected.

When a claim for dental services is secondary, the benefits of the member's BlueShield contract will be reduced so that the total benefits payable under the other policy and under the contract we provide to the member do not exceed the amount we would have paid if we were primary.

The Physician's Role in Managed Care for Members with Special Needs (Including Medicare Advantage Dual-eligibles)

For planned and unplanned transitions between care settings (a member's usual care setting to a hospital, or from a hospital to the next setting), the sending provider is expected:

- To share the care plan with the receiving setting within one business day of notification of the transition.
- To inform the member (or the member's responsible party) of the care transition process.
- To inform the member (or the member's responsible party) about changes to the member's health status and plan of care.
- Federal law bars Medicare providers from collecting Medicare Part A and Medicare Part B deductibles, coinsurance, or copayments from those enrolled in the Qualified Medicare Beneficiaries (QMB) program, a dual-eligible program which exempts individuals from Medicare cost-sharing liability. (See Section 1902(n)(3)(B) of the Social Security Act, as modified by 4714 of the Balanced Budget Act of 1997).
- Balance billing prohibitions may likewise apply to other dual-eligible beneficiaries in Medicare Advantage (MA) plans if the State Medicaid Program holds these individuals harmless for Part A and Part B cost-sharing.
- Further, Medicare Advantage enrollees cannot be discriminated against in the delivery of health care services, consistent with the benefits covered in their policy, based on race,

ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, or source of payment. Discrimination based on “source of payment” means, for example, that MA providers cannot refuse to serve enrollees because they receive assistance with Medicare cost-sharing from a State Medicaid program.

Members who are eligible for both Medicare and Medicaid (dually eligible) may have certain services covered by the Medicaid programs. To find out which benefits are covered by the member’s Medicaid benefit, please call provider service at 1-877-327-1395.

Bill Your Usual Charge

Regardless of our allowance for a service, you should always bill your usual charge. This is beneficial in several ways:

- It enables us to determine average charges for procedures.
- By using one charge to bill all insurance companies, the chance of billing errors is reduced.
- If more than one insurance company has liability for a claim, your standard charge eliminates confusion and helps to ensure proper payment.

Payment Voucher

Payment vouchers include a detailed explanation of each claim by line of service. Online vouchers are available via a web application by enrolling for this service at **payspanhealth.com**. Participating provider summary checks are distributed weekly. Summary checks include payment for claims that finalize during the week's processing. Additional checks are issued on a daily basis to ensure that prompt pay requirements are met.

As of August 1, 2009, BlueShield ceased mailing paper vouchers. Providers must view their online vouchers by signing up to **payspanhealth.com**.

Electronic transfer of funds is also available by enrolling for this service at **payspanhealth.com**. Checks are attached to a simplified summary statement which identifies the total number of claims processed, total services processed and paid, adjustments and withdrawn payments.

BlueShield has implemented HIPAA-compliant claim adjustment reason codes, per the HIPAA 835 Electronic Remittance Transaction standard. Placing the adjustment codes as the first characters in the explanation (EX) code description will also allow providers to cross-reference electronic remittance with their paper vouchers.

The complete list of claim adjustment reason codes can be found at **hhs.gov**.

To receive an Electronic Remittance Advice (835), register with Administrative Services of Kansas (ASK) at www.ask-edi.com. Click “Getting Started” on the menu bar. Please fill out the online form completely to register and click ‘Submit’

Claim Inquiries and Adjustments

Providers can contact Provider Service for claim inquiries, claim adjustment requests, and benefit information.

Overpayments

If your claim is overpaid, please request an adjustment by submitting a Provider Claim Inquiry Form and a copy of the payment voucher that lists the payment. The overpayment will be withdrawn from a future payment. If we receive a personal check in the amount of the overpayment, we will return the check to you and make the appropriate adjustment to your voucher.

Provider Support Tools

BlueShield has created a variety of tools to help the staff in your office understand our contract benefits, claim submission procedures and medical policies. Some of the tools available for your use are:

HEALTHeNET

HEALTHeNET (wnyhealthenet.org) is an online community health information network established by an independently incorporated coalition of health insurance plans, including BlueShield of Northeastern New York, and hospital providers. This system provides real-time member eligibility and verifies if the member has dental coverage or not. For detailed dental benefits, please contact Provider Service.

Dental Providers are encouraged to sign up for HEALTHeNET. Instructions to sign up are available at wnyhealthenet.org/signup. The BlueShield of Northeastern New York provider website bsneny.com can also be accessed using your HEALTHeNET username and password.

The standard set of transactions available online are as follows:

- **Eligibility Transaction (270/271)** - The eligibility transaction gives offices a direct connection to membership files and allows Providers to confirm patients' eligibility in just minutes.
 - NOTE: Dental providers will only see that a member has Dental coverage and the member's effective date. For detailed Dental benefits, dental office users must log into www.bcbswny.com/provider.
- **Claim Status Transaction (276/277)** - Allows you to check the status of your claims. Providers are enabled able to obtain detailed information about claims, eliminating the need to contact the Provider Service Department.

To sign up:

1. Go to wnyhealthenet.com
2. Click *Sign Up* at the top of the home page
3. Complete the online enrollment form

A representative will contact you within five (5) business days of your request to provide further instructions and schedule training

Provider Pending Claims Status Report

A weekly report identifies claims that were received and are pending; the following codes are used within the report to identify claims status:

- **PFD** Claim received, pending final disposition

- **AMI** Claim received, awaiting additional medical information
- **RMN** Claim received, reviewing for medical necessity
- **COB** Claim received, COB external information requested
- **ADJ** Adjustment received, pending final disposition

Used in conjunction with your payment vouchers, this report enables you to determine if BlueShield has received your claim. If a claim is not listed on the Status of Pending Claims Report or on your payment voucher within thirty (30) days after submission, please submit a new claim electronically. Please do not write "re-bill" or "re-submission" on paper claims, as this will delay processing.

Section 7 — Provider Reimbursement and Fee Schedules

As a participating dental provider, payments are made directly to you for all services covered under the member's contract. For services rendered by non-participating dental providers, payments are made to the member.

A participating dentist is reimbursed on the basis of his/her usual charge, or the BlueShield maximum allowance, whichever is lower. Participating dentists shall accept our allowance along with the member's liability as payment in full for all covered services. The participating dentist cannot collect charges beyond the patient's responsibility.

The reference in our member's contracts regarding "usual, customary and reasonable charge" means the lower of (a) the usual fee which the dentist who renders dental services most frequently charges to the majority of his/her patients for a similar service or dental procedure or (b) a fee which is charged in the locality by most dentists of similar training and experience for the performance of a similar service or dental procedure.

Fee Schedule - Our fee schedules are updated periodically; they are not automatically updated every January.

Participating dental providers may obtain a copy of our fee schedule at bsneny.com/provider.

Section 8 — Member Information

Member Rights and Responsibilities

As partners in health care, each of us has rights and responsibilities that we must follow in order to make the most of our members' health benefits. The following rights and responsibilities apply to our members:

Member Rights

Members have the right to:

- Receive information about the health plan, its services, its practitioners and providers, and member's rights and responsibilities.
- Treatment with respect, consideration, dignity and right to privacy.
- Information about all services available through the health plan, including how to obtain emergency and after-hours care.
- Confidentiality of their medical records.
- Candid discussions concerning appropriate or medically necessary treatment options for their condition(s), regardless of cost or benefit coverage.
- Voice complaints or appeals about the Health Plan or the care provided.
- Request to see their primary care physician (PCP) instead of another member of his/her office staff for an office visit, if they are willing to wait for an available appointment.
- Make recommendations regarding the health plan's member Rights and Responsibilities policies.

Patient Rights

Our patients have a right to expect the following from their providers:

- To participate in decisions concerning their health care.
- To refuse treatment to the extent permitted by law, and to be informed of the medical consequences of that action.
- To obtain from their provider complete and current information concerning a diagnosis, treatment, or prognosis, in terms they can reasonably be expected to understand. When it is not advisable to give such information to a member, the information shall be made available to an appropriate person on their behalf.
- To receive information from their provider necessary to give informed consent prior to the start of any procedure.
- To know the name and qualifications of all their caregivers. Information can be obtained from the provider or the administrator of any health care facility.

If a member feels that their provider has not given them the kind of service they have the right to expect, our members have the right to follow the complaint procedure for Quality of Care Access Review. They can refer to their member handbook or contact customer service.

Member Responsibilities

- Members need to establish themselves as a patient of the physician they have selected for their primary care services.
- Members are to follow the instructions and guidance of health care providers.
- Provide honest and accurate information concerning their health history and status.
- Participate in understanding their health problems and developing mutually agreed upon

treatment goals.

- Follow carefully the health plan's policies and procedures as described in their member handbook and their contract(s) and rider(s).
- Members are to be sure that their primary care physician coordinates any health care they receive in order to receive the highest level of benefits, if applicable under the terms of your plan coverage.
- Carry their member ID card with them and present it when seeking health services.
- Advise their health plan of any changes that affect them or their family such as birth, change of address, or marriage.
- Submit all bills they have received from a non-participating provider within one year from the date of service.
- Notify their health plan when anyone included in their coverage becomes eligible for Medicare or any other group health insurance.
- Keep their health plan informed of their concerns about the medical care they receive.
- Pay appropriate copayment/deductible/coinsurance or other patient responsibility to providers when services or supplies are received.

Grievance and Appeal

If members encounter any issues, they can usually be resolved with a call to the Customer Service Department.

Unresolved complaints or requests to change contractual determinations that are not in regard to medical necessity determinations or experimental/investigational determinations can be reviewed through the grievance and appeal procedures. Adverse medical necessity determinations or experimental/investigational determinations are reviewed through the Utilization Management (formerly Medical Management) appeals process.

Our grievance and appeal procedure is designed to ensure a timely review of:

- Our members' concerns regarding our policies and procedures
- Any decision which we have made regarding a service which they believe is covered by BlueShield of Northeastern New York, or should be provided to them as part of their coverage

A grievance can be requested for any determination made by BlueShield other than a decision that a service is not medically necessary or is experimental or investigational in nature. Examples of concerns that may be reviewed under our grievance and appeal procedure include, but are not limited to, the following:

- Denial of a referral to a specialist
- Denial of coverage for a referred service
- Denial because a benefit is not covered according to the terms of the member's contract(s)
- Denial of a benefit because it was provided by an ineligible provider or at an ineligible place of service
- A determination that they were not a member of BlueShield at the time services were rendered

There is a two-level grievance and appeal process. As always, they may file a grievance at their discretion. BlueShield will not take any discriminatory action against a member because

they have filed a grievance or an appeal.

Designating a Representative

Members may designate someone to represent them with regard to their grievance or appeal at any level. If a representative is designated, we will communicate with the member and their representative, unless directed otherwise. In cases involving urgent care, a health care professional with knowledge of their medical condition may act as their authorized representative.

Initiating a Grievance (Level I)

Any time BlueShield denies a referral or determines that a benefit is not covered under the member's contract(s), the member will receive notification of our grievance procedures. A written or oral grievance may be filed up to one-hundred eighty (180) days after the receipt of our original determination. Requests for a grievance should state the name and identification number of the member for whom the benefit or referral was denied. It should also describe the facts and circumstances relating to the case. Oral or written comments, documents, records, or other information relevant to the grievance may be submitted.

A grievance may be initiated by calling our Customer Service Department at the number on the back of the member identification card. When our offices are closed, the member may notify us about their grievance by leaving a detailed message with our answering service. We will acknowledge receipt of the oral grievance by telephone within one (1) business day of receipt of the message. We can communicate with non-English speaking members through the AT&T translator service.

Members are instructed to send all grievance requests to:

Grievance Department
BlueShield of Northeastern New York
PO Box 80
Buffalo, NY 14240

We will send a written acknowledgment of receipt of a member's grievance within fifteen (15) calendar days. This letter will include the name, address and telephone number of the department that is handling the grievance. It may be necessary to ask for additional information before we can review the grievance. If this is necessary, we will contact the member.

A service representative that was not involved in the initial determination and who is not a subordinate of the initial reviewer, will thoroughly research the case by contacting all appropriate departments and providers. The service representative will review all relevant documents, records, and other information including any written comments, documents, records and other information the member or their representative have submitted.

If the issues involved are of a clinical nature, it will be reviewed by a health care provider who was not involved in our initial determination and who has appropriate training and experience in the field of medicine involved in the medical judgment. Clinical matters would be those that require appropriate medical knowledge and experience in order to make an informed decision. The member will be contacted within the following timeframes:

- In urgent cases, when a delay would significantly increase the risk to the member's health, a decision will be made and communicated to the member by telephone within forty-eight (48) hours after receipt of the grievance. The member will also be contacted in writing within two (2) business days of the notice by telephone.
- In cases involving requests for referrals or disputes involving contract benefits and all other non-urgent cases, a decision will be made and communicated to the member as follows:
 - Pre-service claims: In writing within fifteen (15) calendar days after receipt of the grievance
 - Post-service claims: In writing within thirty (30) calendar days after receipt of the grievance

Our response to our member will include the detailed reasons for our determination, the provisions of the contract, policy or plan on which the decision was based, a description of any additional information necessary for the member to perfect their claim, and why the information is necessary, the clinical rationale in cases requiring a clinical determination, the process to file an appeal and an appeal form.

Appealing an Upheld Denial (Level II)

If a member remains dissatisfied with the outcome of their grievance, they may file an appeal. A request for an appeal should include any additional information the member feels is necessary. Members have sixty (60) business days from the time they receive the grievance determination to submit an appeal to BlueShield. They may submit their request for an urgent appeal verbally or in writing. For a non-urgent appeal, they may submit a written request in the form of a letter or use our appeal form. The member will receive a copy of our appeal form with the original grievance decision. They may submit any written comments, documents, records or other additional information with their appeal.

We will send written acknowledgment of our receipt of the appeal request within fifteen (15) calendar days. This notice will include the name, address and telephone number of the individual who will respond to the member's appeal.

Non-clinical matters will be reviewed by a panel comprised of representative staff from our Network Operations, Member Services, Quality Management, and Utilization Management areas who were not previously involved in your grievance.

If the appeal involves a clinical matter, it will be reviewed by a panel of personnel qualified to review clinical matters. This includes licensed, certified, or registered health care professionals who did not make the initial determination. At least one of the health care professionals reviewing the appeal will be a Clinical Peer Reviewer. (A Clinical Peer Reviewer is a licensed physician or a licensed, certified, or registered health care professional that has appropriate training and experience in the field of medicine involved in the medical judgment.) We will make a decision regarding the appeal and send the member notification within the following timeframes:

- In urgent cases, a decision will be made and notice provided by telephone within twenty-four (24) hours after receipt of the Level II grievance appeal followed by written notice within two (2) business days after receipt of the appeal.
- For non-urgent pre-service claims, a written decision will be sent within fifteen (15) calendar days from receipt of the appeal.

- For post-service claims, a written decision will be provided within thirty (30) calendar days from receipt of the appeal.

Our notification to the member with regard to their appeal will include the detailed reasons for our determination, the provisions of the contract, policy, or plan on which the decision was based, and the clinical rationale in cases where the determination has a clinical basis.

Utilization Review Policies and Procedures

Utilization review is a process used to determine if services are or were medically necessary or experimental or investigational in nature. Utilization review will occur whenever judgments are rendered pertaining to medical necessity and the provision of services or treatments. In the case of a denial for medical necessity, all decisions will be made by qualified clinical personnel. Notices of denials will include information about the basis of our decision and further appeal rights, if any.

Appeal Process

The appeal process for chiropractic services, mental health and chemical dependency services is handled by the organization managing the benefits for these services.

Our members may designate someone to represent them with regard to their appeal. If a representative is designated, we will communicate with the member and their representative, unless directed otherwise.

In order to appoint a representative, the member must complete, sign, and return the **Appointment of Authorized Representative Form**. In cases involving urgent care, a health care professional with knowledge of their medical condition may act as an authorized representative without the need to complete the Appointment of Authorized Representative Form. You may request this form by calling Customer Service at the number listed on the member identification card.

Our members may either make their request for a utilization review in writing or verbally, twenty-four (24) hours a day, seven (7) days a week. The request should include the name and ID number of the member for whom the review is requested and the facts relating to the case. The member may request a utilization review by calling the number listed on their identification card, or in writing:

Grievance Department
BlueShield of Northeastern New York
PO Box 80
Buffalo, NY 14240

Our telephones are staffed at least forty (40) hours a week during normal business hours. During all other times, a message may be left on our confidential voice mail. We will contact the member by telephone within one (1) business day after receipt of their message.

Pre-Service Claims

Pre-service claims are procedures or treatments that require preauthorization. We will make a determination regarding a pre-service claim and provide notice by telephone and in writing to the member or their representative and their health care provider within three (3) business

days after receipt of all necessary information.

If all necessary information to render a decision has not been provided, we may provide the member with an opportunity to submit the missing information. If we allow the extension, we will notify the member in writing within fifteen (15) calendar days after receipt of the claim of the specific missing information. We will allow the member up to 45 calendar days from the date of our notice to provide the missing information.

If we receive all the information requested, we will make a decision and provide notice by telephone and in writing within three (3) business days of receipt of the information. If only partial information is received, we will make a decision and provide written notice within fifteen (15) calendar days from receipt of the partial information. If we do not receive any information by the end of the 45-day period, we will make a decision and provide written notice within fifteen calendar (15) days from the end of the 45-day period.

If the member or their authorized representative fails to follow our procedures for properly filing a pre-service claim, we will notify them or their authorized representative verbally or in writing within five (5) calendar days after receipt of the claim of the proper procedures for filing a pre-service claim. If the pre-service claim involves urgent care, we will notify the member within twenty-four (24) hours after receipt of the claim. We will only provide notice of an improperly filed pre-service claim if the following requirements are satisfied:

- the initial communication by you, the member, or their authorized representative is received by Utilization Management at 1-800-677-3086
- the communication includes the name of the claimant
- the specific medical condition or symptom is indicated
- a specific treatment, service or product is requested

Concurrent Care Claims

Concurrent care claims involve continued or extended health care services or additional services for a member undergoing a course of continued treatment prescribed by a health care provider/practitioner. Concurrent care claims involve care of an ongoing nature to be provided over a specific period of time or a specified number of treatments.

For non-urgent concurrent care decisions we will render a decision and provide notice to the member or their designee by telephone and in writing within one (1) business day of receipt of all necessary information.

If the member requests an extension of a course of treatment beyond the period of time or number of treatments already approved which involves urgent care, we will render a decision and provide notice to the member or their designee within twenty-four (24) hours of receipt of the claim. We are only required to provide notice within twenty-four (24) hours if the member made the request for an extension at least twenty-four (24) hours prior to the scheduled expiration of the services.

For urgent requests for an extension of a course beyond the period of time or number of treatments approved which were not provided at least twenty-four (24) hours before the scheduled expiration of the services, we will render a decision and provide notice to the member or their designee within one (1) business day or seventy-two (72) hours of receipt of

the claim, whichever occurs first.

If we are reducing or terminating an already approved course of treatment, we will provide notice and the right to an appeal prior to our reduction or termination of the treatment. The member will have forty-eight (48) hours to submit an appeal of the proposed reduction or termination of the treatment. A decision will be made and notice will be provided within forty-eight (48) hours of receipt of the appeal or of the end of the period to submit the appeal, whichever occurs first.

Notification of an approval of continued or extended concurrent care services will include the following:

- the number of extended services provided
- the new total of approved services
- the date the services are authorized to begin
- the date the next utilization review is scheduled to take place

Urgent Care Claims

An urgent care claim is any claim for medical care or treatment for which failure to make an expeditious decision could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function or, in the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment requested.

We will render a decision and provide notice orally or in writing to the member or their representative within seventy-two (72) hours after receipt of all necessary information. If we provide oral notice, we will follow with written notice within three (3) calendar days of the oral notice. If the member fails to provide all necessary information, we will notify them within twenty-four (24) hours after receipt of the claim of the information necessary to complete the claim. The member will have forty-eight (48) hours to provide us with the missing information. We will notify the member of our decision within forty-eight (48) hours after receipt of the missing information or the end of the period afforded them to provide the additional information, whichever is earlier.

Post-Service Claims

A utilization review determination involving services that have already been provided, will be made within thirty (30) calendar days after receipt of all necessary information. If all necessary information is not provided, we may provide the member with an opportunity to submit the missing information. If we allow the extension, we will notify the member in writing within thirty (30) calendar days after receipt of the claim of the specific missing information. We will allow the member up to forty-five (45) calendar days from the date of our notice to provide the missing information.

If we receive any of the information requested, we will render a decision within fifteen (15) calendar days after receipt of the information. If no information is received, we will render a decision within fifteen (15) calendar days after the end of the forty-five (45) calendar day period.

If we fail to make a utilization review decision within the time frames above, it will be deemed an adverse determination subject to the internal appeals process.

Right to Reconsideration

In situations where there has been a denial of services as not medically necessary without attempting to discuss the matter with the provider who recommended the service, procedure or treatment under review, the provider shall have the opportunity to request a reconsideration of the denial. The reconsideration review shall occur within one (1) business day of receipt of the request, except in cases where the reconsideration request is for services that have already been provided.

Appeals Process

At times a member may receive a letter explaining that BlueShield has reached an adverse determination. This means that BlueShield has decided that an admission, extension of a stay, or other health care service is not medically necessary.

Any member has the right to appeal this decision, or appoint a representative to do this for them (see Designating a Representative). The attending physician or the provider who ordered the medical service can appeal an adverse decision if we originally denied the claim before we had all of the information we needed. Hospitals, other health care providers or someone the member chooses to represent them may assist in an appeal.

A notice of an adverse determination will include instructions on how to initiate standard and expedited internal and external appeals and instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used. If we fail to render an internal appeal determination within the specified timeframe, the initial adverse determination will be reversed.

Standard Appeals

A member may request an appeal of an adverse decision using our standard appeals process.

Members may also designate someone to act for them to appeal a decision. A member has one-hundred, eighty (180) calendar days from the date of receipt of our initial adverse determination to request an appeal. Members may call or write to BlueShield to request an appeal. The notice we send them explains why we made an adverse decision and includes the telephone number they can call to request an appeal.

After BlueShield receives the appeal request, we will obtain a copy of the medical record. We will let the member know that we received the appeal request by sending them, or their representative, an acknowledgment letter within fifteen (15) calendar days of the date we receive the request. Our medical director, or a physician consultant who is in the same profession and same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the health care service or treatment under review, will review your records. The reviewer will not have been involved in the original decision, and will not be a subordinate of the person who made the initial determination.

We will provide a written decision to the member, their representative, and where appropriate, their health care provider within thirty (30) calendar days after receipt of the appeal for pre-service claims and sixty (60) calendar days after receipt of the appeal for post-service claims.

In cases where we do not change our original decision, we will also give the member the medical reason for the decision. When a member receives our final adverse determination, they may request an external review. Additional details are provided in following sections.

Final Adverse Determination

The notice of final adverse determination regarding your appeal will include the following:

1. A clear statement describing the basis and the specific, scientific, or clinical rationale for the denial.
2. Reference to the evidence or documentation used as a basis for the decision, including whether any internal rule, guideline, protocol or similar criterion was relied upon in making the determination. In cases involving a denial of services, instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used will be included.
3. The provisions of the policy, contract or plan on which the determination is based.
4. A clear statement that the notice is the final adverse determination.
5. The Plan's contact person and his/her telephone number.
6. The member's coverage type.
7. The name and full address of the health care plan's utilization review agent.
8. The utilization review agent's contact person and his/her telephone number.
9. A description of the health service that was denied, including, where applicable and available, the name of the facility and/or physician proposed to provide the treatment/or the developer/manufacturer of the health care service.
10. A statement that the member may be eligible for an external appeal and the time frames for requesting the appeal.
11. A statement that the member is entitled to receive, upon request and free of charge:
 - Reasonable access to and copies of all documents, records and other information relevant to the claim
 - A copy of each internal rule, guideline, protocol or similar criterion that was relied upon in making the determination on appeal
 - The name of any medical or vocational experts whose advice was obtained in connection with the determination without regard to whether the advice was relied upon in making the determination
12. The information supplied by the Superintendent of the New York State Department of Financial Services describing the external appeal process.
13. A statement the member may have a right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA).

Expedited Appeals

Expedited or immediate appeals are available to members if they want to appeal an adverse decision that involves:

- continued or extended health care services
- procedures, treatments or additional services for a member who is undergoing a course of continued treatment prescribed by his or her health care provider
- a situation where the member's health care provider believes an immediate appeal is needed. However, this does not apply in situations where we originally paid the claim before we had all the information we needed

BlueShield encourages physicians and specialty providers to share information by telephone

and/or fax. The member, or the person acting for them, can contact both the nurse and physician who reviewed your case to talk about the appeal. The member can do this within one (1) business day of the date we receive the notice of expedited appeal.

We will make a decision about the expedited appeal within two (2) business days after receipt of all necessary information or within seventy-two (72) hours, whichever is less. We will notify the member immediately of our decision by telephone. We will send our member a written notice within twenty-four (24) hours of the decision.

The notification will include the information referenced above for a final adverse determination. When a member receives our final adverse determination on the expedited appeal, they may request a standard appeal or an external review. Additional details are provided in following sections.

Member Grievance/Appeal and Utilization Appeal Rights

Upon written request, and free of charge, our members have the right to have access to copies of all documents, records, and other information relevant to their claim. Members also have the right to request, in writing, the name of each medical or vocational expert whose advice was obtained in connection with their claim.

Upon written request, and free of charge, members have the right to an explanation of any scientific or clinical judgment for the determination to deny their claim that applies the terms of their contract, policy or plan to your medical circumstances.

Upon written request, and free of charge, members have the right to a copy of each rule, guideline, protocol or similar criteria that was relied upon in making the determination to deny their claim.

Members may have the right to bring a civil action under the Employment Retirement Income Security Act of 1974 (ERISA) §502 (a) if they file an appeal and their request for coverage or benefits is denied following review. Members have this right if your coverage is provided under a group Health Plan that is subject to ERISA.

External Appeals Process

Upon receipt of a final adverse determination, a member has the right to an external appeal of certain coverage determinations made by us. Final adverse determinations are issued at the end of the internal utilization review appeal process. An external appeal is an independent review of a coverage determination by a third party known as an External Appeal Agent. (External Appeal Agents are certified by New York State, and may not have a prohibited affiliation with any health insurer, health maintenance organization (HMO), medical facility, member or health care provider associated with the appeal.)

Members may have the right to an expedited external appeal if their doctor can attest that a delay in providing the requested service would pose an imminent or serious threat to the member's health. The timeframes for expedited external appeals are shorter than the time frames for standard external appeals. The external appeals agent will make a decision within three (3) days for expedited appeals. Every reasonable effort will be made to notify the member and the plan of the decision by telephone or fax immediately. This will be followed by a written notice.

For standard external appeals, the external appeals agent will make a decision within thirty (30) calendar days after receipt of a completed application for appeal. Five additional business days may be added if the agent needs additional information. If the agent determines that the information submitted to it is materially different from that considered by the plan, the plan will have three (3) additional business days to reconsider or affirm its decision. The member and the plan will be notified within two (2) business days of the external review agent's decision. The Agent must notify the member in writing of its decision within two (2) business days.

In general, a member may not request an external appeal unless we have issued a final adverse determination of their request for coverage. Final adverse determinations are issued at the end of the internal utilization review appeal process. A member may ask us to agree to an external appeal even though they have not completed the internal appeal process and have not obtained a final adverse determination. However, we have no obligation to agree to that request. If we do agree, we will send the member a letter stating that we have agreed to an external appeal even though the member has not completed the internal appeal process.

To be eligible for external appeal, the final adverse determination must be based on a determination that the requested service is not medically necessary, or that the requested service is experimental or investigational. Members do not have the right to an appeal of any other determinations, even if those other determinations affect your coverage.

Medical Necessity

Members may ask for an external appeal if a requested service has been denied because it has been determined to be medically unnecessary. If the requested service is to be provided by a hospital, public health center, diagnostic and treatment center, or other health care facility, the facility must meet either of these criteria:

- The facility must be licensed in New York
- Must participate with a BlueShield plan in another state

If the facility does not meet either of these criteria, members may request an external appeal only if we have referred them to the facility, or have preauthorized or pre-certified services provided by the facility.

Experimental or Investigational Treatment

A member's attending physician must certify that the member has a life-threatening or disabling condition or disease when the member requests an external appeal for experimental or investigational treatment. In the case of a child under the age of 18, a disabling condition or disease is any medically determinable physical or mental impairment of comparable severity. Additionally, the attending physician must certify that:

- Standard health services or procedures have been ineffective or would be medically inappropriate in treating life-threatening conditions or diseases
- No more beneficial standard treatment exists as a covered service under the member's health plan
- The recommended health service or procedure (including off-label usage of a pharmaceutical product) must be based on at least two documents from the available medical literature

To make a recommendation to use experimental or investigational treatment, the attending physician must be board certified or board eligible and qualified to practice in the area appropriate to treat the life-threatening or disabling condition or disease.

Coverage Based on the External Appeal Agent's Decision

After the member, or their representative, or their attending physician applies for an external appeal, an independent external appeal agent will review the appeal and make a final determination based on the circumstances of the case.

The external appeal agent's decision is final and binding on both parties; the health insurance carrier (us) and the patient (our member). In the event that the external appeal agent rules in our favor, we will not cover the requested service. If the external appeal agent decides in the member's favor, we will cover the service as follows:

- For services denied as not medically necessary, we will treat the services as medically necessary and provide coverage subject to all other conditions of the member's coverage plan
- For services denied as experimental or investigational, other than services provided in a clinical trial, we will pay for the patient costs the member incurs for the services, subject to all other conditions of the member's coverage plan
- For services denied as experimental or investigational that are provided in a clinical trial, we will cover the costs of health services required to provide treatment according to the design of the trial, subject to all other conditions of the member's coverage plan. Our coverage doesn't include the cost of the drugs or devices when those items are the subject of the clinical trial

Requesting an External Appeal

A member or their attending physician may obtain an external appeal application from the New York State Department of Financial Services (DFS), the Department of Health (DOH), or by contacting us. We will send an external appeal application to you when we have made a final adverse determination that is subject to external appeal. The application will provide clear instructions for completion.

To request an external appeal application from the New York State Department of Financial Services (formerly NYS Department of Insurance) or the Department of Health, please contact them at:

New York State Department of Financial Services (DFS) One Commerce Plaza
Albany, NY 12257
1-800-342-3736
dfs.ny.gov

New York State Department of Health
Corning Tower
Albany, NY 12237
1-800-206-8125
health.ny.gov

A member must file their application for an external appeal with the DFS within forty-five (45)

calendar days after receiving a final adverse determination of our internal utilization review appeal process or within forty-five (45) calendar days after receiving a letter from us waiving the internal utilization review appeal process. We do not have the authority to grant extensions of this deadline.

Members will lose their right to an external appeal if they do not file an application for an external appeal within forty-five (45) calendar days from the receipt of the final adverse determination of our internal utilization review appeal process.

The member (and their doctors) must sign an appropriate authorization to release all pertinent medical information concerning their medical condition and request for services. If members have any questions, they may contact Customer Service at the number listed on their ID card.

Our walk-in service hours are Monday through Friday, 8 a.m. to 5 p.m.

Our building at 40 Century Hill Drive, Latham, New York is handicapped accessible.

Quality of Care Access Review

BlueShield members have the right to ask us to look into their concerns about quality of care or timely access to a provider. We closely track all complaints. If we receive similar complaints from our customers about a provider during a certain time period, we address those issues with the provider. This is our informal process.

We also have a formal process. At a member's request, we will investigate their concern by requesting records or other documentation. Our medical director reviews this information. If necessary, our medical director will meet with the provider to discuss the concern.

If a member has a concern or problem regarding their ability to see a BlueShield provider in a timely fashion or the quality of care they receive, they may contact Customer Service at the number listed on their member ID card.

We will send the member a letter that explains the complaint process and gives them a number to call if they wish to file a formal complaint. It also explains the appeal process if the member disagrees with the way our staff handles their concerns.

Unresolved Disputes

We always recommend that members follow our grievance or utilization review process to remedy any issues concerning their coverage; however, if they are not satisfied with any BlueShield decision, members have the right to contact the DFS or the DOH:

New York State Department of Financial Services

One Commerce Plaza Albany, NY 12257

1-800-342-3736

dfs.ny.gov

New York State Department of Health

Corning Tower

Albany, NY 12237

1-800-206-8125

health.ny.gov

Appendix

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