

SECTION 9 - BLUE SHIELD DENTAL

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RECORD OCCURRENCE CHART

AA0 & ZA0	A submission may contain multiple files. The total record count for the file cannot exceed 9,999,999 records.
BA0 & YA0	A file may contain up to 9,999 batches. All batches within the file must be for the same payor (Blue Shield).
CA0 & XA0	A batch may contain 9,999,999 claims. All claims within the batch must be for the same provider number.
DA0	There must be one DA0 record per claim and there cannot be more than three DA0 records per claim.
DA2	None to three occurrences per claim.
EA0	One per claim is required.
FA0	One per claim is required. Cannot exceed 20 per claim for Batch Type 200.
HA0	None to twenty per claim.
FD0	Valid only when Batch Type is 200. May not exceed 20 per claim.
BA1, CA1, CB0 DA1, EA1, EA2 FB1, FB2, FE0 GA0, GC0, GD0 GD1, GE0, GP0 GU0, GX0, GX1 GX2	These records are not currently recognized by Blue Shield Dental.

**NSF FIELD REQUIREMENTS
BLUE SHIELD DENTAL**

FIELD	RECORDS											
	A A 0	B A 0	C A 0	D A 0	D A 2	E A 0	F A 0	F D 0	H A 0	X A 0	Y A 0	Z A 0
01.0	R	R	R	R	R	R	R	R	R	R	R	R
02.0	R			R	R		R	R	R		R	R
03.0		R	C								R	
04.0	R		R	R	C	R						R
05.0	R	R	R	R		R	R	C	C		R	
06.0				R	C			C				R
07.0				R	C		R					R
08.0			R		C							R
09.0			R	C			R				R	R
10.0				C						R	R	
11.0			C								R	
12.0										R		
13.0			C				R					
14.0		R	C				R					
15.0	R		C									
16.0				R								
17.0	R			R								
18.0	R			R			R					
19.0	R			R								

**NSF FIELD REQUIREMENTS
BLUE SHIELD DENTAL**

FIELD	RECORDS											
	A A 0	B A 0	C A 0	D A 0	D A 2	E A 0	F A 0	F D 0	H A 0	X A 0	Y A 0	Z A 0
20.0	R			R								
21.0	R						R					
22.0	R											
23.0							C					
24.0												
25.0												
26.0												
27.0												
28.0												
29.0												
30.0												
31.0												
32.0												
33.0												
34.0												
35.0												
36.0						R						
37.0												
38.0						C						

**NSF FIELD REQUIREMENTS
BLUE SHIELD DENTAL**

FIELD	RECORDS											
	A	B	C	D	D	E	F	F	H	X	Y	Z
	A	A	A	A	A	A	A	D	A	A	A	A
	0	0	0	0	2	0	0	0	0	0	0	0
39.0												
40.0												
41.0												
42.0												
43.0												
44.0												
45.0												
46.0												
47.0						C						
48.0												
49.0												
50.0												
51.0												
52.0												
53.0												
54.0												

NSF FIELD REQUIREMENTS BLUE SHIELD DENTAL

FIELD	RECORDS											
	A	B	C	D	D	E	F	F	H	X	Y	Z
	A A 0	A A 0	A A 0	A A 0	A A 2	A A 0	A A 0	D D 0	A A 0	A A 0	A A 0	A A 0
55.0												
56.0												
57.0												
58.0												
59.0												
60.0												
61.0												
62.0								C				
63.0 thru 94.0												

FIELD DEFINITIONS BLUE SHIELD DENTAL

AA0-02.0 SUBMITTER IDENTIFIER

Submitter ID's are assigned by Texas Health Information Network (THIN). THIN will only use the first six positions. Must be identical to the submitter identifier in file trailer (ZA0-02.0) and must match the Login ID used to access rEDI-link Blue. Contact the EDI Helpline for the correct submitter identification number.

FILE REJECT - MESSAGE 121

AA0-04.0 SUBMISSION TYPE

Indicate the input medium or method used to transmit the data.

AA0-05.0 SUBMISSION NUMBER

Must be six digit alpha-numeric value for each submission. No embedded blanks or special characters are allowed. Duplicate file IDs for a submitter (AA0-02.0) submitted within six months will be rejected.

FILE REJECT - MESSAGE 107, 112

AA0-15.0 CREATION DATE

Indicate the date the file was created.

AA0-17.0 RECEIVER IDENTIFICATION

Must equal "84980" for Dental. Must equal receiver identification in file trailer (ZA0-04.0).

FILE REJECT - MESSAGE 124

AA0-18.0 RECEIVER TYPE CODE

Must equal "G" for Dental.

FILE REJECT - MESSAGE 123

AA0-19.0 VERSION CODE - NATIONAL

Current version code is 00301. We will continue to accept version 001.04 and 002.00 until further notice.

FILE REJECT - MESSAGE 113

AA0-20.0 VERSION CODE - LOCAL

Current version code is 00301. We will continue to accept version 001.04 and 002.00 until further notice. Must match National Version Code (AA0-19.0).

AA0-21.0 TEST/PRODUCTION INDICATOR

All files are handled as production unless:

- This field contains “TEST”,
- The provider has not completed and returned all the necessary EDI Enrollment and Agreement forms.
- The submitter is not flagged as production in the BCBSTX submitter file.

AA0-22.0 PASSWORD

Required for all submissions. The password is assigned by THIN. Must be six digit alpha-numeric. Contact the EDI Helpline for verification of the password.

FILE REJECT - MESSAGE 122

BA0-03.0 BATCH TYPE

Batch type “200” - Blue Shield Dental.

BATCH REJECT - MESSAGE 201

BA0-05.0 BATCH IDENTIFICATION

Must be six digit alpha-numeric value for each batch ID. No embedded blanks or special characters are allowed. Duplicate batch IDs for a billing provider (BA0-14.0) submitted within six months will be rejected.

BATCH REJECT - MESSAGE 205, 212

BA0-14.0 PROVIDER BLUE SHIELD NUMBER

Must be six digit Dental Provider Number.

BATCH REJECT - MESSAGE 241

CA0-03.0 PATIENT CONTROL NUMBER

Dental will carry the first twelve positions of this field into the claims processing system and return it on the remittance.

CA0-04.0 PATIENT LAST NAME
Must be entered even if the same as the insured.

BATCH MESSAGE 4BB

CA0-05.0 PATIENT FIRST NAME
Must be entered even if the same as the insured.

BATCH MESSAGE 4BB

CA0-08.0 PATIENT DATE OF BIRTH
Must be the patients date of birth.

BATCH MESSAGE 4BK

CA0-09.0 PATIENT'S SEX
Valid values are M or F.

BATCH MESSAGE 4GH

CA0-11.0 PATIENT ADDRESS - 1
This field is required if DA2 Record is not given.

BATCH MESSAGE 4BQ

CA0-13.0 PATIENT CITY
This field is required if DA2 Record is not given.

BATCH MESSAGE 4BR

CA0-14.0 PATIENT STATE
This field is required if DA2 Record is not given.

BATCH MESSAGE 4BS

CA0-15.0 PATIENT ZIP CODE
This field is required if DA2 Record is not given.

BATCH MESSAGE 4BT

DA0-03.0 PATIENT CONTROL NUMBER
Dental will carry the first twelve positions of this field into the processing system and return it on the remittance.

DA0-04.0 CLAIM FILING INDICATOR
Indicate whether or not this record is being provided to obtain payment from the indicated payor or for informational purpose. Valid values are:
P = payment is being requested of this payor
I = payment is not being requested of this payor

DA0-05.0 SOURCE OF PAYMENT
If DA0-04.0 = "P", then DA0-05.0 must = G.
If DA0-04.0 = "I", then DA0-05.0 may = any of the following values:
A = Self Pay
B = Workers Compensation
C = Medicare
D = Medicaid
E = Other Federal Program
F = Commercial Insurance Company
H = Champus
I = HMO
J = Federal Employee's Program (FEP)
K = Central Certification
L = Self Administered
M = Family or Friends
N = Managed Care - Non-HMO
P = Blue Cross
T = Title V
V = S Veterans Administration Plan (VA)
Z = Other (Medigap)

CLAIM REJECT - MESSAGES 302, 303, 304, 309

DA0-06.0 INSURANCE TYPE CODE
If DA0-05.0 = "G", DA0-06.0 must =
GP= Group Policy

DA0-07.0 PAYOR ORGANIZATION IDENTIFICATION
The value is 84980.

DA0-10.0 GROUP NUMBER
Entered when field DA0-08.0 equals ZGA. The group number must be five, six or seven digit numeric as listed on the subscribers ID card. This field is left justified, blank filled. If DA0-08.0 is other than ZGA, the group number is not required.

DA0-16.0 PAT SIGNATURE SOURCE

Valid values: C - Signed HCFA - 1500 claim form on file.
S = Signed signature authorization form for Block 12 on file.
M = Signed signature authorization form for Block 13 on file.
B = Signed signature authorization form or forms for both Block 12 and Block 13 are on file.
P = Signature generated by provider because the patient was not physically present for services.

DA0-17.0 PATIENT RELATIONSHIP TO INSURED

The only valid values are:
01 - Self
02 - Spouse
03 - Dependent
16 - Sponsored Dependent

CLAIM MESSAGE 4BJ

DA0-18.0 INSURED IDENTIFICATION NUMBER

Must be the insured's subscriber ID number as listed on the ID card. The following criteria should be used to validate this field.

If DA0-08.0 is ZGA, this field will be 9 or 11 numerics.

DO NOT allow claims with a subscriber id beginning with "R". Submit on paper.

CLAIM REJECT - MESSAGE 4B2

DA0-19.0 INSURED'S LAST NAME

Enter the last name of the insured even if the same as the patient.

CLAIM MESSAGE 4BA

DA0-20.0 INSURED'S FIRST NAME

Enter the first name of the insured even if the same as the patient.

CLAIM MESSAGE 4BA

- DA2-04.0 INSURED ADDRESS 1**
Enter the insured's address. If the record is sent but this field is blank, the claim will be rejected.
- CLAIM MESSAGE 4BD*
- DA2-06.0 INSURED CITY**
Enter the insured's city. If the record is sent but this field is blank, the claim will be rejected.
- CLAIM MESSAGE 4BE*
- DA2-07.0 INSURED STATE**
Enter the insured's state. If the record is sent but this field is blank, the claim will be rejected.
- CLAIM MESSAGE 4BF*
- DA2-08.0 INSURED'S ZIP CODE**
Enter the insured's zip code. If the record is sent but this field is blank, the claim will be rejected.
- CLAIM MESSAGE 4BG*
- EA0-04.0 EMPLOYMENT RELATED INDICATOR**
Must not be blank. Valid values are N or Y.
- CLAIM MESSAGE 4BL*
- EA0-05.0 ACCIDENT INDICATOR**
Must not be blank. If condition is not an accident, enter "N".
When the diagnosis is accident related one of the following is required.
A for auto
O for other
- CLAIM MESSAGE 4BM*
- EA0-36.0 PROV ASSIGN IND**
Valid values are: Y = Assigned
N = Not Assigned

EA0-38.0 DOCUMENTATION IND

When x-rays have been mailed this field value will be 1.

EA0-47.0 DATE DOCUMENTATION SENT

When Documentation Ind is 1, enter the date the x-rays were mailed.

FA0-05.0 SVC FROM DATE

The Service From Date is required on each detail line. The date cannot be a future date and must not be prior to the patient's date of birth.

CLAIM REJECT - MESSAGE 404

FA0-07.0 PLACE OF SERVICE

The correct place of service for dental services is 11, office.

CLAIM REJECT - MESSAGE 408

FA0-09.0 HCPCS PROCEDURE CODE

ADA procedure codes should be used.

Prophylaxis (01110 - 01120) and scaling (04340 - 04341) are not to be billed separately if both are performed on the same day by the same provider. Combine the charges and submit under the scaling code (04340 - 04341).

Submit multiple simple extractions billed on the same day as follows. Code the first extraction 07110. Code each additional extraction 07120.

Claims for services totaling \$1,000.00 or more on a single date of service require the submission of x-rays.

If treatment includes the replacement of missing teeth, please submit x-rays of the entire arch involved.

X-rays should be mailed to:

Dental
Blue Cross and Blue Shield of Texas, Inc.
P. O. Box 833924
Richardson, Tx. 75083-3924

FA0-13.0 LINE CHARGE

This is a required field for each detail line. Must be greater than zero.

FA0-18.0 UNITS OF SVC

Must be equal to or greater than 001.0. Must be equal to or less than 999.0.

CLAIM REJECT - MESSAGE 406

FA0-21.0 COB INDICATOR

If values 2 or 4 are used, then Payor Name (DA0-09.0) is mapped into the processing system. Following are the valid values.

- 0 No other insurance
- 1 Texas Blue Shield
- 2 Other Commercial insurance
- 3 Medicaid
- 4 Medicare
- 5 Unknown
- 7 No Medicare "B" coverage

CLAIMS REJECT - MESSAGE 410

FD0-05.0 TOOTH CODE NUMBER 1

Enter a tooth number when the procedure code on the table indicates a tooth number is required. Valid tooth numbers are:

- | | |
|---------|---------------|
| 01 - 32 | Permanent |
| A - T | Primary |
| SN | Supernumerary |

CLAIM MESSAGE 490

Enter an arch code when the procedure code on the table indicates an arch is required. The arch code will be entered in this field. Valid arch codes are:

- | | |
|----|---------------|
| UD | Upper Denture |
| LD | Lower Denture |

CLAIM MESSAGE 492

FD0-06.0 TOOTH SURFACE(S) 1

Enter a tooth surface when the procedure code on the table indicates a tooth surface is required. One to any combination of two-five codes may be submitted.

Valid tooth surfaces are:

M	Mesial
O	Occlusal
D	Distal
L	Lingual
F	Facial
I	Incisal
B	Buccal

CLAIM MESSAGE - 493

FD0-62.0 QUADRANT

Enter a quadrant code when the procedure code on the table indicates a quadrant code is required. Valid quadrant values are:

UR	Upper Right
UL	Upper Left
LR	Lower Right
LL	Lower Left

CLAIM MESSAGE 491

DATE**ALL DATE FIELDS**

If submitted, must be valid dates in CCYYMMDD format.

CLAIM REJECT - MESSAGE 337, 401, 405

STATE**ALL STATE FIELDS**

If submitted, must be valid two-digit state postal abbreviation.

CLAIM REJECT - MESSAGE 4BF, 4BS

ZIP**ALL ZIP CODE FIELDS**

If submitted, must be five (5) numerics or nine (9) numerics. May not contain hyphens. The first characters of the zip code must be within the range for the state according to the U. S. Postal Service.

CLAIM REJECT - MESSAGE 4BG, 4BT

For a complete list of reject messages, refer to Exhibit 5.

PROCEDURE CODES REQUIRING ADDITIONAL DATA

Below is a list of procedure codes that require specific information about the tooth, i.e., tooth number, surface, quadrant or arch. The column marked with X indicates the required information.

PROCEDURE CODE	TOOTH NUMBER	TOOTH SURFACE	QUADRANT	ARCH
00460	X			
01351	X			
01510	X			
01515	X			
01520	X			
01525	X			
02110	X	X		
02120	X	X		
02130	X	X		
02131	X	X		
02140	X	X		
02150	X	X		
02160	X	X		
02161	X	X		
02190 or 02951	X			
02210	X	X		
02330	X	X		
02331	X	X		

PROCEDURE CODE	TOOTH NUMBER	TOOTH SURFACE	QUADRANT	ARCH
02332	X	X		
02335	X	X		
02380	X	X		
02381	X	X		
02382	X	X		
02385	X	X		
02386	X	X		
02387	X	X		
02410	X	X		
02420	X	X		
02430	X	X		
02510	X	X		
02520	X	X		
02530	X	X		
02540	X			
02544	X			
02610	X	X		
02620	X	X		
02630	X	X		
02640	X			
02644	X			
02650	X	X		
02651	X	X		
02652	X	X		
02660	X			
02664	X			
02710	X			

PROCEDURE CODE	TOOTH NUMBER	TOOTH SURFACE	QUADRANT	ARCH
02711	X			
02720	X			
02721	X			
02722	X			
02740	X			
02750	X			
02751	X			
02752	X			
02790	X			
02791	X			
02792	X			
02810	X			
02820	X			
02891 or 02952	X			
02892 or 02954	X			
02910	X			
02920	X			
02930 or 02830	X			
02931	X			
02932	X			
02933	X			
02940	X			
02950	X			
02951 or 02190	X			

PROCEDURE CODE	TOOTH NUMBER	TOOTH SURFACE	QUADRANT	ARCH
02952 or 02891	X			
02954 or 02892	X			
02960	X			
02962	X			
02970	X			
02980	X			
03110	X			
03120	X			
03130	X			
03220	X			
03310	X			
03320	X			
03330	X			
03340	X			
03346	X			
03347	X			
03348	X			
03350	X			
03351	X			
03352	X			
03353	X			
03410	X			
03420	X			
03421	X			
03425	X			

PROCEDURE CODE	TOOTH NUMBER	TOOTH SURFACE	QUADRANT	ARCH
03426	X			
03430	X			
03450	X			
03470	X			
03920	X			
04210			X	
04211	X			
04220			X	
04240			X	
04249	X			
04250			X	
04260			X	
04261	X			
04262			X	
04270	X			
04271	X			
04341			X	
05110				X
05120				X
05130				X
05140				X
05211				X
05212				X
05213				X
05214				X
05281				X
05510				X

PROCEDURE CODE	TOOTH NUMBER	TOOTH SURFACE	QUADRANT	ARCH
05520	X			
05610				X
05620				X
05630				X
05640	X			
05650	X			
05660				X
05710				X
05711				X
05720				X
05721				X
05730				X
05731				X
05740				X
05741				X
05750				X
05751				X
05760				X
05761				X
05860				X
05861				X
05862	X			
06010	X			
06020	X			
06030	X			
06210	X			
06211	X			

PROCEDURE CODE	TOOTH NUMBER	TOOTH SURFACE	QUADRANT	ARCH
06212	X			
06240	X			
06241	X			
06242	X			
06250	X			
06251	X			
06252	X			
06520	X	X		
06530	X	X		
06540	X			
06545	X			
06546	X			
06547	X			
06720	X			
06721	X			
06722	X			
06750	X			
06751	X			
06752	X			
06780	X			
06790	X			
06791	X			
06792	X			
06930	X			
06940	X			
06970	X			
06971	X			

PROCEDURE CODE	TOOTH NUMBER	TOOTH SURFACE	QUADRANT	ARCH
06972	X			
06980	X			
07110	X			
07120	X			
07130	X			
07210	X			
07220	X			
07230	X			
07240	X			
07241	X			
07250	X			
07270	X			
07272	X			
07280	X			
07281	X			
07310			X	
07320			X	
07340			X	
07350			X	
07425	X			
07470				X
07960				X

DENTAL - GENERAL INFORMATION

- **DIAGNOSIS CODE REQUIREMENTS**

Not required on Dental claims.

- **TYPE OF SERVICE**

Not required on Dental claims.

- **CLAIMS REQUIRING SUPPORTING DOCUMENTATION**

If treatment includes the replacement of missing teeth, x-rays of the entire arch involved must be sent. The x-rays should be mailed to:

Dental
Blue Cross and Blue Shield
P. O. Box 833924
Richardson, Tx. 75083-3924

- **PAPER BILL SERVICES**

Accident Related Services
Pre-determination
Subscriber ID's that begin with "R"

DENTAL - TEST DATA

Section 3 of this Implementation Guide describes the testing process. We recommend that new EDI System Vendors and Submitters include the following claim situations when testing Dental. Testing each of these situations, will ensure that all possible claims processing situations have been tested.

Services that require:

 Tooth Surfaces

 Tooth Number

 Quadrant

Prophylaxis

X-rays