SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.45 DENTAL

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Professional Provider Office Manual*. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.bcbsla.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.bcbsla.com/providers.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail Blue Cross policies. Blue Cross retains the right to add to, delete from and otherwise modify the *Professional Provider Office Manual* as needed. This manual and other information and materials provided by Blue Cross are proprietary and confidential and may constitute trade secrets of Blue Cross.

DENTAL BILLING GUIDELINES

The following billing guidelines are to assist you with filing dental claims. Please follow these guidelines regardless if the claim pays under the member's major medical or dental benefits.

General Guidelines

- When filing Current Dental Terminology® (CDT) codes, please use the 2006 American Dental Association (ADA) Dental Claim Form.
- Do not file both an ADA claim form and a CMS-1500 claim form for the same service. We will reject the second claim as a duplicate claim.
- Do not list both the CDT and Current Procedural Terminology® (CPT) code for each service on a claim form. When both CPT and CDT codes are listed, it is our policy to process the claim using the CDT code.
- File your actual charge.
- Do not file OSHA charges separately. OSHA charges are included as an integral part of the procedures performed on the same date of service. There is no member liability for OSHA charges.

Claims Filing Process for Dental Claims

- Dental claims must be filed with the appropriate CDT code. Dental procedure claims filed with CPT codes will be returned to the dentist for proper coding.
- When filing code D9630, include the name(s) of the drug(s) used (Block 30 of the ADA Dental Claim Form).

Claims Filing Process for Oral Surgery Claims

Oral surgeons may bill either CPT or CDT codes for major oral surgical procedures but cannot file them together on the same claim form. CPT codes must be billed on the CMS-1500 claim form. If CPT codes are billed on an ADA Dental Claim Form, the claim will be returned for the appropriate claim form. Oral surgeons may also bill for medical evaluation and management (E&M) services only when associated with major oral surgical procedures as appropriate. Claims for these services must be filed on a CMS-1500 claim form.

Our member benefit plans require that oral surgery claims are processed first under the patient's dental coverage. Do not submit as a medical claim first.

Appropriate CDT codes must be billed when performing extractions. If CPT codes are submitted for extractions, the claim will be returned for appropriate CDT code.

- Any and all services related to impacted teeth must be filed with a diagnosis code indicating impacted teeth. This includes all surgical and non-surgical procedures.

- Claims filed for office visits and X-rays with diagnosis codes indicating anomalies of tooth position of fully erupted teeth, but without a primary procedure code, must have a brief description of services that will be rendered (Block 30 of the ADA form). If there is no description, the claim will be rejected.
- Do not file CPT code 41899 for surgical services, such as extractions. Any claim filed with CPT code 41899 will be returned for the appropriate CDT code.
- Please bill CDT code D6010 for dental implants to expedite the processing of your claims.

Sedation

When billing for sedation, dentists and oral surgeons should bill the appropriate CDT codes (D7210, D7220, D7230, D7240, D7241 and D7250) for the removal of impacted wisdom teeth in conjunction with the following sedation code guidelines:

Code	Units
D9222	deep sedation/general anesthesia - first 15 minutes
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment
D9239	intravenous moderate (conscious) sedation/ analgesia - each subsequent 15 minute increment
D9243	intravenous moderate (conscious) sedation/ analgesia - first 15 minutes

Note: Anesthesia time begins when the doctor administering the anesthetic agent initiates the anesthesia and monitoring protocol and is in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of a trained personnel.

Multiple Surgical Procedures

Multiple surgical procedures are those performed during the same operative session. Bilateral procedures are considered multiple procedures. When multiple procedures are performed, the primary or major procedure is considered to be the procedure with the greatest value based on the allowable charge and may be reimbursed up to the allowable charge. Use Modifier 51 to report multiple procedures and Modifier 50 to report bilateral procedures.

- Secondary covered procedures are reimbursed up to 50% of the allowable charge.
- Extractions of impacted teeth are not subject to multiple surgery reduction.

If a service includes a combination of procedures, one code should be used rather than reporting each procedure separately. If procedures are coded separately, Blue Cross may recode the procedures and apply the appropriate allowable charge.

Orthodontia Work in Progress

Blue Cross will honor claims for monthly adjustment visits for orthodontia work in progress up to the orthodontic maximum specified in the member's contract. Orthodontists may file claims either monthly or quarterly.

Nitrous Oxide

Blue Cross includes nitrous oxide charges with other dental services rendered and does not reimburse these charges separately. This applies to all CDT codes.

Alternative Dental Procedure Payment Responsibility Form

The Alternative Dental Procedure Payment Responsibility Form included in this manual should be used when a member chooses an alternative, non-covered treatment. The form is completed by the dentist and signed by the member, and the member agrees to be responsible for the difference between the allowed amount of the covered service and the amount charged by the dentist for the chosen alternative procedure in addition to any applicable member cost-sharing amount. The form should be attached to the dental claim form.