BlueCross BlueShield of Louisiana

An independent licensee of the Blue Cross and Blue Shield Association.

DENTAL BILLING GUIDELINES

Blue Cross and Blue Shield of Louisiana (BCBSLA) has provided the following billing guidelines to assist you with filing your dental claims. **Please follow these guidelines regardless of whether the claim pays under the member's major medical benefit or the member's dental benefit.**

If you have any questions about these guidelines, please call Ms. Paula Rome, Network Development Representative, at (504) 832-5897.

General Guidelines

- When filing CDT® codes, please use the 2002 American Dental Association (ADA) claim form.
- Do not file both an ADA claim form and a HCFA-1500 claim form for the same service. We will reject the second claim as a duplicate claim.
- Do not list both the CDT and 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. Allowable charges are provided for informational purposes, and they are not intended for use in establishing fees.
- 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 Non-surgical Claims

- Non-surgical claims must be filed with the appropriate CDT code. Non-surgical procedure claims filed with CPT codes will be returned to the dentist for proper coding.
- Due to contract limitation criteria, if you report prophylaxis and fluoride services on the same date, as one procedure (e.g. D1201 or D1205), the claim could be rejected. When reporting these claims, file them separately to ensure that you receive full benefits.
- When filing code D 9630, include the name(s) of the drug(s) used.

Claims Filing Process for Oral Surgery Claims

- File your claim form with the appropriate CPT or CDT code for the surgery and with the appropriate CDT code(s) for all related services (e.g. office visits, x-rays).
- When filing for extractions, you **must** use CDT codes. Also, please include the tooth number in the "description" field when using the HCFA-1500 claim form.
- File a HCFA-1500 claim form with the appropriate CPT or CDT code for the surgical procedure and the appropriate CDT code(s) for related services.

- Any and all services related to impacted teeth **must** be filed with diagnosis code **520.6**. This includes all surgical and non-surgical procedures.
- Claims filed for office visits and x-rays with diagnosis code **524.3**, but without a primary procedure code, **must** have a brief description of services that will be rendered. 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.

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. The CPT code modifier used to report **multiple procedures** is **-51.** The CPT code modifier to report **bilateral procedures** is **-50.**

- Secondary covered procedures are reimbursed up to 50 percent 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, BCBSLA may recode the procedures and apply the appropriate allowable charge.