Optimize Your Practice: Understanding The “CODE”

By
The Council on Dental Benefit Programs
Optimize your Practice:
Understanding the Code

Prepared for you by the Council on Dental Benefit Programs

The Code and “CDT” are not the same thing

**Code** = Code on Dental Procedures and Nomenclature

**CDT** = Current Dental Terminology

> The ADA publication containing the Code

> And more . . .

A brief Code history

1969 – published as the “Uniform Code on Dental Procedures and Nomenclature”


Purpose –

> Provide uniformity, consistency and specificity in documenting dental treatment

> Expedite claim adjudication and reimbursement

Code’s structure – 12 Categories, and subcategories

| I. Diagnostic | D0100-D0999 | VII. Maxillofacial Prosthetics | D5900-D5999 |
| III. Restorative | D2000-D2999 | IX. Prosthodontics – fixed | D6200-D6999 |
| IV. Endodontics | D3000-D3999 | X. Oral and Maxillofacial Surgery | D7000-D7999 |
| V. Periodontics | D4000-D4999 | XI. Orthodontics | D8000-D8999 |
| VI. Prosthodontics – removable | D5000-D5899 | XII. Adjunctive General Services | D9000-D9999 |
Components of a Code entry

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Nomenclature (name)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Five character alphanumeric beginning with “D”</td>
<td>Written title of the procedure</td>
</tr>
</tbody>
</table>

**D0210** intraoral - complete series (including bitewings)

A radiographic survey of the whole mouth, usually consisting of 14-22 periapical and bitewing images intended to display...

Descriptor (description)
Narrative providing further definition and intended use of the procedure; most but not all codes have a descriptor

Major Changes effective – 01/01/2011

Eight additions within five categories of service

> Preventive / Endodontic / Maxillofacial
  Prosthetics / Prosthodontics, fixed / Oral & Maxillofacial Surgery

Nineteen revisions across seven categories

> Diagnostic / Restorative / Endodontics / Periodontics / Implant Services / OMS / Adjunctive

Preventive – Addition

D1352 preventive resin restoration in a moderate to high caries risk patient – permanent tooth

Why added?

> There was no code to accurately document decay removal and restoration that did not extend into the dentin

D1352 – preventive resin restoration

Mechanical preparation technique is used to remove decay which does not extend into the dentin

> Includes sealing of any radiating grooves
Preventive – sealant (current code)

When a preparation technique is used only to facilitate flow of sealant material into pits and fissures

D1351 sealant – per tooth
Mechanically and/or chemically prepared enamel surface sealed to prevent decay.

Diagnostic – Revision to D0486

Old: laboratory accession of brush biopsy sample, microscopic examination...

New: laboratory accession of transepithelial cytologic sample, microscopic examination...

Why revised?
> Current text misinterpreted to mean the procedure is only applicable to pathology services on samples collected by a proprietary product

Restorative – Revision to D2940

Old: sedative filling

New: protective restoration

Why revised?
> Current text restricts procedure to pain relief
> Change recognizes other uses of restorative materials to protect tooth from further decay, soft tissue collapse or overgrowth

Endodontics – Subcategory Revision

Apexification / Recalcification and Pulpal Regeneration Procedures

Why revised?
> Recognizes a new technology that is used to regain vitality
> Accommodates revisions to current codes and new code
**Endodontics – Revise D3351**

apexification / recalcification / pulpal regeneration – initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)

Why revised?

> Revised code focus now recognizes a new technology that is used to regain vitality

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**Endodontics – Revise D3352**

apexification / recalcification / pulpal regeneration – interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)

Why revised?

> Revised code focus now recognizes a new technology related to disinfection and regeneration that is used to regain vitality

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**Endodontics - Addition**

D3354 pulpal regeneration – (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp); does not include final restoration

Why added?

> Provides means to document completion of procedures related to pulpal regeneration

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**Periodontics – Descriptor revisions – 1**

D4263 bone replacement graft – first site...

This procedure involves the use of osseous autografts, osseous allografts, or non-osseous grafts to stimulate periodontal regeneration … Other procedures may be required concurrent to D4263 and should be reported using their own unique codes.

Definition for the term “site” precedes code D4210.
Periodontics – Descriptor revisions – 1

Same text deletion for –

> D4264 bone replacement graft – each additional...
> D4266 guided tissue regeneration – resorbable...
> D4267 guided tissue regeneration – non-resorbable...

Why revised?

D4263, D4264, D4266 and D4267 descriptors were revised because

> The definition of site does not affect how these procedures are delivered
> A reference to the definition of “site” is at odds with the format and content of other descriptors

Periodontics – Descriptor revisions – 2

D4320 provisional splinting – intracoronaral

This is an interim stabilization of mobile teeth. A variety of methods and appliances may be employed for this purpose. Identify the teeth involved and the nature of the splint.

Same for:

> D4321 provisional splinting – extracoronaral

Why revised?

D4320 and D4321 descriptors were revised because

> Tooth numbers (individual teeth or a range of teeth) can be reported in the applicable claim service line field
> The nature of the splint cannot be reported because this is not a “by report” procedure
Maxillofacial Prosthetics - Additions

D5992 adjust maxillofacial prosthetic appliance, by report

Why added?
> Appliances adjusted for various reasons and at differing intervals after initial placement
> No code to document post-delivery adjustment
> Adjustment may be provided by a practitioner who did not place the appliance

Maxillofacial Prosthetics - Additions

D5993 maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report

Why added?
> Due to its complexity a maxillofacial prosthesis (e.g., obturator, ocular prosthesis) requires unique maintenance procedures

Prosthodontics, fixed – Additions

D6254 interim pontic
D6795 interim retainer crown

Why added?
> To document delivery of interim prosthesis expected to be in place for less than six months
> Provisional pontic and retainer crown codes are for interim prostheses that will be in place for six months or more

Implant Services – Revise D6055

Why revised?
D6055 nomenclature and descriptor were revised because
> A connecting bar may be supported directly by implant bodies or by intermediary abutments depending on the oral cavity's architecture
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosthodontics, fixed – D6950 descriptor</td>
<td>Report attachment separately from crown; A male and female pair constitutes one precision attachment, and is separate from the prosthesis. Describe type of attachment used.</td>
</tr>
</tbody>
</table>

Why revised?
- Nomenclature reads “precision attachment”
- Not a “by report” code; deleted sentences in conflict with the nomenclature

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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</thead>
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<tr>
<td>Oral &amp; Maxillofacial Surgery - Addition</td>
<td>D7251 coronectomy – intentional partial tooth removal</td>
</tr>
</tbody>
</table>

Why added?
- No current code adequately describes this procedure

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<tr>
<td>Oral &amp; Maxillofacial Surgery - Addition</td>
<td>D7295 harvest of bone for use in autogenous grafting procedure</td>
</tr>
</tbody>
</table>

Why added?
- Enables documenting the harvest of material when this step is not included in a graft placement procedure
  - e.g., D4263; D7953, D7955
- Eliminates need to use “unspecified procedure, by report” code

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<tr>
<td>Oral &amp; Maxillofacial Surgery - Revise D7210</td>
<td>surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth, and including elevation of mucoperiosteal flap if indicated</td>
</tr>
</tbody>
</table>

Why revised?
- Elevation of a flap is not always required
- Eliminates ambiguity and misinterpretation
OMS – Revise D7953 Descriptor

Osseous autograft, allograft or non-osseous graft is placed in an extraction or implant removal site at the time of the extraction or removal to preserve ridge integrity…

Why revised?
> Revision recognizes that graft may be made when a natural tooth or an implant body is removed

Oral & Maxillofacial Surgery - Revise D7960

frenulectomy ( – also known as frenectomy or frenotomy ) – separate procedure not incidental to another procedure

Why revised?
> “not incidental to another procedure” is more appropriate
> frenulectomy, frenectomy and frenotomy are synonyms

Adjunctive General Services – D9215 Δ

local anesthesia in conjunction with operative or surgical procedures

Why revised?
> Clearly defines clinical situation
> Complements nomenclature of D9210
  – local anesthesia not in conjunction with operative or surgical procedures
> Eliminates ambiguity and uncertainty

Adjunctive General Services – D9230 Δ

Old: analgesia, anxiolysis, inhalation of nitrous oxide
New: inhalation of nitrous oxide / anxiolysis, analgesia

Why revised?
> For consistency with other anesthesia nomenclatures
> Type of service followed by intended result
Adjunctive General Services –

D9420 hospital or ambulatory surgical center call

May be reported when providing treatment care provided outside the dentist's office to a patient who is in a hospital or ambulatory surgical center. Services delivered to the patient on the date of service are documented separately using the applicable procedure codes in addition to reporting appropriate code numbers for actual services performed.

Adjunctive – Revise D9420

Why revised?

D9420 nomenclature and descriptor were revised to clarify

> That this code enables a dentist to document that patient service was provided at a hospital or ambulatory surgical center, not at the dentist's office

Coding Scenarios

“What if / How do I” exercises

> Illustrates the Code as a tool for your documentation needs

Key principles:

> Dentist who treats the patient can best determine what procedures were performed.
> Use the procedure code that best reflects what you do.
> A dental benefit plan may not provide coverage for every procedure code.

NOTE: Please do not consider the exercises to be legal advice or a guarantee that individual payer contracts will follow the examples.

First time patient

Patient’s first time to see this dentist who:

> Performed thorough evaluation of hard and soft tissue, including evaluation for cancer
> Reviewed medical and dental history
> Recorded patient's current condition, including existing restorations, periodontal health and needed treatment
> Evaluated new full mouth radiographs
First time patient

**Consider:** D0150 comprehensive oral evaluation - new or established patient

**OR**

D0180 comprehensive periodontal evaluation...

> For patients who show or have:
  - Signs or symptoms of periodontal disease
  - Risk factors such as smoking or diabetes

Periodic patient visit

Patient returns for regular visit; previous oral evaluation 7 months ago

Before teeth cleaning the dentist:

> Updated medical history and charted dental changes since last visit
> Evaluated the latest bitewing radiographs
> Performed head & neck exam
> Explored teeth for decay and evaluated periodontal conditions

Periodic patient visit

**Consider:** D0120 periodic oral evaluation- established patient

For evaluation of patients:

> Previously seen by the dentist
> To identify any changes in oral health since the last periodic or comprehensive evaluation

Emergency service

Patient arrives with abscessed permanent tooth

Dentist reviews and assesses:

> Symptoms and history of the problem
> Hard and soft tissues to locate and identify the problem
> Periapical radiograph(s) taken of the problem area

Patient referred to Endodontist for further care
Emergency service

Consider: D0140 limited oral evaluation - problem focused

For evaluation of patients:
> With a singular, specific problem
> Who may or may not have been seen before
> Where the problem might, but need not, be considered an emergency

Monitoring the patient’s condition

Two weeks ago - initial visit
> Patient with traumatically loosened teeth
> No treatment; return to monitor healing

Today – return visit where dentist:
> Looked for any remaining mobility or bleeding
> Determined that clinical condition had improved
> Suggested patient use an athletic mouthguard

Monitoring the patient’s condition

Consider: D0170 re-evaluation - limited, problem focused (established patient; not post-operative visit)

> For patients who require assessment or monitoring of an identified condition

Topical Fluoride Treatments

Three friends visit the dentist
All have Fluoride Varnish applied
Each has it coded differently

Can you match the procedure to the patient’s condition?
Topical Fluoride Treatments

Manny never had a cavity
? D1204 topical application of fluoride – adult

Moe has decay after years without a cavity
? D1206 topical fluoride varnish; therapeutic application for moderate to high risk caries patients

Jack has sensitive teeth
? D9910 application of desensitizing medicament

Child Under Three – First Visit

First visit for 10 month-old

Visit involved
> Oral examination
> Toothbrush deplaquing
> Fluoride varnish
> Diet and preventive care discussion w/mother

Child Under Three – First Visit

D0145 oral evaluation for a patient under three years of age...

Child prophylaxis (D1120)
Child topical fluoride (D1203)

May use other oral evaluation codes for subsequent visits

Patient, age 11 – First visit

Services provided:
> First exam, cleaning, and fluoride application
> Removal of band loop spacer on #3

Applicable procedure codes:
> D0150 comprehensive oral evaluation
> D1120 prophylaxis – child
> D1203 topical application of fluoride – child
> D1555 removal of fixed space maintainer
<table>
<thead>
<tr>
<th>Patient, age 11 – First visit</th>
<th>Partial Prophylaxis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transitional (primary &amp; permanent) dentition</strong></td>
<td></td>
</tr>
<tr>
<td>&gt; Why not use “adult” instead of “child” codes</td>
<td></td>
</tr>
<tr>
<td><strong>“Adult” codes could be reported</strong></td>
<td></td>
</tr>
<tr>
<td>&gt; ADA policy: determinations should be based on dental development rather than patient age</td>
<td></td>
</tr>
<tr>
<td><strong>However –</strong></td>
<td></td>
</tr>
<tr>
<td>&gt; Payer may process the claim using a code consistent with benefit plan provisions and claim adjudication policy</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is D1110 (adult prophy) appropriate for nursing home patients with missing teeth?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>D1110 may be used</strong></td>
</tr>
<tr>
<td>&gt; Nothing in nomenclature or descriptor precludes use when multiple teeth are missing</td>
</tr>
<tr>
<td><strong>Consider also reporting D9410 when services are delivered in nursing homes</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Longer than usual prophy?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Two appointments (one per arch) to remove heavy nicotine stains &amp; calculus</strong></td>
</tr>
<tr>
<td><strong>What procedure code would be used?</strong></td>
</tr>
<tr>
<td><strong>D1110 prophylaxis – adult</strong></td>
</tr>
<tr>
<td>&gt; Nothing precludes reporting for each appointment needed to complete the procedure</td>
</tr>
<tr>
<td>&gt; Descriptor does not stipulate duration, frequency or number of teeth being treated</td>
</tr>
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<table>
<thead>
<tr>
<th>Longer than usual prophy – fee?</th>
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<tbody>
<tr>
<td><strong>Dentist sets procedure fee – not the Code</strong></td>
</tr>
<tr>
<td>&gt; Adjust fee for out of the ordinary cases (e.g., multiple appointments; unusual amount of time)</td>
</tr>
<tr>
<td><strong>Contracts may affect reimbursement</strong></td>
</tr>
<tr>
<td>&gt; Benefit plan limitations and exclusions</td>
</tr>
<tr>
<td>&gt; Participating provider contract: set fee schedule; balance billing not allowed</td>
</tr>
</tbody>
</table>
Longer than usual prophy – another code?

What about “D4355 full mouth debridement to enable comprehensive evaluation…”

D4355 might be appropriate if
> Patient’s plaque and calculus interfered with the comprehensive evaluation
> The entire oral cavity was involved

Fractured Tooth – After Hours Visit

On a day the office is closed the dentist fitted a polycarbonate temporary crown on #8
> Fractured distal-incisal angle and missing a distal composite restoration

When the office opens it’s your job to document this correctly

Temporary Crown on #8

Before

After

Fractured Tooth – After Hours Visit

<table>
<thead>
<tr>
<th>Code Selected</th>
<th>Why?</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0140 limited oral evaluation – problem</td>
<td>Patient presented with a specific problem</td>
</tr>
<tr>
<td>focused</td>
<td></td>
</tr>
<tr>
<td>D2970 temporary crown (fractured tooth)</td>
<td>This procedure code applies when providing immediate protection for the fractured tooth</td>
</tr>
<tr>
<td>D9440 office visit - after regularly scheduled hours</td>
<td>Care was provided when the office was closed</td>
</tr>
</tbody>
</table>
Indirect Crowns

Office CAD/CAM machine mills post & core, and crown
> Doctor cements post & core and preps tooth for the all-ceramic crown

How would you document the services?

Indirect Crowns

<table>
<thead>
<tr>
<th>Code Selected</th>
<th>Why?</th>
</tr>
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<tbody>
<tr>
<td>D2952 post and core indirectly fabricated – in addition to crown</td>
<td>• The post &amp; core, and the crown, are separate procedures</td>
</tr>
<tr>
<td>D2740 crown – porcelain/ceramic substrate</td>
<td>• Code D2952 applies whether post and core is ceramic or metallic</td>
</tr>
</tbody>
</table>

Indirect Crowns – Office CAD/CAM v. Lab

What would be different?

Instead of milling these items in your office you contacted a dental lab to prepare a cast gold post and all-porcelain crown for you

Indirect Crowns – Office CAD/CAM v. Lab

<table>
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<tr>
<td>D2952 post and core indirectly fabricated – in addition to crown</td>
<td>• Same codes are used because both procedures are indirect (i.e., prepared outside the patient’s mouth)</td>
</tr>
<tr>
<td>D2740 crown – porcelain/ceramic substrate</td>
<td>• These codes apply no matter where the post &amp; core, or crown, are fabricated – in the dentist’s office or in a commercial laboratory</td>
</tr>
</tbody>
</table>
D4910 vs D1110 on follow-up visit

Patient is on a three month recall schedule after periodontal therapy – but dental plan limits D4910 reimbursement to twice a year.

The dentist wonders how to legitimately secure reimbursement for services delivered to a patient.

If the treating dentist determines that a patient’s periodontal health:

- Requires a D4910 procedure every three months
  - Deliver procedure with the patient understanding that the plan will only provide coverage for two per year
- Can be maintained with a D4910 every six months, and be augmented with a periodic routine prophylaxis (D1110) in between
  - Deliver and report those procedures

Treating acute pulpitis

The doctor:

> Opened #5 to gain access to the pulp chamber
> Removed the tissue with a broach
> Closed the tooth with a temporary filling.

Ten days later the canal was:

> Opened, thoroughly flushed and cleaned
> Obturated with gutta percha and an appropriate sealer

What procedure codes apply to each appointment?

Treating acute pulpitis - Appointment 1

D3221 pulpal debridement
D2940 protective restoration

These procedures address relief of pain by:

> Simple removal of acutely inflamed pulp tissue
> Closure with a temporary restoration

This is not a definitive endodontic treatment.
Treating acute pulpitis - Appointment 2

D3320 endodontic therapy, bicuspid tooth (excluding final restoration)
> This is a completed root canal procedure

Note: D3221’s descriptor precludes the same provider from reporting pulpal debridement on the same date as the root canal (D3320)
> Since the dates for each procedure are different, and the patient presented with an emergency, both may be reported

Multiple Restorations on Same Tooth

Patient’s radiographs show two teeth with decay that need immediate restoration
> Tooth #14 received a MO restoration that did not extend into the DO placed at the same time
> Tooth #19 had a buccal pit restoration and an MOD restoration placed during the same visit
> Composite resin was used for all the restorations

How would you code for the procedures on this visit?

<table>
<thead>
<tr>
<th>Tooth #</th>
<th>Code Selected / Why?</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>D2392 resin-based composite – two surface, posterior ✓ Reported twice (MO and DO)</td>
</tr>
<tr>
<td>19</td>
<td>D2391 resin-based composite – one surface, posterior ✓ For the buccal pit</td>
</tr>
<tr>
<td>19</td>
<td>D2393 resin-based composite – three surface, posterior ✓ For the MOD</td>
</tr>
</tbody>
</table>

Multiple Restorations on Same Tooth

Some dental plans limit reimbursement when the same tooth surface is involved (i.e. #14 in the scenario) on the same date
> Separate restorations may be recoded as a single multiple surface restoration (e.g., an MO and a DO to an MOD)

The ADA says separate restorations on the same tooth should be reported individually
> Nothing in the Code says separate reporting is wrong
Patient with specific problem - TMD

Initial comprehensive exam - dentist learns the patient has TMD symptoms

Returns for in-depth TMD evaluation
> Detailed documentation of symptoms
> Analysis of occlusion and range of motion
> Sleep, nutritional, & parafunctional habits
> Examine extraoral radiographs & auscultation of the TMJ

Patient with specific problem - TMD

Consider: D0160 detailed and extensive oral evaluation - problem focused, by report
> In-depth evaluation of a particular problem
> Identified on previous comprehensive exam
> Specific, significant and complicated problem(s)
> Requires narrative when reporting

Pulp removed beyond CEJ – primary tooth

When succedaneous tooth present
> D3230 pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)
  – For primary incisors and cuspids
> D3240 pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)
  – For primary first and second molars

Pulp removed beyond CEJ – primary tooth

If maintaining a primary tooth without a permanent successor -
> D3310 endodontic therapy, anterior tooth (excluding final restoration)
> D3330 endodontic therapy, molar (excluding final restoration)

Both include non-resorbable fillings & apical seal
Treatment to maintain pulp vitality

D3220  therapeutic pulpotomy (excluding final restoration)…
  > For both primary and permanent teeth
  > Not for apexogenesis (as of January 1, 2009)

Stimulating Formation of a Root Apex

Apexogenesis Goals:
  > Maintain vital pulp and achieve apical closure

Use:
  > D3222  partial pulpotomy for apexogenesis - permanent tooth with incomplete root development
    – Effective January 1, 2009

Achieving apical closure (apexification)

Goal: Achieve apical closure to facilitate root canal seal

Use series of three codes:
  > D3351 apexification/recalcification/pulpal regeneration – initial visit…
  > D3352 apexification/recalcification/pulpal regeneration – interim medication replacement…
  > D3353 apexification/recalcification – final visit…

Crown lengthening – which code applies?

Healthy tissue, bone removed - restoration will be done:
  > Consider: D4249 clinical crown lengthening – hard tissue

Same, but NO restoration:
  > Consider: D4230 anatomical crown exposure – four or more contiguous teeth per quadrant
  > D4231 anatomical crown exposure – one to three teeth per quadrant
Crown lengthening – which code applies?

Healthy tissue, bone not removed - restoration may or may not be done:
> **Consider**: D4210, D4211 -- gingivectomy or gingivoplasty

What does “tooth bounded space” mean?

This term is used in the nomenclature of codes:
> D4210 and D4211 (gingivectomy/gingivoplasty)
> D4240 and D4241 (gingival flap)
> D4260 and D4261 (osseous surgery)

Illustrations follow

This is a tooth bounded space

One missing tooth - #5
Bounded by #4 and #6

This is a larger tooth bounded space

Two missing teeth - #s 19 and 20
Bounded by #s 18 and 21
These are two tooth bounded spaces –

Two missing teeth -
#s 18 and 20

Two spaces –
> First bounded by #s
17 and 19
> Second bounded by
#s 19 and 21

Three appointment treatment plan

Peridontally compromised patient presents with:
> mandibular partial and supra-gingival calculus
> suspicious lesions
> missing teeth ("X")

3 appointment plan – 1st appointment

Gross removal of calculus and stain

Complete evaluation (exam)

6 periapical and 3 bitewing radiographs

Disaggregated transepithelial biopsy (brush) of white patch

Dispense one 16 oz. bottle of Chlorhexidine Gluconate rinse

3 appointment plan – 1st appointment

D4355 full mouth debridement…
D0150 comprehensive oral evaluation OR
D0180 comprehensive periodontal evaluation

D0220 intraoral periapical first film +
D0230 intraoral periapical each additional…(5) +
D0273 bitewings – three films

D7288 brush biopsy…
D9630 other drugs and/or medicaments, by report
3 appointment plan – 1st appointment

Could the periapicals and bitewings be coded as a full mouth series?

NO – “fmx” defined in D0210 descriptor
> Follows FDA/ADA radiographic guidelines
> Added to the Code effective January 1, 2009

3 appointment plan – 2nd appointment

Discuss risks of tobacco use and withdrawal program, plus prescription for “The Patch”

Scaling and root planing of the lower right quadrant

Anesthesia by non-injectable periodontal gel in the sulcus

Irrigation of each sulcus with Chlorhexidine Gluconate rinse

3 appointment plan – 2nd appointment

D1320  tobacco counseling for control of dental disease

D4342  periodontal scaling and root planing – one to three teeth per quadrant

D9215  local anesthesia (optional)

No code for sulcular irrigation, but consider:
  D4999  unspecified periodontal procedure, by report

3 appointment plan – 3rd appointment

Review progress on tobacco use cessation program and results of biopsy

Scaling and root planing entire lower left quadrant

Mandibular block anesthesia

Placement of Atridox® antibacterial gel in each sulcus
3 appointment plan – 3rd appointment

D1320  tobacco counseling (if needed)
D4342  periodontal scaling & root planing – 1 to 3 teeth…
D9211  regional block anesthesia
D4381  localized delivery of antimicrobial agents…, by report

“Quadrant” procedure crossing the midline

Fixed partial denture replacing #s 23, 24, 25, & 26
> 4-5 mm pockets around #22 & 27
Flap surgery with open root planing of #s 22 and 27

“Quadrant” procedure crossing the midline

Space adjacent to #s 22 & 27 is a bounded space
> But not bounded in either quadrant
Use the following code twice:

D4261  osseous surgery (including flap entry and closure) - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant

Section an FPD - Patient w/Perio Disease

Doctor wants to save bridge from #13-15, but periodontal disease affects #15
Sectioned bridge distal to #13; refinished & polished crown on #13
D9120  fixed partial denture sectioning

Extracted #15
D7140  extraction, erupted tooth or exposed root…
Root planed #s 12 & 13
D4342  periodontal scaling & root planing – 1 to 3 teeth…
Post and core today – which code applies?

Patient has broken 2nd premolar with adjacent 1st molar missing
> Which post and core code should be used?
If final restoration is a single unit
   D2954 prefabricated post and core in addition to crown
If final restoration is a multiple unit FPD
   D6972 prefabricated post and core in addition to fixed partial denture retainer

Partial denture repair and extension

Existing maxillary partial denture
> #s12 & 13 missing, and #14 broken
3-part treatment plan
> Add prosthesis for 12 & 13 to the partial
> Full cast noble metal survey crown for 14
   - Must fit an existing clasp
> Additional clasp for retention on tooth 11

Partial denture repair and extension

Part 1
   D5650 add tooth to existing partial denture
   - Report twice: once for #12 and again for #13
   D2790 crown – full cast high noble metal

Part 2
   D2971 additional procedures to construct new crown under existing partial denture framework

Part 3
   D5660 add clasp to existing partial denture

Fractured incisors + exposed pulp

Two fractured incisors
> One with exposed pulp

Planned treatment:
- Root canal + prefabricated ceramic post
- Direct resin bonded restorations
Fractured incisors + exposed pulp

D3310  anterior (excluding final restoration)

D2999  unspecified restorative…
> For the prefabricated ceramic post

D2335  resin-based composite - 4 or more surfaces or involving incisal angle (anterior)
> Report twice - two teeth are restored

What do you mean by “fissurotomy?”

“fissurotomy” - trademarked name for particular kind of bur

“fissurotomy” is sometimes used to describe a technique for mechanical enlargement of occlusal pits & fissures to improve access for brushing

For such enlargement you could use:

D9971  odontoplasty 1-2 teeth; includes removal of enamel projections

Two procedures on the same day

Limited pocketing on 2 teeth
> OK to report prophylaxis (e.g., D1110) and scaling & root planing (e.g., D4342) on the same date?

Codes’ nomenclatures or descriptors do not preclude delivery or reporting on same date
> Dentist’s clinical judgment determines which services are appropriate and when they should be delivered

Some third-party payer benefit plan limitations and exclusion do not cover services on same date

Consultation – or an Oral Evaluation?

Oral surgeon has consultation referrals
> Use “problem-focused” exam code or the “consultation” code?

A specialist may use any oral evaluation code or the consultation code D9310
> Use one or the other, but not both on same day

OK to use D9310 if other diagnostic services or treatment provided
> Other services reported separately
When a claim is denied or rejected...

“The existence of a dental procedure code does not mean that the procedure is a covered or reimbursed benefit…”

> When would claim denial or rejection suggest misuse or interpretation of the Code?

See May 28, 2008 ADA News article, “Coding Watchdogs Wanted”

What does HIPAA say?

> Payer must accept valid procedure code for processing
> Payer does not have to base payment on procedure code reported
  - Contract provisions (e.g., limitations and exclusions) may be applied

Denial is possible under HIPAA

What does the ADA say...

OK: payer applies benefit plan limitations & exclusions – and says so
  > e.g., plan does not cover any restorative procedure delivered on the same day a D4355 is reported

Not OK:
  > Payer ignores procedure code’s nomenclature or descriptor
    - e.g., payer states that diagnostic radiographs are part of the D3310 procedure and cannot be reported separately
  > Payer implication that dentist reported incorrect procedure on claim

Example - Core Buildups

You report D2950 (core buildup) and D2750 (PFM) on a claim
  > But payer says core build ups are part of the crown procedure

Payer is wrong from the Code’s perspective
  > But payer may make single reimbursement based on benefit plan design
  > Dentist’s ability to balance bill is subject to participating provider contract, if any
What do the contracts say?

What are your participating provider contract provisions – e.g., dentist agrees to:

- Least expensive alternative treatment “LEAT” reimbursement
- Reimbursement based on Payer guidelines v. specific codes reported on claim

Dentist who signs a participating provider contract is generally bound to its legally sound provisions

- Know what you are agreeing to before signing – ADA Contract Analysis Service

When a claim is denied or rejected…

Coming now - hypothetical examples of what is:

- OK
- Not OK

Note: Each example is limited to the facts given for it

OK or not OK?

Not OK – you report D1110 and payer says report D1120 for reimbursement

- Patient is 13 with predominantly adult dentition and plan design sets 15 as adult age
- Payer is asking you to report wrong procedure

BUT – OK for payer to accept D1110 and pay at D1120 based on plan design

- EOB should reflect what was submitted
OK or not OK?

You report D0120, D1120 and D1203
  > Payer says that these are not separate procedures
  > Payer says all three procedures are part of D0120

Not OK –
  > Payer is redefining D0120
  > Payer may be “bundling”

OK or not OK?

EOB to patient shows different codes
  > Claim form: D0120 and D1110
  > EOB: D0120 and D1120
    - Message says these are the correct codes for child patient

Not OK: payer implication that dentist reported incorrect prophylaxis procedure code

What can you do?

Q&A section of CDT manual provides ADA’s guidance on appropriate procedure code selection

Contact ADA Member Service Center (MSC) to report problems
  > Payers using the Code must be licensed
  > License does not dictate how a code is paid

Arbitrary payer action is ADA concern
  > Reports enable staff to address recurring issues with payers

Coding for Reimbursement

Question – What procedure codes have the best chance of reimbursement?

Answer – Codes for procedures that are covered by the benefit plan.

Facts of Life –
  > Not all procedures are covered, and some have annual or lifetime limitations
  > Dentist’s ability to balance bill is subject to participating provider contract, if any
“...by report” – What to say

A clear and concise narrative that includes:
> Clinical condition of the oral cavity
> Description of the procedure performed
> Specific reasons why extra time or material was needed
> How new technology enabled procedure delivery
> Any specific information required under a participating provider contract
Payer may still request additional documentation

Determining the date of service

There is a single code for an immediate denture
> But procedure requires multiple appointments
What is the date of service?
> ADA policy - for prosthodontic treatment the final impression date is date of service
> But - state laws, third-party policies & contracts may specify completion date as the date of service

Quadrants...

Could you explain the quadrant codes?

Two character numeric codes to designate:
> Entire mouth
> Each arch
> Each quadrant

<table>
<thead>
<tr>
<th>Code</th>
<th>Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>entire oral cavity</td>
</tr>
<tr>
<td>01</td>
<td>maxillary arch</td>
</tr>
<tr>
<td>02</td>
<td>mandibular arch</td>
</tr>
<tr>
<td>10</td>
<td>upper right quadrant</td>
</tr>
<tr>
<td>20</td>
<td>upper left quadrant</td>
</tr>
<tr>
<td>30</td>
<td>lower left quadrant</td>
</tr>
<tr>
<td>40</td>
<td>lower right quadrant</td>
</tr>
</tbody>
</table>

Quadrants…and teeth

For procedure codes with “quadrant” in the nomenclature should I report area of the oral cavity, tooth number or both?

For “quadrant” codes always report area of oral cavity
> Do not report area if already specified in nomenclature
Include tooth numbers when required for precise procedure reporting
The Code and dental claims

Must be used on the HIPAA standard electronic dental claim transaction

> Also used on paper claims

ADA paper claim content mirrors the HIPAA standard electronic dental claim, as much as possible

> First seen on (2002 © ADA) version

ADA paper claim form

Current version (2006 © ADA) enables reporting

> National Provider Identifier (NPI)
> Payer assigned Provider Identifiers

IDs placed in ‘Billing Dentist’ and ‘Treating Dentist’ sections

> Comprehensive completion instructions in CDT manual

ADA claim form – Billing & Treating Dentist

Field for payer assigned proprietary ("Legacy") ID

"Provider ID" field changed to "NPI"
National Provider Identifier (NPI)
Required for dentists who
> Use any HIPAA transaction
> Subject to a state or participating provider agreement requirement

For more information (no cost) go to
www.ada.org/goto/npi

Coordinating the Benefits
Which payer is primary when both parents have coverage for the dependent patient?
> How may I handle coordination of benefits?
  – Many companies use “the birthday rule”
  – Attach copy of the other payer’s EOB to the secondary claim

See May 12, 2008 ADA News article on COB

Claims against medical benefits
Different form
> “1500” paper form or HIPAA electronic equivalent
> May be submitted by any dentist delivering service within scope of state licensure

Different code sets
> CPT or HCPCS procedure codes and modifiers
> ICD-9 diagnosis codes

TMD service – dental v. medical
How do I file a dental or medical claim for a mandibular occlusal bite appliance?
Dental – ADA Dental Claim Form with procedure “D7880 occlusal orthotic device, by report”
Medical – ‘1500’ form with CPT/HCPCS procedure codes and ICD-9 diagnosis codes:
  > HCPCS - S8262 Mandibular orthopedic repositioning device, each
  > ICD-9 - 524.60 Temporomandibular joint disorders, unspecified
Medical benefits claim form

Information on the 1500 Health Insurance Claim Form, including completion instructions, can be found at:
www.nucc.org

Medical claim form – key items

1: ICD-9 Diagnosis Code (at least one)
2: CPT or HCPCS Medical Procedure Code
3: Procedure Code Modifier
4: Diagnosis Code Pointer

Medical claims for dental services

Not always an exact match between dental and medical procedure codes
> One or more medical procedure code modifiers may be necessary
> One primary ICD-9 diagnosis code required
  – Additional ICD-9 codes as needed
Tooth # and oral cavity area reported using codes published in CDT manual

Medical coding sources

From the ADA – “The CDT Companion”
> Procedure cross-coding (dental to medical) and diagnosis codes

Other sources
> Procedures (CPT & HCPCS)
  – National Dental Advisory Service - www.ndas.com ☏ 800-669-3337
  – Webb Dental - www.webbdental.com ☏ 877-628-3366
> Diagnosis codes (ICD-9)
  – icd9cm.chrisendres.com
  – www.icd9coding.com
before some closing comments

No code describing a procedure?

Unspecified, “by report” (Dnn99) procedure codes

> Use when there is no applicable procedure code

Attached narrative should include:

> Treatment plan; supplementary information

Then consider submitting a code change request form

Revising the Code

Code Revision Committee (CRC)

> Deliberative body with equal representation from third-party payers and ADA

> Biennial ‘batch-driven’ review and voting protocol
  > Includes appeal process

Revising the Code

Process open to any interested party

> Information about the process on-line
  > ada.org/goto/dentalcode

Questions?

> Council on Dental Benefit Programs (CDBP)
  > dentalcode@ada.org
  > ADA member toll-free number or 312-440-2500
CDT 2011/2012
Includes:
> The Code, with illustrations of all revisions and deletions
> Questions & Answers, a Glossary, and more
> The manual on CD

To order your copy, call 800-947-4746 or visit our on-line product catalogue at www.adacatalog.org

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