

**STAY OUT OF JAIL:
AVOID CODING ERRORS AND EXCEL IN INSURANCE ADMINISTRATION**

**PRESENTED BY:
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DECEMBER 3, 2014



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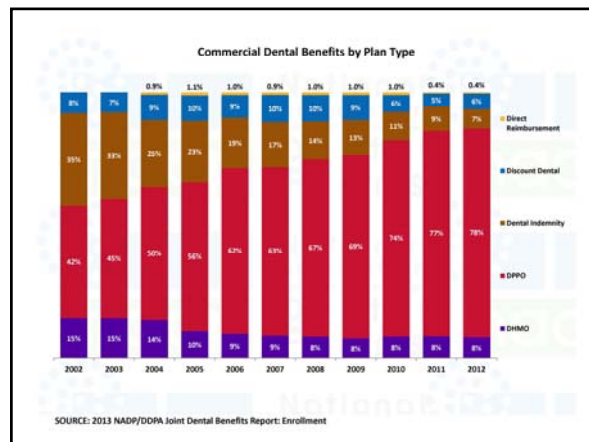
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FUTURE OF DENTISTRY

- Dental PPOs are at a tipping point and mirror medicine's – Now!
- ****MUST PRODUCE MORE TO HOPE FOR THE SAME INCOME.****
- Solo is shifting to multi-doctor.
- Dentistry is a \$110 Billion industry and corporate dentistry will increase.
It is compounding from \$5 billion of revenues (largest corporations) - -
About 3,000 location - -A tipping point!

FUTURE OF DENTISTRY REALITY

- Some practices gaining market share. – Winners!
- Some practices losing market share. – Losers!
- Fees will be frozen, very low fee increases, or lowered.
- Procedure mix monitoring - National Databases Already Here!
 - Limit network outliers through audits
 - PPO network dismissal of outliers
- Practice sales prices will decline with the lower profit margins of PPOs

Change is for sure!

DISCLAIMER

1. Coding as presented has been researched. Statements made do not necessarily apply to all plans as there is great variation. There is no guarantee that a given plan will reimburse along the guidelines presented.
2. Always code “what you do.”
3. Follow the current CDT code set exactly to the best of your ability.

CURRENT CDT CODES

- Code and report “what you do” strictly by the current CDT code.
 - HIPAA is “law of the land”
- Codes are not specialty-specific
- New codes every year – **Over 50 changes for 2014 and over 72 changes for 2015!**
- There are over 500 codes under CDT 2014

ANTI-FRAUD LAW LANGUAGE

(TYPICAL STATE LAW)

"Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud." (Ohio Law)

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ADA CLAIMS FORM LANGUAGE

"I hereby certify that the procedures as indicated by date are in progress (for procedure that require multiple visits) or have been completed"

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DISCOUNTED FEE FOR PRE-PAYMENT

TREATMENT PLAN	\$1,000
5% CASH DISCOUNT	\$ 950

What goes on the form? \$1,000 or \$950?

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DISCLOSING CO-PAY FORGIVENESS

- All states prohibit co-pay forgiveness without third-party notification.
- Virtually all PPOs prohibit co-pay forgiveness by contract!
- If you "forgive" the co-pay in an *isolated situation*, the remarks section should read:

"The patient is not participating in the cost of treatment."

Note: Always disclose fee forgiveness to third-party.

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AUDITS

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AUDIT ELEMENTS

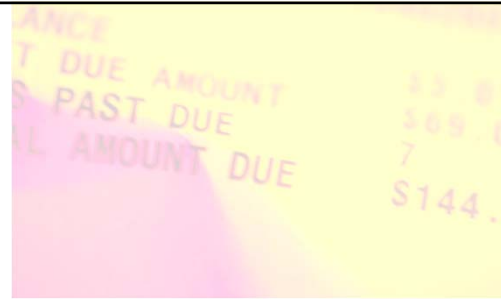
- **The audit would confirm:**
 - That the procedure was performed.
 - That the procedure was "medically necessary."
 - That the procedure was not cosmetic.
 - That the fee charged was the same fee charged to non-insurance patients in similar circumstances.
 - That the clinical protocol for non-insurance patients was the same clinical protocol for insurance patients in similar circumstances.

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AUDIT ELEMENTS (CONTINUED)

- ❑ That the procedure is not up-coded
 - Example: A surgical extraction (D7210) is charged instead of a routine extraction (D7140).
- ❑ That the claim form was accurate.
- ❑ That the procedure was properly represented by the current CDT code reported.

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FEES

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CAN YOU LEGALLY...

- ❖ Charge different fees for different people?
- ❖ Charge different fees for different plans?
- ❖ Charge different fees for same procedure code?

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FULL FEE ON CLAIM FORM - ALWAYS

SUBMIT FULL UNRESTRICTED FEE. WHY?

- ❑ For calculation of coordination of benefits for proper patient reimbursement.
- ❑ So you don't miss a PPO increase in fee reimbursement.
- ❑ For purposes of UCR setting by insurance companies with claims filed, not fees registered.
- ❑ Determine write-offs for each plan to compare.

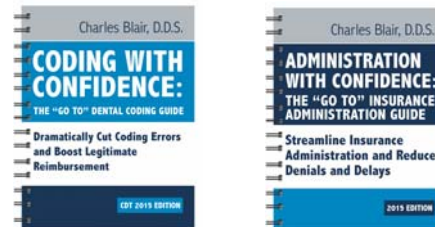
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MANAGED CARE ASSESSMENT

- ❑ Fees
- ❑ Quality of Patient
- ❑ Administrative Hassle
- ❑ Managed Care Penetration
 - Percentage of Current Practice
 - Percentage of New Patients

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CODING AND ADMINISTRATION WITH CONFIDENCE



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CLEANING UP YOUR CODING *LOWER ERRORS!*

- Delete/inactivate the deleted codes.
- Enter *only* the new codes that specifically apply to your practice. For the typical GP practice, only five to ten of the new codes may apply.
- Delete inactive codes.
- Print a report showing fees and counts for each CDT procedure to determine miscoding.

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CLEANING UP YOUR CODING *LOWER ERRORS!*

- Make sure that the numerical code sequence for range starting D0120 and ending D9999 is used only for valid CDT codes. Move in-office codes such as broken appointment, deliver crown, etc. to code numbers below code D0120. For instance, code these in-office codes using range numbers D0000 – D0119.

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ORAL EVALUATIONS (EXAMS)

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COMPREHENSIVE ORAL EVALUATIONS

- “2 /Year Rule” or “1/Six Months” (*OF ANY KIND*)
- D0145-Under age 3 includes counseling.
- D0150-Age 3 and up – probing and charting “where indicated” oral cancer evaluation “where indicated”
- D0180-Must be perio patients (or have perio risk factors) and full-mouth probing and charting is mandatory.

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CHECK-UP EVALUATIONS

- D0120-Periodic Evaluation – probing and charting “where indicated” oral cancer evaluation “where indicated”.
- D0180-Must be perio patients (or have perio risk factors) and full-mouth probing and charting is mandatory.*

*Insurance companies commonly downgrade D0180 to D0120.

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D0140 PROBLEM-FOCUSED EXAM ISSUES

- Always a “Stand Alone” Code
- Subject to 2/year or 1 per six months rule
- “Not paid with definitive procedure” limitation
- Can be used infrequently at recall with extra time.

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OTHER EVALUATION-TYPE CODES

- Detailed & Extensive (Follows D0150/D0180) D0160
- Re-Evaluation (Limited)
(Follows D0140/D0150/D0180) D0170
- Consultation-Referred by DDS/MD
- Not a patient self-referral D9310

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CASE PRESENTATION (D9450) - DETAILED VISIT

- Used as a “visit” code to present a treatment plan at a later date (after evaluation).
- Is not generally billed/reimbursed.

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PALLIATIVE (D9110)

- One of the least-reported codes.
- Palliative is a minor procedure (not a definitive procedure) at an emergency visit with pain/discomfort reported by the patient.
- Typically allowed up to 2 to 3 times a year.
- Not a “take-back” code, and generally not subject to a deductible.
- Cannot report any other treatment on same visit date with most plans. X-rays are OK.
- Always use narrative
- Variable fee, depending on procedure and the time spent.

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MINOR PROCEDURES (PALLIATIVE – D9110) AT EMERGENCY VISIT

- Smooth sharp corner of tooth
- Adjust occlusion for pain relief
- Remove decay, IRM placed
- Desensitize tooth
- Open tooth (partial debridement) or lance abscess for pain relief
- Partial heavy calculus debridement (only with patient complaint of discomfort)
- Aphthous ulcer relief

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PULP VITALITY TEST (D0460)

- May not be reimbursed in addition to problem-focused evaluation (D0140) on same service date.
- The pulp vitality test is considered a “stand alone” code.

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COMMON X-RAY LIMITATIONS

- Full Series or Pan – Every 3 or 5 years
- Maximum x-ray reimbursement – full series UCR
- Bitewings – once per year/twice for children?
- Maximum bitewing reimbursement – four bitewings limitation at recall visit
- Vertical bitewings – 7-8 films (D0277) may pay 80% of full series fee but may count under full series limitation rules. May downgrade to 4BW in some cases.

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INTRAORAL PERIAPICALS (D0220/D0230)

- Generally one or two periapicals are reimbursed at problem-focused (emergency) exam (D0140) or Palliative (D9110) appointment.
- Use (D0230) for each additional periapical.
- Periapicals taken at the emergency visit do not generally affect the “once-a-year” bitewing rule.
- Multiple bitewings taken at an emergency visit will often affect the “once a year” bitewing rule. One bitewing may, or may not, “trigger” rule.

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PANORAMIC FILM (D0330)

- Payable every 3 or 5 years, just like full series (D0210). Either one or other.
- If a pan and bitewings (D0272/D0274) are taken on the same service date, then many carriers convert to the lower full series UCR payment amount. Sometimes Pan is paid only; a pan pays best by itself on a given service date.
- Consider pan or 4BWx at an emergency visit to “get it out of the way”.

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CONE BEAM CT

- Various New Codes
- D0391-Interpretation

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PROPHYLAXIS

- **Definition:**
 - Prophylaxis is preventative
 - Scaling and polishing of tooth structures
 - Gingivitis is inflammation of Gingiva
 - Includes removal of irritational factors (gingivitis)
 - No mention of Perio-free status in descriptor

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RECALL

Child Prophylaxis:

- Child prophyl (D1120)
 - primary or transitional dentition
- 2 Bitewings (D0272) generally until second molars are erupted.

Adult Prophylaxis:

- Adult Prophyl (D1110)*
 - Transitional or permanent dentition
- 3 Bitewings (D0273)
- 4 Bitewings (D0274)

*14 years of age and up is the most common limitation, sometimes 16 years. Occasionally D1110 is paid for 12-13 year olds.

*Also second molars erupted can be criteria.

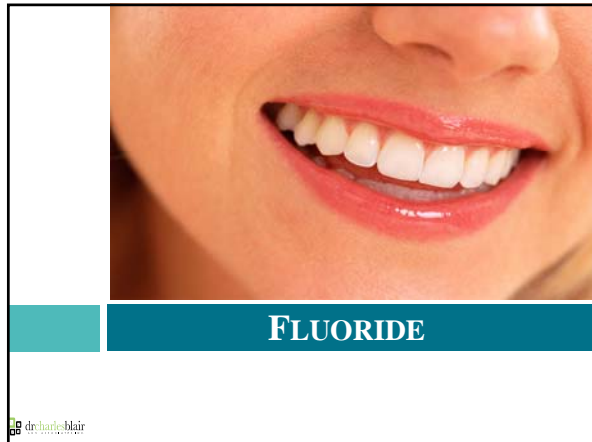
*ADA code does not specify age, but insurance generally does.

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ADULT PROPHY (D1110)

- Extended Prophyl
- Adult Prophyl (*routine*)
- Teenage Prophyl
- Brief Prophyl (*partial*)
- D8999 Utilization

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FLUORIDE APPLICATION LIMITATIONS

- ❖ Payable once or twice per year. Fluoride cannot be in prophylaxis paste. Payable up to 16-17-18 years.
- ❖ D1206-Fluoride Varnish (Children or Adults)
- ❖ D1208-Fluoride Application (Children or Adults)

*Caries risk is no longer considered for D1206.
D1203/D1204 is Deleted.

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OPERATIVE RESTORATIONS

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RESTORATIVE DEFINITIONS

- ❑ Don't charge for liners, bases and etching.
- ❑ Operative restorations are in occlusion and have adjacent contact, if applicable.
- ❑ Posterior Amalgam/Composite Restoration: Must be in the Dentin!

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“OPERATIVE FRAUD ?”

Closing Diastema or “Bonding” (Cosmetic)

- ❑ 3-surface anterior
- ❑ 4-surface anterior/incisal angle

Perio Splinting

- ❑ Reporting of routine fillings instead of Perio splinting.

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NEW CODES (EFFECTIVE 1/1/13)

- ❑ D2929-Primary Tooth Pre-Fabricated Ceramic Crown
- ❑ D2990-Icon Resin Infiltrant

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DEFINITION

INCISAL “EDGE” OR INCISAL “ANGLE”?

INCISAL EDGE

- 1 Surface D2330
- 2 Surface D2331
- 3 Surface D2332

INCISAL ANGLE

- 4 Surface D2335 (MIFL/DIFL)

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INLAYS/ONLAYS

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INLAYS/ONLAYS

- Inlays are generally reimbursed as amalgams/composites.
- Onlays can be reimbursed with excellent documentation (photos, x-rays, need for crown, etc.).
- To be considered an onlay, one or more cusps must be “capped” or “shoed.” An onlay always involves the facial and/or lingual surfaces.
- MOD is not an onlay.
- MOF, MOL, MODFL—all okay.

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INLAY/ONLAY MATERIALS

Three types of inlay/onlay materials:

- Gold
- Ceramic/Porcelain
- Resin-based (lab - Cristobel®, Artglass®, Bellglass®)

Resin-based (lab) materials:

- Sometimes excluded as a material
- May reimburse 40-50% less than gold/ceramic material

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ONLAY/CROWN CRITERIA

1. Missing Cusps
2. Undermined Cusps
3. Fractured Cusps
4. Fracture
5. Decay
6. Endodontic Tooth

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CROWN AND BRIDGEWORK

- Use correct metal
- Price accordingly
- Match correctly the pontic material to the retainer type of material
- 3M Lava Ultimate Crowns are now reported as ceramic, not as a resin crown

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CROWN BUILDUP TYPES*

Types:

- Core Buildup (D2950) - typically for vital - sometimes Endo
- Indirect Cast or Milled Post (D2952) – Endo teeth
- Prefab Post & Core (D2954) – Endo teeth

*Report these codes under bridges.



CORE BUILDUP (D2950)

- Must be for “retention” of crown and “strength” of tooth.
- Cannot report for “box form”, “undercuts”, or “ideal prep.”
- “A core buildup is required for the retention of the crown and strength of the tooth.”
- “65% of the tooth was missing.”
- “The tooth was endodontically treated on mm/dd/yy”. Enclosed is completed endo x-ray.



PREFAB POST/CAST BUILDUPS

- For Endodontically treated teeth (only).
- Routinely approved.
- Watch Cast or Milled Buildup miscoding!



EXTRA LAB PROCEDURES W/ PARTIAL

- Bill code (D2971) plus crown procedure.
- Lab charges extra \$50 - \$70 to make a new crown under an existing partial denture.
- About \$150 fee for the D2971 procedure.

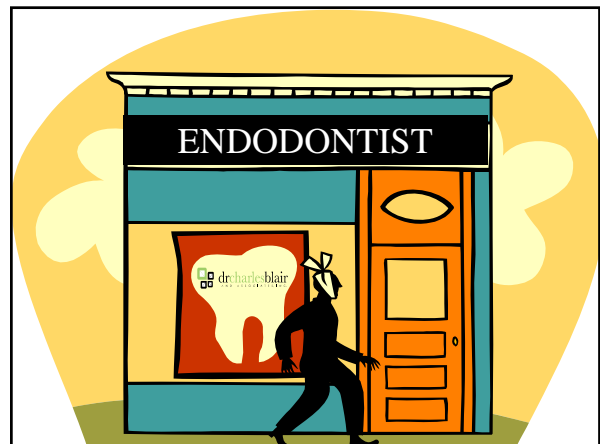


REPAIRS

(NECESSITATED BY RESTORATIVE MATERIAL FAILURE)

- Crown (D2980)*
- Inlay (D2981)
- Onlay (D2982)
- Veneer (D2983)

*Do not use for endodontic access hole closure.



PRIMARY TOOTH ENDO PROCEDURES

Use these codes for primary teeth:

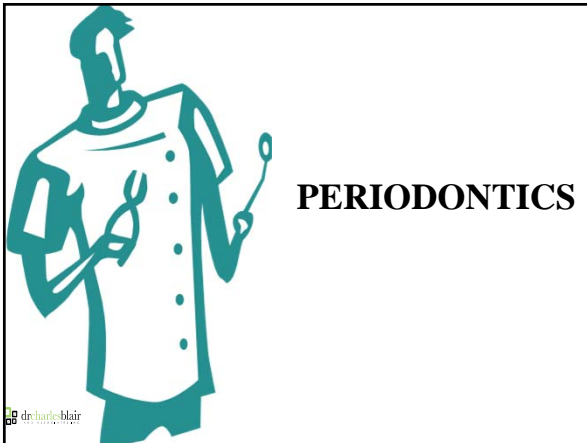
- ◆ Pulpotomy (D3220) – Vital Tooth
- ◆ Pulpal Therapy – Anterior (D3230) Necrotic*
 - ◆ Resorbable material – not gutta percha
- ◆ Pulpal Therapy – Posterior (D3240) Necrotic*
 - ◆ Resorbable material – not gutta percha

*Higher Fee Paid



PULPAL DEBRIDEMENT (D3221)

- “Open tooth” and “get out of pain” code for referral to Endodontist.
- Can be a “take-back” code if RCT treatment follows later in the same billing office.
- Some carriers re-map (D3221) to the Palliative (D9110) code for payment.
- Palliative (D9110) is an alternative at the emergency visit.



PERIODONTICS



RESTORATIVE ACCESS PROCEDURE

- D4212 Gingivectomy to allow access for restorative procedure, per tooth.
- May not be reimbursed
- Different service date from restoration date may help reimbursement



CROWN LENGTHENING (D4249)*

- Hard tissue (remove bone) procedure. Changes crown to root ratio.
- Lay full thickness flap mesial and distal to tooth.
- Bone is not diseased (no Perio issues).
- No Endo Apex problems
- Six week wait or more for final crown prep/impression.

*Must lay full thickness flap.



PERIO SPLINTING* (MOBILE TEETH)

- (D4320) Provisional Splinting - Intracoronal
- (D4321) Provisional Splinting - Extracoronal

*Do Not report individual Composite Restorations - fraudulent!



QUAD SCALING & ROOT PLANING (SRP)*

- 4-5 mm pocket depth , BOP, evidence of bone loss
- (D4341) 4 teeth or more (quadrant)
- (D4342) 1-3 teeth (list teeth on form)

*D4910 follows Scaling and Root Planing or osseous surgery procedure.



PERIO ONGOING MAINTENANCE (D4910)*

- Show history of SRP/surgery, plus attach full mouth charting with initial D4910 form. Turn switch "on".
- Always Follow SRP or Perio Osseous surgery.
- Don't alternate D4910 with prophyl (D1110).
- (D4910) treatment is "indefinite" and "ongoing".
- Many carriers require at least two quads of SRP to qualify for D4910 visits.
- Does not include Periodic Evaluation (D0120) or Comprehensive Perio Evaluation (D0180). D0180 requires full mouth chart and probing to report.

*Sometimes D0180 evaluation is reported, but generally reimbursed as D0120.



D4910 NARRATIVE

"If periodontal maintenance D4910 is not reimbursable, please pay the alternative benefit of Prophylaxis, D1110.

"Periodontal maintenance, D4910 is inclusive of Prophylaxis, D1110."



SIX WEEK RE-EVALUATION

- ❖ D0180-If DDS checks the patient. Evaluation is subject to frequency limitations.
- ❖ D1110-paid generally, but beware of certain plans
- ❖ D4381-Arestin-Possibly paid
- ❖ D4910-Generally not paid six weeks after SRP-Requires three months wait.
- ❖ D4999-Probing and Charting, not paid and there is not a separate code for this service.



CAN D4910S BE FOLLOWED BY PROPHYS?



GROSS DEBRIDEMENT TO ENABLE ORAL EVALUATION AND DIAGNOSIS (D4355)

- "A Gross Debridement was necessary for a subsequent evaluation."
- "Patient has not seen dentist in three - five years."
- Do not charge out Comprehensive Evaluation on same service date! Charge at 2nd visit.
- With a limited debridement procedure, consider using Palliative (D9110) if the patient reports they have discomfort at an emergency



CONTROLLED RELEASE VEHICLE (D4381); PER TOOTH

- ❑ Includes Arestin®, PerioChip®, Atridox®
- ❑ Generally not payable at initial SRP appointment.
- ❑ May be payable at six week re-evaluation or (D4910) visit - getting better.
- ❑ Documentation: 5-6-7mm depth pocket; BOP; probing and charting
- ❑ D4381 is coded per tooth. Fee varies with number of sites placed.
- ❑ Arestin® may be payable by pharmacy benefit plan of medical insurance.

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REMOVABLE PROSTHETICS

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IMMEDIATE DENTURE (D5131/5140)

- ❑ Higher fee to cover soft-tissue “healing” follow-up period.
- ❑ Wait six months (after extraction[s]) for hard acrylic reline, rebase, or even a new denture.
- ❑ If followed by a completely new denture, ask for alternative benefit of reline.

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PARTIALS – FOUR TYPES

1. Resin Partial (D5211/D5212); Indefinite life
2. Cast Partial (D5213/D5214); Indefinite life
3. Flexible Partial (D5225/D5226); Indefinite life
4. Interim Partial (D5820/D5821); 1-12 month life, duration (waiting on Perio, bridge, implant, etc.) not filed with insurance.

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“FLIPPER PARTIAL”*

- ❑ Can be either Resin Partial (D5211/D5212), Valplast Partial (D5225/D5226).

OR

- ❑ Interim Partial (D5820/D5821), depending on use

*Proper code depends on “life” expectancy and use of partial.

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RELINE OR REBASE?

- ❑ A reline maintains original acrylic base and is re-surfacing.
- ❑ A rebase strips acrylic back to the teeth and all new base acrylic is applied.

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LAB/CHAIRSIDE RELINE

- A chairside reline sets at chairside.*
- A lab reline is processed in the office or by an outside lab.

***This is not tissue conditioning. Tissue conditioning is preliminary to a definitive impression for a prosthesis.**

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IMPLANTS

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IMPLANT INSURANCE COVERAGE

- Must have Implant rider for coverage of Implant procedures.
- Generally only a Crown will be paid as an alternative benefit for the Implant, Abutment, and Implant Crown with a conventional plan.

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SURGICAL IMPLANT PLACEMENT (ENDOSTEAL IMPLANT)

- D6010 Full Size Implant-\$1,500 - \$2,000
- D6013 Mini Implant-one-half the fee

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COMMON GP CODING ERRORS

1. Get confused with Abutment-supported and Implant-supported crown.
2. Report an implant crown as a natural tooth crown.
3. D6190 implant index is correct. Do not report surgical stent D5982 or surgical splint D5988.

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IMPLANT CHARGE OUT POSSIBILITIES

- Abutment Placement for Abutment-Supported Crown*
 - Prefabricated Abutment (D6056)
- OR**
- Custom Abutment (D6057)

*Provider must *place* the abutment to report it.

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FURNISH PREFABRICATED ABUTMENT TO GP*

- ❑ D6199 unspecified implant by procedure, by report.

***Oral Surgeon cannot report a Prefabricated Abutment (D6056).**

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IMPLANT-TYPE CROWN CODES

1. Abutment-Supported Examples:

- ❑ D6058 Porcelain/Ceramic
- ❑ D6059 PFM Hi-Noble
- ❑ D6062 Gold Hi-Noble

2. Implant-Supported Examples:

- ❑ D6065 Porcelain/Ceramic
- ❑ D6066 PFM (Any Metal)
- ❑ D6067 Gold (Any Metal)

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IMPLANT BRIDGEWORK CODING MATCH

- ❑ Match Pontic and retainer coding (Common Miscoding)
- ❑ Implant Pontic is the same as natural tooth Pontic
- ❑ Match material type (ceramic, PFM, gold)

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IMPLANT PROVISIONAL PLACEMENT

- ❑ D2799 unspecified implant procedure, by report (place provisional crown on Abutment/Implant).
- ❑ Interim Abutment (D6051)-A healing cap is not an Interim Abutment. (New Code)

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DENTAL IMPLANT SUPPORTED CONNECTING BAR

- ❑ D6055 Implant Connecting Bar
- ❑ Typically a removable Implant Overdenture fits over the Bar.

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OVERDENTURE - CONFUSION

- ❑ Natural tooth Overdenture Vs. Implant Overdenture
- ❑ CDT 2014 Natural tooth Overdenture codes are complete (D5863 and D5864) and Partial Overdenture (D5865 and D5866)
- ❑ D6053 Implant/Abutment supported Implant Overdenture - new CDT 2015 codes have been added reporting each arch
- ❑ D6054 Implant/Abutment Supported Implant Partial Overdenture - new CDT 2015 codes have been added reporting each arch

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OVERDENTURE LOCATOR CODES

- Mini-Implant Type Overdenture – D6053
 - D5862 Mini-Implant Cap embedded in overdenture.*
- Full-Size Type Implant Overdenture – D6053
 - D6052 semi-precision attachment abutment with keeper assembly (locator)

*D5862 is a precision attachment or “locator”.



IMPLANT MAINTENANCE PROCEDURE

- D6080 Implant maintenance procedures-including removal of fixed prosthesis, cleansing of prosthesis and abutments, and reinsertion of prosthesis.
 - Includes prophylaxis of implant(s)
 - X-ray radiographic images and D0120 periodic oral evaluation (exam) are reported separately
 - With natural teeth, prophylaxis D1110 could be reported separately



IMPLANT-RELATED REPAIRS

- D6090 Repair Implant Supported Prosthesis, by report (any part of Prosthesis).
- D6095 Repair Implant Abutment, by report (any part of Prefabricated [D6056] or custom [D0657] Abutment).
- D6091 Replacement of Semi-Precision or Precision Attachment (male or female component of Implant/Abutment supported Prosthesis, per attachment .



PERIIMPLANT PROCEDURES

- ◇ D6101-Debridement of Defect-Surface Cleaning
- ◇ D6102-Debridement of Defect-Osseous Contouring
- ◇ D6103-Bone Graft for Repair of Periimplant Defect
- ◇ D6104 Bone Graft at Time of Implant Placement



BRIDGEWORK



BRIDGEWORK CODING MATCH

- Match pontic and crown retainer
- Match material type
- Pontic code is the same for a natural tooth and implant bridge.



MARYLAND BRIDGE

- Metal Wings (D6545)
- Ceramic Wings (D6548)
- Resin Wings (D6549) – New code for CDT 2015
- Plus Appropriate Pontic Match
- Charge ½ to ¾ Crown Fee for each “Wing”

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ORAL SURGERY

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ROUTINE EXTRACTION

Coronal Remnant: Deciduous Tooth (D7111):

- A remnant is the Crown (no root) of a primary tooth.

Erupted Tooth (D7140):

- Single, multiple, permanent and primary teeth extraction – considered routine

Erupted Root (D7140):

- Code also applies to erupted root removal (not requiring surgical access)

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SURGICAL EXTRACTION (D7210)*

Requires removal of bone and/or section of tooth.

- “Suture” does not count.
- A flap is optional
- Pays about 60% - 90% more than (D7140) due to time and difficulty.
- Document in clinical notes

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SURGICAL EXTRACTION OF RESIDUAL TOOTH ROOTS (D7250)

- Cutting procedure to remove bone/residual roots below gum.
- “Residual” generally means roots left by someone else.
- Use of this code may trigger denial of bridgework or implant coverage due to “missing tooth” clause.
- Common code associated with denture fabrication (removing roots) or use by oral surgeon to remove residual roots left by previous dentist.

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GRAFTS FOR IMPLANTS

- D7950 Graft of Edentulous Area of Mandible or Maxilla-Autogenous or Non-Autogenous, by report. (Includes obtaining Autograft and/or Allograft material. Membrane Extra.
- D7951 “Window” Sinus Augmentation with Bone or Bone Substitutes. (Includes obtaining graft material but excludes membrane, if used).
- D7952 “Vertical punch” sinus augmentation
- D7953 Bone Replacement Graft for extraction or implant removal (01/01/11) site. Does not include membrane, if used. Does not include harvesting bone.

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D7295 Harvest of Autogenous Bone may be used 01/01/11.

FRENUM EXCISION CODES

- ❑ **Frenulectomy (D7960)**
 - ❑ Release of buccal, labial, or lingual frenum “clip and snip”.
 - ❑ Lower fee than D7963.
- ❑ **Frenuloplasty (D7963)**
 - ❑ Excision of frenum plus repositioning of Aberrant muscle and z-plasty or local flap closure.
 - ❑ More complicated and a higher fee than D7960.

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OTHER SURGERY CODES

- ❑ Plasma Rich Protein (D7921)
- ❑ Tooth stabilization after injury (D7270)
- ❑ Soft-Tissue Biopsy* (D7286)
- ❑ OralCDx® Biopsy* (D7288)
- ❑ Excision of Pericoronary Gingiva (D7971)

*For biopsy, wait on pathology report before filing a dental claim.

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OCCLUSAL ORTHOTIC DEVICE (TMJ) - (D7880)

- ❑ Patient exhibiting “signs and symptoms of TMJ.”
- ❑ Treatment is splint, occlusal adjustment, multiple visits
- ❑ Not bruxism which is an occlusal guard (D9940)
- ❑ Generally not paid under dental insurance, except TMJ rider.
- ❑ File medical for payment.*

*Infrequently there is medical reimbursement.

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ORTHODONTICS

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TYPICAL ORTHO CASE TYPES

- ❑ Interceptive Case - Child
 - ❑ fixed, removable (D8060)
- ❑ Limited Case - Adult
 - ❑ fixed, removable, Invisalign® (D8040)
- ❑ Comprehensive Case - Adult
 - ❑ fixed, removable, (D8090) – this is full workup (ceph) and clinical treatment to class I molar relationship

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HABIT APPLIANCE*

- ❑ Removable Appliance Therapy (D8210) – Common Coding Error
- ❑ Fixed Appliance Therapy (D8220) – fixed “rake” in root of mouth

* Harmful habits such as thumb-sucking and tongue thrusting.

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ORTHODONTICS? YES NO

- Extractions
- Transseptal Fiberotomy
- Frenectomy
- Unerupted Tooth Exposure
- Placement of Device (Button)

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ANALGESIA

- D9230-N₂O: Not Payable
- D9248-Non-IV Sedation: Not Payable Generally

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SECTION A FAILED BRIDGE (D9120)

- Section bridge and polish remaining retainer (D9120).
- Charge extraction D7140 plus D9120 for sectioning.

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OCCUSAL GUARD (D9940)

- Not TMJ (D7880) or Athletic Mouth Guard (D9941)
- For Bruxism and Perio Stabilization Only
- Three Types of Occlusal Guards:
 1. D9940A – Soft (suck-down)
 2. D9940B – Hard (lab fee - \$100)
 3. D9940C – NTI

Fee: \$350 - \$650 +Typically 2 or 3 Total Visits

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OCCUSAL GUARD (D9940) (CONTINUED)

- Documentation: Always use a narrative. "Diagnosis = Bruxism"
- Mention Bruxism/Clenching.
- Mention patient has undergone periodontal therapy, if appropriate.
- Six month rule-For Perio coverage, the Occlusal Guard may be required for delivery within six months of SRP or Osseous Surgery.

Note: D4341/D4342 or Osseous Surgery is required for Perio statement.

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TOOTH WHITENING

- Report as upper and lower arch *separately*, at ½ the total fee.
- D9972 In-office only, includes take home trays.
- D9975 Take home trays and strips only.

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SELECTED CDT 2014 CODING CHANGES



CARIES RISK ASSESSMENT AND DOCUMENTATION*

- Three caries risk levels:
 1. D0601 Low Caries Risk
 2. D0602 Moderate Caries Risk
 3. D0603 High Caries Risk

*Not generally reimbursable



PREVENTION PROCEDURE

- D1999 Unspecified preventative, procedure by report*
 - Toothpaste
 - Xylitol Products
 - Devices such as tooth brushes, inter-dental cleaners, and floss

*For take home fluoride, report D9630.



REATTACHMENT OF A TOOTH FRAGMENT

- D2921 Reattachment of tooth fragment, incisal edge or cusp
 - Charge one surface composite
 - Ask for alternative benefit of a one surface restoration
 - Consider D9110 at an emergency visit, as an alternative benefit request



INTERIM THERAPEUTIC RESTORATION - PRIMARY DENTITION

- D2941 Placement of an adhesive restorative material following debridement by hand or other method for the management of early childhood caries. Not considered a definitive restoration.
- This is a very young child procedure
- No anesthetic is used with hand instruments



RESTORATIVE FOUNDATION FOR AN INDIRECT RESTORATION (D2949)

- D2949 Restorative foundation for an indirect restoration
 - Placement of a restorative material to yield a more ideal form including elimination of undercuts
 - It is not a core buildup and generally not reimbursed



NEW ENDO PROCEDURES

- D3427 Periradicular surgery without apicoectomy
- D3428 Bone graft in conjunction with periradicular surgery – per tooth, single site
- D3429 Bone graft in conjunction with periradicular surgery – each additional contiguous tooth in same site.
- D3431 Biological materials in conjunction with periradicular surgery
- D3432 GTR, resorbable barrier, per site, in conjunction with periradicular surgery

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GINGIVAL IRRIGATION (D4921)

- D4921 Gingival irrigation, per quadrant
 - Performed extensively by practices
 - Probably will not be reimbursed
 - The charge is probably not allowed with PPO contracts

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OVERDENTURES (NATURAL TOOTH)

- Maxillary Overdenture
 - D5863 Complete maxillary
 - D5864 Partial maxillary
- Mandibular Overdenture
 - D5865 Complete mandibular
 - D5866 Partial mandibular

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PERIODONTAL MEDICAMENT CARRIER WITH PERIPHERAL SEAL – LABORATORY PROCESSED

- D5944 A custom fabricated laboratory processed carrier that covers the teeth and alveolar mucosa
 - Perio Protect Trays® comply with this code

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SECOND STAGE IMPLANT SURGERY

- D6011 Second stage implant surgery – surgical access
 - Will not generally be reimbursed if the same provider places the implant. Possibly reimbursed better if a different provider performs the second stage surgery, write narrative.
 - If D6011 is reimbursed, the insurance company may have reduced the fee for placing the implant (D6010) around \$200-\$300. Then, the company will pay for the implant (D6010) plus the second surgery (D6013).

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STAY OUT OF JAIL:

EXCEL IN INSURANCE ADMINISTRATION

TYPES OF DENTAL INSURANCE PLANS

1. Traditional dental insurance plan where the insurance company is at risk and is regulated by the state insurance commissioner and includes PPOs.
2. A self-funded plan by the employer has no state oversight. A third-party administrator (TPA) may administer the plan by providing administrative services only (ASO) without the assumption of financial risk. Self-funded plans are large employers, unions, and hospitals.



ERISA TYPE PLAN

- Employment Retirement Income Securities Act (ERISA) – a Federal Law.
- Controls accident and health plans and retirement plans of self-employed and employer's benefit plans.
- Self-funded, not insured plans, are under ERISA. Self-funded plans are often larger employers.
- Can fee cap for non-covered procedures.



EMPLOYEES RIGHTS TO BENEFIT PLANS

- The benefit booklet is called "Summary Plan Description" - 10-20 pages.
- ERISA requires a Benefit Summary Plan (10-20 pages) which is distributed to employees.
- All employees (but not dental offices) may request from Human Resources a copy of the dental benefits plan -50-200 pages.



PREDETERMINATION

- A treatment plan is submitted prior to treatment.
- Payer may notify: eligibility, amounts payable, co-payment, maximums, and covered services.
- However, a predetermination is not binding for payment of the claim.
- Many offices do not file a predetermination but is useful to determine patient responsibility.



PRE-AUTHORIZATION

- This is not a predetermination!
- A treatment plan is submitted prior to treatment with documentation.
- Payer indicates that treatment proposed will be covered under the benefits of the contract.
- Binding as long as patient remains eligible for contracted benefits.
- A pre-authorization may take six weeks for response.
- Write "pre-authorization" across the top of the claim form - - there is no block to check.



OVERBILLING

- Reporting a fee higher than actually charged.
 - Patient pays cash up-front for a discount but the claim form is reported with the full-fee listed.
- Patient pays cash for a new patient discount package but the insurance company is charged the full-fee. The excess is given as a credit against the new patient's account.
- Doctor gives neighbor a 25% discount but full fee goes on the claim form.
 - Crown is billed on the prep date, but not delivered.



CLAIMS FORM FRAUD

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CLAIMS PAYMENT/REPORTED FRAUD

- Intentional manipulation or alteration of facts, which results in a higher insurance payment.

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NATIONAL PRACTITIONER IDENTIFIER (NPI)

- Type 1: Individual or Sole Proprietorship Provider (can be billing entity also)
- Type 2: Corporation or Partnership (billing entity *only*)
 - Associate's claim form submitted always has personal NPI at the bottom of the claim form, not the practice owner/entity NPI.
 - Address of service rendered by the Associate is at the bottom of the claim form, if different from the practice billing address.

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MISLEADING: NPI NUMBER

- Associate's treatment reported under the owner's NPI number for all services – misleading/fraud.
- Associate is not PPO credentialed or Medicaid registered.
- Locum Tenans treatment, reported under the owner's NPI number for all services - misleading.

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MISLEADING: PLACE OF SERVICE

- List the billing address on claim to the left of the claim form.
- At the bottom of claim form, report the place of service, if different from the billing address. Payers set the reimbursement level according to the zip code at the bottom of the claim form. If none, the billing address zip code determines the reimbursement level.

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UNBUNDLING OF PROCEDURES

- CDT 2011/2012 Glossary: "The separating of a dental procedure into component parts with each part having a charge so that the cumulative charge of the components is greater than the total charge to patients who are not beneficiaries of a dental benefit plan for the same procedure."

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UNBUNDLING EXAMPLES

- ❑ Charging extra for a base, liner, or etching for a filling (Amalgam or Composite).
- ❑ Charging for an Alveoloplasty in conjunction with a simple extraction.

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UPCODE

- ❑ CDT 2014 Glossary: "Reporting a more complex and/or higher cost procedure than was actually performed. Also known as overcoding."
- ❑ Examples:
 - ❑ Reporting a surgical extraction instead of an extraction.
 - ❑ Reporting a cast post rather than a prefabricated post.

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MISLEADING: CODING CORE BUILD-UPS

- ❑ One-piece CAD/CAM crown with a "foot" is improperly reported as a separate crown and core build-up.

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CONSUMER FRAUD

- ❑ If a practice participates with two PPOs with family coverage, then the patient is responsible for the lower of the two PPO's contracted fees. Primary-secondary insurance is immaterial in this "patient responsibility" calculation.
- ❑ The practice cannot keep the primary-secondary reimbursements above the practice's full fee. With overpayments above the practice's full fee, check with secondary. If secondary doesn't want the practice's overpayment, then it goes to the patient, which is not a common event.

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PRIMARY-SECONDARY INSURANCE

- ❑ Only determines the sequence of insurance billing.
- ❑ Make no adjustment to patient's account until after secondary has paid.
- ❑ Primary-secondary status does not determine the patient's responsibility. The patient's responsibility is determined by the lower of the contracted fee schedules.
- ❑ Primary payer for a child is determined by which parent whose birthday comes first in the calendar year. The birthday rule can be overridden by a court order (Divorce Agreement).

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MULTI PLAN BENEFITS

- ❑ Coordination of Benefits
 - ❑ Secondary pays in addition to primary.
- ❑ Non-Duplication of Benefits
 - ❑ Secondary does not pay if primary pays equal to secondary payment or greater.

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COORDINATION OF BENEFITS (COB)

- ❑ CDT 2014 Glossary: "A method of integrating benefits payable for the same patient under more than one plan. Benefits from all sources should not exceed 100% of the total charges."



PROMPT PAYMENT LAWS

- ❑ Passed by all states but only applies to insured plans.
- ❑ "Clean Claim" is one with all fields completed and complies with payer's filing (published) requirements.
- ❑ "Clean Claims" must be paid in 30/60 days, according to state law.
- ❑ Prompt Payment Laws do not apply to self-funded (ERISA) plans.
- ❑ Some PPO self-funded contracts spell out the prompt payment policy, however.



INSURANCE "OVERBILLING"

- ❑ Billing a crown on prep-date but never delivered is overbilling.
- ❑ Prep-date billing is commonly a violation of a PPO contract. Read all the contracts!
- ❑ Prep-date billing is ok, according to the ADA claim form, if not a contracted provider. If a contracted provider, then the payer determines the report date for a crown.
- ❑ Always notify, in writing, the payer that the crown was not delivered and why.



If a crown is reported on the prep-date and never delivered, what will the payer do, when notified?

- ❑ Either they want payment returned or don't care.
- ❑ Depends on the "incurred liability date" of the contract.
 - ❑ If "seat date", then they want money back - - the liability is not satisfied.
 - ❑ If "prep-date" then the liability is satisfied and no refund is required.
- ❑ Send the refund amount requested, less the lab bill. Enclose a copy of the related lab bill; some payers will accept the lower payment.



PATIENT GIFTS FOR REFERRAL

- ❑ Prohibited by many state's law.
- ❑ Prohibited by Medicaid or government-funded program.



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INSURANCE CODING CDT 2015 HANDOUT

NEW, REVISED, AND DELETED PROCEDURES FOR CDT 2015

NEW PROCEDURES (SIXTEEN)

CODE	
D0171	RE-EVALUATION – POST-OPERATIVE OFFICE VISIT
D0351	3D PHOTOGRAPHIC IMAGE - This procedure is for dental or maxillofacial diagnostic purposes. Not applicable for a CAD-CAM procedure.
D1353	SEALANT REPAIR – PER TOOTH
D6110	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MAXILLARY
D6111	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MANDIBULAR
D6112	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MAXILLARY
D6113	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR
D6114	IMPLANT /ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH – MAXILLARY
D6115	IMPLANT /ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH – MANDIBULAR
D6116	IMPLANT /ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH – MAXILLARY
D6117	IMPLANT /ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR
D6549	RESIN RETAINER – FOR RESIN BONDED FIXED PROSTHESIS
D9219	EVALUATION FOR DEEP SEDATION OR GENERAL ANESTHESIA
D9931	CLEANING AND INSPECTION OF A REMOVABLE APPLIANCE - This procedure does not include any required adjustments.
D9986	MISSED APPOINTMENT
D9987	CANCELLED APPOINTMENT

CODE REVISIONS (FIFTY - TWO)

CODE	
D0350	2D ORAL/FACIAL PHOTOGRAPHIC IMAGE OBTAINED INTRA-ORALLY OR EXTRA-ORALLY
D0481	ELECTRON MICROSCOPY
D1208	TOPICAL APPLICATION OF FLUORIDE – EXCLUDING VARNISH
D1550	RE-CEMENT OR RE-BOND SPACE MAINTAINER
D2910	RE-CEMENT OR RE-BOND INLAY, ONLAY, VENEER OR PARTIAL COVERAGE RESTORATION
D2915	RE-CEMENT OR RE-BOND INDIRECTLY FABRICATED OR PREFABRICATED POST AND CORE

**CONTINUED
CODE REVISIONS**

D2920	RE-CEMENT OR RE-BOND CROWN
D2975	COPING - A thin covering of the coronal portion of a tooth, usually devoid of anatomic contour, that can be used as a definitive restoration.
D3351	APEXIFICATION/RECALCIFICATION – INITIAL VISIT (APICAL CLOSURE / CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC.) - Includes opening tooth, preparation of canal spaces, first placement of medication and necessary radiographs. (This procedure may include first phase of complete root canal therapy.)
D4249	CLINICAL CROWN LENGTHENING – HARD TISSUE - This procedure is employed to allow a restorative procedure on a tooth with little or no tooth structure exposed to the oral cavity. Crown lengthening requires reflection of a full thickness flap and removal of bone, altering the crown to root ratio. It is performed in a healthy periodontal environment, as opposed to osseous surgery, which is performed in the presence of periodontal disease.
D4260	OSSEOUS SURGERY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP AND CLOSURE) – FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT - This procedure modifies the bony support of the teeth by reshaping the alveolar process to achieve a more physiologic form during the surgical procedure. This must include the removal of supporting bone (ostectomy) and/or non-supporting bone (osteoplasty). Other procedures may be required concurrent to D4260 and should be reported using their own unique codes.
D4261	OSSEOUS SURGERY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP AND CLOSURE) – ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT - This procedure modifies the bony support of the teeth by reshaping the alveolar process to achieve a more physiologic form during the surgical procedure. This must include the removal of supporting bone (ostectomy) and/or non-supporting bone (osteoplasty). Other procedures may be required concurrent to D4261 and should be reported using their own unique codes.
D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN - A single crown restoration that is retained, supported and stabilized by an abutment on an implant.
D6059	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL) - A single metal-ceramic crown restoration that is retained, supported and stabilized by an abutment on an implant.
D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINANTLY BASE METAL) - A single metal-ceramic crown restoration that is retained, supported and stabilized by an abutment on an implant.
D6061	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL) - A single metal-ceramic crown restoration that is retained, supported and stabilized by an abutment on an implant.
D6062	ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL) - A single cast metal crown restoration that is retained, supported and stabilized by an abutment on an implant.
D6063	ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINANTLY BASE METAL) - A single cast metal crown restoration that is retained, supported and stabilized by an abutment on an implant.
D6064	ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL) - A single cast metal crown restoration that is retained, supported and stabilized by an abutment on an implant.
D6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN - A single crown restoration that is retained, supported and stabilized by an implant.

CONTINUED CODE REVISIONS	
D6066	IMPLANT SUPPORTED PORCELAIN FUSED TO METAL CROWN (TITANIUM, TITANIUM ALLOY, HIGH NOBLE METAL) - A single metal-ceramic crown restoration that is retained, supported and stabilized by an implant.
D6067	IMPLANT SUPPORTED METAL CROWN (TITANIUM, TITANIUM ALLOY, HIGH NOBLE METAL) - A single cast metal or milled crown restoration that is retained, supported and stabilized by an implant.
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD - A ceramic retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant.
D6069	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL) - A metal-ceramic retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant.
D6070	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINANTLY BASE METAL) - A metal-ceramic retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant.
D6071	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL) - A metal-ceramic retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant.
D6072	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL) - A cast metal retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant.
D6073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINANTLY BASE METAL) - A cast metal retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant.
D6074	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL) - A cast metal retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant.
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD - A ceramic retainer for a fixed partial denture that gains retention, support and stability from an implant.
D6076	IMPLANT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (TITANIUM, TITANIUM ALLOY, OR HIGH NOBLE METAL) - A metal-ceramic retainer for a fixed partial denture that gains retention, support and stability from an implant.
D6077	IMPLANT SUPPORTED RETAINER FOR CAST METAL FPD (TITANIUM, TITANIUM ALLOY, OR HIGH NOBLE METAL) - A cast metal retainer for a fixed partial denture that gains retention, support and stability from an implant.
D6092	RE-CEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN
D6093	RE-CEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE
D6094	ABUTMENT SUPPORTED CROWN - (TITANIUM) - A single crown restoration that is retained, supported and stabilized by an abutment on an implant. May be cast or milled.
D6101	DEBRIDEMENT OF A PERI-IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT, AND SURFACE CLEANING OF THE EXPOSED IMPLANT SURFACES, INCLUDING FLAP ENTRY AND CLOSURE
D6102	DEBRIDEMENT AND OSSEOUS CONTOURING OF A PERI-IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT AND INCLUDES SURFACE CLEANING OF THE EXPOSED IMPLANT SURFACES, INCLUDING FLAP ENTRY AND CLOSURE

CONTINUED CODE REVISIONS	
D6103	BONE GRAFT FOR REPAIR OF PERI-IMPLANT DEFECT – DOES NOT INCLUDE FLAP ENTRY AND CLOSURE. PLACEMENT OF A BARRIER MEMBRANE OR BIOLOGIC MATERIALS TO AID IN OSSEOUS REGENERATION ARE REPORTED SEPARATELY
D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD (TITANIUM) - A retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant. May be cast or milled.
D6930	RE-CEMENT OR RE-BOND FIXED PARTIAL DENTURE
D7285	INCISIONAL BIOPSY OF ORAL TISSUE-HARD (BONE, TOOTH) - For partial removal of specimen only. This procedure involves biopsy of osseous lesions and is not used for apicoectomy/periradicular surgery. This procedure does not entail an excision.
D7286	INCISIONAL BIOPSY OF ORAL TISSUE-SOFT - For partial removal of an architecturally intact specimen only. This procedure is not used at the same time as codes for apicoectomy/periradicular curettage. This procedure does not entail an excision.
D7292	SURGICAL PLACEMENT OF TEMPORARY ANCHORAGE DEVICE [SCREW RETAINED PLATE] REQUIRING FLAP; INCLUDES DEVICE REMOVAL
D7293	SURGICAL PLACEMENT OF TEMPORARY ANCHORAGE DEVICE REQUIRING FLAP; INCLUDES DEVICE REMOVAL
D7294	SURGICAL PLACEMENT OF TEMPORARY ANCHORAGE DEVICE WITHOUT FLAP; INCLUDES DEVICE REMOVAL
D8660	PRE-ORTHODONTIC TREATMENT EXAMINATION TO MONITOR GROWTH AND DEVELOPMENT - Periodic observation of patient dentition, at intervals established by the dentist, to determine when orthodontic treatment should begin. Diagnostic procedures are documented separately.
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT
D8693	RE-CEMENT OR RE-BOND FIXED RETAINER
D9221	DEEP SEDATION/GENERAL ANESTHESIA – EACH ADDITIONAL 15 MINUTES
D9241	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA – FIRST 30 MINUTES - Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider’s documentation of the anesthetic’s effects upon the central nervous system and not dependent upon the route of administration.
D9242	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA – EACH ADDITIONAL 15 MINUTES
D9248	NON-INTRAVENOUS MODERATE (CONSCIOUS) SEDATION - A medically controlled state of depressed consciousness while maintaining the patient’s airway, protective reflexes and the ability to respond to stimulation or verbal commands. It includes non-intravenous administration of sedative and/or analgesic agent(s) and appropriate monitoring. The level of anesthesia is determined by the anesthesia provider’s documentation of the anesthetic’s effects upon the central nervous system and not dependent upon the route of administration.
CODE DELETIONS (FIVE)	
CODE	
D6053	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR COMPLETELY EDENTULOUS ARCH
D6054	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH

**CONTINUED
CODE DELETIONS**

D6078	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR COMPLETELY EDENTULOUS ARCH - A prosthesis that is retained, supported and stabilized by implants or abutments placed on implants but does not have specific relationships between implant positions and replacement teeth; may be screw retained or cemented; commonly referred to as a "hybrid prosthesis."
D6079	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH - A prosthesis that is retained, supported and stabilized by implants or abutments placed on implants but does not have specific relationship between implant positions and replacement teeth; may be screw retained or cemented; commonly referred to as a "hybrid prosthesis"
D6975	COPING - To be used as a definitive restoration when coping is an integral part of a fixed prosthesis.

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