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

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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 $120 Billion industry and corporate dentistry will increase.
  It is compounding from $8 billion of revenues (largest corporations) - -
  About 3,500 location - - A tipping point!

DIAGNOSTIC CODING AND THE DENTAL CLAIM FORM

- ICD – code set used to communicate to the payer a diagnosis – “Why” the procedure is necessary.
- ICD codes have been required for medical claims for many years.
- The 2012 ADA Dental Claim Form has space for up to four diagnoses codes – ICD-10-CM.
- Some Medicaid and ACA plans with embedded pediatric benefits currently require ICD diagnostic codes.
- ICD may decrease the need to attach lengthy narratives.

ICD-10-CM IS HERE!

- ICD-10-CM (over 70,000 codes)
- Not about getting the claim paid – but ensuring quality patient care.
- Medical necessity – much more medically related than dental procedure reporting.
- Document, document, document!
2012 ADA DENTAL CLAIM FORM

SCENARIO – BASED TEACHING METHOD

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

This presentation is for informational training purposes only, the information contained in this presentation is not to be considered legal advise. Presenter is not a licensed attorney.

For legal advise, consult a healthcare attorney.

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 49 changes for 2017
- There are over 600 codes under CDT 2017

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.
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.
- Makeup codes – below D0120

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.

*Insurance companies commonly downgrade D0180 to D0120.

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.

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.

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.
OTHER EVALUATION-TYPE CODES

- Detailed & Extensive (Follows D0150/D0180) D0160
- Re-Evaluation (Limited) (Follows D0140/D0150/D0180) D0170
- Re-Evaluation (Post-Operative Office Visit) D0171
- Consultation-Referred by DDS/MD Not a patient self-referral D9310
- Case Presentation D9450

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.

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

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.

COMMON X-RAY LIMITATIONS

- DDS must order all x-rays – No protocol
- Full Series or Pan – Every 3 or 5 years
- Maximum x-ray reimbursement – full series UCR. Maximum bitewing reimbursement – four bitewings limitation at recall visit
- Bitewings – once per year/twice for children? Narratives for periapicals with BWX.
- Vertical bitewings – 7-8 films (D0277) may pay 80% of full series fee but may count under full series limitation rules. May downgrade to 4BWX in some cases.

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.
**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 (either) at an emergency visit to "get it out of the way".

**CONE BEAM CT**

- Various new codes
- Image capture and interpretation – D0364-D0368
- Image capture only – D0380-D0384
- Interpretation and report only – D0391

Note: Proper code is determined based on the field of view captured.

**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

**RECALL**

**Child Prophylaxis:**
- Child prophylaxis (D1120)
  - Primary or transitional dentition
  - 2 Bitewings (D0272) generally until second molars are erupted.

**Adult Prophylaxis:**
- Adult prophylaxis (D1110)*
  - Transitional or permanent dentition
  - 3 Bitewings (D0273)
  - 4 Bitewings (D0274)

*74 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.

**NEW SCALING CODE D4346**

- Moderate or severe gingival inflammation.
- Oral evaluation is performed prior to service.
- No bone loss prior to service.
- Document with intraoral camera.
- Followed by prophylaxis after interval set by doctor (2-6 weeks).

**ADULT PROPHY (D1110)**

- Extended prophylaxis
- Adult prophylaxis (*routine*)
- Teenage prophylaxis
- Brief prophylaxis (*partial*)
- D8999 Utilization
**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)
  - Excludes Fluoride Varnish.

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

**Caries Risk Assessment and Documentation**

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

*Report with adult fluoride, six month interval bitewings, and periapicals taken with IWX.

*Not generally reimbursable and reported with “zero” fee.

**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.

**Restorative Definitions**

- Don’t charge for liners, bases and etching (included). Payers will not pay pulp caps with restorations on same day.
- Operative restorations are in occlusion and have adjacent contact, if applicable.
- Posterior Amalgam/Composite Restoration: Caries and prep must be in the Dentin!
“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.

DEFINITION

INCISAL “EDGE” OR INCISAL “ANGLE”?

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

INCISAL ANGLE
- 4 Surface D2335 (MIFL/DIFL)

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

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.

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
### Onlay/Crown Criteria

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

### 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

### Crown Buildup 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.”
- “65% of the tooth was missing.”
- “The tooth was endodontically treated on mm/dd/yy”. Enclosed is completed endo radiograph.

### Prefab Post/Cast Buildups

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

### Endodontic Access Closure

- Report occlusal restoration (D2140/D2330/D2391) not crown repair (D2980).
- If crown is removed then a core buildup (D2950) or prefab post and core (D2954) placed, then it is ok to report.
- Don’t use crown repair D2980. Must be “necessitated by restorative material failure.”
**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

**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.

**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)**

- Dentist schedule is interrupted
- “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 (not always true).
- Some carriers re-map (D3221) to the Palliative (D9110) code for payment.

**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.

CROWN LENGTHENING (D4294)*

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- 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 prophylaxis (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

- D0171-If DDS checks the patient. Evaluation subject to frequency limitations.
- D0180-If DDS checks the patient. Evaluation is subject to frequency limitations. D0180 has higher UCR than D0171.
- 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 visit.

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 reported per tooth. Fee varies with number of sites placed.
- Arestin® may be payable by pharmacy benefit plan of medical insurance.

WHAT'S THE DIFFERENCE IN A PROPHYLAXIS (D1110) AND PERIODONTAL MAINTENANCE VISIT (D4910)?

<table>
<thead>
<tr>
<th>PROPHYLAXIS (D1110)</th>
<th>PERIODONTAL MAINTENANCE (D4910)</th>
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<tbody>
<tr>
<td>Preventative in nature</td>
<td>Therapeutic (treatment) in nature</td>
</tr>
<tr>
<td>Less time required</td>
<td>More time required</td>
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<tr>
<td>Lower fee</td>
<td>Higher fee</td>
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<tr>
<td>Scaling &amp; Polishing</td>
<td>Scaling &amp; Root Planing (site specific) &amp; Polishing</td>
</tr>
<tr>
<td>Less frequent probing and charting</td>
<td>More frequent probing and charting</td>
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Periodontal Maintenance is therapeutic and is treating periodontal disease by performing site specific scaling and root planing. This will assist the patient in understanding the difference. 50 min should be allowed for a clean mouth adult prophy and 1 hour should be allowed for periodontal maintenance. This time allowance difference will also help distinguish between prophy and perio maintenance.
**IMMEDIATE DENTURES**

- 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.

**PARTIALS – FIVE 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.
5. Immediate Partial (D5221/D5222/D5223/D5224)

**“FLIPPER PARTIAL”**

- Can be either Resin Partial (D5211/D5212), Valplast Partial (D5225/D5226).
- Interim Partial (D5820/D5821), depending on use
- "Proper code depends on “life” expectancy and use of partial.

**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.

**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.

**CLEANING AND INSPECTION OF DENTURES**

- Complete Dentures D9932/D9933
- Partial Dentures D9934/D9935
  - Document that doctor inspected the denture and doctor ordered the denture to be cleaned
  - Does not include any adjustment – report separately

Note: D9931 cleaning and inspection of a removable appliance is a deleted code.
**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 reporting this code

**IMPLANTS**

**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.
- Full arch alternative benefit for multiple teeth missing in the arch.

**SURGICAL IMPLANT PLACEMENT (ENDOSTEAL IMPLANT)**

- D6010 Full Size Implant-$1,700 - $2,200
- D6013 Mini Implant-one-half the fee

**SECOND STAGE IMPLANT SURGERY**

- D6011 Second stage implant surgery – surgical access
  - May not 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. Under these circumstances, the payer will pay for the implant (D6010) plus the second stage surgery (D6013).

**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.
**Implant Charge Out Possibilities**

- Abutment Placement for Abutment-Supported Crown*
  - Interim Abutment (D6051)
  OR
  - Prefabricated Abutment (D6056)
  OR
  - Custom Abutment (D6057)

  *Provider must place the abutment to report it.

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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**

- D6085-Provisional Implant Crown.
- Interim Abutment (D6051)-A healing cap is not an Interim Abutment.

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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
- Natural tooth Overdenture codes are complete (D5863 and D5864) and Partial Overdenture (D5865 and D5866)
- D6053 and D6054 are deleted codes (D6110/D6111/D6112/D6113)
- There are new complete overdenture codes (D6110/D6111)
- There are new partial overdenture codes (D6112/D6113)
OVERDENTURE LOCATOR CODES

- Mini-Implant Type Overdenture – D6110/D6111
- D5862 Mini-Implant Cap embedded in overdenture.
- Full-Size Type Implant Overdenture – D6110/D6111
- D6052 semi-precision attachment abutment with keeper assembly
  "D5862 and D6052 are an 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).
- D6091 Replacement of Semi-Precision or Precision Attachment (male or female component of Implant/Abutment supported Prosthesis, per attachment).
- D6095 Repair Implant Abutment, by report (any part of Prefabricated [D6056] or custom [D0657] Abutment).
  Note: D6095 for replacement of screw, if used to affix abutment to implant body. D6199 if the screw affixes the crown directly to the implant body.

BRIDGEWORK

- 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”
**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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**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
- Intraoral camera images to document

*Surgical extraction

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**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.
- D6104: bone graft at the time of implant placement.
- 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.
- D7295: Harvest of Autogenous Bone may be used 01/01/11.

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**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.
OTHER SURGERY CODES

- Tooth stabilization after injury (D7270)
- Soft-Tissue Biopsy* (D7286)
- Excision of Pericoronal Gingiva (D7971)

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

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.

ORTHODONTICS

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 a clinical treatment leading to an improvement of a patient's craniofacial dysfunction, which may include anatomical, functional and/or esthetic relationships.

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.

ORTHODONTICS?  ⚫ YES  ⬜ NO

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

- D9223-Deep sedation/general anesthesia-each 15 minute increments.
- D9243-Intravenous moderate conscious sedation/analgesia-each 15 minute increments.

ANALGESIA

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

SECTION A FAILED BRIDGE (D9120)

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

OCCLUSAL GUARD (D9940)

- Not TMJ (D7880) – bill to medical
- 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
- D9943 – Occlusal guard adjustment
  Fee: $350 - $650 + Typically 2 or 3 Total Visits

OCCLUSAL 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. Narrative: “Type III perio osseous surgery on 1/1/XX.”
- Note: D4341/D4342 or Osseous Surgery is required for Perio statement.

TOOTH WHITENING

- Report as upper and lower arch separately, at 1/2 the total fee.
- D9972 In-office only. includes take home trays.
- D9975 Take home trays and strips only.
NEW PROCEDURE CODES SUMMARY

- D0411 - HbA1c in-office point of service testing
- D5511 - Repair broken complete denture base, mandibular
- D5512 - Repair broken complete denture base, maxillary
- D5611 - Repair resin partial denture base, mandibular
- D5612 - Repair resin partial denture base, maxillary
- D5621 - Repair cast partial framework, mandibular
- D5622 - Repair cast partial framework, maxillary
- D6096 - Remove broken implant retaining screw
- D6118 - Implant/abutment supported interim fixed denture for edentulous arch – mandibular
- D6119 - Implant/abutment supported interim fixed denture for edentulous arch – maxillary
- D7296 - Corticotomy – one to three teeth or tooth spaces, per quadrant
- D7297 - Corticotomy – four or more teeth or tooth spaces, per quadrant
- D7979 - Non-surgical sialolithotomy
- D8695 - Removal of fixed orthodontic appliances for reasons other than completion of treatment
- D9222 - Deep sedation/general anesthesia – first 15 minutes
- D9239 - Intravenous moderate (conscious) sedation/analgesia – first 15 minutes
- D9995 - Teledentistry – synchronous; real-time encounter
- D9996 - Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review

STAY OUT OF JAIL:
EXCEL IN INSURANCE ADMINISTRATION

“Insurance administration is more complicated than coding.”

CHARLES BLAIR, DDS
Coding is the same for in or out-of-network dentists! There is no difference in reporting the codes whatsoever.

The administration of claims is very different whether in or out-of-network!

All states have insurance fraud statutes.

“All persons 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)

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

Note: PPO Contracts and the “incurred liability date” of the dental plan “trump” the ADA claim form and control.
**Patient Discounts**

- On a limited basis, generally ok.
  - For instance, 50% off for employee spouse, grandmother, minister, etc.
  - If insurance is involved, what is the fee entered on the claim? Enter the actual fee charged the patient on the 2012 ADA Dental Claim Form in Box 31 for each procedure.

**Co-Pay and Deductible Forgiveness**

- Most states prohibit co-pay forgiveness whether by law or general insurance statutes.
- Government plans (FEDVIP, Medicare, Military Dependents, etc.) prohibit co-pay forgiveness.
- Virtually all PPOs prohibit co-pay forgiveness by contract!

**Co-Pay Forgiveness**

- The “ADA Principles of Ethics and Code of Professional Conduct” discusses co-pay forgiveness in section 5.B.
  
  **5.B. Representation of Fees.**
  Dentists shall not represent the fees being charged for providing care in a false or misleading manner.

  **Advisory Opinions**
  
  **5.B.1. Waiver of Copayment.**
  A dentist who accepts a third-party payment under a copayment plan as payment in full without disclosing to the third-party that the patient’s payment portion will not be collected, is engaged in overbilling. The essence of this ethical impropriety is deception and misrepresentation; an overbilling dentist makes it appear to the third-party that the amount to be paid to the patient for services rendered is higher than it actually is.

**Co-Pay Forgiveness**

- Patients accept responsibility to pay the copayment by signing Box 36 of the ADA dental claim form, which states the following:
  “I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges.”
**CO-PAY FORGIVENESS AND DEDUCTIBLE**

- If you “forgive” the co-pay in an isolated situation, the remarks section of the claim should read:
  
  “The patient is not participating in the cost of treatment.”

  Note: Always disclose co-pay and deductible forgiveness to the third-party.

**AUDITS**

**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.

**AUDIT ELEMENTS (CONTINUED)**

- That the clinical protocol for non-insurance patients was the same clinical protocol for insurance patients in similar circumstances.
- 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.

**WHO CAN BE AUDITED?**

- In-network dentists can be audited by mail or in-office (with proper notice).
- Out-of-network dentists may be audited by mail only for claims actually filed. A court order is necessary for the payer to go on the premises.
- All dentists can be audited in any respect by the State Board of Dentistry.

**ON-SITE AUDITS**

- PPO must give proper notice (2 – 3 days).
- Can just about check everything: cleanliness, sterilization, ledger cards, patient records, etc.
- Can check for consistent billing, clinical, and financial protocol.
CAN YOU LEGALLY . . .

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

TWO CATEGORIES OF PATIENTS WITH DENTAL INSURANCE

- Subject to state law and insurance commissioner.
- Individual plan.
- Small business plans.
- Insurance company is “at risk”.

- Under federal law, not subject to state law or insurance commissioner.
- Large companies, hospitals, unions, school teacher, etc.
- Generally administered by a third-party administrator (TPA).

ERISA TYPE PLAN (SELF-FUNDED)

- 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 larger employers, unions, hospital systems, school teachers, etc.

SELF-FUNDED PLANS (UNDER FEDERAL LAW)

- Third Party Administrator (TPA) – insurance company
  - Provides actuary to design the dental plan to fit the employer’s budget ($/employee). A trust fund is funded quarterly.
  - Provides a low cost provider PPO network.
  - Processes dental claims at a fixed rate (i.e., $7/claim). Audits the providers by mail and in-office audits, as contracted.
**INSURANCE 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 patient’s 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.

- Billing insurance more than cash patients under similar circumstance.
- Billing insurance then writing off, if they don’t pay.
  - Example: Routinely billing fluoride 2 times a year, but writing off if insurance doesn’t pay but one time.
- Billing insurance but forgiving the co-pay/deductible.

**CLAIMS FORM FRAUD**

- Billing a crown on prep-date but never delivered is overbilling.
- Prep-date billing is typically a violation of a PPO contract. Read all the contracts and processing policy manuals!
- Prep-date billing is ok, according to the ADA claim form, however, the incurred liability date of the dental plan document determines the billing date. If a contracted provider, then the PPO contract determines the report date for a crown.

**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 dental plan document.
  - 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.
CLAIMS PAYMENT/REPORTED FRAUD

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

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.

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 Tenants treatment, reported under the owner’s NPI number for all services – misleading unless reported to the payer.

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.

UNBUNDLING OF PROCEDURES

- CDT 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.”
**UNBUNDLING EXAMPLES**

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

**UPCODE**

- CDT 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.

**MISLEADING: CODING CORE BUILD-UPS**

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

**INSURANCE BASICS**

**ASSIGNMENT OF BENEFITS**

- Authorization by the patient directing the payer to provide all reimbursements directly to the doctor.
- May or may not be honored by the payer – depends on state law and type of plan.

**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 it is very useful to determine “patient responsibility”.

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**DENIED CLAIMS**

- Determine if the EOB claim is rejected or denied.
- If denied, determine the reason for denial – i.e., plan contract limitations and exclusions, additional supporting information needed, incorrect code reported, etc.
- Appeal the denial following the payer’s appeal instructions.

**REFUNDS**

- Patient refunds.
  - Document on ledger if patient request credit to remain on account.
  - Generate and review credit balance AR report to ensure prompt payments are issued.
  - PPO contract regarding timely refund once claim is adjudicated.
- Payer refunds.

**DENTAL BENEFITS PLAN**

<table>
<thead>
<tr>
<th>Summary Plan Description</th>
<th>Plan Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Not comprehensive.</td>
<td>□ The payer pays claims based on coverage as outlined in the plan document.</td>
</tr>
</tbody>
</table>

Note: Only the employee may obtain a copy of the plan document from Human Resources under the U.S. Department of Labor laws. A nominal copying charge may be required.

If the plan is an individual plan, the subscriber may obtain directly from the payer.

**QUIZ**

**Coordination of Benefits Calculation**

**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 financial responsibility is determined by the lower of the contracted fee schedules.

**PRIMARY-SECONDARY SUBMISSION**

- **Child**
  - Birthday Rule: Parent with earliest birthday date is primary.
- **Adult**
  - The adult patient receiving the care is always “primary”.
  - Gender Rule: Man is primary. (Generally the birthday rule applies).
**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 **irrelevant** in this “patient responsibility” calculation.
- The practice cannot keep the primary-secondary reimbursements above the practice’s full fee as submitted on the claim form. 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.

**TWO TYPES OF MULTI PLAN COVERAGE**

1. Coordination of Benefits (Good)
   - Secondary pays in addition to primary.
2. Non-Duplication of Benefits (Bad)
   - Secondary does not pay if primary pays equal to secondary payment or greater.

**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.

**RECORDKEEPING**

- Patient records
- Documentation
- Charting
- Record Retention

**SPECIAL PLANS**

**MEDICAID**
**MEDICAID CONTRACT BASICS**

- Processing Policy Manual – get it!
- Dental insurance is always primary and the Medicaid patient never pays a deductible/co-pay.
- Medicaid requires the insurance EOB be sent. If insurance does not pay, then Medicaid pays if it is a covered expense or pays any balance up to the Medicaid fee.

**RAC – RECOVERY AUDIT CONTRACTOR PROGRAM**

Auditors are “on commission” – an adversarial relationship?

**MEDICARE**

- Mandatory filing requirement.
- Ordering and referring requirements.
- Writing prescriptions – January 1, 2019 – implementation date.
  - Although the deadline has been extended, the notice issued by CMS once again specifically states that the requirement includes dentists.
- Medicare Advantage Plans.

**PPO HANDCUFFS**

<table>
<thead>
<tr>
<th>Contract</th>
<th>Processing Policy Manual</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-8 Pages</td>
<td>150+ Pages.</td>
</tr>
<tr>
<td>States that the provider must adhere to the PPO processing policy manual.</td>
<td>Spells out the payer’s processing policy on many matters.</td>
</tr>
<tr>
<td></td>
<td>Must report all services – can fee cap non-covered services</td>
</tr>
<tr>
<td></td>
<td>Co-pay forgiveness is prohibited</td>
</tr>
</tbody>
</table>
PPO PROCESSING POLICY MANUAL (CONTINUED)

- Must give PPO either PPO fee, or practice fee, if lower.
  - Example: $99 special fee for August?
  - Everybody gets it.
- Requires that all procedures must be completed before billing PPO.
  - Example: Crowns, must be delivered and dentures before billing.
  - Prep date is not ok.
- Must bill PPO same clinically.
  - Example: Cannot do pans at age 6, if PPO and then age 10, if cash pay.

DELTA DENTAL PROCESSING POLICY MANUALS (2)

1. Local Manual
   - For policies sold in-state by the local Delta.

2. Delta USA
   - National contracts.
  - i.e. Coke-Cola, Walmart, etc.

Note: Both manuals may be downloadable on the password-protected Delta Website.

WHY ARE PPO FEES ENTERED INTO THE COMPUTER?

PPO fees are entered to calculate and communicate "patient responsibility" NOT to file claims.

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 negotiated fees.
- Determine write-offs for each plan to compare.

FEE CAPPING FOR NON-COVERED SERVICES

- PPOs require all charges (i.e., tooth whitening, veneers, ortho, crowns charged beyond insurance benefits) be submitted to the PPO.
- The PPO can “fee cap” for non-covered expenses.
- 36 states have passed laws prohibiting fee capping but applies to insured plans (25%).
- Self-funded plans are under federal law and exempt from state law.

OPTIONAL SERVICES

- The Processing Policy Manual (obtained on PPO website) often spells out optional services.
- Can be plan specific or PPO specific.
- Dental plan supersedes PPO contract provisions.
NEGOTIATING PPO FEES

- Third-party negotiation services.
- Doctor only negotiations.
- Delta generally does not negotiate.
- Some payers may refuse to negotiate with a third party.

EOB LANGUAGE

- Deny: Delta will not pay but patient is responsible for payment.
- Disallow: Delta will not pay and patient may not be charged.

MANAGED CARE ASSESSMENT

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

VIOLATION OF PPO CONTRACT

- Considered unethical conduct by all state boards.
- If PPO violations are reported to the State Board of Dentistry, they must investigate.

MISCELLANEOUS ADMINISTRATION

PATIENT GIFTS FOR REFERRALS
**PATIENT GIFTS FOR REFERRAL**

- Gifts can be drawings, gift cards, dinner for two, etc.
- Prohibited by many state’s law.
- Both patients and staff may apply to these laws.
- Prohibited by Medicaid, Medicare, federal employees, military dependents government-funded programs.

Note: A $10 gift card may be given quarterly to Medicaid patients.

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**UNCLAIMED PROPERTY - OFFICE**

- Unclaimed property (bank accounts, stock accounts, receivables, etc.) if abandoned, must be turned over to the state unclaimed property office.
- All dentists are subject to unclaimed property laws.
- If a patient cannot be contacted during a “holding period” (depends on state law and is typically 1-3 years), the money must be sent to the state’s Unclaimed Property Office.
- The patient can petition (with identification) the property office for their money back.

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**IN-HOUSE DISCOUNT PLANS**

- **Discount Plan (Savings Plan):**
  - Availability will greatly increase.
  - Membership Concept – Flat fee for two checkups and 15% - 20% off for treatment.

- **Discount Card:**
  - Percentage Discount Card – Typically 15% - 20% for private practice.
**SPECIALIST IN OFFICE?**

- GP entity does billing, then any payment arrangement is ok.
- Specialist is given W-2 (if employee) or 1099 to the specialist LLC or corporation – this is not fee splitting.
- If specialist does patient billing then…the specialist must pay a fixed FMV rent payment. Paying a rent based on the specialist’s collections is fee splitting.

**INTERPRETATION SERVICES**

- Dental practices receiving certain HHS government funds such as Medicaid or CHIP, Medicare Advantage, etc. then must provide interpretation services free of charge.
- Effective October 16, 2016, dentists must post a notice of nondiscrimination offering free interpretation services for the top 15 languages spoken in your state. Notice must be displayed in the top 15 languages spoken in your state.
- Notice posted on website, in-office, brochures, patient communications, etc.