# ADVANCED DENTAL BILLING 2016

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## CODES:

**DIAGNOSTIC D0120-D0999**

## REVISIONS:

**NO CHANGES**

## NEW CODE:

**D0414**
Laboratory Processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report.

**D0600**
Non ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure and enamel, dentin, and cementum.

## DELETED:

**D0290**
Posterior-anterior or lateral skull and facial bone survey radiographic image.

**D1110-D1999**
Preventive dental prophylaxis

## REVISIONS:

**D1510**
Excluded a distal shoe space maintainer.

## NEW CODE:

**D1575**
Fabrication and delivery of fixed appliance extending subgingivally and distally to guide the eruption of the first permanent molar. Does not include ongoing follow up or adjustments or replacement appliances, once the tooth has erupted.

## DELETED:

**NO CHANGES**

## D2140-D2999 RESTORATIVE

NO CHANGES

## D3110-D3999 ENDODONTICS

NO CHANGES

## D4210-D4999 PERIODONTICS

## NEW CODE:

**D4346**

The removal of plaque, calculus and stains from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation in the absence of periodontitis. It is indicated for patients who have swollen, inflamed gingival, generalized suprabony pockets, in moderate to severe bleeding on probing. Should not be reported in conjunction with prophylaxis, scaling and root planing, or debridement procedures.

## REVISIONS:

**D4263**

The Procedure involves the use of graphs to stimulate periodontal regeneration when the disease process has led to a deformity of the bone. This procedure does not include flat entry and closure, wound debridement, osseous contouring, or the placement of biologic materials to aid in osseous tissue regeneration or barrier membranes. other separate procedures delivered concurrently are documented with their own codes. not to be reported for an edentulous space or and extraction site.

**D4264**

This Procedure involves the use of graphs to stimulate periodontal regeneration when the disease process has led to a deformity of the bone. This procedure does not include flat entry and closure, wound debridement, osseous contouring, or the placement of biologic materials to aid in osseous tissue regeneration or barrier membranes. other separate procedures delivered concurrently are documented with their own codes. not to be reported for an edentulous space or and extraction site.

**D4274**
This procedure is performed in an edentulous area adjacent to the tooth, allowing removal of the tissue wedge to gain access for debridement, permit close flap adaptation, and reduce pocket depths.

## DELETED:

**NO CHANGES**

## D5110-D5899 PROSTHODONTICS

**NO CHANGES**

## D6010-D6199 IMPLANT SERVICES

## NEW CODE:

**D6081**
This procedure is not performed in conjunction with D1110 or D4910.

**D6085**
Use when a period of healing is necessary prior to fabrication and placement of permanent prosthetic.

## DELETED:

**NO CHANGES**

## D7111-D7999 ORAL & MAXILLOFACIAL SURGERY

## REVISIONS:

**D7140**
Includes removal of tooth structure, minor smoothing of socket bone, and closure: as necessary.

**D7210**
Includes related cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure.

**D7250**
Includes cutting of soft tissue and bone, removal of tooth structure, and closure.

**D7280**
An incision is made and the tissue is reflected and bone removed as necessary to expose the crown of an impacted tooth not intended to be extracted.

**D7292**
Placement of temporary anchorage device [screw retained plate] required flap: included device removal.

**D7293**
Placement of temporary anchorage device includes device removal

**D7294**
Placement of temporary anchorage device without flap includes device removal

**D7310**
The Alveoloplasty is distinct from extraction. usually in preparation for prosthesis or other treatments such as radiation therapy and transplant surgery.

**D7485**
Reduction of osseous tuberosity.

**D7610**
Teeth may be wired, banded or splinted together to prevent movement. incision required for intraosseous fixation.

**D7630**
Teeth may be wired, banded or splinted together to prevent movement. incision required to reduce fracture.

**D7710**
Incision required to reduce fracture

**D7730**
Incision required to reduce fracture

**D7750**
Incision required to reduce fracture

**D7770**
Fractured bones are exposed to mouth or outside the face. Incision required to reduce fracture

**D7780**
Incision required to reduce fracture. facial bones include upper and lower jaw, cheek, and bones around eyes, nose and ears.

**D7840**
Removal of all or portion of the mandibular condyle (separate procedure)

**D7873**
Removal of adhesions using the arthroscopic and leverage of joint cavities.

**D7874**
Repositioning and stabilization of disk using arthroscopic techniques.

**D7875**
Removal of disk and remodeled posterior attachment via the arthroscope.

**D7877**
Removal of pathologic hard and, or soft tissue using the arthroscope.

**D7945**
Sectioning of lower jaw. this includes bones cut, fixation, routine wound closure and normal postoperative follow up care.

**D7946**
Sectioning of the upper jaw. this includes exposure, bone cuts, downfracture, repositioning, fixation, routine wound closure and normal postoperative follow up care.

**D7948**
Sectioning of upper jaw. this includes exposure, bone cuts, down fracture, segmentation of maxilla, repositioning, fixation, routine wound closure and normal postoperative follow up care.

**D7960**
Removal or release of mucosal and muscle elements of a buccal labial or lingual frenum that is associated with a pathological condition, or interferes with proper oral development and treatment.

**D7971**
Removal of inflammatory or hypertrophied tissues surrounding partially erupted/ impacted teeth.

**D7982**
Procedure for repair of a defect and/or restoration of a portion of a salivary gland duct.

**D7983**
Closure of an opening between a salivary duct and/or gland and the cutaneous service, or an opening into the oral cavity through other than normal anatomic pathway.

**D7990**
Formation of a tracheal opening usually below the cricoid cartilage to allow for respiratory exchange.

**D7991**
Removal of the coronoid process of the mandible.

## D8010-D8999 ORTHODONTICS

**NO CHANGES**

## D9110-D9999 ADJUNCTIVE GENERAL SERVICES

## NEW PROCEDURE:

**D9311**
Treating dentist consults with a medical health care concerning medical issues that may affect patient's plan dental treatment.

**D9991**
Individualized efforts to assist a patient to maintain scheduled appointments by solving transportation challenges or other barriers.

**D9992**
Assisting in a patient's decision regarding the coordination of oral healthcare services across multiple providers, provider types, specialty areas of treatment, healthcare settings, healthcare organizations and payment systems. this is the additional time and resources expanded to provide experience or expertise beyond that possessed by the patient.

**D9993**
Patient centered, personalized counseling using methods such as motivational interviewing to identify and modify behaviors interfering with positive oral health outcomes. this is a separate service from traditional nutritional or tobacco counseling.

**D9994**
Individual, customized communication of information to assist the patient in making appropriate health decisions designed to improve oral health literacy, explained in a manner acknowledging economic circumstances and different cultural beliefs, values, attitudes, traditions and language preferences, and adopting information and services to these differences, which requires the expenditure of time and resources beyond that of an oral evaluation or case presentation.

## REVISIONS:

**D9630**
Includes, but is not limited to oral antibiotics, oral analgesics, and topical fluoride: does not include writing prescriptions.

## CDT CODE ANALYSIS:

Your practice management software has a report that provides a data snapshot of your practice. By examining this report, you can determine the procedures that you perform most frequently and, equally as important, the procedures you are not providing. Depending on your software program, this report has different names.

These reports can be run in two formats, either sorted by CDT category or by individual CDT code. If you have multiple dentists in the practice, run this report for a given time period for each dentist and for all providers in the practice.

These reports show you how many procedures each dentist and hygienist performed and the practice's total production. Now you can see how many crowns, surgical extractions, quadrants of scaling and root planing, etc. were provided by each dentist and the practice as a whole.

This view of the practice is very revealing and accurate. Remember, this is a production report, so all procedures provided will be reflected in this report. There are many ratios of services and metrics that can be analyzed using this data. For example, you could add up the total number of buildups and compare that to the total number of crowns. Is the practice ratio close to 1:1? If yes, then D2950, core buildup, may be over utilized.

Continue to analyze the report. What services are you providing and not providing?

The "bottom line" dollar amount at the end of the report is the practice production for the specified time period. This leads to the next category of yourself-consulting review.

## COLLECTIONS

Doctors typically like to use their hands and hand piece – review the accounts receivable report with your office manager or administrator once per month. Start with the accounts that are over 90 days old and work backwards to the current accounts. Many dentists do not want to be involved with this part of the business. This is not to suggest that you should make financial arrangements with the patient in the operatory; in fact, do not do that. Your competent staff members will take care of that. But, do not pick up the handpiece until the financial arrangements have been made and agreed to by the patient.

Now is the time to review and update your payment policies. Is the practice extending free loans or payment plans to patients? It is no longer 1965. Every practice needs to be able to offer patients a "healthcare credit card," such as Care Credit.

Multi-appointment treatments, such as implants or fixed bridges, may need a different payment policy than single appointment treatments.

For example, when a crown treatment begins, the patient portion should be due, in full. If the patient does not have third-party benefits and you want to divide the fee into two payments, then half at the impression appointment and half at the crown seating appointment would be appropriate. However, if the patient only wants to pay in full at completion, it is not a good idea. The most important aspect of your practice payment policy is for the entire team, including the doctor, to all be in agreement and comply with the practice policy.

## INSURANCE ADMINISTRATION

For those practices participating in PPOs, it is important to understand which plans impact your practice the most. If the practice management software is setup with billing codes, it should be easy to retrieve a report that will include patient copayments based on the name of the insurance company. What percent of the practice's total collections is attributed to those copayments?

If you do not have billing codes in your practice software, simply enter the annual 1099s received from each payer in a spreadsheet and sort it from greatest to least amount. This illustrates how much the practice was paid by each payer. If the companies at the bottom of the list are difficult to work with, it could be time to discontinue participation with that payer. You should review this list each year.

## FEES

An annual review of the practice fees and the PPO allowances is easy, quick, and obviously important. Review the 15 most frequently performed procedures; be sure to include both preventive and diagnostic procedures. Compare your fees to the top five PPOs in the practice, using the spreadsheet you already created. Obtain a schedule of UCR fees by zip code for your office location and add these to the spreadsheet. Make any appropriate adjustments so that your fees are well above that of the PPO allowances.

## REPORTING THE PROPER FEE

The fee submitted on claims should be the full practice fee or actual fee charged, not the PPO's allowable fee.

As a consultant, you want to be able to determine the "write-off" or "discount" the practice is taking as a participating PPO provider. If the practice submits the PPO fee, the discount is unknown and unable to be tracked.

For example, if the practice's fee for a crown is $1,200 and the PPO's allowable fee is $900, the discount is $300, or 25 percent. Continue this example and assume that another plan's allowable fee is $720, that is a 40 percent discount.

Office staff may feel that there is more accounting to do when the insurance payment is received. However, the write-off amount is a critical piece of information to better understand and administer PPO participation. Just as you reviewed the PPO allowances and adjusted the practice fees, now the PPO discount needs to be determined and reviewed, and decisions need to be made whether to continue to participate in certain plans or join others.

Once you have gathered this information, you are more prepared to make the call. With this information in hand, a better and more informed opening discussion will take place with the consultant. This will lead to a better outcome from the services provided by the consultant.

## ADA CODE OF ETHICS: VERACITY

Section 5 of the *ADA Principles of Ethics and Code of Professional Conduct* is particularly applicable when determining the treatment plan and procedure coding.

**SECTION 5** — Principle: Veracity ("truthfulness")
The dentist has a duty to communicate truthfully.

## CODE OF PROFESSIONAL CONDUCT

**5.A. Representation of Care.** Dentists shall not represent the care being rendered to their patients in a false or misleading manner.

**5.B. Representation of Fees.** Dentists shall not represent the fees being charged for providing care in a false or misleading manner.

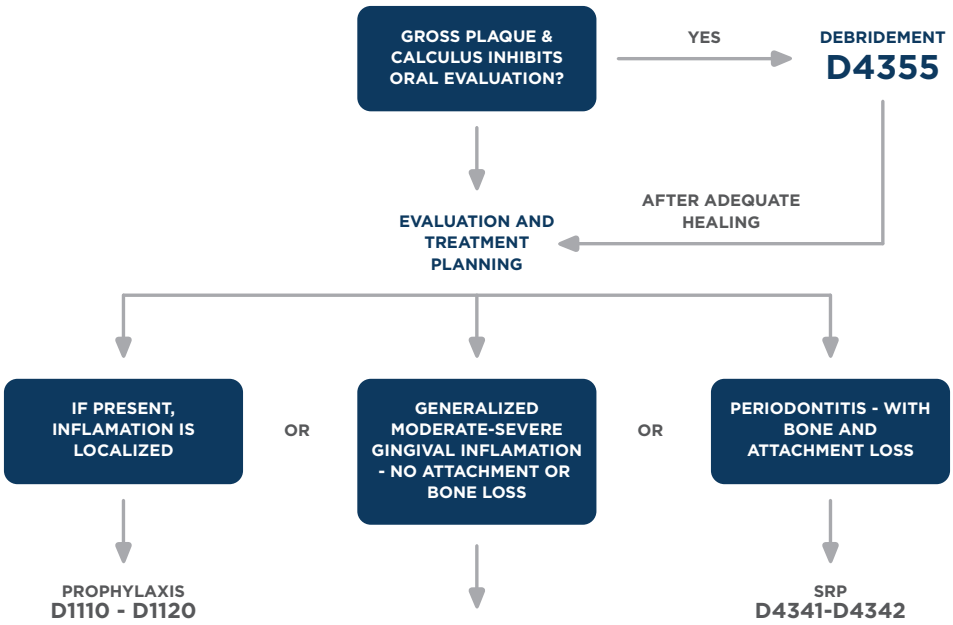
# ADVISORY OPINIONS

**5.B.5. Dental Procedures.** A dentist who incorrectly describes on a third party claim form a dental procedure in order to receive a greater payment or reimbursement or incorrectly makes a noncovered procedure appear to be a covered procedure on such a claim form is engaged in making an unethical, false or misleading representation to such third party.

**5.B.6. Unnecessary Services.** A dentist who recommends and performs unnecessary dental services or procedures is engaged in unethical conduct. The dentist's ethical obligation in this matter applies regardless of the type of practice arrangement or contractual obligations in which he or she provides patient care.

**D4346**
Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation

The removal of plaque, calculus and stains from supra- and subgingival tooth surfaces when there is generalized moderate or severe gingival inflammation in the absence of periodontitis. It is indicated for patients who have swollen, inflamed gingiva, generalized suprabony pockets, and moderate to severe bleeding on probing. Should not be reported in conjunction with prophylaxis, scaling and root planing, or debridement procedures.



# QUESTIONS & ANSWERS

**1. Why was a new "scaling" code added to the CDT Code?**

a) Current CDT codes document procedures for patients with generally healthy periodontium, or patients with periodontal disease that has accompanying loss of attachment (e.g. periodontal pockets and bone loss).

- D1110 is primarily a preventive procedure, but can be therapeutic depending on the periodontium overall health. It is applicable for patients with generally healthy periodontium where any deposits are removed to control irrigational factors, and for patients with localized gingivitis to prevent further progression of the disease.

- Codes D4341 and D4342 are therapeutic procedures, and are indicated for patients who require scaling and root planing due to bone loss and subsequent loss of attachment. Instrumentation of the exposed root surface to remove deposits is an integral part of this procedure.

- There is no CDT Code available to report therapeutic treatment of patients with generalized moderate to severe gingival inflammation, with or without pseudo-pockets but exhibiting no bone loss – this is the gap filled by D4346.

b) Filling this gap will result in more accurate documentation and reporting by eliminating consideration of:

- D4999 as this code requires a narrative containing information that limits auto-adjudication

- "Undercoding" as a Prophylaxis procedure

- "Overcoding" as a Scaling and Root Planing procedure

**2. Would the D4346 procedure be appropriate for a "hard prophy" where more time than usual is required to remove plaque, calculus and excessive staining from the tooth structures in order to control local irrigational factors?**

If the "hard prophy" is being defined strictly by the amount of time required to complete the procedure, then no D4346 is not appropriate. The D4346 procedure is applicable when there is generalized moderate

or severe gingival inflammation in the absence of attachment loss. In other words, the procedure is based on the diagnosis rather than intensity of treatment required.

**3. How do you differentiate this new scaling procedure (D4346) from the current debridement procedure (D4355)?**

D4355 is an enabler for comprehensive oral evaluation i.e. it is performed before the subsequent comprehensive evaluation simply to remove gross deposits from the tooth surface. D4346 is a therapeutic service performed after evaluation and diagnosis of gingivitis to remove all deposits and allow tissue healing.

**4. What sort of oral evaluation is appropriate before delivery of D4346?**

As with all therapeutic procedures, D4346 is performed after a periodic (D0120), comprehensive (D0150), or comprehensive periodontal (D0180) oral evaluation.

**5. May the oral evaluation and the D4346 procedure be performed on the same date of service?**

Yes. There is nothing in either CDT Codes nomenclature or descriptor that precludes their delivery and reporting on the same date of service.

**6. What is the clear and accepted definition of "...generalized moderate to severe gingival inflammation..." so that the D4346 procedure can be differentiated from prophylaxis procedures?**

a) The AAP defines generalized chronic periodontitis 1 to be when 30% or more of the patient's teeth at one or more sites are involved, and it is reasonable to extend this definition to a patient with gingivitis.

*1 (J. Perio July 2015 American Academy of Periodontology Task Force Report on the Update to the 1999 Classification of Periodontal Diseases and Conditions [Original reference – Consensus Report: Chronic Periodontitis. 1999 International Workshop for a Classification of Periodontal Diseases and Conditions. Ann Periodontal 1999;4:38])*

b) The Gingival Index of Löe and Silness defines gingival inflammation as follows:

0 = normal inflammation
1 = mild inflammation- slight change in color and slight edema but no bleeding on probing
2 = moderate inflammation- redness, edema, and glazing, bleeding on probing
3 = severe inflammation- marked redness and edema, ulceration with tendency to spontaneous bleeding.

**7. What procedure is appropriate for patients with localized gingival inflammation (gingivitis)?**

D1110 is applicable for patients with localized gingivitis to prevent further progression of the disease.

**8. Is there a waiting period between completion of a D4346 and delivery of a prophylaxis as part of the patient's routine preventive regimen?**

There is no set waiting period. D4346 is a therapeutic procedure to bring the patients periodontium back to health. Based on the patient's' needs, the dentist is in the best position to determine when the patient can assume a regular preventive regimen that includes oral prophylaxis.

**9. D4346 is a full mouth procedure; does this mean that it is completed in a single day?**

This procedure is expected to be completed on a single date of service, but patient comfort and acceptance may require delivery over more than one visit. Should more than one day be required the date of completion is the date of service.

**10. What dental professional would deliver the D4346 procedure?**

As with all procedures documented with CDT codes, state laws regulating scope of practice determine which persons may deliver the service.

**11. Is local anesthesia used when delivering D4346?**

Patient needs and preferences, as well as the clinical state of the dentition, are factors that the dentist considers when determining the need for local anesthesia. State law determines who may deliver the anesthetic agent, which would be documented on the patient's record using the applicable CDT Code.

**12. What should be documented in the patient's record to support delivery of D4346?**

a) Periodontal charting that records (pseudo) pocket depths and bleeding on probing. (Note: Pocket depth may be recorded without loss of attachment.)

b) Photographs or other diagnostic images (e.g., radiographs) may be helpful to document the gingival condition (e.g., visualize localized v. generalized inflammation) for retention in the patient's chart. *Implant surfaces, without flap." This procedure could be part of the treatment plan for a patient who also has moderate to severe gingival inflammation. Could D6081 and D4346 be delivered to the patient on the same date of service?*

Yes. Both D6081 and D4346 may be delivered on the same date of service as there is nothing in either CDT Codes nomenclature or descriptor that precludes concurrent delivery and reporting.

Please note, however, that the D6081 descriptor includes exclusion language stating – "This procedure is not performed in conjunction with D1110 or D4910." – meaning that these are considered separate procedures and may be reported with the same date of service.

**15. What do you mean by "Loss of attachment"?**

This term is defined (Stedman's Medical Dictionary for Dental Professionals; 1st Edition, 2007) as: "Damage to the structures that support the tooth; results from periodontitis and is characterized by relocation of the junctional epithelium to the tooth root, destruction of the fibers of the gingiva, destruction of the periodontal ligament fibers, and loss of alveolar bone support from around the tooth."

**16. Why was the procedure for "scaling in the presence of…generalized gingival inflammation" assigned a code in the CDT Code's "" (Periodontics) category rather than in "(Preventive)?**

The procedure is considered therapeutic for a patient in a diseased state, as noted by the following sentence in the D4346 descriptor – "It is indicated for patients who have swollen, inflamed gingiva, generalized suprabony pockets, and moderate to severe bleeding on probing." When a patient is diagnosed with generalized gingivitis following an oral evaluation this scaling procedure treats the generalized gingival inflammation and pseudopockets present.

**17. Can a patient who received the D4346 scaling procedure then receive a D4341 (or D4342) scaling and root planing procedure?**

There is no exclusionary language in the nomenclatures or descriptors of D4346, D4341 or D4342, as dentists recognize that periodontal disease may be progressive. The CDT Code fully supports documentation and reporting of procedures at any time the dentist determines they are necessary for the patient's oral health. This is a matter of clinical judgment by the treating dentist. Benefit design should not guide the clinical determination of procedure performed. For example:

(1) Scenario 1: A patient presents and after an oral evaluation the dentist determines that there is generalized moderate to severe gingival inflammation without attachment or bone loss. The treatment plan based on this evaluation is delivery of D4346. When completed the patient receives oral hygiene instruction that when followed would reduce the likelihood of continued or recurring inflammation.

On a later date the same patient presents, complaining of bleeding gums or at the next scheduled oral evaluation, the dentist notices that the patient now has periodontitis with attachment and bone loss. In this event a new treatment plan is prepared that includes scaling and root planing procedures (e.g.,D4341 or D4342). For this recurrent episode of disease scaling (D4346) is not repeated prior to SRP because the patient has bone loss.

(2) Scenario 2: A patient presents and is diagnosed with localized or generalized periodontitis with evidence of bone loss. The treatment plan based on this evaluation is scaling and root planing (D4341or D4342). Any subsequent treatment would be either periodontal maintenance (D4910) or repeating the SRP treatment. The D4346 procedure is not applicable as part of initial or subsequent treatment in this scenario because the patient exhibits bone loss, and "scaling" is an inherent component of the SRP procedure.

### 13. Is D4346 a procedure followed by periodontal maintenance reported with D4910?

No. D4346 is performed in patients who do not exhibit any loss of attachment. D4910 is a procedure that includes site specific root planing as needed in patients who have been treated for attachment loss.

### 14. There is another new entry in CDT 2017 – "D6081 scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the

| Findings upon evaluation | | Treatment rendered/planned |
|---|---|---|
| **Gingiva** | **Attachment/Bone** | **Procedure Code** |
| Generally healthy, if present gingival inflammation is localized | Healthy - No attachment or bone loss | D1110 |
| Generalized moderate to severe gingivitis | Healthy - No attachment or bone loss[1] | D4346 (No D1110) |
| Localized gingivitis | Localized bone loss [2] | D1110 + SRP as applicable (D4341, D4342) + other treatment as needed* |
| Generalized gingivitis | Localized or generalized bone loss [2] | D1110 + SRP as applicable (D4341, D4342) + other treatment as needed* |

**Note: This guide does not address other treatments for periodontitis (e.g. osseous surgery, bone graft etc.) that may be planned to treat the disease.*

### 18. How often will a dental benefit plan provide coverage and reimbursement for the D4346 procedure?

The CDT Code provides a means to document and report services rendered. Reimbursement as with all codes is determined by provisions of the patient's dental benefits plan.

The patient's dental plan determines coverage and defines which services are covered as well as limitations and exclusions, which may vary, based on regulatory requirements and/ or the level of coverage It is likely that coverage limitations and reimbursement amounts will vary between dental benefit plans as such matters are often determined through actuarial experience. It is also likely that payers will take into account the rate of progression of periodontal disease when determining a frequency limitation to the D4346 and follow-up D4341/D4342 procedures. The best way to know is to ask the carrier (e.g., submit a predetermination request).

### Snapshot of differences between procedures codes

| Attribute | Procedure | | | |
|---|---|---|---|---|
| **Nomenclature** | prophylaxis - adult; prophylaxis - child | scaling in the presence of generalized moderate or severe gingival inflammation - full mouth after oral evaluation | periodontal scaling and root planing - four or more *(or one to three)* teeth per quadrant | periodontal maintenance |
| **CDT Code** | D1110<br>D1120 | D4346 | D4341<br>D4342 | D4910 |
| **Precursor Procedure(s)** | Oral evaluation | Oral evaluation<br>Diagnostic image(s) | Oral evaluation<br>Diagnostic image(s) including radiographs | Active periodontal therapy (following SRP, Gingival Flap, or Osseuos surgery) |
| **Precursor Features** | Scaling and polishing | Sub-gingival (pseudo-pockets) scaling and polishing | Sub-gingival (pockets with loss of attachments) scaling and polishing | Scaling, polishing and root planing (site specific) |
| **Clinical Condition** | Localized gingival inflammation, if any | Generalized moderate to severe gingival inflammation | Periodontal disease including loss of attachment | Ongoing therapy to treat periodontal disease |

## CLINICAL SCENARIOS

### 1. Illustrations of situations where gross debridement may be applicable

### D4355 full mouth debridement to enable comprehensive evaluation and diagnosis

The gross removal of plaque and calculus that interfere with the ability of the dentist to perform a comprehensive oral evaluation. This preliminary procedure does not preclude the need for additional procedures.

**2. Illustrations of situations where oral prophylaxis may be applicable**

**D1110 prophylaxis – adult**
Removal of plaque, calculus and stains from the tooth structures in the permanent and transitional dentition. It is intended to control local irrigational factors.

**D1120 prophylaxis – child**
Removal of plaque, calculus and stains from the tooth structures in the primary and transitional dentition. It is intended to control local irrigational factors.

**3. Illustrations of situation where scaling may be applicable**

**D4346 scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation**
The removal of plaque, calculus and stains from supra- and subgingival tooth surfaces when there is generalized moderate or severe gingival inflammation in the absence of periodontitis. It is indicated for patients who have swollen, inflamed gingiva, generalized suprabony pockets, and moderate to severe bleeding on probing. Should not be reported in conjunction with prophylaxis, scaling and root planing, or debridement procedures.

*(Effective: January 1, 2017)*

**4. Illustrations of situations for SRP and future periodontal maintenance**

**D4341 periodontal scaling and root planing – four or more teeth per quadrant**

This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces.

It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of presurgical procedures in others.

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

This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of presurgical procedures in others.

**D4910 periodontal maintenance**

This procedure is instituted following periodontal therapy and continues at varying intervals, determined by the clinical evaluation of the dentist, for the life of the dentition or any implant replacements. It includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing where indicated, and polishing the teeth. If new or recurrent periodontal disease appears, additional diagnostic and treatment procedures must be considered.

## BASIC CLAIMS SUBMISSION CHALLENGES

Getting paid for the procedures performed in your dental practice is essential. In order to gain reimbursement from payers, dental insurance claims must be properly and accurately submitted. The following elements of claim submission are causing continual issues for practices across the country.

## PROPER DOCUMENTATION

Documenting the procedure performed is key in obtaining reimbursement. Properly reporting any procedure begins with selecting the correct and current CDT code. Once the code is selected, be sure to provide any supporting documentation required.

One potential documentation method is the use of a narrative to further explain the need for the procedure. Remember that only 80 characters are guaranteed to be received. If the narrative is longer than 80 characters, you may attach the narrative to the claim.

Images may also be attached to the claim to further support the diagnosis. These images may include radiographic images, such as bitewings or periapicals, or photographs. Be sure that the image is of diagnostic quality and is properly labeled. The chart documentation must support what is demonstrated by the image.

## UPCODING OR DOWNCODING

It is important to report exactly what is performed, regardless of insurance reimbursement. Reporting an inaccurate code or procedure in order to increase reimbursement is improper and may be considered fraudulent.

## UPCODING

Upcoding is when a more complex code is reported than was actually performed in order to gain a higher reimbursement. Consider extractions as an example. A surgical extraction (D7210) requires the removal of bone and/or sectioning of the tooth, and includes (but does not require) the elevation of a mucoperiosteal flap, if indicated. D7140 reports a routine extraction. Not all extractions are surgical in nature. If the extraction does not include the removal of bone and/or sectioning of the tooth, it is not a surgical extraction, and should not be reported as D7210. Furthermore, elevation of a flap alone does not qualify the extraction as a surgical extraction. Reporting D7210 in situations when a routine extraction is performed is considered upcoding.

## DOWNCODING

Downcoding is when a less complex code is reported in order to gain reimbursement in cases where the more complex service would not be reimbursed. For example, reporting a partial denture, when an implant restoration that would not be reimbursed, was actually provided. This would be downcoding and, thus, would be improper.

## UNBUNDLING

Unbundling is the separation of a dental procedure into discrete components, reporting each component with a separate charge, resulting in a higher total fee. Always report the most accurate code for the procedure performed. If a single code exists to report the procedure, report the single code. Do not break the procedure down into its individual components and report them separately in order to increase reimbursement.

## MEDICAL NECESSITY

In order to receive reimbursement for a dental procedure, it must be considered medically necessary. Medical necessity is strictly defined by the payer. However, there are some elements that most payers will consider when determining medical necessity. The procedure should be clinically appropriate to treat the patient's diagnosed condition and must be performed in accordance with the standard of care. Furthermore, many payers require the procedure to be the least costly procedure available to adequately meet the needs of the patient.

As an example, removal of third molars should occur when it is optimal for the patient's oral health. If the third molars are removed too early, there could be complications with the procedure. If the molars are removed too early and there are complications, it does not qualify the procedure for D7241 (removal of impacted tooth – completely bony, with unusual surgical complications) because the treatment was not yet necessary.

There are numerous issues to consider when filing dental claims. Once a patient is diagnosed and treated, the treatment provided should be properly reported using the most accurate dental code.

Claims should be accompanied by any required documentation supporting the diagnosis and need for the procedure.

Remember, always report your full practice fee on all claims. Below are four reasons why this is important:

**1. Occasionally, PPO plans will increase their allowable fees. If a claim is submitted with an old, lower allowable fee instead of the full practice fee, you may miss out on a higher PPO reimbursement.**

**2. Payers track the fees reported on claim forms and use them to establish allowable fees. Billing the lower, contracted fees could reduce the likelihood that fees will be increased in the future.**

**3. When a patient has multiple insurance plans, reporting a contracted fee may reduce the secondary payer's level of reimbursement. Remember, in some situations, a secondary payer could coordinate up to the practice's full fee.**

**4. Reporting the full fee will allow the practice to better compare multiple PPO plans and determine which plans require the largest write offs.**

## CORRECT CODING

In today's rapidly changing world of technology, it is challenging to assign correct coding to services provided when a new or cutting edge technology is employed to generate a service that is new to dentistry. The Code Maintenance Committee (CMC) is often trying to play "catch up," while also striving to maintain a current comprehensive code set to describe all the services provided by the modern dental practice. That challenge is clearly evident when determining the correct coding for some of the newer radiographic images produced from the newest digital technologies. In many cases, as with digital images, the technology is changing more rapidly than the codes can be updated.

Regardless of the existing challenges, the overriding mandate when choosing the proper code to describe the service is: Report what you do using the most accurate code available to describe the service provided.

This article outlines which codes may be used to describe the many images that may be produced from existing extraoral digital imaging 2D

systems, from manufacturers like Planmeca, Carestream, Gendex, Sirona, etc. Most of the existing extraoral 2D imaging systems can produce panoramic images. The existing digital systems that produce panoramic images are similar to those systems that use radiographic film; the difference is that the image is captured by a sensor. All panoramic images can be described using D0330, panoramic radiographic image, regardless of whether the image is captured using a conventional film or is produced digitally. The image and the capture process are very similar, and the coding remains unaltered. Use D0330 to describe a panoramic image produced by either standard or digital panoramic methods.

Confusion often arises when the existing extraoral 2D imaging systems are used to produce an image that isolates particular areas within the broader field of the capture to produce additional images, such as:

**Bitewings.**

**Periapicals.**

**Occlusal views.**

**TMJ images.**

**Cephalometric radiographic images.**

**Posterior-anterior or lateral skull and facial bone survey radiographic images.**

Since the existing nomenclatures and descriptors associated with the codes for radiographic images can be very specific, pay close attention to the nomenclature and/or descriptor to better understand how coding is affected. For example, radiographic image codes may specify whether the image is captured intraorally or extraorally. An intraoral image is produced when the sensor is positioned in the mouth as the image is captured. An extraoral image is produced when the sensor capturing the image is positioned outside the mouth as the image is captured. When the nomenclature is “silent” regarding the position of the film or sensor, the image can be captured either intraorally or extraorally. Also, note that some of the codes specify the number of images produced of a certain type in the code descriptor or the descriptor can establish the inclination of the capture, such as “vertical” bitewings.

So, how does all this affect coding of images produced by extraoral digital imaging 2D systems?

## BITEWINGS

The bitewing codes are "silent" regarding the position of the sensor, so a bitewing image may be produced intraorally or extraorally. The bitewing codes, however, are specific regarding the number of images captured. In the event two elongated bitewing images are produced by the digital extraoral 2D imaging system, and even though those two images may provide the same clinical diagnostic information as four conventional images, the code is specific about the number, not the size. Therefore, the two elongated images produced by the digital extraoral machine should be reported as D0272, bitewings – two radiographic images, not D0274, bitewings – four radiographic images.

Two images were produced and two images should be submitted, regardless of what the manufacturer of these machines may suggest. Note that code D0277, vertical bitewings – 7 to 8 radiographic images, establishes both the inclination of the film when the image is captured and the number of images captured. Today, existing digital extraoral 2D imaging systems are not programmed to produce these types of images. Therefore, reporting D0277 is limited to images produced with conventional intraoral films or intraoral sensors placed in a vertical inclination with seven to eight distinct images created.

## PERIAPICALS

The nomenclature associated with periapical (PA) radiographic image codes are specific about the position of the sensor or film. For example, D0220, intraoral – periapical first radiographic image, the PA code descriptors establish that the PA codes are intended to describe images that are captured with the sensor/film located intraorally (in the mouth) when the image is captured. This would suggest all PAs produced by existing extraoral 2D imaging systems are not to be described as PAs for the sake of describing them with the existing intraoral PA codes.

Images produced by existing extraoral 2D imaging systems should be described using D0250, extraoral 2D projection radiographic image created using a stationary radiation source, and detector. D0251 reports an extraoral posterior dental radiographic image.

When conventional PA images are not possible (i.e., in cases where the patient has a very active gag reflex, large obstructing tori, or inability to tolerate a film/sensor in the mouth, as with a small child) a narrative should establish why conventional intraoral bitewings are not an option to assess the patient for interproximal decay, or assess interproximal bone levels, etc.

## OCCLUSAL VIEWS

Occlusal image coding, like PA coding, must rely on the nomenclature to direct the coding. D0240, intraoral – occlusal radiographic image, establishes that this code describes images captured intraorally and would not be used to describe an image produced using existing extraoral 2D imaging systems. The occlusal images produced by existing extraoral 2D imaging systems should be described using D0250, extraoral 2D projection radiographic image created using a stationary radiation source, and detector.

TMJ images and posterior-anterior or lateral skull and facial bone survey radiographic images may be described using the existing image codes, D0320, D0321, and D0340, as they may be produced by some of the existing extraoral 2D imaging systems, as well as by some of the conventional stationary technologies. A 2D cephalometric radiographic image, D0340, now requires a stationary cephalostat to produce a cephalometric image as revised under CDT 2016. D0340 also includes measurement and analysis of the image.

When reporting radiographs, be careful to review the code nomenclatures to ensure correct coding. Always use the current code that most accurately describes the service provided. Understand that radiographic image(s) are described differently based on of the position of the sensor (i.e., intraoral or extraoral) and that the coding is directly affected by this positioning, even though the resulting images may look very similar

# NARRATIVES FOR PERIO

**Gingivitis**
Approximately 80 percent of the population has gingivitis disease. The oral systemic connection is an important tool in inflammation affecting many body systems as these mouth bacteria's have been found systemically. The inflammation may be reduced significantly by treatment of the infection.

**Inflammatory Disease**
Research has connected C-reactive protein and other cytokines and chemokines to periodontal disease. The literature shows that gum disease is a significant cause of elevations in CRP levels. Diabetes Mellitus(DM),

Current evidence suggests that diabetes mellitus DM is associated with an increased prevalence and severity of gingivitis and periodontitis. Periodontitis may increase the risk for worsening glycemic control in diabetic patients, as well as increasing the risk for diabetic complications. The resulting increase levels of inflammation can result in impairments in the body's ability to manage blood sugar levels. Reference: Diabetes Mellitus and Periodontal Diseases: Mealey, Oates; J. Peridontology 2006Preterm Births.

Hormonal changes and pregnancy gingivitis requires aggressive treatment as research has shown that periodontal disease may be significantly related to preterm low birth weight. Reference: Periodontal Therapy May Reduce the Incidence of Preterm Birthday and Low Birth Weight Infants: Journal of Periodontology, 2007, Vol. 78 No. 5.

**Cardiovascular Disease**
Studies find a direct association between cardiovascular disease and periodontal bacteria. Even small amounts of an inflammatory stimulus can provoke a substantial amount of C-reactive protein (CRP) production which then circulates throughout the body in the bloodstream. Periodontal disease is a primary cause of inflammation in the body and may be predictive of heart disease. References: Moise Devarieus, MD, PhD, Columbia University; NIH News; April 6, 2006;

Conclusion: "...older adults who have higher proportions of four periodontal disease-causing bacteria (A.a., P.g., T.f., T.d.) inhabiting their mouths also tend to have thicker carotid arteries, a strong predictor of stroke and heart attack"

**Perio Protect Method**

Please be advised that this patient has been diagnosed with a gram-negative obligate anaerobic infection that is localized, but has also been demonstrated to be responsible for systemic bacteremia. Proper disinfection is being managed by delivering doctor selected antimicrobial agents, antioxidant medication, chemotherapeutic agents and/or other radioactive or nuclear medication to the source of the infection in a manner to maintain a minimum inhibitory concentration of these agents at the infection long enough to kill the pathogens. This is a medically necessary treatment using an FDA cleared medical delivery device, the Perio Protect Method. A Perio Tray delivers antimicrobial medication interproximally and subgingivally to kill the bacteria causing periodontal disease.

**Chlorine Dioxide**

Chlorine dioxide causes the destruction of spores, bacteria, viruses and other pathogen organisms. Studies demonstrate that use of chlorine dioxide-containing mouth rinse significantly reduces volatile sulfur compound concentration. Reference: Compound. Contin. Educ. Dent., 21 March 2000.

**Laser Assisted**

A study for laser assisted periodontal therapy (laser decontamination plus scaling group) showed the highest number of attached fibroblasts, with the tightly attached fibroblast prevailing while reducing the occurrence of bacterium's. Conclusion: CO2 laser treatment combined with mechanical instrumentation constitutes a useful tool to condition the root surface and increase fibroblast attachment to root surfaces thus reducing pockets and periodontal disease. Reference: J. Periodontology. 2002 Nov. Dentistry Today March 1998: "Nd: YAG-Assisted Periodontal Curettage to Prevent Bacteremia before Cardiovascular Surgery" (laser spreadsheet is for sale thru Links)

**Periodontal Bacteria**
Certain periodontal bacteria may be locally invasive, cause tissue destruction, invade host cells and enter the bloodstream. Possible introduction into the bloodstream may complicate certain systemic situations such as cardiovascular disease, diabetes, preterm and low birth weight babies and other systems.

As previously reported by *Medscape Medical News,* one review suggested that changes in sexual practices are behind the surge in the number cases of oropharyngeal squamous cell carcinoma associated with sexually transmitted HPV. The key factors appear to be multiple sex partners, starting sexual activity at a younger age, and increased oral sex.

Another study, however, found that an increasing incidence of oral tongue cancer in people 18 to 44 years of age was not associated with HPV.

Previous studies have suggested that chronic periodontitis is linked to a higher risk for oral premalignant lesions and head and neck squamous cell carcinoma, Dr. Tezal and colleagues note. A history of periodontitis also predicts poorly differentiated tumor status in the oral cavity.

The authors note that the results of a small study of patients with cancer of the base of the tongue suggested a synergy between periodontitis and tumor HPV status (*Arch Otolaryngol Head Neck Surg.* 2009;135:391-396). Their research "extends this work to assess the association of periodontitis and other dental factors with the presence of HPV-16 in oral cavity, oropharyngeal, and laryngeal cancers." "Periodontitis is easy to detect and may represent a clinical high-risk profile for oral HPV infection," conclude the authors. "Prevention or treatment of sources of inflammation in the oral cavity may be a simple yet effective way to reduce the acquisition and persistence of oral HPV infection."

*The study was supported by grants from the National Cancer Institute and the National Institute of Dental and Craniofacial Research. The authors have disclosed no relevant financial.*

Too many pregnant women are not getting timely dental care, experts say. There are plenty of reasons: Some dentists are reluctant to treat pregnant patients, in no small part because of outdated thinking. OB-GYNs too often fail to check for oral problems and to refer women to dentists. And many women fail to seek out oral care or mistakenly think it's dangerous, even though pregnancy itself may lead to gum inflammation.

The problem among dentists is decades old. Many "were taught in dental school that you can't treat a pregnant woman," said Dr. Renee Samelson, a professor of obstetrics and gynecology at Albany Medical Center, who was an editor of the first guidelines on oral health in pregnancy, which were published by the New York State Department of Health and advised on two more sets of guidelines. Dentists simply erred on the side of caution, she added: "There was no evidence of harm."

Today, although dental treatment during pregnancy is considered beneficial, some dentists still hesitate to see pregnant women, because they fear litigation or harm to the fetus, or their knowledge of appropriate care lags behind the current evidence. One 2009 survey of 351 obstetrician gynecologists nationwide found 77 percent reported their patients had been "declined dental services because of pregnancy."

"A lot of dentists still fear treating pregnant women, and think, 'What happens if I have to do an X-ray?' or 'What happens if I give antibiotics or local anesthesia?'" said Dr. Howard Minkoff, the chairman of obstetrics and gynecology at Maimonides Medical Center in Brooklyn. "None of these are legitimate reasons not to provide appropriate care for women."

Since 2006, a few state organizations and dental associations have issued practice guidelines declaring that dental care is safe and effective at any stage of pregnancy, including diagnostic X-rays, cavity restorations and root canals.

OB-GYNs should check for bleeding gums or oral infection and refer a patient to a dentist if her last visit was longer than six months ago,

according to the first national consensus statement on dental care during pregnancy, published in September by the National Maternal and Child Oral Health Resource Center at Georgetown University.

The statement advised dentists to provide emergency care in any trimester. OB-GYNs can be consulted, as necessary, if a pregnant patient is diabetic or hypertensive, or if general anesthesia is required. Dr. Sally Cram, a periodontist in Washington, and a spokeswoman for the American Dental Association, said dentists she knows provide complete care. She added, "In the last 10 to 15 years, a lot of dentists have promoted the importance of pregnant women having regular cleanings."

Delaying oral care can have serious consequences. Gingivitis, or gum inflammation, affects 60 to 75 percent of pregnant women, and left unchecked, it can become periodontal disease. Untreated periodontal disease can lead to tooth loss. And a mother with active tooth decay can spread cavity-causing bacteria to her child through saliva, perpetuating poor oral health.

Pregnant women with dental pain also may self-medicate inappropriately. In a March 2001 letter to the New York State Department of Health, a doctor described a patient who was unable to get urgent care for her abscessed teeth in upstate New York. She took such excessive doses of Tylenol that she developed acute liver failure, and the fetus died. That prompted the drafting of new state guidelines.

Still, some OB-GYNs do not address oral health during visits with pregnant women, an oversight that angers some dentists. "If you take your dog to the vet, the first thing they do is look in their mouth," said Dr. Nancy Newhouse, a periodontist in Independence, Mo., and the president of the American Academy of Periodontology.

Many pregnant women simply don't seek dental care, perhaps out of misplaced fear or neglect. Some states offer dental Medicaid benefits to low-income expectant mothers, for example, but utilization rates are low. Only 28 percent of eligible women seek and receive services in Oklahoma. In New York, 41 percent of pregnant women on Medicaid visited dentists in 2010, up from 30 percent in 2006.

Such a multifactorial problem requires a coordinated effort between OB-GYNs and dentists to reach mothers-to-be, said Dr. Stefanie Russell, a dentist and an epidemiologist at New York University. But for women with low-risk pregnancies, she said, "things will change when women realize dental care is their right during pregnancy."

## SAMPLE NARRATIVES FOR INSURANCE BILLING

### Crowns: please note initial placement date if possible plus any risk factors that contribute to breakdown

- Crown present when patient became active in our office; patient states that crown is over 10 years' old
- Recurrent decay ML and DB of existing MOD amalgam #31; Filling occupies 2/3 of tooth structure--initial placement of crown
- Distolingual margin open on existing crown #3; recurrent decay present upon removal of existing crown
- Existing MOD #4 amalgam that covers ¾ of buccal lingual occlusal surface. Mesial and distal areas extend into buccal and lingual surfaces also- filling is cracked across mid-occlusal.
- Patient presents with pain on biting #14-sensitive too hot and cold also. Fracture line that extends from occlusal surface to MB line angle. Used tooth sleuth for evaluation- pain indicated on MB cusp. Crown recommended for cracked tooth

### Buildups:

- More than ½ of the tooth structure is missing after removal of existing filling material and decay
- Less than 2-3mm collar of sound tooth structure remaining around gingival margin-build up necessary for retention of crown

### Fillings with multiple surfaced- not connected

- Buccal pit placed and occlusal filling placed. They are separate fillings, not connected. Please reimburse as stated.
- Fillings placed in distal occlusal pit DO and in mesial occlusal pit MO. Fillings did not connect. Please reimburse as two separate fillings.'
- Fillings placed in mesial occlusal pit and distal occlusal pit that connects to the lingual surface- the two fillings MO and OL did not connect- please reimburse as two separate fillings

## Occlusal Guards: List Risk Factors that are present (Bite and Function, TMJ)

- Patient exhibits signs of bruxism from grinding at night. Complains of jaw pain upon waking.
- General attrition of tooth structure due to clenching and grinding. Patient has pain with biting and severe jaw pain after sleeping

## Implant placement followed by temporary bridge or flipper

- Extraction date 2/12 while on this plan; prosthetic will maintain space during implant site healing
- Extraction completed on 10/15/13 and implant placed same day. Removable prosthetic to maintain space during healing

## Payment requested of periodontal maintenance after treatment: List risk factor: genetics, smoking, diabetes, medications, inflammatory diseases

- Scaling & root planing performed on patient in June 2010 while covered under this plan: periodontal risks of Inflammatory Crohns Disease and medications. AAP: Type II-severe chronic generalized
- Scaling and root planing completed May 2012 at previous dental office under another dental plan. Patient has diabetes and HBP meds that cause dry mouth. AAP: Type II Chronic Moderate Generalized
- Please apply benefits for D1110 if no benefit exists for D4910.

## Pulp caps:

- Teeth #Band S had deep visible caries and caries evident on radiographs. After the caries was removed, the decay was very deep in both teeth. Since the fillings were very close to the nerve, pulp caps were necessary to protect against possible irritation of the pulp chambers. Pulp caps were placed to protect the teeth from further trauma. The teeth have been asymptomatic since placement. Please reimburse as coded on the attached claim.

## Temporary Partial used as permanent-per patient choice:

- Please reconsider John Day's March 1, 2013 claim for a lower partial denture. This prosthetic falls outside your missing tooth clause since tooth #20 was extracted on Sept. 7, 2010 while covered under this plan.

The reason for denial on the EOB is that this prosthetic is considered a temporary prosthetic. This however is not the case. Mr. Day realizes that the prosthetic was not the ideal metal cast partial that is normally provided as a permanent prosthetic. Mr. Day requested the all resin partial and understood that this was to be a permanent prosthetic. He was also made aware of the replacement clause within his dental contract.

## Bone Grafting after extraction

- Tooth #18 was extracted on 5/6/13. I determined the tooth not salvageable due to infection and a vertical fracture onto the root structure on the mesial. After discussing this with the patient, it was agreed to extract the tooth and have bone grafting material placed within the socket to preserve the bone. Bone grafting was needed the same day to enhance healing. To place the material on a different day would have necessitated a re-opening of the socket that would have destroyed any healing that had occurred.

## Crown Lengthening:

- Crown lengthening needed on tooth #28 due to improper biological width. Without the procedure the crown margin would have been placed too close to the bone.

## Removable Prosthetics:

- Prosthetic needed to replace missing teeth 9,10,11, 14,1. Teeth have been missing for over 6 years according too patient-extracted due to deep decay and pain.
- Prosthetic will replace missing teeth #3-5, 12-14. Teeth extracted over 10 years ago according to patient.

## Alternate Bridge or removable benefit for Implant:

- Short version: Pt. is aware that policy does not cover implants. Please apply alternative benefit clause for removable prosthetic. (back teeth missing)
- Long version: The patient is aware that the policy does not cover implant placement or restoration. Please consider benefits for the alternate treatment of a 3-unit bridge or removable prosthetic.

The patient is aware that the replacement clause limitation will be applied. Please call with any questions.

- For Implant claims, include date of extraction and if it was covered under this plan, note that also.  If unknown, get the patient's closest estimate.

## ANTERIOR VENEERS:

Teeth #6 through #11 had full facial incisal composites with leaking margins and recurrent decay present. #10 had a MIF composite with open margins and recurrent decay. Vertical fractures from incisal edge to gingiva were present on the mesial and distal surfaces of #7, #8 and horizontal fracture from mesial too distal on facial of #9, #10

**Periodontal Procedures:**

- Patient presents with clinical attachment loss of 4-7 mm generalized throughout mouth. Active infection indicated with generalized bleeding upon probing. Risk factors include smoking, diabetes and medications that cause dry mouth. AAP Type II advanced localized and moderate generalized infection
- Radiographs and periodontal readings attached (send complete probing with mobility, furcation, missing teeth, recession and bleeding noted. Send full-set radiographs of up to 3 yrs. but also send most current bitewing set – preferably 4 bw's)

## BUILDUPS (D2950) AND INSURANCE

Dental insurance reimbursement for build-ups is a common frustration. Here are some points of discussion that will hopefully shed some light on this issue, and help us understand what is going on. These come from discussions in dental study clubs I'm in, and from direct conversations with dentist consultants in the insurance industry.

First, the actual CDT descriptor for D2950 is used by insurance companies when determining whether a procedure is even truly a buildup in the first place, and we all need to be very familiar with it in order to use it properly. This is straight from the CDT 2015 manual:

**D2950 - Core Buildup, Including Any Pins.**

*"Refers to the building up of coronal structure when there is insufficient retention for a separate extracoronal restorative procedure. A core buildup is not a filler to eliminate any undercut, box form, or concave irregularity in a preparation."*

**Contrast that with the CDT 2015 descriptor for a D2949:**

**D2949**
Restorative Foundation for an Indirect Restoration.
"Placement of restorative material to yield a more ideal form, including elimination of undercuts."

**The important points here are:**

- There is a difference between a buildup and a base, liner, or foundation.
- Placing a restorative material in order to idealize the prep is not a buildup.
- Placing a restorative material in order to eliminate undercuts is not a buildup.
- Placing a restorative material in order to protect pulp is not a buildup.
- Placing a restorative material in order to bond tooth structure, cusps, or cracks together is not a buildup.
- When there is sufficient tooth to retain a crown, then the shape or size of the crown prep doesn't matter; the restorative material placed is not a buildup.

Second, what defines "insufficient tooth retention" varies from insurance company to insurance company. Some might use actual numbers, such as over 50% of clinical crown missing before the crown prep is started. Or 50% of supragingival structure missing after prep. Or two of the four cusps completely missing. Or at least 180 degrees of structure missing. Some use prep height as a measure; they look at only the first 3mm above the prep margin when evaluating adequacy of remaining structure.

Third, if we have any kind of a signed agreement with an insurance company, we are bound to their policies regarding buildups.

If they always consider it to be a part of the crown prep procedure for payment purposes, then we have agreed to that. If they say we cannot pass the cost on to the patient, then we have agreed to that. We have to be familiar with our agreements with these companies; if we don't like it, then our only realistic recourse is to drop our participation with them.

Fourth, if the insurance claim is being reviewed by a human, then it will be reviewed based on the information we have sent with our claim. If the x-ray doesn't tell the entire story, then we need to tell it, or the claim will be denied. Include a clinical photo if it helps clarify the need. Include a detailed narrative that is clearly intended for that specific patient's tooth and not a generic one. Occasionally we need to actually look at the x-rays being sent out of our office. Frequently dentists assume that the quality of x-rays going out is as good as the x-rays we are looking at, and are shocked when they see the poor quality that is actually submitted with claims.

Fifth, if we send a narrative to document buildup necessity, we need to make sure it addresses why the buildup was necessary, not why the crown was necessary. These are two different issues, and should be addressed separately.

Sixth, a buildup is not routinely needed for every crown prep. Some dental offices submit a build up with literally every single crown prep. In a sense, these offices have ruined it for the rest of us. Because of them, the rest of us are required to document the necessity of our legitimate buildups.

Seventh, predetermining a buildup can be a toss of the dice, particularly when replacing an existing crown. The consultant will wonder "When the old crown is in place, how do you know a buildup will be necessary to hold the new crown in place?  The old crown might have recurrent caries, but it is still held in place, so there's not really good documentation to show that this new crown will truly need a buildup."

Eighth, when a submitted claim for a buildup is denied, the insurance company is not necessarily telling us that the buildup is not needed. Sometimes that is exactly what they mean. But often it simply means that the insurance plan that this patient's employer bought for them

simply does not cover buildups, or only covers buildups in certain circumstances. Having a procedure not covered in the patient's insurance plan is not always the insurance company dictating treatment; often it is more accurately the patient's employer dictating treatment.

Lastly, some dentist consultants use a very simple method when evaluating buildup necessity. Given the submitted x-rays and/or clinical photos, they try to visualize the tooth prepped with the restorative material in place, then try to visualize how much restorative material is left. Then they simply ask themselves *"Is that restorative material necessary to hold the new crown in place?"* Or, worded differently, *"Would the newly cemented crown fall off if the restorative material was not placed?"* If the answer to either question is no, then they don't consider the restorative material a true buildup, but more likely consider it a base or a liner, which is a different CDT code.

## D2950 BUILDUP VS. D2949 FOUNDATION

Many dentists routinely remove all existing filling from a tooth when they do a crown prep. This can leave irregularities, undercuts, divots. The dentist then places a material to fill in these irregularities, so the final shape of the prepared tooth is "ideal". This is often confused with a D2950 buildup, which is a similar procedure but is done for a very different reason.

A new CDT code (D2949) was implemented in 2014to help eliminate some of this confusion, help providers properly code this service, and submit claims using the procedure codes that most accurately reflect what they performed.

### D2950 - Core Buildup

- Descriptor was changed in CDT 2014; it was simplified to clarify the purpose and intent of a buildup.
- CDT 2014 descriptor: "Refers to building up of coronal structure when there is insufficient retention for a separate extracoronal restorative procedure."
- There is no longer a reference to "tooth strength" in the descriptor.
- In other words, the purpose of a buildup is to help hold the crown on when there is not enough tooth structure left to hold the crown on.

- In other words, if a buildup is not done, then the crown would not stay on.
- The CDT 2014 descriptor also states "A core buildup is not a filler to eliminate any undercut, box form, or concave irregularity in a preparation."
- It is not appropriate to use this code for fillers (see D2949) or bases (included in restorative procedure itself).

### D2949 - Restorative Foundation

- New code in CDT 2014.
- CDT descriptor: "Placement of restorative material to yield a more ideal form, including elimination of undercuts."
- This procedure is what many dentists were previously doing, but incorrectly submitting as a D2950 buildup.
- Describes a procedure where restorative material is placed in the tooth for purposes other than helping the new crown stay on.
- These situations might include:
    - ***Blocking out undercuts so impressions are easier to take.***
    - ***Filling in voids in the prep.***
    - ***Eliminating a box form.***
    - ***Filling in a concavity.***
    - ***Making the shape of the prepped tooth more "ideal" in contour, i.e. a shape similar to how a crown prepped tooth would look on a healthy non-decayed non-restored tooth.***

# NARRATIVE & DOCUMENTATION CHECKLIST

# CROWNS

**Key Issue: Address the pathology and/or missing tooth structure.**
Additional Info:

- Note the size, location, and condition of any prior restorations.
- Note the pain, decay, and/or displaced tooth structure.
- Note clinical observations not visible on the x-ray.
- Note the periodontal and periapical condition(s) of the tooth.

# ONLAYS

**Key Issue:**
**Onlay must ~ a cusp tip and meet the same criteria as a crown.**
Additional Info:

- A buccal and/or lingual surface must be involved to qualify as an onlay.
- Address the crown criteria listed to the left.
- Note that the onlay was provided as a conservative option to a crown.
- Core buildups should not be billed with an onlay.

# BUILDUPS

**Key Issue:**
**Buildups must be necessary for the retention of a crown.**
Additional Info:

- Buildups may be denied unless lingual or buccal tooth height is less than 2-3 mm.
- Some dental contracts only cover buildups on non-vital teeth.
- D2952 and D2954 include both the post ~ the core buildup.
- Buildups for bridge retainers are reported using D697D-D6973.

# VENEERS

**Key Issue:**
**Dental plans assume veneers are cosmetic unless pathology and/or missing tooth structure are/is noted.**
Additional Info:

- Note the size, location, and condition of any prior restorations.
- Note any new or recurrent decay and/or displaced tooth structure.
- Veneers are often denied upon initial submission. Appeal if placed due to deteriorating restorations with new/recurrent decay and/or displaced tooth structure.

# CROWN LENGTHENING

**Key Issue:**
**Bone must be removed and the crown-to-root ratio must be altered.**

- Additional Info: Crown lengthening requires reflection of a flap and is performed in a healthy periodontal environment A single tooth number must be. designated even though the flap design may involve multiple teeth.
- Many dental plans do not pay 04249 on the same day as a crown and require 4-6 weeks healing time.

## GINGIVECTOMIES

**Key Issue:**
**Usually only covered under dental as part of periodontal therapy or for access to subgingival caries.**
Additional Info:

- 5 mm pockets usually required for periodontal coverage.
- Note location of subgingival caries, if applicable.
- Seldom covered in preparation for a crown.
- Consider billing medical if due to medication (e.g., Dilantin).

## SURGICAL EXTRACTIONS

**Key Issue:**
**A flap must be laid and bone must be removed or the tooth must be sectioned.**
Additional Info:

- Simply relieving the gingival cuff and placing sutures does not qualify the procedure as 'a surgical extraction.
- Extracting a tooth without removing bone or sectioning the tooth is billed as D7140.
- Document reason for extraction pain, inflammation, infection, etc.

## TMJ ORTHOTICS

**Key Issue:**
**Focus on the patient's symptoms and radiographic pathology.**
Additional Info:

- Bill D1880 for 1MJ orthotics.
- Only covered if the patient's dental plan includes a TMJ rider. May be covered under medical.
- Describe symptoms (e.g., joint pain, popping, crepitus, deviated opening, closed lock, etc.) and radiographic pathology (e.g., displaced disc, condylar remodeling, etc.).

## ORTHO

**Key Issue:**
**Provide the orthodontic diagnosis, treatment plan, and financial arrangements.**
Additional Info:

- Attach a letter to the initial claim with the diagnosis (e.g., Class II crowded, Class 1II open bite, etc.),
- Itemize the treatment plan (e.g., Phase I=transverse app. 9 mos., Phase II=fixed braces 18-24 mos.).
- Itemize the financial arrangements (e.g., total fee, down payment, and monthly payment requirement).

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# Want to learn more? Contact Links2Success

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