Book sampler:

These are sample pages of the book containing front and back cover, table of contents, explanation of legends, new codes – Blood glucose level test (D0412), Occlusal guard (D9944, D9945, and D9946), and Index.

Charles Blair, D.D.S.

CODING WITH CONFIDENCE:

THE "GO TO" DENTAL CODING GUIDE

Dramatically Cut Coding Errors and Boost Legitimate Reimbursement

CDT-2019 EDITION

TABLE OF CONTENTS

EXPLANATION OF THE USE OF THE LEGENDS

Throughout the CDT 2019 Code section of this manual, you will find Coding Correction Warning, Watch, and Match legends depicting many common mistakes, as well as specific Comments, Limitations, Tips, Narratives, Photos, and Clinical Flow Chart legends. In addition, New Procedure, Revised, Deleted Code, Previously Deleted Code and the Author's Comments comprise the other legends. Each legend's description and purpose is as follows:

LEGENDS	DESCRIPTIONS
CDT 2019	This legend designates the official CDT 2019 code, nomenclature, and descriptor. The Code and nomenclature is always enclosed in a solid "bar", plus a "box", if applicable, which contains the descriptor. Current Dental Terminology (CDT) ©2018 American Dental Association. All rights reserved.
REVISIONS	This legend offers the exact revision to the nomenclature and descriptor as applicable.
	This legend signifies a serious misuse of reporting the code, which could be considered fraudulent (if intentional) or at the minimum, misleading. If discovered, the result could be loss of license, fine, or worse; at the least, repayment or restitution by the practice could be required. The legend's description may offer correct, alternative coding and in some cases offer another legitimate approach for better reimbursement.
	This legend can signify a misuse of reporting the code. The economic result of the misuse may be financially positive in the short term, but misuse is always costly in the long run. In most cases, the correct or alternate code is listed for reference.
	This legend identifies a code which is a "match" for an associated or complimentary code. For instance, this legend would illustrate the proper code match for the pontic and retainer crown of a bridge.
COMMENTS	The "Comments" legend offers commentary and information about the code.
LIMITATIONS	The "Limitations" legend spells out common limitations and exclusions of the use of this code in insurance contract language.
TIPS	The "Tips" legend signifies a legitimate approach that may result in improved benefit coverage.
NARRATIVES	The "Narratives" legend offers suggestions regarding narratives and documentation.
	This legend identifies a photograph of an appliance, restoration, implant, model, or radiographic image.
CLINICAL FLOW CHARTS	This legend illustrates a scenario in which the code is used in a proper clinical sequence associated with other procedures.
NEW PROCEDURE	This legend identifies a new procedure code. There are 15 new procedure codes in CDT 2019.
REVISED	This legend identifies a substantive or editorial revision in the nomenclature and/or the descriptor of a code. Be sure to read the entire description of the revised code. There are 5 code revisions in CDT 2019.
DELETED CODE	This legend identifies a procedure code that was deleted. There are 4 deleted codes in CDT 2019.
PREVIOUSLY DELETED CODE	This legend identifies a procedure code that was previously deleted. The manual continues to carry previously deleted codes for reference and to guide the reader to a current code, if applicable.
AUTHOR'S COMMENTS	This legend identifies the author's general comments at the beginning of a code section.

4. D0395, fusion of two or more 3D images of one or more modalities may also be used to demonstrate changes during growth or subsequent to treatment. It can be used for facial appearance, jaw position, and for measurement of airway effects from placement of a mandibular advancement device to treat sleep apnea.

LIMITATIONS

1. Reimbursement for Cone Beam CT images is highly variable and may be limited to applications of a medical (not dental) nature. Even when listed as a benefit, coverage is determined by clinical necessity.
2. Situations where Cone Beam CT may be covered include:
   a. Impacted third molars positioned close to the inferior alveolar nerve.
   b. Proposed implant placement close to the inferior alveolar nerve or sinus.
   c. Proposed implant placement where there may be inadequate bone.
   d. TMJ abnormalities/pathology.
   e. Reconstructive surgery due to trauma.

TESTS AND EXAMINATIONS — CDT 2019

D0411 HbA1c IN-OFFICE POINT OF SERVICE TESTING — CDT 2019

D0411 includes collection, testing, and generation of any appropriate reports related to the patient's HbA1c status. It does not describe the simple testing of the patient's blood sugar levels (today) with a glucometer (D0412).

D0411 describes the **collection** *and* **testing** of an HbA1c sample conducted by a qualified dental professional. Using a glucometer to determine the patient's current blood sugar level (today) would be described using D0412.

The hemoglobin A1c test indicates average levels of blood sugar over an interval of time (i.e., 2 to 3 months). It is also called HbA1c, glycated hemoglobin test, and glycohemoglobin.

Diabetic patients are monitored regularly to ensure their overall blood sugar levels are staying within range. The A1c test is used to diagnose and monitor diabetes. This code describes both the collection and interpretation of the HbA1c information.

LIMITATIONS HbA1C testing would not generally be paid by conventional dental plans.

TIPS Consider submission to the patient's medical plan for potential reimbursement.

D0412 NEW PROCEDURE BLOOD GLUCOSE LEVEL TEST – IN-OFFICE USING A GLUCOSE METER — CDT 2019

This is not the HbA1c test (D0411) which measures the average blood glucose over several months.

D0412 reports using an in-office glucometer to determine the immediate finding of a patient's current blood glucose level.

D0411 describes the collection and testing of a HbA1c sample conducted by a qualified dental professional.

D0412 describes testing the patient's current blood glucose level in the dental practice using the practice's glucose meter.

COMMENTS Diabetes is a widespread chronic disease frequently encountered by practitioners and is on the rise. Many patients will seek care from a dentist at least annually but may not see their physician. According to the most recent statistical report published by the Centers for Disease Control (CDC) approximately up to 29.7% of the U. S. population has diabetes. Of the estimated 29.7%, 6% - 8.5% are undiagnosed and 21.1% - 25.1% are diagnosed diabetics. It is critical that the doctor and clinical team know the patient's blood sugar level before initiating dental treatment. While the patient's A1C percentage may be at an acceptable control level over a period of time, their actual blood sugar level *today* may be too low and the patient may be heading toward a hypoglycemic event.

If the patients' blood sugar level (which cannot be obtained via an A1C test) is checked with a glucometer prior to treatment, results may show that the patient's blood sugar level is too low. If so, the procedure should be postponed since a hypoglycemic event is likely, placing the patient at risk. Alternately, the patient's current blood sugar level may be too high, even though their A1C level is at an acceptable range. If this is the case, any elective surgical procedure should be postponed since such a high level of blood glucose could lead to delayed healing of the surgical site and infection. Patients presenting with the risk factors of diabetes, but who have not been diagnosed with either pre-diabetes or diabetes should also receive glucometer testing. Additionally, dental teams should receive training to recognize the signs of hypoglycemia and be knowledgeable in treating hypoglycemic patients.

LIMITATIONS This service is generally not covered by dental plans.

TIPS If a patient presents with risk factors for diabetes but has not yet been diagnosed with pre-diabetes or diabetes, based on the risk factors, the doctor might order an in-office blood glucose level test. If a known diabetic patient arrives for treatment and appears "off" or has a long or stressful procedure scheduled, this patient might also receive an in-office blood glucose test glucometer reading before the doctor begins treatment to avoid a possibly life-threatening hypoglycemic or hyperglycemic event. In either scenario, the patient's blood sugar level should be documented in the patient's clinical record. The patient should be informed of their test results, and based upon the test results, given a medical referral if the doctor deems necessary.

NARRATIVES The narrative should establish the need for the blood glucose test, outlining the patient's risk factors and/or symptoms as well as the dangers in treating the patient with either a too high or too low blood glucose levels.

D0414 LABORATORY PROCESSING OF MICROBIAL SPECIMEN TO INCLUDE CULTURE AND SENSITIVITY STUDIES, PREPARATION AND TRANSMISSION OF WRITTEN REPORT CDT 2019

D0415 describes the collection of microorganisms for culture and sensitivity.

D0417 describes the collection and preparation of saliva sample for laboratory diagnostic testing.

D0422 describes the collection and preparation of genetic sample material for laboratory analysis and report.

D0423 describes the genetic test for susceptibility to diseases – specimen analysis.

D0484 describes a consultation on slides prepared elsewhere.

D9943 OCCLUSAL GUARD ADJUSTMENT CDT 2019

D9943 does not report occlusal guard adjustments at the delivery. Adjustments made on the date of the delivery are included in the global fee for the occlusal guard.

COMMENTS After delivery, six months of follow up adjustments are generally considered to be part of the global fee for the occlusal guard (D9944, D9945, and D9946).

LIMITATIONS This code will not be reimbursed by most plans.

NARRATIVES Document the original delivery date of the occlusal guard on the claim.

D9944 NEW PROCEDURE OCCLUSAL GUARD – HARD APPLIANCE, FULL ARCH CDT 2019

Removable dental appliance designed to minimize the effects of bruxism or other occlusal factors. Not to be reported for any type of sleep apnea, snoring or TMD appliances.

It is misleading to report the delivery of an occlusal guard – hard appliance, full arch (D9944) to describe tooth whitening trays (D9975) or for TMJ treatment to increase reimbursement. Tooth whitening trays are provided for cosmetic purposes and are not a covered service. TMJ dysfunction treatment is typically not reimbursed unless there is a TMJ dysfunction rider attached to the dental insurance policy and the TMD appliance is reported as D7880.

The hard occlusal guard (D9944) and the occlusal orthotic device (D7880) are often confused. Report D9944 to describe a hard occlusal guard for minimizing the effects of "bruxism" and "clenching of teeth." Report D7880 to describe an appliance provided to treat TMJ dysfunction, which includes multiple visits.

COMMENTS

1. Bruxism is the parafunctional or habitual "clinching" or "grinding" of teeth.
2. There are three basic, broad types of bruxism appliances:
   - Soft (generally suck down) appliance (D9945), typically fabricated in the dental office.
   - Laboratory made hard acrylic appliance with or without soft liner (D9944).
   - The NTI-tss, an anterior partial hard arch appliance, generally worn at night (D9946).

   The occlusal guard fee will typically vary from $550 to $650, depending on the type of appliance. Factors such as the laboratory bill, the clinical technique used, and the total number of visits for impressions, delivery and follow up may affect the fee charged. Occlusal guards usually require several visits to deliver the appliance.
3. There is a code to report an adjustment of an occlusal guard. See D9943 to report an adjustment of an occlusal guard. Adjusting an occlusal guard is usually not reimbursed.
4. Report D9942 for the repair and/or reline of an occlusal guard.

LIMITATIONS

1. If the hard occlusal guard (D9944), also known as a night guard, perio guard, or bite guard is reimbursed, it is generally reimbursed under dental, not medical insurance.
2. Reimbursement for an occlusal guard (D9944) may be subject to an age exclusion for children 12 years of age or younger.
3. Some payers only reimburse for bruxism; others require periodontal treatment (SRP or in some cases osseous surgery) to justify reimbursement.

4. Occlusal guards may be reimbursed under "preventive," "basic," or "major" classifications. Classification is highly variable. Waiting periods may apply for basic and major coverage.
5. After delivery of the occlusal appliance, six months of follow up care (including adjustments) is typically considered integral in the global occlusal guard fee. For an occlusal guard adjustment, see D9943.
6. Although the occlusal orthotic device, by report (D7880) is generally considered to be for TMJ dysfunction, a few payers will reimburse the occlusal guard (for bruxism) as an alternate benefit of the TMJ dysfunction appliance code D7880.
7. Pretreatment authorization may be required for D9944.

Note: D9944 does not report a TMJ dysfunction appliance or active TMJ dysfunction treatment. TMJ dysfunction is not typically a covered dental benefit without a TMJ dysfunction rider; however, it may be reimbursed through medical insurance. TMJ dysfunction treatment (for pain, symptoms) involves a splint, multiple visits, and occlusal adjustments. The dental code for an appliance used to treat TMJ dysfunction is occlusal orthotic device (D7880). See D7880 for further details.

TIPS

If a patient requires a hard occlusal nightguard covering the entire arch because of night grinding or has advancing periodontal mobility, the appliance is billed using code D9944. If bruxism is the problem, a simple narrative indicating the patient is a bruxer should be all that is necessary. However, if periodontal mobility is the problem, then the narrative should include a periodontal diagnosis along with a comprehensive periodontal charting and mouth images.

If the patient is experiencing temporomandibular joint dysfunction (TMD), the occlusal orthotic should be billed using code D7880. A narrative should describe the diagnosis and symptoms, e.g., joint pain, popping, clicking, crepitus, migraines, deviated opening, etc.

Some plans cover appliances for bruxism, mobility, and/or some for TMD, but few cover all three. Know the clinical problem, (i.e., there is a diagnosis) before you check for benefits.

NARRATIVES

1. To determine if a splint or occlusal guard is covered by a patient's dental plan, one must first determine the purpose of the appliance. Is it needed to minimize the effects of bruxism? Is periodontal mobility a part of the diagnosis, or is the patient experiencing headaches and pain in the temporomandibular joint area?
2. If there is a *history* of scaling and root planing (D4341/D4342) or periodontal osseous surgery (D4260/D4261), note this in the narrative when reporting an occlusal guard. The narrative might state "This patient has undergone periodontal therapy on (date). Include a description of the case type." Coverage for D9944 may vary based on whether the policy includes a supplemental "periodontal rider." The rider could make a difference in coverage if there is a supplemental "periodontal rider" on the contract. Even so, some payers make a distinction between case types and will only reimburse for the more advanced osseous surgery. SRP (D4341/D4342) treatment may not suffice. Some plans require the occlusal guard be placed within six months of active periodontal treatment. If D9944 is reimbursed under a periodontal rider, the benefit may be available only once every five years or be limited to a lifetime maximum. The annual maximum will generally apply. Reimbursement is highly variable.
3. Include a narrative as indicated below:
    - If the diagnosis is bruxism, state "Diagnosis = Bruxism." An occlusal guard is necessary to minimize the effects of bruxism and clenching of teeth."
    - If the diagnosis is periodontitis, state case type, state periodontal treatment that has been performed, and include a current periodontal chart. If treatment is provided for a patient with periodontal treatment, state: "This patient has undergone active periodontal therapy (or osseous surgery, for chronic periodontitis) on mm/dd/yy and is a case Type III. If an occlusal guard (D9945) is not available for reimbursement, please consider an alternate benefit, if available."
    - Some plans require the occlusal guard be placed within six months of the active periodontal treatment (SRP or osseous surgery). If the occlusal guard is required to address periodontal mobility, include a periodontal diagnosis, current periodontal charting, and radiographs.

1. This is an example of a hard acrylic occlusal guard (D9944).
2. Occlusal guards can be fabricated as soft suck-down (D9445), hard acrylic (D9944) or NTI-tss appliances (D9946). Go to the D7880 code to view a NTI-tss appliance. The NTI-tss can function as an occlusal guard and also be used in the treatment of TMJ.

Courtesy Drake Dental Lab

D9945 NEW PROCEDURE OCCLUSAL GUARD – SOFT APPLIANCE, FULL ARCH CDT 2019

Removable dental appliance designed to minimize the effects of bruxism or other occlusal factors. Not to be reported for any type of sleep apnea, snoring or TMD appliances.

CODING WARNING CORRECTION

It is misleading to report the delivery of an occlusal guard- soft appliance, full arch (D9945) to describe tooth whitening trays (D9975) or for TMJ treatment to increase reimbursement. Tooth whitening trays are provided for cosmetic purposes and are not a covered service. TMJ dysfunction treatment is typically not reimbursed unless there is a TMJ dysfunction rider attached to the dental insurance policy and the TMD appliance is reported as D7880

CODING WATCH CORRECTION

The soft occlusal guard (D9945) and the occlusal orthotic device (D7880) are often confused. Report D9945 to describe a soft occlusal guard for minimizing the effects of "bruxism" and "clenching of teeth." Report D7880 to describe an appliance provided to treat TMJ dysfunction, which includes multiple visits.

COMMENTS

1. Bruxism is the parafunctional or habitual "clinching" or "grinding" of teeth.
2. There are three basic, broad types of bruxism appliances:
   - Soft (generally suck down) appliance (D9945), typically fabricated in the dental office.
   - Laboratory made hard acrylic appliance with or without soft liner (D9944).
   - The NTI-tss, an anterior partial hard arch appliance, generally worn at night (D9946).

   The occlusal guard fee will typically vary from $250 to $350, depending on the type of appliance. Factors such as the laboratory bill, the clinical technique used, and the total number of visits for impressions, delivery and follow up may affect the fee charged. Occlusal guards usually require several visits to deliver the appliance.
3. There is a code to report an adjustment of an occlusal guard. See D9943 to report an adjustment of an occlusal guard. Adjusting an occlusal guard is usually not reimbursed.
4. Report D9942 for the repair and/or reline of an occlusal guard.

LIMITATIONS

1. If the soft occlusal guard (D9945), also known as a night guard, perio guard, or bite guard is reimbursed, it is generally reimbursed under dental, not medical insurance.
2. Reimbursement for an occlusal guard (D9945) may be subject to an age exclusion for children 12 years of age or younger.
3. Some payers only reimburse for bruxism; others require periodontal treatment (SRP or in some cases osseous surgery) to justify reimbursement.
4. Occlusal guards may be reimbursed under "preventive," "basic," or "major" classifications. Classification is highly variable. Waiting periods may apply for basic and major coverage.
5. After delivery of the occlusal appliance, six months of follow up care (including adjustments) is typically considered integral in the global occlusal guard fee. For an occlusal guard adjustment, see D9943.
6. Although the occlusal orthotic device, by report (D7880) is generally considered to be for TMJ dysfunction, a few payers will reimburse the occlusal guard (for bruxism) as an alternate benefit of the TMJ dysfunction appliance code D7880.

7. Pretreatment authorization may be required for D9945.

Note: D9945 does not report a TMJ dysfunction appliance or active TMJ dysfunction treatment. TMJ dysfunction is not typically a covered dental benefit without a TMJ dysfunction rider; however, it may be reimbursed through medical insurance. TMJ dysfunction treatment (for pain, symptoms) involves a splint, multiple visits, and occlusal adjustments. The dental code for an appliance used to treat TMJ dysfunction is occlusal orthotic device (D7880). See D7880 for further details.

TIPS

If a patient requires a soft occlusal nightguard covering the entire arch because of night grinding or has advancing periodontal mobility, the appliance is billed using code D9945. If bruxism is the problem, a simple narrative indicating the patient is a bruxer should be all that is necessary. However, if periodontal mobility is the problem, then the narrative should include a periodontal diagnosis along with a comprehensive periodontal charting and mouth images.

If the patient is experiencing temporomandibular joint dysfunction (TMD), the occlusal orthotic should be billed using code D7880. A narrative should describe the diagnosis and symptoms, e.g., joint pain, popping, clicking, crepitus, migraines, deviated opening, etc.

Some plans cover appliances for bruxism, mobility, and/or some for TMD, but few cover all three. Know the clinical problem, (i.e., there is a diagnosis) before you check for benefits.

NARRATIVES

1. To determine if a splint or occlusal guard is covered by a patient's dental plan, one must first determine the purpose of the appliance. Is it needed to minimize the effects of bruxism? Is periodontal mobility a part of the diagnosis, or is the patient experiencing headaches and pain in the temporomandibular joint area?
2. If there is a *history* of scaling and root planing (D4341/D4342) or periodontal osseous surgery (D4260/D4261), note this in the narrative when reporting an occlusal guard. The narrative might state "This patient has undergone periodontal therapy on (date). Include a description of the case type." Coverage for D9945 may vary based on whether the policy includes a supplemental "periodontal rider." The rider could make a difference in coverage if there is a supplemental "periodontal rider" on the contract. Even so, some payers make a distinction between case types and will only reimburse for the more advanced osseous surgery. SRP (D4341/D4342) treatment may not suffice. Some plans require the occlusal guard be placed within six months of active periodontal treatment. If D9945 is reimbursed under a periodontal rider, the benefit may be available only once every five years or be limited to a lifetime maximum. The annual maximum will generally apply. Reimbursement is highly variable.
3. Include a narrative as indicated below:
   - If the diagnosis is bruxism, state "Diagnosis = Bruxism." An occlusal guard is necessary to minimize the effects of bruxism and clenching of teeth."
   - If the diagnosis is periodontitis, state case type, state periodontal treatment that has been performed, and include a current periodontal chart. If treatment is provided for a patient with periodontal treatment, state: "This patient has undergone active periodontal therapy (or osseous surgery, for chronic periodontitis) on mm/dd/yy and is a case Type III. If an occlusal guard (D9945) is not available for reimbursement, please consider an alternate benefit, if available."
   - Some plans require the occlusal guard be placed within six months of the active periodontal treatment (SRP or osseous surgery). If the occlusal guard is required to address periodontal mobility, include a periodontal diagnosis, current periodontal charting, and radiographs.

D9946 NEW PROCEDURE OCCLUSAL GUARD – HARD APPLIANCE, PARTIAL ARCH CDT 2019

Removable dental appliance designed to minimize the effects of bruxism or other occlusal factors. Provides only partial occlusal coverage such as anterior deprogrammer. Not to be reported for any type of sleep apnea, snoring or TMD appliances.

It is misleading to report the delivery of an occlusal guard- hard appliance, partial arch (D9946) to describe tooth whitening trays (D9975) or for TMJ treatment to increase reimbursement. Tooth whitening trays are provided for cosmetic purposes and are not a covered service. TMJ dysfunction treatment is typically not reimbursed unless there is a TMJ dysfunction rider attached to the dental insurance policy and it is reported as D7880.

The occlusal guard – hard appliance, partial arch (D9946) and the occlusal orthotic device (D7880) are often confused. Report D9946 to describe a hard occlusal guard, partial arch for minimizing the effects of "bruxism" and "clenching of teeth." Report D7880 to describe an appliance provided to treat TMJ dysfunction, which includes multiple visits or D5999 to describe a sleep apnea or snoring appliance.

COMMENTS

1. Bruxism is the parafunctional or habitual "clinching" or "grinding" of teeth.
2. There are three basic, broad types of bruxism appliances:
   - Soft (generally suck down) appliance (D9945), typically fabricated in the dental office.
   - Laboratory made hard acrylic appliance with or without soft liner (D9944).
   - The NTI-tss, an anterior partial arch hard appliance, generally worn at night (D9946).

   The occlusal guard fee will typically vary from $250 to $350, depending on the type of appliance. Factors such as the laboratory bill, the clinical technique used, and the total number of visits for impressions, delivery and follow up may affect the fee charged. Occlusal guards usually require several visits to deliver the appliance.
3. There is a code to report an adjustment of an occlusal guard. See D9943 to report an adjustment of an occlusal guard. Adjusting an occlusal guard is usually not reimbursed.
4. Report D9942 for the repair and/or reline of an occlusal guard.

LIMITATIONS

1. If the hard occlusal guard, partial arch (D9946), also known as a night guard or anterior deprogrammer, perio guard, or bite guard is reimbursed, it is generally reimbursed under dental, not medical insurance.
2. Reimbursement for an occlusal guard (D9946) may be subject to an age exclusion for children 12 years of age or younger.
3. Some payers only reimburse for bruxism; others require periodontal treatment (SRP or in some cases osseous surgery) to justify reimbursement.
4. Occlusal guards may be reimbursed under "preventive," "basic," or "major" classifications. Classification is highly variable. Waiting periods may apply for basic and major coverage.
5. After delivery of the occlusal appliance, six months of follow up care (including adjustments) is typically considered integral in the global occlusal guard fee. For an occlusal guard adjustment, see D9943.
6. Although the occlusal orthotic device, by report (D7880) is generally considered to be for TMJ dysfunction, a few payers will reimburse the occlusal guard (for bruxism) as an alternate benefit of the TMJ dysfunction appliance code D7880
7. Pretreatment authorization may be required for D9946.

Note: D9946 does not report a TMJ dysfunction appliance or active TMJ dysfunction treatment. TMJ dysfunction is not typically a covered dental benefit without a TMJ dysfunction rider; however, it may be reimbursed through medical insurance. TMJ dysfunction treatment (for pain, symptoms) involves a splint, multiple visits, and occlusal adjustments. The dental code for an appliance used to treat TMJ dysfunction is occlusal orthotic device (D7880). See D7880 for further details.

TIPS

If a patient requires a hard nightguard covering part of the arch because of night grinding or has advancing periodontal mobility in the anterior, the appliance is billed using code D9946. If bruxism is the problem, a simple narrative indicating the patient is a bruxer should be all that is necessary. However, if anterior periodontal mobility is the problem, then the narrative should include a periodontal diagnosis along with a comprehensive periodontal charting and mouth images.

If the patient is experiencing temporomandibular joint dysfunction (TMD), the occlusal orthotic should be billed using code D7880. A narrative should describe the diagnosis and symptoms, e.g., joint pain, popping, clicking, crepitus, migraines, deviated opening, etc.

Some plans cover appliances for bruxism, mobility, and/or some for TMD, but few cover all three. Know the clinical problem, (i.e., there is a diagnosis) before you check for benefits.

NARRATIVES

1. To determine if a splint or occlusal guard is covered by a patient's dental plan, one must first determine the purpose of the appliance. Is it needed to minimize the effects of bruxism? Is periodontal mobility a part of the diagnosis, or is the patient experiencing headaches and pain in the temporomandibular joint area?
2. If there is a *history* of scaling and root planing (D4341/D4342) or periodontal osseous surgery (D4260/D4261), note this in the narrative when reporting an occlusal guard. The narrative might state "This patient has undergone periodontal therapy on (date). Include a description of the case type." Coverage for D9945 may vary based on whether the policy includes a supplemental "periodontal rider." The rider could make a difference in coverage if there is a supplemental "periodontal rider" on the contract. Even so, some payers make a distinction between case types and will only reimburse for the more advanced osseous surgery. SRP (D4341/D4342) treatment may not suffice. Some plans require the occlusal guard be placed within six months of active periodontal treatment. If D9945 is reimbursed under a periodontal rider, the benefit may be available only once every five years or be limited to a lifetime maximum. The annual maximum will generally apply. Reimbursement is highly variable.
3. Include a narrative as indicated below:
   - If the diagnosis is bruxism, state "Diagnosis = Bruxism." An occlusal guard is necessary to minimize the effects of bruxism and clenching of teeth."
   - If the diagnosis is periodontitis, state case type, state periodontal treatment that has been performed, and include a current periodontal chart. If treatment is provided for a patient with periodontal treatment, state: "This patient has undergone active periodontal therapy (or osseous surgery, for chronic periodontitis) on mm/dd/yy and is a case Type III. If an occlusal guard (D9945) is not available for reimbursement, please consider an alternate benefit, if available."
   - Some plans require the occlusal guard be placed within six months of the active periodontal treatment (SRP or osseous surgery). If the occlusal guard is required to address periodontal mobility, include a periodontal diagnosis, current periodontal charting, and radiographs.

D9950 OCCLUSION ANALYSIS – MOUNTED CASE CDT 2019

Includes, but is not limited to, facebow, interocclusal records tracings, and diagnostic wax-up; for diagnostic casts, see D0470.

COMMENTS

1. D9950 is a mounted case and the diagnostic casts (D0470) would be reported separately.
2. D9950 includes a diagnostic wax-up.

LIMITATIONS Occlusion analysis – mounted case (D9950) is not generally reimbursed.

TIPS Some offices choose to credit the occlusal analysis – mounted case plus diagnostic cast fees by 50-100% toward the overall case fee, particularly if it's associated with a preliminary wax-up prior to treatment.

D9951 OCCLUSAL ADJUSTMENT – LIMITED CDT 2019

May also be known as equilibration; reshaping the occlusal surfaces of teeth to create harmonious contact relationships between the maxillary and mandibular teeth. Presently includes discing/odontoplasty/enamoplasty. Typically reported on a "per visit" basis. This should not be reported when the procedure only involves bite adjustment in the routine post-delivery care for a direct/indirect restoration or fixed/removable prosthodontics.

D9951 "should not be reported when the procedure involves minor bite adjustments in the routine post-delivery care for a direct/indirect restoration or fixed/removable prosthodontics."

COMMENTS

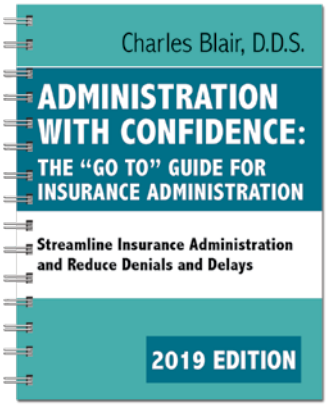
1. If an occlusal adjustment is required within a short period of completion of a restorative procedure, it is considered a part of the global restorative procedure and D9951 should not be reported.

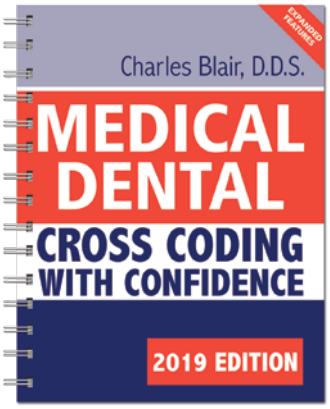
INDEX

Dr. Charles Blair is one of dentistry's leading authorities on practice profitability, fee analysis, insurance coding and administration, insurance coding strategies, and strategic planning. As a former successful practitioner, his passion for the business side of dentistry is unparalleled. Dr. Blair has personally consulted with thousands of practices, helping them to identify and implement new strategies for improved productivity and profitability. Dr. Blair is a nationally acclaimed speaker for dental groups, study clubs, and other professional organizations. He is also a widely read and highly respected author and publisher. His extensive background and expertise makes him uniquely qualified to share his wealth of knowledge with the dental profession.

In this publication, Dr. Blair continues the use and application of **Predictive Error Correction**SM technology – a simple and easy-to-follow system. Dr. Blair developed **Predictive Error Correction**SM technology as the end result of the clinical protocol, code reporting, clinical procedure count and fee analysis of thousands of dental practices across the country. His analysis also included personal interviews with thousands of doctors and office staff, providing him the insight to develop this invaluable manual. It is designed to predict typical coding errors and to discover misuse and other common coding mistakes made by the mainstream dental practice.

Related Resources





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