Preview Pages of This Guide:

Our 2022 edition is jam-packed cover-to-cover with strategies and information to help your practice boost profitability, reduce insurance denials and delays, and operate more efficiently. Here are a few sample pages to illustrate the content included in this vast 496-page must-have resource for your practice.

ADMINISTRATION WITH CONFIDENCE

THE "GO TO" GUIDE FOR FRONT OFFICE AND INSURANCE ADMINISTRATION

Maximize Reimbursement & Reduce Denials and Delays

2022 EDITION

drcharlesblair

eAssist DENTAL SOLUTIONS PUBLISHING

PRACTICE Booster® CODING WITH CONFIDENCE

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Additional Administrative and Coding Q&As, updates, bonus material, as available

Discounts and Copay Forgiveness

In general, doctors should steer clear of granting discounts or forgiving a patient's copay and/or deductible. Likewise, doctors should proceed with caution before advertising or promoting discounts. These marketing decisions could potentially be illegal in your state; thus, before doing so, consult with a healthcare attorney regarding your state's specific laws and policies regarding discounts.

The "ADA Principles of Ethics and Code of Professional Conduct" discusses copay forgiveness in section 5.B.

5.B. REPRESENTATION OF FEES.

Dentists shall not represent the fees being charged for providing care in a false or misleading manner.

ADVISORY OPINIONS

5.B.1. WAIVER OF COPAYMENT.

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

As the ADA's Code of Ethics states above, doctors cannot and should not accept payment from third-party payers as payment in full when a copayment is contractually required by the patient's dental plan. This applies whether the doctor is in- or out-of-network. Patients accept responsibility to pay their copayment by signing Box 36 of the 2019 ADA Dental Claim Form, which states:

> *"I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges."*

All states have laws prohibiting copay forgiveness in one form or another—either directly or indirectly. A few states do allow limited copayment forgiveness in the case of financial hardship, extreme circumstances, etc. Some states require third-party notification if copayments are forgiven. Every dental practice should understand the specific laws of your state before granting any copay forgiveness. Some State Dental Boards provide details of state dental practice laws on their website. However, sometimes copay forgiveness laws are included in the state's general statute regarding insurance matters and these laws apply to all healthcare providers in the state, not just dentists. Also, federal law restrictions regarding copay forgiveness apply to Medicaid, Medicare, FEDVIP plans, military plans, and other federally-funded plans.

The ADA's Code of Ethics includes the phrase "*… without disclosing to the third-party that the patient's portion will not be collected."* This means if a copayment is forgiven, the doctor must notify the payer as such. The payer will then decide if they will recalculate the claim and pay a lower amount, require the patient to pay the copayment (per the contract), or refuse payment altogether.

Payers vary in how they handle copay forgiveness. Sometimes a practice will disclose they do not intend to collect the patient's copayment ("the patient is not participating in the cost of care") in the remarks section of the 2019 ADA Dental Claim Form (Box 35). Some payers will not take action on this notification and pay the claim as submitted due to auto adjudication (the automated processing of claims). However, some payers pay nothing (per the Plan Document) when they learn the practice intends not to collect the patient's obligation. Almost all PPO contracts specifically state contracted providers cannot offer copay or deductible forgiveness. It is a violation of the contract—and consequently a high audit area. Participating providers may not waive copayments without breaching the PPO contract, even if the payer is notified.

Regardless of state law, there are also federal laws pertaining to waiving patient financial responsibility. One of these laws is the anti-kickback statute (AKS). In its document "A Roadmap for New Physicians—Fraud and Abuse Laws", the Office of Inspector General (OIG) states the following:

> *The kickback prohibition applies to all sources of referrals, even patients. For example, where the Medicare and Medicaid programs require patients to pay copays for services, you are generally required to collect that money from your patients. Routinely waiving these copays could implicate the AKS and you may not advertise that you will forgive copayments.*

This law applies to all insurance payers, commercial and government, medical and dental. The document does go on to say that copayments may be forgiven when a good faith effort has been made to collect payment from the patient. Also see "Anti-Kickback Statute", page 137.

Forgiving Copayments

Is it ever legal to lessen a deserving patient's financial responsibility? Forgiving copayments is sometimes allowed—but under very limited circumstances.

As we outlined above, if the doctor is out-of-network, they must notify the payer of any copay forgiveness—the payer will then decide if they will recalculate the claim and pay a lesser amount or refuse payment altogether. Copay forgiveness is very likely a violation of your PPO contract and you cannot waive copayments, even if the insurance company is notified.

However, sometimes providers will still elect to write off balances for patients who meet specific financial hardship qualifications. When considering copay forgiveness for financial hardship, the following should be taken into account:

- Write-offs for financial hardship should be very infrequent.
- Create a practice policy to standardize the situations in which you will make the exception to write off a copayment. This policy should clearly define the reason and criteria used to determine patient financial hardship. The policy should include a process for periodic review and auditing.
- Patients applying for a financial hardship waiver should complete a form or provide some type of document to be retained as proof that financial hardship was requested, reviewed, and approved. Recordkeeping and documentation of any copay forgiveness is a must.
- Utilizing copay forgiveness as a marketing technique is illegal.

Additionally, according to the OIG, it is not illegal to write off a patient's copay balance if the provider makes a good-faith attempt to collect. However, it becomes illegal when a provider has a policy of not making an honest attempt to collect copays. Suggestions to develop good policy and avoid being caught in a trap of copay forgiveness include, but are not limited to:

Health Insurance Portability and Accountability Act (HIPAA)

The inception of HIPAA dates back to the early 1990s when it became apparent that healthcare could become more efficient by using electronic medical records (EMR). As a result, HIPAA Public Law 101-191 was passed in 1996.

Ensuring Data Privacy and Security Compliance in the COVID Era

Shortly after we rang in a new decade on January 1, 2020, we found ourselves in the middle of a pandemic. Many businesses, including dental office , were scrambling to comply with mandated closure of non-essential businesses. Regulatory agencies, such as the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS), maintained active compliance efforts.

In 2019, prior to the pandemic, OCR announced its Patient Right of Access Initiative. This initiative is an enforcement priority that supports individuals' right to timely access to their health records at a reasonable cost under the HIPAA Privacy Rule. See the Section titled "Patient Right to Access or Restrict Disclosure of PHI" for additional information related to this Initiative.

During the pandemic, the HHS issued several COVID-19 bulletins about patient privacy. Two bulletins are of particular interest to dental practice administrators:

- The February 2020 Bulletin served as a reminder that healthcare professionals are permitted to share patient information that would normally be privacy-protected for treatment and public health activities. This may impact your practice if you are contacted by such agencies as the CDC or a state or local health department for the purposes of contact tracing
- The March Bulletins dealt with telehealth. The Office for Civil Rights (OCR) stated it would not impose penalties for HIPAA violations against healthcare providers in connection with their good faith provision of telehealth using communication technologies during the COVID-19 nationwide public health emergency. The OCR further stated covered health care providers may use certain popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom, or Skype, if they were used in good faith for telehealth during emergency. However, Facebook Live, Twitch, TikTok, and similar public facing video communication applications are not allowed because they are open to the public and/or allow unrestricted access to the communication and do not provide the required level of security.

In January 2021, the HIPAA Safe Harbor Rule was signed into law. Essentially, this law states that if your practice has implemented "government-recognized" security processes and you have a breach, the OCR may not be as punitive as usual when assessing fines and penalties. See the Section titled "Rise of Privacy Complaints and Cyber Security Issues" for additional information related to the HIPAA Safe Harbor Rule.

Background

The Health Insurance Portability and Accountability Act (HIPAA) is divided into five titles or sections. Title II, known as "Administrative Simplification " sets forth national standards for electronic transactions, code sets, and unique provider identifier . This title includes two important rules: the Privacy Rule and the Security Rule. The intent is to ensure security and efficiency during any exchange of protected health information (PHI) throughout the healthcare system.

The **Privacy Rule** establishes regulations governing disclosure and use, by providers and others, of verbal and written PHI. The **Security Rule** requires providers and others who maintain health information in electronic form to protect the confidentialit , integrity, and availability of PHI, frequently referred to as the CIA triad.

Among other things, HIPAA grants patients basic rights to:

- Access their health information
- Obtain an accounting of disclosures of their health information
- Correct or amend their health information
- Receive a copy of your Notice of Privacy Practices
- File a complaint with your office or the Office of Civil Righ

The Privacy and Security Rules were considerably strengthened by the HITECH act of 2009 and the Final Omnibus Rule of 2013.

Who Is Required to Follow HIPAA?

HIPAA regulations apply to "Covered Entities." Under HIPAA, a Covered Entity (CE) is defined as any entity that is one or more of the following:

- A healthcare provider that conducts certain transactions in electronic form
- A healthcare clearinghouse
- A health plan

Healthcare providers such as physicians, dentists, chiropractors, psychologists, clinics, nursing homes, and pharmacies meet the definition of a Covered Entity if they transmit any information in electronic form in connection with a transaction for which the HHS has adopted a standard. HHS adopted standards for the following administrative and financial healthcare t ansactions:

- Health claims and equivalent encounter information
- Enrollment and disenrollment in a health plan
- Eligibility for a health plan
- Healthcare payment and remittance advice
- Health plan premium payments
- Health claim status
- Referral certification and authorizatio
- Coordination of benefit

The regulations require Covered Entities (CEs) who transmit PHI in any form (paper, electronic, or verbal) to take measures to protect patient information.

Medicaid and Children's Health Insurance Program

Contract Basics

Medicaid and the Children's Health Insurance Program (CHIP) are joint federal and state programs that assist with medical costs for those with limited income and resources. Administration of the Medicaid, and CHIP programs vary by state. Typically states use one of three methods:

1. Administration through a state agency (agency is required to follow state provider manual).
2. Administration by a managed care company through a dental carve out (managed care company must follow general state rules and cover the standard benefits) but may be able to set their own policies.
3. Administration by a managed care company where dental coverage is part of a health plan (carved in) – (the health plan must follow general state rules and cover standard benefits) but may be able to set their own policies).

Some health plans administer dental benefits in house, while others may subcontract out to dental benefits administrators. Additionally, managed care contracts (scenarios #2 and #3) can be either "risk" or "administrative services only (ASO)." Risk means the managed care plan takes on the financial risk of claims reimbursed; ASO means that the state maintains the risk of claims reimbursed.

Managed care follows most CMS (federal) guidelines in the MegaRule. One such requirement is the 85/15 medical loss ratio which requires managed care plans to expend 85% of the capitation fees received from the state on claims or "quality" initiatives. If a managed care company does not expend 85% (e.g., 83%) then the company must return the extra money (2%) to the state.

Medicaid contracts and associated Provider Manuals provide extensive information to the Medicaid provider and can be quite lengthy. It is important that the provider and team members fully understand the requirements outlined in both. These documents spell out the obligations of the provider, the fee schedule, the covered procedures, claim submission and documentation requirements, NPI credentialing, forms of payment, and much more.

NPI and Credentialing

All healthcare providers are required to obtain a National Provider Identifier (NPI) as part of the Health Insurance Portability and Accountability Act (HIPAA). This unique, 10-digit number is issued by the Centers for Medicare and Medicaid Services (CMS). There are two types of NPI numbers:

- **Type 1: Identifies an *individual* healthcare provider, such as a doctor. (Note: Type 1 NPI is also used by pharmacies to identify the prescribing doctor.)**
- **Type 2: Identifies an *organization* or *billing entity*, such as a dental clinic, practice, corporation, hospital, or dental school. (Note: An organization may include a partnership or LLC, and does not have to be a corporation.)**

Medicare

Only recently have general dentists more carefully considered the impact of Medicare on their practice. While typically most dental procedures are excluded, rulings from The Centers for Medicare & Medicaid Services (CMS) have brought these issues to the forefront for dental providers.

Understanding how Medicare impacts your dental practice is important and does not have to be complicated. However, it is important that you are aware of what is expected of you as a healthcare provider as well as your patients' rights under Medicare. You also need to be familiar with the Medicare provider status of each doctor in your practice along with the responsibilities related to that status and which benefits your patients may or may not be entitled to.

Medicare was created in 1965, and is a federal health insurance program for:

- People who are 65 or older
- People under age 65 with certain disabilities
- People of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant)

The Medicare program is structured into four distinct "parts," each administering different areas of healthcare. Original Medicare (also referred to as "traditional") is administered by the federal government and is made up of Parts A and B:

Part A (hospital insurance) – Provides premium-free benefits to individuals that have paid Medicare taxes for ten years or more covering costs associated with services such as inpatient hospital care, drugs prescribed while in the hospital, skilled nursing facilities, certain home health, and hospice. Note: dentists would never submit charges to Medicare Part A.

Part B (medical insurance) – Provides benefits for medical services such as physician's fees, laboratory and radiology tests, mental healthcare, and ambulances. Not all beneficiaries have this coverage. It is voluntary and includes a premium to the recipient based on their income level. Part B benefits pay for 80% of medically necessary physician services and out-patient services. The patient or their supplemental plan will pay the remaining 20%.

Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) are also covered under Medicare Part B. Oral appliances for the treatment of obstructive sleep apnea are considered by Medicare to be Durable Medical Equipment (DME) and could be a covered benefit under certain circumstances. Note: while DME is paid by Medicare Part B, providers must submit a separate enrollment to become a DME supplier to file claims for sleep apnea devices.

Part C (hospital and medical coverage combined) – Also referred to as Medicare Advantage (MA). Under this provision, private health insurance companies contract with the Centers for Medicare and Medicaid Services (CMS) to provide Medicare benefit . Rather than provide a separate benefit these plans replace a beneficiary s traditional Medicare benefit . This is a premium-based plan purchased directly from commercial payers and is not federally funded.

MA Plans must provide at least the same benefits as traditional Medicare but may have different rules and coverage restrictions. Also, many MA Plans offer additional benefits not available under traditional Medicare. These include, but are not limited to, coverage for vision, hearing, and dental care.

If your practice is considered in-network with a dental payer administering an MA plan, there is likely a clause within your contract obligating you to treat all patients with dental coverage, including Medicare beneficiarie . This is problematic if you have opted out of Medicare as your dental contract is at risk of being dropped due to your Medicare status. Dentists who previously opted out of Medicare are now enrolling to mitigate possible discrepancies in claims processing for non-Medicare patients with plans through the same payer.

Part D (prescription drug insurance) - Covers outpatient prescription drugs, which are medications obtained from a pharmacy. While Medicare rulings apply to the prescribing and regulation of Part D, it is administered by third-party private payers who have contracts with the government. Traditional Medicare does not cover outpatient prescription drugs. Beneficiaries must purchase Part D coverage separately. However, Medicare Advantage Plans often include prescription drug coverage. Only pharmacies will enroll as Part D providers.

The Centers for Medicare and Medicaid Services (CMS) has designated geographical areas, known as jurisdictions, and placed the administration of these jurisdictions under Medicare Administrative Contractors (MAC). The MAC for each jurisdiction is responsible for claims adjudication, provider enrollment, provider education, and support. All provider enrollment applications and opt out affidavits are submitted to the state-assigned MAC. In addition, fee schedules and some coverage determinations are set by each jurisdiction's MAC. For this reason, there may be some variance in benefits and reimbursement based on geographical location. A list of Medicare jurisdictions by state can be found at: *https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/MAC-Website-List*.

Medicare and Dentistry

Historically, dentists did not consider Medicare to have a major impact on their practice since Medicare does not cover most dental procedures. Recent CMS rulings have forced dentists to reconsider the effect of Medicare laws on their practices. Four regulations impacting dentists today are:

- Mandatory filing law
- Requirements for ordering and referring physicians
- Medicare Advantage Plans
- Oral devices for obstructive sleep apnea

The following will cover the impact each of these have on your dental practice and guidelines for compliance with these rulings.

Mandatory Filing Law

Even though the mandatory filing law has been in effect for nearly 30 years, it remains the least understood Medicare law for dental providers. Since September 1, 1990, healthcare providers have been required under the Social Security Act (section 1848(g) (4)) to file claims for all procedures that Medicare potentially covers. This law applies to all healthcare providers, including dentists.

Preferred Provider Organizations (PPOs)

Managed healthcare is a way of life in our country and is heavily impacting the dental industry. Navigating PPOs requires careful piloting and a lot of forethought to practice location, demographics, and most importantly, profitability.

Nationally, Preferred Provider Organization (PPO) plans are the most favored type of plan among Americans, and this ratio continues to rise. More people than ever before have dental benefit , resulting in greater consumer awareness to in-network providers.

Insurance payers design PPO plans to remain competitive in the marketplace, while meeting the demand for lower cost coverage options. Employers and individuals purchase these plans to take advantage of these lower cost options. Doctors participate in PPO plans hoping to gain an influx of new patients in order to offset the reduced fee schedules they offer, while maintaining their patient base. However, the reduced fee schedule of a PPO results in lower cash flo , causing the doctor to work harder to maintain profitabilit .

Due to the major influence PPOs have in the marketplace, practices feel the pressure to participate, yet are unsure of how to take the helm. Some that avoided joining PPO networks in the past are reconsidering their decision. Likewise, some that joined are now reassessing their continued participation among plans.

In order to successfully navigate today's PPO landscape, practices must be knowledgeable in making the correct decision as to joining, dropping, or remaining in each plan. Review the chapters below for more details and need-to-know information on Preferred Provider Organizations.

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Top Administrative Questions and Answers

Increase your knowledge of dental insurance administration by reviewing the top administrative questions and answers asked by dental teams nationwide.

ALTERNATE BENEFIT

Q: How can we obtain an alternate benefit for a patient?

A: Sometimes a procedure is denied due to a missing tooth or a non-covered procedure clause and an alternate benefit may be available. Most often, an alternate benefit is available with the patient's benefit plan but may not be automatically applied. When this is the case, appeal the denied claim and ask for an alternate benefit of a similar procedure. Some examples would be:

- Fixed partial denture (bridge) is denied due to a missing tooth clause. Ask for an alternate benefit of a single crown for each of the retainer crown(s), if these retainers are in need of a crown on their own merit. Send a brief narrative stating why a retainer tooth would require a crown.
- Many plans will deny coverage for a fixed partial denture (bridge) or an implant when teeth are missing on both sides of the arch. The patient may receive an alternate benefit of a removable partial denture. Patients are often surprised to learn their plan has this type of alternate benefit restriction. This is why the payer will ask for a full mouth series or panoramic radiographic image to confirm missing bilate al teeth when reimbursement for a fixed partial denture (bridge) is sought
- When a plan does not have an implant rider, the patient may receive an alternate benefit for either a single crown for the abutment or implant supported crown, or a partial or complete denture benefit in the case of an abutment or implant supported overdenture.
- When posterior composites are denied, ask for the alternate benefit of an amalgam resto ation.
- If periodontal maintenance is denied due to a frequency limitation, ask for the alternate benefit of a prophylaxis if the plan also has a benefit for a prophylaxis. Be sure to include a brief narrative stating "… If a benefit for periodontal maintenance is not available, please consider the alternate benefit of a prophylaxis, as a prophylaxis was performed as part of the periodontal maintenance procedure." While only D4910 is reported, the hygienist should state in the clinical notes that a prophylaxis (D1110) was performed in conjunction with the periodontal maintenance (D4910) procedure.

The key is to *always* appeal and ask if there is an alternate benefit available. The plan document may also outline the alternate benefit provisions of the plan. The plan document may only be obtained by the patient, not by the provider. The patient may request the plan document from the Human Resources department at their place of employment, or from the insurance company if it is an individual plan purchased by the subscriber.

(Continued on next page)

APPEAL

Q: How do I write an appeal?

A: When submitting an appeal for a denied claim, never submit a new claim. Return a copy of the denial EOB with a note at the top in *bold* print stating "second review request." Attach all supporting documentation even if the supporting documentation was submitted with the initial claim. Also attach an appeal letter describing the procedure and the medical necessity.

Read the EOB carefully. If an additional radiograph or further supporting information is requested, be sure to send it with the second review request. If you are unsure about what information the payer is requesting, call to confirm exactly what information is necessary to continue review of the claim

Send the second review request to the appeal address of the payer. The appeal address is not always the same as the initial claim address. Check with the payer for the proper address prior to sending the appeal. The appeal address is often located on the EOB.

CLAIM SUBMISSION

Q: Who must sign the assignment of benefits? Is it necessary to have the insurance subscriber sign an assignment of benefits and release of dental information form if the spouse and children are patients, but the subscriber is not?

A: Most dental practices simply rely on the patient's signature. A spouse is able to sign the assignment of benefits for herself and for dependent children, as if they are the insured. However, it is important to obtain and keep a copy of the photo ID (i.e., driver's license) of the spouse/patient to verify the identity of the individual using the insurance card. There have been cases where a patient has "borrowed" an insured's identity and insurance card in order to use the insured's benefit . In several cases the provider has been required to reimburse the payer for payments made for the "imposter's care" because the practice failed to properly verify the identity of the patient.

A subscriber does not have to sign a "standing" authorization to release patient information for a spouse except in cases where the subscriber has power of attorney for the patient, or if the patient is a minor. Under HIPAA, once a patient signs an acknowledgment of the provider's Notice of Privacy Practice, unless the patient has paid for services in full at the time of treatment and requested in writing that the provider not bill the dental plan, the provider does not need a separate authorization to release patient information to the payer. This is allowed as an integral part of the treatment, payment, and healthcare operations.

Q: What place of service code and treatment location address should be reported on the claim form when a patient is treated in the emergency room at a hospital?

A: The place of service should be entered in Box 38 of the 2019 ADA Dental Claim Form. The place of service code for a hospital emergency room visit is 23. The treatment location should reflect the address where the treatment was actually performed. The billing entity (office) information remains the sam .

Q: Why is it important to include the address of the place of service on the claim form?

A: If a dental practice has multiple locations and these locations share the same practice name and billing entity, then the address of the place of service must be reported on the claim form if different than the address of the billing entity. The ZIP code of the place of service often determines the fee level of the benefit received. If a hospital case, then the hospital address is listed as the place of service, etc.

Administrative Scenarios

The following administrative scenarios are for training purposes only. The answers provided are specific to the scenario described and any variance in the scenario may change the answer. Be sure to consult with your healthcare attorney regarding your specific administrative policies.

SCENARIO #1

Dr. Smith's pastor presents for dental treatment. Dr. Smith has extended a professional courtesy of 50% to Pastor Jones for his dental treatment totaling $100. Pastor Jones writes a check for $50. During checkout Pastor Jones lets Suzy know that he now has dental benefits under his wife's new plan and he would like to have a claim submitted on his behalf.

The fee intended to be accepted as payment in full (discounted fee) must be disclosed on the claim form as outlined below.

Prophy (D1110) fee $100 (full practice fee) - $50 (50% discount) = $50 (discounted fee)

Note: $50 is reported as the fee charged on the claim form, not the full practice fee. No narrative is needed.

Due to auto adjudication of most claims, we do not recommend submitting your full practice fee along with a narrative in the remarks section stating the patient will be receiving a discount on the fees submitted. With auto adjudication, it is likely that the remark will *not* be viewed and the payer may pay the benefit based upon the full practice fee, not the discounted fee. The patient or provider would then have to refund any excess money received above the actual $50 charged under this scenario. Always enter the fee actually charged. No narrative is needed.

SCENARIO #2

Dr. Smith's pastor presents for dental treatment. Dr. Smith would like to extend a courtesy to Pastor Jones by accepting the Pastor's insurance benefits as payment in full This is a rare occasion.

Dr. Smith submits the claim showing the full practice fee and must disclose to the insurance company that Pastor Jones will not be paying the copayment and deductible. To properly disclose this courtesy to the payer Dr. Smith includes a narrative stating, "The patient is not participating in the cost of treatment." This alerts the payer that the patient will not be paying their required copayment. With auto adjudication, the payer will probably not read the narrative. However, if reviewed, the payer may choose to pay the patient's benefit as described in the plan document, or the payer may choose not to participate in the cost of treatment and not provide reimbursement.

Note: Routine copayment and deductible forgiveness is prohibited by state and federal law and PPO contracts. Consult a healthcare attorney for interpretation and guidance.

Implant Coding

A Complete Review of Reporting Dental Implants

One of the most challenging areas of dental coding is the proper reporting of implant related procedures. Not only are there numerous CDT codes to describe the various implant related procedures, but the codes utilized may not all be in the Implant Services Category (D6000 – D6199) of CDT, leading to even more confusion and coding errors. For example, membranes (D4266/D4267) are in the Periodontics section and sinus lifts (D7951/D7952) are included in the Oral and Maxillofacial Surgery Services Category section of CDT.

Implant techniques and technologies continue to evolve and improve at a rapid pace. These improvements have resulted in an increased number of patients electing to proceed with implants for replacement of missing teeth. Additionally, many dentists, who did not previously offer these services, have added implant placement and/or implant restorations to their clinical procedure mix.

The Implant Body

Proper selection of the implant body code is determined by the type, size, and/or the amount of time the implant is intended to remain in the mouth.

D6010 Surgical placement of implant body: endosteal implant

A full sized, endosteal implant is the most common type of implant placed. D6010 reports a surgically placed, long-term implant into the alveolus or basal bone. Placement of the healing cap may be included in the D6010 procedure, which does not require a second stage surgery.

Implant placement may be reimbursed when a dental plan includes an implant rider, subject to the plan's limitations. These limitations may include annual maximums, annual reimbursements, missing tooth clause, or alternate benefit .

Example of a conventional full size implant. (Courtesy Drake Dental Lab)

D6011 Surgical access to an implant body (second stage implant surgery)

Second stage surgery is a surgical procedure that exposes the implant body, typically after osseointegration. Once the implant is exposed with second stage surgery, an abutment or healing cap may be placed. The healing cap maintains an access opening to the implant body prior to the restorative phase of the implant treatment. Code D6011 includes placement of a healing cap. A healing cap is not reported separately, nor is a separate fee charged for the healing cap.

Historically, payers have considered second stage surgery to be global to implant placement and not reimbursed separately. However, some plans do include coverage for D6011. Practices should review their fees for D6010 and D6011 and adjust accordingly. The practice may miss out on legitimate reimbursement if D6011 is bundled with the fee for D6010.

Laboratory Testing

As integration of medical and dental health services continues to grow, dentists are becoming more involved in the early detection and management of multiple oral and systemic diseases.

As dentistry solidifies its rightful place among health care providers, dentists have become more involved with the testing of saliva and blood. Testing of oral DNA has become more common to assist in providing diagnosis, directing treatment, and/or prevention of periodontal disease.

Because health care professionals have begun to work together to monitor and maintain patients' health, there will be an increase in the number and type of tests dentists offer their patients to elevate overall dental and medical health. While this is considered beneficial to both patients and providers, it is important to note there are federal regulations controlling the collection and testing of specimens.

Clinical Laboratory Improvement Amendments (CLIA) of 1988

The Centers for Medicare and Medicaid Services (CMS) adopted the Clinical Laboratory Improvement Amendments (CLIA) of 1988 *"to establish quality standards for all non-research laboratory testing performed on specimens obtained from humans for the purpose of diagnosis, prevention, or treatment of disease, or assessment of health."* These specimens include saliva, blood, body fluid, and tissue.

Prior to the adoption of CLIA, federal laboratory quality standards applied only to hospital and independent laboratories. Today all laboratories, including those in medical and dental offices, are required to comply with CLIA regulations. Only research laboratories and facilities that perform testing for forensic purposes are exempt from CLIA.

All states and U.S. territories have CLIA regulations. Although CLIA is federally mandated, as of July 2021, there are two states (Washington and New York) that are exempt from CLIA regulations because these states have their own state licensure programs.

Washington

HSQA/IIO-Laboratory Quality Assurance
Clinical Laboratory Evaluation Program
Phone: 253.395.6745
Fax: 253.872.6803

New York

Clinical Laboratory Evaluation Program
State of New York Department of Health
The Nelson A. Rockefeller Empire State Plaza
Phone: 518.485.5378

For this reason, regardless of your location, we recommend you contact your state department of health to inquire about any specific requirements regarding labo atory testing in a dental office applicable to your stat .

(Continued on next page)

Periodontal Matters

Periodontal Re-Evaluation

Periodontal therapy makes up a large part of the hygiene service mix of many general dental practices. Therefore, one of the most common periodontal coding questions asked is "What code reports a six week re-evaluation visit following scaling and root planing?" Unfortunately, there is not a universal answer. Rather, the answer varies depending on the procedure(s) performed. Also, the procedure(s) performed are dependent on your practice's specific protocols and the doctor's recommendation(s). Below, several possible coding scenarios are outlined for reporting a periodontal re-evaluation visit.

D1110, prophylaxis – adult, may be reported when a prophylaxis is performed at the periodontal re-evaluation visit. This procedure typically has a good chance of reimbursement.

Bear in mind that a very few plans may cancel the patient's periodontal benefit if a prophylaxis is performed after scaling and root planing, prior to periodontal maintenance. Some plans have a frequency limitation of 30 to 60 days between any scaling and root planing procedure and a prophylaxis procedure, regardless of the order performed. This is plan-specific Be sure to verify the patient's benefits prior to initiating this treatment sequence. Furthermore, review any Preferred Provider Organization (PPO) contracts and Processing Policy Manuals for frequency limitations regarding reporting a prophylaxis following scaling and root planing.

Examples of contract language that may be found in the Processing Policy Manual are:

- "A separate fee for all necessary postoperative care, finishing procedures (D1110, D1120, D4341, D4342, D4355, D4910), evaluations, or other surgical procedures (except soft tissue grafts) on the same date of service or for three months following the initial periodontal surgery by the same dentist/dental office is non-billable."
- "The fee for the following services: D1110, D1120, D4355, and/or D4910 will be non-billable if the services are rendered by the same dentist/dental office within 30 days after the most recent scaling and root planing (D4341, D4342) or other periodontal therapy."

PPO contract verbiage can differ widely among payers, so it is imperative to read all of your current PPO Processing Policy Manuals for each PPO in which your practice participates. Additionally processing policy provisions can and will be changed from time to time, as long as proper written notification is provided, as outlined in your PPO contract.

D0180, comprehensive periodontal evaluation – new or established patient, may be reported if the dentist performed the oral evaluation and performed a complete periodontal probing and charting for patients with periodontal disease or who are at greater risk for developing periodontal disease. A complete periodontal charting and probing includes, but is not limited to, six-point probing depths per tooth, bleeding points, clinical attachment loss (CAL), areas of furcation involvement, mobility, recession, etc.

(Continued on next page)

Top Coding Questions and Answers

Below are some of the most common coding questions asked by dental teams.

BRIDGE (FIXED PARTIAL DENTURE)

Q: What code reports the re-cement or re-bond of a bridge?

A: To report the re-cement or re-bond of a natural tooth bridge, report D6930. This code is used to report the re-cement or re-bond of conventional fixed partial dentures (bridges) and Maryland bridge .

To report the re-cement or re-bond of an implant bridge, report D6093. This code is used to report the re-cement or re-bond of both implant and abutment supported fixed partial dentures (bridges)

CBCT

Q: Our general dentistry practice has a specialist in another office capture all of our CBCT images. How do we report this?

A: CDT codes for CBCT scans are based either on the capture and interpretation of the image, or just the capture (no interpretation) and may also be determined by the position and size of the image produced and interpreted. See pages 340-341 for a listing of CDT codes to report CBCT scans. Proper CDT coding to report CBCT and related services is determined by 4 variables:

1. Who captured the data or who performed the scan?
2. Who viewed and interpreted the image(s) that were produced by the CBCT?
3. What area of the head was captured by the CBCT?
4. What type of image was produced by the data captured (3D, fused, used in a simulation, or a subtraction process)?

Q: We are sending Mrs. Smith's CBCT image to a radiologist for an additional radiology report. Should we charge a separate fee for this service since we are paying the radiologist for this additional report?

A: The most appropriate way to charge the patient for the radiologist's interpretation is to have the radiologist directly bill the patient and the patient's insurance for the interpretation only. However, if the radiologist prefers you bill the patient and the patient's insurance, report D0391, interpretation of diagnostic image by a practitioner not associated with capture of the image, including report. The radiologist is reported as the treating doctor and your practice as the billing entity on the claim. In this case, the fee reported to the patient and insurance must be the same fee your practice pays the radiologist. Reporting a different fee may be interpreted as fee splitting and is considered inappropriate.

CROWN

Q: What is the definition of a ¾ crown?

A: A ¾ crown on a premolar or molar covers the occlusal and 3 lateral surfaces (generally the mesial, lingual, and distal surfaces) preserving the facial surface. The restoration extends below the height of contour of either the facial or lingual surface. A ¾ crown on an anterior tooth, involves either the mesial, facial and distal surfaces or the mesial, lingual, and distal surfaces. See D2783 for a ¾ porcelain crown (more aggressive prep) versus a porcelain veneer D2962.

DENTURES AND PARTIALS

Q: How is a Cu-Sil® partial denture reported?

A: A Cu-Sil® partial includes a rubber gasket that fits over an anchor tooth. If the partial is fabricated using a flexible base, then D5225 reports the maxillary partial denture and D5226 reports the mandibular partial denture. If the partial is fabricated using a resin base, including the Cu-Sil® rubber gaskets, then D5211 reports the maxillary partial denture and D5212 reports the mandibular partial denture. Diagnostic casts (D0470) are considered a part of the global fee for fabricating a maxillary partial denture.

Q: How is a unilateral partial denture fabricated using Triflex® or Valplast® materials reported?

A: Report D5284, removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests, and teeth) – per quadrant for a Trifle ® or Valplast® unilateral partial denture. This code reports a unilateral partial with a flexible bas .

DIAGNOSTIC

Q: What code reports a caries detectability test using iTero® Element 5D, or similar device?

A: Report D0600 for this diagnostic procedure. The device used must have the ability to quantify structural mineral changes in tooth structure. Reimbursement varies among payers.

Q: Can D0600 report any cavity detecting device or technique?

A: No. The technology used for this diagnostic procedure uses non-ionizing "light" and must be capable of quantifying, monitoring, and recording changes in the structure of enamel, dentin, and cementum. It is inappropriate to report D0600 for traditional transillumination technology or techniques. A few examples of technology that are capable of providing this service are iTero® Element 5D, CariVu™, DIAGNOcam, LUM, and SoproLife diagnostic camera.

Q: Can a separate fee be charged when using the VELscope® or OralID® to perform an adjunctive oral cancer screening evaluation?

A: Yes, report D0431. The hygienist can screen for oral cancer with the device, but the dentist must also perform the procedure in order to make a definitive diagnosis and charge for the procedur .

Q: How do we report diagnostic casts generated via digital scanning technology?

A: D0470 reports both digital and traditional cast models.

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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 dental practices, helping them identify hurdles 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 make him uniquely qualified to share his wealth of knowledge with the dental profession.

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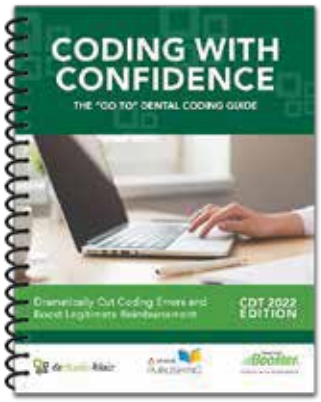

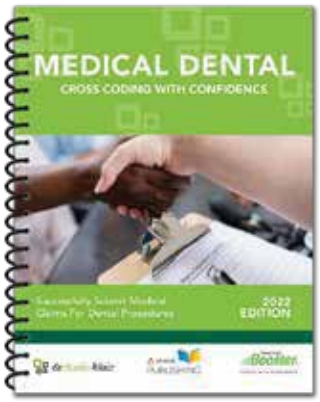

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