These are sample pages of Coding With Confidence containing Front and Back Cover, Table of Contents, Explanation of Legends, Various Codes, Glossary, and Index.

CODING WITH CONFIDENCE

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CDT 2022 EDITION

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PRACTICE Booster CODING WITH CONFIDENCE

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EXPLANATION OF THE USE OF THE LEGENDS

Throughout the CDT 2022 Code section of this Guide, 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, Editorial Revision, 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 2022	This legend designates the official CDT 2022 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) ©2021 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, alternate 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 16 new procedure codes in CDT 2022.
REVISED	This legend identifies a substantive revision in the nomenclature and/or the descriptor of a code. Be sure to read the entire description of the revised code. There are 14 code revisions in CDT 2022.
EDITORIAL REVISION	This legend identifies 10 editorial code changes made by the Code Maintenance Committee for CDT 2022.
DELETED CODE	This legend identifies a procedure code that was deleted. There are 6 deleted codes in CDT 2022.
PREVIOUSLY DELETED CODE	This legend identifies a procedure code that was previously deleted. The Guide 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.

D0171 RE-EVALUATION – POST OPERATIVE OFFICE VISIT CDT 2022

1. D0171 could be reported when "assessing the status of a previously performed procedure," such as grafts, oral surgery, implants, periodontal surgery, removable prosthodontics, and endodontics which may require a *follow-up* post-operative visit.
2. Based on the nomenclature language, the re-evaluation – post-operative visit (D0171) could be reported following definitive treatment (i.e., periodontal, graft, root canal, extraction post-op) or palliative D9110 treatment. The fee for any initial periodontal treatment, such as scaling and root planing (SRP), usually includes any post-operative evaluation associated with said procedure. Likewise, a post-operative (within thirty days) routine evaluation after oral surgery or a root canal would generally be considered inclusive in the global surgery fee.
3. D0171 could be used to report a periodontal re-evaluation that includes charting and probing. The nomenclature of D0171 specifically indicates it is for a post-operative visit. Currently, there is no *specific* code to report a stand-alone periodontal re-evaluation by a hygienist, so unspecified periodontal procedure, by report (D4999) could be used to report this procedure. D4999 is rarely reimbursed. Those doctors who do not participate in the patient's dental plan may hold the patient responsible for payment of the unspecified procedure, D4999. However, if a comprehensive periodontal evaluation is performed by the dentist including complete charting and probing, D0180 may be reported, which should have a higher fee than D0171. However, D0180 (just like D0171) would be subject to any frequency limitations.
4. D0171 could be used to report a post-operative visit to check the stability of an implant after placement. D0171 would include the use of technology, such as Osstell IDx, to check stability. Checking stability as a stand-alone procedure is considered inclusive to the global fee of the implant placement and is not reported as a separate procedure.

LIMITATIONS

1. All periodontal, endodontic, and oral surgery procedure codes generally include any routine follow up (to check healing, etc.) within thirty days of initial treatment (six months if a prosthesis) as a policy limitation, so D0171 will probably not be reimbursed.
2. Most plans will consider D0171 part of the patient's two evaluations per year allowance or one evaluation per six months if charged and reported.
3. The fee for D0171 may be excluded by payers if reported in conjunction with other definitive procedures on the same service date. However, D0171 is a "stand-alone" oral evaluation code and may always be reported separately.

TIPS

1. Consider limiting the billing of re-evaluation – post-operative visit (D0171), since the UCR fee will be *lower* than other oral evaluations. This procedure generally is subject to the "two evaluations per year/12 months" or "one evaluation per six months" limitation. Occasionally payers will reimburse a third evaluation, if the evaluation occurs in a *different* billing office or the patient sees a specialist. See the palliative (D9110) and consultation (D9310) codes for other reporting options that might be applicable.
2. A follow-up visit due to extensive infection and complications, for instance, could be reported separately. See treatment of complications (D9930). However, D9930 generally is not paid as a separate procedure by payers unless a different office (provider) performs the service. A follow-up evaluation is considered a part of the global treatment procedure unless provided by a different billing entity.

D0180 REVISED COMPREHENSIVE PERIODONTAL EVALUATION - NEW OR ESTABLISHED PATIENT CDT 2022

This procedure is indicated for patients showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking or diabetes. It includes evaluation of periodontal conditions, probing and charting, an evaluation for oral cancer, the evaluation and recording of the patient's dental and medical history, and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, and occlusal relationships.

REVISIONS This procedure is indicated for patients showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking or diabetes. It includesevaluation of periodontal conditions, probing and charting, an evaluation for oral cancer, the evaluation and recording of the patient's dental and medical history, and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, and occlusal relationships ~~and oral cancer evaluation~~.

1. Do not report D0180 in *addition* to the comprehensive oral evaluation (D0150) on the *same* service date. However, the general practitioner can always report D0180 provided the patient exhibits signs and symptoms of periodontal disease, or risk factors such as smoking or diabetes. The dentist or hygienist performs a detailed full mouth periodontal charting with six points/tooth probing on the same evaluation date.
2. D0180 is not used to report a periodontal screening record (PSR) since *periodontal screening*, where indicated, is now specifically described as a component of periodic oral evaluation (D0120). D0180 is more detailed and includes " six point per tooth probing (full mouth) and charting," and also identifies furcations, wear facets, abfraction lesions, areas of mobility, bleeding on probing, areas and amounts of recession, amounts of remaining attached gingiva, etc. D0180 may be reported for both new and established patients according to the nomenclature. See comments and limitations below.

COMMENTS

1. Key elements of D0180:
   a. Reported when performing a comprehensive periodontal evaluation only on a "qualified" patient who shows signs and symptoms of periodontal disease, or risk factors such as smoking and diabetes.
      i. May be performed on both new or established patients.
      ii. May be reported by general dentists or periodontists as all codes are available to any dentist practicing within his/her scope of license.
   b. Requires all the components of a comprehensive oral evaluation (D0150) *plus* a complete and comprehensive periodontal charting (of all teeth).
      i. D0150 gives the option of periodontal screening or charting, as deemed necessary.
      ii. D0180 requires complete periodontal charting, which includes, but is not necessarily limited to six-points-per-tooth pocket depths, recessions, furcations, areas of mobility, bleeding points, purulent discharge, minimal attachments, (i.e., amount of remaining attached gingiva) and/or a periodontal diagnosis.
2. The comprehensive periodontal evaluation (D0180) may be reported for *new* or *established* periodontal patients presenting with signs, symptoms, and risk factors (such as smoking or diabetes) of periodontal disease.
3. The comprehensive periodontal evaluation (D0180) is not specialty-specific. The general practitioner can always report it, as with any CDT code. However, the general practitioner would generally report more of the comprehensive, extensive, and all-encompassing comprehensive oral evaluations (D0150) for most new patients. D0180 may be reported for the *qualified* periodontal patient and the Maximum Plan Allowance (MPA) may be higher for it than for D0150.
4. The comprehensive periodontal evaluation (D0180) is indicated for patients showing signs/symptoms of periodontal disease, or for patients with risk factors such as smoking or diabetes. If evident, list these signs/symptoms and/or risk factors in the patient chart. Reporting the D0180 code indicates that extra time and effort were spent in making an in-depth evaluation of the overall periodontal condition, including charting and "full mouth" probing. D0180 may be reported either for the initial (comprehensive) new patient evaluation or for the recall visit. However, D0180 is typically subject to the "two evaluations per year/12 months" or "one per six months" limitation. Some payers will reimburse a third evaluation, if the evaluation occurs in a different office or with a specialist. Some payers will "downcode" D0180 or "remap" it to the D0150 or D0120 lower fee for reimbursement.
5. The comprehensive periodontal evalutation requires an evaluation for oral cancer and should be noted in the clinical notes.

TIPS

1. Some offices take bitewing radiographic images on children at the comprehensive oral evaluation (D0150) and a panoramic radiographic image (D0330 or D0701) (for growth and development studies) at either a subsequent operative visit or on a later recall service date, as determined by the dentist.
2. Reimbursement for a panoramic radiographic image (D0330 or D0701) may be better when taken alone on a given service date than when taken in conjunction with bitewing images on the same service date.
3. Some offices establish a standard panoramic radiographic image (D0330) fee for two clinical situations. A lower standard fee for the panoramic radiographic image taken at the comprehensive oral evaluation (D0150) appointment in conjunction with bitewing diagnostic radiographic images. A higher standard fee for the panoramic radiographic image is established for a stand-alone panoramic image. (Set up a D0330A and D0330B fee to reflect whether the panoramic image is stand-alone or in conjunction with bitewings).
4. See full mouth debridement to enable comprehensive oral evaluation and diagnosis (D4355) for diagnostic radiographic image protocol options.
5. For panoramic radiographic image – image capture and interpretation, see D0330. For image capture only, see D0701.

ADDITIONAL INFORMATION

1. Diagnostic images are *adjunctive* to the diagnosis process, and must be medically *necessary*.
2. Diagnostic images should be *individually* ordered by the doctor, following evaluation of the patient and performed for a *specific* reason(s). The justification for the radiographic image(s) should be documented in the chart.
3. Diagnostic radiographic images should be evaluated and *interpreted* by the doctor, and the indications *documented* in the patient's chart.
4. Read FDA/ADA diagnostic image guidelines at www.ada.org/2760.aspx or https://www.fda.gov/radiation-emittingproducts/ medical-x-ray-imaging/selection-patients-dental-radiographic-examinations.pdf. Important!
5. Poor and/or non-existing *documentation* of the dental necessity for diagnostic radiographic images may result in a demand for repayment of benefits for radiographs taken if audited by the payer, even though the diagnostic radiographic images were taken!
6. Radiographs of diagnostic quality should be dated and labeled in the patient's record.
7. Be careful to note the location, left and right (upper/lower), if not otherwise indicated by the radiograph to avoid review errors.
8. For panoramic radiographic image including interpretation, see D0330. For image capture only, see D0701.

D0702 2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY CDT 2022

Cephalometric radiographic image (D0340/D0702) is considered to be a *component* of orthodontic records. There are no global or specific codes to report *orthodontic* records. See also photographic images (D0350) and diagnostic casts (D0470). These procedures, added to the cephalometric image, typically constitute orthodontic records.

COMMENTS

1. WARNING! A cephalometric cannot be reported as generated by a cone beam CT (CBCT). D0702 requires that the image of the head is made using a cephalostat to standardize anatomic positioning.
2. Cephalometric image (D702) is often payable as a component of orthodontic records. For reimbursement of this code check "yes" in Box 40 asking "Is this for orthodontics?" on the 2019 ADA Dental Claim Form. Also see diagnostic casts (D0470) and photographic images (D0350), which, together with a cephalometric image, are typically the components of the orthodontic records.
3. For 2-D cephalometric radiographic image including acquisition, measurement, and analysis, see D0340 and D0702.
4. It is common for a healthcare provider working in a remote location to perform the image capture only, store the image and send to a dentist for radiographic evaluation and diagnosis. In this instance, the image capture only would be reported by the remote healthcare worker and the dentist performing the interpretation and making the diagnosis would report D0391 interpretation of diagnostic image by a practitioner not associated with capture of the image, including report. Report D9996 for the teledentistry if it is not a real time encounter. Normally this would be a situation for D9996. However, if it is a real time teledentistry encounter then reporting D9995 would be appropriate.

NARRATIVES

1. A narrative should document evidence of *active* disease. Periodontal disease is episodic – it comes and goes. This may include, but is not limited to: 4mm or greater pockets that bleed on probing, radiographic evidence of bone loss, gingival recession, furcation involvement, inflammation, tooth mobility, subgingival calculus, and suppuration. Enclose diagnostic radiographic images to document bone loss. Also send a current periodontal chart which includes the date(s) that the chart was recorded.
2. When scaling and root planing all four quadrants on the same day, include a narrative to document the reason all four quads were treated in the same day, time spent, anesthesia required, pre-medication, apprehensiveness, medical conditions, travel time, etc. Include any supporting documentation that might justify the treatment of all four quadrants on the same service date. Generally speaking, thirty to forty-five minutes or more would be required to complete each quadrant of D4342. A predetermination is highly recommended.
3. If teeth #'s 4 and 5 need SRP one year after teeth #'s 2 and 3 have been treated with SRP, the 24 to 36 month frequency limitation may apply. If reimbursement is initially denied when reporting D4342 for #4 and #5, appeal the denial with an explanation. To aid in this process always include a list of the teeth treated with SRP on the claim form when submitting D4342 even though not necessarily required. Attach a copy of the original D4342 claim form reporting the treatment of teeth #'s 2 and 3 when submitting the subsequent D4342 claim for treatment of #'s 4 and 5. Including the documentation of the first treatment visit may increase the chances of being reimbursed for the second treatment visit.
4. When a patient requires scaling and root planing on one to three teeth in the same quadrant and prophylaxis on the remaining quadrants, and both D4342 and D1110 are provided on the same day, reimbursement for the prophylaxis is usually denied. Always appeal with an explanation outlining circumstances and the time involved, D1110 may be reimbursed upon appeal.

D4346 SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION – FULL MOUTH, AFTER ORAL EVALUATION CDT 2022

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 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.

D4346 does not define or report a "difficult prophy." A "difficult prophy" is D1110 taking a longer period of time. D4346 does not relate to the amount of time or effort required to complete the procedure. The D4346 procedure is applicable when it is used to treat generalized moderate or severe gingival inflammation in the absence of attachment loss. In other words, the procedure is based on the documented diagnosis rather than the intensity of treatment or the time required to complete the procedure.

D1110 is applicable for patients with chronic or acute, mild or localized gingivitis, to prevent further progression of the disease, not as a treatment for periodontal conditions.

D4355 enables a subsequent comprehensive oral evaluation (i.e., D4355 is performed upfront prior to the subsequent comprehensive oral evaluation appointment). D4355 is provided to remove gross deposits from the tooth surfaces that interfere with the ability of the dentist to perform a comprehensive oral evaluation. The descriptor of D4355 prohibits a D0150, D0160, or D0180 on the same service date. See D4355.

D4346 is a therapeutic service performed after a comprehensive oral evaluation (typically on the same day) has been completed and a diagnosis of generalized moderate or severe gingivitis is made. D4346 is provided to remove all deposits and allows the tissue time to heal following the diagnosis of generalized moderate or severe gingival inflammation without attachment loss. Typically a prophylaxis (D1110) would follow D4346 at an interval set by the dentist (2 - 4 weeks).

COMMENTS

1. There has been an ongoing debate about how to code for those situations where the treatment is considered more than a prophylaxis, but not rise to the level of scaling and root planing (slight bone loss). When a patient presents with generalized moderate or severe gingival inflammation, but no bone loss, the time and effort needed to treat the condition is typically beyond the standard prophylaxis. The inflammatory condition can be chronic or acute, but it is important to note there are very specific diagnostic criterion for submission (generalized moderate or severe gingival inflammation [gingivitis]). The descriptor clearly indicates that this code should not be submitted with D1110, D4341, D4342, or D4355. In nearly every case, with appropriate treatment and improved hygiene, moderate or severe gingival inflammation is a reversible condition, so the subsequent maintenance visit (a few weeks later) would be reported using the conventional D1110. D1110 would follow D4346 at an interval deemed appropriate by the dentist. Note: The existence of a code does not obligate the payer to necessarily reimburse it.

   The delivery of D4346 would only follow a diagnosis of generalized moderate or severe inflammation. Those definitions are generally accepted to be:

   A. The American Academy of Periodontology (AAP) defines generalized chronic periodontitis 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.

   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, glazing, and bleeding on probing

      3 = severe inflammation- marked redness and edema, ulceration with tendency to spontaneous bleeding

   C. This D4346 procedure is generally 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 visit be required, the date of completion is the date of service.

2. For additional details regarding reporting D4346, visit *www.practicebooster.com/dentalcoding_2022*. Use the password published on page 4 of this Guide.

LIMITATIONS

D4346 is a fairly new code, and as with all new codes, reimbursement is not guaranteed, especially in the early reporting of this new code. D4346 is generally followed by D1110, prophylaxis, after a short interval of several weeks. There is no set waiting period between D4346 and D1110. D4346 is a therapeutic procedure to bring the patient's periodontium back to a healthy status. Based on the patient's needs, the dentist is in the best position to determine when the patient can assume a regular preventive regimen following the performance of D4346 that includes an oral prophylaxis (D1110) subsequent to D4346.

NARRATIVES

Narratives and supportive documentation should include:

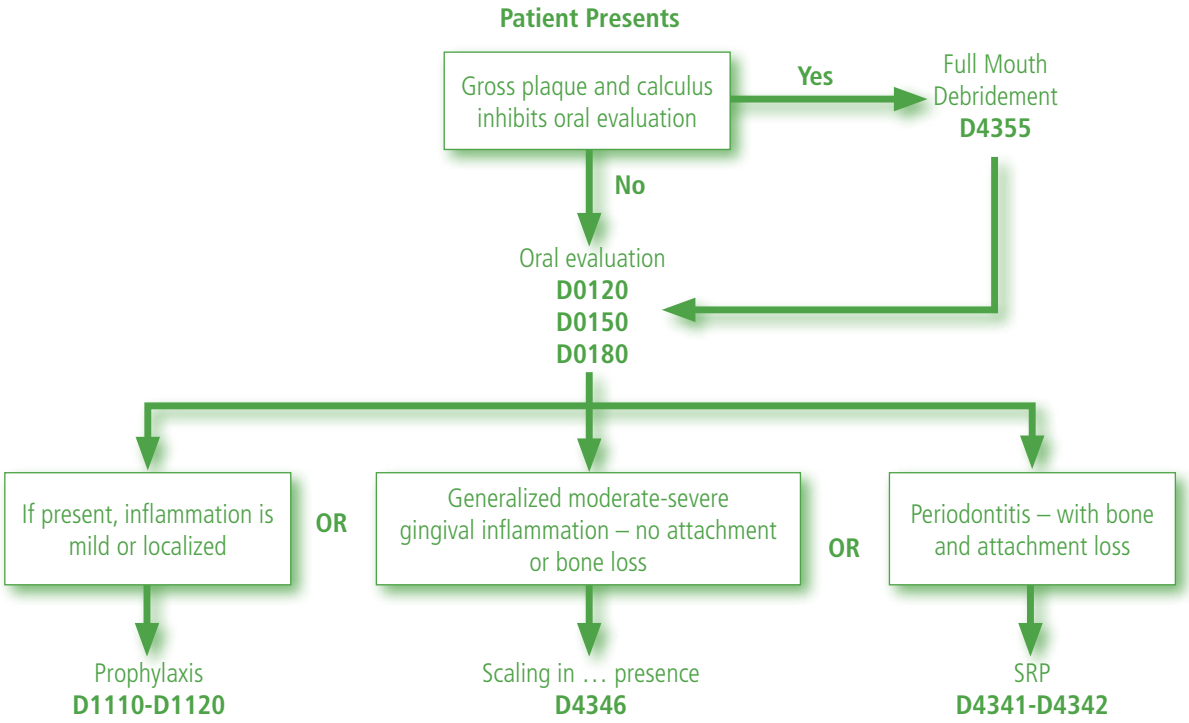
a. Periodontal charting that records (pseudo) pocket depths and bleeding on probing. (Note: Pocket depth may be recorded without loss of attachment.)

b. Photographs are helpful to document the gingiva's condition (e.g., visualize localized vs. generalized inflammation) for retention in the patient's chart.

c. Radiographs are helpful to document no attachment loss.

d. A clinical evaluation is made with a diagnosis of generalized moderate or severe inflammation.

CLINICAL FLOW CHARTS



Note: Interpretation and utilization of this code and flow chart is based on the ADA's Guide to Reporting D4346. This Guide may be found at http://www.ada.org/en/publications/cdt/coding-guidance.

D4355 FULL MOUTH DEBRIDEMENT TO ENABLE A COMPREHENSIVE ORAL EVALUATION AND DIAGNOSIS ON A SUBSEQUENT VISIT CDT 2022

Full mouth debridement involves the preliminary removal of plaque and calculus that interferes with the ability of the dentist to perform a comprehensive oral evaluation. Not to be completed on the same day as D0150, D0160, or D0180.

CODING CORRECTION WARNING

1. The full mouth debridement code (D4355) should never be reported on *every* new patient, but only as indicated.
2. The full mouth debridement code (D4355) does not report "non-invasive chemical debridement." However, gingival irrigation – per quadrant is reported as D4921.

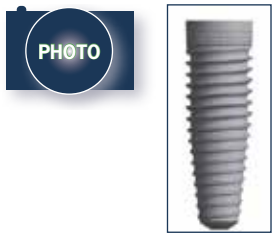
CODING CORRECTION WATCH

1. Full mouth debridement (D4355) is justified when the comprehensive oral evaluation (D0150) or comprehensive periodontal evaluation (D0180) *cannot* be performed due to excessive and bulky calculus, heavy plaque, and debris buildup at the initial visit.
2. A comprehensive oral evaluation (D0150, D0160, or D0180) should follow the full mouth debridement on a subsequent date giving the debrided area sufficient time to heal/react to the D4355 treatment so that a comprehensive oral evaluation may be performed. The D0150, D0160, or D0180 would follow on the subsequent treatment date. D4355 is a paid benefit in only 25-33% of contracts even if sequenced *perfectly*.
3. D4355 is not a definitive treatment. It is *preparatory* and preliminary in nature. The procedure is performed to clean the mouth enough so that the dentist can perform a comprehensive oral evaluation (D0150) or a comprehensive periodontal evaluation (D0180) at a subsequent appointment. The patient may, or may not, be a patient that will require active periodontal treatment. *Either* a prophylaxis (D1110), scaling and root planing (D4341/D4342), or referral to a periodontist follows the D4355 procedure on a subsequent visit.

2. The use of technology, such as Osstell IDx, to check stability after implant placement would be inclusive to the global fee of the implant placement. See D0171 to report a post-operative visit to check stability after implant placement.

LIMITATIONS

1. While surgical placement of implant body (D6010) is not *typically* reimbursed by dental insurance, an implant or abutment supported crown may be reimbursed as an *alternate b*enefit.
2. When D6010 is not reimbursed by dental insurance, the implant may be reimbursed by medical insurance, but only in limited circumstances. Medical justification for an implant might be treatment to restore function following cancer or trauma.
3. Subject to the annual reimbursement limitation, the surgical implant placement (D6010) may be paid if there is an implant rider to the policy.



This is an example of a conventional, full size implant reported as D6010.

Courtesy Drake Dental Lab

D6011 SURGICAL ACCESS TO AN IMPLANT BODY (SECOND STAGE IMPLANT SURGERY) CDT 2022

COMMENTS

1. D6011 is used to describe the "second stage" surgical process whereby the implant body, i.e., D6010, is exposed, after osseous integration. Typically a healing cap is placed into the endosteal implant once the body of the implant is surgically exposed after osseous integration. The healing cap maintains an access opening through the gingiva to the endosteal implant body during the subsequent restorative phase. D6011 also describes the surgical procedure to enable access for the placement of an abutment.
2. D6011 is a separate procedure performed after some period of time (months) after the surgical placement of the implant body, and should be submitted.
3. Not every implant case requires second stage surgery, typically a minority. Healing caps are placed in the majority of cases along with the implant placement. A different dentist from the one who placed the implant(s) may also perform the second stage surgery, reporting D6011.

LIMITATIONS

1. D6011 is variably reimbursed and is considered by some payers to be a part of the global implant placement service, i.e., D6010.
2. D6011 may be better reimbursed if there is implant coverage, the body of the implant is exposed and the healing cap placed by a dentist other than the dentist who placed the endosteal implant body.
3. D6011 also may be considered for reimbursement if the patient has implant coverage, the original prosthesis was broken or was lost and the gingival tissue had overgrown the retained endosteal implant body.

NARRATIVES Support the submission of D6011 by identifying the circumstances in which the second stage surgical access was necessary and that another practitioner placed the endosteal implant body, if applicable.

D6012 REVISED SURGICAL PLACEMENT OF INTERIM IMPLANT BODY FOR TRANSITIONAL PROSTHESIS: ENDOSTEAL IMPLANT CDT 2022

REVISIONS ~~Includes removal during later therapy to accommodate the definitive restoration, which may include placement of other implants.~~

D6051 REVISED INTERIM IMPLANT ABUTMENT PLACEMENT CDT 2022

A healing cap is not an interim abutment.

REVISIONS

INTERIM IMPLANT **ABUTMENT** PLACEMENT

~~Includes placement and removal.~~ A healing cap is not an interim abutment.

Note: While out of numerical order, D6051 is correctly listed here under the Supporting Structures subcategory.

Charge *separately* for an interim implant abutment placement (D6051). *Never* include the individual components of the implant "system" in the global implant crown fee. Reporting the components more accurately will correctly assign the fee and separate the charge for each component to the implant restoration. The implants are not a covered benefit under most contracts and reimbursement may be collected from the patient. Note, the PPO contract may dictate the fee charged for the implant and its components, even though it is not a covered benefit. The patient's responsibility to pay the non-covered amount depends on the state law or if it is a self-funded plan, federal law will apply.

COMMENTS

1. The interim implant abutment placement D6051 and interim implant crown D6085 would be placed while awaiting definitive treatment. They would be replaced by either a prefabricated abutment D6056, or custom abutment D6057, and then an abutment supported crown is cemented. This is typically an anterior abutment supported implant restoration.
2. D1698 reports the removal of the interim abutment. See D6198. Most payers consider the removal in the global fee.

LIMITATIONS

The implant surgeon or restorative dentist who *places the interim implant abutment placement* may report this code. If the implant surgeon *provides* the interim abutment D6051 or the prefabricated abutment, D6056, to the restorative dentist, the surgeon should not report the abutment since he/she did not place it. The implant surgeon could only report D6199, unspecified implant procedure if the interim implant abutment or prefabricated abutment is furnished to the restoring dentist.

D6052 PREVIOUSLY DELETED CODE SEMI-PRECISION ATTACHMENT ABUTMENT CDT 2022

This is a previously deleted code. See D6191 and D6192 for further details.

Note: While out of numerical order, D6191 and D6192 are correctly listed here under the Supporting Structures subcategory.

D6191 SEMI-PRECISION ABUTMENT – PLACEMENT CDT 2022

This procedure is the initial placement, or replacement, of a semi-precision abutment on the implant body.

D6052 semi-precision attachment abutment is a deleted code replaced by D6191 and D6192, commonly called locators.

If the patient has a complete maxillary or a complete mandibular *natural tooth* overdenture (D5863 or D5865), see D5862 to report a precision attachment (e.g., a locator).

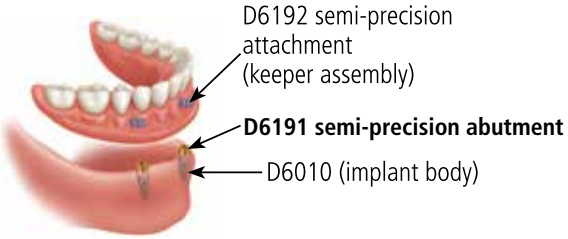
COMMENTS

1. D6191 describes the initial placement, or replacement of a semi-precision abutment on the implant body. This is the male piece of a locator. D6192 reports the female keeper assembly (attachment) luted into the removable prosthesis.
2. Report D6191 and D6192 both in conjunction with the abutment supported removable overdenture (D6110/D6111/D6112/D6113).

LIMITATIONS Semi-precision abutments (D6191) may be reimbursed if the patient has implant coverage and there is sufficient justification for the use of the semi-precision abutment.

NARRATIVES The narrative should establish the need for the semi-precision abutment by describing how the abutment was inserted into the implant body along with appropriate radiographs and/or pictures.

PHOTO



D6192 SEMI-PRECISION ATTACHMENT – PLACEMENT CDT 2022

This procedure involves the luting of the initial, or replacement, semi-precision attachment to the removable prosthesis.

CODING WARNING CORRECTION

D6052 is a deleted code and D6192 replaces it.

CODING WATCH CORRECTION

If the patient has a complete maxillary or a complete mandibular *natural tooth* overdenture (D5863 or D5865), see D5862 to report a precision attachment (e.g., a locator).

COMMENTS

1. D6192 describes the placement, or replacement of, each semi-precision attachment (keeper assembly) placed into the removable implant prosthesis.
2. D6192 reports the keeper assembly/housing placement by either the dentist or lab.

LIMITATIONS Semi-precision attachments (D6192) may be reimbursed if the patient has implant coverage and there is sufficient justification for the use of the semi-precision attachment.

NARRATIVES The narrative should establish the need for the semi-precision attachment by describing how the keeper assembly was attached to the removable prosthesis along with appropriate radiographs and/or pictures.

D9110 PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN – MINOR PROCEDURE CDT 2022

This is typically reported on a "per visit" basis for emergency treatment of dental pain.

Author's Comments:

It is important to always report "what you do" using the CDT code that best describes the procedure performed. At the emergency visit, there may be several coding options available. The information below discusses some minor procedures that may be performed to alleviate the patient's pain/discomfort at the emergency visit as reported by palliative, D9110. Some of these procedures may be considered definitive procedures, meaning the minor procedure performed resolved the patient's pain without subsequent treatment. As long as the patient's record states the issues of the patient's complaint or discomfort, describes the minor procedure performed to alleviate the pain/discomfort, then D9110 may be used at the dentist's discretion. As always, the dentist should determine the current CDT code that best describes overall the context of the procedure and the patient's record must support the D9110 procedure performed and reported.

The insurance industry considers certain procedures "integral" to the procedure and those procedures reported as separate codes may not be reimbursed (re-bonding of an appliance while under active treatment, desensitizing, adjustments, follow-up, treatment of dry socket by the same practitioner, etc.). For instance, desensitizing at the SRP visit or at recall may not be reimbursed, while desensitizing a single "hot tooth" with discomfort at the D9110 emergency visit may be reimbursed. Therefore, always provide a truthful narrative with the reporting of D9110. Thus, the payer makes the ultimate reimbursement decision.

D9110 is not reported when only writing a prescription. D9110 is reported when the patient is actually treated with a minor procedure to alleviate discomfort. For proper compliance, palliative treatment must include the treatment of pain or discomfort which requires the performance of some sort of a minor procedure at an emergency visit.

1. D9110 is reported on a "per *visit*" basis *regardless* of the *number* of procedures rendered on the same service date.
2. The palliative (D9110) code is used to report a *minor procedure* performed to alleviate acute symptoms of pain/discomfort at an emergency visit requested by the patient.
3. Palliative (D9110) should not be used to describe an appointed root canal visit with the start of a root canal when measuring length using an apex locator and then starting instrumentation of the canal(s). Opening the tooth and debriding a *portion* of the pulpal tissue (to relieve pain) at the emergency visit may be reported by D9110. Report the chief complaint and the treatment provided at the emergency visit in a brief narrative.

COMMENTS

1. Palliative (D9110) should not be used to describe *definitive* treatment (extractions, endodontics, crowns, fillings, surgery, etc.). Palliative could mean to ease symptoms without necessarily curing the underlying disease. But, sometimes a palliative treatment eliminates the problem. For instance, smoothing the edge of a chipped tooth might not require any subsequent treatment. Palliative treatment describes a *minor* procedure performed to alleviate the patient's *acute* and/or *spontaneous* complaint/problem. The service is performed at an emergency visit. Most plans exclude reimbursement for palliative procedures when other, definitive treatment procedures are reported on the same service date. Thus, palliative treatment (D9110) should not be reported in conjunction with any other *definitive* treatment provided on the same service date. Note: The descriptor of the code does not prohibit reporting D9110, palliative treatment, with other treatment or a problem focused oral evaluation (D0140) performed on the same service date.
2. D9110 is an *underutilized* code. The reporting of D9110 is appropriate for minor non-definitive procedures, reducing discomfort and/or sensitivity, or relief of acute and/or spontaneous pain at an *emergency visit*. The patient who is complaining of spontaneous discomfort always *initiates* the palliative visit and would present complaining of spontaneous discomfort/pain.

3. Palliative (D9110) can be reported in *conjunction* with an office visit – after regularly scheduled hours (D9440). The patient would be responsible for payment of the after hours visit (D9440) out-of-pocket.

LIMITATIONS

1. An emergency, problem focused oral evaluation (D0140) is an "evaluation or exam" while palliative (D9110) is "performing" a procedure to alleviate pain/discomfort. Palliative treatment is always *initiated* by the patient. The problem focused oral evaluation (D0140) is generally limited by the "one evaluation per six months" or "two evaluations per year" exclusion. The problem focused evaluation (D0140) is *stand-alone* and may always be reported in conjunction with D9110. However, some payers will not reimburse D0140 in conjunction with D9110 if performed on the same service date. The reporting of D0140 and payment "burns up" an oral evaluation. See D0140 for further details.
2. Some payers will reimburse palliative (D9110), the problem focused oral evaluation (D0140), and diagnostic pulp tests, i.e., pulp vitality test (D0460) performed on the same service date. However, this is rare.
3. Reimbursement is variable. Palliative (D9110) may be classified as preventive and reimbursed at 100% of the UCR fee or palliative may be considered a basic service and reimbursed at 80% of the UCR fee. In some cases palliative (D9110) may have a deductible applied before reimbursement is forthcoming, but this is uncommon.
4. Palliative (D9110) *should not* be reported *in conjunction* with an office visit for observation (during regularly scheduled hours), D9430. The descriptor of D9430 stipulates that no other services are performed on the same service date.

TIPS

1. Consider D9110 in situations where D0140 might apply. Note: D0140 is an evaluation code and evaluation codes are generally limited to "one evaluation per six months" or "two evaluations per 12 months." The reporting of D9110 is not generally limited as D0140. Read this section for explanation and comments regarding the application of palliative (D9110) and compare the problem focused oral *evaluation* (D0140) code as to their applicability. See D0140 for details.
2. Palliative (D9110) and one or two periapical diagnostic radiographic image(s) could be performed for the patient of record who presents with acute pain/discomfort *between* recall visits, where a minor, non-definitive service is performed. The fee reported for *palliative treatment could vary according to the time spent and the complexity of the procedure. The fee charged should be consistent for both non-insured and insured patients under similar circumstances*. Local anesthesia related palliative (D9110) procedures could be reported with a higher fee than shorter procedures performed with no anesthesia. However, the UCR fee for palliative is usually a single *fixed* allowable fee by the payer, regardless of the time related to the service.
3. *Periapical radiographic images are often taken in conjunction with the palliative procedure and both codes are generally reimbursed*. Two or three periapical radiographic images may be reimbursed at an emergency visit. Even if a single bitewing is reported at the emergency visit, it may affect bitewing reimbursement at the subsequent *recall visit*. Bitewings may be limited to "once a year." *One* bitewing may be subject to the bitewing limitation with some payers. *Periapicals, taken at emergency visits, typically are not associated with the bitewing limitation*. However, periapicals may be subject to a deductible and may be paid at 80% of the UCR fee in some situations.

NARRATIVES

1. Palliative (D9110) always *requires* a brief narrative in order to receive consistent reimbursement. *Always* submit a narrative, reporting "what you do," with full disclosure regarding the reporting of D9110. *Always* mention the tooth number or area of mouth, if applicable. The narrative, if applicable, should state "patient will return for more definitive treatment." This indicates *definitive* treatment was not performed during the palliative visit. Palliative (D9110) is generally *not reimbursed in conjunction* with any definitive treatment (extraction, filling, etc.) performed on the same service date. However, the descriptor of D9110 itself *does not* restrict the delivery of other services performed on the same service date.
2. The following are possible *palliative* procedures provided to relieve acute and spontaneous pain, discomfort, or sensitivity. These procedures are performed *at an emergency visit* and *initiated* by the patient. Identify the tooth number, if one was treated. Note: Electronic claims software may limit narratives to 80 characters in the "remarks" section of the claim form. If so, shorten the narratives listed below or file with an electronic attachment:
   a. Fractured tooth: "Mesio-buccal cusp of tooth #3 was fractured. Area was smoothed for patient comfort." Add "To be followed by subsequent visit," if the situation requires a subsequent visit.
   b. Fractured tooth: "Gluma was applied to mesio-buccal cusp area to relieve discomfort, tooth #19." Add "To be followed by subsequent visit," if the situation requires a subsequent visit.

GLOSSARY

A

AAE – American Academy of Endodontics.

AAO – American Academy of Orthodontics.

AAOMS – American Association of Oral Maxillofacial Surgeons.

AAP – American Academy of Periodontology.

AAPD – American Academy of Pediatric Dentistry.

AGD – Academy of General Dentistry.

Abutment – An abutment supports a prosthesis; a component of an implant system that is used to affix the crown to the implant.

Adjudication – Refers to the processing of a claim.

Adjunct/Adjunctive – Describes a treatment that is performed following the primary treatment.

Allowable Charge – The maximum amount of benefit allowed for a dental procedure per the indemnity or the PPO plan contract.

Alternate Benefit – A provision of a dental plan allowing the payer to provide a less expensive benefit, or an alternate benefit for a non-covered procedure, such as molar composite restorations. An alternate benefit of an amalgam may be applied for a composite restoration performed on a molar.

Asynchronous Teledentistry – Health information transmitted via the use of secure electronic means to a provider who will evaluate a health condition or render a service outside of real time interaction with the patient.

Auto Adjudication – The payer automatically processes the claim without review.

B

By Report – A brief narrative describing the dental procedure performed, required when reporting certain procedures.

C

CAL – Clinical Attachment Loss – involves the loss of alveolar bone support and gingival attachment as the periodontal fibers migrate apically from the CEJ due to periodontal toxins in plaque.

CBCT – Cone Beam CT imaging technology (3D radiographic image).

CEJ – Cementoenamel junction – the area of the tooth where the enamel covering the crown of the tooth and the cementum that covers the root of the tooth meet.

Claim – A written request to an insurance plan for benefit payment. A claim form may be submitted by the patient or the provider to the payer.

Claim Form – The paper form or electronic format used to submit the claim. These forms are specific to dental and medical claims and the appropriate form must be used. The 2019 ADA Dental Claim Form is the current claim form version.

Clinical – Refers to direct patient care (i.e., the diagnosis and treatment of the patient).

Connective Tissue Grafts (CT) – Donor tissue is taken usually from the patient and is placed in the area of gingival recession to obtain root coverage. Sometimes the tissue is from a donor other than the patient. Materials such as Allograft® may be used.

Current Dental Terminology (CDT) – A code set defined by the American Dental Association that the dentist is required to report for services rendered, as outlined in the summary plan description and the plan document.

D

Debridement – The gross removal of supra and subgingival calculus.

Dental Benefits Consultant – The dentist who reviews dental claims for insurance companies in order to determine benefits per the established criteria of the dental plan document.

Diastema – A space between two adjacent teeth, usually a large space between anterior teeth.

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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.

In this publication, Dr. Blair continues the use and application of **Predictive Error Correction** technology – a simple and easy-to-follow system. Dr. Blair developed **Predictive Error Correction** 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 teams, 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.

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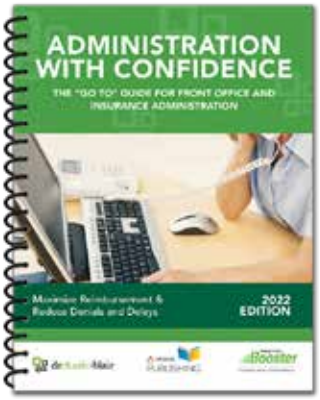

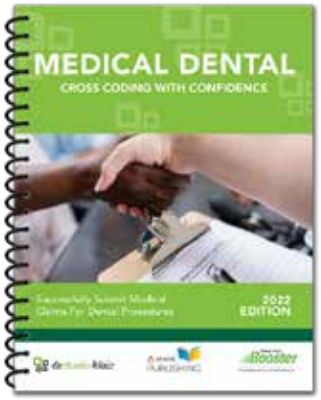

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