Coding Guide for Dental Services

A comprehensive coding, billing, and reimbursement resource for dental services
Introduction
Coding systems and claim forms are the realities for modern health care. Of the multiple systems and forms available, what you use is greatly determined by the setting, the type of insurance, and your practice style.

The Coding Guide for Dental Services provides a comprehensive look at the coding and reimbursement systems used by dentists. It is organized topically and numerically, and can be used as a comprehensive coding and reimbursement resource and as a quick-lookup resource for coding.

Coding Systems
The coding systems discussed in this coding guide seek to answer two questions: What was wrong with the patient (i.e., the diagnosis or diagnoses) and what was done to treat the patient (i.e., the procedures or services rendered).

Coding systems grew out of the need for data collection. By having a standard notation for the procedures performed and for the diseases, injuries, and illnesses diagnosed, it would be possible to identify those treatments that were most effective and to determine practice patterns. It was not long before these early coding systems were also being used as the basis for paying claims.

HCPCS Level I (CPT) Codes
Physicians’ Current Procedural Terminology, Fourth Edition (CPT®) and the Healthcare Common Procedure Coding System (HCPCS) codes are used to indicate what services or supplies were rendered and which procedures were performed during the patient's visit. To receive timely and appropriate reimbursement, one must submit a properly coded claim.

The Centers for Medicare and Medicaid Services (CMS), in conjunction with the American Medical Association (AMA), the American Dental Association (ADA), and several other professional groups, has developed, adopted, and implemented a three-level coding system describing services tendered to patient. Level I is the CPT Coding System.

The most commonly used coding system for reporting outpatient services is CPT, which is published annually and copyrighted by the AMA. CPT codes predominantly describe medical services and procedures and have been adapted to provide a common billing language that providers and payers can use for payment purposes. CPT codes are primarily used by the dental provider when indicating services such as gingivectomy or gingivoplasty. They are required for billing by both private and public insurance carriers, managed care companies, and workers’ compensation programs.

The AMA's CPT Editorial Panel reviews the coding system and makes periodic changes to codes and their descriptions. These changes are posted on the AMA's Web site with the date these code changes are effective. Most code changes by the AMA occur annually and are effective January 1 of each year. The panel accepts information and feedback by providers about new codes and revisions to existing codes that could better reflect the service or procedure being provided.

HCPCS Level II Codes
HCPCS Level II codes are commonly referred to as national codes or by the acronym HCPCS (Healthcare Common Procedure Coding System—pronounced “hik piks”). HCPCS codes are used for billing Medicare and Medicaid patients and have also been adopted by some third-party payers.

HCPCS Level II codes, periodically updated and published annually by CMS, are intended to supplement the CPT coding system by including codes for non-physician services, durable medical equipment (DME), and office supplies. These Level II codes consist of one alphabet character (A through V) followed by four numbers. Dental providers commonly use the “D” code section of the HCPCS Level II system.

Non-Medicare acceptance of HCPCS Level II codes is inconsistent. Providers should check with the payer before billing these codes.
**HCPCS Level III (Local) Codes**

All HCPCS local codes have been phased out, a process that began in 2002. As the first step, effective October 16, 2002, carriers were required to eliminate all local codes and modifiers that had not been approved by CMS. Carriers had to identify those codes and modifiers in use, crosswalk them to national codes, and delete any that were not approved. If carriers felt that an unapproved code should be retained for use, they had to submit a request for a temporary national code for that service/supply, with an explanation as to why the code should be retained. These requests were due to the regional offices by April 1, 2002.

The next phase was the elimination of the official HCPCS Level III local codes and modifiers by December 31, 2003. Again, carriers were required to review all local codes in their systems, crosswalk them to appropriate national codes, and submit requests for replacement temporary national codes by April 1, 2003. Temporary national codes that are requested and approved will be implemented January 1, 2004.

Local codes had been used to denote new procedures or specific supplies for which there was no national code. For Medicare, these five-digit alphanumeric codes used the letters W through Z. Each carrier created local codes as the need dictated. However, carriers were required to obtain approval from CMS's central office before implementing them. The Medicare carrier was responsible for providing you with these codes.

As a result of the Consolidated Appropriations Act of 2001, and as part of the National Code Data Sets implemented under the Health Insurance Portability Accountability Act, the Secretary of Health and Human Services was instructed to maintain and continue the use of HCPCS level III codes through December 31, 2003.

Program Memorandum (PM) AB-01-45 instructed carriers to take the following steps to implement the law on April 29, 2001:

- Maintain and accept current level III HCPCS codes and modifiers until December 31, 2003. However, carriers were not allowed to create any new HCPCS Level III codes or modifiers.
- Carriers were to reinstate any HCPCS Level III codes and modifiers they may have eliminated after August 16, 2000.
- Carriers were to publish on their Web sites any HCPCS Level III codes and modifiers with their descriptors that were in effect August 16, 2000.

Medicare carriers who wished to establish a temporary national code were required to submit the request to their regional office. The regional office then submitted that recommendation to the central office for approval.

**ICD-9-CM Classification System**

*The International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) is used to classify illnesses, injuries, and patient encounters with dental and health care practitioners.

The ICD-9-CM classification system is a method of translating medical terminology into codes. Codes within the system are either numeric or alphanumeric and are composed of three, four, or five characters. A decimal point follows all three-character codes when fourth and fifth characters are needed. Coding involves using a numeric or alphanumeric code to describe a disease or injury. For example, dental caries limited to enamel is coded to 521.01.

Generally, the reason the patient sought treatment should be sequenced first when multiple diagnoses are listed. Many claim forms, with the exception of the ADA dental form, require that the appropriate ICD-9-CM code be reported rather than a description of the functional deficit or defect.

Dental providers need to be aware of the necessity for specific diagnosis coding. Using only the first three digits of the ICD-9-CM
The role played by dental documentation has always been a supportive one. As the practice of dentistry became more sophisticated and complex, the need to record specific clinical data grew in importance. What certainly began as a simple written mechanism to jog the memory of a treating dentist evolved into a more refined system to service others assisting in patient care. Tracking patient history emerged as a fundamental element in planning a course of treatment. When dental specialties evolved, the patient record offered a means to provide pertinent data for treatment, referrals, and consultations.

Still, no clear standards exist for recording dental patient information. Dental documentation was seen, maintained, and used almost exclusively by the dentist and their staff. Patient care information was never submitted to insurance companies or to government payers; only rarely did dental documentation become the focus of malpractice suits.

Prior methods of dental documentation were not adequate to demonstrate provision of all care and/or dental necessity. Some of those methods included the preprinted card where all care was noted in a single line entry and indicated on an illustration of the mouth and teeth. Other dentists used copies of the ADA or other billing forms as their documentation of services.

A national increase in dental malpractice claims and awards abruptly altered the strictly clinical nature of documentation. The patient dental record was swept into the broad realm of civil law. Since most dental liability suits approach resolution years after the contested care, the dental record provides a main source of information about what happened and why. The patient record became a legal document, a basis to reconstruct the quality and quantity of dental care services. In many instances, it also serves as a dentist's only defense against charges of malpractice.

Marked change in the Medicare program also served to broaden the influence of medical documentation. For example, the Centers of Medicare and Medicaid Services (CMS), Medicare's federal administrator, authorizes the program's regional carriers to review paid claims to determine whether the care was medically necessary, as mandated under the Social Security Act of 1996.

This type of review checks processed and paid claims against the documentation recorded at the time of service. The aim is to ensure that Medicare dollars are administered correctly and dental documentation must support the dental necessity of the service, to what extent the service was rendered, and why it was medically justified. For example, based on findings from a routine x-ray exam, a dentist may believe further studies or treatment are warranted. Documentation must indicate the necessity for the added studies. However, the service may require prior authorization from the payer, depending on payer guidelines.

Medicare does not pay for services that are "medically unnecessary," according to Medicare standards. Patients are not liable to pay for such services if the service is performed without prior notification from the physician. Medical necessity requires items and services to be:

- Consistent with symptoms or diagnosis of disease or injury
- Necessary and consistent with generally accepted professional dental standards (e.g., not experimental or investigational)
- Furnished at the most appropriate level that can be provided safely and effectively to the patient

A significant number of providers were found to have billed for services that were not provided or found to be medically unnecessary. These findings led to the creation of the federal fraud and abuse program coordinated by several federal organizations, including the Department of Health and Human Services.
Commercial insurance companies were quick to follow suit. Similar to CMS, private payers monitor claims to uncover coding mistakes and to verify that the documentation supports the claims submitted. Although there are no national guidelines for proper documentation, the guidelines this chapter provides should ensure better quality of care and increase the chances of full and fair reimbursement.

**Methods of Documentation**

The problem-oriented medical record (POMR) is one documentation method. The provider identifies problems individually and arranges them for resolution. The POMR has four elements: (1) database, (2) problem list, (3) initial plans, and (4) progress notes.

At minimum, the data portion of the POMR includes information such as chief complaint, present illness, past, present, family, and social history, review of systems, physical examination, and baseline ancillary data. Medical history may play an important part of dental care as many diseases have dental manifestations or dental treatment may impact the medical care of the patient with disease processes such as heart disease, coagulation defects, and organ replacement.

The problem list consists of any problem that requires management or diagnostic workup. It may be a symptom, an abnormal finding, a physiological finding, or a specific diagnosis. The provider adds or changes the list as problems are identified and resolved.

The third portion, initial plans, states what the provider plans to do to learn more about the problem, to treat it, and to educate the patient about the problem and treatment.

Progress notes are the final element of the POMR. Each problem is documented with regard to the following: (S)ubjective findings (symptoms); (O)bjective findings (measurable, observable); (A)ssessment (interpretation or impression of the current condition); and (P)lan (treatment). This process is often referred to by the acronym “SOAP.” Although originally instituted for the medical record, this method is easily adaptable to dental care and provides a consistent format across all health care specialties.

The integrated dental record is another method of documentation that is strictly chronological without section divisions by the source of care. This keeps the episode of care documented in one continuous flow by date; but may make it more difficult to compare information from the same source, such as radiology reports or consultations. Because of this disadvantage, some chart order arrangements may integrate certain types of forms while maintaining others, such as radiology reports, together chronologically.

No specific format for documentation is recommended. It depends on the provider. But it is important that anyone reading the dental record be able to understand from the documentation the service rendered and the reason for the service.

**General Guidelines for Documentation**

Documentation is the recording of pertinent facts and observations about a patient’s health history, including past and present illnesses, tests, treatments, and outcomes. The dental record documents the care of the patient to:

- Enable a dentist or other health care professionals to plan and evaluate the patient’s treatment
- Enhance communication and promote continuity of care among dentists and other health care professionals involved in the patient’s care
- Facilitate claims review and payment
- Assist in utilization review and quality of care evaluations
- Reduce hassles related to dental review
- Provide clinical data for research and education

(HHS) and its agencies, CMS, and the Office of Inspector General (OIG).

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Reimbursement and Fee Calculations

Receiving appropriate reimbursement for dental and health care services can sometimes be difficult because of the rules and paperwork involved. The following reimbursement guidelines are offered to help you understand the various requirements for getting claims paid promptly and correctly.

Coverage Issues

First, you need to know what services are covered. Covered services are services payable by the insurer in accordance with the terms of the benefit-plan contract. Such services must be documented and medically necessary for payment to be made. Typically, payers define medically necessary services or supplies as:

- Services that have been established as safe and effective
- Services that are consistent with the symptoms or diagnosis
- Services that are necessary and consistent with generally accepted dental or medical standards
- Services that are furnished at the most appropriate, safe, and effective level

The Medicare program does not cover most routine dental services. The Medicare law clearly excludes coverage “for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth” and dentists may not be required to submit Medicare claims for such services.

A narrow exception permits coverage of a few dental services that are necessary to the provision of certain Medicare covered medical services. For example, Medicare may cover the following services:

- Extraction of a tooth as part of a repair of a fractured jaw
- Maxillofacial surgery for pathological or traumatic medical conditions (e.g., in case of a serious injury)

- Prosthetic rehabilitation to replace or treat certain oral and/or facial structures related to covered medical and surgical interventions (e.g., cancer surgery)
- Extraction of teeth prior to radiation treatment of the jaw
- Oral examination prior to kidney transplantation

Medicare may also cover certain medical procedures that dentists are licensed to perform (e.g., a biopsy for oral cancer).

Other payer policies vary regarding the coverage of dental services and, therefore, the payer should be contacted before service is rendered.

Payment Methodologies

Once covered services are known, the next issue to resolve is how you will be paid for those services. Over the last several years, there have been major changes to provider payment systems. The following will discuss the many varieties of payment methodologies used by Medicare and other third-party payers for dental claims.

Usual, Customary, and Reasonable

Fee-for-service reimbursement based on reasonable and customary charges has been the typical payment method for reimbursing providers used for most of Medicare's history, as well as by private payers. Medicare's previous “customary, prevailing, and reasonable” (CPR) payment methodology was similar to the private sector payers' charge system of “usual, customary, and reasonable (UCR).”

This payment system is designed to pay providers based on their actual fees. The provider is paid the lowest charge occurring among the actual fee for the service, the provider's customary charge (figured as the median of that individual's charges for the service over a defined time period), or the prevailing usual charge of all providers within the area. There was no attempt to reimburse...
services based on the work required. Owing to the diversity in fees charged for the same services, this system allows for a wide variance in payment for the same service. With exploding health care costs in the 1970s and 1980s, serious cost-containment needs for medical and dental services led to evaluating alternative reimbursement methodologies.

**Fee Schedules**

Fee schedules are replacing the customary and reasonable payment methodology as the system of choice. Fee schedules eliminate the wide payment variation for similar services that occurs with the customary and reasonable method and allows both payers and providers to estimate the amount of reimbursement they can expect to pay and receive. Using a fee schedule to maintain a fee-for-service system was considered by many medical professionals to be critical in protecting physicians’ clinical and professional autonomy. A key factor in developing a fee schedule can be the use of a relative value scale.

**Relative Value Scale (RVS)**

A relative value scale (RVS) ranks services according to “value” where that value is defined with respect to a base value. All services are assigned a unit value, with more complex, more time-consuming services having higher unit values and vice versa. Values are then multiplied by a dollar conversion factor to become a fee schedule.

**Resource-Based Relative Value Scale (RBRVS)**

After much debate and analysis, Medicare decided to enhance the RVS payment schedule based on the costs of the resources required to provide the services. In a resource-based RVS, the services are ranked based on the relative costs of the resources required to provide those services as opposed to the average fee for the service, or average prevailing Medicare charge. The Medicare RBRVS that was implemented in January 1992 and fully phased in by January 1996 was developed using the results of a Harvard University studies team that first identified and defined three distinct components affecting the value of each service or procedure:

- Physician work component reflecting the physician’s time and skill
- Practice expense (PE) component reflecting the physician’s rent, staff, supplies, equipment, and other overhead
- Malpractice (malprac) insurance component reflecting the relative risk or liability associated with the service

Relative value units (RVUs) are assigned to each component and the sum of these composes the total value of each service. CMS assigns a dollar amount to each CPT or HCPCS code by applying a dollar conversion factor to the total value for each service; however, geographic practice cost indices (GPCIs) must first be applied to each component prior to the dollar amount conversions that become the reimbursement rates found in the fee schedule. The GPCIs are figured into the three component values and added for a total geographically adjusted value for the service, which is then multiplied by the conversion factor to yield the locality-specific Medicare fee in the payment schedule.

Although the RBRVS was developed specifically for reimbursement of Medicare covered services, more than 70 percent of non-Medicare payers use RBRVS to establish their fees and maximum allowable reimbursement rates.

Conversion factors are national dollar amounts that are used to convert relative values into payment amounts. The Medicare conversion factor is published yearly in the Federal Register during the late fall with the Medicare physician fee schedule final rule.

RVUs are not assigned for the following types of services:

- Services that require carrier pricing or payment “by report” such as unlisted codes
- Services reported with local codes
The Insurance Process

The most important document for correct reimbursement is the insurance claim form. Other information, such as operative reports, chart notes, and cover letters, may establish medical necessity, but the claim “sets the stage.”

With commercial insurance companies, submit the claim directly to the payer or provide the patient with the necessary information to submit the claim. If there is a signed agreement with an HMO or PPO, the office may be required to send the claim directly to the insurer. Medicare requires that the office submit all Medicare claims directly to the carrier, whether participating or not in the Medicare program.

For paper claims, use the appropriate form. Multiple forms are available for dental claims, including the accepted national dental form (revised January 1, 2003 to be HIPAA compliant) mandated by many state Medicaid payers or payer specific forms created by individual dental payers. For medical services billed to Medicare or other medical health payers, use the standard CMS-1500 claim form for professional services. When submitting charges, be sure to complete the forms completely and accurately.

The term “claims processing” describes the course of submitting a claim to the payer and subsequent adjudication. Understanding how this process works allows providers and staff members to file claims properly and leads to maximum and timely reimbursement. In addition, this knowledge will allow the provider’s office to serve as a resource to patients in understanding the process.

What to Include on Claims

Patient Information

Before filing any claim, obtain clear, accurate information from the patient, and update the information regularly. Most offices verify the information at each visit. A uniform policy for multiple provider offices or clinics makes everyone accountable for current and correct patient data.

| Primary vs. Secondary Coverage |

Households with dual incomes often have more than one insurer. Determine which is the primary and which is the secondary insurance company. For commercial plans, the subscriber’s or insured’s insurance company is always primary for the subscriber. In other words, the husband’s insurance company is primary for him and the wife’s insurance company is primary for her. However, the primary insurance company for any dependents is determined by the insureds’ birthdays, the primary insured being the individual whose birthday is first during the year. This is often referred to as the “birthday rule.” For example, if the husband’s birthday is October 14, 1960 and the wife’s birthday is March 1, 1962, the wife is primary for their dependents because her birthday is first during the year (year of birth is ignored).

Assignment of Benefits and Release of Information

Consider adding an assignment of benefits statement to the patient information form. It should state that the patient has agreed to have insurance payments sent directly to the provider and that medical information can be released to the patient’s insurance company. Assignment reduces collection expenses. There are payers that require a current signature with each claim. It is important to review your assignment of benefit and release of information statements to ensure that you are HIPAA compliant.

If the office participates with Medicare, an assignment of benefits and release of billing are necessary and must be kept on file.

Determining Coverage

A patient’s insurance coverage should be verified before any service is rendered with the common sense exception of emergency treatment. This policy should not apply exclusively to new patients. Established patients may have changed employers, married or divorced, or are no longer covered by the same policy that was in effect during the last visit. The law requires Medicaid patients to
provide current proof of eligibility with each visit.

**Preauthorization**
Determining in advance the benefits and allowables provides the dentist's office with reimbursement figures before the patient's visit. Under most circumstances, the office should be able to discuss the deductible, copayment, and balance over and above the allowable with the patient prior to providing costly surgical services. Asking a few pointed questions of the patient and insurer will provide additional information regarding deductibles, for example:

- How much is the deductible and has it been met for the current year?
- What are the allowables for the quoted procedures?
- What percentage of the allowables will be paid?

**Clean Claims**
Claims submitted with all of the information necessary for processing are referred to as “clean” and are usually paid in a timely manner. Paying careful attention to what should appear on the claim form helps produce these clean claims. Common errors include the following:

- Failure to pay attention to communications from carriers (including Medicare and Medicaid transmittals)
- An incorrect patient identification number
- Patients’ names and addresses that differ from the insurers’ records
- Provider tax identification number, provider number, or Social Security number that is incorrect or missing
- No or insufficient information regarding primary or secondary coverage
- Missing authorized signatures — patient and/or provider
- Dates of service that are incorrect or don’t coincide to the claims information sent by other providers

- Dates that lack the correct number of digits
- A fee column that is blank or not itemized and totaled
- Incomplete patient information
- Invalid CPT, HCPCS, ADA, or ICD-9-CM codes, or diagnostic codes that are not linked to the correct services or procedures
- An illegible claim

**The Health Insurance Portability and Accountability Act (HIPAA)**
The Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191) is a complex, multi-faceted law containing a number of provisions and amendments. It was passed as a means of improving the portability and availability of health insurance coverage for individuals and groups. While insurance reform (Title 1) is an important aspect of the law, it is the anti-fraud and abuse provisions that have the greatest impact on provider practices and daily operational activities. Other provisions promote the use of medical savings accounts, improving access to long-term care services and coverage, and simplification of health insurance administration.

Possibly the best approach is to be certain that your practice keeps abreast of the rapid changes taking place as the different provisions of HIPAA are implemented. HIPAA also affects services by dentists, medical suppliers, and the provision of drugs. CMS relies on the Dental Content Committee of the American Dental Association (ADA) for all dental health care service consultant advice. One of the best sources of information is the CMS Web site, which provides not only background information, but also keeps you up to date with current rules and CMS requirements. That address is http://www.cms.hhs.gov/hipaa

**Administrative Simplification Provisions**
The Administrative Simplification provisions of HIPAA (Title II) requires the Department of Health and Human Services (HHS) to establish national standards for electronic health care
HCPCS Level II Definitions and Guidelines

One of the keys to gaining accurate reimbursement lies in understanding the multiple coding systems that are used to identify services. To be well versed in reimbursement practices, coders should be familiar with the HCPCS Level II ICD-9-CM, CPT, and CDT-4 coding systems. The first of these, the HCPCS Level II system, is increasingly important to reimbursement, as it has been extended to a wider array of medical services.

HCPCS Level II codes commonly are referred to as national codes or by the acronym HCPCS, which stands for the Healthcare Common Procedure Coding System (pronounced “hik-piks”). When using HCPCS Level II codes, keep the following in mind:

- CMS does not use consistent terminology for unlisted services or procedures. The code descriptions may include any one of the following terms: unlisted, not otherwise classified (NOC), unspecified, unclassified, other, and miscellaneous.
- When billing for specific supplies and materials, avoid CPT code 99070 (general supplies) and be as specific as possible unless the local carrier directs otherwise.
- Coding and billing should be based on the service and supplies provided. Documentation should describe the patient’s problems and the service provided to enable the payer to determine reasonableness and necessity of care.
- Refer to Medicare coverage reference to determine whether the care provided is a covered service.

Symbols

Symbols used in the HCPCS Level II system may be presented in various ways, depending on the vendor. In this publication, the pattern established by the AMA and ADA in the CPT and CDT-4 code books is followed. For example, bullets and triangles signify new and revised codes, respectively.

When a code is new to the HCPCS Level II system, a bullet (●) appears to the left of the code. This symbol is consistent with the CPT system’s symbol for new codes. The bullet represents a code never before seen in the HCPCS coding system.

A triangle (▲) is used (as in the CPT system) to indicate that a change in the narrative of a code has been made from the previous year’s edition. The change made may be slight or significant, but it usually changes the application of the code.

HCPCS Level II Codes

The following is a list of the HCPCS Level II dental and other HCPCS Level II supply codes used to identify supplies commonly used by dentists.

Medical and Surgical Supplies

A4000–A8999

This section covers a wide variety of medical and surgical supplies, and some durable medical equipment (DME), supplies and accessories.

A4350 Surgical trays
MCM 15030
A4649 Surgical supply; miscellaneous

Dental Procedures D0000–D9999

Items and services, in connection with the care, treatment, filling, removal, or replacement of teeth, or structures directly supporting the teeth, are not covered by Medicare. Prosthetic devices that replace the function of a permanently inoperative or malfunctioning internal body organ are, however, a covered service under the Prosthetic Devices guidelines.

The hospitalization or nonhospitalization of a patient has no direct bearing on the coverage or exclusion of a given dental procedure.

This section incorporates numeric codes and descriptors from CDT-4, which is copyright American Dental Association.
<table>
<thead>
<tr>
<th>Prosthodontics (Removable) D5000-D5899</th>
<th>Maxillofacial Prosthetics D5900-D5999</th>
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<tbody>
<tr>
<td><strong>D5120</strong> Complete denture—mandibular</td>
<td><strong>D5913</strong> Nasal prosthesis</td>
</tr>
<tr>
<td><strong>D5130</strong> Immediate denture—maxillary</td>
<td><strong>D5914</strong> Auricular prosthesis</td>
</tr>
<tr>
<td><strong>D5140</strong> Immediate denture—mandibular</td>
<td><strong>D5915</strong> Orbital prosthesis</td>
</tr>
<tr>
<td><strong>D5510</strong> Repair broken complete denture base</td>
<td><strong>D5916</strong> Ocular prosthesis</td>
</tr>
<tr>
<td><strong>D5620</strong> Repair cast framework</td>
<td><strong>D5919</strong> Facial prosthesis</td>
</tr>
<tr>
<td><strong>D5630</strong> Repair or replace broken clasp</td>
<td><strong>D5922</strong> Nasal septal prosthesis</td>
</tr>
<tr>
<td><strong>D5640</strong> Replace broken teeth—per tooth</td>
<td><strong>D5923</strong> Ocular prosthesis, interim</td>
</tr>
<tr>
<td><strong>D5650</strong> Add tooth to existing partial denture</td>
<td><strong>D5924</strong> Cranial prosthesis</td>
</tr>
<tr>
<td><strong>D5660</strong> Add clasp to existing partial denture</td>
<td><strong>D5925</strong> Facial augmentation prosthesis</td>
</tr>
<tr>
<td><strong>D5670</strong> Replace all teeth and acrylic on cast metal framework (maxillary)</td>
<td><strong>D5926</strong> Nasal prosthesis, replacement</td>
</tr>
<tr>
<td><strong>D5671</strong> Replace all teeth and acrylic on cast metal framework (mandibular)</td>
<td><strong>D5927</strong> Auricular prosthesis, replacement</td>
</tr>
</tbody>
</table>

**D5928** Orbital prosthesis, replacement

**D5930** Obturating prosthesis, surgical

**D5932** Obturating prosthesis, definitive

**D5933** Obturating prosthesis, modification

**D5934** Mandibular resection prosthesis with guide flange

**D5935** Mandibular resection prosthesis without guide flange

**D5936** Obturating/prosthetic, interim

**D5937** Trismus appliance (not for TMD treatment)

**MCM 2130**

**D5951** Feeding aid

**MCM 2336, MCM 2130**

**D5954** Palatal augmentation prosthesis

**D5955** Palatal lift prosthesis, definitive

**D5958** Palatal lift prosthesis, interim

**D5959** Palatal lift prosthesis, modification

**D5986** Fluoride gel carrier

**D5987** Commissure splint

**MCM 2136, MCM 2336**

**D5988** Surgical splint. See also CPT.

**D5999** Unspecified maxillofacial prosthesis, by report

**Implant Services D6000-D6199**

**D6053** Implant/abutment supported removable denture for completely edentulous arch

**MCM 2136**
D0473

Accession of tissue, gross and microscopic examination, preparation and transmission of written report

Explanation
This examination is a gross and microscopic pathology exam or a gross and microscopic tissue exam. The tissue is harvested in the course of a surgery and sent for routine lab evaluation. Tissue is submitted in a container labeled with the tissue source, preoperative or tentative diagnosis, and patient identification information. Specimens from separate sites must be submitted in separate containers, each labeled with the tissue source. It includes both a gross and microscopic examination with the microscopic exam mainly to confirm the identification or the absence of disease. This code includes preparation and transmission of a written report, but not the removal of the tissue sample itself from the patient.

Coding Tips
Removal of tissue for examination is reported separately. For biopsy of hard oral tissues (tooth and bone), see D7285. For biopsy of soft oral tissues, see D7286.

Terms To Know
Tissue. A group of similar cells that form definite structures or tissues. These are grouped into organs. Organs, by definition, are composed of tissues of different kinds. Tissue types include epithelial tissue, which line the outside of the body and the inner surface of internal organs; muscle tissue, which can be voluntary (found in limbs and places where movement is voluntary) or involuntary (found in the heart and digestive system where movement is not under conscious control); connective tissue, such as fat, cartilage, bone, or blood; and nerve tissue.

HCPCS Codes
This service is usually provided at the same session as another service. See the primary service for HCPCS Level II codes.

ICD•9 Diagnostic Codes
143.0 Malignant neoplasm of upper gum
143.1 Malignant neoplasm of lower gum
143.8 Malignant neoplasm of other sites of gum
145.6 Malignant neoplasm of retromolar area
145.9 Malignant neoplasm of mouth, unspecified site
754.81 Pectus excavatum

Associated CPT Codes
88305 Level IV – Surgical pathology, gross and microscopic examination, non-traumatic gingiva/oral mucosa, nasopharynx/oropharynx, biopsy nerve, biopsy odontogenic/dental cyst omentum, TUR salivary gland, biopsy sinus, paranasal biopsy skin, other than cyst/tag/debridement, biopsy soft tissue, other than tumor
88307 Level V – Surgical pathology, gross and microscopic examination, odontogenic tumor, soft tissue mass (except Lipoma) – biopsy/simple excision

MCM/CIM References
CIM 50-26, MCM 2136, MCM 2336

<table>
<thead>
<tr>
<th>Work Value</th>
<th>PE RVU</th>
<th>Mal-prac</th>
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**D0474**

**D0474** Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report

**Explanation**
This examination is a gross and microscopic pathology exam or a gross and microscopic tissue exam with the evaluation of surgical margins for the presence of disease. The tissue is harvested in the course of a surgery and sent for routine lab evaluation. Tissue is submitted in a container labeled with the tissue source, preoperative or tentative diagnosis, and patient identification information. Specimens from separate sites must be submitted in separate containers, each labeled with the tissue source. It includes both a gross and microscopic examination and an additional level of evaluation to determine whether the margins of the surgically excised tissue present with disease or have been removed clear of disease. This code includes preparation and transmission of a written report, but not the removal of the tissue sample itself from the patient.

**Coding Tips**
Removal of tissue for examination is reported separately. For biopsy of hard oral tissues (tooth and bone), see D7285. For biopsy of soft oral tissues, see D7286.

**Terms To Know**
**Tissue.** A group of similar cells that form definite structures or tissues. These are grouped into organs. Organs, by definition, are composed of tissues of different kinds. Tissue types include epithelial tissue, which line the outside of the body and the inner surface of internal organs; muscle tissue, which can be voluntary (found in limbs and places where movement is voluntary) or involuntary (found in the heart and digestive system where movement is not under conscious control); connective tissue, such as fat, cartilage, bone, or blood; and nerve tissue.

**HCPCS Codes**
This service is usually provided at the same session as another service. See the primary service for HCPCS Level II codes.

**ICD•9 Diagnostic Codes**
- 143.0 Malignant neoplasm of upper gum
- 143.1 Malignant neoplasm of lower gum
- 143.8 Malignant neoplasm of other sites of gum
- 145.6 Malignant neoplasm of retromolar area
- 145.9 Malignant neoplasm of mouth, unspecified site
- 754.81 Pectus excavatum

**Associated CPT Codes**
- 88305 Level IV – Surgical pathology, gross and microscopic examination, non-traumatic gingiva/oral mucosa, nasopharynx/oropharynx, biopsy nerve, biopsy odontogenic/dental cyst omentum, TUR salivary gland, biopsy sinus, paranasal biopsy skin, other than cyst/tag/debridement, biopsy soft tissue, other than tumor
- 88307 Level V – Surgical pathology, gross and microscopic examination, odontogenic tumor, soft tissue mass (expt Lipoma) – biopsy/simple excision

**MCM/CIM References**
CIM 50-26, MCM 2136, MCM 2336

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Periodontal 523.3
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©2003 Ingenix, Inc. Unspecified Signs & symptoms Codes that require a fifth-digit 199
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Despite the “dental services exclusion” in §1862(a)(12) of the Act (see Intermediary Manual, §3162; Carriers Manual, §2336), an oral or dental examination performed on an inpatient basis as part of a comprehensive workup prior to renal transplant surgery is a covered service. This is because the purpose of the examination is not for the care of the teeth or structures directly supporting the teeth. Rather, the examination is for the identification, prior to a complex surgical procedure, of existing medical problems where the increased possibility of infection would not only reduce the chances for successful surgery but would also expose the patient to additional risks in undergoing such surgery. Such a dental or oral examination would be covered under Part A of the program if performed by a dentist on the hospital’s staff, or under Part B if performed by a physician. (When performing a dental or oral examination, a dentist is not recognized as a physician under §1861(r) of the law.) (See Carriers Manual §2020.3.)

**Medicare Carriers Manual**

**MCM 2049 Drugs And Biologicals**

The Medicare program provides limited benefits for outpatient drugs. The program covers drugs that are furnished “incident to” a physician’s service provided that the drugs are not usually self-administered by the patients who take them.

Generally, drugs and biologicals are covered only if all of the following requirements are met:

- They meet the definition of drugs or biologicals (see §2049.1);
- They are of the type that are not usually self-administered by the patients who take them. (See §2049.2);
- They meet all the general requirements for coverage of items as incident to a physician’s services (see §§2050.1 and 2050.3);
- They are reasonable and necessary for the diagnosis or treatment of the illness or injury for which they are administered according to accepted standards of medical practice (see §2049.4);
- They are not excluded as immunizations (see §2049.4.B); and
- They have not been determined by the FDA to be less than effective. (See §2049.4 D.)

Drugs that are usually self-administered by the patient, such as those in pill form, or are used for self-injection, are generally not covered by Part B. However, there are a limited number of self-administered drugs that are covered because the Medicare statute explicitly provides coverage.

Examples of self-administered drugs that are covered include blood clotting factors, drugs used in immunosuppressive therapy, erythropoietin for dialysis patients, osteoporosis drugs for certain homebound patients, and certain oral cancer drugs. (See §§2100.5 and 2130.D for coverage of drugs which are necessary to the effective use of DME or prosthetic devices.)

**MCM 2136 Dental Services**

As indicated under the general exclusions from coverage, items, and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are not covered. Structures directly supporting the teeth means the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum of the teeth, and alveolar process.

In addition to the following, see §2020.3 and Coverage Issues Manual, §50-26 for specific services which may be covered when furnished by a dentist. If an otherwise noncovered procedure or service is performed by a dentist as incident to and as an integral part of a covered procedure or service performed by him/her, the total service performed by the dentist on such an occasion is covered.

**EXAMPLE 1:** The reconstruction of a ridge performed primarily to prepare the mouth for dentures is a noncovered procedure. However, when the reconstruction of a ridge is performed as a result of and at the same time as the surgical removal of a tumor (for...