Coding and Payment Guide for Dental Services

A comprehensive coding, billing, and reimbursement resource for dental services

2013
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Introduction

CMS-1500 Forms
Most Medicare covered dental services are filed using ICD-9-CM diagnosis codes, HCPCS procedure codes (Levels I and II), and CMS-1500 forms. This includes covered services performed as the result of an illness or injury.

Dental Billing Forms
The ADA has created a generic billing form that is used by most dental third-party payers. The ADA Dental Claim Form provides a common format for reporting dental services to a patient’s dental benefit plan and has been revised to meet the Health Insurance Privacy and Accountability Act (HIPAA) requirements. ADA policy promotes use and acceptance of the most current version of the ADA Dental Claim Form by dentists and payers. The most current version of the claim also allows reporting of the national provider identifier (NPI). There are significant numbers of claims that are filed using forms customized by the provider. These “superbills” typically are multipart check-off forms. While these bills improve the efficiency of the provider’s office, they may create difficulties in the payer’s claims flow and can result in delayed reimbursement.

Contents and Format of This Guide
Coding Guide for Dental Services has three primary sections: reimbursement, definitions and guidelines, and Medicare official regulatory information.

Reimbursement
The first section of the guide provides comprehensive information about the coding and reimbursement process. It has four chapters: “Introduction,” “The Reimbursement Process,” “Documentation—An Overview,” and “Claims Processing.”

Definitions and Guidelines
The second section provides the definitions and guidelines for using the 2011–2012 CDT codes, as well as the ICD-9-CM codes that most commonly support medical necessity of the service, any associated HCPCS Level II codes (other than the D codes), CPT codes, and reimbursement information.

Procedure Code Definitions and Guidelines
This section begins with the standard coding definitions and guidelines for CDT or CPT codes. Following this section is a listing of the most common CDT or CPT codes applicable to dental services. At the top of each page you will find a code or code range with its official description, followed by an explanation of the procedure or supply. Procedure codes are crosswalked to other HCPCS Level II codes, common ICD-9-CM codes, relative value units, and, when applicable, CPT or CDT procedure codes, coding tips, terms to know, pertinent sections from official Medicare manuals, and reference numbers. A listing of official Medicare manual references completes this section. All this information is designed to allow the user to appropriately code and bill for services.

ICD-9-CM Definitions and Guidelines
An overview of the 2012 ICD-9-CM coding conventions and guidelines is presented in this section. A comprehensive alphabetic index of ICD-9-CM diagnosis codes specific to dental services is in the index at the end of this section.

A separate ICD-9-CM index lists the E codes commonly associated with the circumstances and conditions that could cause injury to teeth and oral structures and may require dental services.

Medicare Official Regulatory Information
Full excerpts from applicable Medicare manuals, including the Medicare National Coverage Determinations Manual and the Medicare Benefit Policy Manual applicable to dental services are provided in this section. These excerpts often do not identify the guideline with corresponding HCPCS Level II codes. Our experts have crosswalked the reference, wherever possible, to the appropriate procedure or supply code, so that the reference appears in the main body of the book with the associated codes.
Explanation
X-rays of the skull and facial bones are obtained to determine an injury, fracture, or neoplasm. After positioning the patient, a posterior-anterior or lateral view skull and facial bone survey film is obtained.

Coding Tips
Any evaluation, prophylaxis, fluoride, restorative, or extraction service is reported separately. To report conventional imaging of the temporomandibular joint, see D0321; temporomandibular joint arthrogram is reported using D0320.

Terms To Know
radiograph. Image made by an x-ray.

HCPCS Codes
R0070 Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen
R0075 Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen

ICD-9-CM Diagnostic Codes
144.0 Malignant neoplasm of anterior portion of floor of mouth
144.1 Malignant neoplasm of lateral portion of floor of mouth
144.8 Malignant neoplasm of other sites of floor of mouth
144.9 Malignant neoplasm of floor of mouth, part unspecified
145.5 Malignant neoplasm of palate, unspecified
145.8 Malignant neoplasm of other specified parts of mouth
198.89 Secondary malignant neoplasm of other specified sites
524.50 Dentofacial functional abnormality, unspecified
524.51 Abnormal jaw closure
524.52 Limited mandibular range of motion
524.53 Deviation in opening and closing of the mandible
524.54 Insufficient anterior guidance
524.55 Centric occlusion maximum intercuspation discrepancy
524.56 Dentofacial functional abnormality, non-working side interference
524.57 Lack of posterior occlusal support
524.59 Other dentofacial functional abnormalities
784.92 Jaw pain
802.20 Closed fracture of unspecified site of mandible
802.21 Closed fracture of condylar process of mandible
802.22 Closed fracture of subcondylar process of mandible
802.23 Closed fracture of coronoid process of mandible
802.24 Closed fracture of unspecified part of ramus of mandible
802.26 Closed fracture of symphysis of body of mandible
802.27 Closed fracture of alveolar border of body of mandible
802.28 Closed fracture of other and unspecified part of body of mandible
802.31 Open fracture of condylar process of mandible
802.32 Open fracture of subcondylar process of mandible
802.33 Open fracture of coronoid process of mandible
802.34 Open fracture of unspecified part of ramus of mandible
802.35 Open fracture of angle of jaw
802.36 Open fracture of symphysis of body of mandible
802.37 Open fracture of alveolar border of body of mandible
802.38 Open fracture of other and unspecified part of body of mandible
802.4 Malar and maxillary bones, closed fracture
802.5 Malar and maxillary bones, open fracture
802.8 Other facial bones, closed fracture
802.9 Other facial bones, open fracture
830.0 Closed dislocation of jaw
830.1 Open dislocation of jaw
848.1 Sprain and strain of jaw
873.44 Open wound of jaw, without mention of complication
V72.5 Radiological examination, not elsewhere classified — (Use additional code(s) to identify any special screening examination(s) performed: V73.0-V82.9)

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

Associated CPT Codes
70140 Radiologic examination, facial bones; less than 3 views
70150 Radiologic examination, facial bones; complete, minimum of 3 views

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Work Value</th>
<th>Non-Fac PE</th>
<th>Fac PE</th>
<th>Malpractice</th>
<th>Non-Fac Total</th>
<th>Fac Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0290</td>
<td></td>
<td>0.27</td>
<td></td>
<td>1.72</td>
<td></td>
<td>1.72</td>
</tr>
<tr>
<td>802.26</td>
<td>Closed fracture of symphysis of body of mandible</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>802.27</td>
<td>Closed fracture of alveolar border of body of mandible</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>802.28</td>
<td>Closed fracture of other and unspecified part of body of mandible</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>802.31</td>
<td>Open fracture of condylar process of mandible</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>802.32</td>
<td>Open fracture of subcondylar process of mandible</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>802.33</td>
<td>Open fracture of coronoid process of mandible</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>802.34</td>
<td>Open fracture of unspecified part of ramus of mandible</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>802.35</td>
<td>Open fracture of angle of jaw</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>802.36</td>
<td>Open fracture of symphysis of body of mandible</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>802.37</td>
<td>Open fracture of alveolar border of body of mandible</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>802.38</td>
<td>Open fracture of other and unspecified part of body of mandible</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>802.4</td>
<td>Malar and maxillary bones, closed fracture</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>802.5</td>
<td>Malar and maxillary bones, open fracture</td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>802.8</td>
<td>Other facial bones, closed fracture</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>802.9</td>
<td>Other facial bones, open fracture</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>830.0</td>
<td>Closed dislocation of jaw</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>830.1</td>
<td>Open dislocation of jaw</td>
<td></td>
<td></td>
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<tr>
<td>848.1</td>
<td>Sprain and strain of jaw</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>873.44</td>
<td>Open wound of jaw, without mention of complication</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>V72.5</td>
<td>Radiological examination, not elsewhere classified — (Use additional code(s) to identify any special screening examination(s) performed: V73.0-V82.9)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

These CDT RVUs are not developed by CMS. CDT only © 2011 American Dental Association. All Rights Reserved. © 2011 Optum
### 41820

**Gingivectomy, excision gingiva, each quadrant**

**Explanation**
The dentist excises or trims hypertrophic (overgrown) gingiva to normal contours. The dentist excises the overgrown gingiva using a scalpel, electrocautery, or a laser. Periodontal dressing or packing is often placed. Use this code for each quadrant of the mouth where gingivectomy is performed.

**Coding Tips**
Excision of gingiva from the second, third, or fourth quadrant of the dentition may be reported separately. When 41820 is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51. Local anesthesia is included in the service.

For gingivoplasty, each quadrant, see code 41872 or codes from range D4210-D4211.

**Terms To Know**

- **gingivectomy.** Surgical excision or trimming of overgrown gum tissue back to normal contours using a scalpel, electrocautery, or a laser. CPT code 41820 or HCPCS Level II code D4210 or D4211 is reported for each quadrant of the mouth in which gingivectomy is performed.

- **gingivitis.** Inflamed gingiva (oral mucosa) that surrounds the teeth. Most codes for gingivitis are found in category 523 of ICD-9-CM, and are chosen on the basis of whether the condition is chronic or acute, and whether it is caused by plaque. A few other specific forms of gingivitis cover conditions like herpetic gingivitis (054.2) or acute necrotizing ulcerative gingivitis (101).

- **gingivoplasty.** Repair or reconstruction of the gum tissue, altering the gingival contours by excising areas of gum tissue or making incisions through the gingiva to create a gingival flap.

### HCPCS Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4210</td>
<td>gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant — Involves the excision of the soft tissue wall of the periodontal pocket by either an external or an internal bevel. It is performed to eliminate suprabony pockets after adequate initial preparation, to allow access for restorative dentistry in the presence of suprabony pockets, or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration.</td>
</tr>
<tr>
<td>D4211</td>
<td>gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant — Involves the excision of the soft tissue wall of the periodontal pocket by either an external or an internal bevel. It is performed to eliminate suprabony pockets after adequate initial preparation, to allow access for restorative dentistry in the presence of suprabony pockets, or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration.</td>
</tr>
</tbody>
</table>

### ICD-9-CM Diagnostic Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>143.0</td>
<td>Malignant neoplasm of upper gum</td>
</tr>
<tr>
<td>143.1</td>
<td>Malignant neoplasm of lower gum</td>
</tr>
<tr>
<td>143.8</td>
<td>Malignant neoplasm of other sites of gum</td>
</tr>
<tr>
<td>143.9</td>
<td>Malignant neoplasm of gum, unspecified site</td>
</tr>
<tr>
<td>198.89</td>
<td>Secondary malignant neoplasm of other specified sites</td>
</tr>
<tr>
<td>210.4</td>
<td>Benign neoplasm of other and unspecified parts of mouth</td>
</tr>
<tr>
<td>230.0</td>
<td>Carcinoma in situ of lip, oral cavity, and pharynx</td>
</tr>
<tr>
<td>235.1</td>
<td>Neoplasm of uncertain nature of lip, oral cavity, and pharynx</td>
</tr>
<tr>
<td>239.0</td>
<td>Neoplasm of unspecified nature of digestive system</td>
</tr>
<tr>
<td>523.00</td>
<td>Acute gingivitis, plaque induced</td>
</tr>
<tr>
<td>523.01</td>
<td>Acute gingivitis, non-plaque induced</td>
</tr>
<tr>
<td>523.10</td>
<td>Chronic gingivitis, plaque induced</td>
</tr>
<tr>
<td>523.11</td>
<td>Chronic gingivitis, non-plaque induced</td>
</tr>
<tr>
<td>523.30</td>
<td>Aggressive periodontitis, unspecified</td>
</tr>
<tr>
<td>523.31</td>
<td>Aggressive periodontitis, localized</td>
</tr>
<tr>
<td>523.32</td>
<td>Aggressive periodontitis, generalized</td>
</tr>
<tr>
<td>523.33</td>
<td>Acute periodontitis</td>
</tr>
<tr>
<td>523.40</td>
<td>Chronic periodontitis, unspecified</td>
</tr>
<tr>
<td>523.41</td>
<td>Chronic periodontitis, localized</td>
</tr>
<tr>
<td>523.42</td>
<td>Chronic periodontitis, generalized</td>
</tr>
<tr>
<td>523.8</td>
<td>Other specified periodontal diseases</td>
</tr>
<tr>
<td>996.67</td>
<td>Infection and inflammatory reaction due to other internal orthopedic device, implant, and graft — (Use additional code to identify specified infections)</td>
</tr>
</tbody>
</table>

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

<table>
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<tr>
<th>Work Value</th>
<th>Non-Fac PE</th>
<th>Fac PE</th>
<th>Malpractice</th>
<th>Non-Fac Total</th>
<th>Fac Total</th>
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<td>41820</td>
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<td>3.10</td>
<td>3.10</td>
<td>0.70</td>
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