Coding and Payment Guide for Dental Services

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

Definitions and Guidelines
The second section provides the definitions and guidelines for using the 2013 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 manuals 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 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. 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.

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. The full text of all of the internet-only manuals (IOM) may be found at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html.

How to Use This Guide
The first three chapters: “The Reimbursement Process,” “Documentation—An Overview,” and “Claims Processing” may be read in their entirety and/or used as references. When using this Coding and Payment Guide for code assignment, follow these important steps to improve accuracy and experience fewer overlooked diagnoses and services:

• Step 1. Carefully read the medical record documentation that describes the patient's diagnosis and the service provided. Remember, more than one diagnosis or service may be documented.

• Step 2. Locate the appropriate CPT or dental procedure code in the chapter titled “Procedure Codes.” Read the explanation and determine if that is the procedure performed and supported by the medical record documentation.

• Step 3. At this time, review the additional information pertinent to the specific code found in the coding tips, IOM references, and the Medicare physician fee schedule references. Use the “Terms to Know” to help ensure appropriate code assignment.

• Step 4. Peruse the list of ICD-9-CM codes to determine if the condition documented in the medical record is listed and the code identified. If the condition is not listed refer to the ICD-9-CM index or the ICD-9-CM manual to locate the appropriate code.

• Step 5. Finally, review the list of associated CPT and HCPCS Level II codes to determine if there are applicable CPT and/or HCPCS Level II codes for that may also be reported with or instead of the referenced code.
**D4210-D4211**

**D4210** gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant

**D4211** gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant

**Explanation**
The dentist performs a gingivectomy or gingivoplasty to reshape damaged gingivae or excise excess tissue into a better contour for restorative treatment and/or a more esthetic look. Pockets of gingiva are marked for the line of incision, which is then made with the blade angled to the long axis of the tooth. Supragingival pockets are thereby excised and recontouring of the gums is accomplished using the beveled incision. The strip of remaining gingiva is released, the root surfaces are curetted, and the area is packed and left to heal by granulation. Report D4210 for a gingivectomy or gingivoplasty performed in each quadrant on four or more contiguous teeth or bounded teeth spaces and D4211 for one to three teeth per quadrant.

**Coding Tips**
These codes have been revised for 2013 in the official CDT description. Local anesthesia is included in these services. Any evaluation or radiograph is reported separately. Pathology exam of tissue with interpretation is reported separately. These codes are reported once per quadrant. Usual postoperative care is included in these services. Payers may require periodontal charting. Periodontal charting should include the identification of the quadrants and sites involved, a minimum of three pocket measurements per tooth involved, indication of recession, furcation involvement, mobility and mucogingival defects and identification of missing teeth. These codes include frenulectomy. When reporting code D4211, third-party payers may require clinical documentation and/or x-rays before making payment determination. Check with payers to determine their specific requirements. Report D4212 when the gingival surgery is performed to allow access for a restorative service.

**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.
- **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.
- **tooth bounded space**: Empty space in the mouth due to a missing tooth that is surrounded by a tooth on each side.

**HCPCS Codes**
N/A

**ICD-9-CM Diagnostic Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<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>523.21</td>
<td>Gingival recession, minimal</td>
</tr>
<tr>
<td>523.22</td>
<td>Gingival recession, moderate</td>
</tr>
<tr>
<td>523.23</td>
<td>Gingival recession, severe</td>
</tr>
<tr>
<td>523.24</td>
<td>Gingival recession, localized</td>
</tr>
<tr>
<td>523.25</td>
<td>Gingival recession, generalized</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>523.41</td>
<td>Chronic periodontitis, localized</td>
</tr>
<tr>
<td>523.42</td>
<td>Chronic periodontitis, generalized</td>
</tr>
<tr>
<td>523.5</td>
<td>Periodontosis</td>
</tr>
<tr>
<td>525.23</td>
<td>Severe atrophy of the mandible</td>
</tr>
<tr>
<td>525.24</td>
<td>Minimal atrophy of the maxilla</td>
</tr>
<tr>
<td>525.51</td>
<td>Partial edentulism, class I — (Use additional code to identify cause of edentulism: 525.10-525.19)</td>
</tr>
<tr>
<td>525.52</td>
<td>Partial edentulism, class II — (Use additional code to identify cause of edentulism: 525.10-525.19)</td>
</tr>
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</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.

**Associated CPT Codes**

- 41820 Gingivectomy, excision gingiva, each quadrant
- 41872 Gingivoplasty, each quadrant (specify)

<table>
<thead>
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<th>Procedure Code</th>
<th>Work Value</th>
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<th>Fac PE</th>
<th>Malpractice</th>
<th>Non-Fac Total</th>
<th>Fac Total</th>
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</thead>
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<td>3.17</td>
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<td>D4211............</td>
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</tr>
</tbody>
</table>

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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
D4210 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.

D4211 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.

ICD-9-CM 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
143.9 Malignant neoplasm of gum, unspecified site
198.89 Secondary malignant neoplasm of other specified sites
210.4 Benign neoplasm of other and unspecified parts of mouth
230.0 Carcinoma in situ of lip, oral cavity, and pharynx
235.1 Neoplasm of uncertain behavior of lip, oral cavity, and pharynx
239.0 Neoplasm of unspecified nature of digestive system
523.00 Acute gingivitis, plaque induced
523.01 Acute gingivitis, non-plaque induced
523.10 Chronic gingivitis, plaque induced
523.11 Chronic gingivitis, non-plaque induced
523.30 Aggressive periodontitis, unspecified
523.31 Aggressive periodontitis, localized
523.32 Aggressive periodontitis, generalized
523.33 Acute periodontitis
523.40 Chronic periodontitis, unspecified
523.41 Chronic periodontitis, localized
523.42 Chronic periodontitis, generalized
523.8 Other specified periodontal diseases
996.67 Infection and inflammatory reaction due to other internal orthopedic device, implant, and graft — (Use additional code to identify specified infections)

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.