CMC Makes
39 Substantive Changes
to Dental Codes

The Code Maintenance Committee (CMC) has finalized the changes to Current Dental Terminology (CDT) for 2016, making 39 substantive changes and 41 editorial changes. The CMC, chaired by a member of the American Dental Association (ADA), includes voting representatives from the Academy of General Dentistry (AGD), the American Dental Education Association (ADEA), Centers for Medicare and Medicaid (CMS), the National Association of Dental Plans (NADP), the nine dental specialty organizations, and several major dental insurance payers. The CMC met at the ADA’s Chicago headquarters in March 2015 to consider 74 requests, 37 of which were submitted by practicing dentists or dental team members.

CDT codes provide a standardized language for dental teams to clearly communicate with patients about proposed dental procedures, accurately document the dental services they perform, appropriately bill patients for services rendered, and accurately communicate with third-party payers regarding dental treatments submitted for payment. However, the existence of a code (new or established) does not imply that it will be reimbursed by dental plans. While dental plans are required to recognize current CDT codes when submitted on current claim forms, they are not required to pay for them.

The CDT 2016 substantive code changes include 19 new codes, eight deleted codes, and 12 revised codes. Of the 19 codes that have been added to CDT 2016, dental teams will be particularly pleased to see a new code for the application of an interim caries arresting medicament for the conservative treatment of an active, non-symptomatic carious lesion (without removal of sound tooth structure). There are also new codes for the adjustment of an occlusal orthotic device, the adjustment of an occlusal guard, and the adjustment of a removable orthodontic retainer.

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Oral DNA and the Periodontal Patient

Dentists are becoming more involved in the detection and management of multiple diseases and are using saliva as the sample for diagnostic testing. Some of these tests measure proteins and other analytes in the saliva. Others rely on the fact that saliva is an excellent source for DNA, which is the basis for many cutting edge oral DNA tests. The most common use of oral DNA testing is assisting the dentist and physician in the proper diagnosis, treatment, and/or prevention of periodontal disease.

Periodontal therapy includes, but is not limited to, scaling and root planing, periodontal surgery, and periodontal maintenance. Periodontal disease can progress despite active periodontal therapy and patient compliance. The first step in preventing and/or stopping the progression of periodontal disease in patients with risk factors is detecting and identifying the bacteria causing or likely to cause the disease. The use of oral DNA testing for oral pathogens enables the doctor to identify the specific type of bacteria causing the disease for the patient. Once the bacteria are identified, the treatment and prevention of periodontal disease is customized for the patient.

Many periodontal patients have undergone multiple treatments to manage their disease without success. This can be very frustrating for the patient and the doctor. With testing methods, such as MyPerioPath®, a sample of saliva is collected at a routine recall visit and is then sent to a laboratory for analysis. A laboratory report is created, allowing the doctor to review the results with the patient and work with him to customize a targeted treatment regimen. Such reports may provide specific recommendations for treatment, including the most effective antibiotic regimen to control that patient’s specific bacteria profile.

Dental Coding

While there is little doubt as to the potential benefit that periodontal patients could receive from targeting the specific bacterial cause of the disease and following the corresponding treatment oral DNA testing suggests, insurance payers typically do not provide reimbursement for this type of testing. Some plans may provide benefits for the collection and preparation of the sample only, while other plans may provide benefits for the analysis only. However, dental payers typically exclude Oral DNA testing. Currently, employers do not want the added cost of the procedure. As contracts are renewed over the next several years, more plans may provide coverage. That being said, a claim should be submitted even if a denial is expected. Many PPO plans require their contracted providers to report all procedures, even when the procedure performed is a non-covered procedure.

Codes to be considered for submission to a dental payer for Oral DNA services are:

- **D0417** Collection and preparation of saliva sample for laboratory diagnostic testing
- **D0418** Analysis of saliva sample
  Chemical or biological analysis of saliva sample for diagnostic purposes.

D0417 reports the collection and preparation of the sample only; report the analysis of the sample separately as D0418. Do not report D0417 until the analysis report has been received. Once the analysis has been received, report D0417. Include a copy of the analysis report and a narrative describing the purpose of the saliva sample, the analysis performed, and the diagnosis. Consider reporting D0417 and D0418 for tests such as MyPerioPath®.

- **D0421** Genetic test for susceptibility to oral diseases
  Sample collection for the purpose of certified laboratory analysis to detect specific genetic variations associated with increased susceptibility for oral diseases such as severe periodontal disease.

D0421 identifies specific genetic markers of oral diseases and is used to identify patients who may be at a higher risk for oral infections. This genetic testing is not limited to patients who are at a higher risk for periodontal disease. D0421 includes the collection of the sample and the laboratory testing. Consider D0421 for tests such as MyPerioID© or the Celsus One®.

Note: D0421 is a current CDT 2015 code; however, it is deleted for CDT 2016. For CDT 2016, D0422, collection and preparation of genetic sample material for laboratory analysis and report, will be used to report the sample collection and preparation separately from the analysis. D0423, genetic tests for susceptibility to diseases – specimen analysis, will be used to report the analysis.

Medical Coding

There is a growing number of doctors who believe that, because periodontal disease is closely aligned with a patient's overall health, this type of testing should be submitted to the patient’s medical plan for reimbursement. However, there are very few, if any, medical payers who will consider oral DNA testing for reimbursement. Considering that, if you elect to submit a claim to a medical payer, it is important to select your procedure and diagnoses codes carefully. Remember, medical benefits are often subject to deductibles that must be met prior to any payment.

Procedure Codes

When the dentist performs the test chairside, it may be appropriate to report the code 87801, infectious agent detection by nucleic acid, multiple organisms, amplified probe technique. This medical procedure (CPT) code is inclusive of preparing the specimen.

There is no CPT code to describe the collection and preparation of a saliva sample. If a specimen is collected and transported to a laboratory for testing, you may report code 99000, handling and/or conveyance of specimen for transfer from the office to a laboratory. Be aware that medical payers rarely provide reimbursement for this procedure.

You may also submit an appropriate office visit code at the time of oral evaluation and (Continued on page 16)
Processing Policy Manuals

Did you know that every PPO has a Processing Policy Manual? When the provider (dentist) signs a contract with the PPO, he or she agrees to comply with all provisions in the processing policy manual. However, many contracted providers do not realize that the processing policy manual exists until presented with a situation that results in a claim denial and/or a hefty, unexpected write-off for the practice.

The decision to join or drop a PPO is often based on the contracted fee schedule presented by the payer. The PPO contract also establishes that the practice agrees to adhere to all contract provisions and processing policies of the payer. As a contracted provider, it is essential that all team members fully understand the language of the plan document and processing policy manual.

Dental claims are processed based on the limitations and exclusions established by the plan document and processing policies of the payer. The group or individual dental plan contract (also called the plan document) and the processing policy manual are two separate documents. The plan document takes precedence over the processing policy manual when the claim is processed.

The payer uses the plan document, which may be about 200 pages long, to determine benefits. The practice cannot obtain a copy of the plan document on its own. Patients receive a copy of the summary plan description in their informational booklet about their benefits. However, a patient can obtain the plan document from the employer’s human resources department or directly from the payer and then pass it along to the practice.

Always maintain a copy of the payer’s most current processing policy manual for the patients covered by a particular plan. The processing policy manual can be found on many payers’ provider websites or by contacting the provider relations department. Delta Dental has two processing policy manuals: one for each state’s policies and one for nationally purchased policies. (Delta USA typically covers patients who work for national employers, such as Wal-Mart, Amazon, or Wells Fargo.) Review each PPO contract and processing policy manual carefully. Be aware of what you, as the provider, are agreeing to when signing a PPO contract to join a network.

The following stipulations are typically included in a processing policy manual. However, a given plan’s processing policy manual is not limited to these provisions and may not necessarily include each of these requirements.

» All services and/or charges are required to be submitted to the payer. This includes non-covered services, such as teeth whitening, since the PPO may control the provider’s fee for non-covered services in some circumstances.

» There are specific documentation and claim submission requirements regarding optional services, such as non-covered treatment rendered for cosmetic purposes.

» Payments to the provider may be issued in any form (i.e., virtual credit card payments or a paper check).

» The provider agrees to issue any refunds upon request by the payer, regardless of the reason for the request. This is true even if the request is due to an eligibility issue or error made by the payer during claim processing and is not the practice’s fault.

» One restoration is allowed per tooth surface within a given time period by the same billing entity (e.g., one restoration per tooth every 24 months).

» A pulp cap (direct or indirect) performed on the same service date as a definitive restoration may be disallowed, resulting in a required write-off of the pulp cap procedure. This means the fee charged for the pulp cap procedure cannot be billed to the patient.

» Claims must be filed by the practice within a timely fashion. This timely filing requirement varies among payers.

» All treatments performed must be included in a processing policy manual. Plus, the PPO contract and processing policy manual may not necessarily include each of these requirements.

» Radiographic images must be of diagnostic quality. Furthermore, if a benefit is paid for a radiographic image, and it is later determined that the image was not of diagnostic quality or medically necessary, the payer may request a refund. As a result, the contracted provider may not be allowed to bill the patient for the disallowed fee.

Remember, every PPO has a processing policy manual. Understanding the policies prior to providing treatment can help avoid unnecessary write-offs, additional administrative time after the claim is filed, and awkward conversations with the patient resulting from a denied dental claim.
October 1, 2015 is here and with it comes the implementation of the tenth revision of the International Statistics Classification of Diseases and Related Health Problems (ICD-10)!

In 2009, Centers for Medicare and Medicaid Services (CMS) announced that a new set of diagnosis codes would be introduced into the nation’s healthcare system. When the announcement was made, there was an audible groan heard from physicians and their staff. It seemed we had only just learned ICD-9 and a new code set seemed unnecessary. Nevertheless, this new code set was introduced and the Health Insurance Portability and Accountability Act (HIPAA) covered entities were told that they would be required to comply. Health and Human Services (HHS) set an initial compliance date of October 1, 2013. Since that time, there have been two delays, but no additional delay has been announced. Beginning October 1, 2015, all healthcare providers will be required to report ICD-10 codes on all claims requiring a diagnosis code.

It is true that the medical field has been, and will continue to be, impacted by ICD-10 to a greater degree than the dental field. However, with the recent changes in healthcare regulations and in the insurance industry, many dental practices may find that they will also need to report ICD-10 codes on the 2012 ADA Dental Claim Form or a medical claim form.

As the October 1, 2015 implementation date arrives, many practices are being inundated with information on how to prepare for this new code set. The reality is that most dental providers do not know what an ICD-10 code is, the requirements for reporting ICD-10 codes, or how to properly select an ICD-10 code to report.

There are two different segments of ICD-10: ICD-10-PCS (Procedure Coding System) and ICD-10-CM (Clinical Modification). Only inpatient hospital claims use ICD-10-PCS. All outpatient encounters (including visits and treatments) use ICD-10-CM. In this article, every use of the term ICD-10 refers to ICD-10-CM.

**What Does an ICD-10 Code Look Like?**

ICD-10 contains approximately 69,000 codes, which may seem overwhelming. However, the truth is that all specialties, including dentistry, will only use a fraction of the available codes. In fact, most dentists will find that there are only a few codes they will use regularly. Let us take a look at the structure of ICD-10 codes and their usage in the dental office.

The ICD-10 code set is comprised of 21 chapters, each dealing with a specific part of the anatomy, type of disease, condition, symptoms, complicating factors, or effects of external causes. For each chapter there are specific reporting guidelines. Many codes found in Chapter 11, “Diseases of the Digestive System,” may be used to describe conditions of the mouth.

ICD-10 codes are alphanumeric and each consists of three to seven characters.

» The first character is always a letter. This letter signifies the chapter where the code is located.

» The first three characters of each code signify the code’s category.

» When a code is greater than three characters, a decimal point follows the third character, which is always numeric.

» The following three characters provide greater information, such as the severity of the condition or symptom and/or specifies the anatomic site.

Reporting a valid diagnosis code requires that all applicable characters be included. The different characters can become confusing. Let us review an example of the structure of a diagnosis code to describe dental cavities (caries) to clarify these different characters.

**Category**

**K02** Dental caries

The letter K indicates this code is located in Chapter 11, “Diseases of the Digestive System.” The numbers “02” indicate this code relates to dental caries.

**Specifics**

**K02.5** Dental caries on pit and fissure surface

Per the guidelines mentioned above, there is a decimal point following the first three characters. The number 5 indicates that caries are on the pit and fissure surface.

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ICD-10: It’s Here! (Continued from page 4)

An additional character is also required, as follows:

K02.51 Dental caries on pit and fissure surface limited to enamel
K02.52 Dental caries on pit and fissure surface penetrating into dentin
K02.53 Dental caries on pit and fissure surface penetrating into pulp

K02.6 Dental caries on smooth surface
Per the guidelines mentioned above, there is a decimal point following the first three characters. The number 6 indicates the caries are on the smooth surface of the tooth.

An additional character is also required, as follows:

K02.61 Dental caries on smooth surface limited to enamel
K02.62 Dental caries on smooth surface penetrating into dentin
K02.63 Dental caries on smooth surface penetrating into pulp

K02.7 Dental root caries
Per the guidelines mentioned above, there is a decimal point following the first three characters. The number 7 indicates the caries are located on the tooth root. There are no additional characters required to further describe this condition.

K02.9 Dental caries, unspecified
Per the guidelines mentioned above, there is a decimal point following the first three characters. The number 9 indicates an unspecified area or extent of the caries. There are no additional characters required to further describe this condition. However, some payers may reject this code and require a more specific diagnosis to process a claim.

This code, while relatively simple, requires that the code reported be specific for the type of cavity treated. In coding terminology, this is referred to as “specificity.” This is a term you may hear often in relation to ICD-10; one benefit of this code set is the ability to report more specific and detailed information than was possible with ICD-9.

Codes requiring six characters will describe a condition in even greater detail. For example, when reporting a partial loss of teeth due to an accident, the applicable codes will be:

K08.41 Partial loss of teeth due to trauma
This code has a fifth digit; however, guidelines further instruct this code requires a sixth digit. The codes listed below offer the highest degree of specificity for this code. Only codes reported to the highest possible level of specificity will be accepted for claims processing. The codes below are the only valid codes for reporting this type of tooth loss.

K08.411 Partial loss of teeth due to trauma, class I
K08.412 Partial loss of teeth due to trauma, class II
K08.413 Partial loss of teeth due to trauma, class III
K08.414 Partial loss of teeth due to trauma, class IV
K08.419 Partial loss of teeth due to trauma, unspecified class

With the recent changes in healthcare regulations and the insurance industry, many dental practices may find that they will also need to report ICD-10 codes on the 2012 ADA Dental Claim Form

K08 Other disorders of teeth and supporting structures
Guidelines state this code requires a fourth digit.

Specifics

K08.4 Partial loss of teeth
This code has a fourth digit; however, guidelines further instruct this code requires a fifth digit.

K08.41 Partial loss of teeth due to trauma
This code has a fifth digit; however, guidelines further instruct this code requires a sixth digit. The codes listed below offer the highest degree of specificity for this code. Only codes reported to the highest possible level of specificity will be accepted for claims processing. The codes below are the only valid codes for reporting this type of tooth loss.

K08.411 Partial loss of teeth due to trauma, class I
K08.412 Partial loss of teeth due to trauma, class II
K08.413 Partial loss of teeth due to trauma, class III
K08.414 Partial loss of teeth due to trauma, class IV
K08.419 Partial loss of teeth due to trauma, unspecified class

Sometimes the seventh character is required for a diagnosis code, which otherwise would be comprised of five characters or less. In this case, the missing character(s) are replaced with the placeholder, “X.” The concept of placeholders is unique to ICD-10 and creates a space for possible expansion of these codes. An example of a code that requires both placeholders and a seventh character is:

S02.5XXA Fracture of tooth (traumatic) initial encounter for closed fracture
The letter S indicates this code is from Chapter 19, “Injury, Poisoning and Certain Other Consequences of External Causes.” The numbers “02” indicate that this code relates to a fracture of skull and facial bones. Note that there are four characters following the decimal point. The number five indicates a fractured tooth, followed by two placeholders. The seventh character is the letter “A,” which in this case indicates this is the initial visit for a closed fracture.

This may seem confusing, but it is actually pretty simple. All code listings indicate these codes clearly indicate each code and the required specificity.

Category
K08 Other disorders of teeth and supporting structures
Guidelines state this code requires a fourth digit.

Specifics

K08.4 Partial loss of teeth
This code has a fourth digit; however, guidelines further instruct this code requires a fifth digit.

K08.41 Partial loss of teeth due to trauma
This code has a fifth digit; however, guidelines further instruct this code requires a sixth digit. The codes listed below offer the highest degree of specificity for this code. Only codes reported to the highest possible level of specificity will be accepted for claims processing. The codes below are the only valid codes for reporting this type of tooth loss.

K08.411 Partial loss of teeth due to trauma, class I
K08.412 Partial loss of teeth due to trauma, class II
K08.413 Partial loss of teeth due to trauma, class III
K08.414 Partial loss of teeth due to trauma, class IV
K08.419 Partial loss of teeth due to trauma, unspecified class

With the recent changes in healthcare regulations and the insurance industry, many dental practices may find that they will also need to report ICD-10 codes on the 2012 ADA Dental Claim Form
CMC Makes 39 Substantive Changes to Dental Codes
(Continued from front cover)

This article reviews the 19 codes added to CDT 2016. The article on page 12 lists the eight deleted codes. The code revisions will be discussed in the November/December 2015 issue of Insurance Solutions Newsletter.

Nineteen Codes Added to CDT

D0251 Extra-oral posterior dental radiographic image
Image limited to exposure of complete posterior teeth in both dental arches. This is a unique image that is not derived from another image.

Rationale for adding D0251: An extraoral image of posterior teeth may be necessary when the patient is not able to tolerate intraoral placement of the imaging medium (e.g., a film or charge coupled device [CCD] receptor). There are no current CDT codes that accurately describe this imaging procedure. D0251 will now be used to describe an extraoral posterior dental radiograph of both dental arches. If an image is produced using an extraoral sensor or film that does not capture a posterior image of both the upper and lower jaws, D0250 should be reported since it is nonspecific as to the area of exposure.

In order to report D0251, the image may not be produced from another image, meaning the image is unique and is not a duplicate of another image. This indicates that D0251 should not be used to report secondary image processing, meaning that it is not applicable to cone beam CT reconstruction.

According to Dr. Alan G. Farman, past president of the American Academy of Oral and Maxillofacial Radiology, this new code is intended to report special procedures presently produced using a restricted orthogonal field with panoramic radiology systems.

Example: A clinical scenario may involve a patient who is not physically able or willing to open her mouth for placement of an intraoral imaging medium (e.g., film, CCD receptor, etc). In such a situation, a provider may elect to adjust an extraoral imaging device (e.g., panoramic) so that only the teeth to be imaged receive ionizing radiation.

D0422 Collection and preparation of genetic sample material for laboratory analysis and report

D0423 Genetic test for susceptibility to diseases – specimen analysis
Certified laboratory analysis to detect specific genetic variations associated with increased susceptibility for diseases.

Rationale for adding D0422 and D0423: The collection of sample material and the laboratory analysis used to detect genetic variations in it are two distinct processes, which are typically performed by different parties in separate settings. The CMC agreed that two codes should exist to allow for separate recording and claims adjudication of specimen collection and analysis. The rationale for having two genetic testing codes is similar to the distinction between the saliva sample collection and analysis codes, D0417 and D0418.

The practice of dentistry is migrating closer to medicine, so dentists will be increasingly involved in the detection and management of various diseases. To preserve the historical accuracy of tracking claims data, D0421 is being retired, and is replaced by these two new codes. As a result, D0422 should now be used to report the collection of genetic sample material and D0423 to report the laboratory analysis of the genetic sample. The two codes are reported separately.

D0422 is used to describe the various means of collection and preparation of genetic material to send to the laboratory for analysis and the subsequent report. Examples of this type of test could include EasyDNA or MyPerioID®. The subsequent analysis of the genetic sample is described by D0423. The laboratory analysis of a specimen is performed to detect specific genetic diseases, not just the increased susceptibility for oral disease, such as severe periodontal disease.

Note: This new code should not be used to report fluoride varnish. The use of topical application of fluoride varnish or topical application of a fluoride that is not a varnish is reported by D1206 or D1208, not D1354. (Continued on page 7)
CMC Makes 39 Substantive Changes to Dental Codes  (Continued from page 6)

**D4283** Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site

*Used in conjunction with D4273.*

**Rationale for adding D4283:** The reporting of connective tissue grafts has been a source of considerable confusion for providers. D4283 has been added to CDT 2016 to help differentiate between autogenous connective tissue grafts (using a patient’s own tissue for the graft) and non-autogenous connective tissue grafts (using a material such as Alloderm®, Mucoderm®, etc. with no donor site involved). The new code also differentiates between each additional contiguous tooth, implant, or edentulous tooth position in the same graft site.

Certain steps of graft procedures (e.g., anesthesia) are performed once, regardless of the size of the graft. In other words, there is not a major difference in the time and effort required to graft additional contiguous teeth or edentulous tooth positions. This new code, D4283, should be used to report each additional contiguous tooth, implant, or edentulous tooth position in an autogenous connective tissue graft. The first tooth/site in the non-autogenous connective tissue graft should be reported as D4273.

Differentiating the type of connective tissue graft (autogenous vs. non-autogenous) and the first tooth/site involved in a graft from each additional tooth/site brings the reporting of non-autogenous connective tissue grafts more in line with other soft tissue procedures. This reporting practice also facilitates better data tracking and more uniform reimbursement policies.

**D4285** Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site

*Used in conjunction with D4275.*

**Rationale for adding D4285:** D4275, soft tissue allograft, has been a source of considerable confusion for providers, many of whom have questioned whether it should be reported for a single graft site or multiple, contiguous sites. As previously mentioned, there is not a huge difference in the time and effort required to graft additional contiguous teeth or edentulous tooth positions.

This new code, D4285, should be used to report each additional contiguous tooth, implant, or edentulous tooth position in a non-autogenous connective tissue graft (i.e., no donor site is involved and the graft uses a material such as Alloderm®, Mucoderm®, etc.). The first tooth in the non-autogenous connective tissue graft should be reported as D4275.

Differentiating the type of connective tissue graft (autogenous vs. non-autogenous) and the first tooth/site involved in a graft from each additional tooth/site brings the reporting of non-autogenous connective tissue grafts more in line with other soft tissue procedures. This reporting practice also facilitates better data tracking and more uniform reimbursement policies.

**D5221** Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)

*Includes limited follow-up care only; does not include future rebasing/relining procedure(s).*

**Rationale for adding D5221:** There is a significant difference between an immediate partial denture and an interim partial denture. Interim, by definition, means that it is not the final prosthesis. A maxillary flipper, for example, may be reported as an interim partial denture (D5820). An immediate partial denture, on the other hand, is the final prosthesis that is delivered immediately after the assigned teeth have been extracted.

D5221 describes a conventional maxillary removable resin partial denture delivered some time after the teeth being replaced by the partial have been removed. D5221 describes an immediate partial that is delivered on the same day the assigned teeth are extracted.

This procedure is somewhat similar to D5140 (immediate denture – mandibular) except that it is for an immediate maxillary partial denture. This immediate maxillary partial denture is usually made of acrylic or resin, and is intended as the definitive partial. In the past, this procedure has been reported as D5899 (unspecified removable prosthodontic procedure, by report) because no specific code existed.

**D5222** Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)

*Includes limited follow-up care only; does not include future rebasing/relining procedure(s).*

**Rationale for adding D5222:** This procedure is somewhat similar to D5140 (immediate denture – mandibular) except that this new code is for an immediate mandibular partial denture. This immediate partial denture is usually made of acrylic or resin and is intended as the definitive partial. In the past, this procedure has been reported as D5899 (unspecified removable prosthodontic procedure, by report) because no specific code existed.

Furthermore, interim, by definition, means that it is not the final prosthesis. A mandibular flipper, for example, may be reported as an interim partial denture (D5820). An immediate mandibular resin partial denture, on the other hand, is the final prosthesis that is delivered immediately after the assigned teeth are extracted.

**D5223** Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)

*Includes limited follow-up care only; does not include future rebase/relining procedure(s).*

**Rationale for adding D5223:** This is a definitive or final removable prosthesis. (Continued on page 8)
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Patients often do not want the extra expense of a flipper while waiting for healing before delivering the final partial denture. An immediate maxillary partial denture (cast metal framework with resin denture bases) can be fabricated prior to the extraction of the assigned teeth and delivered immediately following the extractions. The immediate maxillary partial may require relining after healing is complete. The reline should be reported separately as D5740 if the reline is performed chairside, or D5760 if the reline is processed.

D5213 reports a maxillary partial denture – cast metal framework with resin denture bases delivered some time after tooth extraction. D5223 reports the cast metal immediate maxillary partial that is delivered on the same day as the extraction of the assigned teeth.

D5224 Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
Includes limited follow-up care only; does not include future rebasing/relining procedure(s)

Rationale for adding D5224: This is a definitive or final prosthesis. An immediate mandibular partial denture (cast metal framework with resin denture bases) can be fabricated prior to the assigned teeth being extracted and delivered immediately after the extractions. The immediate mandibular cast partial may require relining after healing is complete. The reline should be reported separately as D5741 if the reline is performed chairside, or D5761 if the reline is processed.

D5214 reports a mandibular partial denture – cast metal framework with resin denture bases delivered some time after the assigned teeth have been removed. D5224 reports the immediate mandibular cast partial that is delivered on the same day as the extraction of the assigned teeth.

D7881 Occlusal orthotic device adjustment

Rationale for adding D7881: In past versions of CDT, there was no specific code for reporting the adjustment of an occlusal orthotic device that includes splints provided for the treatment of temporomandibular joint dysfunction (TMJ), D7880. The only option was to report a “999” by report code, which required a narrative.

D7881 should not be submitted to describe adjustments made to the occlusal orthotic device at delivery. Payers say that adjustments made on the date of the delivery and during a defined follow-up period are included in the global fee for D7880.

Rationale for adding D8681: The adjustment of a removable orthodontic retainer may be performed by a provider who did not initially place the orthodontic retainer. Past versions of CDT have not had a specific code for reporting this type of retainer adjustment. A provider’s only option was to report D8999 (unspecified orthodontic procedure, by report). The addition of this new procedure code will eliminate the requirement to provide a narrative report when adjusting a removable orthodontic retainer after active therapy.

D8681 should not be reported for the adjustment of an appliance for a patient in active orthodontic therapy. The adjustment of an appliance for a patient in active therapy is included in the global case fee.

D9223 Deep sedation/general anesthesia – each 15 minute increment

Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties.

The level of anesthesia is determined by the anesthesia provider’s documentation of the anesthesia’s effects upon the central nervous system and not dependent upon the route of administration.

Rationale for adding D9223: With past versions of CDT, deep sedation/general anesthesia was reported using D9220 for the first 30 minutes and D9221 for each additional 15 minute increment. With the implementation of the Affordable Care Act (ACA) and the Pediatric Essential Health Benefit, dental benefits are sometimes embedded in medical plans and covered under the medical side of full-service health plans. It has become necessary to align CDT time increments for deep sedation/general anesthesia with medical (CPT) codes. Converting to a 15 minute time increment mirrors the anesthesia codes used in CPT (e.g., CPT 00170) and provides consistency between the dental and medical integrated plans.

D9223 is measured in whole 15 minute increments. Any period of less than 15 minutes should not be submitted for reimbursement.

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CMC Makes 39 Substantive Changes to Dental Codes  (Continued from page 8)

D9243  Intravenous moderate (conscious) sedation/anesthesia – each 15 minute increment

Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may safely leave the room to attend to other patients or duties.

The level of anesthesia is determined by the anesthesia provider’s documentation of the anesthetic’s effects upon the central nervous system and not dependent upon the route of administration.

Rationale for adding D9243: With past versions of CDT, intravenous moderate (conscious) sedation/anesthesia was reported using D9241 for the first 30 minutes and D9242 for each additional 15 minute increment. With the implementation of the ACA and the Pediatric Essential Health Benefit, dental benefits are sometimes embedded in medical plans and covered under the medical side of full-service health plans. It has become necessary to align CDT time increments for intravenous moderate (conscious) sedation/anesthesia with medical codes. Converting to a 15 minute time increment mirrors the anesthesia codes used in CPT (e.g., CPT 00170) and provides consistency between the dental and medical integrated plans.

D9243 is measured in whole 15 minute increments. Any period of less than 15 minutes should not be submitted for reimbursement.

D9322  Cleaning and inspection of removable complete denture, maxillary

This procedure does not include any adjustments.

Rationale for adding D9322: CDT codes for removable complete and partial dentures are differentiated based upon arches and remaining dentition. The CMC decided that the cleaning and inspection codes should provide the same level of specificity. Note that this new code, D9932, does not include any required adjustments and should be used to report the cleaning and inspection of a maxillary removable complete denture.

D9935  Cleaning and inspection of removable partial denture, mandibular

This procedure does not include any adjustments.

Rationale for adding D9935: CDT codes for removable complete and partial dentures are differentiated based upon arches and remaining dentition. The CMC decided that the cleaning and inspection codes should provide the same level of specificity. Note that this new code, D9935, does not include any required adjustments and should be used to report the cleaning and inspection of a mandibular removable partial denture.

Adjustments of a removable prosthesis provided in addition to the cleaning and inspection of the prosthesis are reported as:

» D5410, adjust complete denture – maxillary
» D5411, adjust complete denture – mandibular
» D5421, adjust partial denture – maxillary
» D5422, adjust partial denture – mandibular

D9943  Occlusal guard adjustment

Rationale for adding D9943: An occlusal guard is reported as D9940 and includes removable appliances, which are designed to minimize the effects of bruxism/grinding and other occlusal factors (e.g., nightguards for bruxism and periodontal stabilization). In past versions of CDT, there has not been a specific code for reporting such an adjustment. The only option has been to report a “999,” by report code.

This new code can be reported when adjusting any type of occlusal guard. However, D9943 cannot be reported on the same day as delivery of a new occlusal guard. Remember that “fitting” an occlusal guard on the day of delivery or subsequent visits is different than “adjusting” an occlusal guard at a subsequent visit. Adjustments made on the delivery date and during a defined follow-up period (as defined by the payer) are included in the global fee for D9940.
I have always felt the need to perform a full mouth debridement (D4355) when calculus and debris prevent me from periodontal probing and charting. However, if the dentist at our office can diagnose decay, he does not want us doing a full mouth debridement. This means that I am unable to properly chart the patient’s pocket depths. What are your thoughts on this?

First, let us review the nomenclature and descriptor for D4355:

**D4355  Full mouth debridement to enable comprehensive evaluation and diagnosis**

The gross removal of plaque and calculus that interfere with the ability of the dentist to perform a comprehensive oral evaluation. This preliminary procedure does not preclude the need for additional procedures.

This code is intended for patients who present with so much plaque and calculus covering the teeth that an accurate periodontal assessment cannot be made. In the example provided, it would impede a doctor from performing a thorough diagnosis and developing a treatment plan. Furthermore, the amount of buildup prevents the hygienist from properly completing periodontal probing and charting. A full mouth debridement makes the dentition visible, allowing the doctor to perform a preliminary assessment. However, it is still impossible to complete an accurate six-point per tooth periodontal probing on the same service date. Other components of periodontal charting may be performed.

Remember, the reason for performing the gross debridement is to get a more accurate assessment of the periodontal status at a subsequent appointment. This allows the inflamed tissue to resolve and the pseudo pockets to “shrink” so that more accurate probe readings can be obtained. This also lets the doctor arrive at a more definitive diagnosis of the periodontal condition. In most cases, the probe measurements can be determined at the first appointment after the gross debris is removed. However, these measurements may not yield an accurate assessment of the baseline periodontal condition that the patient presents at the first appointment and should be noted as such in the chart.

D4355 is a preliminary procedure. The next step is to schedule the patient for a comprehensive oral evaluation (D0150) or a comprehensive periodontal evaluation (D0180) at a second visit. If the patient shows signs and symptoms of periodontal disease or has risk factors, such as smoking or diabetes, the patient should be scheduled for a comprehensive periodontal evaluation (D0180). It is important to understand that, by definition, a comprehensive oral evaluation cannot be completed on the same day as a full mouth debridement. Most practices schedule this second appointment at least 10 to 14 days later to allow for healing of the gingival tissues.

In addition, only about 25 to 30 percent of payers actually provide reimbursement for D4355. Often, the payer remaps D4355 to D1110 (prophylaxis) for reimbursement. Notify the patient of this limitation and of the fact that he or she may be responsible for out-of-pocket costs.

This type of patient may require nonsurgical periodontal therapy (D4341 or D4342). In order to reduce the number of patient visits, it may be prudent to schedule the comprehensive periodontal evaluation (D0180) and the first quadrant of scaling and root planing (SRP) on the same service date. Since the periodontal charting is partially completed at the first appointment, the probe readings can be done at the subsequent visit, thus providing an accurate measurement of clinical attachment. Six-point periodontal probing and a visual evaluation will determine if there is attachment loss, allowing the doctor to determine the medical necessity of either prophylaxis or SRP treatment. Typically, SRP procedures require 4mm to 5mm pockets, bleeding on probing (indicating active periodontal disease), and radiographic evidence of bone loss in order to gain reimbursement.

**An Opinion on Full Mouth Debridement**

I personally do not provide a full mouth debridement (FMD) for patients unless they are like the one discussed above, where you cannot see the teeth. D4355 is frequently misreported as a gross removal procedure or a “first prophylaxis visit,” even when it is obvious that the patient would more appropriately benefit from two separate prophylaxis visits (for gingivitis) or a sequence of nonsurgical periodontal therapy (Continued on page 11)
I’m glad you asked... Full Mouth Debridement (Continued from page 10)

(SRP). There is no research available from the American Academy of Periodontology (AAP) to support that FMD is beneficial prior to SRP. In fact, research in the mid-to-late 1980s states that it can be detrimental.

When nonsurgical periodontal therapy is the appropriate treatment, why use a portion of the patient’s annual benefits to provide a full mouth debridement if it is not necessary? That payment could be better spent on other necessary procedures recommended by the doctor. (Note: Never base treatment recommendations on potential insurance reimbursement.)

Consider a patient who has heavy amounts of supra-gingival calculus extending down onto the root surfaces. With about 4mm of recession on these teeth, alone, SRP will generally be indicated. Additionally, accurate probe readings cannot be made without removing the calculus that has permeated into the dentin and any other debris that may be in the periodontal pocket.

It is not logical to perform a FMD to be able to superficially probe the pockets. This methodology would require the patient to return for an additional appointment to begin SRP. A better strategy is to inform the patient of his or her periodontal disease at the initial visit, based on the radiographs taken, and complete the periodontal charting without the pocket depths. Then, review a treatment plan with the patient to provide the appropriate nonsurgical treatment (SRP), using anesthesia, at the next visit.

The most common follow-up question to this discussion is, “What if the payer requires preauthorization for SRP?” In my experience, most offices elect not to preauthorize SRP and this practice has been accepted. If complete documentation is submitted for the procedure, including diagnostic radiographs, complete periodontal charting, definitive diagnosis, narrative description, and intraoral photographs the treatment will be reimbursed according to the patient’s plan document.

Bottom Line

When deciding to provide your patient with a full mouth debridement, consider why you are doing it. Based on D4355’s nomenclature, a FMD should be performed to enable the doctor to complete a comprehensive oral evaluation and diagnosis at a subsequent appointment. Following FMD, the patient will receive either a prophylaxis, SRP, or a referral to a periodontist. Regardless of the subsequent treatment provided, it should occur at a second appointment, since FMD is a preliminary procedure at the first visit.

The doctor should see the patient prior to any FMD procedure in order to assess the entire dentition and order specific radiographs so that a complete workup and comprehensive treatment plan can be developed afterwards. In addition, if there is no therapeutic benefit to the patient by providing a gross removal of calculus prior to SRP, then simply begin SRP treatment, quadrant by quadrant. This saves the patient time and is the optimal clinical treatment sequence.
Eight Codes Deleted From CDT

The final count for 2016 Current Dental Terminology (CDT) changes comes to 39 substantive changes and 41 editorial changes. Of those changes, 19 codes are created, 8 codes are deleted, and 12 codes are revised. Some of the more commonly reported codes that have been deleted include D2970, temporary crown (fractured tooth), and various sedation codes.

D0260 Extraoral – each additional radiographic image

Rationale for deleting D0260: The Code Maintenance Committee (CMC) determined that there is no need for a separate CDT code for every additional extraoral image captured at the same time the first image is captured. This is because the procedural steps, such as placement of the imaging medium or placement of the ionizing radiation source, are the same. A single code to identify an extraoral procedure (i.e., D0250) is sufficient, and the total number of images captured can be reported on a dental claim in the “Quantity” field, if the practice software accepts the entry. Also enter the appropriate fee in the correlating “fee” box.

D0421 Genetic test for susceptibility to oral diseases

Sample collection for the purpose of certified laboratory analysis to detect specific genetic variations associated with increased susceptibility for oral diseases such as severe periodontal disease.

Rationale for deleting D0421: The CMC determined that proposed revisions to D0421 substantially changed the nature of the procedure as described in CDT 2015. The proposed revision changed the focus to the analysis of a specimen rather than the collection of a specimen. To preserve the value of historical claims data collection, the CMC voted to retire D0421 and create two new codes to replace it, collection and preparation of genetic sample material for laboratory analysis and report (D0422) and genetic test for susceptibility to diseases – specimen analysis (D0423).

D2970 Temporary crown (fractured tooth)

Usually a preformed artificial crown, which is fitted over a damaged tooth as an immediate protective device. This is not to be used as temporization during crown fabrication.

Rationale for deleting D2970: The CMC agreed with the ADA Council on Dental Benefit Programs that D2970 is not necessary since the procedure may be documented and reported using one of the following codes:

- D2799 Provisional crown – further treatment or completion of diagnosis necessary prior to final impression
- Not to be used as a temporary crown for a routine prosthesis restoration.
- D2940 Protective restoration

Direct placement of a restorative material to protect tooth and/or tissue form. This procedure may be used to relieve pain, promote healing, or prevent further deterioration. Not to be used for endodontic access closure, or as a base or liner under restoration.

- D9110 Palliative (emergency) treatment of dental pain – minor procedure

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

D9220 Deep sedation/general anesthesia – first 30 minutes

Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties.

The level of anesthesia is determined by the anesthesia provider’s documentation of the anesthetic’s effects upon the central nervous system and not dependent upon the route of administration.

D9241 Intravenous moderate (conscious) sedation/analgesia – first 30 minutes

Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties.

The level of anesthesia is determined by the anesthesia provider’s documentation of the anesthetic’s effects upon the central nervous system and not dependent upon the route of administration.

D9242 Intravenous moderate (conscious) sedation/analgesia – each additional 15 minutes

Rationale for deleting D9241 and D9242: With the implementation of the Affordable Care Act (ACA) and the Pediatric Essential Health Benefit, dental benefits are sometimes embedded in medical plans. Converting to a 15 minute time increment mirrors the anesthesiology codes used in CPT (e.g., CPT 00170) and provides consistency between dental and medical integrated plans.

With past versions of CDT, deep sedation/general anesthesia has been reported using D9220 for the first 30 minutes and D9221 for each additional 15 minute increment. However, to create consistency for dental and medical plans and to preserve the historical value of claims data tracking, a new CDT code (D9223) has been created for deep anesthesia/general anesthesia services performed on or after January 1, 2016. D9220 and D9221 will then become obsolete for anesthesia services performed on or after January 1, 2016.
ICD-10: It’s Here! (Continued from page 5)

Will Dentists be Required to Report ICD-10 Codes?

You may be wondering if ICD-10 is something you need to learn. Once ICD-10 is implemented, all claims requiring a diagnosis code will require that ICD-10 codes be used. If you never report diagnoses codes on your claims, then you may be minimally affected by ICD-10. It is important to note, however, that there are changes in the healthcare and insurance fields, which may necessitate the use of diagnoses codes in the near future. The potential changes include the following:

» CMS has mandated that ICD-10 be implemented for all HIPAA covered entities. This includes state Medicaid plans and affects Medicaid dental claims in some states.

» Some Affordable Care Act (ACA) plans currently require a diagnosis code on dental claim forms submitted for charges under the mandated pediatric dental benefits.

» Many dental payers are now requiring that claims for surgical extractions be filed under the patient’s medical plan.

The January/February 2015 issue of Insurance Solutions Newsletter published an article titled “Diagnostic Coding: The New Reality for Dentists” that outlined these requirements and their effects on the dental practice.

What should I do to prepare?

With the understanding that most dentists will eventually need to report a diagnosis code, the following basic steps are advised:

1. Check with your software vendor. This may be the single most important action you can take. As already noted, many practices rarely submit a diagnosis code. If you suddenly find the need to report a diagnosis code on a specific claim, locating the code is relatively easy. If your software is not capable of creating a claim to include a diagnosis code, this could cause a significant delay in reimbursement. Your software vendor should be prepared to accommodate the 2012 ADA Dental Claim Form, thus allowing the reporting of ICD-10 codes.

2. Become familiar with the most common codes used in the dental practice. You do not have to be an expert coder to understand the basics of how a diagnosis code is assigned. There are both printed and online sources for ICD-10 codes, such as www.icd10data.com. Be aware that all sources are not developed specifically for the dental practice. Read code descriptions carefully to determine the most accurate code to report in each circumstance.

3. Review your clinical documentation. Accurate and complete documentation is critical for many reasons, including the continuity of patient care. As we have discussed, ICD-10 requires very specific information from the clinical notes, not a verbal discussion with the dentist. Thorough, complete, and concise documentation will help ensure not only excellent care for your patients, but will assist in correct reporting of diagnoses codes.

Gaining Confidence

This is only a brief overview of ICD-10 codes and their impact on the dental practice. Familiarizing yourself with the medical coding basics is only the first step in expanding your knowledge of the new ICD-10 codes. As with any other challenge, this is best met by learning and applying each concept one at a time. By beginning to identify and understand those codes common to your practice, you will soon become proficient in correctly reporting diagnoses codes.

Diagnostic Coding for the Dental Claim Form can help your practice successfully report ICD-10 codes on the 2012 ADA Dental Claim Form.

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How to Negotiate Fees  (Continued from front cover)

Assess the Current Situation

Before entering into a negotiation, it is vital to first examine your current position. In any negotiating process, the stronger the position you have, the greater the chance of success. If you are currently participating with any plans, begin the analysis by collecting the following data:

» Identify all plans with which the practice participates. For each plan, determine the number of practice patients covered by the plan, the amount of practice revenue generated from those patients over the past year, the percentage of total revenues for each plan, and the total required write-offs generated from the plan.

» Examine the practice’s current busyness and financial position. Consider the practice’s current busyness: Is the practice stagnant and in need of new patients in order to grow? A good rule of thumb is that ideal “doctor busyness” is being solidly booked one to two weeks ahead. (Note: Using block scheduling and/or utilizing an unbooked operatory can provide openings for emergencies and new patients.) Also, determine the practice’s total annual overhead expenses and the amount of revenue required to continue practice operations.

» Gather the plan’s contact information. Identify the phone number or email address for each plan’s provider relations department, network recruiting department, and provider retention department.

» Track the important dates. Determine the initial participation date with the plan and the date of any fee changes made by the plan, either “automatic” changes or prior negotiations.

» Consider the other potential plans with which the practice could contract. Track the number of patients requesting participation information regarding all plans. Also, track the number of patients who call about plans with which you are in-network and out-of-network. Breakdown that number based on the rate at which callers make appointments regardless of your in- or out-of-network status. Finally, determine if there are PPO plans covering the employees of major employers in the area with which the practice does not participate. But, keep in mind that employers do change their plans, so there are no contracted doctors. The best time for negotiation is when a payer is actively “recruiting” doctors to participate in a plan in a new area.

For the plans that are open to negotiation, do your homework and come to the negotiating table prepared. It is better if the doctor engages in the negotiations rather than a staff member. Delta will not negotiate, and MetLife has announced that it will not negotiate with a third party. Be aware of leased panel agreements between insurance companies and leased networks. Networking relationships can provide an opportunity to participate with multiple payments at higher levels of reimbursement. However, networking can be complicated and it has its drawbacks.

Remember, timing is everything. For new enrollees, this is particularly important. Also, never accept the first offer. As in any other negotiation, the first offer is seldom the best offer.

Understand that every doctor must enter into the negotiation process individually. There are some very significant antitrust issues that could arise from a “group effort” initiated by a number of doctors in a particular area to increase fees. Antitrust laws prohibit doctors from conducting “group

(Continued on page 15)
How to Negotiate Fees  
(Continued from page 14)

negotiations” or even to discussing fees. So, if you want to negotiate fair and accurate insurance reimbursements, it must be done on an individual basis.

A third party negotiator may be a good option to help you review your insurance participation, analyze your current insurance contracts, and complete negotiations on your behalf. Your dental team may not have the time, expertise, or desire to complete the necessary research and work required. Some third party negotiators have a good understanding of leased panel networking, have established relationships with payers, and understand the negotiation process. The quality of third party negotiators varies by company. Be sure to understand the services offered and get references from a trusted source.

Start the Negotiation Process

It was once unheard of to negotiate with a payer to increase a fee schedule, but today these negotiations are becoming more commonplace and are frequently quite successful. Do not be surprised when the payer is open and willing to make some fee concessions after simply asking for the increase.

Begin the process by drafting a letter requesting a fee increase. This request should be simple, direct, and to the point. No one wants to read through a lengthy dissertation extolling the virtues of and arguments for a fee increase. Keep the request short, two paragraphs at most. State that you are seeking to negotiate your reimbursement rates and suggest a time frame to begin the negotiation. Provide multiple methods of contact (i.e., phone, email, and/or fax) and indicate which method is best for your practice.

Be sure to direct the communication to the correct person or region. In most cases, a call to the plan’s provider relations department can help determine the appropriate contact. Get the name, title, address, email address, and fax number of the responsible party. It is also a good idea to use the representative’s preferred method of communication.

Negotiate

Make your request simple and clearly stated. Focus on the practice’s most commonly reported codes by revenue. Also, include the alternate procedure codes in the negotiation. During the conversation, politely convey the practice’s dissatisfaction with the existing fee schedule. Following the initial discussion, the representative may instruct you to submit your office fees and/or your most utilized procedures.

All communications made during the negotiation process should be clearly and concisely documented in the event that there is ever a question about what was discussed or agreed upon. If the discussion occurs over the phone, send or request an email confirmation from the representative confirming the topics discussed and/or agreed upon. Follow-up as necessary with each request.

Evaluate the Response

As previously stated, never accept the first offer. Carefully evaluate any proposed fee changes and determine how they apply to the procedures performed in your office and to the practice’s overall revenue. Focus on the codes with the highest total revenues and/or profit margins.

Keep in mind the fee negotiation process is a numbers game. The offer may include what appears to be an eight percent overall increase for all reimbursed services, but may actually only provide a one percent increase for the practice’s most frequently performed services. Evaluate each offer based on your top 25 procedures to determine the potential impact the offered increase would have on your practice. Do not be afraid to ask for an increase as high as 20 percent, especially if participation in your area is low. However, keep in mind that most offers will be in the three to 10 percent range for a one to two year time frame.

Sign the Agreement

Following the negotiation, the payer will provide the practice with an agreement that will contain a list of new fees and the effective date of the fee increases. Review the contract carefully to determine if the agreement is the best option for the practice and if it contains any new provisions. If the new agreement is acceptable, notify the payer of your acceptance in writing. The payer should then acknowledge your acceptance in writing. Confirm the effective date of the increased fee schedule with the payer. Remember, the new fee schedule is not considered effective until both parties have signed the new contract.

Follow Through

Sometimes the updated fee schedule is not reimbursed with the first claim submitted after the effective date. Monitor explanation of benefits (EOBs) received for a few weeks or months following the implementation of the new fee schedule. If underpayments occur, always notify the payer and request correct reimbursement.

Summary

Negotiating a new fee schedule can be daunting and time consuming. However, it is usually worth the effort. Payers may be open to negotiating, and you should take advantage of any opportunity to increase your in-network reimbursements. Before beginning the negotiation process, be sure to analyze the major contributing factors.

The bottom line is that, if you do not ask for a fee increase, it is unlikely you will ever receive one. Most payers will entertain a request for a fee increase every two years, sometimes annually. Be prepared to contact the proper individual, make your case, and let the negotiations begin. Remember, the worst thing that could happen is for the payer to say “no.”
Oral DNA and the Periodontal Patient  (Continued from page 2)

again when the patient returns for follow-up and discussion of the test results. The most common evaluation codes associated with this type of visit are:

99202 Office or other outpatient visit, new patient, expanded problem focused history and examination, straightforward medical decision making

99212 Office or other outpatient visit, established patient, problem focused history and examination, straightforward medical decision making

Note: The codes above are summarized. Italics are added for emphasis.

Diagnoses Codes

Medical claims require at least one diagnosis code for processing. A few ICD-10-CM codes that could apply are:

K05.21 Aggressive periodontitis, localized
K05.22 Aggressive periodontitis, generalized
K05.31 Chronic periodontitis, localized
K05.32 Chronic periodontitis, generalized

Note: ICD-10-CM is effective as of October 1, 2015.

It is important to note that there are a limited number of procedure and diagnoses codes listed here. There may be additional codes that could be used to describe the condition and/or services provided. As with all claims submitted, the codes reported should accurately reflect the service provided, as well as the patient’s condition and symptoms.

While many dental and medical payers do not currently provide benefits for oral DNA testing, there continues to be more oral DNA testing options available to identify the genetic markers and bacteria causing diseases. The doctor’s role in the detection and management of a multitude of diseases is changing within the practice of dentistry. Numerous patients will benefit from many of these simple tests performed by the dentist. The option should be offered to the patient based on need and not limited by the fact that the procedure may not be reimbursed.

Oral DNA and the Periodontal Patient (Continued from page 2)

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