



## ARE YOU BILLING IMPLANT RESTORATIONS CORRECTLY?

With over 40 implant codes to choose from in CDT 2009/2010, dental teams often find implant codes confusing. Oddly enough, coding the implant surgery seems to be the easy part. Selecting the correct code(s) and receiving insurance reimbursement for the implant retained restoration can be challenging if the staff member coding the claim does not understand how the implant codes are organized.

### THE ABUTMENT APPEARS TO BE THE PROBLEM

When it comes to coding restorations on implants, the problem seems to be that some staff members do not realize that the term “abutment” no longer refers to the crown that anchors a bridge. What dentistry used to refer to as an “abutment” as part of a traditional bridge procedure is now called a “retainer.” If you turn to pages 52 and 53 of the CDT 2009/2010 codebook, you will find codes for fixed partial denture “retainers.” In coding terms, a three-unit bridge is now identified as a retainer-pontic-retainer, not an abutment-pontic-abutment.

Today, the term “abutment” refers to the connection device that attaches a restoration to a root-form implant. The connection device can be either “prefabricated” or “custom.” A prefabricated abutment (D6056) is one in which the implant manufacturer has fabricated an abutment to fit the company’s manufactured implant. Prefabricated abutments may require adjustments using burs or diamonds prior to placing the prosthetic crown and are often screw retained. Custom abutments (D6057) are fabricated to the individual case, usually cast (or milled) by a dental lab, and may still require some minor adjustments prior to placement of the prosthetic crown.

### BILL THE ABUTMENT SEPARATE FROM THE CROWN

One of the most costly mistakes dental teams make is that they fail to charge for the implant abutment separately. All too often, dentists lose money on implant dentistry because they charge a single fee that includes both the prosthetic crown and the implant abutment. When the fee for the abutment is combined with the fee for the prosthetic crown, the charge is certain to exceed the dental plan’s allowable fee for the crown. This creates the appearance to the patient that the dentist has overcharged for the crown (or retainer). To make matters worse, participating providers are hit especially hard when they are instructed to write off fees above their contracted crown or retainer fee. By charging separately for the abutment, the patient may receive additional benefits for the abutment if his/her dental plan offers implant

*(Continued on page 4)*



## ORAL APPLIANCE COVERAGE

*The diagnosis is the key*

To determine if an oral appliance will be covered by a dental or medical plan, the coder first needs to know the diagnosis. If a nightguard is required because the patient grinds his teeth, D9940 should be reported and a narrative provided stating that bruxism is the diagnosis. However, if periodontal mobility is the problem, then a complete periodontal charting and diagnosis should be submitted along with D9940. Some dental plans will also request a recent full mouth radiographic series to confirm the extent of the bone loss. If the patient is experiencing temporomandibular joint dysfunction (TMD) D7880 should be billed for the occlusal orthotic and a narrative provided stating the diagnosis and symptoms (e.g., joint pain, popping, clicking, crepitus, migraines, deviated opening, etc.).

What’s the bottom line? Always check the chart for the diagnosis before you check the plan for benefits. 📖

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## DON'T EAT THAT LAB BILL!

It happens to most dentists sooner or later. Despite your best efforts, a patient doesn't show up to seat the crown, bridge, denture, etc. You suspect the patient doesn't have the money because he failed to bring the required down payment at the impression appointment. You have invested a lot of time in the case and are now facing a hefty lab bill as well. What are your options?

Promptly notify the patient's dental plan of the situation and submit copies of your expenses. While not all insurance companies will respond favorably, many will consider reimbursement if given any discretion by the patient's dental plan.

The following is one of several testimonies from dental practices whose expenses have been reimbursed:

*Dear Insurance Solutions,*

*Here is an update to the situation I spoke to you about earlier. We had a patient who requested a complete upper denture and a partial lower denture. At delivery, he was angry that everything was not perfect. In his mind, if the dentures needed adjustment, they were not done right the first time, and he would not accept them.*

*To keep the peace, we refunded the amount he had paid and advised Delta Dental of Michigan of the situation. Delta Dental requested complete repayment. As you advised, we sent a check in the amount Delta requested along with a request for consideration of payment of the materials and lab fees we incurred in making the dentures. We sent copies of all invoices involved.*

*Today, eight weeks later, we received a check reimbursing us for the total amount of the invoices sent. We are glad we made the effort and want to thank you for your helpful advice.*

*Happy in Michigan 📖*

## CONSTRUCTING A NARRATIVE FOR CRACKED TOOTH SYNDROME

Cracked tooth syndrome can be difficult to diagnose and even more difficult to get paid. The tooth can look fine clinically and radiographically, yet the patient still experiences pain. The dilemma is compounded when the patient cannot determine exactly which tooth hurts. Describing this scenario to a dental plan is not likely to get a crown claim paid unless additional information is provided.

### *What information do dental insurance consultants look for before approving a crown due to cracked tooth syndrome?*

After numerous conversations with dental consultants, we have concluded that they primarily want to know how the dentist arrived at his/her diagnosis. Consider the following questions when constructing a narrative for cracked tooth syndrome:

#### **Although the crack could not be seen on the radiograph, could it be seen clinically?**

*If so, where was it? (Drawings are helpful.)*

#### **Did the tooth have any existing restorations or prior endo?**

#### **What were the patient's symptoms?**

*Pain upon biting or release? Which cusp? Was a tooth slooth used?*

#### **How did the dentist differentiate the crack from a craze line?**

*Was transillumination with magnification used?*

#### **Did the dentist rule out other possible diagnoses?**

*Does the radiograph verify that there are no periapical lesions?*

*Did placing an ortho band alleviate the pain?*

When the answers to these questions are noted in the patient's chart, it is much easier for administrative staff members to construct meaningful narratives and obtain payment for cracked tooth syndrome. 📖

### SAMPLE NARRATIVE

**Chief Complaint:** Pain when biting, symptoms present for several months **Clinical Findings:** Visible fx. into dentin on mesial & distal marginal ridge, pain to #19 DL cusp upon release of bite confirmed & crack verified during prep **Differential Diagnosis:** Pulpitis and apical osteitis ruled out by clinical diagnostic testing

## LOOKING FOR ROOT FRACTURES?

Periradicular surgery is a term used to describe a variety of procedures performed on tooth roots. This includes surgery to the root surface, repair of a root perforation or resorptive defect, exploratory curettage to look for root fractures, removal of extruded filling materials or instruments, removal of broken root fragments, sealing of accessory canals, etc. The type of tooth and number of roots involved determines which code should be reported. D3410 is used to report surgery on the root of an anterior tooth, D3421 for surgery on the root of a bicuspid tooth, and D3425 is for surgery on the root of a molar. Each additional root is reported using D3426. Although periradicular surgery is paid by most carriers when looking for root fractures, be aware that some carriers may want to know how the flap was performed. 📖

## AN OPEN AND BROACH INVESTIGATION

### Question

An insurance carrier has accused a dentist in my study club of insurance fraud because he submits claims for an open and broach on one day and charges for the completed root canal on another day. When this dentist sees a patient for an emergency that requires a root canal, he uses code D3221 to report the open and broach appointment. When/if the patient comes back, he instruments and fills the canal and then submits a claim for the completed root canal.

In your opinion, has he done anything illegal based on the facts that I have presented? I understand that most insurance companies do not want to pay separately for an open and broach. However, in my opinion, if the dentist did the procedure and billed the insurance company accurately, he should have nothing to worry about. If the insurance company paid him and now wants its money back, that is a separate issue altogether. Would your opinion change if this dentist billed for an emergency open and broach on the same day as the root canal?

### Answer

D3221 generates many questions from providers and insurance carriers alike. The purpose of D3221 is to report the emergency relief of endodontic pain, which is accomplished by removing acutely inflamed pulp tissue. Both the American Association of Endodontists (AAE) and the American Dental Association (ADA) have clarified that D3221 is to be used when an endodontic patient in acute pain interrupts the dentist's schedule. If the patient presents in pain *but has not interrupted the schedule*, then D3221 should not be billed by the dentist who performs the root canal (whether on the same date or a subsequent date). Essentially, D3221 is intended for the after hours open and broach patient or the emergency endo patient who has been *squeezed* into the dentist's schedule.

With regard to the dentist in your study club, if the endo patient was in acute pain and interrupted his schedule, then D3221 appears to have been billed correctly. Hopefully, the dentist had noted in the chart that the patient was seen on an emergency basis. If not, the carrier may require a refund unless verified by a written affidavit from the patient.

Much of the confusion surrounding D3221 exists because its descriptor in CDT 2009/2010 does not specifically state that the patient must interrupt the dentist's schedule. The current descriptor only states that pulpal debridement is performed for the relief of acute pain prior to conventional root canal therapy. The fact that the patient is in acute pain certainly implies that it is an emergency visit, but the descriptor does not specifically state this.

D3221 is often used in two other situations: 1) when a dentist opens a tooth to relieve a patient of pain and then refers the patient to an endodontist for root canal therapy; and 2) when a dentist opens the tooth to relieve the patient of pain, and the patient never returns for completion of the root canal. Alternatively, some dental practices report D9110 (palliative treatment) in both of these situations.

With regards to your second question, it would not be appropriate to bill D3221 when the same dentist performs an open and broach and a root canal on the same tooth on the same day. 📖

## ADA POLICY ON ROOT CANALS

Although the American Dental Association (ADA) encourages third-party payers to recognize the impression date as the date of service for indirect procedures such as crowns, bridges, partials, dentures, post/cores, etc., it recommends that providers report, and third-party payers pay, endodontic therapy upon completion.

### **ADA Policy: Eligibility and Payment Dates for Endodontic Treatment (1994:674)**

*Resolved, that the American Dental Association, through its Council on Dental Benefit Programs, encourages all third-party payers to recognize the date that endodontic therapy is begun as the eligibility date for coverage for endodontic therapy, and be it further...*

*Resolved, that the Association, through its Council on Dental Benefit Programs, encourages all third-party payers to recognize the completion date as the date of service, that is, the payment date, for endodontic therapy.*

Note that the ADA can only "encourage" dentists and third-party payers to report and pay root canal procedures upon completion. This is because the ADA recognizes that state law and/or dental contract language might mandate otherwise. 📖

[www.ada.org](http://www.ada.org)

## CAN WE BILL ENDO X-RAYS SEPARATELY?

Although root canal therapy codes include working radiographs, the evaluation, diagnostic radiographs, and/or pulp tests should all be reported separately. Also note that a limited evaluation (D0140) should not be billed if the same dentist diagnosed the problem during a previous comprehensive or periodic exam/evaluation. When multiple visits are necessary, the diagnostic tests should be reported on the first visit even if you report the root canal upon completion. 📖

## APPEAL DENIED IMPLANT RETAINED RESTORATIONS

With three out of four general dentists now placing crowns and bridge retainers on implants, it is important to know what to expect from your patients' dental plans.

Don't be surprised to find implant retained restorations denied initially. Unless the patient's employer group has purchased implant benefits, some dental plans automatically deny the implant retained restorations. These claims are often denied in error. Although patients may not have coverage for the surgical placement of the root-form implant, most dental plans do provide coverage for the prosthetic crown or bridge retainer as long as there is no missing tooth clause or prosthetic replacement clause that interferes with coverage.

A dental plan cannot deny implant retained restorations unless the patient's contract language specifically excludes them. The dental contract must contain wording such as, "restorations are only payable on natural teeth" or "implants and implant-related services are excluded" in order to categorically deny an implant retained restoration.

That being said, it is also important to note that some dental plans will limit payment to the benefit of a removable partial denture when more than one tooth is missing in an arch. This is why dental plans often request a panorex or full mouth radiographic series before paying an implant claim; they are looking to see if there are other teeth missing in the arch.

So, when a restoration on an implant is denied, have the patient send an appeal letter asking for a copy of the contract language that specifically excludes restorations on implants. If the exclusion is not clearly written in the patient's contract, the dental plan must cover implant retained restorations, assuming benefits have not been exhausted. 📖

### Are You Billing Implant Restorations Correctly?

*(Continued from front cover)*

coverage. Even if the fee for the abutment is not covered by the patient's dental plan it is considered patient responsibility, and many dental networks still have no contractual fee limitation for D6056 or D6057.

Underestimating the lab fees associated with a custom abutment is another common mistake made by dental practices. Because lab fees can vary widely on implant cases, it is important for the clinical team to document the type of abutment used in the patient's chart notes. In some parts of the country fees for prefabricated abutments range from \$600-\$900, whereas fees for custom abutments can range from \$700-\$1200 (or more). Consequently, it is important to know how much the lab will charge before ever quoting the patient a fee for a custom abutment.

#### IMPLANT SUPPORTED vs. ABUTMENT SUPPORTED

The first step to receiving payment is to code the claim correctly. There are two different types of implant systems. Implant retained restorations can be either "implant supported" or "abutment supported." An implant supported prosthesis connects directly to the implant. There is no separate connection piece.

The most commonly used implant system is called "abutment supported" because an abutment (connection piece) is used to attach the prosthesis to the implant.

#### CODING THE ABUTMENT SUPPORTED CROWN

Since abutment supported systems are more common, let's first review how to code abutment supported crowns. In January 2005, the abutment codes (D6056 and D6057) were revised to include the placement of the abutment. As a result, only two restorative codes are now required when billing an abutment supported crown:

**1st Code:** If the restorative dentist also places the abutment, select either D6056 or D6057, depending on whether the abutment is prefabricated or custom.

**2nd Code:** Select the abutment supported crown code that represents the material used: D6058, D6059, D6060, D6061, D6062, D6063, D6064, or D6094.

#### CODING THE ABUTMENT SUPPORTED RETAINER

The term "abutment supported retainer" means that the bridge retainer is connected to an implant using an abutment. Each retainer requires two codes if the abutment and the retainer are placed by the same dentist:

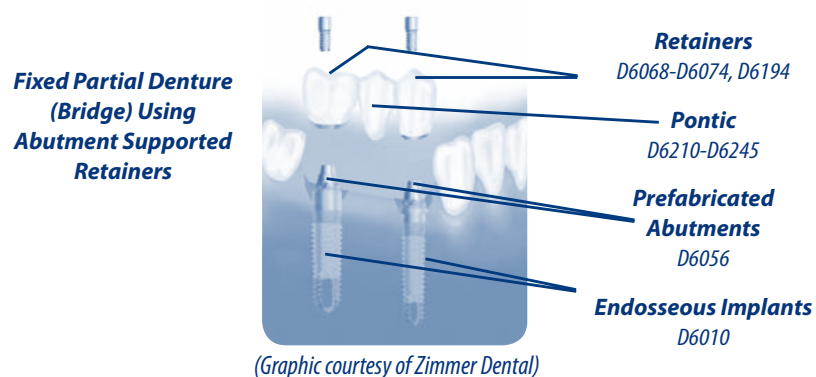
**1st Code:** If the restorative dentist also places the abutment, select either D6056 or D6057, depending on whether the abutment is prefabricated or custom.

**2nd Code:** Select the abutment supported fixed partial denture retainer code that represents the material used: D6068, D6069, D6070, D6071, D6072, D6073, D6074, or D6194. The pontic is billed using the traditional pontic code that represents the material used. (See illustration at the top of page 5.)

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## Are You Billing Implant Restorations Correctly?

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### CODING THE IMPLANT SUPPORTED CROWN

Since implant supported systems do not require the use of an abutment piece, an implant supported crown only requires one code. Depending on the material used, implant supported crowns are billed using either D6065, D6066, or D6067.

### CODING THE IMPLANT SUPPORTED RETAINER

Since an implant supported retainer does not utilize an abutment piece, implant supported retainers also only require one code. Depending on the material used, implant supported retainers are billed using either D6075, D6076, or D6077.

### DO YOU HAVE ALL THE INFORMATION YOU NEED?

In order to code an implant retained restoration correctly and receive payment, you first need answers to the following questions:

- 1) Is the prosthesis a crown, or is it a bridge retainer?
- 2) Is the prosthesis implant supported or abutment supported?
- 3) If abutment supported, is it a prefabricated abutment or custom abutment?
- 4) What material was used?

Once this information is documented in the patient's chart, coding the claim is a breeze, and insurance reimbursement is more likely. 📖

### COB Write-off Calculator

Full Fee Submitted on Claim	\$2,190.00	A
Lowest <u>Contracted</u> Fee (plus any noncovered services)	\$1,623.00	B
Dental Insurance #1	\$105.00	
Dental Insurance #2	\$218.00	
Medical Insurance #1	\$800.00	
Medical Insurance #2	\$208.00	
<b>Total Amount Paid by All Plans</b>	<b>\$1,331.00</b>	<b>C</b>
(B minus C) = Amount Owed by Patient	\$292.00	D
(A minus [C+D]) = Dr.'s Write-Off Amount	\$567.00	

## CALCULATING WRITE-OFFS WHEN BILLING MULTIPLE PLANS

Our phones lit up after the April 2008 issue of *Insurance Solutions* landed in dental practices across the country. Our concern that many dental practices have indeed been writing off too much money when patients have multiple dental and/or medical plans were validated. Running an accounts receivable report of all credit balances revealed the problem for many practices after reading the article.

To avoid writing off too much money, dental practices should delay taking any write-offs until all plans have paid. Yes, this means ignoring the write-off information on the EOBs. It is essential that you do your own math before writing off any money when patients have multiple dental and/or medical plans. If you trust the calculations on the EOBs, you are likely to write off too much money, which all too often gives the patient a credit balance on his/her account.

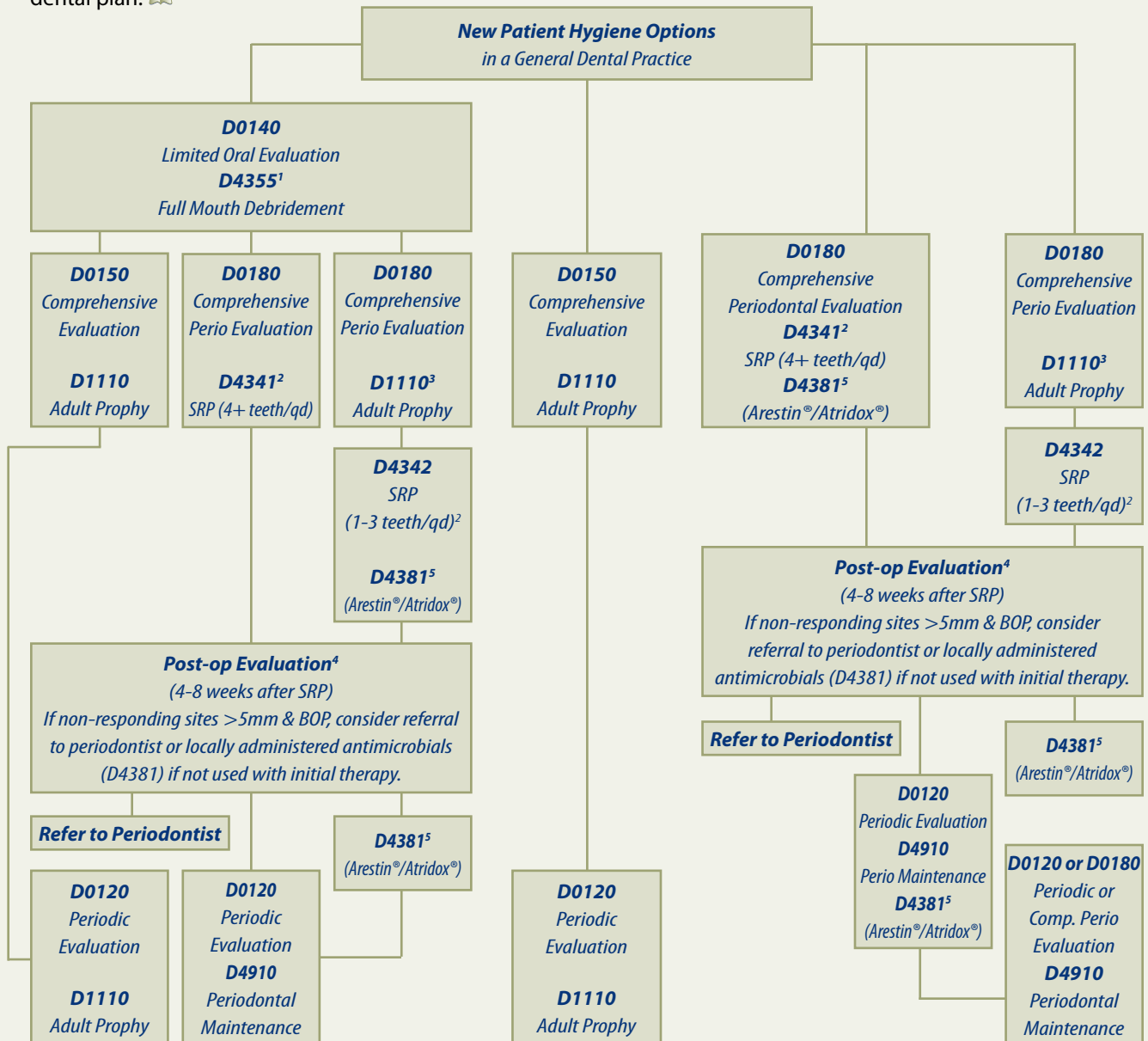
To make the calculation effortless for front office staff, Dr. Alphonso Mack, a long-time subscriber in Bloomfield, Connecticut, used our example to create an Excel COB Write-off Calculator, which he has kindly allowed us to share with readers. Staff can simply plug in the numbers, and Excel calculates the amount owed by the patient and the amount to be written off by the dentist.

We have also developed a line-by-line write-off calculator. Subscribers can obtain a copy of Dr. Mack's COB write-off calculator and our line-by-line write-off calculator (free of charge) by sending an e-mail to [amds@ncfweb.net](mailto:amds@ncfweb.net) with "Write-off Calculator" in the subject line. We will promptly e-mail you both Excel COB write-off calculators. Please provide the name of your practice and phone number in the body of your e-mail so we know how to contact you if our reply is returned as undeliverable. 📖

**Note:**  
If B is less than C, then D = Zero (-0-)

## CDT 2009/2010 HYGIENE FLOW CHART

The following flow chart illustrates just a few of the many coding sequences that may be appropriate for a new patient in a general practice. This certainly does not address all the possible coding scenarios; however, it gives the reader a glimpse of some of the possibilities. As most dental offices are well aware, proper coding still does not guarantee payment. It is essential to proactively educate patients about the destructive nature of periodontal disease and remind them that their employer typically determines which procedures are covered by their dental plans. Only when patients understand that periodontal disease is a bacterial infection, which can lead to tooth loss and cause complications with pregnancy, diabetes, heart disease, etc., will they value periodontal treatment enough to pay for services not covered by their dental plan. 📖



<sup>1</sup> Some plans do not pay D4355 if billed on the same day as D0150, D0180, or D0120.

<sup>2</sup> Patients may need several appts. of SRP depending on periodontal diagnosis. Some carriers limit payment to 2 quads per day.

<sup>3</sup> When a patient requires isolated root planing (D4342), it may be best to do the prophy first (on the areas without bone loss) since some plans do not benefit D1110 within 90 days of D4341/D4342.

<sup>4</sup> The post-root planing evaluation is typically considered part of the fee for D4341/D4342.

<sup>5</sup> While many dental plans now cover D4381 on the same day as D4341/D4342, some only consider payment if placed 4-6 weeks after SRP.

## DENTAL PLANS LOOKING FOR MORE THAN POCKET DEPTHS

By Kathy S. Forbes, RDH, BS

Is a 6 mm periodontal pocket equivalent to 6 mm of attachment loss? The answer is, "Not necessarily."

Understanding this issue is critical, not only from a documentation point of view, but from a treatment planning and insurance reimbursement perspective. For years, many dental plans based reimbursement for periodontal therapy almost exclusively on pocket depths. However, pocket depths alone do not tell the whole story, and some carriers are now requiring more information before paying periodontal claims.

Even today, some practice management consultants still advise practices, "If the patient has a 4 mm pocket, they must be treatment planned for scaling and root planing." There is little (or no) discussion about bone loss (also termed loss of attachment or clinical attachment loss), bleeding, gingival tissue integrity, suppuration, mobility, furcations, and AAP classification. These issues must also be evaluated in order to determine and document an appropriate treatment plan.

In order to understand the difference between pocket depths and clinical attachment loss, let's first review the basic definitions of the anatomical parts of the tooth and supporting structures.

**Crown:** *That portion of the tooth normally covered by, and including enamel.*<sup>1</sup>

**Root:** *That anatomic portion of the tooth that is covered by cementum and is located in the alveolus where it is attached by the periodontal apparatus.*<sup>1</sup>

**CEJ:** *The identifiable line around the external surface of a tooth where the enamel and cementum meet.*<sup>2</sup>

**Gingiva:** *Soft tissues overlying the crowns of unerupted teeth and encircling the necks of those that have erupted.*<sup>1</sup>

**Gingival Sulcus:** *Crevice created by fibrous connective tissue extending coronally from the gingival attachment to the height of the gingival margin.*

**Periodontal Ligament:** *The fibrous attachment of the tooth cementum to the alveolar bone.*<sup>2</sup>

**Periodontal Pocket:** *Pathologically deepened gingival sulcus; a feature of periodontal disease<sup>1</sup>; toxins in plaque destroy the gum and connective tissues beneath the gumline. The gums pull away from the teeth, forming a pocket (space). As the disease progresses toward the bone, the pocket fills with plaque and infection. If not treated, the bone and connective tissue surrounding the tooth may become so severely damaged that the tooth will fall out or need to be extracted.*<sup>3</sup>

**Clinical Attachment Loss (CAL):** *Loss of alveolar bone support as the periodontal ligament fibers migrate apically from the CEJ due to periodontal toxins in plaque.*

In particular, note the definitions of gingival sulcus, periodontal pocket, and clinical attachment loss (CAL). Attachment loss occurs when the periodontal ligament fibers pull away from the root, and the attachment migrates away from (below) the CEJ.

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### HOW DOES FULL MOUTH DEBRIDEMENT FIT INTO YOUR HYGIENE PROGRAM?

The intent of full mouth debridement (D4355) is to give a dentist the ability to gross scale the patient so he/she can obtain accurate periodontal probings and render a more accurate diagnosis and treatment plan.

D4355 is not a definitive procedure. It is a preliminary procedure, which is necessary when supragingival and subgingival plaque and calculus interfere with the dentist's ability to complete a comprehensive evaluation and diagnosis. The expectation is that the patient will return two to three weeks after the debridement so the dentist can complete the periodontal charting and comprehensive evaluation and render a definitive diagnosis after the tissue has had time to heal. If the diagnosis is gingivitis, the patient may only require a prophylaxis on the second visit. If the diagnosis is periodontitis, scaling and root planing may need to be initiated, or the patient may need to be referred to a periodontist. While some dental plans will deny payment for D4355 if billed on the same day as a comprehensive oral evaluation (D0150), many will consider payment when billed on the same day as a limited oral evaluation (D0140). 📖

## SRP DENIED DUE TO INSUFFICIENT LOSS OF ATTACHMENT

### Question

In my 17 years of managing our patients' dental claims, I have never seen a carrier deny quad scales. We have a patient who has MetLife and has been denied coverage for SRP in all four quadrants. The EOB states: "...No benefits can be allowed due to insufficient pocket depth and/or loss of attachment." The patient has 4, 5, and 6 mm pocket depths in all four quads. He clearly meets the pocket depth requirements. What else is MetLife looking for?

### Answer

Attachment loss can be a difficult concept for administrative staff to understand. According to Lynne Slim, RDH, MS, the Perio Therapy columnist for *RDH Magazine*, clinical attachment loss (CAL) refers to a specific measurement on the tooth that can be computed as follows:

*"With a periodontal probe that is marked with the appropriate millimeter markings, measure the distance from the cemento-enamel junction (CEJ) on a tooth to the base of the pocket. If the gingival margin is higher than the CEJ, subtract the distance from the gingival margin to the CEJ from the probing depth to get the clinical attachment level. If, on the other hand, the tooth presents with gingival recession, simply measure the distance from the CEJ to the base of the pocket."*

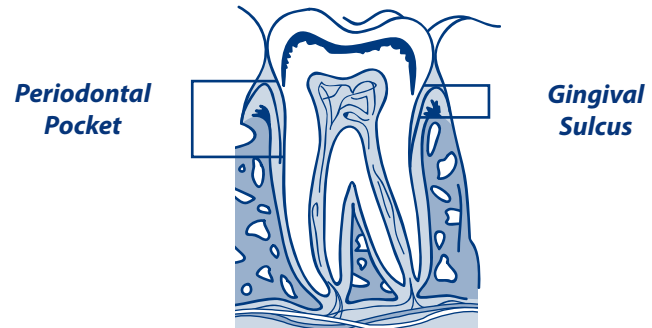
Slim agrees that CAL is a more reliable measurement than probing depth alone because it is a fixed measurement on a tooth. *"For example, if you were probing a tooth with significantly swollen gingiva, the probing depth would be a bit exaggerated or higher because of the swollen gingival tissue. If you were probing a tooth that already had 3 mm of recession and the probing depth was only 4 mm, the 4 mm probing depth might not seem like much, but add that measurement to the 3 mm of recession and you have significant attachment loss."*

Understanding this distinction between pocket depths and clinical attachment loss is essential to proper coding and reimbursement of hygiene services. 📖

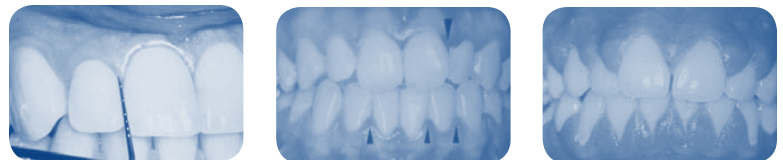
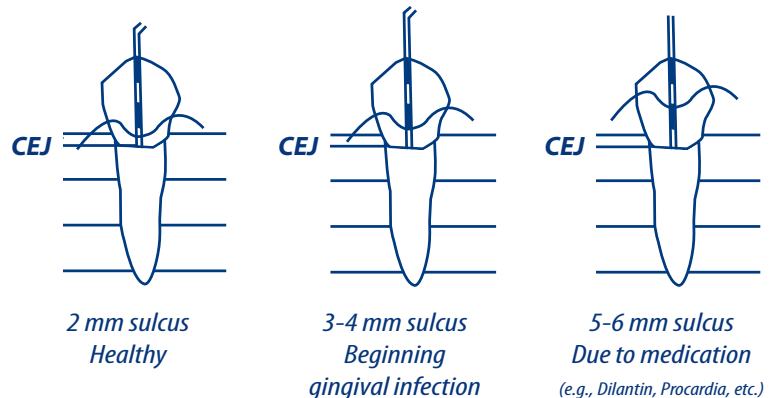
## DENTAL PLANS LOOKING FOR MORE THAN POCKET DEPTHS

(Continued from page 7)

This is illustrated in the following diagram where the gingival height is the same, but the loss of bone support is evident in the periodontal pocket:



Next are three examples of gingival inflammation/enlargement with varying degrees of pocket depths. Note that the probe is touching the attachment at the CEJ. This means that there is no loss of bone support around any of these teeth, even though the measurements are 2 mm, 3-4 mm, and 5-6 mm. This means that scaling and root planing (D4341 or D4342) would be contraindicated as a treatment therapy since the clinician would not be touching the root surface with any instruments.



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## AARP DENTAL COVERS THREE CLEANINGS

According to the American Association of Retired Persons (AARP), the AARP Dental Plan (administered by Delta Dental Insurance Company) now covers three cleanings per year (beginning in 2008). The increased coverage includes regular cleanings (D1110) and periodontal maintenance (D4910). The additional benefits are provided in response to growing evidence showing an association between gum disease, diabetes, heart disease, and other medical conditions. 📖

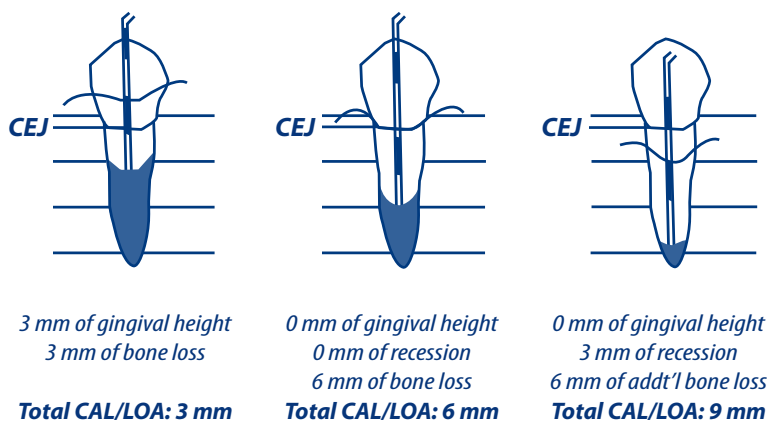




## DENTAL PLANS LOOKING FOR MORE THAN POCKET DEPTHS

(Continued from page 8)

The drawings below illustrate the common misunderstanding about pocket depths. Here are three examples where the probe readings are all 6 mm. However, each shows differing levels of clinical attachment loss (bone loss).



It is extremely important for the clinician to provide complete documentation of the patient's periodontal condition in order to determine appropriate treatment planning as well as to provide accurate information to the dental carrier. If a dental carrier receives a periodontal charting with only pocket depths recorded, it may deny well-deserved benefits for scaling and root planing because it cannot determine if there is clinical attachment loss (bone loss).

### References:

<sup>1</sup>CDT 2005, American Dental Association, Glossary

<sup>2</sup>Concise Dental Anatomy and Morphology, Fuller & Denehy, 1984

<sup>3</sup>Glossary of Terms, American Academy of Periodontology, [www.perio.org](http://www.perio.org).

## METLIFE CLARIFIES ITS D4910 POLICY

The moment dental practices started receiving denied claims from MetLife for periodontal maintenance (D4910) because only one quadrant of root planing (D4341) had been performed, our phones started ringing off the hook. According to the MetLife EOBs, periodontal maintenance is only covered if two or more quadrants have received prior active therapy (D4341/ D4342).

When we contacted MetLife officials to obtain more information about their latest D4910 policy, they confirmed that this policy applies to all MetLife dental plans unless an individual employer's contract language states otherwise.

MetLife's clinical director, David Guarrera, DDS, acknowledged that D4910 (as described in the current ADA coding manual) does not identify how many teeth or quadrants require prior root planing in order to bill D4910 for subsequent treatments. However, MetLife changed its policy because periodontal maintenance is a whole mouth procedure that is only intended to be used after active therapy has been completed. Since periodontal disease typically affects more than one quadrant, MetLife expects all root planing to be completed before covering D4910. This is why MetLife now requires a history of at least two quadrants of definitive therapy (SRP or perio surgery) before paying D4910. Two quadrants of either D4341 or D4342 satisfies MetLife's criteria for D4910.

**What code should you bill if the patient only required one quadrant of root planing?** D4910 is your only coding option for follow-up perio therapy when exposed roots have been treated due to the apical migration of the periodontal ligament. However, if D4910 is denied because only one quadrant of scaling and root planing was previously performed, send an appeal letter explaining that there was no evidence of disease activity in the other three quadrants. According to our sources, the claim should be approved if the patient has not maxed out his/her benefits.

## PERIODONTAL DISEASE

### ANTICIPATING YOUR PATIENTS' QUESTIONS

#### Why do I need to come back in 3-4 months? My insurance only covers two cleanings a year.

You have a chronic bacterial infection called periodontal disease. By measuring the pockets surrounding your teeth, evaluating the gum tissue, and reviewing your radiographs, your dentist and hygienist have discovered the infection in your gums.

As your dentist and hygienist mentioned, 1-3mm pockets without bleeding and recession are typically considered healthy. Deeper pocket depths of 4 mm or greater with bleeding indicate gingivitis (inflammation of the gum tissue) or possibly periodontitis, a more advanced infection, which is characterized by the loss of bone support. Patients who have periodontitis are not able to clean the infected periodontal pockets by regular brushing and flossing, which is why a dentist or hygienist must use special instruments to remove the bacterial toxins every 90-120 days (typically) to prevent further bone loss. Without adequate bone support tooth loss may occur.

Concerning your insurance benefits, it is true that most dental plans allow two cleanings a year for **healthy** patients. For patients with periodontal disease, however, you have separate benefits aimed at arresting the **bacterial infection** and preventing additional bone loss. Depending on the premiums paid by you and/or your employer, periodontal benefits usually range from 30-80 percent. A deductible may also apply.

Once you have been diagnosed with periodontal disease, we are obligated to provide your dental plan with the appropriate billing codes and sometimes a copy of your periodontal measurements and radiographs. Legally and ethically, as your dental care team, we cannot ignore the infection in your mouth. Be assured that we will do our best to see that you receive the dental benefits provided by your employer.

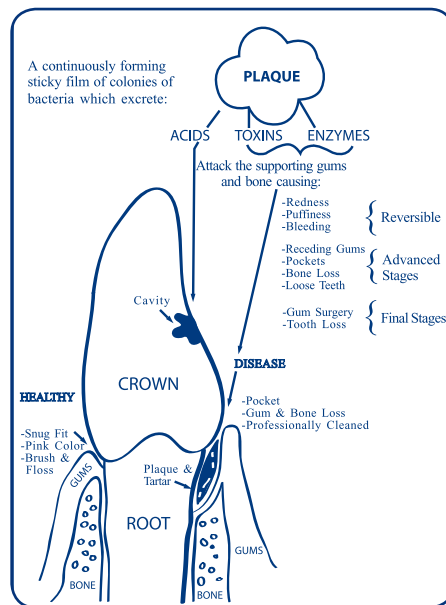
#### Will my insurance cover my periodontal visits?

To give you an accurate estimate of your dental benefits, we must first see a copy

of your dental plan. If you bring in a copy of your dental plan, our business staff will gladly interpret it for you. Most dental plans expect patients to pay a portion of their periodontal visits. As a general rule, periodontal patients should expect to pay at least 30-50 percent of their treatment needs over the course of the year since most dental plans require a deductible and copayment on periodontal services.

As you know, our goal is to provide excellent dental care to all our patients. In good conscience, we cannot ignore a bacterial infection simply because of insurance limitations. With periodontal disease, the risk is too great. If left untreated, periodontal disease can lead to tooth loss and may compromise patients who are pregnant or who have heart disease, respiratory disease, or diabetes.

If your dental benefits seem unreasonably low, we encourage you to contact your employer and express your concerns about the limitations of your dental plan so that future dental contracts are reviewed more closely. We are happy to provide any information you need to assist you in this effort.



#### Why haven't I been told about periodontal disease before?

This is an understandable question. Quite simply, our bodies change. Bacterial plaque can cause decay in our teeth or cause an infection in our gums called periodontal disease. When you come in for your cleaning and exam, the dentist evaluates

both the health of your teeth and the health of your gums and bone support. Just as you may have developed a cavity since your last appointment, you may have also developed an infection in your gums which may be the beginning stages of periodontal disease.

A variety of risk factors and medical conditions may be associated with periodontal disease, including: smoking, diabetes, heart disease, respiratory disease, pregnancy, osteoporosis, stress, radiation, chemotherapy, medications, inadequate home care, hereditary predisposition, etc. Our goal is to protect your oral health, which is essential to your overall physical health.

#### Can't you just change the code?

If only it were that easy. It is important to understand that there are serious consequences for falsifying dental codes.

The Health Care False Claim Act states: *"No person shall knowingly make a false statement or false representation of a material fact to a health care payer for use in determining rights to a health care payment. Each claim that violates this subsection shall constitute a separate violation."*

Dentists and hygienists have a legal responsibility to select the dental code that most accurately reflects the treatment rendered. Changing a code to obtain better benefits for a patient is a violation of the Health Care False Claim Act and could draw the attention of the F.B.I. and U.S. Postal Inspectors, because a false claim sent via the U.S. Postal Service is considered mail fraud.

If your dental plan's phone representative suggested that we bill a different code in order for you to receive payment, he/she apparently does not understand that dentists have a legal obligation to code correctly. While the phone representative may know which codes are payable under the terms of your dental contract, he/she may not realize that dentists and hygienists are risking their license if they falsify codes to obtain those benefits.

Changing dental codes is not the answer to getting dental procedures paid. Instead, dentists and patients need to work together to educate and encourage employers to increase periodontal benefits when negotiating their next dental contract. 📖

## EVER WONDER IF CARRIERS READ YOUR NARRATIVES?

By Alan Feldman

Dentists, understandably, want dental claims to be paid as quickly as possible. Like many dental practices, you may be submitting claims electronically in order to expedite payment. Knowing that dental plans often require additional information before processing certain procedure codes, you probably enter that information in the “remarks” section of the electronic claim. By indicating upfront why a crown or buildup was needed or how much the primary plan has paid, you hope to prevent the claim from landing back on your desk, which, of course, delays payment. After providing all the additional information you think the patient’s dental plan might require, you sit back and hope that the insurance carrier will actually read the comments you have submitted.

Does this sound familiar? It may come as no surprise to some of you that comments submitted in the remarks section of a dental claim are not always read. This is why claims sometimes land back on your desk with a request for the very same information that was submitted on the original claim. Why does this happen? There are several reasons why a dental plan may not read information you enter in the remarks section of the dental claim form. Some of the more common reasons include:

- *Space limitations on electronic claims*
- *Handwritten narratives on paper claims*
- *Key word filters*
- *CDT code filters*

### *Space Limitations on Electronic Claims*

The old adage, “Too much of a good thing is bad,” certainly applies to narratives submitted on electronic claims. The more detailed and descriptive your narrative is on an electronic claim the greater the possibility that a dental carrier will not receive (and therefore not read) your entire narrative. There are three reasons why this happens. First, practice management systems (PMS) often limit the number of characters and spaces they can transmit in the remarks section. Second, even if your PMS system is able to transmit your entire narrative, clearinghouses usually limit the number of characters and spaces they can receive and transmit to the insurance carrier. Since dental claims often go through several clearinghouses before arriving at their final destination, it is not unusual for a narrative to be truncated by one or more clearinghouses. Finally, some insurance carriers’ computers limit the number of characters they can accept in the remarks section of an electronic claim. The following is an example of what can happen to an electronic narrative.

#### **Original Narrative:**

*Emergency patient presented in pain after falling off bike. Pt’s lips and gums were swollen and bleeding, rocks and debris were embedded into soft tissue areas, and 8 and 9 were fx off at gumline.*

The original narrative contained 196 characters, including spaces and punctuation and was sent from the dental practice’s computer system to a clearinghouse. Upon arrival at the clearinghouse, the narrative appeared as follows:

*Emergency patient presented in pain after falling off bike. Pt’s lips and gums were swollen and ble*

*(Continued on page 12)*

## CONSULTANT’S CORNER

We are pleased to welcome Alan Feldman, President of Dental Directions Services, as our Guest Consultant. Mr. Feldman is one of the nation’s leading experts on electronic data interchange (EDI) and has helped dental practices across the country take the leap from paper to electronic transactions during his 17 years in the dental industry. Mr. Feldman has given EDI presentations at the Greater New York Dental Meeting, the Oregon Dental Executives’ Association Fall Conference, the Big Apple Dental Meeting, and the American Academy of Periodontology Annual Sessions.

Questions about this article or electronic transactions can be directed to Mr. Feldman at [ahfeldman@verizon.net](mailto:ahfeldman@verizon.net). 📖

## AETNA CHANGES COB POLICY

Unless the patient’s medical contract states otherwise, Aetna medical no longer coordinates benefits if services are covered under a patient’s dental plan.

In the past, it has been possible for patients to receive benefits under both their dental and medical plan for certain procedures. However, Aetna medical will now likely require a denial from the patient’s dental plan before considering the claim. Although dental and medical plans are supposed to work together to determine which plan is primary when a claim is simultaneously filed to both, this does not always happen. This can result in overpayments.

When you suspect that certain dental services might be covered under an Aetna medical plan, it is best to file the claim to the patient’s dental plan even if you expect the claim to be denied. You can then attach the dental plan’s denial when submitting the claim to Aetna medical. 📖

## EVER WONDER IF CARRIERS READ YOUR NARRATIVES?

(Continued from page 11)

In this case, the narrative was cut off after 100 spaces because that was the maximum number of spaces the clearinghouse was able to receive. The clearinghouse then forwarded the claim to the dental insurance carrier, which was only able to accept 84 characters in the remarks section.

*Emergency patient presented in pain after falling off bike. Pt's lips and gums were*

As you can see, this narrative now leaves far too much to the dental consultant's imagination. Unfortunately, this claim will be sent back to the dental practice along with a request for additional information--the very information that was sent with the original electronic claim!

This is just one illustration of what can happen to a lengthy narrative on an electronic claim. The number of characters you are able to successfully transmit depends on which practice management system you use, which clearinghouse(s) is/are involved in transmitting the claim, and which insurance carrier receives the claim. Suffice it to say, it is best to be as brief as possible, use common abbreviations as much as possible, and stick to the relevant facts.

### Handwritten Narratives on Paper Claims

Are you aware that handwritten narratives may not even be visible by the time the claim enters the carrier's claims processing system? This is because many carriers scan paper claims into digital files when they arrive, and their computers can only convert and recognize typed notes. Because of this, narratives on paper claims have a much better chance of being read when they are typed.

### Key Word Filters

Whether claims are submitted electronically or on paper, the goal of most dental carriers is to process as many claims as possible without human intervention. To accomplish this, some carriers program their claims processing systems to look for certain key words or phrases in the remarks section and ignore any other comment that is not needed to process the claim. Only when a comment contains one of the key words is the claim kicked out of auto-adjudication and read by an insurance representative. Some key words (and common abbreviations) that might trigger human intervention include:

- NEA
- Delivered
- Patient Paid
- Occlusion
- Emergency
- Completed
- Multiple Teeth
- Cosmetic/Esthetic
- Root Canal
- Cemented
- Credit/Discount
- Vertical Dimension
- Post/Core
- Injury
- Evaluated
- Abfraction
- Prep
- Accident
- Abrasion
- RPC
- Seat
- Prime Paid
- Erosion
- Baseball/Softball

### CDT Code Filters

Some insurance carriers only read the "remarks" section of the claim form when certain CDT codes are billed. When this is the case, narratives go totally unnoticed if a carrier does not require a narrative for the CDT code that is being billed. Fortunately, this also means that the claim remains in auto-adjudication, so it will be paid more promptly.

Be aware that an increasing number of carriers are becoming more selective about reading narratives because they want to increase their auto-adjudication rates. When a claim requires human intervention, payment to the provider is delayed, and the carrier's cost to process that claim jumps considerably.

Keep in mind that there are some carriers that still read every note submitted in the remarks section of the dental claim, whether submitted on paper or electronically. However, in order to read the remarks, the claim must be kicked out of auto-adjudication and rerouted for human intervention. Ironically, comments such as, "Pay this claim within 30 days, or we will file a complaint with the Department of Insurance" can actually cause a delay in payment.

While some third-party payers are notoriously slow in paying dental claims, including this note in the remarks section seldom solves the problem. You will be much more successful if you encourage the patient to complain loudly to his/her employer when dental claims are not paid in a timely manner. (Patients are motivated to do so if you ask them for their credit card when claims are outstanding.) You may be surprised to learn that employers are often the source of the problem. Many employers do not adequately fund their self-funded dental plans. They hire third-party administrators to process their claims, but they fail to put enough money in the bank to pay them. It often takes pressure from employees to get an employer's attention. If the third-party administrator or insurance carrier is actually the source of the problem, a quick call from the employer's HR manager is usually all it takes to get claims moving again. 📖



## SHOULD WE BILL DENTAL OR MEDICAL?

*The diagnosis determines if an oral appliance is more likely to be covered under the patient's dental plan or medical plan.*

### **Bruxism:**

Occlusal guards placed to reduce the effects of bruxism are often covered under dental plans. Approximately 70 percent of all dental plans provide a benefit for occlusal guards (D9940) when bruxism is the diagnosis. While some medical plans also provide a benefit for the treatment of bruxism, the majority do not.

### **TMJ Pain /Dysfunction:**

TMJ orthotics may be covered under the patient's dental or medical plan. Most states require insurers to offer

some level of TMJ coverage. If TMJ services are not covered under a patient's dental plan, there is a good chance that they will be covered under his/her medical plan. Documenting a diagnosis of temporomandibular joint dysfunction (TMD) or TMJ syndrome and relevant symptoms is the key. Symptoms might include joint pain, muscle soreness, crepitus, joint sounds (e.g., popping/clicking), ringing of the ears, frequent headaches, facial pain, neck pain or stiffness, limited or deviated opening of the mouth, limited ability to swallow or chew, joint stiffness, locking jaw, etc.

### **Headaches:**

Oral splints, orthotics, or repositioning devices used to treat migraine headaches are often excluded by both dental and medical plans unless there are also TMD symptoms.

### **Sleep Apnea:**

Custom-fitted oral appliances placed by dentists to treat obstructive sleep apnea (OSA) are often billed to medical plans. It is common for medical carriers to require a copy of the patient's sleep study report (e.g., nocturnal polysomnograph) and/or a physician referral. Note that prefabricated appliances are seldom covered, and snoring is not considered a medical problem unless associated with OSA.

### **Jaw Fracture:**

Oral surgery splints used to immobilize jaw fractures are often covered under medical plans because the injuries are often accident-related.

### **Questions?**

Subscribers are welcome to contact our support team with coding and billing questions (Mon-Fri, 8am-4pm, PST). 📖

## BILLING ORAL APPLIANCES TO MEDICAL

### **Occlusal Orthotics, Splints, Nightguards, & Sleep Apnea Appliances**

Ask ten different insurance carriers which medical procedure code you should bill for an oral appliance and you will likely get ten different answers (assuming you get any answer at all). The problem is exacerbated because there are so many different terms used to describe the types of appliances dentists place: occlusal guard, occlusal orthotic, oral splint, orthopedic splint, diagnostic splint, mandibular repositioning splint, pain control splint, myofacial splint, nightguard, bruxguard, sleep apnea appliance, TAP appliance, NTI appliance, etc. In the past, it has been challenging enough for dental teams to differentiate between two dental codes, D7880 (occlusal orthotic device) and D9940 (occlusal guard). Now they find themselves in the position of having to bill TMJ appliances, sleep apnea appliances, and, occasionally, bruxguards to medical plans using totally unfamiliar codes. Understandably, dental teams feel confused and frustrated when they cannot get the same answer twice when trying to locate the appropriate medical code for an oral appliance.

A quick Internet search exposes some of the inconsistencies. For example, a quarterly bulletin from a Blue Cross Blue Shield carrier reminds providers:

*In a recent review of claims, Blue Cross Blue Shield (BCBS) of Tennessee found that occlusal orthotic devices (e.g., splints and nightguards, used for treatment of Temporomandibular Joint [TMJ] Dysfunction) are being reported inappropriately, e.g., 21089 (unlisted maxillofacial prosthetic procedure) and E1399 (durable medical equipment, unlisted). Use of inappropriate codes to report this service may result in incorrect reimbursement, delay in processing, and/or rejection of claim. To ensure correct and timely reimbursement for occlusal orthotic devices, use the Level II HCPCS code D7880 (occlusal orthotic device), and bill on a CMS 1500 claim form.*

Another Blue Cross Blue Shield carrier suggests dentists use 21085 (impression and custom preparation; oral surgical splint) when submitting TMD orthotics to medical plans. Regence BCBS of Oregon suggests providers use 21085 or 21089. However, be aware that the use of 21085 can be controversial as some believe it more accurately reflects CDT D5982 or D5988. (D5982 is reported when a surgical stent is used to apply pressure to soft tissues to facilitate healing and prevent collapse. D5988 is used to report a surgical splint that uses existing teeth or alveolar processes as points of anchorage to assist in stabilization and immobilization of broken bones during healing.)

Most Medicare contractors' websites instruct providers to bill 21089 when submitting a claim for an oral splint. However, the Centers for Medicare and Medicaid Services (CMS) published "Instructions for Billing Maxillofacial Services," which clarifies

*(Continued on page 14)*

## BILLING ORAL APPLIANCES TO MEDICAL

(Continued from page 13)

that 21089 should only be billed when the dentist actually constructs the prosthesis/appliance:

*...If the physician makes the prosthetic impression and an outside lab constructs the prosthesis, the physician bills CPT code 21299 (unlisted craniofacial and maxillofacial procedure).*

Based on this CMS memo, some carriers feel that 21299 is the most appropriate code for oral appliances since most are constructed by outside labs. And since 21299 is an unlisted (miscellaneous) code, a narrative describing the type of orthotic is required on the initial claim. Also, keep in mind that TMJ services are only covered by Medicare if the TMJ condition is directly attributable to a medical condition (e.g., direct result of arthritis) or accidental injury.

In addition to 21085, 21089, and 21299, several other CPT codes have been used to report oral appliances, including 21110, 21499, 99002, and 99070. However, these codes have limited applications. According to Olya Zahrebelny, DDS, author of *Assessing Medical Benefits in the Comprehensive Dental Practice*, 21110 should not be used to report bruxguards and TMJ orthotics because it involves the actual wiring/fixation of teeth (unrelated to jaw/alveolar fractures), and most oral orthotics are removable, not fixed appliances.

Although 99002 and 99070 have often been used in the past for oral appliances and are still valid CPT codes, many carriers have stopped covering them based on billing guidelines released by Medicare in 2005. Those guidelines stated that 99002 and 99070 should be included in other procedure codes. Many insurance carriers interpret this to mean that 99002 and 99070 should not be billed or paid separately. CPT 99002 involves the handling, conveyance, and/or any other service in connection with the implementation of an order (e.g., designing, fitting, packaging, handling, delivery, or mailing) when devices such as orthotics or prosthetics are fabricated by an outside laboratory but which have been designed and are to be fitted and adjusted by the physician/dentist.

CPT 99070 has been used to report supplies and materials provided by the physician over and above those usually included with the office visit or other services rendered. While there are some carriers that will still consider payment for 99002 and 99070, many will deny the claim and request a more specific code.

### After all this, what procedure code should be used to bill medical?

Oddly enough, sometimes it is best to report a dental procedure code even when submitting the claim to medical. The reason is that the American Dental Association's CDT codes are part of the Healthcare Common Procedure Code System (HCPCS--pronounced "hick-picks") Level II code set. Medical carriers often require providers to use HCPCS codes when procedures are not specifically identified by medical CPT codes. Since 21089, 21299, and 21499 are all unlisted CPT codes, HCPCS codes are often preferred.

When billing oral appliances to medical plans, take the time to make a quick call to the patient's medical carrier to ask which of the following codes it prefers (based on the patient's diagnosis):

#### TMJ Appliances Codes

##### HCPCS D7880

*Occlusal orthotic device, by report,*

##### HCPCS S8262

*Mandibular orthopedic repositioning device, each*

##### CPT 21089

*Unlisted maxillofacial prosthetic procedure, or*

##### CPT 21299

*Unlisted craniofacial and maxillofacial procedure*

#### Bruxism Appliances Codes

##### HCPCS D9940

*Occlusal guard, by report, or*

##### CPT 21299

*Unlisted craniofacial and maxillofacial procedure*

*Note: Some medical carriers still prefer CPT 99070 for bruxism appliances.*

#### Sleep Apnea Appliance Codes

##### HCPCS E0485

*Oral device/appliance used to reduce upper airway collapsibility, adjustable or nonadjustable, prefabricated, includes fitting and adjustment,*

##### HCPCS E0486

*Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated, includes fitting and adjustment, or*

### CPT 21299

*Unlisted craniofacial and maxillofacial procedure*

#### More on Oral Appliance Codes

Although CMS's billing instructions clarify that 21089 is only to be used when the dentist actually constructs the orthotic, 21089 can still be billed by the dentist (even if an outside lab fabricates the appliance) if field #20 of the medical claim form indicates that the lab's fee is included in the dentist's charge for the appliance. This informs the insurance carrier that the lab will not be submitting a separate fee for its services.

Despite the fact that 21089 and 21299 are more appropriate for billing oral orthotics/splints, some medical carriers still prefer 21110 or 21085. Knowing that the use of these codes can be controversial, be sure to attach a narrative describing the type of appliance that you have provided so there is no confusion.

#### Reporting Lab Fees

If the lab is billing your office for its services (which is often the case), indicate "Yes" in box 20 of the medical claim form. This tells the carrier that the dentist's fee includes the fee for the laboratory services. The amount of the lab fee should be noted according to current CMS 08/05 form completion instructions. For example, if the fee is \$92.00, then 9200 is noted to the LEFT of the vertical line, with no dollar sign. Also note that no period is used between the dollars and cents amounts. Answering "Yes" in box 20 notifies the medical plan to send the entire benefit to your office, since it will not receive a separate bill from the lab.

#### Medical Narratives

Any medical CPT code ending in "89" or "99" requires a narrative describing the procedure in the shaded area directly above the CPT code in Section 24D of the current medical claim form. The narrative should be preceded by "ZZ," which is a required qualifier (e.g., ZZ Mandibular Pain Relief Orthotic). Without a narrative in the shaded area above an unlisted procedure code, the claim will be returned with a message similar to the following sent by BCBS of Michigan:

(Continued on page 15)

(Continued from page 14)

**Field 24D:** Procedure Code is missing narrative. A narrative description is required for an unlisted procedure code. Use single spaces to print a description in the shaded area of fields 24a through 24h directly above the line containing the unlisted procedure code.

*When resubmitting a claim, please use an official red-drop ink claim form CMS 1500 and send it to us as soon as possible.*

While a separate, more detailed narrative may not be required, it is highly recommended. Field 19 can be used to notify carriers that a more detailed narrative is attached.

### Occlusal Orthotic Adjustments

Adjustments made to an oral appliance within the first thirty days are often considered by insurance carriers to be part of the procedure and are not reimbursed separately.

Adjustments made thereafter can be reported using the following code:

#### CPT 97762

*Checkout for orthotic/ prosthetic use, established patient, each 15 minutes*

CPT 97762 replaced CPT 97703, which was deleted in 2006. CPT 97762 is used to report the assessment of an established patient's response to an orthotic and any necessary adjustments. If an adjustment takes 30 minutes, 97762 should be reported in 24D and the number "2" shown in the "Units" column (24G) on the CMS 08/05 medical claim form.

Some carriers prefer adjustments to oral appliances to be billed using CPT unlisted code 21299 with a narrative. And, as with any other service, payment for adjustments to oral appliances depends on the language in the patient's medical plan. The following is an example of what you might find in an Aetna medical policy:

*For plans that cover intra-oral appliances, adjustments performed within six months of initial appliance therapy are considered medically necessary, while adjustments performed after six months are subject to review to determine necessity and appropriateness. More than four adjustments or adjustments*

*done more than one year after placement of the initial appliance are subject to review.*

### Selecting the Diagnosis Code(s)

When billing any occlusal orthotic to a medical plan, a thorough diagnosis is essential to coverage. Diagnosis codes (ICD-9) are used to identify the *medical* problems that are being addressed. In other words, medical plans seldom pay for appliance therapy if the purpose is to correct a malocclusion. However, if bruxism has led to neck pain, muscle spasms, TMJ pain, etc., an orthotic may be covered under the medical plan.

For example, occlusal orthotics are often placed when a patient experiences pain in the temporomandibular joint (TMJ), which may be related to trauma (e.g., a blow to the face), inflammatory or degenerative arthritis, or due to a posterior displacement in which the mandible is pushed back toward the ears, causing pain when the patient chews or swallows. Sometimes, the muscles around the TMJ go into spasm, causing head and neck pain and difficulty opening the mouth. Some patients experience joint sounds such as clicking, popping, grating, or crepitus in the TMJ, while others experience earaches, headaches, and facial pain. Documenting these pain related and loss of function symptoms establish that the oral appliance is medically necessary. While some medical plans cover occlusal guards when bruxism is the only diagnosis, most consider bruxism to be a dental problem. However, when the bruxism patient also has TMJ related symptoms as described above, oral appliances are often covered under medical because they are considered medically necessary.

It is also important to note that medical codes are updated annually. Far too many medical claims are denied simply because obsolete ICD-9 or CPT/HCPCS are used. As such, it is important to verify that the medical codes you have used in the past are still valid. *Insurance Solutions* subscribers are encouraged to contact our support team to verify medical diagnostic and procedure codes before billing dental procedures to a medical plan (888-825-0298). 📖



## CODING LOCATOR ATTACHMENTS

### *Root Retained vs. Implant Retained Overdentures*

Most dental practices are aware that a complete overdenture retained by natural teeth is reported using D5860, and a partial overdenture retained by natural teeth is reported using D5861. However, some may not be aware that complete and partial overdentures supported by implants are billed as D6053 and D6054, respectively.

### *Coding Locator Attachments*

An increasing number of dentists are using locator attachments and asking which code(s) to bill. There are primarily two types of locator attachments. One is called a **locator root attachment**, and the other is called a **locator implant attachment**. The locator *root* attachment is used with root retained overdentures and is coded as D5862, precision attachment, by report.

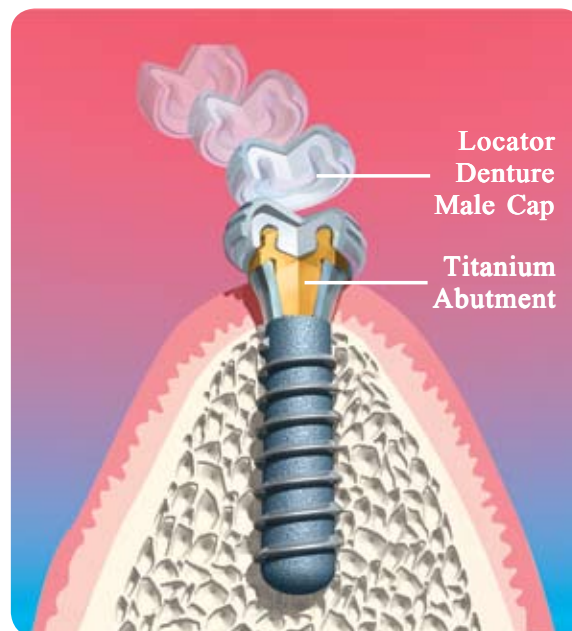
A **locator implant attachment** is used to attach an overdenture to an implant and has two components:

- 1) A titanium abutment (locator abutment), and
- 2) A locator denture male cap that is cured into the denture with acrylic resin. The metal male cap has a nylon retention insert (shown in the picture above) that snaps onto the locator abutment.

According to CDT 2009/2010 (p. 163), the locator implant abutment is coded as D6056 (prefabricated abutment, including placement) and the locator denture male cap is coded as D5862 (precision attachment, by report).

Recognizing the difference between a locator root attachment and a locator implant attachment is important because it affects how the procedure should be coded and how it will be paid. While D5862 is often considered patient responsibility, D6056 may be covered if the patient has implant benefits available under his/her dental plan. 📖

### *Locator Implant Attachment*



*Graphic courtesy of Zest Anchors, Inc.*

*“Recognizing the difference between a locator root attachment and a locator implant attachment is important because it affects how the procedure should be coded and how it will be paid.”*

### *About This Newsletter*

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