HOW TO AVOID COMMON CDT CODING MISTAKES

This resource aims to help you avoid many common dental coding mistakes and assist you in ensuring you are able to follow insurance carrier and regulatory requirements when reporting procedures to insurance carriers. This tool will also help you maximize your patients' insurance benefits and ensure you get paid for the treatment they need but should not be used to dictate diagnosis or treatment, nor is it meant to take any position regarding what is considered the "right way" of any carrier's reimbursement strategy. This information is not all-inclusive and has been limited to the most common charting and reporting mistakes. Refer to the "insurance maximizer" for more coding details.

The charting and billing systems have many checks and balances that look for potential reporting and billing mistakes. Anything that falls outside of normal reporting and billing protocol is manually reviewed by a team of billing specialists and reviewed with the office and clinician who provided the treatment prior to being sent to the insurance carrier. Further, in order to prevent coding mistakes, many of the rarely-used CDT codes are not available as default selections within the charting and billing systems. These rarely-used codes can be provided as needed.

The most important note on coding of dental procedures is that, regardless of who assigns the codes to the procedures being provided, the clinician is ultimately responsible for the accuracy of all claims that leave their office. Therefore, clinicians should be sure to:

- Understand proper coding of the procedures provided to patients.
- Routinely review charts at the end of each day to ensure each procedure is properly reported within the patients' charts.
- Effectively document each procedure. This includes detailed narratives, radiographs, and pre- and post-operative intra-oral photos. The two best sayings to remember here are "a picture's worth a thousand words" and "if it isn't in the chart, it didn't happen."

Also, just because a carrier may pay for something charted and reported a certain way does not necessarily mean it was charted and reported correctly. The best example of this relates to periodontal maintenance and frequency limitations. Many plans often only pay for two periodontal maintenances per year.

This limitation may lead to the temptation to alternate the reporting of periodontal maintenance with a regular prophylaxis. While many plans will pay for this sequence of reported procedures, it does not mean that the carrier is giving its approval to report these procedures in this manner. If this, or any other reported procedure, does not match the actual procedure provided to the patient, adverse actions could take place if a carrier or regulatory body were to conduct a detailed audit of the patient's chart. Together, we will both maximize your patient's benefits for the treatment he or she needs and ensure that all procedures are properly coded and billed to the insurance carriers.

References

"Coding with Confidence: The "Go To" Dental Insurance Guide", Charles Blair, D.D.S. CDT-2011/2012 Edition ISBN 978-0-615-36232-8 8

Insurance Solutions Newsletter – January / February 2011, American Dental Support, LLC

Common Digital Coding Mistakes

Code often misreported	Procedure Description	Mistake/situation code is misreported	Code to use instead	Procedure Description	Solution that best maximizes patients benefits
D0150	Comprehensive oral evaluation - new or established patient	Reported once every 3 years irrespective of whether patient has been into office. Reported less than 3 years since last D0150 and no significant change in patient's oral health condition	D0120, D0140	Periodic oral evaluation; limited oral evaluation – problem focused	Report when comprehensive oral evaluation is provided to new patient; for a continuing care patient that has not been in the office in over 3 years; or for any continuing care patient with a significant change in oral health condition that necessitates a comprehensive oral evaluation.
D1110	Prophylaxis - Adult	Reported for cleanings on patients that have had prior active D4910	D4910	Periodontal maintenance	Once D4910 reported for a patient, irrespective of plan limitations, continue to report D4910 and not D1110 for future visits. The only exception is when pocket depths after several D4910's are 2-3 mm with little to no bleeding and stable. Once D1110 is reported again, another SRP is required before reporting D4910 again.
D2391	Resin-based composite - one surface, posterior	Reported when caries do not extend into the dentin or a deeply eroded area	D1352, D1351	Preventative resin restoration in a moderate to high caries risk patient – permanent tooth ; sealant – per tooth	Use D1352 for high risk caries patients when the pit or fissure decay does not extend into the dentin. Use D1351 when the enamel surface is non-carious and the surface is sealed to prevent decay.
D2950, D2952, D2954	Core buildup, including any pins; post and core in addition to crown, indirectly fabricated; pre-fabricated	Missed being reported when there is insufficient tooth strength and / or structure to retain a crown (usually defined at less than 50%) and a build-up is provided	D2950, D2952, D2954	Core buildup, including any pins; post and core in addition to crown, indirectly fabricated; pre-fabricated	Report D2950 (or alternate code if provided with post) for any buildup on tooth with insufficient tooth strength and retention for crown. Includes any tooth structurally weak and existing shape or form of tooth after prep insufficient to retain crown. D2950 also justified when undercuts caused by erosion / abfraction are so deep they leave the tooth vulnerable to fracture when prepared for crown
D3220, D3332	Therapeutic pulpotomy; incomplete endo therapy	Reported when doing an open and broach / med	D3221, D9110	Pulpal debridement; emergency palliative	Report D3221 (pulpal debridement) for an open and broach procedure if gross pulpal debridement has been performed. This includes when the provider determines he/she cannot complete treatment and refers. Gross pulpal debridement would be defined as opening up the tooth using an apex locator and starting a sequence of files / instrumentation. Report D9110 if only partial pulpal debridement was done (i.e. cleaning out the pulpal area and going down the canals only part way before placing medicament to relieve acute pain).
D3310, D3330	Endodontic therapy anterior / molar tooth	Reported for root canal on single-rooted bicuspid	D3320	Endodontic therapy bicuspid tooth	Report the correct procedure based on the type of tooth, regardless of number of canals.
D4249	Clinical crown lengthening – hard tissue	Reported when performing "soft tissue crown lengthening." Note that most plans also consider soft tissue crown lengthening inclusive of restorative procedure.	D4210, D4211, D4212	Gingivectomy; gingivoplasty	D4249 should only be reported when reflecting a flap and removing bone in a healthy environment (i.e. no periodontal disease) to create adequate tooth structure and / or biologic width to support a restorative procedure.
D4263	Bone replacement graft – first site in quadrant	Reported when placing a bone graft in an edentulous area in preparation for an implant or in an extraction site at the time of extraction	D7950, D7951, D7953	Osseous, osteoperiosteal, or cartilage graft; sinus augmentation with bone or bone substitutes; bone replacement graft for ridge preservation	Use 7000 series codes for these situations. Refer to the details of each code to determine if and when each should be reported. Also, be sure to confirm with each plan as to when to report the procedure, as some require reporting at extraction and others at implant placement.
D4341	Periodontal scaling and root planing – four or more teeth	Reported when four or more teeth do not meet the insurance carrier's criteria	D4342	Periodontal scaling and root planing – 1 - 3 teeth	When reporting the 4341 (SRP 4+ teeth), four or more in quadrant must meet the insurance carrier's criteria. For most carriers, this requires four or more infected teeth that bleed on probing, have at least 4mm pockets, and show radiographic evidence of bone loss. If only one to three teeth meet the carrier's criteria, report 4342 (SRP 1–3 teeth). Refer to the hygiene insurance maximizer for specific carrier pocket depth requirements
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	Reported when a difficult prophy is provided to the patient or reported after a comprehensive exam	D1110	Prophylaxis – adult	D4355 should only be reported when gross scaling is necessary as a preliminary procedure to remove plaque and calculus that interferes with the clinician's ability to complete a comprehensive oral evaluation
D6058 - D6094, D6068 - D6194	Abutment supported vs. implant supported crowns and bridges	Incorrect reporting of abutment vs. implant supported crown / bridge	D6058 - D6058, D6068 - D6194	Abutment supported vs. implant supported crowns and bridges	When a prefabricated or custom abutment is used to attach a crown or bridge to an implant body, use the abutment supported codes. When the crown or bridge is directly attached to the implant body without a separate abutment, utilize the implant supported codes. In these cases, the term "abutment" refers to the device that connects or attaches the crown or bridge to the implant body.
D7210	Surgical removal of erupted tooth requiring removal of bone and / or sectioning of tooth.	Surgical extraction reported without the need for removal of bone and / or sectioning of the tooth	D7140	Extraction, erupted tooth, or exposed root	Either bone removal or sectioning must be performed in order to properly report D7210. The placement of sutures alone does not qualify an extraction as surgical. Note that elevation of a flap is optional in order to properly report a D7210.
D7310; D7311	Alveoloplasty in conjunction with extractions	Reported when only minor smoothing of bone was performed in conjunction with extractions	N/A	Considered integral with extractions when only minor smoothing provided	D7310 or D7311 should only be reported when significant recontouring is provided and clearly documented in the patient's chart. Dental plans often exclude payment for alveoloplasty on the same day as extraction unless a narrative is submitted describing the significant recontouring of bone.
Various misc. procedures	Miscellaneous procedures involving the emergency treatment of dental pain	When providing a minor procedure that alleviates dental pain to a patient that came into the office for the specific purpose of alleviating the pain: nothing is reported; only the minor procedure is reported; or only the D0140 (limited oral evaluation - problem focused) is reported	D9110	Palliative (emergency) treatment of dental pain – minor procedure	Report for emergency visit when another minor procedure is also performed to treat the pain. Report per reimbursement, usually higher and paid more consistently than minor procedures. Minor procedures could include smoothing of fractured tooth, temporary filling (instead of 2940); open, remove pulpal tissue and drainage of tooth for pain relief (instead of 3221); relief of hot / cold sensitivity or anesthetic applied (instead of 9910); small bite adjustment (instead of 9951); or partial debridement of heavy calculus, debris, or gingival inflammation. May be reported with problem / focused oral evaluation D0140. Also consider plan exclusions on number of exams per year.
D9630	Other drugs and / or medicaments	Used for "in office" drug / medicament such as chlorhexidine; used for writing a prescription	D4999, D9910	Unspecified periodontal procedure; application of desensitizing medicament	D9630 is strictly for drugs or medicaments dispensed in the office for take-home use and does not include writing of prescriptions.