Glossing Over Potential Possibilities for Coding and Income Potential

Potential opportunities to bring in income can be ignored when billable services are not submitted for reimbursement. Overutilization of a code/service that can also lead to an increased risk of an audit and/or a request for refunds. This is not to say there is anything is suspicious going on in the practice when the frequencies are considered out of range, but it does help to identify areas where there may be an increased risk of coding errors or a potential for increased reimbursement requests. For these identified codes, supporting documentation is imperative.

Here are some prime examples of such glossed-over blunders:

**Evaluations:**

**D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver**

Diagnostic services performed for a child under the age of three, preferably within the first six months of the eruption of the first primary tooth, including recording the oral and physical health history, evaluation of caries susceptibility, development of an appropriate preventive oral health regimen and communication with and counseling of the child’s parent, legal guardian and/or primary caregiver.

Many practices are not aware that D0145 exists. Furthermore, many do not provide this service when indicated or report it when performed.

*Note: The goal of this evaluation is early intervention and the development of a prevention plan for pediatric patients under three years of age.*

**D0145 includes the following diagnostic services:**

- recording the oral and physical health history.
- Evaluation of caries susceptibility (risk assessment).
- Consideration of developmental problems.
- Consideration of the primary caregiver’s oral health.
- Development of an oral health regimen to reduce the child’s risk of caries.
- Counseling with the child’s primary caregiver:
  - Instructions for cleaning the child’s teeth.
  - Fluoride recommendations.
  - Diet recommendations.
  - Recommendations to reduce the transmission of bacteria (e.g., antibacterial rinses, xylitol, etc.).
D0145 is not identified as either “comprehensive” or “periodic.” Therefore, D0145 may be reported for the initial oral evaluation and may be used for subsequent oral evaluation visits, as long as the child remains under the age of three. Also, counseling must be provided at each visit, as the code specifically requires counseling with the primary caregiver.

Once the child reaches three years of age, periodic oral evaluation (D0120) is typically reported. If the child is under three years of age at the time of the periodic oral evaluation and counseling is not provided to the primary caregiver, consider reporting D0120.

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**D0180 Comprehensive periodontal evaluation – new or established patient**

This procedure is indicated for patients showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking or diabetes. It includes evaluation of periodontal conditions, probing and charting, evaluation and recording of the patient’s dental and medical history and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer evaluation.

Many doctors are not aware that they may submit D0180 for their periodontal patients and those patients at higher risk of periodontal disease. Some think that D0180 can only be reported by a periodontist, but this is not the case.

**Note:**

*D0180 is reported when performing a comprehensive periodontal evaluation on a specific patient who shows signs, symptoms, or risk factors for periodontal disease, such as smoking or diabetes. In order to report D0180, all components of a comprehensive oral evaluation (D0150) must be performed, as well as a complete and comprehensive periodontal charting. This periodontal charting includes, but is not necessarily limited to, the documentation of six-point per-tooth pocket depths, areas of recessions, furcations, mobilities, bleeding points, purulent discharge, minimal attachments (i.e., amount of remaining attached gingiva), and a periodontal diagnosis. D0180 may also include an oral cancer evaluation.*

A comprehensive periodontal evaluation is not specialty specific. Any general dentist or specialist may report D0180, as all codes are available to any dentist practicing within the scope of his license. Furthermore, D0180 may be reported for either a new patient’s initial (comprehensive) evaluation or at an established periodontal patient’s ongoing recall visit (D4910).

General dentists usually report the extensive and all-encompassing comprehensive oral evaluation (D0150) for new patients. However, D0180 may be reported for specific and qualified periodontal patients, and may even provide a higher maximum plan allowance (MPA) than D0150.

As previously stated, a comprehensive periodontal evaluation is indicated for patients showing signs or symptoms of periodontal disease, or for patients with risk factors, such as smoking or diabetes. Reporting D0180 indicates that extra time and effort were spent making an in-depth evaluation of the overall periodontal condition, including complete charting and full mouth probing. List the patient’s signs, symptoms, and/or risk factors for periodontal disease in the patient’s chart.
D0180 is typically subject to the “two evaluations per year/twelve months” or “one per six months” overall evaluation limitation. A few plans will reimburse a third evaluation if the evaluation occurs in a different office or with a specialist. Note that some payers will “downcode” or “remap” D0180 to D0120 as an alternate benefit for reimbursement at recall visits.

D9310 Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician

A patient encounter with a practitioner whose opinion or advice regarding evaluation and/or management of a specific problem; may be requested by another practitioner or appropriate source. The consultation includes an oral evaluation. The consulted practitioner may initiate diagnostic and/or therapeutic services.

Some dentists erroneously report this code for case presentation (D9450) or for a second opinion for a self-referred patient. If a patient self-refers, report one of the oral evaluation codes.

Note:

D9310 is only reported when the dentist provides an opinion or advice for a patient who was specifically referred by a physician, dentist, or other appropriate source. A self-referred new patient presenting to a dentist for a second opinion with a complete treatment plan from a previous dentist, should be charged a comprehensive oral evaluation (D0150 or D0180). If the new patient requests a consultation regarding a single or limited service (example: evaluating a tooth for a crown), the dentist should consider reporting a consultation for specifically referred patients.

D9310 always includes an oral evaluation related to the specific request for an opinion or advice. The consulting dentist may also initiate diagnostic and/or therapeutic services.

Following the consultation, the doctor providing the consultation should send (and maintain a copy of) written communication to the referring dentist or physician detailing her findings and/or treatment.

D0140 Limited oral evaluation – problem focused

An evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date as the evaluation.

Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc.

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

This is typically reported on a “per visit” basis for emergency treatment of dental pain.
Beware: D0140 may be over reported, especially for specialists such as pediatric dentists and D9110 under reported.

Note:

A problem focused oral evaluation (D0140) is an evaluation; the dentist is “looking.” Meanwhile, palliative (D9110) is a treatment to alleviate pain or discomfort at an emergency visit.

A palliative treatment visit is always initiated by the patient. Typically, an emergency patient or a patient of record presents with acute pain or discomfort between recall visits and the doctor provides a minor, non-definitive service to alleviate the patient’s pain.

D0140 is a stand-alone code and may always be reported in conjunction with D9110. However, many payers will not reimburse D0140 in conjunction with D9110 if performed on the same service date. In very limited situations, some payers may reimburse D9110, D0140, and diagnostic pulp tests (i.e., pulp vitality test, D0460) performed on the same service date. In any case, always report what you do.

The fee reported for palliative treatment could vary according to the time spent and the complexity of the procedure. Remember, the fee assessed should be consistent for both noninsured and insured patients. When local anesthesia is provided at a palliative visit, the procedures could be reported with a higher fee than shorter procedures performed without anesthesia.

The usual, customary, and reasonable (UCR) fee for palliative is a fixed rate determined by the payer. Reimbursement for palliative treatment is variable. D9110 may be classified as preventive and reimbursed at 100 percent of the UCR fee, or it may be considered a basic service and reimbursed at 80 percent of the UCR fee. In some cases, a deductible may be applied before reimbursement. Remember, always submit a brief narrative for D9110.

If a bitewing is reported at an emergency visit, it may jeopardize the four bitewing reimbursement at a subsequent recall visit. Bitewings may be limited to “once a year” and some payers may subject a single bitewing to the annual bitewing limitation. On the other hand, periapical images taken at emergency visits typically are not subject to bitewing frequency limitations.

Periapical radiographic images are often taken in conjunction with a palliative procedure. For example, one or two periapical diagnostic image(s) may be provided in conjunction with palliative treatment. Typically, both the palliative treatment and the radiographic image(s) are reimbursed. However, periapicals may be subject to a deductible and may be paid at 80 percent of the UCR fee by some payers.

So, palliative plus two periapicals may provide enough revenue at an emergency visit without using up an oral evaluation (D0140), which can be saved for the recall visit.

Radiographic Images

Radiographic images should always be specifically ordered by the doctor based on medical necessity. Radiographic images should never be taken simply because the payer will provide reimbursement for them. Some patients with certain risk factors should have radiographic images taken more frequently than the average patient. Similarly, patients with lower risks would be expected to have radiographs
taken less frequently. Caries risk assessment codes (D0602, moderate risk or D0603, high risk) may be reported to support an increase in the frequency of radiographic images (typically at no fee).

Align the Numbers: Full Mouth Series (FMX) and Panoramic Radiographic Image (Pan)

The majority of new patients require either an FMX or pan, plus bitewings, to meet the prevailing standard of care. Furthermore, active hygiene patients, both prophylaxis and periodontal maintenance recall patients, should typically have a FMX or pan every three to five years, on average.

Align the Numbers: Bitewings (BW)

When analyzing BWs, the number of hygiene patients should be considered. In the average dental practice, BWs are taken every year or less often, based on medical necessity. For low risk adult patients, 18 to 24 months may apply.

Restorative

Confusion on reporting D2950 or D2949.

D2950 Core buildup, including any pins when required

Refers to building up of coronal structure when there is insufficient retention for a separate extracoronal restorative procedure. A core buildup is not a filler to eliminate any undercut, box form, or concave irregularity in a preparation.

D2950 refers to the building up of coronal structure when there is insufficient retention for a separate extracoronal restorative procedure (i.e., crown). A core buildup is not a filler to eliminate any undercut, box form, or concave irregularity in a cavity preparation.

A core buildup may be reimbursed when its necessity is objectively determined and properly documented. While core buildups may be performed on vital teeth, some payers may limit coverage to nonvital posterior teeth. Meanwhile, core buildups performed on nonvital teeth are generally covered, especially on a posterior tooth.

Some payers will not reimburse a core buildup on a vital tooth, indicating that the core buildup is a part of the crown preparation. If a payer denies reimbursement for this reason, have the patient request a copy of her specific dental insurance contract (plan document) from her Human Resources department. Use the plan document to verify the contract language for the specific exclusion of a core buildup.

Some payers require a certain “date sequence” to justify reimbursement for the core buildup. Some payers will not reimburse the core buildup unless a predetermination has been submitted for the planned crown or until the crown has been seated (on a subsequent date). The third-party contract (PPO) may dictate that the crown be reported on either the start or completion date. Accordingly, the reporting date should typically be the completion date. Refer to the contract language and the PPO processing policy manual for proper reporting.

Note: Per the ADA, procedures may be reported either at the start date or on the completion date. See the current language at the bottom of the 2012 ADA Dental Claim Form. The claim form states, “I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple
visits) or have been completed.” However, PPO contracts “trump” the claim form language and often require all procedures be completed prior to submission for reimbursement.

Some practices file a paper claim form on the preparation date with the “predetermination” and “statement of actual services” blocks checked (at the top of the form). Enter the core buildup with fee and date. Also, enter the crown to be placed. Leave the treatment date empty, but enter the fee. Many payers will consider this type of core buildup claim for reimbursement, as they have been alerted that the crown is predetermined and will follow the core buildup on a subsequent date.

D2949 Restorative foundation for an indirect restoration
Placement of restorative material to yield a more ideal form, including elimination of undercuts.

D2949 is used to report the placement of a restorative material (as a foundation) in a tooth to prepare for the subsequent placement of a crown, bridge, inlay, onlay, veneer, and/or other type of fixed indirect restoration. A restorative foundation is used to provide a more ideal form for the processing and adaptation of the final indirect restoration and/or to eliminate undercuts. On the other hand, D2950 is reported when a buildup is necessary for the retention of the final indirect restoration.

It is unlikely that D2949 will be reimbursed. Most payers have determined that a restorative foundation is a part of the global reimbursement provided for the indirect restoration. Even so, it is recommended that the procedure is reported, as it will provide utilization information for payers to consider it for possible future reimbursement. The fee might be nominal and expect that PPOs may require a write-off.

In terms of relative frequencies observed, about 45 to 50 percent of crowns reported require a core buildup for the retention of a crown. Frequencies of submissions for D2950 substantially greater than 50 percent may lead to further scrutiny from payers.

Miscellaneous Coding Errors
When an endodontic access opening is made through an existing crown, there seems to be confusion as to how to report sealing that access opening. The access closure should not be reported as a core buildup or a crown repair if the crown is intact (in place) following endodontic treatment. That closure, using composite or amalgam, should be described using the corresponding restorative code, usually a single surface direct restoration (e.g., D2391). The submission should include a narrative, “an occlusal composite was placed in the crown for endodontic access closure.”

D2921 Reattachment of tooth fragment, incisal edge or cusp
There is an existing code to describe the reattachment of a tooth fragment that is often reimbursed or an alternate benefit is paid. Sometimes carriers change D2921 to palliative (D9110).

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**Surgery**

**D7111 Extraction, coronal remnants – deciduous tooth**

Removal of soft tissue-retained coronal remnants.

D7111 reports the removal of a soft tissue retained coronal remnant of a primary tooth. If the primary tooth is intact (i.e., the tooth crown plus some root), report D7140 for the extraction. D7111 is reimbursed at a lower rate than D7140.

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D7210 Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated

Includes related cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure.

D7210 reports a surgical extraction of an erupted tooth. Some dental payers require that the procedure be submitted to the patient’s medical payer before reimbursement is considered under the dental plan. If the medical claim has been submitted to the medical payer, attach the medical explanation of benefits (EOB) to the dental claim form.

If the extraction of an erupted tooth requires the removal of bone and/or sectioning of the tooth, report D7210. Some payers may require both removal of bone and sectioning of the tooth to qualify for reimbursement. Some payers require that laying a mucoperiosteal flap be performed for reimbursement, even though the code’s nomenclature only requires the elevation of a mucoperiosteal flap, if indicated, to report D7210.

Do not report D7140 when a surgical extraction is performed. D7210 is typically reimbursed at 150 to 180 percent more than D7140. The increased reimbursement is justified since the surgical removal requires more time, and the procedure itself is more difficult.

Suture placement and removal, minor smoothing of bone, closure, and routine follow up is included in the global surgical fee for D7210. Alveoloplasty in conjunction with an extraction is generally considered a part of the extraction when performed on the same service date for a single tooth. Bone removal during a single surgical extraction site is not considered a separate billable alveoloplasty service.

General practitioners often do not utilize the surgical extraction code (D7210) when justified. The procedure counts for D7210 generally make up a fraction of the “routine” extraction (D7140) counts in a general dental office. On the other hand, if the number of surgical extractions exceeds 30 percent of the routine extractions in a general practice, the use of code D7210 could be scrutinized by payers.

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**D7250 Surgical removal of residual tooth roots (cutting procedure)**
Includes cutting of soft tissue and bone, removal of tooth structure, and closure.

D7250 reports the “cutting of the soft tissue and bone, removal of tooth structure, and closure.” This code is appropriate to use when removing residual root fragments remaining in the bone left from a previous, incomplete extraction. Some payers require a diagnostic radiographic image to confirm that the residual root is completely embedded in bone and requires surgical access and D7250 should not be reported if a general practitioner (GP) attempts to extract a tooth, is unable to remove all the root structure, and refers the patient to an oral surgeon for the removal of the remaining tooth root(s). In this scenario, the oral surgeon reports D7250 and the GP reports D7999, unspecified oral surgery procedure, by report (if there is a charge by the GP).

Suture removal and follow up is included in the global fee for D7250. Treatment of extensive, unusual infection after this procedure would be reported separately (D9930). However, most payers consider the post-surgical D9930 to be included in the global extraction fee, if the same doctor performs both procedures.

The reporting of surgical removal of residual tooth roots (D7250) may invoke the “missing tooth” limitation. Payers may refuse to pay for a replacement of previously lost tooth structure. Clearly explain the circumstances in a brief narrative and appeal the denial.

Some dental payers require that the medical plan be billed before consideration of this surgical service. If medical billing is required, attach the medical explanation of benefits to the dental claim form.

For questions or concerns, contact Mary Essling Dental Benefit Director at messling@aapd.org