DENTAL ESSENTIALS
DENTAL CODING AND BILLING
“FROM PATIENT TO PAYMENT”

1/1/2016
American Dental Coders Association
ABOUT THE AUTHOR

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A dedicated professional, Mindi L. Rothans worked as a dental assistant for 3 years before becoming a treatment coordinator and eventually insurance biller/coder for various dental practices. During her 20-year career, she has owned and operated a billing service, been a California State Certified Coding and Billing instructor as well as taught the Medical Coding and Billing course at Kaplan College’s (formerly Maric College) Lake Forest Campus, and is a published author in the dental field.

She was on the 2005-2006 advisory board for the Coding and billing curriculum at Kaplan College, and was on the editorial review board in 2005 for “Fordney’s Insurance Handbook for the Medical Office, Ninth Edition.”; currently she is on the editorial board for the BC Advantage as well as being a contributing author.

Ms. Rothans has a Bachelor’s degree in Healthcare Administration with a concentration in Management and holds the following certifications through the American Dental Coders Association (ADCA™) Certified Dental Billing Specialist (CDBS), Certified Dental Coder (CDC) and Certified Dental Coding Specialist (CDC-S) as well as being a Certified Professional Coder (CPC™) through the American Academy of Professional Coders (AAPC™). She was President-Elect for the Laguna Niguel AAPC chapter 2004-2006 terms; in addition to proctoring several CPC and CPC-H exams for the AAPC. She is currently working on obtaining her Master’s Degree in Healthcare Administration with a concentration in Information Technology.

She is the director of Education for the ADCA and has a successful dental consulting company. She continues to strive for excellence in all aspects of her career.

To learn more about Ms. Rothans visit her on the web at www.mindirothans.com
PREFACE

Welcome to the Sixth Edition
If you are reading this book chances are good that you are interested in becoming a Certified Dental Billing Specialist (CDBS) or a Certified Dental Coder (CDC™) as you might suspect this book is filled with ideas, tips, and best practices on how to properly code and bill procedures for the general dental office.

More experienced users will find some of this content as review, while beginners will be challenged. Nonetheless we encourage you to stick with the topics and request help whenever needed in the ADCA online forums or in your member’s only section on our website.

Many talented individuals contributed hours of work to bring forth this one of a kind step-by-step resource. Be assured that if you successfully grasp all the concepts in this book, with a bit of practice, and hard work, you will be well on your way to a successful career.

Purpose
The goals of this text are to prepare students, office managers, treatment coordinators, dental billers, dental assistants, dental hygienists, dentist’s and any other dental team member to excel at insurance billing by increasing efficiency and streamlining administrative procedures for one of the most challenging and complex tasks of a dental practice; insurance billing and coding.

Content
Each chapter has been updated to reflect 2016 policies and procedures.

Experts in the field have reviewed the material for improvements in content, clarity of topics and deletions to be considered. Through this unique collaboration we have come up with a dental coding and billing guide that surpasses any in the field. This book makes the learning process more effective by helping dental professionals learn the essentials of billing and coding for a dental office.

Summary
The book along with the practice exams, and coding exercises provides a complete competency-based educational program. This book will take you from patient to payment and instruct you on how to code for both simple and difficult procedures. Healthcare reform, managed care plans, coding crosswalks and technology has all had an impact on insurance billing. Therefore, it is imperative for all dental personnel handling claims to continue to educate themselves and their staff on proper guidelines and billing processes.
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MODULE 1

Dental Terminology

Objectives

After reading this module you should be able to:

• Identify the difference between a prefix, suffix and root word.

• Have a good working knowledge of word analysis, learning how to separate a word into its parts, determine the meaning of those parts, put the meanings back together in the correct order and thereby understand the word.

• Understand commonly used dental terminology for each specialty.

• Understand dental benefit terminology and how it applies to a dental office.

• List and name the teeth, quadrants and structures of the mouth.

• Identify the difference between permanent and primary dentition.

• Have a good working knowledge of facial anatomy.
Introduction

This Module will teach you the basics of Dental Terminology. Even though this module is an introduction you will most likely come across several dental terms you have never seen before. For this reason, we have added the phonetic spelling of each new dental term in parenthesis after the term. A phonetic spelling, spells the word as it actually sounds. You should practice saying the word out loud after you read it.

The phonetic spelling for each dental term is outlined in the simplest way possible. You should use the following guidelines as you read and speak each term out loud.

- Long vowel sounds are marked with a straight bar over them. For example, the phonetic spelling of plate is (plāt), the phonetic spelling of genes (jēnz), the phonetic spelling of deep (dēp), and so on and so forth.

- Short vowel sounds are marked with a breve (˘) over them. For example, the phonetic spelling of leg is (lĕg), the phonetic spelling of hit is (hĭt), so far so good?

- Primary (′) and secondary (″) accents are marked as such. The accent that is stressed the most is called the primary accent. For example, a common dental term is dentist, this word has two short vowels and is accented on the first part of the word; the phonetic spelling of the word is dēn′tĭst. The word is pronounced DEN-tist.

Mastering dental terminology is often a difficult task. In order to master the terminology presented in this module you’ll need to practice. Try practicing with a friend or co-worker, making sure to refer to the definitions until you feel comfortable with the pronunciation and meaning of each term.

You must remember dental terminology isn’t an exact science. You will find certain dental terms will vary a little depending on which references you consult. Although, with practice, you will master dental terminology and be able to tackle any term you come across.

In today’s fast paced world, you need to possess strong dental vocabulary skills to succeed in a dental office. However, it is almost impossible to memorize every single dental word in a medical dictionary. The easiest way to master dental terminology is to understand how terms and words are constructed. The following steps will help you learn how to breakdown a word and give it meaning.

TIP: If you understand and know what the parts of a word are and how they function in whole words you will be able to figure out any term that comes your way.
New words are constantly being used to name new medical/dental discoveries. These new words usually have Greek or Latin origins. This is how medical and dental terminology is constructed. Learning dental terminology is a lot like learning a foreign language. Learning another language isn't just a matter of memorizing the vocabulary. There's a certain code, shall we say, to language. The parts need to go into a certain order to make sense; change the order and most likely you change the meaning. Here is an example of a simple sentence, play around with the order of the words to help you understand.

The rope hit Bailey.

Hit the rope, Bailey.

Even a small detail like punctuation can change the entire meaning of a sentence.

Bailey hit the rope.

Bailey, hit the rope!

While some combinations don’t make any sense or mean anything at all

Rope Bailey the hit.

The hit Bailey rope.

This principle applies to dental terminology as well. All words have a specific meaning; if you mix up the order you could change the meaning or the term and make the term seem meaningless. Since dental documents are of grave importance you cannot afford to type or write the dental equivalent of “the rope Bailey hit” when the dentist meant “The rope hit Bailey”!

Dental terminology does have a few rules of its own, but the code is easily cracked. If you are able to determine the meaning of the word parts and how those parts function in connection with each other, you will be able to figure out almost any word you hear PROVIDED OF COURSE IT’S REALLY A WORD AND IT’S PRONOUNCED FAIRLY ACCURATELY.

You are about to learn how to analyze a word. The term analysis means the separation of the whole into its component parts. WORD ANALYSIS IS THE MOST VALUABLE TOOL IN UNDERSTANDING DENTAL TERMINOLOGY. Separate a word into its parts, determine the meaning of those parts, put the meanings back together in the correct order and thereby understand the word. The following is what you will be looking for when analyzing dental terms.
Suffixes

A suffix is added to the end of a word or stem to complete the word or give it new meaning. In most instances a suffix will indicate the procedure, condition, disorder, or disease.

For example, gingiv/o means gingival tissue, gums. When a suffix is added to the word it changes the meaning by telling you what is happening to the gingiva.

Gingivitis (jin-jih-VYE-tis) means inflammation of the gums (gingiv meaning gums and –itis meaning inflammation).

Gingivectomy (jin-jih-VECK-toh-mee) means surgical removal of gum tissue (gingiv meaning gum tissue and –ectomy meaning the surgical removal).

As stated above suffixes may give many meanings to a root word. They may change the root word into an adjective (a word that describes a noun) such as periodontal (pehr-ee-oh-DON-tal) meaning pertaining to the supporting and surrounding tissues of the teeth (peri- meaning surrounding, -odont- meaning teeth and -al means pertaining to), or change the word into a noun (person, place or thing) as is the case with the term cranium (KRAY-nee-um) which means the portion of the skull that encloses the brain (crani- meaning skull and -um is a noun ending) they may even give a general meaning such as abnormal condition or disease as is the case with the term halitosis (hal-ih-TOH-sis) meaning an unpleasant breath odor or bad breath caused by dental diseases, respiratory or gastric disorders (halit- means breath and -osis means abnormal condition or disease).

Suffixes may also be related to pathology (the study of disease). The following suffixes identify or describe specific disease or conditions.

- **-algia** means pain and suffering. **Neuralgia** (new-RAL-jee-ah) means pain in nerve or nerves (neur- means nerve -algia means pain or suffering).

- **-itis** means inflammation. **Sinusitis** (sigh-nuh-SIGH-it is) means inflammation of the sinuses (sinus- means sinus cavity and -itis means inflammation).


Suffixes may also be related to procedures. The following suffixes identify or describe a procedure that may be performed on a body part or area.
• **-centesis** means the surgical puncture or aspiration of fluid for diagnostic purposes or to remove excess fluid. **Arthrocentesis** (ar-thro-sen-TEE-sis) is the surgical puncture of the joint space to remove fluid (arthro- means joint and -centesis means a surgical puncture to remove fluid).

• **-ectomy** means surgical removal. A **Pulpectomy** (pul-pee-TECK-toh-mee) is the surgical removal of vital and non vital pulp tissue from the root canal space (pulp- means vital and non vital tissue from the root canal space and -ectomy means surgical removal)

• **-graphy** means the process of recording a picture or record. **Radiography** (ray-dee-og-REEe-fee) is use of x-rays to expose a film that shows either a single tooth or multiple teeth (radio- means x-rays or radiation and -graphy means process of recording)

• **-plasty** means surgical repair. **Osteoplasty** (OSS-tee-oh-poh-las-tee) is the surgical repair of bones (Osteo- means bones and -plasty means surgical repair).

• **-scopy** means visual examination. **Endoscopy** (en-DOS-koh-pee) is the visual examination of the interior of a body cavity by means of a special instrument such as an endoscope.

You should note not every word ends in a suffix. Words can begin or end with root words and often they will. Let’s take a look at prefixes now, shall we?
Prefixes
A prefix is placed at the beginning of a word and therefore changes the meaning of the word. The word Prefix begins with a prefix itself. PRE- means “before or in front of.” While the root FIX means “attach or fasten” thereby giving us our definition; a prefix is attached in front of something. Prefixes often but not always indicate location, time, or number. As with suffixes not every word begins with a prefix however, a prefix is always placed at the beginning of a word.

The term mandibular means pertaining to the mandible or lower jaw (mandibul- means lower jaw and -ar means pertaining to). The following examples will show you how a prefix can change the meaning of a term or root word.

• Submandibular (sub-MAN-dih-bul-are) means pertaining to the space underneath or below the lower jaw. (sub- means under or below -mandibul- means the lower jaw and -ar means pertaining to).

• Supramandibular (sue-pah-rah-MAN-dih-bul-are) means pertaining to the space above the lower jaw (supra- means above or beyond -mandibul- means lower jaw and -ar means pertaining to).

Simply changing one or two letters in a prefix can make a huge difference in the meaning of the entire word. Furthermore, there are some prefixes that are confusing because they are very similar in spelling although they have opposite meanings. You need to remember that terms often begin with root words rather than prefixes. If you mistake a root word for a prefix you are liable to confuse yourself. If you are unsure whether the term is a root word or prefix look for the combining vowel that signals a root word such as mandibul/o or gingiv/o if you are unable to find a combining vowel you may safely assume it is a prefix. Remember prefixes function as adjectives or prepositions; they tend to describe something rather than name something.
### Common Prefixes include

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<tr>
<th>Prefix</th>
<th>Meaning</th>
<th>Example</th>
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<tr>
<td>AB-</td>
<td>Away from</td>
<td>Abnormal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Away from normal, not normal</td>
</tr>
<tr>
<td>BI-</td>
<td>two, both</td>
<td>Bilateral</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Both sides, right &amp; left</td>
</tr>
<tr>
<td>DIS-</td>
<td>apart, away from</td>
<td>Dissect</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cut apart</td>
</tr>
<tr>
<td>HEMI-</td>
<td>Half</td>
<td>Hemisection</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Separate half of a section, quadrant or root</td>
</tr>
<tr>
<td>INTER-</td>
<td>Between</td>
<td>Interproximal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Between the adjoining surfaces</td>
</tr>
<tr>
<td>MICRO-</td>
<td>Small</td>
<td>Microscope</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Instrument used to enlarge small objects</td>
</tr>
<tr>
<td>PRE-</td>
<td>Before</td>
<td>Premedication</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The use of medications prior to dental treatment</td>
</tr>
<tr>
<td>TRI-</td>
<td>Three</td>
<td>Tricuspid</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Third cuspid</td>
</tr>
<tr>
<td>UNI-</td>
<td>One</td>
<td>Unilaterial</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Affecting only one side</td>
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Root Words

Root words are known as combining forms and are the origin of a term. They will act as a foundation for most dental terms. These words will usually function as nouns (person, place or thing) or verbs (action) and are the strongest parts of speech. However, you should be careful not to overlook root words that indicate color such as erythr/o meaning red or leuk/o meaning white.

A root word is the only part of a term that may sometimes stand by itself as a separate word. For example LARYNG/O, the combining form meaning “throat” A larynx (lar-RIN-ex) is your throat. This root needs no prefix or suffix to create a complete word.

The letter “o” may come in handy when you are learning and analyzing terms, since this will usually indicate there’s a root word before it. Although the “o” can be helpful when you are learning dental terminology it may sometimes become confusing. Sometimes it may not be a combining vowel but instead it is an actual letter in a prefix, root, or suffix. For example, the term psychotic - the suffix is –OTIC which means the combining vowel is dropped and the remaining “o” becomes part of the suffix.

Don’t expect to become an expert right away; it’s ok if you have some trouble sorting out prefixes, root words and suffixes. Almost everyone does! Once you become comfortable and more confident you will see the pieces eventually fall into place. Being able to analyze and break down a word will become second nature to you.

The Roots of Dental Specialists

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<tr>
<th>Root Word</th>
<th>Meaning</th>
<th>Specialist</th>
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<tbody>
<tr>
<td>ORTH/O</td>
<td>Straight, normal</td>
<td>Orthodontist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diagnosis’ and treats abnormalities of teeth position</td>
</tr>
<tr>
<td>OR/O</td>
<td>Mouth</td>
<td>Oral Maxillofacial Surgeon</td>
</tr>
<tr>
<td>MAXILL/O</td>
<td>Jaw</td>
<td>Treats diseases of the mouth, jaw, and face</td>
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<td>FACL /O</td>
<td></td>
<td></td>
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<tr>
<td>PED/O</td>
<td>Child</td>
<td>Pedodontist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diagnosing, treating and preventing disorders in children’s teeth and mouth</td>
</tr>
<tr>
<td>PROSTH/O</td>
<td>Addition, restoration</td>
<td>Prosthodontist</td>
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<tr>
<td></td>
<td></td>
<td>Restoration of natural teeth or replacement of missing teeth with artificial substitutes.</td>
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</tbody>
</table>
# Common Dental Root Words

<table>
<thead>
<tr>
<th>Root</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANESTHET / O</td>
<td>Sensation, sense of perception</td>
</tr>
<tr>
<td>ALIGN / O</td>
<td>Bring into line or correct position</td>
</tr>
<tr>
<td>ALVEOL / O</td>
<td>Alveolus, air sac, small sac</td>
</tr>
<tr>
<td>ANKYL / O</td>
<td>Crooked, bent, stiff</td>
</tr>
<tr>
<td>APLAST / O</td>
<td>Lack of development, defective development</td>
</tr>
<tr>
<td>ARC / O</td>
<td>Bow, arc or arch</td>
</tr>
<tr>
<td>ARTHR / O</td>
<td>Joint</td>
</tr>
<tr>
<td>BACTERI / O</td>
<td>Bacteria</td>
</tr>
<tr>
<td>BIFURCAT / O</td>
<td>Divide or fork into two branches</td>
</tr>
<tr>
<td>BRUX / O</td>
<td>Grind</td>
</tr>
<tr>
<td>BUCC / O</td>
<td>Cheek</td>
</tr>
<tr>
<td>CALC / O</td>
<td>Calcium</td>
</tr>
<tr>
<td>CARCIN / O</td>
<td>Cancerous</td>
</tr>
<tr>
<td>CEMENT / O</td>
<td>Cementum, a rough stone</td>
</tr>
<tr>
<td>CHONDR / O</td>
<td>Cartilage</td>
</tr>
<tr>
<td>CIATRIC / O</td>
<td>Scar</td>
</tr>
<tr>
<td>CRANI / O</td>
<td>Skull</td>
</tr>
<tr>
<td>CUTANE / O</td>
<td>Skin</td>
</tr>
<tr>
<td>DEGLUTIT / O</td>
<td>Swallow</td>
</tr>
<tr>
<td>DENT / O</td>
<td>Tooth, teeth</td>
</tr>
<tr>
<td>DIPS / O</td>
<td>Thirst</td>
</tr>
<tr>
<td>DISLOCAT / O</td>
<td>Displacement</td>
</tr>
<tr>
<td>DISSECT / O</td>
<td>Cutting apart</td>
</tr>
<tr>
<td>EPIGLOTT / O</td>
<td>Epiglottis</td>
</tr>
<tr>
<td>ESOPHAG / O</td>
<td>Esophagus</td>
</tr>
<tr>
<td>ETI / O</td>
<td>Cause</td>
</tr>
<tr>
<td>EVACU / O</td>
<td>Empty out</td>
</tr>
<tr>
<td>EXCIS / O</td>
<td>Cut out</td>
</tr>
<tr>
<td>EXHAL / O</td>
<td>Breathe out</td>
</tr>
<tr>
<td>FACI / O</td>
<td>Face, form</td>
</tr>
<tr>
<td>FIBROS / O</td>
<td>Fibrous connective tissue</td>
</tr>
<tr>
<td>FREN / O</td>
<td>Limited movement</td>
</tr>
<tr>
<td>FRACT / O</td>
<td>Break, broken</td>
</tr>
<tr>
<td>FRONT / O</td>
<td>Forehead, brow</td>
</tr>
<tr>
<td>GINGIV / O</td>
<td>Gingival tissue, gums</td>
</tr>
<tr>
<td>GLOSS / O</td>
<td>Tongue</td>
</tr>
<tr>
<td>GLOTT / O</td>
<td>Back of the tongue</td>
</tr>
<tr>
<td>GNATH / O</td>
<td>Jaw</td>
</tr>
<tr>
<td>HALIT / O</td>
<td>Breath</td>
</tr>
<tr>
<td>HIAT / O</td>
<td>Opening</td>
</tr>
<tr>
<td>HIDR / O</td>
<td>Sweat</td>
</tr>
<tr>
<td>HIST / O</td>
<td>Tissue</td>
</tr>
<tr>
<td>IMPACT / O</td>
<td>Pushed against, wedged against, packed</td>
</tr>
<tr>
<td>INFECT / O</td>
<td>Infected, tainted</td>
</tr>
<tr>
<td>KEL / O</td>
<td>Growth, tumor</td>
</tr>
<tr>
<td>LABI / O</td>
<td>Lip</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>LARYNG / O</td>
<td>Larynx, throat</td>
</tr>
<tr>
<td>LEUK / O</td>
<td>White</td>
</tr>
<tr>
<td>LINGU / O</td>
<td>Lingual, tongue</td>
</tr>
<tr>
<td>MASTIC / O</td>
<td>Chew</td>
</tr>
<tr>
<td>MAXILL / O</td>
<td>Maxilla, upper jaw</td>
</tr>
<tr>
<td>MELAN / O</td>
<td>Black, dark</td>
</tr>
<tr>
<td>MEMBRAN / O</td>
<td>Membrane, skin tag</td>
</tr>
<tr>
<td>MENISC / O</td>
<td>Meniscus, crescent</td>
</tr>
<tr>
<td>MESI / O</td>
<td>Middle, median plan</td>
</tr>
<tr>
<td>MUC / O</td>
<td>Mucus</td>
</tr>
<tr>
<td>MUSCUL / O</td>
<td>Muscle</td>
</tr>
<tr>
<td>MUT / O</td>
<td>Unable to speak, inarticulate</td>
</tr>
<tr>
<td>MYX / O</td>
<td>Mucus</td>
</tr>
<tr>
<td>NARC / O</td>
<td>Numbness</td>
</tr>
<tr>
<td>NAS / O</td>
<td>Nose</td>
</tr>
<tr>
<td>NECR / O</td>
<td>Death</td>
</tr>
<tr>
<td>NERV / O</td>
<td>Nerve</td>
</tr>
<tr>
<td>NODUL / O</td>
<td>Nodule, little knot</td>
</tr>
<tr>
<td>OCCLUS / O</td>
<td>Shut, close up</td>
</tr>
<tr>
<td>ODONT / O</td>
<td>Tooth</td>
</tr>
<tr>
<td>OLFACT / O</td>
<td>Smell, sense of smell</td>
</tr>
<tr>
<td>ONC / O</td>
<td>Tumor</td>
</tr>
<tr>
<td>OR / O</td>
<td>Mouth, oral cavity</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>ORTH / O</td>
<td>Straight, normal, correct</td>
</tr>
<tr>
<td>OSTE / O</td>
<td>Bone</td>
</tr>
<tr>
<td>OSM / O</td>
<td>Pushing, thrusting</td>
</tr>
<tr>
<td>PALAT / O</td>
<td>Palate, roof of mouth</td>
</tr>
<tr>
<td>PHARYNG / O</td>
<td>Throat, pharynx</td>
</tr>
<tr>
<td>PHLEGEM / O</td>
<td>Thick mucus</td>
</tr>
<tr>
<td>PLAC / O</td>
<td>Flat plate or patch</td>
</tr>
<tr>
<td>PLAK / O</td>
<td>Plaque</td>
</tr>
<tr>
<td>PLAS / O</td>
<td>Development, growth formation</td>
</tr>
<tr>
<td>POSTER / O</td>
<td>Behind, toward the back</td>
</tr>
<tr>
<td>PROSTH / O</td>
<td>Addition</td>
</tr>
<tr>
<td>PUR / O</td>
<td>Pus</td>
</tr>
<tr>
<td>PY / O</td>
<td>Pus</td>
</tr>
<tr>
<td>QUADR / O</td>
<td>Four</td>
</tr>
<tr>
<td>RADI / O</td>
<td>X-rays, radiation</td>
</tr>
<tr>
<td>RADICUL / O</td>
<td>Nerve root</td>
</tr>
<tr>
<td>RHIN / O</td>
<td>Nose</td>
</tr>
<tr>
<td>SALIV / O</td>
<td>Saliva</td>
</tr>
<tr>
<td>SIAL / O</td>
<td>Saliva</td>
</tr>
<tr>
<td>SIALADEN / O</td>
<td>Salivary gland</td>
</tr>
<tr>
<td>SINUS / O</td>
<td>Sinus</td>
</tr>
<tr>
<td>SPUT / O</td>
<td>Spit</td>
</tr>
<tr>
<td>TEMPOR / O</td>
<td>Temporal bone, temple</td>
</tr>
<tr>
<td>ULCER / O</td>
<td>Sore, Ulcer</td>
</tr>
</tbody>
</table>
Common Clinical Dental Terms

Introduction:
There are several dental terms you need to be familiar with when working in a dental office. Dental Coding and Billing is one of the most demanding professions in terms of knowledge and skills required. If you are not familiar with commonly used terms and language in a dental office you may find yourself lost and confused. Below is a list of dental specialties that are officially recognized by the American Dental Association’s Commission on Dental Accreditation:

- **Endodontics** – this specialty is concerned with the etiology, diagnosis, prevention and treatment of disease and injuries of the pulp and associated periradicular conditions. (These dentists specialize in Root Canal Therapy)

- **Oral Pathology** – this specialty focuses on the nature of the diseases affecting the oral structures and adjacent regions. (These dentists focus on recognition, diagnosis, investigation and management of diseases of the oral cavity and jaw)

- **Oral & Maxillofacial Surgeon** – this specialty is concerned with the diagnosis, surgical and adjunctive treatment of diseases, injuries, deformities, defects and esthetic aspects of the mouth, face and neck. (These dentists usually remove impacted wisdom teeth and correct facial deformities such as cleft palate)

- **Orthodontics** – this specialty focuses on the interception and treatment of malocclusion (misalignment of teeth) of the teeth and their surrounding structures. (This dentist places and removes braces)

- **Pediatric Dentistry** – this specialty focuses on the preventative and therapeutic oral healthcare of children from birth through adolescence. They may also care for special patients beyond adolescence who demonstrate mental and or physical ailments. (This dentist is also known as a pedodontist)

- **Periodontics** – this specialty focuses on the diagnosis and treatment of the supporting and surrounding gum tissue of the teeth.

- **Prosthodontics** – this specialty focuses on restoration and maintenance of oral functions by restoring natural teeth or replacing missing teeth. (This dentist is known for crowns, bridges and dentures)
Depending on which specialty you work in you will hear different “commonly used” terms, we want you to be familiar with all dental terms so you are well versed and can work in any type of office. However, to make it easier to remember we have broken the terms up into specialty groups.

1. General Terms
2. Endodontic Terms
3. Oral & Maxillofacial Surgery Terms
4. Orthodontic Terms
5. Periodontic Terms

TIP: Make flash cards and test yourself.
Commonly used General Terms

Anesthesia: there are four types of anesthesia used -

1. general anesthesia: a controlled state of unconsciousness, accompanied by a partial or complete loss of protective reflexes, including loss of ability to independently maintain airway and respond purposefully to physical stimulation or verbal command
2. intravenous sedation/analgesia: a medically controlled state of depressed consciousness while maintaining the patients’ airway, protective reflexes and the ability to respond to stimulation or verbal command
3. local anesthesia: an injection given to numb the area, the loss of pain sensation over a specific area of the mouth without loss of consciousness
4. non-intravenous conscious sedation: a medically controlled state of depressed consciousness while maintaining the patients’ airway, protective reflexes and the ability to respond to stimulation or verbal commands

Anterior: refers to the teeth and tissues located towards the front of the mouth

Anxiolysis: reduction of anxiety utilizing a pharmacologic agent such a benzodiazepine or nitrous oxide

Buccal: pertaining to or around the cheek

Deglutition: meaning to swallow

Dental prophylaxis: scaling and polishing procedure to remove coronal plaque, calculus, and stains

Distal: toward the back of the dental arch

Enamel: hard calcified tissue covering dentin of the crown of a tooth

Evaluation: there are seven different types of dental evaluations or examinations

1. Periodic oral evaluation (D0120): this is performed on an established patient to check for any changes in the patient’s dental or medical health status. This is typically done once every 6 months.

2. Limited oral evaluation (D0140): this is a problem focused exam. For example, if a patient comes in complaining of a tooth ache.

3. Oral evaluation for a patient under three years of age and counseling with primary caregiver (D0145): This type of exam is performed on a child under the age of three, preferably within the first six months of the eruption of the first primary tooth.

4. Comprehensive oral evaluation (D0150): This type of exam is usually performed on a new patient and is done when the general dentist or specialist is evaluating the patient comprehensively. It is a complete and thorough exam.
5. Comprehensive periodontal evaluation (D0180): this exam is typically performed by a periodontist. It will typically include periodontal charting, oral cancer screening and a complete dental and medical history.

6. Detailed and extensive oral evaluation (D0160): a detailed and extensive problem focused exam followed by a report. This type of exam is usually performed by an oral surgeon evaluating TMJ disorders or dentofacial anomalies.

7. Re-evaluation- limited or problem focused (D0170): this exam is used when the patient is seen for assessing the status of a previously existing condition.

Extraoral: outside the mouth

Facial: the surface of the tooth directed toward the face

Incisal: pertaining to the biting edges of the incisor and cuspid teeth

Interproximal: between the adjoining surfaces of adjacent teeth in the same arch

Intraoral: inside the mouth

Labial: pertaining to or around the lip

Palate: the hard and soft tissues forming the roof of the mouth that separates the oral and nasal cavities

Lingual: pertaining to or around the tongue, surface of the tooth directed toward the tongue

X-ray: also known as radiograph. is a negative image on photographic film made by exposure to radiation that have passed through matter or tissue
Commonly used Endodontic terms

**Abscess**: Acute or chronic, localized inflammation, with a collection of pus, associated with tissue destruction and frequent swelling usually secondary to infection.

**Periapical abscess**: Acute or chronic inflammation and pus formation at the end of a tooth root in the alveolar bone, secondary to infection.

**Apicoectomy**: Amputation of the apex of a tooth

**Apex**: the tip or end of the tooth root

**Canal**: a relatively narrow tubular passage or channel:

**Root canal**: space inside the root portion of a tooth containing pulp tissue

**Cementum**: hard connective tissue covering the tooth root

**Periapical cyst**: cyst at the apex of the tooth with a non-vital pulp

**Decay**: the lay term for carious lesions in a tooth; also known as a cavity

**Dentin**: the part of the tooth that is beneath enamel and cementum

**Direct pulp cap**: procedure in which the exposed pulp is covered with a dressing or cement with the aim of maintaining pulp vitality

**Enamel**: hard calcified tissue covering dentin of the crown of tooth

**Furcation**: the anatomic area of a multi-rooted tooth where the roots diverge

**Hemisection**: surgical separation of a multi-rooted tooth

**Indirect pulp cap**: procedure in which the nearly exposed pulp is covered with a protective dressing to protect the pulp from additional injury and to promote healing and repair via formation of secondary dentin

**Palliative**: action that relieves pain but is not curative.

**Periapical**: the area surrounding the end of the tooth root

**Pulp**: connective tissue that contains blood vessels and nerve tissue which occupies the pulp cavity of a tooth

**Pulp cavity**: the space within a tooth which contains the pulp

**Pulpectomy**: complete removal of vital and non-vital pulp tissue from the root canal space

**Pulpitis**: inflammation of the dental pulp
Pulpotomy: surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing.

Radicular: pertaining to the root

Retrograde filling: a method of sealing the root canal by preparing and filling it from the root apex

Root: the anatomic portion of the tooth that is covered by cementum and is located in the alveolus (socket) where it is attached by the periodontal ligaments.

Residual root: the remaining root structure following the loss of the major portion (over 75%) of the crown of the tooth

Root canal: the portion of the pulp cavity inside the root of a tooth; the chamber within the root of the tooth that stores the pulp

Root canal therapy: the removal of the pulp designed to treat the disease and injuries of the pulp and associated periradicular conditions

Commonly used Oral & Maxillofacial Surgery Terms

Alloplastic: refers to synthetic material often used for tissue augmentation.

Alveoloplasty: surgical procedure for re-contouring alveolar structures, usually in preparation for prosthesis such as a denture.

Avulsion: also known as evulsion, separation of the tooth from its socket due to trauma.

Benign: the mild character of an illness or the non-malignant (non cancerous) character of a neoplasm.

Bilateral: pertaining to both sides of a body surface (right and left).

Biopsy: process of removing tissue for histological evaluation.

Bruxism: grinding of the teeth, usually unintentional.

Caries: referring to tooth decay (cavity).

Cleft palate: congenital deformity resulting in lack of fusion of the soft and or hard palate, this may be either partial or complete.

Clenching: the biting down or pressing of the jaws and teeth together in occlusion with great pressure or force.

Closed reduction: the re-approximation of segments of a fractured bone without open surgery.

Compound fracture: also known as an open fracture, is one in which the break in the bone is exposed to external contamination.
Curettage: scraping and cleaning the walls of a cavity or gingival pocket.

Cyst: pathological cavity, usually lined with epithelium, containing fluid or soft matter.

Odontogenic cyst: cyst derived from the epithelium (a protective covering for all of the internal and external surfaces) of odontogenic tissue (developmental).

Deciduous: also known as primary teeth, having the qualities of falling off or shedding.

Dentition: the teeth in the dental arch.

Permanent dentition: refers to the adult teeth or permanent teeth in the dental arch.

Deciduous dentition: refers to primary or baby teeth in the dental arch.

Discectomy: excision of the intra-articular disc of a joint.

Displaced tooth: partial avulsion of a tooth in any direction or area of the mouth.

Evulsion: also known as avulsion, a separation of the tooth from its socket due to trauma.

Excision: surgical removal of bone or tissue.

Foramen: natural opening into or through bone.

Frenum: muscle fibers covered by a mucous membrane that attaches the cheek, lips and or tongue to associated dental mucosa.

Impacted tooth: an un-erupted or partially erupted tooth that is positioned against another tooth, bone, or soft tissue so that complete eruption is unlikely.

Implant: material inserted or grafted into tissue.

Jaw: common name for the mandible or maxilla.

Lesion: injury or wound; area of diseased tissue.

Malar: pertaining to the cheek bone.

Malignant: having the properties of invasion or metastasis (cancerous).

Maxilla: upper jaw.

Mucous membrane: also known as the mucosa, the lining of the oral cavity.

Obturator: a disc or plate which closes an opening; a prosthesis that closes an opening in the palate.

Odontogenic: forming teeth, arising in tissues that give origin to the teeth.

Oперculectomy: removal of operculum (tissue over an un-erupted or partially erupted tooth).

Orthognathic: functional relationship between the maxilla and mandible.
Osteoplasty: surgical repair of bone.

Osteotomy: surgical cutting or opening of bone.

Palate: the hard and soft tissues forming the roof of the mouth.

Parafuncional: other than normal function or use.

Sialodochoplasty: the surgical repair of a defect and/or restoration of a portion of the salivary gland duct.

Sialography: diagnostic visual exam of the salivary ducts and glands by x-ray after a radiopaque injection has been administered.

Sialolithotomy: surgical removal or opening by which to remove a stone within a salivary gland or duct.

Suture: stitch used to close an incision or wound.

Temporomandibular joint (TMJ): the connecting hinge mechanism between the base of the skull and the lower jaw.

Temporomandibular joint dysfunction: abnormal function of the TMJ.

Torus: a bony elevation or protuberance of bone.

Transseptal: through or across a septum.

Trismus: restricted ability to open the mouth.

Un-erupted: tooth/teeth that have not penetrated into the oral cavity.

Unilateral: pertaining to one side.

Vestibuloplasty: surgical procedure used to increase relative alveolar ridge height.

Xerostomia: decreased salivary secretion it may create a dry or burning sensation of the oral mucosa.

Zygomatic bone: quadrangular bone on either side of the face that forms the cheek prominence, see also malar.
Commonly used Orthodontic Terms

**Activator**: is an appliance designed to promote the expansion of an arch.

**Anchorage**: the ability of a tooth to resist displacement (movement) by applied mechanical forces.

**Anderson Appliance**: lies loose in the mouth, stimulating the muscles to provide a reflex closure of the mandible and casing the teeth to contact the appliance. The appliance trains and directs the muscles of the mouth to shape the occlusion.

**Angle’s Class I or Neutrooclusion**: the anterior or individual teeth are misaligned in their position in the arch. The relationship of the permanent first molars determines classification.

**Angle’s Class II or Distooclusion**: The mandibular arch and the body of the mandible are in distal relationship to the maxillary arch by half the width of the permanent first molar. This frequently gives the appearance that the maxillary anterior teeth protrude.

**Angle’s Class III or Mesioclusion**: The mandibular arch and the body of the mandible are in bilateral, mesial relationship to the maxillary teeth. This frequently gives the appearance that the mandible protrudes.

**Appliance**: a device used to provide function or therapeutic effect.

**Articulation**: the contact relationship of upper and lower teeth as they move against each other.

**Bands**: are preformed stainless steel rings that are fitted around the teeth and cemented in place.

**Bioversion**: is the inclination of the teeth to extend facially beyond the normal overlap of the incisal edge of the maxillary incisors over the mandibular incisors.

**Bonding**: the force by which a substance is secured in intimate contact with another substance. It may be mechanical, chemical or physical.

**Brackets**: a small attachment used to fasten the arch wire to the teeth or to the orthodontic bands.

**Cephalometric radiograph**: A radiographic (x-ray) head film utilized in the scientific study of the measurements of the head with the relation to specific reference points.

**Centric Occlusion**: when the jaws are closed in a position that produces maximum stable contact between the occluding surfaces of the maxillary and mandibular teeth.

**Cross Bite**: an abnormal relation of one or more teeth of one arch to the opposing tooth or teeth of the other arch due to labial, buccal or lingual deviation of tooth position, or abnormal jaw position.

**Crozat Appliance**: is a removable appliance designed to exert a gentle force on the teeth to effect movement during treatment.

**Diagnostic Cast**: plaster or stone model of teeth and adjoining tissues; also referred to as study model.
**Diastema:** an abnormal space between two adjacent teeth in the same arch, usually found between the maxillary central incisors.

**Equilibration:** the act of putting the mandible in a state of balance with the maxilla.

**Hawley Retainer:** is worn to passively retain the teeth in their new position following the removal of orthodontic bands.

**Ligature tie wires:** stainless steel wire used to bind teeth together or to hold structure in place.

**Linguoversion:** refers to the position of the maxillary incisors as being in back of the opposing mandibular incisors.

**Moulage:** a positive reproduction of a body part formed on a cast from a negative impression.

**Overbite:** a vertical overlap or projection of upper teeth over the lowers.

**Overjet:** a horizontal overlap or projection of upper teeth over the lowers.

**Protrusion:** a position of the mandible placed as far forward as possible from the centric position as related to the maxilla.

**Prognathism:** the abnormal projection of one or both jaws beyond the established normal relationship with the cranial base.

**Rotating:** is the force of moving it to the right or left in its socket.

**Separators:** are elastic, steel, spring, or brass wire, they are used to create temporary space between the teeth that are to be banded.

**Space maintainer:** is made of acrylic or metal and is used to hold the space between a tooth that has been lost prematurely or is pending eruption.

**Tension:** refers to the side of the tooth away from the direction in which the tooth is being moved.

**Tipping:** refers to moving the tooth more upright.

**Tongue thrust:** the act of pressing the tongue forward against the anterior teeth each time a person swallows.
Acute Necrotizing Ulcerative Gingivitis: also known as ANUG is a recurrent gingivitis of young and middle aged adults characterized clinically by gingival erythema (redness) and pain, odor, and necrosis (death) or separation of interdental papillae and marginal gingival which will sometimes appear gray in color.

Allogenic graft: having cell types that are anti-genetically distinct form a patient’s cell type.

Alloplastic: refers to synthetic material often used for tissue augmentation.

Alveoloplasty: surgical procedure for re-contouring alveolar structures, usually in preparation for prosthesis.

Autogenous graft: is taken from one part of a patient’s body and transferred to another.

Calculus: is an accumulation of inorganic salts of the saliva or blood. Hard deposits of mineralized material adhering to crowns and/or roots of teeth.

Connective tissue: is the tissue located between the pocket wall and the alveolus.

Crown Lengthening: surgical procedure exposing more teeth for restorative purposes.

Curettage: is the process of cleansing and area or pocket by removing dead or necrotic tissue in the infected area.

Debridement: removal of subgingival and/or supragingival plaque and calculus which obstructs the ability to perform an evaluation.

Dental implant: a device specially designed to be placed surgically within or on the mandibular or maxillary bone as a means of providing for dental replacement; the three types are endosteal (endosseous), eposteal (subperiosteal), or transosteal (transosseous).

Gingivectomy: is the surgical removal of the soft tissue wall of a periodontal pocket.

Gingivitis: inflammation of gingival tissue without loss of connective tissue.

Gingivoplasty: is the surgical procedure by which gingival deformities particular enlargements are reshaped and reduced to create normal and functional form.

Graft: a piece of tissue or alloplastic material placed in contact with tissue to repair a defect or supplement a deficiency.

Histopathology: is the study of disease processes at the cellular level.

Homologous graft: is a graft transplanted from a donor of the same species (human).

Implant: material inserted or grafted into tissue.

Mobility: is the movement of the tooth within the socket.

Osseous surgery: is the surgical procedure to reshape the alveolous while maintaining basic support to the teeth it may be either additive or subtractive in nature.
**Pericoronitis**: is a condition caused by inflammation and infection of the gingival tissues surrounding the crown of an erupted tooth.

**Periodontal Abscess**: abscess of the gingival or periodontal tissue secondary to periodontal infection.

**Periodontal Charting**: is the act of charting the periodontal pockets for depth and disease, to map out missing teeth and make an overall assessment of the mouth.

**Periodontal disease**: inflammatory condition of the gingival tissues and/or periodontal membrane of the teeth.

**Periodontal maintenance**: therapy for preserving the state of health of the periodontium, also known as routine periodontal cleanings.

**Plaque**: a soft sticky substance that accumulates on teeth composed largely of bacteria and bacterial derivatives.

**Quadrant**: one of the four equal sections into which the dental arches can be divided; it begins at the midline of the arch and extends distally to the last tooth.

**Root Planing**: is the process of removing microbial flora, bacterial toxins, calculus, and diseased cementum or dentin on the root surfaces and in the pocket.

**Scaling**: is the process of removing calculus, plaque, and bacteria, using instruments designed to reach under the mass and remove debris in teeth.

**Stomatitis**: inflammation of the membranes of the mouth.

**Sulcus**: is the singular and describes the area surrounding one tooth.

**Sulci**: is the plural form of sulcus and describes the area surrounding more than one tooth.

**Tissue Conditioning**: is the material intended to be placed in contact with tissues, for a limited time period, with the aim of assisting the return to a healthy condition.
Commonly used Prosthodontic Terms

**Abutment**: is a natural tooth that becomes the support for the replacement tooth or teeth.

**Abutment Crown**: artificial crown serving for the retention of support of a dental prosthesis.

**Anatomical Crown**: the portion of tooth normally covered by, and including enamel.

**Articulator**: is a laboratory device that simulates the movements of the mandible and the temporal mandibular joint.

**Artificial crown**: restoration covering or replacing the major part, or the whole part of the clinical crown of a tooth.

**Bridge**: a series of fabricated teeth used to replace missing teeth using healthy teeth as anchors.

**Clinical Crown**: the portion of a tooth not covered by supporting tissues.

**Dental prosthesis**: any device or appliance replacing one or more missing teeth.

**Denture**: an artificial substitute for natural teeth and adjacent tissues.

**Denture base**: the part of a denture that makes contact with soft tissue and retains the artificial teeth.

**Direct restoration**: a restoration fabricated inside the mouth.

**Edentulous**: without teeth.

**Electrosurgery**: is the surgery performed using an electric tip that quickly cuts away the excess tissue and controls the bleeding.

**Equilibration**: reshaping the occlusal surfaces of the teeth to create harmonious contact relationships between the upper and lower teeth; also known as occlusal adjustment.

**Fixed partial denture**: is a prosthetic replacement of one or more missing teeth cemented or attached to the abutment teeth or implant abutments adjacent to the space.

**Immediate denture**: is a prosthesis device constructed for placement immediately after removal of remaining natural teeth.

**Maryland Bridge**: fixed partial denture featuring conservative retainers which are resin bonded to abutments.

**Overdenture**: a removable prosthetic device that overlies and may be supported by retained tooth roots or implants.

**Partial denture**: usually refers to a prosthetic device that replaces missing teeth; this is typically used for patients that are partially edentulous.

**Pontic**: is an artificial tooth, or part of the dental appliance, that replaces a missing natural tooth.
Post: an elongated projection fitted and cemented within the prepared root canal, this is used to strengthen and retain restorative material and/or a crown restoration.

Precision attachment: interlocking device, one component of which is fixed to an abutment or abutments and the other is integrated into a fixed or removable prosthesis in order to stabilize and/or retain it.

Prosthesis: an artificial replacement of any part of the body.

Rebase: process of refitting a denture by replacing the base material.

Reline: process of resurfacing the tissue side of a denture with new base material.

Removable prosthesis: dental prosthesis designed to be removed and reinserted by the patient.

Stress breaker: the part of a tooth-borne and/or tissue-borne prosthesis designed to relieve the abutment teeth and their supporting tissues from harmful stress.

Study model: plaster or stone model of teeth and adjoining tissues; also referred to as diagnostic cast.

Veneer: a layer of tooth colored material usually made up of either porcelain, composite or acrylic resin that is attached to the surface of the tooth by direct fusion, cementation or mechanical retention. This type of restoration is placed in the facial surface of the tooth.

Wax pattern: a wax form that is the positive likeness of an object to be fabricated.
Dental Benefit Terms

The purpose behind dental insurance is to make dental care more accessible by reducing the patients out of pocket cost. Although dental insurance is intended to reduce the cost of care it typically will not cover all expenses incurred. We will explore common dental benefit terms so you are able to understand and communicate with both the insurance carriers and patients concerning their accounts receivable. We will use terms such as allowable charge, coordination of benefits and coinsurance to name a few.

Allowable charge: this is the maximum dollar amount allowed by the carrier; the patient’s benefit payment is based on this for each dental procedure. This will only apply to dentist’s that are considered “in-network” by the carrier.

Assignment of Benefits: authorizes an insurance carrier to send payment directly to the treating dentist for covered procedures performed on the patient.

Audit: an examination or exploration of dental records or accounts to check their accuracy. This is to make sure you are billing charges to the carrier appropriately.

Beneficiary: a person who receives benefits under a dental benefit contract.

Birthday Rule: coordination of benefits regulation stipulating that the primary payer of benefits for dependent children is determined by the parents’ date of birth. This rule checks the month and day only, whichever parent’s birth date falls first in the year is primary regardless of age. This applies when a patient has dual dental insurance. (i.e. Patient has coverage under their mother and father).

By report: a narrative description used to report a service.

Capitation: a capitation program is one in which a dentist or group contracts with the HMO or IPA to provide all or most of the dental services to patients covered under the plan in return for payment on a per-capita basis. For example, a dentist may have 200 plan participants assigned to his practice and receive $5.00 a month per patient however he may only treat 10 patients for that month.

Claim: a request for payment under a dental or medical benefit plan.

Claim Form: the form used to file for benefit payment under a dental plan. This is usually an ADA form however you may use a medical HCFA or CMS 1500 form for medical claims.

Coinsurance: this is the portion of monies due from the patient after their insurance has paid their portion of the claim. This is a cost share between the insurance and the patient, this fee is deemed by the insurance carrier depending on the patients plan.

Contract: a legally enforceable agreement between two or more individuals or entities. This is usually a contract between the insurance carrier and the dentist to participate in the dental plan.

Contract Dentist: a contracted provider who agrees to provide services for a specific insurance carrier under special terms and conditions, while utilizing financial reimbursement arrangements.
Coordination of benefits: the method of integrating benefits payable for the same patient under more than one plan. This may be between two dental carriers or a dental and a medical carrier. The amount paid for all sources should NEVER exceed 100% of the total charges.

Co-payment: a set fee by the insurance carrier that the patient must pay when being seen or treated by the dentist. This fee is usually between $5.00 to $60.00 per visit.

Coverage: Benefits available to an individual covered under a dental benefit plan

Covered Services: services for which payment is provided under the terms of the dental benefit contract. What the insurance carrier will pay for.

Current Dental Terminology (CDT): these are a list of codes and their descriptive terms published by the American Dental Association (ADA) ® for reporting dental services and procedures to dental plans and Medicaid.

Current Procedural Terminology (CPT): these are a list of codes and their descriptive terms developed by the American Medical Association (AMA) ® for reporting medical services and procedures to medical plans and Medicare.

Customary Fee: the fee level determined by the dental plan for specific dental procedures to establish a maximum benefit payable under a given plan for a specific procedure and area. The fee is usually determined by totaling the fees charged by all the dentists in a given area and then averaging the fee to come up with what should be customary.

Deductible: the amount owed by the patient before the insurance plan will assume any liability for payment of benefits. This is usually an annual fee and could range in price from $25.00 to $150.00.

Dental Health Maintenance Organization (DHMO): see Health Maintenance Organization.

Dependents: This usually includes the spouse and children of the dental subscriber who will be covered under the dental plan.

Direct Billing: a process in which the dentist bills a patient directly for his/her fees.

Direct reimbursement: a self-funded program in which the individual is reimbursed based on a percentage of dollars spent for dental care provided, and which allows beneficiaries to seek treatment from the dentist of their choice.

Discount Dental Plan: this is a dental plan that has a set discount for a patient usually 20% to 30% off the UCR fees.

Downcoding: a practice of third-party payers in which the benefit code has been changed to a less complex and/or lower cost procedure than was reported.

Eligibility Date: the date an individual and/or dependents become eligible for benefits under a dental benefit contract. Often referred to as the effective date.

Exclusions: dental services that are not covered under a dental plan.
Exclusive Provider Organization: also known as an EPO, this is a dental benefit plan that provides benefits only if care is rendered by institutional and professional providers with whom the plan contracts this is called an “in-network” provider.

Expiration Date: the date on which the dental benefit contract expires. Also known as the coverage termination date.

Explanation of benefits: a written statement to a beneficiary and/or dentist from the insurance carrier after a claim has been filed to indicate the benefit/charges covered or not covered under the plan. Also known as an EOB.

Family deductible: a deductible that is satisfied by combined expenses of all covered family members. For example, you may have an individual deductible of $25 and a family deductible of $75 regardless of the number of family members. You do not have to pay your individual deductible if the family deductible has been met.

Fee-for-Service: a method of paying dentists on a service-by-service rather than a salaried or capitated basis.

Fee Schedule: a list of the charges established or agreed to by a dentist for specific dental services.

Flexible Spending Account (FSA): employee reimbursed account primarily funded by the employee’s designated salary reductions. This fund may be used for any medical or dental expenses incurred. The card usually looks like a Visa or MasterCard and may be run through a credit card machine.

Health Maintenance Organization (HMO): a legal entity that accepts responsibility and financial risk for providing specified services to a defined population during a defined period of time at a fixed price.

Indemnity Plan: a dental plan where a third party payer provides payment usually in the full amount of the dentist fees.

Individual Practice Association (IPA): a legal entity organized and operated on behalf of individual participating dentists for the primary purpose of collectively entering into contracts to provide dental services to enrolled populations. These dentist’s may practice in their own offices or in a large group settings.

Insurer: an organization that bears the financial risk for the cost of defined services for a group of beneficiaries.

Insured: person covered by a dental plan or program.

International Classification of Diseases (ICD-9-CM): diagnostic codes designed for the classification of morbidity and mortality information. These codes define the diagnosis or problem of the patient.

Liability: an obligation for a specified amount or action.

Maximum allowable benefit (MAB): the maximum dollar amount a dental program will pay toward the cost of dental care over a specified period of time, usually a calendar year.
Non-duplication of benefits: when a subscriber is eligible for benefits under more than one insurance plan a non-duplication of benefits may occur. This means if the primary carrier pays any amount toward a covered procedure the secondary insurance carrier may not be liable for any cost incurred.

Overcoding: reporting a more complex and/or higher cost procedure than what was actually performed. See also up-coding.

Payer: this refers to the insurance carrier responsible for financing or reimbursing the cost of dental services.

Point of Service (POS): arrangement in which patients with a managed care or HMO dental plan have the option of using an “out-of-network” provider. The benefit to the patient is usually reduced.

Preauthorization: statement by a third-party payer indicating that proposed treatment will be covered under the terms of the benefit contract.

Precertification: confirmation by a third-party payer of a patient’s eligibility for coverage and coverage determinations under a dental benefit program.

Predetermination: submission of a treatment plan to the third-party payer for determination of benefits before treatment is begun.

Pre-existing condition: oral health condition which existed before a patient was enrolled in a dental plan.

Preferred Provider Organization (PPO): a formal agreement between an insurance carrier and a dentist to treat a specific patient population at a discounted rate. When a patient uses a PPO provider they receive a larger benefit than using a non PPO provider.

Prefiling of fees: The submission of a dentist fees to a carrier or third party payer for the purpose of establishing, in advance, the dentist’s usual and customary fees.

Pretreatment estimate: an estimate of benefits and allowable charges for treatment of covered services by an insurance carrier. This will usually include the allowable amount, the expected reimbursement from the insurance carrier and the expected amount owed by the patient.

Reimbursement: payment made by a third party to the patient or dentist on behalf of the patient for expenses incurred for a service covered by the dental plan.

Subscriber: the person, usually the employee, who represents the family unit in relation to the dental plan.

Third-Party payer (TPA): an organization other than the patient (first party) or health care provider (second party) involved in the financing of personal health services.

Unbundling of procedures: the separating of a dental procedure into component parts with each part having a charge so that the cumulative charge of the components is greater than the total charge to patients who are not beneficiaries of a dental plan.

Upcode: using a procedure code that reflects a higher intensity service than would normally be used for the services delivered.
Usual, Customary and Reasonable (UCR): the fees charged for a specific procedure set by the dentist and/or insurance company that are usual and customary in their area.

Waiting period: when a covered person becomes eligible for benefits. Most dental plans have a 3 to 12 month waiting period for Basic and Major services.
Facial Anatomy and the Tooth Numbering System

Facial Anatomy

There are 22 bones that make up the skull. The bones of the skull are grouped into two categories one group the neurocranium surrounds and protects the brain and there are a total of eight bones in this category. Some of the bones are single and some are paired meaning there are two; one on each side.

- The frontal bone forms the forehead (single)
- The parietal bones form most of the roof and upper sides of the skull (paired)
- Occipital bone forms the posterior floor and wall of the skull (single)
- Temporal bones form the sides and base of the skull (paired)
- Sphenoid bone forms part of the base of the skull and parts of the floor and sides of the orbit or bony socket that surrounds and protects the eyeball. (single)
- Ethmoid bone forms part of the nose, the orbit, and the floor of the skull (single)

The second category is the viscerocranium, or the bones of the face. Some of the bones are single and some are paired as with the neurocranium bones. There are fourteen bones that make up the face.

- mandible also known as the lower jaw is the only movable bone of the skull, it is attached to the skull at the temporomandibular joint (single)
- vomer bone forms the base for the nasal septum or the cartilage structure that divides the two nasal cavities (single)
- nasal bones form the upper part of the bridge of the nose (paired)
- lacrimal bones make up part of the orbit and inner angle of the eye (paired)
- zygomatic bones are also known as the cheekbone (paired)
- inferior nasal conchae are thin scroll like bones that form part of the interior of the nose (paired)
- palatine bones form part of the hard palate of the mouth and the floor of the nose (paired)
- maxillae also known as the maxillary bones form most of the upper jaw (paired)
Frontal View
Side View

temporal bone, squamos part
superior temporal line
inferior temporal line
parietal bone
squamosal suture
occipital bone
lambdoid suture
external acoustic meatus
mastoid process
condyle
zygomatic process
zygomatic bone
c coronal suture
frontal bone
temporal line
lacrimal bone
sphenoid bone
nasal spine
maxilla
ramus
mandible
**The Oral Cavity**

The oral cavity is made up of the lips also known as the labia, which form the anterior border of the mouth. The lips are formed both internally by the mucous membrane and externally by the skin. The vermilion border or the red free margins of the lips represent a zone of transition from skin to the red mucous membrane portion.

Then there is the frenum which is a narrow band of tissue that connects two structures. There are three types of frenum in the oral mucosa the first is the upper labial frenum, this connects the upper lip to the gingiva of the outer surface of the maxillary arch. The second is the lower labial frenum which connects the lower lip to the gingiva of the outer surface of the mandibular arch. The third and final is the lingual frenum which passes from the floor of the mouth to the midline of the undersurface of the tongue.

Then there are the cheeks which form the side walls of the oral cavity. The buccal (cheek) vestibule also known as the alveolar ridge is the area between the cheeks and the teeth.

After the cheeks are the oral mucosa, the entire oral cavity is lined with mucous membrane. The oral mucosa or lining covers the inside of the cheeks, vestibule lips, ventral surface of the tongue and soft palate.

The hard palate is next and serves as the roof of the mouth. It is the bony anterior or forward portion and separates the mouth from the nasal cavity.

The soft palate forms the flexible posterior or back portion of the palate.

The tongue which is attached only at the back or posterior end consists of a very flexible muscle. For billing purposes the tongue is broken up into the anterior two-thirds and posterior one-third.

There are three salivary glands. The parotid glands are the largest and are located just in front of and below each ear subcutaneously. The sublingual glands are the smallest and are located underneath the tongue on either side. Last is the submandibular gland which lies on the floor of the mouth and are equivalent to the size of a walnut.

See Figure 1.A
Diagram of Oral Cavity

Figure 1.A

Tooth Numbering System

In 1968 the ADA® (American Dental Association) adopted the use of the universal numbering system. To ensure accuracy and universal identification as well as increasing the speed of charting, dictation and
transcription a numbering system was developed and used in the charting and description of the teeth. This system is designed to uniquely identify permanent and primary dentition.

**Primary**

In this universal numbering system the primary or baby teeth are lettered using capital letters A through T starting with the upper right second primary molar and ending with the lower right second primary molar. There are a total of 20 primary teeth, the shedding or exfoliation of the primary teeth begins between the fifth and twelfth years of age. See Figure 2.A

**Permanent Detention**

In this universal numbering system the permanent or adult teeth are numbered 1 to 32, starting with the upper right third molar and working around to the upper left third molar. This gives you teeth 1 through
16 on the top and then dropping down to the lower left third molar with tooth number 17 and carrying it around to the lower right third molar ending at 32. There are typically 32 teeth in permanent dentition with eight teeth per quadrant. Each quadrant will consist of one central incisor, one lateral incisor, one cuspid, two premolars, and three molars. See Figure 2.B

**Designation of Teeth**

Teeth are designated by a two digit code as well. The first digit of the code indicates the quadrant and the second indicates the tooth in the quadrant.

First digit (quadrant) numbered clockwise from the upper right side
Permanent teeth – numbers 1 through 4
Primary teeth – numbers 5 through 8
Second digit (tooth) numbered from the medial line in a distal direction
Permanent teeth- numbers 1 to 8
Primary teeth – numbers 1 to 5

Examples
Permanent Dentition
12 upper right incisor
36 lower left 1st molar
Primary Dentition
53 upper right canine and/or cuspid
72 lower left incisor

Conclusion
Congratulations you have just completed Module 1 of the ISP. At this point you should be familiar with the following topics, Prefixes, Suffixes, Root Words, Common Dental Terminology, Dental Benefit terms, Facial anatomy and the tooth Numbering System.

TIP: Be sure you have studied adequately before attempting the practice exams

Next Steps
Complete the Module 1 practice exam at the following URL: http://www.adcaonline.org/pexams you will need to register yourself for the first exam, for assistance contact support@adcaonline.org. When you have completed the practice exam with a passing score you are ready to move on to Module 2.
MODULE 2:

Insurance Billing and Appeals

Objectives

After reading this module you should be able to:

• Identify the difference between Pre-authorizations, Pre-certifications, and Pre-determinations.
• Understand coordination of benefits and how it is utilized in the dental office.
• Understand how the birthday rule works.
• Understand the difference between an ADA form and CMS-1500 form.
• Understand how to read an insurance card.
• Understand the Health Insurance Portability and Accountability Act of 1996.
• Learn how to write an effective appeal letter.
• Learn how to make an effective patient collection call.
• How to properly fill out a specialty referral form.
Introduction
This module will teach you the basics of billing claims in a dental office setting. Even though this module is an introduction you will learn dental policy, how to read an insurance card and retrieve a patient’s dental benefits, learn how to fill out the ADA 2012 form, and the CMS 1500 form; along with learning how to construct an effective appeal letter.

Before we begin every dental coder should have their coding essentials. The following is a check list…

Order your current year CDT (Current Dental Terminology) manual. This is issued once per year and usually becomes available in October.

CPT (Current Procedural Terminology) manual. This usually becomes available no later than September for the following calendar year. Remember to also update your computer system with deleted, revised and new codes to be effective January 1st of that year.

ICD-9-CM codes are effective October 1st through September 30th per calendar year. Order yours in August/September. (There is no longer a 90-day grace period for code implementation).

ICD-10 codes will be released for use on October 1, 2014. CMS has said they will not delay ICD-10 from release and they are on track for the October release date.

For Dental and Medical Coding Books there are several vendors, consult your dental representative for best pricing or the following websites sell coding manuals: www.amazon.com, www.medicalcodingbooks.com, or www.optumcoding.com.

For any general dentistry questions or clarification visit www.ada.org or www.adcaonline.org.

For Dental Fee Schedules go to www.ndas.com

Always be prepared by having the most current tools available to you. Never use old coding books as medical and dental codes are updated yearly. Staying current will help you avoid any unnecessary delays or claim denials.
The Billing Process

An enormous number of claims are rejected every year; according to the National Health Insurer Report Card (NHIRC) years 2008-2013 the following denials/rejections were reported.

Metric 8 - Source of payer disclosed claim edits

Description: On what percentage of claim lines is the source of the disclosed claim edit applied by the payer based on one or more of the following: CPT, NCCI, CMS Publication 100-04, ASA Relative Value Guide or payer-specific edits?

<table>
<thead>
<tr>
<th>Metric</th>
<th>Aetna</th>
<th>Anthem</th>
<th>Cigna</th>
<th>HCSC</th>
<th>Humana</th>
<th>Regence</th>
<th>UHC</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT</td>
<td>3.20%</td>
<td>25.20%</td>
<td>27.60%</td>
<td>9.10%</td>
<td>4.90%</td>
<td>93.90%</td>
<td>4.90%</td>
<td>8.90%</td>
</tr>
<tr>
<td>ASA</td>
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<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>NCCI</td>
<td>4.90%</td>
<td>7.80%</td>
<td>7.90%</td>
<td>14.00%</td>
<td>4.40%</td>
<td>2.20%</td>
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</tr>
<tr>
<td>CMS</td>
<td>19.90%</td>
<td>37.70%</td>
<td>54.00%</td>
<td>51.20%</td>
<td>24.70%</td>
<td>3.80%</td>
<td>47.60%</td>
<td>35.10%</td>
</tr>
<tr>
<td>Payerspecific</td>
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<td>29.40%</td>
<td>10.50%</td>
<td>25.70%</td>
<td>66.00%</td>
<td>0.20%</td>
<td>40.90%</td>
<td>46.80%</td>
</tr>
</tbody>
</table>

The percentage of denial/rejections listed above is alarming and completely avoidable. Some of the most common causes for rejection include inaccurate demographics (address), incorrect diagnosis coding, charges not itemized correctly, incorrect dates, missing periodontal charting and missing provider (Treating Dentist) signature.

The reimbursement process is a sequence of interdependent steps that start with the dentist's service. The following is an outline of the sequence:

1. Collecting accurate and completed information from the patient at the initial visit before being seen. (Demographics, current insurance card, SSN, DOB, etc.)
2. The professional service. (What the doctor did)
3. The documentation of the service(s)
4. The coding of all reportable and billable services
5. The charge entry
6. Submission of the claim for reimbursement
7. Claim review or processing of the claim for payment
8. Payment to the provider or the request for additional information for the carrier to review the claim (i.e. need x-rays)

The dentist should be actively involved in all aspects of the coding process. The dental record is a legal document; it is the property of the dentist rendering services and must accurately describe the work.
performed on the patient at the time services were rendered. It is vital to document work completely, accurately, and legibly with the elements necessary to justify all selected codes to be billed. The rules of documentation are simple; if a service is not documented, it was not done and may not be billed; if a note is illegible, then it was not performed.

Dental billing professionals need to be provided with all of the necessary information to code for the services rendered. This information should include the following:

1. Patient demographics (New form should be filled out every year)
2. The services rendered and documented (What was done)
3. Correct date of service (For oral surgeons making hospital calls this is the date a consult was preformed not admission date to hospital)
4. Diagnosis for the service(s) rendered
5. Any special circumstances that may have occurred
6. The front office should be knowledgeable and current on all billing/coding guidelines set forth by your contracted carriers and Medicare/Medicaid.

**Pre-authorization, Pre-certification, Pre-determination & Coordination of Benefits**

**Authorization**

For certain treatments or visits a prior authorization for the service and approval for that service must be obtained from the payer. This is usually attached to a document which is used in connection with the billing to the payer. Either a numeric entry on the CMS-1500 or ADA 2012 claim form for electronic transmission or as a document attached to a paper claim when mailed to the carrier.

**Pre-certification or Pre-determination**

Many private insurance carriers and prepaid health plans require one or the other before they will approve certain hospital admissions, inpatient or outpatient surgeries and elective procedures. The carrier can refuse to pay part of or the entire fee if this requirement is not met.

**Pre-certification**

Means: Discovering if treatment (surgery, hospitalization, tests) is covered under a patient’s benefit plan.

**Pre-determination**

Means: Discovering the maximum dollar amount that the carrier will pay for primary surgery, consulting services, postoperative care and so on.
Pre-authorization

Relates not only to whether a service or procedure is covered but also to finding out whether it is medically necessary.

Coordination of Benefits

Coordination of Benefits – is a process that occurs when two or more group plans provide coverage on the same person. Coordination between two plans is necessary to allow for payment of 100% of the allowed expenses, without allowing the member to make money over and above the total cost of care.

Primary benefit plan determines and pays its normal benefits first without regard to the existence of any other coverage.

Secondary plan pays after the primary plan has paid its benefits. The benefits of the secondary plan take into consideration the benefits and payment of the primary plan and reduces its payment so that only 100% of allowed expenses are paid.

Order of Benefit Determination

These are the 13 rules that determine the order of payment: “Order of Benefit Determination” (OBD).

1. The plan WITHOUT a COB (coordination of benefits) provision will be primary to a plan WITH a COB provision.

2. The plan that does not have these OBD rules and as a result, the plans do not agree on the OBD, will determine the order of payment.

3. The plan that covers a person as an employee will be primary to a plan that covers that person as a dependent.

4. If a person is an employee under two plans, the primary plan is defined as the one that has been in effect the longest.

5. If an employee is an active employee under one plan and a retiree (or lay off) under another, the active plan will pay as primary.

   The parent birthday rule, explained in rules 6 and 7, affects the OBD for dependent children of parents who are living together and married. (Except in the states of GA, HI, ID, VA, MS, VT, and Washington DC, they do not have birthday laws.)

6. The plan of the parent whose birthday (based on month and day only) occurs first in the calendar year is the primary plan.
7. When both parents’ birthdays are the same date (based on month and day) the benefits of the plan that covered one parent the longest is the primary plan.

For dependents of legally separated or divorced parents and those parents have remarried, the OBD will be based on the following rules:

8. If there is a court-approved divorce decree, the plan of the parent specified as having legal responsibility for the health care expense of the child is the primary plan.

9. The plan of the parent with custody is primary.

10. The plan of the step-parent with whom the child resides is secondary.

11. The plan of the natural parent without custody is tertiary.

12. The step-parent (if any) who does not reside with the child has no legal right to declare dependency of the child and therefore, no coordination should be performed, since the child is (probably) not an eligible dependent under the plan.

13. For joint custody, with no additional responsibility designation, the plan of the parent whose coverage has been in effect the longest would be the primary payer.

Birthday Rule

Birthday Rule – is in conjunction with whose insurance is primary on the children when both parents are employed and both parents have family insurance coverage through their employer group health plans.

Prior to the 1980’s the male/father was always considered prime insured on the family’s children. But during the 1980’s with so many husbands and wives working to pursue the American dream and the insurance carriers always looking to reduce their own liability the “Birthday Rule” was born.

HOW IT WORKS…
Both husband and wife must be employed

Both husband and wife must carry family insurance coverage through their employers’ group health plan

The parent whose birthday falls first in a calendar year is the primary coverage. The birthday rule is only looking at the month and day (year of birth is excluded). If both parents are born in the same month you must then use the day of birth. Always use the parent whose birth date falls 1st in the year as PRIME.
Example:
Jim and Sara are married and have two 2 children both Jim and Sara are employed and have group insurance with family coverage. Jim's birthday is 1/21 and Sara’s birthday is 11/6

Whose coverage will be primary on their children?
In this scenario Jim’s insurance coverage will be primary on himself and the two children, and Sara’s insurance will be primary on her and secondary on Jim and the kids

Why?
Look at both Jim and Sara's birthdates. January falls first in the year and November is the next to the last month of the year.

Exceptions to the Rule

• Same birthdays. If both parents happen to have the same birthday, the plan that has covered a parent longer pays first.

• The Employee Retirement Income Security Act of 1974 (ERISA), designates that the birthday rule can be applied to determine which plan is the primary health plan for the children of working parents, according to the child support guidelines from the Center for Policy Research. While the parent whose birthday comes first is still the primary insurance plan, the birthday rule does not apply to children whose parents have divorced, or are members of a blended family. A court order about children's health coverage after a divorce supersedes the birthday rule. If children live with a custodial parent and step parent, the custodial parent provides the primary insurance plan, regardless of whether the step parent's birthday comes first. Divorce or separation. When two or more plans cover your children as dependents when you're divorced or separated, the plan of the parent who has custody pays first. The plan of the new spouse of the parent with custody pays second. And finally, the plan of the parent who doesn’t have custody pays last.

• Active employees. If you are currently employed and have health insurance through your employer, and your spouse has coverage through a former employer (such as COBRA), and your children are listed as dependents on both plans, your plan is primary.

• Group health and individual health plans. If you and your ex-spouse have different types of health plans, the rules are also different. If you have a group health plan and your former spouse has an individual plan, the group plan pays first, regardless of the birthday rule.
**Claim Forms**

During the normal course of billing there are three different claim forms that may be used in a dental office. The first one is called an encounter form and is used for DHMO plans. These forms are pre-made by the individual carrier and used to report procedures performed on patients rather than using a standard ADA 2012 form. These forms request particular information needed to process a claim. For example, you will notice there is an area marked office number for the dental office number that is assigned to your practice. There are also special procedures that an office may get additional money from the carrier. These are called “carve outs”. Typically, an office that is capitated will receive additional money from both the patient and the carrier for difficult or expensive procedures such as crowns and bridges. See the figure 3.A below; this encounter form is from Delta Dental DHMO.

There are several carriers that offer HMO plans, listed are the most commonly accepted plans:

- **Aetna DHMO** - Providers contact 800-451-7715
- **Cigna DHMO** – Providers contact 800-882-4462
- **United Concordia DHMO** - Providers contact 866-357-3304
<table>
<thead>
<tr>
<th>PROD. CODE</th>
<th>SERVICE</th>
<th>TOOTH NO.</th>
<th>CHARGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>19105</td>
<td>Periodontal Exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19110</td>
<td>Limited Oral Exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19150</td>
<td>Comprehensive Oral Exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19160</td>
<td>Detailed Ext Oral Exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19170</td>
<td>Re-eval - Lab Prod Focused</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19190</td>
<td>Comprehensive Perio Eval</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19210</td>
<td>Extal Bar Cover, Series</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19220</td>
<td>Intral Arch Periurgical 1st</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19230</td>
<td>Intral Arch Para Ax Add</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19240</td>
<td>Intral Arch Distal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19270</td>
<td>Bellow - Single Film</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19272</td>
<td>Bellow Ngs - Two Films</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19277</td>
<td>Bellowings - Four Films</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19279</td>
<td>Vert Bellowings - 7 to 8 Films</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19300</td>
<td>Perio Panoramic XRay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19306</td>
<td>Pulm X Ray</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19310</td>
<td>010100-01099 PREVENTIVE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>193110</td>
<td>Prop /Flax, Child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>193120</td>
<td>Fluor. Inh. Pre Child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>193130</td>
<td>Tmt Age, Hair, Child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>193135</td>
<td>Oral Hygiene Instruct</td>
<td></td>
<td></td>
</tr>
<tr>
<td>193140</td>
<td>Sealant, Per Tooth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>193150</td>
<td>Scleras Maintainer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>193160</td>
<td>MEDICAL/DENTAL RESTORATIVE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>193165</td>
<td>Amalgam 1 Surf Perma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>193166</td>
<td>Amalgam 2 Surf Perma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>193167</td>
<td>Amalgam 3 Surf Perma</td>
<td></td>
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</tr>
<tr>
<td>193168</td>
<td>Amalgam 4 Surf Perma</td>
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<td></td>
</tr>
<tr>
<td>193200</td>
<td>Resin 1 Surf Anterior</td>
<td></td>
<td></td>
</tr>
<tr>
<td>193201</td>
<td>Resin 2 Surf Anterior</td>
<td></td>
<td></td>
</tr>
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<td>193202</td>
<td>Resin 3 Surf Anterior</td>
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<td>193203</td>
<td>Resin 4 Surf Anterior</td>
<td></td>
<td></td>
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<tr>
<td>193204</td>
<td>Resin 5 Surf Anterior</td>
<td></td>
<td></td>
</tr>
<tr>
<td>193300</td>
<td>MEDICAL/DENTAL RESTORATIVE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>193305</td>
<td>Crown/Resin Lab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>193306</td>
<td>Crown/Resin Lab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>193307</td>
<td>Crown/Resin Lab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>193308</td>
<td>Crown/Resin Lab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>193309</td>
<td>Crown/Resin Lab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>193310</td>
<td>Crown/Resin Lab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>193311</td>
<td>Crown/Resin Lab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>193312</td>
<td>Crown/Resin Lab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>193313</td>
<td>Crown/Resin Lab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>193314</td>
<td>Crown/Resin Lab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>193315</td>
<td>Crown/Resin Lab</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Patient Encounter Form**

**Delta Dental**

**Employee Name**

- (Last)
- (First)
- (M.I.)

**Employee Social Security Number**

- 
- 

**Group Number**

- 
- 

**Patient Name**

- (Last Name)
- (First Name)
- (Middle Initial)

**Send Form To:**

Delta Dental of Illinois
P.O. Box 3178 * Lisle, IL 60532
(800) 942-3772

**Relationship to Employee**

- Self
- Spouse
- Child

**Treatment Date:**

- 0
- 1
- 2

**Dental Provider Number:**

- 

**Dental Office Name:**

-
The next form used is called an ADA 2012 form. This should be used for all dental patients with a PPO, POS or indemnity plan. While some offices still use old and out dated ADA forms it is recommended that your office update to current forms for expedited claims processing. When claims are sent electronically they should always use current forms. The following table is a guideline of the ADA-2012 block numbers and Resources:

The ADA 2012 Form

<table>
<thead>
<tr>
<th>Block #</th>
<th>Description</th>
<th>Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Type of Transactions</td>
<td>Chart</td>
</tr>
<tr>
<td>2</td>
<td>Predetermination/Preauthorization Number</td>
<td>Insurance Company</td>
</tr>
</tbody>
</table>

**Insurance Company / Dental Benefit Plan Information**

| 3       | Company / Plan Name, Address, City, State, Zip Code    | Insurance Card               |

**Other Coverage**

| 4       | Other Dental or Medical Coverage                       | Patient's Registration Form, Chart, Insurance Card |
| 5       | Name of Policyholder / Subscriber in # 4               | Patient’s Registration Form   |
| 6       | Date of Birth                                          | Patient’s Registration Form   |
| 7       | Gender                                                 | Patient’s Registration Form   |
| 8       | Policyholder / Subscriber ID (SSN or ID)               | Patient’s Registration Form   |
| 9       | Plan / Group Number                                    | Patient’s Registration Form   |
| 10      | Patient’s Relationship to Person Named in # 5          | Patient’s Registration Form   |
### Policyholder / Subscriber Information

<table>
<thead>
<tr>
<th>No.</th>
<th>Field Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Policyholder / Subscriber Name, Demographics</td>
<td>Patient’s Registration Form, Chart</td>
</tr>
<tr>
<td>13</td>
<td>Date of Birth</td>
<td>Insurance Card</td>
</tr>
<tr>
<td>14</td>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Policyholder / Subscriber ID or SSN</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Plan / Group Number</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Employer Name</td>
<td></td>
</tr>
</tbody>
</table>

### Patient Information

<table>
<thead>
<tr>
<th>No.</th>
<th>Field Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>Relationship to Policyholder / Subscriber in #12</td>
<td>Patient Registration Form, Chart</td>
</tr>
<tr>
<td>19</td>
<td>Reserved for future use</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Name and Demographics</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Date of Birth (MM/DD/CCYY)</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Patient ID / Account # (Assigned by DDS)</td>
<td></td>
</tr>
</tbody>
</table>

### Record of Services Provided

<table>
<thead>
<tr>
<th>No.</th>
<th>Field Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>Procedure Date (MM/DD/CCYY)</td>
<td>Chart</td>
</tr>
<tr>
<td>25</td>
<td>Area of Oral Cavity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gingivectomy, perio scaling, alveoloplasty, denture repair</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Tooth System</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Tooth Number(s) or Letter(s)</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Tooth Surface</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Procedure Code</td>
<td></td>
</tr>
<tr>
<td>29a</td>
<td>Diagnosis pointer</td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>-------------------</td>
<td></td>
</tr>
<tr>
<td>29b</td>
<td>Quantity</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Fee</td>
<td></td>
</tr>
<tr>
<td>31a</td>
<td>Other Fee(s)</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Total Fee</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>Missing tooth information (Place an “X” on each missing tooth)</td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>Diagnosis Code List Qualifier (ICD-9 B, ICD-10 AB)</td>
<td></td>
</tr>
<tr>
<td>34a</td>
<td>Diagnosis Code(s)</td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>Remarks</td>
<td></td>
</tr>
</tbody>
</table>

**Authorizations**

| 36  | Patient / Guardian Signature and Date |
| 37  | Subscriber Signature and Date         |

**Ancillary Claim / Treatment Information**

<p>| 38  | Place of Treatment                   |
| 39  | Number of Enclosures                 |
|     | Radiograph(s), oral Image(s), Model(s) |
| 40  | Is Treatment for Orthodontist        |
| 41  | Date Appliance Placed                |
| 42  | Months of Treatment Remaining        |
| 43  | Replacement of Prosthesis            |
| 44  | Date Prior Placement                 |
| 45  | Treatment Resulting from (check applicable box) |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>46</td>
<td>Date of Accident</td>
</tr>
<tr>
<td>47</td>
<td>Auto Accident State</td>
</tr>
</tbody>
</table>

**Billing Dentist or Dental Entity**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>48</td>
<td>Name, Address, City, State, Zip Code</td>
</tr>
<tr>
<td>49</td>
<td>NPI</td>
</tr>
<tr>
<td>50</td>
<td>License Number</td>
</tr>
<tr>
<td>51</td>
<td>SSN or TIN</td>
</tr>
<tr>
<td>52</td>
<td>Phone Number</td>
</tr>
<tr>
<td>52a</td>
<td>Additional Provider ID</td>
</tr>
</tbody>
</table>

**Treating Dentist And Treatment Location Information**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>53</td>
<td>Dentist’s Signature Block</td>
</tr>
<tr>
<td>54</td>
<td>NPI</td>
</tr>
<tr>
<td>55</td>
<td>License Number</td>
</tr>
<tr>
<td>56</td>
<td>Address, City, State, Zip Code</td>
</tr>
<tr>
<td>56a</td>
<td>Provider Specialty Code</td>
</tr>
<tr>
<td>57</td>
<td>Phone Number</td>
</tr>
<tr>
<td>58</td>
<td>Additional Provider ID</td>
</tr>
</tbody>
</table>

The form below is an actual ADA 2012 Form.

Note: The highlighted areas are important changes that have been made to the form.
### ADA Dental Claim Form

**HEADER INFORMATION**

1. Type of Transaction (Mark all applicable boxes)
   - Statement of Actual Services
   - Request for Predetermination/Preauthorization

2. Predetermination/Preauthorization Number

**INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION**

3. Company/Plan Name, Address, City, State, Zip Code

**OTHER COVERAGE** (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental
5. Medicare
6. Other

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/YYYY)
7. Gender

8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Relationship to Person named in #5

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

**RECORD OF SERVICES PROVIDED**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(MM/DD/YYYY)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
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<td>2</td>
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<td>3</td>
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<td>4</td>
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<td>5</td>
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<td>6</td>
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</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**AUTHORIZATIONS**

56. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or if the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X

Patient/Provider Signature

Date

57. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity:

X

Subscriber Signature

Date

**BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

**ANCILLARY CLAIM/TREATMENT INFORMATION**

26. Place of Treatment
   - E.g., Office, Hospital, Dental Clinic

39. Enclosures (Y or N)

**TREATING DENTIST AND TREATMENT LOCATION INFORMATION**

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X

Signed (Treating Dentist)

Date

54. NPI
55. License Number
56. Address, City, State, Zip Code
57. Provider ID
58. Speciality Code

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J4300 (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)
The third and final form you may need to use is called the CMS1500 form. This is the standard form sent to medical carriers. Not all dental software is capable of printing or creating CMS1500 forms. If this is the case with your office you will have to type in the information or have the office purchase a program called HCFA1500 fill & print. The software will allow you to fill in the necessary information and print a form and it will not interfere with your current dental software.

The following table is a guideline of the CMS-1500 (HCFA) block numbers and Resources:

The CMS-1500 (HCFA) Form

<table>
<thead>
<tr>
<th>Block #</th>
<th>Description</th>
<th>Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 1a</td>
<td>Insurance Type and Patients ID Number</td>
<td>ID card</td>
</tr>
<tr>
<td>2, 3, 5, 6</td>
<td>Patient’s name, DOB, address, telephone number</td>
<td>Patient’s Registration Form, Chart</td>
</tr>
<tr>
<td></td>
<td>And relationship to insured</td>
<td></td>
</tr>
<tr>
<td>4, 7</td>
<td>Policyholder / Subscriber name and address</td>
<td>Patient’s Registration Form, Chart</td>
</tr>
<tr>
<td>8</td>
<td>Patient’s status (Single/Married, Employed/ Student)</td>
<td>Patient’s Registration Form, Chart</td>
</tr>
<tr>
<td>9, 9a-d</td>
<td>Other insured’s name and information – policies that supplement the primary carrier.</td>
<td>Patient’s Registration Form, Chart</td>
</tr>
<tr>
<td>10a-c</td>
<td>Patient’s condition related to care</td>
<td>Chart</td>
</tr>
<tr>
<td>11, 11a-d</td>
<td>Primary Insurance Carrier Information</td>
<td>Patient’s Registration Form, Chart</td>
</tr>
<tr>
<td>12</td>
<td>Release of information: signed by insured or patient. To release the information regarding the patient’s condition.</td>
<td>Authorization of Benefit Form</td>
</tr>
<tr>
<td>13</td>
<td>Authorization of payment. If signed by insured/patient the provider receives benefits directly from the carrier. If unsigned the benefits go to the insured. (May included “signature on file”)</td>
<td>Authorization of Benefit Form</td>
</tr>
<tr>
<td>14</td>
<td>Date of current illness (first symptom date), injury (accident date), or pregnancy (LMP).</td>
<td>Chart</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Source</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>15</td>
<td>First date of same or similar illness</td>
<td>Chart</td>
</tr>
<tr>
<td>16</td>
<td>Dates patient was unable to work</td>
<td>Chart</td>
</tr>
<tr>
<td>17, 17a, 17b</td>
<td>Referring physician, UPIN number (universal provider identification number) and NPI</td>
<td>Chart, Consultant Treatment form, Managed Care PreAuthorization Form</td>
</tr>
<tr>
<td>18</td>
<td>Hospitalization dates</td>
<td>Chart</td>
</tr>
<tr>
<td>19</td>
<td>Reserved for local carriers’ specified information</td>
<td>Insurance Manual</td>
</tr>
<tr>
<td>20</td>
<td>Usage of outside lab</td>
<td>Chart, Ledger</td>
</tr>
<tr>
<td>21</td>
<td>ICD-9-CM diagnosis codes (1, 2, 3, 4 items)</td>
<td>Chart &amp; ICD-9-CM Coding Book</td>
</tr>
<tr>
<td>22</td>
<td>Only used on Medicaid claims</td>
<td>Medicaid Manual</td>
</tr>
<tr>
<td>23</td>
<td>Prior Authorization number</td>
<td>Contact Carrier</td>
</tr>
</tbody>
</table>

**Claim Information**

| 24a-g | Services rendered – One procedure per line, maximum of six lines per claim form | Chart, Superbill, Ledger, Coding Book |
| 24a   | Date of service                                                               |                                             |
| 24b   | Place of service                                                              |                                             |
| 24c   | Type of service code                                                          |                                             |
| 24d   | CPT and/or HCPCS code and modifiers if applicable                             |                                             |
| 24e   | Diagnosis code (relate to box 21, item 1, 2, 3, 4)                            |                                             |
| 24f   | Charge of the service                                                         |                                             |
| 24g   | Number of times the service was rendered                                      |                                             |
| 24h   | EPSDT Family Planning                                                         |                                             |
| 24i   | Check if hospital medical emergency existed                                   | Chart, Superbill, Ledger, Coding Book      |
| 24j   | Provider ID Number or NPI                                                     | Doctor Information                         |
### Provider Information and Claim Totals

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>Employer’s Federal Tax ID number (EIN) or Social Security Number</td>
<td>Doctor Information</td>
</tr>
<tr>
<td>26</td>
<td>Patient’s account number</td>
<td>Chart, Ledger</td>
</tr>
<tr>
<td>27</td>
<td>Accept Assignment</td>
<td>Doctor Information</td>
</tr>
<tr>
<td>28, 29, 30</td>
<td>Total charge, Amount paid, balance due</td>
<td>Ledger</td>
</tr>
<tr>
<td>31</td>
<td>Signature of physician and date (&quot;signature on file&quot; is also acceptable)</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Name and address of outside facility used other than home or office</td>
<td>Chart, Ledger</td>
</tr>
<tr>
<td>32a</td>
<td>NPI of the service facility</td>
<td>Facility Information</td>
</tr>
<tr>
<td>32b</td>
<td>ID Qualifier of the service facility</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>Provider’s billing name, complete address, and phone number</td>
<td>Doctor Information</td>
</tr>
<tr>
<td>33a</td>
<td>NPI of the billing provider or group</td>
<td></td>
</tr>
<tr>
<td>33b</td>
<td>PIN of the billing provider or group</td>
<td></td>
</tr>
</tbody>
</table>

Below is a CMS1500 form.
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 06/05

<table>
<thead>
<tr>
<th>1. MEDICARE</th>
<th>MEDICAID</th>
<th>TRICARE</th>
<th>CHAMPVA</th>
<th>GROUP HEALTH PLAN</th>
<th>HMO</th>
<th>FECA ELIG. MISC.</th>
<th>OTHER INSURED</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Medicare #)</td>
<td>(Medicaid #)</td>
<td>(Sponsor’s SSN)</td>
<td>(Member ID)</td>
<td>(SSN or ID)</td>
<td>(Member ID)</td>
<td>(SSN)</td>
<td>(ID)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. PATIENT’S NAME</th>
<th>SUPERVISOR’S NAME</th>
<th>EMPIRICAL DESCRIPTION OF DISEASE OR INJURY</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Last Name, First Name, Middle Initial)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. PATIENT’S BIRTH DATE</th>
<th>SEX</th>
<th>4. INSURED’S NAME</th>
<th>(Last Name, First Name, Middle Initial)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM DD YY</td>
<td>M F</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. PATIENT’S ADDRESS</th>
<th>SEX</th>
<th>6. PATIENT’S ADDRESS</th>
<th>SEX</th>
</tr>
</thead>
<tbody>
<tr>
<td>(No., Street)</td>
<td></td>
<td>(No., Street)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. INSURED’S ADDRESS</th>
<th>SEX</th>
<th>8. INSURED’S ADDRESS</th>
<th>SEX</th>
</tr>
</thead>
<tbody>
<tr>
<td>(No., Street)</td>
<td></td>
<td>(No., Street)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9. OTHER INSURED’S NAME</th>
<th>INSURED’S DATE OF BIRTH</th>
<th>10. OTHER INSURED’S NAME</th>
<th>INSURED’S DATE OF BIRTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Last Name, First Name, Middle Initial)</td>
<td>MM DD YY</td>
<td>(Last Name, First Name, Middle Initial)</td>
<td>MM DD YY</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11. INSURED’S POLICY GROUP OR PPO NUMBER</th>
<th>12. INSURED’S POLICY GROUP OR PPO NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>13. INSURED’S OR AUTHORIZED PERSON’S SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>(I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>14. DATE OF CURRENT ILLNESS</th>
<th>ILLNESS (First symptom) OR INJURY (Acute or Chronic)</th>
<th>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM DD YY</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>16. DATES PATIENT Unable TO WORK IN CURRENT OCCUPATION</th>
<th>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>FROM MM DD YY TO MM DD YY</td>
<td>NPI</td>
</tr>
</tbody>
</table>

| 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | |
|-------------------------------------------------------| |
| FROM MM DD YY TO MM DD YY | |

<table>
<thead>
<tr>
<th>19. RESERVED FOR LOCAL USE</th>
<th>20. OUTSIDE LAB $ CHARGES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES</td>
</tr>
</tbody>
</table>

| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY | |
|---------------------------------------------| |
| (Include items 1, 2, 3, 4 to item 24 by Line) | |

<table>
<thead>
<tr>
<th>22. MEDICAID RESUBMISSION CODE</th>
<th>23. PRIOR AUTHORIZATION NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>24. DATE(S) OF SERVICE</th>
<th>PROCEDURE(S) OR SUPPLIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM DD YY</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>25. FEDERAL TAX ID NUMBER</th>
<th>26. PATIENT’S ACCOUNT NO.</th>
<th>27. ACCEPT ASSIGNMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSN SSN</td>
<td></td>
<td>(For gov. only, use back)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>28. TOTAL CHARGE</th>
<th>29. AMOUNT PAID</th>
<th>30. BALANCE DUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>31. SIGNATURE OF PHYSICIAN OR SUPPLIER</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Including degrees and credentials)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>32. SERVICE FACILITY LOCATION INFORMATION</th>
<th>33. BILLING PROVIDER INFO &amp; PH.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NCCI Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)
Now that you know how to fill the forms out and submit them to the carrier you should know the most common causes of claim denials

The following is a list of the most common errors…

- PATIENT/SUBSCRIBER NAME OR ID NUMBER MISSING
- PATIENT’S GROUP NUMBER MISSING
- PHYSICIAN SIGNATURE MISSING ON PAPER CLAIMS
- DATE OBVIOUSLY INCORRECT ON CLAIM
- CHARGES NOT ITEMIZED
- PROCEDURE CODES MISSING OR INCORRECT
- FEE COLUMN IS BLANK
- CLAIM UNCLEAR AS TO WHO THE PATIENT WAS BEING TREATED
- DIAGNOSIS CODE MISSING ON MEDICAL CLAIMS
- DIAGNOSIS DOES NOT MATCH TREATMENT BEING DONE WHEN SUBMITTED TO THE MEDICAL CARRIER
- OTHER KNOWN CAUSES FOR REJECTION
- IMPROPER PRINTER ALIGNMENT OF THE ADA 2012 OR CMS1500 CLAIM FORM WHEN SENT VIA PAPER
- USE OF LOWER CASE LETTERS (SHOULD ALWAYS USE UPPER CASE WHEN SENDING CLAIMS BY PAPER THE OCR CANNOT DISTINGUISH IN LOWER CASE)
- INCORRECT PAYER ID NUMBER WHEN SUBMITTED ELECTRONICALLY
- RELATIONSHIP TO INSURED NOT SPECIFIED
- INCORRECT SUBSCRIBER NAME (USED NICKNAME OR MIDDLE NAME INSTEAD OF BIRTH NAME)
- INCORRECT OR MISSING DATE OF BIRTH

It is extremely important that your claim have all the information necessary for the insurance company to process what is called a “clean claim”. A clean claim is one that has all the information on the patient and subscriber as well as the correct dates of service, treatment performed and fee for service on the patient.
Now that you have knowledge and understanding of billing forms and basic knowledge of how the billing process works you need to learn office standard protocol. When we refer to office standard protocol we mean what we are allowed and not allowed to do with regards to patient rights.

We will start out with HIPAA. What is HIPAA?

**HIPAA is the acronym for the Health Insurance Portability and Accountability Act of 1996. The Centers for Medicare & Medicaid Services (CMS) is responsible for implementing various unrelated provisions of HIPAA, therefore HIPAA may mean different things to different people.**

On August 21, 1996 President Clinton signed into law the Health Insurance Portability and Accountability Act (HIPAA) also known as the Kennedy-Kassebaum Act, Public Law 104-191. This law impacts all areas of the health care industry and was designed to provide insurance portability, to improve the efficiency of health care by standardizing the exchange of administrative and financial data, and to protect the privacy, confidentiality and security of health care information.

HIPAA is comprised of two major legislative actions: Health Insurance Reform and Administrative Simplification. The Health Insurance Reform provisions have been in effect for some time and require implementation of certain practices by health plans and insurers regarding portability and continuity of health coverage. Administrative Simplification mandates standards for electronic data interchange (EDI) and code sets, seeks protections for the privacy and security of patient data and establishes uniform healthcare identifiers.

Does HIPAA apply to you and your practice?

YES, HIPAA applies to Healthcare Providers, Billing Agencies, Hospitals and Clearinghouses, to read more visit: [http://www.HIPAA.org](http://www.HIPAA.org)
HIPAA: Misunderstandings

1. Although HIPAA helps protect you and your family in many ways, you should understand what it does NOT do:
2. HIPAA does NOT require employers to offer or pay for health coverage for employees or family coverage for their spouses and dependents;
3. HIPAA does NOT guarantee health coverage for all workers;
4. HIPAA does NOT control the amount an insurer may charge for coverage;
5. HIPAA does NOT require group health plans to offer specific benefits;
6. HIPAA does NOT permit people to keep the same health coverage they had with their old job when they move to a new job;
7. HIPAA does NOT eliminate all use of pre-existing condition exclusions; and 8. HIPAA does NOT replace the State as the primary regulator of health insurance.

ASCA prohibits HHS from paying Medicare claims that are not submitted electronically after October 16, 2003. It further provides that the General Secretary must grant such a waiver if there is no method available for the submission of claims in electronic form or if the entity submitting the claim is a small provider of services or supplies.

Beneficiaries will also be able to continue to file paper claims if they need to file a claim on their own behalf. The Secretary may grant such a waiver in other circumstances.

To sum it up; HIPAA is a regulatory body governing the uniform billing of claims and your patient’s right to privacy. It should be common practice for your office to supply each patient with a copy of how your office has implemented HIPAA rules and guidelines. You should further have each patient sign a release of information and consent giving the office specific instructions on which phone numbers are ok to contact the patient and if a message may be left. Additionally, which family members are allowed to have information on the patient. Your office may create its own form or forms may be purchased through companies such as Medical Arts Press, Burkhart Dental, Henry Schein, and Patterson.

When calling a patient to confirm an appointment you should be very vague when leaving a message unless instructed otherwise by the patient. A standard message should go something like this…

Hello, this is Judy from Dr. Smith’s office calling to confirm your appointment with us on Friday at 12:00 noon, should you need to cancel or change your appointment please give our office a call at 888-5555555. Thank you

No information regarding the type of appointment should be given as this is a violation of the HIPAA patient privacy act.

Let’s move on to insurance carriers and obtaining your patient’s dental benefits. There are a few ways of obtaining dental benefits for your patient. The first way is using a software program called TROJAN; this
software allows you to pull up thousands of different plans simply by entering your patient’s information into the system. The TROJAN system will give you a complete breakdown of benefits for your patient. This system may be linked with several different software systems and is most popular on the Dentrix dental software system, for more information on TROJAN you may logon to www.trojanonline.com. The second way to obtain dental benefits is to log into the specific dental carriers website. For example, if your patient has delta dental you would log onto deltadental.com enter your office user name and password and once you are logged into the system you simply enter your patients information and his/her benefits will appear. The third and final way to obtain benefits is to simply call the carrier speak to a customer service representative and obtain benefits over the phone. This way is an extremely time consuming option and is not the preferred method of obtaining benefits and/or eligibility.

You should always check your patient’s eligibility on the day service is being rendered as well as checking their benefits prior to seeing the patient. This will ensure there are no surprise bills or unexpected payments. By doing this you will see positive cash flow to the practice with minimal hassle.

**How to read an insurance card**

It is extremely important you understand how to read an insurance card; this will help you determine if the patient has a dental HMO, PPO, Indemnity, or discounted dental plan. All dental cards are usually pretty similar and the most important thing to look for is the dental claims mailing address which is typically located on the back of the card at the bottom middle. Below is an actual copy of the back of an insurance card.

If you notice it tells you where to submit claims to this carrier and gives you the provider phone number for claims follow-up and benefit verification.
The front of the card will look like the following; however it will display the patient’s name, subscriber or Member ID, dental group number, plan or policy ID, and Payer ID for electronic claim submissions. The card below is a standard PPO dental card.

![UnitedHealthcare Dental Card](image)

One key indicator in determining whether or not the card is a dental card or a medical card is somewhere on the card will state Dental Identification or send dental claims to and list a claims mailing address.

Now that we know what a PPO dental card looks like let’s take a look at a standard DMO card. If you notice it clearly states in the upper middle of the card DMO. If your card does not state DMO, another indicator that it may be a DMO plan is there will be a PCD (Primary Care Dentist) assigned to the patient. You should note if your dental group is not listed on the card the patient may not be eligible to be seen in your office and may or may not need a referral.

![Aetna DMO Card](image)

The final type of insurance card you will see is called a discount dental card. This type of card is for patients that have enrolled in a discounted dental plan. We do not bill insurance for these types of plans they are considered a discounted fee for service. This means we have contracted to take a discounted rate from the patient at the time of service. You will have a fee schedule specifically for these patients and all monies are collected at the time of service as there is no insurance to bill.
We can recognize a PPO, DMO, and discounted dental card with ease but how do we determine if the card presented is Medical in nature. There are a couple of ways, the first way to tell is by looking at the front of the card and if it does not state DMO or Dental ID Card it is most likely medical.

Another way to tell is the bottom left of the card usually has co-pay amounts listed (see figure below) you will see 25 OV/35 SP OV/ 100 ER this is a good indicator that the card is a medical card and of no use to you unless you are performing a procedure that requires medical to be billed. Oral Surgeon’s offices are the only ones that should take a copy of both the medical and dental cards as routine a practice. The co-pay for an Oral Surgeon would fall under SP OV $35 as they are considered a specialist. The card below is an example of a Point-of-Service (POS) medical card.

The following card is an example of a medical Health Maintenance Organization (HMO) insurance card. We can tell this is an HMO card as it clearly states the words HMO at the top right of the card.
We need to be careful when taking medical insurance cards as most dental providers are not eligible to contract with medical carriers. If the card is a PPO or POS you may bill the carrier even though you are not contracted or “in-network” with the carrier. You will find the carrier will either pay for the procedure or apply it to the patient's deductible either way the patient wins.

Ok you've taken a copy and read your patient's insurance card checked your patient's eligibility and benefits and he/she has been seen by the dentist who states to you that the patient will require a crown on tooth number 4. Since you have obtained the patient benefits ahead of time you will now create a treatment plan for the patient. A treatment plan is a statement showing the patient that further care is needed and what the cost of that care will be. Most office's dental software will be able to generate a treatment plan by simply inputting the data into the required areas and hitting print. If your software is unable to do this you will need to create a treatment plan template by hand. Below is a sample treatment plan. Treatment plans should always include the UCR fee or billed amount, contracted or allowed amount, what the insurance is expected to pay and what the patient is liable for. You should always inform the patient this is “NOT A GUARANTEE” it is an estimate or best guess of what they will owe. Actual cost cannot be determined until a claim has been submitted and processed by the carrier.
## Treatment Plan

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Th</th>
<th>Billed Amount</th>
<th>Allowed Amount</th>
<th>Insurance Pays</th>
<th>Patient Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Removal - Completely Bony Impacted</td>
<td>1</td>
<td>378.00</td>
<td>226.00</td>
<td>203.40</td>
<td>22.60</td>
</tr>
<tr>
<td>Removal - Completely Bony Impacted</td>
<td>16</td>
<td>378.00</td>
<td>226.00</td>
<td>203.40</td>
<td>22.60</td>
</tr>
<tr>
<td>Removal - Completely Bony Impacted</td>
<td>17</td>
<td>378.00</td>
<td>226.00</td>
<td>203.40</td>
<td>22.60</td>
</tr>
<tr>
<td>Removal - Completely Bony Impacted</td>
<td>32</td>
<td>378.00</td>
<td>226.00</td>
<td>203.40</td>
<td>22.60</td>
</tr>
<tr>
<td>Intravenous Sedation, 1st 30 Min.</td>
<td></td>
<td>331.00</td>
<td>158.00</td>
<td>142.20</td>
<td>15.80</td>
</tr>
<tr>
<td>Intravenous Sedation, Addl 15 Min.</td>
<td></td>
<td>125.00</td>
<td>38.00</td>
<td>34.20</td>
<td>3.80</td>
</tr>
<tr>
<td>Intravenous Sedation, Addl 15 Min.</td>
<td></td>
<td>125.00</td>
<td>38.00</td>
<td>34.20</td>
<td>3.80</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>2093.00</strong></td>
<td><strong>1138.00</strong></td>
<td><strong>1024.20</strong></td>
<td><strong>113.80</strong></td>
</tr>
</tbody>
</table>

**Estimated Insurance Payment:** $1024.20

**Patient Portion - estimated out-of-pocket expense $113.80**

This portion is due at the time services are rendered unless other arrangements have been made prior to your scheduled appointment.

Please note, this is not a guarantee of benefits. Per your insurance company no guarantee can be made until the final claim for treatment has been received. This is an estimate of benefits provided by your insurance carrier, if you have any questions regarding this estimate of benefits please contact your insurance carrier at 1-877-638-3379.

**To schedule an appointment, please contact the main office at 555-555-5555.**

Signature: _________________________________
Appeals and denials

There are some general rules for dental providers for appealing your claims:

1. Most state laws require dental plans to have “fast, fair and cost effective grievance process.” Therefore you should look through your plan contract and provider manuals for specific appeal procedures to help speed up the process. Remember each plan is different and may require different procedures.

2. When making phone calls to insurance carriers and third party payers ALWAYS document the date, time and name of person you spoke with regarding the claim and whenever possible request a reference number for the call. It is always a good idea to become familiar with supervisors and managers. These people are the ones at the insurance carrier who have the capacity to get your claims paid or resolved.

3. Keep a close eye on your aging reports to identify the worst offenders. Most states require that a “clean claim” be processed within 30 to 60 days of receipt of the claim. For carriers that continually cause delays or nonpayment you may want to review your contract and decide if being an in-network provider is cost effective to the office.

4. Be prepared to write a formal appeal. Less than 5% of providers ever file a written appeal. Insurance carriers tend to get away with nonpayment because you let them. Use an appeal letter that is effective, factual and non-threatening. You should never threaten a carrier unless you are prepared to follow through with your threat.

5. Make sure to state on both the envelope and the letter that this is a written formal appeal. Include the patient’s name; date of service, amount in question, Document control number (DCN) located on the EOB and medical necessity for the denied treatment. Make your appeal short and to the point do not fill it with useless information.

6. Finally record the date of the appeal in your practice management system and flag it for followup. If possible store a copy of the appeal in the software for quick and easy access. All appeals should be kept in the patients file or alternative filing storage area for no less than 7 years.
Combating denials

You have sent in your claim and receive an EOB from the carrier stating that the claim cannot be paid until student status is verified for the patient. Now what? The most effective way to handle this situation is to contact the patient and have a three way call between the insurance company, the patient and you to ensure the information is received and the claim can be processed.

There may be times when your claim gets denied for what is called “Timely Filing.” This means the carrier is stating you did not send your claim for review in a timely fashion. Most carriers require the initial billing be sent in within 30 days of treatment otherwise it may be denied for “timely filing.” If you receive a denial for this reason and the initial claim was in fact sent in according to the carrier’s specific guidelines you will need to send a formal appeal. You will need to prove the claim was sent in prior to timely filing deadlines. If you send your claims electronically you will need to pull your electronic claims submission report, locate the patient and send a copy along with your appeal to the carrier. If the claim was initially sent by paper you will need to run the patient’s ledger or insurance claim report showing initial billing date and send that in with your appeal. Either of these reports will prove timely filing. On the next page is a sample letter that would be appropriate to send with your report.
[Current Date]

Attn: Director of Claims  
[Insurance Policy Carrier]  
[Insurance Policy Address]

Re:  
Patient: [Patient Name]  
Policy: [Insurance Policy Number]  
Insured: [Responsible Party Name]  
Treatment Dates: [Admission Date] - [Discharge Date]  
Amount: [Total Charges]

Dear Director of Claims,

This letter is to request immediate payment of the above referenced claim. According to your representative, this claim was not processed due to failure to meet the applicable timely claim filing requirement.

This claim was submitted within the timely filing limits set forth by your company, please see the attached claims submission verification report showing this claim was filed in a timely manner.

We appreciate your prompt processing of this claim. If you require further information or have any questions regarding this claim please contact our office at 555-555-5555.

Respectfully,

Patient Accounts Manager

On occasion you may find yourself receiving a denial for treatment on a patient due to no authorization or referral on file. In a case were the patient was treated due to an emergency and there was no time to obtain a referral or authorization the patient should sign an advance insurance waiver. This will allow you to collect from the patient and inform them the maximum they will owe if the carrier denies the claim. Below is an example of an appeal letter for this situation.

[Insurance Carrier]
Dear Appeals Coordinator:

This claim was denied due to “authorization not on file”. This patient was referred to us by [facility or doctor’s name], at the time the patient was seen in our office it was on an emergency basis and there was no time to obtain authorization. Notwithstanding, benefits for this claim have been denied. It is our understanding in emergency situations the patient does not require authorization to be seen.

We have attached operative notes to support the level of emergency.

We believe this claim has been denied in error and are asking for you to review the claim and pay accordingly.

If you have any questions please contact [your name] at [your phone number]

Thank you,

[You’re Name]
[Title]
[Dentist Name]
[Name of your Facility]
All appeal letters should be short and to the point. There is no need for a long letter. The only information needed for a good appeal letter is the following:

- Date letter is being sent
- Insurance Address (make sure you are using the appeals address not the claims mailing address; most carriers will have a separate address for appeals)
- Patient Name
- DCN (Document control number from EOB)
- Brief explanation of perceived billing error and correction that needs to be made
- Your contact name and number where you may be reached

Some carriers may have specific forms that they require you to fill out and send in. Make sure you check with the individual carrier you are sending an appeal to. Best way to do this is go to their website and type “appeal form” in the search box and see if anything comes up. If nothing comes up then create your own letter.

Now that you have looked at appeals let’s take a look at Collection and Aging reports.

What is an aging report? An aging report is the report which tells you how many outstanding or unpaid claims you may have. It is a running tab of money owed to the practice. A good aging report should have only 10% of the money beyond 30 days.

You will keep your aging report current by continually following up on claims. This means you will run your aging report at the end of every month and call on claims that are exceeding 21 days old. If you are sending claims electronically you can also stay on top of claim issues by running a submission verification report daily and correcting any problem claims you may see on the report.

Submission verification reports are invaluable to a practice. The report will give you the name of the patient, insurance company and amount billed. It will also tell you if the claim has been received by the insurance company for adjudication or processing. Furthermore it will tell you if the claim has been rejected and why. For example, if the claim was missing the subscriber’s group number you may see a rejection by the clearinghouse and it will state the exact reason. In this case you would see “missing group number” and you can correct your claim and resubmit it without waiting for a claim rejection or denial in the mail.
Rejection vs. Denial

What is the difference between a claim rejection and a claim denial? A claim rejection means the claim cannot be processed for whatever reason and must be corrected and resubmitted as a new claim. An example of this would be “subscriber ID number not found” this tells you your information on the claim is incorrect. If you receive this rejection you should pull the patients chart look at the insurance card and make sure you have entered the number correctly. If the number is entered correctly you will need to contact the patient and make sure the insurance information given was correct and has not changed. If the patient states everything is correct you should then have a three-way call between you, the patient and the carrier to correct the problem.

A claim denial means the claim has been processed through the insurance carrier and been denied for any number of reasons. The most common denial reasons are “Not a covered benefit”, “frequency limitation” and “missing x-rays.” If the claim comes back as being “not a covered benefit” or “frequency limitation” then the balance becomes the patient’s responsibility. However if it comes back denied requesting further information it is your job to supply the carrier with the requested information in a timely manner.

Patient Collections

It is very important for you to make sure to collect the patient’s portion prior to treatment. This will ensure strong cash flow into the practice. It is easier to have the patient pay for treatment before it is complete than it is to collect after the fact. However there will be times when a patient may set up a payment plan or may have left the office before paying, these things happen. In most instances simply send the patient a statement. This will usually solve the issue however there may be times when patients do not pay their bills and you may need to make a “collection call.”

When you must make a collection call there is some ground work that will need to be done prior to making that call. Remember these simple rules:

- Collection calls should be about helping and supporting the patient to be “responsible” about their account and money
- Consider that most people do want to pay what they owe, they may have questions regarding their bill or may be having financial difficulties (lost job, added expenses) and are simply unable to pay at this time
- Be yourself; have patience and understanding for their needs
- Never threaten anyone with collections. It just heats up the conversation and may cause anger or resentment with the patient. It is better to say; we may have to take further action.
- Try to work out a plan that is best for both the practice and the patient
Next you need to understand who you are speaking to. Who they are and what they mean to your practice may determine what you say or how you say it. For example, there are new patients, existing patients, nice patients and angry patients. Let’s break them up into categories:

Category 1 – the good patient

This would be an existing patient with a good pay history and generally cooperative.

Category 2 – the slow patient

This would be an existing patient who may be slow to pay but willing to work with you.

Category 3 – the problem patient

This may be a new or established patient who is generally uncooperative and unwilling to work with you no matter what you say or do. In some instances this patient should be dismissed from the practice.

Now that you have laid your ground work and are aware of the type of patient you are dealing with you may be better equipped to make your call.

This is an example of taking control of a call:

You:
Good afternoon Mr. Smith, how are you today?

Patient:
I am well thank you.

You:
The reason for my call today is I noticed your account is past due and I would like to make arrangements with you to get caught up. We accept Visa, MasterCard, and American Express. Which would you like to use today?

Patient:
Visa I guess.

You:
Great and what is the number on your card?

Patient:
Hold on while I get my card.
Now granted not all calls go this smoothly however if you take charge of the call rather than allowing the patient to take charge of the call you find yourself making greater progress collecting some money.

Here is an example of allowing the patient to take control of the call:

You:
Good afternoon Mr. Smith, how are you today?

Patient:
I am well thank you.

You:
The reason for my call is we noticed your account is past due and we wanted to make arrangements with you to get caught up.

Patient:
Well money is tight right now why don’t I get back to you.

By leaving the following sentence out; “We accept Visa, MasterCard, and American Express. Which would you like to use today?” You gave the patient control to put off paying his/her account. How you say something can make all the difference in the world.

There are currently companies that will pay off your patients balance with no recourse to the practice if your patient does not pay. If you are interested please visit Care Credit on the web www.carecredit.com or National Business Dynamics on the web www.nationalbusinessdynamics.com.

Practice making calls with your friends and come up with different scenarios so you are able to handle any type of call.

Being a great billing manager is always being “in the know.” You should become familiar with your patients and their needs as well as keeping on top of aging reports and patient accounts. Making sure there is always positive cash flow running through the office is a top priority.

**Conclusion**

Congratulations you have just completed Module 2 of the ISP. At this point you should be familiar with the following topics; Insurance billing and appeals, The Billing Process, Preauthorization, Precertification, Predetermination, Coordination of Benefits, Order of Benefit Determination, Birthday Rule, Claim Forms, HIPAA, How to read an insurance card, Appeals and denials, and Patient Collections.

**Next Steps**

Complete the Module 2 practice exam at the following URL: [http://www.adcaonline.org/pexams](http://www.adcaonline.org/pexams) when you have completed the practice exam with a passing score you are ready to move on to Module 3.
MODULE 3:

Dental Coding and Medical Crosswalks

Even though this module is an introduction you will most likely come across several dental and medical codes you have never seen before. For this reason, we suggest you have the following coding books available ICD-10-CM for Physicians, CPT, and CDT (all current year) to help assist you through this module.

Not all dental codes have a compatible medical code. We will discuss which codes have corresponding codes and which codes do not as well as what to do when there is no corresponding medical code. You will learn how to use and find ICD-10-CM Codes (Diagnosis), how to use and find CPT codes (Medical), and when to use them instead of CDT codes (Dental).

History of ICD Codes

Back in the 1700s, the first attempt at classifying diseases was made by a French physician, François Boissier de Sauvages de Lacroix, who wrote the first book on the subject ”Nosologia Methodica.” Many different physicians followed up on his process, upgrading it to better reflect diseases as more were discovered.

In 1853, at the first International Statistical Congress in Paris, it was agreed that there should be a uniform classification of diseases for the world to use. In 1855, the first standards for classification were introduced, and from that point on, there was an outline for how the coding process should work.

For the next 95 years, there were multiple revisions and changes to the code, but no universal agreement on the standards. Many countries developed their own coding system, although all used the bases that were already established in categorizing these diseases.

In 1938, Canada introduced a proposal for the listing of causes of diseases. The Fifth International Congress adopted the ruling although there was no formal action taken on it. By 1944, there was a provisional list of diseases and injuries, presented by the U.S. and the United Kingdom.

It wasn’t until 1948, just after the creation of the World Health Organization, that there was a committee put together to establish one revision to represent all countries. The idea was to put together not only a classification of causes of death, but also classifications of illnesses and injuries. This became known as the Sixth Revision of the International Lists. The committee created the "Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death" from the data, which was in two volumes. By the time of the 7th revision, in 1955, the name International Classification of Diseases had been adopted.
The 9th version of ICD came about in 1977. To date, it’s the last version that every country adopted at the same time. Incorporated into it were many of the category extensions of diseases and morbidities that several represented countries wanted for better clarity of what was occurring in their areas.

The next update for ICD was supposed to begin in 1985, following what had become a 10-year process for working on ICD codes. However, it was pushed back to 1989, and continuing delays kept it from coming out until 1995.

While most of the world has switched to ICD-10, the U.S. has remained on the current system because of billing and payment issues. In 1983, ICD-9 was introduced as being a critical part of medical billing by physicians and hospitals, and was further embedded by the passage of the Medicare Catastrophic Coverage Act.

That act was later repealed, but the payment process was already set, as other insurance companies adopted the same standards. At this point, the U.S. was expected to change over to the ICD-10 system by 2011, but the actual date has once again been postponed. The official implementation date given by CMS (Centers for Medicare and Medicaid Services) is October 1, 2015.

**How to Use the ICD-10-CM for Physicians**

The International Classification of Disease, Tenth Revision, Clinical Modification or (ICD-10-CM) classifies morbidity and mortality information for statistical purposes, as well as indexing hospital records by disease and operations, for data storage and retrieval. Diagnostic coding was developed for the following reasons:

- Tracking of disease and health outcomes
- Classification of causes of mortality (death rate)
- Medical Research
- Evaluation of hospital service utilization

The ICD-10-CM manuals are updated every year on October 1 and are valid through September 30th of the following year. There is no longer a 90-day grace period for code changes so it is very important to keep current manuals on hand.

Dentists are paid for procedures or dental services provided. However, each service should be supported by a diagnosis code from the ICD-10-CM manual for dental procedures and **MUST** be supported for procedures being sent to medical carriers. To show the carrier medical necessity or the reason for the procedure it is important to have the most specific diagnosis code available for the patient’s problem or condition.

The ICD-10-CM manual is divided into two sections the Index (Volume 2) which is known as your dictionary and in most manuals will be located in the front of the manual. The Tabular List (Volume 1) is located in the back of the book. The Index allows you to locate the diagnosis code by term, and then confirm the accuracy of the code in the Tabular List. Coders should ALWAYS use both the Index and the Tabular List when locating and assigning a diagnosis code. Reliance on only the Index may lead to errors in code assignment and less specificity with code selection.
Index or Volume 2

The index is organized in alphabetical order and is generally known as your dictionary for the ICD-10-CM coding manual. You may search the index by condition, anatomical site, disease, sign, or symptom. If searching by anatomical site, the manual may refer you to “see condition”.

The index also contains the index to diseases and injury, the neoplasm table, the table of drugs and chemicals and the index to external causes of injury. Your main terms will identify the disease or the condition and should be found in the clinical documentation if it is not found you will need to send the chart back to the provider for clarification and more detailed information.

Main terms are always in bold and start with an upper case letter. Such as Fracture, Erosion, Abrasion, and Periodontal Disease. These are examples of a main term you will find located in your index. Make sure to follow any cross references given such as “see also”, with or without”, “due to”, “code by site” etc. There are also modifier and sub terms which will be defined later these are usually located under the main term. ICD-10-CM unlike ICD-9-CM uses grey vertical lines to keep your eye on track. It further uses notes to help give additional direction. A non-essential modifier is literally a word that follows the main term it is always found in parenthesis and will give additional information for the main term. Essential modifiers are sub terms that modify the main term they are always listed below the main term in alphabetical order they are indented a few spaces to the right and are in regular type and start with a lower case letter.

Helpful Tips

- Never code by memory as ICD-10-CM codes are completely different than ICD-9-CM
- Never code by using only the index as you may find additional information in the tabular list
- Always make sure to follow your “includes” and “excludes” notes
- There may be up to 7 alphanumeric characters in a single code
- Always code to the highest level of specificity
- NEC (Not elsewhere classified), documentation is there however no specific code exists
- NOS (Not otherwise specified), documentation is lacking or not enough specific detail
  - This code should not be used routinely only when absolutely necessary

Neoplasm Codes

The Neoplasm table contains headings of Malignant, Benign, Uncertain Behavior, and Unspecified. Neoplasm codes are selected by anatomical site. When coding a neoplasm you should ask yourself the following questions:

- What is it?
- Where did it start?
You should note that cysts and lesions are not neoplasm’s and should not be coded as such. The following is a description of a neoplasm:

Benign: simply means it does not have the properties of invasion or metastasis (the transfer of disease from one spot or organ to another)

Malignant: refers to a tumor or mass that has properties of invasion or metastasis

Carcinoma in situ: means cancer confined to one site without attacking or invading neighboring tissues or organs

Primary: refers to the original site of a malignancy or neoplasm (where it started)

Secondary: refers to the site where the primary or original malignancy has spread

Uncertain Behavior: is a diagnosis that is rendered by the pathologist when the cellular activity observed is uncertain to its morphology (meaning the pathologist is unsure if it is malignant)

Unspecified: is a diagnosis used when a preliminary diagnostic workup is inconclusive, most commonly used when the decision comes back as a tumor.

**Tabular list or Volume 1**

The Tabular List gives you the code and instruction for the code it is divided into 21 chapters. These codes may be up to 7 digits with the first character always being alpha and the second digit is always being numeric with all other digits being a combination of either alpha or numeric. Prior to the decimal point that will show the category of the patient’s condition. The first three characters will always identify the chapter the code was taken from the next three characters will identify or further specify the etiology, anatomical site, and/or severity. The seventh character is new to ICD-10-CM it will give an extension for additional information for specific injuries.

The Tabular list has replaced E codes with Z codes. The new Z code is used to report injury and poisoning.

The letter X is a character used as a placeholder and allows for expansion. This letter is used to fill empty characters in codes that require full seven characters.

Code Structure for the Tabular List is as follows; the list is divided into 21 chapters that are a numerical listing of codes. Third characters are the main code or category and may be a primary code if no further specificity is required. The fourth character that follows the decimal point defines the site, etiology and/or manifestation. The fifth and sixth characters further specify your code and the seventh character identified status of care.

The fifth code character specifies laterality and is defined as follows
1 Right side
2 Left side
3 Bilateral
0 Unspecified
9 Unspecified

Seventh characters are used to identify status of care and are as follows:

A initial encounter
D subsequent encounter
S sequel

Punctuation – Brackets and/or Parentheses

Brackets enclose synonyms or give any alternative terminology that may be helpful in tying in documentation. This may also indicate manifestation codes found in the index. When a bracket is used it usually indicates you will need additional coding.

Parentheses will include nonessential modifiers or supplementary words. These are further explanation that will not impact whether you select or do not select a particular code.

Instructional notes

These notes appear immediately under the three-digit code title at the beginning of a chapter or a section. It gives clarification or further defines the content of the category.

Includes - simply means the following terms may be included or used in the code set

For example: J32 Chronic sinusitis
              [INCLUDES] sinus abscess
              sinus empyema
              sinus infection
              sinus suppuration

Excludes – May indicate that another code more fully describes a diagnosis or the terms following the word “exclude” are not classified to the code under which it is found.

For example: J32 Chronic sinusitis
              [EXCLUDES] acute sinusitis (J01.-)
ICD-10-CM Coding

With ICD-10 being implemented this year here are some additional things you should know.

The World Health Organization (WHO) is responsible for the publication of ICD-9-CM and ICD-10-CM codes. The official publication of ICD-10-CM is set to be released and implemented October 1, 2015.

The Department of Health and Human Services (HHS) has mandated the transition of ICD-10-CM codes for provider (dental and medical practices) and ICD-10-PCS for inpatient procedures be implemented for electronic health care transactions beginning October 1, 2015. This transition will affect all entities covered by the Health Insurance Portability and Accountability Act (HIPAA) this includes dental offices.

Why change?

The periodic revisions of ICD-9-CM mirror changes in the medical and dental field. The U.S. has been using ICD-9-CM since 1979, and it is not adequate enough to serve health care needs of the future. The content is no longer clinically accurate and has limited data about patients’ medical conditions and hospital inpatient procedures. Furthermore, the number of available codes is limited, and the coding structure is too restrictive. The U.S. is unable to directly compare morbidity data to state and national mortality data, mainly because mortality data has already transitioned to ICD-10 code sets. Most developed countries have already made the transition to ICD-10 code sets, leaving the U.S. to an old outdated system that cannot compare U.S. morbidity data at the international level.

ICD-10-CM/PCS code sets will enhance the quality of data for:

- Tracking public health conditions (complications, anatomical location)
- Improved data for epidemiological research (severity of illness, co-morbidities)
- Measuring outcomes and care provided to patients
- Making clinical decisions
- Identifying fraud and abuse
- Designing payment systems/processing claims

Code set differences

ICD-9-CM codes are very different than ICD-10-CM/PCS code sets:

- There are nearly 19 times as many procedure codes in ICD-10-PCS than in ICD-9-CM volume 3
- There are nearly 5 times as many diagnosis codes in ICD-10-CM than in ICD-9-CM
- ICD-10 has alphanumeric categories instead of numeric ones
- The order of some chapters have changed, some titles have been renamed, and conditions have been grouped differently
Key differences between ICD-9-CM and ICD-10-CM and ICD-10-PCS code sets.

**Benefits to Public Health**

Although the transition to ICD-10-CM/PCS codes sets will be a major change, there are significant advantages that the new coding system has over ICD-9-CM. Some noteworthy benefits include:

**Easier comparison of mortality and morbidity data**

As of October 1, 2015 the U.S. has transitioned to utilizing ICD-10-CM codes for morbidity and mortality data. This transition is in effect for all providers including dental providers.

**Improved quality of data**

- The greater level of detail in the new code sets includes laterality, severity, and complexity of disease conditions, which will enable more precise identification and tracking of specific conditions.
- Terminology and disease classification are now consistent with new technology and current clinical practice.

**What will the codes look like?**
ICD-9-CM Code | ICD-10-CM Code
--- | ---
520.6 Disturbances in tooth eruption Includes: embedded, impacted, natal, neonatal, prenatal, primary, premature shedding, late tooth eruption, obstructed tooth eruption, premature tooth eruption. | K00.6 Disturbences in tooth eruption K01.0 Embedded teeth K01.1 Impacted teeth
522.8 Radicular Cyst Includes: apical cyst, periapical cyst, radiculodental cyst, and residual radicular cyst. | K04.8 Radicular cyst
523.6 Accretions on teeth Includes: dental calculus, subgingival calculus, supragingival calculus, betel, materia alba, tartar, tobacco deposits. | K03.6 Deposits (accretions) on teeth
524.11 Maxillary asymmetry | M26.11 Maxillary asymmetry
520.1 Supernumerary teeth Includes: distomolar, fourth molar, mesidens, paramolar, and supplemental teeth. | K00.1 Supernumary teeth

There are several differences in the ICD-9-CM to ICD-10-CM coding system. If you notice our first code of 520.6 has been broken up into three different codes that may be utilized. The ICD-10-CM code set will be much more specific in nature and will not include several possible diagnosis as the ICD-9-CM code sets.

The codes listed above are based on the General Equivalency Mapping (GEM) files published by CMS and are not intended to be used as an ICD-10-CM conversion. This is just an overview of what ICD-10 code will look like.

Keep in mind that while many codes in ICD-9-CM map directly to codes in ICD-10, in some cases, a clinical analysis may be required to determine which code or codes should be selected for your mapping. Always review mapping results before applying them.

The ADCA will be offering ICD-10-CM courses specifically for dentistry starting August 1, 2016 for more information please visit our website under the CEU course tab.
Background and History of CPT Codes

The American Medical Association (AMA) created and published CPT codes in 1966. The first edition was used as a standard of terms and descriptors of documentation for procedures in a patient’s medical record or chart. This system was comprised of a four-digit coding system. The standard of set codes and descriptors helped communicate accurate information on services and procedures performed to assist in accurate payment from insurance carriers and third party payers. It further assisted in the development of software systems to report statistical data. The first edition was comprised primarily of surgical procedures with limited sections on medicine, radiology, and laboratory procedures.

The second edition was released in 1970 and offered a more expansive system of terms and codes to designate diagnostic and therapeutic procedures in surgery, medicine, and the specialties. This version switched from a four-digit coding system to a five-digit coding system along with adding a procedures relating to internal medicine.

In the mid to late 1970’s the third and fourth editions of CPT were released. The fourth edition was released in 1977 offering significant changes and updates in medical technology, and a system of periodic updating.

The Centers for Medicare and Medicaid Services (CMS) adopted and mandated the use of CPT for outpatient hospital surgical procedures in 1987 as part of the Omnibus Budget Reconciliation Act. Today in addition to use in federal CMS programs CPT is used extensively throughout the United States as the preferred system of coding and describing health care services.

In 2002 dental insurance companies started requiring certain dental procedures to be billed on a CMS1500 form to the medical carriers using both ICD-9-CM and CPT codes for payment prior to determining payment under the dental plan.

CPT codes are updated, revised, modified and deleted every year by the CPT editorial panel. The editorial panel is comprised of 17 members, 11 of the members are physicians nominated by the National Medical Specialty Societies and approve by the AMA Board of Trustees. The remaining 6 are members of the panel’s executive committee.

One physician is nominated from each of the following:

- The Blue Cross and Blue Shield Association
- America’s Health Insurance Plans
- American Hospital Association
- Centers for Medicare and Medicaid Services (CMS)
- CPT Health Care Professionals Advisory Committee

The Advisory Committee is limited to national medical specialty societies seated in the AMA House of Delegates and to the AMA Health Care Professionals Advisory Committee (HCPAC).

How to Use the CPT Coding Book
Introduction to CPT (Current Procedural Terminology)
The Current Procedural Terminology (CPT), fourth edition, is a set of codes, descriptions and guidelines intended to describe procedures and services performed by physicians and other health care providers. Each procedure is identified with a five digit code.

There are three categories listed in the CPT, category I is the main body and has six sections.

<table>
<thead>
<tr>
<th>Category</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation and Management (Exams)</td>
<td>99204-99499</td>
</tr>
<tr>
<td>Anesthesiology (Sedation)</td>
<td>00100-01999, 99100-99140</td>
</tr>
<tr>
<td>Surgery (Main procedures)</td>
<td>10021-69990</td>
</tr>
<tr>
<td>Radiology (X-Rays)</td>
<td>70010-79999</td>
</tr>
<tr>
<td>Pathology &amp; Laboratory</td>
<td>80048-89356</td>
</tr>
<tr>
<td>Medicine (Special services)</td>
<td>90281-99199, 99500-99602</td>
</tr>
</tbody>
</table>

Each section is divided into subsections with anatomic, procedural, condition and or descriptor subheadings.

Category II codes
The use of these codes is optional. The codes are not required for correct coding and may not be used as a substitute for category I codes. These are used to describe clinical components that may be typically included in evaluation and management services or clinical services and, therefore, do not have a relative value or dollar amount associated with them.

Category III codes
This section contains a set of temporary codes for emerging technology, services, and procedures.
Modifiers
A modifier is used when a procedure has been discontinued or altered by some specific circumstance but not changed in its definition or code. Modifiers may be used to indicate the following:

- A procedure had both a professional (physician/dentist) and technical (facility) component.
- A procedure was performed by more than one physician/dentist in more than one location
- A procedure was increased or reduced
- Only part of a service was preformed
- A bilateral procedure was preformed
- A procedure was provided more than once
- Unusual events occurred

For example, a RE-reduction of a facial fracture and or dislocation performed by the primary doctor such as the Oral Surgeon may be identified by the addition of the modifier 76 to the usual procedure number to indicate “Repeat Procedure by same physician/dentist”

Format of the Terminology
The CPT code sets are stand alone descriptions of medical or dental procedures. However, some of the procedures in the CPT book are not printed in their entirety but refer back to a common portion of the procedure listed in a preceding entry.

Example

40840 Vestibuloplasty; anterior

40842 posterior, unilateral
Note that the common part of code 40840 (the part before the semi colon) should be considered part of the code 40842. Therefore the full procedure represented by code 40842 should read:

40842 Vestibuloplasty; posterior, unilateral
Guidelines
At the beginning of each of the six sections you will find specific guidelines that define items that are necessary to appropriately interpret and report procedures and services contained in that section. For example, in the musculoskeletal section specific instructions are provided for closed and open treatment of fractures as well as manipulation of dislocations.

Unlisted Procedure or Service
There is always the possibility that a service or procedure may not be found in the CPT codebook. Therefore, a number of specific codes have been designated for reporting unlisted procedures. Each of these unlisted procedural codes is listed in each specific section of the book.

For example, there is no current CPT code for D7240 (Extraction of full bony impaction) instead you would use 41899 (unlisted procedure, dentoalveolar structures)

CPT Coding Review
Look for the main term in the Index. Each main term can stand alone, or be followed by up to three modifying terms. Main terms are identified in bold type and are the term that best describes the procedure.

There are four primary classes of main entries.

1. Procedure or service: For example: Antrostomy, Ankylosis or Arthrodesis
2. Organ or other anatomic site: For example: Salivary Gland, Teeth or Tongue
3. Condition: For Example: Abscess
4. Synonyms, Eponyms and Abbreviations: For Example: TMJ, Abbe-Estlander, Douglas type

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ANESTHESIA SERVICES

What is Anesthesia?
Anesthesia is the use of medicine to prevent the feeling of pain or another sensation during surgery or other procedures that might be painful (such as getting stitches or having a tooth removed). Given as an intravenous injection, intramuscular injection, orally, or through inhaled gasses or vapors, different types of anesthesia affect the nervous system in various ways by blocking nerve impulses and, therefore, pain.

Billing Guidelines for Anesthesia Services
Anesthesia services include, but are not limited to, general, regional, intravenous conscious sedation, and inhalation of nitrous oxide. Anesthesia service includes the following:

- The usual anesthesia preoperative and postoperative visits
- Administration of the anesthetic for the site of surgery
- Anesthesia care during the procedure
- Administration of fluids and/or blood replacement
- The usual monitoring services (e.g. ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry)

Physical status modifiers distinguish between various levels of complexity of the anesthesia service provided based on the patient’s condition, and are represented by the letter “P” followed by a single digit:

- P1: a normal healthy patient
- P2: a patient with mild systemic disease
- P3: a patient with severe systemic disease
- P4: a patient with severe systemic disease that is constant threat to life
- P5: a moribund patient who is not expected to survive without the operation
- P6: a declared brain-dead patient whose organs are being removed for donor purposes

How Anesthesia Services are Calculated
Anesthesia services are calculated based on the following criteria: difficulty of the procedure, time, and other modifying factors such as, health of the patient. Calculation anesthesia charges also include a cost specific to a particular location.

Generally the formula for calculating anesthesia charges looks like this:

\[(\text{Base units} + \text{Time units} + \text{Modifying units}) \times \text{Conversion factor} = \text{Anesthesia charge}\]

**Base units** = each anesthesia procedure has an assigned code and each code has a base unit value. The base unit value is reflective of the difficulty and skill required for the procedure. The higher the difficulty, the higher the base units will be. Base units are constant and do not change.
Time units = time units are calculated in 15 minute intervals. After an additional eight minutes of anesthesia, please round up to the next unit. For fewer than eight additional minutes, please round units down.

See Example:

- 30 minutes of anesthesia is equal to two units (30=15+15)
- 38 minutes of anesthesia is rounded up to three units (38=15+15+8)
- 37 minutes of anesthesia is rounded down to two units (37=15+15+7)

When submitting paper claims for anesthesia services make sure to indicate in box 19 of the CMS-1500 form the total time (in minutes) that anesthesia was administered.

Modifying Unit = a modifying unit accounts for special conditions that affect the anesthesia plan and procedure. Modifying factors may include a patient’s physical health or emergency situation.

Conversion Factor = this is the cost that has been assigned to each unit and are specific to the location of the anesthesia provider/administrator. This cost will vary across the United States.

Total Anesthesia Charge = once you have added the total number of units together it is multiplied by the conversion factor and the total anesthesia charge is calculated.

Anesthesia Time Reporting

Anesthesia time is for procedures are reported according to local state and carrier guidelines. Anesthesia time usually begins when the dentist or anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room (or an equivalent area) and ends when the dentist or anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under postoperative supervision.

CPT Codes used to Report Anesthesia

CPT codes used to report anesthesia services for dental procedures are 00100-00222

To report moderate (conscious) sedation provided by a doctor also performing the service for which conscious sedation is being provided use CPT codes 99143-99145

To report regional or general anesthesia provided by a doctor also performing the services for which the anesthesia is being provided see modifier 47 in Appendix A of the CPT manual.
CPT CODING EXERCISE 1

Find the following codes in the CPT Manual.

1. Biopsy of cheek
2. Gingivectomy
3. Dilation salivary duct
4. Extraction partial impaction
5. Alveoloplasty
6. I & D of cheek abscess
7. Palatal exostosis removal
8. Foreign body removal from gum tissue
9. Repair laceration to posterior of tongue
10. Frenulectomy
CPT CODING EXERCISE 1 – Answers

1. **48080**

   How was this code found?

   You would first look in the index of your CPT book under the main heading BIOPSY, from there you will find your sub heading MOUTH, this will give you a code range of 40808 & 41108. You would then look up code 40808 & 41108 to see which best fits your description. Since this is a biopsy of the cheek and the cheek is considered part of the vestibule of the mouth the most accurate code is 40808.

2. **41820**

   How was this code found?

   You would first look in the index of your CPT book under the main heading GINGIVECTOMY, this will give you the code 41820. You would then look up code 41820 to make sure this description of the code is accurate. You should note this code is billed out per quadrant as per the description of the code.

3. **42650**

   How was this code found?

   You would first look in the index of your CPT book under the main heading DILATION, from there you will find your sub heading SALIVARY DUCT, this will give you a code range of 42650-42660. You would then look up code 42650 as it is the first code in the code range. You would see that code 42650 is the correct code as it states dilation salivary duct, so you would not need to look any further.

4. **41899**

   How was this code found?

   You would first look in the index of your CPT book under the main heading UNLISTED SERVICES AND PROCEDURES, from there you will find your sub heading GUM, this will give you code 41899. You will then look at the code description and see it states unlisted procedure, dentoalveolar (pertaining to the tooth and tooth socket) structures.

5. **41874**

   How was this code found?

   You would first look in the index of your CPT book under the main heading ALVEOPLASTY, this will give you the code 41874. You would then look up code 41874 to make sure this description of the code is accurate. You should note this code is billed out per quadrant as per the description of the code.
6. 40800

How was this code found?

You would first look in the index of your CPT book under the main heading INCISION & DRAINAGE, from there you will find your sub heading MOUTH this will give you the code range of 40800-40801, 41005-41009, 41015-41018. You would then start by looking up the first code range of 40800-40801 to see what the description of the code states. Code 40800 states Drainage of abscess, cyst, hematoma, and vestibule of mouth simple. Since the cheek is part of the vestibule of the mouth we know 40800 is our code.

7. 21032

How was this code found?

You would first look in the index of your CPT book under the main heading EXCISION, from there you will find your sub heading MAXILLA, then you will go a step further and look for EXOSTOSIS this will give you the code 21032. You would then look up code 21032 to make sure this description of the code is accurate. Since this code does not state if it is unilateral or bilateral you would code this per side meaning you get both the right and left sides if you are doing the entire maxilla.

8. 41805

How was this code found?

You would first look in the index of your CPT book under the main heading GUMS, from there you will find your sub heading REMOVAL, then you will go one step further and find FOREIGN BODY this will give you the code 41805. You would then look up code 41805 to make sure this description of the code is accurate.

9. 41251

How was this code found?

You would first look in the index of your CPT book under the main heading REPAIR, from there you will find your sub heading TONGUE, then you will go one step further and look for LACERATION this will give you the code range of 41250-41252. You would then look up the code range starting with 41250 which states Repair of laceration 2.5 cm or less floor of mouth and/or anterior 2/3 rd of tongue, we know this is not our code because we are looking for the posterior area. So we would move on to 41251 which states posterior 1/3 we know this is our code because of the posterior aspect. No need to look further.

10. 40819

How was this code found?

You would first look in the index of your CPT book under the main heading FRENULECTOMY, this will give you the code 40819.
CPT CODING EXERCISE 2

Find the following codes in the CPT Manual.

1. Anesthesia 45 minutes for biopsy
   _______ unit’s ________

2. Dental implant (endosteal) tooth #3
   ______

3. Bone graft for single dental implant
   ______

4. Biopsy; floor of mouth
   ______

5. Incision & drainage of abscess intraoral in the submaxillary space
   ______

6. Uvulectomy
   ______

7. Maxillary impression for palatal prosthesis
   ______

8. Biopsy; upper lip
   ______

9. Bilateral posterior vestibuloplasty
   ______

10. Sialodochoplasty, simple repair
    ______
CPT CODING EXERCISE 2 – Answers

1. 00170 units 3

How was this code found?

You would first look in the index of your CPT book under the main heading ANESTHESIA, from there you would look up the sub heading MOUTH, this will give you the codes 00170 and 00172. You would then look up codes 00170 and 00172 and read the code description to make sure this description of the code is what you are looking for. We would then find that code 00170 is our correct code. The biopsy took 45 minutes so you would bill for 3 units.

2. 21248

How was this code found?

You would first look in the index of your CPT book under the main heading ENDOSTEAL IMPLANT, from there you would look up the sub heading RECONSTRUCTION, you would go one step further and look at MAXILLA this will give you the code range of 21248-21249. You would then look up code 21248 and read the code description to make sure this description of the code is what you are looking for. You will see code 21248 states endosteal implant and 21249 states complete. We would select 21248 because there is only one tooth involved.

3. 20900

How was this code found?

You would first look in the index of your CPT book under the main heading GRAFT, from there you would look up the sub heading BONE, you would go one step further and look at HARVESTING this will give you the code range of 20900-20902. You would then look up code 20900 and read the code description to make sure this description of the code is what you are looking for. You will see code 20900 states bone graft, any donor area, minor or small. Because we are only grafting one tooth space this would be the most appropriate code.

4. 41108

How was this code found?

You would first look in the index of your CPT book under the main heading BIOPSY, from there you would look up the sub heading MOUTH, this will give you the code range of 40808-41108. You would then start with the first code and read the code description to make sure this description of the code is what you are looking for. You will see code 41108 states biopsy of the floor of the mouth this would be the most appropriate code.
5. 42310

How was this code found?

You would first look in the index of your CPT book under the main heading INCISION & DRAINAGE, from there you would look up the sub heading ABSCESS, you would go one step further and look at SUBMAXILLARY this will give you the code range of 42310-42320. You would then look up code 42310 and read the code description to make sure this description of the code is what you are looking for. You will see code 42310 states drainage of abscess; submaxillary or sublingual, intraoral therefore this would be the most appropriate code.

6. 42140

How was this code found?

You would first look in the index of your CPT book under the main heading UVULECTOMY, this will give you the code 42140. You would then look up code 42140 and read the code description to make sure this description of the code is what you are looking for.

7. 42280

How was this code found?

You would first look in the index of your CPT book under the main heading PROSTHESIS, from there you would look up the sub heading PALATE, this will give you the code range of 42280-42281. You would then look up code 42280 and read the code description to make sure this description of the code is what you are looking for. You will see code 42280 states maxillary impression for palatal prosthesis. Since this is our code we do not need to look further.

8. 40490

How was this code found?

You would first look in the index of your CPT book under the main heading BIOPSY, from there you would look up the sub heading LIP, this will give you the code 40490. You would then look up code 40490 and read the code description to make sure this description of the code is what you are looking for. You will see code 40490 states biopsy of lip making this the most appropriate code.
9. 40843

How was this code found?

You would first look in the index of your CPT book under the main heading VESTIBULOPLASTY, this will give you the code range of 40840-40845. You would then look up the first code and read the code description to make sure this description of the code is what you are looking for. You will see code 40843 states Vestibuloplasty; posterior, bilateral this would be the most appropriate code.

10. 42500

How was this code found?

You would first look in the index of your CPT book under the main heading SIALOCHOPLASTY, this will give you the code range of 42500-42505. You would then look up the first code and read the code description to make sure this description of the code is what you are looking for. You will see code 42500 states Plastic repair of salivary duct, sialodochoplasty; primary or simple therefore this would be the most appropriate code.
How to Use the CDT Coding Book

Introduction to CDT (Current Dental Terminology)
The CDT codes are a five character alphanumeric code beginning with a capitol letter “D” to identify a specific dental procedure. Furthermore the codes are organized into twelve categories of service, each with its own series of codes listed below:

<table>
<thead>
<tr>
<th>Category of Service</th>
<th>Code Series</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic</td>
<td>D0100-D0999</td>
</tr>
<tr>
<td>Preventive</td>
<td>D1000-D1999</td>
</tr>
<tr>
<td>Restorative</td>
<td>D2000-D2999</td>
</tr>
<tr>
<td>Endodontics</td>
<td>D3000-D3999</td>
</tr>
<tr>
<td>Periodontics</td>
<td>D4000-D4999</td>
</tr>
<tr>
<td>Prosthodontics, removable</td>
<td>D5000-D5899</td>
</tr>
<tr>
<td>Maxillofacial Prosthetics</td>
<td>D5900-D5999</td>
</tr>
<tr>
<td>Implant Services</td>
<td>D6000-D6199</td>
</tr>
<tr>
<td>Prosthodontics, fixed</td>
<td>D6200-D6999</td>
</tr>
<tr>
<td>Oral and Maxillofacial Surgery</td>
<td>D7000-D7999</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>D8000-D8999</td>
</tr>
<tr>
<td>Adjunctive General Services</td>
<td>D9000-D9999</td>
</tr>
</tbody>
</table>

CDT Coding Review
The content found in the American Dental Associations CDT manual is mostly self explanatory, however, has completely changed from previous years. The CDT coding manual is published by the American Dental Association (ADA) and is updated and revised each year. The ADA’s council on Dental Benefit Programs is responsible for maintaining the CDT code set in accordance with ADA Bylaws and policy, and federal regulations. The ADA will allow recommendations by dental professionals for possible additions, revisions or deletions to the CDT code set, direct access to the process is available via the portal established on the ADA web page at ADA.org/3827.aspx.
Using the CDT Code

The Alphabetic index is located in section 3 of the manual and color coded for convenience of use, while the code on dental procedures is located in section 1 of the manual and Changes to the CDT code is located in section 2. If you are using a HCPCS book for Dental Codes please note this may be a little more difficult. While the dental codes in the HCPCS book are the same, they are arranged differently and are less descriptive in nature.

The mere presence of a CDT code does not mean a procedure is covered or reimbursable by a carrier. Insurance carriers such as Delta Dental have created and follow utilization review guidelines (URG). These guidelines determine whether or not a particular procedure is covered by the plan. You may find utilization review guidelines for many carriers on their prospective websites; we have listed some of Delta Dental’s URG for 2014 below. If you would like a copy of the entire URG you may find the manual at the following URL: https://www.deltadentalrionline.com/Public/PDF/DDRI_ProviderManual.pdf

CDT 2014 Code Change Summary
New codes effective 1/1/2014

<table>
<thead>
<tr>
<th>Code</th>
<th>Nomenclature</th>
<th>Delta Dental Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0601</td>
<td>Caries risk assessment and documentation, with a finding of low risk</td>
<td>Covered with limitations</td>
</tr>
<tr>
<td>D0602</td>
<td>Caries risk assessment and documentation, with a finding of moderate risk</td>
<td>Covered with Limitations</td>
</tr>
<tr>
<td>D0603</td>
<td>Caries risk assessment and documentation, with a finding of high risk</td>
<td>Covered with limitations</td>
</tr>
<tr>
<td>D1999</td>
<td>Unspecified preventive procedure, by report</td>
<td>Covered with limitations</td>
</tr>
<tr>
<td>D2921</td>
<td>Reattachment of tooth fragment, incisal edge or cusp</td>
<td>Covered with limitations</td>
</tr>
<tr>
<td>D2941</td>
<td>Interim therapeutic restoration – primary dentition</td>
<td>Covered with limitations</td>
</tr>
</tbody>
</table>

(Delta Dental of Washington 2014 Code Change Summary)
CDT DENTAL CODING EXERCISE 1
How well do you know your CDT book?

Try to find the following codes in the CDT Manual

1. Dental Exam, New Patient, 2 years old

2. Prophylaxis for 12 year old patient

3. Amalgam filling tooth #S; Distal & Occlusal surface

4. Re-treatment of previous root canal therapy, tooth #3

5. Gingivectomy teeth # 8 & 9

6. Lip Splint

7. Dental implant (endosteal) tooth #4

8. Connector bar for fixed partial denture

9. Extraction of soft tissue impaction tooth # 1

10. Replace broken orthodontic retainer
CDT DENTAL CODING EXERCISE 1 – Answers

1. D0145

How was this code found?

You would first look in the index of your CDT book found in section 8, under the main heading EVALUATIONS, then you will look for the evaluation description. Since you have an evaluation on a child that is under three years of age the most appropriate code would be D0145 (for patient under 3 years & counseling with primary care giver).

2. D1120

How was this code found?

You would first look in the index of your CDT book found in section 8, under the main heading PROPHYLAXIS, this will give you a code range of D1110, D1120. You would then flip to section 1 “Codes on Dental Procedures” and read the description to see which code best describes what you are looking for, since you know any person under the age of 13 is considered a child the best answer would be D1120 (prophylaxis – child).

3. D2150

How was this code found?

You would first look in the index of your CDT book found in section 8, under the main heading AMALGAM RESTORATIONS, this will give you a code range of D2140-D2161. You would then flip to section 1 “Codes on Dental Procedures” and read the description to see which code best describes what you are looking for, since you know both the distal and occlusal surfaces are involved you can safely say this is a two surface filling on tooth #S (a primary) tooth, so the best answer would be D2150 (amalgam – two surfaces, primary or permanent).

4. D3348

How was this code found?

You would first look in the index of your CDT book found in section 8, under the main heading RETREATMENT, ENDODONTIC, this will give you a code range of D3346-3348. You would then flip to section 1 “Codes on Dental Procedures” and read the description to see which code best describes what you are looking for, since you know tooth # 3 is a molar you can safely say D3348 (re-treatment of previous root canal therapy-molar) is the best answer.
5. D4211

How was this code found?

You would first look in the index of your CDT book found in section 8, under the main heading GINGIVECTOMY/GINGIVOPLASTY, this will give you a code range of D4210-D4211. You would then flip to section 1 “Codes on Dental Procedures” and read the description to see which code best describes what you are looking for, since you know there are two teeth involved numbers 8 and 9 you can safely say D4211 (ginvivectomy or Gingivoplasty—one to three teeth) is the correct or best answer.

6. D5987

How was this code found?

You would first look in the index of your CDT book found in section 8, under the main heading SPLINTING, you will then look for the sub heading COMMISSURE (since you know from your terminology that commissure splint is synonymous with lip splint) this will give you the code D5987. You would then flip to section 1 “Codes on Dental Procedures” and read the description to make sure you have the best and most accurate code.

7. D6010

How was this code found?

You would first look in the index of your CDT book found in section 8, under the main heading IMPLANT, then you would look for the sub heading ENDOSTEAL, this will give you a code D6010. You would then flip to section 1 “Codes on Dental Procedures” and read the description to make sure you have the best and most accurate code. Note: this is the most common code used for the surgical phase of dental implant surgery.

8. D6920

How was this code found?

You would first look in the index of your CDT book found in section 8, under the main heading CONNECTOR BAR, this will give you code D6920. You would then flip to section 1 “Codes on Dental Procedures” and read the description to make sure you have the best possible code. If you notice there is another code (D6055) right below connector bar in the index that states connector bar for a dental implant, since there is nothing in the documentation that states this is part of a dental implant this code would not be appropriate.
9. D7220

How was this code found?

You would first look in the index of your CDT book found in section 8, under the main heading EXTRACTIONS, then you look for the sub heading SURGICAL; this will give you a code range of D77210-D7250. You would then flip to section 1 “Codes on Dental Procedures” and read the description to see which code best describes what you are looking for, since you know it is a soft tissue impaction the best code would be D7220 (removal of impacted tooth-soft tissue).

10. D8692

How was this code found?

You would first look in the index of your CDT book found in section 8, under the main heading REPAIR, then you look for the sub heading ORTHODONTIC APPLIANCE, this will give you code D8691. You would then flip to section 1 “Codes on Dental Procedures” and read the description to see if the code best describes what you are looking for, since you know it is broken retainer you will see D8691 is incorrect, however, you will notice the code directly below it D8692 states replacement of orthodontic appliance which would be correct.
CDT DENTAL CODING EXERCISE 2

Find the following codes in the CDT Manual.

1. Panoramic film
2. Diagnostic casts
3. Composite filling tooth #9, lingual & incisial
4. Apicoectomy, tooth #7
5. Osseous Surgery teeth # 4, 5 & 6
6. Replace Tooth #9 on a complete denture
7. Removal of root tips tooth #2
8. Hyperplastic tissue removal tooth #18
9. Nitrous Oxide 30 minutes
10. Athletic mouthguard for 14 year old; football player
CDT DENTAL CODING EXERCISE 2 – Answers

1. **D0330**

   How was this code found?

   You would first look in the index of your CDT book found in section 8, under the main heading PANOROMIC FILM, you will see the code D0330. You would then flip to section 1 “Codes on Dental Procedures” and read the description to see confirm it is the best description for what code you are looking for, you will see it clearly state panoramic film.

2. **D0470**

   How was this code found?

   You would first look in the index of your CDT book found in section 8, under the main heading DIAGNOSTIC CASTS, this will give you code D0470. You would then flip to section 1 “Codes on Dental Procedures” and read the description to make sure your code is accurate.

3. **D2331**

   How was this code found?

   You would first look in the index of your CDT book found in section 8, under the main heading RESTORATIONS, from there you will look up RESIN-BASED COMPOSITE, this will give you a code range of D2330-D2394. You would then flip to section 1 “Codes on Dental Procedures” and read the description to see which code best describes what you are looking for, since you know both the lingual and incisal surfaces are involved you can safely say this is a two surface filling on tooth #9 (a permanent) tooth, so the best answer would be D2331 (resin-based composite – two surfaces, anterior).

4. **D3410**

   How was this code found?

   You would first look in the index of your CDT book found in section 8, under the main heading APICOECTOMY/PERIRADICULAR SURGERY, this will give you a code range of D3410-D3426. You would then flip to section 1 “Codes on Dental Procedures” and read the description to see which code best describes what you are looking for, since you know tooth # 7 is a lateral incisor or anterior tooth you can safely say D3410 (Apicoectomy/periradicular surgery- anterior) is the best answer.
5. D4261

How was this code found?

You would first look in the index of your CDT book found in section 8, under the main heading OSSEOUS SURGERY/GRAFT, this will give you a code range D4260-D4264. You would then flip to section 1 “Codes on Dental Procedures” and read the description to see which code best describes what you are looking for, since you know tooth #4, #5, & #6 are involved you can safely say D4261 (osseous surgery-one to three contiguous teeth or tooth bounded spaces per quadrant) is the best answer.

6. D5520

How was this code found?

You would first look in the index of your CDT book found in section 8, under the main heading DENTURES (REMOVABLE), from there you will look at the subheading REPAIRS, COMPLETE AND PARTIAL this will give you a code range of D5510, D5520, D5610-D5671. You would then flip to section 1 “Codes on Dental Procedures” and read the description to see which code best describes what we are looking for, since we know this is a replacement of tooth #9 on a complete denture you can safely say D5520 (replace missing or broken teeth- complete denture each tooth) is the best answer.

7. D7250

How was this code found?

You would first look in the index of your CDT book found in section 8, under the main heading EXTRACTIONS, then you would look for the subheading SURGICAL; this will give you a code range of D7210-D7250. You would then flip to section 1 “Codes on Dental Procedures” and read the description to see which code best describes what you are looking for, since you this is a root tip removal on tooth #2 you can safely say D7250 (surgical removal of residual tooth roots) is the best answer.

8. D7970

How was this code found?

You would first look in the index of your CDT book found in section 8, under the main heading HYPERPLASTIC TISSUE REMOVAL, this will give you code D7970. You would then flip to section 1 “Codes on Dental Procedures” and read the description to make sure there are no exclusions or previsions on the code.
9. D9230

How was this code found?

You would first look in the index of your CDT book found in section 8, under the main heading NITROUS OXIDE, this will give you code D9230. You would then flip to section 1 “Codes on Dental Procedures” and read the description to make sure there are no exclusions or previsions on the code.

8. D9941

How was this code found?

You would first look in the index of your CDT book found in section 8, under the main heading MOUTHGUARD, ATHLETIC, this will give you code D9941. You would then flip to section 1 “Codes on Dental Procedures” and read the description to make sure there are no exclusions or previsions on the code.

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Introduction to Dental & Medical Procedural Coding

The following information will take you through common dental procedures with an emphasis on proper coding from a dental and medical standpoint. We will go through each of the twelve sections of the CDT coding book. It is recommended that you try to look up the codes as we go along so you will familiarize yourself with how a code is found. We will be coding the most common procedures done in a general dentist office. For more detailed specialty coding you will need to review one of our specialty coding modules on Oral Surgery, Periodontics or Orthodontics (when they become available).

Diagnostic Procedures

Exams

Dental Exams are extremely important to the patient’s overall oral health. Exams are used to detect tooth decay, oral cancer, gum disease and tooth alignment among other things. Dental exam codes include both new and established patients where Medical exam codes are separated by whether the patient is new or established. When coding dental claims you may use the same code for a new patient as you would for an established patient. When coding medical exams you will need to check and see if the patient is new or established within the practice prior to selecting a code. A new patient is someone who has never been seen or who has not been seen in the last three years by any provider within the practice. Exams are considered diagnostic and typically covered at 100% on the patients plan; however, you will always want to contact the carrier for an accurate breakdown of benefits. The following codes are used for exams in a dental practice.

Dental Codes Used

D0120 Periodic oral evaluation

- This code is to be used on a new or established patient that comes in for routine cleanings, this code is usually allowed once every 6 months to the date, however, there are some carriers that will allow this code to be billed twice per year. It is a good idea to check with the carrier prior to billing this code.

- May be billed in addition to but is not limited to the following codes D0210, D0330, D0272, D0274, D1110 and D1120.

- Compatible with medical codes new patient 99202-99204 and/or established patient 9921299214.

- This code is covered by Medicare if its purpose is to identify a patient’s existing infection prior to kidney transplantation, patients with cancer undergoing radiation therapy or about to start chemotherapy.
D0140  Limited oral evaluation – problem focused

• This code is to be used for a new or established patient with a specific dental problem or complaint (e.g. broken tooth, dental pain, trauma, acute infection).

• Most dental carriers will cover this code in conjunction with a dental procedure.

• This code is usually allowed once every 6 months to the date.

• Compatible medical codes are 99201-99202 new patient and/or 99212-99213 established patient (Note while dental carriers will cover this exam with a procedure medical carriers will not).

D0145  Oral evaluation for a patient under 3 years

• New code 2007.

• This code is to be used for children under 3 years of age and must include the recording of the child’s oral and physical health, caries susceptibility, and development of a preventive oral health plan along with counseling of the child’s primary caregiver.

• New or established patients.

• Compatible medical codes 99202-99203 new patient and/or 99212-99213 established patient.

D0150  Comprehensive oral evaluation

• This code is to be used to thoroughly evaluate a patient. The exam should include a patient’s dental and medical history along with a general health assessment. It should also include a complete perio chart and recording of the extraoral and intraoral hard and soft tissues such as dental carries, missing or un-erupted teeth, restorations, occlusal relationships, periodontal conditions, hard and soft tissue anomalies, oral cancer screening, etc. (e.g. evaluation for dental implants or extraction wisdom teeth).

• New or Established patients.
• Most carriers cover this code once every 3 to 5 years, however, some will limit this code to once per lifetime per provider.

• Compatible medical codes 99203-99204 new patient and/or 99213-99214 established patient.

D0160  Detailed and extensive oral evaluation – problem focused

• This code is to be used to evaluate a patient when an extensive problem is discovered. This type of evaluation is typically used after a comprehensive evaluation presents specific findings or conditions such as dentofacial anomalies, complicated perio-prosthetic conditions, complex TMJ dysfunction, etc. When billing this code to a carrier it must have a report accompany it.

• This code is covered once every 6 months or once every 12 months. Always check with your carrier for specific coverage guidelines.

• Compatible medical codes 99203-99205 and/or 99213-99215.

D0180  Comprehensive periodontal evaluation

• Performed by a Periodontist or other qualified healthcare professional, when the patient is showing signs or symptoms of periodontal disease or has a high risk factor such as smoking or diabetes.

• New or established patients.

• Covered once every 12 months; some carriers do not allow this code while others will allow this code once per lifetime per provider. Always check with the patient’s carrier for specific guidelines.

Medical Codes Used

The terms problem focused, expanded focused, detailed and comprehensive are used for medical examinations. In order to select the appropriate level of exam you must first know what these terms mean. The extent of the examination performed is dependent on the clinical judgment and on the nature of the presenting problem(s). The four types are defined as follows

• Problem focused – A limited exam of the affected body area
- Expanded problem focused – A limited exam of the affected body area and other symptomatic or related organ system

- Detailed – An extended exam of the affected body area and other symptomatic or related organ system

- Comprehensive – general multi-system exam or a complete exam of a single organ system

**99201 Office visit – problem focused**

- Used for new patient (has never been seen by anyone in the practice or has not been seen in the last three years by anyone in the practice)

- Usually the problem is self limited or minor

- Typical time spent is 10 minutes face to face with the patient

- Must include these three components: problem focused history, problem focused exam and straightforward medical decision making (MDM).

**99212 Office visit- problem focused**

- Used for an established patient.

- Usually the problem is self limited or minor.

- Typical time spent is 10 minutes face to face with the patient.

- Must include these three components: problem focused history, problem focused exam and straightforward medical decision making (MDM).

**99202 Office visit – expanded problem focused**

- Used for new patient (has never been seen by anyone in the practice or has not been seen in the last three years by anyone in the practice).

- Usually the problem is of low to moderate severity.

- Typical time spent is 20 minutes face to face with the patient.
Must include these three components: expanded problem focused history, expanded problem focused exam, and straightforward medical decision making (MDM).

**99213 Office visit – expanded problem focused**

- Used for an established patient.
- Usually the problem is of low to moderate severity.
- Typical time spent is 15 minutes face to face with the patient.
- Must include these three components: expanded problem focused history, expanded problem focused exam, and low complexity medical decision making (MDM).

**99203 Office visit – detailed**

- Used for new patient (has never been seen by anyone in the practice or has not been seen in the last three years by anyone in the practice).
- Usually the problem is of moderate severity.
- Typical time spent is 30 minutes face to face with the patient/family.
- Must include these three components: detailed history, detailed exam, and low complexity medical decision making (MDM).

**99214 Office visit - detailed**

- Used for an established patient.
- Usually the problem is of moderate to high severity.
- Typical time spent is 25 minutes face to face with the patient/family.
• Must include these three components: detailed history, detailed exam, and moderate complexity medical decision making (MDM).

99204 Office visit – comprehensive

• Used for new patient (has never been seen by anyone in the practice or has not been seen in the last three years by anyone in the practice).
• Usually the problem is of moderate to high severity.
• Typical time spent is 45 minutes face to face with the patient/family.
• Must include these three components: comprehensive history, comprehensive exam, and moderate complexity medical decision making (MDM).

99215 Office visit – comprehensive

• Used for an established patient.
• Usually the problem is of moderate to high severity.
• Typical time spent is 40 minutes face to face with the patient/family.
• Must include these three components: comprehensive history, comprehensive exam, and high complexity medical decision making (MDM).

99205 Office visit – comprehensive

• Used for new patient (has never been seen by anyone in the practice or has not been seen in the last three years by anyone in the practice).
• Usually the problem is of moderate to high severity.
Typical time spent is 60 minutes face to face with the patient/family.

Must include these three components: comprehensive history, comprehensive exam, and high complexity medical decision making (MDM).

A dictated report of the exam should be in the patients chart.

Medical decision making is a term used quite frequently throughout medical evaluation and management (exam) codes. The following is a basic guide to deciding what the level of medical decision making is on a particular exam.

The first thing you will look at to decide the level of medical decision making is:

- The nature and number of clinical problems
- The amount and complexity of the data reviewed by the doctor
- The risk of morbidity and mortality to the patient.

The overall level of medical decision making is determined by referring to the following table:

<table>
<thead>
<tr>
<th>Number of diagnoses or management options</th>
<th>Amount and/or complexity of data to be reviewed</th>
<th>Risk of complications and/or morbidity or mortality</th>
<th>Level of complexity of medical decision making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
<td>Straightforward</td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td>Low Complexity</td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>

(EMUniversity. 2011)

**Pre-diagnostic Services**

**D0190 Screening of a patient**

- Screening for Federally Qualified Health Care Clinics to access the need for a patient to see a dentist. Performed by hygienist or other qualified healthcare personnel.
- New or established patients.
Consultations
A consultation is a type of examination provided by a dentist whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another dentist, physician or other appropriate source.

If a consultation is mandated or required by a third party payer for medical claims, modifier -32 should be appended to the HCFA or CMS 1500 claim form in box 24D.

If an additional request for an opinion or advice regarding the same or a new problem is received from another physician or dentist the office consultation codes may be used again.

You will report these codes as routine office exams, using medical codes 99201-99215 or dental codes D0140, D0150, D0160, or D0180.

Dental Code Used

D9310 Consultation

• Diagnostic service provided by dentist other than practitioner providing treatment
• Common reason is for second opinion or pre-operative evaluation • The dentist may initiate diagnostic or therapeutic services

Medical Codes Used

Consultation codes 99241-99245 have now been modified to be used for Transfer of Care. The definition of transfer of care is the process by which a doctor who is providing some or all of the patients care relinquishes the responsibility to another doctor who agrees to take over the patients care.

CPT Codes 99201 – 99205 should be used for new patients and CPT codes 99212-99215 should be used for established patients.

Radiographs/Diagnostic Imaging

Radiographs commonly referred to as X-rays should be taken to diagnosis a current problem or for review of a patients dental condition every 12 months or as deemed reasonably necessary by the treating dentist. All X-rays should be of diagnostic quality and properly marked with the patients first and last name, date x-rays were taken and treating dentist. If the X-ray is a panoramic film it should
be marked with an R and L to indicate the right and left side. Original X-ray films are the property of the treating dentist and should **NEVER** be given to a patient or third parties. If a copy of records is requested by the patient or a third party such as an insurance company or another dentist, a duplicate film or digital copy should be given. All original X-rays should be kept in the patients chart at all times. X-rays are considered diagnostic and typically covered at 100% on the patients plan; however, you will always want to contact the carrier for an accurate breakdown of benefits. The following codes are commonly used codes for a general practice. You should note there are some codes not listed for specialty codes please see other specialty coding programs.

**Dental Codes Used**

**D0210**  
**Intraoral – complete series of radiographic images**

- This is typically covered once every 3 years
- This code is typically billed in addition to but is not limited to the following codes D1110, D1120, D4341, D4342, D4910 and D4355
- A full mouth series will consist of 14-22 periapical and posterior bitewing images
- Compatible medical code 70320 (To find this medical code use your CPT book and go to the index look up the main term “X-ray”, the category “teeth” and it will guide you the code series 70300-70320)
- CPT code 70320 reads Radiologic examination, complete, full mouth

**D0220**  
**Intraoral – periapical first film**

- This code is allowed to be billed as deemed necessary by the dentist; there is no limitation on billing for this code
- Periapical films should include a clear view of the tooth including the root. See Figure 1A
- Compatible medical code 70300
- CPT code 70300 reads Radiologic examination, teeth, single view
D0230  **Intraoral – periapical each additional film**

- This code is to be billed in addition to D0220 when two or more films are taken
- Compatible medical code 70300
- CPT code 70300 reads Radiologic examination, teeth, single view

D0270  **Bitewing – single film**

- This code may be billed separately or in addition to D0220, D0230
- Bitewing films should include a clear view of the inter-proximal of the tooth; this x-ray is used to detect decay. See Figure 1B
- Compatible medical code 70300
- CPT code 70300 reads Radiologic examination, teeth, single view

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**Figure 1B**

[Image of an X-ray showing teeth with emphasis on the interproximal areas]
D0272  Bitewing – two films

- This code may be billed separately or in addition to D0220, D0230
- Follow guidelines of D0270

D0274  Bitewing – four films

- This code may be billed separately or in addition to D0220, D0230
- Compatible medical code 70310
- CPT code 70310 reads Radiologic examination, teeth, partial examination, less than full mouth.
- You would select 70310 because there are four films that show the entire posterior of the mouth.

D0330  Panoramic Film

- This is typically covered once every 3 years
- Panoramic films may be taken on children to access the development of primary/adult tooth growth and position as seen in Figure 2A
- This code is typically billed in addition to but is not limited to the following codes D7210, D7220, D7230, D7240 and D7241
- This may also replace a full mouth x-ray, if a full mouth series has been taken in the last three years this will be denied due to frequency limitation by the dental carrier. In the event this happens it is a good idea to bill the medical carrier to see if a benefit may exist.
- Compatible medical code 70320
- CPT code 70355 reads Radiologic examination, orthopantagram

Panoramic Film
Tests and Examinations
From time to time your dentist may choose to do certain diagnostic tests. For example, test the vitality of a tooth or to view the relationship between the mandible and maxilla. These tests are covered at the dental carriers’ discretion and a breakdown of the patients benefits should be acquired prior to treatment so the patient may elect whether or not to proceed with treatment. A pre-treatment estimate should always be given to the patient prior to treatment so the patient is aware of their expected payment. The following codes are most commonly used in general dentistry:

D0421  Genetic test for susceptibility to oral diseases

- This test is used to determine a patient is more likely to develop oral disease such as periodontitis and oral cancer to name a few.

- Most carriers do not cover this dental expense you will need to check with each individual carrier for specific benefit guidelines.

D0425  Caries susceptibility tests

- This is a method of determining the concentration of acid-producing bacteria in the saliva. The reliability of this and other salivary bacterial tests for dental caries susceptibility is questionable.

- Not all carriers cover this test so you will need to check with each individual carrier for benefit guidelines. In the event the carrier does not cover this procedure it becomes the responsibility of the patient.
D0431  Pre diagnostic testing for malignant lesions

• In 2005 The American Dental Association approved the above code for tests intended to aid in oral mucosal examinations. The full definition reads “Adjunctive pre-diagnostic test that aids in the detection of mucosal abnormalities including pre-malignant and malignant lesions not to include cytology or biopsy procedures.”

• More and more dental insurance plans are covering this procedure code and, while not all insurance companies are currently reimbursing for it you will need to check with your individual carriers for benefits and coverage.

D0460  Pulp vitality test

• This procedure uses thermal, electrical, or mechanical stimulation to determine the response of the pulp in a tooth. It is usually done to determine whether a tooth needs to undergo root canal therapy treatment.

• This code typically has no frequency limitation meaning they may be billed out as often as the dentist deems medically necessary.

D0470  Diagnostic casts

• Diagnostic casts are used for many different things some uses would be to check the relationship of the maxilla and mandible, create custom trays for night guards or mouth guards and create prosthetics.

• This code typically has no frequency limitation meaning they may be billed out as often as the dentist deems medically necessary.
D0475    Decalcification procedure

- This is a procedure to remove calcium salts from the teeth to determine certain oral disease
- Most carriers will cover this procedure however it will require a pathology report to accompany the claim

Preventative Procedures

Cleanings
Dental Cleanings may be periodic/routine (every 6 months) for patients with good oral health or they may be more involved (root planning & scaling) for patients with extensive tarter and plaque or deep periodontal pockets. Cleanings are typically performed by the Dental Hygienist, although the Dentist may perform the cleaning as well.

A dental hygienist is a highly trained and licensed oral health professional who provides patients with educational, clinical, and therapeutic services to enhance their oral and overall health. A dental hygienist uses their skills and knowledge to prevent, detects, and treats gum disease and tooth decay in his/her patients.

Hygienists receive intensive, specialized education and training that includes courses in chemistry, head and neck anatomy, physiology, microbiology, pathology, nutrition, pharmacology, advanced dental sciences, and dental hygiene.

The Hygienist may perform cleanings and take x-rays on patients without the Dentist present; although, they may not perform an exam and must inform the patient the doctor will review the X-rays and contact you should he see any problems on the X-ray film.

Dental Codes Used

D1110    Prophylaxis-Adult
• This procedure is covered once every 6 months; some carriers will not consider this charge unless it is 6 months to the day or after. You should always make sure what the carrier guidelines are to avoid a denial of payment.

• An adult is considered age 14 years and older.

**D1120 Prophylaxis-Child**

• This procedure is covered once every 6 months.

• A child is considered age 13 years and under.

**D4341 Scaling & Root planing – four or more teeth per quadrant**

• Root planings may be done for a single quadrant and are billed per quadrant.

• (I.e. upper right, upper left, lower right and lower left).

• Includes local anesthetic.

**D4342 Scaling & root planning – one to three teeth per quadrant**

• Same as D4341

**D4910 Periodontal maintenance**

• Is usually allowed every 4 months (check with each carrier for specifics).

• Some carriers will allow every 3 months if medical necessity is proven.

• They must have had prior periodontal surgery (osseous, scaling & root planning) for this to be covered.

• Includes local anesthetic if necessary.
Topical Fluoride Treatment

Fluoride treatments may be done in conjunction with a routine cleaning; these codes are billed separately in addition to the cleaning. There is no medical code for a routine cleaning and should not be billed to the medical carrier as it is not covered.

Fluoride is available in many forms. There is sodium fluoride (NaF), monofluorophosphate (MFP), and stannous fluoride (SnF). There are fluoride rinses, gels, foams, tablets and varnishes. Home treatments include over the counter and prescription rinses, toothpastes, gels, and tablets.

The Council on Scientific Affairs (CSA) classifies patients who have no tooth decay for at least three years and no other risk factors as low risk patients. Moderate risk patients have little or no decay in the previous few years, but do have some of the factors that increase their risk. High risk patients are young children (under 6) with any history of decay and older patients with at least a few cavities and multiple risk factors.

D1206  Topical application of fluoride varnish

• This is covered for children less than 12 years of age. Adults with high risk carries factor may be eligible for coverage.

• Depending on the carrier it may be covered one or two times a year.

• If Duraflor is being used the FDA has only approved this for root carries control. You should use this code to bill Duraflor for any other condition.

D1208  Topical application of fluoride

• This is covered for children less than 12 years of age. Adults with high risk carries factor may be eligible for coverage.

• Depending on the carrier it may be covered one or two times a year.

• This is a fluoride gel or foam application.

Counseling

From time to time the dentist or other dental staff may need to counsel a patient on various issues concerning their oral health. These codes should be billed when an extensive review of the patient’s oral health has been discussed. You should make sure the dentist or other dental staff document the time and a brief description of what was discussed along with the plan of treatment or final outcome.

The following is an example of proper documentation:

Time in 8:10am     Time out 8:30am

Oral hygiene instructions
The patient has the start of gingival recession and extensive calculus. I explained to the patient the importance of brushing and flossing after every meal. I reviewed proper brushing and flossing technique and recommended the patient switch from a manual toothbrush to sonic care to assist in keeping the calculus down. The patient is to use a sonic care tooth-brushing system before bed and a soft toothbrush after every meal along with flossing after every meal. I will review oral health in 6 months.

Jane Doe RDH

D1310  Nutritional counseling

• This code is usually billed for control of dental disease in patients that have poor nutrition and oral disease.

• This code is not covered by most carriers, you should check with your individual carriers for coverage.

• You may want to put a brief descriptor in box 35 of your ADA 2006 form.

• If sending to the patient’s medical carrier you will use the code that is closest to the time spent with the patient.

99401  preventive counseling approx. 15 minutes
99402  preventive counseling approx. 30 minutes
99403  preventive counseling approx. 45 minutes
99404  preventive counseling approx. 60 minutes

D1320  Tobacco counseling

• This code is billed for tobacco cessation (quit smoking, chewing, dipping or using tobacco).

• This may be billed to the patient’s medical carrier using CPT codes 99401-99404 depending on the length of time spent with the patient (see above).

• You should also include CPT code 4000F on the CMS Claim form. There is no fee for this code it simply describes what type of counseling is being preformed (i.e. tobacco counseling) this code should be listed on line 2 of the CMS form after the initial CPT code of 99401-99404.
• Covered diagnosis codes would be 305.1 Tobacco dependence, V15.82 history of tobacco use, or 649.0 smoking complicating pregnancy.

D1330  Oral hygiene instructions

• This procedure currently has no compatible medical code and is not covered under the patient’s medical plan this is to be billed to the dental carrier only.

• This code is usually not a covered dental benefit; you will need to check with each carrier for guidelines. In the event it is not covered the charge would be the responsibility of the patient.

• This code may be billed to the patient’s dental carrier with the following codes but is not limited to CDT codes D1110, D1120, D0210, D0150, and D0160.

Space Maintainers and Sealants
Space Maintainers are used for children when a primary (baby) tooth is lost early due to decay, injury or trauma. When this happens the child’s surrounding teeth could shift and begin to fill in the empty space. When the child’s permanent (adult) teeth begin to emerge there may not be enough room or space for them. The result is crooked or crowded teeth and difficulties with chewing or speaking.

To prevent this from happening, the dentist will insert a space maintainer (See Figure 1A) to hold the space left by the lost tooth until the permanent tooth emerges. The space maintainer may be fixed or removable. If the dentist chooses to place a fixed space maintainer it will need to be removed by the dentist at a later date when the permanent tooth starts to emerge. (See Figure 1B)

Figure 1A – Fixed Space Maintainer  Figure 1B - Emerging tooth

D1510  Space Maintainer – fixed; unilateral

• This code is used when only one space maintainer on one side of the mouth is being placed.
• There is no frequency limitation for this code and it may be billed with other CDT codes.

• This procedure is not covered under most medical plans and there is no CPT (medical code) for this procedure.

• There may be an age limitation of 12 year old or younger; make sure to check with the specific carrier for guidelines.

D1515 Space maintainer – fixed; bilateral

D1520 Space maintainer – removable; unilateral

D1525 Space maintainer – removable; bilateral

D1550 Re-cementation of space maintainer

• This code is used for patients that need their space maintainer re-cemented because it has come loose or fallen off. There is no frequency limitation to this code.

D1555 Removal of fixed space maintainer

• This code may be billed by the treating dentist (eg the dentist who placed the space maintainer)

• A sealant is applied to the chewing surfaces of molars and premolars. It acts as a barrier, protecting the teeth against decay-causing bacteria. Sealants are usually applied to permanent (adult) teeth but may be applied to primary teeth if the child is high risk for decay. (See Figure 1A)

D1351 Sealant – per tooth

• Most carriers allow sealants for those patients that are 16 years and younger. You will need to verify specific guidelines for each carrier.

• Most carriers will cover sealants on the following teeth numbers 1-5, 16-12, 17-21 and 28-32.

• While other carriers will only allow teeth numbers 1-3, 16-14, 17-19 and 30-32. It is always a good idea to verify the patient’s benefits before proceeding with treatment.

• Sealants are typically covered once per lifetime.

• Sealants are not a covered medical benefit and should only be billed to the patient’s dental carrier for reimbursement.

    Figure 1A - Dental Sealant
Basic Procedures

Filings
A dental filling also known as a dental restoration is made of either amalgam (a mixture of mercury with at least one other metal; see figure 1A) or composite resin (also known as white fillings; see figure 2A) and is used to artificially restore the function, integrity and morphology of missing tooth structure. The structural loss typically results from caries also known as cavities. It is also lost or removed intentionally during tooth preparation to improve the aesthetics or the physical integrity of the intended restorative material.

Amalgam Restorations
D2140  Amalgam – one surface

• This code is billed for both adults and children and is used for both primary and permanent teeth.

• You will need to add the tooth number and surface being restored. For example, if the occlusal surface of tooth number 14 was being restored you would put 14 in box 27 and O in box 28 of the ADA 2006 form.

• This service may have a waiting period so you will need to make sure to check with the patient’s insurance carrier prior to treatment.

• This is not covered by medical carriers, DO NOT bill this to the patient’s medical insurance.

D2150  Amalgam – two surface

• This code is billed for both adults and children and is used for both primary and permanent teeth.

• You will need to add the tooth number and surface being restored. For example if the occlusal and distal surface of tooth number 12 was being restored you would put 12 in box 27 and OD in box 28 of the ADA form.

• This service may have a waiting period so you will need to make sure to check with the patient’s insurance carrier prior to treatment.

• This is not covered by medical carriers, DO NOT bill this to the patient’s medical insurance.

D2160  Amalgam – three surface

• This code is billed for both adults and children and is used for both primary and permanent teeth.

• You will need to add the tooth number and surface being restored. For example if the mesial, occlusal and distal surface of tooth number 3 was being restored you would put 3 in box 27 and MOD in box 28 of the ADA form.

• This service may have a waiting period so you will need to make sure to check with the patient’s insurance carrier prior to treatment.

• This is not covered by medical carriers, DO NOT bill this to the patient’s medical insurance.
D2161 Amalgam – four or more surfaces

- This code is billed for both adults and children and is used for both primary and permanent teeth.
- You will need to add the tooth number and surface being restored. For example if the mesial, occlusal, distal and lingual surface of tooth number 4 was being restored you would put 4 in box 27 and MODL in box 28 of the ADA form.
- This service may have a waiting period so you will need to make sure to check with the patient's insurance carrier prior to treatment.
- In most instances if the tooth is so badly damaged that it requires a four surface restoration the dentist may decided to cap the tooth in addition to the filing.
- This is not covered by medical carriers, DO NOT bill this to the patient's medical insurance.

Composite or Resin Restorations D2330-D2394

D2330 Resin based composite – one surface, anterior

- This service may have a waiting period; you should always check with the patient’s carrier for exclusions and limitations.
- This is not a covered medical benefit; it should be billed to the dental carrier only.
- This code is used on anterior teeth only (eg 6-10 and 22-27).
- This is for restorations that include only one surface of the tooth.

D2331 Resin based composite – two surface, anterior

- This service may have a waiting period; you should always check with the patient’s carrier for exclusions and limitations.
- This is not a covered medical benefit; it should be billed to the dental carrier only.
- This code is used on anterior teeth only (e.g. 6-10 and 22-27), and may include any two surfaces of the tooth.
**D2332  Resin based composite – three surface, anterior**

- This service may have a waiting period you should always check with the patient’s carrier for exclusions and limitations.

- This is not a covered medical benefit; it should be billed to the dental carrier only.

- This code is used on anterior teeth only (e.g. 6-10 and 22-27).

- This is for restorations that include any three surfaces of the tooth.

**D2335  Resin based composite – four or more surfaces, anterior**

- This code must include the incisal angle of the tooth (top part of the anterior tooth).

- This code is used on anterior teeth only (e.g. 6-10 and 22-26).

- This is not a covered medical expense and should be billed to the dental carrier only.

**Dental Extractions D7111-D7250**

A dental extraction is the removal of a tooth from the mouth. Extractions are performed for a wide variety of reasons; the most common reason is excessive tooth decay. This is when the tooth structure is destroyed enough to prevent a restoration. Extractions of impacted or problematic wisdom teeth or third molars are also routinely performed, as are extractions of some permanent teeth to make space for orthodontic treatment.

**D7111  Extraction coronal remnants – deciduous tooth**

- This extraction is only cover under the patient’s dental plan; do not send to medical.

- This is preformed on deciduous (baby) teeth only.

**D7140  Extraction erupted tooth or exposed root**

- This is considered a “simple” extraction and is preformed on teeth that do not require cutting.

- This code includes closure; do not bill separately if sutures are used.

- This extraction is only covered under the patient’s dental plan; do not send to the medical carrier for reimbursement as it is not a covered benefit.
D7210  Surgical removal of erupted tooth

- This code is used when a mucoperiosteal flap, removal of bone or a sectioning of tooth is required.
- This code includes closure; do not bill separately if sutures are used.
- Delta dental frequently requires the patient’s medical plan be billed for this procedure even though it is not usually covered under the medical plan. It is recommended to alleviate having to bill the patient’s medical carrier you state in box 35 “Remarks” the following “Per Insurance this dental procedure is not covered under the medical plan”. If the dental carrier does not accept this you will have to bill the medical carrier and then send a copy of the denial from the medical carrier along with a new claim to the dental carrier.

Impacted Wisdom Teeth codes D7220 – D7241 and Surgical removal of residual tooth roots codes D7250 are covered in the oral surgery specialty course.

Major Procedures

Crowns D2710-D2799    Bridges D6210-D6794

A dental crown also known as a cap is tooth shaped and placed over a natural tooth to restore shape, size, strength and improve appearance. When a crown is cemented into place it may (depending on the type of crown) fully encase the entire visible portion of the tooth that lies above the gum line or it may blend into the tooth just above the gum line.

Dental crowns are usually placed for the following reasons:

- To protect a weak tooth (a tooth that has had root canal therapy).
- To restore an already broken tooth or cracked tooth.
- To cover and support a tooth with a large filling when there isn’t a lot of tooth left.
- To cover mis-shaped or severely discolored teeth.

Permanent crowns may be made from all metal, porcelain-fused-to-metal, all resin, or all ceramic.
**Metal** crowns are still used however they are not popular due to the metallic color. They may be made from gold alloy, other alloys (for example, palladium) or a base-metal alloy (for example, nickel or chromium). Some pluses to having a metal crown is less tooth structure needs to be removed with metal crowns and the metal crowns withstand biting and chewing forces well and probably last the longest in terms of wear and tear. Also, they rarely chip or break. Metal crowns may still be a good choice for out-of-sight molars.

![Metal Crown](image)

**Porcelain-fused-to-metal** crowns may be color matched to your adjacent teeth (unlike the metallic crowns). However unlike metal crowns the crown's porcelain portion may chip or break off. Next to allceramic crowns, porcelain-fused-to-metal crowns look most like normal teeth. However, sometimes the metal underlying the crown's porcelain can show through as a dark line, especially at the gum line and even more so if your gums recede.

![Porcelain-fused-to-metal Crown](image)

**All-ceramic or all-porcelain** dental crowns provide the best natural color match than any other crown type and may be more suitable for people with metal allergies. However, they are not as strong as porcelain-fused-to-metal crowns. Most all ceramic crowns are not covered by the dental carrier.
Most common crowns billed in a dental setting

D2750  Crown- Porcelain fused to high noble metal
        • Typically used for PFG or porcelain fused to gold crown

D2751  Crown – Porcelain fused to predominantly base metal
        • Typically used for PFM or porcelain fused to metal

D2740  Crown- Porcelain/ceramic substrate
        • Typically used for all ceramic or all porcelain crowns

D2790  Crown- full cast high noble metal
        • Typically used for full gold crowns or FGC

You should note there are 18 different types of crowns. The ones listed above are the most commonly used. You should always read the dental chart and verify with your dentist to make sure you are coding and billing the correct crown for the patient.

General guidelines for crowns:

• Crowns should be bill to the carrier on the seat date not the prep date.

  1. Prep – the day the dentist prepared the tooth to receive a permanent crown. A temporary crown is usually placed and the patient is typically scheduled two weeks out for the permanent seat date
2. **Seat** – is the date or day the permanent crown is cemented on the prepared tooth.

- If a crown is prepped and seated on the same day you will bill the charge the same day. Some office’s have the technology to make permanent ceramic crowns in office.
- Most dental carriers will cover a new crown once every 5 years.
- Most carriers consider crowns to be a benefit under the major portion of the dental plan and are typically covered at 50% of the contracted rate.
- It is a good idea to pre-authorize any and all crowns to check for frequency limitations, waiting periods and patient portion to avoid any unnecessary surprises to your patient.
- Local anesthetic is considered to be part of the procedure and may not be billed separately.

**Other restorative services for crowns**

**D2920**  
**Re-cement crown**

- This code is pretty self explanatory; it is used when a dentist has to re-cement a crown that has come off for whatever reason.

**D2940**  
**Sedative filling**

- This code is used to relieve pain and is placed under temporary restorations.
- It is not to be used as a base or liner under permanent restorations such as fillings or crowns. For permanent restorations see codes D3110-D3120.

**D2950**  
**Core buildup, including any pins**

- This code is used when the treating dentist needs to build up the anatomical portion of the crown prior to crown preparation.
This may or may not include pins for stability, do not bill out separately for pins if used.

You should note there are several different kinds of build-ups with post or pin retention. This code is the most popular but not the only code used. See codes D2951 through D2957 for more options.

**D2980  Crown repair, by report**

- This code is used when a repair is done to a crown that is not listed in the CDT book.
- You must have a report accompany this code for reimbursement.
- Example would be: porcelain crown chipped on the cusp and was repaired with composite material.

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**Dental Bridge**

A dental bridge is used to replace a missing tooth. The false tooth, known as a pontic, is fused between two porcelain crowns, known as abutments to fill in the area left by the missing tooth. The two abutment crowns holding it in place are attached onto your natural teeth on each side of the false or missing tooth. This is known as a fixed bridge. This procedure is used to replace one or more missing teeth. Fixed bridges cannot be taken out of your mouth as you might do with removable partial dentures. See figures A and B below

**Figure A**

**Figure B**
If you notice the two teeth on either side of the missing tooth has been shaved down and prepped for the bridge. There are different types of bridges; this one is called a fixed bridge. Figure C is a Maryland bridge and Figure D is a Cantilever bridge.

![Figure C](image1.png)  ![Figure D](image2.png)

You will find codes for dental bridges located under the “fixed partial denture” Section in your CDT book.

Codes **D6210** through **D6253** are your pontic (missing/false tooth) codes, while Codes **D6720** through **D6793** will be used for your abutment codes.

Example: Your procedure is a fixed porcelain fused to metal bridge involving teeth numbers 3,4 and 5 with your missing tooth being number 4. You would use the following codes on your ADA form

<table>
<thead>
<tr>
<th>Code</th>
<th>Tooth</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6721</td>
<td>3</td>
</tr>
<tr>
<td>D6211</td>
<td>4</td>
</tr>
<tr>
<td>D6721</td>
<td>5</td>
</tr>
</tbody>
</table>

Other types of crowns and bridges are made using dental implants. Some medical carriers may pay for a dental implant however most dental carriers will not. If you would like more information on Dental implants you will need to read the Oral Surgery Specialty module.
Root Canal Therapy / Endodontics D3000-D3999

When the nerve or root of a tooth becomes abscessed, infected or necrotic root canal therapy is necessary to treat the pain and infection of the tooth. This procedure is usually preformed by an Endodontist, but may be performed by a general dentist.

The procedure is performed by giving the patient a local anesthetic and drilling a hole on the occlusal surface of the tooth to gain direct access to the pulp and root chambers. These chambers are then hollowed out with endodontic files until there is no remaining pulp, nerve or blood vessels present in the tooth. Once that is complete the hollow chambers are filled with a substance called gutta percha. The tooth is then capped with a temporary crown or filled with a sedative filling. See Figure A

Endodontic codes are broken up by the type of tooth (i.e. anterior, bicuspid and molar)

- **D3310** Anterior RCT
- **D3320** Bicuspid RCT
- **D3330** Molar RCT

Root Canal Therapy General Guidelines

1. Root canal therapy does not include the final restoration (i.e. crown or filling) this is to be billed separately and in addition to the root canal
2. This is typically covered under the patient’s major care of the dental plan and usually paid out at 50% of the contracted rate with the patient being liable for the other 50%.
3. In some instances this procedure may be covered at the basic level of care. You should always get a breakdown of benefits to make sure the level at which it is covered.
4. This procedure is not covered under the patient’s medical plan and should not be billed to the medical carrier.

Pulp cap is a procedure that is performed when there is exposed pulp; it is not a root canal, it is used as a preventative measure to avoid root canal therapy.

**D3110  Pulp cap – direct**

- This is a dressing or cement that is placed directly on exposed pulp to aid in healing, protect the exposed pulp and hopefully repair the defect.
- This procedure does not include the final restoration, this code is billed in addition to the final restoration (i.e. resin filling).

**D3120  Pulp cap – indirect**

- This is a protective dressing to protect the pulp from additional injury and promote healing from nearly exposed pulp. This means the pulp is not fully exposed.
- This procedure does not include the final restoration, this code is billed in addition to the final restoration (i.e. resin filling).
- In some instances a root canal may need to be retreated or may not be completed.

For example a dentist may be treating a patient with an abscess and performing a root canal when he/she discovers the tooth is severely fractured and un-restorable at this point he refers the patient to an oral surgeon for extraction. You would still bill the patient’s insurance for the time the doctor spent trying to perform the procedure. In this case CDT code **D3332 (Incomplete endodontic therapy: inoperable, unrestorable or fractured tooth)** would be appropriate to bill.

There may be an instance where a root canal needs to be retreated due to an incomplete or incorrectly done root canal. If this were the case CDT codes **D3346-D3348** would be appropriate.

An Apicoectomy is the removal of the root tip and the surrounding infected tissue of an abscessed tooth. This procedure may be necessary when inflammation and infection persists in the area around the root
tip after root canal therapy (CDT codes D3410-D3426). This procedure is not currently covered under the medical plan.

**Prosthodontics (Removable) D5000-D5899**

Dentures are a prosthetic device made to replace missing teeth. There are complete or full dentures which replace the entire arch either mandibular, maxillary or both and there are partial dentures which replace a series of missing teeth in a row which can be either on the mandibular arch, maxillary arch or both as well. These dentures are removable and may be made chair side or in a laboratory depending on the type of denture.

<table>
<thead>
<tr>
<th>Full Denture Upper &amp; Lower</th>
<th>Partial Denture</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5110 Complete denture – maxillary</td>
<td></td>
</tr>
<tr>
<td>D5120 Complete denture – mandibular</td>
<td></td>
</tr>
</tbody>
</table>

- Both of these dentures are custom made and include routine post delivery care.

<table>
<thead>
<tr>
<th>D5130 Immediate denture - maxillary</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5140 Immediate denture – mandibular</td>
</tr>
</tbody>
</table>

Both of these dentures are prefabricated and typically used as temporary dentures for placement immediately after the removal of natural teeth until the complete denture is made. These may be used as permanent dentures however they are not custom to the patient’s mouth. These dentures include
limited follow-up care only; they do not include required future rebasing/relining or a complete new denture.

From time to time adjustments may need to be done on a patient’s denture. For example, they may have a high spot on the denture that is causing pain and sometimes sores. The following codes are used for complete denture adjustments:

D5410  Adjust complete denture - maxillary
D5411  Adjust complete denture - mandibular

These codes are to be used once per visit. Meaning if the dentist adjusted several areas of the denture, you do not get to report this code for every area; you only report this code once.

**Miscellaneous Services**

The following services may be performed by a general dentist. Most of these services are not covered by the carrier. I strongly suggest you make sure to check with both the medical and dental carrier as to coverage determination.

**D9940  Occlusal guard**

- This is used for patients with TMJ disorders, excessive clenching or grinding and small fracture lines in the teeth
- This may be billed to the medical carrier; the appropriate CPT code would be 21089 if made in office or 99002 if made by an outside lab

**D9941  Athletic mouth-guard**

- This is used for children or adults involved in sports that require a mouth-guard such as boxing, football, wrestling etc.
- This may be billed to the medical carrier; the appropriate CPT code would be 21089 if made in office or 99002 if made by an outside lab
D9910  application of desensitizing medicament

• This is used for patients that have gum recession and sensitivity along the gum line. It is applied to the tooth to alleviate pain and sensitivity to cold or hot.

D9972  External bleaching – per arch

• There are two different methods for external bleaching; the first is to have the dentist take impressions of the patient’s teeth so that custom trays (specifically for bleaching) can be made. When the trays are completed, you give the trays and a bleaching kit to the patient to take home so that they can bleach their teeth at home. The second is performed entirely in the dental office. This process takes about an hour from start to finish. While the patient is seated in an operatory chair the bleaching compound is placed directly on their teeth after some preparation to protect their lips and gum tissue. A high intensity light is directed at their teeth for approximately 30 minutes. The code for either of these types of bleaching is D9972 per arch or D9973 per tooth

• This is considered a cosmetic procedure by most carriers and is typically not a covered benefit.

• This procedure is billable to the patient and insurance carrier per arch.

Conclusion

Congratulations you have just completed Module 3 of the ISP. At this point you should be familiar with the following topics; How to Use the ICD-9-CM, How to Use the CPT Coding Book, Modifiers, Guidelines, CDT Coding Review, Common Medical and Dental procedures.

Next Steps

Complete the Module 3 practice exam at the following URL: http://www.adcaonline.org/pexams when you have completed all three practice exams with a passing score you will receive your certificate of completion and are now qualified to take the CDC or CDC-A certification exam.

CONCLUSION AND NEXT STEPS

You did it!

Congratulations on completing the 8 week online class or Independent Study Program.
**Practice Exams**

Please complete all practice exams. If you took the 8 week online course you must pass all three exams with a 75% or higher to receive your certificate of completion. If you took the Independent Study Program you will not receive a certificate of completion, however, it is recommended you take all three practice exams to help with learning retention.

**Certification**

For information on our certification exams or to schedule your CDC or CDC-A exam please visit the following URL: [http://www.adcaonline.org/certification](http://www.adcaonline.org/certification)
References


