OPTUM360°™

Coding *and* Payment Guide for Dental Services

A comprehensive coding, billing, and reimbursement resource for dental services

2016

Contents

procedures, including diagnostic, preventive, restorative, endodontal, and periodontal services.

CMS-1500 Forms

Most Medicare covered dental services are filed using ICD-9-CM diagnosis codes, HCPCS procedure codes (Levels I and II), and CMS-1500 forms. This includes covered services performed as the result of an illness or injury. Because of the need to accommodate ICD-10-CM codes and other ASCI X12 requirements the National Uniform Claim Committee has revised the CMS-1500 claim form. The latest revision or the 02/12 version has been approved by the Office of Management and Budget. At the time of printing however, an effective date for the use of the revised form has not been released.

Dental Billing Forms

The ADA has created a generic billing form that is used by most dental third-party payers. The ADA Dental Claim Form provides a common format for reporting dental services to a patient's dental benefit plan and has been revised to meet the Health Insurance Privacy and Accountability Act (HIPAA) requirements. ADA policy promotes use and acceptance of the most current version of the ADA Dental Claim Form by dentists and payers. The most current version of the claim also allows reporting of the national provider identifier (NPI). There are significant numbers of claims that are filed using forms customized by the provider. These "superbills" typically are multipart check-off forms. While these bills improve the efficiency of the provider's office, they may create difficulties in the payer's claims flow and can result in delayed reimbursement. The most recent revisions to this claim form were made in July 2012.

Contents and Format of This Guide

Coding and Payment Guide for Dental Services has three primary sections: reimbursement, definitions and guidelines, and Medicare official regulatory information.

Reimbursement

The first section of the guide provides comprehensive information about the coding and reimbursement process. It has four chapters: "Introduction," "The Reimbursement Process," "Documentation—An Overview," and "Claims Processing."

Definitions and Guidelines

The second section provides the definitions and guidelines for using the 2014 CDT codes, as well as the ICD-9-CM codes that most commonly support medical necessity of the service, any associated HCPCS Level II codes (other than the D codes), CPT codes, and reimbursement information.

Procedure Code Definitions and Guidelines

This section begins with the standard coding definitions and guidelines for CDT or CPT codes. Following this section is a listing of the most common CDT or CPT codes applicable to dental services. At the top of each page you will find a code or code range with its official description, followed by an explanation of the procedure or supply. Procedure codes are crosswalked to other HCPCS Level II codes, common ICD-9-CM codes, relative value units, and, when applicable, CPT or CDT procedure codes, coding tips, terms to know, pertinent sections from official Medicare manuals, and reference numbers. A listing of official Medicare manual references completes this section. All this information is designed to allow the user to appropriately code and bill for services.

ICD-9-CM Definitions and Guidelines

An overview of the ICD-9-CM coding conventions and guidelines is presented in this section. A comprehensive alphabetic index of ICD-9-CM diagnosis codes specific to dental services is in the index at the end of this section. Please note that this list of associated ICD-9-CM codes is not all inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

A separate ICD-9-CM index lists the E codes commonly associated with the circumstances and conditions that could cause injury to teeth and oral structures and may require dental services.

Medicare Official Regulatory Information

Full excerpts from applicable Medicare manuals, including the *Medicare National Coverage Determinations Manual* and the *Medicare Benefit Policy Manual* applicable to dental services are provided in this section. These excerpts often do not identify the guideline with corresponding HCPCS Level II codes. Our experts have crosswalked the reference, wherever possible, to the appropriate procedure or supply code, so that the reference appears in the main body of the book with the associated codes. The full text of all of the internet-only manuals (IOM) may be found at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html.

How to Use This Guide

The first three chapters: "The Reimbursement Process," "Documentation—An Overview," and "Claims Processing" may be read in their entirety and/or used as references. When using this *Coding and Payment Guide* for code assignment, follow these important steps to improve accuracy and experience fewer overlooked diagnoses and services:

- **Step 1.** Carefully read the medical record documentation that describes the patient's diagnosis and the service provided. Remember, more than one diagnosis or service may be documented.
- **Step 2.** Locate the appropriate CPT or dental procedure code in the chapter titled "Procedure Codes." Read the explanation and determine if that is the procedure performed and supported by the medical record documentation.
- **Step 3.** At this time, review the additional information pertinent to the specific code found in the coding tips, IOM references, and the Medicare physician fee schedule references. Use the "Terms to Know" to help ensure appropriate code assignment.
- **Step 4.** Peruse the list of ICD-9-CM codes to determine if the condition documented in the medical record is listed and the code identified. If the condition is not listed refer to the ICD-9-CM index or the ICD-9-CM manual to locate the appropriate code.

  Assessing the ICD-10-CM Code Crosswalks on October 1, 2015

  Optum will include the ICD-9-CM to ICD-10-CM crosswalk in the web-based http://www.MedicalCodeExpert.com. This

D0140-D0145

D0140 limited oral evaluation - problem focused

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

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

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

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

Explanation

The limited evaluation is problem focused on a particular dental health problem or concern presented by the patient. It includes the interpretation of information acquired through additional, separately-reportable, diagnostic oral health tests. It may lead to the decision that other definitive procedures are also required. Report D0145 when patient is younger than three years and primary caregiver is counseled.

Coding Tips

Code D0140 reports a type of evaluation typically provided if the patient presents with trauma, acute infection, other oral care emergency, or when the patient has been referred for a specific problem. When an oral health assessment is performed by someone other than the dentist for example, a licensed dental hygienist, some third-party payers may require that modifier DA Oral health assessment by a licensed health professional other than a dentist, be appended to codes D0140 and D0145. Check with third-party payers for their specific requirements. Report code D0160 when a detailed and extensive oral evaluation is provided. When a comprehensive examination is performed, see D0150. When the provider performs a caries risk assessment using a standardized risk assessment tool, see D0601-D0603. Documentation for code D0145 should include oral and physical health history, evaluation of caries susceptibility, and development of appropriate oral health regimen including discussion of said regimen with caregiver. Because of the level of care required by children under the age of 3, code D0145 may be reported for reevaluations if all of the above components are performed and documented. Any radiograph, prophylaxis, fluoride, restorative, or extraction service is reported separately.

Terms To Know

evaluation. Dynamic process in which the dentist makes clinical judgments based on data gathered during the examination.

HCPCS Codes

N/A

ICD-9-CM Diagnostic Codes

054.2	Herpetic gingivostomatitis
145.0	Malignant neoplasm of cheek mucosa
145.5	Malignant neoplasm of palate, unspecified
210.4	Benign neoplasm of other and unspecified parts of mouth
230.0	Carcinoma in situ of lip, oral cavity, and pharynx
520.1	Supernumerary teeth
520.6	Disturbances in tooth eruption
521.01	Dental caries limited to enamel
521.02	Dental caries extending into dentine
521.22	Diseases of hard tissues of teeth, abrasion, extending into dentine
521.23	Diseases of hard tissues of teeth, abrasion, extending into pulp
521.24	Diseases of hard tissues of teeth, abrasion, localized
521.25	Diseases of hard tissues of teeth, abrasion, generalized
521.33	Diseases of hard tissues of teeth, erosion, extending into pulp
521.81	Cracked tooth
522.0	Pulpitis
522.4	Acute apical periodontitis of pulpal origin
522.8	Radicular cyst of dental pulp
523.00	Acute gingivitis, plaque induced
523.01	Acute gingivitis, non-plaque induced
523.10	Chronic gingivitis, plaque induced
523.11	Chronic gingivitis, non-plaque induced
523.31	Aggressive periodontitis, localized
523.32	Aggressive periodontitis, generalized
523.33	Acute periodontitis
524.30	Anomaly of tooth position, unspecified
525.61	Open restoration margins
525.63	Fractured dental restorative material without loss of material
525.64	Fractured dental restorative material with loss of material
528.00	Stomatitis and mucositis, unspecified
V72.2	Dental examination — (Use additional code(s) to identify any special screening examination(s) performed: V73.0-V82.9)

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

	Work Value	Non-Fac PE	Fac PE	Malpractice	Non-Fac Total	Fac Total
D0140	0.00	0.00	0.00	0.00	0.00	0.00
D0145	0.00	0.00	0.00	0.00	0.00	0.00

12020-12021

12020 Treatment of superficial wound dehiscence; simple closure
12021 with packing

Explanation

There has been a breakdown of the healing skin either before or after suture removal. The skin margins have opened. The dentist cleanses the wound with irrigation and antimicrobial solutions. The skin margins may be trimmed to initiate bleeding surfaces. Report 12020 if the wound is sutured in a single layer. Report 12021 if the wound is left open and packed with gauze strips due to the presence of infection. This allows infection to drain from the wound and the skin closure will be delayed until the infection is resolved.

Coding Tips

For extensive or complicated secondary wound closure, see 13160. For wound closure by tissue adhesive(s) only, see HCPCS Level II code G0168. To report extensive debridement of soft tissue and/or bone, not associated with open fractures and/or dislocations, resulting from penetrating and/or blunt trauma, see 11042–11047. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage. When the condition is the result of an accident, the dental insurer may require that the medical insurance be billed first. When covered by the medical insurance, the payer may require that the appropriate CPT code be reported on the CMS-1500 claim form.

Terms To Know

dehiscence. Complication of healing in which the surgical wound ruptures or bursts open, superficially or through multiple layers.

infection. Presence of microorganisms in body tissues that may result in cellular damage.

irrigate. Washing out, lavage.

packing. Material placed into a cavity or wound, such as gels, gauze, pads, and sponges.

HCPCS Codes

N/A

ICD-9-CM Diagnostic Codes

998.30 Disruption of wound, unspecified
998.32 Disruption of external operation (surgical) wound
998.33 Disruption of traumatic injury wound repair
998.59 Other postoperative infection — (Use additional code to identify infection)
998.83 Non-healing surgical wound

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

	Work Value	Non-Fac PE	Fac PE	Malpractice	Non-Fac Total	Fac Total
12020	2.67	4.98	2.36	0.40	8.05	5.43
12021	1.89	2.52	1.83	0.30	4.71	4.02