MODULE 9
CDT Documentation and Coding

Introduction

Welcome to week nine of this twelve-week online course. You should now be familiar with how to use the ICD-10-CM and CPT coding manuals. This week we will explore the history of CDT codes along with basic knowledge of CDT coding

Objectives

After reading this module you should be able to:

- Have in-depth knowledge of the history of CDT codes
- In-depth knowledge of how to use the CDT coding manual
- Explain components of a dental procedure code entry
- In-depth knowledge of Categories of Service
- General knowledge of official guidelines for coding and reporting
- In-depth knowledge of step by step coding

History of CDT Codes

According to the American Dental Association the purpose of the CDT Code is to achieve three common goals when accurately documenting dental treatment. The first is uniformity simply put means to make something the same, the second is consistency meaning to adhere to the same set of principles, and the third is specificity meaning to be a specific as possible. There are two major functions or uses of the CDT code. One use of the CDT Code is to provide for the efficient processing of dental claims, and another is to populate an Electronic Health Record.

On August 17, 2000 the CDT Code was named as a HIPAA standard code set. Any claim submitted on a HIPAA standard electronic dental claim must use dental procedure codes from the version of the CDT Code in effect on the date of service.

Code Maintenance Committee

The Council on Dental Benefit Programs (CDBP) has ADA Bylaws that are responsible for CDT Code maintenance. To fulfill this obligation CDBP established its Code Maintenance Committee (CMC). The CMC is made up of representatives from various sectors of the dental community (e.g., ADA; dental specialty organizations; third-party payers). CMC members, by their votes, determine which of the requested actions are incorporated into the CDT Code.

CMC Member Organizations

- Five representatives from the American Dental Association, one of whom will serve as chair
- One representative from each of the nine recognized dental specialty organizations
    - American Academy of Oral and Maxillofacial Pathology
    - American Academy of Oral and Maxillofacial Radiology
    - American Academy of Pediatric Dentistry
    - American Academy of Periodontology
    - American Association of Endodontists
    - American Association of Oral and Maxillofacial Surgeons
    - American Association of Orthodontists
    - American Association of Public Health Dentistry
    - American College of Prosthodontics
- One representative from the Academy of General Dentistry
- One representative from each of the following third-party payer organizations
    - America's Health Insurance Plans
    - Blue Cross and Blue Shield Association
    - Centers for Medicare and Medicaid Services
    - Delta Dental Plans Association
    - National Association of Dental Plans
- One representative from the American Dental Education Association

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:

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

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 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 www.ada.org/en/publications/cdt.

Components of a Dental Procedure Code Entry

In the CDT coding manual every dental procedure code consists of three components, procedure code, nomenclature, and descriptor.

- Procedure code – This is a five-character alphanumeric code beginning with the letter "D". You should note procedure codes cannot be changed or abbreviated.
- Nomenclature – simply means a system of naming, in this case it is the written title of the procedure code. You should note nomenclature may be abbreviated when printed on a claim form or when limited space is available.
- Descriptor – This is a written narrative that gives definition or explanation of the code and its use.

Using the CDT coding Manual

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 Dentals URG for 2016 below. If you would like a copy of the entire URG you may find the manual at the following URL:

https://www.deltadentalri.com/Content/Docs/URGuidelines.pdf

D0100-D0999 I. Diagnostic Procedures

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 usually 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 most patient insurance plans; however, it is always recommended you contact the carrier for an accurate breakdown of benefits. There a total of eight exam codes for dental use, we will go over the descriptors and proper use of each examination code.

- **Periodic oral evaluation – established patient**
    - Used for an established patient who is coming in for a routine cleaning, the allowance on this code is typically once every six months to the day. There are some carriers who will allow this code to be billed twice a year regardless of the interval between cleanings.
    - May be billed in addition to cleanings, radiographs, and fluoride treatment.
    - Compatible with medical codes 99212-99214 depending on documentation provided in the patient's chart
    - This code is covered by Medicare if its purpose is to identify a patients existing infection prior to kidney transplantation, patients with cancer undergoing radiation therapy or about to start chemotherapy.

- **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, acute infection etc.)
    - 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 with medical codes 99201-99202 and 99212-99213

- **Oral evaluation for a patient under three years of age and counseling with primary caregiver**
    - New or established patient
    - Compatible with medical codes 99202-99204 and 99212-99214
    - 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, carries susceptibility, and development of a preventative oral health plan along with counseling of the child's primary caregiver
    - This code is to be used once per lifetime on initial comprehensive examination

- **Comprehensive oral evaluation**
    - New or Established patients
    - 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 extra oral 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).
    - 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 99203-99205 new patient and/or 99213-99215 established patient.

- **Detailed and extensive oral evaluation – problem focused, by report**
    - 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. The report should be extensive in nature detailing the patient's condition(s)
    - 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.

- **Re-evaluation – limited problem focused (established patient; not post-operative visits)**
    - Established patient only
    - This code is used to assess the status of a previously existing condition such as continue mouth pain, soft tissue lesion requiring follow-up visit
    - Used in between limited oral evaluation
    - Compatible with medical codes 99201-99202 and 99212-99213

- **Re-evaluation – post operative office visit**
    - Established patient only
    - This code is used for post-operative visits (e.g. biopsy, extraction of wisdom teeth, root canal therapy, bone or tissue graft)
    - Carriers usually will not pay for post-operative care it is considered inclusive of the initial procedure
    - Compatible with medical code 99024

- **Comprehensive periodontal evaluation – new or established patient**
    - 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.

Radiographs are considered part of diagnostic services in the CDT coding manual. Radiographs commonly referred to as X-rays should be taken for clinical reasons as deemed necessary by the patient's 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 patient's chart at all times. X-rays are considered diagnostic and typically covered at 100% on the patient's 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 review your CDT coding manual.

- **Intraoral – complete series of radiographic images**
    - This is typically covered once every 3 years
    - 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

- **Intraoral – periapical first radiographic image**
    - 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

- **Bitewing – single radiographic image**

    - Bitewing films should include a clear view of the inter-proximal of the tooth, this x-ray is used to detect decay.
    - Compatible medical code 70300. CPT code 70300 reads Radiologic examination, teeth, single view

- **Panoramic radiographic image**
    - 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
    - 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

D1000-D1999 II. Preventive

Cleanings (Dental Prophylaxis)

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, detect, 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.

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.

Dental Services (Basic and Major Treatment)

Basic services under dental carrier guidelines usually include restorative fillings and extractions. These types of procedure are usually covered at 80% however, you should always check the patient's benefits prior to the procedure. Major services typically include root canal therapy, crowns, bridges, dental implants, partials dentures, and full mouth dentures these types of services are usually covered at 50%. You must take into consideration that while the carrier will cover a service at 80% or 50% the patient will still have an annual cap of funds for each year. Meaning they may have an annual maximum of $1500 and a deductible of $50 and depending on the time of year they may have used some of the funds. Therefore, to say a procedure is covered at 50% may be a bit misleading. Here's an example:

Patient needs a crown on tooth #3 it is covered at 50%

Annual Maximum: $1500
Deductible: $50
Funds already used for the year: $1100
Cost of Crown: $1050 Covered at 50% $525
Actual cost covered: $425

Because the patient had already used $1100 for the year there was only $425 left in the annual maximum. Even though the carrier should have paid 50% $525 there was not enough funds therefore the patient liability is greater.