Top Dental Coding Errors

Filing complete and accurate dental claims is key to receiving the maximum reimbursement available the first time the claim is filed. In order to file a complete and accurate claim, the billing team members need to be knowledgeable of current dental codes and understand the procedures that they are reporting. Unfortunately, many dental teams do not have the training or reference materials necessary to properly file dental claims.

Administrative team members typically complete and file insurance claims. However, the dentist is ultimately responsible for the accuracy of each dental claim filed. Coding errors, at a minimum, can cause reimbursement delays. They can also lead to fines, actions by dental boards, and even prison time.

While dental team members need an in-depth understanding of all dental codes, identifying common coding errors can be helpful. The following is an overview of some of the more frequent coding errors that occur.

Comprehensive Evaluations

D0180 **Comprehensive periodontal evaluation – new or established patient**
This procedure is indicated for patients showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking or diabetes. It includes evaluation of periodontal conditions, probing and charting, evaluation and recording of the patient's dental and medical history and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer evaluation.

D0180 is an evaluation code that may only be submitted if the patient shows signs and symptoms of periodontal disease or are at higher risk. Patients are considered to be at risk of periodontal disease if they are smokers, diabetics, or pregnant.

Based on the nomenclature of D0180, the dentist is required to perform all of the components of a comprehensive oral evaluation (D0150) in addition to

comprehensive periodontal probing and charting. However, you should not report D0150 and D0180 together; only report D0180 for patients who demonstrate the signs and symptoms necessary and the required procedures are performed.

Reporting Radiographic Images

Reporting the various radiographic image codes can be confusing. Some radiographic image codes dictate the number of images taken, the method of image capture, and/or the area of the mouth that the image details. On the other hand, there are some image capture codes that do not define any of this. It is vital that you report the correct image code based on the images taken.

For example, the bitewing codes dictate the number of images captured, as can be seen below.

D0270	**Single bitewing radiographic image (horizontal or vertical)**
D0272	**Two bitewing radiographic images (horizontal or vertical)**
D0273	**Three bitewing radiographic images (horizontal or vertical)**
D0274	**Four bitewing radiographic images (horizontal or vertical)**

When reporting bitewings, always report the code that correlates to the number of images captured. Furthermore, any image code should be reported based on the definition as laid out in the codes nomenclature and descriptor.

Fluoride vs. Fluoride Varnish

D1206	**Topical application of fluoride varnish**
D1208	**Topical application of fluoride – excluding varnish**

The fluoride codes have historically been an area of confusion. Previously, the various fluoride codes (D1203 and D2014) varied depending on caries risk. These codes have been deleted and replaced with the two codes listed above. Most recently, CDT 2015 revised D1208 to specifically state "excluding varnish." This revision is intended to clarify that D1206 reports the application of fluoride varnish, while D1208 reports the application of fluoride, excluding varnish.

Do not report D1206 or D1208 for the treatment of sensitivity. Instead, report D9910 (application of desensitizing agent). Furthermore, if fluoride is applied at an emergency visit to desensitize, report palliative (D9110).

Core Buildup

D2950 **Core buildup, including any pins when required**
Refers to building up of coronal structure when there is insufficient retention for a separate extracoronal restorative procedure. A core buildup is not a filler to eliminate any undercut, box form, or concave irregularity in a preparation.

Core buildups have historically been misreported. Remember, a core buildup is required for the retention of a crown. D2950 is often reported when filling undercuts or box form. However, D2950 should only be reported when there is insufficient tooth strength or structure to support a crown and more than 50 percent of the tooth is missing.

Furthermore, a core buildup should only be reported when it is a separate procedure. For example, if a post and core (D2952 or D2954) is required as part of the crown procedure, D2950 should not be reported. Rather, it is included with the post and core code.

Finally, a core buildup may be required when an existing crown is endodontically treated. In this case, the crown must be removed completely from the tooth, a core buildup performed, and the crown recemented to the tooth. If the procedure only involves an access hole, not the complete removal of the crown, then report a one surface restoration. In the remarks section of the claim form state, "A restoration was placed for access hole closure after endodontic therapy."

Scaling and Root Planing

D4341 **Periodontal scaling and root planing – four or more teeth per quadrant**
This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others.

D4342 **Periodontal scaling and root planing – one to three teeth per quadrant**
This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these

surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others.

The diagnosis of periodontitis includes some level of clinical attachment loss, which involves the loss of alveolar bone support and gingival attachment. The degree of periodontitis is determined from periodontal pocket depths. These pockets are formed when toxins weaken the gum and connective tissues beneath the gumline. If not treated, these pockets will fill with plaque and become inflamed and infected, eventually leading to tooth loss.

Scaling and root planing (SRP) involves the instrumentation of both crown and root surfaces to remove plaque and calculus. The chart notes must indicate that root planing was required to remove cementum and dentin that is permeated by calculus or is contaminated. The need for SRP is indicated by bleeding on probing, increased pocket depths, attachment loss, purulent discharge, tooth mobility, or high bacterial count.

To report SRP, several conditions must be present, including bleeding on probing, four to five millimeter pocket depths, and radiographic evidence of bone loss. If bone loss is not evident, the procedure will typically not be reimbursed.

Full Mouth Debridement

D4355 **Full mouth debridement to enable comprehensive evaluation and diagnosis**
The gross removal of plaque and calculus that interfere with the ability of the dentist to perform a comprehensive oral evaluation. This preliminary procedure does not preclude the need for additional procedures.

A full mouth debridement is performed when the heavy buildup of plaque and calculus interferes with the ability to complete an oral evaluation. Full mouth debridement cleans the mouth so that the dentist can complete a subsequent oral evaluation. Following debridement, the gum tissue should be allowed to heal (typically 10 to 14 days) before the oral evaluation or any other subsequent procedures are completed.

D4355 should only be reported if it is required to perform a subsequent oral evaluation. D4355 does not report a difficult prophylaxis. Furthermore, D4355 should not be reported for all new hygiene patients.

D4355 is a preliminary procedure that is followed by definitive treatment, usually either a prophylaxis (D1110) or SRP (D4341 or D4342). Keep in mind that the proper sequencing of procedures is vital for the reimbursement of D4355 and all subsequent procedures. If proper timing and sequencing is not followed, reimbursement may be denied or frequency limitations may apply.

Keep in mind that only about 30 percent of plans reimburse D4355. Otherwise, D1110 is paid as an alternative benefit.

Abutments

D6051 **Interim abutment**
Includes placement and removal. A healing cap is not an interim abutment.

D6056 **Prefabricated abutment – includes modification and placement**
Modification of a prefabricated abutment may be necessary.

D6057 **Custom fabricated abutment – includes placement**
Modification of a prefabricated abutment may be necessary.

Abutments are often purchased from a manufacturer or furnished by a specialist. For instance, prefabricated abutments are typically purchased from an implant manufacturer. When this is the case, the restorative dentist who *places* the abutment will report the abutment code (D6051, D6056, or D6057). The implant surgeon who manufactures or provides the abutment to the restorative dentist reports the unspecified procedure code D6199 to report the cost of the abutment materials. The specialist should not report the abutment procedure.

Bone Grafts

D6104 **Bone graft at time of implant placement**
Placement of a barrier membrane, or biologic materials to aid in osseous regeneration are reported separately

D7953 **Bone replacement graft for ridge preservation – per site**
Graft is placed in an extraction or implant removal site at the time of the extraction or removal to preserve ridge integrity (e.g., clinically indicated in preparation for implant reconstruction or where alveolar contour is critical to planned prosthetic reconstruction). Does not include obtaining bone

graft material. Membrane, if used should be reported separately.

D6104 reports the placement of a bone graft in conjunction with implant placement. D7953 reports a bone graft placed in a fresh extraction site when there will be healing prior to implant placement, which will occur on a later service date. It is very important to distinguish between these two codes.

D6104 reports the placement of a bone graft on the same service date that the implant is placed or removed. This is true whether the tooth has just been extracted, the failed implant has just been removed, or the tooth has been missing for a long period of time. The distinction is that the two procedures are performed at the same time.

On the other hand, D7953 reports a bone graft that is to be followed by the placement of an implant on a later date. This implant may be placed 6 months following the bone graft procedure.

In any case, if a membrane (D4266 or D4266) is utilized as part of the bone graft treatment, report it separately.

Palliative

D9110 **Palliative (emergency) treatment of dental pain – minor Procedure**
This is typically reported on a "per visit" basis for emergency treatment of dental pain.

Report a palliative treatment when a minor procedure is performed to alleviate dental pain. Generally speaking, D9110 may be reported at an emergency visit where the dentist performed some type of procedure to reduce the patient's pain or discomfort. D9110 is reported on a "per visit" basis, regardless of the number of procedures provided.

If a patient presents for the treatment of a painful condition on a stand-alone basis and no other services are performed, palliative will generally be reimbursed. However, if the palliative treatment is provided along with the definitive treatment of another condition at the same appointment, the palliative treatment will most likely not be reimbursed. When filing a palliative claim, always include a narrative that supports the medical necessity of the procedure. Describe the condition treated, the service provided, and establish the time needed to address the condition. Any necessary radiographs should be submitted separately.

Palliative is often misreported when only a prescription is provided, but no procedure is performed. Note that a procedure must be performed to report D9110. And, writing a prescription does not count as a procedure.

For example, a patient calls for the treatment of a chipped tooth. The patient is experiencing sensitivity to hot and cold and pain when chewing. The dentist sees the patient at an emergency visit and provides a protective restoration to seal the tooth and alleviate the patient's pain. The patient is then reappointed for a second appointment so that the final restoration maybe placed. For this visit, you would report palliative, D9110.

The proper submission of dental procedures is vital in gaining proper reimbursement and protecting your dental practice. Understanding these common coding errors can help your dental team to more accurately report these dental procedures. However, those team members also need the proper training and access to coding resources to ensure that each claim is filed correctly.