AAPD appreciates the generous support from Avesis Dental, Delta Dental of California, Liberty Dental and MCNA Dental to bring you updates to the AAPD Coding and Insurance Manual 2017.

Current Dental Terminology, © 2017 American Dental Association. All rights reserved.
The Code on Dental Procedures and Nomenclature (CDT) is updated annually. The American Dental Association (ADA)’s Code Maintenance Committee (CMC) meets early each year to review the code change requests that are submitted, and votes to either accept, deny, or table each request.

New and revised codes pertinent to pediatric dentists become effective Jan. 1, 2018.

Before reviewing the new codes, it is important to remember a few key facts about CDT. First, the primary purpose of CDT is to provide dental teams with a standardized language to report dental procedures. This standardized language allows doctors to:

- Clearly communicate with patients about proposed dental procedures.
- Accurately document all dental services performed.
- Appropriately bill patients for services.
- Accurately report dental procedures to third-party payers.

The existence of a code does not necessarily mean that it will be reimbursed. Payers are required to recognize current CDT codes when submitted on claims, but they are not obligated to pay for them. Furthermore, different payers may start providing reimbursement for new procedure codes at various times, depending on when they update their plan document. Despite this fact, it is vital to always report the most accurate, current CDT code to describe the procedure performed. The more frequently a code is reported, the more likely that it will be reimbursed in the future.

### REVISED CODES

**D1354 interim caries arresting medicament application – per tooth**

Conservative treatment of an active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure.

Rationale: The current nomenclature lacks specificity as to the application of the caries arresting or inhibiting agent. It is unclear if the application should be coded and reimbursed as a per-surface, per tooth, per quadrant, per arch, or per mouth service. Unless procedure D1354 is interpreted and reported as a per tooth procedure, it is impossible to track individual tooth outcomes and follow-up procedures in the patient record. Some treated teeth will require reapplication at determined intervals, some will be followed to exfoliation, and others will eventually receive definitive restorative care as individual patient circumstances dictate.

**D1555 removal of fixed space maintainer**

Procedure performed by dentist or practice that did not originally place the appliance.

**D4355 full mouth debridement to enable a comprehensive evaluation and diagnosis on a subsequent visit**

Full mouth debridement involves the preliminary removal of plaque and calculus that interferes with the ability of the dentist to perform a comprehensive oral evaluation. Not to be completed on same day as D0150, D0160, or D0180.

Rationale: Clarifies that subsequent visit is necessary for comprehensive evaluation.

**D9223 deep sedation/general anesthesia – each subsequent 15 minute increment**

Rationale: Aligns with the medical model for the provision of anesthesia services.

**D9243 intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment**

Rationale: Aligns with the medical model for the provision of anesthesia services.

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Inadvertently omitted from AAPD Coding and Insurance Manual 2017

**D6985 pediatric partial denture, fixed**

This prosthesis is used primarily for aesthetic purposes
NEW CODES

• D0411  HbA1c in-office point of service testing
• D8695  removal of fixed orthodontic appliance(s) for reasons other than completion of treatment
  Rationale: This procedure is not associated with the removal of fixed appliances and the placement of fixed or removable orthodontic retainers at the completion of treatment (D8680). This includes the removal of appliances by another dentist when the patient has left the practice of the treating dentist. Example: remove brackets for wedding day or prior to MRI

• D9222  deep sedation/general anesthesia – first 15 minutes
  Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties.
  The level of anesthesia is determined by the anesthetic provider's documentation of the anesthetic effects upon the central nervous system and not dependent upon the route of administration.
  Rationale: Aligns with the medical model for the provision of anesthesia services.

• D9239  intravenous moderate (conscious) sedation/analgesia – first 15 minutes
  Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties.
  The level of anesthesia is determined by the anesthetic provider's documentation of the anesthetic effects upon the central nervous system and not dependent upon the route of administration.
  Rationale: Aligns with the medical model for the provision of anesthesia services.

• D9995  teledentistry – synchronous; real-time encounter
  Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date.
  Rationale: This administrative code documents the synchronous transmission of patient information to a remote site and allows not only documentation but also billing for the costs associated with such transmission.

• D9996  teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review
  Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service.
  Rationale: This administrative code documents the asynchronous transmission of patient information stored and forwarded to a remote site and allows not only documentation but also billing for the costs associated with such transmission.

UPDATED CARRIER DENTAL CONSULTANTS

DR. CLAY HEDLUND

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Dental Director
(972) 863-5021

For more information, please contact AAPD Dental Benefits Director Mary Essling at messling@aapd.org or (312) 337-2169, ext. 36.
because this form is used by various government and private health programs, see separate instructions issued by applicable programs.

notice: any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

refers to government programs only

Medicare and Tricare Payments: A patient’s signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient’s signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault worker’s compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient’s signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or Tricare participation cases, the physician agrees to accept the charge determination of the Medicare carrier or Tricare fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or Tricare fiscal intermediary if this is less than the charge submitted. Tricare is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient’s sponsor should be provided in those items captioned in “insured”: i.e., items 1a, 4, 6, 7, 8, and 11.

Black Lung and Feca Claims

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and Feca instructions regarding required procedure and diagnosis coding systems.

Signature of Physician or Supplier (Medicare, Tricare, Feca and Black Lung)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or Tricare; 6) for each service rendered incident to my professional service, the identity (legal name and NPI), license #, or SSN of the primary individual rendering each service is reported in the designated section; 7) for services to be considered “incident to” a physician’s professional services, 1) they must be rendered under the physician’s direct supervision by his/her employee, 7) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician’s offices, 4) the services of non-physicians must be included on the physician’s bills. For Tricare claims, I further certify that I (or any employee) who rendered services are not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contractor employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32). Notice: any one who misrepresents or falsifies essential information to receive payment from Federal funds requested in this form may be imprisoned and punished under applicable Federal laws.

Notice to Patient About the Collection of Use of Medicare, Tricare, Feca, and Black Lung Information (Privacy Act Statement)

We are authorized by CMS, Tricare and OWCP to ask you for information needed in the administration of the Medicare, Tricare, Feca, and Black Lung programs. Authority to collect information is in section 265(a), 1962, 1972 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (8), and 44 USC 3101.41 CFR 101 et seq and 10 USC. 1079 and 1088, 6 USC 6001 et seq; and 20 USC 6001 et seq.; 98 USC 615; E.O. 9367.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to ensure the proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties pay to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

For Medicare Claims: See the notice modifying system No. 09-70-0501, titled, ‘Carrier Medicare Claims Record,’ published in the Federal Register, Vol. 55 No. 177, page 37545, Wed. Sept. 12, 1990, or as updated and republished.


For Tricare Claims: Principle Purpose(s): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

Routine Uses: Information from claims and related documents may be given to the Department of Veterans Affairs, the Department of Health and Human Services and/or the Department of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Department of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service for collection of taxes, enforcement of federal provisions, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement; claims adjudication, fraud, abuse, utilization review; quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

Disclosures: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 112B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 101-503, the “Computer Matching and Privacy Protection Act of 1988,” permits the government to verify information by way of computer matches.

Medicaid Payments (Provider Certification)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State’s Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, copayment or similar cost-sharing charge.

Signature of Physician (Or Supplier): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

Notice: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or concealing of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1167. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-25-25, Baltimore, Maryland 21244-1856. This address for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.
<table>
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<td><strong>COLORADO HEALTH CARE POLICY AND FINANCING</strong></td>
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AAPD appreciates the generous support from Avesis Dental, Delta Dental of California, Liberty Dental and MCNA Dental to bring you updates to the AAPD Coding and Insurance Manual 2017.