Dental Services

An essential coding, billing and reimbursement resource for dental services

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Contents

Getting Started with Coding and Payment Guide

The *Coding and Payment Guide for Dental Services* is designed to be a guide to the specialty procedures classified in the CDT® and CPT® books. It is structured to help coders understand procedures and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book. The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

Resequencing of CDT and CPT Codes

The American Dental Association (ADA) and the American Medical Association (AMA) employ a resequenced numbering methodology. According to the associations, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes were not changed or had only minimal changes, the ADA and AMA have assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence. Codes within the Optum360 *Coding and Payment Guide* series display in their resequenced order. Resequenced codes are enclosed in brackets for easy identification.

ICD-10-CM

Overall, the 10th revision goes into greater clinical detail than did ICD-9-CM and addresses information about previously classified diseases, as well as those diseases discovered since the last revision. Conditions are grouped with general epidemiological purposes and the evaluation of healthcare in mind. New features have been added, and conditions have been reorganized, although the format and conventions of the classification and documentation requirements remain unchanged for the most part.

Detailed Code Information

One or more columns are dedicated to each procedure or service to a series of similar procedures/services. Following the specific CDT and CPT code and its narrative, is a combination of features. A sample is shown on page 2. The black boxes with numbers in them correspond to the information on the page following the example.

Appendix Codes and Descriptions

Some procedure codes are presented in a less comprehensive format in the appendix. The CDT and CPT codes appropriate to the specialty are included the appendix with the official code description. The codes are presented in numeric order, and each code is followed by an easy-to-understand lay description of the procedure.

CCI Edit Updates

The *Coding and Payment Guide* series includes the a list of codes from the official Centers for Medicare and Medicaid Services' *National Correct Coding Policy Manual for Part B Medicare Contractors* that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version XX.X, the most current version available at press time. The CCI edits are now located in a section at the back of the book. Optum360 maintains a website to accompany the *Coding and Payment Guide* series and posts updated CCI edits on this website so that current information is available before the next edition. The website address is https:// www.optum360coding.com/Product Updates/. The 2022 edition password is: **XXXXXXXX22**. Please note that you should log in each quarter to ensure you receive the most current updates. An email reminder will also be sent to you to let you know when the updates are available.

Index

Comprehensive indexes for both the CPT and the CDT coding systems are provided for easy access to the codes. The indexes have several axes. A code can be looked up by its procedure name or by the anatomical site associated with it. For example:

Debridement
    endodontic, D3221
    periodontal, D4355
        implant
            peri, D6101-D6102
            single, D6081

General Guidelines

Providers

The ADA and AMA advises coders that while a particular service or procedure may be assigned to a specific section, the service or procedure itself is not limited to use only by that specialty group. Additionally, the procedures and services listed throughout the book are for use by any qualified dentist, physician, or other qualified healthcare professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Supplies

Some payers may allow providers to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting.

Professional and Technical Component

Radiology and some pathology codes have a technical and a professional component. When providers do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

Sample Page and Key

On the following pages are a sample page from the book displaying the new format of *Coding and Payment Guide for Dental Services* with each element identified and explained on the opposite page.

Procedure Codes

One of the keys to gaining accurate reimbursement lies in understanding the multiple coding systems that are used to identify services. To be well versed in reimbursement practices, coders should be familiar with the CDT, HCPCS Level II, ICD-10-CM, and CPT® coding systems. The first of these, the CDT system, is increasingly important to reimbursement, as it has been extended to a wider array of dental services.

- Coding and billing should be based on the service and supplies provided. Documentation should describe the patient's problems and the service provided to enable the payer to determine reasonableness and necessity of care.
- Refer to Medicare coverage reference to determine whether the care provided is a covered service. The references are noted, when they apply, on the pages following.

HCPCS Level I or CPT Codes

Known as HCPCS Level I, the CPT coding system is the most commonly used system to report procedures and services. Copyright of CPT codes and descriptions is held by the American Medical Association. This system reports outpatient and provider services.

CPT codes predominantly describe medical services and procedures, and are adapted to provide a common billing language that providers and payers can use for payment purposes. The codes are required for billing by both private and public insurance carriers, managed care companies, and workers' compensation programs. Dental professional may find that a third-party payer will occasionally require that a procedures be reported using a CPT code. Unless otherwise instructed, dental professional should report services using the appropriate American Dental Association (ADA) dental code when one exists.

HCPCS Level II Codes

HCPCS Level II codes are commonly referred to as national codes or by the acronym HCPCS (pronounced "hik piks"). HCPCS codes are used for billing Medicare and Medicaid patients and have also been adopted by some third-party payers. HCPCS Level II codes published annually by CMS, are intended to supplement the CPT coding system by including codes for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS); drugs; and biologicals. These Level II codes consist of one alphabetic character (A–V) followed by four numbers. In many instances, HCPCS Level II codes are developed as precursors to CPT codes.

A complete list of the HCPCS Level II codes and the quarterly updates to this code set may be found at http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html.

The following is a list of the HCPCS Level II supply codes used to identify supplies commonly used by dentists.

Medical and Surgical Supplies A4000–A8999

The A and E code sections of the HCPCS Level II code system cover a wide variety of medical and surgical supplies, and some durable medical equipment (DME), supplies and accessories.

A4550	Surgical trays
A4649	Surgical supply; miscellaneous
E1700	Jaw motion rehabilitation system
E1701	Replacement cushions for jaw motion rehabilitation system, package of 6
E1702	Replacement measuring scales for jaw motion rehabilitation system, package of 200

Drugs Administered Other Than Oral Method J0000–J8999

Drugs and biologicals are usually covered by Medicare if: they are of the type that cannot be self-administered; they are not excluded by being immunizations; they are reasonable and necessary for the diagnosis or treatment of the illness or injury for which they are administered; and they have not been determined by the Food and Drug Administration (FDA) to be less than effective. In addition they must meet all the general requirements for coverage of items as incident to a physician's services. Generally, prescription and nonprescription drugs and biologicals purchased by or dispensed to a patient are not covered.

The following list of drugs can be injected either subcutaneously, intramuscularly, or intravenously. Third-party payers may wish to determine a threshold and pay up to a certain dollar limit for the drug.

J codes fall under the jurisdiction of the DME regional office for Medicare, unless incidental or otherwise noted. See Pub. 100-2, chap. 15, sec. 50.4

J0670	Injection, mepivacaine HCl, per 10 ml
J1790	Injection, droperidol, up to 5 mg
J2250	Injection, midazolam HCl, per 1 mg
J2400	Injection, chloroprocaine HCl, per 30 ml
J2515	Injection, pentobarbital sodium, per 50 mg
J2550	Injection, promethazine HCl, up to 50 mg
J3010	Injection, fentanyl citrate, 0.1 mg
J3360	Injection, diazepam, up to 5 mg

Temporary National Codes (Non-Medicare) (S0000–S9999)

S0020	Injection, bupivicaine HCl, 30 ml

D0160

D0160 detailed and extensive oral evaluation - problem focused, by report

A detailed and extensive problem focused evaluation entails extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. Integration of more extensive diagnostic modalities to develop a treatment plan for a specific problem is required. The condition requiring this type of evaluation should be described and documented. Examples of conditions requiring this type of evaluation may include dentofacial anomalies, complicated perio-prosthetic conditions, complex temporomandibular dysfunction, facial pain of unknown origin, conditions requiring multi-disciplinary consultation, etc.

Explanation

The detailed, extensive oral evaluation focuses on a specific problem with extensive diagnostic and cognitive skills being used, based on the findings of a comprehensive oral exam. Developing a treatment plan through integrating more extensive diagnostic faculties for the specific problem is a requirement. Thorough documentation of the condition requiring this service should be made. Examples of such conditions may include acute peri-prosthetic complications, temporomandibular joint (TMJ) dysfunction, and pain of unknown origin.

Coding Tips

When a comprehensive examination is performed and documented, see code D0150. When the patient is referred by another dentist for an opinion or advice regarding a particular condition, see code D9310. When a comprehensive periodontal evaluation is performed, report D0180. When the provider performs a caries risk assessment using a standardized risk assessment tool, see D0601-D0603. Any radiograph, prophylaxis, fluoride, restorative, or extraction service is reported separately. Pertinent documentation to evaluate medical appropriateness should be included when this code is reported.

Documentation Tips

The following information can be documented on a tooth chart: treatment/location of caries, endodontic procedures, prosthetic services, preventive services, treatment of lesions and dental disease, or other special procedures. A tooth chart may also be used to identify structure and rationale of disease process and the type of service performed on intraoral structures other than teeth.

Reimbursement Tips

Coverage of this procedure varies by payer and there may be frequency limitations.

ICD-10-CM Diagnostic Codes

K00.1	Supernumerary teeth
K00.2	Abnormalities of size and form of teeth
K00.3	Mottled teeth
K00.4	Disturbances in tooth formation
K00.5	Hereditary disturbances in tooth structure, not elsewhere classified
K00.6	Disturbances in tooth eruption
K00.7	Teething syndrome
K01.0	Embedded teeth
K01.1	Impacted teeth
K02.3	Arrested dental caries
K02.51	Dental caries on pit and fissure surface limited to enamel
K02.52	Dental caries on pit and fissure surface penetrating into dentin
K02.53	Dental caries on pit and fissure surface penetrating into pulp
K02.61	Dental caries on smooth surface limited to enamel
K02.62	Dental caries on smooth surface penetrating into dentin
K02.63	Dental caries on smooth surface penetrating into pulp
K02.7	Dental root caries
K03.0	Excessive attrition of teeth
K03.1	Abrasion of teeth
K03.2	Erosion of teeth
K03.3	Pathological resorption of teeth
K03.4	Hypercementosis
K03.5	Ankylosis of teeth
K03.6	Deposits [accretions] on teeth
K03.7	Posteruptive color changes of dental hard tissues
K03.81	Cracked tooth
K04.01	Reversible pulpitis
K04.02	Irreversible pulpitis
K04.1	Necrosis of pulp
K04.2	Pulp degeneration
K04.3	Abnormal hard tissue formation in pulp
K04.4	Acute apical periodontitis of pulpal origin
K04.5	Chronic apical periodontitis
K04.6	Periapical abscess with sinus
K04.7	Periapical abscess without sinus
K04.8	Radicular cyst
K05.00	Acute gingivitis, plaque induced
K05.01	Acute gingivitis, non-plaque induced
K05.10	Chronic gingivitis, plaque induced
K05.11	Chronic gingivitis, non-plaque induced
K05.211	Aggressive periodontitis, localized, slight
K05.212	Aggressive periodontitis, localized, moderate
K05.213	Aggressive periodontitis, localized, severe
K05.221	Aggressive periodontitis, generalized, slight
K05.222	Aggressive periodontitis, generalized, moderate
K05.223	Aggressive periodontitis, generalized, severe
K05.311	Chronic periodontitis, localized, slight
K05.312	Chronic periodontitis, localized, moderate
K05.313	Chronic periodontitis, localized, severe
K05.321	Chronic periodontitis, generalized, slight
K05.322	Chronic periodontitis, generalized, moderate
K05.323	Chronic periodontitis, generalized, severe
K05.4	Periodontosis
K05.5	Other periodontal diseases
K06.011	Localized gingival recession, minimal
K06.012	Localized gingival recession, moderate
K06.013	Localized gingival recession, severe
K06.021	Generalized gingival recession, minimal
K06.022	Generalized gingival recession, moderate
K06.023	Generalized gingival recession, severe
K06.1	Gingival enlargement
K06.2	Gingival and edentulous alveolar ridge lesions associated with trauma
K06.8	Other specified disorders of gingiva and edentulous alveolar ridge
K08.0	Exfoliation of teeth due to systemic causes
K08.111	Complete loss of teeth due to trauma, class I
K08.112	Complete loss of teeth due to trauma, class II
K08.113	Complete loss of teeth due to trauma, class III
K08.114	Complete loss of teeth due to trauma, class IV

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K03.2   Erosion of teeth

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D2650	3.39	3.00	0.70	7.09
D2651	3.99	3.52	0.82	8.33
D2652	4.47	3.95	0.92	9.34
Facility RVU	Work	PE	MP	Total
D2650	3.39	3.00	0.70	7.09
D2651	3.99	3.52	0.82	8.33
D2652	4.47	3.95	0.92	9.34

	FUD	Status	MUE	Modifiers				IOM Reference
D2650	N/A	N	-	N/A	N/A	N/A	N/A	None
D2651	N/A	N	-	N/A	N/A	N/A	N/A	
D2652	N/A	N	-	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

composite. In dentistry, synthetic material such as acrylic resin and quartz particles used in tooth restoration.

facial surface. In dentistry, tooth surface that is facing the cheeks or lips.

indirect restoration. In dentistry, restoration produced outside of the mouth.

inlay. Restoration made outside of the mouth to fit a prepared cavity and placed on the tooth.

D2662-D2664

D2662 onlay - resin-based composite - two surfaces
D2663 onlay - resin-based composite - three surfaces
D2664 onlay - resin-based composite - four or more surfaces

Explanation

A resin-based composite or composite/resin onlay covering two surfaces (top of the tooth and one side of the tooth) is applied. An onlay, like a filling or a crown, is a type of dental restoration procedure. Onlays are constructed of metallic or non-metallic materials and are considered indirect restorations. An onlay fits like a puzzle piece onto the tooth, covering the cusp or pointed portion of the tooth. An onlay is used to restore teeth that require more than a filling, but do not require a crown. The tooth is anesthetized and prepared for the onlay. If an old filling is present, it is removed, along with any decay. A mold is made of the tooth, the opposing tooth that the inlay bites against, and adjacent teeth. When a resin-based composite or composite/resin onlay is used, the dentist uses a color chart to match the color of the onlay to the color of the tooth. The mold and the tooth color information are then sent to a laboratory where the onlay is constructed. Onlays made with resin-based composite include all reinforced heat or pressure-cured polymer materials. While the onlay is being constructed, temporary onlay material is placed onto the tooth cusp. When the permanent onlay is returned from the laboratory, the patient returns to the dentist office and the onlay is cemented (luted) onto the tooth cusp. The onlay covers two surfaces (top and one side) of the tooth in D2662; three surfaces in D2663; or four or more surfaces in D2664.

Coding Tips

Resin-based composite includes fiber or ceramic reinforced polymer compounds. Correct code assignment is dependent upon the number of surfaces involved. When assigning a code for multiple surfaces, the surfaces must be continuous. For resin-based inlay procedures, see D2650–D2652. Ceramic/porcelain inlay/onlay procedures are reported with D2610–D2644. For metallic inlay/onlay procedures, see D2510–D2544.

Documentation Tips

Treatment plan documentation should reflect any treatment failure or change in diagnosis and/or a change in treatment plan. There should also be evidence of any initiation or reinstatement of a drug regime, which requires close and continuous skilled medical observation. The following information can be documented on a tooth chart: treatment/location of caries, endodontic procedures, prosthetic services, preventive services, treatment of lesions and dental disease, or other special procedures. A tooth chart may also be used to identify structure and rationale of disease process and the type of service performed on intraoral structures other than teeth.

Reimbursement Tips

Third-party payers often consider laboratory costs, tooth preparation, pulp caps, temporary restorations, porcelain margins, cement bases, impressions, and local anesthesia to be components of a complete restoration and, therefore, will not make separate payment for these services.

ICD-10-CM Diagnostic Codes

K02.52	Dental caries on pit and fissure surface penetrating into dentin
K02.53	Dental caries on pit and fissure surface penetrating into pulp
K02.61	Dental caries on smooth surface limited to enamel
K02.62	Dental caries on smooth surface penetrating into dentin
K02.63	Dental caries on smooth surface penetrating into pulp
K02.7	Dental root caries
K03.0	Excessive attrition of teeth

Dental - Restoration

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D5640-D5650

D5640 replace broken teeth - per tooth
D5650 add tooth to existing partial denture

Explanation
Partial dentures are composed of a metal framework with plastic teeth and gum areas. The framework contains metal clasps or other attachments that hold the denture in place. Two types of attachments are available: metal clasps and precision attachments. Metal clasps consist of C-shaped pieces of denture framework that fit around adjacent natural teeth. A precision attachment uses a receptacle created within a remaining tooth. The receptacle typically is covered with a crown. The precision attachment extends into the receptacle securing the partial denture. If the framework, clasps, or precision attachments break they are repaired in the dentist's office or sent to a dental laboratory. To repair cast framework or replace a fractured clasp or precision attachment, an alginate impression in a stock tray is made of the denture with the patient wearing the denture. Care must be taken to ensure the impression material does not displace the denture from its correct position. The new framework, clasp, or precision attachment is fabricated and attached to the existing denture using the impression to correctly align and place the required part. Repair of the cast framework is reported with D5621 (mandibular or upper) or D5622 (maxillary or lower). Repair of a metal clasp or precision attachment is reported with D5630.

Coding Tips
Local anesthesia is generally considered to be part of removable prosthodontic procedures.

Reimbursement Tips
Third-party payers may not reimburse separately for this service. Check with the payer for specific guidelines.

ICD-10-CM Diagnostic Codes
Z46.3   Encounter for fitting and adjustment of dental prosthetic device

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D5640	0.89	0.79	0.18	1.86
D5650	1.10	0.97	0.23	2.30
Facility RVU	**Work**	**PE**	**MP**	**Total**
D5640	0.89	0.79	0.18	1.86
D5650	1.10	0.97	0.23	2.30

	FUD	Status	MUE	Modifiers				IOM Reference
D5640	N/A	N	-	N/A	N/A	N/A	N/A	None
D5650	N/A	N	-	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know
denture base. Portion of the artificial substitute for natural teeth that makes contact with the soft tissue of the mouth and serves as the anchor for the artificial teeth.

partial dentures. In dentistry, artificial teeth composed of a framework with plastic teeth and gum area replacing part but not all of the natural teeth. The framework can either be formed from an acrylic resin base, cast metal or may be made more flexible using thermoplastics.

D5660

D5660 add clasp to existing partial denture - per tooth

Explanation
A clasp is added to an existing partial denture. To add a clasp to a denture, an alginate impression in a stock tray is made of the denture with the patient wearing the denture. Care must be taken to ensure that the impression material does not displace the denture from its correct position. An impression of the opposing dentition is also made if the component to be added is affected by the occlusion (bite), as this will influence the design and position of the component. If the casts cannot be placed by hand into the intercuspal position, an interocclusal record will be obtained to allow the casts to be mounted on an articulator. A new clasp arm is then produced by adapting a wrought stainless steel wire to the tooth on the cast and attaching the wire to the existing denture base.

Coding Tips
Local anesthesia is generally considered to be part of removable prosthodontic procedures.

Reimbursement Tips
Third-party payers may not reimburse separately for this service. Check with the payer for specific guidelines.

ICD-10-CM Diagnostic Codes
Z46.3   Encounter for fitting and adjustment of dental prosthetic device

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D5660	1.47	1.30	0.30	3.07
Facility RVU	**Work**	**PE**	**MP**	**Total**
D5660	1.47	1.30	0.30	3.07

	FUD	Status	MUE	Modifiers				IOM Reference
D5660	N/A	N	-	N/A	N/A	N/A	N/A	None

* with documentation

Terms To Know
partial dentures. In dentistry, artificial teeth composed of a framework with plastic teeth and gum area replacing part but not all of the natural teeth. The framework can either be formed from an acrylic resin base, cast metal or may be made more flexible using thermoplastics.

prosthodontics. Branch of dentistry that specializes in the replacement of missing or damaged teeth.

Dental - Removable Prosthodontics

D6710-D6722

D6710 retainer crown - indirect resin based composite

Not to be used as a temporary or provisional prosthesis.

D6720 retainer crown - resin with high noble metal
D6721 retainer crown - resin with predominantly base metal
D6722 retainer crown - resin with noble metal

Explanation

A fixed partial denture retainer crown is made for a tooth that needs to be the connecting or anchoring tooth for the retainer but may be decayed or damaged enough to require restoration. The crown is made to accommodate the attachment of the retainer from impressions taken of the tooth's anatomy and the tooth with the retainer (see previous restorative crown codes D2710-D2722 for the method). Report D6710 when tooth-colored resin composite is bonded to the crown. Report D6720 for resin with high noble metal; D6721 for resin with predominantly base metal; and D6722 for resin with noble metal.

Coding Tips

Local anesthesia is included in these services. Any evaluation or radiograph, core buildup, or post or preparation service is reported separately. For individual restorations, see D2710–D2799.Prefabricated crowns are reported using the appropriate code from the D2930–D2934 range; for abutment supported, see D6058–D6064 or D6094. Implant supported crowns are reported with a code from the D6065–D6067 range. Code D6710 should not be used to report a temporary or provisional prosthesis, see D6793. For crowns used as a fixed partial denture retainer fabricated using porcelain or ceramic, see codes D6740–D6752; for 3/4 cast metals or porcelain/ceramics, see D6780–D6783. Full crowns used for partial denture retainers are reported with the appropriate code in the D6790–D6792 range. A titanium fixed partial denture retainer crown is reported with D6794. High noble metals include gold, palladium, and platinum. The content must be ≥ 60 percent gold plus platinum and ≥ 40 percent gold. Noble metals include 25 percent or less gold plus platinum group. Predominantly base alloys contain a noble metal content of < 25 percent gold plus platinum group. The metals of the platinum group include platinum, palladium, rhodium, iridium, osmium, and ruthenium. Resin-based composite includes fiber or ceramic reinforced polymer compounds.

Documentation Tips

Documentation should indicate the location and number of missing teeth.

Reimbursement Tips

Payers may require documentation including the tooth number and preoperative periapical x-rays showing the entire treatment site for codes D6720-D6722.

ICD-10-CM Diagnostic Codes

K02.51	Dental caries on pit and fissure surface limited to enamel
K02.52	Dental caries on pit and fissure surface penetrating into dentin
K02.53	Dental caries on pit and fissure surface penetrating into pulp
K02.61	Dental caries on smooth surface limited to enamel
K02.62	Dental caries on smooth surface penetrating into dentin
K02.63	Dental caries on smooth surface penetrating into pulp
K02.7	Dental root caries
K03.0	Excessive attrition of teeth
K03.1	Abrasion of teeth
K03.2	Erosion of teeth
K03.3	Pathological resorption of teeth
K03.4	Hypercementosis
K03.5	Ankylosis of teeth
K03.6	Deposits [accretions] on teeth
K03.7	Posteruptive color changes of dental hard tissues
K03.81	Cracked tooth
K03.89	Other specified diseases of hard tissues of teeth

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D6710	5.22	4.61	1.08	10.91
D6720	6.29	5.55	1.30	13.14
D6721	5.64	4.98	1.16	11.78
D6722	5.88	5.19	1.21	12.28
Facility RVU	**Work**	**PE**	**MP**	**Total**
D6710	5.22	4.61	1.08	10.91
D6720	6.29	5.55	1.30	13.14
D6721	5.64	4.98	1.16	11.78
D6722	5.88	5.19	1.21	12.28

	FUD	Status	MUE	Modifiers				IOM Reference
D6710	N/A	N	-	N/A	N/A	N/A	N/A	None
D6720	N/A	N	-	N/A	N/A	N/A	N/A	
D6721	N/A	N	-	N/A	N/A	N/A	N/A	
D6722	N/A	N	-	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

abutment crown. Artificial tooth cap for the retention and/or support of a dental prosthesis.

artificial crown. In dentistry, a ceramic or metal restoration made to cover or replace a major part of the top of a tooth.

composite. In dentistry, synthetic material such as acrylic resin and quartz particles used in tooth restoration.

coping. Thin covering that is placed over a tooth before attaching a crown or overdenture.

denture. Manmade substitution of natural teeth and neighboring structures.

moulage. Model of an anatomical structure formed via a negative impression in wax or plaster.

Dental - Fixed Prosthodontics

D8660-D8670

D8660 pre-orthodontic treatment examination to monitor growth and development

Periodic observation of patient dentition, at intervals established by the dentist, to determine when orthodontic treatment should begin. Diagnostic procedures are documented separately.

D8670 periodic orthodontic treatment visit

Explanation

Report D8660 when the oral care giver provides treatment in a visit specifically for care before an orthodontic treatment regimen is begun and report D8670 when the treatment is given as part of a contracted periodic orthodontic treatment visit.

Coding Tips

Any radiograph is reported separately. Services related to orthodontic treatment are usually benefits of a patient's diagnostic or basic coverage, even when the program provides orthodontic coverage. Such procedures may include examination, x-rays, and extractions.

Reimbursement Tips

Coverage of these procedures varies by payer. Check with the payer for specific coverage guidelines.

ICD-10-CM Diagnostic Codes

M26.31	Crowding of fully erupted teeth
M26.32	Excessive spacing of fully erupted teeth
M26.33	Horizontal displacement of fully erupted tooth or teeth
M26.34	Vertical displacement of fully erupted tooth or teeth
M26.35	Rotation of fully erupted tooth or teeth
M26.36	Insufficient interocclusal distance of fully erupted teeth (ridge)
M26.37	Excessive interocclusal distance of fully erupted teeth
M26.39	Other anomalies of tooth position of fully erupted tooth or teeth

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D8660	0.78	1.54	0.09	2.41
D8670	0.58	1.16	0.07	1.81
Facility RVU	**Work**	**PE**	**MP**	**Total**
D8660	0.78	1.54	0.09	2.41
D8670	0.58	1.16	0.07	1.81

	FUD	Status	MUE	Modifiers				IOM Reference
D8660	N/A	N	-	N/A	N/A	N/A	N/A	None
D8670	N/A	N	-	N/A	N/A	N/A	N/A	

* with documentation

D8680-D8681

D8680 orthodontic retention (removal of appliances, construction and placement of retainer(s))

D8681 removable orthodontic retainer adjustment

Explanation

The orthodontic retention, also referred to as the orthodontic contention is the stabilization or retention period minimizing unwanted dental movements and maintaining the corrections obtained during the initial period following the removal of the braces or other appliances used for correction. The retention period is for a period of at least six months. Code D8680 describes the removal of the fixed appliance and the creation of a retainer. Removal of the previously placed appliance is dependent upon the brace used. After the removal the provider constructs and places a retainer(s), which is dependent upon the retainer used. Code D8681 describes the adjustment of the retainer provided during the orthodontic retention period.

Coding Tips

To report periodic orthodontic treatment visit, see D8670.

Documentation Tips

Some payers may require that x-rays and/or x-ray reports be submitted with the claim.

ICD-10-CM Diagnostic Codes

K00.6	Disturbances in tooth eruption
K08.421	Partial loss of teeth due to periodontal diseases, class I
K08.422	Partial loss of teeth due to periodontal diseases, class II
K08.423	Partial loss of teeth due to periodontal diseases, class III
K08.424	Partial loss of teeth due to periodontal diseases, class IV
K08.431	Partial loss of teeth due to caries, class I
K08.432	Partial loss of teeth due to caries, class II
K08.433	Partial loss of teeth due to caries, class III
K08.434	Partial loss of teeth due to caries, class IV
M26.31	Crowding of fully erupted teeth
M26.32	Excessive spacing of fully erupted teeth
M26.33	Horizontal displacement of fully erupted tooth or teeth
M26.34	Vertical displacement of fully erupted tooth or teeth
M26.35	Rotation of fully erupted tooth or teeth
M26.36	Insufficient interocclusal distance of fully erupted teeth (ridge)
M26.37	Excessive interocclusal distance of fully erupted teeth

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D8680	1.81	3.60	0.22	5.63
D8681	0.70	1.39	0.08	2.17
Facility RVU	**Work**	**PE**	**MP**	**Total**
D8680	1.81	3.60	0.22	5.63
D8681	0.70	1.39	0.08	2.17

	FUD	Status	MUE	Modifiers				IOM Reference
D8680	N/A	N	-	N/A	N/A	N/A	N/A	None
D8681	N/A	N	-	N/A	N/A	N/A	N/A	

* with documentation

Dental - Orthodontics

99202-99205

▲★**99202** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

▲★**99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

▲★**99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

▲★**99205** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

Explanation

Providers report these codes for new patients being seen in the doctor's office, a multispecialty group clinic, or other outpatient environment. All require a medically appropriate history and/or examination. Code selection is based on the level of medical decision making (MDM) or total time personally spent by the physician and/or other qualified health care professional(s) on the date of the encounter. Factors to be considered in MDM include the number/complexity of problems addressed during the encounter, amount and complexity of data requiring review and analysis, and the risk of complications and/or morbidity or mortality associated with patient management. The most basic service is represented by 99202, which entails straightforward MDM. If time is used for code selection, 15 to 29 minutes of total time is spent on the day of encounter. Report 99203 for a visit requiring a low level of MDM or 30 to 44 minutes of total time; 99204 for a visit requiring a moderate level of MDM or 45 to 59 minutes of total time; and 99205 for a visit requiring a high level of MDM or 60 to 74 minutes of total time.

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are no longer used when determining the level of service. Codes should be selected based upon the CPT revised 2021 Medical Decision Making table. Alternately, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. For office or other outpatient services for an established patient, see 99211-99215. For observation care services, see 99217-99226. For patients admitted and discharged from observation or inpatient status on the same date, see 99234-99236. Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes. Services at the origination site are reported with HCPCS Level II code Q3014.

Documentation Tips

Documentation should include the history and exam performed in addition to the medical decision making performed. When time is the determinant for code selection, total time should be documented. Medical necessity must be clearly stated and support the level of service reported.

Reimbursement Tips

The place-of-service (POS) codes used for reporting these services are the same as those for a new patient: POS code 11 represents the clinician's office environment and POS code 22 represents the outpatient setting. When a separately identifiable E/M service is reported at the same time as another procedure or service, modifier 25 should be appended to the E/M service to indicate the service is distinct from the other service performed.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: 99202 2020,Sep,3; 2020,Sep,14; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,13; 2016,Jan,7; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3; 2014,Oct,8; 2014,Oct,3; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3 **99203** 2020,Sep,3; 2020,Sep,14; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3; 2014,Oct,8; 2014,Oct,3; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3 **99204** 2020,Sep,14; 2020,Sep,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,13; 2016,Jan,7; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3; 2014,Oct,3; 2014,Oct,8; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3 **99205** 2020,Sep,3; 2020,Sep,14; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,10; 2018,Apr,9; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3; 2014,Oct,8; 2014,Oct,3; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3

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Coding and Payment Guide for Dental Services

[Resequenced]

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