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2015 American Academy of Pediatric Dentistry
This fifth edition of American Academy of Pediatric Dentistry (AAPD) Coding and Insurance Manual: A Comprehensive Resource For Reporting Pediatric Dental Services – 2016 is published specifically for pediatric dentists, and general dentists who treat children, as a quick and convenient guide for effectively reporting procedure codes when filing dental and medical insurance claims. The AAPD Committee on Dental Benefit Programs (CDBP) designed this manual to include a select set of dental codes from the latest version of the Code on Dental Procedures and Nomenclature (Code) CDT 2016 that pertain to pediatric dentistry. This version of the Code is effective for services rendered on or after Jan. 1, 2016, through Dec. 31, 2016.

For information on the coding process and submitting future codes for consideration, please go to http://www.ada.org/3827.aspx. The recommendations should be sent to the AAPD Committee on Dental Benefit Programs for review prior to the Code Maintenance Committee (CMC) review. This ensures that the submission receives the proper attention and avoids duplication of submissions. If the proposal has merit, the AAPD may also decide to add its endorsement and support.

Because pediatric dentists often render services in hospitals and ambulatory surgical centers (ASC), it is often necessary for them to bill to medical insurance using CPT medical codes and ICD9/10-CM diagnostic codes. This manual will assist you in converting dental codes to corresponding codes. We have selected a subset of CDT codes frequently used by pediatric dentists and then linked (cross-coded) these dental codes to the medical CPT procedure codes and diagnostic ICD-9/10 codes as published in 2015 Physicians Current Procedural Terminology, and ICD-10-CM Mappings. These sources are quite reliable; however, the accuracy cannot be guaranteed by the AAPD. A section on modifiers, sometimes necessary for reporting extenuating circumstances on the CMS 1500 form, is also included.

To guide the dental team with third party issues, information on completing the ADA Dental Claim Form, CMS 1500 Medical Claim Form, cross-coding dental/medical procedures and diagnostic codes, frequently asked coding questions, vignettes describing typical patients and circumstances and contact information for various government and third party carriers are included.

Coding decisions are personal choices to be made by individual dentists exercising their own professional judgment in each situation. The information provided to you in this manual is intended for educational purposes only. In no event shall AAPD be held liable for any decision made or action taken or not taken by you or anyone else in reliance on the information contained in the American Academy of Pediatric Dentistry (AAPD) Coding and Insurance Manual – 2016.

The listing of a CDT/CPT procedure and its code number in this publication does not restrict its use to any particular specialty group. Any procedure or service in this manual may be used to report the service when appropriately rendered.

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This fifth edition of the AAPD Coding and Insurance Manual 2016; a Comprehensive Resource for Reporting Pediatric Dental Services represents a combination of efforts of the AAPD Councils on Dental Benefit Programs and Clinical Affairs and respective consultants.

Dr. Paul Reggiardo chaired the CDBP during development of the fifth edition. Other members of the CDBP included Drs. Sara Filstrup, Warren Brill, Yasmi Crystal, Bill Steinbauer, and Santos Cortes. Consultants for the CDBP is Jim Nickma. Dr. David Tesini served as liaison to the board of trustees.

The AAPD staff wishes to express sincere thanks to each of these individuals for their time, expertise and commitment to this project. This project was managed by Dental Benefits Manager, Ms. Mary E. Essling. Please contact Ms. Essling by phone at (312)-337-2169 or by email at (messling@aapd.org) with questions or comments concerning this manual.

Future editions will coincide with the annual revision of Current Dental Terminology (CDT).

BEST PRACTICE PRINCIPLES OF CODING

The following principles are offered to assist pediatric dentists and others in developing a basic philosophy of coding. Once established, these principles allow for more consistent and accurate coding.

• The pediatric dentist who provided the service is legally responsible for any coding submitted for the service, and therefore, is the person to select the diagnosis and procedure codes.

• It is important that pediatric dentists and other dentists document in the dental record, with regard to justification for the selection of a particular code for the service rendered. At a minimum, the record should contain the date of service, procedure performed, complaint with appropriate history, dental examination findings, laboratory tests results, diagnosis, recommended treatment, prescribed prescriptions and follow up plans. Carriers and courts assume that if it is not documented in the dental record, it did not happen.

• Code appropriately for different types of encounters. Medical (CPT) evaluation and management codes have various levels based on the complexity of medical decision making, patient history and examination. Hospital visits have three to five levels of service within a family of codes. Encounters should be evaluated to determine which level is appropriate.

• When billing for medical procedures, always use a CPT modifier when altering a standard fee or when required by CPT guidelines. Use of modifiers informs the payer that there are extenuating circumstances that may require manual adjudication of the claim.

• Since the pediatric dentist is responsible for the codes and charges applied to any particular service, the dentist should review the charges and codes used in the office periodically with the office manager.
CHAPTER 1
Code on Dental Procedures
and Nomenclature for Pediatric Services

Category of Service Code Series
The CDT Code is organized into twelve categories of service, each with its own series of five-digit alphanumeric codes:

I. Diagnostic D0100 – D0999
II. Preventive D1000 – D1999
III. Restorative D2000 – D2999
IV. Endodontics D3000 – D3999
V. Periodontics D4000 – D4999
VI. Prosthodontics, removable D5000 – D5899
VII. Maxillofacial Prosthetics D5900 – D5999
VIII. Implant Services D6000 – D6199
IX. Prosthodontics, fixed D6200 – D6999
X. Oral & Maxillofacial Surgery D7000 – D7999
XI. Orthodontics D8000 – D8999
XII. Adjunctive General Services D9000 – D9999

These categories exist solely as a means to organize the CDT Code. As a result, some categories of service are divided into subcategories of related procedures. Many categories and subcategories have descriptors applicable to all procedure codes therein.

Components of a Dental Procedure Code Entry
Every procedure in the CDT Code must have the first two of the following three components:

1. Procedure Code – A five character alphanumeric code beginning with the letter “D” that identifies a specific dental procedure. A Procedure Code cannot be changed or abbreviated.
2. Nomenclature – The written title of a Procedure Code. Nomenclature may be abbreviated when printed on claim forms or other documents that are subject to space limitation. Any such abbreviation does not constitute a change to the Nomenclature.
3. Descriptor – A written narrative that further defines the nature and intended use of a single Procedure Code, or group of such codes. A Descriptor, when present, follows the applicable Procedure Code and its Nomenclature. Descriptors that apply to a series of Procedure Codes precede that series of codes.

Using the CDT Code
The following points should prove helpful when using the CDT Code for recording services provided on the patient record, and when reporting procedures on a paper or electronic claim submission.

1. The presence of a CDT Code does not mean that the procedure is:
   a. endorsed by any entity or is considered a standard of care
   b. covered or reimbursed by a dental benefits plan
2. General practitioners, specialists, and other individuals may report any of the listed CDT Codes as long as they are acting within the scope of their state law.
3. CDT Codes that require inclusion of a narrative description on the claim have the words “by report” in their nomenclature.
4. “Unspecified… procedure, by report” codes are used when, in the opinion of the dentist, there is no other CDT Code entry that accurately describes the services provided the patient.
CLASSIFICATION OF MATERIALS

Names of dental materials are included in numerous procedure nomenclatures within several Categories of Service (e.g., Restorative; Prosthodontics, fixed). The following list of dental materials is included in the CDT Code solely to aid in selection of a procedure code applicable to the service provided. The noble metal classification system has been adopted as a more precise method of reporting various alloys used in dentistry. The alloys are defined on the basis of the percentage of metal content.

CLASSIFICATION REQUIREMENTS

High Noble Alloys
Noble Metal Content ≥ 60% (gold + platinum group*) and gold ≥ 40%

Titanium and Titanium Alloys
Titanium ≥ 85%

Noble Alloys
Noble Metal Content ≥ 25% (gold + platinum group*)

Predominantly Base Alloys
Noble Metal Content < 25% (gold + platinum group*)

* metals of the platinum group are platinum, palladium, rhodium, iridium, osmium and ruthenium

Porcelain/Ceramic
Refers to pressed, fired, polished or milled materials containing predominantly inorganic refractory compounds including porcelains, glasses, ceramics, and glass-ceramics.

Resin
Refers to any resin-based composite, including fiber or ceramic reinforced polymer compounds, and glass ionomers.

Required Statement

If there is more than one code in this edition that covers a procedure and a dentist submits a claim under one of these codes, the payer may process the claim under any of these codes that is consistent with the payer’s reimbursement policy.

Code on Dental Procedures and Nomenclature

The current version of the Code on Dental Procedures and Nomenclature (CDT Code) that follows is effective for the calendar year Jan. 1, 2015, through Dec. 31, 2015. There are a number of changes from the prior version, which are identified by the following symbols:

• New procedure code

▲ Revision to a nomenclature or descriptor

Please note that when a code’s nomenclature includes a “by report” notation, a narrative explaining the treatment provided must be included with the claim submission.