PRACTICE Booster®

drcharlesblair and Associates

Medical Dental Cross Coding With Confidence

These are sample pages of ***Medical Dental Cross Coding with Confidence*** containing

- Front and Back Cover
- Table of Contents
- Medical Code Sets
- Page of Codes
- Illustration Medical Claim Submission
- Scenario Table of Contents and Index
- ICD-10-CM Reference
- Samples of Index Pages

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CDT/CPT

2024

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Medical Procedural Code Sets

This chapter covers the various code sets used to report procedures to medical payors. HIPAA (Health Insurance Portability and Accountability Act) has adopted standard transaction sets to create a consistent method of submitting electronic data for processing and paying claims. Medical and dental payors use these code sets in the adjudication of claims. Below is a list and brief description of the standard code sets pertaining to procedures.

CPT® (Current Procedural Terminology)

- Also referred to as HCPCS Level I codes
- Used to report procedures to medical payors when the code fully describes the dental service rendered
- Maintained by the AMA (American Medical Association)

HCPCS (Healthcare Common Procedure Coding System)

- Also referred to as Level II codes
- Commonly pronounced by its acronym, "hick picks"
- Primarily used to report medical services, equipment, and supplies on the medical claim form
- Maintained by CMS (Centers for Medicare and Medicaid Services)
- CDT codes are recognized as HCPCS-D codes making them billable procedure codes to most medical payors

CDT® (Current Dental Terminology)

- Used to report dental procedures
- Considered an HCPCS Level II procedural code on medical claims and accepted by most payors
- Maintained by the ADA (American Dental Association)

Reporting Procedures

Dentists and their team members are familiar with CDT® codes reported to dental payors. These codes communicate to the payor the dental procedure performed. This can be challenging when reporting dental procedures to a medical payor, since there are very few medical CPT® codes that describe the most frequently performed dental procedures.

Medical coding guidelines require reporting the code(s) most specific to the service or procedure provided. Sometimes that will be a CDT code. Many medical payors will allow CDT® codes to be reported on the CMS-1500 (02-12) Medical Claim Form. In addition, when no medical CPT® code exists to describe the procedure or services provided, the CDT® is the most appropriate code to report.

Some medical payors prefer dental procedures be reported with an unlisted CPT® code. This is appropriate only when no CPT® code exists describing the procedure or service provided, an example of this is 41899 (unlisted procedure, dentoalveolar structures). This medical code is listed multiple times throughout this Manual as an appropriate cross-code for a variety of dental procedures. It may be reported to describe extractions, restorations, and many other dental procedures which have no comparable CPT® code.

Unlisted codes are the CPT® versions of unspecified CDT® codes, which must be submitted with a narrative describing the nature of the procedure performed. (These unlisted CPT® codes are identifiable by ending in 99.) In much the same way, unlisted CPT® codes must be defined for the payor. When submitting CDT® codes to a dental payor, a narrative is usually attached. Medical payors will typically request documentation such as clinical chart notes to describe the procedure or service provided. In addition, a brief description of the procedure must be included on the claim form. See "Completing the CMS-1500 (02-12) Medical Claim Form" for instructions on how to include a description of services when reporting an unlisted code.

CLINICAL ORAL EVALUATIONS — CDT 2024

CDT	Nomenclature
D0120	Periodic oral evaluation – established patient

CPT®	Description
99212	Office or other outpatient visit for the evaluation and management of an established patient Editor's Comments: See the chapter "Evaluation and Management Services (E/M)" for information on submitting evaluation and management codes.

RATIONALES

When reporting an evaluation to a medical payor, the CPT® code reported is based on whether the patient is new or established, as well as factors such as level of medical history taken, level of examination performed, and level of medical decision-making. Refer to the chapter "Evaluation and Management Services (E/M)" for additional information on reporting examination visits.

The CDT code D0120 describes an evaluation of an established patient which is problem focused and requires straightforward medical decision-making. The appropriate CPT® code to report this level of evaluation is 99212.

DIAGNOSES/ ICD-10-CM

Code	Description
E10.630	Type 1 diabetes mellitus with periodontal disease
E10.638	Type 1 diabetes mellitus with other oral complications
E11.630	Type 2 diabetes mellitus with periodontal disease
E11.638	Type 2 diabetes mellitus with other oral complications
K02.–*	Dental caries (decay and cavities)
K05.–*	Gingivitis and periodontal disease
Z01.20	Encounter for dental exam and cleaning without abnormal findings
Z01.21	Encounter for dental exam and cleaning with abnormal findings
Z04.1	Encounter for examination and observation following transport accident
Z04.2	Encounter for examination and observation following work accident
Z04.3	Encounter for examination and observation following other accident
Z13.84	Encounter for screening for dental disorders
Z33.1	Pregnant state, incidental

NOTE

Please note the above list of linked ICD-10-CM codes is not all-encompassing. The procedure may be performed for reasons other than those listed. The clinical documentation must support the medical necessity of the procedure, and only those conditions supported by the clinical documentation should be reported.

*Diagnosis codes indicated with an * are not valid codes. These codes are category or sub category codes. Refer to the "ICD-10-CM Reference" in this Manual for additional coding guidelines and selection of the most specific code to report these conditions.

BILLING TIPS

Traditional Medicare statutorily excludes most dental treatment. Examinations for the purpose of dental treatment are also excluded. Examinations for medical conditions such as temporomandibular joint disorders or lesions of the oral cavity are typically a covered benefit by all medical payors, including Medicare. Any service or procedure covered by Medicare is subject to the mandatory filing law.

Medicare Advantage plans may have limited dental benefits. It is advisable that benefits be verified prior to treatment as coverage is plan specific.

See the chapter "Medicare and the Dental Practice" for additional information regarding Medicare.

Practical Scenarios to Illustrate Medical Claim Submission

Scenario-Based Learning – A Simplified Approach

For those new to submitting dental procedures to the patient's medical plan, the "Scenario Section" of this Manual will provide an in-depth example for submitting procedures to the medical payor. Many different scenarios with step-by-step guidance are provided. The scenarios begin with a simple explanation of the clinical situation at hand. The related CPT®, diagnosis code(s), and any applicable modifiers are then reviewed and the rationale for those codes chosen is provided. From there, a demonstration of proper reporting on the CMS-1500 (02-12) Medical Claim Form is provided. Further information and coding tips are detailed to improve your understanding of the coding process.

Scenario Legend

CDT	**Nomenclature**	
00000	CDT 2024 Nomenclature	
CPT®	**Description**	
00000	CPT® 2024 Description	
	Alternative Coding Option	
	Any possible alternative coding options.	
RATIONALES	The rationale behind the selected CPT® procedure codes and their appropriateness for the procedures reported. **Modifier:** Any modifier applicable, and the rationale for its necessity.	
DIAGNOSES/ ICD-10-CM	**00000**	Potentially linked ICD-10-CM diagnosis codes that may be reported with the procedures reported.
BILLING TIPS	Billing tips for submitting claims to medical payors, including Medicare.	
CDT	**Deleted Code**	**Current Code**
00000	CDT 2024 **DELETED** and **PREVIOUSLY DELETED CODE**	CDT 2024 Current Code

1

Non-Trauma / Preventive

New Patient, Periodontal Oral Evaluation, Full Mouth Radiographs for the Diabetic Patient

NON-TRAUMA

SCENARIO

New adult patient presents for a routine dental evaluation. Patient is a type 1 diabetic complaining of bleeding gums. Upon review of the patient's medical and dental history, the dentist recommends a complete series of full mouth radiographic images. Comprehensive periodontal evaluation was performed by the dentist. Periodontal charting and probing revealed multiple areas of 6mm+ pocket depths and areas of mobility. Radiographs reviewed. No decay visible clinically or radiographically. Radiographs show significant bone loss. Review findings with patient and refer patient to Periodontist for further evaluation and treatment.

DIAGNOSES/ ICD-10-CM

Pointer	ICD-10-CM	Description	CPT® Codes	Modifier (if required)
A	K05.6	Periodontal disease, unspecified	99202	
			70320	
B	E10.630	Type 1 diabetes mellitus with periodontal disease	99202	
			70320	

PROCEDURE

CDT 2024	Nomenclature	CPT® 2024	Modifier (if required)	Description
D0180	Comprehensive periodontal evaluation – new or established patient	99202		Office or other outpatient visit; expanded problem focused history, expanded problem focused examination, straightforward medical decision making, or, 15-29 minutes
D0210	Intraoral – comprehensive series of radiographic images	70320		Radiologic examination, teeth, complete, full mouth

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY — MM DD YY QUAL. 431
15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. K05.6 B. E10.630 C. D.
E. F. G. H.
I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	MM DD YY	MM DD YY	11	N	99202		AB	XX.XX			NPI	XXXXXXXXXX
2	MM DD YY	MM DD YY	11	N	70320		AB	XX.XX			NPI	XXXXXXXXXX
3											NPI	
4											NPI	

N OR SUPPLIER INFORMATION

11 Non-Trauma / Oral Surgery

Extraction of Teeth Prior to Radiation Treatment

SCENARIO

A patient 81 years of age, presents for removal teeth #4, #5, #30, #31 following comprehensive oral evaluation. Teeth have deep caries with pulpal involvement. Records received from the patient's oncologist document that the patient has recently been diagnosed with stage 2 malignant tumor of the parotid. Patient's oncologist requested extraction of any teeth with potential infection prior to beginning radiation treatment for oral cancer.

DIAGNOSES/ ICD-10-CM

Pointer	ICD-10-CM	Description	CPT® Codes	Modifier (if required)
A	Z40.8	Encounter for other prophylactic surgery	41899	
B	C07	Malignant neoplasm of parotid gland		
C	K02.53	Dental caries on pit and fissure surface penetrating into pulp		

PROCEDURE

CDT 2024	Nomenclature	CPT® 2024	Modifier (if required)	Description
D7140	Extraction, erupted tooth or exposed r oot (elevation and/or forceps removal)	41899		Unlisted procedure, dentoalveolar structures

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: MM DD YY QUAL. 431

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. Z40.8 B. C07 C. K02.53 D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	zz Extraction of teeth D7140 JP04 05 30 31									
	MM DD YY MM DD YY	11	N	41899	ABC	XX.XX	4		NPI	XXXXXXXXXX
2									NPI	
3									NPI	
4									NPI	

N OR SUPPLIER INFORMATION

Workers' Compensation

The Office of Workers' Compensation Programs (OWCP) is operated by the United States Department of Labor. The OWCP administers four major disability compensation programs. If a federal worker is injured at work or contracts an occupational disease, these programs will provide:

- Wage replacement benefits
- Medical treatment
- Vocational rehabilitation
- Other benefits to workers who experience work-related injury or occupational disease[1]

If an employee suffers a workplace injury from the neck up, it is likely to involve a dental injury. Dental trauma may result from a workplace vehicular accident, construction or manufacturing accident, tumbles or slips, falling objects, workplace violence, etc. Some workers' compensation cases may be very complex in nature, involving multiple appointments with a general dentist and one or more specialists. Other cases may be much less severe, involving only a single chipped tooth, for example.

Most dentists provide a comprehensive treatment plan for all new patients based on the findings of their initial evaluations. However, if a patient presents with a work-related injury and the dentist discovers an unrelated issue, the two should be reported separately. To be covered by workers' compensation, the treated condition must be directly related to a work injury.

For example, a patient may present with a work-related injury and simultaneously be diagnosed with three cavities. A more complex scenario might be a patient who was hit in the mouth by a falling box, resulting in loose teeth and jaw pain. They have not been to a dentist in four years and has a history of periodontal disease. In this case, the dentist is aware that the payor is not responsible for the treatment of the patient's periodontal disease. However, the infection must be sufficiently rectified before the injury specific procedures can be performed in order to avoid future complications.

Obligation to Accept Workers' Compensation

Providers are not obligated to accept workers' compensation cases. Once a case has been accepted, and treatment initiated, the provider is obligated by law to accept workers' compensation reimbursement as payment in full for all authorized services. Although some workers' compensation payors may be willing to negotiate fees, once reimbursement is accepted by the provider, the patient may not be billed for any service authorized by the plan. It is important to establish an office policy on whether your practice will accept work-related injuries. For example, you may choose to limit workers' compensation to established patients only or limit the number of cases you accept. Once a policy is in place, be sure to screen calls for treatment carefully.

Often, the employer will make the first contact with a provider's office when workers' compensation is involved. This is a best-case scenario as they will be clear that this is a workers' compensation case. If you are accepting the case, ask if an authorization is in place and make a note of the authorization number.

Other times, patients may call directly. When this occurs, and you suspect this may be a workers' compensation case, ask questions such as:

- How did this injury occur?
- Were you at work?
- Is this considered work related?
- Was this reported to your employer?
- Is this to be covered by workers' compensation?

If determined to be a workers' compensation case, you will either advise the patient that your office is not accepting workers' compensation cases at this time or ask if the patient has an authorization. It is critical to obtain an authorization prior to treatment to obtain reimbursement from workers' compensation. If no authorization is in place, contact the patient's employer. The patient will be responsible for treatment deemed not to be work related.

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Scenario Index by Dental Procedure

This index will assist you in locating each scenario by specific dental procedure. To use this index, find the applicable procedure in the CDT code column. Then locate the scenario number(s) that apply, broken down by type of visit.

CDT Code	Procedure	Evaluation/ Prevention Visit	Treatment Visit	Emergency Visit	Trauma Visit
D0120	Periodic Oral Evaluation – Established Patient	2, 3, 5, 6, 7, 11			
D0140	Limited Oral Evaluation – Problem Focused	20, 21		26, 27, 28 29, 30	
D0145	Oral Evaluation for a Patient Under Three Years of Age and Counseling with Primary Caregiver	1			
D0150	Comprehensive Oral Evaluation – New or Established Patient	2			
D0180	Comprehensive Periodontal Evaluation – New or Established Patient	1, 7, 8, 10			
D0190	Screening of a Patient	4			
D0191	Assessment of Patient	3			
D0210	Intraoral – Comprehensive Series of Radiographic Images	1, 8, 11			
D0220	Intraoral – Periapical First Radiographic Image	20		27, 28, 29 30, 32, 33, 34	
D0230	Intraoral – Periapical Each Additional Radiographic Image	20		29	
D0272	Bitewings – Two Radiographic Images	2			
D0273	Bitewings – Three Radiographic Images	7			
D0277	Vertical Bitewings – 7 to 8 Radiographic Images	10			
D0330	Panoramic Radiographic Image	5, 9, 20, 21			
D1110	Prophylaxis – Adult	7			
D1120	Prophylaxis – Child	1, 2, 3, 5, 6			
D1206	Topical Application of Fluoride Varnish	1, 2, 3, 4, 5			
D1208	Topical Application of Fluoride – Excluding Varnish	2, 6			
D1351	Sealant – Per Tooth		12		
D1352	Preventive Resin Restoration In a Moderate to High Caries Risk Patient – Permanent Tooth		13		
D1353	Sealant Repair – Per Tooth		12		
D1354	Interim Caries Arresting Medicament Application – Per Tooth		13		
D1510	Space Maintainer – Fixed, Unilateral – Per Quadrant		14	31	
D1517	Space Maintainer – Fixed – Bilateral, Mandibular		14	31	
D1575	Distal Shoe Space Maintainer – Fixed, Unilateral – Per Quadrant		15		

CDT Code	Procedure	Evaluation/ Prevention Visit	Treatment Visit	Emergency Visit	Trauma Visit
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D3220	Therapeutic Pulpotomy (Excluding Final Restoration) – Removal of Pulp Coronal to the Dentinocemental Junction and Application of Medicament		20		
D3221	Pulpal Debridement, Primary and Permanent Teeth			27	
D3320	Endodontic Therapy, Premolar Tooth (Excluding Final Restoration)			29	
D3330	Endodontic Therapy, Molar Tooth (Excluding Final Restoration)			29	
D4341	Periodontal Scaling and Root Planing — Four or More Teeth Per Quadrant	8	6		
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D5130	Immediate Denture – Maxillary		21		
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D5820	Interim Partial Denture (Maxillary)		22		

CDT Code	Procedure	Evaluation/ Prevention Visit	Treatment Visit	Emergency Visit	Trauma Visit
D6010	Surgical Placement of Implant Body: Endosteal Implant		23		
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SCENARIOS

ICD-10-CM Reference Material

How to Use the ICD-10-CM Reference

ICD-10-CM

The ICD-10-CM code list is organized by categories and subcategories. Codes are alpha-numeric. All categories begin with an alpha character with the following two characters being numeric. Additional characters may be either alpha or numeric. All ICD-10-CM codes must be reported to the highest level of specificity to be considered valid. Simply stated, this means a valid code will include all characters required to fully describe the condition being reported. Additional information on the structure of ICD-10-CM codes is provided on page 30 of this Manual.

Some codes have editor notations regarding correct use of specific codes or categories of codes. These notes assist in determining appropriate reporting of codes and are based on ICD-10-CM official guidelines. Complete ICD-10-CM guidelines are found at: *https://www.cms.gov/medicare/icd-10/2024-icd-10-cm*

Explanation of the ICONS

This reference has been designed to assist the user in easily determining a valid code. An explanation of the icons used in this Guide are below.

- 🔴 Indicates a code which requires additional characters to be considered valid. Do not report codes indicated by the red icon.
- 🟡 Indicates additional information which is important in determining the most accurate code to report.
- 🟢 Indicates a valid code, containing all required characters, that may be reported for the condition described by that code. Sometimes, multiple valid codes may pertain to the same condition. It is important to report the code that most accurately describes the patient's condition, as documented in the clinical notes.

Exclusion and Inclusion Notes

You will notice some codes have exclusion notes. These notes are indicated with a yellow icon. Each of these notations will include a list of codes, that may include informational statements, such as "not to be coded here." These notes are specified by the CDC and CMS, who develop and maintain the code set. The instructions, as defined by CMS, are as follows (excerpted from CMS "ICD-10-CM Official Guidelines for Coding and Reporting") modified with punctuation and icons.

- **Excludes Notes**
  The ICD-10-CM has two types of excludes notes. Each note has a different definition for use but they are both similar in that they indicate that codes excluded from each other are independent of each other.
- **Excludes1**
  A type 1 Excludes note is a pure excludes. It means "NOT CODED HERE." An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 is for used for when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.
- **Excludes2**
  A type 2 Excludes note represents "Not included here." An Excludes2 note indicates that the condition excluded is not part of the condition it is excluded from but a patient may have both conditions at the same time. When an Excludes2 note appears under a code it is acceptable to use both the code and the excluded code together.

In addition, you will see under some codes, an inclusion note. The word "Includes" appears immediately under certain categories to further define, or give examples of, the content of the category, a list of diseases or conditions which may be reported with that code. This list contains examples of how that code may be applied for reporting.

ICD-10-CM Reference

This listing is not intended to be a comprehensive listing of all ICD-10-CM codes or their application to specific conditions and diseases. Examples listed for the application of use for each code are edited to include those most common to the dental practice. For a complete listing of all ICD-10-CM codes and their application please refer to an ICD-10-CM code book. The complete ICD-10-CM code set is available for downloading, free of charge, at *www.cms.gov*

Many accident codes require the appropriate 7th character to be added. The green icon represents valid codes and includes the appropriate 7th character. The definition of the 7th character in this section is described below.

A – Initial encounter (receiving active treatment for the condition)

D – Subsequent encounter (encounters after the patient has received active treatment of the injury and is receiving routine care for the injury during the healing or recovery phase)

S – Sequela (complications or conditions that arise as a direct result of a condition or injury)

Notes

VIRAL INFECTIONS CHARACTERIZED BY SKIN AND MUCOUS MEMBRANE LESIONS

Codes A00-A99 and B01-B99.99 typically are not reported by dental providers and have been omitted from this list. Refer to a complete ICD-10-CM book for these code descriptions.

Code			
B00	**Herpesviral [herpes simplex] infections**		
	Excludes1	congenital herpesviral infections (P35.2)	
	Excludes2	anogenital herpesviral infection (A60.-)	
		gammaherpesviral mononucleosis (B27.0-)	
		herpangina (B08.5)	
	B00.0	**Eczema herpeticum**	
		Kaposi's varicelliform eruption	
	B00.1	**Herpesviral vesicular dermatitis**	
		Herpes simplex facialis	
		Herpes simplex labialis	
		Herpes simplex otitis externa	
		Vesicular dermatitis of ear	
		Vesicular dermatitis of lip	
	B00.2	**Herpesviral gingivostomatitis and pharyngotonsillitis**	
		Herpesviral pharyngitis	
	B00.3	**Herpesviral meningitis**	
	B00.4	**Herpesviral meningitis**	
		Herpesviral meningoencephalitis Simian B disease	
		Excludes1	herpesviral encephalitis due to herpesvirus 6 and 7 (B10.01, B10.09)
			non-simplex herpesviral encephalitis (B10.0-)
	B00.5	**Herpesviral ocular disease**	
		B00.50	**Herpesviral ocular disease, unspecified**
		B00.51	**Herpesviral iridocyclitis**
			Herpesviral iritis
			Herpesviral uveitis, anterior
		B00.52	**Herpesviral keratitis**
			Herpesviral keratoconjunctivitis
		B00.53	**Herpesviral conjunctivitis**
		B00.59	**Other herpesviral disease of eye**
			Herpesviral dermatitis of eyelid
	B00.7	**Disseminated herpesviral disease**	
		Herpesviral sepsis	

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