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INSURANCE SOLUTIONS
NEWSLETTER

Coding for Implant Supported Removable Prostheses

IN THIS ISSUE

While fixed hybrid All-On-X restorations have surged in popularity (see the coding for All-on-4 article from ISN Mar/Apr 2022), there are still many times an implant supported removable prosthetic may be considered the better choice for patient treatment. These appliances generally require fewer implants to be placed, are easily removed by the patient for routine cleaning, and need little maintenance with the exception of occasionally replacing retentive o-rings or gaskets.

Coding for these restorations is a frequent topic of questions submitted to our support center. This article will discuss coding for the different stages of fabrication of both implant dentures and partials as well as maintenance procedures for implant supported removable prosthetic restorations.

Implant Placement

There are two common types of implants that may act as support for removable prostheses; full sized endosteal implants and mini implants. There are advantages and disadvantages of each, and the decision of which type to place is dependent on clinical evaluation and preference.

If a surgical guide is utilized for implant placement, report D6190.

D6190 RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT

An appliance, designed to relate osteotomy or fixture position to existing anatomic structures, to be utilized during radiographic exposure for treatment planning and/or during osteotomy creation for fixture installation.

It is a common error to report either a surgical stent (D5982) or surgical splint (D5988) when providing a surgical implant index. These codes represent guides for reshaping bone (stent) or supporting structures to aid healing after a jaw fracture (splint) and are not appropriate for surgical guides for implant placement.

For full sized endosteal implants (sometimes called "root form" implants), report:

D6010 SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT

Endosteal implants (D6010) are the most commonly used surgically placed (long-term) full-size implants for the alveolus or basal bone.

An alternative to full sized implants is the placement of mini implants (D6013). These implants have a smaller diameter, integrate quickly, and generally have a lower cost for the patient. They also commonly have an integrated ball-shaped head which takes the place of a separate abutment. Nonetheless, mini implants transmit about twice the load to the supporting bone, and thus, control of occlusal loading is important. Indications for mini implants include areas with inadequate site length or width, atrophic bone, medical issues, fragility, financial hardship, patient declination of grafting, and patient fear of surgery[1].

When reporting the placement of a mini implant, use:

D6013 SURGICAL PLACEMENT OF MINI IMPLANT

Most implant placements don't require a second stage surgery since the healing caps are generally exposed. If required, subsequent tissue removal and placement of the healing cap or abutment (after osseous integration) is NOT included in the initial surgical placement fee for the implant body. Subsequent surgical exposure (after osseous integration) of the implant to enable placement of a healing cap is referred to as "second stage surgery" and is reported separately as D6011 if applicable.

For second stage implant surgery, report:

D6011 SURGICAL ACCESS TO AN IMPLANT BODY (SECOND STAGE IMPLANT SURGERY)

Reporting and charging this procedure separately, even if you keep the same "global" implant fee, will also maximize reimbursements from insurance plans, as total fee schedule write offs will be reduced if covered. D6011 is variably reimbursed and is considered by some payers to be a part of the global implant placement service, i.e., D6010. D6011 may be better reimbursed if there is implant coverage, the body of the implant is exposed and the healing cap placed by a dentist other than the dentist who placed the endosteal implant body, or if the original prosthesis was broken or was lost and the gingival tissue had overgrown the retained endosteal implant body.

Implant Supported Removable Prostheses

Implant supported removable prostheses are coded with respect to whether they are complete dentures (D6110/D6111) or partial dentures (D6112/D6113) and if they are maxillary or mandibular. Note: A natural tooth-supported overdenture – complete (D5863/D5865) is often erroneously reported when the implant-supported removable denture for the edentulous arch (D6110/D6111) is the correct code to report the implant overdenture prosthesis.

For implant supported removable complete dentures, report :

D6110 IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH - MAXILLARY

D6111 IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH - MANDIBULAR

For implant supported removable partial dentures, report:

D6112 IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH - MAXILLARY

D6113 IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH - MANDIBULAR

Oftentimes the patient may have an existing prosthesis in good shape, and fabrication of a new prosthesis may not be necessary. If, instead of fabricating a new prosthesis, the existing prosthesis was modified to be used with the new implants, report D5875.

D5875 MODIFICATION OF REMOVABLE PROSTHESIS FOLLOWING IMPLANT SURGERY

Attachment assemblies are reported using separate codes.

Do not report the modification of an existing removable prosthesis if a new prosthesis will be fabricated. D5875 may be reimbursed if the policy has an implant rider. If implant coverage is available, the benefit could be reimbursed as a denture repair or a reline or rebase of the removable prosthesis following implant surgery may be reimbursed.

Semi-precision Abutments and Attachments

Often called locators, the retentive elements of implant supported removable dentures were previously reported using code D6052. This code has since been deleted and replaced with two codes (D6191/D6192) that represent each "half" of the locator system. The first of these codes is:

D6191 SEMI-PRECISION ABUTMENT - PLACEMENT

This procedure is the initial placement, or replacement, of a semi-precision abutment on the implant body.

The semi-precision abutment is the "male" component attached to the implant body in the patient's mouth. It must exist as a separate piece from the implant body. If mini implants are used, the abutment is usually integrated onto the implant body itself and is not reported separately. There are other one piece endosteal implants that have integrated abutment heads as well. Again, these would not be reported separately.

D6192 SEMI-PRECISION ATTACHMENT - PLACEMENT

This procedure involves the luting of the initial, or replacement, semi-precision attachment to the removable prosthesis.

The semi-precision attachment is the "female" component embedded into the removable prosthesis that the abutment head "snaps" into. It is normally composed of a metal housing (often called the keeper assembly) which holds a retentive o-ring or gasket. This code includes the initial o-ring or gasket in the keeper assembly but not the replacement of 0-rings or gaskets (see below). It is also appropriate to report D6192 if replacing an entire keeper assembly that has been damaged.

Connecting Bar Retention

Another option for stabilizing an implant removable overdenture is to use a connector bar (e.g., Hader® bar or Dolder® bar). The implant overdenture is fabricated to clip onto the connector bar. This attachment restricts movement of the prosthesis and makes the overdenture more secure. The connector bar should be reported once, regardless of the number of abutments/implants supporting it.

If utilizing a connector bar, report:

D6055 CONNECTING BAR - IMPLANT SUPPORTED OR ABUTMENT SUPPORTED

Utilized to stabilize and anchor a prosthesis.

Each female implant attachment or "clip" embedded in the denture is reported separately as D6192. As such, there may be one bar and multiple clips, each reported individually.

The connector bar (D6055) attaches to implant abutments or directly to the implants themselves. These implant abutments should each be reported as a prefabricated (D6056) or custom abutment (D6057). They are not semi-precision abutments under the connecting bar. If attaching directly to implants, there is no abutment reported.

Removable Implant Prosthesis Maintenance

Implant maintenance procedures for removable appliances are commonly miscoded or not reported at all. Incorrect coding can lead to delays, denials, and lost reimbursement. Report each removable denture for cleaning and inspection separately. Do NOT report D6080 implant maintenance procedure as this code is indicated for implant supported fixed prostheses.

Prosthesis Cleaning

Any team member may clean the denture, but the inspection must be performed by the dentist. Document that the dentist inspected the removable prosthesis and recommended that the procedure be performed. The clinical notes of the dentist should describe the inspection by the dentist and the cleaning of the denture.

To report the cleaning and inspection of a removable complete denture, report D9932/D9933 as appropriate:

D9932 CLEANING AND INSPECTION OF A REMOVABLE COMPLETE DENTURE, MAXILLARY

This procedure does not include any adjustments.

D9933 CLEANING AND INSPECTION OF A REMOVABLE COMPLETE DENTURE, MANDIBULAR

This procedure does not include any adjustments.

To report the cleaning and inspection of a removable partial denture, report D9934/D9935, as appropriate:

D9934 CLEANING AND INSPECTION OF REMOVABLE PARTIAL DENTURE, MAXILLARY

This procedure does not include any adjustments.

D9935 CLEANING AND INSPECTION OF REMOVABLE PARTIAL DENTURE, MANDIBULAR

This procedure does not include any adjustments.

The cleaning of the implants themselves without inflammation or mucositis may be reported using D1110 or D4910 as applicable, since these codes include the cleaning of implants. D4346 is not appropriate, as if active inflammation is present D6081 applies. These codes may not be reported on the same date as D6081.

D1110 PROPHYLAXIS - ADULT

Removal of plaque, calculus and stains from the tooth structures and implants in the permanent and transitional dentition. It is intended to control local irritational factors.

D4910 PERIODONTAL MAINTENANCE

This procedure is instituted following periodontal therapy and continues at varying intervals, determined by the clinical evaluation of the dentist, for the life of the dentition or any implant replacements. It includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing where indicated, and polishing the teeth. If new or recurring periodontal disease appears, additional diagnostic and treatment procedures must be considered.

If insurers resist reporting a prophylaxis or periodontal maintenance due to the lack of natural dentition, you may resubmit and report D6199 unspecified implant procedure by report. Write a narrative describing the procedure and ask for the alternate benefit of the prophylaxis or periodontal maintenance, as applicable.

D6199 UNSPECIFIED IMPLANT PROCEDURE, BY REPORT

Use for procedure that is not adequately described by a code. Describe procedure.

Scaling and debridement of individual implants, if performed in the presence of inflammation or mucositis, may be reported using D6081. This procedure cannot be reported in conjunction with D1110, D4910, or D4346 on the same service date.

D6081 SCALING AND DEBRIDEMENT IN THE PRESENCE OF INFLAMMATION OR MUCOSITIS OF A SINGLE IMPLANT, INCLUDING CLEANING OF THE IMPLANT SURFACES, WITHOUT FLAP ENTRY AND CLOSURE

This procedure is not performed in conjunction with D1110, D4910, or D4346.

A narrative should always be provided to support the submission of D6081 for each implant that describes inflammation and/or mucositis treatment. Provide probing depths, bleeding points, radiographs, and photographs to support the need for D6081 treatment. Reimbursement for this procedure is greatly limited and is generally restricted to patients with implant coverage, if any.

Prosthesis Repair

As mentioned, it is appropriate to report D6192 if replacing an entire keeper assembly that has been damaged. If only replacing a worn-out or non-retentive o-ring or gasket as a part of routine maintenance (not the entire keeper assembly), report D6091:

D6091 REPLACEMENT OF REPLACEABLE PART OF SEMI-PRECISION OR PRECISION ATTACHMENT OF IMPLANT/ABUTMENT SUPPORTED PROSTHESIS, PER ATTACHMENT

Do NOT report D5867, as this code is for the replacement of o-rings or gaskets associated with natural tooth anchored prostheses or natural tooth overdenture attachments. This is a common error.

For other repairs to the implant supported prosthesis, report D6090:

D6090 REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT

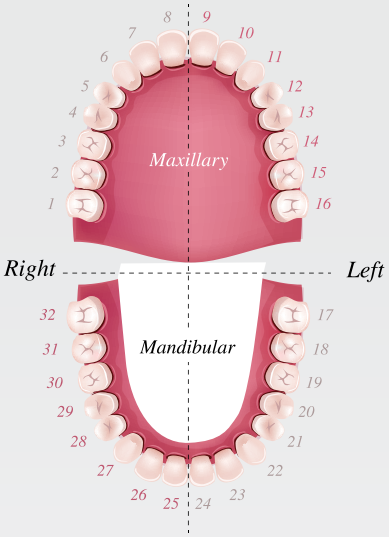
This procedure involves the repair or replacement of any part of the implant supported prosthesis.

When reporting D6090, a brief narrative is required. The narrative should identify the original date of placement and describe the repair to the implant-supported prosthesis provided. If a contract has no implant benefits, there would be no benefit for the repair of an implant-supported prosthesis. Reporting D6090 may reset the five- to ten-year exclusion period limitation for the implant-supported prosthesis if reimbursed.

Relines and rebases are reported separately using the traditional reline and rebase codes found in the Removable Prosthodontics category of service (D5710-D5761). There are no specific implant variants of these codes.

Please refer to the ***2024 Dental Coding with Confidence*** manual or the online Code Advisor at PracticeBooster.com for more information.

[1]Dennis Flanagan; Rationale for Mini Dental Implant Treatment. J Oral Implantol 1 October 2021; 47 (5): 437–444. doi: https://doi.org/10.1563/aaid-joi-D-19-00317



Reporting Area of the Oral Cavity and Tooth Anatomy by CDT Code

Submitting "clean claims" with all the correct information the first time is crucial to being paid quickly and without resubmissions. Part of that information is the proper reporting of the quadrant, tooth number, tooth surface, and additional information under "Record of Services Provided," as required by the particular CDT code. However, not all procedure codes clearly state what information is required for proper submission. How do you know what to report for each code?

The American Dental Association provides a document that is updated annually outlining their specific recommendations for reporting the area of the oral cavity and tooth anatomy listed by individual CDT code[1]. The latest iteration was effective Jan 1, 2024, based on the latest CDT code set. The suggestions are applicable to both the current ADA dental claim form and HIPAA standard electronic dental claim transaction (837D v5010). The document is cited as an online resource in the ADA 2024 CDT Coding Companion publication and is freely available online to both members and non-members at the link cited at the end of this article.

Area of the Oral Cavity

Per this document, the "Area of the Oral Cavity," when appropriate to report, is marked in Box 25 of the ADA claim form using the following code sets:	
Entire Oral Cavity	00
Maxillary Arch	01
Mandibular Arch	02
Upper Right Quadrant	10
Upper Left Quadrant	20
Lower Left Quadrant	30
Lower Right Quadrant	40

The ADA Dental Claim Form Completion Instructions[2] point out that the use of this field (Box 25) is conditional. Always report the area of the oral cavity when the procedure reported in Item #29 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure's nomenclature. For example:

a. Report the applicable area of the oral cavity when the procedure code nomenclature includes a general reference to an arch or quadrant, such as **D4263 bone replacement graft – first site in quadrant**.	
b. It is not necessary to report the applicable area of the oral cavity when the procedure either:	
1) Incorporates a specific area of the oral cavity in its nomenclature, such as **D5110 complete denture – maxillary**; or	**2)** Does not relate to any portion of the oral cavity, such as **D9222 deep sedation/general anesthesia – first 15 minutes**.

Tooth Numbers

Tooth numbers, when appropriate to report, are generally notated using the Universal Numbering System in Box 27 of the dental claim form. This system utilizes tooth numbers 1-32 for permanent dentition and A-T for primary dentition. These numbers/letters move from the patient's upper right to upper left, then lower left to lower right. In Box 26, under "Tooth System," you should enter "JP" to indicate this Universal System is being used. If instead using the International Standards Organization System, enter "JO." In this system, each tooth is represented by two digits, with the first number representing the quadrant and the second number representing the tooth in the quadrant numbered from the midline out.

When reporting supernumerary teeth in the Univeral Numbering System, add 50 to the closest permanent tooth number or add the letter S after the closest primary tooth letter. For example, these would result in tooth numbers 51-82 and AS-TS.

Also note that numbers or letters reported are based on tooth morphology, not anatomic position. For example, if a premolar tooth has been extracted and the molar tooth distal to it drifts forward, the tooth number would still be that of the molar even though it is in the anatomic position of the premolar. Implants are numbered using the morphological equivalent of the missing tooth.

Again, the use of this field (Box 27) is conditional. Report the tooth number when the procedure reported in Item #29 (Procedure Code) is applicable for a single tooth or a range of teeth less than a full quadrant. For example:

a. Always report the tooth number(s) when the procedure code nomenclature involves individual teeth or includes a reference to a range of teeth less than one quadrant, such as **D4342 periodontal scaling and root planing - one to three teeth per quadrant**.

b. Reporting the tooth numbers is not necessary if the procedure does not relate to specific areas of the mouth, such as **D9230 inhalation of nitrous oxide/analgesia, anxiolysis**.

c. Reporting becomes trickier when dealing with procedure codes that involve areas of the mouth but may still need to meet insurance plan criteria. In these cases, it is best to report both tooth number and quadrant, as with many surgical and periodontal codes such as **D4341 periodontal scaling and root planing - four or more teeth per quadrant**. It is best to review the ADA Dental Claim Data Recommendation in these instances, as cited at the end of this article.

Tooth Surfaces

When a procedure involves one or more specific tooth surfaces, those surfaces should be reported in Box 28 using the one-letter surface abbreviations as listed below:	
Buccal	B
Distal	D
Facial (or labial)	F
Incisal	I
Lingual	L
Mesial	M
Occlusal	O

When reporting multiple surfaces, insert each surface abbreviation together with no spaces in between letters. For example, report a filling that covers the mesial, occlusal, and distal of a tooth using "MOD", not "M O D", "M.O.D.", or "M-O-D". This can affect the initial scanning of tooth surface information into the computer systems used to adjudicate claims at the insurer and potentially lead to a delay in reimbursement.

In addition, if multiple restorations are performed on the same tooth that do not meet, they should each be reported separately. Always "code what you do." This allows the patient record to match what is in the patient's mouth. Carriers likely have clauses that will allow them to combine these restorations into one restoration for purposes of reimbursement, and this must be taken into account when estimating the patient portion of a restoration. Allow them to make this adjustment, however. Do not do it for them.

When In Doubt…

Whenever there is confusion about what identifying information needs to be included in a submission, always turn to the latest ADA Dental Claim Data Recommendation, Reporting Area of the Oral Cavity and Tooth Anatomy by CDT Code. This document may be found by searching the ADA.org website or by entering the link below listed in the first citation. This will show a list of all CDT codes and the ADA suggestion for what information should be included in Boxes 25-28 on the claim form. For further information on narratives and attachments to include, reference the 2024 Dental Documentation with Confidence manual or the online Code Advisior at PracticeBooster.com.

[1]ADA Dental Claim Data Recommendation, Reporting Area of the Oral Cavity and Tooth Anatomy by CDT Code, Effective Jan 01, 2024. https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/publications/cdt/appendix_3_guide_to_reporting_area_of_the_oral_cavity_and_tooth_2024jan.pdf

[2]ADA Dental Claim Form Completion Instructions, Version 2024.
https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/publications/cdt/2024_completioninstructions_adaclaimform_2024.pdf

New Dental Compact Eases Professional Mobility Across States

The recent activation of the Dentist and Dental Hygienist Compact marked a significant advancement in the dental profession, promoting greater mobility and flexibility for dental professionals across multiple states. Nine states have now passed the legislation, easing licensure requirements for dentists and dental hygienists in participating states. The DDH Compact legislation specified it would become effective upon the enactment of the 7th state, which happened when Maine joined in April. Colorado became the eighth state and Minnesota the ninth in May of 2024.

A Collaborative Effort

The compact is the result of a collaborative effort among various stakeholders, including state dental boards, the American Dental Association (ADA), the American Dental Hygienists' Association (ADHA), the Council of State Governments (CSG), the Association of Dental Support Organizations (ADSO), and the Department of Defense (DoD). This initiative addresses workforce shortages and aims to enhance access to dental care. The stakeholders recognized the need for a streamlined licensure process to facilitate the movement of qualified dental professionals across state lines, reducing bureaucratic hurdles and ensuring that dental care can be provided more efficiently to communities in need.

Key Features of the Compact

The Dentist and Dental Hygienist Compact introduces several key features designed to simplify and standardize the licensure process for dental professionals:

Uniform Licensing Standards: The compact establishes consistent licensing standards that participating states agree to follow. This ensures that dental professionals meet high competency requirements and maintain the quality of care regardless of the state in which they practice. The uniform standards help mitigate discrepancies between state requirements, promoting a more cohesive national dental workforce.

Interstate Practice Privileges: Under the compact, dentists and dental hygienists licensed in one member state can practice in other member states without needing to obtain additional licenses. This provision eliminates redundant administrative processes, significantly reducing the time and cost of acquiring multiple state licenses. Professionals can now move more freely, responding to demand in different regions without facing bureaucratic delays

Improved Access to Care: The compact aims to address regional shortages by facilitating the easier movement of dental professionals, particularly in underserved areas. Many rural and underserved communities struggle to attract and retain dental professionals. The compact's provisions can lead to improved access to dental care for patients in these areas, who might otherwise face long wait times or have to travel considerable distances to receive care. Enhanced mobility allows dental professionals to fill gaps in service more effectively.

Military Support: The compact particularly benefits military families, who frequently relocate across state lines. Military spouses who are dental professionals often face challenges in maintaining their licensure due to frequent moves. The compact supports these professionals by easing licensure processes, ensuring they can continue their careers without significant interruption. This provision is crucial for maintaining the stability and readiness of military families.

Implementation and Future Steps

With nine states now on board, the compact will be officially enacted, with more states expected to join in the near future. The ADA and the Dental Hygienist Compact Commission are actively working to assist additional states in adopting the compact. The implementation process for the compact is expected to take 18 to 24 months before compact privileges are able to be issued.

According to the "What's Next?" resource document provided by the Dental Hygienist Compact Commission, the implementation phase will involve the establishment of a centralized database for tracking licensure status and disciplinary actions. This database will help maintain the integrity and accountability of dental professionals practicing under the compact.

Furthermore, educational outreach and training will be conducted to ensure that dental professionals and state boards are fully informed about the compact's provisions and benefits. This will include webinars, informational sessions, and detailed guidelines to facilitate a smooth transition to the new system.

States Involved

As of this writing, the Dentist and Dental Hygienist Compact has had legislation enacted in Colorado, Iowa, Kansas, Maine, Minnesota, Tennessee, Virginia, Washington, and Wisconsin. Legislation is pending in five other states, including Illinois, New Jersey, Missouri, Ohio, and Pennsylvania.

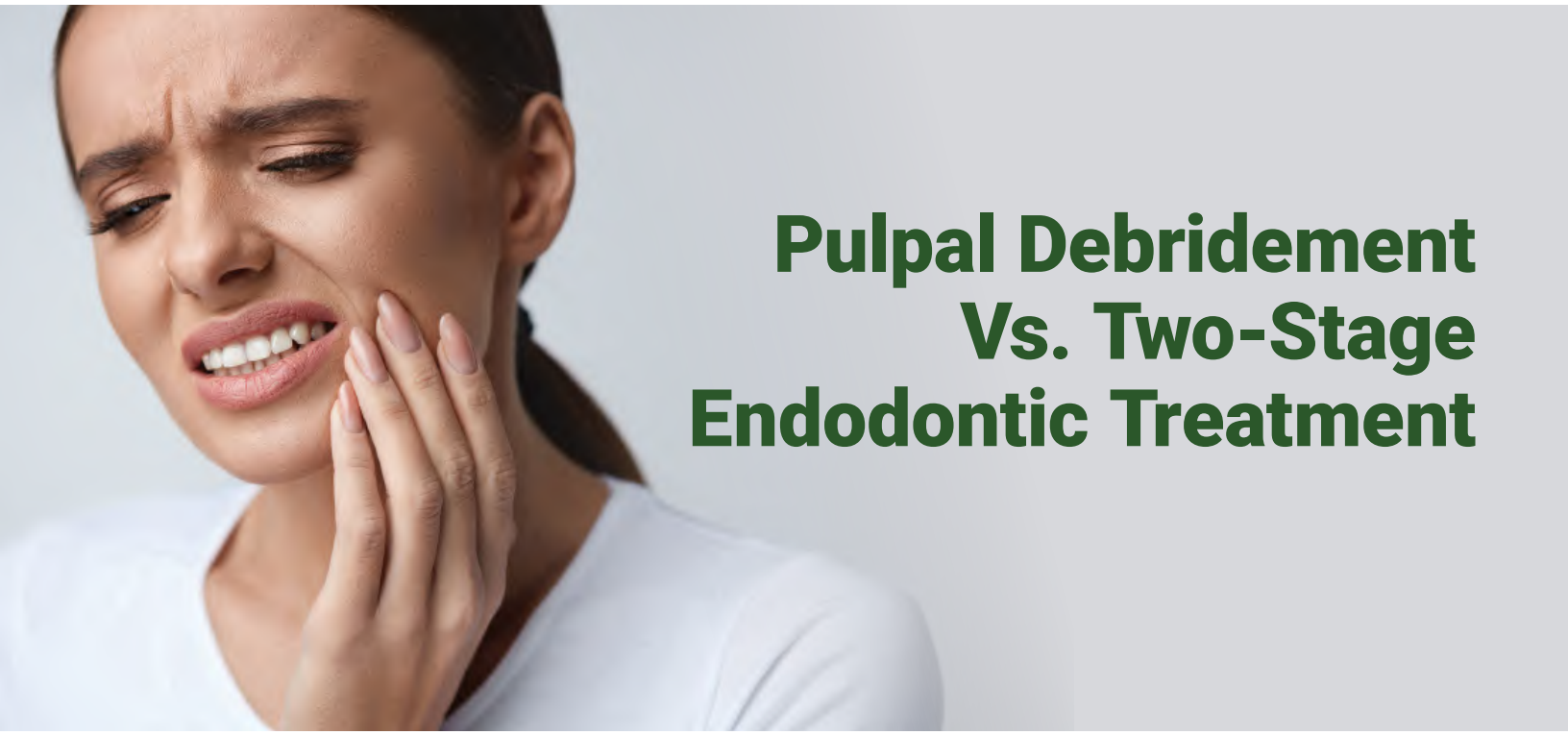
Conclusion

The Dentist and Dental Hygienist Compact represents a landmark step toward modernizing dental licensure and ensuring a more flexible, responsive dental workforce. By breaking down barriers to practice across state lines, the compact not only benefits dental professionals but also significantly enhances patient access to quality dental care. As more states consider joining, the compact is poised to become a cornerstone of dental licensure in the United States, reflecting a commitment to both professional mobility and public health.

[1]American Dental Association. "Seventh State Approves Legislation Establishing Dental Compact." ADA, 25 Apr. 2024. https://www.ada.org/about/press-releases/seventh-state-approves-legislation-establishing-dental-compact.

[2]Dentist and Dental Hygienist Compact. "Dentist and Dental Hygienist Compact." DDH Compact, 2024. https://ddhcompact.org.

[3]Dentist and Dental Hygienist Compact Commission. "What's Next Resource." DDH Compact, Apr. 2024. https://ddhcompact.org/wp-content/uploads/sites/31/2024/04/Whats-Next-Resource-DDH.pdf.



Pulpal Debridement Vs. Two-Stage Endodontic Treatment

From a Practice Booster Subscriber:

Q Hello! We are seeking additional clarification and guidance with respect to coding/billing of Root Canal Therapy procedures that are routinely performed in more than one visit. The Practice Booster Code Advisor describes these scenarios, however the information provided is far more detailed than what we can find in the ADA coding book and insurance office desk manuals.

More specifically, D3221 is described on Code Advisor online as "reports opening and debriding the pulp for relief of acute pain prior to completing endodontic treatment at a later time. The emergency patient 'interrupts' the dentist's schedule. Obturation of canals may be performed at this emergency visit. After the pulpal debridement, the patient is then referred to an endodontist or the patient's dentist of record completes the root canal therapy. Note that some payors may "remap" and reimburse the pulpal debridement at the lower palliative (D9110) fee."

We cannot locate the information underlined above in the ADA CDT book or in carrier manuals. Can you please provide the source of this information? Similarly, is there a source or additional guidance you can provide that addresses whether D3221 can be used to bill the first visit of a routine two-visit RCT case when pulpal debridement is performed at the first visit, and the RCT is completed at the second visit (The RCT code would be used on the second visit)? If it is inappropriate to bill D3221 on the first visit of a routine two-visit RCT case, is there a different code that should be used?

Lastly, if a patient does not return for the second visit of a planned two-visit RCT case, Practice Booster recommends billing D3999; however, if D3221 was performed, would that not be the correct code to use when the patient does not return?

A The language you highlighted is a treatment scenario, not direct verbiage from the CDT. It is based on conversations we have had with the ADA Code Committee regarding the intent of the code and its usage. These are two distinct codes with specific meanings and usages and do not represent two routine steps of normal root canal therapy.

D3221 pulpal debridement is intended to be used for "the relief of acute pain prior to conventional root canal therapy. This procedure is not to be used when endodontic treatment is completed on the same day," per the code descriptor. So this code would be appropriate for when a tooth is opened up and cleaned out to relieve a patient's pain, but definitive endodontics is not completed at the time. It should not be used routinely for opening a tooth in two-step endodontics where acute pain is not present. Note the presence of acute pain in the patient's clinical record to support the use of D3221 as a necessary step.

Root canal therapy (D3310, D3320, D3330) is defined in the ADA glossary of Dental Clinical Terms as "The treatment of disease and injuries of the pulp and associated periradicular conditions." This treatment would include all steps to treat the disease of the pulp, and debridement of diseased nerve tissue would be included as an integral part of the treatment. Root canal therapy may be performed across several visits but should only be reported upon completion of the treatment. Attempts to routinely report this step separately would fit the definition of unbundling, which is "The separation of a dental procedure into discrete components, charging separately for each component, resulting in a higher total fee." Therefore, D3221 may only be used when the patient has acute pain, which is relieved by opening and cleaning out the canals. This is most often during an emergency visit, not during a scheduled, routine two-visit endodontic procedure.

Often, when an emergency patient is worked into the schedule, opening and debriding are all you have time to do. If D3221 is reported and then followed within a few weeks by definitive endodontic treatment, payors will consider that as if it was traditional two-visit endodontic therapy; opening one day and filling on another day. If they have paid you for D3221, most likely they will deduct that payment from the reimbursement for the definitive procedure once reported. This is what we refer to as a "take back" code. In this case, it is better to call the first visit D9110 palliative treatment. That cannot be taken back, so you get to keep all reimbursements in full.

Alternatively, if you are referring the case to an endodontist, the first visit should be called D3221 pupal debridement. This has a higher fee and a higher reimbursement, but strategically it should only be used when "take back" is not an issue. Reporting D3221 will not affect the endodontist's ability to charge or get reimbursed since it is a different provider.

As to your last question, as D3221 is a procedure unto itself. If the patient does not return, the D3221 has already been completed and may still be reported and reimbursed if it was used to relieve acute pain. However, if root canal therapy is initiated but not completed (in absence of acute pain), then D3999 is the appropriate code to report. Include a narrative describing the stages of the procedure completed and that the patient did not return for completion of the root canal therapy even after multple attempts were made to reappoint. The attempts to contact and reappoint the patient should also be included in the clinical notation.

PBQ&A

Answers to real questions asked by Practice Booster subscribers

Q **Hello! I am reaching out to ask about code D2989 - We used the code to see if it is restorable and, if so, what it would be on a tooth. He would not know until he removed the decay to see the damage. We had the patient return on another for restoration. If the restoration is done on another day, is this not the appropriate code? I am being told that his time removing the decay to determine its restorability cannot be billed if we restore it even on another day. I know if we were to restore on the same day, we would charge for what we did, but if it is restored on another day, would this not be the appropriate code?**

A The full nomenclature for D2989 reads:

D2989 EXCAVATION OF A TOOTH RESULTING IN THE DETERMINATION OF NON-RESTORABILITY

The code is new for 2024. It specifically reimburses for time spent removing decay only to determine that it was not restorable. It may not be used for exploratory decay removal that was then restored to function.

Alternatively, you may report D2999 unspecified restorative procedure by report along with a narrative describing the procedure as exploratory decay removal to determine restorability. While insurance still will not pay, they may allow this fee to be passed to the patient, particularly if the restoration was done on another day. Oftentimes, however, in-network payors will see this as an integral part of the definitive restoration and not allow the patient to be charged. You must read the EOB. If not in-network, the patient may always be balance billed.

Another option would be to report the procedure as D2940 protective restoration. This frequently falls under the same issues though. Many payors will pay for D2940 but then deduct the reimbursement for D2940 from the definitive restoration if performed soon after the protective, which nets no reimbursement for D2940 in the end. You may call and discuss with the plan to see if they "take back" D2940 after definitive restorations vs. if they will allow D2999 to be passed to the patient. Unfortunately, this varies from plan to plan, so there is no one "right" answer to use in every situation.

If you are a Practice Booster subscriber and have coding and administration questions for one of the Practice Booster Advisors, you can email your question to **support@practicebooster.com**. If you aren't a subscriber yet, *what are you waiting for?*

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