Top Clinical Coding Errors

Proper dental coding can be a challenge for all practices. Understanding common errors that occur in the coding and administrative process can help dental teams improve accuracy of claim submissions in order to receive maximum reimbursement the first time a claim is filed.

Dental teams around the country are challenged to reduce dental coding errors on a daily basis. One of the main goals of this Guide is to help you accurately report dental procedures through proper coding practices.

To follow are some of today's most common coding errors pertaining to dental insurance coding. For more details on each and every CDT code, refer to our ***Dental Coding With Confidence***. Order it today at *https://dentalcoding.com/shop/*, or scan the QR code on the inside front cover. Please note the symbol represents references to additional coding guidance within ***Dental Coding With Confidence***.

ERROR	PROPER CODING TECHNIQUE OR ADMINISTRATIVE PROTOCOL
Reporting periodic oral evaluation (D0120) instead of the comprehensive oral evaluation (D0150) for the pediatric comprehensive (initial) evaluation (3 years old and up) to reduce the child's total fee for the visit.	Doctors who wish to charge a lower fee for pediatric oral evaluations should establish 2 separate fees, adult and pediatric, for the same comprehensive oral evaluation (D0150). Use D0150A and D0150B (or similar, based on practice management software capabilities) to distinguish between the higher adult fee and the lower pediatric fee. Accordingly, the UCR fee reimbursement by payors will be higher if the correct code, D0150, is submitted for the child, not D0120. See D0150 and D0120 for further explanation.
Reporting D0150 or D0120 if patient is under the age of 3.	To report an oral evaluation for a patient under 3 years of age, which must include counseling with the primary caregiver, report code D0145. See D0145 for further explanation.
Reporting limited oral evaluation – problem focused (D0140) at every emergency visit.	Plan frequency limitations normally allow for two evaluations to be covered per year. D0140 "burns up" an oral evaluation, so when applicable consider reporting palliative (D9110), pulpal debridement (D3221), or pulp vitality test (D0460) as a possible alternative. See D9110, D3221, and D0460 for further explanation.

ERROR	PROPER CODING TECHNIQUE OR ADMINISTRATIVE PROTOCOL
Reporting consultation (D9310) for new patient oral evaluations when a self referred patient presents for a second opinion related to a single issue or a comprehensive treatment plan issue.	If a self-referred patient presents with a comprehensive treatment plan from another doctor and wants a second opinion, then report comprehensive oral evaluation (D0150) or comprehensive periodontal evaluation (D0180), as may apply. If the self-referred patient presents for a limited treatment issue, report limited oral evaluation (D0140). Do not report consultation (D9310) for self referred patient visits. D9310 reports an evaluation of a patient who is specifically referred by a physician, dentist, or other licensed healthcare professional. If a physician, dentist, or other licensed individual refers the patient, a written report should be sent to the referring physician or dentist. On the other hand, D9450 should be used to report a case presentation to the patient subsequent to a comprehensive oral evaluation, or a consultation (D9310). See D9310 for further explanation.
Failure to report D0180 when a comprehensive periodontal evaluation was completed. *(Advisor Corner Response!)*	If the patient has signs and symptoms of periodontal disease, systemic medical conditions, or patients with social risk factors, and the comprehensive oral evaluation is completed with full mouth probing and charting, then D0180 is more appropriate than D0150. In addition, D0180 could have a higher UCR than D0150 in some cases. See D0180 for further explanation.
Failure to document the medical necessity for radiographic images and recording the clinical impressions of those images.	Radiographic images should be ordered specifically by the doctor and should only be taken when medically necessary, based on the individual patient's needs. Furthermore, the image must be interpreted by the doctor, and the clinical record should note the doctor's interpretations of those images.
Billing for nondiagnostic radiographic images, including images not clearly showing the area of concern or images taken as part of the delivery of a procedure.	Nondiagnostic radiographic images should not be submitted to the payor for reimbursement. If submitted and later determined by the payor to be of nondiagnostic quality or integral to a procedure (such as check films), the payor will request a refund of any benefit paid.
Reporting a single bitewing radiograph at the limited oral evaluation – problem focused (D0140) visit.	Reporting a single bitewing (BW) image at an emergency visit could affect the annual BW limitation for a subsequent recare visit. Several periapicals reported at the emergency visit should not count against the annual bitewing exclusion. Consider periapical radiographs (at different angles) for diagnostic purposes. Two necessary periapicals (D0220/D0230) reported at the problem focused visit may be reimbursed routinely. However, the clinical need for specific radiographic images, as determined by the doctor, should prevail regardless of any concern for benefit reimbursement or limitation. A bitewing radiographic image could always be taken on a complementary basis in conjunction with the billed periapical radiographs, if deemed appropriate by the dentist. See D0270 for further explanation.

ERROR	PROPER CODING TECHNIQUE OR ADMINISTRATIVE PROTOCOL
Reporting a panoramic radiographic image (D0330) and bitewings (D0272, D0273, or D0274) as a complete series of intra-oral images (D0210), rather than reporting separately as a panoramic and bitewings.	Report the panoramic and bitewing images separately, as performed, on the correct service date. Let the payor "remap" an alternate benefit for a complete series of intraoral radiographic images in accordance with any plan limitations and exclusions. Always report exactly "what you do." A panoramic radiograph could be taken at an emergency visit with a potential new patient, and the bitewings then taken at the subsequent new patient visit. See D0330 for further explanation.
Reporting 2 bitewings (D0272) for children and 4 bitewings (D0274) for adults as standard clinical protocols.	Remember that radiographs should only be taken after the doctor has evaluated the patient and prescribed any necessary radiographs according to ADA/FDA guidelines not based solely on insurance frequencies. See D0272 and D0274 for further explanation.
Not taking necessary radiographs on a timely basis in accordance with the diagnostic need, as indicated, for each individual patient.	Ensure that panoramic or complete series of radiographs are current, and are updated in accordance with the clinical need of each individual patient, as ordered by the doctor (typically every 3 to 5 years). Radiograph guidelines (ADA/FDA) were updated in 2012. For more information, visit: *https://www.ada.org/resources/practice/practice-management/radiographic-imaging*
Overcharging for adjunctive pre-diagnostic tests (VELscope®, Oral ID™, and Identifi®).	Consider charging a lower fee ($10 to $15) for an annual adjunctive oral cancer screening to gain much wider acceptance by adult patients. Charging a higher fee ($50 – $65) is a barrier to patient acceptance. See D0431 for further explanation.
Reporting prophylaxis – adult (D1110) when scaling in the presence of moderate or severe gingival inflammation is performed.	Coding guidelines require that current CDT code that best describes the procedure performed be used to document and report procedures. When clinical documentation supports a documented diagnosis of generalized (more than 30%) moderate or severe gingival inflammation with no bone loss, report D4346, regardless of benefits or lack thereof for D4346. See D1110 and D4346 for further explanation.

ERROR	PROPER CODING TECHNIQUE OR ADMINISTRATIVE PROTOCOL
Reporting prophylaxis – adult (D1110) when periodontal maintenance (D4910) was performed.	If the patient previously received scaling and root planing treatments and/or periodontal surgery and subgingival plaque and calculus removal with site-specific scaling and root planing as indicated is performed, then report D4910. Providing periodontal maintenance (D4910) would be the standard of care, not prophylaxis (D1110). See D1110 and D4910 for further explanation.
Reporting topical application of fluoride – excluding varnish (D1208) when fluoride varnish (D1206) was applied.	The nomenclature for topical application of fluoride (D1208) has been revised to specifically state "excluding varnish." Report D1206 for topical application of fluoride varnish. D1206 often has a higher fee reimbursement. See D1206 and D1208 for further explanation.
Reporting a preventive resin restoration (PRR) when decay does not extend into dentin instead of a one surface posterior resin based composite (D2391).	The revision to D2391 in 2026 removed considerations about the depth of decay, making the restoration of a tooth having any decay now reportable using D2391. The code for preventive resin restoration (D1352) has been deleted.
Reporting separate, noncontiguous fillings performed on the same tooth as one restoration.	At the beginning of the Restorative category of service in the Explanation of Restorations table, the CDT notes that restorations are described as "Placed, without interuption." The CDT Coding Companion further mentions that dentists must document what they do, and reporting a single restoration when two separate restorations were placed will cause a discrepancy between the patient records, the carrier claim records, and what's actually in the patient's mouth. Note: Most payors will combine these separate restorations for reimbursement purposes, but always code what you do.
Reporting multi-surface anterior fillings to close a diastema or cover discolorations without noting the purpose of the restorations.	Almost all insurance plans deny coverage of restorations performed purely for cosmetic reasons. It is both ethical and a contractual obligation to disclose when restorations are placed that are not due to decay or fracture. The patient will generally be responsible for the entire contracted fee.
Reporting an MO, DO, or MOD onlay.	Onlays must always include a facial or lingual surface. Appropriate onlay codes include, but are not limited to, MODF, MODFL, DOL, MOL, or MOF.

ERROR	PROPER CODING TECHNIQUE OR ADMINISTRATIVE PROTOCOL
Reporting D2740 crown – porcelain/ceramic for the restoration of an implant.	The crowns found in the restorative category of service (D27xx) are exclusively for single unit restorations on natural teeth. Single unit implant crowns may be found in the implant category of service (D60xx). Be certain to match the material type of the restoration to the correct code.
Reporting core buildup D2950 to describe filling an access hole made in an existing crown after an endodontic procedure.	A D2950 core buildup is only appropriate when there is "insufficient retention" to hold a crown in place. If the crown does not come off, then D2950 is not an appropriate code to report for this procedure. A one-surface amalgam or composite restoration should be reported to describe the filling of an access hole of the crown (that remains in place) after returning from endodontic treatment. A narrative would read "An occlusal composite was placed for endodontic access hole closure." See D2950 for further explanation.
Reporting the prefabricated post and core (D2954) as an indirectly fabricated CAD/CAM or cast post and core (D2952), and vice versa.	Do not confuse the reporting of the various post and core codes. Always report "what you do." The prefabricated post and core and a cast or milled post are separate and distinct procedures from the crown placement. See D2952 and D2954 for further explanation.
Reporting D2954 to describe endodontic access hole closure with the placement of a post in a tooth with an existing crown.	Unspecified restorative procedure, by report (D2999), should be used to report post placement in a crown that remains in place and has been endodontically treated. In order to report D2954, the crown must be removed from the tooth, the prefabricated post and core placed, and the crown then re-cemented or re-bonded into place for retention. See D2954 for further explanation.
Reporting crown repair (D2980) for endodontic access closure.	D2980 has been revised such that the crown repair code requires that it be "necessitated by restorative material failure." D2980 does not report endodontic access closure. A 1 surface amalgam or composite should be reported to describe filling the access hole of the crown, providing it remains in place after the endodontic treatment. In the remarks state "An occlusal composite was placed for endodontic access closure." However, a few payors still require D2980 for endodontic access closure. See D2980 for further explanation.

ERROR	PROPER CODING TECHNIQUE OR ADMINISTRATIVE PROTOCOL
Miscoding the type of metal used to fabricate a crown (e.g., titanium, high noble, noble, predominantly base, etc.).	Always report the code that describes the materials and surface coatings (porcelain or resin) used to fabricate the fixed prosthesis. The treatment plan entry, lab slip, computer procedure entry, and insurance claim form entry should all be consistent in the type of metal coping and surface coating reported.
Reporting pulp cap (D3110 or D3120) in conjunction with an amalgam or composite restoration submitted on the same service date.	All bases and liners for pulpal protection or thermal sensitivity are included in the global restoration fee under most plans. Pulp caps may be reported and documented using D3110/D3120; however, do not expect reimbursement. If not in network, the global fee may be increased to offset the additional time required for the removal of deep decay with placement of a base/liner. However, a direct pulp cap (D3110) placed for stimulating secondary dentin (healing) after the direct exposure of the pulp may be reimbursed on a stand-alone basis, if the tooth is not restored on the same service date. D3120 is an indirect pulp cap that can be placed when all of the caries is not removed on a stand-alone basis. See D3110 and D3120 for further explanation.
Routinely reporting pulpal debridement (D3221) as the first stage of a scheduled 2 appointment root canal.	Pulpal debridement (D3221) is an *emergency* procedure interrupting the dentist that relieves pain by opening the tooth for access and removing all pulpal tissue from the pulpal chamber and roots. The appropriate root canal codes (D3310, D3320, D3330) should be reported for a 2 visit endodontic treatment.
Reporting the anterior root canal (D3310) for a root canal (endodontic therapy) performed on a premolar with only 1 canal.	Practices should report D3320 for root canals on all premolar teeth, regardless of the number of canals or roots. Root canals are reported according to the tooth (i.e., anterior, premolar, or molar) treated, not the number of canals. However, a higher fee might be charged for a more complex procedure. See D3320 for further explanation.
Reporting D4211 for a gingivectomy for restorative access.	D4212 reports a gingivectomy for restorative access, per tooth. D4211 reports a gingivectomy or gingivoplasty – 1 to 3 contiguous teeth or tooth bounded spaces per quadrant which is related to periodontal issues and requires charting for documentation. D4212 is typically not paid if performed on the same date of service as the restoration and is considered to be part of the global restoration fee by payors. See D4212 for further explanation.

ERROR	PROPER CODING TECHNIQUE OR ADMINISTRATIVE PROTOCOL
Reporting hard tissue clinical crown lengthening (D4249) when a soft tissue procedure was performed.	Clinical crown lengthening (D4249) requires the reflection of a full thickness flap and removal of hard tissue (bone), altering the crown to root ratio. Some payors require up to a 6-week healing period, prior to the crown preparation and subsequent final impression. If bone is not removed, consider reporting a gingivectomy for restorative access, per tooth (D4212). D4212 is typically not paid if performed on the same date of service as the restoration and is considered to be part of the global restoration fee by payors. See D4249 and D4212 for further explanation.
Reporting a bone replacement graft (D4263) for a bone socket graft (extraction site) (D7953).	D4263 reports a bone replacement graft associated with periodontal osseous surgery where natural teeth are involved, while D7953 reports a bone socket graft (after an extraction or implant removal) for ridge preservation. See D7953 for further explanation.
Reporting guided tissue regeneration – resorbable barrier, per site (D4266) when a collagen plug was placed.	Payors consider placement of a collagen plug inclusive to the global procedure and the fee for the extraction and is not reimbursed separately. A collagen plug is not considered a barrier membrane. A collagen plug is appropriately reported using D7922, when applicable. Report D7956 for a resorbable barrier membrane if placed separately from the bone graft (D7953). See D7922 and D7956 for further explanation.
Reporting full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis (D4355) as a first visit on the same service date as periodontal records and diagnosis.	If accurate periodontal charting and diagnosis cannot be completed due to the excessive buildup of calculus and debris and/or the presence of pseudo pocketing, consider performing a full mouth debridement (D4355) at the initial visit. D4355 is a preliminary procedure. The patient may, or may not, have periodontal disease. Ideally, the completion of a comprehensive oral evaluation (D0150 or D0180) should follow the full mouth debridement (D4355) on a subsequent date, about 15 days later, allowing time for healing prior to subsequent probing and charting. If access to care issues are involved, D0150 may now be delivered on the same date of service, but the periodontal diagnosis must be delayed. D1110 is often paid as an alternate benefit if the plan document does not cover D4355. (Note: D4355 is reimbursed only about 30% of the time). See D4355 for a further explanation and the clinical flow chart.

ERROR	PROPER CODING TECHNIQUE OR ADMINISTRATIVE PROTOCOL
Not reporting the immediate denture (D5130 or D5140) after extracting the remaining natural teeth.	The immediate denture procedure is generally followed (after an appropriate healing period) by either a reline, a rebase, or a new complete denture. The immediate complete denture (D5130 or D5140) reimbursement may include any soft tissue temporary liners utilized during the healing interval after placement. Some payors require up to a 6-month healing interval (sometimes to the day) prior to a subsequent hard acrylic reline or rebase. The subsequent reline or rebase may either be a chairside procedure (not processed) or a lab reline (processed outside the mouth in-office or by an outside lab). In some situations, a new complete denture may be indicated if the immediate denture cannot be successfully relined or rebased. The new denture will be subject to the plan's frequency limitation. Some payors may pay a reline or rebase fee toward the second denture set, so request the alternate benefit. See D5130 and D5140 for further explanation.
Reporting direct (chairside) reline codes (D5730-D5740) for an in-office processed reline (D5750-D5761).	Report an indirect (lab) reline procedure if the reline is processed (triad oven or pressurized hot water bath) either in the dental office lab or an outside lab. Note: An indirect (lab) reline typically has a higher reimbursement than a direct (chairside) reline.
Reporting direct (chairside) relines (D5730-D5740) as tissue conditioning (D5850 or D5851).	Tissue conditioning (D5850 or D5851) is a temporary lining. The purpose of tissue conditioning is to prepare unhealthy soft tissues for a final impression for some type of definitive, removable procedure, such as a complete or partial denture. Tissue conditioning provided over a limited period of time aids in the healing of unhealthy ridges prior to taking final impressions for a definitive removable restoration. See D5850 and D5851 for further explanation.
Reporting an interim complete denture code (D5810 or D5811) to report the placement of a complete denture after extracting any remaining teeth.	Generally, the *immediate* complete denture code (D5130 or D5140) should report the delivery of an immediate denture after the extraction of any remaining teeth, if the intention is a subsequent hard acrylic reline or rebase. The *interim* complete denture (D5810 or D5811) may also be reported when placed at time of extractions if the prosthesis is intended to be replaced and not relined or rebased. The interim complete denture may also be used in an already edentulous mouth for a limited time period, to be replaced later by a more definitive restoration, such as an implant overdenture. Note: The interim prosthesis, if paid, is reimbursed at a lower rate than the immediate denture and may be withheld from the reimbursement amount of a definitive replacement. See D5130, D5140, D5810, and D5811 for further explanation.

ERROR	PROPER CODING TECHNIQUE OR ADMINISTRATIVE PROTOCOL
Reporting D6010 for a mini implant.	Report D6013 for a mini implant and D6010 for a full size endosteal implant. See D6010 and D6013 for further explanation.
Not reporting D6011, second stage implant surgery.	D6011 reports second stage implant surgery – removal of tissue to enable placement of any type of fixture onto the implant body. This code is reported in addition to placement of the full size implant (D6010) and any interim or definitive restorative component when tissue is removed. See D6011 for further explanation.
Reporting the abutment placement code D6020, a previously deleted code.	The interim, prefabricated, and custom abutment codes (D6051, D6056, and D6057) are inclusive of the labor component for placement of the implant abutment. The all-inclusive global abutment placement fee includes any associated labor. The implant surgeon who furnishes an abutment to the general dentist may NOT report the abutment procedure, but should report furnishing the abutment part as D6199. See D6051, D6056, and D6057 for further explanation.
Reporting implant crowns as routine single crowns (D27xx) for natural teeth, not as abutment supported or implant supported crowns.	Do not report crowns supported by abutments or implants as routine natural tooth crowns. Reporting crowns supported by abutments or implants as natural tooth crowns may be considered fraudulent. Report the proper abutment or implant supported crown and let the payor reimburse the alternate benefit of a natural tooth crown, if available.
Not reporting the implant abutment (D6051, D6056, and D6057) separately when placing abutment supported restorations.	An interim, prefabricated, or custom *abutment* should be reported separately from the abutment supported crown. See D6051, D6056, and D6057 for further explanation.
Reporting abutment supported crowns as implant supported crowns.	If the one piece implant crown is attached directly into an implant (with no separate associated abutment), then it is an implant supported crown. If an abutment is attached to the implant first and then the associated crown fits over the abutment, then it is an abutment supported crown. Abutment supported crowns are always associated with either a manufactured, prefabricated abutment (D6056) or a custom abutment (D6057). Custom abutments are custom cast or CAD/CAM milled. See D6056 and D6057 for further explanation.

ERROR	PROPER CODING TECHNIQUE OR ADMINISTRATIVE PROTOCOL
Reporting surgical implant removal (D6100) at a high fee and including the placement of a bone replacement graft (D7953) and a resorbable barrier membrane (D7956).	Separately report the implant removal (D6100), bone replacement graft placement (D7953), and resorbable barrier membrane (D7956), if applicable. Adjust fees accordingly. See D6100, D7953, and D7956 for further explanation.
Reporting D5810/D5811 for interim dentures to report interim fixed implant/abutment supported dentures.	Report implant/abutment supported interim fixed denture (D6118/D6119). See D6118 and D6119 for further explanation.
Reporting D5863/D5864/ D5865/D5866 for implant/ abutment supported overdentures. These codes are for overdentures fabricated to fit over natural teeth and/or retained tooth roots.	Report D6110/D6111/D6112/D6113 for implant/abutment supported overdentures. See D6110, D6111, D6112, and D6113 for further explanation.
Reporting D7953 for a bone graft in conjunction with implant placement.	D7953 is a bone graft (at extraction or implant removal site) placed for bone socket ridge preservation. A healing period would follow D7953 placement. However, a bone graft in conjunction with implant placement on the same service date is reported as D6104. See D7953 and D6104 for further explanation.
Reporting fixed partial denture (bridge) retainer core buildup, cast post and core, or prefabricated post and core codes (D6970, D6972, and D6973). These codes have been deleted.	Report bridge retainer crown core buildups, indirectly fabricated (includes CAD/CAM) and prefabricated post and core codes appropriately with their current CDT codes. See D2950, D2952, D2953, D2954, and D2957 for further explanation.
Not reporting the appropriate material type for a fixed partial denture (bridge) pontic material with the retainer crown material.	Generate a production report by procedure code frequency and confirm that the pontics by material type consistently match the number of retainer crowns of the same material type for a multi-unit fixed bridge. A review of this report will assist the practice in determining if this error is occurring.

ERROR	PROPER CODING TECHNIQUE OR ADMINISTRATIVE PROTOCOL
Reporting coronal remnants (D7111) for routine deciduous (primary) tooth extractions.	Report the routine erupted tooth extraction code, D7140, if the primary (deciduous) crown component and partial or full root structures remain. Report D7111 when the primary tooth root has undergone complete resorption and only a coronal remnant, or shell of the crown, remains embedded in the soft tissue. Note: D7111 reimbursement is less than D7140. See D7111 and D7140 for further explanation.
Reporting D7250 for removal of *residual* tooth roots for the removal of *exposed* roots.	D7140 reports the routine extraction of a primary or permanent tooth, or an *exposed* root, not D7250. D7250 includes a cutting procedure for the removal of residual tooth root(s) left from a previous extraction on a different date of service. See D7140 for further explanation.
Reporting a routine erupted tooth extraction as a surgical extraction (D7210) when only a suture is placed, or a flap is laid.	A surgical extraction (D7210) requires "removal of bone and/or sectioning of tooth." Simply placing a suture or laying a flap does not meet the requirement for reporting D7210, so report D7140. See D7210 which requires sectioning and/or removal of bone for further explanation. D7210 is commonly called a *surgical* extraction.
Reporting D7250, removal of residual tooth roots (cutting procedure) for a difficult root extraction.	Reporting D7250 for the difficult extraction of a residual tooth root could invalidate subsequent reimbursement for a fixed partial denture (bridge), partial denture, or implant crown due to the "missing tooth clause." D7250 does not apply to a procedure that originally started as an erupted tooth extraction, but results in the extraction of a residual root during the same procedure, or when the tooth is at or below the gum line. D7250 is a cutting procedure, which removes a *residual* tooth root left from an extraction performed on a previous date of service that must involve a cutting procedure to remove. If a root fractures during an extraction and additional procedures must be performed on the same date of service to remove the fragment, still report D7210 but increase the fee to address the increased difficulty. Note the complication in the clinical record and subsequent narrative. If a root tip must be left behind, report D7999 and note an incomplete extraction. See D7250 and D7210 for further explanation.
Reporting occlusal orthotic device (D7880) when a hard acrylic occlusal guard (D9944) applies.	D7880 is for a TMJ related occlusal orthotic device (i.e., pain, clicking joint, multiple visits). An occlusal guard – hard appliance, full arch (D9944) is placed to reduce tooth deterioration due to the patient's bruxing or clenching of teeth. An occlusal guard may also be placed after scaling and root planing or osseous surgery for stabilization of the dentition. See D7880, D9944, D9945, and D9946 for further explanation.

ERROR	PROPER CODING TECHNIQUE OR ADMINISTRATIVE PROTOCOL
Reporting the placement of a bone replacement graft and a barrier membrane as D7953.	Report a bone graft (D7953) and barrier membrane (D7956/D7957) separately for proper reimbursement. This method of reporting may also lessen the effects of fee capping for non-covered services, if applicable. See D7953 and D7956/D7957 for further explanation.
Reporting removable appliance therapy (D8210) for minor tooth movement (e.g., correcting a cross bite) when another code may be more applicable.	Report D8210 when a removable habit appliance is placed to stop habits, like thumb sucking and tongue thrusting. Use specific codes to report other various appliances, both fixed and removable. Limited orthodontic treatment of the transitional dentition (D8020) is appropriate for minor tooth movement during the transitional dentition phase. See D8020 and D8210 for further explanation.
Reporting orthodontic retention (D8680) for the replacement of a lost or broken orthodontic retainer.	Orthodontic retention (D8680) placement follows the removal of *active* orthodontic appliances with the immediate construction and placement of removable and/or fixed retainers for retention. Instead, use replacement of lost or broken retainer (D8703 or D8704) to report replacement of a fixed/removable orthodontic retainer that is lost or broken. See D8680 and D8703 or D8704 for further explanation.
Reporting re-cement or re-bond fixed retainer (D8698 or D8699) for re-bonding/ re-cementing a fixed retainer when palliative (D9110) may apply.	At an emergency visit, palliative (D9110) may be reimbursed for re-cementing or re-bonding a fixed orthodontic retainer (partially detached and causing patient discomfort/pain). Always report an accurate narrative based on the doctor's clinical notes. See D9110 for further explanation.
Not reporting palliative (D9110) at routine visits for relatively minor procedures to alleviate pain or discomfort as reported by the patient in some manner.	D9110 is an underutilized code. This treatment code should be reported at a visit when the patient reports pain/discomfort which is relieved with a minor treatment that has no distinct procedure code. Over utilization of problem focused oral evaluation (D0140) may result in reduced benefits. Many plans limit evaluations to 2 oral evaluations of any type per plan year. The aggressive use of D0140 at an emergency visit may exhaust an oral evaluation that could be used at a recare visit. See D9110 and D0140 for further explanation.

ERROR	PROPER CODING TECHNIQUE OR ADMINISTRATIVE PROTOCOL
Reporting consultation (D9310) for a treatment plan presentation.	If applicable, report D9450 for case presentations. Consultation (D9310) is for rendering a diagnostic opinion to a requesting licensed healthcare professional, not a self-referred patient. A consulting doctor may or may not provide the subsequent clinical treatment after a consultation visit (D9310). For self-referred patients, report the oral evaluation codes (D0140, D0150, D0180). See D9450 and D9310 for further explanation.
Reporting an office visit for observation (D9430) as a no charge follow-up visit after operative treatment.	Report D0171, which is the code to report a re-evaluation – post-operative office visit. This should be reported for a no charge, follow-up visit to previous treatment rendered. See D0171 for further explanation.
Reporting an office visit for observation (D9430) for a re-evaluation of a specific issue.	Consider using palliative (D9110) or limited oral evaluation (D0140), when applicable. Also consider a definitive code, if applicable. D9430 describes a visit for patient observation with no other evaluations or services rendered. D0170 re-evaluation limited, problem focused, or D0171, re-evaluation – post-operative office visit may also apply, which are newer codes. Note: D9430 is typically not reimbursed. See D9110, D0140, and D0171 for further explanation.
Reporting external bleaching (D9972 or D9975) as a total fee.	D9972 and D9975 should be reported "per arch," which lowers the fee capping for non-covered procedures profile. See D9972 and D9975 for further explanation.
Reporting D9972 for take home bleaching.	Report D9975 for take home bleaching trays and materials. D9972 reports in-office power bleaching which would include take home trays, if any. See D9972 and D9975 for further explanation.
Reporting D9972 for endodontic tooth whitening.	Report D9974 for internal bleaching – per tooth (this is a global fee) for endodontically treated teeth. D9972 is for in-office bleaching, not endodontic tooth whitening. In-office tooth whitening (D9972) should be reported "per arch." See D9974 for further explanation.
Reporting D9975 for teeth whitening refills.	D9975 includes materials and fabrication of trays. Report D9999 for dispensing whitening refills. Use D9985 to report any associated sales tax required by state law.