Top Clinical Questions and Answers

Below are some of the most common coding questions asked by dental teams.

Bridge (Fixed Partial Denture)

Q: What code reports the re-cement or re-bond of a bridge?

A: To report the re-cement or re-bond of a natural tooth bridge, report *D6930*. This code is used to report the re-cement or re-bond of conventional fixed partial dentures (bridges), Maryland, and Carolina bridges.

To report the re-cement or re-bond of an implant bridge, report *D6093*. This code is used to report the re-cement or re-bond of both implant and abutment supported fixed partial dentures (bridges).

CBCT

Q: Our general dentistry practice has a specialist in another office capture all of our CBCT images. How do we report this?

A: CDT codes for CBCT scans are based either on the capture and interpretation of the image, just the capture (no interpretation), or just the interpretation. Proper coding may also be determined by the position and size of the image produced and interpreted. Proper CDT coding to report CBCT and related services is determined by 4 variables:

1. Who captured the data or who performed the scan?
2. Who viewed and interpreted the image(s) that were produced by the CBCT?
3. What area of the head was captured by the CBCT?
4. What type of image was produced by the data captured (3D, fused, used in a simulation, or a subtraction process)?

Q: We received records from a new patient's former dentist which included a recent full mouth series of radiographs. We don't want to take a new set unnecessarily. Is there anything we can report for reviewing the transferred radiographs?

A: Yes, you may report *D0391* interpretation of diagnostic image by a practitioner not associated with capture of the image, including report. While most frequently used for interpretation of an "image capture only" radiograph taken by a different provider, this code may be used for review of any radiograph your practice did not take. That said, many dental plans will deny or even disallow reimbursement if capture and interpretation was previously reimbursed to another provider under the same plan.

Crown

Q: What is the definition of a ¾ crown?

A: A ¾ crown on a premolar or molar covers the occlusal and 3 lateral surfaces (generally the mesial, lingual, and distal surfaces) preserving the facial surface. The restoration extends below the height of contour of either the facial or lingual surface. A ¾ crown on an anterior tooth, involves either the mesial, facial and distal surfaces or the mesial, lingual, and distal surfaces. See *D2783* for a ¾ porcelain crown (more aggressive prep) versus a porcelain veneer *D2962*.

Dentures and Partials

Q: How is a Cu-Sil® partial denture reported?

A: A Cu-Sil® partial includes a rubber gasket that fits over an anchor tooth. If the partial is fabricated using a flexible base, then D5225 reports the maxillary partial denture and D5226 reports the mandibular partial denture. If the partial is fabricated using a resin base, including the Cu-Sil® rubber gaskets, then D5211 reports the maxillary partial denture and D5212 reports the mandibular partial denture. Diagnostic casts (D0470) are considered a part of the global fee for fabricating a partial denture.

Q: How is a unilateral partial denture fabricated using Triflex® or Valplast® materials reported?

A: Report D5284, removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests, and teeth) – per quadrant for a Triflex® or Valplast® unilateral partial denture. This code reports a unilateral partial with a flexible base.

Diagnostic

Q: What code reports a caries detectability test using iTero® Element 5D, or similar device?

A: Report D0600 for this diagnostic procedure. The device used must have the ability to quantify structural mineral changes in tooth structure. Reimbursement varies among payors.

Q: Can D0600 report any cavity detecting device or technique?

A: No. The technology used for this diagnostic procedure uses non-ionizing "light" and must be capable of quantifying, monitoring, and recording changes in the structure of enamel, dentin, and cementum. It is inappropriate to report D0600 for traditional transillumination technology or techniques. A few examples of technology that are capable of providing this service are iTero® Element 5D, CariVu™, DIAGNOcam, DIAGNOdent, LUM, and SoproLife diagnostic camera.

Q: Can a separate fee be charged when using the VELscope® or OralID® to perform an adjunctive oral cancer screening evaluation?

A: Yes, report D0431 for enhanced oral cancer screening evaluation. The hygienist can *screen* for oral cancer with the device, but the dentist must also perform the procedure in order to make a *definitive diagnosis* and charge for the procedure. The manual oral cancer evaluation by the dentist is now mandatory for the D0120, D0150, and D0180 evaluations.

Q: How do we report diagnostic casts generated via digital scanning technology for orthodontic cases?

A: D0470 reports both digital and traditional cast models for orthodontic cases. D0801 may be reported with no additional charge as a way to document that the models were taken with a 3D intraoral surface scan.

Extraction

Q: What code reports an incomplete extraction?

A: D7999 reports an *unintended*, incomplete extraction (e.g., when the general dentist refers the patient to an oral surgeon to complete the extraction of the remaining root fragment[s]). To report an *intentional*, incomplete extraction of an impacted tooth, see coronectomy – intentional partial tooth removal (D7251). For the intentional removal of coronal tooth structure of an erupted tooth for preservation of the root and surrounding bone, see decoronation or submergence of an erupted tooth (D3921).

Q: Is there a separate billing code for a collagen plug placed following extractions?

A: D7922 reports placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site. A collagen plug placed at the time of extraction is considered inclusive to the extraction by most dental plans and not reimbursed as a separate procedure. PPO contracts generally disallow this charge unless placed by a different provider than the one that extracted the tooth, or *possibly* if the plug is placed on a different date of service.

Implants

Q: How do we report a rebase procedure for an implant or abutment supported removable prosthesis?

A: This procedure may be reported using D5710/D5711 full denture; D5720/D5721 partial denture rebase codes.

Q: How is the tightening of an implant screw reported?

A: If retightening an existing implant screw, report D6089 accessing and retorquing loose implant screw – per screw.

In addition, the replacement of the restorative material to close the access opening of a screw-retained implant supported prosthesis can be reported using D6197.

Q: How do I report a permanent implant bridge?

A: Use codes D6068-D6074 or D6194-D6195 to report an abutment supported retainer crown of the bridge. The appropriate code is determined by the material used to fabricate the retainer crown. To report the pontic, select the appropriate code from D6205-D6252, based upon the material used to fabricate the pontic. The material reported for the retainer crowns and the associated pontic(s) must match.

Use codes D6075-D6077, D6098-D6099 or D6120-D6123 to report an implant supported retainer crown of the bridge. The appropriate code is determined by the material used to fabricate the retainer crown. To report the pontic, select the appropriate code from D6205-D6252, based upon the material used to fabricate the pontic. The material reported for the retainer crowns and the associated pontic(s) must match.

Q: What codes report mini implants and a removable overdenture?

A: Each mini implant is reported as D6013. The removable overdenture (edentulous mouth) is reported as D6110 for the maxillary overdenture, and D6111 for the mandibular overdenture. The keeper assemblies (female connector housings containing O-rings or gaskets, embedded in the overdenture) are each reported as D6192 (a semi-precision attachment), and are considered the locators.

Q: What code reports the routine replacement of an implant screw?

A: Report D6193 replacement of an implant screw. Also report D6197 for the replacement of the restorative material to close the access hole.

D6096 reports the removal of a broken implant retaining screw.

Q: How do I report maintaining space while an implant is healing when I use the crown of the extracted tooth bonded to the adjacent teeth as a space maintainer?

A: A fixed space maintainer code may be used to report this procedure. Depending on where the extracted tooth is located, you would use a fixed unilateral space maintainer (D1510) or a fixed bilateral space maintainer (D1516/D1517) if it crosses the midline. For example, if the extracted tooth is #8, the appropriate code to use would be D1516 because the retaining teeth will be in two different quadrants. Include a narrative describing the procedure and why the space is being maintained. Typically space maintainers have an age limit, so reimbursement is unlikely for adults.

Q: What code reports cleaning around an implant?

A: D1110, D1120, and D4910 now include cleaning around any implants as a part of the prophylaxis or periodontal maintenance procedure.

D6081 reports scaling and debridement of a single implant body in the presence of mucositis. D6049 reports the non-surgical scaling and debridement of a single implant when there is bone loss present due to inflammation (peri-implantitis). Neither D6049 or D6081 may be performed in conjunction with a prophy or periodontal maintenance procedure on the same service date.

D6080 reports implant maintenance procedures where a fixed hybrid prosthesis is removed, cleaned, inspected, and replaced, including cleaning the abutments. D6180 reports implant maintenance procedures where a fixed hybrid prosthesis and abutments are cleaned and inspected without removal. D6280 reports implant maintenance on a removable implant supported denture, including cleaning the abutments. D6080/D6180/D6280 are frequently not reimbursed unless the patient has implant coverage as a part of their dental insurance plan.

D6280 reports implant maintenance on a removable implant supported denture, including cleaning the abutments. D6101 reports debridement of the area around an existing implant with peri-implantitis, including a surgical flap. D6102 reports debridement of the area around an existing implant with osseous contouring of peri implant defect, including a surgical flap. D6103 reports a bone graft placed in the area around an existing implant where a bony defect exists. D6103 is reported in addition to D6102.

Scaling and root planing (SRP) codes, D4341 and D4342, are reported for natural teeth only, and these services never apply to implants.

Q: What is the difference between implant supported crowns and abutment supported crowns?

A: Abutment supported crowns are attached to and obtain stability from an intermediary abutment, which can be SEPARATELY attached to the implant body. The retention of the crown comes from it's attachment to the abutment only, and is not secured to the implant body directly.

Alternatively, implant supported crowns attach DIRECTLY to and gain support from the implant body. The retention of the crown comes from the implant. Even though an "abutment" may be used in the manufacturing process, it is delivered as an integral part of the one-piece implant supported crown and cannot be reported separately with implant supported crowns.

Q: If an implant abutment is cemented or bonded to an all ceramic crown then affixed to the implant as a one piece screw retained crown, can the crown restoration be reported as an abutment supported crown? Would the abutment be reported separately?

A: Generally no. If the abutment cannot be placed on its own without the crown, the crown is implant supported and has no separate reportable abutment. In this case the crown gains its retention from attachment directly to the implant body.

If the abutment is placed separately, or *could* be placed separately (as with screwmentable crowns), the crown is an abutment supported restoration. These crowns are retained only by their attachment to the intermediary abutment, which is separately connected directly to the implant body.

Since the abutment may not be reported with an implant supported restoration, the fee for an implant supported restoration should be roughly equivalent to an abutment supported restoration plus a separate abutment.

Q: What code reports an abutment-supported, interim implant crown?

A: D6085 reports an interim implant crown. Most plans exclude reimbursement, and some PPO contracts disallow this service unless it is considered an optional service. Refer to each applicable PPO Processing Policy Manual for clarification of optional services. An interim abutment is reported as D6051.

Q: What code reports an interim fixed hybrid denture?

A: Report D6118 for a mandibular and D6119 for a maxillary *interim* fixed hybrid denture.

Q: What code reports the replacement of acrylic and teeth on an implant/abutment supported denture for an edentulous arch?

A: Report D6090 for the repair or replacement of any part of any implant or abutment supported prosthesis. The fee will vary according to the difficulty or scope of the repair.

Q: How do I report an abutment and housing associated with an implant overdenture?

A: The implant locator abutment is appropriately reported as a separate component using code D6191. The placement of each semi-precision attachment or keeper assembly (female component) placed into the removable prosthesis (overdenture) is reported using code D6192.

Code D6192 reports the keeper assembly/housing placement by either the dentist or an outside laboratory and includes the initial O-ring or gasket. The removable implant overdenture prosthesis itself is reported with one of the following codes: D6110 – D6113.

Q: How do I report the attachment associated with a mini implant and removable prosthesis?

A: Code D6192 is appropriate to report the female keeper assembly attachment that is luted into the removable implant/abutment supported prosthesis.

There is no separate implant locator abutment with a mini implant. The removable prosthesis itself is reported with one of the following codes: D6110 – D6113.

Q: How do I report the replaceable part of an attachment associated with an existing implant overdenture?

A: Report code D6091 (replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment). Code D6091 is reported per attachment replaced.

Miscellaneous Services

Q: How is the use of Exparel® reported?

A: When injecting Exparel® or other non-opioid analgesia to control pain for an extended period (for example, after an extraction), report D9613 infiltration of sustained release therapeutic drug, per quadrant.

Q: What code reports the sale of an electric toothbrush?

A: There is no current CDT code to describe the sale of any consumer product. Unspecified preventive procedure, by report (D1999) could describe the sale of products such as an electric toothbrush. Check with your tax professional for additional guidance regarding sales and sales tax reporting. In some cases, PPO contracts require all charges to be reported to the PPO.

Q: What code is used to report tooth whitening refills?

A: D9999 should be used to report tooth whitening refills. (Note: D9975 states "includes materials" and does not specify when the refills are dispensed.)

Q: What code is used to report the smoothing of a chipped tooth at an emergency visit?

A: Consider reporting D9110, palliative treatment if in the dentist's opinion that this code applies. Include a narrative describing the procedure and outlining the patient's pain/discomfort resulting from the chipped tooth. See D9110. Another option would be to report an odontoplasty (D9971), which typically has low odds of reimbursement.

Q: What code reports an additional fee for an after hours office visit? *(Advisor Corner Response!)*

A: Report D9440, office visit – after regularly scheduled office hours, in addition to any additional services rendered. The dentist must come back to the office after closure and reopen the office. This should not be reported when the dentist has simply agreed to stay late.

Q: Can a consultation (D9310) and any type of oral evaluation be reported on the same date of service?

A: No, D9310 includes an oral evaluation, as part of the global service. Note that D9310 also requires referral from another health care provider. Self referrals are best reported using D0140 limited oral evaluation-problem focused.

Q: How do we document and report interpretation services, as required by Section 1557 of the Affordable Care Act (ACA)?

A: CDT code D9990 documents and reports interpretation services performed by a certified translator.

Section 1557 of the ACA prevents dental practices from charging a patient for interpretation services; however, document what you do. Proper reporting is sometimes required under federally funded programs as a way to quantify case management efforts, such as interpretation services.

Q: How is a blood glucose level test documented and reported?

A: Report D0412 blood glucose level test – in-office using a glucose meter. This reports either a fasting or random glucose level. An Hba1c, which tests the average glucose level over 2-3 months, is reported using D0411.

Occlusal Guards

Q: How is an NTI anterior appliance reported if used as an occlusal deprogrammer?

A: The appliance is reported as D9946, occlusal guard-hard appliance, partial arch.

Q: How is a perio hard occlusal guard reported?

A: Report a bruxism-related perio guard as D9944, occlusal guard – hard appliance, full arch. Typically, a perio guard is excluded from reimbursement consideration. If considered, it typically must be placed within 6 months of osseous surgery or SRP.

Oral Surgery

Q: What code reports the removal of an epulis caused by an ill-fitting denture?

A: D7970 should be used to report this procedure and is reported on a per arch basis. The per arch fee should be adjusted to the situation (i.e., single epulis removed or multiple epulis removed).

Q: What code reports an operculectomy?

A: D7971 reports an operculectomy, the excision of pericoronal inflammatory or hypertrophied tissues surrounding a single, partially erupted/impacted tooth, also referred to as pericoronitis. Include a brief narrative identifying the specific tooth number and outlining why the procedure was necessary.

Orthodontics

Q: How is the removal of orthodontic appliances (i.e., brackets, wires, etc.) reported when removal is necessary for completion of other dental treatment, or at the request of the patient for special events such as a wedding, or to discontinue treatment due to financial obligations?

A: Report D8695 removal of fixed orthodontic appliance for reasons other than completion of treatment. Include a narrative that establishes the reason for the premature removal of the appliances. Note this is typically considered a patient responsibility.

Q: After orthodontic records and an evaluation have been performed, how can a consultation regarding the treatment plan of an orthodontic case be reported?

A: Report D9450 case presentation, detailed and extensive treatment planning. This procedure is typically no charge.

Q: How do we report a Myobrace® appliance?

A: The appropriate code is based on the documented diagnosis (or treated condition). If the appliance is used to treat a habit, such as tongue thrusting, report D8210. If the appliance is used to reposition the tongue to treat sleep apnea, see D9947.

Note: Most medical plans, including Medicare, exclude coverage for the use of a tongue repositioning appliance to treat sleep apnea or snoring.

Q: How do we report the replacement of an existing orthodontic retainer, fixed or removable?

A: If the retainer is lost or broken, report D8703 or D8704, replacement of a lost or broken retainer, maxillary or mandibular, respectively. In the clinical notes, document that the retainer placed after orthodontic treatment was lost or broken and requires replacement.

Q: How do we report the placement of a fixed retainer at the request of a patient who is currently wearing a removable retainer?

A: There is no code to describe a retainer being replaced under these circumstances. Report D8999, unspecified orthodontic treatment, by report

Q: How do we report the reattachment of a fixed orthodontic retainer?

A: Report D8698 or D8699, maxillary or mandibular, respectively, when re-cementing or re-bonding a fixed orthodontic retainer.

Q: What code reports the repair of an existing broken fixed orthodontic retainer?

A: Report D8701 or D8702 maxillary or mandibular, respectively, for the repair of a fixed orthodontic retainer (includes reattachment).

Periodontal

Q: Can D6080, implant maintenance be reported per prosthesis? For example, the patient has both an upper fixed hybrid and a lower fixed hybrid.

A: Yes, D6080 is reported per fixed hybrid prosthesis removed, examined, cleaned, and reinserted. If the full

arch fixed hybrid is NOT removed, but instead cleaned in place, report D6180. If any natural teeth remain on the opposing arch, then a prophylaxis (D1110) may be reported along with D6080. Radiographs and the doctor's periodic oral evaluation may be reported separately.

Q: What code is used to report gel refills for perio protect trays?

A: D9630 reports a medicament dispensed in the office for home use. Include a narrative describing the medicament, the quantity dispensed, and the need for the medicament. Do not expect reimbursement from most payors.

Q: How do we report the placement of Arestin® when the patient's prescription benefits were used to purchase the Arestin®?

A: D4381 reports the placement of Arestin®. If the doctor purchases and places the Arestin®, then D4381 reports both the medicament and placement. The practice may consider 2 fees for D4381; a lower fee for placement only and a higher fee for purchase and the placement of Arestin®.

Q: Can D4346, scaling in the presence of moderate or severe gingival inflammation, be reported with 1 quadrant of D4342 when performed on the same service date?

A: No. The descriptor for D4346 procedure states "… Should not be reported in conjunction with prophylaxis, scaling and root planing or debridement procedures." Also, D4346 indicates no bone loss. Scaling and root planing (SRP) requires bone loss to gain access to the root, and would not be appropriate.

Q: It is rare that payors reimburse D4346, scaling in the presence of moderate or severe gingival inflammation as a periodontal benefit, applicable to the plan deductible and periodontal reimbursement percentage. Can we report a prophylaxis instead of D4346?

A: No. You are required to report what you do, based on the documentation of the procedure performed using the most specific current CDT code available, regardless of benefit or lack thereof. Instead, report D4346 and ask for the alternative benefit of D1110 if benefits are not available for D4346. Reporting D1110 directly to receive or increase reimbursement is undercoding and may be considered a fraudulent billing practice. Refer to Section 5 of the ADA Principles of Ethics and Code of Professional Conduct below:

"SECTION 5 — Principle: Veracity ("truthfulness")

5.B.5.Dental Procedures. A dentist who incorrectly describes on a third party claim form a dental procedure in order to receive a greater payment or reimbursement or incorrectly makes a non-covered procedure appear to be a covered procedure on such a claim form is engaged in making an unethical, false or misleading representation to such third party."

Q: What is the difference between an autogenous graft (D4273) and a non-autogenous graft (D4275)?

A: The distinction between the 2 types of grafts is that an autogenous connective tissue graft (D4273) uses a patient's own tissue for the graft. The donor and recipient surgical sites are included in the D4273 procedure.

Contrarily, a non-autogenous connective graft (D4275) does not use the patient's own tissue, but instead utilizes either human or collagen-based materials, such as Alloderm®. Thus, no donor site is involved. The material is included when reporting D4275.

Q: If a full mouth debridement is not to be completed on the same day as D0180, since the dentist needs to determine that D4355 is required, what can be charged out for this determination?

A: Consider D0191 assessment of a patient, but reimbursement is limited. Alternatively, D0140 may instead be reported subject to the plan's frequency limitations.

Preventive

Q: How is a cleaning reported for a patient who presents with generalized severe gingival inflammation and calculus, but has no bone loss; therefore, scaling and root planing (SRP) cannot be performed?

A: Report D4346 for the patient with a documented diagnosis of generalized moderate or severe gingival inflammation with no bone loss. The patient's inflammatory condition may be chronic or severe and may be followed up with a prophylaxis (D1110)

at a subsequent visit as determined by the dentist (2-6 weeks).

Radiographs

Q: How should we report extraoral bitewing images? Can these images be reported using *D0251*, extra-oral posterior dental radiographic image?

A: An extraoral bitewing image may be reported as an extra-oral posterior dental radiographic image (*D0251*), provided the image is not derived from another image. Some radiographic imaging machines have a setting (mode) for the machine to be in a stationary position when capturing an image(s). Payor reimbursement for *D0251* is variable. If *D0251* is not benefited, request the alternate benefit of a bitewing. *D0251* produces an image of the posterior teeth area of both dental arches. Report *D0251* twice for extraoral bitewing images on each side.

Alternatively, the current bitewing codes may be reported since the nomenclatures are silent regarding whether the image is captured intraorally or extraorally and they may be taken vertically or horizontally.

Often, an extra oral bitewing captures the same diagnostic data as two intraoral bitewings. However, only one exposure was taken. This should therefore be reported as a single bitewing, or if a bitewing is taken on either side it should be reported as a two bitewing set. Note that *D0277* is specific to 7-8 vertical bitewings.

Q: Can a payor request a refund for radiographic images considered to be of nondiagnostic quality?

A: Yes. Nondiagnostic radiographic images are considered worthless and should not be submitted to the payor for reimbursement. If submitted and later determined by the payor to be of nondiagnostic quality, the payor will request a refund of any benefit paid.

Restorative

Q: How do I report the bonding of a fractured piece of natural tooth (rather than a repair using composite restoration)?

A: The bonding procedure is reported as *D2921* (reattachment of tooth fragment, incisal edge or cusp). Reimbursement for this procedure is variable.

Q: How do I report the closing of an anterior diastema?

A: Diastema closures may be reported using code *D2335*, resin-based composite, for each mesial and distal of a tooth. The claim should clearly state in the remarks section that the procedure was performed to close a diastema for cosmetic purposes if no decay or fracture was present. Cosmetic procedures are not generally reimbursed, if recognized by the payor.

Q: What code reports an acrylic pontic bonded to adjacent teeth when used as a temporary between extraction of the tooth and fabrication of a Maryland bridge?

A: There are several coding options that may apply:

- Consider an interim pontic (*D6253*) if placed to allow for further treatment or diagnosis prior to final impression. Some dental plans consider a provisional of any kind to be a definitive restoration. Include a narrative describing the interim pontic as the claim may be rejected if no provisional retainer crowns are listed on the claim form.
- If the pontic is placed to maintain space until a definitive procedure is rendered, consider *D1510* fixed space maintainer. The clinical note should state "the pontic was placed to maintain space until a definitive restoration is rendered."

Q: Can I report a buildup or prefabricated post and core placed through an access hole of a crown after endodontic treatment?

A: A buildup (*D2950*) or prefabricated post and core (*D2954*) may be reported only when the crown has first been removed and then the procedure performed. If the crown is off the tooth and a buildup or prefabricated post and core is necessary for retention of the crown, report either the buildup (*D2950*) or prefabricated post and core (*D2954*) and the re-cementation

of the crown (D2920). If the crown remains intact and seated and a post is placed through an access hole, report D2999 for the post placement in addition to the restorative material placed to seal the access hole. If the restorative material is placed to close the access hole and the crown remains intact and seated, report the restoration as a one surface restoration (D2140, D2330, or D2391 dependent on the material used). A narrative might state, "An occlusal composite was placed for endodontic access hole closure."

Snore Guard

Q: How is a Snore Guard® reported ?

A: D5999, unspecified maxillofacial prosthesis, reports a Snore Guard® appliance. This is typically not a covered procedure. If the patient undergoes a sleep study, then a sleep apnea appliance may be considered for reimbursement by medical insurance.

It is advisable to contact your State Dental Board regarding scope of practice when providing an appliance to treat snoring. Most states require that a sleep appliance, regardless of the diagnosis (i.e., snoring, obstructive sleep apnea, etc.) be ordered by an MD. Sleep apnea is a medical condition while snoring is considered a social issue.

Teledentistry

Q: If our hygienist takes x-rays and intraoral photos, then relays the findings from the visual exam to the doctor, and the doctor reviews the intraoral photos and x-rays and calls the patient to discuss the findings, can the practice bill for the D0120?

A: No. D0120 is a periodic oral evaluation by the doctor and State Dental Boards require "hands-in-the-mouth." Check with your State Dental Board for confirmation. Also, the x-rays taken by the hygienist cannot be billed unless read by the doctor. If the hygienist is the only one to see the patient, the procedure is not billable as D0120.

Teledentistry is not intended to be utilized while the patient and doctor are in the same location; rather when the dentist is in a different location interacting with the patient via electronic communication. It is not appropriate to report D0120 for any teledentistry scenario. The ADA website lists possible associated teledentistry evaluation codes and D0120 is not included. The ADA COVID-19 interim coding guidance is available at www.ada.org.

Tissue Conditioning

Q: Is tissue conditioning the same as a reline for a complete denture?

A: No. 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 limited time aids in the healing of unhealthy ridges before taking final impressions for a definitive removable restoration.

TMD/TMJ

Q: How do we report deprogramming therapy when we provide an anterior splint first, and then a full bite splint?

A: Report D9946 occlusal guard – hard appliance, partial arch for the anterior deprogramming appliance. Then if a diagnosis of TMD/TMJ is made at a later date, report D7880 for the subsequent definitive splint. Include a narrative that states the diagnosis and describes the signs, symptoms, prognosis of treatment, estimated treatment duration, and type of appliance and materials used. It is important to note that an anterior deprogrammer appliance (D9946) is used to treat the effects of bruxism, not TMD/TMJ. However, bruxism may be a contributing factor for a patient diagnosed with TMD/TMJ. D9946 will only be reimbursed for bruxism, not TMJ, by dental payors. Also include any radiographic images and TMD workup notes for D7880. The TMD/TMJ splint should be reported to medical insurance first. Dental plans generally do not reimburse D7880.

D0160 (detailed and extensive oral evaluation – problem focused, by report) or D0170 (re-evaluation – limited, problem focused [established patient; not

post-operative visit]) may also be reported as part of the associated evaluation process. D0160 and D0170 are subject to plan limitations for evaluation frequency.

Q: What dental code can be used to report the use of a TENS unit to treat TMD?

A: Report D9130 temporomandibular joint dysfunction – non-invasive physical therapies. This is reported on a per visit basis. It is advisable to contact your State Dental Board to confirm what TMD treatments are considered to be within your scope of practice in your state. This includes, but is not limited to, massage therapy, ultrasound therapy, and use of or prescribing a TENS unit.

Q: Are 2 crowns splinted together reported as single crowns or retainer crowns?

A: Two single crowns that are splinted together are reported separately as single crowns, not retainer crowns. A retainer crown is adjacent to a pontic, retaining the pontic, and is part of a fixed partial denture (bridge). Additionally, D4322 may be reported for the intra-coronal splinting of the crowns.

Veneer

Q: What code reports the repair of a chipped veneer?

A: D2983, veneer repair necessitated by restorative material failure, should be reported.

Notes