Medical Coding for Dental Practices

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Dr. Z's TOP TEN LIST of Medically Billable Procedures©

1. ANY trauma and its treatment. This includes ALL oral and dental procedures;
2. Exams/consults for Soft and hard tissue PATHOLOGY;
3. Emergency treatment of oral inflammation or infection;
4. Diagnostic, radiographic, or surgical stents
5. MEDICAL Radiographs
6. Biopsies and excisions;
7. Extraction of teeth: wisdom teeth, supernumeraries, ankylosed teeth, exposure of impacted teeth.
8. Any SURGICAL procedure needed to:
   - rebuild or reconstruct alveolar or jaw bone due to bone loss/destruction or
   - treat an infection;
9. Prosthetics
10. Appliances- any removable/fixed appliances used to treat ANY dysfunction or anatomic anomaly

So……. how can you access these medical plan benefits?

You MUST speak the medical billing and coding "language"

ICD-10 (diagnosis) codes
- Diagnosis codes are established by the World Health Organization (WHO) and describe the medical condition/problem- updated and revised YEARLY

CPT (procedure) codes
- Procedure codes set by the American Medical Association (AMA) that describe all diagnostic, therapeutic/medical, and surgical treatments- updated and revised YEARLY

CMS-1500 (02/12) claim form
- Only Medical Codes can be used on this form!!!
- Dental codes CAN BE ONLY be used for impacted/ankylosed/unerupted tooth removal for certain insurers (D7210-D7250)
- In cases of traumatic injury or removal of teeth on instructions of MD, D7140 can also be billed
- No need to order claim forms. We use SpeedyClaims for the Z book and recommend it as the easiest and most user-friendly that we've tested

Medical Reimbursement Options

1. COMMERCIAL plans, including:
HMO
PPO
POS

2. GOVERNMENT Programs:
Medicare
Tricare/ChampVA
Affordable Care Act

You do NOT have to be a Participating Provider to bill medical plans
Payment will be sent to you from medical insurers, *in most cases*

1. COMMERCIAL PLANS

a. CAPITATED PLANS/HMO

- Primary Care Provider (PCP) must be selected
- *If treatment by a specialist is required, it will only be covered if the patient first gets a referral from the PCP*
- Some HMO's have out of network (OON) benefits, so patients can go to ANY provider, but ALWAYS must first get a referral from the PCP;
- *No matter what type of an HMO the patient has, the card will always state PCP on the front and the name of the Medical Group or individual provider that the Subscriber has selected*

b. PREFERRED PROVIDER ORGANIZATIONS/PPO

- Participating (par-) physicians provide care for a contracted fee, *typically 50-70% of the U&C professional fee OR LESS, then MUST legally write off the difference (per Provider contract)*
- No referral is needed,

2. GOVERNMENT PROGRAMS

a. MEDICARE

- Federal government program
- Covers those >65 yrs of age, the disabled, and the mentally and physically handicapped
- VERY Limited benefits for oral services
- Poor reimbursement

Procedures covered include:

- Exams (not consults)
- Specific screening and diagnostic X-rays
- Removal of pathology
- Reconstruction of severe atrophy or post-CA tx (implants, BG's, CT grafts)
- OSA appliances

b. TRICARE

- ACTIVE DUTY military and their families
- Require pre-certification for ALL procedures (easy to do online)
- EASY TO GET PAID
- You must be enrolled as a MEDICAL Provider in order to pre-cert online and get online authorizations (response within 24-72 hours)

c. CHAMPVA

- For RETIRED military and their families
- Same benefits as for active duty military

d. THE AFFORDABLE CARE ACT

- Insurance must be purchased through www.healthcare.gov *or individual state insurance exchanges* in order for the enrollee to qualify for taxpayer funded subsidies, if they cannot afford the full premium
- If insurance is purchased through an individual insurer i.e. BCBS, the person is NOT eligible for a subsidy

80% of those enrolled in these plans receive taxpayer-funded subsidies (*meaning you and I pay for this*)
Deductibles are not taxpayer subsidized
Patients MUST pay the FULL deductible UP FRONT before benefits kick in

Several plans are available:
"Metallic" plans: Platinum, Gold, Silver, Bronze
Catastrophic

TRICARE is the ONLY program I recommend you participate in- need to get a "medical waiver"

Medicare- it is recommended that you become an "Ordering or Referring Provider" AND a DMEPOS Provider (requires two separate applications and you will receive two different UPIN's).

How can patients pay their out-of-pocket costs? There are several options…

FLEX SPENDING ACCOUNT (pre-tax dollars)

- Set up by Employer to cover costs not covered by medical/dental plans
- Employee contributes an amount *up to a pre-set maximum*, set by the IRS
- **MONEY DOES NOT ACCRUE INTEREST**
- **This is a "USE IT OR LOSE IT" account**

HEALTH SAVINGS ACCOUNT/HSA (pre-tax dollars)

- Can be set up by ANYONE at a bank of their choosing for ANY medical/dental expenses
- Contribution maximum *determined by IRS guidelines*, based on % of income
- **MONIES IN THE ACCOUNT ACCRUE INTEREST**
- **funds *ROLL OVER FROM YEAR TO YEAR* if not used**

THE MEDICAL POLICY

NO MATTER WHAT TYPE OF POLICY A PATIENT HAS…. there are similarities to all of them!

BASIC

- Diagnostic and therapeutic/medical procedures (non-surgical)
- Emergency and palliative services performed in-office
- *Deductible very low or non-existent*
- Reimbursement typically close to 100%

i. Diagnostic services

Exams, consultations, x-rays (*excluding PAs and FMXs*), diagnostic stents, biopsies, excisions

ii. Therapeutic services

Surgical stents, diagnostic or therapeutic injections, appliances, in-office emergency tx

MAJOR

Surgery and ALL associated procedures:

- Oral and IV sedation, general anesthesia, and N_2O analgesia
- Intra-operative drug injections (SC, IM and IV i.e. antibiotics, steroids, etc.)
- Surgical supplies that are not included in the procedure codes
- *Deductible MUST be satisfied* (this usually occurs by submitting the diagnostic and pre-surgical services)
- Typical reimbursement is 70-100% of Provider's fee

Billable procedures:
a. Extractions and tooth exposures:
b. Implant placement and associated surgical procedures i.e. tissue and bone grafts, "sinus lifts"
c. Periodontal surgical procedures

COMPREHENSIVE

- Treatment for traumatic injuries and major illnesses
- *NO deductible requirement for many plans*
- Reimbursement is at, or close to, 100%
- Covers virtually **ALL ORAL and DENTAL procedures**

MEDICAL BILLING- GETTING STARTED USING THE Z METHOD©

You CANNOT verify benefits and billable procedures without the Doctor first performing the examination, followed by radiographs.

Benefits verification *requires diagnosis and procedure codes*, which are determined AFTER THE COMPREHENSIVE EXAM and RADIOGRAPHS ARE COMPLETED.

STEP 1: Take a complete MEDICAL HISTORY

STEP 2: COMPREHENSIVE HEAD AND NECK EXAM

STEP 3: CLINICAL PROGRESS NOTES

- Medical history must be VERY detailed
- Clinical examination must be approached from a MEDICAL standpoint
- THEN add the charting, etc. for dental chart completion
- Exam/Consultation notes MUST follow the SOAP format

S **Subjective:** patient's perceived problems *in their own words*
O **Objective:** medically diagnosed problems clinical and radiographic evaluation, other tests
A **Assessment:** detailed summary of patient's condition
P **Plan:** step-by-step treatment plan

STEP 4: VERIFYING PATIENTS' BENEFITS

- *Before even considering filing a patient's medical claim, a benefits and eligibility verification MUST be done*
- determines whether procedures to be done are medically billable under the patient's plan
- Benefits can be verified online or by phone
- ONLINE VERIFICATION IS RECOMMENDED (we use Change Healthcare)
- Do NOT verify benefits for exams- they are always covered for legitimate medical diagnoses

Prepare Yourself:

- Confirm that you are NOT Par-Providers (they assume you are)
- Ask whether the procedures to be performed are "billable procedures"
- Inquire about special qualifications
- Ask about procedure restrictions: *"Are there any procedure limitations?"*

VERY IMPORTANT: Obtain reference number
The reference number is not an authorization for the procedure(s) and does not guarantee coverage!!!!!!!!!!!

STEP 5: PREPARING THE LETTER OF MEDICAL NECESSITY (LMN)

WHAT is it? IT is NOT the same as a Narrative!

- It is submitted by the treating healthcare provider, *to show justification for the procedures being billed*

WHO prepares it?

- Doctor or a knowledgeable member of the Clinical Team
- Use "medical billing language" that an RN or MD will understand.

What if the patient has contributing medical problems?
Clinical progress notes, *obtained from the treating MD, are recommended to* confirm these medical issues

Does the patient have to have medical problems outside the jaws/mouth?
NO!!!!!!!!!!!!!! An infection, bone atrophy, mucosal inflammation or neoplasm can occur anywhere in the body- THE SEVERITY of the PROBLEM is what makes it "medically necessary" to treat

LMN GUIDELINES

i. Brief history of the area being treated, previous tx in same, summary of points that support the medical necessity of the planned procedure(s).

Include contributing general medical factors/conditions, if present;

- Use ANATOMIC landmarks when describing locations, NOT dental ones
- Use language or terminology that an RN or MD would understand

ii. Diagnoses- descriptions
iii. Treatment- CPT (procedure) codes and their description
iv. Phone number and/or e-mail address where the Doctor can be reached for questions by the Reviewer

When is an LMN submitted? An LMN is submitted by the Treating Dentist…

1. If a **pre-auth is required by Contract** OR confirmation of coverage is desired by the Doctor and/or Patient

FAX the LMN and supporting documents *directly* to MEDICAL REVIEW

2. When treatment has been completed-**submit LMN WITH EACH CLAIM** as an attachment to the claim, *even if the procedures were previously pre-authorized and approved by Medical Review*

STEP 6: PRE-CERTIFYING PROCEDURES- MANDATORY- not an option!

REQUIRED BY CONTRACT for the following procedures:

- maxillo-facial CT scans
- ALL ELECTIVE surgical procedures
- Pharmacy Services (therapeutic injections i.e. Botox for TMD issues)

Choices for Pre-certification:
1. by phone (for CT scans only)- refer to back of Patient's medical card for pre-cert phone number)
2. Faxed directly to Medical Review: For ALL ELECTIVE (non-emergency) surgical procedures:

What is meant by "elective" surgery? Surgery that is planned and scheduled IN ADVANCE

PRE-AUTHORIZATION IS NOT REQUIRED FOR EMERGENCY PROCEDURES/SURGERY. ***HOWEVER, some insurers require that they be notified within 48 hours if an emergency procedure was performed.***

Pre-authorizations submitted in writing and sent via SNAIL MAIL are rejected 99.9% of the time. *WHY? If you can wait 6-8 weeks for a written response, it is determined to be OPTIONAL and considered "not medically necessary".*

LMN is submitted TO MEDICAL REVIEW online with:
1. Comprehensive Head & Neck evaluation
2. Clinical Notes from MD *(ONLY IF pt has contributing medical issues)*

IMPORTANT: Authorizations are for specific diagnoses and associated procedures ONLY

- If the diagnoses or procedures CHANGE, then the authorization that you obtained is INVALID *and a new one must be obtained*
- Authorizations are only valid for 30 DAYS, *unless the authorization states otherwise*

BE SURE TO LET PATIENTS KNOW ABOUT THIS EXPIRATION RULE, so that they do not end up paying for treatment out of pocket!

You need to be familiar with MEDICAL Diagnosis and Procedure Codes, IN ORDER TO VERIFY BENEFITS AND/OR PREPARE AN LMN, so let's do that now…

DIAGNOSIS (ICD-10) CODING GUIDELINES

- Filing claims without diagnosis codes (problem(s) and condition(s) that are being treated) will *result in a DENIAL and NO PAYMENT*

ICD-10 codes describe both definitive problems, as well as ill-defined conditions, signs and symptoms

- Format starts with a combo of ONE letter, followed by TWO numbers, then a period: L##.
- This is followed by up to FOUR characters, combination of letters and numbers:

K##.#
M##.##
S##.###S
S##.##xA
S##.#xxD

Information Codes: Provide additional information about the patient's Hx or Condition, in these situations:

1. MEDICAL CONDITION/HISTORY
2. TRAUMATIC INJURIES
3. Rx MEDICATIONS, RECREATIONAL DRUGS, or PREVIOUS/CURRENT MEDICAL Tx

ICD-10 CODES: HOW DO WE SELECT THEM?

- **ONLY THE DOCTOR CAN MAKE A DIAGNOSIS**
- **CLINICAL TEAM *can then provide the diagnosis codes to the Billers***

A. ORAL SURGERY

K00.1	Supernumerary teeth
K00.6	Disturbance in eruption
K01.0	Embedded teeth
K01.1	Impacted teeth
K03.5	Ankylosis of teeth
R68.84	Jaw pain
R59.0	Localized Lymphadenopathy
R59.1	Generalized Lymphadenopathy

LOSS OF TEETH DUE TO TRAUMA

- ALL INJURY claims start with the code S09.93xA Injury to face/mouth
- "A" indicates *initial encounter/first appt*

FRACTURED TOOTH, FIRST VISIT <u>ONLY</u>:

S02.5xxA	Fx tooth, traumatic, *initial encounter,* closed fracture
S02.5xxB	Fx tooth, traumatic, *initial encounter*, open fracture

For SUBSEQUENT Visits and Sequela:

D= Subsequent encounter for fracture w/*routine healing*
G= Subsequent encounter for fracture w/*delayed healing*
S= Sequela (late effects)

ORAL SURGERY- CLINICAL EXAMPLE

Visit #1: Patient presents with tooth that fractured while eating. The piece that fractured off was swallowed.

Dx code for first visit is **S02.5xxB Fx tooth, *initial encounter*, open fracture**

- Tooth is extracted at this time.

Visit #2: Patient returns for follow up with no complaints. An X-ray is taken, just to check healing progress.

Dx code for this visit is **S02.5xxD Fx tooth, *subsequent encounter,* routine healing**

- ***The X-ray can be billed but NOT the exam.***

B. BRUXISM AND TMD ISSUES

Bruxism, very straightforward:

G47.63	Bruxism, nocturnal grinding
R68.84	Jaw pain

TMD- More complex issues:

H92.09	Otalgia, referred pain (Earache, referred from another area)
M26.51	Abnormal jaw closure
M26.52	Limited range of motion (ROM)
M54.2	Cervicalgia (neck pain)
M62.48	Spasm of muscle
M79.1	Myalgia, myositis (muscle inflammation, pain)
R51	Cephalgia (headache, facial pain)

C. SLEEP APNEA

CODES ARE TAKEN FROM THE SLEEP STUDY RESULTS

F51.9	Non-organic sleep disorder
F51.01	Primary insomnia
G47.33	Obstructive Sleep Apnea
G47.61	Sleep-related limb movement
J39.2	Pharyngeal myoclonus
G47.30	Insomnia w/sleep apnea
G47.00	Insomnia non-specific
G47.30	Hypersomnia w/sleep apnea
G47.10	Hypersomnia non-specific
G47.20	Disruption of sleep cycle
G47.8	Dysfunction associated w/sleep stages or arousal from sleep
G47.30	Upper airway resistance
R06.00	Dyspnea, unspecified
R06.3	Periodic breathing
R06.83	Snoring

FOR ADDITIONAL CODES, RECOMMENDED SUBSCRIPTION SITES:

www.flashcode.com
www.findacode.com
www.supercoder.com

PROCEDURE (CPT) CODING GUIDELINES

- ONLY CPT codes can be used- NO "D" codes EXCEPT for extractions, *with limitations on use (BCBS only)*
- Deleted codes are no pay codes and are NOT converted to the new codes
- Coding is very specific and *depends on the part of the mouth being treated*
- Format is __ __ __ __ __

EXAMINATIONS AND CONSULTATIONS/DEFINING THE TYPE OF PATIENT BEING EVALUATED

i. **NEW**- referred by your ad/another pt OR who has been away from the practice > 3 yrs.
ii. **ESTABLISHED**- one with an ongoing relationship with the practice
iii. **REFERRED (for Consultations, when you may/may not initiate treatment)**- when referred by an MD, DDS, or any other medical entity i.e. physical therapist, hospital, etc.

ALL exams and consults start with the numbers "992_ _"

FOURTH digit reflects the origin of the patient:

0= New	New Patient	99201-99205
1= Established	Established Patient	99211-99215
4= Referred	Referred Patient	99241-99245

FIFTH digit reflects the LEVEL of Difficulty, NUMBER of Areas involved, and the TIME it takes to make a diagnosis (-es)

1= brief, simple, "no-brainer"
2= expanded
3= detailed
4= comprehensive
5= extensive, difficult Dx

BRIEF EXAM/CONSULT- last digit is a "1"

- problem focused history
- problem focused examination
- straightforward (easy) medical decision making (minor or self-limiting problem)
- typically the Doctor spends 10 minutes face to face with patient

New patient	**99201**
Established patient	**99211**
Referred patient	**99241**

EXPANDED EXAM/CONSULT- last digit is a "2"

- Expanded problem focused history
- Expanded problem focused examination
- straightforward (easy) medical decision making (low-moderate severity)
- typically the Doctor spends 20 minutes face to face with patient

New patient	**99202**
Established patient	**99212**
Referred patient	**99242**

DETAILED EXAM/CONSULT- last digit is a "3"

- Detailed history
- Detailed examination
- Medical decision making of low complexity (moderate severity)
- typically the Doctor spends 30 minutes face to face with patient

New patient	**99203**
Established patient	**99213**
Referred patient	**99243**

COMPREHENSIVE EXAM/CONSULT- last digit is a "4"

- Comprehensive history
- Comprehensive examination
- Medical decision making of moderate complexity (moderate-high severity)
- typically the Doctor spends 45 minutes face to face with patient

New patient	**99204**
Established patient	**99214**
Referred patient	**99244**

EXTENSIVE EXAM/CONSULT- last digit is a "5"

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity (moderate-high severity)
- typically the Doctor spends 60 minutes face to face with patient

New patient	**99205**
Established patient	**99215**
Referred patient	**99245**

RADIOGRAPHS

The following X-rays are ROUTINELY covered:

70350	Cephalogram
70355	Orthopantogram

The following X-rays are ROUTINELY covered *(require phone pre-authorization):*

70486	Maxillo-facial CT scan w/o contrast
76380	CT scan, limited or localized

These X-rays are covered ONLY in cases of traumatic injury:

70300	Radiologic exam, teeth, single view
70310	partial exam, <FMX
70320	complete exam, FMX

ORAL SURGERY

A. Drainage of Abscess/Cyst

10060	I&D abscess, simple
10061	complex (Penrose drain)
40800	Abscess/cyst, vestibule of mouth, *simple*
40801	*complicated*

B. Extractions

41821	Operculectomy
41830	Alveolectomy, includes curettage of osteitis, removal of sequestrum
41899	Extraction- only for non-BCBS plans. Use D code for BCBS

TMD SERVICES

CPT 21085 is the same, no matter the type of appliance. Payment will vary (from $500-$1200+, depending on the documentation submitted)

If an OUTSIDE (not in-house) lab is used, the charge to your office by the lab can be billed on the medical claim form (Box 20).

OUTSIDE lab charges should be billed with ALL appliances, IF THE LAB SENDS YOUR OFFICE THE BILL

97762	Office visit, including orthotic check-out (use for billing each visit after initial 30 days of delivery)

SLEEP DISORDERS

21083	Palatal lift Prosthesis
E0486	Sleep apnea appliance (OSA appliance- custom fabricated) ***(requires Modifiers KH and NU)***

TREATING SIMPLE TRAUMATIC INJURIES

A. DENTAL PROCEDURES

41899 is the generic code for dental (restorative, debridement (SRP), endodontic) procedures

Billers need to be told:

1. Description of the procedure
2. Tooth number(s)

Dental treatment is ONLY covered when associated with a TRAUMATIC INJURY or a MEDICAL CONDITION i.e. Bulimia, Post-CA tx, etc.

- Procedure codes that end is 89 or 99 are GENERIC codes and require an explanation
- The explanation is given using a QUALIFIER to describe the procedure. The QUALIFIER is ZZ and is followed by the description of the procedure
- **In addition, you must indicate the LOCATION of the procedure with a SECOND QUALIFIER**
- **For the generic code, 41899, identifying a DENTAL procedure, you would use QUALIFIER JP. This would be followed by the TOOTH NUMBER, *like this*: ZZEndodontic treatment JP8**

B. CODING PROSTHETICS

21089 is the generic code for all prosthetic (CROWNS, BRIDGES, REMOVABLE AND FIXED DENTURES) procedures

Billers need to be told:

1. Whether it is an interim or final prosthesis
2. Which jaw it is being placed in

PROSTHETICS ARE CONSIDERED JAW PROCEDURES, *even if the prosthesis is an individual crown or a bridge*

- Because the prosthetic code 21089 ends in 89, TWO QUALIFIERS MUST BE USED

Qualifier ZZ describes the procedure
Qualifier JO indicates the JAW

CODING THE PROVISIONAL CROWN:

A provisional crown on the **right central incisor** would be coded like this, with **TWO qualifiers above CPT code**:

ZZInterim prosthesis JO01
21089

NOTE THAT PROSTHESIS CODE 21089 DOES NOT ALLOW A TOOTH NUMBER TO BE INDICATED!!! It is a JAW code so the JAW must be identified: 01= Maxilla 02= Mandible

C. FIXATION/WIRING/SPLINTING OF TEETH

21440	Closed tx/max/mand alveolar fx
21110	Application of dental wiring/bonded splint (each arch, includes removal of same)

D. REMOVAL OF FOREIGN BODY

40804	Vestibule/cheek, simple
40805	complicated
41805	Dentoalveolar, soft tissue
41806	bone

ORAL SEDATION & ANALGESIA

A. Oral sedation/pre-medication

J8499 is used for therapeutic/sedative oral drugs

- Qualifier N4 is stated in the shaded area, together with the National Drug Code (NDC) for the drug and dosage used (find the NDC code on the web)

B. Nitrous Oxide Analgesia

- Provide Billers with info if N_2O analgesia was used
- Include the analgesia in the total fee for the procedure

CLINICAL EXAMPLE:

Sx removal of tooth #32	FEE $350
N_2O, 15 mins	FEE $25

CPT	**Charge**
JP32	
D7220	$375.00

C. Diagnostic Injections

96372	Therapeutic/diagnostic inj, SC/IM (per injection)
96374	Therapeutic/diagnostic inj, IV (per injection)

For ANY drugs, whether ORAL or INJECTED SC/IM/IV, the qualifier N4 and designated drug code for a particular drug MUST be stated in the shaded area above the CPT code used

For ANY drugs administered, Billers must be informed of:

1. National Drug Code (NDC)
2. amount of drug used i.e. 5mg x 2, 10 ml x 2, etc.

BILLERS CANNOT SELECT THE NDC!!!!
It is dependent on the mode of entry, the manufacturer, the dosage per unit administered

DOCTORS NEED TO HELP WITH THIS. ***If meds are purchased in bulk from a Pharmacy, then the NDC code often appears on the prescription bottle.***

DOCUMENTATION REQUIREMENTS

I. PRE-CERTIFICATION
DO NOT PRE-CERTIFY EXAMS AND ORTHOPANTOGRAMS FOR BILLABLE PROCEDURES. For all others:
FAX documentation to Medical (surgery) or Pharmacy (Botox etc.) Review with:

- LMN
- Head & Neck evaluation

II. CLAIMS FOR COMPLETED TREATMENT
EXAMS/CONSULTS/XRAYS, DIAGNOSTIC PROCEDURES
SUBMIT WITH CLAIM:

- LMN from Treating DDS/DMD
- Head & Neck evaluation

SURGICAL PROCEDURES
SUBMIT WITH CLAIM:

- LMN from Treating DDS/DMD
- Head & Neck evaluation
- Operative report, Anesthesia Record

TMD APPLIANCES
SUBMIT WITH CLAIM:

- LMN from Treating DDS/DMD
- Head & Neck evaluation
- TMD report

SLEEP APNEA APPLIANCES
SUBMIT WITH CLAIM:
- LMN from Treating DDS/DMD
- Head & Neck evaluation
- Sleep Study results

TRAUMATIC INJURIES
SUBMIT WITH CLAIM:
- Police report/ER discharge papers, if available
- LMN documenting all potential future treatment
- Head & Neck evaluation

Limit on coverage is now 3-6 months w/o an LMN indicating that treatment will take longer.

CLAIM CODING: Let's code some simple examples!

EXAMPLE #1: BASIC ORAL EVALUATION

HISTORY: A new patient presents on October 16 2016 for a comprehensive examination. The patient has no complaints and just requests a "complete check up". The Doctor performs a complete head and neck exam, including both extra- and intra-oral soft and hard tissues, the evaluation of the TMD, lymph nodes, etc. An orthopantogram and 4 BW radiographs are taken. There are no positive findings and the patient is scheduled for a dental prophylaxis

DOCTOR CHOOSES THE APPROPRIATE DIAGNOSIS CODES AND PUTS THEM IN THE CORRECT ORDER
A. Z12.81 Special screening for oral malignancy, mouth
B. Z12.89 Special screening for maxillo-facial cancer (CA)

Note that, because there were no positive findings, the examination was strictly a "check up" or screening visit.

THEREFORE, ONLY NARRATIVE CODES ARE USED TO DESCRIBE THE REASON FOR THE PATIENT ENCOUNTER

Without a reason for the visit, an exam, radiographs, and any testing procedures <u>will not be paid</u>. The reason is for screening purposes ONLY

DOCTOR SELECTS THE PROCEDURE CODES AND LISTS THEM IN THE CORRECT ORDER
99202 NP Exam, expanded
70355 Orthopantogram

The orthopantogram was only used to screen for maxillofacial CA and NOT oral (soft tissue) CA

- **BW cannot be billed to the medical insurance, as they are dental x-rays and *not diagnostic for a medical problem***
- **Bill to the dental plan, or incorporate the fee into the orthopantogram fee**
- **DENTAL X-RAYS CAN ONLY BE BILLED IN CASES OF TRAUMATIC INJURY**

DOCUMENTATION- NONE REQUIRED
Exams, consults, and orthopantograms DO NOT require a pre-certification/pre-authorization.

EXAMPLE #2: TRAUMATIC INJURY- FRACTURED TEETH

HISTORY: Patient sustained fractured teeth in the maxilla (both central incisors) and mandible (all four incisors) when she tripped and fell while running on a bike path. An exam, CT scan, and six periapicals were taken. All teeth are non-restorable and require extraction, with fabrication of an interim prosthesis. Patient has BCBS.

BECAUSE OF THE NUMBER OF PROCEDURES PERFORMED, THE TREATMENT WILL BE SUBMITTED ON TWO CLAIM FORMS, even though they were all done on the same DOS:

CLAIM #1: Diagnostic and Therapeutic Procedures
CLAIM #2: Surgery

CLAIM #1: DIAGNOSTIC AND THERAPEUTIC PROCEDURES

DOCTOR CHOOSES THE APPROPRIATE DIAGNOSIS CODE(S) AND PUTS THEM IN THE CORRECT ORDER

A. S09.93xA Injury to Mouth, *initial encounter*
B. S02.5xxB Fractured tooth, open fx, *initial encounter*
C. R68.84 Jaw pain
D. W01.0xxA Fall on same level, from tripping, *initial encounter*

DOCTOR SELECTS THE PROCEDURE CODES

99203 NP, detailed exam
70486 Diagnostic maxillo-facial CT scan
70300 Single X-ray, teeth
21089 Interim prosthesis, MX/MD

DOCUMENTATION:

1. LMN indicating all future possibilities for treatment
2. Head & Neck evaluation

CLAIM #2: SURGERY

DOCTOR CHOOSES THE APPROPRIATE DIAGNOSIS CODE(S) AND PUTS THEM IN THE CORRECT ORDER (same as for Claim #1)

A. S09.93xA Injury to Mouth, *initial encounter*
B. S02.5xxB Fractured tooth, open fx, *initial encounter*
C. R68.84 Jaw pain
D. W01.0xxA Fall on same level, from tripping, *initial encounter*

DOCTOR SELECTS THE PROCEDURE CODES

D7210 Surgical odontectomy, erupted tooth, mandible
D7210 Surgical odontectomy, erupted tooth, maxilla

DOCUMENTATION

1. LMN indicating all future possibilities for treatment
2. Head & Neck evaluation
3. Operative report

HANDLING FEE NEGOTIATIONS: THIRD PARTY ADMINISTRATORS

- Sometimes insurance companies "farm out" claims to be handled by third party administrators
- **The claims have not yet gone through the Medical Review Process**
- How you handle this negotiation process will determine what you get paid and what you have to write off

IMPORTANT

- Whatever fee is finally agreed upon is only the **STARTING POINT. IT IS NOT WHAT YOU WILL BE PAID!**
- From there, the deductible and co-payment (IF ANY) are taken out and the remainder paid to the Provider.

WHY APPEALING CLAIMS IS SO IMPORTANT

The AMA now recommends appealing EVERY underpaid, denied, or reversed claim

AMA audits show that only 50% of claims that are denied or underpaid are appealed by Physician's offices…. meaning patient's unknowingly pay for covered procedures out-of-pocket!!!!!!!

SETTING AND COLLECTING FEES: CO-PAYS AND DEDUCTIBLES

LET'S TALK LEGALITIES

YOUR FEE IS YOUR FEE IS YOUR FEE- ***no matter who/to which insurer you are billing*****- patient with NO insurance, dental insurance, or medical plan, IT DOES NOT MATTER!**

- If you are NOT a Participating MEDICAL Provider, then you MUST collect the difference between what insurance pays and the fee billed (to the insurance company)
- Otherwise you are FRAUDULENTLY inflating your fee for insurance purposes
- **If you are sending claims to an insurer then know that…ANY insurance company can randomly come into your office for an audit of claims sent to ANY MEDICAL INSURERS**

ILLEGAL SITUATION #1:

If you are performing FREE exams/X-rays, as advertised on a flyer- *YOU CANNOT BILL INSURANCE for these procedures or they are not really "free" and you are falsely advertising them as such*

ILLEGAL SITUATION #2:

If you are REDUCING your fees and giving a "patient incentive" i.e. exam BWXR+ prophy at a discounted fee of $100…
THEN YOU CANNOT BILL YOUR "NORMAL" FEE TO THE INSURANCE COMPANY FOR THOSE PROCEDURES
You CAN ONLY BILL THE DISCOUNTED FEE of $100 TOTAL for the three services.

If you bill your "normal" fee, YOU ARE INFLATING THE FEE CHARGED TO THE PATIENT and FRAUDULENTLY BILLING INSURANCE FOR HIGHER REIMBURSEMENT

- That is called INSURANCE FRAUD and is HIGHLY ILLEGAL
- If these claims are also being sent through the mail, it is also considered **MAIL FRAUD and is a FEDERAL OFFENSE**
- If sent electronically, it is also considered **WIRE FRAUD and is a FEDERAL OFFENSE**

Thank you for your interest!

FOR ADDITIONAL INFORMATION, comprehensive Basic and Advanced courses, and educational materials, check out The Z Group LLC web site: thezgroupllc.com

If you have follow up questions, are interested in a customized program for your office/study club, please complete the Contact Form on The Z Group LLC web site.