**FOR INTERNAL USE ONLY**

# ADA CDT CODE CORRECTIONS

**Type:** Revision

**Original Date: 5/2/2014** **Revision Dates: 08/16/2017**

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| Codes: | Periodontics: D4210, D4230, D4240, D4260, D4341<br>Surgical Extraction Codes: D7210, D7220, D7230, D7240, D7241<br>Alveoloplasty Codes: D7310, D7320<br>All crown and bridge codes<br>Conventional crown to implant crown<br>Conventional bridge abutment to implant bridge abutment<br>Additional abused codes D2950, D2952 |
| Policy: | Claims submissions for several CDT Codes will suspend for Dental/Professional Clinical Review to determine appropriateness and accuracy of coding when the member's contract supports clinical review. Corrections to coding will be made by actively licensed dental consultants according to the below guidelines. |
| Guidelines: | The CDT reference manual, published by the ADA, is designated by the federal government as the national accepted terminology for reporting dental services on claim forms submitted to third party payers, in accordance with the authority granted by the 1996 HIPAA laws. The CDT Manual is maintained by the Maintenance Committee of the ADA and is updated annually. The CDT Manual lists the procedure codes, nomenclatures, and descriptors for all dental procedures. Dental/Professional Clinical Review, Dental Review Unit and professional Review utilize the descriptors to determine the accuracy of the CDT codes submitted for payment.<br><br>Dependent upon the procedure performed or the code category submitted, documentation typically required for Review may include the following:<br>• Most recent dated correctly mounted pre-operative x-rays (radiographic images) which may include full mouth x-ray images or panoramic image, vertical bitewings, periapical |

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| | images, or conventional bitewing images.<br>• A current dated periodontal chart with periodontal pocket depth recordings.<br>• Patient record notes.<br>• A narrative which includes the diagnosis (symptoms and/or pathosis), treatment plan, and procedures performed operative report, and other pertinent information.<br>Dental Service analysts and Dental Consultants will review the documentation to determine whether the reported CDT codes submitted are accurate and supported. When Dental Service Analysts determine a CDT code is not supported by the documentation, a referral will be made to a Licensed Dental Consultant for final CDT code and benefit determination.<br><br>Guidelines for ADA CDT Procedure Code Definitions:<br>Dental Service Analysts and actively licensed Dental Consultants compare claim line coding with CDT Procedure Code(s), Nomenclature(s), and Descriptors as listed in the appropriate CDT Manual. Procedure Codes that do not match the descriptor after review of the clinical documentation will be corrected by a Licensed Dental Consultant with a recommendation to benefit the most the appropriate CDT code in Workclaims/WDS or DDS (DeCare Dental System).<br><br>As noted in the DRU/PR Policies, clinical review by an actively licensed dentist is based on the clinical documentation submitted and the actively licensed Dental Consultant's professional determination to apply the most appropriate CDT code.<br><br>[Corrections for closure of the claim/pre-determination will utilize the appropriate WDS or PR (DeCare) reprocessing code. A claim line will be added below the original submitted procedure code to reflect the appropriate/corrected CDT procedure code. The original claim line submitted must reference zero monies across the board and the newly added claim line(s) will reflect the original amount billed for the original procedure code plus reference the correct CDT procedure code and its contracted allowable amount when applicable. Indication of the code correction will appear on the EOB as a separate claim line and properly calculate the member's portion. Do not delete the original submitted code.] *This paragraph will be deleted and inserted into WDS and DDS claims processing policies and procedures.*<br><br>Example:<br>Tooth #32 (lower right third molar) is submitted as a D7240 (removal of impacted tooth – complete bony). DRU/PR DSA and/or the Licensed Dental Consultant reviews the radiographs to make a determination of the clinical information and if the code submitted is |

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<tr><td></td><td>accurate. Using the CDT descriptors, the licensed dentist makes a determination that the CDT coding is correct or incorrect. The Licensed Dental Consultants utilizes the appropriate reprocess code, for example: WDS uses AP and ZT and PR 84 to indicate the change recommendation requesting to “add line” with the corrected extraction procedure code.</td></tr>
<tr><td>History</td><td>
<table>
<tr><td colspan="2">URAC Guidelines 12-6-2005</td></tr>
<tr><td colspan="2">7210 - 7241</td></tr>
<tr><td>Approve</td><td>If there is radiographic evidence of appropriate extraction type for 3rd molars</td></tr>
<tr><td>Deny</td><td>Not applicable</td></tr>
<tr><td>Alternate Benefit</td><td>If radiographic evidence suggests a different extraction category then an alternate benefit would be applied based on the appropriate ADA CDT code.</td></tr>
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<tr><td>CDT Procedure Code(s)/Claim Result</td><td>Procedure Descriptions/Reason(s) for Approval or Denial</td><td>Diagnostics/ Description of Materials Needed</td><td>DRY Review Criteria Denial Codes</td></tr>
<tr><td>D7140 to D7250</td><td>Extractions</td><td>Dated Pre-op x-rays</td><td></td></tr>
<tr><td></td><td>If pathosis and/or symptomatic third molars with radiographic evidence of appropriate extraction type.</td><td></td><td>Review of third molar, bicuspid, and cuspid extractions without pathosis will be denied according to contract; orthodontic purposes. If undetermined, the claim/pre-determination will be sent to the Dental Consultant for review. On PPO, if insufficient information was received, claim will be denied requesting additional information. Once appeal has been received, if additional information is insufficient and does not adequately support symptomology and/or pathosis, plan may address a request to specialist or general dentist chart notes or any</td></tr>
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| | | | | additional information for clarification. |
| | Deny | Incorrect coding. 3rd molars are non-pathologic and/or asymptomatic | | AP D7241 to D7240 unless radiographic images demonstrate exceptional difficulty which must be documented by narrative and/or chart notes (Operative Report) indicating complications at the time of extraction. |
| | Alternate Benefit | If radiographic images suggest a different extraction category than alternate benefit would be applied based on the appropriate code. | | |
| | Contractual Denial | Denial based on contract exclusion or limitation. | | |

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| Inquiries: | Inquiries by Providers regarding correct coding based on CCB Inquiry Tracking Record: Dental Consultants will return telephone calls within plan specific business days to discuss with providers. Dental Consultants will utilize CDT Coding descriptors as needed when discussing DRU/PR determinations. |
| References: | Current Procedural Terminology - CPT® 2017 Professional Edition – American Medical Association. All rights reserved.<br>Current Dental Terminology - CDT © 2017 American Dental Association. All rights reserved.<br>ICD-10-CM 2017: The Complete Official Codebook. All rights reserved. |
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