



CODING

What to Know about the CDT Code

By Wayne S. Silverman, DDS, FAGD, and Jennifer J. Bone, DDS, MAGD

Prior to 2014, the American Dental Association's (ADA) Current Dental Terminology (CDT) was updated once every two years. Now, the CDT Code is revised every year, and the revisions are significant. CDT 2015 introduced 16 new procedural codes, revised 52 codes and deleted five. CDT 2016 introduced 19 new codes, revised 12 codes and deleted eight. Effective Jan. 1, 2017, CDT 2017 will introduce yet another 11 new codes, while revising five codes and deleting one.

In addition to these substantive changes, each new version of the CDT Code includes numerous administrative changes. Use of the incorrect codes not only can postpone or disable claims reimbursement, but it can also result in charges of fraud or violations of other state or federal law, including noncompliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Transactions and Code Sets (TCS) regulations, even if the incorrect code set was used by mistake. It is critical for your practice to budget for the purchase of a new CDT every year. Read on for an in-depth introduction to CDT.

What is CDT?

It is a reference manual published annually by ADA and contains the Code on Dental Procedures and Nomenclature (CDT Code). The CDT Code is a set of procedural codes for oral health and adjunctive services that are provided in dentistry. Each procedural code consists of an alphanumeric character beginning with the letter "D" (the procedure code) and a title (the nomenclature). It also includes written narratives (descriptors) for some of the procedural codes. The CDT Code categorizes codes by type of service: diagnostic, preventive, restorative, endodontics, periodontics, removable prosthodontics, maxillofacial prosthetics, implant services, fixed prosthodontics, oral and maxillofacial surgery, orthodontics and adjunctive general services. However, nothing in the CDT supports or indicates limitation of use by dentists — general dentists or specialists — to any categorical section(s) of the CDT Code.

Do I have to use CDT?

If you submit dental benefits claims as either an in-network or out-of-network provider, or engage in electronic communications or transactions that fall under HIPAA, the answer is yes. The U.S. federal government has designated the CDT Code as the national terminology that must be used for reporting dental services on claims to third-party payers. Additionally, under HIPAA's TCS

regulations, HIPAA designates "standard" transaction formats that must be used for electronic exchange of administrative and financial health care data. Health care data includes claims, payment information, health care advice, claims status inquiries, authorizations and referrals, among other items. The CDT was designated as the mandatory "standard" for electronic communication of dental services.

How are changes to the CDT Code determined?

Changes to the CDT Code are generally attempts to better reflect the current practice of dentistry. The CDT Code is maintained by the ADA Code Maintenance Committee (CMC), which was established by the ADA Council on Dental Benefit Programs but has the authority to act independently of ADA in rendering decisions about changes to the CDT Code. The CMC has 21 voting members — five ADA representatives, one AGD representative, nine ADA-recognized dental specialty organizations and five dental benefits (third-party) payer organizations including Centers for Medicare and Medicaid Services, and one representative from American Dental Education Association — who approve or reject ADA Code changes that may be requested by any person or organization. While revisions to CDT 2017 are already in place, you may request changes to the subsequent CDT Code, which will be published in CDT 2018 and become effective Jan. 1, 2018. Change requests for that CDT Code are due to ADA no later than Nov. 1, 2016. The CMC will hold an open meeting March 9–10, 2017, to vote on these change requests. For more information and forms to request a CDT Code change, visit www.ada.org/en/publications/cdt/request-to-change-to-the-code.

How do I code to make sure I get paid quickly and correctly on my claim?

First, ensure that the codes in your claim are accurate, which means using the version of the CDT Code that is in effect on the date of service and coding for what you did. With most dental benefits administrators, when a claim is received with the incorrect code for a stated treatment (for example, using single unit crown codes with a pontic), the benefits administrator can only deny the claim for the incorrect code and cannot change the code to reflect the service actually provided. While accurate submission of the procedure code is critical, so is accurate data entry of the patient's personal information, including birthdate, Social Security number, and insurance policy and group numbers.

Secondly, ensure that supporting documentation is provided. Radiographs must be diagnostic and labeled with the patient's name and the date on which they were taken. Provide periapical images for teeth treated with crowns or onlays. Periodontal charting and radiographs are generally requested for periodontal treatment determinations. While photos are helpful as an adjunct to radiographs, they do not replace the need for radiographs. Narratives should be clear and concise, and they should include the diagnosis or reason for performance of a procedure. In 2012, the ADA Dental Claim Form was amended to include boxes 34 and 34a for recording diagnostic codes. While recording diagnostic codes in the claim form is not mandatory for reimbursement, except when submitting claims

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to a few states' Medicaid agencies, some private payers provide expanded benefits for certain recorded diagnoses.

Thirdly, ensure that your practice's administrative team has a basic working knowledge of the patient's insurance policies. This can help keep you and your patient from surprises; for example, a bridge not covered due to a missing tooth clause or a crown not covered because the existing crown was placed less than five years ago.

What do I do if I'm experiencing difficulties with the insurance company?

Many adverse claim decisions are as a result of policy restrictions in the insurer's benefits policy. These include frequency limitations, date of service restrictions, least expensive alternative treatment provisions and other policies. Except in the occasional case that an insurer's benefit policy places a restriction that is disallowed by the CDT Code's descriptor of the submitted code, not much can be done to overcome a policy-based denial.

Some claim payment delays may be related to the use of incorrect codes or failure to submit radiographs and other information. It is generally best to work with the insurance company to identify and provide the necessary information or corrected claims to expedite payment. However, where claims payment delays violate state prompt-payment laws for payment of clean claims, or where collaboration with the insurer is rendered impossible, then it may be best to work with the patient to file a complaint with your state's insurance commissioner, or, in the case of self-funded plans, which fall within the purview of the Employee Retirement Income Security Act, with the U.S. Department of Labor.

Finally, if all requested information, including narratives and radiographs, have been submitted, but your claim is denied for lack of dental "necessity" or "appropriateness," most explanations of benefits (EOBs) articulate appeal rights. When filing an appeal, ensure that you use language from the code's nomenclature and/or descriptor in the CDT Code to explain why the services you provided were necessary or appropriate.

Where can I get more help?

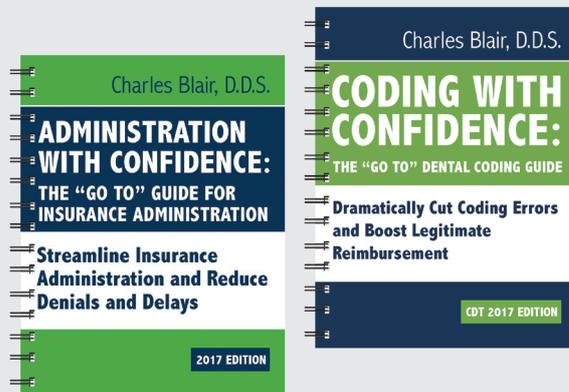
Contact AGD at practice@agd.org for inquiries with specific matters. AGD cannot offer legal consultation or representation; the information provided will not replace consultation with an attorney licensed in your state. ♦

BOOK REVIEW

Coding with Confidence: The "Go To" Dental Coding Guide and Administration with Confidence: The "Go To" Guide for Insurance Administration by Charles Blair, DDS*

If you missed seeing Charles Blair, DDS, at AGD's 2016 annual meeting in Boston, run — don't walk — to his next course. Although I have a fee-for-service practice, we still complete and file insurance claims for our patients. My staff members find his reference books to be invaluable and refer to them quite often. Just like good instruments are developed by doctors who use them, so is the case by a fellow dentist who has had to deal with dental insurance. Both books are "must-haves" for any practice dealing with third-party claims. Together, they will help you organize and accurately complete the forms in the proper context of the procedures you have performed. Not only does Blair have a degree in dentistry (the University of North Carolina at Chapel Hill), but he also holds degrees in accounting, mathematics and business administration. The Code on Dental Procedures and Nomenclature (CDT Code) can be confusing, but Blair's books are easy to follow and clearly demonstrate what you need to do for yourself or the patient to be reimbursed.

—Howard S. Glazer, DDS, FAGD



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Wayne S. Silverman, DDS, FAGD, maintains a private practice in Hanover, Pennsylvania. Silverman is also a clinical instructor, dean's faculty, at the University of Maryland School of Dentistry in Baltimore and serves as the dental director at Dominion National, a dental benefits company based in Virginia.

Jennifer J. Bone, DDS, MAGD, is a 2001 graduate of UT Dentistry at the University of Texas Health Science Center at San Antonio. She is a co-owner of a private practice in Kerrville, Texas. To comment on this article, email impact@agd.org.