

ADA Coding

Questions and Answers (Q&A) Archive

These Q&A are brought to you by the Council on Dental Benefit Programs (CDBP) and add to what are in the current CDT manual. Q&A are here to assist dentist's and practice staff determine the most appropriate procedure code to document the service provided, as well as better understand the claim form completion and adjudication processes.

Please note that; 1) this information is not part of the *Code on Dental Procedures and Nomenclature (Code)*, and 2) dental benefit plan coverage limitations and exclusions, and where applicable the provisions of a participating provider agreement, affect third-party payer claim adjudication.

Coding

1. What is an operculectomy, and how would it be coded?

In dentistry, an operculum is a small flap of inflamed tissue surrounding the back molars and "...ectomy" is a surgical suffix referring to the removal of something. Therefore, an operculectomy is the surgical removal of a flap of tissue surrounding a partially erupted or impacted tooth.

Available procedure code:

D7971 excision of pericoronal gingiva Surgical removal of inflammatory or hypertrophied tissues surrounding partially erupted/impacted teeth.

2. What is the code for using a laser?

A laser is an instrument and can be used in many dental applications. The dental procedure codes are procedure based rather than instrument based. For example, if a gingivectomy on tooth 8 was performed using a scalpel or a laser, the procedure code would be the same.

Available procedure code:

D4211 gingivectomy or gingivoplasty – one to three teeth or bounded teeth spaces per quadrant.

3. What is a dry socket and how would treatment be coded?

A dry socket is localized inflammation of the tooth socket following extraction due to infection, loss of the blood clot; osteitis.

Available procedure code:

D9930 treatment of complications (post surgical) – unusual circumstances, by report For example, treatment of a dry socket following extraction or removal of bony sequestrum.

4. What is a fibroma and how would removal be reported?

A fibroma is a benign tumor composed of fibrous or connective tissue. They can grow in all organs.

Available procedure codes:

D7410 excision of benign lesion up to 1.25 cm

D7411 excision of benign lesion greater than 1.25 cm

5. What is a flipper/stayplate and how would it be documented?

A flipper/stayplate is a temporary removable partial denture typically fabricated out of hard acrylic, the same material used to make a standard complete denture.

Available procedure codes:

D5820 Interim partial denture (maxillary) Includes any necessary clasps or rests

D5821 interim partial denture (mandibular) Includes any necessary clasps or rests

6. What is a torus/exostosis and how would removal be reported?

A torus/exostosis is a benign overgrowth of bone forming an elevation or protuberance of bone. They can form in the patient's palate, lingual or lateral aspect of the maxilla or mandible.

Available procedure codes

D7471 removal of lateral exostosis (maxilla or mandible)

D7472 removal of torus palatinus

D7473 removal of torus mandibularis

7. The dentist performed a frenectomy on a child that had been diagnosed with ankyloglossia. What is ankyloglossia and how would treatment be documented?

Ankyloglossia, more commonly referred to as tongue tied, is a condition in which the lingual frenum is short and attached to the tip of the tongue, making normal speech difficult.

Available procedure code:

D7960 frenulectomy (frenectomy or frenotomy) – separate procedure

The frenum may be excised when the tongue has limited mobility: for large diastemas between the teeth; or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal disease.

8. A patient is having endosteal implants placed. A stent like appliance will be used as a guide while the implants are surgically placed. Would the appliance be documented as D5982 surgical stent, or D6190 radiographic/surgical implant index, by report?

Available procedure code:

D6190 radiographic/surgical implant index, by report

An appliance, designed to relate osteotomy or fixture position to existing anatomic structures, to be utilized during radiographic exposure for treatment planning and/or during osteotomy creation for fixture installation.

A surgical stent (D5982) applies pressure to soft tissues to facilitate healing and prevent cicatrization or collapse.

9. Prior to the replacement of an ill fitting maxillary complete denture, it was necessary to surgically remove an excess formation of palatal tissue. How would this procedure be documented?

Available procedure code:

D7970 excision of hyperplastic tissue – per arch

Adjudication

Example #1:

A patient is missing teeth 3,4,12 and 13. The dentist's treatment plan includes two- four unit fixed partial dentures. When the claim is adjudicated, the benefit contract makes an allowance equivalent to a removable bilateral partial denture. This is an example of a benefit contract containing a **least expensive alternative treatment (LEAT)** clause.

LEAT is a contractual limitation that will only allow benefits for the least expensive treatment when there are multiple treatment options for a specific condition. LEAT does not determine treatment, but does determine level of benefits available.

Please remember – dental benefit plan coverage limitation & exclusions, and where applicable the provisions of a participating provider agreement, affect third-party claim adjudication.

Codes referenced are from the *Code on Dental Procedures and Nomenclature* as printed in the ADA publication titled CDT 2007/2008.

Claim Form

In the past, our office has always used UR, UL, LR, and LL to indicate the area of the oral cavity. I have heard that these symbols are not being used any longer. Is this correct?

Yes, the Area of the Oral Cavity is now designated by a two-digit numeric code, which is a HIPAA standard. This code is placed in Item 25 of the current ADA paper claim form (2006 © American Dental Association). Completion instructions for this field, as published in the CDT manual, follow:

25. Area of Oral Cavity: Use of this field is conditional. Always report the area of the oral cavity unless one of the following conditions in Item #29 (Procedure Code) exists:

- a. The procedure identified in #29 requires the identification of a tooth or a range of teeth.
- b. The procedure identified in #29 incorporates a specific area of the oral cavity in its nomenclature (for example, D5110 complete denture – maxillary).
- c. The procedure identified in #29 does not relate to any portion of the oral cavity (for example, D5914 auricular prosthesis, or D9220 deep sedation/general anesthesia – first 30 minutes).

Area of the oral cavity is designated by a two-digit code, selected from the following code list:

Code	Area
00	entire oral cavity
01	maxillary arch
02	mandibular arch
10	upper right quadrant
20	upper left quadrant
30	lower left quadrant
40	lower right quadrant