Optum

Coding &
Payment Guide

Dental Services

An essential coding, billing and reimbursement resource for dental practices

2025

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Contents

Getting Started with Coding and Payment Guide

The *Coding and Payment Guide for Dental Services* is designed to be a guide to the specialty procedures classified in the CDT® and CPT® books. It is structured to help coders understand procedures and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book. The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

Resequencing of CDT and CPT Codes

The American Dental Association (ADA) and the American Medical Association (AMA) employ a resequenced numbering methodology. According to the associations, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes were not changed or had only minimal changes, the ADA and AMA have assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence. CPT codes within the Optum *Coding and Payment Guide* series display in their resequenced order. **Resequenced CPT codes are enclosed in brackets [ ] for easy identification.**

ICD-10-CM

The most current ICD-10-CM codes are provided, each listed with their full official description. Refer to the ICD-10-CM book for more ICD-10-CM coding information.

Detailed Code Information

One or more columns are dedicated to each procedure or service to a series of similar procedures/services. Following the specific CDT and CPT code and its narrative, is a combination of features.

Appendix Codes and Descriptions

Some procedure codes are presented in a less comprehensive format in the appendix. The CDT and CPT codes appropriate to the specialty are included the appendix with the official code description, followed by an easy-to-understand explanation.

CCI Edits, RVUs, and Other Coding Updates

This *Coding and Payment Guide* includes the a list of codes from the official Centers for Medicare and Medicaid Services' *National Correct Coding Policy Manual for Part B Medicare Contractors* that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version 29.3, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The website address is http://www.optumcoding.com/ProductUpdates/. The 2025 edition password is: **XXXXXX.** Log in frequently to ensure you receive the most current updates.

Index

Comprehensive indexes for both the CPT and the CDT coding systems are provided for easy access to the codes. The indexes have several axes. A code can be looked up by its procedure name or by the anatomical site associated with it. For example:

Debridement
endodontic, D3221
periodontal, D4355
implant
peri, D6101-D6102
single, D6081

General Guidelines

Providers

The ADA and AMA advises coders that while a particular service or procedure may be assigned to a specific section, the service or procedure itself is not limited to use only by that specialty group. Additionally, the procedures and services listed throughout the book are for use by any qualified dentist, physician, or other qualified healthcare professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Supplies

Some payers may allow providers to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting.

Professional and Technical Component

Radiology and some pathology codes have a technical and a professional component. When providers do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

Sample Page and Key

The following pages provide a sample page from the book displaying the format of *Coding and Payment Guide* with each element identified and explained.

D1206-D1208

D1206 topical application of fluoride varnish
D1208 topical application of fluoride - excluding varnish

Explanation

Topically applied fluoride treatments are done in the office with a variety of solutions or gels and different application protocols, excluding rinsing or "swish." The fluoride may be applied with trays or specifically to a few, isolated teeth at a time to prevent a high systemic dose from occurring. Fluoride varnish is painted directly on certain areas to help prevent further decay. The fluoride treatment reported here must be applied separately from any prophylaxis paste. Report D1206 for therapeutic application of varnish or D1208 for topical application of fluoride other than varnish.

Coding Tips

These services must be provided under direct supervision of the dental provider. Appropriate code selection is determined method used. Code D1206 should be used for the application of topical fluoride varnish only. Report D1208 for other topical applications. Any evaluation, radiograph, restorative, or extraction service is reported separately. Removal of coronal plaque is reported separately using D1110 or D1120. Report D9910 if the varnish is applied solely to desensitize the tooth. To report application of interim caries arresting medicament, see D1354.

Documentation Tips

The following information can be documented on a tooth chart: treatment/location of caries, endodontic procedures, prosthetic services, preventive services, treatment of lesions and dental disease, or other special procedures. A tooth chart may also be used to identify structure and rationale of disease process and the type of service performed on intraoral structures other than teeth.

Reimbursement Tips

When selecting the procedure or service that accurately identifies the service performed, dentists must use the most accurate code. If the CDT code more accurately identifies the service, this should be used rather than the CPT codes. When an oral health assessment is performed by someone other than the dentist, for example, a licensed dental hygienist, some third-party payers may require that modifier DA Oral health assessment by a licensed health professional other than a dentist, be appended to the code. Check with third-party payers for their specific requirements.

Associated CPT Codes

99188	Application of topical fluoride varnish by a physician or other qualified health care professional

ICD-10-CM Diagnostic Codes

Z01.20	Encounter for dental examination and cleaning without abnormal findings
Z01.21	Encounter for dental examination and cleaning with abnormal findings
Z41.8	Encounter for other procedures for purposes other than remedying health state
Z46.4	Encounter for fitting and adjustment of orthodontic device
Z91.120	Patient's intentional underdosing of medication regimen due to financial hardship
Z91.128	Patient's intentional underdosing of medication regimen for other reason
Z91.14	Patient's other noncompliance with medication regimen
Z91.841	Risk for dental caries, low
Z91.842	Risk for dental caries, moderate
Z91.843	Risk for dental caries, high
Z98.810	Dental sealant status
Z98.811	Dental restoration status
Z98.818	Other dental procedure status

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D1206	0.20	0.39	0.02	0.61
D1208	0.10	0.19	0.01	0.30
Facility RVU	**Work**	**PE**	**MP**	**Total**
D1206	0.20	0.39	0.02	0.61
D1208	0.10	0.19	0.01	0.30

	FUD	Status	MUE	Modifiers				IOM Reference
D1206	N/A	N	-	N/A	N/A	N/A	N/A	None
D1208	N/A	N	-	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

fluoride. Compound of the gaseous element fluorine that can be incorporated into bone and teeth and provides some protection in reducing dental decay.

plaque. Accumulation of a soft sticky substance on the teeth largely composed of bacteria and its byproducts.

prophylaxis. Intervention or protective therapy intended to prevent a disease.

scaling. Removal of plaque, calculus, and stains from teeth.

1. CDT/CPT Codes and Descriptions

This edition of *Coding and Payment Guide for Dental Services* is updated with CDT and CPT codes for year 2024. The following icons are used in the *Coding and Payment Guide*:

- ● This CDT/CPT code is new for 2024.
- ▲ This CDT/CPT code description is revised for 2024.
- ✚ This CDT/CPT code is an add-on code.

Add-on codes are not subject to bilateral or multiple procedure rules, reimbursement reduction, or appending modifier 50 or 51. Add-on codes describe additional intraservice work associated with the primary procedure performed by the same practitioner on the same date of service and are not reported as stand-alone procedures. Add-on codes for procedures performed on bilateral structures are reported by listing the add-on code twice.

- ★ This CPT code is identified by CPT as appropriate for audio-visual telemedicine services

Documentation should include the type of technology used for the treatment in addition to the patient evaluation, treatment, and consents.

According to CPT guidelines, the codes listed below may be used for reporting audio-only telemedicine services when modifier 93 Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System, is appended. These procedures involve electronic communication using interactive telecommunications equipment that at a minimum includes audio.

90785	90791	90792	90832	90833	90834	90836
90837	90838	90839	90840	90845	90846	90847
92507	92508	92521	92522	92523	92524	96040
96110	96116	96121	96156	96158	96159	96160
96161	96164	96165	96167	96168	96170	96171
97802	97803	97804	99406	99407	99408	99409
99497	99498					

[ ] CPT codes enclosed in brackets are resequenced and may not appear in numerical order.

2. Explanation

Every CDT or CPT code or series of similar codes is presented with its official CDT code description and nomenclature or CPT code description. However, sometimes these descriptions do not provide the coder with sufficient information to make a proper code selection. In *Coding and Payment Guide for Dental Services*, a step-by-step clinical description of the procedure is provided, in simple terms. Technical language that might be used by the dentist is included and defined. *Coding and Payment Guide for Dental Services* describes the most common method of performing each procedure.

3. Coding Tips

Coding and reimbursement tips provide information on how the code should be used, provides related procedure codes, and offers help concerning common billing errors, modifier usage, and anesthesia. This information comes from consultants and subject matter experts at Optum and from the coding guidelines provided in the CDT or CPT book.

4. Documentation Tips

Documentation tips provide code-specific tips to the coder regarding the information that should be noted in the medical record to support code assignment. Documentation should be complete and support the CDT, CPT, or ICD-10-CM codes reported.

5. Reimbursement Tips

Medicare and other payer guidelines that could affect the reimbursement of this service or procedure are included in the Reimbursement Tips section.

6. Associated CPT Codes

The 2024 edition of the *Coding and Payment Guide for Dental Services* contains a crosswalk from the driver CDT or CPT code to its corresponding CPT or CDT code. CDT codes should be reported for the majority of dental services. On occasion, coverage of trauma, injury, or neoplasm may be covered by the health care insurer. In the rare instance when reporting a medical claim, CPT codes should be reported. This heading will not appear if there is no valid crosswalk.

7. ICD-10-CM Diagnostic Codes

ICD-10-CM diagnostic codes listed are common diagnoses or reasons the procedure may be necessary. This list in most cases is inclusive to the specialty. Some ICD-10-CM codes are further identified with the following icons:

- **N** Newborn: 0
- **P** Pediatric: 0-17
- **M** Maternity: 9-64
- **A** Adult: 15-124
- ♂ Male only
- ♀ Female Only
- ☑ Laterality

Please note that in some instances the ICD-10-CM codes for only one side of the body (right) have been listed with the CPT code. The associated ICD-10-CM codes for the other side and/or bilateral may also be appropriate. Codes that refer to the right or left are identified with the ☑ icon to alert the user to check for laterality. In some cases, not every possible code is listed and the ICD-10-CM book should be referenced for other valid codes.

8. Relative Value Units/Medicare Edits

The 2024 Medicare edits were not available at the time this book went to press. Medicare edits were current as of November 2023. Updated 2024 values will be posted at https://www.optumcoding.com/ProductUpdates/. The 2025 edition password is **XXXXXX.**

Gap Filled Relative Value Units

Included in this edition are 2023 gap filled relative value units (RVU) for the CDT codes. These are useful in assisting with establishing fee schedules for your practice.

The gap relative value units are created by Optum using various methodologies depending on the code. For most codes, gap relative values are calculated by using relative value information from the Optum Relative Value Scale and adjusted to a scale similar to the Medicare physician fee schedule (MPFS) relative values (RBRVS). The Optum relative values are developed by and are proprietary to Optum, Inc. The Optum relative values are assigned when Optum has an understanding of how the procedure is typically billed by the industry and how it relates to other procedures. Relative values are based on difficulty, time, work, risk, and resources. Relative values are established by Optum employees, including an Optum medical director, clinicians, certified procedural coders, and analysts. Optum also consults with a panel of outside physicians and dentists during the relative value development process for certain codes.

Because the Optum relative values are on a different scale than RBRVS relative values, ratios are developed relating the RBRVS and Optum scales for approximately 250 code ranges within the CPT, HCPCS, and CDT coding systems. These ratios are multiplied by the Optum relative value to create the gap value. If Optum does not assign a relative value to a code, a gap value is not calculated.

Relative Value Units

In a resource based relative value scale (RBRVS), services are ranked based on the relative costs of the resources required to provide those services as opposed to the average fee for the service, or average

Procedure Codes

One of the keys to gaining accurate reimbursement lies in understanding the multiple coding systems that are used to identify services. To be well versed in reimbursement practices, coders should be familiar with the CDT, HCPCS Level II, ICD-10-CM, and CPT® coding systems. The first of these, the CDT system, is increasingly important to reimbursement, as it has been extended to a wider array of dental services.

- Coding and billing should be based on the service and supplies provided. Documentation should describe the patient's problems and the service provided to enable the payer to determine reasonableness and necessity of care.
- Refer to Medicare coverage reference to determine whether the care provided is a covered service. The references are noted, when they apply, on the pages following.

HCPCS Level I or CPT Codes

Known as HCPCS Level I, the CPT coding system is the most commonly used system to report procedures and services. Copyright of CPT codes and descriptions is held by the American Medical Association. This system reports outpatient and provider services.

CPT codes predominantly describe medical services and procedures, and are adapted to provide a common billing language that providers and payers can use for payment purposes. The codes are required for billing by both private and public insurance carriers, managed care companies, and workers' compensation programs. Dental professional may find that a third-party payer will occasionally require that a procedures be reported using a CPT code. Unless otherwise instructed, dental professional should report services using the appropriate American Dental Association (ADA) dental code when one exists.

HCPCS Level II Codes

HCPCS Level II codes are commonly referred to as national codes or by the acronym HCPCS (pronounced "hik piks"). HCPCS codes are used for billing Medicare and Medicaid patients and have also been adopted by some third-party payers. HCPCS Level II codes published annually by CMS, are intended to supplement the CPT coding system by including codes for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS); drugs; and biologicals. These Level II codes consist of one alphabetic character (A–V) followed by four numbers. In many instances, HCPCS Level II codes are developed as precursors to CPT codes.

A complete list of the HCPCS Level II codes and the quarterly updates to this code set may be found at http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.

The following is a list of the HCPCS Level II supply codes used to identify supplies commonly used by dentists.

Medical and Surgical Supplies A4000–A8999

The A and E code sections of the HCPCS Level II code system cover a wide variety of medical and surgical supplies, and some durable medical equipment (DME), supplies and accessories.

A4550 **Surgical trays**

A4649 **Surgical supply; miscellaneous**

E1700 **Jaw motion rehabilitation system**

E1701 **Replacement cushions for jaw motion rehabilitation system, package of 6**

E1702 **Replacement measuring scales for jaw motion rehabilitation system, package of 200**

Drugs Administered Other Than Oral Method J0000–J8999

Drugs and biologicals are usually covered by Medicare if: they are of the type that cannot be self-administered; they are not excluded by being immunizations; they are reasonable and necessary for the diagnosis or treatment of the illness or injury for which they are administered; and they have not been determined by the Food and Drug Administration (FDA) to be less than effective. In addition they must meet all the general requirements for coverage of items as incident to a physician's services. Generally, prescription and nonprescription drugs and biologicals purchased by or dispensed to a patient are not covered.

The following list of drugs can be injected either subcutaneously, intramuscularly, or intravenously. Third-party payers may wish to determine a threshold and pay up to a certain dollar limit for the drug.

J codes fall under the jurisdiction of the DME regional office for Medicare, unless incidental or otherwise noted. See Pub. 100-2, chap. 15, sec. 50.4

J0665 **Injection, bupivicaine, not otherwise specified, 0.5 mg**

J0670 **Injection, mepivacaine HCl, per 10 ml**

J1790 **Injection, droperidol, up to 5 mg**

J2250 **Injection, midazolam HCl, per 1 mg**

J2401 **Injection, chloroprocaine HCL, per 1 mg**

J2402 **Injection, chloroprocaine HCL (clorotekal), per 1 mg**

J2515 **Injection, pentobarbital sodium, per 50 mg**

J2550 **Injection, promethazine HCl, up to 50 mg**

J3010 **Injection, fentanyl citrate, 0.1 mg**

J3360 **Injection, diazepam, up to 5 mg**

Resequenced CDT Codes

The ADA has resequenced some code numbers to place codes in the same category but not in numeric sequence. The following table contains a list of codes that are not in numeric order in the CDT book.

Code	Reference
D0480	See code following D0474.
D0486	See code following D0474.
D0600	See code following D0470.
D0601	See code following D0470.
D0602	See code following D0470.
D0603	See code following D0470.
D0604	See code following D0470.
D0605	See code following D0470.
D0606	See code following D0470.
D0701	See code following D0389.
D0702	See code following D0389.
D0703	See code following D0839.
D0705	See code following D0389.
D0706	See code following D0389.
D0707	See code following D0389.
D0708	See code following D0389.
D0709	See code following D0389.
D0801	See code following D0374.
D0802	See code following D0374.
D0803	See code following D0374.
D0804	See code following D0374.
D1353	See code following D1351.
D2928	See code following D2929.
D2955	See code following D2957.
D2989	See code before D2910.
D2990	See code before D2910.
D2991	See code before D2910.
D3471	See code following D3426.
D3472	See code following D3426.
D3473	See code following D3426.
D3501	See code following D3426.
D3502	See code following D3426.
D3503	See code following D3426.
D4274	See code following D4285.
D4276	See code following D4285.
D4277	See code following D4285.
D4278	See code following D4285.
D4283	See code following D4273.
D4286	See code following D4267.
D5225	See code following D5214.
D5226	See code following D5214.
D5765	See code before D5850.
D5912	See code before D5911.
D5914	See code before D5911.
D5915	See code following D5916.
D5919	See code following D5911.
D5922	See code following D5913.
D5923	See code following D5916.
D5924	See code before D5911.
D5925	See code before D5911.
D5926	See code following D5913.
D5927	See code before D5911.
D5929	See code following D5911.
D5931	See code following D5913.
D5932	See code following D5913.
D5933	See code following D5913.
D5934	See code following D5911.
D5935	See code following D5911.
D5936	See code following D5913.
D5937	See code following D5988.
D5951	See code following D5911.
D5953	See code following D5928.
D5954	See code following D5928.
D5955	See code following D5928.
D5958	See code following D5928.
D5959	See code following D5928.
D5960	See code following D5928.
D5982	See code following D5988.
D5983	See code following D5996.
D5984	See code following D5928.
D5985	See code following D5928.
D5986	See code following D5988.
D5987	See code before D5911.
D5991	See code following D5996.
D5992	See code before D5911.
D5993	See code before D5911.
D6055	See code following D6050.
D6056	See code following D6050.
D6057	See code following D6050.
D6082	See code following D6066.
D6083	See code following D6066.
D6084	See code following D6066.
D6086	See code following D6067.
D6087	See code following D6067.
D6088	See code following D6067.
D6089	See code following D6095.
D6094	See code following D6064.
D6097	See code following D6061.
D6098	See code following D6076.
D6099	See code following D6076.
D6100	See code following D6050.
D6101	See code following D6050.
D6102	See code following D6050.
D6103	See code following D6050.
D6104	See code following D6050.
D6105	See code following D6050.
D6106	See code following D6050.
D6107	See code following D6050.
D6110	See code before D6058.
D6111	See code before D6058.
D6112	See code before D6058.
D6113	See code before D6058.
D6114	See code before D6058.
D6115	See code before D6058.
D6116	See code before D6058.
D6117	See code before D6058.
D6118	See code before D6058.
D6119	See code before D6058.
D6120	See code following D6076.
D6121	See code following D6077.
D6122	See code following D6077.
D6123	See code following D6077.
D6190	See code before D6010.
D6191	See code following D6051.
D6192	See code following D6051.
D6194	See code following D6074.
D6195	See code following D6071.
D6624	See code following D6607.
D6793	See code following D6794.
D7298	See code following D7292.
D7299	See code following D7293.
D7300	See code following D7294.
D7465	See code following D7415.
D7939	See code following D7940.
D9947	See code following D9999.
D9948	See code following D9999.
D9949	See code following D9999.
D9953	See code following D9999.
D9954	See code following D9999.
D9955	See code following D9999.
D9956	See code following D9999.
D9957	See code following D9999.
D9961	See code following D9975.
D9997	See code following D9994.

D0600

D0600 non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum

Explanation

The dentist, utilizing a portable caries detection device using transillumination technology, examines teeth for the identification of occlusal, interproximal, and recurrent carious lesions (caries) and/or cracks that cannot be diagnosed clinically or radiographically. There are a number of devices currently on the market with some using lasers that result in fluorescence of the mineral structure of the tooth. Other devices use transillumination to visualize through the enamel.

Coding Tips

Report clinical oral evaluations using D0120–D0170. To report caries risk assessment, see D0601–D0603. To report diagnostic x-ray examination, see D0210–D0274.

Documentation Tips

Medical record documentation must include all findings including changes in structure of enamel, dentin, and cementum.

Reimbursement Tips

Third-party payers may consider this service as a limiting service and do not cover this service. Check with third-party payers prior to providing the service.

ICD-10-CM Diagnostic Codes

K02.3	Arrested dental caries
K02.51	Dental caries on pit and fissure surface limited to enamel
K02.52	Dental caries on pit and fissure surface penetrating into dentin
K02.53	Dental caries on pit and fissure surface penetrating into pulp
K02.61	Dental caries on smooth surface limited to enamel
K02.62	Dental caries on smooth surface penetrating into dentin
K02.63	Dental caries on smooth surface penetrating into pulp
K02.7	Dental root caries

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D0600	0.00	0.00	0.00	0.00
Facility RVU	**Work**	**PE**	**MP**	**Total**
D0600	0.00	0.00	0.00	0.00

	FUD	Status	MUE	Modifiers				IOM Reference
D0600	N/A	R	-	N/A	N/A	N/A	80*	[None]

* with documentation

Terms To Know

caries. Localized section of tooth decay that begins on the tooth surface with destruction of the calcified enamel, allowing bacterial destruction to continue and form cavities; may extend to the dentin and pulp.

cavity. Tooth decay.

noncovered procedure. Health care treatment not reimbursable according to provisions of a given insurance policy, or in the case of Medicare, in accordance with Medicare laws and regulations.

D0601-D0603

D0601 caries risk assessment and documentation, with a finding of low risk

Using recognized assessment tools.

D0602 caries risk assessment and documentation, with a finding of moderate risk

Using recognized assessment tools.

D0603 caries risk assessment and documentation, with a finding of high risk

Using recognized assessment tools.

Explanation

Using a standardized risk assessment tool, the provider evaluates the patient's level of risk for developing caries. Assessments and level of risk vary based on the age of the patient but include such factors as fluoride exposure, dietary risks, general health conditions, and dental clinical conditions including but not limited to visible plaque, xerostomia, dental/orthodontic appliances, and unusual tooth morphology. Report D0601 when the level of risk is low, D0602 when the level of risk is moderate, and D0603 when the level of risk is determined to be high.

Coding Tips

These are out of sequence codes and will not display in numeric order in the CDT manual. After review of the assessment tool, the level of risk may be increased or decreased dependent upon clinical judgment and the review of other pertinent information. Documentation as to the reason for the revised level of risk should be recorded in the medical record. To report nutritional counseling, see D1310. To report oral hygiene counseling, see D1330. To report caries susceptibility testing, see D0425. Coverage of this procedure varies by payer. Check with payers for their specific coverage guidelines.

Documentation Tips

After review of the assessment tool, the level of risk may be increased or decreased dependent upon clinical judgment and the review of other pertinent information. Documentation as to the reason for the revised level of risk should be recorded in the medical record.

Reimbursement Tips

Coverage of this procedure varies by payer. Check with the payer for specific coverage guidelines.

ICD-10-CM Diagnostic Codes

Z01.20	Encounter for dental examination and cleaning without abnormal findings
Z01.21	Encounter for dental examination and cleaning with abnormal findings
Z71.3	Dietary counseling and surveillance
Z91.841	Risk for dental caries, low
Z91.842	Risk for dental caries, moderate
Z91.843	Risk for dental caries, high

D2980

D2980 crown repair necessitated by restorative material failure

Explanation

Work required to repair a damaged crown may vary considerably. A detailed report of the specific procedures and services performed is required for this by report procedure.

Coding Tips

Report this code when the repair is performed because of restorative material failure. Local anesthesia is generally considered to be part of restorative procedures. Providers should submit a detailed description of services and procedures when reporting this code. Third-party payers may require clinical documentation and/or x-rays before making payment determination. Check with payers to determine their specific requirements. This code includes removal of the crown, if necessary.

Documentation Tips

A tooth chart may also be used to identify structure and rationale of disease process and the type of service performed on intraoral structures other than teeth. Providers should submit a detailed description of services and procedures when reporting this code. Third-party payers may require clinical documentation and/or x-rays before making payment determination. Check with payers to determine their specific requirements.

ICD-10-CM Diagnostic Codes

K08.530	Fractured dental restorative material without loss of material
K08.531	Fractured dental restorative material with loss of material
K08.539	Fractured dental restorative material, unspecified
K08.54	Contour of existing restoration of tooth biologically incompatible with oral health
K08.55	Allergy to existing dental restorative material
K08.56	Poor aesthetic of existing restoration of tooth
K08.59	Other unsatisfactory restoration of tooth

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D2980	0.99	0.87	0.20	2.06
Facility RVU	**Work**	**PE**	**MP**	**Total**
D2980	0.99	0.87	0.20	2.06

	FUD	Status	MUE	Modifiers				IOM Reference
D2980	N/A	R	-	50	N/A	N/A	80*	[None]

* with documentation

Terms To Know

artificial crown. In dentistry, a ceramic or metal restoration made to cover or replace a major part of the top of a tooth.

tooth bounded space. Empty space in the mouth due to a missing tooth that is surrounded by a tooth on each side.

D2981-D2983

D2981 inlay repair necessitated by restorative material failure
D2982 onlay repair necessitated by restorative material failure
D2983 veneer repair necessitated by restorative material failure

Explanation

The provider repairs a previous restoration due to marginal defects. The repair of limited defects allows the previous restoration to be left undisturbed for several years or more. In D2981 the provider creates a fixed restoration outside of the mouth, which is then luted onto the tooth with the failed restorative material. In D2982 the repair restores one or more cusps and adjoining occlusal surfaces and is then retained by adhesive means. In D2983 a thin covering is placed over the damaged restorative material.

Coding Tips

When the failed restoration is replaced, see the appropriate code for the type of procedure performed.

Reimbursement Tips

The tooth/root number should be indicated on the claim.

ICD-10-CM Diagnostic Codes

K08.530	Fractured dental restorative material without loss of material
K08.531	Fractured dental restorative material with loss of material
K08.539	Fractured dental restorative material, unspecified
K08.54	Contour of existing restoration of tooth biologically incompatible with oral health
K08.55	Allergy to existing dental restorative material
K08.56	Poor aesthetic of existing restoration of tooth
K08.59	Other unsatisfactory restoration of tooth

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D2981	0.00	0.00	0.00	0.00
D2982	0.00	0.00	0.00	0.00
D2983	0.00	0.00	0.00	0.00
Facility RVU	**Work**	**PE**	**MP**	**Total**
D2981	0.00	0.00	0.00	0.00
D2982	0.00	0.00	0.00	0.00
D2983	0.00	0.00	0.00	0.00

	FUD	Status	MUE	Modifiers				IOM Reference
D2981	N/A	R	-	50	N/A	N/A	80*	[None]
D2982	N/A	R	-	50	N/A	N/A	80*	
D2983	N/A	R	-	50	N/A	N/A	80*	

* with documentation

Terms To Know

inlay. Restoration made outside of the mouth to fit a prepared cavity and placed on the tooth.

onlay. In dentistry, restoration made outside of the mouth that is cemented over a cusp or cusps of the tooth.

D5611-D5612

D5611 repair resin partial denture base, mandibular
D5612 repair resin partial denture base, maxillary

Explanation

A cracked or broken complete denture base is repaired. Depending on the nature of the break, different repair techniques may be required. If the fractured base can be accurately positioned outside of the mouth, the dentist will unite them with a wire held in place by sticky wax or by applying an adhesive to the fracture surfaces. The assembled denture will then be fitted in the mouth prior to repair. If the fractured denture pieces cannot be positioned accurately outside of the mouth, they are placed in the best position possible and a cold-curing acrylic resin is applied. While the resin is still pliable, the denture is placed into the mouth and the broken pieces held in place until the resin hardens. The denture is then sent to a laboratory for completion of the repair. It is sometimes possible to repair dentures in the office (chair side) using a cold-curing acrylic or heat-curing resin. Cold-curing resins will cure in six to nine minutes. Heat-curing resins require approximately 15 minutes. Report D5511 when performed on a mandibular (upper) denture or D5512 when performed on a maxillary (lower) denture.

Coding Tips

To report the repair of a denture base other than resin, see D5511–D5512.

Reimbursement Tips

Providers should be certain that sufficient documentation is provided in the record to accurately verify and describe the service rendered (i.e., the repair provided and the type of denture base).

ICD-10-CM Diagnostic Codes

Z46.3 Encounter for fitting and adjustment of dental prosthetic device

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D5611	1.02	0.90	0.21	2.13
D5612	1.02	0.90	0.21	2.13
Facility RVU	**Work**	**PE**	**MP**	**Total**
D5611	1.02	0.90	0.21	2.13
D5612	1.02	0.90	0.21	2.13

	FUD	Status	MUE	Modifiers				IOM Reference
D5611	N/A	R	-	50	N/A	N/A	80*	[None]
D5612	N/A	R	-	50	N/A	N/A	80*	

* with documentation

Terms To Know

denture base. Portion of the artificial substitute for natural teeth that makes contact with the soft tissue of the mouth and serves as the anchor for the artificial teeth.

partial dentures. In dentistry, artificial teeth composed of a framework with plastic teeth and gum area replacing part but not all of the natural teeth. The framework can either be formed from an acrylic resin base, cast metal or may be made more flexible using thermoplastics.

prosthodontics. Branch of dentistry that specializes in the replacement of missing or damaged teeth.

D5621-D5630

D5621 repair cast partial framework, mandibular
D5622 repair cast partial framework, maxillary
D5630 repair or replace broken retentive clasping materials - per tooth

Explanation

Partial dentures are composed of a framework with plastic teeth and gum areas. The framework contains clasps or other attachments that hold the denture in place. Two types of attachments are available: clasps and precision attachments. Clasps consist of C-shaped pieces of denture framework that fit around adjacent natural teeth. A precision attachment uses a receptacle created within a remaining tooth. The receptacle typically is covered with a crown. The precision attachment extends into the receptacle securing the partial denture. If the framework, clasps, or precision attachments break they are repaired in the dentist's office or sent to a dental laboratory. To repair cast framework or replace a fractured clasp or precision attachment, an alginate impression in a stock tray is made of the denture with the patient wearing the denture. Care must be taken to ensure the impression material does not displace the denture from its correct position. The new framework, clasp, or precision attachment is fabricated and attached to the existing denture using the impression to correctly align and place the required part. Repair of the cast framework is reported with D5621 (mandibular or upper) or D5622 (maxillary or lower). Repair of a clasp or precision attachment is reported with D5630.

Coding Tips

To report the repair of a denture base other than resin, see D5511–D5512; for resin, see D5611–D5612.

Reimbursement Tips

Coverage of this procedure varies by payer. Check with the payer for specific coverage guidelines.

ICD-10-CM Diagnostic Codes

Z46.3 Encounter for fitting and adjustment of dental prosthetic device

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D5621	1.39	1.23	0.29	2.91
D5622	1.39	1.23	0.29	2.91
D5630	1.28	1.13	0.26	2.67
Facility RVU	**Work**	**PE**	**MP**	**Total**
D5621	1.39	1.23	0.29	2.91
D5622	1.39	1.23	0.29	2.91
D5630	1.28	1.13	0.26	2.67

	FUD	Status	MUE	Modifiers				IOM Reference
D5621	N/A	R	-	50	N/A	N/A	80*	[None]
D5622	N/A	R	-	50	N/A	N/A	80*	
D5630	N/A	R	-	50	N/A	N/A	80*	

* with documentation

Terms To Know

conventional dentures. Dentures made and inserted after the teeth have been extracted and the gums have healed. The patient is edentulous while the denture is being made.

D7465

D7465 destruction of lesion(s) by physical or chemical method, by report

Examples include using cryo, laser or electro surgery.

Explanation

The dentist or oral surgeon destroys a lesion, particularly of the oral soft tissue without excision, but by physical or chemical methods. These include different techniques of lesion destruction. Electrocautery may be used to burn the lesion, cryotherapy to freeze the lesion, chemical injections or topical applications may be used to destroy the lesion, or a laser, which produces high-intensity light, may be used to destroy the lesion. No suturing is required and the resultant surgical wound is left to heal secondarily.

Coding Tips

This is an out-of-sequence code and will not display in numeric order in the CDT manual. Any evaluation or radiograph is reported separately. Pathology exam of tissue with interpretation is reported separately.

Reimbursement Tips

When selecting the procedure or service that accurately identifies the service performed, dentists must use the most accurate code. If the CDT code more accurately identifies the service, this should be used rather than the CPT codes. Pertinent documentation to evaluate medical appropriateness should be included when this code is reported. Some payers may require that the pathology report be attached to the claim when performed. This procedure may be covered by the patient's medical insurance. When covered by medical insurance, the payer may require that the appropriate CPT code be reported on the CMS-1500 claim form.

Associated CPT Codes

40820 Destruction of lesion or scar of vestibule of mouth by physical methods (eg, laser, thermal, cryo, chemical)

41850 Destruction of lesion (except excision), dentoalveolar structures

ICD-10-CM Diagnostic Codes

D10.0 Benign neoplasm of lip

D10.1 Benign neoplasm of tongue

D10.2 Benign neoplasm of floor of mouth

D10.39 Benign neoplasm of other parts of mouth

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D7465	2.30	2.03	0.47	4.80
Facility RVU	**Work**	**PE**	**MP**	**Total**
D7465	2.30	2.03	0.47	4.80

	FUD	Status	MUE	Modifiers				IOM Reference
D7465	N/A	R	-	50	N/A	N/A	80	[None]

* with documentation

Terms To Know

cryotherapy. Any surgical procedure that uses intense cold for treatment.

destruction. Ablation or eradication of a structure or tissue.

electrocautery. Division or cutting of tissue using high-frequency electrical current to produce heat, which destroys cells.

D7471

D7471 removal of lateral exostosis (maxilla or mandible)

Explanation

A lateral exostosis, also known as buccal exostosis, is a bony spur found only on the facial surface of either the upper or lower jaw. To remove the exostosis, the dentist makes an incision to expose the exostosis under the gum. The bone is cut into sections and the pieces are removed. The surface is then smoothed using a diamond bur on a hand piece. The gum is then closed over and sutures are placed.

Coding Tips

Any evaluation, radiograph, or restoration service is reported separately. Local anesthesia is generally considered part of any surgical procedure.

Documentation Tips

The following information should be documented on a tooth chart: treatment/location of caries, endodontic procedures, prosthetic services, preventive services, treatment of lesions and dental disease, or other special procedures. A tooth chart may also be used to identify structure and rationale of disease process, and the type of service performed on intraoral structures other than teeth.

Reimbursement Tips

The third-party payer may require an x-ray or x-ray report before processing the claim.

ICD-10-CM Diagnostic Codes

M27.8 Other specified diseases of jaws

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D7471	4.87	4.30	1.00	10.17
Facility RVU	**Work**	**PE**	**MP**	**Total**
D7471	4.87	4.30	1.00	10.17

	FUD	Status	MUE	Modifiers				IOM Reference
D7471	N/A	R	-	N/A	N/A	N/A	80*	[None]

* with documentation

Terms To Know

buccal. Relating to or toward the cheek.

exostosis. Abnormal formation of a benign bony growth.

incision. Act of cutting into tissue or an organ.

lateral. On/to the side.

local anesthesia. Induced loss of feeling or sensation restricted to a certain area of the body, including topical, local tissue infiltration, field block, or nerve block methods.

mandible. Lower jawbone giving structure to the floor of the oral cavity.

maxilla. Pyramidally-shaped bone forming the upper jaw, part of the eye orbit, nasal cavity, and palate and lodging the upper teeth.

removal. Process of moving out of or away from, or the fact of being removed.

Evaluation and Management (E/M) Services Guidelines

E/M Guidelines Overview

The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter with the patient and/or family/caregiver. (For 99211 and 99281, the face-to-face services may be performed by clinical staff.)

In the **Evaluation and Management** section (99202-99499), there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home or Residence Services
- Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories, such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided in the Guidelines for Selecting Level of Service Based on Time.)

The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.

New and Established Patients

Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

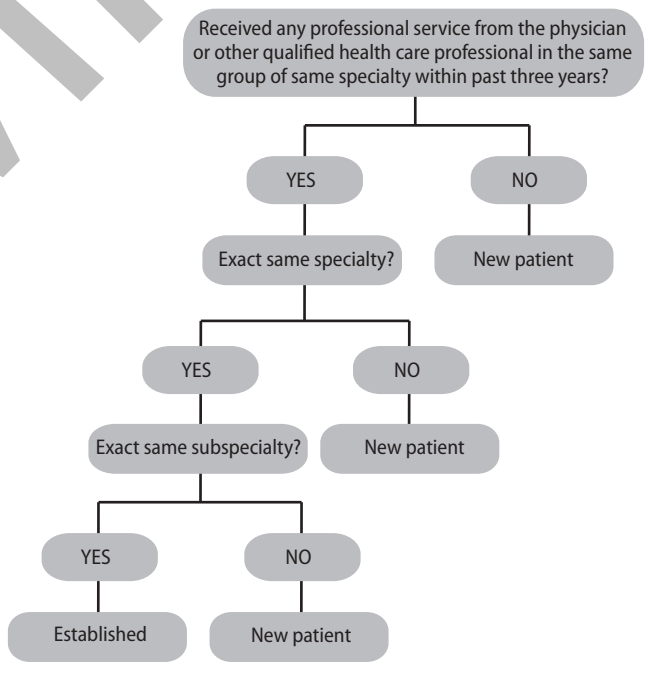
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the **exact** same specialty **and subspecialty** as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Decision Tree for New vs Established Patients



Initial and Subsequent Services

Some categories apply to both new and established patients (eg, hospital inpatient or observation care). These categories differentiate services by whether the service is the initial service or a subsequent service. For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. An initial service is when the patient has not received any professional services from the physician or

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▶ ◀ = Contains new or revised text

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
41000	1.35	2.91	0.18	4.44
41005	1.31	5.75	0.17	7.23
41006	3.34	6.54	0.34	10.22
41007	3.20	6.34	0.30	9.84
Facility RVU	**Work**	**PE**	**MP**	**Total**
41000	1.35	1.63	0.18	3.16
41005	1.31	2.11	0.17	3.59
41006	3.34	3.21	0.34	6.89
41007	3.20	3.07	0.30	6.57

	FUD	Status	MUE	Modifiers				IOM Reference
41000	10	A	1(3)	N/A	51	N/A	80	[100-04,12,90.4.5]
41005	10	A	1(3)	N/A	51	N/A	80*	
41006	90	A	2(3)	N/A	51	N/A	80*	
41007	90	A	2(3)	N/A	51	N/A	80*	

* with documentation

Terms To Know

abscess. Circumscribed collection of pus resulting from bacteria, frequently associated with swelling and other signs of inflammation.

cellulitis. Infection of the skin and subcutaneous tissues, most often caused by *Staphylococcus* or *Streptococcus* bacteria secondary to a cutaneous lesion. Progression of the inflammation may lead to abscess and tissue death, or even systemic infection-like bacteremia.

cyst. Elevated encapsulated mass containing fluid, semisolid, or solid material with a membranous lining.

hematoma. Tumor-like collection of blood in some part of the body caused by a break in a blood vessel wall, usually as a result of trauma.

incision and drainage. Cutting open body tissue for the removal of tissue fluids or infected discharge from a wound or cavity.

41008

41008 Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submandibular space

Explanation

The dentist makes a small intraoral incision through the mucosa of the tongue or floor of the mouth overlying an abscess, cyst, or hematoma and drains the fluid. The dentist incises through the mucosa of the floor of the mouth to the supramylohyoid muscle and carries the dissection deeper into the tissue to reach the submandibular space. The abscess, hematoma, or cyst is opened with a surgical instrument and the fluid is drained. An artificial drain may be placed.

Coding Tips

Placement and removal of drain are not reported separately. Local anesthesia is included in the service. Payers may require that this service be reported using D7510 or D7511 on the ADA dental claim form. Check with payers to determine their requirements.

Associated HCPCS Codes

D7510 incision and drainage of abscess - intraoral soft tissue

D7511 incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)

ICD-10-CM Diagnostic Codes

K09.8 Other cysts of oral region, not elsewhere classified

K12.2 Cellulitis and abscess of mouth

K13.29 Other disturbances of oral epithelium, including tongue

K14.0 Glossitis

K14.8 Other diseases of tongue

S00.532A Contusion of oral cavity, initial encounter

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
41008	3.46	7.91	0.40	11.77
Facility RVU	**Work**	**PE**	**MP**	**Total**
41008	3.46	3.81	0.40	7.67

	FUD	Status	MUE	Modifiers				IOM Reference
41008	90	A	2(3)	N/A	51	N/A	80*	[100-04,12,90.4.5]

* with documentation

Terms To Know

abscess. Circumscribed collection of pus resulting from bacteria, frequently associated with swelling and other signs of inflammation.

incision and drainage. Cutting open body tissue for the removal of tissue fluids or infected discharge from a wound or cavity.

Dental Code Index