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Fun with Coding 2016

- ACLM Annual Meeting
- FEB 2016
- Austin, TX

- Daniel L. Orr II, DDS, MS (anesth), PhD, JD, MD
  - Professor and Director
  - OMS and Anesthesiology
  - UNLV SDM

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2016 CDT vs ICD-10

- Another reason it is great to be a dentist:
- CDT codes ≈ 650
  - (Very hard to comply)
- ICD-10 codes ≈ 140,000
  - (Impossible to comply)
    - I.E. injury via parrot vs maccaw bite, etc.

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CDT History

- In 1986 the ADA determined to develop an educational manual:

- Code review and revision is a dynamic process. Individuals can participate at:
  - www.ada.org/goto/dentalcode

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CDT

- Billing to third parties often requires a code
- There may be more than one code that describes a procedure
- There are two types of codes where a narrative must be included on the claim submission
  - When nomenclature requires a narrative
  - When none of the codes accurately describe the services

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CDT 2016


Oral and Maxillofacial Surgery 1

D7000–D7999 X. Oral and Maxillofacial Surgery

Local anesthesia is usually considered to be part of Oral and Maxillofacial Surgical procedures.

For dental benefit reporting purposes a quadrant is defined as four or more contiguous teeth and/or teeth spaces distal to the midline.

Extractions (Includes Local Anesthesia, Suturing, If Needed, and Routine Postoperative Care)

D7111 extraction, coronal remnants – deciduous tooth
Removal of soft tissue–retained coronal remnants.

D7140 extraction, erupted tooth or exposed root (elevation and/or forceps removal)
Includes routine removal of tooth structure, minor smoothing of socket bone, and closure, as necessary.

Surgical Extractions (Includes Local Anesthesia, Suturing, If Needed, and Routine Postoperative Care)

D7210 surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
Includes related cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure.

D7220 removal of impacted tooth – soft tissue
Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation.

D7230 removal of impacted tooth – partially bony
Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.

D7240 removal of impacted tooth – completely bony
Most or all of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.

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- CDT codes define procedures, but who defines the definitions when controversy ensues? Academia? ADA? State? Feds? Courts?

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Definitions: 7140 “Erupted”

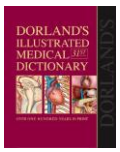
- Questions:
  - What is an erupted tooth?
  - When is a tooth erupted?

7140 Definition: "Erupted" (cont.)

- *Eruption*: "The final state of odontogenesis, in which a tooth breaks out from its crypt through the surrounding tissue."
  - Dorland's 31st
- Questions:
  - Is "Erupted" just breaching ST, in functional occlusion, or somewhere in-between?
  - Does it matter if the process involved is active or passive eruption?

7140 Definition: "Erupted" (cont.)

- *Active Eruption*: "The continued eruption of the teeth after complete formation of their dentinal roots, consisting of movement of the teeth in the direction of the occlusal plane, and being coordinated with attrition."



- *Passive Eruption*: The apparent eruption of a tooth that is actually the exposure of the crown of the tooth by separation of the epithelial attachment from the enamel and migration to the cementoenamel junction." (Dorland's 31st)

7140 Definition: "Exposed Root"

- Questions:
  - Does "exposed root" mean no soft tissue, no bone, or both?
  - What if there is a crown attached?
  - What if the root is laying on the gingiva?

7140: "Elevation"

- Questions:
  - *Elevation*: Of what? Tooth, ST, bone?
  - Does "*Elevation"* require an elevator?
    - What if one elevates with forceps?
    - What if one elevates with a periosteal elevator?
    - What if one elevates hydraulically?
    - What if one elevates with elastics?
    - What if one does elevate with a dental elevator?
      - Does use of an elevator equate to 7140?
      - What if one uses an elevator for a gouge?
      - What if one uses an elevator to remove bone?

7140: "Forceps"

- Is there a difference?
  - Between removing a clinically mobile, non-root fractured, single rooted tooth with a 62 forceps and
  - Using the 62 forceps to displace soft tissue, remove bone, and deliver an ankylosed 28mm maxillary cuspid?

7140 Definition: the fine print

- Questions:
  - What is "routine" removal of tooth structure?
    - CDT: written for GP's and/or OMS's?
    - Is what is routine for a GP routine for an OMS?
  - What is "minor" smoothing of socket bone?
    - Is it rasp vs rongeur vs bur?
    - Is it 2-3 rasp swipes vs 4-5?
  - What is "closure, as necessary"?

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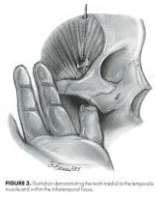
Another Question…

- How does one code a tooth that is removed without a forceps or elevation?
  - i.e. with gauze, dental floss and a doorknob, by hand, with a rongeur?
  - i.e. a planned 7140 that is displaced into the hypopharynx, GI system, respiratory system, maxillary sinus, infratemporal fossa, floor of mouth, as part of a resection, to complete a traumatic subluxation, etc., etc., etc.?



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7210 Definition: "Surgical" and "Flap"

- *"Surgical"*: "Tx…by manual or operative methods" (Dorland's 31st)…so even 7140 is technically a _____ procedure
- *Mucoperiosteal flap* questions:
  - Does that include subgingival placement of an elevator to split roots?
  - Does that include stripping the PDL?
  - Does that include a really small flap, i.e. subperiosteal elevation of the gingival cuff?

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7210 Definition: "Flap" (cont.)

- *Mucoperiosteal flap* (cont.):
  - Does it matter if the flap is unintentional?
  - I.E. partially degloving the alveolus for a 7140, does that indicate a flap was "required" even though operator tried to avoid?
  - I.E. damage to adjacent HT and ST:
    - Bone, teeth, restorations, soft tissues
  - *7210: "Includes cutting of gingiva…"*
  - *7140: <u>No</u> mention of ST manipulation during "elevation and/or forceps" extraction*

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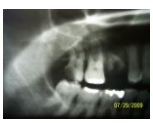
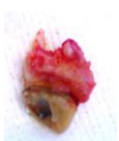
7210 Definition: "Bone"

- *Requiring removal of bone* questions:
  - What if bone is spontaneously removed with the tooth, i.e. between roots?
  - What if one didn't intend to remove bone but did anyway?





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7210 Definition: "section of tooth"

- *Requiring section of tooth* questions:
- Is tooth "sectioned" by any intentional split, i.e. with bur, elevator, forceps, osteotome?
- Is tooth "sectioned" by unintentional split, i.e. broken dilacerated roots after attempted forceps removal?
- What if the tooth is partially sectioned prior to extraction by trauma, malignancy, prior Tx, etc?

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Ethical Moment

- How does one code (i.e. charge) when things don't make sense?
  - 7210 Broken down endodontically treated molar. Can remove with elevator 5 min.
  - 7220 ST impaction with 1-2mm inflamed distal coronal tissue. Can remove in ≤ 5 sec.
  - 7240 CB impaction #1. Can remove in ≤ 10 sec.

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Ethical Professional Evaluation

- Codes represent points along the spectrum of 0-100% difficulty for Tx including care, skill, judgment, time, experience*
  - *Ref: Harvard coding development study
  - How should one code if 99% of the way to the "next" code?
  - How should one code if 1% beyond the "last" code?

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Anesthesia Fees, FYI

- Ongoing SDM chart review prompted an e-mail query about correlation between surgical and anesthesia times
- I.E. why were anesthesia times found to be longer than surgical procedure times?
- Answer: A. First the anesthesia, then the surgery. B. There is a difference between single-operator anesthetist anesthesia time and anesthesiologist time.

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Operator-anesthetist

- "Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties." (2009-2010 ADA CDT)

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Dedicated Anesthesiologist

- "Time for anesthesia procedures may be reported as is customary in the local area. Anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under postoperative supervision." (ASA RVS)
  - No CDT codes for this paradigm

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DS conversations: scenario #1

- "I feel sorry for my patients and I want to give them a break, so I code all teeth 7140."
- Guideline: OMS/ER Faculty are to code reasonably pre-op, accurately post-op
- Guideline: When one is in private practice, one can discount ad lib (but must code correctly). UNLV SDM has a fiduciary obligation to the public/taxpayers to code reasonably.

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UNLV SDM Statistics

- Ancient Hx UNLV SDM: 90%+ coded 7140
- 2009 Hx UNLV SDM: 75% coded 7140
- Other SDM's: 50-75% coded 7140
- OMS residencies: Can approach 0% 7140

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DS conversations: scenario #2

- DS: “I’m not sure how to code this”
- Guideline: Neither is OMS faculty. Coding is ultimately determined *during surgery* (i.e. see the Orr inlay/onlay, 1978 NV SBDE exam)
- When reasonable doubt pre-operatively estimate high so SDM can offer a refund rather than be accused of bait and switch by unhappy patients

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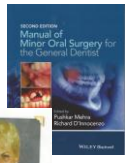
DS conversations scenario #3 cont.



- A reason for the problem:
  - 2015 Manual of Minor Oral Surgery
- Still:

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Scenario #3: Hx last week

- Contrast to last week’s UNLV SDM DS:
  - Tooth pre-op coded 7140
  - DS spent 30 min. with forceps and elevator without successful removal, consulted OMS
  - OMS recommended flap, bone removal prn, sectioning prn, and removal
  - DS proudly reported at 2+ hours tooth removed with forceps/elevator only, “saving patient $$”
  - Duty to patient(s) fulfilled?

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Who Determines the SOC?

- Initially professions
- Secondarily regulators
- Ultimately patients…

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Finis: Emergency Instructions…