Summary of CDT 2018 changes

CDT 2018 is the newest version of the American Dental Association's code on dental procedures and nomenclature. Federal HIPAA law requires that CDT codes be used in electronic health care transactions. When the ADA changes the codes, carriers must adopt the changes. Please use CDT 2018 codes when submitting claims to Dentegra for services you perform on or after January 1, 2018.

The CDT updates for 2018 include 18 new codes, three code deletions and several nomenclature and description revisions. Following is a summary of the changes; please note that coverage for new codes is dependent on the patient's particular benefit plan. The Dentegra Dentist Handbook will be updated to reflect CDT 2018 by January 1, 2018 and is available by logging in to Online Services at dentegra.com/for-providers.

Important Notes:

- CDT coding and nomenclature are the copyright of the American Dental Association and a trademark of the ADA; all rights reserved. There are important differences between Dentegra's plan benefits and processing policies and the descriptors found in the CDT code.
- Fees for disallowed services are not chargeable to the patient or Dentegra.
- Fees for denied services are the responsibility of the patient.
- Text that appears in italics is specifically intended to clarify the delivery of benefits and is not to be interpreted as CDT 2018 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association.

New CDT Codes

D0411 HbA1c in-office point of service testing
This service is not a benefit of most Dentegra plans. The fee is the patient's responsibility.

D5511 Repair broken complete denture base, mandibular
When performed on the mandibular arch, this procedure replaces deleted code D5510 and is subject to the same policy and limitations.

D5512 Repair broken complete denture base, maxillary
When performed on the maxillary arch, this procedure replaces deleted code D5510 and is subject to the same policy and limitations.

D5611 Repair resin partial denture base, mandibular
When performed on the mandibular arch, this procedure replaces deleted code D5610 and is subject to the same policy and limitations.

D5612 Repair resin partial denture base, maxillary
When performed on the maxillary arch, this procedure replaces deleted code D5610 and is subject to the same policy and limitations.

D5621 Repair cast partial framework, mandibular
When performed on the mandibular arch, this procedure replaces deleted code D5620 and is subject to the same policy and limitations.

D5622 Repair cast partial framework, maxillary
When performed on the maxillary arch, this procedure replaces deleted code D5620 and is subject to the same policy and limitations.

D6096 Remove broken implant retaining screw

Procedure D6096 is a benefit only for groups that have implant coverage. The fees for D6096 are denied unless implants are covered by the plan. For plans that do cover implants, procedure D6096 is allowed once per tooth in a 60 month period. The fee for this procedure is included in the fees for placement of the implant or implant supported prosthesis when performed by the same provider/provider office within six months.

D6118 Implant/abutment supported interim fixed denture for edentulous arch – mandibular

This service is not a benefit of most Dentegra plans. The fee is the patient's responsibility.

D6119 Implant/abutment supported interim fixed denture for edentulous arch – maxillary

This service is not a benefit of most Dentegra plans. The fee is the patient's responsibility.

D7296 Corticotomy – one to three teeth or tooth spaces, per quadrant

This service is considered a specialized procedure that is not a benefit of most Dentegra plans. The fee is the patient's responsibility.

D7297 Corticotomy four or more teeth or tooth spaces, per quadrant

This service is considered a specialized procedure that is not a benefit of most Dentegra plans. The fee is the patient's responsibility.

D7979 Non–surgical sialolithotomy

This service should be submitted to the patient's medical carrier as the primary insurer. Please submit an operative report.

D8695 Removal of fixed orthodontic appliances for reasons other than completion of treatment

This service is not a benefit of most Dentegra plans. The fee is the patient's responsibility.

D9222 Deep sedation/general anesthesia – first 15 minutes

Procedure D9222 is a new procedure code with CDT 2018 to be used when billing for the first 15 minutes of deep sedation/general anesthesia. Procedure D9223 is being revised to be used when billing for each additional 15 minutes of deep sedation/general anesthesia. There is no change to policy for general anesthesia. Any combination of D9222 and D9223 is allowed a maximum of four times per date of service; any additional time will be disallowed. Providing more than one hour of deep sedation or general anesthesia for routine dental procedures is unusual and additional submissions will only be considered on a by-report basis. When documentation of exceptional circumstances is submitted, benefits may be approved for additional units of D9223.

D9239 Intravenous moderate (conscious) sedation/ analgesia – first 15 minutes

Procedure D9239 is a new procedure code with CDT 2018 to be used when billing for the first 15 minutes of intravenous moderate (conscious) sedation/analgesia. Procedure D9243 is being revised to be used when billing for each additional 15 minutes of intravenous moderate (conscious) sedation/ analgesia. There is no change to policy for intravenous sedation. Any combination of D9239 and D9243 is allowed a maximum of four times per date of service; any additional time will be disallowed. Providing more than one hour of deep sedation or general anesthesia for routine dental procedures is unusual and additional submissions will only be considered on a by-report basis. When documentation of exceptional circumstances is submitted, benefits may be approved for additional units of D9243.

D9995 Teledentistry – synchronous; real-time encounter

The fees for teledentistry – synchronous are considered inclusive in overall patient management. A separate fee may not be charged to the patient.

D9996 Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review

The fees for teledentistry – asynchronous are considered inclusive in overall patient management. A separate fee may not be charged to the patient.

Deleted CDT Codes

D5510 Repair broken complete denture base

This procedure is being replaced by D5511 (mandibulararch) and D5512 (maxillary arch).

D5610 Repair resin denture base

This procedure is being replaced by D5611 (mandibular arch) and D5612 (maxillary arch).

D5620 Repair cast framework

This procedure is being replaced by D5621 (mandibular arch) and D5622 (maxillary arch).

Processing Policy and Procedure Update (Effective January 1, 2018)

D0273 - D0274 Bitewing Images

For most Dentegra plans, the maximum allowance for bitewing images for patients under age 10 is that of D0272. A D0273 or D0274 submitted for a patient under age 10 will be benefited as D0272 and any fees in excess of the approved amount for D0272 are disallowed.

D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis on a subsequent visit

This procedure is disallowed when performed by the same provider/provider office on the same day as evaluation procedures. A separate fee may not be charged to Dentegra or the patient.

D7960 Frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure

For most Dentegra plans, procedure D7960 is not a covered benefit when performed as a separate procedure. The fee is the patient's responsibility. Procedure D7960 may be reconsidered in cases of ankyloglossia interfering with feeding or speech as diagnosed and documented by a physician. This is usually done in concert with an IBCLC (International Board Certified Lactation Consultant). Adequate records should include pre and postoperative intraoral images, a diagnosis and a description of the procedure in the treatment record.

D7963 Frenuloplasty

For most Dentegra plans, procedure D7963 is not a covered benefit when performed as a separate procedure. The fee is the patient's responsibility. Procedure D7963 may be reconsidered in cases of ankyloglossia interfering with feeding or speech as diagnosed and documented by a physician. This is usually done in concert with an IBCLC (International Board Certified Lactation Consultant). Adequate records should include pre and post op intraoral images, a diagnosis and a description of the procedure in the treatment record.

D9450 Case presentation, detailed and extensive treatment planning

For most Dentegra plans, the fee for procedure D9450 is considered to be included in the fees for oral evaluations, procedure D9450 is not a covered benefit when performed as a separate procedure. The fee is the patient's responsibility. Dentegra may consider D9450 as a separate benefit for complex treatment planning cases involving multiple treatment disciplines and multiple providers of care.

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