Shifting to Medical Insurance As A Dentist

Christine Taxin
Welcome to the Greater New York Dental Meeting

Greater New York Dental Meeting™
Executive Headquarters
200 West 41st Street, Ste. 1101, New York, NY 10036
Tel. (212) 398-6922, Fax. (212) 398-6934
E-mail: victoria@gnydm.com
www.gnydm.com
Sponsored by New York County & Second District Dental Societies

All programs and exhibits are held at the Jacob K. Javits Convention Center (unless otherwise indicated)
11th Avenue between 34th and 39th Street, New York City

General Registration Hours
Friday, November 29          12:00 Noon - 4:30 P.M.
Saturday, November 30         8:00 A.M. - 4:30 P.M.
Sunday, December 1 - Tuesday, December 3
8:00 A.M. - 5:30 P.M.
Wednesday, December 4        8:00 A.M. - 4:30 P.M.

Exhibit Hall Hours
Sunday, December 1 - Tuesday, December 3
9:30 A.M. - 5:30 P.M.
Wednesday, December 4        9:30 A.M. - 5:00 P.M.

COURSE REGISTRATION
Pre-registration is required for all continuing education courses with the exception of the “Live” Dentistry and Affiliated Groups. Your seat will be held for 15 minutes after the start of the course; after that, those without tickets will be seated according to space availability. When the room is filled, no additional people will be admitted due to fire department regulations. If you have not pre-registered, please be prepared to select an alternate session to attend.

Tickets
Tickets are required for all courses excluding Live Dentistry. Tickets for all functions can be purchased at all general registration booths located in the Registration Area on the Upper Level in the Crystal Palace and online.

6 Days of Education Seminars, Hands-on Workshops & Essays
Friday - Wednesday

4 Days of Exhibits
Sunday - Wednesday

FREE “Live” Dentistry
Hi-Tech 450 Seat Arena

SUNDAY
9:45 - 11:45
VOCO America, Inc.
Drs. Ron Kaminer & Marc Geissberger
Restorative

9:45 - 11:45
Shofu
Dr. Ron Kaminer
Restorative

12:00 - 2:00
VOCO America, Inc.
Drs. Ron Kaminer & Marc Geissberger
Restorative

3:30 - 5:15
Phillips Sonicare
Dr. Gerard Kugel
Whitening

3:30 - 5:15
First Fit
Drs. Frederick E. Solomon
Cyrus Tahmasebi
Digital

MONDAY
1:30 - 2:45
Align I Invisalign I Itero
Drs. Karla Soto & Christian Coachman
Restorative

3:30 - 5:15
Shofu
Dr. Ron Kaminer
Restorative

12:00 - 2:00
VOCO America, Inc.
Drs. Ron Kaminer & Marc Geissberger
Restorative

TUESDAY
9:45 - 12:00
Millennium
Dr. Sunil D. Thanik
Laser

2:00 - 4:15
Glidewell
Dr. Justin Chi
Digital

WEDNESDAY
9:45 - 12:00
Apa / CareCredit
Drs. Michael Apa
Aesthetic

2:00 - 4:15
Benco / Vatech
Dr. Aeklavya Panjali
Implant

Celebrity Luncheon Speaker

John Quiñones
Monday, December 2nd
12:00 - 2:00 - Ticket $4010
$125.00

3D Printing & Digital Dentistry Conference

Dental Laboratory Technicians Programs

Sleep Apnea Symposium

Oral Cancer Symposium

WORLD IMPLANT EXPO
5th Annual Global Orthodontic Conference

3rd Annual Pediatric Dentistry Summit

12th Annual
INVISALIGN® - GNYDM EXPO
4 Days of Programming:
Sunday - Wednesday

Botox and Facial Fillers Seminar & Workshop

Over 1,700 Exhibit Booths

BUY A BUNDLE AND SAVE WITH GNYDM’S CE PASSPORT

Obtain more CE Credits and save money by purchasing one of our Education Bundles.

The GNYDM CE Passport Bundle includes Seminar and Essay courses.

When purchasing a bundle, attendees can register for as many Seminars and Essay courses as they want during all six days of the show.

Registration for all courses is required.

$595.00
entitles an individual to take unlimited* seminars and essays

$895.00
entitles a dentist and their entire staff to take unlimited* seminars and essays

*Excludes Workshops, Botox & Fillers, Sleep Symposium and Invisalign

GNYDM’s CE Passport

For more information on GNYDM’s CE Passport, go to www.gnydm.com.
Shifting to Medical Insurance As A Dentist

Presented by:
Christine Taxin Adjunct Professor

I, Christine Taxin, do have a financial affiliation with the organization(s) listed below.
- CareCredit as an Educational Grant Sponsor
- Weave as an Educational Grant Sponsor

All codes are owned by the ADA and the AMA and permission was granted to use for educational purposes.
Thank you for your educational support
Today, your brain is MINE!
The key to all coding both dental, medical and diagnostic coding is to forget what dental plans told you! Keeping updated, knowing the changes and understanding the clues we can get with different questions.

Changes you need to make in order to expand your knowledge.

1. Quit thinking about dental rules. How did this patient lose their teeth, did they have an accident?

2. Do they have an illness?

3. Transform how you think by asking yourself if you want to change.

4. Understand that growth for all of us can only happen if we want it to happen.

Getting Denied!

Why is this listed and then not covered?

This group no longer has that covered
Clinical Template

Make a clinical template with these questions to allow your biller to write a letter of medical necessity. These are the legal requirements for all clinical notes.

1. Subjective: Front Reception Area Administrator
   A. Are there any issues that need to be addressed on your visit during your examination? Do you have any medical issues we need to be aware of?
   B. Do you take any medications both by doctor and over the counter? Yes. No. Please bring a copy of the medications you take.
   C. Name of your doctor and his phone number and permission to ask for your records to collaborate with him on all treatment.
   D. Female/Male Age
      - Please email me a copy (front and back) of both dental and medical insurance. (or you may fax this information)
      - We will send you our package of paperwork to fill out prior to your appointment can you please send me that back to (insert contact name and office address here)

2. Objective: Assistant, Doctor, Hygienist
   A. Take all patient vitals, including blood pressure
   B. Follow doctor and hygiene orders for the following:
      - X-rays, or CBCT (make sure you get verification from Administrator)
      - Saliva
      - Diabetic Blood Testing
      - Pictures
      - Intra oral Diagnostic walk
   C. Documentation
      a. Doctor must tell why he needs any of the tests
      b. Assistant must document why the doctor ordered them
      c. Provider must then document in assessment the outcome of all diagnostic tests.
   D. Make sure the state allows your assistant to perform all the duties listed.

3. Assessment: Doctor, Hygienist, Assistant
   A. Document what clinical examination showed
   B. What test were ordered and what did the test results show?
      a. Read results
      b. Document results
   C. How did you formulate your treatment plan? Did you supply an alternate plan if there is one?
   D. Make sure all forms are signed by assistant before it is handed to financial coordinator.
      a. Informed Refusal
      b. Acceptance of treatment

4. Plan: Financial Coordinator
   a. Following the truth and lending rules and your office manual
   b. Allowing the patient to ask questions while you are documenting into your notes to be compliant
   c. Reviewing all forms again with patient and have them sign all financial forms
   d. If patient wants to think them up with a follow up call to do a meeting with them either by phone, or a compliant site thru the computer.

What did you hear from the story?

1. SUBJECTIVE:
   a. __________
   b. __________
   c. __________

2. OBJECTIVE:
   a. __________
   b. __________
   c. __________

3. ASSESSMENT:
   a. __________
   b. __________
   c. __________

4. PLAN:
   a. __________
   b. __________
   c. __________

What did the story tell you about the patient's medical necessity?

What do you think should be added to the story in order for an insurance company to provide you with payment?

What was missing in any part of the story that will prevent payment?
S.O.A.P. FORMAT

- Subjective
- Objective
- Assessment
- Plan

S=Subjective... are symptoms the patient verbally expresses or are stated by a significant other. Subjective observations include the patients’ description of pain or discomfort, when the problem started, and other indicators and dysfunctions described by the patient.

O=Objective... observations include symptoms that can actually be measured, seen, heard, touched, felt or smelled...i.e., vital signs, radiographs, swelling.

A=Assessment... is the diagnosis of the patient’s condition. Some may be clear where others require additional diagnostic tests.

P=Plan/Procedure... may include other diagnostic tests along with the treatment plan to complete the procedure.

- Add a signature line allowing you to contact their medical provider and ask for his phone number.
- Add a signature line to contact all insurance plans since your doctor wants to help them maximize all benefits if available.
- Ask the medical provider to send a copy of the patients notes with diagnostic codes and email to send them any information related to their patient’s health.
Changes With Attachments

- We also offer FastAttach for medical claim attachments through Vyne Medical and are working to grow our payer list. Contact us to see if the FastAttach medical solution is right for your practice.

- If your medical policy is not set up, ask them to do so! If not ask if you can connect with Vyne Connect since it is compliant.

- Vyne Connect

- Encrypted Email Exchange Now Available with FastAttach.

- Communicate with confidence by sending encrypted emails to patients and referring providers.

Establish medical necessity.
Determine which patients are dentally/medically compromised through our risk and patient forms.
Update medical forms to include the following...
- Patient or family history of:
  A. Heart disease or stroke
  B. Diabetes
  C. Rheumatoid Arthritis
  D. Osteoporosis
  E. Obesity
  F. Artificial Joints
  G. Periodontal Disease
Charles Mayo noted, over 90 years ago, that people who keep their teeth live an average of ten years longer than people who do not.

Your first step in your investigation was established by Charles Mayo! What do you see, what are the patients telling you, what does the patients' medical history and your first exam is telling you.

Practice Growth in the oral system age
So What In Dental Can Be Billed To Medical Insurance?

<table>
<thead>
<tr>
<th>Diagnostics</th>
<th>Medical Treatment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Exams, consults, radiographs and</td>
<td>• Patients with diabetes, epilepsy, heart disease, hormonal conditions, Parkinson’s</td>
</tr>
<tr>
<td>other diagnostics like photos, models,</td>
<td>• Non-trauma related emergency procedures such as incision and drainage,</td>
</tr>
<tr>
<td>and stents</td>
<td>curettage of perio abscesses and irrigation of tissue overlying wisdom teeth</td>
</tr>
<tr>
<td>• Injections that are needed to</td>
<td>• Treatment during pregnancy, especially in high risk patients</td>
</tr>
<tr>
<td>determine cause of pain</td>
<td>• Night guards, TMD orthotics and sleep apnea appliances</td>
</tr>
<tr>
<td>• Bacterial testing</td>
<td>• Fluoride trays for at home use</td>
</tr>
<tr>
<td></td>
<td>• Treatment of effects of long term medication use or conditions as in radiation,</td>
</tr>
<tr>
<td></td>
<td>tetracycline, etc.</td>
</tr>
<tr>
<td></td>
<td>• Periodontal or oral treatment to prepare your patient for joint replacement</td>
</tr>
<tr>
<td></td>
<td>surgery</td>
</tr>
<tr>
<td></td>
<td>• Treatment of chewing/swallowing difficulties</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Surgical Treatment:</th>
<th>Traumatic injury to the oral cavity</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Removal of teeth in non-emergency</td>
<td>• Includes reconstructive, restorative, endodontic, surgical, implant replacement,</td>
</tr>
<tr>
<td>situations</td>
<td>removable and fixed prosthodontic treatment, as well as orthotics and stents.</td>
</tr>
<tr>
<td>• Biopsy or excision of any hard or</td>
<td></td>
</tr>
<tr>
<td>soft tissue lesions,</td>
<td></td>
</tr>
<tr>
<td>• Surgical placement of implants</td>
<td></td>
</tr>
<tr>
<td>and periodontal hard and soft tissue</td>
<td></td>
</tr>
<tr>
<td>procedures (non-cosmetic)</td>
<td></td>
</tr>
<tr>
<td>• Adjustments, suture removal, and</td>
<td></td>
</tr>
<tr>
<td>anesthetic</td>
<td></td>
</tr>
</tbody>
</table>
Demanding Fee Schedule Disclosure

Are your carriers, forthcoming with fee schedule information?

Incorrect payment appeals must be backed up with accurate fee schedule information. However, payment calculations may be affected by several variables including fee schedule modifications, bundling/coding logic and negotiated terms specific to your organization. Therefore, when a claim appears to be underpaid, your appeal may need to seek disclosure of how the payment was calculated. Start with a brief explanation regarding the anticipated payment. Once your expected payment is outlined, ask the carrier to disclose why payment was not made as expected using language such as the following:

- Our review of the provider contract does not reveal any language justifying the current level of payment. In order to assess the accuracy of payment, we request your response regarding how the payment was calculated and what portion of the fee schedule was utilized. It is our position that if terms of the contract are in direct conflict, the higher reimbursement should be allowed. As you are likely aware, many courts have ruled that managed care contracts are contracts of adhesion and that the organization responsible for drafting the contract wording can be responsible for unclear and ambiguous terms.

- Most states have managed care protections, which require managed care organizations to disclose the fee schedule upon contract finalization or upon request by participating providers. Furthermore, states may impose additional restrictions on modifying the fee schedule without prior notification. It is, therefore, important to obtain the fee schedule and keep track of any modifications and the respective implementation dates. For codes that are individually negotiated by your organization, written documentation must be disseminated to the billing and appeal staff so that this documentation can be easily attached to appeals.

Notification language should be negotiated that prohibits fee schedule changes without advance notification to the provider. It is also important to attempt to limit fee schedule changes to an acceptable time span, such as yearly.

Once accurate, up-to-date fee schedule information is obtained, providers with high volume billing will want to consider contract management software which can identify underpaid claims based on loaded fee schedule information.

- Dentists continue to struggle with reimbursement as the market changes. Morgan Staley research firm AlphaWise examined the past and future reimbursement rates for dentists.

Here are five statistics:

1. In 2017, dentist's reimbursement rate dropped 0.7 percent. However, between May 2018 and May 2019, dentists are predicted to experience a 2.7 percent reimbursement rate decline.

2. For orthodontists, reimbursement rates are predicted to drop 4.9 percent. In 2017, the reimbursement rate decreased 4.7 percent.

3. Solo practitioners will see the biggest reimbursement rate decrease at 8.7 percent by May 2019. In 2017, solo practitioners saw a 6.7 percent decline in reimbursement rates.

4. Group practices are expected to see reimbursement rates increase 1.6 percent during the 12-month period. In 2017, the reimbursement rate grew 0.5 percent.

5. In total, dental reimbursement rates are anticipated to drop 3.3 percent.
Reimbursement rates: 2017
-1.7% Dentists
-6.7% Solo Practitioners
-4% Orthodontists

+0.5% Group Practices

Predicted reimbursement rates: 2019
-2.7% Dentists
-8.7% Solo Practitioners
-4.9% Orthodontists

+1.6% Group Practices

-3.3% Resultant total reduction

Dentists continue to struggle with reimbursement as the market changes.

What organizations have said

View of the Commercial Insured Market

Over 40% of the Covered Commercial Members represented in DentaBase®

Over 90% of the covered commercial members had at least one visit in the last 12 months.

Over 150 Million Commercially Insured Members had at least one dental visit in the last 12 months

NADP reports 165 Million Commercially Insured Members
Capping of Non-Covered Services

Alabama    Alaska    Arizona    Arkansas    California    Connecticut    Florida    Georgia    Idaho    Illinois    Iowa    Kansas
Kentucky    Louisiana    Maryland    Minnesota    Mississippi    Missouri    Montana    Nebraska    Nevada    New Jersey    New Mexico    North Carolina
North Dakota    Oklahoma    Oregon    Pennsylvania    Rhode Island    South Dakota    Tennessee    Texas    Virginia    Washington    Wisconsin    Wyoming

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Why are diagnostic codes included in claims filed for dental benefits?

In dental claim filing, CDT codes are used to inform the dental payer of what procedures were performed. Diagnostic codes will identify why that procedure was performed, by informing the payer of the associated disease, illness, symptom or disorder.
While dental insurance is what we do, your oral and overall wellness is what we’re all about. At United Concordia, we’re committed to offering specialized dental plans, tools and educational resources to help our members become or stay as healthy as possible.

**Dental plan enhancements for certain members**

As a United Concordia customer, your employer can choose to offer these dental plan additions designed for members who may benefit from extra care at the dentist.

**Smile for Health® – Wellness**

If you have this benefit through your company, you can receive improved dental coverage if you have one of the following:

- Cerebral vascular disease (including stroke)
- Cardiovascular (heart) disease
- Diabetes
- Lupus

- Oral cancer
- Organ transplant
- Rheumatoid arthritis

**Pregnancy Benefit**

Because a woman’s _dental health can impact her pregnancy_ and vice-versa, most United Concordia plans cover one additional cleaning and certain other services for members who are pregnant.

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**ADA Dental Claim Form Completion Instructions**

*Version 2019 © American Dental Association*

<table>
<thead>
<tr>
<th>Change Description</th>
<th>#</th>
<th>Field Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consistent completion instruction captions for these fields.</td>
<td>8</td>
<td>Policyholder/Subscriber Identifier</td>
</tr>
<tr>
<td>Changed from two check boxes, one for Male (M) and another for Female (F), to three with the third being a box for Unknown (U).</td>
<td>7</td>
<td>Gender</td>
</tr>
<tr>
<td>Addition of NOTE that points to other online guidance on when this information is reported.</td>
<td>14</td>
<td>Area of Oral Cavity</td>
</tr>
<tr>
<td>Consistent instructions for reporting procedures involving multiple teeth</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Addition of NOTE to clarify that tooth numbers are based on morphology, not anatomic location.</td>
<td>27</td>
<td>Tooth Numbers or Letters</td>
</tr>
<tr>
<td>Removal of coding option &quot;B&quot; as it applies to an ICD-10-CM version that is no longer valid for use.</td>
<td>34</td>
<td>Diagnosis Code List Qualifier</td>
</tr>
<tr>
<td>Addition of clarifying NOTE that: a) addresses when this information would be reported, and b) refers to other online guidance for completion when this information is reported.</td>
<td>34a</td>
<td>Diagnosis Code(s)</td>
</tr>
</tbody>
</table>
### ADA American Dental Association® Dental Claim Form

#### Header Information
1. Type of Transaction (Mark all applicable boxes)
   - Statement of Actual Services
   - Request for Predetermination
   - EPSDT / Title XIX
2. Predetermination/Preauthorization Number

#### Record of Services Provided

<table>
<thead>
<tr>
<th>Procedure Date (MM/DD/CCYY)</th>
<th>Procedure Code</th>
<th>Number(s) or Letter(s)</th>
<th>Tooth Surface</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>entire oral cavity</td>
<td>00</td>
<td>upper right quadrant</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>maxillary arch</td>
<td>01</td>
<td>upper left quadrant</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>mandibular arch</td>
<td>02</td>
<td>lower left quadrant</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>lower right quadrant</td>
<td>40</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Enter a letter ("A" through "D") to point to a diagnosis entered in 34A.**

**Enter "AB" in #34 to indicate ICD-10 CM codes.**

**Enter ICD-10-CM diagnosis codes on lines A-D in box 34A.**

#### Missing Teeth Information
- 1
- 2
- 3
- 4
- 5
- 6
- 7

#### Tooth Anatomy

<table>
<thead>
<tr>
<th>Tooth Anatomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
</tr>
<tr>
<td>1 - 16</td>
</tr>
<tr>
<td>Permanent</td>
</tr>
<tr>
<td>17 - 32</td>
</tr>
<tr>
<td>Number</td>
</tr>
<tr>
<td>Maxillary</td>
</tr>
<tr>
<td>Patient Right to Left</td>
</tr>
<tr>
<td>Mandibular</td>
</tr>
<tr>
<td>Patient Left to Right</td>
</tr>
<tr>
<td>Surface</td>
</tr>
<tr>
<td>Mesial</td>
</tr>
<tr>
<td>Occlusal</td>
</tr>
<tr>
<td>Distal</td>
</tr>
<tr>
<td>Incisal</td>
</tr>
<tr>
<td>Buccal</td>
</tr>
</tbody>
</table>

**"X" in columns titled "N/R" - ADA does not recommend reporting any Area of the Oral Cavity or Tooth Anatomy information for that row's CDT code.**

**"Y" in other columns under "Area of the Oral Cavity" or "Tooth Anatomy" - ADA recommends reporting the indicated information for that row's CDT code.**

### Version History

<table>
<thead>
<tr>
<th>Number</th>
<th>Remarks / Change Summary</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Initial publication</td>
<td>Jan 2018</td>
</tr>
<tr>
<td>2</td>
<td>CDT 2019 update</td>
<td>Jan 2019</td>
</tr>
</tbody>
</table>

### CDT Code

<table>
<thead>
<tr>
<th>#</th>
<th>Nomenclature</th>
<th>Area of the Oral Cavity</th>
<th>Tooth Anatomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120</td>
<td>periodic oral evaluation - established patient</td>
<td>X</td>
<td>N/R</td>
</tr>
<tr>
<td>D0140</td>
<td>limited oral evaluation - problem focused</td>
<td>X</td>
<td>N/R</td>
</tr>
<tr>
<td>D0145</td>
<td>oral evaluation for a patient under three years of age and counseling with primary caregiver</td>
<td>X</td>
<td>N/R</td>
</tr>
<tr>
<td>D0150</td>
<td>comprehensive oral evaluation - new or established patient</td>
<td>X</td>
<td>N/R</td>
</tr>
</tbody>
</table>

Billling medical... Where do I start?

Step One: Set up Type 2 NPI online

www.nppes.cms.hhs.gov

To complete the online NPI application, you must first obtain an Identity & Access (I&A) User ID. You may obtain this User ID by accessing https://nppes.cms.hhs.gov and completing steps below:

- Select the Create a Login link on the Individual Provider side of the National Plan and Provider Enumeration System (NPPES) Home page.
- Note: You will be redirected to the I&A website.
- Follow the steps to complete your I&A Registration.
- Once you have successfully obtained an I&A User ID, you may return to the NPPES Home page and log into the NPPES website with your newly created I&A User ID.
- Select the Submit a New NPI Application to begin the NPI application process.
Step Two: Set up a CAQH Proview account

Step Three: Set up medical profiles with insurance companies

- Most medical insurance companies require you have a medical profile or medical pin for your CMS 1500 forms to not be rejected.
- Contact them or apply online to be recognized as a medical provider.
- Ensure this is done before sending out any claims, otherwise claims will be rejected as “Unable to identify provider”.
- You are an oral physician and need to be set up as such with medical insurance for claims to process in their system.
- This can be a lengthy process, sometimes up to 3 months.
- Don’t get frustrated, just understand preparation is involved in being successful!
Step Four: Checking Eligibility & Submitting Pre-authorizations

HTTPS://WWW.AVAILITY.COM/
YOU MAY DO THIS ONLINE AT AVAILITY
REGISTER ONLINE
Availity provides detailed subscriber & plan information at the time the eligibility request is processed.

- In and out of network deductibles, out of pocket information, and coverage percentages displayed on Availity.
- In and out of network coverage can vary greatly.
**Pre-Authorization Info**

**Requested Procedure Code Authorization**

No pre-authorization information was requested.

**Service Level Authorization**

<table>
<thead>
<tr>
<th>Service/Procedure Code</th>
<th>Auth Required?</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic IN NETWORK</td>
<td>AUTH REQUIRED</td>
<td></td>
</tr>
<tr>
<td>Chiropractic NETWORK NOT APPLICABLE</td>
<td>AUTH REQUIRED</td>
<td></td>
</tr>
<tr>
<td>Chiropractic OUT OF NETWORK</td>
<td>AUTH REQUIRED</td>
<td></td>
</tr>
<tr>
<td>Hospital IN NETWORK</td>
<td>AUTH REQUIRED</td>
<td>Inpatient Hospital</td>
</tr>
<tr>
<td>Hospital OUT OF NETWORK</td>
<td>AUTH REQUIRED</td>
<td>Inpatient Hospital</td>
</tr>
<tr>
<td>Hospital - Inpatient IN NETWORK</td>
<td>AUTH REQUIRED</td>
<td>Complex Benefit: Call Plan for Full Benefit Detail</td>
</tr>
<tr>
<td>Hospital - Inpatient OUT OF NETWORK</td>
<td>AUTH REQUIRED</td>
<td>Complex Benefit: Call Plan for Full Benefit Detail</td>
</tr>
</tbody>
</table>

Contact Info:

CLINICAL INTAKE OPERATIONS (505) 343-3725
CLINICAL INTAKE OPERATIONS (505) 765-7851

- Some insurance companies will provide pre-authorization information in the eligibility request.
- Others will allow a pre-authorization request to be created during checking eligibility on Availity.

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**Real-Time Estimates/Claims**

Listed below is an estimate of the cost of the services that are expected to be provided as part of the treatment for your condition or services. Please recognize that this is an estimate and specific details may change between the time the estimate is generated and the final claim is submitted which may affect the amount you will be required to pay. For example, the healthcare provider may deliver services that are not listed here or we may pay claims on your behalf which may lead you to make a deductible or out-of-pocket maximum that may result in changes to your liability amount. However, this estimate accuracy reflects your responsibility amount if a claim for these services was submitted to and paid by the insurance carrier at this point in time.

- **Submitted:** 2018-08-11 13:12:31.710
- **Status:** Estimate - Pre-Determination Pricing Only; No Payment
- **Provider:** [Name (NPI): [Address:]]
- **Network Indicator:** In Network
- **Accept Assignment:** No
- **Estimated Claim Totals:**
  - **Charges:** $598.00
  - **Adjusted:** $0.00
  - **ICD Versions:**
  - **Not Covered:** $0.00
  - **Processed: ICD-10**
  - **Plan Pays:** $763.30
  - **Deductible:** $0.00
  - **Copay:** $0.00
  - **Coinsurance:** $134.70
  - **Total Patient Responsibility:** $134.70
  - **Less HRA Payment:** $0.00
  - **Patient Balance:** $134.70

- **Claim Details:**

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Procedure Code</th>
<th>Charge</th>
<th>Adjusted</th>
<th>Deductible</th>
<th>Copay</th>
<th>Coinsurance</th>
<th>Less HRA Payment</th>
<th>Patient Balance</th>
<th>Plan Pays</th>
<th>Claim Code</th>
</tr>
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<tbody>
<tr>
<td>2018-08-11</td>
<td>99202325</td>
<td>$150.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$114.70</td>
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<td>$154.70</td>
<td>$154.70</td>
<td>1</td>
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<tr>
<td></td>
<td>2018-08-11</td>
<td>$763.30</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$114.70</td>
<td>$0.00</td>
<td>$134.70</td>
<td>$134.70</td>
<td>2</td>
</tr>
</tbody>
</table>

- **Total:** $813.30

- **Care Management:**

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Procedure Code</th>
<th>Care Management Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018-08-11</td>
<td>99202325</td>
<td>000</td>
</tr>
<tr>
<td></td>
<td>2018-08-11</td>
<td>000</td>
</tr>
</tbody>
</table>

- **Procedure Code Descriptions:**

  99202325: OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT TYPICALLY 15-30 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY

- **Reason Codes:**

  2: Coinsurance Amount

- **Resource Key Not Found:** pdf label auth code

---

**Same day exam & TMD Appliance prior authorization**
Most insurances require electronic submission
If submitting a paper claim, it must be typed on the red CMS-1500 claim form
Some claims may also be submitted directly through Availity

Step Five: Select a Clearing House to submit electronic claims

S.O.A.P. FORMAT

- Subjective
- Objective
- Assessment
- Plan

S=Subjective... are symptoms the patient verbally expresses or are stated by a significant other. Subjective observations include the patients’ description of pain or discomfort, when the problem started, and other indicators and dysfunctions described by the patient.

O=Objective... observations include symptoms that can actually be measured, seen, heard, touched, felt or smelled...i.e., vital signs, radiographs, swelling.

A=Assessment... is the diagnosis of the patient’s condition. Some may be clear where others require additional diagnostic tests.

P=Plan/Procedure... may include other diagnostic tests along with the treatment plan to complete the procedure.
The Structure Of An ICD-10-CM

All codes begin with a letter, followed by a series of both numbers and letters.

Dx codes are composed of 3, 4, 5, 6 or 7 characters (digits). The first 3 digits are the category, 4-6 are subcategories to provide greater detail of etiology and anatomical site and severity.

An X is called a placeholder and is used when a code less than six characters needs a 7th.

Selection of Principal Diagnosis

- Codes for symptoms & ill-defined conditions
- Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis
- Two or more diagnoses that equally meet the definition for principal diagnosis
- Two of more comparative or contrasting conditions

- A symptoms followed by contrasting/comparative diagnoses
- Original treatment plan not carried out
- Complications of surgery and other medical care
Example:
Patient is a 12 year old male with caries of the smooth surface of teeth
#31 penetrating the dentin and
#32 limited to the enamel.
K02.62 dental caries penetrating into dentin
K02.61 dental caries limited to enamel

Choose the primary diagnostic code?
Necessary Diabetes Tests

Diabetes is a condition that can affect your entire body. When your blood glucose stays too high for too long, it can lead to problems with your heart, blood vessels, eyes, and kidneys and even your teeth and gums.

By getting regular tests and checkups, you can help control your glucose level and prevent or delay damage caused by high blood glucose. Watching your health closely lets you react to problems early before they get more serious.

Here’s a list of several diabetes-related tests and checkups as well as guidelines for how often each one is needed. Keep in mind that you may need more frequent testing or checkups if you have signs of problems. Your health care provider can suggest the best schedule for you.

A1c test. This blood test shows the average amount of glucose in your blood during the past two to three months. The results indicate how well your blood glucose is controlled and whether your treatment plan needs any changes. Aim for an A1c level of less than 7 percent.

How often. At least two times a year

D0100-D0999 1. Diagnostic New Code

D0412  blood glucose level test – in-office using a glucose meter

This procedure provides an immediate finding of a patient’s blood glucose level at the time of sample collection for the point-of-service analysis.

A blood sample is obtained to measure total (quantitative) blood glucose level.

Use 82948 for blood glucose reagent termination strip. A drop of blood is placed on a reagent strip, which is then compared to a color calibrated scale and a visual determination is made as to the amount of glucose present in the specimen.

Z13.1 Encounter for screening for diabetes mellitus

PLEASE PURCHASE THE UPDATED CDT 2019: DENTAL PROCEDURE CODES FROM WWW.ADA.ORG/EN/PUBLICATIONS/ADA-CATALOG/CDT-PRODUCTS
Diabetic Test

R03.0 Elevated blood pressure reading w/o diagnosis of htn  
R03.1 Nonspecific low blood pressure reading

BLOOD PRESSURE CHART BY AGE

<table>
<thead>
<tr>
<th>Age</th>
<th>Min</th>
<th>Normal</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 12 months</td>
<td>75/50</td>
<td>90/60</td>
<td>110/75</td>
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<tr>
<td>1 to 5 years</td>
<td>80/55</td>
<td>95/65</td>
<td>110/79</td>
</tr>
<tr>
<td>6 to 13 years</td>
<td>90/60</td>
<td>105/70</td>
<td>115/80</td>
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<tr>
<td>14 to 19 years</td>
<td>105/73</td>
<td>117/77</td>
<td>120/81</td>
</tr>
<tr>
<td>20 to 24 years</td>
<td>108/75</td>
<td>120/79</td>
<td>132/83</td>
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<tr>
<td>25 to 29 years</td>
<td>109/76</td>
<td>121/80</td>
<td>133/84</td>
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<tr>
<td>30 to 34 years</td>
<td>110/77</td>
<td>122/81</td>
<td>134/85</td>
</tr>
<tr>
<td>35 to 39 years</td>
<td>111/78</td>
<td>123/82</td>
<td>135/86</td>
</tr>
<tr>
<td>40 to 44 years</td>
<td>112/79</td>
<td>125/83</td>
<td>137/87</td>
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<tr>
<td>45 to 49 years</td>
<td>115/80</td>
<td>127/84</td>
<td>139/88</td>
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<tr>
<td>50 to 54 years</td>
<td>116/81</td>
<td>129/85</td>
<td>142/89</td>
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<tr>
<td>55 to 59 years</td>
<td>118/82</td>
<td>131/86</td>
<td>144/90</td>
</tr>
<tr>
<td>60 to 64 years</td>
<td>121/83</td>
<td>134/87</td>
<td>147/91</td>
</tr>
</tbody>
</table>

SHARE WITH EVERYONE
C9290: Injection, bupivacaine liposome, 1 mg

D9613
INFLTRATION OF SUSTAINED RELEASE THERAPEUTIC DRUG SINGLE OR MULTIPLE SITES

Contact Pacira
www.exparel.com
855-793-3727

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Code Range</th>
<th>Estimated # of Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A00-B99</td>
<td>1,055</td>
<td>Certain infectious and parasitic diseases</td>
</tr>
<tr>
<td>2</td>
<td>C00-D49</td>
<td>1,620</td>
<td>Neoplasms</td>
</tr>
<tr>
<td>3</td>
<td>D50-D89</td>
<td>238</td>
<td>Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism</td>
</tr>
<tr>
<td>4</td>
<td>D00-D89</td>
<td>675</td>
<td>Endocrine, nutritional and metabolic diseases</td>
</tr>
<tr>
<td>5</td>
<td>F01-F99</td>
<td>724</td>
<td>Mental, behavioral and Neurodevelopmental disorders</td>
</tr>
<tr>
<td>6</td>
<td>G00-G99</td>
<td>591</td>
<td>Diseases of the nervous system</td>
</tr>
<tr>
<td>7</td>
<td>H00-H59</td>
<td>2,452</td>
<td>Diseases of the eye and adnexa</td>
</tr>
<tr>
<td>8</td>
<td>H60-H95</td>
<td>642</td>
<td>Diseases of the ear and mastoid process</td>
</tr>
<tr>
<td>9</td>
<td>J00-J99</td>
<td>1,254</td>
<td>Diseases of the circulatory system</td>
</tr>
<tr>
<td>10</td>
<td>J00-J99</td>
<td>336</td>
<td>Diseases of the respiratory system</td>
</tr>
<tr>
<td>11</td>
<td>K00-K95</td>
<td>706</td>
<td>Diseases of the digestive system</td>
</tr>
<tr>
<td>12</td>
<td>L00-L99</td>
<td>769</td>
<td>Diseases of the skin and subcutaneous tissue</td>
</tr>
<tr>
<td>13</td>
<td>M00-M99</td>
<td>6,339</td>
<td>Diseases of the musculoskeletal system and connective tissue</td>
</tr>
<tr>
<td>14</td>
<td>N00-N99</td>
<td>591</td>
<td>Diseases of the genitourinary system</td>
</tr>
<tr>
<td>15</td>
<td>O00-O99A</td>
<td>2,155</td>
<td>Pregnancy, childbirth and the puerperium</td>
</tr>
<tr>
<td>16</td>
<td>P00-P96</td>
<td>417</td>
<td>Certain conditions originating in the perinatal period</td>
</tr>
<tr>
<td>17</td>
<td>Q00-Q99</td>
<td>790</td>
<td>Congenital malformations, deformations and chromosomal abnormalities</td>
</tr>
<tr>
<td>18</td>
<td>R00-R99</td>
<td>639</td>
<td>Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified</td>
</tr>
<tr>
<td>19</td>
<td>S00-T88</td>
<td>39,659</td>
<td>Injury, poisoning and certain other consequences of external causes</td>
</tr>
<tr>
<td>20</td>
<td>V00-V99</td>
<td>6,812</td>
<td>External causes of morbidity</td>
</tr>
<tr>
<td>21</td>
<td>Z00-Z99</td>
<td>1,178</td>
<td>Factors influencing health status and contact with health services</td>
</tr>
</tbody>
</table>

DENTAL

TMJ

Pregnant Pt

Congenital

Signs / Symptoms and Abnormal Findings

Injury / Trauma

Backup Info

Backup Info
### K00-K14 Diseases of oral cavity and salivary glands (K00-K14)

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K00.0 - K00.9</td>
<td>K00 Disorders of tooth development and eruption</td>
</tr>
<tr>
<td>K01.0 - K01.1</td>
<td>K01 Embedded and impacted teeth</td>
</tr>
<tr>
<td>K02.3 - K02.9</td>
<td>K02 Dental caries</td>
</tr>
<tr>
<td>K03.0 - K03.9</td>
<td>K03 Other diseases of hard tissues of teeth</td>
</tr>
<tr>
<td>K04.01 - K04.99</td>
<td>K04 Diseases of pulp and periapical tissues</td>
</tr>
<tr>
<td>K05.00 - K05.6</td>
<td>K05 Gingivitis and periodontal diseases</td>
</tr>
<tr>
<td>K06.010 - K06.9</td>
<td>K06 Other disorders of gingiva and edentulous alveolar ridge</td>
</tr>
<tr>
<td>K08.0 - K08.9</td>
<td>K08 Other disorders of teeth and supporting structures</td>
</tr>
<tr>
<td>K09.0 - K09.9</td>
<td>K09 Cysts of oral region, not elsewhere classified</td>
</tr>
<tr>
<td>K11.0 - K11.9</td>
<td>K11 Diseases of salivary glands</td>
</tr>
<tr>
<td>K12.0 - K12.39</td>
<td>K12 Stomatitis and related lesions</td>
</tr>
<tr>
<td>K13.0 - K13.79</td>
<td>K13 Other diseases of lip and oral mucosa</td>
</tr>
<tr>
<td>K14.0 - K14.9</td>
<td>K14 Diseases of tongue</td>
</tr>
</tbody>
</table>

### K00 Disorders of tooth development and eruption

**Excludes2:** embedded and impacted teeth (K01.-)

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>K00.0</td>
<td>Anodontia</td>
</tr>
<tr>
<td>K00.1</td>
<td>Supernumerary teeth</td>
</tr>
<tr>
<td>K00.2</td>
<td>Abnormalities of size and form of teeth</td>
</tr>
<tr>
<td>K00.3</td>
<td>Mottled teeth</td>
</tr>
<tr>
<td>K00.4</td>
<td>Disturbances in tooth formation</td>
</tr>
<tr>
<td>K00.5</td>
<td>Hereditary disturbances in tooth structure, NEC</td>
</tr>
<tr>
<td>K00.6</td>
<td>Disturbances in tooth eruption</td>
</tr>
<tr>
<td>K00.7</td>
<td>Teething syndrome</td>
</tr>
<tr>
<td>K00.8</td>
<td>Other disorders of tooth development</td>
</tr>
<tr>
<td>K00.9</td>
<td>Disorder of tooth development, unspecified</td>
</tr>
</tbody>
</table>
Teledentistry

- D0190 screening of patient
- D0220 intraoral periapical first radiographic image
- D0230 intraoral periapical each additional periapical image
- D0350 2D oral/facial photographic image obtained intra orally or extra orally
- D0351 3D photographic image
- D9996 Teledentistry
- Or D9995 Teledentistry

D9995 teledentistry – synchronous; real-time encounter Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service.

D9996 teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service.

Appendix 1

Special Claim Completion Instructions – Coding a Teledentistry Event

A teledentistry event claim or encounter submission involves reporting the appropriate Place of Service (POS) code and CDT Code.

- POS code 02 (Telehealth – the location where health services and health related services are provided or received, through telecommunication technology) was added to that code set effective January 1, 2017.

- CDT Codes D9995 and D9996 are effective January 1, 2018. These codes are reported in addition to other services (e.g., diagnostic) reported separately when the patient presents for care. They document services provided by the dentist, or other practitioner providing care, who is not in direct contact with the patient at the time of the encounter.

These instructions apply only to the ADA Dental Claim Form. Please contact your practice management system vendor for guidance when reporting D9995 or D9996 on the HIPAA standard electronic dental claim (837D v 5010).

POS code 02 is recorded in Item # 38 on the claim form.
Conditions you see every day! Contact GC America for Saliva Tests
Michele Petre 914-233-3685

K11.7 - Disturbances of salivary secretion
Hypoptyalism
Ptyalism
Xerostomia

R68.2 - Dry mouth, unspecified

K03.2 - Erosion of teeth
Erosion of teeth due to diet
Erosion of teeth due to drugs and medicaments
Erosion of teeth due to persistent vomiting
Erosion of teeth NOS
Idiopathic erosion of teeth
Occupational erosion of teeth

M35.00 - Sicca syndrome, unspecified

M35.01 - Sicca syndrome with keratoconjunctivitis

• Alleviating dry mouth caused by certain medications and medical treatments
• Reducing high oral acid levels from excessive soft-drink consumption, although the best treatment is to avoid consumption of soft drinks
• Helping with tooth sensitivity before or after professional cleaning
• Helping pregnant women who may have high oral acid levels associated with pregnancy
• Buffering acids produced by oral bacteria and plaque
• Preventing white spot lesions that can occur during orthodontic treatment
• Providing a topical coating to ease suffering from acid erosion, caries and conditions arising from dry mouth, often medication-induced MI Paste

D2940 - Protective restoration Direct placement of a restorative material to protect tooth and/or tissue form. This procedure may be used to relieve pain, promote healing, or prevent further deterioration. Not to be used for endodontic access closure, or as a base or liner under a restoration.

Related ICD-10-CM Codes:

11. Diseases of the digestive system (K00-K95)
K00-K14 Diseases of oral cavity and salivary glands (K00-K14)
  K02 Dental caries
    K02.3 Arrested dental caries
    K02.5 Dental caries on pit and fissure surface
    K02.6 Dental caries on smooth surface
    K02.7 Dental root caries
    K02.9 Dental caries, unspecified
  K03 Other diseases of hard tissues of teeth
    K03.2 Erosion of teeth
    K03.8 Other specified diseases of hard tissues of teeth
    K03.81 Cracked tooth
• “More than 800,000 annual ER visits arise from preventable dental problems,” says Dr. Allen Willis Kennerly, an orthodontist. Dr. Glassman adds that this year alone 50,000 people will be diagnosed with oral cancer, adding, “Probably 10,000 of those people will die, but these are things that if caught really early can be better treated, before they spread and metastasize.”

D0417 – collection and preparation of saliva sample for laboratory diagnostic testing

Cross Codes
82397 – Chemiluminescent assay
87070 – Culture, bacterial: any other source except urine, blood, or stool, aerobic with, isolation and presumptive identification of isolates
87071 - Culture, bacterial: aerobic with, isolation and presumptive identification of isolates, any other source except urine, blood, or stool
87081 – Culture presumptive, pathogenic organisms, screen only;
87181 – Susceptibility studies, antimicrobial agent, agar dilution method, per agent(eg, antimicrobial gradient strip)
87999 - Unlisted microbiology procedure
99001 – handling and/or conveyance of specimen for the transfer from the patient in other than an office to a laboratory (distance may be indicated)
K09.8  Other cysts of oral region, not elsewhere classified
M34.9  Systemic involvement of connective tissue, unspecified
40799  Unlisted procedure, lips
Always specify the area in the oral cavity
Staging and Grading Periodontitis

The 2017 World Workshop on the Classification of Periodontal and Peri-Implant Diseases and Conditions resulted in a new classification of periodontitis characterized by a multidimensional staging and grading system. The charts below provide an overview. Please visit perio.org/2017wwdc for the complete suite of reviews, case definition papers, and consensus reports.

**PERIODONTITIS: STAGING**

Staging intends to classify the severity and extent of a patient's disease based on the measurable amount of destroyed and/or damaged tissue as a result of periodontitis and to assess the specific factors that may attribute to the complexity of long-term case management.

Initial stage should be determined using clinical attachment loss (CAL). If CAL is not available, radiographic bone loss (RBL) should be used. Tooth loss due to periodontitis may modify stage definition. One or more complexity factors may shift the stage to a higher level. See perio.org/2017wwdc for additional information.

<table>
<thead>
<tr>
<th>Periodontitis</th>
<th>Stage I</th>
<th>Stage II</th>
<th>Stage III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interdental CAL (at site of greatest loss)</td>
<td>1 – 2 mm</td>
<td>3 – 4 mm</td>
<td>≥ 5 mm</td>
</tr>
<tr>
<td>Severity</td>
<td>RBL</td>
<td>Coronal third (&lt;15%)</td>
<td>Coronal third (15% - 33%)</td>
</tr>
<tr>
<td>Tooth loss (due to periodontitis)</td>
<td>No tooth loss</td>
<td></td>
<td>≤ 4 teeth</td>
</tr>
</tbody>
</table>
| Local | • Max. probing depth ≤ 4 mm | • Max. probing depth ≤ 5 mm | • Mostly horizontal bone loss | In addition to Stage II complexity:
  • Probing depth ≤ 6 mm
  • Vertical bone loss ≤ 3 mm |

Training for Hygiene will be at the Insurance Extravaganza.
Step 1: Initial Case Overview to Assess Disease

Screen:
- Full mouth probing depths
- Full mouth radiographs
- Missing teeth

Mild to moderate periodontitis will typically be either Stage I or Stage II
Severe to very severe periodontitis will typically be either Stage III or Stage IV

Step 2: Establish Stage

For mild to moderate periodontitis (typically Stage I or Stage II):
- Confirm clinical attachment loss (CAL)
- Rule out non-periodontitis causes of CAL (e.g., cervical restorations or caries, root fractures, CAL due to traumatic causes)
- Determine maximum CAL or radiographic bone loss (RBL)
- Confirm RBL patterns

For moderate to severe periodontitis (typically Stage III or Stage IV):
- Determine maximum CAL or RBL
- Confirm RBL patterns
- Assess tooth loss due to periodontitis
- Evaluate case complexity factors (e.g., severe CAL frequency, surgical challenges)

Step 3: Establish Grade

- Calculate RBL (% of root length x 100) divided by age
- Assess risk factors (e.g., smoking, diabetes)

What type of Insurance is it?
Patients with Embedded Dental

Keep smiling. It's never been easier.

With a dental plan this simple, you can keep it healthy and keep smiling for all the years to come. The AARP Dental Insurance Plan is insured and administered by Delta Dental Insurance Company. Designed exclusively for AARP members, it offers wide-ranging coverage and quality dentists at affordable rates to fit the needs of you and your family. You wear your smile every day—start protecting it today.

Another way AARP brings you Real Possibilities.

Get your free information guide from Delta Dental

- Visit aarpdental.com/info
- Mail the attached postage-paid card
- Call toll-free at 1-866-583-2084 (TTY: 1-800-735-2929)

AARP Dental Insurance Plan
administered by:
Delta Dental Insurance Company

There is no such thing as just Medicare

10,000/day started 1-1-11
Talk to Jan Palmer about Medicare!

- Jan Palmer
- 617-933-8420
- jan@dentmedins.com

### Payment Amounts – Participating and Nonparticipating Providers and Suppliers

<table>
<thead>
<tr>
<th>Amount</th>
<th>Participating Provider/Supplier</th>
<th>Nonparticipating Provider/Supplier Who Accepts Assignment</th>
<th>Nonparticipating Provider/Supplier Who Does Not Accept Assignment</th>
</tr>
</thead>
<tbody>
<tr>
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<td>$250.00</td>
<td>$250.00</td>
</tr>
<tr>
<td>PFS Allowed Amount</td>
<td>$200.00</td>
<td>$190.00</td>
<td>$190.00</td>
</tr>
<tr>
<td>80 Percent of PFS Allowed Amount</td>
<td>$160.00</td>
<td>$152.00</td>
<td>$152.00</td>
</tr>
<tr>
<td>Beneficiary Amount Due to Provider/Supplier (after deductible has been met)</td>
<td>$40.00 Coinurance</td>
<td>$38.00 Coinurance</td>
<td>$66.50 Coinurance + Limiting Charge Portion</td>
</tr>
<tr>
<td>Total Payment to Provider/Supplier (payment for nonassigned claims goes to the beneficiary, who is responsible for paying provider/Supplier)</td>
<td>$200.00</td>
<td>$190.00</td>
<td>$218.50</td>
</tr>
</tbody>
</table>
70150  Cone Beam CT for maxilla TC D0382
70110  Cone Beam CT for mandible TC D0381
70486  Cone Beam CT for Both Arches TC D0383
76376  Cone Beam CT of Mandible Arch IN OFFICE D0365
76377  Cone Beam CT of Maxilla Arch IN OFFICE D0366
70320  Intraoral complete series of radiographic images
70300  Intraoral first radiographic image
70355  Panorex
70350  Cephalogram, orthodontic
70486  Cone beam CT capture & interpretation with limited field of view- less than one whole jaw
76380  Computed tomography, limited or localized follow up
70490  Computed tomography, soft tissue neck; without contrast material (sleep apnea)

Using A Modifier and what it means for payment!

The suppliers of the technical component:
• TC = taking the film

The professional component is not subject to the accreditation process.
• PC = Professional Component

On claim use 26 on claim form if you are not reading the film.

At this time some states require, but Medicare requires in all states.
$581.24 \times 30 = $139,000 per year

**Service Line Information**

<table>
<thead>
<tr>
<th>Begin Service Date</th>
<th>End Service Date</th>
<th>Rendering NPI</th>
<th>Paid Units</th>
<th>Proc/Rev Code</th>
<th>Mod</th>
<th>Billed Amount</th>
<th>Allowed Amount</th>
<th>Deduct Amount</th>
<th>Coins Amount</th>
<th>CoPay Amount</th>
<th>Late Filing Red.</th>
<th>Other Adjustments</th>
<th>Provider</th>
<th>Paid</th>
<th>Remark Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/20/2014</td>
<td>5/20/2014</td>
<td>1</td>
<td>92242,25</td>
<td>$200.00</td>
<td>$75.07</td>
<td>$0.00</td>
<td>$30.35</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$124.13</td>
<td>PR-45</td>
<td>$45.52</td>
<td>M15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5/20/2014</td>
<td>5/20/2014</td>
<td>1</td>
<td>70486</td>
<td>$1,500.00</td>
<td>$698.40</td>
<td>$0.00</td>
<td>$387.76</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$530.60</td>
<td>PR-45</td>
<td>$381.64</td>
<td>M15</td>
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<td></td>
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<tr>
<td>5/20/2014</td>
<td>5/20/2014</td>
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<td>70376</td>
<td>$300.00</td>
<td>$9.00</td>
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<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$300.00</td>
<td>PR-234</td>
<td>$0.00</td>
<td>M15</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SERVICE LINE TOTALS:**

- Claim Adjustments: $0.00
- Billed Amount: $4,935.32
- Allowed Amount: $2,496.54
- Deduct Amount: $636.22
- Coins Amount: $0.00
- CoPay Amount: $0.00
- Late Filing Red.: $1,908.46
- Other Adjustments: $1,254.32
- Total Paid: $1,254.32

**Service Line Status**

Show/Hide Status Messages

<table>
<thead>
<tr>
<th>From Service Date</th>
<th>To Service Date</th>
<th>Procedure Code</th>
<th>Revenue Code</th>
<th>Modifier</th>
<th>Quantity</th>
<th>Billed Amount</th>
<th>Paid Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/29/2016</td>
<td>10/29/2016</td>
<td>70486</td>
<td></td>
<td>1</td>
<td></td>
<td>$295.00</td>
<td>$202.22</td>
</tr>
</tbody>
</table>

Status: Finalized/Payment. The Claim/Line has been paid.
Processed according to contract provisions (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services). Status Date: 04/11/2017

Total: $295.00, $202.22
Could you tell an insurance company why you need to treat in order to help your patient?

Signs and/or symptoms may be reported as primary diagnostic code for pre-authorization •
Signs/Symptoms
M26.60: Temporomandibular joint disorder, unspecified
M26.632: Articular disc disorder of left temporomandibular joint
<table>
<thead>
<tr>
<th>K08.412</th>
<th>Partial loss of teeth due to trauma, class II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y04.0XXA</td>
<td>Assault by unarmed brawl or fight, initial encounter</td>
</tr>
</tbody>
</table>

**Implant**

**Bone Graft**

**What NPI number do you put in service facility?**

**What type of claim is this?**

**What type of treatment was completed and why is it listed that way?**