

Blue Shield Report

A NEWSLETTER FOR PROFESSIONAL PROVIDERS AND THEIR STAFF MEMBERS

October 13, 2000

D-1-00

Bundle up! Current Dental Terminology codes billing.

Currently, Blue Cross and Blue Shield of Kansas (BCBSKS) allows separate payment for Current Dental Terminology (CDT) codes D0270, D0272 and D0274. This was to accommodate the billing of seven vertical bitewing x-rays. CDT-3 2000 coding now has a pure code for seven vertical bitewings, D0277, therefore BCBSKS will again bundle the bitewing x-rays.

For example, if a claim is billed with a combination of D0270 and D0272, three bitewing films total, it will be bundled and paid as D0274, four bitewing films. The following chart demonstrates some of the most frequently billed code combinations that are effective November 15, 2000.

CDT code billed:	With code:	Bundled as:
D0270 bitewing - single film	D0272 bitewings - two films	D0274 bitewings - four films
D0274 bitewings - four films	D0272 bitewings - two films & D0270 bitewing - single film	D0274 bitewings - four films
D0274 bitewings - four films	D0274 bitewings - four films	Denied as duplicate. Only one unit is allowed per date of service.

Count your teeth!

When using the CDT code D4341 for periodontal scaling and root planing, it is important to bill the appropriate modifiers based on the number of teeth being treated and the case type (see table). BCBSKS staff will no longer change coding to recognize case types. As a billing aid, the case type definitions are included with this newsletter. See attachment number one.

Key to this Issue:

- ◆ CDT billing bundling for bitewings.
- ◆ Billing D4341 with appropriate modifiers.
- ◆ Crowns and prosthetics.
- ◆ "D" codes versus "O" codes.
- ◆ Attachment: Atridox, Actisite and PerioChip guides.
- ◆ Attachment: "Who To Call" phone list.

ACKNOWLEDGEMENT:

CDT five-digit codes, nomenclature and other data are copyright 1994 American Dental Association. All Rights Reserved. No fee schedules, basic unit, relative values or related listings are included in CDT. The ADA assumes no liability for the data contained herein.

QUESTIONS:

Contact your Professional Relations Representative, or the Professional Relations Hotline at 1-800-432-3587, or in the Topeka area, 785-291-7060.

OUR WEB ADDRESS:

<http://www.bcbsks.com>

The Blue Shield Report is Published by your Professional Relations Department

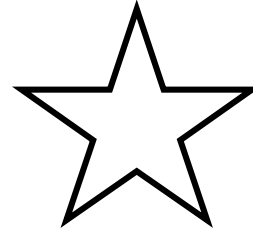
D4341	3 or more teeth, case type 2
D4341 ⁵²	1-2 teeth, regardless of case type. Each tooth must be indicated on a separate line item.
D4341 ²²	3 or more teeth, case type 3-4. The service required is greater than that usually required for the listed procedure.

Please remember that the periodontal chart must be attached to all claims when billing the D4341 CDT code.



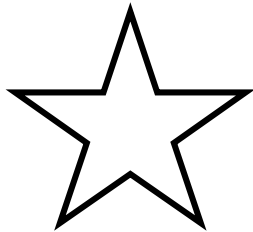
Billing crowns and prosthetics.

Two quick reminders about billing crowns and prosthetics: Fillings, core build-ups and pins will be denied as content of service, when provided on the same day as crowns and prosthetics. Crowns and prosthetics are to be billed on the day they are seated.



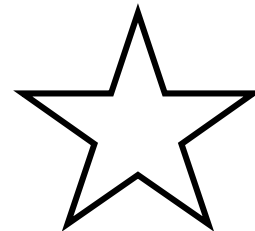
CDT "D" and "O" Codes

The Blue Shield Report issue D-2-99 raised question to the use of "D" and "O" codes with the implementation of the CDT-3 Coding Manual Change in January of 2000. After January 1, 2001, only the CDT-3 "D" codes will be accepted. All claims submitted with the "O" codes will be returned for invalid code.



Dental Manuals 2001

Announcement was made at the August 2000 Dental Workshop that the dental manuals would be issued this fall. The manual is currently being updated and revised for improved clarity and accuracy. In order to provide the most current and accurate information, the manuals are expected to be issued the first quarter of 2001.



Attachment Number One: Helpful Guidelines and Policies

To assist in submitting your claims for maximum reimbursement, the following guidelines and policies are provided.

Case Types and Guides

When submitting services for scaling and root planing procedures, please use the following descriptions and guidelines.

A. Case Type I

Gingivitis - Inflammation of the gingival tissue accompanied with bleeding.

Submit claims using code D4355, full mouth debridement.

B. Case II

Early Periodontitis - Inflammation and bleeding of the gingival tissue, with pocket depths of 3 - 4 mm between teeth and gums in one or more areas of the mouth. X-rays could display slight bone loss horizontally.

Submit claims using code D4341* and attach a copy of the predetermination. If a predetermination has not been obtained, the case type, periodontal chart, treatment plan, and x-rays will need to be included.

* If billing one or two teeth per quadrant, use code D4341 with modifier 52 and list the tooth number(s).

C. Case Type III

Moderate Periodontitis - Inflammation and bleeding with possible abscesses, pocket depths ranging from 4-6 mm. X-rays display horizontal and angular bone loss. Tooth mobility could occur, may see furcation in multi-rooted teeth.

Submit claims using code D4341*, with modifier 22, per quadrant, and attach a copy of the predetermination. If a predetermination has not been obtained, the case type, periodontal chart, treatment plan, and x-rays will need to be included.

* If billing one or two teeth per quadrant, use code D4341 with modifier 52 and list the tooth number(s).

D. Case Type IV

Advanced Periodontitis - Severe bone loss had occurred horizontally and angularly causing the teeth to shift, may see furcation in multi-rooted teeth. Pocket depths are in excess of 6 mm.

Submit claims using code D4341*, with modifier 22, per quadrant, and attach a copy of the predetermination. If a predetermination has not been obtained, the case type, periodontal chart, treatment plan, and x-rays will need to be included.

- * If billing one or two teeth per quadrant, use code D4341 with modifier 52 and list the tooth number(s).

Note: When a patient has more than one case type present, the case type most prevalent indicates the classification.

PERIODONTAL THERAPY WITH A CONTROLLED CHEMOTHERAPY AGENT (I.E., ACTISITE®, ATRIDOX™, PERIOCHIP®)

D4381 Localized delivery of chemotherapeutic agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.

NOTE: This procedure code is to be billed PER TOOTH, not per quadrant, as the nomenclature ascribes.

An example of the Blue Cross and Blue Shield Medical Necessity Form for Periodontal Therapy with a Controlled Chemotherapy Agent accompanies this attachment. This form, including the perio chart, must be completed and attached to each claim or predetermination for the following periodontal therapies.

ACTISITE®

Placement of ACTISITE®, periodontal fiber therapy, is reimbursed when the patient/insured has coverage for periodontal services and meets the following criteria:

1. Patient has a diagnosis of periodontitis. (Abscess is not an indication for treatment with periodontal fiber therapy.)
2. Patient has a history of prior mechanical intervention (i.e., scaling and root planing/surgery) within the past 12 months. Patient must have followed the periodontal treatment plan during that time period.
3. Disease is localized. No more than two teeth per quadrant are affected. Three or more teeth/quadrant are considered generalized disease and will be denied as not medically necessary.
4. Unstable pocket depths of 5 to 8 mm subject to bleeding upon probing.
5. Coverage may also be provided to patients with unstable pocket depths greater than 8 mm who have bleeding upon probing and less than stage two mobility. BCBSKS dental consultant will review these claims for individual consideration. X-rays and a copy of the perio chart must be attached to the claim.

6. The aforementioned medical necessity form must be completed and attached to each claim or predetermination.
7. Scaling and root planing done at the time of the placement of fibers, replacement of lost fibers, or removal of fibers are considered content of service of the placement. Re-treatment with periodontal fibers within 12 months of previous treatment will be denied as not medically necessary.

ATRIDOX™

Placement of ATRIDOX®, 8.5% doxycycline in the Atrigel® Delivery System, is reimbursed when the patient/insured has coverage for periodontal services and meets the following criteria.

1. Patient has a diagnosis of periodontitis. (Abscess is not an indication for treatment with ATRIDOX™ therapy.)
2. Patient has a history of prior mechanical intervention (i.e., scaling and root planing/surgery) within the past 12 months. Patient must have followed the periodontal treatment plan during that time period.
3. Disease is localized. No more than two teeth per quadrant are affected. Three or more teeth/quadrant are considered generalized disease and will be denied as not medically necessary.
4. Unstable pocket depths of 5 to 8 mm subject to bleeding upon probing.
5. Coverage may also be provided to patients with unstable pocket depths greater than 8 mm who have bleeding upon probing and less than stage two mobility. BCBSKS dental consultant will review these claims for individual consideration. X-rays and a copy of the perio chart must be attached to the claim.
6. The aforementioned medical necessity form must be completed and attached to each claim or predetermination.
7. Scaling and root planing done at the time of the placement of ATRIDOX™, replacement of ATRIDOX™, or removal of ATRIDOX™ are considered content of service of the placement. Re-treatment with ATRIDOX™ within 12 months of previous treatment will be denied as not medically necessary.

PERIOCHIP®

Placement of the PerioChip® will be reimbursed when the insured has coverage for periodontal services and meets the following criteria.

1. Patient has a diagnosis of periodontitis (abscess is not an indication for treatment with a PerioChip®).
2. Patient has a history of prior mechanical interventions (i.e., scaling and root planing, surgery) within the past 12 months

3. Disease is localized. No more than three teeth per quadrant. Four or more would be considered generalized disease and denied as not medically necessary.
4. Have unstable pocket depths of 5 – 8 mm.
5. Not to be used for pediatric cases.
6. The aforementioned medical necessity form must be completed and attached to each claim or predetermination.
7. Replacement of a lost PerioChip®, or removal of the PerioChip® are considered content of service of the placement. Re-treatment within 12 months of previous treatment will be denied as not medically necessary.
8. Reimbursement for individual placement of a PerioChip® at the time of maintenance recall visit(s) includes scaling and root planing of the tooth.

BLUE CROSS AND BLUE SHIELD OF KANSAS MEDICAL NECESSITY FORM FOR
PERIODONTAL THERAPY WITH A CONTROLLED CHEMOTHERAPY AGENT

PATIENT NAME: _____ ID#: _____

TOOTH/TEETH INVOLVED: _____

Chemotherapy Agent Used: _____

Please check appropriate indications below. Also please include significance of this tooth/teeth such as root anatomy factors, loss of adjacent teeth, etc.

bleeding on probe unstable pocket depths severe gingival inflammation
 furcation involvement mobility

Please list previous treatments including maintenance, planing and scaling, surgeries, and prior periodontal therapy with a controlled chemotherapy agent.

FREQUENCY OF MAINTENANCE

3 Months 6 Months Yearly Date of Last Visit: _____
 Other: _____

DATES OF SCALING AND ROOT PLANING:

Quadrant I: _____ Quadrant II: _____
 Quadrant III: _____ Quadrant IV: _____

DATES OF PERIODONTAL SURGICAL THERAPY:

Quadrant I: _____ Quadrant II: _____
 Quadrant III: _____ Quadrant IV: _____

PRIOR PERIODONTAL THERAPY WITH A CONTROLLED CHEMOTHERAPY AGENT:

Quadrant I: _____ Quadrant II: _____
 Quadrant III: _____ Quadrant IV: _____

LONG RANGE TREATMENT PLAN:

Proposed treatment plan for periodontal therapy with a controlled chemotherapy agent (include the number of teeth being treated at each appointment)

Appointment #1 - Teeth #'s: _____

Appointment #2 - Teeth #'s: _____

Appointment #3 - Teeth #'s: _____

Please attach a copy of the perio chart. Also include x-ray(s) if teeth have advanced mobility/disease.