CDT: Code on Dental Procedures and Nomenclature

The purpose of the CDT Code is to achieve uniformity, consistency and specificity in accurately documenting dental treatment. One use of the CDT Code is to provide for the efficient processing of dental claims, and another is to populate an Electronic Health Record. On August 17, 2000 the CDT Code was named as a HIPAA standard code set. Any claim submitted on a HIPAA standard electronic dental claim must use dental procedure codes from the version of the CDT Code in effect on the date of service. The CDT Code is also used on paper dental claims, and the ADA’s paper claim form data content reflects the HIPAA electronic standard.

Code Maintenance Committee (CMC)

CDBP established its Code Maintenance Committee to ensure that all stakeholders have an active role in evaluating and voting on CDT Code changes. It is the body that votes to accept, amend or decline requests. The CMC is expected to arrive at decisions that are in the best interests of the profession and patients, and third-party payers/administrators. CMC membership is:

- Five representatives from the American Dental Association, one of whom will serve as chair
- One representative from each of the nine recognized dental specialty organizations
  - American Academy of Oral and Maxillofacial Pathology
  - American Academy of Oral and Maxillofacial Radiology
  - American Academy of Pediatric Dentistry
  - American Academy of Periodontology
  - American Association of Endodontists
  - American Association of Oral and Maxillofacial Surgeons
  - American Association of Orthodontists
  - American Association of Public Health Dentistry
  - American College of Prosthodontics
- One representative from the Academy of General Dentistry
- One representative from each of the following third-party payer organizations
  - America’s Health Insurance Plans
  - Blue Cross and Blue Shield Association
  - Centers for Medicare and Medicaid Services
  - Delta Dental Plans Association
  - National Association of Dental Plans
- One representative from the American Dental Education Association
Explanation of Fees, Insurances, and Patient’s Responsibility

In adherence with established industry standards, our office will precisely follow the Current Dental Terminology (CDT) and claim guidelines as determined by the Code Maintenance Committee (CMC). However, some insurance companies errantly state policies outside these parameters by either “bundling” several codes together or disallowing certain codes or combinations of codes. These are not only illogical assertions but they are unsanctioned by the CMC as described above.

For example, it is becoming more common for some insurance companies to disallow DIAGNOSTIC procedures from being claimed the same day as TREATMENT procedures. As you the patient might already understand, it is inappropriate to treat a tooth without first concluding that the tooth has a problem and then firmly diagnosing what the problem is. Would you have your car fixed without knowing that something was broken? Would you undergo major surgery without having the doctor run tests, determine a diagnosis, and then tell you what your options were first before you entered the operating room? What sometimes dental insurances will incorrectly tell you and us is that the x-ray (code D0220) and the pulp vitality test (D0460), both DIAGNOSTIC procedures, are to be “bundled” with the TREATMENT of the root canal itself. The CDT Manual, the official handbook compiled by the CMC, explicitly describes and distinguishes all of these procedures as separate items, each able to stand on its own.

Another erroneous declaration made by the insurance company is the disallowance of the code D3331, stating that it is part of the root canal. This procedure describes an obstruction within the root canal that complicates and lengthens the root canal process. Think of it as the difference between installing a new swimming pool in soft ground versus digging the hole in a yard full of caliche. Be certain that the pool contractor will be assessing an additional charge for time and materials should caliche be discovered while excavating. Likewise, depending on the difficulty of the root canal case, we will sometimes need to invest extra time and materials and assess an additional fee as justified by the CDT manual. Interestingly, ALL insurance companies have a designated fee for this procedure but some choose not to honor it by unjustly “bundling” it based on “contractual agreement”. Never have we or will we ever affirm this contractually.

Our philosophy is to give you the BEST treatment in order to provide the highest probability of success. Excellence in endodontic treatment requires attention to the smallest details and there is no substitute for time and materials. Insurance companies are simply concerned with costs and we cannot let them dictate our treatment decisions especially when they do not follow the rules. It is neither our goal to provide the fastest treatment nor the cheapest treatment - we are simply concerned with favorable outcomes. Unfortunately, some insurances, in contradiction to the established guidelines as listed on the other side and in the accompanying office CDT manual, will groundlessly disallow certain legitimate fees during the claims process. Accordingly, these fees will be collected at the time of service as a co-pay. Should the insurance company later cover them, the patient will be reimbursed within two weeks by Sunset Endodontics. Conversely, should the Explanation of Benefits (EOB) later stipulate a denial or disallowance of payment for the provided services, payment for said services might not be reimbursable.

By signing below, the patient agrees that he/she has reviewed the accompanying CDT manual and accepts the payment policy as described above.

Signature: ____________________________________________  Date: __________________________