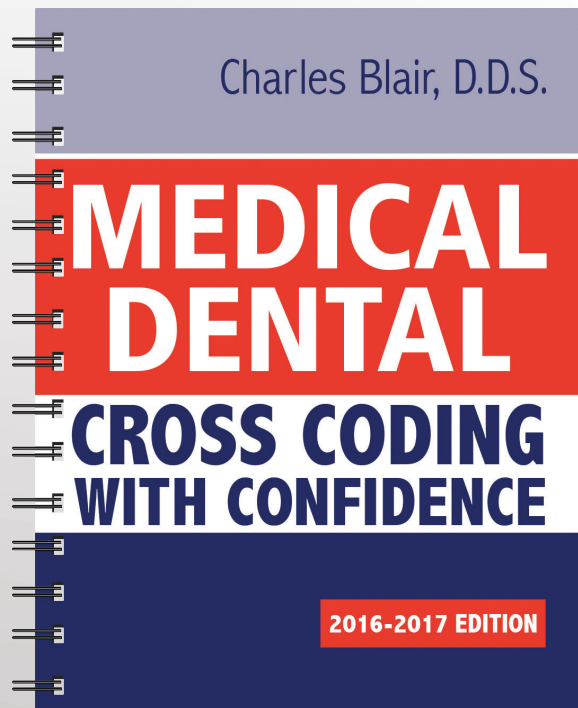# Dental to Medical Cross-Coding Tips

By Charles Blair, DDS

Many dentists are asked to submit dental procedures to a patient's medical plan, requested by the patient's dental plan or the patient. In some cases, dental team members feel overwhelmed and frustrated submitting medical claims for dental procedures such as surgical extractions, trauma-related procedures and biopsies. However, submitting a medical claim is not as challenging as it may seem or different from submitting a dental claim.

Understanding the Code Sets

Successful medical billing begins with an understanding of the various code sets available that allow for proper cross coding and/or the use of the appropriate code set. Always report what you do using the most accurate code to describe the procedure performed. It is imperative that only procedures and diagnoses supported by the clinical documentation be reported.

Administrative simplification provisions as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) include a requirement to adopt standard transaction sets. Within these transaction sets are standard codes sets for reporting medical and dental procedures. As of December 2000, Current Dental Terminology (CDT), Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS) and International Classification of Diseases (ICD) code sets must be accepted by all HIPAA-covered entities. ICD-10 was implemented effective Oct. 1, 2015. While there are ICD-10-PCS (Procedure Coding System) and ICD-10-CM (Clinical Modification) code sets, dentists will only report the ICD-10-CM code set. Any reference made to ICD-10 in this column will be in reference to ICD-10-CM. Here's an explanation of common coding terminology:

- **CDT:** The CDT code set is the most common set, known and used by dentists to report dental procedures. CDT procedure codes are used when reporting dental procedures to a dental payer. Many medical payers will accept the CDT code when there is no applicable medical cross code (CPT) or when the CDT is the most accurate code to describe the dental procedure performed. It is advisable to contact the medical payer prior to claim submission to determine if submission of CDT codes is allowable. This code set is maintained by the American Dental Association.

- **CPT:** CPT is often referred to as Level I codes and used to report procedures to medical payers. This code set is maintained by the American Medical Association.

- **HCPCS:** A HCPCS code consists of five alpha-numeric characters, and the code set is often referred to as Level II codes, which is primarily used to report medical services, equipment or supplies. For dentists, this code set is used to report oral sleep apnea and temporomandibular joint disorder appliances, which are considered to be durable medical equipment. The HCPCS code set is maintained by Centers for Medicaid and Medicare Services (CMS).

- **ICD:** An ICD code is commonly referred to as a diagnosis code. ICD codes are used to report diagnoses, symptoms and procedures. ICD codes communicate to the payer why a procedure may be medically necessary and may decrease the need for lengthy narrative. ICD-10-PCS is a procedure coding system used only by hospitals in an inpatient setting. ICD-10-CM is the clinical modification developed for use by physicians and other health care professionals; e.g., dentists for use in outpatient settings. Dentists will only use the ICD-10-CM code set, regardless of where the procedure is performed, even if in a hospital. The ICD code set continues to be developed by the World Health Organization, but in the United States, it is maintained by the National Center for Health Statistics and Centers for Disease Control and Prevention.

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Submitting the Medical Claim Form

Submission of a clean claim will help eliminate claim rejections and frustration. Many claims submitted by dental practices are rejected by medical payers due to the use of an outdated form, incomplete information and the improper placement of required information.

The current form required by all medical payers is the CMS 1500 (02-12) Medical Claim Form. Some dental practice management software is capable of printing a medical claim form; however, some do not have this capability. There are many affordable sources for completion of the medical claim form, and forms may be purchased from office supply companies in large or small quantities. Some payers will accept a handwritten claim form. However, it is advisable to submit a printed claim form, as claim forms are scanned and read by computer software and must be legible to prevent a rejection. There are few payers that will only accept an electronic medical claim; most will still allow a form to be submitted by mail.

It is important to follow the claim form instructions exactly when submitting a medical claim. Common claim form errors include, but are not limited to, the use of punctuation (i.e., a decimal point in the ICD code), the absence of a description when reporting an unlisted CPT code, and use of the appropriate modifier or qualifier, when required.

Always report what you do using the most accurate code to describe the procedure performed. It is imperative that only procedures and diagnoses supported by the clinical documentation be reported.

As with the dental claim form, the medical claim form is a legal document, and the treating doctor is responsible for the information reported on the claim form. It is important for dentists to invest in staff training and resources to ensure accurate completion of any claim form to all third parties. Additionally, it is imperative that dentists and team members document the clinical notes thoroughly to the greatest level of specificity. ✦

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