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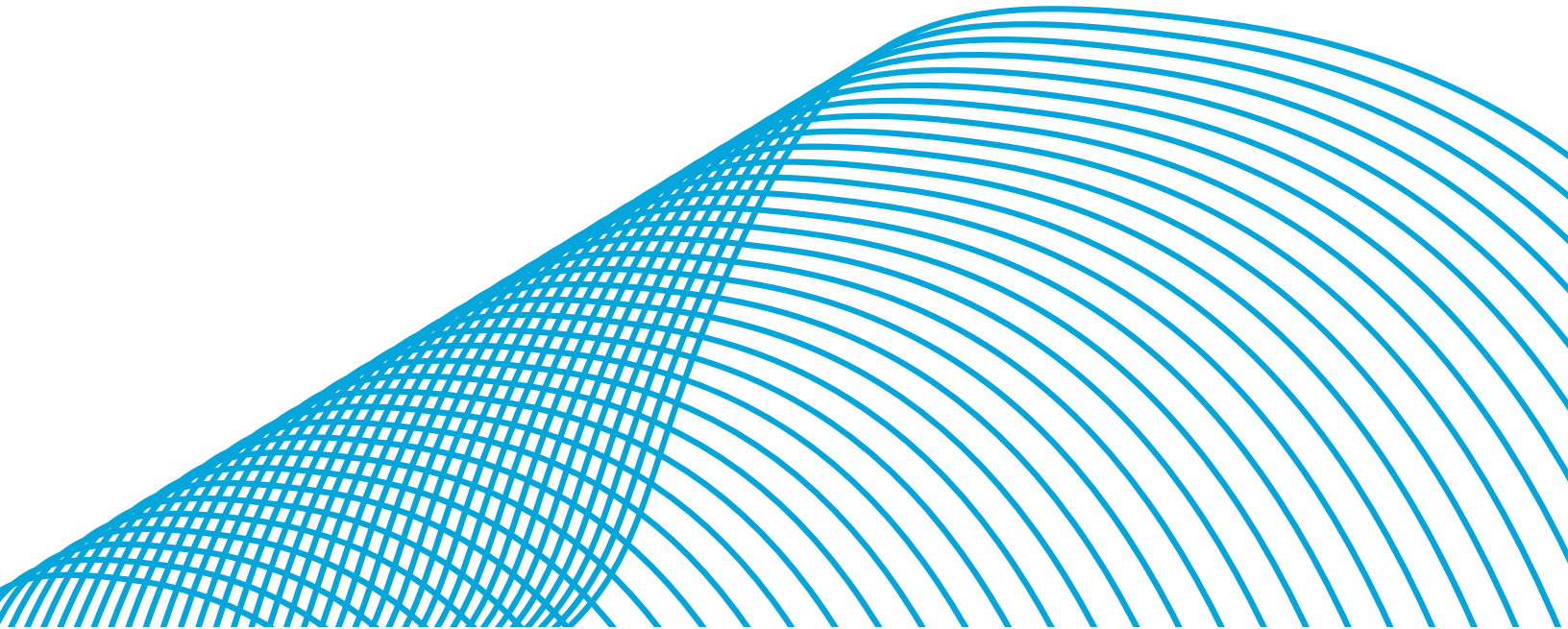
The Standard for Dental Coding & Insurance Adminstration

Dr. Charles Blair's orthodontic coding and insurance guide

Prepared for Align Technology, Inc.



Disclaimer: The information and codes contained in this Guide are intended to be used for informational purposes only and represent no statement or guarantee by Dr. Blair that these codes will be appropriate or that reimbursement will be made in any particular situation. The information is not intended to be legal advice. ***It is the provider's responsibility to determine and submit the appropriate codes and modifiers for any service, supply, procedure or treatment rendered. Actual codes and/or modifiers used are at the sole discretion of the provider. Contact your local payer for specific coding and coverage guidelines.*** *The codes, rules and their interpretations change. Always refer to the latest code revision, CDT-2020 and use the latest ADA claim form ©2021, which applies to CDT-2020. The codes are updated and revised each year. This document and all information herein is supplied and prepared by Dr. Charles Blair and Align Technology, Inc. is not responsible for any information contained herein, and Align provides no statement or guarantee that any codes provided herein will be appropriate or that reimbursement will be made in any particular situation. Please contact Dr. Charles Blair at 866.858.7596 if you have any input or notice any discrepancies. Please visit www.practicebooster.com to learn more about Dr. Blair's coding and insurance administration resources and services.*

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Introduction

The following insurance information is not intended to provide complete instruction on submitting insurance claims, but rather provide information that may help the office incorporate orthodontic services into their practice.

The insurance information in this supplement has been provided by Charles Blair, DDS of American Dental Support, LLC.

Dr. Blair is an expert in proper coding and insurance administration regarding Invisalign treatment.

General overview

The following information is provided to give you a quick summary of the process of filing insurance claims for orthodontic services.

Eligibility

- Orthodontic reporting is based on the dentition and scope of treatment (rather than the specific appliance, technology or technique). Generally, Invisalign® treatment should be covered under dental insurance plans that offer orthodontic coverage to the same extent as other orthodontic treatment appliances or techniques, but there may be exceptions.
- ALWAYS contact the patient's insurance payer to determine eligibility and coverage of Invisalign treatment.
- Refer to the Orthodontic Benefits Checklist at the back of this Guide to collect information regarding the patient's coverage prior to financial discussion.
- If your claim is rejected, review the most recent CDT codes (currently CDT-2020), payer guidelines and this document to verify proper coding. The vast majority of claim rejections caused by improper coding or incomplete documentation.

Records appointment

- Records fees (if filed separately) may or may not be counted against the orthodontic lifetime maximum.
- An advantage of filing records separately is to verify how the payer handles records claims prior to active treatment, and it may accelerate payment of claims.
- It's an early warning if the payer doesn't reimburse the records; they may not reimburse the case.
- There is not a specific CDT code to report orthodontic records. Typical records are made up of photographic images, diagnostic casts, and cephalometric radiographic image (if applicable).

Submission

- Do not send diagnostic casts, photographic images, or radiographic images unless specifically requested by the payer (generally not required).
- Make sure claims are clean and accurate and are submitted with the correct documentation. Never submit general dentistry treatment with orthodontic treatment on the same claim form.

Orthodontic reimbursement

- Normally spread over the course of treatment
- Some payers pay automatically, while others require a monthly (or other interval) claim form. An annual deductible may apply.

Step 1: Determining eligibility

The biggest difference between processing claims for orthodontic treatment and claims for general dental procedures is how benefit payments are broken down and dispersed across the course of treatment. This is managed differently from payer to payer, with many insurance payers paying benefits automatically at regular intervals, after the initial claim is filed. Others require monthly, quarterly, or other filing interval claims during active case treatment.

Dependent high school and college students are often eligible for orthodontic benefits. About 10%-15% of adults have orthodontic benefit coverage.

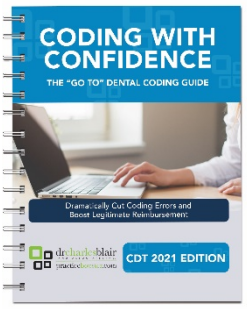
Orthodontic benefits differ significantly from policy to policy; ALWAYS contact the patient's insurance payer to determine specific eligibility and coverage. Use the **Orthodontic Insurance Call Reference Guide** (see page xx) to collect information on key eligibility questions. By checking the eligibility or benefit information prior to the patient's evaluation or consultation, your practice is not only set up to provide a more organized consultation, but it helps your patient quickly evaluate the financial options available. Simply place a copy of the form in the patient's file.

Step 2: Complete the insurance claim form.

The current claim form is the 2019 ADA Dental Claim Form.

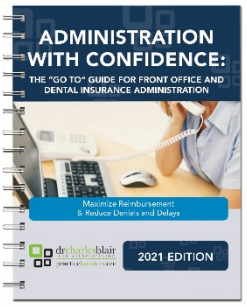
The following information provides a general overview of how to properly complete an orthodontic claim form. Orthodontic claims do differ from restorative and preventive claims. Now available is ***Coding with Confidence: The "Go To" Guide for CDT-2020*** *and* ***Administration with Confidence: The "Go To" Guide for Insurance Administration.*** *Also, online* ***PracticeBooster*** *is available. For further information, call 866.858.7596 or visit www.practicebooster.com to learn more about our resources and to place an order.*

Claim form information section: Make sure all required information is completed in the top section of the insurance form.



Ancillary claim/treatment information section: Provide all the required information. Make sure to check box 40 ("yes") that asks "Is treatment for orthodontics?" on each claim for orthodontic services.

Initial appliance placement: If the visit is the initial appliance placement (appliances placed), indicate the "date appliance placed," Indicate "months of treatment" in the appropriate box. You will generally not be required to submit radiographs, oral images, or diagnostic models.



Periodic orthodontic treatment appointments: If the visit is the periodic orthodontic treatment visit (D8670) and a claim is required for continued reimbursement, then enter the "date appliance placed," and "months of treatment" in the appropriate box.

Retention appointment: Orthodontic retention (D8680) is placed immediately upon completion of the active case. The vast majority of payers include retention as part of the global orthodontic case fee, and is not billed separately. Replacement of lost or broken replacement retainers (D8703/D8704), placed in the future, are generally the patient's responsibility since the lifetime benefit is probably most likely exhausted.

Description of common Invisalign® related services

The following treatment codes are suggested for the various phases of treatment:

I. **Pre-orthodontic treatment visit (D8660)** is typically reported for a growth and development checkup, prior to taking orthodontic records and starting active treatment. This is considered a pre-orthodontic visit. In the general practitioner setting, often the Invisalign adult candidate is seen at the regular checkup visits. In some cases, the general dentist will report the Case Presentation (D9450) code for the treatment presentation, not to report orthodontic records. Generally, there is no charge for the Pre-Orthodontic Treatment Visit (D8660) or Case Presentation (D9450) and a fee is not generally recommended.

The vast majority of orthodontists do not charge for the Pre-Orthodontic Treatment Visit (D8660), which is almost always complimentary. However, taking orthodontic records is generally charged at a subsequent visit by both orthodontists and general dentists. Orthodontic records may include photographic images, diagnostic casts, and cephalometric radiograph image, if applicable.

In the **"Record of Services Provided"** section of the claim form enter the following procedures **if** a fee is charged:

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	07/25/2020					XXXXX		1	Preortho treatment exam monitor growth/d	XX.XX

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	07/25/2020					XXXXX		1	Case presentation detailed/extensive trt plan	XX.XX

Author's note: Fees represented are not fee recommendations and only used as examples in completion of the claim form.

In the "**Ancillary Claim/Treatment Information Section**" of the claim form, confirm the following entry:

Is treatment for orthodontics? Indicate yes in Box 40.

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")	39. Enclosures (Y or N) N
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☑ Yes (Complete 41-42)	41. Date Appliance Placed (MM/DD/CCYY) XX/XX/XXXX
42. Months of Treatment XX	43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44)
	44. Date of Prior Placement (MM/DD/CCYY)

II. **Invisalign records visit reporting**

Before reporting the records for payer reimbursement, an impression or iTero® scan is sent to Align for a ClinCheck® plan. The ClinCheck plan is returned so the dentist and patient can review the case. Normally there is no fee for case presentation to the patient. Once the patient accepts treatment, records may be

submitted upfront for reimbursement. There is no specific "orthodontic records" code. A records visit may include photographic images (D0350) and diagnostic casts (D0470) procedures, as well as a cephalometric radiograph image (D0340). Any records procedures performed (photos, casts) on the records date may be paid out of either general dental benefits or orthodontic benefits, if available, depending on the funding provisions of the policy. If the records reimbursement is applied against orthodontic benefits, this will often reduce the lifetime ortho benefit amount accordingly. But, in some cases, the fees for records are paid in addition to the lifetime ortho benefit.

Note that an iTero scan can report diagnostic casts (D0470). D0470 is reported for virtual models provided a "hard copy" can be produced upon request.

Notes:

- *A recent panoramic film (D0330) or full series (D0210) may have already been taken at the patient's routine evaluation visit (paid out of the general dental benefits). If so, these recent x-ray procedures may not be required to be taken on the orthodontic records date.*
- *Some dentists do not report a separate records fee, but an all-inclusive case treatment fee. However, it can hasten claims processing to file for records when initially taken. The second advantage is to see if the claim is paid as expected, prior to active treatment. This is an early warning. If the records are paid; probably the case fee will be paid. The third advantage is that the records fee in some instances is funded separately, in addition to the orthodontic lifetime maximum.*

In the "**Record of Services Provided**" section of the claim form enter the following procedures, as applicable:

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	07/25/2020	00				D0350		3	2D oral/facial photo image intra or extra oral	XX.XX
2	07/25/2020	00				D0470		1	Diagnostic Casts	XX.XX

In the **Ancillary Claim/Treatment Information Section** of the claim form, confirm the following entries:

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment [11] (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")		39. Enclosures (Y or N) [N]
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☑ Yes (Complete 41-42)		41. Date Appliance Placed (MM/DD/CCYY) XX/XX/XXXX
42. Months of Treatment XX	43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44)	44. Date of Prior Placement (MM/DD/CCYY)

III. Treatment start visit (Active appliance placement)

Directly in the "**Records of Services Provided**" section of the claim form, document the information as listed. This may be done in long hand, typed, or through a computerized billing system as there is not a specific section labeled for some of this information:

- Total case Fee: $$$
- Patient's Down Payment: $$$
- Monthly Payment Terms: $$

- Case Classification –
  - D8030 Limited orthodontic treatment of the Adolescent dentition* or
  - D8040 Limited orthodontic treatment of the Adult dentition**
  - D8080 Comprehensive orthodontic treatment of the Adolescent dentition* or
  - D8090 Comprehensive orthodontic treatment of the Adult dentition. **
- Case Diagnosis - Angle Class I, II, III malocclusion
- Other Documentation as required by payer: other information as required

*Adolescent dentition indicates permanent dentition, but growth is not complete.
**Adult dentition indicates permanent dentition and growth is complete. Typically eighteen or above.

In the "**Ancillary Claim/Treatment Information Section**" of the claim form, confirm the following entries:

ANCILLARY CLAIM/TREATMENT INFORMATION		
38. Place of Treatment [11] (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")		39. Enclosures (Y or N) [N]
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☑ Yes (Complete 41-42)		41. Date Appliance Placed (MM/DD/CCYY) XX/XX/XXXX
42. Months of Treatment XX	43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44)	44. Date of Prior Placement (MM/DD/CCYY)

*Enter total estimated months of active treatment. Box 41 indicates the delivery date of the first set of removable orthodontic appliances.

IV. Periodic orthodontic treatment visit (D8670)

Some plans require a monthly or quarterly claim for payment.

In the "**Record of Services Provided**" area of the claim form, enter the following:

RECORD OF SERVICES PROVIDED										
	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	07/25/2020					D8670		1	Periodic Orthodontic Treatment Visit	XXXX.XX

Author's note: The fee reported for D8670 is generally the entire case fee. Refer to payer for any payer specific instructions as to how to report D8670.

In the "**Ancillary Claim/Treatment Information Section**" of the claim form, confirm the following entries:

ANCILLARY CLAIM/TREATMENT INFORMATION		
38. Place of Treatment [11] (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")		39. Enclosures (Y or N) [N]
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☑ Yes (Complete 41-42)		41. Date Appliance Placed (MM/DD/CCYY) XX/XX/XXXX
42. Months of Treatment XX	43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44)	44. Date of Prior Placement (MM/DD/CCYY)

V. D8680 orthodontic retention (removal of appliances, construction and placement of retainer(s) Payers typically insist that retention is included in the global case fee. If a PPO, commonly it is disallowed, non-billable to the patient ; a write off for the practice. If retention is reported separately (from the global case fee) then enter the "date appliance placed," and "months of treatment" in the appropriate boxes. Indicate the arch(es) involved. By submitting the retention claim, active case treatment has been completed.

If a separate "retention" fee is reported at the end of active treatment, in the "**Record of Services Provided**" area of the claim form, enter the following:

RECORD OF SERVICES PROVIDED										
	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	08/01/2020	00				D8680		1	Ortho retention	XXX.XX

In the "**Ancillary Claim/Treatment Information Section**" of the claim form, confirm the following entries:

4. Indicate arch(s) treated in Box 25 of the 2019 ADA Dental Claim Form. Enter "00" for entire oral cavity; "01" maxillary arch; "02" mandibular arch.

Claim summary

A summary of potential entries for Invisalign® related services is provided in the following table. The current claim form is ADA ©2019, and applies to CDT2021:

ADA[1] 2021 #		
	PRE-ORTHODONTIC TREATMENT VISIT CLAIM FORM	
29	Procedure code – Pre-/Periodic Orthodontic Evaluation	D8660/D8670
40	Is Treatment for Orthodontics?	Check "yes" Block
	RECORDS VISIT CLAIM FORM	
29	Procedure code – oral/facial photographic images 2D/3D/caries	D0350/D0351/D0600/1/2/3
29	Procedure code – diagnostic casts	D0470
29	Procedure code – cephalometric radiograph image (if applicable)	D0340
39	Radiographs, oral images or models enclosed / Enclosures	Enter "N"
40	Is Treatment for Orthodontics?	Check "yes" Block
41	Date appliance placed	Leave blank
42	Months of treatment	Leave blank
	ACTIVE TREATMENT START CLAIM FORM	
29	Procedure code – Invisalign Anterior Case Limited Ortho – Adolescent or Limited Ortho – Adult	 D8030 or D8040
29	Procedure code – Invisalign Full Case (address both arches) Comprehensive Ortho – Adolescent or Comprehensive Ortho – Adult	 D8080 or D8090
39	Radiographs, oral images or models enclosed/Enclosures	Enter "N"
40	Is Treatment for Orthodontics?	Check "yes" Block
41	Date appliance placed	Enter “mm/dd/ccyy”
42	Months of treatment	Enter months of treatment
	Under the "**Record of Services Provided**" section of the form, include the following in the description box next to the procedure code entered (you can write it long-hand, typed or via computerized system):	
	Estimated length of treatment	'est. # months'
	Total Case Fee	'$XXX'
	Patient's down payment	'$XX'
	Monthly payment terms[2]	'$XX'
	Case Diagnosis	Angle Class I, II, III malocclusion
	Other documentation as required by carrier	

[1] Copyright 2021 American Dental Association. Disclaimer: The above and below claim form examples are not all potential codes for a patient visit. These are some of the potential codes relevant to orthodontic treatment that a GP/Ortho may code for reimbursement during a patients’ Invisalign treatment.

Claim summary (continued)

ADA[2] 2021 #		
	PERIODIC ORTHODONTIC TREATMENT VISIT CLAIM FORM	
29	Procedure code – Periodic orthodontic treatment visit	D8670
39	Radiographs, oral images or models enclosed / Enclosures	Enter "N"
40	Is Treatment for Orthodontics?	Check 'yes' Block
41	Date appliance placed	Enter “mm/dd/ccyy”
42	Months of treatment	Enter months of treatment
	ORTHODONTIC RETENTION CLAIM FORM (after active appliances are removed and retainers placed)	
29	Procedure code – Orthodontic Retention	D8680
39	Radiographs, oral images or models enclosed /Enclosures	Enter "N"
40	Is treatment for orthodontics?	Check 'yes' block
41	Date appliance placed	Enter “mm/dd/ccyy”
42	Months of treatment	Enter months of treatment

[2] Copyright 2021 American Dental Association. Disclaimer: The above and below claim form examples are not all potential codes for a patient visit. These are some of the potential codes relevant to orthodontic treatment that a GP/Ortho may code for reimbursement during a patients’ Invisalign® treatment.

Invisalign® Q&A

1. **Is orthodontic treatment covered by medical insurance?**

   Orthodontic coverage for pediatric patients is considered part of the EHB under the ACA and is available through some medical plans (up to age 18) only when determined to be "medically necessary." This coverage always requires prior authorization and typically has a 12-month waiting period. Coverage and contract language varies among plans, so verification of orthodontic benefits is highly recommended. One example of orthodontic coverage for a pediatric patient (under age 19) may be the treatment of severe malocclusion or dental misalignments for certain clinical indications. Criteria of the medical necessity, as well as the documentation requirements of the plan, must be met in order for the patient to receive orthodontic benefits. Medical necessity for malocclusion may include treatment that contributes to recalcitrant temporomandibular (TMJ) syndrome as defined in the medical policy. Treatment of malocclusion that contributes to speech abnormality, pre- and post-surgical orthodontics as part of a medically necessary treatment plan for orthognathic surgery, or significant intraoral trauma while chewing as it relates to malocclusion may also meet medical necessity of the patient's plan. The patient's plan will have specific guidelines, which must be met to ensure coverage. Documentation requirements may include, but are not limited to, the following:

   - Documentation from the provider of service establishing medical necessity.
   - A written report from the pediatrician, other attending physician, or qualified medical specialist.
   - Orthodontic records such as cephalometric radiographic images, extraoral and intraoral photographs, panoramic radiographic images, study models, and any other records needed to provide a complete diagnosis.
   - Documentation showing severe malocclusion or dental misalignment as outlined in the patient's plan.
   - Orthodontic treatment plan or contract, anticipated initial placement of appliances, and number of months of anticipated treatment.

2. **Who typically has an orthodontic benefit included in their dental insurance plan?**

   While many Americans have dental insurance, only 10-15% of the population has dental insurance *with* an orthodontic benefit. Of those that have dental insurance, the majority receive the policy through an employer. Generally, there must be an orthodontic rider purchased by the employer for there to be orthodontic coverage.

   - Employees/members of a plan themselves may be covered,
   - Generally an employee' s/member's dependent(s) up to age 19.
   - Generally a dependent up to ages 23-25, if a full-time student.
   - Employees/Members over age 19 are occasionally benefited under the orthodontic rider.

   Despite the above, there is no constant rule; it is necessary to check each patient's individual plan for the specific coverages, as each dental insurance plan can vary widely. Plan benefits will be outlined in the plan's plan document.

3. What are the stages of dentition when selecting the proper dentition code?

The stages of dentition, as defined by CDT 2020, are as follows:

- Primary Dentition: Teeth developed and erupted first in order of time.
- Transitional Dentition: The final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.
- Adolescent Dentition: The dentition that is present after the normal loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment.
- Adult Dentition: The dentition that is present after the cessation of growth that would affect orthodontic treatment.

4. What are the typical ADA codes for the "limited" and "comprehensive" Invisalign® cases?

- **D0810** – Limited orthodontic treatment of the primary dentition
- **D8030** – Limited orthodontic treatment of the adolescent dentition

OR

- **D8040** – Limited orthodontic treatment of the adult dentition
- **D8070** – Comprehensive orthodontic treatment of the transitional dentition

OR

- **D8090** – Comprehensive orthodontic treatment of the adult dentition

5. What is the typical orthodontic lifetime limit and coverage?

- The most common orthodontic lifetime limit is $1,500; most coverages will fall in the $1,500 -$2,500 range. However, some policies have a lower limit of $1,000 and a few pay as high as $5,000.
- Benefits are typically paid at 50%. Some have a recurring annual deductible ($50-$150) during the course of treatment.
- The typical coverage of a lifetime $1,500 benefit is generally all-inclusive orthodontic and global (includes records, active case treatment and retention). It may also include orthodontic-related procedures such as extractions, fiberotomies, frenectomies, miscellaneous ortho-related periodontal procedures, and surgical access to an unerupted tooth. These orthodontically-related procedures may not generally be covered under regular dental benefits and the claim form should indicate they are "orthodontic-related procedures." Thus the claim form question, "Is treatment for orthodontics?" is checked "yes" in the appropriate block.
- The orthodontic lifetime limit is often in addition to the regular dental benefit limit for the vast majority of plans.
- In some cases, the maximum annual limit is fixed at $1,500 for both orthodontic and regular dental coverage in the same plan year. Thus, if the regular dental benefit is used, then the orthodontic benefit may be reduced dollar-for-dollar for that treatment period. In other cases, a maximum (for instance $1,500) is stated but only a portion is available for orthodontic reimbursement, even if the general dentistry portion is not used. For instance, the ortho benefit is limited to $500 of the $1,500 total benefit.

With so much variability of benefits, a call to determine eligibility and benefit coverage is a must for each orthodontic case! Use the Orthodontic Benefit Checklist found in this Guide on page xxx .

6. Do annual deductibles apply to orthodontic benefits?

Some polices have recurring annual deductibles of $50-$150. Be sure this is one of the questions to ask when the call is made to check the patient's eligibility.

7. Should I predetermine orthodontic coverage?

Always. Call and verify eligibility, deductibles, exclusions, limitations, lifetime maximum benefit, and any orthodontic benefit already used. Also determine if dental and orthodontic coverage are coordinated with an upper limit (maximum) for both. This is a trap, as any dental benefit used during the year may reduce the orthodontic benefit dollar-for-dollar. In some other cases, a maximum (for instance $1,500) is stated, but only a portion is available even if the general dentistry portion is not used. For instance, the ortho benefit is limited to $500 out of a total $1,500 benefit. Fortunately, this limitation is not common.

8. How do I handle secondary coverage for orthodontics?

File primary first, then secondary. Do not wait until treatment is completed to file secondary for orthodontic claims. Secondary will determine benefit based on the established COB rule of the plan and pay accordingly just like primary (i.e., bulk benefit paid, quarterly or monthly payments)

9. Are there any maximum orthodontic fee limitations?

A. No, if the dentist does not participate in any third-party contracted plan. They are out-of-network.

B. Yes, if the dentist is a provider for a PPO/capitation plan that pays for an orthodontic benefit. The PPO/capitation plan sets the maximum fee (contracted fee) that may be charged for the case. The PPO/capitation plan pays up to the lifetime maximum (typically at 50%) while simultaneously controlling the total out-of-pocket paid by the patient. Thus, the practice fee is controlled to the "contracted fee".

C. Yes, if the dentist participates in a "self-funded" plan which by contract sets the maximum orthodontic fee that may be charged the patient – even though the plan pays no orthodontic benefit. These "self-funded" plans control the fee paid by the patient even though they pay no reimbursement. This is called "fee capping for non- covered services". Self-funded plans are a large entity (union, hospital chain, schoolteachers, Wells Fargo Bank, Walmart, etc. Self-funded plans are under federal ERISA law and are exempt from state insurance commissioner or state law oversight. Fee capping for non-covered procedures state law does not apply.

   If an "insured plan" under state law and the insurance commissioner, then at least 39 states allow the practice to charge its full fee. The rest of the states have no law, so the payer can "fee cap for non-covered services." Our Administration with Confidence book extensively addresses fee capping for non-covered services.

10. What is the start date for an orthodontic case?

The start date is the date the case starts, which is the delivery date of the aligners, which is defined as the day the aligners are fitted in the patients' mouth.

11. For orthodontic treatment, what is considered the "start date" of treatment?

The start date for orthodontic treatment is the date appliances are delivered (e.g., clear aligners, Herbst, etc.) or placed (e.g., brackets, etc.).

12. How can a consultation regarding the treatment plan of an orthodontic case be reported?

Report D9450 case presentation, detailed and extensive treatment planning. In most cases, a fee is not charged for the case presentation.

13. Can a dentist/orthodontist bill a case management fee when they have a discussion with the patient's physician?

Yes, D9992 is billable for the coordination of care. But reimbursement presently is poor.

14. I just started Invisalign® cases. I am a member of several PPOs. I never negotiated ortho fees in the past, and they are low. Who can I contact to start that discussion?

In many cases, PPOs will not negotiate fees but on an annual or semi-annual basis. They may not accept negotiations until your anniversary date.

You may be able to submit a case under "Optional Services." Every PPO has a Processing Policy Manual (obtained on the PPO's password-protected website). Delta Dental has two manuals-- one manual for plans sold within the state, and Delta USA for a national contract. These manuals are essential for the practice to know your obligations to the contract and manual.

Every manual addresses Optional Services and how to file for an exception. Read the process and submit an exception for Optional Services. Some payers might be receptive to a higher fee for Invisalign aligners.

15. How are the panoramic film D0330 and intra-oral – complete series D0210 reimbursed?

This may vary by patient insurance policy, payer, state, and/or your network credentialing contract. These radiographic images are taken for routine dental care and generally covered under regular dental plan coverage. The panoramic or complete series x-rays are generally payable at the initial comprehensive evaluation (D0150) and thereafter either on a three- or five-year basis, based on policy limitations, provided, of course, that they have not been taken in the previous three- or five-year period. Further, they both are not covered simultaneously; it's either one or the other for the benefit period. If they are taken as a part of orthodontic records on the same service date, as opposed to routine care, they may come out of the orthodontic lifetime maximum, reducing the orthodontic benefits available. Be sure to check the patient's dental plan policy processing manual for definitive answers on coverages, time frames, and billing.

Orthodontic records, (images, photos, casts, study models, and/or intraoral scans), are also potentially reimbursed out of the dental benefits or orthodontic benefits, depending on the date of service and other accompanying codes on the claim form.

Always refer to and abide by the payer's policy processing manual and your credentialing contract when coding and submitting claims for reimbursement of covered and non-covered services.

16. Is the standard ADA claim form completed differently for orthodontic reimbursement versus general dentistry?

Yes. The latest ADA claim form (2019 version) for CDT 2020 asks the question (No. 40), "Is treatment for orthodontics?" This question must be answered "yes" to receive reimbursement for orthodontic records, active treatment, retention, and any other orthodontic-related procedures subject to the orthodontic coverage, limitations, exclusions, and provisions if any. In addition, there are related orthodontic sections of the ADA claim form that are listed as enclosures, date appliance placed, and months of treatment, which must be answered. (Numbers 39, 41, and 42)

Note: Generally, photographic images, diagnostic models, and radiographic images are not required to be submitted. Do not send unless the payer requests explicitly such records.

17. Is the reporting of any CDT-2020 code limited to the orthodontic specialist?

The reporting of any orthodontic code is not limited to the orthodontic specialist. Any practitioner providing a dental service within the scope of his or her licensure may report any CDT-2020 procedure code for reimbursement.

However, certain Medicaid states and the Affordable Care Act plans may limit treatment to an orthodontic specialist for very difficult cases. Also, note that reimbursement to specialists may be higher with certain Delta Dental or other plans.

18. What are generally considered orthodontic "records" and what is generally reimbursed under orthodontic benefits, if available?

- Cephalometric radiographic image (D0340)
- Oral/facial photographic images (D0350)
- Diagnostic casts (D0470)

  Note that an iTero scan reports diagnostic casts (D0470). D0470 is reported for virtual models provided a "hard copy" can be produced upon request.

Align Technology does not require a cephalometric radiographic image, a current full-series (D0210), or panoramic radiographic image (D0330). However, it is highly recommended, prudent, and in the best interest of the patient's treatment, health, and dental hygiene to have a full series of x-rays and photos which may include cephalometric or panoramic radiographic imaging.

Note: Align Technology, Inc. does not require the submission of X-rays for the processing of the case or the manufacture of Invisalign® clear aligners, however the doctor should take all records necessary for the clinical diagnosis of the patient and proper orthodontic treatment plan for the patient's case prior to submission to Align Technology, Inc.

Also note: The records reimbursement is often included in the lifetime orthodontic benefit, not in addition to the orthodontic benefit. Sometimes, however, records reimbursement is paid out of general dental benefits or not counted toward the orthodontic lifetime maximum. Always report the orthodontic records separately, upfront, for best reimbursement, and in doing so, adhere to the patient's dental plan payer policy processing manual for proper and legitimate coding.

19. I realize that billing the orthodontic records (photographic images and diagnostic casts) up front has advantages and the potential of higher overall reimbursement. But, I like to quote an all-inclusive fee to the patient. Is that possible?

Yes. Tell the patient, "We have an all-inclusive fee for Invisalign® treatment, and its $XXXX. There are no surprises, or add-ons. But we will bill the payer separately for the orthodontic records component of your treatment in order to maximize your potential insurance reimbursement".

The records are billed upfront for immediate payment, if covered. Also, by billing the records if they are not benefitted, then the case won't be benefitted. In some cases, the payer will pay the records fees in addition to the lifetime orthodontic benefit, and in other cases the records fees come out of the lifetime benefit.

20. I've heard of "Optional Services". What is that?

Every PPO has a contract and also a Processing Policy Manual (typically 150 pages) which spells out, in detail, the contractual relationship. In the Processing Policy Manual is an Optional Services section that spells out how to apply for an exception to the PPO fee. This is not a sure thing but will work in some situations, and may be worth pursuing.

21. I use an iTero scanner to submit a scan for ClinCheck treatment plan. When records are submitted for payment can I file diagnostic casts (D0470) for reimbursement?

Yes. An iTero scan can report diagnostic casts (D0470) for reimbursement. D0470 is reported for virtual models provided a "hard copy" can be produced upon request.

22. Is Invisalign treatment treated differently from regular orthodontics with respect to the CDT procedure codes utilized?

No, the same CDT2020 codes are utilized to report all types of orthodontic treatment, regardless of technology or technique used to perform the procedure. It is the treatment outcome that determines the proper case code.

23. Is Invisalign treatment treated differently from regular orthodontics with respect to reimbursement?

Generally, there is no difference in respect to payer reimbursement, if orthodontics is benefited in the patient's plan. However, there are a few plans that cover only brackets and wires and do not benefit Invisalign Clear Aligners.

24. I've heard that I can charge the D8999 code in addition to the case so I can receive an overall higher fee. Will that work?

You should check with the third-party payer on this question. Some payers require you to submit an orthodontic fee schedule and will only reimburse up to that amount. Although you are 'allowed' under some contracts to charge the patient more for "aesthetic" orthodontic options such as Invisalign aligners or lingual brackets, it may be possible to list the 'premium' by reporting the code D8999, by report. This approach may allow you to charge the patient the difference. The D8999 code and fee must clearly be listed separately in the treatment plan presentation and the patient must agree in writing. Also, the D8999 fee must be disclosed on the claim form to the PPO.

In some instances, the use of D8999 would not be allowed. An example is Delta Dental of California and their recent policy changes regarding the D8999 code elimination.

25. Do I need to mention "Invisalign® treatment" anywhere on the claims form?

No. CDT coding is for the purpose of "reporting" a procedure. The method, materials, and technique (or combination of techniques) to accomplish the orthodontic treatment procedure are immaterial. Orthodontic case procedures are reported, not specific clinical techniques or methods to accomplish a given procedure.

The only two orthodontic codes that even differentiate the appliance types are the removable appliance therapy code (D8210) and fixed appliance therapy code (D8220). These codes are listed under minor treatment to control harmful habits, such as thumb-sucking or tongue-thrusting.

There is no differentiation of appliance-type, methods, or materials for the general categories of "limited orthodontic treatment" or "comprehensive orthodontic treatment."

Should the payer request further information beyond the required ADA claim form as to a specific orthodontic technique, methods, or materials, respond accordingly to the request. A very few plans may exclude the Invisalign clinical technique, while only reimbursing standard braces.

See Question 24 above regarding reporting D8999.

26. Does Medicaid cover Invisalign treatment?

Not usually. Medicaid will only cover severe cases, often defined as “medically necessary” orthodontic correction (not routine jumbled teeth), and oftentimes limits this complicated treatment to a specialist. Check your state's Medicaid Provider Manual.

27. Can a Medicaid patient pay directly for orthodontic treatment, which are considered non-covered procedures?

Yes, a provision is made for billing non-covered procedures to the patient in the Provider Manual. The patient must be notified, in writing, that the service is a non-covered service prior to starting treatment. A waiver must be signed by the patient stating that the patient is solely responsible for payment. The Medicaid visit copay, if applicable, cannot be charged for non-covered procedures. Refer to your state's provider manual for details.

28. How do we report the replacement of an existing orthodontic retainer, fixed removable later, after the treatment is complete and retainers have been placed?

If the retainer is lost or broken, report D8703 or D8704, replacement of a lost or broken retainer. In the clinical notes, document that the retainer was lost or broken and requires replacement.

29. With Covid-19, Is it possible to contact an Invisalign patient through teledentistry and charge for it?

Yes, teledentistry-synchronous; real-time encounter D9995 is possible if your state board permits. There are still some states where this is not legal, so check with your state dental board. Very few payers will reimburse D9995 at this time. Please note, however, Invisalign treatment requires an in-office appointment prior to beginning treatment.

In addition, re-evaluation-limited, problem-focused (established patient; not post-operative visit), D0170 may be billed if there is a visual and audio component to the call.
There is a full tele-dentistry webinar presentation for dentists, and a separate one for orthodontists, accessible in the library of resources that you can access as an Invisalign provider.

For further information, go to Practicebooster.com and check the Blog for further information concerning teledentistry.

30. Can I bill my Invisalign® patients for PPE?

Yes, you can. You would report, D1999, by report (narrative describing the PPE).

When some practices announced an extra PPE charge, there was immediate pushback with negative feedback from both patients on social media and reports in the press perceiving increased PPE was simply a cost of doing business and should not be passed on to the consumer. Historically, costs related to PPE and sterilization procedures were considered inclusive of the procedure.

If out of network, a better option for those that want to offset the cost is to slightly increase your fee schedule, rather than charging a separate PPE fee for each patient encounter If you participate with any PPOs, they require all charges to the patient must be submitted to them for review – after which they can deny (meaning the cost is passed on to the patient), or they can disallow (meaning the practice must write off the charge).

Recognizing the significant financial challenge, some payers (for only a designated time period) are paying an additional $10 fee per unique patient visit monthly, no billing required, while others are offering a 1% rebate or lump sum payment relief. However, the greatest economic cost of COVID is the decreased efficiency required by seeing patients more one at the time. PPE will become a fraction of the cost once the cost reverts to commodity pricing.

WARNING: Some states disallow charging for PPE and sterilization procedures. Know your state law. Contact your state dental board or state dental association for clarity of your state law prior to implementing a fee for PPE in your practice.

31. I am a participating member of XYZ Insurance Company. They pay no orthodontic benefits but list a "table of procedures" with maximum fees for various procedures. My orthodontic fee is $5,500 and they list $3,700 for an adult full-case fee on their table of procedures. Do I have to discount my fee under their contract?

If your contract calls for you to provide the service for $3,700, even though the insurance payer does not pay any benefit toward treatment, you are to accept that amount as payment for the services. This is a "bonus" to the patient/employer and *limits* your fee since you are a participant. However, it's worth a call to the payer and see if there is a way to receive more reimbursement. They may permit you to bill separately for the "aesthetic premium" to be coded as D8999. Provided, of course that the patient agrees in writing and the "aesthetic option" charge is listed on the treatment plan.

Read Question 24 regarding the D8999 option. Also, if an "insured plan", state law may protect you. See Question 24 as to whether your state has "fee capping legislation" that protects you if it is an "insured plan". However, state law does not protect you if it is a "self-funded" plan, under federal law.

32. My Invisalign® treatment fee is $5,500. I offered a 7% cash bookkeeping adjustment to the patient and they accepted. What fee amount goes on the insurance claim form?

The latest ADA insurance claim form (©2019) has the following statement on the bottom of the form: "I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed". The $5,500 fee as discounted by 7% to the patient for cash is $5,125. Therefore, $5,125 is to be entered on the insurance claim form as the total fee, which the patient is obligated to pay.

33. What does "coordination of benefits" and "non-duplication of benefits" mean?

Coordination of benefits means the secondary payer will pay in addition to primary. The secondary will coordinate up to the primary contracted fee, secondary contracted fee, or in the best of circumstances up to the full fee of the practice.

Non-duplication of benefits is not good. The secondary payer calculates what benefit it will pay on the claim. Then, if primary pays up to that amount, then secondary pays nothing. This is a way for the secondary payer to cut costs and is typically the self-funded plans (plans under ERISA). See question xxxx also.

Orthodontic benefits checklist

Date:_____ Rep Name: _____

Patient: _____

Patient's Date of Birth: _____

Relationship to Subscriber:

☐ Self ☐ Spouse ☐ Dependent

Eligibility Date:_____

Who is eligible for Orthodontic benefits:

☐ Subscriber ☐ Spouse ☐ Dependents up to age ____

Maximum benefit: $ _____

☐ Annual ☐ Lifetime ☐ Combined Dental/Ortho

Remaining Benefit: $ _____

Ortho Deductible: $ _____

☐ Annual ☐ Lifetime ☐ Combined Dental/Ortho

Waiting Period ☐ Yes, how long? _____ ☐ No

Subscriber:_____

Subscriber Date of Birth: _____

Subscriber ID# (SS or ID#): _____

Employer/Group Name:_____

Group #: _____

Insurance Company: _____

Mailing Address:_____

_____

Phone:_____ Fax:_____

Plan Type:

☐ PPO ☐ Traditional ☐ Capitation ☐ Fee schedule

Out-of-Network benefits: ☐ Yes ☐ No

If the Doctor is a member of the orthodontic patient's insurance network, does the plan control the maximum fee that the doctor may charge by contract, even though there is no orthodontic coverage by the plan?

☐ Yes ☐ No

Payment of Orthodontic Benefits

Are benefits paid on an automatic schedule after the initial claim for active treatment? ☐ Yes ☐ No

If yes, what are the payment intervals? ☐ Monthly ☐ Quarterly ☐ Other _____

Is the placement of post-orthodontic retainers paid separately? ☐ Yes ☐ No

Is it necessary to establish medical necessity for benefits to be paid? ☐ Yes ☐ No

If treatment is provided as a cosmetic service, does the PPO control the fee? ☐ Yes ☐ No

Note: Case fees may be subject to fee capping when participating with a PPO in a state without non-covered benefit legislation and for patients covered by self-funded (ERISA) plans. That is, the payer can dictate the fee charged for orthodontic services, even when no reimbursement is provided. If in a state with non-covered benefit legislation and orthodontic services are not a covered service of the plan, the patient will generally be responsible for the full orthodontic fee with no mandated write-offs if an insured plan.

Related resources

www.practicebooster.com/store.asp

Addendum: Helpful codes[3]

Clinical oral examination codes

Code	Description of service	Prior authorization?	Limitations and requirements (varies by state and insurer)
D0120	Periodic oral evaluation – established patient	No	One per six-month period, per member, per provider, for members under the age of 21.
D0140	Limited oral evaluation – problem focused	No	One per six months, per member, per provider.
D0150	Comprehensive oral evaluation – new or established patient	No	One per three years, per member, per provider.
D0160	Detailed and extensive oral evaluation – problem focused, by report	No	One per three years, per member, per provider.
D0170	Re-evaluation – limited, problem focused (established patient; not post-operative visit)	No	Allowed once per year, per member, per provider. Allowable in office, virtual, hospital or other POS (place of service).
D0191	Assessment of a patient	No	One per six months, per member, per provider. Code billable only by dental hygienists.

[3] For proper and legitimate insurance coding, always check your state dental board rules and regulations, as well as the patient's dental insurance plan *Summary Plan Description* and *Plan Document* for claims reimbursement. The above codes are for informational purposes only. The treatment provider filing claims assumes all responsibility.

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Tests and examinations codes[4]

Code	Description of service	Prior authorization?	Limitations and requirements (varies by state and insurer)
D0470	Diagnostic casts	No	Orthodontia diagnosis only. Allowed with PA (prior authorization) for members ages 21 and over, at insurance carrier's request (e.g., for dentures). a. Diagnostic casts are payable only once when performed in conjunction with orthodontic services. Additional casts taken by the same dentist/dental office during or after orthodontic treatment are included in the fee for orthodontics and separate fees are not billable to the patient by a participating dentist. Benefit once per lifetime. b. Benefits for casts taken for any other procedure may be denied.
D0999	Unspecified diagnostic procedure, by report	Yes	Used for procedure that is not adequately described by a code. Requires narrative and may require IC review by Dental Consultant. When using a "D_999" code: a. The information submitted, specifically the narrative, should be reviewed for its content and translated to a recognized code if possible. b. If, however, an unusual procedure was performed for which there is no code, the narrative should be reviewed along with the submitted charge. The Dental Consultant will determine a "reasonable fee" is for the procedure based on both the degree of difficulty and the time involved.
D1999	Unspecified preventive procedure, by report	No	Per ADA interim guidance: When billing a payer and patient for PPE cost reimbursement using this miscellaneous code, a narrative (max of 80 characters) must be included which documents what PPE was used for the visit, the cost of the PPE, the charge to the patient, and it must be reported on a per-visit/claim basis in an attempt to cover the cost of PPE.

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Common radiographs/imaging/records (including interpretation)[5]

Code	Description of service	Prior authorization?	Limitations and requirements (varies by state and insurer)
D0210	Intraoral – complete series of radiographic images	No	One per three years, per member, per provider. Not billable within six months of other X-rays including D0220, D0230, D0240, D0270, D0272, D0274, and D0330 except in an emergency. Retain records in member files regarding nature of emergency. Panorex plus bitewings may be billed under D0210.
D0220	Intraoral – periapical first radiographic image	No	One per day. Not payable with D0210 on same DOS or up to six months after.
D0230	Intraoral – periapical each additional radiographic image	No	Up to three per day. Must be billed with D0220. Not payable with D0210 on same DOS or up to six months after. Six-month limitation may be exceeded in an emergency.
D0240	Intraoral – occlusal radiographic image	No	Up to two per day. Not payable with D0210 on same DOS.
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	No	Emergency only, one per day. Retain records in member files regarding nature of emergency.
D0270	Bitewing – single radiographic image	No	One per day, up to two per six-month period, per member, per provider. Not payable with D0210, D0270, D0272, D0273, or D0274 on same DOS or up to six months after. Six-month limitation may be exceeded in an emergency.
D0272	Bitewings – two radiographic images	No	One set of bitewings per six-month period, per member, per provider. Not payable with D0210, D0270, D0272, D0273, or D0274 on same DOS or up to six months after. Six-month limitation may be exceeded in an emergency.

[5] For proper and legitimate insurance coding, always check your state dental board rules and regulations, as well as the patient's dental insurance plan *Summary Plan Description* and *Plan Document* for claims reimbursement. The above codes are for informational purposes only. The treatment provider filing claims assumes all responsibility.

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D0273	Bitewings – three radiographic images	No	One set of bitewings per six-month period, per member, per provider. Not payable with D0210, D0270, D0272, D0273, or D0274 on same DOS or up to six months after. Six-month limitation may be exceeded in an emergency.
D0274	Bitewings – four radiographic images	No	One set of bitewings per six-month period, per member, per provider. Not payable with D0210, D0270, D0272, D0273, or D0274 on same DOS or up to six months after. Six-month limitation may be exceeded in an emergency.
D0277	Vertical bitewings – 7 to 8 radiographic images	No	**Only** for adults ages 21 and older once per 12 months. Not payable with any other bitewings on the same DOS.
D0330	Panoramic radiographic image	No	One per year, except when another radiograph is insufficient for proper diagnosis. Not payable with D0210, D0270, D0272, D0273, or D0274.
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	No	Orthodontia diagnosis only. Allowable for members up to age 20.
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	No	Allowable for members up to age 20. Allowable for orthodontia or oral surgery.
D0351	3D photographic image	No	This procedure is for dental or maxillofacial diagnostic purposes. Not applicable for a CAD-CAM procedure. 3D photographic images may be denied as a specialized procedure.
D0393	Treatment simulation using 3D image volume	No	Post-processing of image or image sets. CDT: The use of 3D image volumes for simulation of treatment including, but not limited to, dental implant placement, orthognathic surgery and orthodontic tooth movement. May be denied as a specialized technique.
D0600	Caries detection	No	Nonionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum. The iTero 5D with NIRI qualifies for this code and may be reimbursed.

For proper and legitimate insurance coding, always check your state dental board rules and regulations, as well as the patient's dental insurance plan *Summary Plan Description* and *Plan Document* for claims reimbursement. The above codes are for informational purposes only. The treatment provider filing claims assumes all responsibility.

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Common orthodontic treatment codes[7]

Code	Description of service	Prior authorization?	Limitations and requirements (varies by state and insurer)
D8030	Limited orthodontic treatment of the adolescent dentition	Yes	This reimbursement is for the initial placement when the date of service and the appliance placement date are the same. In some cases, this includes panoramic and cephalometric films, diagnostic casts, photos and consultation (records). If patient agrees to treatment, the fee for records may be included in the total treatment fee and is not separately payable.
D8040	Limited orthodontic treatment of the adult dentition	Yes	This reimbursement is for the initial placement when the date of service and the appliance placement date are the same.
D8080	Comprehensive orthodontic treatment of the adolescent dentition	Yes	This reimbursement is for the initial placement when the date of service and the appliance placement date are the same.
D8090	Comprehensive orthodontic treatment of the adult dentition	Yes	This reimbursement is for the initial placement when the date of service and the appliance placement date are the same.
D8999	Unspecified orthodontic procedure, by report, i.e. Miscellaneous	Yes	Used for a procedure that is not adequately described by a code. Requires narrative and may require IC review by Dental Consultant.
D8691 D8696/7	Repair of orthodontic appliance	No	New CDT codes 2020, D8696 – repair of orthodontic appliance – maxillary D8697 – repair of orthodontic appliance – mandibular. Previously D8691
D8692 D8703/4	Replacement of lost or broken retainer	No	New CDT codes 2020, D8703 – replacement of lost or broken retainer – maxillary. D8704 – replacement of lost or broken retainer – mandibular
D8660	Pre-orthodontic treatment examination visit		This dental procedure code covers a patient visit prior to starting orthodontic treatment, which are scheduled to monitor growth and development of a patient's dentition, at intervals established by the doctor, to determine if/when orthodontic treatment should begin.

[7] For proper and legitimate insurance coding, always check your state dental board rules and regulations, as well as the patient's dental insurance plan *Summary Plan Description* and *Plan Document* for claims reimbursement. The above codes are for informational purposes only. The treatment provider filing claims assumes all responsibility.

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D8670	Periodic orthodontic treatment visit (as part of contract)	Yes	This dental procedure code covers regular, contracted orthodontic visits, which are to scheduled to evaluate and update patient care while undergoing orthodontic treatment.
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	Yes	This reimbursement is for the initial placement when the date of service and the appliance placement date are the same. May have time constraints for reimbursement and may require treating doctor placement.

For proper and legitimate insurance coding, always check your state dental board rules and regulations, as well as the patient's dental insurance plan *Summary Plan Description* and *Plan Document* for claims reimbursement. The above codes are for informational purposes only. The treatment provider filing claims assumes all responsibility.

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