



## PRACTICE BOOSTER® CODING ADVISOR READY TO LAUNCH SEPTEMBER 15TH

Have you ever wished you could find the correct dental code for a new procedure with just a quick touch of a button? Do you wish you knew how to write narratives for the dental procedures that typically require them? Would it be helpful to know which procedure codes are likely to have frequency limitations and/or receive an alternate benefit? Perhaps you would like to view a short clinical video clip to better understand certain services that are performed in your practice. Or maybe you would like to be notified when major dental carriers change processing policies that will affect reimbursement. Wouldn't it be nice to have access to all of this information 24/7? We have been listening to you. The Practice Booster® Coding Advisor launches September 15th, and we think you are going to love it.

*Insurance Solutions Newsletter* and Dr. Charles Blair have joined forces to bring you the Practice Booster® Coding Advisor—a powerful new web-based solution that provides answers to all your coding and billing questions any hour of the day, any day of the week. With the Practice Booster® Coding Advisor, coding dental procedures and writing narratives has never been easier. Its powerful search engine allows you to quickly find dental codes for any service performed by a dentist, as well as commonly used products and materials such as Arestin®, OraVerse®, OralCDx®, ViziLite®, Valplast®, Lava®, etc.

Simply enter a key term to find a code, review our experts' comments and warnings, and click on any one of an assortment of icons that allow you to view additional tips, narratives, images, video clips, flowcharts, and/or articles—all related to that code.

Dr. Blair—one of dentistry's leading authorities on practice profitability, fee analysis, and insurance coding strategies—and the staff of *Insurance Solutions Newsletter* have combined and organized their collective knowledge and research into a single web-based portal to bring you the most extensive dental coding and billing toolbox at your fingertips 24 hours a day, seven days a week.

As an *Insurance Solutions Newsletter* subscriber, you will be among the first to be offered a Practice Booster® membership. You can preview the new website at [www.practicebooster.com](http://www.practicebooster.com). If you find it as helpful as we think you will, you may transfer the balance of your current newsletter subscription over to a Practice Booster® membership. Those who subscribe to Practice Booster® will continue to receive *Insurance Solutions Newsletter* by

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## DEADLINE APPROACHES FOR CODE REQUESTS

Surprisingly few code requests have been received thus far by the ADA's Code Revision Committee for dentistry's next code set. The deadline for submitting code requests for CDT 2013-2014 is October 1, 2011.

Instructions, evaluation criteria, and forms for requesting new or revised CDT codes (or deletions) are available online at [www.ada.org/3835.aspx](http://www.ada.org/3835.aspx). Questions about the code revision process can be sent to [dentalcode@ada.org](mailto:dentalcode@ada.org) or call 312-440-2500. 📖

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## **PRACTICE BOOSTER® CODING ADVISOR READY TO LAUNCH SEPTEMBER 15TH**

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mail and will also enjoy the following Practice Booster® Coding Advisor features:

- A single portal where users can obtain expert guidance for reporting CDT procedure codes, review common dental plan limitations, and receive tips for reducing coding errors and improving reimbursement
- A powerful search engine to look up codes for dental procedures and commonly used products and materials
- Sample narratives plus quick tips for constructing meaningful narratives customized for each patient
- Video clips and images to ensure that all staff understand and are confident in reporting dental procedure codes
- Flowcharts to help staff understand common sequencing of treatment and procedure codes
- Decision trees to help staff troubleshoot administrative billing issues such as refund requests, prompt payment laws, Medicare participation, etc.
- Late-breaking news alerts and quick links to helpful articles on coding and other administrative and billing issues such as HIPAA, HITECH, Medicare, Workers' Comp, etc.
- PPO write-off calculator—helping staff calculate patient responsibility and provider write-offs when patients have multiple dental and/or medical plans
- Easy-to-use discussion forum—allowing subscribers across the country to share their knowledge, experiences, and questions
- Comprehensive index of frequently asked questions and helpful coding articles
- State laws pertaining to coordination of benefits, prompt payment, insurance refunds, record keeping, dental practice acts, etc.

All of this information is available 24/7 and can be accessed from any web-enabled computer, I-Pad, etc.

### **What does it cost?**

The Practice Booster® Coding Advisor will be available beginning September 15th for a \$359 annual membership.

As mentioned earlier, current *Insurance Solutions* subscribers who wish to upgrade to the Practice Booster® Coding Advisor can transfer the balance of their remaining newsletter subscription toward their Practice Booster® membership. Practice Booster® members will continue to receive *Insurance Solutions* newsletters by mail in addition to having access to all of the features that Practice Booster® has to offer. Be sure to visit our website at [www.practicebooster.com](http://www.practicebooster.com) for additional information about obtaining a Practice Booster® membership beginning September 15th. 📖



*The Practice Booster® Coding Advisor is coming September 15th, and we think you are going to love it.*

### **THE NEW CODING ADVISOR**

- Improves cash flow by expediting reimbursements
- Decreases time-consuming and potentially litigious coding errors
- Improves documentation on claims resulting in quicker payment
- Highlights common dental benefit limitations so staff can proactively prepare patients for their financial responsibility
- Provides videos and flow charts to help business staff better understand clinical procedures and common treatment sequencing

## Simply listing “exam” in the patient record does not meet the standard of care and will be problematic if treatment is challenged in the court system, by your state dental board, or during an insurance audit.

### PREPARING FOR YOUR NEXT EXAM

It goes without saying that a thorough evaluation is necessary to develop a thorough treatment plan. Without a thorough evaluation, conditions may exist that, if missed, may lead to misdiagnosis, maltreatment, and negative outcomes. Likewise, without a thorough evaluation of the CDT evaluation codes, billing errors are likely. The purpose of this article is to take a closer look at dentistry’s seven evaluation codes and clear up some of the most common misconceptions. In doing so, we hope to help readers reduce reporting errors and potentially improve reimbursement by correctly coding evaluation procedures.

Let’s start by clarifying that CDT codes D0120 through D0180 are not exam codes. They are evaluation codes. What is the difference, and why is it important?

**Examine: v.** The act or process of examining; to inspect closely ([www.m-w.com](http://www.m-w.com))

**Evaluation: n.** The patient assessment that may include gathering of information through interview, observation, examination, and use of specific tests that allows a dentist to diagnose existing conditions (CDT 2011-2012)

An exam is a component of the evaluation process, but an exam is not an evaluation. An evaluation has not been completed until the dentist uses the information gathered during his/her examination of the patient (and dental and medical history) to make a determination/assessment regarding the patient’s oral condition.

In other words, the dentist must render a diagnosis in order to accurately report an evaluation code. Furthermore, that diagnosis must be recorded in the patient’s chart. If a diagnosis is not documented in the chart, CDT codes D0120–D0180 should not be reported.

While on the subject of record keeping, remember the following: If it’s not in the patient’s treatment record, you didn’t see it, you didn’t say it, you didn’t do it, it didn’t need to be done, and it didn’t exist—from a legal perspective. In other words, if you completed a thorough exam, made a definitive diagnosis, devised a comprehensive treatment plan that addresses any pathology, obtained informed consent, and presented patient options, but then failed to record this information in the clinical record—from a legal perspective—you never performed an evaluation.

Simply listing “exam” in the patient record does not meet the standard of care and will be problematic if treatment is challenged in the court system, by your state dental board, or during an insurance audit.

Keep thorough records in each area of your practice, but be especially diligent when documenting patient evaluations. A thorough oral evaluation is the foundation from which thorough treatment plans are built and upon which defending your treatment ultimately rests.

### Why must we record a diagnosis in the patient’s chart when performing an evaluation?

The healthcare culture in the U.S. is finally more integrated. Dental health is now seen as an essential component of overall physical health. Insurance carriers are moving toward a more diagnosis-driven treatment and reimbursement model. Over the past few years, certain medical conditions and risk factors have become important justification for performing and receiving reimbursement for certain dental procedures.

A thorough oral evaluation and properly recorded diagnosis has become the foundation upon which sound treatment models are developed and reimbursement decisions are made by third party payers in this newly integrated healthcare environment. Take code D1206, for example. Application of fluoride varnish (child or adult) is justified by a caries risk assessment of moderate to severe caries risk, a case where the diagnosis must be recorded to justify the treatment and reporting of the code. Keep this in mind as we discuss the following questions that we frequently receive about the CDT evaluation codes and their proper usage.

### When is it appropriate to report D0180 instead of D0150 for a comprehensive evaluation of a new patient?

#### Common D0180 Coding Scenario:

*Mrs. Allan presents to the office as a new patient and has completed her health history form. Upon review of the health history, the doctor notices (in part) that Mrs. Allan is a smoker. The American Academy of Periodontology states that “recent studies have shown that tobacco use may be one of the most significant risk factors in the development and progression of periodontal disease. In addition, following periodontal treatment or any type of oral surgery, the chemicals in tobacco can slow down the healing process and make the treatment results less predictable.”*

Research shows that a smoker is more likely than a nonsmoker to have the following problems:

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## PREPARING FOR YOUR NEXT EXAM

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- Calculus
- Deep pockets
- Loss of bone and tissue that support teeth

Because smoking is a significant risk factor for periodontal disease, Dr. Smith (a general dentist) determines that a comprehensive periodontal evaluation (D0180) is needed for this new patient.

Although D0150 (comprehensive oral evaluation) could have been used to describe the comprehensive evaluation for this new patient instead of D0180, D0150 does not emphasize the concern for, attention to, existence of, or potential for, periodontal disease.

Also note that a comprehensive periodontal probing and charting is a required component of D0180, whereas D0150 includes a periodontal screening and/or charting as indicated. If a comprehensive oral evaluation has been performed but only PSR or six-points-per-tooth periodontal probing has been charted, then D0150 is the appropriate code to report.

D0150 is typically indicated for new patient evaluations where a general dentist performs a comprehensive oral evaluation but the patient has no signs, symptoms, or risk factors of periodontal disease, or—based on the results of a periodontal screening—the general dentist has made the decision to refer the patient to a periodontist, who will then perform a more comprehensive periodontally focused evaluation (D0180).

### What is required to report a comprehensive periodontal evaluation (D0180)?

In its Parameters on Comprehensive Periodontal Evaluation, the American Academy of Periodontology stipulates that a comprehensive periodontal evaluation requires the following to be performed and all relevant findings to be documented in the patient record:

1. A medical history should be taken to identify predisposing conditions that may affect treatment, patient management, and outcomes. Such conditions include (but are not limited to) diabetes, hypertension, pregnancy, smoking, substance abuse, medications, or other existing conditions that impact traditional dental therapy.
2. A dental history should be taken and evaluated, past dental and periodontal records and radiographs should be reviewed, and the chief complaint/reason for visit should be documented.
3. Extraoral structures should be examined and evaluated. The temporomandibular apparatus and associated structures may also be evaluated.
4. Intraoral tissues and structures should be examined and evaluated, including the oral mucosa, muscles of mastication, lips, floor of mouth, tongue, salivary glands, palate, and oropharynx.

5. The teeth and their replacements should be examined and evaluated, including observation and recording of missing teeth, condition of restorations, caries, tooth mobility, tooth position, occlusal and interdental relationships, signs of parafunctional habits, and, when applicable, pulpal status.
6. Radiographs, based on the needs of the patient, should be utilized for proper evaluation and interpretation of the status of the periodontium and dental implants. Radiographic abnormalities should be noted.
7. Presence and distribution of plaque and calculus should be noted.
8. Periodontal soft tissues, including peri-implant tissues, should be examined and the presence and types of exudates (if any) determined and documented.
9. Probing depths (six points/tooth), location of the gingival margin, clinical attachment levels, and the presence of bleeding on probing should be evaluated.
10. Mucogingival relationships should be evaluated to identify

deficiencies of keratinized tissue, abnormal frenulum, and other tissue abnormalities such as clinically significant gingival recession.



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### I'm Glad You Asked... BILLING NITROUS OXIDE

#### Question

Do dental plans typically cover nitrous oxide? For those that do, do they pay per *visit*, or is payment based on *time*?

#### Answer

D9230 is reported per visit. Although most dental plans do not provide a benefit for nitrous oxide, some may if you submit a narrative indicating why N<sub>2</sub>O was necessary.

For example, some dental plans will provide a benefit if multiple surgical extractions are performed on the same day, the patient is very young, the patient has behavior management problems, the patient is allergic to local anesthesia, or local anesthesia is ineffective due to an infection or anatomic variation. 📖

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11. The presence, location, and extent of furcation involvements (if any) should be noted.
12. In addition to visual inspection, probing, and radiographic examination, the patient's periodontal condition may warrant the use of additional diagnostic aids. These include, but are not limited to, diagnostic casts, microbial and other biologic assessments, radiographic imaging, or other medical laboratory tests.
13. All relevant clinical findings should be documented in the patient's record.
14. Referral to other healthcare providers should be made and documented when warranted.
15. Based on the results of the examination and evaluation, a diagnosis and proposed treatment plan should be recorded and presented to the patient. Patients should be informed of the disease process, therapeutic alternatives, potential complications, expected results, and their responsibilities in treatment. Consequences of no treatment should also be explained to the patient.

### When can we report D0150 or D0180 instead of D0120 for an established patient evaluation?

D0150 can be reported when performing a comprehensive oral evaluation on an *established* patient who has been absent from active treatment for three or more years or for those who have had a significant health change. A significant change in health may include a recently diagnosed condition such as Sjogren's syndrome, osteoporosis, pregnancy, heart disease, stroke, cancer, or perhaps the patient is now taking immunosuppressive drugs or medications known to cause xerostomia.

With regard to reimbursement, some dental plans are structured to allow payment for D0150 every three to five years. Some only pay if documentation is submitted showing that a comprehensive evaluation was performed and why. Others only allow payment for D0150 once per provider but will pay an alternate benefit of a periodic oral evaluation (D0120). Regardless of how often a dental plan will pay for D0150, CDT limits the use of D0150 for established patients to those who have had a significant change in health conditions (by report) or who have been absent from active treatment for at least three years or more. In other words, chart notes should indicate why a comprehensive oral evaluation was warranted and performed on an established patient.

Conversely, D0180 can be reported any time a comprehensive periodontal evaluation and charting is performed on a new or established patient who has been diagnosed with periodontal disease—or who has signs, symptoms, or risk factors associated with periodontal disease. CDT imposes no frequency limitations for reporting D0180. In fact, the AAP recommends that all periodontal patients receive a comprehensive periodontal evaluation (D0180) at least once a year.

D0120 should only be used to report a periodic oral evaluation of an established patient. A periodic oral evaluation involves updating any and all information that has been previously gathered, examined, and evaluated. D0120 should never be used to describe an evaluation of a new patient, even if that new patient is a young child. Some dental practices report D0120 when evaluating young children who are new to the practice because their fee for D0120 seems more appropriate. However, new patient evaluations for children under three years of age should be reported as D0145 (oral evaluation for a patient under three years of age and counseling with primary caregiver), and new patient evaluations on children three years or older should be reported as D0150. Dentists always have discretion to charge a lower fee for D0150 on children if they choose to do so.

### Common D0150 Coding Scenario:

*Mrs. Smith's husband, John, transfers from Dr. Jacob's office to Dr. Robinson's office. John received regular care at Dr. Jacob's office and is current with his six-month recare regimen. Although John may view this visit as just another periodic oral evaluation, John is not a patient of record in Dr. Robinson's office. As such, extra time is needed for Dr. Robinson to become familiar with John's oral condition. Dr. Robinson will need to review John's dental and medical history, perform a general health assessment, thoroughly examine the extraoral and intraoral hard and soft tissues, record the existence and condition of prior restorations and prostheses, record missing or unerupted teeth, evaluate occlusal relationships, look for and evaluate hard and soft tissue anomalies, perform a visual and palpation exam for oral cancer, and evaluate periodontal conditions by doing a periodontal screening (PSR or six-points-per-tooth probings).*

Although certain elements of this exam may be performed by Dr. Robinson's staff, the dentist must examine the patient's mouth, determine the diagnosis, and develop the treatment plan. This new patient evaluation is appropriately coded as D0150. If John had presented signs, symptoms, or risk factors associated with periodontal disease, and Dr. Robinson had performed a comprehensive periodontal charting (recording six-points-per-tooth pocket depths, bleeding points, furcations, recessions, clinical attachment levels, purulent discharge, etc.), then D0180 would have been reported.

### When is it appropriate to report a detailed and extensive problem-focused oral evaluation (D0160)?

D0160 can be reported when a condition that was discovered during a comprehensive oral evaluation (D0150 or D0180) requires further diagnostics, analysis, and evaluation in order to determine a diagnosis and develop a treatment plan. D0160 is a "by report" code, which means that a narrative should be sent with the claim describing the condition

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that required a more extensive oral evaluation. Examples of conditions that may require a detailed and extensive problem-focused evaluation (D0160) include complicated perio-prosthetic conditions, complex temporomandibular dysfunction, complex orthodontic conditions, complex implant cases, etc.

### Common D0160 Coding Scenario:

*During John's comprehensive oral evaluation (D0150) above, he mentioned that he could not open his mouth very wide and had chronic jaw pain following a recent bicycle accident in which he was thrown over the handle bars. Although his facial lacerations had healed, Dr. Robinson noted that John had popping and clicking in both temporomandibular joints and confirmed that he was not able to open his mouth fully. John was informed that another appointment was necessary to perform an extensive examination of the head and neck muscles, range of motion, and areas of tenderness. At the second appointment, radiographs of the temporomandibular joint were taken and occlusal relationships recorded. After a thorough clinical and radiological examination and evaluation of both joints, Dr. Robinson determined that a TMJ orthotic would be necessary to reposition the joints to allow for healing. The detailed and extensive problem-focused evaluation performed during the second appointment was reported to John's insurance carrier using D0160.*

In the scenario above, "Other accident" should also have been checked in field #45 of the dental claim form and the date of the accident entered in field #46, since the TMJ condition was caused by a bicycle accident. Some dental plans offer higher coverage for accident-related services. Others require accident claims to be submitted to medical insurance before considering payment.

### Should we report D0145 each time we perform an evaluation on a patient under three years of age? Or should we report the first visit as D0145 and then D0120 thereafter?

It is appropriate to report D0145 for each evaluation of a child under three years of age. Technically, a periodic oral evaluation (D0120) is not appropriate to report because the CDT descriptor for D0120 specifically states that it is performed to determine any changes in the patient's dental and health status since a previous comprehensive or periodic evaluation. D0145 is neither a comprehensive (D0150) nor a periodic evaluation (D0120). D0145 was added to CDT because of the unique procedures that are necessary when evaluating a very young child.

### Common D0145 Coding Scenario:

*Six months after the eruption of her first tooth, Pippa's parents took her to Dr. Robinson, their family dentist. Although little Pippa balked considerably, Dr. Robinson managed to look at her oral soft tissue and front*

*teeth. Dr. Robinson determined that Pippa was at high risk for caries because her parents put her to bed with a bottle of juice every night and there was no fluoride in the water system in the community where she lived.*

*Dr. Robinson presented his findings and treatment recommendations to Pippa's parents. He also counseled them on her diet, the bottle of juice at bedtime, and her high risk for caries. He recommended a prophylaxis and fluoride varnish treatment. Pippa's parents agreed, and with the help of both parents, Dr. Robinson managed to deplaque Pippa's baby teeth with a toothbrush and placed fluoride varnish. At the end of the appointment, Dr. Robinson reported codes D0145, D1120, and D1206.*

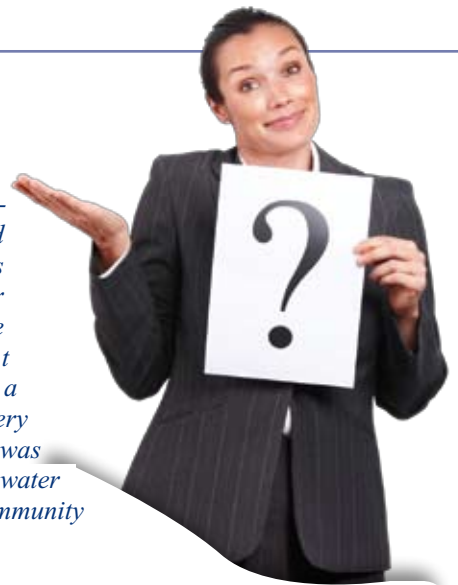
*Dr. Robinson continued to see Pippa regularly until she was three years old, each subsequent time reporting D0145 after performing an evaluation and counseling Pippa's parents about her diet and continued need for cleaning and fluoride treatments. After Pippa turned three, she was very comfortable with Dr. Robinson and allowed him to perform a comprehensive evaluation, which he then reported as D0150. Subsequent visits were then reported as D0120.*

### Is it appropriate to report a problem-focused evaluation (D0140) in addition to palliative treatment (D9110)?

D0140 is used to report the evaluation of a specific problem, dental emergency, acute infection, etc. It is a diagnostic/evaluation code—not a treatment code. Although some dental plans exclude payment for D0140 when performed on the same day as palliative or definitive treatment, there is nothing in CDT that prohibits a dentist from reporting both—if both are performed. However, D0140 should only be reported when evaluating a problem that has not been previously diagnosed. In other words, if a root canal is recommended as a result of a comprehensive or periodic oral evaluation, it is not appropriate to then report D0140 for the problem-focused evaluation when the root canal is performed.

Along that same line, D9110 should not be reported unless some type of treatment is performed to relieve dental pain/discomfort (i.e., when the dentist uses a curette to remove a popcorn hull from under inflamed gum tissue, a finishing bur is used to smooth the rough edge of a fractured tooth, wax is placed over an ortho bracket that is lacerating gum tissue, etc.).

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Furthermore, in order to report D9110, the chart notes must specify that the patient was in some pain and identify the palliative treatment that was performed to relieve the pain. Also remember that palliative treatment should not be reported when the dentist examines the patient but ends up only writing a prescription. In that situation, D0140 would be the appropriate code to report.

### Common D0140 Coding Scenario:

*Mrs. Smith unexpectedly bit down on an olive pit while eating a salad during lunch. She complained that two teeth on the lower right were very sore. The area was evaluated by Dr. Robinson, but no treatment was deemed necessary. D0140 is reported in this type of evaluation in addition to coding for any radiographs that were taken.*

### Common D9110 with D0140 Coding Scenario:

*Mrs. Smith went to the movies with her husband over the weekend. She awoke on Monday morning in pain and with a swollen gum in the upper right quadrant. When she tried to brush the area it was tender and bled. After performing an examination and reviewing the periapical radiograph he took, Dr. Robinson diagnosed a periodontal abscess. He used a curette to clean the pocket and removed a popcorn hull. D0140 can be reported for the evaluation and diagnosis, D9110 can be reported for the emergency treatment provided to remove the popcorn hull, and D0220 can be reported for the periapical x-ray.*

As previously mentioned (but worth repeating), D9110 is not used to describe a situation where only a prescription is provided and no treatment is performed to alleviate pain. Report D9110 only when some type of treatment is actually performed to relieve pain.

### When is it appropriate to report a consultation (D9310) instead of a problem-focused evaluation (D0140)?

D9310 can be reported when a dentist or physician refers a patient to another dentist for an evaluation or second opinion. D9310 involves both a consultation and an oral evaluation. Any treatment performed by the consulted dentist should be billed separately.

D0140 is used to describe an oral evaluation where the patient presents with a specific problem, emergency, trauma, and/or acute infection without necessarily being referred by another practitioner.

### Common D9310 Coding Scenario:

*A patient presents with acute pain and gingival inflammation surrounding tooth #17. Due to the position and curvature of the roots, her general dentist is concerned that the removal of #17 could risk injury to the inferior alveolar nerve and decides to refer the patient to an oral surgeon for a second opinion and treatment.*

*The oral surgeon shares the general dentist's concern and decides to perform a coronectomy rather than a full extraction. Since the patient was referred by her general dentist, the oral surgeon reports the evaluation/consultation as D9310. The coronectomy was reported as D7251, and a narrative was submitted.*

Although CDT does not specifically require a specialist to use one code over the other, D9310 more accurately describes that the patient has been referred to a specialist by another dentist or physician. However, the current reality is that most specialists report a limited problem-focused evaluation (D0140) rather than a consultation (D9310) because previous editions of CDT implied that D9310 could not be reported if the consulted dentist initiated treatment. A revision to CDT has since clarified that D9310 may be reported even if the consulted dentist initiates treatment, but D9310 is inappropriate for self-referred second opinions.

With regard to reimbursement, some dental plans include D9310 in their list of evaluation codes that are typically limited to two per year. Some provide a benefit for D9310 in addition to the number of evaluations they allow per year. Likewise, some dental plans include D0140 in the list of evaluation codes that are limited to two per year, whereas others allow an additional benefit for D0140. Some dental plans allow up to three problem-focused evaluations per year, and others have no frequency limitations for D9310 or D0140.

### Can D0170 be used to report a periodontal re-evaluation following SRP?

Although code D0170 is available to report a limited problem-focused re-evaluation of an established patient, CDT specifies that D0170 is not to be used to report a post-operative re-evaluation. As such, it is not appropriate to report D0170 for a periodontal re-evaluation following scaling and root planing.

There is no specific CDT 2011-2012 code for reporting a periodontal re-evaluation following scaling and root planing. Dentists can either include the post-operative oral evaluation in their fee for scaling and root planing or report D4999, unspecified periodontal procedure, by report.

### Common D0170 Coding Scenarios:

#### Scenario #1

*A 14-year-old patient was rushed to Dr. Robinson's office after being hit in the face with a baseball. Although bleeding was substantial and the lips were very swollen, Dr. Robinson determined that no teeth were mobile or avulsed, and sutures were not needed. Dr. Robinson requested that the patient be seen in a week for a follow-up evaluation.*

*The initial visit was coded as a limited problem-focused evaluation (D0140), and the re-evaluation performed the following week was billed as D0170.*

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### Scenario #2

A patient complains of a dull ache and points to the upper right quadrant. After several diagnostic tests, Dr. Robinson is still unable to identify which tooth is causing the pain. The patient is asked to come back in a week for further evaluation.

The first visit is coded as a limited problem focused evaluation (D0140), and the re-evaluation performed the following week can be billed as D0170.

### Also remember...

1. For a CDT evaluation code to be reported, it must be performed by a dentist. Staff may help gather information, conduct certain tests, and expose x-rays. However, the dentist must have clinical contact with the patient, examine the patient's mouth, analyze the information, and record a diagnosis in the patient's chart in order to complete and bill for an evaluation.
2. A notation of "exam" listed in the patient's treatment record is not enough to justify the submission of codes D0120 through D0180. Submission of these evaluation codes must include the evaluation of the information gathered during the exam and the conclusions (diagnosis) determined as a result of the evaluation.
3. Evaluations D0120, D0150, and D0180 include a basic oral cancer screening (where indicated). The fact that the oral cancer screening was performed should be recorded in the patient's clinical record to meet the standard of care and to justify reimbursement. The type of oral cancer screening may vary depending on the patient's age and risk factors.



## SIX COMMON MISCONCEPTIONS THAT LEAD TO INACCURATE CODING

### Misconception #1:

#### D0180 is a hygienist's exam code

**Truth:** D0180 is a comprehensive periodontal evaluation code used to report evaluations performed on patients who have signs, symptoms, and/or risk factors associated with periodontal disease. The hygienist may gather much of the information, but the dentist must do the evaluation, diagnosis, and treatment planning. D0180 is a comprehensive evaluation with an extra focus on the patient's periodontal status and needs.

### Misconception #2:

#### Only a periodontist can bill D0180

**Truth:** D0180 represents a comprehensive periodontal evaluation performed by any licensed dentist on a patient who has signs, symptoms, and/or risk factors for periodontal disease.

### Misconception #3:

#### D0150 can be billed every three years

**Truth:** D0150 may be reported for a comprehensive evaluation of an established patient in limited circumstances. Generally, this requires a significant change in health status or absence from active treatment for three or more years.

Some dental plans only reimburse D0150 once per provider but will pay an alternate benefit of D0120. Other plans will reimburse D0150 once every three or five years. Even so, the code stipulates that D0150 can only be reported for established patients if they have a significant change in health status or have been absent from active treatment for three or more years.

### Misconception #4:

#### D0140 should not be used because plans only allow two exams per year

**Truth:** Some dental plans limit benefits to two evaluations per year, no matter how they are coded. However, others have no limitation for emergency exams (D0140). Bill and code for what you do—not what you believe will be paid. Physicians bill for all evaluations regardless of insurance coverage, and dentists should too. Simply inform patients prior to treatment that some dental plans limit the number of evaluations they pay each year. If that occurs, the patient will be responsible for the emergency evaluation fee.

### Misconception #5:

#### D9310 is never covered

**Truth:** While some dental plans do not pay for consultations (D9310), many do. Some require a copy of the referral letter provided by the referring entity. If the referral is made as a result of a medical condition that affects the oral cavity, or vice versa, be sure to also include that information as documentation for D9310.

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## PREPARING FOR YOUR NEXT EXAM

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### Misconception #6: D0160 is never covered

**Truth:** An extensive problem-focused evaluation (D0160) may be reimbursed but must be supported with documentation that includes a diagnosis. History of a comprehensive oral evaluation (D0150 or D0180) may be required prior to receiving reimbursement for D0160. Sending a copy of well-documented treatment records is often adequate.

### In Summary

Dental plans vary widely in how often they pay for the various evaluation codes, so do not paint all dental plans with the same broad brush. Just because a local Delta Dental plan limits or does not cover a certain evaluation code does not mean that all dental carriers do the same.

Dentists must bill for what they do—not what they believe will be paid. Physicians bill for all evaluations, regardless of insurance coverage, and dentists should too. Simply inform patients prior to treatment that coverage varies for each plan. If a patient complains about plan limitations, remind the patient that his/her employer determines which dental services are covered and which are patient responsibility. Some employers are very generous; others are not. While you are happy to submit the claim for the patient, emphasize that you cannot guarantee coverage because only the patient and his/her employer have access to *all* the specific details of his/her dental plan. 📖



## ADA CLARIFIES REQUIREMENTS FOR BILLING OSSEOUS SURGERY CODES

### Important update for laser users...

In response to questions submitted by Delta Dental of Michigan, Ohio, and Indiana, the American Dental Association's Council on Dental Benefit Programs (CDBP) has clarified its position regarding the requirements for billing osseous surgery using CDT codes D4260 or D4261. Although the original discussion occurred in May 2009, it is highly relevant today because some dental practices are reporting the osseous surgery codes (D4260 and/or D4261) for laser assisted periodontal procedures.

### Coding Osseous Surgery

The ADA was first asked if a dentist can submit a claim for osseous surgery (D4260 and/or D4261) without reflecting a flap in the surgical site of the procedure submitted for benefits. The ADA/CDBP's response follows:

Nomenclature for dental procedure codes D4260 and D4261 contain the following salient text:

*“osseous surgery (including flap entry and closure)...” This wording is meant to preclude separate reporting of flap entry and closure when they are components of the osseous surgery procedure performed by the dentist.*

Surprising to some dentists and dental insurance carriers, the ADA/CDBP's response clarifies that reflection of a flap is not required in order to report D4260 or D4261. However, if performed, the flap is *included* in the osseous surgery code and should not be billed separately.

### Coding Laser Assisted Periodontal Procedures

The second question submitted by Delta Dental Plan of Michigan, Ohio, and Indiana asked the ADA/CDBP which CDT code is appropriate for reporting the “laser assisted new attachment procedure,” also referred to as LANAP®, a non-surgical alternative laser treatment protocol for gum disease patented by Millennium Dental Technologies, Inc.

In its response, the ADA/CDBP emphasized that the full procedure code (as published in CDT) must always be considered when determining which dental procedure code to use to document services provided. With regard to osseous surgery, the ADA/CDBP pointed out that procedure codes D4260 and D4261 are used to document an osseous surgery procedure that “modifies the bony support of the teeth by reshaping the alveolar process to achieve a more physiologic form.”

#### The full code as published in CDT 2011-2012 reads:

**D4260** Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant

This procedure modifies the bony support of the teeth by reshaping the alveolar process to achieve a more physiologic form. This may include the removal of supporting bone (osteotomy) and/or non-supporting bone (osteoplasty). Other procedures may be required concurrent to D4260 and should be reported using their own unique codes.

(Continued on page 10)

## ADA CLARIFIES REQUIREMENTS FOR BILLING OSSEOUS SURGERY CODES

### Important update for laser users...

(Continued from page 9)

Based on the ADA/CDBP's response, if a dentist has actually modified the bony support of the teeth by reshaping the alveolar process, then he/she can report the appropriate osseous surgery code (D4260 or D4261), regardless of the instrumentation used. The ADA/CDBP declined to render an opinion specifically regarding coding the LANAP® procedure, stating that the question is more of a scientific and procedural issue.

Therein lies the controversy. Most insurance carriers are not convinced that laser assisted periodontal procedures involve modifying and reshaping alveolar bone. They point to the fact that the majority of lasers being used for periodontal procedures are marketed as soft tissue lasers, and the treatment protocols that are advertised do not indicate that alveolar bone is removed, modified, or reshaped. Until insurance carriers are convinced that alveolar bone is actually modified and reshaped to achieve physiologic form, they are denying D4260/D4261 claims if they learn that a soft tissue laser was used.

### Which CDT code IS appropriate for periodontal procedures performed with a soft tissue laser?

According to the ADA/CDBP, in cases where no modification of bony support is performed, a dentist may wish to consider the gingival flap (including root planing) procedure codes (D4240/D4241) or the periodontal scaling and root planing procedures codes (D4341/D4342). If none of these codes accurately describe the periodontal procedure being performed with the laser, D4999 (unspecified periodontal procedure, by report) should be submitted with documentation that explains the service provided.

### Our opinion...

Until such time that the ADA and the dental insurance industry become convinced that periodontal procedures performed with lasers actually involve reshaping alveolar bone, dentists should consider billing a gingival flap procedure (D4240 or D4241) or periodontal scaling and root planing (D4341/D4342).

A gingival flap procedure may be appropriate if a flap is reflected or resected, a laser is used to debride/decontaminate the periodontal pocket, and an ultrasonic scaler and/or hand instruments are used to perform scaling and root planing. Based on the ADA/CDBP's comments regarding osseous surgery, we now know that the flap may involve the dentist simply relieving the gingival cuff.

If the dentist does not reflect or resect a flap, and the laser is used to debride/decontaminate the periodontal pocket at the time of and as an adjunct to traditional/mechanical scaling and root planing, D4341/D4342 may be reported. Your fee for D4341/D4342 may be modified upward if you choose. However, participating providers will likely be limited to their network allowable fee.

If the laser is used to debride/decontaminate the periodontal pocket on a date separate from scaling and root planing, D4999 (by report) is your only coding option, which is not likely to be paid by most dental plans. 📖

## REQUIREMENTS FOR REPORTING SURGICAL EXTRACTIONS (D7210)

**Q.** A couple of months ago I asked our doctor what constitutes a surgical extraction. He said if a periosteal elevator is used to separate the gingival tissue from the tooth prior to using forceps to extract the tooth, it is a surgical extraction. However, as I was reading one of your previous newsletters about the revised CDT 2011 codes, it appears that a surgical extraction requires bone removal and/or sectioning the tooth. I don't consider separating the gingiva from the tooth to be a mucoperiosteal flap, and I don't think it qualifies as a surgical extraction. My guess is that it should be coded as D7140. Which one of us is right?

**A.** You will be doing your doctor a big favor to revisit your discussion about coding surgical extractions. Dental insurance carriers monitor claims for D7210 closely because they are aware that there is substantial confusion about this code.

The ADA's Code Revision Committee (CRC) revised D7210 in CDT 2011-2012 to clarify that the elevation of a flap is not always required. The flap is optional. However, according to the CRC's official rationale and the current nomenclature and descriptor, removal of bone and/or sectioning the tooth is required in order to report a surgical extraction of an erupted tooth (D7210). 📖



## BACK TO BASICS: IMPLANTS

### Retrofitting Dentures to Accommodate Implants

**Q.** When billing D5875 for the modification of existing removable dentures to accommodate new implants, is a denture reline considered part of the modification code?

**A.** According to Frank Pokorny, Senior Manager, Dental Codes Maintenance and Development for the Council on Dental Benefit Programs, “Modification refers to actions that affect the prosthesis’ structure, such as drilling space for healing caps and placement of retentive attachments. Any required reline is a separate procedure.”

### Valplast® Boomer Bridge

**Q.** Any idea how we should code a “boomer bridge” that will be used for approximately six months to replace a maxillary anterior tooth while the implant is healing?

**A.** A “boomer bridge” is actually a partial (or “flipper”) made of Valplast® material. It may be used as an interim partial to replace an anterior or posterior tooth. D5820 should be billed when a boomer bridge is used as an interim replacement of a maxillary tooth, and D5821 should be billed when a boomer bridge is used to replace a mandibular tooth on an interim basis.

### Interim and Provisional Implant Restorations

**Q.** We never get paid for interim and provisional restorations. Could we be billing them incorrectly?

**A.** The Implant Coding Flow Chart below will help you determine if you are billing interim and provisional restorations correctly. Although often excluded from dental plans, some will cover them if replacing an anterior tooth or if the tooth was lost due to an accident. 📖

## IMPLANT CODING FLOW CHART

### Phase I: Surgery, Integration, and Healing

Ready-to-Restore Fixed Implant Case	Interim Restorations	Provisional Restorations
<i>Coding the Implant Placement:</i>		
<p>When either a conventional implant or a mini-implant is used on a permanent basis, report the following code:</p> <p>D6010 Surgical placement of implant body: endosteal implant</p>	<p>When an interim implant is placed prior to permanent implant placement to permit healing while an interim prosthesis is in use, report the following code:</p> <p>D6012 Surgical placement of interim implant body for transitional appliance: endosteal implant</p> <p>When a permanent implant (mini-implant or conventional implant) is placed to support an interim prosthesis, report the following code:</p> <p>D6010 Surgical placement of implant body: endosteal implant</p>	<p>When an interim implant is placed prior to permanent implant placement to permit healing while a provisional prosthesis is in use, report the following code:</p> <p>D6012 Surgical placement of interim implant body for transitional appliance: endosteal implant</p> <p>When a permanent implant (mini-implant or conventional implant) is placed to support a provisional prosthesis, report the following code:</p> <p>D6010 Surgical placement of implant body: endosteal implant</p>
<i>Coding the Connection Device/Abutment (if used):</i>		
<p>D6056 Prefabricated abutment – includes placement</p> <p>or</p> <p>D6057 Custom abutment – includes placement</p>	<p>D6056 Prefabricated abutment – includes placement</p> <p>or</p> <p>D6057 Custom abutment – includes placement</p>	<p>D6056 Prefabricated abutment – includes placement</p> <p>or</p> <p>D6057 Custom abutment – includes placement</p>

Phase I: Surgery, Integration, and Healing (Cont'd)

Ready-to-Restore Fixed Implant Case	Interim Restorations	Provisional Restorations
<p><b>Coding the Temporary Restoration(s):</b></p>	<p><b>Coding the Interim Restoration(s):</b></p>	<p><b>Coding the Provisional Restoration(s):</b></p>
<p>No codes are reported when placing an immediate temporary after taking an impression for the definitive prosthesis. (This is considered part of the global crown procedure.)</p>	<p><b>Fixed Components</b> The following codes apply to fixed <i>interim</i> restorations that are used for <i>less than six months</i> (and the final impression has not been made), whether attached to teeth or implant abutments:</p> <p>D6795 Interim retainer crown D6254 Interim pontic</p> <p><b>Removable Components</b> Note: No specific time limit applies to interim removable components</p> <p><b>New Interim Prosthesis</b></p> <p>D5810 Interim complete denture (maxillary) D5811 Interim complete denture (mandibular)</p>	<p><b>Fixed Components</b> The following codes apply to fixed <i>provisional</i> restorations that are used for <i>at least six months</i>, whether attached to teeth or implant abutments:</p> <p>D6793 Provisional retainer crown D6253 Provisional pontic</p> <p><b>Removable Components</b> Since there are no provisional codes for removable prostheses, and since no specific time limit applies to the interim removable partial and interim removable complete denture codes, refer to the following interim removable partial denture or complete denture codes for new <i>provisional</i> removable partial dentures or new <i>provisional</i> complete dentures:</p>
	<p>D5820 Interim partial denture (maxillary) D5821 Interim partial denture (mandibular)</p> <p>D5810/D5811 may be used after extractions prior to placement of implants. Once implants are placed, D5875 may also apply.</p> <p><b>If Retrofitting an Existing Prosthesis to Use as an Interim Prosthesis</b></p> <p>D5875 Modification of removable prosthesis following implant surgery</p> <p>D5875 may also apply in those cases where interim partial dentures are used to permit healing and implants are placed to fit beneath the partials at a later date.</p> <p><b>Coding Attachments</b> If attachments are placed in an interim prosthesis and both portions (male and female) of the attachment are present, report the following:</p> <p>D5862 Precision attachment, by report</p>	<p>D5810 Interim complete denture (maxillary) D5811 Interim complete denture (mandibular)</p> <p>D5820 Interim partial denture (maxillary) D5821 Interim partial denture (mandibular)</p> <p><b>If Retrofitting an Existing Prosthesis to Use as a Provisional Prosthesis</b></p> <p>D5875 Modification of removable prosthesis following implant surgery</p> <p><b>Coding Attachments</b> If attachments are placed in a provisional prosthesis and both portions (male and female) of the attachment are present, report the following:</p> <p>D5862 Precision attachment, by report</p>

## Phase II: Definitive Implant Restoration

Fixed Cases	Removable Cases	Fixed/Removable Cases
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### *Coding the Definitive Implant Placement:*

<p>When either a conventional (full-size) implant or a mini-implant is used on a permanent basis, report the following code:</p> <p>D6010 Surgical placement of implant body: endosteal implant</p> <p>Note that D6040 (surgical placement: eposteal implant) or D6050 (surgical placement: transosteal implant) may also apply.</p>	<p>When either a conventional (full-size) implant or a mini-implant is used on a permanent basis, report the following code:</p> <p>D6010 Surgical placement of implant body: endosteal implant</p> <p>Note that D6040 (surgical placement: eposteal implant) or D6050 (surgical placement: transosteal implant) may also apply.</p>	<p>When either a conventional (full-size) implant or a mini-implant is used on a permanent basis, report the following code:</p> <p>D6010 Surgical placement of implant body: endosteal implant</p> <p>Note that D6040 (surgical placement: eposteal implant) or D6050 (surgical placement: transosteal implant) may also apply.</p>
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### *Coding the Connection Device/Abutment (if used):*

<p>D6056 Prefabricated abutment – includes placement</p> <p>or</p> <p>D6057 Custom abutment – includes placement</p>	<p>If a removable precision attachment is incorporated into an abutment, D6056 is typically billed for the abutment portion [i.e., if using a Locator™ attachment]. The precision attachment can be billed separately using D5862.</p> <p>D6056 Prefabricated abutment – includes placement</p> <p>D5862 Precision attachment, by report</p> <p>or possibly...</p> <p>D6057 Custom abutment – includes placement</p> <p><b>Connector Bar</b> (if used)</p> <p>D6055 Connecting bar – implant supported or abutment supported</p> <p>Report D6055 only once, regardless of how many implants or abutments the bar connects.</p>	<p>D6056 Prefabricated abutment – includes placement</p> <p>or</p> <p>D6057 Custom abutment – includes placement</p> <p><b>Connector Bar</b> (if used)</p> <p>D6055 Connecting bar – implant supported or abutment supported</p> <p>If a fixed/removable denture screws into a bar attached to the implant bodies, report D6055 only once, regardless of how many implants the bar connects.</p>
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## Phase II: Definitive Implant Restoration (Cont'd)

## Fixed Cases

## Removable Cases

## Fixed/Removable Cases

## Coding the Definitive Restoration

**Single Crown or Bridge Retainer**

When an abutment is used to connect a single crown to an implant, select one of the following codes (based on the materials used) from the subcategory *Single Crowns, Abutment Supported*:

D6058, D6059, D6060, D6061, D6062, D6063, D6064, or D6094

When a single crown is attached directly to the implant body (with no separate abutment) select one of the following codes (based on the materials used) from the subcategory *Single Crowns, Implant Supported*:

D6065, D6066, or D6067

**Bridge Retainer(s)**

When the restoration supports a fixed partial denture (bridge), the “crown” portion is referred to as a “retainer.”

When an abutment is used to connect a bridge retainer to an implant, select a code (based on the material used) from the subcategory *Fixed Partial Denture, Abutment Supported*:

D6068, D6069, D6070, D6071, D6072, D6073, D6074, or D6194

If the retainer is attached directly to the implant body (with no separate abutment), select one of the following codes (based on the materials used) from the subcategory *Fixed Partial Denture, Implant Supported*:

D6075, D6076, or D6077

**Bridge Pontic(s)**

Each pontic is reported (based on the materials) using one of the codes from the subcategory *Fixed Partial Denture Pontics*:

D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, or D6252

**Precision Attachment(s)**

If a precision attachment is used, report the following code:

D6950 Precision attachment

**Converting an Existing Denture**

When converting an existing complete or partial denture into the definitive restoration, report the following:

D5875 Modification of a removable prosthesis following implant surgery

Modification refers to actions that affect the prosthesis' structure, such as drilling space for healing caps and placement of retentive elements. (Any required denture reline can be reported separately.)

**Removable Denture(s)**

When restoring a completely edentulous arch with a removable denture supported by implants/abutments, report the following:

D6053 Implant/abutment supported removable denture for completely edentulous arch

When restoring a partially edentulous arch with a removable partial denture supported by implants/abutments, report the following:

D6054 Implant/abutment supported removable denture for partially edentulous arch

**Note**

If there is no implant overdenture component to the partial denture, but the partial denture clasps to any combination of teeth or implant crowns/retainers, one of the following codes may apply:

D5211, D5212, D5213, D5214, D5225, D5226, or D5281

**Attachment(s)**


If the mated pair of an attachment is incorporated into both an abutment and the denture base, report D5862.

D5862 Precision attachment, by report

**Hybrid Prosthesis**

The codes used to report fixed partial or complete dentures that can only be removed by dental staff are located in the subsection *Implant/Abutment Supported Fixed Dentures (Hybrid Prosthesis)*:

D6078 Implant/abutment supported fixed denture for completely edentulous arch

D6079 Implant/abutment supported fixed denture for partially edentulous arch 



## IT'S TIME TO IMPLEMENT YOUR "FALL-BACK" PLAN

By Harlene S. Stevens, CPA

As our nation continues to struggle economically, it is no surprise that many patients are still watching their finances carefully and putting dentistry at the bottom of their "to do" list. In some areas of the country, dentists are finding it difficult to keep operatory chairs filled during normal work hours. As summer comes to an end and autumn leaves start appearing, it's time to implement a "fall-back" plan—which involves reaching out to inactive patients to remind them about the importance of dental care and looking for ways to trim expenses.

### Reach Out to Inactive Patients

Whenever there are holes in the schedule—or downtime of any kind—every staff member should be expected to help contact patients to remind them about the importance of regular dental care and/or look for ways to trim practice overhead. In other words, downtime should be a productive time for everyone. This includes business staff, dental assistants, and dental hygienists. Below are a few simple recommendations to help get you started on your action plan for the coming fall season:

- One staff member should be appointed to lead and coordinate a comprehensive chart audit of the practice. This coordinator is responsible to oversee the chart audit until completion by using any and all available staff during their downtimes to systematically go through patients' charts to identify the date of their last exam and prophylaxis, recommended treatment that was never scheduled or completed, and/or areas that the dentist wanted to "watch."

Whether your patient charts are paper or electronic, staff should go through each chart and contact patients who are overdue for their exam and cleaning and/or have dental work which was not completed. One particularly effective method of auditing paper charts is to physically separate charts into two separate filing categories. Both filed A-Z, the first set of charts includes patients who are current on all treatment. The second set of charts includes those who are overdue for hygiene or who failed to schedule or

complete recommended dental treatment. This provides the entire team with a visual reminder of how many patients have fallen off the radar—even when the economy was good!

Yes, chart auditing can be a daunting task. However, it is an essential one and should be done at least once per year. Patients who are overdue should be contacted initially by telephone or email. If a patient is not able to schedule an appointment at this time, make a note of the call, why the patient was not able to schedule, and when the patient would like another reminder. If there is no response within three weeks, follow up with a personalized letter that reminds him/her of the specific treatment that is overdue.

- If there are holes in your schedule, your top priority should be to keep all chairs occupied TODAY. Worry about tomorrow only after all chairs are filled today. If you notice that today's schedule is "light" look at the next week of scheduled appointments and try to get patients in earlier (if their dental plan allows).
- Your practice management software should have a "missed appointment file" which displays patients who have missed appointments. Is your staff appropriately tracking these patients? Do you have a list of patients who would like to be placed on a cancellation list if an appointment becomes available at a more convenient time? Does the entire staff know how to use these tools to help fill the schedule?
- If doing a comprehensive chart audit is not feasible at this time, start by reaching out to patients who have not been seen in your office in over two years. There are a myriad of reasons why they may not have returned to the practice (unemployment, insurance, time, etc.), and they are often embarrassed. A friendly call or reactivation letter may encourage them to come in. For a copy of a reactivation letter, send an email to [healthcare@nisivoccia.com](mailto:healthcare@nisivoccia.com) with "Reactivation Letter" in the subject line.

- Make use of social media. Does your office have a Facebook page? This can be an inexpensive and effective way to promote your practice if a staff member is assigned to monitor it regularly and keep the practice information fresh.
- How does your practice give back to the community? There are ways to promote your practice and support your patients and community at the same time. Sponsor local teams or booster clubs, put up a sign at your local little league field, volunteer at nursery schools during dental health week, etc.

### Look for Ways to Reduce Overhead

It is imperative that every dental practice work as a team to decrease costs. Every effort to reduce overhead adds up and will help offset some of the revenues lost due to the economy and/or reduced PPO fees.

As we all know, payroll expenses account for the largest overhead costs. Every office wants and needs a great team, and team members should be compensated appropriately. However, how often have you taken a good look at your scheduling? Are your patients booked every 10 or 15 minutes? Changing to a 10-minute appointment interval can free up about an hour per day. That hour can be used to either add another patient or to decrease the staff hours per day. During slow times, it may be worthwhile to consolidate the days worked per week. What are your staffing needs? It is always difficult to terminate an employee, but an employee who is not productive should not be allowed to deplete practice resources.

Consider the following additional ways to cut costs:

- Most software programs are equipped to send bills and appointment reminders electronically. Are you taking advantage of this? All claims should be submitted electronically as should x-rays and other documentation. Office bills should be paid electronically. Over time, the savings in staff time and postage will be substantial.

*(Continued on page 16)*

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### For Additional Information

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## IT'S TIME TO IMPLEMENT YOUR "FALL-BACK" PLAN

(Continued from page 15)

- Be aware of the cost of running utilities. If you do not have a timer on your thermostat, invest in one. Those that have it, make use of it. There is no need to run the air conditioner or turn up the heat during the night or when the office is closed. What are your costs for computers and phone lines? Most phone companies are now equipped to also provide internet services as a value-added service at a considerable cost savings.
- Review your large overhead expenses:
  - Lab costs – When was the last time you negotiated lab costs or compared prices for different labs?
  - Dental supplies – Do you buy in bulk? Does your office receive incentives or bulk pricing?

Don't let the economy cause practice paralysis. Most dental practices are small independent businesses. The strength of a small business is that it has the ability to react quickly to market conditions. Be profitable even in these difficult times by being proactive and involving your entire team in the process of reactivating patients, increasing efficiency, and reducing overhead. Everyone will benefit—you, your team, and your patients. 📖

### About the Author

Harlene S. Stevens, CPA, is a leader of the Nisivoccia LLP Healthcare Segment, which concentrates in providing services to physician and dental practices. Nisivoccia LLP offers traditional tax, accounting, audit, and business advisory services and has offices in Mt. Arlington and Newton, New Jersey. Ms. Stevens can be reached at [hstevens@nisivoccia.com](mailto:hstevens@nisivoccia.com) or 973-328-1825.

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