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DPAT DATA QUESTIONS TO ENSURE NEW PATIENT CALCULATION ACCURACY AND DETECT FRAUDULENT REPORTING

1. Does the practice report recall evaluation (D0120) for new patient children to hold down the *initial* evaluation fee?
   - If yes, set up two new patient DO150s:
     - D0150a (higher adult fee)
     - D0150b (lower child fee)

Note: D0150 has a higher UCR than D0120 so use D0150 for all patients, including children. For under three years of age, report D0145 if parent is counseled.

2. If there is Comprehensive Periodontal Evaluation (D0180) count activity, do they report this comprehensive perio evaluation code for new patients and/or checkup perio patients?
   - If yes, for new patients: What percentage of D0180 counts are for new patients?
   - Next, convert the percentage of total D0180 counts into new patient counts. Revise the D0150 new patient count upward (to reflect the new patients reported as D0180) in DPAT to reflect the correct count of new patients. Otherwise, the DPAT new patient count will be inaccurate.
   - If D0180 is used just for checkups, do nothing as to the revision of the new patient D0150 count.

3. Are they reporting consultation (D9310) counts in the data?
   - If so, is D9310 used for patients who come in for second opinions?
   - If yes, revise the new patient D0150 count upward to reflect an accurate new patient count for DPAT. Code D9310 requires that a dentist or physician refers the patient, and that it is not to be used with a patient's self referral. For patients self referral, report D0150 or D0180. D0180 requires the patient be a perio patient or have perio risk factors, plus full mouth probing and charting is required.

Note: Some practices incorrectly report D9310 for case presentations. This is incorrect and case presentation (D9450) should be used properly to report a case presentation, which always follows (on a different date) an evaluation.

4. Are bitewing x-rays (D0274 or D0272) and panoramic x-rays (D0330) incorrectly reported as a full series (D0210)? Some companies only pay for the pan.
   - If so, this is fraud.

5. Does the business staff date the bitewings (D0272 or D0274) on the evaluation date and the panoramic x-rays (D0330) on a different day (example: the next day or next week)?
   - If so, this is fraud.

DPAT ORDER OF CODES IN PRESENTATION

1. The practice doesn't know that there is a new code for sectioning a failed bridge (D9120) in which the good retainer is left indefinitely in the mouth. An extraction (D7140) of the failed retainer with pontic should be reported in addition to D9120.

2. The practice is not coding out D2971 (extra lab procedures are required to make the new crown fit the existing partial denture). The lab charges $50 - $70 extra. Bill crown (regular fee) plus D2971 (typical fee $150) on the seat date.

3. The practice is not coding out core buildups (D2950) separately and raises the crown fee (which leaves money on the table). The PPOs limit the crown fee and the buildup could have been paid with proper documentation and narrative. The average dentist reports various types of buildups on 43% of the crowns and crown retainers.

4. Not reporting Fluoride Varnish (D1206) which is for moderate-to-high caries risk (adult and child) patients only. D1206 is generally a higher UCR than D1203 or D1204. It may pay for adults older than eighteen sometimes. Effective 1/1/2013 use D1206 for fluoride varnish application, regardless of caries risk and the new code, D1208 for any fluoride (other than fluoride varnish).

5. Not using D1204 with Adult Prophys for low-risk patients (afraid to switch to D1204 for fear of non-coverage of adult fluoride). However, D1204 should be paid up to age 18 with most plans. Always switch from D1203 to D1204 when the child prophylaxis is switched to adult prophylaxis. Fluoride varnish may also report D1203 and D1204. Generally, fluoride varnish should be used as the type of fluoride for all patients. Effective 1/1/2013, D1203 and D1204 are DELETED and your only choices are D1206 or D1208.

6. Is the practice not reporting the Comprehensive Periodontal Evaluation (D0180) for new patients at all? D0180 typically reimburses better than D0150 and has a higher UCR allowance. However, to report D0180 the patient must be either a perio patient (4-5 mm pocket depths, BOP, and some bone loss) or have risk factors for periodontal disease such as diabetes, smoking, or heart disease. In addition, a full mouth probing and charting is mandatory to report D0180.

7. Does the practice have high emergency evaluation (D0140) counts while the Pallative (D9110) counts are low? While D0140 can always be reported at an emergency visit, it remains subject to the "two evaluations a year" rule. If D0140 is reported in *conjunction* with definitive treatment (such as fillings, extractions, root canals, etc.), often D0140 is not reimbursed. However, if the doctor only uses one evaluation a year (checking recall once, not twice) then a second emergency evaluation D0140 would probably be paid. The general objective is for the D0140 counts to be lower while Pallative (D9110) counts should be higher. Generally Pallative (D9110) has a higher UCR than D0140.

8. Are single bitewings taken at the emergency visit which can use up the annual 4BWX coverage? Check the single film (D0270) counts. The count should be close to zero. Instead, consider two periapicals (justified for different diagnostic angles) at the emergency visit, which are almost always clinically justified and paid.

9. The practice thinks the coronal remnant code (D7111) is for a routine baby tooth extraction. No, the D7111 code is only for the coronal remnant (piece of the shell of a crown). D7140 is reported when the primary (baby) tooth has a full crown and if any root portion remains. The D7140 UCR is higher than D7111. A tip to miscoding is a D7111 count of more than five counts. Verify that the practice reports D7140 for routine baby tooth extractions (includes full crown and some root).

10. Are 2BWX reported when 4BWX should be reported when the second molars have erupted? If so, lots of money is left on the table. The diagnosis for this situation is a higher count for 2BWX than 4BWX in the adult practice.

11. The practice rarely codes a surgical extraction (D7210) for an erupted tooth, and uses D7140 for all extractions. The UCR of D7210 pays 50% to 100% more than D7140. D7210 should document that bone was removed and/or the tooth was sectioned. A flap is not required but optional starting 1/1/11.

12. Is one recall evaluation (D0120) reported annually when two are generally payable? Most policies pay either two evaluations a year or one evaluation per six months, so reimbursement is available. However, if the doctor is checking multiple hygienists and only wants to check recall patients once a year, then once a year is OK.

13. Using two surface fillings (D2331) for the incisal angle of an anterior tooth when it is always four surfaces (D2335) - MIFL or DIFL. A low procedure count of code D2355 is a tip off. For the incisal edge of the tooth, the surfaces would be one, two, or three depending on the dentist's preparation of the tooth.

14. The practice codes out a perio bone graft (D4263/D4264) (associated with osseous surgery and natural teeth) when the graft is actually a bone socket graft (D7953) done in conjunction with an extraction.

15. Could use lab relines D5750-D5761 (which pay more) instead of chairside relines D5730-5741 if a Triad oven or pressurized water bath is used to process the denture in the dental office.

16. Does not know that the immediate denture (higher fee) is reported upfront and that later a reline/rebase is paid if the proper waiting period is observed (can be up to six months after the extraction date, to the day). Do not include the reline/rebase fee in the immediate denture fee.

17. The practice reports a standard denture when they are really doing an implant supported denture. The implant supported denture has a higher fee allowed, if controlled by a PPO plan. This generally results in a lower write-off.

18. The practice charges for a standard crown when it really is an implant crown. This can be fraud, if done to get a better benefit. However, generally with PPO's, a higher fee is allowed by charging out an implant crown, which is a better benefit.

19. The practice charges a high nlobal fee for an implant crown (and PPOs knock down the fee substantially) when they should charge *separately* for the abutment (either a prefab abutment-D6056 or custom abutment-D6057).

20. The practice doesn't know that abutment-supported codes should be reported instead of implant-supported codes if an abutment (D6056 or D6057) is involved. If an abutment is not involved, charge out the implant-supported codes, which are not generally done by most offices.

21. Low counts for Occlusal Guard (D9940), less than 10. Occlusal Guards are paid about 35% of the time with the proper narrative. Mention "bruxism" and "perio case", if applicable. This is not TMJ (D7880).

22. Tooth whitening is a per arch code. Therefore, code out D9972-upper arch (at half the total fee) and D9972-lower arch (at half the total fee). Effective 1/1/2013 D9972 is only for in-office whitening, while the new code D9975 is for at-home trays/strips.

23. Not taking pans starting at age 6. Use pan to illustrate grown & development and for marketing (parent show pan to other mothers). This is leaving money on the table.

SOME ADDITIONAL SUGGESTED CALCULATIONS

1. Count the number of active procedures done in the office. For the GP's, the average is about "90" while the "refer-o-dontist" does about "60" and the "decathlon dentist" does about "120". If the doctor is not booked out at least one and a half to two weeks, suggest adding *additional* procedures - automated endodontics, simple oral surgery, implant over-dentures, Six Months Smiles, and sleep apnea.

2. Count the new patients plus 25% of the prophys (child and adult) plus one-half of the D4910 counts to get a "ball park" of how many full series plus pans should be occurring. Assume in this calculation, the new patient count is 150 patients.

RECALL VISITS:

Adult Prophy	1,500
D4910 (÷ 2)	100
Child Prophy	200
Total Counts	**1,800**

CALCULATION:

25% of Recall Visits (1,800 ÷ 4)		450	
New Patients (D0150)	+	150	
Forecasted Pans/Full Series		**600**	**Compare this to actual x-rays (pans plus full series) taken.**

3. Calculate the percentage of child prophys to adult prophys (include D4910 counts divided by two) Then calculate the percentage of 2BWX (D0272) to 4BWX (D0274).

Child Prophy (D1120)		200	11%
Adult (D1110 + D4910)	+	1,600	89%
Total		**1,800**	**100%**

CALCULATION:

Two Bitewings		500	50%	
Four Bitewings	+	500	50%	89% - 50% (1,000) x $20 Differential = $7,800
Total		**1,000**	**100%**	

Dr. Charles Blair is the CEO of Dr. Charles Blair & Associates, Inc., in Mt. Holly, North Carolina. His Revenue Enhancement Program includes fee consulting and proper insurance coding guidance. Thousands of offices have gone through the program. Call 866.858.7596 or contact Dr. Charles Blair and Associates, Inc. by email at info@drcharlesblair.com for further information on his unique programs, services, and publications.

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