Practice Management

Medical Insurance Billing for Splint Therapy

by Rose Nierman, RDH

Are you aware that many of the specialized services that you provide can be billed successfully to a patient’s medical insurance? This ability to bill and receive compensation from medical insurance is a win-win for your patient and your practice. Your patient is more likely to get needed treatment, thus taking advantage of care that medical insurance is intended to provide. Your practice benefits because your expertise and skills are sought and compensated in realms that are both medical and dental in nature. Successfully billing medical insurance for such orthotic claims or splints for temporomandibular disorder (TMD) calls for careful and well-documented insurance coding, but the results can be gratifying.

Medical billing for dental services is not always well understood. Knowing the differences between evaluation and management level 1, 2, 3, and 4 visits will help you to choose the appropriate history, examination, and workup codes to document each patient visit, allowing you to proceed with treatment and to receive fair reimbursement for your services. You provide your patients with the best possible care: learn to provide the highest quality documentation and code to medical when a treatment is medically necessary.

Coding with Confidence

Medical billing requires diagnosis-based documentation, and there are numerous codes available for TMD and sleep apnea conditions, as well as oral problems and diseases. Emulating the “medical model” in your recordkeeping will be an important first step in confident coding. Among the standardized forms and procedures that you will need for successful claims are:

1. Medical claim form CMS 1500.
2. ICD diagnostic codes showing the condition, disease, or symptoms.
3. CPT procedure codes to document your services.
4. Written SOAP reports (Subjective complaints, Objective exam findings, Assessment and Plan) of medical necessity with the orthotic claim, because TMD claims are subject to review. SOAP reports should include such medical model elements as review of systems, social history, history of present illness, and other essential elements of patient diagnostic reports.

SOAP reports and letters should be sent with the claim to medical insurance for appropriate reimbursement. With your patient’s signed permission, the reports also should be sent to physicians who have treated the patient. This informs the physicians about treatments underway for your mutual patient, and it provides coordinated care. An added benefit is that such reports provided to the physician help spread the word about your expertise and specialized services. Few dentists send such important details to a patient’s physician: such attention to detail will set your
practice apart and may generate future referrals. Recent research has pointed out the oral-systemic connection, demonstrating the importance of medical reports for conditions that might once have been considered strictly dental. Report writing is even more important now due to recent findings concerning the oral-systemic connection, as well as for patients with TMD.

Verification of Medical Benefits
Medical plans can be verified for benefits and exclusions regarding “temporomandibular joint (TMJ) orthotics, splints, appliances” or TMD/TMJ treatment in general. To verify benefits, call the insurance carrier or visit the plan’s Web site to check for diagnosis and procedure codes that are covered.

Common ICD Diagnostic Codes for Splints:
- 784.0 Cephalgia (head or facial pain—can be used for orofacial and craniomandibular pain)
- 350.2 Atypical Face Pain (recently renamed persistent idiopathic facial pain—PIFP)
- 729.1 Myalgia/Myositis
- 524.60–524.69 Temporomandibular joint disorders. Different codes in this category include: arthralgia, articular disc disorder, joint sounds, etc.
- 830.0–830.1 Dislocation of jaw, closed or open (injury)

Common CPT Codes for Orthotics:
- S8262 Mandibular Orthopedic Repositioning Device, each. This is a newer code accepted by most carriers within the last few years. Some prefer other codes.
- 21299 Unspecified craniomandibular procedure, with report

Dental Insurance Codes:
- D7880 Occlusal Orthotic Device, by report
- D7889 Other TMD treatment

Appliances for bruxism are typically excluded under medical plans, but they may be covered under dental plans. Dental insurance is the more likely payer for diagnosed bruxism, which is often excluded from medical coverage. When dealing with dental insurance, the patient usually has a lower yearly benefit than under medical insurance and a splint allowance will apply toward the yearly limit.

Does Medical Insurance Pay for Adjustments?
For plans that cover orthotics, adjustments within six months of initial appliance therapy are generally considered medically necessary. If a patient needs long-term appliance therapy, four adjustments after 1 year of initial appliance placement are often provided.

Once you learn the rules, choosing the appropriate treatment code is easier than you think. Learning these rules and a few commonly used codes can have multiple benefits. Your patients’ oral health goals will be
more achievable. For most, the treatments will relieve pain and provide them with a more comfortable jaw position. For your practice, the attention to rules and treatment codes will result in more timely reimbursement, so it is a win-win all around!

*If you are interested in having a complete packet of questionnaires and examination forms for TMJ evaluation, please contact the author at 800-879-6468 or e-mail her at rose@dentalwriter.com. Or you may visit her Web site: www.dentalwriter.com and click on "Free Questionnaire and Examination Forms."

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