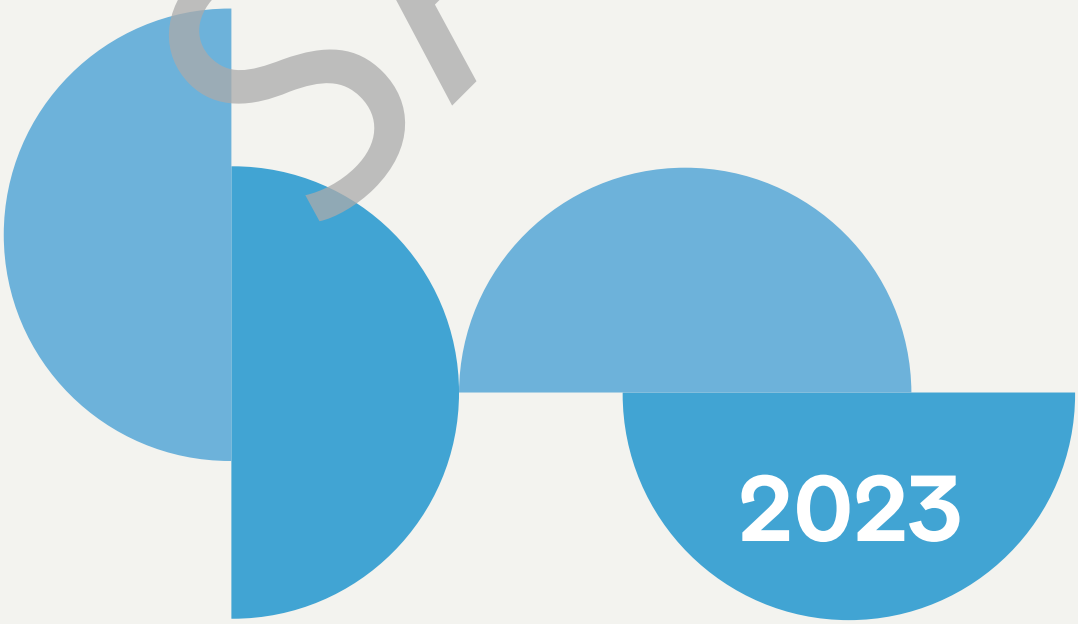
Optum

Coding &
Payment Guide

Dental Services

An essential coding, billing and reimbursement resource for dental services



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Contents

Getting Started with Coding and Payment Guide

The *Coding and Payment Guide for Dental Services* is designed to be a guide to the specialty procedures classified in the CDT® and CPT® books. It is structured to help coders understand procedures and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book. The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

Resequencing of CDT and CPT Codes

The American Dental Association (ADA) and the American Medical Association (AMA) employ a resequenced numbering methodology. According to the associations, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes were not changed or had only minimal changes, the ADA and AMA have assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence. Codes within the Optum360 *Coding and Payment Guide* series display in their resequenced order. Resequenced codes are enclosed in brackets for easy identification.

ICD-10-CM

Overall, in the 10th revision of the ICD-10-CM codes, conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. Features include icons to identify newborn, pediatric, adult, male only, female only, and laterality. Refer to the ICD-10-CM book for more ICD-10-CM coding information.

Detailed Code Information

One or more columns are dedicated to each procedure or service to a series of similar procedures/services. Following the specific CDT and CPT code and its narrative, is a combination of features. A sample is shown on page 2. The black boxes with numbers in them correspond to the information on the page following the example.

Appendix Codes and Descriptions

Some procedure codes are presented in a less comprehensive format in the appendix. The CDT and CPT codes appropriate to the specialty are included the appendix with the official code description. The codes are presented in numeric order, and each code is followed by an easy-to-understand lay description of the procedure.

CCI Edits and Other Coding Updates

This *Coding and Payment Guide* includes the a list of codes from the official Centers for Medicare and Medicaid Services' *National Correct Coding Policy Manual for Part B Medicare Contractors* that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version XX.X, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The CCI edits are located in a section at the back of the book. As other CPT (including COVID-related vaccine and administration codes), CDT, and ICD-10-CM codes relevant to your specialty are released, updates will be posted to the Optum360 website. The website address is http://www.optum360coding.com/ProductUpdates/. The 2022 edition password is: **XXXXX.** Log in frequently to ensure you receive the most current updates.

Index

Comprehensive indexes for both the CPT and the CDT coding systems are provided for easy access to the codes. The indexes have several axes. A code can be looked up by its procedure name or by the anatomical site associated with it. For example:

Debridement
endodontic, D3221
periodontal, D4355
implant
peri, D6101-D6102
single, D6081

General Guidelines

Providers

The ADA and AMA advises coders that while a particular service or procedure may be assigned to a specific section, the service or procedure itself is not limited to use only by that specialty group. Additionally, the procedures and services listed throughout the book are for use by any qualified dentist, physician, or other qualified healthcare professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Supplies

Some payers may allow providers to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting.

Professional and Technical Component

Radiology and some pathology codes have a technical and a professional component. When providers do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

Sample Page and Key

On the following pages are a sample page from the book displaying the new format of *Coding and Payment Guide for Dental Services* with each element identified and explained on the opposite page.

D1206-D1208

D1206 topical application of fluoride varnish
D1208 topical application of fluoride - excluding varnish

Explanation

Topically applied fluoride treatments are done in the office with a variety of solutions or gels and different application protocols, excluding rinsing or "swish." The fluoride may be applied with trays or specifically to a few, isolated teeth at a time to prevent a high systemic dose from occurring. Fluoride varnish is painted directly on certain areas to help prevent further decay. The fluoride treatment reported here must be applied separately from any prophylaxis paste. Report D1206 for therapeutic application of varnish or D1208 for topical application of fluoride other than varnish.

Coding Tips

These services must be provided under direct supervision of the dental provider. Appropriate code selection is determined method used. Code D1206 should be used for the application of topical fluoride varnish only. Report D1208 for other topical applications. Any evaluation, radiograph, restorative, or extraction service is reported separately. Removal of coronal plaque is reported separately using D1110 or D1120. Report D9910 if the varnish is applied solely to desensitize the tooth. To report application of interim caries arresting medicament, see D1354.

Documentation Tips

The following information can be documented on a tooth chart: treatment/location of caries, endodontic procedures, prosthetic services, preventive services, treatment of lesions and dental disease, or other special procedures. A tooth chart may also be used to identify structure and rationale of disease process and the type of service performed on intraoral structures other than teeth.

Reimbursement Tips

When selecting the procedure or service that accurately identifies the service performed, dentists must use the most accurate code. If the CDT code more accurately identifies the service, this should be used rather than the CPT codes. When an oral health assessment is performed by someone other than the dentist, for example, a licensed dental hygienist, some third-party payers may require that modifier DA Oral health assessment by a licensed health professional other than a dentist, be appended to the code. Check with third-party payers for their specific requirements.

Associated CPT Codes

99188	Application of topical fluoride varnish by a physician or other qualified health care professional

ICD-10-CM Diagnostic Codes

Z01.20	Encounter for dental examination and cleaning without abnormal findings
Z01.21	Encounter for dental examination and cleaning with abnormal findings
Z41.8	Encounter for other procedures for purposes other than remedying health state
Z46.4	Encounter for fitting and adjustment of orthodontic device
Z91.120	Patient's intentional underdosing of medication regimen due to financial hardship
Z91.128	Patient's intentional underdosing of medication regimen for other reason
Z91.14	Patient's other noncompliance with medication regimen
Z91.841	Risk for dental caries, low
Z91.842	Risk for dental caries, moderate
Z91.843	Risk for dental caries, high
Z98.810	Dental sealant status
Z98.811	Dental restoration status
Z98.818	Other dental procedure status

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D1206	0.20	0.39	0.02	0.61
D1208	0.10	0.19	0.01	0.30
Facility RVU	**Work**	**PE**	**MP**	**Total**
D1206	0.20	0.39	0.02	0.61
D1208	0.10	0.19	0.01	0.30

	FUD	Status	MUE	Modifiers				IOM Reference
D1206	N/A	N	-	N/A	N/A	N/A	N/A	None
D1208	N/A	N	-	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

fluoride. Compound of the gaseous element fluorine that can be incorporated into bone and teeth and provides some protection in reducing dental decay.

plaque. Accumulation of a soft sticky substance on the teeth largely composed of bacteria and its byproducts.

prophylaxis. Intervention or protective therapy intended to prevent a disease.

scaling. Removal of plaque, calculus, and stains from teeth.

1. CDT/CPT Codes and Descriptions

This edition of *Coding and Payment Guide for Dental Services* is updated with CDT and CPT codes for year 2023. The following icons are used in the *Coding and Payment Guide*:

- ● This CDT/CPT code is new for 2023.
- ▲ This CDT/CPT code description is revised for 2023.
- ✚ This CDT/CPT code is an add-on code.
- ★ This CPT code is identified by CPT as appropriate for telemedicine services
- [ ] CPT codes enclosed in brackets are resequenced and may not appear in numerical order.

Add-on codes are not subject to bilateral or multiple procedure rules, reimbursement reduction, or appending modifier 50 or 51. Add-on codes describe additional intraservice work associated with the primary procedure performed by the same practitioner on the same date of service and are not reported as stand-alone procedures. Add-on codes for procedures performed on bilateral structures are reported by listing the add-on code twice.

2. Explanation

Every CDT or CPT code or series of similar codes is presented with its official CDT code description and nomenclature or CPT code description. However, sometimes these descriptions do not provide the coder with sufficient information to make a proper code selection. In *Coding and Payment Guide for Dental Services*, a step-by-step clinical description of the procedure is provided, in simple terms. Technical language that might be used by the dentist is included and defined. *Coding and Payment Guide for Dental Services* describes the most common method of performing each procedure.

3. Coding Tips

Coding and reimbursement tips provide information on how the code should be used, provides related procedure codes, and offers help concerning common billing errors, modifier usage, and anesthesia. This information comes from consultants and subject matter experts at Optum360 and from the coding guidelines provided in the CDT or CPT book.

4. Documentation Tips

Documentation tips provide code-specific tips to the coder regarding the information that should be noted in the medical record to support code assignment. Documentation should be complete and support the CDT, CPT, or ICD-10-CM codes reported.

5. Reimbursement Tips

Medicare and other payer guidelines that could affect the reimbursement of this service or procedure are included in the Reimbursement Tips section.

6. Associated CPT Codes

The 2022 edition of the *Coding and Payment Guide for Dental Services* contains a crosswalk from the driver CDT or CPT code to its corresponding CPT or CDT code. CDT codes should be reported for the majority of dental services. On occasion, coverage of trauma, injury, or neoplasm may be covered by the health care insurer. In the rare instance when reporting a medical claim, CPT codes should be reported. This heading will not appear if there is no valid crosswalk.

7. ICD-10-CM Diagnostic Codes

ICD-10-CM diagnostic codes listed are common diagnoses or reasons the procedure may be necessary. This list in most cases is inclusive to the specialty. Some ICD-10-CM codes are further identified with the following icons:

- N Newborn: 0
- P Pediatric: 0-17
- M Maternity: 9-64
- A Adult: 15-124
- ♂ Male only
- ♀ Female Only
- ☑ Laterality

Please note that in some instances the ICD-10-CM codes for only one side of the body (right) have been listed with the CPT code. The associated ICD-10-CM codes for the other side and/or bilateral may also be appropriate. Codes that refer to the right or left are identified with the ☑ icon to alert the user to check for laterality. In some cases, not every possible code is listed and the ICD-10-CM book should be referenced for other valid codes.

8. Relative Value Units/Medicare Edits

Gap Filled Relative Value Units

Included in this edition are 2021 gap filled relative value units (RVU) for the CDT codes. These are useful in assisting with establishing fee schedules for your practice.

The gap relative value units are created by Optum360 using various methodologies depending on the code. For most codes, gap relative values are calculated by using relative value information from the Optum360 Relative Value Scale and adjusted to a scale similar to the Medicare physician fee schedule (MPFS) relative values (RBRVS). The Optum360 relative values are developed by and are proprietary to Optum360, Inc. The Optum360 relative values are assigned when Optum360 has an understanding of how the procedure is typically billed by the industry and how it relates to other procedures. Relative values are based on difficulty, time, work, risk, and resources. Relative values are established by Optum360 employees, including an Optum360 medical director, clinicians, certified procedural coders, and analysts. Optum360 also consults with a panel of outside physicians and dentists during the relative value development process for certain codes.

Because the Optum360 relative values are on a different scale than RBRVS relative values, ratios are developed relating the RBRVS and Optum360 scales for approximately 250 code ranges within the CPT, HCPCS, and CDT coding systems. These ratios are multiplied by the Optum360 relative value to create the gap value. If Optum360 does not assign a relative value to a code, a gap value is not calculated.

Relative Value Units

In a resource based relative value scale (RBRVS), services are ranked based on the relative costs of the resources required to provide those services as opposed to the average fee for the service, or average prevailing Medicare charge. The Medicare RBRVS defines three distinct components affecting the value of each service or procedure:

- Physician work component, reflecting the physician's time and skill
- Practice expense (PE) component, reflecting the physician's rent, staff, supplies, equipment, and other overhead

Procedure Codes

One of the keys to gaining accurate reimbursement lies in understanding the multiple coding systems that are used to identify services. To be well versed in reimbursement practices, coders should be familiar with the CDT, HCPCS Level II, ICD-10-CM, and CPT® coding systems. The first of these, the CDT system, is increasingly important to reimbursement, as it has been extended to a wider array of dental services.

- Coding and billing should be based on the service and supplies provided. Documentation should describe the patient's problems and the service provided to enable the payer to determine reasonableness and necessity of care.
- Refer to Medicare coverage reference to determine whether the care provided is a covered service. The references are noted, when they apply, on the pages following.

HCPCS Level I or CPT Codes

Known as HCPCS Level I, the CPT coding system is the most commonly used system to report procedures and services. Copyright of CPT codes and descriptions is held by the American Medical Association. This system reports outpatient and provider services.

CPT codes predominantly describe medical services and procedures, and are adapted to provide a common billing language that providers and payers can use for payment purposes. The codes are required for billing by both private and public insurance carriers, managed care companies, and workers' compensation programs. Dental professional may find that a third-party payer will occasionally require that a procedures be reported using a CPT code. Unless otherwise instructed, dental professional should report services using the appropriate American Dental Association (ADA) dental code when one exists.

HCPCS Level II Codes

HCPCS Level II codes are commonly referred to as national codes or by the acronym HCPCS (pronounced "hik piks"). HCPCS codes are used for billing Medicare and Medicaid patients and have also been adopted by some third-party payers. HCPCS Level II codes published annually by CMS, are intended to supplement the CPT coding system by including codes for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS); drugs; and biologicals. These Level II codes consist of one alphabetic character (A–V) followed by four numbers. In many instances, HCPCS Level II codes are developed as precursors to CPT codes.

A complete list of the HCPCS Level II codes and the quarterly updates to this code set may be found at http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html.

The following is a list of the HCPCS Level II supply codes used to identify supplies commonly used by dentists.

Medical and Surgical Supplies A4000–A8999

The A and E code sections of the HCPCS Level II code system cover a wide variety of medical and surgical supplies, and some durable medical equipment (DME), supplies and accessories.

A4550 **Surgical trays**

A4649 **Surgical supply; miscellaneous**

E1700 **Jaw motion rehabilitation system**

E1701 **Replacement cushions for jaw motion rehabilitation system, package of 6**

E1702 **Replacement measuring scales for jaw motion rehabilitation system, package of 200**

Drugs Administered Other Than Oral Method J0000–J8999

Drugs and biologicals are usually covered by Medicare if: they are of the type that cannot be self-administered; they are not excluded by being immunizations; they are reasonable and necessary for the diagnosis or treatment of the illness or injury for which they are administered; and they have not been determined by the Food and Drug Administration (FDA) to be less than effective. In addition they must meet all the general requirements for coverage of items as incident to a physician's services. Generally, prescription and nonprescription drugs and biologicals purchased by or dispensed to a patient are not covered.

The following list of drugs can be injected either subcutaneously, intramuscularly, or intravenously. Third-party payers may wish to determine a threshold and pay up to a certain dollar limit for the drug.

> J codes fall under the jurisdiction of the DME regional office for Medicare, unless incidental or otherwise noted. See Pub. 100-2, chap. 15, sec. 50.4

J0670 **Injection, mepivacaine HCl, per 10 ml**

J1790 **Injection, droperidol, up to 5 mg**

J2250 **Injection, midazolam HCl, per 1 mg**

J2400 **Injection, chloroprocaine HCl, per 30 ml**

J2515 **Injection, pentobarbital sodium, per 50 mg**

J2550 **Injection, promethazine HCl, up to 50 mg**

J3010 **Injection, fentanyl citrate, 0.1 mg**

J3360 **Injection, diazepam, up to 5 mg**

Temporary National Codes (Non-Medicare) (S0000–S9999)

S0020 **Injection, bupivicaine HCl, 30 ml**

D0120

▲ **D0120** periodic oral evaluation - established patient

An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation, periodontal screening where indicated, and may require interpretation of information acquired through additional diagnostic procedures. The findings are discussed with the patient. Report additional diagnostic procedures separately.

Explanation

The periodic oral evaluation is done to determine the patient's dental health status since the previous check-up. It includes screening for periodontal disease and/or oral cancer and possibly the interpretation of information acquired through additional, separately reportable diagnostic oral health tests.

Coding Tips

When the patient is referred by another dentist for an opinion or advice regarding a particular condition, see code D9310. When a comprehensive oral examination is performed, see code D0150. When a problem-focused limited oral evaluation is performed, see codes D0140-D0145. A detailed oral evaluation that is problem focused is reported using code D0160; a limited, problem-focused exam is reported using D0170. When the provider performs a caries risk assessment using a standardized risk assessment tool, see D0601-D0603. A comprehensive periodontal evaluation, new or established patient, is reported using D0180. Code D0180 should not be reported in addition to this code as the components of D0120 are included in the comprehensive periodic evaluation. According to the ADA, codes D0120 and D4355 may be reported on the same date of service; however, it should be noted that some third-party payer policies prohibit billing these procedures concurrently. Any radiograph, prophylaxis, fluoride, restorative, or extraction service is reported separately.

Documentation Tips

The following information can be documented on a tooth chart: treatment/location of caries, endodontic procedures, prosthetic services, preventive services, treatment of lesions and dental disease, or other special procedures. A tooth chart may also be used to identify structure and rationale of disease process and the type of service performed on intraoral structures other than teeth.

Reimbursement Tips

When an oral health assessment is performed by someone other than the dentist, for example, a licensed dental hygienist, some third-party payers may require that modifier DA Oral health assessment by a licensed health professional other than a dentist, be appended to the this code. Check with third-party payers for their specific requirements.

ICD-10-CM Diagnostic Codes

K00.0	Anodontia
K00.1	Supernumerary teeth
K00.2	Abnormalities of size and form of teeth
K00.3	Mottled teeth
K00.4	Disturbances in tooth formation
K00.5	Hereditary disturbances in tooth structure, not elsewhere classified
K00.6	Disturbances in tooth eruption
K00.7	Teething syndrome
K00.8	Other disorders of tooth development
K01.0	Embedded teeth
K01.1	Impacted teeth
K02.3	Arrested dental caries
K02.51	Dental caries on pit and fissure surface limited to enamel
K02.52	Dental caries on pit and fissure surface penetrating into dentin
K02.53	Dental caries on pit and fissure surface penetrating into pulp
K02.61	Dental caries on smooth surface limited to enamel
K02.62	Dental caries on smooth surface penetrating into dentin
K02.63	Dental caries on smooth surface penetrating into pulp
K02.7	Dental root caries
K03.0	Excessive attrition of teeth
K03.1	Abrasion of teeth
K03.2	Erosion of teeth
K03.3	Pathological resorption of teeth
K03.4	Hypercementosis
K03.5	Ankylosis of teeth
K03.6	Deposits [accretions] on teeth
K03.7	Posteruptive color changes of dental hard tissues
K03.81	Cracked tooth
K04.01	Reversible pulpitis
K04.02	Irreversible pulpitis
K04.1	Necrosis of pulp
K04.2	Pulp degeneration
K04.3	Abnormal hard tissue formation in pulp
K04.4	Acute apical periodontitis of pulpal origin
K04.5	Chronic apical periodontitis
K04.6	Periapical abscess with sinus
K04.7	Periapical abscess without sinus
K04.8	Radicular cyst
K05.00	Acute gingivitis, plaque induced
K05.01	Acute gingivitis, non-plaque induced
K05.10	Chronic gingivitis, plaque induced
K05.11	Chronic gingivitis, non-plaque induced
K05.211	Aggressive periodontitis, localized, slight
K05.212	Aggressive periodontitis, localized, moderate
K05.213	Aggressive periodontitis, localized, severe
K05.222	Aggressive periodontitis, generalized, moderate
K05.223	Aggressive periodontitis, generalized, severe
K05.311	Chronic periodontitis, localized, slight
K05.312	Chronic periodontitis, localized, moderate
K05.313	Chronic periodontitis, localized, severe
K05.321	Chronic periodontitis, generalized, slight
K05.322	Chronic periodontitis, generalized, moderate
K05.323	Chronic periodontitis, generalized, severe
K05.4	Periodontosis
K05.5	Other periodontal diseases
K06.011	Localized gingival recession, minimal
K06.012	Localized gingival recession, moderate
K06.013	Localized gingival recession, severe
K06.021	Generalized gingival recession, minimal
K06.022	Generalized gingival recession, moderate
K06.023	Generalized gingival recession, severe
K06.1	Gingival enlargement
K06.2	Gingival and edentulous alveolar ridge lesions associated with trauma
K08.0	Exfoliation of teeth due to systemic causes
K08.111	Complete loss of teeth due to trauma, class I

K08.112 Complete loss of teeth due to trauma, class II
K08.113 Complete loss of teeth due to trauma, class III
K08.114 Complete loss of teeth due to trauma, class IV
K08.121 Complete loss of teeth due to periodontal diseases, class I
K08.122 Complete loss of teeth due to periodontal diseases, class II
K08.123 Complete loss of teeth due to periodontal diseases, class III
K08.124 Complete loss of teeth due to periodontal diseases, class IV
K08.131 Complete loss of teeth due to caries, class I
K08.132 Complete loss of teeth due to caries, class II
K08.133 Complete loss of teeth due to caries, class III
K08.134 Complete loss of teeth due to caries, class IV
K08.191 Complete loss of teeth due to other specified cause, class I
K08.192 Complete loss of teeth due to other specified cause, class II
K08.193 Complete loss of teeth due to other specified cause, class III
K08.194 Complete loss of teeth due to other specified cause, class IV
K08.21 Minimal atrophy of the mandible
K08.22 Moderate atrophy of the mandible
K08.23 Severe atrophy of the mandible
K08.24 Minimal atrophy of maxilla
K08.25 Moderate atrophy of the maxilla
K08.26 Severe atrophy of the maxilla
K08.3 Retained dental root
K08.411 Partial loss of teeth due to trauma, class I
K08.412 Partial loss of teeth due to trauma, class II
K08.413 Partial loss of teeth due to trauma, class III
K08.414 Partial loss of teeth due to trauma, class IV
K08.421 Partial loss of teeth due to periodontal diseases, class I
K08.422 Partial loss of teeth due to periodontal diseases, class II
K08.423 Partial loss of teeth due to periodontal diseases, class III
K08.424 Partial loss of teeth due to periodontal diseases, class IV
K08.431 Partial loss of teeth due to caries, class I
K08.432 Partial loss of teeth due to caries, class II
K08.433 Partial loss of teeth due to caries, class III
K08.434 Partial loss of teeth due to caries, class IV
K08.491 Partial loss of teeth due to other specified cause, class I
K08.492 Partial loss of teeth due to other specified cause, class II
K08.493 Partial loss of teeth due to other specified cause, class III
K08.494 Partial loss of teeth due to other specified cause, class IV
K08.51 Open restoration margins of tooth
K08.52 Unrepairable overhanging of dental restorative materials
K08.530 Fractured dental restorative material without loss of material
K08.531 Fractured dental restorative material with loss of material
K08.54 Contour of existing restoration of tooth biologically incompatible with oral health
K08.55 Allergy to existing dental restorative material
K08.56 Poor aesthetic of existing restoration of tooth
K09.0 Developmental odontogenic cysts
K09.1 Developmental (nonodontogenic) cysts of oral region
K09.8 Other cysts of oral region, not elsewhere classified
K11.0 Atrophy of salivary gland
K11.1 Hypertrophy of salivary gland
K11.21 Acute sialoadenitis
K11.22 Acute recurrent sialoadenitis
K11.23 Chronic sialoadenitis
K11.3 Abscess of salivary gland
K11.4 Fistula of salivary gland
K11.5 Sialolithiasis
K11.6 Mucocele of salivary gland
K11.7 Disturbances of salivary secretion
K11.8 Other diseases of salivary glands
K12.0 Recurrent oral aphthae
K12.1 Other forms of stomatitis
K12.2 Cellulitis and abscess of mouth
K12.31 Oral mucositis (ulcerative) due to antineoplastic therapy
K12.32 Oral mucositis (ulcerative) due to other drugs
K12.33 Oral mucositis (ulcerative) due to radiation
K12.39 Other oral mucositis (ulcerative)
K13.0 Diseases of lips
K13.1 Cheek and lip biting
K13.21 Leukoplakia of oral mucosa, including tongue
K13.22 Minimal keratinized residual ridge mucosa
K13.23 Excessive keratinized residual ridge mucosa
K13.24 Leukokeratosis nicotina palati
K13.29 Other disturbances of oral epithelium, including tongue
K13.3 Hairy leukoplakia
K13.4 Granuloma and granuloma-like lesions of oral mucosa
K13.5 Oral submucous fibrosis
K13.6 Irritative hyperplasia of oral mucosa
K13.79 Other lesions of oral mucosa
K14.0 Glossitis
K14.1 Geographic tongue
K14.2 Median rhomboid glossitis
K14.3 Hypertrophy of tongue papillae
K14.4 Atrophy of tongue papillae
K14.5 Plicated tongue
K14.6 Glossodynia
K14.8 Other diseases of tongue

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D0120	0.31	0.17	0.02	0.50
Facility RVU	**Work**	**PE**	**MP**	**Total**
D0120	0.31	0.17	0.02	0.50

	FUD	Status	MUE	Modifiers				IOM Reference
D0120	N/A	N	-	N/A	N/A	N/A	N/A	100-01,5,70.2

* with documentation

Terms To Know

evaluation. Dynamic process in which the dentist makes clinical judgments based on data gathered during the examination.

D3222

D3222 partial pulpotomy for apexogenesis - permanent tooth with incomplete root development

Removal of a portion of the pulp and application of a medicament with the aim of maintaining the vitality of the remaining portion to encourage continued physiological development and formation of the root. This procedure is not to be construed as the first stage of root canal therapy.

Explanation

Apexogenesis is performed to promote development and formation of the root end. The dental provider removes of a portion of the pulp and then applies medicament for the purpose of maintaining the vitality of the remaining portion of the pulp and encourage growth.

Coding Tips

This code should be used to report apexogenesis. For therapeutic pulpotomy, see code D3220. Pulpal debridement is reported using code D3221. Do not use this code to report the first stage of root canal therapy, see codes D3310–D3330. For pulpal therapy performed on molars, see D3240.

Reimbursement Tips

Third-party payers may require clinical documentation and/or x-rays before making payment determination. Check with payers to determine their specific requirements.

ICD-10-CM Diagnostic Codes

K04.01	Reversible pulpitis
K04.02	Irreversible pulpitis
K04.1	Necrosis of pulp
K04.2	Pulp degeneration
K04.3	Abnormal hard tissue formation in pulp
K04.4	Acute apical periodontitis of pulpal origin
K04.5	Chronic apical periodontitis
K04.6	Periapical abscess with sinus
K04.7	Periapical abscess without sinus
K04.99	Other diseases of pulp and periapical tissues

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D3222	0.98	0.87	0.20	2.05
Facility RVU	**Work**	**PE**	**MP**	**Total**
D3222	0.98	0.87	0.20	2.05

	FUD	Status	MUE	Modifiers				IOM Reference
D3222	N/A	N	-	N/A	N/A	N/A	N/A	None

* with documentation

Terms To Know

apexogenesis. Procedure performed to remove a portion of the pulp of a tooth; medication is then applied to encourage root growth and vitality.

root. Part of the tooth located in the socket, covered by cementum, and attached by the periodontal structures.

D3230

D3230 pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)

Primary incisors and cuspids.

Explanation

Pulpal therapy is performed on the anterior primary teeth, which include the primary incisors and cuspids. The procedure includes only the resorbable filling placement. Final restoration services are reported separately.

Coding Tips

Local anesthesia is generally considered to be part of endodontic procedures. Pulpectomy is considered an integral part of the procedure and should not be reported separately. Report final restoration services separately. When performed on a posterior tooth, see D3240.

Reimbursement Tips

Coverage of this procedure may vary by payer and patient contract. Check with the payer for specific coverage guidelines.

ICD-10-CM Diagnostic Codes

K04.01	Reversible pulpitis
K04.02	Irreversible pulpitis
K04.1	Necrosis of pulp
K04.2	Pulp degeneration
K04.3	Abnormal hard tissue formation in pulp
K04.4	Acute apical periodontitis of pulpal origin
K04.5	Chronic apical periodontitis
K04.6	Periapical abscess with sinus
K04.7	Periapical abscess without sinus
K04.99	Other diseases of pulp and periapical tissues

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D3230	1.02	0.90	0.21	2.13
Facility RVU	**Work**	**PE**	**MP**	**Total**
D3230	1.02	0.90	0.21	2.13

	FUD	Status	MUE	Modifiers				IOM Reference
D3230	N/A	N	-	N/A	N/A	N/A	N/A	None

* with documentation

Terms To Know

anterior teeth. Six upper and six lower front teeth; the upper and lower incisors and cuspids.

primary tooth. Any of 20 deciduous teeth that usually erupt between the ages of 6 and 24 months.

pulp. Living connective tissue within the tooth's root canal space that supplies blood vessels and nerves to the tooth.

retrograde filling. Filling of a root canal by sealing it from the root apex.

D6608-D6609

D6608 retainer onlay - porcelain/ceramic, two surfaces
D6609 retainer onlay - porcelain/ceramic, three or more surfaces

Explanation

An overlay, or overdenture, fastens a denture to the jawbone, and it is secured by precision dental attachments placed in tooth roots or dental implants. Types of overdentures include bar joint dentures and telescopic dentures. The adjacent teeth may be altered with locking devices or connecting bars to ensure the denture fits properly. Bars on the upper arch always require more implants than do bars on the lower arch due to the lesser bone density in the upper jaw. A telescopic denture is often the choice for patients with compromised bone density due to age or poor oral hygiene. The procedure consists of a double crown system, the telescopic, and involves fitting inner crowns, outer crowns, and copings on the remaining natural teeth to create a natural-looking, removable overdenture. Copings consist of either a gold thimble over the tooth or a post-retained dome and are used to protect a weakened tooth from fracture and wear, but they do not prevent caries. Code selection depends on the number of surfaces and the type of material used for the onlay. These codes report porcelain/ceramic onlays; code D6608 reports two cusps; and code D6609 reports three or more cusps. The porcelain/ceramic dental materials include porcelain, ceramic, or glasslike fillings and crowns.

Coding Tips

Local anesthesia is generally considered part of restorative procedures.To report onlay using high noble metal, see D6610–D6611; using base metal, see D6612–D6613, noble metal, see D6614–D6615. A titanium onlay is reported using D6634. Porcelain/ceramic refers to pressed, fired, polished, or milled substances, which predominantly contain inorganic refractory compounds such as porcelains, glasses, ceramics, and glass-ceramics.

Documentation Tips

The following information should be documented on a tooth chart: treatment/location of caries, endodontic procedures, prosthetic services, preventive services, treatment of lesions and dental disease, or other special procedures. A tooth chart may also be used to identify structure and rationale of disease process, and the type of service performed on intraoral structures other than teeth.

Reimbursement Tips

Payers may require documentation including the tooth number and preoperative periapical x-rays showing the entire treatment site. Coverage for these procedures varies by payer and by individual contract. Check with payers for specific coverage guidelines.

ICD-10-CM Diagnostic Codes

K08.401 Partial loss of teeth, unspecified cause, class I
K08.402 Partial loss of teeth, unspecified cause, class II
K08.403 Partial loss of teeth, unspecified cause, class III
K08.404 Partial loss of teeth, unspecified cause, class IV
K08.409 Partial loss of teeth, unspecified cause, unspecified class
K08.411 Partial loss of teeth due to trauma, class I
K08.412 Partial loss of teeth due to trauma, class II
K08.413 Partial loss of teeth due to trauma, class III
K08.414 Partial loss of teeth due to trauma, class IV
K08.419 Partial loss of teeth due to trauma, unspecified class
K08.421 Partial loss of teeth due to periodontal diseases, class I
K08.422 Partial loss of teeth due to periodontal diseases, class II
K08.423 Partial loss of teeth due to periodontal diseases, class III
K08.424 Partial loss of teeth due to periodontal diseases, class IV
K08.429 Partial loss of teeth due to periodontal diseases, unspecified class
K08.431 Partial loss of teeth due to caries, class I
K08.432 Partial loss of teeth due to caries, class II
K08.433 Partial loss of teeth due to caries, class III
K08.434 Partial loss of teeth due to caries, class IV
K08.439 Partial loss of teeth due to caries, unspecified class
K08.491 Partial loss of teeth due to other specified cause, class I
K08.492 Partial loss of teeth due to other specified cause, class II
K08.493 Partial loss of teeth due to other specified cause, class III
K08.494 Partial loss of teeth due to other specified cause, class IV
K08.499 Partial loss of teeth due to other specified cause, unspecified class

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D6608	5.06	4.46	1.04	10.56
D6609	5.31	4.69	1.09	11.09
Facility RVU	**Work**	**PE**	**MP**	**Total**
D6608	5.06	4.46	1.04	10.56
D6609	5.31	4.69	1.09	11.09

	FUD	Status	MUE	Modifiers				IOM Reference
D6608	N/A	N	-	N/A	N/A	N/A	N/A	None
D6609	N/A	N	-	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

onlay. In dentistry, restoration made outside of the mouth that is cemented over a cusp or cusps of the tooth.

retainer. In dentistry, portion of a fixed partial denture that attaches an artificial tooth to the abutment tooth or implant.

D7961-D7962

D7961 buccal/labial frenectomy (frenulectomy)
D7962 lingual frenectomy (frenulectomy)

Explanation

The surgeon removes the labial, buccal, or lingual frenum (frenectomy). The buccal frenum is a band of mucosal membrane that connects the alveolar (dental) ridge to the cheek and separates the lip vestibule from the cheek vestibule. The labial frenum is a connecting fold of mucous membrane that joins the lip to the gums at the inside mid center. The lingual frenum is a connecting fold of mucous membrane that joins the tongue to the floor of the mouth on the mid center of the tongue underside. Incisions are made around the frenum and through the mucosa and submucosa. The underlying muscle may be removed as well. The excision may extend to the interincisal papilla for the buccal and labial frenum. The mucosa is closed simply, or the dental surgeon may rearrange the tissue in z-plasty technique. Report D7961 for buccal or labial frenectomy and D7962 for lingual frenectomy.

Coding Tips

Local anesthesia is generally considered part of these services. These procedures are not usually separately reimbursed when done at the time of a more complex procedure. Check the guidelines for the more complex procedure or consult third-party payers for specific guidelines.

Reimbursement Tips

When selecting the procedure or service that accurately identifies the service performed, dentists must use the most accurate code. If the CDT code more accurately identifies the service, this should be used rather than the CPT codes. When covered by medical insurance, the payer may require that the appropriate CPT code be reported on the CMS-1500 claim form.

Associated CPT Codes

40806	Incision of labial frenum (frenotomy)
40819	Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frenectomy)
41010	Incision of lingual frenum (frenotomy)
41115	Excision of lingual frenum (frenectomy)

ICD-10-CM Diagnostic Codes

K06.1	Gingival enlargement
K06.2	Gingival and edentulous alveolar ridge lesions associated with trauma
K06.8	Other specified disorders of gingiva and edentulous alveolar ridge
K14.0	Glossitis
K14.6	Glossodynia
Q38.1	Ankyloglossia
Q38.3	Other congenital malformations of tongue
Q38.6	Other congenital malformations of mouth

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D7961				
D7962				
Facility RVU	**Work**	**PE**	**MP**	**Total**
D7961				
D7962				

	FUD	Status	MUE	Modifiers				IOM Reference
D7961	N/A		-	N/A	N/A	N/A	N/A	
D7962	N/A		-	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

buccal frenum. Band of mucosal membrane that connects the alveolar (dental) ridge to the cheek, separating the lip vestibule from the cheek vestibule.

frenulectomy. Excision of the labial, buccal, or lingual frenum.

labial frenum. Connecting fold of mucous membrane that joins the upper or lower lip to the gums at the inside midcenter.

D9248

D9248 non-intravenous conscious sedation

This includes non-IV minimal and moderate sedation. A medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes and the ability to respond to stimulation or verbal commands. It includes non-intravenous administration of sedative and/or analgesic agent(s) and appropriate monitoring. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic's effects upon the central nervous system and not dependent upon the route of administration.

Explanation

Nonintravenous conscious sedation is given to the patient.The patient breathes without assistance and responds to commands. The time is calculated when the doctor begins the appropriate protocol for administering the agent and monitoring the patient, remaining in the room and in continuous attendance until the patient may be safely left in the care and observation of trained personnel.

Coding Tips

To report intravenous moderate (conscious) sedation, see D9243. To report deep sedation/general anesthesia, see D9223.

Reimbursement Tips

Check with third-party payers for specific guidelines on reporting time increments as well as line item versus units reporting.

Associated HCPCS Codes

J2250 Injection, midazolam HCl, per 1 mg
J2515 Injection, pentobarbital sodium, per 50 mg
J3360 Injection, diazepam, up to 5 mg

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D9248	0.45	0.89	0.05	1.39
Facility RVU	**Work**	**PE**	**MP**	**Total**
D9248	0.45	0.89	0.05	1.39

	FUD	Status	MUE	Modifiers				IOM Reference
D9248	N/A	R	-	N/A	N/A	N/A	N/A	None

* with documentation

Terms To Know

analgesia. Absence of a normal sense of pain without loss of consciousness.

analgesic. Agent that relieves pain without causing loss of consciousness.

anesthesia. Loss of feeling or sensation, usually induced to permit the performance of surgery or other painful procedures.

monitored anesthesia care. Sedation, with or without analgesia, used to achieve a medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes, and ability to respond to stimulation or verbal commands. In dental conscious sedation, the patient is rendered free of fear, apprehension, and anxiety through the use of pharmacological agents.

D9310

D9310 consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician

A patient encounter with a practitioner whose opinion or advice regarding evaluation and/or management of a specific problem; may be requested by another practitioner or appropriate source. The consultation includes an oral evaluation. The consulted practitioner may initiate diagnostic and/or therapeutic services.

Explanation

This code is a consultation service requested by the providing dentist, physician, or other appropriate professional. Another dentist or dental specialist's opinion and advice regarding the evaluation and care treatment plan of the patient's specific problem is given. The consulting dentist or specialist may initiate diagnostic and therapeutic procedures, but is not the practitioner providing the treatment.

Coding Tips

Any radiograph, diagnostic, or therapeutic procedure initiated is reported separately. Any oral evaluations performed are included in this procedure and, therefore, are not separately billable. To report problem-focused examinations of a patient who is not referred by another provider, see D0140 or D0160. Initial examinations of a patient who is not referred by another provider is reported using D0150 or D0180. To report the oral evaluation of a patient under 3 years of age including counseling of the primary caregiver, see D0145.

Documentation Tips

Third-party payers may require clinical documentation and/or x-rays before making payment determination. Check with payers to determine specific requirements.

Reimbursement Tips

Coverage of this procedure varies by payer. Check with the payer for specific coverage guidelines.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D9310	0.64	1.27	0.08	1.99
Facility RVU	**Work**	**PE**	**MP**	**Total**
D9310	0.64	1.27	0.08	1.99

	FUD	Status	MUE	Modifiers				IOM Reference
D9310	N/A	I	-	N/A	N/A	N/A	N/A	None

* with documentation

Terms To Know

dental consultation. Advice or an opinion rendered by a dentist or dental specialist who is not the treating doctor provided at the request of the providing dentist, physician, or other appropriate professional.

diagnostic dental procedure. Procedure performed to evaluate the patient's complaints or symptoms and help the dentist establish the nature of the patient's disease or condition so that definitive care can be provided.

Evaluation and Management Guidelines Common to All E/M Services

Information unique to this section is defined or identified below.

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office consultation. Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided following the Decision Tree for New vs Established Patients.)

Definitions of Commonly Used Terms

Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting by physicians and other qualified health care professionals. The definitions in the E/M section are provided solely for the basis of code selection.

Some definitions are common to all categories of services, and others are specific to one or more categories only.

New and Established Patient

Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report E/M services with a specific CPT® code or codes. A new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See the decision tree on the following page.

When a physician/qualified health care professional is on call or covering for another physician/qualified health care professional, the patient's encounter is classified as it would have been by the physician/qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialties as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The decision tree on the following page is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Time

The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions of the CPT codebook. The inclusion of time as an explicit factor beginning in CPT 1992 was done to assist in selecting the most appropriate level of E/M services. Beginning with CPT 2021, except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Different categories of services use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult to provide accurate estimates of the time spent face-to-face with the patient.

Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service. Time may only be used for selecting the level of the **other** E/M services when counseling and/or coordination of care dominates the service.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The appropriate time should be documented in the medical record when it is used as the basis for code selection.

Face-to-face time (outpatient consultations [99241, 99242, 99243, 99244, 99245], domiciliary, rest home, or custodial services [99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337], home services [99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350], cognitive assessment and care plan services [99483]): For coding purposes, face-to-face time for these services is defined as only that time spent face-to-face with the patient and/or family. This includes the time spent performing such tasks as obtaining a history, examination, and counseling the patient.

99202-99205

★**99202** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

★**99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

★**99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

★**99205** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

Explanation

Providers report these codes for new patients being seen in the doctor's office, a multispecialty group clinic, or other outpatient environment. All require a medically appropriate history and/or examination. Code selection is based on the level of medical decision making (MDM) or total time personally spent by the physician and/or other qualified health care professional(s) on the date of the encounter. Factors to be considered in MDM include the number and complexity of problems addressed during the encounter, amount and complexity of data requiring review and analysis, and the risk of complications and/or morbidity or mortality associated with patient management. The most basic service is represented by 99202, which entails straightforward MDM. If time is used for code selection, 15 to 29 minutes of total time is spent on the day of encounter. Report 99203 for a visit requiring a low level of MDM or 30 to 44 minutes of total time; 99204 for a visit requiring a moderate level of MDM or 45 to 59 minutes of total time; and 99205 for a visit requiring a high level of MDM or 60 to 74 minutes of total time.

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are no longer used when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternately, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. For office or other outpatient services for an established patient, see 99211-99215. For observation care services, see 99217-99226. For patients admitted and discharged from observation or inpatient status on the same date, see 99234-99236. Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes and using the appropriate place of service. Services at the origination site are reported with HCPCS Level II code Q3014.

Documentation Tips

Documentation should include the history and exam performed in addition to the medical decision making performed. When time is the determinant for code selection, total time should be documented. Medical necessity must be clearly stated and support the level of service reported.

Reimbursement Tips

The place-of-service (POS) codes used for reporting these services are the same as those for a new patient: POS code 11 represents the clinician's office environment and POS code 22 represents the outpatient setting. When a separately identifiable E/M service is reported at the same time as another procedure or service, modifier 25 should be appended to the E/M service to indicate the service is distinct from the other service performed.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: **99202** 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2020,Dec,11; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3 **99203** 2020,Sep,3; 2020,Sep,14; 2020,Oct,14; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,10; 2018,Apr,9; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3 **99204** 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,12; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,16; 2015,Jan,12; 2015,Dec,3 **99205** 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,12; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3