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## CIRCULAR 29 OF 2010

### Clarification of Circular 26 of 2008, "ICD-10 coding for dental laboratory and technician claims"

#### 1. Background

On 1 February 2008 regulations were gazetted amending the Dental Technicians Act enabling direct claiming of fees for payment by patients or medical schemes to dental technician contractors for dental laboratory work done.

On the 12<sup>th</sup> of September 2008, circular 26 of 2008 was published by the CMS, instructing all dental technicians - irrespective of whether or not they choose to submit claims directly to healthcare funders, to include ICD-10 codes on their claims, which must conform to the line item requirement (the mandatory submission of ICD-10 codes at a line level).

Implementation of this however was largely delayed in order to accommodate logistic arrangements by technicians, dentists and medical schemes. This circular aims to clarify any misunderstanding of the previous circular and to emphasize the importance of this implementation proceeding across the industry.

#### 2. Detail

All dental practitioners, irrespective of whether or not they choose to submit claims directly to healthcare funders, are now required to include ICD-10 codes on their claims, which must conform to the line item requirement (the mandatory submission of ICD-10 codes at a line level). Dental technicians are non-diagnosing practices and are therefore unable to determine which ICD-10 diagnostic code(s) to use. They should therefore use one of the following default codes on each line on their claims:

- ☐ **Z46.3 Fitting and adjustment of dental prosthetic device**
- ☐ **Z46.4 Fitting and adjustment of orthodontic device**

It is important for dental practitioners to note that regardless of the method of submission of a claim, the dental technician component must always have the relevant ICD-10 codes included. In the event that a

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dentist submits the claim on behalf of the technician, the ICD-10 codes for the technician's portion of the claim must have the specified ICD-10 codes.

The referring dentist should supply a referral diagnosis code which should be placed in the designated space for referral diagnosis within a dental technician's claim. This will allow schemes to determine if the services rendered refer to a prescribed minimum benefit (PMB) condition and thus ensure that the correct benefits are allocated for the services rendered.

When a dental technician submits a claim to a patient, dentist or medical scheme, that the following ICD-10 coding information must be present:

1. Referring diagnoses received from the dentist – in the appropriately allocated place on a summary level on the claim.
2. The dental technician's ICD-10 code(s) per line item.

When a dentist submits a claim on behalf of a dental technician as part of the dental claim, the dental claim must contain:

1. The dentist's own ICD-10 diagnostic codes on each line item including the 8099 Laboratory work performed item.
2. When listing the dental technician's codes underneath the 8099 item line, the dental technician's ICD-10 codes must be included on each laboratory line item.

### **3. Conclusion and recommendation**

Due to the delay in the industry complying to these requirements, the ICD-10 Task team has endeavoured to negotiate timelines with the relevant administrators, practice management systems as well as the various representative bodies. The intent is to ensure that compliance across the industry is enforced by **September 30<sup>th</sup>, 2010.**

For any further information please feel free to contact the Council for Medical Schemes at [support@medicalschemes.com](mailto:support@medicalschemes.com).

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