adha CLL 2015
92ND ANNUAL SESSION
JUNE 17-23•2015
NASHVILLE, TN

CE Course Handout

Solving Insurance Reimbursement Dilemmas for Dental Hygiene Procedures

Thursday, June 18, 2015
9:30am-12:30pm

American Dental Hygienists' Association

Fee-for-service vs. “Insurance”

- Fee for Service

$100 procedure
- $60 overhead
$40 profit

- PPO (20% discount)

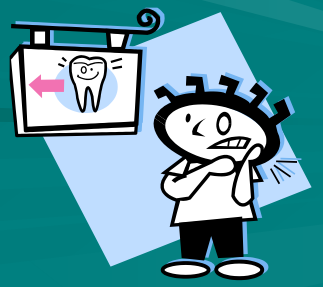
$80 procedure
- $60 overhead
$20 profit

Insurance:

Protection against the occurrence of an infrequent, catastrophic event.

Dentistry:

Involves the frequent occurrence of non-catastrophic events.



Dental “Insurance”

Not really insurance but a

Dental Benefit

or

Healthcare Financing

Dental “Insurance”
1972

- Most plans paid by incentive:
  - First year - paid 70% of dentist’s fees
  - Second year - paid 80% of dentist’s fees
  - Third year - paid 90% of dentist’s fees
  - Fourth year and beyond - paid 100%
- Maximum benefit?

Dental “Insurance”
2015

- Paid according to negotiated contract between employer and insurance company
- Varying rates of reimbursement
  - Some based on % of UCR computed by insurance company
  - Some based on LEAT (least expensive alternative treatment)
  - Some rely on “evidence-based” research
  - Some based on “who knows what”
- Maximum benefit?

Other Changes in Benefit Coverage

- Monitoring dental practices for over-utilization of certain procedures. Is office treating patients based “on routine”?
- Utilization ratios are being tracked by insurance carriers.

Dental “Insurance”

(Stats from Insurance Solutions Newsletter, Sept/Oct 2014)

- Dentistry is more dependent on PPOs
- 2002: 42% of all plans in US were PPOs
- 2012: 78% of all plans in US were PPOs
- Employers wanted lower cost coverage
- Providers developed lower cost products (ie. include cost containment features like LEAT)
- “Dentists have also fueled this shift to PPOs.”

Dental “Insurance”

(from Insurance Solutions Newsletter, Sept/Oct 2014)

“Unfortunately, many dental practices believe that, as a participant provider, they are obligated to accept a reduced reimbursement with no recourse. However, in many instances, the practice and the patient do have options that help the patient choose the best alternative. This also allows the practice to balance bill the patient for the difference between the LEAT and the best option for the patient.

The answer lies in what the insurance industry has described as Optional Services.”

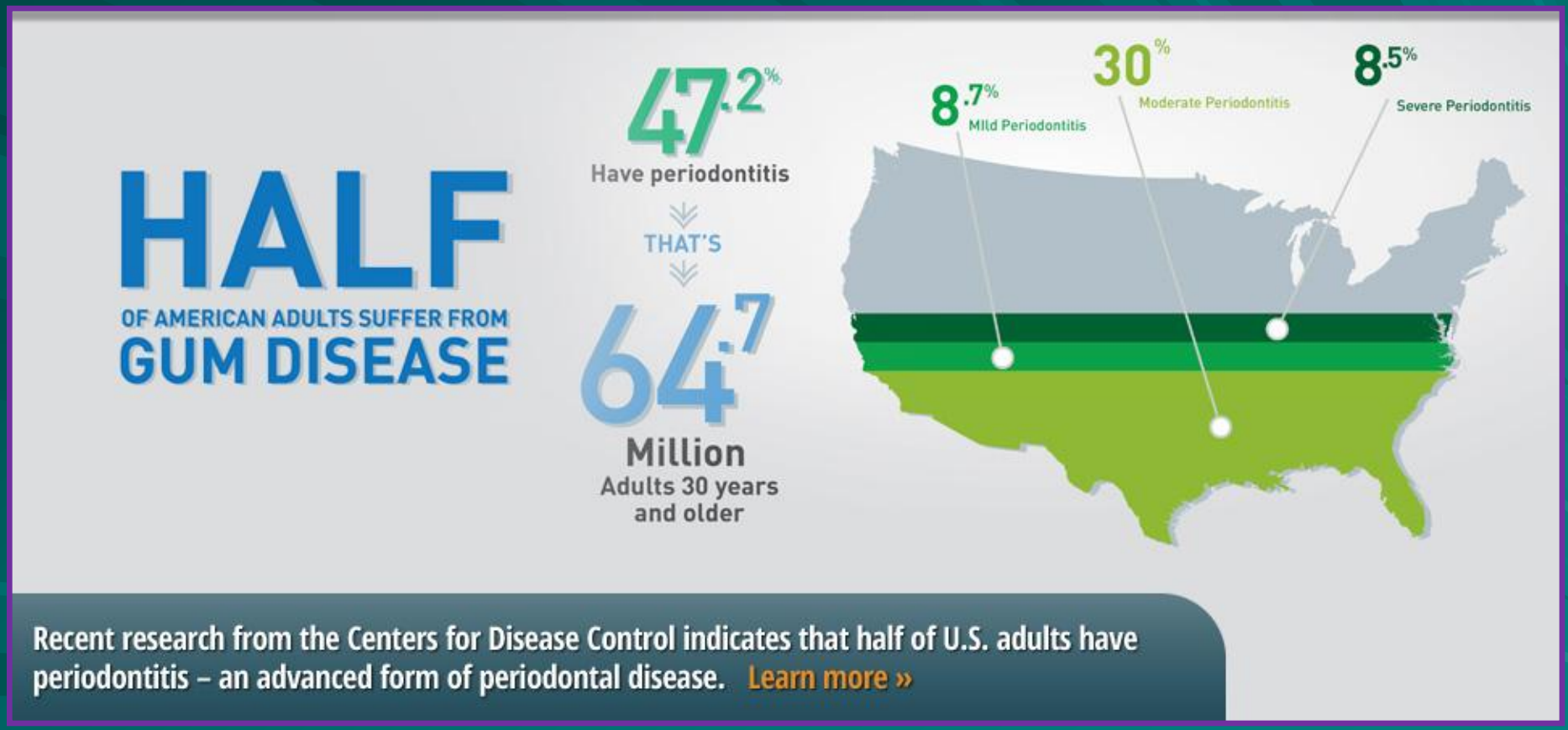
March 3, 2014 Issue

Delta Dental plan for employees limits cleanings for healthy adults to one per year.

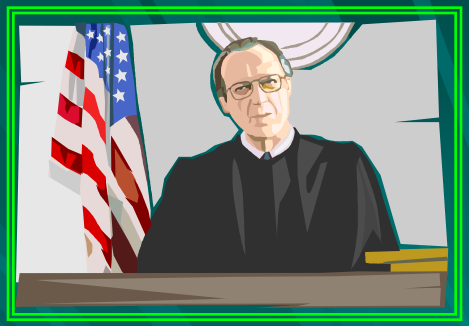
Reimbursement for dental hygiene procedures (as well as all dental procedures) depends, in a large part, on accurate and complete documentation.

Opening page of AAP website:

(2015)



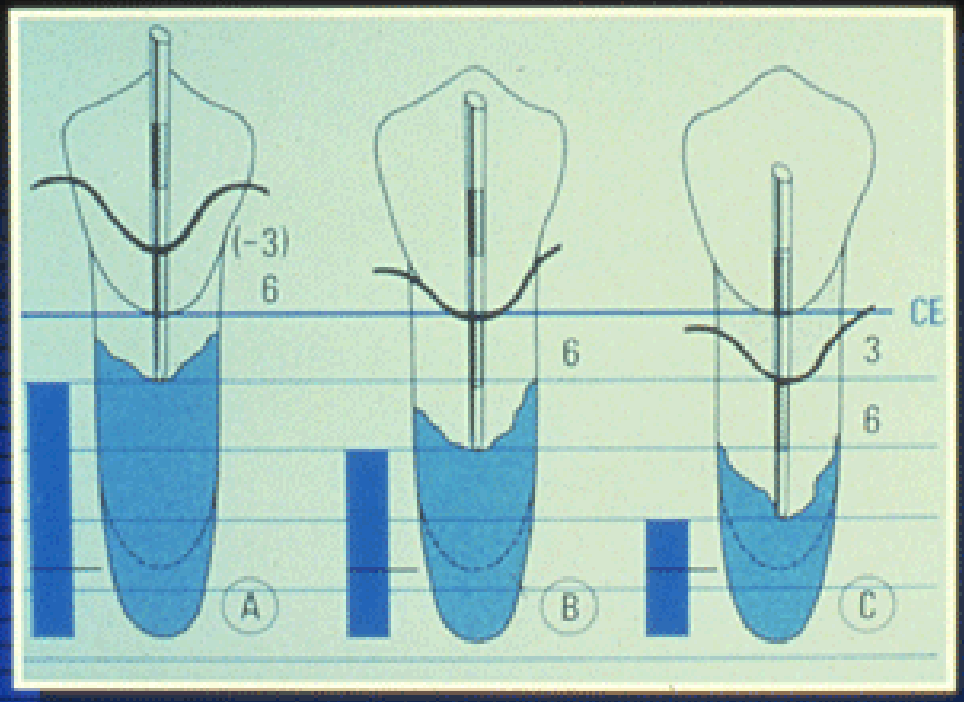
Concerns:



- Many dental hygienists provide periodontal procedures (periodontal maintenance, scaling and root planing) but document preventive procedures (adult prophylaxis).
- Many business staff bill for preventive procedures when the hygienist has performed periodontal procedures.
- Both scenarios cause the practice to lose money.
- Both scenarios would be considered risk management issues.

Are probe readings alone enough to determine the extent of periodontal disease?

Gingival Recession



Measuring attachment loss

Each measures as a 6 mm pocket

Development of a Classification System for Periodontal Diseases and Conditions

Ann Periodontol

Development of a Classification System for Periodontal Diseases and Conditions

Gary C. Armitage*

* University of California, San Francisco, California.

For more detailed information on the revised classification system, purchase ANNALS OF PERIODONTOLOGY, VOL. 4 in the AAP Products Catalog.

Classification systems are necessary in order to provide a framework in which to scientifically study the etiology, pathogenesis, and treatment of diseases in an orderly fashion. In addition, such systems give clinicians a way to organize the health care needs of their patients. The last time scientists and clinicians in the field of periodontology and related areas agreed upon a classification system for periodontal diseases was in 1989 at the World Workshop in Clinical Periodontics.[1] Subsequently, a simpler classification was agreed upon at the 1st European Workshop in Periodontology.[2] These classification systems have been widely used by clinicians and research scientists throughout the world. Unfortunately, the 1989 classification had many shortcomings including: 1) considerable overlap in disease categories, 2) absence of a gingival disease component, 3) inappropriate emphasis on age of onset of disease and rates of progression, and 4) inadequate or unclear classification criteria. The 1993 European classification lacked the detail necessary for adequate characterization of the broad spectrum of periodontal diseases encountered in clinical practice. The need for a revised classification system for periodontal diseases was emphasized during the 1996 World Workshop in Periodontics.[3] In 1997 the American Academy of Periodontology responded to this need and formed a committee to plan and organize an international workshop to revise the classification system for periodontal diseases. The proceedings in this volume are the result of this reclassification effort. The process involved development by the Organizing Committee of an outline for a new classification and identification of individuals to write state-of-the-science reviews for each of the items on the outline. The reviewers were encouraged to depart from the preliminary outline if there were data to support any modifications. On October 30–November 2, 1999, the International Workshop for a Classification of Periodontal Diseases and Conditions was held and a new classification was agreed upon (Fig. 1). This paper summarizes how the new classification differs from the classification system developed at the 1989 World Workshop in Clinical Periodontics.[1] In addition, an analysis of the rationale is provided for each of the modifications and changes. *Ann Periodontol 1999;4:1-6.*

KEY WORDS

Periodontal diseases/classification; gingival diseases/classification.

CHANGES IN THE CLASSIFICATION SYSTEM FOR PERIODONTAL DISEASES

Addition of a Section on "Gingival Diseases"

As mentioned above, the 1989 classification did not include a section on gingival diseases. This has been remedied by the development of a detailed classification of gingival diseases and lesions that are either dental plaque-induced (pages 18-19) or not primarily associated with dental plaque (pages 30-31). An important feature of the section on dental plaque-induced diseases is acknowledgment that the clinical expression of gingivitis can be substantially modified by: 1) systemic factors such as perturbations in the endocrine system, 2) medications, and 3) malnutrition. The section on non-plaque induced gingival lesions includes a wide range of disorders that affect the gingiva. Many of these disorders are frequently encountered in clinical practice.

Replacement of "Adult Periodontitis" With "Chronic Periodontitis"

From the outset, the term "Adult Periodontitis" created a diagnostic dilemma for clinicians. Epidemiologic data and clinical experience suggest that the form of periodontitis commonly found in adults can also be seen in adolescents.[4] If this is true, how can non-adults (e.g., adolescents) with this type of periodontitis be said to have "adult periodontitis?" Clearly, the age-dependent nature of the adult periodontitis designation created problems. Therefore, workshop participants concluded that it would be more

Annals of Periodontology
December, 1999

www.perio.org

AAP Classification of Periodontal Diseases and Conditions

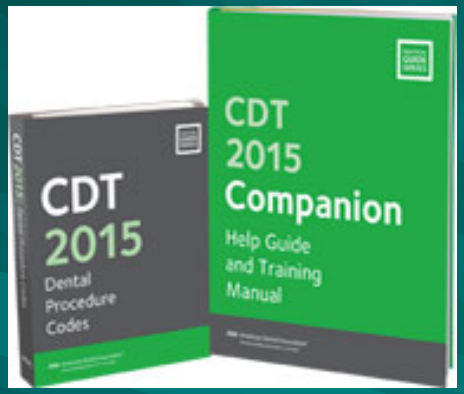
(Based on 1999 International Workshop)

- Gingival Diseases
- Chronic Periodontitis
- Aggressive Periodontitis
- Periodontitis as a Manifestation of Systemic Diseases
- Necrotizing Periodontal Diseases
- Abscesses of the Periodontium
- Periodontitis Associated with Endodontic Lesions
- Developmental or Acquired Deformities and Conditions

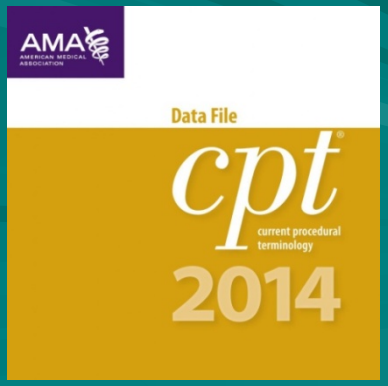
- AAP Disease Classification/Diagnosis
  - Use descriptive words:
    - Generalized mod. chronic periodontitis
    - Isolated sl. chronic periodontitis - stable
    - Localized plaque-induced gingivitis
- Billing Class/Case Type/Code
  - Use roman numerals (I-IV)
  - May use description title also:
    - IV: Moderate chronic periodontitis

Code sets currently recognized and used by dental and/or medical practices:

- **C**urrent **D**ental **T**erminology (CDT) for dental procedures

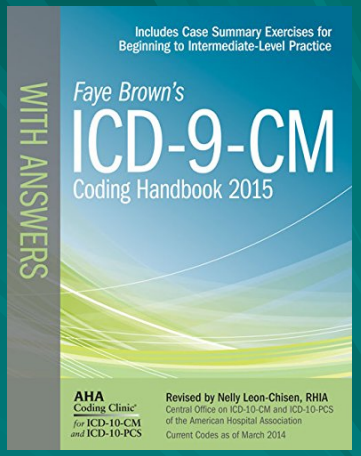


- **C**urrent **P**rocedural **T**erminology (CPT) for medical procedures

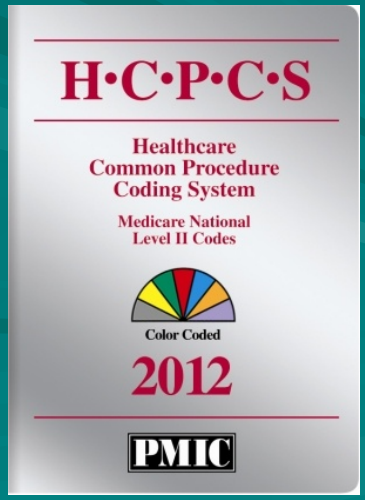


Codes sets currently recognized and used by dental and/or medical practices: (contd)

- **I**nternational **C**lassification of **D**iseases, 9th revision, Clinical Modification (ICD-9-CM) for both dental and medical diagnoses,



- **H**ealthcare **C**ommon **P**rocedure **C**oding **S**ystem (HCPCS) for both dental and medical procedures.

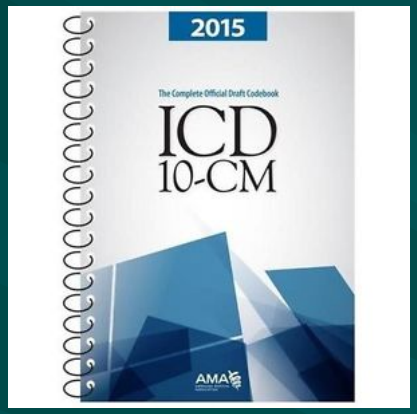


What is ICD-9?

- 3 volumes
- Tells why the procedure was necessary
- More than **30** years old
- For every dental procedure there is an ICD-9-CM which can be assigned
- Contains outdated, obsolete terms inconsistent with current medical practice
- Contains13,000 codes for diagnoses.

Sampling of ICD-9 dental codes:
(from www.findacode.com)

Complete matches:	
523.8	Periodontal disease NEC
525.1	Loss of teeth due to trauma, extraction or periodontal disease
523.9	Gingival/periodontal disease NOS
525.12	Loss of teeth d/t periodontal disease
523.10	Chronic gingivitis, plaque
523.30	Aggressive periodontitis NOS
Partial Matches:	
HCPCS	S0315 Disease management program



What is ICD-10-CM?

- International Classification of Diseases, Tenth Revision,
  Clinical Modification (ICD-10-CM)
- Contains 68,000 codes.

October 1, 2015 is the compliance date to transition to ICD-10 code sets.

From CNBC.com: Feb. 12, 2014

- “Docs face ‘crushing’ costs from diagnosis code switch, AMA says.”
- “AMA expects doctors will have to pay three times the original estimate for implementing these new and more numerous codes.”
- Large physician practices: $2 million - $8 million to transition.
- Small practices: $56,600 to $226,100 to transition.

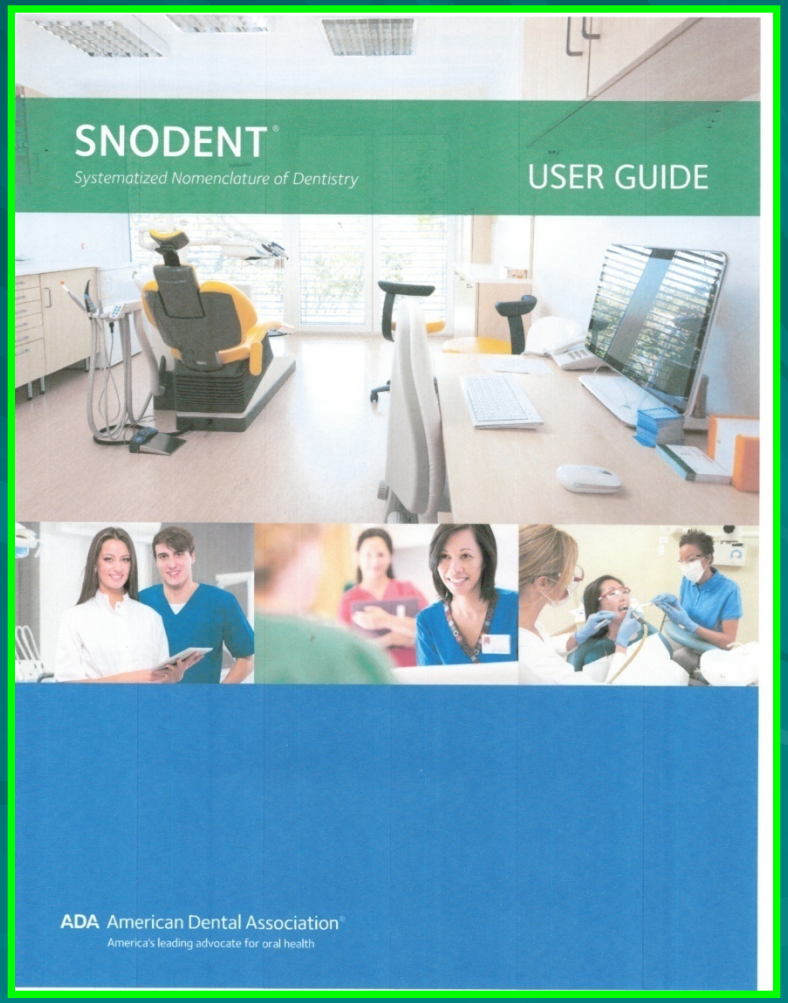
From CNBC.com: Feb. 12, 2014

- “This 2008 estimate for implementation costs was based on the assumption that physicians would [be] involved and proactive in this conversion.”
- “The projected cost increase is based on the fact that many independent practices have been resistant to ICD-10 implementation. Everyone has had ample time to prepare and many have simply chosen not to.”

SNODENT®

- Systematized Nomenclature of Dentistry

Developed and maintained
by the ADA
Council on Dental Benefits



News for Dental Practices:

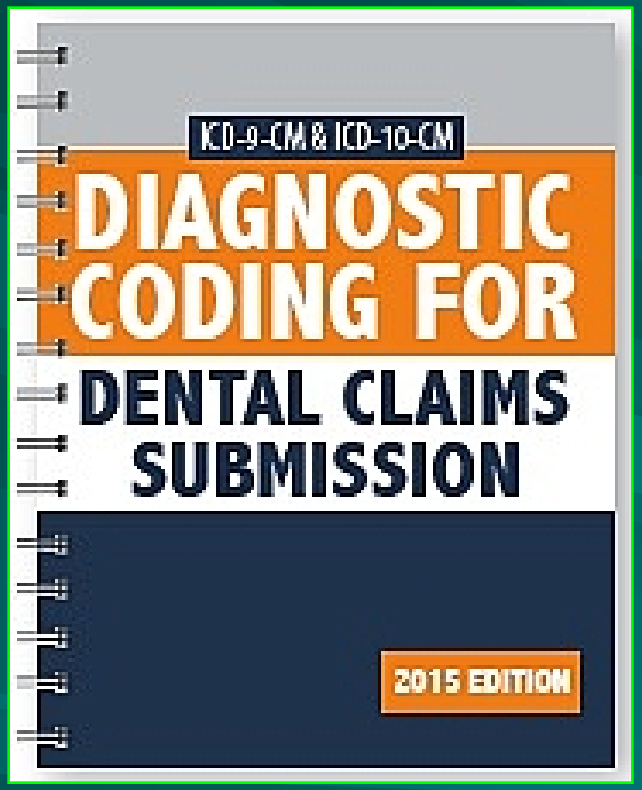
- CHANGED January 1, 2012 when all covered entities were required to upgrade their processing software to be compliant with the new version 5010.
- Diagnosis codes can now be reported on an electronic dental claim. (up to 4)
- ADA also revised paper claim forms to these new standards.

From Insurance Solutions Newsletter, February 2015:

- Examples of two diagnosis codes in ICD-10-CM:

- Z01.20 Encounter for dental examination and cleaning without abnormal findings
- Z01.21 Encounter for dental examination and cleaning with abnormal findings.

Coming May-June 2015



Will include guidance on the proper use of diagnosis codes for both ICD-9-CM and ICD-10-CM

Documentation

Top Two Areas of Claim Frequency:

#1: Failure to diagnose periodontal disease.

#2: Failure to diagnose oral cancer

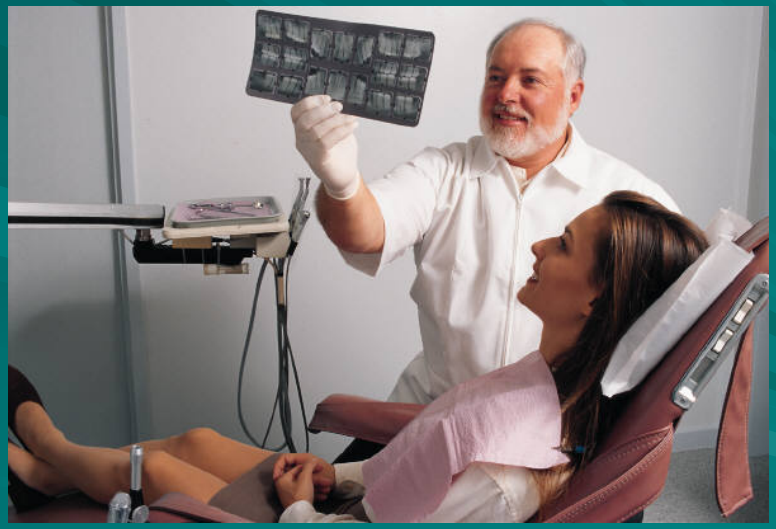
#3: Legal considerations, poor record keeping, and a lack of informed consent.

Also note #9:

Failure to refer or referring too late.

- Avoid personal shorthand that others cannot understand and non-relevant comments that could prove embarrassing if read in court.
- **Allow adequate time** to complete the treatment record to avoid poor documentation and frustration.
- **Document all data immediately;** delays lead to inaccuracies.
- Remember that the patient record is always confidential.

Informed Consent



Informed Consent defined:

- The patient's agreement that he or she has had a thorough discussion with the doctor (dentist), understanding the recommended treatment or procedure, its alternatives, risks and consequences, and desires the dental procedure to be preformed.
- American Medical Association

Informed Consent defined:

- Informed consent is more than simply getting a patient to sign a written consent form. It is a **process of communication** between a patient and physician (dentist) that results in the patient's authorization or agreement to undergo a specific medical (dental) intervention.
- First Professional Insurance Co, Inc.

INFORMED REFUSAL

IS THERE SUCH A THING?

- “Our providers are required to code according to medical standards.”
- “Please do not ask to have your diagnosis changed to accommodate your insurance.”

Examples of Fraud

- Billing for services not performed.
- Altering dates of service.
- Up coding, for example:
  - Billing D4341 (Scaling and Root Planing) when you provided D4910 (Periodontal Maintenance).
  - Billing a night guard or fluoride trays when you've only provided whitening trays.

Examples of Fraud

- Waiver of co-payments and/or deductibles

  The insurance plan is a contract between the patient's employer and the insurance company. The dentist is not a party to that contract. As such, **dentists cannot accept payments from insurance companies as payment in full when a co-payment is contractually required.**

Examples of Fraud

The **American Dental Association's Code of Ethics** states (5.B.1): A dentist who accepts a third party payment under a co-payment plan as payment in full without disclosing to the third party that the patient's payment portion will not be collected, is engaged in overbilling. The essence of this ethical impropriety is deception and misrepresentation: an overbilling dentist makes it appear to the third party that the charge to the patient for services rendered is higher than it actually is.

Examples of Fraud

- Unbundling Codes – separating dental procedures so the benefits of the component parts total more than the procedures as defined would normally be reimbursed.

"If you inform the patient before it happens, it's a reason;

if and when the patient finds out afterward, it will be nothing more than an excuse."

Tom Limoli, Jr.

President

Limoli and Associates

Current Dental Terminology

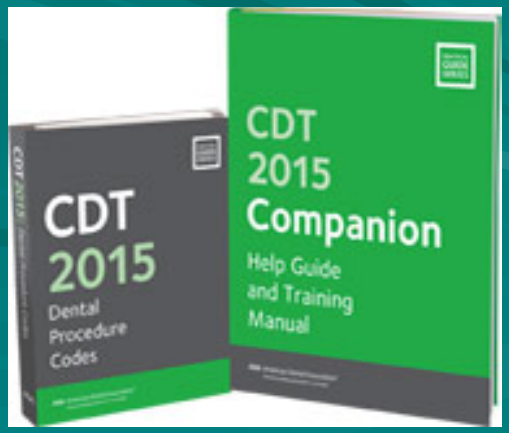
CDT-2015

Jan. 1, 2015 – Dec. 31, 2015

Available from

American Dental Association

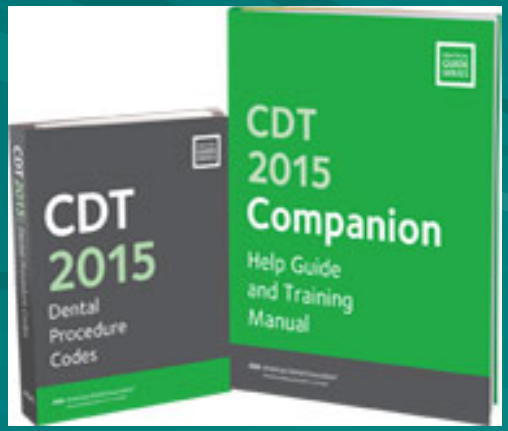
www.ada.org



Recent History of CDT . . .

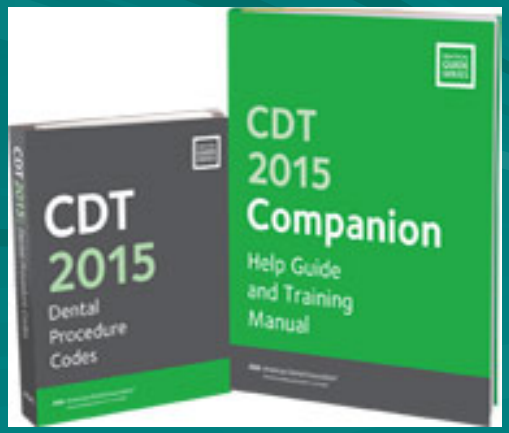
- CDT-2013 had over 80 changes
- CDT-2014 had more than 50 changes
- CDT-2015 has 73 changes

  (119 requests submitted)



CDT-2015

- American Dental Association's Council on Code Management (CMC)
- Final tally:
  - 16 new codes
  - 5 deleted codes
  - 52 revised codes



At a Glance

- New Codes
  - Re-evaluation at a post-operative office visit
  - 3D photographic image
  - Sealant repair – per tooth
  - Cleaning and inspection of removable appliances
  - Retainers for resin bonded fixed prosthesis
  - Missed and cancelled appointments
  - More

At a Glance

- Revised Codes
  - Topical application of fluoride
  - Coping
  - Inlay/onlay restorations
  - Clinical crown lengthening – hard tissue
  - Osseous surgery
  - Peri-implant defects
  - More

Clinical Oral Evaluations

(Not Exams)

Periodic Oral Evaluation – established patient

D0120

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 and periodontal screening where indicated and may require interpretation of information acquired through additional diagnostic procedures. Report Additional diagnostic procedures separately.

What is the definition of a "Periodontal Screening" ?

- Many hygienists and dentists consider a periodontal screening to include nothing more than spot probing

  BUT…

- The American Academy of Periodontology states that a charting containing only six points per tooth pocket depths is a Periodontal Screening.

Does this mean that 6 points per tooth pocket depths must be recorded at each appointment when a D0120, Periodic Oral Evaluation is performed?

Answer: Not Necessarily

- Probe all six points per tooth and make summary statement such as

  “All areas probed and within 1mm of previous last recordings”.

- Perform PSR® where all six points must be probed on all teeth but only the highest number/deepest pocket in each sextant is documented.

Comprehensive Oral Evaluation – New or Established Patient

D0150

Typically used by a general dentist and/or specialist when evaluating a patient comprehensively. This applies to

- new patients;
- established patients who have had a significant change in health conditions or other unusual circumstances, by report, or
- established patients who have been absent from active treatment for three or more years.

It is a thorough evaluation of . . .

Comprehensive Oral Evaluation – New or Established Patient

D0150

Evaluate and record:

- An evaluation for oral cancer where indicated
- Extra-oral and intra-oral hard and soft tissues
- Dental history
- Medical history
- A general health assessment
- Dental caries, missing or unerupted teeth
- Restorations
- Existing prostheses
- Occlusal relationships
- Periodontal conditions, including periodontal screening and/or periodontal charting
- Hard and soft tissue anomalies

What is the definition of a "Periodontal Charting" ?

- The American Academy of Periodontology states that a complete periodontal charting, including a description of periodontal conditions, includes
  - six points per tooth pocket depths,
  - recession,
  - furcations,
  - mobilities,
  - bleeding points,
  - minimal attached gingiva notations,
  - AAP diagnosis, etc.

Comprehensive Periodontal Evaluation – New or Established Patient

D0180

This procedure is indicated for patients showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking or diabetes. It includes evaluation of periodontal conditions, probing and charting, evaluation and recording of the patient's dental and medical history and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer evaluation

What is the difference in the definitions between Comp. Oral Eval and Comp. Perio. Eval?

Oral Evaluation

- Evaluation for oral cancer
- Extra-oral and intra-oral hard and soft tissues
- Dental history
- Medical history
- A general health assessment
- Dental caries, missing or unerupted teeth
- Restorations
- Existing prostheses
- Occlusal relationships
- Periodontal conditions, including periodontal screening and/or charting
- Hard and soft tissue anomalies

Periodontal Evaluation

- Oral cancer evaluation
- Not included
- Dental history
- Medical history
- A general health assessment
- Dental caries, missing or unerupted teeth
- Restorations
- Not included
- Occlusal relationships
- Periodontal conditions, including periodontal charting
- Not included

Limited Oral Evaluation – Problem Focused

D0145

Diagnostic services performed for a child under the age of three, preferably within the first six months of the eruption of the first primary tooth, including recording the . . .

Limited Oral Evaluation – Problem Focused

D0145

- Oral and physical health history,
- Evaluation of caries susceptibility,
- Development of an appropriate preventive oral health regime,
- Communication with and counseling of the child's parent, legal guardian and/or primary caregiver.

New

Re-evaluation –Post Operative Office Visit

D0171

- Not to be confused with D0170 – limited, problem focused (established patient; not post-operative visit)
- According to Coding with Confidence:

  “Could be used to report a periodontal re-evaluation that includes charting and probing.”

  Reimbursement by providers may be limited.

Pre-diagnostic Services

New Codes as of Jan. 1, 2013

From CDT:
…. and other individuals may report any of the listed CDT Codes as long as they are acting within the scope of their state law.

Screening of a Patient

D0190

- A screening, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis

From:

Coding with Confidence

CDT-2015, page 17

- While diagnosis and treatment are the responsibilities of the dentist, a dental screening may be performed by other medical or dental professionals who are acting within the scope of their state licenses (i.e. mid-level provider, hygienist, physician, physician's assistant, nurse or other authorized personnel).
- A dental screening may or may not lead to a referral to a dentist

Assessment of a Patient

D0191

- A limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment.

Assessment of a Patient

Recommend the following be included:

- Review/documentation of the patient's medical and dental history
- Limited clinical examination including but not limited to:
  - Recording dental restorations and conditions such as
    - Hard and soft tissue abnormalities
    - Plaque and debris levels
    - Dental caries
    - Oral injuries
    - Tooth eruption
    - Tooth loss
    - Etc.
  - Collection of other oral health data

RDH Magazine
January 2013

DENTAL HYGIENISTS IN EMERGENCY ROOMS

BY **CHRISTINE NATHE,** RDH, MS

The Florida Public Health Institute recently published that there were 115,000 emergency room visits for preventable dental conditions in Florida in 2010, at a cost of $88 million. One third of those visits were charged to the state Medicaid program at a cost of almost $30 million, according to the report.1 This raises the question of whether the same amount could have been used to prevent the emergencies from occurring.

In the long run, dental care provided in the emergency room should be a true c concern to all American is preventive dental care is proven to be cost effe The routine coverage o

This solution addresses short- and long-term cost effectiveness principles. In the short term, patients can be triaged and followed up so that necessary dental care is provided to stop infection and pain. This decreases the costs associated with continued use of pain medicine and

Career
Alternative?!?

Preventive Services

(Other than Prophylaxis/Periodontal Procedures)

Fluoride Treatment (Office Procedure)

Prescription strength fluoride product designed solely for use in the dental office, delivered to the dentition under the direct supervision of a dental professional. Fluoride must be applied separately from prophylaxis paste.

“Evaluation of caries susceptibility”

- Caries Risk Assessment Forms for
  - Age 0 to 6 years and
  - >6 years

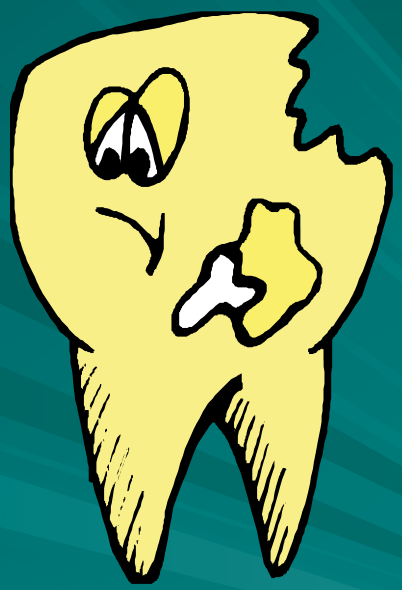
www.ada.org

Search, enter:

“caries risk assessment forms”

*Factors increasing risk for caries may include but are not limited to:

- High level of caries experience or demineralization
- History of recurrent caries
- High titers of cariogenic bacteria
- Existing restoration(s) of poor quality
- Poor oral hygiene
- Inadequate fluoride exposure
- Prolonged nursing (bottle or breast)
- Frequent high sucrose content in diet
- Poor family dental health
- Developmental or acquired enamel defects
- Developmental or acquired disability
- Xerostomia
- Genetic abnormality of teeth
- Many multisurface restorations
- Chemo/radiation therapy
- Eating disorders
- Drug/alcohol abuse
- Irregular dental care



*ADA Guidelines, July 2004

Topical application of fluoride varnish

D1206

*Topical application of fluoride – excluding varnish

D1208

Revision to a descriptor

Sealant – per tooth

D1351

- Mechanically and/or chemically prepared enamel surface sealed to prevent decay

New

Sealant Repair – per tooth

D1353

Preventive resin restoration in a moderate to high caries risk patient – permanent tooth

D1352

- Conservative restoration of an active cavitated lesion in a pit or fissure that does not extend into dentin; includes placement of a sealant in any radiating non-carious fissures or pits.

Documentation for Radiographs

Guidelines for Prescribing Dental Radiographs

From: American Dental Association and
U.S. Food & Drug Administration
Updated 2012

www.ada/org/prof/resources/topics/radiography.asp
www.fda.gov/cdrh/radhlth/adaxray.html

Guidelines for Prescribing Dental Radiography, 2012

- Page 3 of Report
- Radiographic screening for the purpose of detecting disease before clinical examination should not be performed. A thorough clinical examination, consideration of the patient history, review of any prior radiographs, caries risk assessment and consideration of both the dental and the general health needs of the patient should precede radiographic examination.

“Cleaning” Codes

Prophylaxis – Child

D1120

Removal of plaque, calculus and stains from the tooth structures in the **primary** and **transitional** dentition. It is intended to control local and irritational factors.

Prophylaxis – Adult

D1110

Removal of plaque, calculus and stains from the tooth structures in the **permanent** and **transitional** dentition. It is intended to control local and irritational factors.

What about the adult patient who needs 2 appointments and has no loss of attachment or clinical attachment loss?

The American Dental Association has stated that dental offices are to use Adult Prophylaxis for prophylaxis patients who require multiple visits. Adult Prophylaxis is billed at each separate appointment.

What about insurance benefits for multiple prophylaxis appointments?

Inform the patient before you perform the procedure.

"Additional appointments may not be reimbursed due to contract limitations negotiated by their employer"

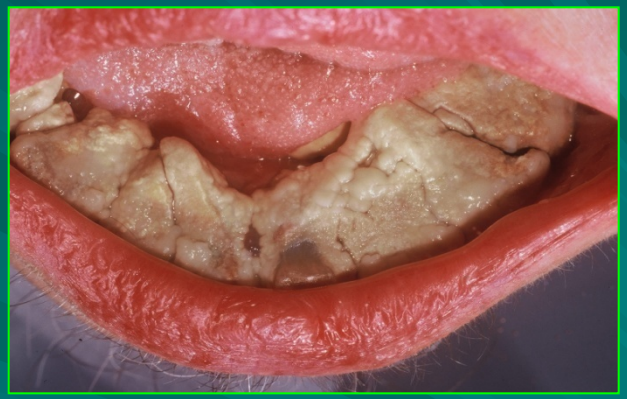
Full mouth debridement to enable comprehensive evaluation and diagnosis

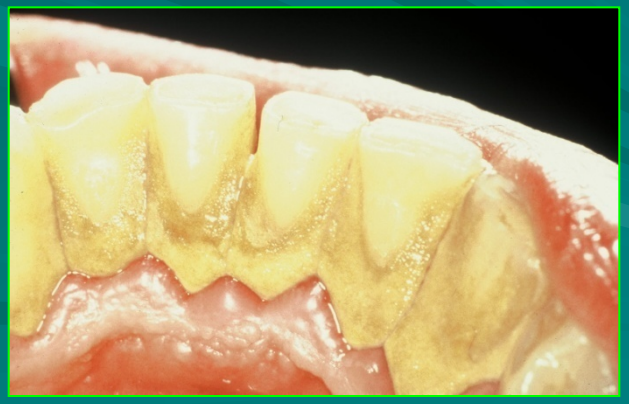
D4355

The gross removal of plaque and calculus that interfere with the ability of the dentist to perform a comprehensive oral evaluation. This preliminary procedure does not preclude the need for additional procedures.

Full mouth debridement to enable comprehensive evaluation and diagnosis

This procedure would be used when the dentist/hygienist cannot perform a periodontal charting due to the amount of plaque and calculus present above and below the gum line.





Full mouth debridement to enable comprehensive evaluation and diagnosis

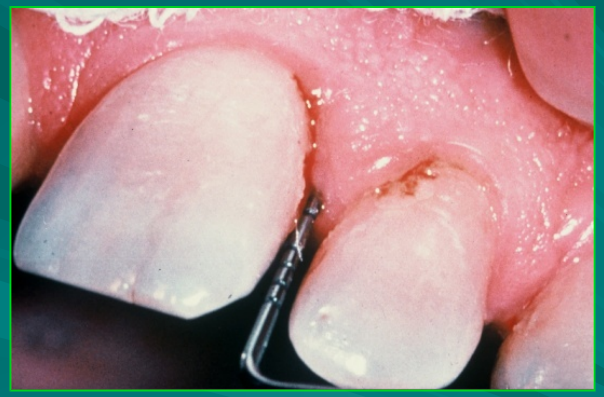
Narrative needed describing:

- why debridement necessary
- description of tissues, bleeding, amounts of plaque and calculus, etc.
- length of time since last “cleaning”
- x-rays and/or photos showing calculus deposits and degree of gum infection

When is Initial Periodontal Therapy (Scaling and Root Planing) Indicated?

When there is evidence of active disease

- Bleeding on probing



- Increased pocket depth
- Continued attachment loss (i.e. recession)
- Increased tooth mobility
- Purulent (pus) discharge/suppuration
- Sequential radiographic change of crestal bone

Comprehensive Periodontal Therapy: A Statement by the American Academy of Periodontology

J Periodontol • July 2011

Comprehensive Periodontal Therapy: A Statement by the American Academy of Periodontology*

The American Academy of Periodontology (AAP) periodically publishes reports, statements, and guidelines on a variety of topics relevant to periodontics. These papers are developed by an appointed committee of experts, and the documents are reviewed and approved by the AAP Board of Trustees.

The American Academy of Periodontology offers the following statement that sets forth the scope, objective, and procedures that constitute periodontal therapy. This statement is provided to assist all members of the dental team who provide periodontal care and should be considered in its entirety. This statement may also be useful to those who supervise, teach, or regulate the provision of periodontal therapy.

SCOPE OF PERIODONTAL THERAPY

As a result of advances in knowledge and therapy, the majority of patients can retain their dentition over their lifetime with proper treatment, reasonable plaque/biofilm control, and continuing care. Periodontics is the specialty of dentistry that encompasses prevention, diagnosis, and treatment of diseases of the supporting and surrounding tissues of teeth and dental implants.

The scope of the specialty of periodontics also encompasses maintenance of the health, function, comfort, and esthetics of all supporting structures and tissues in the mouth. The goals of periodontal therapy are to preserve, improve, and maintain the natural dentition, dental implants, periodontium, and peri-implant tissues in order to achieve health, comfort, esthetics, and function. A healthy periodontium is characterized by the absence of inflammation, which may appear clinically as redness, swelling, suppuration, and bleeding on probing.

PERIODONTAL EVALUATION

A comprehensive assessment of a patient's current health status, history of disease, and risk characteristics is essential to determine the periodontal diagnosis and prognosis of the dentition and/or the suitability of dental implants. Patients should receive a comprehensive periodontal evaluation and their risk factors should be identified at least on an annual basis. Such an evaluation includes discussion with the patient regarding his/her chief complaint, medical and dental history review, clinical examination, and radiographic analysis. Microbiologic, genetic, biochemical, or other diagnostic tests may also be useful, on an individual basis, for assessing the periodontal status of selected individuals or sites. The following procedures should be included in a comprehensive periodontal evaluation:

1. Extra- and intraoral examination to detect non-periodontal oral diseases or conditions.
2. Examination of teeth and dental implants to evaluate the topography of the gingiva and related structures; to measure probing depths, the width of keratinized tissue, gingival recession, and attachment level; to evaluate the health of the subgingival area with measures such as bleeding on probing and suppuration; to assess clinical furcation status; and to detect endodontic-periodontal lesions.
3. Assessment of the presence, degree, and/or distribution of plaque/biofilm, calculus, and gingival inflammation.
4. Dental examination including caries assessment, proximal contact relationships, the status of dental restorations and prosthetic appliances, and other tooth- or implant-related problems.
5. An occlusal examination that includes, but may not be limited to, determining the degree of mobility of teeth and dental implants, occlusal patterns and discrepancy, and determination of fremitus.
6. Interpretation of current and comprehensive diagnostic-quality radiographs to visualize each tooth and/or implant in its entirety and assess the quality/quantity of bone and establish bone loss patterns.
7. Evaluation of potential periodontal–systemic interrelationships.
8. Assessment of the need for and suitability of dental implants.
9. Determination and assessment of patient risk factors such as age, diabetes, smoking, cardiovascular disease, and other systemic conditions associated

*This statement was developed under the direction of the Task Force to Update the Guidelines for Periodontal Therapy and approved by the Board of Trustees of the American Academy of Periodontology in November 2010.

DISCLAIMER: This statement represents the views of the Academy regarding periodontal therapy and related procedures. It must be recognized, however, that decisions with respect to the treatment of patients must be made by the individual practitioner in light of the condition and needs of each specific patient. Such decisions should be made in the best judgment of the practitioner, taking into account all relevant circumstances.

NOTE: The Academy updates guidelines and statements on a periodic basis. All previous publications should be considered in light of their historical context with regard to current knowledge and practices.

doi: 10.1902/jop.2011.117001

www.perio.org

- Health Professionals
- Clinical/Scientific Resources
- Scroll to Academy Statements
- Comp Perio Therapy
  (from jop, July 2011)

Report sets forth the scope, objective and procedures that constitute periodontal therapy:

- Scope of Periodontal Therapy
- Periodontal Evaluation
- Establishing a Diagnosis, Prognosis and Treatment Plan
- Informed Consent and Patient Records
- Treatment Procedures
- Evaluation of Therapy
- Factors Modifying Results
- Periodontal Maintenance Therapy

Our responsibility to our patients:

- We inform.
- We document.
- We all share the same culture in the office.
- We all have the same “Standard of Care”.
- We have a team (business and clinical) working together to serve the patients’ perio and restorative treatment needs.

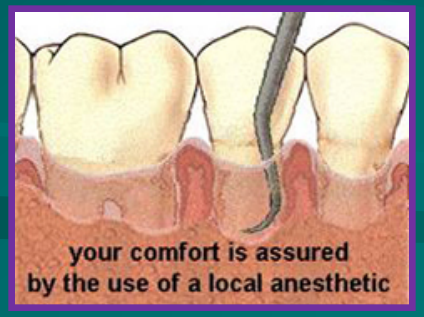
Scaling and Root Planing

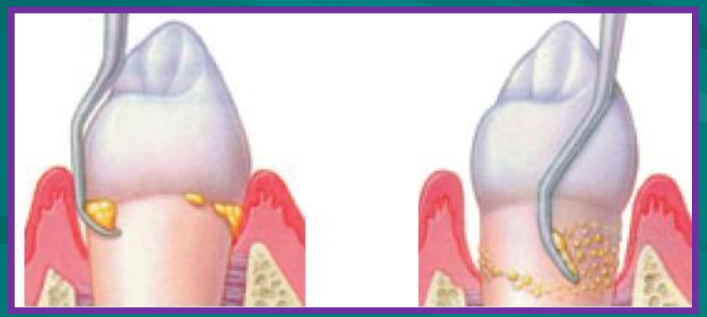
This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others.

Insurance Solutions Newsletter

July/August 2010

- Periodontal Scaling and Root Planing (SRP) is one of the most closely scrutinized procedures in dentistry
  - Periodontal Maintenance
  - Locally administered antibiotics





- Periodontal Scaling and Root Planing – four or more teeth, per quadrant

D4341

- Periodontal Scaling and Root Planing – one to three teeth, per quadrant

D4342

Scaling and Root Planing
(Example: 5 teeth on the right side, 2 quads)

6-18-15	UR	D4342	SRP #2, 3, 4 All other teeth in quad completed as Adult Prophy. --------Hygienist, RDH	$ 189.00
6-18-15	LR	D4342	SRP #29, #30 All other teeth in quad completed as Adult Prophy. --------Hygienist, RDH	$ 189.00

Periodontal Maintenance Procedures

D4910

This procedure is instituted following periodontal therapy and continues at varying intervals determined by the clinical evaluation of the dentist, for the life of the dentition or any implant replacements. It includes removal of bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing where indicated, and polishing the teeth.

If new or recurring periodontal disease appears, additional diagnostic and treatment procedures must be considered.

RDH Magazine
November, 2014

FEATURE

The tale of two codes

WHEN PERFORMING SITE SPECIFIC SCALING AND ROOT PLANING, WHICH CHOICE DO YOU MAKE?

BY **KATHY S. FORBES**, RDH, BS

Site specific scaling and root planing — *To do or not to do?* That is the question. Or, maybe it is one of many questions. Maybe it should be done only as an initial therapy procedure, or maybe as an ongoing therapeutic procedure, or maybe combined with something else. Then there's the question about how many "sites" are involved. What is a "site?" After all, there are two CDT procedure codes which address site specific scaling and root planing. What, you ask? *Two codes?*

Treatment planning of dental hygiene/periodontal procedures continues to seem complicated as clinical staff struggle to accurately diagnose and create treatment plans for periodontal diseases and select the appropriate procedure codes for billing purposes. At the same time, business staffs are under pressure to help patients understand that insurance carriers are continuing to limit benefits for periodontal procedures, and the out-of-pocket portion may be higher than the patient expects to pay.

There is no better time for both clinical staff and business staff to understand the specific definitions for the procedures they are recommending as well as billing. There is no code more confusing than "site specific scaling and root planing."

The American Dental Association's CDT 2014 Dental Procedure Codes manual defines these two codes related to site specific scaling and root planing on pp. 36-37. The most recognized code for isolated scaling and root planing is: "D4342 – Periodontal Scaling and Root Planing – one to three teeth per quadrant. This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. (partial definition)"

Typically, this is the procedure recommended when a patient has active periodontal disease that includes evidence of bleeding on probing, inflammation c gival tissues, clinical attachment loss of 4mm or greater, gingival r sion, and significant subgingival cal deposits. There may also be evider beginning furcation involvement, mobility and radiographic eviden bone loss. The limiting factor is that this code, *only one to three teeth in a rant* would benefit from this proced more than three teeth in a quadrar appropriate code would be D4341.)

SRP 4+	SRP 4+
SRP 4+	SRP 4+

SRP 1-3	SRP 1-3
SRP 4+	SRP 4+

SRP 1-3	SRP 1-3
Adult Prophy	

SRP 1-3

Adult Prophy

Palliative

Adult Prophy

SRP 1-3

Perio Maintenance ??

RDH Magazine
February Issue, 2014

"Perio and Insurance: The Periodontal Maintenance Patient and How To Get Perio Maintenance Covered by Insurance"

What do we do about . . .

Patient of record who:

- is obviously a “perio” patient,
- has never specifically had Scaling and Root Planing (D4341),
- should be coded as a Periodontal Maintenance (D4910) due to loss of attachment, but
- has been coded an Adult Prophylaxis (D1110)?

What do we do about . . .

Patient of record who:

- received Scaling and Root Planing (D4341) in the past,
- should be coded as a Periodontal Maintenance (D4910) but
- has been coded as an Adult Prophylaxis (D1110) ever since?

Bottom Line . . .

Did we
solve insurance reimbursement dilemmas?

For more information:

- Kathy S. Forbes, RDH, BS
- Phone: 253-670-3704
- FAX: 866-669-9308
- Email: prodentseminars@gmail.com

Professional Dental Seminars, Inc.
387 W. Prestwick Way
Castle Rock, CO 80104

AAP Classification System for Periodontal Disease and Conditions

(for more specifics: www.perio.org)

Gingival Diseases	A. **Plaque Induced**	1. Associated with dental plaque only
		2. Modified by systemic factors
		3. Modified by medications
		4. Modified by malnutrition
	B. **Non-plaque induced**	1. Bacterial origin
		2. Viral origin
		3. Fungal origin
		4. Genetic origin
		5. Manifestation of systemic conditions
		6. Traumatic lesions
		7. Foreign body reactions
		8. Not otherwise specified (NOS)
Chronic Periodontitis	A. **Localized** ≤ 30% *(30% or less of sites are involved)*	1. Modified by systemic factors
		2. Modified by medications
		3. Modified by malnutrition
	B. **Generalized** ≥ 30% *(more than 30% of sites are involved)*	1. Modified by systemic factors
		2. Modified by medications
		3. Modified by malnutrition
Aggressive Periodontitis	A. **Localized** ≤ 30% *(30% or less of sites are involved)*	
	B. **Generalized** ≥ 30% *(more than 30% of sites are involved)*	
Periodontitis as a Manifestation of Systemic Disease	A. Associated with hematological disorders	
	B. Associated with genetic disorders	
	C. Not otherwise specified (NOS)	
Necrotizing Periodontitis	A. Necrotizing ulcerative gingivitis (NUG)	
	B. Necrotizing ulcerative periodontitis (NUP)	
Abscesses of the Periodontium	A. Gingival, periodontal, pericoronal abscess	
Periodontitis Associated with Endodontic Lesions		
Developmental or Acquired Deformities and Conditions	A. Localized tooth-related factors	
	B. Mucogingival deformities and conditions around teeth	
	C. Mucogingival deformities and conditions on edentulous ridges	
	D. Occlusal trauma	

Updated 09/11

Case Types/Billing Codes for Third Party Claims: I-V (1989 AAP System)

Case Type	**Status Defined**	**Loss of Attachment (LOA)** Or **Clinical Attachment Loss (CAL)**
Case Type 0	Clinically Healthy	No LOA/CAL
Case Type I	Early/Chronic Gingivitis	No LOA/CAL Pseudopocketing possible
Case Type II	Established Gingivitis/ Early Periodontitis	Slight LOA/CAL = 1-2 mm
Case Type III	Moderate Periodontitis/ Chronic Periodontitis	Moderate LOA/CAL = 3-4 mm
Case Type IV	Advanced Periodontitis	Severe LOA/CAL = 5+ mm
Case Type V	Refractory Periodontitis	

Terminology Defined

(Encouraged by AAP in combination with new Disease Classification System)

Extent	**Severity**
Localized = 30% **or less** of sites are involved	**Slight** = LOA/CAL 1-2 mm
Generalized = **more than** 30% of sites are involved	**Moderate** = LOA/CAL 3-4 mm
	Severe = LOA/CAL 5+ mm

Updated 1/08

PERIODONTAL DISEASE TYPE
DEFINITIVE DIAGNOSIS / NARRATIVE

Patient Name: _____ **Age:** _____

Time since last preventive/periodontal appointment (i.e. "cleaning"): _____

AAP Classification/Diagnosis: _____
(Based on 1999 Clinical Workshop in Periodontics)

CASE TYPE FOR BILLING PURPOSES
(Based on 1989 World Workshop in Clinical Periodontics)

O **Healthy**
No gingival inflammation. No bleeding or isolated bleeding upon probing. No facial/lingual recession or bone loss. No (or isolated) sulcus depths over 3 mm.

O **Type I – Early/Chronic Gingivitis**
Inflammation of the gingiva characterized clinically by changes in color, gingival form, position, surface appearance, and presence of bleeding and/or exudate upon probing. No LOA. Pseudopockets may be present.

O **Type II – Established Gingivitis/ Early Periodontitis**
Progression of gingival inflammation into the deeper periodontal structures and alveolar bone crest, with slight bone loss. There is usually a slight loss of connective tissue attachment and alveolar bone loss. Slight LOA: 1-2 mm.

O **Type III – Moderate Periodontitis/ Chronic Periodontitis**
A more advanced stage of the above condition with increased destruction of the periodontal structures and *noticeable* loss of bone support, possibly accompanied by an increase in tooth mobility. There may be furcation involvement in multi-rooted teeth. Moderate LOA: 3-4 mm.

O **Type IV – Advanced Periodontitis**
Further progression of periodontitis with major loss of alveolar bone support usually accompanied by increased tooth mobility. Furcation involvement in multi-rooted teeth is likely. Severe LOA: 5+ mm.

O **Type V – Refractory Periodontitis**
This category includes those patients with multiple disease sites, which continue to demonstrate attachment loss after appropriate therapy. These sites presumably continue to be infected by periodontal pathogens no matter how thorough or frequent the therapy is provided. It also includes those patients with recurrent disease at a few or many sites.

Comments:

CALCULUS CLASSIFICATION

☐ **0** No supragingival or subgingival calculus present.
☐ **1** Isolated light supragingival calculus and/or light isolated subgingival calculus.
☐ **2** Generalized light to moderate spicules and/or small ledges of non-tenacious subgingival calculus and light to moderate supragingival calculus.
☐ **3** Generalized ledges of moderate to heavy subgingival calculus and/or rings of moderate to heavy subgingival calculus with light to moderate supragingival calculus.
☐ **4** Generalized heavy ledges, rings, and/or sheets of subgingival calculus that extend down the roots and isolated and/or generalized moderate areas of supragingival calculus; tenacious.

SULCULAR BLEEDING INDEX

☐ **0** No inflammation or bleeding evident.
☐ **1** Bleeding from the gingival crevice on gentle probing; tissues otherwise appear healthy.
☐ **2** Slight to moderate bleeding on probing plus a color change due to inflammation; no or minimal edema/swelling.
☐ **3** Moderate to severe bleeding on probing plus significant changes in color and edema.
☐ **4** Additional symptoms to above; ulceration.

FURCATION CLASSIFICATIONS
(Check all that apply)

☐ **0** No furcation involvement evident.
☐ **I** Beginning lesion; easily discovered by circumferential use of probe/explorer; may sink into shallow v-shaped notch/fluting; no infrabony lesion.
☐ **II** Open lesion; horizontal destruction into furcation with roof, floor and sides.
☐ **III** Through and through furcation; communicates with a second or third furcation opening.

MOBILITY CLASSIFICATIONS
(Check all that apply)

☐ **0** No mobility evident.
☐ **+** Slight mobility compared with general nature of patient's dentition.
☐ **I** Slight mobility most evident facially/lingually.
☐ **II** Moderate mobility noted both facially/lingually and mesially/distally.
☐ **III** Advanced mobility noted facially/lingually and mesially/distally with ability to depress tooth apically.

COMPREHENSIVE ORAL EVALUATION completed on _____

Patient Name_____

BP_____/_____
Pulse_____ Resp_____

HEAD AND NECK:	**WNL**	**Comments:**
Face	O	_____
Sinuses	O	_____
Muscles/mastication	O	_____
Preauric/Postauric	O	_____
Submen/Submand	O	_____
SCM-superficial	O	_____
SCM-deep	O	_____
Trap-superficial	O	_____
Trap-deep	O	_____
Occipital-superficial	O	_____
Neck region	O	_____

SOFT TISSUES:	**WNL**	**Comments:**
Lips	O	_____
H/S palates	O	_____
B/V mucosa	O	_____
Parotid gland	O	_____
Floor of mouth	O	_____
Tongue	O	_____

Tobacco user? No
Yes : Cigs Cigar Pipe Smokeless

Additional Comments:

TMJ EVALUATION:

Right: O Crepitus O Snapping/Popping O Other:
Left: O Crepitus O Snapping/Popping O Other:

Tenderness to Palpation: O Right O Left

Maximum Opening:_____ mm Side shift: R_____mm L_____mm

OCCLUSAL EVALUATION:

Centric Relation	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
Right Lateral	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
Left Lateral	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
Pro-trusive	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Molar Class: _____R _____L
Cuspid Class: _____R _____L

Overjet: _____mm Crossbite: No Yes:
Overbite: _____% _____

Habits: Bruxism Clenching
Mouth breathing Tongue
Other:

GINGIVAL ASSESSMENT: **WNL**

Color: gen. slight moderate severe _____
isol. slight moderate severe _____
Consistency: edematous soft spongy boggy hyperplastic Other:_____
Bleeding on probing: No Yes:_____

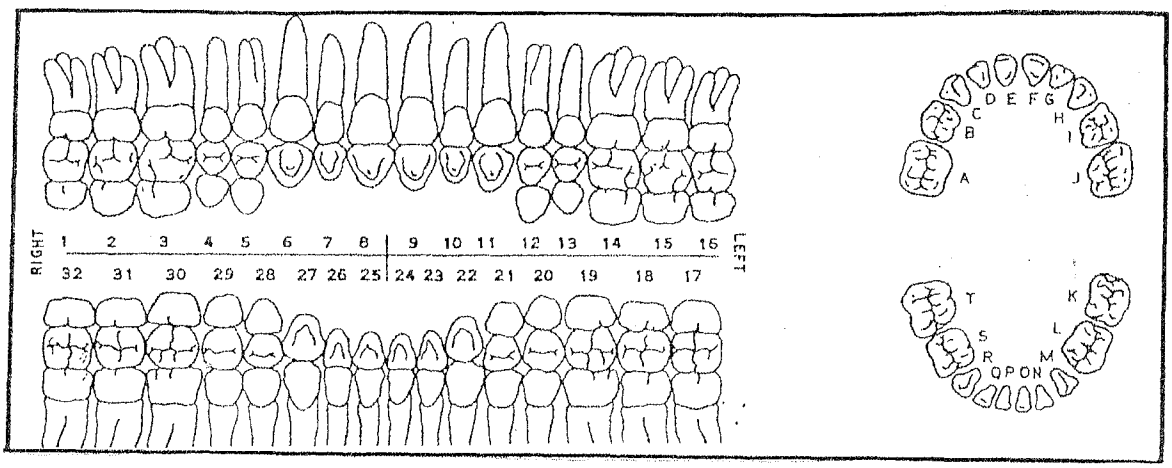
DEPOSITS PRESENT:

Plaque:	None	Slight	Moderate	Heavy
Supra calculus:	None	Slight	Moderate	Heavy
Sub calculus:	None	Slight	Moderate	Heavy
Stain:	None	Slight	Moderate	Heavy

Comments:

AAP CLASS: _____

EXISTING RESTORATIONS:



GUIDELINES FOR PRESCRIBING DENTAL RADIOGRAPHS

(American Dental Association, U.S. Food & Drug Administration, 2012)
Available on www.ada.org

Important Note from Report, p. 3: *"Radiographic screening for the purpose of detecting disease before clinical examination should not be performed. A Thorough clinical examination, consideration of the patient history, review of any prior radiographs, caries risk assessment and consideration of both the dental and the general health needs of the patient should precede radiographic examination."*

Type of Encounter	**Patient Age and Dental Developmental Stage**				
	Child with Primary Dentition (prior to eruption of first permanent tooth)	**Child with Transitional Dentition** (after eruption of first permanent tooth)	**Adolescent with Permanent Dentition** (prior to eruption of third molars)	**Adult, Dentate or Partially Edentulous**	**Adult, Edentulous**
New Patient* being evaluated for oral disease	Individualized radiographic exam consisting of selected periapical/occlusal views and/or posterior bitewings if proximal surfaces cannot be visualized or probed. Patients without evidence of disease and with open proximal contacts may not require a radiographic exam at this time.	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images.	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images. A full mouth intraoral radiographic exam is preferred when the patient has clinical evidence of generalized dental disease or a history of extensive dental treatment.		Individualized radiographic exam, based on clinical signs and symptoms.
Recall patient* with clinical caries or at increased risk for caries**	Posterior bitewing exam at 6-12 month intervals if proximal surfaces cannot be examined visually or with a probe.			Posterior bitewing exam at 6-18 month intervals.	Not applicable.
Recall patient* with no clinical caries and not at increased risk for caries**	Posterior bitewing exam at 12-24 month intervals if proximal surfaces cannot be examined visually or with a probe.		Posterior bitewing exam at 18-36 month intervals.	Posterior bitewing exam at 24-36 month intervals.	Not applicable.
Recall patient* with periodontal disease	Clinical judgment as to the need for and type of radiographic images for the evaluation of periodontal disease. Imaging may consist of, but is not limited to, selected bitewing and/or periapical images of areas where periodontal disease (other than nonspecific gingivitis) can be identified clinically.				Not applicable.

Patient (New and Recall) for monitoring of growth and development and/or assessment of dental/skeletal relationships	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development or assessment of dental and skeletal relationships	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development or assessment of dental and skeletal relationships. Panoramic or periapical exam to assess developing third molars.	Usually not indicated for monitoring of growth and development. Clinical judgment as to the need for and type of radiographic image for evaluation of dental and skeletal relationships.
Patient with other circumstances including, but not limited to, proposed or existing implants, other dental and craniofacial pathoses, restorative/endodontic needs, treated periodontal disease and caries remineralization.	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring in these circumstances.		

Clinical situations for which radiographs may be indicated include but are not limited to:

A. Positive Historical Findings	B. Positive Clinical Signs/Symptoms	
1. Previous periodontal or endodontic treatment	1. Clinical evidence of periodontal disease	12. Positive neurologic findings in the head and neck
2. History of pain or trauma	2. Large or deep restorations	13. Evidence of foreign objects
3. Familial history of dental anomalies	3. Deep carious lesions	14. Pain and/or dysfunction of the temporomandibular joint.
4. Postoperative evaluation of healing	4. Malposed or clinically impacted teeth	15. Facial asymmetry
5. Remineralization monitoring	5. Swelling	16. Abutment teeth for fixed or removable partial prosthesis
6. Presence of implants or evaluation for implant placement	6. Evidence of dental/facial trauma	17. Unexplained bleeding
	7. Mobility of teeth	18. Unexplained sensitivity of teeth
	8. Sinus tract ("fistula")	19. Unusual eruption, spacing or migration of teeth
	9. Clinically suspected sinus pathology	20. Unusual tooth morphology, calcification or color
	10. Growth abnormalities	21. Unexplained absence of teeth
	11. Oral involvement in know or suspected systemic disease.	22. Clinical erosion
		23. Peri-implantitis

**Factors increasing risk for caries may be assessed using the ADA Caries Risk Assessment forms (0-6 years of age and over 6 years of age.