CE Course Handout

Solving Insurance Reimbursement Dilemmas for Dental Hygiene Procedures

Thursday, June 18, 2015
9:30am-12:30pm
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.”
“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.”
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.
HALF OF AMERICAN ADULTS SUFFER FROM GUM DISEASE

47.2% Have periodontitis

THAT'S 64.7 Million Adults 30 years and older

8.7% Mild Periodontitis
30% Moderate Periodontitis
8.5% Severe Periodontitis

Recent research from the Centers for Disease Control indicates that half of U.S. adults have periodontitis – an advanced form of periodontal disease. Learn more »
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?
Each measures as a 6 mm pocket
Development of a Classification System for Periodontal Diseases and Conditions

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:

- **Current Dental Terminology (CDT)** for dental procedures

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

- **International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM)** for both dental and medical diagnoses,

- **Healthcare Common Procedure Coding System (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
- Contains **13,000 codes** for diagnoses.
Sampling of ICD-9 dental codes:  
(from www.findacode.com)

<table>
<thead>
<tr>
<th>Complete matches:</th>
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<tbody>
<tr>
<td>523.8</td>
<td>Periodontal disease NEC</td>
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<tr>
<td>525.1</td>
<td>Loss of teeth due to trauma, extraction or periodontal disease</td>
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<tr>
<td>523.9</td>
<td>Gingival/periodontal disease NOS</td>
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<tr>
<td>525.12</td>
<td>Loss of teeth d/t periodontal disease</td>
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<tr>
<td>523.10</td>
<td>Chronic gingivitis, plaque</td>
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<td>523.30</td>
<td>Aggressive periodontitis NOS</td>
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<table>
<thead>
<tr>
<th>Partial Matches:</th>
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<tbody>
<tr>
<td>HCPCS</td>
<td>S0315   Disease management program</td>
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</table>
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.
“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.
“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.
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.
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 performed.

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
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
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

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?

<table>
<thead>
<tr>
<th>Oral Evaluation</th>
<th>Periodontal Evaluation</th>
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</thead>
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<tr>
<td>Evaluation for oral cancer</td>
<td>Oral cancer evaluation</td>
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<tr>
<td>Extra-oral and intra-oral hard and soft tissues</td>
<td>Not included</td>
</tr>
<tr>
<td>Dental history</td>
<td>Dental history</td>
</tr>
<tr>
<td>Medical history</td>
<td>Medical history</td>
</tr>
<tr>
<td>A general health assessment</td>
<td>A general health assessment</td>
</tr>
<tr>
<td>Dental caries, missing or unerupted teeth</td>
<td>Dental caries, missing or unerupted teeth</td>
</tr>
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<td>Restorations</td>
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<td>Periodontal conditions, including periodontal screening and/or charting</td>
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</tr>
<tr>
<td>Hard and soft tissue anomalies</td>
<td>Not included</td>
</tr>
</tbody>
</table>
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.
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
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

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
DENTAL HYGIENISTS IN EMERGENCY ROOMS

BY CHRISTINE NATHB, 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. 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 concern to all Americans. Is preventive dental care proven to be cost effective? The routine coverage of...
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

[ADA logo]

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

Sealant Repair – per tooth
D1353
New

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-caries fissures or pits.
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

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.
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)

<table>
<thead>
<tr>
<th>Date</th>
<th>Site</th>
<th>Code</th>
<th>Description</th>
<th>Cost</th>
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<tr>
<td>6-18-15</td>
<td>UR</td>
<td>D4342</td>
<td>SRP #2, 3, 4 All other teeth in quad completed as Adult Prophy.</td>
<td>$189.00</td>
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<tr>
<td></td>
<td></td>
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<td>------Hygienist, RDH</td>
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</table>
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.
The tale of two codes

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

BY KATHY & FOMER, 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 “steps” are involved. What is a “step”? After all, there are two CDT procedure codes which address site specific scaling and root planing. Which one is it? Two codes.

Treatment planning of dental hygiene’s periodontal procedures continues to seem complicated as clinicians struggle to accurately diagnose and create treatment plans for periodontal disease and select the appropriate procedure codes for billing purposes. At the same time, business staffs are under pressure to help patients understand that insurance companies are restricting access to treatment plans and that out-of-pocket expenses 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.

The American Dental Association’s CDT, 2014 Dental Procedure Codes manual defines these services related to site specific scaling and root planing on pp 36-37. The most recognized code for site isolated scaling and root planing is: T4434-49. 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 and prophylactic in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or covered by microorganisms or connective tissue attachment loss.

Typically, this is the procedure recommended when a patient has active periodontal disease that includes evidence of bleeding on probing (calculus, attachment loss, gingival color, size, and significant subgingival pelvic deposits). There may also be evidence of gingival recession, mobility and radiographic widening bone loss. The limiting factor in that this code allows one to three teeth, one quadrant.

The appropriate code would be T4434-49.
<table>
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<td>SRP 4+</td>
<td>SRP 4+</td>
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<tr>
<td>SRP 1-3</td>
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<td>---------</td>
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<td>Adult Prophy</td>
<td></td>
</tr>
<tr>
<td>Srp 1-3</td>
<td>Adult Prophesy</td>
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</table>
Palliative

Adult Prophy
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](http://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)

<table>
<thead>
<tr>
<th>Case Type</th>
<th>Status Defined</th>
<th>Loss of Attachment (LOA) Or Clinical Attachment Loss (CAL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Type 0</td>
<td>Clinically Healthy</td>
<td>No LOA/CAL</td>
</tr>
</tbody>
</table>
| 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)

<table>
<thead>
<tr>
<th>Extent</th>
<th>Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Localized</strong> = 30% or less of sites are involved</td>
<td>Slight = LOA/CAL 1-2 mm</td>
</tr>
<tr>
<td><strong>Generalized</strong> = more than 30% of sites are involved</td>
<td>Moderate = LOA/CAL 3-4 mm</td>
</tr>
<tr>
<td><strong>Severe</strong></td>
<td></td>
</tr>
</tbody>
</table>

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.

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.

Comments:

PDS/2015
**COMPREHENSIVE ORAL EVALUATION completed on ____________**

**Patient Name: ____________________________**

<table>
<thead>
<tr>
<th>HEAD AND NECK:</th>
<th>WNL</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Sinuses</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Muscles/mastication</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Preauric/Postauric</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Submen/Submand</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>SCM-superficial</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>SCM-deep</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Trap-superficial</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Trap-deep</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Occipital-superficial</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Neck region</td>
<td>O</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SOFT TISSUES:</th>
<th>WNL</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lips</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>H/S palates</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>B/V mucosa</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Parotid gland</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Floor of mouth</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Tongue</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Tobacco user?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Yes: Cigs</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Cigar</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Pipe</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Smokeless</td>
<td>O</td>
<td></td>
</tr>
</tbody>
</table>

**Additional Comments:**

---

**TMJ EVALUATION:**

<table>
<thead>
<tr>
<th>Right: Crepitus</th>
<th>Snapping/Popping</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Left: Crepitus</td>
<td>Snapping/Popping</td>
<td>Other:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tenderness to Palpation:</th>
<th>O Right</th>
<th>O Left</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Maximum Opening:</th>
<th>mm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Side shift: R mm</td>
<td>L mm</td>
</tr>
</tbody>
</table>

---

**OCCLUSAL EVALUATION:**

<table>
<thead>
<tr>
<th>Centric</th>
<th>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relation</td>
<td>32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Right</th>
<th>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lateral</td>
<td>32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Left</th>
<th>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lateral</td>
<td>32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Protrusive</th>
<th>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Molar Class:</th>
<th>R</th>
<th>L</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cuspid Class:</td>
<td>R</td>
<td>L</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Overjet: mm</th>
<th>Crossbite: No</th>
<th>Overbite: %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Habits:</td>
<td>Bruxism</td>
<td>Clenching</td>
</tr>
</tbody>
</table>

---

**GINGIVAL ASSESSMENT: WNL**

<table>
<thead>
<tr>
<th>Color: gen. slight moderate severe isol. slight moderate severe</th>
</tr>
</thead>
</table>

| Consistency: edematous soft spongy boggy hyperplastic Other: |

<table>
<thead>
<tr>
<th>Bleeding on probing: No</th>
<th>Yes:</th>
</tr>
</thead>
</table>

---

**DEPOSITS PRESENT:**

<table>
<thead>
<tr>
<th>Plaque:</th>
<th>None</th>
<th>Slight</th>
<th>Moderate</th>
<th>Heavy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supra calculus:</td>
<td>None</td>
<td>Slight</td>
<td>Moderate</td>
<td>Heavy</td>
</tr>
<tr>
<td>Sub calculus:</td>
<td>None</td>
<td>Slight</td>
<td>Moderate</td>
<td>Heavy</td>
</tr>
<tr>
<td>Stain:</td>
<td>None</td>
<td>Slight</td>
<td>Moderate</td>
<td>Heavy</td>
</tr>
</tbody>
</table>

**AAP CLASS: _____**

---

**EXISTING RESTORATIONS:**

---

**DIAGRAMS:**

---
GUIDELINES FOR PRESCRIBING DENTAL RADIOGRAPHS
(American Dental Association, U.S. Food & Drug Administration, 2012)
Available on [www.ada.org](http://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.”

<table>
<thead>
<tr>
<th>Type of Encounter</th>
<th>Child with Primary Dentition (prior to eruption of first permanent tooth)</th>
<th>Child with Transitional Dentition (after eruption of first permanent tooth)</th>
<th>Adolescent with Permanent Dentition (prior to eruption of third molars)</th>
<th>Adult, Dentate or Partially Edentulous</th>
<th>Adult, Edentulous</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New Patient</strong></td>
<td>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.</td>
<td>Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images.</td>
<td>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.</td>
<td>Individualized radiographic exam, based on clinical signs and symptoms.</td>
<td></td>
</tr>
<tr>
<td><strong>Recall patient</strong> (with clinical caries or at increased risk for caries***)</td>
<td>Posterior bitewing exam at 6-12 month intervals if proximal surfaces cannot be examined visually or with a probe.</td>
<td>Posterior bitewing exam at 18-36 month intervals.</td>
<td>Posterior bitewing exam at 24-36 month intervals.</td>
<td>Not applicable.</td>
<td></td>
</tr>
<tr>
<td><strong>Recall patient</strong> (without clinical caries and not at increased risk for caries***)</td>
<td>Posterior bitewing exam at 12-24 month intervals if proximal surfaces cannot be examined visually or with a probe.</td>
<td>Posterior bitewing exam at 18-36 month intervals.</td>
<td>Posterior bitewing exam at 24-36 month intervals.</td>
<td>Not applicable.</td>
<td></td>
</tr>
<tr>
<td><strong>Recall patient</strong> (with periodontal disease)</td>
<td>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.</td>
<td></td>
<td></td>
<td>Not applicable.</td>
<td></td>
</tr>
<tr>
<td>Patient (New and Recall) for monitoring of growth and development and/or assessment of dental/skeletal relationships</td>
<td>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</td>
<td>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.</td>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring in these circumstances.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Clinical situations for which radiographs may be indicated include but are not limited to:

<table>
<thead>
<tr>
<th>A. Positive Historical Findings</th>
<th>B. Positive Clinical Signs/Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Previous periodontal or endodontic treatment</td>
<td>1. Clinical evidence of periodontal disease</td>
</tr>
<tr>
<td>2. History of pain or trauma</td>
<td>2. Large or deep restorations</td>
</tr>
<tr>
<td>4. Postoperative evaluation of healing</td>
<td>4. Malposed or clinically impacted teeth</td>
</tr>
<tr>
<td>5. Remineralization monitoring</td>
<td>5. Swelling</td>
</tr>
<tr>
<td>7. Mobility of teeth</td>
<td>18. Unexplained sensitivity of teeth</td>
</tr>
<tr>
<td>8. Sinus tract (“fistula”)</td>
<td>19. Unusual eruption, spacing or migration of teeth</td>
</tr>
<tr>
<td>9. Clinically suspected sinus pathology</td>
<td>20. Unusual tooth morphology, calcification or color</td>
</tr>
<tr>
<td>11. Oral involvement in known or suspected systemic disease.</td>
<td>22. Clinical erosion</td>
</tr>
<tr>
<td></td>
<td>23. Peri-implantitis</td>
</tr>
</tbody>
</table>

**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.)**