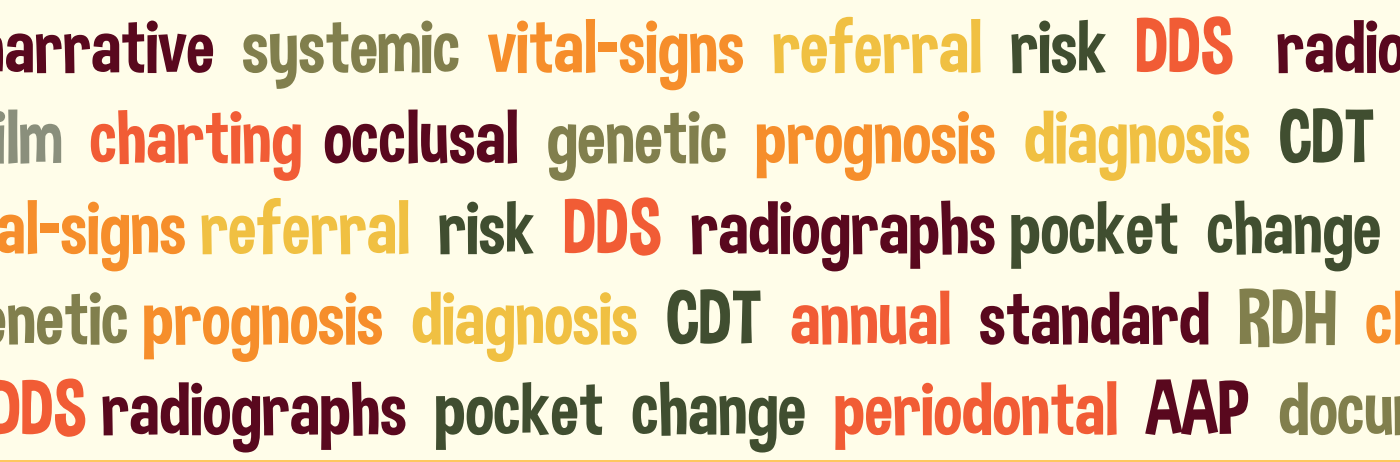
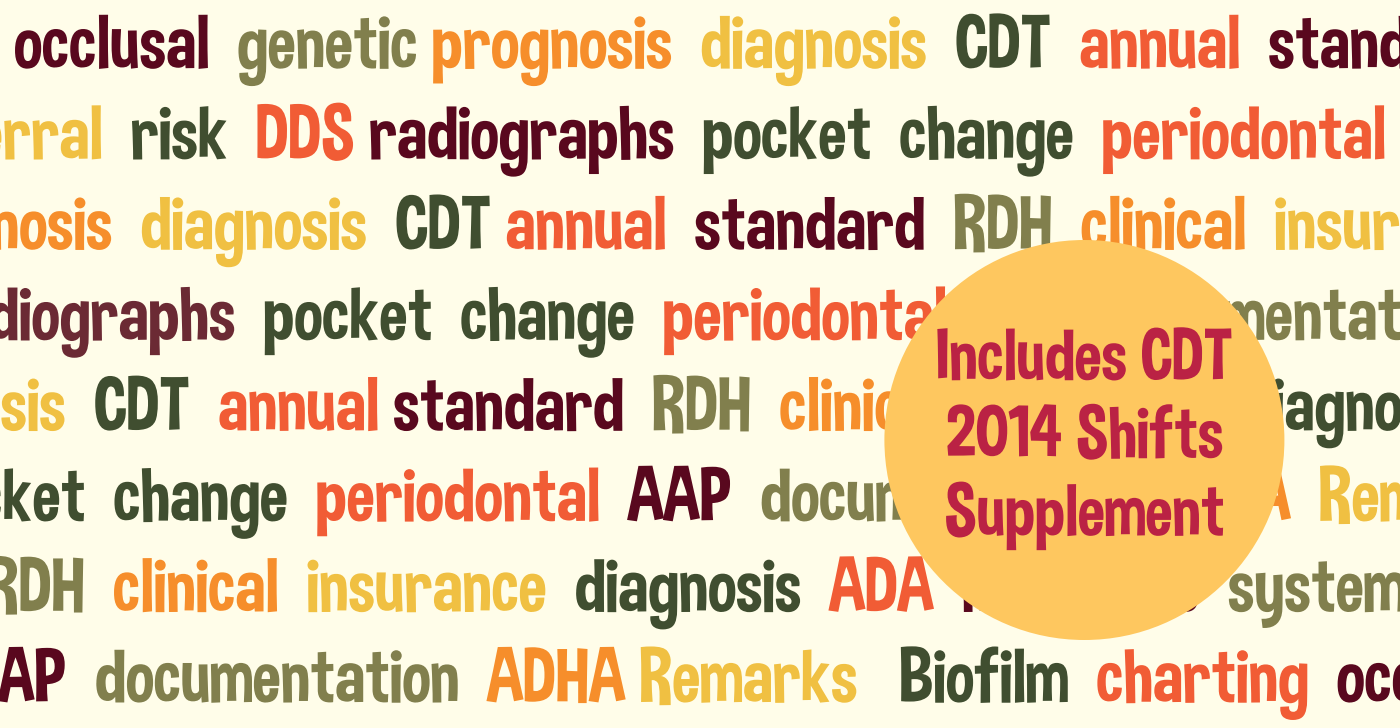


BOOK 1

DentalCodeology

More than Pocket Change

Patti DiGangi, RDH, BS



Dentalcodeology: More Than Pocket Change

Periodontal Coding
for the Hygiene Department
of a General Practice

By Patti DiGangi, RDH, BS

Dentalcodeology: More Than Pocket Change Periodontal Coding for the Hygiene Department of a General Practice

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Dear hygiene friends,

This guide is the first in a series of MiniBüks-books meant to provide simple answers to your day-to-day dilemmas with coding. Can D4341/2 and D1110 be used on the same day? The insurance carrier said to alternate D1110 and D4910. Is this correct? Why are there no codes for care for active gingival disease without bone loss? What the code for periodontal charting?

It is time for you to have those answers and more when and where you need them-in your pocket. Case-based learning can assist you in applying the information. You will meet Dominic, Kelly, Nancy, Albert and Wu who are very much like patients you see every day.

I hope you find this information useful. Enjoy the journey.

-Patti

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My husband Mike and my entire family

Table of Contents

Introduction

Dentalcodeology: More Than Pocket Change is intended for use by dental hygienists, dentists, business staff and office managers to put to rest some of the recurring questions regarding coding of periodontal care provided by the dental hygiene department in a general dental practice. It is designed to be kept in a pocket for easy reference or as an e-Book that, once downloaded, fits on your cell phone.

The Codes for Periodontal Care

This book will cover 4 of the 12 sections of the Code in need of discussion related to periodontal care.

- D0100-0999 I. Diagnostic
- D1000-0199 II. Preventive
- D4000-0499 V. Periodontics
- D9000-9999 XII. Adjunctive Services

This book does *not* contain all CDT 13 codes. It is a companion piece for *Current Dental Terminology*

The existence of a code

"The presence of a CDT Code does not mean that the procedure is:

- endorsed by any entity or is considered a standard of care
- covered or reimbursed by a dental benefits plan." (CDT 2013)

Easy to Find

To find items quickly, look for icons. Most sections also have:

- **Bottom line:** synopsis.
- **Eternal questions:** periodontal care coding questions asked over and over.
- **Sample Remarks/narrative:** assistance in coding.

ICONS

New/Revised CDT 2013

Code

Remarks/narrative Suggestions

Diagnosis/Documentation

Stop Possible Fraud

Author Opinion

Eternal Coding Questions

Standard of care

The definitions in CDT are important to understand from a legal standard of care perspective. *Standard of care* is a term most often defined by a court of law. On August 17, 2000, HIPAA (Health Insurance Portability and Accountability Act) named the CDT code as the *standard* code set for dentistry. A standard of care is the *lowest* level of conduct under which practitioners may operate.

Bottom line: In effect, practicing at the standard of care is operating on an academic grade of C.

The answer to nearly every coding question

Two simple words, diagnosis and documentation, are the answer to nearly every periodontal coding question.

Dealing with codes is not a matter of good guys against the bad guys. Documentation by the clinical team provides the most important data for the business team.

Clinicians' role in insurance coverage advice

Clinical professionals *MUST* stop telling patients what they *think* is covered. There is no way to accurately guess and it is *not* the role of the clinical professional.

Office managers and the business staff professionals are qualified to discuss insurance coverage and payments because they have the tools, access, and expertise to do so.

Bottom line: The American Academy of Periodontology (AAP) says "The treatment plan should be developed according to professional standards, *not* according to the provisions of the contract."

Dental Hygiene Diagnosis Reality

Most dental hygienists understand and appreciate how the dental hygiene diagnosis is incorporated into the comprehensive dental diagnosis made by the dentist. It is the position of the American Dental Hygienists' Association (ADHA) that the dental hygiene diagnosis is a necessary and intrinsic part of dental hygiene education and practice.

The traditional model has been the dentist completes an evaluation *after* the dental hygienist has completed care. As such, the dental hygienist has made a dental hygiene diagnosis already.

Like driving a car without GPS

"Treating without a diagnosis is like driving a car without GPS. Treating without a diagnosis is malpractice."

-Kelly Swanson Jaecks, MA, RDH describing ADHA 2010 Position Paper on the Dental Hygiene Diagnosis

Evidence Based Dentistry

The American Dental Association (ADA) Center for Evidence Based Dentistry (EBD) and Clinical Practice Guidelines establish a benchmark to initiate treatment under a particular set of circumstances. It does not prevent a professional from altering the treatment plan. EBD also includes individual patient circumstances and the clinical judgment of the professional.

Foundation of best practices

Health care providers, managed care organizations, administrators, payers, and policy analysts are all interested in improving the quality of health care and are likely to be customers of best practices informational resources.

Bottom line: ADA Evidence Based Dentistry (www.edb.ada.org) Clinical Recommendations is establishing *best practices* as part of the interoperable electronic health records.

Need to know before looking at specific codes

To gain the best value of this book, before looking at the specific codes, there are some basic pieces requiring explanation.

2012 ADA Claim Form

Important parts of 2012 ADA claim form

In 2012 ADA revised the claim form to incorporate key HIPAA changes. Space was added for a *diagnosis code* (right arrow on diagram) for when the specific diagnosis may minimize the risks associated with the connection between the patient's oral and systemic health conditions. At this time, only medical diagnosis codes are used.

Box 35 Remarks/narrative

The left arrow on the diagram points at Box 35 Remark, a very small area for a narrative. Concise remarks providing supplementary information pertinent to the determination of benefits will facilitate processing a claim to determine proper payment.

A narrative should contain *Dental/Medical necessity* defined as services or supplies needed for treatment of a condition and meeting accepted standards of practice.

A narrative may be requested by a third party payer. All *by report* codes require a narrative.

Medical consultation

Chronic oral infection may trigger or intensify systemic conditions and vice versa. Patients are becoming aware of the oral systemic connections. Acute dental conditions are major players in the oral systemic group. Dental benefit carriers also are aware of these links and may *offer enhanced coverage based on the evidence*.

Bottom line: All submissions should have entries in Box 35 Remark, to support dental/medical necessity.

Updated language needed

With the answer to nearly every periodontal coding question as diagnosis and documentation, a major problem is periodontal language that has not been updated to meet current philosophy.

Decade trends in periodontics

1955-1965	calculus theory	plane those roots
1965-1975	non-specific plaque theory	if everyone flossed, we would have world peace
1979-1990	bacterial specificity era	kill all the bugs
1991-Today	host-bacterial ecological interaction theory	biofilm disruption

SRP language problems

As this table shows, we have moved through at least four broad eras in periodontal philosophy. Yet both language and thought get stuck in old thinking by the continued use of outdated terminology. Scaling and root planing is terminology from more than 50 years ago. The unfortunate reality is that even CDT 2013 still uses these archaic terms.

More accurate language

More accurate language is needed that supports better understanding and divides periodontal therapy into:

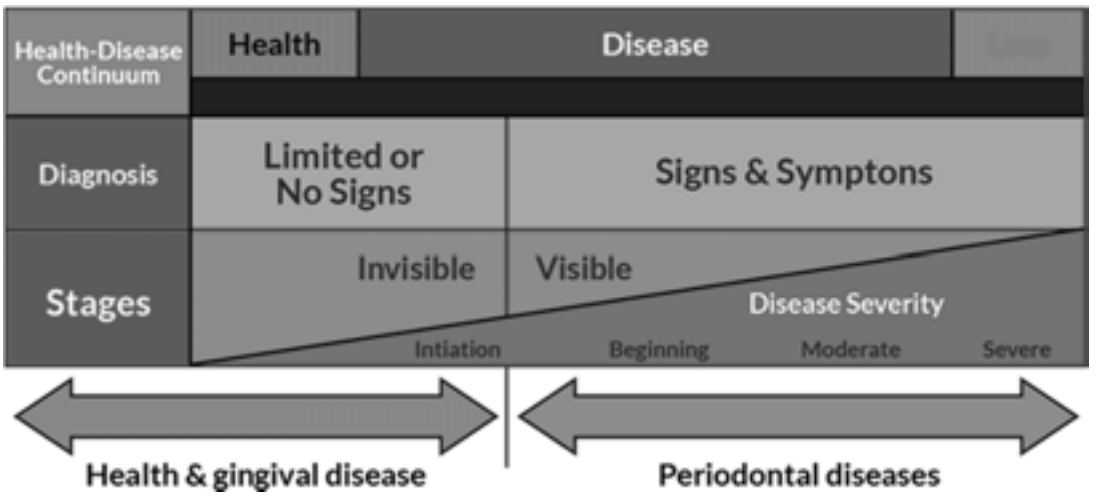
- Non-surgical care
- Surgical care

Bottom line: Scaling and root planing language must die

Simplistic thinking

Historically, all gingival disease was treated as gingivitis and periodontal disease meant periodontitis. This simplistic thought process has led to as much as 50% *under*-diagnosis per Centers for Disease Control. Let's go back to the basic definition of periodontium: the supporting structures of the teeth including the cementum, the periodontal ligament, the bone of the alveolar process, and the gingival tissues.

Periodontal continuum



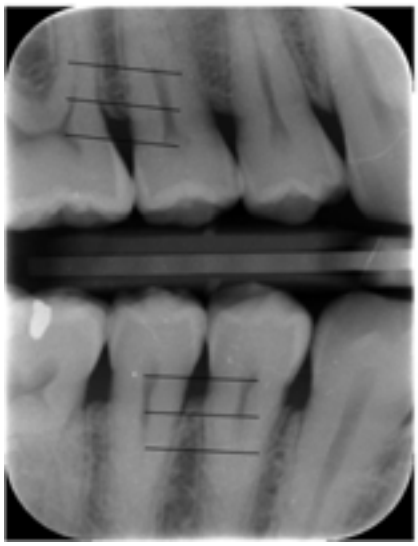
An AAP 2011 statement says, periodontics encompasses the maintenance of health, comfort, and esthetics of all supporting structures and tissues in the mouth, as this periodontal continuum shows. Bone height is very significant in the coding.

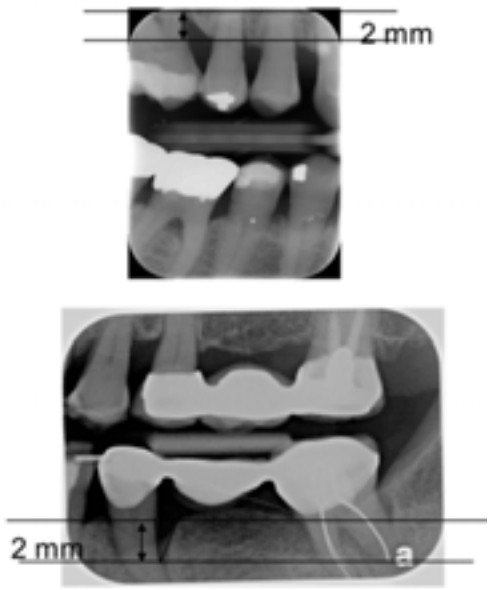
Documenting bone height

Bone height/loss is the parameter used most often to differentiate between gingival and periodontal diseases. Yet, few practitioners' measure and document bone height. Many don't remember what is a normal/healthy measurement if measured from the aveolar crest to the CEJ? Healthy tissue should measure approximately **1.5-2mm**. (1993)

Radiographic images should be evaluated for crestal irregularities, interseptal alveolar changes, pattern, distribution, and severity of bone loss and furcation involvement. Careful recording of bone height will often reveal a different view. Many patients that had been treated for gingival disease have bone loss. This means the diagnosis was incorrect.

If we don't measure it, we can't manage it.





Bottom line: Charting bone height from radiographic images should be a routine part of documentation.

Steps needed for proper periodontal coding

For the past 30 years, many general practitioners have performed non-surgical periodontal care. This care should meet AAP standards. AAP redefined *Comprehensive Periodontal Therapy* and stated patients should *annually* receive a comprehensive periodontal and risk factor evaluation. (AAP 2011)

AAP comprehensive periodontal examination

1. Health status/medical consultation
2. Periodontal examination
3. Diagnostic radiographs
4. Further testing
5. Establishing a diagnosis
6. Periodontist co-management
7. Determining a treatment plan
8. Prognosis estimation
9. Informed consent
10. Treatment
11. Evaluating therapy

Diagnostic coding

Documentation often lacks diagnostic information, because there are limited diagnostic codes. AAP developed the Classification System for Periodontal Diseases and Conditions to give clinicians a way to categorize and diagnose periodontal diseases. (AAP 1999)

Not all gingival disease is gingivitis, and there are many types of periodontal disease. Making a specific, accurate diagnosis is the first step to proper coding.

AAP Classifications of Disease

Gingival diseases are divided into two categories:

- Plaque-induced
- Non plaque induced

Periodontal diseases are divided into seven categories.

Gingival Diseases

Dental plaque-induced gingival diseases

- Gingivitis associated with dental plaque only
- Gingival diseases modified by systemic factors
- Gingival diseases modified by medications
- Gingival diseases modified by malnutrition

Non-plaque-induced gingival lesions

- Gingival diseases of specific bacterial origin
- Gingival diseases of viral origin
- Gingival diseases of fungal origin
- Gingival lesions of genetic origin
- Gingival manifestations of systemic conditions
- Traumatic lesions
- Foreign body reactions
- Not otherwise specified (NOS)

Periodontal Diseases

- Chronic Periodontitis
  - Localized
  - Generalized *(> 30% of sites are involved)*
- Aggressive Periodontitis

Localized

Generalized *(> 30% of sites are involved)*

Periodontitis as a Manifestation of Systemic Diseases

Associated with hematological disorders

Associated with genetic disorders

Not otherwise specified (NOS)

Necrotizing Periodontal Diseases

Abscesses of the Periodontium

Periodontitis Associated With Endodontic Lesions

Developmental or Acquired Deformities and Conditions

Bottom line: A specific diagnosis of health, gingival disease or periodontal disease must be part of the documentation.