

Proper Insurance Coding may be your *Best Defense*

Learn the most important code to protect yourself from a malpractice suit



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If you're like most dentists I know, you'd rather discuss just about anything other than malpractice claims or dealing with insurance. Dentists are paying higher premiums and meeting stricter underwriting criteria in response to a shrinking dental liability insurance market. A recent case may illustrate how imperative it is for you to update your knowledge on proper coding, to protect yourself and your practice.

The insurance industry, especially the cost cutting managed-care plans, is more critical of sloppy, incorrect, misleading or fraudulent dental insurance claims coding. Recently, I received a telephone call from a West Coast dentist who told me that although he had coded the hygiene/perio as instructed by the dentist who signed him as a provider, the company was now demanding more than \$40,000 in reimbursement for those claims. Check your pockets; do you have \$40,000 to cover a reimbursement request like that?

How many times have you read or been told the biggest cause of malpractice claims is the doctor attempting to take a shortcut, often in an attempt to save the patient money. The other major, even critical, problem in malpractice suit defense is the poor or improper documentation. These two factors are likely occurring in your office every day. If you are coding your diagnosis and treatment properly, these statements would be hard to prove against your practice.

For example: If prophylaxis means, "to prevent," can you do a prophylaxis on a patient with gingivitis? Can you legally do a prophylaxis on a patient with gingivitis complicated by a systemic disease, one of which is diabetes? So far, we have only mentioned gingivitis. Heaven forbid there are any anaerobic bacteria lurking under those gums! You must do a proper diagnosis before you can design the treatment. You must record that diagnosis on the chart. You cannot, with impunity, do a prophylaxis on a patient with a disease present!

Parameter on Plaque-Induced Gingivitis

The American Academy of Periodontology (AAP) has developed the following parameter on plaque-induced gingivitis in the absence of clinical attachment loss. *Plaque-induced gingivitis is the most common form of the periodontal diseases,*¹ affecting a significant portion of the population in susceptible individuals. Patients should be informed of the *disease process, therapeutic alternatives, potential complications, expected results, and their responsibility in treatment.* Consequences of no treatment should be explained. *No treatment* may result in continuation of clinical signs of disease, with possible development of gingival defects

and progression to periodontitis. Given this information, patients should then be able to make informed decisions regarding their periodontal *therapy* (**J Periodontol** 2000; 71:851-852).

Treatment Considerations²

Contributing systemic risk factors may affect treatment and therapeutic outcomes for plaque-induced gingivitis. These may include diabetes, smoking, and certain periodontal bacteria, aging, gender, genetic predisposition, systemic diseases and conditions (immunosuppression), stress, nutrition, pregnancy, substance abuse, HIV infection, and medications. A treatment plan for active therapy should be developed that may include the following:

1. *Patient education and customized oral hygiene instruction.*³
2. Debridement of tooth surfaces to remove supra- and subgingival plaque and calculus.
3. Antimicrobial and antiplaque agents or devices may be used to augment the oral hygiene efforts of patients who are partially effective with traditional mechanical methods.

The most important code is the one you never use

Code D1330 needs to be on every chart that comes out of the hygiene department. Oral hygiene instruction is the first treatment consideration listed by the AAP for the treatment of gingivitis. Therefore, there are actually two new items that must be on every chart leaving hygiene at this point. First, you absolutely must have a diagnosis recorded based on the current AAP definitions. Get those and use them. Second, document the OHI by using code D1330. I can hear the screaming from here. "The insurance company doesn't pay for code D1330!" The insurance companies exist to make a profit. They are not there to protect you from a malpractice suit based on non-diagnosis and or non-disclosure of the disease(s) present. "The patient won't pay for it!" How much would *you* pay for "oral hygiene instruction"? By charting these codes you have covered yourself legally. If you have made a diagnosis, and told the patient how to take care of the problem, where is the basis for a lawsuit for undiagnosed and/or under-treated problems?

Debridement of tooth surfaces to remove supra- and subgingival plaque and calculus

What CDT-3³ code uses the words "debridement" and "supra-gingival plaque" as part of the definition? That would be D4355. Some of you will remember D4345—scaling in the presence of gingival inflammation. That code has been eliminated in the CDT-3. There is no treatment code that includes the term gingivitis in the description. D4355 *does not* define the disease. It can be used with the diagnosis of gingivitis and periodontitis. Based on the terminology of point two in the treatment considerations, treat-

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ment code D4355 is the best fitting code that we have for the typical patient. Remember, *plaque-induced gingivitis is the most common form of the periodontal diseases*, affecting a significant portion of the population in susceptible individuals.

Antimicrobial and antiplaque agents or devices may be used to augment the oral hygiene efforts of patients who are partially effective with traditional mechanical methods.

Localized delivery of chemotherapeutic agent is covered by code D4381. Desensitization—per tooth is code D9911. Desensitization—full mouth, typically using fluoride, is D9910.

Coding for the gingivitis patient—Summary

Diagnosis—make sure you write it on every chart every time. If they happen to be healthy, it would be a good idea to write that. If there is a disease, be sure to record that!

Evaluation—probably D0150

OHI—D1330

Radiology—as indicated

Treatment—D4355. CDT-4 removes the need to separate evaluation and treatment dates⁴.

What if you find subgingival calculus and/or anaerobic organisms?

By my count, there are seven types of periodontitis listed by the AAP. Since “Chronic Periodontitis” is the most commonly treated, I will limit the coding to that disease. You must know the definitions of the other diseases and so must everyone in the hygiene department.

Slight Periodontitis, a subset of Chronic Periodontitis, is characterized by the amount of clinical attachment loss (CAL). Slight Periodontitis is described as 1mm or 2mm CAL. That gives you a pocket depth of 3-4mm. Normal is 2-3mm. Therefore, you don’t have to have much attachment loss to qualify. If you are cleaning subgingivally and on the root of the tooth, you are doing root planing. Root planing occurs on the root! If you are doing a definitive instrumentation of the root, you are doing root planing. The code for root planing per quadrant is D4341. How many patients did the hygienist “clean” subgingivally and on the root surface, this year, while using the prophylaxis code for the visit? How many of those patients could (potentially) sue you for the non-diagnosis of periodontal disease after their new dentist tells them that the disease is probably chronic in nature? Along with root planing, many dentists use irrigation techniques with the appropriate chemical agents.

D0170 Re-evaluation—limited. Problem focused, soft tissue lesion, requiring follow-up evaluation.

Periodontitis is a soft tissue lesion and you certainly need a follow-up evaluation after you complete your root planing. The number of quadrants root planed would be dictated by the diseased areas. Certainly, chemotherapeutic agents may be indicated at this visit also.

D4910 This procedure is for patients who have completed periodontal treatment (surgical and/or non-surgical periodontal therapies exclusive of D4355).

There seems to be a lot of confusion about this code. One source

of confusion is that the code included (exam) evaluation years ago and does not now. It follows treatment—and root planing is a treatment that qualifies. It is payable twice a year under most policies. Typically, there are three months between appointments. It is not synonymous with a prophylaxis.

Coding for the periodontitis patient—Summary

Visit One: Diagnosis—make sure you write it on every chart every time. If they happen to be healthy, it would be a good idea to write that. If there is a disease, be sure to record that!

Evaluation—probably D0150

OHI—D1330

Radiology—as indicated

Treatment—D4355

Visit Two: (*may take more than one visit*): D4341 Root Planing per quadrant. Usually, it is one quadrant per visit. I was told following the California Dental Association meeting in Anaheim this year, that some of the classes were teaching that the latest idea is to do as much as you can per visit, to reduce the “cross contamination” of the other quadrants. In other words, it was suggested that you do more than one quadrant per visit.

The CDT-4 brings a new code for root planing in less than a full quadrant⁴.

Visit Three:

D0170 Re-evaluation

D4381 Local delivery of chemotherapeutic agent(s)

Last two visits of the sequence: D4910 Periodontal Maintenance procedure, which is usually performed twice, three months apart.

Summary

There are three major points to this article:

1. You **must make a diagnosis** and record it on the chart and on the paper insurance claim form if you are using paper. You must base the diagnosis on current descriptions from the American Academy of Periodontology.
2. If you recognize and record the presence of disease, you **must use correct treatment codes** not preventive procedure codes. You must not code for a prophylaxis if you are doing treatment in the presence of a disease.
3. You must update your treatment coding to comply with CDT-4 standards, HIPAA standards require you to use the correct and current codes, and **you must treatment code for protection against malpractice claims.**

Udell (Del) Webb, DDS, is a nationally recognized expert in the area of dental insurance management. He is not an attorney, an insurance company employee or licensed by any group or agency to answer insurance-related questions. If you seek legal advice, contact your favorite legal expert.

You can contact Dr. Webb at **(877) 628-3366** or post your comments on this article on the DentalTown message boards at www.dentaltown.com.

Footnotes:

1. *Italics added by this author*

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4. *This article was sent to the printer before complete CDT-4 details were released*