Claims Submission: Scaling and Root Planing (SRP)

D4341 – PERIODONTAL SCALING AND ROOT PLANING – FOUR OR MORE TEETH PER QUADRANT
D4342 – PERIODONTAL SCALING AND ROOT PLANING – ONE TO THREE TEETH PER QUADRANT

According to the American Academy of Periodontology, a patient is a periodontitis case in the context of clinical care if:

-- Interdental CAL is detectable at ≥2 non-adjacent teeth, OR

-- Buccal or oral CAL ≥3 mm with pocketing >3 mm is detectable at ≥2 teeth

And the observed CAL cannot be ascribed to non-periodontal causes such as: 1) gingival recession of traumatic origin; 2) dental caries extending in the cervical area of the tooth; 3) the presence of CAL on the distal aspect of a second molar and associated with malposition or extraction of a third molar, 4) an endodontic lesion draining through the marginal periodontium; and 5) the occurrence of a vertical root fracture.[1]

According to the ADA Evidence-Based Clinical Recommendations for patients with chronic periodontitis i.e. with the clinical indicators noted above, clinicians should consider scaling and root planing (SRP) as the initial definitive treatment.

SRP Claims

- D4341 and D4342 are not "by report" codes.
- However, in order to adjudicate the patient's benefit based on plan policies, carriers require additional information to process the claims. Dentists, especially those in-network are contractually obligated to respond to such requests. Supporting documentation that may facilitate faster claim processing include:
    - Narrative indicating periodontal disease
    - Documentation of the amount of millimeter attachment loss/ bone loss. Documentation options include:
        - Diagnostic quality radiographs showing bone loss (see inset for more information). Include images for all affected teeth that need SRP
        - Complete periodontal chart Indicating loss of attachment/bone loss, bleeding on probing, and pocket depths. Proper periodontal charting typically includes documentation on at least 6 sites around each affected tooth/ implant.
- If four (4) quadrants of SRP were completed in one visit/appointment, be sure to indicate why and submit a narrative outlining the reason (Examples of circumstances that may require treatment in multiple quadrants on the same date include but are not limited to: patient's needing IV sedation for treatment, patients with special needs, patients with transportation barriers, patients need pre-treatment antibiotics etc.).

DIAGNOSTIC QUALITY RADIOGRAPHS

Dental plans have stated that a common reason for SRP claim denials or requests for additional information are due to receiving radiographs that are not of diagnostic quality. Staff should perform a quality review before an SRP claim is submitted to a dental plan and verify that:

- ✓ Preferably bite-wings (vertical or horizontal as long as the image captures the bone height in relation to the root and any furcation involvement) or sometimes the full mouth series are submitted. **NOT** panoramic X-rays.
- ✓ Radiographs are properly mounted and labeled (e.g., left and/or right, and with the patient's name)
- ✓ Diagnostic quality depicting appropriate structures
- ✓ Submitted radiographs should be duplicates and taken immediately prior to the diagnostic treatment planning appointment.
- ✓ See Appendix 2: Examples of Good and Poor Radiographs for SRP Claims

[1] https://aap.onlinelibrary.wiley.com/doi/10.1002/JPER.18-0006

- Some plans may not benefit 4 quadrants in one visit, regardless of documentation submitted. Refer to the plan's processing policies for more details.
- Some plans may additionally request a copy of your schedule indicating allocation of chair-time necessary to complete 4 quadrants on the same day.
- Some plans may request documentation that in fact local anesthesia was used during the procedure.

Offices that submit the proper documentation will have better chances of getting these claims correctly adjudicated on the first submission.

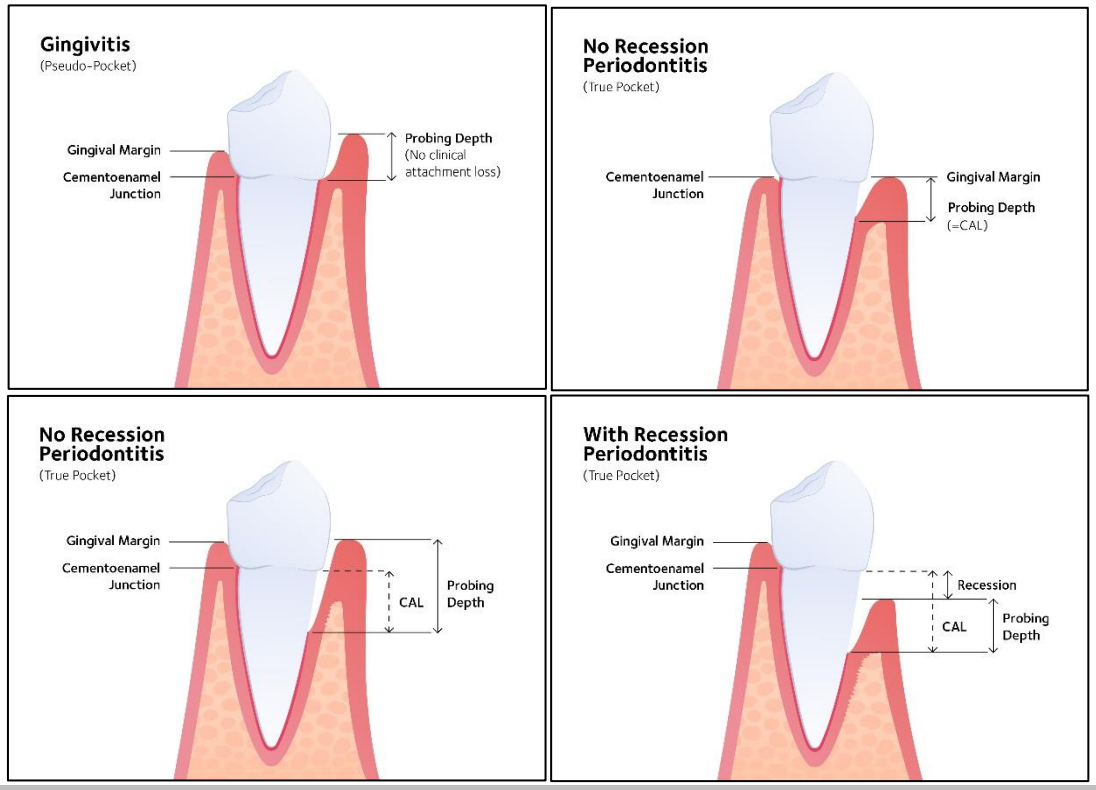
Dentists need to be involved in the claim submission quality review process as the treating dentist has an important responsibility to assure the accuracy of submitted claims. This includes completion of all accompanying clinical documentation necessary for proper claim adjudication.

Front office staff should address any concerns with the completed claim form and accompanying documentation with the treating dentist *before* submission of the claim. This includes radiographs, claim forms, periodontal charting and narrative descriptions.

Recording Attachment Loss

Probing depth or pocket depth is measured from the gingival margin, and the measurement is affected by gingival recession or inflammation. Clinical attachment loss (CAL) is measured from a fixed reference point (typically the cementoenamel junction) and is a more stable indicator of periodontal health.

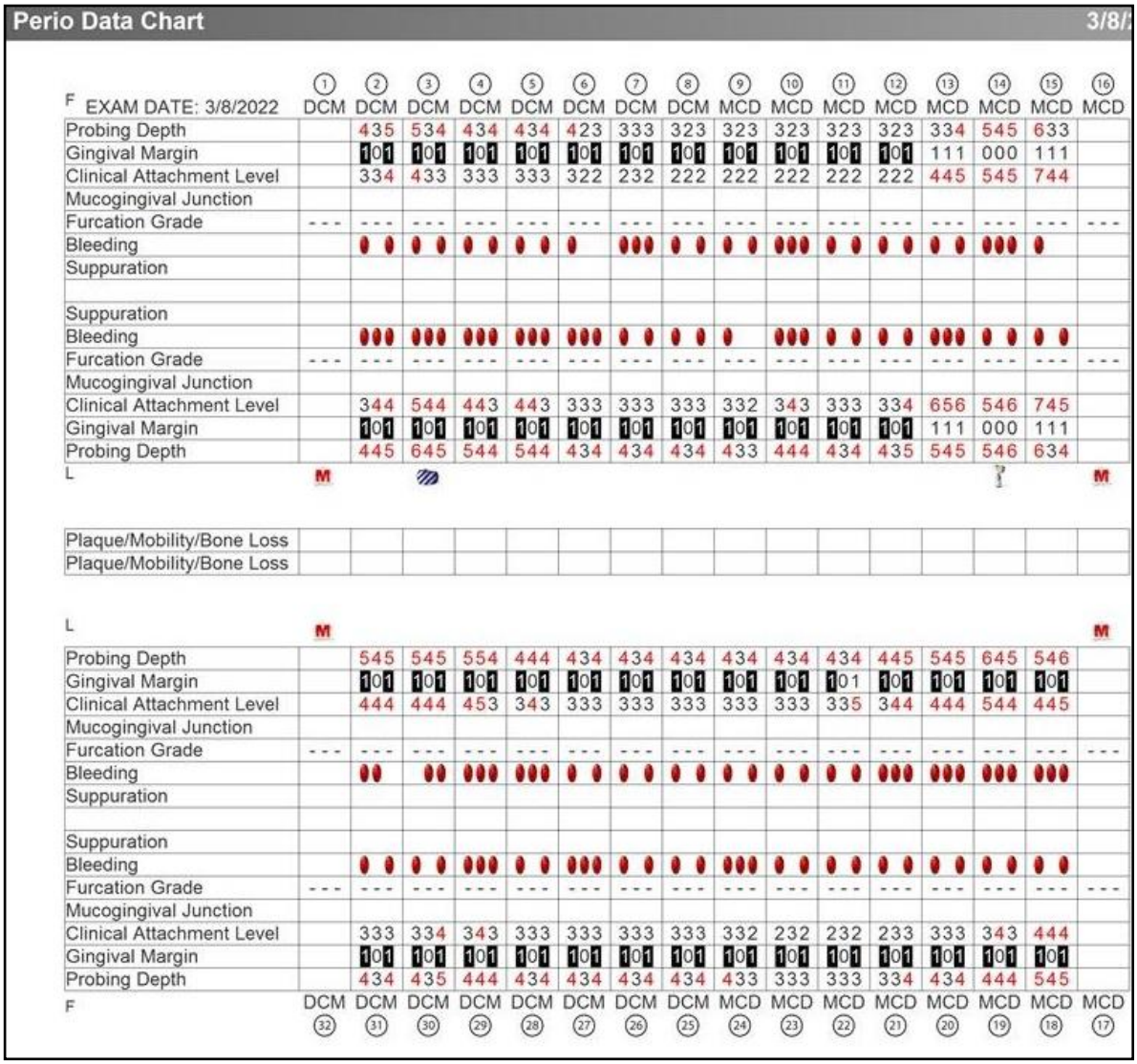
In cases without any recession, Loss of attachment (mm) = Probing Depth (mm) – mm from gingival margin to CEJ.
In cases with recession, Loss of attachment (mm) = Probing Depth (mm) + Recession (mm from CEJ to gingival margin).



Pseudo-pocketing caused by hyperplastic gingival tissue or inflamed gingival tissue can result in abnormal probing depth without concomitant bone loss/ loss of attachment. Treatment of this condition should be reported as a prophylaxis (D1110 or D1120) or scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation (D4346). More info can be found in the ADA Guide to Reporting D4346.

Sample Periodontal Chart

Dental offices that use a practice management software typically have a periodontal module that can generate a periodontal chart that can be communicated to the dental plan. A sample chart appears below. Note the different periodontal parameters included on a **complete periodontal chart**.



Perio Data Chart 3/8/

F EXAM DATE: 3/8/2022	① DCM	② DCM	③ DCM	④ DCM	⑤ DCM	⑥ DCM	⑦ DCM	⑧ DCM	⑨ MCD	⑩ MCD	⑪ MCD	⑫ MCD	⑬ MCD	⑭ MCD	⑮ MCD	⑯ MCD
Probing Depth		435	534	434	434	423	333	323	323	323	323	323	334	545	633	
Gingival Margin		101	101	101	101	101	101	101	101	101	101	101	111	000	111	
Clinical Attachment Level		334	433	333	333	322	232	222	222	222	222	222	445	545	744	
Mucogingival Junction																
Furcation Grade	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Bleeding		• •	• •	• •	• •	•	•••	• •	• •	•••	• •	• •	• •	•••	•	
Suppuration																
Suppuration																
Bleeding		•••	•••	•••	•••	•••	• •	• •	•	•••	• •	• •	•••	• •	• •	
Furcation Grade	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Mucogingival Junction																
Clinical Attachment Level		344	544	443	443	333	333	333	332	343	333	334	656	546	745	
Gingival Margin		101	101	101	101	101	101	101	101	101	101	101	111	000	111	
Probing Depth		445	645	544	544	434	434	434	433	444	434	435	545	546	634	
L	M															M

Plaque/Mobility/Bone Loss	
Plaque/Mobility/Bone Loss	

L	M															M
Probing Depth		545	545	554	444	434	434	434	434	434	434	445	545	645	546	
Gingival Margin		101	101	101	101	101	101	101	101	101	101	101	101	101	101	
Clinical Attachment Level		444	444	453	343	333	333	333	333	333	335	344	444	544	445	
Mucogingival Junction																
Furcation Grade	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Bleeding		••	••	•••	•••	• •	• •	• •	• •	• •	• •	•••	•••	•••	•••	
Suppuration																
Suppuration																
Bleeding		• •	• •	•••	• •	•••	• •	• •	•••	• •	• •	• •	• •	• •	• •	
Furcation Grade	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Mucogingival Junction																
Clinical Attachment Level		333	334	343	333	333	333	333	332	232	232	233	333	343	444	
Gingival Margin		101	101	101	101	101	101	101	101	101	101	101	101	101	101	
Probing Depth		434	435	444	434	434	434	434	433	333	333	334	434	444	545	
F	DCM ㉜	DCM ㉛	DCM ㉚	DCM ㉙	DCM ㉘	DCM ㉗	DCM ㉖	DCM ㉕	MCD ㉔	MCD ㉓	MCD ㉒	MCD ㉑	MCD ⑳	MCD ⑲	MCD ⑱	MCD ⑰

ADA®

Why do my SRP claims get denied?

Periodontal scaling and root planing (SRP) procedures (D4341 and D4342) tend to have a higher frequency for denial and/or requests for additional information from dental plans in comparison to many other procedures. Dentists may not always understand why claims for SRP are denied when the patient has abnormal pocket depths. A claim may be paid on one patient while at other times a plan may deny the same procedure on another patient who had a similar clinical presentation.

- Different dental plans have different coverage and processing policies for SRP claims. Examples include:

  "Document at least 4mm pocket depths on the diseased teeth involved. No payment is made and the fees are not billable to the patient by a participating dentist in the absence of radiographic documentation of bone loss and documentation of clinical attachment loss."

  "Benefits for D4341 and D4342 require root surface calculus, radiographic bone loss and bleeding upon probing. Additional information such as gingival recession, frenum involvement and furcation defects are also evaluated, but in general, documented 5-8 mm pockets determine benefits".

- Plans will typically not pay separately for SRP on the same date of service as a surgical periodontal procedure on the same teeth.
- Plans may have different coverage policies for SRP around natural teeth versus implants.
- Plans may implement frequency limitations for retreatment within a designated time frame, for example, twenty-four months from the original treatment date.
- Plans may not provide coverage for more than 2 quadrants of SRP on the same date of service unless there are extenuating circumstances and the documentation supports the need. These plans may request the amount of time it took to scale and root plane and a narrative (which includes details on use of anesthesia) in order to determine coverage and benefits.

It is essential for dentists and their teams to fully read and understand each payer's processing policies.

Payers note that if there is no radiographic evidence of bone loss, root surface calculus or adequate clinical attachment loss demonstrated by the submitted periodontal charting, the claim will typically be denied. If only certain teeth in a quadrant meet these criteria, a partial quadrant, only D4342 may be benefitted. Payers report that a common issue is that radiographs submitted with claim(s) are not properly mounted, labeled, or are not of diagnostic quality. Payers have stated that at times the charting is not legible or is incomplete.

When the claim is denied due to frequency limits, annual benefit or other plan limitations and depending on how the explanation of benefits (EOB) statement is worded, some patients may think that the dentist has provided unnecessary work. This may create unnecessary friction in the dentist-patient relationship. To help prevent this, **dental plans should make it clear to both patients and dentists that claims denials due to processing policies does not mean that the treatment was unnecessary; the denial is based on solely on plan limitations.** Dentists should advise their patients that coverage is often based on employer funding of the policy purchased rather than the clinical needs of the specific patients.

It is the ADA's position that all communications to beneficiaries from third-party payers that attempt to explain the reason(s) for a benefit reduction or denial of a dental benefits plan include the following statement, "*Any difference between the fee charged and the benefit paid is due to limitations in your dental benefits contract. Please refer to your summary plan description for an explanation of the specific policy provisions which limit or exclude coverage for the claim submitted*."

It is always appropriate to appeal the benefit decision if the dentist thinks the claim has not been properly adjudicated. A proper appeal involves sending the plan a written request to reconsider the claim with any additional information.

Guiding Values for the Treating Dentist

The American Dental Association (ADA) makes a commitment to society that member dentists will adhere to ethical standards of conduct, which have the benefit of the patient as their primary concern as noted in the Preamble of the ADA Principles of Ethics and Code of Professional Conduct (ADA Code). All member dentists voluntarily agree to abide by the ADA Code.

Specific to determining the treatment plan and procedure coding, in Section 5 of the ADA Code, the principle Veracity ("truthfulness") is one which all dentists should remain mindful of. This section specifically states that, “the dentist has a duty to communicate truthfully.”

> *This principle expresses the concept that professionals have a duty to be honest and trustworthy in their dealings with people. Under this principle, the dentist's primary obligations include respecting the position of trust inherent in the dentist-patient relationship, communicating truthfully and without deception, and maintaining intellectual integrity.*

For specific information about how Section 5 of ADA Code of Professional Conduct pertains to dentist’s responsibility to assure all claims submitted on their behalf are done so correctly, please refer the ADA Guide *Assuring Accuracy of Claims as a Treating Dentist*.

The Future of Artificial Intelligence (AI) and Its Role in SRP Claims Review

Dental payers complete utilization reviews on all or a portion of the claims they receive, but most notably on SRP claims. Payers use the types of required documentation covered in this guide to review submitted SRP claims, and these reviews have traditionally been carried out by the payers’ dental consultants.

Many payers are now looking towards new technology that can automate the claims review process.

The application of AI as a first pass in the screening of the large amount of documentation being requested and sent in related to SRP claims is something that is becoming more commonplace across the dental payer landscape. When used appropriately, the hope is that AI can step in and deliver immediate benefits that reduce frustration between dentists and dental carriers by ensuring claim completeness, more consistency in payers ’reviews, and an overall increase in efficiency for all parties. The ADA will continue to closely monitor the application of AI to make certain that claims are not unfairly adjudicated during its use.

Additional information on valuable educational ready-to-use resources on innovative dental insurance solutions for dentists can be found at ADA.org/dentalinsurance.

ADA®

Appendix 1: Example of Processing Policies

Payer #1:

D4341 Periodontal scaling & root planing-four or more teeth per quadrant

a. Document at least 4mm pocket depths on the diseased teeth involved. No payment is made and the fees are not billable to the patient by a participating dentist in the absence of radiographic documentation of bone loss and documentation of clinical attachment loss.
b. Do not count teeth bounded spaces for D4210, D4341. Count only diseased teeth.
c. When there is a contractual time limitation on the frequency of benefits for scaling and root planing, and subsequent requests for scaling and root planing benefits are submitted within that contractual time limitation, benefits are DENIED. In the absence of a contractual time limitation for scaling and root planing, fees for D4341 are not billable to the patient by a participating dentist within 24 months when done by the same dentist/dental office. If treatment is done by a different dentist within 24 months, benefits are DENIED.
d. Adult prophylaxis procedures (D1110), full mouth scaling (D4346) or debridement (D4355) are considered a component when submitted on the same date of service as D4341. This time limitation, like all other contractual time limitations, should be defined in the group/individual contract. Fees for the prophylaxis procedure by the same dentist/dental office are not billable to the patient by a participating dentist.
e. Benefit no more than two quadrants of scaling and root planing on the same date of service. More than two quadrants on the same date of service are not billable to the patient by the same participating dentist/dental office/DENIED-nonparticipating dentist.
f. For patients under the age of 30, clinical treatment notes, the most current (less than two years old) complete series of radiographic images, complete periodontal charting (no more 12 months old) and a copy of the appointment schedule showing the length of the appointment time are required. No payment is made for periodontal maintenance (D4910), scaling in presence of generalized moderate or severe gingival inflammation (D4346) or prophylaxis (D1110) when performed on the same day as scaling and root planning (D4341). The fee is not billable to the patient by a participating dentist.

D4342 Periodontal scaling & root planing-one to three teeth per quadrant: Scaling and root planing in the same quadrant is benefited once every 24 months unless specified by group contract. Reporting separately for periodontal root planing is not billable to the patient by a participating dentist on the same date as procedures D4240-D4241, D4249, D4260-4261, D4270-D4285.

Do not count tooth bounded spaces for D4341, D4342. In order to qualify for benefits probing depths must be 4mm or greater on 4 or more teeth. If only 1-3 teeth qualify, use partial quadrant code (D4342). If no teeth in the quadrant qualify, the Dental Consultant will DENY.

Payer #2:

When supporting documentation is requested for periodontal services, please refer to the submission guidelines as outlined in this section.

- A quadrant is defined as four or more contiguous teeth per quadrant.
- A partial quadrant is defined as one to three teeth per quadrant. For billing purposes, a sextant is not a recognized designation by the American Dental Association.
- Alveolar crestal bone loss must be evident radiographically for scaling and root planning to be covered.

When more than one periodontal service (codes D4000-D4999) is completed within the same site or quadrant on the same date of service, carrier will pay for the more extensive treatment as payment for the total service.

Benefits for all periodontal services are limited to two quadrants per date of service. If you want to request an exception to this due to a medical condition that may require your patient to receive extended treatment, please include a detailed narrative including general or intravenous anesthesia record, medical condition and length of appointment time.

Payer #3:

Benefits for D4341 and D4342 require root surface calculus, radiographic bone loss and bleeding upon probing. Additional information such as gingival recession, frenum involvement and furcation defects are also evaluated, but in general, documented 5-8 mm pockets determine benefits.

Payer #4:

Scaling and Root Planing
Scaling and Root Planing is indicated for the treatment of localized or generalized active Periodontal Disease characterized by:
Periodontal probing depths of 4-6+ mm with radiographic evidence of horizontal or vertical bone loss
Refractory or recurrent Periodontal Disease
Periodontal abscess

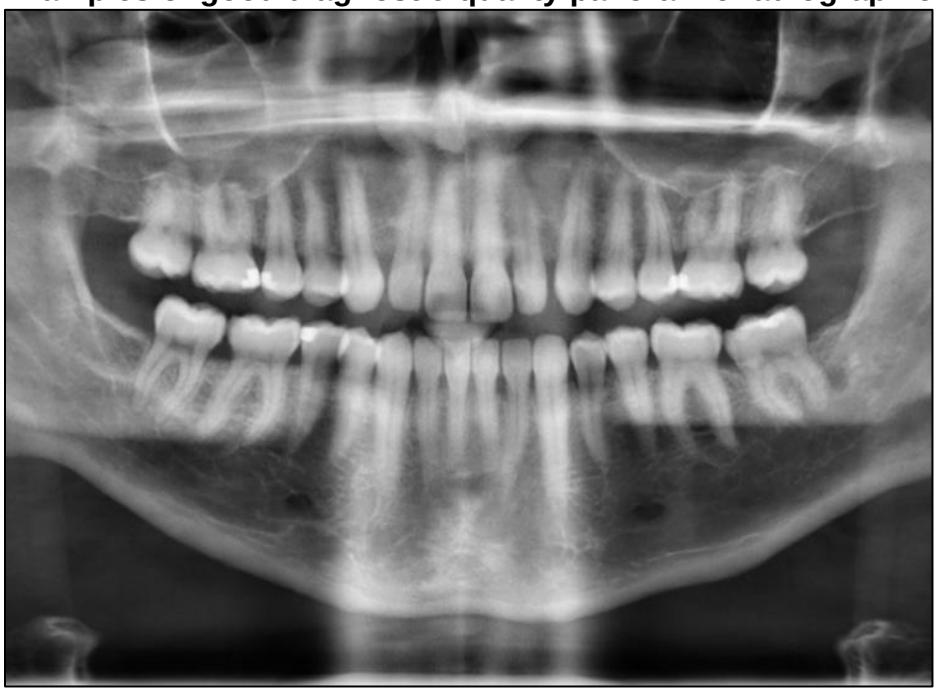
Scaling and Root Planing is not indicated for the following:
For the removal of heavy deposits of calculus and plaque in the absence of clinical attachment loss
Gingivitis as defined by inflammation of the gingival tissue without loss of attachment (bone and tissue)

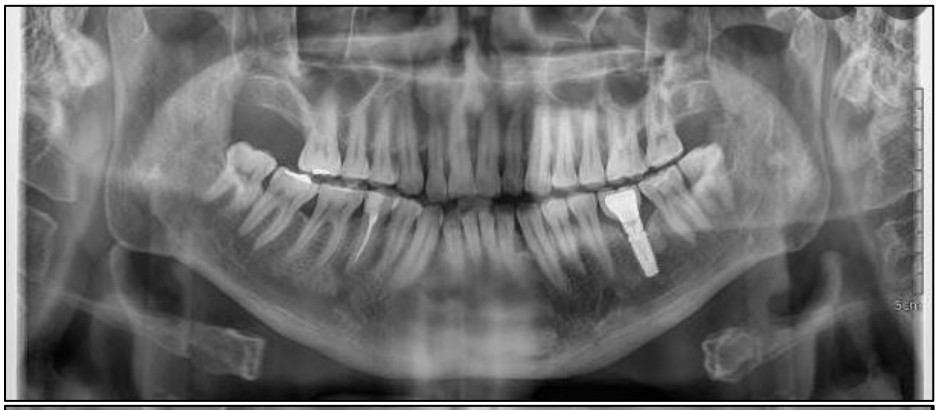
Coverage Limitations
Scaling and Root Planing is limited to 1 time per quadrant per consecutive 24 months

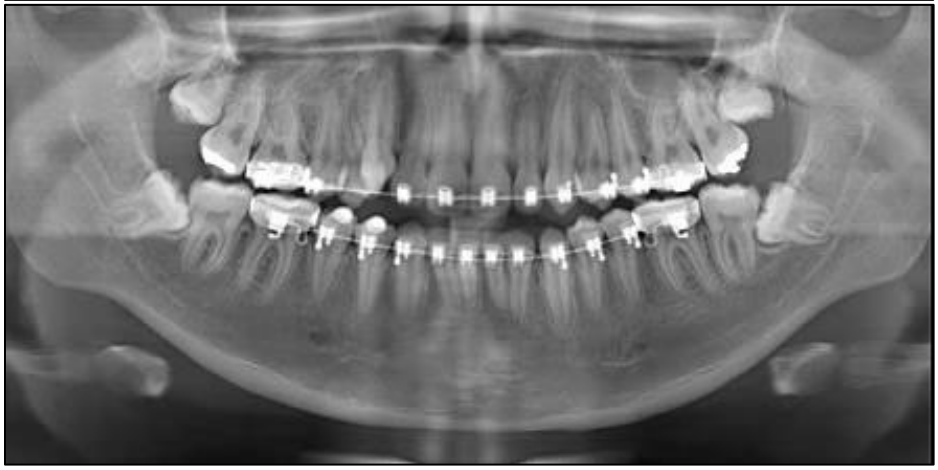
Appendix 2: Examples of Good and Poor Radiographs for SRP Claims

[Note: some of the enclosed examples are images that are zoomed-in and enlarged.]

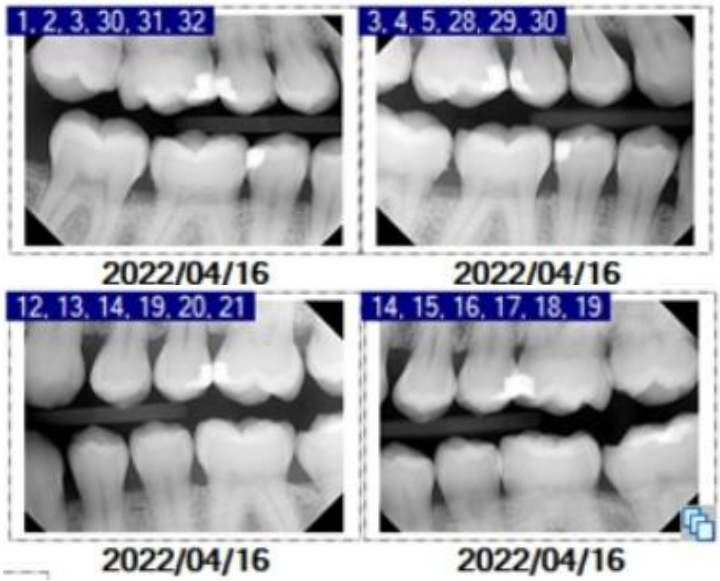
Examples of good diagnostic-quality panoramic radiographic images



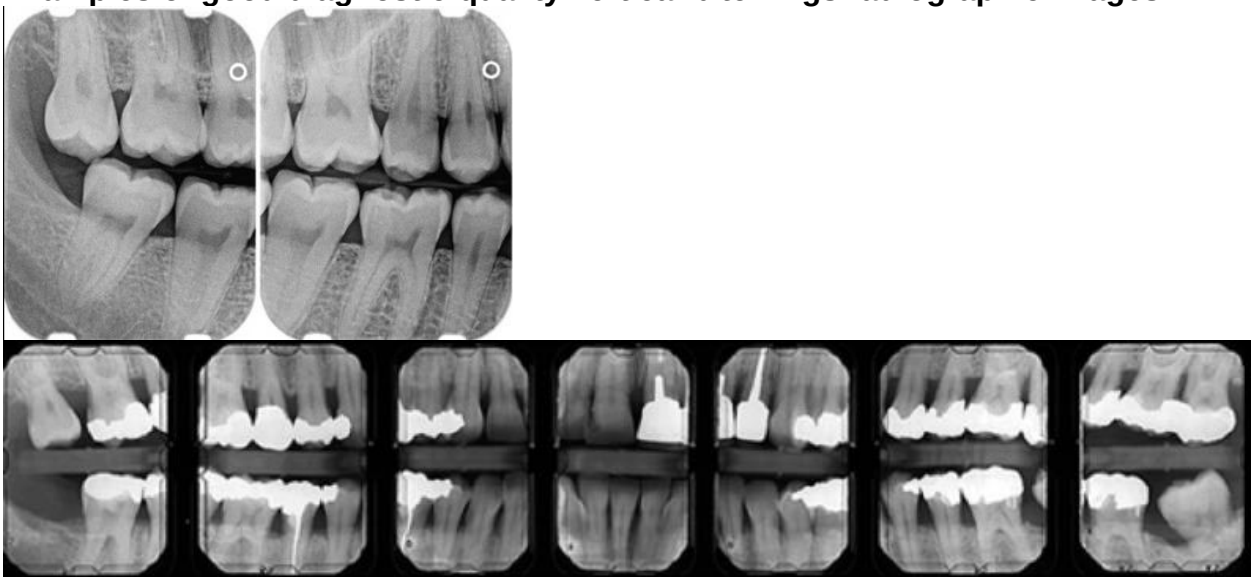




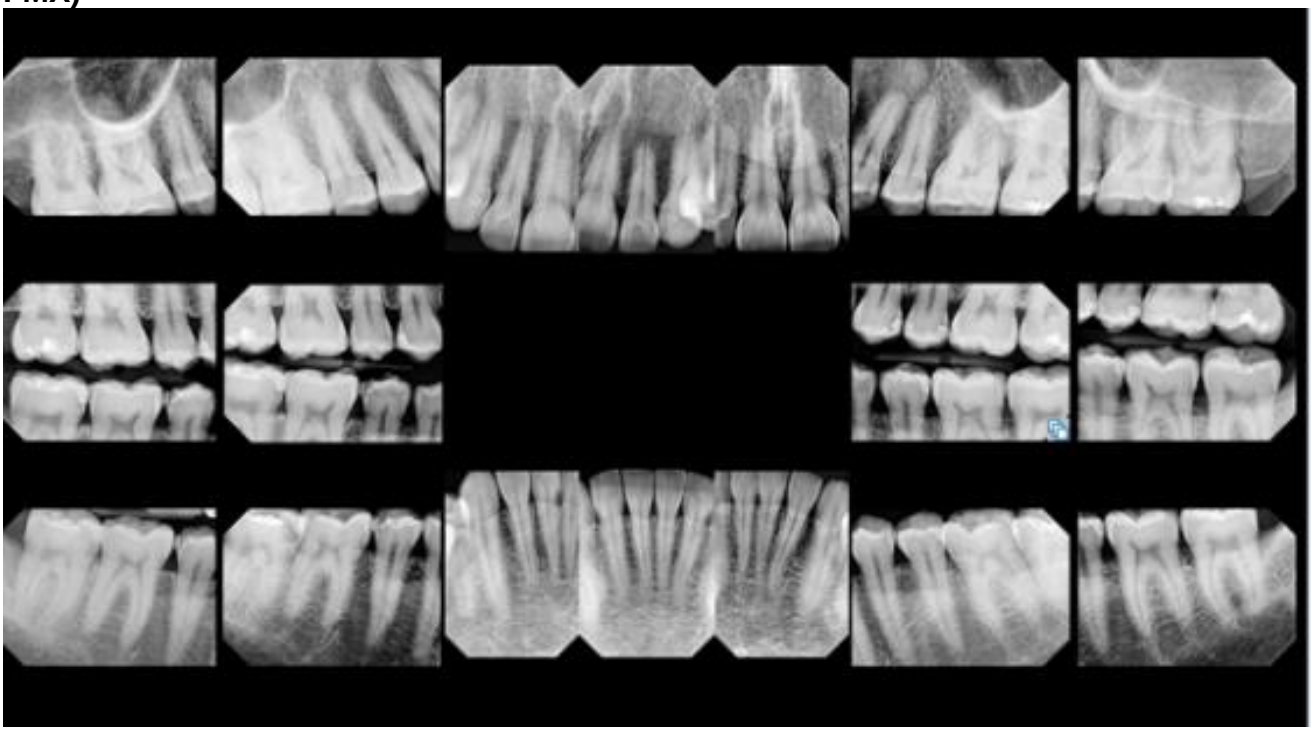
Examples of good diagnostic-quality bitewing radiographic images

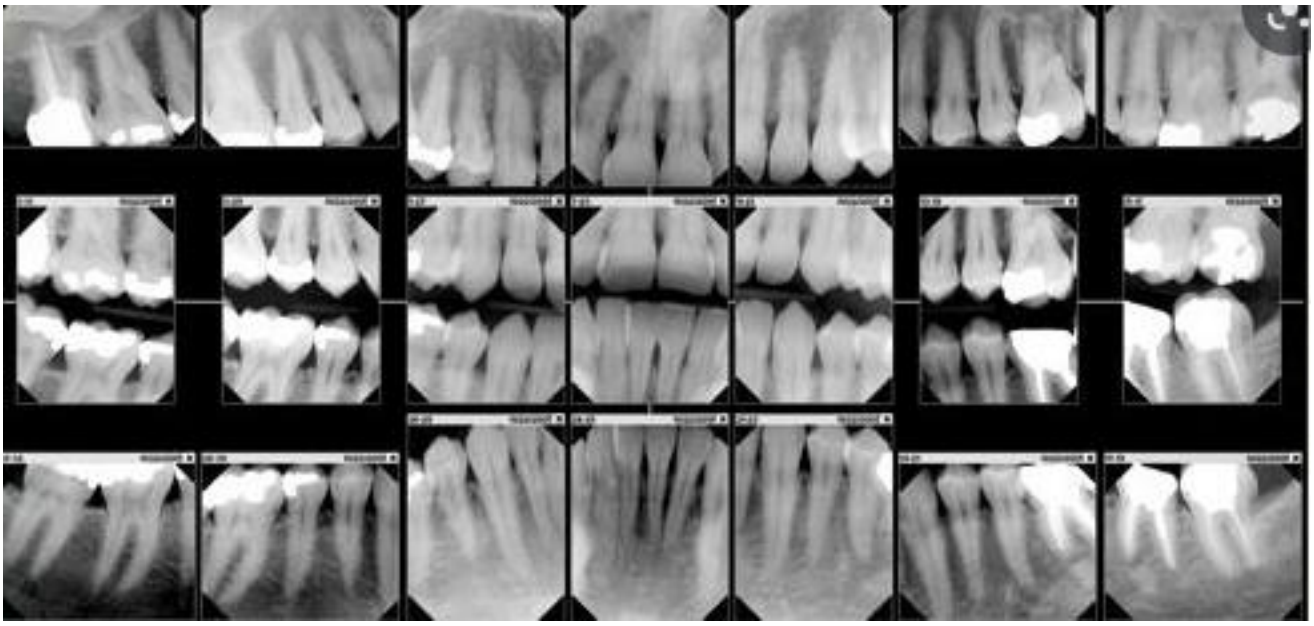


Examples of good diagnostic-quality vertical bitewings radiographic images

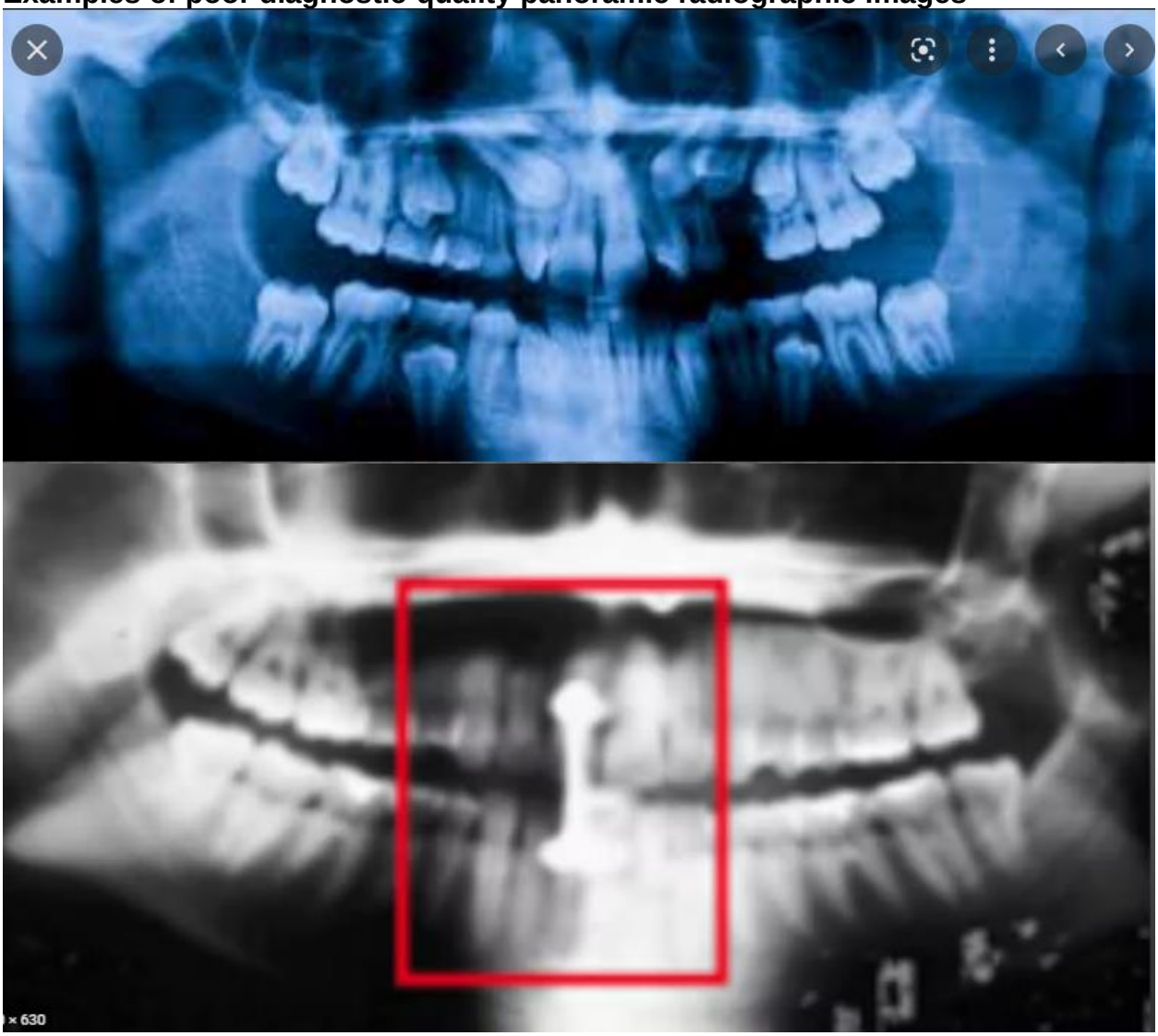


Examples of good diagnostic-quality intraoral – complete series of radiographic images (i.e., FMX)





Examples of poor diagnostic-quality panoramic radiographic images



Examples of poor diagnostic-quality bitewing radiographic images