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.).
  - 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.

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

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:

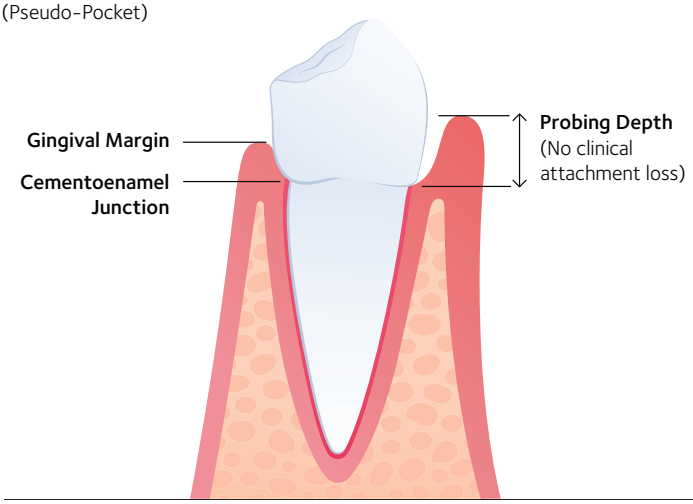
- Preferably bitewings (vertical or horizontal as long as the image captures the bone height in relation to the root and any furcation involvement) or sometimes the full mouth series are submitted. NOT panoramic X-rays.
- Radiographs are properly mounted and labeled (e.g., left and/or right, and with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

Recording Attachment Loss

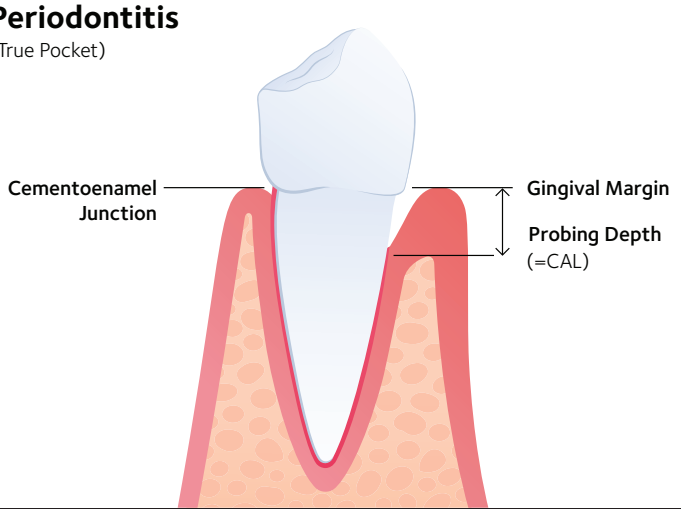
Probing depth or pocket depth is measured from the gingival margin, and the measurement is affected by gingival recession or inflammation. Clinical attachment loss (CAL) is measured from a fixed reference point (typically the cementoenamel junction) and is a more stable indicator of periodontal health.

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**.

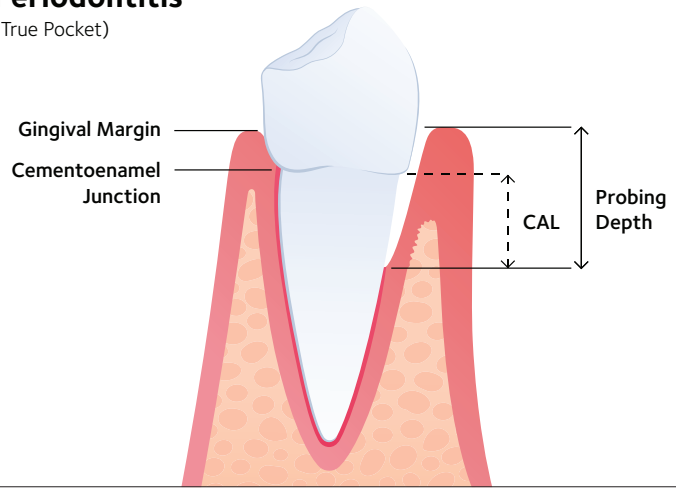
Gingivitis
(Pseudo-Pocket)



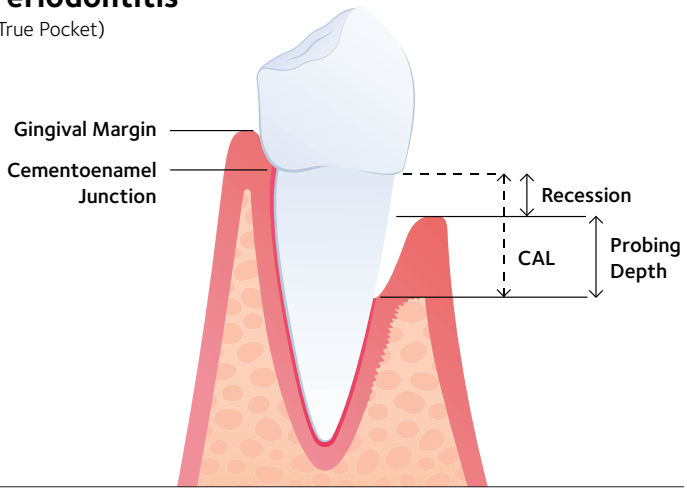
No Recession Periodontitis
(True Pocket)



No Recession Periodontitis
(True Pocket)



With Recession Periodontitis
(True Pocket)



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