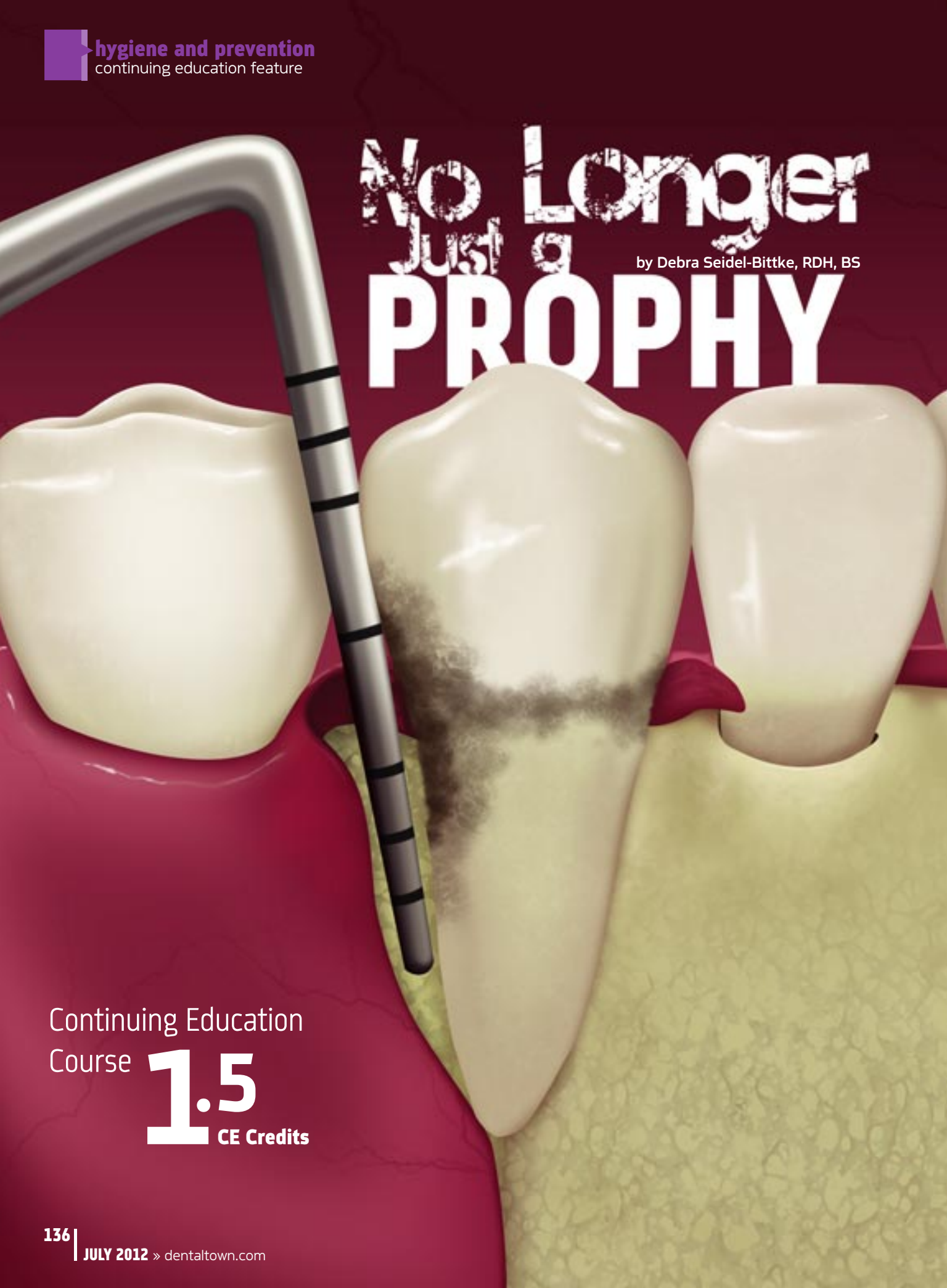
No Longer Just a PROPHY

by Debra Seidel-Bittke, RDH, BS



Continuing Education Course **1.5** **CE Credits**

When scaling exceeds 20 minutes during a regular dental hygiene appointment, periodontal disease might be underestimated. Subgingival instrumentation is actually periodontal therapy and should not be provided during a prophylaxis appointment.

A prophylaxis is reserved for healthy patients with no signs of periodontal disease. The need for more than 20 minutes of subgingival instrumentation during a prophylaxis appointment shifts the focus from health to periodontal disease. Periodontal disease might be overlooked during a prophylaxis because of four reasons: improper probing technique, insurance roadblocks, unclear practice philosophy and financial profiling. To avoid providing periodontal therapy during a prophylaxis, a three-step plan of action should be followed. This plan includes periodontal assessments, discussing the findings with the patient and taking the time to explain to the patient the treatment that is needed. Understanding the reasons periodontal disease might be overlooked and following a plan of action when periodontal disease is present will assure that prophy appointments do not include unplanned periodontal instrumentation.

Objectives

At the end of this program, participants will be able to:

1. Describe the difference between health and periodontal disease
2. List four reasons periodontal disease diagnosis is overlooked
3. Explain the three critical elements of successful periodontal therapy
4. Discuss how periodontal probing can underestimate periodontal disease
5. Understand the definition of CDT Code D1110

Are you scaling more than 20 minutes during a regular dental hygiene appointment? If you are, this is more than just a "prophylaxis" appointment. Your good intentions are actually leading you to provide subgingival instrumentation and periodontal therapy as part of a prophylaxis, which is a treatment reserved for healthy patients with no signs of periodontal disease.

You must have an accurate diagnosis and you must make the distinction between health and disease before providing the appropriate treatment. If the patient is periodontally healthy, the appropriate treatment is a prophylaxis, which should not take longer than 20 minutes for scaling and polishing. If probing depths, however, exceed 4mm and there is bleeding upon probing, the patient has periodontal disease, and you should provide the appropriate treatment and use accurate treatment codes. The purpose of the CDT codes is to achieve uniformity, consistency and specificity in accurately reporting dental treatment. The CDT code for a prophylaxis is D1110 and is defined as "the removal of plaque, calculus and stains from the tooth structures in the permanent and transitional dentition. It is intended to control local irritational factors."

CDT Code D1110 is, thus, a preventive procedure for patients who don't yet have periodontal disease and you should use it only with patients who have a healthy periodontium.

Here's an example of a prophy visit no longer fitting the definition of health. Every six months Mr. Goodtooth comes in for his "cleaning" appointment, and it always ends up becoming more than just scaling and polishing. There is bloody gauze on the patient tray, evidence of disease rather than health. Mr. Goodtooth needs topical anesthetic applied to alleviate the pain of subgingival instrumentation. His hygienist, Bethany, is stressed out and continually runs behind when he is on her schedule. Bethany finds herself scaling and polishing at least 40 minutes every six months, and she finds it difficult to do anything more than scale, polish, take X-rays and have the doctor complete an exam when she sees Mr. Goodtooth. She has no time for important assessments to evaluate for xerostomia, inquire for a smile analysis, provide an oral cancer screening exam, a caries assessment, an evaluation of implants, check for defective restorations, open contacts, malocclusion, etc.[1]

Do you find yourself in this situation all too often? Do you turn the treadmill up to a much faster pace just to stay on schedule and complete the "cleaning" appointment your

1. *Parameter on Comprehensive Periodontal Examination, J. Perio May, 2000.*

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patient anticipated? We have all been there, and it is a frustrating feeling! There are several reasons that might explain why this was no longer just a prophy.

1. Improper Probing Technique

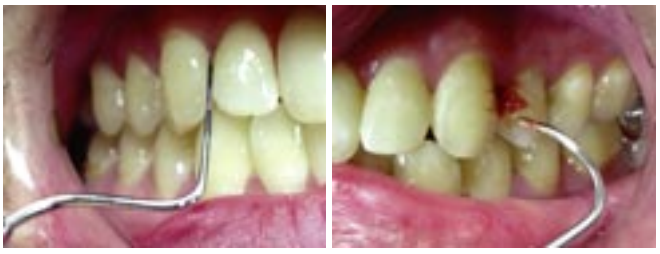
If you complete a periodontal screening exam and find no disease, yet still find yourself in the same situation as Bethany, it might be due to how you insert the periodontal probe into the sulcus during the screening exam. Some dental hygiene programs teach a reproducible probing technique, requiring the probe to be positioned parallel with the long axis of the tooth. While this might be a reproducible technique for researchers, it misses the mid-interproximal surface. To accurately probe the mid-interproximal surface, the probe needs to be angled into the interdental space. This is one reason periodontal disease is greatly underestimated.[2] What might appear healthy at first glance with the probe held parallel to the long axis of a tooth at the line angle is in fact an interproximal periodontal pocket. It goes without saying that missing a periodontal disease diagnosis can cause your prophylaxis appointment to be unusually complex.

2. Insurance Roadblocks

Many dental offices today are insurance-driven. Patients are subconsciously educated to believe their insurance company will cover all the treatment they receive. Rarely if ever does the patient's insurance plan pay 100 percent of the treatment needed. In 1970 many insurance companies had a maximum annual patient benefit of $1,000, and this value is still the same today. Never begin a conversation about treatment with this sentence: "Your insurance will pay X percent, and your anticipated portion will be Z dollars." The conversation needs to begin with a discussion about the patient's oral health status, disease diagnosis if applicable, necessary treatment and the benefits of undergoing the recommended treatment. This discussion works best with open-ended questions to determine the patient's openness and willingness to accept and undergo treatment.

3. Unclear Practice Philosophy

The lack of a detailed practice philosophy on periodontal treatment is another reason patients are scheduled for a prophylaxis when in fact they need periodontal therapy. Defining the diagnostic criteria distinguishing the difference between health and disease will provide the foundation for a practice philosophy on periodontal treatment. This philosophy should include specific diagnostic criteria, treatment plans for early, moderate and severe periodontitis, periodontal maintenance intervals, appointment details and specifics of oral hygiene for periodontal patients. This philosophy should also include criteria for referral to a specialist. Daily interproximal plaque control is critical to controlling and preventing further infection and attachment loss, so the entire team should understand and provide patients with effective tools and instructions. This is an essential part of the practice philosophy on periodontal treatment. The primary role of health care providers is to prevent dental disease and secondarily, to treat it. An important aspect of this role is communication. Effective communication can create a change in patients' values and the treatment choices they make.



4. Financial Profiling

Dental professionals subconsciously pre-determine exactly what treatment they *think* their patients are willing to accept financially. It is our role as dental professionals to communicate the truth and all the treatment options available and not necessarily what we think our patients want to hear. It is important from an ethical and legal perspective to provide patients with all the options available to them for their particular condition. Financial profiling is not done on a conscious level. Many times, subconsciously, a decision is made as to what the patient can afford. This might explain why a patient with periodontal disease is treated with a prophylaxis rather than scaling and root planing. Rather than discussing periodontal disease with Mr. Goodtooth, Bethany assumes he can't afford scaling and root planing. Instead, she removes what calculus she can during his prophylaxis appointment, cutting short the time needed to educate him about his true periodontal condition, the treatment he needs and the necessary preventive actions he needs to take each day to prevent ongoing disease.

These four reasons explain why some prophylaxis appointments should actually be periodontal treatment appointments instead. Based on this information, it's time to formulate a plan of action that will accurately diagnose periodontal disease before instrumentation begins. Ideally, a 60-minute prophylaxis appointment can be divided into three 20-minute segments. The first segment is for data gathering, assessment, diagnosis, treatment planning, case presentation and oral hygiene instructions. The second segment is for scaling and polishing, and the third segment is for the doctor's exam, completing chart notes, scheduling of future appointments and turning the room around for the next patient.

Follow this plan of action when periodontal disease is present:

Step 1: Assessments

Gather the data necessary to accurately distinguish between health and periodontal disease. Have your prophylaxis and periodontal therapy definitions clear in your mind. Data gathering

2. *Page, R., Eke, P. Case Definitions for Use in Population-Based Surveillance of Periodontitis. J Perio 2007; 78:7:1387- 1399.*

should include: full-mouth, six-point periodontal probing, bleeding upon probing, recession, mobility and all attachment levels, etc. Patient history of periodontal treatment and daily oral hygiene practices should be determined. Use this time of data gathering to discuss occlusal issues, and explain the relationship between occlusion and periodontal disease, treatment recommendations, benefits of treatment and prevention.[3] The dentist and dental hygienist should regularly calibrate their probing technique to be sure measurements are consistent.

Step 2: Discuss Findings

After gathering the necessary data, sit the patients upright in the chair, and discuss the findings. Tell them the truth! The best thing you can do for your patients is to explain what is present in their oral cavity, why they need to return for non-surgical periodontal treatment and how this will benefit their overall health.

Always give patients the disease facts. Explain the process of periodontal disease. Periodontal disease is an inflammatory disease that affects the soft and hard tissues that support the teeth. The early stage of this disease is gingivitis. In later stages the teeth might become loose and the bone surrounding the teeth can degenerate.[4] For example, Bethany might say, "Mr. Goodtooth, today we found bleeding and many of the probe measurements were more than 4mm. This indicates the start of periodontal disease."

(Wait for the patient to respond. When he does respond, acknowledge any concerns.)

Bethany continues: "If these areas are left untreated, tooth loss can occur, in addition to bad breath and bleeding gums. Also, research shows that periodontal disease affects the whole body. It is associated with many diseases such as diabetes, Parkinson's disease and even Alzheimer's disease. All this said, we recommend scaling and root planing all four quadrants of your mouth and a re-evaluation six weeks afterward. Then, we will need to see you at least every three months for periodontal maintenance because this disease can return at various times during your life due to stress, diet and other risk factors like smoking, and those systemic diseases as I mentioned before, diabetes, rheumatoid arthritis, Crohn's disease and more."[5, 6]

Step 3: Explain the Necessary Therapy

The patient must accept three important aspects of periodontal therapy before treatment can begin. Two are professional care provided by the dentist or hygienist: scaling and root planing and regular maintenance visits. The third is daily plaque biofilm control by the patient. He or she must agree to all three in order to achieve treatment success. Depending on the practice philosophy of periodontal treatment, you might spend the bulk of that appointment going over facts about periodontal disease and daily plaque biofilm control by the patient. If time permits, you may then begin scaling and root planing or your patient might need to schedule one long or several one-hour appointments for Phase I periodontal therapy (scaling/root planing, chemotherapeutics). Tell your patients that from here on out, they need to return every 12 weeks, or at frequent, appropriate intervals, for supportive periodontal maintenance.[7]

Integrating Change

When integrating a change like this into your practice, meet as a team to get everyone on the same page. This is a perfect time for the team to discuss the practice philosophy on periodontal treatment and to clearly define periodontal health and periodontal disease.

Keep up-to-date with all the evidence-based research. Research is constantly changing, and more evidence to support your findings is available. When we understand the research regarding periodontal pathogens, we can better communicate to our patients why they need to return in 12 weeks – and maybe sooner in some cases.

Conclusion

As dental professionals we are concerned about our patients' oral, as well as overall health, and we want the very best for them. Educating patients on the difference between health and disease and providing appropriate treatment is the best way to achieve good oral health. To avoid spending more than 20 minutes scaling during a prophy appointment, accurate assessments are needed at the start of the visit. Probing into the mid-interproximal areas will establish accurate baseline data upon which a treatment plan can be made. Before beginning instrumentation, discuss the clinical findings and necessary treatment with the patient. Avoid making judgments about what you think your patient wants or is willing to accept financially. By distinguishing between health and disease, and prevention and treatment you will no longer find yourself on the "more than just a prophy" treadmill. ■

3. *American Dental Hygienists' Association, Standards for Clinical Dental Hygiene Practice. Accreditation Standards for Dental Hygiene Programs. (1998). Accessed at www.adha.org.*
4. *Periodontal Disease Fact Sheet. Accessed at www.perio.org/consumer/disease_facts.htm.*
5. *Mosqueegs T., Listgarten M., Stoller N. Effect of sampling on the Composition of the Human Subgingival Micrbioal Flora. J Perio Res 1980;15:137-143.*
6. *Koromantzos, P., Makrilakis, K., et al. Effect of Non-Surgical Periodontal Therapy on C-Reactive Protein, Oxidative Stress, and Matrix Metalloproteinase (MMP)-9 and MMP-2 Levels in Patients With Type 2 Diabetes: A Randomized Controlled Study. J Perio 2012; 83:3-10.*
7. *Cohen R. Academy Report Position Paper. Periodontal Maintenance. J Perio 2003;74:1395-1401.*

Author's Bio

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Post-test

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1. According to the CDT Codes, D1110…
   a. is a preventive procedure.
   b. includes scaling and root planing.
   c. includes periodontal data collection.
   d. should be provided every 12 weeks.

2. A patient may receive a prophylaxis when, in fact, he or she needs periodontal therapy. This treatment mistake is often due to:
   a. improper probing technique.
   b. insurance coverage.
   c. financial profiling.
   d. practice philosophy.
   e. All of the above

3. An appropriate amount of time to spend scaling during a prophylaxis appointment is:
   a. 10 minutes.
   b. 20 minutes.
   c. 30 minutes.
   d. 40 minutes.

4. Dental insurance companies…
   a. have not increased maximum annual benefit for many decades.
   b. pay for most scaling and root planing procedures.
   c. increase patient benefit maximum in line with cost of living.
   d. None of the above

5. The primary role of dental professionals is to:
   a. increase production from periodontal therapy.
   b. prevent dental disease.
   c. provide professional whitening.
   d. None of the above

6. Current research suggests that patients return for supportive periodontal maintenance…
   a. every twelve weeks, or at frequent, appropriate intervals.
   b. when patients notice bleeding during home care.
   c. as often as they would for a regular prophylaxis.
   d. once a month.

7. Periodontal data collection should include:
   a. full-mouth, six-point probing.
   b. recession.
   c. mobility.
   d. All of the above

8. A plan of action when periodontal disease is present includes:
   a. assessments.
   b. discussing findings with the patient.
   c. explaining necessary treatment.
   d. All of the above

9. Three important aspects of periodontal therapy include:
   a. treatment, periodontal maintenance and daily plaque control.
   b. treatment codes, financial arrangements and payment.
   c. scaling, root planing and curettage.
   d. diagnosis, treatment planning and follow-up.

10. When integrating change in the practice…
    a. just do it.
    b. discuss the changes in a team meeting.
    c. start with new patients, not existing patients.
    d. explain the changes in a letter to patients.

Continuing Education Answer Sheet

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CE Post-test

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