Dental Practice REPORT
SYSTEMS, STRATEGIES AND SOLUTIONS FOR A PROFITABLE PRACTICE

COVER STORY

Perio Focus

When Casey Hein, RDH, gets together with other hygienists whose careers span a few decades or so, talk sometimes turns to a couple of intriguing, yet unsettling, questions. "We look back at the past 20 or 30 years that we've practiced and we ask, knowing what we know now, would we have picked up on the periodontal disease of women who had either lost babies or delivered pre-term? And if we had, would it have made a difference? Those are the questions we're starting to ask, those of us who are older now."

By DANIEL McCANN

No issue in dentistry today has such potentially far-reaching health implications as the perio-systemic link. While causation remains undetermined, the association between periodontitis and medical problems such as cardiovascular disease, diabetes, low birthweight and more already has had some tangible consequences—for patients and general dentists alike.

For one, it's helped raise public awareness about the importance of oral health in general, and periodontal problems in particular. According to a *Dental Products Report* survey earlier this year, 63 percent of the dentists polled said their patients have questioned them about the connection between periodontal disease and other illnesses.

That heightened public consciousness has been reinforced by health initiatives such as the Surgeon General's 2000 report on oral health, Oral Health America and Healthy People 2010—all of which include an emphasis on the importance of oral health to overall health.

For general dentists, specific measures have been taken that reflect an added emphasis on combatting periodontal disease.

In January 2003, the American Dental Association's Code on Dental Procedures and Nomenclature was updated to include a periodontic screening as part of a patient's Periodic Oral Evaluation (D0120). In addition, the association added a new code entry, Comprehensive Periodontal Examination (D0180), which involves a thorough assessment of the severity and extent of infection among "patients showing signs or symptoms of periodontal disease."

And there's an abundance of such patients, according to the American Academy of Periodontology (AAP). The academy estimates that 75 percent of American adults have some degree of periodontal disease—though eight out of 10 of these people are unaware of it.

What all this adds up to is a growing emphasis today on early diagnosis and treatment. And to upend an aphorism, the buck starts with the general practitioner. "I truly believe that the AAP regards the general dentist as the gatekeeper," says Dr. Samuel Low, an AAP trustee.

The call to address periodontal problems as early as possible presents new challenges and opportunities for general dentists. While some prefer to limit their perio services to data collection and diagnosis, others are eyeing expanding their practices to include comprehensive programs that include non-surgical treatments.

For both groups, consultants and dentists who already have added new perio services have a variety of clinical and practice management tips to offer.

Data collection and diagnosis

It's been four years now since Dr. Linda Golden of Manhasset, N.Y., decided to incorporate more perio treatments into her practice. And today, as soon as a new patient walks through her office door, her staff sets out to take a medical and dental history that includes risk factors unknown a generation ago.

"Physicians," says Golden, "take a family history, asking whether a patient's mother has had breast cancer or if someone died of heart disease, for example. Most dentists don't do that, but we do in my practice. We ask whether anyone in the patient's family has had periodontal disease, for instance, because there are hereditary issues here."

Other red flags that alert dentists to an increased risk for periodontal disease include a history of smoking, diabetes and stress. Also, certain antidepressants and heart medications can increase a patient's susceptibility to oral infection because they reduce saliva flow.

Central to the data collection is the perio exam, which is a topic that can stir debate. A mere screening, say some dentists, can leave a patient's periodontal disease undetected. For instance, the ADA's updated periodic evaluation code calls for dentists to conduct a Peri-

PHOTO: BRAND X PICTURES

odontic Screening and Recording system (PSR), probing six sites per tooth and assigning a grade to the probing depth at each site. The dentist or hygienist records only the deepest site in each of the six sextants of the mouth. A score of two grade threes (4mm to 5.5mm probing depth) or one grade four (5.5mm or greater) calls for a comprehensive periodontal examination, which includes a detailed probing and charting of every tooth and checking other diagnostic criteria, such as clinical attachment loss.

Dr. Joe Trovato of Kearney, N.J., says it's only prudent to use the comprehensive exam every time. "I feel we're missing the boat [with the PSR]," says Trovato, who also incorporates non-surgical perio treatments in his practice and heads up the firm Integrated Periodontal Solutions to help dentists add perio services. "I think that you need to probe and chart six sites per tooth, every single tooth in the mouth."

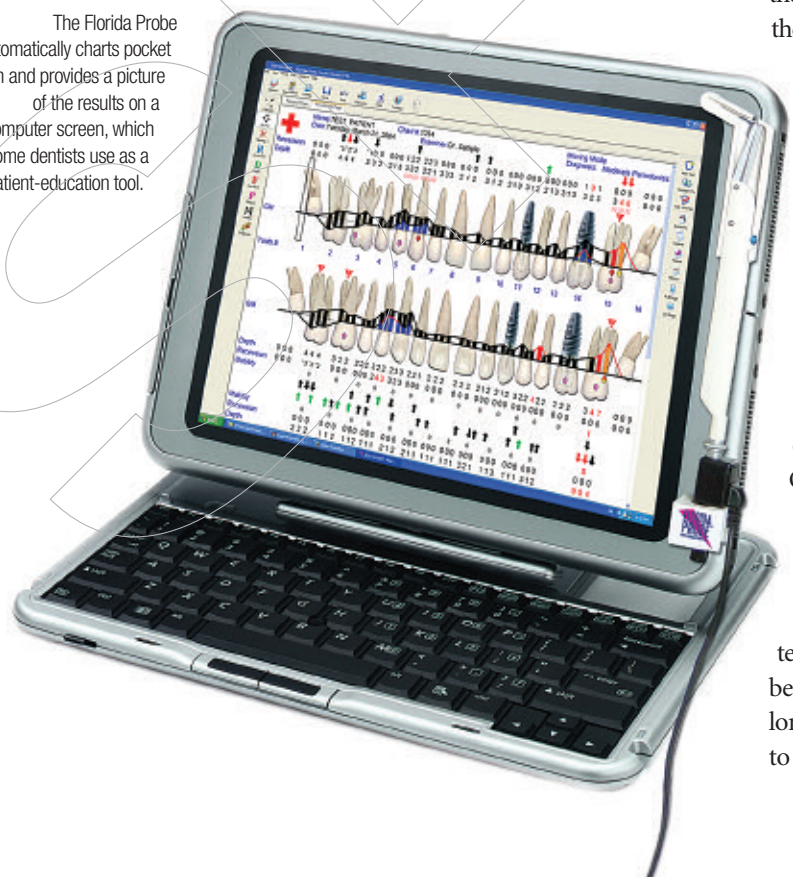
Tracking the change

He explains that since periodontal disease is episodic, it only makes sense to keep detailed records that could chart changing pocket depths over time. "It's generally agreed," he continues, "that a 2-mm change in pocket depth over time is an indication of active disease. Now the only way you're going to be able to realize that is if you chart every pocket measurement so that you can make comparisons down the road."

This approach frequently has proved its value, Trovato maintains. "Very often if patients have a very minor periodontal case, they decide they don't want to go through treatment. But when I probe again on their next visit and those pockets start showing up a little deeper, then they realize that they'd better do something." Trovato recommends comprehensive perio exams for healthy patients at least once a year.

Hein also endorses the comprehensive exam over screening. Hein, founder and president of PointPerio, a consulting firm aimed at helping clinicians incorporate the latest periodontal research into their practices, says, "If you're using the PSR and all you're looking at is probing, it could very well be that the patients might have a 3-mm pocket and there could be 2mm of recession at the same site, which is very different. Now a screener would often say that patient looks great. Yet in other professional circles, that patient would be regarded as having 5mm of clinical attachment loss, which is considered moderate periodontal disease."

When it comes to periodontal probing, 98 percent of the general practitioners in *DPR*'s 2004 survey said they use manual probes. When choosing these instruments, says Hein, it's important to purchase one that all staffers are comfortable with. Consistency is key; different people can apply different pressures when using probes, so the staff "should be calibrated to make sure everyone has the same technique," says Hein.



The Florida Probe automatically charts pocket depth and provides a picture of the results on a computer screen, which some dentists use as a patient-education tool.

PHOTO COURTESY OF FLORIDA PROBE CORPORATION

It was lack of consistency between Golden's probings and her hygienists' that prompted her to adopt a computerized instrument, the Florida Probe. This technology automatically charts and audibly announces pocket depths while also providing a picture of the probing on a computer screen. So aside from not requiring an extra person in the operatory to record readings, the instrument also serves as an educational tool, she says.

The manual probe, she says, "provided no visual for patients. They'd hear me call out [probing depths of] 'five, four, three, two, four,' but they didn't get it. Once they could see it up on the computer, though, they had a better understanding."

'Why didn't you catch this before?'

When a dentist does adopt an improved method or technology for diagnosing periodontal disease, it can be a dicey proposition presenting positive findings to longtime patients. Consultant Dr. Steven Gutter refers to it as the general dentists' fear to diagnose. "It's the

dreaded question that the doctors are scared to death of: 'Well, how come you never told me about this before?'"

Gutter, who lectures widely on adding perio treatments to the general practice, says he provides dentists with something of a rough script to follow. "First, you introduce the probing," he says. "You say, 'we've been following new research and attending conferences on plaque and tartar and gingivitis, and we want to make sure that your gums, Mrs. Jones, are as healthy as possible. So we've routinely been incorporating this new exam for early warning signs of gum disease and we'll be doing that for you right at the outset, OK?'

"So you've just told the patient that there's new research, new information, and in doing so you've answered the question of why you never told her about her periodontal disease before she even asked it."

It also helps if the patient understands exactly what's going on as the dentist probes and charts the results. "What you want to do," continues Gutter, "is enlist the patient as your co-therapist and co-diagnostician."

Once the exam reveals sure signs of periodontal disease, the dentist either refers the patient to a periodontist or opts to manage the problem himself. "We consider early periodontitis to be pocket depths in the range of 3mm to 5mm," says Low, part owner of Florida Probe. "Moderate disease ranges from 5-mm to 6-mm pockets, and severe periodontitis is from 6mm on." Low adds that the best treatment for moderate to severe periodontitis is surgery.

Lucrative pursuit

But non-surgical treatment—namely, scaling and root planning with adjunctive medical therapy—has also proven its worth in managing the disease by fighting bacteria and (though more modestly than surgery) reducing pocket depth. "One of the real problems in periodontal disease is no one knows what success is," Low continues. "We don't cure periodontal disease, and we don't necessarily arrest it as much as we attempt to maintain a more healthy state so that patients can keep their teeth over time."

Those practitioners who have opted for comprehensive perio treatments say the undertaking can be lucrative. For instance, Trovato reports that in 2001, his two hygienists, who handle 90 percent of his perio program, produced $600,000, seeing one patient per hour during a four-day work week.

Still, there are challenges to be met and adjustments made. In Dr. Paul Schwartzman's case, one adjustment involved adding two chairs to his practice in Rockville, Md. The extra space accommodates the expanded perio services, which can involve added time for patient education and treatments. "I have six chairs in my practice and four are for hygiene," says Schwartzman. "So my hygienists always have a clean room to move into."

63%

Dentists who say patients have questioned them about the connection between periodontal disease and other illnesses.

Source: Dental Products Report

While the diagnosis of periodontal disease falls to the dentist, hygienists typically take on much of the data collection, patient education and management of the perio cases. "I'm responsible for the diagnosis and I recommend the treatment, but I also listen to my hygienists' advice," says Trovato. "I've found that hygienists are very motivated by this program; they want to be clinicians."

The treatment

Once the diagnosis is made, getting the patient to agree to treatment—and comply with home-care recommendations—can be a challenge. "There's still a certain number of patients who believe that if insurance doesn't cover a recommended treatment, they don't need it," says Schwartzman. "So I explain that insurance is a benefit; it's a way to defray some of the costs, but it's not a diagnosis."

Schwartzman also provides patients with an analogy. "I tell them, 'You have car insurance, but when you have maintenance on your car your insurance doesn't cover it. You sometimes need to do things that aren't necessarily covered by insurance.'" Other dentists report that pictures illustrating disease progress also are effective treatment-acceptance tools.

Ensuring compliance

On the issue of patient compliance, consultant Gutter suggests that dentists "help the patients be your partners right from the very beginning. You might say, for instance, 'There's nothing we can do that'll overcome what you won't do, Mrs. Jones. So let's not get started if you're the least bit hesitant. Or, if you think that for some other reason you won't do your part, I'd rather you save your money.' And that works very well; it's almost like a negative sell. Patients appreciate that the dentist doesn't just want them to say yes to a recommendation if the investment may not be preserved."

Non-surgical treatments of periodontal disease often center on scaling and root planning followed by local

or systemic anti-microbials to reduce pocket depth. In addition some dentists, such as Golden, have found lasers to be especially useful. "I sometimes do what's called non-surgical laser periodontal therapy to sterilize the pockets, and it gives remarkable results," she says.

As far as Low is concerned, one of the key tools for general dentists in the perio arena is the ultrasonic scaler. That instrument, he says, has "become the panacea of treating patients non-surgically. These devices probably have more magnitude in reducing periodontal disease non-surgically in early periodontitis than any other therapeutic device out there. They move at about 30,000 cycles a second and at the same time they're very thin, so they can go down into the pockets and destroy bacteria. And there's several companies out there that make excellent ultrasonic devices," adds Low.

After scaling and root planing, dentists sometimes treat pockets with locally delivered anti-microbials as an adjunctive therapy. Dr. Gary Greenstein, clinical professor of periodontology at the University of New Jersey dental school, who also lectures on perio treatments for general practitioners, offers advice on choosing antibiotics.

He suggests that dentists closely scrutinize a product's claims. While the local anti-microbials have been shown to significantly enhance scaling and root planning by statistical measures, "the problem is that statistical significance doesn't always translate into clinical significance," Greenstein says. He explains that a statistically significant result might translate to a difference of only 3/10mm in pocket depth. "If that's all the improvement a dentist is looking for fine, but practitioners should be aware of what products can achieve.

"When I lecture," Greenstein continues, "I tell the dentists there are three questions they have to think about: One, what is the magnitude of change that can be induced by the product, how big on average is the bang? Number two, what is the size of the defect that you're treating? Because if you're treating a 7-mm or 8-mm pocket, that (combined with your answer from the first question) will tell you if you're going to get a reasonable result. And third, what is the desired outcome you want? So if you're starting with an 8-mm defect, for example, and if you're routinely going to get a 1mm change with a certain product, is that going to satisfy you?"

Key to treatment is the reevaluation phase. "There will often be certain areas that don't resolve after our initial debridement," says Gutter. "So four to six weeks later, if there are sites that are still bleeding after you reprobe and chart the patient's entire mouth, then you have to go back and retreat."

As with any procedures involving third-party payments, perio treatments in the general practice need to be thoroughly detailed in order to secure reimbursement, dentists say.

Schwartzman adds that since he expanded his perio services, "We've probably gotten more thorough in our diagnosis and charting. So if anything, I'm seeing very little balking by insurance companies because they see we know what we're talking about."

American adults with some degree of periodontal disease. **75%**

80% *Americans with periodontal disease who don't know it.*

Source: American Academy of Periodontology

Billing medical insurance

Trovato typically directs his bills to medical insurers. "Bacterial infection," he says, "is under the realm of medical insurance. So any of the treatment we're doing for periodontal disease has been covered to a large extent from the medical insurance companies, provided it's coded for properly and the details are put in there with narratives. The insurance company needs to know exactly what you're doing."

Dr. Paul Bornstein, cofounder of Dental Office Consultants, says that for most dentists who seek payment from medical insurance, the procedure is to "charge dental first, get turned down and then go to medical using the proper form [HCFA-1500] and correct American Medical Association diagnostic and treatment codes."

Oral surgeons, Bornstein adds, regularly use medical claims. So if a general practitioner needs to know how to bill a medical insurer correctly, the dentist might call up the oral surgeon's office he refers patients to and "ask the person there in charge of billing for guidance." □

Daniel McCann is senior editor at Dental Practice Report. He can be reached via e-mail at dmccann@advanstar.com.