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# hygienetown

*July 2014*

with **Perio Reports** by Trisha E. O'Hehir, RDH, MS



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# Perio Charting

How often does your office perio chart, and do you charge differently for the appointment when you do?



**Healthy Smiles**
Member Since: 10/25/11
Post: 1 of 21

How often does your office perio chart? Do you charge differently for the appointment when you do perio chart? I appreciate any feedback! Thank you. ■

OCT 29 2013

**Crevicular**
Member Since: 02/28/13
Post: 2 of 21

In Federally Qualified Health Centers (FQHC), we see a high volume of patients, so we use the PSR system for quick perio screening. All sites are probed, but recordings are done within the guidelines for PSR, and if indicated then we do full perio charting. Basically none of the Medicaid managing insurers cover periodontal evaluation whatsoever, so we have to incorporate it into other procedures. ■

OCT 29 2013

**ozzy2985**
Member Since: 02/14/08
Post: 3 of 21

We do a full perio charting annually on all patients over the age of 18. Perio patients are updated as needed on individual case-by-case basis with at very least annual charting. We do not charge at this time but did in the past. Patients balked at the fee and insurance did not cover it so we just accept it as standard of care and included in periodic exam. We are paper-less and us the Dental R.A.T foot pedal to enter numbers into computer so we don't need to rely on assistants or office staff to help us. ■

OCT 29 2013

**Tina95**
Member Since: 07/09/07
Post: 6 of 21

We used to charge, but then the insurance would kick out the doctor's exam, so I just include it now. If the doctor is on vacation, and I still see patients then I will do perio exam and charge for it. Most insurance pays only two exams per year. ■

OCT 10 2013

**janha**
Member Since: 06/17/06
Post: 7 of 21

I believe only the DDS can charge out for any type of exam. If you do a perio exam you cannot bill out for it. ■

OCT 10 2013

**Debbirm**
Member Since: 09/24/10
Post: 8 of 21

We perio chart changes at each visit. We probe each bleeding point and previous pocket depths 4mm or greater so that current values/changes are documented. This way, the patient's perio records are updated and current by the end of each visit and healing can be tracked from visit to visit. We are all about healing infection and tracking this at each visit. ■

OCT 18 2013

**Christadent**
Member Since: 12/03/06
Post: 9 of 21

Debbie, what about a 3mm pocket that changes to a 5? When will you know that pocket depth had changed? ■

OCT 18 2013

**jla**
Member Since: 01/14/11
Post: 11 of 21

In Ontario, if we do a perio assessment and charge for it, the dentist must do an exam at that time, and is unable to charge for the doctor's exam. It's one or the other. I probe at each visit, and make note of any changes. ■

MAR 3 2013

This may sound crazy but we do a comp perio eval on each patient every time at no charge. If it's the first time to chart this, it is time consuming using Dentrix and manually entering everything. But after the initial chart we only have to chart any changes than save. I agree with previous posts that state how do you know if a healthy 3mm has changed? We call out the numbers so patients are involved in the process and schedule an hour for recare/perio main, new patients 90 minutes. If there are any areas that need treatment we discuss, educate and usually complete it right then. ■

MAR 3 2013

**Smileyblue75**
Member Since: 01/31/06
Post: 13 of 21

Full mouth probing is done once every year. Spot probing on perio maintainance patients every recall. Spot probing on inflamed areas. I've never hear of anyone charging for perio charting. ■

MAR 3 2013

**CamilleKhazar**
Member Since: 07/17/07
Post: 15 of 21

Have you ever used code 0180? This code is for periodontal examination. Use this code in place of code 0120 when you do a complete perio charting (6 readings, all bleeding sites, recession, mobility and furcations). A complete charting includes healthy numbers as well as readings 4mm or greater. I would advise all patients who are treated for periodontal disease and return for periodontal maintenance appointments (4910) should receive updated probe readings at each of those visits. Updates are included in a 120 exam. Take some time to read your CDT codes for what's expected. This doesn't guarantee reimbursement, but it helps us to know what we should be submitting. ■

MAR 3 2013

**PSooy**
Member Since: 08/18/11
Post: 16 of 21

What does one do if you are only given 45 minutes for 4910 and 0120, possibly with 0274? There is no time for FMP, so spot probing is my only option. I also try to do 4999, but again time is at a premium. I sometimes do get an hour, then I do a FMP. ■

MAR 4 2013

**triciamm**
Member Since: 03/18/07
Post: 17 of 21

Involving the patients in co-diagnosis works best when you use Howard and Trisha's method of telling the patient you are going to probe the surfaces that you brush (buccals, linguals); those will be mostly 2s and 3s. Then tell the patient that you are now going to probe the flossing or toothpicking surfaces. Those numbers can go anywhere, but the patient really starts to pay attention when his 2s start being 4s, 5s and deeper. He then diagnoses his own problems. ■

MAR 4 2013

**shazammer1**
Member Since: 12/20/00
Post: 20 of 21

**Join the discussion online at: www.hygienetown.com**

Perio Charting

## More Interest in Fresh Breath than Oral Health

Despite scientific evidence to prevent both caries and periodontal disease, the incidence remains high. According to the American Academy of Periodontology, 47 percent of Americans have some form of periodontal disease. Dental hygienists focus on the importance of oral health as they provide regular oral hygiene instructions. In spite of repeated instructions, the incidence of periodontal disease, even in clinical practice, remains high.

Repackaging of the oral hygiene message was undertaken by an RDH to determine if using an emotional hook was more effective than focusing on science and logic. Patients are not generally motivated to prevent periodontal disease, but they spend over $3 billion dollars on mouth rinse each year. The majority of patients do not floss or clean between their teeth on a daily basis.

For this study, 60 patients participated. When asked if they wanted information to prevent periodontal disease to have fresh breath, 78 percent chose fresh breath over oral health. When information was presented about cleaning between the teeth, with a variety of interdental tools, patients were receptive when it was linked to having fresher breath. Surprisingly, patients had little understanding of the oral or systemic link and did not understand the role bacteria play in the mouth.

Switching from the scientific educational approach about periodontal disease, bleeding gums and tooth loss to providing patients with ways to keep their breath clean all day resulted in better compliance with daily interdental cleaning. The end result was the same: good oral health; but the motivation was fresh breath, not oral health.

**Clinical Implications: Linking interdental cleaning with fresh breath leads to better patient compliance with daily oral hygiene.** ■

*LaDolce-O'Brien, D.: By Altering My Oral Hygiene Presentation, Will My Patients be More Receptive to Improving Their Oral Health? OHU Action Research 10A-13, 2014.*

**Perio Reports Vol. 26, No. 7**

Perio Reports provides easy-to-read research summaries on topics of specific interest to clinicians. Perio Reports research summaries will be included in each issue to keep you on the cutting edge of dental hygiene science.

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## Cochrane Review of Triclosan/Copolymer Toothpaste: Colgate Total

The Cochrane Collaboration reviewed 30 research studies to determine the long-term benefits of Colgate Total toothpaste compared to a standard fluoride toothpaste. Only randomized, controlled trials were included in the review. A total of 14,835 subjects were included in the 30 published research papers reviewed for this report.

Plaque measurements were compared in most studies after six months. Colgate Total, the only triclosan/copolymer toothpaste tested, showed a 0.5 reduction in plaque using a plaque score of zero to five. This was determined to represent a 22 percent reduction in plaque compared to the fluoride toothpaste group. After six to nine months, gingivitis scores were reduced by 0.3 in the Total group for scores of zero to three. This also represented a 22 percent reduction compared to the fluoride toothpaste group.

Regarding periodontitis, no difference was seen between the Colgate Total toothpaste and the fluoride toothpaste for attachment loss figures after three years of use. For caries incidence, there was a slight reduction in the Colgate Total group, with five percent fewer decayed, missing and filled surfaces (DMFS) after 24 to 36 months.

Adverse effects were not specifically evaluated, but 22 of the 30 studies reported no adverse effects caused by either toothpaste.

The clinical relevance of these findings was not determined for this review paper.

**Clinical Implications: Colgate Total toothpaste containing triclosan, a copolymer and fluoride appears to be safe and effective.** ■

*Riley, P., Lamont, T.: Triclosan/Copolymer Containing Toothpastes for Oral Health. The Cochrane Library Published Online, 5, Dec, 2013.*

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# SENSITIVITY TOOTHPASTE WORKS ONLY WHEN PATIENTS USE IT.

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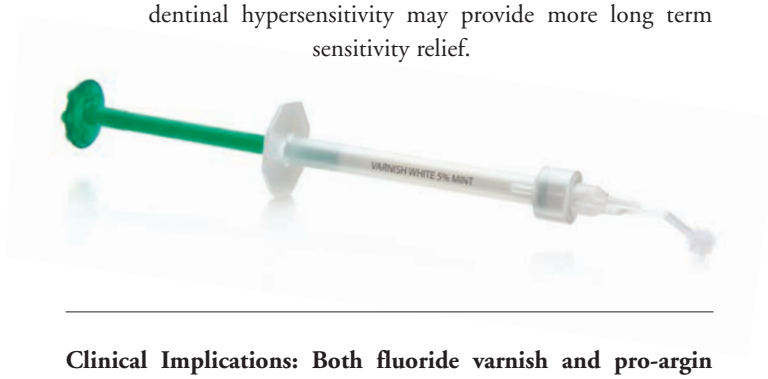
## Fluoride Varnish Reduces Dentinal Hypersensitivity

The incidence of dentinal hypersensitivity varies between eight to 35 percent, depending on the study. Many products are available to treat sensitivity, but there is no gold-standard product that works for all patients. Approaches being used today include: dentin bonding agents, pro-argin technology, amorphous calcium phosphate (ACP), tricalcium phosphate (TCP) and lasers.

Fluoride varnish is used for caries prevention, but it was first introduced and accepted by the FDA as a product to reduce sensitivity. In this small action research project, four patients, ages 28 to 71 years of age, with dentinal hypersensitivity were treated with 5% sodium fluoride varnish. The varnish was applied at the end of the dental hygiene visit. Subjects were tested weekly for sensitivity to touch, air, cold and tooth brushing at baseline for four weeks. All of the test subjects experienced relief to some degree. Some of the subjects experienced more relief than others.

To address the issue of incomplete reversal of the sensitivity, another product was introduced, a polishing paste using pro-argin technology. This was applied with a rubber cup at slow speed for three seconds on the affected area. This was done at the start of the dental hygiene visit, leading to a comfortable appointment for both patient and hygienist. This application resulted in immediate blocking of the dentinal tubules and therefore immediate relief from sensitivity. The combination of these two approaches to dentinal hypersensitivity may provide more long term sensitivity relief.




**Clinical Implications: Both fluoride varnish and pro-argin polishing paste relieve dentinal hypersensitivity.** ■

*Papadakas, M.: Applying Fluoride Varnish to Reduce Dentinal Hypersensitivity. OHU Action Research 12A-13, 2014.*

## Oral Health Behaviors for Nine-Year-Olds

Elementary schools are the ideal place to implement oral health instructions that will impact the future habit of the children. Parents, especially mothers, play a crucial role in establishing oral health habits for their children.

This three month study included 338 children, all 9 year olds. Two test groups and one control group were formed. Students were enrolled from 12 elementary schools in Iran, including six schools for girls and six schools for boys. Baseline examination included a clinical exam and questions of the children about who influenced their oral hygiene practices and about their last dental visit.

The two intervention groups included a classwork group and a parent guided group. The control group received no intervention. The classwork group used puzzles to convey oral health messages about daily toothbrushing and use of fluoride toothpaste. The parents were given a pamphlet about daily toothbrushing and the use of fluoride toothpaste. They were also encouraged to limit sugary snacks and to model good behavior to their children.

Nearly 90 percent of children reported that their parents were their main source of oral health information. Two-thirds, or 68 percent, reported visiting the dentist within the past year. Girls more often than boys visited the dentist.

At baseline, all the boys expect two had bleeding gums. After three months, 60 percent of those in the two intervention groups and 32 percent of controls had improved gingival health (Hawthorne Effect).

**Clinical Implications: Improvement in oral health results from an oral health message presented by either the health counselor or the parent.** ■

*Saied-Moallemi, Z., Murtomaa, H., Virtanen, J.: Change in Conceptions of Iranian Pre-Adolescents' Oral Health After a School-Based Programme: Challenge for Boys. Oral Health Prev Dent 12:(1) 21-28, 2014.*

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This is the third of five installments on the topic of implementing a perio program in your practice. The first installment focused on assessing the periodontal health in your practice, asking, "how healthy are your patients and how healthy do you want them to be?" Answers to these questions provided the foundation for the second installment, focused on getting the conversation going between dentists and hygienists on their philosophies of periodontal treatment and prevention. With those concepts identified, it is now time to create the plan for your perio program. Is it a cookie-cutter plan or individualized for each patient? Our clinical experts provide their perspectives on creating the plan.

**Diane Brucato-Thomas, RDH, EF, BS, FAADH:**

The first step in creating your plan is determining who will gather the periodontal data, treatment plan and present the case. This varies from practice to practice. In many practices, the dentist will perform these duties. However, more than thirty-one years of practice limited to periodontal therapy in general practice, the dentists I worked with only performed preliminary periodontal screenings (like PST) for initial diagnosis of periodontal disease at their examination appointment (complete series of radiographs taken). Then the doctor schedules the patient with me for a full periodontal evaluation and gathering of data.

Before looking in a client's mouth, a thorough review of their health history is complete. It is extremely important to know systemic diseases or drugs that may affect the periodontal and gingival tissues. For periodontal evaluation appointments (and maintenance), I negotiated to be provided an assistant to record on a perio data chart, maintaining infection control and saving time. Missing teeth, mobility, furcation involvement, probe scores, bleeding, purulence, recession, protective gingiva, tooth positioning, occlusion, tissue description, case type, oral habits, risk factors and oral hygiene habits are all recorded.

Once I have the data coupled with the patients' health history, the rest of that appointment is spent on education specific to that patient's situation, reviewing possible options of care, and facilitating their decisions to accommodate the level of commitment and health that they choose for themselves. In this way, potential treatment plans are developed. They may or may not include block anesthesia; they may or may not involve using the endoscope. Everything is individualized to the clients desires and needs. My dentist usually pops his head in to concur with findings and support the treatment plan. It is up to me to determine and present fees for services.

In other practices, the dentist may do all of the above and all you have to do is implement his treatment plan. In this case, you should work together to calibrate. Make sure you agree where to draw the line and how much time you need to provide a service. Some people have bionic hands and can treat a quadrant in 45 minutes. I am s-l-o-w. It generally takes me up to two hours per quadrant. The doctor needs to respect your expertise in determining how much time you want to be scheduled and set fees to accommodate. After all, you do not tell him he can do a crown prep in the amount of time it takes to do a two surface filling. The same goes for scheduling your post-treatment supportive periodontal therapy appointments. A client with recession has a lot more tooth surface to cover than a client with healthy gums up to their CEJs, and it takes more time to be thorough.

In the case of patients who are scheduled with you for maintenance, make it a habit to pick up your probe before you scale, because the moment you pick up that curette/scaler, the message is: "All is well and this is routine." Additionally, learn to effectively read the tissue. Besides bleeding, look for purulence, color, texture and/or swelling of the tissues.

To simplify, if you are new at this, divide findings into one of three groups:

1. 1-3mm, no bleeding healthy routine prophy
   1-3mm, with bleeding and/or purulence gingivitis treatment
2. 4mm with bleeding and/or purulence gingivitis or mild periodontitis treatment varies depending on degree of difficulty
3. 5mm or above with bleeding and/or purulence moderate up to severe periodontitis treatment or refer depending on expertise/level of comfort

If the patient falls within a treatment category, sit them up and tell them, "I'm sorry, I don't feel comfortable 'cleaning' your teeth, because I see infection that needs treatment. I believe 'cleaning' your teeth today would be a disservice."

You can explain the disease process and show their chart, complete with visuals—i.e., red bleeding points and yellow purulence, etc.—then offer the appropriate treatment plan that works for you. It may involve two simple debridement appointments and local antimicrobial delivery; or DNA or saliva testing for more information, followed by several more advanced treatment appointments; or it may simply involve referral to a periodontist. The important points are to recognize disease, communicate your findings and know your limitations.

## Sarah Cottingham, RDH, CEO of BCS Leadership, LLC:

In creating a treatment plan for periodontal therapy it is vital to take into consideration the actual patient. There is no "cookie-cutter approach" to treating periodontal disease. A patient's immune system, age, level of oral hygiene and degree of disease present must be taken into consideration prior to putting together the complete treatment plan.

The codes that we are given in the CPT 2013 coding book are quite limited in regard to providing complete care for every type of periodontal disease scenario that is seen in the dental practice.

With that said, there are many codes that are available for use that sometimes fall to the wayside. Beginning with diagnosing the situation the code D0180, comprehensive periodontal evaluation is a significantly underutilized code. This is a comprehensive code that can be used on an existing patient when periodontal disease has been identified and a comprehensive exam is completed. After the initial diagnosis has been made a plan of attack should be put together that will allow for the patient to have the disease treated to a point of stability.

The additional codes that we have available for use that are significantly underutilized are the codes for testing procedures (salivary diagnostics, oral DNA testing, oral hygiene instruction, nutritional counseling, smoking cessation and many others).

There are many schools of thought in regard to how to schedule for active periodontal treatment. This is where regular team meetings and discussing your periodontal philosophy will have a huge impact. Generally there are schools of thought for full-mouth disinfection versus quadrant or half mouth therapy. If the office is doing two quadrants per visit, generally the appropriate amount of time is one-and-a-half hours per side. Utilizing timesaving techniques such as compounded topical anesthetics that are available will be instrumental in keeping the timeline contained.

Additionally, the practice should begin looking at the amount of time using ultrasonic scalers versus hand instrumentation. There is evidence to support that each has its place and that the utilization of ultrasonic scalers for a larger majority of

*continued on page 9*

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the time can have a significant impact on biofilm and bacterial load reduction. The goal is to get a biologically acceptable root surface in an efficient amount of time with as little hand fatigue as possible, all while keeping the patient comfortable.

When it comes to setting up a patient for success, many offices find value in creating a "convenience area" where patients can purchase items that have been recommended. Generally patients would rather pick up the suggested items at the dental office, rather then tracking down any specialty items recommended. Many offices carry items that can only be obtained from a professional, therefore carrying some of the items is necessary. To assist in making sure that the patient has everything he or she needs to succeed, we find that the most successful practices will send the patients home with literature that supports the home care regimen that was recommended, while supplementing this with an "oral health report card" at each supportive periodontal therapy appointment.

## Rachel Wall, RDH, BS, Owner of Inspired Hygiene:

Over the past 10 years, working with hundreds of practices, we've found that even the best dental teams often have some hidden obstacles. They have some inefficiencies or beliefs that hold them back from fully implementing a progressive perio diagnosis and treatment program.

Most teams have some type of perio system in place and yet there is always room for refinement. When creating your perio plan, here are a few obstacles to look out for and overcome. When you proactively identify and clear these obstacles, you are setting yourself up for success in implementing a perio program.

Of course your perio plan should include a written Standard of Care identifying the disease threshold at which you will recommend treatment for your patients, the proper procedure codes to use, fees for treatment and so on. But there are other pieces of the plan that might not be as obvious, but are just as important to have in place.

**Schedule:** As we've analyzed the hygiene department of hundreds of practices, we often see the hygiene schedule as a primary roadblock to implementing a proactive perio program. The time allowed for the recare appointment is a key factor in perio diagnosis and treatment enrollment. If there's no time for a thorough periodontal exam, disease will often not be detected until later stages. With additional time comes additional expectations. Be sure your perio plan includes a specific checklist for the hygiene exam including how and when the perio exam is completed. And how that information is presented to the patient, including powerful and consistent enrollment language.

Setting aside or 'blocking' time in the hygiene schedule for perio therapy is a major factor in implementing your perio plan. An interesting thing happens in the mind of a hygienist when the schedule is so full, there's no available hygiene appointments for four to six weeks. Even if that hygienist recognizes active infection, if there's no time to bring the patient back for treatment, he/she may think, "Even if I present treatment, there's no where on the schedule for them to come back so I'm just going to do the best I can today and check it in three months." And so the cycle of undertreatment continues. It's not intentional, it is a function of the framework (the schedule) in which that hygienist works.

Once time is set aside for active perio therapy, it's amazing how the perio plan is implemented. Even in a hygiene schedule with open time, having blocks reminds the hygienist to be very diligent in his/her examination of the patients' soft and hard tissues. When disease is present, the sense of urgency is met with a timely visit to treat the infection.

**Finances:** The teams that are the most successful at implementing a perio plan are those that have a confident and well-trained administrative team. When your admin team is confident and excited about the payment options offered, the clinical team is free from the worry about money and whether their patients can afford what they are recommending.

We have as an industry motto that "insurance should not dictate the treatment." We all believe it, but how well we follow this belief varies widely. Yes, insurance and finances are a real part of the treatment process and we must be practical in our approach. I believe we must be creative in finding ways to make it easy for our patients to pay for their dental care. There are options with long-term financing, short-term in-office financing and in-house savings plans. Be sure everyone on your team is familiar with what you offer. Have the admin team present the financial portion of the perio plan with confidence and coordination with the clinical treatment options.

**The Team:** While hygienists and dentists play the biggest clinical role in executing a perio plan, it takes every person on the team to make it a success. When we help teams create their perio diagnosis and treatment program, it is done in a full-team workshop. Everyone is able to voice questions, concerns and excitement about taking perio care to the next level. The cornerstone of any perio program is the belief that optimal care is in your patients' best interest. Educating the entire team on specific oral-systemic connections is crucial to building a strong belief. Presenting optimal care may require you and your team to step out of your comfort zone. Developing a strong conviction that you can't *not* tell your patients when they have active infection will help you on those days when the words don't come out right or you're running behind and want to skip perio charting. It will help your admin and operative teams to confidently answer the patient when they ask, "Do I really need to do this?"

Arm your entire team with the knowledge that developing a clear, consistent, science-based perio program is the foundation for success for both the patients and the practice. ■

Share your experiences with implementing a perio program. Discuss at Hygienetown.com

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