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With the implementation of the Affordable Care Act due to take place this quarter, now may be a good time to reassess our view of dental terminology as it relates to the diagnosis and treatment of various periodontal and implant conditions within the context of interoffice communication as well as insurance reimbursements. Proper management of our patient is dependent upon an accurate and well defined diagnosis using terminology widely recognized by the professional dental community. The problem in Periodontics today is that there are numerous sources suggesting different criteria for defining a diagnosis of periodontitis with differences in definition and a lack in commonality. To date, there is no single consensus document which contains all the information needed to form a diagnosis, shall we say no “gold standard” (Periodontal Diagnosis Affected by Variation in Terminology. J.Perio.2013;84:606-6130) The absence of the requirement to document diagnostic codes in dentistry as part of reimbursement has led to a low level of usage in dentistry as compared to the medical field. Is there any wonder our colleagues sometimes fail to diagnose, refer or treat in the most appropriate manner.

The disconnect between diagnostic codes(ICD) and procedure codes(CPT) may be a result of confusion resulting from research in which data is combined from disparate sites, where similar terms are used interchangeably in the literature, but are taken by different groups of researchers and clinicians to mean very different things. Most recently, Harvard University’s Office of Technology communicated an initiative to standardize diagnostic terminology by combining concepts from ICD9/10 and the American Academy of Periodontology augmented with additional concepts from the literature and expert panels to arrive at what they call the EZ Codes 2012. Catalyzed by the Consortium for Oral Health Research and Informatics, it has been implemented within the axiUm dental electronic health record (EHR). There is speculation that in order for Dentistry to be part of the greater health care paradigm it must be able to interact with the other health care professionals where electronic health records will morph into the Electronic Medical Home and where OUTCOMES can be assessed. PROCEDURE CODES WILL NO LONGER HAVE THE SAME LEVEL OF SIGNIFANCE IN THIS VENUE. The patient centered medical home may provide for screening by ancillary personnel and determine the extent patients see physicians and dentists. This will maximize doctor contact time with the patient. The new health care act will give dentists a chance to participate and interact with other health care professionals and with oversight by an audit trail.

The diagnostic terminology of Peri-Implant disease is even more enigmatic than that of periodontal disease. The American Academy of Periodontology’s Task Force on Peri-Implantitis drafted a statement, approved by the Board of Trustees and published in January 2013, regarding diagnosis, etiology, and possible algorithms to manage the diseased implant site.(Peri-Implant Mucositis and Peri-Implantitis: A Current Understanding of Their Diagnosis and Clinical Implications. J.Perio.2013; 84:436-442.) Briefly, there are two manifestations: Peri-Implant Mucositis and Peri-Implantitis. The former demonstrates inflammation confined to soft tissues without bone loss beyond initial remodeling; the later characterized by soft tissue inflammation with progressive bone loss. Again, evidence based outcomes only occur if a proper diagnosis is ascertained. Also, all implant treatment must be performed with an informed consent emphasizing the need for proper maintenance therapy to avoid peri-implant diseases.

Health care reform appears to be the potential impetus for change in the diagnosing and coding in periodontal and implant dentistry. A clearer understanding of our patients’ condition will lead to proper treatment more aligned to evidence based outcomes. The importance of fee for service will eventually be overshadowed by outcomes, as is predicted for the medical profession. There are insurance reforms being proposed to reimburse physicians for outcomes. Additionally, the general practioners as gatekeeper will be held accountable and fiscally responsible for outcomes of the specialists they refer to, reimbursing the insurance company for any additional expenses that arise from a shortcoming in an expected outcome result.

 For a more detailed review of the referenced articles please visit my website under PerioProbe Newsletter @ www.prospectimplant.com

Best Regards

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