Perio maintenance forever?

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Dear Dianne,

I have a patient who went through root planing/scaling and has been on periodontal maintenance for the last 10 years (D4910). His probing depths are all within normal limits at 2 to 3 mm, with no bleeding on probing. He has recession that has been stable since I've been treating him, and he comes in every six months. His wife called recently and was very upset with our coding. Their insurance does not cover periodontal maintenance procedures at 100% like they would if we used a prophylaxis code (D1110). Our office has two dentists who are recent graduates, and six hygienists. We all need to be on the same page concerning this issue. Could you give us any advice on this matter?

Christy

Dear Christy,

You have posed a great question, one that many hygienists struggle with regularly. I think the initial confusion centered on the strict wording of code D4910, which contains the phrase "for the life of the dentition." Many people took this quite literally and proclaimed "once a periodontal patient, always a periodontal patient." That phrase is true, in the sense that periodontal disease is chronic and must be controlled. However, due to concerns expressed by clinicians to the ADA CDT code committee, a clarifying statement was added to allow dentists to judge how each patient is maintained. Here is the statement:

"This is a matter of clinical judgment by the treating dentist. Follow-up patients who have received active periodontal therapy (surgical or nonsurgical) are appropriately reported using the periodontal maintenance code D4910. However, if the treating dentist determines that a patient's oral condition can be treated with a routine prophylaxis, delivery of this service and reporting with code D1110 may be appropriate."

So they are saying that some people can be maintained with a prophylaxis. I think we have all seen periodontal patients with periodontal disease, who had it treated successfully, who got to a point where they had no signs of active disease. Such patients can be maintained with a prophylaxis.

Let's take the patient in your example. You say he has been stable for a number of years on six-month recare cycles. By "stable," you mean he has no continuing loss of attachment or supporting bone and no signs of active disease. If this gentleman moved to a different city and went to a dental office as a new patient, where after examination they saw no signs of active disease, how would they treat him? Most likely, he would get a prophylaxis.

Carrying this example further, let's say the doctor decides this patient can be maintained with a prophylaxis. Two years later, what if the patient exhibits signs of disease again — bleeding on probing, inflammation, and increased pocket depths? Then the patient has to have definitive periodontal treatment again and will need periodontal maintenance (D4910) until stability returns. If the patient never gets to that stable point, he will need to be maintained with periodontal maintenance indefinitely.

What is the difference between a prophylaxis and periodontal maintenance? A prophylaxis is preventive in nature and includes "removal of plaque, calculus, and stains from the tooth structures in the permanent and transitional dentition. It is intended to control local irritational factors." Said differently, a prophylaxis is for people who may have gingivitis but no signs of active periodontal disease. Periodontal maintenance is therapeutic in nature and includes "removal of bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing where indicated, and polishing the teeth." Periodontal maintenance should always follow definitive periodontal therapy for a period of time, typically one year or longer. I advocate the extensive use of power scalers with thin inserts that are effective in reaching the depths of periodontal pockets for thorough debridement, touching every square millimeter of root surface multiple times, in addition to hand scaling where needed.

One thing that makes our work so interesting is that there is so much variation among patients with regard to

their ability to fight off and control disease. Host defense is not a static entity, but fluctuates over a lifetime. Systemic diseases and stress can cause fluctuations in host resistance, which can lead to changes in periodontal health. One patient may get along well for several years, and then suddenly go downhill periodontally. Sometimes we can pinpoint reasons for such regression, but many times the reason eludes us. People have many differences related to the host and its ability to fight off disease. Certainly a patient's home care is important, but people with established periodontal disease cannot stop or control their periodontal problem without good professional care. Conversely, we have all seen people with terrible oral hygiene who do not progress into periodontal disease. Some patients come to every appointment looking as though they brushed their teeth with a doughnut, yet they do not have periodontitis.

One other caveat I should mention is that some insurance companies have instituted new guidelines that will only pay on D4910 for a period of time, such as two years. One example is United Healthcare. Under pressure from insurance companies and patients, some practices might feel compelled to revert back to D1110 in those circumstances. Beware! Let me be clear that *all clinicians have legal and ethical obligations to bill accurately for what they do.* If the patient is provided with a periodontal maintenance procedure, you must bill D4910, regardless whether the patient's benefits will cover the procedure or not. If a patient receives a prophylaxis, the correct billing code is D1110. (This was covered in the July/August 2008 issue of *Insurance Solutions Newsletter* at www.dental-ins-solutions.com).

Patients are happy when we tell them they have made such good progress that they can be maintained with a prophylaxis. Typically, it is the dental hygienist that monitors the patient's progress closely, and based on the patient's clinical outcome over time, recommends to the doctor what he or she feels is appropriate treatment for the future. The decision is very important to the patient's long-term success and should be decided individually, based on stability or the ongoing signs of active disease.

Further, it's not appropriate to alternate between code D1110 and D4910, as the former is reserved for patients who do not exhibit signs of periodontal disease. How can a person be disease-free one visit, then need periodontal maintenance three months later, then be disease-free in another three months? Keep in mind the nature of the procedures as stated previously — one is preventive, one is therapeutic.

I hope this helps to get everyone in your office calibrated concerning periodontal maintenance. Thanks for spotlighting this important issue!

Best wishes,
Dianne