Once They're Perio., They're Always Perio.. Oh No!

As we treat our patients, we seek out the best treatment options for them. This means we take into account their health status and their ability to follow their home care regimen and treatment plan. Unfortunately, when finances are involved, we begin to question our plan going forward. The 2017 staging and grading guidelines have brought both clarity and confusion to dental hygiene treatment planning and coding.[1] As a dental hygiene clinician, instructor, and graduate student, I want to share with you why a thorough understanding of staging and grading will improve patient health outcomes. With a deeper understanding comes a more calibrated approach to billing and coding. In many patient situations, I have run across the phrase "but, once they're perio., they're always perio." To process this statement and the issue at hand, it is necessary to consider what periodontal disease is, how it progresses, what the dental team can do to stabilize it, and what happens once it is stabilized.

What is obvious is that periodontal disease involves an inflammatory response to irritants that leads to degradation of the periodontium.[2] What is not as obvious is the source cause in each individual patient and whether or not the source has been controlled and stabilized. Are they losing bone due to traumatic occlusal forces, periodontal pathogens, restorative overhangs, fractured roots, or something else? As salivary and genetic testing are not yet widely utilized by dental teams, and clinical attachment loss is not always able to be measured with accuracy, often we rely on periodontal probing, bleeding on probing, and radiographic bone loss as our trusted methods for detecting periodontitis.[3] With this information, in combination with the medical and dental history, adherence to the staging and grading system can become quite comfortable. The system considers how far the disease has progressed, what areas are affected by it, what is likely causing it, and how rapidly is it progressing.[4]

As dental hygienists, we must often decide how to perform accurate, thorough, and optimal treatment on tight schedules. It is tempting to forego or abbreviate sections of treatment to make up time. As new dental hygiene graduates, we come out wanting to conquer the world! As time goes on, frustration with non-compliant patients and overloaded schedules can lead us to apathy and negligence. Next thing we know, we are not discussing with Mrs. Jones why continuing to forego x-rays could be detrimental to her health, because the conversation would "waste time on a patient who isn't going to change." On the next patient, we find localized 7mm pockets on a prophy patient who has been getting spot probed for years! What has happened here? Let's look back at our dental hygiene code of ethics to remind ourselves that beneficence and non-maleficence go hand-in hand.[5] Not only are we reducing our risk of litigation by following our ethical code: we also are giving our patients their best chance at health now and in the future. In order to give them their best chance, we must use our skills and tools to accurately diagnose their gingival status and bring them into a treatment plan that benefits them the most!

If periodontal disease is detected, treatment planning aims to stabilize the disease. At earlier stages, it is hoped that the dental hygienist can work directly with the patient to improve oral hygiene and stabilize the disease. This involves scaling and root planing, improved home care, and adjunct therapies. As staging and grading levels advance beyond our scope of practice, we must refer patients to a periodontist. Periodontists have the knowledge and equipment needed to stabilize periodontal disease once it is beyond our reach. Not wanting to label the patient as periodontally involved because of the financial effects on the patient now and in the future is not a valid excuse for taking away their autonomy. Dental hygienists are prevention providers. Foregoing preventative treatment today can lead to extensive rehabilitation later! For reference, the staging and grading guides are shown below.[6]

Assuming the patient has stabilized periodontal disease, how do we treat their case? The 2017 World Workshop on the Classification of Periodontal and Peri-implant Diseases and Conditions concluded that periodontitis patients remain so for life, and require increased evaluation and maintenance to prevent recurring active disease.[1] This tells us that, indeed, "once they're perio., they're always perio.". Let us not undermine our own education and skills by allowing this fact to keep us from discussing a periodontal diagnosis with our patients and the dentists we work with. The sooner we discover destruction, the sooner we can stabilize the process. A common misconception is that evidence of past periodontal dis-

ease automatically results in the use of periodontal maintenance (D4910) coding. The Code on Dental Procedures and Nomenclature specifies periodontal maintenance as occurring after periodontal therapy and proceeding throughout the life of the dentition.[5] So, a patient with reduced bone levels and recession in many areas, but no pocketing over 3mm and minimal bleeding upon probing who never received periodontal treatment would not need necessarily need scaling and root planing, and would not be eligible for periodontal maintenance coverage. Without a history of periodontal intervention, the patient would be coded for a prophylaxis (D1110), since they fall into a healthy category of stable periodontal disease. Only once there is evidence of active inflammation and/or bone loss would you look into SRP and periodontal maintenance.

As we follow the 2017 classification for staging and grading, we can feel confident in our role in improving the oral and systemic health of our patients. We can fulfill our role as care providers for our patients and give them an important role as informed decision-makers in their own health. The more we approach treatment in this fashion, the more natural it will become. Use your expertise to serve as a role model to your peers, and educate patients how "once they're perio., they're always perio." is not an expletive phrase. On the contrary, it guides our treatment process to better the health of the patient and keep them that way well into the future!

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Staging and Grading Periodontitis

The 2017 World Workshop on the Classification of Periodontal and Peri-Implant Diseases and Conditions resulted in a new classification of periodontitis characterized by a multidimensional staging and grading system. The charts below provide an overview. Please visit **perio.org/2017wwdc** for the complete suite of reviews, case definition papers, and consensus reports.

PERIODONTITIS: STAGING

Staging intends to classify the severity and extent of a patient's disease based on the measurable amount of destroyed and/or damaged tissue as a result of periodontitis and to assess the specific factors that may attribute to the complexity of long-term case management.

Initial stage should be determined using clinical attachment loss (CAL). If CAL is not available, radiographic bone loss (RBL) should be used. Tooth loss due to periodontitis may modify stage definition. One or more complexity factors may shift the stage to a higher level. See **perio.org/2017wwdc** for additional information.

	Periodontitis	Stage I	Stage II	Stage III	Stage IV
Severity	Interdental CAL *(at site of greatest loss)*	1 – 2 mm	3 – 4 mm	≥5 mm	≥5 mm
	RBL	Coronal third (<15%)	Coronal third (15% - 33%)	Extending to middle third of root and beyond	Extending to middle third of root and beyond
	Tooth loss (due to periodontitis)	No tooth loss		≤4 teeth	≥5 teeth
Complexity	Local	• Max. probing depth ≤4 mm • Mostly horizontal bone loss	• Max. probing depth ≤5 mm • Mostly horizontal bone loss	In addition to Stage II complexity: • Probing depths ≥6 mm • Vertical bone loss ≥3 mm • Furcation involvement Class II or III • Moderate ridge defects	In addition to Stage III complexity: • Need for complex rehabilitation due to: – Masticatory dysfunction – Secondary occlusal trauma (tooth mobility degree ≥2) – Severe ridge defects – Bite collapse, drifting, flaring – < 20 remaining teeth (10 opposing pairs)
Extent and distribution	Add to stage as descriptor	For each stage, describe extent as: • Localized (<30% of teeth involved); • Generalized; or • Molar/incisor pattern			

PERIODONTITIS: GRADING

Grading aims to indicate the rate of periodontitis progression, responsiveness to standard therapy, and potential impact on systemic health.

Clinicians should initially assume grade B disease and seek specific evidence to shift to grade A or C.

See **perio.org/2017wwdc** for additional information.

	Progression		Grade A: Slow rate	Grade B: Moderate rate	Grade C: Rapid rate
Primary criteria	Direct evidence of progression	Radiographic bone loss or CAL	No loss over 5 years	<2 mm over 5 years	≥2 mm over 5 years
Whenever available, direct evidence should be used	Indirect evidence of progression	% bone loss / age	<0.25	0.25 to 1.0	>1.0
		Case phenotype	Heavy biofilm deposits with low levels of destruction	Destruction commensurate with biofilm deposits	Destruction exceeds expectations given biofilm deposits; specific clinical patterns suggestive of periods of rapid progression and/or early onset disease
Grade modifiers	Risk factors	Smoking	Non-smoker	<10 cigarettes/day	≥10 cigarettes/day
		Diabetes	Normoglycemic/no diagnosis of diabetes	HbA1c <7.0% in patients with diabetes	HbA1c ≥7.0% in patients with diabetes

The 2017 World Workshop on the Classification of Periodontal and Peri-Implant Diseases and Conditions was co-presented by the American Academy of Periodontology (AAP) and the European Federation of Periodontology (EFP).

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