Where are the diagnostic codes in dentistry?

During a small group session the other morning, dental students were well into a discussion about the use of antibiotics for different situations, and it became clear that some students were having trouble segregating certain information to make the appropriate treatment recommendation. As observed many times before, the accumulation of facts were not being fully collated and logically directed toward a diagnosis. Instead, a quantum leap was being made from the collation of a few signs or symptoms to the end point, the treatment plan. This unfortunate occurrence is common in dentistry, where a few facts translate to a plan of action, and in my opinion it reflects the overall “get ‘er done” attitude of dentistry and many Americans. This “get ‘er done” attitude is not all bad, because many accomplishments result from action; however “get ‘er done” should not be advocated without analytical processes that allow us to reflect on what needs to be “got done.” Haste to treat before making a diagnosis renders the dentist more a technician than a professional.

Ours is not the only profession that benefits from making decisions in a logical sequence before implementing a plan of action. During the recent football season, I heard television sports analysts comment on why National Football League (NFL) quarterback Peyton Manning is so good and talented. In addition to his physical size, they touted his mental capacity. Analysts were fascinated by his ability to “process information better than any other” and “recognize defenses and makes rapid adjustments.” And, although his decision-making skills did not result in a Lombardi trophy for the Colts that day, these skills did bring about much of his team’s consistent success throughout the season that led them to Super Bowl XLIV.

Consistency in decision making relies on collecting, collating, and connecting the important information. Like NFL quarterbacks, we too are presented with information, albeit from a patient and not a 6-feet 5-inch rushing lineman. Once the patient presents, we must collate the information, sequence the information, distinguish what is important, and assign a diagnosis within a certain time frame. Whereas Peyton Manning or Drew Brees sees 5 lineman at the line of scrimmage and a scheme of linebackers and then diagnoses “blitz from the right side,” we review information from the medical history, collate signs and symptoms from the physical evaluation, select and review the findings from diagnostic tests (e.g., radiographic, clinical, and laboratory evaluations), and synthesize these facts, resulting in diagnoses, such as “periodontal disease,” “chronic periapical inflammation,” or “squamous cell carcinoma.” Both professionals filter through the information presented, select the most important information, and arrive at a decision/diagnosis then call the play, in our case a treatment plan item.

Unfortunately, dentistry in general lacks emphasis on making and recording diagnoses. This is quite evident in our treatment planning and billing procedures. For decades, dentists have been reimbursed from insurance companies without diagnoses, as long as the appropriate procedural code is entered and filed. This is evident in the review of many private practice dental records, which reveal procedural/billing codes but seldom diagnoses. On the surface, this could indicate to the public that we are more interested in procedures than diagnoses, and is this the message we want to be sending to the public?

In contrast, our medical colleagues use diagnostic codes as well as procedural codes for reimbursement. Within the medical system, the International Classification of Diseases, 9th Revision (ICD-9) codes are well established and used. This diagnostic classification scheme provides several advantages, including the use of a common language and standard criteria, the requirement for evidence for use of diagnostic codes, as well as the ability to track relationships between diagnoses and treatment. This system also provides the basis for qualitative and quantitative outcome measures that contribute to improvements in public health. Many dentists and dental specialists in the USA who bill
medical insurance already use these standardized codes; however, a large percentage of general dentists are likely unaware of these diagnostic codes and would benefit from their use, albeit training would be required. In my opinion, the benefits outweigh the disadvantages, because implementation of the diagnostic sequence is critical for proper treatments that lead to relief or cures in dentistry as well as medicine. Clearly, the adoption of diagnostic codes would represent a major paradigm shift for dentistry; however, foresight in the adoption of diagnostic codes would be a proactive and critical step for implementing electronic health records by 2015 as recommended by the National Health Information Infrastructure of the Department of Health and Human Services.

One hundred seventy years after the establishment of the first dental school in the USA, it is good to remind the profession that “diagnosis dictates treatment.” We should also be reminded that both patients and clinicians benefit from the diagnostic sequence in which a final diagnosis is formulated and rendered based on the collection of data in an accurate and logical manner, and that these diagnoses lead to treatments that are desired and needed and help prevent lawsuits based on “failure to diagnose.” After all, doctors are human and occasionally make mistakes that could be minimized by making and recording proper diagnoses. If we truly want to minimize the uncertainty and errors in dentistry, the use of diagnostic codes is a step in the right direction that can make us more like the professionals that we profess to be.

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