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Exactly What IS the Hold Up?

I FULLY appreciate that everyone is very busy. In fact, I cannot recall when there has been so much to do, and so little time in which to do it. That is also true of my faculty practice time—time that I particularly relish in an otherwise very hectic schedule. I truly enjoy the limited time I have available to spend with my patients, in spite of their demands on my time, my clinical skills, and what is left of my intellectual resources. I appreciate the fact that patients today bring tremendous challenges to my diagnostic skills, even though my educational background and decades of practice have appropriately trained me to face these challenges. Looking back on my 21 years as a prosthodontist, the types of patients I now see and treat are vastly different from those I treated at the inception of my career in 1984. They are more challenging, have more complex oral and systemic conditions, are more demanding, and are much more difficult in terms of the diagnostic and technical complexity they present with. Certainly, the use of dental implants and improvements in prosthetic materials have enabled us to rehabilitate these individuals to proper form, function, and esthetics in new and exciting ways, but I still contend that the patients I now treat present with more clinically difficult conditions than those I treated earlier in my career in prosthodontics.

The increasing demand for prosthodontic services by a much savvier group of consumers has changed the face of the prosthodontist's practice; we have begun an era in which we base clinical therapies on scientific evidence instead of dogma. It is a wonderful time to be in dentistry, and especially in prosthodontics.

The American College of Prosthodontists (ACP) has worked diligently to enhance our abilities to provide exemplary services for our patients. This has occurred in a variety of ways. First, the ACP has provided watchful diligence over the educational standards for our postgraduate training programs, and has greatly enhanced all programs with contemporary educational and clinical guidelines. Second, the ACP's Center for Prosthodontic Education continues to provide exceptional continuing prosthodontic education geared toward our members and general practitioners alike. Third, the ACP, in conjunction with ADEA, has promoted several contemporary educational training programs as pre-meeting symposia that continue to enhance the teaching skills of faculty in our predoctoral and graduate training programs. And fourth, the ACP has developed three classification systems[1–3] for assisting us in the diagnosis of patients in need of prosthetic services.

That being said, I have to ask, "Where are YOU with implementation of the three ACP Classification Systems in your own practice?" And, if you have NOT begun to use them, I have to ask "Exactly what IS the hold up?" The ACP has invested nearly 25 years, and countless man-hours and financial resources, in development and implementation of the three classification systems. Recently, the ACP Board of Directors renamed them the Prosthodontic Diagnostic Index (or PDI) to simplify the nomenclature. The PDI can be used to classify patients based on a diagnosis of the complexity of their oral conditions at the time of initial presentation. Each of the PDIs uses categories for patient diagnosis, from Class I (uncomplicated) to Class IV (most complex or high-risk patient). The PDIs are now part of the

College's Parameters of Care document (the next edition of the Parameters will be published in late 2005 or early 2006 as a supplement to the *Journal of Prosthodontics*). Additionally, the PDIs have been incorporated in the latest edition of the Glossary of Prosthodontic Terms, scheduled for publication later this year. Individuals challenging the American Board of Prosthodontics certification examination are required to use the PDIs when presenting their patients. And, any clinical articles sent for review to the *Journal of Prosthodontics* are now required to classify patients using the PDI.

From a clinical viewpoint, the benefits of incorporating the PDIs into your practice are tremendous. First, the PDIs enable you to more accurately diagnose a patient prior to initiating treatment, which should lead to improvements in patient care. Second, implementation of the PDIs should improve communication with colleagues with whom you share treatment of patients—think about it, everyone knows what a Type I, II, III, and IV Periodontal patient is, so why shouldn't they understand what a Class I, II, III, and IV PDI patient is? Third, use of the PDI is the best way to justify specialty-level fees to patients and to other third-party payers for reimbursements (hasn't this been a problem with our specialty long enough?). Fourth, it gives us a standard (it "sets the bar," so to speak) for strongly recommending *when patients should be referred by a general dentist to a specialist for treatment*. Fifth, the PDI (at least, the Completely Edentulous part), has recently been included as an official part of the ICD-9 coding! In fact, the ICD-9 will have a complete set of dental codes within the next 2 years! This is of critical importance to those prosthodontists who do their own surgery and maxillofacial prosthetics. And finally, for those of us in academics, the PDIs can provide an improved screening tool for admission clinics, and provide a standardized set of criteria by which to measure outcomes for research and clinical treatments.

With so many positive aspects of the PDI, exactly what, then, is the hold-up for its implementation? Some say it is the responsibility of the dental schools to implement the PDI; while this is taking place, it may take years to fully implement them, and to graduate sufficient numbers of predoctoral students to have an impact. Some may say the PDI is too difficult to locate, and too complex to understand; for those individuals, I have provided the journal references below. I would also direct you to the Blackwell homepage, and the ACP website (www.prosthodontics.org); the bottom of the ACP homepage links you to the "Prosthodontic Classification Systems," which enables a download of the original PowerPoint slides for review and training purposes. The ACP homepage will soon have forms you can download for clinical use of the three PDIs. Additionally, at this year's ACP annual session in Los Angeles, training in the use of the PDI will occur on Wednesday. Some may even ask how the use of PDI can be implemented into their own practice. For me, it was simple—every patient I see for an oral examination or consultation receives a detailed letter from me, outlining what our clinical findings were, and what my recommendations for their therapy are (whether it will be performed by me or someone else). I use a standard letter I modify with each patient's particular information, to "customize" the letter to their specific needs. This has saved me a tremendous amount of time over the years by not having to create an entire letter for every patient I see. In this "form" letter, I have added the following paragraph: "Based on the clinical information gathered during our data gathering appointment, and using the American College of Prosthodontists' (ACP) Prosthodontic Diagnostic Index (PDI), I would classify your existing oral condition as a Class (III or IV), which is (one of the two, or the) most complex types of oral condition that exists. Based on this classification, the ACP would strongly urge you to seek treatment by a trained a Prosthodontist." Since it is rare for me to actually see a PDI Class I or II patient, this paragraph works for me in the vast majority of cases. I use a similar paragraph in my consultation letters to general dentists, other specialists, and attorneys (the changes should be obvious). I use a similar paragraph in letters to third-party payers. For each of the letters, I ALWAYS PROVIDE THE REFERENCES (see below) for their information. Is it working? Personally, my acceptance rate for treatment plans is now very high (above 90%), and I have had several third-party payers inquire about obtaining more information on the PDIs over the past year or two. Given the ever-challenging patients that we see and treat, I am not sure I could provide the same level of diagnosis (and thus, care) without the PDIs. Can you?

1. McGarry TJ, Nimmo A, Skiba JF, Ahlstrom RH, Smith CR, Koumjian JH. Classification

system for complete edentulism. J Prosthodontics 1999;8:27-39.
2. McGarry TJ, Nimmo A, Skiba JF, Ahlstrom RH, Smith CR, Koumjian JH, Arbree NS. Classification system for partial edentulism. J Prosthodontics 2002;11:181-193.
3. McGarry TJ, Nimmo A, Skiba JF, Ahlstrom RH, Smith CR, Koumjian JH, Guichet GN. Classification system for the completely dentate patient. J Prosthodontics 2004;13:73-82.
4. www.prosthodontics.org (at the bottom of the home page, click on "Prosthodontic Classification Systems" for the PowerPoint presentations)
5. www.prosthodontics.org (enter "Members" section, and click on "Journal" to access the references in # 1-3 above)

The next time you see one of the authors of the PDIs listed above, take a moment to thank them for their dedication, their time, and their significant contribution to the specialty of prosthodontics. They deserve our gratitude for making prosthodontics a diagnosis-driven specialty!

David A. Felton, DDS, MS, FACP
Editor-in-Chief,
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American College of Prosthodontics