Epic Hygiene

BIOLASE

Epic Hygiene Practice Guide

Welcome to the BIOLASE family with your purchase of the Epic Hygiene Dental Laser

Epic Hygiene

EPIC HYGIENE PRACTICE GUIDE

Written by:

Samuel B. Low DDS, MS, MEd
Lynn Atkinson, RDH
Angie Wallace, RDH

The Epic Hygiene™ is a dental laser intended for the treatment of specific soft-tissue conditions, in particular for the ablation, vaporization and coagulation of oral soft-tissue, including marginal and interdental gingival and the epithelial lining of free gingiva.

Epic Hygiene utilizes a solid-state diode as a semiconductor source for invisible infrared non-ionizing radiation. The energy is delivered to the treatment site via a flexible fiber connected at one end to the laser source and the other end to the handpiece. Various types of single-use, disposable tips are designed and optimized for different applications. The device is activated by means of a wireless footswitch.

This is a prescription device that is indicated for professional use only by dentists and other licensed dental professionals, such as dental hygienists, where permitted by state or local practice regulations. The use of this device requires proper clinical and technical training. This manual provides instructions for those professionals that have completed the appropriate training.

When used and maintained properly, the Epic Hygiene will prove a valuable addition to your practice.

Several states allow delegation of duties consisting of laser procedures to the dental hygienist. With a significant amount of nonsurgical periodontal care already being rendered by the dental hygienist, the addition of laser to the periodontal armamentarium provides a synergistic approach to the patient.

WHY A LASER

Periodontal disease is a multifactorial risk condition that has not only a microbial etiology but also a host inflammation component. The bacterial aspect is in the nature of a microbiome comprised of many organisms. The response to local factors such as biofilm, calculus, and endotoxins results in a hyperactive inflammatory response that destroys connective tissue and eventual loss of teeth. There also exists an oral-systemic connection.

The nonsurgical periodontal procedure of choice is periodontal debridement (scaling and root planing) generally performed by a dental hygienist. The objective is to remove local irritants from the root surfaces of teeth and thus decrease the inflammatory response.

There are varying opinions of what procedures to perform for various periodontal conditions; however, removing or decreasing the microbial etiology and enhancing wound healing/repair are the cardinal principles of periodontal management. The clinician is wise to use appropriate data collection, including risk assessment to make decisions regarding the choice of treatment.

A general rule is to base a choice of surgical versus nonsurgical periodontal care on pocket depth, existence of local factors, furcation involvement, nature of bone loss, and compliance. Nonsurgical periodontal care with pocket depths less than 6 mm, calculus on roots, few concavities, edematous tissue, and horizontal bone loss is effective with periodontal debridement augmented with local laser therapy.

The diode laser can enhance periodontal debridement effect by its antimicrobial properties, distending the sulcular wall for ultrasonic access, decreasing hemorrhage for improved visualization, and possibly enhancing wound healing by biostimulation.

Indications for using the laser with the Epic Hygiene include:

- Pocket therapy
- Perio debridement/curettage
- Aphthous ulcers/herpetic lesions
- Hemostasis

CAN A DENTAL HYGIENIST USE A LASER?

While the majority of states allow a dental hygienist to use a dental laser, the dentist and hygienist should be aware of their respective statutes and regulations. Areas to note should be level of supervision, necessary training/certification, and the circumstances under which a particular kind of laser can be used and how it can be used in those circumstances.

Quality training is essential through groups such as the Academy of Laser Dentistry. As an example, some states allow the hygienist to only perform laser bacterial reduction with an uninitiated tip and less than 0.5 watts while others are more liberal and include use of the device in soft-tissue curettage.

In states that do not allow hygiene laser use, it is suggested that the laser be placed in the hygiene operatory with the appropriate settings and attention to safety protocols. After the hygienist prepares the patient, including anesthesia, the dentist performs laser perio debridement on respective periodontal sites to gain access. The dental hygienist completes the procedure with ultrasonic instrumentation.

IS THERE A RETURN ON INVESTMENT?

The acquisition of a diode dental laser is not cost-prohibitive when one considers the enhancement to periodontal procedures and use in multiple other dental procedures.

While there are no reimbursement third-party codes specific to laser management, practices do increase the fee for nonsurgical periodontal procedures by as much as 50%. Developing the appropriate script to deliver a laser treatment plan is key for patient education and acceptance.

As with many areas of effective delegation to our dental hygienists, adding laser technology to our dental practice adds tremendous value for our respective patients. Explanation and education from all team members to the patient is essential for consistent and beneficial use of the laser.

OVERALL MANAGEMENT OF THE PERIODONTAL PATIENT: "THE TOTAL SOLUTION"

In general, dental patients can be categorized into a periodontal diagnosis of four categories:

Gingivitis, Early Periodontitis, Moderate Periodontitis and Severe Periodontitis. All gingivitis and early periodontitis should be managed in the practice of general dentistry with gingival debridement (Prophylaxis) and periodontal debridement (scaling and root planing).

Pocket Therapy is considered to be a laser procedure where debris can be reduced in the sulcular area in a conservative fashion and generally can be performed at the beginning of any dental hygiene appointment to prevent cross-contamination and reduce inflammation risk.

For nonsurgical periodontal care and a diagnosis of **early periodontitis**, the following patient characteristics are encountered.

1. Pocket Depth: greater than 3 mm possibly with Class I furcations
2. Local factors as calculus
3. Edematous
4. Horizontal Bone loss

For **moderate to severe periodontitis** we can observe the following characteristics

1. Pocket depths 5mm greater generally with Class II or greater furcation involvement
2. Minimal local factors as calculus
3. Fibrotic gingivae
4. Multi-rooted
5. Angular bone loss

Perio Debridement includes sulcular debridement with epithelial and granulation tissue removal and implemented only during a periodontitis diagnosis. When 4 mm pockets with bleeding on probing, clinical attachment loss (CAL) or 5+mm pockets are present, we consider Perio Debridement (Laser Assisted Periodontal Therapy) added to scaling and root planing treatment plans.

When periodontal debridement **does not** manage the periodontal condition, especially with moderate to severe periodontitis diagnosis, the dentist or periodontist performs a surgical laser minimally invasive procedure as REPAIR Perio™.

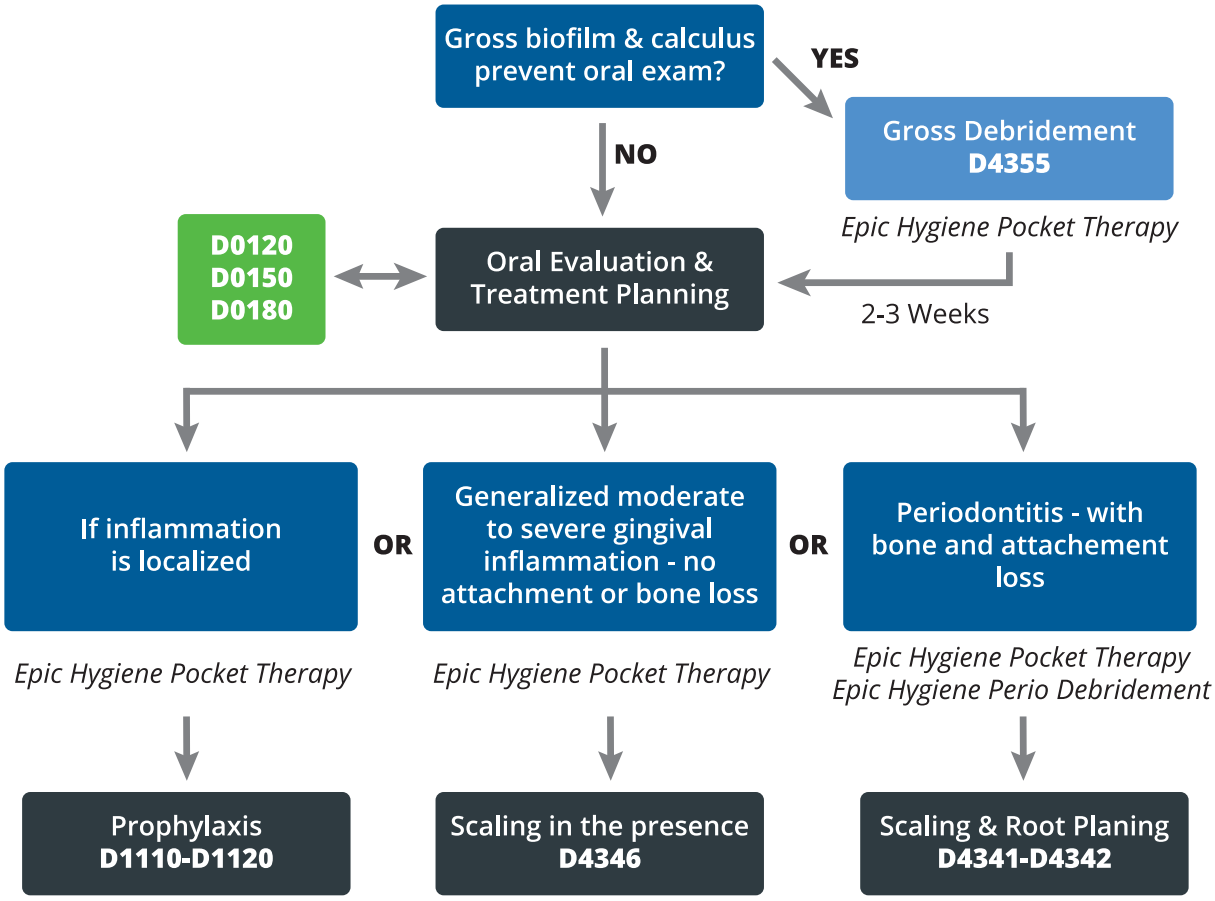
The Epic Hygiene is capable of performing the following procedures. Each will be explained in detail as to rationale and technique.

SETTINGS:

Preset	Preset Name	Mode	Peak Power	Average Power	Pulse Length	Pulse Interval	Duty Cycle	Tip
1	Pocket Therapy	CP10	5 Watt	0.5 Watt	10µs	90µs	10%	E4
2	Perio Debridement	CP50	1.6 Watt	0.8 Watt	20ms	20ms	50%	E4[3] / PI4
3	Curettage	CP50	1.6 Watt	0.8 Watt	20ms	20ms	50%	E4[3] / PI4
4	Aphthous Ulcers[1]	CW	0.7 Watt	0.7 Watt	N/A	N/A	N/A	E4
5	Herpetic Lesions	CW	0.7 Watt	0.7 Watt	N/A	N/A	N/A	E4
6	Hemostasis[2]	CW	0.5 Watt	0.5 Watt	N/A	N/A	N/A	E4

These presets are suggested average settings and patient's tissue type, pigmentation, bleeding, pain threshold, severity of the disease, procedure and individual health concerns should be taken into consideration and adjustments made accordingly. The key is to observe tissue changes and adjust if needed.

The following are treatment sequence plans for both a gingival debridement (prophylaxis) with laser ***Pocket Therapy*** and periodontal debridement (scaling and root planing) with ***Perio Debridement***.



I. GINGIVAL DEBRIDEMENT — PROPHYLAXIS
(*Either New Patient or Recare Patient*)

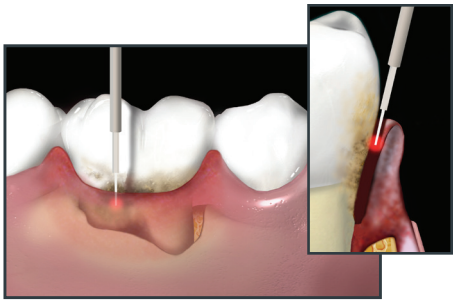
1. Review the patient's medical (including blood pressure), dental, and social history and assess their present status.
2. Acquisition of appropriate radiographs and diagnostic images.
3. Comprehensive oral examination.
4. Enhanced soft tissue and mucosal examination.
5. Periodontal probing.
6. Comprehensive Periodontal Evaluation/Charting (including pocket depth, bleeding on probing, suppuration, furcations, clinical attachment loss, and mobility)
7. Assessment of the information obtained and the establishment of a treatment plan with the associated treatment time required, related costs, and responsibilities
8. Oral hygiene assessment and focused detailed oral hygiene instructions.
9. Optional Glycine/Erythtol air polishing
10. ***Pocket Therapy***:***
    Epic Hygiene setting for **Pocket Therapy** (uninitiated tip with length selection based on access, generally E4-4)

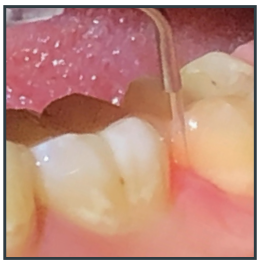
Preset	Preset Name	Mode	Peak Power	Average Power	Pulse Length	Pulse Interval	Duty Cycle	Tip
1	Pocket Therapy	CP10	5 Watt	0.5 Watt	10µs	90µs	10%	E4

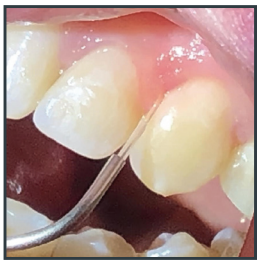
– There is no need for local or topical anesthesia.

– Aim the tip into the sulcus, but do not enter sulcus, or if you feel you need to, go only 0.5 mm into it.

– If tip self-initiates (tissue starts to stick to the end) wipe off the debris so that the laser energy will enter the sulcus. Make slow short horizontal exploratory strokes at the entire pocket entrance especially interproximal mesial –distal and also buccal lingual. Include the entire tooth without using pressure against the tissue. The average time is 10 seconds per tooth. Pocket Therapy can be performed at the beginning or at the end of the hygiene procedure as indicated.







11. Ultrasonic and manual instrumentation.
12. Re-evaluation of the patient's oral health status and treatment outcomes.
13. Ongoing maintenance and observation.

II. PERIODONTAL DEBRIDEMENT — SCALING AND ROOT PLANING (*Either New Patient or Recare Patient*)

1. Review the patient's medical (including blood pressure), dental, and social history and assess their present status.
2. Appropriate radiographs and diagnostic images.
3. Comprehensive oral examination.
4. Soft tissue and mucosal examination.
5. Comprehensive periodontal evaluation/charting (including pocket depth, bleeding on probing, suppuration, furcations, clinical attachment loss, and mobility.)
6. Oral hygiene assessment and custom oral hygiene instructions.
7. Possible Glycine/Erythritol air polishing
8. Assessment of the information obtained and the establishment of a treatment plan with the associated treatment time required, related costs, and responsibilities.
9. ***Pocket Therapy*** (optional)
10. ***Perio Debridement:***

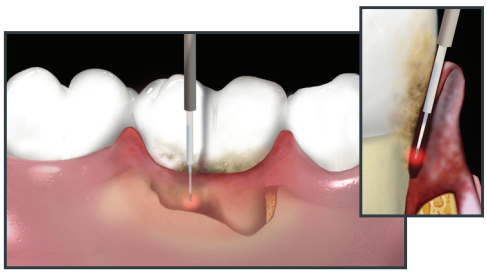
    Must have definite local or sulcular topical anesthesia due to removing tissue. If Topical Anesthetic is needed — Apply a very small amount of topical into pocket and allow anesthesia to penetrate the pocket tissue for 60 seconds (follow the product instructions). Rinse and suction — the patient should avoid swallowing topical anesthetic.

    Epic Hygiene setting for ***Perio Debridement*** (initiated tip with length selection based on access generally E4-7(manual initiation required) or PI 4-7 (BIOLASE Pre-initiated tip.)

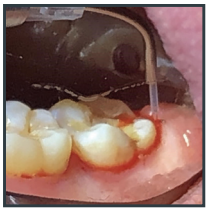
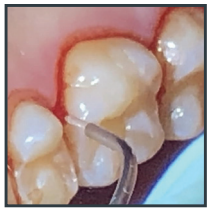
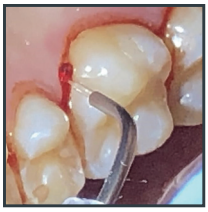
Preset	Preset Name	Mode	Peak Power	Average Power	Pulse Length	Pulse Interval	Duty Cycle	Tip
2	Perio Debridement	CP50	1.6 Watt	0.8 Watt	20ms	20ms	50%	E4[3] / PI4
3	Curettage	CP50	1.6 Watt	0.8 Watt	20ms	20ms	50%	E4[3] / PI4

– Always use suction — high suction evacuator tip. Point the laser fiber towards the sulcus parallel to the tooth. Insert the fiber to the full depth of the pocket and without activating the laser gently probe the geometry of the pocket. Enter the pocket and activate the laser. Move the tip in short slow horizontal and diagonal working strokes to debride necrotic tissue. Angle the tip slightly towards the tissue without pressure on the tissue.

– Treatment is most often performed by starting in the interproximal area and moving the fiber within the pocket buccal or lingually (circumferentially) around the tooth to the opposite interproximal area.



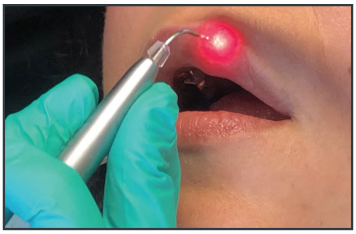
Some clinicians use a zigzag motion from the top to the bottom of the pocket, then use a cross-hatch motion from the bottom to the top of the pocket. Wipe the tip with water-soaked gauze as needed. Take care not to disrupt current attachment; never touch the bottom of the pocket.

- Total time in pocket should not exceed 60 seconds. **Note:** Always angle the fiber away from the tooth surface. Now we have tissue access and can proceed to power instrumentation.
- Ultrasonic and manual instrumentation. The goal is to remove calculus, debris and biofilm from the root surfaces of the tooth and pocket and to flush out the debris from the pocket Use slim ultrasonic tips, triple bend (right and left angled tips optional.) Light hand instrumentation of the tooth and root surfaces as needed and if so, use specialized specifically designed curettes. Inspect the root surfaces with an ODU Explorer and remove any remaining calculus or deposits. Diode lasers are NOT indicated for calculus removal, only Erbium YSGGlasers as the BIOLASE Waterlase line of all tissue lasers.
- Apply finger pressure to the gingiva to place it in close contact with the tooth structure to obtain the close adaptation of the soft tissues to the root surface and to help control the environment while the clot is being formed and organized.

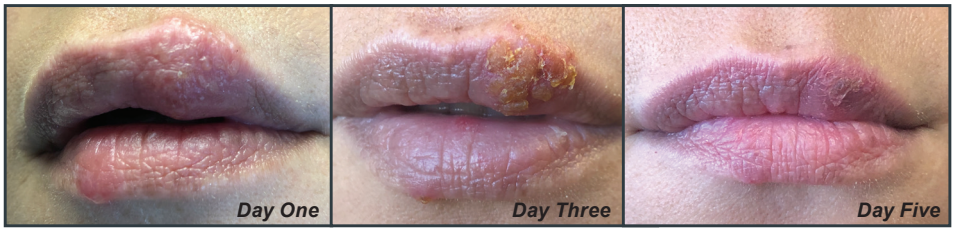
11. Re-evaluation of the patient's oral health status and treatment outcomes.
12. Post-operative instructions and specific home care instructions.
13. Re-evaluation in 90 days and 3 months ongoing periodontal maintenance with retreatment as necessary.
    NOTE: DO NOT PROBE THE POCKET FOR A MINIMUM OF 90 DAYS.

III. TREATMENT OF ORAL ULCERATIONS — HERPES LABIALIS AND APHTHOUS ULCERS



The laser energy kills the surface viral or microbial etiology, inactivating the lesion. Therefore, the active process is stopped and lesion retracts and heals. The severity, frequency and reoccurrence of the lesion is significantly reduced. The lesion will still go through the normal healing stages but at a much accelerated rate (typically reducing a 10-14 day healing time to 3-5 day healing time). Nerve endings may be insulated/cauterized, so the symptoms subside (itching, burning, tingling and pain are relieved.)

Be vigilant for other lesions, as this is also successful for denture sores, sores from removable orthodontic aligners, and sores from fixed orthodontic appliances.



Patients become passionate disciples for your laser dental practice.

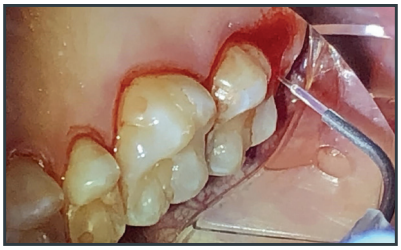
Step-by-Step Protocol

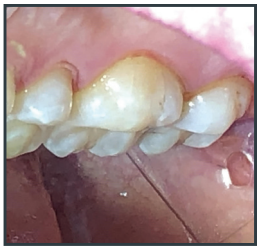
1. Do not anesthetize. In most cases anesthesia is not required but since the threshold of pain varies, patient response should be monitored. If at any time pain is elicited the energy output is lowered or a topical anesthetic should be applied.
2. Use the **Aphthous Ulcers** setting with an uninitiated tip (E4-4)

Preset	Preset Name	Mode	Peak Power	Average Power	Pulse Length	Pulse Interval	Duty Cycle	Tip
4	Aphthous Ulcers[1]	CW	0.7 Watt	0.7 Watt	N/A	N/A	N/A	E4
5	Herpetic Lesions	CW	0.7 Watt	0.7 Watt	N/A	N/A	N/A	E4

3. Hold the E-4 tip perpendicular to the lesion at a distance of 2 mm from the surface and begin lasing the tissue with a circular motion. Continue to lase the entire lesion as well as the tissue slightly beyond the borders (3mm) of the ulcer for approximately 45 to 90 seconds.
4 Allow the lesion to rest for 10 seconds then repeat the procedure 3 times. Lasing is complete when the patient no longer feels pain from the ulcer or possibly when the visual appearance has changed to white appearance.
5. **Mandatory:** high volume evacuation (HVE) tip near the field to eliminate the "plume" generated from the laser effect.
6. No antibiotics are necessary and a saline rinse can be used on occasion.

IV. HEMOSTASIS





Hemostasis is achieved when adequate zone of the remaining tissue is elevated to a temperature above 60 degrees centigrade. The heat spreads to the surrounding tissue and coagulate blood since it is a diode target chromophore.

Step-by-Step Protocol

1. Use the **Hemostasis** settings with an E4-4 or 7.

Preset	Preset Name	Mode	Peak Power	Average Power	Pulse Length	Pulse Interval	Duty Cycle	Tip
6	Hemostasis[2]	CW	0.5 Watt	0.5 Watt	N/A	N/A	N/A	E4

2. This requires slow movement of the tip after removing any clot with a wet gauze. Finger pressure is then necessary to complete hemostasis.

REQUIRED PATIENT CHART DOCUMENTATION AND EXAMPLES

Laser Documentation can include the following:

1. Laser manufacturer, brand, and type
2. Tip used
3. Emission mode: Continuous/pulsed
4. Energy/power settings
5. Area lased
6. Time of Exposure
7. Safety precautions – **wavelength specific** eye protection worn by patient and clinician and all others in attendance.

EXAMPLE: POCKET THERAPY

- Pocket therapy performed prior to prophylaxis
- BIOLASE Epic Hygiene 980nm diode laser
- E-4-4 non-initiated tip used, 0.5 watts (average power) used in pulsed mode (CP10).
- 5 minutes for full mouth
- Wavelength specific safety glasses worn by clinician and patient
- Patient tolerated the procedure well and post op instructions given.

EXAMPLE: PERIO DEBRIDEMENT

- S/RP performed UR quadrant with LA 2% Lidocaine 1:100,000 epi.
- Laser Soft Tissue management was utilized for curettage (Laser Assisted Perio Therapy)
- Biolase Epic Hygiene 980nm diode laser
- EPI 4-7 initiated tip, 0.8 Watt Perio Debridement setting. CP50,
- 8 minutes for URQ
- Wavelength specific safety glasses worn by the patient and clinician and all in attendance.

EXAMPLE: APHTHOUS ULCER OR HERPETIC LESION

- Ulcer/Lesion treated w/ Biolase Epic H Diode Laser 980nm
- Located on upper left labial mucosa
- E-4 non-initiated tip 0.7 Watt, Continuous Wave mode for 90 seconds
- Wavelength specific safety glasses worn by patient and clinician.
- Patient tolerated the procedure well and post op instructions given.

BILLING GUIDE

This resource has been designed especially for BIOLASE customers to assist with billing and coding procedures associated with your laser. Share this information with all team members – starting off on the same page means there is a common message being shared with patients! Your administrative team will likely refer to this guide often. Clinical team members will find tips for documentation. Many offices will create clinical chart note templates with these guidelines. Feel free to create your prompts based on this guide so that all relevant information is captured. (see **Procedures** for more information).

Documentation plays a huge role in obtaining reimbursement. Many insurance carriers will return claims with additional requests. Diligent and comprehensive record keeping can help with this frustration. Look for Coding Tips throughout the guide.

During the course of patient treatment, you will be tasked with diagnosing, talking with and providing treatment for your patient. We hope this guide simplifies the billing and documentation part of that process.

USE OF CODES

The procedures below are the most commonly used among laser clinicians. You may start with a few procedures and then begin to utilize your laser more often. Be sure to keep a current coding manual in the office so that all team members can be familiar with dental codes. The American Dental Association (ADA) offers coding manuals and an app for your mobile device.

You must always code for performed services. Many offices code 'helpfully' for the patient so that higher reimbursement is made. This is not only against the law (insurance fraud) but against the ADA's Code of Ethics. Become familiar with the codes so that you not only bill but document correctly.

> Code descriptions in your software are often truncated versions of the full code. A coding manual will provide the full details.

CODING PROCEDURES WITH LASER INVOLVEMENT

Reimbursement trends for laser specific procedures are still evolving. While many of the discussed procedures are reimbursable by carriers they must be submitted with accurate documentation. This includes images and narratives. It is recommended to submit a narrative that includes required information. The information is carrier specific. The mention of laser usage in the initial narrative should be used only if necessary. Most carriers do not reimburse additionally for laser procedures.

> Coding for **Herpes labialis and aphthous ulcers** is **CODE 7465**. (D7465 – destruction of lesion(s) by physical or chemical method, by report.) Examples include using cryo, laser or electro surgery. Code D7465 is the one and only procedure code that is specifically technique-sensitive to the laser.

By checking benefits prior to the patient's treatment, you can become more familiar with any reimbursement limitations.

EVALUATIONS

Periodontal evaluations are not used as often as they should be. A comprehensive evaluation includes but is not limited to assessment of both hard and soft tissue, risk factors, occlusal function and oral health history. A periodontal evaluation (D0180) includes all of this but for a patient with signs and symptoms of periodontal disease. You are most likely using D0150 when you could use D0180.

D0171 is perfect for follow up appointments after an operative procedure. Many providers spend a good deal of time and do not charge for this time. If you are spending time and using materials along with operatory space then it could make sense for you to charge for this appointment.

Laser bacterial reduction (LBR) does not have its own code, however D4999 is often used. Another common finding is that any submission of D4999 for LBR is 'bundled' into the larger procedure. As a result, some offices utilize a certain HIPAA form to avoid filing a claim for that service. You can check the Non-covered Services section of this guide for information on charging a code but not submitting it to an insurance company.

D4999 is a code used to report any periodontal procedure that doesn't quite fit the current code offerings. List any material costs and describe the procedure as clearly as possible. Remember that your narrative should paint an easily understandable image of the situation. An appeal after a denial will likely need to be filed to obtain benefits.

*https://www.ada.org/en/about-the-ada/principles-of-ethics-code-of-professional-conduct

CDT Code	Nomenclature	Low	Middle	High
D0150	Comprehensive oral evaluation - new or established patient	86	116	145
D0171	Re-evaluation – post-operative office visit	63	86	108
D0180	Comprehensive periodontal evaluation - new or established patient	96	131	165

THIRD-PARTY REIMBURSEMENT ISSUES

BEST PRACTICES FOR CLAIMS SUBMISSIONS

The fact that you are using a laser to obtain the best results for the patient is not essential to the claims process. Because not every dentist is yet using a laser it is a fair assumption that reviewing claim consultants may not have experience with the procedure. The codes themselves (save for one) do not mention laser therapy at all. The descriptions for scaling and root planing and the treatment of peri-implantitis do not mention modality. For this reason, it is not necessary to call out the usage of a laser in the initial claim submission. Should it come to an appeal feel free to discuss laser therapy but hopefully your claims will be paid and that is unnecessary.

Most carriers provide benefits for two hygiene procedures in a plan year. If a patient has more than that be sure to let them know. No surprises!

BUNDLING OF SERVICES & DOWNCODING

Carriers often **“bundle”** submitted services to determine benefits. The language on the Explanation of Benefit (EOB) indicates that an ‘alternate benefit’ or ‘alternate treatment allowance’ has been applied. Bundling results in reduced benefit to the patient and a reduction in fee for the provider. If you are not contracted by the carrier then the balance of the fee charged is the patient’s responsibility.

Contracted providers often need to appeal these bundling situations. We’ll address that in a bit.

"Downcoding" is often confused with bundling. Downcoding is when the original procedure code is acknowledged but a different benefit is applied. The patient’s contract is allowing a lower level of benefits. Often insurance consultants are used to make these benefit determinations. A common example of downcoding is scaling and root planing.

Submitted Procedures	Contracted Fee	Non-contracted Fee
D4341 – upper left	Copayment billable to patient	Copayment billable to patient
D4341 – lower left	Copayment billable to patient	Copayment billable to patient
D1110 - prophylaxis	–	–

Carrier has determined that the information submitted does not support SRP benefit criteria.

This results in a much larger patient responsibility and can be difficult to explain. Insurance coordinators often become familiar with the clauses of problematic codes such as SRP and gingivectomies. This helps them to submit the necessary information with the original submission and reduce their appeals.

Always send current full periodontal probing with SRP and osseous surgery claims

PATIENT FINANCIAL CONVERSATIONS

Accurate copayment estimations will build trust and preserve the office-patient relationship. Patients will lose faith in your office as a whole if they receive a surprise when opening a billing statement. To combat this, use language that shows you have given your best estimate of treatment. Consider using these phrases when discussing financial arrangements:

- "This is our best estimate of your co-insurance costs. If I find out it will be different, I’ll let you know." (Follow-up is key here!)
- "We do our best to research your plan and how it will work in our office."
- "We find with this procedure that many plans don’t cover it. I’ll do my best to get it covered but I would plan on not having it covered." (Good for procedures such as gingivectomies, periodontal irrigation.)
- "Many patients have questions about their benefits – that’s we’re here for!"

Your patients look to your office to help them with their benefits. It doesn't really matter if you're contracted or fee-for-service. Patients simply aren't as aware of their benefits as we'd like them to be. Always be ready for these conversations with an estimate of patient costs and financial arrangement forms.

What happens if the patient ends up with a larger than expected responsibility? Be upfront with the patient. A key conversation piece is to enlist the patient to help you with any appeals. Mention to them that they may need to contact their Human Resources department to help with a stubborn denial.

> Don't be afraid to role-play these conversations! It's better to practice on each other than to fumble with a patient!

Try these conversation soothers:

- We're surprised it's not covered too. We plan to appeal it and we'll keep you updated.
- Other patients are also surprised when plans don't cover procedures. You're not alone!
- I'm going to appeal this, but we find that it helps when patients also call the carrier or their HR department.
- Insurance is to assist not to cover completely

Keep the patient updated on any surprise denials – they may be annoyed but it's better than surprising them with a large bill. Being helpful and **CONFIDENT** with your conversations will show your patients that they've selected the right partner for their dental needs.

Consider **PATIENT SCRIPTING** to explain the following:

- What is a laser?
- How does it work?
- Is it safe?
- Why do I need it for my condition?
- What are the adverse events?
- Do I need more than one treatment?

The key is **COMMUNICATION**.

- Entire team is educated in the correct verbiage
- Use key phrases
- Educate the patient
- Have open communication
- Reiterate information (Doctor exam, front office hand-off)
- Provide handouts and information for the patient

AND always, continue with education and training as procedures and protocols are continually changing and advancing. The Academy of Laser Dentistry (www.laserdentistry.org) is an excellent resource.

Billing and coding information courtesy of:

TERESA DUNCAN, MS

ODYSSEY MANAGEMENT, INC.

www.OdysseyMgmt.com.

BIOLASE

biolase.com

Epic Hygiene

EPIC HYGIENE PRACTICE GUIDE

BIOLASE, INC.

4 Cromwell
Irvine, CA 92618 USA

Telephone: (888) 424-6527
Telephone: (949) 361-1200
Fax: (949) 273-6687
Service: (800) 321-6717

MADE IN THE USA