



HEALTH PROMOTION SPECIALISTS

100 Old Cherokee Road, Suite F PMB 14, Lexington, SC 29072

1-800-276-2398 • 803-234-8892 • www.hps-sc.com

March 7, 2014

Federal Trade Commission
Office of the Secretary Room H-113 (Annex X)
600 Pennsylvania Avenue NW
Washington, DC 20580

Dear Honorable Commissioners,

I am writing to submit comments for the "Examining Health Care Competition (Health Care Workshop) Project No. P13-1207. With my written testimony, I have included a summary of research supporting my comments. The research papers are included on an enclosed disc due to their size.

I thank you for holding this workshop. As past president of the American Dental Hygienists' Association, I had the honor of testifying at the last workshop the Federal Trade Commission held over a decade ago. I was also very involved with the commission and their investigation and subsequent charges and sanctions brought against the South Carolina State Board of Dentistry. The commission's involvement has been instrumental in bringing care to tens of thousands of underserved populations that otherwise would not have been afforded access to dental hygiene services. The Health Promotion Specialists' program has seen over 20,000 children each year, and most on a continuing care basis.

Thank you for your interest in this area of competition. We still have many barriers that need to be removed, but your involvement is helping to break these barriers down, bringing help to vulnerable and underserved populations and saving taxpayers' hard earned money.

Should you have any questions, I can be reached at 803-348-2973 or tbyrd@hps-sc.com

Sincerely,

Tammi O. Byrd, RDH
CEO/Clinical Director

"promoting health with a smile"

Health Care Workshop Project No. P13-1207

Other factors that should be considered when analyzing the competitive implications of professional regulation of healthcare:

1. Professional trade associations' tactics to control costs and regulations that will affect change in the delivery, supervision level and reimbursement of services.
 - a. Although they claim to operate separately, The American Dental Association (ADA) controls the accreditation of dental related schools, through The Commission on Dental Accreditation (CODA), that teach dental hygiene and dentistry and soon dental therapy. This control allows them to change standards to increase and decrease the influence each profession has with regulatory and legislative bodies. For example:
 - i. Dental hygiene accreditation standards stated for decades that dental hygienists' "process of care" must include the ability to conduct a dental hygiene diagnosis. As dental hygienists changed state statutes and gained less supervision and increased practice settings, the CODA removed "dental hygiene diagnosis" from the standards and started lobbying legislators and regulatory boards that dental hygienists cannot "diagnose" and therefore should not be allowed to have direct access to patients. I was educated to the level of dental hygiene diagnosis and all programs still teach to that level or above. In fact, the South Carolina Dental Association tried to pass legislation that stated a dental hygienist could not perform a "diagnosis". I was able to use the accreditation standards to have their legislation changed to say a "dental diagnosis" for a dental treatment plan.
 - ii. The proposed dental therapist standards contain language stating that "a dentist must diagnose and treatment plan". This language has been included for the exact reason "dental hygiene diagnosis" was removed from the dental hygiene accreditation standards. It is an effort by organized dentistry to regain and control the flow of dental related income directly to dentists, regardless of the lack of evidence to support these efforts.
 - b. The ADA credentials dental specialties (orthodontics, periodontics, pediatric dentistry, public health, etc.). On November 4, 2013, the ADA House of delegates passed Resolution 33 that states "in order for an area to become or maintain recognized as a dental specialty, it must be represented by a sponsoring organization: (a) whose membership is reflective of that proposed or recognized specialty; (b) in which privileges to vote and hold office are reserved for dentists who have either completed a CODA-accredited residency program in that proposed or recognized specialty or a formal advanced education program. (c) that demonstrates the ability to establish a certifying board".
 - i. The American Association of Public Health Dentistry has served as the sponsoring organization for many years. It has also served as the certifying board for the specialty of public health dentists, through a standing committee that only includes dentists that have either completed a CODA-accredited residency program in that proposed or recognized specialty or a formal advanced education program. However, its membership has included anyone interested in public oral health including dentists, dental hygienists, medical doctors, etc., all of which have been able to hold office and vote. The

passage of this resolution is directly related to the associations becoming an ally for increased access to dental hygiene and dental therapy services and recently having a dental hygienist as president. It is wrong to force an organization to change how it is governed if it meets the criteria to be able to certify a specialist.

- c. The ADA owns dental insurance codes used for reimbursement by private insurance, Medicaid/Medicare, and private payers. They can control who is reimbursed and cause costs to be higher through the codes and definitions they develop.
 - i. There are very few codes that accurately reflect the services delivered by dental hygienists, especially for those having direct access to patients and/or working independently (dental hygiene diagnosis, etc.)
 - ii. Code D2990 was recently created for a new product in the USA. It has been used in Europe for many years as a sealant. The procedure requires no drilling, no anesthesia, and no loss of tooth structure – easily a procedure that the need can be determined and delivered by a dental hygienist. The code has been classified as a restoration rather than a sealant to drive costs higher and to make it less likely for a dental hygienist to place and get reimbursed. This product could be widely used by dental hygienists to treat incipient lesions in young children and the elderly – populations that are underserved and experiencing the greatest proportion of preventable dental disease. (See attachment A)
 - iii. ART/ITR (Atraumatic restorative technique or Intermediate therapeutic restoration) requires little to no removal of tooth structure, no drilling, and no anesthesia. It is in harmony with the paradigm shift to minimally invasive dentistry based on maximum preservation of tooth structure and minimal discomfort and pain. It places sealant material over a cavity. This seals out the food supply and starves the bacteria stopping decay and in many cases reversing the decay. It is a cost effective way to treat many populations and has years of research to support it. (See attachment B)
- d. The regulation of the dental hygiene profession by boards that are overwhelmingly comprised of dentists is a major factor keeping services from vulnerable and underserved populations. In most states there are more dental hygienists than dentists, yet they are being charged licensure and registration fees but have little to no representation. Dentists have a vested economic interest in controlling the education, licensure and practice of dental hygiene.

Interdisciplinary boards required to make evidence based decisions may be a possible solution to many of the regulatory problems. They could cut costs of regulation and help diminish the vested economic interests that are clearly evident now.

An independent and interdisciplinary commission that develops and oversees insurance codes for all medical and dental professions would be a step forward to having universal codes without undue influence by one profession.

Schools should be accredited by an independent accrediting agency.

TREATING CARIOUS LESIONS BY RESIN INFILTRATION

by Shannon Brinker CDA, CDD • www.cpsmagazine.com

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"A view from the other side"

CONTEMPORARY PRODUCT SOLUTIONS

The CPS Evaluation Team combine product review for the whole team consisting of dentists, assistants, hygienists, patient coordinators and the dental laboratory review this product. CPS produced the following comments and reviews following its evaluation.

"Wait and See" is an everyday occurrence in dental offices. Every day, we observe small areas of demineralization that are too small to restore but do require attention and treatment. Historically dentists and hygienists have had only 2 principal options for treating carious lesions in their young patients; remineralization therapies for those too small to restore and restoration of those that have progressed into dentin. There is a third option, a "bridge" treatment that closes the gap between remineralization and restoration- **resin infiltration**. Beginning in January 2013 the ADA Council on Dental Benefits Program has concluded that resin infiltration is a discrete procedure not currently in the CDT Code and should therefore be included. The concept was thoroughly investigated by

the Counsel which included expert testimony and a complete review of all clinical and scientific evidence. Data recently published shows that resin infiltration reduces the progression of "watch and see" lesions to a fractional percentage of those treated by other means.

Code D2990- resin infiltration of incipient smooth surface lesions involves lesions on all but occlusal surfaces. The description of the procedure in the 2013-14 Code describes the treatment as "placement of an infiltrating resin restoration for strengthening, stabilizing and/or limiting progression of the lesion".

An infiltrating resin is designed to penetrate and fill the sub-surface pore system of an incipient caries lesion. Therefore, resin infiltration is a restorative procedure, not a sealant. It places a

penetrating resin into the lesion without the need to drill a hole. The innovative treatment utilizes a special "high-penetration" resin (Icon® - DMG America) which is drawn into the lesion by capillary action. Once inside the lesion, the resin sets up a barrier which research has shown substantially reduces the progression of lesions. Because Icon is encased within the enamel, below the surface, it is not subject to the normal wear and marginal discoloration that affects traditional composite restorations. The procedure requires no drilling, anesthesia or loss of any tooth structure. Unlike even the most conservative Class 2 restorations, Icon preserves both healthy and demineralized tooth structure and provides a completely new way to treat early caries thanks to this remarkable breakthrough.



Figure 1.



Figure 2.



Figure 3.

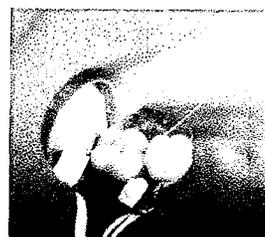


Figure 4.



Figure 5.



Figure 6.

Photo Credit: Dr. Marcio Garcia dos Santos and Dr. Vera Mendes Soviero

For the test and receive credit or request a sample please go to <http://cpsmagazine.com/one-cc-credit-treating-carious-lesions>