

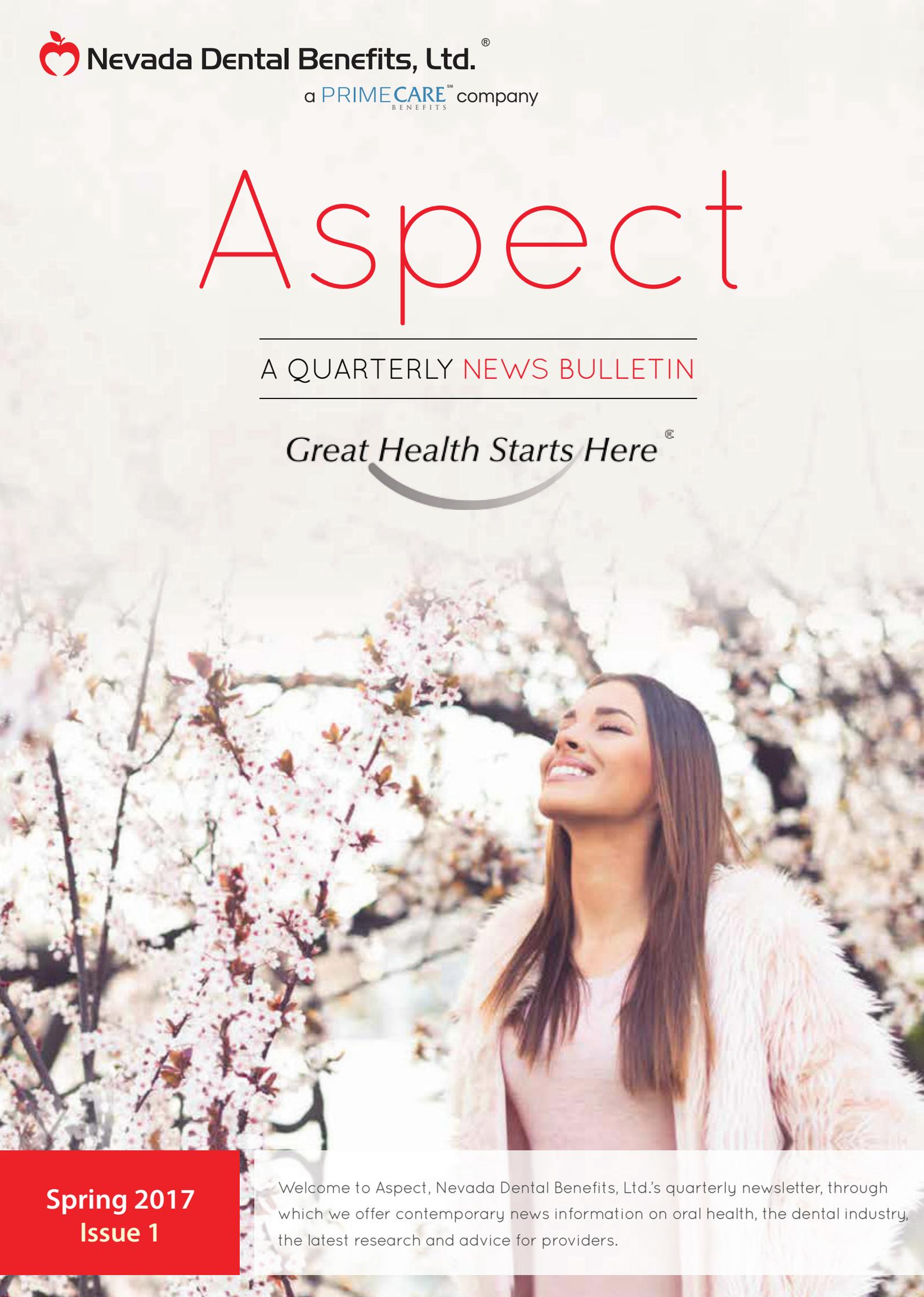
 Nevada Dental Benefits, Ltd.®

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Aspect

A QUARTERLY NEWS BULLETIN

Great Health Starts Here®



Spring 2017
Issue 1

Welcome to Aspect, Nevada Dental Benefits, Ltd.'s quarterly newsletter, through which we offer contemporary news information on oral health, the dental industry, the latest research and advice for providers.

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ARGININE, CALCIUM TOOTHPASTE COMBATS DENTAL CARIES

By Laird Harrison | Medscape

Adding arginine and calcium salt to fluoride toothpaste makes it more effective in preventing dental caries, a large new clinical trial shows.

Children using the experimental toothpaste for 2 years had 17.7% fewer decayed, missing, and filled teeth than children using a standard fluoride toothpaste, researchers from Colgate-Palmolive reported in an [article published](#) in the November issue of *Caries Research*.

"It is clear that arginine, [sodium monofluorophosphate], calcium-salt formulations do reduce caries over time," Clifton Carey, PhD, a professor of cariology at the University of Colorado in Aurora, told *Medscape Medical News*. Dr. Carey was not involved in the study.

Public health researchers have credited fluoride with dramatically reducing the prevalence of dental caries, but the disease remains very common worldwide, spurring researchers to look for new compounds to use against it.

Although researchers do not completely understand how arginine combined with insoluble calcium affects caries, evidence suggests it changes the acid balance in saliva.

In dental caries, bacteria metabolize sugar to produce acids that dissolve calcium phosphate in tooth enamel. When the bacteria metabolize arginine and insoluble calcium, they produce ammonia, an alkali, making saliva less acidic. Formulations of arginine and calcium may also replace calcium that has dissolved from tooth enamel.

Previous clinical trials in people at high risk for caries have shown that toothpastes with fluoride, calcium, and arginine could reverse small early carious lesions more effectively than toothpastes with only fluoride as an active ingredient after 6 months of use. However, these studies did not show whether the arginine toothpastes could prevent actual cavities from forming during a longer period in a population at low to moderate risk for dental caries. Researchers have also wondered whether arginine was more effective when combined with dicalcium phosphate or calcium carbonate.

To answer these questions, P. Kraivaphan, from the Faculty of Dentistry, Mahidol University, Bangkok, Thailand, and colleagues recruited 6000 children 6 to 9 years of age in Bangkok, where the fluoride level in tap water is less than 0.3 parts per million.

The researchers randomly divided the children into 3 groups of equal sizes. One group received toothpaste with 1.5% arginine and dicalcium phosphate. One group received toothpaste with 1.5% arginine and calcium carbonate. Both of these toothpastes contained 1,450 parts per million of sodium monofluorophosphate. The control group received a toothpaste with silica and 1,450 parts per million of sodium fluoride.

At 24 months, 1,679 children remained in each group. At the end of 1 year, all 3 groups had a lower prevalence of caries than when they started. After 2 years, the prevalence of caries had risen to levels similar to baseline in the 2 arginine and calcium groups but had risen above baseline in the control group. The arginine and dicalcium phosphate group, which started at 0.51 decayed, missing, and filled teeth, dropped to 0.25 at 1 year and then rebounded to 0.49 at 2 years.

In contrast, the arginine and calcium carbonate group started at 0.49, dropped to 0.26 at 1 year, and then finished at 0.51. The control group started at 0.49, dropped to 0.24, and then finished at 0.62.

Changes in caries were similar whether the researchers counted the number of damaged teeth or the number of damaged tooth surfaces.

At the end of the study, the difference between the 2 arginine groups in decayed missing and filled teeth was not statistically different ($P = .82$), but the difference between the arginine and dicalcium phosphate group and the control group was statistically significant ($P = .001$), as was the difference between the arginine and calcium carbonate group and the control group ($P = .007$).

The researchers recorded no adverse reactions to the toothpastes. Few studies have shown superiority of anticaries compounds relative to controls in populations at only moderate risk for caries, the researchers point out.

"The ability of this study to demonstrate superior efficacy for the arginine-containing dentifrice relative to the fluoride only control could, thus, be viewed as a strength of the study," they write.

They also cite previous studies showing that arginine-containing toothpastes were more effective than control toothpastes, regardless of which type of fluoride the controls contained (sodium fluoride or sodium monofluorophosphate). In addition, they point out that previous studies have shown the arginine and calcium combination effective not only in enamel caries but also root caries.

Still, these studies do not add up to enough evidence for dental professionals to recommend arginine and calcium toothpastes to their patients, said Dr. Carey. "We still need more studies to demonstrate the mechanism of action of the arginine and any interactions that may be apparent with the toothpaste composition."

The study was funded by Colgate-Palmolive, and some of the authors are employees of that company. Dr. Carey has disclosed no relevant financial relationships.



Meet NDB's Dental Director Patricia Steiner, DMD. Currently a Dental Quality Alliance Ambassador, Certified Dental Consultant and member of the American Dental Association, Nevada Dental Association and Southern Nevada Dental Society, Dr. Steiner is using her 17 years of experience in the healthcare industry to provide valuable tips as our resident dental expert.

CDT Code D4346

D4346 is a new 2017 CDT code available for scaling in the presence of generalized moderate or severe gingival inflammation. As you integrate this treatment code into your practice, the following information may be helpful from a benefits perspective:

- ▶ CDT Code D4346 covers treatment for the full mouth, and must be completed after the oral evaluation.
- ▶ We interpret generalized to mean 30% of the remaining teeth are affected, and documentation of the diagnostic findings supporting the use of D4346 is required for the claim to be considered.
- ▶ Periodontal charting should record the presence or absence of (pseudo) pocket depths and bleeding on probing.
- ▶ Photographs may be helpful to document the presenting condition.

Please refer to the member's plan benefit information for specific plan guidelines, copayment and frequency limitations or contact one of our Care Coordinators at (866) 998-3944.

For additional education on this code, please visit www.ada.org.



By Fred L. Horowitz, DMD

The Environmental Protection Agency (EPA) issued a final rule on December 15th mandating the use of Amalgam Separators in dental offices that routinely place and/or remove amalgam. The move is made to reduce the amount of mercury from various water sources. Free mercury in the aquatic environment can be converted to methylmercury, a neurotoxin, by certain bacteria, which can then be ingested by fish and shellfish, moving it along the food chain. The EPA estimates that it will cost a dental office, on average, \$800 annually to comply with this rule. The rule "does not apply to mobile units or offices where the practice of dentistry consists only of the following dental specialties: oral pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics, periodontics, or prosthodontics." We suggest that all dentists that may be impacted by this rule review how amalgam is handled in their offices and determine if they are compliant with all of the rule's requirements, which go beyond just installing an amalgam separator.

To read the full article on this ruling click [here](#).



ORGANIZE YOUR KITCHEN ON A BUDGET WITH BUCKY

- 🍏 Place canned food in a file folder bin
- 🍏 Use a tissue box for leftover plastic grocery bags
- 🍏 Buy dollar store place mats for the fridge – no more taking out those big bulky shelves to clean
- 🍏 Utilize a shower rack or hanging shoe rack for cleaning supplies and storage
- 🍏 Hang a garbage bag role by placing a stick in the center and securing with curtain rod brackets



By Fred L. Horowitz, DMD

Over the last half century the practice of dentistry has differed from medicine in how we record and communicate diagnoses, findings and observations. Physicians and all other health care professionals use two sets of terminology: SNOMED CT and ICD. Dentistry is now able to use both of these and join our colleagues in sharing this vital information.

The clinical record or electronic health record often requires significant granularity to describe what we see with each patient. That is where SNOMED CT and a subset called SNODDS come to play. This terminology is used, as codes, to enter clinical findings in the patient's records. This same terminology will be used (more on that in the next issue of our newsletter) to also communicate important diagnostic information to other health care providers. It includes both medical and dental information.

When submitting a claim for payment, we use a different code set that is designed to talk to payers. It is called ICD codes, and we are now on version ICD-10. While it is less granular than SNOMED (or SNODDS, which is derived from SNODENT), it provides enough information for a payer to understand the circumstances for treatment.

Our Practice Management Software plays the key role of housing both code sets and mapping one to the other, so the clinical practitioner does not have to master the crosswalk. Why are we doing this? For one, some states, and others will be added, now require ICD diagnosis codes on all dental claims for Medicaid. The more important reason is that for the first time we will have a better understanding of disease presentation and the procedures used to treat it. This will allow true outcomes measures and evidenced based care.

The topic and its concepts are complex. If you would be interested in learning more, send me an email (Fhorowitz@nevadadentalbenefits.com), and if the interest level is high we will host a short seminar or webinar to discuss fully.

Tammy Ishibashi | Provider Relations

Every February is National Children's Dental Health Month (NCDH) where dental professionals and educators promote the importance of good oral health for children. Nevada Dental Benefits is proud to have such a skilled and caring team of pediatric dentists to care for its members. One such professional is Dr. William F. Waggoner, who is both a top pediatric dentist and well-respected educator.



Within the first few minutes of speaking with Dr. Waggoner, his passion for pediatric dentistry is clear. During his nearly 37 years in dentistry, he has written approximately 25 research publications for peer-reviewed journals and delivered presentations in 35 states and across 15 different countries. "At one time, I had a goal of presenting in every U.S. state, but as my experience began to take me all over the world, I've now had the pleasure of presenting on every continent, except Australia. I'm still trying to get there!"

When asked about his experiences in other countries, Dr. Waggoner explained, "I love the cross-cultural exchange that you experience when meeting and working with other dentists from so many different countries. In fact, about three years ago, I had such a surreal experience as I found myself in South Korea, teaching a workshop alongside pediatric dentists from Egypt, Ireland and S. Korea, to dentists from 12-13 different countries. You realize that we're all not that much different, and it opens your eyes to see that there is really good dentistry being done all over. Every time I visit another country, it makes the world a little bit smaller, more welcoming."

Aside from Dr. Waggoner's contributions to teaching, he finds his clinical practice to be greatly rewarding as well. "After 20 years in practice, I'm seeing children that I've cared for when they were only two years old, now graduating high school". Although, that's not the only aspect that Dr. Waggoner appreciates about being in practice. "As dentists, we're really small business owners. I look around my office and realize that as owner of three practices, this creates jobs for nearly 45 people. Besides helping improve children's oral health, I've helped create a living for employees and their families."

So, what's next for Dr. Waggoner? "Well, since I started my career in academics, I considered that my first career. Now after 20 years in practice, I guess that could be considered my second career. Maybe my next career will be back to focusing more on teaching again. In fact, after this, I'll be sitting down to work on a piece for a dental school text book that I'm now revising for its sixth edition. I'm also a co-founder and faculty member of "The Institute for Pediatric Dentistry", an educational institute that is helping to train young general dentists to get, faster, better, and more efficient at delivering care to children. Dental students don't receive very much experience in more complex pediatric dental procedures, and the Institute tries to help fill that gap. So, I would say my third career is to continue teaching, growing my practices, and mentoring young dentists."

If you know of a dentist that might like to be featured in one of our upcoming newsletters, please let us know. E-mail Tammy Ishibashi at tishibashi@nevadadentalbenefits.com.



By The Way



It's not too late to join the PrimeCare Administrators Network!

Your invitation already arrived at your office via USPS. Return your application with the prepaid envelope included or request an application on our website.

This is your chance to be part of a network of dental professionals partnering with the most reliable and valuable dental plan administrator.



Infection Prevention and OSHA for Dentistry 2017

Key Objectives

- ▶ Develop an effective plan for sterilization area workflow
- ▶ Identify pitfalls and shortcomings associated with instrument reprocessing
- ▶ Identify appropriate solutions and techniques for cleaning/disinfecting the environment of care
- ▶ Discuss OSHA standards and implementation within outpatient healthcare facilities

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Reminder FDA Bans Powdered Gloves

While most dentists in practice in the United States no longer utilize powdered gloves, the Federal Food and Drug Administration (FDA) has now banned the practice. Effective **January 18, 2017** dentists and other healthcare professionals can no longer use powdered gloves, exam and surgical, or the powder used in them. This includes any powdered gloves that have already been purchased and are in a dentist's inventory. The entire document and evidence can be viewed in the Federal Register **81 FR 15173**.



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