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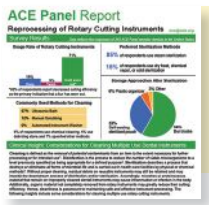

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ADA News

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BRIEFS

September JADA examines effect of dental treatment before heart surgery

It is unclear if post-operative outcomes differ in patients who receive dental treatment before cardiac valve surgery

compared with those who do not, according to a systematic review published in the September issue of The Journal of the American Dental Association.

The cover story, titled "Effect of Dental Treatment Before Cardiac Valve Surgery: Systematic Review and Meta-analysis," is the result of Resolution 86H-2016 from

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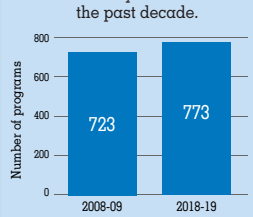
JUST THE FACTS

Accredited advanced dental education programs

The number of accredited advanced dental education programs in the U.S. has steadily increased during the past decade.



Source: ADA Health Policy Institute, ADA.org/hpi, hpi@ada.org, ext. 2568

ADA proposes five solutions for cutting federal paperwork

BY JENNIFER GARVIN

Baltimore — The ADA is proposing five standards-based solutions to the Centers for Medicare & Medicaid's request for information to reduce administrative and regulatory burdens on health care providers as part of the agency's Patients over Paperwork initiative.

"The ADA considers an unfettered patient-dentist relationship as the foundation for ongoing oral health," wrote ADA President Jeffrey M. Cole and Executive Director Kathleen T. O'Loughlin in a July 29 letter to CMS. "Further, this patient-centric relationship is supported by efficient and effective administrative processes that enable the dentist and her or his practice staff to provide necessary care. Paperwork, electronic or otherwise, requires time and resources to compile, complete, file or transmit."

The ADA told CMS that between Medicaid, Medicare Advantage

See PAPERWORK, Page 9

At Volpe Research Center, women seek to improve dental technologies, materials

BY KIMBER SOLANA

Editor's note: This is the sixth article in an ADA News series examining the changing demographics and increasing diversity in dentistry.

For 90 years, scientists have developed materials, tools and technologies for the dental community at the Volpe Research Center. These have resulted in over 200 products that have provided the foundation for how dentistry is practiced throughout the world.

Today, of the VRC's six principal investigators — those who manage and direct the projects and research — four are women.

These VRC scientists are focused on developing improved "smart" dental materials such as dental composites that are resistant to breakdown, are capable of self-healing and have antimicrobial properties. They are also developing improved sensors to help early detection of dental decay and periodontal diseases.

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Scientists: From left, Styliani Alimperti, Ph.D., Nicole Ritzert, Ph.D., and Shinae Kim, Ph.D., are three of the six principal investigators at the Volpe Research Center in Gaithersburg, Maryland. Their research includes developing improved "smart" dental materials, such as dental composites resistant to breakdown and sensors that can detect dental decay and periodontal diseases.

Saudi Arabia predoctoral dental program receives first international CODA accreditation

BY KIMBER SOLANA

The Commission on Dental Accreditation announced in August it accredited a predoctoral dental education program at the King Abdulaziz University in Saudi Arabia — becoming the first international predoctoral dental education program to receive the accreditation.

The commission, at its Aug. 1 meeting, granted an accreditation status of Approval Without Reporting Requirements. This means that students from the university who are enrolled and successfully complete the program at the time of accreditation will be considered graduates of an accredited program. Students who graduated from the program prior to Aug. 1 are not considered graduates of an accredited program.

"An important reason international programs apply for CODA accreditation is to be assessed against CODA's requirements," said Dr. Arthur C. Jee, CODA chair. "The CODA accreditation evaluation process ensures and improves

See ACCREDITATION, Page 11

Joint Commission: 'wrong site block dental local anesthesia' a sentinel event

BY KIMBER SOLANA

The Joint Commission, the nation's largest standards-setting and accrediting body in health care, clarified to the Association in July 11 that it continues to consider a "wrong site block dental local anesthesia" as a sentinel event — a term generally defined as an incident that results in death, permanent harm or severe temporary harm.

Dr. Dave Preble, ADA Practice Institute vice president, said the Joint Commission could not make an exception for dental block anesthesia without opening a Pandora's box, possibly leading to requests for exceptions for all manner of block anesthesia.

The clarification stems from a correspondence last year when the Association requested the Joint Commission reevaluate and consider that all wrong site local anesthesia administrations in dentistry were patient safety events but did not rise to a level of sentinel events.

The Joint Commission responded with a July 2018 letter that it considered "wrong site infiltration of local anesthesia" a patient safety event that did not rise to the category of a sentinel event.

The terms "block" and "infiltration" denote different specific injections — especially in dentistry.

The addition of the word "infiltration" in the Joint Commission's letter led to some misunderstanding in the interpretation.

The terms "block" and "infiltration" denote different specific injections — especially in dentistry.

"Local anesthesia needs to be delivered to both the maxilla and the mandible," Dr. Preble said in an April 2019 letter to the Joint Commission. "The maxilla is composed of porous bone that lends itself to local anesthesia direct infiltration, allowing the local anesthetic agent to reach the tooth, nerve and surrounding structures."

However, the mandible is composed of dense bone that "does not lend itself to effective local anesthetic direct infiltration, so local anesthetic blocks are commonly used," he added.

"The addition of the word 'infiltration' has caused only infiltration types of wrong site local anesthetic injections to be considered patient safety events, but not sentinel events, and wrong site local anesthetic block injections to be considered sentinel events," Dr. Preble wrote, requesting that the Joint Commission remove the word "infiltration" from its decision.

The Joint Commission declined, citing it could cause other health care providers to request exemptions for all manner of block anesthesia, Dr. Preble said.

Sentinel events are one category of patient safety events that require a higher level of reporting and scrutiny, to assist accredited programs in identifying process issues and improvements that can reduce the likelihood of these events occurring in the future.

Patient safety events are incidents or conditions that could have resulted or did result in harm to a patient. They can be, but are not necessarily, the result of a defective system or process design, a system breakdown, equipment failure or human error. These events also include instances that could have but do not cause harm to a patient, as well as close calls. ■

—solanak@ada.org

Group seeks status as national certifying board for dental anesthesiology

The American Dental Board of Anesthesiology submitted on July 25 an application and request to the National Commission on Recognition of Dental Specialties and Certifying Boards to be recognized as the certifying board for the newly approved specialty of dental anesthesiology.

The application comes about four months after the National Commission adopted a resolution to recognize dental anesthesiology as a dental specialty, based on its determination that the American Society of Dentist Anesthesiologists' application met all the ADA's Requirements for Recognition of a Dental Specialty.

If approved by the National Commission, the American Dental Board of Anesthesiology would become recognized as the national certifying board that administers the board certification examination certifying qualified dentists as diplomats in the specialty of dental anesthesiology. According to the Requirements for Recognition of National Certifying Boards for Dental Specialists, the National Commission will recognize only one certifying

See CERTIFYING, Page 5

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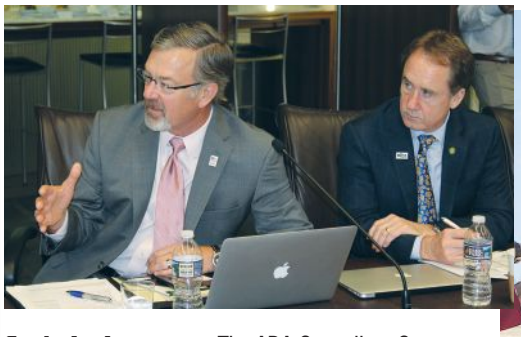


Capitol adventures: The ADA Council on Government Affairs met Aug. 1-3 in Washington. Right, during pre-council activities, Dr. Phillip Fijal, vice chair, left, and Dr. Craig Armstrong, chair, enjoyed a tour of the Capitol Dome. The tour includes a series of more than 300 steep stairs to reach the top. Top, Drs. Fijal and Armstrong listen during a presentation on membership.

VIEWPoint

MyView

Stronger together: Organized dentistry


Sharon Parsons, D.D.S.

I would like to say that I am one of those women who has always had her life planned to the last detail and has done everything for the right reasons, but that just isn't so. What I did plan was becoming a dentist, and what a wonderful plan that was. Back in the 1970s there weren't many women dentists. In fact, I had never seen one in my small town. My mother had the foresight to choose my orthodontist in a much larger city: Columbus, Ohio. Dr. Hull, my orthodontist, took an interest in me and became my mentor. He gave me insightful advice and helped pave the way for my career. One bit of advice he gave me was to be sure to get involved in organized dentistry because that is what shapes our collective profession. I really never forgot that, but it was in the back of my mind, not at the forefront. Life gets in the way. Most of us women know that all too well — the struggle for that little bit of time not taken up by your office or your family.

At the beginning of my career I got involved in organized dentistry at the local level with my component dental society, on various councils and attending general membership meetings. But after I had children, it became more difficult, as my husband traveled for his job and I was essentially a single parent through the week. My involvement dropped off, but I always kept my membership. After what seemed like only a couple of years, my children were almost ready to leave home. Perusing the mail at the office one day, I opened the ballot that the Columbus Dental Society sent out. As I carefully went through the names, deciding who I would vote for, I went into shock. There, under the category of candidates for delegate to the Ohio Dental Association, was the name Sharon Parsons. I never put my name in. Well, I thought, I'm safe. No one knows me, and besides, I never supplied them information for my bio. As it turns out, my friend and co-worker Linda, who was president of the Columbus Dental Society at the time, volunteered me. She thought that I would be a good addition and that I would do the right thing. To my surprise, I was voted in, and that was the start of my organized dentistry journey. No planning at all on my part.

As fate would have it, I enjoyed being involved in the Ohio Dental Association House of Delegates but did not totally understand all the inner workings yet. At our caucus meeting, they were nominating and electing people for positions on councils and committees inside the Ohio Dental Association. They described each committee/council and what it does. After the description of a particular council, it was mentioned that this is a really important council. Before I realized what I was doing, my hand was in the air, and I had nominated myself. What did I know about any of this? Then to my dismay I had to explain to everyone why I would be the best choice. I think I mumbled something about it being time for me to give back. I really don't remember; it happened so quickly. Once again, totally not planned and for all the wrong reasons. However, I was voted in.

I was so apprehensive about being on this council. All of my self-doubt started bubbling up. What did I know to qualify me for this, and would I make a fool of myself? It certainly does not always work like this, especially for women, but my experience was wonderful. I started off observing

See MY VIEW, Page 5

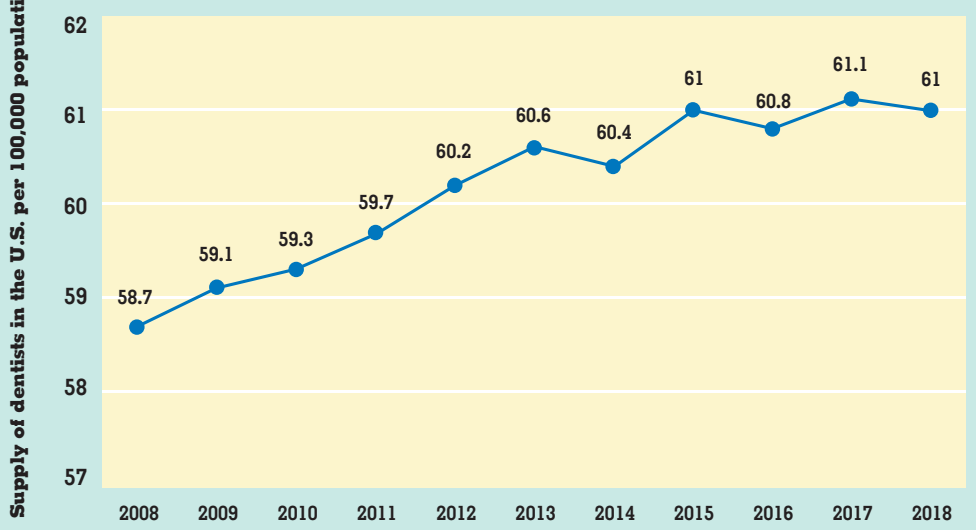
LETTERSPolicy

ADA News reserves the right to edit all communications and requires that all letters be signed. The views expressed are those of the letter writer and do not necessarily reflect the opinions or official policies of the Association or its subsidiaries. ADA readers are invited to contribute their views on topics of interest in dentistry. Brevity is appreciated. For those wishing to fax their letters, the number is 1-312-440-3538; email to ADANews@ada.org.

SNAPSHOTS OF AMERICAN DENTISTRY

Supply of dentists in the U.S. per 100,000 population

The number of dentists per 100,000 population who reported working in dentistry was 61 in 2018, a net increase of 3.9% since 2008.



Source: ADA Health Policy Institute, "Supply of Dentists in the U.S.: 2001-2018." Available from ADA.org/en/science-research/health-policy-institute/data-center/supply-and-profile-of-dentists.

Letters

Dental education

I would like to thank Dr. Robert N. Bitter for his thoughtful My View "What Can We Do For Dental Education?" in the June 17 ADA News. Indeed, the exorbitant cost of a dental education is daunting to individuals and the profession at large. As someone who was a dental educator for a dozen years and has been a private practice dentist for 32, I agree that this has far-reaching consequences for students and practitioners alike.

However, with due respect, I think that the idea of going hat-in-hand to the government to try to solve this issue is a mid-20th century solution to a 21st century problem. Student debt is the symptom, as he points out, but lack of government funding is neither the only nor even the major cause. In an era when the federal government is more than $20 trillion in arrears and state, county and municipal governments are also in debt to the tune of several times that figure, it is difficult if not impossible to imagine that austerity generally will not be the way forward for the nation for the foreseeable future, and that government spending generally will need to be curtailed for the very survival of our country. Of course we are all passionate about our profession and the good it can do, but at the end of the day, we must have the humility to admit that we are simply a competing interest with other entities. In such an environment it is also difficult to imagine that an injection of cash will even be there to stop the bleeding. The solution he prescribes to have Medicaid subsidies will likely not completely

cover any current shortfall and runs the risk of making dental education even more dependent on government at a time when it sorely needs to be less so.

Beyond that, a mere injection of money will not end the structural problems and perverse incentives that led to a dental education costing as much as it does (and increasing in price far beyond the every other good or service in society) in the first place. To be sure, this bloat is not specific to dental education — it is endemic to the education industry at large, and increases of 500-600% in administrative costs plus the effect of student loans and subsidies on removing any feedback loops for universities to control costs are not limited to dental schools.

Nonetheless, the cost of a dental education will continue to rise unless and until such feedback loops are reintroduced into the dental education industry. The small increase in subject matter in the past 30 years in no way justifies this type of price increase.

Perhaps dentistry can be the leader in this regard and blaze the trail for other fields of education by getting back to basics on the amount of administration while at the same time innovating in terms of how to deliver a great training and education without such a high price tag. I think we're up to that. At any rate, the big-government money solution will be a kick-the-can approach at best.

Better to roll up our sleeves now and do a real, sustainable fix.

Robert K. Thompson, Jr., D.M.D.
Cohasset, Massachusetts

Certifying

Continued from Page 2

board that has a close working relationship with the sponsoring organization.

The national certifying board for dental specialty must go through an application process and meet several requirements as outlined in the ADA's Requirements for Recognition of National Certifying Boards for Dental Specialists, according to the National Commission.

All documentation in the application is confidential until the review committee has determined that the application is complete. If the application is complete, the National Commission will invite public comment for a 60-day period on whether the applicant has demonstrated that it meets each of the requirements for recognition.

The national certifying board for dental specialty must go through an application process and meet several requirements as outlined in the ADA's Requirements for Recognition of National Certifying Boards for Dental Specialists.

Incomplete applications are returned to the sponsoring organization or certifying board for modifications.

The American Dental Board of Anesthesiology examines and certifies dentists who complete an accredited program of anesthesiology training in the U.S. or Canada. The group was founded to ensure that dentists who have completed approved dental anesthesiology residency programs have attained, and will maintain, the "highest possible level of knowledge and skill in the spectrum of anesthesiology care for dentistry," according to its website.

The National Commission, at its March 11 meeting, had revised its policies related to the application process requiring it to publish a notification to its communities of interest when an application has been received.

The ADA House of Delegates in 2017 established the National Commission to oversee the decision-making process for recognizing dental specialties. The Requirements for Recognition of Dental Specialties is still managed by the ADA's Council on Education and Licensure and the ADA House of Delegates.

For more information on the National Commission on Recognition of Dental Specialties and Certifying Boards, visit ADA.org/en/ncrdscb or by calling 1-312-440-2697. ■

MyView

Continued from Page 4

and getting the lay of the land. Slowly, I engaged more and found that I was passionate about this. We were discussing all aspects of dental practice and making recommendations to the dental board. We were engaging with third-party payers and advocating for dentists with the insurance companies. I had no idea that organized dentistry did so much, and this was just one council. After a few years of participation, I was voted chair of the council and found that I could be in a leadership position and not choke. Again, not planned but very appreciated.

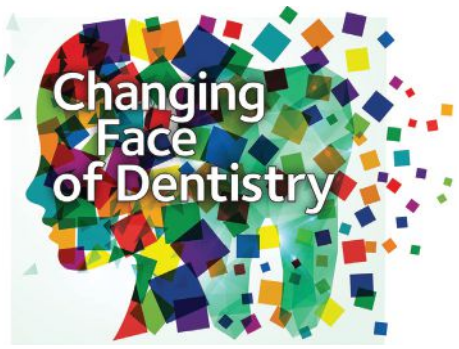
Today, I am president-elect of the Ohio Dental Association and will become president in October of this year. Only the third woman to fill this position in over 150 years. As luck, or fate, would have it, the other two women are friends of mine. One practiced with me, and the other was my "little sister" in dental school. Both have been nothing short of amazing in their support of me. I am very humbled. I am especially humbled by the inordinate amount of work that our tripartite does for our profession. It is no accident that dentistry has not gone the way of medicine. The American Dental Association has one of the most powerful lobbies in Washington and has championed legislation that has helped both our profession and our patients. Nonmembers tell me that this will happen whether or not they join, so they may as well save their money. But here's the rub. We (the ADA) only have this power if we represent over 50% of the dentists in the country. No one listens if we represent the minority, and our voice is diminished. We, as entrepreneurs, have benefited in ways too numerous to mention. Many entities hope to control our profession and, by default, our livelihood. I absolutely love being a dentist. I love my work and my patients. I firmly believe that I know better what treatment benefits my patients the most, not a third party. If we lose our voice, we lose that sacred dentist-patient decision-making process. The cost of dues is recouped many times over by all of the benefits provided, not to mention our collective voice.

This is but one aspect of being a dentist, but I firmly believe that without it our profession, as we know it, will forever be changed by others. My involvement may have been by chance but what a lovely, fortunate chance that was.

This editorial, reprinted with permission, originally appeared in Dew.life on April 25 and is available at www.dew.life/2019/04/25/stronger-together-organized-dentistry. Dr. Parsons is the president-elect of the Ohio Dental Association.

Volpe

Continued from Page 1



The ADA News spoke with three of them to discuss their work and background. While not dentists, these women play a large part in how dentists work and, ultimately, the oral health of patients.

Nicole Ritzert, Ph.D.

Imagine a faster and more accurate way to assess a person's health such as risk of heart disease and diabetes through inspecting a person's mouth.

That's the focus of Dr. Ritzert's work at the VRC.

"We're designing and testing sensors that we can one day use in people's mouths to detect a variety of diseases," she said. "I'm not a biologist or dentist, but I know how to measure relevant parameters such as pH. I'm able to use my expertise to help fill in gaps in oral health research."

With a background in electrochemistry, Dr. Ritzert has over 10 years of experience in characterizing the electrochemical properties of proteins, organic molecules and thin, layered materials.

Growing up, Dr. Ritzert said, she enjoyed science, math, reading, working with her hands and often made art.

"Seeing something that I've created from my imagination, whether it is a new piece of lab equipment or a finished drawing of a flower, is exciting," she said.

After seeing her sister go to college, she wanted to pursue course work beyond high school. She chose to study chemistry, earning her degree from Slippery Rock University in Pennsylvania.

"I wanted to work on practical problems, just like my dad," she said. "He didn't have a high school degree (but later earned his GED), but he had a huge impact on my education. He was curious about many topics and taught me the value of learning continuously."

She then earned her master's degree in chemistry and a Ph.D. in analytical chemistry from Cornell University in Ithaca, New York. After graduating, she was a National Research Council postdoctoral fellow at the National Institute of Standards and Technology in Gaithersburg, Maryland — also the home of the Volpe Research Center.

About two years ago, a colleague's boss asked Dr. Ritzert if she wanted to join the VRC.

"I took the job because I could apply my knowledge of electrochemistry and expertise in fabrication and testing of small electrodes in a field new to me," she said. "I was excited for the opportunity to help in developing products that could be used to improve health, as well as work with researchers in the VRC to make measurements that may help them better understand how disease affects dental tissues."

Shinae Kim, Ph.D.

Dr. Kim, the newest principal investigator, is participating and managing two projects at the VRC.

Similar to Dr. Ritzert's work, Dr. Kim is developing oral-sensors for fast diagnosis of oral disease or real-time monitoring of the disease's progress.

Another is investigating the effects of e-cigarette vape, especially the sweet-flavored e-liquids, on oral health.

"Based on the biological and physiochemical data, we found that certain e-liquid ingredients interact with hard tissues of the oral cavity in such a way that resembles high-sucrose candies and acidic drinks," she said.

Born and raised in Seoul, South Korea, Dr. Kim moved to the U.S. in 2011 to pursue a postdoctoral fellowship in laboratory for microsystems at Georgia Institute of Technology in Atlanta. She first came to the U.S. as a visiting researcher at Cornell University in 2008.

Dr. Kim has extensive background in optics, electronics, nano/micro-fabrication and microfluidics. She first joined the VRC as a postdoctoral fellow in February 2017 before becoming a principal investigator in April.

"We help dentists by offering newly engineered diagnostic tools, which are fabricated with cutting-edge technology," she said of the work conducted at the VRC.

According to the latest National Health and Nutrition Survey, 47.2% or 64.7 million American adults are suffering from periodontitis. Dr. Kim said that current diagnostic methods for periodontitis are based on conventional methods, which include clinical parameters (color changes, bleeding upon probing, etc.) and review of radiographs.

"However, these methods are limited in their ability to accurately detect and diagnose the dynamic states of exacerbation and remission that characterize periodontal diseases," she said. "Our new diagnostic tool, which can provide dentists with the ability to identify an active disease site, would be an important addition to help clinical periodontal disease assessment."

In addition, by offering scientific data and evidence, dentists can better help their patients understand the potential harmful effects of e-cigarette flavors.

"[The work at the VRC] does not start with a mere intellectual curiosity, but we do research to help dentists," Dr. Kim said. "There, it is very attractive to me to conduct more practical and directly usable research. It's different from other research institutes or universities."

Styliani Alimperti, Ph.D.

As a biomedical engineer, Dr. Alimperti said her goal is to develop methods and technology that can reduce the burden of patient suffering from devastating diseases.

"This has revealed significant challenges, but has also been a privilege," said Dr. Alimperti, who joined the VRC in January 2018. "It is this tangible benefit to individuals, along with the progress it fosters, that cements my commitment to biomedical research and engineering."

Utilizing "organ-on-a-chip" technology — a microfluidic device that mimics the functionality of an organ — Dr. Alimperti seeks to develop new tissue engineering and regenerative therapies to help patients suffering from dental diseases, including periodontal diseases.

"Periodontal diseases are considered among the most expensive to treat," she said. "Although different treatments have been developed against gum diseases, significant challenges remain, such as the high cost of tooth or bone grafts."

Patients who receive these grafts, she added, are subject to lifelong side effects such as increased rates of gum infections, diabetes and oral malignancies.

"Thus, it's necessary to engineer methods

See VOLPE, Page 9

ACE Panel Report shows most dentists use steam sterilization for instrument reprocessing

BY MARY BETH VERSACI

An ADA Clinical Evaluators Panel Report released in August offers insights into the methods dentists use to reprocess rotary cutting instruments.

For the report, 345 practicing U.S. dentists and ADA members shared their usage rate of the same rotary cutting instrument and their most used cleaning methods, sterilization methods and storage approaches after sterilization.

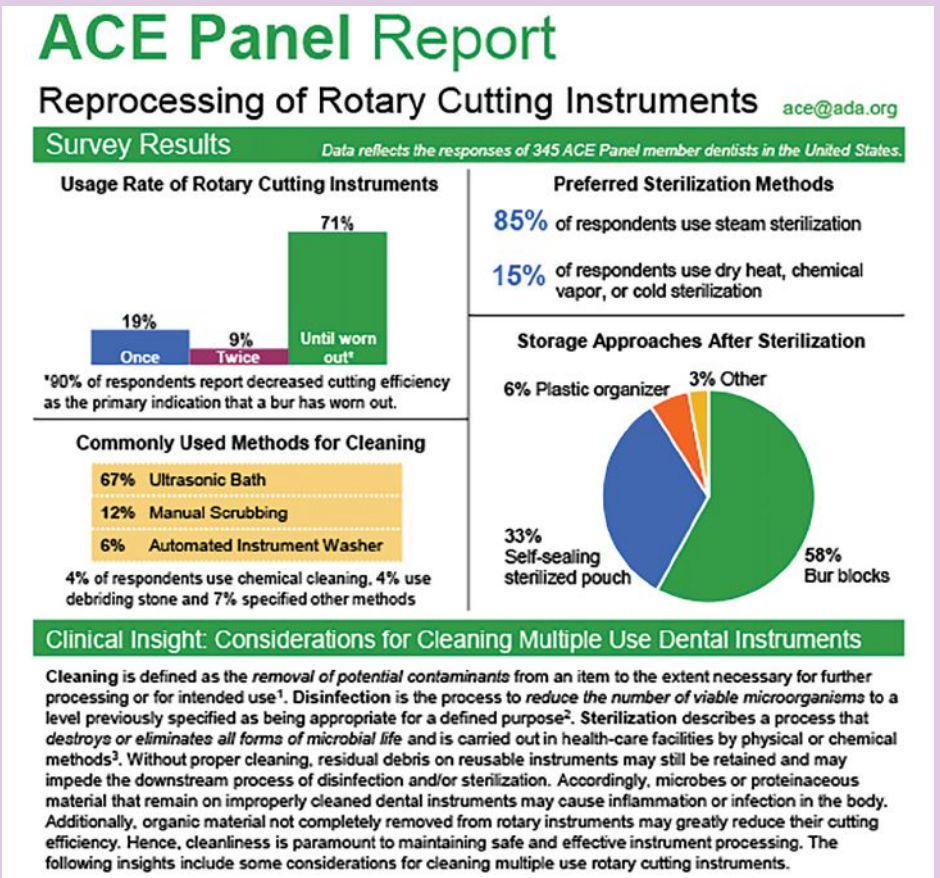
"Overall, a majority of the dentists use steam sterilization, but some of the dentists use dry heat, chemical vapor or cold sterilization," said Dr. Jacob G. Park, a member of the ADA Council on Scientific Affairs' Product Evaluation Subcommittee. "Based on recommendations from a majority of manufacturers, dentists should consider using the steam sterilization method instead of dry heat, chemical vapor or cold sterilization. Certain rotary cutting instruments, such as a diamond or carbide cutting bur, can be damaged through the potential detachment of diamond grit or corrosion problems."

Since 2014, the Food and Drug Administration has shared concerns with the dental standards community that reprocessing instructions are unclear or inadequate for diamond rotary instruments and carbide burs. In March 2015, the FDA published a guidance document on "Reprocessing Medical Devices in Health Care Settings: Validation Methods and Labeling," which recommends that manufacturers have cleaning protocols and instructions that are validated, clear and feasible or else they will have to label their multi-use instruments as single use.

The ADA is currently working on a technical report on cleanliness with input from the FDA entitled "Dentistry – Guidance on Method Development and Validation of Cleaning Processes for Dental Instruments."

Members can view the entire ACE Panel Report online at ADA.org/ACE.

ACE Panel Reports feature data compiled from surveys completed by ADA member dentists who have signed up to participate in short studies related to dental products, prescribing habits and other clinical topics. The Product Evaluation Subcommittee, along with ADA Science Institute staff, write the reports.

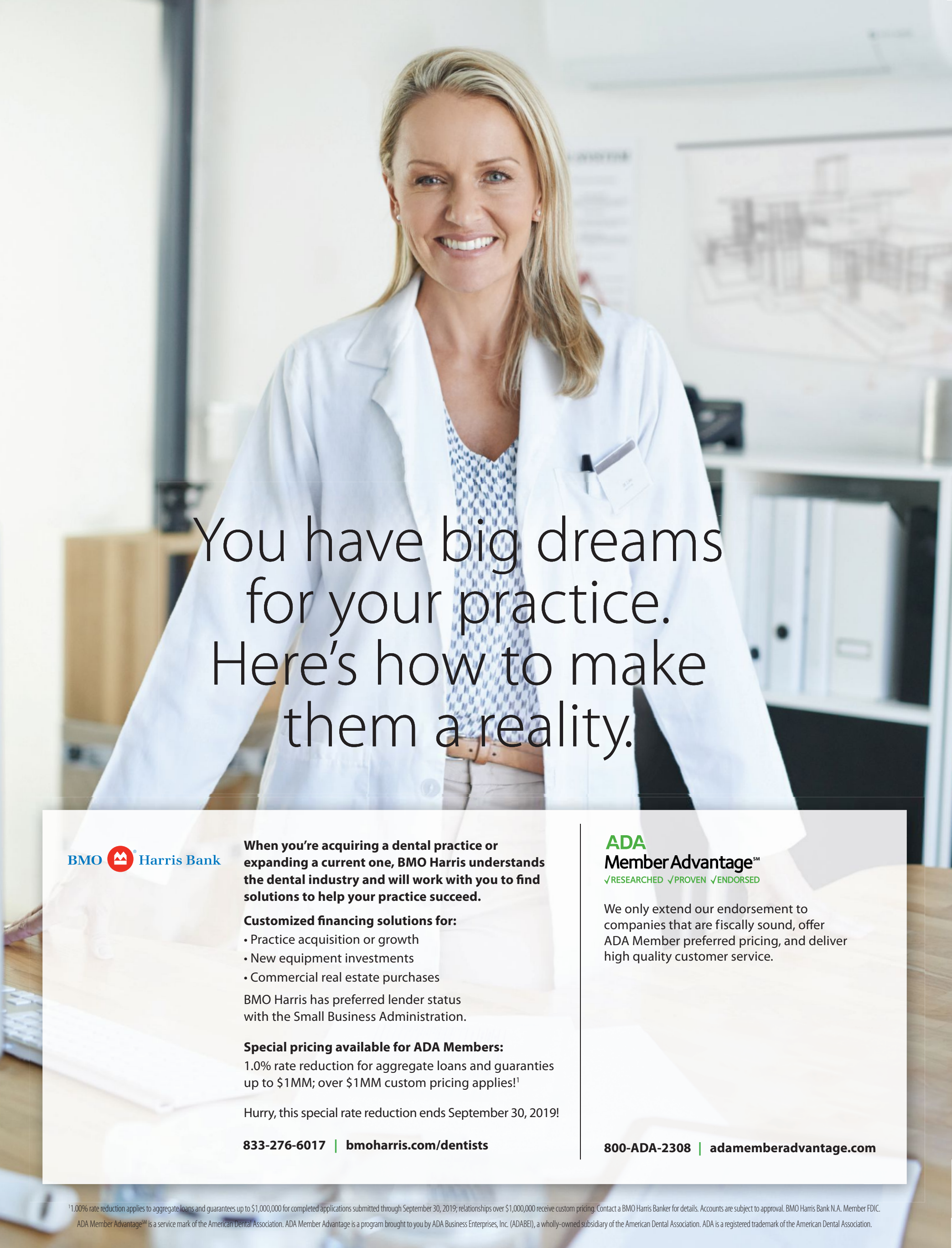


The resource aims to offer ADA members a way to understand their peers' opinions on various dental products and practices, offering insight and awareness on new products and techniques that can benefit patients and the profession.

Past ACE Panel Reports focused on antibiotic use in endodontic infections, bonding agents, dental erosion and bioactive materials. These reports are available to view online at ADA.org/ACE.

ADA members are invited to join the ACE Panel and contribute to upcoming surveys, which occur no more than once a month and usually take five to 10 minutes to complete.

To learn more or join the ACE Panel, visit ADA.org/ACE. ■



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Responses to fluoride study flood in from all over the globe

BY DAVID BURGER AND JENNIFER GARVIN

Alongside organizations and publications around the world, the ADA on Aug. 19 issued a press statement in response to widespread media interest in a study that suggested an association between higher prenatal fluoride exposure and lower IQ scores in children 3-4 years of age.

"The American Dental Association remains committed to fluoridation of public water supplies as the single most effective public health measure to help prevent tooth decay," according to the ADA statement in response to the study published in JAMA Pediatrics. The Association also noted that this commitment is shared by the World Health Organization, U.S. Public Health Service, Centers for Disease Control and Prevention, American Medical Association and American Academy of Pediatrics.

One of the study's authors, Dr. Angeles Martinez-Mier, chair of cariology, operative dentistry and dental public health at the Indiana University School of Dentistry, said while she stands "fully behind our study's conclusions, as an individual, I am happy to go on the record to say that I continue to support water fluoridation." Dr. Martinez-Mier is a member of the ADA Council on Advocacy for Access and Prevention's National Fluoridation Advisory Committee.

Study prompts quick response

For the study, researchers examined whether there was any association between IQ of children and fluoride exposure of their mothers during pregnancy. The study measured the maternal urinary fluoride levels in 512 women across 10 Canadian cities during each trimester of their pregnancies as well as the self-reported fluoride intake from 400 women. The study also recruited a subset of 601 children — 254 who lived in a nonfluoridated region, 180 who lived in a fluoridated region and 167 whose fluoridation status was unknown — and completed neurodevelopmental testing. The results showed that a 1 milligram per liter increase in maternal urinary fluoride was associated with a statistically significant 4.49-point lower IQ score in boys and a non-significant increase of 2.4 IQ points for girls. The researchers concluded that "maternal exposure to higher levels of fluoride during pregnancy was associated with lower IQ in children age 3-4."

Christine Till, Ph.D., an assistant psychology professor at Toronto's York University and co-author of the study, defended the study in an interview with ADA News from the Netherlands. She anticipated the controversy of the research, given that there are strong opinions on both sides of the issue, she said.

"We've been under so much scrutiny," Dr. Till said of the review process. "We've addressed dozens and dozens of reviews."

"This decision to publish this article was not easy," wrote the journal's editor, Dimitri A. Christakis, M.D., in an editorial comment accompanying the study. "Given the nature of the findings and their potential implications, we subjected it to additional scrutiny for its methods and the presentation of its findings. The mission of the journal is to ensure that child health is optimized by bringing the best available evidence to the fore. Publishing it serves as testament to the fact that JAMA Pediatrics is committed to disseminating the best science based entirely on the rigor of the methods and the soundness of the hypotheses tested, regardless of how contentious the results may be. That said, scientific inquiry is an iterative process. It is rare that a single study provides definitive evidence. This study is neither the first, nor will it be the last, to test

the association between prenatal fluoride exposure and cognitive development. We hope that purveyors and consumers of these findings are mindful of that as the implications of this study are debated in the public arena."

In responding to the study's conclusion, the ADA said that "public health policy is based on a collective weight of scientific evidence" and called for "further scientific study of the issue to see if the [study's] findings can be replicated with methods that demonstrate more conclusive evidence."

In a statement published online Aug. 19 in the American Academy of Pediatrics News, the academy said it will also continue to recommend children use age-appropriate amounts of fluoride toothpaste and drink fluoridated tap water.

"There are thousands of articles pointing to the safety of community water fluoridation and we need to continue to look at the impacts, but this study doesn't change the benefits of optimally fluoridated water and exposure to fluoride," said Patricia A. Braun, M.D., professor of pediatrics at the University of Colorado and chair of the AAP Section on Oral Health Executive Committee.

American experts weigh in

Other organizations questioned the study's credibility, methodology and conclusions.

The American Council on Science and Heath published a story a few days after the study was released called "No, Fluoride Doesn't Lower IQ. It Fails to Satisfy Hill's Criteria of Causality." Alex Berezow, Ph.D., vice president of scientific affairs for the council, wrote that the study's conclusions are "doubtful" and that the study doesn't meet the benchmarks devised by epidemiologist Austin Bradford Hill that are meant to "tease apart correlation from causation."

"The American Dental Association remains committed to fluoridation of public water supplies as the single most effective public health measure to help prevent tooth decay."

Dr. Berezow said that the paper is not consistent with other data on the topic, so that particular benchmark is not reached. He continued by opining that the study doesn't meet the benchmark for coherence, noting that "while the authors conclude that a 1-mg increase in fluoride detected in the mother's urine is linked to an IQ drop of about 4.5 points in boys, there is no statistically significant IQ difference among girls … Obviously, that is incoherent. There is no sensible biochemical reason why fluoride would harm the brains of boys but not those of girls."

Dr. Berezow concludes with this assessment: "So, are the authors wrong? Probably."

Another story, published on Forbes.com and written by senior contributor Bruce Y. Lee, M.D., weighs in on the subject, again asserting that the study is invalid.

An associate professor of international health at the John Hopkins Bloomberg School of Public Heath, Dr. Lee says in his piece, "If you think these findings prove that fluoride in drinking water leads to lower intelligence, remember that associations do not mean that one thing causes another … Observational studies, like this JAMA Pediatrics one, cannot, cannot, cannot, cannot prove cause and effect. People who live in areas where tap water is fluoridated could also be exposed to other things or have behaviors that may affect their children's IQ scores. For example, could they or their children be eating more processed foods with artificial ingredients? Could they be exposed to more chemicals in the environment? We do not know enough about the details of the study participants' lives to know what really is happening."

Furthermore, Dr. Lee believes that "IQ scores are just one measure of thinking ability and development and an imperfect one at that. IQ scores can be misleading as not everyone can perform to the best of their ability on tests."

Steven Novella, M.D., a clinical neurologist at Yale's School of Medicine, questioned in an Aug. 21 article on the website Science-Based Medicine how the study's authors interpreted the study's data and pointed out what he called several "red flags" in the study, including "the huge variance in results, and the disconnect between performance and verbal IQ."

The American Fluoridation Society issued a statement Aug. 23 that disputed the study's conclusions. "The American Fluoridation Society welcomes robust research on fluoride and fluoridation," the statement read. "However, we are concerned that the [study] may produce headlines that do not accurately reflect the study's data and methodology. It should be understood that an 'association' does not prove causation."

The statement continued: "It's important to consider the context. In recent years, multiple studies have found no link between fluoride exposure and intelligence/cognitive skills … People and communities should not be scared into making a decision that will harm their oral health and overall health."

The American Association for Dental Research too weighed in on the study, releasing a statement on Aug. 20 that said that while the study results raise "important questions worthy of future research, the authors identify a number of limitations that make it unclear if and how these results should influence current policy on water fluoridation. One of the study's most significant limitations is the quantification of fluoride intake. Only beverages were considered in the measure of fluoride intake, but there are several common dietary sources of fluoride. Furthermore, data on beverage intake were collected using self-report, which is subject to recall bias, and the authors did not have access to the concentration of fluoride from each subject's tap but had to estimate based on where the subject lived. As the authors state, an individual's tap water could be supplied by multiple treatment plants."

Worldwide questions

Opinions across the world have been equally skeptical of the new study.

The Science Media Centre, an independent British organization that sources expert opinions on science in the news, compiled expert opinion on the study this week, providing statements from eight professors and scientists across the world that all call into question the legitimacy of the study's findings.

Thom Baguley, Ph.D., professor of experimental psychology at Nottinghall Trent University in England, said, "The claim that maternal fluoride exposure is associated with a decrease in IQ of children is false … In summary, it is not correct to imply that the data here show evidence of a link between maternal fluoride exposure and IQ. The average change in IQ is not statistically significant."

Dr. Oliver Jones, associate professor of analytical chemistry at RMIT University in Australia, said that "there is also a lot of variation in the data — which makes drawing firm conclusions/predictions from it difficult. There are also a number of potential confounding factors, including the fact that the water intake was self-reported and, as the authors admit, some of the methods used are not validated."

Alastair Hay, Ph.D., professor emeritus of environmental toxicology at the University of Leeds in England, said the study contains a "crucial failure" when the authors acknowledge that the maternal intake of fluoride had not been validated. "For a substance with a short half-life, such as fluoride, urine concentrations vary hugely and are really only representative of the last drink. Validation of intake is something you just do before looking at associations." He adds that another "major serious gap" is the "range of exposure to multifarious substances, including lead, that the children would have had between birth and IQ assessment at ages 3 and 4. We know that lead exposure has devastating effects on IQ in children and this study takes no account of postnatal lead exposure."

Stuart Ritchie, Ph.D., a lecturer at King's College London, summed up his misgivings about the study by saying, "I wouldn't have much confidence in this finding being robust or replicable."

Media response

Media coverage of the study has been extensive, with stories appearing in Time magazine, The Washington Post, the Philadelphia Inquirer and many more.

The Inquirer quotes Dr. Brittany Seymour, a Harvard School of Dental Medicine assistant professor and member of the ADA CAAP's National Fluoridation Advisory Committee. In the story, she said one study is not enough to alter public health policy. She was also quoted in USA Today and The Washington Post.

Dr. Till appeared on Canada's CTV News to defend the study. "There's been a bit of pushback as you can imagine, when you're doing such a controversial study," she said on the program. "The data are what the data are … Our recommendation is that pregnant women reduce fluoride intake in pregnancy. This is a reasonable conclusion based on the findings and not just our findings."

In the ADA News interview, Dr. Till addressed whether more studies will be forthcoming about the safety and necessity of fluoride. "I should hope so," she said.

According to the ADA press statement, "The ADA remains focused on how and if emerging evidence might impact public health recommendations and policies. We will continue to evaluate the validity of emerging evidence and research to support the advancement of the health of the public."

More information about fluoride and community water fluoridation can be found at ADA.org/fluoride. ■

Paperwork

Continued from Page 1

and the Children's Health Insurance Program, approximately 87.8 million individuals are covered for some oral health services.

In the letter, the ADA addressed five paperwork intensive administrative activities that have standards-based solutions:

• Streamlining the credentialing process. The ADA is encouraging standardized use of CAQH ProView — a web-based, universal credentialing program — as a means to reduce credentialing paperwork required of any health care practitioner. CAQH is an acronym for the Council for Affordable Quality Healthcare.

• Health Insurance Portability and Accountability Act standard eligibility inquiry and response transactions — X12 270 and 271. The ADA believes that a more robust 270/271 transaction set combination can supplant the proliferation of proprietary payer portals and recommends that 270/271 be modified to accept the content described in the National Dental Electronic Data Interchange Council's Top Dental Eligibility and Benefit Questions Response Guide and recommends that CMS develop a specification that enables "real-time" transmittal and receipt of the 270/271 transaction sets.

• Claim submissions. The ADA encourages dentists to implement the HIPAA-standard electronic dental claim transaction, and for those who continue to submit on paper, to use the current version of the ADA Dental Claim Form. The ADA would like to see that federal guidance concerning consistency in dental claim submission via paper be expanded to include statefunded programs and not limited to federally funded programs. The ADA would also like the dental community to adopt a HIPAA standard for claim attachments and believes that CMS should use its authority to ensure that processing policies, prior authorization guidelines and attachment requirements are clear and consistent.

• Coordination of benefits. To reduce paperwork and related administrative time and resources, the ADA recommends that the appropriate federal authority publish regulations that require third-party payers to implement payer-to-payer coordination of benefits. This regulation could be initially directed towards managed care organizations that administer state Medicaid programs. Another avenue to promote payer-to-payer coordination of benefits is CMS' Administrative Simplification Enforcement and Testing Tool. "Widespread adoption of Payer to Payer [coordination of benefits] is a goal that the ADA sees as a collaborative effort that involves HIPAA-covered entity education, modification of third-party payer processing software, and upgrades to provider practice management software. There are short-term expenses associated with these efforts, all of which lead to achieving greater overall efficiencies through reduction of manual interventions and paperwork."

• Reimbursements. The ADA supports the continued use of paper checks for dentists who prefer this method, but also strongly encourages that dentists implement the applicable HIPAA-standard transactions in order to lower admi-istrative time and costs for reconciliation. The ADA does not support virtual credit cards as a viable payment mechanism, as they simultaneously add to practice administrative costs since new protocols must be put in place to process these reimbursements, and they reduce the amount actually received after accounting for transaction costs and card processing fees. The ADA requests that CMS provide regulations that will permit reimbursement via virtual credit cards "only when specifically requested by a dentist or any other health care provider." The ADA also noted the need for a universal electronic funds transfer enrollment mechanism since some third-party payers require health care providers to enroll using a proprietary process in order to receive payments electronically. The ADA recommended that CMS open the Remittance Advice Remark Code maintenance process to permit the industry's full participation, which would be achieved by adopting an external, independent code management process akin to X12's external code maintenance process.

The ADA concluded by encouraging CMS to appoint a chief dental officer that can speak out on the specific administrative burdens faced by dentists. To read the full version of this story, visit ADA.org/adanews. ■

Volpe

Continued from Page 6

for gum therapeutics, which can be applied to personalized medical treatment based on individual characteristics of each patient, enhancing medicine treatments," she said.

Dr. Alimperti received her Ph.D. in chemical and biological engineering at the University at Buffalo in New York, where she established a strong background in stem cells and vascular biology. This led her to a postdoctoral position at Boston University and the Wyss Institute for Biologically Inspired Engineering at Harvard University to concentrate on developing new tissue engineering methods with potential application in regenerative medicine.

At the VRC, Dr. Alimperti said, she's found a unique place because of the center's interdisciplinary research areas of engineering, physics, chemistry and dentistry.

"The collaboration between physicists, chemists, material engineers and dentists is fantastic," she said. "By integrating chemical material synthesis and characterization, engineering methods such as 3D printing and establishing robust physical measurements, we can answer complex biological problems." ■

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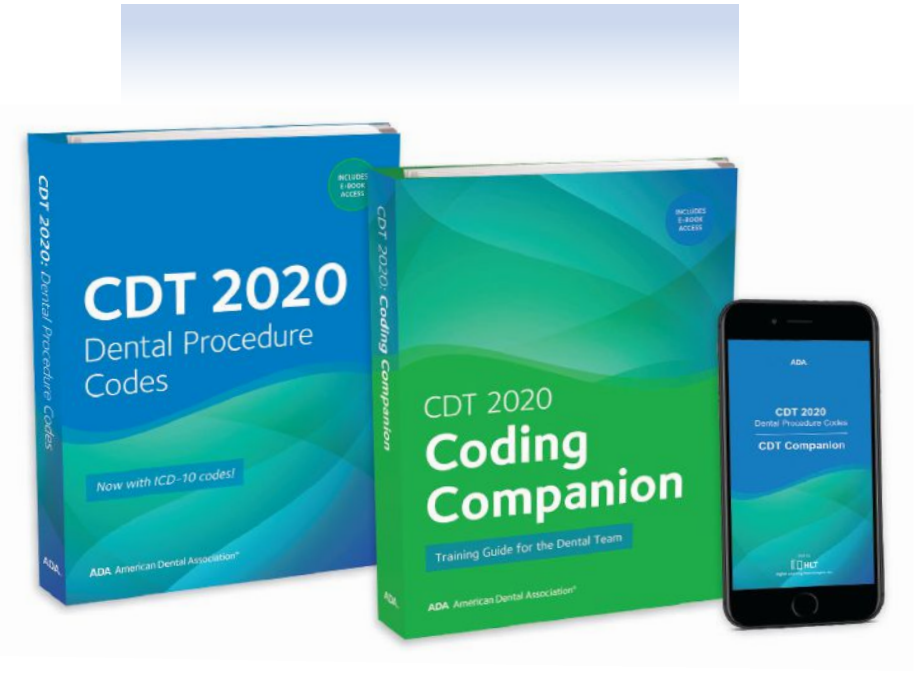

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Accreditation

Continued from Page 1

program through the commission's accreditation process."

The international consultation and accreditation process stems back to 1999, when CODA received a request from the California State Board of Dental Examiners for assistance in developing guidelines the state board can use to comply with a state law.

In 1998, the state had enacted a law that created an approval process by the California Board of Dental Examiners for foreign dental schools that apply, according to the commission.

After several resolutions and studies, the CODA international process was born from ADA House of Delegates Resolution 39H-2005, which offered support for the commission's initiative to offer consultation and accreditation services to international dental schools.

It also created the Joint ADA/CODA Advisory Committee "to provide guidance to the commission in the selection, development and implementation of an international program of consultation and accreditation for dental education," according to a 2006 CODA annual report.

Requirements for international predoctoral dental education programs accredited by the Commission are equivalent to requirements for U.S.-based programs.

Prior to applying for accreditation, an international program must undergo an international consultation and preliminary accreditation consultation visit (PACV) process, which involves four stages: completion of the PACV survey; observation of a CODA dental school site visit and individual consultation; PACV self-study and consultation visit; and application to the commission's accreditation process.

Since 2007, the joint committee (now called the Standing Committee on International Accreditation since ADA House of Delegates Resolution 53H-2015) has accepted PACV surveys from international predoctoral dental education programs that are interested in the commission's accreditation program through the four-stage process.

The commission's Standing Committee on International Accreditation assesses the program's progress through the first three stages.

However, according to the commission, a positive determination from the standing committee does not guarantee the application for accreditation by the commission will be successful.

The commission assesses the application for accreditation at stage four, using the same policies, procedures and accreditation standards that are in place for U.S.-based programs.

A CODA accreditation does not mean graduates from King Abdulaziz University are licensed to practice dentistry in the U.S. Licensure for a graduate of any program accredited by CODA is still dictated by individual states' practice acts.

The final authority on licensure requirements rests with the individual state dental boards or similar agency. ■

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JADA

Continued from Page 1

surgical procedures.

Under this directive, the council assembled an expert panel of dentists and physicians to review the literature surrounding the effect of dental interventions on morbidity and mortality when performed as preparation for cardiac valve surgery. Six studies met the inclusion criteria.

"Given what we know about the nature and frequency of bacteremia from the mouth and the potential for oral bacterial species to cause infective endocarditis, some dentists and cardiac surgeons emphasize the importance of a thorough dental evaluation for patients about to undergo cardiac valve surgery," said Dr. Peter B. Lockhart, the article's lead author and a research professor in the Department of Oral Medicine at Carolinas Medical Center in Charlotte, North Carolina. "Findings from this systematic review, however, demonstrate a lack of data to show a protective effect."

While the authors could not determine an effect based on the evidence currently available, they advised that dentists and medical professionals should collaborate on an appropriate course of action for each patient, weighing any potentially relevant care considerations.

Patients with cardiac valves are the first of several medically complex or immunocompromised patient populations to be examined under the resolution. The next group is patients with head and neck cancer.

"Importantly, this review does not demonstrate a lack of patient benefit but simply a lack of scientific evidence to support or reject this practice of presurgical dental evaluations," Dr. Lockhart said. "It clearly points to the need for a well-designed and conducted clinical study. In the meantime, this systematic review does not suggest we should abandon this practice, but that dentists and cardiac surgeons should take several factors into consideration in order to arrive at the most appropriate decision on which presurgical patients to screen and treat for dental disease."

To read the article, visit JADA.ADA.org. ■

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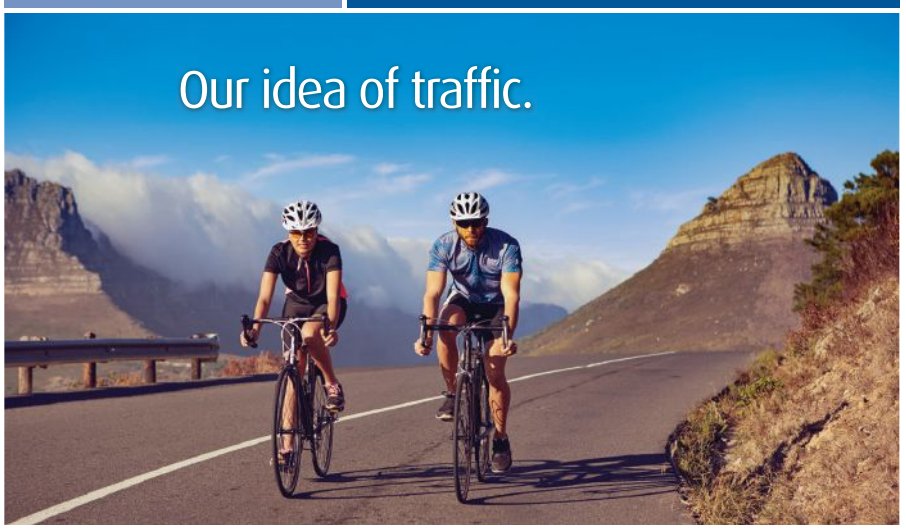

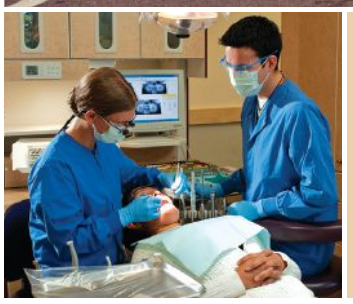

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PENNSYLVANIA — York. Practice for sale $450,000: thriving general dental practice (average gross revenue: $535,000) at prime location of major medical center. 2,000 active patients; 5,000 medical records. Excellent growth potential as practice currently operates only 3 days per week (5 days of hygiene/week). Accepts only Delta Dental. Office condo leased with sale: 1,420 sq. ft., 4 operatories, panorex, Softdent, lab, break, reception, admin areas. **Contact: BestYorkPractice@gmail.com.**

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Member dentists continue 'Legacy' of marathons in southern California

BY DAVID BURGER

Los Angeles — While training for a 1992 marathon, Dr. Calvin Lau broke his leg during a ski trip in Utah.

He was so determined not to miss the race that he "ran" the entire 26.2 miles.

On crutches.

That commitment helps to explain how he, along with fellow member dentist Dr. Kevin Sheu, is known as a Legacy Runner for the Los Angeles Marathon.

Being a Legacy Runner means that they have run every official marathon of the City of Angels since the L.A. Marathon's inception in 1986.

There are 137 Legacy Runners who have completed all 34 Los Angeles Marathons so far, according to the 2019 media guide for the race. The guide also confirms the two's accomplishment.

Dr. Sheu said he is proud of being a member of a select group.

"Being a Legacy Runner is being part of a group and accomplishing a single goal but doing it individually," said Dr. Sheu, director of clinical services-quality of care for Delta Dental of California. "We get moral support from our fellow Legacy Runners as well as other course runners when they recognize our Legacy bibs. It is unique to have a group of all careers to be joined together by a distinctive type of accomplishment. The feeling is one of camaraderie and a group effort, rather than an individual achievement."

"Being a Legacy brings me joy," said Dr. Lau, a private-practice practitioner and part-time faculty member for over 40 years at the University of Southern California's Herman Ostrow School of Dentistry. "It's an opportunity to meet so many diverse people where the only thing we share in common is having done all Los Angeles Marathons."

Both said they never thought about running until dental school.

"Running became my road to fitness after being a couch potato through all of my initial formal education," Dr. Lau said. After beginning his fitness quest by hiking, he decided to run his first marathon when he was convinced to do one by a fellow hiker on the John Muir Trail in central California.

Dr. Sheu, too, started running to lose the weight he put on during a busy first year of dental school at the University of the Pacific.

"My first year in dental school I had gained a lot of weight, so I started to run to lose the pounds," Dr. Sheu said. "As I lost the weight, I ran 5Ks and 10Ks to challenge myself, and then I found myself running every weekend. A dental student colleague dared me to finish a marathon, and if I did, she would cook a meal for me. As a dental student and with a home-cooked meal on the line, I trained and finished my first marathon in 1978 in San Francisco. I got my first marathon T-shirt and a free meal."

For Dr. Sheu, that first marathon was the catalyst for what would become his lifetime hobby.

"When I was in high school, the closest I came to being a part of any sport was that I was the sports editor of the high school newspaper," Dr. Sheu said. "I was the geek/nerd who was more comfortable in math competitions than sports competitions. So now I had proven to myself I could run and finish a marathon, I found that inner athlete that showed to myself I could anything I set my mind to."

Dr. Lau is so dedicated to marathons that he is also a Legacy Runner for the Long Beach Marathon, which began in 1982.

All of his collective experiences defined his philosophy of life.

"You are who you are," Dr. Lau said. "Life experiences can be good, neutral or bad. Your response can be positive, neutral or negative. Your choice. Life is a journey and depending on your core values — if you have discovered them — you can do the proverbial lemonade or wallow in the mire. I strive to do my best, focus on what is important, and do the right thing for the right reasons."

Dr. Sheu said he never thought running all of those marathons as significant until he realized fewer than 140 had done it. About 24,000 people ran in the 2019 Los Angeles Marathon.

"It makes me a better person," he said of races. "While striving to always do your best to push through adversity, there is also that element of knowing there are forces beyond our control that makes you realize there are limits as well. Running as a physical sport is also a mental exercise as well. If you set your mind to a task, that gives you strength to want to complete it, but doing something physical also imparts that inner voice to know when it is time to accept alternatives. Therefore, as a better person anything I do should culminate in the best effort possible, which includes being a human being, a dentist and a director."

On your mark: Dr. Kevin Sheu waves to the camera before the start of the 2014 Los Angeles Marathon.

Broken but not defeated: Dr. Calvin Lau crosses the finish line on crutches in the 1992 Long Beach Marathon. He broke his left fibula several weeks before the race.

The 35th edition of the Los Angeles Marathon is in 2020, and both are signed up. They wouldn't miss it. No matter what.

And don't be afraid to tell them to break a leg. They'll still find a way to complete the race. ■

—burgerd@ada.org

Association scientists present research in Vancouver

BY MARY BETH VERSACI

Vancouver, British Columbia — American Dental Association scientists shared their research at the 97th General Session and Exhibition of the International Association for Dental Research June 19-22 in Vancouver.

The session took place in conjunction with the 48th Annual Meeting of the American Association for Dental Research and the 43rd Annual Meeting of the Canadian Association for Dental Research.

Research presented by ADA scientists included:

- Assessing Dentists' Diagnosis and Management of Dental Erosion, presented by Jamie Spomer, Ph.D., senior director of research and laboratories.
- Low-Temperature Degradation of Dental Zirconia, presented by Spiro Megremis, Ph.D., director of research and standards.
- Mechanical Behavioral Assessment of Zirconia Ceramics Using Vickers Indentation Hardness, presented by Max Gruber, engineering research assistant.
- Sociodemographic Variability in Proportion of Amalgam Restorations in the U.S., presented by Cameron Estrich, health science research analyst.
- Using Network Meta-analysis to Inform Policy and Clinical Practice Guidelines, presented by Malavika Tampi, manager of the Center for Evidence-Based Dentistry.
- Systematic Review: Dental Pretreatment Impact on Cardiac Valve Surgery Outcomes, presented by Hillary DeLong, policy analyst.
- Cleanliness in Reprocessing of Dental Instruments, presented by Prerna Gopal, Ph.D., senior oral microbiologist.
- Assessing Dentists' Perspectives and Uses of Bonding Agents, presented by Rashad Vinh, scientific communication specialist.
- Running Network Meta-analysis in Dentistry: Assumptions, Methodological Approach and Challenges, presented by Olivia Urquhart, research assistant.
- Effects of Antibiotics as Adjuncts for Pulp-related Dental Emergencies, presented by Lauren Pilcher, research assistant.
- Identification and Quantification of Dentin/Enamel on Multi-use Diamond Instrument Using Raman Spectroscopy, presented by Henry Lukic, engineering research assistant.

The ADA Science Institute also sponsored a symposium at the session on Building Translational Bridges for Oral Health, Evidence-based Policy and Clinical Practice. It was organized and moderated by Dr. Marcelo Araujo, vice president of the Science Institute.

For more information about the General Session and Exhibition, visit IADR.com. ■

—versacim@ada.org

Need dental plan for employees pronto?

ADA has resources to guide plan purchasers on how to create happy smiles

BY DAVID BURGER

Editor's note: This is the 27th story in the Decoding Dental Benefits series featuring answers and solutions for dentists when it comes to the world of dental benefits and plans. The series is intended to help untangle many of the issues that can potentially befuddle dentists and their teams so that they can focus on patient care.

West Greenwich, R.I. — Research suggests that patients with a dental benefit plan are more likely to seek dental care. Most individuals are covered by a benefit plan through their employers who negotiate group discounts for their employees and sometimes pay part of the premium for the plan.

When employers offer a dental plan for their employees, they're not only helping to create great smiles.

They're also trying to generate healthy, confident and productive employees who can help make companies successful.

A concern, though, according to Dr. Paul Calitri, a Rhode Island-based general dentist and member of the ADA Council on Dental Benefit Programs, is that employers tend to spend most of their time researching and evaluating the medical portion of health care

coverage — and comparatively very little time on dental benefits.

And that should concern other dentists as well.

"Dental coverage, along with vision, is often an afterthought," said Dr. Calitri.

Many employers rely on brokers or consulting firms for recommendations on coverages, processing policies and other considerations.

The ADA policy on Standards for Dental Benefit Plans discusses the Association's point of view on optimal structure for these plans. Further, the ADA Council on Dental Benefit Programs has developed a set of tools to help employers choose the best plans for their organizations, Dr. Calitri said.

Dentists who treat human resources professionals, owners of businesses and other influential employees should talk to these individuals about concerns with their current plans and discuss what constitutes a good dental plan.

If encountering problems with plans not covering their particular treatment, consumers can be directed to the ADA's consumer website MouthHealthy.org, which houses a survey consumers can take that generates a score they can use to evaluate their plan: Mouthhealthy.org/en/dental-care-concerns/paying-for-dental-care.

The toolkit contains information to help employers evaluate their employee dental plans and is located at ADA.org/en/public-programs/dental-benefits-plan-for-employees.

The toolkit offers questions that a purchaser should ask when shopping for the best plan for their employees, as well as questions to ask oneself when determining whether the plan chosen fits their needs.

"We often hear dental benefit companies tell us at the council that they only implement the employer's choices and that the employer has the final decision," said Dr. Calitri.

Dr. Calitri said, "When many patients get upset with insurance companies when the latter won't cover certain treatment, they should also look at their employers."

Dr. Calitri stressed the next point.

"Plans that restrict patients' choice of dentists should not be the only plans offered to subscribers," he said. "In all instances where this type of plan is offered, patients should have the annual option to choose a plan that affords unrestricted choice of dentist, with comparable benefits and equal employer-contributed premium dollars. Employers should try to understand the overall satisfaction of dentists in the plan's network to ensure that employees receive care within a network that values the doctor-patient relationship."

To speak with someone about selecting a dental benefit plan, employers can call the ADA's Center for Dental Benefits, Coding and Quality at 1-312-440-2500.

The ADA's online landing page for dental benefits information that can help dentists address and resolve even their most vexing questions is at ADA.org/dentalbenefits, part of the ADA Center for Professional Success.

Staff from the Center for Dental Benefits, Coding and Quality can help dentists with dental benefits-related and coding problems, questions and concerns. Call the ADA's Third Party Payer Concierge at 1-800-621-8099 or email dentalbenefits@ada.org, or for questions on the code email dentalcode@ada.org.

Previous installments in the Decoding Dental Benefits series are available at ADA.org/decoding. ■

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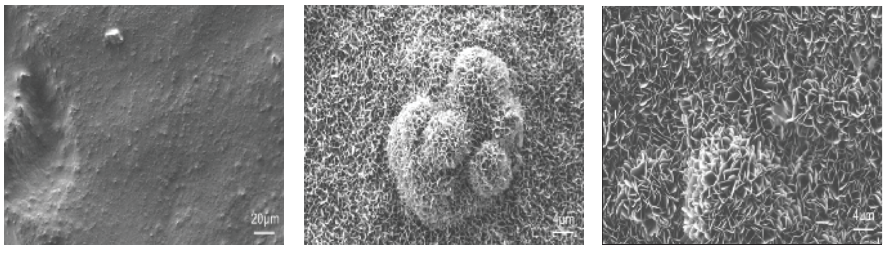
Mineral Apatite Formation SEM Analysis of Predicta™ Restorative Surface after 28 Days in Simulated Body Fluid (SBF).



Left: *Predicta control, no SBF.* ***Center:*** *Predicta, 7 days in SBF.* ***Right:*** *Predicta, 28 days in SBF. SEM images courtesy of Uppsala University, Sweden.*

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