

Transcript for NC DHHS COVID-19 Guidance for Dental Professionals
May 6, 2020
5:30 – 6:30pm

Presenters:

Sarah Tomlinson, DDS- State Dental Director

Tim Wright, DDS, MS- UNC Adams School of Dentistry

Mark W Casey, DDS, MPH- Medicaid Dental Director

Darlene P Baker, RDH- Medicaid Lead Dental Policy Analyst

PLEASE STAND BY FOR REALTIME CAPTIONS.

Hugh Tilson:

This meeting is being recorded.

It is 5:30. Good evening, everybody, let's get started. Thank you for participating in today's webinar on COVID-19 Guidance for Dental Professionals and NC Medicaid Non-surgical Caries Management. This is put on for Dental Professionals by the NC Department of Health and Human Services and NC AHEC. The purpose is to provide an update on the state's activities and answer your questions. My name is Hugh Tilson, I'll be moderating today's forum. As you can see, we have a great group of panelists tonight, Dr. Sarah Tomlinson, our State Dental Director, Dr. Tim Wright from the UNC Adams school of dentistry, Dr. Mark Casey, our Medicaid Dental Director, and Darlene Baker who is our Medicaid Lead Dental Policy Analyst. Thank you all so much for making time in your busy schedules to provide this great information for us tonight.

Before I turn it over to Sarah, I would like to take just a brief moment to thank everybody for making the time to be with us tonight. We know that you all are all busy, and carving out time to get this information is an important thing for you to do and we hope that the information you get tonight will help you do your work even better and make navigating these trying times a little easier. Next slide. After the presenters finish their updates, we will turn to your questions. We have learned in past forums that when the presenters will often address your questions during the presentations. I encourage you to wait until the presenters are through with their presentation before presenting a question. Please know that if for some reason we cannot get to all your questions, we will forward them to the panelists who can follow up with you directly. To submit a question, use the Q&A function on the black bar at the bottom of the screen, that Q&A function on the black bar on the bottom. On the phone, you cannot do that, so send us an email at questionsCOVID19webinar@gmail.com. And we will be able to ask your questions to our panelists. Please know we will also make a recording of this webinar, we will make that recording a written transcript of it, any slides available on the NCAHEC website as early as tomorrow. Next slide. Now we will turn it over to Sarah.

Sarah Tomlinson:

Okay, thank you, Hugh. I'm going to update on some guidance that has been given by the Board of dental examiners, the ADA, the CDC, and some new guidance from OSHA. On April 28th, the North Carolina State Board of Dental Examiners released a statement on providing dental services during the COVID-19 state of emergency. So although the guidance for dental offices to limit care to emergency and urgent needs still stands, the board wanted to provide resources to help guide dentists in the safest possible way to offer dental services should they continue emergency care only or begin to offer additional services. The board recommended providers review several resources and gave links to the ADA toolkit, which I will talk about in just a second, return to work toolkit. The ADA document on minimizing risk of COVID transmission, a 35 page OSHA guide to

preparing workplaces for COVID-19 and the CDC infection control in dental settings which I will also talk about tonight.

The ADA, our second resource, created an advisory task force on dental practice recovery and on April 27, this task force launched a toolkit because dentists across the nation are beginning to reengage in providing routine care. Inside the 17 page ADA return to work interim guidance toolkit, you will find sample letters to patients, guidance on pre-appointment screenings, in office patient registration procedures, reception area preparation strategies, a chair side checklist, and staff protection strategies. The CDC guidance infection control and dental screenings is referenced as a resource in the recent statement by the State Board of Dental Examiners and in the ADA toolkit. This has recently been updated. On April 27th, to include implement source control by requiring masks for everyone entering the dental setting, both staff and patients regardless of whether or not they have COVID-19 symptoms. And, to actively screen everyone, both staff and patients, on the spot for fever and symptoms of COVID-19 before they enter the dental setting.

Now, for North Carolina, I do want to add here that dentists who perform COVID-19 testing are expected to report results to their local health department. So, COVID-19 testing is different from on the spot screening for symptoms and fever. So, just wanted to interject that. There are some differences between the ADA toolkit guidance and the CDC resources. One difference between the ADA toolkit and the CDC, is there purpose. The ADA document is for offices returning to providing nonemergency care while the CDC recommends providing emergency care only, as long as the pandemic is going on. So, additionally the ADA says to wash hands and donned gloves in the room while the CDC guidance recommends doing this before entering the room. The ADA specifically recommends protecting pregnant staff by limiting exposure to patients and that is not in the CDC guidance, and the ADA does not mention anything about protecting older adults or staff with pre-existing conditions. Finally, the ADA does not give enough details about extended use or reuse of N95's, so please refer to CDC and OSHA on reuse of N95 respirators. The CDC allows respirators to be reused up to five times unless soiled. So our final guidance tonight comes from OSHA. They have released respirator guidance and affirmed recommendations to limit care to emergency and urgent needs only.

In a news release in an accompanying memo on April 24th, the U.S. Dept of Labor shared that if respiratory protection must be reused, both the CDC, OSHA and the National Institute for Occupational Safety and Health have evidence supporting the following methods, offer the most promise for decontaminating respirators. Vaporous hydrogen peroxide, and this is used in large hospitals to decontaminate in bulk, or UV germicidal irradiation or moist heat, and those are more appropriate perhaps for dental offices. If the mask manufacturer offers guidance on reuse, the mask can be reused for Aerosolizing procedures. If not, then masks that have been decontaminated can be reused for other patient care activities. Other methods such as autoclaving, the use of bleach, alcohol or soap are not considered acceptable at this time.

OSHA also launched a new website May 1st under there OSHA COVID-19 control and prevention with the title of Dentistry Workers and Employers. Their website reads on March 16th, 2020 the American Dental Association called for dentists to keep their offices closed to all but urgent and emergency procedures during the COVID-19 outbreak. Unless emergency dental procedures absolutely cannot be delayed, OSHA further recommends that emergency dental procedures be performed on patients with suspected or confirmed COVID-19, only if appropriate precautions, including PPE, are available and used.

Okay, so that concludes my part of the guidance updates. And I'm going to pass this presentation over to Dr. Tim Wright, a pediatric dentist from the UNC Adams School of Dentistry, he is a national expert in the use of fluorides and will be speaking on non-Aerosolizing dental services. Dr. Wright.

Dr. Wright:

Thank you so much, if you could go ahead and pull up the slide deck. Switch that over. I will get started. Welcome everybody to the presentation, as you can here, we get a little bit of varying guidance here. I'm going to try this. Can you pull up my screen there or should I do it here? Can you hear me?

Hugh Tilson:

Yes, I think you need to share your screen.

Dr. Wright:

Okay. Because that is -- yeah, all right. There you go. You got it, can you see it?

Yes sir, thank you.

Good.

It is interesting doing this, usually I like to work the audience and I read faces and do these things. It is not quite the same as a live audience but anyway, this evening I'm going to talk about non-aerosol Caries Management and as you were just hearing, aerosol is such a big part of what we do and such a big part of this whole pandemic. And part of the unknown that we are actually facing. And part of the reason we have got different marching orders from different groups and they are changing so rapidly. So, stay apprised of what the experts out there are saying in the different groups and then be careful when you do things.

So, I'm going to talk about -- there we go. So, aerosols. We generate aerosols all the time just by talking, we generate aerosols but in the dental office we have got really effective aerosol producing equipment. 3 way syringes, all these different things. They generate a lot of droplets in addition to aerosols, and from a transmission point of view, there is droplet transmission and there is airborne transmission. And even in the literature out there, we know it is droplet transmitted, there is question about the airborne transmission and although there is some evidence suggesting that happens as well, that is more difficult to manage. Droplet transmission is a different level of, as far as distance goes, as far as how long the viral particles stay within the air, there is all of those issues. And we do not have all the science yet to answer all the questions related to this, which is part of why you hear different recommendations and it is challenging for folks.

This is not where we are with dentistry, I hope we do not get to this point. This is what I pulled off the Internet with high-speed suction which people are selling right now and even the patient here is in a moon suit. I actually would like to have this suit for my protective equipment, I think this is pretty cool. I don't think I will look as good as a movie star does but anyway, I don't know where we are headed with all of this, it is interesting times. Talking about nonsurgical, non-aerosol producing, the group at school in Pediatric Public Health, our division, put together this nonsurgical caries management approaches and I am going to talk about most all of these tonight, not everything, but this is the North Carolina Oral Health Collaborative put this up so it is a written document, you can get it online, it has been up on public health listservs and other things. North Carolina State Dental guidance. If you need it and can't find it, shoot me an email, I would be happy to send it over.

So, first I will talk about the caries management and prevention aspects and then I will move into the nonsurgical restorative, but we obviously deal with all kinds of folks who are nonsurgical

management, even in a non-COVID environment and non-aerosol producing is handy, whether because of uncooperative patients, medically compromised, cognitively impaired patients where having nonsurgical approaches can be extremely beneficial and useful in everyday practice. Traditionally, we have tried many different things to manage caries from an antimicrobial perspective, for a long time we thought surgical management really debunked and got rid of a lot of the bacteria. Then we had more medical management approaches, chlorhexidine has been shown not to be effective even at concentrations higher than what's commercially available. Povidone-iodine they are still looking into this but there is no guideline currently that recommends the use of povidone-iodine. There are some interesting things on this in relation to preventing aerosol contamination for dental patients. There is a variety of things out there that they are currently being looked at. Iodine combinations, hydrogen peroxide iodine. I saw one today online that's actually a silver hydrogen peroxide was marketed as Halo and it has been pulled off the market because they are doing testing on it right now to see if that is an effective pretreatment to help prevent aerosol -- reduce aerosol transmission. So, silver diamine fluoride, I'm going to focus on that, silver nitrate is another one, those are focused, so chlorhexidine and povidone iodine and hydrogen peroxide, sort of globally knocked down the bacteria where these other modalities are really directed at targeted for lesion specific management.

Commercially, there are three silver salt products on the market in the United States, silver nitrate has been around forever, commonly used in the 25% concentration, but you can get it in powder and mix it up in different concentrations. There are some studies on this that show that that concentration is pretty effective. The first of the silver diamine fluoride on the market was the Advantage Arrest by the company Elevate and then -- more recently came on the market last year which is a two-step product, that is what we have on the market.

So how does silver work? Silver is very antimicrobial and has a variety of different mechanisms of action, it disrupts the cell membrane and a broad spectrum of microbes and is also has antiviral as well but it also gets into the cells, disrupts organelles, it sticks and messes with the DNA, it messes with enzyme systems and it just has a variety of ways and mechanisms by which it targets and kills a broad spectrum of microbes. So, on the oral microbes, there have not been a lot of studies on this, but studies that have looked, and some are specific in vitro, looking at specific microbes, different ones, and it kills pretty effectively. And all of the different products, all of the silver products are very effective in killing the oral microbiome bacteria and fungus and other things that live in the complex biofilm that we have.

We do not know what is the long-term effect, if you go in and treat a bunch of caries lesions, will that have a long-term effect on the overall biofilm in the mouth? Evidence would suggest from people I have talked to, so it's anecdotal, but yeah, it probably is not. It's not going to shift a -- caries producing oral biofilm to one that is all of a sudden going to be healthy. So, SDF is silver fluoride, this is a study where they broke it down into different components and they have compared these in their bacteriological effects on some of the bugs that are of interest in caries, strep, lacto, and the bottom line is what they found, it is silver that is doing the killing in here. Some of the other agents have potential effect but it basically is silver that gives you your antibacterial component.

So, Advantage Arrest, this is what is on the market, both of the SDF products are 38% and there have been studies comparing 10%, 30%, 38%, I think I saw one recently where it was even higher than that, a little bit. But, this is one that was found to be more effective than the lower concentrations, certainly more effective than 10% in clinical trials. It is now a lightly blue tinted solution, which was meant to help it be visualized when you place it in a lesion. It is slightly basic and it has a strong metallic taste. It is like chewing pennies or something, it doesn't taste very good. And that is the

chemical formula for it. It became commercially available in 2015. It received clearance similar to the way varnish did, it is not on the FDA cleared as a medicament for caries, it was cleared as a device. Tooth hypersensitivity and there are a number of warnings and labels on the box of SDF such as not recommended for use in people under the age of 21. I am a pediatric dentist, I clearly do not follow that recommendation at all. They also have recommendations as to how many lesions and we are actually using it off label. We are using it for caries management, it is not used much for tooth hypersensitivity. Maybe some, but the vast majority of the market share is for caries management and that is what I'm talking about in this presentation. So, varnish is the same thing, it came on as a medical device, not for caries management, and it is used off label for that purpose.

So, what is in this stuff? It is 25% silver and it is about 10% ammonia, 5% fluoride, not 5% sodium fluoride, it is 5% fluoride, so this is twice as strong as varnish. Varnish is about 22,000 parts per million and change and this is 44,000 parts per million and change. So it is twice as strong as fluoride varnish. It is the most concentrated fluoride product we have in the market in the United States. And the rest of it is water, and then there is the blue, which is a food grade dye that is in there that is stable as well. So it is not a gel, it is liquid running, it is a solution. So, the different components in there have different actions, so the silver diamine fluoride, basically the fluoride component does what fluoride does and in high concentrations like this, it precipitates on the surface, predominantly with calcium fluoride, where it then slowly reacts and provides the re-mineralizing benefits of fluoride, helping to re-mineralized, partially demineralized, crystallize and to regrow the mineral and build floor appetite which is more acid resistant. So you're not only rebuilding the lesions but you're making them more resistant to future demineralization. The ammonium part may have a little bit of anti-microbial activity but not much. That is really the silver which is doing all the different things I talked about earlier. It will precipitate into a variety of things, silver phosphate, silver chloride, silver oxide. Some of those precipitates, they are different colors depending on what it is, but silver oxide is what gives you your black color. Silver phosphate, any of these salts that are in there, the silver may be able to re-dissociate and then have antimicrobial effect. Some of these like phosphate, silver phosphate may serve as a reservoir for phosphate ions to participate in the re-mineralization. That is not all worked out in the science world, not for sure known exactly how all this works and how much contributes to which, but we know silver is the antimicrobial part, fluoride is the re-mineralization part, that is kind of the bottom line as we understand it today.

So, what kind of outcomes are we looking for? There are two outcomes, the primary outcome that most people are looking at is Caries arrest. So, your painting it on an active lesion, these are a couple of root surface lesions that Scott Edson provided to me in an elderly patient. There is evidence from a number of studies that you can get primary caries prevention, so if you paint it onto a surface that is at risk for root caries for example, studies have compared SDF versus varnish and other treatments on root surfaces and compared to just putting water on there as a placebo control, and you definitely have got a caries benefit by putting SDF on, and at risk exposure that was non-carious. Similarly, there is at least one study that has looked at fissure caries and showed a pretty good fraction in the 60% range for primary prevention on pits and fissures. So, not a lot of data on that but that is an outcome, and that is not typically how most people are using it, it may be in the future, but that is not what most of the data is on at this point in time. It does work in both primary and permanent teeth, there is data on both of those.

So. There are evidence-based guidelines that include SDF now, this came out in late 2018, the evidence-based clinical practice guidelines for non-restorative treatments for carious lesions. And this is the one for primary teeth and there is also one for permanent teeth and you can see here, that the SDF, it is almost like all roads lead to SDF, not all roads, but this one doesn't, but SDF is considered an integral part and it is evidence-based and its part of a guideline, which means it has to

be based on systematic reviews, and there are multiple systematic reviews for SDF at this point. So, that is those for primary and for permanent teeth.

So, the American Academy for Pediatric Dentistry also, based on systematic reviews that were already published, same with the ADA guidelines, was based on previously published systematic reviews, and it states that, you know, it is part of a comprehensive caries management program. They had conditional recommendation, low quality, as this came out a couple of years ago and there is still debate between, there is discussion as to whether or not patients and clinicians and the clinical trials all are in agreement, that is why I get the conditional recommendation as opposed to a strong recommendation. There is no question that it works, but it has not been adopted across the country, it is not paid for all across the country, those are different issues. So, these will change over time as this becomes more of a mainstream therapeutic that is adopted by the dental profession.

So, switching over to the clinical sort of application of where the rubber hits the road with this. So, this is actually where the silver nitrate case, but this is before and this is a kid, an older sibling had been to the operating room and they found everything, parents did not want to do that, this got treated and then this shows the arrest that you're expecting, the dark and hard, fractured off one of the teeth, was part broke off of that one. But not aesthetically so much of an issue in this kid because it is mostly on the lingual. But if that is on the facial, that is a different story, and that can be an issue. But that is what you're looking at and the endpoint for arrest in caries is dark and hard. So, light and soft, not good. Dark and hard, good. That is what you're looking for in treatment of these things.

So, is it superficial or does it actually penetrate? So, these are where they actually treated teeth and then extracted them and they are looked at, this is a cross-section across the tooth with the electron probe and what they are showing is that there is a lot more calcium and phosphorus that is remineralized on the surface compared to the body in the lesion, and it is about 200 microns, so it is not just a superficial layer and over time this may increase, there is not a lot of data on this but this is a nontreated lesion where there is no uptake. So, it is not just a few microns on the surface, it is actually penetrating into the lesion fairly deeply, and what it does in enamel, that is not known. How deeply it goes, it will arrest enamel caries, that is for sure, but how deep it penetrates, that is not a known issue.

So, I get a lot of questions about pulp. And what we know about pulp? There have been both animal studies and human studies, animal studies where they did this, they prepped the teeth so they could be pretty precise in how close they were to the pulp, and what they found was that there were not any histological changes, evidence of causing inflammatory issues. That it did not generate an inflammatory response. Again, it is not that far off of physiologic pH and products that are in there that clearly would be transmitted through the odontoblast process, the dental tubules or the odontoblast if you're close enough, the actual processes. They did not cause inflammation in the animal studies that were published. When we looked at the human, so this was indirect pulp caps and they were saying, estimating quarter to half a millimeter, these are Class V preps. They did not find when they then extracted the teeth and looked, they got good tertiary dentin formation, this is a lower mag and higher mag, so this is tertiary dentin, the red arrow, here it is, these are odontoblast and pulp but not inflamed, so good for generating tertiary dentin and one of the offshoots of the study was that it might be good for an indirect pulp therapy. Studies have looked at it, there have been a lot of different studies, but studies that looked at it as a potential direct pulp capping agent, showed it wasn't effective. So if you get a pulp exposure that is not where you want to be. But can you put it down in a deep carious lesion? Yes, you can and it will not cause things to get worse if the lesion is

deep enough and the pulp is already involved, probably not going to make it get better either, so that is the diagnostic decision-making coming in.

Safety and toxicity, if you look at the MSDS sheet in there, because it has ammonia and things in it, it does have warnings on their. Sodium fluoride, they give you the actual dosage for what the hazardous ingredients are and possible outcomes. For silver, it is harder to find what the silver dose issues are because there is not a lot of acute toxicity studies that have been done, a lot of studies on toxicity of silver from back in the 70s, the issue is chronic and not acute. You can have a pretty good acute exposure and it will not cause you a problem but if you have that over time, it will cause argyria, because it is taken up in the body and retained and you will eventually turn into a Smurf. You get argyria and turn silver.

So, there have been two studies now, this is the first one, there has been a more recent one, neither one was a large study, this was only in a handful of people and they were looking at three teeth and they were treating them, they used about six microliters per tooth and they figured, put it on, they calculated how much they put on, micrometer amounts, it was very small amounts. Then they actually drew serum and looked at them subsequently and they measured fluoride levels and silver levels. And these are adults, so this is milligram, kilogram looking at dose-response. This is whether they are -- thresholds recommended by the EPA. They found that even with these very small amounts, they only used 20 microliters there, they were exceeding the silver reference dose, but that would be if you are doing this daily over a longtime. If you have intermittent exposures like that, it is not a toxic issue. Fluoride was not below the threshold. Again, these are adult people, so if you're doing this on a 2-year-old, you want to use the least amount you can possibly get away with to treat the lesions that you want, probably keep it in the lesion and not having it run all over the place, that is my take home message on this. There is a newer study that has similar results.

So, yeah, this was a guy who drank colloidal silver for years and it is still on the market and you can buy 10 part per million or 20 part per million colloidal silver, which actually does not work the same as ionic silver, silver salts with dissociate. Nano silver, nano particle, if you hear that, there is none on the market in the United States but people are looking at it, and they work differently. The size of the nanoparticles has an impact on the antimicrobial ability of it, colloidal silver is not the same as silver salt. There are actually warnings now on these after the comments about drinking or consuming antimicrobial as a possible COVID thing, they now have warnings on these things, and there have been people trying to market some of these things that say yeah, this will cure or prevent COVID, and there is no evidence of colloidal silver having any benefit whatsoever.

Silver salts on the other hand, there is some evidence ends as far as cleaning if you look at the CDC site for COVID and things that kill and clean, like sodium hypochlorite bleach, those things are shown and known, some of the silver salts are in there as well. But drinking this stuff is not going to help, and gargling with colloidal silver, there is no evidence that is going to help. So, unless you have some reason to have chronic exposure, it's not going to be a problem, SDF is not going to cost argyria. This is a kid who used medication for burn patients, Silvadene cream that has silver in it, and he used it every day to prevent skin infections and he developed argyria from the medication, but that was a lifetime of use and he was an adolescent here. If you get it on you, this is silver nitrate, which is a little blacker, SDF is a little more of a brown, henna stain, it will stay in your skin, it sticks to it and then the black of the silver oxide, as your skin turns over, it will go away, which on your hands will happen fairly quickly. If you got it on your neck or back or someplace, not so quick. However long it takes your skin to turn over, which could be a week to two weeks, depending on again, where it is. Days to weeks. But it is reversible. As your skin often changes over. So, you can make cool tattoos with it if you want. One thing about this, if you do get it on somebody or you get it

on a kid's lip or something like that or their skin, lips are not an uncommon place to have it either because it wicks up on your finger or if you're trying to do something like proximals with floss, then you may get it on there. If you use hydrogen peroxide, just pick up a cotton swab and, or Clorox bleach and put it in there and wipe the tissue off, it will, if you're seeing there is a color reaction starting to take place, and that happens as it gets exposed to light, it will take it off. I put it on my hand and waited 30 minutes and had a pretty good tattoo going and I just used sodium hypochlorite out of the bottle straight, and it all came off. So, that will work. I have heard, if you get it on dental equipment, your countertops or places, that the magic eraser, Mr. Clean magic erasers, will work on that. I bought one and tried it two times, one on a stain that had been on one of our carts for a long time and it made a little bit lighter but it sure didn't take it off. But I have heard from people that they swear that it works, so try that. But on skin, hydrogen peroxide or sodium hypochlorite both work to get it off really good if you have an issue with that.

So, critical things, case selection, I will talk about application technique and then protocol for follow-up, and then I will switch over to a little bit about restoring things. So, possible advantages of doing this, it is noninvasive, it is not pain inducing. A little kid this age, probably not going to like it still because they don't like anything that I'm going to do except giving them the toybox. Infection control, it is inherent in the material, again it probably kills COVID but that is not a big issue with what we are talking about. It is easy to do, it is affordable, it does not take long to apply it, and germane to this discussion, it is non-aerosol producing. So if you have patients that are coming in, part of the thing that we put into the North Carolina health collaborative was you have got somebody that comes in for an emergency and it is probably not one tooth, most people do not come in with caries in one tooth. You're having to deal with that one, whether it be extraction or whatever you have to do to it, you go ahead and stabilize, help stabilize, hopefully stabilize the rest -- using SDF and then get them when things are a little more stable, hopefully a little less closed down than they are right now.

So, case a selection, parents have to give consent or patient gives consent. You know, even little kids if I can, I'm not going to sit around and discuss this with a 2 or 3-year-old, but if I have a 5 or 6 year old, I may say, how would you feel about this, doing this? And see if that doesn't mean that I will necessarily do what they want but I would rather have consent if I can. Parents have got to be okay with this and they have to understand exactly what its going to look like, maybe not exactly, but they have to have a reasonable idea because parents can have issues with this. There have been a couple of studies on this now, but not surprisingly, parents felt anterior teeth were less acceptable than posterior teeth. People have done studies now even looking at, well, if you had to do general anesthesia or sedation or restrain somebody, would you rather have SDF for that or the surgical management? And it varies depending on the people. It is not everybody would say yeah, I would rather have you hold them down and do a white crown than have a black tooth, just unacceptable to some people. Interestingly, it is more acceptable for boys to have SDF treatment than it is for girls to have SDF treatment. So, we make good pirates or something.

Consent forms, when we started doing this we were just doing verbal consent. This is a UNC form and it is showing posterior teeth, if I was doing this in kids, there is a bunch of them online, you can get two and look at different pictures. Another example, I will not show them if I'm going to make other front teeth black, and just show them this one picture. Jump online, there is a bunch of pictures and show them what it looks like. So, case selection, what are you trying to accomplish? Ideally, we are looking at dental caries that you can actually access, that is what the data is on, proximal little lesions in here that are maybe not even cavitated but maybe extended to the DEJ or a little further, there is one paper that just came out showing pushing 80% using floss at 12 plus, 80%, no progression rate rated graphically by comparison to the -- well, it wasn't a comparison, it was not a

randomized trial, just a study where they were reporting a retrospective review but they were saying they got another 80% arrest based on it. But, lesions that are open like this is traditionally what has been published in the literature and that is what is in the clinical trials. And ideally there is not pulpal involvement, so we are trying to assess, do they have pain? solicited pain or unsolicited pain? That is not always reliable in kids, more reliable as they get older, most of the time, and certainly more reliable in adults, if you're trying to assess that. But preferably not pulpal involved teeth.

Again, goals. Arresting, preventing further surgical treatment needs, that may require sedation or GA or multiple appointments, you maybe are trying to prevent pulpal involvement and stabilize them until we can get to doing the restorative, and then consider subsequent restorative, this is not going to ever replace restorative care completely, it may in some cases, but if you have got open proximal lesions where they are packing food in here, they may be having pain that is not pulpal pain, they maybe having periodontal pain and food impaction and I have certainly seen that in some of my patients.

Informed consent from parents, protect surfaces with tray covers, put out one drop, and they have both a bottle where you can put out a drop and -- doses that are available. And you also want to avoid contact with skin. There are a variety of things, around crowns and root surfaces, pits and fissure caries, there are a lot of different places where you potentially could do this. Eye protection, I don't know if this is true or not but I have heard that if you drop it into somebody's eye that the sclera, the white of the sclera will actually stain and it doesn't turn over, so you put a permanent stain in their eyeballs, so make sure they have eye protection. Some people put on petroleum jelly on the lips to prevent tattoo on the lips. You can do that, you shouldn't put it in the mouth, some of the early protocols were calling to Vaseline the gums, if you're going to do that, use something that is edible like -- jelly or something, but petroleum jelly is not for internal use. If you have a bunch of debris in the lesion full of food or Cheetos or whatever, just clean that out but you do not need to excavate caries for it to be effective.

Isolate the area as best you can. The better and drier it is, the more is going to wick in there, you just want to moisten the lesion with the least amount you can, either with a micro-brush, this is the little sort of honey dipper kind of micro-brush that it comes with the Elevate Arrest that you can order. They pick up a fairly specific amount, micro brushes are going to be a little less consistent in amount but either one works. I would not pick up a big brush and just start slathering this all over, you want to get it on the lesion and get it to stay there is much as you can, do not get it on soft tissues. Even with the blue, it's kind of hard to tell how much is there. So, there is a tendency I think to kind of overfill the thing and then if they have saliva like in this case, if it is wicking out, you will see a little white precipitate start to go around the tissue, as the light hits it, that will turn dark. But you got too much in there, which you have a big Class II lesion, it is easy to have it rolling out and if you have an uncooperative patient, easy to have that happen. Again, least amount, that is the safest amount, get on the lesion.

How long do you leave it on there? When we originally were writing the particles, we said 2 to 3 minutes, which is a lifetime. But, I have heard, and again there's nothing published on this, that it takes about 90 seconds for the reactions for the silver phosphate, some of those reactions to take place. The reality is that that may or may not be realistic depending on the patient. We do know the longer it sits there the better positive action it will have. So, in my world, if I have a cooperative patient, I will sit there for a couple of minutes, and I cannot extend my attention span for too long but a couple of minutes and you know, 2 1/2 minutes and then I will move on. In a little kid, just getting it into the lesion is the best I can do sometimes and I will run with that, and it still works. It still

works. So, no studies have been done to show what is an absolute critical and how much variation of that result in sort of you know, as far as success goes.

We put 5%, well, so the FDA says don't treat more than five lesions. You do the math on this, you know, a 2-year-old is not the same as a 20-year-old as far as the milligram per kilogram dose. I have done 10 teeth on six, seven, 8-year-olds, and were not even anywhere close to the toxic levels for fluoride at that point, and for the silver part of it, because it is transient, one-time acute does, it's not going to cause a problem either. So, you can do that as well. But that is what is on the box. But if you think about it from a milligram per kilogram, it is not one-size-fits-all all over the world. We treat the rest with 5% varnish for two reasons. One is it is giving us primary prevention, in this picture you can see the decalcification along the -- back here, we are going to hit all of that with the varnish afterwards. And we are going to cover over the lesion, does that give any benefit? It might. There is no studies on SDF and varnish, whether there is a difference with or without. But it does taste a lot better. And so for that reason, and it probably does have some benefit, but we don't know that for sure. There are studies where they have compared silver diamine fluoride to silver nitrate +5% varnish and they are equivocal, there is not a difference between the two.

So, this is a kid who had been treated before, came in, she didn't like it, and they were referred to us to do sedation or GA. We had these carious lesions in here, class III here, some linguals on the back. None of this was pulpal, not even close, so as an option here, would you rather do this or go to the operating room and they elected to go the SDF route, and she didn't like that either. Here were SDF in these lesions. She wasn't too bad, but she wasn't happy about it. They were varnishing over top, she got her tiara, she is all happy now. And here is what it looked like when we brought them back, this was about a month visit. And they are black. Black and brown. When I'm telling them for consent, I do not say it's going to get dark, I point to black stuff and say you know, close your eyes on a dark night, is going to be that kind of black. So this is good. Do you retreat these? If they are dark and hard, you do not need to but what we -- yeah, so here is the lingual. You have a good arrest there.

So, when we ask them to return, and this is what we do for our visit, 2 to 6 weeks, for two reasons. One is that we know it is about 60% successful with a one-time treatment, it is about 90% with two. So we want to assess whether or not we got success with the one treatment, and then we also want to reissue all of our guidance, which is what got them there in the first place. How are you doing with your diet, are you brushing with fluoride toothpaste? So all of those things, and we will reapply it if we need to but we just do not like to apply it every time they walk in the door. It is based on whether or not they are arrested or not arrested. Same thing with subsequent recalls, they would go on to whatever recall system at this point, whether it be three months or six months or whatever it is, and then we again do the same thing. Reevaluate and see if they need to be retreated. So you can buy it in the bottle, this is the cheaper way to get it. And it goes down a little bit in price if you buy a whole bunch, and then there is unit doses, which you snap the top and throw them away after each one, this is a more expensive way to go. 30 of these, this will treat a couple of hundred kids, and here you have 30. So it is much more cost-effective to buy the bottle, and just make sure whoever is dipping it out, dropping out, is not filling up a dish with the stuff, one drop will go a long ways if you are using it.

The code, the CDT code for reimbursement, 1354, that has been around for a while now. In North Carolina, we were one of the earlier states to adopt reimbursement, we will talk, Casey will talk about this at the end, following this presentation, but this is where it currently stands is \$10 for the first tooth, five dollars for additional, up to 25 total, and it covers kids under 5. So, bottom line on this, there have been multiple clinical trials and the take-home message is, 38% is better than lower.

There is no advantage to excavating caries, you do not have to do that. And repeated application gives you an increased benefit. And again, we do not just do that on every tooth, we monitor them and see whether we need it or don't need it.

Can you restore them? Studies have -- there have been quite a few, mostly laboratory studies, where they have looked at the bond strength to SDF and SDF/KI and resins both, compared to carious dentin, both work better on the remineralized SDF treated, because it is harder probably because it is harder and is a better foundation. If you are using resins and your bonding, if you use a traditional etch and rinse, prime and bond kind of a system, that works well. If you're using a one-step, it does not work as well, so the recommendation is to etch rinse and do your bonding agent, do not use a universal type alone without etching, that doesn't adhere as well.

This is a kid who we were just trying to stabilize, had a lot of caries, they wanted this all restored. And I show this for two reasons, one I'm going to show you the restoration, but here you can see the enamel lesions, non-cavitated, these are twos, maybe a three, but there is also biofilm all over this and studies have shown the kids that continue to have biofilm buildup on this, those are the lesions that will reactivate and you have to appreciate, these are not as black in some of these areas as they might be, and this kid is headed for trouble again. If they do not change their habits. That is what got them. SDF is not going to cure this if they are still doing whatever it is they are doing that is causing the biofilm to eat their teeth up. Here they are postop, immediately we did lose a couple of teeth, we did not save them all, trying to prevent pulpal involvement but we did salvage all of these and some resins, here they are back, so. They are restorable for sure, you can salvage it. This is just a case where it is a good caries control, wait three, four, five months to get into the operating room or sedation or whatever, emergencies right now, trying to manage them when it may be months before we are able to manage the whole flow of our patients again, this provides an opportunity to help do caries control with a non-aerosol producing way.

So, nonsurgical approaches. Let's talk about a couple of these. Atraumatic restorative treatment, it has been around for a long time, it was really developed for providing treatment for people who did not have access to rotary instruments like in Thailand, Africa, places like that. And then it was picked up by basically around the world, as being an alternative for patients where you have teeth that may not be there that long or you're trying to stabilize things, get, for a variety of reasons. And you can do it on a patient where the cooperation may not be as optimal as otherwise. Traditionally, it was scoop out, in this you did remove caries, you try to get a clean margin with hand instruments, and so additionally with a glass ionomer. There are now resin modified glass ionomers and there have been a number of studies on those as well.

This was a systematic review where they compared high-viscosity glass ionomers to amalgams, this came out of South Africa. They were reporting that in six years they were holding up as well as amalgams. Systematic reviews, when you look at the overall -- amalgam is pretty good stuff, and when you compare it to most other restorative materials, it tends over the long haul to have a greater success rate than most things. Resins, glass ionomers, stainless steel crowns, that is a different story. But you carry this out a little bit further, I'm not sure what the results would be. But my take-home from that is, they are pretty successful and from a caries control, non-aerosol approach, that would work. What you cannot do with amalgams is to stick these in there with hand instruments, because you will not have enough form and function to probably get a very good restoration. The glass ionomers are resin modified are much more forgiving in that regard.

So, this has come out, and some people do not like the acronym, SMART, but it is a Silver Diamine Fluoride Modified Atraumatic Restorative Technique, so that is what the acronym stands for. Treat

the lesion with SDF and then you do the same thing. And, there's no studies on that, this is the case that -- Meyer did, in a lesion, and treated it and then put the, and this is a resin modifier. A couple of points is, one, these can work pretty well for a long time, so on this little kid, it was easy to do. It is painless, it is quick. And we use resin modifier because --, it illustrates that these things will turn black as soon as you hit the line, they are black when you treat them with SDF and they are black afterwards. If you wait a couple of weeks and you come back, they will not do that. Because all of the reactions have taken place with the silver, but if you do it right away, whatever white stuff you put in there, it's not going to be white any longer. Conventional resin will shine through as well. So that is an issue.

Hall Crown Technique, this is a technique predominately used in kids, but there are permanent stainless steel crowns where you can do it on permanent teeth as well, not on anteriors but on posteriors. And it basically is a technique where you just pick the crown out and it will sit over that tooth without prepping it or without excavating and you intomb the caries in there with the glass ionomer cement and arrest the lesion. Needless to say this has been controversial, it is very popular in Europe and done in many countries around the world. Not done nearly so much in the United States, we still are pretty much conventional on the, not completely, but it has gained some traction but still remains controversial with some folks. The idea is again, that you would select cases with a non-inflamed pulp, not this guy, but this guy, and preferably the same kind of thing just with SDF, we prefer not to have any kind of pain -- or otherwise and again you have an issue with parents, the aesthetic issues if you're doing this in a kid or in an adult and they say I don't want a silver tooth back there. But you can be doing this also as a temporary to stabilize the tooth until which time you could get in there and do something else.

This is a kid, a young one, with a first primary molar, these tend to be the most commonly done. Frequently you have space between the first primary molar and the primary canine making it easier to get to and they have already opened up the distal for me by having a carious lesion there, and just pick your crown out, and it shouldn't be crazy big, you can see some blanching here, but surprisingly radiographically I have done these and I probably do them maybe a quarter of, maybe even less than that, of cases I do are Hall crowns versus regular crowns. Prepped, and the occlusions and the actual contours and radiographs and recalls, they look amazingly good. Sometimes if the occlusion has opened up a little bit, studies have actually shown they stabilize fairly quickly. In an adult, that is a different story. You're doing this on an adult tooth, you put it into hyperocclusion, you will probably have problems. But, they look pretty good.

This was a study comparing conventional, this is a randomized controlled trial that came out last year, and when they looked at the life table actuarial on this there was no difference between the Hall crown and the conventional crown. I was a little bit surprised, I thought there were but might be more pulpal demise from the actual conventional surgical therapy because teeth do not like to be cut on, but they are not, they are but the same. You can see almost 3 years, this is a 30 month, 36 month study, very high success rate. They are like 90% on both of these things. So they work and there have been some other randomized controlled trials on this as well. That is the most recent.

So, case selection and all of these things regardless of whether you are doing, in this case, I am talking about non-aerosol caries management approaches, so caries arrest, the silver diamine fluoride or the nonsurgical management in case selection, the consent is critical, what are your goals, what are you trying to accomplish? Thinking about which one of those may be the most applicable for that. Some of these are fairly easy to do, others are more technique sensitive and more complicated, Hall crown technique is not as easy as doing SDF, no doubt about it. There is still not all the data out there for some of these things but mechanical caries removal for some of them, it is recommended

like for the atraumatic restorative techniques, and some of the other cases it is not, SDF is not recommended, not required. Doesn't offer any benefit based on trials. Hall crown technique, not necessarily, not necessary and shown to be of any advantage either. So, you have a variety of non-aerosol approaches that you can adopt, and right now given the concerns about aerosol production and the kind of PPE that we need to don depending on what you're doing is something else to think about for sure. So, I actually got done pretty much right on time, and if there are questions that folks have, I would be happy to try and answer some of those.

Hugh Tilson:
Thanks. Go ahead.

Dr. Wright:
I was just going to stop sharing my screen so you can take it back over. But you got it. Yeah. Any questions?

Hugh Tilson:
So, the only question I have gotten so far, is what is the shelf life for a bottle of SDF?

Dr. Wright:
Good question. So, SDF is in a light proof kind of a bottle, and you would have to look on the bottle, but it is pretty long. It is a pretty long shelf life. There was a study done, -- Crystal did this and looked at concentration changes, and those were minimal, over six months to a year, I cannot remember if they went as far as a year but I know they went six months. But, it is pretty stable over time. So, for 120 bucks, and I don't actually know the exact shelflife on the bottle, that is a good question.

Hugh Tilson:
The only other thing that you got was a shout out from the North Carolina Oral Health Collaborative saying nice job, thank you very much.

Dr. Wright:
I appreciate that.

Hugh Tilson:
All right, we have one quick question, then I will turn it over to Mark. Is the code the same for Hall crown as to submit for SSC?

Dr. Wright:
Yeah, currently there is only the one, it is the same one. So. Yeah.

Hugh Tilson:
There you. It is a great segue to Mark.

Dr. Casey:
Yes, thank you. And I want to say thank you to Dr. Wright, that was a great presentation. It is really wonderful to have experts in the field, national experts in the field, to speak to groups that DHHS brings together, so thanks for that. It is often wonderful to have two dental schools with experts that we can rely on for information. And speaking of great partners, I also want to thank Dr. Sarah Tomlinson and her crew, they have done a lot in terms of disseminating important information to providers, sorry again, I'm going to be whispering a lot so I am hoping that folks can hear me. It is

just a medical condition, I cannot speak at loud volumes, I apologize. And also, where would we be without our partners at AHEC? Hugh Tilson, Nevin Fouts and their team has been really wonderful in helping, not just dental staff but all DHHS staff, particularly Medicaid staff, and disseminating important information to our providers. So, thanks to AHEC for what they have done and continue to do over the last few months. And last but certainly not least, I want to thank our providers. I want to express gratitude to you, the North Carolina dental health professionals, for rising to meet the challenges presented by the pandemic. Without your commitment ensuring we assist folks with emergent urgent health problems, receive the quality care they deserve, our jobs would be next to impossible, and believe me I can tell you that, there have been days when we get calls from providers and it seems like it is next to impossible to deal with all of the issues, so thank you for all you are doing for disadvantaged North Carolinians and particularly the folks in our Medicaid health choice beneficiary and populations.

So let's turn to the objectives. First of all, we are going to give you a brief look at the policy changes, that is the fluoride varnish surfaces changes and silver fluoride changes. I will start with the rationale for the policy changes and just to give you an idea of why we did what we did. Darlene Baker is going to take over for the details about the varnish surfaces. Effective dates, the reimbursement we pay for the services, some tips about claims submission, also review of the last webinar we presented information on, we have one slide to review the COVID services for tele-dentistry. And of course our contact information. Next slide, please. Next slide.

Thank you. So, in terms of rationale, you have heard that Dr. Wright and others, Dr. Tomlinson mentioned the CDC recommendations to not use aerosolizing equipment. The CDC continues to recommend avoiding the use of those. We want to give our providers the tools they need to continue treating patients with active disease. So I looked at silver diamine fluoride and fluoride varnish as sort of a one-two punch. Dr. Wright talked about silver diamine fluoride and it's ability to arrest caries. He also mentioned that they treat patients with varnish. That's the primary preventive agent, so that 1-2 punch can help our beneficiaries who present with problems, I think Dr. Wright mentioned that the patients -- was treated with silver diamine fluoride, or even fluoride varnish, maybe both. I think that is appropriate to do. So there are a lot of decisions that practice owners need to make and you're getting a lot of recommendations from various organizations, and just recommendations not mandates, so really it is up to you, the prudent provider, to make those decisions to protect yourself, to protect your staff and your patients and we recognize that. Those are not easy decisions to make and we recognize that too.

You will see that our pulse units, we've raced to cover all ages for both fluoride varnish and silver diamine fluoride and that is a big change from our policy in the past. We will explain that more in other slides. We do understand that there is a lack of availability of appropriate personal protective equipment, I have been talking to dentists just as a matter of fact, yesterday, about the ability to get PPE from Henry Schein, the salesperson told him that if he placed an order yesterday, he will not get it until mid-June, so what is he supposed to do as a provider to ensure the financial health of this practice and to protect his staff and patients? Those are really difficult questions, so again another reason why we need to give you additional tools. And the other point I want to make, the last bullet point, once the restrictions are lifted, there's going to be a lot of patients who need care, restorations, they need other treatments so the additional tools, we are hoping that you can stabilize a patient as Dr. Wright suggested, stabilize patients, bring them back in the future at some point where you can restore it so you can have more time with the patient, so we anticipate there is going to be a big demand for care, once the restrictions are lifted. And we are here to help you. So, with that, I want to turn it over to Darlene. And she is going to go into more details about the changes. Thank you.

Darlene Baker:

Thank you Dr. Casey. So good evening everyone, I'm Darlene Baker with NC Medicaid, the lead Dental Policy Analyst. And I'm going to go through quickly some policy changes that will be effective in our NC Tracks system on Monday, May 11. Our first change is with the topical application of fluoride varnish procedure code D1206. I've listed here our existing policy and then our policy changes. So we currently cover the topical application of fluoride for beneficiaries under age 21, once every 6 calendar months. And it can be thus be applied to all the teeth that are erupted on that date of service. So the policy changes that will be effective May 11, are that we will allow the application of fluoride varnish for all ages, including adults so all Medicaid and health choice beneficiaries of all ages. We will allow this to be done every three calendar month period if the patient is at high-risk for caries. So that means that they currently have active disease or they have had teeth extracted or previous caries related treatment. Next Slide.

We are also making a change to our Silver Diamine fluoride application, so this is covered under procedure code D1354 and our current policy is limited to beneficiaries ages 1 to 5, and they can apply that on a total of 5 teeth on a certain date of service once every 6 calendar month period. It is limited to only certain teeth, all the primary teeth and permanent first molars. Because this was limited to patients, just ages 1 to 5, these were the only teeth that would be erupted on this young child. So our policy changes are going to allow this for patients of all ages and include all permanent teeth 1-32. And so this could be very beneficial to nursing home patients or special needs patients in a group home, if you're having to see them due to issues due to sensitivity or pain and you could apply the silver diamine fluoride and arrest the decay until you could get them in for more aerosolizing dental treatment and actually restore the tooth. Next Slide.

So the effective date of these changes, will be Monday, May 11 and it will be retroactive of March 10, 2020 which was the date of our other policy changes. And it will end with the state of emergency if rescinded. Next Slide.

And this is the current reimbursement for the topical application of fluoride for the dentist or pediatric dentist. And also the silver diamine fluoride, so there was an across the board rate increase that was effective January 1, 2019. So we now pay \$11 for the first tooth and \$5.50 for the second, third and fourth tooth for a total of \$27.50 on a given date of service. Next Slide.

So we want to talk a minute about billing in the NCTracks system. So these codes do not require prior approval, and prior approval will not be required for the new ages and the tooth numbers. So there will be no prior approval requirement. You will notice when you submit your claim in NCTracks, the claim will pend and be in a pending status. Please note that this is not a denied claim but a pending claim and no action is needed by the provider. The NCTracks will realize that it is an adult patient during a state of emergency and it will override the age limitation automatically in 24-48 hours and the claim will move on and finalize and pay. And you will see it move from the pending status to a paid status. So it will not be a denied status so do watch your status closely and you will notice that the status will update and move to a paid status. To pay for adults receiving the topical application of fluoride varnish or the silver diamine fluoride application. Next Slide.

And we also wanted to give you some info about Medicaid Prescription Fluoride Products. So for your high-risk patients you can prescribe fluoride that they can fill at their pharmacy, so we thought it would be helpful if you new the covered services. We have included all the toothpaste and gels that are available under NC Medicaid coverage. And we will share these slides tomorrow or the next day or so and they will be available on the AHEC website. So that you can get this information from

the slides and they are also recording tonight's presentation so that information will be available to you. Next Slide.

And this is just a refresher of the webinar that was held on April 22. Where we introduced the teledentistry procedure codes. So D0999 is our telephonic only, teledentistry procedure. D9995 is a real-time teledentistry encounter, D9996 is a store-and-forward so the patient sends you information in an email and you respond back with an email and you are not actually speaking with the patient directly. And both the synchronous and asynchronous teledentistry procedures, you must bill those with an emergency exam, either D0140 or D0170 reevaluation emergency exam code. And you have to report the emergency exam on line 1 and then the teledentistry service, D9995 or D9996 on line 2 of your claim for the claim to process correctly. Prior approval is not required for any of these services and you must bill it with place of service 2 to indicate that it is telehealth. So if you do not enter your claim correctly with the telehealth place of service you will need to void that claim and resubmit it correctly so that all services are billed with the place of service 2 for telehealth. Next Slide.

And this is a refresher of the current reimbursement rates for our telephonic codes listed first here for \$22, then the real-time teledentistry \$62.50, the store and forward teledentistry is reimbursed at \$22 and again we have a note just to remind you to bill your emergency exam on detail line 1 of the claim and then the teledentistry service on detail line 2. And you have to be able to make a diagnosis in order to bill these teledentistry services, so you have to have enough video, photographs, evidence so that you can make a diagnosis in order to bill these teledentistry services, the D9995 or D9996. And you have to use your place of service 2 for telehealth. Next Slide.

And this is our contact information and we do have about 4 minutes left that we can take some questions, and so we will open up the call now for questions for any of our presenters tonight.

Hugh Tilson:

Thank you so much, I'm going to be quick. **Is NC Medicaid considering covering a facility fee for dentists to cover COVID19 safety measures, N95 masks etc.?**

Darlene Baker:

This is Darlene Baker, I can address that. So there have been some suggestions that the procedure code D1999 would allow providers to bill for PPE and the extra cost. We have not added that procedure at this time. And Dr. Casey, do you have anything additional that want to share.

Dr. Casey:

Yea, I just wanted to add that I hope that folks stay tuned to information coming from NC Medicaid. Because we are going to address reimbursement issues for all providers, so I can't make of a definitive announcement right now but please keep up with the news that is coming out of DHHS. Thanks.

Darlene Baker:

And the way you can keep up with that information is be sure in the NCTracks system, that you go to the provider communication option and sign up on the mailing list so that you are getting all of the communications coming from NCTracks.

Hugh Tilson:

Are the D1354 code, are there a maximum amount of teeth that are allowed to be treated in one visit?

Darlene Baker:

So Dr. Wright's recommendation was 5 teeth per date of service, that was the recommendation in his presentation. And for reimbursement, the total reimbursement is for 4 teeth at a rate of \$27.50, if 4 teeth are treated on the same day.

Hugh Tilson:

Two questions about whether the changes to fluoride varnish and SDF will continue after the state of emergency?

Dr. Casey:

That's a good question and it's something that we will be looking at in our review of expenditures. So and when I tell you to stay tuned, that also applies to news about teledentistry and whether those services will continue after the COVID19 restrictions go away. So to be addressed in the future.

Hugh Tilson:

Can you complete D1206 and D1354 at the same visit?

Darlene Baker:

And that is, yes. Um, as Dr. Wright recommended, you would apply silver diamine fluoride using procedure code D1354 to the teeth that have decay and then apply fluoride varnish to all the remaining teeth or all the teeth and there was hope that there was some benefit to adding fluoride varnish after the silver diamine fluoride was placed. So you can apply that to all teeth and bill both procedures on the same day.

Hugh Tilson:

Can a prophylaxis procedure be billed if the prophylaxis gets done with hand instruments and a toothbrush prophylaxis?

Darlene Baker:

NC Medicaid does not cover a toothbrush prophylaxis though. They do need to use sickles and the teeth do need to be scaled in addition to the toothbrush prophylaxis.

Dr. Casey:

[Indiscernible] Pediatric dentists do selective prophylaxes, where they do scaling on some teeth and then they do a – of all teeth and that's acceptable to bill for the scaling.

Darlene Baker:

The documentation in the chart should include that the teeth were scaled because a toothbrush prophylaxis alone is not covered.

Dr. Casey:

But that's not in the policy.

Hugh Tilson:

We are a little over time, can you guys stick around for 2 more questions maybe? **How many applications of SDF are covered in a calendar year?**

Darlene Baker:

A total of 4 per tooth in one year.

Dr. Casey:

It's 2, it's every six months. It's 4 lifetime per tooth, but twice a year.

Darlene Baker:

You are correct, Dr. Casey. So, it's because the current policy was once every 6 calendar months, so each tooth was two times in a year for a total of 4 per lifetime.

Hugh Tilson:

Can the -- prophylaxis and scaling be for any age?

Darlene Baker:

For scaling and toothbrush prophylaxis is that the question?

Hugh Tilson:

Yes.

Dr. Casey:

So the concern is that the hygienists don't want to do prophylaxis because rotation will throw off saliva and so forth. I would say during the restrictions, that it would be acceptable to bill scaling if you are picking up hand instruments and actually using the hand instruments in addition to the toothbrush prophylaxis. Darlene do

Darlene Baker:

Yes, I think that's fine. And maybe to help with some of the stain it could be they could use a prophylaxis paste with the toothbrush to see if that would help with some of the stain.

Dr. Casey:

And I've had questions from providers asking if they could use the prophylaxis paste with a toothbrush and that's a good point.

Hugh Tilson:

Where do you go to sign up for the Medicaid information? Someone missed that for the Medicaid listserv, I think that was the NCTracks perhaps?

Darlene Baker:

That's correct, so go to NCTracks.nc.gov and then on the provider page, click on provider communication and then it will show up on the right hand side of the screen 'Sign up for NCTracks mailing list'.

Hugh Tilson:

Gotcha. Last question. **What do we charge for using Silver Diamine Fluoride and glass ionomer on the same tooth?**

Dr. Casey:

So that sounds like technique that Dr. Wright was talking about, and currently we are not giving any guidance about that but if there is going to be a phase 3 of policy change, that is the direction we are headed with SMART technique, Hall crowns and atraumatic restorative treatments. So stayed tuned for that.

Hugh Tilson:

Gotcha. We are getting some more questions but we are out of time so, those of you who have sent in questions, we have your email address and can reply directly. You got a couple of last comments saying good information, timely training, thanks all for pulling it together. Kudos to NC Medicaid, thank you to Mark and Darlene for their leadership and changes to best meet the needs of communities across NC amidst COVID19. Thanks, again. I can't think of a better way for me to summarize tonight, other than also to thank everyone who made time to be apart of this. So thank everyone. Mark and Darlene I will turn it back over to you.

Dr. Casey:

Thanks very much. Just again, we are so grateful for all of the service that dental healthcare professionals in NC are providing to Medicaid and health choice recipients. I can't even begin to tell you how proud I am of the dental health professionals in NC, so thanks. Keep up the good work and we will be there to answer your questions.

Hugh Tilson:

Thanks everyone, take care.

[Event ended]