Many North Carolinians lack access to affordable oral health care. The COVID-19 pandemic has further heightened and exposed the systemic barriers that exist for vulnerable populations across our state. As restrictions on routine dental procedures are lifted post-COVID-19, the system will be faced with a backlog of patients requiring preventive and restorative treatment.

Given this reality, it is prudent that oral health stakeholders consider the following changes aimed at systems reform to increase access to oral health care for all North Carolinians.

The below mentioned priorities will serve as a strong foundation for increasing access to oral health care, and our hope is that the guide helps agencies prioritize their own engagement in oral health policy advocacy.

*Please note: the outlined recommendations are not necessarily current policy priorities of NCOHC.

For specific supplemental links, please click here.
SUPERVISION REQUIREMENTS

1. **Elimination of the two hygienists per dentist restriction** — According to projections by the UNC Sheps Center for Health Services Research, by 2025 there will be 459 fewer dentists than necessary to meet anticipated demand in North Carolina. At the same time, there is a growing surplus of hygienists in the state. We recommend reconsidering the two hygienist per supervising dentist limit as outlined in G.S.90-233 (b).

**COVID-19 Opportunity:** In order to prepare for the anticipated resumption of non-emergent dental care, and to maximize the geographic coverage and services provided by our state’s existing dental workforce, we recommend that revision of direct supervision be considered at this time.

2. **Revision of direct supervision** — While the 16W.0104 rule change in early 2020 allows dental hygienists to work outside of a supervising dentist based on a written standing order, it only applies to public health hygienists in limited settings. Through North Carolina statute or rule change, we can increase access to preventive care by eliminating setting and location-specific restrictions. We recommend that, for more efficient and effective use of limited supervision provisions under 21 NCAC 16Z .0101, further modification of 90-233(a1) be made to reevaluate required training, years of experience, and number of minimum clinical hours. In addition, we recommend modification of G.S. 90-233(a1)(3) to extend the time period during which dental hygienists may provide services without a dentist physically present from 120 days to 270 days.

**COVID-19 Impact:** Now is the time to revisit this restriction, as fully leveraging North Carolina’s dental hygienist workforce will play an integral role in meeting bottleneck demand immediately post-COVID-19 and beyond as elective procedures are resumed.

REVISION OF DELEGATED DUTIES

1. **Revision of delegated duties for hygienists** — In order to meet interim needs such as caries removal and filling placement in community-based settings like schools, nursing facilities and rest homes, we recommend that North Carolina policymakers consider lifting restrictions on dental hygienists’ delegated duties. These restrictions, contained in 21 NCAC 16G .0101 and .0103, prevent the delivery of therapeutic restoration by hygienists. We recommend the addition of interim therapeutic restorations (ITR) to the delegated functions of dental hygienists as outlined in 21 NCAC 16G .0101.
WORKFORCE UTILIZATION (CONTINUED)

2. **Elimination of restrictions on dental hygienists’ delivery of local anesthesia** — Permitting the application of local anesthesia by dental hygienists would improve efficient delivery of care by allowing dentists to focus on the restorative and surgical needs of their patients and eliminating interruptions to workflows. This could be accomplished by amendment of Chapter 90, Article 16 of the Dental Hygiene Act, specifically G.S.90-221(a), G.S.90-221(f), and G.S.90-223.

3. **Recognition and credentialing of Expanded Function Dental Assistants (EFDAs)** — In North Carolina, current delegated duties for dental assistants can be found within 21 NCAC 16H .0100, specifically 21 NCAC 16H .0203. Duties delegated to dental assistants in North Carolina are fairly comprehensive, with the exception of certain restorative procedures. Our recommendation is that, in addition to delegated duties listed under 21 NCAC 16H .0203, functions be expanded with appropriate credentialing, to include the direct placement and modification of restorative filling material. Further information can be obtained from the Dental Assisting National Board Inc., as it pertains to its Certified Restorative Functions Dental Assistant (CRFDA) certification examination. In addition to allowing these expanded functional duties, we recommend that the North Carolina State Board of Dental Examiners (NCSBDE) develop a certification and monitoring process for dental assistants.

**COVID-19 Opportunity:** EFDAs can play a critical role in streamlining workflows and increasing efficiency while addressing oral health needs after the COVID-19 pandemic. We therefore recommend that the NCSBDE begin consideration of the proposals above.

TELEDENTISTRY

1. **Adoption of teledental service utilization** — Teledentistry is an effective and efficient means to connect providers and patients regardless of time and physical space in order to help further narrow access gaps, particularly in rural areas. The use of asynchronous teledentistry in community-based and school-based settings, in particular, presents significant potential for addressing the needs of North Carolina’s most vulnerable populations. NCOHC recommends legislation be proposed for the permanent adoption of teledental service utilization. Recommendations include modification of G.S.90-29(b)(11) to further define the practice of dentistry to include through electronic or other means, including the internet or telephone. Additionally, we recommend the statutory addition of proposed G.S.90-30.2 (“Teledentistry Practice and Requirements”). Finally, we recommend modification of G.S.90-221(f) to remove “physically present” language within the supervision definition for the practice of dental hygiene.
COVID-19 Impact: During the pandemic, teledentistry provides an efficient model by which providers can connect with patients while in-person visits are restricted to emergent dental services. During this crisis, teledentistry can be applied for triage, assessments and examinations, patient education, pharmacological maintenance, as well as home care instruction and follow-up. Now is the time to move forward on teledentistry because private payers and the North Carolina Department of Health Benefits (NCDHB, Medicaid) have released temporary modifications to internal policies allowing for the reimbursement of the following: D0999 (telephonic), D9995 (synchronous) and D9996 (asynchronous). In addition, the NCSBDE has issued guidelines allowing use of teledental services to meet patient demand during the pandemic. Not advancing toward a permanent adoption of legislative changes to support teledentistry’s continuation as an effective and efficient modality to oral health care delivery post-COVID-19, may prove to have an unintended and negative impact on access to care for North Carolinians.

COVID-19 Opportunity: We recommend that policymakers support and adopt permanent legislative changes allowing for the use of teledentistry, both through synchronous, asynchronous, telephonic, remote patient monitoring and mobile health modalities.

INTEGRATION

1. Teledentistry's role in primary care — Building upon the foundation established in the “Teledentistry” section above, teledentistry offers a unique opportunity to enhance integrative practice. In particular, software platforms and intraoral photo capture could be initiated in primary care settings, among others, as supplementary patient information for referral and tracking to the dental community.

2. Dental navigators / community care coordination — CDT code D9992 provides for care coordination management, which involves assisting in a patient’s decisions regarding coordination of oral health care across multiple providers, health systems, specialty areas of treatment, and payment systems. In North Carolina, we recommend that the patient-centered workforce be expanded. Options include development and execution of training modules for “dental navigators,” Community Dental Health Coordinators (CDHC), and Community Health Workers (CHW) with an oral health focus. CHW programs with an oral health focus are currently being piloted in Oklahoma and New York, and CDHC curriculum has been developed in 45 states.
PAYMENT REFORM

TELEDENTISTRY

1. **D0999, D9995, D9996** — We recommend that NCDHB and the private payer sector continue to embrace teledentistry as outlined in the “Teledentistry” section above, with permanent adoption of payment schedules for D0999 (telephonic), D9995 (synchronous) and D9996 (asynchronous). In addition, we recommend that payers strongly consider parity of payment.

PRIVATE AND PUBLIC ALIGNMENT ON PREVENTION-FOCUSED, NON-SURGICAL MANAGEMENT OF CARIES

1. **Silver Diamine Fluoride (SDF)** — As we shift away from a surgical approach to caries management, the expanded use of silver diamine fluoride (SDF) should be considered. SDF is a non-aerosolizing, cost-effective treatment modality for the non-surgical management of caries, making it an ideal treatment option for reducing risk and eliminating future emergent needs during this crisis. SDF provides an effective opportunity to arrest decay, prevent pain and infection, and decrease the potential likelihood of utilization of emergent dental services.

**COVID-19 Opportunity:** During COVID-19 and extended 18 months post March 2020, we recommend that NCDHB remove all age restrictions on SDF treatment. Post-COVID-19, we recommend that, at a minimum, NCDHB reimburse for SDF for all beneficiaries 21 years and younger. This structure is consistent with other age-restricted, covered service codes. Lastly, we recommend the private payer sector evaluate and implement effective, incentivized reimbursement strategies for SDF during and post-COVID-19.

2. **Interim Therapeutic Restorations (ITRs)** — Interim therapeutic restoration (ITR) is also a cost-effective, non-surgical treatment modality for the arrest of decay. This is particularly appropriate for school-based settings and delivery by hygienists. Our recommendation is that ITR reimbursement for D2941 through NCDHB be provided post-COVID-19. Many private payers already reimburse for D2941; however, we recommend a payment analysis to ensure incentivization as an effective non-surgical treatment modality for caries management of primary dentition. It is important to note, however, that in addition to our payment reform recommendations for ITR, dental hygiene delegated duties will need to be amended as outlined in the “Revision of Delegated Duties” section above.
PAYMENT REFORM (CONTINUED)

MOVE TOWARD VALUE-BASED ORAL HEALTH CARE & PAYMENT

1. **D9991, D9992, D9993 and D9994** — Service covered by CDT code D9992 (care coordination management) plays an important part in providing patient-centered care. We therefore recommend that public and private payer sources add D9992 as a covered service. Additional codes that should be considered as part of incentivizing patient-centered care include: D9991 (addressing appointment compliance), D9993 (motivational interviewing), and D9994 (patient education to improve oral health literacy).

2. **Preventive bundled payments** — To incentivize a prevention-focused culture of clinical care and improve outcomes, we recommend private and public payer sources evaluate the ability to provide bundled payments for the services outlined above. Specifically, payers should focus on incentivizing a higher rate of bundled service delivery. To incentivize oral health management through a focus on prevention, as a way to effectively leverage value-based care through payment reform, we recommend the following codes be paid for at an incentivized, higher rate as part of a bundled payment if completed together at the same date of service:

   - D0150 (comprehensive oral evaluation) OR D0120 (periodic oral evaluation) + D1110 (prophylaxis – adult) OR D1120 (prophylaxis – child) + D1206 (topical application of fluoride varnish) + D1351 (sealant, per tooth)

   As adjunctive, non-paid services, we also recommend the bundle include D1310 (nutritional counseling for control of dental disease), D1320 (tobacco counseling for the control and prevention of oral disease – if applicable) and D1330 (oral hygiene instructions).

PARITY OF PAYMENT

1. **Parity of payment across public and private payer sources** — Teledentistry is an effective modality for connecting patient and provider as referenced in the “Teledentistry” section above. As such, teledentistry does not replace treatment provided, but can be thought of as a modifier code, alerting payers to the modality by which the treatment or patient examination was provided. Therefore, we recommend that payers consider parity of payment in order to not de-incentivize teledentistry, particularly as a means of addressing access gaps.