AMERICAN ACADEMY OF OROFACIAL PAIN

Spring 2017
Newsletter

Upcoming meetings

American Academy of Orofacial Pain

When: Thursday, May 4, 2017 to Sunday, May 7, 2017

Where: TALKING STICK RESORT
9800 E. Indian Bend Road
Scottsdale, AZ 85256

American Pain Society

APS 36th Annual Scientific Meeting

When: May 17–20, 2017

Where: David L. Lawrence Convention Center
Pittsburgh, PA

American Headache Society

When: June 8-11, 2017

Where: Westin Boston Waterfront
425 Summer St.
Boston, MA 02210

AMERICAN ACADEMY
OF OROFACIAL PAIN

AAOP 41st SCIENTIFIC MEETING

THE EVOLVING WORLD OF OROFACIAL PAIN

MAY 4–7, 2017

TALKING STICK RESORT

Scottsdale, AZ

An Update on Specialty Status in Orofacial Pain

Where we are and what comes next?

Jeff Crandall and James Fricton

Introduction. Specialty recognition for the field of Orofacial Pain has always been a goal of the AAOP. The American Board of Orofacial Pain (ABOP) has recently achieved specialty recognition through the American Board of Dental Specialties (ABDS, http://dentalspecialties.org/). Passage of Resolution 65 by the American Dental Association (ADA) House of Delegates in October of 2016 has opened the door for individual state boards to recognize the ABDS as a specialty certification board.[1] Now, in collaboration with the ABOP, the ABDS needs to advance this process by seeking recognition at the state board level with active participation by the membership of each of its member boards. This report summarizes the background leading up to Resolution 65, the recent developments in the recognition of dental specialties by the ADA and ABDS, the access to care problem for orofacial pain disorders, and how our members can help to make this a reality in each state by updating statutes and regulations that define specialties.

The Problem of Orofacial Disorders. Orofacial disorders include many complex conditions such as temporomandibular disorders, orofacial pain disorders, headache disorders, neurosensory and chemosensory disorders, oromotor disorders, orofacial infections, orofacial sleep disorders, and salivary disorders. These various conditions have a prevalence over 40% of the general population including many children and teenagers.[2-7] Because the head, jaw, teeth, and orofacial structures have close association with functions of eating, communication, breathing, swallowing, sight, and hearing while forming the basis for appearance, self-esteem and personal expression, persistent pain or disease in this area can deeply affect an individual both physically and psychologically.[8] The specialties of Orofacial Pain and Oral Medicine have emerged due to the high prevalence of orofacial disorders and lack of access to care. These specialties also work closely with both general dentists and other dental specialists to assist in managing these problems.

Limited Access to Care. Unfortunately, the access to care for patients with these disorders is lacking in part due to the limited number of dentists who specialize in this area. Furthermore, the care provided lies between medicine and dentistry, which crosses the boundaries of these fields, thus confusing most dentists and physicians. Because of limited access to care, patients often doctor shop with array of medical and dental primary care and specialty providers which can result in multiple medications, surgeries, and other treatments, often without resolution of the problem. A survey of 405 health professionals in the Midwest found that 95% either do or would like to refer these patients to a specialist because of their complex nature.[9] Most dentists and physicians do not have the specialized training to be clinically proficient in this area. As a result, orofacial conditions are primarily managed by dental specialists in Orofacial Pain and Oral Medicine.

State Board Regulations limit access to care. In many cases access to care for patients with these disorders is difficult because of the limited number of dentists who focus their practices in this area, the lack of coverage by health and/or dental benefit plans, and the lack of recognition of these specialties by State Boards. The inability of these specialists to announce that they have advanced knowledge and skills for these conditions limits recognition by the general public and all other health professions. Unless a specialty is recognized by State Dental Boards, access to care is not likely to improve because dental and medical insurers, including Medicare and Medicaid are limiting reimbursement to general dentists managing these disorders.

Existing Specialties Block New Dental Specialties. These access to care problems have persisted for decades because specialty status for emerging new fields of dentistry have been blocked by the ADA and its recognized specialties. For the past 4 decades, five emerging dental specialties (Dental Anesthesiology, Implant Dentistry, Oral Medicine, Oral and Maxillofacial Radiology, and Orofacial Pain) have submitted proposals to obtain ADA specialty recognition status in an effort to improve access to care. However, only one of these organizations, the American Academy of Oral and Maxillofacial Radiology, has achieved this status.[10] This decision occurred only after the initial ADA House of Delegates voted to reject Radiology's specialty application. Due to pressure from the Federal Trade Commission in a year-long investigation of the ADA's restraint of trade practices resulting from conflict of interest restrictions of specialty recognition, the legal counsel for the ADA intervened to convince the House of Delegates to extend a re-vote in an effort to avoid federal regulatory intervention. With the exception of the approval of Oral and Maxillofacial Radiology, the ADA has not recognized a new dental specialty in the past 50 years.

Has Dentistry Advanced as a Profession? This failure to accept new specialties suggests that the dental profession has not advanced sufficiently to warrant recognition of any new fields. However, most dentists know that this is not true. Rather, there has been an explosion in technological, scientific and clinical advances in imaging, genomics, proteomics, recombinant vaccines, biological devices, personalized drugs, biological agents, anesthetic agents, immunotherapies, and many more to improve care for oral conditions, orofacial pain, medical-dental conditions, autoimmune diseases, dental implants, oral cancer and many other orofacial conditions over the past 50 years. Clearly, the escalating pace of knowledge in dentistry demands that the dental profession keep pace so our patients continue to benefit with improved access to quality care. In all other health care professions, this leads to the evolution of new fields and specialties. Now, elements of the dental profession are stepping forward independent of the ADA to recognize these new developments and specialties in dentistry.

Legal Decisions regarding Specialty Status in Dentistry. Several legal decisions have supported the concept of an independent and objective process for recognizing certifying boards for Dental Specialties. A group comprised of the American Academy of Implant Dentistry, American Academy of Oral Medicine, the American Society of Dentist Anesthesiologists, and the American Academy of Orofacial Pain in conjunction with dentists who practice these specialties in the State of Texas, prevailed in litigation in the Texas District Court.[10] While this decision is currently under appeal, the outcome is unlikely to change. The findings of the court prohibited the Texas State Board of Dental Examiners from solely deferring to the American Dental Association (ADA) for the recognition of specialties in Texas. This decision is consistent with previous, similar decisions in Florida and California and has implications for every state board across the United States. In summary, these decisions prohibit state boards from deferring to the ADA, a trade organization, as the only resource for the dental specialty recognition process. This also prohibits the establishment of regulations that restrict the advertising of board-certification for recognized specialties in Dentistry.

ADA Resolution 65. As a result of these legal decisions, the ADA House of Delegates met in Denver, Colorado in October of 2016 and passed Resolution 65 submitted by the Council on Ethics, Bylaws and Judicial Affairs.[1] This Resolution permits "educationally qualified dentists practicing in areas of dentistry recognized as specialties in their jurisdictions, but not by the ADA, to announce as specialists". The passage of Resolution 65 by the ADA House of Delegates is a milestone in the development of an independent and objective process for recognizing certifying boards for both Dental Specialties (Level 1) and Subspecialties (Level 2) within the Profession of Dentistry. Consistent with ABDS and ADA requirements, each dental specialty board or association has assembled and submitted appropriate documentation to demonstrate that each of the objective criteria for specialty recognition have been met.

The Emergence of the American Board of Dental Specialties. With this background, the American Board of Dental Specialties (ABDS) has evolved with the stated mission of encouraging the further development of the profession of Dentistry through independent recognition of certifying boards, improving the quality of care, and protecting the public. The ABDS requires that applicant specialty boards demonstrate advanced evidence-based knowledge and clinical decision-making skills in its respective field by evaluation of competency with written and oral board examinations of candidates with valid, reliable, and calibrated testing methods. Successful achievement of educational standards is established through support of accredited Dental Schools to establish advanced education programs in each specialty area. Each specialty board is responsible for the development of its high quality, validated Board Certification process. Accordingly, through a rigorous process of reviewing objective criteria submitted by each field, the ABDS has recognized four new dental specialties: Dental Anesthesiology, Implant Dentistry, Orofacial Pain, and Oral Medicine. The ABDS welcomes both existing and emerging dental specialties to apply because it believes that dentistry should continue to grow through research and advanced education programs. Moreover, there is strength in new dental specialties representing the continued evolution and growth of the profession.

Changes in State Dental Boards Regulating Dental Specialties. ADA Resolution 65 opens the door for State Boards of Dentistry to recognize an independent, objective-based path for the certification of specialty fields and to determine who may announce and be approved for licensure as a dental specialist. It also relieves State Boards from the legally precarious position of having a trade organization, the ADA, serve as the sole determinant of dental specialty status. This task is the responsibility of State Dental Boards and they are now able to recognize all credible dental specialties based upon specific criteria. State boards will be evaluating the impact of Resolution 65 on their specialty determination process and some have already expressed interest in utilizing the ABDS process as a more objective and valid resource for certifying dental specialty boards. Most State Boards also recognize the importance of offering a national, objective, and independent process for evaluating and certifying qualified dental specialties and subspecialties while keeping the issue out of the courts and in the hands of dentists. State boards can grant specialty licenses in the various specialty areas of dentistry. The ABDS criteria requires that specialty areas are those that are 1) recognized by the Commission on Dental Accreditation, 2) represent a field of dentistry with advanced evidence-based knowledge and clinical decision-making skills that requires at least a two (2) year, full-time, advanced post-doctoral educational program within an accredited educational institution, or 3) at least 400 didactic hours and the equivalent of one (1) year of clinical practice training (2,000 hours) in the previous 36 months.[11]

The Need for Action by AAOP Members and the Access to Care Committee. As the development of specialty recognition continues, AAOP members will need to become more active in the AAOP to help change State Board regulations regarding specialty and to expand access to care for patients with orofacial disorders. The AAOP Access to Care Committee, chaired by Dr. Hal Menchel with a small number of members, is obtaining a CPT code for splints through an AMA CPT application, and has updated the new ICD-10 diagnosis coding for OFP. Acceptance of this new code would open the way for reimbursements of splints in all health plans including Medicare and Medicaid. In addition, there is a need to document our successful outcomes in terms of improved pain, function, and health care use. Current investigation, led by Dr. Eric Schiffman, has been developed through the support of the NIDCR and the use of the National Dental Practice Based Research Network. One of the stated objectives of this research is to “Describe observed changes from baseline at 1-, 3- and 6-month follow-up in pain intensity and jaw function associated with treatments.” These findings will serve to encourage health care plans to ensure that all patients have access to care from specialists in orofacial pain. There is much more that should be done if the Access to Care Committee included more active members. In the near future, our recognition as a specialty field of dentistry, combined with the new ICD-10 coding for OFP, a CPT code for intraoral appliances and outcomes documentation, will position us well for expanded interaction with the health care community and third party insurers.

In the near future, the AAOP and ABOP membership will need to become involved with their respective state boards to expand the interpretation of the rules and statutes to grant recognition of the ABDS as the credible alternative to the ADA for specialty recognition. This is the end game for specialty recognition and will complete the specialty recognition process for orofacial pain practitioners. Dr's Fricton and Crandall are pursuing this in Minnesota and Vermont, respectively, and other members have initiated contact with their State Boards as well. Already, some states are actively looking at the ABDS criteria for specialty recognition as a resource for the application and certification of new dental specialties. There is much more that the AAOP and ABOP needs to do in order to continue its leadership role in the field of OFP. We must motivate and activate the exceptional resources we have within the Academy. Our various committees represent the needs and objectives of the Academy but these committees need more than just members. They need active participants who are willing to invest in the future of our Academy and the specialty of OFP.

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Newsletter Editors

Dr. Robert Mier, D.M.D
bobmier@mac.com

Dr. Shuchi Dhadwal, B.D.S, D.M.D
Shuchi.Dhadwal@gmail.com