American
TeleDentistry
Association

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The Honorable Richard Hilderbrand
Chair, Kansas Senate Committee on Public Health and Welfare
Kansas State Capitol
300 SW 10th St., Room 445-S
Topeka, Kansas 66612

Dear Chair Hilderbrand and committee members,

My name is Dr. Marc Ackerman, and I am the Executive Director of the American Teledentistry Association (ATDA). I write you today to **express our organization's opposition to Senate Bill 121** as currently written. We encourage you to work with all stakeholder groups involved to ensure that the technological innovations driving down the cost of and increasing access to high-quality oral health care across the nation are permitted in your state so that all Kansans can get the dental care they want and need.

Biography

I have had the opportunity to publish numerous peer-reviewed articles on orthodontics during my academic and clinical career. I am a proud recipient of the B.F. and Helen E. Dewel Award, which is given annually to the highest-rated clinical research article published that year. I am passionate about helping others and ensuring that everyone receives the care that they deserve; that is why I work to advance the American Teledentistry Association's mission to increase access to dental care by advocating for the proliferation of innovative teledentistry solutions and the implementation of permissive teledentistry guidelines. I believe that the public policy debate surrounding telehealth in Kansas as it applies to Senate Bill 121 will benefit from the national, third-party perspective that our organization provides.

Teledentistry Policy and Guiding Principles

As someone who has been working on these issues for years, I have observed a troubling trend across the United States. As technological innovations associated with teledentistry have made oral care more accessible, affordable, and safe for patients, organized traditional dentistry has mounted campaigns aimed at reversing the significant gains that teledentistry technologies have afforded American patients. Teledentistry is an example of how free market solutions can effectively drive down costs for health care – an important issue in all 50 states.

Regrettably, the anti-competitive attacks pushed by organized dentistry manifest themselves as arbitrary barriers to care that create unfair and uneven standards for teledentistry providers when compared to dentists delivering care in person. Such barriers include requiring licensure for zero-risk procedures, requiring examinations not needed to meet the standard of care, or holding teledentistry to a different standard than traditional dentistry absent clinical justification. These attacks are thinly veiled as "patient safety" concerns, but the real reason for organized dentistry's assault on technology is that teledentistry is disrupting the market in a way that negatively affects the financial bottom line. In reality, there are no clinical studies which suggest that teledentistry is unsafe or ineffective; in fact, there are numerous peer-reviewed clinical studies which demonstrate that teledentistry is just as effective as traditional dentistry and that, in some cases, patients actually prefer the patient-centered experience teledentistry provides. It is these unsubstantiated, non-clinical, and anti-competitive objectives which I believe organized dentistry is promoting in Senate Bill 121.

The ATDA maintains that teledentistry policy should aim to:

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1. **Enact technology-neutral language**. Legislation should enable providers to use the wide range of appropriate teledentistry technologies without favoring one type of modality over another and accommodate for future innovations.
2. **Maximize patient choice and access.** Legislation should promote patient choice to the fullest extent possible and centralize the patient experience.
3. **Rely on professional discretion.** Legislation should rely on providers' professional discretion as to whether any given teledentistry technology is appropriate and adequate to diagnose and treat the condition as presented by the patient.
4. **Promote transparency.** Both patients and treating dentists should identify themselves to each other.
5. **Ensure the standard of care is upheld through licensure.** Only licensed dentists should be able to evaluate, diagnose, and provide treatment. The standard of care should be the same for teledentistry interactions as it is for in-person patient encounters.
6. **Remove artificial barriers to care.** Legislation and regulations should not require licensure for digital photography, impose geographic restrictions for care, or mandate dual licensure for treating dentists.

To that end, please see my specific comments regarding Senate Bill 121 below:

Standard of Care and Radiography Requirement

Page 1, lines 8-17: This legislation would require that radiographs be reviewed before a diagnosis could be made or treatment could be started for patients with mild to moderate malocclusions – irrespective of the patients' presentation and the applicable standard of care. This language is in direct conflict with the current standard of care for orthodontics and would significantly increase costs and decrease access for Kansas' most underserved communities. Notably, there is no clinical evidence to support the assertion that patients would be safer if radiograph review were required. As mentioned before, there are numerous peer-reviewed clinical studies which prove the opposite: **Teledentistry is just as effective at treating mild to moderate malocclusions as traditional dentistry, regardless of whether the treating provider has reviewed radiographs.**

Every dentist, regardless of the delivery method used to provide dental care, is held to the same standard of care and is subject to the licensure requirements and discipline of the Kansas Dental Board. There are treatments for which teledentistry is an inappropriate mode of delivery; however, there are many other treatments that can be provided safely and effectively via teledentistry. Teledentistry should not have an arbitrarily mandated standard of care enforced upon it when the services provided are the same as those rendered in person.

To be sure, radiographs are necessary in some cases – particularly where the treating dentist discerns that they will provide diagnostic value for the patient condition presented. **However, the standard of care for the correction of mild to moderate malocclusions does not require the review of radiographs in all cases.** In the interest of accounting for patients' individualized needs, our organization believes that legislatures should defer to the standard of care (coupled with the treating dentist's professional discretion and experience) to dictate what information needs to be reviewed by the treating dentist in any given situation rather than implementing sweeping legislation which mandates that providers attain radiographs in all instances.

This legislation ironically poses serious risks to patients insofar as it would require patients to be exposed needlessly to harmful x-rays. The American Cancer Society has found evidence in clinical studies which shows that dental radiographs significantly increase the risk of developing meningioma – tumors of the brain. That is why worldwide radiographic policy – informed by the American Academy of Oral and Maxillofacial Radiology, the International Commission on

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Radiological Protection, and academics across the globe – dictates that x-rays should only be ordered if they add diagnostic value and that x-rays should never be considered routine. This legislation is in direct contradiction to the guidelines and standards of both national and international radiographic experts. If you would like to review these studies, I would be happy to share them with you.

What is important to remember is that Kansas-licensed dentists, with their exceptional training, experience, and professionalism, should be deciding when radiographs are required – not legislation that fails to account for both patients' individual presentation and clinical research.

Complaints

The ATDA believes that no oral health care providers should attempt to prevent a patient from filing a complaint with the Kansas Dental Board. Patients should be free to contact the Board at any time. Accordingly, the ATDA supports the language on page 2, lines 18-20 as it applies to all licensed dentists and not just those who treat patients through teledentistry.

Contact Information

The ATDA agrees with and supports the contact information requirements found on lines 28-31 of page 1. It is critical that patients know the identity of their treating dentist and can contact them with ease.

Conclusion

Teledentistry delivers care to Kansans who, for far too long, have been denied the chance to get the smile they deserve. Kansans living in rural areas who do not have a dentist located nearby and those who lead incredibly busy lives and simply do not have the time to go to a brick-and-mortar dentist's office can now – thanks to technology – **get care when, where, and how they want it**. Let us continue to give Kansas residents the flexibility they want and deserve. **I urge you to reject the onerous and clinically unsupported requirements proposed in Senate Bill 121.**

If you have any questions, feel free to call me at (617) 413-2740. I would be happy to offer any clinical insight that you or the Committee would like.

Sincerely,

Marc Bernard Ackerman, DMD, MBA, FACD

CC: Members of the Senate Committee on Public Health and Welfare

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