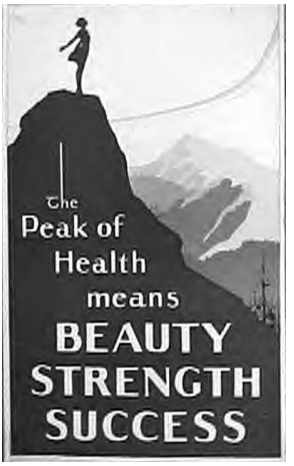
XVII. DEFEND YOUR LIFE

Life is short and the art is long. **Hippocrates (c.460-377 B.C.) Greek, philosopher, physician—"The Art of the Physician".**
&
A child of five would understand this. Send someone to fetch a child of five.. **"Groucho" (1890-1977)—Comic, Marx Brother.**



ORAL HEALTHCARE DELIVERY:

The Office of the U.S. Surgeon General has stated that "oral health is inseparable from total health" and that we have an oral disease epidemic. Research has repeatedly demonstrated that our dental and oral health have direct and significant effects on our general health. The oral cavity and its dentition *must* be considered a vital organ, as it is essential to the overall well-being of our bodies.

According to 2012 figures, more than 130 million Americans have no *dental* insurance. Public programs pay for less than three percent of all dental services (*www.healthypeoplenow.gov*). The importance of oral health makes this lack of coverage unacceptable. Furthermore, regular dental care has never been included with elderly Medicare benefits. This may account for the fact that regular dental visits are not the norm in America's fastest growing population, the 85+ year-old age group.*

Dental health problems are also extremely common in America's youth population. Severe and contagious tooth decay** is the most common childhood disease, condemning millions of small children to chronic pain, humiliation and a lifetime of dental disorders. Fifty-one million school hours are lost annually to dental-related illness.[1]

Among all income levels twenty percent of all children ages 2-17 receive no dental care.[2] A landmark "U.S. Surgeon General's Report on Oral

---

* A Greek saying states, "Everyone wants to go to heaven, but no one wants to die." Health may remain merely the slowest possible rate at which one can die, but today, extending our lives and maintaining our youth seems less explicitly incompatible. With many medical, economic and ethical considerations, it is difficult to anticipate the myriad, lasting effects of our ever-increasing longevity. Societal implications of extending human longevity is challenging for our species and makes for perennial consequential and categorical reflection.

**Some tooth decay has been shown as transmitted through shared eating utensils and/or shared toothbrushes.

Health," a three-year study published in 2002 and revised in 2006, not only highlights serious problems in oral health within various age groups but also found disparities along racial lines.[3] Ethnic and income-based dental-visit figures remain even more alarming. "Dental caries" (tooth decay) is more common among minorities and most common among children from low socioeconomic families.

The 2000/2002 U.S. Surgeon General oral-health study also found low-income and poor Americans make up the majority of America's deficient oral-health population. About eighty percent of child dental disease is concentrated in twenty-five percent of children, primarily those from low-income families and minorities. Ethnically, half of Hispanics Americans (now America's largest minority), half of African Americans, and sixty-eight percent of Native American or Asian-Pacific American children have untreated tooth decay as compared to fourteen percent of "white" Americans. A successful societal approach to this childhood disease is essential and in everyone's best interest.

One sound, cost-effective strategy in combating tooth decay is the use of dental "sealants." Sealants are coatings that can be applied to teeth to protect them from bacterial damage. A study quoted by Centers for Disease Control and Prevention, noted that as few as three percent of poor children have dental sealants, compared to a national average of twenty-six percent. The Task Force on Community Preventive Services' recent noted a sixty percent decay reduction in children treated with sealants. Extending sealants to poorer children should be of immediate and extremely high priority (see: C.D.C.'s "Healthy People 2020" and Health Resources and Services Administration: "Oral Health Initiative.") Reaching children at an earlier age is far more beneficial than waiting until they reach high school. The elderly could also benefit from, prevention-oriented, dental sealants.

The percentage of people without health insurance coverage for the entire 2014 calendar year was 10.4 percent, down from 13.3 percent in 2013. The number of people without health insurance declined to 33.0 million from 41.8 million over the period. (See: "Income, Poverty, and Health Insurance Coverage in the U.S.: 2015") However, that Census Report, also found that the number of Americans living *below* the "poverty line" had reached 46.7 million.

In private and employer-based dental insurance the problems are similar to those in general health care. Managed care contract terms are simplistically defended as effective means to keep premiums more widely affordable. Without ample accountability and despite expansions in treatment possibilities, and costs, many dental plans' "maximum-yearly-benefit" reimbursement have not been appreciably increased over the past several decades.

Specific to dentistry, "cost-saving" contract language includes the "alternate benefits provision," where a plan will pay only for the least expensive, professionally "acceptable" or "alternative" treatment (LEPAT). In some plans the least expensive service, such as a filling, is the only coverage provided, regardless of what treatment might be desired or even be recognized as more durable and/or beneficial.

A "medically necessary," single crown, or lab-processed single onlay filling may often be "coded" with "major," or arguably more "elective" services, which might better be reserved for fixed, multiple tooth replacements, as in "fixed bridge work" (or even costlier options, like "dental implants.") Such treatments often receive lesser *percentage*-benefit reducing payments to patients and providers.

Similarly, blanket contract exclusions on "attrition and abrasion treatments" that are unfortunately standard in most current dental plans, can be very harmful (see previous, XI. "BRUXISM," "ATTRITION," "EROSION" & "FUNCTION" and/or *Dentistry Today*: "Enamel Loss and Functional Occlusal Vertical Dimension™—Current Considerations for Treatment" by R. L. Chacona, D.M.D. at *www.LongevityLogic.com*: Links—*FOVD*™.)

Allegedly to reduce claims that have primarily cosmetic origins, some exclusions are commonly used to "legally" deny patients primarily health-oriented treatments. Shrouding such contractual exclusions can currently uphold benefit denials, even when the treatment can easily be verified as both medically and functionally beneficial and indicated, under the most currently accepted medical and dental treatment standards.

At present, certain, more costly, procedures have strict five-year "re-treatment" payment-limitation. To reduce longer-term cost and improve care, the functional "durability" of treatment could be "financially incentivized" and some short-term treatment failure, equitably penalized. Insurer time-limitations for "retreatment" should not

categorically deny benefit-coverage, if less than adequate prior treatment needs immediate attention.

Appropriate cost-savings strategies could be explored, such as financial incentives for "higher-quality" doctor-care and well-defined patient education programs. Specific, verifiable, and recognized as beneficial treatment *procedural steps*, properly used for higher-quality treatment "results" or "durability" could also be more cost-effectively *rewarded*.

Additionally, while some health and auto-insurance-premium-discounts are available for non-smokers or for a member's auto-safety efforts, similar wellness-discounts are non-existent in dental-insurance. Dental plan premium discounts could be based on certified oral health education, or good hygiene verification, and research-based beneficial dietary considerations.

Insurance "Codes for Dental Treatment" (CDT) are used to standardize descriptions of dental services for insurance "reimbursement" or payment. Implemented on January 1 of 2017, "CDT 2017/2018" is the most current code-revision now being used. "Usual and customary reimbursements" (UCRs) or fees are monitored and can be adjusted by zip code, to compensate for varying, regional, cost-of-doing-business factors. Each insurance company assigns an amount to their "covered" CDT benefit in relation to UCRs. These UCRs should always have a fairly reviewed region-by-region component. Covered CDTs are assigned specific benefit amounts by each insurance company; actual dollar-amounts paid, call for more impartial calculation, with more patient-consumer and service-provider input. New 2017 UCRs may allow patients to receive better coverage and lower out-of-pocket expenses by using medical insurance coding in dental treatment for the same procedure. Helping patients receive proper insurance coverage for their necessary treatments, helps ensure that they can adhere to treatment plans and better restore health.

Every new cavity requires a filling; fillings need periodic replacements and sometimes may lead to more extensive treatments like crowns and root canals, even tooth loss and tooth replacement. The 2004, average "cost-savings," from each and every "prevented" cavity on each and every patient was about $2,000.[4] Today, that savings has likely tripled!

Codes for specific prevention-oriented services that involve more patient-education can be explicitly verifiable and should also become eligible for