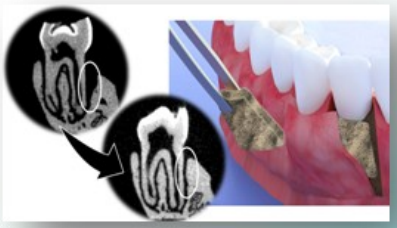
APEX

Publication of the Stanislaus Dental Society

STANISLAUS DENTAL SOCIETY SDS

Summer 2019

Emerging Trends in Dentistry



THE FUTURE IS NOW!
LOOK INSIDE TO SEE WAYS
THE FIELD OF DENTISTRY IS
RAPIDLY CHANGING.

Content

Articles

Backyard

Published by the Stanislaus Dental Society

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Your contributions in the form of articles, photos and/or ideas are greatly appreciated. The APEX editorial staff is interested in articles of general membership interest. This can include an accomplishment, interesting hobby, innovative idea, volunteer effort, etc. Please feel free to submit an article or call for an interview. All articles are subject to editorial review.

Presidential Pondering

Dr. Amanda Farley, SDS President

When I began my term with the Stanislaus Dental Society Board, I had an idea of what I would be doing. I would be participating in local meetings, attending various leadership meetings, and representing Stanislaus County while participating on a state level with the CDA. I knew that the SDS and the CDA had a large impact on how we, as solo practitioners, associates, group practice dentists or corporate practicing dentists could and should practice, however I did not know how many benefits we receive on a daily and annual basis by being a tripartite member.

What is a tripartite member? By paying our annual dues, we sign up for the SDS, the CDA and the ADA. In the state of California, as of March 2019, there are currently 27,296 dentists that are CDA members. In Stanislaus County, we represent a small but strong portion of dentists at 285 members. What does membership actually do for you?

With SDS membership you get, first and foremost, the lovely and talented Robin Brown as our Executive Director. She has her fingers on the pulse of Stanislaus County. She can give you direction on what the local laws are regarding amalgam separators, where to find your updated labor law posters, if you are in need of a temp RDA, RDH or are looking for a per diem dentist or what offerings are coming up with the CE offerings we offer. She is an invaluable resource to us as SDS members. The SDS offers quarterly CE courses for dentists and staff and run a wildly successful Summer Symposium to bolster your CE credits and expand your knowledge. The SDS strongly believes that value needs to be provided with each event that is put on throughout the year. We also offer fun for the family and for your staff with events like "Modesto Goes Nuts" and our annual Staff Appreciation event. My staff looks forward to the Staff Appreciation evening as a fun team building evening. I appreciate the affordability to treat my whole staff to a night out as a wonderful perk of being an SDS member.

With the CDA, you are able to get some of the best coverage available for your EPLI, Worker's Comp, Business Owner's Insurance and more. With the strength of the TDIC, you can rest assured that you have comprehensive coverage with savings included. I know that as a young dentist, I feel confident that I am saving money without sacrificing the quality of my insurance coverage. The controversial lawsuit is wrapping up with Benco, Henry Schein and Patterson, alleging that they had conspired to suppress price dental supplies and equipment" (ADA website Sept 7, 2018). Prior to this lawsuit, the CDA saw a glaring gap in the market for the dentist - finding reliable, affordable dental supplies that do not require a large markup. Am I alone in thinking that you label a product as "dental" and the prices triples? With this, the CDA created the TDSC Marketplace. Having recently acquired the Arnold Dental Supply company, TDSC now is shipping nearly countrywide affordable, quality dental supplies and small equipment. In speaking with dentists all over the state, it is clear that the cost savings are significant. At no cost to you, you can submit your current supply

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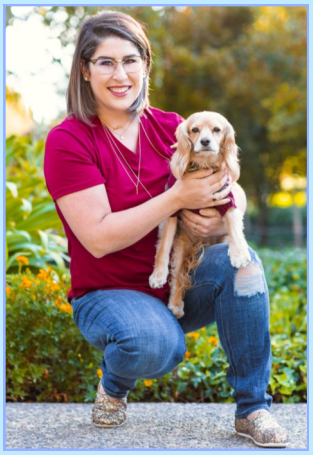

Dr. Farley with her friend and office therapy pup, Lady

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(Continued from page 3)

invoice from any vendor to TDSC and within in a week, they will send you a customized savings breakdown. This TDSC membership can ONLY be taken advantage of by being a tripartite member. How is that for benefits of membership?

With the ADA, there are many larger benefits that you may not be aware of. The ADA represents us as dentists on Capitol Hill. The ADA is lobbying to repeal the McCarran Ferguson Act. As per the ADA, "federal law does not prohibit state-regulated health insurers from engaging in collusive practices, such as price fixing, bid rigging and market allocation schemes." (ADA website, Feb 15, 2019). This contributes to the differential we see with rising patient premiums and reducing provider reimbursements. It is critical to have a voice in Washington D.C. and by being a member of the ADA we are able to support this effort that will ultimately allow us to be able to provide an income for ourselves and families and provide quality dental care for our patients. Additionally, we are provided CE resources, discounts on insurance policies, the essential JADA subscription, student loan refinancing and many more benefits.

I have thoroughly enjoyed the past few years moving through the positions of the SDS board. I have attended the House of Delegates meeting annually and have been astounded with the impact that the CDA makes. We, the CDA, are the example of an efficiently run, successful organization that other states (and the ADA) strive to model themselves after. These organizations are not able to run without committed volunteers who care about how we can influence our healthcare industry. With graduation coming, encourage those new grads to be involved. Encourage your colleagues to be a tripartite member - they may not know what they are missing out on. Lastly, consider getting involved yourself! Being a part of the SDS board has been an honor and a privilege for me. We are a strong, supportive and incomparable community and I am proud to represent the Stanislaus Dental Society.

"The greatness of a community is most accurately measured by the compassionate actions of its members." – Coretta Scott King

Amanda Farley, DDS
SDS President

The objective of the Stanislaus Dental Society shall be:

"To encourage the improvement of the oral health of the public, to promote the art and science of dentistry, to encourage the maintenance of high standards of professional competence and practice, and to represent the interests of the members of the dental profession and the public which it serves.

John L. Sulak, D.D.S.

The board of trustees for the California Dental Association had its first meeting of the year and its first meeting under direction of our new CDA president, Dr. R. Del Brunner, on February 22-23. Dr. Brunner has set some ambitious goals for the board so that CDA may continue to better serve its members, the profession of dentistry, and the public's oral health needs.

Our meeting on February 22 began with the board's ongoing self-assessment and development. We looked at ways we can work together better as a board, be more efficient, and identify potential areas for further improvement. We reviewed the board members' fiduciary responsibilities and duties, and our relationship with the subsidiaries of CDA. We will also be evaluating the board's composition in an ongoing effort to increase efficiency.

We received an update from TDIC and were advised on the successful completion of the merger of *The Dental Benefits Insurance Company, The Dentists Benefits Corporation, and Northwest Dentists Insurance Company* with TDIC, uniting all companies as one. This will allow for over 5,000 additional policy holders in five states.

TDIC is also currently positioning itself for future national growth, negotiating for continued endorsement in Oregon, Idaho and Washington. TDIC will also consolidate all policy administration into *Guidewire*, a three-year endeavor, and will begin implementation of a data warehouse.

Under the direction of the 2018 House of Delegates, the board approved the establishment of the *Medicare Task Force.* We identified the task force's scope and composition. The task force is now looking for volunteer leadership, and an application is now available at cda.org/leadership. Serving on a CDA task force or committee is a great way to get involved and serve your profession.

The board also approved modifications to the peer review process for cases involving minors. It is now required that a minor's compromise process be completed, if a refund is issued. Much of our discussion was held in closed session because of information that is legal in nature and protected by attorney-client privilege, but the final resolution and the new policy is available for public review.

The board received an extensive update from TDSC (The Dentists Supply Company) and its goals for out of state expansion. Thus far, 21 states have agreed to participate in the TDSC program. Remember, as CDA members, you receive substantial discounts on all your dental supplies through TDSC. I encourage you to check them out on the TDSC website.

Another hot topic is the Dental Licensure Portfolio Examination, which allows an applicant to receive their dental license by completing their requirements through an accredited program instead of taking a state board examination. CDA anticipates potential legislation, at the state level, updating the portfolio examination process this year. CDA will be working closely with the California dental schools to promote this alternative to a state board examination.

It is an honor to serve as your trustee for the Stanislaus Dental Society. If you have any questions or concerns regarding our profession or the workings of the CDA, please feel free to contact me. I will be attending trustee meetings on: June 7-8, Aug 23-24, Oct 11-12, and Dec 5. I also attend the House of Delegates on November 14, and meetings for the Council on Membership on May 9, Aug 2, and Sept 4. These are the best times for all of us to participate in organized dentistry and for our voices to be heard.

Sincerely,

John L. Sulak, DDS
CDA Trustee

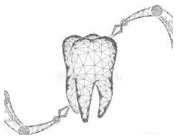
Terry Swehla

Financial Life Management:

What's Changing in the Financial Services Industry

Editorial

Will There Ever Be a Robotic Dentist That Replaces a Human Dentist?



by Charles C. Kim DDS, SDS Editor

The advances in science and technology have their eyes set on automation of daily tasks in all fields of occupations powered by all mighty artificial intelligence technology. Back in 2017, Yomi, the first robotic dental surgery system has been cleared by the FDA. The same year, the Chinese robot dentist was first to fit implants in a patient's mouth without any human involvement. Many of the general public hoped such successful procedures could help minimize human errors while also overcoming a shortage of qualified dentists in many places around the world. Now the question remains, will there ever be a robotic dentist that replaces human dentists?

The fully robotic dentist era might happen in the future, but as of now, it seems like it would be a very distant future indeed. According to a study conducted in Oxford Martin School, University of Oxford, dentists were sitting at the 0.4th percentile whereas telemarketers were sitting at the 99th percentile in terms of probability of jobs being replaced by robots in 2013 and much of the data stayed the same since then. Generally speaking, the occupations that require more creative thinking has a lower probability of automation. Dentistry remains to be one of the occupations least likely to be replaced by robots.

The complexity of making a functional robot backed by artificial intelligence quickly heightens as each field of the task of a different category has to be added on top of each other; especially when you have to take into account of the human behavior that it has to accommodate for. For example, it would be one thing to program a robot to win over humans in the game of chess or the game of go but another thing if it has to interact and teach such skills as a teacher to a human student.

A recent online survey conducted online on 502 people by Embryo-Riddle Aeronautical University shows us how the general public still wants people treating them rather than a robotic dentist. Dr. Stephen Rice, Ph.D. who conducted this survey finds, "significantly less willing to undergo more invasive procedures, such as gum surgery and a root canal, and significantly more willing to undergo procedures such as tooth cleaning or whitening performed by a robot when given a discount". With a 50 percent discount in fees, 83 percent said yes for robotic dentist cleaning and whitening. However, when there were no financial incentives, the results were quite different. Without a discount, 66 percent said no way for an invasive dental procedure performed by a robot, 51 percent said no thanks in general, and 32 percent said no thanks even for cleaning and whitening.

Realistically speaking, as far as the field of dentistry is concerned, the advances in robotics and artificial intelligence won't replace dentists as a whole; rather, it will be aiding in individual occupational tasks such as aiding or guiding dentists to fixture drill implant insertion angle using a 3D image as its own guide. We would definitely see more of automation in the treatment coordination aspect regarding things such as billing, scheduling and confirming appointments.

In conclusion, rather than fearing of robots or rejecting of technological advances; we should place our efforts on keep taking best care of our patients and wisely embrace technology and its future adaptation to the wonderful field of dentistry so that we can continue to take our part in taking better care of our patients with our passion, creativity, and care for fellow human beings. We should also keep in mind the importance of appreciating and understanding the profound value in time-tested materials and treatment methods almost equal or many times even greater than the latest and greatest technology.

Anesthesiology Recognized as a Dental Specialty

ADANews

By Kimber Solana

Dental anesthesiology becomes the 10th dental specialty recognized by the National Commission on Recognition of Dental Specialties and Certifying Boards.

The recognition comes after the National Commission on March 11 adopted a resolution based on an application from the American Society of Dentist Anesthesiologists to recognize dental anesthesiology as a dental specialty.

“This historic vote by the National Commission certainly reflects the ADA’s ongoing efforts towards improved patient care and safety in the areas of dental sedation, dental anesthesiology and access for those with special health care needs,” said Dr. James Tom, president of the American Society of Dentist Anesthesiologists.

The ADA House of Delegates in 2017 established the National Commission to oversee the decision-making process for recognizing dental specialties. The "Requirements for Recognition of Dental Specialties" is still managed by the ADA's Council on Education and Licensure and the ADA House of Delegates.

Dental anesthesiology now joins the following dental specialties: dental public health, endodontics, oral and maxilla-facial pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, and prosthodontics

Dental specialties are recognized "to protect the public, nurture the art and science of dentistry and improve the quality of care," according to the National Commission website.

A sponsoring organization seeking specialty recognition for discipline of dentistry must document that the discipline satisfies six requirements, as outlined in the "Requirements for Recognition of Dental Specialties." The sponsoring organization of the proposed specialty must provide documentation to show that it is a distinct and well-defined field that requires unique knowledge and skills beyond those commonly possessed by dental school graduates, that it requires advanced knowledge and skills, and that it scientifically contributes new knowledge, education and research in both the field, and the profession.

The American Society of Dentist Anesthesiologists submitted its application to the National Commission in September 2018. Following a review by the National Commission's Review Committee on Specialty Recognition in November 2018, the National Commission invited public comment for a 60-day period.

At its February 2019 meeting, the review committee considered all the comments received that directly related to whether the application met all the requirements for specialty recognition and made a recommendation to the National Commission to grant specialty status. At its March 11 meeting, the National Commission determined that the application did indeed meet the "Requirements for Recognition of Dental Specialties" and adopted a resolution recognizing dental anesthesiology as a dental specialty. A resolution needs a two-thirds majority vote to be approved.

Following approval by the National Commission, the sponsoring organization must establish a national board for certifying diplomats in accordance with the "Requirements for Recognition of Dental Certifying Boards."

The National Commission on Recognition of Dental Specialties and Certifying Boards is comprised of nine general dentists appointed by the ADA Board of Trustees and approved by the House of Delegates, one specialist from each of the nine recognized specialties appointed by the sponsoring organization, and a public/consumer member appointed by the National Commission.

“Being the 10th ADA-recognized specialty in 20 years validates to the public and the profession that organized dentistry is willing to challenge the status quo and explore new collaborative efforts with our counterparts in medicine and nursing,” said Dr. Tom. “We look forward to widely promulgating sedation and anesthesia awareness and education in all facets of oral health care, and as dentist anesthesiologists working alongside all other dental professionals, we hope to drive the profession forward cooperatively.”

The recognition comes nearly 175 years after a Hartford, Connecticut, dentist extracted one of his third molars to test the analgesic properties of nitrous oxide. It was Dr. Horace Well's introduction of nitrous oxide, and the demonstration of anesthetic properties of ether by Dr. William Morton, a student of Dr. Wells', that gave the gift of anesthesia to medicine and dentistry.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Congratulations!

Meet Darby Schmidt, daughter of SDS member, Dennis Schmidt DDS, the wonderful teen vocal artist who will perform the role of Maria Bertram in next January's Opera Modesto production of Jonathan Dove's beautiful opera, MANSFIELD PARK (in the US Premiere of the new orchestrated version of the opera, at the State Theatre).

Darby wearing her concert gown AND her 2nd place medal!

On March 23, Darby won first prize in her division of Opera Modesto's Kristina Townsend Memorial Competition.

Yesterday, Darby competed in an important national level competition for teen vocalists, the Schmidt Voice Competition (the name is purely coincidental!), which took place in Berkeley, on the UC Berkeley campus, with national level judges and pianist.

She had been chosen as one of 35 regional teens and was the only singer from the Central Valley. Most of the others were from high powered Bay Area performing arts high schools and academies, such as the San Francisco School of the Arts.

After the first round, Darby was excited to be one of the seven finalists to compete in the Finals, which took place in the Hertz Concert Hall...and was even more excited to win 2nd Prize, the only female medalist!

In further proof of what a wonderful and dedicated young lady she is, she and her dad, Dennis Schmidt, drove back to Modesto and jumped right into the ongoing staging rehearsal for the chorus (and her mother, Amelia Schmidt!) of Opera Modesto's upcoming exciting production of CARMEN (May 3 & 5).

All of us at Opera Modesto are incredibly proud of this wonderful young lady.

Roy Stevens - General & Artistic Director, Opera Modesto

ED Note: Apparently talent runs in the family! SDS member, Dr. Dennis Schmidt as well as Dr. Geoffrey Uhrik both sang in the chorus of the Carmen product May 3 and 5!

Giving from the heart

Thank you to everyone who volunteered and helped make our 7th Annual Dentistry from the Heart event a huge success:
Our Amazing Team at Turlock Dental Care, Dr. Pak and his team at Turlock Oral & Maxillofacial Surgery, Dr. Baker and his team from Greater Modesto Dental Implant & Oral Surgery Center, Henry Schein Dental Supply, Zest Dental, Tower Compounding Pharmacy & everyone who came to give their time and talents! We were able to provide free dental care for almost 80 people Saturday, over $42,000 of dental care!

SDS Members Drs. Victor Pak, Robert McCulla, Stan Baker and Dr. Jeanine Nordeen

New Online Form Available for Reporting Dental Benefits Plan Issues

Reprinted with permission from California Dental Association

Working with dental benefit plans and other third-party payers can be challenging for many practices. CDA's Practice Support analysts often hear from members and their practice teams who are experiencing claim miscommunications, denials and delays.

CDA members already benefit from access to guidance from a dedicated dental benefits plan analyst through Practice Support. In addition, members can log in to a library of online resources that facilitate working with benefit plans — from navigating the unique requirements of provider agreements to filing claims efficiently to understanding appeal rights as a dentist.

Now, Practice Support is enhancing those benefits with an online submission process for dentists to use to report issues with dental benefits plans.

This new process will enable CDA to continue to facilitate resolution through its expert analysts while giving the association a more defined view of the types of dental benefits plan issues its members face.

To receive assistance, simply submit your issue electronically using the new submission form available online within your cda.org account. Visit My Account, click the link for Dental Benefits Issue Submission and follow the prompts. The intake form will collect basic information about your issue. It is easy to use, secure, HIPAA-compliant and will only take about two minutes to complete. Once submitted, Practice Support will analyze the issue, evaluate it for possible resolution and clearly communicate next steps.

By streamlining the intake process, this form will make it easier for practicing dentists to quickly reach out for assistance and submit issues at their own convenience.

CDA uses the details of specific grievances as well as emerging trends in dental benefits to help determine the best way to serve dentists. The association is committed to continuing to identify the most efficient and effective ways to support, advocate for and act on behalf of members — including evaluating potential opportunities for legislative or legal action — when it comes to challenges with dental benefit plans.

To learn more or submit an issue for resolution, visit **cda.org/dentalbenefits.**

!!NEWS FLASH!!

Required 2019-2020 poster set distribution

CDA created a single, easy to display poster set that address all posting regulations and compliance requirements. One poster set is available free of charge to each CDA member who owns a practice. However, members who have more than one practice location can purchase additional posters for $15 each with free shipping. **Please note: If you own a practice, be sure to review and update your cda.org profile to ensure it accurately reflects your status as a practice owner in order to receive one 2019-2020 poster set free of charge.**

https://ebusiness.cda.org/ebusiness/ProductCatalog/Product?ID=10119

Marijuana Usage and Oral Health

By Barry Taylor, DMD, FAGD, FACD, CDE

Your opinion and knowledge of marijuana (cannabis) usage is most likely based on anecdotal stories and personal observation. In good part this was due to the fact that it was an illegal drug until recently and it still remains a Schedule I drug as categorized by the FDA. Despite it being the number one used recreation drug in the United States[1], there is limited evidence and studies in regards to marijuana usage and oral health.

Recreational use of marijuana is now legal in eleven states when Illinois legalizes it in January of 2020. Washington D.C., and another 21 states have approved the legal use of medical marijuana. In addition to these 32 states, there are 15 states that allow the medical use of marijuana which has a high concentration of cannabidiols (CBD) which are not psychoactive and low in tetrahydrocannabinol (THC) which is psychoactive and gives the user the *high*. A recent Gallop poll indicated that 60% of the public supported legalizing marijuana although the poll did not stipulate between recreational or medical use. The trend of usage is also increasing. In the past three years the number of adults who use marijuana has nearly doubled from 7% to 13%. In the age cohort younger than 25 the usage rate is closer to 20%.

There is extensive research on tobacco usage and alcohol usage in regards to how it affects our patient's oral health. With marijuana usage much of our evidence-based knowledge has to be extrapolated from the limited published studies that there are. A search on Medline reveals only 214 papers for "marijuana and oral health"; less than 60 address caries or periodontal disease. Confounding the difficulty is finding a population that only uses marijuana and does not use alcohol or tobacco so that the direct effect of marijuana is able to be studied. Also complicating matters is finding a population that uses it on a daily basis and not just occasionally.

When we discuss marijuana it should also be noted that some effects caused by cannabis are from the non-psychoactive CBDs of which there are 104 identified. In addition there are flavonoids, terpenes, fatty acids and other chemicals which have potential medicinal use[2]. We do have two endogenous receptors in our own bodies for CBDs. So what does the evidence tell us about how marijuana use affects oral health?

As one would suspect, the caries rate in marijuana users does appear to be higher in people that use the drug. This appears to be due to the fact that marijuana users have poor oral healthcare, have a higher plaque score, and have greater inflammation of gingival tissue[3],[4]. This likely can also be attributed to short term hypo-salivation due to the fact that marijuana does cause xerostomia. Some evidence suggests that this hypo-salivation decreases over time as an individual builds up tolerance for the drug. Marijuana is also an appetite stimulant and users have shown to have a much higher rate of sugar consumption via food and beverage after smoking marijuana[5].

For periodontal disease the story is a bit more complicated because there is evidence that maybe some CBDs have the potential to be anti-inflammatory[6] and may help limit bone resorption[7]. THC on the other hand may be pro-inflammatory[8]. There is not a consensus as to what is the direct effect that marijuana has on periodontal disease. More recent studies have shown that users do have a higher incidence of periodontal disease when compared to non-users. A large study from New Zealand monitoring many heath issues was recently published. The study followed a cohort over a 20 year span measuring many

(Continued on page 13)

[1]National Institute on Drug Abuse

[2]Gould, Julie, Nature 525;S2-S3 (24 Sept. 2015)

[3]Ditmyer M; Demopoulos C; McClain M; Dounis G; Mobley C., The effect of tobacco and marijuana use on dental health status in Nevada adolescents: a trend analysis. J Adolesc Health. 52(5):641-8, 2013 May.

[4]Darling MR, Arendorf TM. Review of the effects of cannabis smoking on oral health. Int Dent J 1992;42:19-22.

[5]Schulz-Katterbach M[1], Imfeld T, Imfeld C., Cannabis and caries--does regular cannabis use increase the risk of caries in cigarette smokers?, Schweiz Monatsschr Zahnmed. 2009;119(6):576-83. (abstract)

[6]Liu WM, Fowler DW, Dalgleish AG.Curr Clin Pharmacol. 2010 Nov;5(4):281-7. Review

[7]Napimoga et al, Cannabidiol decreases bone resorption by inhibiting RANK/RANKL expression and pro-inflammatory cytokines during experimental periodontitis in rats. Int Immunopharmacol. 2009 Feb;9(2):216-22.

[8]Sacerdote 2015, Freidman 2013, Versteeg 2008, Meier 2016

(Continued from page 12)

common general health issues. Participants were observed at age 18, 21, 26, 32, and 38 years. Of the 11 health issues monitored, only periodontal disease was the health issue that had a statistical difference in marijuana users[9]. Unlike the incidence of caries in marijuana users which is attributed to poor diet and a lack of good oral health care, the case for periodontal disease is more complex.

As dentists we are of course concerned if marijuana smokers have a higher rate of oral cancer or damage to the oral soft tissue. Marijuana does contain many of the same carcinogens as cigarettes such as bydrocarbons, benzopyrene and nitrosamines[10]. There is also evidence that the quantity of tar inhaled is greater than in cigarettes. However the evidence appears to be that when tobacco is accounted for in studies, there is not any increase in the incidence of oral cancer in regular users[11]. There is however a higher incidence of leukoedema and candida amongst regular users of marijuana. As with all oral health issues discussed there are other factors as well such as genetics, tobacco and alcohol use among regular users. One concern in regards to marijuana use and oral soft tissue is that "cannabis has a higher combustion temperature than tobacco and therefore, one would expect that a user is at greater risk of thermal injuries to the oral soft tissues"[12].

Recently I was approached by a colleague who was curious if marijuana was a contraindication for placement of implants. I was curious as well because I had recently overheard another colleague commenting that he had recently been in a course in which it was stated that it was a contraindication. A literature search reveals just one published article on cannabis use and dental implants, and this was a study completed in mice. The conclusion was "Considering the limitations of the present study, the deleterious impact of cannabis sativa smoke on bone healing may represent a new concern for implant success/failure"[13]. So as with much of our curiosity about oral health and marijuana use there is a lack of evidence and not a clear answer. Clearly more research needs to be done.

There are of course several other issues that dentists are concerned about in regards to our patients and their marijuana usage such as how does marijuana interact with other medications that the our patients are taking. It is again the recurring theme; there is not enough evidence. Some medications may be inhibited and some may be potentiated. As one well respected pharmacy newsletter stated, "We can make some predictions of potential interactions based on the known pharmacology of marijuana". In addition to drugs that may affect the metabolism of THC, we can expect marijuana to have interactions with sympathomimetic activity, central nervous system depressants, and anticholinergic effects[14]. There are no documented cases of medical emergencies in the dental office attributed to marijuana usage although there is a risk of impact on opioids and muscle relaxants. Dr. Rob Hendrickson, associate medical director of the Oregon Poison Center, also notes in an article that marijuana sued with sedatives and hypnotics can have an additive affect.

With what we do know about marijuana it is best to treat regular users with the same care that we treat patients who regularly use alcohol and tobacco. Educate your patients about homecare, a proper diet, and inform them that marijuana does have many of the same carcinogens as cigarettes. For the patient that only uses it occasionally and does not smoke tobacco there does not appear to be much evidence that occasional use has any effect on oral health.

Note: This article was originally published in Membership Matters. The data has been updated.

[9]Meier et al, Associations between cannabis use and physical health problems in early midlife. JAMA Psychiatry, published online June 1, 2016.
[10]Cho CM, Hirsch R, S Johnstone, General and oral health implications of cannabis use, Australian Dental Journal 2005; 50:2.
de Carvalho et al, Head and neck cancer among marijuana users: a meta-analysis of matched case-control studies.
[12]S. Joshi and M. Ashley, Cannabis: A joint problem for patients and the dental profession, British Dental Journal 2016; 220:597-601.
[13]Nogueira-Filho Gda R, Cannabis sativa smoke inhalation decreases bone filling around titanium implants: a histomorphometric study in rats., Implant Dent. 2008 Dec;17(4):461-70.
[14]John R. Horn, Phillip D. Hansten, Drug Interactions with Marijuana, Pharmacy Times, and personal correspondence.

New Class of Membranes Shown to Regenerate Tissue and Bone, Viable Solution for Periodontitis

Reprinted with permission from the UCLA School of Dentistry

Periodontitis affects nearly half of Americans ages 30 and older, and in its advanced stages, it could lead to early tooth loss or worse. Recent studies have shown that periodontitis could also increase risk of heart disease and Alzheimer's disease.

Alireza Moshaverinia, left, and Paul Weiss are co-lead authors of the study.

A team of UCLA researchers has developed methods that may lead to more effective and reliable therapy for periodontal disease — ones that promote gum tissue and bone regeneration with biological and mechanical features that can be adjusted based on treatment needs. The study is published online in ACS Nano.

Periodontitis is a chronic, destructive disease that inflames the gums surrounding the tooth and eventually degrades the structure holding the tooth in place, forming infected pockets leading to bone and tooth loss. Current treatments include infection-fighting methods; application of molecules that promote tissue growth, also known as growth factors; and guided tissue regeneration, which is considered the optimal standard of care for the treatment of periodontitis.

Guided tissue regeneration, in the case of periodontitis, involves the use of a membrane or thin film that is surgically placed between the inflamed gum and the tooth. Membranes, which come in non-biodegradable and biodegradable forms, are meant to act not only as barriers between the infection and the gums, but also as a delivery system for drugs, antibiotics and growth factors to the gum tissue.

Unfortunately, results from guided tissue regeneration are inconsistent. Current membranes lack the ability to regenerate gum tissue directly and aren't able to maintain their structure and stability when placed in the mouth. The membrane also can't support prolonged drug delivery, which is necessary to help heal infected gum tissue. For non-biodegradable membranes, multiple surgeries are needed to remove the membrane after any drugs have been released — compromising the healing process.

"Given the current disadvantages with guided tissue regeneration, we saw the need to develop a new class of membranes, which have tissue and bone regeneration properties along with a flexible coating that can adhere to a range of biological surfaces," said Dr. Alireza Moshaverinia, co-lead author of the study and assistant professor of prosthodontics at the UCLA School of Dentistry. "We've also figured out a way to prolong the drug delivery timeline, which is key for effective wound healing."

The team started with an FDA-approved polymer — a large-scale synthetic molecule commonly used in biomedical applications. Because the polymer's surface isn't suitable for cell adhesion in periodontal treatment, the researchers introduced a polydopamine coating — a polymer that has excellent adhesive properties and can attach to surfaces in wet conditions. The other benefit of using such a coating is that it speeds up bone regeneration by promoting mineralization of hydroxyapatite, which is the mineral that makes up tooth enamel and bone.

After identifying an optimal combination for their new membrane, the researchers used electrospinning to bond the polymer with the polydopamine coating. Electrospinning is a production method that simultaneously spins two substances at a rapid speed with positive and negative charges, and fuses them together to create one substance. To improve their new membrane's surface and structural characteristics, the researchers

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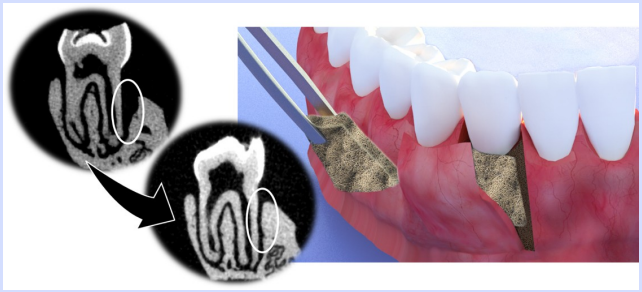
used metal mesh templates in conjunction with the electrospinning to create different patterns, or micro-patterning, similar to the surface of gauze or a waffle.



“By creating a micro pattern on the surface of the membrane, we are now able to localize cell adhesion and to manipulate the membrane’s structure,” said co-lead author Paul Weiss, UC Presidential Chair and distinguished professor of chemistry and biochemistry, bioengineering, and materials science and engineering at UCLA. “We were able to mimic the complex structure of periodontal tissue and, when placed, our membrane complements the correct biological function on each side.”

To test the safety and efficiency of their new membrane, the researchers injected rat models with gingival-derived human stem cells and human periodontal ligament stem cells.

After eight weeks of evaluating the degradation of the membranes and the tissue’s response, they observed that the patterned, polydopamine-coated polymer membrane had higher levels of bone gain when compared to models with no membrane or a membrane with no coating.

In order to suit a wide range of medical and dental applications, the researchers also figured out a way to adjust the speed at which their membranes degraded when inserted in their models. They did this by adding and subtracting different oxidative agents or using lighter polymer bases before going through the electrospinning process. The ability to turn the degradation rates up or down helped the researchers control the timing of the delivery of drugs to the desired areas.

“We’ve determined that our membranes were able to slow down periodontal infection, promote bone and tissue regeneration, and stay in place long enough to prolong the delivery of useful drugs,” Moshaverinia said. “We see this application expanding beyond periodontitis treatment to other areas needing expedited wound healing and prolonged drug delivery therapeutics.”

The researchers’ next steps are to evaluate whether their membranes can deliver cells with growth factors in the presence or absence of stem cells.

The study’s first author is Mohammad Mahdi Hasani-Sadrabadi, a UCLA project scientist in chemistry; and biochemistry and bioengineering. The other authors are Patricia Sarrion, Nako Nakatsuka, Thomas Young, Nika Taghdiri, Sahar Ansari, Tara Aghaloo, Song Li and Ali Khademhosseini, all of UCLA. Weiss is also a member of the UCLA California NanoSystems Institute, the Jonsson Comprehensive Cancer Center and the Eli and Edythe Broad Center of Regenerative Medicine and Stem Cell Research at UCLA.

The research was supported by a grant from the National Institute of Dental and Craniofacial Research.

Ad

Rotary Club of ModestoFLEX

New "Flexible" Rotary Club chartered in Modesto

Fewer meetings, more family involvement emphasized

The civic scene in Modesto may have changed forever. While service club memberships have suffered from a downward trend across the globe for the past two decades, 41 members are active and already beating the odds. Sponsored by Rotary Club of Ceres, the new Rotary Club of ModestoFLEX chartered on January 9, 2019 with 30 charter members.

"We're thrilled to have officially chartered earlier this year," said Eugene Awuah who is serving as the club's first President and leads Rotary membership growth efforts in the Central Valley and Mother Lode. "What was once a dream is now reality. We are living the dream and want to share this flexible and fun experience with you and your family."

Most traditional Rotary clubs world-wide hold weekly adults-only meetings during business hours with firm attendance requirements and mandated meals. ModestoFLEX marries the same Rotary principles and benefits with a more flexible and less costly format. "We keep the cost and time commitment down to appeal to families who may have hesitated becoming Rotarians in the past," says Public Image Chair Michael Gaffney. "Achieving work life-balance is a real problem. Setting aside time to give back to the community is challenging for many families. The FLEX concept is proving to be the solution. My wife Victoria and I each hold a leadership role on the board and take our four-year-old son Connor to the meetings. Instilling Rotary's solid values and morals in him is very important to us."

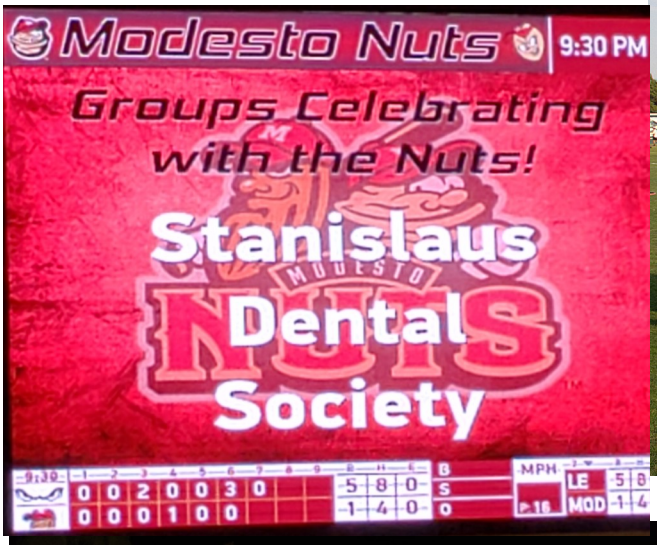
The club's enthusiastic, diverse, and growing membership has quickly fostered a very positive club culture that promotes a warm, welcoming, and inclusive environment for all who value family, life-long friendships, and a hands-on approach to Rotary service. "I've been searching for a place to develop my leadership skills while pursuing my passion for financial literacy. ModestoFLEX provides me with both," says young business professional Cecilia Rosales who is proud to be the club's President-Elect.

An array of affordable membership levels is available including: Individual, Single Family, Couples Family, Small Business, Corporate, and Young Business Professionals. "The FLEX concept provides me with a vehicle to do something about homelessness in our community, an issue that needs our immediate attention," says big-hearted but time-challenged local business owner Dory Tucker, who recently launched The Hopeful Garden Project that focuses on homeless mitigation.

ModestoFLEX meets on the first Wednesday of the month from 6:00 to 7:30 p.m. at rotating locations including member's place of work. The second meeting is also flexible with dates and times agreed to by members ahead of time based on their work and family schedules.

To learn more about the Rotary Club of ModestoFLEX or attend an upcoming event, please contact Michael Loschke at 209-988-2000 or visit www.facebook.com/modestoflexrotary.

SDS Goes to the Nuts!



The Three Essential Functions of Your Employee Manual

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When it comes to your dental practice, one of the most important documents in your HR toolkit is your employee manual. Not only can definitive employee policies resolve disputes, but they can thwart issues before they arise, protecting both the employer and the employee from any sort of misperception and the potential for litigation.

Exercising your due diligence is the key to getting the most out of your employee manual.

Your manual's three essential functions:

1. **Protection — your due diligence**

First, a well-written employee manual contains objective guidelines for workplace policies, rules and regulations in consideration of federal, state and local labor laws. Additionally, your manual outlines the consequences of policy violations all in one place.

The absence of an employee manual greatly increases the likelihood of an employee filing suit. After polling an opposing plaintiff's attorneys about what factors helped them decide to file suit on behalf of current or former employees with complaints, their responses are always the same: It depended on whether the practice had an employee manual.

Practices that don't have employee manuals are considered proverbial low-hanging fruit for successful lawsuits because it is indicative of potential negligence in other aspects of the business. In other words, if you want to avoid employee legal claims, a manual is one of the simplest yet most effective ways to deter opposing legal counsel from deciding to file a lawsuit in the first place.

2. **Consistency — thwarting discrimination claims**

Manuals are essential because they emphasize consistency — most importantly, protecting you against discrimination claims, such as retaliation and a hostile work environment. But all situations should be handled objectively and consistently. A manual allows you to outline policies (and the consequences of violating these policies) as they apply objectively to your entire team. Referencing your manual for applications of principles and procedures ensures you are handling all situations consistently and, more importantly, objectively, to avoid high-risk discrimination claims.

Furthermore, your employee manual outlines your practice's culture. This includes benefits, dress code, punctuality and attendance expectations. Outlining your expectations on these policies is imperative to ensure you are not unfairly or inadvertently singling someone out.

3. **Compliance — federal and state-mandated laws**

While it is not legally required that you specifically have an employee manual, a manual is the most effective way to outline your compliance with legally mandated laws and ordinances. Federal agencies, such as the U.S. Department of Labor, Division of Labor Standards Enforcement and the U.S. Equal Employment Opportunity Commission require business owners to outline rights, such as the Family and Medical Leave Act, whistleblower protections, minimum wage, time off to vote, the Uniformed Services Employment and Reemployment Rights Act, etc.

State agencies also mandate that employers follow local ordinances. In California, employers must distribute 13 policies to each employee regardless of hours worked. One example is the recently imposed mandatory paid sick leave requirement. Legally, all employees are rightfully allowed to review their employer's paid sick leave policy as well as their accrued paid sick leave hours. Having these policies outlined in your manual ensures you are compliant while also informing your team of their rights within each policy and the procedures to exhaust mandated leaves.

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The perils of generic manuals

1 Many times, practices want to use generic manuals provided by their payroll company. Although this may seem to be easy and straightforward, it typically creates more risk than reward. In the compliance world, most things that are low effort and easy tend to prove hazardous. Here's how:

1. All businesses are not alike. Simply copying the contents of another company's employee manual is unlikely to satisfy the particular HR needs of your workforce.
2. You risk not being specific, consistent and objective. Your manual should outline benefits and policies that your practice uses to reference disciplinary action and benefit accruals. By outlining policies in your manual to reference during disciplinary action, you ensure every situation is handled objectively and consistently. Without sound policies in place, how does an employer discipline an employee who has violated an unspecified "rule?"
3. Labor laws change every year. It's imperative that your employee manual is revised to acknowledge these updates. Your employee manual is an ongoing project. Annual updates ensure you do not fall out of compliance.

A powerful tool

If you are not currently using a customized, up-to-date employee manual, you are missing out on a powerful yet easily implemented tool to improve and safeguard your practice. To insulate yourself from future lawsuits, increase productivity and minimize confusion about the policies and regulations affecting your practice, take the time to draft an employee manual. Your manual will serve as your primary defense in everything from day-to-day office disputes to full-blown legal claims. It is a simple, effective way to protect your practice — and yourself.

Build your employee manual with help from CDA

CDA Practice Support is your resource for navigating the business side of dentistry. As part of your CDA membership, you have access to tools and resources such as a Sample Employee Manual template, which lets you build your own employee manual. And new this year is an online **Employee Manual Generator**. This easy-to-follow tool will guide you through developing a customized and compliant handbook.

https://www.cda.org/member-resources/practice-support/employee-manual-generator

Find resources on employment practices, including tools for developing your employee manual, at cda.org/practicesupport.

Are You in Compliance?

Dental practices must comply with new laws and regulations on the following dates:

March 12, 2019: Transition period to new controlled substances prescription forms

January 1, 2019: Warning notice required on opioid container

January 1, 2019: Mandatory opioid prescription discussion with minor or minor's parent

January 1, 2019: Prescriber obligation to prescribe and educate on naloxone use

January 1, 2019: New infection control standard for procedures that expose dental pulp

January 1, 2019: Implement new minimum wage increases

January 1, 2019: Updated Lactation Accommodation location requirements

January 1, 2019: Amendments to clarify ambiguities to salary history ban law

January 1, 2019: Update standard mileage reimbursement rate for 2019 (released by Internal Revenue Service)

Tips O' the Trade

California employers have the ability to round employee timecard entries up to the nearest quarter of an hour as long as the practice is neutral. Meaning that, over time, it doesn't favor either the employer or the employee. Employers should periodically audit timecards to ensure the system is neutral.

You are obligated to make reasonable arrangements for the emergency care of your patients of record. A charge of patient abandonment may result from a failure to make reasonable arrangements. In addition, many dental benefit plans require contracted providers to arrange for after-hours emergency care of their patients.

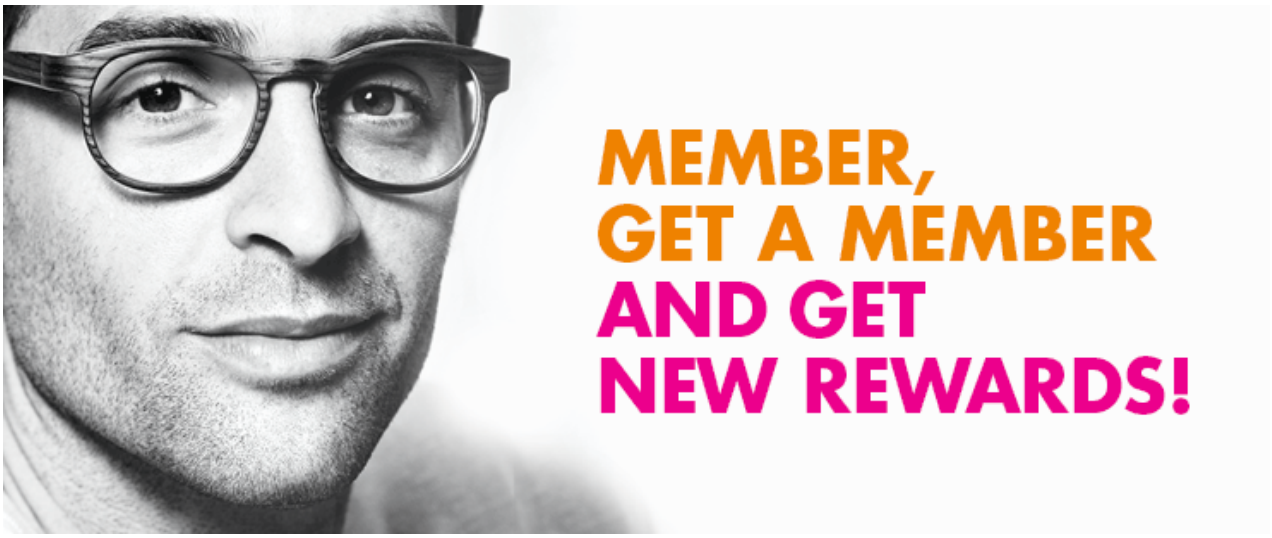
As of January 1, 2018, all employers must electronically submit their employment tax returns, wage reports, and payroll tax deposits to the EDD. Review the California Employers Guide for more information.

Benefit plans conduct re-credentialing at regular intervals after a provider has been contracted with their benefit plan. The re-credentialing process is time sensitive and should not be ignored. Failure to comply with a re-credentialing request could result in termination from the plan and could require re-contracting. When the benefit plan notifies a provider of the need to re-credential, follow their instruction closely and make sure you meet their compliance date. Be sure to follow up to guarantee that the information was received before the due date.

Dental practices are exempt from completing and posting the OSHA Log 300 form unless the practice has been requested to do so in writing by OSHA, the Bureau of Labor Statistics or Cal/OSHA. Most businesses must complete the log annually and post at the workplace from February 1 to April 30.

Have you ever had to wait weeks for months or a dental benefit plan to re-issue a check that got lost in the mail? Consider enrolling in direct deposit with the dental benefit plans to avoid this. The funds from your check are electronically transferred into your bank account and you can usually print the explanation of benefits from the plan's website.

If you've received a request to re-credential from Delta Dental, understand that Delta is notifying the dentist that if a dentist does not comply with Delta's request to re-credential within the time frame indicated on the letter, Delta will terminate that dentist's contract(s) with them. If the contract(s) were terminated due to lack of re-credentialing compliance and the dentist decided to reapply, they would be required to sign Delta Dental's current contract which includes the participation in both their PPO and Premier networks, and compensation when treating a PPO patient would be based off the PPO rate for the region. To avoid termination of the dentist's Delta Dental contract(s), comply by returning one complete re-credentialing packet (best practice by email), including current copies of requested supporting documents. Follow up by calling Delta Dental's Credential Department at 866.689.7884 to verify receipt and that no other action is necessary on the dentist's part.



A CDA member's personal experience with our support, advocacy, education and protection is a powerful referral tool. And, there's no better time to introduce a colleague to the value of organized dentistry.

With 27,000 dentists working together, our community is growing stronger than ever. Our newest benefit of membership, tdsc.com, leverages that shared strength to deliver big savings on 25,000 dental supplies through one easy-to-shop site.

Share the benefits by referring your colleagues to join CDA and encourage them to shop and save. The more referrals, the more group purchasing savings for everyone!

You'll be rewarded up to three ways for every successful referral:

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- **Receive $100 to shop tdsc.com** from CDA.[1]
- **Receive $50 more** to shop tdsc.com if the new member places orders totaling $250.[2]

Confused about Medicare?

By Jan Palmer, FAADOM

To clarify Medicare options and help you make the best decision for **your** practice, let's start with the basics: Medicare, what is this and what does this have to do with my dental practice?

For any reimbursement for a potentially covered medical service to be considered, **all** sequential providers must be recognized in the Provider Enrollment Chain and Ownership System (PECOS).

The Medicare program provides health coverage for eligible Americans 65 years of age and those deemed disabled or diagnosed with end stage renal disease. This is a federal contractor and was implemented in 1965 under Title XVIII of the Social Security Act passed by congress. Medicare is handled under the Social Security Administration and administered by the Centers for Medicare and Medicaid Services (CMS) within the Department of Health and Human Services (HHS). Any decision on changes to the program is governed by congress, then filtered through the Centers for Medicare and Medicaid services (CMS) and then to your jurisdiction's contractor.

Original Medicare excluded all dental services. In 1980 an amendment was made to allow a few specific services to be eligible for coverage. Examples include some inpatient services related to dental disease, extractions done to prepare for radiation therapy, or a dental evaluation performed on an inpatient as part of a comprehensive workup prior to transplant surgery or heart valve replacement. These would be potentially covered services. Because most dental services are not covered, the dental community has had the ability to ignore Medicare in the past. As dentistry is now one of the allowed specialties that may provide items that are potentially covered under Medicare such as pathology sent to a laboratory for testing or referred services for some medical conditions, the dental community should no longer ignore the options.

Medicare recognizes dentists as oral physicians. With more than 10,000 Americans turning 65 every day and eligible for Medicare, you're probably seeing an aging population in your practice, especially with the Medicare replacement plans, also known as Medicare Advantage policies. It is important to understand the potential effects in your dental practice.

There are 4 "Parts" of the Medicare program, A, B, C and D.

Medicare Part A covers hospital services— the patient (beneficiary) is eligible, there is no need for a dentist to enroll as a part A provider.

Medicare Part B physician services may be purchased by the patient if they are eligible for Part A– Since most dental services are not covered, a dentist should have no need to enroll as a provider, however you may choose to opt-out or enroll as an ordering and certifying provider.

- **Durable Medical Equipment** (DME) is a sub-part of Part B—This benefit is included in the purchase of the Part B rider. DME has its own contractors, separate from physician services and requires enrollment as a supplier of DME; this is where sleep apnea appliances would be processed.

Medicare Part C Advantage plans are replacement policies that are purchased through commercial insurance companies. Many Advantage plans have embedded dental coverage within the policies, you have most likely seen this already in your general dental practice.

Medicare Part D is prescription coverage, also a purchased rider, patient must be entitled to Part A and have purchase Part B.

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For any reimbursement for a potentially covered medical service to be considered, **all** sequential providers must be recognized in the Provider Enrollment Chain and Ownership System (PECOS). Think of this as a "chain" of providers and you are a link in the chain. If you refer a patient for a biopsy, or send a specimen for pathology and you are not recognized or enrolled as an ordering and certifying (formerly referring) provider, the service for the next provider or lab would not be covered, even if that provider or lab is enrolled, you broke the chain, no coverage for the service and an unhappy patient.

In 2015/2016, Medicare proposed all dentists were required to choose an option of becoming a participating, non-participating Part B provider, opting-out or enrolling as an ordering and referring provider. Opting-out and ordering and certifying do not grant billing privileges, they both allow coverage for prescriptions written by a dentist as long as the patient has Part D coverage. The main difference between opting-out and enrolling as ordering and certifying, is that if a provider has opted-out Medicare would not allow benefits for any referred services, where enrolled as an ordering and certifying provider, benefits would be allowed for the office/lab referred to.

Many Medicare Advantage/replacement plans started denying claims for dental services performed by any dentist that was not enrolled as a Part B provider. With the assistance of the American Dental Association (ADA), the National Association of Dental Plans (NADP) and Delta Dental Plans Association sent a joint letter to the U.S. Department of Health and Human Services ask the enrollment requirement be removed. The rule was rescinded, and dentists no longer are **mandated** to opt-out or enroll as ordering and referring in order to receive payment under the Advantage policies. Although no longer mandated, it is strongly recommended to enroll as an ordering and certifying provider to allow benefits for patients who are referred for potentially covered services. You don't want to break the chain!

For offices that are supplying oral appliances for sleep apnea, you have options regarding supplier services; you cannot ignore Medicare any longer and you have responsibilities. *The Dental Sleep Apnea Team* can assist you with clarification of the responsibilities of being a DME provider, the application process, policies, and protocols along with clinical and team education for Dental Sleep Implementation for both new and existing practices.

Whatever your decision, it is important to completely understand and choose the best option for your patient population! For more information on services available on our website, Dental Sleep Apnea Team www.***DSATS***leep.com or contact us at info@***DSATS***leep.com for more information.

Since 2000, Jan Palmer, FAADOM has been working assisting dentists all over the country to better understand the rules, regulations and responsibilities of dentists in the commercial medical insurance and Medicare realm. In addition to speaking and consulting roles, Ms. Palmer is a co-founder of the Dental Sleep Apnea Team, sits on the Provider Outreach and Education committee for Medicare Jurisdictions A and D, is vice-president of the WNY Dental Managers Group and a facilitator of the American Academy of Dental Sleep Medicine Mastery course.

If you in need of further information regarding Medicare, are looking to implement dental sleep medicine into your practice, are struggling with workflow of dental sleep medicine or have an established practice that needs to advance to the next level, we have established highly effective processes to implement DSM to the highest level of care for your patients.


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Put a Stop to Fake Invoices With Sample Letter From CDA Practice Support

6/6/2019

Reprinted with permission from California Dental Association

Fake invoices from at least one company are making the rounds in California, with several dentists contacting CDA for advice on how to handle the scam.

The dentists, including CDA members in Bakersfield, Fresno and Los Angeles, report receiving invoices from Pinnacle Medical Supply for products that neither they nor any of their staff members ordered. One dental practice received an invoice for $252 for a three-pack of glucose test strips. Seven fake invoices from Pinnacle Medical or Pinnacle Medical Supply were reported in April using the Better Business Bureau's online BBB Scam Tracker, and reports of the scam have also made it into Dentaltown Magazine's message boards.

The "fake invoice" is one of the more common scams targeting dental offices and other small businesses, according to the Federal Trade Commission. But dental practices and others on the receiving end of the scam can take simple steps to both report the scam and avoid falling victim to it.

"Sending a letter to the invoicing company is not required, but it is usually the fastest way to put a stop to the company's practice," says Teresa Pichay, CDA regulatory compliance analyst.

Dentists can use a sample letter available from CDA Practice Support to notify the company that practice staff were able to determine, after reviewing records, that they did not order the invoiced material that was delivered to them. The letter further advises the company that because they received unordered merchandise, they are allowed by federal and state law to use or dispose of the merchandise as they see fit and are not obligated to pay for it.

"Keep a copy of the letter," Pichay advises. And if the company asks that the product be returned, Pichay says it is OK to do so "as long as the company pays for all return-shipping costs."

If the dental practice sends this letter but continues to receive invoices for the unordered product, the practice may choose to file a formal complaint with the FTC or the California Office of the Attorney General.

Additionally, as in the case of the Pinnacle Medical Supply invoices — and for any unordered merchandise sent via the U.S. Postal Service, dentists also have the option of filing a complaint directly with the USPS by phone (800.275.8777) or online.

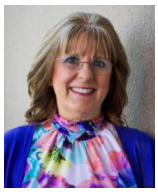
Inspect invoices, train staff

Pichay says dental practices can take steps to avoid falling victim to the fraud.

"The scammers hope that the busy dental office will see familiar product names or product types, assume they were ordered — by someone — and pay the invoice," Pichay says.

FTC guidance encourages small businesses to always inspect their invoices and to train their staff to recognize the scam. Practices might, for example, compile a list of companies they typically order supplies from, which will be especially helpful if they don't have a purchase order system in place. They might also designate one or two specific employees to approve purchases and pay bills since these staff would be most likely to recognize an unfamiliar supplier or questionable order.

Access the CDA resource "Receipt of Unsolicited Products or Services," which includes the sample letter referenced in this article, at cda.org/practicesupport.



EXPERIENCE IS NOT EXPERTISE

By Theresa Sheppard, RDA

Check out your local "help wanted" listings…. most employers are looking for someone with 1 or more years of "experience" in the position they are looking to fill. Over the last 35 years of my career in dentistry, I have discovered that "experience" is over-rated. Let me explain.

In a practice, once the patient has had their diagnostics & treatment consultation, they will be turned over to the person that handles the insurance and the financial arrangements.

This is where all of your hard work and credibility can implode without proper training. Coding and billing is the **one position that has the most financial impact** on your practice and that impact can be profitable or catastrophic.

A well-trained insurance administrator is a very valuable team member. They can usually assist the Dr. to increase monthly production by several hundred to several thousand dollars, but it isn't good enough to have experience, you must be an expert…. **EXPERIENCE IS NOT EXPERTISE**

Doctor…. have you invested in formal training for your "insurance administrator"? Who actually trained that person? Was she trained by the "girl that did the job before"? Or is she doing things a certain way because that's "how I did it in my old office?" I have had administrators tell me that "the Dr. doesn't care, so why should I?" (maybe healthcare isn't the profession for her!)

As dental professionals we should set our personal bar very high, always making sure our number one priority is to exceed the standard of care. Lack of training is a dangerous way to do business. That being said, the responsibility for proper coding starts with the clinical team. I say that because the documentation from the clinicians MUST be accurate if the insurance administrator is going to be able to code properly.

During chart audits, I typically discover between $2 - $10 thousand dollars a month lost revenue (sometimes much more) just from incomplete or incorrect documentation. A few examples:

- A patient has a 3-unit bridge, but only because the abutments are prepped, that's what gets documented, the pontic revenue is lost.
- Legitimate pulp caps being documented as a base—lost revenue.
- Tooth needed extracting and added to existing partial. Many times that could have been the tooth that was clasped, so not only do we need a new tooth, we need a new clasp. Lost revenue because clasp was not billed out.
- BW & 2 PA's taken on a hygiene patient—after exam Dr. needs one more PA. BW get billed out but only 2 PA's…more lost revenue.

I have had office managers say, "Well, that's only 1 PA". Yes, but let's say 1 PA @ $25.00 x 3 times a day x 4 day a week x 4 weeks a month = $1,200.00. Would the manager feel differently if "only" those PA's were gone from **her** check? They are certainly gone from the Dr.'s!

I could go on & on & on, but you get the idea.

If the ENTIRE team is not properly trained in accurate, exact documentation and coding, it will result in a loss of revenue and could even be considered insurance fraud. Insurance fraud is definitely not a road you want to take. Fraud can lead to fines, disciplinary action, license probation or revocation, and possible incarceration. Insurance fraud does not have to be intentional to be prosecuted and auxiliaries are not exempt.

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Let's look at this example:

#6-11 pre-auth was sent for Pontic Porc to High Noble and Abutment High Noble. The plan re-assigned the codes and approved for Pontic Porc to Base Metal and Abut Porc to Base Metal. When the pre-auth came back, NO ONE noticed that the codes were re-assigned to a lesser benefit OR that even though it was "approved", the patient was well over his max. No one advised the patient what his financial responsibility would be.

Treatment done…No consent form, no financial arrangements. No communication regarding treatment plan change in the chair to an all ceramic bridge. Pre-auth was sent for payment, the insurance paid and the patient was billed the balance of several thousand dollars. What do you think happened next? The patient filed a grievance with his insurance company and the dental board. The Dr. was held responsible. The insurance company performed an audit and the Dr. was ordered to reimburse the insurance company, and the patient owed $0. I'm sure the patient loves their free bridge!!

Team training would have avoided this and brought the approximately $11 thousand dollars of revenue to the practice instead of back to the insurance company and patient. In reality, the loss is much higher. The Dr. had to absorb chair time, wages, lab fees, and materials, but perhaps the biggest cost was damage to the reputation of the practice.

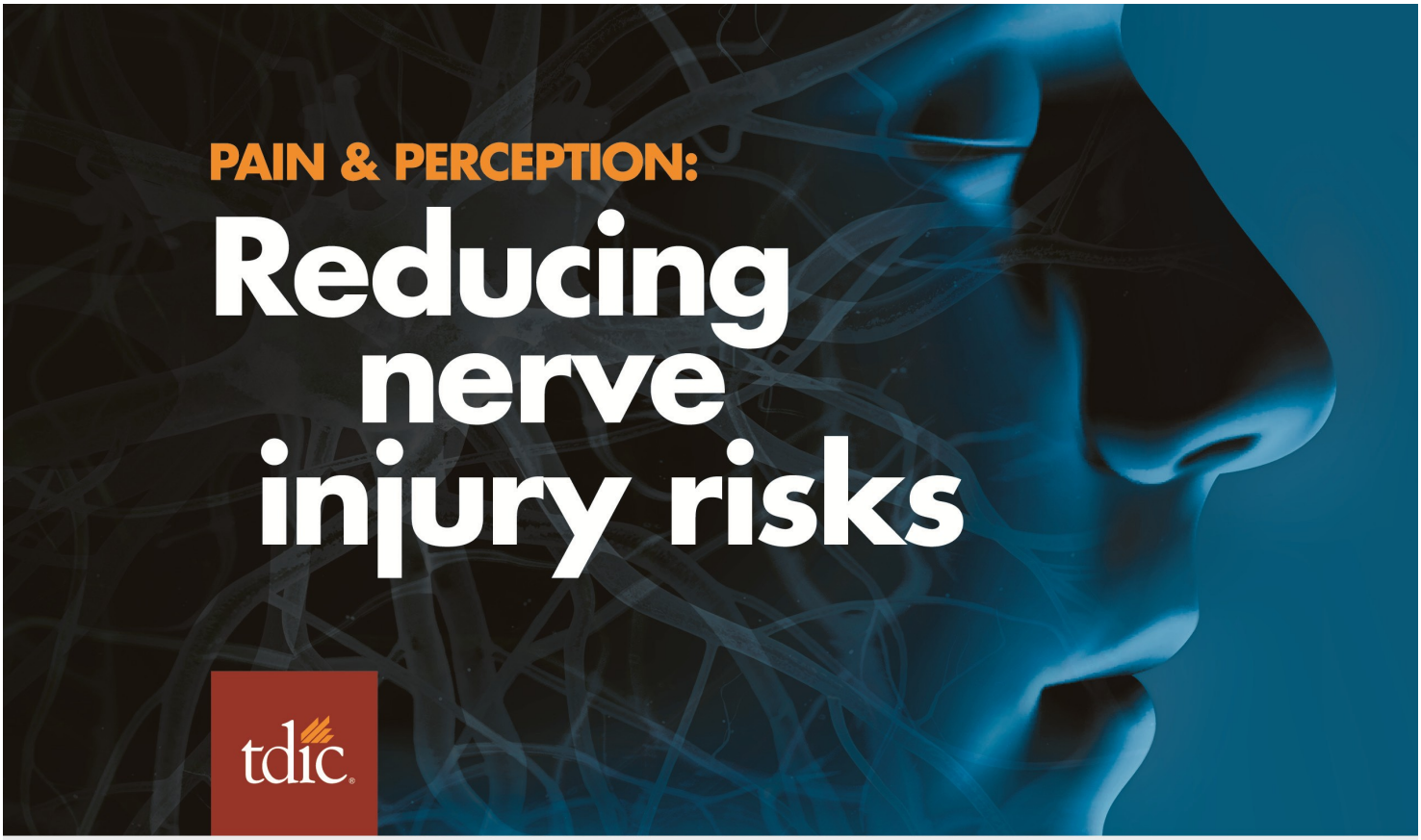
Regardless of how much a patient loves a dentist, they will turn in an instant if the financials are not what they expect. And you better believe that everyone they know on Facebook will hear about it!

By investing in team training on coding and business systems, you can actually get paid for the procedures performed, reduce stress, and your patients will be happier.

IT'S "JUST" A WORD

How can we expect a patient to value our services if we don't? Whether speaking to a patient on the phone or in person, you should never ask a patient if they "just need a cleaning", or "just need a filling". I once heard an assistant describe Velescope screening as "just a light the Dr. uses to see cancer" WOW! There are several things that concern me about that phrase. This team needs some training to make sure the wordage is correct and the message is consistent.

By using the word "just" it undermines the importance of the patient's dental health and urgency for treatment. If we want patients to value our services, we must not minimize the perception of the doctor's expertise or the procedure time involved. Stressing the importance of the procedure will help reduce no shows or last minute cancellations.



Unsure how to handle patients who are experiencing prolonged numbness following dental procedures? The Dentists Insurance Company's new Risk Management seminar is designed to build your confidence in these interactions.

Participate in the Pain & Perception seminar and learn how to:

- Institute communication protocols when multiple dentists are involved in treatment.
- Recognize the importance of complete and appropriate documentation.
- Communicate unexpected treatment outcomes to patients and know when to refer.
- Understand that informed consent is a process, not a form.

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*TDIC policyholders who complete a seminar or eLearning option will receive a two-year, 5 percent Professional Liability premium discount effective their next policy renewal. To obtain the two-year, 5 percent Professional Liability premium discount, Arizona, California and Nevada dentists must successfully complete the seminar by April 26, 2019. Alaska, Hawaii, Illinois, Minnesota, New Jersey, North Dakota and Pennsylvania dentists must successfully complete the seminar by October 26, 2018. Any eLearning tests received after the deadline will not be eligible for the discount. Non-policyholders who complete a seminar or eLearning option and are accepted for TDIC coverage will also be eligible for this discount.

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Endorsed by the Stanislaus Dental Society

Tele-Dentistry

By Theresa Sheppard, RDA and Nicole Flaherty, RDH

It's a typical Thursday morning. So typical, in fact that, when I arrived at the office, I already had two voicemails from patients who wanted to cancel their hygiene appointments. Sadly, this has become typical for practices throughout the United States. The reasons vary but the theme remains the same. Patients believe they are too busy to come into office. After all, that appointment is no big deal, right? It's just a cleaning, right?

How have we reached the point where our patients don't value the service provided by dental practices? In short, I believe we have done this to ourselves. We base the patient's treatment plan and diagnostics on their insurance rather than their oral health needs. When a patient calls to cancel or reschedule, we tell that patient, "That's OK. It was just a cleaning." have heard it countless times … and it has become a huge problem for our industry. When we use the word "just" we de-value our services.

As providers, are we *just* providing cleanings? Are we actually diagnosing and treating patients as individuals or are we "working on them?" These are the questions that we have to ask ourselves and answer honestly.

For dentists, you also have to ask yourselves another question and answer it honestly: Are you "just a dentist" or are you an oral physician? There is no other physician that treats conditions and diseases of the oral cavity. If we diminish our role in the overall health and longevity of our patients, then we will continued to be viewed as a tooth mechanic or running our patients through our hygiene department like a car wash. You choose dentistry for a reason. You deserve to be recognized for the healthcare professional that you are. We must strive to be oral physicians in order for the community to take us seriously … and for our patients to become healthier.

If you doubt that you are a physician, check out your current ADA claim form. Box #34 allows you to put diagnosis codes on the form to support medical necessity. I encourage you to start moving toward a medical model with small steps, such as reviewing your perio protocol and using a SOAP notes format for documentation.

In the next few years, EHR will become the standard. Most of medicine follows this standard now and tele-medicine is becoming the norm.

Dentistry is coming along in that same respect as well. With the introduction of tele-dentistry, we can eliminate our patients' excuses and bring the diagnostic, preventive and perio services to them.

WHAT IS TELE-DENTISTRY?

Tele-dentistry is an opportunity to connect with patients who may seem too busy for a "normal visit." This can include millennials, working mothers, people who have to pull kids out of school, people afraid that taking time off would jeopardize their job and others with barriers to access.

Why is now the time for tele-dentistry? Here are some of the reasons:

We live in a social world. We are in constant communication by phone, email, text, FaceTime and Skype. Why are we not using tele-dentistry technology to connect to our patients?

Tele-dentistry can help meet the challenge of greater efficiency and connect care providers at the point of care. It can also improve interdisciplinary health care, collaboration and patient health.

The world is quickly changing and many aspects of our day-to-day lives are evolving to accommodate a busier, more high-tech and increasingly demanding schedule where convenience is essential to make it all work. We live in a time where we don't hail a taxi. Rather, we ping for an Uber through an app. We don't shop for our own groceries. Instead, we order them online and they're delivered right to our cars.

(Continued on page 30)

Robin's Relevant Remarks

SDS Executive Director

Well THAT was a surprise! It didn't take long for our 5th Annual Summer Dental Symposium to almost completely fill up! And most everyone who registered received the early-bird registration fee. Well done! Rest assured though that those who were unable to take the sexual harassment course (despite the fact that we even squeezed another course into the break room!) will have more than one opportunity to take the course before the end of the year. More details will follow in early July.

Attendance at this year's Nuts event was a bit lower than expected thanks to Memorial weekend falling at a most inopportune time (it was the only Friday we could book!); however, next year we are expecting to be back at the upper party deck celebrating our 10th year holding our Night at the Nuts event, especially since many expressed their disappointment at not being able to attend this year due to holiday plans. The team at the Nuts league will be working to connect with us sooner to give us better date opportunities so look forward to attending with the inclusion of a special raffle opportunity! Rest assured that the guests who were able to attend this year had a great time with the weather being practically perfect and a good time was had by all. Congratulations to Sawyer Kolody for throwing the first ball!

Here I am, happy as a clam, coming up on my 11th year as your ED with SDS knowing...

... SDS members (and team): preserve the dental health of the earth's population, one patient at a time!

(Continued from page 29)

What has happened to the taxi cabs or grocery stores that have not evolved with the times? They have been left behind as other businesses in their industry adapt and create a higher standard.

Tele-dentistry doesn't change who you are, what you are or what you do. Executed properly, it does not change the standard of care or the scope of your license. The only difference is the method used to treat your patient … as well as the number of patients you can reach.

However, keep in mind that, while technology moves quickly, advancements in accepted protocol for dentistry move very slowly. Despite this, we must keep up and even stay ahead of the curve.

Tele-medicine was created to connect a physician to their patients via email or facilitated virtual exam. The beauty of tele-dentistry is that not only can we reach patients for their dental needs but also connect with their specialists, physicians, and other healthcare professionals!

Improve the interdisciplinary health care, collaboration and patient health.

Learn More

We have all had the experience of having that one patient pop in our head… We haven't seen Mrs. Smith for a long time, I ran into her daughter in the store and she said she now is in assisted living, or someone calls to schedule a patient for re-care to find out that they are in a nursing home or assisted living. WHAT NOW? Do we just let these patients go untreated until a serious emergency takes them to the emergency room? Or are you going to have a care mechanism in place? If you would like to learn more about embracing new opportunities for care, contact the professionals at Care 2 U to train your team.

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Security Risk Assessment Tool Updated for Smaller Practices

Reprinted with permission from California Dental Association

All HIPAA-covered entities and their business associates are required to conduct an initial comprehensive security risk assessment to identify "potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information," the federal privacy rule states. Achieving and maintaining the security of PHI is not only a requirement of the rule but a way to help prevent costly data breaches.

Small- to medium-sized health care practices with one to 10 providers now have an upgraded tool that is specifically designed to assist them with completing this assessment. The U.S. Department of Health and Human Services' Office of Civil Rights released a version of its security risk assessment tool — the SRA 3.0 — to make it easier to use and to apply more broadly to possible risks to health information.

Along with an enhanced user interface, new features were built into the SRA 3.0, including:

- Detailed reports
- Improved rating of threats and vulnerabilities
- Progress tracker
- Business-associate and asset tracking

The OCR launched the SRA 3.0 in October 2018 after conducting and analyzing comprehensive usability testing of the previous version (2.0). Health care practice managers completed certain tasks in SRA 2.0 and then repeated the same tasks with the SRA 3.0 for a comparison of user experience. The result, the OCR says, was an overall improvement of the user experience.

With the new detailed reports, for example, results of the risk assessment are displayed to help practice managers determine risks in existing policies, processes and systems. While performing the assessment, the user receives suggested methods for mitigating these security risks.

Currently, SRA 3.0 is only available for Microsoft Windows operating systems. Any practices using iPads may still download the previous version of the tool from the Apple App Store. Both versions of the SRA are free to use or download.

CDA Regulatory Compliance Analyst Teresa Pichay reminds HIPAA-covered dental practices that after the initial comprehensive risk assessment is completed, they are not required to perform the risk assessment annually. "They can instead do periodic gap analyses," she said, but they must perform a comprehensive risk assessment when the data security environment or the entity's information system, policies and procedures have "significantly changed since the last assessment."

Dental practices can download the SRA 3.0 from the Office of the National Coordinator for Health Information Technology. https://www.healthit.gov/topic/privacy-security-and-hipaa/security-risk-assessment-tool

Calendar 2019

June

21 SDS Summer Dental Symposium

July

4 Independence Day (office closed)
9 SDS Board Meeting

August

16 CE Meeting-TBD

September

2 Labor Day (office closed)
5-8 ADA Annual Session/HOD—San Francisco
10 SDS Board Meeting
19 Staff Appreciation
27-28 CDA Cares—San Bernardino

October

17 General Membership Meeting
18 CE Meeting—*TMD & Orofacial Pain*

November

7 Board Meeting
11 Veteran's Day (office closed)
14-17 House of Delegates—Sacramento (office closed)
28-29 Thanksgiving Holiday (office closed)

December

5 Member/Spouse Holiday Mixer
23-January 1 Winter Holiday (office closed)

SnapShots Prevent Mug Shots

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*Accurate & complete diagnostics gathering and coding
*Proper documentation and claim narratives to mitigate risk
*Use of adjunctive services, and proper coding
*Insurance payment posting and proper adjustments
*Accurate insurance breakdowns and route prep
*Supervised Neglect / Standard Of Care Protocol

* A SnapShot is a limited, one-time, no obligation look into your practice that will not only uncover areas of clinical and financial risk, but often reveals hundreds to thousands of dollars a month in lost revenue. It is performed remotely so there are no travel expenses incurred. Upon completion, you will receive a detailed, written Report of Findings & Recommendations.

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AKA "The Fraud Finder"

Theresa is a Registered Dental Assistant with over 35 years experience in clinical, administrative & academics. She is a California Radiation Safety Course & CE Provider that specializes in Risk Management, HIPPA, and Oral Systemic Link. She is a member of many professional organizations.

Welcome New members!

Shehzad Ahmad, DDS
General Dentist
Western Dental
703 N. Golden State Blvd. Turlock—216-4198
Mexico-Universidad De La Salle, 2017

Sameera Arbabaraghi, DMD
General Dentist
Quality Dentists
3608 Dale Rd, Modesto—577-0777
Roseman University of Health Sciences, 2018

Baljot Bains, DDS
Pediatric Dentist
First Smiles Children's Dentistry
1801 Tully Rd Ste B, Modesto—343-3500
New York University, 2014

Scott Blackhart, DDS
General Dentist
Smile Bright Family Dentistry
1419 W F St, Oakdale—847-0309
Boston University, 2009

Gilberto Ledesma, DDS
General Dentist
No practice address listed
UOP Arthur A. Dugoni School of Dentistry, 2019

Brett Springer, DDS
General Dentist
In practice w/ Drs. Stan Baker and Jacob Barber
201 E. Orangeburg Ave. Ste A, Modesto—527-5050
Post-Grad Student

SDS Members by the Number

Total: 285

Market Share: **85.8!**

(Total # of Dentists in Stanislaus County who are members of the Tripartite (ADA, CDA, SDS)

Active – 183

(Recent graduate-Reduced dues members)

RDO – 2 / RD1 – 12 / RD2 – 6 / RD3 – 4 / RD4 – 4

Life Active-17 / Life Retired – 43 / Retired 2

Dual – 2 / Permanently disabled - 2

Classifieds

- **GD Full-time assoc.**—Looking for a full-time associate general dentist in Modesto, CA for a busy, modern, multidisciplinary dental practice. We have a great staff and are looking for someone great to be a part of our team. Needs to be a team player, detail-oriented to exceptional dental work and have great communication skills. We have a lot of technology in office: CEREC, CBCT, digital charts, digital sensors, intraoral cameras, implementing CAMBRA, 3D printer, in house ortho, and Invisalign. We also place implants, make our own surgical guides, molar RCT and EXT.

  All are welcome to apply. Competitive compensation package around 25-30% collections, health benefits, 401K and many more items to discuss. Please send your resume to set up a phone interview, paxmandental@gmail.com

- **GD Modesto area**—Modesto area private practice looking for a general dentist to take care of my patients and keep my practice growing for a few years while I'm on extended leave. I have an office manager and consultant to help make your transition as easy as possible. I work normal hours 4-5 days/week. Your daily salary will be $1,000/ day or a percentage of production (whichever is higher). Please send your resume to modestodds88@gmail.com

- **GD New Practice Start up!**—Competitive compensation package around 25-30% collections. Office location has been determined. Contact Dr. Sefcik (801) 372-0439 for more details. If there is no answer, leave a message.

- **GD Associate Modesto**—Private practice in Modesto seeking an Associate Dentist to join our excellent team who provides exceptional dentistry. Very competitive compensation package based on experience.

  Please email your resume to 209dentist@gmail.com with the best time to contact.

- **Associate Modesto**—Well-established Modesto general dentistry office is looking to add another doctor to the team. The owner doctor purchased this practice 5 years ago and it is stable and growing rapidly. Presently, we average over 30 new patients a month. The office is currently open Monday through Thursday and have just recently added Fridays. This is a wonderful part-time or full-time opportunity for a doctor with a minimum of two years experience to move into a practice that is a finely-tuned machine. The salary structure is to be determined by the candidate's qualifications. Please send resume to stan@stanlent.com.

- **Whip Mix Facebowl Needed**—Please contact SDS member, Dr. Jack Holt if interested in selling your used Whip Mix facebowl. (209) 521-5959

The above Classified ads are also listed on the SDS website, stanislausdental.org. SDS offers its members free advertising related to their practice including, member employment, equipment to buy or sell and practice sales or purchases. For more information, contact Robin at the SDS office, 522-6033.

Did you know?.....

In addition to posting a classified ad on the SDS website and APEX Newsletter, CDA also has a classified section where you can post jobs, dental equipment, practice sales, etc. Free to CDA members! To post or view current ads, go to….www.CDA.org/jobs