FALL 2012

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NDA JOURNAL

OFFICIAL MAGAZINE OF THE NEVADA DENTAL ASSOCIATION AND COMPONENT SOCIETIES

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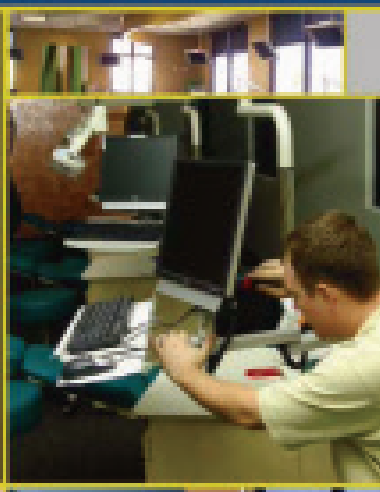
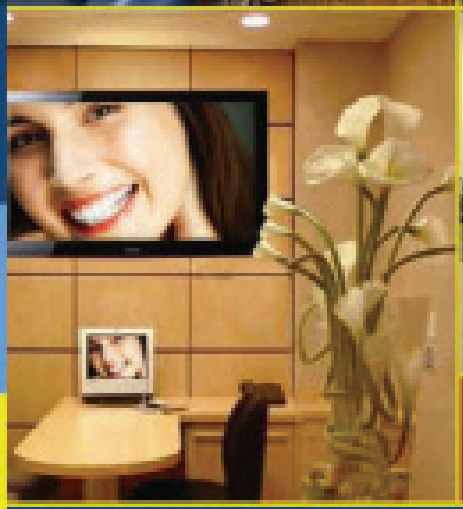
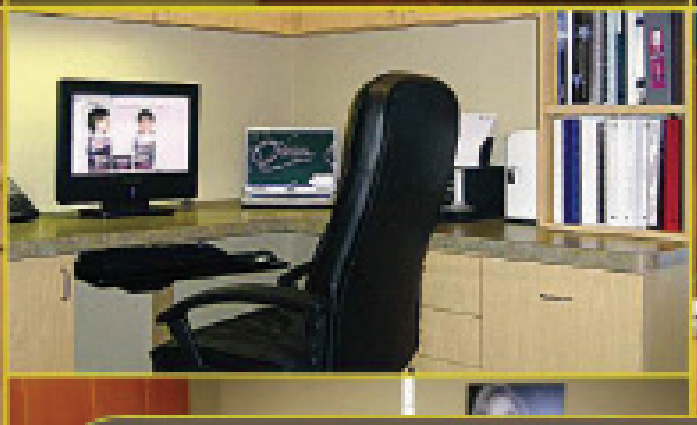


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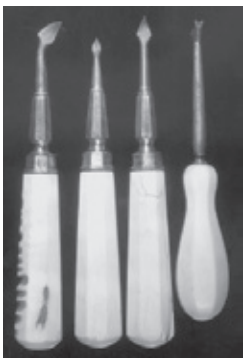
NDA JOURNAL

FALL 2012

On the Cover

Paul Revere, 1768. John Singleton Copley (1738–1815). Current location: Museum of Fine Arts, Boston

The science of military forensic identification traces its roots back to the American Revolution and one of its most renowned protagonists. Best remembered for his midnight ride, Paul Revere performed a variety of roles in Boston, such as gold and silversmith, engraver, and dentist. In 1776, he added pioneer in the field of forensic science to his multi-feathered cap by identifying the dental remains of a fallen major general.



(right) Set of dental elevators allegedly owned by Paul Revere.
Credit: (NCP 1331). OHA 250: New Contributed Photographs Collection. Otis Historical Archives. National Museum of Health and Medicine.

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When Charity Becomes too Costly

Daniel L. Orr II, DDS, MS (anesth), PhD, JD, MD
editornda@nvda.org

After providing service to the entity for over thirty years, I sadly sent a letter of resignation to Nevada Medicaid this month. The letter was not sent because of the ubiquitous poor reimbursement rates, relatively high percentage of no show/no call appointments, malpractice allegations, or even the continuous growth of associated paperwork and other red tape. The resignation was proffered because a "may" morphed to a "will."

On the recredentialing form Medicaid provided earlier this year, doctors are asked to answer all the related and not so related questions facilitating the analysis of one's ability to continue to provide acceptable service to patients. However, one paragraph requests personal bank account information so that Medicaid can directly deposit reimbursement. If not agreed to, the form warns that Medicaid "*may* not" reenroll the doctor. On one recredentialing form at least (mine), the doctor balked…even drawing a red line through that portion of the document and writing "no."

I didn't refuse to provide my routing number for any of the practical reasons any long-term Medicaid doctor could iterate (i.e. automatic deposit can equal automatic withdrawal and the associated accounting nightmare until the books are straightened out), but simply because it wasn't, in my opinion, right. I jokingly thought about offering to reenroll if Medicaid would give me direct access to its bank account, but that wouldn't be right either, would it? Then, in my just deal with it mode, I thought about opening a bank account dedicated for Medicaid use only, from which deposits could be immediately withdrawn, leaving a two cent or so balance. But, that would just be like pretending that I agreed with the premise that it is reasonable for Medicaid to have access to my practice account. Plus, since the form said "*may* not," I figured we would just continue status quo as we have over the past few decades.

After all, I've treated thousands of Medicaid patients, including hundreds of trauma cases and the extremes of age, from way under eight to way over eighty. Some offices keep time open every day for emergencies, including Medicaid patients. I was happy to occasionally review other doctors' radiographs, the legally recognized medium, for Medicaid with regard to appropriateness of treatment and the like. We accepted two or three Medicaid patient referrals from the Governor's office when those patients, reportedly, could not arrange for treatment elsewhere. I also did not mind treating patients who were healthy enough to be gainfully employed (things happen, right?), even if they had newer cell phones than anyone else in the office. However, one might legitimately wonder about the effectiveness of the system a bit after treating the growing population of third-generation Medicaid patients.

Continues ➲

Dr. Orr practices Oral & Maxillofacial Surgery in Las Vegas, is a Clinical Professor of Surgery & Anesthesiology for Dentistry at UNSOM, Professor and Director of OMS at UNLV SDM, and is a member of the California Bar. He can be reached at editornda@nvda.org *or 702-383-3711.*

"To patients in need that do not demand my banking information, I will continue to provide charitable service according to whatever arrangements my patients and I agree upon..."

In my recredentialing adventure, a short time after submitting the requested forms, we received a call advising that we were not going to be reenrolled because Medicaid required our bank information, the "may not" notwithstanding. A heart-felt letter was then forwarded to Medicaid in gratitude for facilitating my efforts to provide charitable service to patients. An early mentor, Dr. Richard Hamilton, logically explained to me at the beginning of my practice, how *he* felt it was *his* (not necessarily yours or my) obligation to provide charitable services to patients in need. To patients in need that do not demand my banking information, I will continue to provide charitable service according to whatever arrangements my patients and I agree upon, at least until the Affordable Care Act comes to complete fruition and such conduct is deemed illegal.

When a third-party payer process become too intrusive, too labor intensive, too punitive, or even harmful to those it is allegedly designed to serve,[1] there comes a time where it is literally more cost-effective to treat patients in exchange for whatever they can afford that day, including nothing, rather than continue the slow dance of practice and professional death with guideline and regulation wielding administrators.[2] ◆

Endnotes

1. Roy, A, How Obamacare Harms the Poor, Where to Begin?, *National Review*, 30 July 2012.
2. Orient, JM, "Obamacare": What is in it?, *J Am Assoc Phys Surg*, 15:3, 87-93, Fall 2010, http://www.jpands.org/vol15no3/orient.pdf, accessed 01 Sep 2012.

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NDA Executive Director's Message

Robert H. Talley, DDS, CAE
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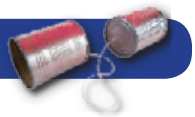
Your NDA officers and I just returned from our first 14th District Caucus in preparation for the annual ADA meeting in San Francisco. Most of our time was spent listening to discussions on Governance changes the ADA is considering this year. The ADA commissioned a study of governance last year which produced 80 suggestions. There are some of us who believe that the ADA House would be better as a smaller entity but we will have to see. I hope they make significant changes so the money spent on that study is not wasted. The company that implemented the study interviewed me as part of the process. I told them as a state we had reduced our house of delegates by 50 percent and it helped us become more efficient and get truly interested people involved. A 50 percent reduction in the ADA House will not happen but I believe a 33 percent reduction is doable (that's 473 to 315). We would go from three delegates to two in Nevada. That is only one of the 80 suggestions and there are many more that would make the ADA better. ◆

Affiliate News



Executive Director's Note: Here is some information from CareCredit, one of our endorsed products. Please consider using them if you need patient financing.

CareCredit unveils new logo as part of 25th Anniversary Celebration

As part of its 25th Anniversary celebration, CareCredit is introducing a new brand image which consists of a new logo, icon and tagline, *Making care possible…today.* While CareCredit continues to focus on helping patients get care, ease of use and patient satisfaction, the new branding look more closely represents the key role CareCredit's healthcare credit card has had in the families of 20 million patients over the past 25 years.

With input from consumers, providers and cardholders, CareCredit's logo, icon and tag line were enhanced to retain the qualities of trust, strength and dependability, while evolving to more accurately reflect their cardholder's perception of the benefits the brand brings to their everyday lives. When surveyed, patients who have chosen to use CareCredit identified the company as "accessible," "empowering," and "helpful." Their input resulted in a logo and icon that was visually uplifting and positive and in a tag line that clearly communicates the company's core philosophy and focus: making it simple and easy for families to access the care they desire, when they desire it.

"Our 25th Anniversary provided us the opportunity to reach out to our providers and cardholders and ask why they chose to use CareCredit to pay for their family's care," said Cindy Hearn, Sr. Vice President, CareCredit. "What we gained was a clear understanding of the experiences they have with our brand, which benefits they valued most and how our brand fits in their lives. We used this information to visually refine our brand, giving it a fresh and contemporary look that has already been extremely well received."

Practices that accept CareCredit as a payment option will receive a free, comprehensive kit of materials for their practice and patients in June, including exciting new patient educational and display materials.

To learn more about CareCredit, visit www.carecredit.com. ◆

Save the Date!

NDA Midwinter Meeting

Friday, January 25, 2013
Gold Coast Hotel & Hotel, Las Vegas
Visit www.nvda.org or call 702-255-4211 for details

Welcome back from summer vacation! Hope everyone had a great and fun summer.

For those who attended the NDA Summer Meeting, thank you very much. Thank you also to our past president, Michael Banks, for an outstanding meeting in Monterey, CA and for his outstanding year as president. Michael worked very hard on your behalf and we all appreciate his time and effort.

The Executive Committee recently attended a very successful 14th District caucus meeting in Denver, CO. Dr. Jade Miller did a wonderful job as chair, as did Dr. Robert Talley who served as Secretary of the Caucus. Nevada was well represented as our attendees served on several important committees. The 14th District is the fourth largest district in the U.S. and we are well organized and motivated to the ideal of keeping dentistry as the voice of dental care in the U.S.

In October, we will attend the ADA House of Delegates Meeting in San Francisco representing our Nevada dentists. There are many exciting resolutions coming up that will show our young dentists that the ADA (and NDA) want them to join and participate in our organization. There is a great push in the ADA to address the many challenges we are facing. This push is lead by the state delegations who want an ADA that looks toward the future and responds more quickly and effectively to its members.

The Executive Committee and the Legislative Committee are working to identify areas where we can better serve our members. We are also keeping track of legislation that could potentially harm our public and our members. Our lobbyist, Chris Ferrari, and his staff are working on matters pertaining to the elections and legislative actions. We are instituting a public awareness email campaign to our legislators that is comprised of our patients. We hope to compile a large database of concerned citizens that can reach out to their representatives should we feel that legislation that is detrimental to the public be brought up. We will be rolling this out soon to all dentists in Nevada.

We are also exploring legislation to sponsor to better serve our dentists and our public. We are fortifying our New Dentist Committee with individuals who are passionate about our future. We realize that dentistry is being challenged by outside forces that could undermine our profession and the public good. Organized dentistry is the only way that we can effectively respond to our environment and we hope to increase our market share of dentists. Please attend your local and state meetings and bring colleagues to these meetings. We strive to have a united front of dentists to meet our challenges. This is a legislative year in Nevada and we are prepared to represent our dentists well in Carson City this winter.

Gilbert A. Trujillo, DDS
gtdds@charter.net

I am very happy to serve with many talented individuals on the Executive Committee and all of our other committees. I would also like to thank Dr. Robert Talley and his staff for all his expertise. ◆

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ADA Golden Apple Award for Outstanding Leadership in Mentoring

Dr. David White

Dr. David White received the ADA Golden Apple Award for Outstanding Leadership in Mentoring at the ADA 26th New Dentist Conference. Dr. White was lauded for a variety of activities including urging the UNLV SDM and the Univ. of Nevada—Reno's Pre-Dental Society to create an early-admission program to identify gifted students who would stay in Nevada to pursue their education.

Pictured with Dr. White is Dr. Jennifer Enos, 14th District Representative to the New Dentist Committee.

Fae Ahlstrom Heritage Award

Dr. William (B.G.) Smith

This year the Fae Ahlstrom Heritage Award was presented posthumously to Dr. William (B.G.) Smith for his dedication to the dental profession and to organized dentistry over his 50 years of practice. His long time friend, Dr. William Scheer, accepted the award on behalf of the Smith family, who were unable to attend.

A Message to Young Professionals

By Franson K.S. Tom, MS, DMD

There are several practice options young dental professionals may choose depending on the economy and future career and lifestyle goals.

An important first question is, "What are one's reasonable lifestyle costs, including expenses for home, food, transportation, loans, etc.?" It may be prudent to consider maintaining ones' expenses as close to student status quo for at least a year. A nice new paycheck doesn't necessarily stay in one's pocket after all the nice new expenses that appear in the first year of practice are factored in. The new car might be better deferred for a bit.

I recommend that one open a savings account, checking account, and obtain a credit card with cash, mileage, or other bonuses. Initially, it is best that new doctors download everything into a Quicken type tax program. Put everything earned into the savings account in order to know exactly how much has been earned even when working for several entities. Pay all business expenses with business checks or credit card and personal expenses with personal checks and credit card. Pay the credit card off each month.

Two career choices are associating or to start a solo practice. Associates can be classified as an employee or independent contractor—there are important differences between the two. As with an employee designation, employee taxes are withheld, while independent contractors pay their own taxes. Associates require minimal expenses and hard work for dollars now, but potentially nothing much in the future. Starting a practice requires funding and hard work dollars now to build a future. Today, 80% of all dentists own their own practice. Being an associate defers many of the responsibilities and risks of owning a practice, but also delays the rewards of successfully accepting that responsibility.

In any case, dentistry is a highly-regulated industry with multiple licenses, permits, standards, and credentials required that are unique to each state and community. Young professionals would be wise to join their local dental society, if only to find a mentor who is practicing and living the lifestyle seen in one's future. A good mentor will advise correctly not only about dentistry, but also about the business of dentistry. A good mentor will be able to identify advisors of merit, such as a dentally savvy attorney and CPA. Once one leaves employee status, immediate business decisions need to be made and each one can be a million dollar plus or minus decision over a practice lifetime, such as the legal structure for one's practice: C or S corporation, sole proprietorship, etc.

Ideally, one will carefully evaluate all potential practice choices and ask advisors of merit the right questions. Second opinions are viable outside the

health professions too. A potential list of issues to consider should include:

- Patients: % Welfare/insurance/ fee for service
- Achieving independence
- Potential financial return
- Tax planning
- Practice benefits
- Practice budget
- Minimizing financial risk
- Office practice
- Staff management experience/ responsibilities
- Staff hours & flexibility of taking time off
- Specific location preference
- Design of work environment
- Choosing specialists, labs, etc. for referrals
- Emergency coverage
- Continuing education
- Ability to do research
- Ability to teach

The current economy is the worst since the 1930s. Many analysts balk at the comparison of 2012 to the Great Depression, but the comparison is valid. Consumer spending is minimal and as long as lack of consumer trust exists, the economy will not recover.

This economy directly affects one's current situation and career choices. There are fewer associate positions in private practices. Starting a new practice or buying an existing practice can range from $400,000 to $500,000, all with no cash reserves and no consumer confidence. The average dental practice owner is over age 50, but fewer and fewer practitioners can afford to retire. Many doctors overpaid for improvements and equipment, so landlords and banks are holding onto non-productive, worthless property that will never recover.

Established dentists should be highly interested in providing an opportunity for a young professional. A way for young dentists to stop struggling with minimal dental skills, zero business skills, and no financing, is to join an experienced mentor in a practice as a start-up independent contractor. Be willing to learn dental and business skills from an experienced doctor with affordable overhead based on your business.

Remember, 80% of all dentists are sole proprietors. Many start-up practices initially signed up for all insurances and then over time dropped low paying dental plans as business increased. Even today, there are fee-for-service practices that could incorporate a young doctor who signs up for all insurances to fill some empty operatories. Once a good relationship is established, a future buy-in would be mutually beneficial.

Futures for new graduates are very bright if one can find a quality mentor. It is worth the price of membership in your local ADA society. ◆

Franson K.S. Tom, MS, DMD is a delegate and Chair of the Southern Nevada Dentist Health and Wellness Committee. He also mentors students at UNLV School of Dental Medicine. He can be reached via email at tlcdmd@gmail.com or on his website at www.drfransontom.com.

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CPT Coding:

Practice of Medicine or Insurance Function?

By Lawrence R. Huntoon, MD, PhD

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Current procedural terminology (CPT) codes were developed by the American Medical Association (AMA) and were first published in 1966. According to the AMA website, CPT codes "…helped communicate accurate information on procedures and services to agencies concerned with insurance claims.…"[1]

CPT codes provide a standardized means for reporting medical services and surgical procedures to third-party payers (government programs and private insurance) on claim forms so that payment can be made for services provided.

In 1983, the AMA made a secret pact with the Health Care Financing Administration (HCFA) to impose use of the CPT coding system on all physicians.[2] HCFA was the precursor of the Centers for Medicare and Medicaid Services (CMS), the government agency that runs the Medicare and Medicaid programs. A copy of the secret pact is posted on our AAPS website.[3]

In a lawsuit filed against the AMA (*Practice Management Information Corp. v. the American Medical Association*, 121 F.3d 516, 520-21 (9th Cir. 1997), modified on reconsid. 133 F.3d 1140 (9th Cir. 1998)), a three-judge panel in the 9th Circuit found:

> On the undisputed facts in the record before us, we conclude the AMA misused its copyright by licensing the CPT to HCFA in exchange for HCFA's agreement not to use a competing coding system…. [T]he plain language of the AMA's licensing agreement requires HCFA to use the AMA's copyrighted coding system and prohibits HCFA from using any other….The controlling fact is that HCFA is prohibited from using any other coding system by virtue of the binding commitment it made to the AMA to use the AMA's copyrighted material exclusively…. Conditioning the license on HCFA's promise not to use competitors' products constituted a misuse of the copyright by the AMA.[2] The AMA's CPT monopoly, which imposes significant annual unreimbursed costs on physicians, provides a very lucrative revenue stream for the AMA.

CPT codes do not aid in the diagnosis or treatment of any patient. Although CPT codes are used for data-mining purposes by private bounty hunters contracted by CMS to recoup money paid to physicians, the primary purpose remains standardized reporting of medical services in order to obtain payment from third-party payers. Certification as a coding specialist does not qualify one to practice medicine, and use of CPT codes clearly does not constitute the practice of medicine.

Elimination of CPT Coding: Administrative simplification, improved access, and lower cost of care

Physicians who legally opt out of Medicare (Sec. 4507 of the Balanced Budget Act of 1997) and who do not have contracts with private insurers (third-party-free physicians) often find that they are able to provide care at a much more affordable cost. They have eliminated the huge administrative expense of coding and claims filing, a choice that ultimately results in significant savings for patients. Moreover, time not spent on coding, or staying current with coding requirements and changes, is time that can be spent providing actual medical care. Elimination of CPT coding also eliminates a lot of physician frustration associated with obtuse evaluation and management (E&M) bullet-point requirements, bundling rules, and"gaming"of the system in an attempt to obtain fair reimbursement in an environment of government devaluation of physician services. Elimination of CPT coding is the epitome of administrative simplification, and benefits both patients and physicians. Less stress for physicians enables more mutually satisfying patient-physician encounters.

Is CPT Coding part of medical practice?

In July 2011, AAPS member Kathleen Brown, MD, left the clinic where she had practiced since 1997 and opened her own third-party-free dermatology practice. Working directly for patients, instead of working for government and insurance companies, Dr. Brown decided to eliminate the unnecessary bureaucratic hassle and expense of using CPT codes in her third party-free practice. All of her fees are transparent, listed on her website (www.oregonderm.com), and are affordable for both insured and uninsured patients. It was a win-win situation for Dr. Brown and her patients.

Hostile response from insurers

Insurance companies, however, were not happy with Dr. Brown's decision to eliminate CPT codes in her practice. An article in *The Lund Report* stated:

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> When she left to start her practice, Brown told *The Lund Report*, her patients received phone calls from representatives at Regence BlueCross BlueShield and ODS [Oregon Dental Service Health Plans] telling them not to see her, and ODS counsel sent a letter to her office threatening to report her to the Oregon Medical Board.… Regence spokesperson Scott Burton declined to comment for this story.… Jonathan Nicholas, ODS' vice president of corporate branding and communication, said he was unaware of any ODS employees having contacted Brown's patients, and added that ODS is unable to reimburse patients for services if their providers don't submit billing codes. CPT billing codes are mandatory, Nicholas said."You can't be half in and half out. If you want to bill insurance companies [which Dr. Brown did not wish to do], you have to have a code."[4]
>
> Thinking she had escaped the abuse, power, and control of insurance companies by going third-party-free, Dr. Brown instead found, "I didn't anticipate that insurance companies would still attempt to control the way I practice."[4]

Response from Oregon Medical Association

Seeking help and support from her state medical association, Dr. Brown received a response from the Oregon Medical Association (OMA) that showed lack of courage at best, and enablement of an abusive position involving the role of CPT codes in medical practice at worst.

Dr. Robert Orfaly, who chairs OMA's Health Care Finance Committee, wrote:

> [M]any committee members were supportive of your right to practice medicine in a way you feel best serves your patients to the greatest extent possible.… However, given the realities of current systems in place, the OMA cannot support your billing practices.… Committee members expressed that while you are entitled to not use CPT codes, this practice is ultimately onerous to the patient who often times is unable to be reimbursed.[5] So in the tradition of doublespeak, the OMA claimed to support her choice to practice in the best way to serve her patients, but in reality could not support her choice to practice in a manner that fails to serve the needs of insurance companies and the CPT monopoly. Like the AMA, the OMA derives revenue as a result of the CPT monopoly by offering CPT coding courses to physicians ($269 per person for members, $338 per person for non-members).[6]

Dr. Orfaly's letter goes on to state:

> The OMB [Oregon Medical Board] has indicated that it has decided to uphold the current rule stating that "the use of procedure codes are an important part of practice, and the Board does not want to change the rule to allow practitioners to use codes OR a narrative description of the procedure. Instead, both will continue to be required. The Board considers such procedure codes to be necessary as a standardized way to document procedures." While it has not indicated the intent to pursue any action at this time, you will understand that the Board retains exclusive rights to set the standards for licensure in the state.[5]

If this is indeed the position taken by the Oregon Medical Board, as quoted in Dr. Orfaly's letter, it represents overreaching and a blatant abuse of power by the Oregon Medical Board.

Declaring that CPT coding is part of medical practice or standard of care has led to some very inappropriate and adverse consequences. In a case of sham peer review in another state, for example, a hospital attorney alleged that the physician breached the standard of care by not providing documentation to support each of the E&M bullet points for a history and physical the physician conducted in the hospital. Bureaucratic bullet points, used for the sole purpose of billing, were offered as a medical standard of care to justify taking adverse action against the physician's hospital privileges!

Dr. Orfaly went on to state:

> The second development was that both ODS and Regence informed the OMA that they were amending the language in their contracts with patients to state that in order for members to be reimbursed, they need to provide CPT and ICD-9 codes. Given this situation, there is effectively no option to practice in a fee for service model without the use of these codes.[5]

This desperate action by insurance companies, to avoid incurring the full cost of claims processing by foisting the responsibility for CPT coding onto patients, is a clear attempt to use patients as pawns to pressure third-party-free physicians to provide free labor to insurance companies.

Dr. Orfaly also told Dr. Brown: "Committee members also expressed that your billing methodology is not aligned with the administrative simplification efforts that the OMA has been strongly involved in and could, potentially, add to health care expenses."[5] However, it defies both logic and common sense as to how a physician's choice not to use CPT codes adds to administrative complexity or health care expenses. Eliminating CPT coding from a medical practice has the exact opposite effect.

Dr. Orfaly ended his letter to Dr. Brown by saying: "I hope that you find this information useful in your future deliberations. Thank you for participating in the OMA. We value your membership and hope to assist you again in the future."[5]

So, after refusing to stand up and fight to help her escape the abuse of insurance companies so as to best serve her patients, the OMA offered to "assist" her again in the future. Unfortunately, by refusing to stand up against abuse

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by insurance companies, as enabled by a medical board, the OMA effectively sealed the fate of both member and non-member physicians in the state of Oregon. By refusing to fight the abuse, the OMA has invited more abuse. Inviting more abuse by insurers harms both patients and physicians.

Antitrust and constitutional issues

Coerced physician participation in a CPT monopoly may also be in violation of antitrust laws. Forcing physicians to comply with private insurance company requirements when the physician has voluntarily chosen not to contract with insurance companies is anticompetitive and harmful to patients by increasing the cost of care. As CPT codes are inextricably linked to fixed fees, coerced participation in the CPT monopoly may also constitute a form of illegal price-fixing.

Coerced physician participation in the CPT monopoly also discourages patients from seeking medical care from a physician of their choice, when that physician happens to be a third-party free physician. Such action enhances the market power of the monopoly by effectively prohibiting competition by third-party free physicians in the interest of providing better care at a lower cost. Medical associations should not be complicit in coercing physician participation in a monopoly or price-fixing scheme.

Moreover, there are significant constitutional issues to consider. A physician who legally operates a third-party-free practice makes an implicit contract with patients, such that the patient understands and agrees that the physician is not bound by insurance company rules (e.g. CPT coding) and price-setting. Any government agency (e.g. medical board) that interferes with patient-physician contracts of the third-party-free physician in the area of billing practices or fee setting is in violation of Article I Section 10 of the U.S. Constitution, which forbids government from interfering in the obligation of contracts.

Forcing a physician to provide uncompensated labor by spending time providing billing codes to insurance companies violates the Takings Clause of the Fifth Amendment (without just compensation), and violates the Thirteenth Amendment (involuntary servitude) as well. Physicians who voluntarily choose not to contract with insurance companies have no legal obligation to provide free labor to any insurance company for the purpose of claims processing.

Contract between patient and insurer

Patients who have medical insurance and who choose to see a third-party-free physician can utilize their coverage benefits by sending a copy of their office visit record to the insurer should they choose to do so. This does not represent an onerous imposition on patients. Insurance companies clearly have the capability of choosing an appropriate CPT code based on review of a copy of an office visit note provided by the patient so that the claim can be processed and the patient can receive reimbursement. Some patients may choose not to file a claim so as to preserve their privacy.

The third-party-free physician is not party to the contract between patient and insurer, and incurs no legal obligation based on the patient-insurer contract. The administrative cost of claims processing, including CPT coding, is the full responsibility of the insurer. Medical boards and medical associations should not act as enforcers or enablers to allow insurers to forcibly recruit non-contracted physicians to provide free labor (CPT coding) to insurance companies for the purpose of claims processing.

Conclusions

CPT coding is clearly not part of the practice of medicine. Claims processing, including use of CPT codes, is an insurance function. The cost of administrative claims processing, including CPT coding, should be borne by the insurance company, as it represents a normal cost of doing business in the insurance industry.

Third-party-free physicians, who have no contracts with insurance companies, should not be forced to provide unpaid labor to any insurance company for the purpose of claims processing. It is also inappropriate for insurers to foist the responsibility for CPT coding upon patients as part of a patient-insurer contract. This is an abusive insurance practice and an onerous imposition on patients. State legislatures should act to end abuse by insurance companies and medical boards.

Medical boards and medical associations that act to enforce or enable a monopoly and act to place unconstitutional burdens on physicians should be held fully accountable for their actions. They also deserve their place of disgrace in the AAPS Hall of Shame.[5] ◆

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Mammograms, Oral Cancer Screening, and Understated Advertisement Warnings

By Daniel L. Orr II, DDS, MS (anesth), PhD, JD, MD

Many health professionals, concerned about the direction of health care in the United States during this Presidential administration, noticed with some concern the recent US Preventive Services Task Force (USPSTF) recommendation to not screen, via mammography, for breast cancer until age 50. This was significant change from the long-standing recommendation to begin screenings at age 40, which the American Cancer Society (ACS) still advises.

What may be of interest to dentists is that the USPSTF has also opined about oral cancer screenings. (www.uspreventive servicestaskforce.org/3rduspstf/oralcan/oralcanup.pdf)

The USPSTF analyzed three questions:

1. Does screening for oral cancer lead to decreased morbidity and mortality from oral cancer? Although the studies used to evaluate this question are nearly ten years old, the USPSTF found that "oral cancer mortality rates were similar in the screened and unscreened study groups."
2. Is there new evidence of harms associated with screening for oral cancer? The USPSTF found none.
3. Are there effective treatments for mitigating the morbidity/mortality of oral cancer if the lesions are identified earlier rather than later? "No controlled studies examining treatment efficacy of early detection of oral cancer lesions were identified. Treatment of oral leukoplakia, a form of premalignancy, has been studied in RCTs with several modalities, demonstrating success at promoting remission; but he numbers of trial patients are small (10 to 59, about 50 for most) and there have been no long-term (>2 years) follow-up studies to assess the effects on cancer incidence or mortality."

Thus the USPSTF, and the National Cancer Institute (NCI) both do not recommend routine screening for oral cancer because the benefits have not been proven in the literature reviewed.

On the other hand, the ACS still recommends regular checkups during routine dental visits. (www.cancer.org/acs/groups/content/@nho/documents/document/oralcancerpdf.pdf)

Closer to home, an American Dental Association (ADA) panel stated in May 2010 that: "We still don't understand the answers to a lot of fundamental questions like the progression of the disease and whether intervention helps. It's plausible that early diagnosis helps, but we don't even know that." (www.ada.org/news/4100.aspx)

A comprehensive review article in the May 2010 *JADA* concluded that screening by means of visual and tactile examination to detect potentially malignant and malignant lesions may result in detection of oral cancers at early stages of development, but that there is insufficient evidence to determine if screening alters disease-specific mortality in asymptomatic people seeking dental care. Further, the panel suggested that clinicians remain alert for signs of potentially malignant lesions or early-stage cancers while performing routine visual and tactile examinations in all patients, but particularly in those who use tobacco or who consume alcohol heavily. Finally, *JADA* acknowledged that additional research regarding oral cancer screening and the use of adjuncts is needed.

The ADA statement can be contrasted with tear-out ads in sports magazines offering free topical tobacco products. It is ironic that a sports publication, reporting on humans that make their livings from being arguably the most physically healthy members of society, advertises tobacco products.

The tobacco ads do include the disclaimer: "Warning: This product can cause gum disease and tooth loss." Well, so can a lot of other things that are not required to have a warning, everything from milk in baby bottles to restoration displacing caramel candies, especially if one doesn't brush and floss from time to time.

Although truthful, the tobacco disclaimer might be a bit more accurate if it warned that "This product can cause cancer and death."

It is admirable that the ADA recognizes the importance of cancer screening, particularly in tobacco and alcohol users, even if studies haven't demonstrated the beneficial evidence in the literature yet. ◆

Does Ultrasonic Dental Equipment Affect Cardiovascular Implantable Electronic Devices?

By Eric T. Stoopler, DMD; Ying Wai Sia, DMD; Arthur S. Kuperstein, DDS

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Ultrasonic dental devices have been in use since the 1950s and are important in the armamentarium of oral health care providers.[1] Ultrasonic scaling is as effective as hand instrumentation for the removal of calculus and is widely used.[1] Ultrasonic cleaning baths reduce cross-contamination of dental instruments and prostheses.[2,3] Electronic apex locators and pulp testers have been important in the advancement of clinical endodontics.[4,5] Other dental devices that emit electromagnetic energy include certain types of dental handpieces, amalgamators and electrosurgery units.[6,7]

The two methods of producing ultrasound are based on the magnetostriction and piezoelectric principles. Magnetostriction, a property of ferromagnetic materials, converts electromagnetic energy into mechanical energy; vibrations and heat are produced during this process.[5] The piezoelectric principle is based on the deformation of crystals when an electrical charge is applied; this deformation is converted into mechanical oscillations without producing heat.[5] Ultrasound energy has a frequency above the range of human hearing (i.e., above 20 kHz). Piezoelectric instruments operate at higher frequencies than those based on magnetostriction.[5]

Implantable electronic devices

Cardiovascular implantable electronic devices, chiefly implantable cardiac pacemakers and implantable cardioverter–defibrillators, are used to treat a variety of electrical cardiac defects, including bradyarrhythmia, ventricular tachycardia and fibrillation; they are also used in patients with complete heart block.[7,8] It is estimated that 3 million people globally, including more than 500,000 individuals in North America, have implantable cardiac pacemakers.[8] The use of such devices has significantly reduced mortality rates among patients with a history of life-threatening ventricular arrhythmia,[7] and they are becoming more commonplace in the general population.

An implantable cardiac pacemaker is a small device sealed in a metal case. The unit consists primarily of a pulse generator, which produces an electrical impulse that is sent directly to the cardiac muscle via plastic-coated wires, and a long-lasting battery.[6] Pacemakers are usually implanted under the skin in the chest wall (*Fig. 1*).[6] In the most common type of device, the demand pacemaker, electrical impulses from the heart are transmitted to the pulse generator, which is programmed to monitor electrical activity and to provide additional electrical stimulation if necessary.[6] Implantable cardioverter–defibrillators are similar to pacemakers, in that both devices are designed to monitor the heart rate continuously. When ventricular tachycardia or fibrillation is detected, the cardioverter–defibrillator delivers a precisely calibrated shock to stop the abnormal electrical activity and restore the normal heart rate (*Fig. 2*).[7]

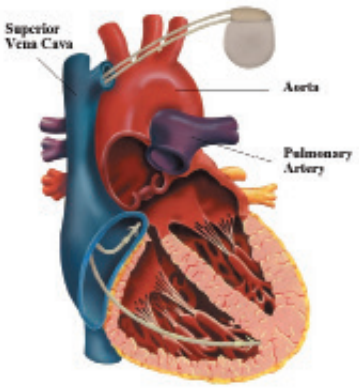

Figure 1 *Implanted cardiac pacemaker.*

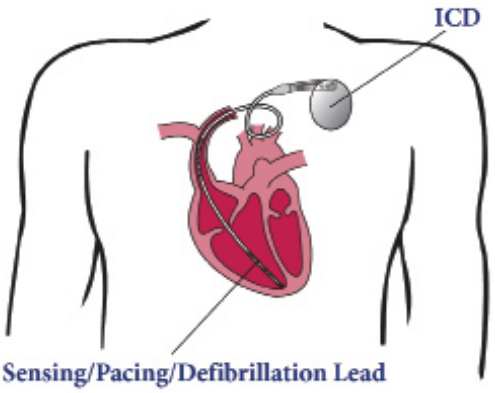

Figure 2 *Implanted cardioverter–defibrillator (ICD).*

Interaction between ultrasonic equipment and implantable devices

Ultrasonic dental equipment has been implicated in electrical interference with the normal functioning of implantable cardiac devices, and the use of this type of equipment for patients with these devices has been a source of controversy. Miller and colleagues[9] used telemetry for in vitro evaluation of the Medtronics Thera 7942 dual-chamber bipolar pacemaker and the Minix 8340 single-chamber unipolar pacemaker. They found that both atrial and ventricular pacing, particularly in the unipolar pacemaker, was inhibited by electromagnetic interference produced by the magnetostrictive ultrasonic scaler, bath cleaner and electrosurgical unit that they tested.[9] Trenter and Walmsley[1] reported that magnetostrictive scalers

may interfere with the operation of pacemakers, but that piezoelectric ultrasonic scalers did not affect pacemaker function. In 2000, the American Academy of Periodontology published a position paper with a recommendation that dentists avoid exposing patients with cardiac pacemakers to magnetostrictive ultrasonic scalers, because of the deleterious effects that ultrasonic instruments might produce in patients with these devices;[10] however, this paper was rescinded in 2007.[11] In a 2006 clinical study, Wilson and colleagues[4] concluded that electronic apex locators and electrical pulp testers did not interfere with implantable cardiac pacemakers or cardioverter–defibrillators. In a 2007 in vitro study, Brand and colleagues[7] demonstrated that the electromagnetic interference generated by most dental equipment, with the exception of one type of ultrasonic bath cleaner, did not interfere with the normal functioning of implantable cardioverter–defibrillators. In a recent in vitro study, Roedig and colleagues[8] found that operation of one type of ultrasonic scaler, ultrasonic cleaning system and battery-operated composite curing light inhibited the pacing function of implantable cardiac pacemakers, but only the scaler and the curing light interfered with the pacing function of implantable cardioverter–defibrillators. In addition, they concluded that one type of amalgamator, electric toothbrush, electric pulp tester, electrosurgical unit, and high-speed and low-speed dental handpieces tested produced no electromagnetic interference.[8] However, in subsequent correspondence, various authors have questioned the validity of these results.[12,13]

Management of the clinical issue

The inconsistency of the supporting evidence makes it difficult to offer authoritative guidelines on the use of ultrasonic dental devices for patients with cardiovascular implantable electronic devices. We suggest a practical, conservative approach to using such equipment in this patient population. All patients who have an implantable cardiac pacemaker or cardioverter–defibrillator should be encouraged to carry the manufacturer's identification card with them at all times. Oral health care providers should document the following in the patient's record: manufacturer of the device, model number, serial number, date of implantation and mode of operation.[14] Caution should be exercised when operating ultrasonic equipment and battery-operated curing lights near dental patients or health care workers who have cardiovascular implantable electronic devices.[8] Based on the current evidence, it is recommended that use of magnetostrictive ultrasonic equipment be avoided on or near individuals with implantable cardiac pacemakers or cardioverter–defibrillators.[6] At this time, piezoelectric equipment appears to have no substantial effects on these devices.[1,6] Further in vivo clinical trials are warranted to determine the precise effect of ultrasonic dental equipment on cardiovascular implantable electronic devices. ◆

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If you, or someone you know, needs assistance, please contact the SNDS at 702-733-8700. More information is available online at www.sndsonline.org under Southern Nevada Dentist Health and Wellness Committee. ◆

Clues to Impairment in the Dental Office

I. Professional

Office

- ✓ Workaholic (early)
- ✓ Office hours may change to accommodate drinking or drug use and avoid withdrawals at work
- ✓ Inaccessibility to patients and staff
- ✓ Disorganized schedule
- ✓ Unreasonable behavior
- ✓ Frequent office absences
- ✓ Decreased workload and tolerance
- ✓ Ordering patterns for stock medications may change—e.g. Excessive drug use prescriptions and supply, i.e. nitrous
- ✓ Staff may be asked to phone in prescriptions, sometimes using other names for dentists own use
- ✓ Frequent complaints by patients to staff regarding doctor's behavior, i.e. altercations with patients
- ✓ Prolonged lunch breaks
- ✓ Alcohol on breath
- ✓ Opiate withdrawal such as nausea, vomiting or diarrhea may disrupt patient care
- ✓ Stimulant abuse may cause fatigue and impaired concentration

Hospital

- ✓ Often late, absent or ill
- ✓ Decreased work/chart performance
- ✓ Inappropriate ordering—e.g. unavailable for verbal orders at night; slurred or incoherent over phone
- ✓ Subject of hospital gossip
- ✓ Unavailable for discussions
- ✓ Heavy drinking at staff functions
- ✓ Altercations with hospital personnel
- ✓ Appears at rounds at inappropriate times
- ✓ Negative patient feedback

Other Problems

- ✓ Frequent job changes or relocation
- ✓ Unusual medical history
- ✓ Vague letters of reference
- ✓ Inappropriate qualifications
- ✓ Deteriorating relationships to patients and staff (office and hospital)
- ✓ Deteriorating professional performance—increasing malpractice incidents

2. Personal

- ✓ Deteriorating personal hygiene, clothing and dressing habits
- ✓ Multiple physical complaints—e.g. Frequent ER visits; Frequent accidents and hospitalizations
- ✓ Personality and behavioral changes
- ✓ Inappropriate tremulousness and/or sweating
- ✓ Many prescriptions for self and family
- ✓ Emotional crises
- ✓ Irritable and short-tempered behavior

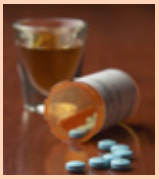
3. Home and Family

- ✓ Behavior excused by family (and friends)
- ✓ Drinking activities priority
- ✓ Fights, arguments, violent outbursts
- ✓ Sexual problems: impotence, extra-marital affairs
- ✓ Unexplained absences from home
- ✓ Withdrawal from family and fragmentation of family
- ✓ Children neglected: abnormal, illegal, anti-social actions of children, i.e. drug & alcohol abuse
- ✓ Financial crises
- ✓ Separation or divorce

4. Friends and Community

- ✓ Personal isolation
- ✓ Embarrassing behavior
- ✓ Drunken driving arrest(s)
- ✓ Legal problems
- ✓ Neglect of social commitments
- ✓ Unpredictable behavior, such as inappropriate spending

If you need assistance, contact the SNDS at 702-733-8700 www.sndsonline.org



SNDS Executive Director's Message

Robert Anderson
s_nds@hotmail.com

After all the planning and details, our program year has successfully launched. We've already held our 2012 Community Night, kicked off our Mentor Program, our CE series, and our CE Café series! Not bad for one month's time! It's very heartening to see how our programs, member benefits and outreach have grown and diversified over the years.

As we set these milestones behind us, we look ahead to the Dental Elf Project, our annual holiday effort in conjunction with the 99th Dental Squadron at Nellis Air Force Base. For those new to our Society, this is a program in which our members gather gifts for the holiday season, the gifts are turned over to the 99th Dental Squadron and distributed to families of deployed airmen at Nellis Air Force Base. This year, we hope to give advance notice and better support materials to give our members the opportunity to involve their team members, families, and even patients! Each year has seen an improvement—in fact, last year the folks at Nellis had to make two trips to get everything collected. Besides the fact that these gifts definitely go to deserving children and spouses, it's nice that it's all run by dentists and everything remains local.

Our Give Kids A Smile committee will start meeting soon, planning for next February's event. This small group helps guide and coordinate around 200 volunteers delivering care to children with no insurance, no Medicaid, and no ability to pay. Last year, with the help of every single dental educational program in southern Nevada, and volunteers from UNLV's School of Dental Medicine and Roseman University, we treated 220 children in just 5 hours. While many other programs give exams to many more children, ours is one of a handful in the country that delivers full hygiene and restorative care.

About the time all of this starts, we'll be gearing up for our annual membership renewal efforts. We work hard all year to make your membership dues a great value, and in fact, this year will be the 8th year in a row with no membership dues increase. The SNDS share of your tripartite dues is only $280, and that includes Peer Review, discounted fees for CE, all of our dinner meetings, and much more.

Of course, this will all be easier to follow when our new website is up. We've changed webmasters and are giving the website a complete makeover. You'll see an expanded member section, including a virtual brochure featuring our Continuing Education offerings. It will be more user-friendly, have more complete and up-to-date information, and the public will be able to use it 24/7 to find a dentist. Paired with our relatively new Facebook page, our members will have a plethora of information and multi-media just a click away.

We'll be keeping you informed about these developments and more, including upcoming seminars and events, our dinner meetings and

Continues ➲

I hope everyone enjoyed their summer! As quickly as it went by, it's nice to settle into a routine with children in school, team member vacations all finished up, and the UNLV Runnin' Rebels back on the field.

Summer is a busy time for the SNDS, as we prepare for our program season which just kicked off. Community Night was a great event where I enjoyed seeing friends and colleagues, and catching up on things. We're kicking off our CE Seminar series, and our CE Café series, which Byron Blasco has done a great job coordinating. More than in recent years, the SNDS is providing members with a plethora of benefits, opportunities, and events.

Community Night also provided an opportunity to invite colleagues who are not members of our Society, to give them a chance to see what they're missing.

While Community Night has passed, the opportunity to spread the word and reach new members is always here. Between our Continuing Education opportunities, Peer Review, dinner meetings, Give Kids A Smile, and the Dental Elf project with our colleagues at Nellis Air Force Base, we have a compelling story to tell. Add into that the work that NDA accomplishes on our behalf in Carson City, and organized dentistry is a great value.

In addition to thanking Dr. Blasco for overseeing the continuing education program, I also want to thank Dr. AnnaLee Kruyer for refreshing our Mentor Program. She's made some important changes, mainly in lining up our volunteer mentor-dentists with first year students at the UNLV SDM. The hope is to build relationships that will help and follow the students through their dental education and into practice. This is not only an appropriate activity for our society, but it also provides an important opportunity to affect our profession. How many times have we had conversations or thoughts, about the various directions the dental profession seems to be taking? The Mentor Program is a way to make a difference, and help the next generation of dentists get started on the right foot… to say nothing of lending support as they progress toward graduation.

We are planning an upgrade of our Dental Elf Project, too. We'll be getting promotional materials out to you earlier this year in order to better involve not just our members, but also their families, office teams, and even their patients. This is a truly unique program, gathering holiday gifts for the families of deployed airmen at Nellis Air Force Base, then turning them over to our colleagues at the 99th Dental Squadron for distribution on the base. In this program, everything is local and it's totally organized and supported by dentists. The volume has grown each year, to the point that last December the folks from Nellis had to make two trips to transport everything!

Of course, when you add the mentor program and the Dental Elf project to our Give Kids A Smile event, you can really see the breadth of the impact that we're making here in our end of the state, for our profession, our members, and the community at large. I've been committed to making sure the public, as well as our non-member colleagues, are aware of the good that we do together.

Brendan Johnson, DDS
docbgj@cox.net

As my term as president progresses, I continue to be impressed with the people who selflessly give their time to support the SNDS and its programs. Officers, delegates, committee chairs, to say nothing of the members who participate in our meetings and seminars, all contribute to the success of the Society, and our sense of community. I'm learning to think of the SNDS, not as a single entity, but as a group of committed colleagues who contribute according to a variety of interests, but who share a common commitment to our profession.

Though we're not always aware of it, we really are putting a smile on southern Nevada. ◆

SNDS Executive Director's Message, *continued*

featured speakers, and much more. If you are still receiving the Prezfax by fax distribution and would rather have it by e-mail, contact our office to make sure we have your correct e-mail address so you be paperless and get the information quickly.

We have one change to our dinner meeting policies. Beginning with the October 9, 2012 meeting, we will be charging a $20 fee for guests. This includes spouses, significant others, or colleagues who are not eligible for membership (such as those visiting from out-of-state). Watch the Prezfax, emails, and the new website for details.

I hope to see you at our meetings, seminars and events, and I hope you enjoy the change of season and the cooler weather it brings! ◆

Northern Nevada Dental Health Program

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In Memoriam

Joel F. Glover, DDS

"Dentists Giving Back for Children's Smiles"

Time seems to pass by more quickly every year. Our lives are changed by countless events. When situations arise, the Northern Nevada Dental Society (NNDS) is here to help. We offer many professional and personal services for our members. Some services include: reduced costs for continuing education (CE) classes, the Temporary Dentist Network, fellowship with like professionals, the Committee for the New Dentist, and, of most value, our Peer Review Program.

The cost of everyday life has become a serious concern these past few years. NNDS strives to bring CE classes that are informative and affordable. Dinner meetings are held on the second Thursday of each month and offer CE credit and a meal. Dinner meetings run from October through April and cost $35 for NNDS members.

Dr. Michael Almaraz, our acting CE coordinator, has scheduled Robert London, DDS, to speak on "Peridontal and Periimplant Diseases" for the November 8 meeting and a full day of CE on November 9 at the Atlantis. A full list of the CE lecture schedule is available at www.nndental.org.

There are times when we need help. Sometimes there are only certain people who can help, such as when a dental practice is concerned. The NNDS offers a program called The Temporary Dentist Network for situations when a dentist is unable to work due to injury or, as we witnessed too many times this past year, death. The network provides volunteer dentists to service scheduled patients in order to keep the practice running until a permanent solution can be initiated.

Dentists work hard to provide for patients and to manage the business. The NNDS special events, such as the annual picnic and spouse's night, give us an excuse to get out of the office and enjoy quality social time with family, friends, and professionals. This year, the NNDS will be hosting a more traditional holiday party—an elegant dinner with dancing and entertainment. Please bring friends, family and staff to the Eldorado on December 15.

The most valuable service members of the NNDS benefit from is the Peer Review Committee. This committee was created to protect patients and dentists when misunderstandings arise. The committee consists of impartial volunteers—dentists, and laypersons—to evaluate the quality of care, fees for services provided, and anything else relevant. All factors, including a review of patient records and clinical exam, if needed, are considered by the committee to resolve the conflict. A recommendation is then given to the parties involved in hopes of a mutually agreeable solution. The advantage of this process is that most cases can be resolved before escalating to a lengthy and expensive legal battle.

Jason Ferguson, DDS
jasferg@hotmail.com

The NNDS is made up of the Executive Board, an invaluable Executive Director, and our members. Our society is unique in number of participants and their support of one another. Thank you for making the NNDS what it is. ◆

HIPAA – Hoppa

By Robert E. Horseman, DDS

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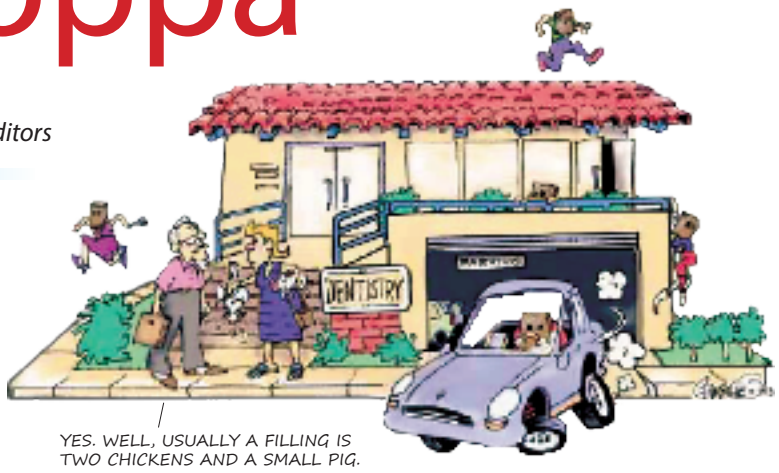

We've been looking the Health Insurance Portability and Accountability Act (HIPAA) over very carefully. We took an impromptu survey of our patients to ascertain their interest and understanding of the issues involved. The mandatory dozen pages of fine print explaining exactly what those issues are were initially met with wooden incomprehension. The Legalese-to-English Conversion pamphlet explaining the explanation proved to be invaluable, however, giving the evening office cleanup crew something useful to do.

I know we are not alone in our appreciation for a beneficent government that devotes so much time and money dedicated to furthering our best interests. The typical response from patients has been an enthusiastic, "Huh?"

Our only regret is that this privacy issue took so long to be addressed. Years ago, two patients, who were genetically programmed to hate each other on sight, met quite by accident in our reception room. When this encounter concluded and left the area frigid enough in which to hang meat, we realized privacy had become our top priority next to departing the premises at 5 PM.

An ensuing incident clinched our decision. It has been our custom over the years to tape a day sheet to the operatory wall indicating who is scheduled and what the appointment is for. Not liking surprises, this precludes demanding the seated patient to state clearly who she is and what she wants, a request that annoys some people who unreasonably feel we should know these facts in advance.

Mrs. Farrah Noya, age 47, height 5' 6½", weight 149, chemically-processed hair and with other possible surgical enhancements, notices the day sheet upon dismissal. At 10:45 AM, according to the sheet, a certain Shania Schwartz, divorcee, age 39 (unconfirmed), height 5' 4½", weight 124 (also unconfirmed), 36–26–48 (ha!), usually encased in a *K-Mart* knockoff frock and *Revlon's* entire line of cosmetics, is due to have an lower cast partial seated.

In what we now acknowledge as a blatant breach of privacy, the day sheet plainly states: *10:45, Schwartz, Shania, seat PLD.* Espying this, Mrs. Noya blanches, clutches her bosom as if in cardiac arrest and visibly shaken, flees the office without pausing at the front desk for her free sample of *Listerine's FreshBurst PocketPak*.

Within 48 hours, everybody in town knows of Shania Schwartz' oral falsies, the grapevine extending as far away as Nebraska. As a result, the following transpires:

1. Ms. Schwartz, privacy compromised beyond salvation, leaves town hurriedly, leaving no forwarding address. Her family believes she is headed for *McMurdo Station*, Antarctica because she takes her muk-luks and a change of *Victoria's Secret* thermal briefs with her.
2. Our office, fearing litigation of monumental proportions, immediately implements comprehensive privacy strictures. The Schwartz records are expunged from our files, her new partial is destroyed, observing meticulously all EPA, OSHA, FBI and HIPAA rules involving disposal of *prosthetic appliances, metal/acrylic, vol.9, sect.4 application 32 between 0345 and 1610 Zulu.*

Noting the successful application of the government's *Witness Protection Program*, we now have a *Patient Protection Program* implemented. Patients upon dismissal are issued a paper sack with eye holes to wear while they descend to the parking lot via a firepole installed adjacent to the chair. They are instructed not to return home for 48 hours and then by a circuitous route, speaking to no one in transit.

Our staff now speaks only in whispers using a code devised by Navajo Code Talkers. The day sheet looks like this: XXXX A.M. XXXX, Mr. XXXX

Electronic submission of claims that held so much promise initially, but evolved into a veritable blabbermouth of privacy invasions, has gone by the board.

We are presently using a barter system, negotiating our services for usable items like quilts, costume jewelry and the occasional chicken or small pig.

NOTE: *All of the above is to be held in strictest confidence and should you reveal the contents thereof, you will be terminated (HIPAA, p. 93, vol. 7, line 16).* ◆

Robert E. Horseman, DDS, graduated from USC SD in 1943, was a USN marine pilot in WWII. He has practiced dentistry from California to Australia and back and is a long-time contributing editor for the Journal of the California Dental Association. *He is now retired and enjoys making it through each day.*

Calendar of Events

OCTOBER–DECEMBER 2012

OCTOBER

FRI 5	*SNDS presents:* CE Seminar with Misty Absher Clark	9 am – 4 pm	Gold Coast Hotel, Las Vegas
TUE 9	SNDS Monthly Member Dinner Meeting	5:30 pm	Gold Coast Hotel, Las Vegas
TUE 9	NNDS Executive Committee Meeting	5:45 pm	161 Country Estates Cir, #1B, Reno
WED 10	*SNDS presents:* CE Café	6 pm	Nevada State Bank, Las Vegas Jones/Twain Branch, 3688 S Jones Blvd
THU 11	NNDS General Membership Dinner Meeting— Dr. Thomas Flynn	6 pm	The Grove at SouthCreek, Reno
FRI 12	*SNDS presents:* CE Seminar, "Infection Control"	9 am – 1 pm	Gold Coast Hotel, Las Vegas
WED 17	SNDS Peer Review Committee Meeting		*Contact SNDS at 702-733-8700*
THU 18	AGD General Membership Dinner Meeting	6 pm	Bricks Restaurant & Wine Bar, Reno
18–23	ADA Annual Session. Register online at www.ADA.org/session **THU 18**: Opening General Session and Distinguished Speaker Series **FRI 19**: New Dentist Reception **SAT 20**: Closing Reception in the Exhibit Hall **MON 22**: ADA Foundation Give Kids A Smile® 10th Anniversary Gala		
FRI 19	*NNDS presents:* 2 Brothers Charity Concert	6 pm	Atlantis Hotel Casino, Reno
TUE 23	SNDS Executive Committee Meeting	6 pm	SNDS Office

NOVEMBER

WED 7	*SNDS presents:* CE Café	6 pm	Nevada State Bank, Henderson 1501 W Warm Springs Rd
THU 8	NNDS General Membership Dinner Meeting—Dr. London, Perio	6 pm	Atlantis Hotel Casino, Reno
FRI 9	*NNDS presents:* Continuing Education Course—Dr. London	8 am	Atlantis Hotel Casino, Reno
FRI 9	*SNDS presents:* CE Seminar with Dr. Gary M. DeWood	9 am – 4 pm	Gold Coast Hotel, Las Vegas
TUE 13	SNDS Monthly Member Dinner Meeting	5:30 pm	Gold Coast Hotel, Las Vegas
TUE 13	NNDS Executive Committee Meeting	5:45 pm	161 Country Estates Cir, #1B, Reno
THU 15	NDA Executive Committee Meeting	6 pm	*Videoconference*
THU 15	AGD General Membership Dinner Meeting	6 pm	Location: *TBD*
WED 28	SNDS Peer Review Committee Meeting		*Contact SNDS at 702-733-8700*
29–DEC 1	ADA Lobbyist Conference		San Diego

DECEMBER

WED 5	*SNDS presents:* CE Café	6 pm	Nevada State Bank, Henderson Jones/Twain Branch, 3688 S Jones Blvd
SAT 15	NNDS Annual Christmas Party	6:30 pm	El Dorado Hotel Casino, Reno
FRI 21	AGD Holiday Party	6 pm	Drs. Jason & Cariann Champagne's home

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