FALL 2010

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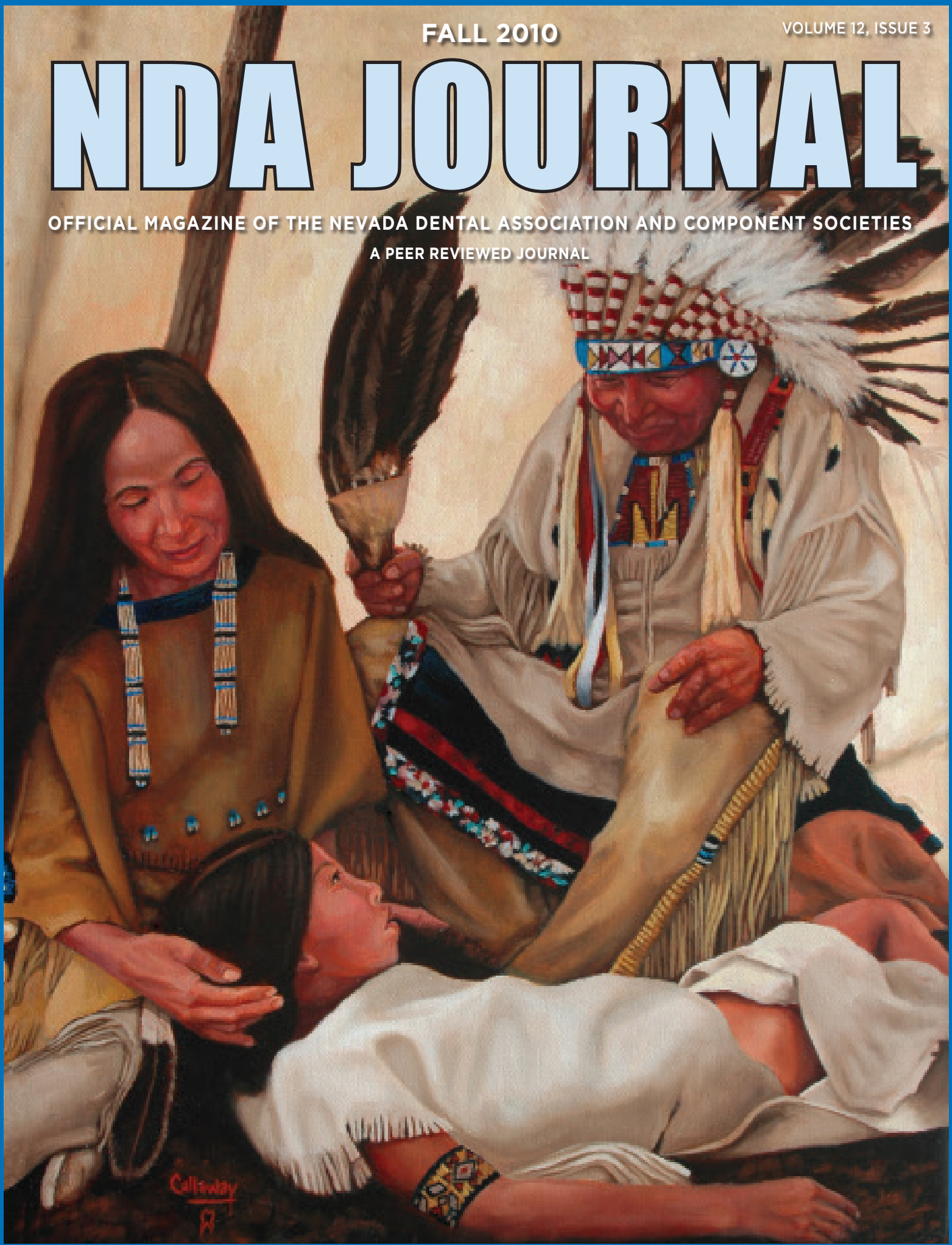
A PEER REVIEWED JOURNAL

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NDA JOURNAL

FALL 2010

On the Cover

The Healing

The Journal **is privileged once again to present cover art by NDA dentist Dr. James Callaway.**

This work, titled "The Healing," depicts a Lakota Sioux mother bringing her son, tormented by a dental abscess, to the tribal healer. The healer is depicted during the healing ceremony.

Dr. Callaway's first *Journal* cover, "Mountain Man Dentist Jay Lewis" (*NDA Journal*, Fall 2008) received a Journalism Award from the International College of Dentists in 2009.

Nevada Dental Association
8863 W Flamingo Rd, Ste 102
Las Vegas, NV 89147-8718
PHONE 702-255-4211
TOLL-FREE 800-962-6710
FAX 702-255-3302
EMAIL info@nvda.org
WEB www.nvda.org

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Editor
Daniel L. Orr II,
DDS, PhD, JD, MD
editornda@nvda.org

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Robert H. Talley, DDS, CAE
Exec. Director
8863 W Flamingo Rd, Ste 102
Las Vegas, NV 89147
PHONE 702-255-4211
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FAX 702-255-3302
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Patients as Healers

There aren't too many better feelings than providing our low-tech (relative to Mother Nature) interventions in successfully helping facilitate a patent's recovery to full function and optimal esthetics. At times, dentists are even paid to provide such services. What could be better? Read on…

We're granted licenses to physically invade others' corpi with needles, drills, blades, lasers and other instruments that, if used outside our offices, would be considered at least battery, legally speaking. In conjunction with the instrumentation universally considered pretty scary, we administer controlled substances, leave foreign bodies, and prescribe substances that if used injudiciously could cause great harm rather than heal.

Amazingly, the vast majority of the time what dentists do improves the situation. Even if we aren't perfect doctors on any given day, the aforementioned Mother Nature predictably steps in as an able assistant (or is really we who assist her?) and the patient's situation is improved.

We can feel pretty good about all these positive results on a routine basis. We can objectively appreciate great restorations that don't click even with a sharp explorer. We can have self-content about making so many bad situations better. We can be pleased about effectively dealing with acute pain. We can even feel heroic at times when restoring function after years, even decades, of compromise. Of course, we have to judge our own efforts as objectively as we can because even those closest to us, including spouses or even our patients, unless fellow dentists, simply don't understand what is necessary to successfully synthesize the endless combinations and permutations of treatment plans in creating a, to the world, seemingly simple procedure predictably successful.

We ethically are obligated to ask ourselves the question about whether or not we've done our best and accomplished goals that are in the best interest of our patients. Only then can we feel justifiably content with our own efforts and give ourselves a mental pat on the back.

But how much better is it when our patents acknowledge our efforts, providing some positive, independent, albeit subjective, third-party feedback? Don't such comments enhance our self-determined opinions of excellence?

How great is it when one finishes a procedure and the patient can't believe it's already done? Recently, after an extraction, a patient accused me of putting someone else's tooth on the tray and pretending that it was his recently removed dental remains. I'm not sure if he ever thanked me, but his sequential expressions of doubt, shock, and awe were pretty fun to observe.

The quick patient thank yous are so appreciated. Eye contact and a hand shake or hug, when appropriate, are universally valued.

Occasionally, patients will help create a great day by sending a thank you card or some cookies a few days after their services were provided, acknowledging the staff and the doctor.

At times, I've even had patients want to give me and/or my staff a tip. I know this is Nevada, perhaps the tipping capital of the world, but patients wanting to tip never cease to amaze me (sometimes they still owe money for services for heck sake).

However, the expressions of gratitude that may be the most moving and memorable are probably one of two types.

Continues ➲

Dr. Orr practices Oral & Maxillofacial Surgery in Las Vegas, is a Clinical Professor of Surgery and 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.

NDA Executive Director's Message

Robert H. Talley, DDS, CAE
robert.talleydds@nvda.org

First, let me say *thank you* to the members of this great association for your support of the NDAPAC Fund. The response to John's letter for contributions has been great. Your officers, the Legislative Committee and the NDA staff work hard on your behalf in this somewhat crazy legislative arena with all the new legislators, a record budget deficit and a stagnant economy.

There have been a lot of calls and e-mails about the Public Employees' Benefits Program (PEBP) and their board's decision to cut dental benefits to their members back to just preventative services. This board was required to shift $111.2 million in costs to the employees and retirees either through decreased benefits or increased premiums. It is important to realize that this board is made up of public employees and not legislators. That being said, the best way to affect change in decisions that have been made by this board is through the public employees themselves. We as dentists need to re-emphasize the importance of good dental care and have the employees contact their representatives on the PEBP board and voice their opinion. It cannot be about us. Your association continues to work behind the scenes on this issue.

You will see information on the Annual Midwinter Meeting being held again at the Silverado Resort in Napa, CA on February 11–12, 2011. We are planning a dinner at Markham Winery on Saturday night with something special for our ladies for Valentine's Day. The price includes transportation to and from the winery that night.

I have also included an article about one of our ADA-endorsed products, the Emergency Record.

Thanks again for your support and for letting me serve as your Executive Director. ◆

Save the dates for our 2011 meetings!

Mid-Winter Meeting
February 11–12, 2011
Silverado Resort • Napa Valley, CA

93rd Annual Summer Meeting
July 7–9, 2011
Grand Wailea Resort & Spa
Maui, Hawaii

Patients as Healers, *from page 4*

First, patients who return years later to say thank you and maybe even describe how one's treatment has changed their life in a positive, and at times significant non-dental treatment way. I myself am a dentist in large part because of the profoundly positive experiences I had with my childhood dentist, Dr. Stratico. I have had former employees become hygienists and dentists…and one attorney…thank heavens I didn't scare them all away. Sometimes, such personally significant interactions are recalled by the doctor, perhaps because of the case complexity. Most often though, to the doctor the care in question may have been totally routine, just another day at the office, like thousands of similar cases…except of course, for that particular patient, for whom the procedure was not mundane at all, but epic and unforgettable.

Second to none, of course, are those patients who share their gratitude for one's efforts even when the results aren't achieved in the most straightforward or pain-free manner or are not ultimately what both doctor and patient had hoped for.

It's nice to have the confidence to know that one has tried their best at providing ethical and quality service, but it's so much better when one's relationship with patients fosters an environment that allows those patients to express gratitude, even when we haven't done anything lately or when the results were less than hoped for.

In such moments, a valuable role reversal takes place. The patient becomes the physician and a humble health professional becomes the healed. Cherish those moments, because more than any other circumstance, such occurrences are what truly make it all worthwhile.

We should never forget to express our personal gratitude for the privilege of being our patients' dentist when such opportunities arise. ◆

NDA President's Message

John C. DiGrazia, DDS

It is an honor and a privilege to serve as President of the Nevada Dental Association. I was handed the gavel from Dr. Peter Balle at the summer meeting in San Diego. Peter did an excellent job as president and set a standard of commitment to which I hope to build upon during my term as President. It has been a pleasure to serve on the Executive Board with Peter, and on behalf of the entire Board, we extend our thanks to him for his time and efforts over the past years.

With the passing of the Presidential gavel also comes our new slate of Executive Board members. I would like to welcome Dr. Steven Rose to the Board experience as Secretary. Steven will bring a fresh view and new perspective to the Board, and I look forward to working with him.

If you were unable to attend our meeting in San Diego, you missed a productive and informational session. ADA President, Dr. Ron Tankersley presented a report from the national perspective. Our 14th District Trustee, Dr. Ken Versman provided us with a report from our District offices. We were also honored with an appearance by Nevada Congresswoman Shelly Berkley. Congresswoman Berkley discussed Nevada budget shortfalls and woes, Dr. Tankersley discussed midlevel providers and access to care, and Dr. Versman commented on the capping of non-covered insurance benefits—issues that all affect us in our day-to-day life. I was encouraged to find our dental and governmental leaders exhibiting efforts aimed at protect our future as small business owners and as healthcare providers.

We were also joined at the summer meeting by NDA Executive Director, Dr. Robert Talley and other committee members who have been working tirelessly to represent our members and who have been actively promoting the highest standards of oral health. These are difficult times and such valiant efforts have not been made without meeting difficult challenges. Many of you are aware of the threat of mid-level provider care on our profession, which threatens not only us, but the public we serve. This challenge is not being taken lightly. Please know that the NDA is actively combating the issue. We have been actively meeting with and educating the candidates and elected officials about the importance of keeping the dentist as the leader in the area of dentistry. Our lobbyist Jeanette Belz and Dr. David White have spent countless hours attending fundraisers and meeting with politicians to assert and promote our message.

In addition to the above, by now all of you should have received my letter outlining the many challenges dentistry has in its future and the issues that we will face. I again urge your donation in support of our PAC fund. To date, your response has been impressive, showing the dedication that we as a group have to our profession. Thank you all for your donations. We intend to use this money to continue to fight in support of the issues that are important to the NDA membership.

I know this year will go by very fast, but I do look forward to the opportunity to meet many of you. I encourage you to get involved in and attend our House of Delegates meetings at our summer and mid-winter meetings. Our success is measured in the strength of our participant members. ◆

ADA Western States Presidents' Conference

Committee on the New Dentist

By David White, Nevada CND Chair

I would like to take this opportunity to thank those who attended our first Committee on the New Dentist (CND) social in Reno on August 12. We were fortunate to be joined by NDA President, John DiGrazia and NNDS President, Mark Handelin. These two individuals acknowledged the challenges facing new dentists and reinforced their support moving forward.

On September 11, CND representatives from the 14th District (NV, AZ, NM, UT, WY, HI, CO) met in Denver, CO to caucus. Amongst the discussion were thoughts on the mid-level provider, challenges facing new dentists, and how to engage new dentists in organized dentistry. The ADA's 14th District Trustee, Ken Versman and 14th District ADPAC trustee, Rhett Murray, joined us. They too have expressed their support for the CND's chapters of the region.

In an effort to keep everyone informed on the CND, we created a Facebook account to announce upcoming CND events, CE courses, and pertinent journal articles. You can find us at Nevada Committee on the New Dentist. Already we have over 50 individuals whom have joined our page and the numbers are growing.

As new dentists, we are facing hard times during this economic climate and we encourage you to invite your colleagues to join the NDA. The NDA fully supports new dentists of Nevada.

If you have any questions about becoming involved or about the Committee on the New Dentist, please contact me at whitedav@umich.edu or 775-287-7960. ◆

NDA 92nd Annual Summer Meeting

Hotel Del Coronado
San Diego, CA
July 8–10, 2010

NDA Annual Mid-Winter Meeting

February 11–12, 2011

Silverado Resort, Napa, CA

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FRIDAY, FEBRUARY 11	**Time**			
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President's Reception	6:30–8:30PM		$ 60	
SATURDAY, FEBRUARY 12	**Time**			
Breakfast	8AM		$ 25	
House of Delegates	9AM–12 NOON		$ 0	—
Dinner at Markham Winery	6–9PM		$ 100	
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Society of American Indian Dentists (SAID) Celebrates 20th Annual Convention

By Dave Smith DDS, MS (Oneida); SAID President

The Society of American Indian Dentists (SAID) celebrated its 20th Annual Convention at the Creighton School of Dentistry in May 2010. The first President and Founder, Dr. George Blue Spruce was honored at the site of the 1st Annual Convention held at Creighton.

The SAID is a non-profit organization with a primary focus to improve the Oral Health of the American Indian population and to mentor American Indian students interested in a career in Dentistry. We work with dental schools and other national groups such as the National Dental Association and the Hispanic Dental Association in mentoring traditionally under-represented groups.

American Indian children have very high rate of decay and the number of American Indian/Alaska Native dentists is small. With our small group, we are gradually changing those numbers. ◆

Editors' Note: *Dr. Smith was featured on the cover of the* ADA News *July 12, 2010 as President of SAID.*

Editor's Note:

Mary Alice Brown, a full-blooded Cherokee Princess, was adopted by John and Hulda Brown in Columbus, Cherokee County, Kansas, circa 1870. The Cherokee were trying to recover from a difficult period in their history at this time, having endured the "Trail of Tears," or the U.S. Government forced relocation from their traditional lands in the valleys of the Appalachians to Indian Territory (Oklahoma). The relocation was ordered by President Andrew Jackson in spite of a contrary ruling in favor of the Cherokee by the United States Supreme Court (*Worcestor vs. Georgia*). Although the USSC had deemed the Removal Act unconstitutional, Jackson infamously stated: "[Chief Justice] John Marshall has made his decision, now let him enforce it."

General Winfield Scott subsequently demanded that the "…emigration must be commenced in haste…" At least 4,000 Cherokee died of starvation or disease before Indian Territory was reached.

Mary is one of the Editor's great grandmothers passed native American remedies on to her children, some of these remedies are for dental conditions such as:

- Willow—Leaves or inner bark can be chewed or boiled into a tea, releasing acetylsalicylic acid for pain relief. The willow was known as the "toothache tree."
- Yarrow—Leaves contain acetylsalicylic acid.
- Clove—Flower buds contain eugenol for odontalgia.
- Goldenseal—Applied directly or in tea for mouth ulcers.
- Hops—Flowers can be dried and used for odontalgia.
- Sage—Used to clean the teeth.
- Echinachea—Used to combat infection.

Nerve Block Recommendations Trigger Dispute over Certain Patients on Blood Thinners

By Rosemary Frei, MSc

Reprinted with permission from Anesthesiology News, *Issue: 4/2010 | Volume: 36:4*

New guidelines from the American Society of Regional Anesthesia and Pain Medicine aim to clarify the appropriate use of nerve blocks in patients across the gamut of clinical scenarios.

But the document has sparked a controversy over the safety of antithrombotic agents in some cases, and according to one expert, could raise unnecessary concerns among clinicians about certain patients, especially those receiving thromboprophylaxis who undergo deep plexus and peripheral blocks.

The 37-page guidelines, which update ASRA recommendations published in 2003, address a wide range of situations, from women who are pregnant or in labor to patients undergoing plexus or peripheral blockade (Reg Anesth Pain Med 2010; 35:64-101).

"The guidelines are very comprehensive, so I think anyone will find the document extremely useful," said Vincent Chan, MD, ASRA president and professor of anesthesiology at the University of Toronto, in Ontario, Canada.

Kenneth D. Candido, MD, chairman of anesthesiology at Advocate Illinois Masonic Medical Center in Chicago, called the document a "landmark" and said the recommendations are "thorough, comprehensive and well referenced."

Dr. Candido, who also is a professor of clinical anesthesiology at the University of Illinois, in Chicago, said he uses ASRA guidelines as a framework for identifying individuals at risk for potential bleeding. "However, just as no two patients are identical, so too are no two clinical scenarios exactly equal," he cautioned. "Therefore, adhering too rigidly to any set of criteria is likely to exclude some patients who logic dictates should receive regional anesthesia."

But, Jacques E. Chelly, MD, PhD, MBA, professor of anesthesiology and orthopedic surgery, vice chair of clinical research and Director of the Div. of Regional Anesthesia and Acute Interventional Perioperative Pain in the Dept. of Anesthesiology at the University of Pittsburgh Medical Center (UPMC), objected to the way the new guidelines lump deep plexus and peripheral nerve blocks with neuraxial procedures in patients receiving thromboprophylaxis. In particular, the recommendations call for large gaps between when clot-preventing drugs are stopped and started and when the blocks are performed.

Guidelines often have the effect of narrowly defining practice patterns because clinicians, fearing malpractice suits, are loath to stray from the recommendations, Dr. Chelly noted. "It is already difficult enough for anesthesiologists who perform blocks to be the first to be blamed for any postoperative nerve injury, even when they are surgically related, without adding unbalanced recommendations related to the risk for major bleeding in patients receiving thromboprophylaxis and deep plexus and peripheral nerve blocks," he said.

Heparin Guidance Varies from Earlier Version

In a departure from the 2003 document, the 2010 guidelines state that patients receiving low-molecular-weight heparin (LMWH) should not be given other drugs that affect hemostasis, such as standard heparin, antiplatelet agents or dextran.

The guidelines also call for anesthesiologists to discuss LMWH therapy with surgeons prior to initiating treatment, and to delay the drugs for 24 hours after surgery. They call for at least a 10- to 12-hour delay between the last standard LMWH dose and

"...adhering too rigidly to any set of criteria is likely to exclude some patients who logic dictates should receive regional anesthesia."

needle placement for anesthesia, or at least a 24-hour delay between a higher LMWH dose and needle placement.

One of the main goals is to reduce the occurrence of spinal hematoma. The guideline authors, led by Terese Horlocker, MD, professor of anesthesiology and orthopedics at Mayo Clinic, in Rochester, Minn., cited recent epidemiological data suggesting the frequency of the complication is increasing and now may be as high as one in 3,000 in some populations.

A Swedish study of 1.26 million spinal and 450,000 epidural blocks performed in a 10-year period found 33 cases of spinal hematoma (Anesthesiology 2004; 101:950-959). The study also found that one in 3,600 Swedish women taking LMWH once per day who underwent total knee replacement experienced a spinal hematoma—a rate that is similar to that reported in North America, where a twice-daily dosing regimen of the drug is routine, Dr. Horlocker said.

In the majority of cases in which a spinal hematoma occurred, one of two things happened, Dr. Horlocker said: Either the recommended intervals between LMWH dosing and catheter removal were not followed, or patients received an additional hemostasis-altering medication such as dextran, ketorolac or a nonsteroidal anti-inflammatory drug with the neuraxial anesthesia. "Based on this, we concluded it is best to avoid even once-daily LMWH administration unless there is no possibility that an additional antithrombotic agent, including antiplatelet medication, could be administered."

The guidelines committee said recommendations for neuraxial techniques also should apply to deep plexus and peripheral nerve blocks. These procedures include lumbar plexus, lumbar sympathetic and paravertebral blocks, Dr. Horlocker said.

Dr. Chelly, in a forthcoming letter to Regional Anesthesia and Pain Medicine, disputed that precaution. He noted that the new guidelines acknowledge the series his group published in 2008 on 670 patients who received warfarin and continuous lumbar plexus blocks (Br J Anaesth 2008; 101:250-254). However, the committee did not review another 2008 article involving 6,935 peripheral blocks in more than 3,500 patients receiving thromboprophylaxis without interruption; none of these patients experienced major bleeding, Dr. Chelly said (J Arthroplasty 2008;23:350-354).

"The consensus does not distinguish between the therapeutic and thromboprophylaxis indications of anticoagulants," Dr. Chelly told *Anesthesiology News*. "This distinction is important because, first, the doses recommended to treat deep vein thrombosis and pulmonary embolism are higher than those recommended for thromboprophylaxis; second, most patients who benefit from peripheral nerve blocks receive thromboprophylaxis, meaning lower dosing of LMWH; and third, although there is evidence supporting the concern expressed in the consensus for neuroaxial blocks and LMWH, evidence supporting the recommendations that deep blocks should be treated like neuroaxial blocks is lacking."

In the third edition of the consensus, Dr. Chelly added, the authors only reported 13 cases of major bleeding following blocks in patients receiving antithrombotic therapy. Of those, a minority was related to the combinations of thromboprophylaxis, including aspirin and continuous nerve blocks. In most of these cases, the placement of the blocks was associated with major trauma.

"In our practice, we have not interrupted the thromboprophylaxis when removing perineural catheters for more than 15 years and have not observed any major bleeding complications," Dr. Chelly said.

Dr. Chelly's group has submitted an abstract to the 2010 Spring meeting of ASRA documenting no serious complications associated with the removal of 136 paravertebral catheters in patients receiving uninterrupted enoxaparin thromboprophylaxis.

Yet Dr. Horlocker said the additional data would not affect the ASRA recommendations. "Only a very small proportion of patients received a continuous lumbar plexus (psoas compartment) block—that is, a deep block—and who were on a regimen that would perhaps preclude a block," she said. "That is, there were just 23 patients receiving twice-daily enoxaparin and another 193 receiving fondaparinux [Arixtra, GlaxoSmithKline]. So this series will not change the ASRA guidelines, because we need larger numbers and more rigorous study of the risk–benefit ratio." ◆

Editor's Note:

Medical literature, such as this discussion of guidelines for anticoagulated patients scheduled to receive nerve blocks, are of interest to dentists because, for instance, inferior alveolar nerve blocks are every bit as much a concern as any other nerve block.

The *British Journal of Oral and Maxillofacial Surgery* reported earlier this year two cases of delayed trismus following restorative procedures requiring inferior alveolar blocks.[1] The trismus developed over a period several days 4–6 weeks after the original procedures and was associated with inferior alveolar nerve hypoesthesia. The etiology of the trismus was subsequently determined to be hematoma or inflammatory edema involving the medial pterygoid muscle and pterygoid space.

(Endnotes)

1. Smyth j, Marley J: An unusual delayed complication of inferior alveolar nerve block. Br J Oral Maxillofac Surg, 48:51-52, 2010.

Performance Derives Value in a Dental Practice

By John S. Bauer, MBA, FACMPE, CPA, CFE, CVA

Understanding the relationships and the differences between practice performance and the estimated value of a dental practice provides vital information to increase practice profit and the eventual monetary value of the practice. In the dental practice arena, there are practice evaluations and practice valuations.

A practice evaluation is a comprehensive review of a dental practice which is intended to provide information to make the practice both more efficient and profitable. Think of a practice evaluation as an investment in the practice's future. A properly performed practice review consists of reviewing a minimum of three years tax, financial and practice management information as well as any practice related contracts and agreements. Once that information is collated the reviewer or consultant would make a site visit and review the internal controls in place, objectively measure the performance of the revenue cycle and analyze managed care contracts. In addition, the reviewer would assess other attributes commonly found in a dental practice such as the use of contemporary business related technology, pension plans and overall human resource management. A properly performed practice review consists of a review of all business functions of a practice. Next, the reviewer should provide a written report of the weaknesses found during the evaluation, discuss the report with the owners and possibly assist with the implementation of corrective action. The overall intent of a practice evaluation is to increase efficiencies and thereby increase profit.

When selecting the person or a firm to review a practice, make sure to check credentials It is suggested that the reviewer have extensive financial, accounting and practice management education in the dental field. In today's complex business environment, experience alone is not sufficient.

A practice valuation is an estimated practice value or range of value based upon sound accounting methodologies. Practice valuations are performed for a myriad of reasons. Examples are the sale of the practice, tax and estate planning, as well as marital dissolution.

Typically, there are three basic methods to value a practice.

- **Market approach**—Values a practice based upon what other similar practices sold for in similar markets.
- **Asset method** —Value of the assets minus the liabilities, thus giving no value to the "ongoing concern" of the business. The asset approach has little application to a profitable dental practice.
- **Income approach**—Uses the past five years of adjusted profit to derive future profit projections and then calculates a present value.

I believe in the vast majority of dental practices, the best method of valuing a practice is a combination of the market approach and the income approach. With this combination, the valuation analyst can include local market trends as well as recognize the actual profitability of a practice. This recognition of the practice's performance and profitability is titled "goodwill". Goodwill is basically the recognition of many years of work in an up and running practice, with trained employees, a marketing program attracting new patients, and all the other attributes of a practice. Goodwill can only be purchased when someone buys or buys into a practice.

Several related points need to be made during any discussion regarding practice valuations. First, valuations are performed for a purpose and that purpose typically directs how that valuation is calculated. That is to say that a valuation for the sale of a practice could be performed differently than a valuation used in a marital dissolution and their values may differ. With that said, valuations should only be used for their intended purpose. Second, if the practice has several owners, the valuation method to determine the practices value needs to be established in advance and in an agreement called a buy-sell agreement. If not established in advance and in writing, there is a good possibility of incurring significant legal fees in just determining a valuation methodology.

An evaluation establishes objective performance reporting which provides "measurements" to manage the practice. It has been said, if it cannot be measured, it cannot be managed. A properly performed practice evaluation provides the practice with industry benchmark achievable goals. Management can then manage for efficiencies and higher profits. Higher profits over time translate into larger historical profits that increase the practice's value. Related to practice profitability and value, a common mistake made is that some dentists purposely "slow down" a few years from retirement and that causes a decrease in profit and hence a decreased practice value.

Practices that have evaluations often benefit greatly soon after the evaluation and into future years. ◆

John S. Bauer is a co-founder of the Aspen Consulting Group, Ltd., Strongsville, OH. He can be reached at jbauer@aspen-ltd.com.

Dr. Rick Thiriot Honored for Outstanding Volunteerism

Dr. Rick Thiriot was recently honored by the Volunteers of America for his outstanding activities with UNLV SDM students.

Dr. Rick Thiriot, a lifelong Nevadan, is a graduate of UNLV and the University of the Pacific School of Dentistry. He currently serves as Asst. Professor of Clinical Science at UNLV SDM and Interim Co-Associate Dean of Clinical Services. He has served as past President of the Clark County and Nevada Dental Association, as well as Sec/Treasurer of the Nevada State Board of Dental Examiners.

Dr. Thiriot spearheads a program that provides pro bono dental care at the Huntridge Homeless Clinic, coordinating treatment by student and faculty volunteers from the UNLV SDM. By securing grants and donations, over 200 homeless residents and veterans were able to have their mouths restored to better function.

Dr. Thiriot also helps coordinate volunteers donating dental care at UNLV's Ferrin Memorial Clinic which helps meet the dental needs of area dentally non-deployable National Guard troops with no access to care due to financial conditions. Since its inception, the Ferrin Clinic has helped over 500 Nevada National Guard troops with materials donated by dental supply companies and the UNLV SDM.

"ObamaCare": What Is in It

By Jane M. Orient, MD *Reprinted with permission from the* Journal of American Physicians and Surgeons, *Fall 2010*

House of Representative Speaker Nancy Pelosi famously said at the 2010 legislative conference for the National Association of Counties on March 9: "But we have to pass the bill so that you can find out what is in it, away from the fog of the controversy." Before the bill's passage, Rep. John Conyers (D-MI), chairman of the House Judiciary Committee, said: "I love these members, they get up and say, 'read the bill.' What good is reading the bill if it's a thousand pages long and you don't have two days and two lawyers to find out what it means after you read the bill?"

In fact, it took much longer than two days, more like a week, just to skim through the Patient Protection and Affordable Care Act ("the Act") as passed into law, which is 906 pages long in single-spaced statutory format. It would also take a whole team of lawyers just to look up the citations to previous laws. Since the Act passed, tax accountants, insurance actuaries, and others have been attempting to translate its provisions into numbers that affect their industries. Most importantly, it is actually impossible to know the ultimate impact: this is an enabling act that sets up the infrastructure for later implementation by some 159 new bureaucracies. The all-important details are not in the Act itself, but will be created by administrative agencies, insulated from the controversies in the political process—and from accountability at the ballot box.

While reading, I placed tabs, using sticky notes of five colors: green for taxation; pink for regulation; blue for legal consequences (litigation, prosecution, and penalties—administrative, civil, or criminal); peach-colored for pork or special-interest group favors; and yellow for other, such as social engineering. Of course, the classification is arbitrary, and there is significant overlap. There are no "patient protection" or "affordable care" tabs per se: these may be the desired objectives, but the machinery involves taxation, regulation, and punishment, as in the form of mandates, subsidies, and price controls. All provisions actually increase the cost of providing care, although they redistribute the burden of meeting the costs—from subscribers to insurers, patients to "providers," or one group of taxpayers to another. The key themes are redistribution of wealth, political and racial favoritism, and expansion of the welfare/surveillance state.

The following analysis is by no means exhaustive. As is apparent from the quotations of the statutory language, enormous implications may easily hidden in a few words.

Taxation

Redistribution

The section entitled "prohibition of discrimination based on [low] salary" (p17, §2716) prohibits requiring low-wage workers to contribute the same dollar amount or percentage of income as higher wage workers to their health plan. This means that higher-wage workers can be required to contribute more, in absolute or relative terms. In other words, premiums can be based on wages, and if a required premium is viewed as a tax, it is a progressive or redistributive tax.

Individual Tax Credits

Complex rules for determining eligibility for refundable tax credits, reduced cost sharing, and exemptions from "individual responsibility" requirements begin on p 95. Factors include employment status, income, family size, marital status, religion, membership in an Indian tribe, whether one or more individuals in the beneficiary's family are not lawfully present (p 100), and other information that the secretary of the Department of Health and Human Services (HHS) ("the Secretary") shall prescribe. The Secretary will have to verify information in consultation with the secretary of the U.S. Treasury, the secretary of the Department of Homeland Security, and the commissioner of the Social Security Administration.

Small Employer Tax Credit

Small business owners received a postcard from the Treasury Department informing them of a 35% tax credit to employers with less than 25 full-time employees averaging less than $50,000 per year in wages (p 120, §45R). For the "three simple steps," the National Federation of Independent Business (NFIB) prepared a calculator (www.nfib.com/issues-elections/healthcare/credit calculators). One business owner calculated that his credit would actually be zero, and that a 35% tax credit would be available only to firms with 10 employees averaging $25,000 per year.[1]

Individual Mandate

In Subtitle F, Shared Responsibility for Healthcare, Part 1–Individual responsibility (p 124, §1501), the "requirement to maintain minimum essential coverage" begins with the constitutional rationale: The requirement is "commercial and economic in nature, and substantially affects interstate commerce…." The Act notes that without the individual mandate, many individuals would wait to purchase health insurance until they needed care—without acknowledging that this results partly from the guaranteed issue and community rating provisions of the Act.

Although Obama argued, while campaigning for the bill, that this mandate was not a tax, the Department of Justice cites the Anti-Injunction Act in its motion to dismiss a challenge brought by the state of Florida and other plaintiffs. This law restricts the courts from interfering with the government's ability to collect taxes.[2] The taxing power of Congress is another rationale claimed to support constitutionality, in case the Commerce Clause is held to be inapplicable.

Employer Mandate

Part II of Subtitle F, beginning on p 134, concerns the employer's part of the "shared responsibility." The treatment of employers under the law depends on the number of employees.

Hiring the 201st, 101st, or 51st employee has significant implications. Rules for counting the number of employees are given on pp 53–54, §1304. The rules are quite complex and concern not only the provision of coverage, but for "large" employers (+200 full-time workers) include extensive reporting requirements.

More than two-thirds of companies, and 80% of small businesses, could be forced to change their current coverage because it is so easy to lose the "grandfathered" status of existing plans. Even businesses that offer "correct" coverage may not escape penalties, as they will have to pay penalties up to $3,000 for every employee who receives a subsidy because his contribution is deemed unaffordable (exceeding 8% of his income). As many as one-third of employers could face these penalties, which amount to an additional tax on employment.[3]

Expansion of Medicaid

Medicaid coverage is extended to those whose income does not exceed 133% of the poverty line (p 153, Title II, Subtitle A, §2001). The "Cornhusker Kickback," reportedly used to buy the vote of Sen. Ben Nelson of Nebraska, is extended to all 50 states (p 154). Federal funding for medical assistance for individuals newly eligible under the mandate will be 100% from January 1, 2014, until December 31, 2016. After this, the amount of federal subsidies seems to depend on whether the state qualifies as "an expansion state."

A special adjustment to the Federal Medical Assistance Percentage (FMAP) is made for certain states recovering from a major disaster. Louisiana, owing to Hurricane Katrina, appears to be the only state meeting the definition (p 156, §2006), hence the appellation "Louisiana Purchase," believed to be the price of the vote of Sen. Mary Landrieu of Louisiana.

Of the 32 million people who are expected to gain benefits because of the Act, 16 million will result from the expansion of Medicaid and the Children's Health Insurance Program (CHIP). "The fate of health care reform depends on the fate of Medicaid," writes Sara Rosenbaum, J.D., of the George Washington University Medical Center.[4] States that are challenging the Act in federal district court in Florida argue that Congress has essentially hijacked the Medicaid program, forcing states to become unwilling partners in an unlawful legislative scheme.[4]

In addition to the direct tax implications from expanding Medicaid, states lose premium taxes when people lose their private coverage and are forced into Medicaid. These taxes contributed some $6.5 billion to state budgets in 2008; in Nevada, they funded one third of Medicaid.[5]

Taxes on Medical Items and Insurance Benefits

Presidential promises notwithstanding, many explicit taxes in the Act will affect middle and low-income individuals. The 40% tax on excess "Cadillac" benefits, assuming anybody will still want them in lieu of higher wages, is estimated to hit 12% of workers at the outset but by 2018 will likely include many of today's average plans as the threshold is indexed to general inflation rather than medical cost inflation.[3]

Taxes on the sick are increased by limiting the itemized deduction for medical expenses to the amount that exceeds 10%, rather than 7.5% of adjusted gross income (p 750, §9013). By the time this is fully implemented, the Joint Committee on Taxation estimates it will affect 14.8 million taxpayers, 14.7 million of whom earn less than $200,000/year.[6] Half of those taking advantage of this deduction earn less than $50,000/year.[7]

Then there are taxes on prescription drugs, medical devices from CT scanners to surgical scissors, insurers, and tanning beds whether used for medical or cosmetic purposes. These taxes could cost the typical family of four with job-based coverage an additional $1,000 a year in higher premiums.[3]

Billions of Additional Tax Forms

Because of the "Expansion of Information Reporting Requirements," (p 737, §9006), businesses will have to issue a form 1099 to any entity with which it does more than $600 worth of business in a year, including corporations. This includes rent, fuel, office supplies, new or used cars, package delivery services, and lunch—not just non-wage income to unincorporated independent contractors. As an unrelated "pay for" in the Act, the provision is estimated to increase revenue by $1.7 billion a year. Rep. Dan Lungren (R-CA) introduced H.R. 5141 to repeal this costly accounting nightmare.[8]

Tax on Investment Income

Starting in 2013, the 3.8% Medicare tax will be applied to capital gains and investment income if an individual's total gross income exceeds $200,000 or a couple's exceeds $250,000. Middle-class people would be subject to this tax even if they were "rich" for only one day: the day they sold their house and bought a new one.[9]

The Effect of Inflation

If inflation hits 10%, the $100,000 a year earner gets to the $200,000 threshold in 7.5 years.[10] The threshold for additional taxes is not indexed for inflation—an additional incentive for government to debase the currency.

Regulation

Regulations that Outlaw True Insurance

There can be no lifetime limits on coverage (p 13, §2711), and annual limits are also restricted. Actuaries need to know the risk of incurring a loss and the dollar value of the loss. Casualty insurance places a replacement value on your car or house, and liability coverage places a limit on the amount of payout. Health insurance, in contrast, will have to be open ended and virtually unlimited—except of course by the solvency of the insurer or the government, or the rulings of a de facto rationing board.

The prohibition on rescissions (p 13, §2712) meets a popular demand, although it may not represent much change from the status quo. It has generally been illegal to cancel a policy just because a claim is made, although it was and still is legal to cancel it if the insured has committed fraud or made an intentional misrepresentation of material fact.

"Fair health insurance premiums" (p 37, §2701) are redistributional, and overcharge low-risk individuals. There is guaranteed issue (p 36) and a form of community rating: Variation of

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premiums by age is limited, and they may not be based on health status (except for smoking).

"Quality" and "Efficiency"

"Ensuring the quality of care" (p 17, §2717) requires implementation of quality reporting, activities to reduce medical errors through the use of "best clinical practices," "evidence-based-medicine," and "health information technology." It encourages the use of new structures such as medical homes and thus discourages traditional independent forms of practice. The Secretary is given the authority (p 18) to develop and impose "appropriate penalties" for noncompliance.

The goal "Improving the Quality and Efficiency of Healthcare" (p 235, Title III) is to be achieved through "Transforming the Health Care Delivery System" and its payment mechanism. Specifics include "linking payment to quality outcomes under the Medicare program," measuring Medicare spending per beneficiary, and improving the Physician Quality Reporting System (p 245, §3002). The Secretary is to establish appropriate measures of quality (p 256), apply a payment modifier in a manner that promotes systems-based care (p 257), and integrate quality reporting with requirements for "meaningful use" of electronic health records (p 247).

Thus, the academics' wish list for dictating acceptable medical practices is to be imposed from above, and the Physician Quality Reporting Initiative (PQRI), which originated in the 2006 Tax Relief and Health Care Act and has been tinkered with for several years, is to expand. The process is reminiscent of what occurred with the "pilot program" of diagnosis-related groups (DRGs), which was inflicted on hospitals nationwide without any apparent effort to analyze its effect on medical outcomes.[11]

In one of about 13 such provisions in the Act, the Secretary's establishment of methodology for determining an "episode of care" is insulated from administrative or judicial review (p 249).

A key part of the Secretary's national strategy to improve healthcare quality (p 260, §3011) is to "reduce health disparities across health disparity populations…and geographic areas." Thus "quality" may be defined by equality, with the implication that while some may receive more or better care, others may receive less or worse care, depending on where they live and what population subgroup they belong to.

The Interagency Working Group on Health Care Quality (p 262, §3012) includes senior-level representatives of agencies A through X, with A being the Department of HHS and X being any other federal agencies and departments with activities relating to improving healthcare quality and safety, as determined by the President. In between are the Coast Guard, the Dept. of Education, the Federal Bureau of Prisons, and 19 others.

The payment models to be tested (p 272) as replacements for fee for-service include varying payments to physicians according to adherence to appropriate criteria for ordering services. One redistributive mechanism is the accountable care organization (ACO), which "shall have a formal legal structure that would allow the organization to receive and distribute payments for shared savings…to participating providers and services and suppliers" (p 278)—and thus collectivize responsibility for denying care.

Insurance Mandates

Cost sharing for "preventive services" is prohibited (p. 33, §2713). This is likely to increase the demand for screening by low risk patients who don't value the service enough to pay for it, without necessarily bringing in high-risk patients who could benefit most. Increased short-term spending is assured; long-term savings are speculative.

Limits on insurers' spending on "administration," called "ensuring that consumers receive value for their premium payments" (p 19) could put many insurers, especially smaller ones, out of business. Few, if any, high-deductible plans, which are required for patients with health savings accounts (HSAs), can meet the minimum 80% medical-loss ratio.[3] The Secretary has the power to adjust requirements and may "use this flexibility to err on the side of ensuring that disruption and the accompanying political fallout are minimal until the exchanges are in place in January 2014."[12]

The Act puts the cost of "quality improvements" in the same category as "clinical services," not of administrative functions. The definition of "medical costs" has become the topic of heated debate.[12]

Price Controls

The Secretary, along with individual states, shall establish a process for annual review of "unreasonable premium increases" (p 21, §2794). To help the states cope with the additional burden, $250 million in grants will be appropriated over 5 years. There is as yet no regulatory definition for "unreasonable" and no federal authority to deny rate increases. Further legislation that would establish a national health insurance rate authority to set limits on premiums has been proposed by Sen. Dianne Feinstein.[13]

Eligibility

In the guise of "administrative simplification" (p 28, §1104), transaction standards will enable "to the extent feasible and appropriate," the "determination of an individual's eligibility and financial responsibility for specific services prior to or at the point of care." In addition, it will require timely status reporting that supports a "transparent *claims and denial management* process" [emphasis added]. This implies that access to services will by no means be universal, but rather contingent on eligibility. It looks as though this sets up a process for denying the services themselves, not just the claims afterwards.

Health plan certification (p 31) will require very extensive data and information systems for electronic funds transfers and a determination of eligibility for the plan, enrollment and disenrollment, health plan premium payments, and "referral certification and authorization."

With reference to the threat of "death panels," it seems reassuring that the Secretary shall "ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individual's age or expected length of life or the individuals present or predicted

disability, degree of medical dependency, or quality of life" (p 46). The term "essential benefits," however, is subject to definition, and individual wishes, to manipulation.

Insurance "Exchanges"

The centerpiece of "reform" is the Health Insurance Benefit Exchange. By 2014, all states are supposed to establish one or more exchanges, or else default to a national exchange. The exchanges would serve as clearinghouses through which consumers could purchase plans meeting minimum federal requirements, as well as all state mandates. Individuals or small businesses could buy a plan through an exchange; individuals receiving a tax subsidy or credit would be required to do so. After 2017, states have the option of expanding the exchanges to large employers.[3] In nearly every way, the Act mirrors the Massachusetts model, the Commonwealth Connector. Some suspect that a delay in guidelines for the state programs might be purposeful, and will cause more states to default.[14]

High-risk pools are supposed to help bridge the gap between now and the establishment of exchanges. More than 20 states have rejected the federal pools. Minnesota's Governor Tom Pawlenty cited concerns about "federal bureaucracy with centralized decisionmaking."[15] Then there's the cost: $5 billion was allocated, but cost is expected to be $15 billion by 2013. John Graham of the Pacific Research Institute called the $5 billion a "gateway drug" to "a complete federal takeover of our access to medical services," and applauded the wisdom of states that refused it.[16]

"Comparative Effectiveness Research" and Rationing

The goals of "patient-centered outcomes research" (p 609, §6301) are to determine the "effect on national expenditures associated with a healthcare treatment, strategy, or health conditions" and to reduce "practice variation and health disparities." Although the section on "limitations on certain uses of comparative clinical effectiveness research" (p 622, §1182) provides that the Secretary shall not use these findings to determine coverage in a manner that "treats extending the life of an elderly, disabled, or terminally ill individual as of lower value than extending the life of an individual who is younger, nondisabled, or not terminally ill," the next paragraph says this prohibition is not be construed as preventing the Secretary from using evidence to determine coverage based on a comparison of the difference in effectiveness of alternative treatments in extending an individual's life due to the individual's age, disability, or terminal illness. The actual meaning of this will probably be defined by the regulations that are to come.

"Fixes" to Medicare's Administrative Pricing System

Medicare has a complex scheme for varying payments by region, which is supposed to reflect varying costs and bring about fairness. See, for example, "extension of the work geographic index floor and revisions of the practice expense geographic adjustment under the Medicare physician fee schedule" (p 298, §3102). Perceived inequity in payment to hospitals and physicians in Oregon was supposedly corrected in order to obtain the vote of Rep. Peter DeFazio of Oregon. But the centralized, inherently arbitrary scheme remains in place.

Medicare disproportionate share hospital (DSH) payments for uncompensated care are "improved" (p 314, §3133), and the estimates that the Secretary makes for implementing them are not subject to administrative or judicial review (p 315).

The Independent Medicare Advisory Board

The heart of the effort to control Medicare spending is the Independent Medicare Advisory Board (IMAB) (p 371, §3403). The purpose of this section is to reduce the per capita growth rate in Medicare spending by (1) requiring the chief actuary of the Center for Medicare and Medicaid Services (CMS) to project spending growth; (2) requiring the IMAB to develop and submit a proposal containing recommendations to reduce the per capita growth rate if the projected spending exceeds the target; and (3) "by requiring the Secretary to implement such proposals unless Congress enacts legislation pursuant to this section." Thus it appears that by failing to act, Congress is delegating its authority to the Secretary.

The proposal shall include recommendations that "will result in a net reduction in total Medicare program spending…." However, "the proposal shall not include any recommendation to ration healthcare, raise revenues or Medicare beneficiary premiums…, increase Medicare beneficiary cost-sharing, including deductibles, coinsurance, and copayments, or otherwise restrict benefits or modify eligibility criteria." So how shall the objective be achieved—other than by reducing payments for services? And how shall this provision be characterized, other than as an extension of the sustained growth rate (SGR) concept to all expenditures?

The Act spells out the procedure to be followed for Congress to consider the proposals submitted by the IMAB (p 377), and it attempts to bind future Congresses: "It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report…that would repeal or otherwise change the recommendations of the board if that change would fail to satisfy the requirements [above]" (p 378). Additionally, "it shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report that would repeal or otherwise change this subsection." This prohibition could be waived or suspended in the Senate only by affirmative vote of three-fifths of the members.

For the first time in Medicare history, the chief actuary called the projections in the Medicare Trustee's report "implausible" and encouraged consideration of an "illustrative alternate" report. This report concludes that if the Act is implemented as written, 25% of hospitals, skilled nursing facilities, and home health agencies would be unprofitable by 2030, and 40% by 2050.[17]

Provider Enrollment

The Medicare, Medicaid, and CHIP Program Integrity Provision (p 629, §6401) includes screening of providers and suppliers, a provisional period of enhanced oversight, the imposition of temporary enrollment moratoria, and the establishment of compliance programs. These procedures are supposed to go into effect not later than 180 days after enactment. The Secretary will determine the level of screening required according to the

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risk of fraud, waste, and abuse. It may include a criminal background check, fingerprinting, unscheduled and unannounced site visits, and database checks. In order to be screened, each provider will have to pay $200 in 2010 ($500 for institutional providers), with increases in subsequent years based on the percentage change in the Consumer Price Index. Current providers will have to pay a fee for revalidation of enrollment two years after the date of enactment. New providers will be subjected to prepayment review and payment caps for up to a year following enrollment.

Any application for enrollment or revalidation must disclose any current or previous affiliation (directly or indirectly) with a provider or supplier that has uncollected debt, has been or is subject to a payment suspension under a federal healthcare program, has been excluded from participation under the program, or has had its billing privileges denied or revoked. If the Secretary believes any previous affiliation poses an undue risk of fraud, waste, or abuse, the Secretary may deny the application. The Secretary also has the authority to make "any necessary adjustments to payments" to a provider in order to satisfy any past-due obligations.

The Secretary may impose a temporary moratorium on the enrollment of new providers of services and suppliers, if she determines that such a moratorium is necessary to prevent or combat fraud, waste, or abuse. Such a moratorium is not subject to judicial review. She may also impose a numerical cap for providers or suppliers that she identifies as being at high risk for fraud, waste, or abuse.

No later than January 1, 2011, the Secretary shall promulgate a regulation requiring that all providers who qualify for a national provider identifier (NPI) include it in all applications for enrollment or claims for payment (p 638).

Must All Physicians Who Serve Medicare Patients Enroll?

A section that could be the equivalent of requiring a federal license to practice medicine, at least if a physician ever sees a Medicare beneficiary, is titled "Physicians Who Order Items or Services Required to be Medicare-Enrolled Physicians or Eligible Professionals" (p 650, §6405). This definitely concerns durable medical equipment and home health services, but the Secretary may extend (and has extended) the requirement to all other categories of items or services under title XVIII of the Social Security Act (Medicare).

Legal Consequences

Penalties on Insurers

The Secretary's standards for notifying beneficiaries of coverage or changing coverage will preempt any state standards (p 16). Entities shall be subject to a fine of $1,000 for each failure, and such a failure with respect to each enrollee shall constitute a separate offense. This is a regulatory cost, likely to subject beneficiaries to more "notifications," while providing a way to levy arbitrarily heavy fines on a disfavored insurer.

For plans failing to meet extensive reporting standards, the Secretary *shall* assess a penalty fee against a health plan in the amount of $1 per covered life per day until certification is complete (p 35). In addition, there are fees of up to $40 per covered life under the plan if the plan knowingly provides inaccurate or incomplete information.

Penalties for Failure to Maintain Coverage

Although the mandate is called a tax for purposes of arguing the constitutionality of the Act, the Act itself refers to a "penalty" imposed for every month without acceptable coverage (p 1265, §5000A). The amount depends upon one's modified gross income and family size, and will be indexed by cost of living adjustments. It begins in 2014 and ramps up quickly to a minimum of $2,085 for a family of four in 2016, with a maximum of 2.5% of annual income—still much less than the cost of "minimum essential coverage."

Curiously, the Act provides that criminal penalties are waived for failure to pay the penalty (p 131), and "the Secretary shall not file notice of lien" or levy any property by reason of failure to pay. However, IRS Deputy Commissioner Steven Miller has said that the IRS may withhold tax refunds from noncompliant individuals. The IRS could, notes Michael Tanner of the Cato Institute, apply part of a person's regular tax payments toward the mandate penalty, and then punish him for failure to pay regular taxes in full.[3]

Although employer penalties might be considered a tax, the Act calls them an "assessable penalty," which is not tax deductible (p 137).

Enhanced Civil Monetary Penalties

A civil monetary penalty of $50,000 is set for each false statement or misrepresentation of a material fact by any individual or entity on any application, agreement, bid, or contract to participate or enroll (pp 639-640). The penalty also applies to anyone who orders or prescribes an item of service during a period in which the person was excluded from a federal healthcare program, if he knows or should know that a claim will be submitted under such a program.

The $50,000 penalty also applies to any false record or statement material to a claim (p 652, §6408), presumably including any statement in the medical record used to document the service as well as on the claim itself.

Physicians must keep documentation related to referrals for items at high risk of waste and abuse, such as durable medical equipment or home health service (p 651, §6406). The penalty for failure to maintain and provide access on request of the Secretary to this documentation is $15,000 for each day of the failure to permit access, as well as revocation of enrollment for a period of not more than one year for each act. The effective date for this section is for acts committed on or after Jan. 1, 2010 (p 654), although the Act was not passed until Mar. 23, 2010.

Enhanced Power for Law Enforcement

The Act confers increased testimonial subpoena authority (p 641).

The government's burden of proof for healthcare fraud is reduced. Section 1128B of the Social Security Act (42 U.S.C. 1320a–7b) is amended by adding: "With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section."

If there is a "credible allegation of fraud," the Secretary has the authority to suspend payments pending an investigation. Potentially, this could stop most of a physician's cash flow for an indefinite period of time upon mere suspicion that a fraud may have occurred.

Enhanced Reporting and Self-incrimination

Even as Congress created a new program of gargantuan size and complexity, it recognized that since 1990 the Government Accountability Office (GAO) has designated Medicare a high-risk program "because its vast size and complexity make it vulnerable to fraud, waste, and abuse." In addition to strike forces, more rigorous screening provisions, and other law enforcement efforts, the Act apparently adopts the goal enunciated by James Sheehan, Medicaid's inspector general in New York: "to compel organizations to police their own activities. It shifts the burden to the provider to be vigilant about the legality of activities or potentially pay a price for not doing so."[18] For example, a provider that does not report an overpayment from Medicare or Medicaid and repay within 60 days is liable under the False Claims Act (p 637). Another such provision is requiring public disclosure of payments and other "transfers of value" to providers from manufacturers.[18]

Harsher Sentences

Federal sentencing guidelines will be revised to provide that the aggregate dollar amount of fraudulent bills submitted to the government healthcare program (not the amount paid) shall constitute prima facie evidence of the amount of the intended loss by the defendant (p 888, §10606). The U.S. Sentencing Commission shall ensure that the federal sentencing guidelines and policy statements "reflect the serious harms associated with healthcare fraud and the need for aggressive appropriate law enforcement action to prevent such fraud; and provide increased penalties for persons convicted of healthcare fraud offenses "in appropriate circumstances" (p 889).

Special-Interest Group Favors

Smoking Cessation Privileged

While healthy individuals cannot benefit from lower premiums, all who participate in certain favored "wellness" programs may be rewarded—as well as those offering the programs. The cost of a smoking cessation program is reimbursed (p 39), whether or not the individual quits smoking. Steven Schroeder, former president and CEO of the Robert Wood Johnson Foundation (RWJF), the most prominent promoter of such programs (and tax-funded support thereof), implicitly admits that they don't work very well. The prevalence of smoking has barely budged in recent years: It was 20.8% in 2006, 19.8% in 2007, and 20.6% in 2008. Schroeder makes a case for continued funding of tobacco cessation programs, claiming that "by assuming that the tobacco war has been won, we risk consigning millions of Americans to premature death."[19]

RWJF owns more than 42 million shares of Johnson & Johnson stock, valued at more than $2.2 billion. J&J profits from the sale of Nicoderm and Nicorette, and has cornered the marked on over-the counter nicotine replacement products, which show a 98.4% failure rate for long-term quitting.[20]

Priorities

The listing of favored "wellness and prevention" programs (p 18 and numerous other locations) and "chronic conditions" (p 203) reflects the priorities of reform advocates such as RWJF, which have for decades used grants to promote the funneling of legislative subsidies to entities that engage in certain activities. These prominently include smoking cessation, weight management, stress management, and chronic conditions. Working at, but never solving such problems could be a lucrative long-term program for stakeholders, diverting resources from the care of the sick.

Abortion Coverage

The wording related to abortion coverage (p 50, §1303) is artful and complex. Public funding is prohibited for some abortions, but allowed for others. Community health centers may provide abortions, and may receive federal funds, but the funds must be segregated. In any insurance exchange, the Secretary shall assure that there is at least one plan that provides coverage of abortion and at least one plan that does not (p 52). The federal premium subsidies are not to be used to bear the insurance risk for abortions—although money, of course, is fungible.

Grantees for Reporting and Payment Mechanisms

"Eligible entities" (p 265), which have been hovering around since the Clinton Task Force on Healthcare Reform and before, are in line for grants and contracts to develop the measurements, guidelines, and payment models, and provide the certified health information technology.

Expansion of Public, Contraction of Private Sector

Spending for federally qualified ("community") health centers is slated to increase from $3.0 billion in 2010 to $8.3 billion dollars for fiscal year 2015 (p 559, §5601). It is expected that the percentage of the U.S. population served by such health centers will increase from about 5% to 10%.[3] In these centers, the federal government assumes liability for alleged malpractice. As injured patients would have to sue the federal government, malpractice litigation is discouraged. Physicians employed there do not need to purchase professional liability insurance, giving them a significant competitive advantage over private physicians, who must collect sufficient revenue from patients to cover the cost of this insurance.

As the Act expands federally owned facilities, further restrictions are placed upon physician-owned facilities, in Title VI, Transparency and Program Integrity, Subtitle A, Physician Ownership and Other Transparency (p 566, §6001). A reported 60 physician-owned hospitals, which had promised to offer an innovative alternative to big corporate and nonprofit facilities, are virtually destroyed, and another 200 already-existing facilities may be put out of business by the Act. This is considered a victory for the American Hospital Association, the sixth biggest lobbyist in Washington, D.C.[21]

Continues ➲

"OBAMACARE", from page 21

Social Engineering, Ethical Issues, and Other Considerations

Marriage Penalty

Requiring inclusion of "children" up to age 26 in parents' coverage—*unless* married (p. 14, §2714)—is one example of a marriage penalty. Another is that the income threshold for subjecting couples to extra taxes is not double that for individuals, but only $50,000 higher.

Multiculturalism

Appeals processes (p 19, §2719) must provide enrollees information that is "culturally and linguistically appropriate."

In developing a "healthcare career pathway" (p 471), "cultural competency," health literacy, and dealing with "health disparity populations"must be included in the curriculum.

To be eligible for Mental and Behavioral Health Education and Training Grants (p 508, §5306), an applicant shall demonstrate "participation in the institution's programs of individuals and groups from different racial, ethnic, cultural, geographic, religious, linguistic, and class backgrounds, and different genders and sexual orientations." Any internships will have to prioritize "cultural and linguistic competency."

Social Leveling

"Nondiscrimination in healthcare" (p 42, §2706) prohibits better pay for better qualified personnel. It does, however, allow the Secretary or a health plan to establish varying reimbursement rates based on compliance with quality or performance measures. Thus, all providers acting within their "scope of practice" will be paid at the same rate, whether a nurse practitioner, primary-care physician, or fellowship-trained specialist.

"End-of-Life"Treatment

Individuals or institutions refusing to participate in "assisted suicide, euthanasia, or mercy killing" may not be discriminated against by government, entities receiving federal financial assistance under this Act, or health plans created under this Act (p 141, §1533). This protection, however, explicitly does not apply to or affect "any limitation relating to—(1) the withholding or withdrawing of medical treatment or medical care; (2) the withholding or withdrawing of nutrition or hydration; (3) abortion, or (4) the use of any item for the purpose of alleviating pain even if such use may increase the risk of death as long as such an item is not furnished with the purpose of causing, or the purpose of assisting in causing, death, for any reason."

Apparently, physicians are protected against retaliation for declining to perform what is recognized as euthanasia, but not for refusing to ensure death by abortion, overmedication, or withdrawal of fluid, nutrition, or medical care. This provision also may contradict other provisions of the Act that seem to protect those who decline to participate in abortion (p 53).

Immediately following is a provision (p 141, §1554) that the Secretary shall not promulgate any regulation that "creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care." Apparently, the Secretary defines "unreasonable" and "appropriate," and could define it to preclude any barrier to abortion. The prohibition apparently does not apply to health plans, which could perform the unpopular rationing functions.

Family Life

Enhanced surveillance of child rearing will begin with "at risk" populations (p 216, §2951), including smokers, drug abusers, low achievers, and members of the military or veterans. This includes home visits with extensive data collection on health-related measures, expansively defined to include poverty, school readiness, and crime.

The Secretary is encouraged to be concerned about postpartum depression (p 226, §2952), and the director of the National Institute of Mental Health may conduct a longitudinal 10-year study of "the relative mental health consequences for women of resolving a pregnancy (intended and unintended) in various ways, including carrying the pregnancy to term and parenting the child, carrying the pregnancy to term and placing the child for adoption, miscarriage, and having an abortion."

Personal Responsibility Education grants to states (p 229, §2953) are to help achieve goals for reducing pregnancy rates and birth rates in youth populations. Sex education materials must be "medically accurate and complete," which means "verified or supported by the weight of research conducted in compliance with accepted scientific methods and published in peer reviewed journals, where applicable; or comprising information that leading professional organizations and agencies with relevant expertise in the field recognize as accurate, objective, and complete."

School-based health centers will take over much of the family's responsibility for health, providing "comprehensive health assessments"; diagnosis and treatment of minor, acute, and chronic medical conditions; mental health and substance use disorder assessment; crisis intervention; counseling; and referral to emergency psychiatric care, community support programs, inpatient care, and outpatient programs. Health professionals in the centers will abide by parental consent and notification laws—as long as they are not inconsistent with federal law.

Social Transformation

The section on "Creating Healthier Communities" (p 446, §4201), establishes the rationale and infrastructure for a fundamental transformation involving redistribution of wealth and changing the basic culture of communities through Community Transformation Grants. There is to be "a detailed plan that includes the policy, environmental, programmatic, and as appropriate, infrastructure changes needed to promote healthy living and reduce racial and ethnic disparities," including "social, economic, and geographic determinants of health."

National Servitude

Student loans will be contingent upon a 10-year commitment to practice in underserved areas (p 488). Funding for the National Health Service Corps increases from about $320 million in fiscal year 2010 to $1.1 billion in fiscal year 2015

(p 494, §5207). A Ready Reserve Corps will be established (p 496, §5210), which shall "be available and ready for involuntary calls to active duty during national emergencies and public health crises, similar to the uniformed service reserve personnel." They are also to be available for "backfilling critical positions left vacant during the deployment of active duty commission corps members, as well as for deployment to respond to public health emergencies, both foreign and domestic, and to be available for service assignment in isolated, hardship, and medically underserved communities."

Conclusions

This analysis can only hit the highlights of a massive program, whose details are yet to be written in regulations. Only about one third of the Act's provisions would fit on a chart prepared by minority members of the Joint Economic Committee led by Rep. Kevin Brady (R-TX) and Sen. Sam Brownback (R-KS).[22]

Enactment of Obama Care has been called "a historic moment in U.S. social policy." Elenora E. Connors, J.D., M.P.H., and Lawrence O. Gostin, J.D., of Georgetown University Law Center write that: "Like Medicare and Social Security, which were highly contested before enactment, national health insurance reform hopefully will, in time, become part of accepted social structures."[23] Nevertheless, the program may be designed to fail.

"In case you didn't notice," writes Philip Jenkins, "all the actuarial assumptions that have kept the insurance system afloat for some 300 years just got repealed." The more egregious the failure, the louder the demands for an ever-larger state mechanism, he observes. "Failure is a terrible thing to waste."[24]

Implementation is not a fait accompli. Already there are bills to repeal at least sections of the Act, promises by many congressional candidates to repeal or defund it, and lawsuits to enjoin it.[25,26] States are signaling reluctance to accept costly and intrusive new programs, even to the extent of turning down federal funds. The leap in regulatory requirements and the increasing criminalization of medicine may finally lead to an exodus of large numbers of physicians—into truly private medicine. ◆

Jane M. Orient,M.D., is an internist practicing in Tucson, Ariz., and serves as executive director of AAPS. Contact her at jane@aapsonline.org.

Editor's Note:

Dr. Orient's article is addressed primarily to physicians, but dentists need to be aware of their at times involuntary participation in new federal health programs. As reported in the *Academy of General Dentistry Impact* in September 2010: "…the thrust of the requirement is that providers who refer patients who are Medicaid-eligible for Medicare-covered services or order Medicare-covered medical equipment must be one of two things: either enrolled in Medicare's Provider Enrollment, Chain and Ownership System (PECOS) or opt-out-of Medicare."

The Assn. of American Physicians and Surgeons has instructions on how to opt-out of Medicare at: www.aapsonline.org

The most recent ADA report on the relationship of dentistry and Medicare can be found at: www.ada.org/news/4732.aspx

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Early Detection, Diagnosis, and Treatment of Pemphigus Vulgaris

By Carla Benson, BS and Victoria Woo, DDS

The purpose of this article is to present an interesting clinical pathology case for review by dental practitioners. The differential diagnosis for each case will be discussed, followed by a presentation of the histologic, radiographic and/or laboratory findings that will aid in arriving at a definitive diagnosis. Appropriate management and treatment options will also be discussed.

Case Report

A 26-year-old male patient presented for evaluation of multiple, painful mouth sores affecting his tongue, buccal mucosa, and gingiva. He reported that these sores had been ongoing for five months and began shortly after an episode of "sore throat". According to the patient, the sore throat resolved in two weeks with no treatment; however, the oral lesions persisted and worsened over time. He was unable to correlate the lesions with any other precipitating events, including mechanical or thermal trauma, factitial injury, new medications, and exposure to cinnamon-containing products. Of note, the patient revealed that approximately two months prior, he had consulted an otolaryngologist for these lesions. The otolaryngologist had prescribed an alternating weekly regimen of 40mg and 20mg of prednisone daily for one month. During this month, the patient observed significant improvement of his lesions although complete resolution was never achieved. On questioning, the patient also recalled no changes in his dietary habits and denied any recent-onset gastrointestinal discomfort or diarrhea. Further review of the past medical history was unremarkable for any co-existing medical conditions and no prescriptions or OTC medications were being taken at the time of presentation.

Extraoral examination revealed no lymphadenopathy, no swelling, and no masticatory muscle or temporomandibular joint pain. On intraoral examination, numerous beige-yellow, linear and arcuate ulcers were identified, involving the patient's mandibular vestibule, labial mucosa, gingivae, soft palate, lateral/ventral tongue, and floor of mouth (*Figures 1 and 2*); the patient's hard palate appeared spared. The peripheral borders of the lesions were characterized by accumulations of epithelial slough. Additionally, ragged lesions with a mildly granular appearance were noted

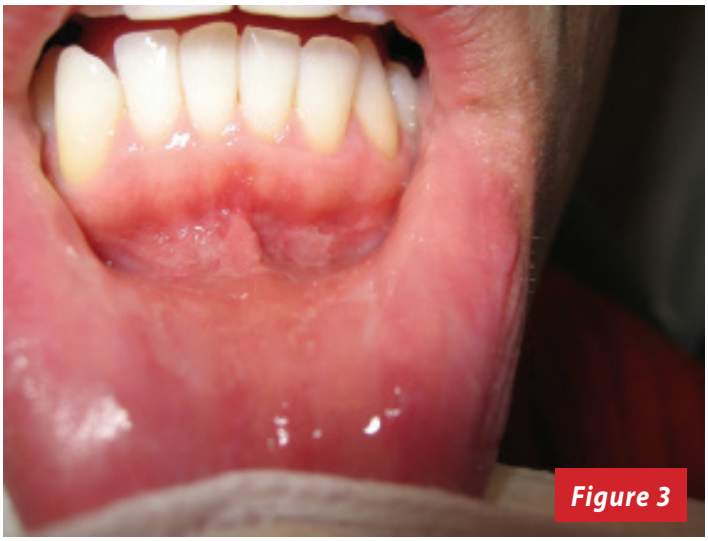
Clinical view of right lateral border of tongue showing multiple ulcers with irregular borders.

Clinical view of floor of mouth showing diffuse involvement by linear ulcers.

involving the mandibular vestibular mucosa (*Figure 3*). Examination of the eyes and nose revealed no conjunctival or nasal lesions, respectively. Cutaneous lesions were not evident on the exposed skin and the patient denied skin involvement elsewhere.

Based on the clinical presentation of the patient, the differential diagnosis consisted of an oral vesiculobullous disorder, including pemphigus vulgaris and erosive lichen planus; erythema multiforme; herpes simplex; a granulomatous inflammatory process such as Crohn's disease; and less likely, pyostomatitis vegetans. Erythema multiforme was not highly suspected due to the long duration of the patient's lesions and lack of characteristic features such as hemorrhagic crusting of the lips and targetoid skin lesions. Likewise, the diagnosis of herpes simplex was not favored given the relatively long duration and atypical location of the ulcers (predominantly non-keratinized mucosa) as well as reported improvement with corticosteroid therapy. Lastly, although our patient's lesions shared some clinical overlap with the oral presentation of Crohn's disease and pyostomatitis vegetans (a manifestation of ulcerative colitis), his lack of gastrointestinal symptoms rendered these diagnoses unlikely.

Given the unusual presentation of this patient's lesions, including the young age of onset, it was strongly recommended that mucosal biopsies be performed to provide a definitive histopathologic diagnosis. Incisional biopsies were obtained from the left lateral/ventral tongue and left mandibular vestibule. Histologic examination of both specimens revealed an intraepithelial clefting process (acantholysis), consistent with pemphigus vulgaris (*Figure 4*). Viral cytopathic effect, as seen in herpetic lesions, was not observed. Tissue was also submitted for direct immunofluorescence (DIF) studies, which revealed intercellular localization of immunoglobulin G (IgG) and complement 3 (C3) (*Figure 5*), further supporting the diagnosis of pemphigus vulgaris.



Clinical view of mandibular vestibule showing ulcers with ragged borders associated with a "piled-up" appearance to the superficial epithelium.

After consultation with the patient's physician, he was placed on oral prednisone with a strict tapering regimen. On follow-up 1 month later, his lesions exhibited almost complete resolution (*Figures 6 and 7*) and the patient noted significant improvement in his symptoms. He is currently lesion-free, on a maintenance dose of prednisone (2.5mg on alternate days) with no reported adverse effects.

Discussion

Pemphigus vulgaris (PV) is an intraepithelial blistering disease which affects skin and mucous membranes. Involvement of the oral mucosa is seen in over 50% of all

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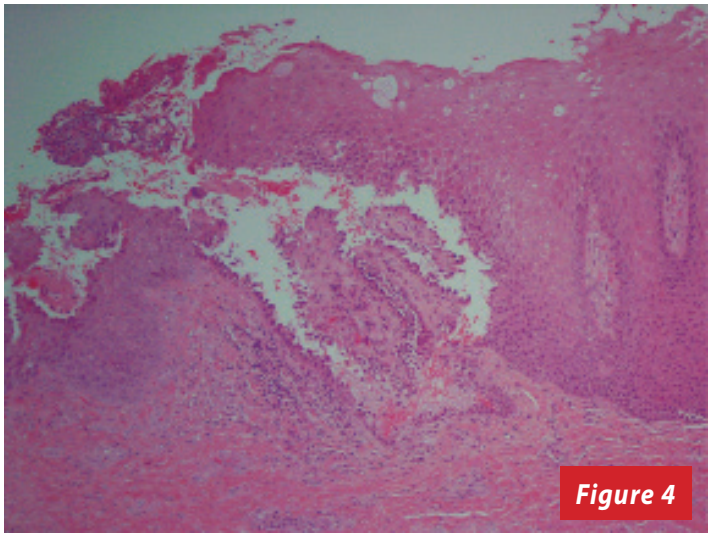
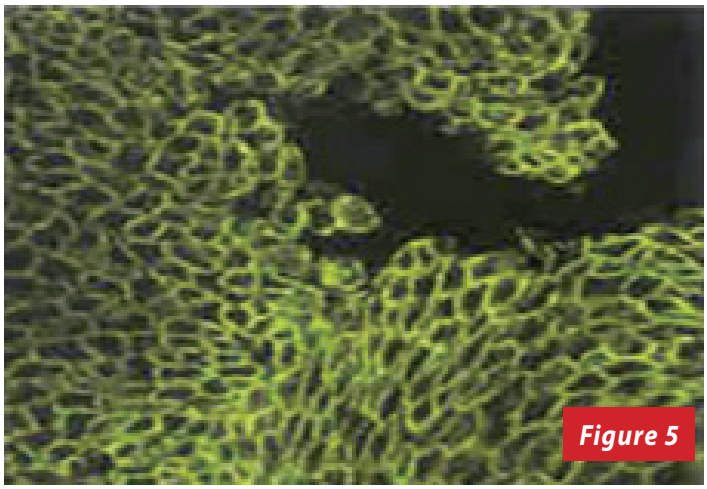


Microscopic view showing suprabasilar clefting (acantholysis) and "tombstone" formation of the epithelial basal cells (hematoxylin and eosin, 10X magnification).



Fluorescence microscopic view showing intracellular localization of IgG in a "chicken wire" pattern.

cases, with oral lesions being the presenting sign in 75% of cases.[1] PV tends to be a disease of older individuals (>50 years); however, rare examples in children to young adults have been reported.[1]

PV lesions must be recognized and diagnosed for appropriate treatment to be rendered. Flaccid blisters which contain clear fluid can be seen involving the skin of affected patients, especially on the scalp and face. The blisters can rupture, leaving superficial erosions which may be painful but rarely itch. Similar lesions can be seen on the mucous membranes although intraorally, early rupture of the blisters results in the more typical appearance of diffuse mucosal ulcerations rather than intact vesicles or bullae. Lesions may present on any oral or oropharyngeal surface, but are commonly seen in the buccal, palatal, and gingival regions of the oral cavity. The ulcers have ill-defined, ragged margins and may be bordered by epithelium that appears to be "piled-up" at the periphery. Affected areas may also demonstrate blister formation on exposure to gentle lateral pressure, a finding known as a positive Nikolsky sign.[1] Although this can be seen in other vesiculobullous disorders, such as mucous membrane pemphigoid, a positive Nikolsky sign can help to support a diagnosis of PV in conjunction with clinical and histologic findings. Interestingly, oral lesions have often been described as "the first to show but last to go", indicating that they tend to be the most challenging to clear.[2]

PV is an autoimmune disease mediated by circulating antibodies—namely IgG—directed against desmosome-associated protein antigens.[3] Desmosomes are structures that function to adhere epithelial cells to each other. Specifically, PV patients produce autoantibodies directed against two components of the desmosomes known as desmoglein 1 (Dsg 1) and desmoglein 3 (Dsg 3).[4] The binding of IgG to the desmogleins results in a loss of cell-to-cell adhesion, termed *acantholysis*.[2] This acantholytic process leads to formation of an intraepithelial vesicle that manifests clinically as fragile blisters that slough off, producing diffuse sores.[2] Microscopic examination of the blisters and adjacent mucosa or skin (perilesional tissue) will show a separation of the epithelium above the basal cell layer (suprabasilar clefting), leaving a row of basal cells with a "tombstone appearance" that remain attached to the floor of the blister and underlying connective tissues.[2]

Distinguishing PV from other vesiculobullous, blistering diseases can be challenging because of significant clinical and sometimes histologic overlap. Historically, the term "pemphigus" once included most bullous dermatologic eruptions.[5] However, improvements in diagnostic and molecular testing have permitted more accurate classification of these bullous diseases, including distinction between different forms of pemphigus such as pemphigus vulgaris and pemphigus foliaceaus.[5] One test that has proven valuable in the evaluation of vesiculobullous disorders is immunofluorescence (IF). IF is an ancillary test that involves the labeling of autoantibodies with fluorescent dyes and can be performed on tissue (direct IF) or serum (indirect IF).[3] In PV patients, IF will show deposition of these dyes and along the desmosomes between the epithelial cells, indicating the presence of the autoantibodies at these sites. This will manifest as a highlighting of the interepithelial spaces in a so-called "chicken wire" pattern. Preserving the tissue in a special medium (Michel's solution) is essential for direct IF as fixation in traditional formalin will destroy antigen proteins, deeming the direct IF process useless. Indirect IF involves obtaining the patient's blood in order to detect circulating autoantibodies. In PV, a positive titer is seen in approximately 80% of patients.[4] Therefore, it is important to note that a negative indirect IF does not rule out PV. On the other hand, a

Figure 6

Clinical view of right lateral tongue one month after treatment.

Figure 7

Clinical view of floor of mouth one month after treatment.

positive result is a useful diagnostic tool and can also be helpful in assessing therapeutic response and predicting disease relapse.

Treatment of PV is aimed at reducing symptoms and preventing complications, such as infections. A systemic oral corticosteroid regimen, usually prednisone, is the first-line treatment for PV.[6] The corticosteroids are given initially in fairly high doses until the lesions are cleared, then gradually tapered to as low a dose as possible while still maintaining remission. Anti-inflammatory drugs (e.g. dapsone) as well as immunosuppressive drugs (e.g. azathioprine, methotrexate, cyclosporine, cyclophosphamide, and mycophenolate mofetil) may be administered in addition to the corticosteroids and serve to reduce the overall steroid dose (steroid-sparing effect).[6] Adjunctive therapies may include IV administration of fluids, protein, and electrolytes. Plasmapheresis, a process by which a patient's plasma is removed and replaced with IV fluids and plasma donated from a patient without PV [3], is an option but used uncommonly today. Lastly, intravenous gamma globulin (IV Ig) is an effective alternative in select cases of PV.[6] Mild PV cases may respond to the application of topical steroids, although complete control of lesions tends to be rare with topical therapy alone.[6] Antibiotics are indicated should the ulcerative lesions become secondarily infected. Lastly, palliative measures can be used for localized symptom relief, such as talcum powder applied to prevent ooze from adhering to clothing and other materials in contact with the lesions.

Delays in the treatment of PV can be fatal, with mortality related mostly to infection of the sores and loss of electrolytes. However, treatment itself can be associated with side-effects that can be severe and even debilitating. In particular, long-term use of systemic steroids can lead to serious problems such as cataracts, diabetes, and increased risk of infection, osteoporosis and increased risk for bone fractures, suppressed adrenal gland hormone production, and delayed wound healing.[6] In addition, care must be taken in adjusting steroid dosing as abrupt corticosteroid withdrawal may lead to an inability of the body to respond adequately to the acute physical stress of illness or injury (adrenal crisis). Therefore, the primary goal of PV treatment is to maintain the patient on the lowest steroid dose possible to control the condition.[2] This is best accomplished with a closely managed corticosteroid tapering regimen prescribed by a clinician with expertise in immunosuppressive therapy. Careful monitoring of patients by their healthcare providers—which may include physicians, rheumatologists, dermatologists, and dentists—is crucial to limit treatment side effects and yet achieve the most effective treatment of PV.

Timely recognition is also of utmost importance as it has been shown that patients treated in the early stages of PV respond better to therapy and experience less relapses.[1] Therefore, early diagnosis generally portends to a better prognosis.[1] Uncommon as it is, dental professionals should not rule out PV in their differential diagnosis of chronic and diffuse ulcerative oral lesions. As the oral lesions of PV are "the first to show", astute awareness of this condition gives the dentist a unique opportunity to refer the patient to an appropriate specialist for treatment. Ultimately, this can have an enormous impact on the patient's prognosis and quality of life. ◆

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Carla Benson, BS, is a Student Doctor, Class of 2011, School of Dental Medicine, University of Nevada, Las Vegas, Nevada.

Victoria Woo, DDS, is an Associate Professor In-Residence, School of Dental Medicine, University of Nevada, Las Vegas, Nevada.

SNDS Executive Director's Message

Robert Anderson

Our fifth annual Community Night has come and gone, and I'm happy to report it was a success. We had great attendance and solid support from our many corporate partners. It was a great kick-off for our program year!

I'm also happy to report that more than two dozen of our members have volunteered to be mentors for students from the UNLV School of Dental Medicine. This can be a very rewarding program and a real win-win for the dental profession. Making the transition from school to practice can be a great leap for a new dentist, and as much help as is offered by the ADA, NDA, and SNDS, these volunteer mentors are the real medium for helping students to bring all of these resources together. More and more students want to access this opportunity, but more volunteers are still needed to ensure that this is a worthwhile program. Please contact the SNDS office if you are interested in volunteering. I should also thank LVI for their continued support of the mentor program as our traditional hosts for the mentor program kick-off. It's great to see so many elements of the dental community come together to create a meaningful, successful program that can do so much good.

Our CE series is set to kick off, and in addition to the many members who have already signed up for our series (a bargain that works out to less than $190 per seminar!), many have signed up for individual seminars in the series. This includes dentists from Alaska, Kansas, Indiana, and elsewhere around the country. While we often have dentists coming in from out of town for our seminars, I can't remember when the response has been this strong from so many diverse locations. There is still time to sign up for the entire series; call the SNDS office or check online.

We are also finalizing details on our CE Café series. This series is comprised of two hour seminars, held after work, on niche topics ranging from practice management to clinical. Again, thanks to our partners we are able to provide this series and 8 CEUs, free to members. Watch the prezfax and our website for details.

There will not be a dinner meeting in October due to the proximity of the ADA Annual Conference Schedule. We'll be meeting again in November.

In the coming months you'll be hearing about more opportunities to stay connected with the SNDS events, political issues, and education. Our website is going through some upgrades, and our 2010–2011 member directory will be coming out soon. All together, we hope this season will mark some real advances for the SNDS, and for our members. ◆

Evangeline Chen, DDS

Our program year has begun, and I must say, things move very quickly!

As I write this, our Fifth annual Community Night has taken place and was a great success. I felt very privileged to have met and spent time chatting with Dr. Fae Ahlstrom, for whom our Heritage Award is named. She is an outstanding representative of our profession, and a charming person. As I also was able to meet our representatives from the UNLV School of Dental Medicine ASDA chapter, I was struck by the many generations of dentists gathered at our meeting. There is so much we can learn from each other, not just about new technologies, but about our profession, past, present, and future. And of course, I was happy to have as our guest a family member of Dr. William D. Berry, this year's recipient of the Fae Ahlstrom Heritage Award. Dr. Berry was not able to attend due to health reasons, but I look forward to going and meeting him and presenting him with the award in person. Dr. Berry, Dr. Ahlstrom, and many others like them, blazed a trail for us to follow in our practices, and I'm happy to see that they are recognized for their many contributions.

We are preparing now for our mentor program kick-off, bringing our members and the UNLV dental students together in a hopefully enriching relationship. The students, of course, are approaching the point where they will be making that great leap from school to active practice. But for our members who volunteer as mentors, it can also bring some rewards. We all care about our profession, and have ideas about how we'd like to see things change, but our mentors have the rare opportunity to actually influence the future. I'd like to think that it's also rewarding to see the next generation of practitioners take their places.

In the meantime, as President, I'm finding the many aspects of keeping our society running well. We have our dinner meetings, of course, and our CE seminars. But amidst this political season, there are many influences and issues cropping up that will affect not only our practices, but also the concerns and care of our patients. Politicians have constituents, but we, as oral health care providers have patients, after all, and their care is our primary concern. I'm impressed at how the Nevada Dental Association leadership works to reconcile the many political agendas with what is best for the care of our patients.

Due to the scheduling of the ADA Annual conference in Orlando this year, we will NOT be having a dinner meeting in October. But we will be kicking off our annual Continuing Education series with Dr. Donald Lewis. Dr. Lewis will be giving a personal and in-depth presentation on his experience with embezzlement in his practice. This is a very real concern for any business or practitioner. Our Continuing Education Chairman, Dr. Joel Casar, has put together a series that incorporates practical practice management subjects such as this one, with solid clinical topics and excellent presenters such as Dr. Carl Misch, all in one series. I encourage you to sign up today for our CE series. It truly is one of the great bargains of being an SNDS member!

We will also be having the first of our CE Café seminars in October. Watch our website and prezfax for details. This series is presented free of charge to our members, who can acquire 8 CEUs for free simply by attending this after work series.

All of this is possible, in part, to our many members who volunteer their time as delegates and committee members. We also have a good number of corporate partners who make so much of this possible. As your President, I continue to be impressed with all of the support the SNDS receives from its members and the community that enable us to continue making a difference.

I look forward to carrying on the vision and goal of our immediate past president, Dr. George McAlpine, to further improve communication with our members and to aggressively address the needs of the membership. My fellow officers and I are working hard to make progress in this endeavor and anticipate greater enthusiasm and increased involvement from all of our fellow members. ◆

NNDS Executive Director's Message

Lori Benvin

Autumn has begun in northern Nevada. I love the change in colors and cooler temperatures; and with optimism autumn brings hope of better economic climate for all of us. Please take a moment to read your current NNDS President's editorial in this journal *(see page 31)*. Dr. Handelin brings up some vital points and it is certainly worth the read and your time.

Continuing Education opportunities in Northern Nevada

We have some great CE sessions lined up for 2010–11. Your Speaker Chair, Dr. Brandi Dupont, has done a great job in booking some talented guest presenters; so we hope the topics for this year's lineup will spur many of you to attend. Please remember that our monthly dinner meetings also include continuing education units in addition to our all-day courses. All of our dinner meeting notices are sent only via email. If you have an email address and you have not been receiving emails from the NNDS, please contact me at 775-337-0296 so I can be sure your address is included.

Our all-day speakers this season include:

- November 5, 2010—Dr. Paul Feuerstein, "Dental Technology Review and Update."
- March 11, 2011—Dr. Richard Williamson, "Update in Contemporary Removable Prosthodontics."
- May 6, 2011—"Annual OSHA Update" and CDC info and requirements as voted upon by the NSBDE.
- November 11, 2011—Dr. Stanley Malamed, "Emergency Medicine."

NNDS Website

The NNDS website will be under construction to update and improve our seven-year-old site. As with all technology and age comes glitches and hiccups, so we are excited to show you our new site and features and hope that it will be much more user-friendly for you, your staff and the community. Please watch for our new face-lifted site at www.nndental.org.

Northern Nevada Dental Health Program & Pro-Bono Dentistry

If you are a pro-bono provider of dental care for NNDHP or any other program we want to know. Please fax your superbills to the NNDS office at 775-337-0298 if you are treating patients pro-bono in your office. We need to report that information to the NDA so our incoming legislators know how *you* are giving back. If you are a NNDHP provider, please continue to fax your superbills after treating a NNDHP child to the NNDHP office fax directly 775-770-6375. Thank you for your extreme generosity to this community!

Do you want to get involved? Do you want to be informed? Become a NNDS Delegate.

Here's how: The NNDS is looking for you. As a Delegate you represent your fellow society members biannually at the Nevada Dental Association House of Delegates meeting; once in February and again in July. If you want to stay informed, be a part of issues facing your profession or to be a part of making your dental association better and stronger, then become a Delegate.

Continues ➲

Annual NNDS Member BBQ

Bartley Ranch Park

NNDS President Mark Handelin and Nick Benvin

NNDS President's Message

Mark J. Handelin, DDS, MSD

As I write this the days are beginning to shorten and the temperature is creeping ever lower. Fall is upon us with all of its grandeur.

This fall is especially important to our great state due to the mid-term elections being held this November. No matter what your political affiliation please make sure your voice is heard and vote. Shortly after you read this article, the makeup of our state assembly and senate will be determined and the legislative rat race of 2011 will be underway. As many of you know, there will be a marked turnover in both houses this year due to the mandated term limits for both houses that our state passed in 1996. This turnover will greatly alter the familiar faces dentistry has known for years and we must work diligently this legislative year to introduce ourselves to our newly elected legislators. All of you have received a letter from our NDA President, Dr. John DiGrazia, requesting help bolstering our political action committee (PAC) funds for the upcoming session. Please re-read this wonderfully written letter and make a donation to the NDA PAC fund.

The PAC funds have enabled the dental society to introduce our issues to many candidates and legislators. We are all very fortunate to have Jeannette Belz representing our interests. I have seen firsthand the work and time she has put into her position as dental society lobbyist and have found her advice sage, her energy unrelenting, and her commitment true. Ms. Belz, Dr. Talley, Dr. David White, and Dr. Jim Jones have been very active in meeting as many candidates as possible and discussing the issues we face and touting our contributions to our local communities. I encourage all of you to attend the Mid-Winter Meeting in February 2011 where Ms. Belz and the Legislative Committee will present the legislative issues our profession, our business, and our patients will face in the upcoming session.

Please watch your email inboxes for the ADA legislative updates as well as Dr. Talley's Capwiz emails. The emails that Dr. Talley send enable us to easily and effectively send letters to our elected representatives. The effectiveness of these emails relies on shear numbers, so please respond as soon as you can.

The importance of swift and abundant responses to our legislators is critical to maintain the ownership of our profession. Should we choose to abdicate the responsibility to protect the sacred dentist-patient relationship the vacuum will be filled by attorneys, insurance executives, politicians, and others who have "managed" medicine into its present convoluted and deficient condition. We cannot follow the example set by our physician brethren of the late 70s and early 80s who instead of leading medicine into the future became passive followers who were willing to allow others to determine how they would deliver care to their patients. Dentistry is now facing the same challenges they faced, but thirty years later. Our unified stance and the education of our patients will be critical to keep these interests at bay.

This legislative session may prove to be another challenge to our profession. The next time you see Ms. Belz, Dr. Talley, Dr. White, Dr. Jones, and Dr. DiGrazia give them a big hug and a hearty thank you for their time and energy spent on behalf of all of us. Bobby Jones once said "You get bad breaks from good shots, you get good breaks from bad shots, but you have to play the ball where it lies." We all live with decisions that politicians make, however it's much more palatable if we're at the table helping them make informed decisions.

On another note, I'm extremely excited to announce that the NNDS has begun the process of revamping our website. In the coming months we hope to have a new look that will greatly increase its functionality. We are continuing to strive to be as efficient and effective as possible and our new website will help immensely. Our goal is to become as paperless as possible, so please be sure to update the dental society should your email address change.

Thank you very much for your time and your support. Grab a friend and let's catch up at the next monthly membership meeting! ◆

Exec. Director, from page 30

Again, the time commitment of becoming a Delegate is only twice each year. For more information, contact our Chief Delegate, Dr. Frank Caffaratti, at fdcdds@gmail.com or myself. We would be happy to tell you more about it.

If this doesn't sound like something you want to do, we'd be happy to tell you more about our other hard-working committees that help your profession and your practice. Call or email me at nnds@nndental.org. ◆

UNLV School of Dental Medicine Report

Karen P. West, DMD; UNLV SDM Dean

Greetings from the SDM!

Student Body

We are pleased to welcome 80 new students into the Class of 2014. From a total of 2,346 applicants we selected 22 females and 58 males to join the ranks of the School of Dental Medicine student body. 56 of the students are from Nevada while 24 of them are from other states which include Arizona, California, Florida, Utah, Montana, Virginia, Washington and Connecticut. 14 of the students are from UNLV while 8 went to UNR. This year for the first time, the students were assigned advisors for year one so as to have a mentor to help guide them through their initial adjustment to dental school. Later, their clinical mentors will work with them as they are initiated into the patient care environment.

The class was welcomed by ASDA at a student party and the SDM had our traditional Mt. Charleston picnic with the mountain trail hike led by Dr. Ron Lemon.

We congratulate our student body for their involvement in community activities. They give countless numbers of hours toward providing free care to the community. During the past year, almost $500,000 of free or reduced dental care was provided to Las Vegas and its surrounding areas. In addition, they are recognized yearly for their contributions to the ASDA and the American Dental Education Association.

Also, this was an outstanding year for Part 1 national board performance. With only a 3% failure rate and average scores well above the mean, we also give kudos to the Class of 2012.

Pediatric Dentistry

Six new residents began the fully-accredited Pediatric Dentistry Program on July 1, 2010. Two new rotations for the residents have been developed with the Children's Center for Cancer and Blood Disorders of Las Vegas and with the Lied Pediatric Clinic at UMC. Dr. Arlene Joyner has joined the faculty as a full time associate professor of pediatric dentistry who comes to the program from private practice in Los Angeles, California. The inaugural class of pediatric residents completed their 2 year program on August 31, 2010. We were quite proud of all of their accomplishments in the clinical and research arena.

Orthodontics

Four new residents/graduate students began the program on July 1, 2010. This is the second class to matriculate through the newly developed 30+month Masters curriculum. Currently we have nine residents and three fellows functioning as an efficient team with our faculty for patient care activities. We have approximately 150 applications for next year's class and are beginning the review for interviews. Two of our faculty members have left for private practice and our part-time faculty have increased their time with us as we recruit for their replacements.

Faculty

Many of our faculty have been recognized for their achievements and contributions to dental education and to the dental community:

- **Dr. Karl Kingsley**: Awarded promotion and tenure as Associate Professor on July, 2010. He was the first full-time faculty member to successfully complete the promotion and tenure process as UNLV SDM.
- **Dr. Rick Thiriot**: Honored for his outstanding volunteer activities with the UNLV SDM students by the Volunteers of America, October, 2010.
- **Dr. Andrew P. Ingel**: Awarded Fellowship in the Academy of General Dentistry in July, 2010 and awarded Fellowship in the Pierre Fauchard Academy in October, 2010.
- **Dr. George F. Richards**: Elected to OKU in February, 2010.
- **Dr. Edward Herschaft**: Gained membership to the Board of Directors of Smile Specialists Foundation, Inc. and included in the publication *Las Vegas Top Dentists—2010.*
- **Dr. Marcia Ditmyer**: Accepted into the American Dental Education Institute, 2010-2011.
- **Dr. Christine Ancajas**: Appointed State Dental Officer for the Nevada Army National Guard.

Announcements

- **Dr. Wendy Woodall** and **Dr. Rick Thiriot**—named Interim Co-Associate Deans for Clinical Services.
- **Dr. David Ord**—named Director of Quality Assurance.
- **Dr. Frances Curd**—named Director of Alumni Affairs and External Relations.
- **Dr. Marcia Ditmyer**—named Director of Outcomes Assessment.
- **Dr. Wenlian Zhou**—appointed Assistant Professor in Residence in the Department of Clinical Sciences.

Events

- The **Fall Golf Outing of the School of Dental Medicine** will be held on October 22,. Please contact Karleen Smith at 774-2504 if you would like to join this annual event.
- The **Part-time, Adjunct and Volunteer Faculty Appreciation Dinner** will be held on November 8 at the Foundation Building on UNLV Main Campus. Please contact Lori Polster at 774-2727 for information ◆

Southern Nevada Dental Society

2010-2011 Continuing Education Series

October 22, 2010

Dr. Donald Lewis

"Doctor, your check has bounced, AGAIN!"

This is a special seminar open to ONLY doctors, their spouses and their accountants.

After many years in the private practice of Oral and Maxillofacial Surgery, he found out that he was a victim of a very silent and financially devastating crime – employee embezzlement and fraud. After the investigation and prosecution of this crime and recovering lost revenue, Dr. Lewis began to extensively research the subject of white-collar crime.

***Thursday*, December 2, 2010**

Dr. Carl Misch

"Treatment Plan For Progressive Loading of Implants"

Carl E. Misch is Clinical Professor and Director, Oral Implantology at Temple University, Philadelphia. Dr. Misch serves on the Board of Trustees at the University of Detroit Mercy where he is also an Adjunct Professor in the Department of Prosthodontics. Dr. Misch has maintained a private practice restricted to implant surgery (bone grafting and implant placement) and related prosthetics for more than 30 years. He currently practices in Beverly Hills, Michigan.

March 18, 2011

Dr. Joseph Blaes

"Pearls for Your Practice"

Dr. Blaes has created a unique, innovative, insurance-free, fee-for-service general practice in St. Louis, Missouri, that emphasizes preventive, esthetic, reconstructive and implant dentistry. Because of his interest in new and innovative materials and techniques, Dr. Blaes began writing "Pearls for Your Practice" in Dental Economics. The column quickly became a trusted resource for new dental materials and techniques. In October 1996, he was named editor of Dental Economics and is responsible for the new editorial direction of the magazine. His lecture and hands-on programs for dentists and auxiliaries have won rave reviews around the country.

April 15, 2011

Dr. Robert Cronin

"Etiology and Restoration of Worn Dentition"

Dr. Robert J. Cronin, Jr., D.D.S., M.S., is the Director of the Postdoctoral Prosthodontics Program and Professor at The University of Texas Health Science Center at San Antonio Dental School. Dr. Cronin is a Diplomate of The American Board of Prosthodontics and has written and lectured extensively on prosthodontic and dental implant topics. He served as Chairman and Director of the Graduate Prosthodontics Program at Wilford Hall USAF Medical Center and as the Special Consultant in Prosthodontics to the Surgeon General. Dr. Cronin maintains an active faculty practice with an emphasis on dental implant-based oral rehabilitation with an esthetic and functional focus.

All seminars are at the Gold Coast Hotel and provide 6 CEU's

4000 West Flamingo Road, Las Vegas, NV Seminar Hours: 9am - 4pm Registration opens at 7:30am

Fee Schedule

(Check all that apply)

ADA CERP

TOTAL:

$

Complete Series:

Early Bird (2 weeks prior): ☐ $750 ADA Member

Regular & At the Door: ☐ $800 ADA Member ☐ $1,250 Non-Member

Individual Seminars:

Early Bird (2 weeks prior): ☐ $275 ADA Member

Regular & At the Door: ☐ $300 ADA Member ☐ $450 Non-Member

☐ $100 SNDHA Member Hygienist ☐ $125 Non-Member Hygienist

☐ $75 Auxiliary ADA Staff Member ☐ $100 Auxiliary Non-Member

☐ $100 Dental Students & Residents

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Mail, fax, or email information to: **Southern Nevada Dental Society**

8863 West Flamingo Road, Suite 101, Las Vegas, NV 89147 Phone: 702-733-8700 Fax: 733-6062 Email: S_nds@hotmail.com

Recordkeeping for Emergency Appointments

It's a scenario that many dentists experience: a new patient calls and arrives in the dental practice a few minutes later with a need for emergency care, and the dental staff has limited time to create a complete chart for that patient. Even if there is time to create a chart for this new patient, it may only be a one-time visit for this patient, and the new chart may take up space among active patient charts. The recordkeeping experts at The Dental Record have a solution to save dentists time and valuable recordkeeping space when creating emergency patient records.

The Dental Record has created a unique Emergency Record that measures a compact 6" x 9", yet it is a complete mini record that includes information on patient registration, patient history, the doctor's notes, and release and consent information as well. There is no need to create a full chart for a patient a practitioner may see only once.

A front office staff person can begin logging information from the patient's first telephone contact, eliminating the need for the patient to repeat details when he or she arrives at your office. The Emergency Record provides space to record information on past treatments, illnesses, current medications or pertinent medical conditions.

Ms. Lee Johnston, President of The Dental Record, believes their Emergency Record will help dentists in many ways. "The Emergency Record is a big value in small packaging. Now dentists can save valuable record space among their active patient files, yet still have all the critical information they require. There's no need to create a whole chart for the patient dentists may see only one time." The Emergency Record provides room to write detailed treatment notes, plus a section to verify that release and consent was obtained after discussing the treatment plan, the risks involved, the procedure, and alternatives prior to performing services.

If the patient subsequently becomes a patient of record, the Emergency Record is two-holed punched and can easily be incorporated into a permanent record.

For more information about Emergency Records, please call The Dental Record at 800-243-4675, or visit www.dentalrecord.com. For a limited time only, mention your state endorsement and receive 15% off your first order of Emergency Records. ◆

Calendar of Events

OCTOBER–DECEMBER 2010

OCTOBER 2010

NOTE: SNDS October dinner meeting canceled due to conflict with ADA meeting

OCT 20	SNDS Peer Review Committee Meeting	6 pm	Call SNDS for location, 702-733-8700
OCT 21	AGD General Membership Dinner Meeting, "Legislative Update"	6 pm	Coney Island Bar & Grill, Reno
OCT 22	SNDS CE Seminar—Dr. Donald Lewis, "Doctor, your Check has Bounced. *Again*!"	9 am–4 pm	Gold Coast Hotel, 4000 W Flamingo Rd, Las Vegas
OCT 26	SNDS Executive Committee Meeting	6 pm	SNDS, 8863 W Flamingo Rd, Las Vegas
OCT 27	NNDS Peer Review Committee (if clinical)	5:30 pm	3575 Grant Dr, Reno

NOVEMBER 2010

NOV 2	NNDS Executive Committee Meeting	5:30 pm	161 Country Estates Cir, #1B, Reno
NOV 4	NNDS General Membership Dinner Meeting, featuring Dr. Paul Feuerstein	6–9 pm	Peppermill Hotel Casino, Reno
NOV 5	NNDS Continuing Education Course—Dr. Paul Feuerstein, "Dental Technology Review & Update"	8 am–4 pm	Peppermill Hotel Casino, Reno
NOV 9	SNDS Dinner Meeting	5:30 pm	Gold Coast Hotel, 4000 W Flamingo Rd, Las Vegas
NOV 10	SNDS Dentist Health and Wellbeing Committee Meeting	6 pm	Call SNDS for location, 702-733-8700
NOV 16	SNDS CE Café— Allen Kim, "Last Minute Tax Strategies"		
NOV 17	SNDS Peer Review Committee Meeting	6 pm	Call SNDS for location, 702-733-8700
NOV 18	AGD General Membership Dinner Meeting	6 pm	location: tba
NOV 24	NNDS Peer Review Committee (if clinical)	5:30 pm	3575 Grant Drive, Reno

DECEMBER 2010

DEC 2	SNDS CE Seminar—Dr. Carl Misch, "Treatment Plan for Progressive Loading of Implants"	9 am–4 pm	Gold Coast Hotel, 4000 W Flamingo Rd, Las Vegas
DEC 7	NNDS Executive Committee Meeting	5:30 pm	161 Country Estates Cir, #1B, Reno
DEC 10	NNDS Annual Christmas Party & Dance (Hawaiian theme)	6:30 pm	Hidden Valley Country Club, Reno
DEC 10	SNDS Holiday Party		
DEC 17	AGD Holiday Party	6:30 pm	Drs. Jason & Cariann Champagne's home

NDA Mid-Winter Meeting • February 11-12, 2011
Silverado Resort, Napa Valley, CA

SILVERADO

CLASSIFIED ADS

Dental Opportunities

Immediate Opening for Full time, Part time, Weekend, Extended Hr—Multi-location group practice seeking Dentist (GP, ortho, endo, OS, Pedo), Hygienist, office manager, team members. FT, PT, weekends, afterhours. You must be motivated, reliable and most importantly be willing to provide superior care for the patients. Contact: tinghr@gmail.com or fax 702-947-6571.

Practices for Sale

DENTISTS SERVING DENTISTS—Western Practice Sales invites you to visit our website, **westernpracticesales.com** to view all of our practices for sale and to see why we are the broker of choice for Sellers throughout Nevada, California & Arizona. Because we are owned by dentists, we know the profession well and understand your unique needs. **800-641-4179**.

ADA Online Classes

Dental Coding

In response to numerous questions about the Code on Dental Procedures and Nomenclature, a new CE course is now available at ADA CE Online (www.adaceonline.com).

The ADA fields about 7,000 calls annually from members and others with questions about the Code, and this course is designed to address basic concerns by offering instruction on coding issues. This course is offered to participants at no cost during its introductory period and one unit of continuing education will be granted upon successful completion of the material.

ADA CE Online lists multiple courses, including seven at no charge at this time, relating to topics such as coding, peer review, dental benefits, esthetics, and other key topics in dentistry.

AFFILIATED PRODUCTS

The following companies are NDA affiliated products. These products have been evaluated and are recommended for use in running your practice. Please let us know if you have any feedback or would like to recommend a product or service for affiliation.

Bank of America	*Professional Practice Finance*	**800-497-6076**
Best Card LLC	*Credit Card Processing*	**877-739-3952**
CareCredit	*Patient Financing*	**800-300-3046 x4519**
citibank	*Student Loans*	**866-863-6758**
citifinancial auto	*Auto Financing*	**888-248-4325**
citimortgage	*Real Estate Assistance*	**888-466-3232**
Collegiate Funding Services	*Student Financing*	**866-312-7227**
CoreVault	*Offsite Data Backup*	**405-391-8123**
D-Mmex	*EasyRefine Program*	**800-741-3174**
DRNA	*Waste Management*	**800-360-1001 x11**
EBESCO	*Subscription Service*	**800-527-5901 x1652**
FedEx	*Shipping Services*	**800-636-2377**
Hertz	*Car Rental*	**800-654-8216**
IC System	*Collection Service*	**800-279-3511**
JAT	*Printed Business Communications*	**800-421-5452**
Lands' End	*Business Outfitters*	**800-990-5407**
TDIC	*Professional Liability*	**888-319-7477**
Tel-A-Patient	*Appt Reminders/ Message on Hold*	**800-553-7373**

NDA PAST PRESIDENTS

1922 George H. Marvin	1951 Leonard G. Jacob	1980 Duane E. Christian
1923 John V. Ducey	1952 Clifford A. Paice	1981 Dwight Meierhenry
1924 Thomas H. Suffol	1953 Walter R. Bell	1982 Clair F. Earl
1925 George A. Carr	1954 Raymond J. LaFond	1983 R. D. Hargrave
1926 Samuel T. Spann	1955 Jack E. Ahlstrom	1984 James L. Davis
1927 Bruce Saulter	1956 J.D. Smith	1985 N. Richard Frei
1928 Frederick H. Phillips	1957 Kern S. Karrash	1986 Lloyd Diedrichsen
1929 Frederick J. Rulison	1958 Vincent J. Sanner	1987 Gerald Hanson
1930 William H. Cavell	1959 Wallaxe S. Calder	1988 Gerald C. Jackson
1931 Harold E. Cafferata	1960 John B. Hirsh	1989 James C. Evans
1932 Louis M. Nelson	1961 David W. Melarkey	1990 Whit B. Hackstaff
1933 Carlton E. Rhodes	1962 David W. Melarkey	1991 William E. Ursick
1934 Pliney H. Phillips	1963 Fae T. Ahlstrom	1992 Dennis J. Arch
1935 Harold R. McNeil	1964 Morris F. Gallagher	1993 A. Ted Twesme
1936 Lawrence D. Sullivan	1965 Wayne L. Zeiger	1994 Bruce Pendelton
1937 Alexander A. Cozzalio	1966 Mario E. Gildone	1995 J. Gordon Kinard
1938 Charles A. Cozzalio	1967 William D. Berry	1996 Joel F. Glover
1939 George A. Carr	1968 James F. Archer	1997 Rick Thiriot
1940 George A. Steinmiller	1969 Philip J. Youngblood	1998 Jade Miller
1941 George A. Steinmiller	1970 Carl M. Hererra	1999 Patricia Craddock
1942 Omar M. Seifert	1971 George P. Rasqui	2000 William C. McCalla
1943 Stephen W. Comish	1972 William H. Schaefer	2001 Robert H. Talley
1944 Quannah S. McCall	1973 Robert L. Morrison	2002 Susan Jancar
1945 Oliver M. Wallace	1974 John S. McCulloch	2003 Dwyte Brooks
1946 Gilbert Eklund	1975 James M. Jones	2004 Peter DiGrazia
1947 Robert H. Gatewood	1976 Harry P. Massoth	2005 Robert Thalgott
1948 E. Ross Whitehead	1977 Leeland M. Lovaas	2006 Arnie Pitts
1949 Howard W. Woodbury	1978 Blaine R. Dunn	2007 George Rosenbaum
1950 Roy P. Rheuben	1979 Louis J. Hendrickson	2008 Joel T. Glover

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