FALL 2015

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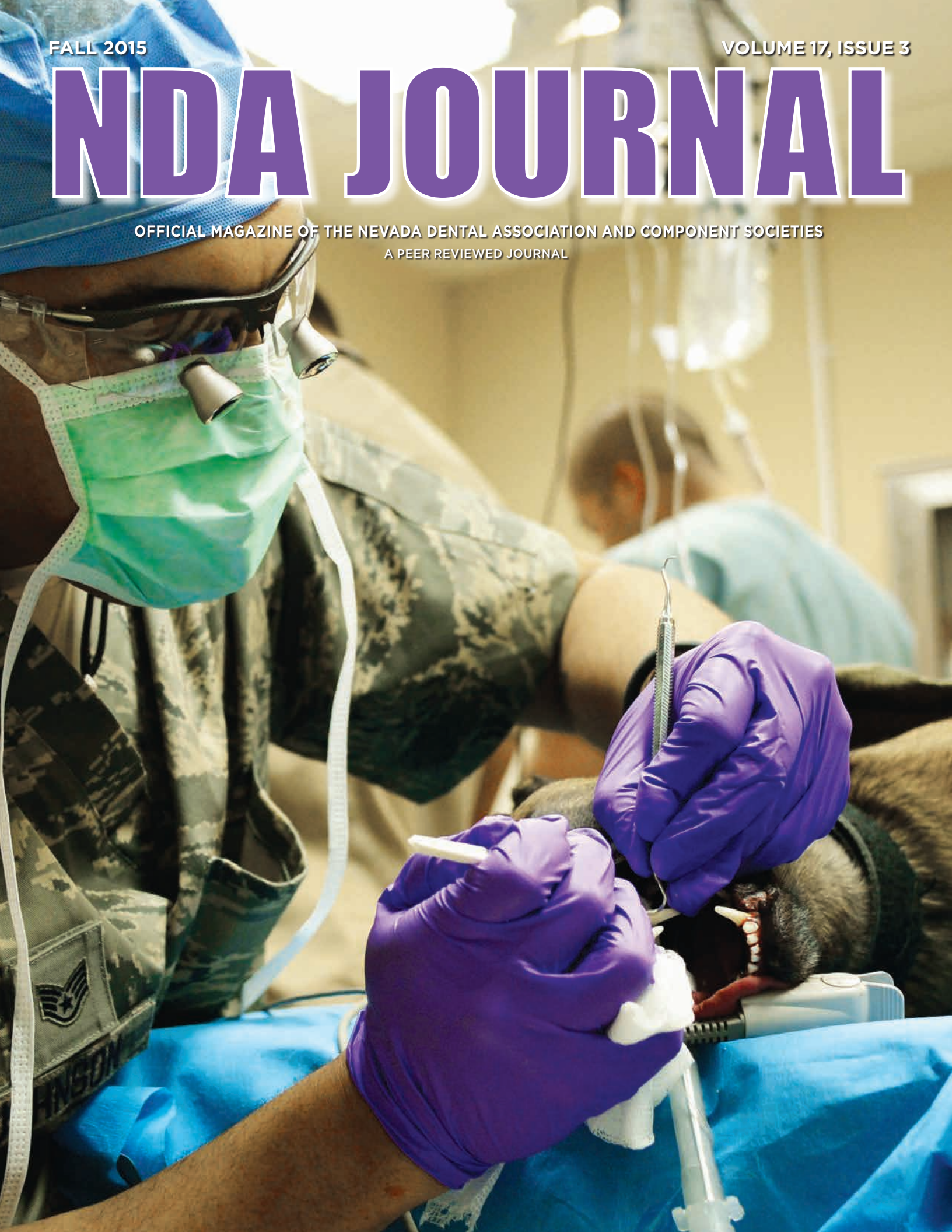
A PEER REVIEWED JOURNAL



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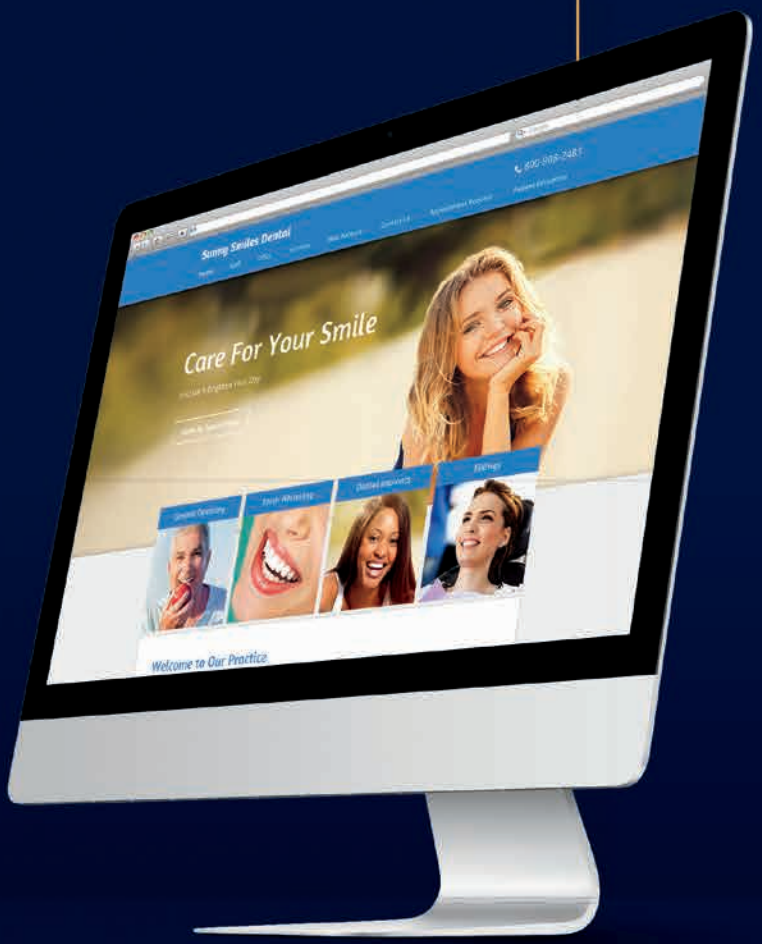

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NDA JOURNAL

FALL 2015

On the cover

Military Working Dog dental prophylaxis

Staff Sgt. Gregory Johnson, from the 386th Expeditionary Medical Support Squadron, removes plaque from a military working dog's teeth during a dental cleaning in Southwest Asia, Aug. 27, 2015. MWD Frida is with the 386th Expeditionary Security Forces Squadron.

Photo credit: U.S. Air Force photo/Senior Airman Racheal E. Watson.

Daniel L. Orr II, DDS, MS (anesth), PhD, JD, MD
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Dr. Orr practices OMS in Las Vegas, is a Clinical Professor of Surgery and Anesthesiology for Dentistry at UNSOM, Professor and Director of OMS and Advanced Pain Control at UNLV SDM, and a member of the CA Bar and the Ninth Circuit Court of Appeals. He can be reached at EditorNDA@nvda.org or 702-383-3711.

A Good Rx Redux

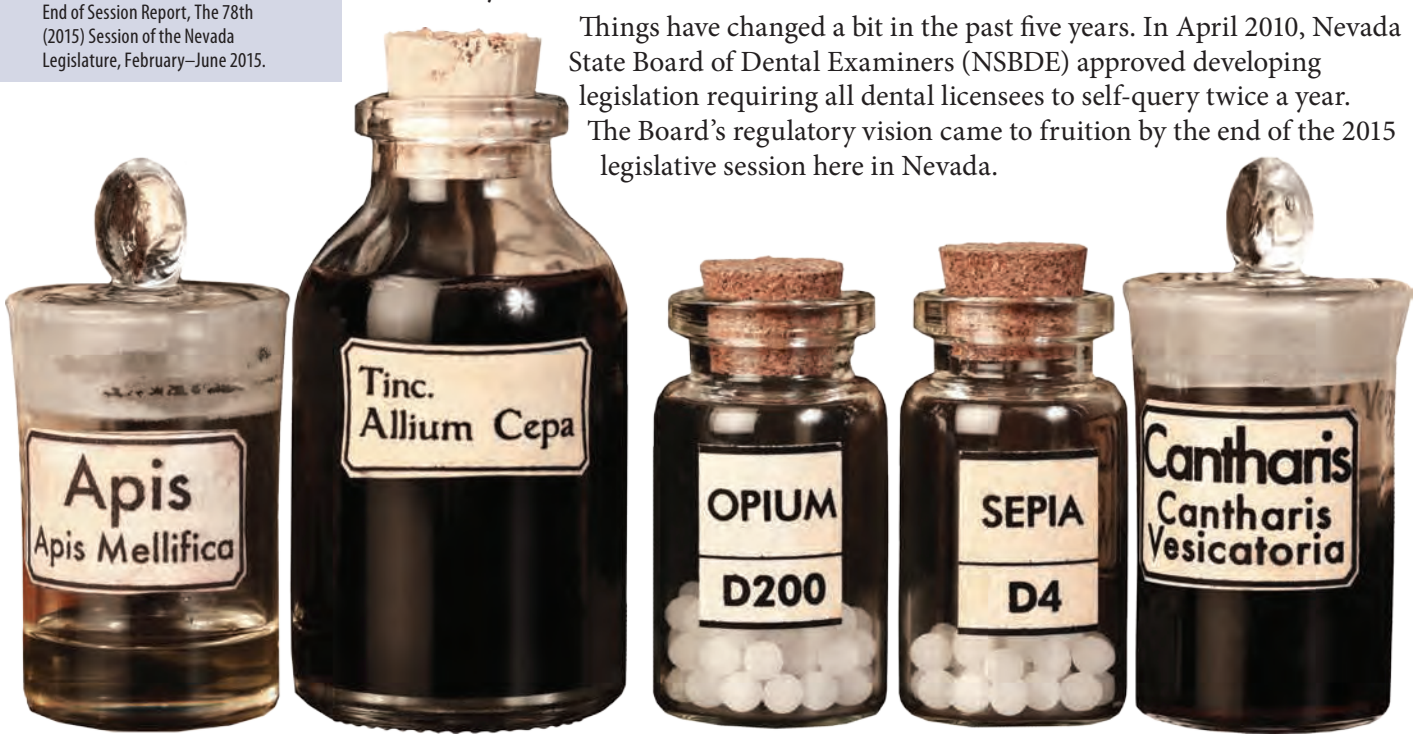
In 2010, the *NDA Journal*'s editorial dealt with the Nevada Controlled Substance Abuse Prevention Task Force's (CSAPTF) data bank and the ability of doctors to access the data on line.[1] The original intent of this, and other such data banks, was to make individual patient drug histories available to responsible prescriber doctors, in part because some of the diverted drugs in the United States today originate from legitimate doctor prescribers. In 2003, emergency room visits because of illegal drug use (i.e. cocaine, heroin) were twice as common as visits secondary to legal (over-the-counter or prescribed) drug consumption. The Centers for Disease Control has now reported that as of 2008 visits from both groups were about the same.[2]

A tool available on the CSAPTF web site was the option for a prescriber to self-query all one's prescriptions written during certain time frames. Doctors could voluntarily run their own data and functional means (such as direct pharmacy phone numbers) were made available to facilitate the correction of the inevitable errors that were noted in the histories. For instance, there are at least four Drs. Orr in Las Vegas and every time my own personal history is run I have found prescriptions from the other Orrs and other surnamed legitimate prescribers assigned to my database. Generally, a call to the pharmacy/pharmacist identified as having filled the prescription resulted in the removal of the erroneously assigned prescription from my DEA number within minutes.

Additional problems could previously be identified from a self-query too, such as obviously altered legitimate prescription quantities, for instance an additional digit added to the dispensed amount, or prescriptions filled that were never written by the doctor at all. Again, the first step with such concerns was to contact the pharmacy dispenser, with a possible second call to the Nevada State Board of Pharmacy (NSBP), to address the issue. Occasionally, such calls from the prescriber would lead to law enforcement's involvement.

In 2010 the *NDAJ* supported the concept of dentists' voluntary use of the data bank, not only a valuable information resource but a functional program to help address the issues noted in a data bank query related to prescribing, dispensing, and perhaps ultimately diversion.

Things have changed a bit in the past five years. In April 2010, Nevada State Board of Dental Examiners (NSBDE) approved developing legislation requiring all dental licensees to self-query twice a year. The Board's regulatory vision came to fruition by the end of the 2015 legislative session here in Nevada.



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1. A Good Rx, *NDAJ* 12:2, 4–5, Summer 2010
2. CEC Morbidity and Mortality Weekly Report, 59:23, 18 June 2010.
3. Ferrari C, Nevada Dental Association: End of Session Report, The 78th (2015) Session of the Nevada Legislature, February–June 2015.

The new prescription monitoring programs (PMP) statues allows conduct that was forbidden previously including:

1. Law enforcement officers now have access to the PMP to conduct investigations.
2. The NSBDE may investigate PMP data in order to help determine if a patient is obtaining the prescription via fraudulent means or if the doctor is inappropriately prescribing.
3. Failure to check the database every six months is now considered unprofessional conduct.
4. One hour of CE training in the misuse or abuse of prescriptions drugs is now required for all prescribers for each licensure renewal. Failure to obtain this training is deemed unprofessional conduct and is grounds for discipline.
5. Prescribers are required to run a patient utilization report when beginning a new course of treatment of more than seven days.

These new statues and other non-drug related legislation related to dentistry are well reviewed by the NDA's lobbyist, Chris Ferrari, in his session report.[3]

Another change is the data content provided on the PMP web site. The prior CSAPTF web site is no more. Some of the changes include:

1. Pharmacy direct phone numbers are no longer included.
2. PMP does not document a prescriber's visit to the website.
3. Drug amounts dispensed are not listed, but "days" are.

Time will tell if these changes are helpful. When a representative of the NSBP was asked why direct pharmacy phone numbers were not listed the answer given was that the data form does not have enough room, but that pharmacy numbers are in the phonebook.

Prescribers that seek to fulfill the new law mandating two annual monitoring visits to the PMP web site may want to consider how to document the visit themselves.

The reason given for not listing the amount of drug prescribed is that when a practitioner finds finds he or she is being investigated by a regulator or law enforcement, the practitioner could access the data base, see what is listed, and then alter office records to mirror what is iterated in the PMP data base. In order to avoid letting practitioners actually see what pharmacies report is dispensed, the new PMP site incorporates a formula to convert the actual dispensed amount into "days." The formula does not factor in many variables, for instance, the fact that different patients take different amounts of drugs over the same time frame and that a singular patient may decide to take a different amount of drug on different days.

In retrospect, the original purpose of PMP type data banks was to help doctors prevent diversion. It now seems that a new purpose of PMP data and new Nevada legislation will be to facilitate proceeding against prescribers not only for both malum in se (intentional evil) but also malum prohibitum (unintentional regulatory) violations.

Evidently, some politicians and regulators feel that if a dentist forgets to take CE training showing that that misuse or abuse of prescription drugs is bad or checks the PMP site less than twice a year, diversion is promoted? According to this logic, Nevada should require more than one hour of CE per renewal and more than two PMP checks per year to crack down even more on diversion. ▪

REMOTE AREA MEDICAL 2015

VOLUNTEERS WANTED

RAM is an international organization that travels the country and throughout the world providing free medical services with no qualifications. This event is for those in Southern Nevada who are uninsured or underinsured, with no eligibility requirements and no ID necessary. Medical services are provided on a first come, first serve basis.

Types of volunteers needed:

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Dentists (for adults & children)
Oral Surgeons
Dental Hygienists, Assistants & Technicians
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Optical Lab Technicians
Laboratory Technicians
Medical, Dental and Vision Students
1000 General Volunteers

Want to help in other ways?

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OCTOBER 16–18
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Check out last year's successful RAM 2014 event.
Search YouTube: 2014 Las Vegas Remote Area Medical

Hosted by CARE coalition

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Call 702.900.2124, email RAMinfo@CARECoalitionNV.org, or visit www.CARECoalitionNV.org to register and become a volunteer, questions about the event, or how to become a sponsor.

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

Fall is truly one of my favorite times of the year. It used to be that the kids were back in school but now Becky and I are just happy that our temperatures in Las Vegas are starting to cool down and we are about to enjoy our best weather of the year.

We recently set the dates for our two House of Delegate meetings in 2016. The Mid-Winter meeting will be on Sat., January 30, 2016 at the Springs Preserve in Las Vegas. They have a very nice conference room and participants have the opportunity to explore this Vegas landmark after the meeting. The Annual Summer meeting will be held June 16–18, 2016 in Napa Valley, California at the Meritage Resort and Spa. This is a unique resort with a winery on the property; we plan to have the welcome reception in their wine cave. We are also planning to have a dinner on Friday at a winery to be determined. I know it is Dr. Wilbur's plan to try and get all living past presidents of the NDA to attend this meeting, so mark your calendars for a truly special weekend.

Your ADA Delegates recently attended the first caucus meeting of the 14th District to prepare for the ADA Annual meeting in November. The 14th District Trustee, Gary Yonemoto from Hawaii, is running for President Elect of the ADA. The whole district is excited about the campaign as his visits to other districts have been going very well. I ask that if you have a classmate who you know is a delegate in another state, contact me so I can talk to you about Gary.

You will see an announcement in this *Journal* about the RAM (Remote Area Medical) events being held in Nevada in October. Please consider volunteering for one of these events to treat the underserved. You have total control of which day and how much time you give, so join us. Sign up information is on the announcement.

NDA Lobbyist Chris Ferrari has written a great summary of important legislative measures that were passed this last session and how they will affect your practice. ▪

Brad Wilbur, DMD

Cohesion: The action or fact of forming a united whole

It is my honor to serve this year as President of the Nevada Dental Association. It is a humbling experience to follow a long list of outstanding leaders, but I will endeavor to fulfill the duties of the office to the best of my abilities. Dr. Mark Handlin did an exceptional job, so I am fortunate to follow his term with well-oiled systems already in place.

The word to summarize my goal for this year is "cohesion," defined as "the action or fact of forming a united whole." What will make this process easier is the outstanding leadership of the component societies, along with my fellow members of the state board and executive director's office. Innovative ideas are being promulgated that should help retain and expand membership, plus make the value of belonging to the greatest dental association more transparent to the eye. It is easy to get lethargic, and go through our days with our head down and the handpiece up, but when we do, opportunities abound.

Our next state meeting will take place in Las Vegas on Sat., January 30, 2016. The meeting has been moved to Saturday to facilitate participation from dentists who practice on Fridays. It will be held at the Springs Preserve and start at 9 AM.

One other facet of cohesion I am going to explore concerns the NDA summer annual meeting. I proudly announce that the 2016 meeting will be on the weekend of June 18th, in Napa Valley, California. We will be staying at the Meritage Resort, a fine property at the south end of Napa. My goal is to get *every NDA* past-president to attend this meeting. There is a natural tendency when leaving office to take a break from the high level of commitment that is required, but at no time has there ever been a ceremony to honor all those who have served. I envision a weekend that allows the past presidents to rekindle old acquaintances, plus allows younger members to build relationships that can lead to some welcomed mentoring.

The Napa area is world-renowned for wine tasting, but there is much more to do than just drink wine. Some of the various activities are: balloon rides, food tours, cooking classes, spas, biking, kayaking, golf, and fly fishing! There literally is something for everyone to do. The hard part may be finding time to fit in everything on your wish list.

My last recommendation is to make an effort to attend the ADA 2015 in Washington, DC, from Nov. 5–8. It's an unusual opportunity to see new products, ask questions from suppliers, and gain valuable CE from speakers that you either know, or have wanted to see. I have always felt recharged by attending the event—and that doesn't include the outstanding opportunities to see our nation's capital. ▪

2015 Legislative Session Wrapup

Chris Ferrari

The 2015 Legislative Session was an interesting spectacle filled with drama, intrigue, and compromise, with the goal of progress. The NDA identified necessary statutory changes, based on member input and through information from the American Dental Association. We are pleased to inform you that your three objectives from the 2015 were passed.

The passage of legislation may sound simple on the surface, but it is mired in challenges from other interests, and there is no such thing as an easy bill. We will spare you the gory details of how these measures became law in this article, but if you would like for us to recount any tales from the trenches, don't hesitate to ask.

This article highlights these three specific areas so that you can adapt your offices and staff to the new requirements and opportunities.

We want to thank the NDA, the NDA Legislative Committee, and Dr. Bob Talley for their collective time and effort to help foster success for the dental profession and the patients you serve. It is a privilege for our team to work for the NDA, and we are extremely proud of the work we do in and the progress that has been made over the past two legislative sessions.

NDA proactive measures passed

The NDA proactively worked on three measures last Session, all of which passed successfully: Senate Bills 137, 159, and 341.

Senate Bill 159

Makes a small but important change to existing insurance law: It adds the word "*dentist*" to a portion of the law concerning independent medical evaluations. Under current law, if an insurer disagrees with the medical necessity of a procedure recommended by a doctor or chiropractor, the insurer can require an independent evaluation be performed by a licensed or trained doctor, or chiropractor of the appropriate specialty. There was no similar requirement for procedures recommended by dentists, and thus some insurers exploited that by having the independent reviews performed by unlicensed or untrained individuals. As of January 1, 2016, that will no longer be the case. That's not to say that insurer will not deny claims based on dental necessity, but at least when they attempt to do so, your orders will be reviewed by a licensed dentist.

Senate Bill 341

Makes changes to medical discount plans—non-insurance plans that offer a percentage discount to members. This is an area of discussion among many NDA members. Senate Bill 341 was designed to alleviate some of the concerns without adversely affecting the benefits the plans may bring. What we heard from members who dislike discount plans was the fact that one often did not know one was part of the plan until it was too late. Perhaps your name was included in a provider list of an insurance company you had never heard of, or perhaps a patient—who was going to pay cash—signed up for a discount plan on their smartphone in your waiting room. Beginning October 1, 2015, any time you sign a contract with a discount plan, the insurer is required to notify you if that contract may be assigned to a third party. If your contract is assigned to a third party, you will be notified within 30 days. You will know to whom the contract was assigned, how to contact that party, and the estimated number of members in the new plan. If you are not notified at the time the contract is signed, or are not notified when it is assigned to a new party, then you have no obligation to perform services under that contract.

Senate Bill 137

Made a clarification that stand-alone dental insurance policies are the primary insurers when dealing with oral and maxillofacial surgery claims. Oral surgeons were encountering scenarios in which both the medical and dental insurers were denying claims on the basis that the other insurer was responsible. This is similar

Continues on page 10 ➲

to scenarios that those of you who see pediatric patients may encounter when the patient has a stand-alone dental insurance policy and pediatric dental benefits embedded in a medical insurance policy. We attempted to proactively fix that issue in this bill as well, but unfortunately, there was no appetite from other non-providers to do so. As a side benefit to that discussion, we did receive a commitment from the Division of Insurance to add the American Dental Association J430-D form to the list of approved insurance claim forms as soon as it addresses some temporary staffing issues it is experiencing. For those of you who have had trouble submitting claims using CPT codes and the CMS-1450 or -1500 forms, this should be a welcome change.

SB 137 became effective June 5, 2015 for the purpose of adopting any regulations and performing any other preparatory administrative tasks necessary to carry out the provisions of this act; and January 1, 2016, for all other purposes.

Prescription Drug Monitoring

A priority of Gov. Brian Sandoval's administration, as well as that of First Lady Kathleen Sandoval, was prescription drug reform to combat opioid painkiller abuse. They chose to tackle that reform primarily through legislation involving opioid antagonists, like naloxone, and through changes to the prescription drug monitoring program, or PMP. The Board of Dental Examiners generally requires you to register with the PMP. New legislation takes that a step further and requires you to obtain and review a report from the PMP on the patient if you write that patient a prescription for a schedule II, III, or IV controlled substance, and one of the following conditions is met:

- The patient is a new patient to you.
- The prescription is for more than seven days *and* part of a new course of treatment.

The Board of Pharmacy is looking to make compliance with this new requirement a bit easier by allowing you to designate people within your practice to run the PMP reports for you (discussions have brought up two such authorized persons per practice, or per prescriber, as possibilities). Additionally, there are software vendors who can embed PMP data directly into an electronic medical record. No matter who runs the report, the responsibility to actually review the data contained therein lies upon the prescriber.

The new laws relating to the PMP also permit the Board of Dental Examiners to require one hour of continuing education in misuse and abuse of controlled substances. The language is permissive, meaning the Board of Dental Examiners may elect not to levy that continuing education requirement, but even if they do, your total number of continuing education hours will not change, as the law also permits you to use the hour to satisfy any other hour of continuing education required by the Board.

Business Taxes

The last topic to discuss is perhaps the most controversial: Changes to the business tax structure in the state. While the new "Commerce Tax" has received plenty of publicity and discussion, we need to briefly mention changes to state business licenses and the Modified Business Tax (MBT).

State business licenses for non-corporate businesses have been set at $100 per year, though recently that amount has been doubled to $200 per year through "sunset" measures. In 2015, the rate for annual business licensed filings was set at $200 permanently. In addition, the cost of filing an annual member list for corporations and limited-liability partnerships has increased by $25 per year.

The MBT is the state's payroll tax levied upon wages in excess of $85,000 per quarter. The original tax rate was 0.63% of the amount over the $85,000 threshold, and was previously raised to 1.17%. The tax bill passed this year will both the rate rise permanently to 1.475%, and the threshold drops to $50,000 per quarter. A business with $100,000 in quarterly payroll will see its MBT liability increase from $175.50 per quarter to $737.50 per quarter, a total of $2,248 in extra tax payments per year.

The final tax component is the Governor's "Commerce Tax" proposal. This tax is essentially a modified gross receipts tax. To begin with, there is a flat $4,000,000 revenue deduction. If your practice does not bring in $4,000,000 or more in gross revenue, meaning no expenses are deducted, per year, then you are exempt from this tax. Even if you cross the $4,000,000 threshold you may be able to exempt certain types of income from your revenue:

- Payments from Medicaid, Medicare, the Children's Health Insurance Program (CHIP), the Fund for Hospital Care for Indigent Persons, and TRICARE.
- Payments received on workers' compensation claims.
- The amount of uncompensated care you provide.

If your gross revenue exceeds $4,000,000 even with those exemptions, the tax rate for a health care provider is 0.19% on the amount in excess of $4,000,000. For practices that do end up with a Commerce Tax liability, there is a tax credit available. After you pay your Commerce Tax liability, you can take 50% of the amount paid as a credit against your Modified Business Tax liability for one year, or until the credit is used up, whichever occurs first.

Collection of the commerce tax will begin in 2016, with accrual impacting revenues collected on or after July 1, 2015. The lower threshold for the MBT took effect on July 1, 2015. ▪

The Next Generation of Dental Leaders

By Jarod Johnson, DDS

Dentistry is a commitment to lifelong learning. My father is a dental educator who begins his first course with his classic line, "Half of what we will teach you will be wrong." For the most part he is right. There have been many developments in the field of dentistry in the past decades that were not taught to many of us in our dental education.

Analog radiographs are becoming a thing of the past. Emerging technologies have developed the use of digital impressions and computer aided design for crowns, partials, and dentures. Researchers have shown a paradigm shift in treating immature permanent teeth with regenerative endodontic procedures leading to the hope that someday we will be able to grow replacement teeth. Implants have become more successful in replacing missing teeth. Many dentists were not taught these procedures in their academic education, but learned to adapt through continuing education courses. Dentists adapt in their practice as more evidence is obtained to provide support for procedures.

As the practice of dentistry changes so should organized dentistry. The ability to attract young leaders to become involved in our profession is vital to maintain the respect of the dental field. There was a time when local pharmacies were the main business to get one's prescription filled across the U.S. Now it seems as if there is a Walgreens or CVS on every corner. Dentistry should not have to succumb to the pressures of corporations that pharmacists have accepted.

Dentistry is at a tipping point. The recession has led to many baby boomers practicing for a longer period of time. This coupled with the addition of new dental schools means that fewer practices are available for sale to new dentists. Add to the fact that the cost of a dental education has grown drastically in the last few decades. The average dental student today graduates with $241,097 in debt. This debt has doubled since 2001. The days of a recent graduate hanging his or her own shingle may be gone. More graduates are looking for a more consistent income in the role of an associate to ensure repayment of student debt.

Many new dentists look to corporate dentistry to provide a reliable income. Corporate dentistry is attractive because there is minimal stress related to running a business and one can practice dentistry without taking these issues home. Corporate dentistry; however, separates the interest of dentists as a practitioner, dental health provider, and as a small business owner. This can negatively impact patient care if the dentist is pressured to produce a certain dollar amount of treatment.

When both the interests of the dentist and the business are one, the patient will receive the best care possible. It is not the dentists that are practicing at these locations, but rather the pressures to produce that can have a negative impact on care; pressures specifically related to the environment in which practitioners work. Many young dentists move on from corporate dentistry to become associates, partners, or owners. These are the same dentists, but the environment changes to one where the image of a person is more important to patients than an image of a corporation.

As many younger dentists enter the corporate field, the issues pertaining to organized dentistry become more distant. Why would a dentist care about covered and non-covered benefits if he or she will take home the same amount from the corporation? Patients are also put under undue stress as insurance companies are now required to coordinate benefits between medical and dental insurance, and patients may be left with an unexpected bill. Corporations are not joining our organizations as members and advocating on behalf of the patient. It is our responsibility as dentists to advocate for our profession, and more importantly our patients. Without advocacy our patients will lose respect for us as practitioners.

Our dental association needs to appeal to the new generation of dentists; and it is taking positive steps. It starts with our dental students and providing a platform for them to be involved in organized dentistry from the beginning of their careers. A recent New Dentist Committee meeting held by the Southern Nevada Dental Society had more fourth year dental students in attendance than recent graduates. They are more engaged and ready to soak up information as they begin their careers than any point in time. It is a perfect time to educate them and recruit them as lifelong members. Even if they do not stay in Nevada they hopefully will go to a state and become involved and

have an impact on dentistry, or participate nationally.

New faces at meetings, young or re-inspired, should be the focus of everyone in the room. Each member should make it a goal to talk to someone new at each meeting, and not just friends and familiar faces. This will help the organization grow and make for a friendly, welcoming, atmosphere.

To encourage young dentists to serve the public Nevada should work with the insurance companies and legislators to develop student loan repayment programs for dentists that serve rural and underserved populations (such as our children, those with special healthcare needs, and elderly). This would provide new dentists with a healthy alternative that is an attractive job opportunity. It would also provide much needed loan repayment, bring dentists to rural Nevada, and serve our state greatly by having a positive impact on oral health. Addressing the needs of the public while offering loan repayment is a winning combination for dentists and the public.

There are many issues that are facing dentistry today. Where will our profession go if we do not develop the talent in our new professionals? The transition of knowledge and leadership from our experienced leaders is essential to provide organizations with continuity and the ability to the next generation to maintain the respect of our profession. This cannot be transferred unless we recruit and attract the next leaders. ▪

Dr. Johnson earned a BS in Biomedical Engineering from The University of Iowa in 2009 and a DDS from The University of Iowa in 2013. He completed the Advanced Education Program in Pediatric Dentistry at the UNLV, School of Dental Medicine in June 2015. He served as a Southern Nevada Dental Society delegate to the NDA. He is currently developing a private practice in rural Iowa.

Teledentistry:
Part 2 Legal Considerations

By Toan Foeng (Bill) Tham, DDS, JD, FCLM

Teledentistry has the ability to improve access to care, improve delivery of health care, and lower its costs. However a number of issues can arise with the use of teledentistry.[1] These include privacy, security, ethical and legal issues associated with the communication and transfer of information on and over the Internet. This article, in particular, will only discuss the legal issues of malpractice and licensure.

Malpractice

Extending a practice to encompass teledentistry brings with it an extension of malpractice risk. While the definition of malpractice varies according to the laws of each state, in general, malpractice is defined as any act of heath care performed by a practitioner that falls below the standard of care. Proof of malpractice to establish negligence rest solely with the patient that was injured. To establish malpractice, the following elements must be proven:

1. The existence of duties that the doctor owes to a patient established through a doctor-patient relationship;
2. The deviation of healthcare practitioners from applicable standard of care;
3. A relationship between care standards related to the injury of the patient and the deviation of the health care professional that caused any permanent or temporary injury to the patient;
4. It also needs to be proven that the conduct of the doctor fell below the standard of care.

As I alluded above, in respect to teledentistry consultation, there would be no cause of action for malpractice negligence unless the issue of doctor-patient relationship has been established.[2] Doctor-patient relationship can be established such as in real-time video conferencing consultation when practitioner offering an opinion over the Internet, or via email, either to a colleague or a layperson.[3] On the other hand, traditional informal consultations where the practitioner discusses the patient's dental history and current conditions with colleagues do not establish a doctor-patient relationship. Once a doctor-patient relationship is established, the practitioner has a duty to act within the parameters of the standard of care. Any deviation of such subjects the practitioner to the risk of malpractice.

Licensure

Licensure is defined as one who has the legal responsibility to grant a health professional the permission to practice their profession. Article X of the U.S. Constitution gives states the authority to regulate activities that affect the health, safety, and welfare of their citizens including the practice of healing arts within their borders.[4] The purpose of licensing health care professionals is to protect the public from incompetent or impaired practitioners.

In light of teledentistry, licensure requirements can be complicated. It has always been a barrier in incorporating teledentistry into any practice because many states view one of the beneficial qualities of teledentistry, an electronic consultation, constitute as the practice of dentistry in those states, and therefore must be licensed in each state in which they practice. The rational is that states have a legitimate local interest in ensuring that out of state practitioners meet the same standards as professionals licensed within the state because states view teledentistry consultation as affecting the health and well-being of individuals physically located in the state, and want a method to ensure liability from out-of-state practitioners.

There are several models to ease the cross-state licensure issue: 1. **Licensure by endorsement**. Licensure by endorsement is used to grant licenses to health professionals licensed in other states that have equivalent standards. 2. **Mutual recognition**. Mutual recognition is a system in which the licensing authorities voluntarily enter into an agreement to legally accept the policies and licensure processes of a licensee's home state. 3. **Reciprocity**. Reciprocity is an agreement between two or more states whereby each agrees to grant a license to practice to any person licensed by other state.

According to Daniel T. Golder et. al., there are 20 states that have restrictive licensure laws which require the health care practitioner to obtain a full license (with some exceptions) to participate in teledentistry across state lines. A state such as Alabama, California, and Oregon allow practitioners who maintain licensure and is in good standing to obtain limited license to practice telemedicine (inclusive teledentistry). The acceptance of limited license by practitioner comes with the consequence of being sued in the jurisdiction of the state in which the patient resides.

The remainder of 27 states and the District of Columbia has not as yet established any law requiring licensure for the practice of teledentistry. It is wise, not to assume these states and the district allow practice teledentistry without a license. As such, a practitioner who is participating in a teledentistry consultation must recognize the increased risk in professional liability because this could be viewed as practicing dentistry without a license.[5]

Institute of Medicine, Washington, DC, 2012 Workshop Summary, stated cross-state licensure as the top barriers to the expanded use of telemedicine/teledentistry across the country.[6] There are some alterations to licensing regulations and policies to facilitate cross-state telemedicine/teledentistry practices. Under U.S. Constitution Article I, Sec. 10 cl. 3, Congress recognized the states' authority to enter into any agreement or compact with one another subject the Consent of the Congress. Interstate compact is an agreement between two or more states established for the purpose of remedying a particular problem of multi-state concern.[7] The National Council of State Boards of Nursing's Nurse Licensure Compact (NLC) is one of example of multi-state compact that intended to ease the barriers to nurses holding multiple licenses across state lines. NLC was launched in 2000 and currently has 24 states as members.[8] The compact allows the nurse to have one license that will enable the licensee to practice in other NLC states either physically or electronically, subject to each state's practice law and regulation.

In May 2014, Federation of State Medical Boards (FSMB) has also taken up the issue and draft model language for an interstate compact to expedite medical licensing. However, unlike NLF, the FSMB's proposed compact will not issue a single license that can be used across state lines but require each physician to apply for a license in each state.[9]

Furthermore, as the demand for telemedicine/tele-dentistry increases, two congressional bills were introduced to address this issue. First, The TELE-MED Act of 2013, introduced by Representatives Devin Nunes (R-CA) and Frank Pallone, Jr. (D-NJ), would allow Medicare-participating clinicians licensed in one state to provide services electronically to Medicare beneficiaries in other states as long as they are licensed to provide the services in question. Another recently introduce federal bill, the Telehealth Enhancement Act, proposes that, for the purposes of liability in the Medicare program, telemedicine services be viewed as being delivered at the location of the clinician, not that of the patient. Such a policy could certainly change the licensing landscape.[10]

Conclusion

It is clear that teledentistry offers many benefits such as the ability to improve access to oral health care of the undeserved areas,[11] the reduction of health care costs,[12] improvement of the delivery of oral health care,[13] the mitigation of dental professional shortages.[14] Albeit all the progress mentioned above, we cannot fully reap all its benefits and potential until we truly overcome cross-line licensure problem. ▪

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Service Animals

From the Americans with Disabilities Act at www.ADA.gov

The Dept. of Justice published revised final regulations implementing the Americans with Disabilities Act (ADA) for title II (State and local government services) and title III (public accommodations and commercial facilities) in September 2010, in the Federal Register.

- Since March 15, 2011, only dogs are recognized as service animals under titles II and III of the ADA.
- A service animal is a dog that is individually trained to do work or perform tasks for a person with a disability.
- Generally, title II and title III entities must permit service animals to accompany people with disabilities in all areas where members of the public are allowed to go.

How "service animal" is defined

Service animals are defined as dogs that are individually trained to do work or perform tasks for people with disabilities. Examples of such work or tasks include guiding people who are blind, alerting people who are deaf, pulling a wheelchair, alerting and protecting a person who is having a seizure, reminding a person with mental illness to take prescribed medications, calming a person with Post Traumatic Stress Disorder (PTSD) during an anxiety attack, or performing other duties. Service animals are working animals, not pets. The work or task a dog has been trained to provide must be directly related to the person's disability. Dogs whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA.

This definition does not affect or limit the broader definition of "assistance animal" under the Fair Housing Act or the broader definition of "service animal" under the Air Carrier Access Act.

Some State and local laws also define service animal more broadly than the ADA does. Information about such laws can be obtained from the State attorney general's office.

Where service animals are allowed

Under the ADA, State and local governments, businesses, and nonprofit organizations that serve the public generally must allow service animals to accompany people with disabilities in all areas of the facility where the public is normally allowed to go. For example, in a hospital it would be inappropriate to exclude a service animal from areas such as patient rooms, clinics, cafeterias, or examination rooms. However, it may be appropriate to exclude a service animal from operating rooms or burn units where the animal's presence may compromise a sterile environment.

Service animals must be under control

Under the ADA, service animals must be harnessed, leashed, or tethered, unless these devices interfere with the service animal's work or the individual's disability prevents using these devices. In that case, the individual must maintain control of the animal through voice, signal, or other controls.

Inquiries, exclusions, charges, and other specific rules

- When it is not obvious what service an animal provides, only limited inquiries are allowed. Staff may ask two questions: (1) is the dog a service animal required because of a disability, and (2) what work or task has the dog been trained to perform. Staff cannot ask about the person's disability, require medical documentation, require a special identification card or training documentation for the dog, or ask that the dog demonstrate its ability to perform the work or task.
- Allergies and fear of dogs are not valid reasons for denying access or refusing service to people using service animals. When a person who is allergic to dog dander and a person who uses a service animal must spend time in the same room or facility, for example, in a school classroom or at a homeless shelter, they both should be accommodated by assigning them, if possible, to different locations within the room or different rooms in the facility.
- A person with a disability cannot be asked to remove his service animal from the premises unless: (1) the dog is out of control and the handler does not take effective action to control it or (2) the dog is not housebroken. When there is a legitimate reason to ask that a service animal be removed, staff must offer the person with the disability the opportunity to obtain goods or services without the animal's presence.
- Establishments that sell or prepare food must allow service animals in public areas even if state or local health codes prohibit animals on the premises.
- People with disabilities who use service animals cannot be isolated from other patrons, treated less favorably than other patrons, or charged fees that are not charged to other patrons without animals. In addition, if a business requires a deposit or fee to be paid by patrons with pets, it must waive the charge for service animals.
- If a business such as a hotel charges guests for damage that they cause, a customer with a disability may also be charged for damage caused by himself or his service animal.
- Staff are not required to provide care or food for a service animal. ▪

Frequently asked questions

Service dogs can be trained to perform many important tasks to assist people with disabilities, such as providing stability for a person who has difficulty walking, picking up items for a person who uses a wheelchair, preventing a child with autism from wandering away, or alerting a person who has hearing loss when someone is approaching from behind.

The Dept. of Justice continues to receive questions about how the ADA applies to service animals. The ADA requires State and local government agencies, businesses, and non-profit organizations (covered entities) that provide goods or services to the public to make "reasonable modifications" in their policies, practices, or procedures when necessary to accommodate people with disabilities. The service animal rules fall under this general principle. Accordingly, entities that have a "no pets" policy generally must modify the policy to allow service animals into their facilities.

A Psychiatric Service Dog In Training.
Photo by Crjs452

What is a service animal?

Under the ADA, a service animal is defined as a dog that has been individually trained to do work or perform tasks for an individual with a disability. The task(s) performed by the dog must be directly related to the person's disability.

What does "do work or perform tasks" mean?

The dog must be trained to take a specific action when needed to assist the person with a disability. For example, a person with diabetes may have a dog that is trained to alert him when his blood sugar reaches high or low levels. A person with depression may have a dog that is trained to remind her to take her medication. Or, a person who has epilepsy may have a dog that is trained to detect the onset of a seizure and then help the person remain safe during the seizure.

Are emotional support, therapy, comfort, or companion animals considered service animals under the ADA?

No. These terms are used to describe animals that provide comfort just by being with a person. Because they have not been trained to perform a specific job or task, they do not qualify as service animals under the ADA. However, some State or local governments have laws that allow people to take emotional support animals into public places. You may check with your State and local government agencies to find out about these laws.

What questions can a covered entity's employees ask to determine if a dog is a service animal?

In situations where it is not obvious that the dog is a service animal, staff may ask only two specific questions: (1) is the dog a service animal required because of a disability? and (2) what work or task has the dog been trained to perform? Staff are not allowed to request any documentation for the dog, require that the dog demonstrate its task, or inquire about the nature of the person's disability.

Who is responsible for the care and supervision of a service animal?

The handler is responsible for caring for and supervising the service animal, which includes toileting, feeding, and grooming and veterinary care. Covered entities are not obligated to supervise or otherwise care for a service animal.

Does a hospital have to allow an in-patient with a disability to keep a service animal in his or her room?

Generally, yes. Service animals must be allowed in patient rooms and anywhere else in the hospital the public and patients are allowed to go. They cannot be excluded on the grounds that staff can provide the same services.

Continues on page 20 ➲

What happens if a patient who uses a service animal is admitted to the hospital and is unable to care for or supervise their animal?

If the patient is not able to care for the service animal, the patient can make arrangements for a family member or friend to come to the hospital to provide these services, as it is always preferable that the service animal and its handler not be separated, or to keep the dog during the hospitalization. If the patient is unable to care for the dog and is unable to arrange for someone else to care for the dog, the hospital may place the dog in a boarding facility until the patient is released, or make other appropriate arrangements. However, the hospital must give the patient the opportunity to make arrangements for the dog's care before taking such steps.

Must a service animal be allowed to ride in an ambulance with its handler?

Generally, yes. However, if the space in the ambulance is crowded and the dog's presence would interfere with the emergency medical staff's ability to treat the patient, staff should make other arrangements to have the dog transported to the hospital.

When can service animals be excluded?

The ADA does not require covered entities to modify policies, practices, or procedures if it would "fundamentally alter" the nature of the goods, services, programs, or activities provided to the public. Nor does it overrule legitimate safety requirements. If admitting service animals would fundamentally alter the nature of a service or program, service animals may be prohibited. In addition, if a particular service animal is out of control and the handler does not take effective action to control it, or if it is not housebroken, that animal may be excluded.

When might a service dog's presence fundamentally alter the nature of a service or program provided to the public?

In most settings, the presence of a service animal will not result in a fundamental alteration. However, there are some exceptions. For example, at a boarding school, service animals could be restricted from a specific area of a dormitory reserved specifically for students with allergies to dog dander. At a zoo, service animals can be restricted from areas where the animals on display are the natural prey or natural predators of dogs, where the presence of a dog would be disruptive, causing the displayed animals to behave aggressively or become agitated. They cannot be restricted from other areas of the zoo.

What does under control mean? Do service animals have to be on a leash? Do they have to be quiet and not bark?

The ADA requires that service animals be under the control of the handler at all times. In most instances, the handler will be the individual with a disability or a third party who accompanies the individual with a disability. In a school (K–12) or similar setting, the school or similar entity may need to provide some assistance to enable a student to handle his/her service animal. The service animal must be harnessed, leashed, or tethered while in public places unless these devices interfere with the service animal's work or the person's disability prevents use of these devices. In that case, the person must use voice, signal, or other effective means to maintain control of the animal. For example, a person who uses a wheelchair may use a long, retractable leash to allow her service animal to pick up or retrieve items. She may not allow the dog to wander and must maintain control of the dog, even if it is retrieving an item at a distance from her. Or, a returning veteran who has PTSD and has great difficulty entering unfamiliar spaces may have a dog that is trained to enter a space, check to see that no threats are there, and come back and signal that it is safe to enter. The dog must be off leash to do its job, but may be leashed at other times. Under control also means that a service animal should not be allowed to bark repeatedly in a lecture hall, theater, library, or other quiet place. However, if a dog barks just once, or barks because someone has provoked it, this would not mean that the dog is out of control.

What happens if a person thinks a covered entity's staff has discriminated against him or her?

Individuals who believe that they have been illegally denied access or service because they use service animals may file a complaint with the U.S. Dept. of Justice. Individuals also have the right to file a private lawsuit in Federal court charging the entity with discrimination under the ADA. ▪

For more information

ADA website: www.ADA.gov
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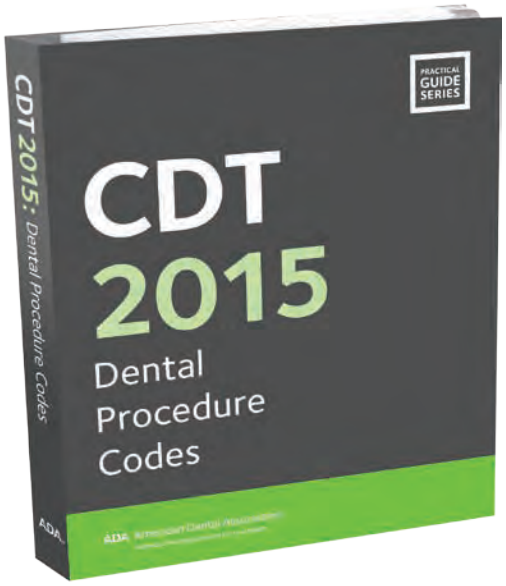


Bitewing Images

Addressing the CDT Code and Technology Conundrum

By Joan Feifar

Today, extra-oral imaging devices are capable of acquiring similar diagnostic information to that seen on multiple bitewings. This image may also capture additional information, all by a single exposure captured on one extra-oral receptor. How does a dentist document this procedure—is it a bitewing or bitewings, an extra-oral image, or what? Before answering the question let's look at the definition found in the ADA's online Glossary of Dental Clinical and Administrative Terms (www.ada.org/en/publications/cdt/glossary-of-dental-clinical-and-administrative-ter#b):

> **Bitewing radiograph:** Interproximal radiographic view of the coronal portion of the tooth/teeth. A form of dental radiograph that may be taken with the long axis of the image oriented either horizontally or vertically, that reveals approximately the coronal halves of the maxillary and mandibular teeth and portions of the interdental alveolar septa on the same image.

With all this in mind, there is more than one CDT Code to consider:

D0270 bitewing—single radiographic image
or
D0250 extra-oral—first radiographic image

Both are consistent with the glossary definition, but is one more appropriate than the other? It depends. A bitewing (e.g., D0270), with the film or receptor placed in the oral cavity, is the well-known method for imaging posterior teeth. But what about patients who are not able to accept placement of an intra-oral film or receptor? D0250 is more appropriate since the imaging media would be extra-oral as specified in this code's nomenclature.

Some may disagree, saying the bitewing nomenclature does not limit it to intra-oral imaging. No matter what CDT Code is selected by the dentist, the choice must be supported by information and images placed in the patient's records. There is a more elegant and specific solution on the horizon—a new code in CDT 2016 that dentists may use on patient records and claims—but we will have to wait until Jan. 1, 2016 before using it.

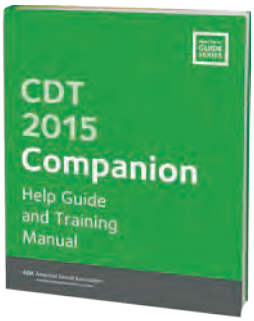
> **D0251 extra-oral posterior dental radiographic image**
> Image limited to exposure of complete posterior teeth in both dental arches. This is a unique image that is not derived from another image.

The addition of D0251 is one of three interrelated changes to the extra-oral imaging codes in CDT 2016. As illustrated below: D0250 is revised to clarify the procedure's scope and methodology so there is no overlap with D0251 and it is no longer a "…first..." image procedure; D0260 is deleted as it becomes redundant by the D0250 revision. Multiple D0250 images are documented on a claim using the "Qty." (Quantity) field on the service line.

> **D0250 extra-oral – ~~first~~ 2D projection radiographic image~~s~~ created using a stationary radiation source, and detector**
>
> These images include, but are not limited to: Lateral Skull; Posterior-Anterior Skull; Submentovertex; Waters; Reverse Tomes; Oblique Mandibular Body; Lateral Ramus.
>
> ~~**D0260 extraoral – each additional radiographic image**~~

CDT Code maintenance requests from ADA members prompted these coming changes, and exemplify the importance of member participation in the CDT Code maintenance process. For information about this and other CDT Codes, and how the CDT code set is maintained, go online to www.ada.org/en/publications/cdt, email dentalcode@ada.org, or call ADA Practice Institute staff at 800-621-8099. ▪

Joan Feifar is the Coordinator, Center for Dental Benefits, Coding & Quality at the American Dental Association. She can be reached at feifarj@ada.org



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Summer flashes by and we're into the Fall season. We hope that you and your families made the most of the summer, but we also know there's a certain relief when kids go back to school and we settle in to our normal routine.

At the SNDS, summer is our busiest time of the year as we prepare for the coming program season. This is especially true this year, with many changes and upgrades coming.

Our Premier CE series is set, with an outstanding lineup:

Dr. Edward Lowe, October
Dr. Bernard Villadiego, November
Dr. Ross Nash, March 2016
Dr. Michael Block, April of 2016

Once again, there is no fee increase this year, so members can subscribe to the whole series for just $750. This brings the cost per seminar down to $187.50! In fact, even if you can only make three of the four seminars, you still save by subscribing to the series. Each seminar provides 6 CEUs. We're also hard at work getting things in place for the 2016–2017 season!

The other big news about the Premier Series is that the seminars will be held at the Palms Resort Casino! By now, many of you have attended our Community Night at the Palms, and have a taste of what that's like. For the Premier Series, we've reserved the Addison Room for our headquarters. The Addison Room is on the main casino floor, but it is a perfect size for our events and you'll enjoy the space. This will be a year of transition, so be sure to let us know what you think about the changes.

Our member dinner meetings will be held in our usual room at the Gold Coast Hotel. We scheduled a great, eclectic mix of speakers and topics; including Dr. Leonard Morse from New York, to talk about his experiences with Medicaid and the New York State Attorney General. In November, a team —featuring NDA member Dr. Tina Brandon-Abbatangelo—will speak on "Animal Dentistry." You think some of your patients are a bear to deal with? Come to our November dinner meeting to hear how exciting it can be!

Our other project is revamping the Member section of our webpage. We are "A Community of Leaders" and every community needs a central marketplace, so that is what you'll find when you log into our website. New site features include associate listings, classifieds, and recognition for our faithful Corporate Partners. There will also be a community bulletin board for newsy items which will augment our Facebook page. More features will be added, but for now, it's a user-friendly, interactive place for members to visit, interact, and do business.

Thank you to our Corporate Partners. From our dinner meetings to the CE Café series, to Shredding Day, and of course, Give Kids A Smile, we have a great team of supporters who demonstrate their care and commitment to the dental community.

In October, we have the Rural Area Medicine (RAM) event. Last year was the first time this event was held, and we didn't have a lot of notice prior to the event. This year we're hoping that there will be a good turnout of volunteer dentists. The RAM event is open to the public, adults and children, and will provide medical, dental, vision, and other treatment for the underprivileged in Las Vegas.

The RAM event will be held at Tarkanian Basketball Academy on October 2–4. This huge event is a great opportunity for the public to see how southern Nevada dentists care, and to do some real good for deserving people. It also shows that we truly are "A Community of Leaders!" Contact the SNDS office for more information, or to volunteer. You can go online to YouTube to see last year's event by searching for "2014 Las Vegas Remote Area Medicine."

The other nice thing about RAM is that it is offset from our Give Kids A Smile event, which is set for Saturday, February 6, 2016. This means that the opportunity for those in need to receive treatment is spread over different parts of the year, and in different parts of the valley.

There's a lot of excitement in the fall air this year, and we hope that all of our members will be a part of a memorable new program year! ▪

CE PROGRAMS

Southern Nevada Dental Society
A Community of Leaders

To meet *your* needs, the SNDS has a full menu of CE opportunities. You can mix and match a CE program that suits your interests, your schedule, and your budget. Check out our schedule at www.sndsonline.org.

- *Premier CE Series*: brings world-class speakers to Las Vegas.
- *CE Café*: a free, members-only series.
- *CE On-Demand*: our most flexible option to fit almost any schedule.

Continuing Education Premier Series
CE Café
CE On Demand

The Many Hats of a Dentist

JB White, DDS

There is no doubt that the landscape of private practice is rapidly changing across the country. More and more dentists, especially recent graduates, are joining group practices and corporate dentistry. But deep down, most of us envision ourselves as entrepreneurs and when we picture our ideal life as a dentist, we dream of being our own boss and doing our own thing.

Dentists, like most U.S. small business owners, do technical work. And like most entrepreneurs, often times make a fatal assumption: if you understand the technical work of a business, you understand a business that does that technical work. They are in fact two totally different things, and frequently the technician fails to see this. The tragedy is the realization that the business that was supposed to free you from the limitations of working for someone else, actually enslaves you.

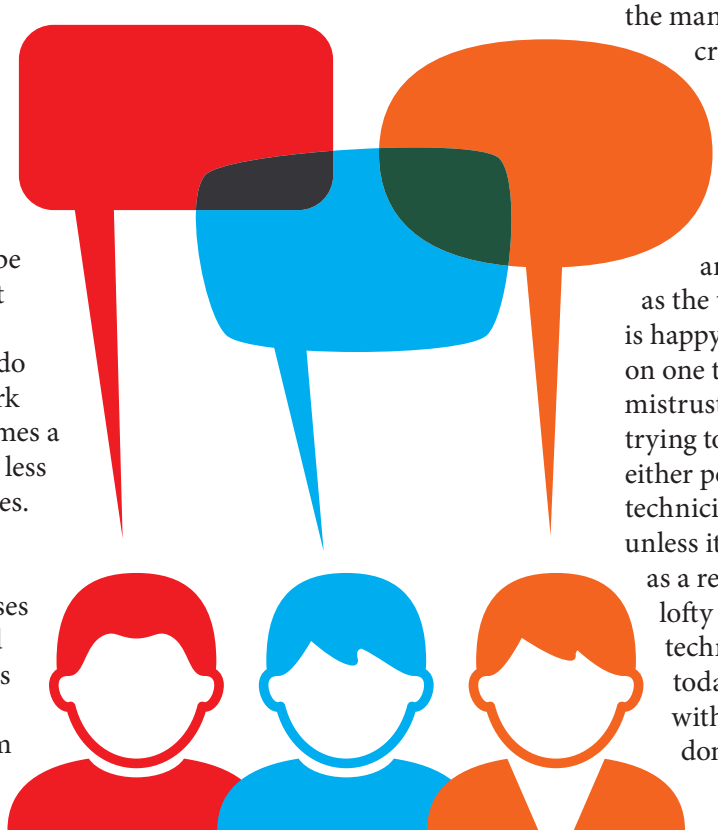
Suddenly the clinical aspects of dentistry that you know how to do so well, becomes one job you know how to do plus a dozen others you don't know how to do at all. The entrepreneur inside of you started the business, but the dentist that goes to work may be facing a nightmare. The dentist with an entrepreneurial dream takes the work he/she loves to do and turns it into a job. The work that was born out of love becomes a chore, among a welter of other less familiar and less pleasant chores. Rather than maintaining its specialness, representing the unique skill the dentist possesses and upon which he/she started the business, the work becomes trivialized, something to get through in order to make room for everything else that must be done.

Almost all dentists chasing their dream experience the same feelings. First, exhilaration; second, terror; third, exhaustion and finally, despair. A terrible sense of loss, not only the loss of what was closest to them, their special relationship with their work, but the loss of purpose, the loss of self.

The problem is that every dentist that goes into business is actually three-people in one: the entrepreneur, the manager, and the technician. It gets more complicated by the fact that while each of their personalities wants to be the boss, none of them wants to have a boss. They started a dental practice together in order to get rid of the boss…and the conflict begins.

The entrepreneurial personality is the visionary, the dreamer. The one that turns problems into opportunities and craves control so the imagination can run free. This personality lives in the future, never in the past, and rarely in the present. To the entrepreneur, the world is made of an overabundance of opportunities and people in the way.

The managerial personality is pragmatic and loves to plan and have order and predictability. The manager is the part that organizes hundreds of burs in tiny bins that are divided into diamonds and carbides and stacked perfectly on equally spaced shelves stored in the ideal location and labeled perfectly with pictures as to never disturb order. As the entrepreneur lives in the future and craves control, the manager lives in the past and craves order. Where the entrepreneur thrives on change, the manager compulsively clings to the status quo.



The technician is the doer and lives in the present. As long as the technician is working, he/she is happy, but only if they are working on one thing at a time. The technician mistrusts the owner who is always trying to get more work done than is either possible or necessary. To the technician, thinking is unproductive unless it's about the current task, and as a result, he/she is suspicious of lofty ideas or abstractions. The technician feels responsible for today's production and feels that without them nothing would get done; but lots of people would be

➲ *Continued on page 26*

thinking about the work. In other words, the entrepreneur dreams, the manager frets, and the technician ruminates.

The technician is often frustrated and annoyed by the entrepreneurial ideas that interrupt the course of what needs to be done, as they feel that something new that probably doesn't need to be done at all. The manager is also a hindrance because he/she is determined to impose order on the technician's work to enforce "the system." To the technician "the system" is impersonal, dehumanizing and violates his/her individuality as an artist. To the manager, however, work is a system of results in which the technician is but a component part. Thus, the manager thinks the technician becomes a problem to be managed. The technician thinks the manager is a meddler that needs to be avoided. To both of them, the entrepreneur is the one who got them into trouble in the first place.

Every dentist has an entrepreneur, manager, and technician inside of them. If the personalities were equally balanced we would be describing an extremely dynamic individual. Unfortunately, few dentists are blessed with such balance. Dentists tend to follow other small business owners in that they are 10 percent entrepreneur, 20 percent manager, and 70 percent technician. The entrepreneur speaks up one day and says, "I should own my own practice." The manager screams, "Oh, no!" and the technician is in charge.

Once you realize you are no different than the majority of small business owners across the world, technicians who went into business, you realize there is hope. I'll even give you a hint…it's not an occlusion course. ▪

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To learn more visit healthcare.goarmy.com/h489 or for Las Vegas recruiting center call 206-242-9357, or Reno recruiting center call 916-927-4084.

U.S.ARMY

Lori Benvin
nnds@nndental.org

We'd like to welcome many new dental professionals to northern Nevada. We openly invite all of you to the NNDS 2015–2016 continuing education and event calendar year. Please watch for our emails and eNewsletters, check our website at www.nndental.org, and look for our mailings regarding upcoming chapter events. Value to our members is important to the NNDS and we continue to offer lower prices for our members.

The biggest change this fall is the new logos and name for our 30+ year old program; the Northern Nevada Dental Health Programs. In early September 2015 we will launch our website for NNDHP: www.nndhp.org. We were extremely fortunate to hire the public relations firm Ocean PR; and Kaity Ocean's team created a new brand for NNDHP. We are extremely proud of our new look and rollout; and we can't wait for you to view it.

NNDHP continues to serve children and veterans thanks to our generous volunteer providers.

Northern Nevada
DENTAL HEALTH PROGRAMS

The veteran's program name will remain "Adopt a Vet Dental Program."

AAVD
Adopt a Vet Dental Program

The children's program has a *new* name within NNDHP—"Healthy Smile Healthy Child."

HEALTHY SMILE
HEALTHY CHILD

Community Health Alliance is our administrator and we are fortunate for our collaboration. Please take a moment to visit our Facebook page which is available "Northern Nevada Dental Health Programs" and check out the new website (coming soon).

Our 2015–16 year literally kicks off on Saturday, Sept. 12 with our *UNR vs. Arizona* Spouses/Guest/Family Night football tailgate. We will be stationed in the private barbecue area at the north end of Mackey Stadium for UNR. Price includes, dinner, drinks, and game seats—or watch from our private tailgate area at north end of stadium. Don't miss it!

Our general membership dinner meetings begin on October 15. Please check our website for all information related to our events; including on-line registration.

We also have outstanding continuing education speakers coming to Reno this year and 2016. Check your email for our monthly eNewsletters and our Calendar of Events (also on page 31). If you are not receiving our emails, contact our office at (775) 337-0296, email us at nnds@nndental.org, and go to our website at www.nndental.org. ▪

Welcome to our new NNDS members

Aaron U. Adamson, DMD
Oral and Maxillofacial Surgery

David J. Dapra, DMD
General

Ryan R. Falke, DDS
Oral and Maxillofacial Surgery

Katie B. Foster, DMD
Pediatric Dentistry

Whitney E. Garol, DMD
Pediatric Dentistry

Kathleen H. Hood, DDS
General

Christopher Lingard, DMD
General

Jamie R. Smith, DDS
General

Mathew L. Stewart, DMD
General

Ryan D. Waring, DDS
General

Brandi Dupont, DMD

I express my gratitude to Dr. Perry Francis for his time and dedication over the past year as the NNDS president. His leadership was an important contribution to our success, and I hope to live up to his example. Our incoming executive board is ready to work: Dr. Maggie Heinen, Vice President; Dr. Spencer Fullmer, Sec./Treasurer; Members at Large, Drs. Stephen Sims and James Mann. Also, welcome to our CE Chair, Dr. Craig Andresen, as he tirelessly works to bring informative and relevant CE opportunities to Northern Nevada. And, we are grateful to continue to work with our executive director, Lori Benvin. Lori has a wealth of knowledge and experience—we don't know what we would do without her!

Dr. Adam Welmerink has been the NNDS Membership Chair for the past three years. Recently he procured two ADA grants to use in the New Dentist Committee. So, I happily welcome New Dentist Committee chair, Dr. Erin Anderson. Dr. Anderson has great ideas on teaching new dentists in our community about the NNDS benefits and resources. The committee will also host new Give Kids A Smile events in the upcoming year.

The NNDS continues to offer dinner meetings at a lower cost to members. We have some exciting upcoming CE opportunities. In November we welcome Dr. S. Thikkurissy, Director of Residency Program at Cincinnati Children's Hospital, as he gives a presentation on pediatric dentistry.

Thank you to our wonderful dental professionals that provide free dental care to our community members. In September, the NNDHP hosted its annual Joel F. Glover Charity Golf Tournament to support the NNDHP and AAVD. We are grateful to Dr. Eberle for supporting our programs with the Jason Eberle Memorial Concert. We also encourage you to volunteer in October for the Remote Area Medical (RAM) clinics in both Carson City and Yerington.

I look forward to a productive year as your NNDS President. Thank you for your continued support of our Society. It is an honor to serve you in this coming year. ▪

Admissions and Student Affairs

The Office of Admissions and Student Affairs is nearing the end of the selection process for the incoming class of 2019. There were 1,919 applicants for the 2014–15 application cycle. We welcomed approximately 80 new students to the UNLV SDM family.

On Sept. 18, our Class of 2018 had their White Coat Ceremony, with keynote speaker Dr. Raymond Rawson. The 2015–16 application cycle for the recruitment of the Class of 2020 began on June 2. As of July 1, 692 applications have been received.

Advanced Education Program in Pediatric Dentistry

The six members of the Class of 2015 completed their program in June. Dr. Emily Whipple is practicing in Reno, Dr. Matthew Herring and Dr. Katrina Naasz in Arizona, Dr. Jamie Son in California, Dr. Jaime Williams in Texas, and Dr. Jarod Johnson in Iowa.

We are pleased to welcome part-time instructor Dr. Bibiana Ezeanolue to the pediatric program. Dr. Ezeanolue did her pediatric residency at Children's Hospital of Michigan in Detroit and is a Diplomate of the American Board of Pediatric Dentistry.

Office of Research

Dr. Connie Mobley has been a member of the American Dietetic Association for 50 years. She will be a guest of honor and recognized for her distinguished scholarly work in nutrition and dietetics at the Annual American Dietetic Association Conference in Nashville, TN this October.

Congratulations to the UNLV SDM Class of 2015! The following graduates were recognized as the 2015 recipients of the following awards for their outstanding research efforts:

Oral Biology Award—Sabrina Dragan
Quintessence Award—Lindsay Row
Innovation Award—Kelsey Loveland

Dental students are encouraged to participate in research. The following courses have been added to the curriculum:

DEN7163—Summer Research Enrichment Program for DS1 (1 credit)
DEN7263—Summer Research Enrichment Program for DS2 (1 credit)
DEN7363—Summer Research Enrichment Program for DS3 (1 credit)

Faculty publications

Raynor H.A., Anderson A.M., Miller G.D., Reeves, R., Delahanty, L.M., Vitolins, M.Z., Harper, P., **Mobley C.**, Kondersman, K. Mayer-Davis, E. "Partial Meal Replacement Plan and Quality of the Diet at 1 Year: Action for Health in Diabetes (Look AHEAD) Trial." *Journal of the Academy of Nutrition and Dietetics.* Volume 115, Issue 5, May 2015, Pages 731–742.

Van Breukelen F. & **Hillyard S**. "Paradoxical Anaerobism in Desert Pupfish." *The FASEB Journal.* Volume 29, No. 1, May 2015.

Stanley J. Nelson. Wheeler's Dental Anatomy, Physiology, and Occlusion, 10th Edition (Elsevier), 2015.

Student publications

Sorenson L, Hughes CC, Demopoulos CA, Mobley CC, Ditmyer M, Bott B, Morris J, Neu T, Penalosa K. "Parent's Knowledge of Children's Oral Health and Their Ability to Retain Information." *Nevada Journal of Public Health*, 2015.

Faculty news

We are pleased to welcome back Dr. Eve Chung as she joins the department of Clinical Sciences as a Visiting Assistant Professor. She completed her DMD at the UNLV SDM in 2012 and was awarded a BS degree from the University of Nevada, Reno in 2008.

Congratulations to the following full-time faculty on being included in the *Desert Companion* Top Dentist List: Dr. John Gallob, Dr. Edward Herschaft, Dr. George McAlpine, Dr. Daniel Orr, Dr. Rick Thiriot, and Dr. Raymond Tozzi. In addition, part-time instructors Dr. Peter Balle, Dr. George Rosenbaum, Dr. Michael Saxe and Dr. Mark Tingey and volunteers Dr. Chad Ellsworth and Dr. Steven Saxe were named to the list.

Community service

Faculty, students, staff and post-doctoral pediatric students continue to provide preventive services in community-based, underserved settings in Clark County and Nye County. From May 1 to Aug. 10, 2015, we attended 14 events, and the total value for donated services is $8,329.

RAM (Remote Area Medical), an international organization that travels the country and throughout the world providing free medical services with no qualifications will be holding events on Oct. 2–3 at the Tarkanian Basketball Academy in Las Vegas, Oct. 9–11; in Yerington; and on Oct. 16–18 in Reno. Dentists, oral surgeons, dental hygienists, assistants, and technicians are needed to provide dental care. To register and become a volunteer, please visit www.CARECoalitionNV.org.

Continuing Education

Courses being offered by the UNLV SDM include the following:

- *"Oral Soft Tissue Lesions"* presented by Edward Herschaft, DDS, on Sept. 25.
- *The Sixth Annual Las Vegas AAID Maxicourse for Implant Dentistry* presented by the Dental Implant Learning Center, on Sept. 25 and 26.
- *"Real World Endo Seminar—The Evolution of Endodontic Technique"* with Dr. Keith Evans, on Oct. 10.
- *"Clinical Dentistry Updates 2015"* led by UNLV SDM faculty members Ed Herschaft, DDS; Cody Hughes, DMD; Bernard Hurlbut, DDS; Robert Lockhart, DDS, MS; Stanley Nelson, DDS, MS; Randy Phillips, DDS; and Richard Walker, DDS, Med, on Sept. 26.
- *"ICPPD: Fundamentals of Pediatric Dentistry"* presented by Roger Sanger, DDS; Ray Stewart, DMD; Bill Waggoner, DDS; and Stephen Wilson, DMD, on Oct. 16 and 17.

To register for any of these courses or for more information on CE, please visit http://sdm.unlv.edu/ce.

Development news

Recent donations to the SDM include $5,000 from Henry Schein (annual part-time faculty dinner sponsor), $10,000 from the Delta Dental Community Care Foundation to pay for free care of the "working poor," and $10,000 from USAA to support the Sgt. Clint Ferrin Dental Clinic. Thank you for your support and generosity. ▪

SEPTEMBER			
Fri 25	**NNDHP/Joel F. Glover 13th Annual Charity Golf Tournament**	8 AM	LakeRidge Golf Club, Reno
Wed 30	NDA Executive Committee Meeting	6 PM	Video Conference
OCTOBER			
2–4	**Remote Area Medical (RAM) Event—Las Vegas** *NEED VOLUNTEER DENTISTS*		Tarkanian Basketball Academy, Las Vegas
9–11	**Remote Area Medical (RAM) Event—Yerington** *NEED VOLUNTEER DENTISTS*		Boys and Girls Club, Yerington
Tue 13	NNDS Executive Committee Meeting	5:30 PM	161 Country Estates Cir, #1B, Reno
Thu 15	SNDS General Membership Dinner Meeting	5:30 PM	Gold Coast Hotel, Las Vegas
Thu 15	NNDS General Membership Dinner Meeting "Dental Ergonomics"	6 PM	The Grove Event Center, Reno
16–18	**Remote Area Medical (RAM) Event—Reno** *NEED VOLUNTEER DENTISTS*		Carson City High School, Reno
NOVEMBER			
Tue 10	NNDS Executive Committee Meeting	5:30 PM	161 Country Estates Cir, #1B, Reno
4–8	**ADA Annual Session and New Dentist Conference**		Washington, DC
Thu 12	NNDS General Membership Dinner Meeting "Pediatric Dentistry"	6 PM	The Grove Event Center, Reno
Thu 12	*SNDS presents:* New Dentist CE	TBD	WestPac Wealth Partners
Fri 13	*NNDS presents:* All Day CE Pediatric course, with Dr. Thikkurissy	8 AM	The Grove Event Center, Reno
Wed 18	NDA Executive Committee Meeting	6 PM	Video Conference
Thu 19	SNDS General Membership Dinner Meeting	5:30 PM	Gold Coast Hotel, Las Vegas

Securing Abandoned/ Unclaimed Nevada Property

By Daniel L. Orr II, DDS, PhD, JD, MD; Editor, NDAJ

THE OFFICE OF the State Treasurer in Nevada gives one the opportunity claim property presumed abandoned. In my case, the successful return of property has involved the Treasurer releasing held insurance checks which somehow did not end up in my dental office, but in the Treasurer's office.

The process is relatively straightforward. Log into **www.NevadaTreasurer.gov** and enter a search in the unclaimed property area. I have successfully searched property under my name and various combinations and permutations of the same, i.e. Dr. Orr, Orr DDS, etc. If properties are then displayed, one must determine if they belong to the searcher. If the properties should be sent to the searcher, a claim form can be filled out on-line or in a hard copy after printing it.

During a call to the Unclaimed Property Office (702-486-4140) the *Journal* was advised that most unclaimed property is sent to the State Treasurer by default when the intended owner is no longer at a previous address. In addition, the *NDAJ* was advised that one should allow up to 120 days for processing and payment.

Some rules apply and should be noted. For instance, claims over $500 require notarization and proofs relating the monies to the claimant, such as a driver's license, social security or TIN numbers, and/or an office address.

In my case, I run a search about every five years and the returned property amounts have always more than justified the hour or less spent filing the claim. ▪

How Can I Be Part of a Plan When I Didn't Sign Up?

Network Leasing and Affiliate Carriers

THERE ARE TWO WAYS in which this might happen:

- You signed a contract with a network leasing company and that contract allows the leasing company to rent, lease or sell a network of dentists to dental plans, third party administrators and any other entity.
- You signed a PPO contract with a third party payer that allows the third party payer to rent, lease or sell the network of dentists to an affiliated carrier or any other entity. Another similar situation is when you may have signed a contract that allows the carrier to place you in-network for all their plans.

Such an agreement can actually be beneficial especially if:

- It results in new patients coming into your office, and
- the fee schedules are not different from what you originally agreed to in your contract with the primary company.

On the other hand, if many of your cash patients become eligible for the discounted fee, it may adversely affect your practice. Your practice may also be affected when the agreement between the primary and secondary carrier allows the secondary carrier to further discount your fee schedule. Again this can happen without your explicit consent depending on terms in your original contract.

Looking at contract clauses closely is very important to avoid such situations. Members can use the ADA's Contract Analysis Service by submitting an unsigned contract to their state or local dental societies who will forward it to the ADA Service. The Service provides a plain language explanation of contract terms of each agreement analyzed. The Service does not provide legal advice or recommend whether a contract should or should not be signed. The analysis will be subsequently sent to the member at no charge.

In an effort to promote transparency, the ADA Council on Dental Benefit Programs is working on concepts to support legislation that will require dental plans and third party leasing organizations to properly disclose all such relationships and provide the dentist the opportunity to explicitly agree to such agreements before they are placed into affiliated carrier networks.

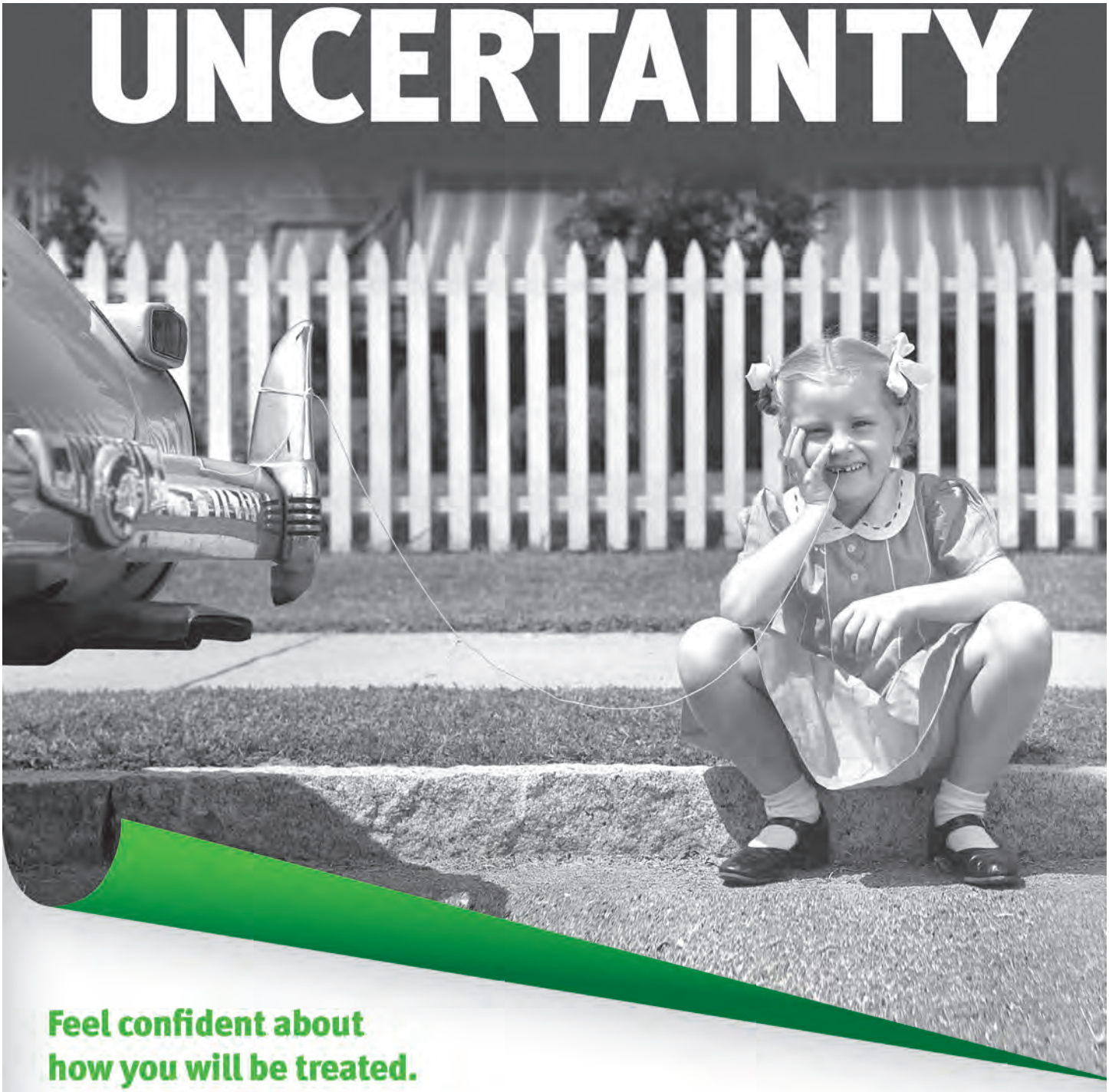
Make sure to check your mail. Some letters are marked "No action needed." Letters often talk about how the new program allows you to "grow your practice." Always read these letters to understand what impact they have on your practice. ▪

Illegal Legal CLE

THE MAY 2015 *Cal Lawyer* reported two disciplinary actions involving attorneys:

- Warren Arthur Harms was charged with an act of moral turpitude by falsely reporting to the State Bar that he had fulfilled his Minimum Continuing Legal Education (CLE) requirements.
- Bryan Hildalgo was suspended for 30 days and placed on one year of probation for falsely reporting to the State Bar that he was in compliance with his Minimum CLE requirements when he knew that he was not, an act involving moral turpitude. Hidalgo later satisfied the requirements and returned to active status. ▪

UNCERTAINTY



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