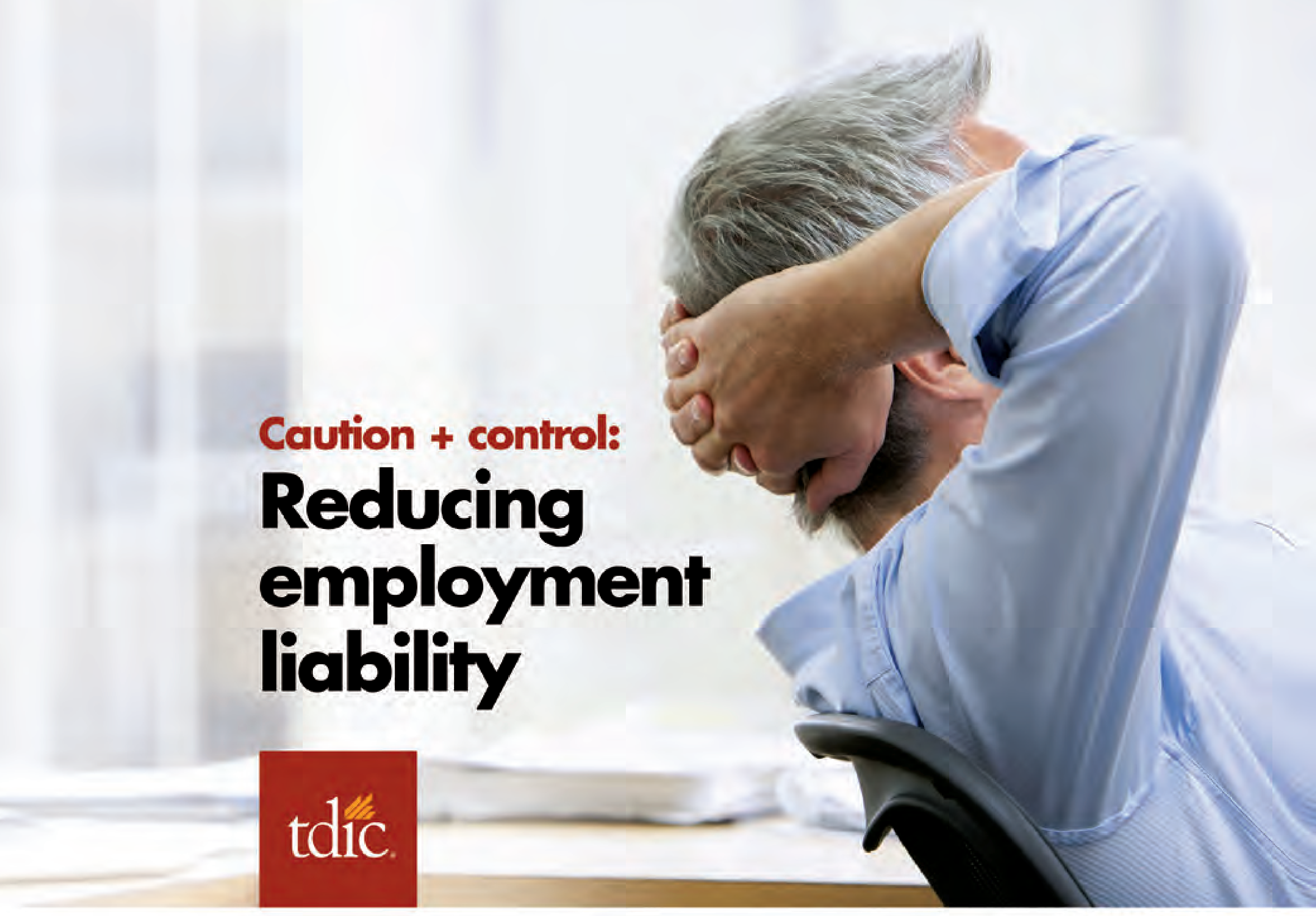
Spring 2018 Volume 20, Issue 1

NDA JOURNAL

Official Magazine of the Nevada Dental Association and Component Societies
A Peer Reviewed Journal



Changing employment laws and a litigation-conscious public can intimidate the most confident dentists. Especially when practice employees are prepared to take legal action if they feel an employer breached their rights. With insights from Employment Practice Liability claims experience and calls to our Risk Management Advice Line, TDIC's seminar shows how to best handle employment concerns. Gain the caution and control to navigate past potential violations such as pregnancy discrimination, termination and sexual harassment.*

Get expert advice while earning **C.E. credits** and a **5% Professional Liability premium discount** for two years. Even better, **take the seminar online** at your convenience.

TDIC policyholders who complete a seminar or elearning option will receive a two-year, 5% Professional & Dental Business Liability premium discount effective their next policy renewal. To obtain the two-year, 5% Professional & Dental Business Liability premium discount, dentists must successfully complete the seminar by April 28, 2018. Any eLearning tests received after the deadline will not be eligible for the discount. Nonpolicyholders who complete a seminar or eLearning option and are accepted for TDIC coverage will also be eligible for this discount.

See more ways we reduce your risk at **tdicinsurance.com**

- Confidential guidance through our Risk Management Advice Line
- Publications dedicated to exploring timely dentistry liability issues
- Helpful guides, informed consent forms and sample manuals
- A variety of live and eLearning C.E.-eligible seminars

*Due to the sensitive nature of the issues being addressed and our employer-oriented approach, this course is available to dentists and their spouses only.

Endorsed by the Nevada Dental Association

Protecting dentists. It's all we do.®

800.733.0633 | tdicinsurance.com

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

NDA JOURNAL

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

Publisher
LLM Publications
800-647-1511
www.llmpubs.com
Design: Benjamin Caulder

NDA Journal is published four times each year by the Nevada Dental Association and state component societies. All views expressed herein are published on the authority of the writer under whose name they appear and are not to be regarded as views of the publishers. We reserve the right to reduce, revise, or reject any manuscript submitted for publication.

Materials: All articles, letters to the editor, photos, etc. should be sent to Daniel L. Orr II, DDS, via email to EditorNDA@nvda.org. All chapter and committee reports and business communications should be sent to Robert Talley, DDS, Exec. Dir., Nevada Dental Assn., 8863 W Flamingo Rd, Ste 102, Las Vegas, NV 89147, Ph 702-255-4211 or 800-962-6710, Fax 702-255-3302. Materials may be reproduced with written permission.

Subscription: Members receive each publication as a membership benefit paid by membership dues. Non-members may subscribe to the Nevada Dental Association Journal for $50 annually.

Advertising Policy: All advertising appearing in the NDA Journal and other Nevada dental publications must comply with the advertising standards of the Nevada Dental Association and its component societies. The publication of an advertisement is not to be construed as an endorsement or approval by the publishers of the product or service being offered in the advertisement unless the advertisement specifically includes an authorized statement that such approval or endorsement has been granted. The publishers further reserve the right to cancel any and all contractual advertising agreements should an advertiser be engaged in litigation concerning their product or service, or should the product or service be in conflict with the standards of the NDA or its component societies. Advertising rates and specifications are available upon request. Contact Dan Hartzog, LLM Publications, at 800-647-1511 ext 2229 or email danh@llmpubs.com. Mailing: Send address changes to: NDA, 8863 W Flamingo Rd, Ste 102, Las Vegas, NV 89147.

© 2018 Nevada Dental Association

NDA JOURNAL

SPRING 2018

Editor's Message Daniel L. Orr II, DDS, MS (anesth), PhD, JD, MD 2

Reports

NDA Executive Director Robert H. Talley, DDS, CAE 4

NDA President George McAlpine, DDS 5

SNDS Executive Director Jessica Beason 26

SNDS President Joseph Wineman, DMD 28

NNDS Executive Director Lori Benvin 30

NNDS President Spencer Fullmer 31

UNLV SDM Report 34

Sections

Reports: ADA District 14 Trustee Report 6

Government Relations 12

Featured Articles

2017 NDAJ Billy Cannon Award Reactions 10

Nevada *AB474* 18

The Perils of Opioid Prescribing 21

Equivalent Degrees 24

Columns

Treasures of Pioneer History 32

Event Calendars 33

From the NDA

NDA Summer Meeting 8

NDA Administrative Offices 36

On the Cover

The opium poppy has been ubiquitous for millennia. *AB474* took effect in January. Are addiction issues now solved, or perhaps exacerbated?

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

Why We Love Coding

(OK, OK, not really)

In fact most health professionals despise coding, something they never anticipated doing when they applied to dental or medical school. Where did all this coding stuff come from? How did doctors become voluntary clerical staff for private insurers, governmental payers, and regulators? Certainly there are advantages for everyone beside the doctor (and the patients of course) who is required to sign every plea for reimbursement subject to multiple civil and criminal penalties. Regulators love to cost efficiently pit their high school graduate code checkers against doctors… how many osteoblasts are required to qualify for D7230 "removal of bone" by the way?

Doctors, at least the clinical ones actually doing procedures, didn't have time to devise this evil paradigm. Payers and regulators, step by step, led us down the path to the current iteration of CDT with its many predictably confusing codes. How can codes with handy nomenclature "literal definition in the bolded font" and descriptor "the further definition" explanations be confusing? That the system is frenetic is amply demonstrated by the biennial publication of CDT refinements to existing codes. Each edition of the ADA's money making CDT code book also has new codes, 18 of them in 2018. If we're lucky, there may be a deleted code or two. But the book predictably keeps growing, getting pretty close to 700 total codes now.

700 codes are way too many, but nothing compared to our medical colleagues now dancing with 140,000 codes and counting. Do we really need codes for parrot vs macaw bite? How about injury from a water ski vs a burning water ski? Well, yes, because how else can the regulators make sure they have a violation, or at least a controversy requiring additional explanation from the doctor? And if our explanation is not good enough for the apparatchik, fraudulent coding is assumed (Obamacare provision) and the burden of proof is on the doctor to show he/she didn't miscode, not on the prosecutors to prove the doctor did.

Initially, codes were developed by asking doctors how much time it took to do a certain procedure, such as closed reduction vs. open reduction of a fracture. Then the time based codes were assigned a dollar value. So codes were originally loosely related to the time it took to perform a procedure.

This framework is in place for CDT codes also; too bad it doesn't work. Some dentists can complete a D7240 extraction in less than a minute, while others spend an hour or more on a D7410 extraction. What sense does that make…don't try to answer, the reasoning does not make sense on any level.

Does coding every really make sense? No, not really, but coding for anesthesia comes the closest. Anesthesia is billed in 15-minute increments, but there are still too many modifiers involved. Plus, sedation is paid at a lesser rate than general anesthesia, even though the administration of general anesthesia is not as labor intensive as sedation.

By the way, why is it that physicians bill $1,500 for a peripheral trigeminal block while the same procedure is "included" in the overlying fee for dentists? CDT codes bundle local anesthesia (LA) with procedures. If a dentist includes a separate charge for LA, the insurance carrier notifies the patient that LA should be included with the procedure. Is there any less skill or risk involved when dentists administer head and neck LA than when a physician does?

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 Anesthesiology 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.

In addition, what if one's patient refuses local anesthesia?[1] As was reported in the ADA News: "There is also a question of ethical and legal practices involved. If I do not use LA for a procedure, how can I say the fee includes this service? Can we include a charge for a service we don't provide?"[2] Ethically, should the included fee be zeroed out if not done, thus lowering the total fee?

Obviously negative commentary on coding could fill this entire journal, but we'll forgo the fun of that by providing the solution to all coding issues. It is actually very straightforward and one doesn't need explanatory texts to navigate the rules.

While many doctors reflexively try to justify bills by iterating procedures, another profession is valued for its time no matter what the project is. It has to do with the definition of "profession" that prioritizes mental effort, the employment of the mind, and not primarily technical expertise. Surgeons, especially dentists, are second to none in technical proficiency. But the key to being a professional is why we do what we do, the cerebral part of the equation.

Our attorney colleagues generally bill for the time they spend acting professionally. Attorneys determine what it takes for them to work for an hour, add in their external costs, and the total is what they charge no matter what the project. It's a beautiful concept.

Health professionals could do the same. Once the doctor decides what his/her services are worth per hour, other fees would be added in as expenses. When individual lab fees, drugs, materials, and other costs are involved, they can be itemized on the bill. The patient can then express concern to the entity that used to tag along, unnamed, on the doctor submitted invoices (insurance forms). Importantly, included in the doctor's hourly fee would be all his/her services for that time frame, including cerebration during consultations without an actual physical procedure being done.

The result will be a predictable fee and cost savings all the way around as the coding minions and their costs fade away in time.

This is not the impossible dream; some doctors are already doing it.[3]

References

1) Orr D, Channeling Apollonia, NDAJ 19:1, 3-4, Spring 2017.
2) Muller, JW, ADA News, Letter to the Editor, February 2, 2004.
3) Multiple Authors, Restoring Free Markets to Medicine, https://aapsonline.org/freedom/, accessed March 5, 2018.

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

Executive Director's Spring Message

Plans are under way for our Annual Summer Meeting to be held at the Mandalay Resort in Las Vegas on June 22–23, 2018. You will find registration material in this issue of the journal. I hope you will consider attending our meeting and bringing your family. The House of Delegates meeting will take place on Friday morning, June 22. Dr. Mcalpine has planned a very special President's dinner at the world famous Aureole Restaurant on the Mandalay property on Friday night. There will also be a Continuing Education class on Saturday morning sponsored by Bio Horizons at a very low price.

These are the Legislative activities we are participating in:

- Interviews of candidates for State Assembly and Senate to educate them on our issues
- Participation in selected Assembly and Senate caucus functions to get to know new candidates and make some decisions on who we need to interview
- Interim Legislative Healthcare and coalition meetings
- Several Nevada State Board of Examiner meetings and workshops
- Opioid crisis meetings with the Attorney General's office
- NDA Legislative Committee meetings to determine our legislative agenda for 2019

Please see the Announcement below about our new Advocacy Tool meant to get patients involved with our issues.

An Open Letter to our Members, from the Nevada Dental Association

Dear NDA Member,

Every two years at the Nevada Legislature, the dental profession faces opposition from those seeking to erode the doctor patient relationship and instead allow outside, non-medical professionals to make important care decisions.

According to the American Dental Association, four out of five dentists cannot afford to live, survive, run a business, give staff raises, invest in technology, and operate a practice with insurance reimbursement fees.

Dental insurance first became available in 1963 had a $1,000 limit. Today, 54 years later, the average policy still has that $1,000 limit, but deductibles and co-pays are higher, fewer procedures are covered, and the buying power of that $1,000 today is significantly lower.

The Nevada Dental Association has created a platform to engage your patients to help us preserve the doctor patient relationship. *And we need your help*. Please have your staff, friends, and patients visit teethnotpolitics.org or text "Dentist" to 52886. This will allow us to communicate with them when important issues arise. *Without your engagement and action, this program will not succeed.*

We are ready and willing to visit your office personally, provide the needed materials to your staff, and to answer any questions. Our professionals only require 5 minutes with your front office staff and there is no additional burden on them. Please call the NDA office at 702-255-4211 for materials.

Thank you for taking the time to engage and make a difference.

President's Spring Message

George McAlpine, DDS

As I sit down to write this article, Nevada has been enjoying unusually mild weather. Spring appears to be arriving early this year. As my time as NDA President winds down, I have to reflect on the ups and downs of the last seven months. I think, by nature, most dentists tend to be solitary individualists. This can make it difficult to work in a group setting where compromise is often necessary. As dentistry moves more and more toward corporate and large group practice offices, it is essential that Nevada dentists work together to protect and preserve our profession for those that follow us.

Meanwhile, both the North East and Northern Nevada contingents have done a great job of membership retention and attracting new members. Lori Benvin has been a very strong leader at NNDS and Jessica Beason at SNDS. Their work has been exceptional.

At the NDA our Legislative session will be soon upon us. We have our "team" prepping and readying themselves to work on our behalf to oppose Midlevel providers and any other anti-dental legislation that may arise. We are extremely fortunate to have our chief lobbyist, Chris Ferrari, and his superb team representing and defending our association. Another formidable member of our legislative arsenal is our highly respected Executive Director, Dr. Bob Talley, who spends almost as much time in Carson City as he does in Las Vegas during a legislative session. We are, also, very fortunate to have the incoming President, Dr. Rick Dragon, and Past President Dr. David White to help tag team our legislators during the session. Now, more than ever, it is critical for Nevada dentists to band together to present a united front against our foes that seek to diminish the access and quality of care that we provide to our patients.

Dr. Talley was recently asked to become a member of the Governor's/ Attorney General's Statewide Partnership to address the Opioid Crisis. Bob's outstanding statewide reputation is paying dividends as state legislators and the Governor's staff think of Bob whenever an issue effecting dentistry surfaces.

We're, also, very fortunate to have Suzi Fobbs to oversee our website and social media contacts.

The Nevada Dental Association Summer meeting will be held at the Mandalay Bay Resort in Las Vegas on June 22–23, 2018. The House of Delegates will meet on Friday morning and Bio Horizons is helping to sponsor a Continuing Education course on Saturday morning. We have planned a special President's dinner event at the world famous Aureole restaurant on Friday night. Please see the registration materials in this journal issue or visit our website.

Announcement

of Election for Secretary of the Nevada Dental Association

The Nevada Dental Association House of Delegates will vote on a new Secretary at the Annual Summer meeting on June 22,2018 being held in Las Vegas at the Mandalay Bay Resort.

Nominations as of this printing include:

Dr. Edward De Andrade

Dr. Emily Ishkanian

Voting at the meeting will be by secret ballot with only Delegates to the NDA House of Delegates voting. These delegates include: delegates assigned by the components, the ADA delegates, the student delegate and the officers of the NDA assigned as voting delegates.

ADA District 14 Trustee Report

By Daniel Klemmedson, DDS, MD, District 14 Trustee

I have just returned from the first major Board of Trustees (BOT) meeting since the Annual Session in Atlanta. A BOT retreat was held in December where some limited business was conducted. This was primarily focused on updates to the ADA Business Model Project and consideration of a “Vision” statement for the ADA.

The meeting this past 6 days was much more intense. Special sessions were held to discuss the relationships between ADABEI, the ADA Foundation, our business model project and of course CODA. The standing committees of the ADA BOT occupied Friday and Saturday. The New Dentist Committee was in Chicago as well, which provide an opportunity to interact both strategically and socially. Dr. Lindsay Compton, our NDC representative can provide perspective from the committee directly to you if you reach out to her. The New Dentist Committee announced their selections for the new “10 under 10” awards. Those recepients have been notified and District 14 did very well with two selections. Help Lindsay and me congratulate Dr. Amisha Singh from Colorado and Dr. Mai-Ly Duong from Arizona.

From my perspective, our most important discussions involved the ongoing evolution of dental therapist workforce models in the US, and the active effort of many patient advocacy groups to push for dental benefits in Medicare. I will address both issues separately.

Dental therapy workforce models continue to expand. As a reminder, states that have approved some form of dental therapy provider include Minnesota, Vermont and Maine. They are not yet working in Vermont or Maine. Dental Health Aide Therapists are also in Alaska serving Alaska Natives only. This same model is also on several reservations in Oregon. Approximately 25 other states are actively under threat and constant advocacy efforts from Pew or Kellogg. Kansas and Massachusetts, have created compromise bills that will allow for inevitable passage in those states. In Arizona, a bill has cleared the Senate Health committee and is headed to an Education committee. 33 of 90 legislators are cosponsors and represent both liberal and conservative points of view. The BOT held strategic discussions regarding this topic several times over the course of the meeting. Intensive review of all available background material and research is planned with additional discussion planned for April.

A dental benefit in Medicare is a very big issue and loaded with nuance. It is primarily being driven by multiple patient advocacy groups. Many of these groups have members who are prominent educators and leaders in dentistry. This effort has been moving forward for some time. The ADA was not initially at the table due to a presumption that we would not be interested. The ADA has been involved for the past several years in an effort to represent us and provide much needed information and perspective. A special session was held with the New Dentist Committee and the BOT (four hours) to discuss this. There was wide diversity of opinion and consensus was not reached. Multiple variables exist that influence this decision-making process. This includes potential plan design and extent (unknown), distrust over government programs, reimbursement, reporting requirements, regulation, electronic health records. The growing crisis in unmet oral healthcare needs in the elderly was probably the only consensus reached. Non-government alternative benefit development was a frequent recommendation by those involved in the discussion. An overriding concern, that the ADA has little control over, is the number of Medicare recipients who can control the process via advocacy and at the voting booth. Clearly, the ADA exists to represent member dentists and is looking at the issue from that perspective, while respecting core principles that exist in our organizational documents and within each of us as healthcare providers. In the ADA Constitution we state, “The object of this Association shall be to encourage the improvement of the health of the public and to promote the art and science of dentistry.” ADA policy also exists which supports benefits. Multiple councils are looking into this issue and it may very well come before the HOD this fall.

The ADA Business Model Project is nearing the end of a second phase. A primary driver of this project is a need to reimagine our business model via development of innovative business initiatives that produce both member benefit and non-dues revenue. A second consulting group “Continuum,” was engaged to “build” and expand on an initial design by “frog” Consultant recommendations. Some changes in the initial concept have occurred (anticipated) and information that is much more concrete will be considered by the BOT in April. At that time, additional meaningful information should be available for me to share with you. I ask for your patience.

The ADA engaged a consultant to assist the Communications staff to refine the ADA Master Brand Strategy. The BOT received a presentation on this effort, which was tested with ADA

members and received favorable impressions approaching 90%. The strategy focuses on our core audience (members) and our impact on the world. The following statement was developed: The ADA powers the profession of dentistry to advance overall oral health of the public. This will be used internally to coordinate the ADA brand across all media platforms (print, websites, marketing).

Additional marketing news relates to our three-year exclusive ADA-CVS collaboration. The ADA and ADA Seal products will receive high visibility in every CVS store. Our Find-A-Dentist program will be highlighted as well.

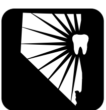
The new Specialty Recognition Commission members have been named by the ADA and all recognized specialties. The will be meeting this spring to develop organizational documents and begin their important work. Dr. Chuck Norman has been named interim Chair.

Membership decline remains an important issue. The ADA had a net gain of 1200 in 2016, but a net decline of 700+ last year. Membership must be driven at the constituent level. Increased efforts will be made through ADA Client Services and via the Trustees as well to assist all states in their efforts to increase membership. I urge each and every one of you to reach out to non-member colleagues in support of that effort.

As you can imagine, there were numerous other issues that we were updated on. These included our "Find a Dentist" marketing initiative, the credentialing service project, the dental licensure objective structured clinical examination and more. But enough is enough. The next BOT meeting is in April. I will see many of you at the ADA–Student Lobby Day in Washington DC and will also be at the Arizona and Utah meetings that month as well.

Please do not hesitate to contact me with any specific questions. dklemmedson@sazoms.com, 520-603-1122.

NDA's 100th Annual Summer Meeting



Registration Form | June 22–23, 2018 | Mandalay Bay Resort

Event	Time	Attendees		Fee/person	Total
Registration—NDA Member/Spouse/Child		________		No Charge	
Registration—Non-NDA Member (required)		________	x	$ 300	$ ________
Registration—Non-ADA Member (required)		________	x	$ 500	$ ________
Thursday, June 21					
Executive Committee Meeting	3–5 PM	________		No Charge	
Dinner on Your Own					
Friday, June 22					
Breakfast	7–8 AM	________		No Charge	
House of Delegates	8 AM–1 PM	________		No Charge	
Lunch on Your Own					
President's Dinner Adult	7–10 PM	________	x	$ 125	$ ________
President's Dinner, Child (Age 5–20)		________			
Saturday, June 23					
Breakfast	7 AM	________		No Charge	
Continuing Education: Bio Horizons	8 AM–12 NOON	________		$49	
Dinner on Your Own	1 PM				
				Grand Total	$ ________

Registration for Events will be accepted until June 8

No refunds given past June 15, 2018. Hotel reservations and pricing are only guaranteed through May 22, 2018!

Dentist or Member Name ______________________________ ADA Number ______________

Guest(s)

Address ______________________ City ______________ State ____ Zip __________

Phone ______________________ Fax ______________________

Accepted forms of payment are: check (payable to NDA), Visa, MasterCard and AMEX. Please indicate below.

Credit Card Number ______________________ Exp. Date ________ Security Code ________

Name on card ______________________ Email ______________________

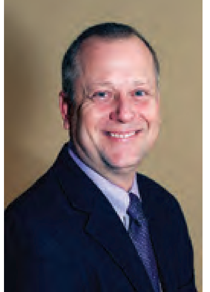
Billing Address ____

Authorized Signature ______________________ Card Type ______________

Mail or fax completed form to: Nevada Dental Assn, 8863 W Flamingo Rd, Ste 102, Las Vegas, NV 89147 • Fax: 702-255-3302

Hotel Reservation Information: **Location:** Mandalay Bay Resort (cutoff for rooms is Friday May 22, 2018)
Web: https://aws.passkey.com/go/snda0618mb | **Phone:** 877-632-9001
Group: Nevada Dental Association

Images from the Mandalay Bay Resort



Summer Meeting Speaker

David Marten is the Digital Workflow Manager for BioHorizons Implant Systems where he supports the implementation of digital technology for implant planning, placement, and restorative solutions throughout North America. Mr. Marten has been using digital technology in dentistry for the past 15 years. He has a B.S. in Materials Engineering which has complimented his experience in implant dentistry. In the past ten years, Mr. Marten has held positions such as CAD/CAM Regional Manager, Guided Surgery Specialist, and most recently Digital Workflow Manager. He has had the opportunity to work closely with hundreds of clinicians and labs in many different markets to utilize digital workflows.

Strategy & Strength

ATTORNEYS WHO KNOW HOW TO WIN.

HUTCHISON & STEFFEN
ATTORNEYS

A FULL-SERVICE, AV-RATED LAW FIRM

PECCOLE PROFESSIONAL PARK • 10080 WEST ALTA DRIVE, SUITE 200 • LAS VEGAS, NEVADA 89145
702.385.2500 • HUTCHLEGAL.COM

LETTERS TO THE EDITOR RE: NATIONAL CHAMPS

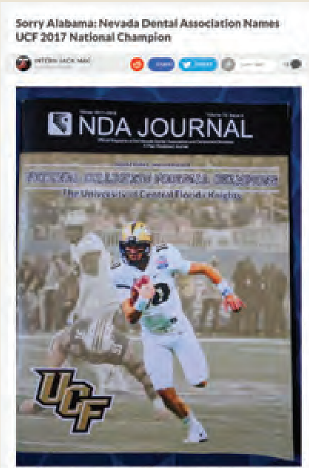
Dear Editor,

The Latest Issue of the NDA Journal has been featured on Barstool Sports:

"It's been a very fun month for UCF, but a criticism against the national championship claims are the lack of legitimacy. That was until TODAY:

That's it. Game over. Time for Alabama to hand over the trophy to UCF. The dentists of Nevada have SPOKEN. Paul Finebaum and the rest of SEC Network can't make any more jokes. Their time has come and gone. Time for some new material, because once the Nevada dentists speak, everything goes out the window.

The Nevada Dental Association has been naming champions throughout the 21st century."



-Benjamin Caulder, Portland OR

Dear Editor:

I commend the NDAJ on the selection of Central Florida as National Champions. It, of course, would have been great to see UCF in the playoffs, but as you aptly wrote the cartel will never let that happen.

Sincerely,
Steven Nevada Fleming, DDS
USC SOD 1967

NATIONAL COMMENTARY RE: NDAJ 2017 NATIONAL CHAMPS

See what the Internet had to say about NDA's National Champion Selection

Barstool Sports

https://www.barstoolsports.com/barstoolu/sorry-alabama-nevada-dental-association-names-ucf-2017-national-champion/?_branch_match_id=488091427091104337

The Spun

http://thespun.com/aac/ucf/ucf-knights-national-champs-nda

The Score

https://www.thescore.com/s/3903317

SBNation

https://www.sbnation.com/2018/2/1/16959018/ucf-national-championship-claim-2017

"The sport has never had an official champ at its highest level. Even the Playoff is only recognized by the NCAA as a title selector, albeit the sole one still being added to the record books these days. Titles have been awarded over the years by polls, historians, math, and anything else you can think of."

Cougar Board

https://www.cougarboard.com/board/message.html?id=19282015

"Utes? Dumb dentists!"

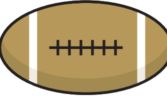
"That's an opinion you can really sink your teeth into."

"A good dental hygienist can take care of the plaque."

"That's great! Anything to drive more controversy to get a 16-team playoff."

"A lot of folks will have to brace themselves from this news."

"Leave it to the dentists to crown the true champion."



Reddit

https://www.reddit.com/r/CFB/comments/7ue9lk/its_decided_nevada_dental_association_names_its/

https://twitter.com/redditcfb/status/958845181498920961

“We may have more major selectors, but UCF has the molar selectors. I concede on behalf of the University of Alabama.”

“Finally an argument that has the teeth to put the National Champion debate to rest.”

“I accept the Nevada Dental Association as the only selectors who really matter.”

“Do we even have dentists in the South?”

“I think our dentists are more impartial than our people.”

“The cartel cosmetically changed from a 2-team BCS format to a 4-team CFP paradigm in 2014, but as is predictably obvious in 2017, it still doesn’t work.”

“See, these people get it!”

“I’m glad they could disclose it!”

“As a future dentist, it’s nice to see I’ll have a say in deciding the national champ every year.”

“Boise State was undisputed in 2006 and tied with Bama in 2009. I think we can trust this source.”

“I’m flying out to Nevada for every single dentist appointment from now on.”

“Only one for Alabama since 2002? Sold.”

“This is the best thing I’ve ever seen.”

“Oh man that is excellent.”

“Looks legit to me...”

“Where do I subscribe to the NDAJ?”

UCFSports.com

https://ucf.forums.rivals.com/threads/nevada-dental-professionals-call-college-football-playoff-a-%E2%80%98cartel%E2%80%99-declare-ucf-national-champion.60637/

“This became a banned topic on Rivals’ Soundoff. People are upset that others are recognizing UCF as National Champions.”

“It’s great to see dental professionals being objective and for calling out the ESPN cartel.”

REBRN

http://rebrn.com/re/its-decided-nevada-dental-association-names-its-national-champio-4026771/

“I accept the Nevada Dental Association as the only selectors who really matter.”

“Surely any institution of higher learning sporting a Crest is eligible.”

“They better brace themselves for the hate they will get from Alabama fans though.”

“Not Oral Roberts? Colgate?”

“They awarded Ohio state the 2012 National Championship as well... I like these guys!”

“I’m gonna keep a comedian on retainer to make puns as good as yours.”

“Their selectors are more concentrated; UCF’s claims are of a higher molarity.”

“‘2012 Ohio State 12-0’ I for one welcome our new dentist overlords.”

“They need to Aim high.”

“It’s over, UCF has the high molar ground.”

“Funnily enough, the other article is actually about the son of Jerry Tarkanian, who coached UNLV to the 1990 title and had the great line “the NCAA is so mad at Kentucky, it’s going to give Cleveland State two more years of probation.” He was a pretty big small school advocate.”

“I hope to strong Arm my way into this competition and hit all those teeth with a Hammer.”

One True Poll

“I’m highly conflicted here. They should’ve given the 2007 title to Georgia, and not USC, which makes me mad. But they also didn’t give Florida one for 2006 or 2008, and that makes me giddy.”

“USC 2003, 2004, and 2007.”

“I approve this list.”

“Beats the ____ out of being the Golf Digest National Champion...”

“9 out of 10 dentists agree that UCF is the national champion.”

Editor’s Note: The feedback from the almost annual NDAJ National Championship issue has been significant this year. Evidently the NDAJ iterated what a lot of people feel about the latest paradigm used to pick the college football champion. Shortly before press time, ESPN asked for the NDAJ published material and permission to discuss it. Stay tuned…

AAPS Challenges Price Controls in California

By Andrew L. Schlafly, Esq.

On Sept. 23, 2016, California Gov. Jerry Brown signed into law the strictest wage and price control in history against physicians in our nation: *AB 72*, which went into effect July 1, 2017, in California. Insurance companies are now trying to emulate it by enacting similar legislation in other states.

AB 72 authorizes private health plans to set the rates of reimbursement for physicians who are not under any contract with them. Traditionally, whenever government sets rates, as in the context of utilities, there is political accountability both for the officials and for the decision-making process. There is almost always the availability of due process to challenge such rate-setting, and there are typically safeguards against the taking of private property in the form of mandating underpayment for services rendered.

Not so for this dangerous new form of wage and price controls that became law in California, whereby the legislature has delegated the rate-setting authority to purely private entities, namely insurance companies. Concerned about the effect of this law in California and the likelihood it may spread to other states, our Association of American Physicians and Surgeons (AAPS) investigated further and discussed this with our members in the Golden State.

We learned that although the law was justified under the pretext of controlling "surprise medical bills," in fact the genesis of this law was not inspired by that issue. Instead, the law came about because a California agency rejected an attempt by the insurance industry to impose wage and price controls on out-of-network physicians by regulation. What the insurance companies failed to obtain from the administrative state, they then sought directly from the legislature. When that effort sputtered, even in the overwhelmingly liberal California legislature, someone seized upon the public-relations stunt of saying the bill would end "surprise medical billing," which has never been a genuine, substantial public concern. Most out-of-network hospital bills are to be paid by insurance companies at market rates, and rarely do patients actually face collection efforts on so-called surprise medical bills.

But slick campaigns can result in bad legislation, and such was the case with *AB 72*. This new law is not merely misguided; it is also unconstitutional. Allowing health plans to regulate reimbursement rates with the authority of government is in violation of the Fifth Amendment safeguard against the taking of property without just compensation (the "Takings Clause"), and the Fourteenth Amendment guarantee of due process of law (the "Due Process Clause").

Less than a month after *AB 72* was signed into law, AAPS filed a lawsuit to overturn it. On Oct 19, 2017, the federal court in Sacramento, Calif., held an historic hearing on these issues in front of a gallery of physicians on one side of the courtroom, and employees of the California Department of Managed Health Care on the other.

Our Legal Arguments against *AB 72*

"By any measure, handing off regulatory power to a private entity is 'legislative delegation in its most obnoxious form.'" So observed Supreme Court Justice Samuel Alito in his concurrence to a decision in 2015 that invalidated a federal law delegating regulatory authority to Amtrak, the semi-private railroad company.[1]

Yet the new California *AB 72* does exactly what is impermissible: it authorizes private entities—health insurance plans—to impose wage and price controls on private physicians who have no relationship with the payers. This law is akin to authorizing one professional football team to set the compensation for players on a competitor's team, or one oil company to set the price at which its competitors must sell gasoline.

Economically, "out-of-network" physicians are in competition with the plans' "in-network" physicians, and insurers should not be authorized to set rates for their competitors.

In addition to being unconstitutional for violating the Due Process and Takings clauses, the law is bad policy. If left unchecked, it will result in rationing of care in under-served areas, and will discourage physicians from practicing in California altogether, while boosting the already prodigious profits of insurance companies.

Moreover, even if the pretextual purpose of *AB 72* to eliminate "surprise medical bills" were valid, the statute benefits health plans far beyond what that goal would justify. A requirement of transparency, or simply of informed billing consent, would have attained the purported goal of reducing "surprise" medical bills without need to delegate rate-setting authority to private payers. Instead, *AB 72* benefits private health plans by broadly authorizing them to set fees for out-of-network physicians, thereby giving insurance companies leverage to drive independent physicians out of business.

In fact, as many AAPS members know, only a small percentage of total medical costs are attributable to physician fees. In the roughly $600 billion Medicare program "roughly one-fourth was for hospital inpatient services, 12% for physician services, and 11% for the Part D drug benefit. Another one-fourth of benefit spending

Dental Practice Sales

702.897.6028

NvDentalPracticeSales.com

9890 S Maryland Pkwy # 200A

Las Vegas, NV 89183

Bob Randolph

Broker

With over 45 years of experience in the Dental Industry, we have the knowledge, experience, and connections to make your dreams a reality. Dental Practice Sales, helping to educate, finance and successfully transition Buyer's and Seller's for over 15 years in Nevada. We are the busiest we have ever been with motivated Buyer's and Seller's. We are happy to explain the process and get you on the path to where you want to be.

Lisa Hogan

Southern Nevada

702-.897.6028

NvPracticeSales@aol.com

Jeanette Allison

Southern Nevada

702-.897.6028

NvPracticeSales@aol.com

Jack Harrington, DDS

Northern Nevada

775.544.0821

Harringtonj@live.com

PVSG
National Organization
of Dental Practice
Evaluators

» was for Medicare Advantage private health plans covering all Part A and Part B benefits…. [emphasis added]"[2]

Constitutional Violations and Resultant Harm

AB 72 violates the Due Process Clause of the U.S. Constitution by delegating rate-setting authority to private companies, with respect to physicians who are not under any contract with the health plans, and by requiring arbitration by out-of-network physicians on their reimbursements, thereby denying them their due process rights.

AB 72 violates the Takings Clause of the U.S. Constitution because it empowers private insurance companies to deprive out-of-network physicians of the market value for their services, and arbitrarily denies them just compensation for their labor.

AB 72 violates the Equal Protection Clause of the U.S. Constitution by having a disparate impact on minority patients for whom the availability of medical care will sharply decline as *AB 72* coerces out-of-network physicians to withdraw services from predominantly minority communities.

Each of these violations of constitutional rights by *AB 72* causes harm to AAPS members who practice in California, and to their patients. Accordingly, AAPS sued on behalf of its members in California and their patients, to seek a declaration that AB 72 is unconstitutional and to seek an injunction against it.

The harm to AAPS members caused by *AB 72* is substantial. Individual AAPS members, such as California ophthalmologist Michael Couris, M.D., suffer imminent threatened injury, including financial harm, as a result of the enactment and enforcement of *AB 72*. Additional harm from *AB 72*, with respect to the Equal Protection claims, have been suffered by patients of AAPS members in the form of reduced availability of medical care.

Out-of-Network Physicians

Out-of-network physicians, who are called "non-contracting" physicians by *AB 72*, are truly independent physicians unencumbered by the many restrictions imposed by insurance companies on in-network doctors. Out-of-network physicians do not have the benefits or obligations of being contractually bound with insurance companies.

There are both advantages and disadvantages to patients and physicians resulting from an out-of-network status. Some physicians are out of network not by choice, but because insurance companies increased their profits by excluding them for reasons other than quality of care. Out-of-network physicians often lack the referral volume of physicians who are within the network, and as a result, tend to provide more charity care than in-network physicians do. To remain in business, out-of-network physicians may charge more for certain services than the in-network insurance reimbursement rates.

Often, insured patients have obtained policies that require their insurance companies to pay the charges of out-of-network physicians, or at least a substantial percentage of those charges. Moreover, the only meaningful leverage that a physician or hospital has in negotiating a contract with an insurance company is the option of the physician or hospital to go out-of-network and not accept the insurance company rates. Yet *AB 72* denies the right of a physician to go out-of-network with an insurance company and charge out-of-network rates.

Specifically, *AB 72* requires the following for out-of-network physicians, effective July 1, 2017: "The plan shall reimburse the greater of the average contracted rate or 125% of the amount Medicare reimburses."[3] *AB 72* thereby prohibits an out-of-network physician from recovering fully on his claims for services lawfully rendered.

This price-setting imposes confiscatory rates in violation of the Due Process Clause. "Confiscatory," as used in numerous court decisions, refers to rates that are inadequate to fully compensate for the services provided. In a 1990 case, the Ninth Circuit Court of Appeals found a constitutionally defective failure to "contain any provisions for relief from potentially confiscatory rates."[4]

The rate mechanism imposed by *AB 72* violates the Takings Clause by depriving physicians of their property rights for their labor, without just compensation, and also by transferring property from one private group (physicians) to other private entities, namely insurance companies, in the form of the latter's underpayment for services.

AB 72's price setting also harms underserved minority communities. Many out-of-network physicians, including members of AAPS, depend on their ability to bill at market rates for their services to insured patients in order to be able to offer charity or under-compensated care. *AB 72* forces out-of-network physicians out of business or into insurance networks that render it infeasible to provide substantial amounts of care to such patients, who are predominantly minorities, thus causing them imminent harm, in the form of lost access to out-of-network physicians and decreased availability of medical care.

The Independent Dispute Resolution Process

By requiring out-of-network physicians to participate in arbitration rather than pursue their claims in court, *AB 72* further violates the Due Process Clause. *AB 72* improperly shifts the burden onto physicians to challenge the price controls, and also denies them their due process rights to do so.

AB 72 required the California Department of Managed Health Care, by Sep 1, 2017, to "establish an independent dispute resolution

process for the purpose of processing and resolving a claim dispute between a health plan and a noncontracting individual health professional for services" rendered.[5] And while *AB 72* generally exempts medical services rendered on an emergency basis, it does not expressly exempt services rendered after transfer of a patient from an emergency room to an intensive-care unit (ICU).

This process imposes on California physicians the equivalent of mandatory binding arbitration. If this merely applied to physicians under contract with insurance health plans, it might be understandable. Instead, it applies broadly to physicians who have no contractual relationship with health insurance companies, i.e., "out-of-network" physicians. *AB 72* thereby compels entirely independent physicians first to pursue internal proceedings with the insurance companies, and then participate in a proceeding that is expressly made "binding" by *AB 72* as follows [emphasis added]:

Section 1371.30 is added to the Health and Safety Code, immediately following Section 1371.3, to read: 1371.30 … (d) The decision obtained through the department's independent dispute resolution process shall be binding on both parties. The plan shall implement the decision obtained through the independent dispute resolution process. If dissatisfied, either party may pursue any right, remedy, or penalty established under any other applicable law.[5]

This imposition of the equivalent of binding arbitration on physicians, who have no contractual or other relationship with the opposing party, a large corporation, raises grave constitutional concerns. AAPS points out that a system of binding arbitration for parties who are strangers to each other is in violation of the Due Process Clause of the U.S. Constitution (Section 1, Fourteenth Amendment).

The California Department of Managed Health Care (DMHC), which is the defendant (through its director) in AAPS's lawsuit, was required by Sep 1, 2017, to develop its process for the Independent Dispute Resolution under *AB 72*, and the summary of its decision-making procedure as posted by DMHC is as follows:

About the Decision Process

The independent organization reviewing each *AB 72* IDRP claim(s) dispute will have a maximum of 30 calendar days following receipt of payment to provide the DMHC with an *AB 72* IDRP Decision Letter. The independent organization's decision regarding the appropriate reimbursement amount for the claim(s) dispute shall be based on all relevant information as submitted by the parties to the *AB 72* IDRP. This information includes, but is not limited to, information submitted by the parties regarding the factors set forth in Title 28 of the California Code of Regulations, Section 1300.71(a)(3)(B)(i)-(vi), listed here:

- the provider's training, qualifications, and length of time in practice;
- the nature of the services provided;
- the fees usually charged by the provider;
- prevailing provider rates charged in the general geographic area in which the services were rendered;
- other aspects of the economics of the medical provider's practice that are relevant; and
- any unusual circumstances in the case.

The *AB 72* IDRP decision drafted by the independent organization will provide a written explanation of the appropriate reimbursement amount decision, and will include a list of appropriate reimbursement amounts by relevant billing code. The independent organization is not limited to the suggested appropriate reimbursement amounts offered by each party when making its decision.[6]

Notably absent is any transparency about the decision-makers; any participation by physicians in the selection of the decision-makers (arbiters); any possibility of having a hearing; any right to rebut the insurance company's submission; and any right to appeal.

Why the Dispute Resolution Process Is Unconstitutional

Were we still in the "Roaring 20s" of free enterprise, its exuberant culture, and the advent of jazz music, there would not be any doubt about the unconstitutionality of the Independent Dispute Resolution Process. Multiple decisions during the 1920s invalidated state legislation that compelled certain industries to submit to arbitration rather than litigate their disputes.[7-9] These cases held that attempts by government to fix wages and compel arbitration were constitutionally flawed because the industries being regulated (the meat packing and coal mining industries) were not sufficiently "clothed with a public interest"—i.e., not sufficiently intertwined with pervasive public interests, as a railroad or utility is—to support government control over the pricing.[10]

But then the Great Depression hit, and it disrupted the legal system as much as it did the financial markets. The pressure to end individual rights against government regulation apparently became overwhelming, and ultimately the Supreme Court caved into the demands of the New Deal. From the ashes of economic devastation rose the regulatory state, and rather than block it, the federal courts eventually gave it their blessing.

Dozens of Supreme Court decisions in this field from the 1920s and early 1930s ostensibly remain good law today, but in reality any court that strictly relies on them without referring to their modern counterparts is taking a risk of reversal on appeal. AAPS

» informed the court that we would prefer it to rely on the pre-Depression precedents, but candidly admitted that those precedents may not carry as much weight today as AAPS would like.

Instead, the leading precedent today on the meaning of due process rights against regulation is the more flexible standard set forth in Goldberg v. Kelly.[11, pp 266-271] Due process is "flexible and calls for such procedural protections as the particular situation demands," as explained in a subsequent decision in Morrissey v. Brewer.[12]

The Goldberg v. Kelly line of precedents by the U.S. Supreme Court continues to be cited favorably by multiple federal courts each month. For example, two years ago the U.S. Court of Appeals for the Ninth Circuit, which presides over California and many other Western states, invalidated regulatory procedures relating to housing based on the following explanation in Nozzi v. Housing Authority:

> Procedural safeguards come in many forms, including, inter alia, "timely and adequate notice," pre-termination hearings, the opportunity to present written and oral arguments, and the ability to confront adverse witnesses. See Goldberg v. Kelly. Which protections are due in a given case requires a careful analysis of the importance of the rights and the other interests at stake.[13]

There are at least four reasons why *AB 72*, with its mandatory, binding arbitration-like procedure, fails to satisfy the minimum level of due process required by the U.S. Constitution. Each is explained below.

The Lack of Any Right to a Hearing under the Independent Dispute Resolution Process Violates Due Process.

The process established by *AB 72* deprives the physician of any right or even any possibility of being able to present his case at a hearing. "The fundamental requisite of due process of law is the opportunity to be heard. The hearing must be at a meaningful time and in a meaningful manner," explained the Supreme Court in its landmark precedent of Goldberg v. Kelly [emphasis added].[11, p 267]

It is true that in judicial proceedings, not every dispute warrants a hearing in court. But virtually every litigant does have a due process right to request a hearing, and to make a showing for why a hearing would be justified. For example, if an insurance company denies a claim, then a hearing may be necessary for the physician to cross-examine any witnesses who provided statements against him, or against the reasonableness of his fees. "In almost every setting where important decisions turn on questions of fact, due process requires an opportunity to confront and cross-examine adverse witnesses."[11, p 269] The Supreme Court earlier explained, in Greene v. McElroy, that "[w]e have formalized these protections in the requirements of confrontation and cross-examination…. This Court has been zealous to protect these rights from erosion. It has spoken out...in all types of cases where administrative...actions were under scrutiny."[14]

Despite these well-established procedural requirements, the arbitration-like proceeding under *AB 72* allows for no hearings, ever, no matter how large or important the dispute. This denial of even the possibility of a hearing is a violation of due process.

The Lack of Transparency and Physician Participation in Selecting the Arbiters Violates Due Process.

The Independent Dispute Resolution process lacks transparency, lacks participation by physicians in selecting the decision-makers, and lacks sufficient safeguards against conflicts of interest. For example, the decision-makers could even be receiving compensation, directly or indirectly, from insurance companies.

Due process requires a system that ensures an impartial decision-maker. "And, of course, an impartial decision maker is essential," the Supreme Court emphasized in Goldberg v. Kelly.[11, p 271] Yet *AB 72* fails this basic requirement.

The Lack of Meaningful Judicial Review under *AB 72* Violates Due Process.

AB 72 provides that "either party may pursue any right, remedy, or penalty established under any other applicable law." But its dispute resolution procedure is binding, such that under California law judicial review will be meaningful only if there is proof of corruption, fraud, undue means, or substantial prejudice due to misconduct.[15] As the federal court in the Northern District of California has explained, "where parties to a contract agree to binding arbitration, the decision of the arbitrators is not subject to judicial review absent a showing that vacatur is warranted for a reason provided by Cal. Civ. Proc. Code § 1286.2."[16]

When this problem is combined with lack of transparency, it impossible for a physician to prove or even become aware of one-sided partiality or misconduct sufficient to overcome a binding award. This is plainly unconstitutional.

Requiring Participation in a Prior Internal Review with an Insurance Company Violates Due Process.

With *AB 72*, insurance companies created as many burdens on independent physicians as they could. But obstacles to dispute resolution are themselves violations of due process. *AB 72* requires physicians first to participate in an internal review process by payers with whom the physicians have no relationship. As explained by the website of the California Department of Managed Health Care, "Before the DMHC can begin a review, the provider is required to submit the dispute

to the payer's Dispute Resolution Mechanism for a minimum of 45 working days or until receipt of the payer's written determination, whichever period is shorter."[6] This imposes delay and expense, and grants to one side of a dispute an unjustified elevated authority over the other. That is wholly defective from the perspective of due process.

Laws that comport with due process do not require one to submit one's claim to an adversary and wait for a response before suing him on the claim. In addition to delaying ultimate relief, such a mandatory process could have a disadvantageous effect on a litigant, as he must "show his cards" to his adversary well before the Independent Dispute Resolution process begins, without the payer having the same obligation to disclose its litigation strategy. "[T]here is no doubt that requiring only one side to disclose questions in advance could put the disclosing party at a serious disadvantage in a given case," observed the U.S. Court of Appeals for the Ninth Circuit in another case.[17] This one-sided burden placed by *AB 72* on physicians before they can even initiate the Independent Dispute Resolution procedure violates due process.

Moreover, the Due Process Clause "requires the States to afford certain civil litigants a 'meaningful opportunity to be heard' by removing obstacles to their full participation in judicial proceedings."[18] Requiring an internal review by an adversary with whom a claimant has no relationship, prior to the claimant being able to seek relief in an independent venue, is a due process violation.

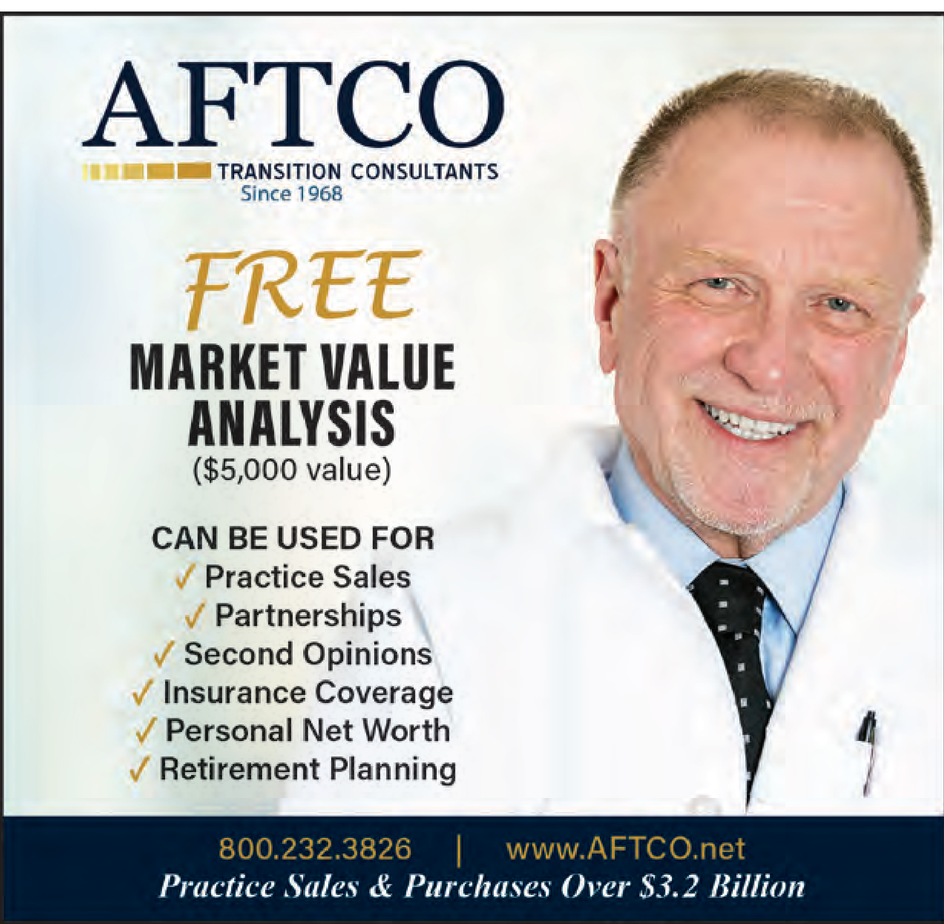
Conclusion

The federal court held an extensive, well-attended hearing on Oct 19, 2017, in Sacramento. The learned federal judge was thoroughly prepared and thanked both sides for their detailed briefing of the issues. He requested additional briefing on whether the Independent Dispute Resolution Process is constitutional. He then reserved judgment on the matter until after he has had the opportunity to review the additional briefs, which the parties submitted in November.

Andrew L. Schlafly, Esq., is General Counsel of the Association of American Physicians and Surgeons. Contact: aschlafly@aol.com.

References

1. Dept. of Transp. v. Assoc. of American Railroads, 135 S. Ct. 1225, 1238 (2015) (Alito, J., concurring) (quoting Carter v. Carter Coal Co., 298 U.S. 238, 311 (1936)).
2. Cubanski J, Neuman T. The Facts on Medicare Spending and Financing. Henry J. Kaiser Family Foundation: Jul 18, 2017. Available at: http://www.kff.org/medicare/fact-sheet/medicare-spending-and-financing-fact-sheet/. Accessed Nov 18, 2017.
3. AB 72 § 2 (adding Section 1371.31 to the Health and Safety Code).
4. Guar. Nat'l Ins. Co. v. Gates, 916 F.2d 508, 514 (9th Cir. 1990).
5. AB 72 § 1 (adding Section 1371.30 to the Health and Safety Code).
6. Non Emergency Services Independent Dispute Resolution Process (AB 72 IDRP). Available at: https://www.dmhc.ca.gov/FileaComplaint/ProviderComplaintAgainstaPlan/NonEmergencyServicesIndependentDisputeResolutionProcess.aspx#.WfYkTKLuPhw. Accessed Nov 18, 2017.
7. Wolff Packing Co. v. Indus. Court, 262 U.S. 522 (1923).
8. Dorchy v. Kansas, 264 U.S. 286 (1924).
9. Wolff Packing Co. v. Indus. Court, 267 U.S. 552 (1925).
10. Nebbia v. New York, 291 U.S. 502, 534 (1934).
11. Goldberg v. Kelly. 397 U.S. 254 (1970).
12. Morrissey v. Brewer. 408 U.S. 471, 481 (1972) (applying Goldberg v. Kelly).
13. Nozzi v. Housing Authority. 806 F.3d 1178, 1192 (9th Cir. 2015).
14. Greene v. McElroy, 360 U.S. 474, 496-97 (1959).
15. Cal. Civ. Proc. Code § 1286.2.
16. Mitchel v. City of Santa Rosa, No. C 09-05004-SI, 2010 U.S. Dist. LEXIS 49540, at *6 (N.D. Cal. Apr. 26, 2010).
17. Miller v. L.A. Cty. Bd. of Educ., 799 F.2d 486, 488 (9th Cir. 1986).
18. Tennessee v. Lane, 541 U.S. 509, 523 (2004) (quoting Boddie v. Connecticut, 401 U.S. 371, 379 (1971)).



Nevada *AB474*

By Steven A. Saxe DMD, President of Nevada State Society of Oral and Maxillofacial Surgeons

Dear Senator, I write to you today to provide feedback regarding the recent implementation of Nevada *AB474*. I have been compliant with this law for the past three weeks and would like to bring to your attention the following observations.

AB474 was introduced and unanimously passed at the eleventh hour. Its intent was to stop abuse of prescribed opioids and to reduce the associated. Time is needed to properly evaluate the impact *AB474* will have in days to come, but it is already apparent that the law and its related regulations are already proving somewhat overwhelming for providers.

As a licensed Dentist/Oral & Maxillofacial Surgeon, nearly every patient that I operate on requires pharmaceutical pain relief of 48 hours. Opioids are often the modality of choice.

Time truly is the issue. Time used for compliance means time away from other patients. Time is also needed to generate income for my business overhead, a topic that seems to be conveniently ignored when it comes to health care providers.

As I hope you are aware, in order to be compliant the following steps are required:

1. A 2–3 page consent with 14 items the patient must read, understand, agree to, and initial next to each item.

2. The proper explanation of this consent by the provider is also a requirement which averages an additional 15–20 minutes per patient.

3. The time spent with patients is precious and limited. Reimbursement for time spent with patients continues to dwindle for insured patients as well as Medicaid and Medicare recipients. There are no provisions or applicable CDT (dental) codes for billing opioid consultations nor are there any available medical codes.

4. ICD 10 codes are required on every prescription written for narcotics. Not only is this troublesome for office staff but it is not incorporated in any dental software manufactured in the United States.

5. The patient may be burdened with extra copays for additional necessary prescriptions.

Opioid prescription writing has been decreasing in dentistry for approximately ten years. Dentists are aware of the PMP online system, at once time voluntary, and have been utilizing it.

The medications we write for are filled at pharmacies. I find it incongruous that pharmacists are not held to the same standard doctors are. Pharmacists need to share the responsibility and not fill opioid prescriptions for patients that have an unacceptable history upon PMP review. Pharmacists put data into the PMP system for each patient and they are also compensated for patient counseling. Burdening doctors with our current system is not a sustainable solution and ultimately result in more doctors simply not writing prescriptions.

Some examples of alternate pain-management strategies include psychiatric or psychological care, physical therapy, surgery, injections, patches, and acupuncture. These modalities are practically limited because there is little or no coverage from traditional insurance or government payers. Consider the following: many insurance companies in Nevada have limited coverage for temporomandibular Joint (TMJ) disorders and Medicaid for adults in Nevada has no coverage for any treatment whatsoever. Not being financially able to absorb or meet the real need of our patient, we are still obliged as caring providers to address their pain. What else can we do at this point in the journey except prescribe a narcotic responsibly?

One hundred million Americans live with pain. Legislators set the parameters of coverage for Medicaid. Medicare has coverage for some of these treatment modalities.

Black market Fentanyl is a major culprit in our current epidemic. Fentanyl is 100 times stronger than Heroin. Consider the shipment of opioids from China, Mexico, and Hungary to the American buyer via international and U.S. Mail. Illicit opioids kill more than motor vehicle accidents.

As Medicaid benefits have expanded across the United States, opioid overdose deaths have remained relatively low in Nevada although our state's physicians and dentists are now burdened with some of the most cumbersome laws in the nation. For instance, in NV there are 6.2 deaths per 100,000 in 2015, compared to Ohio with 24.7 deaths per 100,000. Are Nevada's physicians and dentists to blame?

A recent study revealed that the average number of toxic substances found upon death by coroners was 6, including alcohol 46% of the time and amphetamines 25% of the time. If one of the 6 toxic substances happened to have been a prescribed opioid, the case was signed out as a "prescription opioid death."

I humbly request for an opportunity to address law makers for further consideration to fine tune the regulations associated with this law.

www.truckeemeadowsconstruction.com

NEW CONSTRUCTION INCLUDING DESIGN BUILDS
REMODELS ▪ EMERGENCY WORK

Constructed and/or remodeled many Dental and Medical offices over the past 18+ years

Please feel free to call for references.

5945 S Los Altos Pkwy, Ste 103
Sparks, NV 89436
775-747-2322

Unfortunately, *AB474* has now become yet another cumbersome statute for dentists and physicians to be burdened with, to the detriment of their patients. Regulations as well as other factors such as low insurance compensations have forced a number of health care professionals to stop writing prescriptions and in some cases leave our state. This issue is multifaceted and deserving of input especially from Nevada's clinical doctors that have the most education, training, and experience in the concern.

Editor's Note: The NDAJ thanks Dr. Saxe for his love of dentistry, his commitment to fighting for what is best for our patients, and his letters.

Would that Nevada dentists were veterinarians which were excluded from AB474 by the late inclusion of "human" into the bill. Note for legislators: opiate Rx's are the same whether written for humans or non-humans. Diverters can now kick the dog, get an Rx from the vet, and distribute ad lib.

You are also not a sales goal or a quota or a statistic. You are a dentist. And if you're looking for a company that understands that distinction, we'd like to introduce ourselves. We are The Dentists Insurance Company, TDIC. We only protect dentists and are relentless in our pursuit of innovative ways to protect you, your first year in the profession and every year after. Take our New Dentist Program.

New Dentist Program

$50 Professional Liability insurance for your first year.

45% discount in your second year and 25% in your third.

Guidance through our Risk Management Advice Line.

Five-minute short form and e-signature make the online application process a breeze.

Apply today at **tdicinsurance.com/newgrad**

First year TDIC Professional Liability coverage rate depicted is for newly licensed and never practiced dentists in the state of Nevada and is valid for a $1M/$3M coverage amount. Rates subject to increase per schedule in years two through eight until they reach maturity.

Endorsed by the Nevada Dental Association

Protecting dentists. It's all we do.®

800.733.0633 | tdicinsurance.com

Advertise to Support Your Association!

Contact us today!

www.llmpubs.com | 800-647-1511

The Perils of Opioid Prescribing

Lawrence R. Huntoon, M.D., Ph.D. Published with permission of the Association of American Physicians and Surgeons

Pain management has become a minefield where physicians often walk at their peril between accusations of under-treatment and over-treatment of pain.

Prosecutors in recent years have focused on alleging inappropriate prescribing of opioids, or on over-treatment of pain, which they state leads to addiction, abuse, overdose, and death.

Myths, erroneous perceptions, and ignorance often trump reality, and along with political ambition, drive prosecutors to seek convictions and long prison terms for those whom they assert are responsible for what has been labeled the opioid crisis.

Physicians who find themselves in the crosshairs face a grand jury system that operates without any checks and balances. As pointed out in an article in our journal, authored by our AAPS General Counsel, Andrew Schlafly:

If a grand jury appears reluctant to issue an indictment requested by a prosecutor, then he can simply convene another grand jury, and then another, until he gets the indictment he wants…. (If) a prosecutor wants an indictment against someone, then he will get it.[1]

As Schlafly points out, once indicted, the physician faces a dismal future:

Many victims of overzealous prosecutions in the federal system feel compelled to accept plea bargains or commit suicide, regardless of their guilt, because the odds of conviction in a federal trial are so high, and the prison sentences so long if a jury does not acquit on each and every count of an indictment…. In federal court the likelihood of an acquittal on all counts is only about one percent of all federal prosecutions brought.[1]

Being No. 1 Makes Physicians a Target

Being number one in pain management is often not good. The top opioid prescriber in your state will inevitably be subjected to increased scrutiny and risk of prosecution alleging inappropriate prescribing or over-prescribing.

Unfortunately, following strict, well-established monitoring and prescribing protocols may not prevent entanglement in the legal system. Those who are committed to obtaining opioids for getting high, or to selling drugs on the street for profit, are often very accomplished at deceiving compassionate physicians.

Trial by Media

Once a physician is targeted for prosecution, prosecutors often use media to portray the physician as nothing more than a drug dealer with a degree, who has violated the public trust in a most heinous manner. If the physician has worked hard and accumulated a degree of wealth, luxury cars, vacation homes, or boats, the prosecutors will frequently play class warfare to foment widespread public resentment, making it more likely that a jury will seek to convict the "greedy" doctor. The implication is that a person who has such wealth must have done something wrong, and needs to be held accountable.

The more sensational the charges, the greater the interest and benefit for the prosecutor and compliant media. An indictment containing a large number of charges, highlighted by media, can further condition the public to side with the prosecution. Operating on the concept of where there is smoke there must be fire, the public may ask why the prosecutor would bring so many charges against the doctor if he did nothing wrong? Trial by media, in which a physician is on the front page of the local newspaper and is the lead story on television and radio, makes it very difficult to find impartial jurors.

Who or What is Responsible for the Opioid Crisis?

According to Dr. Jeffrey A. Singer, a practicing surgeon in Phoenix and a senior fellow at the Cato Institute:

Policymakers in Washington and in state capitals are misdiagnosing the opioid crisis as a doctor-patient problem…. While raids on black market drug dealers continue to net hauls from a seemingly endless sea of diverted, smuggled or counterfeit prescription opioids and heroin, policymakers can't shake free of the myth that the opioid crisis is caused by doctors prescribing opioids to their patients in pain. The numbers show that isn't the case.[2]

A 2010 Cochrane Review found that less than 1% of well-screened patients become addicted to their opioids prescribed for chronic non-cancer pain.[3] The vast majority of opioid misuse is not caused by physicians prescribing opioids for patients who have pain. Approximately 75% of opioid abuse stems from individuals who obtained opioids from a friend or family member (including by theft), or from drug dealers and other sources including purchase over the internet.[4]

According to an article posted last year on the *Scientific American* MIND Guest Blog:

Typically, young people who misuse prescription opioids are heavy users of alcohol and other drugs. This type of drug use, not medical treatment with opioids, is by far the greatest risk factor for opioid addiction….[5]

»

» Childhood trauma, mental illness, personality disorder, poverty, unemployment, and social marginalization are also cited as risk factors for opioid addiction and abuse.[5]

The vast majority of opioid-related deaths involve mixtures of various illicit drugs including fentanyl and heroin, and are not due to physicians over-prescribing opioids. According to an article posted on Reason.com blog:

What's true of prescription opioids is also true of heroin: Most "overdoses" involve combinations. The danger is magnified by the unpredictable potency of black-market heroin, which in turn has been magnified by the recent proliferation of fentanyl as a heroin adulterant and substitute.[6]

Physicians Prosecuted for Patient's Choice to Abuse Drugs

Unfortunately, when a patient fails to follow the instructions and heed warnings provided by the prescribing physician, deciding to combine the drugs with other substances, like alcohol, or crushes, dissolves and injects a medications/drug mixture, and then dies, the physician may be subject to prosecution and conviction for manslaughter.[7] One physician, Dr. James F. Graves, was sentenced to 63 years in prison at age 55 (a life sentence), a sentence later reduced by 17 years due to a sentencing error.

In a letter to the Office of Executive Clemency in Florida, requesting commutation of Dr. Grave's sentence, his son wrote:

Dr. Graves had several patients visit his office that were drug addicts faking symptoms in order to obtain narcotics for the purpose of getting high. Dr. Graves became aware of this and started discharging patients. He wrote a letter to the state attorney general requesting assistance in investigating suspicious patients. It was later discovered that several patients were indeed abusing medications prescribed by Dr. Graves and using them in a manner that was against explicit instructions from Dr. Graves and the pharmacies that filled the prescriptions. Some patients combined the drugs with other substances, like alcohol, while others would crush, dissolve and inject the medications intravenously. Some actually died…. If you are interested in finding out more about my father's case and about similar cases where medical doctors are being held liable for the wrongful behavior of their patients, I suggest you obtain a copy of The Criminalization of Medicine written by Ronald T. Libby, a political science professor at the University of North Florida.[8]

In a textbook case of trial by media, a Buffalo, New York, area pain specialist faces charges tied to six patient deaths. As covered in a recent Buffalo News story, Dr. Eugene Gosy was said to be "the first local doctor to be charged with such a crime."[9] In the News article, the prosecutor refers to "killer drugs," in much the same manner as gun control advocates refer to "killer guns":

We need to stop the abuse of prescription drugs, and one way to do that is stop those doctors who prescribe these killer drugs outside the usual course of their medical practice and not for a legitimate medical purpose," Acting U.S. Attorney James P. Kennedy said in announcing the new charges.[9]

However, the three physicians who filled in to treat Dr. Gosy's patients when his office closed temporarily last year found something very different from what was portrayed by the prosecutor in the media. According to a 2016 article in the Buffalo News: "Three weeks since they arrived, the three fill-in doctors are impressed with Gosy's practice and the safeguards he put in place to spot drug seekers."[10]

Dr. Nancy Nielsen, associate dean for health policy at the University at Buffalo's Jacobs School of Medicine and former president of the American Medical Association, stated: "I thought I was going to see 35-year-old guys on workers' comp who didn't want to go back to work," Nielsen said. "That is not what I have seen."[10]

Another fill-in-physician, Dr. Christopher Kerr, chief medical officer at the Center for Hospice & Palliative Care, stated:

"We were so unknowledgeable. We had to tell the staff to walk us through everything," Kerr said. "I'm more than a little impressed by the quality of the practice. The nurse practitioners—they are really, really good… A contradiction exists between the way these patients have been characterized and how they actually appear," Kerr said. "What is most impressive is that we have yet to see a case that is not striking in its authenticity… These patients are struggling with function in the face of adversity. They are trying to be parents, trying to be employed."[10]

The Buffalo News article also noted the chilling effect that the prosecution of Dr. Gosy has had on the willingness of local primary care physicians to fill the void and prescribe opioids to Dr. Gosy's patients, who lived in fear of going through withdrawal when his practice was temporarily closed.

The prosecutor in the Gosy case strongly rejected the notion of patient responsibility: When asked whether Dr. Gosy's patients had some level of personal responsibility for their addiction, Kennedy responded, "That's not right. It's time to stop blaming the victims," he said. "They're not the ones profiting from these drugs. In fact, they're the ones dying."[9]

Dr. Gosy's attorney, Joel L. Daniels, held a very different view: "He treated these patients for pain. He's a compassionate guy... If they wanted to abuse their medication, you can't blame him."[9]

Dr. Gosy's attorney also noted that Dr. Gosy has treated tens of thousands of patients over the years, and the percentage of overdose deaths associated with his practice is well below the national average.[9]

Like Dr. James Graves, if Dr. Gosy is convicted on all charges, he could face a sentence of life in prison.[9]

Government Intervention: Making the Problem Worse

Government has responded to the opioid crisis by increased laws, regulations, and restrictions affecting physician prescribing of opioids. Prescription drug monitoring programs, intended to stop patients who doctor-shop for opioids, have not reduced the opioid overdose death rate, which continues to rise. As physicians become more reluctant to prescribe opioids for pain, the supply decreases, and patients seek alternative sources on the street to alleviate their pain and avoid withdrawal. Street drugs are, of course, not subject to any quality control of ingredients or potency. Individuals who use opioids for non-medical purposes also are increasingly driven to the black market, where they risk death, as the supply of prescription opioids contracts.

Meddling legislators, who believe they have the knowledge to micromanage medicine, have passed laws restricting opioid prescriptions to a seven-day supply for acute pain. The patient who still has pain on the eighth day may be expected to suffer. And, a patient who receives a prescription for a 10-day supply of pain medication may not be able to get the prescription filled at all if the patient lives in one of the states that restricts opioid prescriptions to seven days for acute pain. The CDC has also issued guidelines for the prescription of opioids.

According to an article published on Reason.com blog:

The prescription guidelines that the CDC issued last year, which encourage physicians to be stingy with opioids, already have had a noticeable impact on patients' ability to get adequate treatment for their pain.[6]

The President's Commission on Combating Drug Addiction, chaired by New Jersey Gov. Chris Christie, reports that the healthcare system, "with a growing compulsion to detect and treat pain," is to blame for the opioid crisis.[6] In fact:

The commission thinks that patients should no longer be asked about the adequacy of pain treatment in surveys mandated by the Centers for Medicare & Medicaid Services, lest providers "use opioids inappropriately to raise their survey scores." The commission criticizes the campaign to treat pain as "the fifth vital sign," which it blames for encouraging excessive opioid use. It recommends closer and more comprehensive scrutiny of prescription practices.[6]

Are Physicians Being Treated More Harshly than Terrorists?

In September 2003, Assistant U.S. Attorney Gene Rossi stated to a reporter: "Our office will try our best to root out [certain doctors] like the Taliban. Stay tuned."[11]

In 2003, all six members of the "Lackawanna Six" (Lackawanna, New York, is a suburb of Buffalo), "who attended an Al Qaeda terrorist training camp," pleaded guilty to providing material support to the Al Qaeda terrorist organization, and were sentenced to prison.[12] Sentences ranged from seven to ten years. All of them are now out of prison.

How does this compare with the situation of physicians sentenced to life in prison for the wrongful behavior of their patients?

Conclusion

Legislators and government policymakers have misdiagnosed the cause of the opioid crisis and have prescribed solutions to control physician prescribing and micromanage medicine. These actions have harmed the public, physicians, and the patient-physician relationship.

Patients who have legitimate pain are now faced with increased difficulty getting adequate treatment for their pain because of restrictive and coercive opioid laws and policies and overzealous misguided prosecutions, which have had a chilling effect on the willingness of many physicians to continue to prescribe opioids.

In an environment in which prosecutors believe that someone other than the drug abuser must be responsible for abuse of drugs resulting in death, who should be held responsible for the deaths caused by the "supply side solution" of government intervention that has driven individuals to the street to purchase truly deadly drugs?

References

1. Schlafly A. War on doctors: tricks used in prosecutions. J Am Phys Surg 2016;21:57-61. Available at: www.jpands.org/vol21no2/schlafly.pdf. Accessed Nov 19, 2017.

2. Singer JA. Misdiagnosing the opioid crisis. InsideSources, Sep 27, 2017. Available at: www.insidesources.com/misdiagnosing-opioid-crisis/. Accessed Nov 19, 2017.

3. Noble M, Treadwell JR, Tregear SJ, et al. Long-term opioid management for chronic noncancer pain. Cochrane Database of Systematic Reviews 2010, Issue 1. Art. No.: CD006605. doi:10.1002/14651858.CD006605.pub2. Available at: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006605.pub2/pdf/abstract. Accessed Nov 19, 2017.

4. Center for Behavioral Health Statistics and Quality (CBHSQ), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). RTI International. Results from the 2014 National Survey on Drug Use and Health: Detailed Tables. Available at: https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH-DetTabs2014.htm#tab6-47b. Accessed Nov 19, 2017.

5. Szalavitz M. Opioid addiction is a huge problem, but pain prescriptions are not the cause. MIND guest blog. Scientific American, May 10, 2016. Available at: https://blogs.scientificamerican.com/mind-guest-blog/opioid-addiction-is-a-huge-problem-but-pain-prescriptions-are-not-the-cause/. Accessed Nov 19, 2017.

6. Sullum J. Opioid Commission mistakenly blames pain treatment for drug deaths. Reason.com blog, Nov 2, 2017. Available at: http://reason.com/blog/2017/11/02/opioid-commission-mistakenly-blames-pain. Accessed Nov 19, 2017.

7. Meier B. Doctor guilty in 4 deaths tied to a drug. NY Times, Feb 20, 2002. Available at: http://www.nytimes.com/2002/02/20/us/doctor-guilty-in-4-deaths-tied-to-a-drug.html. Accessed Nov 19, 2017.

8. Graves J. Letter to the Office of Executive Clemency (Florida), Jun 18, 2009. Available at: https://groups.google.com/forum/#!topic/tppcd-at-nftp/lv_BsBJRgCI. Accessed Nov 19, 2017.

9. Fairbanks P. Dr. Gosy faces new charges tied to six deaths. Buffalo News, Nov 8, 2017. Available at: http://buffalonews.com/2017/11/08/dr-gosy-faces-new-charges-tied-to-six-fatal-overdoses. Accessed Nov 19, 2017.

10. Davis HL. Fill-in doctors for Gosy gain appreciation of pain patients, practice and problems. Buffalo News, Jun 8, 2016. Available at: http://buffalonews.com/2016/06/08/fill-in-doctors-for-gosy-gain-appreciation-of-pain-patients-practice-and-problems. Accessed Nov 19, 2017.

11. AAPS. Administration declares war on doctors—vows to treat like Taliban—drug war ensnares doctors, not dealers. Press Release. Sep 29, 2003. Available at: https://www.aapsonline.org/press/hurwitz929.htm. Accessed Nov 19, 2017.

12. Final 'Buffalo Six' member pleads guilty. Associated Press, May 19, 2003. Available at: www.foxnews.com/story/2003/05/19/final-buffalo-six-member-pleads-guilty.html. Accessed Nov 19, 2017

Equivalent Degrees

Letter to the ADA

By Steven A. Saxe DMD, President of Nevada State Society of Oral and Maxillofacial Surgeons

I hope that every member of the House of Delegates that voted in favor of the resolution defining "equivalent degree." in Atlanta this year can read the Nov. 6, 2017, article in the ADA News titled "Becoming a Dentist"... Perhaps they should rethink their vote. A vote in favor of this resolution defines that individual state legislations can now determine the qualifications necessary to be a dentist.

Do we possibly compromise this reputation to raise membership numbers? Is the ADA in existence for its members or the organization? I say the ADA needs to uphold the definition of "equivalent" when it comes to the definition of our American earned dental degree or remove it from our bylaws.

The qualifications and sacrifices of our American students in the ADA News article consider themselves as being honored to earn their degree to become a part of our honored profession.

Compromising this honor with recognition of a substandard definition of "equivalent" and equating the qualifications of foreign dental schools to our American dental school system is not what they signed up for.

Equivalent? How desperate for members are we? What is the ADA communicating to our newest potential membership? The ADA should encourage high standards to support the sacrifices and dedication of young students entering into our profession. We send the wrong message to ASDA members and pre-dental students by embracing mediocrity to beef up our ADA membership numbers. I can guarantee this is not what the dental students in the ADA News article—Ben, LaShanda or Dan—signed up for.

Response from the ADA

Editors note from the ADA Council on Membership: At its 2016 meeting, the ADA House of Delegates adopted Resolution 791-1-2016, which calls for Chapter! of the ADA Bylaws to be deleted in its entirety and replaced with a revised version, effective beginning with the 2018 membership year. The underlying intent of these revisions is to improve the member experience, minimize the barriers to joining and increase the flexibility of making necessary changes in the future.

While the bylaws language has been streamlined for 2018, the guidance about an equivalent degree has not fundamentally changed. Amended Chapter 1 of the bylaws states that individuals are eligible for membership in the ADA if, among other criteria, they hold a D.D.S., D.M.D. or equivalent degree without any requirement for licensure.

However, it is inaccurate to assume that any dental degree awarded outside the United States is the "equivalent" of a D.D.S. or D.M.D. degree. Equivalency should be determined by looking to see if the degree is one that permits the degree holder to sit for licensure examinations in the jurisdiction without any additional training (e.g., a two-year advanced standing program for international dentists).

Many state dental boards only allow individuals holding degrees from CODA-approved dental educational programs to apply for licensure. In those states, for purposes of determining eligibility for active ADA membership under the revised ADA Bylaws, them would be no degrees considered to be "equivalent" to D.D.S. and D.M.D. degrees.

Dental boards that allow an individual trained outside of the United States holding only a foreign degree to apply for licensure are relatively rare. One example is California, where a foreign-educated dentist may apply directly for licensure if their foreign dental school has been approved by the Dental Board of California. Under this allowance, dentists would be licensed to practice in California only and not eligible to practice in other states. Currently, only the University de La Salle in Leon, Guanajuato, Mexico and the State University of Medicine and Pharmacy "Nicolae Testemitanu"of the Republic of Moldova have been approved by the board. Consequently, in California, only dental degrees conferred by University de La Salle in Leon, Guanajuato, Mexico and the State University of Medicine and Pharmacy "Nicolae Testemitanu"of the Republic of Moldova would be considered "equivalent" degrees for purposes of being eligible for active ADA membership.

Given the very limited number of degrees that are considered equivalent under the amended Chapter I of the ADA Bylaws, it is not believed that an issue has been created as a result of the removal of the licensure requirement for ADA membership.

Response from Steven A. Saxe

While I appreciate the ADA News' response to my letter published January 22, 2018, I question the promulgated concepts of "increasing the flexibility" and "has not fundamentally changed." I do not believe these quotes will reassure our ADA student members that the ADA has dentists' concerns in mind. Our students typically pay from $300,000 to over $500,000 to complete their dental studies…then many have to open practices.

Does the ADA really think it's fair that some of their future ADA colleagues matriculate to foreign dental schools in large part to pay a fraction of what a U.S. education requires?

We shouldn't forget the sacrifices U.S. Dental students make to complete high school, study for the ACT or SAT, and then graduate from college with bachelors, masters, or even doctorate degrees in order to be some of the small percentage of applicants accepted into U.S. dental schools.

Given the response of the ADA News, it might be said that the ADA continues to wear blinders, limiting its vision of the future.

There is no question that these changes will in fact fundamentally change the pre-dental paradigm as politicians, states, and schools chase more dollars and such alternative paths become more acceptable to the short sighted.

The foreign dental education programs that have been approved by California for several years now do not have CODA certification. More and more states will adopt the "relatively rare" practice and unaccredited schools will become nationally accepted unless the ADA takes a stand now.

All this will be detrimental to our profession's future because the American Dental Association "brand" is foundationally defined by the education, ethics, and standards of our members.

We have dropped the ball in the past when it comes to encouraging awareness of issues confronting our future as dentists, such as Medicaid which now covers a third of the U.S. population, and now the advent of Medicare coverage for dental procedures. We cannot effectively address these issues retroactively.

I stand by my opinion that those of us in the ADA House of Delegates need to rethink our vote and the multiple detrimental effects it will have for our young colleagues currently in school or planning their paths into the profession.

Beautiful MEDICAL/DENTAL OFFICE

SPACE FOR LEASE

IN THE PECCOLE PROFESSIONAL PARK. PRIME NORTHWEST LOCATION AT HUALAPAI AND ALTA DRIVE. **2,400 square feet.**

Peccole Professional Park
10080 West Alta Drive, Suite 200
Las Vegas, NV 89145

Contact Trent Cannon at tcannon@hutchlegal.com or

702.385.2500 • HUTCHLEGAL.COM

Jessica Beason
jessica.beason@sndsonline.org

SNDS Executive Director's Message

Have you ever been stuck in a rut wondering how to navigate out of it? Have you ever said there has to be a better way of doing this? I think it is easy to get in auto pilot mode. When you are thinking about your professional daily experience as an employee or a business owner have you stopped and asked yourself if you are operating with efficiency and getting the most out of your day or just going through the motions as you have in the past. I think we all want to optimize productivity, and ultimately our bottom line. In order to do this, we need to identify our priorities, goals and a vision of success. Once we see what that picture is we have to create the road map to get there, find the right tools as well as outline the possible obstacles and challenges.

Prioritizing

What is at the top of your list. Customer first, right? So, have you drilled down on your customer service lately? Have you listened to your customers? Have you had the conversation lately with your team on office procedures and what can be done to improve them? What about your technology, could you update to improve your efficiency, product and service? Is there technology you could change or add to your routine that would improve your bottom line? Thinking through and mapping out a priority list is the first step to identify whether you are on the right track.

> Because the process of change does not happen overnight it is not always identified as the right thing and sometimes there is resistance because it is different.

Resistance to change

Many of us are fixed in routines and have been going through the motions for so long we can't see outside the box. This makes it hard to see alternatives and better methods. We have to have the conversation with our teams to identify the resistance. Change to some creates fear and loss of control. Let your team be part of the process and they will likely buy in. Clear the air, change does not mean the previous process was wrong. Things change and we have to adapt to these changes around us finding relevancy for our product and service. How many changes in technology or dental product have you seen in the last couple of years. Were the previous products bad or wrong or did someone create something better. Bottom line we have to always be seeking improvement and relevance.

I share all of these thoughts with you to say that the SNDS is going through change, change to improve efficiency, and change to bring you a better product. Because the process of change does not happen overnight it is not always identified as the right thing and sometimes there is resistance because it is different. The SNDS leadership is going through the motions of looking at all of the processes and determining where change is needed. The mission we are aligning our change to is "Helping all Members Succeed." Specifically looking at how we can we improve our structure to provide the best product and service for our members. This is our commitment as we move

forward. Currently we are looking at a new website, an advanced Career Center that will roll out in a few months and a variety of new discounted products and services that will provide you savings. As we go through this process we want to hear from you. If there are products and services in your office that you would like to see added to our existing member benefits, just ask. It might be something we have already aligned with to bring members discounts, if not we will look into it. Our priority is *our members*.

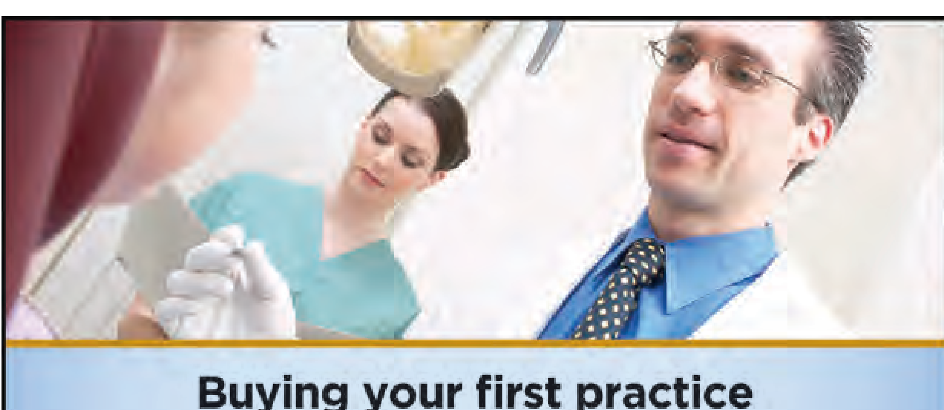
I am proud to work with the leaders and volunteers that are committed to helping our members succeed! If you have an interest in plugging into leadership or working with one of our committees such as peer review. Please reach out we do have some opening coming this spring!

CLASSIFIEDS

Intraoral X-Ray Sensor Repair/ Sales. Repairs with rapid turnaround. Save thousands over replacement costs. We specialize in Kodak/Carestream, Dexis Platinum, and Gendex sensors. We also buy/sell dental sensors. Call us 919-229-0483 www.repairsensor.com

To Place a Classified Ad

Contact Dan Hartzog at 503-445-2229 or danh@llmpubs.com

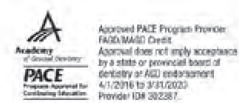


Buying your first practice doesn't have to be painful.

PARAGON cultivates relationships, not just clients. We'll match you with the opportunity that fits your career aspirations, and guide you through every step of the process.

Start your practice with a smile. Call now.

Your local PARAGON dental transition consultants
Lance and Becky Self



866.898.1867 info@paragon.us.com paragon.us.com

Joseph Wineman, DMD

SNDS President's Message

As we enter the year of the Dog, we in the Southern Nevada Dental Society, see our calendar is full of CE opportunities, Give Kids a Smile 2018, our third seminar in the series for 2017–2018 with our US Air Force partners, USAF 99th Dental Squadron on Nellis Air Force Base, our third SNDS dinner meeting, the newly mandated class on Substance Abuse, Executive Board meetings, Executive Committee meetings and the Business of Dentistry classes. After April Fools and Easter (they are on the same day) we will enjoy the annual Resident lectures and cast our ballots for new SNDS officers and delegates. All these events keep our Executive Director and society officers hopping.

A few months back, this column ran an article about Eight Habits of Highly Effective People from Steven Covey. Through a mix up, that column was attributed to me but Dr. Richard Featherstone was its author. For my first actual column as the SNDS President, I would like to share a great article by Dr. Travis Bradberry I recently read regarding the Eight Habits of Highly Influential People.

While some people are influenced by changes with the season, the unique habits of influential people remain constant. Their pursuit of excellence is driven by eight habits that you can emulate should you choose to do so.

Influential people have a profound impact on everyone they encounter. While some people are influenced by changes with the season, the unique habits of influential people remain constant. Their pursuit of excellence is driven by eight habits that you can emulate should you choose to do so.

1. They think for themselves

Influential people do follow the latest trend or by public opinion, but form their opinions carefully, based on the facts. They are willing to change their mind when the facts support it, but they aren't influenced by what other people think, only by what they know.

2. They are graciously disruptive

Influential people are never satisfied with the status quo; instead they constantly ask, "What if?" and "Why not?" Unafraid to challenge conventional wisdom or past practices they don't disrupt things for the sake of being disruptive; they do it to make things better.

3. They inspire conversation

When influential people speak, conversations spread like ripples in a pond. And those ripples are multidirectional; influencers inspire everyone around them to explore innovative ideas and think differently about their work.

4. They leverage their networks

Influential people know how to make lasting connections. Not only do they know a lot of people, they add value to everyone in their network. They share advice and know how, and they make connections between people who should get to know each other.

5. They welcome disagreement

Influential people do not react emotionally and defensively to dissenting opinions—they welcome them. They're humble enough to know that they don't know everything and that someone else might see something they missed. And if that person is right, they embrace the idea

wholeheartedly because they care more about the result than being right.

6. They are proactive

Influential people don't wait for things like new ideas and new technologies to find them; they seek those things out. They are early adopters who anticipate what's next. They are influential because they can see "the future." They see what's coming because they intentionally look for it. Then they spread the word.

7. They respond rather than react

If someone criticizes an influential person for making a mistake, or if someone else makes a critical mistake, influential people don't react immediately and emotionally. They wait, think and then deliver an appropriate response. Influential people know how important relationships are, and they will not let an emotional overreaction harm theirs. They also know that emotions are contagious, and overreacting has a negative influence on everyone around them.

8. They believe

Influential people always expect the best. They believe in their own power to achieve their dreams, and they believe others share that same power. They believe that nothing is out of reach, and that belief inspires those around them to stretch for their own goals. They firmly believe that one person can change the world.

Bringing it all together to increase your influence, you need to freely share your skills and insights, and you must be passionate in your pursuit of a greater future.

So, as we approach the nomination period for the SNDS election and start the campaigns for our state officers and ADA delegates, perhaps this column will convince those with desire and passion to throw themselves into the fray called leadership.

Need CE?

WELCOME

UNLV School of Dental Medicine

UNLV School of DENTAL MEDICINE

Continuing Education

unlvdentalce.com

702-774-2822

Like Us On facebook unlvdentalce

Lori Benvin
nnds@nndental.org

News from the Northern Nevada Dental Society

Big news to share this month coincidentally with National Children's Dental Health month. NNDS' non-profit dental care programs entitled the Northern Nevada Dental Health Programs (NNDHP), is happy to announce the REOPENING of Healthy Smile Healthy Child (HSHC) and our collaborating partner Renown Children's Hospital/Child Health Institute. We are also elated to announce our former Dental Case Coordinator Monica Vazquez is back as our coordinator for our low-income children at HSHC. The Northern Nevada Dental Health Programs is always looking for volunteer dental professional providers and we hope if you were a provider for HSHC before its closure in August 2016, you will return as a provider of at-risk children. We are always looking for new providers of care and if you are interested in 'giving back' to our community by helping either of our programs; HSHC or Adopt a Vet Dental, we'd love to hear from you. Contact information at the end of this article.

The Northern Nevada Dental Society's New Dentist Committee in conjunction with the Northern NV Dental Health Programs' Healthy Smile Healthy Child teamed up with Champagne Family Dental to host our 8th Annual Give Kids a Smile event on Saturday, Feb. 3rd. This year we had 15 volunteer dentists, 2 hygienists, dental assistants and other volunteers. 84 children received $64,307 worth of pro-bono dental care at this year's event. There were 18 children identified who will need continued care for additional restorative treatment. HSHC is following up with all of those parents of these children, verify eligibility and place them with participating volunteer HSHC providers. The NNDS would like to *thank* the following dentists who participated this year: Drs. Hannah Beus, Paul Brosy, Cariann Champagne, Jason Champagne, Drew Champagne, Austin Cope, Bradlee Davis, Morrigan Drew, James Jensen, Andrew Leland, Luz Molina, Benita Ng, Michelle Schiro, Garrett Swanson, and Trent Gookin the GKAS Chair.

Please continue to watch for our upcoming events and top-quality continuing education opportunity flyers and notifications in your mailbox, email and on the NNDS Facebook page. We have some excellent education opportunities this year. If you are not receiving them please contact the NNDS directly or email me at nnds@nndental.org

Contact information

Northern NV Dental Health Programs

lori.benvin@nndhp.org or contact each program directly:

Adopt a Vet Dental (775) 470-8707
Healthy Smile Healthy Child (775) 982-7989

Welcome Newest NNDS Members

Charles Cordova, Jr., DDS – General

Megan Dinh, DMD – General

Alec Fillmore, DDS – General
(welcome back)

Stuart Labowe, DDS – General
(welcome back)

Erin McEvoy, DMD – General

Amy Nygren, DMD – General

Anisha Paul, DMD – General
(welcome back)

NNDS President's Summer Message

Spencer Fullmer, DDS, MS
nnds@nndental.org

Esteemed Colleagues,

If time flies when you're having fun, then my life must be a hoot! I do believe it is, and I'm grateful for that. I hope that everyone had a safe and healthy Holiday season and this message finds you all well as we are, unbelievably well into 2018.

The Northern Nevada Dental Society is as healthy as ever. I attribute that, of course, to all you. Your membership and support are what make us who we are. It has been positively overwhelming to see our numbers steadily increase as we strive to provide you with outstanding benefits and privileges that come from membership.

We came out of the gates sprinting in the first quarter of 2017. We want our members to have the information and tools they needed to tackle the complex regulation passed with opioid prescriptions, so we brought in Drs. Pinson and Long from the State Board of Pharmacy to educate us. This was extremely helpful. Then our Give Kids a Smile program was again a massive success held on February 3. Later, on February 15, our members were given free entrance, and 2.5 CE credits to attend our annual vender fair. The events all opened up the year to another year of valuable and practical CE courses that we have coming up.

Another piece of exciting news is that the Northern Nevada Dental Society and Northern Nevada Dental Health programs announced the reopening of the Healthy Smile Healthy Child Program (HSHC) in partnership with the Renown Child Health Institute. We are also welcoming back Moni Vazquez as the program coordinator. Those familiar with this program know that you can bless the life of a child while earning up to 6 CEUs per year.

For my message in last winters issue of this journal, I challenge. each of us to reach out to a colleague that needed support. I hope we each did this. I'd like to issue us all a new challenge for 2018. My challenge is for each of us to volunteer in the HSHC program for at least one child in 2018. Please reach out to Moni Vazquez and let her know you are interested. She can be reached at 775.982.7989 or mvazquez@renown.org. Her office is located at 75 Pringle Way, Suite #702, Reno, NV 89502.

Again, I want to thank each of our members for your continued support of the NNDS, and personally, for the great examples you all are to me. God Bless.

It has been positively overwhelming to see our numbers steadily increase as we strive to provide you with outstanding benefits and privileges that come from membership.

Treasures of Pioneer History

In the alphabetized list of personal entries of the Salt Lake City 1869 Directory is the following: "W. F. Anderson, M.D. Physician and Surgeon-13th Wd, 2 East, bet. 2 and 3 S." Dr. Anderson was a courtly gentleman from Virginia and also a Utah Pioneer of 1857. He continued to live at the above address through many years of service to the people of Utah and the West in civic as well as professional fields, and was greatly respected and loved.

It was from this physician that Lorenzo S. Clark, Utah pioneer of 1853, purchased a set of three pairs of forceps and learned to use them correctly. He resided in the Sugar House district where he began and carried on a practice of extracting troublesome teeth; thus relieving suffering fellow pioneers in an age when the objective was not to save the offending member, but rather to get rid of it if the extraction pain was considered less than that of the continuous aching agony.

The setting of action and equipment were essentially primitive. A sturdy kitchen chair in which the patient might sit and hold on if necessary, a nearby cup of water, with a strong helper to hold the patient's head firmly, constituted the equipment of the great outdoor dental chamber.

The Clark children were intensely interested in the fascinating operation that so quickly turned a distressed, suffering visitor into a smiling grateful friend. Every window in their cottage home provided a grandstand position for scenic observations. One of these experiences became an outstanding and lasting memory. We all knew our venerable neighbor, Samuel Garn. He had seen many younger days and, now with the infirmities of age, he was still respected and his conspicuous snowy white beard was a mark of distinction. Evidently his tooth was unusually difficult to remove. Father had to shake and pull hard while Big Brother exerted all his strength in the head-holding position. Through tense seconds we held our breath, and then—horrors! Oh!—The snowy white beard ! From head-holding, Brother dashed quickly to the old windlass well, lowered the bucket and drew it hastily to the top; a cup passed through the kitchen door as if by magic. No one spoke, but all intently looked away for a few minutes; then friendly, pleasant "good byes" were spoken and neighbor Garn went on his happy way, his distinguished beard as handsome and white as ever.

Years traveled by and the children were grown. Indian Reservation lands were being bestowed upon white applicants in the Duchesne and Uintah wilds. Two of the Clark sons moved their families to the new romantic fields, led by their "dyed-in-the-wool" pioneer father, Lorenzo S. Clark. With him went the good old tried and true pairs of forceps which lost no time in going to work in the new pioneering field. Roads were rough and crude with frequent difficult washes to cross and distances were forbiddingly far when measured by time. From Roosevelt town to Tabiona settlement, though they were only 20 to 30 miles apart, it required at least a whole day's travel by white top to cover the distance. Tabiona is located on the Duchesne River at the foot of Tabby mountain and the settlers' cottages and huts followed the line of the river. Both white people and Indians traveled the winding course by pony or riding horse usually to obtain the only relief they knew when tooth troubles were unendurable.

Some of the Indians who found relief thus were: Mary Pidgeon, Alice Kroppe, Natsu Kroppe, Smith Shumburo, Muse Harris, Joe Bush, who claimed to be a son of Jim Bridger and a friend of the whites. He was present when a tooth was pulled for Natsu Kroppe and is reputed to have said, "Natsu all same white man; he turn so pale and say, It hurts pretty good.'" There was also Ephraim Panowitz, who claimed to have been born in Spanish Fork Canyon at Indianola, and was a grandson of Chief Tabby whom he said was baptized by Brigham Young. He also claimed that only he really knew where Chief Tabby was buried on Tabby mountain.

As the infirmities of old age crept on, pioneer Lorenzo S. Clark found life in the wilds too strenuous and so gave it up; but not until he had taught his eldest son, Lorenzo W. Clark, to use the precious forceps as he had done. Pioneering is a slow process and so the new guardian gave many years of service before he also moved back to the comforts of civilization, leaving the efficient dental tools in younger hands.

Grandson Frank L. Clark who still lives in Tabiona has used the historic forceps most recently. He writes: "I held the heads and helped Father, Lorenzo W. Clark, as long as he performed this service and have continued the good work among the people here since he left us. I have had men ride fifty miles on horseback in winter to have a tooth pulled and have helped both whites and Indians in this way even during the last few years." Improved transportation, scientific knowledge and the kind comfort of anesthetics have brought a new era to dentistry, but still we recall with humble gratitude the efforts and accomplishments of volunteers from the past and gratefully acknowledge that they did the best they knew how to do and really made a valuable contribution to the development of the wonderful West. *– Annie C. Kimball*

Reprinted with permission of the Daughters of the Utah Pioneers

Event Calendars

2018			
April 24	NDA Executive Meeting	Video Conference	6pm
June 5	NDA Executive Meeting	Video Conference	6pm
June 21–23	NDA Summer Meeting	TBD	TBD

Dinner Meetings 2018			
April 19	Election/GPR	TBD	TBD
CE Premeier 2018			
April 20	"Great Team + Great Business = Great Practice" and "The Art of the Smile" With Dr. Tony Tomaro, Sponsored by 3M	Nevada State Bank	9am

2018			
April 10	NNDS Executive Committee Meeting	5605 Riggins Court, #101A, Reno	5:30pm
April 12	Mario Gildone Lifetime Achievement Award Dinner to honor Dr. Jade Miller	Atlantis Casino Resort Spa, Reno	6pm
April 19	AGD Dinner meeting with Dr. David Reeves—Endo	TBD	6pm
April 24	NDA Executive Committee Meeting	NNDS & NDA offices	6pm
May 8	NNDS Executive Committee Meeting	5605 Riggins Court, #101A, Reno	5:30pm
June 1	OSHA & Infection Control 2018 CE	Atlantis Casino Resort Spa, Reno	7:30am
June 5	NDA Executive Committee Meeting	NNDS & NDA offices	6pm
June 12	Delegate Pre-Mtg. & NNDS Executive Committee	5605 Riggins Court, #101A, Reno	5:30pm

JOIN HENRY SCHEIN®
PROFESSIONAL PRACTICE TRANSITIONS

Achieve financial and career success!

- Opportunities in top markets
- Leading compensation package
- Great work environment
- Top respected brand
- Largest national presence
- Extensive marketing support

Excellent opportunity for Dentists as well as Sales Representatives, lenders, business owners, consultants, accountants, and others with dental business knowledge and experience.

Send resume and cover letter in confidence to: **ppt@henryschein.com.**

www.henryscheinppt.com
1-800-988-5674

▪ PRACTICE SALES ▪ VALUATIONS
▪ TRANSITION CONSULTING/PLANNING
▪ ASSOCIATESHIPS

REPORT

ADMISSIONS AND STUDENT AFFAIRS

The Office of Admissions and Student Affairs reported receiving more than 1,800 applications for the 2017-18 application cycle. The selection for the Class of 2022 is still underway with interviews occurring during February. Acceptances will continue to be sent until the class is filled with 80 students.

Important dates:

Spring Break
March 19–23

Spring Semester ends
April 20

Summer Semester begins
May 14

Class of 2018 Senior Gala
TBD

Class of 2018 Convocation
May 11

Application Cycle 2018–19 begins
May 15

Summer Semester ends
August 17

ADVANCED EDUCATION IN PEDIATRIC DENTISTRY RESIDENCY PROGRAM

The program announced its Class of 2020 that begins July 1. Members of that class are:

- Dr. Morgan Bisbas, USC Class of 2015
- Dr. S. Kent Mann, Temple Class of 2017
- Dr. Charlene Mo, Roseman Class of 2018
- Dr. Audrey Nghiem, Baylor Class of 2010
- Dr. Noura Rezapour, Nova SEU Class of 2018
- Dr. Chris Viravongsa, UNLV Class of 2016

ADVANCED EDUCATION IN ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS RESIDENCY PROGRAM

The program hired the following as part-time clinical faculty.

- Dr. Matt Bruner
- Dr. Tom Pitts
- Dr. John Pobanz
- Dr. Bill Schmohl
- Dr. Eric Wu

FACULTY NEWS

Kenneth Izuora (School of Medicine), Ammar Yousif (School of Medicine), Gayle Allenback, Civon Gewelber (School of Dental Medicine) and Michael Neubauer (School of Dental Medicine) presented “Dental Loss Among Hospitalized Patients with and without Diabetes” at the American Public Health Association Annual Meeting and Expo held in Atlanta. This poster presentation included results of an investigator initiated study designed to understand the clinical outcomes associated with dental loss among hospitalized patients with and without diabetes.

For the first time in the dental school’s history, orthodontic residents had article reviews published in the American Journal of Orthodontics and Dentofacial Orthopedics. Mentored by Dr. Brian Chrzan and Dr. Walter Babula, six third-year residents reviewed clinically relevant articles that practicing clinicians may not encounter. The journal’s practice of printing such summaries is afforded to a dental school once each year or every other year. Reviews of this nature, especially within high impact journals, enhance the reputation of the school and its residency program. The published residents are Dr. Vincent Khang, Dr. Satya Nayak, Dr. Anh Nguyen, Dr. Amy Tam, Dr. Suzanne Wen, and Dr. Adam Whitely.

FACULTY PUBLICATIONS

Faculty within the departments of Biomedical Sciences and Clinical Sciences published 20 articles since last noted in this journal.

STUDENT RESEARCH

Students mentored in research:

Undergraduate Students: 9

DMD Students: 57

Graduate Students: 22

INVITED PRESENTATIONS

Marcia Ditmyer: American Association of Orthodontists, 117th Annual Session, Effective Teaching and Learning Strategies in CBE Learning Environment

Jeffrey Ebersole: North American Saliva Symposium New York University Dental School Oral Biology Seminar Series Harvard School of Dental Medicine lecture

Victoria Woo: Oral vesiculoerosive disorders: Diagnosis to management. Anthem Periodontics Study Club, Las Vegas, NV

Victoria Woo V and Edward Herschaft (co-presenters): Multifocal localized juvenile spongiotic gingival hyper-plasia treated with combined laser and topical corticosteroid therapy. Presented at the AAOMP annual meeting, 2017

Christina Demopoulos: State of Oral Health: HPV and Beyond, Nevada Health Conference Closing the HPV Vaccination Gap: The Fundamentals of HPV for Oral Health Care Providers, High Sierra AHEC

PROMOTIONS/FACULTY RECOGNITION AWARDS

- Tanya Al-Talib: Promoted to Assistant Professor in Residence
- Fiona Britton: New faculty, Associate Professor and Vice Chair of Biomedical Sciences
- Brian Chrzan: “Graduate Coordinator” for MS Oral Bio program
- William Davenport: Promoted to Executive Associate Dean
- Christina Demopoulos: Promoted to Associate Professor of Clinical Sciences
- Marcia Ditmyer: Promoted to Assistant Dean for Academic Affairs, Assessment, and Instruction
- Jeffrey Ebersole: Appointed Interim Chair of Biomedical Sciences
- Rhonda Everett: Promoted to Assistant Dean of Student Services
- John Gallob: Promoted to Assistant Professor in Residence
- Stanley Hillyard: George and Helen Hertzog Enduring Service Award from the Western Region of the US National Park Service for 40 years of participation in the SCUBA survey of the Devils Hole pupfish
- Stanley Hillyard: Recognized for 40-plus years of service as a faculty member at UNLV
- Frank Jones: Promoted to Assistant Professor in Residence
- Karl Kingsley: UNLV Graduate College - Extraordinary Service Award medallion
- Karl Kingsley: Awarded “Best Article” from journal EC Dental Science for “Prevalence of Scardovia wiggsiae among a Pediatric Orthodontic Patient Population”
- Linh Nguyen: New faculty, Assistant Professor, Biomedical Sciences

COMMUNITY SERVICE REPORT

UNLV School of Dental Medicine had a very productive year with community outreach events. From January 1, 2017 to December 31, 2017, the community outreach team offered almost 3,000 screenings and 1,500 dental sealants to underserved patients in Nevada. The team also provided almost 2,700 applications of fluoride varnish. With the assistance of dental students, they offered oral hygiene instruction to more than 18,000 students. The school’s newest project, the Early Childhood Caries Prevention Project, reached patients in Carson, Churchill, Clark, Douglas, Elko, Humboldt, Lyon, Mineral, Pershing, White Pine, and Washoe counties. The value of the donated services for this time period was more than $860,000 using an average summary for the ADA fees.

DEVELOPMENT NEWS

UNLV School of Dental Medicine, in collaboration with the Southern Nevada Dental Society, hosted a highly successful inaugural Benefit for Smiles Gala on December 1. The gala recognized Dr. Robert Talley for his many contributions to improving oral health, and raised more than $46,000 for the UNLV School of Dental Medicine’s Saturday Morning Community Clinics and student scholarships. We are thankful to all of our sponsors and donors, especially Henry Schein, the gala’s presenting sponsor. Your support allows the dental school to provide much needed care to many of Southern Nevada’s underserved populations. We would also like to acknowledge Dr. Steve Saxe for coming up withthis wonderful idea. Please save the date for the 2nd Benefit for Smiles Gala—Friday, December 7, 2018.

UNLV School of Dental Medicine appreciates and thanks Absolute Dental for its continued generosity and support. Their recent $100,000 multi-year pledge enables student and faculty dentists to provide additional care and services to pediatric patients within the UNLV Absolute Dental Saturday Morning Children’s Clinic.

To learn more about supporting the UNLV School of Dental Medicine, please contact Nikki Khurana-Baugh at 702-774-2362 or via email at nikki.khurana-baugh@unlv.edu.

Administrative Offices

NDA Executive Offices

Robert H. Talley DDS CAE, Exec. Director
8863 W Flamingo Rd, Ste 102
Las Vegas, NV 89147
702-255-4211 • 800-962-6710
FAX 702-255-3302
robert.talleydds@nvda.org • www.nvda.org

PRESIDENT	George McAlpine DDS
PRES.- ELECT	Richard Dragon DDS
VICE PRESIDENT	Michael Sanders DMD
SECRETARY	Mark Funke DMD
PAST PRESIDENT	David White DDS
TREASURER	Dwyte Brooks DMD

Nevada State Board of Dental Examiners

Debra Shaffer-Kugel, Exec. Director
Rick B. Thiriot DDS, DSO Coordinator
Candice Stratton, Licensing Specialist
6010 S Rainbow Blvd, Ste A1
Las Vegas, NV 89118
702-486-7044 • 800-DDS-EXAM
FAX 702-486-7046
nsbde@nsbde.nv.gov
www.nvdentalboard.nv.gov

Northern Nevada Dental Society

Lori Benvin, Exec. Director
161 Country Estates Circle, Ste 1B
Reno, NV 89511
775-337-0296 FAX 775-337-0298
nnds@nndental.org • www.nndental.org

PRESIDENT	Spencer Fullmer DMD
VICE PRESIDENT	Adam Welmerink DDS
SEC./TREASURER	Craig Andresen DDS
PAST PRESIDENT	Maggie Heinen DMD

Northeastern Nevada Dental Society

Robert H. Talley DDS CAE, Exec. Director
8863 W Flamingo Rd, Ste 102
Las Vegas, NV 89147
702-255-4211 • 800-962-6710
FAX 702-255-3302
www.nends.org

PRESIDENT	Jeremy Keener DDS
VICE PRESIDENT	N/A
SEC./TREASURER	Todd Thompson DMD
PAST PRESIDENT	Jamie Marvel DDS

Southern Nevada Dental Society

Jessica Beason, Exec. Director
Linden Peterson, Office Manager
8863 W Flamingo Rd, Ste 101
Las Vegas, NV 89147
702-733-8700 FAX 702-733-6062
s_nds@hotmail.com
www.sndsonline.org

PRESIDENT	Joe Wineman DDS
PRES.-ELECT	Robin Lobato
SECRETARY	Ed De Andrade DDS
TREASURER	Tate Guild DDS
PAST PRES.	Richard Featherstone DDS

American Dental Association

211 E Chicago Ave, Chicago, IL 60611-2678
312-440-2500 • 800-621-8099
www.ada.org

ADA DELEGATES	Richard Dragon DMD
	Steven A. Saxe DDS
	David M. White DDS

NDA Committees

Council on Communications

Peter Balle DDS, *Co-Chair*
Daniel L. Orr II DDS MS (anesth) PhD JD MD, *Co-Chair*

Council on Ethics, Bylaws and Judicial Affairs

Dwyte Brooks DMD, *Chair*

Council on Government Affairs

David White DDS, *Chair*
Arnie Pitts DDS

Council on Membership

Emily Ishkanian DMD, *Chair*
Erin Anderson DMD

New Dentist Committee

Erin Anderson DMD, *NNDS Chair*
Emily Ishkanian DMD

NNDS Health and Wellness Committee

Eric Pendleton DDS- Membership Chair
Paul Brosy DMD- Peer Review Chair
Erin Anderson DMD- New Dentist Committee Chair
Trent Gookin DDS- Give Kids a Smile Chair
Stephen Sims DMD- Chief Delegate
Eric Pendleton DDS- Health and Wellness Chair

| FREE |

Online CDE

ADA CE Online www.adaceonline.org
Kerr Learning Source www.kerrlearningsource.com
Procter & Gamble Dental Care www.dentalcare.com
Wiley Health Learning www.wileyhealthlearning.com

ADA Business Resources affliated

We are pleased to announce that the NDA and ADA have combined the purchasing power of dentists to gain discounts on a large variety of products and services. Call the company or the NDA to learn more.

CareCredit
Patient financing
800-300-3046 x4519 www.carecredit.com

InTouch Practice Communications
877-493-9003
www.intouchdental.com/ada

Wells Fargo Practice Finance
888-937-2321 www.wellsfargo.com/dentist

NDA-Affiliated Products

These companies and their products have been evaluated by the NDA and are recommended for use in running your practice. Let us know if you have any feedback or would like to recommend a product or service for affiliation. For a weblink to each company, go to www.nvda.org/affiliatedproducts.shtml.

Best Card, LLC
Credit card processing
877-739-3952 www.bestcardteam.com

The Dental Record
Digital record keeping
800-243-4675 www.dentalrecord.com

TDIC
Professional liability
800-733-0633 www.tdicsolutions.com

NDA Supplies
Save up to 35% on dental supplies
www.ndasupplies.com

IC System
Collection service
800-279-3511 www.icsystem.com/nda.htm

Lands' End Business Outfitters
Uniforms
800-490-6402 www.ada.landsend.com

Lenovo
800-426-7235 ext. 4886
www.adabusinessresources.com/en/endorsed-programs/computers

Mercedes-Benz
Mercedes-Benz leasing
866-628-7232 http://ebusiness.ada.org/adabei/luxury-vehicles.aspx

Office Max
Office supplies
702-647-8662 www.officemax.com

SurePayroll
Payroll processing
866-535-3592 www.surepayroll.com/ada

UNLV School of Dental Medicine
Hands-on continuing education
702-774-2400 www.dentalschool.unlv.edu

UPS
Shipping services
800-636-2377
www.adabusinessresources.com/en/endorsed-programs/shipping

Whirlpool Corporation
866-808-9274 www.whirlpoolinsidepas.com

Keeping the **game fair...**

...so you're not **fair game.**

The fast-changing practice of dentistry is getting hit from all angles.

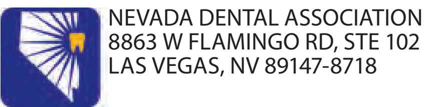
Choose a specialized protection plan designed to help you cover your unique Nevada risks.

You get game-changing coverage made easy.

Professional Liability Insurance & Risk Resource Services

ProAssurance Group is rated **A+ (Superior)** by A.M. Best.

800.625.7814 ProAssuranceDentistCare.com



CHANGE SERVICE REQUESTED

PRSRT STD
U.S.POSTAGE
PAID
Jefferson City, MO
PERMIT 210

Get 15% OFF
Repair Coupon Code: NVDA15

HANDPIECE REPAIR . . . .
that won't drill your pocket

Cost effective savings of 30% - 60% over factory repairs • Experienced in-house technicians • Quick turnaround • Free estimates • Free pick-up & delivery • All repairs performed are in compliance with OEM specifications • Parts used are original or of the same quality as manufacturers' • Hassle-free warranty

YOUR ONE STOP SHOP FOR ALL YOUR HANDPIECES!

HANDPIECE SOLUTIONS

Shop online @
www.HandpieceSolutions.com

Call us for free pick-up @ 1.888.488.3885 or 702.388.1888
6785 S. Eastern Ave., Unit #11, Las Vegas, NV 89119