MONTEREY BAY

SmileLine

The Newsletter of The Monterey Bay Dental Society

Summer 2007

Inside This Issue

MONTEREY BAY
SMILELINE

NOTES FROM THE PRESIDENT...

Members of the Monterey Bay Dental Society have been busy with our annual elementary school screenings and the CDA sponsored "Give Kids a Smile Day." In 2006, approximately 5,000 children were seen in the schools program and we are fast approaching that number this year. Over $70,000 worth of services were provided to patients by 20 CDA member dentists during GKAS Day. Thank you to Drs. Alison Jackson, Kenji Saisho and Carl Sackett who coordinated the programs. During the past several years, I have participated in both activities and always have had a great time. It's a lot of fun to work with other dentists and the appreciative smiles from the children let us know how much our work is appreciated.

In our dental practices, we provide care to our patients. We relieve their pain, improve their appearances, and oversee their dental health. But we also have opportunities to affect people in other ways. A high school student visited our office to learn about the dental profession. What was a single visit became a part time after school job. The student filed charts, became interested in assisting and recently received her x-ray license. Because of the positive interactions with the staff and patients, the student is considering a career in dentistry. Another student,who is interested in becoming a dentist, was invited to volunteer at one of the "Give Kids a Smile" sites and was able to experience the joy that comes from helping another person. He thought he could not help in any way. Each of these students just needed encouragement to recognize their individual strengths. We all have many opportunities to encourage and support others in our regular work day.

I recently heard someone say that the "Golden Age" of dentistry is over but I think it is really happening now. We have technology to aid us in our work, magnifying loupes to make our work easier, rotary files, vast improvements in composites, bonding agents and materials, cad-cam. Computers to make our work easier. New products are always being developed to help us provide better patient care. I recognize that there are many business challenges that come with maintaining our dental practices. Anyone ever had a network server go down twice in one year? Yet, it's still an exciting time to practice dentistry.

Organizations such as the ADA, CDA, and the Monterey Bay Dental Society are constantly working on our behalf. For example, the ADA recently responded to statements by the media that dentists should solely be held responsible for treating the underserved. Their response emphasized that everyone has a responsibility for improving access to dental care. CDA provides input at the State level so that our concerns are included into any legislative action related to dentistry. On a local level, our MBDS Executive Director, Carole Hart, has probably interacted with each one of us at some point in our career. She handles telephone calls from dentists, staff, and patients on a daily basis while coordinating the various committees such as Peer Review, and provides the link to new dentists interested in working within our communities.

Join us at a board meeting, anytime. See you there.

Best regards,

Stuart Osaki, DDS

Monterey Bay Dental Society

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In This Issue

From The Editor

Greetings and Best Wishes for a wonderful 2007! Your newsletter hasn't shown up in quite some time, and while you have been languishing, lots of important things in the world of dentistry have been taking place. It is my hope to provide you, on a regular basis, with items of interest to you as a professional, dental office items for sale, occasionally some humor, and to keep you updated on upcoming educational opportunities.

In each newsletter, I'll do my best to include articles pertaining to the various specialties, including restorative dentistry, orthodontics, endodontics, periodontics, oral surgery/oral pathology, and will also occasionally include items about pediatric dentistry, implant dentistry, dental hygiene, geriatric dentistry, medical/dental interrelationships, and legal aspects of practice. If you have suggestions, or have interest in seeing coverage on a particular topic or concern, or if you are interested in writing an article for your Society's newsletter, please let me know!!! You can reach me online at gumdude@sbcglobal.net via phone at (831) 649-3661 or mail, 333 El Dorado Street, Monterey, CA 93940.
The very best!

Lloyd Nattkemper, DDS

Calendar of Events

MBDS Staff Appreciation Night
Monterey Bay Aquarium
Friday, September 21
7 P.M. – 11 P.M.

ADA Scientific Sessions
San Francisco
Thursday, September 27th –
Sunday, September 30th

MBDS Installation of Officers Meeting &
Golf Tournament
Pasadera Country Club
Friday, October 26th

David Hornbrook, DDS
"Hot Topics in Aesthetic Dentistry:
Review of State of the Art Materials & Techniques"
Friday, February 8, 2008
9 A.M. – 5 P.M.
7 CEUS

To Dental Specialists

What Every General Dentist Really Wants

Specialists: Here are the secrets to the general dentist's heart. Follow the steps below and your chances of unending loyalty and devotion, not to mention minions hanging out at your office on Fridays, will increase substantially.

We, as general dentists, must provide the best service for our patients to attract more business. You, as specialists, have to impress both the patient and the referring dentist to be financially successful. I have always been quite happy with the level of expertise and academic abilities of specialists with whom I have worked. Patients have rarely complained of the treatment. Except, of course, the standard, "Why do I get charged $900 for a root canal that took only 45 minutes?" My reply, "I can do it for the same price and take an hour and a half. Which would you prefer?" I have, however, experienced very different levels of communication with specialists – some much more effective than others. General dentists depend on you – the specialist – to help them provide the best course of continuing dental health for their patients. Adopting the following communication pearls should ensure that the needs of both the referring doctor and the specialist are met:

1. Both the general dentist and specialist need to work together to make sure the patient is psychologically prepared for the specialist. You, as the specialist, can assist with professional practice brochures, detailing the ambience and personnel of your practice. A web site can assist the patient with information on the procedure(s) to be performed. The referring dentist has the responsibility to prepare the patient for your services by providing access to that information. Nothing substitutes for confidence in your skills shown by the referring dentist!

2. Your staff must be able to "close the deal" financially with the patient. This may involve more than one consult with advanced cases; all parties, including the patient and the referring dentist, have a stake in the work being completed. Next month I will comment in detail about "closing the deal."

3. You must have effective and ongoing communication with the referring doctor throughout the treatment cycle. This requires at least the following:

- Always let the referring doctor know that the patient has seen you for an initial exam. Don't forget the "thank you." It is especially important to report any patients that fail to keep appointments, as the referring dentist can easily lose track of the patient for any continuing care. Many specialists miss this step---it is critical. We GP's need to know within a short period of time, not six months later at recall, whether the patient made contact.

- Inform the referring doctor, in writing for complex cases, of your treatment plan and ask for any additional input from the doctor. For example, the general dentist may have information that the specialist does not regarding previous positive or negative results the patient has had with the proposed treatment. He also may know of special physical conditions, such as back pain or TMJ issues that haven't been addressed. Also, any major treatment changes from the initial proposal of the referring doctor may impact future treatment that the referring doctor may have planned.

- After treatment, always provide a full written report, including any changes from your original plan and any further work you find necessary for the general dentist to perform. A phone call isn't sufficient. Calls work well for consultations during the treatment phase, yet they do not meet the proper legal and ethical standards for the primary care dentist's permanent records. I rarely have had problems with this area. Yes, a handwritten note on a final radiograph sheet by your endodontist is sufficient. And alternatively, numerous written communications are necessary for an orthognathic surgery/ orthodontic/cosmetic case.

- Send the patient back for final examination on any involved case to the referring doctor. Most patients are excited---yes, they do get excited, and will seek the general dentist's approval of your nice work and their great cooperation. This follow-up visit is a chance for a win/win/win for patient/specialist/general dentist. I found it a huge practice builder and confidence raiser for my general practice. I loved it when the specialist showed off great work!

Another communication pearl is to ask referring doctors to come and watch your procedures, garden variety or exotic. An amazing percentage will, and once they do, they are pretty much referral sources for life, unless you continually forget Part 3, paragraph 3 above.

Yes, I've "fired"---not continued to refer---numerous times, and it was always for one of two reasons: lack of a timely follow-up report, or receiving a complex treatment plan via phone call only.

Service is king in our profession, and communication is necessary 8/4or 8/5. Thankfully, not 24/7.

Published in San Diego County Dental Society Journal, Facets, February, 2007.
Published in Harbor Dental Society Journal, The Journal, March, 2007.

Dentists are Responsible for Office Billing Practices

By Robyn Thomason
Risk Management Analyst, TDIC

Most dental offices designate one staff person to be responsible for all insurance billing. Unless given reason, the dentist/practice owner does not question the insurance billing process. As long as there is revenue, most dentists are naïve to the practice's billing procedures. However, the dentist will ultimately be held responsible if allegations of dishonest billing practices surface, which can be costly.

The following transactions often occur; but they are illegal and create red flags for insurance audits:

- Routinely failing to charge or collect full co-payment or deductible
- Offering to waive co-payments or deductibles
- Concealing other insurance coverage
- Falsifying the date of treatment
- Submitting a claim for a covered service, when a non-covered service was performed

In fact, these "acts of goodwill" usually create substantial loss for the dentist's practice. Since the practice does not benefit financially, many dentists and staff do not consider this practice as being insurance fraud.

A common example of a fraudulent billing practice is billing for an amalgam filling instead of a composite filling because the insurance policy does not cover composite fillings. Another more difficult problem is where work is billed for but not performed. This typically occurs when the billing is initiated either at the beginning of or during treatment that involves several teeth. Staff merely bill as per the treatment plan assuming all the work was performed; however, for various reasons the work was not completed that day. In cases of Denti-Cal or Medicare, the government presumes fraudulent billing and does not accept "clerical error" as a defense.

Once dentists discover the improper billing practices, they will seek ways to recover the resulting lost revenue. Unfortunately, dentists believe that since the lost revenue was the fault of an employee, they will have coverage under the "employee dishonesty" section of their office property insurance policies. There is no coverage available to recover this type of loss, as it is considered fraud. Also, should a third party payer accuse a dentist of insurance fraud, the dentist would be responsible for his or her own defense costs. Attorney fees and reimbursing the insurance company with fines and penalties can be extremely expensive. In addition, insurance fraud can lead to criminal prosecution and have an impact on licensure.

Since fraudulent billing practices can be very costly, dentists need to be involved in the billing process itself. The best way to prevent any type of billing issues is to be proactive by monitoring all billing patterns. Consider the following:

- Review all third party payer contracts. Do not leave this to a staff person.
- Periodically review and/or audit your insurance claim history. Look for inconsistencies.
- Cross reference bank deposits to the treatment provided.
- Review patients' financial charts to ensure all treatment is being billed.
- Be sure the work performed matches the work billed.
- Determine if there are there batches of claims that are not being paid by insurance carriers.
- Find out if insurance carriers are denying claims due to improper documentation.
- Ensure that there are not large amounts of suspended claims waiting to be processed.
- Post the office's collection policy for co-pays and deductibles in an area where all patients can read it.
- Cross-train staff so one person is not solely responsible for insurance billing.

Many dentists prefer to "just treat patients" and avoid billing by relying on their office staff to handle this task. Dentists need to understand as practice owners they are ultimately responsible for any allegations related to fraudulent billing practices. If found guilty of insurance fraud, dentists face losing their provider number, jeopardizing their dental license, paying hefty fines and possible jail time.

Minimize Peer Review Nightmares Before They Start

By David Stein, dmd Peer Review Chairman

Here you are, Dr. Nice Person, in the middle of a busy day when your front office staff member comes to you to inform you that you have a package of important looking papers from the Monterey Bay Dental Society. You open the package only to find you have been served with a peer review case against you brought by Mr. Pain Ina Neck. You hardly remember seeing him since it has been several months since his last visit so you pull his chart to review the treatment rendered. Then it hits you. You remember seeing him over several emergency visits to "patch" together several teeth, as he only wanted minimal treatment; "nothing extensive or expensive, Doc! Just get me by for now" he said. Good old Pain never wanted to come in for a comprehensive examination or the full series of x-rays you suggested. As you read the paperwork from the dental society you learn he was seen by Dr. Fan T. Flames who was quick on the draw to tell Mr. Neck that the work he had done was improper and substandard—and he should be really unhappy with his previous dentist for providing this type of care. Well of course Mr. Neck took this to heart and was on the phone in an instant to the dental society office to get the paperwork going to get back at you for treating him in such a manner. Mr. Neck naturally forgot he told you to "just patch me up" and now wants you to reimburse him for the work you did as well as pay for the work Dr. Flames wants to do to get him in proper shape.

How could this have happened?

Unfortunately we see this type of scenario all too often in the peer review process. It is all too easy to criticize another dentist's treatment not knowing anything about the steps that lead up to the treatment planning or treatment rendered. Yet, we all have been or will be guilty of doing this very thing at some point in our careers. There are many tips you can use to avoid peer review—I'll cover some of the "biggies" in a subsequent Smileline issue—but the first thing that should happen, as a subsequent treating dentist, is a phone call to the patient's previous dentist.

If you see a new patient and you have some issues with the treatment rendered by a previous dentist, stop and think before making any statements regarding their treatment and call this dentist to get the entire story. All too often patients don't recall exactly what they told their previous dentist or how they may have guided him/her in the treatment decisions made by either their desires or finances. Once you know the full story only then can you make a good decision as to what you feel is or is not appropriate to say to the patient. Don't start a new patient relationship with less than complete information regarding their previous treatment until speaking with their dentist. Wouldn't you appreciate the same courtesy if you were Dr. Nice Person?

In many cases with one phone call the entire painful process of peer review can be avoided all together. We are all in this together and have had cases that have not progressed as well as we would like. Be kind to one another and spend a few minutes on the phone explaining the situation and getting information that will ultimately be in the best interest of the patient. Don't be so quick to criticize another's work and remember it could be yours that gets the next critique.

Deadline Approaching for NPI Compliance

May 23 of this year was the deadline for dentists who are regulated by HIPAA to have received their National Provider Identification number (NPI).

CDA has written two articles on the NPI rule, which is one of the family of rules generated by the federal HIPAA law. Those background articles can be accessed on CDA's website here under the Update archives for July 2004, and July 2005. In the second article is a link to a website set up by the U.S. Department of Health and Human Services to facilitate online applications for individual NPI numbers. That link is https://nppes.cms.hhs.gov/NPPES/Welcome.do .

The NPI number is intended to standardize and simplify health care administration by replacing a myriad of provider ID numbers used by separate payers. The standard national provider identifier rule, or NPI, will ensure that one unique identifier number will be assigned to each provider and will be used in transactions with all health plans and insurers. You should have, or will likely soon, be receiving information from the dental plans and insurers to which you frequently submit claims on how and when they wish you start using your NPI. If you have any immediate questions about how a plan will implement and use your NPI, you may contact the provider relations department of that plan and ask them.

For other information on applying for an NPI, you may contact the National Plan and Provider Enumeration System by calling 800-465-3203, or by email at customerservice@npienumerator.com.

For other questions, you may also contact Greg Alterton at CDA, at 916-554-4994.

Hot Tips For Hot Weather

By Linda Miles

Failed and short-notice changed appointments are serious problems at any time during the year, but can really play havoc on the summer months production, typically vacation months for doctors, and team members.

Parents and patients don't intend to be less committed to their appointments but during the lazy days of summer let's face it--if anyone makes them a better offer than going to the dentist, off they go, which means your scheduling coordinator works at top speed keeping the changes in the schedule filled. Not to mention the stress involved with the confirmed patient no-shows.

First lets look at the major causes of broken appointments:

1) A lack of communication from the doctor and entire dental team to the patient regarding the importance of their next visit while they are sitting in the dental chair on their current appointment. If you have ever wondered why some practices have 3-4 times as many broken appointments as another practice, listen to the amount (or lack of) patient education regarding the next appointment in your own practice starting immediately.

If the office communication in your practice is 75% social and only 25% dental education, no wonder you have more than your share of open time which is totally non- productive. Reversing the conversations to 75% dental education and 25% social chitchat is key. All it takes is a 30 second eye to eye, heart to heart talk about the importance of keeping the next appointment, and VIOLA, a reduction in over HALF the amount of wasted time. While socializing with patients may be fun,it should never be more than 25% of the conversation and at that, focused on the patient, not the dental team member.

2) Non-motivated team member is another serious reason for open chair time. Their attitude is: I'm going to make the same amount of money today no matter how many people show up, so why work so hard? If you donít already have an incentive bonus plan in place, I highly recommend one. Or the doctor could have a daily bonus kitty and drop a $10, $20 or $50 bill into the locked box or office safe for each day with zero to X number of open slots on the schedule. Each open slot costs the team their ìfun-money, which is divided at the end of the month and pro-rated to part time team members. With an average of $30 per day times 16 days, this could be close to $500 per month!

3) Weak verbal skills and untrained scheduling coordinators determine why a large percentage of changed or failed appointments take place in a practice. There are three tones of voice that might be used when a patient calls to try and change or cancel their appointment: 1) happy, 2) neutral, 3) friendly disappointment. If employees like downtime, they will sound happy when an opening occurs. Because patients like to make the person taking the call happy, they will continue being a source of failed appointments because they know the team member actually seemed elated with the call.

If the patients receive a neutral or vanilla response such as Oh, no problem at all Mrs. Webster, let's see when I get little Samantha back in, How about this coming Thursday at the same time? Again, if it is easy to change or cancel appointments because the caller feels it's OK and no problem at all, look out--your practice will again have more than your share of broken and failed appointments. I have heard from some scheduling coordinators in my audiences that they spend a third of each day restructuring each day that falls apart!!

The only way to control wasted chair time especially in the summer months is always sound friendly yet firm when someone calls to ruin your schedule. Oh Mrs. Webster, I'm sure that the trip to the lake that Samantha has been invited to participate in is very important, but so is her appointment with us. I have reserved the doctors entire late morning just for her bandings. As you know, it would be impossible for me to fill this amount of the doctors time on short notice. Is there any way we can work around Samantha's invitation so that they may leave around noon instead of 10 AM?

If and when your scheduling coordinator develops the skill of being very friendly yet disappointed when patients try to fail or postpone their appointments, patients and parents begin to realize the inconvenience of this, especially the last minute changes. REMEMBER: An appointment will NEVER become more important to the patient than it appears to be to you!

A good test is to have the doctor go across the parking lot with a cell phone while covering the mouthpiece with a handkerchief to disguise their voice. Call the office and pretend to cancel the most productive appointment for today or tomorrow and see just how it is handled in your office!

You may also list on the back of your appointment cards: A broken appointment is a loss to three people: 1) The patient who missed the valuable time. 2) The patient who could have used the valuable time. 3) The dentist who was fully staffed and prepared for the appointment time.

Summer play time does not have to ruin your production. Be pro-active--play it cool by having each member of the team improve his or her verbal communication skills. And remember it has to be congruent and everyone has to be committed to that goal. With verbal skills communication, you are only as strong as your weakest link."

Linda L. Miles, CSP, CMC, CEO
Certified Speaking Professional
Certified Management Consultant
CEO, Linda Miles and Associates
Virginia Beach, VA
1-800-922-0866
www.DentalManagementU.com
lindamiles@cox.net

Assembly Bill 1433

By Paul Morris, DDS and
Lloyd Nattkemper, DDS

Governor Swarzenegger approved Assembly Bill 1433, developed by CDA and the California Society of Pediatric Dentistry and authored and promoted by Assembly members Bill Emmerson and John Laird, on 9/22/06.

As of 1/1/07, all kindergarten-age children in the state of California are required by law to receive oral health assessments by licensed dentists or licensed oral health professionals. $4.4 million has been slated for implementation of AS1433; public schools are working, along with CDA, the State Department of Health Services and thousands of private pediatric and general dental offices to make this happen.

The intention of AS1433 is to develop an accurate database regarding the incidence of dental caries and other dental pathology in our state, and to build capacity to help children find the dental care they need, according to CDA. Ultimately, the aim is to improve oral health for all children in California.

The Surgeon General has called dental disease in children a silent epidemic. The U.S. Center for Disease Control found in a 2006 study that more than 4 million preschoolers are affected by tooth decay, a leap of more than 600,000 in a decade. In a recent study conducted by the Dental Health Foundation, it was found that dental caries affects two thirds of children in third grade in California, that 4% of these kids need urgent dental care because of pain or infection, and that of 25 states with similar studies on children's dental health, only Arkansas ranked below California. It was the findings in these studies that spurred legislatures to address this crisis. A key finding: Treatment is good. Prevention is better. Early prevention is best.

AB1433 targets kindergartners around 5 years of age, which is a little late to be considered early prevention, but the earliest age possible in the school system. There are really three benefits of the new law:

It encourages families to find a ìdental homeî for their children. Hopefully most children will get a comprehensive exam by a dentist, but at the very least they will receive a dental assessment which could identify whether there is need for further examination by a dentist. It will help in identifying barriers to accessing dental care.

It requires that the school provide information on the importance of oral health and itís relationship to overall health and school readiness.

It requires that the school help its students access dental care by providing enrollment information to parents about programs such as Healthy Families and Medi-Cal.

What does this all mean for the private practitioner?

CDA recommends that dental offices set up an office protocol to respond to calls from parents requesting a oral health assesment (dental screening) for their kindergartner or first grader. An oral health assesment is nothing more than a cursory look in the mouth with a tongue blade and then reporting the findings on a standard form. It does not create a doctor/patient relationship.

An oral health assesment is not a comprehensive exam, however a comprehensive exam satisfies the screening requirement. More often than not, when a parent is informed by the dental office of the difference between a screening and a comprehensive exam the parent schedules a comprehensive exam. If, after being informed of the difference and limitations of a screening, they want only the screening done to satisfy the school requirement, CDA encourages all dentists to provide this service at no charge.

Reporting forms and more information about the oral health assessment can be found at www.cda.org

Dr. Paul Morris practices pediatric dentistry full time and is a partner with the Central Coast Pediatric Dental Group. He serves as the chair of the new dentist committee of the Monterey Bay Dental Society.

Del Mar Tapered Wax

by Jim Addiego

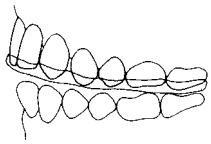
Premature posterior occlusal contact on bruxism, splint and ortho appliances can often be traced to a bite registration problem. When your lab is required to fabricate a bite opening appliance without a construction bite, or to open up a CR/CO bite registration, the articulator cannot duplicate the biological movement of the patient's mandible. Premature contact of the distal most teeth in the opposing arch is the usual result, and the doctor will spend valuable chair-time adjusting the bite.

A construction bite that represents the exact vertical and AP position that you desire in the finished appliance will save you much valuable time. Here are some 'Pearls" on construction bites:

- If a very thin, Blue Mousse-type bite is given to the technician or if a wax record is provided that bends and molds itself to the models, errors will be masked.
- The DeLar Wax Wafer is an excellent bite material. When heated, the wafer becomes "dead soft," allowing you to guide your patient into the proper position without muscle interference.
- When cooled, the wax record becomes rigid and retains its shape completely. The DeLar wax record is also tapered to keep indexing even—thicker in the anterior, and thinner in the posterior, taking into account the arc of closure.

The material prescribed for an occlusal appliance can also cause seating problems and bite irregularity. Standard hard acrylic is very rigid:

- If undercuts are blocked-out too much to allow easy seating, the appliance becomes too loose and requires clasping.
- If undercuts are not blocked-out enough, the appliance will be difficult to seat.



Astron ClearSplint™ is a thermoplastic, self-adjusting, hard material which provides an excellent fit and good retention without clasps with minimal adjustments (if a good construction bite is included).

Jim Addiego is the Director of Education and Customer Care at Brabant Dental Lab in Sacramento. He enjoys hiking and dancing. He can be reached at 916-830-7327.

An Opportunity To Share Your Expertise And Make A Real Difference

David D. Shin, dds

Monterey Bay's most successful volunteer medical/dental program provides free emergency care to hundreds of people without means in our affluent area. Flying under the radar for years, RotoCare provides this much needed service.

Operating in Seaside for twelve years, RotoCare serves the working poor, homeless, and the uninsured. Saving Community Hospital millions of dollars each year from unpaid emergency room fees, RotoCare's annual budget is $52,000.00. Monterey Longs and Seaside Walgreens charges RotoCare below cost patient prescriptions, and patients pay nothing. CHOMP provides free diagnostic tests.

Funding comes from grants and donations, which are 100% tax deductible, but the greatest need is for triage volunteers. Dentists can be trained on site for this fully insured role. Volunteers meet Wednesdays from 5:30 pm to 8:30 pm at 1150 Fremont Street in Seaside. Or local dentists can offer free emergency treatment for referred patients (which is mostly extractions). This may entail between one and perhaps as many as four patient visits a month. For more information on how to donate time or funds, please contact Pamela Norton at 831-659-8037.

Editor's note: Dr. Shin is a general dentist practicing in the Ryan Ranch Development in Monterey. He received degrees in Biology and Dentistry from the University of Missouri, Kansas City in 1994. He has actively volunteered his time since beginning practice in Monterey with Dientes, Rotary International and our dental society. He is currently serving as MBDS County Director (Monterey) and is a member of the MBDS Ethics Committee.

Embezzlement Prevention

By Pauline Grabowski

Just what is the crime of embezzlement?

Embezzlement is defined as "the fraudulent conversion of property of another or by a person in lawful possession of that property." Typically, crimes involving embezzlement involve a previous relationship of trust and confidence.

It is a challenge to prevent and detect embezzlement in the dental practice. Statistics show two out of three offices have had some form of theft, whether it has involved documentation of hours worked, office supplies, petty cash, or practice revenue.

It is important to have systems in place to prevent these crimes that drain your profits. As a consultant, I see how critical it is to implement systems in your business and to monitor your numbers monthly. The numbers will show trends, which will help determine red flags that should be investigated.

In the past six years of my consulting business, I have been involved with several embezzlement cases, each one of which was different. One of particular interest was a practice in Virginia Beach, my hometown, where the team member who was working the front office along (and wore all the hats in front office management), embezzled approximately $100,000 form the practice.

This individual, who we will call Jane, had been with the practice for two years. She was a very nice person. The doctor was a very busy general practitioner, who was trying to build a dental practice and balance a new family all at the same time. Jane was going through some challenges in her own personal life as well. This is a time when the team member is most vulnerable. Since Jane's personal financial well being was being altered at home to the degree she could no longer afford to pay for her daughter's orthodontic treatments or gymnastic classes, she decided to implement a system of her own in the practice.

Jane's system consisted of altering the practice write-offs to her benefit. For example, a patient with Optima Insurance coverage would come into the practice for treatment. The Optima Insurance Plan allocates a 10% courtesy to the patient on all treatment performed since the practice participates with the Optima Insurance Plan. When a patient paid cash for his portion, the Jane would make an adjustment to include the cash payment. And if that was not enough, she was making Optima write-offs for patients who did not have the Optima plan.

If you are interested in preventing embezzlement in your office, consider instigating the following prevention guidelines:

- Investigate every employee with a background check and ask for appropriate information on the employment application, including whether the applicant has been convicted of a felony.
- Contact references including prior employers.
- Set a precedent from the top in outlining job descriptions for every team member, which include checks and balances on a daily, weekly, and monthly basis.
- Define User Passwords on practice management software programs for all team members with appropriate security levels.
- Review Day Sheets from software programs daily to make sure all patients are entered with treatment performed.
- Balance deposits daily.
- Periodically review the work of every employee, especially those serving a bookkeeping function, including accountants and consultants.
- Insist all employees take vacations as outlined in the employee manual.
- Review collection records weekly and accounts receivable balances once a month.
- Mandate in the employee manual that the doctor approve all write-offs over $100.
- Compare write-offs with cash receipts monthly.
- As owner, make your own deposits, if possible.
- Stamp "for deposit only" on all patient checks received.
- Conduct audits at irregular intervals on scheduling, accounts receivable, day sheets, and reconciliations of deposits. Inform employees the practice conducts these audits to discourage embezzlements.
- Review Audit Trails, which identify each user, on software programs weekly to identify changes and deletions on patient records.
- For a petty cash fund, have only $50-$100 on hand and keep a register in a locked cash drawer.
- Hire a consultant/accountant to review financial records. An expert can determine areas of weakness.

As you look for signs of possible embezzlement, learn to spot the ten red flags. Be suspicious of an employee who:

Does not want anyone else to do the job and/or doesn't want to cross train others to do the work.

1. Holds daily work over to post the next day.
2. Prefers to be unsupervised.
3. Does not want to take a vacation.
4. Points a finger at other team members.
5. Has no explanation for mistakes made.
6. Asks the business owner to sign checks while seeking patients.
7. Maintains a lifestyle beyond what might be expected.
8. Incurs unexplainable expenses for the business.

Because embezzlement often includes a major betrayal of trust in a relationship, it can be particularly devastating to a small business. An ounce of prevention is worth far more than a pound of cure! Honest employees will appreciate having systems in place to keep records clear and clean.

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To Document or Not to Document That is the Question

By Robyn Thomason
Risk Management Analyst, TDIC

Risk management presenters repeatedly instruct dentists about the importance of proper documentation. At the end of most seminars, the final words of wisdom are typically: document, document, document. There are some things, however, that do not belong in the patient's chart. So how does a dentist know what details are essential and what details could be damaging?

Appropriate documentation provides treatment continuity. Any health care provider should be able to pick up a patient's chart and know what dental treatment the patient has undergone and be able to continue with remaining treatment. However, not all information obtained from the patient is treatment related and if documented in the patient's chart could pose a problem. Patients and their attorneys can obtain a patient's record; therefore, all information in the chart is discoverable and not privileged. Some of those items that do not belong in the patient's chart include:

- Financial information. The cost of treatment and the patient's payment history can influence how care is perceived. References to cost may have the appearance that the dentist is more concerned with finances than treatment. Dollar figures can encourage a plaintiff's counsel to focus on cost instead of care. Therefore, financial records should be kept in a file separate from the treatment record.

- Documentation regarding any discussion with your attorney or liability carrier regarding a particular situation. These discussions may be interpreted as defensive rather than a desire to do the right thing for the patient. Plaintiff's attorneys could use such entries to suggest that dentists knew they had done something wrong and contacted their malpractice carrier for protection. While these types of conversations are important and should be documented, keep them in a separate file. They are privileged and confidential unless they are put in the treatment records.

- Critical or subjective comments about the patient. The chart should only include relevant, factual comments regarding the patient's health and treatment. When documenting a negative conversation or comment from the patient, be sure to directly quote the patient.

The information in a patient's chart is the first line of defense when facing allegations of negligence. However, you do not want to keep information that distracts from clinical decision-making in the treatment record. Ask yourself, "would I be comfortable with this entry being enlarged and projected on a screen in front of a jury?" While it may be important, it is best to keep it separate from the record maintained for your attorney or insurance carrier.

An Interview with Dr. Jeff Brucia by Jeff Dalin

(The following article, written by Dr. Jeff Dalin, DDS, FACD, FAGD, FICO, is a condensed interview with Dr. Jeff Brucia and reprinted with kind pennission from Dental Economics, January 2006.)

Let's take a moment to review the different bonding systems that are available. I will skip the first three generations of bonding agents since they are not commonly used anymore. We will start with fourth-generation bonding agents.

They are commonly referred to as etch-and-rinse, multiple-bottle systems. The placement and rinse of a 32 to 37 percent phosphoric acid gel is followed by separate primer and adhesive placement steps. Excellent examples of this category would include OptiBond FL, PermaQuik, All Bond II, and Scotchbond MP+. These systems have a long history of success. The drawback of these materials is their perceived difficulty of use.

The fifth-generation materials still fall in the etch-and-rinse category, but now have combined the primer and adhesive into one bottle of material. Examples of this generation are Bond 1, PQ-I, Single Bond, One Step Plus, Excite, Prime and Bond NT, and OptiBond Solo +. These systems have brought with them a reported increased incidence of sensitivity due to complex chemistry, and a smaller window of opportunity for technique errors.

The sixth generation is referred to by many as a nonrinse, self-etching multi-bottle system. They use a mild etch combined with the primer that no longer requires rinsing. The adhesive is then placed as a separate step. Examples of these include Clearfil SE, Simplicity, NanoBond, and Tyrian. These systems address the sensitivity problem. But at what cost? The seventh generation further simplifies this by combining the self¬etching primer and the adhesive into a one-application system. Some still require mixing prior to placement, like Prompt, while others are packaged in a single bottle, like I-Bond, G-Bond, Clearfil S3, and Xeon IV.

When a material comes in one bottle, I would recommend turning the bottle upside down a couple of times, or in the case of a single-use material, stirring the material lightly with a microbrush. I believe these materials do separate into layers, and should be slightly mixed. But is faster really better?

It also should be mentioned that self-etching systems now are subdivided into three additional categories based on acid strength. They are mild, medium, and aggressive acid systems. It is hoped that the more aggressive systems will more closely match the etching patterns and perfonnance of 32 to 37 percent phosphoric acid on enamel. There have been some reports of sensitivity with these systems, so time will tell.

The new-generation products (fifth generation and on) are definitely simpler to use because of the decreased number of steps and bottles.

We do see less sensitivity with some of the newer materials, but at the expense of bond strength and durability. When materials of different properties are combined, the science becomes more complex and the perceived simpler application techniques become much more sensitive to small changes in the working environment and placement technique. The newer materials all have a lower pH to allow for this combined chemistry. At the very least, this can lead to under-polymerization, subsequent weaker bond strengths, and more rapid breakdown of the bond due to water absorption through the dentin-resin interface. This lower pH also has shown more incompatibility issues, especially with the delayed light-curing, dual-curing, and self-curing materials.

Dr. Jeff Brucia

I think the fourth-generation bonding agents are still the gold standard. I am etching the enamel thoroughly, then applying a primer and bonding agent separately.

I am also a big fan of glass ionomer bases or liners on deeper excavated areas of dentin and non-enamel margins. Products like OptiBond FL and Perm a Quik have stood up to the test of science and time. It also would be difficult to practice without reaching for products like Fuji IX and Ketac Molar.

In the past few years, we have seen many new products in the field of bonding agents; however, I do not feel that these changes truly have been improvements.

If you use proper technique with the fourth-generation bonding systems, you will find low rates of postoperative sensitivity, less concern with incompatibility issues, and you will achieve the most durable bond and seal that currently can be attained. Don't be shy. Get as much education about this science as you can. We need to be informed consumers and care providers.

Jeff Brucia, DDS, is a graduate of the University of the Pacific School of Dentistry where he has held faculty positions in the crown and bridge and operative departments. He currently is an assistant professor of dental practice at the school. Dr. Brucia practices esthetic and restorative dentistry full time in San Francisco. Dr. Brucia can be contacted at (415) 435-3323.

Law Requires Benefits Continuation Only in Certian Circustances

by Dana Leisinger, Labor Law Consultant

We have an employee who is going out on pregnancy disability leave (PDL), and following that, baby bonding leave. I know we have to continue health benefits for an employee on federal Family Medical Leave Act (FMLA) leave, but do we have to continue to accrue vacation and sick leave during this time?

No. There is no law that requires an employer to continue to accrue vacation and sick leave when an employee goes out on a leave of absence. It is best to develop a policy that addresses this issue and to apply it uniformly to all leaves of absence so as to avoid any adverse impact.

Benefits Continuation

The only law that requires continuation of benefits is for health and welfare benefits when an employee goes on FMLA leave.

Under FMLA, an employer is obligated to continue health and welfare benefits for up to 12 weeks. Additionally, in a situation such as the one described above, the employee only gets the first 12 weeks of health benefits.

When the initial 12 weeks has passed, even if the employee is taking baby bonding time under the California Family Rights Act (CFRA), her health benefits end, unless the employer's policy or practice is to continue them for a longer period.

The PDL law alone does not require the employer to provide health insurance while an employee is on PDL. If the employer provides health benefits for other temporary disability leaves, however, the employer must provide benefits for PDL to the same extent and for the same length of time.

If PDL is unpaid leave and the employee normally pays a portion of her insurance premium, she should pay her share of the premium to the employer monthly by cash or check.

Employee-Paid Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers with 20 or more employees to offer all employees covered by health care the option of continuing to be covered by the company's group health insurance plan at the worker's own expense for a specific period after employment ends.

If an employee does not qualify for FMLA and goes out on any other leave (that is, workers' compensation, PDL or any internal leave an employer might offer), it is considered a reduction in hours and, therefore, triggers COBRA notices/rights.

Some policies, however, allow an employee to remain on the company policy as if she/he were actively employed when on an approved leave of absence for a limited duration, rather than requiring the employee to go on COBRA.

This option could eliminate a great deal of paperwork and some costs for both employer and employee, but it is prudent to check with your broker and/or carrier to verify that this is an allowable option.

Resuming Benefits

When an employee goes out on a protected leave of absence and returns, benefits must be resumed upon the employee's reinstatement in the same manner and at the same levels as provided when the leave began, without any new qualification period, physical exam, etc.

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New Paradigms in Orthodontics

Brian J. Schabel, DDS, MS

As a recent graduate of the University of Michigan Department of Orthodontics, I feel fortunate to have been exposed to the latest paradigms in orthodontic practice. As with all other areas in dentistry, orthodontics is continually evolving. Recent innovations are affecting all aspects of the specialty, from the way in which we diagnose and treatment plan to the mechanics involved in achieving the desired result. Mini-screw implants for orthodontic anchorage, self-ligating brackets, and a re-introduction of esthetics in diagnosis and treatment planning are a few examples that are having a profound impact on clinical orthodontic practice.

Mini-screw implants are small (1.2 to 1.9mm diameter) temporary anchorage devices that are inserted directly through the cortical plate of the maxilla, mandible, or infra-zygomatic crest. These temporary implants are used to facilitate tooth movements that were previously unattainable with conventional orthodontic mechanics. Newton's Third Law reminds us that every action has an equal and opposite reaction. When applied to orthodontics, these equal and opposite reactions cause reciprocal forces that result in undesirable tooth movements, especially when teeth or segments of teeth act as the anchor unit. Mini-screw implants provide "absolute" anchorage, allowing for maximum desired tooth movements because reciprocal forces are resisted by cortical bone.

I recently returned to Ann Arbor to attend the 34th annual Moyer's Symposium, a conference dealing with the most current issues in orthodontics and craniofacial biology. The focus of this three-day interdisciplinary symposium, as it was in 2004, was the use of implants as temporary anchorage devices in orthodontics. This is a hot topic because of the clinical results that have been achieved using these mini-screw implants (e.g., posterior intrusion for the correction of severe open bite cases, protraction of posterior teeth, maximal anterior tooth retraction, intrusion/extrusion to correct occlusal cants). Because the FDA has only approved the use of mini-screw implants for orthodontic anchorage in the United States within the past three years, we are lacking long-term data; however, short term results appear very promising.

Self-ligating brackets also have had an impact on the practice of orthodontics. Self-ligating means that a clip or door on the bracket itself is used to engage the wire into the bracket slot (as compared to a conventional bracket whereby a colored elastic tie is used for this purpose). The clip or door is often made of stainless steel, which has been shown to result in less friction between the bracket-wire interface, sometimes resulting in more efficient tooth movement. Some people have claimed that extremely light forces with these self-ligating brackets can result in orthopedic effects on the jaws; however, this assertion has yet to be substantiated. In my opinion, a bracket by any other name is still a bracket. I do, however, use self-ligating brackets in particular instances, such as on patients with an open-bite tendency. The decreased friction helps to control the vertical dimension and prevents lateral open bites as ectopic anterior teeth are brought into the arch.

The final paradigm affecting orthodontics today is the re-introduction of esthetics as a major component of diagnosis and treatment planning. I recently submitted for publication a paper based on my Master's thesis ("Orthodontic Esthetics: A Systematic Evaluation of the Smile") in which I found no correlation between occlusal outcome (as measured by the American Board of Orthodontics Objective Grading System), and smile esthetics. Traditionally in orthodontics, diagnosis and treatment planning were based on characteristics of the profile, largely in part because of the availability of the lateral cephalogram. A Medline search of "orthodontics and profiles" from 1968-2003 resulted in 158 articles, while a search of "orthodontics and smiles" from the same time period resulted in 23 articles. In the past four years, a tremendous amount of attention has been placed on smile esthetics, and specifically on attributes that are consistent with an attractive smile. Within the past year, I submitted three other papers relating to dental and facial esthetics. The results of these studies are beyond the scope of this article; however, I feel it is necessary to understand principles of esthetics to meet the demands of an increasingly image-conscious society. . Obviously, functional considerations are still paramount. E. Esthetic objectives should also be determined before treatment begins, to maximize both functional and esthetic results.

Regardless of the technological advancements affecting orthodontics, the true art of orthodontic treatment still lies in obtaining an appropriate diagnosis and establishing clear-cut functional objectives. New paradigms merely aid the clinician in achieving results reliably and with greater efficiency.

Dr. Schabel received his DDS from UCLA and his MS in Orthodontics from The University of Michigan. He currently maintains private practices in orthodontics in Aptos and Santa Cruz, California.

Watsonville Water Flouridation

Bruce Donald, DDS
Fluoridation Chairman
Monterey Bay Dental Society

To date, the issue of water fluoridation for California cities has been settled by the courts all the way to the California Supreme Court. According to California state law, cities with greater than 10,000 water hookups must fluoridate, when moneys are available from outside sources. Moneys are available to the city of Watsonville, over a million dollars, through the California Dental Association Foundation. We all know what a tremendous benefit in caries prevention this will be for this city's citizens and hopefully this case will have led the way for more communities to gain the benefit of fluoridation.

The MBDS Board and I would like to extend a sincere thanks to all of the Watsonville dentists who have taken the time to write and call their City Council members supporting water fluoridation. Special thanks to Jim Jacobson and Tim Griffin for their support with local community leaders and dentists, and to Ben Tarsitano for his many calls and letters to state and national organizations and California Governor Schwarzenegger. It is with the broad based support by local dentists, medical and other health care providers along with local community organizations that we hope to convince the City Council to make the decision to get on with the project of fluoridation for the citizens of Watsonville.

Editor's note: Dr. Donald has logged literally hundreds of hours' time as MBDS Fluoridation Chairman, serving as our voice at the community and state levels, and in CDA. His efforts have received nationwide attention and acclaim, and were lauded by this year's ADA President at the CDA House of Delegates Meeting.

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Two Good Stories

Story was contributed by
Capt. Patrick Wm. Coil, USAF (ret)

STORY NUMBER ONE - Many years ago, Al Capone virtually owned Chicago. Capone wasn't famous for anything heroic. He was notorious for enmeshing the windy city in everything from bootlegged booze and prostitution to murder. Capone had a lawyer nicknamed "Easy Eddie." He was his lawyer for a good reason. Eddie was very good! In fact, Eddie's skill at legal maneuvering kept Big Al out of jail for a long time. To show his appreciation, Capone paid him very well. Not only was the money big, but also, Eddie got special dividends. For instance, he and his family occupied a fenced-in mansion with live-in help and all of the conveniences of the day. The estate was so large that it filled an entire Chicago City block. Eddie lived the high life of the Chicago mob and gave little consideration to the atrocity that went on around him. Eddie did have one soft spot, however. He had a son that he loved dearly. Eddie saw to it that his young son had clothes, cars, and a good education. Nothing was withheld. Price was no object. And, despite his involvement with organized crime, Eddie even tried to teach him right from wrong. Eddie wanted his son to be a better man than he was. Yet, with all his wealth and influence, there were two things he could not give his son; he could not pass on a good name or a good example. One day, Easy Eddie reached a difficult decision. Easy Eddie wanted to rectify wrongs he had done. He decided he would go to the authorities and tell the truth about Al "Scarface" Capone, clean up his tarnished name, and offer his son some semblance of integrity. To do this, he would have to testify against The Mob, and he knew that the cost would be great. So, he testified. Within the year, Easy Eddie's life ended in a blaze of gunfire on a lonely Chicago Street . But in his eyes, he had given his son the greatest gift he had to offer, at the greatest price he could ever pay. Police removed from his pockets a rosary, a crucifix, a religious medallion, and a poem clipped from a magazine. The poem read:

The clock of life is wound but once,
And no man has the power
To tell just when the hands will stop
At late or early hour.
Now is the only time you own.
Live, love, toil with a will.
Place no faith in time.
For the clock may soon be still.

continued on back cover...

World War II produced many heroes. One such man was Lieutenant Commander Butch O'Hare. He was a fighter pilot assigned to the aircraft carrier Lexington in the South Pacific. One day his entire squadron was sent on a mission. After he was airborne, he looked at his fuel gauge and realized that someone had forgotten to top off his fuel tank . He would not have enough fuel to complete his mission and get back to his ship. His flight leader told him to return to the carrier. Reluctantly, he dropped out of formation and headed back to the fleet. As he was returning to the mother ship he saw something that turned his blood cold: a squadron of Japanese aircraft were speeding their way toward the American fleet. The American fighters were gone on a sortie, and the fleet was all but defenseless. He could not reach his squadron and bring them back in time to save the fleet. Nor could he warn the fleet of the approaching danger. There was only one thing to do. He must somehow divert them from the fleet. Laying aside all thoughts of personal safety, he dove into the formation of Japanese planes. Wing-mounted 50 caliber's blazed as he charged in, attacking one surprised enemy plane and then another. Butch wove in and out of the now broken formation and fired at as many planes as possible until all his ammunition was finally spent. Undaunted, he continued the assault. He dove at the planes, trying to clip a wing or tail in hopes of damaging as many enemy planes as possible and rendering them unfit to fly. Finally, the exasperated Japanese squadron took off in another direction. Deeply relieved, Butch O'Hare and his tattered fighter limped back to the carrier. Upon arrival, he reported in and related the event surrounding his return. The film from the gun-camera mounted on his plane told the tale. It showed the extent of Butch's daring attempt to protect his fleet. He had, in fact, destroyed five enemy aircraft. This took place on February 20, 1942, and for that action Butch became the Navy's first Ace of W.W. II, and the first Naval Aviator to win the Congressional Medal of Honor. A year later Butch was killed in aerial combat at the age of 29. His home town would not allow the memory of this WW II hero to fade, and today, O'Hare Airport in Chicago is named in tribute to the courage of this great man. So, the next time you find yourself at O'Hare International, give some thought to visiting Butch's memorial displaying his statue and his Medal of Honor. It is located between Terminals 1 and 2.

SO WHAT DO THESE TWO STORIES HAVE TO DO WITH EACH OTHER? Butch O'Hare was "Easy Eddie's" son.

MONTEREY BAY
SMILELINE
8 Harris Court, #A2
Monterey, CA 93940