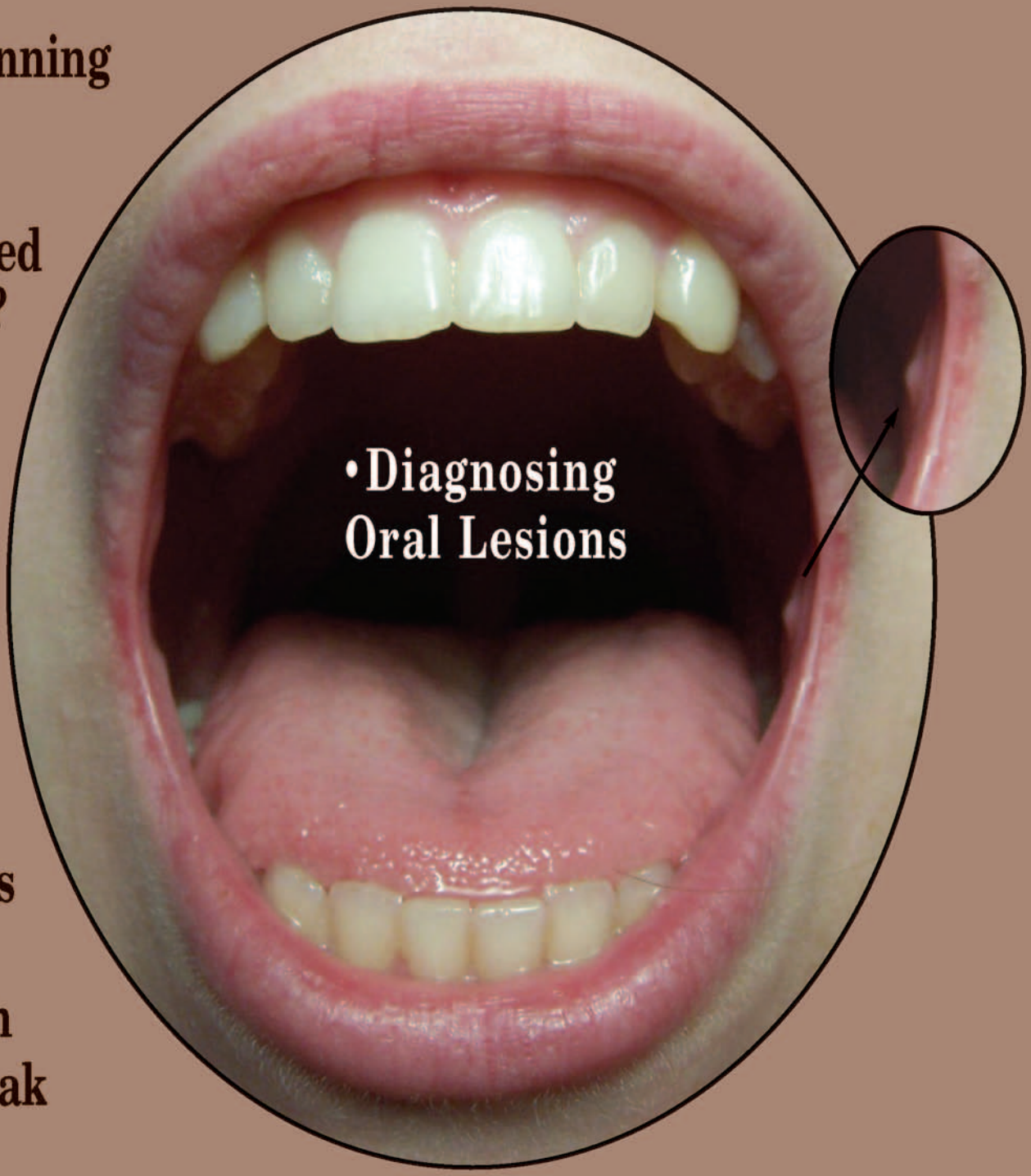
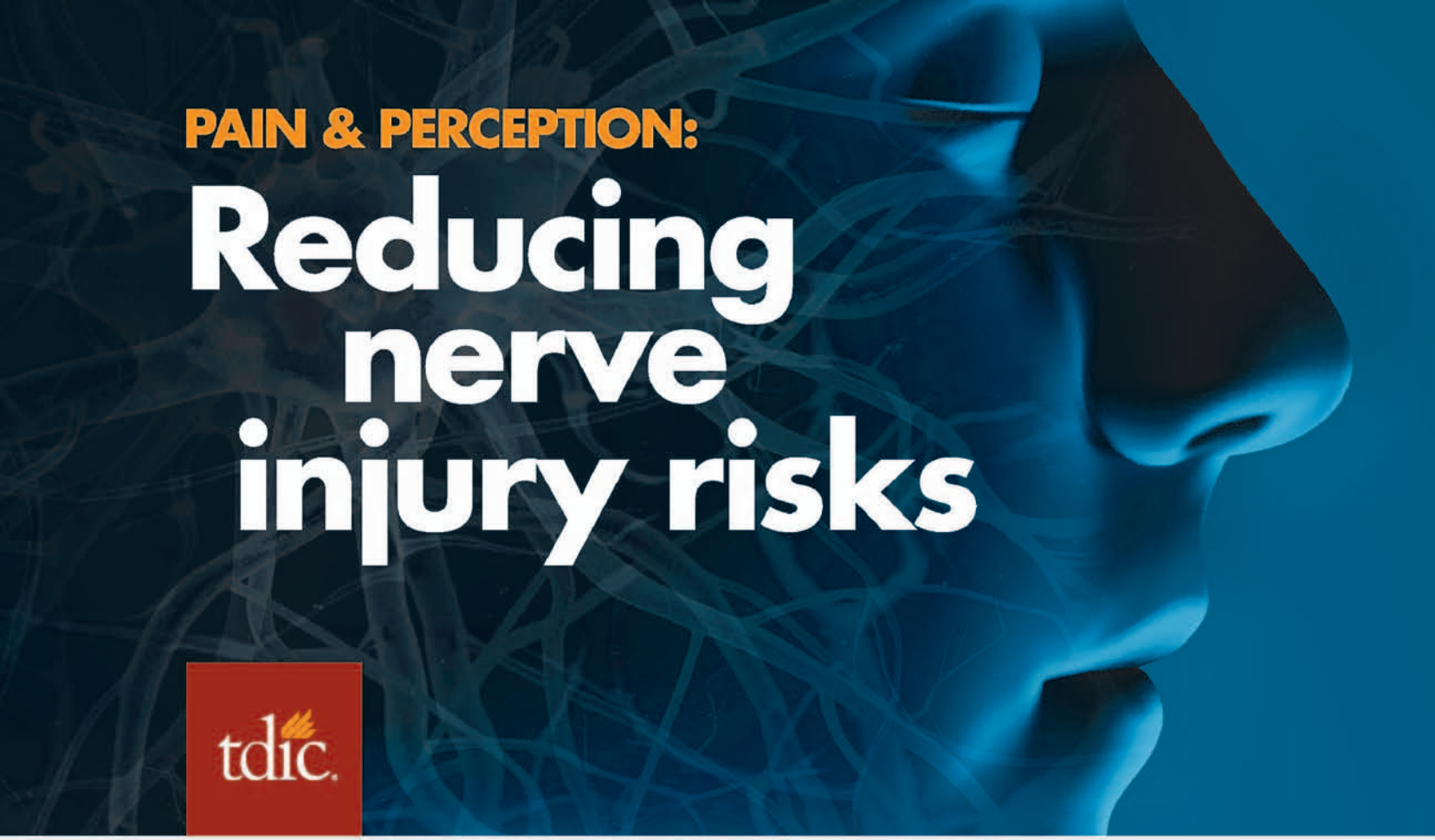
Bulletin of the San Fernando Valley Dental Society

Dental DimensionS

Fall 2018
www.sfvds.org

- Tax Planning
- Is it a Covered Benefit?
- ADA's New Opioid Policy
- Small Business Pass Through Tax Break





PAIN & PERCEPTION:
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Unsure how to handle patients who are experiencing prolonged numbness following dental procedures? The Dentists Insurance Company's new Risk Management seminar is designed to build your confidence in these interactions.

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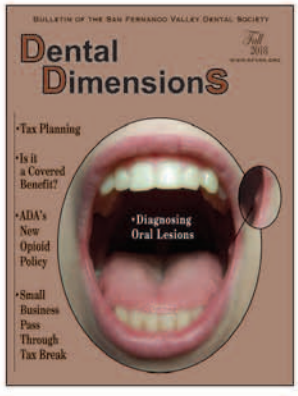
In this issue

Call for Submissions

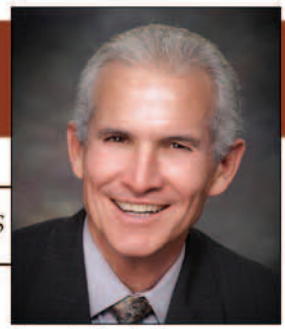
Do you have an unusual case study or an interesting article you would like to have published? Dental Dimensions is looking for articles from our members so we can share our collective knowledge. Articles should be 500-1000 words with references where applicable and photos if possible. Send your submissions to:
exec@sfvds.org
or contact the dental society office at 818-576-0116



On The Cover.....

Diagnosis is a process. It is one of the most critical components in dental practice especially as it pertains to oral lesions. Starting on page 16, Olga Ibsen, RDH, MS, FAADH, Adjunct Professor of Oral and Maxillofacial Pathology at NYU, and Kristin Minihan-Anderson, RDH, MSDH, Assistant Professor at the University of Bridgeport, CT, review the diagnostic process pertaining to oral lesions.

From the Desk of the President



Gib Snow, DDS

A meeting with the U.S. Surgeon General, Dr. Jerome Adams, was scheduled in mid-September with our own Dr. Myron (Mike) Bromberg, but hurricane Florence put a delay on the meeting. Mike said one of his main topics to discuss would have been what defines limited access to dental care. When an area is defined as limited access (like remote areas in Alaska) some begin to promote solutions like dental therapists and mid-level providers. We are affected because some areas in Los Angeles have been so defined.

Immediate past-president, Dr. Karin Irani, will soon be taking her seat on the CDA Board of Trustees. Her past history indicates that she will serve us well. Karin has also been placed on the AAWD Board (American Association of Women Dentists). Good work Karin!!

A day of free dentistry was set for our Society at MEND in Pacoima. However, their dental clinic manager recently resigned so the date had to be changed until the new clinic manager is on board. It was suggested that we change the date of our free clinic at MEND to early 2019. We hope that you'll be able to join us as a volunteer, so watch your emails for the invitation to help.

Please stay tuned, we also need your help as we provide free treatment to veterans during the week after Veterans Day, November 12-17, 2018. If you would like to participate in this program, contact Wendy at the central office (818.576.0116) to sign up.

As delegates to the upcoming CDA House of Delegates meeting, we are considering a resolution regarding the upcoming federal proposition to include dental coverage within the Medicare program. The ADA has already taken a stand on this issue and our delegation feels that we need to be sure CDA takes the same stand. The statement would include the position that CDA is against including dentistry in the Medicare program as well (because it would very likely limit the fees paid for dental procedures processed through Medicare, which in turn, will affect the reimbursement fees offered by insurance companies).

If you are aware of any of your colleagues that are not members of the SFVDS/CDA/ADA please have them get in touch with the main office. Remind them of the benefits of membership and remember that if you refer someone to membership, once accepted you will earn a $200 reward (see the advertisement on the back cover) under the 'Member Get a Member' program.

As your board of directors, we are here to serve the members of the San Fernando Valley Dental Society. We welcome ideas that we can use to serve you better, so please don't hesitate to call.

Sincerely,
Gib

Trustees' Report

By: George Maranon, DDS

It is a little bittersweet that I offer my last trustee report. In 2013, I began my first term in the shadow of the first CDA Cares - Modesto and a Special House of Delegates. Both of those events were about not only expanding access to dental care for Californian's but also making sure that the standard of care was maintained.

Many dramatic events happened that would end up as important stepping stones of future association successes in 2013. First, the Dental Benefits Taskforce began to provide results of its work. The charge of this taskforce had been to identify strategies and make recommendations to enhance the position of providers and patients in the dental benefits marketplace. The next sentinel event was the legal action filed by CDA against Delta Dental's attempt to change provider agreements. Lastly the association began a governance review process to assure that the association's decision-making structure was optimized to effectively respond to dynamic changes in the health-care environment.
The association continued to make significant moves in 2014. CDA and a coalition of more than 600 organizations helped to overwhelmingly defeat Proposition 46. This proposition would have dramatically increased health care costs and reduced patients' access to care by raising the payouts in lawsuits against dentists and other health care providers. CDA Cares demonstrated the pent up need for dental care. As a result, the legislature re-established a basic adult dental program. The association was also successful in stopping the state from implementing retroactive Denti-Cal reimbursement cuts. Finally, after many years of advocacy by CDA, the dental board approved the portfolio examination licensure model in California's dental schools in November, 2014.

In 2015, the work that was started by the Dental Benefits Taskforce, culminated in the formation of a new subsidiary, The Dentists Service Company (TDSC). CDA has had a long history of responding to member needs. In response to the dental liability crisis, CDA formed The Dentists Insurance Company (TDIC) in 1980. TDSC was formed to support members with the business side of their practices. The company would support members making them more competitive and efficient. TDSC planned to offer group purchasing of supplies, practice advising, marketing, human resources and assistance with forming group practices. 2015 saw other fruits of CDA's early labors. Due to CDA's efforts, Gov. Brown announced that Jayanth V. Kumar, DDS, MPH, would serve as California's new state dental director.

CDA secured another significant advocacy victory in 2015. The California Department of Health Care Services announced that the federal Centers for Medicare and Medicaid Services (CMS) had approved the reversal of the Denti-Cal 10 percent rate cut for dental services. CDA also took a lead role that year in the new Save Lives California coalition. The coalition was formed to reduce tobacco consumption and put more resources in health care programs. The coalition filed its final version of a ballot measure (Proposition 56) for the November 2016 election to raise the state's tobacco tax by two dollars per pack.

Not satisfied with its A.M. Best "A" rating for 22 consecutive years and exemplary service to more than 18,000 dentists, TDIC announced the signing of a definitive agreement to purchase three Moda-held companies — Dentists Benefits Insurance Company (DBIC), Dentists Benefits Corporation (DBC) and Northwest Dentists Insurance Company (NORDIC) in 2016. There was also a significant governance change for the association in 2016. The CDA House of Delegates was named as the policy setting body and the board of trustees were granted the sole authority to approve the annual budget and final authority on business decisions, with the exception of the determination of member dues, which would remain the responsibility of the house of delegates. The November 2016 election gave a legislative victory to CDA and the Save Lives California coalition. Proposition 56 passed overwhelmingly. To end the year, CDA celebrated an important milestone as membership grew to 27,000 dentists.

The successes of the association continued in 2017. The Dentists Service Company officially launched its services to CDA members and a preliminary settlement was announced in the Delta Dental litigation. The board of trustees established a task force to evaluate and make recommendations regarding composition of the CDA board of trustees to assure that members of the board possess the necessary skills, and reflect the diverse experiences and perspectives required to achieve organizational goals. CDA's advocacy agenda included pursuit of a medical loss ratio requirement for dental benefit plans. CDA sponsored Senate Bill 1008 (Skinner), which would increase the value and transparency of dental benefit plans. A task force was called for to review dental insurance and economic issues within the practice to assist members in responding to changes in dental delivery and coverage.

Continued on page 21

Legislation *Report*

Medi-Cal – Proposition 56 Funding
More than half of children and a third of adults — more than 13 million Californians — now rely on the state's Medi-Cal program for their medical and dental coverage. The passage of Prop. 56 in 2016 — a tobacco tax increase co-sponsored by CDA — is leading to significant Medi-Cal funding improvements. Medi-Cal patients have faced major barriers to care for many years, including long delays for appointments, trouble finding specialists and traveling long distances to receive care. A primary reason for this has been that California's reimbursement rates to Medi-Cal providers have been among the lowest in the nation, resulting in a lack of providers able to participate in the program. The recently signed 2018-19 state budget includes $210 million in additional dental provider reimbursements from Prop. 56 funds — a 50 percent increase over last year's allocation. The current budget increases rates for adult prevention and periodontal treatment, as well as for the top 25 most commonly billed services, anesthesia and sedation, and paying for extra time when treating patients with special needs. This builds upon last year's funding, which resulted in 40 percent rate increases for hundreds of dental procedures including restorative, prosthodontic, surgical and adjunctive services. Furthermore, the 2018-19 budget includes $30 million from Prop. 56 funds for a new dental school loan repayment program, which should improve access to dentists in underserved areas. The criteria of the program will be developed in the months ahead. While fixing Medi-Cal will be a long-term process, CDA is very pleased with the progress made since the passage of Prop. 56.

State Office of Oral Health – Proposition 56 Funding
CDA's Access Plan to reduce barriers to oral health care prioritizes the need for a comprehensive state oral health program led by a state dental director. The state began providing ongoing funding for a dental director and Office of Oral Health (based in the Dept. of Public Health) in the 2014-15 budget for the first time in decades, and Jay Kumar, DDS, MPH was appointed to the position in 2015. Dr. Kumar came to California with more than 25 years of experience in the New York State Bureau of Dental Health, where he also held the position of state dental director and developed the first comprehensive state oral health plan for New York. Dr. Kumar and stakeholders, including CDA, spent the first half of 2016 developing a state oral health plan, which was officially released earlier this year. The plan includes objectives such as building community-clinical linkages, expanding access to fluoride, dental sealants and screenings, dental coverage, tobacco use counseling and interventions, and developing programs that promote oral health literacy and healthy habits. These efforts will receive a strong boost from the passage of Prop. 56, which includes an annual $30 million for the state oral health program—a tenfold funding increase and the first time the program has ever had a dedicated revenue source.

American Dental Association Announces Policy to Combat Opioid Epidemic

By: ADA staff

In the Spring of 2018, the American Dental Association (ADA) announced a new policy on opioids supporting mandates on prescription limits and continuing education in what could be the first of its kind among major health care professional organizations.

The policy states:

The ADA supports mandatory continuing education in prescribing opioids and other controlled substances.

The ADA supports statutory limits on opioid dosage and duration of no more than seven days for the treatment of acute pain, consistent with the Centers for Disease Control and Prevention evidence-based guidelines.

The ADA supports dentists registering with and utilizing Prescription Drug Monitoring Programs (PDMPs) to promote the appropriate use of opioids and deter misuse and abuse.

Most opioids prescribed to patients in the U.S. are written by physicians and other medical professionals for management of chronic (long-term) pain. Dentists with an appropriate license may also prescribe opioids, and do so most often for management of acute (short-term) pain such as severe tooth decay, extraction of teeth and root canals. In 1998, dentists were the top specialty prescribers of opioid pain relievers, accounting for 15.5 percent of all opioid prescriptions in the U.S. By 2012, this number had fallen to 6.4 percent.

You need a friend in the business.

The practice of dentistry is challenging…especially in California. Changing tax laws, redefinitions of Independent Contractors and discovery of errors, omissions and outright fraud related to dental practice acquisition (especially those offered by FSBOs) require experienced, expert handling. You need someone who has seen it all and knows what to look for…someone to protect your interests, your money and long-term profitability. I am that man.

- **Acquisitions and Due Diligence**
- **Tax Planning and Compliance**
- **Accounting, Payroll, Business Management**
- **Cash and Debt Management**
- **Risk Management**
- **Business Plan and Strategy**
- **Loan Negotiations**
- **Dental Forensic Accounting**
- **Divorce Financial Analysis**

"We walked away from many unsuitable deals and offices before we finally found a great office. Fazel is persistent, highly educated & experienced, and an expert in dental industry."
Actual DDS client. Reference can be provided upon request!

Request your complimentary copy of my e-book, "Dental Practice Valuation & Due Diligence" or call to reserve a seat at my workshop, *"What to look for when buying a practice."* Learn the simple questions to ask that reveal the truth about a dental practice's actual net worth! (Mention this ad and receive your seminar seat free.)

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General Meeting Review

September 26, 2018 - Cutting Edge Technology With Digital Design and Real World Cosmetic Dentistry: Faults, Failures and Fixes.

Joyce Bassett, DDS

This course focused on aesthetics that are built to last. Clear, concise and systemized techniques were be presented on treating every aspect of simple to complex cases involving veneers, crowns and implant restorations. These protocols, she presented, will increase profitability by preventing failures that occur day-to-day in the dental office.
Cutting edge preparation techniques that simplify difficult space management cases were presented, along with how to handle shade challenges and when preparation modifications may be necessary. Attendees learned that the art of digital smile design linking 3D prosthetic planning with fundamental principles and real-time communication decreases dentist chair time and ceramist re-work.

September 29, 2018 - The Art & Science of Prosthodontics "Hands-on" — From Basic to Complex.

Rob Lowe, DDS

The purpose of this course was to demonstrate, in a detailed step-by-step fashion, the procedures that can impact your ability to deliver an improved level of artistic and functional dentistry in one's practice.

Didactic Objectives:

- Discussed and differentiated various ceramic restorative options for different clinical situations.
- Reviewed preparation requirements for all ceramic systems
- Attendees learned the importance of biologic provisionalization in overall case management
- Attendees learned about a proven reliable technique for "flawless" master impression making.
- Attendees learned about a cementation protocol for reliable placement and occlusal adjustment during delivery of definitive restorations.
- Attendees learned about some "creative" ways to plan and treat complex aesthetic and functional problems.

Hands-On Objectives:

1. Attendees learned, hands-on, about various anatomic tooth preparation procedures for full coverage e-max and zirconia restorations.
2. Attendees learned, hands-on, how to handle tooth preparation for the "crowded arch" to predictably create aligned restorations that have the proper restoration contour and position, yet control excessive tooth reduction.

October 24, 2018 - Conservative Cosmetic Dentistry for Teenagers and Young Adults.

Susan McMahon, DDS

With practices full of younger patients with minor cosmetic dental needs and desires, this course helped attendees understand how best to work with these demands. After all attendees were told, being able to recognize these desires and offering these elective conservative treatment options can boost their confidence and boost our bottom lines.

Reviewed were strategies for how to initiate discussions about cosmetic procedures with this age group. This course included a look at cosmetic dental issues that are of particular concern to teenage and young adult patients: tooth color and staining issues, post orthodontic refinement of smiles, spacing and crowding, dental trauma, tooth size discrepancies, misshapen teeth, peg laterals, congenitally missing teeth, and soft tissue considerations. Treatment options and step by step treatment procedures were discussed. The speaker looked at whitening and microabrasion, direct composite bonding, finessing of post-orthodontic smiles & laser soft tissue sculpting.

General Meetings -2018

November 28, 2018 - Tips, Tricks & Techniques for the Esthetics Based General Dentist

Gary Radz, DDS

Today's general dental practice has many patients that are interested in improving the appearance of their teeth. This lecture is created to give an overview of the many different types of procedures and materials that can be successfully used to enhance your patients' appearance. From posterior direct composites to 10 units of porcelain veneers, this course with discuss case selection, material choices, predictable techniques and helpful pearls of information that will allow dentists to be able to add more cosmetic services to their practices. Throughout the program, Dr. Radz will also discuss how he has marketed his general practice to create a practice that is now over 50% elective dentistry, while maintaining a steady flow of new general dentistry patients."

CURES 2.0

California's Controlled Substance Utilization Review and Evaluation System, also known as CURES 2.0, was certified as ready for statewide use by the Department of Justice on April 2, 2018.

Therefore, beginning Oct. 2, all licensees authorized to prescribe, order, administer, furnish or dispense controlled substances in California must, with some exceptions, check a patient's prescription history in CURES 2.0 before prescribing a Schedule II-IV substance.

One notable exemption to mandatory CURES consultation that applies to dental care and that CDA helped secure is summarized: If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient as part of the patient's treatment for a surgical procedure and the quantity of the controlled substance does not exceed a non-refillable, five-day supply of the controlled substance to be used in accordance with the directions for use.

When circumstances require dentists to review a patient's controlled-substance history, they must do so "no earlier than 24 hours, or the previous business day, before prescribing a Schedule II, Schedule III or Schedule IV controlled substance to the patient for the first time and at least once every four months thereafter if the substance remains part of the treatment of the patient," according to Senate Bill 482 signed by Gov. Jerry Brown in September 2016.

Additional exemptions to mandatory CURES consultation that could apply to prescribing dentists include "temporary technological or electrical failure" that restricts a practitioner's access to CURES, "technological limitations that are not reasonably within the control of the health care practitioner" and if the CURES database is determined by the Department of Justice to be nonoperational. The law states that a health care practitioner should correct the cause of the temporary technological or electrical failure "without undue delay."

It is recommended that dentists document in their patients' charts that they checked CURES. Unsuccessful attempts to access CURES and the reasons for not being able to do so must be recorded in patients' charts.

Prescribers should understand that even if they are exempt from the mandatory CURES consultation, they must still be registered to use CURES if they have a DEA number. The registration deadline was July 1, 2016, as mandated by Assembly Bill 679 signed into law by Gov. Jerry Brown in October 2015.

Noncompliance with either the CURES registration requirement or the mandatory consultation requirement, except as exempted by law, are considered a violation of the Dental Practice Act. If not in compliance with the registration requirement, prescribers should register now.

CURES-related questions can be directed to the DOJ at 916.210.3187.

Treasury Provides Guidance On Pass-Through Deductions

The ADA News (8/8, Garvin) reports that during an Aug. 8 conference call with the ADA and other stakeholders, the Internal Revenue Service confirmed that "small businesses with income below $315,000 for joint filers and $157,500 for single filers will be eligible for a 20 percent tax deduction on pass-through income." The IRS and US Department of Treasury also issued on the provision of the Tax Cuts and Jobs Act that "allows owners of sole proprietorships, partnerships, trusts and S corporations to deduct 20 percent of their qualified business income." Go to: https://www.irs.gov/pub/irs-drop/reg-107892-18.pdf to read the entire set of proposed regulations. The ADA News reports that "eligible taxpayers can claim the new deduction – also known as the Section 199A deduction or pass-through deduction for qualified business income – on their 2018 federal income tax returns, the IRS said in an Aug. 8 news release."

The IRS has issued the following FAQ:
Tax Cuts and Jobs Act, Provision 11011 Section 199A - Deduction for Qualified Business Income FAQs
Basic questions and answers on the new 20-percent deduction for pass-through businesses

Below are answers to some basic questions about the new 20-percent deduction for pass-through businesses. Also known as the section 199A deduction or the deduction for qualified business income, the deduction was created by the 2017 Tax Cuts and Jobs Act.

Q1. What is the Deduction for Qualified Business Income?

A1. Section 199A of the Internal Revenue Code provides many taxpayers a deduction for qualified business income from a qualified trade or business operated directly or through a pass-through entity. The deduction has two components.

1. Eligible taxpayers may be entitled to a deduction of up to 20 percent of qualified business income (QBI) from a domestic business operated as a sole proprietorship or through a partnership, S corporation, trust or estate. For taxpayers with taxable income that exceeds $315,000 for a married couple filing a joint return, or $157,500 for all other taxpayers, the deduction is subject to limitations such as the type of trade or business, the taxpayer's taxable income, the amount of W-2 wages paid by the qualified trade or business and the unadjusted basis immediately after acquisition (UBIA) of qualified property held by the trade or business. Income earned through a C corporation or by providing services as an employee is not eligible for the deduction.

2. Eligible taxpayers may also be entitled to a deduction of up to 20 percent of their combined qualified real estate investment trust (REIT) dividends and qualified publicly traded partnership (PTP) income. This component of the section 199A deduction is not limited by W-2 wages or the UBIA of qualified property.

The sum of these two amounts is referred to as the combined qualified business income amount. Generally, this deduction is the lesser of the combined qualified business income amount and an amount equal to 20 percent of the taxable income minus the taxpayer's net capital gain. For details on figuring the deduction, see Q&A 6 and 7. The deduction is available for taxable years beginning after Dec. 31, 2017. Most eligible taxpayers will be able to claim it for the first time when they file their 2018 federal income tax return in 2019. The deduction is available, regardless of whether an individual itemizes their deductions on Schedule A or takes the standard deduction.

Q2. Who may take the section 199A deduction?

A2. Individuals, trusts and estates with qualified business income, qualified REIT dividends or qualified PTP income may qualify for the deduction. In some cases, patrons of horticultural or agricultural cooperatives may be required to reduce their deduction. The IRS will be issuing separate guidance for co-ops.

Q3. How do S corporations and partnerships handle the deduction?

A3. S corporations and partnerships are generally not taxpayers and cannot take the deduction themselves. However, all S corporations and partnerships report each shareholder's or partner's share of QBI, W-2 wages, UBIA of qualified property, qualified REIT dividends and qualified PTP income on Schedule K-1 so the shareholders or partners may determine their deduction.

By: ADA Staff

Q4. What is qualified business income (QBI)?

A4. QBI is the net amount of qualified items of income, gain, deduction and loss from any qualified trade or business. Only items included in taxable income are counted. In addition, the items must be effectively connected with a U.S. trade or business. Items such as capital gains and losses, certain dividends and interest income are excluded.

Q5. What is a qualified trade or business?

A5. A qualified trade or business is any trade or business, with two exceptions:

1. Specified service trade or business (SSTB), which includes a trade or business involving the performance of services in the fields of health, law, accounting, actuarial science, performing arts, consulting, athletics, financial services, investing and investment management, trading, dealing in certain assets or any trade or business where the principal asset is the reputation or skill of one or more of its employees. This exception only applies if a taxpayer's taxable income exceeds $315,000 for a married couple filing a joint return, or $157,500 for all other taxpayers

2. Performing services as an employee

Q6. How is the deduction for qualified business income computed?

A6. The SSTB limitation discussed in Q&A 5 does not apply if a taxpayer's taxable income is below $315,000 for a married couple filing a joint return and $157,500 for all other taxpayers; the deduction is the lesser of:

A) 20 percent of the taxpayer's QBI, plus 20 percent of the taxpayer's qualified real estate investment trust (REIT) dividends and qualified publicly traded partnership (PTP) income

B) 20 percent of the taxpayer's taxable income minus net capital gains.

If the taxpayer's taxable income is above the $315,000/$157,500 thresholds, the deduction may be limited based on whether the business is an SSTB, the W-2 wages paid by the business and the unadjusted basis of certain property used by the business. These limitations are phased in for joint filers with taxable income between $315,000 and $415,000, and all other taxpayers with taxable income between $157,500 and $207,500. The threshold amounts and phase-in range are for tax-year 2018 and will be adjusted for inflation in subsequent years.

Q7. I have income from a specified service trade or business. How does that affect my deduction?

A7. The SSTB limitation does not apply to any taxpayer whose taxable income is below the $315,000/$157,500 threshold amounts discussed in Q&A #6. For taxpayers whose taxable income is within the phase-in range discussed in Q&A #6, the taxpayer's share of QBI, W-2 wages and UBIA of qualified property related to the SSTB may be limited. If the taxpayer's taxable income exceeds the phase-in range, no deduction is allowed with respect to any SSTB. The threshold amounts and phase-in range are for tax year 2018 and will be adjusted for inflation in subsequent years.

Q8. In 2018, I will report taxable income under $315,000 and file married filing jointly. Do I have to determine if I am in an SSTB in order to take the deduction? Is there any limitation on my deduction?

A8. No, if your 2018 taxable income is below $315,000, if married filing jointly, or $157,500 for all other filing statuses, it doesn't matter what type of business you are in. You will be able to deduct the lesser of:

A) Twenty percent (20%) of your QBI, plus 20 percent of your qualified REIT dividends and qualified PTP income, or

B) Twenty percent (20%) of your taxable income minus your net capital gains.

Q9. In 2018, I will report taxable income between $157,500 and $207,500 and file as single. I receive QBI. Does it matter if it is from an SSTB?

A9. Yes, because your taxable income is above the threshold amount, your section 199A deduction with respect to any SSTB will be limited. However, because you are within the phase-in range, you may be allowed some section 199A deduction with respect to an SSTB. In addition, for taxpayers above the threshold amount, the section 199A deduction with respect to any trade or business, including an SSTB, may be limited by the amount of W-2 wages

Continued on page 12

paid by the trade or business and the UBIA of qualified property held by the trade or business. The phase-in range is $315,000 to $415,000 for joint filers and $157,500 to $207,500 for all other filing statuses. Section 1.199A-1 of the proposed regulations provides additional information.

Q10. In 2018, I am single and will report taxable income over $207,500. My only income is from an SSTB. Am I entitled to the deduction with respect to the SSTB?

A10. No. The same is true for a married couple filing a joint return whose taxable income exceeds $415,000. However, you may be entitled to a deduction for QBI earned from another trade or business that is not an SSTB or from qualified REIT dividends or qualified PTP income.

Q11. In 2018, I am single and will report taxable income over $207,500. I am NOT in an SSTB. Am I entitled to the deduction?

A11. Yes, if you have QBI, qualified REIT dividends or qualified PTP income. For eligible taxpayers with total taxable income in 2018 over $207,500 ($415,000 for married filing joint returns), the deduction for QBI may be limite by the amount of W-2 wages paid by the qualified trade or business and the UBIA of qualified property held by the trade or business. The proposed rulesprovide additional information on these limitations. The IRS also issued a notice of proposed revenue procedure providing methods for determining W-2 wages for purposes of the limitation.

Q12. How do co-ops qualify for the 199A deduction?

A12. The IRS will be issuing separate guidance for co-ops.

Also, for information on calculating W-2 Wages in regards to Section 199A, click https://www.irs.gov/pub/irs-drop/n-18-64.pdf

Tax Planning For Dentists

Section 179 Depreciation.

By: Fazel Mostashari, MBT, CPA/PFS, CFP, CDFA

The 4th quarter is upon us and if you still have not met with your CPA, you probably should do so to check your progress and potential tax liability for 2018.

Some potential issues that will be of importance this year are:

1. Section 199A. Exclusion of 20% of net income for pass-through entities.
2. General tax planning. (A must for all dentists).
3. New Section 179 & bonus depreciation rules.
4. Personal financial planning
5. Employees vs. independent contractor status of associate dentists and specialists (hot topic)

Most articles I write deal with daily issues that happen to my clients or my close friends' dental offices since I am involved in those the most and can speak from frontline firsthand. This article will primarily focus on 2018 tax reducing equipment strategies for dentists. Please note that the same approach will not be suitable for all professionals so you should employ the services of your own tax and legal consultant before implementing any changes.

This article will elaborate on purchasing equipment to be used in a dental business from medical/dental, financial, tax and marketing points of views.

This was my analysis for my wife's dental office that just purchased a cone beam.

While it was my intention to write about the above subject matters in that specific order, since the most important consideration should be how it can add value from medical/dental side of the business, the main focus of this article deals with the financial and tax side of the acquisition. My analysis always looks at a transaction from many different points of view. Through my exposure, experience and education (and especially through my mistakes), I pay close attention to the financial and non-financial sides of a transaction.

First, how come our office needs a cone beam?

1. Our old Pano recently stopped working.
2. We have two specialists that offer advanced dentistry and who want three-dimensional images to assist with complicated procedures (e.g. Perio & Endo). That allows them to evaluate patients' conditions more accurately which can avoid serious medical and legal complications.
3. We can use the images to expand our medical billing (e.g. Sleep Apnea).
4. We can use the availability of cone beam technology to increase our marketing exposure.
5. We expect this year to be an average profit year but, we have no more depreciation expense available after expensing it all since we bought the practice.
6. The financing rates and terms available are good.
7. We will be able to present treatment plannings better to patients.
8. We expect increased case acceptance.
9. Prior to owning a CBCT system, we found ourselves regularly sending patients for 3-D images provided by an outside scanning company. Our patients were charged almost $300 and it slowed down the process. We can increase our own production with our own machine.

2018 TAX BACKGROUND:

Section 179 of the IRC allows the taxpayer to expense the purchase of qualified equipment in the year of purchase as opposed to depreciating the cost of the purchase over several years (typically 5-7 years for equipment). Section 179 depreciation expensing limits have been raised to $1 million per year, with a spending cap phase-out starting at $2.5 million of equipment purchased in a given year. This became

Continued on page 14

effective on Jan. 1. Bonus depreciation, which was 50 percent, increased to 100 percent for any equipment acquisitions subsequent to September 27, 2017. This includes both new and used property acquired. Consult with your dental CPA on the specifics of depreciation and bonus depreciation.

QUESTION: When is the right time to purchase new equipment?

Usually these types of discussions come up at the end on the year when the taxpayer/dentist has a good year, has too much money and starts to compute his/her potential tax liability, and is shocked or unhappy to send big checks to taxing agencies. Another issue that might trigger such thoughts at the end of the year is when the taxpayer/dentist withdrew and spent too much money during year, made no estimated prepayments and does not know how to bring up the necessary cash to pay current year's taxes (read: tax trap).

The end of the year is also the time when you might receive a phone call from your equipment vendor or dental equipment sales rep informing you of their new deals, discounts, incentives and rebates. These types of sales/incentives also occur right before these companies realize their annual sales goals have come up short before closing their own fiscal years and want to improve sales/books with another incentive to increase sales. Taxes should never be your primary concern to purchase any equipment.

ANSWERS:

1. Only buy when you think the purchase will give you a positive economic return and there is clear business demand.
2. You should always meet with your dental CPA and financial adviser (preferably a 'fee only' and fiduciary that is not a sales person at the beginning and during the year for tax planning and cash management.
3. Buy equipment in your practice ONLY when it makes business sense to do so!
4. Don't ever spend money just for a tax deduction
5. If you do not have cash to pay your taxes, do not incur more debt. Talk to a tax resolution specialist. Also talk to a dental CPA and financial adviser to work on a budget and system to avoid these mistakes in future.
6. Section 179 might be overvalued. There is no extra tax deduction.
7. Buying equipment must add to your overall practice and personal finances, and make you a wealthier person.

SoCal Dental CPAs is located in Woodland Hills and if you have any questions about potential transactions and 2018 tax planning, please call SoCal Dental CPAs at 818-884-2549 or 310-270-6347, or email fazel.mostashari@gmail.com). They work with general dentists, independent dental contractors, orthodontists, oral surgeons and other dental professionals.

Is it a covered benefit?

Understanding the non-covered services law

By: CDA Staff

A common question received by Practice Support is whether a dental plan that a dentist is in contract with can dictate fees on procedures that the policy does not cover. What CDA members specifically want to know is what the dentist can charge the patient. I wish I could provide a simple answer, but the simple truth is that there is very little that is simple about the dental benefit marketplace.

Let's look at why CDA sponsored legislation around this topic.

CDA had noticed that dental plans were beginning to dictate fees to contracted dentists for procedures that the policy did not cover. In response, CDA proposed legislation, Assembly Bill 2275, to ban a dental plan from placing a fee cap on services the policy did not cover. The law took effect in January 2011, allowing dentists to charge patients their usual fee for non-covered services, which are the fees that a dental practice would charge a patient who has no coverage.

As with most complex situations, it helps to dissect an issue one layer at a time. The first layer around this issue concerns the definition of a "covered service." Legislation defined a covered service as a plan's responsibility to pay according to an enrollee's policy. As a result, a non-covered service is defined as a service that a policy would never cover.

To explore this further, there are times when a plan covers a service but does not make a payment for the service due to policy limitation, e.g., maximum, frequency limitation and waiting periods. A common example of this would be when the patient has exceeded their maximum. In other words, the policy covers the service, but no payment can be made because there are no funds available to pay for the service. The law enacted with the legislation states that "contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, or alternative benefit payments" applied to a service do not qualify that service as non-covered.

Further confusion arises when a plan applies an alternative benefit during claim processing. Here is an example: The policy does not cover a porcelain/ceramic crown D2740 on posterior teeth. However, during processing of the claim, an alternative benefit is applied, paying off the fee for a porcelain fused to high noble metal crown D2750. You might be thinking that because D2740 is not a covered benefit, the plan cannot cap the fee, but in fact the law does allow for fee capping in these cases. The law looks at it like this: The policy covered a crown — it just covered it at the porcelain fused to high noble metal fee. In addition, if a dentist is in contract with a plan and the contract/policy of the plan states that a contracted dentist cannot bill above their contracted rate of the D2740 when an alternative benefit has been applied, the dentist is bound by this agreement and cannot bill above their contracted fee for the D2740.

A third scenario that causes confusion is when a plan fee caps a service that the policy does not cover. You may be saying to yourself, "Wait a minute, we just learned that if a policy does not cover the service, they cannot apply a fee cap. Right?" Again, I wish it were that simple. But the law we've been discussing is a California state law, yet many groups in the dental marketplace are self-funded and self-funded groups are not required to follow state law as they are federally regulated. With self-funded groups, the employer that provides dental benefits to its employees does so using its own funds.

Self-funded dental policies are typically administered by well-known commercial dental plans, but they are not policies purchased in the market. Here's how this type of policy can impact claim processing. Let's say the office submits a claim to a well-known dental plan. The plan then sends an explanation of benefits and payment to the office. While reviewing the EOB, the office notices that the plan placed a cap on what the dentist may charge the patient for a service the policy does not cover. This is usually when the office calls CDA Practice Support for help, as they are sure the plan is violating California law. During the call, we determine that the group is a self-funded group and that they are therefore not violating California's non-cov
ered benefit law.

Remember that the law on capping fees for non-covered services is in California state law, so it does not apply to federally regulated policies. One way to find out if the employer is funding its own policy is to search for the employer using the Free ERISA website, freeerisa.benefitspro.com (free registration required). If the employer shows up in the search results, it is self-funded.

For CDA Practice Support resources related to dental benefit plans visit cda.org/resourcelibrary or call 800.232.7645 to speak with a practice analyst.

A REVIEW OF THE

Diagnosis is a process. It is one of the most critical com ponents in dental practice especially as it pertains to oral lesions. According to the Oral Cancer Foundation, almost 49,000 Americans will be diagnosed with oral/oropharyngeal cancer this year. The five year survival rate from the time of diagnosis is 57%. Approximately 9,750 deaths will result. One person still dies every hour of every day from oral/oropharyngeal cancer and this statistic has not significantly changed in over forty years. The reason is not that it is hard to discover or diagnose, but it is discovered in the late stage of development. This compromises successful treatment and prognosis. It is vital for dental professionals to follow an established systematic data collection protocol.

"Let's watch it", is a term many dentists have used but, what is being watched and when? What is the protocol for documenting and following up on identified lesions? If a definitive diagnosis is made of the lesion intended to be watched, you know what you are watching. This is the safest way to "watch" a lesion. If the lesion has not been biopsied, the suggested time frame upheld in the scientific literature and in all current pathology textbooks for reevaluation is two weeks. This is based upon the average turnover time of oral mucosa which ranges from 10 to 14 days. And, "when in doubt, refer it out." This is the best solution after the components of the diagnostic process have been explored.

All aspects of data collection and documentation are interrelated and must be performed correctly. Data collection can be recorded by a dental hygienist who is educated and licensed to perform these services. For example, proper assessment of extraoral/intraoral examination findings requires the incorporation of data collected during the medical and dental history components of the process as well as a full mouth series of radiographs. All these pieces come together during the extraoral/intraoral examination to aid in the development of a differential diagnosis.

There are eight categories in the diagnostic process: Clinical, radiographic, historical, laboratory, microscopic, surgical, therapeutic and differential. One, two or several of these categories may contribute to a final diagnosis. They are like pieces of a puzzle that contribute to the whole. In reviewing the diagnostic process, it is a methodical approach to evaluating lesions.

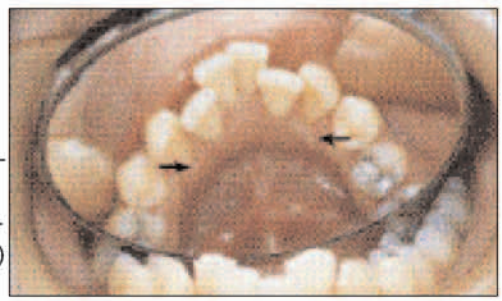
Let's review the diagnostic processes and provide examples under each one. The strength of the diagnosis may come from more than one category.

CLINICAL DIAGNOSIS

The strength of the diagnosis usually comes from the clinical picture alone. The lesions should be described in detail including size, shape, color, consistency and location. Examples include:

Fordyce granules are ectopic sebaceous glands that appear in clusters of yellow papules. Commonly found in older individuals on labial or buccal mucosa.

Retrocuspid Papillae are bilateral developmental, raised red nodules on the lingual gingival margin of mandibular canines. (Figure 1 - Retrocuspid Papilla) →



Fissured tongue is a variant of normal with deep grooves on the dorsal of tongue. Patient should brush gently with a soft toothbrush as some scrapers are insufficient and others can cause irritation.

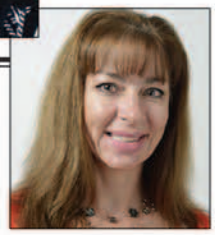
Black Hairy Tongue is a condition in which the filiform papillae are elongated, and discolored brown to black. It is caused by chromogenic bacteria. Smoking, alcohol, hydrogen peroxide and antacids can contribute to this condition.

Erythema Migrans, previously referred to as geographic tongue, is usually asymptomatic but the patient occasionally complains of burning and it may be exacerbated by certain foods and stress. Clinically there are diffuse areas devoid of filiform papillae on the dorsal or lateral surfaces. Genetic factors may play a role in etiology.

Tori have a classic clinical and radiographic appearance, and location. Radiographically mandibular tori and torus palatinus appear radiopaque.

DIAGNOSTIC PROCESS

*By: Olga A. C. Ibsen RDH, MS, FAADH**

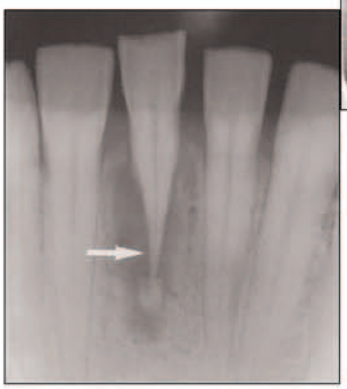


*Kristin Minihan-Anderson RDH, MSDH***

RADIOGRAPHIC DIAGNOSIS:
In this category, the strength of the diagnosis may come from a radiograph. Periapical pathosis is a radiolucency seen at the apex of the root. This can be diagnosed as a cyst, periapical granuloma, or periapical abscess. Diagnosis of any one of these depends on microscopic findings.

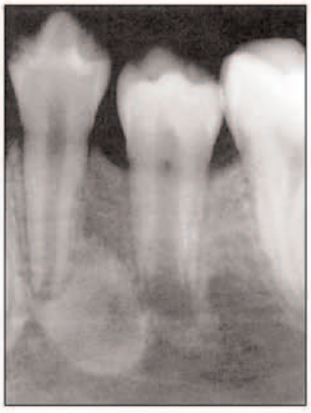
Radicular cyst, also referred to as a root end cyst, appears as a radiolucency at the apex of a non-vital tooth. It must be evaluated microscopically for the diagnosis as it is a true cyst lined with epithelium.

Internal tooth resorption appears as a radiolucency in the pulpal area and is an inflammatory response of the pulp. (Figure 2 - Internal Tooth Resorption) →



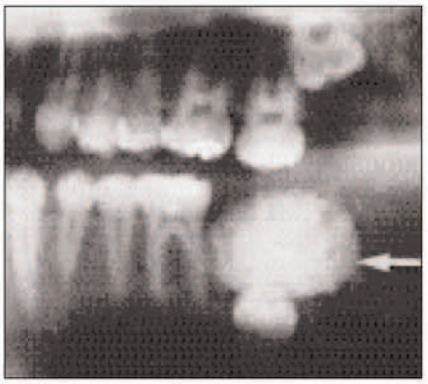
External tooth resorption is an inflammatory response from the periodontal ligament to the pulp. This condition cannot be reversed. (Figure 3 - External Tooth Resorption) ←

Focal sclerosing osteomyelitis, formerly referred to as condensing osteitis, is asymptomatic and a reactive change in bone at the apex of the root. It is thought to be a response to low grade infection. A radiopacity is seen below the roots. It is common to the mandibular first molar or premolar and there is no pain unless there is pulpal involvement. Treatment is usually not required although sometimes a biopsy is performed to rule out other radiopaque lesions. (Figure 4 - Focal Sclerosing Osteomyelitis) →



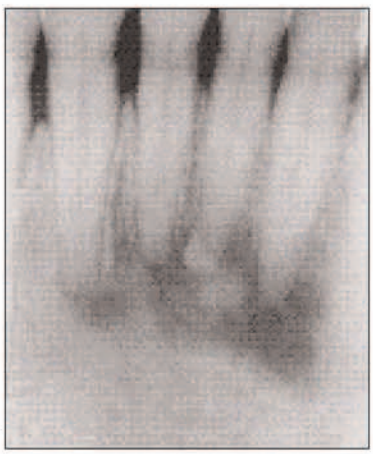
Compound odontoma is a developmental condition that appears as a radiopaque mass of numerous small teeth. All tooth components can be identified. Usually found in the maxillary anterior region.

Complex odontoma is a mass of radiopacity in which you cannot identify normal tooth structure. Large lesions prevent eruption of teeth, and can cause swelling and displacement of teeth. Biopsy is necessary for a definitive diagnosis. (Figure 5 - Complex Odontoma) →



HISTORICAL DIAGNOSIS
Includes aspects of the medical and dental histories, personal history, family history and history of the lesion. Radiographs may also be contributory in certain conditions.

Periapical cemento-osseous dysplasia was previously called a cementoma. Patient history is most contributory to the diagnosis. Classically, it is found in black females in their thirties. It is asymptomatic and all teeth will pulp test vital. The lesion begins as a radiolucency around the apicies of one or several mandibular anterior teeth. Some radiopacity can be observed and the lesion becomes more radiopaque with time. No treatment is necessary. (Figure 6 - Periapical Cemento-Osseous Dysplasia) →

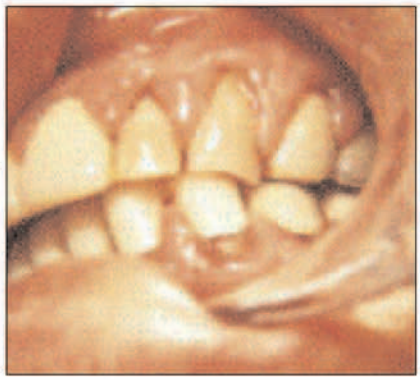


Ulcerative colitis is part of a medical history. With this condition, the patient experiences oral ulcerations when the colitis is exacerbated. These oral ulcers have a similar clinical appearance to minor aphthous ulcers. However,

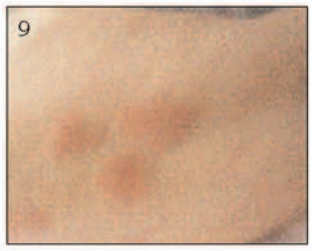
the medical history plays a significant role in the correct diagnosis of the oral ulcers.(Figure 7 - Ulcerative Colitis) →

Amelogenesis Imperfecta is a genetic condition that is autosomal dominant. There are several types and all teeth are usually affected. Questioning the patient on family history regarding relatives who have teeth with the same clinical appearance can help lead to the diagnosis. Radiographs will show missing or very thin enamel.

The patients *drug history* helps to determine drug-induced oral conditions. Procardia (nifedipine) is one of the calcium channel blockers that can cause gingival enlargement. (Figure 8 - Gingival Enlargement) →



Hypersensitivity reaction, urticaria (hives), usually has a rapid onset and exhibits well demarcated areas of swelling and pruritus on the skin. Antihistamine drugs are used to treat this condition, and attempts should be made to identify and remove the cause. Pictures 9 and 10 illustrate an 8 hour time lapse of urticaria in the same patient. (Figure 9 & 10 - Hypersensitivity Reaction) →



Minor aphthous ulcers are diagnosed based upon the clinical picture and history of the lesion. These ulcers are located on movable oral mucosa and they have an immunologic pathogenesis. Clinically, the ulceration is oval/round in shape, 3-5 mm in size, with a yellowish/white fibrin center and erythematous halo. There is a 1-2 day prodromal period that precedes the eruption of the ulcer. History of the lesion will include the patient reporting that these lesions appear every few weeks, last about 7-10 days, and recur every few weeks. Stress is a contributing factor to this lesion.

LABORATORY DIAGNOSIS:

Blood tests, urine analysis and cultures are clearly indicated for the diagnosis of a number of conditions. Many times, they are important components of the diagnosis.

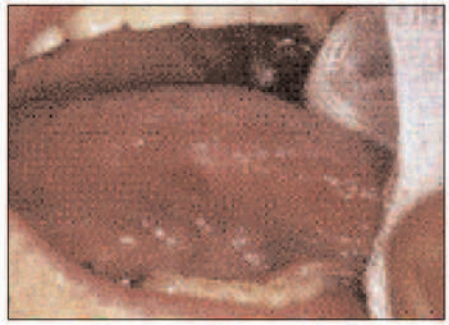
Paget Disease is a chronic metabolic bone disease with classic dental radiographic features. These include hypercementosis of the roots and a radiopaque "cotton wool" appearance of the bone. When jaws are involved, the maxilla is more commonly affected. Clinically you may observe enlargement of the involved bone. Etiology is unknown except theories include, viral, genetic or environmental factors. The diagnosis of Paget Disease is made with laboratory test results showing a significantly elevated serum alkaline phosphatase level. Ie. Normal Bodansky units may be 1.5-5.0, in Paget disease the serum alkaline phosphatase level can be over 250. This value is seen in active disease.

MICROSCOPIC DIAGNOSIS

This diagnostic process is often the main component in the differential diagnosis. Almost every lesion needs to go under the microscope for an absolute definitive diagnosis.

Erythroplakia and *Leukoplakia* are clinical terms for lesions for which you have no idea of the cause. Scalpel biopsies are essential for a definitive diagnosis. The tools, tests, rinses, etc. that are on the market do not have the ability to provide a definitive diagnosis. You cannot scrape the surface of a lesion and get a definitive diagnosis. Scalpel biopsy is necessary. It takes time using magnification and extra illumination to enhance vision to identify small subtle lesions. It is important to recognize when lesions should be referred to the appropriate specialist for a definitive diagnosis.

Erythroplakia is described as a red lesion for which you have no idea of the cause. As illustrated in Figure 11, upon clinical examination, the lesion was seen on the right lateral boarder of the tongue. The patient experienced no pain and was unaware the lesion was there. This is NOT a lesion to watch! Why, because 90% of erythorplakias are microscopically epithelial dysplasia or squamous cell carcinoma. The subtle appearing lesion in Figure 11 turned out to be squamous cell carcinoma. Waiting or watching until the next recare could have resulted in a terminal prognosis. (Figure 11 - Erythroplakia) →



SURGICAL DIAGNOSIS

Surgical diagnosis comes from a surgical intervention. The diagnosis comes from the information secured during the surgical procedure.

Stafne bone cyst is developmental and is also referred to as lingual mandibular bone concavity. It is a pseudocyst. Radiographically, an oval shaped radiolucency is seen in the posterior mandible, anterior to the angle of the ramus and inferior to the mandibular canal. Normal salivary gland tissue fills this radiolucency. If location is superior to the mandibular canal, a biopsy is performed to determine the exact diagnosis. Multiple cysts, the ameloblastoma as well as other pathologic conditions are diagnosed in the posterior mandible.

Traumatic bone cyst is also diagnosed through surgical intervention. It is a well-defined unilocular or multilocular radiolucent lesion that appears to scallop around the roots. It is asymptomatic and surgical intervention shows a void, like a bubble within the bone. Curettage of the wall of this lesion creates bleeding and the lesion heals within a few months.

THERAPEUTIC DIAGNOSIS:

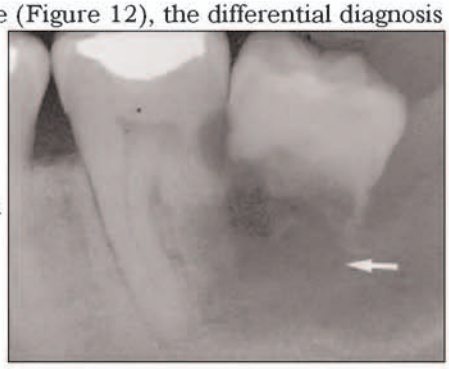
Therapeutic diagnosis is used when you suspect a lesion or condition may be treated with a particular prescription or OTC medication or vitamin. Nutritional deficiencies are clearly an example of a condition treated with therapeutic diagnosis.

Angular Cheilitis is often caused by candida albicans but nutritional deficiencies can be contributory. Bilateral cracked crusted areas in the commissures of the lips are seen clinically. A review of the medical history can rule out nutritional deficiencies. Prescribe an antifungal medication and the condition should resolve if your suspicion of candida was correct. Try to identify the cause and have the patient return after use of the antifungal to reevaluate.

DIFFERENTIAL DIAGNOSIS:

Is that point in the diagnosis when you determine it could be one, two or even three lesions or conditions. A procedure is used to rule out those that were previously suspected to arrive at a definitive diagnosis.

In the following case (Figure 12), the differential diagnosis was Odontogenic Keratocyst, Malignancy or Ameloblastoma. A scalpel biopsy was performed to obtain the definitive diagnosis, which was Odontogenic Keratocyst.



- A 60 year old man returns to a specialists office one year after his previous appointment to the office. The medical history was reviewed and an extra/intra oral exam was performed. The FMS was placed on the viewbox. It was obviously miss ing one periapical film that was apparently also missing the previous year when the patient was seen for the first time in this practice. The patient was asked "do you have any dental complaint?" The patient stated he did, a tooth had suddenly become loose. A periapical was taken in the area of the patient's chief complaint, the same area where the periapical was missing from the FMS. Dramatic radiographic findings were observed however, diagnosis could not be made on these findings alone.
- The general dentist who sent the FMS and referred the patient was called and asked for a periapical of that area from his files. The dentist stated he had no other records or radiographs of any kind and said everything had been sent to the specialist when the patient was referred.

This case identifies multiple issues related to liability which could have been avoided. The referring dentist neglected to maintain complete and accurate documentation of this patient which lead to incomplete information being forwarded with the referral to the specialist. Additionally, the specialist neglected to expose the one missing periapical to complete the FMS which would have resulted in earlier detection of this condition and perhaps less invasive treatment. Ironically, this patient was an attorney by profession.

Documentation Procedures:
Dental professionals are educated regarding the legal and ethical importance of fully documenting all aspects of the patient encounter. The ability to make a definitive diagnosis is predicated upon having complete documentation. The establishment of a succinct documentation protocol to be followed by all dental professionals within a practice will ensure optimal care of patients and help limit exposure to liability.

A review of current documentation procedures within the practice will identify strengths and possible gaps with current procedures. Is the practice utilizing hardcopy documentation (paper), electronic documentation or a combination of both methods? When recorded electronically, data related to a lesion or condition can become fragmented, making it difficult to review and monitor these lesions from visit to visit.

Lesions or conditions encountered at previous visits that may have required a biopsy need to be followed or monitored. Precise descriptive terminology must be used during the documentation process to ensure consistency and

reliability of data collected as well as ensuring efficient communication between professionals of exact findings. Documentation must include clinical descriptions and radiographic findings, referral and follow-up recommendations for the lesion or condition.

The following is a listing of appropriate criteria and lesion descriptors that can be incorporated into a comprehensive documentation protocol.

ANATOMIC LOCATION:

Where is it: Give exact location. It is not a red lesion on the tongue. It is an erythroplakic lesion, 7mm in diameter, on the right lateral boarder, in the middle of the middle third of the tongue.

BORDER:

Shape: Symmetrical or asymmetrical
Circumscribed: Well circumscribed, borders and margins clearly identified
Diffuse: Borders almost impossible to detect exact parameters of lesion
Base of Lesion:

- Sessile: Base is flat or broad
- Pedunculated: Base is stemlike, similar to the stem of a mushroom

COLOR, CONFIGURATION & CONSISTENCY:

Color of Lesion:

- *Red:*
  - Erythema: abnormal redness
  - Erythroplakia: Clinical term describing oral mucosal lesion appearing as a red , smooth, granular , or velvety patch
- *White:*
  - Leukoplakia: Clinical term for a white lesion on oral mucosa that cannot be rubbed off and cannot be diagnosed as any other disease on a clinical basis
- *Pallor:* Paleness of skin, mucosal or gingival tissues as seen in anemia

Configuration of Lesion: Single or multiple lesions

- Discrete: separate
- Clustered: Grouped together, ie. As ulcers seen in herpes simplex
- Coalescence: Parts of a whole join together to make one
- Unilocular: Single rounded compartment;
- Multilobular: Multiple rounded compartments;
- Linear: Appear in a line or band-like configuration

Consistency of Lesion:

- Soft or fluid filled
- Firm, fibrous or semi-firm
- Surface Texture:
  - Papillary/Verrucous: Small nipple-shaped pro jections or elevations, usually in clusters
  - Fissured: Linear cracks, clefts, grooves showing significant depth
  - Corrugated: wrinkled
  - Crusted: Result of dry plasma on skin or lips
  - Scar: fibrotic changes to skin following injury

SIZE:

- Centimeter (cm) less than half an inch
- Millimeter (mm) use the periodontal probe to measure length and width.

TYPE:

Flat Lesions: Non-palpable discolored spot

- Macule: Color different than surrounding tissue, less than 1 cm in size (ie. Freckle)
- Patch: Macule greater than 1 cm in size
- Petechiae: Pinpoint red/purple spot on skin or mucous membranes resulting from escape of a small amount of blood.

Elevated Lesions:

- *Blisterform:*
  - *Vesicle:* Contains serum or mucin, less than 1 cm in diameter
  - *Pustule:* Variably sized, circumscribed, pus-filled, raised lesion
  - *Bulla:* Circumscribed, elevated, fluid-filled lesion within or below the skin or mucous membranes, greater than 1 cm in diameter, usually contains serous fluid
- *Nonblisterform:*
  - *Plaque:* Solid, raised, flat-topped lesion, appears "pasted on". Greater than 1 cm in diameter
  - *Papule:* Small circumscribed lesion usually less than 1 cm in diameter, protrudes above the sur face of normal surrounding tissue
  - *Nodule:* Palpable, solid lesion in soft tissue, up to 1 cm in diameter. May be above, level with, or beneath the skin or mucosal surface
  - *Tumor:* A neoplasm; a swelling or enlargement. Larger than a nodule, may be benign or malignant
  - *Exophytic:* Outward growth beyond the sur rounding surface epithelium

Depressed Lesions:

- Ulcer:
  - Most common soft tissue lesion of oral cavity; loss of epithelium, various etiologies
  - Necrosis of epidermis, dermis or subcutaneous tissue
  - Center is yellow/gray with erythematous border
  - May be result of ruptured vesicle, pustule or bulla

- Erosion:
  - Shallow, depressed lesion, does not extend through epithelium to underlying tissue

A review of the diagnostic process has provided a methodical approach to assist in reviewing lesions and conditions. However, as can be seen throughout the diagnostic process, careful, accurate documentation of all aspects of the patient history and history of the lesion can assist in the diagnosis.
In most cases, scalpel biopsy is essential for a definitive diagnosis.

A review of terminology has provided descriptive vocabulary that should be used when identifying those lesions and conditions which are not normal. These terms are clearly understood by all dental professionals but not routinely used. Perhaps time to update documentation procedures.

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Trustees' Report

Continued from page 5

The dental office staffing crisis was addressed in the creation of a task force to study and develop actionable statewide solutions in response to the dental office staffing shortage. Denti-Cal also received a significant investment of $210 million from Proposition 56 for dental provider reimbursement.
CDA continued to make news in 2018. The TDSC, e-commerce site hit the $1 million milestone in shopper savings. The CDA sponsored SB 1008 (Skinner, D-Berkeley) passed both the senate and assembly and is headed to the governor's desk for signature. But the biggest news of 2018 was the finalization of the Delta Dental litigation settlement. In that settlement, approximately 14,000 dentists are expected to receive payments by the end of October.

As a solo practitioner, controlling costs is an everyday concern. CDA dues are discretionary expenditures and in our busy practices, the value of membership can sometimes be lost. The association's mission statement is that "CDA is committed to the success of our members in service to their patients and the public". This report is just a brief summary of some of the work of the association but it is by no means complete. As a trustee, I have been able to witness the accomplishments firsthand and recognize the value of membership to all of us.

As I end my trustee term, one direction of this association concerns me. Miriam-Webster defines association as 'an organization of persons having a common interest'. Another definition of the association is the fact of 'being involved with or connected to someone or something'. There is the potential that member programs may become secondary to the business interests of the association. Potential changes in the house of delegates schedule and changes in board composition may decrease opportunities for members to be connected with the association and their leadership. That being said I have been honored to have been able to serve as your trustee for the last six years. This privilege has benefited me personally with the opportunity to work with many volunteer colleagues from all over the state in managing the association. In addition, I would like to thank the association and the San Fernando Valley Dental Society component staff for their tireless and often unrecognized work.

Antelope Valley Report

by: Michael Rabizadeh, DDS

It has been quite an exciting summer for the Antelope Valley! This past quarter has been full of opportunities for the engagement and growth of our loyal dental professionals. Our committee continues to provide meaningful events to engage our members in a professional, social and service oriented setting.

On August 21, we hosted an OSHA Infection Control & Dental Practice Act Seminar with safety consultant Bill Hollowell at the Green House Café. In addition to a delicious dinner, participants received 2 CE credits for attendance of the course. More than 50 people were present for the seminar, which meets OSHA's annual BBP training requirements and is certified by the Dental Board of California.

We also offer CPR certification to our members for $35/person upon participation of at least nine members per class.

For information on upcoming continuing education courses contact: Vanessa@drsnow.com or call 661-450-0033.

Glendale-Foothills Report

By: Chi Leung, DDS

As an SFVDS leadership team member (I will be the SFVDS president-elect in 2019), I attended the ADA's 2018 presidents-elect and management conference at the ADA headquarters on July 22-26, 2018.

Dr. Jefferey Cole, ADA President-elect welcomed state and component presidents-elect and gave us an exciting speech about the future of the dentistry. He spoke about the shifts in consumer attitudes toward health care, particularly among younger generations, the growing diversity in the profession, and the ways organizations recruit and engage members. He proudly pointed out, "The future of our profession is bright".

The one presentation that deeply affected my heart was the topic presented by the keynote speaker, Austin Eubanks, Chief Operations Officer, Foundry Treatment. He shared his own life experience of how the physical and emotional pain he suffered during the Columbine massacre spiraled into opioid addiction, to demonstrate how injuries and emotional trauma could drastically affect one's life, leading to substance abuse. He has devoted his career to helping those who have journeyed into addiction by the way of trauma. As dental professionals, we prescribe medications to our patients every day. The drug epidemic, specifically opioid abuse, has been all over the headlines, so we have to keep this in the forefront of our minds when we consider pain medication prescriptions for our patients.

Question: Dr. Chi Leung of the San Fernando Valley Dental Society asks a question during the 2018 Presidents-Elect & Management Conference. This year's conference focused on innovation and data-driven decision-making to help state and local dental associations respond and stay ahead of the changes in the profession

Welcome New Members

Jonathan Akhavan, DDS
21781 Ventura Blvs
Woodland Hills, CA 91364
818-917-8122
Arizona School of Dentistry and Oral Health, 2015
General

Meghrik Assadourian, DDS
UCSF, 2015
General

Eduard Avetisyan, DDS
USC, 2018
General

Maryet Badrood, DDS
1635 N. Victory Pl
Burbank, CA 91502
818-445-0662
General
USC, 2018

Armen Pezeshkian, DDS
1016 E. Broadway Ste. 104
Glendale, CA 91205
818-409-0999
General
Howard University College of Dentisty, 2017

Linda Borna, DDS
General
USC, 2015

Raivyn Conway, DDS
General
USC, 2018

Kamal Dahabi, DDS
849 W Palmdale Blvd.
Palmdale, CA 93551-
818-404-0480
General
Universidad De La Salle, Mexico, 2017

Martina Elenkova, DDS
General
Univ. of Tennessee, 2018

Soma Esmailian Lari, DDS
Periodontics
UCLA, 2018

Nora Ghodousi, DDS
General
University of Nevada, 2018

Nune Grigorian, DDS
General
USC, 2007

Eddie Karabidian, DDS
General
USC, 2018

Padideh Lavaaldin, DDS
General
USC, 2018

John Lunsford, DDS
General
USC, 2018

Daniel Macias, DDS
17756 Saticoy St.
Reseda, CA 91552
805-638-7553
General
Universidad De La Salle, 2017

Jonathan Mai, DDS
General
UOP, 2017

Shahriyar Banihashemi, DDS
10116 Riverside Dr. Ste. 301
Toluca Lake, CA 91602
818-766-6126
Endodontics
USC, 1990

Audra Robinson, DDS
General
University of Michigan Hospital, 2017

Garrett Russikoff, DDS
18911 Nordhoff St. Ste. 35
Northridge, CA 91324
General
NY- Lutheran Medical Center, 2018

Jean-Pierre Rwigema, DDS
23501 Cinema Dr. #112
Valencia, CA 91355
General
USC, 2011

Neil Sangani, DDS
727 Windwood Dr.
Walnut, CA 91789
General
USC, 2014

Michael Shamtoub, DDS
18047 Erwin St.
Encino, CA 91316
818-987-4284
General
NYU, 2016

Nadia Taheri, DDS
12903 Victory Blvd.
North Hollywood, CA 91606
General
Western University of Health Sciences, 2016

Mark Watanabe, DDS
General
UCSF, 2017

CLASSIFIED ADS

GENERAL MEETING PREVIEW

2019 SNEAK PEEK

January 23
PRACTICE MANAGEMENT
BERNIE STOLTZ

February 20
DENTAL PRACTICE ACT
& INFECTION CONTROL
NANCY DEWHIRST, RDH

March 20
ENDO FOR THE GENERAL DENTIST
ALLEN NASSEH, DDS

April 6
CROWN AND BRIDGE – HANDS ON
RON KAMINER, DDS

San Fernando Valley Dental Society
9205 Alabama Ave., Suite B
Chatsworth, CA 91311

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[2] Rewards issued to referring member once referral joins, pays required dues and spends $250+ in the TDSC Marketplace by December 31, 2018.