Dental Dimensions

Summer 2016
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- Billing Medical Plans
- Fitness 101 for Dentists
- Management of a tooth with a large Radiolucency

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In This Issue

Summer 2016

Volume L Number 3

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:
shukandds@gmail.com
or contact the dental society office at 818-576-0116

On The Cover.....

(l-r) Drs. Andre Kanarki, Rozheh Babaan, Jim Mertzel, Assemblyman Matt Dababneh, Drs. Mahfouz Gereis and Michael Whang pose in the CA State Assembly room in the state capitol in Sacramento during CDA's Advocacy Day for the San Fernando Valley Dental Society on June 22, 2016.

From the Desk of the Editor

Shukan Kanuga DDS, MSD.
Board Certified
Pediatric Dentist

A few neighborhoods within our component dental society sustained a catastrophic disaster last fall. The infamous Aliso Canyon Gas Leak, which displaced thousands of families from their homes and children from their schools, was a public health nightmare. Over the course of four months, the invisible catastrophe gushed out over 97,000 metric tons of methane into the Southern California skies. While an array of ill health effects were reported, the scientists and residents are still trying to figure out just how much damage was done.

The disruptions caused by the strong gas odor, displacement of homes and schools forced us out of our comfort zones, and helped us appreciate our homes and our neighborhoods. When all the turmoil was finally behind us, I started reflecting on how the practices in the area would be affected. A series of questions ensued, which sparked the idea of conducting a survey to study the effects of the gas leak on the dental practices of our members during that time period. I drafted a short 12 question survey and refined it with the help of colleagues. With our executive director's help we were able to reach out to approximately 70 member dentists in the neighborhoods of Porter Ranch, Granada Hills, Chatsworth and Northridge by email. Because we only received a handful of responses by the publication deadline, we will discuss the results in our subsequent Fall issue of DD. If your practice falls within one of the listed five zip-codes (91311, 91324, 91325, 91326) and you have not yet responded, kindly complete the survey by August 31st using the link-http://goo.gl/forms/hdI9dQjYXMyrwexP2. Alternately, you can print out the survey and mail or fax in the completed survey to our central office at: Editor, SFVDS, 9205 Alabama Ave, Ste B, Chatsworth, CA 91311 or fax: 818.576.0122

"What doesn't kill us makes stronger", they say and I hope all of you in the areas affected by the gas leak had minimal disruptions and had normalcy restored in your lives and practices.

Wishing you the best.
Shukan

Gratitude *and* Change

From the Desk of the President

Anita Rathee, D.D.S., M.P.H.

During the summer, the bustle of work activity seems to slow down as children are out of school and families take summer vacations. Activities at the dental society continue, although at a slightly slower pace. We take a break from our CE courses and board of directors meetings, which resume again in September. The warm summer nights and abundance of free concerts and activities over the summer gives us a chance to enjoy more time outside and away from our offices, to be with friends, family and loved ones, and to appreciate the many things we have to be grateful for.

Sometimes when we are in our practices or at our jobs, we feel alone and wonder how we're going to tackle a particular issue or problem that has come up. When we graduate from dental school, we earn the title of "doctor" and we become a member of a profession that has long held the respect of the public. With this respect comes the responsibility of upholding the high regard our profession enjoys. When faced with those difficult issues, choose the solution that best serves your patients, the public and your profession, for it is not just your reputation at stake, but that of our profession.

One thing you can count on in life is change. Embracing change is not always easy but how we handle change often determines our level of happiness. The biggest natural gas leak in recent history occurred right here in the San Fernando Valley. It was an unexpected event that affected many people in different ways and those affected had to adapt. The heat of summer in a season of drought always brings the risk of fires, which we've already experienced this summer, as well as in summers past. Smaller unexpected events can affect our practices and although we have insurance to help mitigate financial consequences, we still have to deal with the inconveniences and hassles associated with restoring things back to normal.

Changes are imposed on our practices from outside forces including government agencies, insurance companies and the dental board. We are fortunate to have people in organized dentistry who fight to represent us and our patients' interests. Changes are imposed on us by life: A loved one is diagnosed with cancer; an iconic singer tragically dies; we lose a colleague to a serious illness or death; a friend gets married; a child is given an award; a couple is blessed with a healthy baby. Changes, good or bad, require adjustment and acceptance. I have found that in the face of change, gratitude goes a long way in helping adapt. As the ravages of a forest fire wipes out everything in its path, it brings beautiful new vegetation the following year. As difficult changes come our way, we must remember that change ultimately opens new doors.

I would like to take a moment of personal privilege to express my gratitude for wonderful patients that give me the privilege of not just treating them, but being part of their families, for the amazing colleagues that work with me on the dental society board, and for my fantastic support system including my staff at the dental society as well as in my office, my family, friends and loved ones. I am grateful to be part of a profession that allows me the freedom to practice in a way that best serves my patients and fights to preserve that right every day. I am honored to serve as your president and grateful for all of the trust you've given me in representing you.

2016-17 SFVDS Election Results

President: Karin Irani, DDS
President-elect: Gib Snow, DDS
Treasurer: Mahfouz Gereis, DDS
Secretary: Chi Leung, DDS

CDA House of Delegates
(term begins at the close of the November 2016 House):
Mehran Abbassian, DDS
Mahrouz Cohen, DDS
Chi Leung, DDS

CDA House of Delegates Alternates
(for the November 2016 House only):
Emad Bassali, DDS
James Mertzel, DDS
Jorge Alvarez, DDS
Ted Feder, DDS
Mark Amundsen, DDS
Shukan Kanuga, DDS
Alan Lewis, DDS
Philomena Oboh, DDS
Alfred Penhaskashi, DDS
Serge Lokot, DDS
Anette Masters, DDS

By-Laws amendment:
A by-laws amendment passed which specifically excludes our CDA Trustees from having a vote on the SFVDS Board of Directors as the result of a new CA corporate governance law that took effect in 2016.

Trustee's Report

By: Martin Countney, DDS

CDA EXIT?

By now, you likely have heard of BrExit - Great Britain exiting the European Union (EU).

As of the writing this article, the BrExit referendum, which resulted in a majority vote to exit the European Union, is only a few days old, but what does this have to do with the California Dental Association (CDA)? Possibly more than you may think at first glance.

Just two weeks prior to this writing, in early June, the California Dental Hygienists Association (CDHA) voted to secede from the American Dental Hygienists Association (ADHA). The stated reason for the CDHA exit was to keep more of their members' dues under local control, while reducing the amount of dues each member pays by virtue of eliminating national dues.

The West Los Angeles Dental Society (WLADS) considered separating into two components. Better, more convenient service to local members and fiscal control over member dues were cited as part of the rationale for separating.

Similar to the CDHA's reasoning of keeping local dues money local, the BrExit spoke of promises of hundreds of millions of Pound Sterling savings per week that would no longer be funneled to the EU (immigration control was also an added and large component of the BrExit campaign).

Local control and real savings for UK citizens, CDHA and WLADS members is the rallying cry. Is this a trend?

CDA announced that the Dentists Insurance Company (TDIC) recently bought several professional liability insurance carriers, the profit of which will help to offset possible future dues increases for CDA members. In addition, with the recent creation of The Dentists Service Company (TDSC), CDA is in a position to provide practice management services and benefits to its members that ADA does not. This begs the question: What really do CDA members gain by remaining in the tripartite fold? Advocacy for issues with the federal government, mostly duplicated member benefits, and, of course, the credibility and brand recognition of the ADA brand.

As we all know, a significant factor in deciding to join or stay in CDA is the overall cost of membership. How many new members would CDA gain by reducing membership costs by more than $500 by dropping out of the ADA? Beyond the dollars saved by existing CDA members, what other benefits for CDA would happen if there was a CDAExit?

Perhaps a significant number or most of the non-member dentists in the state would then join and perhaps retention rates among current members would increase to the point where membership might surpass the roughly 70% market share CDA currently enjoys. Would the membership growth be expected to increase CDA's clout on the legislative front? The legislature already sees CDA as a force to be reckoned with and the voice of professional dentistry in CA so no real gain there. As it is, unless there are national implications to a law, rule or regulation that CA is considering, ADA doesn't get involved in CA affairs so no loss there either.

In financial terms, CDA is bigger than ADA, so it's really not an issue of financial stability or pooled resources needed to achieve objectives deemed important to CA dentists.

As a CDA Trustee I have a duty to do what is in CDA's best interest. Does that include actions that could weaken the ADA? Losing 25,000 members and their dues would certainly have an impact on the ADA. Is this strictly a business decision? If it is, then based on CDA's recent reorganization, the decision would completely be made by the CDA Board of Trustees - 43 representatives of the 32 local components and nine executive committee members. If a CDAExit is determined to be a dental policy issue, then the CDA House of Delegates (consisting of between 200 and 216 delegates from the California component dental societies and accredited dental schools) would make the decision. Or should there be an organizational referendum so that each of the nearly 25,000 members of CDA would have the same say in the matter as the British citizenry did through the BrExit referendum?

Am I suggesting that CDA break away from the ADA? No. I am directing your attention to examining the value of a tripartite membership now and in the future - in light of current trends.

Legislative Committee Report

By: Jim Mertzel, DDS

One of the advantages of serving as legislative chairman is that I have had the opportunity to meet and get to know many of our local legislators. Last month some of our members, Rozheh Babaan, Andre Kanarki and Michael Whang were first-time visitors to Sacramento as part of CDA's advocacy program. They, together with Mahfouz Gereis and I, met with assembly members, Matt Dababneh, Tom Lackey, Adrin Nazarian, Scott Wilk and a member of state senator, Robert Hertzberg's staff. I have found that when newcomers are introduced to the political process, there is a certain excitement and realization that as an individual, you can effect change within our society. Legislators are willing to listen to experts in their specific field and can learn from them.

Our visit included an orientation regarding important issues of concern to CDA including efforts to increase funding for Denti-Cal providers. At the present time half of all children and one-third of all adults in California are now eligible for Denti-Cal services. However, since 2008, the number of Denti-Cal providers has declined 15%, while 5 million more Californians have enrolled in the program. CDA supports AB 1051 which asks for an additional $200 million to fund provider rates and to increase preventive care. Assemblyman Jim Wood, a dentist who was quite active in CDA, introduced a bill, AB 2207, to encourage Medi-Cal provider physicians to screen patients regarding their oral health and to refer to dentists for care. In addition the bill would streamline provider enrollment procedures and improve the accuracy of a provider directory.

Another issue we discussed with the Legislators, AB 2485, would make it easier for dental student graduates to commit to enrolling in a program to serve in an underserved area for three years and will provide for up to a $105,000 repayment on their student loans.

CDA is a member of the coalition, "Save Lives California", that supported an initiative that will appear on the November ballot. The initiative calls for a tax increase of $2.00 per pack of cigarettes, raising the tax to $2.85 per pack and increasing the tax on other tobacco products proportionately. California presently has one of the lowest tobacco taxes in the nation. Studies have shown that when tobacco taxes are raised, fewer teenagers begin to smoke. Discouraging smoking will ultimately lower the cost of treating tobacco related illnesses which presently claim more than 40,000 lives per year and costs the state more than $13 billion per year including $3.5 billion in Medi-Cal costs. The new revenue, estimated at $1.5 billion, would go toward Medi-Cal/Denti-Cal programs, smoking prevention, cessation programs and the state's oral health programs. The coalition was previously effective in promoting legislation passed by the state, to raise the minimum purchase age from 18 to 21 and to regulate e-cigarettes as a tobacco product.

CURES prescription drug data base: The state's Controlled Substance Utilization Review and Evaluation System (CURES) registration deadline was July 1, 2016. The system provides essential information to assist prescribers, dispensers and law enforcement to identify and deter prescription drug abuse. The system would require a prescriber to check a patient's history before prescribing class II to IV substances for the first time and annually thereafter. CDA was successful in modifying the bill's requirement to avoid checking the history if the prescriber is writing a prescription following a surgical procedure, if the prescription is non refillable and is for 5 days or less.

AN OBSERVATION AND A PLEA:
Over the past few years I am certain that you have observed that some patients, desperate to purchase individual dental insurance policies, have purchased, or are considering purchasing one of these policies. It is usually the patient who knows he needs a considerable amount of dental treatment. I have reviewed a few of the policies and I have not found one that benefits the patient. The problems are:

1. The fee schedule is well below most dentists' fees.
2. There is often a deductible
3. There is usually a waiting period for one year for major procedures, which includes periodontic treatment, endodontic treatment, crowns, prosthetics, etc. I saw one policy that considered a surgical extraction as a major procedure. This meant that the patient was obligated to

Continued on page 21

General Meeting Review

Douglas Young, DDS

June 22 - Dental Materials, With an emphasis on Caries Management.

Dr. Young presented on 'caries management by risk assessment' (CAMBRA) as an evidence-based method of treating and preventing the disease of dental caries. Dr. Young reminded attendees that this includes much more than just restoring the damage on teeth caused by the disease. He presented that new biofilm theories shed light on why drilling and filling does little to treat caries disease. Attendees learned about preventing and even reversing early caries lesions using oral disinfectants, xylitol, fluoride, pH, calcium/phosphate, salivary diagnostics, including newly FDA approved silver diamine fluoride (SDF), rather than relying solely on traditional surgical techniques. Dr. Young presented a overview of chemical and site-specific management of caries lesions using glass ionomers and the new ADA Caries Classification System.

General Meeting Preview

September 21 - The Biggest Problems in Implant Dentistry

Kyle Stanley, DDS

This presentation will present key points formulated into a systematic step-by-step approach to resolve significant esthetic problems restoring the esthetic zone up to full-mouth rehabilitations. Dr. Stanley will show you the biggest problems in implant dentistry and how to avoid them. Topics will include: Digital Smile Design; Upper lip planning and augmentation for maximum esthetics; The team approach to guided implant surgery planning with Nobel Clinician; Abutment modifications to maximize soft tissue around implants; and, How and when to use pink porcelain. Dr. Stanley will also introduce a state of the art approach to restore teeth with actual enamel and dentin.

October 19 - Esthetic Dentistry for the GeneralPractitioner

Bob Lowe, DDS

In this technique filled seminar, Dr. Lowe will teach you the skills you need to refine your restorations to a level that will help you create consistent quality. New technologies and techniques will be discussed along with how implementation of these technologies can help the "bottom line" of your practice. A discussion regarding the latest dental materials and delivery modalities will help in treatment planning even the most difficult functional and aesthetically challenging cases.

November 16 - Oral pathology for the Dental Professional and Differential Diagnosis of Oral Lesions

Ms. Olga Ibsen, RDH, MS

With the course, the oral cavity will be divided into the following areas: lips, tongue, floor of the mouth, buccal mucosa, palate and gingiva. First, examples of normal will be reviewed. Then 15-20 conditions for each area will be discussed including variations of normal, reactive lesions, immunologic conditions, infectious diseases, developmental disorders, chromosomal abnormalities, and neoplastic conditions. What are some features used in differentiating one lesion from another? What are the questions you should be asking yourself and the patient? What is the "gold standard" in the diagnostic process? Emphasis will be placed on the diagnostic methods that contribute the most to the final diagnosis.

By: Nishan Odabashian, DMD

Management of a tooth with a large radiolucency

Dr. Nishan Odabashian discusses treatment of teeth with failing previous root canal treatment exhibiting large radiographic lucencies

Introduction

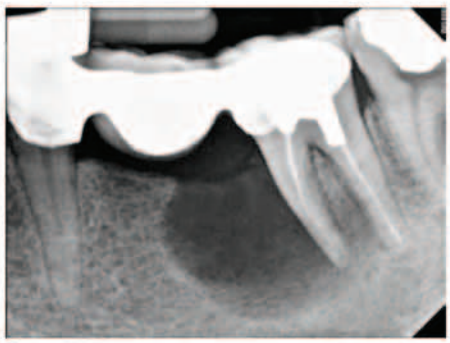
A healthy 53-year-old male presented to our office on May 9, 2011, after being referred by a friend who was treated at our office. He was advised that he needed to have tooth No. 19 removed, and the extraction site grafted with bone and soft tissue. After 4 months, he needed to have the area evaluated for implant placement. Otherwise, his options were to place a 4-unit fixed partial denture (FPD), or a removable partial denture (RPD). The implant route was cost-prohibitive for him, and he was desperately seeking someone who would try to save his tooth.

Clinical and Radiographic Examination

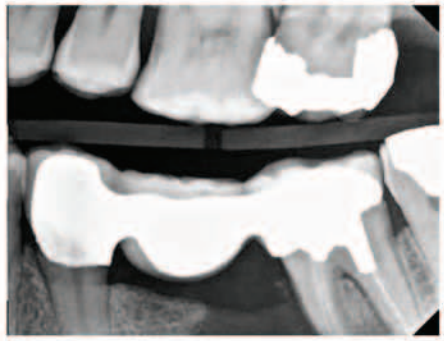
Clinical findings: The patient had a 3-unit FPD on the left mandibular molar area extending from the second premolar, mesially, to the second molar (18-20) distally. A slight swelling was present, buccal to tooth No. 18, and the probing depths were surprisingly within normal limits, even when probed under anesthesia. Patient reported pain on chewing, percussion, and palpation.

Radiographic findings: Periapical and bitewing radiographs were taken. (Today, a CBCT scan would also be taken as part of the radiographic examination.) The preoperative PA radiograph showed a 3-unit prcelain fused to metal (PFM) FPD extending from tooth No.18 to tooth No. 20. Tooth No. 18 had previously treated root canals with a cast metal post extending into the distal root, while tooth No. 20 did not have previous endodontic treatment. A large (~15 mm in diameter, see PA radiograph) PA lucency was present on the mesial root of tooth No. 18, extending midway to tooth No. 20, extending from the osseous crest to the level of the root apex of tooth No. 18.

Nishan Odabashian, DMD, graduated from Tufts University School of Dental Medicine in 1991. After 8 years of practicing general restorative dentistry, he received a certificate of specialty and a Master's Degree in Endodontics from Loma Linda University School of Dentistry (LLUSD) where he is a part time Assistant Professor of Endodontics. He practiced in Las Vegas, Nevada, and Bakersfield, California, and in 2008, he returned to Glendale, California, and established Glendale MicroEndodontics (GME).



Pre-op 5/9/11



Pre-op bitewing

Pre-op clinical

Access

Mesial part of cast post removed

Medical history

Non-contributory. Patient was prescribed amoxicillin 500 mg TID for 2 days by his general dentist.

Diagnosis

- **Pulpal:** Previously treated pulp
- **Periapical:** Symptomatic periapical abscess

Differential diagnosis

- Lesion of endodontic origin
- PA cyst
- Lateral periodontal cyst
- Odontogenic keratocyst

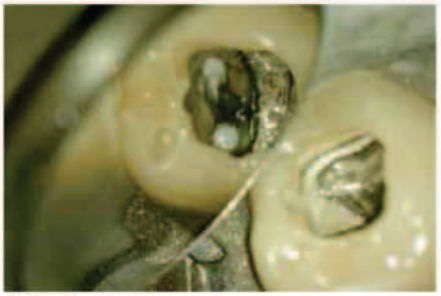
Immediate treatment plan

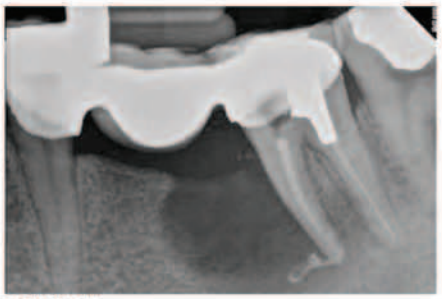
- Incision and drainage (I and D)
- Initiate retreatment, and based on results, send for biopsy or continue with endodontic retreatment.

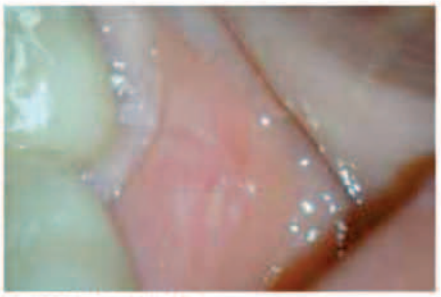
Treatment

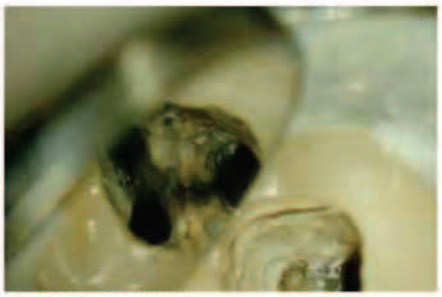
Treatment was initiated with an I and D of the buccal swelling. The patient's antibiotic regimen was changed to clindamycin 300 mg, sig 1 tab TID for 5 days. Retreatment followed by accessing the distal abutment of the 3-unit FPD. The cast post and existing gutta percha were removed. The canals were cleaned, shaped, and dressed with calcium hydroxide for a total period of 7 months. In the interim, there were three calcium hydroxide changes after the internal aspect of the tooth was cleaned — first at 1 month, second at 3 months, and then at 5 months. The internal aspect of the crown was cleaned, and restored using Encore® paste (see photo). At the end of the endodontic treatment, the 3-unit FPD was removed, and a temporary bridge was made using the original impression taken at the first appointment. The patient was referred back to the referring doctor with a temporary bridge and the lucency considerably reduced. Recall radiographs

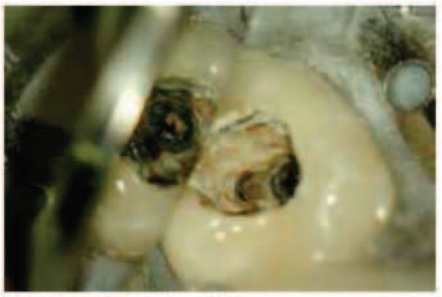

Mesial canals


CH in mesial canals

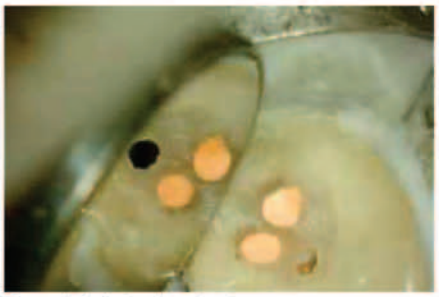

CaOH 5/9/11


Healing of buccal I and D

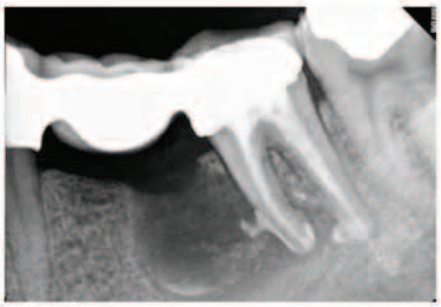

Chamber decay removed


Distal part of cast post removed


GP spacers in canals

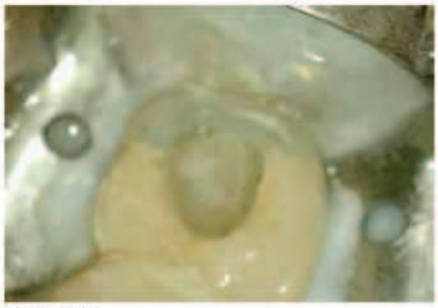

Composite injection into chamber

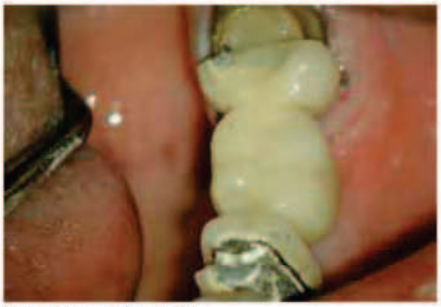

GP spacers removed

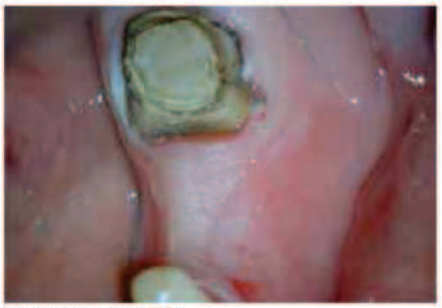

CaOH 11/7/11

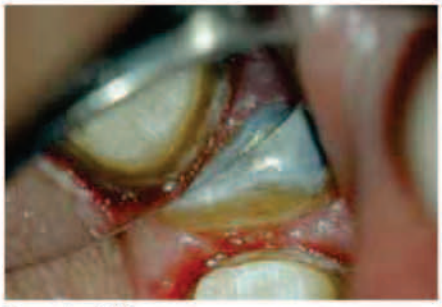

Final canal C and S

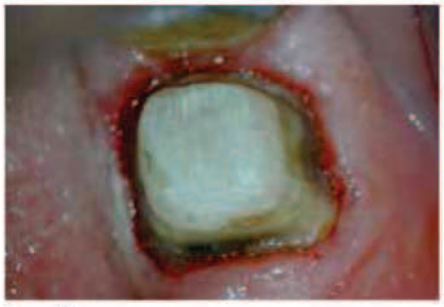

GP obturation

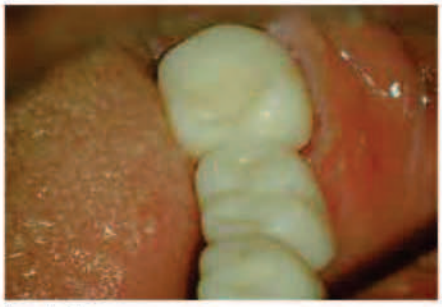

Core buildup

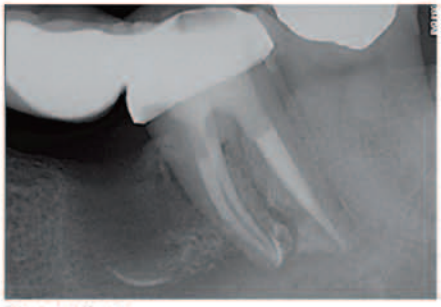

Removal of existing bridge

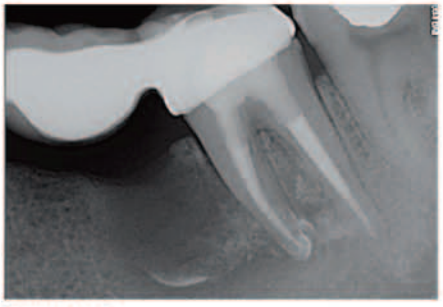

Existing bridge removed

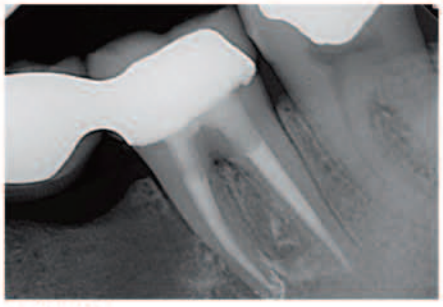

Prep under SOM

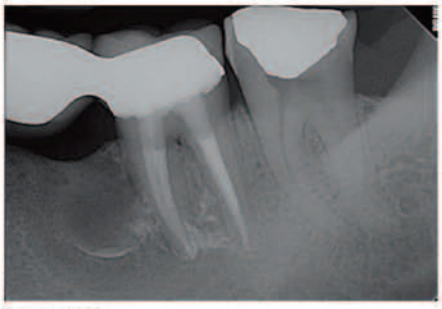

Preparation

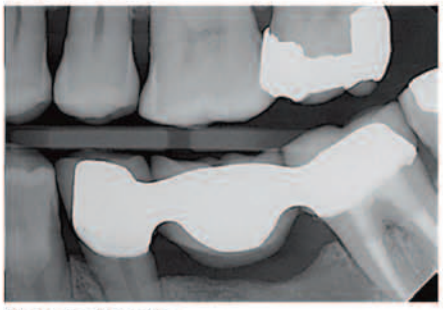

Temp bridge

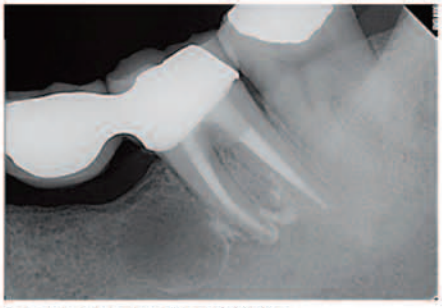

Post-op 1/2/12


3-month recall


1-year recall


2-year recall


2-year recall bitewing


3-year recall post treatment initiation

were taken at 3 months, 6 months, 1 year, 2 years, and very recently 3 years from the initiation of treatment. We will continue to recall patient every year for an indefinite period of time.

Discussion

Management of teeth with previous root canal treatment that is failing requires more than just performing endodontic retreatment or surgery. The treating clinician must evaluate the cause of failure. These causes can range from being endodontic, restorative, periodontic, occlusion, patient's habit (i.e. tongue ring), trauma, etc. Often, teeth with prior root canal treatment that present with large radiolucencies require a commitment from the patient and the treating doctor. Without this understanding and firm commitment to see the treatment through, it is not possible to see outcomes such as the one presented here. The endodontist has a responsibility of not only performing the endodontic retreatment, but to also make sure that the restorative treatment will be appropriate in order to ensure a long-term success. One of the ways that the endodontist can control a more positive outcome of his treatment is to place the core buildup after completing the endodontic treatment, under rubber dam isolation. This will eliminate one of the links that may lead to failure of the treatment. Another way that the endodontist can control a possible problem with his/her treatment is paying close attention to the occlusion of the patient during the recall appointment after placement of the final restoration. As a case in point, at the 3-month recall appointment, this patient returned with a 3-unit FPD placed. Upon radiographic examination, a widened PDL space was noted on the mesial aspect of tooth No. 18. This was not present at the postoperative radiograph. An occlusal evaluation revealed a working side interference in lateral excursive movement. The interference was adjusted, and the patient showed a normal PDL space at the next recall appointment.

Obviously, treatments such as these require much more time than a single appointment that is needed for a vital molar tooth. However, the satisfaction of saving such teeth and seeing what is possible with meticulous coordinated dental treatment is immeasurable. A tooth such as this in no way can satisfactorily financially compensate us for the time that is expended on it. However, not everything is measured by money! As the MasterCard® commercial says, these are "priceless."

Summary

I thought this case study would serve a few purposes:

- To show that teeth with large radiolucencies can be treated/retreated endodontically
- To demonstrate that large amount of bone can be regenerated without any bone grafts
- That it takes a committed patient and clinician to see cases such as this through to successful treatment
- That teeth that would otherwise be extracted can be saved
- To expand our hypothesis space when treatment planning a failing root canal treated tooth.

Billing *medical plans* for dental treatment

By: CDA Practice Support Staff

There is an ongoing trend within health care toward integration and consolidation of health care delivery systems. This trend is reflected in provisions of the federal Affordable Care Act, such as the envisioned coordination of care provided under a single entity, the "Accountable Care Organization." The objective of such integration and consolidation is to provide better management of care, create greater efficiencies in the provision of care and improve patient outcomes.

How this trend will affect dentistry largely remains to be seen. But one area that is apparent is in an overlap between medical and dental services and how care is paid. What this means is that, increasingly, dental offices are being required to bill a patient's medical plan for treatment that is essentially dental in nature. These types of treatment situations can include trauma from an accident, sleep apnea, oral or periodontal surgery procedures, or dental disease that is secondary to cancer treatment. In those cases, an option exists for billing a patient's medical insurance. These are procedures that medical plans not only pay for, but increasingly dental plans are deferring to as the primary payers.

There are advantages to billing patients' medical benefits plans, including easing the financial burden on patients and conserving their annual dental insurance benefits. The disadvantage is the dental office must have the knowledge and business systems in place to file and manage medical claims. The learning curve can be considerable. It makes sense for practices that treat a reasonable volume of medically related issues to create and implement such systems.

What medical plans will cover

Medical insurance typically pays for treatment provided by dentists, but not as dental procedures. Dental services that have corresponding medical codes will be reimbursed by medical insurers. For example, Medicare Part B, which covers provider services, considers dentists "physicians" to be reimbursed for performing procedures that are Medicare benefits. The services provided, of course, must be within the scope of practice of the Dental Practice Act.

Similarly, commercial medical plans will pay for procedures performed by a dentist, provided they are properly coded as medical procedures. Medical plans pay for procedures that are medically necessary, that is, when the patient is medically compromised by a problem that the dentist treats.

For example, medical plans will pay for:

- Treatment related to inflammation and infection.
- Dental repair of teeth due to injury.
- Exams for orofacial medical problems.
- Extraction of wisdom teeth, under certain conditions.
- Extraction of multiple teeth at one time.
- Certain periodontal surgery procedures.
- Consultation for and excisional biopsy of oral lesions.
- Consultation and treatment for temporomandibular joint problems.
- Infection that is beyond the tooth apex and not treatable by entry through the tooth.
- Pathology that involves soft or hard tissue.
- Procedures to correct dysfunction.
- Emergency trauma procedures.
- Appliances for mandibular repositioning and/or sleep apnea.
- Congenital defects.

Medical and dental benefit designs are determined by the insurance company and the plan sponsor, which is usually an employer purchasing coverage for employees. Many plan sponsors want specific oral surgical procedures paid under their medical benefit plan. Coverage by the medical policy allows the preservation of dental plan benefits, which generally have a low annual maximum compared to medical plans. Under a medical plan's coverage, dental care can be accessed without exhausting the dental plan's annual maximum in one surgical appointment.

Coding systems

The key to successful claim filing is the correct use of codes to identify what treatment was provided, and in the case of medical claims, the reason the treatment was provided. Current Dental Terminology (CDT) are the code sets established by the ADA for identifying procedures provided to patients for oral treatment. The CDT codes are used when

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submitting claims to dental plans. Medical plans do not pay for treatment claimed as CDT procedures.

Current Procedural Terminology (CPT) is a listing of procedure codes used to describe medical treatment and used when submitting claims to medical plans. CPT codes are developed and maintained by the American Medical Association. The medical claim form is designated as CMS-Form 1500.

International Classification of Diseases (ICD) is the diagnostic coding system used with medical claims to describe the condition presented by a patient for which treatment was rendered. The current iteration of diagnostic codes is ICD-10. There are two types of ICD codes – ICD-10CM (Clinical Modification) and ICD-10PCS (Procedure Coding System). The CM codes are used for all health care settings, particularly outpatient care, while the PCS codes are used in hospital inpatient settings. ICD-10 codes are required as part of the 1500 medical claim form. ICD-10 codes are not required as part of the dental claim form, although the ADA claim form contains a field for placing diagnostic codes. This field is provided in anticipation of diagnostic coding used with dental procedures, but is not widely required by dental plans. ICD-10 is an alphanumeric coding system. Codes in the ICD-10 categories K00 to K95 describe diseases of the digestive system. This includes diseases of the mouth, including conditions treated by dentists.

A complete set of the ICD-10 codes are available on icd10data.com. ICD-10 codes associated with oral health conditions are also part of the appendix to the CDT Companion book published and updated annually by the ADA.

Obtaining medical claim forms

Medical claim forms may be ordered from the AMA bookstore at AMAbookstore.com under "insurance products." Some practice management software vendors provide the CMS-1500 form. Many commercial medical plans provide copies of the CMS-1500 form on their websites. Also, paper forms can be purchased at major office supply stores as well. Information on the CMS-1500 Health Insurance Claim Form, including instructions on completing the form, is available from the National Uniform Claim Committee at nucc.org.

This information is simply a brief introduction to billing medical plans. Beyond understanding dental/medical cross-coding, specific CPT coding, using diagnostic codes and navigating the CMS-1500 claim form, it is important to also become proficient at the use of "asterisk" codes, evaluation and management (E/M) codes, and modifiers to both procedure and diagnostic codes. These codes tell the insurer not only the nature of an injury, but how the patient got the injury.

In climbing the learning curve of medical billing, finding a training course that discusses all aspects of the process should be considered.

As the need for dental office staff to become proficient in medical billing increases, CDA will be providing new resources to help. For more information, contact CDA Practice Support at 800.232.7645.

Resources on the medical billing process

For now, the following resources will help to develop an understanding of the medical billing process. (Note: CDA does not endorse these resources, but provides this list as helpful resources for medical billing):

Standard 1500 medical claim form (nucc.org)

How to Accurately Fill Out the CMS-1500 Form for Faster Payment (https://www.youtube.com/watch?v=aNYtFee0q6A)

1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12 (nucc.org)

Introduction to CPT Coding (wasserman-medical.com)

ADA's CDT Companion (adacatalog.org or call to order at 800.947.4746)

CPT Coding (catalog.ama-assn.org)

ICD10 diagnostic codes (icd10data.com)

Cross Walking – A Guide Through the Cross Walk of Dental to Medical Coding (wasserman-medical.com)

NDAS Medical-Dental Coding & Fee Guide (ndas.com)

Medical/Dental Insurance Cross Coding & Billing Online Course (dentalpracticecareers.com)

AAOMS Coding and Billing workshop (www.aaoms.org)

Cross Coding and Medical Billing (vivalearning.com - 51 minute lecture available online)

Medical Billing Codes (medicalbillingcodings.org/)

Parking Pitfalls for Dental Tenants

By: Dale Willerton and Jeff Grandfield

Do you have enough parking spaces for your visiting patients, you and your staff? It's a common problem The Lease Coach sees with both new and established dental tenants. We've discussed the problems with parking in our new book, Negotiating Commercial Leases & Renewals FOR DUMMIES in greater detail but here are a number of factors to consider.

First and foremost, what is the availability of parking spaces? Does it appear that there are there enough stalls for all to use? Where are these parking spaces – in front of, behind or at the side of the building? Parking spaces located behind or beside your practice may not be conspicuously visible to visiting patients. Are the spaces "rush parking" (first-come, first-served) or assigned specifically for your practice's use? These "designated" parking spots are desirable and discourage others from taking your space(s). If your dental practice is located near a major grocery store, consider that the best available parking spots may be taken by food shoppers. Parking spaces located close to your door will be advantageous for seniors who do not like to or cannot walk too far.

For many dental tenants, parking is free. But for some, monthly parking charges for staff vehicles can range from $85/month to several hundreds of dollars per month. Even if you are prepared to pay for parking, don't assume it will be available. Consider any parking costs for visiting patients as well as the convenience factor – dental patients can't be expected to interrupt dental work being done to run out side to drop more money in the parking meter.

In our experience of working for dental tenants, we recall visiting a couple of tenants who had hired us to do a new lease in a property they had found and liked. When we arrived at the property, it was around 10:00 a.m. and the parking lot was already packed with other cars. We pointed this out and questioned just how busy would this same lot be after the vacant units were occupied with more tenants. With hearing this advice, these two tenants wisely decided it would not be in their best interests to pursue this leasing opportunity. In another case, we also remember a couple of other dentists who had been doing business for almost 18 years in the same property and hired us to negotiate their lease renewal. These two dentists were very frustrated that their landlord had converted the property's free parking lot into paid parking – this, of course, would cause greater inconvenience to visiting patients. Our message here is to never assume that your parking situation will always remain the same.

As some final words of advice, always assume that the only parking rights you will have are the rights you get in writing in your lease agreement. Also, remember that it is best if your patients can park in the best stalls while you and your staff can park elsewhere. Determine whether the landlord has a designated area for staff to park and whether there's a parking policy that the property manager polices or regulates. Smart landlords require both tenants and staff to provide their vehicle license plate numbers to the property manager for this very purpose. If the landlord or real estate agent tells you that all parking is first come, first serve, you may want to include a clause in the lease agreement stating that if (in the future) the landlord gives special parking rights or privileges to other tenants that they will have to give those same privileges to you. Parking is often used as an incentive by a landlord trying to attract new tenants, and landlords have been known to unfairly divvy up the parking to suit themselves or to attract other tenants.

Dale Willerton and Jeff Grandfield - The Lease Coach are Commercial Lease Consultants who work exclusively for tenants. Call 1-800-738-9202,e-mail DaleWillerton@TheLeaseCoach.com or visit www.TheLeaseCoach.com. For a complimentary copy of our CD, Leasing Do's & Don'ts for Dental Tenants, please e-mail JeffGrandfield@TheLeaseCoach.com..

Fitness 101 for Dentists:

How to Select Exercises that Improve Your Health — Not Make it Worse!

By: Bethany Valachi, PT, MS, CEAS

No one said you had to be an athlete to be a dentist, but the truth is that the delivery of dental care is extremely demanding on the body. Exercise is one of the most important interventions that dentists can implement to prevent injury and ensure a long & healthy career. However, what most dentists do not realize is that they are predisposed to unique muscle imbalances, and that certain generic exercises (that are not a problem for the general population) can throw a dentist into the vicious pain cycle. When dentists come to understand these muscle imbalances, the proverbial light bulb appears…"Ah, that's why I always had pain after that exercise."

Preventing work-related pain or disability among dental professions is rightfully a growing concern, as up to 81% of dentists and hygienists experience work-related pain in a 12-month period[1-4]. A natural tendency is to 'wait for the painful episode' before action is taken. Unfortunately, by this time, irreversible structural damage may have occurred.[5] Team members must therefore become advocates for their own musculoskeletal health and implement wise prevention strategies prior to the 'painful episode'. Developing balanced musculoskeletal health through proper strengthening exercise can help dentists avoid work-related pain, injury or early retirement.

Because dentists are predisposed to unique muscle imbalances, all exercise is not necessarily good exercise for dentists.

View the Video: "Why Dental Professionals Require Specific Exercise"
http://www.posturedontics.com/video_excercise_why_dentists.php

PAIN AND UNBALANCED MUSCLES

In order to perform the precision tasks of dentistry, the arms must have a stable base from which to operate. For example, the delivery of dental care requires excellent endurance of the shoulder girdle stabilizing muscles (especially the middle and lower trapezius muscles) for safe shoulder movement and working posture. These shoulder stabilizing muscles tend to fatigue quickly with forward head, rounded upper back and elevated arm postures—all commonly seen among dentists. When these muscles fatigue, other muscles (upper trapezius, levator scapulae and upper rhomboids) compensate and become overworked, tight and painfully ischemic.[6]

This muscle imbalance may result in 'tension neck syndrome', a frequently diagnosed disorder among dentists. Symptoms include pain, tenderness and stiffness in the neck and shoulder musculature, commonly with pain that radiates between the shoulder blades or up into the occiput. Dental professionals who perform strengthening exercise on these short, tight, ischemic muscles will usually experience a worsening of pain. (Fig 1). (However these exercises are not a problem for the general population who are not prone to the imbalance!)

Fig. 1 *Dental professionals can worsen painful muscle imbalances by strengthening the wrong muscles, such as the upper trapezius.*

EXERCISE TO CORRECT MUSCLE IMBALANCES

An effective exercise regimen for dentists will target specific shoulder girdle, trunk and back stabilizing muscles, without engaging the muscles that are prone to tightness and ischemia. This requires expert knowledge of dental ergonomics, biomechanics and kinesiology.

Studies show that heavy weight training is NOT protective against pain syndromes caused by prolonged, static postures, as in dentistry.[7] However, research shows that a method called muscular endurance training can help dental professionals reduce neck, shoulder and back work-related pain[7-10]. Developing the endurance of postural muscles of the trunk and shoulder girdle is key to preventing pain and injuries in dentistry.

TODAY'S DENTAL STAFF MEETS THE BALL & BAND

All of the exercises needed to correct dental professionals' muscle imbalances can be achieved with a simple Swiss ball and elastic exercise band. The Swiss ball has been an accepted therapy tool used by physical therapists worldwide for more than 30 years, and is utilized in many exercises that research shows help manage and prevent back pain.[11] Studies show that exercises performed on the Swiss ball elicit more muscle activity than when performed on a stable

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Fitness 101 for Dentists: Continued from page 15

surface.[12] The ball provides a safe and effective method for improving spinal health via endurance strengthening of the deep postural muscles, increasing coordination and balance, and improving flexibility of the spine. The elastic exercise band enables exercise that corrects shoulder girdle and upper body imbalances. The exercise ball and band are inexpensive and easy ways to perform effective workouts in the comfort of your own home, which, in turn, leads to greater adherence to your exercise program.

Following are examples of three exercises from the "Smart Moves for Dental Professionals On the Ball". Home Exercise DVD (Available at www.posturedontics.com Enter Discount Code OTB2016 upon checkout to receive Dental Dimensions special discount.)

Downward Squeeze

Helps prevent neck pain by correcting an upper/lower trapezius imbalance that is common in dental professionals. Position door anchor above head level. Loosely wrap band around both hands and position arms at sides, fingers pointing upward. Make sure the downward angle of the theraband is about 45 degrees. Pull navel to spine, holding this contraction throughout the exercise. Roll shoulders back and down, squeezing shoulder blades downward and together. Pause briefly and slowly return. Repeat 10-20 times. If you have discomfort, decrease the resistance of the exercise band.

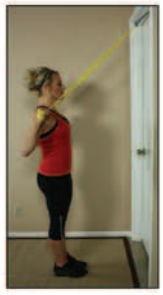

Fig. 2 Downward Squeeze

External Rotation

This exercise helps correct a painful muscle imbalance in the rotator cuff that frequently occurs among dentists due to elevated arm postures. With the door anchor at elbow height, stand at a right angle to the door holding a small pillow or rolled towel between your elbow and your body. Squeeze shoulder blades together, then slowly rotate the arm outward, then return. Keep the elbow pressed firmly against your side throughout the exercise. You should be able to perform 10-20 repetitions easily. Repeat with other arm.

Fig. 3 External Rotation

Pointer Dog Studies show that individuals who effectively utilize & train their natural 'back belt'—the tranverse abdominal muscles—have less low back pain.[14-15] This exercise targets 4 essential stabilizers in one exercise! Position yourself on hands and knees over the ball with your chin slightly tucked. Pull your navel up toward your spine and hold this contraction throughout the exercise. Make sure your back is flat and hips are level. Slowly lift the right arm, thumb pointing up, hold, then lower it. Slowly lift the other arm, hold, then lower. Repeat for the right and left legs. Continue to perform five lifts on each arm and leg. Advanced version: Lift the right arm and left leg together and hold. Make sure you are still contracting your lower abdominals! Repeat for opposite arm/leg.

Fig. 4 Pointer Dog

Conclusion

Embarking upon an exercise program requires prudence and discretion, considering team members' predisposition to certain muscle imbalances. Selecting improper exercises can lead to imbalance, ischemia, nerve impingement, and other pain syndromes. Developing balanced musculoskeletal health with a well-designed exercise program can help dentists prevent work-related pain, avoid injuries, extend their careers and improve their quality of life.

To receive the free article: "Exercises that can Worsen the health of Dental Professionals", please e-mail info@posturedontics.com.

Bethany Valachi, PT, MS, CEAS lectures internationally on the topic of dental ergonomics and wellness for dental professionals. She is author of the book, "Practice Dentistry Pain-Free: Evidence-based Strategies to Prevent Pain and Extend your Career" and clinical instructor of ergonomics at OHSU School of Dentistry in Portland, OR. Bethany can be reached at info@posturedontics.com.

Article references are available by e-mailing info@posturedontics.com

THREE QUESTIONS THAT PREDICT FUTURE QUALITY OF LIFE

BY: Tim McNeely

Once upon a time, 49-year-old Kate Holliday paid a visit to her family doctor. Kate had recently gone through a comprehensive medical checkup to assess the current status of her health and learn whether there were any health conditions she should be concerned about. Now that the results of the lab tests were in, she was revisiting her doctor for the final word. After going through the papers, her doctor said she was doing "fairly well" for her age.

Kate asked, "Doctor, with my current health status, and the good results you see there, do you think I could live to be 80?" The doctor asked, "Well, let's see, do you drink beer or smoke, even occasionally, Kate?"

"Oh, no I don't," Kate responded, "I've never done either."

The doctor asked, "Do you eat barbecued ribs or grilled steaks, then?"

"I've heard that red meat is very unhealthy, so I've not been a fan of those," Kate answered.

"Do you stay out in the sun for long hours, like when you're playing golf?" the doctor continued.

"No, I don't," Kate replied.

Then the doctor asked, "Hmmm, do you drive fast cars, then, relentlessly gamble or mess around with men?"

"No," said Kate, "I've done none of those things."

The doctor looked at Kate and asked, "Then why do you want to live to be 80?"

Does Kate's situation sound familiar? Like many people after the age of 45 or so, Kate would like to determine "what lies ahead." Aging, and aging gracefully, may mean different things to different people. Kate was curious and asked her doctor questions about aging after learning her medical results, without considering that her current health status is not the only thing that matters in living until 80. Kate overlooked her quality of life—whether her daily practices will bring her comfortably to the age she hopes to reach.

This is where the studies of MIT's AgeLab can help. MIT's AgeLab is a multidisciplinary organization and an integral part of the MIT School of Engineering, where it is housed. Its goal is to learn and capture the consumer preferences and demographic trends of those aged 45 and above and study how changes in demographics, technology and culture are impacting the way we do things. This information is then converted to workable goals to help promote trends in longevity, so that life spans will continue to increase. This is a strategy designed to help those who are living longer to live better.

MIT AgeLab has come up with new ideas to creatively translate technologies into practical solutions that will help improve people's health and enable them to accomplish things that give them a sense of fulfillment throughout their life span. With their scientific findings about consumer-centered systems, the study results provide platforms and means to understand the challenges and opportunities of longevity so that emerging generational lifestyles can catalyze innovation across business markets and individual lives. MIT AgeLab has identified a simple, three-step self-inquiry that can assess how equipped we are to live well in our retirement. To make its vision more tangible, AgeLab uses the symbols of a light bulb, an ice cream cone and a fork to represent what quality of life is all about.

Three questions were identified by AgeLab as being significant in uncovering important factors that help determine one's future quality of life and designing a sustainable retirement, and all three questions are related to retirement planning. When it comes to retirement preparation, we're likely to focus on accumulating assets and ensuring that we spend our money sensibly. Although it distresses us to think that we may outlive our wealth as we age, we generally overlook the fact that we have an even higher risk of not being able to do some basic things that will make us feel capable and fulfilled as we grow older. We may have less access to the big and small things that make us happy, we could lose our independence due to deteriorating health, and we will likely have fewer friends within our social circle who can bear with us as we age. The three questions we refer to, however, all relate to our personal agendas, or the manner in which we conduct our lives. The way we prioritize and cultivate our time each day determines the volume, complexity and velocity of our lives.

As we age, adapting to changing priorities may become more difficult than ever before. Balancing the needs of several generations—perhaps caring both for our children and

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THREE QUESTIONS THAT PREDICT FUTURE QUALITY OF LIFE - *continued from page 17*

for our parents while also working—can increase the "vol ume" up and down the generational scale. The complexity of our lives is determined by the different responsibilities we need to act upon and respond to every day as we attend to our families, to our work and to things that are of interest to us. Our adaptability in responding to all these changes and challenges, whenever needed, determines the velocity necessary to keep up with everything happening in our lives. All of these factors intertwine to provide us a weave of our possible arena, the manner in how we live our lives until we age in retirement.

Your financial advisor should integrate these issues into a comprehensive planning discussion. Thinking about how to live comfortably, both financially and in these other ways, can make an ambiguous retirement future—often decades away—more tangible to you and can help you commit to preparing for your retirement plan as early as today.

Three Questions to Lead You to a Quality Retirement

1. Who will change my light bulbs?

This may seem like a mundane household occurrence, but look closer: when you are 85, going up the ladder and changing a light bulb is not as humdrum as it used to be. This and other simple actions can pose a challenge as you age, and can become a source of frustration because you cannot accomplish on your own all that you previously could. And you might not have the available means to get service help easily when needed. Since help at home may be in short supply when we grow older, it is good planning to prepare for long-term home maintenance, even as simple as changing light bulbs, as early as now. Ask yourself, "Do I have plans for how to maintain my home when I get old and I am alone?" When we are younger, we take for granted our ability to clean, maintain and perhaps even repair our homes. But as we age, these can become major issues if we do not have the ability to maintain the house nor the means to get trusted service providers to help us in our daily chores.

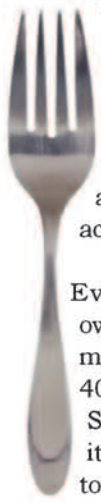
Identifying the possible costs of home modifications and trusted service providers needed to maintain the home is as critical a part of preparing for retirement as saving.

2. How will I get an ice cream cone?

Picture this ... a hot summer night, the perfect time to get an ice cream cone to cool you down a bit—and ooh, yes, chocolate it is. As you age, will you have the capacity and means to easily and routinely access the little joys that can bring you a smile? Quality of life often hinges on such simple joys, which may not be as easy for you to have as they used to be.

Transportation may be a challenge as your legs and your eyesight weaken. So while having an ice cream cone is not a financial stress, the means and method to get to your "cone"—or any simple joy, for that matter—may pose difficulty, strain or frustration if it is no longer as accessible to you as it used to be. By preparing for means or alternatives that will enable you to get your simple joys when you want them—like having your own transportation or living in a community that can support the kind of activity or enjoyment you want as you age—can give you a more comfortable and fulfilled life as you get older. Fun and enjoyment should be not only for the young, but also for the young at heart.

3. Whom will I have lunch with?



Lunch can be one of the most satisfying and gratifying occasions of everyday life—a short instance to celebrate togetherness and camaraderie with the people with whom you are at ease, are connected and have fun. These are the people who share your thoughts, aspirations and challenges, and who make your life healthy, active and profound.

Even if you are financially stable, living on your own without a robust round of social support can make life unhealthy as you age. Currently, over 40 percent of 65-year-old women in the United States live on their own. From these numbers, it's clear that planning where to retire and whom to spend your retirement with may be as imperative as knowing how much it'll cost. As much as you may want to retire in a home in the mountains, doing so may situate you with fewer friends, and you may eventually find yourself completely secluded and alone. But if you prepare

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yourself for a retirement that can bring you fulfillment in all aspects of your aging life, you will still be able to enjoy the chitchat and tête-à-tête the occasional simple lunch may bring.

Yogi Berra once said, "The future ain't what it used to be." As we grow older, that statement becomes more and more true. Thanks to the research of MIT AgeLab, we have three great questions to ask that can help us determine our quality of life as we age and prepare for a future that "ain't what it used to be."

Tim McNeely is a Certified Financial Planner™ who has advised hundreds of dentists on a wide range of personal, professional and financial questions and in the process has helped to simplify complex financial lives.

If you would like your free copy of the "Quality of Life Worksheet," or a Second Opinion on your complex financial life email tim@lifestonewm.com or call 818-534-4949.

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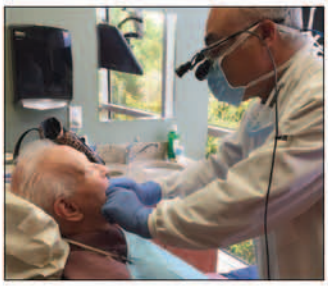
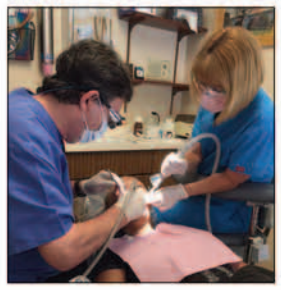
Geaorge Maranon, DDS
Jorge Alvarez, DDS
Mahrouz Cohen, DDS
Thomas Rennaker, DDS – Non-Member
Philomena Oboh, DDS
Gib Snow, DDS

Give Kids a Smile

Kahn Le, DDS
Anetter Masters, DDS
Roya Shoffet, DDS
Henide Arias, DDS
Kevin Gropp, DDS
Sarkis Aznavour, DDS
Randi Oyama, DDS
Hyungrim Oh, DDS
Basel Herbly, DDS – Non-Member
Ingrid Scoble, DDS



Smiles from the Heart

The San Fernando Valley Dental Society Foundation and the patients that have been served by its Smiles From the Heart program, wish to express their warm and heartfelt thanks to those members who have voluntarily worked to alleviate their pain and restore their dental functionality and smiles.

Mehran Abbassian, DDS - Valencia
Nooshi Akavian, DDS - Tarzana
Jorge Alvarez, DDS - Tarzana
Henide Arias, DDS - Reseda
Sarkis Aznavour, DDS
Rex Baumgartner, DDS - Newhall
Mahrouz Cohen, DDS - Encino
Martin Courtney, DDS - Northridge
Nita Dixit, DDS - Studio City
Mahfouz Gereis, DDS - Panorama City
Gary Herman, DDS - Valley Village
Birva Joshi Jones, DDS - West Hills
Andre Kanarki, DDS - Palmdale
Shukan Kanuga, DDS - West Hills
Kavian Kia, DDS - Encino
Bob Kogen, DDS - Newhal
Chi Leung, DDS - Glendale
Serge Lokot, DDS - Encino
Randy Lozada, DDS - Palmdale
George Maranon, DDS - Encino
Afshin Mazdey, DDS - Northridge
Jim Mertzel, DDS - Sunland
Jorge Montes, DDS - N. Hollywood
Philomena Oboh, DDS - Reseda
Sarah Phillips, DDS - Santa Clarita
Anita Rathee, DDS - West Hills
Teresa Romero, DDS - N. Hollywood
Phillip Sacks, DDS - Woodland Hills
Michael Seastrom, DDS - Tarzana
Michael Simmons, DMD - Tarzana
Gib Snow, DDS - Palmdale
Mark Stein, DDS - Encino

Our programs are looking for additional volunteers to help those in need. The Foundation pays all required lab fees and volunteers provide the expertise in their own offices. Call Wendy at the central office, 818.576.0116, to sign up and help a patient who has no means to pay for desperately needed dental treatment.

Call for Volunteers

The San Fernando Valley Dental Society Foundation is looking for a few good volunteers to help us meet our goal of serving the oral health needs of veterans and the uninsured, indigent and even homeless and elderly residents within the boundaries of our compnent.

The SFVDS Foundation will pay for all lab expenses required to save as many teeth as we can, and to restore our communities poorest members' dental health and functionality.

Both general dentists and specialists are needed, and if each volunteer can take just two patients per year (in the comfort of your own offices), we can make a dent in the oral health problems of our most needy residents who cannot otherwise afford dental treatment.

While our volunteer efforts can't solve the "Access to Care" problems in our community, we can alleviate pain and restore the dental functionality and self-image of those we do help.

Please contact Wendy at (818) 576-0116 or wendy.sfvds@sbcglobal.net and join in our efforts to 'change one life at a time!'

Legislative Committee Report

Continued from page 7

pay premiums for two years before any major procedure could be done.

I would ask you to inform your patients who may be considering purchasing an individual dental insurance policy, to let you help them review the policy before they purchase it, and compare what the cost would be if they purchased the policy or just paid their total out-of - pocket costs. I think we have an ethical responsibility to protect our patients.

OUR SOCIETY WILL SPONSOR A FORUM TO MEET THE CA STATE SENATE CANDIDATES FOR DISTRICTS 25 AND 27. I ENCOURAGE YOU TO BRING YOUR FAMILY AND FRIENDS TO ATTEND. SEE THE DETAILS BELOW.

As I have in the past, I encourage you to get involved in the political process. Become informed, meet the candidates, and VOTE.

Candidate Forum

The San Fernando Valley Dental Society will sponsor two open forums for: The 27th district state senate candidates, Steve Fazio and Henry Stern; and, The 25th district state senate candidates, Michael Antonovich and Anthony Portantino on Wednesday, September 28 starting at 7:00PM at our office in Chatsworth.

District 25 includes Glendale, Burbank, Pasadena, La Canada, La Crescenta, Sunland, Tujunga and the western portions of the San Gabriel Valley

District 27 includes Malibu, Simi Valley, a portion of Santa Clarita, the western portion of the San Fernando Valley (through Northridge, Reseda and Encino), and the eastern portion of Ventura County (Moorpark, Thousand Oaks, Agoura Hills, Oak Park and Westlake Village).

The forum will interview each candidate privately, with a presentation by the candidate and questions from the audience. Each interview will be one-half hour beginning at 7:00PM and terminating at 9:00PM

Friends and family are invited. I encourage you to bring your high school and older aged children to expose them to the political process. I encourage you to meet the candidates before you vote. Do not be persuaded by the negative literature, which is unfortunately, part of every campaign, or the designated "D" or "R" attached to the candidate.

Please text, email or call our office (818-576-0116) to let us know how many will attend, so we can set up the room with enough seating for everyone.

Antelope Valley Report

By: Kathy McKay

SCHOOL SCREENINGS
2016: Visited 12 Schools; screened approximately 2,500 4th grade students.

VETERANS DAY: We are gearing up … FREE dentistry for our vets.

CPR CERTIFICATION
Classes will be scheduled as needed. $35 per person Dental Discounted Price w/ $5 Donation to the SFVDS Foundation Minimum of 9 people per class (can be combined with other offices). CONTACT: Eric Sarkissian @ 661.273.1750.

DR. MELISSA NABORS hosted SFVDS' Schlep & Shred event.

ANTELOPE VALLEY CONTINUING EDUCATION SEMINARS - *JULY 19, 2016:* OSHA – INFECTION CONTROL SEMINAR
Learn the most current information about OSHA, infection control, medical waste disposal and more. Our Dental Infection Control seminar fully meets OSHA's annual BBP training requirements and the Dental Board of California's biennial requirement. The seminar is certified by the Dental Board of California for continuing education.
2 CE CREDITS • $35.00 INCLUDES DINNER
TIME: 6:00 PM • LOCATION: LANCASTER, CA

AUGUST 23, 2016: CALIFORNIA DENTAL PRACTICE ACT SEMINAR Learn about current licensing requirements and regulations, licensing renewals, auxiliaries, duties and permits, patient referral and compensation laws, disciplinary measures and more. Our California Dental Practice Act seminar fully meets and exceeds the California Dental Board training requirements for all licensed dental professionals on the subject of the Dental Practice Act. The seminar is approved by the Dental Board of California for continuing education.
2 CE CREDITS • $35.00 INCLUDES DINNER
TIME: 6:00 PM • LOCATION: LANCASTER, CA

For more information or to make a reservation:
Call: (661) 208-4749 or Fax (661) 945-4750

Glendale-Foothills Report

By: Chi Leung, DDS

On April 21, 2016, we had our first zone meeting in Glendale / Foothill area. The event was "Thinking about Buying a Dental Practice" and was held at El Torito in Burbank. There were 13 attendees and the presenters were Tim McNeely of Lifestone Wealth Management, Jerome French with Munn CPA's, Jason Schneller and Michael Anderson from Wells Fargo Bank. The event was very successful. It presented valuable information, especially for new dentists who want to look into buying their own dental office.

Welcome New Members

Aram Grigoryan, DDS
6058 Lankershim Blvd.
North Hollywood, CA 91606
818.424.5505
General
UOP, 2015

Dzhoni Avetisyan, DDS
814 E. Broadway
Glendale, CA 91205
818.726.8160

Shahrooz (Shawn) Matian, DDS
17200 Ventura Blvd. Suite 314
Encino, CA 91316
818.345.2227
General
USC, 2008

Richard Rojas, DDS
1154 E Palmdale Blvd.
Palmdale, CA 93550
661.947.2135
General
USC, 1980

Arlan Diamond, DDS
3935 Hollyline Ave
Sherman Oaks, CA 91423
818.406.3306
General
USCF, 1959

Martin Orro, DDS
22770 Soledad Canyon Rd.
Santa Clarita, CA 91350
661.259.9674
General
UCLA, 1981

Albert Mindel, DDS
22770 Soledad Canyon Rd.
Saugus, CA 91350
661.259.9674
General
UCLA, 1985

John Okuyama, DDS
23418 Lyons Ave
Newhall, CA 91321
661.260.0833
Orthodontics
Cayetano Heredia University, Peru, 1995

Benjamin Alyesh, DDS
General
Midwestern University, AZ, 2015

Malineh Arakelian, DDS
411 N Central Ave Ste. 120
Glendale, CA 81203
818.956.7137
General
USC, 1992

Kiumars Rahimi, DDS
28632 Roadside Dr. Ste. 270
Agoura Hills, CA 91301
818.706.6077
General
USC, 1987

Alice Chalian, DDS
1512 W Burbank Blvd
Burbank, CA 91506
818.843.1600
General • UCLA, 1985

Araceli Mandi, DDS
1620 W Magnolia Ave
Burbank, CA 91506
818.588.3075
General
University of the East, Philippines, 1991

Pierre Jojo Joven, DDS
2251 Colorado Blvd.
Los Angeles, CA 90041
323.259.3118
General
University of the East, Philippines, 1986

Regina Espinoza, DDS
20173 Saticoy St.
Winnetka, CA 91306
818.717.9066
General
UCLA, 2008

Maria Saguin, DMD
9800 Topanga Cyn Blvd. Ste J
Chatsworth, CA 91311
818.576.0600
General
Centro Escolar, Philippines, 1999

Shahram Azizian, DDS
13205 Osborne St. Ste. F
Arleta, CA 91331
818.890.2426
General
UOP, 1989

Cathrine Guerrero, DDS
Pediatric
Arizona School of Dentistry, 2014

Saeid Razi, DDS
27450 Tourney Rd. Ste. 260
Valencia, CA 91355
General
661.702.1900
UCLA, 1997

Aida Arasteh, DDS
General
Western University of Health Sciences, 2015

Ramin Moravveji, DDS
1616 N Verdugo Rd. Ste. 11
Glendale, CA 91208
415.794.4194
General
Loma Linda, 2015

CLASSIFIED ADS

Valencia general practice is looking for an Endodontist, 2-3 days per month. Please call 661.609.0540 for more information.

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Dentist wanted to start own practice and eventually merge into existing practice. Excellent Burbank area. Call for details. (818) 841-4695

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Lan Su, DMD, PhD, Diplomate, American Board of Oral & Maxillofacial Pathology
31332 Via Colinas, Suite 109 Westlake Village, CA 91362 Telephone: 818-865-1039 www.oralpathmed.com

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Woodland Hills practice desires associate dentist part time. Position has potential to lead to buy out/partnership.Well established office, digital.
Contact Susan: dr.susan@ymail.com

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

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