Bulletin of the San Fernando Valley Dental Society

Dental DimensionS

Winter 2020

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No 'One Size Fits All' When it Comes to Dental Benefit Contracting

Dental Benefit Plan Handbook

Insurance Review:

Prior Authorization VS Claims

2020 CDT Code Changes

New Legal Rules for 2020

Winter 2020
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Dental DimensionS

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9205 Alabama Ave., Suite B
Chatsworth, CA 91311
Office: (818) 576-0116
Fax: (818) 576-0122
E-mail: exec.sfvds@sbcglobal.net
Web Site: www.sfvds.org

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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.....

As the 2020 new year unfolds, members face increasing issues with dental benefit providers, which are explored in this issue.

Photo courtesy of: DentalIQ.com

From the Desk of the President

Chi Leung, DDS

Today I am honored to be the president of The San Fernando Valley Dental Society for the year 2020.

Challenges to our profession are numerous. The cost of dental education is increasing, which makes for increased debt for our dental students. The shifting of the practice model has been increasing - changing from private practice offices to corporate owned practices. Insurance payments for dental services have been declining which is affecting our professional income.

These challenges support our faith: Organized dentistry is the only way to strengthen our profession. ADA, CDA and your local component have been making great efforts to support our members. Our mission statement is to help our members flourish and succeed. The San Fernando Valley Dental Society has been a very strong organization. Our Membership Committee under the chair, Dr. Anette Masters' guidance, has focused on recruitment and retention. The result has been a steady increase in our membership numbers. Dr. Nita Dixit, the chair of our Leadership Development Committee, explores and develops programs to increase the pool of potential volunteer leaders. I believe we are just about the best team of delegates at the annual CDA House of Delegates because of our knowledge, intelligence and fully involved and educated delegates.

The success of the SFVDS cannot exist without our dedicated staff, Wendy and Bella. They are the force behind us. I could not be what I am today without board members' encouragement, support and guidance. To my staff, Lesly and Jenny, thank you for taking such good care of my office's daily activities during my absences. It is because of you that I am able adjust my work schedule to allow me to have the time to fulfill my volunteer tasks.

Finally, to my family, to my husband Tom, thank you for being my best friend and supporter. He is the one behind the scenes, but makes things happen. I never thought that as a woman coming from China, knowing nothing and only having a 3rd grade education, I could become what I am today without his support. My sons, Dennis and Evan, thank you for being in my life, my hope and my future. My life is full of joy because of you. I am proud and cheerful every day, knowing that your success and growth is the best path to manhood.

Trustee Report

Karin Irani, DDS

CDA is turning 150!
During the last 150 years, CDA has innovated and grown to become a community of 27,000 member dentists and is the largest state association in the ADA. Its rich heritage is filled with radical ideas that changed dentistry for the better. And it all began with just 23 founding dentists.

2020 marks CDA's 150 anniversary, Today, CDA is a dynamic enterprise that encompasses the association, a nonprofit foundation, a dentist-centric insurance company and an e-commerce dental supply company.
A judge has issued an initial ruling in FTC case against dental suppliers accused of conspiracy:
An administrative law judge has partially ruled in favor of the Federal Trade Commission's complaint that dental products distributors conspired to not provide discounts to buying groups. The judge's initial decision held that two of three respondents named in the complaint, Benco Dental Supply Company and Patterson Companies Inc., violated U.S. antitrust laws by conspiring to refuse to provide discounts to, or otherwise serve, buying groups representing dental practitioners

The CDA Board of Trustees met in October, 2019 and discussed a number of items. Highlights of the meeting included: (Refer to CDA.org for a copy of all reports)

- Dental Benefits and Economics Task Force report: In fulfillment of the 2017/2018 house directives, the dental benefits and economics task force addressed dental insurance and practice economics issues to make recommendations as to how CDA can assist members in responding to the ever-changing environment.
- Medicare Task Force Report: In 2018, the house directed CDA

Legislation Report

Jorge A. Alvarez, D.D.S.

Happy New Year to all of you!

The year 2020 will bring us a lot of electoral legislative action. Starting, on March 3, 2020, elections will be held for Los Angeles City Council seat numbers 2,4,6,8,10,12 and 14, and Los Angeles Unified School Board races, as well as the primary presidential election, this year set to happen in March instead of June, bringing California to the forefront of national politics.

On November 3, 2020 the general election is expected to be one of the most contested in years. 2020 is to be a significant year to be involved in knowing the candidates in local, state and federal levels. Our component will try to invite local and state candidates to our central office for fireside chats with them.

On Tuesday November 5, we hosted a meeting with Dr. Loraine Lundquist, candidate for City Council District 12. The meeting took place at our component central office, where Drs. Masters, Jensvold, Gereis, Snow, Bassali, Alvarez and Executive Director Ozols were present.

Points of our conversation were:
How expensive it is getting to open and operate a business in the City of Los Ángeles; longer times waiting for construction permits in relation to other neighborhood cities; the homeless dilemna and how Los Angeles City leaders are paralyzed and seemingly do nothing to solve the problem; and, Dr. Lundquist being a career environmentalist, our conversation included water use and retention.

Our guest, graciously spent quite a bit of time trying to cover all of the issues we discussed. Remember, the election for District 12 is on March 3, 2020.

The following are some of the state legislative actions to dentistry, supported or sponsored by CDA:

AB 1519: Direct-to-Consumer Orthodontic Protections & Dental Board Sunset Review – Support

Also known as the sunset review bill, AB 1519 extends the operation of the dental board for four years and makes a number of related policy changes. Among other provisions, the bill sets a single standard of care by requiring that dentists providing orthodontics review radiographs (X-rays) prior to the move ment of teeth. Additionally, the bill preserves patients' ability to file complaints with the Dental Board of California. The bill also requires dentists who use teledentistry, such as the direct-to-consumer model, to disclose information about their license number and dental board contact information to their patients, similar to the existing mandate for brick-and-mortar dental offices.

Providing dental care that involves the movement of teeth without a proper evaluation can lead to serious patient harm, including loose or cracked teeth, bleeding tongue and gums, gum recession or a misaligned bite. With the emergence of new direct-to-consumer business models offering various dental services that are ordered without an in-person clinical examination, it is imperative that dental treatment continues to meet a uniform standard of care regardless of whether a dentist provides treatment in person or through teledentistry. The provisions in AB 1519 ensure that telehealth advancements continue to grow in a thoughtful way that puts patient safety first and is as effective as in-person treatment. These new requirements take effect January 1, 2020.

AB 954: Dental Plan Network Leasing – Sponsor

CDA sponsored AB 954 (Wood) in 2019, which passed the legislature with unanimous support and was signed by the governor. The bill requires dental benefit plans to be more transparent about the common practice of "leasing" access to a network of contracted dentists from another dental benefit plan. The growing trend of network leasing is causing confusion and difficulties for California dentists and their patients. Some dentists want the benefits that can come with network leasing, such as increased visibility and patient retention. However, the disadvantages are that oftentimes dentists who signed contracts with one dental plan aren't aware that their contract is being sold or which plans they have been sold to, nor is the purchasing plan required to comply with the terms the provider and the original plan agreed to. Additionally, there is no requirement for the dental plan that is leasing its network to communicate with the purchasing plan to make sure that a dentist who opts out or cancels their contract is taken off the leased network. Lack of transparency in network leasing can cause confusion for patients and dentists, making it difficult for providers to educate patients about treatment options and the cost of care. Dentists need to know whether they are in network or out of network when working with a patient to determine their share of the costs, and dentists must be able to easily locate the terms of a new contract to know important limitations on services, waiting periods, how treatments are categorized and co-payment rates.

AB 954 makes several changes to address this, including: 1) requiring dental plans to clearly identify a contract clause allowing network leasing; 2) maintaining an up-to-date website list of all third parties that have access to a provider network contract; and 3) giving dentists the ability to opt out. The bill will provide clarity for both patients and providers, reduce con fusion and help preserve trust in the dentist-patient relationship.

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Legislation Report

Continued from page 5

SB 154: Silver Diamine Fluoride – Sponsor

CDA sponsored SB 154 (Pan) in 2019 to add silver diamine fluoride (SDF) as a Medi-Cal benefit for treatment of dental decay when applied as part of a comprehensive treatment plan. SDF is a topical medication used to slow down or stop cavities in both primary and permanent teeth. The use of SDF is a non-surgical approach to treating dental decay, as it does not require local anesthetic and can be applied quickly and painlessly. SDF is a colorless liquid that contains both silver and fluoride; although it stains the decayed portion of a tooth, it is becoming more widely used, especially in posterior and primary teeth. In California, Medi-Cal is already using SDF as part of a broader pilot project in 29 counties to manage dental decay in children younger than 6 years old.

Recent studies of Medicaid expenditures in six states show an average savings of $100 to $350 per child treated with SDF. This could translate to $10 million to $30 million in annual savings for California's Medi-Cal program. SDF is a proven effective tool worldwide in managing cavities and the serious health problems associated with unmanaged dental decay and is now being shown to provide significant cost savings for public health insurance programs. While SDF may not fully eliminate the need for additional care, it gives Medi-Cal providers a new and effective tool to treat dental decay among the growing Medi-Cal population. SB 154 passed out of the legislature with unanimous support but was vetoed by Gov. Newsom due to its costs to the state. CDA is continuing to work with his administration to secure budget funding for this effective, non-invasive and low-cost tool to treat dental decay.

Sugar-Sweetened Beverages (SSBs)

CDA and the California Medical Association are leading efforts to reduce SSB consumption and have launched a campaign — Soda's Sticky Business — highlighting the industry's deceptive marketing tactics targeting children and low-income and minority communities. CDA and CMA introduced three bills in 2019 that would reduce the consumption of sugary beverages including soda, energy drinks, sugar-added juices and sports drinks:

- AB 764 (Bonta) will limit promotional pricing incentives used by the beverage industry to heavily subsidize discounts on SSBs.
- AB 765 (Wicks), the Healthy Checkout Aisles for Healthy Families Act, will prohibit placement of SSBs near the check-out counter at supermarkets, large grocery stores and warehouse clubs.
- AB 766 (Chiu) will ban the sale of unsealed beverages larger than 16 ounces at food-service establishments.

SSBs are the single largest source of added sugar in the American diet and a primary cause of various health conditions including tooth decay, which affects more than two-thirds of California children (making it the most common chronic childhood disease). The frequency of consumption along with the combination of high levels of sugar and acid make these beverages uniquely damaging to teeth and overall health. Sport, energy and soft drinks are leading to unprecedented levels of decay and loss of tooth enamel for a new generation of youths and young adults. The overconsumption of sugary, acidic drinks is reversing more than 50 years of public health gains realized through preventive measures such as fluoridated water and dental sealants. CDA also supports AB 138 (Bloom), which creates a tax on the distribution of SSBs, and SB 347 (Monning), which will require a warning label on sugary drinks to help educate consumers as they make their purchasing decisions. All of these pieces of legislation are now two-year bills and are up for reconsideration in 2020.

General Meeting Review

Tom Viola, RPh, CCP

November 20, 2019 – Pharmacology Declassified: An Overview and Update for Dental Professionals

Tom Viola, R.Ph,C.C.P. drew from his 30 years' experience as a pharmacist, dental educator and author offering an entertaining and complete overview of the principles of dental pharmacology. Attendees learned to master the art of tailoring dental therapy to patients' existing medical conditions while avoiding potential complications.

General Meetings Preview

A Quick Look at 2020's first half schedule

February 19	CA Dental Practice Act & Infection Control	Diane Arns, RDH
March 25	Bone Grafting and Implant Success	Alina Krivitsky, DDS & Sam Alawie, MDT
April 22	Adhesive Dentistry	Gerard Kugel, DMD, MS, PhD
May 2 (Hands-On)	3D/Digital Dentistry	August DeOliveira, DDS

Insurance Review:
Prior Authorization VS Claims

Dentistry is an ever-changing, constantly evolving profession with many moving parts to consider, both from the clinical and business points of view. Understanding how a patient's dental insurance plan affects and interacts with a dental office is a critical factor in creating and maintaining a successful dental practice. In this article, we will discuss the differences between a prior-authorization vs. a claim; the most common reasons a claim or prior authorization is denied; and strategies to avoid potential delay or denial of proposed treatment. We will also discuss the role that a Dental Benefits Administrator (DBA) plays in this process and the types of services they provide.

Prior Authorization vs. Claim

Prior Authorization

Depending on a patient's type of insurance plan, certain procedures require Prior Authorization (PA), meaning approval of a proposed treatment before the patient receives the care. An approved PA provides advanced approval for the service. If the treatment provided reflects the approved PA, the claim should be paid without any further documentation. But if the treatment provided differs from the PA, then additional documentation may be required prior to payment of the claim.

Claim

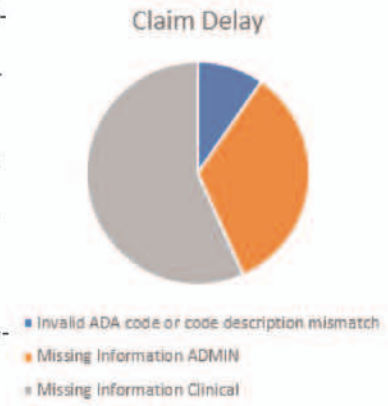
A claim is a request for payment and can be submitted to the DBA from either the provider or the patient. Regardless of whom submitted the claim, the following information is required: patient's name, date of birth, address, provider's name, provider's NPI, provider's EIN, rendering office address, treatment details including current year CDT code, procedure description, tooth, surface and any supporting clinical evidence or narrative that may help expedite claim payment. Failure to send all required information may result in a delay or denial of a claim. To help ease the administrative burden of claim submission, DBA's have multiple ways that claims can be submitted including electronically using a clearinghouse partner, secure e-mail, fax and paper submission. Most DBA's offer a direct web portal where dentists can send claims and claim attachments electronically, without using a clearinghouse. When possible, electronic form of submission is recommended to ensure x-rays are diagnostic.

Determining which dental services require Prior Authorization or Claim level review is based on number of factors, including:

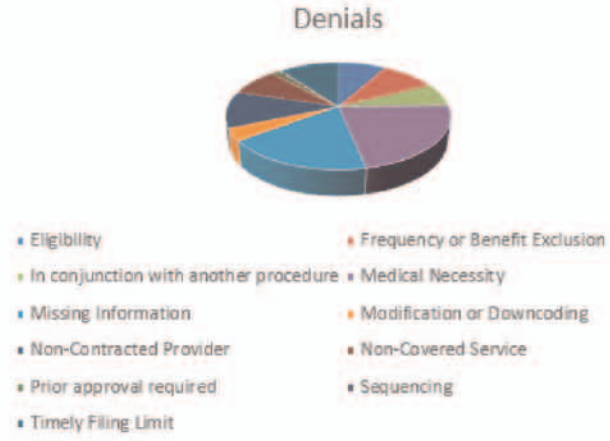
- Clinical Standards of Practice: The clinical criteria and guidelines (CCG) developed and used by appropriately state-licensed dentists employed by a DBA to determine the medical necessity decision-making process and ensure all decisions are based on sound, clinical evidence.
- External guidelines used to develop CCG's: Organizations such as the American Dental Association, and guidelines published by recognized dental specialty organizations.
- Adherence to State and Federal guidelines.
- Peer Review Committee: Review and update the clinical criteria and guidelines at least yearly and more often, as needed. Should consist of network dentists and DBA clinical team of licensed dentists.

Potential Areas for Delay or Denial of a Claim

Claim delays are typically related to the DBA's need to request additional or clarifying information from the dentist. Commonly, missing clinical information such as diagnostic x-rays, photographs, periodontal charting, or narratives that help the reviewing dentist approve the PA or claim payment is to blame for a delay. Since the DBA's reviewing dentists do not have the benefit of having the patient in the chair, they rely solely on the information submitted from the treating dentist. The more information submitted, the better chance the claim will be paid in a timely manner. Other causes for delays are related to non-clinical information such as other coverage, change of providers Employer Identification Number (EIN) or Tax Identification Number (TIN), and place of service.



Claim denials may be directly linked to claim delays. Denials for missing information is near the top of all claim denial reasons, with the leading reason being medical necessity or "lack of supporting evidence." These two reasons make up almost half of the overall denied payments. Data shows other leading denial reasons to be claims submitted outside of the timely filing limits, non-covered procedures, denials for frequencies or benefit exclusions, prior authorization requirements, and patient eligibility.



DBA's receive a surprising number of refund checks from offices where the dentist intended to submit prior authorization, however the office staff mistakenly submitted a dated claim. Often, the date of service on this type of claim is the date that the office staff prepared the PA. This accounts for about 75% of all refunds. Other reasons include DBA staff processing errors and retro eligibility terminations for states that mandate claim recoupment.

Strategies to avoid delays and/or Denial(s) of claims

There is nothing more frustrating than completing a procedure only to have the payment denied or delayed. To avoid this scenario, it is important to understand how the process works.

Dentists and patients should be educated by the Dental Benefits Administrator about Prior Authorization and Claims requirements, including which procedures fall into this category. Avenues to achieve this include:

- Provider Reference Guides (PRG) and Benefit Plans that reflect all plan requirements, including detailed explanations of covered services, limitations and exclusions, and pre-service authorization requirements, processes, and timelines.
- New Dentist and Patient Onboarding, including service visits for network dentists and welcome packets and/or welcome calls for patients.

What you should expect from Your Dental Benefit Administrator Partners

A Benefit Dental Administrator should be a trusted partner in providing quality services to you and to your patients. While it is your responsibility as the doctor to diagnose and treat patients based on your training and expertise, the DBA is responsible and should strive for, continuous improvement in the service delivery and quality of clinical dental care provided to patients. Among other things, a DBA should ensure:

- Accessibility of care
- Appropriateness of care
- Continuity of care
- Effectiveness of care
- Safety of the care environment
- Patient satisfaction (from the dentist and the DBA itself)
- Dentist satisfaction (with the DBA's administrative and service coordination services)
- Operation measurements and improvement (ongoing monitoring and improvements on all levels of service).

Dentist Engagement

Communication is vital to creating a trusted, lasting, and mutually beneficial bond. If the goal is a partnership, then continuous engagement by the DBA with the dentists in network is a necessity. This is achieved via regular in-person and telephonic outreach between the dentist and the DBA's Clinical and Provider Relations teams.

Clinical Outreach

Collaboration between a competent clinical team and the dentists providing care is a key component in creating a positive relationship between the two parties. As a participating dentist in any network, you should be given the opportunity to speak with your peer colleagues from the DBA's Clinical Team. Engaging network providers and making themselves available to discuss issues or questions that arise should be a priority of all DBA clinicians. Understanding the clinical decision making that went into the review of a submitted claim/PA is important and dentists should be provided the opportunity to speak with the clinicians who make those decisions. All dentists who are employed by a DBA and involved in making determinations on a Claim or PA should be appropriately licensed and meet all federal, state, and regulatory guidelines.

Responsibilities of a DBA Clinical Team

Prior Authorization and Claims level review of services: Oversee and make determinations on the medical necessity and appropriateness of care for clinical services.

By: Dr. Todd Gray and Ms. Michelle Crum

Utilization Management: Monitor and review service patterns, including over and under-utilization of services, identifying treatment patterns for analysis, and ensuring that all Utilization Management (UM) decisions are made in a timely manner which accommodates the urgency of the situation and minimizes disruption in the provision of care.

Peer Review: Reviewing authorizations and patient records for appropriateness of care, patient and provider grievances, and identifying and investigating trends of questionable care. When necessary, a Peer Review Committee consisting of both DBA clinicians and non-employed network dentists should review cases of questionable care and/or complaints and resolve any issues in a fair, non-biased manner. Peer Review clinicians are also responsible for the development, updating, and maintenance of the Clinical Criteria and Guidelines used for making medical necessity decisions.

Collaborate/Communicate with Network Dentists: Whether on a Peer to Peer call, or in person, clinicians should be available to speak with network dentists on a regular basis.

Provider Relations

Provider Relation (PR) teams consist of Network Managers who serve as the primary point of contact network providers and provide personalized customer service. The goal of an effective PR team should be to provide excellent service, build, and maintain strong partnerships. The dental office team should be familiar and comfortable with their Network Manager and able to contact the rep whenever issues arise. Functions a PR team should provide:

- Provider focus groups, used to identify dentist's concerns.
- Dental Advisory Committees, providing a forum for dentists to receive information about the DBA and provide input.
- Annual dentist surveys, measuring satisfaction.
- Electronic communication and outreach through newsletters, email alerts, fax blasts, and online Provider Portal content.
- Dentist training(s), given by Network Managers or Operations Staff either one-on-one, through group trainings, or webinars

Establishing a good relationship with the dentist will benefits all parties- the dentist, the DBA, and the patients by ensuring timely solutions to problems or issues that may arise.

Dentistry is a unique and rewarding career that allows an opportunity to have a direct and positive impact on the lives of those in our communities, while also challenging us to learn and grow professionally. To be effective, one must be willing to continuously adapt to the inevitable changes from both a clinical and business perspective. Having a Dental Benefits Administrator as a trusted partner is an essential piece to ensuring success.

Authors:
Dr. Todd Gray is the Chief Dental Officer and Senior VP of Quality Management for LIBERTY Dental Plan
tgray@libertydentalplan.com

Ms. Machelle Crum is the Vice President of Claims for LIBERTY Dental Plan
machellem@libertydentalplan.com

Dental plans are multi-faceted. There are various types of plans such as PPOs, DHMOs, indemnity plans, or point of service plans, to name a few. Plans can be financed in different ways, such as by an insurance company or an employer group. Another dimension to dental plans is their design — which can be traditional, dollar-based, preventive only/limited benefit, or cafeteria plans/section 125 plans.
Traditional plan designs are commonly used in indemnity and PPO plans. Dollar-based plans are plans in which benefits are stated as a maximum dollar limit per year per eligible individual, or a percentage thereof. Direct Reimbursement is a type of dollar-based dental plan.

A cafeteria plan is an employee benefit program established by an employer for employees that meet the specific requirements of, and regulations of, section 125 of the Internal Revenue Code. A cafeteria plan allows employees to pay for certain qualified expenses (such as health insurance premiums) on a pre-tax basis, thereby reducing the employee's taxable income and increasing the employee's take-home pay. The funds that are placed in these accounts are not subject to federal, state or Social Security taxes.

Health savings accounts were created to provide tax-advantaged alternatives to traditional medical plans. In essence, a health savings account is a savings account that permits employees to pay for necessary medical care and expenses with tax-free dollars. Employees must obtain coverage through a high deductible health plan (HDHP) in order to participate in an HSA.

A health reimbursement arrangement is an employer-funded account set up for employees. The money in an HRA can be used to pay for qualified medical expenses not covered by a healthcare plan.

A flexible spending account is one of several tax-advantaged financial accounts that can be established through a cafeteria plan of an employer. An FSA allows an employee to set aside a portion of his or her earnings to pay for qualified expenses as determined by the cafeteria plan, most often for health care expenses, but also for dependent care or other expenses. The money deducted from an employee's pay into an FSA is not subject to payroll taxes, which could also create a huge savings in payroll taxes for the employer.

Learn more about the various dental plan designs by downloading the entire publication, Dental Benefits: An Introduction, which also includes information about the management of dental plans, communicating with third-party payers, handling coordination of benefits and more.

Types of Dental Plans

With so many dental benefit plans available to patients today, it's important to learn the differences between them. Some plans require your dental practice to be part of a network, others limit maximum charges and many have set fees for specific services.

1. Preferred Provider Organizations (PPO)
A PPO plan is regular indemnity insurance combined with a network of dentists under contract to the insurance company to deliver specified services for set fees and according to the provisions of the contract.
Contracted dentists must usually accept the maximum allowable fee as dictated by the plan, but non-contracted dentists may have fees either higher or lower than the plan allowance.

2. Dental Health Maintenance Organizations (DHMO)/Capitation Plans
Under a DHMO or capitation plan, contracted dentists are "pre-paid" a certain amount each month for each patient that has been designated or assigned to that dentist. Dentists must then provide certain contracted services at no-cost or reduced cost to those patients. The plan usually does not reimburse the dentist or patient for individual services and therefore patients must generally receive treatment at a contracted office in order to receive a benefit.

3. Indemnity Plans
An indemnity dental plan is sometimes called "traditional" insurance. In this type of plan, an insurance company pays claims based on the procedures performed, usually as a percentage of the charges. Generally an indemnity plan allows patients to choose their own dentists, but it may also be paired with a PPO. Most plans have a maximum allowance for each procedure referred to as "UCR" or "usual, customary and reasonable" fees.
4. Direct Reimbursement (DR®)
Benefits in this type of plan are based on dollars spent, rather than on the type of treatment. Direct Reimbursement is a self-funded plan that allows patients to go to the dentist of their choice. Depending on the plan, the

patient pays the dentist directly (or the benefit may be directly assigned to the dental office) and then submits a paid receipt or proof of treatment. The administrator then reimburses the employee a percentage of the dental care costs. With some plans there are no insurance claim forms to complete and no administrative processing to be done by the dental office or an insurance company.

5. Point of Service Plans
Point of service options are arrangements in which patients with a managed care dental plan have the option of seeking treatment from an "out-of-network" provider. The reimbursement to the patient is usually based on a low table of allowances; with significantly reduced benefits than if the patient had selected an "in network" provider.

6. Discount or Referral Plans
Discount or referral plans are technically not insurance plans. The company selling the plan contracts with a network of dentists. Contracted dentists agree to discount their dental fees. Patients pay all the costs of treatment at the contracted rate determined by the plan and there are no dental claim forms to file. Originally these plans were sold to individuals; however, more and more employers are purchasing these types of plans as the dental plan for the company's employees.

7. Exclusive Provider Organizations (EPO)
Exclusive provider organization plans require that subscribers use only participating dentists if they want to be reimbursed by the plan. These closed panel groups limit the subscriber's choice of dentists and also can severely limit access to care.

8. Table or Schedule of Allowances Plans
These types of plans are indemnity plans that pay a set dollar amount for each procedure, irrespective of the actual charges. The patient is responsible for the difference between the carrier's payment and the charged fee. The plan may also be paired with a PPO that limits contracted dentists to a maximum allowable charge.
To learn more, download the entire publication: Dental Benefits: An Introduction. Created by the ADA's Council on Dental Benefit Programs, it includes information about the management of dental plans, communicating with third-party payers, handling coordination of benefits and more.

Typical Dental Plan Benefits and Limitations

Dental benefits vary widely between carriers, but there are certain restrictions and limitations that are fairly common. These include preexisting conditions, annual maximums, and managed care cost containment measures.

Some group health plans restrict coverage for dental conditions that are present before an individual enrolls in the plan, such as missing teeth. These restrictions are known as "preexisting condition" exclusions. If a plan imposes preexisting condition exclusions, the length of the exclusion must be reduced by the amount of any prior creditable coverage. Most coverage can be considered creditable coverage, including group dental coverage, COBRA continuation coverage, or coverage under an individual dental policy. Dental plans may use the terms "Usual, Customary, and Reasonable" (UCR) to determine the portion of the dental treatment fee they are willing to pay for a particular procedure. However, the words usual, customary and reasonable are not interchangeable and UCR is a misleading acronym. UCR is actually three different concepts, not one. Usual fees are determined by the dentist. The fee the insurance company determines to be customary may be lower than the area dentists' usual or reasonable fees for the same service. There is no universally accepted method for determining the customary fee schedule, which may vary a great deal among plans, even when those plans operate in the same area. So, the benefit paid will generally be based on a percentage of the insurance company's customary fee schedule. Patients often do not know what their out-of-pocket costs will be because third-party payers generally do not release these customary fee schedule maximums to the public.

Many dental plans feature a total annual maximum – a maximum dollar amount that may be reimbursed each year, even if the patient's dental costs exceed that limit. These totals can be based on individual or family maximums.

Cost containment measures are features of a dental benefit program, or of the administration of the program, designed to reduce or eliminate certain charges to the plan. Dental plans should disclose information on how cost containment measures are used, or how they will affect the claim being considered.

Managed care dental plans are health plans that integrate the financing and delivery of health care services to covered individuals by means of some or all of the following:
• Arrangements with selected providers to furnish services to members
• Defined criteria for the selection of dental care providers
• Significant financial incentives for members to use contracted providers

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- Procedures associated with the plan, subject to limitations and exclusions
- Formal programs for quality assurance and utilization review

Dental Plans - Coordination of Benefits

One area of dental benefits that can cause some confusion is coordination of benefits (COB). COB takes place when a patient has more than one dental plan and is able to use both of them to cover their dental procedures. When this occurs, the two plans work together to coordinate benefits to eliminate over-billing or duplication of benefits.

What happens when both plans have COB provisions?

- The primary plan is the one in which the patient is enrolled as an employee or as the main policyholder.
- The secondary plan is the one in which the patient is enrolled as a dependent.
- State laws and regulations often mandate coordination of benefits, but plan sponsors should be certain that the selected plan specifies its method of coordination.

How does COB work with dependents?

- The policy that pays first for dependents depends on the rules of the insurance company or state laws.
- The typical protocol for dependents whose parents have overlapping coverage is to follow the birthday rule: The parent whose birthday is earlier in the calendar year is primary.
- In the case of divorced/separated parents, the court's decree would take precedence.

When does the secondary policy pay?

- Usually, the secondary policy will not accept a claim until after the primary claim is paid, and then the secondary policy will often require a copy of that payment information (referred to as an explanation of benefits, or EOB).
- In addition, state laws and regulations often mandate coordination of benefits.
- Plan sponsors should be certain that the plan they select specifies its method for coordinating benefits with other plans.

ADA Guidance on Coordination of Benefits can be downloaded online. The ADA recommends that patients impacted by these policies consult with their human resources department to determine their entitled level of benefit prior to treatment.

FREE TO MEMBERS OF SFVDS/CDA

Dental Benefit Plan Handbook

Dental Benefit Plan Handbook - Chapter 1
Understanding Dental Benefit Plan Coverage
In order to help a patient maximize dental plan benefits, both the staff within the dental practice and the patient should understand the type of services covered by the patient's plan, specifically, the plan's limitations and exclusions. This section is intended to educate you on the many types of dental coverage and the differences between dental and medical coverage, in order to aid you in explaining dental coverage to patients.

Dental Benefit Plan Handbook - Chapter 2
Understanding Dental Benefit Plan Contracts & Fees
This chapter defines the types of plans to consider for your practice, contract analysis, how to establish fees and much more!

Dental Benefit Plan Handbook - Chapter 3
Verification and Explanation of Dental Benefit Coverage
The process of verifying dental benefit coverage with a patient's plan and providing explanation to the patient is one of the most critical first steps in building a trusting relationship with a patient. Patients rely on the dental practice to help them not only maximize their dental benefit coverage, but also interpret their plan benefits, limitations, exclusions and financial responsibility.

Dental Benefit Plan Handbook - Chapter 4
Understanding Coordination of Benefits
Every carrier or dental benefit plan has a policy to coordinate the payment of benefits when enrollees or policyholders have more than one company insuring them. Additionally, this chapter will explain the California law pertaining to coordination of benefits.

Dental Benefit Plan Handbook - Chapter 5
Working with Patients and Their Plans
Part of every practice's new patient process is to help patients understand the relationship the practice holds with dental benefit plans. Whether the provider particaptes with the patient's plan or not, every provider faces the question of "Do you accept my insurance?" and should be prepared to not only answer this question, but guide the patient through the steps of verifying eligibility and explaining how the practice works with dental benefit plans.

Dental Benefit Plan Handbook - Chapter 6
Completing and Filing the Claim Form
With the patient's eligibility verified, their benefits estimated or determined and the treatment completed, it is now time to complete the claim form.

Dental Benefit Plan Handbook - Chapter 7
Billing Medical Plans
This chapter will help you select the correct CPT code and ICD-10 codes when billing medical plans.

Dental Benefit Plan Handbook - Chapter 8
Explanation of Benefits
Congratulations! The dental plan has paid your claim. Understanding the elements of the Explanation of Benefits and what to look for.

Dental Benefit Plan Handbook - Chapter 9
Managing Payment Problems
Claims denials are certainly a nuisance to a dental practice. There are some ways to reduce or avoid denials for administrative omissions. It is always best to make sure the claim was submitted correctly before pursuing the appeals process. Be sure to review Chapter 6 to avoid common pitfalls for claim denials.

Dental Benefit Plan Handbook - Chapter 10
Understanding the Claim Appeal Process
By legal mandate, California requires every dental plan to have a formal procedure that network providers can use to challenge adverse payment practices or specific payment decisions. Know the proper steps in appealing a claim.

Dental Benefit Plan Handbook - Chapter 11
Understanding Dental Benefit Plan Audits
Dental plans conducting quality assessment audits in dental offices is a common occurrence. It's often asked, "What will the auditor look for? Can auditors access patient records? What if the assessment finds deficiencies?" This chapter will help you understand dental plan audit authority.

For additional information, please contact Cindy Hartwell at CDA, 916.554.5941, cindy.hartwell@cda.org

Dental Benefit Plans
Coverage through dental benefit plans is one of the primary ways patient care is funded, and the ability to navigate the dynamic world of dental benefit plans is one key to managing a smart practice. Use the resources included here to learn how to navigate the unique requirements of provider agreements, manage and file dental claims efficiently and effectively, improve your understanding of your appeal rights as a dentist and more.

Dental Benefits Issue Submission
Challenges with claim delays, denials and miscommunications? As a benefit of CDA membership, you can now share your issues working with dental benefit plans through a form that's easy, quick and secure.

Log in to submit a Dental Benefits Issue Submission Form online at any time for expert analysis, evaluation and next steps. This new process enables Practice Support analysts to better facilitate resolution of your specific issue, while giving CDA a better view of the type and amount of benefits plan challenges faced across the membership.

To submit a form as a practice team member on behalf of a CDA member-dentist, call Practice Support at 800.232.7645 for assistance.

No 'one size fits all' when it comes to dental benefit contracting It's a personal business decision

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CDA Practice Support receives calls from dentists who are considering adding or dropping participation with a dental benefit plan/network. The same question comes up repeatedly in these conversations: "Have you heard of a dentist who joined or dropped their participation with a dental benefit plan and experienced a successful transition?"
My answer is "yes."

Typically, the caller then asks a second question: "Have you heard of a dentist who joined or dropped their participation with a dental benefit plan, which resulted in an unsuccessful transition? Again, my answer is "yes."
It's important to remember that adding or dropping a contract with a dental benefit plan is a personal business decision. There is no one size fits all in these types of business decisions, as what might work for one dentist might not work for another.

You may be asking yourself how a dentist can make a good decision about adding or dropping a dental plan/network participation, but there is one key element in each success story and it's this: The dentist analyzed the pros and cons of adding or dropping participation with the plan/network. The saying "If you fail to plan, you are planning to fail" certainly rings true in this situation.

I occasionally receive calls from dentists who were in contract with a dental benefit plan, then added or dropped participation with the plan/network and are now experiencing issues related to their decision. What we find is that dentists often make their decision to join a plan/network predominantly based on the fee schedule. A dentist should not make their decision to join or drop a plan/network solely based on fees.

Practice Support has resources available to help dentists consider the risks and advantages of adding or dropping a plan and/or network. These include:

- Dental Benefit Plan Handbook - Chapter 2: Understanding Dental Benefit Plan Contracts & Fees
- Dental Benefit Contracting: It's not all about the fees. What you need to know before you sign
- What You Need to Know About Dropping Dental Plan Contracts

As a CDA member, you can access these resources in the Practice Support online resource library. Simply visit cda.org/dentalbenefits and locate them under "Contracting." In addition to providing an online resource library, CDA Practice Support makes it easy to get answers to dental benefit questions. If you haven't heard, CDA members can now use a simple online form to report issues and questions related to dental benefits. The online submission form lets dentists request assistance and submit their questions 24/7. In the short time since the form was launched, CDA members have remarked that the form is easy to use, fast and convenient.

While contracting or dropping participation with a plan is voluntary, CDA cautions dentists that due to antitrust laws, dentists cannot band together collectively and refuse to participate with a plan. For more information on antitrust laws, refer to the ADA's "The Antitrust Laws in Dentistry: A Primer of 'Do's, Don'ts and How To's for Dentists and Dental Societies" (www.ada.org/en/~/media/ADA/Member%20Center/FIles/antitrust_booklet_full).

For resources on dental benefit plans or to report a dental benefits issue using the simple online form, visit cda.org/dentalbenefits.

Prepare for CDT 2020 dental code changes

By: CDA Staff

CDA encourages dentists to prepare for CDT 2020 dental code additions, revisions and deletions that go into effect Jan. 1, 2020. The new year will bring 37 new and five revised codes, plus six deleted codes.

While dental plans are required to recognize current CDT codes, it is important to keep in mind that they are not required to pay for or provide benefits for the new or revised codes. Dentists should review each dental plan's payment and processing guidelines to determine whether benefits will be payable. Typically, plans will start sending updates about policy changes for the new year in late October and early November.

New CDT 2020 procedure codes:

1. D0419 – assessment of salivary flow by measurement
2. D1551 – re-cement or re-bond bilateral space maintainer – maxillary
3. D1552 – re-cement or re-bond bilateral space maintainer – mandibular
4. D1553 – re-cement or re-bond unilateral space maintainer – per quadrant
5. D1556 – removal of fixed unilateral space maintainer – per quadrant
6. D1557 – removal of fixed bilateral space maintainer – maxillary
7. D1558 – removal of fixed bilateral space maintainer – mandibular
8. D2753 – crown - porcelain fused to titanium and titanium alloys
9. D5284 – removable unilateral partial denture – one piece flexible base (including clasps and teeth) – per quadrant
10. D5286 – removable unilateral partial denture – one piece resin (including clasps and teeth) – per quadrant
11. D6082 – implant supported crown – porcelain fused to predominantly base alloys
12. D6083 – implant supported crown – porcelain fused to noble alloys
13. D6084 – implant supported crown – porcelain fused to titanium and titanium alloys
14. D6086 – implant supported crown – predominantly base alloys
15. D6087 – implant supported crown – noble alloys
16. D6088 – implant supported crown – titanium and titanium alloys
17. D6097 – abutment supported crown – porcelain fused to titanium and titanium alloys
18. D6098 – implant supported retainer – porcelain fused to predominantly base alloys
19. D6099 – implant supported retainer for FPD – porcelain fused to noble alloys
20. D6120 – implant supported retainer – porcelain fused to titanium and titanium alloys
21. D6121 – implant supported retainer for metal FPD – predominantly base alloys
22. D6122 – implant supported retainer for metal FPD – noble alloys
23. D6123 – implant supported retainer for metal FPD – titanium and titanium alloys
24. D6195 – abutment supported retainer – porcelain fused to titanium and titanium alloys
25. D6243 – pontic – porcelain fused to titanium and titanium alloys
26. D6753 – retainer crown – porcelain fused to titanium and titanium alloys
27. D6784 – retainer crown _ – titanium and titanium alloys
28. D7922 – placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site
29. D8696 – repair of orthodontic appliance – maxillary
30. D8697 – repair of orthodontic appliance – mandibular
31. D8698 – re-cement or re-bond fixed retainer – maxillary
32. D8699 – re-cement or re-bond fixed retainer – mandibular
33. D8701 – repair of fixed retainer, includes reattachment – maxillary
34. D8702 – repair of fixed retainer, includes reattachment – mandibular
35. D8703 – replacement of lost or broken retainer – maxillary
36. D8704 – replacement of lost or broken retainer – mandibular
37. D9997 – dental case management – patients with special health care needs

CDT code revisions:

1. D1510 space maintainer – fixed, unilateral – per quadrant. Excludes a distal shoe space maintainer.
2. D1520 space maintainer – removable – unilateral – per quadrant
3. D1575 distal shoe space maintainer – fixed – unilateral – per quadrant fabrication and delivery of fixed appliance extending subgingivally and distally to guide the eruption of the first permanent molar. Does not include ongoing follow-up or adjustments, or replacement appliances, once the tooth has erupted.

In addition, there will be periodontal category descriptor revisions.
Site:
– If two contiguous teeth have areas of soft tissue recession, each area of recession tooth is a single site.
– Depending on the dimensions of the defect, up to two contiguous edentulous tooth positions may be considered a single site.

CDT code deletions:

1. D1550 – re-cement or re-bond space maintainer
2. D1555 – removal of fixed space maintainer
3. D8691 – repair of orthodontic appliance
4. D8692 – replacement of lost or broken retainer
5. D8693 – re-cement or re-bond fixed retainer
6. D8694 – repair of fixed retainers, includes reattachment

There are also 15 editorial (e.g., syntax and spelling) actions that clarify without changing the CDT Code entry's purpose or scope. CDA encourages all billing dentists to obtain a current copy of the American Dental Association's CDT 2020 Dental Procedure Codes. The book (with included e-book) is available for purchase at adacatalog.org. It is recommended that all dental offices have a current copy to assist with proper claim billing.

Additionally, when coding, dentists must code for the work that was done, not for what is covered under the patient's benefit plan.

• Contact the ADA at 312-440-2500 or dentalcode@ada.org with inquiries about dental code changes.

Employers will heed new laws on arbitration agreements and more in the new year

California employers will need to take action soon to comply with new laws pertaining to employment discrimination claims, paid family leave, harassment prevention training and other areas of employment practice. The laws take effect as early as Jan. 1, 2020.

Employment discrimination claims
Description: Assembly Bill 9 extends the statute of limitations from the current one year to three years for complaints alleging employment discrimination under the Fair Employment and Housing Act.

Effective Jan. 1, 2020, employees (or former employees) will have three years from the date of their termination or the end of the alleged discriminatory conduct to file a discrimination charge with the Department of Fair Employment and Housing using the DFEH intake form. then has one additional year to file a lawsuit under current law and AB 9.

Employment arbitration agreements waiver
Assembly Bill 51 bans employers from requiring employees or applicants to waive any right, forum or procedure under the Fair Employment and Housing Act or Labor Code as a condition of employment. It also prohibits employers from retaliating or threatening employees who refuse to waive such rights. The new law will apply to agreements entered into, modified or extended on or after Jan. 1, 2020, but does not apply to post-dispute settlement or negotiated severance agreements.

There is still much controversy surrounding this statute because it violates the Federal Arbitration Act that preempts state laws that attempt to regulate or restrict arbitration agreements. Because of the risk of possible criminal action, employers who wish to continue to implement arbitration agreements and employers who currently have agreements in place are highly encouraged to review any current arbitration agreements with legal counsel.

Enforcement of Arbitration Agreements
Employees or consumers will be eligible for certain remedies under SB 707 should a drafting party breach an arbitration agreement by failing to pay the costs and fees required to initiate the arbitration. The bill also requires the court to impose a monetary sanction on a drafting party. If a company failed to pay the arbitration fees in a consumer or employment arbitration, it would be a material breach and it would allow the employee or consumer to proceed in court and requires the court to impose sanctions.

Antidiscrimination training for temporary and seasonal workers
Senate Bill 530 delays until Jan. 1, 2021, the completion of sexual harassment prevention training for seasonal, temporary or other employees hired to work for less than six months.

Paid Family Leave expansion
Beginning July 1, 2020, Paid Family Leave benefits under California's State Disability Insurance program will increase from the current six weeks to eight weeks as required by SB 83.

Failure to pay wages: Remedies, penalties, contract wages
Employees seeking wages owed to them are authorized under AB 673 to bring a legal action either to recover statutory penalties against their employer or to seek to enforce civil penalties under the Private Attorneys General Act. The employee cannot take both actions for the same violation. The law takes effect Jan. 1, 2020.

In addition, SB 688 extends the state Labor Commissioner's authority to cite an employer's failure to pay minimum wages under a contract. The Labor Commissioner can cite an employer for failing to pay wages less than the wage set by contract in excess of the minimum wage. The employer can contest the citation by posting a bond, but the bond will be forfeited if the employer loses.

Living organ donation
Employers of 15 or more employees are required beginning Jan. 1, 2020, to provide additional unpaid leave time to an employee for the purpose of organ donation. Current law provides 30 days paid leave for the purpose of organ donation. The new law allows for an extension of that leave by requiring the employer to grant an additional 30 days of unpaid leave to any employee who donates an organ to another person in a one-year period.

Privacy
The California Consumer Privacy Act enacted in 2018 changed the consumer data collection rules, allowing consumers to know about and request deletion of data that businesses collect about them. The CCPA's broad language includes a business's employees and job applicants, which means employees, upon their request, could potentially have information from their personnel files deleted under the CCPA.

AB 25 excludes from the CCPA the deletion of employment data collected and used within the context of a person's employment or application for employment. However, this exemption is only good for one year.

Find a Sample Employee Manual and other employment resources in the CDA Practice Support resource library.

Amalgam Separator Rule takes effect on July 14, 2020

By: ADA Staff

Current estimates indicate that less than 1% of the mercury released into the environment comes from dental preparations and uses.1, 2 The majority of mercury from dentistry-related origin is in the form of elemental mercury in amalgam and not methylmercury, which is the form of mercury of particular environmental concern. Notwithstanding, following are insights about stewardship efforts with respect to dental amalgam in the waste stream.

American National Standards Institute/American Dental Association (ANSI/ADA) Standard No. 109 defines amalgam waste as including amalgam (scrap), chair-side trap filters containing amalgam vacuum pump filters containing, amalgam, saliva ejectors if used in dental procedures involving amalgam, used amalgam capsules, extracted teeth with amalgam restorations, and waste items that are contaminated with amalgam.3

Amalgam Waste Best Management Practices

Dental best management practices for amalgam waste handling and disposal4include use of chair-side traps, use of amalgam separators, regular inspection and cleaning of traps, and use of appropriate commercial waste service to recycle and/or dispose of collected amalgam (Table). Compliance with the EPA final rule on amalgam separators is required.

Table. Best Management Practices for Amalgam Waste4

- **Do** use precapsulated alloys and stock a variety of capsule sizes
- **Don't** use bulk mercury
- **Do** recycle used disposable amalgam capsules
- **Don't** put used disposable amalgam capsules in biohazard containers
- **Do** salvage, store, and recycle non-contact (scrap) amalgam
- **Don't** put non-contact amalgam waste in biohazard containers, infectious waste containers (red bags), or regular garbage
- **Do** salvage (contact) amalgam pieces from restorations after removal and recycle their contents
- **Don't** put contact amalgam waste in biohazard containers, infectious waste containers (red bags), or regular garbage
- **Do** use chair-side traps, vacuum pump filters, and amalgam separators to retain amalgam and recycle their contents
- **Don't** rinse devices containing amalgam over drains or sinks
- **Do** recycle teeth that contain amalgam restorations (Note: Ask your recycler whether extracted teeth with amalgam restora tions require disinfection)
- **Don't** dispose of extracted teeth that contain amalgam restora tions in biohazard containers, infectious waste containers (red bags), sharps containers, or regular garbage
- **Do** manage amalgam waste through recycling as much as possible
- **Don't** flush amalgam waste down the drain or toilet
- **Do** use line cleaners that minimize dissolution of amalgam
- **Don't** use bleach or chlorine-containing cleaners to flush wastewater lines

Amalgam Separators

Amalgam separators remove amalgam particles from the wastewater to reduce the amount of amalgam entering the sewage system. Amalgam separators are devices designed to capture amalgam particles from dental office wastewater through sedimentation, filtration, centrifugation, or a combination of these mechanisms.5 Some separators may also use ion exchange technology to remove mercury from wastewater.5 Whenever there is need for plumbing work or other activities that might dislodge amalgam waste adhering to the inside of the pipes, it is recommended that steps be taken to minimize potential health or environmental issues.

The Environmental Protection Agency (EPA) regulation on the use of amalgam separators was recently finalized6 and is effective as of July 14, 2017 with the date for compliance being July 14, 2020.

SUMMARY

The Environmental Protection Agency (EPA) is promulgating technology-based pretreatment standards under the Clean Water Act to reduce discharges of mercury from dental offices into municipal sewage treatment plants known as publicly owned treatment works (POTWs). This final rule requires dental offices to use amalgam separators and two best management practices recommended by the American Dental Association (ADA). This final rule includes a provision to significantly reduce and streamline the oversight and reporting requirements in EPA's General Pretreatment Regulations that would otherwise apply as a result of this rulemaking. EPA expects compliance with this final rule will annually reduce the discharge of mercury by 5.1 tons as well as 5.3 tons of other metals found in waste dental amalgam to POTWs. The final rule is effective on July 14, 2017. The compliance date, meaning the date that existing sources subject to the rule must comply with the standards in this rule is July 14, 2020. After the effective date of the rule, new sources subject to this rule must comply immediately with the standards in this rule. For more information, see EPA's Web site: https://www.epa.gov/_eg/_dental-effluent-guidelines. For technical information, contact Ms. Karen Milam, Engineering and Analysis Division (4303T), Office of Water, Environmental Protection Agency, 1200 Pennsylvania Ave. NW., Washington, DC 20460-0001; telephone: 202-566-1915; email: milam.karen@epa.gov.

References

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New state law prohibits discrimination based on natural hairstyle

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A new state law prohibits discrimination on the basis of hair textures or protective hairstyles that are historically associated with race. Senate Bill 188, also known as the CROWN Act, was signed in July by Gov. Gavin Newsom and will take effect Jan. 1, 2020.

California's Fair Employment and Housing Act was amended by the law to include in the definition of race "traits historically associated with race, including, but not limited to, hair texture and protective hairstyles." Protective hairstyles can include but are not limited to braids, locks and twists.

The preamble to the CROWN Act declares in part that the Civil Rights Act of 1964 protects against discrimination against afros but that "the courts do not understand that afros are not the only natural presentation of Black hair" and that workplace dress codes and grooming policies that prohibit natural hair "are more likely to deter Black applicants and burden and punish Black employees than any other group."

"Practice owners should review their dress and grooming policies to ensure they are not discriminatory of natural hairstyles and revise the policies if needed," said Michelle Corbo, employment practices analyst at CDA Practice Support.

California infection control regulations do not address hair; however, employers can still generally maintain policies that require employees to secure their hair for safety and hygienic reasons.

The Centers for Disease Control and Prevention does not have published guidelines about hair but does have recommendations for fingernail grooming and jewelry use in the dental care setting. These are: keep fingernails short with smooth, filed edges to allow thorough cleaning and prevent glove tears; do not wear artificial fingernails or extenders when having direct contact with patients at high risk; use of artificial fingernails is usually not recommended; and do not wear hand jewelry if it makes donning gloves more difficult or compromises the fit and integrity of the glove.

Σ Visit the resource library at cda.org/practicesupport for employment-related resources including a Sample Employee Manual and the Legal Reference Guide for California Dentists.

CURES 2.0

Prescribers can check CURES for misuse of prescription pads

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A dentist who writes controlled substance prescriptions can now review CURES (Controlled Substance Utilization Review and Evaluation System) for patients for whom the dentist is listed as a prescriber. This ability to review the list is useful when a dentist has misplaced a prescription pad or has had a prescription pad stolen or when a dentist suspects someone is misusing their DEA number.

A new law (AB 2086) allows prescribers to run CURES reports that contain each patient's name, address, date of birth and gender. The report will cover the time period of up to one year prior to the date the report is generated.

The process for generating a patient list is as follows:

1. Log in to CURES and choose the Patient Activity Report tab.
2. Search Criteria – Choose the button for Patient List by DEA#s, then select your DEA number. (Note: A dentist with more than one DEA number can choose all DEA numbers.) Then enter the date.
3. Patient List – Once users submit the search, the matching patient lists are displayed.

After a list is created, a dentist can go back into the system and run separate CURES reports for each patient on the list if more information is needed. If a dentist discovers a prescription in the CURES report that they did not prescribe, the dentist should contact the pharmacy as well as the California State Board of Pharmacy.

Σ

Find additional information about CURES by calling 916.210.3187 or at CURES@doj.ca.gov.

Proceed with caution when making pay deductions for salaried employees

The decision to classify your employee as exempt or nonexempt should not be taken lightly. The distinction between the two is significant, and the two are also managed very differently. Therefore, employers should understand not only how to determine an employee's classification but how to follow appropriate pay requirements as well.

What does it mean to be exempt? Essentially, an employee who is paid a fixed biweekly or monthly salary is not subject to the protections of California's industrial wage orders. Employees classified in this manner are not afforded payment of overtime, are not subject to meal and rest break requirements and are generally not required to track their working hours. Practice owners can view Wage Order 4-2001 for a full description of the requirements.

In general, an executive, administrative or professional exempt employee is in a position of management or possesses a decision-making role in the business. Within that role, the employee must spend a majority of time (at least 51%) on essential exempt duties. Meaning, if an office manager's duties are similar to those of a practice receptionist for a majority of the time, those duties dilute the exemption. A job title or desire to ease administrative payroll burdens does not alone suffice as justification for an exempt salary classification. (Learn more in the article "Exempt vs. nonexempt: Understand employee classifications.")

"Stated another way, an exempt employee is paid to do a job, not punch a clock," says Michelle Corbo, employment practices analyst at CDA Practice Support.

Employers must meet minimum wage standards for exempt employees and understand that there are very limited instances when an employee's pay may be deducted. An employer can set minimum hourly expectations but, ultimately, if an employee works a part-time schedule, works a partial day or takes a day away from the office, there isn't a simple way to deduct for the time the employee is absent from the practice.

Employers must meet minimum salary threshold requirements of two times the current state minimum wage, regardless of the employee's schedule. Current minimum wage requirements for an exempt employee in 2019 are: employers of 25 or fewer employees must pay the minimum of $3,813.33 per month/$45,760 annually; and employers of 26 or more employees must meet the $4,160.00 per month/$49,920 annually requirement.

Impermissible deductions

Employers cannot reduce an exempt employee's pay in California for not meeting performance expectations or for poor work quality. Nor can they reduce the pay for exempt employees who have been disciplined for conduct issues.

An employer may not make salary deductions for the quantity of work performed. This is especially important for practice owners who classify associate employees as exempt under the professional exemption and who work part time one or two days a week and pay only on a percentage of adjusted production. The associate's wages would still need to meet the minimum threshold should the associate not meet production goals.

Changes sometimes occur in the workweek schedule that are out of the employee's control. An employee may be ready, willing and able to work but the practice closes for part of a workweek. For example, let's say the employee works Monday and Tuesday, a holiday falls in the middle of a workweek and the practice closes for the remainder of the week. In this case, the exempt employee is entitled to a full week's pay. In turn, if there is no work available for the full workweek, the employer is not obligated to pay that week's salary. Employers should provide reasonable advance notice of a practice's closure when possible.

There are no allowable deductions from an exempt employee's salary for exempt employees who must appear for jury duty, witness duty or military duty during the workweek and perform work during that week. However, if the exempt employee does not perform any work within the week, you can deduct from their salary for the week.

Vacation and absences

Full-day absences: If an exempt employee has no paid sick leave, vacation or paid time off accrued, or has used up all available PSL, vacation pay or PTO, you can make deductions from the salary for full-day absences. To determine the daily rate, an employee's annual salary should be divided by 52 for the weekly amount, then divided by the number of days the employee usually works in a week. The California Labor Commissioner's Office allows deductions of no more than one-fifth of a week's salary for each day of absence, even if the employee normally works fewer than five days per week.

Partial-day absences: Deductions from an exempt employee's salary for partial-day absence are not permissible. If an exempt employee is absent for a partial work day and has no PSL, vacation or PTO available, the employee must be paid for a full day if they perform any work that day.

Although you cannot deduct from an employee's salary, you are allowed to deduct from an exempt employee's PSL, vacation or PTO accrual bank for a partial-day absence.

Continued on page 22

Veterans' Smile Week!

Veteran patient Allen Villanova, was seen by President, Mahfouz Gereis, DDS on 10/17/19. Allen had extensive treatment needs, and has Denti-Cal. Between Denti-Cal covered services and volunteer treatment, Dr. Gereis went the extra mile to help him.

By: Wendy Zaslove, SFVDS Foundation Programs Coordinator

November 4 – November 8, 2020

Every year, on or about Veterans' Day, member dentists from the San Fernando Valley Dental Society open their offices to provide free one day dental care for veterans whose dental needs are sadly not covered by the V.A.

What a week this was!!!

Starting in September/October, we started reaching out to as many veterans' organizations as possible to have them reach out to their veterans to let them know that we would treat them for FREE, for one day! These treatments included, exams, x-rays, cleanings, fillings, extractions, oral cancer screenings and if possible, root canal therapy!!

Some of the organizations that we reached out to included: Wings over Wendy's, VA of Sepulveda/ West LA, VFW of Canoga Park, Veterans of Goodwill, and many of the college campus' veterans centers including Cal State Northridge, Pierce College and College of the Canyons!

We received more than 130 phone calls and more than 100 of these veterans were treated!!

This is in thanks to the 31 general dentists and the five specialists who opened their offices to treat these veterans! This program would not have be successful without these volunteers, so they are truly appreciated!!

The numbers are still coming in but as of the writing of this article, we have provided more than $58,700 worth of dentistry to these veterans in need!!!

We truly cannot wait to see how we can increase these numbers next year and serve those who serve us!!

Dr. Mahrouz Cohen provided a root canal for this veteran during the 2019 Veterans Smile Week program.

List of SFVDS Oral Surgeon Members

James Habashy, DDS	1000 W Carson St.	Torrance, CA 90502-2004	(818) 339-7220
Ryan J. Colletta, DDS	27421 Tourney Rd. #150	Valencia, CA 91355	(661) 255-1515
Mark M. Urata, DDS	221 E Glenoaks Blvd. Ste 140	Glendale, CA 91207-2123	(818) 241-4217
The T. Phan, DDS	11200 Corbin Ave. # 208	Porter Ranch, CA 91326-4120	(818) 368-8522
James P. Jensvold, DDS	6325 Topanga Cyn Blvd. #435	Woodland Hills, CA 91367-2046	(818) 999-0900
Nam S. Cho, DDS	221 E Glenoaks Blvd. #140	Glendale, CA 91207-2123	(818) 241-4217
Candelaria Ayala, DDS	1005 S. Central Ave.	Glendale, CA 91204	(818) 244-2155
Alexei I. Mizin, DDS	24013 Ventura Blvd. #100	Calabasas, CA 91302-1145	(818) 225-2211
Sheldon H. Katz, DDS	5363 Balboa Blvd. Ste 233	Encino, CA 91316-2824	(818) 788-4424
Robert W. Mower, DDS	27421 Tourney Rd. Ste 150	Valencia, CA 91355	(661) 255-1515
John M. Scaramella, DDS	23450 Lyons Ave.	Newhall, CA 91321-5778	(661) 254-0390
Rennie Cheung, DDS	11550 Indian Hills Rd. #320	Mission Hills, CA 91345-1203	(818) 365-0817
Sergey Lokot, DDS	5363 Balboa Blvd. Ste 233	Encino, CA 91316-2824	(818) 788-4424
Nicholas G. Salaita, DDS	44441 16th St. W Ste 103	Lancaster, CA 93534-2873	(661) 942-4353
Robert Lytle, DDS	500 N Central Ave. Ste 710	Glendale, CA 91203-3386	(818) 240-1805
Jeffrey A. Hammoudeh, DDS	221 E Glenoaks Blvd. #140	Glendale, CA 91207-2123	(818) 241-4217
Dennis G. Smiler, DDS	4521 Sherman Oaks Ave. #201	Sherman Oaks, CA 91403-3807	(818) 849-0602
Elgan P. Stamper, III, DDS	1370 Foothill Bl., Ste 200	La Canada Flintridge, CA 91011-2117	(818) 952-8183
Robert G. Hale, DDS	6325 Topanga Canyon Blvd. #435	Woodland Hills, CA 91367-2046	(818) 999-0900
Christopher Kang, DDS	1137 W Ave. M14 Ste 101	Palmdale, CA 93551-1429	(661) 266-8840
David Stephens, DDS	1021 W Ave. M14	Palmdale, CA 93551-1440	(818) 270-0713
Rudolph D. Lang, DDS	27450 Tourney Rd. Ste 160	Valencia, CA 91355-1863	(661) 253-3500
George A. Maranon, DDS	16311 Ventura Blvd. Ste 820	Encino, CA 91436-4394	(818) 990-5500
Ted F. Feder, DDS	9066 Tampa Ave.	Northridge, CA 91324-3523	(818) 993-3700

Trustee Report

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to form a task force to explore issues relevant to the inclusion of dental benefits in the Medicare program, including implications in California on the aging population and the delivery of care.
During the past year, the Medicare Task Force gathered information from several sources and experts; received background information on the national and California health care environments; and Medicaid and Medicare programs; obtained data on aging Californians and other relevant materials as identified; and engaged in a detailed analysis of potential benefit approaches and multiple considerations.

TDSC Update: The board received an update regarding the TDSC.com out-of-state expansion. This discussion was held in closed session as it contained proprietary information that is not appropriate to discuss externally due to the competitive nature of TDSC's market. However, we can share that TDSC will be national, across all 50 states in 2020. TDSC has affiliation agreements with 37 states and growing strongly to help our members save money.
Major legislative issues to be aware of:

• AB 1519: Direct-to-Consumer Orthodontic Protections & Dental Board Sunset Review: Also known as the Sunset Review bill, AB 1519 extends the operation of the dental board for four years and makes a number of related policy changes. Among other provisions, the bill sets a single standard of care by requiring that dentists providing orthodontics review radiographs (X-rays) prior to the movement of teeth.
• AB954:Dental Plan Network Leasing:
CDA sponsored AB 954 (Wood) in 2019, which passed the legislature with unanimous support and was signed by the governor. The bill requires dental benefit plans to be more transparent about the common practice of "leasing" access to a network of contracted dentists from another dental benefit plan.
Dental Plan Transparency:
Californians deserve accountability and value from their dental benefit plans, and AB 954 (Wood) builds on a series of recent successful legislative efforts sponsored by CDA that have greatly increased the transparency of these plans.
• SB 154: Silver Diamine Fluoride:
CDA sponsored SB 154 (Pan) in 2019 to add silver diamine fluoride (SDF) as a Medi-Cal benefit for treatment of dental decay when applied as part of a comprehensive treatment plan. SDF is a topical medication used to slow down or stop cavities in both primary and permanent teeth.
Karin Irani, DDS

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Proceed with caution when making pay deductions for salaried employees

Here's an example: Judy asks to leave work at 10 a.m. on a Friday for a medical appointment. Her normal scheduled hours are from 8 a.m. to 4 p.m. She has only two hours available in her accrued PSL bank. Because Judy worked two hours of her typical schedule, she must receive her full salary for the day.

Even though she does not have enough time in her PSL bank to cover her absence, her employer cannot deduct from her salary for the time missed. The employer may, however, apply the two hours remaining in her PSL bank toward her salary for the day.

(Read more in the Policies and Interpretations Manual from the Division of Labor Standards Enforcement.)

A practice owner might choose to classify an associate dentist employee under the professional exemption, but it's uncommon for other employees of a dental practice to meet the administrative, professional or executive exemption classifications. Because the stakes of noncompliance with wage and hour laws and costly penalties are so high, employers should carefully consider their employee classifications and have job descriptions in place that clearly establish the duties of those employees who do truly meet the exemption.
For a library of job descriptions and an Employee Exemption Checklist for members, go to the CDA Practice Support resource library.

Welcome New Members

Maryam Aghchay, DDS
15001 Sunstone Pl.
Sherman Oaks, CA 91402
818-605-2225
UOP, 2004
General

Ani Alexander, DMD
University of Nevada, 2019
General

Artur Barakazyan, DDS
NYU, 2019
General

Aaron Camacho, DDS
NYU, 2019
General

Arys Dembekjian, DDS
Tufts, 2019
General

Youngmo Kang, DDS
26 Broadway Ste. 1303
New York, NY 10004
917-868-1552
General
NYU, 2019

Bran' D Hutalla, DMD
Arizona School of Dentistry, 2019
General

Vatche Halajian, DDS
230 N. Maryland Ave., #205
Glendale, CA 91206
USC, 1990
General

Kirill Kvitko, DDS
14378 Ventura Blvd.
Sherman Oaks, CA 91423
General
International, 1993

Donald Luong, DDS
44558 10th St. W
Lancaster, CA 93534
661-723-1111
General
NYU, 1994

Sofia Uraizee, DDS
Univ. of N. Carolina, 2017
General

Leiza Walia, DMD
University of Pennsylvania, 2016
Lutheran Medical Center, 2019
Endodontist

CLASSIFIED ADS

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

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