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AMERICAN DENTAL ASSOCIATION WWW.ADA.ORG

ADA NEWS®

DECEMBER 13, 2010 VOLUME 41 NO. 22

Red Flags exemption OK'd

ADA leads dental, medical, business coalition

BY KELLY SODERLUND

Washington—The U.S. House of Representatives Dec. 7 passed legislation exempting certain businesses, including dental practices, from the Federal Trade Commission's Red Flags Rule.

The vote passed without opposition and now awaits President Obama's signature.

The U.S. Senate passed an identical bill on Nov. 30. The legislation's passage was a result of the work of an ADA-led coalition of 28 dental, medical and business groups.

The new legislation will save dental practices money in implementation costs to review and understand identity theft rules. Dentists will also save money and time by not having to train their staff on compliance. The ADA estimates the nationwide savings associated with this exemption to be $72 million for dental offices.

"This legislation is important for practicing dentists who are mindful of their budget and their time. This rule

See RED FLAGS, page eight

FDA amalgam hearing Dec. 14-15, page six

Grand reopening: Headlining the Creston Children's Dental Clinic reopening ceremony Sept. 13 in Portland, Ore., are, from left, Friends of Creston Children's Dental Clinic Board member Sue Sanzi-Schadel; Creston School Principal Andy McKean; A-dec President Steve Parrish (cutting ribbon); FCCDC Board Officer and Multnomah Dental Society Executive Director Lora Mattsen; and FCCDC Vice President Dr. Dale Canfield.

Creston reopens

Portland dental volunteer efforts help to save children's clinic

BY STACIE CROZIER

Portland, Ore—The smiles are back at the renovated and reorganized Creston Children's Dental Clinic, a Portland safety net for nearly 50 years that reopened Sept. 13 with the help of volunteer dentists and donors.

In February, the clinic lost its longtime sponsor, the Assistance League of Portland, and $250,000 in annual

See CRESTON, page 12

Delegates move forward on national licensure exam

BY KAREN FOX

Orlando, Fla.—The 2010 ADA House of Delegates underscored its commitment to developing a national clinical licensure examination that evaluates candidates in accordance with Association policies on live patients.

The action follows a year-long study by an ADA workgroup and some new innovations in state licensure. In passing Resolution 42H-2010, the House initiated a request-for-proposals process for the "development of a portfolio-style examination for licensure purposes designed to assess a candidate's clinical competence with a third-party assessment that is valid and reliable psychometrically, including a complementary written/interactive examination to assess issues not deemed adequately addressed in the portfolio model, such as ethics and professionalism."

"The House has said, in clear terms, a new examination process must be developed," said Dr. Samuel B. Low, the ADA 17th District trustee who was recently appointed chair of a new workgroup brought together by Res. 42H-2010.

"There is no doubt there is a schism

See EXAM, page eight

BRIEFS

Travel deals: Beginning in January 2011, ADA members can enjoy new car rental deals with Alamo, Enterprise and National Car Rental. For great cars and low rates, go to "www.ada.org/carrental" or call 1-866-960-5880.

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JUST THE FACTS

Part-time dentists

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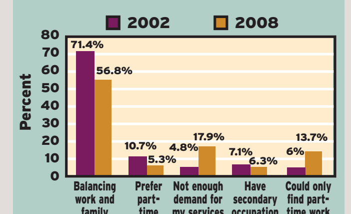

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Photo by Bill Geiger

Stakeholders: From left, Dr. Ray Gist, ADA president; Mary Wakefield of the Health Resources and Services Administration; and Dr. Paul Glassman, conference moderator, pause for a photo Nov. 18 during the ADA National Consensus Conference on the Oral Health of Vulnerable Older Adults and Persons with Disabilities. Details on the conference will appear next month in the ADA News.

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ViewPoint

MyView

Celebrating 25 years of Donated Dental Services

Larry Coffee, D.D.S.

Not long ago, a 36-year-old woman named Deena was referred to Donated Dental Services for care. A very brave young woman who had suffered from renal failure since age 19, she received dialysis three times a week and was ruled ineligible for a kidney transplant due to her severe dental disease. Recently, after the help of two New Hampshire DDS volunteers, a general practitioner and an oral surgeon, Deena was able to write to us about the care she received:

"It is so nice to find people who truly care about other people. Thank you so much for giving me my smile back. I should be put on the kidney transplant waiting list very soon."

Year 2010 marks the 25th anniversary of the DDS program under the National Foundation of Dentistry for the Handicapped. In January, when NFDH becomes Dental Lifeline Network, the DDS name and its extraordinary collaboration will continue. We are profoundly grateful to and proud of the 15,000 dentists and 3,000 laboratories who volunteer their services; the companies that contribute in many ways; and the dental organizations that enlist their members as volunteers. Our goal is to coordinate and grow this collaboration as a program of Dental Lifeline Network—to serve more people in need and to enhance the value and impact of our work.

What has changed in the past 25 years? Our mission to help America's truly vulnerable individuals including people with disabilities and the elderly remains the same. However, we also have been compelled to focus on more individuals like Deena whose need for dental care can prevent them from receiving life-saving medical procedures.

Dental disease and chronic need for care impact people with cancer who cannot receive chemotherapy, those with autoimmune diseases who cannot be administered lifesaving medications, cardiac patients who cannot be treated surgically, and people with crippling arthritis who are prevented from joint replacements. For these people, the alternative to dental therapy and subsequent treatment for their medical conditions is a path to progressive illness or premature death.

Our new name, Dental Lifeline Network, is inclusive of all of the people served by DDS and our other programs—the disabled, elderly or medically at-risk—because the inherent dignity of every individual is reflected in a healthy smile.

If you are one of the thousands of dentists who have participated as a DDS volunteer over the years, we thank you and hope that you share our pride in helping the 100,000 people who have received $181 million in donated services.

If you are not a DDS volunteer, please know that from a wait list of 17,000 cases, DDS can match people in need to your practice specifications, your interests and your comfort level. As a volunteer, you review the patient profiles in advance, choose or decline to see any patient, and determine your own treatment plan. You see patients in your office on your own schedule, never pay for lab costs and a DDS coordinator facilitates the entire process including paperwork. Volunteering is easy. You treat the patient; DDS does everything else. For information, contact us at

See MY VIEW, page five

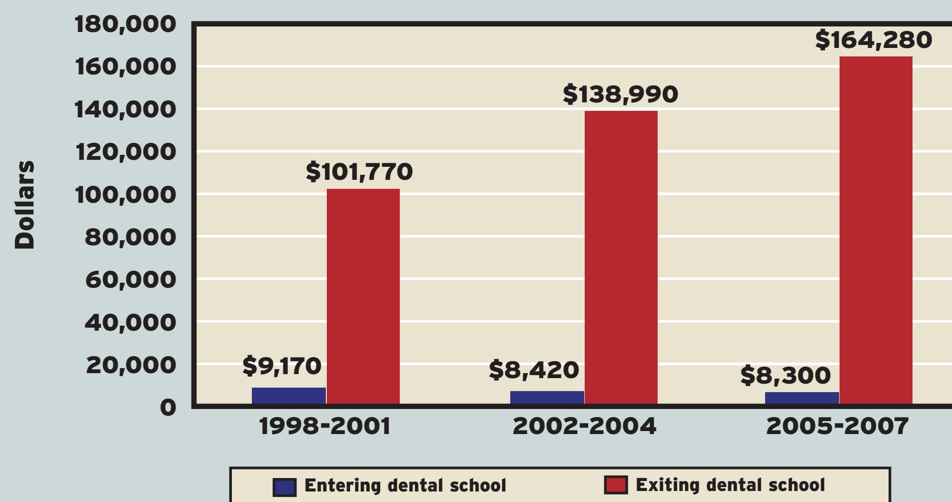
LettersPolicy

ADA News reserves the right to edit all communications and requires that all letters be signed. The views expressed are those of the letter writer and do not necessarily reflect the opinions or official policies of the Association or its subsidiaries. ADA readers are invited to contribute their views on topics of interest in dentistry. Brevity is appreciated. For those wishing to fax their letters, the number is 1-312-440-3538; e-mail to "ADANews@ada.org".

SNAPSHOTS OF AMERICAN DENTISTRY

Educational debt by graduation year

New dentists who graduated between 2005 and 2007 left dental school with $62,510 more in educational debt than those graduating between 1998 and 2001.



Source: American Dental Association, Survey Center, *2008 Survey of New Dentists.*

Letters

Midlevel providers

Dr. Brian Homer's letter on midlevel providers (Oct. 18 ADA News) is on target. His recollection is correct about the Carter/Califon strategy in the '70s of flooding the market with health providers to lower the costs of health services. It was a specious economic policy, representing another contrived intrusion into the marketplace.

This past failed policy portends another failure of government incentives to get dentists and/or midlevel providers into critical shortage areas.

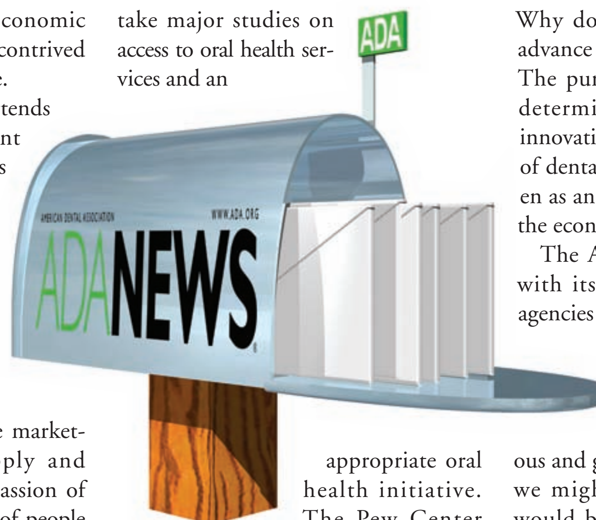
We have to learn the hard lessons of nondental entities interfering with our profession. There is nothing wrong with dentistry that being left alone won't fix.

Through the genius of the marketplace with its law of supply and demand, and with the compassion of the profession, we'll take care of people in need very well, thank you. And without self-serving social do-gooders and bureaucrats looking over our shoulder.

Robert D. Helmholdt, D.D.S.
Fort Lauderdale, Fla.

DHATs

Dental Health Aide Therapists have been practicing in Alaska under dentists' supervision, and without any untoward incidents, since 2005. Congress, in the reauthorization of the Children's Health Insurance Program, required the General Accounting Office to study the addition of a new provider to the dental team to expand access to care. The Health Resources and Services Administration has funded the Institute of Medicine to undertake major studies on access to oral health services and an appropriate oral health initiative. The Pew Center Report on the States included the existence of a new primary care provider of oral health care as one of its eight criteria in grading states on the dental policies affecting children. The Kellogg Foundation, which helped fund the Alaska initiative, has funded the American Public Health Association to develop a two academic year curriculum to train dental therapists and in committing additional funding to the therapist initiative.



In response to what is occurring all around us, our House of Delegates passed a resolution that supports pilot programs that do not allow a nondentist to perform irreversible/surgical procedures ("Workforce Resolutions: House Emphasizes Dentist's Role as Team Leader," Nov. 1 ADA News). Why do we need pilot programs to advance what is already ADA policy? The purpose of pilot programs is to determine the efficacy of new and innovative ideas. The Kellogg training of dental therapists is being undertaken as an attempt to improve access for the economically disadvantaged.

The ADA is acting like an ostrich with its head in the sand. Outside agencies and foundations will continue training dental therapists at institutions, such as community colleges. If the ADA were really serious and got involved in such programs, we might assure that these people would be educated at an accredited dental education program in either a hospital or a dental school that has documented the ability to conduct and evaluate such efforts, which were approved by an appropriate institutional review body.

Such programs could be used to determine what dental therapists can actually perform, under what circumstances, and for what populations. Also, representatives of the

See LETTERS, page five

Letters

Continued from page four

ADA could be included in the planning, implementation and evaluation process.

Keep hiding your heads, House of Delegates, until dental therapists trained for one year at trade schools are practicing in all 50 of our states.

Edwin S. Mehlman, D.D.S.
Warren, R.I.
ADA Former Vice President (1994-95)
ADA Former Trustee (1999-2003)

States share blame

In response to the letter from Dr. Fred Zietz (Oct. 18 ADA News), I don't disagree with him that every dentist should step up to the plate and treat a percentage of patients in need. However, the problem isn't necessarily an issue with funding.

Funding is always an issue, but in Alaska and particularly with the Medicaid program, it is more of an issue with the contract that providers must sign with the state of Alaska where the providers are necessarily put in the position of possible liability exposure that is not insurable.

The state has sidestepped responsibility in all matters dental-related by virtue of a hold-harmless clause that puts everything on the shoulders of the providers. An extended effort to change the hold-harmless clause to make the provider liable for any harm that is caused solely as a result of the provider's work—something that is both reasonable and insurable—was dropped by the state as not being an issue. At that point, I resigned from the Medicaid program and started providing treatment to people in need at my choosing and with no reimbursement.

Perhaps others should look at their contracts with their respective states and see if liability exposure really is the issue—not the fees—and, if so, let their state legislators know.

Thomas G. Hipsher, D.D.S.
Anchorage, Alaska

Milestones

As a long-standing member of the ADA, I would like to commend the membership on the election of Dr. Raymond F. Gist as president. The Association has demonstrated its foresight and wisdom over many years in its selection of outstanding leaders, and I am confident that Dr. Gist will furnish the quality of leadership that we have become accustomed to expect. Please extend to him my congratulations and best wishes for a very successful and rewarding tenure as president.

Regarding your reflection on diversity and inclusion in our profession ("Diversity Commitment Reinforced in Apology," Nov. 1 ADA News), please be advised this is not a new concern for many of our members who have lived a life in their practices and private lives of respect for all people, regardless of gender, race or religion.

I have been a practicing dentist for 64-plus years, and from my first patient forward, I have welcomed all patients equally. When it was customary for many of our colleagues to have separate reception rooms and operatories for minorities, beginning with the very first day, I made no distinction. I dare say that in this day and time, the dentists of the United States have long ago put these old biases behind them and are living and practicing respectfully of all who come to them for dental services.

This also has been demonstrated in their election of Dr. Gist as president of the ADA. He is a man who is imminently qualified to fulfill this most important office. No one can do less than wish him well and much success in this important office. Furthermore, I seriously doubt that Dr. Gist is spending much capital making apologies for the membership and the hard working staff of the ADA for long past transgressions. I would guess he would like nothing better than to put all that stuff behind him and move forward with the needs of the ADA, its members and the public that is to be served by this great profession.

Henry S. Zaytoun, D.D.S.
Raleigh, N.C.

Apology

Am I the only ADA member to take exception to the ADA apologizing in 2010 for its past racist ways … from 50 years ago?

How many more times are we going to be lumped as guilty by association for the actions of our long ago dead or retired predecessors? Do we really have to apologize for the sins of our fathers? Today's dental profession came of age in the new and improved post-1964 Civil Rights Era. It never even occurred to me that the ADA (I'm a proud member since 1977) is now or ever was a racist organization.

Those of us who were around in the early '60s remember the way things were. But have we not moved on? Is it really necessary to make an issue of which ethnic groups are represented (or under-represented) in our profession? Do our patients really care? Does it actually make a difference in their dental care? Does anyone actually choose their doctors by the color of their skin? Attention, ADA: We've moved on. Perhaps you should do the same.

Let's celebrate the accomplishments of our new president and wish him good luck this year.

Michael D. Lefkove, D.D.S.
Milledgeville, Ga.

MyView

Continued from page four

1-888-471-6334 or "www.dentallifeline.org".

Why volunteer? Karen, one of our patients from Illinois whose dental treatment qualified her for the donor list for a lung transplant, wrote: "I truly believe you all are angels here on earth to make sure people still have hope and believe never to give up. Thank you with all my heart."

Dr. Coffee is the founder and CEO of Dental Lifeline Network.

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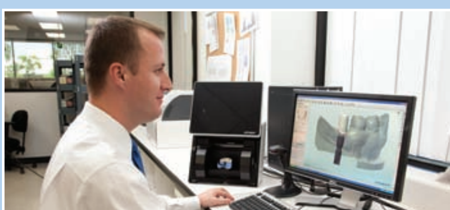

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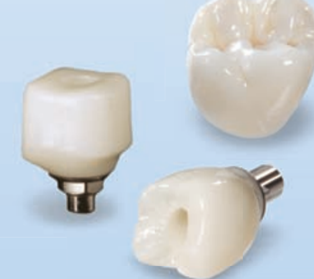

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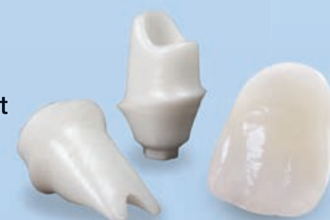

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Government

ADA: No scientific reason to revisit amalgam regulation

BY CRAIG PALMER

Washington—The American Dental Association "strongly urges" a Food and Drug Administration advisory panel to support the current regulation of dental amalgam when the advisors meet Dec. 14-15.

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The FDA will convene a dental advisory panel to review "scientific issues that may affect the regulation of dental amalgam," the agency announced in June. The panel can advise the FDA but has no authority to change amalgam regulations adopted just a year ago and supported by the Association. The FDA can accept or reject any recommendations that may issue from the panel's public review. The FDA regulates amalgam as a medical device.

"There is no scientific reason to revisit the 2009 FDA amalgam ruling," the Association said in comments filed Dec. 1 for the dental products panel of FDA's medical devices advisory committee. "The state of the science on the issue of the safety of dental amalgam is clear. The best scientific evidence continues to support the safety of dental amalgam."

> **"The ADA is a science-based organization and bases its comments solely on the scientific evidence. Based on that evidence, the ADA strongly urges the FDA advisory panel to support the well researched and thoughtful conclusions reached by the FDA only last year, after years of study."**

The Association's comments include an update of the scientific literature by ADA's Council on Scientific Affairs covering studies published between Jan. 1, 2004 and June 15, 2010.

"Overall, studies continue to support the position that dental amalgam is a safe restorative option for both children and adults," the ADA's scientific experts concluded.

The 17-member ADA council "has no interest in the outcome of scientific debate other than to provide dentists with the best available scientific information on which to base their treatment decisions," the Association said.

"The ADA is a science-based organization and bases its comments solely on the scientific evidence. Based on that evidence, the ADA strongly urges the FDA advisory panel to support the well researched and thoughtful conclusions reached by the FDA only last year, after years of study."

The FDA concluded in 2009 that dental amalgam was a safe and effective restorative treatment and issued a final rule, which the Association supported, that reclassified dental mercury and amalgam components for regulatory purposes.

But on June 10, 2010, the FDA called for a new review after receiving petitions "raising various issues relating to the [2009] final rule and special controls," the agency said. The FDA announcement and related Federal Register notice are posted at "www.fda.org".

"The scientific evidence regarding the safety of dental amalgam is well established and has not changed since FDA's 2009 ruling," the Association said. ■

Stark Law deadline set for Jan. 1

Certain imaging services subject to notification provision of law

BY KELLY SODERLUND

A change to an existing law will require dentists who supply certain imaging services to give Medicare and Medicaid patients written notification of alternative suppliers.

The new requirement takes effect Jan. 1, 2011.

A tweak to the federal physician self-referral law, the Stark Law, means a dentist whose practice supplies certain MRI, CT or PET imaging services may be required to notify Medicare and Medicaid patients that they can obtain the services from another supplier. Notification in the form of a written list of five alternative imaging suppliers in a 25-mile radius must be given to the patient at the time of the referral for the service.

Publications look at legal questions on fraud, other laws, page 10

Penalties for violating the Stark Law include not being paid for claims for designated health services, fines and/or being excluded from participating in federal health care programs. Violating the Stark Law may also constitute a violation of the federal Anti-Kickback Statute, which carries criminal penalties. A number of states have also enacted physician self-referral and anti-kickback statutes.

"While this new requirement does not apply to routine dental radiographs, any dental practice that provides, or is considering providing, CT, MRI or PET imaging services should be aware of this change to the Stark Law," said Dr. Stephen Glenn, chair of the ADA Council on Dental Practice.

The Stark Law prohibits a dentist from referring patients for designated health services payable by Medicare or Medicaid to people or companies where the dentist or a member of the

See STARK, page 10

WHO releases report on dental materials, amalgam

BY JENNIFER GARVIN

A new report from the World Health Organization reinforces dental amalgam as a safe and effective restorative material and also notes the widespread public health impact of any proposed ban of the material.

The report, "Future Use of Materials For Dental Restoration" stems from a 2009 meeting in Geneva that the WHO Global Oral Health Program hosted jointly with the United Nation's Environmental Program Global Mercury Partnership.

The two-day meeting highlighted the current scientific evidence on dental materials, including amalgam and non-amalgam restoratives, and gathered information for future recommendations on the use of dental restorative materials—stressing the need to avoid environmental pollution.

According to Dr. Daniel Meyer, senior vice president, ADA Division of Science/Professional Affairs, who was present in Geneva, the FDI worked diligently to keep the talk at the conference focused on the prevention and improvement of restorative materials rather than banning amalgam. The result was the report's conclusion that "dental amalgam remains a dental restorative material of choice."

"Our goal was for the FDI, WHO, the public health communities and professional organizations concerned about health to put more emphasis on assessing risks and preventing oral diseases such as dental caries rather than just treating it. Fortunately, that's what they did to help safeguard, promote and advance oral health care," Dr. Meyer said.

The report rejected a call from those opposed to the continued availability of amalgam to ban its use, instead opting for a "phase down" of the material in hopes that improved prevention efforts worldwide will eventually decrease the need for all restorations. The report also reaffirmed the safety of amalgam, reinforcing the Association's position—backed by with the FDA's 2009 ruling—that the material is a safe and viable choice. It also stressed preventive methods such as fluoride, fluoride varnish and sealants, and emphasized the need for ongoing research to improve alternative materials. ■

—garvinj@ada.org

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Red Flags

Continued from page one

would have put an unnecessary demand on resources and forced dentists to comply with yet another regulation," said ADA President Raymond Gist. "The success of this bill is a good example of how working with coalitions strengthens the ADA's ability to achieve legislative goals."

The Red Flags Rule requires financial institutions and creditors to develop a written plan to prevent and detect identify theft. The FTC has said that dentists and other health professionals are creditors subject to the regulation depending on their credit arrangements with patients as defined by the Fair and Accurate Credit Transactions Act and must implement a Red Flags program by Jan. 1, 2011.

The ADA has challenged the FTC on that interpretation of the law and its application of the rule to dentists. The ADA maintains neither the FACT Act nor the final rule issued by the FTC specifically mentions dentists or other health care professionals as creditors.

The Red Flags Rule went into effect on Jan. 1, 2008, but the agency delayed enforcement until Congress could address what many in the small business community viewed as unintended consequences. The current delay expires Dec. 31.

The coalition included the Academy of General Dentistry, Ambulatory Surgery Center Association, American Academy of Family Physicians, American Academy of Nurse Practitioners, American Academy of Ophthalmology, American Academy of Pediatric Dentistry, American Academy of Periodontology, American Association of Endodontists, American Association for Marriage and Family Therapy, American Association of Neurological Surgeons/Congress of Neurological Surgeons, American Association of Nurse Anesthetists, American Association of Oral and Maxillofacial Surgeons, American Association of Orthodontists, American Chiropractic Association, American College of Prosthodontists, American College of Radiology Association, American Dental Association, American Gastroenterological Association, American Optometric Association, American Physical Therapy Association, American Podiatric Medical Association, American Psychological Association, American Society of Cataract and Refractive Surgery, American Speech-Language-Hearing Association, American Veterinary Medical Association, National Association of Social Workers, National Dental Association and U.S. Chamber of Commerce. ■

Dr. Gist: "The success of this bill is a good example of how working with coalitions strengthens the ADA's ability to achieve legislative goals."

Exam

Continued from page one

between the examining community, the academic community and practicing community on this issue, but we are going to have to start collaborating so that we can achieve the best of all worlds: that is, live patient examinations, quality psychometrics, and a written exam that deals with ethics and treatment planning," said Dr. Low. "I truly believe we can do this."

The idea of having one national exam that assesses clinical competence of dental graduates dates back to the early 1900s. What's new are alternative methodologies for evaluating competency for initial licensure and concerns over the ethical treatment of patients, such as the growth of "patient brokers," or business interests that identify "ideal" patients for testing services and sell those services to students.

"What we need is an exam that meets the needs of everyone," said Dr. Brian T. Kennedy, chair of the Council on Dental Education and Licensure. "That could be a portfolio-style assessment that is truly curriculum-integrated, one that evaluates more competencies and allows for outside objective evaluation that would protect the public, and one that avoids putting students in a situation where there is patient brokering for a snapshot, high-stakes exam."

A new workgroup will oversee the development and announcement of the RFP process in 2011 and consideration of the received proposals in 2012. In addition to Dr. Low and Dr. Kennedy (the ADA representative to CDEL), the group includes Dr. Edward J. Vigna, ADA 10th District trustee; Dr. Patrick M. Lloyd (the American Dental Education Association representative to CDEL); Dr. David Perkins (the American Association of Dental Boards representative to CDEL); Dr. Christopher Salierno, ADA New Dentist Committee; and Brittany Bensch, American Student Dental Association.

Dr. Kennedy

The House of Delegates re-visited the issue of a national exam in 2009 with the consideration of Resolution 26S-1-2009, which called for the House to direct CDEL to study the development of a Part III examination of the National Boards that would evaluate clinical competency, ethics and professionalism in keeping with the ADA policy, Eliminating Use of Human Subjects in Board Examinations. That workgroup was chaired by Dr. William R. Calnon, now ADA president-elect; and included Dr. Charles H. Norman, ADA 16th District trustee; Dr. Kennedy; Dr. Lloyd; and Dr. Perkins.

With representation from the practice, education and examining communities, the workgroup held frank discussions of issues related to dental licensure.

"I don't think there was an opinion that was not voiced and not voiced strongly," said Dr. Kennedy. "We took this issue apart from every angle we could trying to find common ground and move things forward. In the end, we agreed that if the concept of a national exam is to be viable, it would have to address the concerns of all parties. The ADA can facilitate that process."

Dr. Low

(Read more about the 26S-1 workgroup at "www.ada.org/news/3915.aspx".)

The workgroup studied the perspectives and policies of the licensure community, as well as dental educators and students; the history of dental licensure; alternative initial licensing methods now in use; and California's recently enacted legislation making the state the first in the nation to create a dental school-based portfolio examination process.

Many are watching California as the state unveils a new licensure process that gives dental students the option of taking a school-based licensure exam that allows them to build a portfolio of completed clinical experiences and competency exams in seven subject areas over the entire course of their final year of dental school.

(Read more about the legislation at "www.ada.org/news/4890.aspx".)

The workgroup zeroed in on portfolio-style assessments, which are conducted using patients of record, as a methodology that shows great promise and supports policies on the ethical treatment of patients, said Dr. Kennedy. Portfolio assessments could also address the examining community's concerns over the lack of fidelity in simulation alternatives that do not involve live patients.

The strength of Res. 42H-2010 is that it's a compromise resolution, added Dr. Low.

"With a portfolio-style assessment, you still have a live patient but not in a scenario where the patient can be used for a particular objective and possibly never seen again," said Dr. Low. "I think that is why the House reinforced the elimination of live patients but also sought a compromise that enables the dexterity of dental students to be tested."

A secondary challenge facing the workgroup is whether states will accept one national exam.

"States have the right to accept any examination or methodology for initial licensure that they choose," said Dr. Kennedy. "However, if we can come up with something objective that allows for independent evaluation and meets state boards' regulatory obligations to protect the public, we can move toward broader acceptance." He likened a national exam to licensure by credentials, which was initially met with some resistance but is now accepted in 46 states.

"This will be an evolutionary process," said Dr. Kennedy. "If it's something that makes sense, is economically feasible and can be ethically accomplished, the states have no objective reason not to consider its implementation.

"As more states utilize the process," Dr. Kennedy continued, "there will be less rationale to administer a less comprehensive examination process with all the problems we know to be associated with it."

Developing and administering an exam has high start-up costs and ongoing administrative costs for dental boards, schools and students. "The request for proposals will give us a more accurate estimation of the financial implications," said Dr. Low.

The workgroup will begin its meetings in 2011. ■

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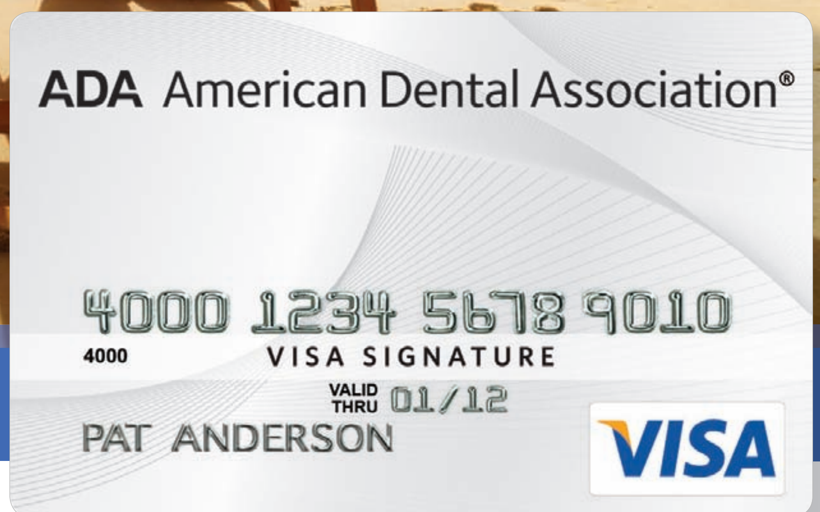

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Two publications offer help in understanding fraud law, frequently asked legal questions

A new publication is available to help dentists understand the Stark Law and other federal fraud and abuse laws.

The U.S. Department of Health and Human Services Office of the Inspector General has published "A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse." The book discusses five fraud and abuse laws; practitioner relationships with payers, vendors and fellow providers; compliance programs and where to go for help. For more information on the book, visit "http://oig.hhs.gov/fraud/PhysicianEducation". To download a printable copy, visit "http://oig.hhs.gov/fraud/PhysicianEducation/roadmap_web_version.pdf".

Fraud and abuse laws can affect dentists even if they don't bill Medicare or Medicaid. Penalties for violations include fines, exclusion from federal health care programs, and in some cases even criminal prosecution. A mere inadvertent violation can have devastating consequences. Health care fraud and abuse laws prohibit certain business practices that may be acceptable in other industries.

The recently enacted federal health care reform legislation includes new tools and increased funding to fight health care fraud. For example, the act requires health care providers who identify a Medicare or Medicaid overpayment to report and return it with a written explanation of the reason for the overpayment within 60 days. Retaining an overpayment for longer than 60 days violates the False Claims Act.

The American Dental Association publication, "Frequently Asked Legal Questions," was recently updated and offers answers to nearly 190 questions commonly asked by members. The spiral bound book and CD-ROM (l756) is $89.95 for members and $134.95 for nonmembers. The e-book (L756D) is $59.95 for members and $89.95 for nonmembers. To order, call the ADA Member Service Center at 1-800-947-4746 or visit "www.adacatalog.org". ■

Stark

Continued from page seven

dentist's immediate family has a financial relationship. There are exceptions to the law.

Designated health services include clinical laboratory services; physical therapy services; occupational therapy services; outpatient speech-language pathology services; radiology and certain other imaging services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services.

To help dentists understand this change to the Stark Law, the ADA Legal Division has written an article that provides more comprehensive and detailed information on the new requirement. For more information, visit "www.ada.org/members/sections/ProfessionalResources/stark_law_article.pdf". ■

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Honoring volunteer service

Nominations sought for 2011 international certificates

The ADA Division of Global Affairs is accepting nominations for the 2011 Certificate for International Volunteer Service. Dental society officers and dental school deans must submit nomination materials by April 1, 2011.

The certificate is awarded to active, life, student or retired ADA members who have served abroad for a minimum of 14 days in a given 24-month period. Application forms and award guidelines can be found online at: "www.ada.org/1473.aspx". For more information, call the ADA Division of Global Affairs at 1-312-440-2726 or e-mail "international@ada.org". ■

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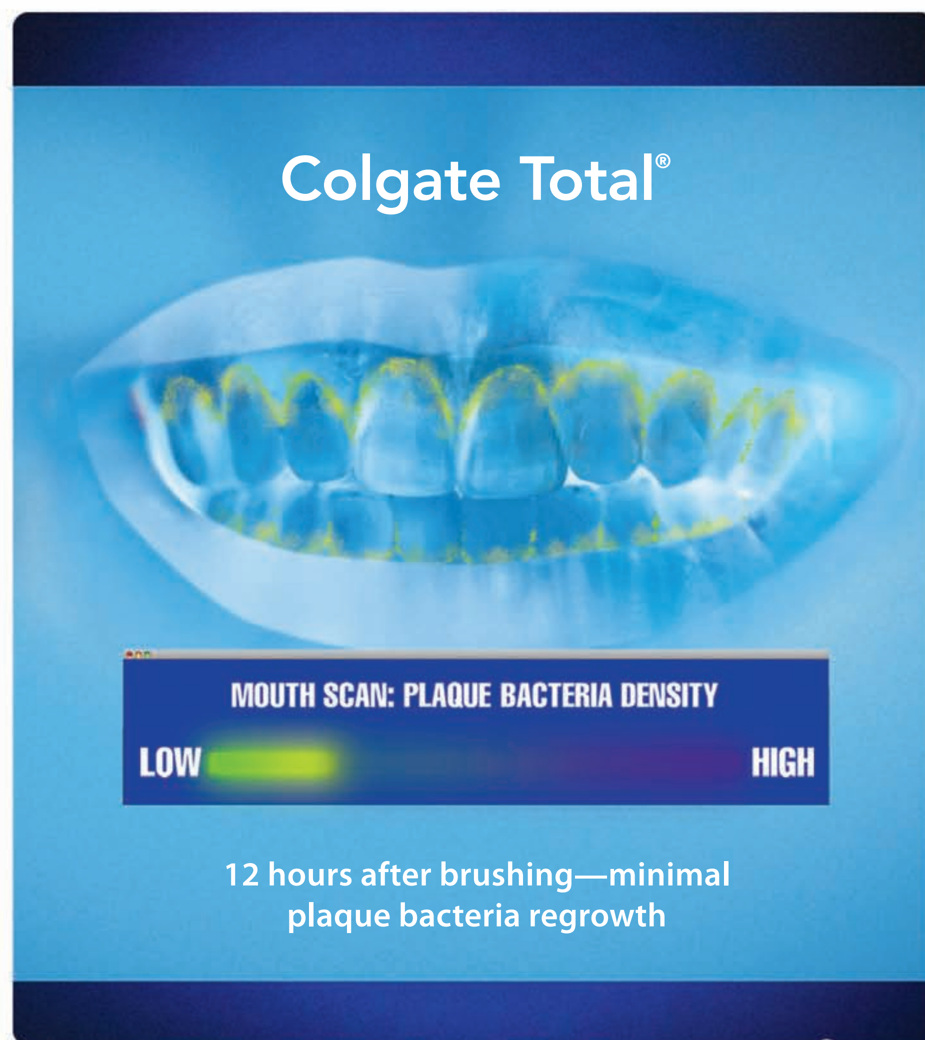

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Creston

Continued from page one

funding, and had to close its doors.

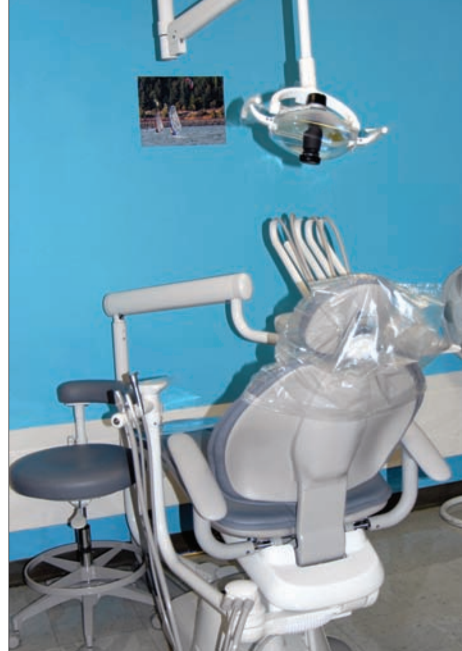
Clinic supporters jumped into action, forming the Friends of Creston Children's Dental Clinic. The organization began the process to become a 501(c)(3) entity, obtained grants from Multnomah County and the dental society, as well as other donations and started recruiting volunteer dentists and dental hygienists to staff the clinic to reduce its operating costs by 50 percent, said Dr. Kurt Ferré, immediate past president of the Multnomah Dental Society.

The clinic still gets a generous in-kind donation from the school system because it is housed in Creston Elementary School, Dr. Ferré said. The clinic pays $1 a year for rent, which includes heat, lights, Internet, phone and janitorial services. Paring down the paid staff and enlisting the support of volunteer dental professionals was the key to reducing the operating budget, he added.

"It's so important for dentists to develop a philosophy of giving back," said Dr. Ferré, who is now retired from dental practice. "I practiced 23 years before I volunteered, but when I did, I was hooked. I feel very privileged. Dentistry has been so good to me. It's allowed me to retire early and concentrate on volunteering."

The grand reopening showcased the clinic's facelift—including new paint, some updated ambience from a pro bono interior designer and two new dental chairs donated by A-dec, which is based in nearby Newberg, Ore.

Since Sept. 14, the clinic has provided more than 375 patient appointments and care valued at $100,000, said the clinic's new administrative director Erica Soto. Ms. Soto's primary responsibility at the clinic is to recruit, retain and coordinate volunteers as well as to oversee its day-to-day operations.



Donation: A new dental chair donated by A-dec sparkles against the Creston Children's Dental Clinic's freshly painted walls.

"Volunteers—including 31 dentists, 12 hygienists, three dental assistants and seven office support volunteers—have donated 426 volunteer hours," she said. "And our patients and their families are grateful for the services we can provide to them."

"You should know that you have changed my daughter's life," said the mother of a 17-year-old patient. "Before she was so scared to come to the dentist and refused to go. In that time, her teeth just got worse. She is no longer scared of the dentist and we are so happy that she is almost done with treatment. Thanks for making my daughter smile again."

The four-chair clinic treats about 1,500 students from the Portland school system each year that don't have dental insurance and are qualified for the free and reduced lunch program. FCCDC estimates that since the clinic opened in 1962, more than 50,000 children have received dental care services there.

While making the transition to a 501(c)(3) organization, United Way of Columbia-Willamette has served as the clinic's fiscal sponsor until its charitable status is official, said Lora Mattsen, executive director, Multnomah Dental Society. "They are underwriting the administrative costs and providing 100 percent of donations that are made to the clinic." ■

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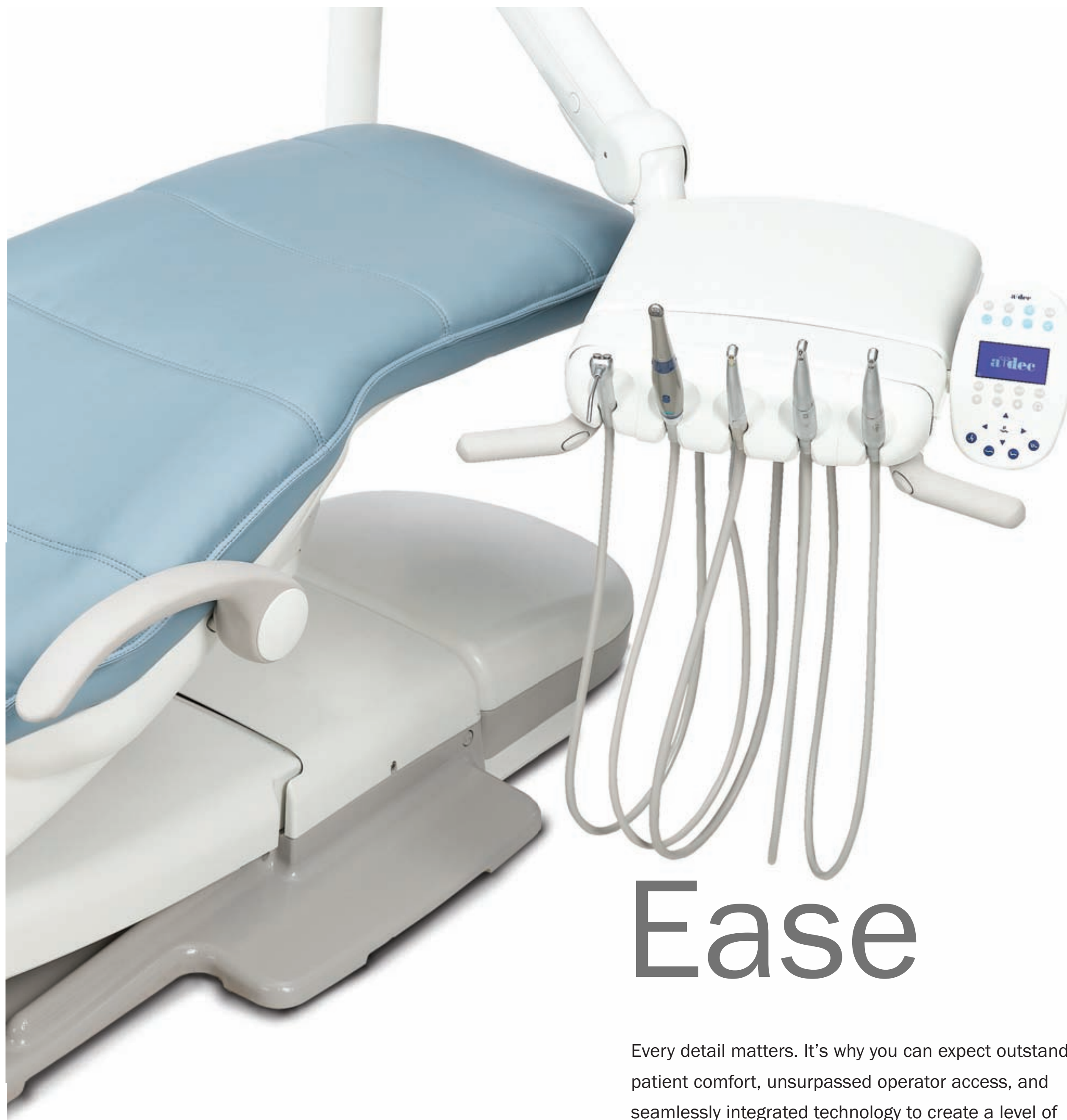

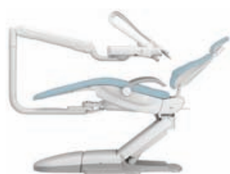

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Special Care Dentistry meeting planned for April

Dental professionals who want exposure to the latest in continuing education, trends, equipment and supplies that can help them better serve patients with special needs should plan to attend the 23rd annual meeting on Special Care Dentistry, with the theme "Total Patient Care," April 1-3, 2011, at the Swissôtel Chicago.

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- both longtime expert speakers in the field as well as newcomers, offering programs designed to inspire and invigorate;
- an exhibit gallery featuring products and services such as dental equipment and supplies, educational material and more;
- the SCD Association Gala and other networking events that honor practitioners and create an atmosphere for making peer-to-peer connections happen.

Clinically focused CE sessions are focused on treating the medically complex patient. Guests also have access to the SCDA Exhibit Gallery, where they can check out products and services such as dental equipment and supplies, educational materials and more.

An advance program is available for downloading and registration is now open online at "www.scdaonline.org". Those who register by Feb. 9 will save $100. ■

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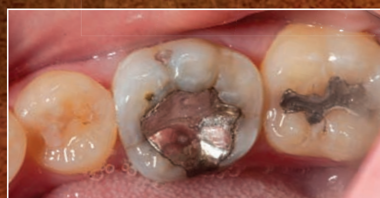

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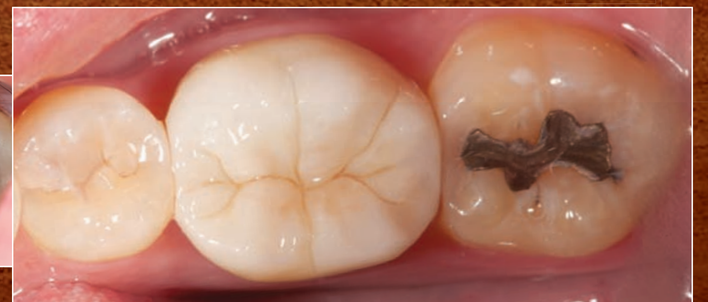

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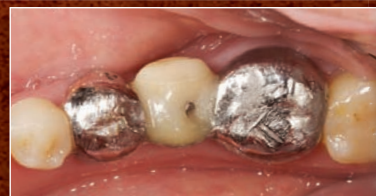

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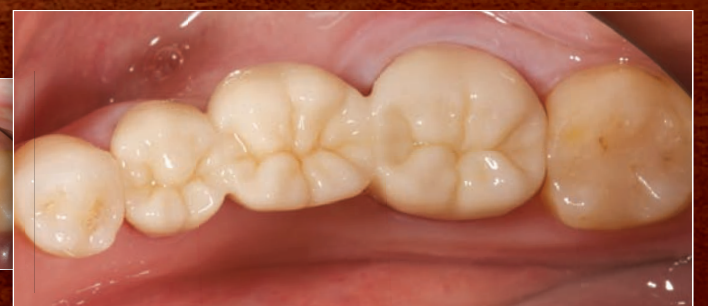

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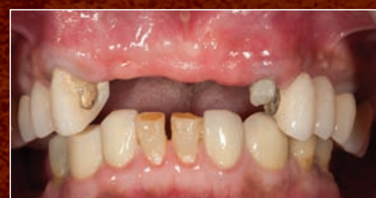

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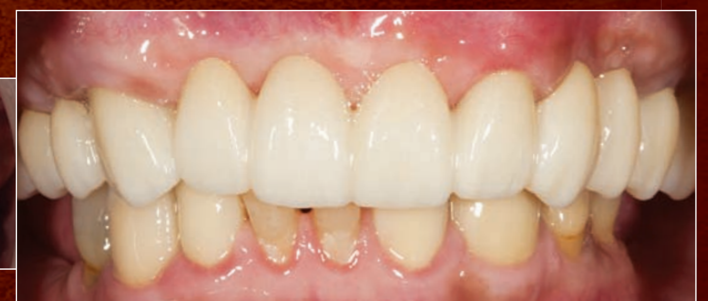

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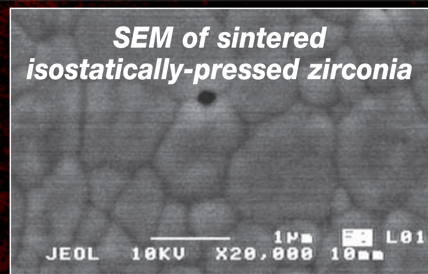

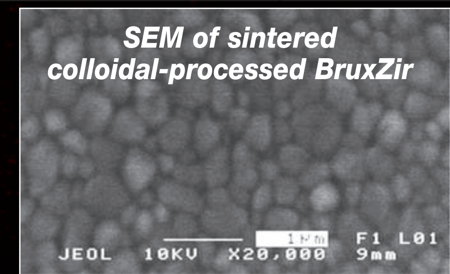

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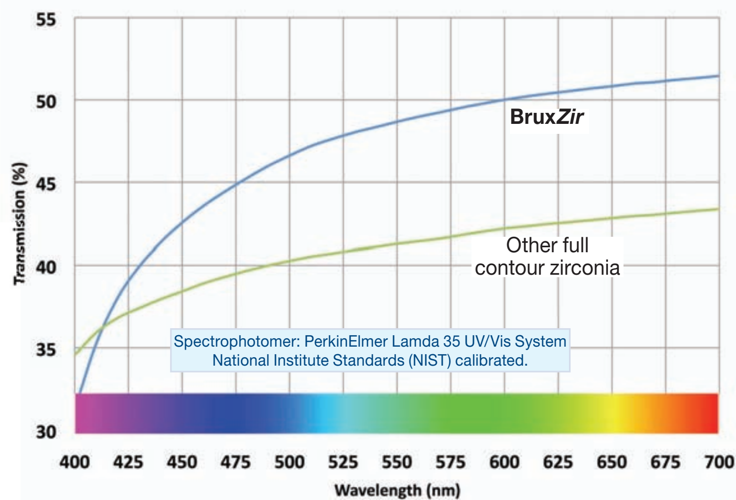

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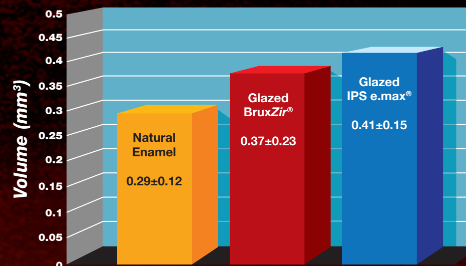

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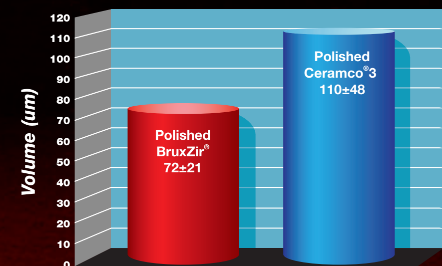

The antagonistic (Steatite balls) wear shows BruxZir only with 72±21 micron, which is significantly lower than Ceramco® 3 (110±48 micron). The University of Tübingen study was run using an eight chamber Willytec Chewing Simulator at 1.2 million cycles.

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TLC Dental Laboratory	Orlando	FL	800-262-2547
New Image Dental Laboratory **	Morrow	GA	800-233-6785
Oral Arts Dental Lab Georgia	Chamblee	GA	800-229-7645
The Lab 2000, Inc.	Columbus	GA	800-239-3947
Oral Arts Dental Lab Iowa	Dubuque	IA	800-747-3522
Distinctive Dental Studio, Ltd.	Naperville	IL	800-552-7890
Dental Arts Laboratories, Inc.	Peoria	IL	800-322-2213
Ito & Koby Dental Studio	Indianapolis	IN	800-288-6684
Keller Dental Laboratory	Louisville	KY	800-292-1894
Crown Dental Studio	Shreveport	LA	800-551-8157
Pfisterer-Auderer Dental Lab	Metairie	LA	800-288-8910
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Eliason Dental Lab	Portland	ME	800-498-7881
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D.H. Baker Dental Laboratory	Traverse City	MI	800-946-8880
Excel Dental Studios Inc.	Minneapolis	MN	800-328-2568
Saber Dental Studio	Brooklyn Center	MN	800-264-3903
Thoele Dental Laboratory	Waite Park	MN	800-899-1115
Webster Dental Laboratory	St. Paul	MN	800-621-3350
Wornson-Polzin Dental Lab	North Mankato	MN	800-950-5079
Keller Laboratories, Inc. **	Fenton	MO	800-325-3056
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Oral Tech Dental Laboratory	Pearl	MS	800-321-6201
The Freeman Center	Stallings	NC	800-659-7636
Kiess Kraft Dental Laboratory	Omaha	NE	800-553-9522
H & O Dental Laboratory	Manchester	NH	800-543-4312
Excel Berger Dental Laboratory	North Brunswick	NJ	800-438-3384
Ideal Dental Laboratory	Albuquerque	NM	800-998-6684
Las Vegas Digital Dental Solutions **	Las Vegas	NV	800-936-1848
Smile Design Dental Laboratory	Port Washington	NY	516-472-0890
Salem Dental Laboratory	Cleveland	OH	800-747-5577
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Dental Quality Alliance update

BY KELLY SODERLUND

The Dental Quality Alliance is in the process of forming an advisory committee on Research and Development of Performance Measures, which will begin its work after the first of the year.

Although the ADA is facilitating and leading the DQA, the advisory committee and approval of its work product will be guided by the DQA Executive Committee.

"The Centers for Medicare & Medicaid Services came to the ADA requesting that we take the lead in forming the DQA and we were wiling to do so, however the development of meaningful quality measures will be a multi-stakeholder endeavor," said Dr. R. Wayne Thompson, DQA chair and ADA 12th District trustee.

Forming the committee topped the DQA's agenda at its Oct. 29 meeting in Washington, D.C. The meeting also included discussions about future funding and the procedures for selecting a public member of the DQA.

The advisory committee on Research and Development of Performance Measures is one of four such groups advising the DQA and is scheduled to start developing performance measures in the first quarter of 2011. The member organizations of the DQA will nominate individuals to serve on the committee, and the DQA Executive Committee will determine the final members from the slate of nominees, who do not necessarily have to be a member of the nominating organization.

The formation of the advisory committee is scheduled for completion Dec. 17. The first meeting will be held via conference call in early 2011.

At its next meeting, scheduled for June 2011, the DQA will discuss how a public member will be identified. A second DQA meeting is also scheduled for November 2011. In conjunction with those meeting dates, the advisory committees will also meet. All meetings will be held at ADA Headquarters in Chicago and are open to observers.

The DQA is developing programmatic performance measures to assess oral health care quality for Medicaid patients. ■

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Align federal court hearing set for Dec. 17

BY KELLY SODERLUND

A court hearing requesting preliminary approval of a settlement in a class action lawsuit between dentists and Align Technology Inc. has been scheduled for Dec. 17.

The lawsuit was filed May 10 in federal court in northern California by dentists who allege that, after taking the training course, the company instituted a case quota, reportedly decertified doctors who didn't comply with the company's new rules and failed to reimburse dentists for thousands of dollars in training fees. Jason Hartley, attorney with Stueve Siegel Hanson LLP, the Kansas City law firm representing the class, estimated this fall that more than 22,000 dentists are included in the class.

The settlement could mean class members can obtain reinstatement to prescribe Invisalign following completion of a free three-hour online course, and certain class members could have the option to elect a cash remedy instead, according to a news release posted on Align's website Dec. 6. The amount of money dentists stand to receive has not been announced. The proposed settlement remains subject to approval by a judge.

If the court grants preliminary approval of the settlement at the hearing, all class members will be notified via postal mail within about two weeks of the decision, according to an Align statement released Dec. 6.

The lawsuit claims Align Technology Inc., which manufactures and sells Invisalign, violated California public policy by requiring doctors to prescribe at least 10 cases each year in order to make money. The lawsuit alleges Align was not concerned about patient welfare but about its own bottom line. It describes Align's practices as unfair and fraudulent.

The class action complaint asked Align to refund dentists the fee they paid to be certified to prescribe Invisalign and said as a result of the practices, the class suffered injury in fact and lost money or property. Align required doctors to pay about $2,000 for a training course to be certified to prescribe Invisalign. In June 2009, Align said doctors would have to start at least 10 cases each year to retain their certification, an action met with protest from numerous groups. The ADA communicated with Align several times, and in April, Align announced it was dropping the requirement.

Dentists who have questions can contact the the attorney for the plaintiff toll free at 1-888-816-1761 or visit "www.stuevesiegel.com/CM/CurrentCases/Invisalign.asp".

Watch the ADA News for updates on the Align case. ■

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Are you on Find-a-Dentist?

Advisers hit road, help dentists get online

BY KAREN FOX

Orlando, Fla.—"Your Find-a-Dentist profile on ADA.org is only as good as you make it."

That message beckoned hundreds to an annual session photo studio equipped with a professional photographer, computers and knowledgeable advisers. By the conclusion of the meeting, 1,000 members had portraits taken and updated their detailed practice profile on ADA.org's "Find-a-Dentist" feature.

"Find-a-Dentist is a tangible tool that can actually help put patients in members' chairs," said Dr. Virginia Hughson-Otte, chair of the Council on Membership. "The service is easy to use and free to members. But since members have to actually upload the photo and update their profile, the service at annual session helped accomplish this for members."

Launched for members only as part of the redesigned ADA.org, Find-a-Dentist enables ADA members to manage photos, practice information and other details online. Patients can view a variety of information about a member on Find-a-Dentist, including a photo of the dentist; office address, map and hours; contact information (including practice website link); education and specialty; languages spoken; years in practice; insurance acceptance and payment options; and recognized-specialty affiliations.

"Find-a-Dentist comes at a critical time when more patients are turning to the Web for information and when the economy has hit some of our members pretty hard," said Dr. Hughson-Otte. "Find-a-Dentist can help market members' practices at no cost to them. The site is receiving nearly 20,000 unique visitors per month—proof that patients are turning to the Web and ADA.org when looking for member dentists and oral health information."

Members can upload a photo of their choosing and update their Find-a-Dentist profile at "ADA.org/memberprofile".

The Find-a-Dentist Photo Studio will also be offered at several dental meetings in 2011, including the ADA New Dentist Conference, the Chicago Dental Society Midwinter Meeting, California Dental Association's annual meeting (CDA Presents), Hinman Dental Meeting and the Greater New York Dental Meeting.

The Photo Studio was just one part of the ADA Pavilion. Staff members answered questions on a variety of membership services, including the Center for Evidence-Based Dentistry; ADA Dental Practice Hub; ADA Political Action Committee; and free survey reports.

Congratulations to Dr. Philip Kuhl, a new dentist from Daytona Beach, Fla., who won a drawing for an iPad at the ADA Pavilion. ■

Candid camera: ADA staff member and professional photographer Steve Horne takes a photo of a dentist during the 2010 annual session.

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Great beginnings: The earliest known photograph of annual session delegates was taken in 1864 at Niagara Falls, N.Y.

Give the gift of ADA history

Are you looking for a unique holiday gift idea for a colleague in dentistry?

The commemorative coffee-table book "150 Years of the American Dental Association: A Pictorial History, 1859-2009" is still available.

Filled with interesting anecdotes and over 300 historic photos, the 200-page hardcover book tells the story of the dental profession with a look at its past, present and future. It's an excellent addition to every dentist's personal library or waiting room.

All proceeds from the book sales support the activities of the ADA Foundation.

The book (J105) is available through the ADA Catalog ("www.adacatalog.org" or 1-800-947-4746). Member price is $49.95; nonmember price is $74.95. ■

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In fact, Sonicare For Kids is clinically proven to remove up to 90 percent more plaque overall than a Crest battery-powered Spinbrush®.[2] It's no wonder 91 percent of dental professional parents surveyed preferred Sonicare For Kids for their own children.[3]

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2. Milleman J, Putt M, Olson M, et al. *International J Pediatric Dent.* 2009;19:s1
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Forensics data standard set

BY JENNIFER GARVIN

For more than three years, the ADA Standards Committee on Dental Informatics has worked to establish a national forensics data standard.

Those efforts paid off last month when the American National Standards Institute approved ANSI/ADA Specification No. 1058 for Forensic Dental Data Set as an American National Standard. Designed to assist dentists and dental professionals in establishing positive identification of human remains, the new standard will standardize how forensic dental data is handled and ultimately gives dentists a uniform electronic format to transfer that data.

The new specification also standardizes the submission of supporting documentation from the dentist or dentists who treated the patient. Dentists can directly submit radiographs, charts and progress notes to the forensic odontologist or through a clearinghouse.

The goal of the new standard was not to define the extent of information collected but to develop uniform nomenclature for the description of forensic dental data and to define a standardized set of common terms.

"The important thing is that it keeps everyone on the same page," said Dr. Kenneth Aschheim, chair, SCDI Joint Working Group 10.12 on Forensic Odontology Informatics, and assistant chief forensic odontologist for New York City's Office of the Chief Medical Examiner, as well as an associate clinical professor at Mount Sinai Medical Center. "Ultimately, the goal is to create a standardized electronic format to transfer this data."

Dr. Aschheim described the new standard as similar to a Current Dental Terminology for Forensic Dentistry. "Sometimes we receive charts that are difficult to interpret," he said. "Dentists are using different names for restorations, nonstandard abbreviations and nonspecific descriptors. The committee set out to unify these descriptors because as we move toward electronic records, any data that cannot be coded cannot be transferred."

The new standard also lends itself to use by electronic dental databases, such as ones used by the National Missing and Unidentified Persons System and the Federal Bureau of Investigation, to assist in identifying missing people using dental records.

The Forensic Dental Data Set will consist of an Antemortem Data set of six components: Familial Data, Dental History Data, Tooth Data, Mouth Data, Visual Image Data and Radiographic Image Data. The Postmortem Data Set consists of four components: Tooth Data, Mouth Data, Visual Image Data and Radiographic Image Data.

Dr. Aschheim credited the chairs of the working group's subcommittees: Dr. Lawrence Dobrin, Familial and Dental History; Dr. Harry Zohn and Dr. Sheila Dashkow, Mouth; Dr. Richard Weledniger, Radiographic; and Dr. Scott Benjamin, Image; and Winnie Furnari, RDH, committee secretary, for their diligent effort in getting the standard formulated.

Dr. Robert Barsley, American Board of Forensic Odontology; Dr. Thomas David, American Academy of Forensic Sciences; Dr. Ken Hermsen, American Society of Forensic Odontology; and numerous private, federal, state and local agencies ensured that the forensic community's needs were met in the standard.

When asked about the future, Dr. Aschheim stated there is still work to be done.

"The next step is for the ADA to complete the requirements for an electronic dental health record. When that is finalized there will be a single unified standard for the transfer of dental data and it will include all of the information necessary to aid the forensic odontologist."

If you are interested in being a part of the ADA SCDI Joint Working Group 10.12 on Forensic Odontology Informatics, contact Paul Bralower at Ext. 4129 or "bralowerp@ada.org".

To purchase ANSI/ADA Specification No. 1058, contact the ADA at Ext. 2506 or "standards@ada.org". ■

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Dental workforce projection model report available

The ADA Health Policy Resources Center has released the 2010 ADA Dental Workforce Model: 2008-2030.

The report provides a long-term projection of the U.S. dental workforce using statistical transition models for retirements, occupation changes, location choice, specialty education and death. It also includes national projections of the number of professionally active dentists, private practitioners, dental school applicants, first-year dental school enrollment and dental school graduates up to 2030.

To purchase a copy of the report (DWM-2010), call the ADA Catalog at 1-800-947-4746 or visit "www.adacatalog.org". Cost is $80 for members, $120 for nonmembers and $240 for commercial firms, plus shipping and handling. There is also a version available for download (DWM-2010D) for the same price, excluding shipping charges. ■

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Oklahoma CDHCs receive white coats

BY STACIE CROZIER

Oklahoma City—Oct. 23 was a day of celebration at the University of Oklahoma Health Sciences Center as five Community Dental Health Coordinator participants received their white coats in a special recognition ceremony.

Courtney Roberts, Katherine Mathews, Kimberley Cave, Jessica Johnson and Melissa Tyler are among the first cohort of CDHCs to complete the ADA's pilot program, following nearly 1,900 hours of instruction that included 12 months of online study, in-person clinical training and six-month internships.

The new CDHCs are now ready to bring dental education, prevention services and patient assistance to communities with inadequate access to oral health care and disproportionate oral disease rates.

"The ADA is proud of these participants, who we hope will be the vanguard of a new way—we believe a better way—of preventing disease in underserved communities, in large part by empowering people to take charge of their own oral health," said ADA President Raymond F. Gist. "This type of community-based approach has worked well in other fields of health care. We believe we can improve people's health and lives by preventing dental disease and raising awareness of the importance of good oral hygiene habits."

The new CDHCs can also provide specific clinical services under the supervision of a dentist such as fluoride treatments and placement of dental sealants when allowed by existing state laws.

The participants are also trained to help patients navigate the health system and to connect patients with dentists by helping them overcome barriers to care such as lack of transportation or child care.

CDHC participants: Cohort 1 participants from the ADA's Community Dental Health Coordinator pilot program at the University of Oklahoma Health Sciences Center include graduates (from left): Courtney Roberts, Katherine Mathews, Kimberley Cave, Jessica Johnson and Melissa Tyler.

CDHCs are recruited from the same communities in which they are trained to serve, including remote rural areas, urban areas and Native American communities, thus eliminating many of the cultural, language and sociological barriers that might otherwise impede their effectiveness.

"I'll help dentists by knowing the people of the community. They know me and trust me," said Melissa Tyler. "I can go to schools, nursing homes or community centers to educate people. The more I can help someone, the better they'll be."

"The new CDHCs are excited about the roles that they will play in their communities," said Marsha Beatty, co-director of the CDHC program at the University of Oklahoma. "They all worked hard to learn valuable skills that they can use to help improve the oral health of people who live in underserved communities. We couldn't be more pleased by what they have accomplished, and we look forward to future success."

CDHCs can be employed by federally qualified health centers, the Indian Health Service and tribal clinics, state or county public health clinics, or private practice dental clinics in underserved areas.

Participants must complete 12 months of online course work, in-person clinical training and six-month internships, including instruction in topics such as human psychology, sociology and communications, biomedical sciences, dental sciences and clinical sciences. The CDHCs will incorporate their new skills in their current positions at the clinics with which they are affiliated.

Each pilot program is under the direction of a major university. Temple University in Pennsylvania is training participants to work in urban areas; the University of Oklahoma is training participants to work in rural communities; and the University of California at Los Angeles, in conjunction with Salish Kootenai College in Montana, is training participants to work in Native American communities. All of the educational institutions collaborate with Rio Salado College in Tempe, Ariz., to deliver the online and clinical components of the curriculum.

The ADA is funding the pilot program through 2012 and is seeking additional future funding from corporations, foundations and government. In September, Henry Schein Inc. committed nearly $860,000 in dental office equipment needed for the second and third cohort participants in pilot project training.

Currently, nine additional participants are enrolled in the CDHC program at the three pilot program sites, and recruitment is planned for a third cohort of participants that will begin their training in March 2011.

Visit "www.ada.org/cdhc.aspx" to learn more about the ADA's CDHC pilot program. ■

—croziers@ada.org

Kellogg moves ahead on dental therapist project

BY STACIE CROZIER AND KELLY SODERLUND

Battle Creek, Mich.—The W.K. Kellogg Foundation Nov. 17 announced that it will invest more than $16 million by 2014 in its Dental Therapist Project, focusing on efforts in Kansas, New Mexico, Ohio, Vermont and Washington.

ADA President Raymond Gist, though welcoming the Kellogg Foundation "to the fight to improve the oral health of the millions who suffer from its lack," noted that the foundation's recent efforts to address this complex issue focus exclusively on expanding a single provider model, based on the controversial Alaska Dental Health Aide Therapist.

The limited research evaluation conducted by Kellogg did not provide the robust examination or projectable metrics on which to base such important policy and public health decisions, he said. In addition, there is no comprehensive model or report with an economic analysis from a cost benefit perspective for this new dental

Workforce

workforce model.

"No matter where you stand on the issue of nondentists performing dental surgery—and we stand firmly against it—limiting the approach to overcoming the many access barriers to promoting this one workforce model ignores numerous, and we believe much greater, barriers to care," said Dr. Gist. "Frankly, these energies and resources would be better directed toward fixing existing programs."

Barriers that need to be removed, he added, include lack of adequate funding for public assistance dental programs and geographic and other practical barriers like transportation, securing time off from work, translation services, health literacy levels and child care.

"Prevention is the ultimate solution to the epidemic of untreated oral disease," said Dr. Gist. "The nation will never drill and fill its way out of this health crisis. Yes, we must bring millions more into the system to receive comprehensive and coordinated care overseen by dentists. But almost all of this disease is entirely preventable.

"The ADA supports workforce innovations that address prevention and providing care to those with the most urgent needs, without putting the patient at risk," Dr. Gist added. "In 2009, the Association launched the Community Dental Health Coordinator pilot project. The CDHC model is based on community health workers, who have proven extraordinarily successful on the medical side. The CDHC focuses primarily on prevention, through oral health education, and the application of preventive measures like sealants and fluoride varnishes. The CDHC enables the patient to overcome several of the more practical barriers to care—cultural, language, scheduling coordination—and helps the community members navigate these obstacles successfully. The majority of the first class of CDHCs completed its training this fall. They now are working in clinics and other public health settings." (See story, this page.)

The ADA's statement in response to the Kellogg initiative is posted online at "www.ada.org/5065.aspx".

The Kellogg Foundation said it will work in the five states with its national lead grantee Community Catalyst, a nonprofit health care advocacy organization. The project will support what it describes as "community-led efforts" in those five states to establish dental therapist programs as a way to expand access to oral health care, said the Kellogg Foundation in a press release.

Last month, Kellogg issued a report on the Alaska Dental Health Aide Therapist program. The October study by RTI International of Research Triangle Park, N.C., concluded that dental therapists practicing in Alaska provide safe, competent and appropriate dental care. The study evaluated five therapists and 300 patients.

In December 2009, Kellogg released a report that advocated midlevel dental providers who would perform some surgical procedures as a solution to the nation's oral health care access crisis.

State dental society officials would first like to solve the more mundane barriers to accessing routine comprehensive care and lack of money dedicated to dental care for low-income residents before adding another member of the dental team. Dentistry already includes several team members, including dental hygienists, dental assistants and expanded function dental assistants whose capacity to support increasing access to comprehensive care is currently underleveraged within the existing dental delivery system.

See KELLOGG, page 24

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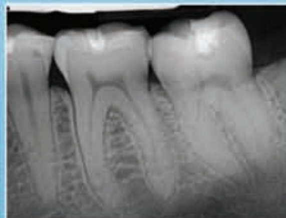

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CDT manual continues to meet dentistry's changing needs

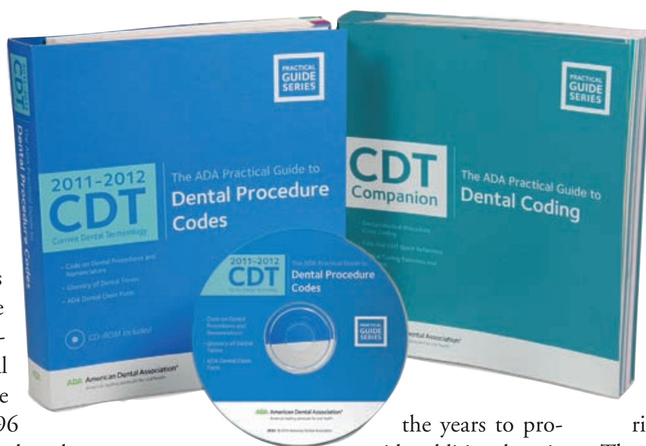
8th edition, now available, offers variety of coding resources

BY KELLY SODERLUND

Twenty years, eight editions, 189 additional pages.

The Current Dental Terminology manual has changed quite a bit since the first edition was published in 1990. Evolutionary changes have made it a valuable and necessary reference for dentists to have at their fingertips.

The new CDT 2011-2012 is 297 pages and is the 8th edition. It contains the Code on Dental Procedures and Nomenclature, which is designated by the federal government under the Health Insurance Portability and Accountability Act of 1996 as the national terminology for reporting dental services and is recognized by third-party payers nationwide.



"CDT aids dentists in finding the best procedure code for documenting the care they provided," said Dr. Christopher J. Smiley, chair of the ADA Council on Dental Benefit Programs. "The Code on Dental Procedures and Nomenclature is named a HIPAA national standard by the federal government. Third-party payers license its use from the ADA and they cannot change the codes, the code descriptors or their intent. Knowledgeable use of the Code allows dentists to advocate for their patients when third-party administrators refuse to provide the entitled benefit."

The ADA expanded sections of the manual over the years to provide additional topic information. The section titled "Tooth Numbering and Area of the Oral Cavity" now includes the scheme for enumeration of supernumerary teeth as recommended by the CDBP and adopted by the House of Delegates; anatomically correct illustrations of teeth in the permanent arches; and a graphic representation of the universal/national tooth numbering system.

Sections have also been added to provide more information. "Changes to the Code" includes color-coded text that shows, by category of service, new, revised and deleted code entries; "Claim Form Completion Instructions" has comprehensive item-by-item instructions with illustrations and additional codes; and a Q-and-A section provides more than 100 questions and their answers, by category of service, that convey CDBP's views on how the Code is used for recordkeeping and claim submission.

A practical example of the value of the CDT occurred when Dr. Dennis Engel, ADA 9th District trustee, was seeking the proper code for fabrication of trays to deliver at-home fluoride treatments for his patient undergoing radiation treatment. CDBP member Dr. James Richeson suggested a hint to find codes. "Check out the alphabetical index in the back of CDT," Dr. Richeson said. "In this case, look up 'fluoride' and under that heading see 'gel carrier.' There you will find the code D5986 Fluoride Gel Carrier, the page to find it in the Code and any other page on which it's referenced."

Dr. Richeson presents the code workshop for the ADA and this is one of the tips offered in the class.

The CDT manual has also spawned a slew of Code-related educational programs and products, including the Code Workshop; ADA CE Online's Introduction to the Code and Its Use; and the CDT Companion, another reference publication for dentists and their staff that is now in its 3rd edition and features coding scenarios.

To purchase the new CDT 2011-2012, visit "www.adacatalog.org" or call 1-800-947-4746. ■

—soderlundk@ada.org

Kellogg

Continued from page 22

"Clearly we don't think this is necessary in the state of Kansas. If a problem exists in a maldistribution of dentists in our state, we think the best approach is to put our heads together and do a better job to provide incentives to put dentists in those areas that are needed," said Dr. Dave Hamel, president of the Kansas Dental Association.

Dr. Hamel said the KDA has approached the state legislature about providing incentives for dentists to practice in rural areas and is finalizing a good oral health package to present in the next legislative session. Funding for Kansas' Donated Dental Services program has been cut and needs to be restored; the state doesn't have an adult Medicaid program; and there need to be revisions made in the existing Medicaid program that could incite dentists to participate.

The Vermont State Dental Society has not taken a position on Kellogg's plan, instead focusing on solving the root problems driving the issue.

"We believe that it is a broader issue that must be considered: Who are the people without access to care and what are the reasons they are without access? We definitely know that resources and financing are a critical component. We will be continuing our efforts to expand the Vermont Medicaid program for those clearly identified in financial need to better access oral health services," said Peter Taylor, executive director.

"It concerns us that the dental therapist model is being proposed as the solution when we realize there are many facets to these problems," he said. "While that effort is going on, we will be working with our Vermont Department of Health and other advocacy groups to look at the big picture of oral health in Vermont."

The New Mexico Dental Association does not believe access to care barriers in its state are related to scope of practice and would have liked to see coalitions work to eliminate a tax on dental care instead, said Mark Moores, NMDA executive director.

"We have a huge social justice issue in New Mexico," Mr. Moores said. "There is a sales tax on dental care in our state of 7 or 8 percent. This is an unfair tax on the working poor. We would have loved to work with Kellogg to eliminate this unjust tax policy and eliminate this huge barrier that the working poor have in accessing quality oral health care. The New Mexico Dental Association was displeased that Kellogg didn't reach out to the largest and most respected dental organization in the state to work together to improve oral health care for all New Mexicans."

The Washington State Dental Association's charitable foundation, the Washington Oral Health Foundation, has school programs in place to address prevention, which Washington dental leaders believe is the ultimate solution.

"I think it's a very complex problem. Kellogg is looking at a very narrow part of that problem. We're looking at a much broader scope of the issue that's before us," said Dr. Doug Walsh, president of the WSDA.

Dr. Walsh said the WSDA is more concerned with losing funding for adult Medicaid, which will occur beginning Jan. 1, and about the lack of fluoridation throughout the state. Both are issues he wishes Kellogg would pay attention to.

The Kellogg news release is available online at "www.wkkf.org". ■

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ADA issues statement on Pew study

The ADA said Dec. 8 that a new Pew study on midlevel dental providers focuses too heavily on the economics of dental care and loses sight of patient oral health.

"We are extremely disappointed at the Pew Center for the States' apparent attempt to influence policy by 'selling' midlevel providers as a way for dentists to increase profits," the ADA said. "These are critical issues and they should not be trivialized. ADA opposition to nondentists performing surgical procedures, whether in a dental office or elsewhere, remains unchanged and unequivocal, and our position is based solely on what we believe best serves the public."

The report released by the Pew Center on the States examines the financial impact of incorporating midlevel dental providers such as dental therapists in private practice settings, and suggests that most practices could serve more patients, improve productivity, and maintain or improve bottom line profit while increasing access to dental care, particularly for Medicaid patients.

The ADA said in its statement posted online at "www.ada.org/5107.aspx" that it supports innovations in the dental team meant to break down barriers to oral health care for those in need.

"The Community Dental Health Coordinator pilot project best exemplifies how that can be done, focusing heavily on prevention—the real key to improving oral health—and helping patients who need care to receive it from fully trained dentists."

The Pew report, "It Takes a Team: How New Dental Providers Can Benefit Patients and Practices" and a Productivity and Profit Calculator tool, released Dec. 6, are available online at "www.pewcenteronthestates.org/ittakesateam". ■

ADA offers variety of NCDHM products

The ADA is celebrating National Children's Dental Health Month in February by offering special patient education materials to help get in touch with kids and pre-teens.

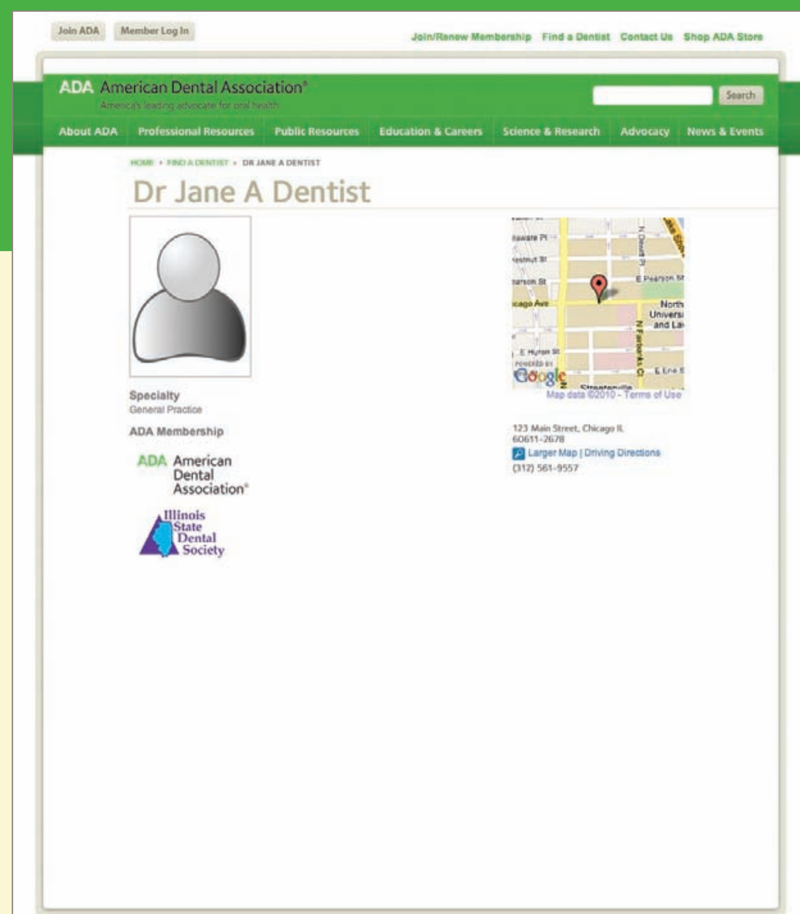
The Healthy Friends 2011 NCDHM Kit (W744) features something for kids of all ages: Elmo pop-up books for young children; Dental Fun Books with activities for kids in grades K-4; and supply bags with brush and floss. The kit is $59.95 for members and $89.95 for nonmembers—a $43 savings off individual product prices.

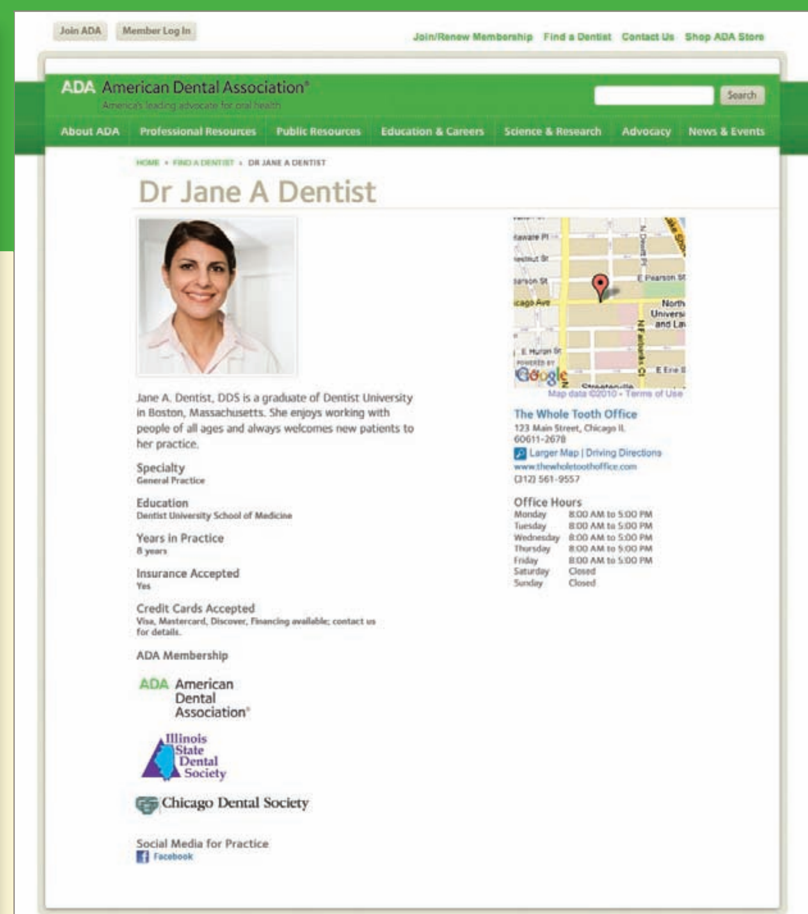
The Dudley 2011 NCDHM DVD Kit (W745) is designed for school visits and presentations.The kit also includes a teaching guide and Dudley coloring book to help dentists reinforce oral health messages. Cost is $99.95 for members and $149.95 for nonmembers—a $59 savings off individual product prices.

Other NCDHM items include the Healthy Smiles Look Good Supply Bags (W747) and the two-sided 16-by-20-inch NCDHM poster (W743).

From now until Feb. 28, 2011, use priority code 10441 to receive a 15 percent discount on all 2011 NCDHM patient education and personalized products with a purchase of $100 or more. For more information, visit "www.adacatalog.org" or call 1-800-947-4746. ■

Which Dentist Would You Choose?





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People turn to the Web to help them make decisions. Nearly 20,000 unique visitors search Find-a-Dentist every month. Update your profile and give residents in your community reasons to select you as their dentist. ADA.org's Find-a-Dentist allows patients to view:

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Top 10 Reasons

to be an ADA member in 2011

Dr. Supriya Verma
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4. Access free tools to help you practice more effectively with the member-only ADA Dental Practice Hub at **dentalpracticehub.ada.org**.
5. Apply relevant science and research for your patients with the ADA Center for Evidence-Based Dentistry at **ebd.ada.org**.
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For more reasons to be an ADA member, visit ada.org/150reasons.

ADA American Dental Association®
America's leading advocate for oral health

The future of dentistry meets in Las Vegas

Las Vegas—"What happens in Vegas will change dentistry forever," said Dr. Kevin M. Laing, general chair of the Council on ADA Sessions. "So it's time to mark your calendars and plan an incentive program to bring your team to the ADA's 152nd annual session."

The annual session will be held Oct. 10-13, 2011, at the Mandalay Bay Hotel and Convention Center in Las Vegas.

With a theme, "The future of dentistry meets here," the annual session will offer more than 260 continuing education courses, and more than half of all lectures offered are free with registration. The World Marketplace Exhibition will feature more than 600 of the leading providers of dental products and services—all conveniently located under one roof at the largest meeting facility on the Las Vegas Strip.

"This year's annual session will feature a special Monday-Thursday schedule, so you can make plans to spend the weekend exploring 'The Entertainment Capital of the World,'" Dr. Laing said. "Las Vegas is home to five-star dining, star-studded shows and some of the best shopping in the world, offering you the opportunity to work hard and play hard."

Registered attendees receive free entry to the ADA General Session and Distinguished Speaker Series. This year also marks the return of the popular Health Screening Program.

Official ADA annual session hotels offer guests comfort and convenience. All six hotels—Mandalay Bay, THEhotel at Mandalay Bay, MGM Grand Hotel and Casino, Signature at MGM, Four Seasons Hotel Las Vegas and Luxor Las Vegas, are conveniently located on the South Strip.

Registration for the meeting, including CE courses and housing, opens April 6 online at "ada.org/session". Request a preliminary program by calling 1-800-232-1432 or e-mailing "annualsession@ada.org". (Please type "Preliminary Program Request" in the subject line of your e-mail.) ■

Photo courtesy Las Vegas News Bureau

South Strip view: The Mandalay Bay Hotel and Convention Center, located on Las Vegas' South Strip, will be the site of the ADA's 152nd annual session Oct. 10-13, 2011.

Still need CE credits for 2010?

Try ADA CE Online

Dentists and dental team members seeking additional continuing education for 2010 are reminded to visit ADA CE Online, which offers more than 125 clinical and practice management courses at an affordable rate.

Courses are accessible 24 hours a day, seven days a week, and users can start and stop as needed.

ADA CE Online has several convenient no-cost options not only for dentists but the entire dental team—all designed to provide quick, pertinent information to help the dental practice become more patient-centered. In addition to the Lunch-and-Learn and Timely Topic no-cost options, there is a practice management option with MP3 audio format for easy listening. Take advantage of the free course underwritten by a grant from MMD Systems Inc., "Introducing the Code."

Dental team members have access to 16 courses in the course library, which are marked "DT" on the website. Specifically developed for the dental team, these courses are designed to build the practice with the team's contributions, and are available for the low cost of $20 per credit.

Visit"www.adaceonline.org" to view all courses and topics. ■

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Impression of a framework:

Figure 1: *Bridge framework with 4-5mm spacing under the pontics.* ***Figure 2:*** *LockFree VPS is syringed covering the entire pontic area, buccal and lingual.* ***Figure 3:*** *A conventional tray material (SHARP™ VPS) is seated over the cured LockFree VPS material.* ***Figure 4:*** *Upon removal, LockFree VPS prevented the impression from locking into the undercut area on the pontics and conveniently tore in that area without compromising the framework.*

Duplication of a bar:

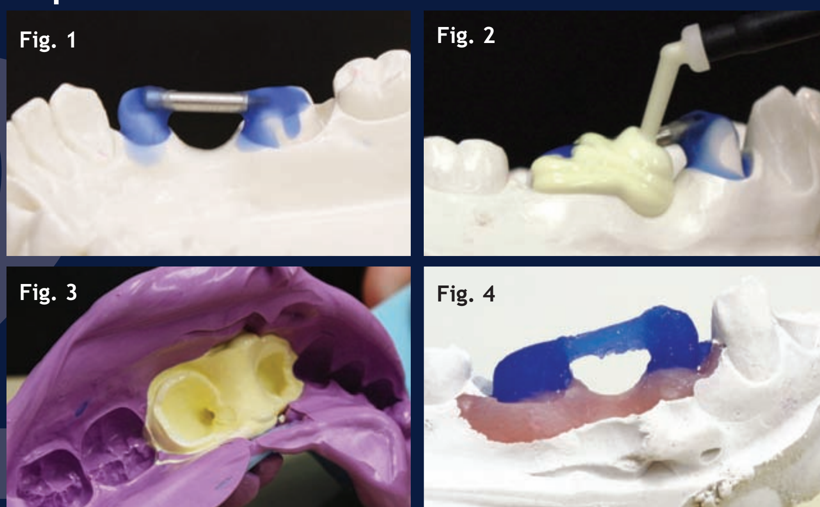

Figure 1: *A simulation of a restorative bar.* ***Figure 2:*** *LockFree VPS is expressed to cover the entire bar, including the edentulous area under the bar.* ***Figure 3:*** *Upon removal, LockFree VPS split around the bar and resumed shape without tearing.* ***Figure 4:*** *A poured model of the bar and tissue area underneath (using Pink SNAP™ and Relate™ acrylics).*

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