October 2016

the Nugget

Tissue is the Issue

Spotlight on Peri-Implant Tissue

A PUBLICATION OF THE SACRAMENTO DISTRICT DENTAL SOCIETY

Get Ready For Our UPCOMING EVENTS

OCT 5
WEDNESDAY
11:00AM-1:30PM

Lunch & Learn
2 CEU, CORE • $75

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Presented by Quincy Gibbs, DDS

Have you ever tried to bond a crown but the gingival tissue bleeds because it is red and inflamed? Want to test the bite before you make the final crown on that patient who always needs adjustments after you deliver? These problems and more can be solved with provisionals! I'll show you how to make consistently great provisionals that will make your patients say "Wow."

OCT 11
TUESDAY
5:45PM-9PM

General Meeting
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Recruitment Night • Emerging Trends in Dental Care Delivery

Presented by Gayle Mathe, Director of Community Programs for CDA

This course highlights three emerging models for delivering dental care outside of the traditional dental practice. As the healthcare delivery system responds to the pressure to turn coverage into access, and dentists seek ways to engage in new and innovative ways to provide dental care, understanding these models can lead to new opportunities.

OCT 26
WEDNESDAY
12PM-1PM

HR Webinar
1 CEU, 20% • $40

CA Leave Laws

Presented by Mari Bradford

One hour online and audio seminar you can listen to while you have your lunch or while you are on the road. You will only need a telephone, cell phone and/or computer (computer not required). All you need to do is dial, listen and ask questions if you desire.

OCT 28
FRIDAY
8AM-3:30PM

Licensure Renewal
6 CEU, CORE • $160

California Dental Practice Act, Infection Control & OSHA Refresher

Presented by Nancy Dewhirst, RDH, BS

We encourage all licensed as well as unlicensed staff to attend this comprehensive education day which covers scope of practice, infection control regulations from the Dental Board, employee safety issues from Cal-OSHA and a review of the duties and functions of practitioners in dental healthcare provision.

Coming In November 2016...

NOV 4 — **Continuing Education** • Friday, 8am-1:30pm
Billing Medical in Your Dental Practice: How to Avoid the Mistakes, Frustration and Making It Actually Work! (5 CEU, 20%)

NOV 8 — **General Meeting** • Tuesday, 5:45pm-9pm
Staff Night • There Is More To A Face Than What You See (3 CEU, CORE)

NOV 9 — **HR Webinar** • Wednesday, 12:30pm-1:30pm
The Wild World of Wage and Hour Laws of Dental Offices (1 CEU, 20%) (FREE to SDDS Member Doctors)

NOV 11 — **CPR BLS Renewal** • Friday, 7:30am-11:30am
(4 CEU, CORE)

NOV 16 — **HR Webinar** • Wednesday, 12pm-1pm
Employee Handbooks (1 CEU, 20%)

NOV 16 — **Business Forum** • Wednesday, 6pm-9pm
Reducing and Managing Debt (NO CEU)

NOV 17 — **Lunch & Learn** • Thursday, 11:00am-1:30pm
Office Emergencies: You Need to Know More Than CPR (2 CEU, CORE)

NOV 18 — **Continuing Education** • Friday, 7:30am-1pm
Mastering Periodontics in Every Practice (5 CEU, CORE)

Annual Holiday Party
Please join us for a wonderful evening of cocktails, dinner, dancing, friends and fun!

DECEMBER 9, 2016 • 6PM-11PM

37TH ANNUAL MIDWINTER CONVENTION & EXPO

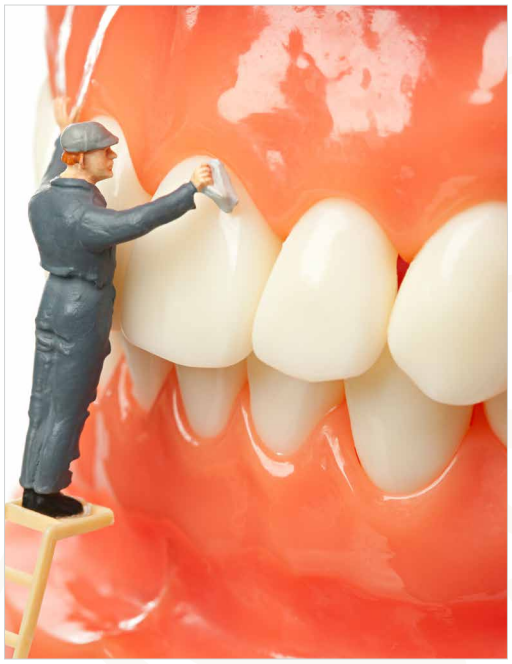
Wrangle Up Your Ranch Hands And Join Us On...

FEBRUARY 9–10, 2017

October 2016
VOLUME 62, NUMBER 8

Contents

FEATURES



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Awards

International College of Dentists (ICD)
2016 • Golden Pen, *honorable mention*
Article / series of articles of interest to the profession
2015 • Special Citation Award, *unusual concept*
2014 • Outstanding Cover, *honorable mention*
2014 • Golden Pen, *honorable mention*
2013 • Outstanding Cover
2012 • Overall Newsletter
2010 • Platinum Pencil
Outstanding use of graphics
2007 • Overall Newsletter
2007 • Outstanding Cover
2007 • Golden Pen, *honorable mention*
Article / series of articles of interest to the profession

Specials

Regulars

President's Message

Tissue Is The Issue – and So Much More

By **Wallace Bellamy, DMD**
2016 SDDS President

To say that soft tissue is important in the art and science of dentistry is a severe underestimation of the simplicity and complexity of the relationship between the soft and hard tissue. We know the technical and anecdotal terms: Biological Width. "Pink Esthetics." LANAP... All have come about with the simultaneous advancements in dental implants and periodontal surgery and therapy.

It has been some time since Dennis Tarnow's research in implants in the field of esthetics, particularly on the vertical distance between the crest of bone to the height of the interdental papilla. And it has fundamentally changed the way we diagnose, treatment plan, and service our patients.

But I digress. What an honor and a pleasure that SDDS has members who are willing and so very well qualified to bring forth this information to our membership through our magazine, THE NUGGET! We have one of the best society magazines in the country, and we have been honored nearly every year with awards and recognition. As my term as President comes to a close, my last three President's Messages also are nearing completion (thank goodness!). I want to recognize our Nugget Editorial Committee and its Chair, Dr. Carl Hillendahl. The committee has "dared to go" on subjects and topics that are controversial (Denti-Cal and MidLevel providers), to articles that are highly clinical (such as this issue) as well as the "feel good," informative and "did you know" topics.

> "The [Nugget Editorial] committee has "dared to go" on subjects and topics that are controversial... to articles that are highly clinical..."

Congratulations to the Nugget Editorial Committee - we look forward each month to your next topic! ■

sacramento
District Dental Society

The Nugget is an opinion and discussion magazine for SDDS membership. Opinions expressed by authors are their own, and not necessarily those of SDDS or ***The Nugget*** Editorial Board. SDDS reserves the right to edit all contributions for clarity and length, as well as reject any material submitted. ***The Nugget*** is published monthly (except bimonthly in June/July and Aug/Sept) by the SDDS, 2035 Hurley Way, Ste 200, Sacramento, CA 95825 (916) 446-1211. Acceptance of advertising in ***The Nugget*** in no way constitutes approval or endorsement by Sacramento District Dental Society of products or services advertised. SDDS reserves the right to reject any advertisement.

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Cathy's Corner

Member Benefits…
Member Benefits…
Free Stuff…

Member Benefits…

By **Cathy B. Levering**
SDDS Executive Director

As we have kicked off our program year in September (with 16 units of CE in September!), we continue with more and more member benefits. Some are affordably priced, some are free; ALL are a great deal!

If you are a member who owns a dental practice, you should be taking advantage of the HR webinars – they are from noon until 1:00 (except for the new Nov 9th webinar). They are not expensive and what you learn will save you hundreds, maybe thousands, of dollars… and they will help you be a better business owner. The YOU THE EMPLOYER article in every issue of the *Nugget* will also help you! If you are an employee dentist, you should be reading these as well.

With all the new labor laws cropping up during all times of the year, dentists need to know how it will affect your office and your employment rules and handbooks. Sadly, these laws and changes continue to plague our business owners – but they must be followed and implemented immediately.

SDDS provides our dentists with the HR Hotline – a free member benefit. If you have questions, you should call the hotline --- you will get an immediate answer. The Salary Survey happened in September and will be available for purchase (only $99, but FREE to those who participated) on October 10th (See insert).

Finally, on November 9th, we are offering a FREE webinar on the new FSLA exempt/overtime laws; this law becomes effective on December 1st this year. If you have an alternative workweek in your office, or you have exempt employees, you need to know the new laws. Again, this is a huge MEMBER BENEFIT! To sign up, please sign up with the form that is inserted in this *Nugget*.

In closing, SDDS continues to provide valuable member benefits – we hope that you take advantage of them. Your SDDS dues are $390 – with no increases next year (they have remained at this level for several years). The value of your benefits are MUCH MORE than $390! Please take advantage of what we have to offer our members! ■

Cathy

Sign up for the HR Webinars Today!

One hour online and audio seminars you can listen to while you have your lunch or while you are on the road. You will only need a telephone, cell phone and/or computer (computer not required). All you need to do is dial, listen and ask questions if you desire.

CA Leave Laws
October 26, 2016 • 12pm-1pm

The Wild World of Wage and Hour Laws of Dental Offices **Free!**
November 9, 2016 • 12:30pm-1:30pm

Employee Handbooks
November 16, 2016 • 12pm-1pm

Labor Law 2017
January 18, 2017 • 12pm-1pm

Building Strong and Engaged Teams
March 15, 2017 • 12pm-1pm

Alternate Workweek
April 19, 2017 • 12pm-1pm

And at The Dentists Insurance Company, TDIC, we won't treat you like one. We were started by, and only protect, dentists. This singular focus has led to an unparalleled knowledge of dentistry and the best ways to protect you. This respect for your profession supports exceptional service, including an in-house claims team, razor-sharp legal team and industry-leading risk management resources.

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From the Editor's Desk

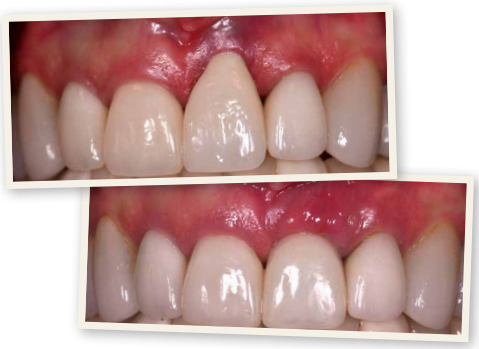
Bone May Set the Tone– But Tissue is the Issue

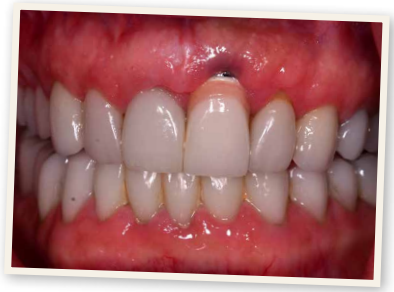
By **Ash Vasanthan, DDS, MS**
Guest Editor

Current day clinical practice has dental implants soaring in its use and applications only to widen the scope of clinical practice and expand treatment planning opportunities. The title of this editorial is something I've heard and used right from my residency days and it is not just catchy but meaningful in every aspect of it. It is common knowledge that the implant gets placed in bone, however it is also the part that never gets seen. It's the tissue that decides the location and positioning of the crown margin and, in esthetically challenging cases, it many times dictates the course of treatment. When a tooth needs to be replaced with an implant, clinicians tend to focus on the hard tissue prep and plan with CT and guides. However, a good clinician always looks at the soft tissue profile that must be worked with to achieve good results. As more implants get placed in the dental office it is critical to know the importance of the tissue types and their profile, especially when treatment planning anterior implant cases.

> "As more implants get placed in the dental office it is critical to know the importance of the tissue types and their profile..."

As a periodontist, I encounter quite a few cases on and off where the biology of the tissues were not respected. This leads to soft tissue collapse and a restorative result much less than ideal or unacceptable in the esthetic zone. Although some cases are fixable with minor changes and one surgical procedure, there are some that almost hit a reset button on the entire implant aspect of treatment. The implant may need to be removed with bone grafting, followed by soft tissue grafting with longer waiting periods of healing prior to and following implant placement to achieve the desired result. The pictures below show one such case which took a lot of time and effort to get the desired result along #9. The implant that was just placed and restored had to be removed with a simultaneous gingival and osseous grafts being placed. The implant was then placed on a later date with a better angulation. Minor soft tissue adjustment procedures were done to enhance the soft tissue profile and achieve the desired result.





Understanding the soft tissue aspect and accounting for it during the treatment planing phase can save a lot of hassle down the road. Knowing the long term implications of the peri-implant mucosal tissue and its nature will help its maintenance for long term health and function. The focus of this issue is on the peri-implant tissue. The 4 articles will help gain good insight into this area. One emphasizes the biological differences between gingiva and peri-implant mucosa while the second one discusses the difference between peri-implantitis and peri-implant mucositis. The term peri-implant mucositis might be relatively new for some of the readers but knowing it and understanding the difference is critical. Articles 3 and 4 lay more emphasis on the surgical aspects. One broadly describes the surgical options to get good tissue profile and the other emphasizes on minimizing surgical trauma to preserve the existing tissue levels. I believe this issue should provide a good read for all clinicians involved with implant dentistry and I'm positive that there will be a good amount of learning in this issue. ■

Dear Editor...

Thoughts on last month's issue

I wanted to let you know this last issue of the *Nugget* was excellent. I especially loved Bev's article. Every new grad should read this. It provided a wealth of information and it was honest and from the heart. She, like many of us have in this generation, has seen the inclusion of amazing technology in our practices while trying to maintain and build relationships that are life sustaining to our practices. I really believe that with so many newer doctors going the route of corporate dentistry this unique and wonderful aspect of private practice is fading. It is one of the things that sets us apart from medicine and one I am fiercely proud of.

– Stella Dariotis, DDS

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YOU SHOULD KNOW

CIVIL RIGHTS RULE COMPLIANCE REQUIRED BY OCT. 16

Reprinted with permission from CDA

CDA has developed California-specific resources to assist dentists in meeting the Oct. 16 deadline for compliance with the U.S. Department of Health and Human Services' Office for Civil Rights' final rule concerning Section 1557 of the Affordable Care Act.

Section 1557, in effect since 2010, is the ACA's nondiscrimination provision, prohibiting discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. The final OCR rule, issued in May, aims to educate consumers about their rights and help covered entities understand their obligations under Section 1557. (The OCR is actively investigating complaints of discrimination under the provision.)

Dentists participating as providers in the Denti-Cal and CHIP (formerly known as Healthy Families) programs and those provider entities who have received Meaningful Use funding from HHS are required to comply with the new rule.

Dentists must comply with the following elements of the rule by Oct. 16:

- Post a Notice of Nondiscrimination in English in dental practices, on websites and in significant publications or communications.
- Post taglines in the top 15 non-English languages spoken in California offering free language assistance. Post them in dental practices, on websites and in significant publications or communications.
- For offices with 15 or more employees, post information regarding the dental practice's grievance procedure.

The new CDA resource, "Nondiscrimination Requirements Under the Affordable Care Act (Section 1557)," will help dentists comply with the OCR rule. The resource provides: a detailed background on the ACA provision and new OCR rule; checklist, instructions and recommended practices for dental practices to follow to meet the compliance requirements under the July 18 deadline (see the related story in the August issue of the CDA Update, page 10) and the forthcoming Oct. 16 deadline; sample grievance procedure and notice of nondiscrimination forms; questions and answers; and a list of additional resources... *[visit sdds.org or cda.org to read the full article]*

CDA will inform its members of any granted deadline extensions or other developments on cda.org and in upcoming issues of the CDA Update. The CDA resource can be downloaded at cda.org/practicesupport

READ ALL ABOUT IT: NEW POSTERS RELEASED AUGUST 1ST

Reprinted with permission from California Employers Association

In case you missed our alert back in July, we thought this notice was worthy enough to repeat.

The Good News – this isn't going to cost you any money!

The Bad News – you don't have much time to act!

Effective August 1, 2016, employers must post new Fair Labor Standards Act (FLSA) and Employee Polygraph Protection Act (EPPA) postings.

The Department of Labor has removed penalty amounts from the posters and has added a section about the rights of nursing mothers to the FLSA poster. Employers are required to post the revised versions of these federal posters by August 1, 2016. Once you print out the new postings, place them near or on top of your poster. Or, purchase a new, fully compliant poster.

To download and print a copy of the Minimum Wage Poster, Polygraph Poster, and to order a New All-in-One Poster from CEA, complete with new postings head to for the links:

www.employers.org/blog/378-read-all-about-it-new-posters-released-august-1st

TAKE A BITE OUT OF STUDENT LOAN DEBT

A new ADA member benefit is helping members save thousands by refinancing their dental school loans. DRB's student loan consolidation/refinancing program, which ADA exclusively endorses, provides ADA members the opportunity to refinance existing federal and private student loans from undergraduate or graduate school at a 0.25% lower rate than DRB's already low rates.

Visit student.drbank.com/ADA to view rates and apply.

OSHA CHANGES - WE'VE BEEN GIVEN A BIT MORE TIME

Reprinted with permission from CEA

Employers have been given a few more months to comply with the OSHA rules that went into effect on August 10, 2016.

OSHA 81 Fed. Reg. 29624:

- Prohibits mandatory post-accident drug testing. OSHA claims these tests discriminate against employees and make them less likely to report injuries and illnesses.
- Prohibits employers from retaliating against employees who report an injury or illness.
- Requires employers to inform employees about this anti-retaliation rule in writing with a signed acknowledgement form.

While the provisions are still effective August 10, 2016, OSHA has delayed their enforcement until **Nov. 1, 2016** in order to provide outreach to the regulated community... *[visit sdds.org or employers.org to read the full article]*

PROVIDER DIRECTORY COMPLIANCE LETTERS IN THE MAIL

Reprinted with permission from CDA

Delta Dental has initiated the first of a three-phase mailing to participating dentists as part of the provider directory verification process required by California Senate Bill 137. Hard copy letters were mailed to more than 8,600 dental practices... *[visit sdds.org or cda.org to read the full article]*

For more information regarding SB 137 compliance, contact CDA Public Policy at 916.554.4984.

Beyond Replacing Teeth...

By **P. Kevin Chen, DMD, MS**
SDDS Member

Dr. Chen graduated from Harvard School of Dental Medicine 1999 and received periodontal certificate from UCSF 2002. He is a Diplomate of the American Board of Periodontology. He is currently in private practice with Capitol Periodontal Group and a clinical instructor at Mare Island VA.

As implant dentistry becomes the main staple of tooth replacement, dental professionals have been documenting and writing about how to achieve clinical success. Implant surface technology has significantly improved since the advent of smooth titanium cylinder, the bone and implant connection is not only predictable today but has shortened the time that is needed to achieve 'osseointegration'. The concept of 'platform switching' has changed the biological environment of the microgap and moving the interface away from bone contact to lessen its influence on coronal bone loss. With newer esthetic abutments and restorative materials, clinicians are able achieve esthetic outcome on a single implant restoration that mimics patient's natural dentition. Despite the tremendous strides made from the implant fixture, to the abutment and to the esthetic crown, the peri-implant soft tissue and understanding its influence on the longevity of the dental implant has been relatively unexplored. This opinion piece is an attempt to highlight the peri-implant anatomy, and revisiting concepts that are critical in the maintenance of the peri-implant soft tissue.

Peri-Implant Anatomy (Figure 1)[1]

The oral, sulcular and junctional epithelia in the peri-implant soft tissue are essentially the same with their periodontal counterparts. The junctional epithelium attaches to the titanium implant is analogous to the epithelial attachment of a tooth ie. hemidesmosomal attachment and serves as a protective seal. The sulcular epithelium that forms adjacent to implant provides the cellular immunologic protection similar to the periodontium and keratinized oral epithelium also serves a protective role. With a lack of periodontal ligaments and vessels derived from them, the epithelial vascularity is different in those surrounding the implant. Furthermore, due to the lack periodontal ligaments and cementum, the implant is connected directly to the bone below the alveolar crest. The connective tissue bundle runs circumferentially like a 'cuff' around the implant along with fibers arising from the alveolar crest to the gingiva that is relative acelluar and avascular as compared to periodontium of a tooth. There is absence of dentoperiosteal and dentogingival fiber bundles that are normally present with a natural tooth as well.

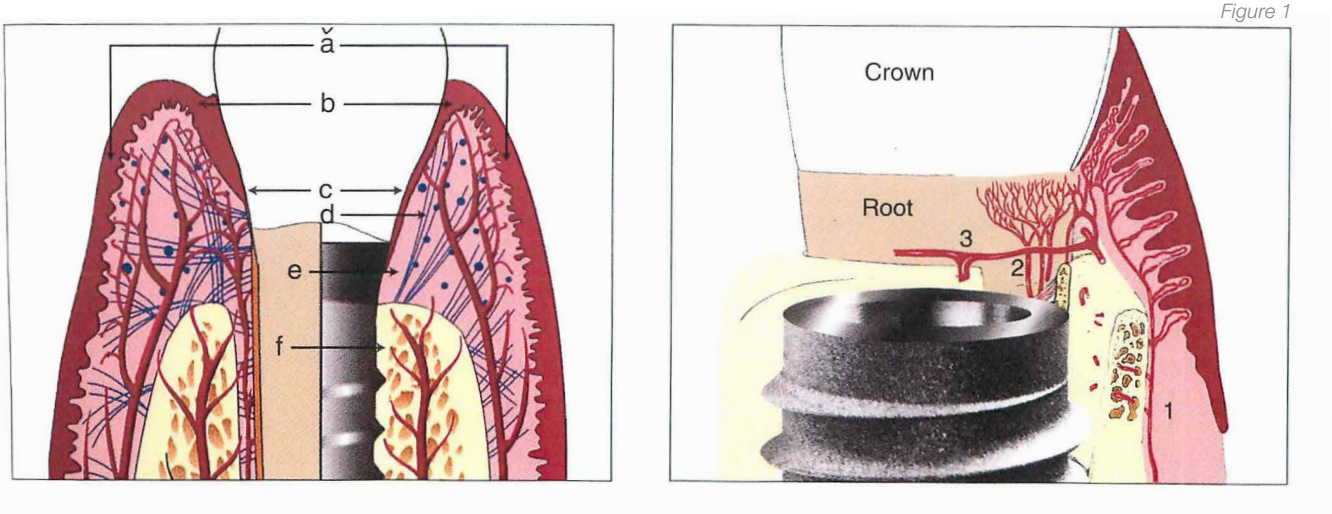
Concept of Biologic Width

Since the days of Gargiulo's histometric study, it has been established the biologic width to be 2.04 mm based on a mean dimension of 1.07 mm for the connective tissue attachment and 0.97 mm for the epithelial attachment.[2] More recent study has suggested the biologic width to be a range between 0.75 to 4.33 mm.[3] The biologic width concept facilitates the stability of the periodontium when an intracrevicular restorative margin is indicated.

Why Is This Concept That Is So Important But Yet Often Ignored?

Histometric study on cadaver specimens during different phases of passive eruption may not constitute information with highest level of scientific evidence, however the derivation of the 'biologic width' concept is what is critical although its dimension may vary from individual to individual. The concept must be considered concurrently with another relatively subjective assessment on the 'soft tissue morphotype' of thin, medium and thick tissue. A similarly placed subgingival margin of a crown 1-2 mm into the sulcus may have very different inflammatory consequences in a patient with thin, scalloped tissue versus one with

Figure 1



thick, and yet blunted tissue. Contour of a restoration also contributes to the extent of biologic width invasion. An implant restoration ignoring this concept as in a crown prep extending beyond 1-2 mm subgingivally suffers the same clinical consequence in the presence of marginal plaque – inflammation moving apically leading to recession and other negative outcomes, but more importantly this process occurs without control on the inflammatory front until the etiology no longer elicit an inflammatory response.

In the world of implant dentistry, platform switching has moved the microgap interface away from the bone contact as indicated previously but more critically the implant/abutment interface can now be manipulated to accommodate the precise sulcular and soft tissue contour. A carefully fabricated custom abutment locates the restoration margin precisely in the sulcular crevice without extending and violating the biologic width. This element of control is analogous to an experienced clinician preparation of a crown margin.

Attached Peri-Implant Soft Tissue

Generally, there is a consensus amongst clinicians that a healthy band of attached keratinized tissue presents a 'restoratively friendly' environment that facilitates prosthetic procedures but also allows oral hygiene to be performed in ensuring long term implant success. The rigorous mechanical challenges, placing and removing of abutment, impression procedures, delivering subgingival restorations are few of the clinical examples where resilient attached keratized soft tissue is far more superior than alveolar mucosa.

The resiliency of the peri-implant soft tissue resists the disruption of the implant junctional epithelium thereby minimizing the downward movement of the inflammatory process that is primarily bacterially based, reducing peri-implant bone loss and potentially loss of the implant. The presence of the 'high' fibrous frenum attachment is also part of this discussion as its presence also disrupt the peri-implant seal.

While the actual width of the keratinized tissue that helps to achieve an 'adequate band' has not been established, but suggestion of 2-4 mm is needed to maintain periodontal health.

Periodontal colleagues have been manipulating soft tissue surrounding dentitions and restorations for decades, the same clinical options are also available to manipulate peri-implant soft tissue while understanding the differences in peri-implant anatomy. The use of free gingival, connective, pedicle graft to augment the band of keratinized are utilized in surgical treatment plans to enhance not only the esthetic but longevity of the dental implants.

Pathologic Peri-Implant Pockets

In everyday clinical practices, an increased number of dental implants are being maintained with peri-implant probing depths beyond 5 mm, but are they all pathologic? Given the connection of the implant starts at the bone level of the alveolar crest, potential spaces or 'pseduo-pockets' are more likely to be recorded with dental implants than around natural dentitions. Other inflammatory parameters such as bleeding on probing, exudate/purulence, pain, redness coupling with radiographic findings with bitewing, periapical, panoramic and/or CBCT have to utilized in facilitating the proper diagnosis of "Peri-Implantitis". The etiologic factors and treatments of Peri-Implantitis are not within the scope of this opinion piece, however understanding the concepts presented in the article certainly will minimize the incidences of ailing and the failing of dental implants that we will see in the dental offices.

Conclusion

There are significant similarities between the periodontal and peri-implant soft tissue anatomy, along with periodontal concepts that can be extrapolated for clinical implant practice. Only with proper execution of these concepts are clinicians the achieving more than just merely replacing teeth. ■

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3. Vacek JS, Gher ME, Assas DA, Richardson AC, Giambiaressi LI. The dimensions of the human dentogingival junction. Int J Periodontics Restorative Dent 1994; 14:155-165

Knowing the Difference Between

Peri-Implant Mucositis and Peri-Implantitis

By **Elaheh Samsani, DDS**
SDDS Member

Dr. Samsani is a Diplomate of the American Academy of Periodontology. She is a graduate of UCLA School of Dentistry and completed her residency at the Department of Veterans Affairs Hospital at West LA. She has been a partner at Sierra Periodontal Group for 11 years and practices at their offices in Rocklin and Citrus Heights.

Peri-implant diseases occur in two forms: peri-implant mucositis and peri-implantitis. Both of these forms of implant diseases are characterized by an inflammatory reaction of the tissues surrounding the implant. Peri-implant mucositis is a reversible inflammatory process causing redness and swelling localized to soft tissues around the dental implants without signs of loss of supporting bone following initial bone remodeling during healing. Peri-implantitis is an inflammatory process that includes both soft tissue and hard tissue with bone loss possibly leading to eventual implant loss. [1-2]

The signs that determine the presence of peri-implant mucositis include bleeding upon probing, and /or suppuration, probing depths ≥4mm and no evidence of radiographic loss of bone beyond bone remodeling. When these same signs are present with any detectable bone loss following the initial bone remodeling after implant placement, a diagnosis of peri-implantitis is made.

Etiology and pathogenesis

The general description of the inflammatory process of peri-implant mucositis around an implant is very similar to gingivitis around natural dentition. The glycoproteins from saliva adhere to the exposed implant surfaces with simultaneous microbiological colonization. The formation of this biofilm plays an important role in the initiation and progression of peri-implant diseases and is crucial for the development of infections around dental implants. Furthermore peri-implant diseases have been associated with Gram-negative anaerobic bacteria similar to those founds around natural dentition in patients with severe chronic periodontitis. [1-3]

It is safe to assume peri-implant mucositis is the precursor to peri-implantitis as it is accepted that gingivitis is the precursor of chronic periodontitis. However, not all gingivitis lead to periodontitis, similarly peri-implant mucositis does not necessarily progress to peri-implantitis. There is evidence to suggest that peri-implant mucositis just like gingivitis is a reversible condition when it is effectively treated. Peri-implantitis similar to periodontitis occurs primarily as a result of apical bacterial invasion and subsequent host immune response. Human and animal studies have demonstrated that the bacterial species associated with periodontitis and peri-implantitis are similar, mostly Gram-negative anaerobic bacteria. [3]

> Both of these forms of implant diseases are characterized by an inflammatory reaction of the tissues surrounding the implant.

Risk factors

In 2006, a periodontal workshop held in Europe identified many risk factors associated with peri-implantitis.[1] The main recommendations of this workshop were more emphasis on plaque management and limiting those factors that could enhance the establishment and progression of peri-implantitis. These risk factors are briefly described in the following paragraphs.

Residual Cement: Some studies have shown that the residual cement can be the number 1 easily identifiable factor for peri-implantitis and implant failure. The cementation of crown is a common technique of restoring dental implants. However the cement that can be left behind subgingivally can lead to potential problems around the surrounding tissue and bone. Many of the commonly used cements are not detectable by radiographs. The roughness of the residual cement can cause inflammation of the gingival tissue and can be a positive environment for bacterial attachment.

Figure 1

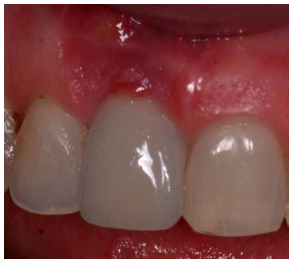

Figure 2

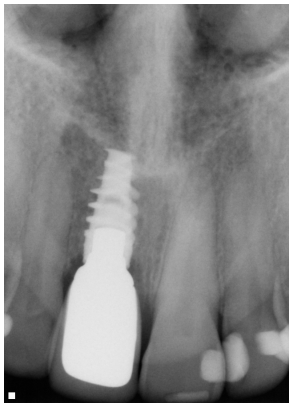

Fig. 1 and 2 show an example of peri-implant mucositis with inflammation of the tissue and no bone loss as seen on the x-ray.

Figure 3

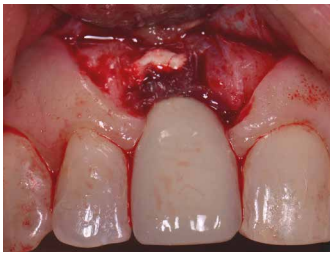

Figure 4

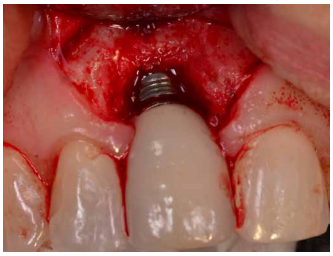

Figure 3 Shows cement way past the implant abutment junction causing inflammation. Figure 4 shows bone loss upon cleaning out the area.

Poor Oral Hygiene: Meticulous oral hygiene habits are crucial in the long-term success of the dental implants. It is the clinician's responsibility to educate the patient in proper plaque control and to ensure the establishment of strict and regular periodontal maintenance visits.

Previous Periodontal Disease: Systematic reviews have shown that peri-implantitis was a more frequent occurrence in patients with a history of periodontitis.[2] A comprehensive periodontal evaluation is necessary prior to implant placement. In addition periodontal disease must be treated before considering whether the patient is a candidate for implant placement.

Smoking: Several studies have demonstrated that there is an increased risk for peri-implantitis in smokers and higher implant failure rates. Smokers are at much higher risk of developing peri-implant mucositis and peri-implantitis.

Diabetes: The poor glycemic control in diabetic patients can influence tissue repair and host defense mechanism. As a result the diabetic patients have a disruption of collagen hemostasis in the extracellular matrix and therefore can be associated with neutrophil dysfunction and imbalance of immune system. Moreover the tissue repair ability and defense mechanism of diabetic patient getting dental implants are impaired. However more prospective studies are necessary to identify the association between diabetes and peri-implantitis.[4]

Occlusal Overload: Dental implants are less tolerable to non-axial occlusal load compared to teeth due to lack of periodontal ligaments. Studies have suggested that the occlusal load is mostly concentrated at the implant marginal bone.[4] Bone remodels in response to strain. Excessive forces can cause microfracture within bone and eventual bone loss.

Inadequate Attached Keratinized Tissue: Systematic reviews have demonstrated a high association between a lack of keratinized tissue and peri-implant soft tissue inflammation. This is due in part to the lack of supracrestal gingival fibers present in the soft tissue that in health insert into natural teeth and will help withstand the inflammatory insult in dental implants. In the case of an implant, these fibers run parallel to the implant surface, and therefore create a hemidesmisomal attachment which is the only line of defense to seal the outer environment from the underlying soft and hard tissues. A thinner gingival biotype is also a sign that the underlying bony housing is thin. If thinner bone is subjected to inflammation, adequate blood supply won't be present to maintain its vitality. When gingiva is thin or absent

Continued on the following page...

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at the time of implant placement, it is highly recommended to augment the gingival tissue prior to implant placement or prior to final restoration.

Loosening And Poor Fitting Prosthetic Componenets: Micromotion can occur due to incomplete seating of the abutment which can lead to a gap and fail to provide adequate seal around the fixture. Micromotion could also be related to loosening of the screw holding the abutment, which could also result from excessive forces and improper torque being provided to fully tighten the abutment. Another reason for loosening of the prosthetic components could be the use of aftermarket parts or trying to mix and match between different implant systems. In all these instances, the lack of intimate fit between the implant and the abutment can predispose the implant to micromotion which in turn could lead to gingival inflammation of peri-implant mucositis and bone loss of peri-implantitis.

Diagnosis

To properly diagnose peri-implant mucositis and peri-implantitis, the probing depth, bleeding upon probing and suppuration should be recorded at each recall/periodontal maintenance visits. A change in these parameters over time may be more important than the initial findings as implants may be placed more apically to achieve optimal esthetics, resulting in deeper pockets.

An initial radiograph after implant placement and following prosthetic installation can be used as good baselines to compare future radiographs. The radiograph should be perpendicular to the implant body to show a clear demarcation between the threads of the implant. Other radiographs such as CBCT may be necessary to visualize the bone loss in the buccal/palatal dimensions.

The degree of mobility should also be tested, however, a mobile implant is a failed implant. The mobility of the prosthesis however should be corrected immediately since a loose implant-prosthesis may contribute to the accumulation of bacterial plaque, which in turn may lead to the development of peri-implant mucositis and peri-implantitis.

In conclusion, routine monitoring of dental implants as part of the comprehensive periodontal evaluation and maintenance is essential. The risks factors associated with developing peri-implant diseases must be identified as early as possible. A baseline radiograph at the time of implant placement and post restoration are good indicators to compare the future health of the implants. Strict periodontal maintenance visits and reinforcement of proper oral hygiene should be established during the early stages of treatment planning. An early diagnosis and intervention will contribute to a more effective management of peri-implant diseases. ■

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Soft Tissue Grafting Around Implants

By **Keerthana Satheesh, DDS, MS**

Dr. Satheesh is the Chairman of the Department of Periodontics at UMKC School of Dentistry. She is a Diplomate of the American Board of Periodontology and maintains a part time private practice in Kansas City. She was inducted into the American College of Dentists in 2015 and is a recipient of numerous awards.

As implant dentistry continues to evolve, the focus is now towards preservation and reconstruction of soft tissues around dental implants. Adequate width of keratinized gingiva surrounding dental implants is a key factor to long term implant success. The peri-implant mucosa is necessary to protect the health of the dental implant and also stability of the underlying bone.

There is significant evidence in the literature regarding the need for keratinized gingiva around dental implants. While some studies conclude that there is an increased risk for bone loss when the implant lacks keratinized gingiva, others report that the presence of keratinized gingiva does not make a difference in maintenance of peri-implant bone. Irrespective of all the debate regarding the need for keratinized gingiva around dental implants, the general consensus is in support of ensuring an adequate band of keratinized gingiva whenever possible. This article reviews all the available options to increase the zone keratinized gingiva.

Histologically, it makes sense that a stable peri-implant mucosa offers support to the underlying connective tissue. Dental implants have collagen fibers that are oriented parallel to the dental implant. The peri- implant tissue has decreased vascularity. These histological differences can significantly increase the risk for plaque induced inflammation around dental implants and consequent bone loss. While keratinized gingiva around a dental implant promotes long term health, it also provides better resistance during restorative phase.

Dental implants are often placed in patients that have lost their teeth due to extensive caries or periodontal disease. That results in tremendous alterations in the anatomy. Often extraction of teeth and ridge preservation grafts result in procedures that move the mucogingival line coronally thereby, decreasing the zone of keratinized gingiva in the site being planned for dental implant placement. Procedures with extensive guided bone regeneration still need primary closure thereby altering the gingival profile of the area.

Successful dental implants in the esthetic zone are possible through preservation of the soft tissue or soft tissue augmentation procedures. Stable peri-implant tissues with a thick tissue biotype provide better esthetics than a thin tissue biotype. Studies have shown that presence of keratinized gingiva reduces the risk for future recession. There is evidence that a thin gingival biotype has underlying bone with dehiscence and fenestrations and is also linked to an increased risk of recession after surgical procedure. Therefore, treatment planning for dental implants should include a soft tissue examination to assess the gingival biotype of the area.

Surgery for Soft Tissue Augmentation Around Dental Implants:

The procedures performed around dental implants are similar to those performed around teeth. These procedures can be performed at the time of extraction of the tooth, at the time of dental implant placement, at the time of uncovery (if needed) or after the dental implant is restored. However, predictability with soft tissue grafts is greatly increased when recognized and performed prior to dental implant placement. The procedures that can be performed to augment the soft tissue around dental implants include but are not limited to pedicle grafts, connective tissue grafts, soft tissue allografts and free gingival grafts. Sometimes a modification of the incision design is adequate to preserve the keratinized gingiva or move the gingiva in a buccal direction. The key is to recognize the need for grafting at the time of evaluation for dental implants.

Epithelialized Gingival Grafts (Free Gingival Grafts):

When patients here the word “Free” they think the gingival grafting procedure is for free! Free gingival grafts have been used

Figure 1

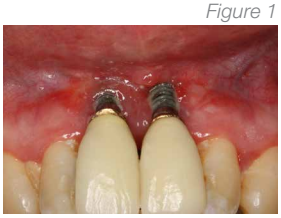

Figure 2

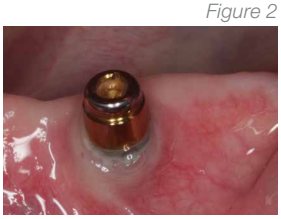

Figure 3

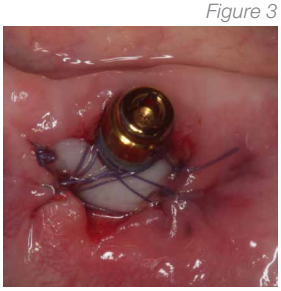

Figure 1 demonstrates dental implants in the area of #8 and #9 with a lack of keratinized gingiva, inflammation and a heavy deposit of plaque.

Figure 2 thin peri-implant tissue and Figure 3 shows a free gingival graft left exposed in place with sutures.

Figure 4

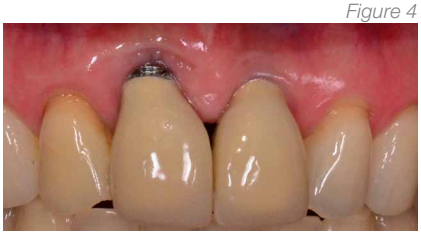

Figure 5

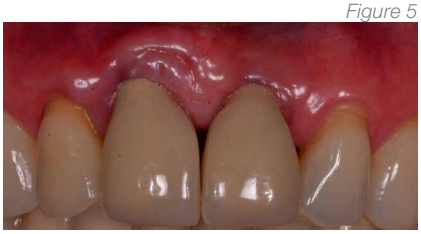

Figure 6

Figure 7

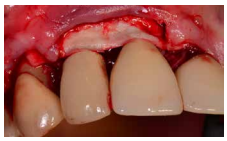

Figure 8

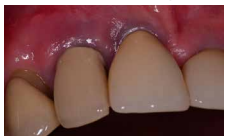

Figure 4 shows metal exposure of implant abutment and Figure 5 shows good coverage of the abutment with a Connective Tissue Graft.

Figure 6 shows soft tissue recession around 2 implants; Figure 7 shows a soft tissue allograft in place and Figure 8 shows good coverage of the metal part of the implants and thickening of the tissue.

successfully to augment the keratinized gingiva around dental implants. The procedure consists of a preparing the recipient site with a split thickness dissection, leaving a connective tissue bed for vascularity. An epithelialized gingival graft is harvested from the palatal area or an edentulous ridge and sutured in place on the vascular bed created around the implant. The graft is left completely exposed as it has epithelium. The disadvantage with a free gingival graft is that it heals with a scar clearly showing a mismatch with the recipient area and also leaves an open wound on the donor site.

Connective Tissue Grafts:

These offer a superior color match compared to the free gingival grafts. Around dental implants, the connective tissue grafts have been used successfully also as a barrier over an extraction socket instead of a membrane and to augment the keratinized gingiva. The procedure involves a split thickness flap in the recipient site. A connective tissue graft is harvested from the palate or an edentulous ridge and sutured in the recipient site. Most times it is completely closed over by the flap or left partly exposed and never completely exposed like the free gingival graft. The connective tissue graft procedure also has the advantage of not leaving an open wound in the donor site and therefore less postoperative pain and morbidity for the patient.

Soft Tissue Allografts:

Soft tissue allografts have been successfully used to achieve a thickened zone of peri-implant tissue. The allografts have also been used as a barrier in extraction sockets and also to thicken the mucosa to mask the metallic color of the implant abutment in an area of thin tissue biotype. Soft tissue allografts are technique sensitive and good blood supply is crucial to their success. They have the advantage of not needing a second surgical site to harvest the graft and the unlimited supply when needed.

In conclusion, good implant dentistry requires attention to both the hard and soft tissue management. The grafting procedures are more predictable prior to dental implant placement and it is critical that attention is paid to this during treatment planning. ■

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Minimally Invasive Dental Implant Surgery (MIDIS)

to Preserve the Soft Tissue Profile

By **Ash Vasanthan, DDS, MS**
SDDS Member

Dr. Vasanthan is a Diplomate of the American Board of Periodontology and American Board of Oral Implantology. He has a practice limited to periodontics and dental implants in Roseville and Citrus Heights.

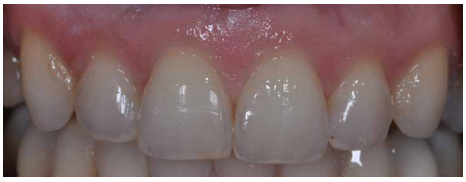
Papilla preservation along with good soft tissue margins around dental implants is an important aspect of dental implant planning for patients in the esthetic zone. Periodontists have mastered and perform soft tissue grafts with relative ease and great predictability to enhance gingival thickness, gain root coverage and improve esthetics with teeth, crowns and implants. Hence regeneration of lost soft tissue thickness or gaining additional thickness and coverage is quite predictable today. However, the inter dental papilla or the implant papilla is not easy to regenerate in the mouth once it is lost. There is no predictable technique till date to regenerate the papilla. Although restorative and surgical options are available, they are not always predictable. Hence, it is best to avoid the papilla being a part of the incision or flap whenever possible.

"Good vascularity is the single most critical factor for tissue integrity and quicker healing along with any regeneration or new tissue growth."

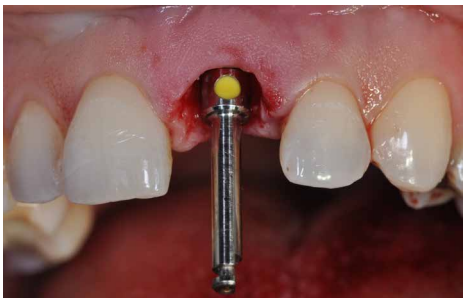
Surgical Trauma

Good vascularity is the single most critical factor for tissue integrity and quicker healing along with any regeneration or new tissue growth. Every time an incision is made, this vascularity is compromised and tissue collapse could occur. It has been shown that flap reflection can be associated with bone loss especially when the bone is very thin. Vertical releasing incisions can also lead to scarring of the tissue and can compromise the blood supply to the region as well. Care should be taken to minimize vertical releases and periosteal releases and avoid reflecting the papilla whenever possible so as to avoid its collapse. Anytime the peri-implant tissue has to undergo any kind of release, the vascularity and thereby healing gets compromised. Thick tissue biotype with a flat profile is the best kind of tissue and is usually resilient. The thick tissue is the keratinized kind which we call as "gingiva." Lack of gingiva is associated with "mucosa" or thin tissue biotype. If one gets to work on tooth with mucosal tissue in the esthetic zone with a high concave profile, it can be very challenging to achieve a good result as the tissue will have a much easier tendency to collapse or retract. Hence it is a good practice to avoid making incisions or reflecting the tissue whenever possible. This makes a great case for flapless surgical options to be considered whenever possible.

Picture A



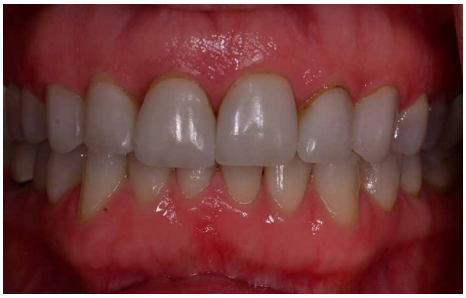
Picture B



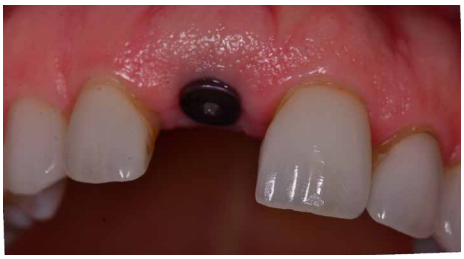
Picture C

Figure A, B, & C – A case of root fracture from trauma (A) on #9 replaced with an implant showing the position of the implant at the time of surgery in the MIDIS protocol (B) and restored showing healthy keratinized gingival tissue along the buccal margin (C).

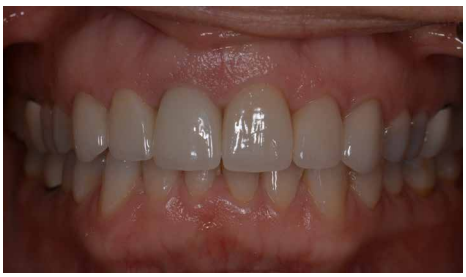
Picture D



Picture E



Picture F



Pictures D, E, F – Tooth #8 being replaced (D) with an implant in the MIDIS protocol, showing good healing at 3 months (E) and final restorations with veneers from #6 – 11 with an implant crown on #8 (F). Notice the healthy keratinized gingival tissue and tissue marginal integrity.

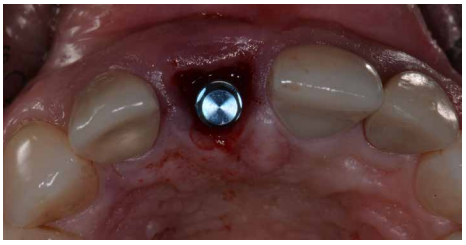
MIDIS

Minimally Invasive Dental Implant Surgery, or MIDIS, is a term that I have loosely used during my time in teaching and in private practice although the minimally invasive surgical approach is not new. It is essentially a flapless surgical approach. The minimally invasive approach to preserve the soft tissue begins with the extraction process. Care should be taken to carefully incise the soft tissue attachment from the tooth and extract the tooth with minimal trauma. Periotomes have been recommended for this but is not required and I actually don't use them. MIDIS can be of great value in the anterior esthetic zone and I've used this technique with great results and high predictability over the past 10 years. Case selection is of great importance with the need to assess the clinical condition leading to the loss of the tooth and the need for any bone grafting.

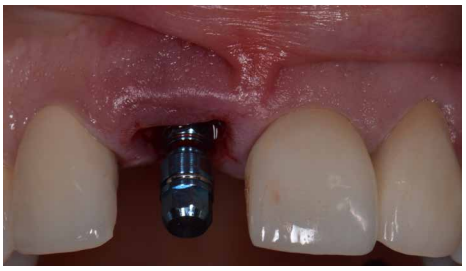
Steps in MIDIS

When immediate implants are placed in the anterior region, tooth extraction should be done without flap. Great care should be taken to avoid fracturing off the buccal plate and so patience is critical. Once the tooth is extracted and the socket is cleaned out the bone profile is assess typically with a periodontal probe to make sure there is an intact buccal place. It is important to know if there is any dehiscence or fenestration along the buccal wall. Once it has been determined that there ia good bone profile, the immediate implant osteotomy is performed. With use of Cone Beam Computed Tomography (CBCT) it is possible to know the bone profile prior to extraction and this also tends to help with identifying the trajectory of the implant to be placed. It is also possible to use Guided surgery with the utilization of the CBCT generate surgical guide. The implant osteotomy is prepared through the surgical guide all through the process and at times even the implant is placed through the guide. This is a viable option but can be a lengthy process with more expense added to the case. The attached photos are examples of clinical cases of extractions without flap reflection where an implant was placed immediately following the MIDIS protocol. Bone grafts can be placed to bridge the gap between the implant and bone although it may not always be necessary. Most times suturing is not evening required as there is no flap to approximate and at times the size of the healing abutment may seal the coronal part of the socket.

Picture G



Picture H



Pictures G and H – Note the implant positioning without any trauma to the tissues. Note the intact keratinized gingival maintained along #8

The peri-implant tissue has described by most dental gurus as very difficult manage once it has been compromised. With the advent of technology and advancing evidence of science, there is no reason that MIDIS cannot be incorporated in everyday clinical practice for selected cases. When indicated, it can help provide predictable soft tissue results that may otherwise not be possible or lead to compromised esthetic results requiring additional surgical and restorative procedures. ■

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YOU ARE A DENTIST. You've been to school, taken your Boards and settled into practice. End of story?

Not quite. Are you up to speed on tax laws, potential deductions and other important business issues?

In this monthly column, we will offer information pertinent to you, the dentist as the business owner.

Why Do Brokers Only Represent Sellers?

By **Tim Giroux, DDS**
Western Practice Sales
(SDDS Vendor Member)

This is a question I asked when I decided to become a "dental broker." The basic answer is that this business is a very finite market as compared to real estate, and therefore there is no "multiple listing service." Another reason is that buying a practice is NOT like buying a house. Houses are very easy to get "comparable values" by looking at similar houses in the neighborhood which have recently sold. Dental practices are as unique and varied as the personalities and skill sets of the dentists that run the practice.

While it is true that the pricing of practices might be similar to finding "comparable" practices in a specific market, the values of practices in the same market depend on the types of dentistry being performed on a particular patient base. For instance, the typical price of a practice in a specific location might be 70% of the year's collections. Most of the dental practices in that neighborhood will probably sell within 5 to 10% variance (at most) of that multiple. However, the percentage of cash flow that hits the bottom line will be different for practices that accept all PPO's and HMO's as compared to a strict fee-for-service practice.

From a legal aspect, buyers must realize that it is the broker's job to represent the Seller's best interests. However, a good dental broker spends a great deal of time compiling important documents which help the buyer decide if the particular practice is a good value IN THAT BUYER'S HANDS. Only the BUYER can determine if his/her own skill sets will be successful in a particular type of practice. A good broker will also provide the accurate cash flow before taxes, computer reports that show the percentages of procedures being performed in the practice, schedules of employee pay and benefits, tax returns, office lease, and any other documents that are pertinent to the practice. A good broker often helps his own client, the Seller, navigate through what is considered normal and customary for the local market and sometimes needs to "re-educate" the Seller on what is expected in a normal transition of a dental practice.

Brokers have every good intention on producing a smooth and successful transition of a practice. A successful transition is the best protection a seller can have, post-sale. Only the attorneys win if a transition does not go well and litigation becomes necessary. Brokers cannot prevent a buyer from making a poor decision, but hopefully they've provided the information necessary to help the buyer make an educated decision. ■

Check Out Our RECENT EVENTS

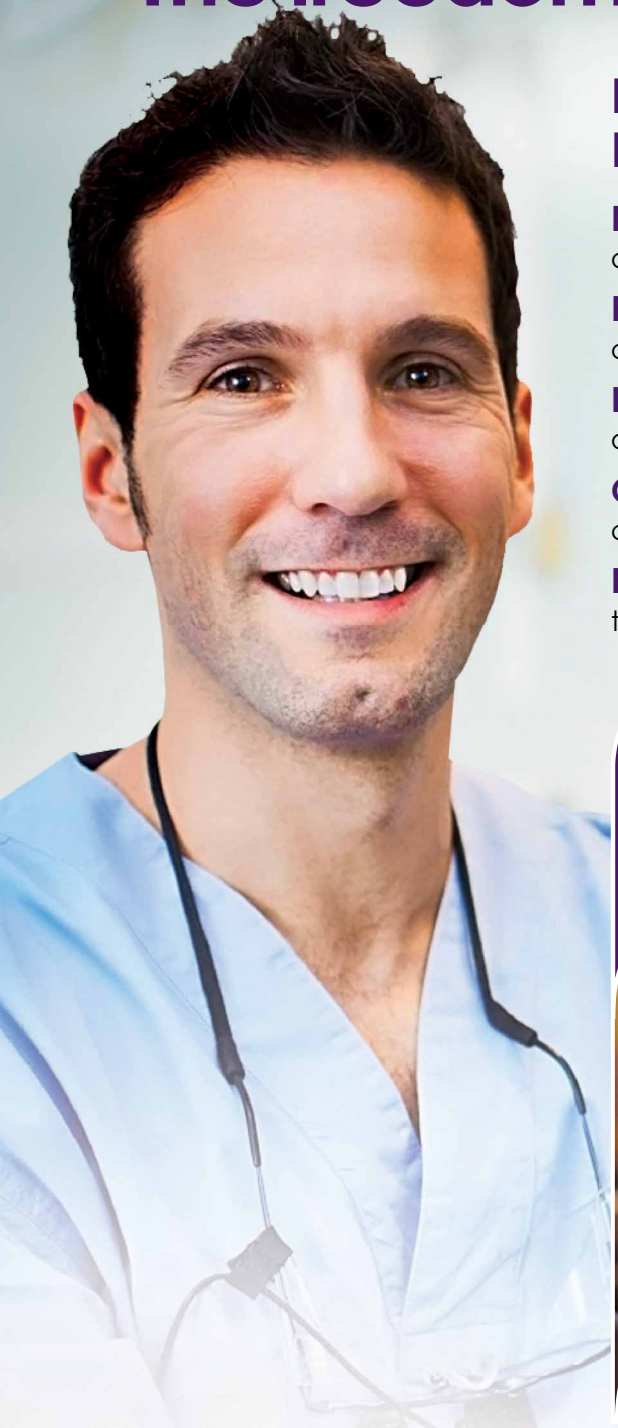
Retired Member Reception

Our retired members came down to the SDDS office to reunite with old friends, meet our new SDDS team and leaders and enjoy our beautiful office and classroom!

New Member Reception

Our new members came by to get a tour of the SDDS office, meet leadership, and network with their peers!

Why are more dentists *(and kids)* smiling?
The freedom of LIBERTY Dental Plan!



Here's what you can expect as a LIBERTY Dental Plan provider:

No Capitation LIBERTY's Medi-Cal Dental Program pays entirely on a Fee For Service Basis per procedure

Fast Payments Enjoy easy online records processing with 95% of claims paid in as little as 10 days

Less Red Tape Zero to minimal pre-authorizations – Ultimately qualifying you for NO pre-authorizations

Quick, Easy Enrollment Dentists joining our network are contracted, credentialed and seeing patients within just 10 days

Higher Satisfaction 9 out of 10 network dentists ranked LIBERTY as the Medi-Cal dental plan doing the best job.* * i/m marketing Study, Feb. 2016

LIBERTY's Medi-Cal Dental Program frees you to grow your practice and provide great care.

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Billing Medical Plans For Dental Treatment

Reprinted with permission from
California Dental Association

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

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

> "There are advantages to billing patients' medical benefits plan, including easing the financial burden on patients..."

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

What Medical Plans Will Cover

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

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

For example, medical plans will pay for:

- Treatment related to inflammation and infection.
- Dental repair of teeth due to injury.
- Exams for orofacial medical problems.
- Extraction of wisdom teeth, under certain conditions.
- Extraction of multiple teeth at one time.
- Certain periodontal surgery procedures.
- Consultation for and excisional biopsy of oral lesions.
- Consultation and treatment for temporomandibular joint problems.
- Infection that is beyond the tooth apex

and not treatable by entry through the tooth.

- Pathology that involves soft or hard tissue.
- Procedures to correct dysfunction.
- Emergency trauma procedures.
- Appliances for mandibular repositioning and/or sleep apnea.
- Congenital defects.

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

Coding Systems

The key to successful claim filing is the correct use of codes to identify what treatment was provided, and in the case of medical claims, the reason the treatment was provided. Current Dental Terminology (CDT) are the code sets established by the ADA for identifying procedures provided to patients for oral treatment. The CDT codes are used when submitting claims to dental plans. Medical plans do not pay for treatment claimed as CDT procedures.

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

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

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

Obtaining Medical Claim Forms

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

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

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

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

FOR MORE INFORMATION ON MEDICAL BILLING, COME TO THE UPCOMING CLASS AT SDDS!

Friday, November 4, 2016

8:00am • Registration
8:30am – 1:30pm • Class

SDDS Classroom I
2035 Hurley Way, Suite 200
Sacramento, CA 95825

To get registered for this class, fill out the insert in this issue or head to sdds.org/events/billing-medical to sign up today!

Billing Medical in Your Dental Practice: How to Avoid the Mistakes, Frustration and Make It Actually Work!

Course Description:

There is much confusion about medical billing in the dental practice. There are many tricks that need to be learned to make it work. Many practices try it and give up. In this course, learn the top coding errors – and how not to make them. The understanding of medical insurance is the key to getting patients to pay their bills, as well as the insurance companies.

Course objectives:

- Advanced dental billing
- Dental to medical cross-coding
- Administrative and wellness systems

Presented by Christine Taxin

With over 30 years of experience in the dental and medical fields, Christine Taxin's workshop and lecture attendees benefit from her expertise in medical to dental cross-code billing, administrative systems, internal and external marketing and financial planning.

Prior to starting her own management consulting company, Christine worked for a large New York City hospital as administrator of a critical department, managed an extensive practice and worked with Coaching Solutions and Dynamic Administrators consulting companies. She has trained in management at LVI.

Foundation
of the Sacramento District Dental Society

Smiles for Kids®

The Nurses Have Arrived!

Our 2017 Smiles for Kids has started. Our school nurses from school districts in the Sacramento area (and even all the way up in Tahoe) have stopped by the office to receive training on the Smiles for Kids program. They have learned what it means to be a part of Smiles for Kids, received informational packets, and left the office with their cars loaded up with screening supplies. Thank you our dedicated school nurses for all you do!

Smiles for Kids Checklist

- [x] School Nurse Meetings (??? nurses attended)
- [ ] Fall Screenings
- [ ] Shopping Day
- [ ] Smiles for Kids Day
- [ ] Adopt-A-Kid

PREVIOUS YEARS' SMILES FOR KIDS STATS

TOTAL SCHOOLS SCREENED
104

TOTAL KIDS SCREENED
26,647

TOTAL VOLUNTEER DOCTORS
313

TOTAL KIDS TREATED ON SFK DAY
346

TOTAL ADOPT-A-KIDS PLACED
151

Volunteer Today for the Upcoming Year!

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Integrity Practice Sales Listings

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Madera - New Listing
Sacramento Ortho - $85,000
Sunnyvale - $750,000
Tahoe City - $115,000

Central

Atascadero - $495,000
Bakersfield - $850,000
Fresno - $750,000
Lake Isabella - $95,000
Montebello - $160,000
San Luis Obispo - $675,000
San Luis Obispo County Coast - $420,000
San Luis Obispo County North- $160,000
San Luis Obispo Perio - $640,000
Santa Maria - $265,000
Santa Maria - $252,000
Tehachapi - $850,000

Southern

Camarillo - $290,000
Encinitias - $575,000
Gardena - New Listing
Glendale - $945,000
Glendale - $900,000
Hemet - $225,000
Huntington Beach Turnkey - $5,500/mo.
Long Beach - $1,800,000
Los Angeles County - $210,000
Mission Viejo - $115,000
Newbury Park Turnkey - $500,000
Oxnard - $1,000,000
Pacoima - $200,000
Poway - New Listing
San Diego - $300,000
San Diego - New Listing
Santa Barbara Wine Country - $599,000
Santa Barbara - $430,000
Santa Barbara - $210,000
Santa Monica - $150,000
Vista - Collected $455,000

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Brian Flanagan

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Brian Flanagan joined Integrity Practice Sales after over 20 years of customer service experience and sales experience. He has worked as an insurance sales representative and customer service at the Auto Club and Farmers Insurance as well as a financial adviser at Morgan Stanley. Brian has been a resource for Dental Practices up and down the state helping them to secure their future. Brian is here to partner with you in your transition and ensure your financial future.

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INTEGRITY™ PRACTICE SALES

Trustee Report

Adrian Carrington, DDS & Terrence Jones, DDS
CDA Trustees

August 19-20, 2016

Highlights of the CDA Board of Trustees Meeting

The California Dental Association met on Friday, August 19th and Saturday August 20th.

The following are some of the highlights from the August Board of trustee meeting.

As is customary at our meetings, the trustees approved modification to the CDA Executive Director's 2016 management objectives. These modifications adjusted the timing of certain projects such as the component Aptify implementation, TDIC's guidewire implementation, as well as clarified the importance of providing oversight and strategic direction to the TDIC process of acquiring DBIC, DBC and NORDIC.

The board was given a presentation by Gary Price who is president and chief executive officer of the Dental Trade Alliance (DTA). DTA is an association of companies that provide dental equipment, supplies and services. DTA coordinates funding for the Partnership for Healthy Lives, Healthy Smiles Ad Council Campaign that brought us the highly successful 2 minute 2x a day tooth brushing campaign. His talk focused on DTA's research and policy work on oral health connections, including diabetes, and the potential opportunities for public-private partnership to address the identified needs. Key points highlighted the cost benefit of investing in oral health care. He encouraged a partnership with health care organizations, policy makers, businesses, physicians, dentists and pediatricians in an effort to integrate oral health care into their core services. Such coordinated oral health integration could dramatically benefit overall wellness and save millions of valuable health care dollars.

The board approved funding for CDA to undertake a campaign to defeat an anti-fluoridation initiative in the city of Healdsburg California.

The board reviewed findings from the CDA Volunteer Leadership Organizational Health Assessment. This assessment was conducted in an effort to obtain a broad level of volunteer input and establish a benchmark to continuously improve the effectiveness of volunteer governance. Several key areas emerged as foundational and are listed below.

- Build stronger leadership pipelines for leadership positions
- Expand communication efforts to HOD
- Expand interactions with components
- Incorporate expanded "skills" development into leadership training activities
- Continue to build trust

The Board also received updates on the Yes on 56 campaign to raise California's tax on tobacco products by $2. The tax which is currently at 87 cents is one of the lowest in the nation. Raising the cost of tobacco is a proven way to reduce use. The revenue generated will in part fund several state health care programs including the oral health care program overseen by our new state dental director Dr. Jay Kumar.

Finally, I wanted to report that our friend and colleague, Dr. Gary Ackerman, delivered an outstanding speech as a candidate for CDA secretary. As we all know, Gary has had a distinguished career here at SDDS and his service as Chair of the CDA Board of Managers for Scientific Session was highly regarded. His service to our profession has always been enthusiastic and focused on the future. Although I am sad to say he was not successful in this venture, I am confident that Gary will continue to provide outstanding leadership at CDA for many years to come. ■

Next Board of Trustees Meeting:
October 6-7, 2016

MIDWINTER BY THE NUMBERS

28 SPEAKERS | **46** COURSES

15 CE UNITS | **70** EXHIBITORS

45 GALLONS OF COFFEE | **2** DAYS OF CE

Featuring

FRONT OFFICE BOOT CAMP

Coordination of Benefits • HIPAA •
Internet Marketing • Collections •
ICD 10 Coding Changes •
Medical Billing • Insurance Audits

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Integrity Practice Sales • Q-Optics • GC America

YOU
THE DENTIST, THE EMPLOYER

YOU ARE A DENTIST. You are also an employer. Employee evaluations, hiring and firing, labor laws and personnel files are an important part of that. This monthly column, will offer current employment law information pertinent to you — the dentist, the employer.

MEMBER BENEFIT!

SDDS HR Hotline
NEW EXCLUSIVE NUMBER
FREE TO SDDS MEMBERS!
888.784.4031

Mental Health Issues in the Workplace

By **Kim Parker, CEO**
California Employers Association (SDDS Vendor Member)

What types of accommodations must employers make for employees with disabilities? What sizes of employers are impacted with the requirement to make a reasonable accommodation? Are mental health issues considered a disability in the workplace?

A recent California Fair Employment and Housing Act (FEHA) ruling about an employee who wanted a work accommodation, not for his own disability, but to assist his son with kidney dialysis treatments, (Castro-Ramirez v. Dependable Highway Express, Inc.), has raised more questions than answers for employers.*

It may surprise employers to know that employees with common mental health conditions have a right to a reasonable accommodation at work under both State and Federal Law.

FEHA applies to 5 or more employees and is enforced by the Department of Fair Employment and Housing (DFEH). California's FEHA prohibits discrimination against an employee with a disability, and also against an employee who is "associated" with a person with a disability. The FEHA also contains family care and medical leave provisions, known as the California Family Rights Act (CFRA), for California employees who work for California employers employing 50 or more employees.

The Americans with Disabilities Act (ADA) is a federal law that prohibits employers with 15 or more employees from discriminating on the basis of disability, and gives employees (and job applicants) with disabilities a right to a reasonable accommodation at work. An employer with 25 employees might think they are off the hook with CFRA, and not realize they still fall under ADA guidelines.

Reasonable Accommodations: A reasonable accommodation may be obtained for any condition that if left untreated, would limit one or more major life activities, including brain/neurological functions and activities such as communicating, concentrating, eating, sleeping, regulating thoughts or emotions, caring for oneself, and interacting with others. As such, stress, anxiety and depression, under certain circumstances, can be considered a disability.

So what's an employer, with 5 or more employees, to do when an employee requests reasonable accommodations which may include time off, under FEHA, CFRA or the ADA?

1. Listen. Engage in the interactive dialogue process with your employee. Find out your employees' concerns. If the employee has sought medical attention, ask for documentation from the doctor. Find out what type of accommodation your employee is requesting.

2. Be fair. Employers are not required to provide an accommodation that is not plausible or that would cause significant financial or operational difficulty. A reasonable accommodation cannot be used to excuse a failure to meet production standards or rules of conduct that are both necessary for the operation of the business and applied equally to all employees.

3. Can you accommodate? Consider whether your company can make a temporary, reasonable accommodation for your employee without undue hardship to the business.

4. Remind them of SDI. If your employee requires a leave of absence, remind them about California's State Disability Insurance (SDI) benefits. This is insurance that all employees automatically pay into with each paycheck. http://www.edd.ca.gov/pdf_pub_ctr/de8515.pdf

5. Be compassionate. Whether it's allowing someone to leave a few hours early for a therapy appointment, take a few weeks off to decompress or telecommute one day a week, often times a little give and take goes a long way with employee appreciation.

6. Document. Document and call CEA. Be sure you are documenting all discussions that occur with the employee. Call the SDDS HR Hotline, powered by CEA, to ensure you have the proper forms necessary when an employee requests time off. ■

**See CEA's July, 2016 newsletter article in Counsel's Corner for more on this court decision. (www.employers.org/blog)*

Sign up for the new CA Leave Law HR Webinar!

One hour online and audio seminar you can listen to while you have your lunch or while you are on the road. You will only need a telephone, cell phone and/or computer (computer not required). All you need to do is dial, listen and ask questions if you desire.

OCT 26
WEDNESDAY
12PM-1PM

CA Leave Laws
1 CEU, 20% • $40
Sign up online at sdds.org/events/ca-leave-laws/

California's Proposition 56

Will Raise Tobacco Tax to Save Lives, Protect Children

In November, Californians will have a vital opportunity to stand up to tobacco companies and save lives. Proposition 56 will raise the state's tax on tobacco products, including electronic cigarettes (e-cigarettes) containing nicotine, which medical experts warn are creating a major public health threat to children.

"Higher taxes on tobacco products get people to quit smoking and are proven to prevent would-be smokers – including youth – from ever starting."

Higher taxes on tobacco products get people to quit smoking and are proven to prevent would-be smokers – including youth – from ever starting. Yet, California's current tobacco tax of 87 cents per pack of cigarettes is among the lowest in the nation. Prop. 56 will raise the tax by $2 per pack with an equivalent increase on all tobacco products – and only those who choose to continue or start this deadly and costly habit will pay this simple user fee.

The California Dental Association, California Medical Association, American Cancer Society Cancer Action Network, American Lung Association in California, American Heart Association and others are sponsoring Prop. 56 because tobacco hurts all Californians – even those who don't smoke.

Tobacco is the leading cause of preventable death in our state and the nation, claiming the lives of 40,000 Californians annually. Each year, tobacco causes more deaths than guns, car accidents, HIV, alcohol and illegal drugs combined. Meanwhile, California taxpayers spend $3.5 billion dollars each year treating cancer and other tobacco-related diseases through Medi-Cal and Denti-Cal, which provide health coverage for over 12 million low-income Californians.

The vast majority of funds generated by Prop. 56 (an estimated $1 billion annually with an additional $1 billion in federal matching funds) will go to pay for health care through Medi-Cal and Denti-Cal to help offset the costs of tobacco use.

Prop. 56 also provides a dedicated funding source for California's state oral health program overseen by the new state dental director. In addition, the measure directs funds to the University of California for research into tobacco-related diseases and to the state Department of Public Health and Department of Education for smoking prevention and cessation programs.

Studies show that 90 percent of smokers start as teens. This year alone, an estimated 16,800 California youth will start smoking, one-third of whom will eventually die from tobacco-related diseases. Tobacco companies are aggressively marketing youth-themed, candy-flavored e-cigarettes

"Tobacco is the leading cause of preventable death in our state and the nation, claiming the lives of 40,000 Californians annually."

containing nicotine to hook a new generation of young consumers. Teen use of these devices tripled in a single year and teens who use e-cigarettes are twice as likely to start smoking traditional cigarettes. A recent UCLA study also found that toxic substances in e-cigarettes increase users' risk of oral disease. Prop. 56 will treat e-cigarettes the same as all other deadly tobacco products.

"Prop. 56 also provides a dedicated funding source for California's state oral health program overseen by the new state dental director."

Please cast your "Yes" vote for Prop. 56 by mail or on November 8. The tobacco industry is already spreading totally false claims about the measure, but the fact is this is a life-saving measure that will safeguard children and improve California's communities, economy and health care system. Although we have made some great strides, we cannot stand down from combatting tobacco's deadly addiction. Learn more at YesOn56.org. ■

Paid for by Yes on 56-Save Lives California, a coalition of Doctors, Dentists, Health Plans, Labor, Hospitals and Non-profit Health Advocate Organizations. Major funding by California Hospitals Committee on Issues, (CHCI) Sponsored by California Association of Hospitals and Health Systems (CAHHS) and California State Council of Service Employees Issues Committee.

Board Report

Margaret Delmore, MD, DDS
Secretary

September 6, 2016

Highlights of the Board Meeting

Call to Order

President, Dr. Wallace Bellamy called the meeting to order at 6:02PM on September 6, 2016. "Let's make it Happen."

President's Report

Successful new member event and retired member event on August 31, 2016 at SDDS.

Secretary's Report

Membership Report August 2016 – 1659 Total Members. 16 new members just in August. Retention % = 95.40%

Treasurer's Report

Balance Sheet as of August 29, 2016 reviewed.

Old Business

- The *Nugget* Advertising Policy as recommended by the SDDS Advertising Task Force was approved by the Board.

Committee Updates

- Committee/Task Force Mid-Year Reports were reviewed by the Board.
- Member Events Task Force could use more participants.
- Membership Benefits and Services Task Force to compile an article for the *Nugget* outlining all the member benefits.

New Business...New Ideas...

- 1557 Rule in effect. See SDDS website under Hot Topics for the latest information. CDA also has information.
- The Board approved Dr. Craig Alpha as a delegate to the CDA HOD and Drs. Gary Ackerman and Matt Campbell as alternates.

Trustee's Report

- CDA Board of Trustees met August 19-20, 2016. Dr. Richard Nagy was elected the new Secretary.
- Programs to correlate medical with oral health to engage the medical community. Next topic of focus to be diabetes.
- CDA Strategic Plan was discussed and progress assessed.

Executive Director's Report

- "We Were Busy This Summer"
- New staff introductions. Welcome Joe Wilson our newest addition.
- 16 for Sept '16 CE.
- Altered staff job descriptions to comply with new wage/hour laws, effective December 1, 2016
- Updated committee descriptions, policy document, employee manual with new laws, emergency manual.
- Scheduled all programs and events for 2016-2017

Adjournment

The meeting was adjourned at 8:08PM after approving the Minutes from the Sacramento Valley Dental Association, July 6, 1880

Next Board Meeting:
November 1, 2016 at 6pm

We're Blowing your horn!

Congratulations to...

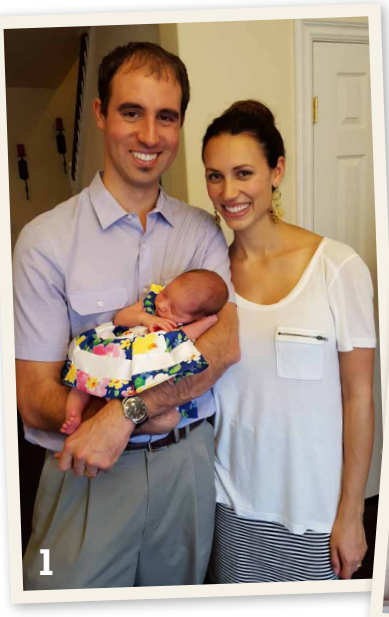
Dr. Jerhet Ask, DDS and his wife Kacie, on the birth of their new baby Evelyn Summer. **(1)**

Kirsten Chang, DDS, on her marriage in August! **(2)**

Paul Dubinetsky (left in photo), winner of the Dr. Herbert and Inez Yee Dental School Scholarship, on his first day of dental school! **(3)**

Gregory G. Olsen, DDS, on the birth of his daughter Quinn Yumi Olsen. She joins two proud older siblings Madeleine (4) and Griffin (2)!. **(4)**

Ed Sims, DDS, on his appearance in VMX Magazine! It is from an article about the CZ World Championships in April. Photo credit to Ken Smith - thanks Ken! The photo caption reads, "During the week he fixes your teeth but come the weekend he's in his period race gear. Ed Sims showed a lot of style on and off the track and the world really needs more dentists like Ed!" **(5)**



LET US KNOW YOUR NEWS!

Get married? Pass your boards? Got published? Let us know your good news and we will feature it in "Blowing Your Horn."

Send us your news to sdds@sdds.org to let everyone know about the great things that are happening!

Congratulations to all our awesome members!

TOTAL MEMBERSHIP

(as of 9/2/16):

1,659

MARKET SHARE:
80%

RETENTION RATE: 95.4%

TOTAL ACTIVE MEMBERS: 1,324

TOTAL RETIRED MEMBERS: 241

TOTAL DUAL MEMBERS: 5

TOTAL AFFILIATE MEMBERS: 13

TOTAL STUDENT/ PROVISIONAL MEMBERS: 9

TOTAL CURRENT APPLICANTS: 11

TOTAL DHP MEMBERS: 50

TOTAL NEW MEMBERS FOR 2016: 72

New Members

October **2016**

TRAMMIE BUI, DDS
General Practitioner
(916) 868-9030
9640 Bruceville Rd Ste 101
Elk Grove, CA 95757-5937

Dr. Trammie Bui graduated from UCLA in 2016.

BRANDON CHRISTENSEN, DMD
Oral and Maxillofacial Surgery
(844) 673-9131
4170 Truxel Rd Ste C
Sacramento, CA 95834

Dr. Brandon Christensen graduated from UNLV in 2012, and finished his post-grad at Emory University – School of Medicine in 2016. Fun Fact: Dr. Christensen tested the Coriolis Effect directly over the Equator.

LILLEY N. GHARAVI, DMD
Endodontist
(916) 318-3894
9323 Laguna Springs Dr. Ste 100
Elk Grove, CA 95758-7838

Dr. Lilley Gharavi graduated from Loma Linda University in 2014, and University of Texas San Antonio in 2016. Fun Fact: Dr. Gharavi loves to run half marathons.

ARMAN HOVHANNISYAN, DDS
General Practitioner
(916) 392-7874
7171 Bowling Dr Ste 240
Sacramento, CA 95823-2043

Dr. Arman Hovhannisyan graduated from USC in 2015.

JUSTIN KIM, DDS
Pediatric Dentist
(916) 660-9487
5182 Commons Dr Ste 101
Rocklin, CA 95677-3911

Dr. Justin Kim graduated from Loma Linda University in 2013.

JAMES LAI, DDS
Pediatric Dentist
(916) 331-4781
5215 Garfield Ave.
Sacramento, CA 95841-3101

Dr. James Lai graduated from University of Illinois at Chicago in 2007.

ROBERT LE, DDS
General Practitioner
(916) 878-9302
1824 Avondale Ave
Sacramento, CA 95825

Dr. Robert Le graduated from USC in 2016.

SARA LINSTADT, DDS
General Practitioner
(916) 773-6565
6522 Lonetree Blvd
Rocklin, CA 95765

Dr. Sara Linstadt graduated from UOP in 2013, and NC-East Carolina University in 2014.

TEX MABALON, DDS
General Practitioner
(209) 993-6641
Pending Office Address

Dr. Tex Mabalon graduated from UOP Arthur A. Dugoni School of Dentistry in 2016.

PRESHUS MAGDANGAL, DDS
General Practitioner
Pending Office Address

Dr. Preshus Magdangal graduated from UOP in 2016. Fun Fact: Dr. Magdangal is musically inclined and enjoys dancing, singing, and playing the piano- especially being a part of her church's worship team/ band.

ALEX MERCADO, DDS
Transferred from Los Angeles Dental Society
General Practitioner
(530) 823-8771
1101 Maidu Dr
Auburn, CA 95603-5864

Dr. Alex Mercado graduated from Herman Ostrow School of Dentistry in 2016.

CLIP OUT this handy NEW MEMBER UPDATE and insert it into your DIRECTORY under the "NEW MEMBERS" tab.

WELCOME to SDDS's new members, transfers and applicants.

IMPORTANT NUMBERS:

SDDS (doctor's line)	(916) 446-1227
ADA	(800) 621-8099
CDA	(800) 736-8702
CDA Contact Center	(866) CDA-MEMBER (866-232-6362)
CDA Practice Resource Ctr	*cdacompass.com*
TDIC Insurance Solutions	(800) 733-0633
Denti-Cal Referral	(800) 322-6384
Central Valley Well Being Committee	(559) 359-5631

New Members

October
2016

GREGORY M. MCEWEN, DDS
General Practitioner
(916) 567-9707
730 Howe Ave
Sacramento, CA 95825-4692

Dr. Gregory M. McEwen graduated from Loma Linda University in 2016.

DAVID PARK, DDS
General Practitioner
(916) 999-0813
3901 Madison Ave Ste 5
North Highlands, CA 95660

Dr. David Park graduated from UCLA in 2004, and USC in 2005. Fun Fact: Dr. Park has four children; and is an avid sports card and memorabilia collector.

RONNEY TAY, DMD
General Practitioner
(916)782-4500
10357 Fairway Dr Ste 100
Roseville, CA 95678

Dr. Ronney Tay graduated from Tufts College in 2016.

KEVIN YEE, DMD
Transferred from Tri-County Dental Society
General Practitioner
(916)443-8701
707 J St
Sacramento, CA 95864

Dr. Kevin Yee graduated from Loma Linda University in 2016. Fun Fact: Dr. Yee loves to go backpacking and flyfishing.

Pending Applicants

Fara Afshar, DDS
Polin Collins, DDS - Returning
Katarzyna Glab, DDS
Miguel Guerra Olvera, DDS – Returning
Guneeta Kalia, DDS - Returning
James Mungcal, DDS
Mehwish Rashid, DDS
Tru Tran, DDS
Steven Walls, DDS
Allen Wilkes, DDS
Lisa Williams, DDS

Member Get A Member Contest Winners

April 2016
Dr. Michael Forde

May 2016
Dr. Jagdev Heir

June 2016
Dr. Kathy Keikhan

July 2016
Dr. Colleen Buehler

August 2016
Dr. Wes Yee

KEEP UP TO DATE...

on all of our upcoming events by liking us on Facebook!
facebook.com/sddsandf/

For a full calendar of all of the SDDS events head to sdds.org, to the Continuing Education tab and choose Calendar!

SPOTLIGHTS:

LIBERTY Dental Plan is one of the nation's fastest growing dental plans, and we are proud to be making our members shine one smile at a time.

Products and Services:

LIBERTY Dental Plan is proud to be one of the Dental Geographic Managed Care plans in Sacramento County, providing outstanding customer service to our members and providers.

Danielle Cannarozzi
(888) 273-2997 ext. 437 phone
dcannarozzi@libertydentalplan.com

(888) 703-6999 phone
(949) 825-8207 fax

libertydentalplan.com

Dean N. Ahmad, DDS, FICOI, DABP maintains a private practice specializing in the treatment of Periodontal Diseases, Periodontal Plastic Surgical Therapies, and Implant Dentistry.

Products and Services

We specialize in the following:

- Comprehensive Periodontal Assessment & Therapy
- Implant Diagnostics Assessment & Therapy
- Periodontal Plastic Surgery/Graft Procedures
- Extractions (Socket/Ridge Preservation & Wisdom Teeth)
- Crown Lengthening
- Biopsy/Oral Medicine/Microbio Analysis
- Occlusal Therapy
- Ortho-Perio & Endo-Perio
- I-CAT Cone Beam 3-D Volimetric Scans

Comel Ahmad
comelahmad@live.com

(916) 434-5151 phone
(916) 434-5575 fax

www.innovaperio.com

welcome
our new SDDS
Vendor Members!

Dental Supplies, Equipment, Repair

Analgesic Services, Inc.
Geary Guy, VP / Steve Shupe, VP
888.928.1068
asimedical.com
Since 2004

Burkhart Dental Supply
Dawn Dietrich, Business Development Manager
916.784.8200
burkhartdental.com
Since 2011

DESCO Dental Equipment
Tony Vigil, President
916.259.2838
descodentalequipment.com
Since 2012

Henry Schein Dental
Mark Lowery, Regional Sales Manager
916.626.3002
henryschein.com
Since 2005

Heraeus Kulzer
Christina Vetter
408.649.8921
heraeusdentalusa.com
Since 2015

Patterson Dental
Roy Fruehauf, Branch Manager
800.736.4688
pattersondental.com
Since 2003

we love
our SDDS
Vendor Members!

Office Construction

Blue Northern Builders, Inc.
Marc Davis / Morgan Davis / Lynda Doyle
916.772.4192
bluenorthernbuilders.com
Since 2007

GP Development Inc.
Gary Perkins
916.332.0300
gpdevelopmentcorp.com
Since 2016

Olson Construction, Inc.
David Olson
209.366.2486
olsonconstructioninc.com
Since 2004

Wells Construction, Inc.
Nicole Wells
916.788.4480
wellsconstruction.com
Since 2014

HR & Legal

BPE Law Group, PC
Keith B. Dunnagan - Senior Attorney
Linda Lewis
916.966.2260
bpelaw.com/dental-law
Since 2016

CA Employers Association
Kim Parker, Executive VP
Mari Bradford, HR Hotline
800.399.5331
employers.org
Since 2004

Wood & Delgado
Patrick J. Wood, Esq., Jason Wood, Esq., Marc Ettinger, Esq
800.499.1474
dentalattorneys.com
Since 2010

Education

The Foundation for Allied Dental Education
LaDonna Drury-Klein
916.357.6680
thefade.org
Since 2015

Staffing

Resource Staffing Group
Debbie Kemper
916.993.4182
resourcestaff.com
Since 2003

Swiss Monkey
Christine Sison
916.500.4125
swissmonkey.co
Since 2016

Dental Specialist

Innova Periodontics & Implant Dentistry
Dean Ahmad, DDS, FICOI, DABP
916.434.5151
innovaperio.com
Since 2016

Media & Advertising

Sacramento Magazine
916.452.6200
sacmag.com
Since 2002

Practice Services

Comcast Business
Lisa Geraghty
916.817.9284
lisa_geraghty@cable.comcast.com
business.comcast.com
Since 2014

Pacific Dental Services
Mindy Giffin
916.705.4515
pacificdentalservices.com
Since 2015

Practice Sales

Integrity Practice Sales
Brian Flanagan & Kirsi Kilpelainen
855.337.4337
integritypracticesales.com
Since 2014

Western Practice Sales
Tim Giroux, DDS, President
John Noble, MBA
800.641.4179
westernpracticesales.com
Since 2007

Financial Services

Ameriprise Financial — The Chandler Group
Thomas Chandler
916.789.9393, ext. 03197
ameripriseadvisors.com
Since 2015

Fountainhead Wealth, Inc.
Steve Raymond
916.431.0425
fountainheadwealth.com
Since 2016

Fechter & Company
Craig Fechter, CPA
916.333.5360
fechtercpa.com
Since 2009

First US Community Credit Union
Gordon Gerwig,
Business Services Mgr
916.576.5650
firstus.org
Since 2005

Financial Services

Innovative Solutions CPAs & Advisors, LLP
Ben Anders, CPA
916.646.8180
innovativecpas.com
Since 2013

Integrated Accounting Solutions
Dave Sholer, CPA, MBA
530.219.0354
OnlyDentalCPA.com
Since 2016

Mann, Urrutia, Nelson, CPAs
John Urrutia, CPA, Partner
Chris Mann, CPA, CFP, Partner
916.774.4208
muncpas.com
Since 2010

The Payment Exchange
Kraig Speckert, President
916.635.8800
thepayx.com
Since 2015

Financial Services

RCA Collection Services
More information coming soon!

Waste/Metal Mgmt.

Star Group Global Refining
Jim Ryan, Sales Consultant
800.333.9990
stargrouprefining.com
Since 2009

EStrategy
More information coming soon!

SDDS members are encouraged to support our Vendor Members as often as possible when looking for products and services.

Dental Laboratory

KP28 Dental Laboratory
Jeremy Lorenzo
916.274.4072
kp28dentallab.com
Since 2015

Marketing

Uptown Studios
Tina Reynolds
916.446.1082
uptownstudios.net
Since 2015

Insurance Services

The Dentists Insurance Company
Chris Stafford
800.733.0633
tdicsolutions.com
Since 2011

LIBERTY Dental Plan
Danielle Cannarozzi
800.703.6999
libertydentalplan.com
Since 2016

SDDS VENDOR MEMBERSHIP SUPPORT IS A WIN-WIN RELATIONSHIP!

SDDS started the Vendor Member program in 2002 to provide resources for our members. No, Vendor Members are not exclusive, and we definitely have some competitive companies who are Vendor Members. But our goal is to give SDDS members resources that would best serve their needs. We suggest that members reach out to our Vendor Members and see what is a best "fit" for their practice and lifestyle.

We currently have 40 Vendor Members. They pay $3,900 per year; that includes a booth at Midwinter, three tables at General Meetings, advertising in *The Nugget*, and much more. Our goal is to provide Vendor Members with the opportunity to connect with and serve our members. We realize that you have a choice for vendors and services; we only hope that you give our Vendor Members first consideration. The Vendor Members program and the income SDDS receives from this program helps to keep your dues low. It is a wonderful source of non-dues revenue and allows us to provide yet another member benefit. Additionally, we reach out to our Vendor Members for articles for *The Nugget* (nonadvertising!).

Our Vendor Members are financial, investment and insurance companies, legal consultants, dental equipment and supply companies, media and marketing companies, hr consultants, construction companies, billing consultants, practice sales and brokers, practice resource and staffing consultants, technology, HIPAA and security consultants, and even our Crowns for Kids refining partner!

Advertiser INDEX

MEMBER GET A MEMBER CONTEST

SDDS is once again partnering with CDA and ADA for the Member Get a Member Promotion – every month we will have a drawing (beginning this May) for any members who participate in this promotion. Here is how it works:

- When a potential members fills out their application, they list who referred them for membership (Will it be you?)
- By doing so, the referring doctor will be entered into the SDDS drawing for a monthly prize
- The referring doctor will also receive $100 cash from CDA and $100 American Express card from ADA
- All referring doctors will also be placed into the SDDS Grand Prize Drawing at the end of November with the grand prize being their 2017 SDDS dues paid for ($390)

Start recruiting new members now for fast and easy winnings!

Classified Ads

EMPLOYMENT OPPORTUNITIES

Seeking an ASSOCIATE DENTIST. Busy Private practice in El Dorado Hills seeking exceptional, enthusiastic, detail-oriented, pediatric dentist to join our team! Please send CV to msdrecruits@gmail.com or fax to 916.941.1443. *8/9-16-C*

RURAL GENERAL DENTIST IS SEEKING GENERAL DENTAL ASSOCIATE to join his practice. Pt's are booked out 6-8 weeks in advance. I am looking for an enthusiastic professional for a full time M-F position. Applicant must be willing to perform all phases of general dental work. I have the largest practice in the small community of Susanville. If interested send CV to: susanvilledentalcare@live.com. *8/9-16*

KIDS CARE DENTAL seeks a Dentist to join our team in Stockton. We believe in a non-traumatic philosophy that focuses on superior customer service and exceptional patient care. Patients love us...come find out why! Send your resume to cschreiber@kidscaredental.com *8/9-16*

WELLSPACE HEALTH ORGANIZATION (an FQHC) is taking applications for fill-in/part-time/full-time dentists. Send your resume/CV to mmullins@wellspacehealth.org. *01/15*

DENTIST (SACRAMENTO/CENTRAL VALLEY) General Dentist- Assoc. position- Full or Part time. Excellent opportunity in a premier well established practice in Sac-Fair Oaks area. We need an experienced GP with outstanding people skills to focus on clinical excellence and patient care, supported by a team of highly skilled professionals. The growth potential is Excellent for the right Doctor-- Potential ownership for the future. Please email resume to hofferber@dental-mba.com. Compensation: Based on Skills and Experience. *12-15*

ORAL SURGEON: BUSY CENTRAL VALLEY DENTAL PRACTICE (near Modesto) looking for an Oral Surgeon to work 1 day a week (Fridays) in our growing practice. We have a busy practice that could definitely serve our community better with an in-house Oral Surgeon (there are none currently in town). Please send a resume and introduction letter to 201wavedds@gmail.com *5-16*

BOUTIQUE MIDTOWN SACRAMENTO OFFICE - Looking for an energetic and ethical Associate Dentist for full/part-time position in busy office with latest technology. Must be detail oriented, have a gentle touch and strong work ethic, with an upbeat personality. Visit: www.midtowndentalsacramento.com. Send resumes to gotfloss@gmail.com *06-7/16*

EMPLOYMENT OPPORTUNITIES

Dental Consultants/Full and Part-Time: Delta Dental of California seeks California licensed dentists to evaluate claims for its Denti-Cal program based in Sacramento. Ten years of clinical experience is desired. Excellent benefits included. Call Dr. Barry Dugger at (916) 861-2519. *10-16*

Oral Surgery Dental Consultant/Part-Time: Delta Dental of California seeks California licensed oral surgeon to evaluate claims for the Denti-Cal program based in Sacramento. Excellent benefits included. Call Dr. Barry Dugger at (916) 861-2519. *10-16*

PRACTICES FOR SALE

LAKE TAHOE'S NORTHSHORE Large patient base maintained by busy Hygiene schedule. Beautiful office. Collects $1 Million/year on Owner's 3-day week. To learn more, go to www.PPSsellsDDS.com. *8-9/16*

EL DORADO HILLS Exceptional facility. Digital radiography, Pano, lasers, air abrasion, paperless charting, beautiful cabinetry, etc. 2015 produced $697,000 and collected $640,000. To learn more, go to www.PPSsellsDDS.com. *8-9/16*

EL DORADO HILLS- EQUIPPED, TURN KEY OFFICE WITH 5 OP'S, busy, thriving community for an energetic doctor to quick start your practice at a great location, asking $75,000, some patients. 1,500 sq. ft. $3,200 per month. Call/Text Joe Hruban at 530.746.8839. joe@omni-pg.com. CA BRE# 01821307. *08/09-15*

Thinking of selling your practice? Want to reduce your stress? Do you want to focus on your patients? If so, please call Dr. Herman of A+ Dental Care at 916-217-2458. *6/7-16C*

FOR LEASE

EXCLUSIVE, PRIVATE DENTAL SUITE; 1200 sq. ft., completely remodeled w/upscale amenities: 3 operatories, lab, reception, business office w/breakroom, private Doctor's office w/bath. Suite is located in a custom dental building w/on-site parking and handicapped access near Country Club Center. If requested, owner will furnish finish equipment upfront: amortize over long term lease (5-10 years). For appt. or further info, call 916.346.0041 *5/16*

SACRAMENTO DENTAL COMPLEX has one small suite which can be equipped for immediate occupancy. Two other suites total 1630 sq. ft which can be remodeled to your personal office design with generous tenant improvements. 2525 K Street. Please call for details: 916.448.5702. *10-11*

FOR LEASE: 1,292 sf Sacramento, move-in ready dental office; 820 sf Carmichael, former dental office; 2,500 sf Rocklin, fully equipped orthodontist office; all in dental office buildings; Contact Ranga Pathak, RE/MAX Gold (916) 201-9247; ranga.pathak@norcalgold.com; BRE01364897 *6/7-16*

PROFESSIONAL SERVICES

MONEY IS WALKING OUT THE DOOR. Have implants placed in your office and keep the profits. Text name and address 916.769.1098. *12-14*

LEARN HOW TO PLACE IMPLANTS IN YOUR OFFICE OR MINE. Mentoring you at your own pace and skill level. Incredible practice growth. Text name and address to 916.952.1459. *04-12*

Selling your practice? Need an associate? Have office space to lease? SDDS member dentists get one complimentary, professionally related classified ad per year (30 word maximum). For more information on placing a classified ad, please call the SDDS office at 916.446.1227.

sacramento
District Dental Society
2035 Hurley Way, Suite 200 • Sacramento, CA 95825
916.446.1211 • www.sdds.org

ADDRESS SERVICE REQUESTED

SDDS CALENDAR OF EVENTS

OCTOBER

4 Ethics Committee Meeting
6:15pm / SDDS Office

5 Lunch & Learn
Drop Dead Gorgeous Temps
Quincy Gibbs, DDS
11:00am / SDDS Office

7 Executive Committee Meeting
7:00am

11 General Membership Meeting
Emerging Trends in Dental Care
Gayle Mathe, CDA
Hilton Sacramento Arden West
5:45pm Social / 6:45pm Dinner & Program

26 HR Webinar
CA Leave Laws
California Employers Association
Noon–1:00pm / Home/Office

28 Licensure Renewal
California Dental Practice Act, Infection Control & OSHA Refresher
Nancy Dewhirst, RDH
8:00am–3:30pm / SDDS Classroom

NOVEMBER

1 Board Meeting
6:00pm / SDDS Office

1 Member Benefits/Services Task Force
6:15pm / SDDS Office

4 Continuing Education
Billing Medical in Your Dental Practice: How to Avoid the Mistakes, Frustration and Making It Actually Work!
Christine Taxin
8:00am / SDDS Office

For more calendar info and to sign up for courses ONLINE, visit: **www.sdds.org**

8 General Membership Meeting
There is More to a Face Than You See
Jagdev Heir, DMD, MD
Hilton Sacramento Arden West
5:45pm Social / 6:45pm Dinner & Program

9 HR Webinar
The Wild World of Wage and Hour Laws of Dental Offices (FREE to SDDS Doctors)
California Employers Association
12:30pm–1:30pm / Home/Office

11 CPR BLS Renewal
7:30am / SDDS Office

16 HR Webinar
Employee Handbooks
California Employers Association
Noon–1:00pm / Home/Office

16 Business Forum
Reducing and Managing Debt
Steve Raymond & John Urrutia
6:00pm / SDDS Office

SAVE THE DATE FOR THE **37TH ANNUAL MIDWINTER CONVENTION & EXPO**
WRANGLE UP YOUR RANCH HANDS AND JOIN US ON **FEBRUARY 9–10, 2017**

OCT 11
TUESDAY 5:45PM-9PM

General Meeting: Recruitment Night

3 CEU, CORE • $69

Emerging Trends in Dental Care Delivery

Presented by Gayle Mathe, Director of Community Programs for CDA

This course highlights three emerging models for delivering dental care outside of the traditional dental practice. As the healthcare delivery system responds to the pressure to turn coverage into access, and dentists seek ways to engage in new and innovative ways to provide dental care, understanding these models can lead to new opportunities.

Earn 3 CE Units!

5:45pm: Social & Table Clinics
6:45pm: Dinner & Program
Hilton Sacramento Arden West
(2200 Harvard Street, Sac)

ARE YOU REGISTERED FOR THE OCTOBER GENERAL MEETING?