FLORIDA FOCUS

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the publication exclusively for the general practitioner

EDUCATION AND ADVOCACY

Drs. Naresh Kalra and Gerald Botko

Salivary Testing

Lasers in Facial Esthetics

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5 Myths About Medical Billing

4-Time Lifelong Learning Recipient Dr. Tony Menendez With Office Therapy Dog Cassi

FLORIDA ACADEMY of GENERAL DENTISTRY

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Patricia "Tri" Jenkins

A Message from your FLAGD President

Hello All,

Here comes our third edition of the year. It is amazing that we are already into the third quarter of the year. As much as I wanted to avoid the topic of Covid beyond my first message, I have to address it! Covid came and Covid went and then Covid came again in Delta form. It is relentless.

But remember, our Planet Earth has been ceaselessly rotating around itself and revolving around the sun for eons. No matter if there are stardust storms or hurricanes or earthquakes, it just never stops. It just keeps going. That is what we need to learn from these lifeless forms; to keep moving on, no matter what. Whether it is Delta or Lambda or Kappa, just keep going and keep doing what you intend to do.

You might say the Earth is humongous in mass compared to the little disturbances that it gets on its surface. But guess what? So is your willpower! Harness it!!

If you are adamant and persistent, nothing should stop you. Don't look back. Don't discuss negative things or encourage other people's negativity. Just do the opposite. Focus only on the good, and the good will follow you. Trust me, it works.

I will give you an example. Our practice of 28 years, at the same location, is headed for the best year ever in my lifetime, although we are short-handed at our front desk, down from three team members to only one! This is in spite of the fact that we have the pandemic and people are out of jobs. Guess what would have happened if I had constantly focused on my shortage of staff versus talking about the best year ever in terms of production and collection? Talking and thinking about and appreciating our best team of three in the back, who jump in to help the one person in the front? If this is not the proof of "positivity breeds positive results," then what is?

Also, we had an amazing medley of implant courses from '24 Hour Teeth' to 'Ridge Split Technique' to 'Sinus Elevation Techniques,' in the middle of school opening in August. The latter (Sinus Elevation) was unanimously voted as the best of the best. But just wait. More of the best is yet to come!! God willing and we, the people, willing :)

Thank you humbly,
Naresh A Kalra,
BDS, DDS

From left: Drs. Merlin Ohmer, Harvey Gordon, Gerald Botko, and Naresh Kalra

Editor's Note

Although COVID cases surged in Florida this summer, it was heartening to see that FLAGD members were determined to pursue our goals of education and advocacy for the general dentist. Under the leadership of our President and Vice-President, Drs. Kalra and Scarpitti, live courses resumed, with a full day of implant education in August and two hands-on courses on soft tissue grafting and crown lengthening scheduled on November 5 and 6. In addition, a live meeting of the FLAGD board was held in August, highlighted by the AGD President-Elect, Dr. Gerald Botko, addressing the board in person.

Virtual AGD Hill Day, the AGD's annual advocacy event, took place in July. This was my first time participating in AGD Hill Day, and I was impressed with the thorough training and the variety of topics covered. The AGD had four priorities to present to the legislators or their representatives this year:

(1) Support of the Dental and Optometric Care Access Act, "which would prevent insurers from holding dentists to fees for services they don't cover;"*

(2) Support of the Resident Education Deferred Interest Act, "which would allow medical and dental students to defer interest accrual on their federal student loans while serving in an internship or residency program;"*

(3) Support of the Oral Health Literacy and Awareness Act, to develop education strategies for vulnerable populations;

(4) Opposition to the broad expansion of Medicare dental benefits to all seniors, support for the existing Medicare Advantage dental programs, and support for the creation of a Medicaid dental program for low-income seniors.

Drs. Botko, Merlin Ohmer (Region 20 Trustee), Linda Trotter (R20 Director), your editor, and other members met virtually with representatives of Senators Rubio and Scott to request their support for these issues.

In July, many FLAGD members generously engaged in community service by volunteering to provide dental treatment to low-income patients at the Florida Mission of Mercy in Jacksonville. 1111 patients were treated, and 1.6 million dollars of dentistry was performed. In addition to the volunteer care provided by many members, the FLAGD was a supporter of FL-MOM at the Bronze level of $1000.

We would be delighted to receive your feedback about the Florida Focus and any news or articles you would like to share! Please email FLAGDEditor@gmail.com with your comments or suggestions, and have a healthy and happy autumn!

*From "AGD Hill Day 2021.

Editor Millie K. Tannen, DDS, MAGD

FLAGD Members Volunteer at FL Mission of Mercy July 28-31, 2021

Left: Dr. Dan Gesek and AGD Region 20 Director Dr. Linda Trotter. Far left: Dr. Donald Thomas.

Above: Dental spouses Drs. Douglas Massingill and Herminia Rodriguez. Left: Dr. Jeffrey Jottley, second from right, with friends.

Reflections from Dr. Gerald Botko

As many of you know, I am currently president-elect of AGD, and in November, I will move into the role of president of the organization for the 2021-22 year. There is so much I am looking forward to doing in this role, but one thing I'm most excited about is the AGD Scientific Session which will be held here in Orlando next July 27 thru 30. I look forward to welcoming our colleagues to this great state.

The AGD meeting in Florida is your meeting, and it is important that we do our best to make it the best we can. I am excited to welcome exceptional speakers, hard-to -find hands-on courses and opportunities to connect with other committed dentists like yourself.

I am what one would call a transformational coach and leader. I believe in clear goals, hard work and positive change. I believe change is necessary for progression and growth in an organization. I learned along my life's journey that we can only control what we can control. However, we cannot stagnate.

GERC (AGD's Governance Evaluation and Review Committee) was formed to analyze our governance structure which is almost 70 years old. Fortune 500 companies, the military, the government review their structure at least every two years. AGD is way overdue. We cannot be afraid of change. Status quo gets us the same old results without any progression. AGD is a learning organization. Peter Senge, who wrote *The Fifth Discipline*, speaks of a learning organization and says that the one single thing a learning organization does well is to help its members embrace change. There is no real progress without change. It is our mission that matters. Our roles are never more important than our goals.

The last thing I would like to talk about is membership. Membership starts with each one of us. Quoting from the great Florida leader Dr. Frank Collins,"Let's put the ME in membership." He always said if we all could recruit one new member, what an impact on our organization that would make. This is still true today. There are approximately 160,000 licensed dentists in the U.S. and 20,000 in Canada. 80% of these are general dentists. AGD has only 25% of this market. We can do better. If you feel that AGD made you a better dentist, share your story with a non-member.

The AGD Membership Council has been diligently working on big changes to our membership model, and we are excited to announce these plans later this year. Watch for updates and special announcement in October.

Dr. Gerry Botko, AGD President-Elect

Celebrating the first FLAGD hybrid board meeting! From left: Drs. Douglas Massingill, Linda Trotter, Andrew Martin, John Gammichia, FLAGD President Naresh Kalra, AGD President-Elect Gerald Botko, Harvey Gordon, Merlin Ohmer, Dr. Aldo Miranda, and Toni-Anne Gordon.

Salivary Testing in Pediatric Dentistry: An Interview with Dr. Boyd Simkins

by Dr. Millie Tannen, Editor

Salivary testing has been studied extensively as a diagnostic tool, due to its ease of use compared to serum analysis.[1,2,3,4] While the majority of research has concentrated on finding biomarkers for a variety of diseases, including cardiovascular disease, cancers, autoimmune diseases, renal diseases, HIV and, recently, COVID-19,[1,2,3,5,6] salivary analysis has also given dentists a means of identifying the biochemistry and pathogens present intraorally.[4,5,7] As more dental practices choose to emphasize the relationship between their patients' oral health and their total health, interest in using salivary analysis to evaluate oral conditions has grown. Salivary diagnostic systems offer clinicians the ability to identify unhealthy conditions, communicate them visually to their patients, and recommend healthier choices for oral hygiene and diet. As AGD member Dr. Tom Levine writes, "Connecting the dots between a patient's oral and systemic health is where the next frontier in medicine and dentistry lies."[8]

Two commercial testing systems available to dentists are My PerioPath by Oral DNA, which identifies eleven pathogens present in saliva,including high-risk *Porphyromonas gingivalis* and *Treponema denticola,*[9,10] and SillHa (mySaliva) by Arkray USA, which identifies the markers of ammonia, acidity, buffer capacity, cariogenic bacteria, protein, blood, and leukocytes.[11] It is important to note that, according to the ADA, "As of June 2021, there are no FDA-approved salivary diagnostic tests for evaluating the risk of periodontal disease or dental caries, or head and neck cancer."[12] Both the ADA's Science and Research Institute and other researchers recommend "large-scale, multicenter trials"[5,12] and standardization.[9,10]However, smaller studies have demonstrated positive results for salivary analysis;[1,2,6] and in clinical practice, many dentists have found these tests to be diagnostically useful as well as motivating for their patients.

Dr. Boyd Simkins is a board-certified pediatric dentist who practices in North Ogden, Utah, and lectures on the importance of salivary testing in the dental practice. In June, he gave a corporate presentation at the Florida Dental Convention. As he mentions in this interview, as general dentists, we have an advantage over specialists when recommending changes in oral hygiene and nutrition, since we treat the entire family. As Dr. Simkins reveals, salivary testing can be a powerful method of discovering previously undetectable oral factors and for encouraging our patients to adopt healthier lifestyles.

When I think of salivary testing, I think about checking for markers for various diseases or for improving periodontal health in adults. I hadn't really thought of it in terms of children. What led you to introduce this into your practice?

It was a bit of a long journey. I've been in practice 17 years. I've been treating disease forever, and it just wasn't feeling right, because we were reacting to it. So, we set out on a journey to see what we could do to get ahead of the game. I've been in CrossFit for a long time, and one of the main focuses was nutrition and health. I started thinking, "Why aren't we focusing on nutrition and health with these kids?" So, we started talking more about diet. Then, I started to research, and I started looking at bacteria. We tried a couple of things before we got to SillHa. I don't know if you remember the CRT system. It was an agar plate. You would swab, put it on the agar plate, incubate it for 48 hours, and then you'd have to call in the results, the plaque-forming units. And we wouldn't do it. We were a very busy pediatric practice.

I went to the FDI World Dental Congress in San Francisco, and there, I listened to Dr. Brian Nový speak about the microbiome, pH, acidity, to see what's happening behind the scenes. This gets into the whole conversation about vertical transmission and parental diagnostics, passing all this bacteria to the children. If I can get ahead of the game, then I can stop the disease before it's presented, moving from a western-type philosophy, where we're managing disease as it presents, toward a more eastern type of philosophy, where we're really looking at the root causes. We can talk about diet and carbohydrates, I can talk about snacking and grazing all day long. But

if I don't have something that I can specifically point out to the parents and say, "Hey, this is what's going on..." I mean, it was ineffectual. I can't tell you how many conversations I had about snacking and grazing. Millions. It got to the point where I didn't even need to have the conversation, because my assistants could do it verbatim for me. That's how we got into SillHa. But the idea was, if we could get ahead of these kids, we could catch it before it starts. We're taking a kid now that we're going to turn into a healthy adult. It's the idea of pure prevention.

That's a really interesting point, that you are setting them on a course for health for the rest of their lives. Can you give me a couple of examples of how this has worked in your practice?

You're going to see it across the board; it's just like anything else. You have to have the parents on board, which essentially means the family on board. When we're looking at this, you can't treat one individual child inside the family. I'll give you a couple of different examples that I have. The first is one that didn't go well. I have a family that we've seen for years. Every time they come in, they've got new decay. In fact, this is probably the family we see the most emergencies on. When we started introducing all this, super-excited, especially for this family because they're so high-risk, I talked to the mom. The first child came in, and we started some preventive measures. And then the mom decided that it was too much to do. And so, now, this poor family... Just the other day, this 9-year old, I think he's got endo that we've got to do on one of his 6-year molars. They totally disregarded it, and I've seen the disease just progressing, even to the point that the mom is talking to me now about all of her dental problems. So, this is a typical case that we see. We've got no prevention, we've got no parental involvement, and they're not interested in looking for it.

Now, I've got the other end of the spectrum, and I'll just briefly talk about one I did a case study on. This was a kiddo that we'd seen since he was 2 or 3. Little guy, 5 or 6 years, no decay, we're putting him in a low-risk category. We're still having all the conversations about the carbohydrates and the snacking, but all of a sudden, we're seeing watches, watches that are suddenly turning into fillings. And then, we've got watches on the other side. More teeth. And so, for this one, we thought, okay, we're doing our best. We're not doing well, though. Essentially, I've watched this child slip into disease. This was about the time when we introduced SillHa into the office. We did the study, and we saw that the acidity was up. The buffering capacity was non-existent. We had some inflammation issues. That's the other thing that's really nice about this. I think one of the things in pedo that is completely overlooked is inflammatory status inside these children. So, I've got a definitive way to also monitor inflammatory status. We put in some preventive measures. We found probiotics and some prebiotics. We're using a lot more xylitol. We're using more remineralization toothpastes. So, we took this kiddo from a child who had no disease, to disease; and then, we were able to look at his levels and put him on some Basic Bites, which is a prebiotic. It's got some xylitol and calcium carbonate. The big thing is, it's got arginine, which is what the commensal bacteria use to create ammonia to help reduce the acidity inside that oral environment. We've moved him to the point now where the acidity is coming down, the buffer capacity is going up, and so his protected measures inside his mouth are now coming back to where they're nice and balanced. We're still in the process. This is going to be a marathon, not a sprint. But we're going to get him to the point where, in the next couple of years, we've got permanent teeth coming in, but we're going to colonize those permanent teeth with fantastic bacteria. The risk of him having issues down the road is going to be greatly reduced. That's one of my fun ones because it shows all of my shortcomings, but then it shows the progression that we're making.

In your case, you have to be concerned with the parents complying, the whole family. How do you present this to the parents?

It really is a collaborative effort by all of us. The idea is that, when the hygienist is with the kiddos, the assistant is with the kiddos, this is always brought up. And then, I come in, and I bring it up, as well, and honestly, the response is overwhelmingly positive. For all parents, especially today, there's a huge focus on our kids being healthier than we are. This was one of the things that really motivated us, back when I was talking about nutrition. We're seeing this rampant metabolic disease going crazy inside of our kiddos. I've got kids who are overweight, who are not sleeping well, that are having Type II [diabetes] showing up in my chair, ten, twelve, thirteen years old. The parents want to get ahead of the ball with these kids, because they don't want those diseases. I would say that acceptance for salivary testing inside the office is well over 90%. I'm not going to say it's 100%, just because nobody's going to be 100%. I have very few insurances that will pay for the salivary testing, but because of the relatively low cost of the materials, I can keep it at $30 or less, and parents are willing to put that out there to see what's going on with the kids. The big thing that I always tell parents is that, when we do this, we have them fast. No food, no drink, no brushing for

- **Probiotics:** "Live microorganisms which, when administered in adequate amounts, confer a health benefit on the host."[13] Common oral probiotics include *Lactobacilli Rhamnosus, L. Salivarius, L. Brevis,* and *Bifidobacteria Lactus.*[14]

- **Prebiotics:** substrates that are "selectively utilized by host microorganisms, conferring a health benefit."[15] There are many types, but most are oligosaccharide carbohydrates. Common foods include "asparagus... onion, Jerusalem artichoke, wheat, honey, banana, barley, tomato, rye, soybean, human's and cow's milk, peas, beans... seaweeds and microalgae."[16] In human and animal studies, prebiotics have been shown to improve immunity functions by increasing the population of protective microorganisms.[16]

Dr. Simkins: "The difference we see is that people mistake probiotics, which are specific for gut function and get really acidophilic, with oral probiotics, which are mouth specific and favor a more alkaline environment."

two hours prior, so we can get at rest salivary content. If they're drinking a Gatorade before they come in, obviously things are going to be out of whack.

The thing that I really drive home with the parents is that we're looking at trends. If I can look at trends over long periods of time, we know if we're making a difference, if we need to alter. But really, the big thing is that we're getting these families on board. We're moving these families toward health, because parents can't just do one thing and their kids do another, and we make that really clear. One of the keys that you have to really do inside this system, with everything that we're trying to do to change lifestyle, it's got to be a motivational-type interview. We can't dictate. This system of the hierarchy of the doctor over the patient over the parent, it doesn't work. We've got to be on an even playing field, and we've got to let them have guided decision-making inside their healthcare process. And that's really been the success for us. It's really well accepted. In fact, I can't tell you how many parents are excited. Like they'll go, "I can't believe this, why haven't I seen this before? Why isn't my dentist doing this?" Those are comments that I get all the time.

You gave a corporate lecture in June in Orlando. Have you spoken with any general dentists who are using this system or other salivary diagnostics?

I know people are using some OralDNA, which is great. I have very few people who are even on this saliva-testing spectrum. I had general dentists and one periodontist attend the lecture. People aren't catching on yet, and that really is the shame because we're still in that mode of reactive vs. proactive. That's why we really need to get out of that model. We need to get out of the "We fill a cavity because it's suddenly there," vs. "Why are we not looking for what's leading to the cavity before it shows up? Why aren't we looking into this complete health model?"

That seems to be the trend in many dental practices, emphasizing total wellness.

In regards to that complete health-type model, this really is the future of healthcare. We as dentists – and this is something that we've been really trying to focus on – if we're not collaborating with those MDs, then this system's not going to work. For us, as a pediatric provider, we really should be testing these parents prior to birth. If I can see the microbiome of a pregnant woman, then I know what the child is going to have inside the mouth from zero to one and possibly two years old, because of vertical transmission. Once we hit two and three, and on from there, then it's more diet related. There's research looking at the microbiome of the parents or the primary caregiver and the child, and it's very similar. Really, this is where the general dentists are going to help us, because I don't have access to the parents necessarily, prior to birth. We're hoping to get in even with the OBs on this one, because this is where it needs to go. If we can identify risk prior to birth, then we can start making changes to the parent, who's going to be the carrier for the child, and we can set up these kids from Day 1. As soon as they're born, as soon as they start having contact with the parents, that's when the transmission begins. If you've got someone who's got this crazy, highly pathogenic bacteria going on in their mouth, we're putting it right into these kids' mouths. We're talking about the future, cardiovascular disease, dementia, Crohn's, and diabetes, all of these things that, in the next ten years, are going to be the biggest killers. The biggest killer in the United States is still cardiovascular disease. So why aren't we starting when the kids are still zero to one?

One of the great things that we've been able to do, too, is airway screening in our office for everyone. It's one of the things I've found with SillHa that's been super-beneficial, because parents don't watch their kids sleep. I've got one case right now where we started doing SillHa, and we started seeing inflammatory markers show up. We have this kiddo who is mouth breathing, inflaming the gingiva. We did a sleep study on him, just a home sleep study, and this kid has mild sleep apnea. The issues that tipped us off were: home care by report was great, he really was cavity-free, a few over the years, but nothing that was significant. Then, we were managing the acidity portion, but we couldn't manage the inflammation. Now that we know that the kid's a mouth breather, we're going to get the nasal breathing going, to see if we can reduce that inflammation, and then we're going to manage the sleep apnea. So, we sent him off to the pediatrician. It's super-interesting how with the saliva, you can determine so many things, to help these kids tremendously.

What methods have you found to be effective in encouraging behavioral changes based on testing results?

We use a lot of Basic Bites. Honestly, what child doesn't like caramel and chocolate? I get the hypocrisy of having children eat candy to prevent decay, but it's super-effective. We use a lot of probiotics. We use xylitol a lot, whether it's the gum or the toothpaste. We use a lot of hydroxyapatite in the toothpaste, trying to get remineralization. We really focus on diet, too. We're starting earlier and really making sure that these kids are getting fiber, whole foods, anything that moves us in that direction, because healthy body, healthy mouth – it's all the same. Staying away from the processed soft foods as much as possible also helps. Essentially, what we do (and this is something Dr. Erinne Kennedy, who's fantastic, gave to me), we have a menu we give out to kids, that's got all of these options on it. That's having the patient and the parents involved, looking at the options and looking to see what will work inside of their home, what can be a sustainable practice. The other thing we find is that we're in the 6-month model in dentistry, which is awesome, because we're seeing these kids way more than the pediatricians. But we also have to get out of that mode. In goal setting, if we're not seeing these kids more than 3 to 5 times a year, then it's difficult to sustain. There are times when you've just got to see the kids more frequently.

Do you encourage quarterly visits?

Oh, yes, we'll see a lot of kids at 3 months. Depending on the child and the risk we're seeing, we'll see them more frequently to test the saliva to see if we're having an effect. One thing about it, if we can get from one test to the next, it's really great, because you do a photograph, almost like a box diagram, and you can see changes. We're using that as a huge motivational tool, because anybody who sees success is going to be motivated. If we're seeing success in small increments of time, it's going to lead to success over long increments of time. In speaking with the parents, you're going to figure out what's motivating and what's not. Take some time. You don't learn all this in a day, that's for sure.

The message that I'd really love to get out is that we've got to turn the corner, and I really think that dentistry as a profession is the place that we can lead healthcare into this model, and I think that we need to step up and take our place and do that. It's going to be a game-changer.

References and CE Questions are on page 18.

Showcase your skills and stand out as a general dentist by becoming a Fellow of the AGD! The AGD will be hosting the 2021 Fall Fellowship Review Course and Exam at the Capitol Hilton in Washington, DC, on October 1-3.

Register today at http://bit.ly/32xxLke

September 10-11, 2021
POSTPONED
NEW DATE November 5-6, 2021
LOCATION: Embassy Suites by Hilton Orlando
5835 T G Lee Boulevard, Orlando, FL 32822

Soft Tissue Grafting
WHEN: November 5, 2021
TIME: 8:30 a.m. - 4:30 p.m.
INSTRUCTOR: Dr. James Kohner

Includes light breakfast, networking lunch, and coffee bar refreshed throughout the day.
CEUs: 3 - lecture / morning registration only
8 - Full day / Participation / Workshop
Subject code: 250
AGD Members: $449 (8 CEs)
Non-Members: $550 (8 CEs)
Morning lecture only: $125 (3 CE's)
Staff: $125
**** Full-day course includes an afternoon workshop fee of $125. This includes pig jaws and surgical equipment to use. ****
The morning lecture is 8:30-11:30 AM.

Crown Lengthening
WHEN: November 6, 2021
TIME: 8:30 a.m. - 4:30 p.m.
INSTRUCTOR: Dr. James Kohner

Includes light breakfast, networking lunch, and coffee bar refreshed throughout the day.
CEUs: 3 - lecture / morning registration only
8 - Full day / Participation / Workshop
Subject code: 780
AGD Members: $449 (8 CEs)
Non-Members: $550 (8 CEs)
Morning lecture only: $125 (3 CE's)
Staff: $125
**** Full-day course includes an afternoon workshop fee of $125. This includes pig jaws and surgical equipment to use. ****
The morning lecture is 8:30-11:30 AM.

Is Everyone Smiling But You?

by Dr. David Rice

If you're anything like most dentists I meet, you've pondered our title more than once. You've powered through patient moments in your treatment room while other members of your team laughed it up down the hall. You've struggled through teammate issues ...not the least of which today is your finding team issues. You've wrestled with dental insurance companies denying claims and delaying payments. For Pete's sake, you endured a pandemic.

So...is everyone smiling but you? And if they are, how can you change that?

There are some age-old concepts we know help. I'm sure you've read about building your vision. I know you've heard about team culture. I'm betting you've even thought about what daily habits feed your culture and vision and what habits detract from it.

I want to build on all that. In fact, I want to suggest that in order to change, you have to first change a few words. Rather than how to...I want you to consider who.

A very wise Dan Sullivan and Dr. Benjamin Hardy have invested decades in the concept that...

Who...Not How is our ticket to building our vision...creating our culture...and living our best habits.
Who...Not How is our path to smiling as much or more than everyone around us.

Vision and Who

When I work with dental practices on their vision, the first who that matters is you...the dentist owner. Too many dentists want to lead by committee. Don't get me wrong, as you'll see in our culture and habits pieces, I am a team-centered leader and practice owner. However, you were the one who went to dental school and it's your name on the door. Your vision starts with you!

Now that we've established you as the primary creator of your vision, scout out your happy place. The place you feel most relaxed and think the best. Wherever it is.

Next, if you're an analog fan, grab a pen and plenty of paper. If you're a digital fan, grab your favorite device. Got it? Good.

Part One

Let it out. Think about your ideal practice day. Don't overthink it. Structure is not important yet. Simply imagine that incredible day when everything went right and felt right.

How many patients did you see?
What procedures did you do?
How much time did you have to do them?
Who was working next to you?
What, if anything would you change?

STOP and do that before you read the rest of this. I've seen far too many well-intentioned friends finish this read and never get back to mapping out their ideal day.

Once you're finished, take a break for a few days. You'll be amazed what comes to you when you go back and re-read what you've noted.

Part Two

Re-read your brilliance. Does it still resonate. If no, modify; if yes, it's time to bring your other who's in.

Your next who(s)...your family. Generationally this will either make incredible sense or no sense at all. The longer you've been practicing, the more you're scratching your head. It's okay. You're not alone. Your vision...and smiling starts at home. You and I can only fake it till we make it for so long. After that, it's too much work to sustain.

Bring your ideal professional vision to your significant other. Does it mesh with the personal life and vision? Do you even have a personal vision? If no, repeat part one with your family. If yes, carry on...

Part Three

Take it to your other who's...your team. Your success get's so much easier with their help. Review where you are as a practice today. Show them where you want to go. Let them know you want them to make the journey with them. It is critical to engage, educate and empower your team to see what you see and genuinely want to go where you go.

Culture and Who

The fastest route to true team culture is a strong vision and a leader. Your team needs to know what your win looks like. They need to know what a loss looks like. You all need to have an accountability plan.

That in mind, culture at large is a composite of every who on your team. When you inspire that unity, you avoid the turmoil and the turnover so many are facing today. With that, the best leaders understand that you are best served when you are not the lead who for every aspect of your practice.

As you define your culture, your goal is to identify the most engaged, educated, and empowered team member. You're likely picturing that person right now. They show up early. They excited. The rest of your team looks to them. Your patients love them. They are your go to when you need anything asap. That one team member is your who when it comes to keeping your culture.
Culture, as Peter Drucker once said, eats strategy for breakfast.

Sit this team member down. Share how valuable they are to your practice. Ask for their help. Trust them to keep everyone moving in a unified direction. Meet with them for 10 minutes bi-weekly. When you make this position important, it becomes important.

Habits and Who

I think what I love most about our vision, culture and habits formula is that it works in forward and reverse mode. Strong vision leads to amazing culture and encourages better daily habits. Better daily habits support your amazing culture and drive your strong vision.

So, who do we need in the habits bucket? You know it...everyone! You and I build and lead with our vision. Our keeper of the culture helps us stay on course. Every team member works on living the habits that feed the machine.

Part One

Positive habits that contribute to the culture you're striving for and support your vision are key. That may seem obvious. The devil, as they say is in the details. Positive habits are pretty easy to recognize. How about habits that are focused and support your culture and vision? Are they easy to recognize? Yes! So long as you've invested the time to establish your vision. Give that pause.

Part Two

The habits you eliminate are as, if not more critically important than habits you keep. On the surface, negative habits are as easy to recognize as the positive ones. Digging deeper, what I'd add is any habit that is not in total alignment with your vision becomes a negative habit.

Why?

Appearing positive as some of them may appear, any habit that doesn't drive your vision is a distraction. Distractions add up. Their additive impact will derail your focus. Without focus, you cannot sustain your culture and vision.

Wayne Dyer and Who

When you change the way you look at things, the things you look at change.

Much like our clinical philosophies, the concept of vision...culture... and habits stands the test of time. Much like our technology and delivery evolves, the concept of who, not how is the evolution of what drives our success today.

If you've ever felt like everyone was smiling but you, you're not alone. I've felt that way too. Become the champion of your who vision story. Team up with your new who culture keeper. Engage, educate, and empower your entire team as who's for daily habits. You've worked hard to be here. Live your best life.

Founder of the nation's largest student and new dentist community, igniteDDS, Dr. David Rice travels the world speaking, writing, and connecting today's top young dentists with tomorrow's most successful dental practices. In addition to igniteDDS, Dr. Rice is editor-in-chief of Dentistry IQ and leads a team-centered, restorative and implant practice in East Amherst, NY. With 27 years of practice in the books, he's trained at The Pankey Institute, The Dawson Academy, Spear and most prolifically at the school of hard knocks.

FLAGD Leader, Lifelong Learner, and Dog-Devotee: Dr. Tony Menendez

Dr. Tony Menendez with Cassi

Dr. Menendez, you've been honored with the Frank J. Collins Lifetime Achievement Award and have earned four Lifelong Learning and Service Recognition awards. What motivated you to achieve the additional LLSR awards, rather than stopping with the first?

After graduating from Emory College of Dentistry, continuing education was the last thing on my mind. I quickly realized that a lot of the courses available were minimalist in nature and were offered just to complete your biannual requirements. And although I felt fortunate to have received an excellent basic dental education at Emory, I really wanted to practice comprehensive dental care. As an AGD member I became aware of the Fellowship/Mastertrack guidelines and was introduced to the Comprehensive Dental Program at the University of Florida College of Dentistry. I was able to attain my Fellowship in 2004 and my Mastership the following year in 2005. At the conclusion of the program, I was concerned about the void I would have in my professional life after meeting once a month for the past 25 months. With the program director's blessing, I continued in the program as a visiting faculty member and have been doing so for the past 19 years. It's been more than just an educational experience. I developed wonderful personal and professional relationships with both fellow participants and lecturers. As a result, I was asked to join the Florida Academy of General Dentistry as a board member and am proud to have served as the FL AGD president for two terms and as a regional director. Many of our past presidents were participants of CDP including Rod Shaw, Larry Grayhills and Andrew Martin, just to name a few!

What is your role in the UF Mastertrack/Comprehensive Dental Program?

Following the AGD's Mastertrack requirements, nationally recognized lecturers, faculty, and others cover the numerous disciplines outlined by the AGD via didactic and hands-on participation. Participation is highly encouraged and, as many lecturers are highly specialized and are unaware of the knowledge base of the participants, we make every effort to direct subject matter that is pertinent to the group. Certainly, my most active role is in the participation segment of the weekends, working with individuals at their level of expertise. This interaction is my favorite. I always seem to learn something myself and look forward to putting it into use Monday morning.

Speaking of guest lecturers, I've had the honor of working with some incredible practitioners, including Lee Ann Brady, Jimmy Cassidy, Will Martin and Luis Gonzaga from the Implant Center at U of F, and many others. It's encouraging to find that your philosophy of care closely follows these practitioners and instills confidence in your daily practice. Of course, I would be negligent if I didn't include Jim Haddix, the course director for the past 20 years and an excellent educator that I admire for his calm nature and his commitment to lifelong learning. Jim always participates and is an ardent note taker. I appreciate his mentorship in general and specifically in his two favorite knowledge bases, Endo and TMD. He has been an excellent reference and has always responded when I need clarification on either subject. He will be sorely missed as he approaches retirement next year. I would be remiss if I did not mention Henry Gremillion, a tragic loss to our profession. An expert in orofacial pain, Henry inspired me to learn as much as I could about TMD. He was a gentleman and a scholar!

Being part of the program just became part of my professional life. My monthly trips to Gainesville provide me with a break in my usual schedule and the opportunity to work with likeminded people. In addition to listening to these talented practitioners provide me with up to date concepts and techniques, I get to meet some pretty impressive people who have become friends. The social component of this program begins on the very first weekend. Probably the most important weekend! This is where you get to know you're fellow participants and the people you will be spending the next 25 months with!

What are some of the other volunteer activities you've done?

Well, certainly in the past, it was all about AGD governance and being the president and the regional director. I mentor students, and I advise the Fellow track at LECOM in Sarasota. There's a lot of time spent lecturing. One of the best things about being the advisor to LECOM is that when we had the ability to go into the school, we would have meetings on Thursday evenings. I would do an hour presentation, and at the end of it, you'd always have two or three students who wanted to ask more questions. So, invariably, I would ask them if they would like to assist me in those procedures, whether it was placing implants or periodontal surgery. We'd schedule it so they could come down to my office and be the assistant. I would complete the procedure, and they'd get to see it firsthand. They're certainly knowledgeable, and once again, all they're doing is assisting, but it really gives them the opportunity to see the surgery up close.

Do you have a favorite area of dentistry?

Probably the most intriguing is orofacial pain and TMJ. So much of my practice has been endo, perio, and prosth. What I've come to realize after learning so much about occlusion is that the potential

disharmony between the joint and occlusion can have deleterious effects in some individuals, affecting all aspects of their lives while others seem to be so accepting of the pathology. That's where I'm really getting more involved, and I'm seeing a lot more patients with orofacialpain/TMD. It takes time and you get to know your patients on a completely different level.

You have to understand that at my point in my career, I don't see as many patients as I used to, I have an abbreviated schedule, I have a small staff, but I'm very happy with the way things are going. I'm incorporating so much of the TMD and orofacial pain into the rest of my practice, and I have a number of excellent referring neurologists and physicians that send me cases to work up and to work with. So that's what I'm really enjoying at this time. I don't find practicing stressful. I realized a long time ago that you can't please everybody. We really work hard to make patients happy. I think that's shown in our reviews, and we get so much word of mouth.

As a teacher, I make a point of communicating my findings to the patient. I give them the information to make their own informed decisions I show them the discrepancies in their bite, why they're having headaches, neckaches, their malocclusions, and their fractured teeth, it becomes easy for the patient to understand that before we start placing permanent crowns, we need to evaluate their bite; we want to treat the disease, not the symptoms! Before we put a crown in there, we need to figure out what's going on. One of the things my colleagues always ask me is, "How can you afford to spend so much time talking with a patient?" If I educate a patient, I never, really never, have any issues suggesting treatment. They're as educated as anybody wants to be. Now, can there be a financial hiccup? Certainly, but in most of these cases, especially like the ones I just described, it's "We're going to put you in a provisional restoration. We're going to go ahead and refine your occlusion. And that's going to take time." A lot of my cases will go anywhere from 6 months to a year and a half, if need be, refining everything that we need to do so that the patient and I are both happy with it.

At the UF Mastertrack with Dr. Richard Heinl

Do you have an associate or a partner?

No, I still am practicing by myself, and when people ask me when I'm going to retire, I look at them and say, "I have no idea." I'm enjoying what I'm doing, so right now I'm very happy with that. In the next year or two I'm going to start scanning some of the students that I work with to see if I find somebody who'd like me to mentor them and hopefully take over my practice in the next five to seven years.

Is there a particular technology that you like to use?

I'm very big into loupes. I generally wear an 8-power loupe during my procedures. We have a CBCT and all the latest and greatest electric handpieces. I also was trained with lasers, but I've reverted back to "old fashioned" surgery, because with that high power of loupes, you can do much smaller incisions and be much more careful with the surgeries that you do, and patients heal very, very quickly. I had practiced with a microscope for endo, but found it to cumbersome I worked with Designs for Vision, and I found that most of the optics that I used were about ten power. I immediately purchased a pair of 6 power [loupes], and when they came out with the 8's, I ordered those. When I'm working with the endo weekends, and they see me with my 8-power loupes, they ask, "What can you see with that?" and I say, "I can see about halfway down the canal," if I have the mirror set up right. That allows me mobility without being tied down to a microscope, and I can use my loupes for all my procedures.

What advice do you have for members of the Florida AGD?

If you're a general dentist, I think that you should aspire to provide comprehensive care. The one "five-star" statement that I can make is that my patients seem to relish the fact that they have so much opportunity to do so much of their treatment in one office. In providing comprehensive care, you can complete multiple procedures on one patient in one sitting without having to refer out, and patients really appreciate that. Let's just take an example of a traumatic injury to a central incisor, a fracture just at the crest of the tissue. We go ahead and extirpate the pulp, do the endo, and place a post and a core. We do the crown lengthening procedure and place a provisional crown. We see the patient in a week. Then, we see them in 8 to 10 weeks, and refine the margins, take an impression, and deliver the crown. If a patient has a traumatic esthetic case, we try to get them walking out the door where they feel totally happy with the result, and they don't feel self-conscious about what they see.That's the type of dentistry that I want to do. It limits the number of patients that you see a day, and it makes it much more efficient and stress-free. I let students know , "We now have the ability to scan a tooth and send it off to Texas, and they'll go ahead and fabricate a crown and a jig to so that you can prep the tooth and cement the crown without ever having prepped a tooth before." So, is there any artistry in preparing a tooth for a crown? I remember the early days of CAD-CAM. The fit was like socks on a rooster; the crowns didn't fit like they do today. When I talk with students and other dentists about professional self-preservation, we discuss doing things that a human being needs to do: surgeries, endos, implant placement.

One of the very special members of my team is Cassi, a 175 lb South African mastiff. He's an integral part of our practice He loves meeting patients! He comes in, calms the patients down, sits next to them when we're doing surgeries, and is the official greeter of our office. He's a therapy dog, and the funny part of it is, even as big as he is, he is so accepted by the patients. The only thing we have to do is be careful, because they bring him in so many treats, he could gain about 20 lbs in no time. But he's a very, very sweet pup. His first day in the office, at ten week-old, he was 45 lbs. He was a big boy. And the patients all picked him up and cuddled him. You can't do that now, he's just way too big. He makes going to work enjoyable. He calms me down, and if you're my patient, I think you want me to be really calm when I'm working on you.

So, since I'm happy in practice, and if I'm happy with what I'm doing, then the patients are also happy. Let's face it, a happy patient and a happy doctor makes for a happy appointment. It's just that easy!

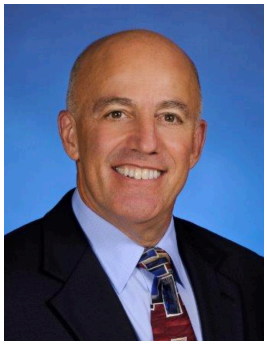
For more information on this wonderful continuum, feel free to contact Dr. Menendez (941.624.4575), contact the University of Florida College of Dentistry continuing education, or go to dental.ufl.edu/courses/mastertrackagd/. We look forward to seeing you there!

Florida Focus Self-Instruction: Esthetics, Exercise 09212

Lasers in Facial Esthetics and the Center for Advanced Rejuvenation and Esthetics

Part 2 of 2

by Drs. Richard Miron and Michael Kanter



Dr. Kanter

Dr. Miron

The use of lasers for facial esthetic procedures has seen a long history of use since the 1960s.[1] While originally clinical procedures and indications were limited to ablative therapies, over the past decade widespread use has been observed owing to technological advancements. Today, over 150 commercially-available lasers exist on the market for various indications including scar revisions, pigmented lesions, vascular lesions, hair removal, facial resurfacing, facial rejuvenation, fat ablation and laser lipolysis. This article does not aim to provide in-depth knowledge on the topic but instead wishes to present uses of laser therapy in facial esthetics. Much like platelet concentrates, laser therapy offers an all-natural regenerative strategy to facial tissues.[1]

While CO2 lasers were first utilized as extensive ablative therapies with long downtimes, modern developments of newer and more frequently utilized wavelengths have seen widespread. In the 1990s, the Erbium:YAG laser (Er:Yag) was introduced demonstrating a positive role in skin resurfacing, especially for mild skin pigmentation, facial wrinkles and acne scaring.[2] Furthermore more recently, their use as non-ablative fractional lasers have been developed with much shorter recovery periods. The use of the Neodymium:YAG laser (Nd:Yag) is a deeper penetrating laser that may be utilized to stimulate tissue regeneration and or ablate/attracted to pigmented lesions. Several indications for laser therapies are reported below.

Figure 6 Laser peel with the Fotona laser system; see QR code.

Laser peels[3]

While chemical peels have been utilized for decades as a resurfacing agent aimed at removing the upper epithelium, the use of laser peels offers a much more controlled and precise ablative therapy whereby a peel can be obtained very simply in a controlled and precise manner. These have been the basis of a growing trend towards resurfacing treatments using the Er:Yag laser. **Figure 6** demonstrates a video of a laser peel being performed with the Fotona laser system, which offers the only Er:Yag/Nd:Yag dual wavelength laser system available on the market to date.

Pigmented Lesion/Mole Removal

To effectively treat pigmented lesions, a good diagnostic and histopathological classification of the lesion is necessary. With this information, the lesion can effectively be categorized according to the depth of the target pigment distribution: epidermal, dermal, or a combination of both.[4] The success of the Q-switched (QS) lasers in the realm of pigmented lesions is based on the ability of these lasers to selectively target melanosomes situated within melanocytes and keratinocytes. The melanosome-specific damage is due to the absorption of high-energy, nanosecond laser pulses.[5,6] Long-pulsed lasers in the millisecond domain can also be used to target epidermal and dermal pigment found in larger clumps such as those in nested melanocytes or confluent melanin in the epidermis.[7] Alternatively, for superficial lesions, the Er:Yag can be utilized to ablate superficial age spots as presented in **Figure 7**.

Hair and Vein Removal

In 1996, Grossman et al. described hair removal with a laser by selective photothermolysis of hair follicles using a normal-mode ruby laser. As with other laser therapies, novel laser sources were thereafter introduced.[8] The target is the melanin pigment present in the hair bulbs. The purpose is to destroy the bulb that leads to permanent epilation. Only the bulbs that are in the anagen phase are destroyed. In the catagenic and telogenic phase, the hair gradually detaches itself from the bulb. For this reason, the melanin chromophore cannot serve as a selective leader to atrophied target cells. Similarly, the Nd:Yag can be utilized to target veins. **Figure 8** demonstrates the use of the Fotona laser targeting both hair and vein removal.

Intraoral rejuvenation of deep nasolabial folds and Marionette lines

Within the past decade, advancements in laser therapy, largely pioneered by Dr. Harvey Shiffman in Boynton Beach Florida, have revolutionized the ability to treat deep nasolabial folds and Marionette lines via intra-oral laser rejuvenating procedures. Thus, the Smoothlase, Necklase and Liplase protocols have been developed as mainly intraoral laser rejuvenating procedures, which take advantage of the benefits of both the Er:Yag and Nd:Yag wavelengths to tighten skin, improve elasticity, skin tone and texture in a minimally invasive manner (**Figure 9**). Most recently this concept has even been extended for the shrinkage of the soft palate for sleep apnea treatments.[9] First, the Nd:YAG laser is utilized to tighten collagen and pre-heat the tissues to 40 degrees centigrade. Thereafter, the Er:YAG laser using a proprietary "Smoothmode" pulse technology (Proprietary to Fotona) is used as a burst of pulses offered in a short series of time creating deep heating, conversion and immedi-

ate tightening of collagen. The advantages of sending these bursts of energy via intra-oral applications include the better ability for the laser energy to penetrate into nasolabial/Marionette tissues owing to the thinner mucosal tissue when compared to the epithelial of skin. Furthermore, intraoral application offers fast downtimes with no visible notice of any treatment having been performed.

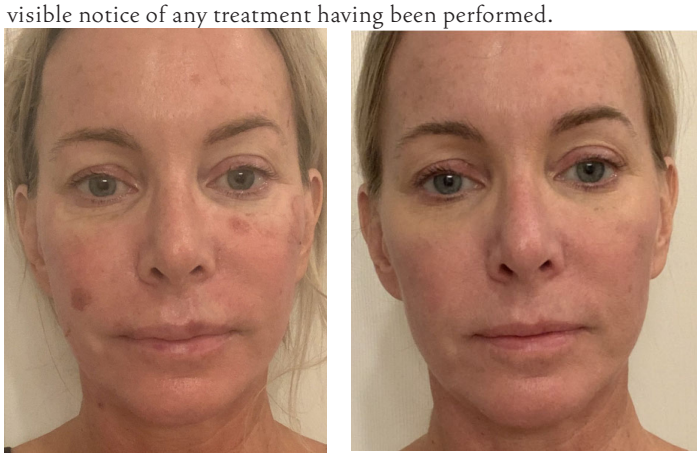


Figure 7: Mid 40-year old woman with apparent sun damage living in Florida. Treatment was done with an Er:Yag laser to remove sites of hyperpigmentation. Note the pronounced improvements before and after treatment (QR code demonstrating age spot removal using the Fotona Lightwalker).

Adapting Facial Esthetic Procedures in a Dental Practice*

One of the key questions commonly asked has been the ability to adapt facial esthetic procedures within a dental practice. Owing to our perceived need to separate both dental and facial esthetics components within our practice, we have successfully re-branded our facial esthetic procedures under the "Center for Advanced Rejuvenation and Esthetics" (CARE Esthetics) to support our growing marketing effort towards the community specifically in facial rejuvenation as opposed to our standard dental office name "Lakewood Ranch Dental." By doing so, greater efforts could be placed on understanding the procedures with a dedicated website and marketing material describing their regenerative potential. Owing to the growing success within our practice in Sarasota, many colleagues have shadowed within our office where we have training programs geared towards teaching/facilitating other dentists and colleagues who wish to adapt similar procedures within their offices (www.prfedu.com/followtheexperts). Following completion of adequate training, dentists in other cities are able to join CARE Esthetics and perform similar all natural and safe facial esthetic procedures within their cities and join our national branding efforts at www.care-esthetics.com/locations.

*Paragraph reprinted from the July 2021, issue.

References and CE Questions are on page 19.

Figure 9: Image of an intraoral laser rejuvenating procedure, which take advantage of the benefits of both the Er:Yag using a PS04 handpiece (Fotona). Advantages include better ability to penetrate into the nasolabial fold region, reduced downtime and non-apparent therapy since the entire procedure may be performed intraorally (QR code demonstrating Smoothmode application intraorally).

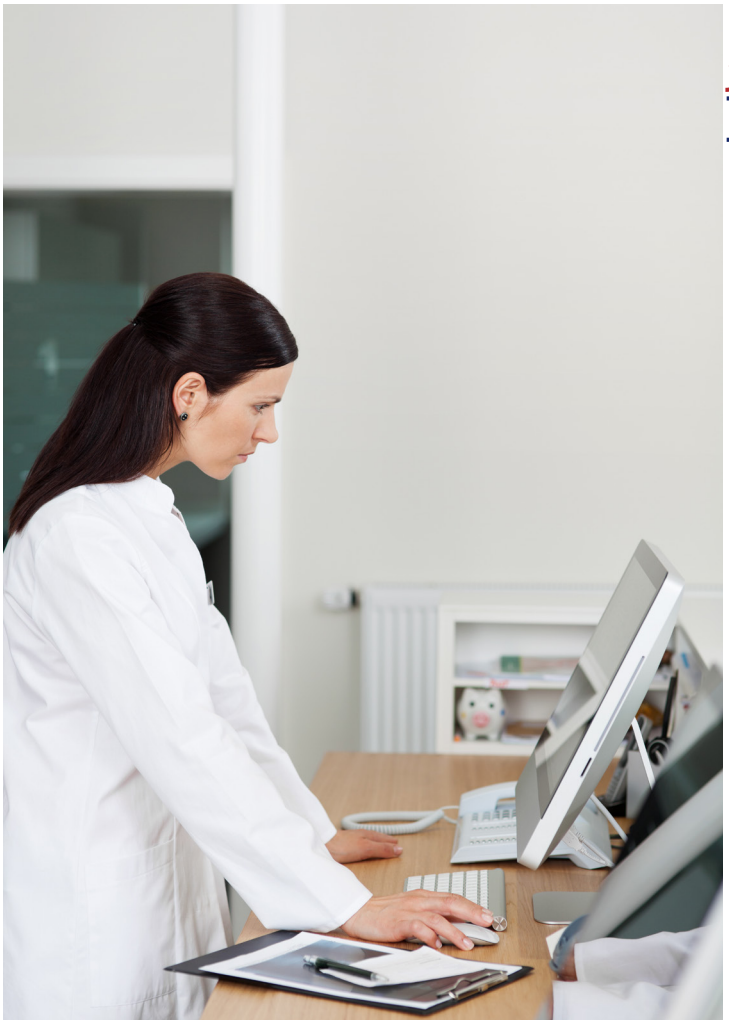
Dr. Richard Miron is currently lead educator and researcher at Advanced PRF Education and an Adjunct Visiting Faculty in the department of Periodontology in Bern, Switzerland. He has currently published over 300 peer-reviewed articles and lectures internationally on many topics relating to growth factors, bone biomaterials and guided bone regeneration. For the past 5 years, Dr. Miron has been recognized by *Dentistry Today* as being one of the top 100 CE providers in the country and the youngest to ever make the list. He has recently been awarded many recent international prizes in dentistry and is widely considered as one of the top contributors to implant dentistry, having won the ITI Andre Schroeder Prize and the IADR Young Investigator of the Year in the field of Implant Dentistry, as well as the IADR Socransky Research award in the field of Periodontology (2020). He has written 5 textbooks widely distributed in regenerative dentistry, including his best-seller in 2019 titled: "Next Generation Biomaterials for Bone and Periodontal Regeneration" and "Understanding Platelet Rich Fibrin" in 2021. Dr. Miron is in practice at Lakewood Ranch Dental and the Center for Advanced Rejuvenation and Esthetics in Sarasota, Florida.

Dr. Michael S. Kanter was born and raised in Miami, FL. After completing his tour of duty in the armed services, he received a Bachelor of Science degree in chemistry from the University of Florida and graduated from the UF College of Dentistry in 1982. Dr. Kanter subsequently completed his residency training at the Jacksonville Health Education Programs. He opened his first dental practice Sarasota, FL in 1984, and later established a second practice in Bradenton and his newest state of the art office in Lakewood Ranch, FL. Dr. Kanter is a graduate and fellow of the prestigious Misch International Implant Institute and has also been awarded Diplomate Status in the International Congress of Oral Implantology.

Dr. Kanter has extensive training in bone grafting, dental implants, cosmetic restoration, and facial esthetics. Currently, under the name "CARE" Esthetics (Center for Advanced Rejuvenation and Esthetics), Dr. Kanter works with Dr. Rick Miron training other doctors in the use of lasers and PRF (platelet rich fibrin). These cutting-edge treatments are setting the standard for 100% all-natural facial rejuvenation.

Figure 6 **Figure 7** **Figure 8A** **Figure 8B** **Figure 9**

Figure 8: QR codes highlighting the use of laser therapy for (A) vein removal and (B) hair removal. Both can be achieved using laser therapy with ease.



5 Myths about Medical Billing for Dentistry

by Crystal May

If you are like most dental professionals, you've heard of medical billing for dental procedures. The chances are high that you've also been misinformed. A lot of the information about medical billing makes it sound scary, complicated, and maybe even unethical. However, it is a fantastic way to help reduce out-of-pocket costs for your patients when done correctly. I want to explore 5 of the most common myths or misconceptions surrounding Medical Billing for Dentistry.

Myth 1
Only specialists or oral surgeons can bill medical insurance for dental procedures.

It is a common misconception that you must be a specialist to bill medical insurance. In truth, any dental professional can bill medical insurance for any procedure that falls within the scope of their license. Every dentist, dental specialist, and even medical professional uses the same set of codes. For example, If you are performing a bone graft in the oral cavity, the code you use is in the same code set as a bone graft performed anywhere else in the body. You simply choose the code that describes the location in the body where you are doing that bone graft.

Many people believe that an oral surgeon is the only dentist that can bill for third molar extractions and IV sedation. Again, that is incorrect, as we all use one set of codes regardless of our specialty. More oral surgeons or specialists may be taking advantage of medical billing simply due to the volume of these procedures they complete.

Myth 2
You can't bill medical insurance for dental proceduress.

You can bill every single dental procedure to medical insurance if you can prove medical necessity. It's not about the WHAT (procedure) but the WHY (diagnosis). You must prove medical necessity, or a medical correlation, to access medical benefits. Here are a few ways to qualify a case as potentially billable to medical insurance.

1. Is the condition of the oral cavity affecting the health of the rest of the body?
2. Is the oral condition caused by a medical condition or medication?
3. Are you screening for a medical condition?

If you answered yes to any of the above questions, there is a good chance you can prove medical necessity. A common misconception is that the procedure code determines if a dental procedure is going to be covered by medical insurance. In fact, the medical necessity and coverage is almost entirely determined by the diagnosis or reason for treatment, not the specific treatment. I have personally seen veneers covered by medical insurance when medical necessity was proven due to tetracycline use. Coverage is not only determined by medical necessity as the policy is ultimately what dictates coverage. Even with the most detailed and documented medical correlation, a plan may have an exclusion or policy limitation that will not allow coverage for a specific procedure. It is important to understand that just because a particular procedure, like an implant, is covered by one payor in one circumstance doesn't mean the same will be true for all other similar cases.

Myth 3
You must be a participating provider to bill medical insurance.

While it is true that benefits vary for in and out-of-network providers, it is not true that you must be a participating provider to bill most plans. There are a few exceptions to this rule, such as state and federal plans like Medicare, Medicaid, and TRICARE, or specific types of plans, like HMOs or EPOs. These plans specifically say that they will only pay out benefits to participating providers. For a majority of traditional PPO plans, which is still the most common type of medical plan in the US, you do not have to be a participating provider to bill them.

There are a few reasons you may want to consider becoming an in-network provider. As an in-network provider, there may be better coverage for your patient, including lower deductibles and higher coverage amounts. You will also be able to provide your patient with much more accurate estimates on coverage and out-of-pocket costs. This is because, as an out-of-network provider, you will not know the exact amounts that will be allowed by the payor for each specific procedure, only coverage percentages and patient-specific deductibles.

Myth 4
You can write off patient co-insurance or deductibles.

When billing medical insurance, you agree with the payor to collect the patient's deductible and co-insurance. Writing these amounts off is insurance fraud, even as a non-participating provider. When you think about plan benefits, patients that choose plans with higher deductibles and co-insurances are paying a lower premium, with the expectation that they are paying out-of-pocket at the agreed-upon amount. The confusion comes from the difference between allowable and billed amounts. As a non-participating provider you are permitted to adjust your full fee down to the amount allowed by the insurance company, if you choose. This is considered a courtesy adjustment. This adjustment cannot include the deductible or co-insurance, and therefore the total amount billed can never be less than the amount allowed by the insurance company.

Myth 5
Getting paid by medical insurance takes too long.

There are three key components to faster claims processing.
1- Is the provider and practice credentialed appropriately?
2- Is the claim coded correctly?
3- Is the claim submitted correctly and electronically?

Credentialing, team training, and technology make all the difference. You must have the practice and provider registered with the insurance correctly. The doctor and team must select the appropriate codes and provide the documentation to prove medical necessity. And you need to be able to submit claims electronically and provide proper follow-up. Remember that insurance companies are not in the business of paying claims. Skipping one of the above steps will give the insurance company a reason to delay or deny claims. When done correctly, medical claims can be processed as fast or faster than dental claims.

Now that I have clarified some of the major misconceptions surrounding medical billing, you can see some of the potential. Most patients desperately want the dental care recommended, but often are making decisions due to financial limitations. I have seen thousands of patients benefit from providers who are willing to bill medical insurance. Ask yourself, if more of your patients could accept the care you recommend because you can decrease their out-of-pocket costs, would it be worth exploring medical billing in your practice? For more information on where to start, finding a course near you, or resources available for software and 3rd party billing services, please visit www.devdent.com.

COO and co-founder of Devdent, Crystal May is dedicated to helping dental practices be successful in dental sleep medicine and medical billing. With over 17 years of medical billing experience, 10 with an emphasis on dentistry, she is a leading educator on these topics. Having owned and managed multiple dental practices, she mastered the process of efficient implementation. She enjoys sharing her passion and knowledge with dental practices throughout the country.

Recognize your fellow AGD members for their dedication to General Dentistry!

Nominations will be recognized at our General Assembly meeting in January, 2022!

Please review the awards below:

- **Humanitarian Award**
- **Most Continuing Education Hours**
- **Most Continuing Education Participation Hours**
- **Distinguished Service Award**

To submit a nomination, please contact Executive Director Patricia Jenkins at flagdinfo@gmail.com.

Florida Focus Self-Instruction Exercise 09211, 1 CE Credit Pediatric Dentistry, Subject 430

1. Research on salivary biomarkers has included positive results for which of the following diseases?
a. Autoimmune diseases c. Cancer
b. Cardiovascular disease d. Renal diseases
A. a, b, and c
B. b and c
C. b and d
D. all of the above

2. Salivary testing systems can assist dentists with all the following except _____.
A. monitoring success of preventive therapies
B. tracking the presence of oral bacteria
C. diagnosing sleep disorders
D. improving patient communication

3. The Food and Drug Administration has approved only ____ salivary diagnostic testing systems for periodontal disease.
A. 0
B. 1
C. 2
D. 3

4. The salivary testing system OralDNA identifies _____, and the SillHa system identifies _____.
A. 9 pathogens, 7 pathogens
B. 9 pathogens, 9 biomarkers
C. 11 pathogens, 7 biomarkers
D. 11 pathogens, 9 biomarkers

5. Vertical transmission of bacteria from parent to child begins _____.
A. in utero
B. at birth
C. at 3 months
D. at age 2

6. Prior to salivary testing, it is necessary to have the patient _____.
A. fast
B. chew sugar-free gum
C. drink 4 oz. of milk
D. drink 4 oz. of water

7. According to Dr. Simkins, effective measures to alter inflammatory status include _____ and _____.
A. comparison of salivary test results, discussions about snacking
B. prebiotics, sodium citrate
C. probiotics, fluoride
D. prebiotics, xylitol

8. Common oral probiotics include _____.
A. Milk
B. Asparagus
C. *Lactobacilli Rhamnosus*
D. *Porphyromonas gingivalis*

9. Prebiotics include all the following except _____.
A. Wheat
B. Eggs
C. Peas
D. Onion

10. In 2021, the leading cause of death in the United States is currently _____.
A. Cancer
B. COVID-19
C. Cardiovascular disease

The 10 questions for this exercise are based on information in the article, "Salivary Testing in Pediatric Dentistry." Reading the article and successfully completing this exercise will enable you to:

- recognize the advantages of salivary testing;
- understand their use in clinical practice; and
- appreciate the variety of preventive therapies available.

Please email your answers with your name and AGD number to flagdeditor@gmail.com. 80% of the answers must be correct to receive credit. Answers for this exercise must be received by December 31, 2021.

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Florida Focus Self-Instruction Exercise 09212, 1 CE Credit Esthetics, Subject 780

The 10 questions for this exercise are based on information in the article, "Lasers in Facial Esthetics." Reading the article and successfully completing this exercise will enable you to:

- understand the contemporary use of lasers for facial esthetic procedures;
- recognize the advantage of an all-natural regenerative strategy; and
- appreciate the variety of esthetic procedures which can be performed with lasers.

Please email your answers with your name and AGD number to flagdeditor@gmail.com. 80% of the answers must be correct to receive credit. Answers for this exercise must be received by December 31, 2021.

1. The use of lasers for facial esthetics began in the _____.
A. 1960's
B. 1970's
C. 1980's
D. 2000's

2. Indications for the use of lasers in facial esthetics include all the following except _____.
A. facial resurfacing
B. removal of pigmented lesions
C. tissue augmentation
D. fat ablation

3. The Erbium:YAG laser is a non-ablative fractional laser which requires longer healing times. The Neodymium:YAG laser allows more superficial penetration to stimulate tissue regeneration.
A. Both statements are true.
B. The first statement is true; the second is false.
C. The first statement is false; the second is true.
D. Both statements are false.

4. Characteristics of laser peels compared to chemical peels include greater _____.
A. precision
B. speed
C. healing time
D. ablation

5. In the treatment of pigmented lesions, Q-switched (QS) lasers selectively target melanosomes within _____ and _____.
A. erythrocytes, endothelial cells
B. melanocytes, cyanosomes
C. keratinocytes, melanocytes
D. eukaryotes, keratinocytes

6. In hair removal, the target is the hemoglobin pigment present in the hair bulbs. The purpose is to destroy the hair bulb, leading to permanent epilation.
A. Both statements are true.
B. The first statement is true; the second is false.
C. The first statement is false; the second is true.
D. Both statements are false.

7. During hair removal, only bulbs in the _____ phase are destroyed.
A. catagenic
B. anagen
C. anakin
D. telogenic

8. The Smoothlase, Necklase, and Liplase protocols allow deep nasolabial folds and Marionette lines to be treated as _____ procedures.
A. ablative
B. intraoral
C. mesotherapeutic
D. fractional

9. Advantages of the Smoothlase, Necklase, and Liplase protocols include all the following except one. Which is the exception?
A. They require only the Er:YAG laser.
B. They have better penetration into the nasolabial fold region.
C. They require a shorter healing time.
D. There is no visible evidence of treatment during healing.

10. More than _____ types of lasers are commercially available today.
A. 50
B. 100
C. 150
D. 200

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FLORIDA ACADEMY of GENERAL DENTISTRY

AGD 2022, ORLANDO, FL

General Information

Location and Housing

AGD2022 will take place July 27–30, 2022, at the Rosen Shingle Creek in Orlando, FL.

Rosen Shingle Creek (host hotel)
9939 Universal Boulevard
Orlando, FL 32819

Registration Includes

- Keynote Speaker Session
- 20-Minute Dental Pearl Lectures
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