

NYSDA

AN OFFICIAL PUBLICATION OF THE NEW YORK STATE DENTAL ASSOCIATION

news

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Pertinent Answer Deleted

It seemed like a good idea, but that was before it was put into practice.

Jeffrey Galler, D.D.S.

Does this scenario seem familiar? Someone, let's say a patient, says something that sounds very impertinent, even somewhat disrespectful.

If you're like me, you cleverly think of the ideal response, perfectly designed to properly chastise that insolent individual, approximately 24 hours later.

Since I am neither quick witted nor glib enough to formulate an appropriate rejoinder on the spot, my office staff has, over the years, compiled a list of what we refer to as "pertinent answers to impertinent remarks," so we are all prepared for the occasional impudent comment. When a patient mutters, "I think you should charge less for children's fillings than for adult fillings," the dental assistant will automatically answer, "Even though children's fillings are so much more difficult, we do not charge any more for them than for adult fillings."

Or, when a patient writes a check and grumbles, "You know, for the cost of these implants, I could have bought a brand new fur coat," the bookkeeper will

automatically respond with, "Yes, that might be true, but you cannot chew your food with a fur coat."

Or, when a patient, after hearing my proposed treatment plan, challenges me with, "Do you guarantee your work?" I automatically respond with, "I guarantee to do the very best that I can."

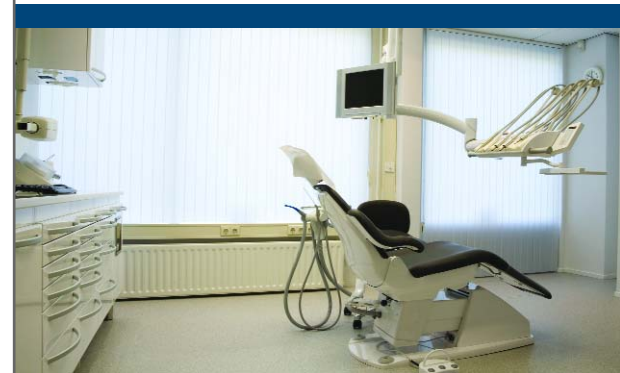
ADDITION TO OUR REPERTOIRE

Many of us have noted that, after extensive cosmetic procedures, patients often need reassurance about how nice they look. This seems to be true even if the patient had been wearing trial provisionals, which mimic the final result, for a period of time.

A dental colleague suggested that from now on, when a completed smile makeover patient asks, "How do I look?" we respond with, "You look so good, your husband/wife will fall in love with you all over again."

This sounded like a great idea, and we decided to immediately try adding this witty response to our catalogue of clever comments. However, we soon found that implementing this new "pertinent answer" did not necessarily have the desired effect.

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Cause and Effect

The most recent recession put a damper on health care spending sooner than expected, with outlays for dental care services curtailed most dramatically.

*H. Barry Waldman, D.D.S.,
M.P.H., Ph.D.;
Dolores Cannella, Ph.D.*

THE LAST RECESSION officially lasted from December 2007 to June 2009. In prior recessions, there was usually a lag before health care spending growth slowed. This time, there was a more immediate impact on the health care sector, in particular, spending for dental care services. The 2011 publication from the Office of the Actuary at the Centers for Medicare and Medicaid Services reported that the most recent recession contributed to the slowest annual rate of increase in health spending in five decades—a 4.6% increase between 2008 and 2009 in personal health care spending, from approximately \$2.0 trillion to \$2.1 trillion.

SPENDING FOR DENTAL CARE

While total expenditures for professional health services increased by \$22.7 billion between 2008 and 2009, there was an actual, small decrease in total spending for dental care during this same period—a \$100 million decrease. Dental care was the only professional health service for which there was a decrease. Between 2005 and 2008, there had been an annual

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Editorial and advertising offices are at

Suite 602, 20 Corporate Woods Boulevard, Albany, NY 12211-2370.

Telephone (518) 465-0044.

Fax (518) 465-3219.

E-mail info@nysdental.org.

Web site www.nysdental.org.



Pertinent Answer Deleted *continued from page 1*

TRIAL NUMBER ONE

A college professor was staring in the mirror, examining his new porcelain laminates. He asked, "Hey, doc, how do I look?"

I was waiting for just this moment. I smiled warmly and answered, "When your wife sees your new smile, she will fall in love all over again."

The patient turned toward me, squinted and said, "She might, but probably with someone else."

I laughed politely, but it did not yet dawn upon me that I should consider abandoning this new response.

TRIAL NUMBER TWO

Allen and Susan had been friends and patients for over 30 years. Susan had just completed a multi-disciplinary treatment plan consisting of Invisalign orthodontics, tooth whitening, cosmetic contouring and bonding.

"How do I look?" asked Susan.

I was ready for this moment. "Susan," I replied, "you look so good, that Allen will fall in love all over again."

Susan looked stricken. She asked all of the assistants to leave the room so that she could speak with me privately.

"Why would you say something like that?" she asked with quavering voice. "Do you know something? I know that Allen always confides in you. Did he say something to you about me? Is there someone else that he's seeing?"

I tried to reassure her that Allen was still madly in love with her and that I was merely trying to sound humorous.

TRIAL NUMBER THREE

We had just cemented the final element of her smile makeover and Maureen was studying her face in the mirror.

"Tell me," she requested, "how do you really think I look?"

"Aha!" I thought to myself. "Maureen," I said soothingly, "you look so good, your husband will fall in love all over again."

Her face ashen, Maureen shrieked and started crying hysterically. The dental assistant ushered me out of the room.

After the patient left the office, staff explained to me that Maureen's husband was in the process of divorcing her.

DELETE, DELETE, DELETE

Apparently, not all new, good-sounding ideas are actually, well, good ideas. Until further notice, when a patient asks, "how do I look?" we will simply smile and say, "Nice. Real nice." ☞

Dr. Galler is a general dentist from Brooklyn and a frequent contributor to the NYSDA News and New York State Dental Journal.

Cause and Effect *continued from page 1*

increase of between \$4.4 and \$5.7 billion spent for dental services.

The Office of the Actuary report stressed that as unemployment increased, with an associated loss of employment-supported health insurance (a loss of 6.3 million enrollees), consumer out-of-pocket spending took on increased importance. Expenditures for dental services led the list of health services that experienced decreases in out-of-pocket spending, which historically accounted for about 45% of total spending for dental care.

SLOWDOWN IN HEALTH CARE SPENDING

The slowing in the expanding rate of spending for health services was largely the result of decreased use, as consumers delayed getting needed care because of recession-related drops in household income and loss of health insurance. The number of visits to health practitioner offices decreased. Many hospitals reported fewer admissions.

However, by the end of 2009, the United States was devoting 17.6% of its gross domestic product (GDP) to its health care system, reflecting both the increase in spending and the contraction of the general economy during the recession. The U.S. has been allocating a far greater proportion of its GDP to its health care system than any other country. Nevertheless, despite the variation in the economy between 1990 and 2009, expenditures for dental services as a percent of total spending for professional health services consistently have remained in the 15.1% to 15.9% range.

GOVERNMENT SPENDING

Partly offsetting the slowdown in private health spending was the rapid increase in Medicaid spending, driven by

the addition of 3.5 million people to its rolls. Federal Medicaid spending increased 22% in 2009, the highest annual rate of growth since 1991. By contrast, annual state Medicaid spending decreased by almost 10%, the largest decline in the program's history.

In 2009, the federal government's share of all health care spending increased to 27%. Federal health care spending represented 38% of total federal revenues in 2008, and 54% in 2009. Federal spending for Medicare reached one-half trillion dollars and \$374 billion for Medicaid.

ADDED EXPENSES

Former Supreme Court Associate Justice Sandra Day O'Connor recently commented, "Starting on Jan. 1, (2011) our 79-million-strong baby boomer generation will be turning 65 at the rate of one elderly every eight seconds." The reality is that 18% of all adults, and in older years as much as 50% or more of the elderly, are encumbered with a wide range of disabilities. A study published in 2009 found that disability-associated health care spending for adults totaled almost \$400 billion, which was almost 27% of U.S. adult health care spending, including 68% of all Medicaid spending and 38% of all Medicare spending. New York State has the highest disability-associated total health care spending, at more than \$40 billion. It is difficult to imagine the total economic impact when, by the end of the next decade, the 79 million elderly will account for one-in-five U.S. residents

THE FUTURE FOR DENTISTRY

Concern for dental care may seem like a low priority in a period consumed with: 1. slow recovery from a momen-

tous economic downturn and the accompanying loss of health insurance coverage; 2. passage of contested national health legislation; and 3. increasing concern over the economic consequences of a burgeoning geriatric population.

The general public would seem to disagree with such an evaluation of the importance of dental services. Once again, despite the variation in the economy between 1990 and 2009, expenditures for dental services as a percent of total spending for professional health services consistently have remained in the 15.1% to 15.9% range, with annual expenditures for services reaching over \$100 billion.

Important to this discussion is the report by Edelstein and colleagues in the December 2010 issue of The Journal of the American Dental Association evaluating the Patient Protection and Affordable Care Act, the 2010 national health legislation. The authors described more than 30 provisions of direct relevance to dentistry within the domains of insurance coverage, dental workforce, safety net, prevention and surveillance. Their conclusion was that, "(t)he oral health provisions in the health care reform bills evidenced strong congressional interest in oral health and dental care, with an emphasis on equitable care for children." The authors stressed the implications for dental practice by imploring the profession "... to recognize the strong and ongoing interest of lawmakers in oral health care and must maintain active engagement in the policymaking process." ☞

Dr. Waldman is distinguished teaching professor in the Department of General Dentistry, School of Dental Medicine, Stony Brook University, Stony Brook, NY. Dr. Cannella is director of behavioral sciences and assistant professor in the Department of General Dentistry at Stony Brook University. Queries about this article can be sent to Dr. Waldman at hwaldman@notes.cc.sunysb.edu.

Take Control

Asset protection in the dental office begins with internal controls aimed at preventing errors and fraud.

William A. Brenner, C.P.A.

INTERNAL CONTROLS are procedures and processes that are put in place by a practice to greatly reduce or eliminate the likelihood of error or fraud. The basic theory behind many internal controls is the segregation of duties. By having several employees involved in a process or workflow, you can greatly reduce the chance of an error going unnoticed and curtail opportunities for fraud to be committed.

Internal controls are designed primarily to safeguard a business's assets. The assets of a typical dental practice generally consist of cash, patient receivables, supplies and equipment. Your office and dental equipment are probably the assets least likely to be misappropriated; however, unless you were really looking, would you notice that a box of implants or a patient's co-pay was missing? Maybe not.

In dental practices, the asset that is most susceptible to error or misappropriation is cash. Without proper controls over cash receipts, disbursements and payroll, employees can easily make mistakes or, worse, rob you blind. Having a solid internal control structure in place would give you some peace of mind.

CONTROL OVER CASH

What follows is a sample series of controls over cash receipts and accounts receivable that are applicable to many dental practices. These aren't stand-alone controls, but, instead, work together as a system to safeguard cash receipts and ensure that patient accounts are properly maintained.

- Two employees should always open the mail. It is much harder for an employee to take cash, money orders or checks that come in the mail if he or she isn't working alone. You might be thinking that this doesn't apply to you because 95% of the payments you receive by mail are checks. However, don't forget that it's not impossible for an employee to open a "new" account for the practice that you don't even know about and over which they have signatory authority.
- Payments received at the counter, in the mail or by credit card should be listed individually on a daily tally sheet (it is helpful to record each type of payment in a separate column). The information listed should include the date, patient name and account number, amount and service

date or invoice number. At the end of the day, the tally sheet should be totaled, initialed by the preparers and given to the office manager, along with the actual cash and credit card slips. A second copy of the tally sheet should be given to your bookkeeper. The purpose of this is to create a trail of patient receipts that will be compared to the actual deposit and postings to patient accounts; its mere existence can be a deterrent to fraud.

- Staff at the front counter should prepare a daily listing of patients who didn't pay when service

was rendered. Copies of this listing, initialed by the preparers, should also be given to the office manager and bookkeeper each day. This is important, because it is a complete listing of invoices that your bookkeeper will reconcile for the day.

- Dentists and hygienists should keep an individual log of all patients they see each day, including the service that was provided to each patient. Copies of these logs should be given to the office manager on a daily basis as well. This may sound redundant, but what if

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Discounts for Noncovered Services? Not so Fast!

There are discount buying clubs and there are insurance policies, separate products that cannot be combined.

Judith Shub, Ph.D.; Lance Plunkett, J.D., LL.M.

The term “noncovered services” refers to dental benefit plans that require a cap on the amount that a participating dentist can bill a patient for services not covered by the insurance plan. In New York State, this means that the service is not insured at all. This practice essentially grafts to the insurance offering a form of discount buying club, something that is not an insurance product.

Dentists nationwide are seeking legislation that would ban insurers from requiring dentists with whom they contract to discount their fees for services not covered by a patient’s dental benefit plan. In New York State, however, regulations are already in place in state insurance laws that make such practices by insurance companies illegal. Section 1113(a) of the New York State Insurance Law prohibits insurance companies from marketing discounted fees for noncovered health care. Such a product is considered a form of discount

buying plan, not a form of insurance. New York Insurance Law Section 3201(a) states that no policy form may contain an item that is not covered under the insurance categories set forth in Section 1113(a).

While this restriction is straightforward, it does not in itself ensure that a contracting dentist will not face problems when implementing multiple-fee schedules in his or her practice. This is one aspect of contracting with third-party payers that can be legally and ethically problematic for licensed professionals.

There are several questions to consider. First, is the plan an insurance product, regulated by the New York State Insurance Department? Self-funded plans are not subject to state insurance laws.

Second, what is a noncovered service? Simply put, a noncovered service is one for which the patient’s benefit plan (insurance policy) does not provide reimbursement under any circumstance. For example, services are considered noncovered when a plan does not provide benefits for orthodontic, cosmetic or implant-related treatment. However, if the plan denies reimbursement for treatment because the patient has exceeded an annual maximum benefit allowance or the plan pays an alternative benefit amount for a less expensive alternative treatment, the treatment provided is considered to be a covered service, albeit not covered to the full extent that the dentist might like.

Third, there are ethical and practical limitations on the protections these regulations provide to a dentist. Insurance laws regulate actions by the insurer, not the dentist. For example, dentists are free to voluntarily join a discount buying plan for dental services. If this is not their intent, they need to be sure they understand what they are agreeing to when they sign a contract. The New York rule on noncovered services only prevents an insurer from coupling a discount buying plan with an insurance offering, not from offering a discount buying plan as a totally separate contractual item. Be careful about what you are signing.

FREE TO CHARGE USUAL FEES

NYSDA recommends that members who are negotiating participating provider contracts, especially those that involve participation in ERISA self-funded plans, discuss with their attorneys the option of including contract language that would specifically indicate that the participating provider will charge patients his or her usual fees for treatment services that are not

covered by the patients' benefit plan. That contractual approach will be honored even under ERISA.

Some participation contracts NYSDA has reviewed already preclude the insurance company from requiring that the contracting dentist discount fees for services that are not covered by the patient's plan. Should a company with which a doctor has a participation contract try to require that the doctor provide a discount for a service that is not covered by the patient's policy, the doctor should register a complaint with the New York State Insurance Department. Such a policy provision is unenforceable in New York. It is also advisable to contact the insurer in writing to explain that the provision requiring such discounts is unenforceable.

As licensed professionals, dentists are subject to other laws and regulations from which insurers are exempt. It is critical that dentists have access to knowledgeable legal counsel when negotiating participating provider contracts with third-party payers. A qualified attorney can help ensure that terms favorable to a dentist's practice are in the contract. It is a myth that dentists are unable to negotiate with insurers. Insurers need to have participating dentists in order to offer any kind of managed care plan, giving every dentist the opportunity to negotiate on his or her own behalf. Of course, you are free to throw away that opportunity and acquiesce in whatever the insurer wants, but would anyone think that is a smart business decision?

A dentist's personal attorney also can address clauses with which the dentist cannot comply without violating state and federal laws, as well as ethical guidelines. One such clause should stipulate the dentist will not discount his or her fees for treatment services that are not covered by the patient's policy because that type of clause cannot be legally coupled to an insurance offering. Additional language could prohibit the carrier from advising patients that the dentist will discount fees for services that are not insured at all. It could also extend protections to—or exempt the dentist from—participation in any panels contracted to self-funded groups.

SACRED TRUST

A dentist's relationship with a patient's third-party payer is only one aspect of the relationship between the dentist, third-party and patient. Dentists need to be certain that they provide accurate and clear notice to patients about office charges. Otherwise, they are on thin ice ethically and legally should the fees they seek be at odds with what patients have been told. Bear in mind, when a third-party provides patients with a fee schedule for an individual doctor, that company, in essence, is advertising the doctor's fees at the doctor's behest. If those fees are not a true representation of what the dentist is

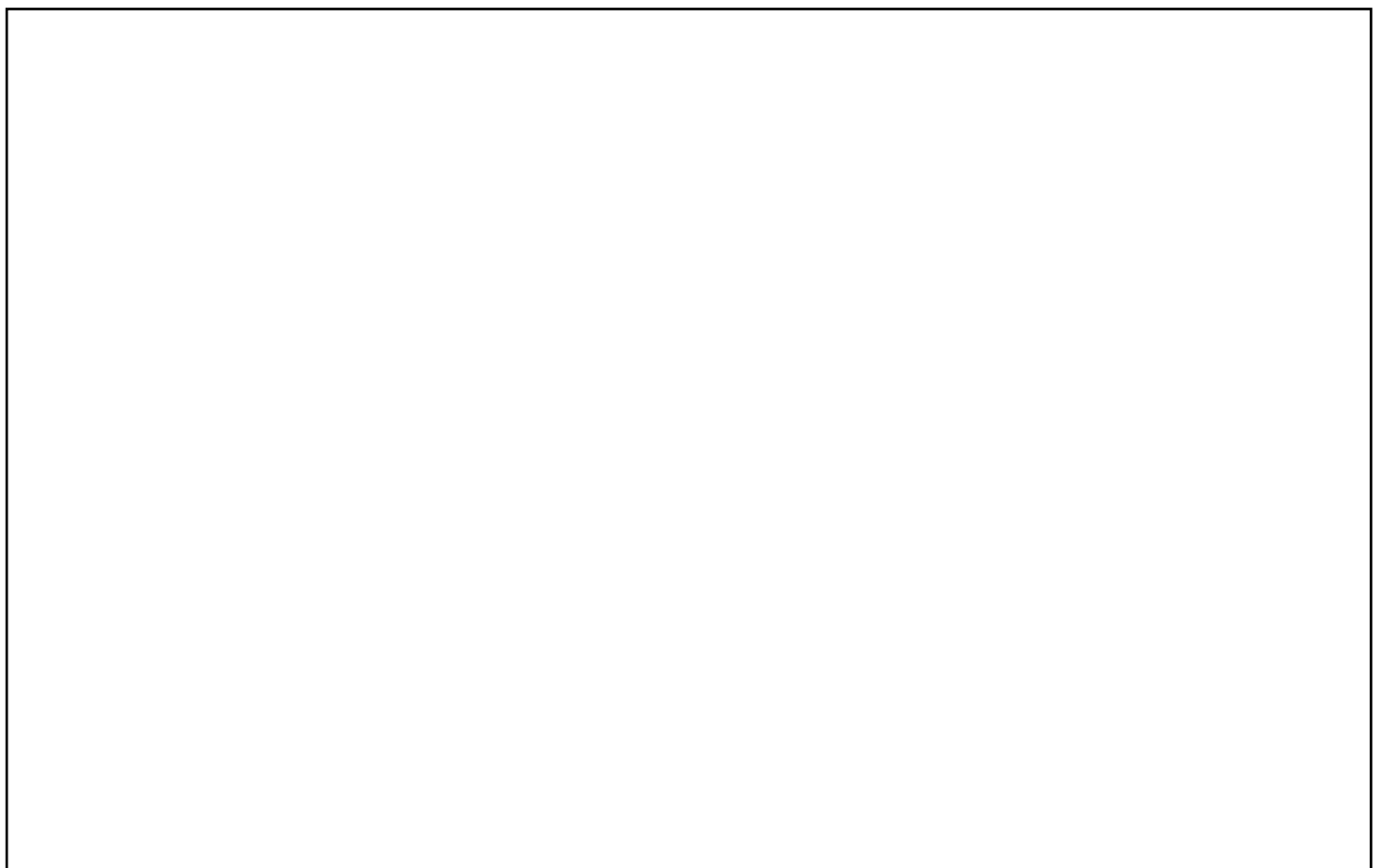
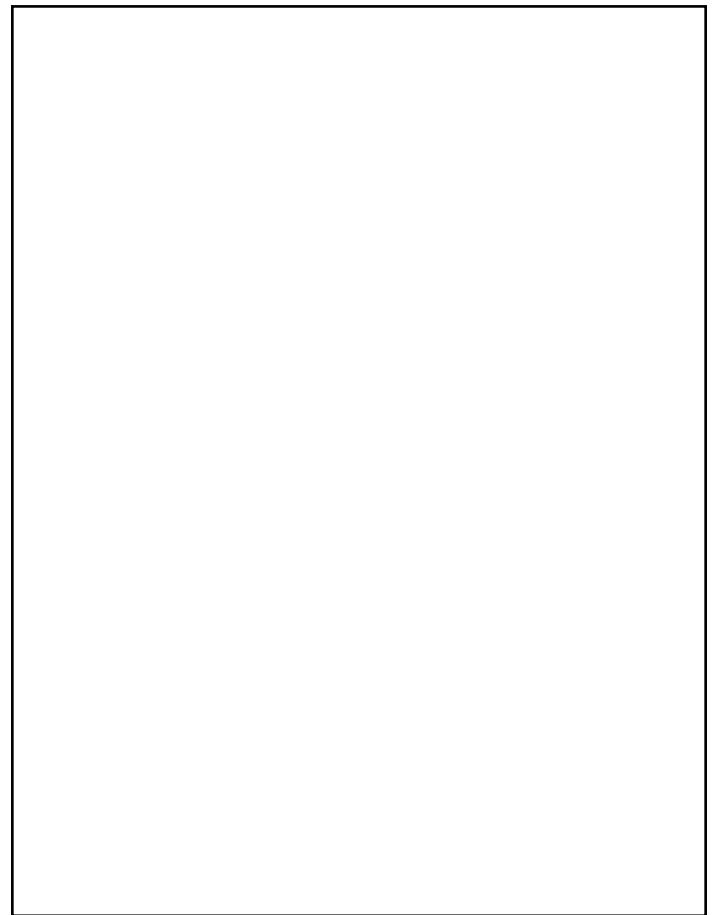
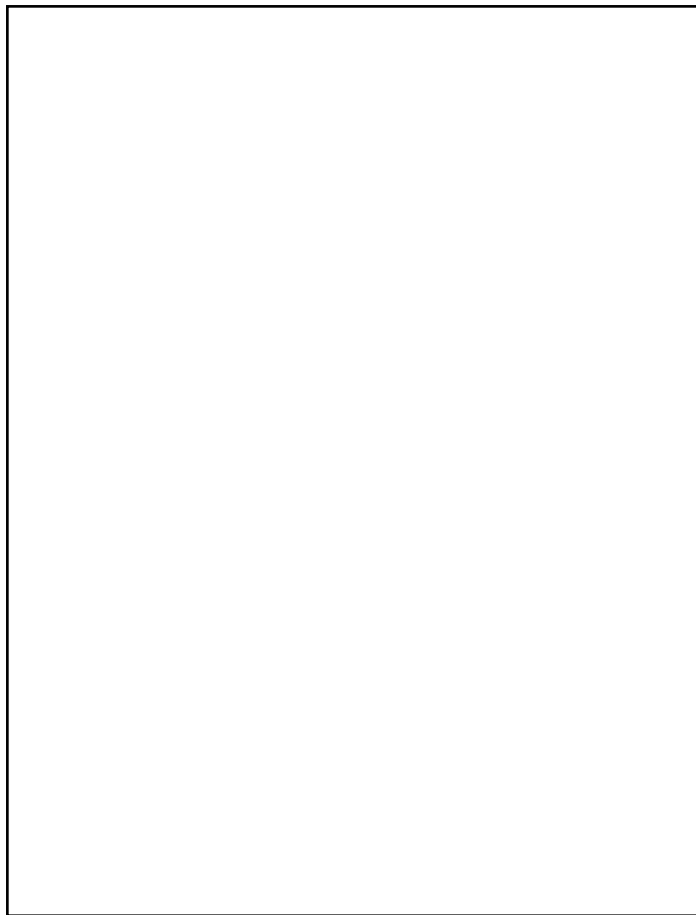
charging or intends to charge, the dentist needs to address that discrepancy with patients.

While the insurance company cannot direct a dentist to discount fees for noncovered services, the dentist, by advertising a discounted fee schedule to the public, can be held accountable for offering such discounts. As a simple advertising matter, you cannot sit idly by while misinformation is disseminated about your fees. If you do, you may be presumed to have adopted those fees voluntarily. Make sure you are vigilant about who is telling the public about your fees and about what they are telling the public. Direct your lawyer to insist that any communications that are inaccurate, misleading or illegal are stopped.

Dentists are reporting problems when they inform patients that they will not extend a discount for noncovered services. Patients are often told by their

carriers that the dentist must honor a contracted fee even when the service is not covered. This discrepancy between the dentist's stated fee to the patient and the information the patient receives from the carrier can disrupt the dentist-patient relationship. It certainly warrants a complaint to the Insurance Department and illustrates why New York law prohibits this practice: The insured is being misled into purchasing a potentially mispriced and disadvantageous insurance product on the promise that services that are not insured at all will be subject to discounts—no different than promising the insured persons discounts on car rentals or air conditioners as an improper inducement to purchase the dental insurance policy. ☞

Dr. Shub is NYSDA Assistant Executive Director for Health Affairs. Mr. Plunkett is NYSDA Legal Counsel.





Profile of Active Dentists in *New York State*

H. Barry Waldman, D.D.S., M.P.H., Ph.D.

New York State, with over 80 dentists per 100,000 population, is well above the national average. Most regions of the state either meet or exceed the national ratio of 58 dentists per 100,000 population. There are wide regional variations in the distribution, however, ranging from 106 dentists per 100,000 population on Long Island to 54 and 53 per 100,000 in the North Country and Mohawk Valley areas, respective-

ly. These data are among the findings from the 2011 report on the "Profile of Active Dentists in New York" (based on a survey at the time of licensure renewal between the 2007 and 2010 period) by the Center for Health Workforce Studies of the School of Public Health at the University at Albany. More than 7,500 dentists of the almost 18,000 licensed dentists in the state responded to the survey. The report presents information from these respondents.

The median age of dentists in New York (53 years) is older than all dentists in the U.S. (50 years). The gender distribution of NY dentists (76% males and 24% female) is similar to distribution of all dentists in the country. White non-Hispanics are overrepresented among New York dentists relative to the state's population (79% compared to 60%), as are Asians (11% compared to 7%). Black and Hispanic dentists are underrepresented relative to the state's population.

Among respondents, 79% were self-employed and 20% indicated they were salaried employees. The most common employer types were hospitals and government institutions. More than three-quarters (77%) of dentists reported working full time, while 18% worked fewer than 30 hours per week. Over 60% of New York dentists graduated from a dental school within state: 61% from NYU; 21% from Buffalo; 12% from Columbia; and 6% from Stony Brook.

Specialty dentists make up a larger proportion of dentists in New York State (26%) compared to dentists nationwide (20%). The most common dental specialties among New York dentists were orthodontics, oral and maxillofacial surgery, and pediatric dentistry.

A small number of New York dentists treat the majority of Medicaid patients who receive oral health care. A majority (54%) do not treat Medicaid patients, while 10% of dentists report that 60% or more their caseload were Medicaid patients. More than half (52%) of respondents indicated they could accept many new/additional patients.

Within the next year, more than 11% of dentists plan to reduce or stop providing patient services in the state. The most frequently cited dental shortages that were identified were in pediatric and public health dentistry.

The report emphasizes the need to address the lack of access to dental services in specific areas, including six federally designated geographic dental health professional shortage areas and 41 federally designated special population shortage areas for either Medicaid or low-income populations. ☞

someone at the front desk loses or pockets a patient payment? They obviously won't list the payment on the tally sheet, and might delete the patient from the daily schedule to cover it up. Without an actual patient log, this error or theft could go unnoticed.

- At the start of the day, the office manager should print a complete copy of the day's patient schedule, which will be used when reviewing the daily transactions at the end of the day. As noted above, changing the patient schedule is a way in which an error or fraud can be covered up. Having a copy of the original daily schedule can be invaluable when reconciling the day's transactions.

Prior to preparing the daily deposit, the office manager should do the following to confirm that all patients and transactions have been accounted for:

- Compare the actual totals of credit card charges, checks and cash to the tally sheet totals by type of payment. Any discrepancies should be investigated.
- Compare each individual check and credit card charge slip to the tally sheet to make sure that the amounts and patients agree.
- Compare the patient logs prepared by dentists and hygienists to the daily patient schedule that was printed at the beginning of the day to make sure that all patients on the schedule are listed on a patient log. Confirm with the front desk that any patients not on a patient log did indeed cancel at the last minute.
- Compare the patient logs to the tally sheet and list of patients who didn't pay to make sure all patients seen during the day have been accounted for.

Once all patients and receipts have been verified and accounted for by the office manager, the daily deposit slip is prepared. You should make the actual deposit yourself if possible. A copy of the deposit slip and the original deposit receipt are given to the bookkeeper. The bookkeeper should compare the deposit receipt to the daily tally sheet to confirm the amounts agree. The bookkeeper should also review accounts receivable, again to confirm that all payments have been properly applied to patient accounts and that any patient who didn't pay for services rendered on that day now has a balance due.

You, as the practitioner, should consider reviewing a report of voided transactions or canceled appointments, if your software can prepare such a report, to make sure that any changed or voided transactions make sense.

Consider having the bank statements mailed to your home instead of to the office. Spend a few minutes each month scanning through the canceled checks to make sure you know the vendors and that the amounts look reasonable. Also, check the statement itself, looking for unusual transfers to or from the account. I strongly recommend that you take the time to review the monthly bank statements, but even if you don't always have the time, you should at least give your staff the impression that you do.

CONTROL OVER EXPENDITURES

Controls over cash disbursements are equally important. Here is a sample series of controls over disbursements. You will notice that, as with cash receipts, the focus is on the segregation of duties.

- Your staff should prepare pre-numbered purchase orders when ordering office or dental supplies. These purchase orders should be approved and initialed by the office manager before the orders are actually placed with vendors.
- When an order is received, the packing slip should be compared to the actual shipment to ensure that nothing is missing and to the approved purchase order to ensure that only the items

ordered were in fact shipped. I suggest giving the responsibility for inspecting and counting supplies that are received to someone other than the person who placed the order. This will reduce the chance of having supplies walk off on their own.

- The packing slip and purchase order, both initialed by the person who received and inspected the delivery, should be given to the individual who is responsible for approving payment.
- Vendor invoices that arrive by mail should also be given to the individual who is responsible for approving payment. While it is not always practical, you as the practitioner should be the individual who approves all invoices. Invoices for items that were ordered should be compared to the purchase orders and packing slips prior to approval. Invoices for recurring items, such as rent or utilities, should be reviewed for reasonableness prior to approval. The individual approving the invoices should initial them as approved for payment and forward them to the bookkeeper.
- The bookkeeper will prepare checks based on the approved invoices, checking to make sure that payments are based on actual invoices and not on monthly vendor statements. Once the checks have been prepared, the invoices should be canceled with a "Paid" stamp indicating the date they were paid. This will help prevent the same invoice from being paid twice. Prepared checks should be clipped to the supporting invoice and any packing slips or purchase orders, if applicable, and then given to an approved signatory.

A note on blank check stock: Blank checks should be kept in a locked cabinet at all times. When your bookkeeper asks for blank checks, only issue the exact number of checks needed. I recommend recording the check numbers in a log so that all blank checks can be accounted for.

When signing the checks, the signatory should compare the vendor and amount to the original invoice as a double check. Also, make sure that all of the checks issued to the bookkeeper are accounted for. Any voided checks should have the signature area of the check torn off so that they cannot possibly be used. I also strongly recommend that you sign the checks yourself. This step in the process is your final chance to catch any errors before the disbursement is actually made.

CONTROL OVER PAYROLL

Finally, let's look at controls related to your payroll. Most dental practices use a third-party provider to process their payroll, which itself is an internal control. When it comes to additional controls over payroll that is processed by a third-party provider, there are really only two that are critical. First, time cards should be tallied by one employee and then double-checked by your office manager before being called in or faxed to the payroll processor. That will help avoid errors or fraud related to the amounts being paid. Second, make sure that you are the only one with authority to change hourly rates and salaries or to add and delete employees. If you give this authority to anyone else, you just might find yourself with an extra employee on the payroll.

As you can see, simply segregating duties by adding another person to a process can help minimize honest errors and deter fraud. However, since

no two practices are alike, I highly recommend a professional evaluation of your current processes prior to the design and implementation of any internal controls. It might seem like a daunting task, but it really isn't. Your accountant or business consultant can document the way transactions are supposed to be processed, based on procedures that you have put into place as the practice owner. These processes are then compared to what is actually being done by walking through real transactions with your staff. By going through this process, your advisor will be able to determine where additional controls are needed, and can then work with you to design and implement them. ☘

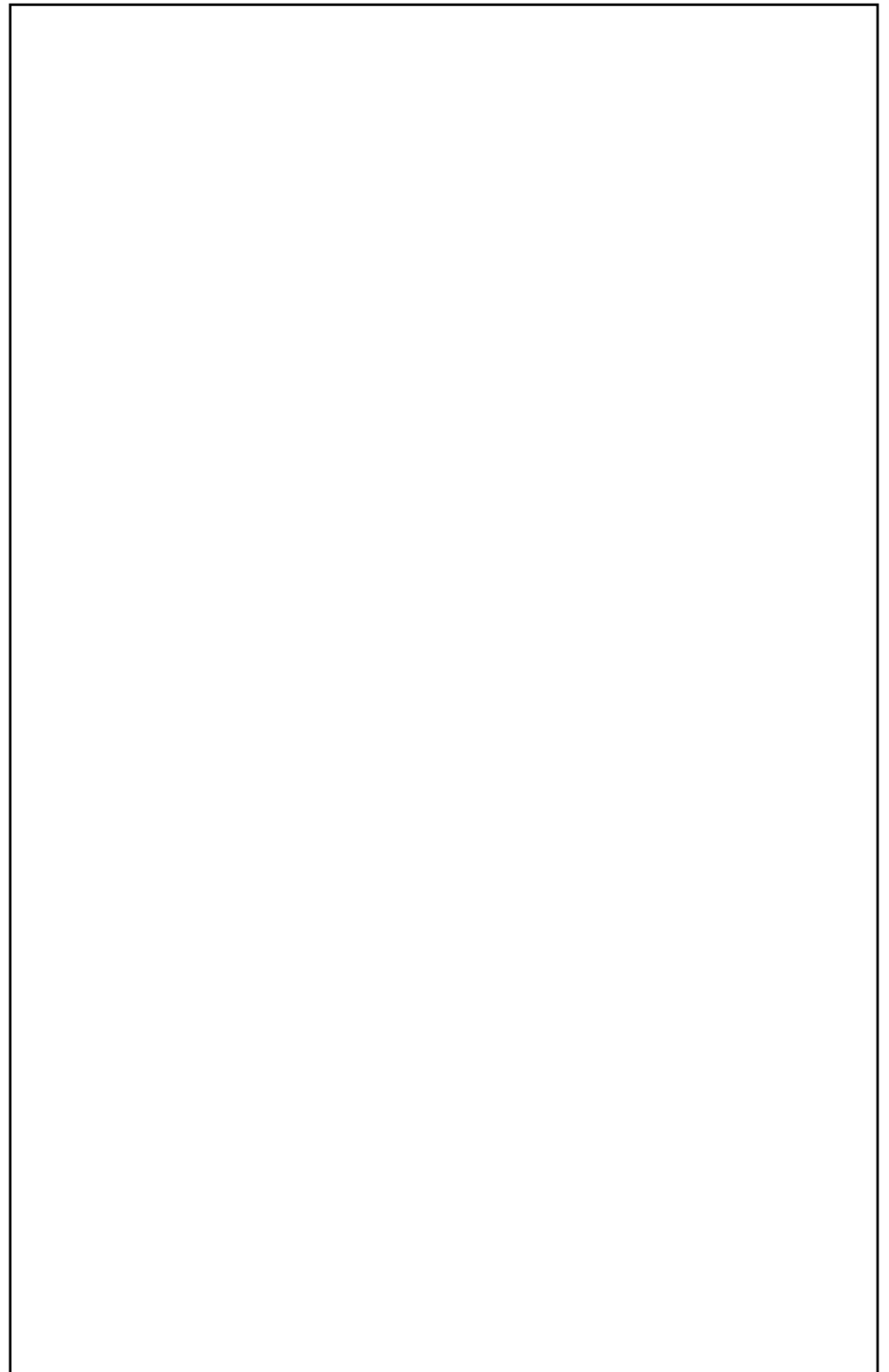
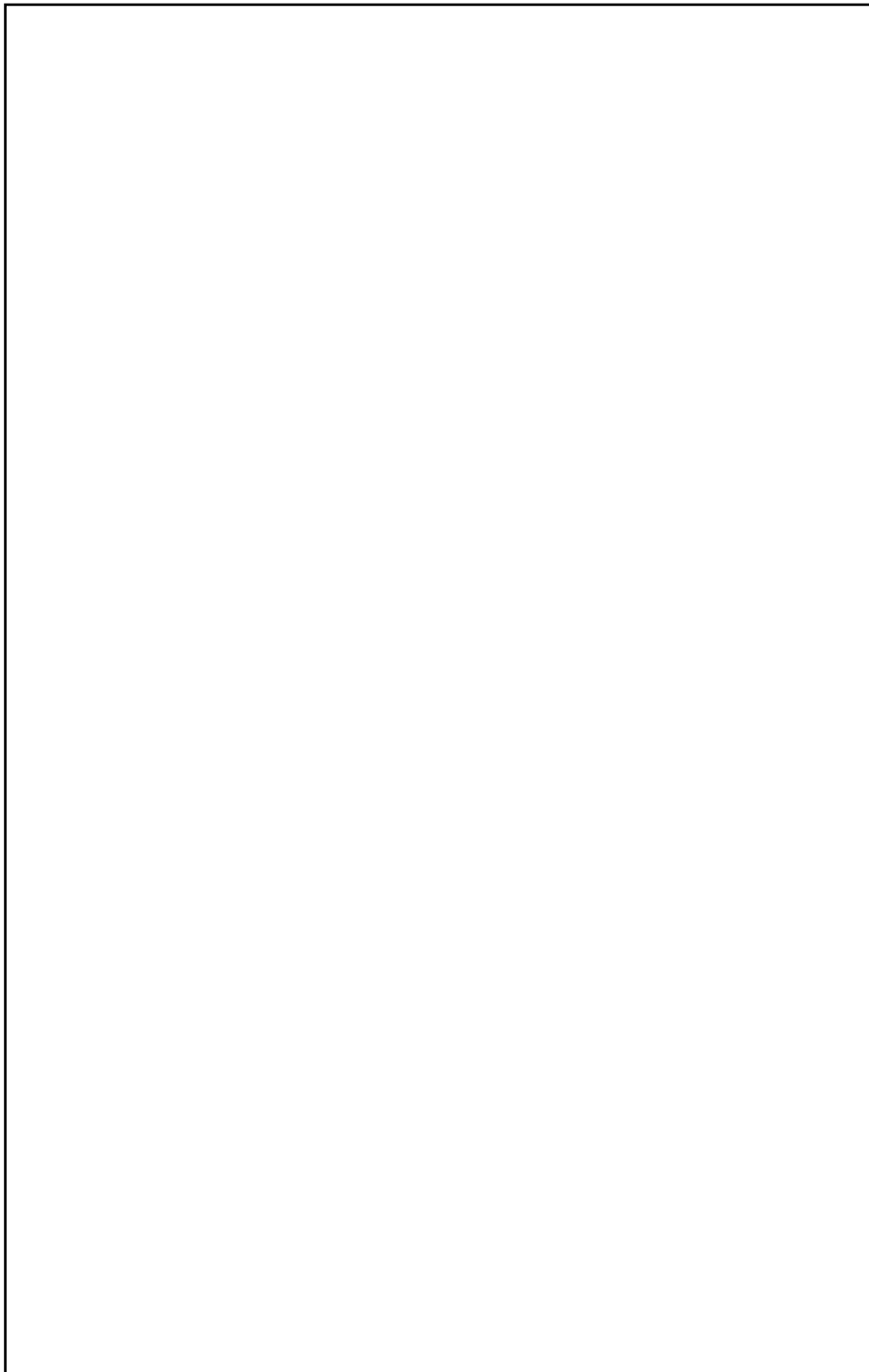
Mr. Brenner is a director in the White Plains office of the accounting firm Citrin Cooperman. He is a member of the firm's dental/medical practice. Queries can be addressed to him by calling (914) 949-2990 or e-mailing him at wbrenner@citrincooperman.com.

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4th Quarter 2010 New Members

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NYC	Paraschiva Gusita	Ridgewood	New York Univ College of Dentistry	2009	07	Latoya Scott	Rochester	Meharry Med College School of Dent	2008
NYC	Gary Klein	New York	New York Univ College of Dentistry	1981	07	Margo Wade	Addison	SUNY Buffalo Schl of Dental Medicine	2008
NYC	Lindsay Lepore	New York	Univ of Pennsylvania Sch of Dent Med	2006	08	Guoqiang Guan	Buffalo	SUNY Buffalo Schl of Dental Medicine	2010
NYC	Asma Muzaffar	New York	Univ of California Los Angeles	2005	08	Stacy Hoffman	Niagara Falls	SUNY Buffalo Schl of Dental Medicine	2009
NYC	Satishchandra Pai	New York	Columbia Univ College of Dental Med	2005	08	Peter Moses	Williamsville	SUNY Buffalo Schl of Dental Medicine	2008
NYC	Steven Schloss	New York	New York Univ College of Dentistry	1981	08	Lisa Spinello	Batavia	Tufts Univ School of Dental Medicine	2007
02	Horst Dziura	Brooklyn	Northwestern Univ Dental School	2000	08	Jill Wierchowski	Buffalo	SUNY Buffalo Schl of Dental Medicine	2006
02	Eric Holmes	Brooklyn	Howard Univ College of Dentistry	2009	08	Lisa Yerke	Williamsville	SUNY Buffalo Schl of Dental Medicine	2006
02	Eun Jeon Lee	Brooklyn	New York Univ College of Dentistry	2008	09	Tiffany Christensen	Briarcliff Manor	Columbia Univ College of Dental Med	2007
02	Jennifer Kim	Woodside	New York Univ College of Dentistry	2009	09	Justin Hendi	Suffern	Tufts Univ School of Dental Medicine	2005
02	Leona Kotlyar	Brooklyn	SUNY Buffalo Schl of Dental Medicine	2009	09	Lauren Kerpel	White Plains	SUNY Stony Brook Schl of Dental Med	2007
02	Hyun Kyu Song	Brooklyn	New York Univ College of Dentistry	2009	09	Michael Manasar	Wappingers Falls	SUNY Stony Brook Schl of Dental Med	2009
02	Tricia Quartey	Newark	New Jersey Univ of Med & Dentistry	2009	09	Roy Park	Highland Mills	Baltimore College of Dental Surgery	1997
02	Leila Seyedsalari	Bronx	Univ of Maryland	2009	09	Lisha Shrestha	White Plains	New York Univ College of Dentistry	2006
02	Garry Shnyder	Brooklyn	New York Univ College of Dentistry	2009	09	Michael Swirsky	Larchmont	SUNY Buffalo Schl of Dental Medicine	2009
02	Peiti Su	Brooklyn	Univ of the Pacific Sch of Dent	2009	09	Samar Tannous	Hastings	New York Univ College of Dentistry	2008
03	Max Reinhorn	Albany	Meharry Med College School of Dent	2003	NAS	Joseph Bruckner	Roslyn	SUNY Stony Brook Schl of Dental Med	2006
04	Christopher Bevin	Greenwich	Univ of Connecticut Sch of Dent Med	2001	NAS	Edward Goziker	Roslyn	SUNY Stony Brook Schl of Dental Med	2006
04	Peter Bozavikov	Schenectady	Univ of Toronto Faculty of Dentistry	2009	NAS	Anthony Panossian	Massapequa	Seton Hall Univ College of Dentistry	2003
04	Michelle Burlingame	Ballston Spa	Univ of Connecticut Sch of Dent Med	2007	NAS	Marieange Panossian	Massapequa	Univ of California Los Angeles	2004
04	Matthew Kovach	Clifton Park	Case Western Reserve Sch of Dent	2009	QUE	Anna Kwasnik	Ridgewood	New York Univ College of Dentistry	2006
04	Erin Page	Cobleskill	SUNY Buffalo Schl of Dental Medicine	2009	QUE	Jennifer Sung	Flushing	SUNY Stony Brook Schl of Dental Med	2009
05	Angel Aviles-Ramos	Syracuse	Univ of Puerto Rico Sch of Dentistry	1980	SUF	Elizabeth Doroski	Riverhead	SUNY Stony Brook Schl of Dental Med	2009
05	Pamela Ottesen	Oneida	Univ of Florida College of Dental	1999	SUF	Laura Frangella	Commack	SUNY Buffalo Schl of Dental Medicine	2008
06	Janice Diaz	Oneonta	Univ of Puerto Rico Sch of Dentistry	2009	SUF	Erik Gonzalez	Huntington	Univ of Maryland	2006
06	Jordan Glenn	Windsor	SUNY Buffalo Schl of Dental Medicine	2009	SUF	Jessica Krausz	E Patchogue	Univ of Pittsburg Sch of Dental Med	2009
06	Stephen McKee	Waverly	SUNY Buffalo Schl of Dental Medicine	2009					



Powerful X-rays for Kids in Braces Should Be Exception, Not Rule

SOME ORTHODONTISTS MAY BE exposing young patients to unnecessary radiation when they order 3-D X-ray imaging for simple orthodontic cases before considering traditional 2-D imaging, suggests a paper published by University of Michigan faculty.

There is ongoing debate in the orthodontic community over if and when to use cone beam computed tomography (CBCT) for orthodontic diagnosis and treatment planning, said Sunil Kapila, lead author of the paper and chair of the Department of Orthodontics and Pediatric Dentistry at the U-M School of Dentistry.

A very small number of orthodontists utilize the 3-D imaging routinely when developing a treatment plan, and this raises concerns of unnecessary radiation exposure. In contrast, the evidence summarized in Kapila's paper suggests that 2-D imaging would suffice in most routine orthodontic cases. One of the tradeoffs for the 3-D images is higher radiation exposure, Dr. Kapila said.

The amount of radiation produced by 3-D CBCT imaging varies substantially depending on the machine used and the field of view exposed, and some clinicians may not realize how much higher that radiation is compared to conventional radiographs. One CBCT image can emit 87 to 200 microsieverts or more compared to 4 to 40 microsieverts for an entire series of 2-D X-rays required for orthodontic diagnosis, Dr. Kapila said. Considering that the average U.S. population is exposed to approximately 8 microsieverts of background radiation a day, 200 microsieverts equates to about 25 days' worth of cosmic and terrestrial radiation.

Dr. Kapila said, when used judiciously, CBCT is an invaluable tool with a definite place in orthodontic treatment planning. His paper advocates "a balanced approach to utilizing CBCT in our patients." To that end, Dr. Kapila and colleagues reviewed the existing data on CBCT and found that this type of imaging is typically recommended in cases that include impacted teeth, temporomandibular joint disease, craniofacial abnormalities and jaw deformities. While other patients could also benefit from 3-D imaging, the decision to scan these patients should be made on a case-by-case basis after a clinical exam and evaluation of specific patient needs, particularly when 2-D imaging has shown that additional 3-D information would result in a demonstrable benefit that would likely alter the treatment plan.

The paper, "The Current Status of Cone Beam Computer Tomography Imaging in Orthodontics," appeared in the *Journal of Dentomaxillofacial Radiology*. Co-authors are R.S. Conley, associate professor at U-M School of Dentistry, and W.E. Harrell, both board-certified orthodontists. ☞

To read the paper online, go to <http://dmfr.birjournals.org/cgi/content/short/40/1/24>.

I.N. Quartararo Retires Position at NYU



Nicholas Quartararo

I. N. (Nick) Quartararo, D.D.S., has announced his retirement as a clinical professor of endodontics at the NYU College of Dentistry (NYUCD), ending a nearly 60-year association with the College of Dentistry faculty. Dr. Quartararo's retirement was effective Jan. 1.

A member of the NYUCD Class of 1952, Dr. Quartararo moved almost immediately into teaching, holding both part-time and full-time positions while also engaged in the private practice of endodontics in Nassau County, Long Island.

Dr. Quartararo served as NYSDA President in 1989, delegate to the ADA House, member of the ADA Council on Dental Practice and chairman of the ADA Advisory Committee on Clinical Dependency in

the Profession. He received the NYSDA Distinguished Service Award in 1996. The following year, he was recognized by NYU, which designated the Dr. Ignatius N. and Sally Quartararo Department of Endodontics in his honor.

In addition to his service to NYUCD and the dental profession, Dr. Quartararo has been an advocate for alumni interests and involvement and has served as president of the NYUCD Alumni Association, chairman of NYUCD's Centennial Celebration and as a member of the Dean's Advisory Committee, among other distinctions. His commitment to the welfare of alumni has been recognized with NYU's Meritorious Service Award, its Sesquicentennial Crystal Award, and with the most prestigious distinction conferred by NYU on an alumnus, appointment to NYU's Board of Trustees, where he represented NYUCD from 1989 to 1995. ☞

Charity Begins at Home

Long Island dentists form charitable organization for benefit of their community.

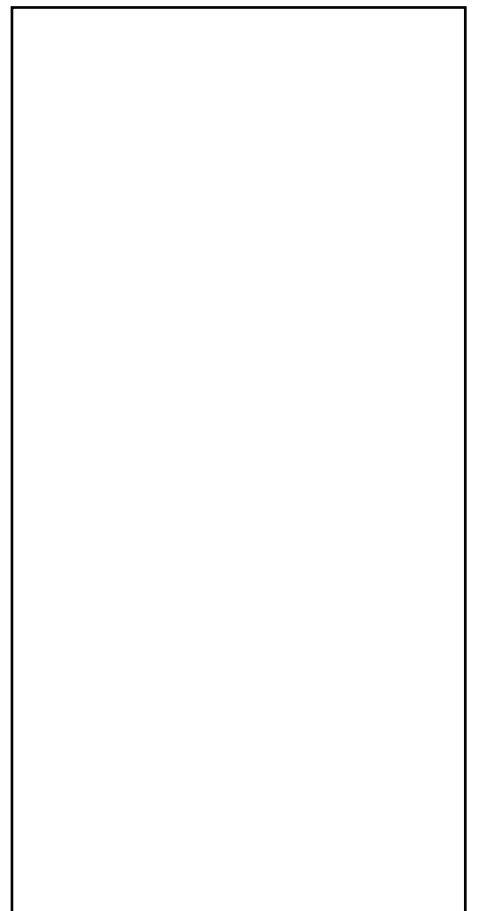
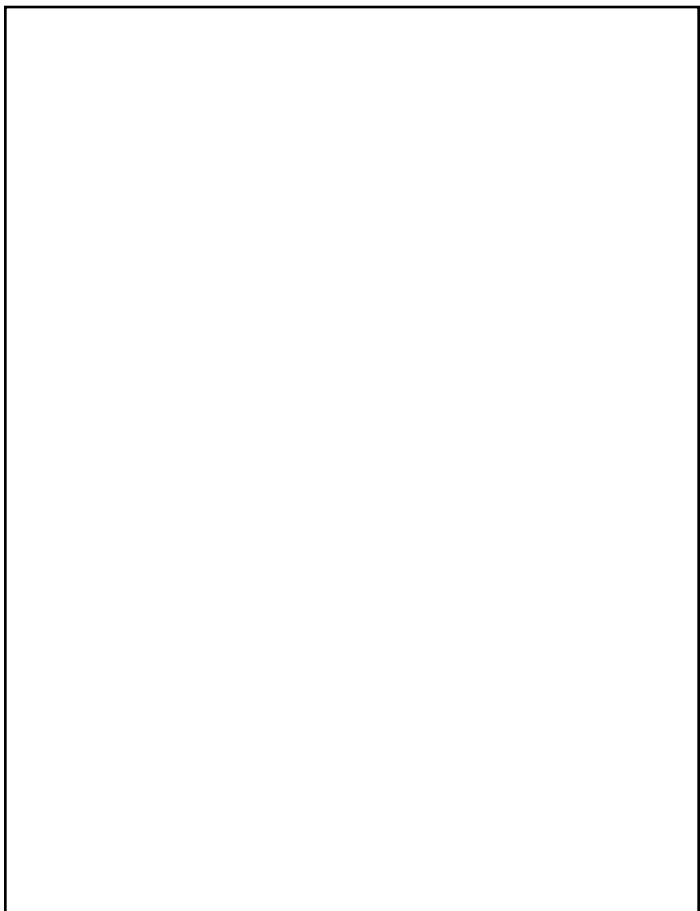
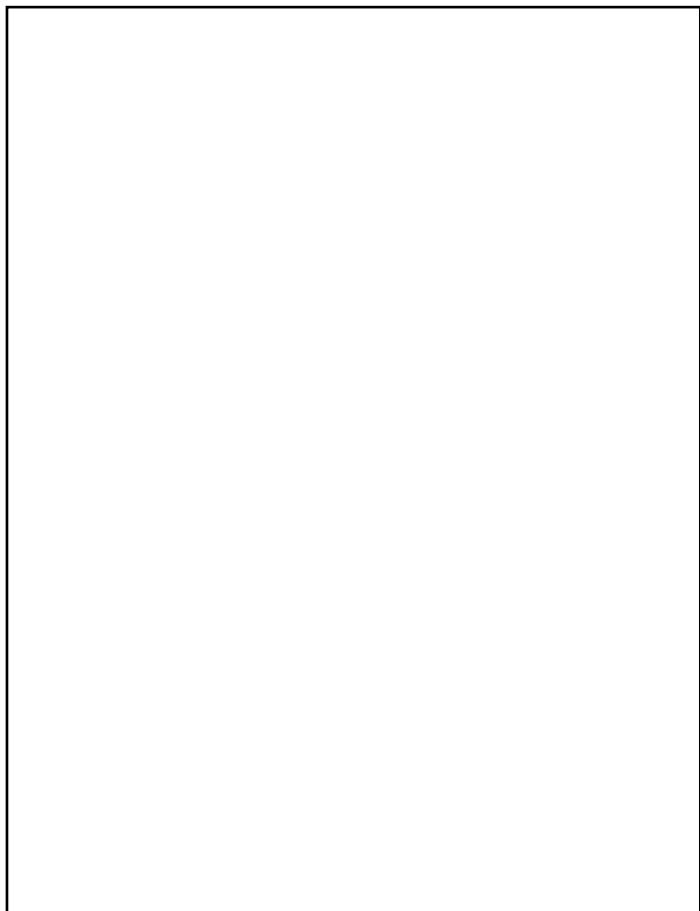
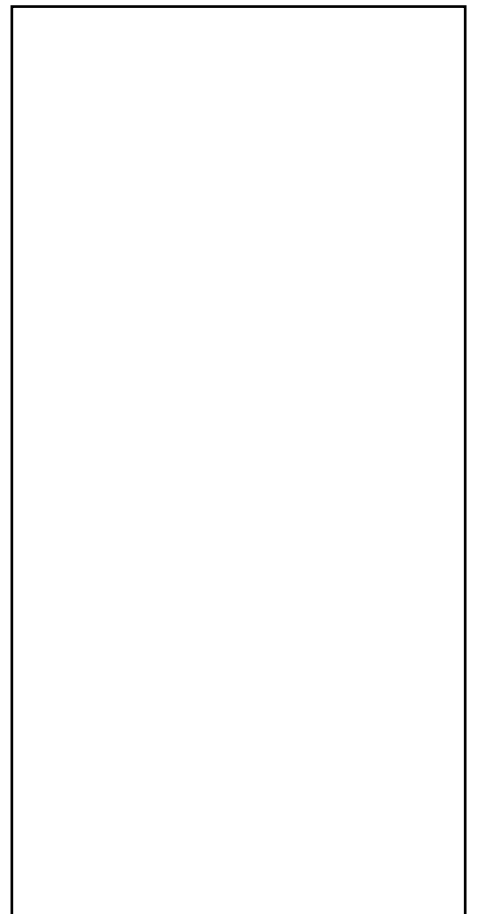
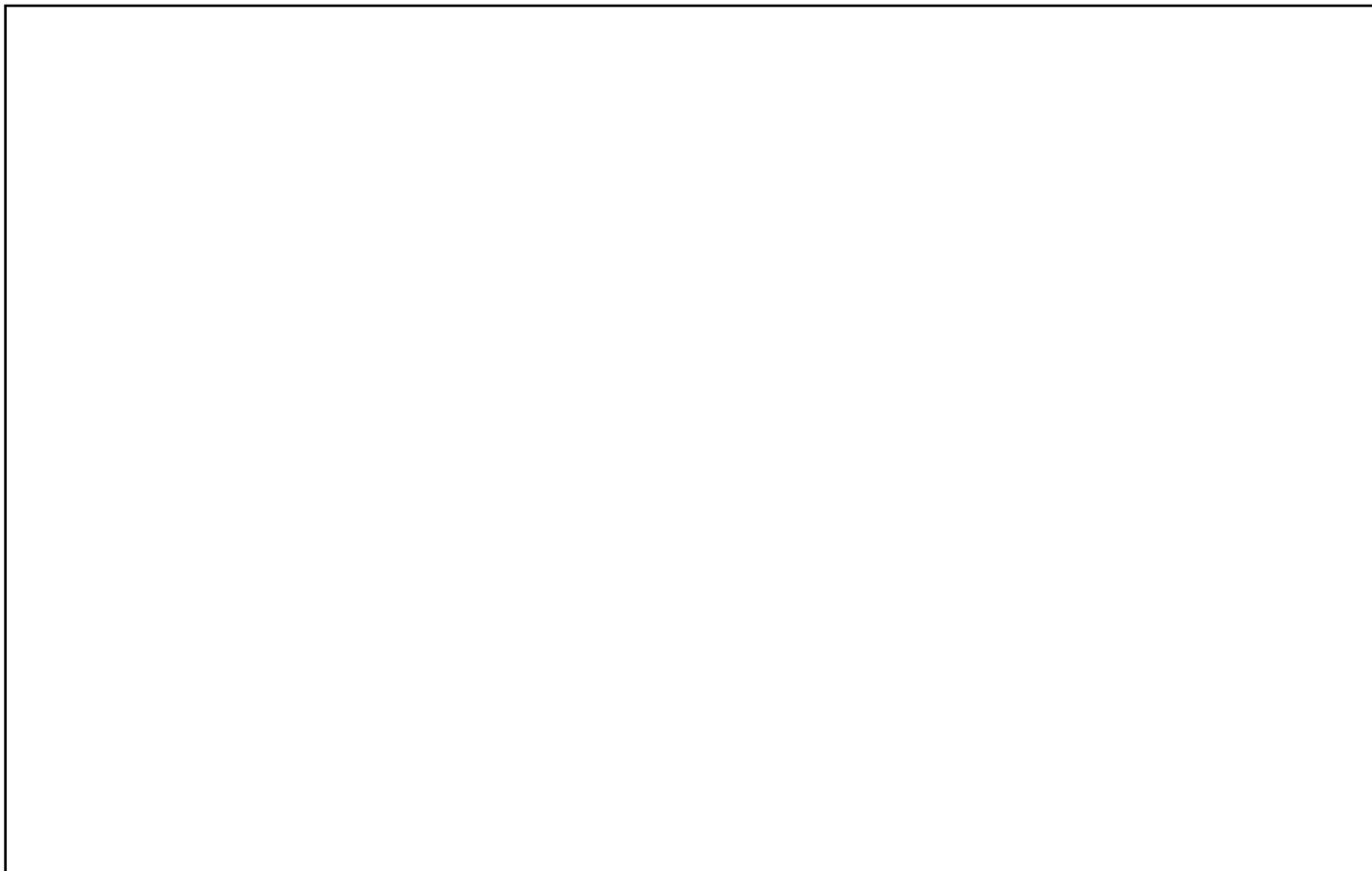
TWO HEADS are said to be better than one. What about 27 Long Island dentists pooling their charitable donations? Can't it be said they can do a whole lot more good than one dentist acting alone? That's what the dentists who make up Dentists for a Better Huntington (DFBH) thought when they created their 501c charity to give back to the community in which they work and live. Since its formation in 1997, DFBH has given over \$100,000 back to the people of Huntington.

One of the Huntington 27, Brian O'Lear, D.D.S., also the organization's president, believes their's may be a unique organization. "While there are many dental and medical charity organizations that supply free or discounted dental and medical care, I am not aware of any other independent group of dentists whose sole purpose is to give

continued on page 16



Dentists for a Better Huntington members at check presentation to Huntington Station Enrichment Center. They are, from left, Lawrence Mailloux, Kelly Kalmar, Thomas Shea, Richard Stabile, Raymond Mascolo, Brian O'Lear, Lawrence Schwartz, Gregory Kalmar, Philip Giusti, Howard Schneider, William Walker.



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GENERAL DENTIST: Highly trained and experienced dentist in all phases of dentistry looking for P/T associateship in Brooklyn, Queens, Nassau and W. Suffolk. Please call (516) 234-0337; or e-mail: ShinBet@gmail.com.

GREATER NYC AREA: Periodontist seeking PT associateship position in NYC or Westchester area. Experienced in high-volume, union-oriented offices. Comfortable with most insurance carriers. Excellent result. Also experienced in general dentistry. Call (201) 585-2455.

RIVERDALE, SCARSDALE, SO. WESTCHESTER: Endodontist with 10 years' experience available to do Endo in your GP or specialty practice 1 day/week. Excellent rapport with patients and referring doctors. Please call (718) 548-4315; or e-mail: yedal@yahoo.com.

CLASSIFIED INFORMATION

RATES: \$35 for 30 words or less; 75 cents each additional word; \$10 additional for Journal box number; \$10 additional for ad to appear on NYSDA Web site. Box display: 1 column wide by 1 inch deep (min.), \$60; each additional 1/2 inch \$25. Payment must accompany all ads. Copy due 1st of month, two months prior to date of publication. All ads are subject to editing by The Journal. **Box replies to:** NYS Dental Journal, 20 Corporate Woods Boulevard, Suite 602, Albany, NY 12211. Please use complete box number with replies.

Charity Begins at Home continued from page 12

back to the community in a 'non-dental' manner," Dr. O'Lear said. "While most if not all of our members provide varying degrees of pro-bono dental care in their private practices, as a member of DFBH, their focus is on fund-raising and giving monetary support to a variety of organizations and causes within the town."

Last year, DFBH gave \$20,000 (gifts of \$4,000 each) to The Huntington Station Enrichment Center, which provides free tutoring and after-school assistance to disadvantaged children; Meals on Wheels of Huntington; Visiting Nurse Service of Northport Hospice; The Salvation Army Veterans Residence of Northport VA; and the Family Service League of Huntington.

DFBH is an all-volunteer organization, Dr. O'Lear

said. It has no paid officers or directors, and its only expenses are for insurance, minor printing and other costs associated with its fund-raising. "As a result, over 95 percent of any dues moneys and donations go directly to the local organization (DFBH) donates to," President O'Lear said. Funds come from dues and various fund-raising events that members are required to participate in. The group has also attracted several dental-related corporate sponsors. Two of its most loyal sponsors, according to Dr. O'Lear, are Henry Schein Dental and Nobel Biocare.

DFBH works closely with the Suffolk County Dental Society, as well, helping to produce an annual full-day seminar at which nationally known dental speakers

present. The group arranges for table sponsors at these seminars to raise funds for its charitable giving.

Beneficiaries of DFBH giving have included little leaguers, Eagle Scouts, the YMCA, American Legion and the Make a Wish Foundation. In addition, DFBH has given over \$15,000 in scholarship and SEPTA awards to graduating seniors from all of the high schools within the Town of Huntington.

Dr. O'Lear describes himself as a proud member of Dentists for a Better Huntington, a sentiment he shares with his fellow members: Lawrence Mailloux, president elect; Raymond Mascolo, vice president; Kelly Kalmar, secretary; Inna Gellerman, treasurer; Thomas Shea; Richard Stabile; Lawrence Schwartz, past president; Gregory Kalmar; Philip Giusti, past president; Howard Schneider; William Walker; Robert Palma; Peter Pruden; Thomas Arcati; William Schneider; Richard Marcus; Neil Auricchio; William Greene; Stephen Shore; Jeffrey Kopman; Christine Vice; Richard Weledniger; Alan Gibbs; Joseph Salierno; and Richard Sand. ☘

NYU Receives Gift for Implant Program

NEW YORK University College of Dentistry (NYUCD) has received a gift from dental products company Dentsply International of over \$450,000 to promote research in implant dentistry. Dentsply's gift will be used to further the mission of NYUCD's implant program, first dental school in the U.S. to teach implant dentistry to predoctoral students.

"The NYU College of Dentistry's reputation as a national and international leader in implant dentistry rests on the clinical research we conduct, research that is made possible by the generosity of major benefactors," said NYUCD Dean Charles N. Bertolami. "We are extremely grateful for the gift to NYUCD from Dentsply International, to advance NYUCD's clinical research mission in implant dentistry." ☘