8th District Bulletin

Volume 61 | Number 3 | Fall 2025

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Volume 61, No 3, Fall 2025
8th District
BULLETIN

Eighth District Dental Society
of the State of New York
3831 Harlem Road, Buffalo, NY 14215
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American Dental Association - 800-621-8099
New York State Dental Assoc - 800-255-2100

Member Publication
American Association of Dental Editors

The Bulletin of the Eighth District Dental Society (USPS 909-900) is published four times a year by the Eighth District Dental Society for its members. Unless officially adopted by the Eighth District Dental Society and so indicated, opinions expressed in this publication are not necessarily the views of the association. Address all communications pertaining to this Bulletin to the Editor, Eighth District Dental Society, 3831 Harlem Road, Buffalo, New York 14215.

The Dental Society is organized for the purpose of encouraging improvement of the health of the public, to promote the art and science of dentistry, and to represent the interests of the members of the profession and the public which it serves.

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From The Editor

Artificial Intelligence is all the rage today. It is permeating every sector of society. We hear about AI just about every day on the news. It will be either the savior of mankind or the cause of its downfall. Unquestionably, advances are being made every day in AI and one wonders where this will all end. Are we headed to a future where AI serves us in the best ways possible, or will it become our overlord and rule over us with cold logic and doom us to a Terminator future? Those are some important questions, but not the ones I will address today. Today, I will look at how AI will influence dentistry and where it could possibly help in the delivery of care to our patients.

AI is a computer program which learns algorithms to perform tasks more quickly and efficiently than humans. AI has been utilized since the 1950s in medicine when the first computer program was used to analyze blood and urine samples. Progress continued in the ‘70s and ‘80s when programs were developed to diagnose and treat infectious diseases,

(Continued on Page 4)

From The Editor

(Continued from Page 3)

medical imaging analysis, and drug research. AI has a long history in medicine. AI is now beginning to make inroads into the practice of dentistry. Advances are being made in AI in dentistry all the time. It is being used is all aspects of dentistry to help provide care to our patients. There are applications available in all areas of dentistry and all specialties.

In periodontics AI tools are being developed to help in the diagnosis of periodontal disease. These programs now in development are showing results closely mirroring results from human observers. Oral diseases such as lichen planus are showing similar results. Diagnosis of dental caries by AI programs show promising results in the early detection of caries. In endodontics, the use of AI may contribute to more accurate root length measurements, more accurate obturation of the canals, and the discovery of accessory canals not visualized on a periapical x-ray. AI is already extensively used in prosthodontics with the advent of CAD/CAM manufacturing of various restorations. Implant placement can be more highly accurate and predictable. AI is currently being used in orthodontics in diagnosis and treatment planning of patients. AI can also be used in orthodontics to better communicate with patients about their treatment and how long such treatment will take. In oral medicine and oral pathology, AI can be used in diagnosing cancer earlier than a clinician can.
AI is also at the forefront of developing robots to assist in all aspects of dentistry. Robotic assisted surgery is now used in medicine. It is only a matter of time before such assistance will be available for oral surgeons, particularly in various surgeries involving patients with soft tissue cancers. In orthodontics, Sure Smile utilizes robots to bend custom archwires to treat malocclusion. Clear aligner providers like Invisalign utilize AI to design the aligners to move teeth rather than using braces. Robotic assistance in dental research helps to determine wear properties of developing restorative materials. Robots can be used by dental labs to set and align teeth for dentures, helping the lab technician to set the teeth optimally. Robotic restorative procedures are being investigated with promising results.

AI in dentistry is in its infancy. However, as with all technological developments, AI will continue to grow exponentially. Dentistry in the future will look much different than it does today. I hope this change will benefit treatment of our patients and allow dentists to provide the absolute best care. We must monitor this development closely. We must be cautious in our acceptance of AI in the dental field. We can't go off and support the current flavor of the month. We must continue to do our due diligence when introducing any new treatment option into our practices. It is our duty to our patients and to us.

Last issue my editorial discussed orthodontic treatment for patients under Medicaid and the criteria for acceptance into the orthodontic program. As part of the editorial, I indicated the criteria would be cited later in the issue. However, that criteria was inadvertently left out. Since I proof the Bulletin before publication, I can only blame myself for the oversight. That information is included in this issue, beginning on page 20. If anyone has any questions, please feel free to contact me. I apologize for this oversight. I will work diligently to make sure such oversights will never happen again.

From The President

Friends and Colleagues,

My message this time around will be brief, like the summers in Western New York. I hope that you all are enjoying the warm weather and taking the time to rest, relax and recharge, while spending quality time with friends and family.

Since my last message, I had the privilege of presenting awards to outstanding graduates of the ECC dental assisting and dental hygiene programs. I attended the NYSDA House of Delegates meeting in Uniondale, NY. It's encouraging to see so many colleagues committed to the well-being of the profession who volunteer their time on our behalf.

Leadership of the 8th District has some additional respite with no Executive Council meetings during the months of June, July and August. That being said, we remain active with ongoing email discussion and committee meetings. The continuing education program committee is still working to examine members' needs, and it's likely that the 8th District will be offering additional CE in 2026. Several members volunteered to join the committee and provide valuable input. If you have interest in serving the profession, please contact the district office to see what might be a best fit.

If you're still reading this, thanks, but see my opening paragraph…rest, relax, etc. I'd rather spend time speaking with people in person. Central Groove has a bunch of gigs this summer. Come see us and talk to me. Let me know what the 8th District can do to help you as a dentist. We can commiserate about staff shortages, insurance reimbursement, business regulations in NY or patients that feel the need to spit every couple of minutes, or better yet, let's wait until fall when I'm done recharging.

All the best,

Dr. Joseph Rumfola
EDDS President

Saturday, June 13, 2026

Executive Director's Note

We hope everyone has been enjoying the summer season; there has been a wide array of weather patterns this year. There are also an array of sweeping changes taking place in our dental community, nationally, statewide, and regionally as we make our way into 2026. First are the recent changes to fluoridation in states and localities. While New York remains committed to keeping this important mineral in our public water supply, in most instances it is technically a local decision to continue that practice or end it altogether. In the past year, the ADA has ramped up support by creating a Fluoride Ambassador Program spearheaded by our 2nd District ADA Trustee, Dr. Brendan Dowd. Certainly, our recent work to get fluoride back into the water in the City of Buffalo played a key role in assisting the processes to create more public and wider appeal support. We remain diligent and focused on providing solid research and insights into keeping it in our local water systems. It is vital to our youth & families, especially those who may not have a regular dental home.

There has been a plan to orchestrate a new Member Model across the tripartite, but that is taking a small step backwards from the plan to include more states. Initially, five states were chosen to pilot a new model of member engagement in 2023-24 with changes to dues structure, services, and a collective array of programs. Those pilot states who elected to serve in this role launched a series of efforts for the ADA to consider engagement strategies. However, since the departure of the former ADA Executive Director, Dr. Raymond Cohlmia in February of this year, plans to continue this new member model are on hold as the national office shifts focus to other areas of concern to include the new membership portal. The ADA also recently sold the national headquarters building in Chicago and has taken residence down the street taking up four floors of another building. One could say it is another attempt to downsize or right size for current & future needs.

NYSDA has also seen its share of changes in recent years with a new ED taking charge, Michael Herrmann. Michael, the former COO for NYSDA for over 35 years, replaced Greg Hill last fall. Mr. Herrmann recently announced at the HOD he would be stepping down at the end of 2026. So, a search will be conducted sometime in 2026 to replace him. There have also been a few organizational restructurings of departments and service platforms at NYSDA.

Locally, we continue to strive to support an array of services and programs that our members find value in while trying to maintain our fiscal health. We are still the lone district in the state that can offer group-based healthcare insurance for members and staff. Our member base is still in the top five of all districts in NY, but many memberships are shrinking across the Empire State. Three of the thirteen districts in NY now operate outside of a more traditional office facility, and two others are seeing shifts in leadership roles in the coming year. Many districts are operating without any significant fiscal reserves to draw on as time gets lean; the cost of doing business is both harder and more expensive. Non-dues revenue, once readily supported by CE programming and sponsorship, has begun to dry up completely as members get their professional development from an array of vendors and providers. In that same light, sponsors expect to see dentists at events they support to continue to drive their business services. We have been fortunate to have great partners who continue to support our programming.

We might begin to see or hear discussions regarding district consolidation in NYS, due to both the decline in overall membership as well as the ability to run a quality member service platform without ample resources in specific regions. The structure of state level programming is varied across the country. New York is the only state that has local component staff support in every district. This conversation may be down the road a bit for the 8th District, but we have been discussing contingency planning for future cliffs in funding loss. As always, if you have any questions or concerns, please contact me at jcraig@8ddsny.org. Bills season is just around the corner!! Let’s GO BILLS!

William C. Knauf Jr. Golf Tournament

The 2025 William C. Knauf Jr. Golf Tournament was held on Monday, June 9th at Fox Valley Country Club in Lancaster. Just over 40 dentists attended the morning continuing education program, which was sponsored by Ivoclar. Dr. Gina DeSouza presented a two-hour CE entitlted “All Ceramic Restorations: Structure, Properties & Bonding Protocols”.

Following the CE program, close to 100 golfers took to the links following a lunch of burgers, sausage and grilled chicken. Mother Nature was NOT our friend this day, as golfers faced downpours for much of the afternoon. A cocktail hour and buffet dinner capped off the evening, with awards and door prizes.

Next year’s tournament will be held on Monday, June 1st at Transit Valley Country Club.








Champion Golfer - Dr. Peter Igoe
Men’s Overall Winner: Kevin Schmidt, Andy Jakson, Alex Jakson, Jeff Rymarczyk (Evolution Dental)
Senior’s Overall Winner: Drs. Joseph Modica, John Tibbetts, John Luchesse Jr, Eugene Sibick
Super Senior’s Overall Winner: TIE - Drs. Joseph Breloff, Robert Schaus, John Athans, Andrew MacDonald and Drs. Robert Reszel, Scott Seier, Ron Chmiel, Greg George
Mixed Overall Winner: Drs. Chet Gary, Frank Sindoni, Rick Redmin, Ms. Julia Gengo
Closest to the Pin: Dr. Louis Schiumo
Longest Drive: Ladies - Dr. Liz Kapral; Men’s - Dr. Richard Medico; Senior - Dr. Robert Reszel

William C. Knauf Jr. Golf Tournament

Joe Breloff celebrates his classmate's life and their UB Class of '75

50th Anniversary by remembering a true friend to the 8th District - Dr. Bill Knauf, Jr.

This annual member Golf & CE event, since 1993, is based on the work of many individuals in the District throughout the years, but most notably, Dr. William (Bill) C. Knauf, Jr.

Immediately after graduating from UB Dental School in 1975, Dr. Bill Knauf became an associate in the dental practice of Dr. Peter Schreier in Arcade, New York; Dr. Tim Stanford joined the practice shortly afterwards.

From Dr. Tim Stanford: "Bill's Cornell degree was in mechanical engineering. I believe this contributed to his technical excellence in the "mechanics" of dentistry. His dentistry was beautifully superb." Dr. Roger Triftshauser encouraged Bill to become involved with the Eighth District Dental Society and Bill became a council member shortly after starting his dental practice.

Bill, along with others, spearheaded and was the driving force to resurrect the concept of a field day for its dentist membership. In 1982, with the help of Drs. Paul Kendall and Joe Pantera, the Bethlehem Management Club in Lackawanna was reserved for the entire day. The Bethlehem Management Club made available several activities including tennis, horseshoes, bowling, softball, golf, and amusing game-centered challenges. This day created an environment where fellow dentists from all over the Eighth District could engage in a variety of ways that best suited their interests and abilities while getting to know people outside of their dental practices and work-related activities.

In January 1991, Dr. Bill Knauf was recognized as the Eighth District "Dentist of the Year." The program quotes: "Dr. William C. Knauf, Jr. has won the respect and admiration of his peers for his service and dedication to the dental profession in having been named the Eighth District Dental Society's Dentist of the Year for 1991. But it is apparent that the effects of his contributions to the profession and his community will be realized for many years to come.

Later that year, Bill was diagnosed with a brain tumor, called astrocytoma. Even with this diagnosis, Bill was installed as President of the Eighth District in 1992 and passed away a few months later. He was only 43 years old.

Tim Stanford recollects: "Bill personally contributed to our community. He SINGLE HANDEDLY advocated for and succeeded in instituting water fluoridation in the Arcade municipal water system. I saw the dramatic results of his efforts over the next 45 years. Members of the Council elected to create a Memorial event in his honor and named the annual golf outing after his legacy. A very fitting tribute to his legacy.

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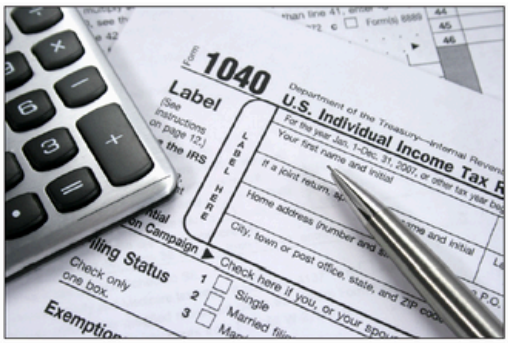

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Mitigating Referral Risks

Referrals play a critical role in ensuring comprehensive patient care, allowing dental professionals to collaborate and provide specialized treatment when necessary. As referring providers, and typically the source of referral information, referrals may have left your office with incorrect or missing information. Referrals lacking accuracy or completeness may present risks, including but not limited to wrong site surgeries, delays in treatment and unrealized patient expectations. Mitigating complications associated with referrals first requires identification of the potential causative factors. Consider how each of the following may apply to the referral process in your office:

1. **Miscommunication**: Miscommunication between providers may lead to misunderstandings regarding the patient's condition, treatment plan, and medical history. This may come in the form of a lack of communication, errors in communicating either referral details, diagnoses or outcomes, errors associated with transfer of images, or a lack of documentation of the referral details.
2. **Patient Expectations**: Patient expectations may be set during a discussion with the referring provider. These conversations may include the time it may take to be scheduled for a specialty referral, what might be expected of the patient, and what treatment and/or anesthesia may be offered.
3. **Change in Patient Presentation**: Referral processing times, patient-related delays, or appointment scheduling may impact referral requests and treatment plans. This becomes particularly important when considering treatment of the minor patient with mixed dentition, whose presentation may change quickly over time or for the patient whose symptoms simply evolve over time.

The following closed claim example illustrates how a breakdown in communication between providers and errors in referral information contributed to wrong tooth extractions:

A general dentist referred their patient to an OMS for consultation of extraction of twelve remaining teeth in preparation for a full maxillary denture. The referral form listed teeth #'s 3 through 12, 18 and 31 to be extracted. A week later, the patient and general dentist discussed retaining teeth #'s 6 and 11 as overdenture abutments for the maxillary denture. A new referral form was electronically sent to the OMS office omitting #6 and #11 to be extracted. On the day of surgery, the original referral form was referenced. The patient consented to extraction of twelve teeth, not ten, and the extractions were performed without incident. The patient visited the general dentist immediately postop for the denture delivery, and it was noted that #6 and #11 were extracted. The dentist contacted the OMS, who confirmed the updated referral form was in the patient's chart and offered to place implants at #6 and #11 at no charge. The patient opted not to see this OMS for the implants and filed suit against both the dentist and the OMS.

A lack of communication between providers in this case led to two wrong tooth extractions and a change in the patient's treatment plan. Ultimately, with the assistance of Fortress defense counsel, and due in part to the dentist's documentation, this claim was dismissed prior to trial.

Mitigating Referral Risks continued

Patients benefit when providers work together to ensure a coordinated referral process. Periodic evaluation of the effectiveness of referral management protocols may identify areas for improvement, and asking providers and staff to offer scenarios for consideration to test current policies and procedures will allow all members of the referral network to assist in mitigating risk as a team.

Risk Management Tips

- Confirm communication preferences within your referral network to encourage coordinated care.
- Discuss how you would prefer to manage changes to treatment plans in order to limit rescheduled appointments, unexpected outcomes, and patient frustration.
- Train staff on the importance of referral detail accuracy, including transfer of patient imaging, in order to limit errors in communicating referral requests.
- Review referral request forms and details before they leave your office, to assist in reducing documentation and imaging related errors.
- Educate patients on treatment plans and what they are being referred for in a way that they can understand to assist in reducing referral related errors.
- Limit any critical comments or concerns regarding another provider's care to the treatment team; offering subjective commentary to patients may influence their satisfaction or perception of the other provider's treatment.

Discussion Questions for Your Team

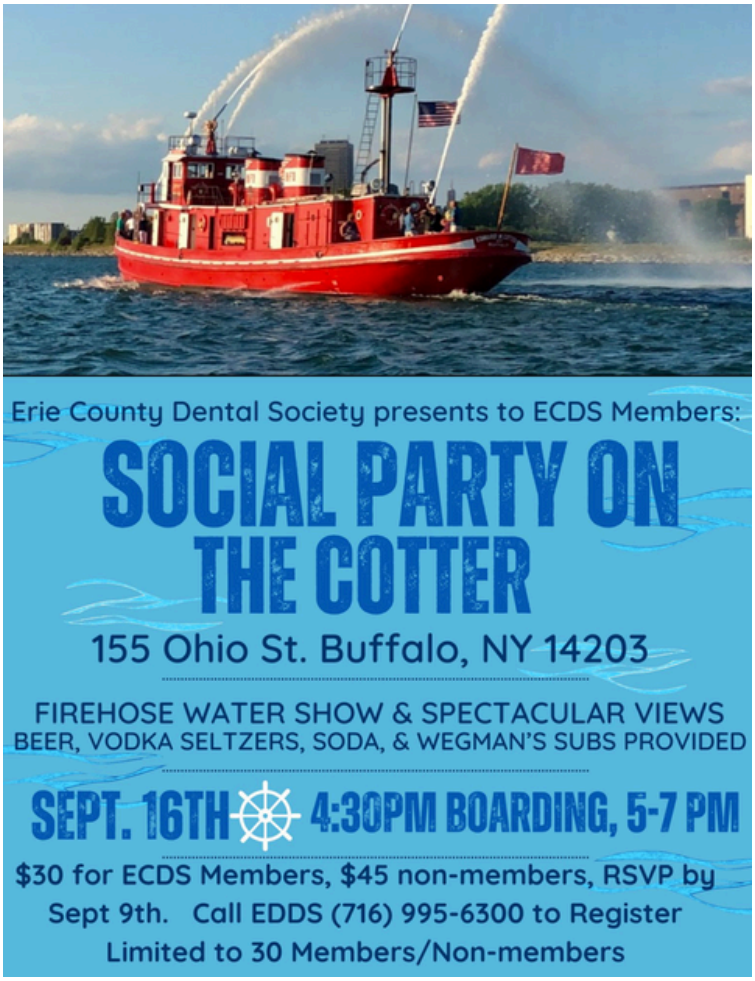
- How and when are referral forms currently completed? Does the provider validate the form prior to handing the referral and/or images to the patient or before sending the referral details to the specialty provider?
- How does your office document communication with those in your referral network? What if the communication comes in the form of a text message or email? What if the communication comes in the form of staff-to-staff communication between offices?
- How are updates to referrals managed if the referring provider is not available to discuss the update?
- Are patients made aware of referral details in a way in which they would understand?
- What communication strategies do your practice currently employ to facilitate "day of treatment" conversations with the patient's other provider(s)?

Erie County Dental Society

I hope this message finds everybody well and that we are all enjoying as much of the summer as possible. As the year progresses, Erie County Dental Society is striving to give its members the chance to connect and foster the sense of community among dentists. This has often been in the form of continuing education events, but the late summer of this year will bring the return of social events.

ECDS has been hard at work planning a social event on The Cotter- The Buffalo Fireboat! On September 16th, we will have a unique opportunity to see and experience the city of Buffalo with our peers in a new way. October 1st will also bring our next CE event at the society office where we will be welcoming Drs. Jessica and Paul Canallatos to present the topic "Unlocking Advanced Treatment Options: Digital Dentistry and Custom Prostheses for Comprehensive Patient Care." I look forward to connecting with you at these events. Have a great summer!

Martin Gorkiewicz
President



Erie County Dental Society Seminar & Meeting

DATE: Wednesday, October 1, 2025
TIME: 5:30pm to 7:30pm (5:30 Registration, 6:00 Dinner/Business Meeting, 6:15 Seminar)
PLACE: Eighth District Dental Society Office (3831 Harlem Road, Buffalo, NY 14215)
COST: $55 for ECDS Members, $75 for Non-Members, $30 for Residents & Office Staff
SPEAKER: Paul & Jessica Canallatos, DDS, MS
TITLE: Unlocking Advanced Treatment Options: Digital Dentistry and Custom Prostheses for Comprehensive Patient Care
CE: 1.5

Program Summary

This lecture highlights cutting-edge advancements in full arch rehabilitation with dental implants, focusing on digital workflows that simplify treatment and deliver exceptional outcomes for edentulous patients. In addition, we'll explore the world of maxillofacial prosthetics, including custom prosthetic eyes, ears, and noses, as well as advanced prosthetic solutions for craniofacial conditions and Nasoalveolar Molding (NAM) appliances for cleft care. Attendees will gain valuable insights into identifying patients who could benefit from these transformative treatments and collaborating with specialists to provide comprehensive, life-changing care.

Course Objectives

- Identify the indications for full arch rehabilitation with dental implants and understand how digital workflows streamline the process and improve patient outcomes.
- Gain an overview of custom prosthetic solutions, including eyes, ears, and noses, and their role in restoring aesthetics and function for patients with craniofacial defects.
- Learn to recognize complex cases that may benefit from referral to specialists for advanced prosthetic or maxillofacial solutions, enabling comprehensive and holistic patient care.

Teaching Methods:

☒ Lecture

Speaker Biography:

Dr. Jessica Canallatos is a prosthodontist and a distinguished member of the Craniofacial Team at Oishei Children's Hospital. She earned her Doctor of Dental Surgery degree from the University at Buffalo School of Dental Medicine, followed by a specialty residency in Prosthodontics at West Virginia University School of Dentistry, where she also earned her Master of Science. Dr. Canallatos specializes in providing comprehensive care to patients with complex dental and craniofacial needs. Her expertise includes fabricating advanced prosthetics, such as Nasoalveolar Molding (NAM) appliances for cleft care, speech aids for cleft-affected patients, and custom prosthetic restorations for patients with missing teeth and/or tissues.

Dr. Paul Canallatos is a current maxillofacial prosthodontist at ECMC. He works closely with surgeons, especially the head and neck department at ECMC to fabricate prosthetics throughout patient's treatments of head and neck cancer. He obtained his doctor of dental surgery degree at University at Buffalo, School of Dental Medicine. Following dental school, he was awarded a certificate of completion of general practice residency from Roswell Park Cancer Institute and certificate of completion of an implant fellowship from University at Buffalo, School of Dental Medicine.

RSVP: Please call the Eighth District Dental Society to register at 716-995-6300

Shred Day

The Eighth District's Annual Shred Day was another big success! This year we made sure to have two large Lincoln Archive trucks at our office to shred and recycle all of those old patient files and x-rays! We want to once again thank our sponsors - Walsh Duffield Insurance and Ivoclar - for assisting in making the 2025 event as successful as it was! We will be holding another shred event on Saturday, June 13th, 2026. We will be sure to notify our members with more information early next year.

Foundation Corner

Since 1952, the Society Foundation has been a catalyst for fiscal support and outreach for members, students, and the public. Over the last 73 years, efforts to support an array of services have been fulfilled and supported. Many of the funds raised for these efforts have been through generous contributions from members themselves, our sponsors and partners as well as endorsed products and services over the years. While our level of endorsed products and services has declined significantly, the willingness of partners to continue to support CE and other efforts through the services we provide has been great and sustained.

Members are aware of our Capital Campaign for this year to raise funding to keep our foundation's efforts viable. We still support Good Neighbors Dental Clinic as part of the Harvest House outreach work on Jefferson Avenue in Buffalo. Indeed, there are many dedicated members who volunteer their time to provide oral health support to people requesting services through the clinic. These efforts have consistently provided well over $300K annually for dental health and are to be commended and recognized. It has been a staple of the Foundation's mission for over 20 years.

Conversely, the level of society-based participation in CE activities has begun to dry up, which has placed the foundation in a poor cash flow reality of sorts. Funding for CE activities use to be a real catalyst for the foundation fund in general, but in recent years, the cost to run in-person events and All-Day seminars has been harder to sustain, even though our All-Day events have restricted funds to support them.

We are not replacing or increasing our fiscal base but taking more from it without sufficient funds to cover the many programs, scholarships or the other outreach efforts we would like to continue. At some point, we are going to have to scale back outreach or increase our donations or revenue.

There are developing plans to consider other fundraising efforts like meat raffles. We are working with President Hinchy to consider an event of this type soon. Again, interest will drive more fiscal support to our foundation. Consider donating to the Capital Campaign or attending more CE events like the spring and fall All-Day lectures. These things can help the Foundation maintain its viability. If you have any ideas or suggestions for the Board to consider, please share them.

Best regards,

Dr. Nicole Hinchy
President

Trustee's Corner

Eighth Letter from the ADA Second District to the NYSDA Components
By: Dr. Brendan Dowd

Spring is here and it is even warming up in my hometown of Buffalo. I hope all of you and your families have made it through the winter in good order and are looking forward to an enjoyable summer. There have been several changes at the American Dental Association, and I will try to get you up to speed with my correspondence to you. To begin with, we are officially in our new headquarters on the top four floors of a 35-floor building at 401 North Michigan Avenue in Chicago. We have a very agreeable long-term lease and just completed the leasehold improvements in February. If you make a trip to Chicago any time soon, please stop by for a tour. The view is spectacular, and the location is second to none.

There has been a change at the top of the ADA administration. Our previous Executive Director, Dr. Ray Cohlmia, stepped down from the position in early February this year. The decision was reached amicably, and the ADA Board is extremely proud of Dr. Cohlmia's service to our organization. We continue to follow his vision for the ADA and hope to see many of the projects he and the ADA Board agreed upon over the past four years come to fruition and/or be completed. Dr. Cohlmia worked incredibly hard during his tenure at the ADA, and we are extremely grateful for his service. In the meantime, Dr. Betsy Shapiro was unanimously approved by the Board as Interim Executive Director. Dr. Shapiro previously served as Chief of Governance and Strategy Management. She originally graduated from dental school at the University of Illinois Chicago College of Dentistry and was in private practice for several years. She has a Juris Doctor from Northern Illinois University. Dr. Shapiro began her career at the ADA as a Hillenbrand Fellowship scholar and ended up staying at the ADA working in many different areas of the organization. The ADA Board is very pleased to have Dr. Shapiro as our interim Executive Director as we conduct a national search for a permanent director.

I would like to apologize to all our members due to the delay of the implementation of the Salesforce Fonteva IT program. Unfortunately, there have been many technical challenges. The ADA has received the help of an external consulting firm, Datazuum, to assist us with a health check of the system and implementation. It considered the overall system health rating "at risk" and recommended targeted remediation to stabilize and standardize the program over the next several months. Remediation will be discussed with the states and the Strategic Forecasting Committee during that time. Although this will take some time, the American Dental Association believes we are making progress and taking the proper corrective measures to get our organization on the right path.

The ADA credit union will be scheduled to launch at the end of Q3 or early Q4 of this year. As many of you know, this has required much background work and due diligence over the past year. The ADA is finishing the final touches on a contract with an established credit union with extensive experience in this area to provide financial services to all ADA members and their families. You will be receiving information on this exciting venture in the very near future.

I spoke to you in my last Trustee's Corner about water fluoridation, but the landscape has changed even more since our last correspondence. The entire state of Utah has passed a law to eliminate water fluoridation in their state. Approximately fifteen other states are discussing it at various levels of their legislative process. Countless other municipalities nationwide have it under review. Not all the news is bad though. New Hampshire just reaffirmed its commitment to water fluoridation as did North Dakota. It is a state by state and municipality by municipality battle, depending on your location in the country. Albion, New York, located between Buffalo and Rochester, has had a hearing about it and will have another one later in the spring.

(Continued on Page 23)

EDDS Program Committee

Redefining our Continuing Education Plans

The Executive Council of the 8th District had an active Program Committee for years. The purpose of the committee was to help shape the services surrounding continuing education (CE) and other ways to support member programming in general.

For the past five years or more, the committee stopped meeting, perhaps because of the nature of the changing face of CE during the pandemic and that dentists and other licensed dental professions were allowed by NYSED to get their required credits directly online or virtually, since in-person sessions were not allowed for almost a 10–13-month period. While in-person sessions restarted in 2021, attendance had not returned to pre-pandemic participation levels.

Last December, it was announced that the UB School of Dental Medicine was ending their support for CE services outside of the annual Alumni Association Fall Meeting in November, which has been running for over 46 years. The revenue generated from services at UB was not sufficient to keep the program and staff operational, so the office closed. The types of seminars varied, but there are literally hundreds of ways dental professionals can secure their required courses for recertification.

As a result of learning about this change, the Executive Council reinstated the Program Committee in March 2025 to begin to review CE outreach, and determine what, if anything, the district should do to fill the void created by this closure. The Committee is being Chaired by Dr. Bochiechio and have met twice to discuss a series of activities and what we can learn from committee members, society members, and faculty at the dental school about CE interests. Two surveys have been developed, one targeted to our members and the other for dental school faculty to better understand their interests in courses and seminars. The hope is to develop new ideas and efforts around CE and even perhaps develop a regional speaker's bureau for topics and formats for the coming years.

A survey link will be shared with the membership in the coming week and with our Weekly Update emails with a deadline for the end of August to take in feedback. A series of prizes will be raffled off to incentivize the effort to participate and get a solid representation of both groups for development.

Please support your thoughts on this important topic for the committee and our district outreach.

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Dental Review

Handicapping Labio-Lingual Deviation (HLD) Index Report

Provider Name:_____ NPI: _____

Recipient Name:_____ CIN:_____ Age:_____

Instructions: (*Assistance from a recorder/hygienist is recommended.*)

1. Position the patient's teeth in centric occlusion;
2. Record all measurements in the order given and round off to the nearest millimeter (mm);
3. Enter a score of "0" if the condition is absent;
4. Enter the requested provider and patient information above. Provider must sign and date at the bottom;
5. Use the accompanying "HLD Index Scoring Instructions" for guidance in completion of the assessment;
6. Submit pages 1 and 2 along with a prior approval request and all necessary diagnostic and supporting documentation (refer to the "Dental Policy and Procedure Code Manual").

Condition	HLD Score
The Conditions In This Section Automatically Qualify For Treatment	
Cleft palate deformity or cranio-facial anomaly. *Indicate an "X" if present and score no further.*	
Deep impinging overbite with severe soft tissue damage. *Indicate an "X" if present and score no further.*	
Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present. *Indicate an "X" if present and score no further.*	
Severe traumatic deviations. *Indicate an "X" if present and score no further.*	
Impacted permanent anteriors where extraction is not indicated. *Indicate an "X" if present and score no further.*	
Overjet greater than 9mm with incompetent lips or reverse overjet greater than 3.5mm with reported masticatory/speech difficulties. *Indicate an "X" if present and score no further.*	
The Conditions In This Section Must Total 26 Or More To Qualify For Treatment	
Overjet equal to or less than 9mm	
Overbite in mm	
Mandibular protrusion (reverse overjet) in mm equal to or less than 3.5mm	_____ x 5 = _____
Open bite in mm	_____ x 4 = _____
If both anterior crowding and ectopic eruption are present in the anterior portion of the mouth, score only the most severe condition. Do not score both conditions.	
Ectopic eruption: Count each tooth, excluding 3rd molar.	_____ x 3 = _____
Anterior crowding: Score one point for MAXILLA, and/or one point for MANDIBLE; two (2) points maximum. Multiply by five (5).	_____ x 5 = _____
Labio-Lingual spread (in mm)	
Posterior unilateral crossbite (involving at least one molar): Score 4 if present.	
Total Score	_____

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NOTE: IF A PATIENT DOES NOT MEET ONE OF THE AUTOMATIC QUALIFYING CONDITIONS AND DOES NOT SCORE **26 OR ABOVE** ON THE HLD INDEX, HE/SHE MAY BE ELIGIBLE FOR SERVICES DEPENDENT UPON PROFESSIONAL ASSESSMENT OF THE DOH IF MEDICAL NECESSITY IS DOCUMENTED. ATTACH MEDICAL EVIDENCE AND APPROPRIATE DOCUMENTATION FOR EACH OF THE FOLLOWING EIGHT AREAS ON A SEPARATE PIECE OF PAPER IN ADDITION TO COMPLETING THE HLD SCORE SHEET ABOVE.

1. Principal diagnosis and significant associated diagnosis; and,
2. Prognosis; and,
3. Date of onset of the illness or condition and etiology if known; and,
4. Clinical significance or functional impairment caused by the illness or condition; and,
5. Specific services to be rendered by each discipline and anticipated time for achievement of goals; and,
6. Therapeutic goals to be achieved by each discipline and anticipated time for achievement of goals; and,
7. Extent of previous services that were provided to address the illness/condition and results of the prior care; and,
8. Any other relevant documentation available which may assist the DOH in making a determination.

All requests for authorization must include:

- A completed and signed HLD analysis and narrative describing the nature of the severe physically handicapping malocclusion, along with any documentation relevant to determining the nature and extent of the handicap; and,
- A panoramic and/or mounted full mouth series of intra-oral x-rays; and,
- A cephalometric x-ray with teeth in centric occlusion and cephalometric analysis / tracing; and,
- Photographs of frontal and profile views; and,
- Intra-oral photographs depicting right and left occlusal relationships as well as an anterior view; and,
- Maxillary and mandibular occlusal photographs; and,
- Photos of articulated models can be submitted optionally *(Do **NOT** send stone casts)*.

Subjective statements submitted by the provider or others must be substantiated by objective documentation such as photographs, radiographs, credible medical documentation, etc. verifying the nature and extent of the severe physical handicapping malocclusion. Requests where there is significant disparity between the subjective documentation (e.g. Handicapping Labio-Lingual Deviation (HLD) Index Report) and objective documentation (e.g. photographs and / or x-rays) will be returned for clarification without review.

Refer to the NYS "Dental Policy and Procedure Code Manual" for additional instructions and submission requirements. The "Dental Policy and Procedure Code Manual" can be found on the internet at:

http://www.emedny.org/ProviderManuals/Dental/index.html

I certify that I am the furnishing provider and that all of the information and documentation submitted is true, accurate and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal penalty and/or prosecution under applicable federal and state laws.

Provider's Signature: _____ Date: _____

HLD Index Scoring Instructions

The intent of the Handicapping Labio-Lingual Deviation (HLD) Index is to measure the presence or absence and the degree of the handicap caused by the components of the Index and not to diagnose "malocclusion." All measurements are made with a Boley Gauge (or a disposable ruler) scaled in millimeters. Absence of any conditions must be recorded by entering "0" (refer to attached score sheet).

The following information is provided to help clarify the categories on the HLD Index Report:

Cleft Palate Deformities or Cranio-Facial Anomaly: Indicate an "X" on the score sheet and do not score any further if present. This condition is considered to be a handicapping malocclusion. Documentation must include photographs and a written report from a qualified specialist(s) treating the deformity / anomaly.

Deep Impinging Overbite with Severe Soft Tissue Damage: When the lower incisors are destroying the soft tissue of the palate. Tissue laceration and/or clinical attachment loss must be present. Indicate an "X" on the score sheet and do not score any further if present. This condition is considered to be a handicapping malocclusion.

Crossbite of Individual Anterior Teeth: When clinical attachment loss and recession of the gingival margin are present. Indicate an "X" on the score sheet when destruction of soft tissue is present and do not score any further. This condition is considered to be a handicapping malocclusion.

Severe Traumatic Deviations: Traumatic deviations include loss of a premaxilla segment by burns or by accident, the result of osteomyelitis or other gross pathology. Include a written report and photographs. Indicate with an "X" on the score sheet and do not score any further. This condition is considered to be a handicapping malocclusion.

Impacted Permanent Anterior Teeth: Demonstrate that anterior tooth (teeth) (incisors and / or cuspids) is (are) impacted (soft or hard tissue); exposure and passive eruption is unlikely; extraction would compromise the integrity of the arch; and, the tooth (teeth) are treatment planned to be exposed ligated / banded and brought into the normal arch form; and, there is, or will be sufficient arch space for correction. Indicate with an "X" on the score sheet and do not score any further. This condition is considered to be a handicapping malocclusion.

Overjet Greater than 9mm or Mandibular Protrusion (reverse overjet) is Greater than 3.5mm: Overjet is greater than 9mm with incompetent lips or the reverse overjet (mandibular protrusion) is greater than 3.5mm with reported masticatory and speech difficulties. Indicate with an "X" on the score sheet and do not score any further. This condition is considered to be a handicapping malocclusion. If the reverse overjet is not greater than 3.5mm, score under the "Mandibular Protrusion in Millimeters" item.

Overjet Equal to or Less than 9mm: This is recorded with the patient's teeth in centric occlusion and measured from the labial portion of the lower incisors to the labial of the upper incisors. The measurement may apply to a protruding single tooth as well as to the whole arch. Round this measurement to the nearest millimeter and enter on the score sheet.

Overbite in Millimeters: A pencil mark on the tooth indicating the extent of overlap facilitates this measurement. Round off to the nearest millimeter and enter on the score sheet. "Reverse" overbite may exist in certain conditions and should be measured and recorded.

Mandibular Protrusion (reverse overjet) equal to or less than 3.5mm in Millimeters: Score exactly as measured from the labial of the lower incisor to the labial of the upper incisor. The measurement in millimeters is entered on the score sheet and multiplied by five (5). A reverse overbite, if present, should be shown under "overbite."

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Open Bite in Millimeters: This condition is defined as the absence of incisal contact in the anterior region. It is measured from edge to edge in millimeters. Enter the measurement on the score sheet and multiply by four (4). In cases of pronounced protrusion associated with open bite, measurement of the open bite is not always possible. In those cases, a close approximation can usually be estimated.

Ectopic Eruption: Count each tooth, excluding third molars. Each qualifying tooth must be more than 50% blocked out of the arch. Enter the number of teeth on the score sheet and multiply by three (3). If anterior crowding is present with an ectopic eruption in the anterior portion of the mouth, score only the most severe condition. DO NOT SCORE BOTH CONDITIONS. However, posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the same arch.

Anterior Crowding: Arch length insufficiency must exceed 3.5mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. Enter five (5) points each for maxillary and mandibular anterior crowding. If ectopic eruption is also present in the anterior portion of the mouth, score the most severe condition. DO NOT SCORE BOTH CONDITIONS. Posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the same arch.

Labio-Lingual Spread: Use a Boley Gauge or a disposable ruler to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to the normal arch line. Otherwise, the total distance between the most protruded anterior tooth and the most lingually displaced anterior tooth is measured. The labio-lingual spread probably comes close to a measurement of overall deviation from what would have been a normal arch. In the event that multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for labiolingual spread, but only the most severe individual measurement should be entered on the index.

Posterior Unilateral Crossbite: This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may either be both palatal or both completely buccal in relation to mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a score of four (4) on the score sheet. **THERE IS NO SCORE FOR BI-LATERAL CROSSBITE.**

(Continued from Page 3)

The most unfortunate factor is the rhetoric of our HHS Secretary in Washington, DC, Robert Kennedy Jr. He has called water fluoridation a toxic process and should be eliminated nationally. Although there is a plethora of well-done evidence-based studies over the past 80 years, he and the anti-fluoridation folks point to poorly controlled dubious international studies that have faulty conclusions. It is sad we have reached this point in our country where some of our national leaders do not understand settled science.

The ADA will not lay down due to this national trend. We have started an ADA Fluoride Ambassador program to sign up an army of dentists, hygienists, physicians, nurses, and community leaders to be ready to testify, be interviewed or provide information as needed all around the country as these hearings are announced. Currently, we have 72% of the communities in this country with properly titrated fluoridated water at .7 parts per million. The goal is to keep it at that level or increase the percentage, along with keeping a running tab of the outcomes to keep practicing dentists apprised of what is going on. The purpose is to keep our members informed to treat their patients properly as things change.

Thank you for letting me continue to serve you as your ADA Trustee and please email me at dowdb@ada.org or call me at 716-510-3217 if you have any questions. Enjoy your summer!

Sincerely,
Brendan Dowd DDS,
ADA Trustee - Second District

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