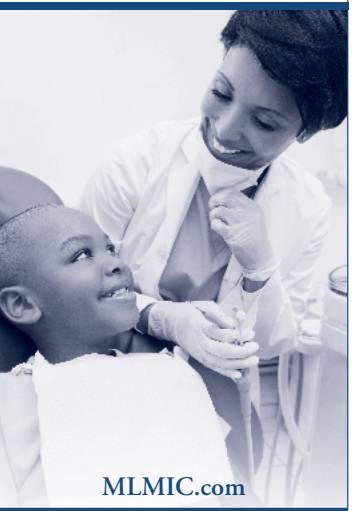
MLMIC

Dental DATELINE

A NEWSLETTER FOR MLMIC-INSURED DENTISTS

Fall 2016

Inside



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To Defend or Settle – The NYSDA Professional Liability District Claims Review

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A hazard of the dental profession is that patients can file lawsuits against you for treatment you did or did not provide to them. To cover this risk, most dentists maintain professional liability insurance coverage, also known as malpractice insurance. Although there is no legal requirement by the State of New York to have this coverage, virtually all dentists have it to protect themselves and their practices. In addition, most insurance companies require it if you are one of their participating providers.

If you are served with a malpractice claim and you are insured by a policy endorsed by NYSDA or one of its component societies, your claim will be reviewed by the NYSDA Professional Liability Claims Review (PLCR) program. This program has been in effect since 1975, is administered by the NYSDA Council on Professional Liability Insurance, and is implemented by subcommittees of the council within each component, hence, its better known designation, District Claims Review. The primary purpose of the PLCR function is to have local committees of your peers review the malpractice case and instruct the insurer whether to settle or defend it. NYSDA has an agreement with Medical Liability Mutual Insurance Company (MLMIC) which states:

"NYSDA Professional Liability Claims Committees will review and make determinations regarding individual claims pursuant to policy provisions consistent with past practice and procedures in accordance with the NYSDA Professional Liability Claims Review Guidelines…."

In addition, each policy issued under the NYSDA-MLMIC Professional Liability program carries this provision:

"We will not settle a ***Claim*** *without the written consent of a majority of the members of your component Society's District Claims Committee of the New York State Dental Association. The decision of this Committee is binding on both you and us."*

The PLCR process was instituted to assist member dentists of NYSDA who become involved in professional liability actions.

The process involves a group of independent dentists who will review the facts of the case and interview the den-

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tist. This process often includes the dentist's defense attorney assigned by the carrier, who will also provide information about the case. In accordance with the PLCR program guidelines, the reviewers provide objective, clear, reasoned, and impartial review. This results in a well-reasoned, thoughtful course of action for the member.

It is beneficial to have this process in place to avoid those instances where one may feel it's better to "save yourself the aggravation" and just settle a defensible claim. Though the insurance company may pay the settlement amount, the effects of settling a claim include:

- automatic reporting to the National Practitioner Data Bank;
- claims history that may jeopardize future insurability;
- automatic reporting of the settlement to the New York State Office of Professional Discipline; and
- claims history that may jeopardize participation in some dental benefit plans.

The PLCR process may, indeed, cause some stress, but most members who were initially reluctant to undergo the process often end up finding the experience to be collegial and informative.

When an incident occurs, the proper course of action is to notify your insurance carrier. The carrier will open an incident file and advise the dentist of his or her options. Should the incident evolve into a malpractice suit, an attorney will be assigned and the case will be reviewed internally. The finding of that review is not included in the case material sent to the claims committee.

When sufficient material on the case is gathered (that is, case synopsis, bill of particulars, patient records, deposition reports, etc.), a meeting of the local claims review committee is scheduled at the request of the insurance carrier. The committee chairperson notifies members of the meeting date, time, and place, and tells them to expect to receive the case materials from the insurance carrier. The insurance company then notifies the defendant dentist. The policyholder is requested to bring original records and radiographs and be prepared to discuss the case. Also invited to the meeting are the defendant's attorney, the insurer's representatives and, if deemed necessary, consultants requested by the committee. Consultants provide input only; they do not vote.

The PLRC committee is composed of at least five members in good standing. Most have served on the committee for many years. Committee members serve without compensation, volunteering their time and expertise for the benefit of their fellow members. The material they receive in advance of the meeting is extensive and requires many hours of reading to become familiar with the case.

All proceedings of the committee are strictly privileged and confidential. Members are not permitted to discuss the case with anyone outside of the review process. Should a committee member have a compelling relationship with the defendant, or have been involved with the plaintiff's treatment, he or she is required to recuse himself or herself from the case. The defendant is told who the committee members are and, if there is a conflict, a member can be recused. In rare instances, another component can review the case with the approval of the chair of the Council on Professional Liability Insurance.

If the insured fails to attend the meeting, it is postponed one time. After that, if the insured does not attend, the case will be decided without his or her input. Committee proceedings are not adversarial or contentious. Committee members have experienced the complexities and pitfalls of dental practice and are cognizant that anyone, no matter how diligent, could find himself or herself in a similar predicament. They understand the range of emotions the defendant can experience including embarrassment, indignation, and anger, and they conduct the meeting with professionalism and respect.

The meeting usually begins with the chairperson requesting that the defendant dentist discuss the particulars of the case and how the treatment evolved. This discussion adds to the information received prior to the meeting. Original records, radiographs, and any other pertinent material are passed around. Questions are asked of the defendant, as well as the defendant's attorney and the insurance representatives. The defendant is also given time to ask any questions he or she may have for the committee. This process helps everyone involved better understand the dynamics of the case. The defendant is usually asked whether he or she prefers to settle or defend. The committee will take

the answer into consideration as they evaluate the strengths and weaknesses of the case. When the committee feels it has sufficient information, the defendant is asked to leave the room while the members deliberate.

After the decision to defend or settle is made, the defendant dentist is usually invited back into the room and is informed of the committee's decision. In some instances, the defendant dentist will be informed of the decision by mail. The chairperson then files a Statistical Report Form (listing the participants at the meeting and the decision to defend or settle) with NYSDA and the insurance carrier. The report form only lists what type of case it is (e.g., endodontics, periodontics, etc.) and if the case is to be defended or settled. This is the only report generated by the committee. All material provided to committee members is then returned to the carrier and/or destroyed.

Sometimes, after a decision is rendered, new information may come to light, the case may deteriorate during trial, or, if a settlement was recommended, the plaintiff may continue to make an unreasonable demand. In these cases, the committee's decision could be reconsidered and changed. If time allows, this can be done in consultation with committee members. Lawsuits, however, are fluid and may progress unexpectedly, requiring a quick response. The claims review committee program guidelines allow the PLCR committee chairperson to change a decision for the full committee, "if conditions warrant such an action by a significant and material change in circumstances." The chairperson must find the reported development very compelling to reverse a decision.

It is important that NYSDA members understand that the claims review process is a unique member benefit. It provides an objective, clear, reasoned, and impartial review of their case. It is a peer-based review designed to protect and serve Association members. ◆

CDC Publishes New Guidelines on Infection Control

The Centers for Disease Control and Prevention (CDC) has published a new resource on basic infection control and prevention in dental settings, including the original 2003 guidelines. A new checklist facilities may use when assessing current practices and procedures against CDC standards has been added. In addition, the document calls for an infection prevention coordinator on staff to develop infection control policy: "At least one individual with training in infection prevention—the infection prevention coordinator—should be responsible for developing written infection policies and procedures based on evidence-based guidelines, regulations, or standards."

For more information, visit http://www.cdc.gov/oralhealth/infectioncontrol/guidelines/index.htm ◆

MLMIC and Berkshire Hathaway – What You Need to Know

Medical Liability Mutual Insurance Company (MLMIC) recently announced that it has entered into a definitive agreement, pending regulatory and policyholder approval, to be acquired by National Indemnity Company, following the completion of the conversion of MLMIC to a stock company from a mutual company. National Indemnity Company is a subsidiary of Berkshire Hathaway Inc., one of the world's leading insurance organizations. The transaction is expected to close in the third quarter of 2017, subject to customary closing conditions and regulatory approvals.

Questions and Answers about MLMIC's Sponsored Demutualization

1. What is occurring?

MLMIC, as a mutual insurance company, is currently owned by its policyholders. Policyholders' ownership interests in MLMIC are known as "Policyholder Membership Interests." These Policyholder Membership Interests include the right to vote on matters submitted to a vote of members (such as the election of directors) and the right to participate in any distribution of surplus, earnings and profits.

Demutualization is the process by which a mutual insurance company converts from a company that is owned by its policyholders into a stock insurance company that is owned by its shareholders. In a sponsored demutualization, the stock of the converted mutual is acquired by a sponsor. National Indemnity Company ("Sponsor"), a subsidiary of Berkshire Hathaway Inc., is the sponsor of the proposed demutualization of MLMIC. If the proposed demutualization of MLMIC is approved by both policyholders and the New York State Department of Financial Services (the "Department"), and the conditions are satisfied or waived in accordance with the plan of conversion and the acquisition agreement, all Policyholder Membership Interests will be extinguished, and Sponsor will become the sole owner of MLMIC.

2. Why is MLMIC demutualizing?

After careful deliberation, the Board of Directors of MLMIC determined that becoming a wholly owned subsidiary of the Sponsor following the completion of the demutualization, and thereby becoming a member of the Berkshire Hathaway group of companies (the "Berkshire Hathaway Group") is in the best interests of MLMIC and its policyholders because, among other things: such affiliation will help ensure the continuity of MLMIC's medical professional liability insurance and other business and will

enhance the competitiveness of MLMIC; MLMIC will become a member of a group that includes other insurers that specialize in providing liability insurance coverage to healthcare providers. The affiliation will provide additional healthcare contacts and insights for MLMIC; such affiliation will enhance MLMIC's financial strength and will provide MLMIC with greater resources to back its obligations to policyholders and to underwrite additional business; and such affiliation will provide MLMIC with increased flexibility to support the growth of existing product lines.

3. Why is Berkshire Hathaway interested in acquiring MLMIC?

Berkshire Hathaway values our operations, Board of Directors, staff and endorsed partners and is committed to MLMIC's future success and its dedication to serving policyholders. Berkshire Hathaway's CEO Warren Buffett said, "MLMIC is a gem of a company that has protected New York's physicians, mid-level providers, hospitals and dentists like no other for over 40 years. We welcome the chance to add them to the Berkshire Hathaway family and enhance their capacity to serve these and other policyholders for many years to come."

4. Will MLMIC get a rating from A.M. Best?

MLMIC is currently not rated by A.M. Best but will seek a rating from them once the transaction closes. National Indemnity Company is rated A++ by A.M. Best.

5. Will policyholders receive a payout?

Once the transaction is completed, each owner of an eligible policy will be entitled to receive a proportionate share of all of the cash consideration paid by National Indemnity Company. In most cases, the person or entity that paid the premium will be considered as the owner of the eligible policy. As required under the New York Insurance Law, proportionate shares will be determined by dividing the premium paid on each eligible policy from July 14, 2013, through July 14, 2016, by the total premium MLMIC received for all policyholders during that period. Such proportionate share will then be multiplied by the cash consideration received from National Indemnity Company to determine the amount of cash allocable to such policyholder. We currently estimate that each owner's cash entitlement will be approximately equal to the sum of the premiums paid to us on the applicable eligible policy during such three-year period. Please note that this is an estimate only and that the actual amount will be determined as of closing and in accordance with all applicable New York insurance law and regulatory requirements. Policies issued with an effective date on or after July 15, 2016, will not be eligible for this cash payout.

6. Is the receipt of cash by owners of eligible policies taxable?

The receipt of cash by owners of eligible policies will be a taxable transaction for U.S. federal income tax purposes.

7. Will any MLMIC director, officer or staff member receive a payout?

No MLMIC director, officer or staff member will receive any of the cash consideration payout from National Indemnity Company in connection with the transaction other than any proportionate share such person is entitled to receive in their capacity as an eligible policyholder.

8. Will policyholders continue to be owners of MLMIC?

Following the conversion from a mutual to a stock company (and subsequent acquisition by Sponsor), policyholders will no longer have an ownership interest in MLMIC and all Policyholder Membership Interests will be extinguished.

9. How will the demutualization and acquisition affect my insurance policy?

Policyholders will see no change in MLMIC's operations and commitment to policyholder-first service. Consummation of the sponsored demutualization will not increase premiums or reduce the coverage under your Policy.

10. Will policyholders continue to receive dividends?

After the transaction is completed, policyholders will no longer have an ownership interest in MLMIC and, as such, will not receive any dividends.

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Consent Issues: Treating Patients with Developmental Disabilities

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It can often be complicated to obtain consent for dental treatment and dental surgery procedures for patients with developmental disabilities who lack capacity. The manner of obtaining consent may well depend upon the age and living arrangements of the patient. Some individuals live at home with families, while others live in group homes or facilities regulated or operated by the New York State Office for People with Developmental Disabilities (OPWDD). State regulations governing who can provide consent apply only to those individuals who live in state regulated settings. However, most medical facilities and dental and medical providers use the state regulations as a guideline for obtaining consent for noninvasive treatment for all patients, even adults who still live with their families.

Minors and Patients Who Live at Home

When a minor patient who lacks capacity due to developmental disabilities lives at home with family, in most instances, parental consent for treatment can be accepted. However, once the minor reaches the age of 18, obtaining consent for treatment from parents may not be appropriate. There are some developmentally disabled individuals who have sufficient capacity to appoint a healthcare agent who can consent to healthcare and dental treatment. Further, if other developmentally disabled patients who are 18 years of age or older have sufficient capacity to understand the disclosures necessary to make a decision about treatment, the consent of those individuals is sufficient. This includes the consent to noninvasive low risk procedures such as dental examinations and cleanings. In those instances, obtaining consent for treatment is not complex but does require thorough documentation of the patient's capacity. All of this is applicable to treatment which is neither complex nor high risk.[1]

1. 14 N.Y.C.R.R. § 633.11 (a)(1)(f).

When the proposed dental treatment is invasive, requires hospitalization, or carries high risk and there is no healthcare agent, consent for individuals living at home for the proposed treatment should be obtained either from a court-appointed guardian or by obtaining a court order. Unfortunately, bringing a court proceeding to appoint a legal guardian is often an expensive proposition. Many families cannot afford to do so and often opt not to have a legal guardian appointed. When this occurs, the provider or facility must seek a court order to obtain consent to high risk/invasive treatment.

Minors Who Live in a Facility Operated or Regulated by OPWDD

If the developmentally disabled individual is younger than 18 years of age and lives in a group home or

other facility, consent for treatment must be obtained from a surrogate, in priority order as follows:

1. a legal guardian;
2. an actively involved spouse or parent;
3. an actively involved adult sibling;
4. an actively involved adult family member;
5. the local Commissioner of Social Services who has custody of the patient under the Social Services Law;
6. a Public Health Surrogate under the Family Health Care Decisions Act (only in the hospital);
7. a surrogate decision making committee (SDMC); or
8. a court of competent jurisdiction.[2]

"Active involvement," for the purpose of giving consent for a procedure, is defined by law as having significant and ongoing involvement in the disabled person's life to enable the individual to obtain personal knowledge of the patient's needs.[3] When there is no other individual who is able to provide consent, a surrogate decision making committee is to be used. The committee consists of 12 individuals who, by law, can decide whether the proposed treatment at a state owned or operated facility is in the best interests of the developmentally disabled patient. The committee then provides written consent for such treatment, if indicated.[4] The local Developmental Disabilities Service Organization (DDSO) agency can provide information about how to contact such a committee if this becomes necessary.

Adult Patients Who Live in an OPWDD Operated or Regulated Facility

When a developmentally disabled patient who lacks capacity is 18 years of age or older, informed consent for treatment can be obtained in priority order from:

1. a legal guardian;
2. the patient's duly appointed Health Care Proxy or alternate agent;
3. an actively involved spouse or parent;
4. an adult child;
5. an adult sibling;
6. an adult family member;
7. the Consumer Advocacy Board for Willowbrook Class members only;
8. a surrogate decision making committee; or
9. a court of competent jurisdiction.[5]

The highest surrogate on the priority list who is available and willing to make a timely decision, given the circumstances of the patient's dental condition, can provide consent if other individuals with higher priority are neither willing nor available to make a decision. If there is more than one person who is in the same priority class, the individual who is the most actively involved with the patient should give consent. If, however, members of the same priority class are equally actively involved, either person may give consent.[6] If the surrogate highest in priority objects to the proposed treatment and refuses to provide consent, the dentist cannot override that surrogate's decision by asking for consent from individuals in a lower priority class. If the highest level surrogate does refuse consent and the dentist believes treatment is clearly reasonable and necessary, the dentist or hospital, if one is involved, must instead seek approval for the proposed treatment from a court or a surrogate decision making committee.[7] If the proposed treatment does not require informed consent, any party can file an objection to the proposed treatment with the local Director of the Developmental Services Organization (DDSO).[8]

In summary, there are a myriad of laws and regulations governing how to obtain consent for the dental treatment of a developmentally disabled patient. As noted, obtaining consent may differ depending on the patient's age, residence, and capacity. However, with legal guidance, dentists may now obtain consent for all treatment decisions for OPWDD patients more easily than in the past.

If you have any questions about how to obtain consent for the treatment of a developmentally disabled patient who lacks capacity and has no guardian, please contact counsel at Fager Amsler Keller & Schoppmann, LLP for guidance. ◆

2. 14 N.Y.C.R.R. § 633.11 (a)(1)(iii)(a).
3. 14 N.Y.C.R.R. § 633.99 (ax).
4. Mental Hygiene Law §§ 80.05 (a), 88.07 (f).
5. 14 N.Y.C.R.R. § 633.11 (a)(1)(b).
6. 14 N.Y.C.R.R. § 633.11 (a)(1)(c, d).
7. 14 N.Y.C.R.R. § 633.11 (a)(1)(e).
8. 14 N.Y.C.R.R. § 633.11 (a)(2).

Case Study

Inadequate Knowledge of Patient's Complex Medical Problems Results in Mandibulectomy

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A 62-year-old married male with a complex medical/surgical history was a longstanding patient of the insured general dentist. The patient had been diagnosed in August 2001 with Stage IV squamous cell carcinoma of the supraglottic larynx and base of the tongue. He was a patient of Memorial Sloan Kettering Cancer Center (MSKCC) and was initially treated with concomitant chemotherapy and head/neck radiation therapy, followed by a right modified neck dissection. The patient had a permanent tracheostomy, required PEG feedings, and developed xerostomia after his treatment. In December 2002, he was diagnosed with a right side skull base metastasis. The patient again underwent head/neck radiation therapy through January 2003. Subsequently, the patient was followed regularly by his treating physicians at MSKCC. His condition remained stable, with no evidence of recurrent disease.

After an approximate two year hiatus, the patient was seen at the dentist's office on 2/18/06 for a full mouth series of X-rays. The dentist did not document the patient's health status, the many medications he took, or the condition of his dentition and oral cavity. Although the dentist was fully aware of the patient's medical history, his record contained scant information regarding the patient's cancer and subsequent radiation treatment. He also failed to document any discussions with the patient about the proposed treatment plan. The dentist later recounted to defense counsel that the treatment plan was to "…clean the bad teeth, extract the ones that could not be saved and then do implants or other work" at a cost of more than $10,000.

On 2/24/06, the patient was seen for an "exam and consult." There was no other documentation in the record. On 3/3/06, the dentist extracted teeth #30 and #31. The dentist's notes reflect: "models taken for flipper. #30 surgically extracted, 3-4.0 chromic gut sutures. #31 one suture." On 3/7/06, the dentist documented: "observation, patient lower right quad small 3mm exposed bone lingual to #31. Removed sutures. RX: Amoxicillin 500 mg and saline rinses." The patient did not keep his next appointment on 3/13/06. However, the patient did return to see the dentist on 4/7/06. At that visit, the dentist documented that he did the following: "lower left and lower right quads scaled. Recemented #20. Impression for flipper (temp removal partial). Sent to lab. NV: extract #23, #24 and #25."

The patient cancelled the appointment scheduled for 5/11/06 and next saw the dentist on 6/13/06. The record stated: "one carp Articaine. Infiltration, #19 filling. NV: upper right quad and upper left quad scaling and curettage." On 6/26/06 the dentist performed: "upper right quad, scaling and curettage, #6 filling." On 8/7/06, the record states: "polish bony edge." On 8/24/06, the dentist documented: "upper left scaling and curettage. #15 filling. NV: models for flipper tooth #5." On 9/11/06, he documented: "#5 models for flipper sent to lab, shade C-3." On 10/30/06, he documented: "#5 extracted, one carp Xylocaine. Two 4.0 sutures."

The patient's last visit was on 11/3/06. The dentist documented: "adjust upper flipper. Lower right quad bone still not covered, lingual to tooth #31. Will contact patient's MD at Sloan Kettering when patient gets name and number." However, on 11/9/06 the dentist advised the patient by telephone to "consult with (oral sur-

geon) re: lingual exposed bone." When the patient returned to MSKCC on 12/11/06, his physician was advised that he had an area of exposed bone in the #32 lingual region. He referred the patient to an oral surgeon at the facility for evaluation. On 1/17/07, the oral surgeon documented that the area appeared to be exposed bone and was not a residual extraction site. The patient had marked trismus. Periapical pathology was seen at #18. The oral surgeon decided to initially treat the patient conservatively with antibiotics, Peridex rinses, and observation. He also was given mouth opening exercises for the trismus.

By February 28, 2007, the oral surgeon suspected that the patient had osteoradionecrosis (ORN) of the right mandible. This was subsequently confirmed on panorex. The patient complained of continuous pain over the right mandible. Additionally, he continued to suffer from trismus and was unable to remove his partial dentures. Over the ensuing months, the patient was followed closely by both medical and dental experts at MSKCC. He was treated conservatively with analgesics and Peridex rinses. However, he began to complain of increased jaw pain and persistent trismus. By November 2007, the pain in his right jaw had greatly increased. A CT of his head, performed on 12/18/07, confirmed progressive ORN with a non-displaced pathologic fracture. On 4/22/08, panorex studies revealed significant progression of the ORN in the right mandible and confirmed the fracture. Therefore, the patient was advised to undergo a right partial mandibulectomy with reconstruction.

On 5/29/08, the patient was admitted to MSKCC for a right partial mandibulectomy and right intraoral reconstruction using a pectoralis major myocutaneous flap and split thickness skin graft to his neck. He subsequently required many months of recovery and rehabilitation from this surgery.

During the pendency of the law suit, the dentist admitted to his defense counsel that he did not have much experience with cancer patients. The dentist advised that the "rule of thumb" is for a patient to complete dental work prior to undergoing cancer treatment, especially extractions. He also believed that no treatment should be done for six months following cancer therapy. Although there was no supporting documentation in the patient's dental record, the dentist claimed that he consulted with an oral surgeon about performing extractions and then placing implants in a patient who has undergone chemotherapy and radiation. He further claimed that the oral surgeon advised him that because the radiation had occurred several years before, no precautions were required.

The dental and medical experts who reviewed the case on behalf of the insured opined that defense of the case would be difficult on a number of levels. First, the dentist's records contained inadequate documentation of the patient's medical history, cancer treatment, complaints, observations, a discussion of the treatment plan, and an informed consent containing the alternatives to extraction. Additionally, due to the dentist's lack of experience treating patients who

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Case Study *continued from page 9*

had received radiation for head and neck cancer, the experts felt that, at a minimum, he should have obtained pre-operative clearance from the patient's physicians at MSKCC.

They also concurred that the dentist was misinformed in his belief that the extractions could be performed after radiation therapy without consequence. They pointed out that the effects of radiation are permanent, and that the damage to irradiated bone does not improve with the passage of time. Therefore, it is always preferable to avoid injuring previously irradiated bone. Additionally, the experts were very critical of the delay in referral to a specialist once the dentist observed the exposed bone at #31. Perhaps the most significant weakness in the defense of this suit was revealed when the experts reviewed the X-rays of teeth #'s 30 and 31. These teeth were salvageable and could easily have been treated with root canal therapy and, in fact, did not require extraction. They questioned whether the dentist had a financial incentive to perform the extractions and implants rather than perform root canal therapy.

This case and expert reviews were presented to the dentist's component Professional Liability Review Committee. The Committee members unanimously agreed that the case should be settled. Negotiations were then promptly commenced by defense counsel and the case subsequently settled on behalf of the insured dentist for $900,000.

A Legal & Risk Management Analysis

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This case presents several legal and risk management issues. Since lawsuits look retrospectively at what occurred, poor documentation is always a significant weakness in evaluating the defense. When there is little to no documentation, settlement may be indicated due to the lack of credibility of the defendant's testimony as to recollections after many years have passed and after seeing many other patients in the interim.

The most serious problem with the defendant's documentation was the absence of a thorough medical history. Although the defendant was aware that the patient had been treated for cancer of the head and neck, he did not document a detailed history of the type and extent of radiation treatment. His treatment notes were also quite sparse. There was no documentation that he had given the patient a written treatment plan and reviewed it with him. Further, he failed to document any informed consent discussion. Because of his complicated medical history, the plaintiff should have been given the option of having his treatment performed by an oral surgeon. Other reasonable alternatives should have been presented which were not only less expensive treatment options (such as root canal treatment) but also less drastic than extraction. The particular teeth involved here were potentially salvageable with root canal treatment. The cost of that would be much less than the planned $10,000 cost of extractions and implants. Unfortunately, the plaintiff could have argued that only extraction was offered as a treatment option because it would result in greater financial benefit for the defendant.

Finally, the documentation did not describe the plaintiff's complaints, prior to extraction. If the defendant had thoroughly evaluated the plaintiff's complaints, he may well have suspected that the patient's pain was not related to the tooth decay, but rather was an initial symptom of the bony mandibular necrosis. This, too, might have led to a prompt referral to an oral surgeon.

Another major deficit in the defendant's care was his failure to contact the patient's oncologist, before proceeding with the extraction, in order to determine whether extraction was in fact appropriate. If he had done so, he might have learned that the plaintiff had twice undergone radiation to his head and neck due to tumor recurrence. Therefore, the development of bony necrosis was a highly likely possibility. Although it does not seem reasonable that the patient would not know the name of

his oncologist when asked, the defendant failed to pursue obtaining the physician's name from the plaintiff.

Finally, this case illustrates how important it is to promptly refer patients with complex medical problems for medical clearance prior to treatment or post treatment when a problem in healing is identified. The generally accepted dental protocol is to refrain from performing extractions post-radiation treatment for cancer. The dentist's failure to follow this protocol was a clear deviation from the standard of care. When the bone was exposed after the extractions were completed and the operative areas were not healing, the defendant should have made the necessary referral in a timely manner.

Lack of referral to a dental specialist for either consultation to determine the appropriate treatment, or to actually complete the necessary treatment with a medically complex patient, is also a deviation from the standard of care. Had the defendant obtained the necessary consultations, or appropriately referred the plaintiff to a specialist for treatment, the plaintiff might not have suffered serious complications. Unfortunately, this plaintiff already had major side effects from his cancer treatment and then suffered further serious complications from the defendant's treatment. Because of all of the procedures necessitated, and the pain and suffering undergone by the plaintiff to attempt to correct the necrotic mandible, a jury would have sympathized with him. When a plaintiff is so disabled and disfigured, settlement of the case becomes prudent and well indicated. ◆

There was a Flood/Fire/The Dog Ate My Records… What Do I Do Now?

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Although no one wants to envision the possibility, natural or manmade disasters and building malfunctions can befall a dentist's office, resulting in the partial or complete destruction of dental records. Weather events and other catastrophes do not, by themselves, automatically absolve a dentist from the responsibility to maintain patient records. If an untoward event does occur, certain steps should and must be taken to satisfy legal obligations and mitigate the harmful effects of the loss.

Record Retention Guidelines

According to New York law and regulations, dentists must maintain all patient records for at least six years. Records of minor patients must be retained for at least six years, and until one year after the minor patient reaches the age of 21 years.[1] These are statutory minimum standards. Because of the statutes of limitations which apply to malpractice and fraud claims, it is recommended that dentists maintain medical records for at least 10 years after the date payment was last received for the patient.[2]

Report the Loss

In the event of a flood, fire, or similar event, you should immediately notify any insurance carrier which covers your building, its contents, and your business operations. Take photos and videos of the premises and events as they unfold, and make a complete inventory of the loss. Keep all documentation and claim paperwork sent to and from your insurance carrier(s), as well as any reports from official agencies (e.g., fire marshall). In the event of a dental liability claim, all of this documentation will be important to protect you against any allegation of intentional "spoliation" of evidence.

Salvage the Information

Since dental records may not be replicated easily, attempt to salvage as much information as you can. There are companies which specialize in this. Be aware that you may need a HIPAA business associate agreement with any vendors who have access to protected health information.

The New York State Department of Health has recommended certain websites to assist you in understanding the process of recovering and preserving records which have been affected by water damage:[3]

Salvaging wet books:
http://www.heritagepreservation.org/savewetbooks/index.html

Recovery methods: freezing and drying:
http://www.ccaha.org/uploads/media_items/ccaha-freezing-drying-techniques.original.pdf

Water damage preservation video:
http://www.heritagepreservation.org/PROGRAMS/WaterSegmentFG.HTM

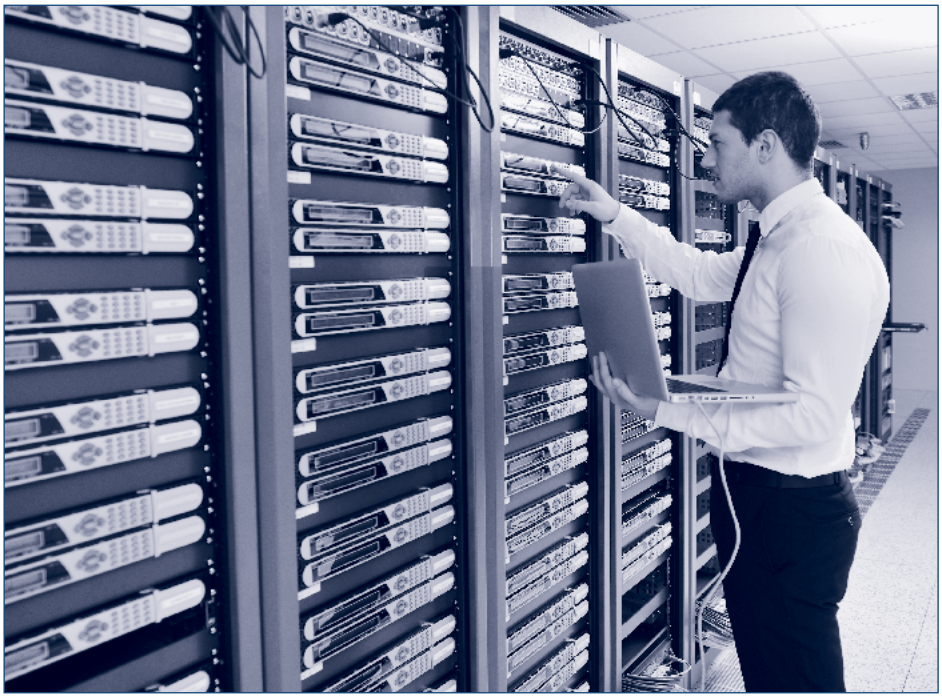
Disposal of Protected Health Information

If the records cannot be salvaged, then the information must be cleared, purged, or destroyed so that nothing can be used to identify patients. It is advised that, prior to destruction, you have an independent expert verify that the records cannot be salvaged. Keep this verification with your documentation of the loss.

The Department of Health and Human Services, Office for Civil Rights has published a Frequently Asked Question guidance document

1. 8 NYCRR 29.2(a)(3). Healthcare facilities must also retain medical records for at least 6 years from the date of discharge or three years after the patient's age of majority (18), whichever is longer, or at least six years after death.

2. CPLR § 214-a; 31 U.S.C.A. § 3731.



on how to safely and properly dispose of protected health information, which can be found here: http://www.hhs.gov/ocr/privacy/hipaa/enforcement/examples/disposalfaqs.pdf.

Recreate What You Can

Try to reconstruct the charts as best you can by contacting other sources. Notify the patient of the loss and ask the patient for copies of any records in his/her possession and the names of other providers who may have copies of his/her records. You may be able to retrieve information from practice management software, transcription or outside services. You should obtain copies of all claims and associated documentation filed with dental insurance carriers. A reconstructed chart should be clearly labeled as such, with a notation as to the current date. You should document what occurred (e.g., record was destroyed in a flood) and indicate that the chart may not reflect complete information on the patient's condition. If the patient is still active, you should ask the patient to complete and return a new history form, and thoroughly review it with the patient at the next visit.

If reconstruction is not possible, then you must create a log of patient records which were lost. Document the date, the information which was lost, along with a complete description of the event which occurred, all attempts you made to salvage and/or recreate the records, and the outcome of your efforts.

Responding to Requests for Records

As stated above, dentists should maintain all documentation relating to the event, and be prepared to provide an explanation regarding the availability of records to patients, payers, and governmental authorities. Payers and other organizations may have forms or attestations they will require regarding destroyed records. If you do not have a form, the Center for Medicare and Medicaid Services has a Sample Provider Attestation Form which can adapted to respond to requests. A copy of this form can be obtained at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/PERM/downloads/PERMLostDocPolicy.pdf, or by contacting Fager Amsler Keller & Schoppmann, LLP. ◆

RISK MANAGEMENT Tips

Tip# 21: Patient Referrals – Communication and Follow-up

The Risk: A dentist's failure to follow up when a patient is noncompliant in seeing a consultant or specialist to whom a patient has been referred creates potential liability for the dentist and impedes the provision of safe patient care.

1. When a patient has been referred to a specialist for a consultation, the dentist should have a tickler system in place to confirm the patient has in fact seen that specialist or consultant.

2. If feasible, the dentist's office should make the appointment for the patient.

3. If there is no report from the specialist/consultant within a reasonable time, the dentist must follow up with the patient to see whether he/she has been seen by the consultant and, if so, contact the consultant's office to obtain a copy of the report or dental record or, alternatively, determine whether the patient cancelled or failed to make or keep an appointment with the specialist.

4. When a patient has failed to seek specialty care or a consultation after being advised to do so, the dentist must send a letter to the patient stressing the importance of doing so.

5. All consultation reports or copies of records from a specialist must be reviewed. Paper reports must be initialed before filing. Electronic reports must contain a notation of review.

6. All efforts to follow up with a noncompliant patient must be clearly documented in the dental record.

7. The patient must be advised of all abnormal findings and treatment recommendations. That discussion must be well-documented in the dental record.

In summary, it is important to refer patients to specialists or consultants when a patient's dental problem is beyond the training or experience of the dentist. If the referral/consultation involves an urgent dental condition, it is best to make the appointment while the patient is still in your office. If the patient is noncompliant, a letter should be sent stressing the risks to the patient (e.g., loss of teeth, infection, etc.). If the patient remains noncompliant with this recommendation, consideration should be given to discharging the patient from the practice. ◆

MLMIC and Berkshire Hathaway *continued from page 5*

11. What will happen to MLMIC rates?
MLMIC will remain a licensed insurer of New York State, regulated by the Department. Premium rates for physicians will continue to be set by the Department. Premium rates for hospitals, dentists, mid-level providers and other lines of business will continue to be approved by the Department.

12. If I have a claim, what will happen?
There will be no change in our claim handling, operations or philosophy of providing a strong defense against claims brought against our policyholders.

13. What are the next steps?
The parties will work with the Department to complete the transaction and provide policyholders with the required notices at the appropriate times. The approval process will include both a public hearing and a meeting of policyholders to approve the transaction. In the meantime, MLMIC will continue to provide the policyholder-first service it has delivered to healthcare providers in New York State for over 40 years. ◆

2016 Event Calendar

MLMIC representatives will be in attendance at the following events:

OCTOBER

13 Fourth District Dental Society New Dentist Meeting
(Saratoga Springs)

13-14 Sixth District Dental Society Annual Meeting
(Owego)

15 Ninth District Dental Association Restorative Conference
(Tarrytown)

18 New York County Dental Society Young Professionals Event
(Manhattan)

NOVEMBER

2-4 Buffalo Niagara Dental Meeting
(Buffalo)

3 Fourth District Dental Society Women's Dentist Meeting
(Clifton Park)

9 Nassau County Dental Society General Meeting
(*Mineola)*

16 Suffolk County Dental Society General Meeting
(Hauppauge)

16 Ninth District Dental Association Meeting
(Rye)

18 Fifth District Dental Society Fall Seminar
(E. Syracuse)

25-30 Greater New York Dental Meeting
(NYC)

For more information on MLMIC's participation at these events and others, please contact Pastor Jorge, Manager, Marketing Services, at 212-576-9680.

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The attorneys at Fager Amsler Keller & Schoppmann, LLP are available during normal business hours to assist MLMIC insureds with a wide range of legal services, including, but not limited to, advisory opinions concerning healthcare liability issues, liability litigation activities, lecture programs, and consulting services.

Healthcare law, regulations, and practices are continually evolving. The information presented in Dental Dateline *is accurate when published. Before relying upon the content of a* Dental Dateline *article, you should always verify that it reflects the most up-to-date information available.*

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