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MLMIC Announces 20% Dividend, Dentist Premium Rates Unchanged for 2016

Danielle R. Zimbardi
Vice President, The NYSDA-MLMIC Program
Medical Liability Mutual Insurance Company

MLMIC's Board of Directors is pleased to announce the approval of a 20 percent dividend for all MLMIC policyholders and that premium rates for dentists will remain unchanged for 2016. The dividend will be awarded to policyholders who are insured as of May 1, 2016, and maintain continuous coverage through July 1, 2016.

MLMIC's mission is to provide insurance at cost. To offset premiums, we offer dividends to our policyholders whenever possible. These dividends are generally declared when MLMIC has sufficient resources to meet its policyholder obligations and when its operating results are better than expected.

Our competitors often promise low initial premiums to attract business, but MLMIC

continually operates without a profit motive. Instead, we work to provide much needed relief to our policyholders, while maintaining financial stability.

MLMIC remains a mutual insurer, owned by our policyholders, and we are committed to policyholder-first service. Over the years, MLMIC's financial strength has allowed us to pay more than \$15 million in dividends to the dentists insured with the NYSDA-MLMIC Program, an accomplishment unmatched by other insurers.

If you have any questions, please contact our underwriting department at one of our regional offices: NYC 1-800-683-7769; Long Island 1-888-263-2729; Syracuse 1-888-744-6729. ♦

New HIPAA Guidelines Published to Clarify Individuals' Right of Access

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On January 7, 2016, the Department of Health and Human Services, Office for Civil Rights (OCR) released a fact sheet and the first in a series of frequently asked questions (FAQs) to clarify the right under HIPAA for individuals to access and obtain a copy of

their health information. The right of access provides individuals with a legal, enforceable right to see and receive copies of the information in their health records maintained by

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Case Study

A Cautionary Tale of Treating Close Friends...

Danielle R. Zimbardi

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Medical Liability Mutual Insurance Company

Two separate actions for dental malpractice were brought against a general dentist by a husband and wife. Both were long time patients of the dentist. Compounding the already stressful event of being involved in a dual litigation was the fact that these patients were also the dentist's close friends.

The dentist's friendship with Mrs. Patient went back 30+ years to the early 1970's. Throughout their friendship he was her treating dentist and saw her for routine checkups and cleanings, as well as for a variety of conditions including crowns on multiple teeth, bridgework, root canal therapies, extractions, and fillings. Occasionally, she was referred by the dentist to an oral surgeon for an extraction. Mrs. Patient was diagnosed with diabetes in the 1980's, and advised the dentist of this condition. The dentist's notes reflect that the "patient went into a diabetic episode" while undergoing extraction of #28 in May 1989. Apart from a notation stating "2000 Diabetes-insulin, hypothyroidism," there are no other notes regarding her diabetic condition.

When Mrs. Patient married, her husband also became a friend and a patient. Mr. & Mrs. Patient frequently socialized with the dentist and his wife.

Mr. Patient's treatment with the dentist spanned about 20+ years, and included checkups and cleanings twice a year. Mr. Patient had all his natural teeth at the outset of treatment. Mr. Patient had fillings, root canals, and extractions, among other things, performed by the dentist over the years.

The treatment, or lack thereof, that was the subject of the litigation began in 2000 and extended through the dentist's last contact with the patients in late 2006. During that period, the patients alleged that the dentist failed to diagnose and treat periodontal disease, bone loss, and decay, resulting in the loss of Mrs. Patient's complete dentition and tooth loss in Mr. Patient.

Starting with Mrs. Patient's treatment for the period at issue, she was seen by the dentist on March 7, 2000 for complaint of a broken tooth in the upper left quadrant. The exact location was not documented. A temporary filling and crown were placed. On March 20, the dentist performed a composite filling on tooth #12. On June 15, the patient was seen for a routine checkup. On August 10, the bridge in the lower right quadrant was recemented. The same bridge was recemented on August 22, August 28, October 3, October 28 and November 30. Notably, on November 30, the patient was given a prescription for Peridex. Although there is no documentation indicating the reason for prescribing Peridex, the dentist noted that the patient's gums looked "puffy." On December 28, the dentist noted that the old bridge in the lower left would be left in as a temporary while a new bridge was fabricated.

Mrs. Patient was next seen on January 11, 2001 to try the bridge. On January 27, she was seen for an exam and cleaning, and bitewings were taken. There were plans to remake the bridge

on the lower right side. On February 10, the dentist recemented a bridge with permanent cement, location unknown. On March 8, he ground down teeth to address mobility. Again, the location was unknown. On April 10, the patient came in complaining of a broken tooth at #12. The dentist planned to place a crown at #12. The patient was seen over the next two months for preparation of the tooth and crown, which was completed June 13.

On April 4, 2002, periapical films were taken of teeth #'s 7, 8, 9, 10, 23, 24, 25, and 26. The dentist proposed placing laminates over the two front teeth, doing restorations, and bonding the two lower front teeth to address mobility.

The dentist's chart entry on April 25 noted ½ mm at #8 and 1 ½ mm at #9. When looking back on this entry during the litigation, the dentist had no idea to what these measurements referred. He did fillings on #7 and #10. On May 22, he noted "no laminates" were to be done on the bottom. On June 19, the patient was seen for an exam, cleaning and bite-wings. The next entry is undated and notes that something was recemented, the location unstated.

On August 26, 2002, a composite filling was done on tooth #14. On October 1, the notes reflect that the bridge at #'s 13 & 14 was to be redone. It was recemented October 15.

On January 2, 2003, the patient was seen for complaint of discomfort at #'s 8 & 9 and #'s 24 & 25. She was seen again January 25 for a cleaning & exam, and a filling on #14.

On June 13, 2003, the dentist saw the patient for a cleaning and took bite-wings. On November 20, the bridge in the lower right was recemented. On December 22, the patient had an exam, and the dentist took bitewings.

In March 2004, the patient was seen for some restorative work, the nature and location of which were not documented. Fillings in #'s 12 & 3 were performed in April and May. On June 26, the lower right bridge was removed to extract the distal root of #19. The bridge was re-cemented and a prescription for amoxicillin written.

On July 28, the dentist wrote a prescription for amoxicillin and referred the patient to an endodontist. However, the record does not indicate why the antibiotic was prescribed or the reason for the referral. On August 11, a crown was removed from the upper left and the patient sent back to the endodontist to instrument. On August 12, 2004, the dentist removed the left lower bridge. Nothing else was noted for that date. On September 11, the patient was giving a prescription for Peridex, and it was noted that the left lower bridge was to be redone.

At several visits during October 2004 the left lower bridge was again removed, and #'s 23, 24, and 25 were rebonded. On November 13, the bridge was cemented in the left lower quadrant, and a prescription for Peridex was written. The bridge was recemented on December 6th.

On January 12, 2005, the patient was seen for an exam. On January 26,



February 8, March 12, and March 29 the bridge in the left lower quadrant was recemented each time.

On May 3, 2005, the crowns on #13 & 14 were recemented. The left lower bridge was recemented on June 8, June 30, and July 13. On July 27, the patient was seen for a cleaning, and the four lower anterior teeth were bonded again. Prescriptions for amoxicillin were written on August 16 and August 18, but the dentist's records do not reflect why. The bridge was recemented on August 18. Restorations on #'s 12 & 27 were done on September 21. On October 29, teeth #'s 23, 24, 25 & 26 were rebonded, and the lower right bridge recemented. The lower right bridge was recemented again on November 19 and December 10. On December 17, the lower anterior teeth were rebonded yet again.

On January 21, 2006, the lower anterior teeth were bonded again. A prescription for amoxicillin was given February 4, reason not noted. On February 25, a 3 surface filling was done on #12. An identical entry was made on February 27. On March 25, the bridge in the lower right was recemented. On

March 26, the 4 lower anterior teeth were rebonded. On April 8, the patient was given a prescription for amoxicillin and Peridex for the lower anterior teeth. On May 6, movement is noted in the lower left bridge. The lower left bridge was recemented on June 3 and June 19. On June 24, the lower anterior teeth were cleaned and scaled.

A mesio-lingual filling was done on #12 on July 20. On July 27, another mesial filling was done on #12, and noted "if this does not stay crown needed." On August 5, the patient was given an appointment to extract #'s 23, 24, 25 & 26 with the plan for a flipper. The patient did not return after that visit, and never spoke to the dentist again.

Mrs. Patient subsequently consulted with another general dentist on October 30, 2006, who examined her and took X-rays. She complained that she was unhappy with the appearance of her teeth and that many of them were loose.

An oral examination revealed that her teeth were severely deteriorated. There was loss of vertical dimension of

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occlusion secondary to flat posterior occlusal surfaces (porcelain filed off of porcelain fused to metal crowns) and a cantilevered four-unit bridge present in the right mandible. She had severe periodontal disease. She had a retained root fragment at #13 under a cantilevered two-unit PFM. There was severe mobility throughout her mandibular and maxillary anterior teeth and #'s 8, 14, and 19 were hopeless. There was no incisal guidance. The dentist recommended photographs and diagnostic casts and wax up. She was referred to a periodontist for comprehensive evaluation for post-implant supported prosthetics.

Mrs. Patient went on to have extensive dental treatment including extractions of remaining teeth, implant placement, and restorative work. There were long time intervals required for healing due to her diabetic condition.

Mr. Patient's treatment with the dentist began in 1988. Over the years, Mr. Patient was seen mainly for exams, cleanings, and bitewing X-rays. Mr. Patient also had restorative work done, but not to the extent of Mrs. Patient.

As with Mrs. Patient, the treatment at issue for Mr. Patient began in 2000. In June 2000, he was seen several times by the dentist for provision of a crown for tooth #19.

He was next seen by the dentist on November 30, 2000 for an exam and bitewings. On December 5, 2000, the dentist performed a cleaning and filled tooth #4.

The dentist next saw the patient on July 17, 2001 for exam and cleaning. Fillings were done on teeth #'s 2 & 20.

Mr. Patient next presented to the dentist on February 25, 2002 for an exam and X-rays. The dentist's notes reflect that the patient reported that he

had had cardiac stents placed. In fact, the patient had suffered an MI.

On March 12, 2002, the dentist performed a cleaning, and a filling on tooth #5. At the visits of September 9, 2002, March 11, 2003, and September 9, 2003, the dentist performed cleanings, exams and bitewings.

On March 10, 2004, the patient had a cleaning. A filling was done on tooth #15 on March 22. On July 29, 2004, the patient returned for a distal occlusal adjustment on tooth #15. Mr. Patient returned for a cleaning on September 14, 2004.

On March 17, 2005, the dentist performed an exam, cleaning and bitewings. On April 21, 2005 the patient returned for a distal occlusal adjustment on #15, and an occlusal lateral adjustment on #3.

On November 3, 2005, the patient was seen for an exam and bitewings. He returned on November 23 and a root canal was started on #28. On November 28, the root canal was continued. On December 8, the root canal was left open. On December 14, tooth #28 was extracted.

Mr. Patient was next seen January 3, 2006, for an exam and cleaning. He returned on April 11, 2006 for extraction of #5. The dentist prescribed amoxicillin and Vicodin. The dentist's notes reflect that he "checked #4" on April 18. On July 13, the dentist placed a pain sedative in tooth #15. A plan was made to replace #5 using a 3 unit bridge.

The dentist last saw Mr. Patient on September 5, 2006, when he referred him to an endodontist. Mr. Patient never returned to the dentist.

Mr. Patient began seeing his wife's subsequent treating dentist on November 21, 2006. Examination at the initial consultation revealed multiple extensive deteriorated amalgam restorations, mul-

iple distal occlusal restorations with visible caries, and missing #30. His gingival tissues were noted to be edematous with visible calculus. X-rays taken that day revealed extensive caries. The patient had ill-fitting restorations with open margins, radiographic calculus, periodontal disease, and impacted third molars. The dentist discussed his findings with the patient, who was understandably upset. A plan was made to address the caries, and the patient was referred to a periodontist for evaluation.

Mr. Patient subsequently underwent extensive periodontal and endodontic treatment, in addition to treatment for numerous carious teeth and extractions of several hopeless teeth. Restorative work included implants, crowns, and bridges.

The dental experts who reviewed the treatment noted a number of indefensible aspects in the care rendered to both patients for a number of reasons.

First and foremost, the dentist's charting was deficient. Neither chart contained yearly medical history forms, and they did not mention any observations, ideology, prognoses, treatment recommendations, or plans. Neither chart noted the condition of the gingiva. The radiographs are also deficient in both charts since full mouth series were not performed as indicated. According to the expert reviewers, it is the standard of care to take a full mouth series on an initial visit and then every two to five years thereafter, dependent on the patient's condition. Of the films reviewed, many were of poor quality and some mislabeled. Some early films in Mrs. Patient's record were likely not of her dentition. Referrals of both patients to the oral surgeon did not mention why the referrals were made, and there was no

indication that the dentist followed up with the oral surgeon. There was not a single consent form, despite the fact that the dentist performed extractions and root canals on both patients. There was no documentation regarding periodontal disease, or referral to a periodontist, for either patient.

The chart for Mrs. Patient never noted whether or not her diabetes was controlled. This is critical due to the relationship between diabetes and periodontal disease as diabetes affects wound healing and tissue regeneration. Additionally, the experts opined that the standard of care would have been to get clearance from the physician managing her diabetes prior to administering dental anesthesia. It would also be standard of care to continue to note her control status.

The experts expressed similar concerns over Mr. Patient's chart in that his heart condition was not significantly noted and that, once he had a heart attack, the dentist should have consulted his cardiologist before treating him.

Another concern involved the multiple prescriptions for Peridex provided to Mrs. Patient. The dentist's notes neither reflect the reasons for the prescriptions, nor were the risks associated with this medication discussed. This is likewise true for the multiple prescriptions for amoxicillin provided to both patients. It was also learned during the litigation that the dentist was aware that Mr. Patient was on Plavix. However, the dentist never altered his treatment to minimize blood loss.

Most problematic was the fact that the dentist did not recognize the extent of periodontal disease in these patients, or make the proper referrals to a periodontist. The expert reviewers noted that Mrs. Patient's radiographs clearly showed



evidence of severe bone loss in the upper right quadrant in 1996 and in the lower left quadrant in 1999.

The cases were also presented to the professional liability claims committee of the dentist's local component society. The committee's findings were consistent with those of the expert reviewers, and deemed the care and treatment of both patients indefensible.

The dentist was devastated when his two friends brought their cases against him. Likewise, the friends could not believe after years of treating with him that their dental health was placed in such jeopardy. The cases were settled on behalf of the dentist prior to his deposition for a total of \$225,000. Of that amount, \$175,000 was paid to Mrs. Patient and \$50,000 to Mr. Patient.

A Legal & Risk Management Perspective

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Questions frequently arise as to whether you should provide dental treatment to patients with whom you have a close relationship. Although the American Medical Association (AMA) has an ethical opinion¹ which discourages the treatment of immediate family members, the American Dental Association (ADA) does not have a similar provision in its current Principles of Ethics and

1. AMA Code of Medical Ethics E-8.19.

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Code of Professional Conduct. Although this code is silent about this specific issue, the decision is left to the discretion of the dentist and the patient. However, other provisions in the ADA Principles of Ethics and Code of Professional Conduct do speak to patient autonomy, nonmaleficence, and beneficence.² Therefore, you must always consider the particular circumstances before deciding to treat a family member or close friend.

The most obvious concern is whether you can be objective when an urgent or emergent situation arises. If a loved one, employee, or close friend experiences an urgent or emergent condition during treatment, your professional response might not be the same as a dentist who is not related to the patient. This may potentially result in ill-advised actions, injury to the patient, and eventual feelings of guilt.

There is also a risk that such a patient may feel pressured or unable to respond to his/her concerns about the proposed treatment plan because of the close relationship with you. This may potentially lead to allegations of undue influence. Unfortunately, dental records for close relatives and friends frequently are not well documented. In some instances, you might even fail to create and maintain a dental record for a family member or friend. The failure to maintain a dental record for the required time period is professional dental misconduct and could subject you to an investigation and/or sanctions by the Office of Professional Discipline (OPD) if a complaint is made to OPD.³ Obtaining a

detailed medical/dental history from the patient may also potentially be embarrassing to both you and the patient. You may fail to ask crucial questions which you normally ask to obtain a thorough history. The patient may also be reluctant to provide important information to you which would assist you in determining whether the proposed treatment is appropriate and safe. Taking a complete dental history and performing a thorough examination requires that you ask all of the same questions and perform the same examinations on a close relative/friend that you would for any non-related patient. This permits you to provide quality care to the patient, regardless of the relationship to you. A discussion of the treatment plan and an informed consent must also take place with the patient. We strongly recommend that the patient sign a consent form when you are performing invasive or risky procedures. Further, it is vital to document that a consent discussion took place in the event this individual later sues you.

The needs and wishes of the patient must be both identified and respected. The patient must not be, or feel, pressured to agree to a proposed treatment plan. If the patient requires a referral to, or consultation with, a specialist, you should not hesitate to refer the patient. This is particularly true when the patient is concerned about finances. Referrals must also be well documented. Further, you should never attempt to perform treatment beyond your skills and training in order to avoid making a referral or because the patient has pressured you to do so. Your care must be reasonable and appropriate and well within the same standard of care and treatment that you provide to all of your other patients. The

decision as to whether you are the right dentist to treat the patient or whether a referral is warranted should not be based on bias or pressure from this relationship.

Finally, you should not assume that because you provide care to a relative or friend at no cost or at a reduced cost, the patient won't pursue litigation if injured. Unfortunately, friends and relatives who are injured often commence lawsuits because they believe you are "insulated" from viewing the litigation as a "personal attack" because you have insurance.

In summary, if you decide to provide dental treatment to friends or relatives, you must be careful to treat them exactly as you would all of your patients. Perform a thorough history and examination. Document your care in an accurate, detailed, and timely manner. Discuss the treatment plan and costs in depth to avoid surprises. Finally, perform a thorough informed consent discussion of the risks, benefits, and alternatives to treatment, including not undergoing treatment, and the risks of the alternatives and document the discussion. Additionally, always obtain the patient's written consent to invasive or risky treatment. When appropriate, make referrals to specialists or consultants. It is important to listen carefully and respond to the patient's concerns and questions, just as you would with any patient. Finally, if the patient at any time indicates he/she feels pressured by you regarding the choice of treatment or he/she pressures you to perform procedures which are beyond your skills, competency, and expertise, you should respectfully decline to continue to treat the patient. When this occurs, promptly refer the patient to the local dental society to obtain the name of a competent professional or specialist. ♦

2. ADA Principles of Ethics & Code of Professional Conduct Sections 1, 2 and 3 (2012).

3. 8 N.Y.C.R.R. § 29.2 (3).

their healthcare providers and health plans.¹

Dentists must be aware that this federal HIPAA guidance document may not accurately reflect New York State law. Because of the doctrine of “preemption,” HIPAA must give way to New York State laws in cases where the New York laws provide the individual with greater rights of access (or greater privacy rights) than the HIPAA law. Therefore, dentists need to understand how New York laws differ from the HIPAA national rule. The attorneys at Fager Amsler Keller & Schoppmann LLP have prepared a summary which incorporates New York State law. This document may be obtained by contacting the Syracuse office at (315) 428-1380.

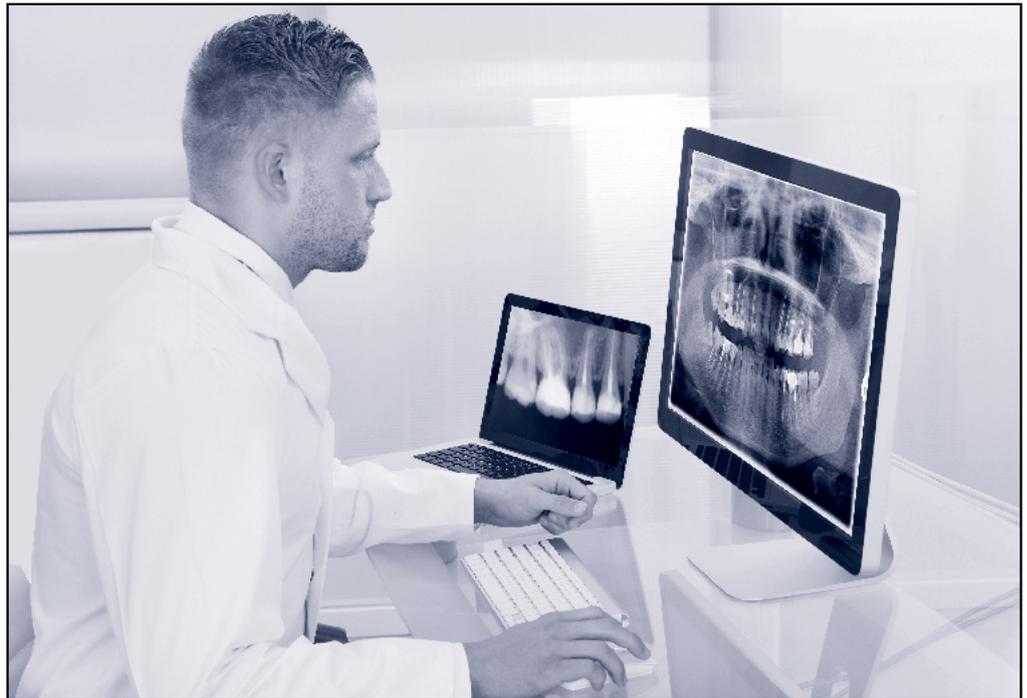
While it is not possible here to summarize every subject in the OCR guidance, dentists should be aware of the following FAQs on the right of patient access.

1. *Is a dentist permitted to deny an individual's request for access to his or her records because the individual has not paid for the dental services provided to the individual?*

No. A dentist may not withhold or deny an individual access to dental records on the grounds that the individual has not paid the bill for services.

2. *Under the HIPAA Privacy Rule, do individuals have the right to an electronic copy of their protected health information (PHI)?*

1. The intersection between the HIPAA Privacy Rule and the HITECH Electronic Health Record Incentive Program is beyond the scope of this article, but details can be found on in the Guidance document at <http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html>.



Yes, in most cases. If the PHI is maintained electronically, an individual has a right to receive an electronic copy of the information upon request. You must provide the individual with access to the PHI in the electronic form and format requested by the individual if it is readily producible in that form and format or, if not, in a readable alternative electronic format as mutually agreed upon. You may provide the individual with a paper copy of the PHI to satisfy the request only when the individual declines to accept any of the electronic formats you are able to readily produce.

If the individual requests an electronic copy of PHI that you maintain only on paper, you must provide the individual with an electronic copy if you can readily produce one (i.e., you can scan the paper record into an electronic format), in the electronic format requested or, if not, in a readable alternative electronic format as mutually agreed upon. If the copy is not readily producible in electronic form, or the individual declines to accept the electronic format(s) you are able to readily produce, then a readable hard copy of the PHI may be provided to satisfy the access request.

3. *If an individual requests an electronic copy of the individual's PHI that is maintained only on paper, am I required to scan the paper records to create an electronic copy of the PHI for the individual?*

While you are not required to purchase a scanner to create electronic copies, if you can readily produce an electronic copy of the PHI for the individual by scanning the records, you must do so. If an individual requests an electronic copy of PHI in a specific format and you maintain that PHI only on paper, you still must provide the individual with the electronic copy in the format requested if you can readily produce that format. If you can produce an electronic copy but not in the specific format requested, you may offer the individual the copy in an alternative readable electronic format. If you are not able to produce a copy in electronic form, or the individual declines to accept the electronic format(s) that you are able to readily produce, then you may provide the individual with a paper copy of the PHI to satisfy the access request. For example, if you main-

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tain the requested PHI only on paper, you may be able to readily produce a scanned Portable Document Format (PDF) version of the PHI but not the requested Word version. In this case, you may provide the individual with the PDF version if the individual agrees to accept the PDF version. If the individual declines to accept the PDF version, or you are not able to readily produce a PDF or other electronic version of the PHI, you may provide the individual with a photocopy of the PHI.

4. *When an individual exercises the right to get an electronic copy of PHI, can the individual choose the electronic format of the copy?*

Individuals do not have an unlimited choice in the form of electronic copy requested, and you are not required to purchase new software or other equipment in order to accommodate every possible individual request. However, the individual does have a right to receive the copy in the form and format requested by the individual if it is readily producible in that form and format. For example, an individual may request an electronic copy of PHI in Microsoft (MS) Word; MS Excel; PDF; or as structured, machine readable data, and you must provide the copy in the requested format if you are able. Further, if the PHI that is the subject of the request is maintained electronically, you are required to have the capability to provide some form of electronic copy.² This means that you may need to make some equipment investments (which cannot be charged to individuals) in order to meet this baseline requirement. If an individual requests a form of electronic copy that you are unable to produce, you must offer other

electronic formats that are available on your systems. If the individual declines to accept any of the electronic formats that you are able to readily produce, only then may you provide a paper copy to fulfill the access request. In short, individuals who request electronic access to PHI maintained electronically can be diverted to receiving a paper copy only in circumstances where all of your existing capabilities for readily producing electronic copies have been presented to the individual but the individual has decided that those formats are not acceptable.

When an individual requests access to PHI in a particular form or format and you have the capability to readily produce the requested format, you are not permitted to deny the individual access to that format because you would prefer that the individual receive a different format, or utilize other record access processes.

5. *Does an individual have a right to access PHI in a particular technical standard?*

In some circumstances, an individual may request access to an electronic copy of PHI in a particular technical standard in order to use that information in other software the individual is using. If you are able to produce the PHI in the requested standard format, you must do so.

6. *Do individuals have a right to get copies of their x-rays or other diagnostic images, and, if so, in what format?*

Yes. The individual has a right to access the information in the form and format requested, as long as you can readily produce it in that form and format. The large file size of some x-rays or other images may impact the mechanism for access (i.e., the format must accommodate the file size).

7. *Do individuals have the right to have copies of their PHI transferred or transmitted to them in the manner they request, even if the requested mode of transfer or transmission is unsecure?*

Yes, as long as the transmission or transfer in such a manner would not present an unacceptable level of security risk to the PHI on your systems, such as risks that may be presented by connecting an outside system, application, or device directly to your systems (as opposed to security risks to PHI once it has left the systems).

For example, individuals generally have a right to receive copies of their PHI by mail or email, if they request. It is expected that all covered entities have the capability to transmit PHI by mail or email and transmitting PHI in such a manner does not present unacceptable security risks to the systems of covered entities, even though there may be security risks to the PHI once it has left the systems. Thus, you may not require that an individual travel to your physical location to pick up a copy of the PHI if the individual requests the copy be mailed or emailed.

In the limited case where you are unable to email the PHI as requested, such as in the case where diagnostic images are requested and email cannot accommodate the file size of the images, you should offer the individual alternative means of receiving the PHI, such as on portable media that can be mailed to the individual.

Further, while HIPAA covered entities are required by the Privacy and Security Rules to implement reasonable safeguards to protect PHI while in transit, individuals have a right to receive a copy of their PHI by unencrypted email if the individual requests access in this manner. In such cases, you must provide a brief warning to the individual that there is some level of risk that the individual's PHI could be read or otherwise accessed by a third party while in tran-

2. 78 FR 5633, <https://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf>.

sit, and confirm that the individual still wants to receive her PHI by unencrypted email. If the individual says yes, you must comply with the request.

Whether an individual has a right to receive a copy of her PHI through other unsecure modes of transmission or transfer (assuming the individual requests the mode and accepts the risk) depends on the extent to which the mode of transmission or transfer is within your capabilities and the mode would not present an unacceptable level of risk to the security of your systems (as explained above), based on your HIPAA Security Rule risk analysis. For example, your risk analysis may provide that connecting an outside (foreign) device, such as a USB drive, directly to your systems presents an unacceptable level of risk to the PHI on the systems. In this case, you are not required to agree to an individual's request to transfer the PHI in this manner, but you must offer some other means of providing electronic access to the PHI.

While an individual can receive copies of PHI by unsecure methods, if that is his/her preference, you are not permitted to require an individual to accept unsecure methods of transmission in order to receive copies of health information.

8. *Am I responsible if I comply with an individual's access request to receive PHI in an unsecure manner (e.g., unencrypted email) and the information is intercepted while in transit?*

No. While you are responsible for adopting reasonable safeguards in implementing the individual's request (e.g., correctly entering the email address), you are not responsible for a disclosure of PHI while in transmission to the individual based on the individual's request to receive the PHI in an unsecure manner (assuming the individual was warned



of and accepted the risks associated with the unsecure transmission). This includes breach notification obligations and liability for disclosures that occur in transit. Further, you are not responsible for safeguarding the information once delivered to the individual.

9. *Do individuals have a right to have their PHI downloaded on portable media that they provide?*

This will depend on the extent to which the requested method of copying, transfer, or transmission is within your capabilities and would not present an unacceptable level of risk to the security of the PHI on your systems, based on your HIPAA Security Rule risk analysis.

With respect to portable media supplied by an individual, covered entities are required by the HIPAA Security Rule to perform a risk analysis related to the potential use of external portable media. You are not required to accept the external media if you determine there is an unacceptable level of risk to the PHI on your systems. However, you are not then permitted to require individuals to purchase a portable media device from you if the individual does not wish to do so. The

individual may in such cases opt to receive an alternative form of the electronic copy of the PHI, such as through email.

10. *Do individuals have a right to have us establish a direct connection between the office system and the individual's app or device in order to provide the individuals with access to their PHI?*

This will depend on the extent to which establishing the connection is within your capabilities and would not present an unacceptable level of risk to the security of the PHI on your systems, based on your HIPAA Security Rule risk analysis.

11. *Does an individual have a right to access their health information in human readable form?*

Yes. Individuals have a right under HIPAA to access PHI about themselves in human readable form. In cases where you are providing an individual with an electronic copy of PHI, it is expected that you will provide the copy in machine readable form (i.e., in a form able to be processed by a computer), to the extent possible and where consistent with the individual's request. ♦

Tip #13: The Proper Handling of Patient Complaints

The Risk: Patient satisfaction is an integral part of providing dental care, regardless of the clinical setting. Dissatisfaction with dental care may be a harbinger of malpractice litigation. When you receive a complaint about care, how you handle the situation may directly impact the potential for future litigation. All dental office practices should have a protocol in place to address patient complaints based upon the following recommendations.

Recommendations:

1. Patient complaints may come from a number of sources, and may include:
 - a. written or verbal complaints from the patient or a family member regarding the dental care or treatment provided by the staff or dentist;
 - b. billing or payment issues which include concerns about the clinical care provided; and
 - c. letters of complaint from third party payors, the New York State Department of Education, the Better Business Bureau, the New York State Attorney General or other state or federal agencies. Any response to the Better Business Bureau requires a HIPAA compliant patient authorization.
- Fager Amsler Keller & Schoppmann, LLP is available to review and assist in responding to a complaint from the patient or the Better Business Bureau. For complaints filed with governmental agencies, we recommend that you retain private legal counsel.
2. If you work in a large office, one individual in the office should be identified and consistently utilized as the point person to handle telephone calls involving patient complaints. This is often the office manager.
 3. If you are speaking with the patient directly and the patient voices a complaint, resist the temptation to provide a quick answer or solution. Do not become flustered, even if the patient seems angry. Take a moment to collect yourself, and advise the patient you will think about the complaint, review the records, and get back to him/her with your response. Do not make rash promises which you may later regret.
 4. Contact MLMIC before making offers of refunds or other payments to discuss whether doing so is appropriate and, if so, the correct way to do so. Be aware that under certain circumstances, a payment to a patient can result in an obligation to report that payment to the National Practitioner Data Bank.
 5. Effective communication skills are essential when addressing patient complaints. These include:
 - a. expressing empathy with the patient and, when appropriate, apologizing for the fact that the patient is unhappy with the care received;
 - b. being an active listener and asking questions when appropriate;
 - c. following up with the patient after reviewing the record and investigating the facts; and
 - d. responding to the patient regarding the results of the investigation (e.g., unable to substantiate the complaint).
 6. Avoid judgmental comments about other dentists and practitioners, since you may not be accurately informed of all the facts by the patient. Never be adversarial or defensive.
 7. Conversations with patients must be documented in the dental record. It is appropriate to exactly cite the patient's complaints in quotation marks.
 8. Letters of response should be concise and simple. A copy of any written response to the patient about the care provided should be retained in the patient's dental record.
 9. A request for records from an attorney may indicate that a patient is unhappy with the dentist's care. The patient's dental record should be carefully reviewed before release to an attorney to assess the potential for dental malpractice litigation. If you feel there may be a basis for a claim, contact MLMIC.
 10. Never document any contact with MLMIC or your attorneys in a patient's dental record. ♦

2016 EVENT Calendar

MARCH 2016

- 3 Nassau County Dental Society's 50 Shades of Dentistry (*Farmingdale*)
- 16 Suffolk County Dental Society General Meeting (*Hauppauge*)
- 23-24 Big Apple Dental Meeting (*Mahwah, NJ*)

APRIL 2016

- 5 Queens County Dental Society General Meeting
- 6 Dutchess County Dental Society Meeting (*Poughkeepsie*)
- 12-13 Greater Long Island Dental Meeting – GLIDM (*Melville*)
- 15 Onondaga County Dental Society Meeting
- 17 Nassau County Dental Society's 50 Shades of Dentistry (*Farmingdale*)
- 27 Stony Brook University Leo & Mickey Sreebny Symposium
- 29 New York County Dental Society CLE Meeting

MAY 2016

- 2 Nassau County Dental Society General Meeting (*Mineola*)
- 4 Suffolk County Dental Society General Meeting (*Hauppauge*)
- 4 Ninth District Dental Association Meeting (*Fishkill*)
- 5-6 Fourth District Saratoga Dental Congress
- 6 Sixth District Dental Society Semi-Annual Meeting (*Binghamton*)
- 13 Third District Dental Society – CE Seminar Series (*Latham*)
- 14 Suffolk County Dental Society's Shredding Event (*Hauppauge*)
- 15 Nassau County Dental Society's 50 Shades of Dentistry (*Farmingdale*)
- 20 Fifth District Dental Society Spring Seminar (*Verona*)

JULY 2016

- 10-11 Indian Dental Association USA Convention (*Manhattan*)

SEPTEMBER 2016

- 13 Onondaga County Dental Society Meeting
- 14 Ninth District Dental Association Meeting (*Bear Mountain*)
- TBD Queens County Dental Society World Fair of Dentistry (*Flushing, NY*)
- TBD Fourth District Dental Society Annual CE & Golf
- 28 Suffolk County Dental Society General Meeting (*Hauppauge*)

OCTOBER 2016

- 5 Queens County Dental Society General Meeting
- 6 Nassau County Dental Society General Meeting (*Mineola*)
- 13-14 Sixth District Dental Society Annual Meeting (*Owego*)
- TBD Fourth District Dental Society Women's Dentist Meeting

NOVEMBER 2016

- 9 Nassau County Dental Society General Meeting (*Mineola*)
- TBD Fourth District Dental Society New Dentist Meeting
- 16 Suffolk County Dental Society General Meeting (*Hauppauge*)
- 16 Ninth District Dental Association Meeting (*Rye*)
- 18 Fifth District Dental Society Fall Seminar (*E. Syracuse*)

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

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Fager Amsler Keller & Shoppmann's attorneys 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 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.

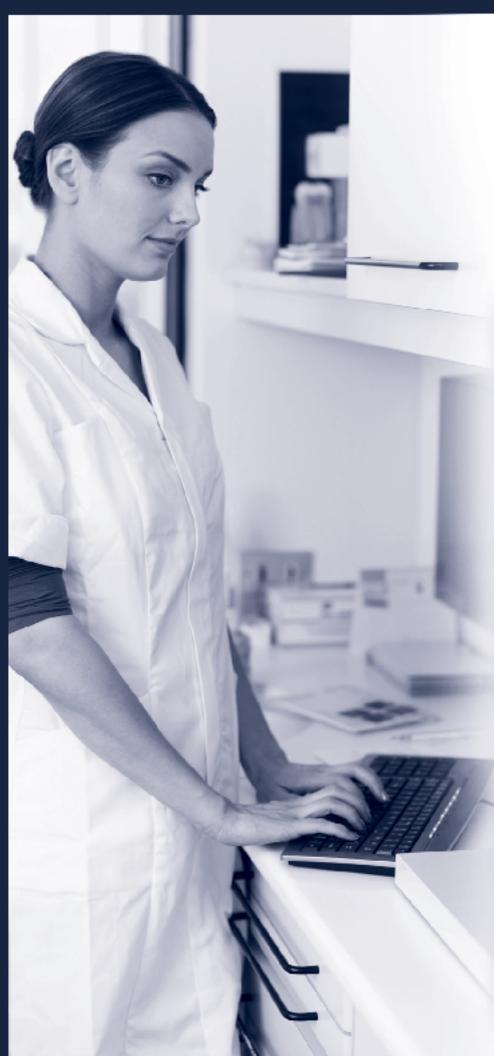


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The screenshot shows the MLMIC.com website interface. At the top is the MLMIC logo and navigation menu (HOME, ABOUT, PHYSICIANS, HOSPITALS, DENTISTS, BLOG, CONTACT US). A search bar and 'LOGIN' button are also visible. The main content area is titled 'Blog' and features two articles:

- New York Joins National Prescription Monitoring Program** (dated FEB 10): The objective of the program is to prevent the improper procurement of prescriptions for controlled substances across state lines. Tagged: controlled substance, electronically prescribe controlled substances, prescribers, prescription.
- Mandatory E-Prescribing Waiver Applications Are Available** (dated FEB 3): Applications for waivers to New York State's mandatory electronic prescribing law are available ahead of the mandate's March 27, 2016, start date. Tagged: e-prescribing, electronic prescribing, eprescribing, mandates, NYSNY, regulations.

On the right side of the blog view, there is a 'GET A QUOTE' button with the text 'Plus, see what discounts you may qualify for.' Below that is a section for staying up-to-date with the latest blog posts, including an email sign-up field and a checkbox for 'Physicians' under 'Choose area(s) of interest.'