MLMIC

Dental DATELINE

A NEWSLETTER FOR MLMIC-INSURED DENTISTS

Spring 2014

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2013 President's Report

Robert A. Menotti, MD, FACS, President
Medical Liability Mutual Insurance Company

Medical Liability Mutual Insurance Company (MLMIC) is the leading medical liability insurer in New York. We insure approximately 16,000 physicians, 5,000 mid-level practitioners, 4,000 dentists and 40 hospitals, and have about a 33% market share statewide (excluding self insurance). MLMIC is a mutual insurance company, which is owned by its policyholders. Our mission is to provide the highest quality liability insurance at the lowest possible cost consistent with long term viability. MLMIC employs about 400 people in four offices throughout New York (Manhattan, Latham, Syracuse, and East Meadow) and has been successfully meeting the needs of its policyholder owners since 1975.

In 2013, MLMIC paid a 5% dividend to its dentists (3% to physician, mid-level practitioner, and hospital policyholders), which provided some needed relief in today's challenging environment. Our policyholders continue to experience reimbursement and operational challenges associated with healthcare reform at the state and national level. As a mutual insurer, we constantly try to provide relief, when it is financially prudent to do so, via policyholder dividends or rate reductions in areas where it is actuarially indicated. As such, in 2013, MLMIC held rates flat for dentists, reduced rates 5% in three geographic regions in New York that favorably impacted over 50% of our insured physicians and mid-level practitioners, and we kept rate increases on insured hospitals to a minimum. Through active risk management, experienced claims handling and expert legal advice, we continue to close the vast majority of claims against policyholders with no payment to plaintiffs. We also keep a close eye on operating expenses, and continue to report one of the lowest operating expense ratios for our peer group in New York and the U.S.A.

In 2014, we expect that our policyholders will continue to face reimbursement and operational challenges associated with healthcare reform. We plan to pay a 5% dividend to all policyholders in 2014, and will look to maintain rates at the actuarially indicated minimum level. Our financial condition remains strong, with over $5 billion in assets and more than $1 billion in policyholder surplus (i.e., assets in excess of liabilities). We know from past experience that financial results can erode quickly when claim costs suddenly increase, and hence the importance of a surplus to cushion these occurrences. Some in our business do not have a surplus, or have only a modest one, and thus are vulnerable to financial strain should claim costs suddenly increase or investments suddenly decline.

Finally, beginning in May, you'll see a new look, tone and feel to our website, policy forms, and advertising. Our goal is to make it easier for policyholders and prospects to do business with us. We believe our strength, experience and commitment to policyholder-first service position us well to respond to the needs of our existing policyholders, and to accept new ones entering the market or switching from other carriers.

Thank you for giving us the opportunity to serve you. We look forward to another successful year in 2014.

Sincerely,
Robert A. Menotti, MD

Communicating with Patients Who Have Limited English Proficiency

Frances A. Ciardullo, Esq.
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Counsel to Medical Liability Mutual Insurance Company

In practically every region in this state, dentists provide care to patients who are culturally and linguistically diverse. Sometimes, these individuals do not speak English as their primary language, or they have a limited ability to read, write, speak, or understand English. Legally, such patients are termed patients with Limited English Proficiency (LEP). As with any patient, it is important to ensure effective communication so that you can provide appropriate care and avoid undue risk.

Title VI of the 1964 Civil Rights Act prohibits discrimination based upon race, color, or national origin in obtaining access to any program or activity receiving federal financial assistance.[1] Language and national origin are closely linked. Healthcare providers who receive federal financial assistance are required by federal law to ensure meaningful access to their services by LEP patients. In 2003, the U.S. Department of Health and Human Services published official guidance (hereinafter the "LEP Guidance") to assist healthcare providers in complying with this obligation, outlining standards for providing language interpretation services at no cost to individuals who have limited ability to read, speak, or understand English.[2]

Title VI and the LEP Guidance apply only to healthcare providers who receive federal financial assistance. The receipt of federal monies triggers an obligation to comply with the federal requirements for non-discrimination. "Federal financial assistance" is defined as grants, training, use of equipment, donations of surplus property, and other forms of federal assistance. It does not, however, encompass Medicare Part B payments or receipt of payment for furnishing services to Medicaid patients. Providers who only receive payment from federal sources "by way of insurance or guaranty contracts" are not subject to Title VI or its regulations.[3]

The majority of dentists in New York State do not receive "federal financial assistance" as that term is used under Title VI, and hence are not subject to all the requirements imposed by the LEP Guidance. This does not mean, however, that dentists are free from the obligations to provide language interpretation services. Under New York law, private dental offices are "places of public accommodation" and subject to the non-discrimination provisions of the New York State Human Rights law. Like Title VI, the Human Rights law prohibits discrimination based upon race, color, creed, or national origin.[4] It is unlawful for a private dental office to refuse to make reasonable modifications in its policies, practices, and procedures which are necessary to afford such persons access to its services. Hence, language interpretation for LEP patients must be provided. Moreover, from a risk management perspective, language barriers can lead to poor care, poor outcomes, increased time and expense, and poor patient satisfaction.

Clinical Concerns

Communication is essential in the dentist patient relationship. Without effective communication, you cannot obtain an accurate health history from your patient, potentially leading to errors in important medications or health conditions. Care instructions may not be understood, which can result in non-compliance and poor outcomes. Moreover, a language barrier may prevent you from obtaining the patient's informed consent to the treatment plan you present. Lack of informed consent is a common theory alleged in dental malpractice cases. New York Public Health Law § 2805-d defines lack of informed consent as the failure of the dentist to disclose to the patient alternative methods of treatment and their reasonably foreseeable risks and benefits in a manner permitting the patient to make a knowledgeable and informed decision whether to consent to the treatment. Patients must understand the information presented well enough to assess their choices and make an informed decision. Patients who cannot understand English and have no language assistance cannot give informed consent to treatment plans, thus exposing you to malpractice liability.

1. Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d et seq.
2. *Guidance to Federal Financial Assistance Recipient Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons.* The Guidance and other related information may be accessed at http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/pocketlanguagecard.pdf
3. 45 CFR 80.2.
4. The New York Human Rights law prohibits discrimination based upon race, creed, color, national origin, sexual orientation, military status, sex, disability or marital status. NYHRL § 296(2); *see also* NYHRL § 291, § 292(9). The highest court in New York, the New York Court of Appeals, has affirmed the position that private dental offices are "places of public accommodation" within the definition of the Human Rights Law and are subject to its provisions. *Matter of Cahill v. Rosa*, 89 N.Y.2d 14 (1996).

Identifying LEP patients

The best way to determine if you have an LEP patient in your practice is to simply ask. A set of "I Speak Cards" in various languages is available from the federal government at http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/pocketlanguagecard.pdf. Questions like "what is your preferred language?" or "do you require any assistance in communicating with our providers?" should be asked when the patient calls for an initial appointment. This will avoid unexpected surprises at the patient visit. Other clues that the patient is LEP may be non-verbal. If a patient does not speak much, simply nods, or does not respond to questions, it may be a signal that he or she does not understand the conversation. This should prompt you to ask them to repeat what you have said so that you can be sure they understood the encounter.

Providing Assistance

Once you become aware that a patient requires language assistance, you must decide how best to meet that patient's needs. Competent language interpretation must be provided. There are various ways you may provide interpretation services. Oral interpretation is most common, either in person or through a telephone interpretation service. You may use bilingual staff, or you may be bilingual yourself. Alternatively, the patient may bring a family member or friend to the visit to interpret. Be cautious about

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Power of Attorney and Patient Records Explained

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May a person holding a power of attorney (POA) from the patient, or the patient's legal representative, obtain a copy of the patient's dental record?

This is a common question among healthcare providers. Public Health Law § 18(1)(g) has long defined the list of "qualified persons" who are entitled to obtain a copy of an individual's healthcare records. In 2004, the definition was amended to include, among others, "an attorney representing a qualified person or the subject's estate who holds a power of attorney from the qualified person or the subject's estate explicitly authorizing the holder to execute a written request for patient information."

This definition does not distinguish between an attorney-at-law and an attorney-in-fact (e.g., a lay person). Attorneys at law, as well as lay persons, may obtain copies of records as long as the POA explicitly authorizes it. In 2009, significant amendments were made to the statutory short form POA, expanding the power of the agent. *Gen. Oblig. Law § 5-1501 et seq*. The new POA form gives power to the agent to handle "health care billing and payment matters," and confers general authority with respect to "records, reports, and statements." Therefore, if these powers are checked on the form, the agent has the right to obtain records relating to healthcare services, and may make decisions relating to the past, present, or future payment for the health care services consented to, by, or on behalf of the principal.

Once a qualified person grants a POA including these powers, the agent is also allowed to sign a HIPAA-compliant authorization to release records to a third party. The new powers granted to an agent do not, however, include the right to make treatment decisions. Those decisions must still be made by the patient, the legal representative of the patient (parent, guardian, committee, or conservator) or, if the patient is incapacitated, the patient's healthcare proxy. ◆

Case Study

Poor Judgement in Patient Care can Have Costly Consequences

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The patient, a 43-year-old male, was seen by a dentist for the fabrication of a partial lower denture. He was referred by that dentist to a second dentist for extraction of his four lower front teeth. The patient signed a consent for extraction of the four teeth. The second dentist then proceeded instead to extract and discard all of the 12 teeth that had been present in the patient's lower gum.

After the extractions were completed, this dentist suddenly realized that he was only to have extracted four teeth, since the patient had been fitted for a partial rather than a full bottom denture. The dentist promptly insisted that the dental assistant find the discarded teeth, four of which were in the hazardous waste container. Despite the assistant's protests, and because the dentist was so insistent, she did search the waste container and located the four teeth. The remaining four teeth were still on the dental tray. The four teeth from the trash were sprayed with a disinfectant and the dentist then reimplanted the eight teeth which should not have been extracted. The patient was never told by the dentist that all of his bottom teeth had been removed.

Later that day, after a great deal of pain, the patient returned to see the dentist complaining of severe pain and very loose teeth. The dentist still did not disclose his error to the patient. In fact, when questioned by the patient, he falsely told him those teeth which were loose had been in poor condition, would not have lasted much longer, and therefore it was necessary to remove them. The patient was surprised, as he had just been told recently by the dentist who fabricated the upper bridge and lower partial bridge that, other than the four which required extraction, the bottom teeth were strong. However, when advised of this opinion, the second dentist explained that this was merely a difference of opinion between two dentists.

He then extracted the reimplanted teeth which, in fact, he had never properly implanted. He then requested that the laboratory change the proposed partial lower denture to a full lower denture. Finally, he also ordered an antibiotic and stronger pain medication for the patient. The patient found it strange to be placed on antibiotics as no antibiotics were prescribed when his upper teeth were extracted.

The patient's dentures never fit well, and he was referred to another practice for possible implants at much greater expense to him.

The dentist was promptly terminated from the practice because of this incident and disclosure was made to the patient. The patient was promptly referred to his family physician for testing for TB, hepatitis A, B, and C and HIV, all of which test results were negative and, fortunately, remained so.

The patient and his wife sued both the dentist and the practice. Further, the practice reported the dentist to the State Education Department alleging professional misconduct. An investigation was promptly commenced. The allegations contained in the lawsuit included: breach of informed consent for extracting all of the patient's lower teeth rather than just four; breach of informed consent for failing to obtain the patient's consent to reimplant the extracted teeth; fraudulent concealment by the dentist for not disclosing the error to the patient; improperly discharging the patient in pain; improper implantation of the extracted teeth; and endangering the safety and life of the patient by potentially exposing the patient to HIV and hepatitis. Because there were no reasonable defenses to any of the allegations, and because of the inflammatory nature of the facts of this case, the lawsuit was promptly settled for $100,000.

A Legal & Risk Management Perspective

This case presents multiple legal and risk management issues. The first is the issue of informed consent. The patient consented to the extraction of only four teeth. Instead, the dentist proceeded to extract and discard all 12 teeth present in the patient's lower gum. Clearly, the dentist went well beyond the scope of the patient's informed consent. The dentist also failed to confirm the procedure with the patient, nor did he review the consent form before the pro-

cedure he was supposed to perform. As with any type of surgical procedure, there should be a "time out" before the procedure is initiated. The dentist must ask the patient what procedure is going to be done, confirm the patient's identity, and ascertain whether the consent form is consistent with the patient's responses. If it is not consistent, the procedure should not continue until the discrepancy has been resolved. If the dentist had performed a time out, this should not have occurred.

Perhaps the most egregious act in the case was the dentist's request that his assistant retrieve the discarded teeth from the hazardous waste and spray them with disinfectant before he reimplanted them. Not only was this a violation of the CDC blood and body fluid regulations and guidelines, but also New York State regulations governing hazardous waste, including blood and bodily fluids. The dentist committed professional misconduct by placing the life and health of both his dental assistant and his patient at risk by exposing them, in violation of state and federal regulations, to unknown pathogens contained in the waste. Further, spraying the explanted teeth to disinfect them was both ineffective and again in violation of laws and regulations governing blood and bodily fluids and hazardous waste. Both the patient and dental assistant were needlessly and dangerously exposed to hepatitis and HIV, among other pathogens.

By failing to disclose what he had done, the dentist further violated the professional misconduct laws by fraudulently concealing his actions. Fraudulent conduct can extend the statute of limitations to one year after the patient has discovered the fraud. In addition to concealing the truth, the dentist affirmatively told the patient a falsehood in response to the patient questioning why these reimplanted teeth were loose and painful. The patient had been told by another dentist that his bottom teeth were strong, with the exception of the four which were intended to be extracted. This was clearly the dentist's opportunity to disclose the adverse event, yet he chose not to do so. He also failed to advise the patient the reason why he prescribed antibiotics for him.

Finally, while the patient was left in severe pain due to such a sizable extraction, the dentist did not prescribe appropriate pain medication for him, in addition to the antibiotics he did prescribe. By failing to do so, he enhanced the patient's ability to claim significant pain and suffering. This, as well as the patient's anxiety about his exposure to HIV, hepatitis and other pathogens, contributed to the size of the settlement.

Once the practice became aware of what had transpired, the employed dentist was immediately terminated. Full disclosure was made to the patient and he was sent to an infectious disease specialist for appropriate testing. The practice also reported this dentist to the New York Office of Professional Discipline. The dentist no longer has a New York State dental license.

In summary, although the facts of this case study were egregious, there are important risk management principles common to other situations which should be implemented in the practices of all dentists. These include: good communication and informed consent; using a "time out" to confirm the proper procedure; the need to honestly and factually disclose adverse events or unanticipated results to patients; the need to appropriately treat pain; and, finally, the need to strictly comply with federal and state laws and regulations regarding exposure to hazardous waste and blood and bodily fluids. ◆

Communicating with Patients *continued from page 3*

using friends or family members. There may be sensitive issues regarding privacy (e.g., mental health conditions), cultural beliefs and practices, and conflicts of interest such as domestic abuse or undue influence. Further, a lay person's translation may not be accurate or complete. He or she may not be able to adequately translate complicated treatment conditions, options, and instructions. Indeed, any time you use an oral interpreter, you must ensure that the interpreter is fluent in clinical terminology as well as payment and insurance terms so that the interpreter is able to fully explain such matters to the patient. If at any time you sense that relying upon a friend or family member is not appropriate, you should provide an independent interpreter. Finally, you should always be especially careful when a patient relies upon a minor child to translate for them. Children should only be used as a last resort. Even then, you must assure yourself that the minor has the life experience, maturity, and vocabulary to serve as an interpreter. It is questionable whether any minor who is not yet in high school could be considered a reliable interpreter.

If you require the services of an interpreter, there are resources in your local community. Trained medical interpreters can be accessed by contacting local health care organizations, such as local hospitals, which are likely covered by the stricter LEP requirements of federal law. Local colleges, cultural or social service organizations, or the court system are other possible sources for locating interpreters. Oral interpretation may also be provided by a telephone interpretation service. There are also a number of national companies which offer telephonic interpretation 24 hours a day, 7 days a week. Such services have the advantage of offering trained interpreters who speak a great number of different languages and dialects. This type of service may be a cost effective and timely option for language interpretation. It is especially effective for routine or non-critical patient encounters. Utilizing this type of service may be as simple as placing a call through a good quality speaker phone. Telephonic interpretation may also be particularly attractive to practices which have a diverse, multilingual patient population.

Written translation also plays a role in effective communication with LEP patients. If your practice customarily serves patients who speak a particular language, you should consider translating significant or frequently used documents into that language. Registration forms, consent forms, payment forms, and common clinical instructions should all be considered as candidates for written translation. You may also be able to locate translated documents online. For example, you may order free brochures in Spanish from the National Institutes of Dental and Craniofacial Research.[5] Most recently, the U.S. Department of Health and Human Services issued Model Notices of HIPAA Privacy Practices in Spanish, which are available on its website.[6]

You cannot pass on the cost of providing interpretation services to your patient. It is your obligation to provide access to your services for LEP patients at no cost to the patient. Under the Human Rights Law, you can only be excused from your obligation if you are able to establish that it imposes an "undue burden" upon you. Under New York law, "undue burden" has a specific definition, and the difficulty or expense to you is measured by certain criteria. The cost of providing an interpreter in relation to your professional fee is not enough to establish an "undue burden." Rather, "undue burden" is measured according to the overall financial resources of all your practice locations, as well as any parent corporation or entity.[7]

5. http://www.nidcr.nih.gov/OralHealth/OralHealthInformation/Spanish/.
6. http://www.hhs.gov/ocr/privacy/hipaa/modelnotices.html.
7. New York Human Rights Law § 296(2)(d).

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MLMIC News

Ninth District Dental Association Exclusively Endorses MLMIC

This past fall, MLMIC was pleased to announce that it received the exclusive endorsement of the Ninth District Dental Association as its dental professional liability insurance carrier.

The Ninth District joins the New York County Dental Society, Second District Dental Society, Third District Dental Society, Fourth District Dental Society, Sixth District Dental Society, Nassau County Dental Society, Queens County Dental Society, Suffolk County Dental Society and Bronx County Dental Society in exclusively endorsing the NYSDA-MLMIC Program for Dental Professional Liability Insurance for their members.

MLMIC is proud to partner with NYSDA and its Components in their commitment to provide their member dentists with the best possible professional liability protection at the lowest premium consistent with fiscal responsibility.

MLMIC to Pay 2014 Dividend

When the New York State Dental Association endorsed Medical Liability Mutual Insurance Company as its professional liability carrier, it was assured that profits generated by the Program would be returned to the policyholders as the owners of this mutual company. This commitment has been honored whenever possible, ***with MLMIC returning over $11 Million to its dentist policyholders over the 22 year history of the Program***. That is unmatched amongst our competitors writing dental professional liability coverage in New York State.

Once again, MLMIC's Board of Directors has approved the recommendation of the NYSDA-MLMIC Underwriting/Claims Committee to declare a dividend for its dentist policyholders. The 2014 dividend will apply to dentist policyholders insured for their primary coverage as of May 1, 2014, and amounts to 5% of the applicable premium as of that date. Dividend checks will be distributed on or around June 1, 2014. This will be the 6th consecutive dentist dividend, and 13th program dividend overall.

Dental Underwriting Corner

A fairly frequent topic of inquiry from our dentist policyholders involves patients who request or demand a refund for dental treatment. If you encounter this situation, please remember that, as a condition of your policy, you must first consult with our MLMIC claims staff before entering into an agreement to refund money. This scenario usually also requires a referral to one of our risk management attorneys at Fager Amsler & Keller, LLP.

To contact the appropriate MLMIC claims department, please call our Syracuse Office at 888-744-6729 if you practice in the upstate area (all counties above Rockland & Westchester). Our downstate policyholders (Rockland & Westchester and below) should contact our Long Island Office at 888-263-2729. ◆

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Fager Amsler & Keller'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, consulting services, and legal audits and assessments.

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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Communicating with Patients *continued from page 6*

When you look at the financial health of your dental practice as an entire entity, it may be extremely difficult to prove that you are subjected to an "undue burden" by providing language interpreters.

Documentation and Privacy Concerns

Documentation of the patient's LEP status and the assistance you provided is extremely important. You should conspicuously note in the dental record if the patient is LEP, as well as his or her primary language. You should document the type of interpretation service you have provided to the patient. If the patient refuses interpretation services, or declines to have an independent interpreter translate the encounter, you must document your offer and the patient's refusal. Where an interpreter is used, you should record the name of the person, as well as the name of any outside company, and the method of translation (telephonic or in-person).

You do not need a patient's written authorization to disclose health information to an interpreter. If you are a covered entity under HIPAA, such disclosures are permissible under the exception for "treatment, payment and health care operations." New York law also allows such disclosures if the patient has indicated his or her agreement, either verbally or by inference. If the interpreter is a member of your staff, no specific agreement is required. If the patient has brought a friend or family member to interpret, you should document that fact, and you may infer the patient's agreement to the disclosure of their health information. If you are utilizing the services of an outside interpretation service (in-person or telephonic), then disclosure is still permitted as long as you have a HIPAA business associate agreement in place.[8]

Conclusion

The LEP population is growing and becoming more diverse. Knowing in advance what your legal obligations are will assist you in planning for your dental practice. Locating and contracting with interpretation services, translating vital documents and signage, and/or perhaps hiring bilingual staff are all effective strategies to provide assistance to your LEP patients. ◆

8. U.S. Department of Health and Human Services, Office of Civil Rights, HIPAA Frequent Questions, accessed at http://www.hhs.gov/hipaafaq/providers/business/760.html.