MLMIC
MLMIC Insurance Company
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THE SCOPE

DENTAL EDITION

ISSUE 03 | FIRST QUARTER 2021

INSIDE

"In these uncertain and anxious times, we need a very dependable professional liability carrier that will protect our most valuable asset – the integrity of our dental practice. MLMIC, with its incredible team of caring and competent attorneys who have been working closely with NYCDS, is our perfect answer."

– New York County Dentist

EXECUTIVE MESSAGE

To Our MLMIC Insurance Company Policyholders:

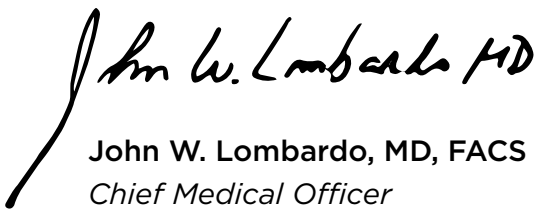
I hope you all had a wonderful and safe holiday season, despite the changes to our lifestyles, and society in general, that all New Yorkers have had to endure over the last year.

It is with optimism that we witness the implementation of three newly developed COVID-19 vaccines. We trust that these treatments will help to minimize or eliminate both the fear and reality of future "waves" of this pandemic, and help us get back to celebrating the traditions we cherish with those we love.

As we usher in 2021, and a new, hopefully downward phase of this COVID-19 pandemic, there may be a temptation to dwell in the past. "If we had only done *this*, things may have been different." And there is certainly value in learning these lessons. With respect to our healthcare industry, what did we do correctly? What mistakes were made? What improvements can we make going forward? These questions will be asked and answered for years.

Throughout it all, MLMIC will continue to work for you. **MLMIC.com** and its portal are being updated with useful features for the administration of dental policies by both our policyholders and their staff, and its COVID-19 resources are being continually updated with the latest guidance, both national and local.

We can expect that COVID-19 will continue to throw us challenges. Let's continue to face them with the determination and resolve that we've demonstrated over the past year.



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Dental Records and Liability Protection – A Defense Attorney's Perspective

As a lawyer for more than 30 years, I have represented dentists who have been sued for dental malpractice and who have been investigated by the New York State Office of Professional Discipline (OPD) for alleged misconduct. I also have the privilege of being a presenter for the New York State Dental Association Risk Management Program. In my experience, the single most important factor in successfully defending a lawsuit or protecting a dentist's license is good recordkeeping by the dentist. Legal concerns aside, good records also improve the quality and consistency of patient care.

...good records also improve the quality and consistency of patient care.

Part 29 of the Compilation of Codes, Rules and Regulations of the State of New York entitled Unprofessional Conduct (8 NYCRR 29.2) states that unprofessional conduct includes:

> **Failing to maintain a record for each patient which *accurately reflects the evaluation and treatment of the patient.* Unless otherwise provided by law, all patient records must be retained for at least six years. Obstetrical records and 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.**

If a dentist fails to maintain a record that accurately reflects the evaluation and treatment of the patient, that dentist has arguably engaged in unprofessional conduct. With respect to defending a lawsuit by a patient alleging dental malpractice, the issue is whether the treatment, or absence of treatment, complied with the accepted standards and practices of the dental profession.

Sometimes the treatment at issue occurred years ago and the patient was only one of many in a busy practice. If the dentist has not maintained a record that accurately reflects the evaluation and treatment of that specific patient, it will be difficult to demonstrate to a judge or jury that the treatment provided by the dentist was in accordance with the accepted standards and practices of the dental profession. That is especially true when the patient's recollection of what occurred during the treatment differs from the recollection of the dentist. Accurate and complete records, prepared at the time of the treatment, are the most objective and reliable way of establishing what happened at the time.

A few examples from my own cases of how recordkeeping can affect the outcome of a lawsuit or disciplinary proceeding are as follows:

Example #1

A patient was seen with a complaint of redness and irritation on the lateral border of the tongue and the dentist suspected that the tongue was rubbing on the sharp edge of an adjacent tooth. The sharp edge was smoothed and, according to the dentist, the patient was instructed to call or return if the sore spot did not resolve. That instruction was not documented in the chart.

The patient was seen some months later for a routine cleaning and examination. No specific reference was made as to the appearance of the previously irritated area and there was no specific notation as to the appearance of the area or that the irritated spot resolved. Following the routine cleaning and examination, a notation was subsequently made in the chart that no further appointments should be scheduled until satisfactory arrangements were made for paying the patient's outstanding balance.

...the patient was diagnosed with oral cancer and underwent a major resection of the tongue.

Several months later, the patient was diagnosed with oral cancer and underwent a major resection of the tongue. The patient brought a lawsuit claiming that the dentist had failed to properly detect, diagnose, and/or treat the oral cancer that initially manifested itself in the red and irritated area of the tongue. The plaintiff testified that the area did not improve after the initial smoothing of the tooth and instead became larger, more painful, and chronically red, surrounded by a white border.

Factors creating difficulty in defending the case were: 1) the absence of a specific scheduled follow-up visit after the initial tooth adjustment that would have documented the patient's condition; 2) the absence of any specific reference to the area at issue during the routine cleaning and examination; and 3) the patient's testimony that she was reluctant to call or request an appointment to address her worsening condition because she knew she had an outstanding balance on her account and believed the dentist would not see her. She had obviously read her records before she testified.

It would have been helpful if the records documented a follow-up examination that revealed a resolution of the irritation; included a specific notation at the routine exam that the sore spot had resolved; and if the records reflecting treatment did not make reference to a potential refusal to treat the patient until her account balance was resolved.

Example #2

A dentist examined a minor child, and a Panorex film was taken that demonstrated, according to the record, "...a large hole on the occlusal surface of #31." The record further stated that "patient is unaware." The note contained no further information. The patient was seen a few months later for a routine cleaning and examination, and no mention was made in the record with respect to the earlier finding.

Ultimately, the mother of the patient filed a complaint with the Office of Professional Discipline alleging that a subsequent dentist diagnosed and treated the problem with tooth #31 and that no such diagnosis had been made, or treatment recommended, by the initial dentist. The initial dentist contended that he had advised the patient and the mother of the hole on the occlusal surface of tooth #31 and had recommended treatment including, at a minimum, the need for a filling as well as the potential for root canal therapy. He recalled that the mother had declined treatment for the child, advising that she would be seeking a second opinion.

...the initial dentist did not document that discussion, the treatment recommendations, or the mother's intention to seek a second opinion.

Unfortunately, the initial dentist did not document that discussion, the treatment recommendations, or the mother's intention to seek a second opinion. In fact, the ambiguity, or poor choice of wording, in the notation "patient is unaware" could, in theory, support the contention that the patient and her mother were not told. Because the record did not document that the diagnosis as well as a plan for treatment were conveyed to the patient, the dentist was sanctioned by OPD for failure to maintain appropriate dental records.

Example #3

A dentist was sued by a patient, who contended that over an approximately 15-year period of time, her periodontal condition was allowed to deteriorate

(continued on page 4)

such that, toward the end of her treatment with the dentist, she had significant pocket depths requiring both periodontal consultation and, ultimately, surgery. Although the dentist eventually diagnosed a periodontal issue at the tail end of the patient's treatment and referred her to a periodontist, she sued alleging that her periodontal problems should have been diagnosed and treated years earlier.

The dentist's records reflected a few scattered bite wing and periapical x-rays taken years apart and no Panorex or full mouth series films at any time during the 15 years of treatment. The records reflected no periodontal charting or screening during the same treatment period. It was the dentist's recollection that he frequently had recommended a Panorex to the patient in order to help assess her overall dental condition, but that she continually declined. In addition, both the dentist and hygienist would periodically conduct random assessments of the patient's pocket depths over the years and the random pocket depths were never concerning; otherwise, there would have been a notation made in the chart.

The x-ray recommendations and periodic pocket depth assessments were not recorded in the chart. As a result, it was difficult to oppose the patient's testimony

It was the dentist's recollection that he frequently had recommended a Panorex to the patient...

that she never refused x-rays and was unaware of any assessment of her periodontal health ever being done. The absence of a Panorex or full mouth series, and no documentation that the patient had refused such studies, made it difficult to oppose the opinion of the patient's trial "expert" that the bone loss present at the time of diagnosis had necessarily occurred, and was undiagnosed, over many years.

Successful Defense

I have also had several other cases, however, where the dentist maintained detailed and accurate records that established proper treatment. The detailed nature of these records established the quality of the care and ultimately resulted in the voluntary discontinuance of malpractice complaints or the dismissal of disciplinary complaints. During risk management presentations, I emphasize that the most important tool for defending

...these records established the quality of the care and ultimately resulted in the... dismissal of disciplinary complaints.

malpractice claims or disciplinary actions is a quality treatment record. A quality record that accurately reflects the evaluation and treatment of the patient contains the following:

- An accurate and current patient history, including the purpose of the visit and the patient's complaints, if any.
- The nature and scope of the clinical examination, as well as documentation of any significant findings, either positive or negative.
- Documentation of any diagnostic images recommended. If the images are taken, any significant findings, either positive or negative, should be documented. If the patient refuses any images, or other treatment recommendations for that matter, including referral to a specialist, the record should document the recommendation made, the reason for the recommendation, that the recommendation was thoroughly discussed with the patient, and that the patient refused.
- The record should reflect the dentist's assessment of the patient, including any diagnosis or the identification of any conditions requiring treatment (a treatment plan).
- If the patient agrees to a treatment plan, that plan should be documented, including the fact that informed consent for such treatment was obtained. If that treatment is performed, the record should document the treatment rendered, including, among other things, the type and quantity of anesthetic. If medication is prescribed, the name and dosage of the medication should be documented. For procedures requiring x-rays taken before, during, and/or after the procedure, the taking of the x-rays should be documented. In short, the documentation should be sufficient for a dentist unfamiliar with the patient to be able to determine from a review of the record alone what treatment was provided and why.
- Referrals to any specialists such as endodontists, periodontists, or oral surgeons should be clearly documented, and the dentist should have a procedure in place to follow up with respect to the outcome of those referrals, including the determinations and recommendations made by such specialists.
- Separate records should be kept with respect to billing, and care should be taken to ensure the procedures billed for were performed and that the billing records match the patient treatment record.

In conclusion, a patient's dental chart provides strong documentary evidence, created at a time contemporaneous to the treatment and before the specter of litigation or disciplinary action ever occurred, that will support, sometimes years after the fact, a dentist's position that the treatment rendered was at all times professional in nature and comported with the accepted standards and practices of the dental profession.

John W. VanDenburgh is a founding partner of the firm Napierski, VanDenburgh, Napierski & O'Connor, LLP, and has successfully tried numerous cases to verdict on behalf of individuals, municipalities, private sector businesses, and insurance companies. Mr. VanDenburgh is Panel Counsel to, and a Risk Management Presenter for, the New York State Dental Association and frequently lectures dental and medical societies on issues of risk management, employment practices, and liability limitation.

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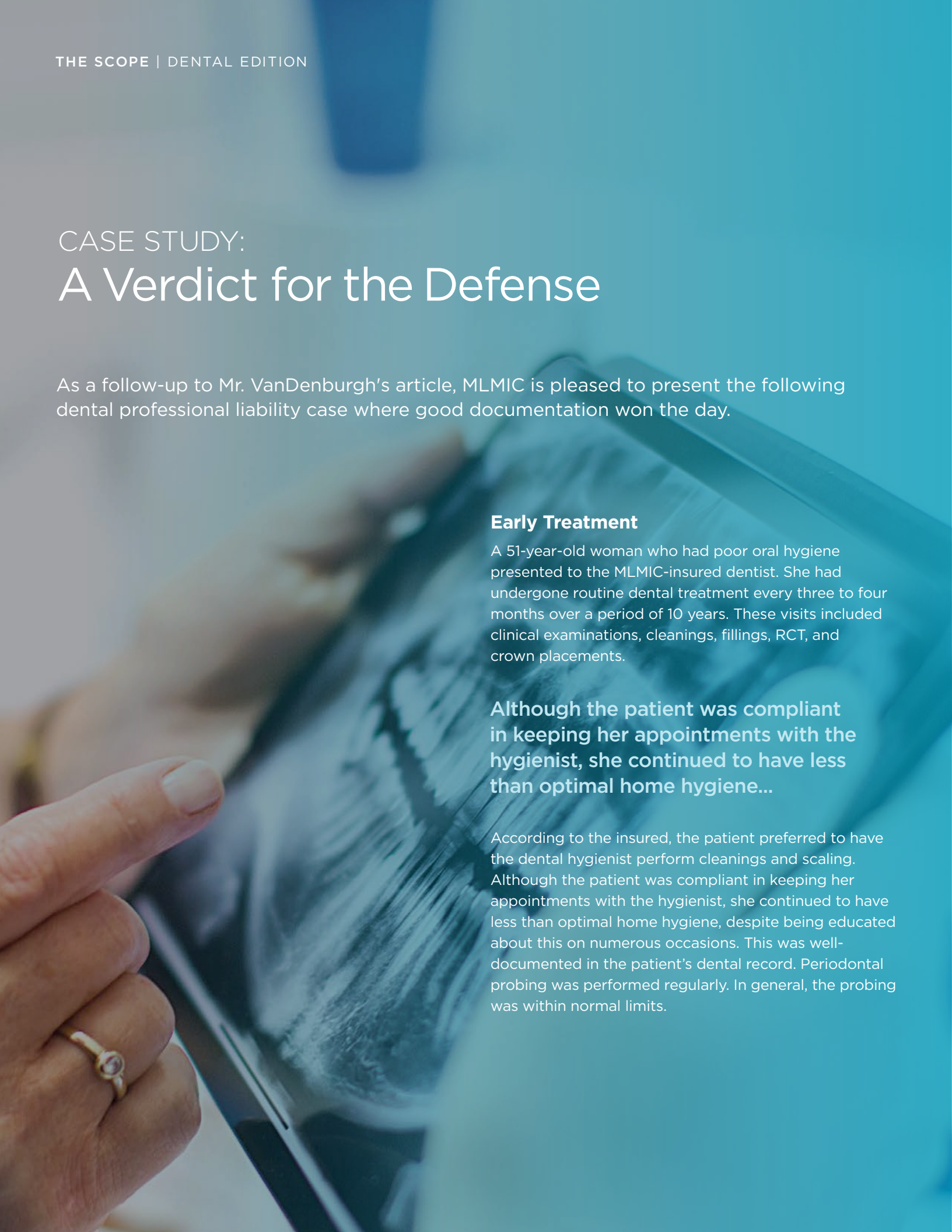
CASE STUDY:

A Verdict for the Defense

As a follow-up to Mr. VanDenburgh's article, MLMIC is pleased to present the following dental professional liability case where good documentation won the day.



Early Treatment

A 51-year-old woman who had poor oral hygiene presented to the MLMIC-insured dentist. She had undergone routine dental treatment every three to four months over a period of 10 years. These visits included clinical examinations, cleanings, fillings, RCT, and crown placements.

Although the patient was compliant in keeping her appointments with the hygienist, she continued to have less than optimal home hygiene...

According to the insured, the patient preferred to have the dental hygienist perform cleanings and scaling. Although the patient was compliant in keeping her appointments with the hygienist, she continued to have less than optimal home hygiene, despite being educated about this on numerous occasions. This was well-documented in the patient's dental record. Periodontal probing was performed regularly. In general, the probing was within normal limits.

Periodontal Referral

After five years of treatment, she was referred to a periodontist due to chronic plaque buildup. The patient reported to the insured that, although she was found to have chronic inflammation, no treatment was recommended. After another five years of routine examinations, the insured observed and documented that the patient had bone loss and recession on her mandibular anterior teeth. The insured also documented that this area needed to be monitored.

Four months later, the patient reported that she was experiencing xerostomia. The insured promptly referred the patient to a periodontist for further evaluation of teeth #23-25.

Two months later, the patient was seen by the insured and reported that she had undergone a frenectomy and was now experiencing discomfort and xerostomia. The insured documented that the tissue had not healed properly. The patient advised she would follow up with a periodontist for this condition.

The patient was then seen by a third periodontist. He performed extensive treatment. This included extraction of teeth #23-26; implants on teeth #23 and 26; an osseous cartilage graft on teeth #23 and 26; an abutment on teeth #23 & 26; and crowns on teeth #23-27.

Lawsuit Filed

The patient then commenced a lawsuit against her dentist. She alleged that the insured failed to recognize and stop the advancing bone loss; performed improper and inadequate tests and x-rays to diagnose the condition; improperly and inadequately documented periodontal pocket depths; and failed to properly refer the patient to a periodontist in a timely manner, thus causing the plaintiff to undergo extensive periodontal surgery and the eventual loss of four lower anterior

She claimed that she had incurred great expense, as well as pain and suffering...

teeth. She claimed that she had incurred great expense, as well as pain and suffering, because of his alleged negligence.

After three years, the case went to trial. The expert witnesses for the defendant dentist all opined that none of the defendant's treatment led to the loss of the plaintiff's teeth. These witnesses testified that, based upon the documentation in the defendant's record, the patient clearly had periodontal disease, decreased salivary flow, and poor hygiene. Further, the insured dentist appropriately referred her to a periodontist on multiple occasions. The experts were impressed with

The experts were impressed with the insured's documentation in the records...

the insured's documentation in the records and his comprehensive treatment plan, both of which helped to refute all of the plaintiff's claims.

After six days of trial, the jury returned with a verdict for the defendant dentist. If not for the excellent documentation of the dental record in this case, the outcome could have been significantly different.

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MLMIC's Online Resources for Dentists

Are you familiar with the online resources available to MLMIC's dentist policyholders? In addition to MLMIC's unparalleled personal service, we aim to provide our insureds easy access to online resources, at your convenience, any time of day. Please take some time to visit us online and share your feedback.

Dentist Resource Page

Access our blog and other publications, tap into our risk management insights, and request an insurance document (e.g., certificate of insurance, claims history, or declarations page) or obtain premium payment information at **www.mlmic.com/dentists/resources**. Additionally, our **"Risk Management Tips"** will provide important advice to help reduce the number and severity of claims.

Policyholders can also view a selection of the most commonly asked practice-related questions in our **"Dental Malpractice FAQs,"** including: (1) What exactly should be documented in the dental record? (2) Should my treatment plan be in writing? (3) How long must I retain dental records? Answers to these and some of the most frequently asked questions from our dental policyholders are now at your fingertips.

Should you need a certificate of insurance, claims history, or declarations page, you will find the necessary form request in **"Resources."** If you do not have access to a scanner or fax machine, no problem. You can take a picture of the executed form with your mobile device and email the information to us. It is that simple.

Blog

We want to give our dental blog a special shout-out. It not only contains invaluable information on the COVID-19 crisis, but it also highlights a number of topics of interest to dentists pertaining to the practice of dentistry, including research articles, dental health issues, risk management advice, and legal updates.

COVID-19

Over the course of this year, our Risk Management Consultants and legal counsel at Fager Amsler Keller & Schoppmann, LLP, have been dedicated to providing our policyholders with up-to-date COVID-19 information impacting our healthcare providers and will continue to do so for the duration of the pandemic. Be sure to check in periodically at **www.mlmic.com/covid-19** for the latest guidance.

From risk management tips and FAQs to publications and the MLMIC blog, we are committed to supporting today's dental professionals. Visit our website today at **www.mlmic.com/dentists/resources** and follow us on LinkedIn or Twitter to take advantage of all MLMIC has to offer.

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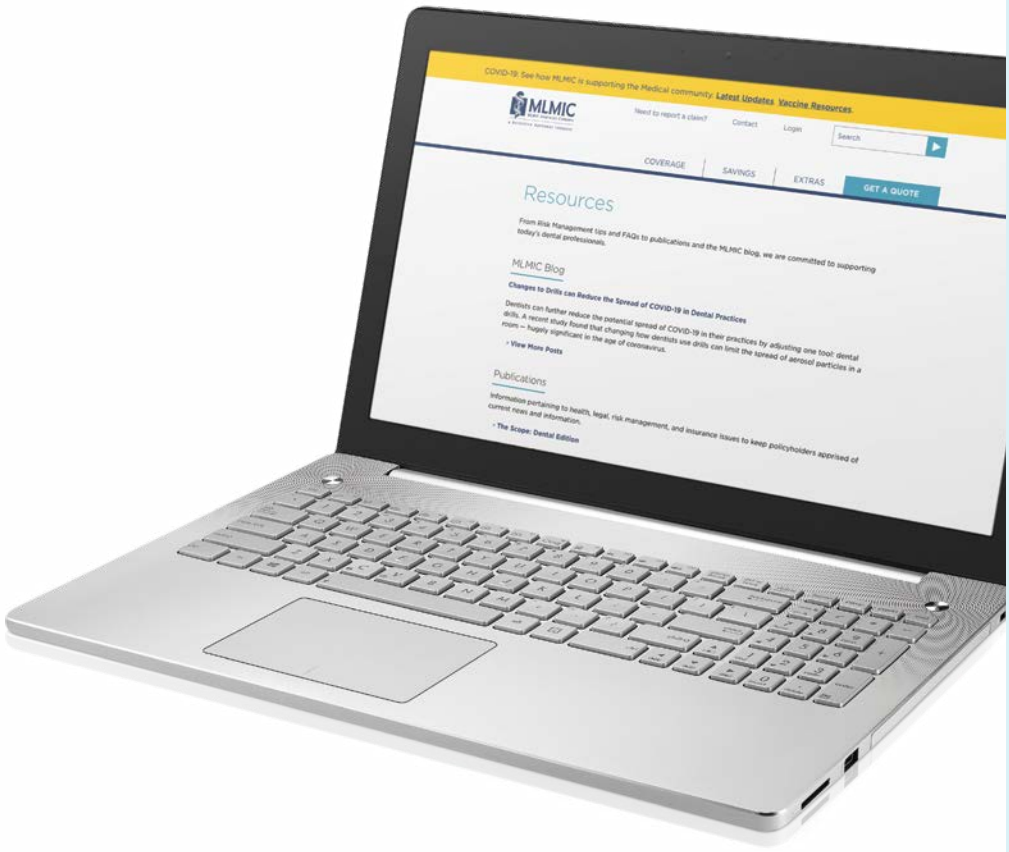

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Risk Management Checklists

MLMIC's series of Risk Management Checklists are designed to assist dentists and their administrators and staff with identifying potential areas of risk in the dental office setting. The strategies presented are drawn from risk management principles as well as our analysis of closed dental professional liability claims that involved office practice issues, improving patient care and satisfaction, helping prevent adverse outcomes, and minimizing professional liability exposure.

To download a complete set of MLMIC's Risk Management Checklists, visit
www.mlmic.com/why-mlmic/services-resources/checklists

COMMUNICATION — CHECKLIST #2

EFFECTIVE COMMUNICATION WITH PATIENTS

Effective communication is the cornerstone of the dentist-patient relationship. Patients' perceptions of dentist communication skills may impact the potential for allegations of malpractice. The following are utilized to promote open communication and enhance our ability to reach an accurate diagnosis and develop an appropriate plan of care.

	YES	NO
1. Active listening techniques are used and patients are allowed sufficient time to voice their concerns.	☐	☐
2. Dentists sit at the level of the patient and maintain eye contact.	☐	☐
3. The patient's literacy level is assessed. This may be as simple as asking what is the highest grade level the patient attained.	☐	☐
4. Lay terminology is used when communicating with patients and their families.	☐	☐
5. Procedures are in place for communicating with patients who are hearing impaired, deaf, or have limited English proficiency.	☐	☐
6. The teach-back method is used when providing patients with instructions and information. This technique requires that patients repeat the information presented in their own words. The teach-back method is particularly useful in assessing patients' understanding of: • Informed consent discussions • Medication instructions, including side effects and adverse reactions • Procedure preparation • Follow-up instructions If the patient is unable to convey the information, it is restated in simpler terms, perhaps utilizing pictures and/or drawings.	☐	☐
7. Educational tools and consent forms have been evaluated to determine the grade level at which they are written. This allows written materials to be given that are understandable to the majority of our patient population.	☐	☐
8. At the conclusion of each patient encounter, the patient/family are asked if they have any questions or concerns that have not been addressed.	☐	☐
9. Record documentation reflects all aspects of patient interactions and comprehension. This demonstrates the effectiveness of our communication skills and promotes patient satisfaction.	☐	☐

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FROM THE BLOG:

MLMIC's blog provides ongoing and up-to-date news and guidance on important events and announcements that affect the practices of our insured dentists.

If you are interested in receiving informational posts such as the following, please be sure to sign up at **www.mlmic.com/dentists/blog** to receive this important information as it is released.

New York State Amendment to Law Regarding Dental Telehealth Services

New York State amended **Public Health Law 2999-dd** to include requirements that dental telehealth services adhere to the same standards of appropriate patient care required in other dental healthcare settings. These requirements include but are not limited to the performance of an appropriate patient examination, taking of x-rays, and a review of the patient's medical and dental history. Dental telehealth providers are also required to identify themselves to patients as well as provide their New York state license number.

In addition, the amendment prohibits a dental telehealth provider from attempting to waive liability in advance of providing services and prohibits a dental telehealth provider from attempting to prevent a patient from filing a complaint with any governmental agency or authority. This amendment was adopted in an effort to preserve patient safety and maintain trust in telehealth as a response to fraudulent telehealth practices and coercion by providers.

The new law takes effect immediately.

How to Improve Emergency Preparedness in Dental Practices

In 2020, dentists navigated many unforeseen challenges and transitions. From wildfires in the West, to hurricanes and flooding in the South and the COVID-19 pandemic around the globe, the year was not easy. As has become clear, it is vital for dental practices to discuss their emergency preparedness plans and make improvements where necessary.

Besides the COVID-19 pandemic, the emergencies dentists report most commonly facing are prolonged power outages and computer system failures. Below are some of the steps to follow to make sure you and your practice are ready for anything.

1. Create an Emergency Action Plan (EAP).

An EAP is vital for dealing with unforeseen situations. According to the **Occupational Safety and Health Administration (OSHA)**, a well-developed plan will limit injuries and facility damage during an emergency. The plan should be written down and available for employees to review. For staffs of 10 people or fewer, the employer can communicate the plan verbally. The EAP should include:

- Procedures for reporting a fire or other emergency
- A plan for evacuating the building and for designating employees to remain to perform rescue or medic operations
- A procedure for accounting for all employees after an evacuation

Dentists should also consider how patient health information is protected in the office and how that data could be better safeguarded against emergencies to comply with **Health Insurance Portability and Accountability Act of 1996 (HIPAA)** rules.

(continued on page 12)

Pro-tip: OSHA has a **"Create your own EAP" template** that makes writing your EAP much easier and faster.

2. Create a business continuity plan.

In the wake of a disaster, dentists will need to know not just how to get through it, but how to continue practicing despite it. According to the **American Dental Association (ADA)**, there are several elements you need to consider when thinking about continuity:

- **Existing plans and procedures.** After an emergency, your normal procedures may need to shift on a dime. Think about how procedures could change or pause depending on the circumstance. Also, it's a good time to review your insurance policies and be aware of the disasters that are covered and the ones that aren't but should be.
- **Equipment.** Not all equipment is easy to replace. Think about where you store your equipment and what risks it is exposed to. Keep electronics off the ground in case of flooding and consider keeping important records or data in a fireproof safe. Also, make sure first aid supplies, emergency power equipment, and personal protective equipment (PPE) are accessible, plentiful, and up to date.
- **Personnel.** Be aware of how many staff you have and how far they are from the office to know who may be available during and after an emergency.
- **Backup systems.** Consider storing your records — or copies of your records — offsite, so they are safe in the event of a disaster that damages the office facilities.

3. Identify resources to help recover after the emergency and while preparing for the next one.

Often, a disaster is not just one event — there are lasting effects and aftershocks that continue to impact the practice. A storm or flooding, for example, can bring issues like mold and mosquitos. After dealing with the immediate needs of the practice during an emergency, turning to the next steps can be overwhelming. Thankfully, the ADA Center for Professional Success **has resources to help**. Visit the site for guidance on ensuring data backup and system recovery, caring for staff after a disaster, and more.

Dentists are reminded to visit the **New York State Dental Association** website for up-to-date information on NYS Health Law alerts and more. MLMIC also encourages dentists to monitor updates on our **resources page** and find additional guidance for dental practices on our **blog**.

If you have questions about the dental telehealth law, policyholders also have access to MLMIC's toll-free **24/7 Legal Hotline**: (855) FAKS-LAW (1-855-325-7529). Our experts are available to help you address any challenges that may arise.

Read more about important developments in dental liability, get risk management tips, and more on our blog at www.mlmic.com/dentists/blog

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