

Preventive Action

The Quarterly Risk Management Newsletter for Policyholders of FPIC Third Quarter 2003

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DENTAL CLAIMS - EVALUATION AND STRATEGIES

Recent national closed claims data from the Physician Insurer's Association of America (PIAA) reveals that dentists ranked #1 of all medical specialties in terms of the percentage of paid claims. According to the PIAA, over 44 percent of claims closed on behalf of dentists resulted in an indemnity payment to the patient.⁽¹⁾ An analysis of the prevalent issues within these claims data can facilitate a proactive approach to risk reduction.

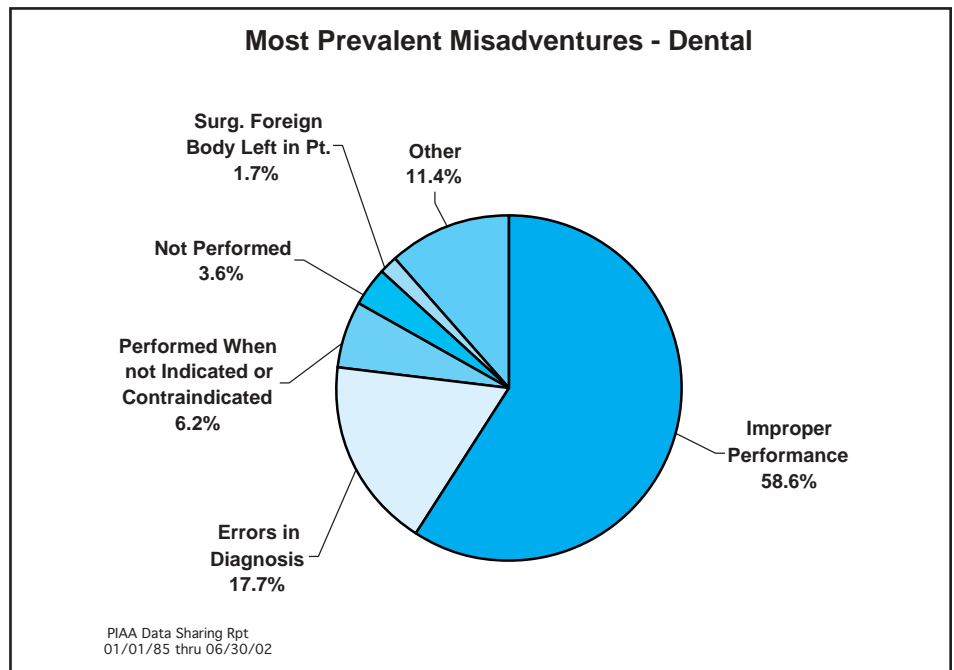
The following risk management strategies can reduce professional liability exposure in the dental practice:

RISK:

Failure to diagnose (or delay in treating) periodontal disease.

STRATEGY:

Monitor patients carefully. Perform and document complete oral exam. Refer patients whose disease is outside your scope of expertise for further treatment.



RISK:

Wrong tooth extractions.

STRATEGY:

Perform radiographic assessment prior to extraction. Carefully review the referral information.

RISK:

Nerve damage, post dental extraction.

STRATEGY:

Carefully examine x-rays. Note proximity of nerves to tooth. Refer molar extractions to oral surgeon. Obtain informed consent, outlining the specific risks, including the possibility of a nerve injury.

RISK:

Infections when sinus cavity is entered.

STRATEGY:

Exercise caution in upper molar extractions where invasion of sinus cavity may occur. Do not attempt sinus lifting without proper training.

Review the patient's medical history before initiating antibiotic therapy. Closely monitor the patient, documenting the clinical absence of signs of infection, and/or adequate response to antibiotic management.

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FPIC publishes Preventive Action on a quarterly basis as a service to its policyholders. Information in this publication does not establish a standard of care, nor is it a substitute for legal advice. The information and suggestions contained in this newsletter are generalized and may not apply to all practice situations. FPIC recommends you obtain legal advice from a qualified attorney for a specific application to your practice. The information should be used as a reference guide only.

For comments, questions, or to obtain additional copies contact the FPIC Risk Management Department at 800-741-3742, ext. 3016. rm@fpic.com

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RISK:

Failure (or delay) to diagnose oral cancer.

STRATEGY:

Monitor patients carefully. Perform and document complete oral exam. Appropriately evaluate patient's symptoms. Do not ignore lesions that do not respond to treatment. Suspect cancer and investigate further. Schedule timely follow-up (two weeks). Track all diagnostics to ensure results are received, reviewed, and response initiated.

RISK:

Anesthesia reactions.

STRATEGY:

Comply with newly revised Florida Administrative Code, Rule 64B5-14, Board of Dentistry, to include the following: Assure thorough training in administration of anesthetics is appropriate to the scope of practice. Closely monitor patient's response to anesthetics. Maintain appropriate emergency equipment and medications. Provide emergency response training for clinical staff members. Obtain consent for the anesthesia with associated risks for type of anesthesia planned.

While the above risks do not comprise all exposures, they address frequent dental misadventures related to malpractice claims entailing improper performance and errors in diagnosis, the two most prevalent categories of misadventures. Simple but effective strategies aimed at prevention of prevalent adverse outcomes also facilitate validation of quality dental care – an essential component in successfully defending malpractice claims.

PIAA Data Sharing System Report Period 021, Cumulative 1/1/85-6/30/02.

HIPAA UPDATE

Understanding and complying with federal HIPAA regulations may prevent a slow-down or disruption in cash flow for offices involved in electronic transmission of protected health information.

Although the HIPAA **Privacy Rule** went into effect on April 14, 2003, (see Preventive Action Vol. 17, Nos. 1 & 2) there are still many rumors and misunderstandings about the rule. Remember that where state laws are more stringent than the federal HIPAA Privacy Rule, the state law prevails. Such is the case with releasing information to insurance companies. Although HIPAA allows the release of information for payment purposes without the patient's consent, Florida laws require the patient's written authorization for release of information to the patient's health insurance company.

Although the Privacy Rule applies to all forms of protected health information – written, oral, and electronic, only *covered entities* are subject to the rule. Covered entities are only those healthcare providers who are transmitting or receiving protected information electronically.

Deadlines for other components of HIPAA are quickly approaching. The **Transaction and Code Set Standards**, which become effective on October 16, 2003, require the use of specific formats when conducting certain electronic transactions. They also require the use of current standard codes, such as ICD-9-CM, CDT, HCPC, or CPT-4 codes. Testing between senders and receivers must be conducted prior to the October 16 deadline to prevent disruptions in cash flow.

April 21, 2005, is the deadline to comply with the **Security Rule**. It sets standards for safeguarding against unauthorized access, alteration, deletion, and transmission of electronic protected health information. There are administrative, physical, and technical safeguards included in this rule.

FPIC continues to offer guidance materials aimed at assisting with Privacy Rule compliance in your office. You may access the materials from FPIC's risk management website at www.medmal.com or you may request a mailing of the materials by calling the Risk Management Department at 800-741-3742, ext. 3016.

Periodontal Charting

An integral part of a comprehensive dental examination is an evaluation and documentation of the patient's periodontal health. This documentation not only provides a lasting record of the patient's current condition, but also provides a baseline record for comparison of any future changes in the patient's periodontal health. Documentation should include at a minimum:

- Recordings of gingival height and contour.
- Description of gingival tissue health.
- Identification of areas of tissue pathology (such as inadequately attached gingiva).
- Circumferential periodontal probings for all teeth present.
- Areas of bleeding or other pathology noted on probing (such as suppuration, tooth mobility, and furcation involvement).
- Diagnosis of the patient's overall periodontal health.

Recording the absence of pathology is as important as recording

the presence of pathology. One of the easiest and most effective methods of documenting the patient's periodontal condition is through the use of standardized periodontal charts such as those available through the American Dental Association and FPIC's *Office Guide For Dental Risk Management* at www.medmal.com, which is also available on CD-Rom.

In addition to the initial comprehensive periodontal examination, it is imperative that the dentist monitor and document the patient's periodontal health at subsequent appointments. In failing to perform and/or document the results of the initial or subsequent periodontal examinations, the dentist is practicing below the acceptable standard of care for the profession.

General dentists who perform extensive or complex periodontal treatments or who practice as experts or specialists in the field may be held to the standards of care of a periodontist rather than that of a general practitioner - a difficult, if not impossible defense hurdle.

New Requirements for Prescriptions

Effective July, 1, 2003, Florida Statute 456.42 requires that all written prescriptions must be legibly printed or typed and must be signed by the prescribing practitioner on the day of issue. Further, the prescription *must* contain the following:

- name of the prescribing practitioner;
- name and strength of the drug prescribed;
- quantity of the drug prescribed in both *textual* and *numerical* formats;
- directions for use of the drug; and
- date of the prescription with the month written out in textual letters.

Failure to issue prescriptions as set forth by the new requirements is a violation of Florida law and will subject the practitioner to disciplinary action of their license to practice.



LOSS PREVENTION

A 42-year-old male dental patient with complaints of chronic and severe oral pain for three weeks duration, and neck and jaw swelling, underwent a root canal. The patient had a medical history of atrial fibrillation with prophylactic anticoagulation therapy. He received parenteral sedation with Versed and Demerol. Romazicon was administered at the end of the procedure; however, 10 minutes later the patient became short of breath, lost consciousness, and collapsed. Resuscitation efforts by the dental staff and EMS personnel were unsuccessful. The autopsy listed cause of death as respiratory arrest. A wrongful death action was brought against the dentist.

Most of the problems in defending this case arose from the lack of documentation. The dental record was absent a medical history, including the history of atrial fibrillation, medication history, or medication allergies. The informed consent discussion and pre-procedure evaluation, including an evaluation and/or adjustment in the anticoagulation therapy, were not documented. Additionally, the timing and dosages of medications administered, and an assessment of the patient during and after the procedure, were not documented. Even in cases where the standard of care is provided, without adequate documentation, the non-meritorious claim may be rendered indefensible. The case settled for \$775,000.



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Q. What are the most prevalent conditions entailing diagnostic error in dentistry?

Ranked in descending order: gingival and periodontal disease; disorders of pulp and periapical tissues of teeth; disorders of hard tissues of teeth, including caries; malignant neoplasms of the mouth; temporomandibular joint disorders.

Q. Do state or federal laws set forth a specific manner in which obsolete patients records must be destroyed?

No. The manner selected must protect patient confidentiality. Under HIPAA provisions, it is recommended that obsolete patient records be shredded for disposal. If a service is contracted for this purpose, it is not only wise to verify in writing that the contractor or entity agrees to maintain patient confidentiality but also to require that a written Business Associates Agreement be executed pursuant to HIPAA requirements. It is suggested that providers require that such entities include indemnification and hold harmless language in the contract and/or written agreement.

Q. Is it against the law to refer to a medical assistant as a "Nurse" in the office practice setting in the State of Florida?

Yes. Florida Statute 464.016, paragraph (2)(a) indicates that "using the name or title "Nurse," "Registered Nurse," "Licensed Practical Nurse," "Advanced Registered Nurse Practitioner," or any other name or title which implies that a person was licensed or certified as same, unless such person is duly licensed or certified" constitutes a misdemeanor of the first degree, punishable as provided in s.775.082 or s.775.083.

Q. Are there laws that govern the legibility of written prescriptions?

Yes. Effective July, 1, 2003, Florida Statute 456.42 requires that all written prescriptions must be legibly printed or typed and must be signed by the prescribing practitioner on the day of issue. Further, the prescription must contain the following:

- name of the prescribing practitioner
- quantity of the drug prescribed in both *textual* and *numerical* formats
- date of the prescription with the month written out in *textual* letters
- directions for use of the drug
- name and strength of the drug prescribed

Failure to issue prescriptions as set forth by the new requirements is a violation of Florida law and will subject the practitioner to disciplinary action of their license to practice.

Q. Are sign-in sheets in waiting rooms prohibited by the HIPAA privacy rule?

No. However, a sign-in sheet or registration log that solicits the reason for the visit or other personal health information should not be used.