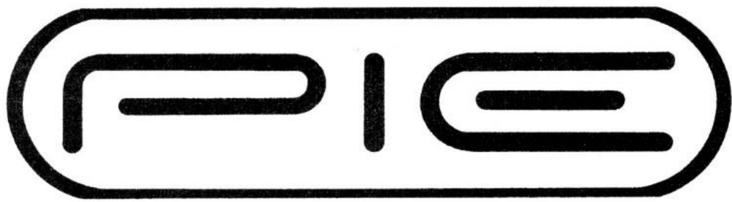

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NEWSLETTER

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Over 35 years of serving the profession

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UMEC SURVEY COMING SOON
BE READY FOR IT!

Periodically the Utah Medical Education Council (UMEC) sends out a Dentist Workforce Survey to obtain information about dental practice habits in Utah. UMEC is funded by the Legislature and their assignment is to ensure that the citizens of Utah obtain adequate medical care and that there are enough health care professionals, including dentists, to meet the needs of the Utah population.

The survey is sent to all dentists licensed in Utah, whether they practice here or not, and asks questions about demographics, education, practice setting and characteristics and practice location. The survey data is analyzed and a report is generated.

PIE encourages all of you to fill out the survey and return it in a timely manner so the report can be based on factual information. There are some questions that ask for estimates, and some ask for more accurate figures. To help you prepare now to answer some of the questions that require knowledge of practice characteristics, we want to provide a few of the questions, as the survey will likely be sent out in mid to late January 2017.

1. What is the amount of educational debt you currently have, excluding pre-dental education and non-educational debt?
2. What is the amount of educational debt you incurred at the time of dental school education?
3. What was your annual gross production for 2015?
4. What was your annual net compensation for 2015?
5. How many hours a week do you spend in
   a. Patient care
   b. Teaching
   c. Research
   d. Administrative work with your practice
6. How many patients do you see per week?
7. What percentage of your patients belong to the following age groups?
   a. Under 1 year old
   b. 2-4
   c. 5-17
   d. 18-44
   e. 45-64
   f. Over 65 years old.
8. What was the value of charity/pro-bono/uncompensated care, you provided in 2016, not counting cash discounts or insurance co-pay write-offs?
9. What percentage of your gross production comes from the care you provide to the following classifications of patients?
   a. Medicaid
   b. CHIP
   c. Self-pay
   d. Privately insured

As you can see, some of these questions will require a little bit of research into your books, etc. on your part or on the part of office personnel assigned to check this out. Hopefully you will learn about the nature of your practice while you do this mini-research project. Generally UMEC will publish the report online so you can see the Utah trends captured by the questionnaire.
--RCE

CONTROLLED SUBSTANCED DATABASE

Later on in this e-mail version of the Newsletter we have reproduced information about the Utah Controlled Substance DataBase Program as we often get telephone calls about the Program. In addition to your own charting, this is an excellent way to track narcotic prescriptions for your patients or check a patient's drug history prior to their presenting to you for treatment.

INFORMED CONSENT UPDATE

For the past several years the basic language at the end of the informed consent forms we have recommended that you use has been unchanged. Recently, however, we have had our lawyers review the language at the very end and have suggested that we make some changes. You will like the changes as they address complaints and objections that some patients have had to the former language used. We have incorporated this language into all of the consent forms that we make available to our insured. For those of you that have these forms as documents in your word

processing systems that can be changed, you can simply go in and substitute the new language for the old.

The main objection in the past had to do with the wording "any and all possible risks." We have thus created language that is more specific to dental procedures and better able to withstand any legal challenge that may arise.

The new language should be worded as follows:

I do voluntarily assume any and all reasonable medical/dental risks, including the substantial and significant risk of serious harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results which may or may not be achieved.

We feel that this language will be well received by patients and will eliminate prior objections raised, especially by your patient who happen to be attorneys!
--RCE

X-RAYS AND STAFF EXPOSURE

The question was asked recently about staff exposure and x-rays. Specifically, a dentist wanted to know if it was acceptable for one staff member to hold the sensor in the patient's mouth while another pushed the button. The answer: This is not acceptable procedure! Whether you use sensors or film, you nor any assistant should ever hold these in the patient's mouth. If a patient is unable to hold the film/sensor with their finger, there are other devices you can order from various dental supply companies to help hold them in place. If a patient has tremors, coordination problems, etc. you can either have a parent try to help or use a panoramic x-ray taken extraorally.

Most staff members, especially those of child-bearing age, are going to be skittish about unnecessary exposure to radiation and it is not sensible nor necessary to require them to be involved in unnecessary or perceived hazardous steps.

We understand that there are often challenges in getting good diagnostic x-rays. Interestingly, with digital x-rays we still see a number of cone cuts and poor bitewing x-rays where there is too much space between upper and lower arches because the patient is not biting down properly. We also see, too often, bitewing x-rays where contacts are not opened sufficiently such that it is difficult or impossible to diagnose interproximal caries. Whether film or digital x-rays are taken, the basic fundamentals must still be followed.
--RCE

LICENSURE LAWS

If you hire a new hygienist or dental associate, what is one of the first things that should be on your checklist? It is to make sure they have a valid Utah license! All of you reading this Newsletter should also have a current Utah license that does not expire until May 31, 2018. If for some reason you did not get the postcard and go through the online renewal process, you had better contact DOPL immediately and get it taken care of because you are illegal. You are also bare as far as malpractice insurance!

What are the ramifications of letting someone such as a hygienist work without a dental license? First of all, there is no malpractice insurance coverage for either you or the hygienist because the policy excludes any procedures done outside the scope of a dental license or dental hygiene license and specifically requires licensure for coverage. This means that in the unlikely event of a claim, you have no coverage and will have to pay any settlements or legal defense costs out of your own pocket.

Several years ago a dentist let his license lapse and then had a problem requiring a substantial refund to a patient. He would have liked PIE to cover the refund but since his license had lapsed, he had no coverage and had to take care of it himself. So there is precedent for such an unfortunate situation and you do not want to be in that same category.

We recommend that you require any applicant for a dental hygiene position or associate dentist position to furnish a copy of their license at the initial interview. In this way you will know immediately if the person is eligible for the position from that standpoint. You should also require all hygienist and dentist employees to furnish copies of their license at renewal. All dentist and dental hygiene licenses in Utah expire in May of even years and renew as of June 1 of even years. You are also required to post licenses in a conspicuous place in your office. If you are an associate working in more than one office, you should make sure you have a copy of your license for every office.
--RCE

AVOIDING BILLING IRREGULARITIES

Although we generally do not cover dental insurance billing matters in this Newsletter, billing practices will come up in potential claims or lawsuits, etc. and we want to help you avoid getting yourself into situations where this could become an issue.

We were recently apprised of an issue where a patient presented to a dentist with a restoration that the patient thought was a crown placed by a previous dentist. The new dentist examined the patient and took x-rays and determined that the restoration looked more like a large composite resin filling. Unfortunately, there was a problem with wear and recurrent caries. The new dentist, wisely, did not immediately open his mouth and condemn the first dentist but noted that when he used his handpiece on the "crown" it could cut through it like butter, not like Bruxir or Cerec restorations, etc. and realized that there was a problem. He removed the defective material and decay and went ahead with a crown buildup and a traditional crown preparation. Staff also found out that, indeed, the insurance carrier had been billed for a crown on the tooth in question.

After discussion with the patient and the staff informing them of the issue with billing for a prior crown and no coverage available as not enough time had elapsed for replacement, the dentist advised the patient to contact the prior dentist to see if some mistake in billing had been made in an effort to rectify the

situation. Apparently an error had been made and the problem was rectified.

We hear regular reports of this scenario and in most cases the problem is an error or oversight, not intentional insurance fraud. But in talking with colleagues who review claims for local insurance companies, they tell me that the biggest problem areas they see are:

1. Charges for porcelain fused to high noble metal when, in reality, the crowns contain only base metal.
2. Charges for crowns when only composite resin or some other material was used, or wrong codes being used due to confusion over the exact material placed.
3. Charges for composite resin when amalgam was placed.
4. Charges for build-ups when only cement is used.

More and more new codes are being developed and used but you should make sure that your staff members involved with insurance or regular billing, for that matter, are using the correct code and charging the correct amount.

One other area that can cause problems is premature billing of insurance for crown and bridgework and dentures. Although most offices seem to want to bill the insurance on the date the procedure is started, the wise and safe thing to do is wait to bill the insurance after the crown/bridgework is seated or the dentures are inserted. Even though the insurance company may want you to bill with the prep date, it is safer to bill after seating. Why? There are some situations where the patient never returns to receive the crown and bridgework, mainly because they did not have the money to cover their co-pay, etc. in the first place, and decide to go elsewhere. Nothing you can do will convince them to come back to your office. You have received payment for a crown they did not receive. The new dentist tries to bill the insurance and, of course, the new claim is rejected. Even though this is not insurance fraud as early billing is allowed, the patient thinks it is and you will be accused. You are better off to wait until the dental work is "out on the street." The same advice applies to root canal therapy.

In both cases, if the patient does not return you can at least bill for a temporary crown and crown prep or palliative treatment and not have to backtrack and figure out an appropriate refund for the insurance company. Of course, we also recommend that you have crown and bridge and denture patients sign a financial agreement ahead of time wherein they agree to cover half of the entire fee or their entire co-pay if they have insurance, before you send the case to the lab or finish the case, if you have Cerec, etc. This way, they have at least paid you something and are thus more likely to return to receive the finished product.
--RCE

LESSONS LEARNED FROM TRIAL INFORMED CONSENT

We recently had a case go to trial. Naturally the good guys won, but it took a great amount of effort and preparation. Of course there were no alterations in the dental records and we had an excellent, local expert witness able to testify about the standard of care.

In all cases we have tried, the topic of informed consent is raised by the plaintiffs' lawyers and is significant. Of course, they want to try to prove that the patient was unaware of the risks of the procedure in question and then try to assert that the patient would have never undergone the procedure had they knew the risks.

Utah law is very favorable on the topic of informed consent but simply shoving a document in a patient's face and requiring them to sign it does not constitute true informed consent. How many of you that have undergone hospital procedures really take the time to read the two page informed consent they give you?

So what constitutes true informed consent? Although we do not set the standard of care when it comes to informed consent, we can provide suggestions to help you ensure that your patients are well informed of the risks and procedures you plan to do and offer their consent to have you proceed.

1. An informed patient is told about the basic steps of the planned procedure, the risks, the prognosis and alternatives.
2. Whether you have an assistant go over the steps, etc. noted in #1 above or you handle this step youself, you, the dentist, should have an opportunity to answer any questions the patient has and make sure they understand what is going on. It does not hurt in some cases to emphasize the most common risks of the procedure and check these off on your written form. Many oral surgeons have the patient initial each part of the informed consent form they use to prove that the patient read and understood each part of the consent document.
3. Having the patient sign a written form verifies that a discussion took place and risks, etc. were presented to the patient. The written form avoids any "he said/she said" scenarios from coming up later.
4. You should add the following comment to your written records: "*Procedure, risks, prognosis and alternative procedures explained to patient. Consent given to undergo procedure.*"
5. If you are doing something like multiple crowns, you can write tooth numbers on the initial form the patient signed. For subsequent procedures you can remind the patient that you went over risks, etc. before and ask if they have any additional questions, and log that in your records.
6. If too much time goes between procedures, or you may be doing a more extensive follow-up procedure, you should have a discussion pertinent to that procedure and use an additional written informed consent form, if appropriate.
7. If patients object or complain about having to sign the form or sit through a discussion about risks and alternatives, you can tell them that you like to have happy patients, and happy patients are informed patients. You can remind them that in the dental office, no one likes surprises, and you make every effort to ensure that your patients understand what is going on and give their permission to allow procedures to be performed.
8. Of course we recommend that you have patients sign a

paper informed consent form and then scan it in rather than using the pad system as it makes it harder for patients to lie about exactly what they signed.
--RCE

RENEWAL FORM TRANSMISSION: WHAT ARE THE BEST WAYS?

More and more PIE insured are sending their renewal forms, etc. electronically and then paying their premiums by credit card. We are happy to accommodate this manner of data transmission and premium payment but have noticed some problems with methods of transmission. To help us more effectively deal with these renewals, please heed the following suggestions:

1. Do not simply take a photo of the renewal form with your cell phone or pad device. These are generally unreadable and will not pass muster with Insurance Department audits.
2. The best way for you to get electronic forms to us is to run them though a good scanner and e-mail them as an attachment. We need a good printed copy for your paper chart and we can easily print them out in this fashion.
3. You can also scan your dental license and include that as an additional attachment or with the renewal form.
4. If you use another entity to handle your accounts payable, make sure they include your name and policy number on the check they send us. From time to time we get checks with no name or number and we have to do some detective work to make sure the check is credited to the right account.
5. Most days we close out the collection of payments at 5:00 PM. If you need to make a credit card payment, please call us before that time. For your safety we do not record credit card numbers anywhere, either in writing or electronically, so we don't wait until the next day to complete a transaction.

PATIENT REFUSALS: WHAT TO DO??

We have covered this subject in prior newsletters, but we still get several calls weekly so the topic requires ongoing reminders. Please share the content of this article with your entire staff. The ongoing issue has to do with patients who refuse your recommendations, especially when it comes to x-rays or periodontal treatment, or patients that just want cleanings done without a periodic exam.

Many of you still ask us to e-mail you a form a patient can sign to waive you, the dentist, from responsibility if a patient refuses to have recommended dentistry done or refuses x-rays. For example, a new patient comes in who just wants a cleaning they refer to as a "quickie" that is not accompanied by an exam or x-rays. Or a recall patient with a documented above-normal decay rate does not want x-rays taken because their insurance plan only covers one set of bitewings/per year under a new set of criteria.

The other common scenario involves a patient with periodontal problems who needs scaling and root planing or even more involved procedures on a regular basis who decides he/she does not want to go through that process and asks you to simply do a prophylaxis. They agree to sign a waiver absolving you of any responsibility.

The problem is that as dentists you cannot manage a patient in any way that condones negligence. If you know that a patient really needs scaling and root planing but ignore the indications and let them off the hook, you are negligent and committing malpractice. What will happen in this case is as follows: You will go along doing "quickie" prophys for a year or two but while you are on vacation the patient will develop a periodontal abscess and go elsewhere. At that point the new dentist will be allowed to take all the x-rays they need to take to perform a proper diagnosis of the situation confronting them. The "new" dentist will tell them, "You have some severe periodontal problems and are probably going to lose some teeth. When was the last time you saw a dentist?" The patient will then exclaim, "Oh, I go to Dr. X, and the hygienist cleans my teeth every six months!" Of course the patient will not admit that they refused periodontal treatment or x-rays. The new dentist will say something to the effect that, "Well, it looks like Dr. X has missed a few things." and the patient will decide that you are now responsible for the extensive treatment they will need to either save or replace their bad teeth. So, what should you do?

When the patient tells you they can't afford periodontal treatment or do not want to go through with it, you should say something like: "We have a culture of prevention we are trying to encourage with our patients. In other words, we would like to help you avoid having expensive dental problems. There is no point in our doing fillings, crowns, or any other treatment if you are not willing to follow our recommendations. Your teeth and gums are in a situation that warrants more than just a standard cleaning. If you are not willing to follow our recommendations and efforts to promote prevention, we cannot function as your dentist. Truthfully, you can't afford not to follow our recommendations if you want to preserve your teeth!"

Likewise, when patients refuse x-rays you can tell them that they are basically asking you to treat them with blinders on and you cannot do your job sufficiently unless they let you gather all the evidence necessary to make a proper diagnosis and help them take care of their teeth. The same goes with them not wanting you to complete a periodic examination.

Of course, not all patients need x-rays every six months. ADA Guidelines on x-rays indicate that the frequency depends on the patient's rate of decay and other factors. Many people do not need x-rays more often than annually. And for those that need them more frequently, you can remind them that x-rays are quite a bit cheaper than the fee for a large restoration or even a root canal if decay develops that is undetected because the patient will not allow x-rays to be taken that would quickly indicate a problem.

Please discuss this issue with your staff, including your hygienists and non-clinical staff since they are the ones who call us and ask for the waiver forms. Your entire office staff needs to know that such forms are not recommended and therefore we have none here to provide since they are not worth the paper they are printed on!

DENTAL IMPLANTS VS. ROOT CANAL THERAPY – IS ONE BETTER THAN THE OTHER?

Recently I had an encounter with a dentist claiming to be an "implantologist" who tried to prove to me with various articles that implants were a better alternative than root canal therapy, especially in cases where endo re-treatment or apicoectomies were being considered. On the other hand, I have spoken with several endodontists who explain that successful endodontic therapy has a long track record yet no one really knows how long implants truly last since they have been on the scene for a relatively shorter period of time.

At the 2015 ADA meeting the topic was covered by a panel of dentists the ADA considered to be experts in various dental disciplines. Their views were interesting and worth repeating here:

1. Making comparisons may be an exercise in futility as each case is different and issues such as location, dealing with anatomic structures and patient healing responses have to be weighed.
2. Ethics must be considered and the best pathways to care for the individual patient must be weighed.
3. Many endodontic failures are primarily related to vertical root fractures and excessive post placement. Treating dentists must consider what can be done to prevent these post-endo issues. Many dentists forget the true purpose of a post, which is to assist in retention of buildup material.
4. Bias often enters into the decision. After eliminating third molar and orthodontic extraction cases, an oral surgeon on the panel noted that 41% of the teeth he extracted had previous endodontic procedures, including an additional 9% of teeth referred by endodontists who determined that there was indeed a root fracture.
5. Endodontists on the panel stressed that the longevity of endodontically treating teeth may be contingent on good oral hygiene practices on the part of the patients and their maintaining their restorations following endodontic treatment through not only good hygiene but periodic examinations by their general dentist.
6. Although five-year success rates are comparable between the two treatment modalities, better well designed long-term studies are needed.
7. Pre-treatment evaluation is important. A tooth should not be considered for endodontic treatment if it is non-restorable.
8. Are there different success rates when you compare implants placed by general dentists vs. periodontists vs. oral surgeons? Does training and experience make a difference?

What has PIE noted over the past two or three years? We have seen more report of failed implants lately due to various reasons, especially in the posterior portion of both arches. Width of available bone can be a major factor and that is where CT/Cone Beam images can be very helpful. Is a healthy root or auto-implant a better alternative than titanium? Is an implant a better alternative than a three unit bridge? There may still be some debate with these questions, and individual patient characteristics must be considered.

AN ALTERNATIVE LOCAL ANESTHESIA TECHNIQUE

How many of you get frustrated when you miss a block? It can happen often and wreak havoc with the schedule. However, one of our very own PIE insured dentists (Dr Gregory Tuttle – Tuttle Family Dental in Orem) has come up with new local anesthetic protocol called **TNN** or TuttleNumbNow. Dr. Tuttle spoke at the 2016 UDA Convention but thought he should check with me at PIE before he spoke at the convention and presented the personal training course for dentists he developed. He wanted to make sure it was within his scope of practice to do so.

He met with me and showed me the training kit he sells online that teaches how to do single tooth intraosseous anesthesia as the primary injection which shows how to penetrate the buccal plate with a 30 ga needle and standard syringe in his 20 step technique. According to Dr. Tuttle, the technique is blowing up threads on DentalTown and he has spoken with several of the world's dental leaders about it.

As far as the TNN technique, I was not only impressed but I wrote a supportive letter for the following reasons:

1. The technique has far less potential for adverse side effects than the standard anesthetic blocks, particularly those used in the mandible. Therefore it is safer for the patient.
2. Less anesthetic is used which eliminates the normal concern of using too many carpules encroaching on the thresholds of safe dosages where block anesthesia is difficult to achieve.
3. The technique has the potential to foster happier patients as the wait time for the anesthetic to become effective is diminished and the patient does not have to go home with a numb lip and tongue. They can also have restorative work done in all four quadrants in the same visit without having to have the entire mouth numb due to block anesthesia.

Being able to anesthetize "difficult to numb patients" is a huge step forward. Happier patients tend to be less litigious.
In summary, I recommend the TNN as an effective and very safe technique and can foresee it as becoming a standard, preferred technique used to deliver local anesthetics as dentists learn about it and have the opportunity to implement it as part of their practice.

Of course, as with any new technique, proper training and equipment is mandatory to ensure safety and success. Dentists trying to do the TNN anesthesia technique without the proper training may become frustrated or may not administer it properly as much of TNN is counter-intuitive. The intellectual property of TNN is trademarked and patented so copying and distributing materials is prohibited.

Over 400 dentists were instructed at the UDA convention and received free TNN training in Dr Tuttle's 3 hour course. If you missed the UDA meeting last year, the training cost is now $490

at TuttleNumbNow.com and their slogan is "Set down the syringe and pick up the drill".

PIE appreciates dentists such as Dr. Tuttle out there having a positive impact on the profession with new techniques.
--RCE

GUEST COMMENTARY

- **By Daniel A. Boston, DDS**
- **Member, PIE Board of Directors**

As many of you know I am a flight instructor up in Logan and have been doing it for about 4 years. To become a certificated flight instructor (CFI) you first have to earn your private license, then get an instrument rating, become a commercial pilot (no I cannot fly for Delta) and then a CFI. There are written tests, oral tests and flight examinations that go along with each of these steps. If you then go on to fly for Delta, Skywest, etc. you then earn the Airline Transport Pilot (ATP) rating.

There is now a shortage of pilots available for the large airlines and so the requirements have been lowered to where you only need 25 hours of multi-engine time where it used to be 250 hours. Some airlines are now taking people with no flying experience and train them in shorter hours to end up in the right seat flying for the public. Has this lower the safety of flight—I don't know and time will tell. The safety record of commercial airlines is remarkable. Part of this is due to recurrent training, FAA oversight and having two or more pilots on board.

Dentistry has quite a similar path on becoming a dentist. We have to first go to college, do well, then go to dental school and again pass written and practical tests. But this is where some of us quit following the aviation model. Some do not do recurrent training except for the bare minimum of 30 hours every two years. They may even attend the same classes over again without really learning the new methods and techniques. I am not suggestion that we all go out and become the first to try the new equipment. But I am suggesting that we study and learn the new materials and equipment that are available.

Overall I would think the safety record of dentistry is very good. We have very few situations that require immediate medical intervention. I remember one local dentist that somewhere remembered that nitrous oxide could be irreversible in patients with low vitamin B12. I, for one, had never heard of that side effect of nitrous oxide. I am sure there are many other examples of possible deadly complications that could affect your dental practice. At Professional Exchange Insurance, Inc we do our very best to help you in maintaining a very good safety record.

If you haven't taking a really good CE course lately let me encourage you to do so as there are many avenues. Both dental schools present courses, become a member of the Academy of General Dentistry, be active in the ADA. The annual meeting this year is in Denver and there are many courses to choose from to help you become a better dentist.
Have a good mentor or friend that can help you when you face a situation that you need help in deciding the best course of action. Just like the airlines with two or more pilots it helps to have an extra set of eyes looking at that panel.

May we be the captain of our dental practice, use good safe procedures and keep the practice upright. Have a safe flight and land at the intended airport
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CSD Information and Reporting Illegal Activity

1. It is unlawful for any person knowingly and intentionally to possess an altered or forged prescription or written order for a controlled substance. Also, to acquire and possess a controlled substance obtained by fraud and deceit.

2. Call the Division of Occupational & Professional Licensing (DOPL), Bureau of Investigation at 801-530-6630 to:
   - Request a pharmacy alert to be issued by DOPL regarding the misuse of the practitioner's (dentist) Drug Enforcement Administration (DEA) number.
   - Report DOPL licensed individuals who may be altering, forging, or prescribing in appropriate amounts of controlled substances.
   - Report a patient that is suspected of "doctor shopping" or committing prescription fraud to DOPL for a pharmacy alert and local law enforcement for investigation.
   - DOPL complaint(s) may be submitted online at http://dopl.utah.gov/investigations/complaint.html

3. All practitioners (dentists) who possess a current Utah license to administer and prescribe controlled substances are required to register to access the Controlled Substance DataBase Program (CSD). The link (url) to register and use the CSD is csd.utah.gov.

4. Practitioners (dentists) are encouraged to search the CSD on a patient before a controlled substance is prescribed.

5. All practitioners (dentists) are encouraged to take advantage of the "Notification Program" (NP) within the CSD.
   - The practitioner (dentist) will be notified by either email, text, or both if a patient obtains another controlled substance prescription from another practitioner within 15-90 days.
   - Practitioners (dentists) may set up their own parameters by clicking on "Notifications Settings" after clicking on the "Notifications" button on the main search page.
   - Practitioners (dentists) may choose to opt out by changing the number of days to zero.

6. Practitioners (dentists) may check their controlled substance prescribing activity regarding their DEA number by clicking the "Search by DEA #" button on the main search page.