PROFESSIONAL
INSURANCE EXCHANGE
MUTUAL, INC.

NEWSLETTER

VOLUME 32, NO. 4

October 2017

Approaching 40 years serving the profession

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MANDATORY COURSE UPDATE

We have presented the first two mandatory courses in Logan and in Ogden and the feedback we have received has been very positive. With your attendance at these courses we can present some sensitive but important information in an effective manner. The attendance has been good so far with 48 dentists attending the Logan course and 160 attending in Ogden.

We have been asked why we do not furnish a handout or post information about the course content on our website or in this Newsletter. As we have mentioned before, we cannot do so since we do not want the information to easily fall into the hands of the plaintiffs' attorneys to use against us and against you, our insured. Because of the nature of the information presented, only you, our insured dentists, are invited to attend. The course is not designed for staff members, strictly dentists.

We have reproduced the schedule of courses on page 6 of this Newsletter. Nearly all venues are set and many of you have signed up to attend. As we mentioned previously, there will be a surcharge assessed of $250.00 at renewal for any PIE insured who do not attend.

If you have not signed up yet you can do it via e-mail or you can call and tell us which location you will be attending. If you call ahead of time, we can have the attendance certificate prepared in advance for you that will be passed out at the conclusion of the course.

Of course there will only be three courses presented during the remainder of 2017 in Provo, Vernal and Moab. We will resume the series again in March 2018 to avoid having to deal with winter road conditions.
--RCE

HIGHER LIMITS OPTION

Some of our insured dentists have asked about the availability of higher limits, ie. $2 million per claim, as some federal entities they work for, etc. are starting to require these limits. Although our current $1 million limits are more than adequate for Utah, effective January 1, 2017 we will be able to offer these higher $2 million limits at renewal time for any of you that need them. There will be an additional premium, of course but more details will be provided in the January Newsletter and in the announcement about the Annual Meeting that will take place next Spring.
--RCE

SOME DENTAL HORROR STORIES

October is the month of Halloween and humorous or macabre tales of pranks or scary situations abound. Most of these are pure fiction but I have been made aware of a few real horror stories that involve Utah dentists. These have to do with abuses occurring in office management protocols in large clinics where non-dentist office managers wield way too much power or in other situations where non-dentist owners commit abandonment or fraud.

My horror story begins with a short re-iteration of experiences described by current UDA editor Dr. Drew Jones in his recent editorial published in the September/October issue of UDA Action. He described working at an HMO in the 1980s which had the following working conditions for dentists:

1. A chart showing monthly totals of dollars produced and dollar per hour production. None of the 10-15 dentists who worked there wanted to be at the bottom of the list.
2. To increase production most of the dentists there resorted to questionable billing practices we have all heard before such as billing for buildups on every crown or improperly using the indirect pulp cap code with every filling even though only a drop of Dycal was placed.
3. Dentists were not called doctors but were called providers. If a dentist did not want to perform procedures on their schedule, the scheduler said there was no choice and since the dentist was merely a provider and not a doctor there was no rank to pull. If the scheduler told you to do it, you had to do it or else!

I recently had another dentist report an experience he had working at a large clinic offering discounted dentistry owned by dentists

but staffed by a draconian non-dentist office manager. He noted the following protocols in that office:

1. You could not refer patients to specialists for root canals. If the patient was taken to the front desk for a referral, the office manager refused to give out names but insisted that the procedure be done by a dentist in the office, whether they were experienced at molar endodontics or not!
2. The office manager would dictate treatment. If, for example, a dentist wanted to start a patient on antibiotics before taking out a tooth in an effort to control an infection the manager would insist that the tooth be taken out that day. As you would expect, there were financial incentives and bonuses for this mis-manager which depended on production quotas which is all that she cared about!
3. Chart entries were altered by the staff at the time of service if they disagreed with anything the dentist tried to write. Treatment plans were made up by the mis-manager and the dentists had no input in scheduling.
4. Dental assistants would routinely take final crown and bridge impressions so the dentists were freed up to do other procedures on other patients. Assistants were also doing dental extractions ala dental health aide therapists.

The third case that came in to me was a telephone call by a relative of a patient who asked about recourse for a situation where money was paid up front and services were not rendered. Apparently the patient paid for a crown and when they went back to the office the door was locked and no one would answer the telephone. The relative knew the name of the dentist who was supposed to render treatment and when I contacted him he explained that there had been a number of complaints against the non-dentist owner and the clinic had been shut down. He never received any compensation for the case in question. I told the relative that her only recourse was to contact the owner directly and to file a complaint with DOPL.

In the past I have been contacted by lawyers who wanted to seek recourse for a client who sustained a paresthesia following third molar surgery at a non-dentist-owed practice but the dentist involved dropped his PIE insurance and did not purchase a tail or coverage from any other company and had actually declared bankruptcy himself. The non-dentist owners had also declared bankruptcy and the lawyers were amazed to realize that there were no deep pockets and basically no recourse for their client. I told them to complain to DOPL and the legislature about the law allowing non-dentists to own practices in Utah.

There are some practices in Utah owned by non-dentists that try to do things properly and let the dentists practice quality dentistry without dictating treatment modalities, etc. but the horror stories seem to outweigh the better situations. In any event, any PIE insured who are in situations where they are encouraged to overtreat or where they are mandated by non-dentists about treatment they must perform, whether they want to or not, may want to seek a position elsewhere! Happy Halloween!

--RCE

PROTECTING PATIENT INFORMATION

A dentist recently contacted me to report that a patient became upset because his office asked for the patient to furnish their social security number (SSN) on their intake form and the patient did not want to give it to them. When I asked him why his office needed to have the SSN he was not sure!

In years gone by we would routinely obtain the patient's SSN as that number was often necessary to complete dental insurance forms, etc. But currently most dental insurance companies give patients a separate member number, etc. so the SSN is unnecessary. There are generally no reasons that accounting records require that number either so unless you have an accountant or other person associated with your practice that gives you a compelling reason why you should keep a record of patient SSNs, then don't bother to ask for them!

We ask for your SSN on our PIE application because we need that number if we ever have to file a Data Bank Report on your behalf. But we do not log these numbers in our computer system. The only place the number is kept is in your written file, and we have never had a situation where any dentist's SSN was taken out of the file. The paperwork is generally buried in the file and would be hard to find as well!

Likewise, patients are probably reluctant to have you keep a record of their credit card numbers unless you can keep it secured from hackers or others who might break into your computer system. You can probably simply have patients swipe their card in your reader or have your staff member enter the number directly either in person or over the telephone if they are paying you that way. If you must store numbers for future payments, they must be secured and protected.

We do not store any credit card numbers anywhere at PIE as we simply enter them into the reader as most of our payments are made by telephone. There is really no financially identifiable information on any of you that is stored in PIE's computers but we still try to have many safeguards in place to keep our information from being broken into by hackers or other unscrupulous individuals.

Some collection agencies do require dentists to furnish social security numbers to facilitate their ability to carry out the legal steps necessary to collect the debt. If you must keep a record of social security numbers, we suggest that you do not include these as part of any computer program but keep them in a hard copy ledger – the old fashioned way – which will keep this information from getting into the hands of hackers!

--RCE

LIABILITY AND HUMANITARIAN CARE

Occasionally we are asked about liability in case a dentist provides humanitarian dentistry with no compensation. The answers to questions about this situation are best handled by referring to the Utah Practice act. It reads:

A health care professional who provides health care treatment at a federally qualified health center, as defined in Subsection 1905(1)(2)(b) of the Social Security Act, or an Indian health clinic or Urban Indian Health Center, as defined in Title V of the Indian Health Care Improvement Act, is not liable in a medical malpractice action if:

(a) the treatment was within the scope of the health care professional's license under this title;

(b) the health care professional:

(i) does not receive compensation or remuneration for treatment provided to any patient that the provider treats at the federally qualified health center, the Indian health clinic, or the Urban Indian Health Center; and

(ii) is not eligible to be included in coverage under the Federal Tort Claims Act for the treatment provided at the federally qualified health center, the Indian health clinic, or the Urban Indian Health Center;

(c) the acts or omissions of the health care professional were not grossly negligent or willful and wanton; and

(d) prior to rendering services:

(i) the health care professional disclosed in writing to the patient, or if a minor, to the patient's parent or legal guardian, that the health care professional is providing the services without receiving remuneration or compensation; and

(ii) the patient consented in writing to waive any right to sue for professional negligence except for acts or omissions that are grossly negligent or are willful and wanton.

(6) Immunity from liability under this section does not extend to the use of general anesthesia or care that requires general anesthesia.

So there you have it! If you are only working under the conditions described above, you do not need malpractice insurance. However, if there is any doubt and the dentistry in question is performed in Utah, it would be a good idea to stick with your current PIE policy!

While on the topic of humanitarian service, a proposal is being considered that would allow 4.5 hours of CE to apply to the 30 hours required by DOPL every licensure period. Four hours of service would equate to one hour of CE.

The details are being worked out but the preferred method of documentation would be for the sponsoring entity to furnish a certificate giving written verification of the total hours of volunteer service provided. Alternatively the dentist would have to provide a letter to certify the total number of hours provided by the dentist or hygienist doing clinical dentistry.

As a reminder, you need to preserve copies of certificates for any CE courses taken for a period of four years after the course. Regular random audits of about 8% of license holders are performed by DOPL to ensure that dentists are actually taking the CE they are required to take.

--RCE

SOCIAL MEDIA AND DENTISTRY

More and more dentists are using social media outlets such as Facebook to post practice related topics. Do any of you have "No Cavities Clubs" for kids and at the end of the appointment you take a picture of you and the child with the intention of publicly rewarding the patient for having good hygiene, etc.? Well, according to an article published in the June 2017 issue of AGD Impact and written by Larry Emmott, DDS, a recognized expert on HIPAA issues, you are in violation of HIPAA if you do this!

Then, you read a bad review and respond with your own posting which states that you, the dentist, examined the patient radiographs and it is clear that the patient has gum disease and cavities that their other dentist has overlooked. Then you tell the patient to "go ahead and continue to live in your world of denial!" This, of course, is another HIPAA violation!

We have covered before the issue of dealing with bad reviews on social media but have not looked at marketing issues. The key that dentists have to constantly deal with, however, is maintaining patient privacy. And dentists need to realize that everything in the patient records, including patient health status, is protected by HIPAA. Even if you don't use the patient's name in a posting, etc. According to Dr. Emmott, HIPAA regulations have pages defining identifiers which, besides names, include initials, ZIP codes, account numbers, birthdays and photos. It is even a violation to just admit that so-and-so is a patient!

Dr. Emmott outlines a number of HIPAA violations in the article he has observed:

1. Responding to patient questions or complaints directly using a social media platform. Even acknowledging that a person posting on a Facebook page is a HIPAA violation! Instead, if a person has a specific question or complaint, it should be taken off-line and might most easily be handled by a telephone call.

2. Staff members or the dentist send "friend" requests to patients via personal Facebook pages. Instead, don't do that but encourage patients to "like" your practice page rather than trying to connect as "friends" with them. When you create a social media site, is must be done in the name of the dentist or the practice, not under the name of a staff member.

3. Any time photos are considered to be made public, the patient must sign a specific release for themselves if adults and on behalf of children under 18. And smart phones can be a problem if, for example, a picture of a patient is taken in front of a computer monitor that had the daily schedule displayed with patient identifiable information clearly visible. Selfies, especially can be a problem as people are not looking to see what is behind them!

Dr. Emmott wrote in the article that patient use of smartphones in the treatment area can be problematic for a number of reasons as

well. He mentioned that because Kim Kardashian posted a photo of herself in the dental chair with a rubber dam on, her loyal fans now want to take their own selfies while in the dental chair. But if you try to ban phones from the operatory, patients will become upset and resist. But you can invoke a policy of no photos or videos being allowed anywhere in the office. You can explain that the reasons involve privacy issues and the need to respect other patients. You can also make a rule that there will be no videoing of treatment or case presentations by patients. If a patient insists you can simply explain that you are not an actor and cannot furnish a decent presentation with the pressure of having something that people may watch out of context to use for ridicule.

Smartphones can also be a problem because any patient photos stored in something like iCloud, according to Dr. Emmott, now Apple is a business associate and you should obtain a business agreement with them and if they are hacked, you have a reportable data breach. This means if you must use your phone to take patient photos, you should turn of the cloud storage feature, which may not be easy. You are better off to use a digital camera dedicated to that purpose that is not part of any cloud storage of images.

Hopefully this article will help to spare you from getting yourself into some bad situations that could generate a HIPAA claim against you. Malpractice insurance does not cover HIPAA violations so you will have to pay for legal counsel and pay any fine out of your own pocket should inappropriate use of social media outlets land you in HIPAA Hot Water!
--RCE

HOW SHOULD WE PRESENT OURSELVES?

During your next lunch break google "Aspen Dental" and look for their advertisements. One of the first to pop up will be a dentist involved saving the day in a bank robbery and, to some, acting like a buffoon at the same time. There was a recent editorial in the ADA News written by Matthew J. Messina, DDS, the executive editor for the Ohio Dental Association. I will excerpt some of his comments below in italics and offer my own commentary.

Like most of you, I have become increasingly annoyed at the way the profession of dentistry is portrayed in the series of advertisements currently being aired by Aspen Dental. While I get it that they are trying to be funny, I am concerned that the Aspen ads perpetuate negative stereotypes of dentists, the practice of dentistry, and the cost of dental care in general. Advertisements like these, even if Aspen feels that they are intended to be humorous by exaggeration, do the profession as a whole a disservice.

We, as dental professionals, understand that many people are apprehensive about visiting the dentist and the fear of the cost of care is a significant component of those concerns. When outside voices work to intensify those perceptions, portraying dentists as greedy, uncaring people and visiting the dentist as time-consuming and uncomfortable, it hurts the public. We should be working to educate the people about why taking good care of their teeth and investing in good oral health is valuable and a necessary component of overall wellness.

Unfortunately dentists are often portrayed in movies, etc. as zealots consumed by dental floss or as a nerd or doof worthy of ridicule. This image is what concerns Dr. Messina. How do PIE insured generally think that dentists should be portrayed. At Halloween time should we be interested in collecting candy from kids to prevent cavities or should we hand out toothbrushes? I used to joke that I do the opposite and hand out Black Cow suckers, Sugar Daddy suckers or Cinnamon Bears to pull out as many fillings or crowns as possible to increase business! Patients used to laugh at that as they knew that I was kidding but was I out of line as well?

We are licensed as dentists because we must be trusted by the public as we may hold their lives, or at least, their teeth in our hands and we are expected to hold to a higher standard as a professional. We are not required to take ethics courses as part of our license renewal process, even though lawyers and insurance agents must take such a course each licensing cycle. Yet, we are expected to practice to high ethical standards and do the right thing for our patients.

Should we be conscious of our image as dentists? We want patients to look up to us, not because we are arrogant and feel that we are above them in social status but because they consider us to be helpful and eager to do our best for them. We want them to have confidence in us and consider us to be above average.

So, maybe doing outlandish things or playing the fool is not a good idea and some may criticize us. Yet, we are individuals and we attract patients for various reasons. Some patients do not like to "conform to the norm" and may like you because you are unique but sincere. What kind of "professional" do you want to be? Consider the ramifications as the choice is yours.
--RCE

GUEST COMMENTARY

- **By C. Brook Olson, DDS**
- **Member, PIE Board of Directors**

"Teeth: The Story of Beauty, Inequality and the Struggle for Oral Health"

The title noted above was the title of a book released this Spring by Mary Otto. She is an experienced writer and has been writing about health care and poverty for many years. The editorial reviews maintain it calls for sweeping change and should be read by every policymaker and health professional who believes we should reduce the barriers to dental care and spur others to social action. While I enjoyed the book, I am uncomfortable with some

of the conclusions proposed to solve the problem of poor dental health among the poor in our country.

The book provides a great history of the professional education of dentists, the separation of dentistry and medicine, and why physicians prefer to examine their patients from the tonsils down. There is also a great review of our transformation to satisfy our patient's desire for "the Great American Smile" and treatment for the "social six" maxillary teeth.

There is frequent referral to the tragic case of a young Maryland boy, Deamonte Driver, who died from an untreated and infected tooth which became toxic. After his death and over $250,000 in hospital expenses, there were many who asked how this could happen. There were local and congressional investigations and the maze of underfunded Medicare contractors and subcontractors was made clear. It was made clear that there has never been money available for meaningful dental care for the poor. Even the money available for children has been inadequate.

When in a discussion of "lack of access," you might assume there are no dentists or providers for the poor. "Lack of access" really means there is no one to pay for the service. When health care officials discuss lack of access they are really discussing who is going to pay for it. It does not mean there are no dentists willing to provide care.

This book offers a great review and history of our government attempting to control and influence the cost of health care, from increasing the number of medical and dental graduates to increase competition, to authorizing the use of auxiliaries and para-professionals to provide service. Our dental boards are being challenged for restraint of trade by the Federal Trade Commission as they attempt to certify and accredit licensure. We can learn from the legislative history and the tactics used in other states to **change the laws and dilute our profession.**

If you don't get the chance to read the book, I've included a few lines I felt were meaningful. They must be by the author as no credits were noted.

1. The mouth is a portal, an interface, an erogenous zone.
2. It is our first connection to the world and our last.
3. It is the domain of the breath, the self-expressing lips.
4. The grotto of the tongue.
5. The realm of the teeth.
6. The teeth that are part animal, part mineral.
7. The teeth, inlaid by jade by the ancient Mayans, still fetishized today.
8. The teeth, rotting and aching at the dawn of agriculture, still tormenting today.
9. The teeth that are whitened and straightened.
10. The teeth that are amputated and thrown away.
11. The teeth that endure longer than the bones, that withstand fires, floods, time.
12. The teeth that identify us, scattered in deserts, buried in caves.
13. The teeth keep a record of our lives, locked in their enamel. They identify us even beyond the grave.

I hope you enjoyed this short foray into the current state of dentistry and society. Thank you for your support of PIE.