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Traveling Dental Specialists

Guidelines for independent contractor arrangements

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It's practical, makes sense economically and increases service to patients. So it's no surprise that risk management and dental policy analysts have seen an increase in questions, claims and cases relating to "visiting" dental specialists in general practices.

"We've heard enough from general dentists and specialists to know it's becoming more common," said Greg Alterton, a policy analyst for the California Dental Association, which has the topic on its policy radar. According to Alterton, the arrangement is typically on a contract basis where a specialist visits a general practice on a periodic basis such as once or twice a month.

The benefits of an in-house specialist arrangement include the potential for general dentists to have better communication about patient care and treatment. They do not have to refer a patient out to a specialist, wait until the patient goes and then hope the patient returns. Offering specialist services keeps patients in the

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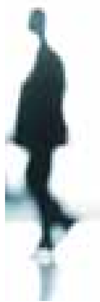

"The vast majority of specialists and general dentists are doing things properly, but there is work to be done to enhance safety and quality and make sure everyone is on the same page and following the same protocol and processes."

GREG ALTERTON, policy analyst for the California Dental Association

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practice and the practice owner in control of the treatment. Advantages for specialists include minimal employee and property overhead and both reduced patient record storage and billing issues. Patients receive convenient "one-stop" treatment in an office with staff they already know and trust.

While there are advantages to all parties involved in traveling specialist situations, risk management analysts and legal experts advise having thorough documentation involving any independent contractor agreements addressing staff, equipment, billing, patient communication, follow-up care, emergency response, insurance coverage and use of provider numbers.

"The vast majority of specialists and general dentists are doing things properly, but there is work to be done to enhance safety and quality and make sure everyone is on the same page and following the same protocol and processes," Alterton said.

A recently closed claim with The Dentists Insurance Company illustrates the need for both parties to establish clear guidelines in writing before patient treatment begins.

In that case, a periodontist was practicing once a month in a general dental office. The general dentist had a patient who was dissatisfied with her gum tissue around teeth Nos. 7 and 8. The general dentist developed a treatment plan including removal of the crown on tooth No. 8 and temporizing it with a shorter margin. The periodontist would perform a gingival graft in the area. The patient agreed, and the staff scheduled the procedure for the next time the periodontist was in the office.

The patient came in for the connective tissue graft. Everything was proceeding without incident and the periodontist excised the donor tissue from the palate on the left side. Unfortunately, the dental assistant accidentally disposed of the tissue graft. The periodontist told the patient what happened and that he would need to take another graft from the right side of the palate. The patient approved. Bleeding occurred during the second procedure, but he was able to get it under control and placed a periopak.

The patient returned to the general dentist's office with ongoing complaints of bleeding and the inability to tolerate the periopak. She removed it shortly after the appointment and had not been able to stop the bleeding. The periodontist was not due back to the office for several weeks and was unavailable to discuss the patient's concerns. Office staff relayed the situation to the general dentist who decided to examine and treat the patient. He used lidocaine with epinephrine to control the bleeding and then a laser to cauterize the area of the second donor site. He placed a stent and the bleeding stopped. The patient left the office then called later to report that she also removed the stent because it was uncomfortable. The general dentist then referred the patient to an oral and maxillofacial surgeon for follow up.

The patient claimed ongoing bleeding for two months and sought emergency room care twice. On one occasion, the patient presented to the emergency room with concerns about ongoing bleeding. During the second emergency room visit, medical staff was unable to control the bleeding and the patient was taken into surgery. Records indicate there was "significant arterial blood pumping in the first molar region." The physician used electrocautery to control

the bleeding and placed packing and sutures. The patient claimed these issues caused her pain, vomiting and dehydration.

She wrote two separate letters to the periodontist during this period, sent in care of the general dentist. The general dentist did not forward the letters to the periodontist, as he believed the specialist would be in his office that month to see patients. He would personally hand the periodontist both letters. However, because no periodontal patients were on the schedule that month, the periodontist did not visit the office. The general dentist did not inform him of the patient's situation.

In the meantime, the patient went to a second oral and maxillofacial surgeon who advised the patient that the periodontist likely nicked the palatine artery while excising the second tissue graft. The patient sent a demand letter for out-of-pocket expenses to the periodontist who forwarded it to TDIC.

TDIC's consulting periodontist reviewed the case concurring with the second oral maxillofacial surgeon saying it was possible the periodontist nicked the palatine artery during the periodontal procedure. That opinion combined with the lack of communication between the two dentists, and no planned protocol for emergencies caused the claims representative concern. Because the patient only asked for out-of-pocket medical and dental expenses, TDIC recommended settling. The periodontist agreed to settle and the case closed.

In reviewing this case, risk management analysts note several concerning areas for both the periodontist and the practice owner. Clearly, both dentists should revisit the follow-up protocol for patients undergoing periodontal surgery. In this case, areas of concern include:

- Records were minimal regarding informed consent for the connective tissue graft surgery. Because the periodontist was conducting the surgery, he should have been the one to provide the informed consent discussion with the patient. This would have also allowed the patient and periodontist to form a solid doctor/patient relationship.

> Risk management analysts say patients have a reasonable expectation to receive help in the event of a treatment related complication.

- The general dentist did not have a procedure in place for untoward events that may occur when patients undergo treatment from the traveling periodontist. While he did respond to the patient's complaint, he did not notify the periodontist when the patient reported pain and bleeding after the procedure. No doubt the general dentist intended to give the periodontist the patient's letters; however, he did not do it. The periodontist did not have an opportunity to respond to an issue his patient had. It appeared to the patient that the periodontist did not care about her situation.

This patient only demanded repayment for out-of-pocket expenses. Considering the sequence of events including the emergency room visits, this case could have been much more involved than it was.

Risk management analysts say patients have a reasonable expectation to receive help in the event of a treatment related complication, and advise both general dentists and specialists to consider the following before entering into an independent contractor situation:

Pretreatment considerations

- How will the specialist develop rapport with staff and patients before beginning treatment? Risk management analysts advise visiting specialists to meet all of the practice's staff. Make sure all staff treating patients are licensed and current. Know who will be assisting the specialist and that individual's qualifications. The specialist should review his/her expectations of the assistant especially in the event of an emergency during the procedure.
- How are patients notified of the separation between the practice and the traveling specialist? This can be in a statement provided to all patients scheduled for treatment with the specialist prior to their appointments. It should outline the specialist's relationship to the practice and that he or she will be in the office once a month (or whatever the agreed upon timeframe is) to provide their services.
- How will billing be handled?
- What if a patient wants a refund?
- What if a patient cancels an appointment with a visiting specialist? Does the patient still receive a bill? Does the specialist receive compensation for showing up even if a patient does not?
- What happens if the specialist separates from the practice? Risk management analysts advise a mandatory 30-day notice in a contract to ensure continuity of care.

Treatment protocol

- Is the staff person assisting the specialist familiar with the procedures he or she will be performing?

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■ What happens in the event of an emergency? Does the specialist know where all of the emergency equipment is located? Does the specialist's emergency protocol differ from the office's emergency protocol?

Post treatment protocol

■ After a procedure, will the specialist complete the post-op check or will the practice owner? Is a protocol in place when responding to issues related to the specialist's treatment?

■ What is the protocol if a patient calls after a procedure with a treatment-related issue? How will the office notify the treating specialist? How will they confirm that the specialist has responded?

■ Is the practice owner capable of handling complications? What is the practice owner's expectation of the specialist when a patient experiences a complication?

■ If a post-treatment concern arises, will the specialist be available to address it?

Specifics include a written contract and insurance verification

As a senior trial attorney with more than 35 years of experience providing legal service to dentists, Arthur Curley has a list of do's and don'ts when it comes to the topic of dental specialists working on a periodic basis in general practices.

"It's really a list devised from the various cases and disputes in which we have been involved," said Curley, who practices in Northern California.

Curley defines the ideal relationship between a visiting specialist and general dentist as an "independent contractor" arrangement, especially if visiting specialists bring all or some of their own instruments and staff. "If a specialist is an independent contractor, patients should sign a notice of that status before receiving any treatment by that independent contractor," he said.

Both parties should "absolutely" have a signed contact, Curley emphasized.

Experts agree on the importance of specialists and general dentists outlining in clear terms the points previously mentioned as well as compensation, refunds, ownership of and access to original patient records and data, supervision of staff and recordkeeping minimums. Each dentist should provide the informed consent and post-operative instructions for the treatment he/she performs. Additionally, include expectations for after-treatment issues, such as addressing post-operative infections, pain or nerve injuries, after-hours and on-call duties and communication protocols. Another area requiring attention is the use of insurance provider numbers and agreement upon which dentist uses what numbers and how.

"Get it all in writing."

ARTHUR CURLEY, senior trial attorney

"Get it all in writing," Curley said.

Additionally, review professional and employment insurance policies to ensure both dentists have adequate coverage. Verify and document active licenses and permits, including licensed staff as needed, and do so on a yearly basis. Curley advises background checks as well.

Disclaimer: This information is intended for general guideline purposes, and is not legal advice.

Structured Settlements

What is a structured settlement and why should you care?

File this under good to know. A structured settlement is a financial arrangement in which a claimant agrees to settle personal physical injury or wrongful death claim for payments made over time instead of in a single lump sum.

Awareness of structured settlements sheds light on a useful tool that can assist with the settlement of claims and mitigation of future damages. "Structured settlements help save indemnity dollars and protect the injured parties to whom the future damages will be paid," according to Stephen Frappier, a certified structural settlement consultant practicing in 20 states.

"Structured settlements have been used for years to help resolve dental cases in which there are claims for significant future damages," said Frappier who has assisted claims professionals at TDIC and other dental insurance companies in arranging for structured settlements to fund future benefits. Cases range from the accidental extraction of permanent teeth, anesthesiology-related incidents and allegations that cancer should have been detected during dental examinations.

Structured settlements are also very common in cases involving minors, according to Sheila Davis, assistant vice president of Claims and Risk Management for TDIC.

"In California, the court must approve of any settlement made on behalf of a minor and this typically involves placing the money for future costs in either a blocked account or a structure," Davis said. "The benefit of a structure is that you can receive a greater payout by extending out the payments in what is essentially an annuity versus a lump sum."

The tax advantages of structured settlements are valuable to both defendant dentists and injured claimants. A properly designed and funded structured settlement excludes all future payments from federal and state income tax, according to Frappier. "When a personal injury claim is resolved for cash, it is also excludable from income tax. However, once the money is invested, the interest earned is usually taxable," he said. By using a structured settlement, both the initial investment in the annuity and the interest build-up that funds the future periodic payments are excluded from income tax. "This can be a significant advantage."

Frappier noted that structured settlements are funded using highly rated life insurance companies. "There is very minimal investment risk and the use of annuity contracts protects against dissipation of funds needed for future medical or dental needs."

Studies by property and casualty companies show that structured settlements are an aid to early claim settlements and help reduce legal expenses by preventing cases from proceeding to trial.

Additional considerations about structured settlements include that once the structured settlement is in place, payments are fixed and cannot be accelerated or changed. "If there is some element of future damages that is uncertain, such as possible future surgery in 10 to 15 years, the funds should be reserved in cash or a trust should be utilized," Frappier said. "Structured settlements are not usually used to address future damages which occur within five years of the settlement. The potential interest that could be accrued when investing settlement proceedings within this short timeframe is not profitable enough to make it worthwhile," he added.

Structured settlements have been used to help convert adverse verdicts to the periodic payment programs for future damages under the Medical Injury Compensation Reform Act (MICRA), which is utilized in California, and other similar tort reform initiatives such as Nevada's Question 3, also known as the KODIN initiative.

Frappier said it is important for dentists to make sure their local legislators are aware of structured settlements as a powerful tool in resolving personal injury and wrongful death claims. "The continuation of structured settlements ultimately helps keep dental liability insurance premiums in check while providing tax-free financial solutions for the care of injured parties."

Emailing Patient Information

TERESA PICHAY, Practice Analyst, California Dental Association

The U.S. Department of Health and Human Services (HHS), the agency that enforces The Health Insurance Portability and Accountability Act (HIPAA), has clarified that unencrypted email may be sent to patients who have been advised of risks and have consented to receive unencrypted email. However, if the use of unencrypted email is unacceptable to a patient who requests confidential communications, other means of communicating with the patient, such as by more secure electronic methods, or by mail or telephone, should be offered and accommodated. In addition, patient consent to receive unencrypted email is not consent to transmit protected health information in nonsecured communications with other entities such as specialists and payers.

The HHS statement was included in the January 25, 2013, publication of the amendments to the HIPAA Privacy, Security and Breach Notification Rules that are required by Health Info Tech for Economic & Clinical Aid (HITECH) legislation approved in 2009.

Patient consent to receive unencrypted email is not consent to transmit protected health information in nonsecured communications with other entities such as specialists and payers.

Here are a few suggestions to obtain patient consent to communicate via unencrypted email. Be sure to retain documentation with the patient record.

Reply to a patient's emailed request for information

We are happy to respond to your query but in order for us to do so via email, you must provide your consent, recognizing that email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. We will use the minimum necessary amount of protected health information to respond to your query.

If you wish to conduct this discussion via email, please indicate your acceptance of this risk with your email reply. You may withdraw your consent at any time. Alternatively, please contact our office to arrange a telephone conversation or office visit if you decide against corresponding via email.

Act on a verbal request from the patient

Ask the patient to send an email to the office, and then the office can respond as described above. Or, you can discuss with the patient the risk of unsecured email and document the conversation and consent in the patient record.

Add to the Patient Information Form

Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provide.

Include check boxes for three statements:

☐ I consent and accept the risk in receiving information via email. I understand I can withdraw my consent at any time. My email address is ________________.

☐ I consent only to receiving appointment reminders via email or text. I understand I can withdraw my consent at any time. My email address is ________________.

☐ I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

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First Quarter Advice Line Report

The Risk Management Advice Line is a service provided to all policyholders and members of Associations that endorse TDIC. Analysts providing this service include Jaime Welcher, Taiba Solaiman, Yasica Corum and Natalie Miller. The Risk Management department has a 24-hour return call policy. Call topics can range from how to address divorced parent situations to communicating with noncompliant patients to various employment issues.

Analysts took 5,115 new calls in the first quarter of 2013. This is a 15 percent increase compared to the first quarter of 2012. Of those calls, 87 percent remained within the Risk Management Department. Analysts referred 5 percent to the claims department. The remaining referrals were divided between employment attorneys, the CDA Practice Support Center and TDICIS Member Services. Eighty-four percent of calls pertained to Professional Liability issues, 15 percent related to Employment Practices Liability matters and the remaining 1 percent of calls concerned General Liability inquiries.

Early intervention may help avoid an issue altogether. TDIC encourages dentists to call the Advice Line at 800.733.0634 ext. 2.

Questions and Answers

Q: I practice in California. Last week, my front-desk employee reported falling in the lobby area and landing on her knee. She told me she thought she would be OK, but then both her knee and back started hurting. I recommended that she get it looked at by her doctor. I also offered to pay for that appointment. She has since given me a workers' compensation form to fill out. Why do I have to do that if I pay for the doctor's bill?

A: In California, an employer who is not legally self-insured may not agree to pay an employee's medical expenses (*other than first aid), in lieu of reporting a workers' compensation claim to his/her insurance carrier. To do so is illegal. Medical doctors who treat work-related injuries are required to provide a physician's first report of injury (PR1) to the employer's worker's compensation carrier following treatment of any industrial injury. Any agreement between an employer and physician to attempt to circumvent the workers' compensation system is considered a form of fraud on both the part of the employer and the medical doctor.

California regulations state that you as an employer must provide a DWC1 claim form to your employee within one working day after the injury or illness is reported. You must provide a copy of the completed DWC1 to your employee within one working day of receipt of the completed form. You must forward the claim form to your workers' compensation insurance carrier within one working day of the receipt of the completed form.

California allows the insurance carrier 90 days to conduct an investigation and either accept or deny liability for the injury or illness. The 90-day period starts from the employer's notice of the injury or illness. Failure to deny a claim deemed noncompensable within the 90-day time period provides a presumption of employer compensability to the employee. Due to this presumption, your workers' compensation carrier may be required to pay for medical treatment and disability that otherwise may have been noncompensable.

Waiting to or failing to report an injury is not helpful for either the employee or the employer and can get the employer in trouble with both his or her carrier and the state. If you are unsure about the requirements for your state, contact your workers' compensation carrier for clarification.

*California regulations define first aid as any one-time treatment and one follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters, etc., which do not ordinarily require medical care. Such treatment as defined above is considered first aid even though provided by a physician or other registered professional.

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