



BULLETIN

CALIFORNIA SOCIETY OF PEDIATRIC DENTISTS

FALL, 1991

Vol. XVII, No. 3



PRESIDENT'S MESSAGE

As pediatric dentists our goals and training direct us toward caring for the child, preventing disease and supporting an environment to carry out these roles. We are poorly prepared for the political manipulation, governmental and insurance regulations which affect how we practice.

Health care this year has been repeatedly "putting out the fires". Unfortunately dentistry has been forced to play a defensive role throughout this period. First, the amalgam/mercury issues, followed by chloral hydrate's possible adverse effects, then an attack on fluorides (again) and always with us, the HIV, infection control and waste management topics. These latter subjects have become political issues, with solutions proposed in legislation often with no scientific basis for solving the problems presented. Spokespersons for our Academy are being schooled and questioned so extensively in response to these issues that they frequently are not able to present the positive subjects of early intervention and the prevention of decay for the children we treat.

On the brighter side, our interaction with other health care groups is having some positive response. The State of California recently has eased it's requirements regarding Dental documentation and substantially improved the reimbursement schedule. Hopefully, these actions and the tentative legal agreements reached will provide for greater use of this system, allowing increased access for children, and more reasonable compensation for those practitioners treating Dental and CCS patients.

The California Cleft Coalition's sponsored bill to require medical insurance coverage for cleft and craniofacial services (now often exempted as preexisting conditions) has been signed into law, and a companion bill requiring coverage for dental, audiological, speech therapy and other supportive services is being developed. Unfortunately, our other efforts to resolve insurance related problems are not finding much success.

The epidemiological study of temporomandibular dysfunction in children (with AAPD) is about to begin. This should provide substantial baseline and prospective data in an area where there is little documentation. In addition, CSPD is partially supporting two research projects: "Reporting practices of dentists who detect child abuse or neglect" (at UCLA) and "The long buccal injection in children is it a clinical necessity?" (at UOP).

A joint group has been working with the California chapter of the American Academy of Pediatrics (although slowly) on projects regarding the prevention of accidents during athletic activities. At the same time CSPD has gotten approval to place a children's oral trauma message on grocery bags during the February, 1993, Children's Dental Health month.

With the completion of our summer distractions, committees of our members are hard at work on internal projects for our practices. These include patient information sheets, office manuals, clarification of practice forms and pediatric dental abbreviations. Many of these will be initially available at our Annual Meeting in April.

Speaking of our meeting, Paul Reggiardo is hard at work making this another super experience. A great program is planned, a wonderful resort will host our meeting and delightful interaction with your friends and peers is guaranteed. Reserve April 2-5 for Rancho Bernardo. See you there!

Richard Sobel

EXECUTIVE DIRECTOR REPORT

Dues notices were mailed early November. Please notify me of changes in address and telephone number for mailing and directory purposes. This is especially important since the phone company is creating new area codes and changing some old ones.

CSPD is comprised of 384 members and is growing.

Tom Barber

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CLASSIFIED ADVERTISING

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LET'S CARE EACH AND EVERY DAY

EXTRA! EXTRA! People help people during crisis! Those were the headlines following the massive Oakland/Berkeley fire and just two years earlier following the Loma Prieta Earthquake.

Why can we be so kind and thoughtful; with actions beyond our normal abilities only in time of crisis?

Why does our society often forget the human needs of one another in our daily interactions? As Pediatric Dentists we have chosen to be a part of the "helping community", deliverers of health care services to children. There is no more laudible role in our society. Let's remember to contribute, each day, not just in crisis. Let's continue by helping our patients and each other; and let's encourage the world around us to do the same.

Richard Sabel

RISK MANAGEMENT

The following is a case presentation provided to us by the **Dental Risk Management Foundation. DRMF** is a non-profit educational organization dedicated to informing dental professionals about risk management. For further information, contact **DRMF** at Altis/DRMF, Shand, Morrhan & Co., 1007 Church St., Evanston, Illinois 60201, 1-800-344-9470.

A mother and her five-year-old child were seen for the first time at the pediatric dental office as an emergency. The child had broken a tooth and needed to be seen immediately. The child resisted efforts to examine the tooth, so the dentist asked the mother if he could use physical restraint in order to proceed. The mother agreed, and this was noted on the chart.

A papoose board was utilized, and the child was examined. The dentist noted that a central incisor was fractured completely to the gingiva, and that a first molar was decayed and needed an amalgam restoration. The dentist discussed his findings with the mother and it was decided that the necessary dental work would be done later that week using physical restraint. The consultation and the mother's consent were noted in the chart.

The staff then appointed the child, and once again explained the procedure and the planned use of restraint to the mother. She was also informed that the procedure might not be covered by her insurance, and that if it was covered, it was possible that only a portion would be paid by the insurance company; any part of the fee not paid by insurance would be the patient's responsibility. The mother agreed to these conditions.

The mother and child returned several days later at the appointed time; the fractured root was removed without incident and the amalgam was done as planned. The mother was grateful, and left the office with her child.

The insurance company was billed and about a month later paid all except for a

nominal portion of the bill representing a "management fee" (\$35.00). The dental office then billed the parents for that amount.

Soon thereafter, the dental office received a call from the father about the bill. He argued that the insurance company should pay the entire amount and stated that he would not pay anything. The dentist carefully explained that the parents were responsible for any amount not paid by the insurance company and discussed in detail the work that had been done for his child. The father was adamant that he should not have to pay at all, and ended the conversation. After a period of time another bill was sent.

The father called the office several more times, now arguing that he never gave permission for his child's dental treatment, that it was unnecessary, and that the use of restraint was excessive and abusive. The dentist, and his staff, attempted to resolve the problem by again explaining to the father the nature of the dental work and billing procedure (the mother did not participate in any of these telephone conversations).

In the meantime, the dentist carefully reviewed the record and discussed the case with his staff. He concluded that (1) the treatment was appropriate and the record clearly reflected this, (2) proper legal and informed consent had been obtained from the mother and had been documented, and (4) there had been no lapse in procedure by either the dentist or staff in the treatment or handling of this case. He therefore decided not to "discount" the bill in this situation.

After the third or fourth telephone conversation with the father the office sent a final bill, stamped with a notice that if it were not paid it would be sent to "collection." The father responded to the final bill by calling the office and stating that he was going to contact an attorney. At that point the dentist stated that he did not wish to further discuss the matter with the father, and suggested that he have his attorney call the office in the future.

Approximately one month later the bill was paid without further comment. The dentist reported that had he not had such a clear and complete treatment record, he would

have handled this situation quite differently.

When attempts to resolve billing problems fail, what choices does the dentist have?

Billing problems occur in all dental practices on occasion, and the manner in which they are handled is something that each dentist should consider carefully. Unfortunately, many malpractice claims against dentists are triggered by aggressive collection tactics. The following comments may help you evaluate solutions to billing problems that arise in your practice.

Patients sometimes refuse to pay their portion of the bill not because they cannot afford it, but because they are dissatisfied with their treatment. When that is the case, attempts should be made to talk to the patient directly about his dissatisfaction. Expressing concern for the patient's care and treatment may help the dentist recognize and appropriately treat an ongoing dental problem. Unfortunately, a busy dentist does not always become aware of the problem until after several notices have already been sent to the patient. It is therefore recommended that the dental office staff alert the dentist to potential billing problems as soon as they arise. Continuing to pursue payment from a dissatisfied patient will alienate the patient further, and may provoke the patient to file a malpractice claim against you.

When communication fails, and an agreement cannot be reached, the dentist must decide whether to pursue the bill or "discount" it. This is not an easy decision. A prudent dentist will weigh the benefits of collecting the bill against the likelihood of provoking a malpractice lawsuit before filing a complaint against the patient. Frequently patients will file a "cross-claim" or "counter-complaint" alleging malpractice in response to the complaint that has been filed against them ("I didn't pay the bill because the dental work was negligently performed"). The dentist's malpractice carrier must then provide an attorney to defend against the malpractice claim (the lawfirm used by the collection agency only handles the billing matter).

Sometimes, as in the case discussed above, the dentist will decide not to discount the bill. This is a decision that only the dentist can make after careful consideration and review of the records. If there is any question regarding the reliability of the records or the course of treatment, it may be best not to pursue collection. If collection is going to be pursued, consultation with legal counsel is advised.

This case history was written for Dental Risk Management Foundation by Alan Klein, DDS, JD, a practicing pediatric dentist from Grand Blanc, Michigan.

CLINICIAN'S CORNER

(Doctor, Are You Sterile?)

It seems that OSHA and all the manufacturers that profit from the current trend in sterilization are to be permanent partners in our practices. The downside is the added cost to our overhead—which must ultimately be passed on to our patients. The upside is that some of our colleagues and their patients will greatly benefit from cleaner, healthier dental environments.

There may be a media storm brewing in the not too far future if a dentally infected patient dies, or if there is another incident of multiple patient HIV infection transmitted from a dentist. It behooves us all to be prepared. In a recent C.D.C. report to Congress, C.D.C. Director Roper noted, "The rise of HIV transmission from an infected health-care worker to a patient is very small, and most medical procedures involve no risk at all of HIV transmission." As informed professionals we may accept and believe this information. Our patients, who get much of their medical and dental information from talk show hosts and "home" magazines, may have quite another opinion.

In anticipation of a potential episode, offices should consider a RISK MANAGEMENT PROTOCOL. Prepare yourself and your staff for questions that patients may pose. The best defense being a good offense. Have a staff meeting devoted to a review of all sterilization matters. Anticipate the questions before they are asked. Everyone should be knowledgeable. Patients probably aren't interested in what products we use, but they sure want to know if we effectively kill HIV!! Some of the topics which should be addressed include: (1) Barrier protection (gloves, masks, glasses, gowns); (2) Handling of used syringes and other sharp instruments; (2) Cleaning, disinfecting, and sterilization reuseable instruments, and (4) Sterilization of work areas, chairs, and units.

A copy of the C.D.C. Guidelines for Universal Precautions may be obtained through the ADA by calling 1-800-621-8099. Standards set by the C.D.C. and OSHA may be difficult and costly to implement, but should the worst case scenario occur in your office, those are the standards with which you will be judged. Product information and technical expertise abound in both the literature and continuing education—we should all avail ourselves of his body of knowledge.

Remember the old adage about falling off and getting back on only applies to horses and bicycles. Today, once you're infected with HIV. . .

Steve Howard

BOARD BRIEFS

The sixty-seventh meeting of the Board of Directors of the California Society of Pediatric Dentists was held at the Los Angeles Airport Hyatt Hotel on October 19th. Present at the meeting were Drs. Sobel, Grossman, Walker, Chan, Grabowsky, Duperon, Berger, Reggiardo, McCartney, Barber, Berson, Howard, and Lum.

Dr. Richard Sobel ran the meeting with his usual organization and intensity. The correspondence reviewed with the Board shows a high level of involvement in child advocacy issues. Dr. Reggiardo presented his tentative schedule for the upcoming annual meeting at Rancho Bernardo. The upcoming meeting will be well organized and very informative; hopefully, we will have the best attendance ever at this meeting. Dr. Pederson, as treasurer, reports that our organization is financially healthy. Dr. Barber reports that our membership has again increased and is now 384. Future annual meetings will be held at Silverado in the Napa Valley and Mission Hills Resort in Rancho Mirage. Several innovative projects are being undertaken: Shopping bag promotion of Pediatric Dentistry, a CSPD brochure promoting our society, and series of letters explaining dental procedures.

Board Motions are as follows:

10-19-91.1 Reggiardo/Berger—That the 1994 Annual Meeting be held at the Mission Hills Resort, Rancho Mirage, April 13-17, 1994. PASSED.

10-19-91.2 Chan/Grabowsky—That the California Society of Pediatric Dentists send the CDA AIDS brochure to California Pediatricians, expense not to exceed \$2000.00. FAILED.

Bob Berson

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ATTENTION! TIME TO SHARE!

A committee exists within CSPD to develop practice information materials for general membership distribution. Some of the topics to be developed include:

1. Pulpotomies
2. Composite Crowns
3. Stainless Steel Crowns
4. Space Maintenance
5. Sealants
6. Preventive resin restorations
7. Microabrasion & bleaching
8. Extractions
9. Harmful oral habits
10. Care of retainers

The goal is to provide these materials in a camera ready format for use in your office. We need to review a variety of materials that are presently used in pediatric dental offices. PLEASE, PLEASE, PLEASE send samples of whatever information materials you are presently using. *Let us know what you find most useful.* We are interested in hearing from you if you have any helpful ideas. Send in your materials by 1/1/92. We want to have some great stuff ready to present at the Annual Meeting.

Write to me,

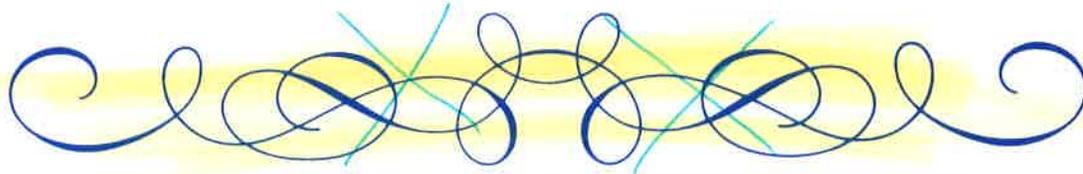
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Dr. Dennis McTigue
 Chairman, Department of Pediatric Dentistry
 Ohio State University

- TRAUMATIC INJURIES IN THE PRIMARY AND YOUNG PERMANENT DENTITIONS
 A CLINICAL UPDATE FOR 1992
- STANDARDS OF CARE IN BEHAVIOR MANAGEMENT: QUALITY ASSURANCE OR PRACTICE INFRINGEMENT?

► **Practice Management**

BLOCKBUSTER REGULATORY COMPLIANCE PANEL PRESENTATIONS

CHAIRMAN AND COORDINATOR Everything you need to know Everything you need to understand Everything you need to have to comply	Dr. Warren Brandli
HAZARDS COMMUNICATION PROGRAM ILLNESS AND INJURY PREVENTION PROGRAM INFECTION CONTROL & UNIVERSAL PRECAUTIONS PROGRAMS MEDICAL WASTE DISPOSAL	Dr. Ray Stewart Dr. James Musser Dr. Santos Cortez Dr. Richard Mungo

► **Recreation**

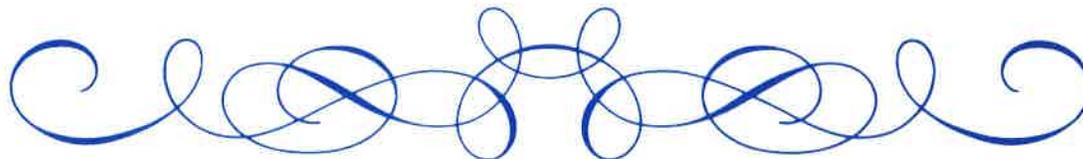
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The professional activities committee, California Society of Pediatric Dentists, announces a call for proposals for grants in aid of up to \$1,000.00 to support research projects. For details, please contact David Rothman, Chairman, Professional Activities, UOP, School of Dentistry, 2155 Webster Street, San Francisco, CA 94115, (415) 929-6558.

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BULLETIN

CALIFORNIA SOCIETY
OF PEDIATRIC DENTISTS
Published 4 times annually.
EDITOR
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CSPD members are encouraged to contribute to the BULLETIN. Articles, letters to the editor, or other items of interest are welcome. The next deadline for submission is January 25, 1992. Items for publication must be double-spaced, typewritten and of reproducible quality for Xerox or Fax.

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