VOLUME 4 | NUMBER 1 | WINTER 2020

RIDA

JOURNAL OF THE RHODE ISLAND DENTAL ASSOCIATION

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All courses on page six

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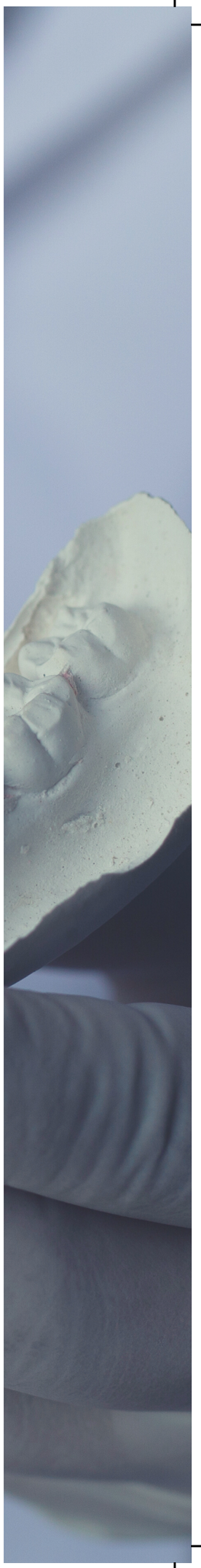


NEW RIDA
EXECUTIVE DIRECTOR

MARTIN ELSON, DDS RIDA PRESIDENT

Christy Durant, Esq.

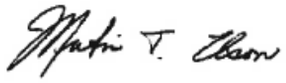
I am pleased to announce the selection of Christy Durant, Esq. as our next Executive Director and General Counsel. She will officially begin her new role in April of this year. The selection was made after an extensive search by our executive search committee.

Christy is an attorney that specializes in all aspects of health care law, risk management, state and federal regulatory compliance, and legislative lobbying. She has been legal counsel for the RIDA since 2014 which has allowed her the unique opportunity to establish relationships with the RIDA's existing leadership and provided her with invaluable insight into the mission of the RIDA that will assist in a smooth transition between Directors. She is also legal counsel for the Rhode Island chapter of the American Association of Oral and Maxillofacial Surgeons as well as several RIDA members. She has lectured both locally and at national conferences on topics impacting dentistry including opioid prescribing, anesthesia and safety compliance. She is also a published author on "Managing Medico-Legal Issues Surrounding Esthetic Facial Surgery" in Complications in Maxillofacial Cosmetic Surgery: Strategies for Prevention & Management; Springer Publishing.

Christy's Bar admissions include Rhode Island, Massachusetts, and the Supreme Court of the United States. She is an appointee to the Rhode Island Commission on Judicial Tenure and Discipline and Rhode Island Bar Association Ethics and Professionalism Committee (Co-Chair).

Professional affiliations include: the American Bar Association; American Health Lawyers Association; American Society of Law, Medicine and Ethics; Defense Counsel of Rhode Island; Federal Bar Association; Massachusetts Bar Association; Rhode Island Bar Association; Rhode Island Bar Association Lawyers Helping Lawyers Committee, and Rhode Island Bar Association Ethics and Professionalism. She will continue to maintain her private practice of Durant Law, LLC.

Christy is married to her husband, Derek and has three children, a 6 year old and twin 1 year old's. She is a life-long resident of Rhode Island who enjoys going to the beach and spending time with her extended family. Please join us in welcoming Christy into this new chapter for the RIDA.



THE NEW YEAR

CHRIS KLIMECKO, RIDA EXECUTIVE DIRECTOR

Normally, from mid-December through mid-January, things here at the RIDA slow down a bit. However, with special House of Delegates meetings in December and January and the component mergers upon us, that has not been the case these last few weeks. Add to the activities with RIDPAC, getting this Journal issue out, and a host of other things in the works, it's been very busy.

Now on top of everything else, as you probably all know by now, I am in my last few weeks at the RIDA. I've enjoyed my time here. And although I originally planned on staying longer, family matters are such that I've decided it best to return to Western NY. I've been most fortunate in that I've had the opportunity to work with incredible officers and board members as well as a multitude of members, agency representatives, company reps, and a host of others that would take another page if I listed all of them. I must single out one though. I am especially grateful to our office manager, Madeline. As there are only the two of us working here, you must be well versed in everything from finance, to publishing, banquets, marketing, and technology. She's great at all of it. But most of all, she's trustworthy - the kind of assistant that all of us in this business strive to find.

I know that my successor, Christy Durant, will be an outstanding executive director. I've had the privilege of working with her over these last three years so I can say with first-hand knowledge that the committee made a wise choice. I wish her the best of luck in the coming months and years.

To the members of the RIDA, I thank you and wish you all the best.

RI DENTAL FOUNDATION

Our philanthropic arm; the Rhode Island Dental Foundation, is accepting grant proposals for 2020. Grant requests for will be considered for various oral health related causes. They include education and research programs designed to improve the art and science of dentistry in the State of Rhode Island, dental public service projects in Rhode Island, programs geared towards improving accessibility and availability of dental care for underserved citizens within our state, oral health education for the public, Rhode Island based charitable or educational projects related to oral health, and Rhode Island based free dental clinics.

Grant request forms are now available via the RIDA website.

MESSAGE FROM THE **ADA PRESIDENT**

CHAD GEHANI, DDS
PRESIDENT, AMERICAN DENTAL ASSOCIATION

Dear ADA Member,

The American Dental Association has long recognized the importance of oral health care as a crucial part of overall health. For our senior population, those 65 and older, this statement is particularly relevant. Today's ADA strives to build upon previous leaders' efforts to educate and elevate this issue's importance. Within the elderly cohort, who continues to expand numerically, it is imperative that the American Dental Association become the solution-based resource for this critical and time-sensitive issue.

The current discussions in Washington, DC, may have caught your attention. There are numerous House Bills attempting to add healthcare services to Medicare Parts A and B, and many include a dental benefit. The American Dental Association sees the pros and cons of individual aspects within these legislative bills, and we strive to yield positive results for both our members and the public.

Allow me to introduce the ADA Elder Care Workgroup.

The Current Landscape of Access to Dental Care for Seniors
Prior to introducing ADA efforts pertaining to elder oral care, it is useful to review the current landscape of dental care access for the elderly cohort. The ADA Health Policy Institute maintains the most robust data on the U.S. dental care system, drawing on publicly available as well as proprietary data sources.

- In 2018, the number of US citizens age 65 and over was 57 million, and that figure is anticipated to balloon to 84 million by 2050.
- 37% of seniors have some source of dental benefits coverage. Approximately 26% have private dental coverage, and 11% have public dental coverage (for example, Medicaid, Tricare, or the small number who receive dental benefits through Veterans Affairs).
- 63% of seniors do not have any form of dental benefits coverage.

What does coverage translate to in terms of oral health care use?

- 43% of seniors had a general dentist visit in 2016, up from 38% in 2000.
- 69% of seniors with private dental coverage had a dental visit in the past year.
- 16% of seniors with public dental coverage visited the dentist.
- 37% of seniors who are uninsured had a dental visit last year.

Dental care also varies by household income.

- 61% of seniors with household income above 400% of the federal poverty level visited the dentist.
- 24% of seniors with household income below 100% of the federal poverty level visited the dentist.

The disparities in dental care use and dental benefit coverage have clear implications for oral health. When it comes to various measures of seniors' oral health, such as prevalence of untreated cavities or tooth loss, disparities by income, race, and dental insurance status are widening over time. That is, high-income seniors, in general, are seeing improvements in their oral health while for low-income seniors, improvements are either not as large or, in some cases, are non-existent.

The Time to Act is Now
As your president, I felt it was important that the ADA, as America's leading advocate for oral health, share this data with policymakers on the House Ways and Means Committee as they consider policy options to improve access to dental care among seniors, specifically through Medicare reform. Sharing data with policymakers in no way signals that the ADA supports any particular bill.

Data in and of itself is also not ADA policy. As a science-based organization, data is an extremely important input, but it is ultimately up to our esteemed House of Delegates to consider and vote upon resolutions to create ADA policy.

Looking back, the oral health success of Medicaid and CHIP for our youth has benefited millions of young Americans. However, our elderly's oral health has not received the same discerning attention as our nation's children. This has been a widely discussed topic over the years within the ADA, and this topic's interest has escalated within the ADA House of Delegates over the past three years. In October, 2018, your ADA House of Delegates authorized Past President Dr. Jeffrey Cole to form the Elder Care Workgroup (ECW). Dr. Cole selected eleven dentists and one physician from varied backgrounds, and I reappointed the Elder Care Workgroup in September, 2019.

The Elder Care Workgroup felt strongly that in order for any dental program to be effective in improving the oral health of seniors and providing for their care, a robust network of providers is essential. If dentists are to be incentivized to enroll and provide care under a program, reimbursement must be at a level that accounts for the unique cost of dental care delivery.

After numerous meetings involving spirited, academic, informed and respectful debate, and secluded in their deliberations, The Elder Care Workgroup will present to the 2020 ADA House of Delegates a list of options. These options include a select portion of Center for Medicare and Medicaid Services (CMS) programs suitable for dentistry's delivery model.

Thus, the Elder Care Workgroup has developed a multi-faceted approach, recognizing that the elder oral care issue's enormity requires innovative thinking. The EWC pursued solutions resulting in coverage for every elderly socio-economic level. The ECW's recommendations are not yet policy as the ADA House of Delegates has yet to vote. However, the

continued on page 3

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ECW's work is progressing towards a presentable House of Delegates product next October.

I am proud to say that your ADA is on the leading edge of a solution, one involving private, non-profit and government programs.

The question is not, "should we do something." The question is, "how do we do it." The time to act is now.

Respectfully,

Chad P. Gehani DDS.

WITHIN YOUR CONTROL
NON COMPLIANT PATIENTS

DEBRA K. UDEY
RISK MANAGER, EDIC

Most patients are compliant with your instructions. However, those who aren't can be a frustration, and potentially a big problem to your practice. How do you deal with them?

Dealing with non-compliant patients occurs in many areas of dentistry, and it's not always easy. A big downside of non-compliant patients is when they don't do what you've told them and then blame you for a poor outcome. But, as Dr. Manuel Sousa, a speaker in a recent EDIC webinar noted, compliance doesn't always need to be a "do it or not" situation. Sometimes both parties can compromise to work out manually agreeable ways to achieve compliance.

There are two particularly difficult situations involving patient compliance. One is patients who refuse to have x-rays taken, and a second entails patients who refuse to deal with periodontal situations.

The issue of non-compliance with the request for taking x-rays can be difficult to resolve. Patients have heard plenty about radiation and its impact on the body, which sometimes leads to a refusal of x-rays. The good news is that the amount of radiation they receive from intraoral x-rays is quite low. According to measurements listed at www.radiologyinfo.org, the amount of radiation one absorbs from an intraoral x-ray is comparable to natural background radiation that a patient absorbs in one day.

Perhaps when a patient hears this information, he or she may agree to having an x-ray. Another tactic one can use to gain the patient's agreement is advising the patient that the lack of x-ray impairs your ability to diagnose anything not visible to the naked eye. A third tactic one can use is to advise that treating a patient without the benefit of x-rays is potentially sub-standard dentistry. Perhaps a patient may change his or her mind after absorbing this information. If the patient still refuses, you certainly have the right to dismiss the patient because he or she is asking you to practice sub-standard dentistry.

As mentioned above, possibly a compromise can work to everyone's advantage. The frequency with which you obtain intraoral x-rays will vary from patient from patient to patient depending on their medical and dental status. Perhaps a patient who refuses x-rays may agree to having x-rays on a less frequent schedule. If the frequency is less than optimal, but still reasonable to allow you to maintain your standard of practice. Your willingness to compromise may convince the patient to agree.

If you dismiss a patient, he or she may not be able to obtain dental care from another dentist. But the decision is up to you - you are not required to continue to see a patient who demands that you practice sub-standard dentistry. The downside of this situation can be devastating. For instance, let's say a patient develops a condition that you can only diagnose by x-ray, such as cancer of the bone. You can't diagnose it because you can't see it and it goes undiagnosed for some time. Then, when symptoms begin, the patient accuses you of having failed to diagnose the condition. It can be difficult to respond to such accusations.

Hopefully, one or more of the tactics mentioned will help you gain the patient's agreement to let you take intraoral x-rays, which can ease the treatment situation greatly.

A second area of non-compliance is periodontal care. Many dentists have diagnosed periodontal disease and recommended treatment for the patient, only to have them refuse treatment. Some patients don't outright refuse treatment, but have no intention of contacting the periodontist to whom you refer them for treatment. Other patients may ask you to render the treatment.

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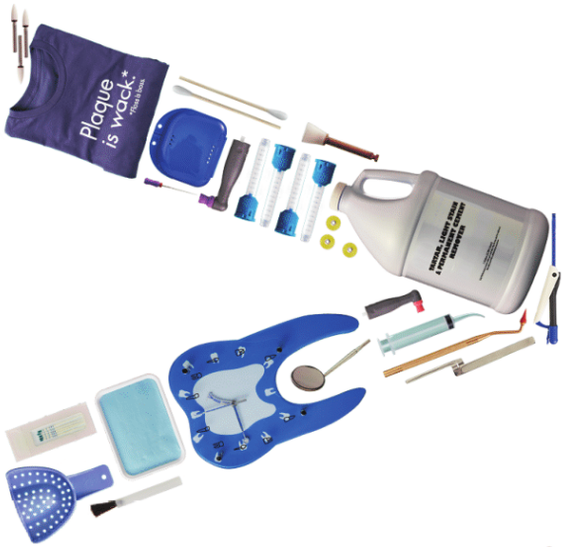
Want to save more on supplies than you pay in dues?



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continued from page 3

Each of these situations carries risks. One problem that can result from untreated periodontal disease is that the patient will return to you for "regular" treatment. You again advise them of the situation and refer them for treatment of the periodontal condition and again, they do not follow through. As this cycle continues, the patient limps along untreated until he or she sustains irreparable damage. If a claim is brought against you, the allegations will include benign neglect. You diagnosed the problem but continued to treat the patient for other conditions while the periodontal disease worsened. It can be difficult to defend such actions.

In such cases where the patient refuses or does not obtain the care necessary to treat their condition, you essentially have two choices, neither of which are ideal. You can dismiss the patient because they will not obtain the necessary care, and you do not want to continue to treat them with "benign neglect" of the problem. This option is difficult because you again put the patient in a situation of trying to find care for the situation.

The other option is to continue to treat the patient while explaining each time you see him or her what care is needed and what the consequences will be if they don't receive the care. This is not ideal, and leaves you open to a charge of benign neglect. But some dentists choose to do this because they realize the patient will have no care at all if he or she is dismissed.

Using the compromise tactic, perhaps one could convince a patient to agree to having the periodontal care on a schedule more favorable to the patient, or to find a periodontist closer or the patient's home or work. Whatever you can work out to get the patient to seek the care needed, the time and effort can be worth it.

If you choose to continue to see either of these types of patients, it is very important that you document your discussion with the patient at each visit. Particularly if you choose to continue to treat a patient because you know he or she will not be able to obtain care if you dismiss them, ensure your documentation includes this. Include the consequences of failing to obtain the treatment you have recommended in your notes. You absolutely want to be able to defend a claim that the patient didn't know what could happen if care wasn't sought.

In summary, dealing with patients who refuse care can be frustrating. If you direct your efforts toward reaching an agreement, through compromise or any other type of tactic, it can work better for both you and the patient.

Rhode Island
DENTAL ASSOCIATION

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Member Dentist: free
Residents: free
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Affiliate Member: $150
Non-Member: $325
Non-Member Staff: $80
Out of State ADA Member: $175

TO REGISTER
www.ridental.org

February 12, 2020 | 9:00am - 4:00pm (6 CEUs)

Thomas Dudney, DMD
"What's a Dentist to Do?": Diagnosis, Treatment Options, and Rehabilitation of Difficult and Unusual Cases" & "Be Aware of Wear: A Systematic Approach to Diagnosing, Treatment Planning, and Restoring the Worn Detention"

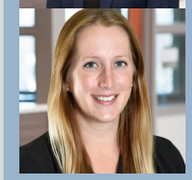
Dr. Dudney is a 1977 graduate of University of Alabama at Birmingham School of Dentistry. Presently he is the clinical director for the newly formed Pacific Aesthetic Continuum (PAC) hands-on programs.

May 13, 2020 | 9:00am - 12:00pm (3 CEUs)

Robert Maguire, DDS
"The Economics of Great Communication"

Dr. Maguire earned his DDS from Georgetown University School of Dentistry in 1984. While attending dental school, he was commissioned in the US Navy Dental Corps. He retired at the age of 60 after 28 years in private practice. In 2009 Dr. Maguire earned a Master of Arts Degree in Strategic Communication and Leadership from Seton Hall University and currently has a consulting business, Dynamic Dental Communications.

September 9, 2020 | 9:00am - 4:00pm (6 CEUs)



Jennifer Frustino, DDS PhD & Elizabeth Kapral, MS DDS
"Current Concepts in Head & Neck Cancer for the Dental Team: Examination, Prevention, and the Role of HPV"

Dr. Frustino is the Director of Oral Cancer Screening and Diagnostics in the Division of Oral Oncology & Maxillofacial Prosthetics at Erie County Medical Center in Buffalo, NY. Dr. Kapral is an Attending Dentist and Director of the Special Needs Dentistry Program in the Division of Oral Oncology & Maxillofacial Prosthetics at Erie County Medical Center.

November 18, 2020 | 9:00am - 4:00pm (6 CEUs)

Tieraona Low Dog, MD
"Integrative Approaches to Pain for the Dental Team"

Tieraona Low Dog, MD is a physician, author, and educator. She practiced herbal medicine and midwifery, before earning her medical degree from the University of New Mexico School of Medicine. She is one of the foremost experts in the United States on the safe and appropriate use of botanical remedies and dietary supplements. A prolific scholar, Dr. Low Dog has published 54 research articles in medical/science journals and written 24 chapters for medical textbooks.

April 15, 2020 | 9:00am - 12:00pm (3 CEUs)

Shannon Mills, DDS
"OSHA Bloodborne Pathogens; Smart Prescribing-Opioisd and Antibiotic Stewardship; Safe Water, Safe Dentistry, Safe Kids" *

Dr. Mills is a graduate of Baylor College of Dentistry and retired US Air Force Colonel. During his Air Force career, he served in the US and overseas and gained experience in dental education, research, technical evaluation, logistics, and healthcare policy. He is currently an independent healthcare consultant and lecturer based in Concord, NH.

- There is a $75 fee for OSHA for all attendees, including members and staff. Non-members are $150. There is a $30 late fee for any OSHA registration after April 7, 2020.

MESSAGE FROM THE COUNCIL ON COMMUNICATIONS CHAIR

Dear RIDA colleagues,

I hope you have heard the GREAT NEWS concerning the restructuring of the Component Dental Societies here in RI. Over the last 18 months, the Committee assigned the task of finding a new formula for bringing our members together on a local level has finished its work. On January 6, the bylaws were amended to allow for the formation of three Component Societies: Northern, Central, and Southern.

This letter is not meant to detail the changes and the particulars of our new components, I will leave that to others at the RIDA to explain as things progress. My reason for reaching out to you, my fellow dentists (young and old), is to encourage you to serve in any capacity possible in the new Component Societies. We are in need of volunteers to fill the roles necessary to make our new societies not only function, but thrive in the years to come. I know what many of you are thinking!! Oh, I already did my part when I was younger -- let the young dentists do it!! There was a time when that was an appropriate response, but I'm afraid we no longer have that luxury. If we want to succeed as an organization that we can be proud of and one that we want to see for generations to come, we MUST step up.

In the December issue of the ADA News, several very important stories were brought to our attention. The ADA has a lawsuit against Delta Dental due to anti-competitive conduct. There was also a VERY timely article on the work that the ADA is doing to encourage legislation restricting and regulating the sale of vaping products in the same way that tobacco has been for decades.

The reason I mention these stories is because everything the ADA does trickles down to the state level and eventually the component level. The need for active participation in YOUR dental association has never been greater, and without all of you, we can never succeed. From Presidents and Secretaries to Trustees and Delegates, there is a role for you to play. Please don't assume someone else will take the lead, they probably won't!! It's up to each of us to face the reality that our futures depend on what we do TODAY to lend support and rise to the task in this great profession that serves us all so well.

Warm Regards,

Dr. Dave Ward
Council on Communications Chair

Brown University's Department of Anesthesia

2020 Rhode Island Anesthesia Conference

Cardiac Anesthesia for the Non-Cardiac Anesthesia Providers

Saturday, May 2, 2020 | 7:00am-4:30pm

Providence Downtown Marriott, Providence, RI

TARGET AUDIENCE

Anesthesiologists, Surgeons, Certified Registered Nurse Anesthetists, Student Registered Nurse Anesthetists, Anesthesia Residents, Dentists, Oral Surgeons

PROGRAM DESCRIPTION

This activity will focus on the complexities of care for patients with underlying cardiovascular disease. Topics covered during the conference include interventional cardiology procedures, the adult congenital heart disease patient for non-cardiac surgery, and the use of echocardiography to guide management for non-cardiac surgery, right heart dysfunction, and mechanical assist devices for cardiac support.

LEARNING OBJECTIVES

At the completion of this activity, participants should be able to:

- Explain the physiology of complex cardiac diseases and devices and be able to formulate a plan for the perioperative care of these patient populations for non-cardiac surgery
- Identify the steps of a structural heart transcatheter procedures and anticipate complications during these procedures
- Assess the RV function and pulmonary HTN and make an appropriate perioperative plan for these patients
- Identify rescue echocardiography to diagnose and reat patients with hemodynamic disturbances

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Registration to follow. Please visit
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STRESS-FREE PRICE COMPARISON THAT LEAD TO SUPPLY SAVINGS

Want to save on supplies and small equipment, but don't have the time to comparison shop? The Dentists Supply Company (TDSC) will do the work for you! Through TDSC's free service, association members can submit invoices from their current suppliers and let experts find the savings potential on their behalf.

The TDSC team analyzes product-by-product pricing to show how tdsc.com prices stack up against actual prices paid elsewhere. The result is a custom price comparison that illustrates just how much a practice could save on the exact same supplies.

Through collective buying power, members of organized dentistry nationwide continue to see the savings add up. Here are four recent case studies from tdsc.com shoppers:

Case study 1: General dentistry practice in Charlotte, N.C.*
Evaluating this practice's invoiced items from a major national supplier, the TDSC team found a 14% savings on exact matches, reducing the practice's total cost from $2,570.74 to $2,202.89 for the same supplies.

Of note:
- **14% average savings** ($367.85) on a single order of 25 items
- **$21.00** savings on Kerr Corp Harmonize™ Nanohybrid Composite Unidose ™ Tips (20/pkg.)
- **55%** savings on Medicom SafeBasics™ Saliva Ejectors (105/pkg.)

Additionally, the practice would pay no shipping fees through tdsc.com, as shipping is free on every order with no minimum purchase requirements.

Case study 2: Pediatric dentistry practice in Boulder, Colo.*
This Colorado practice submitted invoices from the same major supplier as the North Carolina practice. The TDSC team compared prices and found an impressive 22% average savings for exact product matches. This means that the practice would spend $1,830.64 at tdsc.com instead of spending $2,341.14 elsewhere for the same items.

Of note:
- **22% average savings** ($510.50) on a single order of 20 items
- **$18.56** savings on Microbrush Corp Microbrush® Tube Series (100/pkg.)
- **43%** savings in Biotrol Birex Quat Disinfection Wipes (160/pkg.)

Like many practices, this one could see savings add up on disposable and infecion control products. For large nitrile exam gloves, tdsc.com offers a 29% savings compared to the other supplier's invoiced price a ($6.32 difference). And with the practice ordering eight boxes at a time, that means more than $50 savings on a glove order alone.

Case study 3: General & cosmetic dentistry practice in Richmond, VA*
The TDSC team's invoice evaluation revealed 16% average savings for exact matches, meaning that the practice would spend only $5,063.43 at tdsc.com instead of $6,007.85 elsewhere for the same items.

Of note:
- **16% average savings** ($944.42) across 27 items, plus free shipping
- **$20.20** savings on 3M ESPE Filtek Supreme Ultra Universal Restorative Capsules (20/pkg.)
- **83%** savings on Plasdent Corp HVE Suction Tips (100/pkg.)

As in the second case study, this practice could realize significant savings when ordering infection control supplies and other frequently-restocked items. For the same disinfecting towelettes, tdsc.com offers 27% savings (a $3.64 difference per canister), which adds up to nearly $175 in savings since the practice orders 48 canisters at a time.

Case study 4: General dentistry practice in Nevada County, Calif.*
For this California practice, the TDSC team found 18% savings on exact matches from another major supplier. The practice's total cost would be reduced from $2,014.75 to $1,644.93 by shopping tdsc.com

Of note:

- **18% average savings** ($369.82) across 19 items, plus free shipping
- **$60.82** savings on one 3M ESPE RelyX™ Unicem 2 Self-Adhesive Resin Cement-Clicker™ Refill
- **53%** savings on Plasdent Corp Excellent-II Disposable Impression Trays (12/pkg.)

Join dental association members who are seeing their practices' true savings potential. Request your free, custom price comparison at tdsc.com/pricecompare.

*Price comparison based on an actual customer who purchased a comparable product within the last 12 months. All trademarks used herin are the property of their respective owners in the United States and abroad.

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ELECTRONIC PRESCRIBING HAS BENEFITS

BY SAMUEL ZWETCHKENBAUM, DDS, MPH
DENTAL DIRECTOR, ORAL HEALTH PROGRAM, RIDOH

E-prescribing of controlled substances is coming to Rhode Island and as it is likely to provide benefits for the majority of prescribers, there will also be challenges for others. The American Dental Association, in their 2016 White Paper Number 1070, Electronic Pharmaceutical Prescription Standard for Dentistry, encouraged early adoption of e-prescribing by dentists and discussed the benefits of e-prescribing systems. Advantages expressed include a built-in quality assurance system, more fully integrated care, and greater accuracy and efficiency. Ultimately it saves time, saves paper, and decreases the potential for drug misuse and diversion. Disadvantages include cost, practice patterns, and adoption… also known as the learning curve. We've all done things a certain way very effectively for many years, and the idea of taking on a complex, new process is daunting.

I first did e-prescribing when I worked at the VA Medical Center in Ann Arbor, Michigan. While it seemed a bit magical at first, it worked like a breeze. The VA had the advantage of just one pharmacy as one of the challenges of e-prescribing is the initial entry of pharmacy information. To learn more about e-prescribing today, I reached out to dentists who are currently doing it. Dr. Marianne Urbanski is a periodontist in Westerly and New London, CT, and has been e-prescribing for about a year. She uses her brand because it is compatible with her practice-management software.[1] She finds e-prescribing fairly straight forward and has integrated it into her workflow. She describes an added security step that sends a PIN code to her phone for scheduled medications. As for what she doesn't like, she reports difficulties if someone needs a prescription for stronger pain medication on the weekend, as she cannot access the system remotely. It is important to note that several software systems can provide remote access. She also reports that previously, she would have been able to call in a prescription but is now unable to do that for her Connecticut practice. In the past, she provided patients with a "just-in-case" written prescriptions, which some patients would take and fill only if a non-opioid approach did not provide adequate pain control. Now she will e-prescribe a small number of opioid pills and tell the patient to only pick up the meds if needed.

To understand a pharmacist's perspective, I spoke with Brian Bishop, PharmD, who has worked at several retail pharmacies and asked what he thought about "just-in-case" prescriptions. He urged providers to avoid handwritten "just-in-case" prescriptions. In a large number of cases, the patient or family will fill the medication, regardless of need, because they are already at the pharmacy and the medications are relatively inexpensive. There are concerns that if patients fill the opioid medication and don't use it, the medications may be left in the medicine cabinet, allowing for opportunities of misuse and diversion. I talked with him about what he would suggest as an alternative and he shared that most acute pain syndromes can be effectively treated using inexpensive, over-the-counter products, including NSAIDs (i.e. ibuprofen and naproxen) and/or acetaminophen, combined with rest. If the provider believes a non-opioid regimen might fail to relieve the patient's pain, the provider can opt to e-prescribe a prescription and include a note in the comments section saying "Please place on hold until the patient requests. Do not fill after five days from the date written (CAN INSERT DATE)". He also recommended prescribers only let patients know about the "just-in-case" opioid if they call with pain complications. This solution would resolve the issue of the inability to e-prescribe on weekends. Brian emphasized that "just-in-case" prescriptions should not become a standard of practice and non-opioid regimens should be the standard, first-line approach for the majority of dental procedures. Providers need to routinely evaluate the appropriateness of an opioid prescription on a case-by-case basis and for every prescription. Opioid prescriptions should be written for the lowest dose possible and for the fewest number of days possible. Every clinician who prescribes an opioid should be screening their patients for weekends. Brian emphasized that "just-in-case" prescriptions should not become a standard of practice and non-opioid regimens should be the standard, first-line approach for the majority of dental procedures. Providers need to routinely evaluate the appropriateness of an opioid prescription on a case-by-case basis and for every prescription. Opioid prescriptions should be written for the lowest dose possible and for the fewest number of days possible. Every clinician who prescribes an opioid should be screening their patients for substance use disorders[2], checking the Prescription Drug Monitoring Program, and assessing the appropriateness of opioid medications for the given situation.

Dr. Urbanski also asked about why Rhode Island requires ICD-10 codes for controlled substance prescriptions. Providing a diagnosis code on a patient's prescription allows pharmacists to understand why the controlled substance is being dispensed. Pharmacists can use this information to have follow-up conversations with prescribers and with patients to ensure that patients are being treated with the appropriate medication.

As a reminder, the ICD-10 requirement applies to all clinicians with a Controlled Substance Registration (CSR), including dentists, physicians, and others. The ICD-10 code(s) must be entered in a visible location on the prescription. For e-prescribing, the comment box is the most common place to enter the ICD-10 code. I know that as dentists, we are not as familiar with using ICD-10 codes, but the good news is that one of XX ICD-10 codes is most likely applicable to the majority of procedures. More information is available in the FAQs:

https://health.ri.gov/publications/frequentlyaskedquestions/PainMgmtRegs.pdf

Regardless of the reason, dentists who have not yet gotten their office ready for e-prescribing should take action now. If you have an existing practice management system, contact your vendor to discuss the next steps. If your practice is still using paper records, there are several free-standing systems available, many of which are also

compatible with smartphones to allow prescribing on weekends.

In addition to reducing opioid diversion, e-prescribing is more convenient for your patients for all prescribing. There are no delays, fewer errors, and elimination of lost or misplaced prescriptions. E-prescribing is estimated to save between $140 and $240 billion in healthcare costs and lead to lower insurance premiums.[3] You will be perceived as cutting-edge by your patients and able to provide the best care.

Moreover, it:

- Reduces phone calls to pharmacies
- Simplifies the prescription renewal process
- Provides formulary status on medications
- Improves timeliness (instant arrival at pharmacy)
- Increases security - prescriptions are tamper-proof and stolen prescription pads will no longer be a problem. [4]

After recent discussions and communications with the Rhode Island Dental Association, the Rhode Island Department of Health (RIDOH) is aware that dentists want to comply with this regulation; however, doing so is currently a financial hardship or is logistically impractical. RIDOH has heard your concerns. All dentists with a CSR should have already received a letter in the mail and an email informing you that all dentists in the state of Rhode Island will be afforded a waiver for EPCS until July 1, 2020, from the regulations which mandate electronic prescribing of controlled substances in schedules II, III, IV, and V.

RIDOH does expect you to implement a plan of correction to come into full compliance with this regulation prior to the expiration of your time-limited waiver. Any dentist who needs a waiver beyond July 1, 2020, will need to apply individually and include detailed and appropriate justification. RIDOH will examine subsequent requests much more stringently and future granting of waivers will be far less common.

A list of prescribers who have waivers for EPCS will be posted on RIDOH's website and will be used by pharmacists. If you are in compliance with the EPCS and want your name removed from the waiver list, please contact Victoria Ayers at: Victoria.ayers@health.ri.gov.

Finally, a couple of resources to share: PharmD. students from the University of Rhode Island have been performing academic detailing at dental practices to talk about safe prescribing of opioids, non-opioid approaches, and raising awareness of existing RIDOH web resources. It's 30 minutes in your office, followed by an online quiz. Both dentists and dental hygienists can get one CE credit. Additionally, a sheet explaining the non-opioid approach of acetaminophen and ibuprofen has been developed, including a clear guide for patients to take non-opioid medications. (This concept was developed by Ken Hargreaves of San Antonio's endodontics program.) It gives succinct, evidence-based instructions on dosing to the patient, and conveys that non-opioids are effective and are more rationale to use as a first-line agent.

Educating everyone in the office is key so that knowledgeable discussions can take place among staff. Recognizing that it is the dentist who prescribes, it is important to remember that many times, other team members interact with patients about topics like this.

Most practitioners have shared with me that they are using a non-opioid approach: it works, it's safe, it's efficient, AND it does not require accessing the Prescription Drug Monitoring Program (PDMP) database, entering an e-prescription, or remembering the ICD-10 code. In a companion article, you can find an update on how prescribing for pain management in Rhode Island has changed in the past few years.

Next Steps

- **Contact your practice management software company to discuss e-prescribing.**
- **If you've been considering changing or beginning with a new practice management software, consider one that has a cost-effective e-prescribing system**
- **If you don't plan on having practice-management software, consider a free-standing e-prescribe.**
- **Encourage efficiencies by working with your dental association or dental colleagues on strategies to pool resources.**

[1] Neither the author nor the Rhode Island Department of Health endorses one software product over another.
[2] Screening, Brief Intervention, and Referral to Treatment (SBIRT), https://samhsa.gov.sbirt
[3] Porterfield, A., Engelbert, K. and Coustasse, A., 2014. Electronic prescribing: improving the efficiency and accuracy of prescribing in the ambulatory care setting. Perspectives in Health Information Management, 11(Spring).
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TRENDS IN OPIOID PRESCRIBING PRACTICES OF RHODE ISLAND DENTAL PROFESSIONALS

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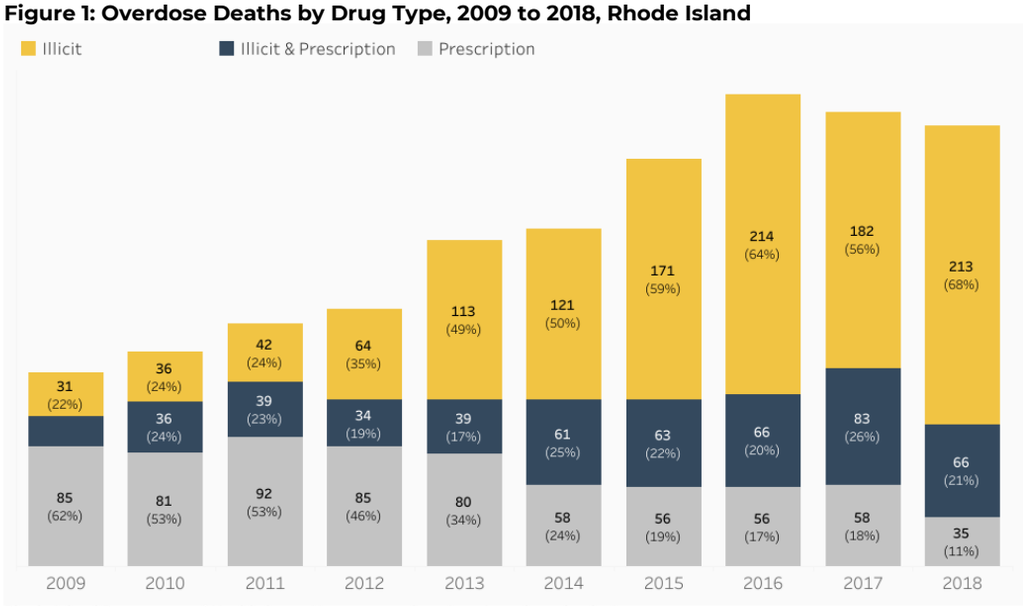
INTRODUCTION

With both a continued rise in drug overdose deaths in Rhode Island from 2009-2016 (Figure 1), the majority in adults and among men1, and national recognition of the opioid crisis as a public health emergency[2], significant effort has gone into strategies to reduce the number of lives lost. A diverse group of stakeholders developed the Rhode Island Overdose Prevention and Intervention Task Force Action Plan with the main goal of decreasing the number of overdose deaths. The plan was updated in 2018 to focus on four main strategies: treatment, rescue, prevention, and recovery, with more complete details available at PreventOverdoseRI.org.

Figure 1: Overdose Deaths by Drug Type, 2009 to 2018, Rhode Island



Rhode Island Department of Health, https://preventoverdoseri.org/overdose-deaths/

The prevention strategies include efforts to minimize unnecessary opioid prescribing and promote safe opioid storage through provider and public education. From January 2017 through September 2019, the number of opioid prescriptions and the number of high-dose opioid prescriptions declined by 25% and 41%, respectively.[3] Furthermore, the number of people who received a new opioid prescription decreased by 31% during this period. Despite these promising prescribing trends, overdose deaths are still observed throughout Rhode Island, and 32% of overdose deaths involved prescription drugs in 2018.

Opioid prescribing varies by specialty in the United States. [4–5] Prescribing by dentists has been a focus due to perceived susceptibility to opioid use disorder of the age group likely to undergo surgical procedures including orthognathic surgery and removal of impacted third molars.[6–7] Previous literature suggests that dentists wrote 6.4% of opioid prescriptions in the United States in 2012.[7] A more recent study conducted in South Carolina showed that dentists contributed to a slightly higher percentage of opioid prescriptions.[8] Prescribing patterns have been studied both by insurance claims data[9–10] and through analysis of state Prescription Drug Monitoring Program (PDMP) data.[11] The Rhode Island PDMP collects data on all controlled substance prescriptions dispensed within the state.[12] These data inform clinical decision-making by prescribers and pharmacists and facilitate monitoring of statewide opioid prescribing trends, including by prescriber specialty. The rescue strategy recognizes the role of naloxone for emergency management of a suspected opioid overdose. Both community naloxone distribution and co-prescribing in cases of high-dose (≥50 MME/day) have resulted in reduced death rates.[13–14]

The objective of this study was to describe trends in opioids prescribing by dental professionals in Rhode Island from 2017 to 2019. We will look at numbers of initiates, those getting their first exposure to opioids, and numbers of people receiving subsequent prescriptions, a potential predictor for opioid use disorder. In addition to identifying numbers of prescriptions, we will report quantity of pills prescribed as well as high dose prescriptions. As high dose prescriptions warrant co-prescribing of naloxone, this activity will also be reviewed.

METHODS

Data from the PDMP were used to identify opioid and naloxone prescriptions to Rhode Island residents dispensed by pharmacies with a controlled substance registration (CSR) in Rhode Island between January 1, 2017, and September 30, 2019.

We defined opioid and naloxone prescriptions based on the American Hospital Formulary Service Pharmacologic - Therapeutic Classification Code (TCC) associated with each product's National Drug Code in the IRB Micromedex RED BOOK. Opioid prescriptions included opiate agonists (TCC 28:08.08), opiate partial agonists (TCC 28:08.12), and tramadol products (TCC 28:08.92.00.50). Naloxone prescriptions included TCCs 28:10.01.00.60 and 52:36.01.01.07.

We defined the prescriber's specialty for each prescription through a hierarchical process. First, we defined specialty based on the degrees listed with the prescriber's last name and on a database of oral and maxillofacial surgeons (OMS) and periodontists maintained by the Rhode Island Department of Health (RIDOH). Second, we filled in some missing specialties by merging in the specialty selected when the prescriber registered with the PDMP, matching on the first five letters of the prescriber's last name, the first three letters of the prescriber's first name, and the prescriber's Drug Enforcement Agency number. Finally, we filled in some still-missing specialties by merging in the specialty selected when the prescriber registered with the PDMP but matching only on the first five letters of the prescriber's last name and the first three letters of the prescriber's first name. We excluded prescriptions with a known institution name (e.g., a hospital) listed as the prescriber's name. We restricted to Rhode Island dental professionals by manually reviewing the names of all OMS, periodontists, and other dental prescribers to identify out-of-state prescribers.

We excluded veterinary prescriptions based on an indicator field for veterinary prescriptions, an animal name field, and a veterinary prescriber specialty. We defined unique patients across prescriptions by matching on the first five letters of the patient's last name, the first three letters of the patient's first name, and the patient's date of birth. We defined an initiate opioid prescription as either the patient's first opioid prescription during the analysis period or an opioid prescription that started more than 60days after their previous opioid prescription ended. We defined a subsequent opioid prescription as one filled after an initiate prescription but within 30 days of the end of the initiate prescription.

Due to our interest in opioids prescribed for pain management, we excluded buprenorphine products that were only FDA-approved for Medication-Assisted Treatment (MAT) of opioid use disorder as of November 1, 2019. For analyses of the average daily morphine milligram equivalent (MME) per prescription, we also excluded buprenorphine products that are FDA-approved for pain management because the risk of overdose by dose differs for buprenorphine compared to other opioid products [cite]. For some measures, we derived 2019 projections by dividing each 2019 YTD count by nine (i.e., the number of months in 2019 with complete data) and then multiplying the result by 12.

RESULTS

Total and Initiate Opioid Prescriptions

From January 1, 2017, to September 30, 2019, a total of 1,366,225 opioid prescriptions were dispensed to Rhode Islanders from all prescribers from any state. During this period, 66,816 opioid prescriptions were written by Rhode Island dental professionals and dispensed to Rhode Islanders. (Table 1). Of these, 35,523 (53.2%) prescriptions were from OMS, 2,321 (3.5%) were from periodontists, and 28,972 (43.4%) were from other dental prescribers. The most common types of opioids were hydrocodone (55.0%), codeine (28.1%), and oxycodone (13.5%). The median quantity of opioids per prescription was 12 units (inter-quartile range [IQR]=10-20) overall; this varied somewhat by prescriber type, ranging from 12 (IQR=10-18) among OMS to 15 (IQR=10-16) among periodontists. The median days' supply of opioids per prescriptions was 3 days (IQR=2-4) overall and similar across prescriber types.

Table 1. Opioid Prescriptions Written by Rhode Island Dental Professionals and Dispensed to Rhode Island Residents, January 2017 to September 2019

	2017		2018		Jan.-Sep. 2019		2019 Est.	
Prescriber specialty	Total N	Initiate † n(%)	Total N	Initiate † n(%)	Total N	Initiate † n(%)	Total N	Initiate † n(%)
OMS	14,770	12,399 (83.7)	12,298	10,617 (86.3)	8,446	7,404 (87.7)	11,261	9,872 (87.7)
Periodontist	1,192	1,030 (86.4)	803	714 (88.9)	326	281 (86.2)	435	375 (86.2)
Other dental prescriber	14,191	10,736 (75.8)	9,468	7,495 (79.2)	5,313	4,323 (81.4)	7,084	5,764 (81.4)

Abbreviations: Estimated (Est.), January (Jan.), September (Sep.).
†Initiate prescriptions defined as either the patient's first opioid prescription or an opioid prescription that started ≥ 60 days after their previous opioid prescription ended.

Of all opioid prescriptions by dental professionals, 55,004 (82.3%) were initiate prescriptions. The percentage of opioid prescriptions that were initiates ranged from 77.9% for other dental prescribers to 87.2% for periodontists. Between 2017 and 2019 YTD, the total number of opioid prescriptions and number of initiate prescriptions decreased each year for each prescriber specialty. For OMS and other dental prescribers, the percentage of opioid prescriptions that were initiate prescriptions increased somewhat during this period. The estimated reduction in prescription quantity between 2017 and an estimated full year for 2017 is 38% for all dental prescribers, or 24% for oral and maxillofacial surgeons, 64% for periodontists, and 50% for all other dentists. (Figure 2 - next page)

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Figure 2. Total Opioid Prescriptions Written by Rhode Island Dental Professionals and Dispensed to Rhode Island Residents, and the Subset of Initiate Opioid Prescripitons, January 2017 to 2019 Est.†

Abbreviations: Estimated (Est.).
†Initiate prescriptions defined as either the patient's first opioid prescription or an opioid prescription that started ≥ 60 days after the last opioid prescription ended.

Subsequent Opioid Prescriptions

Of 55,004 initiate prescriptions from dental professionals, 5,059 (9.2%) had any subsequent opioid prescription (from any prescriber) dispensed within 30 days of the initiate prescription (Table 2). The percentage of initiate prescriptions with any subsequent prescription within 30 days decreased from 10.2% in 2017 to 7.5% in 2019 YTD. Overall, OMS had the lowest percentage of initiate prescriptions with any subsequent prescription within 30 days (5.7%), while other dental prescribers had the highest (14.1%). For OMS and other dental prescribers, the percentage of their initiate prescriptions after which the patient had any subsequent opioid prescription within 30 days decreased somewhat from 2017 to 2019 YTD.

Table 2. Among Opioid Initiate Prescriptions Written by Rhode Island Dental Professionals and Dispensed to Rhode Island Residents, the Percentage with Any Subsequent Opioid Prescriptions from Any Prescriber Within 30 days, January 2017 to September 2019

	2017		2018		Jan.-Sep. 2019		Total	
Prescriber specialty	Initiate † n(%)	Any subsequent ‡ n(%)	Initiate † n(%)	Any subsequent ‡ n(%)	Initiate † n(%)	Any subsequent ‡ n(%)	Initiate † n(%)	Any subsequent ‡ n(%)
OMS	12,377	768 (6.2)	10,617	598 (5.6)	7,404	376 (5.1)	30,398	1,742 (5.7)
Periodontist	1,030	68 (6.6)	714	41 (5.7)	281	22 (7.8)	2,025	131 (6.5)
Other dental prescriber	10,762	1,635 (15.2	7,495	1,047 (14.0)	4,323	504 (11.7)	22,581	3,186 (14.1)
Total	24,170	2,471 (10.2)	18,826	1,686 (9.0)	12,008	902 (7.5)	55,004	5,059 (9.2)

Abbreviations: Estimated (Est.), January (Jan.), September (Sep.).
† Initiate prescriptions defined as either the patient's first opioid prescription or an opioid prescription that started ≥60 days after the last opioid prescription ended.
‡Subsequent prescriptions defined as an opioid prescription filled after an initiate prescription but within 30 days of the end of the initiate prescription. The subsequent prescription may be from the same prescriber or any another prescriber (including non-dental prescribers).

High-Dose Opioid Prescriptions

From January 2017 through September 2019, the median MME per opioid prescription from dental professionals was 25.0 (IQR=18.8=30.0). A total of 70 (0.1%) opioid prescriptions from dental professionals during this period were considered "high-dose," defined as more than 90 MME per day (Table 3 - next page). The percentage of opioid prescriptions that were high-dose was low for all dental professions, ranging from <0.1% among OMS to 0.2% among other dental prescribers, and declined somewhat overall from 0.2% in 2017 to <0.1% in 2019 YTD.

Table 3. High-dose (> 90 MME) Opioid Prescriptions Written by Rhode Island Dental Professionals and Dispensed to Rhode Island Residents, January 2017 to September 2019*

	2017		2018		Jan.-Sep. 2019		2019 Est.	
Prescriber specialty	Total N	≥90 MME n (%)	Total N	≥90 MME n (%)	Total N	≥90 MME n (%)	Total N	≥90 MME n (%)
OMS	14,779	11 (.01)	12,298	2 (<0.1)	8,446	1 (<0.1)	11,261	1 (<0.1)
Periodontist	1,192	2 (0.2)	803	1 (<0.1)	326	0 (0.0)	435	0 (0.0)
Other dental prescriber	14,191	42 (0.3)	9,468	10 (0.1)	5,313	1 (<0.1)	7,084	1 (<0.1)

Abbreviations: Estimated (Est.), January (Jan.), September (Sep.).
*Excludes opioid prescriptions for buprenorphine products.

Both the median quantity of pills prescribed and days duration remained below 20 from January 2017 to September 2019 with prescriptions from OMS having a lower median quantity and number of days in September 2019.

Table 4. Median Number of Opioids Prescribed and Number of Days Supply per Opioid Prescription Dispensed to Rhode Island Residents and Written by Rhode Island Dental Professionals, January 2017 to September 2019

Prescriber Type	2017		2018		Jan.-Sep. 2019	
	Pill Quantity	Day Supply	Pill Quantity	Day Supply	Pill Quantity	Day Supply
OMS	15 (10-20)	3 (2-4)	12 (10-15)	3 (2-4)	10 (8-15)	2 (2-3)
Periodontist	15 (10-16)	3 (2-3)	15 (10-16)	3 (2-3)	12 (10-15)	3 (2-3)
Other dental prescriber	12 (10-20)	3 (2-4)	15 (10-20)	3 (2-4)	15 (10-20)	3 (2-4)

Inter-quartile range noted in parentheses. Abbreviations: January (Jan.), September (Sep.).

Number of Professionals Prescribing

Of 563 Rhode Island dental professionals prescribing opioids dispensed to Rhode Island residents between 2017 and 2019 YTD, 511 (90.8%) were other dental prescribers (Table 5). The number of dental professionals prescribing decreased from 485 in 2017 to 366 in 2019 YTD. Overall, the average number of opiod prescriptions dispensed per prescriber per month decreased somewhat from 5 prescriptions in 2017 to 3 in 2019 YTD (Table 6); the largest decrease was observed among OMS – from 41 in 2017 to 32 in 2019 YTD.

Table 5. Unique Rhode Island Dental Professionals Actively Prescribing Opioid Prescriptions, January 2017 to September 2019*

Prescriber Type	2017 n	2018 n	Jan.-Sep. 2019 n	Total
OMS	30	30	29	34
Periodontist	16	16	14	18
Other dental prescriber	439	398	323	511
Total	485	444	366	563

Abbreviations: January (Jan.), September (Sep.).
*Unique dental prescribers defined based on the first three letters of their first name and the last five letters of their last name. A correction was made for two OMS known to have the same first and last name.

Table 6. Estimated Average Number of Opioid Prescriptions Dispensed to Rhode Island Residents Per Prescriber Per Month by Prescriber Type, January 2017 to September 2019

Prescriber Type	2017 n	2018 n	Jan.-Sep. 2019 n	Total
OMS	41	34	32	32
Peridontist	6	4	3	4
Other dental prescriber	3	2	2	2
Total	5	4	3	4

Abbreviations: January (Jan.), September (Sep.).
Total opioid prescriptions written (Table 1), divided by number of actively prescribing providers (Table 9), divided by 12 months. Does not include prescriptions provided in institutional settings such as hospitals.

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Naloxone Prescriptions

Since the Rhode Island PDMP began collecting naloxone prescription data in October 2017, 91 naloxone prescriptions from dental professionals have been dispensed to Rhode Islanders (Table 7). Of these naloxone prescriptions, most (62, 68%) were from OMS. The overall number naloxone prescriptions from dental professionals increased from 44 in 2018 to 63 in 2019 (estimated).

Table 7. Naloxone Prescriptions Written by Rhode Island Dental Professionals and Dispensed to Rhode Island Residents, October 2017 to September 2019*

Prescriber Type	Oct.-Dec. 2017* n	2018 n	Jan.-Sep. 2019 n	Total
OMS	0	33	29	62
Peridontist	0	6	5	11
Other dental prescriber	0	5	13	18
Total	0	44	47	91

Abbreviations: Estimated (Est.), January (Jan.), September (Sep.).
*The PDMP began collecting naloxone prescription data in October 2017.

DISCUSSION

The data from January 2017 to September 2019 indicate that dentists in Rhode Island generated 5% of all opioid prescriptions, which is less than the national average (6.4%). The trend from 2017 to 2019 shows a reduction in prescribing by all dentists, with the greatest drop among periodontists (64%) in comparison to other dental prescribers (50%) and OMS (24%). Initiates make up the majority of those receiving prescriptions, with four out of five prescriptions being provided to someone who is considered opiate-naïve. Approximately 9% of initiate prescriptions from dental professionals were to patients who received a subsequent opioid prescription from any prescriber within a month, which may be a gateway to opioid dependency. Thus, it is encouraging that the percentage of initiate prescriptions with a subsequent prescription within a month declined between 2017 and 2019

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YTD. Furthermore, dentists' prescriptions were for short durations (median=3 days) and for quantities less than what is permitted by law for an initial opioid prescription for an opioid-naïve individual (median=12 units vs. 20 units permitted by law).

Our data suggest that Rhode Island dentists' opioid prescribing practices changed between 2017 and 2019. The reasons behind the trends are not fully understood. During this period, several activities such as PDMP utilization, updated pain management regulations, and educational outreach on a non-opioid approach to pain management may have had an impact on prescribing behavior. Both the trend in reduction in number of prescriptions by all and reduction in dose and days duration by oral and maxillofacial surgeons is evidence of a commitment to continue work to address the opioid crisis. Organizations such as the American Dental Association and the American Academy of Oral and Maxillofacial Surgeons have offered substantial resources to guide practitioners towards a non-opioid approach.15,16

Our analysis has several limitations. First, despite our varied approaches to identifying prescriber specialty, almost 5% of opioid prescriptions from the analysis period had unknown prescriber type, some of which may have been from dental professionals. Additionally, we may have inappropriately classified some prescriber specialties based on the information available. Second, the Rhode Island PDMP only captures data for prescriptions that were dispensed by retail pharmacies with a CSR in Rhode Island. Thus, our analysis excluded opioids provided in hospitals, prescriptions that were written but never filled, and prescriptions dispensed by pharmacies without a CSR in Rhode Island. Finally, the Rhode Island PDMP does not have naloxone prescriptions from before October 2017, limiting our ability to evaluate trends in naloxone prescribing during the analysis period.

Dentists should continue to review patient's history, utilize the PDMP, prescribe non-opioid treatment options as appropriate, and prescribe opioid medications only when indicated. Dentists contributed to a small percentage of naloxone prescriptions. This may be attributed to opioid prescriptions written for shorter durations and lower daily dosages. Low naloxone uptake by dentists may serve as a potential area for educational outreach. Patients who are identified as high risk and do not have any contraindications should be co-prescribed naloxone to reduce the risk of overdose death. Screening, Brief Intervention, and Referral for Treatment (SBIRT) is a quick tool for all health providers and training is available.

Conclusions

The number of opioid prescriptions written by Rhode Island dentists and dispensed to Rhode Islanders decreased substantially from 2017 to 2019 YTD, along with the number of dental professionals prescribing opioids. All dental prescriber types prescribe a low quantity of opioids per prescription. Prescribing of naloxone by dental professionals is low, likely due to the low dosage of opioid prescriptions by dental professionals. Using a brief screening tool such as SBIRT is encouraged. Continued use of the PDMP, education on the non-opioid approach, and other innovative pain management strategies should continue the key preventive effort of reducing the number of Rhode Islanders who are adversely impacted by opioid analgesics.

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Key Findings

- The number of opioid prescriptions written by Rhode Island dentists and dispensed to Rhode Islanders decreased substantially from 2017 to 2019 YTD, along with the number of dental professionals prescribing opioids.
- All dental prescriber types prescribe a low quantity of opioids per prescription

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DENTAL LIFELINE NETWORK
WILL YOU SEE ONE VET?

Dr. Anna Abernethy is still not sure how one of the patients she treated this year — a 52-year-old Army veteran — managed without teeth for nearly 40 years.

"For some reason or another, he had all his teeth removed before he enlisted," she said. "He didn't know how to smile. He couldn't chew solid food."

But six months ago, Dr. Abernethy gave the Army veteran lower and upper dentures, allowing him to smile and eat normally for the first time in decades.

"We were all crying afterward," she said. "He was such a sweetheart and was so grateful."

The patient was among a dozen U.S. veterans Dr. Abernethy has helped in the past five years through her volunteer work with the Dental Lifeline Network, a national nonprofit that provides no cost, comprehensive dental treatment to people with disabilities or people who are elderly or medically fragile.

Dental Lifeline Network is encouraging other dentists around the country to donate their time and skills to at least one veteran as part of its continuing Will You See One Vet campaign. Their goal: recruit more general dentists and specialists to register as a volunteer at WillYouSeeOneVet.org.

"I volunteered after I realized they simply don't get the care they need," Dr. Abernethy said.

"Veterans have served our country well," said ADA President Chad P. Gehani. "They have sacrificed their lives for peace so that we can remain free. This is a small thank you from the dental community to our veterans."

Last year, Dr. Abernathy was among 900 volunteer dentists who donated their services through Donated Dental Services (DDS), the network's flagship program. However, according to Dental Lifeline Network, many veterans remained on the wait list.

The campaign, which includes targeted outreach, media and advertising, utilizes imagery of veterans telling their life-changing stories after receiving comprehensive dental care. One component of the campaign is a radio public service announcement distributed to media outlets nationwide. In addition, the PSA was distributed for print and digital advertising for national and state outlets across the country.

After volunteers fill out a short form, Dental Lifeline Network screens patients to confirm eligibility, helps ensure that they show up to appointments and coordinates lab work and any needed specialty care.

"Lack of dental care can lead to the inability to have a life-saving surgery, eat again or contribute to the community," said Fred Leviton, chief executive officer of Dental Lifeline Network. "For many of these veterans, volunteer dental professionals are their only hope. Through the Will You See One Vet campaign, DLN hopes to expand its network of dentists and their teams to volunteer to see one veteran with special needs one time per year."

Volunteers will join more than 15,000 other dentists nationwide and 3,400 laboratories that make up the network. Currently, there are more than 17,000 people on waiting lists for Donated Dental Services. Since 1985, the Dental Lifeline Network DDS program has surpassed $378 million in donated dental care.

The ADA and DLN are strategic partners. The two organizations maintain and nurture a collaborative relationship in which the ADA helps to further and promote the Dental Lifeline Network's humanitarian mission, as feasible, especially encouraging its members and constituents to volunteer to help people with special needs including veterans. In exchange, the network will promote the charitable services of ADA members and how the organization and its members improve access to dental care for vulnerable people.

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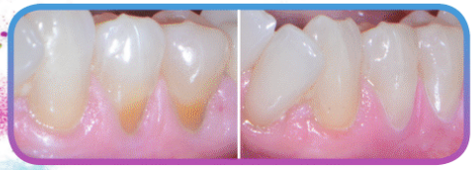
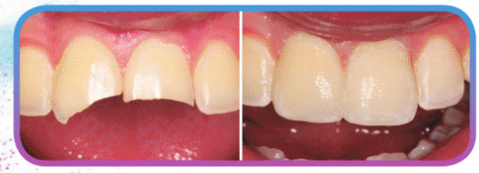
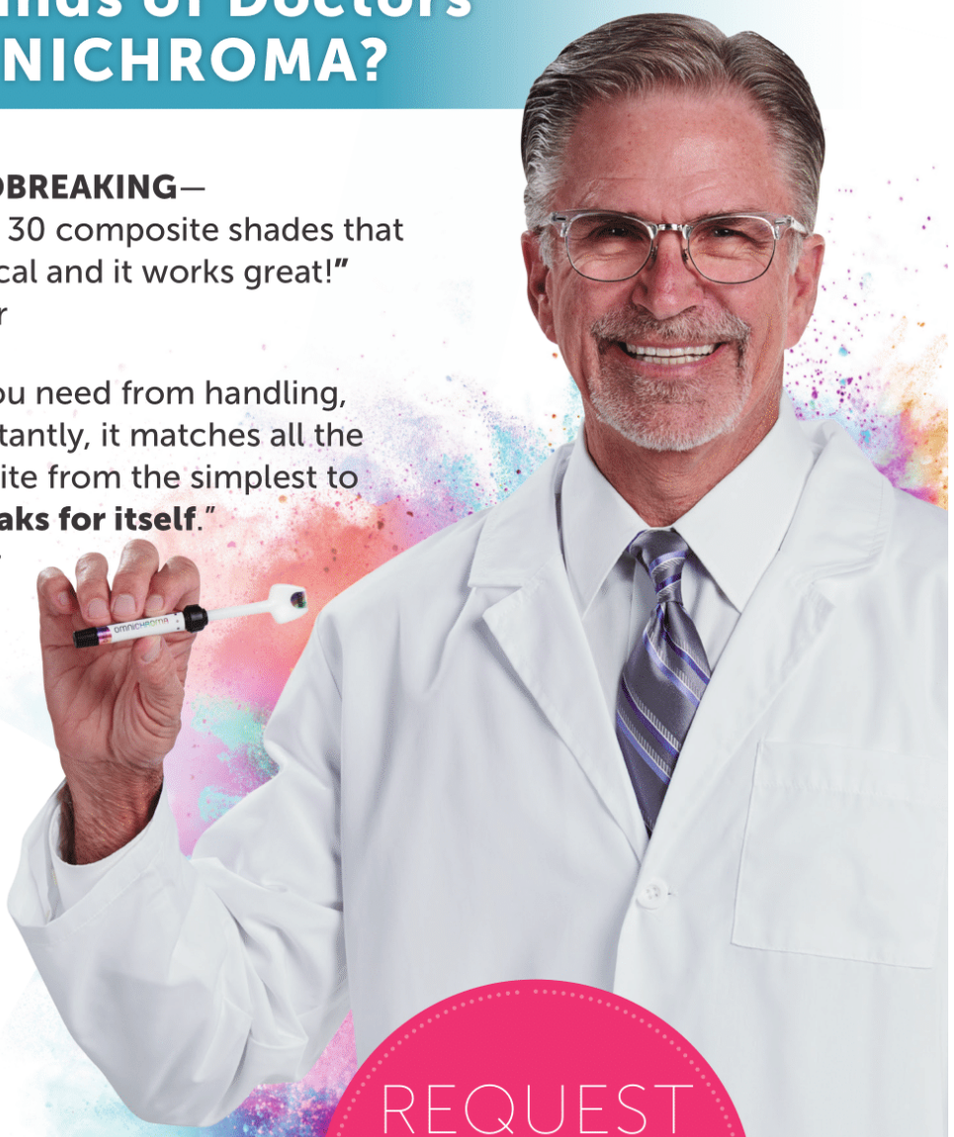


Case image courtesy of Dr. Peter Auster, Pomona, NY



Case image courtesy of Dr. Allan Mohr, Massapequa Park, NY



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LIFE-THREATENING DENTAL INFECTION: A MANIFESTATION OF POOR RESOURCE ALLOCATION

A CASE STUDY AND COMMENTARY BY: RICHARD W. PANEK, DDS, MS

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Abstract

Current funding of Medicaid Dental Fee for Service care is limiting access to oral health care in Michigan. Poor resource allocation affects the lives of Michigan citizens and unnecessarily diverts care to a higher cost environment. This case report is used to highlight issues with distribution of Medicaid resources and the adverse outcomes resulting from limited access to dental care for adults covered by Medicaid. Chronic underfunding of Medicaid Fee for Service dental plans is forcing a shift to higher cost medical care. The case is presented for increasing the Fee for Service Dental Medicaid fee schedule to improve access to care.

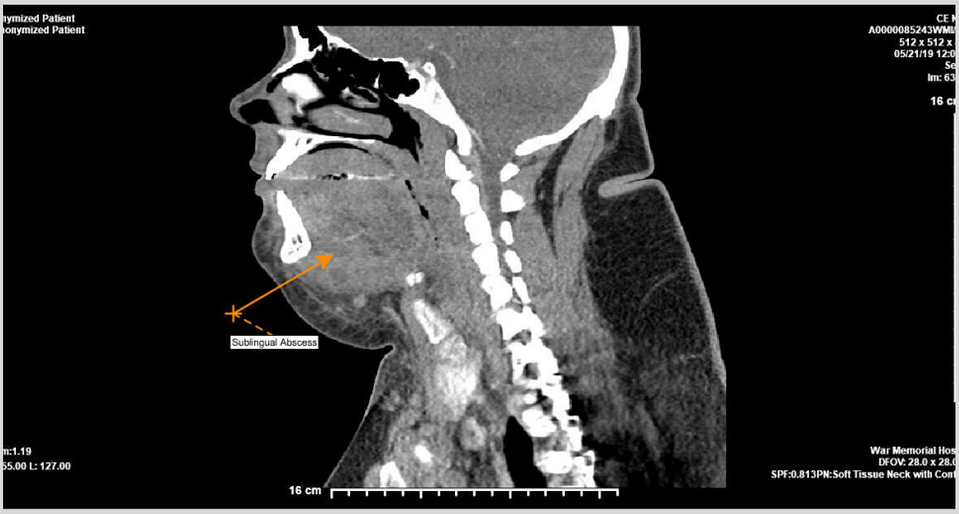
J.N. is a 24-year-old male who was referred from War Memorial Hospital in Sault St. Marie, Mich., to Spectrum Health Butterworth Hospital in Grand Rapids, Mich., for treatment of an impending Ludwig's angina. Ludwig's angina is an infection of the neck that has the potential to cause airway obstruction and death. Most cases are caused by dental infections, and this patient had a history of intermittent pain associated with tooth #31 for several weeks before seeking medical care.

Weeks before the referral, the patient began experiencing swelling around tooth #31 that extended under the right lower jaw. The patient did not seek treatment with a dentist due to lack of dental benefits and financial resources, but did go to a local Urgent Care Medical Center. He was empirically started on oral clindamycin, with improvement in the swelling around the tooth; however, swelling under the lower jaw persisted. He subsequently went to a dentist who referred him directly to the Emergency Department (ED) at War Memorial Hospital in Sault St. Marie, Mich.

On presentation in the ED, the patient had a fever and increased white blood cell count indicative of systemic infection. He had no difficulty breathing but did have pain with swallowing. His past medical history was significant for obesity, hypertension, and asthma. His current medications included albuterol, Lisinopril, and ibuprofen. He gave a history of childhood penicillin allergy. A maxillofacial CT with IV contrast demonstrated submandibular region abscess and necrosis with extension into the tongue (Figure 1). He was started on IV clindamycin.

The advanced stage of the patient's condition required multidisciplinary medical management that was unavailable in the Upper Peninsula or the Northern Lower Peninsula of Michigan. The ED physician in Sault Saint Marie therefore contacted the Spectrum Health transfer center in Grand Rapids, Mich. The transfer center is a service that links outlying ED physicians with Spectrum Hospital on-call medical staff via a four-way recorded phone line. A triage nurse fields the call, then connects the consultant on-call oral surgeon with the ED physician as well as a Spectrum Health Hospitalist to coordinate admission.

Figure 1 - Sagittal plane computed tomogram (CT) showing sublingual abscess.

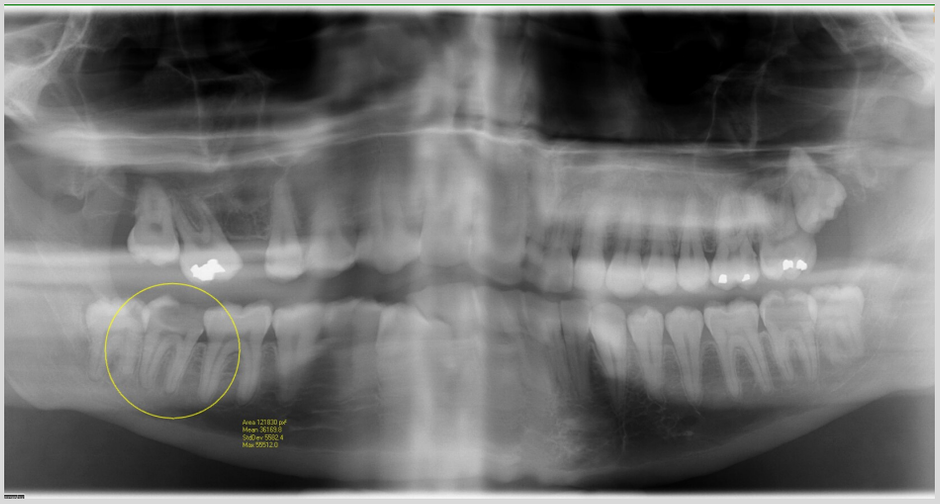


Based on the severity of the infection as described by the ED physician, and lack of specialist coverage in the UP and Northern Lower Michigan, transfer was arranged. The patient was flown 300 miles by helicopter to Grand Rapids. Upon admission in Grand Rapids, his vital signs were BP 138/76, Pulse 90, and he was afebrile. His white blood cell count was 26,980/uL (normal 4-10,000/uL). The patient was administered IV clindamycin 600 MG IV every six hours and was prepared for surgery.

The inpatient oral surgery consultation revealed a firm, tender, non-fluctuant swelling of the submental area with extension into the bilateral

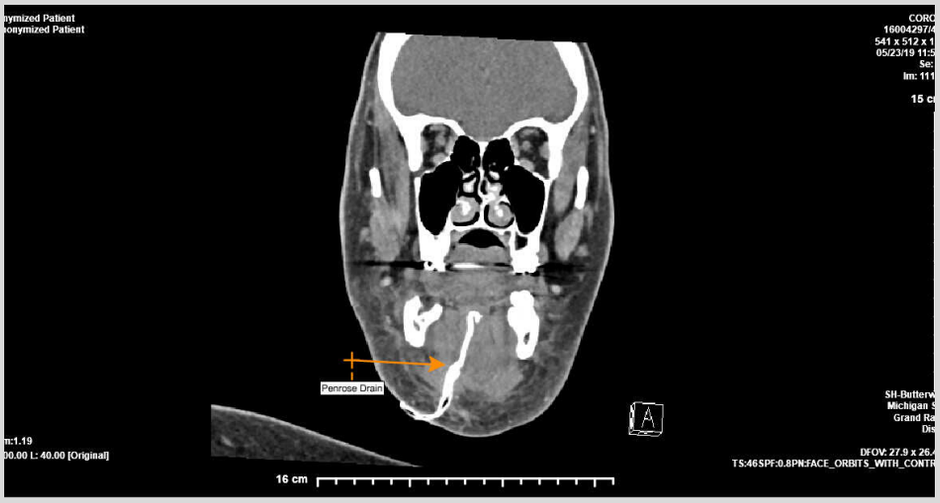
submandibular areas. The patient was able to open his mouth normally, but oral evaluation showed elevation of the floor of the mouth with a raised and swollen tongue. The back of the patient's throat was not visible due to the tongue swelling. The patient could only swallow his saliva when sitting upright. There was no limitation of neck extension or flexion, and the swelling was limited to the area under the lower jaw. Dental examination showed caries to the pulp on tooth #31 (Figure 2), which was the tooth the patient indicated as the source of his past pain and current infection.

Figure 2 - Panoramic tomogram showing dental caries, tooth #31.



The patient was added on to the Operating Room schedule for urgent extra-oral incision and drainage of the submental, bilateral submandibular, and sublingual spaces, and tooth extraction. The informed consent process included a discussion on the possible need for awake fiberoptic tracheal intubation if there was airway difficulty, the possible need for post-operative intubation with ICU care, as well as the remote chance of needing a tracheostomy. The patient consented to the procedure.

Figure 3 - Post-operative coronal plane CT with Penrose drain in place.



The patient was easily intubated by the anesthesia team with no pharyngeal/supra-tracheal abnormalities noted. Incision and drainage of the infection was performed via a single 2 cm submental skin incision.

The submental, bilateral submandibular, and bilateral sublingual spaces were then entered with a hemostat with productive drainage of 10-15 ml of foul-smelling brownish pus, from mainly the submental area. The purulent drainage was swabbed for Gram stain as well as aerobic and anaerobic culture and antibiotic sensitivity testing. A half-inch Penrose drain was then inserted into the abscess space and was sutured to the skin. (Figure 3). Tooth #31 was extracted, and a dressing was placed over the incision and drainage site.

The patient recovered from anesthesia without complication and was transferred to a regular hospital room. The Gram stain of the abscess drainage showed many white blood cells, many Gram-negative rods, and a few Gram-positive cocci. The microbiologic report identified *Haemophilus parainfluenza*, which was resistant to clindamycin. The patient was queried about his penicillin allergy and noted it was not an anaphylactic reaction. The antimicrobial stewardship team gave the patient an oral amoxicillin challenge without complication. He was subsequently started on IV ampicillin-sulbactam 3 grams every 6 hours. Daily dressing changes were performed for three days postoperatively until there was absence of purulent drainage. Once drainage resolved, the Penrose drain was removed, and the patient was discharged home from the hospital on oral augmentin 875 mg twice a day for seven days.

PART TWO: COMMENTARY

This report details the consequences of untreated dental disease as well the outcomes of suboptimal prevention and management. The unfortunate

continued on page 21

continued from page 20

aspect of this case is that the patient had adequate coverage for necessary treatment in the medical system, but inadequate finances and lack of access to outpatient treatment that could have prevented hospitalization.

Ultimately, these circumstances forced the patient from early intervention with comparatively lower cost dental intervention into a much higher-cost hospital-based treatment environment. Air ambulance transport is estimated to cost $6,000 to $13,000, and in-patient surgical treatment with four days of hospitalization costs are more than $11,000. [1–2] Appropriate dental care to remove the tooth as an outpatient (before the problem escalated to the point of infection) would have cost less than $500 in a private dental practice.

Young adults such as this patient (age 20 to 29) are increasingly relying on hospital emergency departments for toothaches and treatment of related infections. The increase in ED utilization for dental problems by this age group has increased 20 times more than the increase in visit rates for back pain in the period from 2001-2010. In 2009 and 2010 this population made an estimated 1.27 million ED visits for toothache. Toothache is, in fact, the third most-common reason for ED visits among this age group.[3]

A recent news article stated the Michiganders in general made 7,286 ER visits for dental problems in 2011, and the total hospital charges equaled $57,5 million.[4] Other state sare facing similar problems with many of these patients having difficulty accessing outpatient care after ED treatment. A recent study of ED dental visits in Massachusetts found that 21% of the patients seeking care for dental problems in hospital EDs returned to the ED for repeat treatment within 30 days. The majority of these patients were in the 26 to 35 year age group.[5]

Spectrum Health is an integrated health care system with nine affiliated hospitals in the West Michigan region. The author's analysis of system-wide emergency department and admission numbers for 2015-16 showed more than 7,000 patients per year sought care at Spectrum for oral health problems.

During the same time period, more than 120 patients were admitted to hospital with a typical one-to two-day length of stay. Although some of these encounters are for traumatic problems, the majority of the cases are toothaches and dental abcesses.

The unfortunate aspect of this case is that the patient had adequate coverage for necessary treatment in the medical system, but inadequate finances and lack of access to routine dental care that could have prevented hospitalization

Spectrum's global per-patient inpatient charge for the Cellulitis Diagnosis Related Group (DRG) is more than $11,000, with Medicaid paying just under $6,000.[2] In 2011, Michigan hospitals were paid $15 million to treat preventable dental problems. That's only about a quarter of what hospitals say was their actual cost of providing the care.[6] The average outpatient ED charge for a dental emergency is estimated nationally to be $760; the average charge for a dental examination, routine x-rays and cleaning is a little less than $235.[4]

The Medicaid system was intended as a "safety net" of health care coverage for the poor of the United States. In Michigan, 2.3 million people are covered by Medicaid at a cost of $16.9 billion or $6,394 per enrollee. Medicaid makes up 30.2% of Michigan's state budget.[7] Expansion of Medicaid through the Affordable Care Act (ACA) has made medical coverage available to a broader cross-section of the population. The ACA falls short, however, by not mandating dental benefit coverage for all Medicaid-enrolled adults. It fails to address the most common chronic oral disease in adults (dental caries), which can inordinately contribute to health care costs, such as in this case.[8]

Management of chronic conditions such as diabetes, coronary artery disease as well as end-of-life care is a major cost driver for our national health care market. The Centers for Medicare/Medicaid Services (CMS) and other federal agencies aim to decrease the cost of health care while increasing value. Economic factors make the current state of health care expenditures unsustainable. According to The Henry J. Kaiser Foundation, the cost of U.S. health care is equivalent to 17.9% of GDP. Sixty-three percent of this amount is spent on hospitals, physicians, and prescription drugs, while only 4% is attributed to dental care.[9]

The Michigan Medicaid experience

How could adequate dental benefit coverage play a role in decreasing the cost of health care in the United States?

More specifically, how could increasing dental Medicaid benefits decrease Medicaid expenditures on the medical side?

The patient in this report would likely have accessed the oral health care system earlier, thereby preventing the development of the infection, if he had access to adequately funded Medicaid adult dental benefit coverage. Just prior to hospitalization, he had started a new job but did not have dental health benefits through his employer. He did, however, have Upper Peninsula Healthcare Medicaid coverage, which provides limited dental benefits on a fee-for-service basis.

Dental Medicaid coverage in the United States can be classified as "emergency only," "limited," or "comprehensive," and states may elect the level of coverage they provide adults in their state through Medicaid plans (see graphic on page 22). The state of Michigan provides "limited" Medicaid dental coverage. "Limited" benefit plans provide coverage for less than 100 preventive, diagnostic and minor restorative procedures, with a per-person maximum expenditure of $1,000 per year. Although this is better than some states that provide "emergency only" care, there are 19 states that provide "comprehensive" coverage. These plans are typically a comprehensive mix of services, including more than 100 diagnostic, preventive, and minor and major restorative procedures, with a per-person annual expenditure cap of at least $1,000.[10]

True cause of the access problem

Michigan dentists participate with Michigan Medicaid at an above-average rate compared

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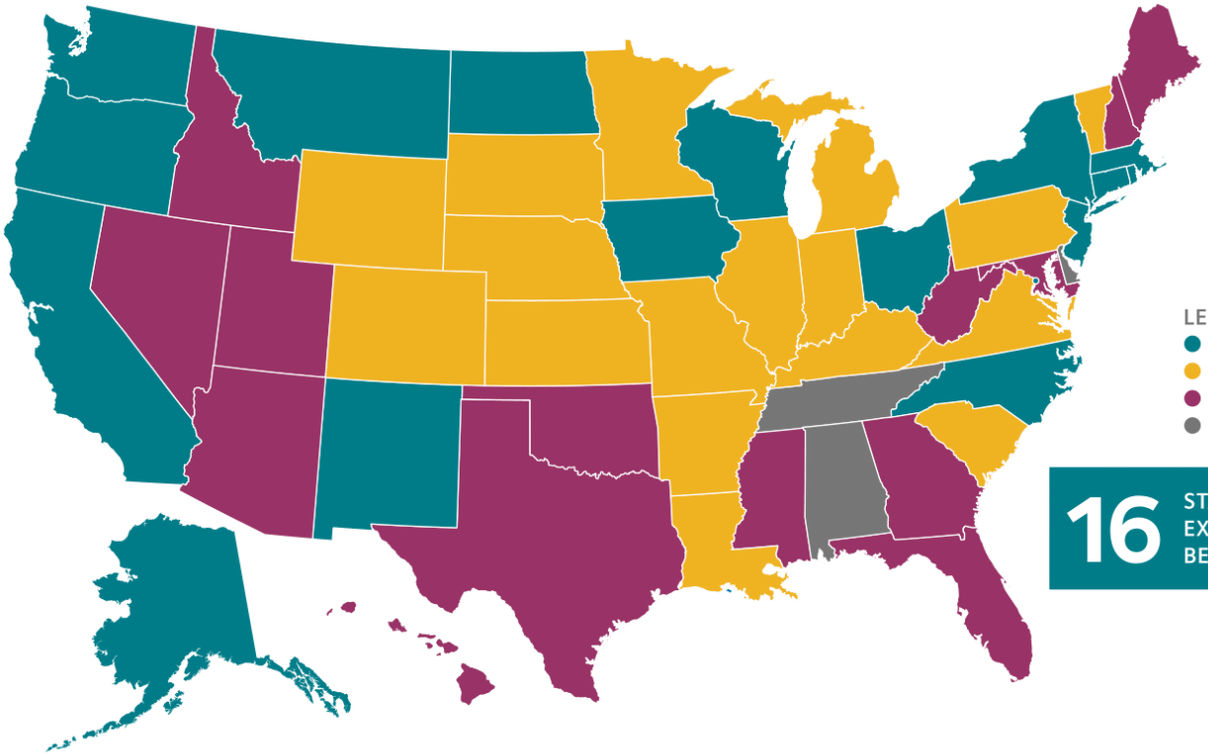
Oral Health and Well-Being Among Medicaid Adults by Type of Medicaid Dental Benefit

MEDICAID ADULT DENTAL BENEFIT LEVELS IN THE UNITED STATES, 2018



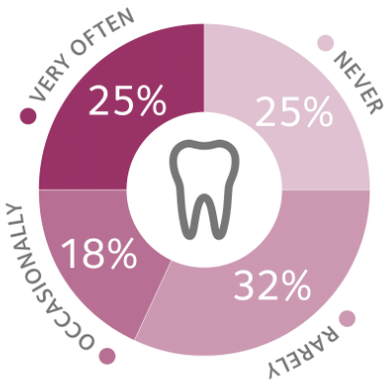
16 STATES AND D.C. PROVIDE EXTENSIVE ADULT DENTAL BENEFITS IN MEDICAID.

35%
ADULTS WITH MEDICAID DENTAL BENEFITS

60%
ADULTS WITHOUT MEDICAID DENTAL BENEFITS

"LIFE IN GENERAL IS LESS SATISFYING DUE TO CONDITION OF MOUTH AND TEETH"

ADULTS WITH MEDICAID DENTAL BENEFITS



ADULTS WITHOUT MEDICAID DENTAL BENEFITS

Sources: U.S. map data are based on Center for Health Care Strategies, Inc. Medicaid Adult Dental Benefits: An Overview. Fact Sheet January 2018. Available from: **https://www.chcs.org/media/Adult-Oral-Health-Fact-Sheet_011618.pdf**. Accessed April 5, 2018. All other figures are based on ADA Health Policy Institute analysis of 2015 Harris Poll survey data, including only adults who indicated that they obtained insurance for 2015 through Medicaid. In 2015, Colorado and Illinois had extensive benefits, D.C. and New Jersey had limited benefits, and Kansas, Louisiana, Missouri, Montana, Virginia had emergency benefits. We combined limited and extensive dental benefits into a single benefit category, adults with Medicaid dental benefits. We also combined emergency and no dental benefits into a single benefit category, adults without Medicaid dental benefits. For detailed survey methodology, visit **ADA.org/statefacts** and see the Oral Health & Well-Being in the United States project.

For more information, visit **ADA.org/HPI** or contact the Health Policy Institute at **hpi@ada.org.**

continued from page 21

to dentists in other states. However, the Medicaid FFS reimbursement in Michigan is 62% of the national average. [11] Most all Michigan Dental Medicaid participating dentists are losing money treating these patients at 38.5% of the private insurance reimbursement rate.

For example, the Michigan Medicaid Fee for Service Schedule reimburses dentists $33.43 for surgical tooth extraction (D7210).[12] This amount does not cover the actual costs of providing this service. Material costs alone for the procedure (including local anesthetic, scalpel, suture, sponges, patient barriers, irrigation solution, disinfectants, etc.) are approximately $15 for a private dental practice. This leaves less than minimum wage (after general business expenses) for the dentist, assistant, and office personnel.

Michigan dentists, as business owners, have no choice but to limit the number of Medicaid patients they treat to maintain sustainable cash flow. This limited access results in shifting the burden to hospitals and the Medicaid system for Emergency Department and, in many cases, in-patient medical care.

Lack of adequate dental coverage leading to increased ED and in-patient hospital care has been well established. Ironically, it has also been shown that providing a comprehensive dental benefit with medical plans decreases the costs associated with management of chronic diseases.[13] Research looking at Medicaid beneficiaries showed that there is for Service Schedule reimburses dentists $33.43 for surgical tooth extraction (D7210).[12] This amount does not cover the actual costs of providing this service. Material costs alone for the procedure (including local anesthetic, scalpel, suture, sponges, patient barriers, irrigation solution, disinfectants, etc.) are approximately $15 for a private dental practice. This leaves less than minimum wage (after general business expenses) for the dentist, assistant, and office personnel.

Michigan dentists, as business owners, have no choice but to limit the number of Medicaid patients they treat to maintain sustainable cash flow. This limited access results in shifting the burden to hospitals and the Medicaid system for Emergency Department and, also a strong correlation between improvements in oral health and self-reported assessment of general health.[14] Adequately funded oral health care not only decreases medical costs but creates value by improving quality of life for patients.

Cost continues to be a major hurdle to people seeking comprehensive oral health care even among those with dental benefits. It is estimated that half of the population has no dental care coverage and of those that have it, more than 40% do not seek care.[15]

Social and cultural determinants that prevent patients from seeking care include fear and/or lack of motivation to seek treatment. The financial hurdles however can be overcome with adequate government funding of Adult Dental Medicaid. Improving the oral health of Michigan citizens ensures a healthy workforce and, for those in poverty, improves the chances of obtaining and keeping employment.

The patient in this report would likely have accessed the oral health care system earlier, thereby preventing the development of the infection, if he had access to adequately funded Medicaid adult dental benefit coverage.

A path forward

The state of Michigan implemented aspects of Medicaid expansion afforded through the ACA. The Michigan Dental Association supported creation of the Healthy Kids Dental as well as Healthy Michigan Plans, which improved the oral health of almost 40% of those covered by such plans.[16] The proven success of these plans shows that they should be maintained. However, more needs to be done.

More than one out of three low-income adults say they avoid smiling, and 17 percent report difficulty doing usual activities because of the condition of their mouth and teeth. Nearly one out of four low-income adults and 14 percent of all adults report that their oral health issues have led them to reduce participation in social activities.[17] These types of oral health issues reduce the quality of life by effecting job performance and employability.

Michigan's governor and the state Legislature determine government program funding priorities based on revenue. Analysis of the cost-to-benefit ratio concerning full funding of an Adult Medicaid Dental Benefit is the responsibility of our elected officials. State government, however, needs the input of constituents regarding this program.

ADA Health Policy Institute research has determined that providing comprehensive Medicaid dental coverage on average adds 1.1% to a state Medicaid budget. Adding such a benefit would prevent the diversion of dental problems to hospital EDs. The limited expansion of medicaid benefits in Michigan through Health Kids Dental did show that enhanced plan funding increased provider participation, access to care, and utilization of services.

**references on next page*

About the Author

Dr. Richard W. Panek is a private practice oral & maxillofacial surgeon and a diplomate of the American Board of Oral & Maxillofacial Surgery. He is an active medical staff member at Spectrum Health Butterworth, Blodgett and Helen DeVos Children's Hospitals as well as Mercy Health Saint Mary's Medical Center. He is currently president of the Michigan Society of Oral & Maxillofacial Surgeons.

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MEDICAL BUSINESSES' UNIQUE CONDITIONS DOUBLE THE VULNERABILITY

BY BELINDA M. KITOS, CFE, FROM THE NOVEMBER/DECEMBER ISSUE OF FRAUD MAGAZINE

A typical medical practice operates with controlled chaos, generous trust of staff and two separate financial accounting software programs — all breeding circumstances for fraud. Here's how to identify internal fraudsters' schemes and apply remedies (even if you don't work at a medical practice).

Mary was an excellent office manager for medical practices except she had a secret — she was a serial embezzler. Early in her career, she'd learned how to improperly remove funds from medical practice billing programs through various techniques. She'd ripped off three other practices before she began to work at yet another because she'd gotten so good at fooling doctors. And now she was doing it again. But she wasn't too worried. She'd already learned with the previous practices that if the physicians caught her, they'd just fire her to save face, and then she'd move on to her next victim.

For several reasons, medical office practices are sitting ducks for employee embezzlement, and most practice owners don't realize it.

Chaos can reign

As you wait for your appointment, you've seen how busy your doctor's office can be, especially when an emergency patient arrives. Physicians notoriously overbook their schedules because of numerous no-shows, so when everyone does make it in, staff and physicians can be overwhelmed. Fraud loves to breed in exhausting pandemonium.

Trusting work culture

Physicians instinctively believe their patients are telling the truth about their symptoms so they can apply the proper treatments. They also trust staff members, who tend to stay with practices for many years and become physicians' second families.

However, trusting medical cultures often are ripe for exploitation. Tired physicians and administrators at the end of chaotic days trust that their staff appropriately fulfilled their responsibilities, so they often skip checking the daily financial internal controls.

Two financial accounting programs

As CFEs, no matter what type of organization we're called upon to examine, we automatically expect to evaluate the financial operating account. Most small businesses maintain an operating account computer program, such as QuickBooks, and all the accounting information for the business is located within that account. To complete a thorough examination, we need to review that account, which contains expenses, accounts payable, monthly statements, billing and invoices, credit card expenses, merchant account statements, inventory, payment income and corresponding deposits.

However, walk into any medical office (including dental and veterinary) and everything is different. Medical businesses maintain two financial accounting software programs: one for patient billing and another for business operations. Fraudsters can target both of these accounts, which can leave a medical office more vulnerable than the average business with one financial account. Several employees can normally access both accounting programs. Usually only one employee is accessing the operating account — the practice office manager — but the billing account routinely has several employees with account access.

The practice or office manager handles the operating account, which maintains office overhead expenses such as utilities, supplies, payroll, repairs, etc. while several staff members handle the practice's billing account, which maintains patients' dates of service, charges, insurance information, insurance billing, and patient and insurance payment records to adjudicate patient accounts.

Doctors have spent endless hours of training to learn how to care for patients, but they might have taken only one course on managing a medical practice's business side. Most of them totally rely on their staff to run their patient billing and office operating accounts and only use CPAs to review financial quarterly or yearly account reporting information. This is a perfect breeding pool for fraud.

CFEs need to understand the EOB

A crooked medical billing account staff member who defrauds a practice must keep patients happy and quickly adjudicate their accounts so they don't receive bills for services they don't expect. One call from an irate patient about a false billing amount could expose fraudulent activity.

A CFE who's evaluating a medical practice billing account needs to understand the explanation of benefits (EOB) from the insurance companies and how to post payments received from those companies based on the EOBs that accompany each insurance payment. It's critical that medical practices post or enter payments on the dates that they receive them and not on the dates of service. The date received is considered the day that the staff is actually posting to the billing account - not the date the payment arrived in the mail.

Fraudsters' methods at medical practices and remedies

Fraudsters have several ways to improperly remove funds from medical practice billing programs. For example, in an incorrect payment posting, let's say the practice provided a service on the first of the month, and it received a payment for that service the following month. The monthly financial data intake for the previous month is calculated in the end-of-month reports that are generated for the practice.

If an unscrupulous staff member back-posts a payment to the previous month — or any prior date — that has already reported the monthly income, the month-end report will change and show more income when the report is regenerated. This type of posting can adjudicate the patient account and allows the staff member to remove the payment. Medical practices don't normally go back and actually regenerate the previous month-end reports. Banking today allows deposits by smartphone or ATM. This allows fraudsters to easily divert and deposit checks made out to the practice into their private accounts or into a created shell-company account.

Cash is king in any business, and it's usually readily targeted when available. Cash is routinely collected in a medical practice for co-pays, deductibles and the daily charges. A crafty staff member can adjudicate the patient account by posting a cash payment as a credit card payment and remove the cash. This method also creates false billing financial reports that are inflated because of the lack of an actual credit card payment. The billing account financial reports will show more income than the practice bank statements. Medical practices should maintain all daily payment receipts in a day file as a check and balance for the end of the day.

A daily-close printout from the billing account tallies up all the credit card receipts, cash and checks collected and posted for the day by each staff member. These amounts should match all the physical receipts maintained by the practice. The daily-close report should match the daily deposit slip that the staff will create. Make sure all deposit carbon slips are accompanied by the bank deposit receipt to verify the amount was deposited.

Maintain a three-part carbon, cash-receipt book to track all cash. Copy all daily credit card receipts, maintain all cash receipts and copy patient and insurance checks as proof of payment. Retain all this financial documentation in the day file along with all EOBs posted for the day to verify the daily practice intake.

Medical practices routinely take credit cards via reader machines on their counters, process payments and maintain receipts for the day. However, practices rarely refund by credit card. So, be sure to review for any credit card refunds in the account statements. A crafty staff member could easily send a refund to their credit card account by swiping their personal card on a reader machine. Practices can prevent this theft with a policy that all refunds must be approved by a supervisor.

We can find most of the typical operating account embezzlement schemes, such as payroll padding and accounts payable frauds in medical practice operating accounts. A crafty office manager can combine their personal bills with vendor bills, which, of course increases a practice's overhead expenses. A physician or CPA reviewing the practice financial reports would only notice that overhead expenses have increased without any vendor changes. The fraudster would slowly add personal bills so they wouldn't draw attention.

For example, an office manager includes their personal Verizon phone bill with the practice's Verizon bill. The practice writes a check for the combined amounts and includes both billing stubs in the envelope.

The only way to discover this type of fraud is to compare all invoices and statements to the payments.

Some doctors in a practice become so trusting of their staff "family" they never even look at invoices and bank statements. They allow staff to reconcile bank statements to the operating account and the office manager to sign all business checks.

Doctors often can't afford to have enough staff to segregate duties, so a single employee might control the revenue stream in small practices. The medical practice must have a system in place to verify that trust. Staff members who know that someone is overseeing their work or will randomly check it are more likely not to commit fraud.

Doctors should tell the practice's bank to send statements to their homes. They should review them first before giving them to the office manager to reconcile. Ensure that the practice's check copies are on the monthly bank statements and review the monthly practice vendor names and check the signatures. Question any vendor names you don't recognize. Sign your own checks. Ensure that the invoices are with each check for you to review if needed. Don't use signature stamps in your practice for checks, and don't allow staff to sign your checks.

Payments via wire and mobile transfers might not be for the practice but transfers of funds from the practice account to a staff member's personal account or shell company.

I repeat, blind trust with no checks and balances creates the perfect opportunity for fraudulent activity.

As always, tone at the top is important. If the staff sees the doctors cheating their partners or doing things inappropriately, then the staff will be more likely to also cheat. If staff members are caught, they can rat out the offending partner to avoid prosecution with dismissal - their

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their partners or doing things inappropriately, then the staff will be more likely to also cheat. If staff members are caught, they can rat out the offending partner to avoid prosecution with dismissal — their worst-case scenario.

What to look for and do

As in any organization, watch for employees who:

- Become secretive about their work or workspaces.
- Display new wealth such as expensive cars or clothes.
- Are that "indispensable" or "loyal" employee — often working late and on weekends unsupervised.
- Don't want to share tasks.
- Refuse to take vacations.
- Bully office managers.

Be wary of the office manager who asks a doctor to sign a stack of checks at a busy time of day. The manager often knows the doctor won't look at the accompanying invoices/statements because of waiting patients.

Call and ask for references for new hires. Conduct background checks on them. Segregation of duties is always an issue in smaller practices. Practices, or any business for that matter, where just one person handles all financial matters are always extremely vulnerable to fraud. Provide adequate guidelines in your employee manual for those who handle financial matters and enforce existing policies. Bond with those who handle funds. Maintain employee dishonesty insurance.

Pay your employees well but pay attention to those with disgruntled attitudes. Employees who constantly complain about their pay could feel justified in stealing. Most medical practices don't consider conducting an evaluation of audit as a preventative measure until they discover embezzlements. A typical case can cost a practice tens of thousands of dollars on top of the cost of the fraud. If the embezzler has been arrested, the CFE can put together the case. Most billing and operating account software applications have audit trails that can help to pinpoint account manipulations by individual staff members if they have unique log-ins.In my experience with medical office embezzlement, I find that after a medical practice has discovered fraud, doctors see clearly where and how it happened. They severely blame themselves for being so foolish to trust, and they suffer from a profound sense of betrayal.

Many are too embarrassed to prosecute because they think their patients will view them as imbeciles. Medical practice embezzlers know that, and so they take the shot. Fraudsters know there's a better chance of just getting fired than going to jail, and the risk to them is well worth the reward. They just take the money and move on to the next practice. Physicians that have been defrauded need to report these fraudsters to prevent them from repeating.

Special circumstances demand more scrutiny

Medical practices' special characteristics make them especially vulnerable to fraud. Chaotic doctors' offices, trusting work cultures and medical businesses maintaining two financial programs are fraud perpetrators' dream working conditions. However, CFEs at all small businesses can take cues from medical practices' unique woes. ●

Belinda M. Kitos, CFE, CICA, MT(ASCP)-RET, is president of SCF Inc. Contact her at BMKitosCFE@hotmail.com.

MEDICAL PRACTICE EMBEZZLEMENT RED FLAGS

- Diminishing cash flow.
- Monthly bank deposits that don't agree with payment posted to the practice billing system
- Increased contractual write-offs that don't agree with the EOBs.
- Inappropriate patient account write-offs without documentation.
- Little to no cash deposits in the practice bank account.
- Staff not collecting patient co-pays and/or deductibles.
- Payment amounts in the past voided, deleted or changed.
- Increased operating accounts payable/increased expenses.
- Increased billing accounts receivable or money owed instead of collected. Transactions lacking documentation or appropriate approval.
- Significant year-end financial account adjustments or journal entries without appropriate appropriate documentation.
- Poorly kept accounting records.
- Lack of account reconciliations.
- Purposely creating overly complex financial records.

WELCOME NEW MEMBERS

David Buczak, DMD
Boston University School of Dental Medicine, 2007
Graduate: Louisiana State University School of Dentistry, 2015
Employed: 1 Richmond Sq., Unit 166W, Providence

Su Jin Bae, DDS
New York University School of Dentistry, 2016
Employed: 335R Prairie Ave., Providence

John Vasko Jr., DMD
Boston University School of Dental Medicine, 2015
Graduate: NY State University at Stony Brook School of Dental Medicine
Employed: 1052 Main St. Warren

Bernhard Bridgewald, DMD
Boston University School of Dental Medicine, 2011
Graduate: ME - Penobscot Community Health Center, 2012
Employed: 3274 W Shore Rd., Warwick

Helen Livson-Mirucki, DMD
University of Connecticut, 2006
Graduate: Danbury Hospital, 2007
Graduate: Harvard University School of Dental Medicine, 2010
Employed: 1545 Smith St., North Providence

Danielle Spinden, DMD
Case Western Reserve University, 2018
Graduate: Ohio Mercy Medical Center, 2019
Employed: 20 Clinton Ave., Jamestown

Joke Alesh, DMD
Tufts University School of Dental Medicine, 2015
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