



F37 Malpractice and Fraud in the First Degree

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After attending this presentation, attendees will understand how proper documentation of patients, especially patients transferring into your practice, can be critical if malpractice or fraud by the previous practitioner is suspected or found.

This presentation will impact the forensic science community by providing a practical example of what can just “walk into your office” and how proper documentation, and compassionate patient care combined with forensic skills can work to correct one of the worst combined cases of substandard care and fraud.

In March of 2009, a new seven-year-old female patient (MM) with a toothache was referred to a private pediatric practice. What would follow was, to say the least, a journey to rectify the worst case of substandard care and fraud had experienced by this practitioner in 30+ years of pediatric and forensic dental practice.

The first of three siblings that were examined and treated MM, presented with multiple abscesses below restored teeth. A clinical exam and charting were completed, four periapical digital (Scan-X) X-rays were taken and read. Because of the acute infections present, the child was placed on amoxicillin for two days and was reappointed. The father was asked to obtain the treating dentist’s records before his daughter’s next visit, which he did. These records included three sets of bitewing X-rays all printed on the same 8½” x 11” photo sheet. Two sets of these X-rays were not properly dated, and were not correctly reflected in the dentist’s record. According to the father, his children had been seen by the previous practice on a regular basis for over two years, and had numerous restorations completed by the practice owner or an associate. The records and X-rays were reviewed prior to commencing actual treatment on MM. Comparing those records to charting and films from the first visit were disconcerting. Due to the noted discrepancies, additional intraoral photos and a panoramic film were added to her record, prior to the five extractions. With the father’s consent, the extracted teeth were preserved for any necessary future examination by insurance or other interested parties. A note to the tooth fairy also allowed an important common childhood experience to occur. Additional restorative and prosthetic treatment for MM was also necessary and completed over a period of three months. At the conclusion of treatment on MM and her two siblings (KM, CM), who also had significant issues with their care, insurance claims, and record continuity, individual letters were issued to the parents documenting findings and subsequent care. This was unusual, but this case was so far beyond routine occurrence, that the parents deserved documentation that they could easily understand, and take any action they felt appropriate. The parents, also patients of the practice in question, were referred to a general dentist for care and to correct any problems found with their treatment.

The documentation became critical to assist the State of Illinois Department of Financial and Professional Regulation to review and successfully prosecute this practitioner, ultimately resulting in a license revocation and the largest fine against a dental provider in the history of the State of Illinois.^{1,2} The practitioner had been cited three other times for bad record keeping, fraud and poor patient care. Both parents were insured, mom via excellent indemnity insurance and the dad via a high-benefit union dental plan. The practice owner, who of course is ultimately responsible for claims and what happens in their office, had billed both insurance plans as primary rather than following correct practice (the birthday rule familiar to any dental practitioner in the United States) to bill primary, await payment, and then bill secondary. In addition, the family had paid a significant amount of money as out-of-pocket costs. Poor dental care, fraud, and poor patient management all were present in these cases. Early in the investigation by the state, representatives of the U.S. Postal Inspector’s Office and the Office of Inspector General of the U.S. Department of Labor initiated contact with the office because the father’s union-provided dental insurance. Prosecution of this case by the U.S. government is pending.

Utilization of not only routine documentation skills for a dental practitioner, but forensic skills of dental aging, documents examination for continuity of content, detailed preparation of the IDFPF prosecuting attorneys, and expert witness testimony all were necessary to bring this case to a successful conclusion.

References:

1. Illinois Department of Financial and Professional Regulation, Division of Professional Regulation: Case 2010-xxxxx. Findings Of Fact, Conclusions Of Law And Recommendation To The Director, by the Illinois Board of Dentistry
2. Illinois Department of Financial and Professional Regulation, Division of Professional



Jurisprudence Section - 2014

Regulation: Case 2010-xxxxx. Administrative Law Judge's Report And Recommendations

Dental Malpractice, Dental Fraud, Substandard Care