

The Temporomandibular Joint and Related Orofacial Disorders

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Record Keeping, Litigation, and Insurance

Nature of the TMD Complaint

The TMD complaint may mimic symptoms common to medical or dental disorders. This unique feature complicates matters for the patient, the practitioner, the health care insurer, and the attorney who is confronted with establishing or negating "probable cause" between the complaint and an injury. The patient may visit a physician who identifies some of the musculoskeletal symptoms and diagnoses the disorder as "TMJ". To confirm the diagnosis, the physician may refer the patient for dental consultation. After initial consultation, the dentist may recognize need for further diagnosis and treatment. Although patients usually have medical insurance, insurers may be reluctant to reimburse them for services rendered by a dentist. Physical therapists have similar problems. Often, the plaintiff's attorney who seeks judgment for a client has difficulty in arranging payment by the insurer for treatment of the client. Conflicts develop from lack of comprehension on the part of all parties concerned.

Impairment and Disability

TMD patients suffer varying degrees of impairment associated with their disorders. *Impairment* is reflected in symptom presentation and overt illness behavior exhibited by the patient. The impairment may lead to disability. *Disability* concerns the inability to engage in gainful (daily living) activities because of the impairment.

Proof of impairment is confirmed by the findings of many epidemiologic studies around the world. Less is known about what degree disability results from impairment. Attempts have been made to determine the extent of this problem.

Disability produced by TMD has been estimated to range from 65% to 80%. This conclusion was based on studies using an index that measured symptom intensity and frequency and the level of functional impairment. Comparable studies conducted on nonpatients showed a range of values from 5% to 10% with the same index. The assumption, then, is that 55% to 70% of the patients suffered some disability.

Other evidence confirms that TMD patients suffer significant disability. Judged from an index concerned with activities of daily living, the level of disability produced by TMD pain alone was estimated to be less by a factor of two when compared with levels described for some other musculoskeletal pain disorders. Other impairments, such as joint noise and limited opening, were not measured, although they contribute significantly to disability.

The compensation system available to TMD patients can promote psychological stress and alter their impairments. Among low back pain patients, compensated recipients receiving regular payments showed more signs of emotional distress, had greater difficulty coping with pain, and reported more disruption in life events than subjects who had settled their claims. Nonetheless, some patients who had settled claims continued to have severe pain. The authors recommended that the compensation system promote patient employment as soon as possible after injury.

Quality Assurance

The chief problem in quality assurance is protection of the patient from misdiagnosis and mistreatment. In many medical specialties, diagnostic tests have proved reliable, and treatment protocols have become standardized. In contrast, few well-defined, valid protocols exist for assessment and management of TMD patients. Thus, the quality of health care received by patients varies greatly. Because there is no speciality in "TMJ", clinicians' opinions differ depending on geographic location and the kind of training acquired at their respective schools. Analysis of the consensus among practitioners about diagnosis and methods of treatment reflects such differences.

No independent agency is empowered to monitor credentials or practices of the various clinicians who manage TMD patients. Instead, practitioners are governed by the same standards of care provided by other practitioners within the same community. A V Pearson, attorney, described the standards of care test in a speech before the Loyola University of Chicago Law School: "Practitioners should possess minimum common skills possessed by the vast majority of dentists, use these skills with care and reasonable diligence and apply good judgement". American courts consider statements of this kind as the basis for the *professional standards test*.

Equally important is the need to notify patients of the considerations involved in (1) diagnosis, (2) reasons for treatment, (3) nature of care and treatment, (4) prognosis, (5) risks, (6) alternatives, and (7) likely outcome for nontreatment. Such information embraces the *prudent patient risk test*. The standard is based on the information needed by a prudent patient to decide whether to undergo a proposed treatment. Attempts have been made to improve standards of care for TMD patients. In 1982, the American Dental Association (ADA) endorsed some limited guidelines in the *Report of the President's Conference on the Examination, Diagnosis and Management of Temporomandibular Disorders*. The ADA missed a major opportunity to update these guidelines at another conference held in 1988. The meeting between a panel of "TMD experts" selected by the ADA and certain community practitioners around the USA led to so much discord little of importance resulted.

After this conference, members of the American Academy of Craniomandibular Disorders sought the aid of other reputable TMD practitioners to evaluate present guidelines. Important changes were made. Most noteworthy was the formulation of a system of diagnostic classification. The main subjects addressed were diagnosis and treatment. Health care use, impairment and disability, and the possibility of TMD developing secondarily from injury were briefly discussed. These modified guidelines have not been endorsed by ADA members or non-ADA practitioners.

Thus, patients are protected by professional standard and prudent patient risk tests. The duty of practitioners is to enforce these standards until more definitive guidelines are accepted by the profession.

Litigation

Clinicians have become subject to lawsuits because of the greater public awareness about TM disorders. Unwarranted legal action has been brought against clinicians by patients. The patients assume negligence (malpractice) and seek legal redress.

Cases have evolved from negligence alleged by plaintiffs concerning unsatisfactory diagnosis and treatment for TMD, as well as for periodontal disease and for root resorption attributed to orthodontic therapy.

Two medicolegal presentations have been found by a study of 731 facial pain cases at London's Eastman Dental Hospital. These concerned the failure to diagnose or treat the patient's facial pain appropriately. Pain developed spontaneously in some patients and became unremitting after unsuccessful treatment with traditional dental procedures. The patients claimed that the dental treatment caused the pain. Clinicians failed to recognize the presence of psychiatric illness in the second presentation. The authors concluded that all patients should have been treated initially with appropriate medication.

Other litigation has focused on the possibility of TMD developing secondary following whiplash or overt trauma within the TMJ region. Drawing conclusions about this potential etiology and recovery of the patient during active litigation has proved perplexing.

Consider some current opinions of dentists about this dilemma. A survey led to the conclusion that if TMD symptoms appeared within 2 months of the injury, there was probably a relation. If the duration was longer, then the probable cause lessens. The authors discussed these findings as a basis for compensation by the insurance industry and by worker's compensation.

During active litigation, there is the presumption that injured patients would be less likely to report relief of symptoms and have poorer treatment outcome. Studies conducted on 53 TMD patients with ongoing litigation for overt trauma or whiplash and 43 other nonlitigating TMD patients produced mixed findings. Certain parameters were significantly higher in litigating patients than in nonlitigating patients. More litigating patients reported facial and neck pain and endorsed more pain sites than nonlitigating patients. Other findings were less impressive. The level of pain determined by visual analogue scale (VAS), the duration of pain, and the affective pain dimension as assessed by the McGill Pain Questionnaire did not differ significantly between groups. The pressure pain threshold for the left masseter and frontal muscles was significantly higher in nonlitigating patients than in litigating patients, but no significant differences existed between groups for the pressure pain threshold of the right masseter, passive range of motion, and joint clicking.

Although the somatization score was higher in litigating than nonlitigation patients, the depression and anxiety scores were not. Significant improvement was observed in VAS pain, range of motion, and pressure pain thresholds for masseter muscle after treatment of

both groups. Litigating patients reported less overall improvement. The authors concluded that the interaction between litigation and TMD symptoms remains unclear.

These conclusions support the findings of another study regarding TMD and trauma. Based on analysis of 230 patients diagnosed into six TMD subgroups, the authors concluded that specific trauma may not initiate TMD symptoms but may have an important cumulative effect.

Prevention of Litigation

Effective communication helps clinicians avoid litigation. Legal action may result from poor interpersonal relationships between clinicians and patients. Many lawyers practicing professional negligence law agree that keeping good rapport with patients reduces the chance of lawsuits. Most dissatisfaction concerns inadequate financial agreement, appointment failures, broken appliances, and faulty restorative or prosthetic treatment.

Several practical suggestions have been made by E J Zinman, dentist-attorney, to improve rapport. He recommended that clinicians be honest and fair, listen to the patient, be prompt, and explain thoroughly.

Myths

Many questions asked by the TMD patient are the same ones asked by attorneys and the patient's insurer. Practitioners can help dispel some of the myths and fears associated with "TMJ". Some of the fallacies that require clarification follow.

- **Fallacy:** *Can a diagnosis be trusted if many clinical findings have proved negative?* Patients expect quick diagnosis and aggressive treatment of their complaints. The fact is that even with accurate diagnosis, existing treatment may fail. Accurate diagnosis does not always lead to a rational choice of therapies. Some diagnoses cannot be treated successfully.

- **Fallacy:** *Early TMD progresses to a worse condition.* Even within TMD clinical populations in which patients share common diagnoses, the timing and stage of the disorder makes prediction of progression difficult. Consider the findings of 262 TMD patients followed independently for either pain or clicking. Just 61% eventually had some limitation of mandibular motion.

Some patients have several symptoms simultaneously. Also, they may erroneously relate the appearance of new symptoms with preexisting symptoms. Consider the long-standing belief, promulgated in Costen's trilogy of TMJ, that jaw pain coincides with nonpainful symptoms of tinnitus and dizziness. Clinicians have perpetuated such myths because they have had limited information. Statistical analysis showed no significant relation among these three symptoms.

- **Fallacy:** *An injured TM joint causes pain in the neck, shoulder, and back.* Some patients tell clinicians that pain within the TM joint radiates down into the shoulder or back. The fact is that if there is a connection, it is in the other direction. Pain originating from the back, the shoulders, and the neck is likely to have a common origin within muscles. Pain may

radiate from the neck to the head or face. Muscular pain in the jaw represents part of the overall muscular dysfunction.

- **Fallacy:** *TMD and headache are caused by hormonal changes.* This notion has been exaggerated. Well-meaning clinicians have told patients about these potential relations. Insurers and patients have spent fortunes trying to associate symptoms with hormonal changes. Proof is lacking of a direct link even between headache and menstrual changes in hormone levels. Future monies should be appropriated for well-designed research protocols designed to study chemical triggers or potential psychological factors that may contribute to these conditions.

- **Fallacy:** *A diagnosis of "TMJ" means that there is a psychological problem.* In reality, clinicians have not been able to establish a clear connection between psychological factors and pain of more debilitating musculoskeletal disorders, such as "bad back". Studies conducted on 75 adult patients admitted to a TMD clinic showed that 31% suffered from depression. The depression was positively and significantly related to limitations in activities in daily living as a result of pain or neuroticism. But even if these patients required psychological therapy, 69% would not.

Patients benefit from psychological counseling when interpersonal or family problems are causing stress and might worsen their condition. Careful screening improves the chance of locating these problems.

- **Fallacy.** *Women are more to TMD than men; they suffer more intense and more frequent pain than men.* No one has established why women register more health complaints than men. TMD is no exception. Analysis of patients visiting TMD clinics across the world shows that the ratio of women to men is about 4 to 1. The disparity is not related to the degree of pain suffered. Women are probably more aware of their bodies than are men, whereas men may be more likely than women to disregard symptoms.

- **Fallacy:** *TMD can be inherited.* Some patients with TM joint sounds or jaw pain report to practitioners that a close relative has similar joint noise or pain. In truth, definitive answers are lacking about familial relations for many musculoskeletal syndromes.

One suspects that the inheritance pattern of TMD patients with myofascial pain is similar to the inheritance pattern of patients with primary fibromyalgia. Both share clinical manifestations of pain and muscular tenderness. Primary fibromyalgia seems to be an autosomal dominantly inherited condition with a variable latent period before clinical expression of the disorder.

- **Fallacy:** *Clinicians can cure TMD.* Wrong. Most recoveries occur naturally. The vast majority of a musculoskeletal disorders resolve with little or no care. Most recalcitrant cases can be managed with home care, medication, and dental or physical therapy. Few require surgical treatment.

- **Fallacy.** *Certain dental treatments cause TMD.* Evidence of deleterious effects is lacking even in cases of orthodontic therapy that has continued for several years. Most

litigation cases of patients blaming dentists for causing TMD have been related to complaints involving occlusal adjustments or faulty bridgework.

Careful screening and examination of patients saves practitioners needless grief. Many patients have TMD signs and symptoms before treatment is initiated. The dental records should detail their occurrence. Patients should be warned of their existence.

- **Fallacy:** *Adjustment of the occlusion solves most TMD complaints.* If the teeth are suspected as triggering complaints, the patient should be fitted with an intraoral appliance before more extensive treatment is begun. Many patients have been overtreated by adjusting their teeth. Most jaw pain originates from tender muscles that limit normal mandibular motion. The patient originates from tender muscles that limit normal mandibular motion. The patient reports this displacement. Overzealous grinding at the peak of the complaint makes no sense. Home care, medication, and an intraoral appliance ease most problems.

- **Fallacy:** *Most TMD patients seek or abuse narcotic medications.* The reality is that most TMD patients refuse even less potent medications. Many patients can obtain significant relief by following a regimen of appropriate medication.

Some patients would benefit by taking medication more powerful than non-steroids to reduce the pain. Some practitioners have been slow to recognize this opportunity. If substance abuse is suspected, practitioners should communicate with pharmacists in the area where the patient lives. They are more than willing to disclose the potential abuse.

- **Fallacy:** *Disk disorders diagnosed by magnetic resonance imaging means TMJ surgery will be successful.* Being tested generally is not helpful. Surgery is performed on the TM joints because some patients demand further treatment once they discover minor problems early in the course of the disorder. Early diagnosis extends the time the patient is aware of the problem. This awareness may produce excessive worry and aggravate the condition.

- **Fallacy:** *Wearing an anterior repositioning appliance eliminates joint sounds.* Certain patients may show improvement in joint sounds by wearing this appliance. There is high probability of altering the patient's occlusion unless the appliance is designed and fitted appropriately and adjusted regularly. Relief of pain may result, but often the patient becomes "appliance dependent". Other useful protocols are available with less destructive potential.

Threat of Litigation

According to Dr D A Hatfield, dentist-attorney, practitioners should conduct a self-assessment regarding TMD. Practitioners may be asked to:

1. Demonstrate competence or experience to diagnose and treat TMD.
2. Provide documentation of the patient's informed consent.
3. Describe the diagnostic records.
4. Provide the basis for treatment and for the kind of treatment rendered.

Some of these concerns have been described elsewhere. Practitioners also may be asked to describe the reason for treating rather than referring the patient. Strategies for coping with litigation have been suggested for the clinician who is sued. Recommended strategies include the following: don't take the case personally, get a good attorney, and learn about the legal process. Additionally, some litigation may lead to initiation of an investigation by the State Dental Board within the clinician's geographic region. This action delays the chance of settlement for the practitioner's negligence insurance carrier. The clinician pays for his or her legal fees caused by action of State Boards.

Records

Clinicians may avoid legal actions by keeping complete, high-quality records of the patient's health. Primary among these records should be a document of *patient consent*. There are two forms of consent: *plain* and *informed*. Plain consent concerns valid exemption from liability for battery. Informed consent concerns appraisal of the nature and risks of a medical procedure.

The document of *informed consent*, to be agreed upon verbally and signed by the patient, should advise the patient that current TMD signs and symptoms may remain after treatment. Although improvement may be expected after treatment, the patient should be notified that new discomfort may arise during and after treatment. Informed consent may be recorded by video, as suggested by Dr E J Zinman, a dentist-attorney who specializes in dental jurisprudence.

No standard form exists for obtaining informed consent from TMD patients. Few would be totally inclusive.

Complete records should include a description of the patient's chief complaint, history of the complaint, questionnaires, examination forms, findings of special tests, and treatment protocols, including a list of procedures from the initiation of diagnosis through treatment. Copies of referral letters or referral forms should be retained. Two examples of referral letters are presented for the practitioner: one to verify the presence of TMD and the other for surgical evaluation.

Details of the progress notes should be written in a legible manner. The notes should show dated follow-ups and progress reviews involving post-treatment conferences. Information regarding vital signs and medical care should be recorded after each appointment.

A simplified form has been developed that allows clinicians an opportunity to record the progress of TMD patients. At the initial and subsequent appointments, patients list their symptoms according to the degree of severity. They use this adjunct to rank the frequency and intensity of their complaint numerically at each appointment. Patients sign and date the form after each treatment. This progress report allows comparison of the patient's status from one treatment session to another.

Records need updating periodically. Updates should be conducted at least yearly. New or forgotten information may necessitate more frequent changes in informed consent, kind of medication, postoperative instruction, or progress notes.

According to D A Hatfield, attorney-dentist, clinicians can initiate and maintain complete patient records by using the SOAP (subjective, objective, assessment, plan) format. SOAP formats promote safe practices.

Reimbursement and Insurance Plans

Who Should Be Reimbursed?

If the patient has a comprehensive health care plan, TMD services should be covered in the same way as other musculoskeletal disorders. Patients should be reimbursed fairly by insurers for the cost of services. Practitioners deserve compensation for providing standards of care equal to those of comparable disorders.

Third-party plans continue to have an increasing role in the delivery of TMD care. Numerous states, including Georgia, Kentucky, Maryland, Minnesota, Nevada, New Mexico, North Dakota, Tennessee, Texas, Washington, and West Virginia, have passed legislation or issued directives for inclusion of TMD treatment in health policies. Most have followed the mandate of Minnesota, which enacted a law (62A.043 subd 3) in 1987 requiring medical coverage for TMD if the treatment is administered or prescribed by a physician or dentist.

On the whole, TMD reimbursements have lagged well behind claims paid for comparable disorders. Among hospital dental practices covered by Medicare, just 14% of dentists reported reimbursement for TMD surgical treatment and 11% for TMD nonsurgical treatment.

If insured TMD care is unavailable, patients and practitioners should negotiate with insurers or seek legislative action to ensure coverage, especially reimbursement for nonsurgical care. Since enactment of the Minnesota legislation, the overall cost for insurers of TMD care has been reduced by about 14% because simpler, less costly treatments (eg, home care) have been used. Fewer surgeries and other complex treatments have been needed, which has reduced costs.

Codes and Claims

Insurance codes pertaining to diagnosis and treatment of TMD are available in versions of the Physician's Current Procedural Terminology (CPT-4), the International Classification of Diseases, Adapted For Use in the USA (ICD-9), and the Code on Dental Procedures, Current Dental Terminology (CDT-1). In contrast to the CPT-4 and ICD-9 codes, the first number of each dental code in the CDT-1 begins with "0". These codes are revised about every 5 years.

Claims for diagnosis or treatment of TMD for insured patients may be submitted on dental or medical forms and must comply with the administrative requirements of each plan. The key factor in securing reimbursement is identifying the appropriate codes used by the patient's insurer.

The terminology used to describe the same treatment differs slightly in some cases between CPT-4 and CDT-1 codes. Other treatments lack codes that overlap. Claims submitted

against these codes must be filed separately on the correct form. A well-documented narrative report to be prepared by the practitioner may be requested by the insurer. A listing of codes most frequently used is provided. These codes have been borrowed from the CPT-4, CDT-1, and ICD-9 systems.

Explanation of Benefits

Much valuable information is available by reviewing the explanation of benefits (EOB) sent to the patient by the insurer. Most claims are rejected for:

1. Incorrect patient name or number.
2. Improper diagnostic code.
3. Submitting an unspecific code without a written explanation.
4. Diagnostic code disagrees with expected treatment.

Questionable Reimbursement

Disputes concerning reimbursement for certain services arise between patients and their insurers. Some guidelines have been proposed for settling these disagreements. Recommended for review on a case by case basis are these criteria:

1. An independent consultant who is uninformed about the party making the request should be selected.
2. Diagnosis and treatment should be supported by valid studies from reputable publications. The value of assessment and modality should be judged by qualified practitioners.
3. Impairment should be based on a rating system, such as (a) disk derangement, (b) range of motion, and (c) arthropathy.
4. Commitment by the insurer for phase I treatment makes the insurer responsible for phase II treatment.
5. Insurers should recognize that treatment may require more than 6 months to achieve successful outcome.
6. Fees should be reasonable for the geographic location and dewgree of difficulty.

Adherence to these or similar guidelines form equitable grounds for settling disputes.

Informed Consent Treatment Report

Information

"The purpose of this report is to inform you _____. Once you fully understand your TMD situation, you will be asked to provide the appropriate signatures on the endorsement pages."

Specific sections

Patient complaint: "You first presented on _____ stating _____."

Medical history: Only that which pertains to this treatment.

Dental history: Only that which pertains to this treatment.

Synopsis: Helpful if the informed consent is long or complex.

Examination: "Clinical and radiograph findings revealed _____."

Consultation: Requires findings from referrals.

Recommended treatment: Benefits, risks.

Treatment alternative: Options, possible effect of nontreatment.

General section

Office Policy: Policy regarding appointments, photographs, video.

Medication: Only that which pertains to treatment, including known side effects that need to be revealed.

Psychological assessment: Analysis of interpersonal relationships and social history that pertains to treatment.

Physical therapy: General description of modality, benefits, risks.

Dental therapy: General description of type, benefits, risks.

Warranty: Describe adjustment periods and warranty policy, if any.

Behavioral therapy: General description of kind, benefits, risks.

Surgical procedure: General description of type, benefit, risks.

Patient acceptance

"I understand the recommendations detailed in my chart and reviewed in this report _____."

Endorsement

"Your endorsement of this report, Part I, indicates _____. These stipulations are requested of all prospective patients so that at least one other option from an "interested" party will be sought by you and that procedures will not be entered into without thorough deliberation on your part. If you have any questions concerning the recommended treatment, alternatives, benefits, procedures, limitations, possible complications, or any other information relative to your proposed treatment, please ask."

Patient signature

Date

Parent or legal guardian (if less than 18)

Date

Spouse or interested cosigner (optional)

Date

Witness (professional staff member)

Date

Sample referral letter to verify the presence of TMD.

Re: Patient's name
Chart No

Dear Dr _____

This 38-year-old white male presented with left side jaw pain on April 12, 1993. He ignored the initial symptoms that developed during the middle of March, 1993, because they were so minor. There has been a steady progression of pain since onset.

His health history is unremarkable for headache and neckache. Recently, he had a physical examination, with vital signs and blood tests within normal limits. He has no family history that suggests problems of this kind.

Clinical examination showed muscle tenderness in the left masseter, medial pterygoid, and anterior fibers of the temporalis. There is some soft clicking in the left temporomandibular joint but no tenderness on palpation.

The jaw motions are 45 mm maximal voluntary opening. Right and left lateral and protrusive movements are 9 mm each. There is no deviation on opening.

The dentition is in excellent condition. He has no restorations and the periodontal health is within normal limits. A panoramic radiograph of the jaws is within normal limits. His occlusion is Class I bilaterally with no major slide between retruded contact position and intercuspal position. There is wear along the anterior teeth. The right maxillary canine and right mandibular canine are severely worn from bruxismmm.

Diagnostic impression is consistent with myalgia of the left temporomandibular joint region. A secondary diagnosis is diskal disorder with reduction in the left temporomandibular joint.

Sincerely,

_____ DDS.

Referral for Surgical Evaluation of the TMJ

Re: Patient's name
Chart No

Dear Dr _____

This 21-year-old white female presented on June 14, 1993, with right side temporomandibular joint pain. She noticed some clicking in the joint approximately 6 months ago. There was little pain initially, but after three episodes of locking, the pain worsened. Routine home-care therapy and delivery of a intraoral appliance have aided with the dysfunction.

On January 2, 1993, she attempted to eat a bagel and was unable to open her mouth fully. Sharp pain ensued, so she visited the office immediately. An examination showed point tenderness in the left temporomandibular joint with some minor tenderness in the left temporalis tendon and masseter regions. Maximum voluntary opening was 8 mm. Lateral jaw motions were 2 mm laterally. Repeated efforts to unlock the joint have been unsuccessful.

Previously, her health was excellent. She had a tonsillectomy as a child and an allergy to penicillin. She has just had a physical examination without evidence of problems.

Based on clinical findings, the diagnosis was diskal displacement without reduction. Please evaluate for possible arthroscopic surgery.

Sincerely,

_____ DDS.