

### **III: CLINIC OPERATIONS**

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## **PATIENT CARE**

### **A. PATIENT'S RIGHTS**

1. People seeking treatment, as well as patients of record, shall be treated with respect and courtesy.
2. All patient records and information shall be treated as confidential material according to HIPAA guidelines.
3. When a patient is accepted for treatment, that patient shall be informed of the nature and scope of the treatment as well as the fees for the proposed treatment before that treatment is started.
4. The patient shall be informed of alternate treatment that is available and the possible consequences of no treatment.
5. The patient shall have the right to accept or reject treatment.
6. Treatment shall have proper continuity and shall be completed as explained.
7. Treatment will be discontinued on patients who do not keep appointments or do not cooperate during treatment.
8. Patients shall receive patient education information that explains the cause of oral and dental problems and how to maintain oral and dental health after proper treatment has been rendered in the clinic.
9. Patients of active record will be informed of the after-hours emergency care system in the University Dental Center.
10. Patients should immediately request receipts for fees that are paid.
11. The patient shall be directed to the attending dentist and/or dental director to discuss any problems relating to receiving care in the clinic.

### **B. RESIDENT/ATTENDING/PATIENT RELATIONSHIP**

Although residents assume responsibility for the progression and completion of dental care for their patients, all patient care is primarily and ultimately the responsibility of the attending staff. Regardless of licensure status, residents practice on the licenses of the attending staff.

In addition, unlike inpatient care where a sole attending is the primary dental care provider under which a resident may treat a patient, in the University Dental Center a resident will generally work with multiple attendings on the same patient.

### **C. ELECTRONIC PATIENT RECORD**

The Dental Branch utilizes the electronic patient record for recordkeeping and administrative purposes. The dental database software for clinical and administrative information is axiUm (Exan Academic) and the imaging software for radiographs and clinical pictures is MiPACS (Medicor Imaging). All clinical charting, image capturing, progress notes and other administrative tasks are performed electronically. Patient signatures are captured electronically to the record, while attending faculty approve electronically, rather than sign off, aspects of the record.

### **D. COMPREHENSIVE CARE**

Sound patient management skills are essential to establish and maintain good patient rapport. Patients look for competence, commitment, and caring. The doctor must be able to communicate through words or actions that "I know what I'm doing", "I'm committed to your health," and "I care about who you are as a person."

Communicating these values to the patient improves patient satisfaction.

1. ***Accepting New Patients***

Appointment requests by prospective new comprehensive care patients are referred through many avenues:

- a. Patients referred by other health care providers (i.e. physician, dentist, etc.)
- b. UT/Memorial Hermann Hospital patients and employees
- c. TIRR (Texas Institute for Research and Rehabilitation)
- d. Patients in the community

When scheduling new patient appointments, the business office staff will discuss the following:

- a. Any specific dental problem(s)
- b. Any specific medical problem(s)
- c. Referred by
- d. Covered by third party insurance

The first appointment for ALL new comprehensive care patients is for consultation with an attending staff member or the hygienist for a prophylaxis, followed by an attending consultation. The purpose of the consultation is:

- a. for the attending dentist to make an initial assessment of the patient's medical/dental history, personal interests and expectations relative to dental care,
- b. to familiarize the patient with the patient care policies and procedures of the University Dental Center and the program's expectations of the patient,
- c. to assist the attending dentist in patient selection and appropriate resident/faculty assignment, and
- d. to determine if the patient requires special consideration or referral for treatment.

## 2. ***Routing of Comprehensive Care Patients after Consultation***

- a. Initial Examination

Once the attending dentist has determined from the consultation that the patient is a qualified candidate for care, the patient is assigned to either that attending or a resident and reappointed for appropriate diagnostic and preventive work-up. The initial work-up will be done either by the doctor or hygienist, depending on the patient's initial periodontal assessment and medical history (see Appendix A). Once a patient is assigned to a resident, the patient is not to be re-assigned, except for situations in which there is a conflict in behavior or interest, or at the discretion of the attending doctor.

- b. Information to be collected and reviewed prior to formulation of a final treatment plan includes:

1. Medical history
2. Dental history, including chief complaint
3. Comprehensive oral examination
4. Indicated dental radiographs and other imaging
5. Indicated clinical laboratory tests
6. Diagnostic models and photographs, if applicable
7. Diagnosis(es)
8. Risk assessment
9. Consultations, if applicable
10. Pathology reports, if applicable

- c. The front office has developed a "quick call list" for patients who may be able to

come in on short notice if there is a cancellation in the schedule. All patients should be asked at their initial treatment planning appointment if they would like to be placed on this list.

### 3. **Treatment Planning**

The treatment plan is the written statement of services that are to be performed for the patient based upon the histories, clinical examination and diagnosis(es). It should attempt to alleviate the patient's symptoms, problems and diseases on a priority basis. It also needs to include a plan to prevent further degenerative changes. If referrals will be necessary for completion of the treatment, they **should be listed as a part of the total plan**. The resident needs to explain carefully to the patient the reason for the referral. In addition, recall intervals should be included.

Residents are expected to gather whatever additional diagnostic information (i.e. study models, photographs, etc.) at the initial "Treatment Planning" appointment with the patient. This includes soliciting input from the patient as to individual desires, concerns, and any other potential modifying factors relative to treatment.

Once a resident has reviewed all appropriate diagnostic information, he or she will develop a tentative treatment plan, **sequenced by appointment**, entered into the EPR. Development of this plan should occur with the attending that performed the initial consultation. Subsequently, presentation of the plan and any alternatives are made at the Clinical Care Conference, which is mandatory prior to initiating treatment. Presentation of the case **must** be performed within one week of the patient's visit, so as to expedite treatment in a timely fashion.

Following finalization of the plan at the clinical conference, the patient returns for final consultation with the resident. Options to the preferred or recommended treatment, the alternative of no treatment at all, and the risks and benefits involved with every treatment proposal must be discussed with the patient and documented in the progress notes. Radiographs should be reviewed with the patient at the finalized treatment plan appointment, and documentation should be made in the progress notes of this review.

When the plan is agreed upon by the patient and dentist, any changes are noted on the in the record and on the patient's print out. The final plan and consent form are then signed by the patient and financial planning is completed by the business office. In summary:

#### **NO TREATMENT WILL BEGIN WITHOUT COMPLETION OF THE FOLLOWING REQUIREMENTS:**

- a. Presentation of the treatment plan at the Clinical Case Conference.
- b. Attending staff electronic approval of the treatment plan.
- c. Patient signature of the treatment plan and consent form.
- d. Patient has been financially planned by business office.

### 4. **Informed Consent**

As a health care provider, dentists are required to inform patients about the nature of their proposed treatment, the risks, the alternatives and the consequences of no treatment. **Every time a diagnosis is made and a treatment plan is recommended, the record should show that the patient was given and was satisfied with this information.** This is the essence of informed consent.

Reviewing the consent with the patient is as important as reviewing the medical history.

Asking the patient to repeat the stated treatment for the day to the doctor confirms the patient's understanding of the treatment and gives the patient the opportunity to ask any questions. Additionally, this allows the dentist to recheck for satisfaction with the agreed upon plan as well as for unreasonable patient expectations prior to treatment.

***The patient's record should reflect that the effort and time has been taken to discuss the treatment and attendant risks with the patient, as well as the consequences of not proceeding with some type of therapy. The record also needs to demonstrate that the discussion was personalized to the patient's needs and understanding.***

By encouraging questions and maintaining a dialogue with the patient, the dentist can show that the patient had an important part in controlling the treatment. The informed patient will be a more cooperative patient.

In summary, the following key elements will help in discussing the information with patients to allow them to make an informed choice:

- a. Personally discuss the benefits and risks of the proposed treatment with the patient as well as the alternatives and the consequences of non-treatment.
- b. Confirm the patient's understanding of treatment.
- c. Give the patient an opportunity to ask questions.
- d. Get a commitment from the patient to proceed.
- e. Use lay terms.
- f. Keep well documented records.

## 5. ***Treatment***

While residents assume primary responsibility for the delivery of dental care to their patients, the attending staff take an active role in resident supervision during treatment.

It is expected that due to the time devoted to the treatment planning phase, residents should quickly gain confidence and appreciation in delivering care and managing patients independently. At the same time, it is necessary that regular consultation between the attending staff and residents occurs.

- a. ***Patient Status*** - All patients of the program are assigned a "code" in the UDC's computer system for ease in tracking patient status. This is done at the initial appointment and modified as necessary during or after the course of treatment. Codes utilized are:

A -	Active
IA -	Inactive
IN -	Inpatient at Memorial Hermann Hospital)
TIRR -	Inpatient at TIRR
HCS -	Home Community-based Services (patients are >21 y/o, attend day program, and have only \$1000 per fiscal year in dental benefits)
Medicaid -	Patients are <21 y/o or are >21 y/o but live in and Intermediate Care Facility (ICF)

- b. ***Medical History/Vital Signs*** - A review of the past medical history should be done and documented at each appointment. In addition to the baseline recordings taken during the initial examination, pre-operative blood pressure, pulse, and respiration are to be ***taken at every patient visit***. For those patients undergoing any surgical procedure, pre- and post-operative vital signs including respirations,

patient alertness and color are also recorded. Also, any patient suspected of infection will have his or her temperature monitored. When automated monitoring is used, the initial and final blood pressure readings should be entered in the progress notes, as well as the continuous pulse oximetry readings.

c. *Patient Routing*

At the conclusion of each appointment the attending, resident, or hygienist charges out the procedure chairside in axiUm, escorts the patient to the front desk, and indicates to the front desk staff information about the next appointment.

This must include:

1. Time interval from current appointment
2. Estimated length of time of next appointment
3. Procedure(s) to be performed
4. Other instructions (e.g. return with hygienist, p.o. sedation, antibiotic prophylaxis, nitrous oxide, etc.)
5. Patient's next prophylaxis or Periodontal appointment

\*\*\*Note\*\*\* All Periodontal patients must make a 6-week follow-up appointment the day of their last scaling and root planing appointment.

At the end of the session, attendings must approve all procedures charged out by residents and hygienist in order for them to be fully captured in the system. **No procedures will be approved without a completed progress note.**

d. *Progress Notes*

When recording information into the patient's record, including the "why" not just the "what", is important. Additionally, in order to receive insurance reimbursement, the progress notes should CLEARLY state the working diagnosis and WHY the treatment was performed. (ex: Ellis III fracture and Periodical pathology #9 status post MVC. Patient will need root canal therapy, build up and crown.) Consider how much more information Example B presents when read than Example A.

Information such as broken or canceled appointments, referrals and whether or not the patient followed through on the referrals, expressed patient dissatisfaction with treatment, and resolutions to problems should be included in the record. Follow-up instructions and phone conversations must also be charted. The record needs to contain sufficient information to:

1. identify the patient clearly
2. justify the diagnosis
3. accurately document the treatment rendered and results

When writing in the patient's record, care should be taken to use only **objective, factual and medically accepted terminology**. Nothing should be written in the record that might embarrass the dentist, the auxiliary staff or the patient. In other words, avoid using the vernacular when writing entries into the patient's record.

**Example A – Unacceptable**

2/22/00 MOD anal #13  
(Signature)

**Example B – Acceptable**

2-20-00 BP 120/70, P-78, R-14 Medical history reviewed. Dam 2% lidocaine 1/100,000 epi on upper left. Caries very deep. Placed glass ionomer base, amal. Patient advised of possible sensitivity and potential need for RCT. Patient also advised that tooth need crown. RTC for comp #8.  
(Signature)

e. *Use of Patient Supplies and Medicaments*

Residents, attending and auxiliary staff members are expected to follow clinical policy regarding use of supplies and medicaments in patient care. All materials that have use and application to more than one patient (i.e. topical anesthetics, irrigating solutions, etc.) must be dispensed separately in disposable or sterilizable containers or with single-use applicators for each patient.

f. *Patient Property*

All gold, partials, dentures, etc. that are removed from the patient's mouth for replacement by new appliances are to be returned to the patient and are NOT to be kept by the clinic. It is the patient's prerogative as to the fate of such appliances. Extracted teeth are not to be returned to the patient with the exception of appropriate instances of primary teeth in children.

E. **CASE COMPLETION**

Upon completion of comprehensive care patients, residents will have their patients examined by an attending staff member. At that time, the attending will credit the resident with a "case complete" (code 34) as the program tracks the number of comprehensive care patients each resident is able to complete during the year. All patient records for completed cases will then be audited by the attending faculty.

Completed patients will also need a review of their recall interval and confirmation of their next recall date prior to departing.

F. **PATIENT RECALL**

All patients that are accepted for comprehensive care in the University Dental Center must complete the preventive phase of care prior to proceeding with active treatment. ***Patients who do not demonstrate the ability or willingness to maintain a minimally acceptable level of oral hygiene are not allowed to proceed out of the preventive phase. This determination is made by the attending dentist who supervises all preventive visits.***

In addition, patients who have completed comprehensive care must remain active in the recall system to remain eligible for treatment in the future.

Patients are reappointed with the hygienist for the recall appointment (3, 6, 9 mos, etc.) at the completion of their preventive visit. Reminder notices are mailed to all appointed patients at least two weeks prior to appointment. Patients needing appointments but not scheduled are contacted by phone.

***While the dental hygienist is responsible for management of the recall system, it is imperative that all personnel support the program's philosophy and policy in preventive care. This includes residents, attending and auxiliary staff reinforcing the importance of proper home care to all patients during active treatment and checking the patient's recall schedule (noted on the route slip) at each appointment.***

#### G. **EMERGENCY PATIENT CARE**

Any patient - ambulatory or inpatient who presents to the clinic for emergency oral care will not be denied care based on race, creed, sex, national origin, or ability or source of payment for care.

These patients will be seen as work-ins on the residents' schedule (except for those patients of record of an attending when the respective attending is present in the clinic) as directed by the attending. While the formal new patient consultation by the attending dentist is typically not performed on emergency patients, the attending will review the resident's evaluation and plan for each emergency patient prior to definitive care as documented in the emergency record in the patient record.

The primary purpose in treating emergency patients is to alleviate pain. Patient's desirous of follow-up comprehensive care will be handled the same as for all patients (as previously described) with regard to treatment and financial planning.

Emergency patients, depending on the time they call, are advised to present to the center at 8:30 a.m. or 1:00 p.m. to complete all necessary forms. To alert the clinical staff, front office staff will notify the attending. Patients will be advised when they call that the wait may be lengthy as they will be seen at some point during the morning/afternoon (as directed by the attending).

"Walk-in" emergencies, including those referred from other services (i.e. emergency room, OB-GYN) are generally not seen and are given an appointment for a later date. At the discretion of the attending staff member, however, exceptions may be made on occasion.

The **Emergency Record (chart page 4.1)** is utilized for documentation of emergency care. Completion of this form, including the procedure to be performed and the patient's signature for consent, is required prior to initiating any treatment for patients who are not of record.

***Note: New patients seen on an emergency basis are not automatically enrolled for comprehensive care. These patients, if they so desire, must schedule an attending consultation like any other comprehensive care candidate.***

Any phone conversations with patients of record should be noted in the record. When prescriptions are called in, documentation should include the name and phone number of the pharmacy.

#### H. **HIGH RISK PATIENTS**

Patients of known or suspected high risk potential such as HIV and/or hepatitis shall be evaluated as a candidate for dental care in the same manner as any other patient presenting to the clinic. Protective measures to be taken before, during, and after any and all procedures are described in Section IV: Infection Control.

#### I. **INTRAVENOUS CONSCIOUS SEDATION AND GENERAL ANESTHESIA CASES**

Cases which are designated as IV or OR cases by the attending doctor will be placed on a waiting list, unless otherwise specified by the attending doctor (emergency OR / IV, etc.) Residents are NOT guaranteed IV Sedation Certification at the completion of the residency year. The state of Texas requires at least 25 cases along with letters of recommendation from a Program Director in order to become IV certified. In general, those residents who are interested in receiving their IV sedation certification will continue the program for a second year in order to fulfill these requirements.

## FINANCIAL PLANNING AND COLLECTION POLICY

The University Dental Center accepts cash, check, credit card and assignment of dental and medical insurance benefits. While all fees are collected by the business office staff, it is the responsibility of all personnel--residents, attending and auxiliary staff members--to help ensure that the collection policy is enforced and that the Dental Center remains as a solid financial operation.

As the treatment plan is being developed, residents will be expected to provide patients with gross estimates of the proposed treatment plan as cost and other obvious factors can influence the final treatment selected. However, it is solely the responsibility of the business office staff to make specific financial arrangements with patients once the plan is finalized. Patients will be provided necessary financial information to prepare them for payment of all fees.

### A. **COMPREHENSIVE CARE**

After the treatment plan has been developed by the resident and signed by an attending staff member, the business office will provide financial counseling to each patient. This financial counseling must take place prior to beginning treatment. Patients must then provide payment as arranged during the course of treatment.

### B. **EMERGENCY CARE**

In most cases, the care delivered is palliative or limited in nature (i.e. extraction, pulpotomy / pulpectomy, I & D). Follow-up treatment (i.e. root canal therapy, restorative, etc.) is planned as described above with comprehensive care.

### C. **COLLECTION POLICY**

#### 1. **Ambulatory Care Patients**

##### No insurance/third party coverage

Patients are expected to pay for all procedures the same day they are incurred. For those procedures involving the dental laboratory, patients are required to pay 50% at the initiation of the procedure(s) and 50% on the day of delivery. For large treatment plans, patients may divide the total cost by the anticipated number of appointments and pay in installments **during** the course of treatment.

##### With insurance/third party coverage

All new patients are advised on the phone when scheduling the first appointment to bring all insurance information (booklet) and a completed and signed form to the initial visit. **Patients are expected to pay in full for the total cost of their first appointment regardless of insurance.** Subsequent arrangements will be made for the clinic to accept insurance assignment on subsequent visits. Patients will then be expected to pay for **their** portion of the fee not covered by insurance as described above for patients without dental insurance.

## 2. **Hospital Patients**

For all patients that are inpatients in Memorial Hermann Hospital or TIRR that are seen in the University Dental Center, no pre-treatment financial planning is required. However, pre-certification of certain dental procedures may be necessary. Therefore, residents are required to make a copy of the hospital face sheet in order to gather insurance information for the business office. These patients will be asked to pay for services at the time they are rendered. However, complete patient and financial information will be collected as with ambulatory patients.

### D. **DISCOUNTS/CHARITY CARE**

The extent of charity services rendered in the University Dental Center is limited to those patients who demonstrate financial need and whose treatment is judged to be a bonafide teaching case. Such charity care is for those patients with significant medical problems who otherwise would have a difficult, if not impossible time receiving treatment elsewhere. Selection of patients to be recommended to the hospital for charity care shall be at the discretion of the dental director. This determination shall be made once a treatment plan has been developed, unless a condition exists wherein determination of eligibility cannot be made until a later time.

Patients must pay for all diagnostic and treatment plan development costs **before** they can be considered for a discount for comprehensive care.

All dental patients are eligible for charity services regardless of race, color, creed, national origin, sex, age or handicap. Once a patient is recommended for charity services, eligibility is based on:

1. All third party benefits have been exhausted.
2. There are no other funds available that can be drawn upon.
3. Payment of the fee(s)/indebtedness would result in severe hardship for the patient and/or family.

***Discounts, charity care and/or preferential financial considerations are made only at the discretion of the attending staff and may not be granted by residents or auxiliary staff. Therefore, all residents and staff should refrain from any suggestions to patients that proposed treatment can be considered under charity care.***

### E. **FAILURE TO PAY/TERMINATION**

Ambulatory patients who fail to pay for services as agreed upon prior to initiating comprehensive care will be discontinued and eligible only for emergency care until such time as their account is no longer in arrears.

## **MEDICAL EMERGENCIES**

See Appendix C and manual located in conference room.

## **TEACHING FACULTY**

### A. **ATTENDING STAFF**

The attending staff, composed of members of the Department of General Dentistry, are solely responsible for all clinical personnel and activity.

Their clinical activities include:

1. providing supervision and consultation to residents
2. supervising all activities of the clinical and business office staff
3. interviewing and examining new patients
4. reviewing recall patients of the hygienist
5. treating patients

All residents and auxiliary staff are expected to respond in a positive manner to requests of the attending staff and direct any and all problems to the respective attending dentist present.

**B. CONSULTING STAFF**

The consulting staff is composed of members of the various dental specialty departments of the Dental Branch, such as:

- Endodontics
- Oral and Maxillofacial Surgery
- Oral Diagnostic Sciences
- Pediatric Dentistry
- Periodontics
- Prosthodontics

The use of consultants is co-determined by the resident and attending. These consultants are available to the program either directly by prearranged appointment for a clinical visit or indirectly through review of records.

The Periodontics and Endodontics faculty are available for consult and supervision on a case by case basis for patients who are referred to these graduate clinics. Residents will accompany and treat patients referred to Graduate Endodontics or Graduate Periodontics under the attending faculty (Drs. Antonio Moretti and Robin Weltman for Perio; Dr. Pileggi for Endo) as deemed appropriate by those faculty members. In some instances, the cases may be assigned to a graduate Endo or Perio resident due to complexity.

The GPR resident must discuss the case with the Graduate Endodontic or Periodontic faculty BEFORE the patient will be scheduled for treatment. The grad Endo or Perio clinics will then schedule the patient, and call GPR to confirm the appointment dates with the GPR resident.

## **AUXILIARY STAFF**

**A. BUSINESS OFFICE STAFF**

It is the responsibility of the business office staff to handle all matters relative to patient scheduling and patient financial management. The front office staff is composed of two front office assistants, who handle all patient appointments, collections, insurance, billing, and make financial arrangements with patients, and the **Office Manager**, who supervises all front office and inpatient activities.

**B. RESIDENCY COORDINATOR**

The Residency Coordinator is responsible for assisting the Program Director with all administrative aspects pertaining to the residents and the program. This would include resident schedules, meal tickets, paychecks and benefits. They also assist in activities in the business office as outlined above.

**C. DENTAL ASSISTANTS**

The dental assistants, along with the dental hygienist, are responsible for management of the

clinical portion of the facility. This includes performing all duties as outlined by the Texas State Board of Dental Examiners as well as all necessary infection control and appropriate laboratory procedures.

Each resident will be paired with the same assistant for a month at a time. This "team" is expected to communicate effectively, e.g. reviewing the daily schedule together each morning, to maximize the efficiency and quality of patient care delivered.

D. **DENTAL HYGIENIST / CLINICAL SUPERVISOR**

The **Clinical Supervisor** is responsible for ensuring efficient clinic operations, and reports to the Office Manager. All dental assistants report directly to the Clinical Supervisor.

The dental hygienist will perform the majority of the scaling and root planning procedures. He / she will intermittently interrupt any resident or attending doctor for administration of anesthesia. All probing depths **must** be performed prior to sending the patient to the hygienist. In addition to the above responsibilities, he / she will share responsibility with the dental assistants for clinical support in infection control and chairside assisting duties as outlined by the program director. All preventive recall will be managed by the dental hygienist.

## DENTAL LABORATORY SERVICES

Residents, under attending supervision, are responsible for completing all laboratory prescriptions and preparation of models, impressions, etc., for pick-up. All laboratory prescriptions are to be countersigned by an attending prior to submission to the lab. The following is a summary of the routing of cases to and from the lab:

1. The lab slip is completed (slip must include return date) by the resident and presented to attending for signature no later than rounds the following day.
2. The dental assistant in charge of the dental laboratory will contact the lab for pick-up, file the yellow copy in the lab file folder.
3. Box is placed up front in business office for pick-up.
4. When the case returns, the dental assistant will pull the yellow slip, note when received, and give to the business assistant. The doctor is also notified that the case is in.
5. If the patient has an appointment and the case has not been received from the lab, the dental assistant will phone the lab for an update. If the patient is not scheduled, the business assistant will contact the patient for an appointment.
6. The treating doctor will be responsible for all aspects of their lab cases

Multiple dental laboratories are utilized by the program. This includes all fixed and removable prosthetic cases. The labs make one pick-up/delivery each day from the dental center. Residents are expected to learn and develop necessary communicative skills for a productive relationship with the lab and its appropriate personnel. Therefore, all residents and attendings will be expected to follow their own laboratory cases.

## MEDICAL CONSULTATION AND REFERRAL

A. **MEDICAL CONSULTATION**

If additional medical information and consultation is necessary prior to proceeding with dental care, a medical consultation form (see Appendix C) is completed by the resident, approved by an attending, and returned to the business office for mailing to the patient's physician.

Those patients needing elective dental treatment may be placed on "hold" until receipt of the physician's reply and review by the resident and attending, if appropriate. In dental emergencies,

a phone consultation followed by the written medical consult request is acceptable and so noted in the patient's record. Various formats are available to the practitioner for requesting consultation with other health care providers:

1. *Clinic Consultation Report* - "Routine" consultative requests, typically where no specific information other than what is noted on the form, may be performed with the Consultation Report form. (Appendix C)
2. *Hospital Consultation Report* - The hospital Consultation form is used when referring the patient to another service in the hospital / medical school, including oral surgery.
3. *Letter* - For those patients with more complex medical and/or dental problems, a letter providing greater detail and additional questions beyond the standard report in #1 above is drafted by the resident with input from the consulting attending as necessary.
4. *Phone* - In emergency or follow-up situations, the phone consult is utilized and properly documented in the patient's record.

## B. **REFERRAL**

Sometimes patients perceive that they are being "shuttled" between the general dentist and various specialists during the referral process. If patients are informed about referrals, they will have improved understanding about the nature and reasons for the referrals. This understanding also decreases anxiety about the treatment.

For those patients needing referral to another dentist or physician, a letter of referral in the name of the attending and resident is drafted by the resident and completed by the business office and mailed. The business office will also provide the patient with all necessary information (i.e. phone nos., addresses, etc.) and / or schedule the appointment with the dentist/physician for the patient.

***ALL referrals must be done with the expressed consent of an attending staff member. Referrals to other dental & medical specialists should also be included in the Treatment Plan.***

The formats utilized include a *Clinic Consultation Report* or a *Letter*. Refer to Medical Consultations above and Appendix D for additional information and examples.

## C. **SPECIAL REFERRED PATIENTS**

Patients referred to the GPR from physicians or dentists for specific problems (i.e.: dental clearance prior to liver or kidney transplantation) will require further correspondence to their referring physician or dentist. This is to be determined by the attending faculty and Residency Coordinator. After coming up with a treatment plan that is approved by an attending faculty, the resident must draft a typewritten letter to be mailed to the referring clinician (see Appendix D). In clearance cases, upon completion of the treatment plan, the resident must complete a memorandum indicating completion of dental treatment.

## **PATIENT HOSPITALIZATION**

If it is determined that the patient will require hospitalization for dental treatment, the following is initiated:

1. Posting of procedure with operating room by office manager
2. Financial planning with business office for:
  - a. Dental fees

- b. Approved hospital admission
- 3. Referral to Anesthesiology for pre-admission evaluation
- 4. Referral to General Medicine for pre-admission history & physical
- 5. Return to UDC with assigned resident for pre-operative:
  - a. History & physical examination
  - b. Diagnoses
  - c. Treatment Plan
  - d. Pre-op orders/notes
  - e. Consent form signed
- 6. Preadmission laboratory testing

Each patient is the ultimate responsibility of a **sole** attending staff member. The same is true for the resident involved except in extended follow-up care that may transfer to the resident on-call. All elective operating room patients are pre-op'd by the resident in charge within one week of the scheduled date. This includes obtaining both the H&P of record from Internal or General Medicine and the dental H&P, identifying and ordering all pre-op lab tests, and delivering all paperwork to the Day Surgery Unit.

A more thorough discussion of admission and management of hospital patients can be found in Section II: Hospital Care.

## CONSCIOUS SEDATION

See *Use of Conscious Sedation and Anesthesia in Dental Branch Clinics* in the Dental Branch Clinic Manual (<http://www.db.uth.tmc.edu/clinic-pat/Documents/CM2004-05.pdf>).

## FACILITY

### A. **CLINIC HOURS**

*Regular Hours* - Patients are scheduled in the UDC, generally, between 8:30 a.m.-12 noon and 1:00-4:30 pm, Monday-Friday. Only patients who have scheduled appointments (including emergencies) through the business office will be seen. Patients should never be told to "come in" to the clinic by any dental personnel (including Memorial Hermann Emergency Center personnel).

*After Hours* - For after hours emergencies, patients will be served by the resident on-call through the hospital's paging service, (713) 704-4284. It is expected that all after hours emergencies will be handled in the hospital emergency room or, if necessary, the in-house clinic.

### B. **SEATING/DISMISSAL OF PATIENTS**

Upon arrival and check-in at the front desk, the receptionist will alert the clinical assistants that a patient is ready to be seated. Assistants are then responsible for seating their doctor's patients as well as alerting them when there is a delay. Any communication necessary from other clinic personnel to the doctor-assistant team during patient care should be done by way of written notes.

Patients are expected to be dismissed from the chair **no later than 10 minutes** before the scheduled completion of the appointment. The **resident** is responsible for walking patients to the front desk at the completion of treatment. Prompt dismissal of the patient gives the resident time to complete necessary paperwork and the dental assistant time to clean and prepare the operatory for the next patient. All entering in the patient record should occur away from the clinic area, in the resident office or in the conference room.

C. **CLINIC FEES**

A complete listing of clinic fees is located in each treatment room. While residents are not responsible for quoting exact fees to patients, these listings can be used during the development of the treatment plan to provide patients with approximate estimates of fees. NO copies of the fee schedule are to be provided to patients.

D. **EQUIPMENT AND SUPPLIES**

All dental personnel are expected to use judgment in the care of all dental and office equipment and in the use of expendable supplies. Special requests for items not regularly found in the clinic are made to the program director.

All equipment is maintained by dental auxiliary personnel for routine care and upkeep. The dental equipment company representative should be contacted for repairs.

E. **INFECTION CONTROL PLAN**

See Section IV: Infection Control.

F. **RESIDENT OFFICES**

Residents are assigned an office for use during the program year. These offices are to be utilized for program-related activities and are expected to be maintained by residents. No models should be left in the resident room and the room should be kept neat and orderly. No patient records will be locked up in resident lockers, and all patient records should be filled out and returned to the attending box at the end of the day.

G. **RADIOGRAPHIC POLICY AND PROCEDURES**

All dental personnel are required to regularly practice proper radiation safety and hygiene techniques. This includes adequate patient and operator shielding, and appropriate exposure selection.

All patients will be protected by lead aprons prior to exposure. Operators are expected to follow appropriate handling protocol relative to infection control requirements as noted in Section IV: Infection Control.

Monitoring devices have been deemed unnecessary by the University of Texas Radiation Safety Department due to continually minimal exposures reported in the past.

## **CLINIC RECORD**

A. **DOCUMENTATION**

All patient records are property of UT Dental Branch and **MUST NOT** be removed from the Dental Center. All dental personnel handling records must exercise proper maintenance of x-rays, forms and other record contents to ensure accuracy. All records must be returned to the business office at the end of the day and/or kept in locked cabinets.

Except in those cases where the state law requires a report, such as child abuse, the record is always confidential. This means that all dental personnel must take care to keep records from the view of other patients. Additionally, records should not be kept in any area where people other than office staff might have access to them.

In addition to maintaining comprehensive records, it is important to remember that records **should**

**not be altered for any reason.** If it is necessary to make corrections in records, these corrections should be made in an open manner, according to the following guidelines:

1. Never erase, scribble through, or use whiting agent on the record.
2. Draw a single line through the incorrect entry.
3. After entering new or corrected information on the record, write down the reason for the change and initial and date the entry.

All entries, corrections and additional information in the records should be written in a way that makes it clear to any reader that such additions to the record were made for the sole purpose of clarifying information or correcting inaccurate data.

## B. **CHARTING**

Charting of clinical findings should be performed at the time the dentist/ hygienist performs the initial examination (see Appendix E). All existing restorations, missing teeth, etc. are to be recorded in black, incipient decay in blue (or note as "watch" or "observe"), and all pathology in red on page 5 of the patient record. **Note: Do not include proposed or completed treatment on this page.**

Clinical probing depths and gingival recession are recorded on the appropriate root surface on the exam chart. When charting furcation involvement, the severity of the defect in an area can be designated as I, II, or III. Mobility should be noted above or below the tooth in a like manner.

The first completed chart reflects the exact state of the patient's mouth at the initial examination and demonstrates how periodic exam findings can be carefully compared to identify areas of loss or gain in attachment levels and changes or deterioration in tooth structure and/or restorations.

## C. **CONTENTS**

See sample patient record.

**NEW PATIENT ROUTING SUMMARY**

<b>APPT #</b>	<b>PROCEDURE</b>
1	<p><b>ATTENDING CONSULTATION APPOINTMENT - CODE 0150 (9310 IF SPECIALIST): OK FOR COMPREHENSIVE CARE?</b>            NO - REFER TO OTHER PROVIDER            YES- ATTENDING DETERMINES MEDICAL/DENTAL NEEDS:                1. Needs Abx Prophylaxis Prior To Next Appt?                    YES- Attending will prescribe                    NO - Go to #2                2. Needs Medical Consult and/or Diagnosis of Perio Type II or Higher?                    YES- Appt with resident for initial examination and Treatment Planning                    NO - Appoint with hygienist</p>
2	<p><b>INITIAL EXAMINATION APPOINTMENT</b> (If done by resident, will include appt #3)            MAY INCLUDE:            INITIAL EXAMINATION - CODE 0150 (Includes soft and hard tissue charting)            RADIOGRAPHS - Usually FMX - CODE 0210 or Panoramic (CODE 0330) + 4 BW's (CODE 0274)            GROSS DEBRIDEMENT - CODE 4355 or PROPHYLAXIS - CODE 1110 (Adult) or 1120 (child &lt; 14)            OHI- Code 1331 when included in exam fee or Code 1330 when separate appointment</p>
3	<p><b>RESIDENT TREATMENT PLANNING APPOINTMENT - CODE 2000</b>            RESIDENT WILL:            COMPLETE HISTORY AND DENTAL EXAMINATION            COLLECT ANY ADDITIONAL DATA (i.e., STUDY MODELS)            DEVELOP REQUEST FOR MED CONSULT, IF APPLICABLE            BEGIN FORMULATING TREATMENT PLAN</p> <p><b>ATTENDING CONSULTATION/CLINICAL CARE CONFERENCE</b>            RESIDENTS DISCUSS TREATMENT OPTIONS WITH ATTENDING WHO PERFORMED ORIGINAL CONSULTATION WITH PATIENT. TREATMENT PLAN AND ANY ALTERNATIVES ARE THEN PRESENTED AT WEEKLY CLINICAL CARE CONFERENCE. ONCE SIGNED BY AN ATTENDING, COPY IS GIVEN TO BUSINESS OFFICE FOR ENTRY IN COMPUTER SYSTEM.</p>
4	<p><b>FINALIZE TREATMENT PLAN APPOINTMENT</b>            RESIDENT WILL:            PRESENT PLAN TO PATIENT            PATIENT TO SIGN PLAN AND CONSENT FORM            BUSINESS OFFICE TO FINANCIALLY PLAN PATIENT</p>

## **APPENDICES**

## APPENDIX A

### GENERAL GUIDELINES FOR PERIODONTAL MANAGEMENT OF COMPREHENSIVE CARE PATIENTS

University Dental Center at Hermann

To make a diagnosis of periodontal disease, the dentist needs to:

1. Determine the presence of bleeding upon probing and whether it is immediate or delayed.
2. Determine total attachment loss by measuring and recording gingival recession and pocket depth.
3. Evaluate the presence of tooth mobility.
4. Evaluate the presence of furcation involvements.
5. Evaluate complete periapical radiographs relative to the extent and pattern of bone loss. Consider using previous radiographs made at different points in time to determine stability of health or progression of disease.

At the initial consultation appointment with the attending, a basic assessment is made from clinical observation only as to the patient's potential periodontal condition. This includes spot probing (unless medically contraindicated), determination of loss of attachment and mobility testing.

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#### CATEGORIES:

##### A. NO PERIODONTAL DISEASE AND GOOD SOFT TISSUE HEALTH

1. No medical contraindication - to hygienist
2. With medical contraindication - to resident first for medical consultation then to hygienist

##### B. NO GENERALIZED PERIODONTAL DISEASE BUT EXTENDED PERIOD OF TIME SINCE LAST PREVENTIVE PROCEDURE (e.g. heavy calculus/stain)

1. No medical contraindication - to hygienist
2. With medical contraindication - to resident first for medical consultation then to hygienist

##### C. GENERALIZED GINGIVITIS (TYPE I)

1. No medical contraindication - to hygienist
2. With medical contraindication - to resident first for medical consultation then to hygienist

##### D. PERIODONTAL DISEASE TYPE II, III, or IV regardless of medical consideration - to resident

##### E. PERIODONTAL DISEASE TYPE II, III, or IV with heavy calcified accumulation that it is impossible to complete perio exam and diagnosis (regardless of medical consideration) - to resident

A. **NO PERIODONTAL DISEASE AND GOOD SOFT TISSUE HEALTH: After attending consult**  
*No medical contraindication - **To hygienist first:***

Appointment #1 - Hygienist

- 0210 FMX or equivalent
- 1110 Prophylaxis (1205 Prophy with fluoride)
- 1331 Oral hygiene instruction (fee included in exam fee at this visit)  
Place on recall

Appointment #2 - Resident

- 2000 Treatment planning consultation  
Collection of any addtl diagnostic information

Appointment #3 - Resident

- 0052 Final treatment planning consultation

*With medical contraindication - **To resident first:***

Appointment #1 - Resident

- 2000 Treatment planning consultation
- 0210 FMX or equivalent
- 0470 Study models (if indicated)
- 0026 Medical consultation

Appointment #2 - Hygienist or Resident

- 1110 Prophylaxis
- 1331 Oral hygiene instruction (fee included in prophy fee at this visit)  
Place on recall

Appointment #3 - Resident

- 0052 Final treatment planning consultation

B. **NO GENERALIZED PERIODONTAL DISEASE BUT EXTENDED PERIOD OF TIME SINCE LAST PREVENTIVE PROCEDURE** (e.g. localized heavy calculus/stain)

Appointment #1

- 0210 FMX or equivalent
- 1110 Prophylaxis (may be done at subsequent appointment if time allotment or need for medical consult dictates)  
or
- 4355 Full Mouth Debridement

Appointment #2

- 1110 Prophylaxis
- 1331 Oral hygiene instruction (fee included in prophylaxis fee at this visit)  
Place on recall

Appointment #3

- 2000 Treatment planning consultation (this would be initial appointment with resident if patient was non-medically compromised; in medically compromised, above would have been performed by resident and this visit would be finalization of treatment plan)

\* The patient needs to be advised at this initial visit that multiple preventive appointments will be necessary and that, if he/she has insurance, that code 1110 will not be covered twice within a 6 month period for most policies.

May utilize extended visit(s) for prophylaxis (1110), periodontal debridement (4355), or scaling and root planing (4341) in lieu of multiple appointments for patients that have special circumstances, e.g. live long distances or are medically compromised. A narrative will have to accompany the insurance claim.

**C. GENERALIZED GINGIVITIS (TYPE I)**

Appointment #1

- 0210 FMX with vertical bitewings
- 4500 TYPE I - GINGIVITIS**

Appointment #2 (repeat if needed)

- 1331 Oral hygiene instruction (fee included in 4355 fee)
- 4355 Gross debridement

Appointment #3

- 1110 Prophylaxis
- 0044 Reinforce OHI  
Place on recall

Appointment #4

- 0050 Treatment planning consultation (this would be initial appointment with resident if patient was non-medically compromised and seen by hygienist; in medically compromised, above would have been performed by resident and this visit would be finalization of treatment plan)

**D. PERIODONTAL DISEASE TYPE II, III, or IV regardless of medical consideration - to resident**

Appointment #1

- 0050 Initial Treatment Plan
- 0210 FMX with vertical bitewings
- 0026 Medical consultation (if necessary)

Appointment #2

0052 Final treatment planning consultation.  
Enter Appropriate Periodontal Diagnosis Code:  
4600 Type II Early Perio  
4700 Type III Mod Perio (Enter one)  
4800 Type IV Adv Perio

Appointment #3

1330 Oral hygiene instruction

Appointment #4

4341 Root planing and scaling (1-2 quads/visit)  
0044 Reinforce OHI

Appointment #5-7

Repeat appointment #4

Appointment #8 (if needed)

9952 Occlusal adjustment - complete, or  
9951 Occlusal adjustment-limited

Appointment #9

0030 Re-evaluate periodontal condition (6 weeks after S/RP)  
9430 Office Visit  
0044 Reinforce OHI

Appointment #10 (if needed)

4260 Osseous Surgery (per quad)  
0044 Reinforce OHI

Appointment #11 (completion of treatment)

1110 Prophylaxis  
0044 Reinforce OHI, Place on recall (3 month)

\* Insurance benefits for code 4341 may be limited to once every 12-24 months per patient.

E. **PERIODONTAL DISEASE TYPE II, III, or IV with heavy calcified accumulation** that it is impossible to complete perio exam and diagnosis (regardless of medical consideration) - to resident

Appointment #1

0050 Treatment planning consultation  
0210 FMX with vertical bitewings  
0026 Medical consultation (if necessary)

Appointment #2

4355 Office visit - to remove gross calculus for accurate pocket and soft tissue evaluation

Appointment #3

0052 Final treatment planning  
Enter Appropriate Periodontal Diagnosis Code:  
4600 Type II Early Perio  
4700 Type III Mod Perio (Enter one)  
4800 Type IV Adv Perio

Appointment #4

1330 Oral hygiene instruction

Appointment #5-11

Same as for "D"

F. **FOLLOW-UP:**

**4-6 weeks after therapy:**

9430 Office Visit (includes any "light" scaling or other perio procedure)  
0030 Re-evaluation  
0044 Reinforce OH  
Place on recall if no further treatment indicated

**Then, after approximately 3 months,**

a. When pathology persists:

Appointment #1

4910 Periodontal maintenance - approximately 3 months later (insurance benefits may be limited to once each year for up to two years after therapy; includes exam charge)

0044 Reinforce OHI

Appointment #2

1-2 weeks later, re-evaluate condition; if resolved, then:

0030 Re-evaluation  
1110 Prophylaxis  
0044 Reinforce OHI  
Continue on recall

b. In the absence of disease:

1110 Prophylaxis  
0044 Reinforce OHI

Continue on recall

G. **EMERGENCY: Patient that presents for limited care and is was not previously a patient of record**

0001 New Patient  
0024 Emergency  
0140 Oral evaluation- problem focused ( if no treatment performed)  
0220 X-rays as appropriate

If treatment is performed than should be coded for treatment done (ie extraction or pulpectomy)

## APPENDIX B

### “Code Blue” Medical Emergency Response University Dental Center

Immediately upon discovering a medical emergency at the University Dental Center, the nearest attending doctor must be notified.

1. The patient will remain in the care of the resident or attending doctor or person discovering the problem. The patient **must not** be left alone.
2. The attending doctor will make the judgment as to whether a possible “coded” emergency truly exists. The decision to call 911 will be made after this initial evaluation.
3. If a “coded” emergency has been declared:
  - a. The attending doctor will request assistance from the office staff and instruct the front desk staff or available personnel to call 911.
  - b. Available staff members will provide the emergency crash cart, equipment, medications, and defibrillator.
4. In all possible emergencies:
  - a. Place the patient in a supine position if unconscious.
  - b. Assess consciousness or responsiveness.
  - c. Check airway, assist respiration, if indicated.
  - d. Check pulse; be prepared to perform CPR if indicated.
  - e. Use AED if needed.
5. The attending doctor assumes responsibility for resuscitative procedures and the administration of emergency drugs until relieved by a more experienced person trained in treating emergencies.
6. Post-Therapy Duties:
  - a. The attending doctor and resident will accompany the patient to the ambulance with a report of the sequence of events.
  - b. The attending doctor and resident will complete all patient records.
  - c. Direct communication must be made between the attending doctor, the paramedics, and the treating physician.
  - d. A post-therapy debriefing for all response team members will follow with the Director of the GPR Program.
7. Mock emergency drills will be conducted yearly. Faculty, staff, and residents are expected to participate.

Revised June 21, 2005

**APPENDIX C  
SAMPLE MEDICAL CONSULTATION**



**THE UNIVERSITY of TEXAS**  
DENTAL BRANCH  
AT HOUSTON

**UNIVERSITY DENTAL CENTER  
MEDICAL CONSULTATION**

TO: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FROM: University Dental Center  
6410 Fannin, Suite 310  
Houston, TX 77030  
P: (713)500-5888  
F: (713)500-0728

**REGARDING:**

Patient name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_/\_\_/\_\_ Male \_\_\_\_ Female \_\_\_\_

The above-named patient presents to our clinic for dental care.

The patient relates the following history: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In addition, the patient relates that he/she is taking the following medications: \_\_\_\_\_  
\_\_\_\_\_

Our tentative dental plan for the patient includes: \_\_\_\_\_  
\_\_\_\_\_

Relative to the patient's ability to undergo dental treatment, we would like to know the following:

	1. Are there any precautions and/or contraindications for dental treatment for this patient?	Y	N
	2. Does the patient require premedication or additional medication before dental treatment? If 'yes' specify: _____	Y	N
	3. Are there any other considerations for this patient prior to initiation of treatment? If 'yes' specify: _____	Y	N
	4. Other:		

Signed: \_\_\_\_\_  
Consultant Physician Date

Thank you for your prompt reply.

\_\_\_\_\_  
Resident Dentist

\_\_\_\_\_  
Attending Dentist

**APPENDIX D – TREATMENT PLAN LETTER TO REFERRING PHYSICIAN**

**Patient:** Doe, John  
**Date:** 10/30/03

**SSN #:** 000-00-0000  
**DOB:** 12/25/56

The General Practice Residency program was consulted to see this 49 year old male for dental evaluation prior to kidney transplantation.

**CC/HPI:** Patient has complaint of tenderness to teeth in maxillary arch.

**PMH:**

1. End-stage liver disease (secondary to Hepatitis C)
2. Thrombocytopenia and coagulopathies –
3. Insulin dependent diabetes mellitus
4. Mitral valve prolapse with regurgitation
5. Hypertension
6. Back problems

**Medications:**

Lasix, Spironolactate, Lactalose, Zyroxiline, Humulin

**Allergies:** Sulfa drugs

Relevant Labs: (10/10/03) Platelets 55,000, INR 1.6 (10/10/06)

**Examination:**

Extraoral examination revealed no significant signs of pathology/infection.

Intraoral examination revealed generalized moderate gingival recession, gingival inflammation, teeth with significant mobility and several carious lesions.

X-rays revealed moderate horizontal bone loss, carious lesions and a periapical radiolucency under the apex of tooth #23.

**Assessment and plan:**

1. Generalized moderate chronic periodontitis
2. Caries: Tooth #3 MO, Tooth #15 D, Tooth #13 O, Tooth #18 D
3. Chronic periapical periodontitis associated with tooth #23

**Plan:**

1. Extraction of teeth with hopeless prognoses periodontally: Teeth #2, #3, #14, #15, #18, #31. Reevaluate for symptoms: Tooth #23 – if symptomatic then extract.
2. Scaling and root planning of remaining teeth in maxillary and mandibular arches.
3. Thrombocytopenia and coagulopathies secondary to ESLD – Patient will require preoperative blood products prior to oral surgery procedures (i.e.: extractions) Will coordinate with liver transplant team regarding hospital admission and treatment in the operating room under general anesthesia or MAC.
4. Mitral valve prolapse – Patient will require antibiotic premedication prior to invasive dental procedures (i.e.: Clincamycin 600 mg PO/IV 1 hr prior to procedure)

Once all treatment is complete, he will be cleared for liver transplantation from a dental standpoint.

Thank you for involving us in the care of your patient.

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Jane M. Resident, DDS  
Resident Dentist

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John A. Attending, DDS  
Attending Dentist

cc: University Dental Center  
Texas Liver Center  
Dr. Liver Doctor