

THE SCOPE

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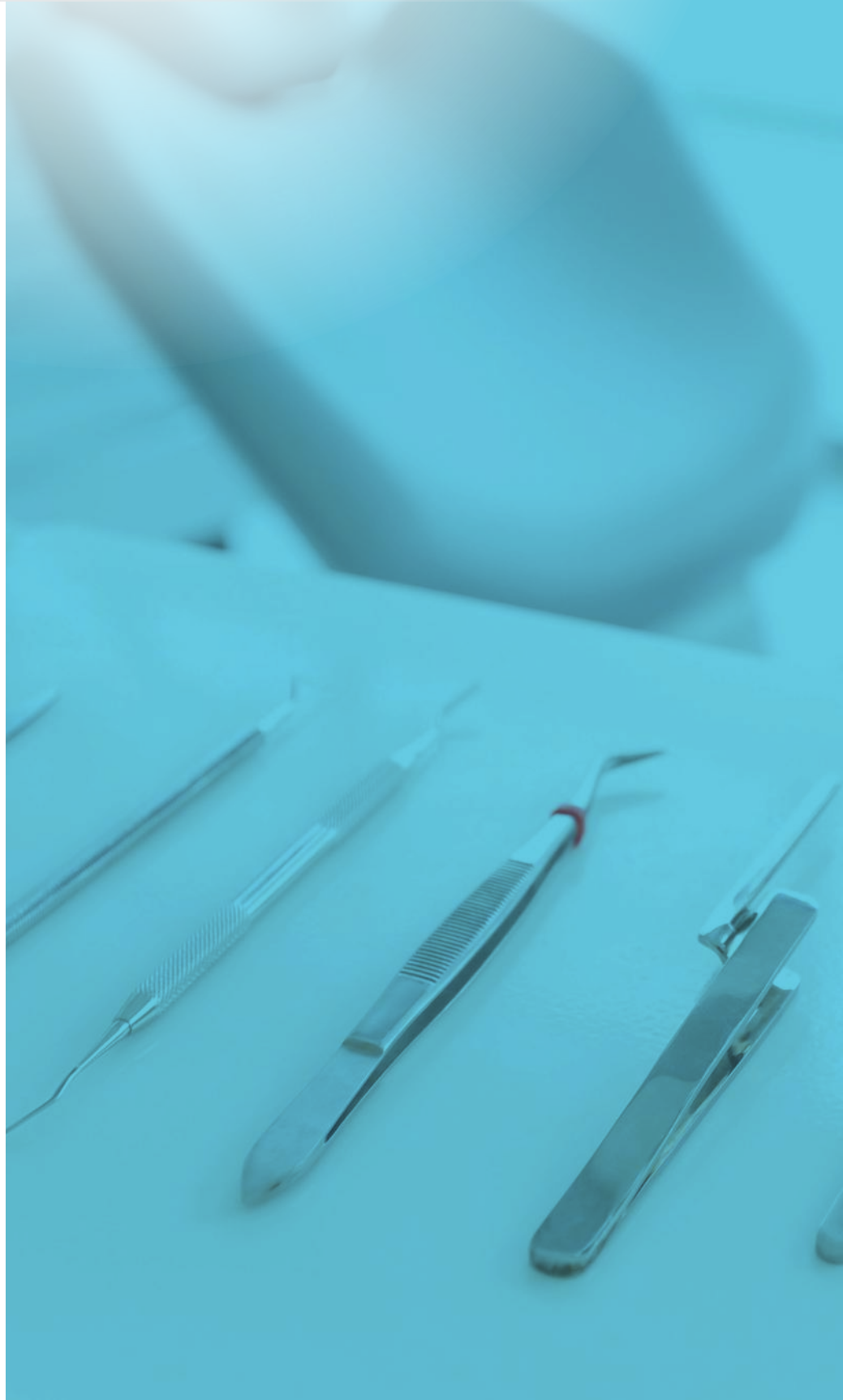
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EXECUTIVE MESSAGE

Dear Policyholders,

As the healthcare landscape in New York, and indeed nationally, is constantly evolving, new regulations and policies are introduced regularly.

MLMIC works closely with our policyholders, as well as our medical and dental professional association and coalition partners, to help prepare physicians, dentists and their staff of healthcare professionals for the inevitable changes that come from new legislation, and *The Scope* endeavors to address these legislative changes with legal and risk management analysis as well as lessons from relevant claims loss data and case studies.

In this issue, MLMIC is pleased to provide the perspective of Moe Auster, Esq., Senior Vice-President, Legislative and Regulatory Affairs with the Medical Society of the State of New York (MSSNY), on the upcoming ramifications of the government's "One Big Beautiful Bill." This controversial legislation has raised many concerns in the healthcare community.

At this writing, the Super Bowl is upon us. Go Seahawks! I envision kicker Jason Myers lining up the winning field goal and the goal posts suddenly moving! Similarly, new legislative challenges like the OBBB have the potential to steal your focus. We at MLMIC will continue our collective efforts to steady your target and bring it even closer so that you can keep your focus on the ball: the delivery of quality care to your patients.

A handwritten signature in black ink, appearing to read "Tom Gray". The signature is fluid and cursive, written on a light-colored background.

Tom Gray, Esq.

Senior Vice President, MLMIC Risk Management

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The Federal Budget Reconciliation Bill Has Huge Implications for New York Physicians

By Morris Auster, Esq.
Senior VP and Chief Legislative Counsel
Medical Society of the State of New York

Despite the collective advocacy efforts of the **Medical Society of the State of New York** together with the American Medical Association and numerous other key healthcare advocacy groups across New York (**NY-Delegation-Letter**) and across the country, the One Big Beautiful Bill (OBBB) passed the U.S. Senate and U.S. House and was signed into law by President Trump on July 4, 2025. It will have significant impacts on patients and healthcare providers across New York, including physicians.

The New York State Budget Director initially estimated that the bill will blow a \$750 million hole in the current 2025-26 State Budget and will cause an additional \$3 billion budget deficit in 2026-27 and future years' State Budgets (**City & State New York**). While some of these potential deficits have since been reduced through an unanticipated increase in state tax revenue (**Wall Street Boom to Reduce New York Budget Deficit by \$3 Billion**), the immense changes arising from the OBBB will necessitate a significant re-write of New York's current laws regarding New Yorkers' ability to receive coverage under state-funded or state-subsidized health insurance plans and discussions of new revenue sources to offset the loss of federal funds.

We are particularly concerned that these still-significant Budget deficits will make it more likely that the State Legislature will be forced to reconsider budget-cutting proposals that it has previously rejected. These include proposals to require physicians to incur a portion of the cost of the Excess Medical Malpractice Insurance program and cuts to the Neurologically Impaired Infants Fund.

Medicare Payments

One general positive to the OBBB was a provision to ensure a 2.5% increase to the Medicare physician payment conversion factor for 2026. However, it did not retroactively address the 2.83% cut that went into effect at the beginning of 2025, nor will it address future potential cuts to the fee schedule in 2027 and thereafter. Furthermore, many specialty care physicians will see this positive increase in the conversion factor swallowed up by significant decreases in numerous Medicare **Relative Value Units** encompassed in the 2026 Medicare Part B payment rule.

Loss of HMO Tax Proceeds

One of the most immediate impacts of the bill is the significant limitation on New York's and other states' authority to draw down federal Medicaid dollars through the taxing of certain providers and health insurance plans.

This year's State Budget incorporated a provision that provided for a tax on health insurance plans that was used to generate \$1.5 billion annually to increase payments for various types of healthcare providers — specifically, it allocated \$50 million to increase physician Medicaid E&M payments from 80% of Medicare to 90% of Medicare. This was a significant victory for the physician community, given that Medicaid physician payment has long been woefully inadequate.

Notably, the enacted Budget contained a provision that gives the State the authority to withdraw these substantial new payments if the funding source, namely, the HMO tax, is not available (**A.3007-C/S.3007-C, Part F**). One modestly hopeful development is the possibility that the loss of this revenue-generating mechanism could be more gradual if the appeal of New York's Congressional delegation to CMS is successful. (**NY Republicans seek to preserve MCO tax for three years | Crain's New York Business**).

Loss of Essential Plan Coverage

For several years, New York has maintained a health insurance plan, called the Essential Plan, which provides low-cost health insurance

coverage to patients who make too much for Medicaid but less than 250% of the federal poverty law (FPL). There are currently 1.6 million enrollees in this plan, of which 730,000 are non-citizen legally present immigrants (**New York State 1332 Waiver Overview Deck**). The OBBB eliminated New York's authority, starting in January 2026, to maintain the enrollment in New York's Essential Plan of over 500,000 lawfully present immigrants earning less than 138%. Court interpretations have clarified that these 500,000 legal immigrants can be enrolled in Medicaid, but it costs New York State far more to provide coverage for these enrollees since the Essential Plan is mostly funded from federal dollars. The cost to New York State is estimated to be \$2.7 billion (**New York State 1332 Waiver Overview Deck**).

Governor Hochul has applied to the federal government for a "workaround" that would use existing Essential Plan surplus funds to cover legal immigrants who earn less than 200% FPL. While the change, if approved, would result in 400,000 legal immigrants with incomes from 200-250% FPL losing eligibility for the Essential Plan, it could also help to preserve coverage eligibility for hundreds of thousands who otherwise would have lost coverage as a result of the provisions of the HR 1 ("One Big Beautiful Bill") Act. It may also help to significantly reduce the lost federal funds that New York would incur, which would otherwise prompt steep budget cuts.

As of this writing, it is not known whether New York will be granted permission for this workaround.

Work Requirements for Many Medicaid Enrollees

Starting in 2027, able-bodied Medicaid enrollees aged 18-64 will be required to demonstrate that they are working or in "community engagement" for 80 hours per month. State Health Department officials have estimated that the cost of implementing this new review system will be more than \$500 million and will cause roughly 1 million current Medicaid enrollees to lose coverage.

Patient Co-Pays

Starting in 2028, Medicaid enrollees who earn more than 100% FPL must pay co-pays or

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deductibles for each medical service that does not exceed \$35. Total cost sharing for a family is capped at 5% of the family's income. Services exempt from cost sharing include emergency services, primary care, and mental health or substance use disorder services ([2025-07-obbba-final-summary-chart.pdf](#)).

Impact on Medical Student Loans

At a time when there is a need to expand the pipeline to replace retiring physicians, this bill will make it harder for many students to access funds to afford medical school tuition. The OBBB significantly limits loans for students considering medical school, imposing an annual loan cap at \$50,000 per year for professional school students, with a total loan cap of \$200,000. The new caps will apply to students who have not borrowed for medical school before the July 1, 2026 cutoff ([AACOM](#)). New borrowers with loans made on or after July 1, 2026, can repay using only two plans: a new standard repayment plan with fixed monthly payments and fixed terms ranging from 10 to 25 years based on the amount borrowed or the new income-based Repayment Assistance Plan.

MSSNY continues to support numerous programs in New York to enhance opportunities for medical students, including supporting expanded funding for student loan repayment initiatives such as the Doctors Across New York program.

Conclusion

There are numerous consequences to New York State's health care system as a result of the OBBB. While some of the most adverse impacts may have been lessened through unexpected revenues and possible workarounds to maintain federal funding for coverage initiatives, the New York State Legislature and Governor will need to enact a comprehensive revision to coverage laws to ensure compliance with the OBBB. It will also make it harder for the Legislature to reject previously rejected Budget-saving proposals to replace lost federal funding.

Please remain alert for further details and requests for collective advocacy.

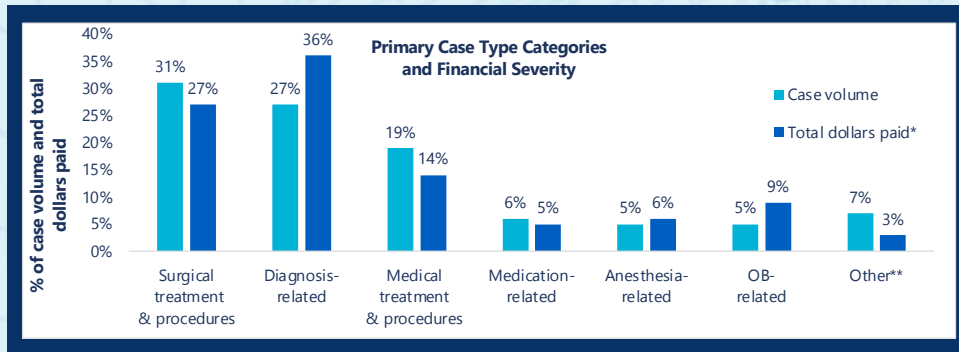
Medical and Surgical Professional Liability Cases: A Ten-Year Overview

MLMIC Insurance Company and MedPro Group are partnered with Candello, a national medical malpractice data collaborative and division of CRICO, the medical professional liability (MPL) insurer for the Harvard-affiliated medical institutions. Using Candello's sophisticated coding taxonomy to code claims data, MLMIC and MedPro are better able to highlight the critical intersection between the quality of care and patient safety and provide insights into minimizing losses and improving patient outcomes.

MLMIC and MedPro analyzed more than **19,000 clinically coded closed malpractice cases** involving medical and surgical providers, focusing on cases opened between **2014 and 2023**. The analysis provides critical and actionable insights into the drivers of patient harm and litigation, including financial and clinical severity, and explores trends within different case types, responsible services, and the locations where these malpractice events commonly occur.

Key Findings

Over the ten-year period, surgical treatment and diagnosis-related case types dominate the landscape. Not surprisingly, obstetric-related, diagnosis-related, and anesthesia-related cases were found to be the most expensive case types to defend, and surgical specialties (orthopedics, general surgery, and ophthalmology) and medicine specialties (internal and family medicine) were among those most often found to be responsible for the patient’s outcome.

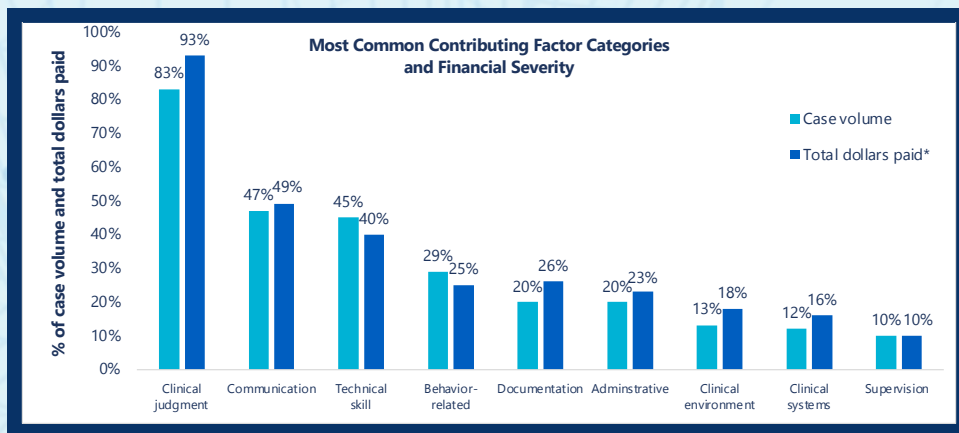


Source: MLMIC and MedPro Group closed medical and surgical provider cases opened 2014-2023 (N = 19,153);
 *Total dollars paid = expense + indemnity;
 **Other includes case types for which no significant case volume exists

More than half of the cases examined involved a clinically severe injury, and, notably, in 23% of all cases, the patient expired.

Offices/clinics and inpatient rooms are the most common settings for adverse events, at 31% and 17%, respectively. However, labor/delivery and radiology cases are the costliest to defend.

Contributing factors, which are multi-layered issues or failures in the process of care, were also identified in this analysis. Failures in clinical judgment were the leading cause of adverse outcomes, appearing in more than three-fourths of cases. These clinical judgment failures included failure to appreciate or reconcile a relevant sign, symptom, or test result and failures and delays in ordering diagnostic testing. Other common — and costly — contributing factors included communication breakdowns and procedural (technical) skill issues.



Source: MLMIC and MedPro Group closed medical and surgical provider cases opened 2014-2023 (N = 19,153).
 *Total dollars paid = expense + indemnity;
 Multiple contributing factors identified in one case, therefore, totals >100%.

By understanding the patterns and drivers of malpractice claims, organizations can implement targeted strategies to reduce harm, improve patient safety, and mitigate financial losses.

Read the full analysis, which includes more detailed information, including examples of actual malpractice cases.



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Concierge Medicine — Should You Offer It?

In 2025, patients more frequently sought a different model of medical practice called the "concierge physician." These physicians, almost always internists or family practitioners, contract with patients to provide specific services in exchange for a yearly fee paid by the patient directly to the physician.



The Concierge Medicine Practice Model, Explained

There are a great many ways in which concierge medicine is practiced, but, in general, in exchange for a yearly fee, which can range from \$500 to \$10,000 or more per patient, the physician agrees to provide 24/7 access for the patient, by cell phone or other means, as well as same-day or next-day appointments, which are typically longer than the average visit. The physician treats a variety of relatively minor ailments, while patients in need of a specialist are referred appropriately, and the appointment is expedited by the concierge doctor. (As the specialist does not participate in the same arrangement, their usual fees prevail.) The concierge doctor does not accept any insurance, but laboratory and other tests are billed to the patient's medical insurance.

This practice model has evolved for a variety of reasons. For the physician, inadequate reimbursements from insurance companies, as well as difficulty and red tape in collecting from them at all, are prevalent. As a result of these and other factors, many medical practices have trouble breaking even. In the concierge medicine model, if a doctor, for example, charges a \$2,000 annual fee for their services, 250 patients would guarantee an income of \$500,000 per year, plus whatever other sources of income are available. In addition, concierge medicine allows the physician to spend much-needed time with each patient. Typically, office visits often include only 5 or 10 minutes with the doctor, which can be barely enough to cover the essentials.

For the patient, concierge medicine addresses what has become a major concern for most patients, namely, speaking with their doctor or securing an appointment, even with a specialist. Being told that a doctor can't see you for four or five months has become a common experience, whether the doctor is a private practitioner or an employed physician in a health system. While critics of the concierge physician model (and there are many) claim that one is paying the doctor to "simply pick up the phone," one can't emphasize enough how important this is to a patient in need. Others claim that this system is a way to marginalize the poor, who can't afford the necessary fee.

Risk Management Considerations and Recommendations

MLMIC currently has little basis to evaluate the frequency of medical malpractice or specific loss drivers unique to concierge medicine, as claims loss data primarily focuses on medical specialty and geographic region. Practice organization structure is not an insurance pricing consideration, and the growth of concierge practices is a fairly recent phenomenon. However, as those offering concierge medicine are largely family practitioners and internists (with some pediatricians), and because concierge practices are largely located in New York's urban areas, MLMIC's collected data on malpractice lawsuits does provide guidance in likely loss scenarios and areas in which to focus risk management resources.

In both family medicine and internal medicine, most malpractice cases involve allegations of a delay or failure to diagnose injury or disease (most often cancer), and, consistent with the concierge model, most cases stem from the ambulatory care and office/clinic settings. The situations driving these lawsuits, in order of frequency, include errors in clinical judgment; poor communication among providers and between family members and providers; coordination of care, including failure or delay in ordering tests and reporting findings; and the failure of follow-up systems.

The concierge medicine model is designed to fill these gaps in communication and treatment. In theory, a concierge patient is afforded more time with his or her doctor, allowing more active patient engagement, leading to better preventative care, earlier identification of illness, and enhanced care coordination. However, **if additional time spent with you is offered as part of your concierge practice model, your documentation should reflect the time spent with your patient.** In a malpractice suit, the plaintiff's counsel will scrutinize your documentation of representations of time spent with patients, and electronic health record metadata may be used to identify the length of the patient's encounter.

A common benefit offered by concierge medicine is 24/7 access to a physician. However, it is still important to **manage the expectations of your concierge patients.** This includes a clear understanding of how quickly a call can be

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addressed, what care can be provided by the practice, and how quickly a patient can be provided an appointment or a referral, especially in light of the concierge physician not having control over the specialist's schedule.

Likewise, as in any practice model, when medical advice or direction is provided in a telephone call, it is important that **calls be documented in the patient's medical record as quickly as possible**. Such encounters are often scrutinized in claims of malpractice, and a lack of adequate documentation of these calls can be difficult to defend.

Ultimately, not all concierge practice models are created equal, and quality of care is dependent on the quality and judgment of the practitioner and the quality of communication. MLMIC offers **practice survey services** and **education programs** to assess a practice's structure and address identified gaps.

Malpractice Case Concerns

As stated, and on the bright side, concierge medicine should reduce the frequency of losses related to access, care coordination, and communication. On the negative side, the severity or value of an injury will likely be higher for concierge patients. Compensation for a patient injured through negligence is made up of both economic and non-economic damage. In theory, non-economic damages, or pain and suffering, should ignore a patient's economic status and class. Economic damages, on the other hand, which include lost wages and loss of earning capacity, are likely much higher for the patient of a concierge practice, as economic damage to a high-wage earner can easily be in the millions.

As to the concierge medicine business arrangement, as in patient care, poor outcomes can result from poor communication and lack of understanding. It is vital that the concierge patient/practice agreement includes a detailed description of what services are included. For example, a patient must be made aware that the concierge service does not include coverage for hospital stays, lab tests, specialist visits, emergency care, and more.

While MLMIC has yet to see any volume of claims associated with concierge medicine, one thing that will need to be considered should a case come to trial is the jury pool's perception of the concierge model: Will potential jurors look negatively at the doctor for offering an enhanced level of care that

plaintiffs are likely locked out from due to the associated costs, or will the jurors be critical of plaintiffs who are alleging that the level of service they expected was not met? In essence, will jurors be critical of a person who might be alleging that they could not get an appointment the next day, when it can take months for other patients to get an appointment? How will jurors scrutinize a telephone call between the parties, when they likewise feel they themselves are unable to talk to a doctor without an appointment?

In any case, the plaintiff's counsel will likely hold that the concierge patient was entitled to something more than the requisite standard of care, based upon representations made to the patient when contracting for concierge medical services. As part of this approach, the care provided to the plaintiff in a suit will be contrasted to any advertisements, representations, or promises made to the patient when they joined the practice. It can be difficult to defend care that did not meet the representations made about the level of care the patient was expecting to receive based on such representations.

Out-of-State Considerations

Concierge medicine physicians should also consider whether their patient population spends a considerable amount of time outside of New York State, as patients currently out of state who are in need of care may expect telehealth visits or to have prescriptions sent to local pharmacies. As most states consider the location of the patient to be the site where the medicine is being practiced, physicians offering concierge services may wish to consider licensure and liability coverage in those states where their concierge patients are often located.

Going Forward

We can see, then, that there are advantages and disadvantages to the practice of concierge medicine for both doctor and patient. If reimbursements to physicians were fairer and made promptly without hours spent on the phone by staff, concierge medicine would probably not be growing as much as it is. In the end, doctors and patients want the same thing, namely, enough time to spend together to best address the patient's needs.



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Commencing a Dental Malpractice Lawsuit

As a dentist, you have spent time and energy to perfect your expertise and develop your skills. But, despite how proficient and attentive you might be, there is no guarantee that you will stay immune to dental malpractice allegations and/or a dental malpractice lawsuit. Being served with a “Summons and Complaint” naming you as a defendant in a dental malpractice case can be alarming, to say the least. However, if you are prepared to respond appropriately, you will have taken an important step toward successfully defending yourself.

It is very important that dentists, like other healthcare professionals, understand the ins and outs of a malpractice lawsuit. This article will provide important information regarding the fundamentals of a dental malpractice lawsuit.

How Should You Prepare for a Dental Malpractice Case?

Many tend to believe that a dental malpractice case begins when a Summons and Complaint are served or filed in court. It is important to consider that the potential for a dental malpractice case begins with your treatment of the plaintiff, as the allegations that form the basis of the lawsuit arguably stem from the treatment you provided. While the lawsuit might not be filed until years after the treatment of the plaintiff, your proactive management of any dental charts or records pertaining to your patients,

ensuring they are accurate and complete, will better support your defense.

Dental providers have a professional obligation to keep complete and accurate dental records in their original format.¹ The failure to maintain complete and accurate records may constitute professional misconduct.² By generating and maintaining complete records, you are complying with the applicable rules and also ensuring you will be prepared if you happen to face a lawsuit.

The failure to maintain complete and accurate records may constitute professional misconduct.²

By the time you receive notification of the lawsuit, you may not have any independent recollection of treating the patient in question. At that point, your defense will be based on the patient’s dental records you created. The attorney responsible for defending you will also base your defense on the information contained in the dental records. Thus, a complete record is an essential component of your defense.

¹ *N.Y. Comp. Codes R. & Regs. tit. 8, § 29.2*

² *Id.*

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Often, before a malpractice lawsuit is filed, the patient will request their records for purposes of retaining an attorney or determining whether they will file a lawsuit. The plaintiff's attorney will review the records to determine if there was any malpractice committed by the dentist in question. If the plaintiff's attorney determines that there is merit to the case, the attorney will likely agree to represent the patient on a contingency fee basis, meaning the attorney will get paid if and only if the plaintiff receives compensation. It is, therefore, imperative that your record demonstrates the good care you provided. If it is a strong record, the attorney may conclude that there was no malpractice and not take the case.

How Does a Dental Malpractice Lawsuit Begin?

Officially, a lawsuit begins when the plaintiff files the Summons and Complaint in the court where they intend to sue the defendant. The documents will identify the parties named in the lawsuit, the court in which the case is being filed, and a general statement of the allegations of dental malpractice.

When a Summons and Complaint are served, it is important that you do not go back to the records to alter or edit them. Altering or falsifying records may constitute professional misconduct under Education Law 6509.³ In fact, altering or editing records after commencement of a lawsuit can result in punitive damages being awarded or allegations of professional misconduct being filed.⁴ If there is something missing from the dental records, you should discuss the specifics with your attorney, who can help you safely address the issue, if necessary.

In New York, along with the Summons and Complaint, the plaintiff's attorney also must file a Certificate of Merit.⁵ In the Certificate of Merit, it is affirmed that a dental expert has reviewed the patient's records and concluded that there is a reasonable basis for the lawsuit.⁶ Practically, what this means is that the plaintiff's attorney must consult with a dental expert who will review the plaintiff's dental records to determine if

there is a meritorious claim. The purpose of this requirement is to ensure that frivolous lawsuits don't enter the legal system.⁷

It is essential to keep in mind that you are

In fact, altering or editing records after commencement of a lawsuit can result in punitive damages being awarded or allegations of professional misconduct being filed.⁴

required by the terms of your insurance policy to immediately notify MLMIC when you are served with a Summons and Complaint. An Answer must be prepared and served to the plaintiff in a timely manner in order to avoid a default judgment. MLMIC will start investigating the claim and, under the insurance policy's terms, will appoint an attorney to defend you. If you do not inform your insurance company as soon as reasonably possible, the insurance company could deny coverage as per the terms of the insurance policy.

Always Answer!

DO NOT IGNORE A SUMMONS AND COMPLAINT! Depending on how the Summons and Complaint are served, there are only 20 or 30 days to interpose an Answer.⁸ Even if you think a case is not meritorious, you are still required to interpose an Answer to the Complaint.

The Answer is where you will get a chance to respond to the allegations set forth in the Summons and Complaint. There might be certain allegations that you will admit, others that you may deny, or even some that you might deny having any knowledge of to answer. Your attorney will be the one who will draft the Answer, where responses to the allegations will be stated. The Answer will also interpose affirmative defenses on your behalf. Failure to respond to the Complaint can result in a default judgment against you, which would mean that you essentially lose the liability case without having the opportunity to defend your care on its merits.

³ N.Y. Educ. Law § 6530 (McKinney)

⁴ *Gomez v. Cabatic*, 159 A.D.3d 62, 70 N.Y.S.3d 19, 20 (2018)

⁵ N.Y. C.P.L.R. 3012-a (McKinney)

⁶ *Id.*

⁷ *Id.*

⁸ <https://ww2.nycourts.gov/COURTS/nyc/civil/answeringcase.shtml#:~:text=If%20you%20have%20received%20a,bring%20the%20summons%20with%20you>

Small Claims: A Different Animal Altogether

Often, plaintiffs do not have a case that would warrant a plaintiff's attorney taking it. This could be because the case is not meritorious or its value is so low that it would not financially make sense for a plaintiff's attorney to handle it. In such a situation, plaintiffs might choose to go to Small Claims Court, where they can file the lawsuit themselves. The most they can recover is \$3,000, \$5,000, or \$10,000, depending on the county where the Small Claims Court is located. Small Claims Court is informal, and many plaintiffs appear pro-se (without an attorney).

Unlike in Supreme Court, a case in Small Claims Court is commenced by filing a statement of claim that explains the reason for the lawsuit as well as the amount of the claim. In Small Claims Court, judges usually give a limited amount of time to both sides to argue their cases, and there is no jury, with the judge being the final arbiter. In Supreme Court, however, the process is significantly more formal, and both sides have adequate time to plead their case. The jury is the final arbiter if the parties cannot settle the lawsuit.

One relative advantage that litigants have in Small Claims Court is that cases are typically resolved faster than Supreme Court cases, which can drag on for years. It is also important to remember that in dental malpractice cases, whether in Small Claims or Supreme Court, the plaintiff will be required to produce an expert witness. Notably, even if you are facing a lawsuit in Small Claims Court and it involves a small damages claim, you are entitled to an attorney under the terms of your MLMIC insurance policy. An attorney will best protect your interests and help guide you through the litigation process.

Statute of Limitations

The statute of limitations is basically the deadline for filing a lawsuit. In New York State, the statute of limitations for filing a dental malpractice lawsuit is 2 years and 6 months from the date of the alleged malpractice.⁹ What this essentially means is that if the plaintiff does not file the lawsuit within the specified time period, then the case is subject to dismissal on motion as untimely.

⁹ NY CPLR § 214-A (2024)

¹⁰ *Id.*

¹¹ N.Y. C.P.L.R. 208 (McKinney)

¹² *Id.*

¹³ N.Y. C.P.L.R. 214-a (McKinney)

However, there are some notable exceptions to the 2.5-year deadline to file a lawsuit. These include:

- **Foreign body exception:** If the malpractice allegation stems from a foreign object being left inside the patient, then the suit must be filed within 2.5 years of the alleged malpractice or within one year of discovery, whichever is later.¹⁰
- **Infancy:** A minor has a total of 10 years from the date of the malpractice to file the lawsuit.¹¹
- **Mental disability:** If a patient is suffering from a mental disability at the time of the alleged malpractice, they have 10 years to file a lawsuit.¹²
- **Lavern's Law:** This exception only applies to malpractice lawsuits that involve failure to diagnose cancer/tumor allegations. Under Lavern's Law, the 2.5-year statute of limitations starts from the date the patient discovers, or should have reasonably discovered, the cancer misdiagnosis.¹³

Conclusion

Malpractice litigation is sometimes daunting, time-consuming, and often a frustrating process. However, having some foundational knowledge of the lawsuit process in New York hopefully gives you at least a bit of confidence in how to respond and what to expect if you are facing, or are ever faced with, a lawsuit.

As a MLMIC policyholder, you can feel confident knowing that you have a MLMIC-appointed defense counsel by your side. Our legal team at MLMIC is well-versed and experienced in all aspects of dental malpractice litigation, and our attorneys will work with you whether you are facing a case in Small Claims Court or Supreme Court. No matter the stage of a claim or suit, MLMIC attorneys are here to advise you.



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CASE STUDY:

Poor Documentation Provides a Scapegoat

This case involves a 26-year-old male who presented to the MLMIC-insured orthodontist looking for “perfect teeth.”

Initial Treatment

Upon examination, it was noted that the patient had an impacted maxillary right cuspid due to a deciduous cuspid that was affecting the right central incisor, causing root resorption.

Three treatment options were provided. The first was to extract #8 and the deciduous cuspid, force the eruption of #6, and move it to a central position with the implant placement at #8. The second option presented was to extract #8 and the deciduous cuspid, move and crown #7 to #8, and place an implant at #7. The third option was to extract the impacted #6 and leave both #8 and the deciduous cuspid with a guarded prognosis.

However, it appears that the treatment plan that was agreed upon, which was not one of the previous options, was to extract the deciduous cuspid and #6 for the placement of an implant. It was noted that the treatment plan was compromised due to the resorption of #8 and that treatment would be 20 to 24 months.

While not documented, the insured advised that all options were discussed with the patient, and it was understood that he would need an implant once the orthodontic treatment was completed due to the root resorption at #8. There was no written informed consent.

A prescription was provided to extract the deciduous cuspid. Thereafter, the chart became confusing, as it appears that appointment dates were pre-written into the chart and, if these appointments were cancelled, the insured inadvertently placed treatment notes for the next visit under the cancelled date.

The patient was seen once or twice a month for adjustments, which were simply noted as “adjusted” or “retied” the archwire.

A year and a half into treatment, and after a Panorex was taken, the treatment plan changed to #7 being moved to #6, with extraction and implant placement at #8. This change in treatment plan was undocumented.

Monthly adjustments continued, and the upper-right cuspid, or upper-right lateral incisor, was periodically checked.

At some point, the lower brackets were removed but not documented.

Just shy of three years after the initial examination, the insured advised that the patient was instructed to have #8 extracted. However, this was not documented.

The patient presented a few days later and refused to leave the office until the upper brackets were removed and a refund was provided. The insured's office typed up a release that reimbursed the patient for his orthodontic treatment as well as the cost of the implant, with restoration to be carried out by his general dentist. The upper brackets were removed, and no retainer was provided. It appears that the study models went missing after being left in the room while the patient was unsupervised.

The patient was subsequently seen by his general dentist, who noted his hygiene was poor and recommended that he start periodontal treatment, but the patient declined due to the cost. The patient's #8 had severe root resorption, and the plan was to extract #6-9 and place implants, but again, the patient did not follow up. Eventually, he had #8 extracted and a flipper placed. Multiple teeth were later extracted; however, that was almost three years after the insured's treatment.

Lawsuit Filed

The patient filed a lawsuit against the MLMIC-insured orthodontist alleging negligent orthodontic treatment resulting in root resorption of #5-10, which caused mobility and the loss of multiple teeth, with the resulting need for implants.

MLMIC's experts all opined that the orthodontist was not at fault for the eventual extractions that took place a few years after his treatment ended and that they were due to the patient's periodontal disease.

However, all experts also agreed that the orthodontist's records were far below the standard of care. Neither the orthodontist, nor any of the employees, could decipher the chart. There was no informed consent and no clear treatment plan.

Further, the overall treatment was not as effective as it could have or probably should have been. The experts could not determine which treatment options the orthodontist was intending to use, and

the movement he utilized was less than effective, as it did not do enough to bring the impacted tooth down and place the back teeth into the right position.

The District Claim Committee agreed with the experts that the patient's allegations were unfounded. However, the committee members believed that the insured's chart would make it exceedingly difficult to defend the case. Further, they found the orthodontist's responses to their questions confusing.

The matter was ultimately settled.

A Legal and Risk Management Analysis

The Dental Record

This case demonstrates the importance of the dental patient record when defending a dental malpractice lawsuit. Creating complete, accurate, and organized patient records is one of the most important steps dentists can take to limit the risk of malpractice lawsuits. The extremely deficient dental record in this case played a large part in

The extremely deficient dental record in this case played a large part in the decision to settle rather than defend the case.

the decision to settle rather than defend the case. While the experts agreed that the patient's claim had little, if any, merit from a clinical perspective, they also agreed that the dentist's record keeping fell well below the standard of care.

The records should have been detailed enough so that the experts could at least determine what treatment was provided and the reasons for this treatment. In this case, even the dentist could not decipher the patient's records. For each visit, there should have been documentation of the scope and nature of examination, any notable findings, an assessment of the patient, including the identification of any conditions that would require a change in the treatment plan, and the treatment provided.



Informed Consent

The records should also have included evidence of informed consent. Demonstrating informed consent is key to defending a malpractice claim. If a known complication occurs after informed consent, it is difficult for a patient to prove malpractice. The informed consent process requires discussion about the nature of the proposed treatment, the potential benefits and risks associated with that treatment, any alternatives to the proposed treatment, and the potential risks and benefits of alternative treatment, including no treatment. All discussions should be summarized in the patient record, dated, and signed. In this case, the dentist documented alternative treatment plans, but there is no evidence that the patient understood or consented to any of the alternatives. In fact, the dentist went with an entirely different treatment plan without documenting the clinical decision-making involved in choosing the alternative plan or the patient's understanding and consent.

Takeaways

Documenting essential information, including informed consent, in the dental patient record is a key factor for risk management. This case may have been defensible had the dentist created accurate and complete patient records. Absent these records, the experts could not adequately defend the case, and settlement was required.



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CASE STUDY:

A Summary Judgment Victory? Not So Fast.

Initial Treatment

A 41-year-old single female and CFO at a Fortune 500 company was referred to the MLMIC-insured internist to take over as her primary care physician. The internist followed the patient over the next decade and was aware of her family history of cardiac disease. The patient underwent routine checkups, and her blood work revealed normal cholesterol levels, with some on the high end of normal and the LDL levels slowly climbing over time to the elevated range.

The patient underwent a nuclear magnetic resonance LipoProfile, which placed her in a “high risk” category. The internist advised her that this was one of the examinations he relied on to determine if a patient needed to start Lipitor, as he was of the opinion that a patient’s cholesterol and LDL can never be low enough, especially with a family history of heart disease. The internist recommended 20 mg of Lipitor a day, but the patient refused and requested an echocardiogram and repeat blood work before taking any statins. The patient subsequently underwent two intima medical thickness measurements that revealed borderline normal results. The patient then agreed to begin 10 mg of Lipitor.

Symptoms Emerged and Patient Hospitalized

Three weeks after starting Lipitor, the patient presented to the internist with a two-week history of chest discomfort. She reported feeling “weird” and had discontinued taking Lipitor, after which her symptoms had decreased. The internist documented her blood pressure of 90/62 and performed a negative cardiac examination. He further recorded that the patient’s symptoms were only on exertion, specifically while running.

Three days later, the patient called the internist and spoke with his nurse. She requested Zithromax for complaints of throat discomfort. The nurse spoke with the internist, who agreed to the prescription request, as the patient had been on Zithromax previously for the same complaint, and the nurse faxed the patient a prescription for Zithromax.

Two weeks later, the patient fainted and was taken to the hospital, where she was diagnosed with second-degree heart block. However, the patient declined the recommendation for pacemaker implantation.

The patient was admitted to the hospital three weeks later and was diagnosed with third-degree atrial ventricular (AV) heart block, which required her to have a pacemaker placed.

Lawsuit Filed and Experts Retained

The patient brought a suit against the MLMIC-insured internist as well as his nurse, who had her own medical professional liability (MPL) coverage with a different carrier. The patient claimed that negligent prescriptions of Lipitor alone or in conjunction with azithromycin resulted in the development of a third-degree heart block and the need for a pacemaker. According to her testimony, several doctors at the hospital stated that the combination of Lipitor and azithromycin could cause a heart block.

MLMIC retained cardiology and pharmacology experts, and they agreed that the standard of care was met. The cardiology expert opined there was no contraindication regarding the use of Lipitor and azithromycin, in combination or separately, and that neither drug causes heart block without rhabdomyolysis, which the patient never had. There was some concern about prescribing Lipitor to someone with essentially normal cholesterol levels. However, given the plaintiff's family history and the internist's desire to have the plaintiff's cholesterol levels as low as possible, this judgment call was deemed appropriate.

Regarding the prescription of azithromycin over the telephone, the cardiology expert felt this was not a departure from the standard of care, as this was a long-standing patient who had a history of sore throat and respiratory symptoms and had received azithromycin previously with positive effects and no negative outcomes. Therefore, it was appropriate to prescribe this medication when the same complaints arose again even without seeing the patient. More importantly, the prescription

The patient claimed negligent prescriptions of Lipitor alone or in conjunction with azithromycin resulted in the development of a third-degree heart block and the need for a pacemaker.

of azithromycin did not cause third-degree heart block. A weakness in the case was the internist's poor recordkeeping. The chart was sparse, handwritten, and often illegible.

Summary Judgment Granted, Then Overruled

The internist's defense counsel filed a summary judgment motion and demonstrated through both expert proof and the submission of medical literature that Lipitor (or any statin), either alone or in combination with azithromycin, has never been known in the scientific community to result in an AV heart block. The plaintiff opposed the defense's motion with a mountain of material, including hundreds of pages of medical "studies," literature, and four separate expert affirmations. However, none of this material established the causal link at the heart of the defense's motion.

The plaintiff then submitted pseudo linkages, including citations to case reports in which Lipitor might have been associated with rhabdomyolysis, which the plaintiff's expert then tried to link to the patient's AV heart blockage, skipping over the record demonstrating that the patient never had rhabdomyolysis in the first place.

The Court granted the defense's summary judgment motion, and the plaintiff's counsel followed with a motion to renew and reargue the case, which the Court denied. The plaintiff then filed an appeal with the Court of Appeals Appellate Division, First Department, which the plaintiff paid for out of pocket. The Court of Appeals stated in a 4-3 decision that the defense had not met their prima facie burden in its summary judgment motion. The majority in the Court of Appeals stated that while the defense addressed the topic of Lipitor alone, it did not adequately address the argument that Lipitor in combination with azithromycin, or azithromycin alone, could not cause electrical disturbances in the heart without myopathy. The Court of Appeals did not address any of the arguments brought up by the plaintiff's counsel. The internist's counsel thought the decision was truly bizarre, especially given the claims that the cause of the plaintiff's injury was the prescription of Lipitor, either alone or in combination with the antibiotic, which was the topic that the defense counsel had addressed.

The plaintiff's allegations subsequently evolved to include the unnecessary prescription of Lipitor in the absence of any indication for its use, as well as the prescription of azithromycin without indicating the rationale for said prescription or without the internist seeing the patient in the office. The plaintiff made a monetary demand that included the entirety of the internist's MPL policy coverage limits.

The Trial

At trial, the plaintiff's counsel made a motion to prohibit the defense from asking the plaintiff about the many other lawsuits she had filed, one of which was a concurrent medical malpractice suit. The Judge advised he would make a ruling before the plaintiff took the stand.

The internist was very nervous and feared the litigious plaintiff would go after his personal assets

The Court of Appeals stated in a 4-3 decision that the defense had not met their prima facie burden in their summary judgment motion.

with an excessive award if the trial resulted in a plaintiff's verdict. The defense was concerned over how the internist would testify at trial, as he did not do well at his deposition and gave more information than required, probably due to stress. There was also a high likelihood of an appeal should the defense prevail. Therefore, after much negotiating, the case was settled for a reasonable amount within the insured's MPL policy coverage limit.

A Legal and Risk Management Analysis

This case highlights that, apart from the facts and legal arguments, there are other factors at play that can affect the outcome of a medical malpractice case. A strong defense can be undermined by other factors, such as inadequate medical documentation or an unsatisfactory performance at a deposition. In this case, the defendant made mistakes that put him at a significant disadvantage.

Poor Documentation

There seem to have been multiple instances of inadequate documentation by the internist. Telephonic prescriptions have become routine but may be problematic when conjoined with the issue of inadequate documentation. Additionally, during a visit where the plaintiff had complained of chest discomfort, the insured did not record the plaintiff's heart rate. The problem with poor documentation did not end here, as it seems the overall documentation was lacking the relevant details and was also illegible. This is something that a jury would have likely perceived as being unprofessional and indicative of malpractice, thereby putting the defense of the case at a severe disadvantage.

Problematic Testimony

Compounding the internist's documentation problems, he did not testify well at his deposition, which is essentially a question-and-answer session in which the opposing attorneys question the defendant regarding the facts and allegations of the case. A deposition presents an opportunity for the opposing side's attorney to come face to face with you to evaluate your demeanor and theorize how a jury will perceive you. Defendants that come across as insincere or unlikeable to a jury could result in the defense being motivated to settle the case.

Unique Challenges

It is also worth pointing out that another dynamic was at play here, namely, that of the internist feeling nervous about going to trial. Notably, he feared that his personal assets would be exposed if the jury returned an excessive verdict. Such fear is not irrational. In personal injury or medical malpractice lawsuits, the insurance company provides financial coverage up to your insurance policy coverage limits. If there is a verdict beyond the coverage limits, that is essentially the defendant's responsibility. This is a factor that comes into play in settlement discussions, especially when there is a good chance that a jury might return a verdict favorable to the plaintiff.



The Unknown

Perhaps one of the most challenging aspects of medical malpractice court cases is the uncertainty of jury verdicts. While there are some venues and jurisdictions that are known to have a pro-plaintiff or pro-defendant jury pool, even a seasoned attorney cannot always accurately predict how a jury will rule in each case. Plaintiffs risk completely losing the trial and receiving nothing from the jury, whereas defendants risk a jury award beyond the insurance policy limits. Because of this uncertainty, malpractice cases often settle.



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The Role of Legal Motions

This case provides a great example of the role that legal motions can play. In this case's summary judgment motion, the court was asked to dismiss the case based on no wrongdoing having been committed by the defendant. However, the results of such motions can be unpredictable. Initially, the motion was granted, but then the plaintiff appealed, and the summary judgment decision was overturned by the highest court in the state. Litigation is unpredictable, as even courts and judges might disagree on how to rule.

FROM **MLMIC.COM**

Elevate Your Practice

Curated Insights for Your Medical Office



December 22, 2025

Navigating the ever-expanding volume of information in the medical field can be a daunting task. How do you efficiently discern critical insights that truly make a difference in your daily practice? At MLMIC, we recognize this challenge. That's why we've meticulously compiled a selection of vital articles, providing you with clear, concise summaries and direct access to the most impactful industry news and analysis. Think of this as your essential guide to staying sharp and comprehensively informed.

Join us as we explore our curations from the month of December.

Drinking Coffee May Lengthen Telomeres in People With Major Psychiatric Disorders

A cross-sectional study published in *BMJ Mental Health* suggests that drinking three to five cups of coffee daily may slow the premature biological aging typically observed in individuals with major psychiatric disorders, such as those on the schizophrenic spectrum or with affective, bipolar, or major depressive disorder with psychosis.

[Learn more about the study >>](#)

The Stillbirth Rate in the United States Dropped 2% Last Year

A recent report from the U.S. Centers for Disease Control and Prevention shows a 2% decline in the national stillbirth rate last year, bringing the rate to approximately 5.4 fetal deaths per 1,000 live births and pregnancies of 20 or more weeks' gestation, the lowest rate in decades.

[Delve deeper here >>](#)

FROM **MLMIC.COM**



Family Physicians Are Leaving Rural Areas, Especially in the Northeast

A study published in the *Annals of Family Medicine* revealed a significant and alarming trend: The share of family physicians working in rural areas dropped by 11% between 2017 and 2023, representing a net loss of over 1,300 rural doctors nationwide. This exodus is raising deep concerns about a nationwide physician shortage, as the loss of even a few doctors in a rural area can immediately jeopardize primary care access for thousands of residents.

[See the full article >>](#)

Call for Universal Lung Cancer Screening After Study Finds Current Guidelines Miss Two-Thirds of Cases

A new study published in *JAMA Network Open* is fueling calls from cancer experts to drastically change current lung cancer screening guidelines, which rely heavily on a history of heavy smoking for eligibility (age 50-80, heavy smoking within the past 15 years).

[Continue reading >>](#)

Loneliness is on the Rise in Americans Over 45 Years of Age

A national study on healthy aging reveals that approximately one-third of older U.S. adults continue to experience feelings of loneliness and social isolation, maintaining a high baseline rate that was only temporarily exacerbated by the COVID-19 pandemic.

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