

Chapter 10:

The Dental Record

Protecting health information is the right thing to do, and it is also good risk management.

The recording of accurate patient information is essential to dentistry. The dental record, also referred to as the patient chart, is the official office document that records diagnostic information, clinical notes, treatment done, referrals, observations, and all patient-related communications that occur in the dental office, such as instructions for home care and consent to treatment.

Many dentists make notes in paper dental records. However, more and more dentists are making use of electronic records. Electronic records have great quality and patient-information security benefits.

First, let's discuss the importance of protecting patient health information. Protecting health information is the right thing to do, and it is also good risk management.

HIPAA/Protecting Health Information

Record-keeping practices in the dental office are currently changing due to the effects of the Health Insurance Portability and Accountability Act (HIPAA). HIPAA is a far-reaching federal legislation that continues to evolve over time. Each component of HIPAA is unique and each has a specific enforcement date. Each dentist should be knowledgeable of the law's impact on record keeping and ensure compliance with each component. Please be aware that more stringent state laws may exist and each dentist should check with the state where they practice for those laws.

Who is Covered by HIPAA?

HIPAA regulations apply only to dentists who are "covered entities." In order to be a covered entity, a dentist must transmit certain patient health information electronically, using a format established by the HIPAA transaction standards. For example, a dentist who submits electronic claims is covered by HIPAA.

To determine if a dental practice is a covered entity, please see the Centers for Medicare and Medicaid Services (CMS) educational resource

located at

<http://www.cms.hhs.gov/EducationMaterials/Downloads/areyoucoveredentity-2.pdf>

If a dentist or dental practice is a "covered entity" all HIPAA rules for Transactions, Privacy, and Security apply. If a dentist or dental practice is not a covered entity, then HIPAA rules do not apply, state law permitting. Even if a dentist or dental practice is not a covered entity, the dentist or dental practice still must comply with applicable state health privacy laws.

HIPAA-Privacy

The privacy component of this law, which went into effect April 14, 2003, establishes the right of patients to control how their information is used or disclosed by covered entities. For covered entities and their employees, it is a violation of patients' HIPAA Privacy rights to use individually identifiable health information for any purpose not related to treatment, obtaining payment for services, or "health care operations".

HIPAA privacy protects written, spoken, and electronic communications that contain individually identifiable health information.

Every dental practice needs to determine whether or not it is a covered entity, assess the applicability of state privacy laws, and then implement whatever compliance measures are necessary.

Covered dentists are required to present patients with opportunities to read a document called a "Notice of Privacy Practices" and then ask them to sign either an Acknowledgement, or, if state law requires it, a Consent. Once an Acknowledgement is signed, covered dentists need not ask patients to sign it again. If a Consent is required by state law, then state law will determine document retention requirements for the Consent. Once signed, Acknowledgements or Consents need to be retained until state document retention laws permit their disposal.

HIPAA -Security

The HIPAA security component, which is separate from and in addition to the privacy component, went into effect April 20, 2005. In contrast to privacy, HIPAA security applies only to electronic healthpatient information exclusively. Some of the security measures that dentists must implement to protect patient health information include using: administrative safeguards such as security policies and procedures, employee background checks, termination procedures, sanctions for security violations, and procedures for handling IT-related emergencies; technical safe-guards such as password protections, data backups, application backups, backup testing, data integrity controls, and entity authentication for remote users and back-ups of patient records; and physical safe-guards, such as limiting access to systems that store protected health information (PHI), wiping old media or equipment clean of PHI prior to disposal/recycling/resale/donation, and physical placement of displays.

Dental offices subject to HIPAA must have policies, procedures and forms for HIPAA compliance. It's a good idea to stay current and informed about these issues, as well as your state laws regarding confidentiality, privacy, security and related issues.

For additional information on HIPAA, go to www.ADA.org/goto/hipaa. You can also order the ADA HIPAA Privacy and The HIPAA Security Kit online, or by contacting ADA Catalog Sales, 1-800-947-4746, or visiting the Web site, www.ADAcatalog.com. For additional information on HIPAA, call the HIPAA hotline at 1-312-440-4608.

Protecting health information — and diligent and complete record keeping — is extremely important for many reasons.

First, it can contribute to providing the best possible care for the patient. Patient records document the course of treatment and may provide data that can be used in evaluating the quality of

care that is provided to the patient.

Records also provide a means of communication between the treating dentist and any other doctor who will care for that patient. Complete and accurate records contain enough information to allow another provider who has no prior knowledge of the patient to know the patient's total dental experience.

Also, because the dental record may well end up being used in a court of law to establish the diagnostic information that was obtained and the treatment that was rendered to the patient.

For example, the dental record can help in a forensic investigation to establish identity and for defense of allegations for malpractice. For example, the information could be useful in determining whether the documented diagnosis and treatment conformed to the standards of care in the community.

Organization of Dental Records

Today, more dentists are using computerized filing systems to maintain patient dental records. However, many still use the traditional paper charts, so we will discuss filing systems briefly. Keep in mind legal requirements that may be imposed by HIPAA and state law when considering the following information.

Generally, patient records are housed in file folders for protection. These files are labeled with the following information (in the following order):

- Patient's surname;
- Patient's first name;
- Patient's middle name; and
- Patient's degree or suffix (i.e., Senior, II).

The files are then arranged in a way for easy retrieval—usually in a lateral, open-shelf filing system.

Dental offices subject to HIPAA must have policies, procedures and forms for HIPAA compliance.

The dental record must adhere to applicable legal requirements.

Color Coding

Many dental offices use a color-coded filing system for patient record files. Color-coded labels containing the first two letters of the patient's last name and active date of treatment are placed on the patient's file. This can help make record retrieval fast and easy.

Active and Inactive Patient Files

Most offices have two categories of patient records files: 1) Active and 2) Inactive.

Active files hold the records of patients currently having their dental care provided by the practice. These records should be conveniently located in the office.

Inactive files hold the records of patients who have been treated in the office in the past but are not currently under care in the office. These files are generally located in the office, but in a remote area.

Please refer to Chapter 5 on Buying a Practice for definitions of active and inactive dental patient records as defined by the American Dental Association. [HIPAA implications!]

A system should be established in the active files to identify a change from active to inactive on a timely basis. All records, active and inactive, should be maintained carefully to be certain that they are not untimely destroyed or lost.

Indexing

The bulk of dental office procedures is maintaining an accurate indexing and filing system.

Dental offices generally keep non-treatment information such as correspondence, letters received, outgoing letters, canceled checks, receipts, invoices, statements, purchase orders, auditor information, paid statements, unpaid statements, and other information organized in separate folders in file drawers for easy reference. In addition, many dental offices today also use a

computerized system for these types of transactions. Establish an index and filing system that works for your particular dental office needs. Keep in mind that all of this information may be subject to HIPAA and/or other laws.

Content of the Dental Record

The information in the dental record should primarily be clinical in nature. The record includes a patient's registration form with all the basic personal information.

The dentist and dental team should be very meticulous and thorough in the dental office record-keeping tasks. The dentist, for example, should write notes in an expeditious fashion following a procedure on patient encounter or authorize, where allowed by law, a staff member to enter certain notes that the dentist later will check. All information in the dental record should be clearly written, and the person responsible for entering new information should sign and date the entry. The information should not be ambiguous. Abbreviations may be used if they can be readily understood.

The dental record must adhere to applicable legal requirements and will typically include the following:

- Database information (name, birthdate, address, and contact information);
- Place of employment and telephone number;
- Dental insurance information;
- General health and dental health questionnaires* documentation and notes;
- Progress and treatment notes;
- Treatment plan notes;
- Patient complaints and resolutions;
- Mold and shade of teeth used in bridgework and dentures and shade of synthetics and plastics;

* The ADA offers a Health History Form, a Children's Health History Form and a Medical Update Form from the *ADA Catalog* by calling 1-800-947-4746.

- Telephone conversation notes;
- Referral letters and consultations with referring or referral dentists;
- Patient noncompliance and missed appointment notes;
- Follow-up and periodic visit records;
- Postoperative instructions (or reference to pamphlets given);
- Medication prescriptions and the dispensing of medication notes;
- Radiographs; and
- Dismissal letter; if appropriate.

No financial information should be kept in the dental record. Ledger cards, insurance benefit breakdowns, insurance claims, and payments vouchers are not part of the patient's clinical record. Keep these financial records separate from the dental record. Keep in mind that these records, even if kept separately, may still be subject to HIPAA and other legal requirements.

The outside cover of the chart should only display the patient's name and/or the account number, unless more is required by state law or you need to flag a chart on the outside cover. If this is the case, use an abstract, in-office system (color or symbol coding) so that only your office staff will be able to decipher it. All medical notations belong inside the chart for only authorized personnel to see.

For offices subject to HIPAA or similar state laws, a single sticker on the outside cover, with no protected health information on the sticker or outside cover, can alert the team to look on the inside for important information regarding allergies, medications, antibiotic pre-medications, and clinical conditions that can affect dental treatment.

Who Makes Entries in the Record?

Attorneys and doctors debate who should make the entries in the dental record, but state law will control, in most cases. The dentist is ultimately responsible for the patient's chart.

Some entries may be delegated to office staff if allowed by state law. The administrative assistant can record telephone calls; prescription changes; and canceled, changed, and failed appointments. The dental assistant records the patient's comments, concerns and disposition; vital signs; medical history notations; radiographs and other diagnostic tools taken and used; and instructions given to the patient, etc. All entries should be initialed and/or signed by the team member writing the entry and the dentist.

If the dentist opts not to make his or her own entries, he/she should dictate what to write to the assistant. The dentist should review the contents of the entry as soon as possible for accuracy and then sign or initial it.

How to Write in the Record

Always think before you make an entry, especially if the remarks are complex in nature. You may want to jot down some of the facts on a piece of paper and then transcribe them in an organized way into the record. It is best to document while the patient is still in the office. The record is the single most important source of evidence in a liability claim.

According to some lawyers, if something is not written down in the chart, for legal defense purposes, it never happened. At a minimum, if it is not written down, it will be harder to prove in court.

Make sure all of your entries are objective in nature. Only record what happened; not what you think is okay. Confine your comments to necessary information about the patient's treatment. Do not make unnecessary negative comments. A patient has a right to request to see their record (including "personal notes" you may keep in a separate chart), and should the record appear in a court case, disparaging remarks could alienate the judge and/or the jury.

Avoid illegible writing. Part of your legal duty to the patient is to maintain a neat, legible record to provide continuity of care. Accurate, legible records

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* generally, study models are not considered part of the record.

Caution must be used in the destruction of records since confidential information is included in the dental record.

discourage litigation. Neatness and consistency also count. Attorneys look for inconsistencies in the record. If you must use abbreviations, make sure they can be easily understood and explained.

There are times when it is necessary to make a correction. There is nothing wrong with a correction if handled properly. The best approach is to append corrections to the record. Never obliterate an entry. Do not use markers or white-out. If you cannot resist the temptation to do more, some states may allow you to simply cross out, with a thin line, the wrong entry and make the appropriate change. Date and initial the change. The important factor is that you must be able to read the wrong entry.

Damaging, destroying, concealing, and obscuring a record must not occur. It does not matter if this is done knowingly, willfully, or not. Do not leave blank lines between entries because it's too tempting to add something at a later date and it could be construed as an improper alteration. Do not squeeze in words or phrases, this invites suspicion and may damage your credibility. If you remember something you wish to record at a later date, just make the entry chronologically, and refer to the date of the visit in question.

Ownership

The dentist owns the physical record of the patient. He/she is the legal guardian of the chart.

Patients have the right to see, review, inspect, request, and obtain a copy of their record. The dental team should be aware of HIPAA and the laws of their particular state governing this issue.

The patient must be given access to personal records within a reasonable time frame, which may be specified under state law.

Under HIPAA and many state laws, a reasonable fee may be charged for copying records, and a doctor may not refuse to release a patient's record just because a dental bill has not been paid. Prompt transfer to another practitioner can avoid any interruption of care for that patient.

Dentists also own radiographs, since they are an important part of the clinical record made by the doctor and cannot be interpreted by laymen. Patients do have the right to obtain copies of their radiographs. The dentist should strive to provide the most useable copies of radiographs possible.

Never release original records to anyone but rather copies, including radiographs. There is one exception to this rule: if you are required to do so by a government agency with proper authority, such as a court order, or in some states, a subpoena. If this situation were to occur, you should make copies for your office. Ask for a receipt when forwarding records.

Retention

State laws generally specify the time following the last patient visit that records must be maintained. There is usually a different requirement for the retention of records of children. HIPAA also affects recordkeeping requirements for offices that are covered. HIPAA requires that a dentist can supply six years of history about certain disclosures. The office's malpractice carrier may have recommendations about retention. Be sure the office has a records retention policy and you understand it.

If storage space for records becomes a problem, the dentist may wish to consider microfilming patient records. Generally, study models are not-considered part of the record. Diagnostic and/or treatment casts may be photographed and stored in some cases. Again, state law must be followed.

Destruction

If your office decides to purge records as allowed by HIPAA and state law, caution must be used in the destruction of records since confidential information is included in the dental record. To find a professional shredder, check in the Yellow Pages under a topic such as "document destruction." A professional shredder will present a "certificate" that the job was completed. If you shred your own records, be sure to fully complete the job.

Storage

Today, many dentists are still using paper patient records stored in file cabinets and shelves.

However, some dentists have already incorporated new technologies in their practices to manage the numerous collections of patient records. This new technology can store information in digital storage units smaller than a shoebox. This information can also be stored on an off-site server that is shared with other users and accessed anytime over the Internet.

The security of access to digital records and the costs of maintaining a system continue to be a concern. But with today's access technologies that may feature fingerprinting, retinal scanning, electronic signatures, and voice recognition, records can be as safe as paper records if managed properly. Data encryption, a process in which data is scrambled before transmission then reconfigured with a special code by the end user, also adds security.

Keep in mind the importance of HIPAA and similar state laws, which are shaping more specifically how this should be done.

Transfer

Due to the confidential and private nature of the dental record, before you send out any portions, either to the patient, a patient representative and/or another provider, make sure that you have necessary permissions. Under HIPAA, many disclosures will be permitted provided you make a good faith effort to secure a patient's acknowledgment of your privacy Notice, which lets the patient know you may use PHI for treatment, payment or health care operations (TPO). Beyond TPO, you may need a patient to specifically authorize transfer. Some states may have more strict requirements, i.e., written consent.

Note: Under HIPAA, send only the minimally necessary information to respond to a request for data. For example, only send, or copy, the portion of the patient record that is requested.

When sending records, make a notation in the patient's chart as to the date, where, and to whom the copies were sent. Never send anything out of the office without the dentist's knowledge and approval. It's also a good idea to keep a copy of a certified mail postal receipt. This proves the records were sent.

Digital Technology and Patient Records

The use of electronic records is increasingly affecting the dentistry profession. As the dentist or as a member of the administrative dental team, you must also take the initiative to learn the terms and the tools of the new electronic world—especially with regard to electronic records and HIPAA regulations.

Listed below are just some of the ways dentistry in the electronic age will affect patient care.

- Communications with patients will be more flexible.
- Medical information will be retrieved more easily.
- Patient data will be accessed faster.
- Dental office management will be more streamlined.
- Computerized medical records databases will become commonplace.

Digital technology, the advancement of networked computing and the digitization of information, will continue to change the profession of dentistry in the 21st century in numerous ways—from the clinical to continuing education and, from practice management transactions such as payment and marketing to e-commerce.

In the office, dentists are already using intraoral cameras hooked to monitors to show “tours” of patients' mouths, or use virtual reality software to present alterations of appearances due to cosmetic dentistry or oral surgery. In the near future, dentists will be able to send patient records with sound, text, and images to dental specialists for second opinions and preauthorization for insur-

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ance purposes. Instead of written descriptions with tooth charts, digital clinical photographs may be used.

Dental Care Via E-mail

Electronic communications use in the dental office can be very beneficial. For example, it can help the dentist save time, and put an end to phone tag with patients. For patients, it may help them compose more detailed questions for the doctor and complete tasks such as scheduling appointments or refilling a prescription.

However, using e-mail for patient care purposes can also raise significant considerations. Confidentiality is of primary concern, and there is simply no way to insure confidentiality when communicating via unsecured e-mail. It is difficult to confirm the identity of the people with whom you are corresponding and e-mail could be misdirected in error, or forwarded to an unknown third party without proper controls. Patients should be made well aware of these risks and agree to accept them before you engage in such practices.

If you proceed down this path, be sure to weave HIPAA and other legal requirements into your process

Making the Transition to a Paperless Office

Digital patient records continue to be a more common practice management tool as the cost of computer hardware and software drops, and advancing technology becomes more effective. However, even with advancing technologies, practitioners and staff must realize that the transition to paperless records is not seamless, totally safe, and problem-free and may not eliminate the need to keep paper records due to legal requirements in some states. Dentists should educate themselves as to the legal, ethical, and technological issues that are related to electronic medium – including whether state law mandates backup paper record-keeping.

The security of digital records and the costs of maintaining a system also should be a concern. No matter what precautions are taken, there is still a possibility that someone might obtain access to stored electronic information. Computer viruses and other computer hardware and software problems can cause information to be lost, as well.

For example, a dental software program should not permit changes to entries in the patient chart section. Once an entry is made, the only way to change that entry should be to amend it in the form of adding a change, with-out being able to access the original entry. In the event of a lawsuit, no one really knows how the court would handle a computerized dental record as to the issues of genuineness and originality.

In the future, more and more dentists will use electronic communication and information technologies to provide dental services. The field of dental informatics, which is fundamentally the application of computer and information science to improve dental practice, research, education, and management, is emerging to work with computer science and telecommunications to bring all of these concepts into workable tools of the future. Dental informatics is helping to develop ways to implement the “sharing” of medical information, yet keep it from unauthorized individuals and comply with HIPAA and other legal requirements.

Interprofessional communications will improve, as dentists will be able to consult more quickly and in greater detail electronically with other healthcare professionals such as physicians, radiologists, pharmacists, psychologists, and nutritionists to deliver the best possible dental care. Of course, this will raise numerous legal and regulatory compliance issues that are beyond the scope of this publication.

Informed Consent

The doctrine of informed consent requires health care providers to secure informed consent before treating patients. This begins with informing patients of the nature of the proposed treatment, the benefits and risks of such treatment and the benefits and risks to the alternatives to treatment, including nontreatment.

The law's recognition of an individual's right to consent is based on the value our society places on privacy and self-determination. It is repeatedly stated in case law that every adult person of sound mind has the right to decide what should be done to his or her own body and that consent in the absence of adequate information is equivalent to no consent at all.

At the present time a party suing a dentist alleging a lack of informed consent must often prove:

1. that a dentist-patient relationship existed;
2. that the dentist had a duty to disclose information;
3. that the dentist failed to provide some or all of this information;
4. that the patient would not have consented to treatment if the dentist had made a full disclosure; and
5. that the dentist's failure to disclose information was the cause of injury to the patient.

The scope of the dentist's duty of disclosure is governed by state law. In most states, a dentist is obligated to supply patients with the same information that would be provided by a "reasonable dentist in similar circumstances."

Consent need not always be express or documented in writing; check your state law on that as well. In cases of complex dental treatment, however, dentists are wise to implement a consent procedure centering on three major components: an oral discussion with the patient, the use of a written consent form, and documentation in the patient's record.

A parent's or guardian's signed consent for a minor's dental treatment helps assure better understanding of the treatment to be rendered and provides documentation that communication and understanding occurred. For techniques such as IV sedation or removal of impacted third molars, the use of detailed and specific consent forms are particularly helpful.

It is imperative that the dentist present treatment information in a manner that the patient can understand. You may want to prepare written statements setting out all relevant information pertaining to a given procedure or treatment to be given to the patient to read and consider before the oral discussion to assure better patient comprehension. Offer the patient an opportunity to ask questions. Then, when appropriate, prepare the form for the patient to sign reflecting his/her informed consent.

Good records prevent law suits

Ideally, patient records can also help to prevent lawsuits. If the records are clear, concise, accurate and current, they serve as a vital communication link between the patient and practitioner, as well as between the practitioner and other health providers involved with the patient's care. These records also serve as a reminder and source of evaluation of the patient's short- and long-term dental care needs.

For all of these reasons, patient records and radiographs should not be destroyed and great care should be taken to prevent their loss. If the original records are demanded under court order, a copy should be retained and a receipt for the originals obtained.

If the patient, the patient's attorney, an insurance carrier or another health provider requests copies of the records, the originals should – subject to HIPAA and state law — either be photocopied or made available for inspection at the practitioner's office. The original records should not be given unless demanded by a court order.

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Sample Form for Informed Consent

Note to the doctor: Informed consent is not something secured by a form, and this form is offered simply as a means to reflect what types of items are part of the consent process. **It is for illustrative purposes only, not offered as legal advice, and may not satisfy your state law requirements.** Before adopting any form for use, consult with personal legal counsel about the adequacy of the form in your state and for your practice. Furthermore, all blanks in the form must be fully completed by the dentist and the patient must have the opportunity to review each item thoroughly before signing.

Patient _____ Date _____

1. The doctor has explained, after an examination, that my dental condition is _____

2. The doctor has advised me that the following treatment is suggested _____

3. The doctor has advised me that if I don't have this treatment done, I can expect the following consequences: _____

4. The doctor has advised me of optional treatments. These options are: _____

5. The doctor has advised me about the risks of these treatments. These risks are: _____

I would prefer to have the following treatment for my conditions. _____

I understand that because people are different and no one responds to dental care the same way, that my doctor cannot predict the exact way my treatment may turn out.

6. Because of the type of treatment that I will receive, the doctor told me _____

7. I understand that I will need to have someone come with me to the appointment, and drive me home after the appointment.

8. The doctor gave me a lot of time to ask any questions that I might have and answered all of my questions to my satisfaction.

I certify that I have read and understand the authorization that I am about to sign for the treatment I am about to have done. I accept the risk of harm, with the hope of getting the benefits the treatment might bring. I have completed the blanks that needed to be filled in.

Patient _____

Legal guardian _____

Doctor _____

Witness _____

Date _____