UNTANGLING THE COBWEBS OF DENTAL RECORDS

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WHAT IS A DENTAL RECORD

- It is the official source of:
  - Diagnostic information
  - Clinical notes

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WHAT IS A DENTAL RECORD

- Treatment and patient related communications that occur in the dental office
- Instructions for home care
- Consent to treatment and finances
- Communications to third parties

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WHY IS GOOD CHARTING NECESSARY?

- A thoroughly documented record is invaluable if there are legal inquiries
- Subsequent providers can understand your treatment plan and why

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WHY IS GOOD CHARTING NECESSARY?

- HIPAA gives your patients the right to review their dental records
- Juries and dental boards find documentation the most reliable and persuasive basis upon which to form their decisions.

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WHAT SHOULD THE DENTAL RECORD CONTAIN

- Clinical
  - Progress notes
  - Medical and dental histories
- Records and third-party payors

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PROGRESS NOTES

- The date of treatment
- A concise but complete description of all services provided
- The treating clinician's identity

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PROGRESS NOTES

- The materials, methods, including type, amount and result of any anesthetic used
- Images and what they revealed
- All recommendations, advice and any discussions regarding possible complications or outcomes

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MEDICAL HISTORIES

- Systemic recording of the patient's present state of health
- Any serious illnesses
- Conditions or past adverse reactions that may affect dental treatment
- Current medications including OTC

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DENTAL HISTORIES

- Charting of existing dental restorations
- History of orthodontics, oral surgery, endodontic procedures, periodontal procedures
- Dental caries present
- Broken, missing teeth

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RECORDS AND THIRD PARTY DOCUMENTS

- Dental records are evidence of the work performed
- Charts may be audited by insurance companies and/or state and federal agencies

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RECORDS

- Date of service and code must align with the treatment recorded
  - For example: a complicated extraction is not something that was difficult, rather it indicates a flap was raised and/or the tooth was sectioned.

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RECORDS

- Never retroactively alter the patient chart
  - If a chart must be corrected, write an addendum with accurate information, date and sign appropriately

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CHARTING IN THE DENTAL RECORD

- Anyone with similar training and experience should be able to understand the treatment planned/provided, why it was provided, and the basis for diagnosis
- The story should be told the same way, every time, with every patient
  - Consistency
  - Credibility

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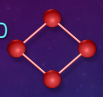
CHARTING IN THE DENTAL RECORD



❖Connect the dots

- Make sure that what is noted during the examination and review of the radiographs gets documented
- This documentation should then be followed by a diagnosis which correlates to treatment

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CHARTING IN THE DENTAL RECORD

- Document prescriptions/OTCs as they relate to the treatment plan
- Document what happens next and patient discussions

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CHARTING IN THE DENTAL RECORD

- Connect the dots – the 6 X's
  - HX History
  - EX Examination
  - DX Diagnosis
  - TX Treatment
  - RX Prescriptions/OTC medications
  - NX What happens next?

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CHARTING THE PARQ DISCUSSION

- Procedure to be performed
- Alternatives to the procedure including no treatment at all
- Risks involved with the treatment, and/or delaying or avoiding treatment
- Questions – opportunity to answer any that a patient may have

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CHARTING BASICS

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- Establish uniform abbreviations with staff
- Dentist should chart last (after hygienist and assistant)
  - Check for accuracy, consistency and thoroughness of staff member charting
  - Consistent nomenclature for procedures

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CHARTING BASICS

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- Initial each entry
- Appointment log and chart dates must conform
- Review transcribed records for accuracy

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CHARTING BASICS

101

- Chart cancellations
- Chart who is responsible for rescheduling appointments
- Chart all no shows
  - Proof that the patient was uncooperative could greatly add to the defense

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CHARTING GUIDELINES

Quotation Marks

- Juries absolutely believe entries in quotation marks
- Quoted portions are complete

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CHARTING GUIDELINES

Use appropriate language and avoid making disparaging remarks

Be objective, not opinionated

If it isn't in the record, it didn't happen!!

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CHARTING NITROUS OXIDE

- Charting musts:
  - Date of sedation
  - Reason for sedation
  - PARQ
  - Patient orientation at discharge

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CHARTING NITROUS OXIDE

- Vital Signs:
  - Body temperature
  - Blood pressure
  - Pulse and respiration rate

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CHARTING NITROUS OXIDE

- Charting shoulds:
  - Rate of total volume of gases delivered (e.g. 8 liters/minute)
  - Post op, 100% oxygen flush
  - Total time of sedation
  - Percentage of nitrous administered (multiple entries from induction to completion of sedation)

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CHARTING IN THE DENTAL RECORD

- Records must be legible, complete and accurate

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CHARTING IN THE DENTAL RECORD

Record must include:

- Provider of treatment and date for each entry
- Up-to-date dental/medical history
- Notation of communication to and from patient

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CHARTING IN THE DENTAL RECORD

- Post treatment instructions
- Patient complaints and resolutions
- Notes cannot be erased or deleted

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CORRECTING AN ENTRY

- When making a correction (paper record)
  - never obliterate a note (correction fluid, etc.)
  - draw a line through the error so information is still legible
  - Date, enter corrected information and sign

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CORRECTING AN ENTRY

- When making a correction (electronic record)
  - never delete an entry
  - Attach an addendum
  - Date, enter corrected information and sign

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CORRECTING AN ENTRY

Never, ever alter treatment dates or notes in a dental record

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CHARTING IN THE ELECTRONIC RECORD

- The hard drive is considered
- the original record
- Never attempt to delete an entry, instead create an addendum with the corrected information and date
- You may be requested to provide access to your hard drive

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CHARTING IN THE ELECTRONIC RECORD

Encrypt, encrypt, encrypt!!!
Have a redundant backup
Conduct an audit to confirm data backup

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CHARTING IN THE ELECTRONIC RECORD

Have two sources of backup protection

- Example:
  - Off site disk
  - Cloud service
  - Server provided backup

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MOST COMMON CHARTING ERRORS

- Not charting PARQ discussion
- Leaving out the diagnosis
- Diagnosis is apparent from films but not noted in the record

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MOST COMMON CHARTING ERRORS

- Failure to document prescriptions/OTCs
  - Dental nexus of meds not noted
- Updated health history not noted

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MOST COMMON CHARTING ERRORS

- No treatment plan
- Failure to document shortfalls in treatment
  - Not documenting follow-up efforts
  - Dentist should do the follow-up

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WHAT TO INCLUDE IN PATIENT RECORD

- Patient registration
  - Address
  - Patient status
  - Preferred contact method
  - Insurance (primary, secondary and other third party information)
  - Recare cycle
  - Associated family members

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WHAT TO INCLUDE IN PATIENT RECORD

- Health History
  - Should be completed at initial visit and reviewed verbally and documented at each future visit.
  - New signature/initial annually or when changes occur.
  - Medical emergency warnings, i.e. allergies
  - Update and collect responsible party(s) signature(s) annually

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WHAT TO INCLUDE IN PATIENT RECORD

- Alerts
  - Allergies and medications impacting dental treatment
  - Patient classification-—available for short notice appointments, only Mondays, etc.

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WHAT TO INCLUDE IN PATIENT RECORD

- Signed agreements—saved based on your practice management system.
  - HIPAA
  - Financial arrangements
  - Consent for treatment
  - Treatment plans

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WHAT TO INCLUDE IN PATIENT RECORD

- Account ledger
  - Posted procedures
  - Items of purchase
  - Payments
  - Insurance reimbursements
  - Adjustments

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WHAT TO INCLUDE IN PATIENT RECORD

- Images (not limited to)
  - Radiographs
  - Photos
  - CBCT
  - CAD/CAM

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WHAT TO INCLUDE IN PATIENT RECORD

- Clinical/Chart notes—objective and consistent
  - PARQ/SOAP
  - Hard and soft tissue examinations
    - ”Exam” is not sufficient because does not tell the procedure, be specific and comprehensive.
  - Supporting clinical examinations
    - Document findings of testing—positive and negative

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WHAT TO INCLUDE IN PATIENT RECORD

- Proposed treatment
  - Whenever possible, any and all treatment should be sequenced in order of highest priority with associated scheduling parameters.
  - Signed treatment plan, saved in your system (best practice)

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WHAT TO INCLUDE IN PATIENT RECORD

- Plan should provide an estimate including full office fee and anticipated insurance benefits when available
  - The patient's signature on the treatment plan acknowledges their understanding of the estimate is not a guarantee and the patient is ultimately responsible for payment.

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HOW TO CHART

- Most accepted format acronym:

SOAP*

*Many dental and medical insurance companies are requesting documentation in the form of SOAP notes.

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HOW TO CHART

S: Subjective
O: Objective
A: Assessment
P: Plan

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SOAP

Subjective—The history section
HPI: Include symptoms dimensions, chronological narrative of patient's complaints.
Information from other sources (always identify the source).

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SOAP

Pertinent past medical history.
Pertinent review of systems , for example, "Patient has not had any cold sensitivity with other teeth."
Current medications (list with daily dosages).

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SOAP

- Objective—The physical exam and laboratory data section
  - Vital signs (BP, pulse, oxygen saturation if indicated)
  - Focuses on physical exam
  - All pertinent labs, radiographs/images, ect completed at the visit

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SOAP

- Assessment/Problem list—Your assessment of the patient's problems and/or list of problems identified.
  - Listed problems supported by the findings in subjective and objective areas above.

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SOAP

- List diagnosis for each problem identified.
- Take assessment of the major problem to the highest level of diagnosis.
  - For example: #19 requires RCT indicated by patient symptoms, radiographic evidence and temperature testing.

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SOA*P*

Plan—Your plan for the patient based on the problems you have identified.

- Develop a diagnostic and treatment plan for each differential diagnosis.

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SOA*P*

- Your diagnostic plan may include tests, procedures, consultations with other providers, etc.
- Your treatment plan should include: patient education, pharmacotherapy, therapeutic procedures.
- You must also address plans for follow up (next scheduled visit, post referral).

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TO TEMPLATE OR NOT

- Patients and their treatment needs are unique
- Risk when trying to “fit” all treatment into a template
- Documentation must be specific to patient

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TO TEMPLATE OR NOT

- If creating templates, consider breaking into segments:
  - Review of medical history/vitals
  - Anesthetic
  - Examinations/evaluations
  - Restorative procedures (crown, composite restoration…)

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IF USING A TEMPLATE

- Specify tooth by tooth status as well as procedure by procedure
- Write entries to support template info
  - Example: template may say #3 MO Composite restoration, supporting information, replacing restoration with recurrent decay diagnosed in radiograph.

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USE OF "SMART PHRASES"

- I was present in the operatory (during or when) this service was rendered and reviewed the patient's health history, condition, treatment plan, and supervised the above services provided and documented.
- I was present in the operatory during or when (detail the service that was rendered) and (note findings and or the treatment plan as appropriate).

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SUMMARY OF CHART NOTES

1. Patient's medical history reviewed, signed and dated.
2. Patient consent forms signed and dated.
3. Vitals taken and recorded
4. SOAP notes
5. Procedure
6. Anesthetic—include pre and post if indicated

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SUMMARY OF CHART NOTES

7. If used, Nitrous oxide
8. Procedure with complete details
9. Post op instructions
10. Any conversation about procedure, payment, and billing

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SUMMARY OF CHART NOTES

11. Lab used and shade taken (or referral for custom shade)
12. Referrals to specialist
13. Any follow up after patient dismissed---after hours follow up call
14. Complications, if any

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