Quality Resource Guide

Dental Record Keeping

Author Acknowledgements

MICHAELL A. HUBER, DDS
Adjunct Professor

GARY F. GUEST, DDS
Associate Dean for Patient Care

UT Health San Antonio
School of Dentistry
San Antonio, Texas

Dr. Guest is the American Dental Education Association representative to the ADA Standards Committee for Dental Informatics and a subcommittee Chairman.

Educational Objectives

Following this unit of instruction, the learner should be able to:

1. Recognize and understand the common elements of a dental record.
2. Understand how to create a good progress note.
3. Recognize the essential elements of the patient's health history.
4. Understand the usage of a Rapid Occlusal Assessment template.
5. Understand the relationship of the dental record to imaging systems used to support patient care.
6. Recognize the importance and legal responsibilities pertaining to record maintenance and protecting the privacy of the patients' health information.
7. Understanding key issues related to HIPAA and information blocking to record keeping with implementation of electronic dental record systems
8. Understand how electronic dental records provide a framework for enhanced utilization of dental record content including standardization of data / information collection, quality improvement, decision support, improved patient safety, more efficient administrative, analytics and regulatory compliance processes, and electronic communications with patients, providers, and payers.

MetLife designates this activity for **1.0 continuing education credits** for the review of this Quality Resource Guide and successful completion of the post test.

The following commentary highlights fundamental and commonly accepted practices on the subject matter. The information is intended as a general overview and is for educational purposes only. This information does not constitute legal advice, which can only be provided by an attorney.

Originally published December 2011. Updated and revised August 2014, December 2017, May 2021 and December 2024. Expiration date: December 2027.

The content of this Guide is subject to change as new scientific information becomes available.

ADA C·E·R·P® | Continuing Education Recognition Program

Accepted Program Provider FAGD/MAGD Credit **05/01/21 - 06/31/25.**

MetLife is an ADA CERP Recognized Provider. ADA CERP is a service of the American Dental Association to assist dental professionals in identifying quality providers of continuing dental education. ADA CERP does not approve or endorse individual courses or instructors, nor does it imply acceptance of credit hours by boards of dentistry. Concerns or complaints about a CE provider may be directed to the provider or to ADA CERP at https://ccepr.ada.org/en/ada-cerp-recognition.

Address comments or questions to:
DentalQuality@metlife.com - or -
MetLife Dental Continuing Education
501 US Hwy 22
Bridgewater, NJ 08807

Cancellation/Refund Policy:
Any participant who is not 100% satisfied with this course can request a full refund by contacting us.

Introduction

The dental record (or chart) is an essential document in one's dental practice. It is the official document that records all diagnostic information, clinical notes, treatment performed and patient-related communications that occur in the dental office, including patient recommendations and consent to treatment. Dental records can be documented manually or electronically. A properly maintained dental record:

- Contributes to the delivery of quality dental care and patient safety, facilitates continuity of care, and supports standards / guidelines for dental care.
- Serves as patient specific documentation and a chronicle of the patients care
- Affords a means of concise communication between healthcare professionals
- Provides an accurate reflection of the patient's oral health, including health histories, diagnoses and findings, treatment recommendations, informed consents, referrals and consultations, procedures and management, as well as medications prescribed and dispensed.
- Serves as the medico-legal document to minimize risk for the provider and can used in the defense of alleged malpractice.
- Must be retrievable even if the patient leaves the practice.
- Serves as supplemental verification of patient identification and may be used as a forensic aid in the identification of a dead or missing person.
- Maintains patient privacy
- Should support quality improvement and patient safety.
- Electronic Patient medical and dental records systems are a combination of Clinic Information Systems (such as administrative functions of revenue cycle, reporting, and scheduling) and the Electronic Patient Record. The American Dental Association (ADA) Health Policy Institute notes as of 2020, approximately 75% of dental practices in the United States were using some of an Electronic Dental Record (EDR).

Table 1 - Components of the Dental Record

- Demographic information and other patient registration information
- Release authorizations (HIPAA, etc.)
- Consents for care
- Medical and dental histories, including updates and alerts
- Diagnostic records, charts, study models, radiographs (with dose exposure) and interpretation of radiographic findings, photographs
- Discipline specific supplemental forms (occlusal/TMJ assessment, risk assessments, periodontal and endodontic assessments, sedation documentation.)
- Diagnoses, prognosis and associated treatment recommendations
- Informed consent forms and/or discussions, including the nature of any proposed treatment (including no treatment), risk/benefits, and alternatives
- Detailed Progress and Treatment Notes
- Prescription information, including medications dispensed as part of patient care.
- Evidence of ongoing patient examination and periodontal maintenance
- Description of implanted devices and materials used during therapy
- Documentation of consultations / referrals
- Waivers/authorizations
- Laboratory work order forms and dental laboratory documents validating specific service/ materials.
- Noncompliance and/or missed appointment notices
- Post-operative instructions and patient education provided
- Documentation of patient conversations (in or out of office)
- Patient complaint information and resolution
- Dismissal letters and other correspondence related to the patient care process.

Advantages of Electronic Health Record (E H R) Systems include:

- Standardization of information / data contained in the record.
- Automation such as patient confirmations and patient condition alerting / warnings to providers.
- Ability to integrate with other systems such as electronic prescriptions and revenue cycle tools, decision support systems and other medical related systems. This can also improve patient safety. New clinically related software that incorporate augmented intelligence will also be integrated to electronic patient record systems.
- Ability to aggregate patient data that provides a framework for quality assessment assurance and practice trending
- Facilitate efficient capabilities for information sharing with patients and other healthcare providers involved in patient care.
- Remote access to patient records so that information is accessible at the point of care.

Dental Providers should be cognizant of the safeguards needed for electronic record systems such as privacy and security of protected health information (PHI), the need for recurring cost of maintenance and upgrades to these systems, the need for training of all staff on use of electronic management systems, redundancy and backup of these systems, and interoperability of E H R and related patient care systems.

The purpose of this Quality Resource Guide is to briefly review the content of a dental record and the principles of dental record management.

The recommendations set forth, unless noted otherwise, are applicable to either traditional hand-written paper records or the numerous Electronic Dental Record (EDR) programs currently available to practitioners. Changes are constant for guidelines and regulations related to electronic health records, and dental professionals should continue to monitor the impact for their practices. Practitioners are encouraged to access other topic-specific Quality Resource Guides and the references provided at the end of this Guide for further guidance.

Content of the Dental Record

The dental record serves as the repository of all information pertaining to patient care. Documentation should adhere to applicable state laws governing the practice of dentistry and conform to the standards established by the American Dental Association and other applicable professional organizations. Whether using paper records or an electronic format, a standardized approach for layout and structure should be used. The actual content of the dental record will be largely dictated by the complexity of the clinical circumstance (*e.g.*, single tooth restoration, full-mouth rehabilitation). Commonly included components of the dental record are noted in **Table 1**.

Documentation

While state law determines who may make entries into the dental record, the dentist is ultimately responsible for its content. All entries must be dated, legible, concise, objective, and initialed or signed. For electronic records, they must be time stamped and digitally signed/approved. The dentist should remember that other individuals such as the patient, insurance carriers and even attorneys might gain access to the dental record. Care should be taken to minimize errors and misrepresentations. If corrections become necessary, they should be accomplished in a manner that does not obliterate the original entry, such as a single line drawn through the entry. In this regard, most electronic formats preserve or archive prior entries according to their unique time stamp.

Table 2 - Progress Notes

S (subjective data)	Reason for visit, chief complaint, and a qualitative and quantitative description of the symptoms as described by the patient (to include history of chief complaint and the medical-dental history review).
O (objective data)	"Measurements" – record of actual clinical, radiographic, and laboratory findings obtained by the clinician (vital signs, periodontal and caries charting, pulp vitality testing, etc.).
A (assessment)	Interpretation of "S" & "O" by the clinician leading to a provisional or definitive diagnosis.
P (plan, treatment)	Plan: proposed treatment plan(s) and actual services (preventative, therapeutic) rendered to alleviate or resolve problems: include plans for consultation or referral to other healthcare providers, prescriptions written, and pre- and postoperative instructions. Treatment: treatment and/or diagnostic procedures rendered including materials utilized, instructions to patients, medications administered or prescribed, and disposition of the patient.

Most commonly, the entry of information into the dental record follows a problem-oriented approach, which allows for the standardized elucidation and documentation of demographic, diagnostic, preventive and therapeutic information. Well-constructed and accurate narrative entries are essential to describe the unique story of an individual patient. A universally accepted format for documentation is a Progress Note utilizing the S.O.A.P. format (**Table 2**). By following the S.O.A.P. format, the practitioner can logically document the reason for the patient visit (subjective findings); the findings of his or her examination (objective findings); the diagnosis or differential diagnosis (assessment); and the indicated plan for management (plan). A progress note should also include a description of interventions (diagnostic and treatment procedures, and prescriptions).

The disciplined use of thorough and concise Progress Notes in the dental record helps to ensure all proposed or delivered treatment is predicated on an established diagnosis. For electronic or computer-based record systems, templates for Progress Notes can tailor documentation of patient visits and treatments specific to procedures to further improve Progress Notes thoroughness.

Complete Progress Notes

Progress notes are an accurate chronological record that describes and reflects the total experience of the patient. The following data elements are considered to be essential for all progress notes:

1. The date the note was written, and if different, the date the service was provided. Progress notes in electronic records should be entered on the day of service to time stamp their entry. Notes entered a later date need to reference the date of service.
2. Diagnosis / reasons for interventions/ procedures, unless this information is located in another part of the record, such as codified clinical findings, the treatment plan or diagnosis sheet.
3. Description and location of each procedure and listing by category of procedure, brand name of all materials used or placed in the mouth. This documentation includes codification of the procedures (CDT / CPT). The narrative description of a progress note needs to align with the codification. Procedures that involve dental laboratory prosthesis narrative description and code should reconcile with the dental laboratory invoices documents describing the dental laboratory service.

4. Description of any drug or medication, including local anesthetics, administered (must specify nonproprietary name, dose, route and, for parenteral medication, site). Sedation documentation is represented in temporal fashion.
5. Documentation of all prescriptions (drug, dosage, duration, instructions, refills). Documentation must be noted in the progress notes or in a separate medication log and follow all state and federal laws for documentation.
6. Documentation of imaging orders and interpretations.
7. Evaluation of treatment completed (including any circumstances or events that occurred during the course of treatment necessitating modification of the treatment plan or altering the original prognosis).
8. The author of written or electronic notes must be identifiable. If the record is written, by a signature, initials, or unique identifier. If the record is electronic, by a printed full name, initials or unique identifier (if initials or a unique identifier are used in either written or electronic records, it is the responsibility of the dentist to be able to identify the original author).
9. Best practices for progress notes also include documenting post-operative instructions, patient education activity and the answering of therapy-related questions posed by the patient.
10. For paper records, entries must be legible and in ink (progress notes are a legal document). For both paper and electronic records, use understandable / non-cryptic narrative entries and standard abbreviations, if the narrative is truncated. Electronic records help address legibility issues.
11. Avoid inflammatory of derogatory comments about the patient in the progress notes - statements about treatment events including patient behavior should be stated objectively and factually (expanded access of patients to their records were made part of the last revisions to HIPAA)
12. Indicate disposition of the patient including the tolerance for procedure(s), next appointment description and timeframe, if relevant, and any unexpected outcomes and the discussion with the patient related to the outcomes.
13. Record entries should be factual, relevant to the patient's care, complete and made in timely manner. Delayed entries are more likely to be incomplete.
14. Record entries should be recorded in clear and concise, understandable, and organized manner so that other health care / dental professional can interpret them.

The use of customized templates or forms (Consent Form, Medical-Dental Histories, etc.) is highly encouraged for both hand-written and electronic records. Much like a pilot's pre-flight checklist, the use of both Progress Notes and standardized forms helps ensure appropriate patient management. The development and use of standardized forms can be tailored to meet the needs of the individual practice. The dentist should be aware that record documentation should be of the highest quality as it reflects the level of care given to patients. If the office treats children, the American Academy of Pediatric Dentistry's Guideline on Record-keeping may be a useful reference. From a medico-legal and patient complaint standpoint, good record keeping is critical to demonstrating standards of care were followed.

Registration Information

Registration information contains key identifiers that support patient identification, data integrity, patient communications and management of financial aspects of patient care. This component of the record may also be linked to the Notice of Privacy Policies as part of HIPAA compliance. Registration information plays an important role in management of patients' payers or assigned providers in a multi-provider environment. Payer information is important to successful management of practitioner's revenue cycle and subsequent patient satisfaction with financial aspects of care. As indicated in this publication, financial information is separate from the Patient Record, but Electronic Patient Record systems contain both clinic information systems and the patient record functionality, where financial information is modularized separate from the Patient Record.

Medical-Dental History

Histories are usually obtained by combining a written questionnaire with a follow-up verbal interview. Typically, the patient will complete the questionnaire prior to meeting the practitioner, at which time the interview will be accomplished. The patient should answer all queries in the questionnaire; there should be no areas left blank. Essential elements that should be addressed in medical-dental history include:

- Adverse Drug Effects - (true allergic and/or other adverse responses)
- Current Medications - (prescription, over-the-counter, and/or self- prescribed supplemental – including dosages). More recently, to better manage controlled substances, both federal and state regulations have been enacted which include electronic prescriptions. For many electronic records systems this process has been integrated into the Patient Record System. The data collected as part of the patient's medication history in many instances can contribute to the diagnosis of oral conditions such as xerostomia or other medication side effects.
- Review of Systems - (past/present illnesses, conditions, and/or surgical events. For children a history of developmental disorders should also be recorded.)
- Family Medical History - (blood relatives)
- Social History - (alcohol, tobacco, and/or recreational drug use, or exposure and behaviors potentially having an impact on dental care)
- History of past dental treatment and review of the chief complaint.

The importance of the follow-up interview process cannot be overstated. Accepting the patient's

questionnaire responses without follow-up is highly discouraged. The interview often represents the first opportunity for the practitioner to have a conversation with the patient and establish a good rapport. It's not uncommon for the patient to be more forthcoming in acknowledging their medical-dental history during the interview process. Federal guidelines require communication in different languages based on demographics of the practice region for all patients whose care is paid for by a federal government program. With the significant increase in Patient Portals, where patients can directly input patient history information, clinicians must review, verify the patient entries and document the interview-based review.

It is important that the clinician not only elicit appropriate details for a positive response on the medical history, but that he/she also verifies each negative response. As an example, let's consider a query regarding hypertension. If the patient responds positively to having a history of hypertension, the practitioner might ask, "How is it being managed?" The patient's response to such an open-type question dictates the need for further specific questioning. As an example of verifying a negative response, the patient may initially answer "no" to a written query regarding hypertension, only to have their memory jogged upon verbal verification by the practitioner.

Obtaining an adequate medical-dental history is essential to determine: 1) the patient's ability to undergo a specific procedure; 2) the need for modifications to the delivery of dental care (*e.g.*, antimicrobial prophylaxis, medication to avoid due to allergy), and; 3) the patient's attitude, desire, and motivation concerning their dental health. Once completed the Medical-Dental History form should be signed and dated by both the practitioner and the patient. At each subsequent visit (regardless of interval) it is advisable to document in the narrative entry that the medical-dental history was reviewed for changes. It is further recommended that each patient's medical-dental history be formally updated and documented on an annual basis or when a major change in the patient's health status has occurred. For Electronic Records, the capability to exchange information between other dentists and physicians can be a means to generate a better understanding of the patient's conditions, treatment needs and management. For the dentist, access to current medical information provides more detail of the patient's overall health, due to standardized codification of the patient's systemic conditions (ICD10 codes). Electronic prescriptions can be automatically integrated into the electronic dental record at the time of creation.

Initial Patient Charting

It is important for the practitioner to record the initial dental condition of each patient. This generally includes documentation of a comprehensive head and neck examination, which includes an intraoral and extraoral hard and soft tissue assessment in addition to traditional dental and periodontal charting, including documentation of health/disease status. Personnel in dental offices should use standardized abbreviations and symbols to document existing conditions and findings. For Electronic Records these findings and conditions can be codified with standardized system nomenclature such as SNODENT. They should be employed by everyone in the office and kept on file for reference. As with the medical-dental history, all questions on forms or questionnaires should be answered. For example, if there is a question / entry concerning the ears and there are no remarkable findings, a comment such as "within normal limits" (WNL) should be entered. It is generally accepted that while dental health professionals are not expected to diagnose all the potential problems and conditions that can occur in the head and neck, dental professionals should recognize aberrations of normal. Any equivocal or suspicious findings should be objectively documented and referred for appropriate follow-up evaluation.

The documentation of findings pertaining to the teeth should be portrayed as accurately as possible. With paper and electronic records, such accuracy may be ensured by carefully drawing what is seen in the patient's mouth onto a tooth chart (odontogram). Digital photography can capture the original condition of the patient's mouth and serial photographs may also be used monitor specific lesions or conditions for change. More SNODENT terminology also serves as means of codifying diagnositic and existing conditions for teeth.

The clinician should carefully design their record to allow recording and access to data in an uncomplicated and efficient manner. The record should provide a method to record, analyze and longitudinally assess dental and periodontal and occlusal status. While most offices are comfortable with standardized dental and periodontal charting formats, many offices struggle with a system to adequately document occlusal conditions. An example template for Occlusal Assessment is included (**Appendix A**) to provide assistance.

Periodontal Conditions: Documentation & Diagnosis

In 2018 the American Academy of Periodontology released a revised the classification schema for periodontal disease that included the diagnosis of periodontal severity and risk of progression by staging and grading criteria. Information/data required to stage and grade periodontal disease includes: probing depths; bleeding on probing; clinical attachment loss; radiographic bone loss; and history of periodontal treatment. This new classification has five stages and three grades of periodontal disease. The Dental Record should reflect the diagnostic data and periodontal classification. Electronic Record systems provide means of documenting all conditions above as discrete data, and therefore can be used in calculations of periodontal disease stage and severity.

Risk Assessments

Risk Assessments are also part of the patient's initial assessment and documentation, to improve the quality of care and enhance long-term outcomes. Risk assessments can be for both mutable (factors that can be modified) and immutable risk (factors that cannot be modified: age, race, and genetics). Risk assessment information related systemic factors, destructive habits, home care, oral cancer, caries and periodontal disease should be captured in the patient record. Electronic records can be interfaced

to algorithms to assist clinicians in calculating and quantifying risk level. See **Appendix B** for an example of risk factors.

Consent for Care

A significant responsibility of the dentist is to obtain and document informed consent. Consents can be general in nature and many times will be "assent" in nature where activities such as patient exam are implied by the patient's presence. Written general consents are beneficial in documenting patient responsibilities during therapy and for follow-up professional and personal care. Written consents may be related to conditions such as patients with a history of anti-resorptive medications (bisphosphonates *et al*.) or procedures with higher risk (surgery, extractions, implants, root canals, *et al*.). Written consents are also recommended for complex care patients. For patients who refuse treatment recommendations that are accepted standards of care, an Informed Refusal consent should be obtained.

Image Management and/or Radiographic Image Systems (RIS)

Oral healthcare providers should also be cognizant of Personal Health Information (PHI) contained within clinical image systems. Standards for imaging in medicine and dentistry have adopted DICOM (Digital Imaging and Communication Systems in Medicine) standards. DICOM imaging files contain metadata such as patient name, date of birth, and chart number. HIPAA standards for images is the same as data within patient record systems. Data integrity is required between two systems if the electronic dental record and the imaging system from different vendors and integrated. CAD-CAM systems are adopting imaging standards that are DICOM compliant, therefore containing PHI as part of their files. More recently surface scanning via CAD-CAM systems and radiographic imaging can be integrated for surgical planning and treatment. As Dental Laboratory manufacturing processes continue to move from analog to digital, access and maintenance of this information /data are also part of the patient record under and should follow imaging data management protocols.

Implanted Material and Devices

The FDA requires manufacturers of implanted devices to assign a unique device identifier (UDI) to their products. It is suggested that documentation for implanted devices and materials contain information on the item's manufacturer, description of the device, lot number and catalog reference number. Electronic records can place these entries in databases, allowing rapid searching and reporting on devices and materials utilized in patient care.

Occlusal/TMJ Assessment

The Occlusal Assessment/TMJ template consists of series of baseline questions and examination findings that may be utilized to assist the clinician in identifying those patients at greatest risk for occlusion-related problems. Documentation of this baseline information is especially valuable when the planned treatment will affect the patient's occlusal scheme or function. If the findings of the Occlusal Assessment indicate either a past or present history of limitations in functional motion, tooth mobility, inappropriate wear, and/or occlusal related-pain, a more detailed assessment and management strategy is warranted.

Study AND Treatment Models/Scans

Many states consider study and treatment models as part of the patient record and provide either general or specific guidelines for their maintenance. Providers should review the Dental Practice Act of their state. As previously noted in the imaging section, digital impressions and resultant models become part of the patient record.

Treatment Plans

Best practices for record keeping include a section for treatment plans. They should be supported by documentation of pathology, conditions, and prognosis. The treatment plan and/or the progress note should denote alternative treatments discussed with the patient. Treatment plans should also include referrals, observations, and re-assessments. Dental Providers should advise the patient that the "Treatment Plan" is subject to change and dependent on the outcomes of subsequent treatment. Ideally, the number and length of appointments and an estimate of fees should be part of the treatment plan and its presentation to the patient. If available, treatment plans should incorporate the codification, such as SNODENT, of existing conditions and pathology. Treatment plans should be dated and signed by the patient and the provider. Tracking completion of the treatment plan procedures aids improved patient management. This process is facilitated by electronic records.

Maintenance of Dental Record

A dental record must be highly protected and secured; it is considered a "vital" record because it cannot be replaced. Records must never be retroactively altered. New entries can be made referring to a previous date and or service. Original records should never be released unless subpoenaed or required by federal or state law. Patients must authorize the release of their record and such authorization should be part of the dental record. Dental records must be protected in accordance with federal and state privacy rules. If a practice transmits health information in an electronic form, it must also follow Health Insurance Portability and Accountability Act (HIPAA) rules. Released in 1996, HIPAA established national standards for the protection of certain health information referred to as protected health information (PHI). The HIPAA Administrative Simplification Interim Rule released in 2009, established a national set of security standards for protecting certain health information that is held or transferred in electronic form (e-PHI). An updated or "Final Rule" went into effect March 26, 2013 to strengthen the privacy and security protections for PHI and tighten HIPAA enforcement provisions. Dental records must be stored in a manner that is secure, yet easily accessible to those authorized to view them. There is no "one size fits all" plan to ensure compliance with HIPAA. Individual offices need to determine the most reasonable and appropriate protocols to ensure the confidentiality of protected health information (PHI and e-PHI). Administrative requirements pertaining

Table 3 - Administrative Requirements Pertaining to HIPAA

Privacy Policies and Procedures	A practice must develop and implement written privacy policies and procedures that are consistent with the Privacy Rule.
Privacy Personnel	A practice must designate a privacy official responsible for developing and implementing its privacy policies and procedures, and a contact person or contact office responsible for receiving complaints and providing individuals with information on the covered entity's privacy practices.
Workforce Training and Management	A practice must train all workforce members on its privacy policies and procedures, as necessary and appropriate for them to carry out their functions. It must have and apply appropriate sanctions against workforce members who violate its privacy policies and procedures or the Privacy Rule.
Mitigation	A practice must mitigate, to the extent practicable, any harmful effect it learns was caused by use or disclosure of protected health information by its workforce or its business associates in violation of its privacy policies and procedures or the Privacy Rule.
Data Safeguards	A practice must maintain reasonable and appropriate administrative, technical, and physical safeguards to prevent intentional or unintentional use or disclosure of protected health information in violation of the Privacy Rule and to limit its incidental use and disclosure pursuant to otherwise permitted or required use or disclosure.
Complaints	A practice must have procedures for individuals to complain about its compliance with its privacy policies and procedures and the Privacy Rule. The covered entity must explain those procedures in its privacy practices notice.
Retaliation and Waiver	A practice may not retaliate against a person for exercising rights provided by the Privacy Rule, for assisting in an investigation by HHS or another appropriate authority, or for opposing an act or practice that the person believes in good faith violates the Privacy Rule. A covered entity may not require an individual to waive any right under the Privacy Rule as a condition for obtaining treatment, payment, and enrollment or benefits eligibility.
Documentation and Record Retention	A practice may not retaliate against a person for exercising rights provided by the Privacy Rule, for assisting in an investigation by HHS or another appropriate authority, or for opposing an act or practice that the person believes in good faith violates the Privacy Rule. A covered entity may not require an individual to waive any right under the Privacy Rule as a condition for obtaining treatment, payment, and enrollment or benefits eligibility.

to HIPAA are summarized in **Table 3**. All practices must conduct a security risk assessment as part of HIPAA compliance. The Office of the National Coordinator (ONC) has developed a Security Risk Assessment following NIST standards which can be downloaded. The Assessment Tool was last updated in 2020.

In March of 2020, the Office of the National Coordinator and Office of Health and Human Service released the Cures Act Final Rule. This rule finalized two transformative rules that will give patients unprecedented safe, secure access to their health data. Interoperability aspects of these rules give patients access to their healthcare data to make informed healthcare decisions and better manage their care. There have also been established exceptions the Cures Act's information blocking provision and adopted new health information technology (health IT) certification requirements. In 2021, the Office of the National Coordinator for Health Information Technology (ONC) issued rules related to health information blocking as part of the 21st Century Cures Act and intended to promote interoperability of electronic health records (EHRs) and the electronic health information (EHI) they contain, as well as ensuring that patients have easy access to their health information. EHI is part of the information blocking definition. Protected EHI is part of a Designated Record Set (DRS) that includes medical records, billing records, payment and claims records, health plan enrollment records, case management records, as well as other records used, in whole or in part, by or for a covered entity to make decisions about individual. A healthcare provider is subject to the information blocking regulations. They should not engage in a processes or protocols likely to prevent or significantly inhibit (interfere with) the access or exchange of EHI. CMS Interoperability and Patient Access Final Rule was developed with a "Patient-first" mindset, supporting the previous rule by giving patients access to their health information when they need it most and in a way that they can use. CMS authority will regulate Medicare Advantage, Medicaid, CHIP, and Qualified Health Plan issuers on the federally - facilitated exchanges to liberate patient data.

There are common sense elements to HIPAA as it relates to patient records:

- keep files out of view other patients
- use minimum necessary information when disclosing information
- implement both physical and information technology security

The American Dental Association HIPAA checklist is a quick reference for dental practices.

Due to the increased public awareness concerning identify theft, many patients are reluctant to release their Social Security Number (SSN). A unique patient ID, in lieu of the SSN, should identify each patient's physical or electronic record. State laws and provider contracts define the regulations controlling ownership and retention of dental records. In multi-practitioner practices, responsibility pertaining to the maintenance and ownership of dental records should be spelled out in a legal agreement or contract. Each office should have a clear policy addressing how and when dental records can be disposed. Typically, after 2 years of inactivity, a dental record may be considered inactive. HIPAA generally requires that inactive records be maintained for 6 years, or 2 years after a patient's death. Many states require records be maintained for 10 years or until a minor becomes of age. Practitioners should consult their states guidelines and rules. However, some risk managers recommend records be maintained indefinitely. The practitioner should know the specific rules in their own state as they do vary, or consult an attorney. If the practitioner chooses to maintain dental charts (either physical or electronic) beyond the aforementioned timelines, he or she should consult an attorney to determine if there are medico-legal concerns, such statute of limitations, to consider. Charts maintained beyond the timelines, must be as securely maintained as active records. An attorney should be contacted when a dental office permanently closes to ensure that patients have continued access to their health information. Providers should review their state's rules and guidelines for record transfer following practice closure or provider departure from a practice.

The disposal of physical records must be accomplished in a manner that ensures the protection of the patient's privacy. The most commonly employed method of record disposal is shredding, which may be accomplished in-office or out-sourced to a professional shredding service. Recycling of intact records or record contents is discouraged, as confidentiality may be compromised. Physical radiographs should be removed, de-identified and submitted for silver recovery or disposal by a certified waste hauler.

An important aspect for managing protected health information in the era of electronic records is the data protection. ePHI should be protected both at rest (while being stored) and in transit (being transferred across any network). Today this done through appropriate and up-to-date firewalling, encryption, and information security protocols.

Summary

The dental record (or chart) is the official document that houses all demographic and diagnostic information, clinical notes, treatment performed, implanted material and devices utilized, and patient-related communications, including patient recommendations and consents to treatment. This Quality Resource Guide briefly reviews the basic elements of documenting and managing a dental record. Practitioners are encouraged to access other topic-specific Quality Resource Guides and the references provided at the end of this Guide for further guidance.

Table 4 - HIPAA Penalties

Violation Category	Penalty Amounts	
	Each Violation	All such violations of an identical provision in a calendar year
Did Not Know	$100 - $50,000	$1,500,000
Reasonable Cause	$1,000 - $50,000	$1,500,000
Willful Neglect - Corrected	$10,000 - $50,000	$1,500,000
Willful Neglect - Not Corrected	$50,000	$1,500,000

References

1. American Dental Association – Mouth Healthy. Dental Records. Available at: http://www.mouthhealthy.org/en/az-topics/d/dental-records (Accessed 16 June 2014). (Accessed 20 June 2014, accessed Nov 2020).
2. Seidberg BH. Dental litigation: Triad of concerns. In: American College of Legal Medicine. Legal medicine. 7th ed. Elsevier: Mosby, 2007. p. 499-506.
3. Terezhalmy GT, Huber MA, Jones AC. Physical evaluation in dental practice. 1st edition. Wiley-Blackwell, Ames, 2009.
4. U.S. Department of Health and Human Services. Health information privacy. Available at: http://www.hhs.gov/ocr/privacy/index.html (accessed 20 June 2014, accessed Nov 2020).
5. U.S. Department of Health and Human Services. HIPAA for Professionals. Available at: https://www.hhs.gov/hipaa/for-professionals/index.html?language=en(accessed Nov 2020).
6. HHS.gov – The HIPAA Enforcement Rule. Available at: https://www.hhs.gov/hipaa/for-professionals/special-topics/enforcement-rule/index.html (Accessed Nov 2020).
7. American Academy of Pediatric Dentistry. Guideline on Record-keeping. Available at: www.aapd.org/media/Policies_Guidelines/G_Record- keeping.pdf (Accessed Nov 20 June 2020).
8. Charangowa BK Dental Records: Best Practices for Information Management and Retention: Risk Analysis and Management. J Forensic Dental Science 2010; Jan-Jun 2(1) 5-10
9. HealthIT.gov – Security Risk Assessment Tool: https://www.healthit.gov/topic/privacy-security-and-hipaa/security-risk-assessment-tool (accessed Nov 2020)
10. Business Model for the Security of a Large-Scale PACS, Compliance with ISO/27002:2013 Standard, Journal J Digit Imagingv.28(4); 2015 AugPMC4501951-https://link.springer.com/article/10.1007/s10278-014-9746-4 (accesed Nov 2020)
11. American Dental Association; A Dentist Guide to the Law – 228 things every Dentist Should Know; 2016; https://ebusiness.ada.org/productcatalog/33421/Practice-ManagementStaff-Training/A-Dentist%E2%80%99s-Guide-to-the-Law-228-Things-Every-Dentist-Should/L756BT
12. Diagnosis and Treatment Planning in Dentistry: Stefanac, Stephen J., Samuel Nesbit. Diagnosis and Treatment Planning in Dentistry, 4th Edition. Elsevier, 2024. VitalSource Bookshelf.
13. Maintaining Proper Dental Records; Wilhemina Leeuw, MS, CDA; www.dentalcare.com/en-US/dental-education/continuing-education/ce78/ce78.aspx
14. Recordkeeping Basics — Good for Patients, Essential for You! – DentistryIQ; www.dentistryiq.com/articles/2009/09/recordkeeping-basics.html
15. Section 1557 of the Patient Protection and Affordable Care Act -https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html
16. HHS Finalizes Historic Rules to Provide Patients More Control of Their Health Data https://www.hhs.gov/about/news/2020/03/09/hhs-finalizes-historic-rules-to-provide-patients-more-control-of-their-health-data.html (accessed Nov 2020)
17. American Dental Association: Standards Committee for Dental Informatics – Dental Provider Guide to the Electronic Health Record (2015, reaffirm 2020): https://ebusiness.ada.org/productcatalog/product.aspx?ID=75848 (accessed Nov 2020)
18. A Guide to Medications Inducing Salivary Gland Dysfunction, Xerostomia, and Subjective Sialorrhea: A Systematic Review Sponsored by the World Workshop on Oral Medicine VI. Drugs RD 2017 Mar17(1): 1-28
19. Office of the National Coordinator for Health Information Technology, Security Risk Assessment Tool v 3.4. https://www.healthit.gov/topic/privacy-security-and-hipaa/security-risk-assessment-tool (accessed May 2024)
20. Office of the National Coordinator for Health Information Technology, Information Blocking. https://www.healthit.gov/topic/information-blocking (accessed May 2024)
21. American Dental Association Center for Professional Success (ADA Members), HIPAA Checklist. https://www.adamemberadvantage.com/resources/culture-of-safety/hipaa-checklist (accessed June 2024)
22. A Review of the Role of Artificial Intelligence in Healthcare, Ahmed Al Kuwaiti et.al, J. Pers. Med. 2023, 13, 951. https://doi.org/10.3390/jpm13060951

Appendix A

TMJ Occlusal Assessment

Patient:_____ Chart: _____

Date:_____

1. TMJ History

Does the patient have difficulty or pain when opening mouth wide?	Y	N
Does the patient have difficulty or pain when chewing, talking, etc?	Y	N
Does the patient's mandible get "stuck", locked" or "go out"?	Y	N
Is the patient aware of noises in his/her TMJ's?	Y	N
Does the patient often have pain in or about the ears, temple or or cheeks?	Y	N
Does the patient have frequent headaches?	Y	N
Is the patient aware of recent changes in his/her bite?	Y	N
Has the patient been treated for unexplained facial pain/TMD problems?	Y	N

2. Opening Range of Motion (include overlap of anterior teeth; minimum normal = 40 mm): _____ mm

3. Palpation Tenderness

Temporalis - Right	Y	N	Temporalis - Left	Y	N
TMJ - Right	Y	N	TMJ - Left	Y	N
Masseter - Right	Y	N	Masseter - Left	Y	N
Lateral Pterygoid - Right	Y	N	Lateral Pterygoid - Left	Y	N

4. Occlusal Dysfunction Assessment

Right Working (Circle Occlusal Scheme) Type of Occlusal Function: _____

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32

Left Working (Circle Occlusal Scheme) Type of Occusal Function: _____

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32

Protrusive (Circle Occlusal Scheme) Type of Occlusal Function: _____

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32

(Circle teeth that have) **Exposed Dentin or Wear Facet**

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32

Does tooth attrition threaten occlusal function? Y N

Does the occlusal scheme merit further investigation? Y N

Appendix B

Oral Health Risk Assessment

Patient:_____ Chart: _____

Date:_____

Risk Assessment Form Question	Answer
Oral Health Disease Factors	
Initial Assessment	
Date of Initial Assessment	
Provider Name:	
Medications that increase risk for oral disease	
1. Medical and Social History	
Autoimmune Disease	
Hyposalivary Medications	
Radiation Therapy	
Physical Disability	
Eating Disorder/GERD	
Diabetes	
Tobacco/Alcohol	
Recreational Drugs	
2. Predisposing Oral Conditions	
Exposed Roots	
Deep Pit and Fissures	
Tooth wear (Erosion, Abrasion)	
PSR (Perio Screening & Recording)	
Plaque/Calculus	
Malocclusion/Crowding	
Appliances	
3. Caries	
Cavitated Lesions	
Radiographic Lesions	
White spots/incipient lesions	
Recent Restorations (last 3 years)	
4. Dietary	
Sugary Snacks	
Sugary Drinks/Sodas	
5. Protective Factors	
Fluoridated Water	
Fluoridated Toothpaste/Mouthrinse	
Xylitol Gum, Mints	
Chlorohexidine Rinse	

POST-TEST

Internet Users: This page is intended to assist you in fast and accurate testing when completing the "Online Exam." We suggest reviewing the questions and then circling your answers on this page prior to completing the online exam.

(1.0 CE Credit Contact Hour) Please circle the correct answer. 70% equals passing grade.

1. **Common dental record contents include all of the following <u>except</u>:**
   a. Demographic information
   b. Billing and payment records
   c. Diagnostic records, charts, study models, radiographs
   d. Laboratory work order forms
   e. Noncompliance or missed appointment notices

2. **Who is responsible for enforcing compliance of the HIPAA Final Rule?**
   a. The State Dental Board
   b. The State Dental Association
   c. HHS Office for Civil Rights
   d. None of the above

3. **Utilizing the S.O.A.P Progress Note format, an example of the subjective data would be:**
   a. The chief complaint
   b. Discussion of the treatment plan
   c. A prescription
   d. A follow-up appointment

4. **Utilizing the S.O.A.P Progress Note format, an example of the objective data would be:**
   a. The patient's past dental history
   b. Periodontal charting
   c. The differential diagnosis
   d. History of drug abuse

5. **Which statement concerning the attainment of the medical history is <u>not</u> true?**
   a. A history of adverse drug events is essential.
   b. The current medication query only pertains to prescribed medications.
   c. A review of systems addressing past and present illnesses should be accomplished.
   d. A history of past and current tobacco, alcohol, and recreational drug exposure should be obtained.

6. **Why is the verbal interview component of the medical-dental history review so valuable?**
   a. It can be delegated to a staff member or call center.
   b. The patient may be more forthcoming discussing their current or past medical-dental history.
   c. The practitioner can coach the patient on their answers.
   d. The provider can judge the patient viewpoint.

7. **Which of the following statements regarding the *Occlusal Assessment* is <u>not</u> true?**
   a. It serves to document baseline information useful for treatment planning.
   b. It assists the practitioner in identifying a patient with an occlusal dysfunction.
   c. It is absolutely predictive in identifying future occlusal dysfunction.
   d. All statements are true

8. **HIPAA Privacy and Security Rules apply if:**
   a. The dental practice has more than 500 active patients.
   b. The practitioner began practicing after 1996.
   c. The practitioner transmits health information in electronic form.
   d. None of the above

9. **In accordance with HIPAA Privacy and Security Rules:**
   a. A dental practice must use lockable file cabinets for record storage.
   b. A dental practice must have a designated individual responsible for developing and implementing its privacy policies and procedures.
   c. A dental practice must use a third-party agency to provide staff training pertaining to HIPAA Privacy and Security Rules.
   d. None of the above

10. **Concerning the disposal of physical dental records:**
    a. For many states, dental records must be maintained for 10 years after the last encounter.
    b. Transferring is the preferred method of disposal.
    c. Shredding is the most common method of disposal.
    d. Shredding must be outsourced to ensure the protection of patient privacy.

Registration/Certification Information (Necessary for proper certification)

Name (Last, First, Middle Initial): _____

PLEASE PRINT CLEARLY

Street Address: _____ Suite/Apt. Number _____

City: _____ State: _____ Zip: _____

Telephone: _____ Email:: _____

State(s) of Licensure: _____ License Number(s): _____

Preferred Dentist Program ID Number: _____ ☐ Check Box If Not A PDP Member

AGD Mastership: ☐ Yes ☐ No

AGD Fellowship: ☐ Yes ☐ No Date: _____

Please Check One: ☐ General Practitioner ☐ Specialist ☐ Dental Hygienist ☐ Other

FOR OFFICE USE ONLY

Evaluation - Dental Record Keeping 5th Edition

Providing dentists with the opportunity for continuing dental education is an essential part of MetLife's commitment to helping dentists improve the oral health of their patients through education. You can help in this effort by providing feedback regarding the continuing education offering you have just completed.

Please respond to the statements below by checking the appropriate box, using the scale on the right.

	1 = POOR 1	2	3	4	5 = Excellent 5	
1. How well did this course meet its stated educational objectives?	☐	☐	☐	☐	☐	
2. How would you rate the quality of the content?	☐	☐	☐	☐	☐	
3. Please rate the effectiveness of the author.	☐	☐	☐	☐	☐	
4. Please rate the written materials and visual aids used.	☐	☐	☐	☐	☐	
5. The use of evidence-based dentistry on the topic when applicable.	☐	☐	☐	☐	☐	☐ N/A
6. How relevant was the course material to your practice?	☐	☐	☐	☐	☐	
7. The extent to which the course enhanced your current knowledge or skill?	☐	☐	☐	☐	☐	
8. The level to which your personal objectives were satisfied.	☐	☐	☐	☐	☐	
9. Please rate the administrative arrangements for this course.	☐	☐	☐	☐	☐	

10. How likely are you to recommend MetLife's CE program to a friend or colleague? *(please circle one number below:)*

10	9	8	7	6	5	4	3	2	1	0
extremely likely					neutral					not likely at all

What is the primary reason for your 0-10 recommendation rating above?

11. Please identify future topics that you would like to see:

Thank you for your time and feedback.

MetLife

To complete the program traditionally, please mail your post test and registration/evaluation form to:
MetLife Dental Quality Initiatives Program | 501 US Highway 22 | Bridgewater, NJ 08807