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drcharlesblair and Associates

Dental Documentation With Confidence

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2024

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Thank you for purchasing Practice Booster's Dental Documentation With Confidence: The "Go-To" Documentation Guide for the Clinical Team (2024 Edition). We trust you will find this to be an invaluable resource for your practice!

> ***It is important for your practice to not only purchase updated coding resources annually, but to also review the entire CDT code set. In addition to the new, revised, and deleted codes for CDT 2024, each CDT code in this publication has been reviewed and updated to provide you with the most up-to-date information possible to assist you and your dental team in maintaining coding compliance. This publication is current through December 31, 2024.***

ACCESS ONLINE BONUS CONTENT (INCLUDING SOAP NOTE TEMPLATE) NOW:

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Note: This password is for the 2024 edition only, valid January 1 to December 31, 2024.

ATTENTION DOCTOR:

We hope you will review and refer to this publication often. The treating doctor listed on the dental or medical claim form is responsible for all information submitted on the claim, including but not limited to procedure codes, diagnoses codes, and narratives. This is true even if the treating doctor is an employee of the practice. Additionally, the team member primarily responsible for billing and/or the office manager responsible for training could be held accountable as well. It is the responsibility of the practice owner to invest in proper training and coding resources for the team. Develop written protocols and documentation of training for compliance. Lack of investment in training and resources can be problematic for a practice. We recommend this Guide be used for new and existing team member training annually.

Table of Contents

Documentation is the cornerstone for keeping you in compliance and maximizing legitimate reimbursement.

CHAPTER TWO

Proper Documentation

Elements of Proper Chart Notes

The importance of complete and legible chart notes has been established. Now, let us review the essential elements of a chart note. Every chart entry must be signed and dated by the doctor or associate provider rendering treatment. In addition, any team member(s) assisting the doctor or hygienist in treating the patient should also be listed in the chart note. If the treatment is provided by someone other than the doctor, this person should write the chart note, sign, and date it. The doctor will then need to review the chart note, sign, and date as well. This proves the doctor is aware of all treatment provided to the patient.

Additionally, there should be as much continuity and standardization between all doctors and team members in the office as possible. The use of common dental abbreviations is allowed. However, since abbreviations will vary slightly from one practice to another, abbreviation meanings need to be consistent in every record. Provide a "key" to the abbreviations used in the practice to ensure all team members utilize the same abbreviations and understand what they mean, so anyone writing or reading a record is familiar with what is being conveyed. The abbreviation "key" should be placed in all operatories for easy access. Be certain all patient records contain consistent and accurate information. This key will help all team members (past, present, and future) function appropriately in maintaining the legal record.

Paper chart notes must be free from scribbles and whiteout errors. If errors are made, draw a thin single line through the error (in ink pen), date and initial, and add the correction. Notations should be written without blank lines or large spaces between the entries. This prevents notes from being added at a later time.

Corrections in computerized formats will vary according to the dental software. Most will "lock" the data and will only allow amendments. These amendments should contain any additional information or corrections with a notation marking them as a revision or correction and refer back to the original note.

Chart Notes Should Include (but are not limited to):

- Date and description of evaluation
- Reason for ordering radiographs and which radiographs are requested
- Reason for ordering intraoral or extraoral 2D photographic images and which images are requested
- A notation stating the radiographs or images were reviewed by the provider
- Date and description of all radiographs, diagnostic casts (study models), and periodontal charting
- Date and description of treatment or services rendered
- Date and description of treatment complications
- Date, name of, quantity of, and strength of all drugs dispensed, administered, or prescribed and refills (if applicable)

CHAPTER FIVE

SOAP Note and PARQ Methods

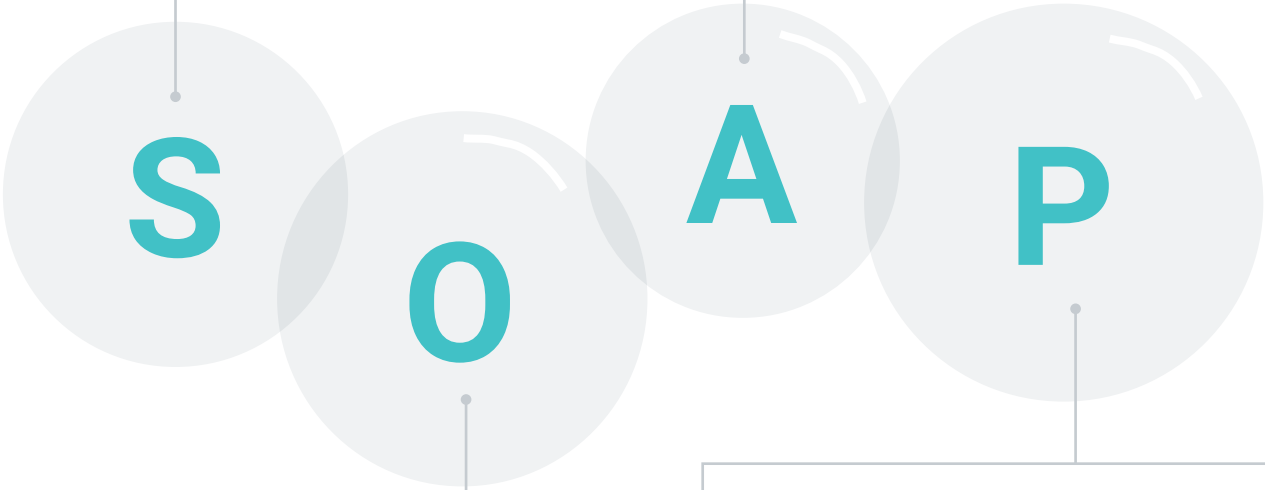
A common method of documentation employed by many healthcare providers is using the SOAP method, which is an acronym for subjective, objective, assessment, and plan. This is a great way to ensure all elements of proper chart notes are included. The four components of a SOAP note are:

Subjective

A brief statement of the patient's purpose for the office visit or a description, location, and duration of symptoms quoted in the patient's own words. This is also known as the chief complaint and includes reviewing/updating medical history. These are things the patient tells you.

Assessment

The diagnosis(ses) of the patient's condition based upon subjective and objective findings.



Objective

Unbiased observations by the doctor and dental team members which include the patient's vital signs (blood pressure, pulse, respiration) and any results of examinations (e.g., perio readings, what is seen on any radiographs taken, etc.). Basically, the facts that can be seen, heard, felt, measured, touched, and smelled.

Plan

The proposed, unique, treatment plan addressing the patient's problem(s). Be specific. For example, "caries" is too general of a diagnosis. Instead, each separate tooth (as well as each surface on each tooth) that is carious should be listed. This should also include the discussion with the patient regarding their condition as well as their decision regarding treatment (i.e., when the patient plans to proceed with treatment, if the patient has been referred to another provider for treatment, or if the patient has declined treatment).

CHAPTER FOUR

The Importance of Images

A picture is worth a thousand words

Many patients are expressing heightened awareness and concern regarding the taking of dental radiographs due to widespread internet access and media attention regarding potential harmful effects of radiation. Justified or not, dental teams need to be aware of and be able to respond to patients' concerns so that they both accept and value radiographs as a meaningful and necessary diagnostic tool.

Payors often limit the number or type of radiographs paid for each benefit year. Refunds are required if an audit reveals radiographs were taken unnecessarily, if the radiographs do not meet the recognized quality standard, or if the dentist never specifically ordered or read them (as noted in the dental record).

The American Dental Association (ADA), in cooperation with the Food and Drug Administration (FDA), established guidelines for the exposure to dental radiographs in 1987 (with subsequent revisions in 2004) and made recommendations subject to the dentist's clinical judgment on best practice regarding the approach of diagnostic imaging on an individual patient basis. The dentist must use professional judgment, a thorough clinical evaluation, consider multiple risk factors, and review the patient's health history to determine the best use of diagnostic imaging for each patient Treatment recommendations, including radiographs, should not be dependent on frequency limitations of insurance plans, but rather based on medical necessity. The doctor should prescribe radiographs based on need, not reimbursement. Never write "Pt. was not due for radiographs" in the chart notes, as it implies treatment based on frequency, not medical necessity.

Because every precaution should be taken to minimize radiation exposure, protective thyroid collars and aprons should be used whenever possible. This practice is strongly recommended for children, women of childbearing age, and pregnant women.

Dental practitioners use radiographic images for a variety of purposes. Radiographs can help identify caries in a tooth or provide the location of an impacted tooth that needs to be extracted. Depending on the purpose of the radiograph, the dental practitioner may choose to utilize one of the two major categories of dental radiographs: intraoral or extraoral.

An intraoral radiograph utilizes a film or sensor positioned inside the mouth during image capture. On the contrary, with extraoral images, the film or sensor is positioned outside of the mouth during image capture.

Intraoral Radiographs

Intraoral radiographs are the most common type of dental radiographic image because they provide significant detail. Among other things, these radiographic images allow the dentist to identify caries, check the health of the tooth root(s) and the bone surrounding the tooth/teeth, determine the status of developing teeth, and monitor the general health of the teeth and other hard tissue structures.

The advent of tomosynthesis as a diagnostic tool in dentistry will further add to the clinician's

Recommendations for Prescribing Dental Radiographs

Type of Encounter	Patient Age and Dental Developmental Stage				
	Child with Primary Dentition (prior to eruption of first permanent tooth)	**Child with Transitional Dentition (after eruption of first permanent tooth)**	**Adolescent with Permanent Dentition (prior to eruption of third molars)**	**Adult, Dentate or Partially Edentulous**	**Adult, Edentulous**
New Patient* being evaluated for oral diseases	Individualized radiographic exam consisting of selected periapical/ occlusal views and/or posterior bitewings if proximal surfaces cannot be visualized or probed. Patients without evidence of disease and with open proximal contacts may not require a radiographic exam at this time.	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images.	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images. A full mouth intraoral radiographic exam is preferred when the patient has clinical evidence of generalized oral disease or a history of extensive dental treatment.		Individualized radiographic exam, based on clinical signs and symptoms.
Recare Patient* with clinical caries or at increased risk for caries**	Posterior bitewing exam at 6-12 month intervals if proximal surfaces cannot be examined visually or with a probe.			Posterior bitewing exam at 6-18 month intervals.	Not applicable.
Recare Patient* with no clinical caries and not at increased risk for caries**	Posterior bitewing exam at 12-24 month intervals if proximal surfaces cannot be examined visually or with a probe.		Posterior bitewing exam at 18-36 month intervals.	Posterior bitewing exam at 24-36 month intervals.	Not applicable.
Recare Patient* with periodontal disease	Clinical judgment as to the need for and type of radiographic images for the evaluation of periodontal disease. Imaging may consist of, but is not limited to, selected bitewing and/or periapical images of areas where periodontal disease (other than nonspecific gingivitis) can be demonstrated clinically.				Not applicable.
Patient (New and Recare) for monitoring of dentofacial growth and development, and/or assessment of dental/ skeletal relationships	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development or assessment of dental and skeletal relationships.		Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development, or assessment of dental and skeletal relationships. Panoramic or periapical exam to assess developing third molars.	Usually not indicated for monitoring of growth and development. Clinical judgment as to the need for and type of radiographic image for evaluation of dental and skeletal relationships.	
Patient with other circumstances including, but not limited to, proposed or existing implants, other dental and craniofacial pathoses, restorative/ endodontic needs, treated periodontal disease and caries remineralization	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of these conditions.				

CHAPTER SEVEN

Patient Records and Records Retention

Record retention guidelines vary widely, depending on the state in which you practice. Before destroying or discarding patient records and/or business records, it is important to review your state laws and consult with your accountant regarding financial record retention, as well as to check with your state dental board regarding rules for patient record retention. To follow are some general guidelines. Any patient information committed to paper must be shredded before discarding.

Patient Records

Requirements for the length of time required for retaining patient records varies widely by state. Most states require doctors to retain records for at least six years from the date of the patient's last appointment. However, be aware that some states require doctors to retain patient records for a longer period of time (seven to ten years). Records for minors are usually retained for at least six years beyond reaching the age of 18. Doctors should verify their state's dental regulations and if the state has no patient records retention directive, then they should reach out to their malpractice carrier for direction. Additionally, once the mandated time frame expires, it is up to the provider to decide how long to retain patient records. Federal programs, such as Medicare, also have record retention policies that must be followed.

Patient requests for records and/or radiographs should be in writing with specific instructions on where to send the records. Some states allow a copying fee (usually reasonable costs, not exceeding actual costs, incurred by the dental office for providing these copies) to be charged to the patient. Keep in mind, however, that the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule does not allow Covered Entities to charge a fee for retrieving records. The amount doctors are allowed to charge for copying records also varies widely from state to state and is often updated to reflect inflation. You should also be aware of your state regulations regarding the time frame for providing the requested information.

Doctors may not withhold patient records due to an outstanding balance on a patient's account as this is a violation of the HIPAA Privacy Rule. Before withholding patient records, it is best to check with your state licensing board to ensure you are in compliance with state law and not at risk of losing your license. In addition, withholding records due to an outstanding balance on a patient's account violates the ADA's Code of Ethics, found at *www.ada.org/en/about-the-ada/principles-of-ethics-code-of-professional-conduct*

S.O.A.P. Notes

To recap, SOAP stands for:

- **Subjective** — Chief complaint and any other information provided by the patient.
- **Objective** — Data that you collect through observation and testing.
- **Assessment** —Differential diagnosis, including the evidence behind the decision.
- **Plan** — The treatment plan, including options available to the patient.

Basic Template:

Disclaimer: This template serves solely as a guide and may not include all information applicable to every procedural charting. This template does not serve as legal advice. If you are in need of legal counsel, be sure to contact a licensed healthcare attorney.

Use the relevant sections of this template and remove the rest. This template is a guide and may not include all information applicable to every procedural charting. Add appropriate information as needed. As always, be as thorough as possible. Including more information is always better than leaving things out.

S.O.A.P. NOTE BASIC TEMPLATE

Date: _____ **Start Time:** _____ **Stop Time:** _____ **Dr:** _____

SUBJECTIVE FINDINGS — S

Reason For Visit/Chief Complaint:

Medical History:

Dental History:

Social History:

OBJECTIVE FINDINGS — O

Vitals:

BP: _____
Pulse: _____
Temp: _____
Blood Glucose Level: _____

Clinical Exam

Radiographs:

Extraoral Exam:

Intraoral Exam:

ASSESSMENT — A

Periodontal Condition:

Hard tissue condition:

PLAN — P

Treatment rendered today:

Rx:

Next visit:

Assistant:
Treating Dentist:

CHAPTER ELEVEN

Additional Documentation for Dental Practices

Between the Drug Enforcement Administration (DEA), state-specific licenses and permits, memberships, and Human Resources (HR) to-dos, keeping all of it straight is a job in itself. While some states require a dental assistant to be licensed, some do not. Some states have expanded functions for dental assistants and hygienists, some do not. Knowing when to pay dues, report continuing education credits, and other administrative tasks is key to dental practice operations.

Employee records management is critical in and of itself. There are several requirements each practice needs to maintain employee records. ***In most states, employee files must be kept for a period of 30 years past the last day of employment***. As always, best practice is to consult with an employment attorney in your state to ensure you are in compliance.

The following is a suggested checklist of records required for a dental practice.

Required Documentation for Dental Practices

Dentist

- Dental License-Every two years
- DEA-State specific
- Required amount of CE credits for licensure
- Malpractice Insurance (annually, unless otherwise noted)
- Cardiopulmonary Resuscitation (CPR) Training
- Membership Dues
  - ADA/AGD
  - Study Clubs
  - Local Dental Association

Dental Assistants

- Radiology permit/license, where applicable
- Expanded Functions permit/license, where applicable
- Infection Control permit/license, where applicable
- Nitrous Oxide permit, if renewable
- Cardiopulmonary Resuscitation (CPR) Training
- Required amount of CE credits for licensure/ DANB/DAANCE

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Page numbers in bold reflect the most pertinent information.

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Thank you for purchasing *Practice Booster's Dental Documentation with Confidence* (2024 Edition). We trust you will find this to be a valuable resource for your entire dental team!

To provide you with the most up-to-date and accurate information available, your purchase also includes additional online bonus printable content.

Dental Documentation With Confidence

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- Caries Risk Assessment
- Staging & Grading for Periodontitis
- Dental Radiographs Types & Usage
- Do Your Lines Cross Radiographically Speaking
- Artificial Intelligence Use Among Dental Payors May Require Medical Coding
- State Laws for Patient Record Retention (Clickable Map!)
- Medical Billing for CBCT
- Utilization Review vs. Focused Review
- HIPAA Checklist
- OSHA & Infection Control Checklist
- Office Maintenance Checklist

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Practice Booster has created yet another guide to dental practice excellence with ***Dental Documentation With Confidence!***

Proper documentation is absolutely essential in today's dental profession. Compiling patient information with quality and sound clinical chart notes is essential for today's dental professionals. Training your team to construct detailed chart notes and providing resources from the experts has never been more important. ***Dental Documentation With Confidence*** is a priceless tool written specifically with the clinical team in mind!

No matter your experience level, this is a must-have for every practice! This exceptional resource not only explains why documentation is so important, but also uses the Scenario Based Teaching Method to eliminate confusion, stay in compliance, and maximize legitimate reimbursement. With procedure specific charting samples, your team will have researched and proven examples of successful documentation. Convenient, and easy to read, this guide will equip your team with everything they need to document with confidence!

Meet the Experts

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"Dr. Blair and his team are fantastic!"

— DEBBIE, OFFICE MANAGER

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