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You Protect Your Patient Records, *But Are Your Records Protecting You?*

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Patient records. As dentists, we all keep them and understand their importance, but are your records good enough? Would they help you or hurt you in a malpractice situation?

The role of records in a dental malpractice case is critical to building a proper defense for any dentist. Without proper documentation, the risk increases on two fronts, the pending civil case and the Colorado Dental Board.

The dental record, hard-copy or electronic, is all about factual "story telling" and how well the story is being told accurately from the beginning to the end by the dentist/staff. A well-documented set of patient records means less recollection by the dentist of what happened during the patient visit. It is based on the actual event(s) at the time, which helps build a strong defense.

The story should be told so not just you, as the dentist, can understand it. It should be understandable by individuals like your attorney, your malpractice carrier, the patient's attorney, the dental insurance company and the Colorado Dental Board.

The Colorado Dental Board, being an interested party, requires the dentist to be responsible for making essential entries. You may be in violation of the Dental Practice Act of Colorado under C.R.S. § 12-35-129(z) if you fail to do so. Telling a good, complete and accurate story will avoid that risk.

The dentist has the responsibility for how the records are documented by any staff member and needs to ensure that staff members are adequately trained to make acceptable patient record entries. Be sure to check all entries for accuracy and content before signing off on them.

The following "Recordkeeping Checklist" is provided for informational purposes to help determine how and what content should be included as part of the "story" about your patient's dental visit. As a preventive measure, The Dentists Professional Liability Trust of Colorado recommends that you periodically review your record keeping protocol.

1. Date and time of appointment (month/date/year/time)
2. Clinical findings
3. Chief complaint of the patient
4. Radiographs and findings, type and number taken
5. Diagnostic tests and results
6. Diagnosis
7. Treatment plan to be rendered (expand fully)
8. Use standard abbreviations
9. How the treatment was rendered
10. Local anesthesia – site, type and dose
11. Post-operative instructions
12. Medications prescribed and how to be taken
13. Treatment refused
14. Patient comments
15. Treatment accepted
16. Failed appointments
17. Lack of following directions
18. Non-compliance by the patient
19. Limitations of treatment
20. Risks of treatment
21. Risks of not having treatment
22. Future treatment that may be required
23. Name of the doctor to whom the patient was referred
24. A copy of the referral sheet
25. Signature for refused recommendations
26. Informed consent documents
27. Discussion topics
28. Drawings or pictures used in describing treatment or clarifying treatment
29. Estimated expenses for the patient
30. Medication reactions
31. Copy of all informational letter(s) regarding the consultation
32. Corroborating notes by your auxiliary with signature or initials
33. Avoid using vernacular
34. Use accepted dental and medical terminology
35. Record oral orders
36. Denture approval
37. Adverse patient attitude
38. All existing restorations and missing teeth
39. Foreign bodies found
40. Inadvertent mishaps during treatment and the advising of the patient (broken file, root tip, etc.). Be complete
41. All patient letters, e-mails or text messages received
42. Materials used

43. Home care instructions and pamphlets
44. Laboratory prescriptions
45. All telephone calls regarding the patient's treatment. Record if no answer or left message
46. Telephone calls received at home or cell phone from a patient
47. Patient's method of payment
48. Complete medical history
49. Complete dental history
50. Allergy to metals
51. Allergy to acrylics
52. Allergy to latex
53. Allergy to vinyl
54. Herbal medicines
55. Supplements
56. Nitrous Oxide administration/ monitoring details
57. Patient behavior and management

What Not to Put in the Progress Notes

The progress notes will be reflecting the detailed "story" of what went on at the patient's visit to your office. If, based on the events that took place with your patient, you or your staff has some personal thoughts, reactions or emotional feelings, you should not let those become words that end up in the progress notes.

You can, however, record those thoughts in a separate file of "doctor's notes," which would be separate from the patient file/progress notes.

Keep any collection calls and follow-up in a log separate from the dental record if you want to keep track of them.

What is a Patient Entitled to?

A request for records can come from several sources: the patient, another dentist, or another person or entity. The patient is entitled, under the Dental Practice Act of Colorado, to receive a copy of their dental record – the entire record. (However, the exception would be your personal "doctor's notes.") You may wish to use a Records Release signed by the patient or provide the information at the verbal request of the patient. Records may not be withheld for past due fees relating to dental treatment (Rule VII, G).

Should the patient request records be sent or if another dentist requests records, then you must get a release signed by the patient that will authorize you to send the indicated information to the third party. Only that information should be sent.

Dentists also get requests from other third parties (i.e. attorneys). Any request for records needs to be accompanied by the HIPAA compliant release signed by the patient. The release will, again, tell you what you are authorized to release.

The question often arises about what to do about the patient who has "20" years worth of records. Do you have to send them all? If the patient's file is robust, contact the requesting party to let them know the extent of the record and find out what they want to receive. Document this action, and send the records with a cover letter that recaps the contact and what is being included as requested.

What Can be Subpoenaed?

The entire record or portions of the record can be required to be produced under a subpoena.

Radiographs, Photographs, Casts and Explanation of Benefits (EOBs)

X-rays are part of the patient record and should be handled as such. Casts and photographs are technically part of the record but some common sense is needed here as far as retention goes. One way of managing casts is to take digital photographs from various views articulated and not articulated to preserve them in an electronic format.

Retaining the casts/images of casts for complex patients and/or complex treatment may be wise, however, especially if the records have been requested earlier or your comfort level and instincts tell you that this may be something that could progress forward.

Retention of EOBs may also vary with your comfort level. Since these are documents retained by the insurance company, your office may decide to retain two years and discard as the third year approaches. Copies can be requested from the insurance company if needed.

Doctor's notes are your personal property and are not discoverable. However, from a risk management perspective, be sure to keep these notes in a separate file for each patient and away from the patient's record.

Record Retention

The Dental Practice Act of Colorado addresses record retention under its Record Retention Policy (Rule VII) which states:

A. Records for minors shall be kept for a minimum of seven (7) years

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after the patient reaches the age of majority (age 18).

B. Records for adult patients shall be kept for a minimum of seven (7) years after the last date of dental treatment or examination, whichever occurs at the latest date.

From a risk management perspective, it is suggested (by the Trust) that you retain records for a longer period of time for "complex" patients or complex treatment, or the combination of both.

Closing the Office Permanently

With some frequency, retiring dentists are choosing to close their offices and wanting to bring closure to their practice careers. Here are some suggestions to limit the risk of abandonment and give due consideration to your patients.

If you firmly decide to not sell the practice (equipment and records), consider working to get a local dentist to at least purchase the records, even for just one dollar. To validate the transaction, put together a letter of understanding between the two parties reflecting the decision on the records. Add as part of the language that you have access to the records for litigation purposes and if the records are going to be purged in accordance with the Colorado Dental Practice Act that, if possible, you be contacted for your agreement. After securing the future care of your patient records, closure can now be finalized.

To officially close your practice, place an ad in the local newspaper and run it at least three times announcing the closure and that Dr. (Jones) has agreed to continue the treatment of your patients. State that all records have transferred to the new office, and provide that location and telephone number.

Lastly, but importantly, give a note of thanks to your many loyal patients, telling them that it was your pleasure to be their dentist.

Information provided by: The Dentists Professional Liability Trust of Colorado, a totally self-insured trust endorsed by the Colorado Dental Association and supported by the contributions paid by the participating dentists. It was formed in 1987 by dentists and is managed by a board of member dentists representing the CDA component societies. The Trust is dedicated to the reduction of risk through continuing dental education. It is administered by Berkley Risk Services.