

To Review

In the February 2002 issue, we reprinted Part I of Dr. Gayle V. Nelson's pair of articles about record keeping in pediatric dentistry. Originally printed in *Pediatric Dentistry*^{1,2,3} the concepts of proper charting and documentation presented by Dr. Nelson are still required in today's practices. Even in the offices that profess to be "paperless," the techniques of charting and the details of record keeping included in these articles are pertinent.

American Board News Records, charting and problem areas in documentation: Part II

Failures in the clinical site visit section of the American Board of Pediatric Dentistry often can be traced to weaknesses in the areas of records, charting and documentation. This article, the second in a two-part presentation, outlines flaws that are evident in patient's records from both the academic and private-practice settings.

The American Board of Pediatric Dentistry endorses guidelines previously established by the American Academy of Pediatric Dentistry which include those applicable to the topics mentioned in this article.

The Developing Occlusion

Pediatric dentists may be managing malocclusions in the primary, mixed, and permanent dentitions. In reviewing charts of patients who are being managed actively for growth and development, examiners of the American Board of Pediatric Dentistry have sometimes noted an absence of follow-up preventive recall visits. Occasionally, recall visits for these children appear to be on an unstructured basis, and only an alert staff member will recall that it has been an extended period of time since the patient was seen for a recall visit.

All pediatric dental services should be documented carefully. Furthermore, if the candidate is offering orthodontic care, the findings, cases analysis—including treatment objectives and treatment rendered—as well as post treatment evaluations, should be recorded accurately.

An orthodontic form should be developed by the candidate to ensure that comprehensive records are maintained (samples are available from orthodontic supply houses). One such chart quickly and clearly shows procedures used, elastic usage, next-

appointment procedures, etc., in individual columns so that information can be retrieved at a glance—without the need to laboriously read through the treatment plan and to determine the extent of completed treatment. A chart must have a ready reminder of the next preventive recall visit, and staff members should look for that date each time another appointment is scheduled. In practices that attempt to integrate pediatric dental and orthodontic treatment, preventive pediatric dental care must continue to be emphasized.

The orthodontic treatment records should include diagnostic information, treatment objective, estimates of treatment times, potential problems, and a sequential treatment plan. Occasionally, the clinical site visit reveals a candidate who cannot interpret diagnostic findings from the patient's records. Failure to indicate the relationship between a cephalometric analysis and treatment objectives is an example of this.

Candidates must document the appliance treatment plan, objective of the treatment, and a time estimate for that particular phase of treatment. Records should show where the candidate started and where the candidate finished. The candidate should conduct a retrospective assessment of the orthodontic results—a quality assurance approach to treatment. Are the results in line with the "keys to the occlusion", which have been discussed thoroughly in orthodontic literature, and are the objectives established at the diagnostic visit?

The treatment mechanics must be in keeping with a supportable standard of care. If not, the documents in the charts should show that the various treatment plans were discussed with the parents, and that the parents opted for a compromised plan and subsequent compromised results. For instance, upper and lower first phase banding and bracketing were recommended, but the parents chose a less desirable course of treatment.

A space should be provided on the orthodontic form for recording the date of the next periodic preventive visit. The staff members should ensure that a recall visit has been scheduled.

A chart should be developed which highlights individual items that need to be recorded at the periodic preventive examinations. A sequential treatment plan also is necessary. The chart should dictate the standard of care that the candidate wants to achieve.

TMJ Concerns

Perhaps the best approach to determine TMJ problems with pediatric patients is to question the parent about whether a child has recurrent headaches. Using a TMJ questionnaire will demonstrate to the parent the practitioner's concern, and it will remind the candidate to follow up on responses that may indicate TMJ problems.

Maintaining Radiographic Records

A candidate at a clinical site visit should be able to show how many dental radiographic exposures have been taken. Tracking a record of dental radiographs of each child patient is an important form of quality assurance. This record includes all radiographs that have been re-taken for each patient. The records in the charts will supply a data base for each child. A separate list provides a record of quality assurance for the office.

Radiographs should be mounted sequentially, either on acetate sheets or by using a punch-out mount. Both systems allow the pediatric dentist to view instantly the past and present needs of the patient. Besides being cost effective, these mounting systems provide a convenient aid to assess the sequence of findings and treatment. A statement about the radiographic findings should be entered routinely in the chart to document that they have been examined for diagnosis. Proper handling of radiographs should include a "log" of the date, type, number, KVP, and ma of film in a separate sheet.

Radiographs should not be hidden in envelopes that prohibit convenient periodic review. Punched mounts on card stock paper or acetate adhesive tape mounts are economical and provide a convenient review of sequential patient treatment.

The radiographs should be readily available in an inside pocket of the chart. Such pockets are available commercially. As an alternative, the chart can have a pocket that occupies the entire inside left front cover. This chart folder design may be more expensive, but it keeps items in the pocket from falling out easily. This type of chart jacket also holds larger items, such as slide pages and panoramic radiographs. Some practitioners object to the expense of these chart folders, because this investment becomes dormant when a patient becomes inactive. One suggestion for dealing with that objection is to transfer the inactive patient records to a less expensive manila file folder; the more expensive jacket then can be reused for active patients.

The Services-Rendered Sheet (Progress Notes)

A record of patient care should be on file in one uniform position within the chart. Data about patient recall visits, orthodontic treatment, sequential procedures used with trauma cases, and information pertaining to sedation dosage and monitoring can be maintained on supplemental special sheets within the chart.

The use of an "S-O-A-P" format, widely accepted throughout medical/dental groups, promotes consistency. Also, problem-treatment-evaluation-next visit (PTEN) may be used by office staff to ensure a uniform approach to patient care.

Essential information that should be entered on patient charts includes: date, plaque score, child and parent behavior, and sedations. A supplemental sheet for sedation details can be placed in the back of the chart along with information on the teeth involved, amount of anesthetic solution used (by cc or mg - not rounded off to the nearest carpule), brand name of materials used, fee, and a notation about the planned treatment for the next visit (including the proposed length of time before the patient's next visit).

All entries should be initialed by the staff member making the entry. In an office complex, where many doctors treat a single child, the initials of the appropriate doctor must be placed on each individual entry. Ideally, the doctor should initial all entries.

All notations in the patient records must be legible. If the handwritten entry is not legible, it can become a liability. Some offices use a dictation system effectively and economically for chart documentation.

Special Considerations

Patient charts containing medical alerts should receive special attention. These records should be "flagged" with prominent wording or symbols. Misplacing charts can interfere significantly with office efficiency and patient care. Filing charts by a color-coded system can help ensure that the patient's records will be readily available.

It is recommended that no service be performed on any child patient until the parent has reviewed a written explanation of the proposed treatment and a fee estimate. These items also should be recorded in the chart. Conversation with a parent about unusual perspectives or out-of-the-ordinary occurrences must be entered in the chart.

Entries into the chart should include: the child's behavior, description of restraints (if used), the number of radiographic exposures (including retakes), plaque scores, medicaments used, and the proposed treatment for the next appointment. All entries should be dated and written in pen or typed. Errors should be crossed out with a single line and the word error written above the line.

Processing Insurance Forms

Patient care records should not be integrated with payment records. The business office should have a file of various insurance forms and universal ADA claim forms. Financial entries are made on the patient's ledger. If a payment is received from a welfare agency or other third-party carriers, the appropriate entry should be recorded on the ledger.

In the event of a disagreement concerning the remittance

from a third-party carrier, copies of the correspondence should be attached to the insurance form and place in a pending file—not in the patient's chart.

Computers

The office is divided into an accounting section and a patient-care section. This division of functions should remain. Keeping insurance forms separate from the charts enables the staff to find important items more efficiently. If the office is computerized, the computer should be used for business functions, but charts should be used for tracking patient care.

Computers and software that perform accounting functions reliably and economically are available. If the candidate wants to track the orthodontic cases, pulpotomies, composites, sedation results, material performance, etc., for research purposes, it would be wise to buy a separate personal computer and/or a separate database program. In the long run this system will be more economical than placing all patient care and accounting records in one program.

Comment

The clinical site visit examination is offered after the other three sections of the certification process have been passed. A candidate is eligible for the clinical site visit after five years in the specialty (i.e., three years after completion of the two-year postdoctoral program). This delay is to ensure through examination that high standards of care are maintained.

Sustained documentation of the diagnosis and treatment of child patients is mandatory to ensure the proper standard of care. Consideration of the legal defensive aspects of pediatric dentistry should be secondary to the primary goal of providing appropriate care.

Editor's Notes

In the section, "Special Considerations," in which Dr. Nelson mentions error correction, please emphasize to staff that the comment, "Errors should be crossed out with a single line and the word error written above the line," is accurate. Never use whiteout on a chart. Once the incorrect data is lined through, the correct notes should follow closely.

In the sections, "Processing Insurance Forms" and "Computers," the reader must realize that about 90% to 95% of practices are now computerized and adjust Dr. Nelson's comments accordingly. As he states, patient care records (i.e. the charts themselves) should not be used for financial records, insurance claim forms and various other business data.

However, most offices are now tracking patient care by computer. Current software programs encompass health history data, case diagnosis, treatment delivery notes, imaging systems, subsequent appointment dates, etc., in ad-

dition to third party payer information, account data, and contracted payment plans. One program may maintain all this information, plus supply inventory records and personnel administration data. With vast advances in technology, record keeping and documentation can be processed differently, but the basics of the type and scope of information which must be included, remains the same as Dr. Nelson indicated.

It is also noteworthy to remember that in this age of unlimited technology, some patient records are stored on microfilm or in a computer file only as well as traditionally in files of paper charts. These facts may cause one to wonder, "Are these records (computerized or on microfilm) admissible in court?" Additionally, the question is often asked, "How long must records for pediatric dental patients be maintained." For years, the "rule" was to maintain pediatric dental patient records until the patient was at least 28 years old. Upon inquiry in February 2002, the American Dental Association legal division personnel stated that all matters pertaining to patient records are mandated by individual states. Therefore, it is advisable to check with an attorney in your state for an answer to these and other questions regarding patient records.

Oral Health America

An Associated Press news report (January 2002) in my local newspaper prompted a search of the Web site for Oral Health America, www.oralhealthamerica.org. Oral Health America is a non-profit advocacy group working to interest and educate the general public about the importance of oral health and the scope of preventive measures now available to improve Americans' dental health. The task force works in tandem with the U.S. Surgeon General's office and a number of other government agencies.

The work of this group is exciting, but disheartening. Two years after the Surgeon General labeled Americans' poor oral health "a silent epidemic," the recent findings of Oral Health America, which assessed our population's oral health status state by state, scored the U.S. a "C" on its national "dental report card." Look at some of the statistics:

1. At least 1/3 of Americans fail to see a dentist even once a year.
2. Tooth decay is the most common chronic childhood disease; half of first-graders already have a cavity.
3. Cavities cause an estimated 50 million hours of missed school each year.
4. The biggest problems are (1) access to care and (2) lack of proper preventive services.
5. In 10 states less than 1/2 the population drinks fluoridated water, one of the best ways to prevent tooth decay.

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6. Some 108 million Americans have no dental insurance, more than twice the 40 million without medical insurance.
7. 24% of the elderly have lost all their teeth.
8. Almost 30,000 Americans will get oral cancer this year and 8,000 will die.
2. Most states have hired dental directors to push improvement locally.
3. The government is developing a National Oral Health Plan, with a string of public meetings across the country starting in March 2002 in San Diego, CA.

There are however, small signs of progress:

1. Some states are raising the fees they pay dentists for treating Medicaid patients, key to getting poor children dental care.

Preview

In the next issue we will look at additional information from the Oral Health America report, and begin exploring need and criteria for associate pediatric dentists.

¹ Nelson, GV. American Board News: Guidelines to the prevention of problems in record keeping: Part I. *Pediatr Dent* 11(2): 174-177.

² Nelson, GV. American Board News: Records, charting, and problem areas in documentation: Part I. *Pediatr Dent* 11(3): 240-242.

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