

# Thorough Documentation Equals Financial Security



Proper patient record documentation is an essential component to quality health care and practice success. The more documentation the better when it comes to securing your financial stability with state and federally funded programs. Patient records are legal documents that can be a significant contributing factor in favorable or unfavorable legal judgments against health care professionals. The rules are changing; budget cuts have taken a toll on state and federally funded dental programs for children. It appears that states are looking for new ways to supplement their reduced budgets. Unfortunately, this may put pediatric dental offices at a high risk for chart audits.

In several states, dentists who are Medicaid providers are experiencing audits and have been asked to refund the program thousands of dollars where proper documentation was not found to warrant the services performed. Specifically, the independent auditors hired by the state are looking for patients who came in before the standard six-month time frame for their recare visit without documentation as to why they needed the visit prior to the six-month limit. Another red flag is performing services without taking the necessary dental X-rays that show the evidence of dental disease to support the recommended treatment. Be sure your team is following best practices in their documentation of all patient interactions.

The documentation process is designed to provide medical and dental history, status of a patient's current dental health, recommended treatment, and all communication that takes place between the office and the patient or parent.

## Chart records should include the following:

- Date of visit.
- Reasons for the appointment.
- **SOAP** notes (an acronym for subjective, objective, assessment, and plan).
- Review of dental and medical information.
- Chief reason for the visit or complaint.
- Symptoms.
- Doctor's findings both visible and comprehensive.
- Diagnostic records.
- Recommended treatment.
- Discussion of alternative treatment.
- Pros and cons for all treatment.
- Course of action accepted.
- Consents understood and signed.
- Details of all treatment rendered.
- Next visit.
- Health care provider's signature documenting the treatment.

In addition to the above, an accurate patient accounting ledger and account information is vital to the success of the practice.

## Elements of record keeping for dental professionals:

- General charting.
- Doctor's notes.
- Referral information.
- Initial intake patient record.
- Patient medical and dental history.
- Comprehensive examination.
- Informed consents.
- Treatment findings/diagnosis.
- Progress notes.
- All correspondence.
- Consultations.
- Appointment history.



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## What to know about patient documentation

1. **Do not ever alter a chart.** One of the top reasons health care professionals lose malpractice cases is that the chart was found to be altered. When a doctor tries to insert additional comments and make them appear as contemporaneous to the original entry, it can be discovered. There are ways to determine in software systems as well as hand written charts when entries were made. It is also fairly simple to determine the age of the ink itself and if two different pens were used. Once a chart is discovered to have been altered, the health care professional loses all credibility and is often found in malpractice. If an entry needs amending, it is best to write an addendum that refers back to the original entry.
2. **If something is not recorded in the chart, it never happened.** Health care professionals have an ethical and legal obligation to record all patient information in the chart. If the chart is not written correctly by staff, it is the responsibility of the health care professional to educate staff and correct inaccuracies prior to the completion of the chart note. Forgetfulness is not a desirable trait when it comes to documentation.
3. **Just the facts please.** Patient charts require fact-based information and should not be subject to the opinions or interpretation of others. For instance, "Patient was upset with our office because of the issues with this tooth." Instead write, "Patient stated that her tooth was still bothering her after two weeks and she still couldn't chew on the left side." Another example: "Patient appeared fine and was released to mom and dad," should be written as "Patient's O<sub>2</sub> levels were normal, the bleeding has stopped and patient was alert. Released to the care of the parents. Post-operative instructions were given to mom." Remember that you are trained in your specific health care specialty and are not to make judgments or guesses outside of your realm of expertise.
4. **Handwritten documentation must be legible.** Although people often make fun of doctor's handwriting, it is essential that all record entries are completely legible. You may understand what you are saying but unless everyone can read the same thing from your documentation it can cause a critical error.
5. **Written chart notes.** Do not skip lines or leave white spaces. Also, do not write in the margins or try to shove in your documentation below the last line. Always use permanent ink and do not ever use a white out or error corrector. When an error is made, simply draw one line through the entry and write, 'last entry was written in error. The correct entry is as follows.'
6. **Remember your timeline of events.** Accurate documentation requires a timeline of events as they happen. Do not state that you injected the patient with anesthesia and then reviewed the medical history. It is crucial that each step is documented in the order it was performed.
7. **Every material used and the amounts need to be documented.** It is not enough to state that the patient was given N<sub>2</sub>O and injected with local anesthesia. All percents of N<sub>2</sub>O and length of time on N<sub>2</sub>O along with the type and amount of anesthesia is required.  
Document types of materials and amounts whenever possible and all steps involved. It is not enough to state that a resin-bonded filling was placed when there are several other factors involved; make sure all the steps (etch, isolation, bond, etc.) are all present in the notes as well as the shade and materials used.
8. **Leave out personal comments.** Since the patient chart is a legal document you should never write things like 'patient is always late,' 'high maintenance patient,' 'PITA patient,' or 'patient has helicopter parents' in the chart. Remember: Just the facts. (e.g. "Patient was late for their appointment; this is the fourth documented occurrence that the patient was more than 10 minutes late to their appointment.")
9. **Be careful with abbreviations.** Although many risk-management companies frown upon using abbreviations, many dentists still use them in their documentation. Caution should be used if you intend to utilize abbreviations. Everyone must remain consistent with their use and it has to be an all or nothing approach. When clinicians sign charts and use their initials, they must keep on file what initials belong to whom. It may be difficult five years from now to remember an assistant that worked for you for only two weeks that used the initials JM. Also, no two clinicians should be using the same initials in the chart. It must always be clear who



wrote what and who performed the services in case that person is questioned.

10. **Each person who performs services should be recorded in the chart.** Many times there are multiple people who work on a patient. One person took the X-rays, another person reviewed the medical history with mom, and maybe a third person actually polished the teeth. Each provider should be documented. If the person who took the X-rays signs the chart for all the procedures but she isn't coronal polish certified it will look as if she was working outside of her realm of expertise and therefore causing the office to be noncompliant.
11. **If there is a potential malpractice issue, you will not know about it for a while.** Many times offices are not notified of any malpractice claims or other issues until

months later. Do not expect to remember all the details of a patient visit. Keep your documentation in the chart professional and within the standard of care. However, if you have a patient or parent interaction that you are concerned about, you can also keep a journal of events. For instance, "Dad declared that he was unhappy that he didn't realize that the crowns were going to be silver and he is upset." Talk to each member of the team that had contact with dad and have them write a statement for your records. Contact your liability insurance and explain the situation and take their advice. Often times a proactive measure is your best defense.

12. **Remember, patient records are your responsibility.** It is not your employee's practice or license that is liable, it is yours. Inaccurate or missing information can make or break a health care professional.

**"Accuracy of statement is one of the first elements of truth; inaccuracy is a near kin to falsehood."**

~ Tyrone Edwards

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*It has been Julie's privilege for the last 19 years to help pediatric dental teams around the country "work smarter, not harder" to reduce stress and increase job satisfaction, profits and access to care for children. On Oct 1, 2014 Julie handed the reins over to Lilly Cortes-Pona to lead the Julie Weir Team. Lilly has worked closely with Julie for the last three years and her experience and passion will successfully carry on the quality consulting and legacy of the "Julie Weir Way" that has helped pediatric dentists. Julie will be staying on as a member of the Julie Weir Team and continue to support clients and the mission of the AAPD.*

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