Dental Clinical Policy: Required Patient Record Documentation

Reference Number: CP.DP.43 Coding Implications
Last Review Date: 02/22 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Comprehensive, accurate, and complete patient record documentation forms the foundation of quality dental practice and serves as the basis to establish medical necessity for treatment and benefit eligibility. It serves to capture every element of patient history, existing conditions upon entry to a dental home or practice, diagnosis of all relevant findings of medical and dental disease, comprehensive and alternate treatment plans to address patient needs, and a complete description of treatment rendered. Treatment-related entries must include, but not be limited to, the following: services by specific tooth numbers or letters, quadrant, arch, or other area of treatment; type, brand name, and amounts of restorative material used; type, brand name, location administered, and amounts of anesthetic used; documentation of the results of medical and dental history review at subsequent dental visits; and all other treatment rendered. Each record entry must be signed (not initialed) and dated by the rendering provider.

Policy/Criteria

I. It is the policy of Envolve Dental Inc.® that patient record documentation meets required documentation standards and **medical necessity criteria** when the following elements are included in the patient record:

A. Patient Record Organization

1. Registration data including a complete health history
2. Medical alert predominantly displayed inside chart jacket or in the electronic record
3. Initial examination data
4. Radiographs (labeled and dated)
5. Periodontal and Occlusal status
6. Treatment plan/Alternative treatment plan(s)
7. Progress notes to include diagnosis, preventive services, treatment rendered and medical/dental consultations
8. Miscellaneous items (correspondence, referrals, prescriptions, and clinical laboratory reports)
9. The record must provide the capability of periodic updates, without the loss of documentation of the previous status, which includes the following:
    i. Health history
    ii. Medical alert
    iii. Evaluation and recall data
    iv. Periodontal status
    v. Treatment plan
    vi. All applicable consents for treatment
10. The design of the record must ensure that all permanent components of the record are attached or secured within the record

11. The design of the record must ensure that all components must be readily identified to the specific patient with the patient's name, date, and identification number on each page or entry
12. Each patient must have their own record

B. Content -- The patient record must contain the following:

1. Patient registration information must include the following items:
2. Patient's first and last name
3. Date of birth
4. Gender at birth
5. Preferred pronouns
6. Home address
7. Telephone number
8. Name and telephone number of an emergency contact
9. A complete health history that requires documentation of these items:
    i. Current medical treatment and physician
    ii. Current and past illnesses
    iii. Past surgeries and hospitalizations
    iv. Current medications
    v. Non-neonatal vaccination status
    vi. Drug allergies
    vii. Hematologic disorders
    viii. Cardiovascular disorders
    ix. Respiratory disorders
    x. Endocrine disorders
    xi. Communicable diseases
    xii. Neurologic disorders
    xiii. History of alcohol, illegal/legal drug, and tobacco use (includes smokeless tobacco and vaping)
    xiv. Signature and date by patient
    xv. Signature and date by reviewing dentist (initials are not adequate)
10. Current dental conditions including the following:
    i. Chief complaint for the dental visit
    ii. History of past dental treatment
    iii. Identification and charting of existing and missing teeth
    iv. Identification and charting of existing restorations and appliances
    v. Identification and charting of caries and tooth fractures
    vi. Identification and charting of any attrition, abfraction, abrasion, or erosion
    vii. Periodontal evaluation
    viii. Soft tissue evaluation
    ix. Oral cancer screening
    x. Signature and date by patient
    xi. Signature and date by reviewing dentist (initials are not adequate)
11. An updated health history at each periodic evaluation including the following items:
    i. Any changes in health status

ii. Current medical treatment
iii. Current medications
iv. Signature and date by patient
v. Signature and date by reviewing dentist (initials are not adequate)

12. An updated dental history at each periodic evaluation including the following:
    i. Chief complaint of any dental problems/concerns
    ii. Any changes in dental and oral health status
    iii. Any dental treatment provided by another provider since last visit
    iv. Signature and date by patient
    v. Signature and date by reviewing dentist (initials are not adequate)
13. A conspicuous and prominently placed medical alert **inside** the chart jacket or the electronic record that documents highly significant medical conditions, allergies, etc., including but not limited to the following:
    i. Health problems that may contraindicate certain types of dental treatment
    ii. Health conditions that may require precautions or pre-medication prior to dental treatment (i.e., heart murmur, prosthesis placement)
    iii. Current medications that may contraindicate the use of certain types of drugs, dental materials, or dental treatment
    iv. Drug sensitivities and allergies
    v. Problems with local anesthetics
    vi. Infectious diseases that may endanger personnel or other patients
14. Adequate documentation of the initial clinical examination, which is dated and includes a complete description of any findings in the following areas:
    i. Blood pressure and heart rate
    ii. Head/neck evaluation
    iii. Soft tissue evaluation
    iv. Periodontal evaluation
    v. Occlusion status
    vi. Dentition charting
15. Adequate documentation of the patient's status at each subsequent periodic evaluation, which is dated and includes a complete description of any findings in the following areas:
    i. Review of medical history
    ii. Blood pressure and heart rate
    iii. Head/neck evaluation
    iv. Soft tissue evaluation
    v. Periodontal evaluation
    vi. Dentition charting
12. Radiographic images, which include the following:
    i. Patient name
    ii. Date of image(s)
    iii. Patient's left and right side of dentition identified
    iv. Conventional (developed) intraoral images must be mounted
13. Documentation of the patient's clinical problems/diagnosis, including appropriate ICD-10 diagnosis codes

14. Documentation of a primary treatment plan and any appropriate alternate treatment plans that describe all planned services
15. Specific procedure by code and nomenclature
16. Location in the mouth using area, arch, quadrant, tooth number, and tooth surface
17. Documentation of periodontal status
    i. Periodontal screening when appropriate
    ii. Periodontal pocket depth charting when appropriate
    iii. Furcation classification(s) when present
    iv. Tooth mobility when present
    v. Bleeding upon probing by probing site
    vi. Measurement of recession when present
    vii. Clinical attachment loss measurements when present
    viii. Status of attached gingival tissue
    ix. Identification of missing teeth
18. Documentation of the patient's oral hygiene status and preventive homecare habits
    i. Gingival conditions
    ii. Description of plaque buildup and location(s)
    iii. Description of calculus buildup and location(s)
    iv. Oral hygiene instruction provided
    v. Patient compliance and receptivity to instruction
    vi. Notation of recommended periodic evaluation frequency
    vii. Date of evaluation/instruction
19. Documentation of internal/external medical and dental consultations including the following:
    i. Name of referral provider
    ii. Reason and requested information/recommendation
    iii. Response from referral provider
20. Documentation of treatment rendered, including the following:
    i. Date of service and/or procedure
    ii. Description of service, procedure and observation(s)
    iii. Type, brand name, amount and dosage of anesthetics and medications given or prescribed
    iv. Type and brand name of restorative materials delivered
    v. Location in the mouth using area, arch, quadrant, tooth number, and tooth surface
    vi. Signature of provider rendering the service (initials are not adequate)
21. Documentation of dental laboratory prescriptions, including the following:
    i. Laboratory name
    ii. Date of prescription
    iii. Detailed lab service request
22. Documentation of medical prescriptions, including the following:
    i. Name and phone number of pharmacy if prescription is by telephone
    ii. Name of medication
    iii. Strength of medication
    iv. Number of tablets, capsules, or liquid ounces prescribed

v. Dosage and frequency

23. Documentation of laboratory tests
    i. Test name
    ii. Laboratory used
    iii. Purpose of test
    iv. Reports and results of tests
24. Documentation of referrals to dental or medical specialty care provider including the following:
    i. Name and phone number of specialty care provider
    ii. Reason for referral
    iii. Information and radiographs sent to specialty care provider
25. Documentation of any specialty care performed by another dentist including the following:
    i. Patient evaluation record
    ii. Treatment planned/proposed
    iii. Treatment provided
    iv. Treatment status
    v. Radiographs and reports received from specialty care provider

C. Internal Office Record Keeping Compliance Standards

1. The dental office uses only one specific patient record format
2. Each area within the patient record format is required of all providers and staff for complete documentation of every individual patient's status and care
3. All providers and office staff consistently use each area of the patient record
4. Hand written documentation is legible for any outside reader/evaluator for every entry
5. Patient record entries of symbols and/or abbreviations are uniform, easily interpreted, and commonly used/understood in the practice
6. The dental office maintains and displays a listing of symbols/abbreviations used in patient record keeping

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	2/22	2/22

References

1. Stefanac, S.J. and Nesbit, S.P., *Diagnosis and Treatment Planning in Dentistry, 3rd Edition*, Elsivier, 2017.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of dental practice; peer-reviewed dental/medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national dental and health professional organizations; views of dentists practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. Envolve Dental makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of dental practice current at the time that this clinical policy was approved. "Envolve Dental" means a dental plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Envolve Benefit Options, Inc, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to dental and medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Envolve Dental administrative policies and procedures.

This clinical policy is effective as of the date determined by Envolve Dental. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Envolve Dental retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute dental or medical advice, dental treatment or dental care. It is not intended to dictate to providers how to practice dentistry. Providers are expected to exercise professional dental and medical judgment in providing the most appropriate care, and are solely responsible for the dental and medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating dentist in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom Envolve Dental has no control or right of control. Providers are not agents or employees of Envolve Dental.

 Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members

and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.