Learning Objectives

- Review what organized dentistry says about professional ethics
- Learn what on-line dental record documentation resources are available for dentists and staff
- Understand what the Oklahoma Dental Practice Act requires of documentation within the dental record
- Understand what the Oklahoma Health Care Authority requires in order to document medical necessity within the dental record
- Review examples of dental record documentation
Oklahoma Dental Association

ABOUT THE ODA

OFFICERS
BOARD OF TRUSTEES
STAFF
MEMBERS IN THE NEWS
PRESS ROOM

Our Mission

The Oklahoma Dental Association fosters an awareness of the obligations and responsibilities of the dental profession to society, to help advance the art and science of dentistry, and to promote public health and health services in the State of Oklahoma.

Our Purpose

The purpose of this Association shall be:

- to promote public health and health services in the State of Oklahoma,
- to advance the art and science of dentistry,
- to represent the interest of the members of the dental profession and the public which it serves, and
- to foster an awareness of the obligations and responsibilities of the dental profession to society.
Listed below are the OAGD Values, Mission, and Vision.

The OAGD Values are:

- Excellence in oral health care
- Diversity
- Universal acceptance of the general dentist as the gatekeeper of oral health care
- Continuous life-long learning
- Advocacy/representation
- Teamwork; camaraderie; mentorship
- Ethical, honest and credit behavior

OAGD’s Vision: The vision of the Academy of General Dentistry is to improve the quality of comprehensive dental care. We are motivated and united by the core human values of integrity and compassion.

OAGD’s Mission: The mission of the Academy of General Dentistry is to serve the needs and to represent the interests of general dentists and to foster their continued proficiency through quality continuing dental education to better serve the public.
Principles of:
- Patient Autonomy – self governance
- Nonmaleficence – do no harm
- Beneficence – do good
- Justice – fairness
- Veracity - truthfulness
“Is my dentist ripping me off?”

“Creative Diagnosis – the peddling of unnecessary treatments” – Jeffrey Camm, DMD (pediatric dentist), ADA News, October 21, 2013

“I Have Had Enough” – Gordon J. Christensen, DDS, MSD, PhD, Dentaltown, September 2003

“Overtreatment in the name of esthetic dentistry without total informed consent of patients, primarily for dentist financial gain, is nothing less than overt dishonesty in its worst form.”
Dental Records

Guideline on Record-keeping

Originating Council
Council on Clinical Affairs

Review Council
Council on Clinical Affairs

Adopted
2004

Revised
2007, 2012

Purpose
The American Academy of Pediatric Dentistry (AAPD) recognizes the patient record is an essential component of the delivery of competent and quality oral health care. It serves as an information source for the care provider and patient, as well as any authorized third party. This guideline will assist the practitioner in assimilating and maintaining a comprehensive, uniform, and organized record addressing patient care. However, it is not intended to create a standard of care.

An electronic patient record is becoming more commonplace, and perhaps will become mandatory. Advantages include quality assurance by allowing comparative analysis of groups of patients or providers, medical and dental history profiles for demographic data, support for decision making based on signs and symptoms, administrative management for patient education and recall, and electronic data interchange with other professional and third parties. The software must contain all the essential elements of a traditional paper record.
The recoding of accurate patient information is essential to dentistry. All information in the dental record should be clearly written, signed, and dated. The identify of the practitioner rendering the treatment should be clearly noted in the record. Handwritten entries should be legible. The dentist must secure informed consent before providing care.
Oklahoma Statutes Citationized

Title 59. Professions and Occupations
Chapter 7 - Dentistry
Part 1 - The State Dental Act

Section 328.1 - Short Title - Composition of Act

A. Part 1 of Chapter 7 of this title shall be known and may be cited as the "State Dental Act".
B. All statutes hereinafter enacted and codified in Part 1 of Chapter 7 of this title shall be considered and deemed part of the State Dental Act.


Section 328.2 - Declarations

The practice of dentistry in the State of Oklahoma is hereby declared to affect the public health, safety and general welfare and to be subject to regulation and control in the public's best interest. It is further declared to be a matter of public interest and concern that the dental profession, through advancement and achievement, merits and receives the confidence of the public and that only properly qualified dentists be permitted to practice dentistry and supervise
Section 328.2 – Declarations

- The practice of dentistry in the State of Oklahoma is hereby declared to affect the public health, safety and general welfare and to be subject to regulation and control in the public’s best interest.

- ...further declared to be a matter of public interest and concern that the dental profession...merits and receives confidence of the public...
A. Every dental office or treatment facility...shall maintain written records on each patient treated at the facility...

B. Each licensed dentist shall maintain written records on each patient that shall contain, at a minimum, the following information about the patient:
Health history

Results of clinical examination...including the identification, or lack thereof, of any oral pathology or diseases

Treatment plan proposed by the dentist

Treatment rendered to the patient

Patient records may be kept in an electronic data format...backup is updated on a regular basis, at least weekly...
Grounds for Penalties

- Being dishonest in a material way with a patient
- Failing to retain all patient records for at least 7 years
- Allowing any corporation, organization, group, person...to direct, control or interfere with the dentist’s clinical judgment
- Limit a patient’s right of informed consent
Grounds for Penalties

Solicitation of Patients

- (19) Offering to effect or effecting a division of fees, or agreeing to split or divide a fee for dental services with any person, in exchange for the person bringing or referring a patient;

- (22) Aiding, abetting, or encouraging a dental hygienist employed by the dentist to make use of an oral prophylaxis list, or the calling by telephone or by use of letters transmitted through the mails to solicit patients formerly served in the office of any dentist formerly employing such hygienist;
The federal OIG may impose a penalty, and where authorized, an assessment against any person (including an insurance company in the case of paragraphs (b)(5) and (b)(6) of this section) whom it determines in accordance with this part...

Offers or transfers remuneration to any individual eligible for benefits under Medicare or a State health care program, that such person knows or should know is likely to influence such individual to order or to receive from a particular provider, practitioner or supplier any item or service for which payment may be made, in whole or in part, under Medicare or a State health care program....

42 CFR § 1003.102(b)(13)
OHCA Policies and Rules

Search Entire Policy
OHCA Policies and Rules Main Page

Browse chapters by clicking on the plus sign to the right of each chapter below.

Chapters
- 30-MEDICAL PROVIDERS-FEE FOR SERVICE
  - 3-GENERAL PROVIDER POLICIES
    - 4-EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM/CHILD HEALTH SERVICES
      - 65.8-Dental services

317:30-3-65.8 Dental services

[Revised 09-12-14]
“Through this agreement, the provider certifies all information submitted on claims is accurate and complete, assures that the State Agency’s requirements are met and assures compliance with all applicable Federal and State regulations.”
“...require that the provider retain, for a period of six years, any records necessary to disclose the extent of services the provider...furnishes to recipients...”

“Records in a provider’s office must contain adequate documentation of services rendered. Documentation must include the provider’s signature and credentials.”

“Where reimbursement is based on units of time, it will be necessary that documentation be placed in the member’s record as to the beginning and ending times for the service claimed.”
“All records must be legible. Failure to maintain legible records may result in denial of payment or recoupment of payment for services provided when attempts to obtain transcription of illegible records is unsuccessful or the transcription of illegible records appears to misrepresent the services documented.”

“Electronic records are acceptable as long as they have a secured signature.”
This section provides specific program benefit guidelines related to diagnostic, preventive, and restorative dental services

- **Comprehensive and periodic oral evaluations**
  - should precede any x-rays, and
  - chart documentation must include:
    - x-ray interpretation,
    - caries risk assessment, and
    - both medical and dental history of the member
X-rays must be of **diagnostic quality and medically necessary**, and:

- X-rays and/or images must be identified by the **tooth number and include the date of exposure, member name and ID, provider name and ID**
- Periapical x-rays **must include at least 3 mm beyond the apex of the tooth** being x-rayed
- Chart documentation must **clearly indicate reasons for panoramic x-rays based on clinical findings**
OHCA 317:30-5-696 Coverage by Category

Documentation of the medical necessity for dental sealants includes:

- Interproximal and occlusal surfaces are free of decay/dental
- Permanent first and second molars
- Benefit through age **18 years, once every 36 months**, if medical necessity is documented
OHCA 317:30-5-696 Coverage by Category

Documentation of the medical necessity for stainless steel crowns and pulpotomies for primary teeth includes:

- Pre- and post-treatment periapical x-rays showing at least 3 mm past the apex of the root
- Written narrative explaining the extent of decay
- 70% or more of root structure remains
- Procedure provided more than 12 months prior to normal loss
OHCA 317:30-5-696 Coverage by Category

Documentation of the medical necessity for endodontics includes:

- Minimum 2 month history of member’s improved oral hygiene and flossing ability
- No other missing anterior teeth in the same arch
- Pre- and post-operative x-rays showing at least 3 mm past the apex of the root
- Providers are responsible for any follow up treatment required due to failed RCT for 24 months post completion
- Prior authorization for treatment plan requiring 2 anterior and/or 2 posterior RCTs
OHCA 317:30-5-696 Coverage by Category

Documentation of the medical necessity for stainless steel crowns for posterior permanent teeth includes:

- **Preoperative x-rays** showing at least 3 mm past the apex of the root
- **Written narrative** explaining the
  - extent of decay – 3 or more surfaces of tooth destroyed, extensive decay, or
  - loss of cuspal occlusion prior to 16 years of age
- **Completed endodontic treatment**
- **Excludes** placement of any other type of crown for 24 months
OHCA 317:30-5-696 Coverage by Category

Documentation of the medical necessity for space maintainers includes:

- **Preoperative x-rays** showing permanent tooth is missing or more than 5 mm below crest of alveolar ridge
- **Postoperative/post-cementation bitewing x-rays**
- **Written narrative** explaining the
  - Absence or presence 2\(^{nd}\) primary and 1\(^{st}\) permanent molars and not in cuspal interlocking occlusion
  - Justification for bilateral band and loop space maintainers
    - If posterior teeth missing bilaterally in the same arch, bilateral space maintainer is treatment of choice
- Providers responsible for recementation for 6 months post insertion for any maintainer placed by their practice
Documentation of the medical necessity for analgesia includes:

- Medical need for nitrous oxide inhalation
- Non-IV conscious sedation
  - Details of the patient’s condition including:
    - Documented handicap or
    - Patient is uncontrollable or
    - Other justifiable medical or dental condition
- Time oriented procedures must document start-stop times in the patient record
- Nitrous oxide, non-IV or IV conscious sedation, general anesthesia cannot be combined for payment however patient’s record must document combination administered
Documentation of the medical necessity for **indirect and direct pulp caps** includes:

- ADA accepted material(s) used
  - Calcium Hydroxide
  - Mineral Trioxide Aggregate materials

- **Intent and reason(s) for use, such as:**
  - “Deep decay excavated, no exposure of pulp chamber noted however mesiobuccal aspect of chamber visualized; calcium hydroxide placed to encourage secondary dentin, reduce sensitivity”
Documentation of the medical necessity for **protective restorations** includes:

-**Removal of decay**, if present
- Placement of indirect or direct pulp cap, if needed
- Permanent restoration allowed **after 60 days**
  - Unless tooth become symptomatic
  - Requires pain relieving treatment
OHCA 317:30-5-696 Coverage by Category

Documentation of the medical necessity for smoking and tobacco use cessation counseling includes:

- **Separate chart notation** with separate signature
- **Time spent** by the practitioner performing the counseling (less than 3 minutes considered part of routine visit)
- **Specifics of the 5 intervention steps covered** during counseling
  - Patient’s description of his/her smoking
  - Advising patient to quit
  - Assessing patient willingness to quit
  - Assistance provided with referrals/plans to quit
  - Arrangements for follow up
Endodontics

- Permanent teeth only
- ADA accepted materials must be used
- Tooth must have adequate natural tooth structure remaining to establish good tooth/restorative margins – should not require post/core to retain crown
- Tooth must have good crown to root ratio
- Tooth must not have weakened furcation area
- Opposing tooth must not be super erupted
- Loss of tooth space is less than $\frac{1}{3}$
- All rampant/active caries removed prior to endo request
Crowns for Permanent Teeth

- Patient must be 16 years of age or older
- All rampant/active caries must be removed prior to requesting any type of crown
- Extent of tooth decay prevents proper cuspal/incisal function
- Clinical crown destroyed/fractured by 1/2 or more
- Provider responsible for replacement/repair for 48 months post insertion due to poor lab process or procedure by provider
Periodontal Scaling and Root Planing

- Patient must be 10 years of age or older; and
- 5 mm or greater depths for 3 or more 6-point measurements, or
- Multiple areas of radiographic bone loss and subgingival calculus; and,
- Must involve 2 or more teeth per quadrant
- Not allowed in conjunction with any other periodontal surgery
Utilization parameters include:

- 1 permanent restorative service per tooth per 24 months
  - Additional restorations may be authorized upon approval of OHCA in cases of trauma
- Teeth receiving restoration are eligible within 3 months for consideration of a single crown if endodontically treated
- Provider is responsible for follow up or any required replacement of a failed restoration
- If determined by the Dental Director that the patient has received poorly/insufficient treatment, may authorize corrective procedures by a second provider
OHCA 317:30-5-699 Restorations

Documentation of the medical necessity for restorations includes:

- Charting of clinical and x-ray findings of decay
- X-rays which show evidence of decay
- Any diagnosis not supported by x-rays requires documentation of medical need on which the diagnosis was made
- Isolation used, e.g. rubber dam, cotton rolls, etc.
OHCA 317:30-5-700 Orthodontic Services

Documentation of the medical necessity for orthodontic services includes:

- **Referral from primary care dentist**
  - Patient has had a *caries free initial visit*; or
  - Has had *all decayed areas restored and remained caries free for 12 months*; and
  - Has *demonstrated competency in maintaining appropriate level of dental hygiene*

- **Cleft palate patients** can be referred directly by treating MD
  - Exempt from above requirements
Documentation of the medical necessity for comprehensive orthodontic services includes:

- Permanent dentition except for cleft defects
- At least 1 of each of the following types:
  - Deep overbite with multiple teeth impinging on the soft tissues of the palate;
  - Impacted canine or molar requiring surgical exposure;
  - Bilateral posterior crossbite requiring fixed rapid palatal expansion; and,
  - Skeletal Class II or III requiring orthognathic surgery
- Minimum HLD score of 30
Medicaid Program Integrity Education

Purpose/Mission

The Center for Program Integrity provides educational resources to educate providers, beneficiaries and other stakeholders in promoting best practices and awareness of Medicaid fraud, waste and abuse.

There are several available resources including print and electronic media, toolkits, train-the-trainer guides, webinars, videos, and other innovative strategies.

Available tools and resources include:

- Audit Toolkit
- Beneficiary Card Sharing Toolkit
- Documentation Matters Toolkit
- Plan Compliance Toolkit
- Program Integrity: Medicaid Compliance for the Dental Professional
- Program Integrity: Medicaid Coordination
- Program Integrity: Fraud, Waste & Abuse Toolkit
- Program Integrity: Managed Care Plan
- Regulations & Guidance
- Research, Statistics, Data & Systems
- Share
- Strategic and Policy Initiative
- Toolkit
- Trains
- Updates
- Video
- Webinars

Found at: www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html
Informed Consent for Restorations, Crowns, and Bridges

1. WORK TO BE DONE
I understand that I am having the following work done: Fillings    Bridges    Crowns    Extractions    (Initials____)
General Anesthesia Root Canals Other

2. DRUGS & MEDICATIONS
I understand that antibiotics and analgesics and other medications can cause allergic reaction causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. Chemical burns to face can cause scarring. (Initials____)

3. CHANGES IN TREATMENT PLAN
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give permission to the dentist to make any/all changes and additions. (Initials____)

4. REMOVAL OF TEETH
Alternatives of removal have been explained to me (root canal therapy, crowns, and periodontal surgery etc.) and I authorize the dentist to remove the following teeth _______ and any others necessary for reasons in paragraph #3. I understand the risks involved in having teeth removed, some of which are pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paraesthesia) that can last for an indefinite period of time, or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment. The cost of which is my responsibility. (Initials____)
Informed Consent?

Physical Restraint by Dentist/Assistants: The restraining of the patient from undesirable movement by stabilizing the patient’s hands, upper body, head and leg movements with the intention of preventing injury to the patient and dental staff.

It is our intent that all professional care delivered in this office shall be of the best possible quality we can provide for our patients. Providing a high quality of care can sometimes be made very difficult, or even impossible, due to a lack of cooperation from the patient. The following behaviors that can interfere with proper provision of quality dental care include: hyperactivity, resistive movements, refusing to open the mouth, kicking, screaming and grabbing the dentist’s hands or sharp instruments.

I hereby give my consent to use physical restraints including, but not limited to: a mouth prop, nitrous mask, IV set up, finger pulse oximeter, blood pressure cuff, hands of dental assistants and or dental auxiliary as an essential part of efforts to render mutually agreed upon dental services for the patient. I further agree that this consent shall remain in full force unless withdrawn in writing by the person who has signed below or on behalf of the patient.
Informed Consent

Please place a √ in each box to indicate that you understand and consent to the following:

☐ Consent to receive dental treatment: I consent and authorize ___________________________ Dentists ___________________________ and their employees to examine, clean, and provide dental treatment to my child.

☐ Consent to receive dental treatment: I consent and authorize ___________________________ Dentists ___________________________

☐ Informed Consent for Restorations, Crowns, and Bridges

This is my consent for ___________________________ to perform the following treatment/procedure:

* Fillings #T(0) #S(0) #T(0) *

I understand that the purpose of the procedure is to treat and possibly correct my diseased oral maxillofacial tissues. I have been advised that if this condition persists without treatment, my present oral condition will probably worsen over time and the risks to my health may include, but are not limited to the following: swelling, pain, infection, cyst formation, malocclusion, premature loss of teeth, and/or premature loss of bone. I have been informed of possible alternative methods of treatment, if any.
Charting of Clinical Findings

Figure 17. Charting Existing Conditions
Imaging – Bitewing or Periapical? Diagnostic Quality?

3/4-5, 18-19/2016
Inaccurate Charting of Clinical and Radiographic Findings
Inaccurate Charting of Clinical and Radiographic Findings
No Charting of Clinical or Radiographic Findings
Radiographic Imaging Incorporated into Multiple Patient Records
Chart Progress Notes

Review PMHx
EOE: wnl
IOE: wnl, gingiva pink
Radiographic: no class II lesions apparent, osseous
OH: Fair, Moderate Plaque
CC: New Patient Exam
Dx: Caries, pit and fissure decay diagnosed by sig explorer
Undocumented Clinical and Radiographic Findings – Treatment Outcomes
Inaccurate Documentation

Gross Scale:
MHR:  
EIE:  
Took 4 B/W, 0 PA x-rays.
Took panoramic x-ray: □ yes □ no.
Treatment plan recommended.
Gross scaled, prophylaxis & OHI given.

Sealant: #4, 5, 12, 13, 20, 21, 28, 29
Pumice tooth/teeth clean. Acid etched.
Placed sealant. Checked occlusion and adherence.
Dental Services Not Provided
Upcoding of Dental Services
Upcoded Dental Services
Progress Notes for treatment on a single date of service for a 2 year 9 month old reflects the following:

- No pre-treatment x-rays taken
- Sedation and nitrous oxide for 25 mins
- 1 carpule of local anesthetic recorded
- 7 teeth filled (#A, C, F, K, I, L, T)
- 3 teeth treated with pulpotomy/SSCs
- Parental consent for papoose without notation of use in record
- Sedation record shows pulse rate variance during treatment from 128-158
- Sedation record documents BP variance during treatment of 71/47 to 130/108
- No notation in Progress Notes of adverse patient response to treatment

### Table:

<table>
<thead>
<tr>
<th>Date</th>
<th>Th</th>
<th>Surf</th>
<th>Dx</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/4/2012</td>
<td>F</td>
<td>O</td>
<td>C1(P)</td>
<td>Pulpotomy</td>
</tr>
<tr>
<td>2/4/2012</td>
<td>A</td>
<td>O</td>
<td>C1(P)</td>
<td>Sedation</td>
</tr>
<tr>
<td>2/4/2012</td>
<td>F</td>
<td>O</td>
<td>SSCPri</td>
<td></td>
</tr>
<tr>
<td>2/4/2012</td>
<td>K</td>
<td>O</td>
<td>C1(P)</td>
<td></td>
</tr>
<tr>
<td>2/4/2012</td>
<td>T</td>
<td>B</td>
<td>C1(P)</td>
<td></td>
</tr>
<tr>
<td>2/4/2012</td>
<td>E</td>
<td>O</td>
<td>Conscious Sedation</td>
<td></td>
</tr>
<tr>
<td>2/4/2012</td>
<td>E</td>
<td>O</td>
<td>SSCPri</td>
<td></td>
</tr>
<tr>
<td>2/4/2012</td>
<td>E</td>
<td>O</td>
<td>Pulpotomy</td>
<td></td>
</tr>
<tr>
<td>2/4/2012</td>
<td>C</td>
<td>F</td>
<td>C1</td>
<td></td>
</tr>
<tr>
<td>2/4/2012</td>
<td>K</td>
<td>B</td>
<td>C1(P)</td>
<td></td>
</tr>
<tr>
<td>2/4/2012</td>
<td>D</td>
<td>O</td>
<td>FDH (under 3)</td>
<td></td>
</tr>
<tr>
<td>2/4/2012</td>
<td>D</td>
<td>O</td>
<td>SSCPri</td>
<td></td>
</tr>
<tr>
<td>2/4/2012</td>
<td>D</td>
<td>O</td>
<td>Pulpotomy</td>
<td></td>
</tr>
<tr>
<td>2/4/2012</td>
<td>I</td>
<td>O</td>
<td>C1(P)</td>
<td></td>
</tr>
<tr>
<td>2/4/2012</td>
<td>L</td>
<td>O</td>
<td>C1(P)</td>
<td></td>
</tr>
</tbody>
</table>
Sequencing of Dental Treatment

Dental sealants and 2-surface filling performed first; no documentation that teeth with large cavities were treated by the practice under investigation or referral made.
Cloning of Progress Notes

"--------Friday. July 02. 2010 at 9:25:42 AM--------"

Visual Exam completed & No Decay Seen. No radiographs taken. RMH. Reinforced OHI w/Parent.

1/25/2011
GrpNote EC WILLIAMS ~GRP~

FIRST DENTAL HOME

Full caries risk assessment performed. Upon exam findings patient presents with HIGH Caries Risk Assessment based on the pt having following environment characteristics- suboptimal systemic fluoride exposure, frequent between meal snacking (3 or more), low level caregiver socioeconomic status, no usual source of dental care, and active caries present in the caregiver.

7/25/2011
GrpNote EC CAMPBELL ~GRP~

FIRST DENTAL HOME

Full caries risk assessment performed. Upon exam findings patient presents with HIGH Caries Risk Assessment based on the pt having following environment characteristics- suboptimal systemic fluoride exposure, frequent between meal snacking (3 or more), low level caregiver socioeconomic status, no usual source of dental care, and active caries present in the caregiver.

Visual Exam, TB prophy and 5% fluoride VARNISH
S: Check up
O: RMH. non-contributory. NKDA ASA: _I___
A: restorative: WNL at this time
P: Reinforced OHI w/Parent. Patient has high ECC risk rate. Recommend Brita filter or bottled water for drinking. Recommend not placing bottle in crib at night when put to bed. Toothbrush Prophy completed w/ 5% fluoride varnish. Answered any questions parent had. POI given to parent.
NV: 3 MRC

3/4-5, 18-19/2016
Cloning of Sedation Records

| Date                  | 3/4-5, 18-19/2016 |

---

### Cloning of Sedation Records

- **Indication for sedation:**
  - Physical/Anesthetic
  - Psychosocial
  - To prevent patient’s developing psych
  - To reduce patient’s medical risk

- **Medical history of anemia (HGA):**
  - Allergy to general anesthetic drug reaction
  - Current medications (including OTC)
  - Relevant disease, physical/neurologic examination
  - Previous sedation or general anesthesia
  - Severe, obstructive sleep apnea, mouth breathing
  - Other significant findings (eg, birth history)

- **ASA classification:**
  - I, II, III, IV

- **Current medication:**
  - Forehead

- **Plan:**
  - Informed consent obtained from patient
  - Pre-op instructions reviewed with patient
  - Post-op instructions reviewed with patient

- **Assessment on Day of Sedation:**
  - Accompanied by:
    - Medical history & ROS update
    - NPO
      - Clear liquids
      - Milk
      - Solid foods
      - Water
    - Weight

- **Assessment on Day of Sedation:**
  - Accompanied by:
    - Medical history & ROS update
    - NPO
      - Clear liquids
      - Milk
      - Solid foods
      - Water
    - Weight
Cloning of Sedation Records
Comparison of Cloned Entries
Incomplete Sedation Records

3/4-5, 18-19/2016
Overtreatment with Adverse Outcomes
Unnecessary Orthodontic Services
Patient Progress Notes

Patients: Dental R. Sample
Provider: Linda M. Altenhoff, Chief Dental Office
Phone: (512) 491-1106
Office: 11101 Metric Blvd
Building I, MC-1300
Austin, TX 78758

Date: 2/24/2016
Chart #: 
Birthdate: 1/1/1960

---

<table>
<thead>
<tr>
<th>Date</th>
<th>Tooth</th>
<th>Surface</th>
<th>Proc</th>
<th>Prov</th>
<th>Description</th>
<th>Stat</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/23/2016</td>
<td>LMA1</td>
<td></td>
<td></td>
<td></td>
<td>Clinical Note</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Patient Progress Notes

<table>
<thead>
<tr>
<th>Date</th>
<th>Tooth</th>
<th>Surface</th>
<th>Proo</th>
<th>Prov</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/24/2016</td>
<td>5/8</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

50 year old white female presents for new patient examination. Written consent for examination, x-rays, cleaning, fluoride, and photographs obtained after explanation of the risks and benefits including responding to patient questions about x-ray exposure due to history of radiation treatments for breast cancer.

Chief complaint: Establish as new patient - no known dental concerns at this time. It's been 9 months since last dental visit, cleaning and x-rays at that time.

Review of health history:
- Patient has a history of allergies to medications - azithromycin, omeprazole, and morphine.
- Patient has a history of elevated blood pressure, elevated cholesterol, post-traumatic stress disorder (PTSD), breast cancer, uterine fibroids with precancerous changes.
- Patient current takes the following medications: lisinopril 10 mg once per day, buspar 15 mg twice a day, lovastatin 20 mg once per day, tetracaine 2.5 mg once per day; patient also takes the following over-the-counter supplements - calcium, Vitamin E, Omega-3 fish oil, probiotics, women's multivitamin.

Surgical history includes:
- 3 C-sections, bilateral tibial ligament, radical mastectomy of the right breast, simple mastectomy of the left breast, 22 lymph nodes removed from left arm, complete hysterectomy, third lobar removal, extraction of 2 upper bicuspids for orthodontic purposes; patient has history of TMJ pain in the past, nothing recent. Patient has a history of chemotherapy (9 sessions) and radiation treatment (9 sessions) following radical mastectomy.

CAUTION: No blood pressure cuff or needle sticks in left arm due to removal of lymph nodes.

Patient states that she is in good health, is on 6-month recall with her oncologist, her blood pressure, cholesterol, and PTSA are controlled with medications.

Vital signs: BP: 107/68; Pulse: 65; Temp: 98.7 F; Weight: 155 lbs; Height: 5'5".

Clinical examination reveals the following: occlusal amalgams on teeth #2, 3, 15, 18, and 19; MF composite on #7; occlusal gold foil #14; OB gold inlay on #30; occlusal gold inlay #31; teeth #5 and #12 are present, with closure of spaces; enamel caviations noted on linguals of #15, 19, 30, and 31; margins of existing fillings intact; no recurrent or new decay noted on examination; palpation of the TMJ's reveals no clicking or deviation; no pain; gum tissues are pink, firm, healthy in appearance; no bleeding of the gum tissues on probing, no probing depths greater than 3 mm; slight interproximal tartar on linguals of lower anterior central incisors; no visible plaque; oral cancer screening performed and is negative.

Radiographic images ordered/taken: 4 B/Ws, 2 PAs, and panorex imaged by Susie Jones, RDH.

Radiographic examination reveals the absence of teeth #1, 5, 12, 16, 17, and 32; no interproximal decay or bone loss noted on x-rays, no pathology noted on panoramic image.

Prophylaxis with minimal scaling of lower anteriors and molars to remove tartar buildup, no bleeding noted during cleaning; polished teeth with prophylactic paste, applied fluoride gel for 1 minute.

Discussed enamel caviations noted on lower molars, advised patient of potential for further fracture; treatment options of no treatment, onlays, or full crown coverage explained to patient; patient has opted to electively have onlays on the lower molars, will start with left side.

Patient released after full check in good condition.

Next visit: 1.5 hrs for preparation of #18 and 19 for onlays.

Next recall visit: due to excellent home care and no evidence of perio disease or recurrent/new decay, will place patient on 12 month recall at this time due to low caries risk.

Signed on Tuesday, February 23, 2016 by Linda M. Altshoff, DDS.
Electronic Dental Record Sample Documentation
Clinical Progress Notes – Entries/Addendum

NEXT VISIT: 10 hrs for preparation of #10 and #12 for crowns

Next recall visit: due to excellent home care and no evidence of periodontal disease or recurrent/new decay, will place patient on 12 month recall at this time due to low caries risk

---------Signed on Tuesday, February 23, 2016 by Linda M. Altenhoff, DDS---------

--Appendix on Tuesday, February 23, 2016 at 8:40:52 AM by LMA1--

Patient encouraged to floss more effectively on the lower anterior teeth and to concentrate more when brushing on the lingual of the lower molars due to the findings of slight tarter build up in these areas; otherwise home care excellent resulting in recommendation of 12 month recall.

<table>
<thead>
<tr>
<th>Date</th>
<th>Tooth</th>
<th>Surface</th>
<th>Proc</th>
<th>Prov</th>
<th>Description</th>
<th>Stat</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/23/2016</td>
<td>1</td>
<td>15100</td>
<td>LMA1</td>
<td>Missing Tooth (&gt;1 Year)</td>
<td>CON</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>2/23/2016</td>
<td>2</td>
<td>O</td>
<td>D2140</td>
<td>LMA1</td>
<td>Amalgam 1 Surface</td>
<td>EO</td>
<td>0.00</td>
</tr>
<tr>
<td>2/23/2016</td>
<td>3</td>
<td>O</td>
<td>D2140</td>
<td>LMA1</td>
<td>Amalgam 1 Surface</td>
<td>EO</td>
<td>0.00</td>
</tr>
<tr>
<td>2/23/2016</td>
<td>4</td>
<td>10000</td>
<td>LMA1</td>
<td>Mesial Drifting</td>
<td>CON</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>2/23/2016</td>
<td>5</td>
<td>10100</td>
<td>LMA1</td>
<td>Missing Tooth (&gt;1 Year)</td>
<td>CON</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>2/23/2016</td>
<td>7</td>
<td>MF</td>
<td>D2331</td>
<td>LMA1</td>
<td>Anterior Resin Composite 2s</td>
<td>EO</td>
<td>0.00</td>
</tr>
<tr>
<td>2/23/2016</td>
<td>12</td>
<td>10100</td>
<td>LMA1</td>
<td>Missing Tooth (&gt;1 Year)</td>
<td>CON</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>2/23/2016</td>
<td>13</td>
<td>10000</td>
<td>LMA1</td>
<td>Mesial Drifting</td>
<td>CON</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>2/23/2016</td>
<td>14</td>
<td>O</td>
<td>D2410</td>
<td>LMA1</td>
<td>Gold Foil 1 Surface</td>
<td>EO</td>
<td>0.00</td>
</tr>
<tr>
<td>2/23/2016</td>
<td>15</td>
<td>O</td>
<td>D2140</td>
<td>LMA1</td>
<td>Amalgam 1 Surface</td>
<td>EO</td>
<td>0.00</td>
</tr>
</tbody>
</table>

Patient Progress Notes

Date: 2/24/2016
Chart #: 1

<table>
<thead>
<tr>
<th>Date</th>
<th>Tooth</th>
<th>Surface</th>
<th>Proc</th>
<th>Prov</th>
<th>Description</th>
<th>Stat</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/23/2016</td>
<td>10</td>
<td>15100</td>
<td>LMA1</td>
<td>Missing Tooth (&gt;1 Year)</td>
<td>CON</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>2/23/2016</td>
<td>17</td>
<td>10100</td>
<td>LMA1</td>
<td>Missing Tooth (&gt;1 Year)</td>
<td>CON</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>2/23/2016</td>
<td>18</td>
<td>O</td>
<td>D2140</td>
<td>LMA1</td>
<td>Amalgam 1 Surface</td>
<td>EO</td>
<td>0.00</td>
</tr>
<tr>
<td>2/23/2016</td>
<td>19</td>
<td>O</td>
<td>D2140</td>
<td>LMA1</td>
<td>Amalgam 1 Surface</td>
<td>EO</td>
<td>0.00</td>
</tr>
<tr>
<td>2/23/2016</td>
<td>30</td>
<td>OB</td>
<td>D2020</td>
<td>LMA1</td>
<td>Metallic Inlay 2 Surface</td>
<td>EO</td>
<td>0.00</td>
</tr>
<tr>
<td>2/23/2016</td>
<td>31</td>
<td>O</td>
<td>D2010</td>
<td>LMA1</td>
<td>Metallic Inlay 1 Surface</td>
<td>EO</td>
<td>0.00</td>
</tr>
<tr>
<td>2/23/2016</td>
<td>32</td>
<td>15100</td>
<td>LMA1</td>
<td>Missing Tooth (&gt;1 Year)</td>
<td>CON</td>
<td>0.00</td>
<td></td>
</tr>
</tbody>
</table>

UL=Upper Left  UR=Upper Right  LL=Lower Left  LR=Lower Right
Patient Progress Notes

<table>
<thead>
<tr>
<th>Date</th>
<th>Tooth</th>
<th>Surface</th>
<th>Proc</th>
<th>Prov</th>
<th>Description</th>
<th>Stat</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/23/2018</td>
<td>16</td>
<td>15100</td>
<td>LMA1</td>
<td>Missing Tooth (&gt;1 Year)</td>
<td>CON</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>2/23/2018</td>
<td>17</td>
<td>15100</td>
<td>LMA1</td>
<td>Missing Tooth (&gt;1 Year)</td>
<td>CON</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>2/23/2018</td>
<td>18</td>
<td>O</td>
<td>D2140</td>
<td>LMA1</td>
<td>Amalgam 1 Surface</td>
<td>EO</td>
<td>0.00</td>
</tr>
<tr>
<td>2/23/2018</td>
<td>19</td>
<td>O</td>
<td>D2140</td>
<td>LMA1</td>
<td>Amalgam 1 Surface</td>
<td>EO</td>
<td>0.00</td>
</tr>
<tr>
<td>2/23/2018</td>
<td>30</td>
<td>OB</td>
<td>D2520</td>
<td>LMA1</td>
<td>Metalic Inlay 2 Surface</td>
<td>EO</td>
<td>0.00</td>
</tr>
<tr>
<td>2/23/2018</td>
<td>31</td>
<td>O</td>
<td>D2610</td>
<td>LMA1</td>
<td>Metalic Inlay 1 Surface</td>
<td>EO</td>
<td>0.00</td>
</tr>
<tr>
<td>2/23/2018</td>
<td>32</td>
<td>15100</td>
<td>LMA1</td>
<td>Missing Tooth (&gt;1 Year)</td>
<td>CON</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>2/24/2018</td>
<td></td>
<td></td>
<td>LMA1</td>
<td>Clinical Note</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Chief Complaint: Patient presents for preparation of teeth #18 and 19 for gold onlays.

Review of health history: Patient reports that she forgot to mention that she has a history of gastric reflux that started following breast cancer surgery and during chemotherapy and radiation therapy, she takes Prilosec daily which controls her symptoms along with diet modification and weight loss, no other changes to health history noted at this time.

Vital Signs: BP: 105/68; Pulse: 65; Temp: 98.7F

Review of treatment plan for today including the risks and benefits of the use of local anesthesia and nitrous oxide, preparation, impressions, and placement of temporaries on lower left molars; patient asked about post-treatment discomfort and the use of Advil for control; patient was told that Advil should be sufficient given the treatment planned for today; no other questions were posed; written consent for local anesthesia, nitrous oxide, and preparation of #18 and 19 for gold onlays was obtained.

Nitrous oxide was initiated at 8:15 am with 100% O2 given for 3 minutes followed by 30% N20/70% O2 through a nasal mask; patient was switched to 100% O2 at conclusion of treatment at 9:15 am.

Local anesthesia: Topical anesthetic was placed for 2 minutes, inferior alveolar injection of 1.5 ml of 2% Lidocaine with 1:100,000 epinephrine was administered followed by 0.3 ml of 2% Lidocaine w/1:100,000 epi injection; patient reported numb lip/tongue at 10 am.

Procedure:
#18 - MODDL gold inlay prep: removed old amalgam, no recurrent decay noted, fracture of lingual enamel noted to extend into dentin, packed tissues with retraction cord on MLD; removed retraction cord prior to Impression being taken; acrylic temporary made and cemented with Tempbond, excess cement removed.

#19 - MODDL gold inlay prep: removed old amalgam, recurrent decay noted and removed, no exposure of pulp however due to depth placed calcium hydroxide base to reduce sensitivity, packed tissues with retraction cord on MLD; removed retraction cord prior to Impression being taken; acrylic temporary made and cemented with Tempbond, excess cement removed.

Post-op instructions given to patient verbally and in writing: advised patient to rinse with warm salt water and take Advil if she experiences tissue discomfort, to be sure and brush normally, when flossing to take the floss from the contacts but then to pull through to the side so as not to dislodge the temporary, should the temporary become loose or comes off, to call the office so that it can be re-cemented to prevent tooth movement; patient also advised to eat primarily on the right side if possible and to not try to eat until the feeling comes back to her tongue and lip. Patient advised to call if she has any questions or concerns.

Post treatment vitals: BP: 120/78; Pulse: 75

Patient released in good condition, walking on her own without any signs of problems

Assistance present during procedure: Joan Perkins, RDA

2/24/2016 - Signed on Wednesday, February 24, 2016 by Linda M. Altenhoff, DDS

2/24/2016 - LMA1 Clinical Note

Called patient at her work phone number to check on how she was doing after today’s visit. Patient reports that...
Electronic Dental Record Sample Documentation
Clinical Progress Notes – Follow Up Call

2/24/2016
LMA1 Clinical Note

Called patient at her work phone number to check on how she was doing after today’s visit. Patient reports that the numbness has worn off, she has feeling in her tongue and lip, she’s a little sore on the “tongue side” of the teeth worked on but otherwise doing fine. She’s had something to drink and eat without any problems or sensitivity. I reminded her that should the temporaries become loose or come off, to call the office so that she can be worked in to have the temporary(s) recemented. I asked if she had been scheduled for seating the onlays and she stated she had informed Mary at the front desk that she would check her schedule and call back. I advised her that the onlays should be back from the lab within 2 weeks and that we would need 30-45 minutes to deliver the onlays.

Next Visit: 2 weeks, 30-45 minutes to seat onlays on left side; impressions sent to Morning Dental Lab for fabrication of onlays

Signed on Wednesday, February 24, 2016 by Linda M. Alttenhoff, DDS

---

Patient Progress Notes

Patient: Dental R. Sample  
Provider: Linda M. Alttenhoff, Chief Dental Office
Phone: (512)491-1106
Office: 11101 Metric Blvd
Building I, MC-1300
Austin, TX 78758

Date: 2/24/2016
Chart #: 1/1/1960

Date     Tooth     Surface     Proc     Prov  Description
UL=Upper Left  UR=Upper Right  LL=Lower Left  LR=Lower Right

---

3/4-5, 18-19/2016
Questions
Contact Information

Linda M. Altenhoff, DDS - Chief Dental Officer
Email: Linda.Altenhoff@hhsc.state.tx.us