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Liability Lifeline

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# PATIENT RECORDS: YOUR FIRST LINE OF DEFENSE

All dentists have been asked to release patient records at one point or another. Whether a patient is moving away, switching practices or documenting expenditures, patient records are commonly requested in dental offices.

But the guidelines on releasing patient records aren't always clear, and the laws and requirements about what information to release, how to release it and when to release it can be difficult to navigate. Luckily, The Dentists Insurance Company is here to help.

Dentists should be aware of their legal obligations

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to release patient records. The first step is to ensure patients sign a form authorizing the release of dental records and to keep a copy of the signed form in the patient's chart. A sample form can be downloaded from tdicinsurance.com/riskmanagement/sampleforms.

Patients can, and have, taken legal action against dentists who, for whatever reason, fail to produce records when requested. As legal documents, these records can be subpoenaed in legal cases and must be produced by the date indicated in the subpoena. Subpoenaed records aren't the only ones that must be released. Patients also have a right to their own records, and dentists are obligated to produce them within a certain period after receiving a written request. For example, California's Health and Safety Code states that dentists have 15 days to comply with such requests and must provide the records in full. Additionally, California Evidence Code states that if a patient's legal representative submits a written request for records, the medical provider must make them available for inspection within five business days.

Attorney Arthur Curley of Bradley, Curley, Barrabee & Kowalski PC in Larkspur, Calif. reported one case in which a dentist refused to release records within the required timeframe. The dentist stated he had no time, as the records were lengthy, and he didn't think they were immediately needed. He eventually conceded, but he refused to provide transcripts; again, he stated he did not have the time for staff to produce them.

The patient filed complaints with the state dental board and peer review, but peer review was unable to render a decision without transcripts and closed the file. In addition, the patient filed a lawsuit claiming the dentist over-prescribed narcotics rather than referring her to a specialist to evaluate her chronic pain, causing her to become addicted. The dental board cited the doctor for failing to produce the records within the required timeframe and opened an investigation.

## What to include and not include in the patient record

### Include

**Progress notes**
*(Treatment is healing appropriately)*

**Objective observations**
*(Patient exhibits slurred speech)*

**Clinical findings**
*(Damaged crown on tooth #5)*

**Facts relevant to patient's condition**
*(Recommended hygiene appt. twice a year)*

**Factual assessment**
*(Heavy plaque, localized bleeding)*

**Missed appointments**
*(Patient failed hygiene appointment)*

**Specific recommendations**
*(Patient advised to quit smoking)*

**Referral recommendations**
*(Referred to endodontist for RCT)*

### Don't Include

**Personal notes**
*(Patient is whiny and needy)*

**Subjective observations**
*(Patient appears drunk)*

**Criticism**
*(Prior dentist failed to seat crown correctly)*

**Irrelevant details**
*(Patient is good looking)*

**Unprofessional commentary**
*(Most disgusting mouth I've ever seen)*

**Missed payments**
*(Patient failed to pay balance for crown)*

**Generalized summaries**
*(Patient advised to improve health)*

**Financial assumptions**
*(Patient unemployed; RCT may be unaffordable)*

Curley warns that failing to provide timely records when requested to do so can open up your practice to scrutiny. Dentists should become familiar with what their obligations are under state and federal laws and fully understand those obligations before delaying or denying requests.

"Always produce the records upon patient request," he cautions. "If uncertain, contact your insurance carrier for advice, although this does not change your obligation to produce the record."

Dentists should consider the ramifications of denying such requests. Failing to comply can trigger an investigation by the state dental board and in some cases lead to fines.

Check with your dental board, local dental society or dental association to determine whether and when records must be released in your state and under what circumstances.

## Who can request a minor's record?

The release of records for minor patients requires special consideration. In most states, including California, parents generally have the right to access the health records of their unemancipated minor children regardless of whether they have custody or financial responsibility. However, a dental practice may deny access to a parent if it determines that doing so would have a detrimental effect on the dentist's professional relationship with the minor patient or the minor patient's physical safety or psychological well-being.

It is important to note that in some states, including California, a dental practice may not release information to a parent without the minor patient's written consent regarding his or her drug or alcohol abuse, pregnancy, use of contraception, abortion, sexual assault, infectious and communicable disease status, HIV/AIDS status, sexually transmitted disease or mental health.

Minors do not have a right to access their own records unless the records relate to health care of a type for which minors are lawfully authorized to consent, they are emancipated, or they have a parent or guardian's authorization.

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## Can I charge for copying records?

Dental practices are the official owners of patient records; however, patients and their representatives are entitled to the information they contain. Therefore, dentists should take care not to release original documents.

Some states allow dental practices to charge patients for the expenses incurred in photocopying records. The U.S. Department of Health and Human Services clarified its regulations in a guidance issued in March 2016. The guidance made clear that the fee for access may include only the cost of:

- Labor to make the requested copy, whether in paper or electronic form
- Supplies such as paper or portable electronic media
- Postage when the patient requests the copy or summary be mailed
- Preparation of an explanation or summary of the record if requested by the patient

A covered entity may either calculate actual labor costs to fulfill a request or develop a fee schedule based on average labor costs to fulfill a request. However, the fee may not include costs associated with verification of the request, documentation, searching for and retrieving the record, maintaining systems, recouping capital for data access, storage or infrastructure, or anything not included in the bullets above. A fee per page may not be charged for records maintained electronically. If a dental practice collects fees, it should prepare a document listing the fees and provide it to the patient with the Authorization for the Release of Dental Records form.

Practices that are not HIPPA-covered entities (those that do not use electronic recordkeeping) must follow the rules outlined in their state. In California, for example, practices may charge no more than 25 cents per page for copying paper documents; the actual cost for duplicating X-rays, photos, models and impressions; and actual postage cost.

That said, TDIC recommends using discretion in charging patients and to make the decision on a case-by-case basis. Consider the unique circumstances surrounding each case before charging patients for any costs associated with

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reproducing records, as it doesn't fare so well with patients who may be unhappy in the first place.

It should also be noted that dentists are not allowed to withhold records based solely on a patient's inability or unwillingness to pay the fee. Nor can a dentist deny access to records if a patient has an outstanding balance or past-due bill on his or her account.

In most states, dentists are required to provide the records in full unless requested otherwise. They are not permitted to pick and choose which parts of the records to make available, nor can they summarize the information they contain in lieu of a complete copy of the chart.

"Selectively choosing which information to provide or deleting information you do not want to be shared with the patient can lead to problems down the road," said TDIC Sr. Risk Management analyst Taiba Solaiman. "It may make patients suspicious and raise concerns as to what information you're hiding and why."

## What goes in the record itself?

Dentists should remember that patient records are the first line of defense should a patient file a liability claim. Keeping records professional, accurate, complete and consistent will help protect you should a case end up in court.

Dentists are warned not to make notations in a patient's record that aren't directly related to the patient's clinical care. In one case reported to TDIC, a dentist had used a code word in a patient's chart indicating that she was not easy to get along with. This put the dentist in an awkward position when the patient requested her chart and the unfavorable nickname was clearly visible.

"A patient chart is considered a legal document, so it is important to include only objective language and remain professional," Solaiman noted.

So what, exactly, should be in a patient's record? TDIC defines a complete record as containing the following:

- A description of the patient's existing dental condition
- Diagnosis and treatment plan
- Progress notes on the treatment performed and the results of that treatment
- Health history (all questions answered) and regular updates, including any possible allergies or medications
- Dental history
- Vital and diagnostic signs
- Oral cancer screening
- TMJ evaluation
- Periodontal evaluation
- Diagnostic test findings and exam notes
- Consultant reports, reports to and from specialists and physicians
- Notes describing patient concerns
- Notes about rescheduled, missed or canceled appointments
- Exam and treatment notes
- Informed consent discussions and forms
- Models (if indicated)
- Photographs
- All radiographs taken at intervals appropriate to patient's condition
- All written authorizations to release records
- Interactions with patients such as correspondence, notes of phone calls, emails, texts, voice messages, letters and face-to-face conversations
- Legal documents such as custody decisions for minors or powers of attorney

In addition, if a complication arises during treatment, documentation in the chart should include that the patient was informed of the complication and options were discussed. For example, if a file separates during a root canal procedure, it should be noted that the patient was advised of the complication and the action taken in this case was a referral to an endodontist.

Patient charts should only contain information regarding one patient. Do not combine charts for family members, spouses or parents and their children. Each piece of information should be kept separate to avoid confusion or miscommunication and to maintain compliance with HIPAA and privacy rules.

TDIC recommends keeping thorough records, not only for patients but also for staff members, friends and family; anyone to whom you provide care should be treated as any other patient. Carefully document your findings and your recommendations. Do not assume that the chart will never be viewed again or that you will remember the details of the case weeks, months or years down the road. Assume you will need to justify your treatment. For example, rather than a simple entry such as "RCT 31," enter "Tooth No. 31: caries into the pulp. Options are extraction or RCT. Recommended RCT. Patient agrees to proceed with RCT."

In one case reported to TDIC, incomplete charting caused a breakdown in communication between a general practitioner and a traveling endodontist. In this case, the endodontist worked at several office locations owned by the

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same general practitioner. A patient had been treated at one location with a filling on tooth No. 4. The patient began experiencing problems with the tooth following the filling and the general practitioner had recommended a root canal on that tooth.

Often the temptation arises to edit the chart when dentists become aware of a patient complaint. While amendments can be made, they must be handled following certain best practices, lest they appear as an attempt to mislead or conceal the truth.

The patient scheduled the root canal at a different location. The endodontist was running behind, so the GP anesthetized the patient. When the endodontist arrived, she reviewed the radiograph displayed on the screen and noted that tooth No. 2 had a widened periodontal ligament; therefore, she assumed this was the tooth that required a root canal. The chart also indicated there was a recent filling on that tooth performed by the GP, so the endodontist began the root canal on tooth No. 2.

Unfortunately, the chart had not been transferred in its entirety, and the endodontist was unaware that she was scheduled to perform a root canal on tooth No. 4, not No. 2.

The patient realized that the endodontist had worked on the wrong tooth after treatment was complete. A root canal was eventually performed on the correct tooth, and the patient was not charged for it. The patient refused to pay for the RCT on tooth No. 4 and demanded compensation for crowns on both teeth.

## What patient information should be kept separately?

While financial information is part of a patient's overall record, TDIC recommends keeping it separate from clinical findings. Any mention of cost or expense alongside diagnosis or treatment recommendations may send the message that the dentist is more concerned with financial gain than with patient health.

Also kept separately should be any documentation relating to discussions with professional liability carriers or attorneys, as well as information regarding any pending complaints, accusations or legal action.

## Who can document in the record?

Dentists should remember that ultimately, what is in the patient's chart is their responsibility. While other clinical staff can enter information in a patient chart, it is up to the dentist to review those entries for accuracy, clarity and legibility.

## How do I amend a record?

Often the temptation arises to edit the chart when dentists become aware of a patient complaint. While amendments can be made, they must be handled following certain best practices, lest they appear as an attempt to mislead or conceal the truth.

Mistakes certainly happen, but dentists should amend incorrect entries as soon as possible. Even if a record is incomplete, it is not advised to amend a record once a suit is filed. Attorneys will often scrutinize records, attempting to prove they were altered through information such as audit trails for electronic records, and forensic experts can, and have, found evidence of alteration when none was visible to the naked eye. This can destroy a defense and add fraud to the list of charges a dentist faces because amendments made after a case is filed appear to be self-serving.

"Amendments are necessary at times, but if done incorrectly, they can appear as if you're trying to hide something," Solaiman says.

Electronic recordkeeping programs have built-in provisions for amendments, but for written records, the following guidelines are advised:

- Drop down to the next available line
- Mark the new entry "addendum to" with the date of entry being amended

- Date and initial each amendment
- Never obliterate an entry (do not black out or use correction fluid)
- Make sure the original entry is readable
- Do not insert or delete words or phrases in an entry

## How long should I keep records?

In a perfect world, dentists would keep all patient charts indefinitely, as they are the only record of a patient's dental treatment. However, that is not always feasible, especially with paper charts. The requirements for inactive patients (those who have not been seen in the last 24 months) varies from state to state, so check your state dental board or dental association. Otherwise, TDIC recommends the following:

**Adults**

- Ten years from the date the patient was last seen, even if the patient is deceased

**Minors**

- Ten years from the date the patient was last seen or seven years past the patient's 18th birthday (age 25), whichever is longer

Keeping accurate, detailed patient records is one of the best ways to protect yourself and your practice in the event of a liability claim. Carefully documenting your professional assessments and treatment decisions provides a solid defense. Knowing the laws and regulations that govern patient records is a crucial part of practicing dentistry and can keep you out of hot water when the unthinkable happens.

"I did a simple extraction on one of my patients today. Everything went smoothly, and I completed the extraction without any problems. Immediately after, I realized that I had extracted the wrong tooth!"

# Question and Answer

**Q: I did a simple extraction on one of my patients today. Everything went smoothly, and I completed the extraction without any problems. Immediately after, I realized that I had extracted the wrong tooth! I informed the patient right away. I reassured her and laid out a plan for her to see an oral surgeon to discuss bone grafting and implant placement. The patient agreed to go, but she was still very upset. I am thinking of calling the patient and offering to pay for her lost wages and pain and suffering. I also know that this patient frequently gets massages and sees an acupuncturist. Should I offer to pay for a few massages and acupuncture appointments as well? I will do anything to avoid a lawsuit.**

**A:** The fear of lawsuits is very real for many dentists so naturally this is a very stressful situation. It was right to immediately inform the patient that the wrong tooth had been extracted. Presenting a plan of action was another step in the right direction. Patients often look to dentists to solve the problem at hand and taking action to resolve the situation ensures the patient's dental needs are met and may help sustain the doctor-patient relationship.

While it is understandable that you would want to make things right for the patient, offering too many concessions too quickly can place you in a position of vulnerability. This is not the message you should send, as the patient may get the wrong impression. The patient may sense that you are desperate and willing to do anything, and this may push her to seek advice from an attorney or make unreasonable demands.

Rather, contact the oral surgeon and obtain a report of his or her evaluation. Once you have the results, offer to cover the expenses associated with both replacing the incorrectly extracted tooth and extracting the correct tooth. To remain transparent, you may want to suggest that the patient obtain a second opinion. The patient can then decide which specialist to see for treatment. Once you come to an agreement, you may want to have the patient sign a release. Signing a release demonstrates that the patient has accepted an agreed-upon amount as full and final settlement. Be sure to inform your insurance carrier of the incident as well.

# Liability Lifeline

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