BOARD OF DENTISTRY
DENTAL RECORDS TASK FORCE AGENDA
VIA TELEPHONE CONFERENCE CALL
MAY 13, 2014
6:00 P.M. EDT
Call In Number (888) 670-3525, Participant Pass Code: 5805370981

I. CALL TO ORDER/ROLL CALL

II. REVIEW OF MINUTES FROM JANUARY 16, 2014 MEETING

III. ITEM FOR TOPIC DISCUSSION
A. Rule Draft 64B5-17.002, FAC, Written Dental Records; Minimum Content, Retention

IV. OLD BUSINESS

V. NEW BUSINESS

VI. ADJOURNMENT

*To connect to the conference call, dial the following number: 888-670-3525 a minute or two prior to the start time of the meeting. You will then be prompted to enter a "participant pass code", which is 5805370981, followed by the # sign.

Please mute your line. Press *6 to mute/unmute the line.

DRAFT

BOARD OF DENTISTRY
DENTAL RECORDS TASK FORCE
VIA TELEPHONE CONFERENCE CALL
JANUARY 16, 2014
6:00 P.M. EDT
Call In Number (888) 670-3525, Participant Pass Code: 5805370981

CALL TO ORDER/ROLL CALL

The meeting was called to order at 6:00 p.m. by Dr. Winker, Chair. Those present for all or part of the meeting included the following:

Committee members present:
Wade Winker, D.D.S., Chair
Catherine Cabanzon, R.D.H.
William Kochenour, D.D.S.

Staff present:
David Flynn, Esq., Board Counsel
Sue Foster, Board Director
Cindy Ritter, Program Administrator

Others present:
Joe Thomas, D.D.S., Board Chair
Angie Sissine, R.D.H. ,Board member
Dan Gesek, D.M.D., Board member
Jan Barrett, FDHA
Jackie Burt-McDonough, FDHA
Terry Buckenheimer, President, FDA
Ron Watson, FDA
Barry Setzer, Pediatric dentist
Ed Bayo, Esq.
Randy Collette, Esq.
Dr. Don Ilkka
Bob Jacobson, Nova SE

REVIEW OF MINUTES FROM OCTOBER 22, 2013 MEETING

The minutes of the October 22, 2013 telephone conference call were reviewed and following review, the following action was taken by the Committee:

Motion: by Dr. Kochenour to approve the minutes
Second: by Ms. Cabanzon
Vote: unanimous

ITEM FOR TOPIC DISCUSSION

Rule Draft 64B5-17.002, FAC, Written Dental Records; Minimum Content; Retention

The Committee reviewed the draft changes and offered edits to the Committee. Following discussion, the following action was taken by the Committee:

Motion: by Dr. Kochenour to assimilate all of the changes noted during this call and hold another telephone conference call meeting before sending to board or another Committee
Second: by Ms. Cabanzon
Vote: unanimous

OLD BUSINESS
None

NEW BUSINESS
None

ADJOURNMENT
The meeting was adjourned at 7:35 p.m.

RECORDS TASK FORCE COMMITTEE
JANUARY 16, 2014

The following changes to rule 64B5-17.002, *Florida Administrative Code*, are based on the recommendations made at Committee Meetings held on October 22, 2013 and January 16, 2014.

Recommendations from January 16, 2014 are coded with an Underline for additions and a ~~Strikethrough~~ for deletions.

64B5-17.002 Written Dental Records; Minimum Content, Retention.

1) For the purposes of implementing the provisions of subsection 466.028(1)(m), F.S., a dentist shall maintain written dental records on each patient which shall contain, at a minimum, the following information:

   a. **Medical History**: Appropriate medical history including any current or previous medical conditions, surgeries, hospitalizations, medications, and legible blood pressure readings (when taken). The updating and review of the medical history, which is done at each appointment, must also be documented.

   b. **Examination and Tests**: Results of clinical examination and tests conducted, including the identification, or lack thereof, of any oral pathology or diseases. ~~and to include, but not limited to the following:~~

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   ~~i. Charting of all existing dental restorations;~~
   ~~ii. Charting of all existing dental pathology;~~
   ~~iii. Evaluation of the Temporomandibular Joint (TMJ) and occlusion; and~~
   ~~iv. Periodontal evaluation including periodontal probing, evaluation of supporting bone and soft tissues, tooth mobility, and presence of gingival inflammation and in~~

   There was support to delete everything after the word "diseases." Needs a final Committee vote.

   c. **Radiographs**: Any radiographs, and the results thereof, used for the diagnosis or treatment of the patient to include, but not limited to the following:

      i. Intraoral and extra oral radiographs, such as a Full Mouth Series, Panoramic, Cone Beam, Cephalometic, Bitewing, Extra Oral, Occlusal and Periapical radiographs, which are necessary to enable and support appropriate diagnosis and treatment rendered; and

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      ii. Limited radiographs for treating emergency patients which are necessary to enable and support appropriate diagnosis and treatment for the limited emergent examination.

      Needs a Committee vote to delete or keep ii.

d. **Treatment Plan & Options**: Treatment plan and treatment options proposed by the dentist.

e. **Treatment**: Treatment rendered to the patient, including but not limited to the following , when applicable to the treatment performed:

i. Type, amount, and mode of delivery (i.e., Mandibular block, Infiltration, etc.) of local anesthesia used;
ii. Type and shade of restorative material used;
iii. Preoperative and/or postoperative medications prescribed;
iv. Medications delivered, administered, or provided to the patient during treatment or for use following treatment;
v. Radiographs taken;
vi. Impression material and type of impression taken (i.e., maxillary, mandibular, interocclusal, digital, etc.);
vii. Medicaments, medications, sutures, irrigants, or bases applied to teeth or periodontal tissues;
viii. Names or initials of all staff involved with clinical care of the patient;
ix. Use of dental barrier or rubber dam;
x. ~~Unusual or unexpected events or reactions during or after the procedure~~;
xi. ~~Tooth name, letter or number treated; and~~
xi. Tooth treated identified by name, number or letter;
xii. Working length, canals treated, identify untreated canals and reason left untreated, master apical files size, and obturation materials used during endodontic procedures; and
xiii Unusual or unexpected events or reactions during or after the procedure including, but not limited to separation, breakage, retention, swallowing or aspiration, of any instrument or portion thereof.

f. **Consent**:

i. General consent of the patient, legal representative, or legal guardian permitting the dentist to provide dental care.
ii. Specific consent listing the expected outcomes, potential complications, risks, benefits and need for additional treatment for procedures with higher associated risk (i.e., Surgical, endodontic, orthodontic, periodontal procedures, etc.).

iii. Written and signed informed consent is not mandated by the Dental Practice Act. However, pursuant to s. 766.013(4)(a), F.S., written signed informed consent creates a rebuttable presumption of valid consent.

g. **Record Alterations**: Any additions, corrections, modifications, annotations, or alterations (hereinafter "change") to the original dental record entry must be clearly noted as such and must include the date when the change was made, must be initialed by the person making the change, and must have an explanation for the change. An original entry to the record cannot be partially or wholly removed. Rather, to represent the deletion of a record entry, the entry must be struck through where it will remain legible (i.e., ~~change~~). A change made on the same date of the original entry must also include the time of the change ~~entry~~.

2) **Record Transfer or Release**: Whenever patient records are released or transferred, the dentist releasing or transferring the records shall maintain either the original records or copies thereof and a notation shall be made in the retained records indicating to whom the records were released or transferred and the authority for such release. Transfer of records in a multi-practice dental office shall be done and documented in strict accordance with s. 466.018, F.S.

3) **Record Retention Period**: A dentist shall maintain the written dental record of a patient for a period of at least four (4) years.

a. The ~~beginning of the~~ four (4) year retention period shall be calculated from the date the patient was last examined or treated by the dentist.
b. Upon the death of the dentist, the retention provisions of Rule 64B5-17.001, F.A.C., are controlling.
c. Dentists should retain records as long as needed not only to serve and protect the patient, but also to protect themselves against adverse actions. The retention period required by this rule may well be less than the length of time necessary for protecting the patient or the dentist. A dentist may wish to seek advice from private counsel or their malpractice insurance carrier on appropriate retention beyond four (4) years.

4) **Appointment Book**: Each licensed dentist shall retain a copy of each entry in his or her patient appointment book or such other log, calendar, book, file or computer data, used in lieu of an appointment book, for a period of no less than four (4) years from the date of each entry thereon.

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This section may warrant further discussion by Committee.

5) **Dentist of Record**: All records that are required by this rule and any other patient record shall be properly annotated to identify the dentist of ~~or~~ record. The dentist of record is the dentist who:

   a. Is identified and noted in the patient record as the dentist of record;
   b. Provides a specific treatment or service and is noted in the patient record as the dentist of record for that treatment or service;
   c. If there has been more than one provider of treatment, is the dentist who places the final restoration, does the surgical procedure, makes the diagnosis or finishes the service or procedure in question; or
   d. If there has been more than one provider of treatment and neither paragraph (a) or (b) or (c) can be determined with reasonable certainty, the dentist of record reverts entirely back to the Florida licensed ~~is the~~ owner dentist of the dental practice in which the dental patient is seen or treated.

6) **Owner of Dental Practice**: All dental records required by this rule and any additional records maintained in the course of practicing dentistry shall be the property of the Florida licensed owner dentist of the dental practice in which the dental patient is seen or treated and the owner dentist shall be ultimately responsible for all record keeping requirements set forth by statute or rule.
   a. The Florida licensed owner dentist is responsible for the records of patients seen or treated by any employee, associate, or visiting dentist.
   b. Multiple owners are severally and equally responsible for the records of patients seen or treated with the dental practice of that dental group.
   c. A~~n~~ lessor or owner dentist is not responsible for the records of an independent dentist who is merely leasing or renting space or staff services for the operation of a separate dental practice within the owner dentist's physical facility.

7) **Electronic Dental Records**: Patient records may be kept in an electronic format, provided that the dentist maintains a back-up copy of information stored in the back-up data processing system using disk, tape, or other secure electronic back-up system, on site or off site, as long as the back-up system is updated in a time frame that does not exceed seventy-two hours (72 hrs.) ~~7 days~~, to assure that data is not lost due to system failure. Any electronic data ~~date~~ system must be capable of producing a hard copy on lawful demand in accordance with and pursuant to federal or state laws and rules.

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Will the 72 hour back-up versus every week create any additional costs?

8) **Pro-Bono Dental Events:** The Board of Dentistry encourages the provision of pro-bono dental screenings though organized events such as Dental Health Screenings and Give Kids a Smile Program. A strict interpretation of this rule would preclude such efforts to the detriment of the public. Therefore, the Board deems that any records generated as a result of such limited, one-time pro-bono dental screenings, examinations, or treatments through organized events should be consistent with the nature and scope of the services rendered, should be provided to the recipient or guardian and will not result in the dentist performing such services becoming the dentist or record. The minimum content and record retention set forth in this rule shall not govern or be required. ~~be required~~. When the dentist performs such examinations or treatments
each recipients or guardian shall be informed in writing of the following:

   a. The limitation of the screening to one-time dental examination and treatment that can reasonably be performed on the same day of screening. In addition, such examinations or treatments would or would not reasonably require follow-up treatment;
   b. The results of the screening examination or treatments; and
   c. That the screening is not representative of or a substitute for a comprehensive dental examination.

9) Effective Date: The amendments to this rule shall become effective on January 1, 2015. Until the effective date of this amended rule, the rule with the effective date of March 27, 2013 controls. The amendments to this rule are to be apply prospectively.