BOARD OF DENTISTRY
DENTAL RECORDS TASK FORCE AMENDED AGENDA (9/18/14)
VIA TELEPHONE CONFERENCE CALL
SEPTEMBER 22, 2014
6:00 P.M. EDT
Call In Number (888) 670-3525, Participant Pass Code: 5805370981

I. CALL TO ORDER/ROLL CALL

II. REVIEW & APPROVAL OF MAY 13, 2014 TASK FORCE MEETING MINUTES

III. ITEM FOR TOPIC DISCUSSION
- **A. Rule Draft 64B5-17.002, FAC, Written Dental Records; Minimum Content, Retention**
- **B. Florida Dental Association Letter and Rule Draft**
- **C. Letter with Proposed Languge from Florida Academy of General Dentistry**
- **D. Revised Rule Draft, 64B5-17.002, FAC, Submitted By Dr. Tejera**

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
MAY 13, 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:
Dr. Wade Winker, Chair
Dr. William Kochenour
Ms. Catherine Cabanzon, R.D.H.

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

Others present:
Dr. Robert Perdomo, board member
Dr. Leonard Britten, board member
Dr. Joe Thomas, board chair
Ms. Angie Sissine, board member
Dr. Dan Gesek, board member
Mr. Ed Bayo, Esq.
Dr. Carl Melzer
Dr. T.J. Tejera, board member
Mr. Ron Watson
Ms. Casey Stoutamire, Florida Dental Association
Dr. Richard Mufson
Dr. Charles Llano
Ms. Jackie Burt-McDonough, Florida Dental Hygiene Association
Dr. Don Ilkka, Florida Dental Association
Dr. Jeremy Alberts
Dr. Mark Romer
Ms. Jan Barrett, Florida Dental Hygiene Association

REVIEW OF MINUTES FROM JANUARY 16, 2014 MEETING

The minutes of the January 16, 2014 meeting 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 rule draft was presented to the Committee and following discussion, the following action was taken:

Motion: by Dr. Kochenour to approve the draft with changes noted
Second: by Ms. Cabanzon
Vote: unanimous

OLD BUSINESS

None

NEW BUSINESS
None

ADJOURNMENT
The meeting was adjourned at 6:48 p.m.

Proposed Rule Change
64B5-17.002

The following changes to rule 64B5-17.002, *Florida Administrative Code*, are based on the recommendations made at the Rules Task Force Committee Meetings held on October 22, 2013; January 16, 2014; and May 13, 2014. The final version was approved on May 13, 2014 by the Rules Committee.

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 must also be documented.

    b. **Examination and Tests**: Results of clinical examinations and tests conducted, including the identification, or lack thereof, of any oral pathology or diseases.

    c. **Radiographs**: Any radiographs to include Cone Beam Computer Tomography (CBCT), and the results thereof, used for the diagnosis or treatment of the patient.

    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. Tooth or arch treated identified by name, number or letter;

xi. Working length, canals treated, identify untreated canals and reason left untreated, master apical file size, and obturation materials used during endodontic procedures; and

xii 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**.**

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.

Proposed Rule Change
64B5-17.002

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 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.

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.

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 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 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 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.), to assure that data is not lost due to system failure. Any electronic data system must be capable of producing a hard copy on lawful demand in accordance with and pursuant to federal or state laws and rules.

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. 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.

florida dental ASSOCIATION SM

FOUNDED IN 1884
GOVERNMENTAL AFFAIRS OFFICE
118 E. Jefferson St. ▪ Tallahassee, FL32301
850.224.1089 ▪ 800.326.0051
Fax 850.224.7058 ▪ floridadental.org

September 12, 2014

Dr. TJ Tejera, Chairman
Florida Board of Dentistry Records Task Force
4052 Bald Cypress Way
Bin C-08
Tallahassee, FL 32399-3258

Delivered via Email to Board of Dentistry Executive Director

Dear Dr. Tejera:

The Florida Dental Association (FDA) opposes the Board of Dentistry's (BOD) recent addition to Rule 64B5-17.002 (Written Dental Records; Minimum Content; Retention), specifically sections 1(a) through 1(e) of the proposed language. Therefore, the FDA respectfully requests no changes be made to sections 1(a) – 1(e) of the current Rule 64B5-17.002; essentially maintaining that section of the current rule. Enclosed please find language to this effect.

Regulations in current law already adequately address the minimum content of dental records. For example, the BOD anesthesia rules, Medicaid conditions of participation, HIPAA and ACA regulations, participating provider agreements, malpractice risk management guidelines, credentialing and medical staff requirements for hospital-based practitioners, etc. all delineate what is appropriate for dental record keeping. Imposing additional rules present the risk of increasing compliance expense and even worse, contradicting existing standards. For example, as of January 2013, the Commission on Dental Accreditation (CODA) requires every graduating dental student to pass a competency exam for head and neck cancer assessment (Standard 2-23b). However, this issue is not addressed in the BOD's proposed changes to the records rule.

Furthermore, in comparison, Rule 64B8-9.003 (Standards for Adequacy of Medical Records) outlines the records requirements for physicians. It is less than one page and could serve as a template for further BOD regulations. Since 1992, it has stood the test of time, is easy to understand and comply with, protects patient safety and serves as the standard of care for the Board of Medicine when prosecuting cases before Division of Administrative Hearings (DOAH).

Thank you for your consideration in this matter. If you have any questions, please do not hesitate to contact me at (904) 571-6048 or Casey Stoutamire, Lobbyist for the FDA, at (850) 224-1089.

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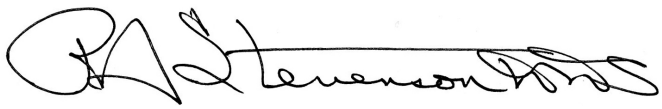
Sincerely,



Richard Stevenson, D.D.S.
President, Florida Dental Association

CC: FDA Board of Trustees
FDA Governmental Action Committee
Drew Eason, FDA Executive Director
Joe Anne Hart, FDA Director of Governmental Affairs

FDA Recommendations to Board of Dentistry Proposed Rule Change 64B5-17.002

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 must also be documented.~~

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   c. **Radiographs**: Any radiographs ~~to include Cone Beam Computer Tomography (CBCT), and the results thereof,~~ used for the diagnosis or treatment of the patient.

   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;~~
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      ~~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. Tooth or arch treated identified by name, number or letter;~~
      ~~xi. Working length, canals treated, identify untreated canals and reason left untreated, master apical file size, and obturation materials used during endodontic procedures; and~~
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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.

Florida Academy of General Dentistry
Leadership in Dentistry

August 4, 2014

Dr. Joseph Thomas, Chairman
Florida Board of Dentistry
4052 Bald Cypress Way
Bin C-08
Tallahassee, FL 32399-3258

Dear Dr. Thomas:

The Florida Academy of General Dentistry would like to go on record as opposing the Proposed Rule Change to 64B5-17.002 regarding dental office record keeping. In particular, the Florida AGD opposes Section 1) e., Treatment.

We suggest the following language to replace the currently proposed rule:

Treatment provided to the patient should give an accurate description of all treatment provided, including any materials and drugs used, and the outcome of treatment. Names and signatures of practitioner or practitioners involved in each step of treatment should be included.

Reasons for opposing section 1) e. include the following:

First, applicability to "treatment performed" is broader in scope than applicability to a particular allegation of error in treatment. For example, if a patient files a complaint against a practitioner with regard to the effect of postoperative medications, the Board could find that the postoperative medications provided were appropriate but that the dentist violated the rule by not documenting use of a rubber dam, even though use of rubber dam or documentation thereof had no bearing on consequences related to post-medication and overall care.

Second, delineation of 12 non-exclusive mandates in the treatment record creates a per se standard of care that may not only be broader but also conflict with record keeping standards in a given jurisdiction. The case here is not one of allegation of error in the performance of treatment, but one of whether the dentist appropriately recorded that a patient consented to treatment. Generally, it is the standard in most jurisdictions to document that the practitioner explained to the patient, the procedures, their alternatives, and the risks, and had provided opportunity for questions. 64B5-17.002 already provides for this requirement of documenting consent. However, the proposed section 1) e. appears to add the onus of documenting 12 aspects of treatment that may not directly affect a finding of patient's consent to that treatment, and yet, may create the finding that failure to document these aspects of treatment violates the "Procedures, Alternatives, Risks and Questions" (PARQ) requirement.

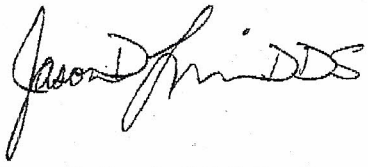
Florida Academy of General Dentistry
2372 NW 8th Street, Delray Beach, FL 33445
Toll Free Phone: 866-620-0773 • Fax: 707-220-2861
Email: flagd@flagd.org • Website: www.flagd.org

Finally, notwithstanding the above concerns, the additional requirements also appear to add an administrative onus upon the dentist.

The Florida AGD respectfully requests that the Board of Dentistry reconsider the enactment of Section 1) e. of the New Rule. We will have one or more representatives at the August 22, 2014, meeting of the Board of Dentistry where they can offer further explanation if desired.

Thank you for considering our letter.

Very truly yours,



Jason D. Lewis, DDS, FAGD
President

Proposed Rule Change Modifications
64B5-17.002

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

A licensed dentist shall maintain patient dental records in a legible manner and with sufficient detail to clearly demonstrate why the course of treatment was undertaken.

1. **Dental Record:** The dental record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment and document the course and results of treatment accurately, by including, at a minimum, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; reports of consultation or referrals; and copies of records or reports or other documentation obtained from healthcare practitioners at the request of the dentist and relied upon by the dentist in determining the appropriate treatment of the patient. [1]

2. **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 Practices Act. However, pursuant to s. 766.013(4)(a), F.S., written signed informed consent creates a rebuttable presumption of valid consent.

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1. *Highlighted text replaces Item 1a-e in the final version of 64B5-17.002 approved on May 13, 2014 by the Rules Committee*