Indian Health Service (IHS) Dental Clinic Manager's Handbook

Last Updated: 9/21/2023

Contents

Record of Changes

Revision Date	Revision Class	Revision Details
9/21/2023	Minor	Updated cover page. Repeated headers across pages of each checklist table. Fixed page numbering.
6/19/2023	Major	Reformatting and rearranging of content, and spelling and grammar corrections throughout. Schedule Optimization: 1.2 Procedure Times – Added multi-code timing section. Patient Record Management: 3. Patient/Household File – Added note. 3.2 Insurance – Added notes regarding verification of benefits, eligibility, and remaining benefits. Revenue Cycle Management 1. Insurance Plan Setup and Maintenance – Added introductory table, and split content for claim settings into two sections: one for dental; and one for medical. Added notes about fee schedules. Added payment table information. 2. Claim Management – Replaced green callout with prerequisites list (referring to applicable parts of the document). 2.1 Claim Submission – Added information regarding claim providers. 4.1 Insurance Reference Utilities – Removed green callout. Added note. 4.2 Fee Schedule Maintenance – Added note. Database Design: 1. Enterprise Setup – Rearranged information. Added notes. Updated content. 2.1 Provider Setup – Added specialty information. Added to details regarding IDs. 3. Dentrix Enterprise Configuration – Reordered topics.
2023	Minor	Billing Updates. Formatting Updates.
2022	New	IT Security Protocols.
2021	New	Checklists.
2020	Minor	Content updates, various sections.
2019	New	Handbook release / first version.

Overview

The IHS Dental Clinic Manager's Handbook outlines the best practices for the management and operation of Dentrix Enterprise in an IHS clinic. This handbook provides guidance for performing specific workflows in Dentrix Enterprise—from program configuration to monthly closeout duties. This handbook is your resource for dental clinic management processes in Dentrix Enterprise.

Note: This document has been updated for Dentrix Enterprise versions up to 11.0.44.

Daily Clinic Closeout Duties

The Daily Clinic Closeout Duties checklist is a comprehensive list of checks and balances to ensure the accuracy of today's entries recorded within Dentrix Enterprise, allow the tracking and reviewing of daily internal key performance indicators, guide preparations for tomorrow's scheduled appointments, and verify the completion of today's insurance revenue processes, where applicable. Each table of the checklist provides details for performing a task. To complete the task's objective, use the suggested report filters, review the report, be aware of any dependencies, and take actions or make corrections if the report does not yield the expected result. To record the task's completion, enter the review date, your name, recommended actions, target date, and completion date.

Checklist Task / Report	Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*	Completion	
Day Sheet Report (All Clinics / All Providers)	• Date Range: Today, by Entry Date • All parameters for Clinic, Provider, Billing Type, and Patient Tag	Dental Chief or Management Lead	Review all transaction activity to gain an understanding of the care provided to patients, identify gaps in care, and determine the productivity of each provider.	Prior to running the Day Sheet Report, all appointments must be marked as <Complete>, which indicates that all procedures have been completed and reviewed for accuracy. • <u>Appointment Book</u>: Confirm all appointment statuses have been changed to COMPLETE. Cross check the schedule with the day sheet for missing patients. • <u>Chart</u>: Assign the correct patient clinic and provider(s) to and complete the day's services. • <u>Ledger</u>: Correct posting errors for payments and adjustments. • <u>Family File</u>: Assign the correct billing type.	The Dental Chief (or Management Lead) will not be able to observe the amount and type of dental care being delivered by the clinic as a whole and/or by specific primary and secondary providers.	• Schedule Optimization • Patient Records • Clinical Records • Revenue Cycle • Reports Reference*	Date Reviewed: Assigned Individual: Actions Required: Target Date: Completion Date:	

Checklist Task / Report	Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*	Completion	
Day Sheet Report (Individual Provider)	• Date Range: Today, by Entry Date • All parameters for Clinic, Billing Type, and Patient Tag • Filter by individual Provider	Individual Provider	An individual provider reviews their completed procedures prior to filing insurance claims so they can take accountability for patient care that was performed.	Prior to running the Day Sheet Report, all appointments must be marked as <Complete>, which indicates that all procedures have been completed and reviewed for accuracy. • Appointment Book: Confirm all appointment statuses have been changed to COMPLETE. Cross check the schedule with the day sheet for missing patients. • Chart: Assign the correct patient clinic and provider(s) to and complete the day's services. • Ledger: Correct posting errors for payments and adjustments. • Family File: Assign the correct billing type.	If accurate data is not in place, it will adversely affect both production and collection numbers. The Provider delivering the patient care is the true source accountable for the patient clinical record. Additionally, submitting insurance claims with incorrect information leads to processing delays, resubmissions, and claim payment delays.	• Schedule Optimization • Patient Records • Clinical Records • Revenue Cycle • Reports Reference*	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	
Daily Appointment List -or- Appointment Book View Printout	• Appointment Date: Tomorrow • All parameters for Provider, Operatory, and Patient • Select Report Type (as preferred)	Provider	Provider reviews tomorrow's schedule to ensure their availability for appointments scheduled and identify patient treatment needs and challenges.	Patients have been confirmed and emergencies have been allotted a time slot in the appointment schedule. • Appointment Book: Attach correct procedures, provider, and time length to appointments. Document additional information when needed for specific appointment types. Lab case follow-ups. • Family File / Patient Records: Identify and record needed patient form updates.	Without this review of tomorrow's schedule, Providers and Staff may be ill-prepared to work through challenges with the schedule that can easily be avoided (such as appointments that are too short to provide the needed care and a provider being out of the office for part of the day).	• Schedule Optimization • Patient Records • Clinical Records	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	

Checklist Task / Report	Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*	Completion	
Insurance Eligibility Report	All parameters for Provider, Employer, Patient, and Insurance Date Range: Tomorrow (and the next day)	Billing or Front Desk Staff	Review patient insurance eligibility and coverage for the date of scheduled treatment.	An insurance plan has been attached to the patient along with dates of eligibility. This will result in an "E" indicator on the patient's scheduled appointment. Color code for eligibility Indicator on appointments: Yellow = Not Checked Green = Eligible Red = Not Eligible • Family File: Attach insurance plan to patient record. Verify insurance eligibility. Enter eligibility dates and coverage detail.	If the insurance information for the scheduled patient is not verified, the coverage or payment for services may be jeopardized. Any treatment rendered and accounts receivable increase without verification of insurance benefits will require further billing review for additional action.	• Patient Records • Revenue Cycle	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	
Scheduling Assistant (v. 8.0.9 and later)	• Select Appointment List: Continuing Care, Unscheduled Appointments, ASAP, Unscheduled Treatment, or Unscheduled Treatment Requests • Select list filters • Clinic and Provider (as needed)	Front Desk Staff	Compare scheduling lists with appointment opportunities to ensure timely patient care.	Continuing care is attached to a patient record. Proper appointment break/wait/will call workflow. ASAP appointment status assigned to appointment. Treatment plans and treatment requests attached to patient record. • Appointment Book: Create appointment and assign ASAP status. Attach continuing care to appointments. For cancellations, break the appointments, and mark them as Wait/Will Call. • Family File: Assign applicable continuing care types and intervals. • Chart: Enter treatment plan. • More Information: Enter treatment request.	Patient care opportunities are not optimized if those in need of appointments before provider availability occurs are not monitored. Open times in the clinic's schedule due to cancellations will not be as easily filled if the scheduling lists are not used.	• Schedule Optimization • Patient Records • Clinical Records	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	

Checklist Task / Report	Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*	Completion	
Signature Manager	• Date Range: Today's date • Select Clinic and Provider • Status: Unsigned	Dental Chief and Individual Provider	Review and approve (sign) all open clinical notes.	Clinical notes and electronic signatures (approvals) are being used in the EDR. • Clinical Notes: Review note for completion. Add or modify clinical note as needed. Sign clinical note.	Not using this fail-safe report leaves unsigned clinical notes open for editing. Identifying those unsigned clinical notes with this report is a quick and easy way for Providers to find any clinical notes that need attention and completion.	• Clinical Records	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	
Day Sheet – Deposit Slip	• Date Range: Today, by entry date • All parameters for Clinic, Operator, Billing Type, and Patient Tag	Billing or Front Desk Staff	Review all payment transaction activity to reconcile receipts for the day.	Prior to running the Day Sheet - Deposit Slip, all payments must be entered into Dentrix Enterprise. • Ledger: Correct posting errors for payments and adjustments.	The Dental Chief (or Management Lead) will not be able to observe the amount and type of payments received by the clinic.	• Revenue Cycle	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	

Checklist Task / Report	Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*	Completion	
Procedures Not Attached to Insurance Report	• Date Range: Today • All parameters for Patient, Clinic, Provider, Billing Type, and Patient Tag	Billing or Front Desk Staff	Ensure that all applicable completed procedures have been attached to insurance claims.	Day Sheets have been reviewed and verified for accuracy. Insurance claims are created for today's completed procedures. • <u>Ledger</u>: Generate and submit a claim for all billable procedures. Mark procedures as "Do not bill to insurance" as needed.	If procedures are completed but not attached to a patient's claim for processing, this is revenue that may be lost or delayed. This report identifies procedures that are missing from claims so that you can quickly and easily add those procedures to claims prior to processing them.	• Revenue Cycle	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	
Secondary Insurance Claims Not Created Report	• Date Range: Today • All parameters for Patient, Insurance Carrier, Clinic, Provider, Billing Type, and Patient Tag	Billing or Front Desk Staff	Identify and process secondary insurance claims that have not yet been created.	Both primary and secondary insurance plans have been attached to a patient in Family File. Primary insurance claims have had posting completed. • <u>Ledger</u>: Confirm the services are ready to be sent to secondary insurance. Update secondary insurance within primary claim. Print claim, or send claim electronically.	This report reveals when a patient's secondary insurance claim has not been created following the posting of a payment or denial from their primary insurance. If the clinic does not routinely run this report, secondary insurance claims are not filed, which effectively lowers revenue.	• Revenue Cycle	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	

Checklist Task / Report	Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*	Completion	
Pre-Estimates Not Sent Report	• Date Range: Today • All parameters for Patient, Insurance Carrier, Clinic, Provider, Billing Type, and Patient Tag	Billing or Front Desk Staff	Identify and process pre-treatment insurance estimates that have not been sent.	Clinical staff created treatment plan in Chart. Front Desk or Billing Staff created a pre-treatment estimate in Ledger. • <u>Chart</u>: Confirm the treatment-planned procedures on the claim are ready to be sent to insurance. Print claim, or send claim electronically.	If the patient (or the clinic) needs a pre-treatment estimate prior to proceeding with recommended treatment, this report will reveal those insurance estimates that have not yet been sent. If the report is not generated, all will be awaiting information that has not even left the office to be processed by insurance.	• Revenue Cycle	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	
Suspended Credits Report	• Date Range: Today, by Entry Date • All parameters for Guarantor, Clinic, Provider, Billing Type, and Patient Tag	Billing or Front Desk Staff	Review and allocate where possible any credits/payments entered today.	Payments and adjustments must be entered and accurate for the day. • <u>Ledger</u>: Apply suspended credits.	Leaving credits suspended will have a direct impact on revenue totals for provider A/R, provider revenue, and collections totals for reports filtered by provider.	• Revenue Cycle	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	

Weekly Clinic Closeout Duties

The Weekly Clinic Closeout Duties checklist is a comprehensive list of checks and balances to ensure the accuracy of this week's entries recorded within Dentrix Enterprise, allow the tracking and reviewing of internal key performance indicators and verify the completion of this week's insurance revenue processes, where applicable. Each table of the checklist provides details for performing a task. To complete the task's objective, use the suggested report filters, review the report, be aware of any dependencies, and take actions or make corrections if the report does not yield the expected result. To record the task's completion, enter the review date, your name, recommended actions, target date, and completion date.

Checklist Task / Report	Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*	Completion	
Oral Health Status Report	• Date Range: Last week's range	Dental Chief / CAC	Identify high-risk dental patients for contact and follow up.	• OHS tool is routinely used in order to populate OHS Report data. • Conduct chart audits for non-compliance. • Re-educate on process for completion of OHS metrics.	If the OHS metrics are not completed at patient visits, and subsequent reports are not run, you cannot effectively identify and follow up with high-risk patients.	• Clinical Records • Patient Records • Reports Reference*	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	
Signature Manager	• Date Range: Last week's date to current • Providers and Clinics as needed	Dental Chief / Individual Provider	Review and approve (sign) all open clinical notes.	Clinical notes and electronic signatures (approvals) are being used in the EDR. • Clinical Notes: Review clinical note for completion. Add or modify clinical note as needed. Sign clinical note.	Not using this fail-safe report leaves unsigned clinical notes open for editing. Identifying those unsigned clinical notes with this report is a quick and easy way for Providers to find any clinical notes that need attention and completion. Note: You cannot launch the OHS tool from this module.	• Clinical Records	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	

Checklist Task / Report	Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*	Completion	
Referral Recap Report	• Date Range: Last week's range	Dental Chief Front Desk / Scheduler	Communicate the status of a patients care with referring doctor. Lists both completed and outstanding treatment plan that was referred into the practice for a given patient.	Treatment referred by a doctor into the clinic must be recorded as such in Chart. • Chart: Document the patient's Referred By referral per treatment-planned procedure.	Not communicating the patient's treatment status could leave the patient in a compromised status.	• Database Design • Schedule Optimization • Patient Records • Clinical Records • Revenue Cycle • Reports Reference*	Date Reviewed: Assigned Individual: Actions Required: Target Date: Completion Date:	
Treatment Plan Approval Report	• Date Range: Last week's range	Front Desk / Scheduler, Clinical Manager, CAC, or Dental Chief	Since the Treatment Plan Approval Report lists Pre-Treatment Estimates for both primary and secondary insurance, along with eligibility dates and benefits remaining, this report is another tool to use when contacting patients with unscheduled treatment-planned procedures.	Primary and secondary (if applicable) insurance pre-treatment estimates were submitted and received. In Treatment Planner, the case for the submitted treatment has been marked as either Accepted or Rejected. • Ledger: Treatment-planned procedures sent to insurance for pre-approval. Document the notification from insurance as accepted or rejected.	If this report is not used, insurance-approved estimates for accepted treatment may remain unscheduled, the time invested in recording the information in EDR will have been wasted, and a patient's oral care may be compromised.	• Schedule Optimization • Patient Records • Clinical Records • Revenue Cycle • Reports Reference*	Date Reviewed: Assigned Individual: Actions Required: Target Date: Completion Date:	

Checklist Task / Report	Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*	Completion	
Treatment Plan Approval Status Report	• Date Range: Last week's range	Front Desk / Scheduler, Clinical Manager, CAC, or Dental Chief	These customizable internal statuses are used to identify a group of patients. Information in this report reflects treatment-planned procedures for selected Approval Statuses. Patient and procedure information may also be included to aid with efforts to contact patients and schedule appointments. Additionally, pre-treatment insurance information may be used as a filter in this report.	Meaningful approval statuses must be added to Definitions in the Practice Setup from Office Manager. When adding treatment-planned procedures in Chart, select the applicable Approval Status. When the approval status of a treatment-planned procedure changes, update the procedure accordingly. • <u>Chart</u>: Mark applicable status for treatment-planned procedures.	Improper set up and use of statuses will render this report useless. Not viewing the information on this report will leave patients who are in need of oral health care without a scheduled appointment. A patient's oral care may be compromised, and a team member's time invested in this process will have been wasted.	• Database Design • Schedule Optimization • Patient Records • Clinical Records • Revenue Cycle • Reports Reference*	Date Reviewed: Assigned Individual: Actions Required: Target Date: Completion Date:	
Scheduling Assistant	• Select Appointment List: Continuing Care, Unscheduled Appointments, ASAP, Unscheduled Treatment, or Unscheduled Treatment Requests • Select list filters • Clinic and Provider (as needed)	Front Desk Staff	Compare scheduling lists with appointment opportunities to ensure timely patient care.	Continuing care is attached to a patient record. Proper appointment break/wait/will call workflow. ASAP appointment status assigned to appointment. Treatment plans and treatment requests attached to patient record. • <u>Appointment Book</u>: Create appointment and assign ASAP status. Attach continuing care to appointments. For cancellations, break the appointments, and mark them as Wait/Will Call. • <u>Family File</u>: Assign applicable continuing care types and intervals. • <u>Chart</u>: Enter treatment plan. • <u>More Information</u>: Enter treatment request.	Patient care opportunities are not optimized if those in need of appointments before provider availability occurs are not monitored. Open times in the clinic's schedule due to cancellations will not be as easily filled if the scheduling lists are not used.	• Schedule Optimization • Patient Records • Clinical Records	Date Reviewed: Assigned Individual: Actions Required: Target Date: Completion Date:	

Checklist Task / Report	Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*	Completion	
Referred By/To	• Date Range: Last week's range	Front Desk / Scheduler, Clinical Manager, CAC, or Dental Chief	Identify how patients are coming to the office and where they are being sent for additional services. Identify if additional resources are needed.	• <u>Family File</u>: Document referred by/to within designated fields. • Activate option to require "referred by" during registration (global setting). • Review and follow up on referred treatment.	Documentation of referral sources supports internal processes for managing patient care. Without this workflow, there is greater potential for patient care needs to be missed or not met.	• Database Design • Schedule Optimization • Patient Records • Clinical Records	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	
Provider A/R Totals - By Summary of all Providers or By Specific Provider	• Date Range: Last week's range	Dental Chief / Each Provider	This report reflects both production and collection net totals because it takes into account adjustments to production (such as patient discounts) and adjustments to collections (such as refunds to patients or insurance company, and NSF checks). The results found in the report reflect actual collectible monies.	Charges, payments, adjustments and allocations must be complete and accurate prior to running the report. If a month has ended during this week's date range, a month-end close out must have occurred. • <u>Ledger</u>: Ensure procedures, payments, and adjustment are properly posted to the providers of the rendered service.	Since this report is the only one in the EDR that contains all adjustment types and their relationship to productions or collections, not reviewing this report will leave the Dental Chief and Providers with incomplete information on the status of the clinic's accounts receivable totals.	• Revenue Cycle • Reports Reference*	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	

Checklist Task / Report	Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*	Completion	
Analysis Summary	• Date Range: Last week's range	Dental Chief / Each Provider	This report provides at-a-glance totals, similar to day sheet "totals," that are used to oversee dental site patient, production, and collection totals at a high level.	• Regular review of Day Sheet Report for accuracy of posted transactions. • Ledger: Charges, payments, adjustments, and allocations must be complete and accurate prior to running the report. Ensure procedures, payments, and adjustments are properly posted to the providers of the rendered service.	When this report is not reviewed on a regular basis, the Dental Chief and Providers have a reduced awareness of productivity within the dental clinic.	• Revenue Cycle • Reports Reference*	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	
Suspended Credits	• Date Range: Last week's date to current	Front Desk / Billing Staff Review	Identify payments that have been made but not assigned (allocated) to a date of dental service.	• Management and posting of payments to the patient account in Dentrix Enterprise. Once posted, the payment or credit must be allocated to a procedure or charge. • Ledger: Allocate payments as they come in utilizing the FIFO method unless there is clear documentation of how and when the payments should be applied.	Suspended credits are an interim state for credits in Dentrix Enterprise. Without proper and timely allocation of suspended credit, the itemized balance and provider collection number will be inaccurate.	• Revenue Cycle • Reports Reference*	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	

Checklist Task / Report	Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*	Completion	
Secondary Insurance Claims Not Created Report	• Date Range: Last week's date to current	Front Desk / Billing Staff Review	Identify and process secondary insurance claims that have not yet been created.	Both primary and secondary insurance plans have been attached to a patient in Family File. Primary insurance claims have been reconciled with either a payment or denial. • Ledger: Confirm the services are ready to be sent to secondary insurance. Print claims, or send claims electronically.	This report reveals when a patient's secondary insurance claim has not been created following the posting of a payment or denial from their primary insurance. If the clinic does not routinely run this report, secondary insurance claims are not filed, which effectively lowers revenue.	• Revenue Cycle	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	

Checklist Task / Report	Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*	Completion	

Secondary Pre-Treatment Estimates Not Created Report	• Date Range: Last week's date to current	Front Desk / Billing Staff Review	Identify and process secondary pre-treatment estimates that have not yet been created.	• Family File: Both primary and secondary insurance plans have been attached to a patient in Family File.
				• Ledger:
				  • Primary insurance pre-treatment estimates were sent, estimates have been received, and the estimated coverage has been entered in Ledger.
				  • Confirm the treatment-planned procedures are ready to be sent to secondary insurance.
				• Print claim, or send claim electronically
					If the patient or clinic needs this information prior to proceeding with treatment, this report will identify patients with secondary insurance that a pre-treatment estimate was not filed for after the estimate information from the primary carrier was received.	• Revenue Cycle	Date Reviewed:
							
							Assigned Individual:
							
							Actions Required:
							
							Target Date:
							
							Completion Date:	

Audit Reports	• Date Range: Last week's date to current	Clinical Manager, CAC, or Dental Chief	Identify patterns or discrepancies in transactional and/or data entry by user. These patterns could show invalid or fraudulent activity or the need for reinforcement training.	• Comprehensive data entry and records management within the EDR. • Varies depending up on the transaction, entry, or audit discrepancy.	If not monitored, problems may be identified late, and correction may be difficult or impossible.	• Database Design • Schedule Optimization • Patient Records • Clinical Records • Revenue Cycle • Monthly Checklist: Audit Reports • IHS Dentrix Enterprise User's Guide* • Reports Reference*	Date Reviewed: Assigned Individual: Actions Required: Target Date: Completion Date:	

Monthly Clinic Closeout Duties

The Monthly Clinic Closeout Duties checklist is a comprehensive list of checks and balances to ensure the accuracy of entries recorded within Dentrix Enterprise and allow the tracking and reviewing of internal key performance indicators. Each table of the checklist provides details for performing a task. To complete the task's objective, use the suggested report filters, review the report, be aware of any dependencies, and take actions or make corrections if the report does not yield the expected result. To record the task's completion, enter the review date, your name, recommended actions, target date, and completion date.

Checklist Task / Report	Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*	Completion	
Aging/Credit Balance Report	• Since the report parameters include the ability to specify individual Clinics and/or Providers, it is possible to reveal more targeted information.	Dental Chief, CAC, or Billing Manager	This report provides complete Aged Accounts Receivable information and Credit Balances (i.e. insurance over payments or over adjustments displayed as Suspended Credits). To identify guarantor/patient balances that may need attention due to: Non-Payment Suspended Credits Outstanding/Overdue Insurance Claims	• Maintain fee schedules and insurance coverage to ensure proper patient responsibility. Fees are being charged as procedures are completed. • Collect patient responsibility at time of service. Identify at risk accounts and accounts with credits - follow site internal guidelines for contact/additional action. • Needed corrections to posted transactions are being made on a daily basis, prior to insurance release. Insurance claims are routinely processed to completion. • Month End Update is completed each month.	Without this monthly review, aging balances and the reasons for the overdue state will not be identified and resolved. Incorrect adjustments may not be recognized and corrected. Not reviewing Aging/Credit Balance Report information by Clinic may allow specific site A/R issues to be overlooked and left unresolved.	• Revenue Cycle • Reports Reference*	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	

Checklist Task / Report	Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*	Completion	
Insurance Claims Aging Report	• Since the report parameters include the ability to specify individual Clinics and/or Carriers it is possible to reveal more targeted information.	CAC / Billing Manager	This report displays each insurance carrier with outstanding claims along with aged insurance estimates based on the claim sent date. Reviewing the information on this report allows follow-up on delayed claims. Through further research of the aged claim, the user will discover what needs to be done to expedite processing so that the claim can be paid/adjudicated.	• Fees are being charged and claims billing processed in the EDR and via eServices/eClaims. • <u>Ledger</u>: Generate a claim to be added to the list. Reconcile the claim to remove it.	Without review of this report, insurance claims that need attention in some way will not be recognized and receipt of revenue will be delayed.	• Revenue Cycle • Reports Reference*	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	
Billing Statements	• Since the report parameters include the ability to specify individual Billing Types it is possible to reveal more targeted information.	Billing	Billing Statements are generated to present a patient with services that have been rendered and any balance that has remained unpaid.	• <u>Office Manager</u>: Filters are used to focus on balances that are overdue and collectible. • <u>Ledger</u>: Proper allocation of payments. • <u>DXOne Reporting</u>: Reviewing aging and suspended credit report prior to running billing statements to ensure accuracy of patient balances.	Managing revenue cycle processes within Dentrix Enterprise ensures patient accounts are reviewed for unpaid balances. Generation of billing statements enables the opportunity to communicate balances owed on accounts following treatment and insurance payments.	• Revenue Cycle • Reports Reference*	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	

Checklist Task / Report	Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*	Completion	
Adjustment Summary Report	• This report displays a list of adjustments applied in the EDR Ledger. Among the parameters available in the report are all or specific adjustment types along with all or selected providers.	Dental Chief, CAC	Among the purposes for examining data includes over-use of a "generic" adjustment types that could be further broken down into more specific adjustment types for better tracking.	• Office Manager: Appropriate staff members have been allowed security rights to add Adjustments in the EDR ledger after in-depth training of the cause and effect of entering adjustments. • Set up and use of adjustment type definitions that reflect detailed reporting needs. • Ledger: Application of adjustments to patient account Ledgers.	Not reviewing the information on the Adjustment Summary Report leaves questions about adjustment use unidentified and unresolved.	• Database Design • Revenue Cycle • Reports Reference*	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	
Production Summary Report	• This report displays a list of Procedure in the EDR Ledger. Among the parameters available in the report are all or specific procedure codes along with all or selected providers.	Dental Chief, CAC	Among the purposes for examining data includes identification of high and low volume procedures to allow for proper staffing based on productivity though adjustment of more or less providers needed based on volume.	• Ledger: All visits are documented with a procedure/service code daily. If inaccuracies are identified they were not properly address in daily and weekly check list.	Not reviewing the information on the Production Summary Report leaves questions about procedure code use and the risk for unidentified staffing needs based on volume of patient services.	• Database Design • Revenue Cycle • Reports Reference*	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	

Checklist Task / Report	Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*	Completion	
Payment Summary Report	• This report displays a list of Payment Types in the EDR Ledger. Among the parameters available in the report are all or specific payment types along with all or selected providers.	Dental Chief, CAC	Among the purposes for examining data includes identification of high and low volume payment types.	• Ledger: All payments properly labeled and posted in a timely manner. If inaccuracies are identified they were not properly address in daily and weekly check list.	Not reviewing the information on the Payment Summary Report leaves questions about payment type use unidentified and unresolved.	• Database Design • Revenue Cycle • Reports Reference*	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	
Practice Analysis	• Previous Month	Dental Chief, CAC	View the practices financial situation from a high level. Total Production, collection, adjustments, and age of balances.	• All daily and weekly reports have been verified accurate. • Review daily and weekly reports and audits for outliers and inaccuracies. Reinforce standard operating process through reinforcement training.	The Practice Analysis Report is intended to provide a high overview of clinic health for production, collections, and overall patient transactions. Without review of this report, there are likely to be gaps in practice health awareness.	• Reports Reference*	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	

Checklist Task / Report	Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*	Completion	
Suspended Credits Report	• This report lists any payments or credits that have been suspended in the patient's ledger.	CAC / Billing Manager	Line item accounting is the accounting principle used in the EDR. When a payment or credit adjustment exceeds the patient's balance, it cannot be allocated so it is "suspended". There are both automated and manual ways of handling these unallocated suspended credits. Reviewing the Suspended Credits Report allows discovery and resolve of accounts that have unallocated funds.	• <u>Ledger</u>: Fees are being charged and payments/adjustments are being posted. Allocate payments when payment is made. • Maintain fee schedules and insurance coverage to ensure proper payment allocation.	Not using the Suspended Credits Report to identify unallocated funds leaves revenue unrecognized by way of application to patient balances/procedures. Until the suspended credits are allocated, the provider will not "get credit" for collection of these funds as the payments have not been posted.	• Revenue Cycle • Reports Reference*	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	
Insurance Transaction Analysis	• Previous Month	Billing Manager	Produce a highly customizable report which identifies how insurance plans are reimbursing.	• <u>Ledger</u>: All Insurance payments and adjustments are properly posted in a timely manner. • Review daily and weekly reports and audits for outliers and inaccuracies. Reinforce standard operating process through reinforcement training.	The Insurance Transaction Analysis is intended to provide a detailed account of insurance transactions reimbursements and adjustments. Without review of this report, there are likely to be gaps in fully understanding the historical and future implications for insurance based transactions.	• Revenue Cycle • Reports Reference*	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	

Checklist Task / Report	Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*	Completion	

Audit Reports Combined	• Filters include selection of all patients or designated patient name.
	• There is a Sort By feature that allows selection of the following:
	  ○ Date/Time
	  ○ User
	  ○ Patient Name
	• Action Type
		Dental Chief, CAC	This report identifies users who have performed the following Changes or Actions: Inserted / Modified or Deleted Procedures, Patient Information Accessed, Printed Patient Reports, Patient Health Exchange Export and Data Accessed.
			Among the purposes of performing this audit: may reveal an indication of those users who may have rights that are "too generous" for their roles and/or help define those users who consistently make mistakes and may need reinforcement training. Users accessing patient records when there is no clinical / business reason to do so may also be monitored.
				• Office Manager: Password Securities are in place for each team member who uses the EDR. Set up security groups to ensure access is limited to job responsibility needs.	Not using the Audit-Combined Report leaves the site in a vulnerable position regarding the security of patient information.
					Since there are very specific situations where Patient Information Accessed are and are not allowed, monitoring this user access is essential. And use of printed or exported patient information functionality must be monitored so that PHI is not leaving the facility.
					If there is a user(s) who is excessively editing completed procedures, the reasons behind this must be explored (it could be a simple need for more/individual training or it could be something else altogether).
						• Database Design
						• Patient Records
						• Clinical Records
						• Reports Reference*
							Date Reviewed:
							
							Assigned Individual:
							
							Actions Required:
							
							Target Date:
							
							Completion Date:	

Checklist Task / Report	Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*	Completion	

Audit Reports Transaction	• Filters include selection of all patients or designated patient name.
	• There is a Sort By feature that allows selection of the following:
	  ○ Date/Time Changed
	  ○ User Changed
	  ○ Patient Name
	• Action Type
		Dental Chief, CAC	This report identifies changes to: Completed Procedures, Guarantor Payments, Insurance Payments, Adjustments
			Among the purposes for using this report to identify these changes would be to pinpoint user deficiencies in their EDR skill-set for setting complete procedures and for posting payments and adjustments.
				• Site is using EDR for Revenue Cycle Management (i.e. billing insurance claims)
				• Office Manager: Password Securities are in place for each team member who uses the EDR. Set up security groups to ensure access is limited to job responsibility needs. The ability to make changes to Completed Procedures, Guarantor Payments, Insurance Payments and Adjustments must be limited to those whose roles absolutely require this access.
					Not using the Audit Report - Transactions to identify changes to financial transactions leaves the site in a vulnerable position regarding the security - and accuracy - of patient charges, payments and adjustments.
					If there are previously unidentified reasons for needed changes to transactions, accountability must be in place. So not monitoring this information - and not exploring reasons behind changes - will leave the clinic open to costly errors.
						• Database Design
						• Revenue Cycle
						• Reports Reference*
							Date Reviewed:
							
							Assigned Individual:
							
							Actions Required:
							
							Target Date:
							
							Completion Date:	

Reminder Cards Letter Merge	Appt. Reminders for: • Continuing Care - Patients who are due but not appointed • Continuing Care - Patients who are scheduled	Front Desk/Scheduler	Reminder cards may be generated using the Letter Merge functionality in Office Manager (MS Word integration with EDR). used in addition to scheduling assistant call list	• Office Manager: Continuing Care types are set up and attached to appropriate procedure codes. • Appointment Book: Continuing Care is attached to Patient appointments scheduled (procedure codes must be used in the Appt. Reasons). • Family File: Continuing Care attached to patient file with correct frequency and due date.	Not using cards as a means of reminding patients of either their scheduled appointments or of the need to contact the clinic to schedule is an avoidable situation that negates meaningful communications with patients.	• Database Design • Patient Records • Schedule Optimization	Date Reviewed: Assigned Individual: Actions Required: Target Date: Completion Date:	

Checklist Task / Report	Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*	Completion	
Data Base Backup	N/A	CAC/IT	The data in your Dentrix Enterprise database is one of your most valuable resources used in managing your dental business. In order to protect your investment, a disaster recovery plan needs to be developed, implemented, maintained, and tested.	• It is recommended that your DBA should be a MCITP Database Administrator (Microsoft Certified IT) • Professional Database Administrator) or MCM (Microsoft Certified Master) for MS SQL Server. A trained and qualified MCM or MCITP Database Administrator will already know how to accomplish the tasks	Not having a data backup can be an extremely costly event in a situation where there is a hardware malfunction with the server, causing potentially significant data loss and down time.	N/A	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	

Checklist Task / Report	Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*	Completion	
Month End Update	N/A	CAC / Billing Manager	Running the month-end update is a crucial management routine. The month-end update completes many maintenance tasks important to getting accurate patient data quickly: Aging account balances - Close each month so that account balances will not remain current on your aging reports. Moving procedures to history - All procedures posted during the month being closed will be moved into history, locking out changes and deletions. Creating totals records - To speed report generation, Dentrix Enterprise creates a monthly totals record each time a month is closed. Without this monthly record, Dentrix Enterprise must calculate analysis information each time a report is generated, which can greatly slow the report generation process. Resetting insurance benefits (optional) - For all patients who have dental insurance coverage that resets during the month being updated, the benefits used and deductible applied amounts will be reset. *can be done independent of the month end if needed	• You cannot close out the current month. You must wait until the first day of the next month before Dentrix Enterprise will allow you to close out that month (for example, you cannot close out the month of June until the first day of July). • Everyone must be logged out of Dentrix Enterprise • The process includes enabling single user mode, processing the month end update (run time varies based on amount of data), then disabling single user mode.	Without a routine process for the Month End Update, MTD/YTD totals will be inaccurate, insurance benefits will not reset, and ledger items are not locked and are able to be deleted or modified with correct security level.	N/A	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	

Administrative Reports Checklist

The Administrative Reports checklist is a comprehensive list of checks and balances to ensure the accuracy of entries recorded within Dentrix Enterprise and allow the tracking and reviewing of internal key performance indicators. Each table of the checklist provides details for performing a task. To complete the task's objective, be aware of any dependencies, and take actions or make corrections if the report or action does not yield the expected result. To record the task's completion, enter the review date, your name, recommended actions, target date, and completion date.

Checklist Task / Report	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	Completion	
Patient List	To be used to query the database based on many different filters and data output. This is a List of patients and not a "totaling" type report.	• Consistently following the daily, weekly monthly check list to ensure Dentrix Enterprise data is accurate.	Data integrity will not be optimized without routine review of this report. The simple concept of "garbage in garbage out" applies here to the level of accuracy, knowledge, and system outcomes.	Date Reviewed:	
				Assigned Individual:	
				Actions Required:	
				Target Date:	
				Completion Date:	
Appointment Statistics	Used to identify how long a patient was in an appointment status. Other statistical information is provided such as Broken appointment count.	• Set up and use of Appointment status and "late appointment" tracking is active. • Consistently following the daily, weekly monthly check list to ensure Dentrix Enterprise data is accurate.	Patients may not appear as being on time if they are not seen on time. This makes planning out days and future availability difficult and will result in reduced productivity of the providers and staff.	Date Reviewed:	
				Assigned Individual:	
				Actions Required:	
				Target Date:	
				Completion Date:	

Checklist Task / Report	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	Completion	
Practice Statistics	The Practice Statistics Report provides a detailed cross-section of the practice's patient base, including demographic, age, and continuing care information.	• Day-to-day data entry is accurate. • Consistently following the daily, weekly monthly check list to ensure Dentrix Enterprise data is accurate.	Data integrity will not be optimized without routine review of this report. The simple concept of "garbage in garbage out" applies here to the level of accuracy, knowledge and system outcomes.	Date Reviewed:	
				Assigned Individual:	
				Actions Required:	
				Target Date:	
				Completion Date:	
Initial Health History	The Initial Health History Report displays the percentage of new oral health patients who have a First Visit Date in the Family File that is within a specified time frame and who had an initial health history (determined by specified ADA and/or condition codes) entered into their electronic records during the same time frame.	• Identify and post proper codes at the time of service. • Consistently following the daily, weekly monthly check list to ensure Dentrix Enterprise data is accurate.	Report data will be inaccurate and patient care not optimized.	Date Reviewed:	
				Assigned Individual:	
				Actions Required:	
				Target Date:	
				Completion Date:	
Oral Health Education	The Oral Health Education Report displays the percentage of oral health patients who received oral health education (determined by specified ADA and/or condition codes) at least once during a specified time frame.	• Identify and post proper codes at the time of service. • Consistently following the daily, weekly monthly check list to ensure Dentrix Enterprise data is accurate.	Report data will be inaccurate and patient care not optimized.	Date Reviewed:	
				Assigned Individual:	
				Actions Required:	
				Target Date:	
				Completion Date:	

Checklist Task / Report	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	Completion	
Periodontal Exam	The Periodontal Exam Report displays the percentage of oral health patients who received a periodontal exam (determined by specified ADA and/or condition codes) at least once during a specified time frame.	• Periodontal data entry into the Perio Chart during patient dental visit/exam. • Consistently following the daily, weekly, monthly check list to ensure Dentrix Enterprise data is accurate.	Report data will be inaccurate and patient care not optimized.	Date Reviewed:	
				Assigned Individual:	
				Actions Required:	
				Target Date:	
				Completion Date:	
Visits by reports	Display the number of visits to an office or clinic by community, dentist and facility, and tribal membership. On the report, the first visit, revisit, broken appointment, and PTC (planned treatment completed) values are calculated.	• All the procedure(s) for a given patient on a given day in the Ledger are counted as one visit. IHS condition codes and ADA codes are posted. • Consistently following the daily, weekly monthly check list to ensure Dentrix Enterprise data is accurate.	Report data will be inaccurate, dental teams will not be properly utilized and patient care could be reduced.	Date Reviewed:	
				Assigned Individual:	
				Actions Required:	
				Target Date:	
				Completion Date:	
OHSS Report	For various age ranges, identify how many patients have caries and how many do not, the number of patients with certain conditions, and patients' period measurements.	• Proper patient registration and charting completed. • Consistently following the daily, weekly monthly check list to ensure Dentrix Enterprise data is accurate.	Report data will be inaccurate and patient care not optimized.	Date Reviewed:	
				Assigned Individual:	
				Actions Required:	
				Target Date:	
				Completion Date:	

Checklist Task / Report	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	Completion	
Dentist Activity Reports	Display the number of patients seen by each provider and the types of treatment given. Also, the report displays the RVUs (relative value units) and RVU percentages for the treatment provided.	• IHS condition codes and ADA codes are posted to the correct provider. • Consistently following the daily, weekly monthly check list to ensure Dentrix Enterprise data is accurate.	Report data will be inaccurate, dental teams will not be properly utilized and patient care could be reduced.	Date Reviewed:	
				Assigned Individual:	
				Actions Required:	
				Target Date:	
				Completion Date:	
Dental Hygienists Activity Reports	Display the number of patients seen by each secondary provider and the types of treatment given. Also, the report displays the RVUs (relative value units) and RVU percentages for the treatment provided.	• IHS condition codes and ADA codes are posted to the correct provider. • Consistently following the daily, weekly monthly check list to ensure Dentrix Enterprise data is accurate.	Report data will be inaccurate, dental teams will not be properly utilized and patient care could be reduced.	Date Reviewed:	
				Assigned Individual:	
				Actions Required:	
				Target Date:	
				Completion Date:	
Endodontic Tooth Access Report	Displays, for each provider, the number of teeth accessed, accessed and completed, accessed and extracted, accessed and restored, and accessed and crowned in a specified date range.	• Proper endo procedure codes are posted to the correct provider. • Consistently following the daily, weekly monthly check list to ensure Dentrix Enterprise data is accurate.	Report data will be inaccurate and patient care not optimized.	Date Reviewed:	
				Assigned Individual:	
				Actions Required:	
				Target Date:	
				Completion Date:	

Checklist Task / Report	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	Completion	
Appointment Cycle Time	Identify patterns in chair time usage through application of appropriate appointment status.	• Appointment statuses are being updated • Consistently following the daily, weekly monthly check list to ensure Dentrix Enterprise data is accurate.	Report data will be inaccurate, dental teams will not be properly utilized and patient care could be reduced.	Date Reviewed:	
				Assigned Individual:	
				Actions Required:	
				Target Date:	
				Completion Date:	
Fee Schedule Maintenance	Remove and update fee schedules to ensure proper billing and patient/insurance estimates.	• Security access and availability of updated fees.	Patient financial responsibly estimates could be inaccurate. Billing to insurance carries could yield lower reimbursement and ultimately lead to an increase in the number of accounts with balance billing or credit refund needs.	Date Reviewed:	
				Assigned Individual:	
				Actions Required:	
				Target Date:	
				Completion Date:	
Insurance Carrier Maintenance	Remove and update Insurance Plan to ensure proper billing and patient copays.	• Security access with ability to merge and purge old or duplicate insurance plans.	Patient financial responsibly estimates could be inaccurate. Billing to insurance carries could yield lower reimbursement and ultimately lead to an increase in the number of accounts with balance billing or credit refund needs.	Date Reviewed:	
				Assigned Individual:	
				Actions Required:	
				Target Date:	
				Completion Date:	

Checklist Task / Report	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	Completion	
Practice Organization List	Inactivate Providers and staff to ensure proper billing and reporting.	• Security access with ability to inactivate team members and update schedules.	Dental Enterprise team will not have correct providers to select when scheduling or charting. Charges will go out incorrectly resulting in delayed or missing payments reporting will be inaccurate.	Date Reviewed:	
				Assigned Individual:	
				Actions Required:	
				Target Date:	
				Completion Date:	

Clinic IT Security Checklist

The Clinic IT Security checklist is a comprehensive list of checks and balances to ensure that your EDR data backup jobs are completing successfully and your SQL server and associated servers and workstations are configured for optimal performance. Each table of the checklist provides details for performing a task. To complete the task's objective, be aware of any dependencies, and take actions or make corrections if the action does not yield the expected result. To record the task's completion, enter the review date, your name, recommended actions, target date, and completion date.

Task Interval	Checklist Task / Report	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	Completion	
Daily	Nightly Backup	Backup is crucial for data protection. A regular nightly data backup saves your important files.	• Check your backup software application log for successful backups and remedy any unsuccessful backup job as soon as possible.	Data loss situations due to potential events such as system crash, malware infection, hard drive corruption and failure.	Date Reviewed:	
					Assigned Individual:	
					Actions Required:	
					Target Date:	
					Completion Date:	
Daily	SQL Maintenance Plans (Daily)	SQL Maintenance plan backs up your EDR SQL Dentrix Enterprise data and EDR SQL transaction log and optimizes your SQL configuration.	• Check your SQL server logs for successful SQL backups and remedy any unsuccessful backup job as soon as possible.	Data loss can occur if the SQL Maintenance plans do not run successfully. The EDR server hard drive will eventually become full and EDR Dentrix Enterprise will stop working.	Date Reviewed:	
					Assigned Individual:	
					Actions Required:	
					Target Date:	
					Completion Date:	

Task Interval	Checklist Task / Report	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	Completion	
Daily	Antivirus Scans (Daily/Continuous)	Antivirus programs and computer protection software are designed to evaluate data such as web pages, files, software, and applications to help find and eradicate malware as quickly as possible.	• Antivirus software is an essential part of a good security strategy.	Data loss situations due to common events such malware infection, hard drive corruption and failure.	Date Reviewed:	
					Assigned Individual:	
					Actions Required:	
					Target Date:	
					Completion Date:	
Weekly	Windows Updates	Installing Microsoft Windows updates is critical task that allows for fixes to known issues in Microsoft products.	• Servers and Workstations should be patched to the latest Microsoft operating system updates.	Servers and Workstations are vulnerable to malware, virus and out of date Microsoft applications which could cause your system to stop working.	Date Reviewed:	
					Assigned Individual:	
					Actions Required:	
					Target Date:	
					Completion Date:	
Weekly	Windows System Logs	Monitor and report on file access, network connections, unauthorized activity, error messages, and unusual network and system behavior.	• Check your Server/Workstation system logs for any critical error codes or messages.	Server/Workstation system logs can indicate a potential failure point or undesirable connections to your Server/Workstation.	Date Reviewed:	
					Assigned Individual:	
					Actions Required:	
					Target Date:	
					Completion Date:	

Task Interval	Checklist Task / Report	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	Completion	
Monthly	Hard/Virtual Drive Maintenance	Optimizing your drives can help your Server/PC run smoother and increase performance.	• Server and Workstation hard drive optimization are inherited tools in all Microsoft operating systems.	Hard Drives not fully optimized will have decreased performance.	Date Reviewed:	
					Assigned Individual:	
					Actions Required:	
					Target Date:	
					Completion Date:	
Annually	Data Recovery	Methods of replicating data for security and its ability to reliably retrieve EDR data should the need arise. Backup and recovery testing is an essential part of a disaster recovery plan.	• Guides below outline steps to backup and restore your EDR data. It is strongly recommended that EDR Support be contacted for assistance with Annual Data Recovery Testing.	Successful Data Recovery testing ensures that your EDR data can be restored in case of a critical system event (virus, fire, theft).	Date Reviewed:	
					Assigned Individual:	
					Actions Required:	
					Target Date:	
					Completion Date:	

IT Security Protocols

The following IT security protocols are a sequence of operations that must be performed by an IT System Administrator or local office IT representative to help mitigate potential EDR data loss and improve server and workstation operational performance. In the event of data loss or a malicious outside attack (such as ransomware), your EDR data would be recoverable if the following IT security protocols have been completed successfully.

1. Systems Administration

1.1. Nightly Backup Verification

Backup is crucial for data protection. A regular nightly data backup saves your important files from inevitable data loss situations due to common events such as system crash, malware infection, hard drive corruption and failure.

- Backup critical system and application files on a nightly basis.

- Typical schedules will be set to run Monday through Friday after business hours. If the facility is open for business on Saturday or Sunday, then a Saturday/Sunday night backup is recommended as well.

- Every morning the backup logs should be reviewed (verified) to confirm a successful backup completed.

- Removable media (such as tape, disk, or external hard drive) should be disconnected and replaced with the next device.

- Disconnected backup media should be stored in a fire-safe location or taken securely offsite.

Critical: Check your backup software application log for successful backups and remedy any unsuccessful backup job as soon as possible.

1.2. EDR and Image Server Backup Folders

The following are the file/folders located on the EDR server and/or Image file server that should be backed up to either a NAS (Network-attached storage) or external media on a nightly basis. Local IT personnel should review their local drives, directories, and files to determine what other data should be included in the backup process.

- **DXONE** – Shared, writeable folder containing customizations and report templates.

- **Original** – All software and settings needed to reinstall the EDR implementation.

- **SQLBACKUPS** – SQL Database backups for Dentrix and DEXIS/MiPACS.

- **X-ray images** – DEXIS or MiPACS:

    - **DEXIS** – DEXIS Imaging Suite /TXOUT.

    - **MiPACS** – D:\MIPACS\Images and D:\MIPACS\TXT_OUT.

Note: If other X-ray image software is used, please refer to the X-ray software manual to verify the file/folders that contain X-ray images and back them up accordingly.

1.3. Data Recovery

A backup and recovery test is the process of assessing the effectiveness of an organization's software and methods of replicating data for security and its ability to reliably retrieve that data should the need arise. Backup and recovery testing is an essential part of a disaster recovery plan.

- Backup and recovery (restoring) testing on an annual basis is highly recommended and should be part of the sites D&R (Disaster and Recovery) procedures.

- Restoring your EDR data to a test SQL instance is essential in verifying that the EDR data can be restored correctly and completely.

- The D&R procedures can be performed with assistance from the EDR Support team which can be contacted by phone at (800) 459-8067 or by email at ihs-support@henryscheinone.com.

1.4. SQL Maintenance Plans

SQL maintenance plans are configured during your EDR installation which backup your EDR Dentrix Enterprise data and provide SQL administration to the SQL database. The SQL data backup files are placed in the **SQL BACKUPS** folder mentioned previously. Backing up SQL databases should be part of your daily software backup routine. The SQL maintenance plan is configured to keep the last five days of EDR data.

There are two ways to check the successful completion of an SQL maintenance plan job.

- **SQL Server Management Studio (Method 1)**:

  1. Open SQL Server Management Studio.

  2. Log in using the following options and credentials:

     - **Server type**: Database Engine.

     - **Server name**: [EDR server name]\Dentrix_Live.

     - **Authentication**: Windows Authentication or SQL Server Authentication.

     - **User name**: D1\[D1 User name] (for SQL Server authentication only).

     - **Password**: The SA password supplied to IT during installation (for SQL Server authentication only).
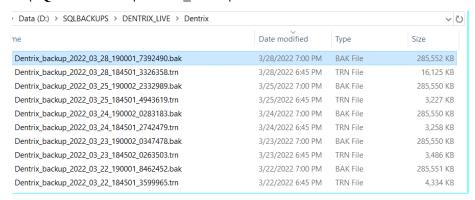
  3. Click the **Connect** tab.

4. On the left, expand **Management** and **SQL Server Logs**, and then click **Current – [M/D/YYYY H:MM:SS AM/PM]**.

The log file summary appears on the right.

5. Review the log, and verify that the SQL backup from the night before successfully completed.

6. If the log file summary indicates that the SQL backup did not complete successfully, call EDR Support by phone at (800) 459-8067 or by email at ihs-support@henryscheinone.com.

- **SQL BACKUP folder review (Method 2)**:

    1. On your EDR SQL server, using File Explorer, navigate to **D:\SQLBACKUPS\Dentrix_LIVE\Dentrix**.

Note: The .bak files are the database data files. The .trn files are the transaction log files.

2. The last five days of SQL backups are listed (.bak and .trn files). In the example above, the SQL maintenance backup plan is configured to run Monday through Friday.

3. For each .bak or .trn file, the date it was created and the file size appear. There should be .bak and .trn files for the last five business days.

- The .bak files usually increase in size each day (as more data is input), but the sizes can be the same from one day to the next.

- The .trn files will vary in size but are much smaller (in size) than the .bak files.

4. If the last five business dates are missing or incorrect and/or the .bak file size is less than the previous days SQL backup, there could be issues with the SQL maintenance backup plan. Review the SQL maintenance backup plan for errors or call EDR Support by phone at (800) 459-8067 or by email at ihs-support@henryscheinone.com.

1.5. Windows Updates/Patches

Installing Microsoft Windows updates is a critical task that allows for fixes to known issues in Microsoft products. The modifications to hardware and software help improve performance, reliability, and security.

Configuring your server and workstations to receive Windows updates automatically is recommended so the latest update is applied on a regular basis. Review the Microsoft update routine for your Windows version.

1.6. Windows System Logs

Windows event log management is important for security, troubleshooting, and compliance. When you look at your logs, you can monitor and report on file access, network connections, unauthorized activity, error messages, and unusual network and system behavior.

The Windows Event Viewer shows a log of application and system messages, including errors, information messages, and warnings. It's a useful tool for troubleshooting all kinds of different Windows problems.

Examples of logged errors and events:

- Disk error messages referring to "bad blocks" that warn of likely drive failures—the event logs are often the first or only place you will learn of such problems.

- Security events that can reveal someone making a sustained effort to access the system.

- Application errors relating to SQL connection errors.

1.7. Hard/Virtual Drive Maintenance

Optimizing your drives can help your server or computer run smoother and increase performance. The process of defragmenting or optimizing the hard drive is an essential step to keep it in good condition.

When your hard drive becomes more than 80 percent filled, your computer will start to work less efficiently. The reason for this is because, when your computer runs out of memory, it will start to use the hard drive space as "virtual memory" to compensate.

Use the following guidelines for drive maintenance:

- Defrag the drive monthly.

- Make sure the free space on the drive is at least 15% of the total size of the drive so Windows can defrag the drive efficiently.

Note: *Virtual hard drives may not need to be defragged.*

1.8. Antivirus Scans

Antivirus programs and computer protection software are designed to evaluate data such as Web pages, files, software, and applications to help find and eradicate malware as quickly as possible. Even if you are experienced with using a computer and cautious in avoiding contact with a virus, antivirus software is an essential part of a good security strategy.

Virus scans search through your system to locate and remove any malicious threats on your device. Most antivirus software guards against malware. This can include threats like viruses, worms, spyware, Trojans, ransomware, and adware.

Follow local and area policies for reporting issues detected by your antivirus application.

Note: *IHS currently uses CrowdStrike and other antivirus applications.*

2. General Firewall Rules

A network firewall is a crucial security tool that must be as robust as possible while balancing security and performance for the users. Network firewalls should protect against external security threats, protect from malware that could exfiltrate sensitive data from your network to other locations, and protect the network from any prospective security threats in the future.

Firewall rules are very specific to the business running the firewall. For network administrators, the following are best practices for using firewalls to protect the network from any existing or potential threat.

2.1. Block traffic by default and monitor user access

In general, the firewall rules should follow a "deny all" philosophy with the exceptions being those few allowed IPs or URLs that the organization has deemed necessary for business. This helps control who can access the network and prevents security breaches from occurring.

2.2. Establish a firewall configuration change plan

A network's firewall will need to be updated from time to time for various reasons to ensure that the firewall remains strong and capable of protecting against new threats. It is important to have a change management plan so that the process is smooth and secure. Any unplanned configuration change leaves a loophole in your network's security.

A well-defined and robust firewall change management plan includes certain basic features:

- Define the changes that are required and their objectives.

- List the risks involved due to the policy changes and their impacts on the network, and provide a mitigation plan to minimize the risks.

- Have proper audit trails that record who made the change, why it was made, and when it occurred.

2.3. Optimize the firewall rules of your network

The firewall rules must be well-defined and optimized to provide the expected protection. Be specific and purposeful with rules. If possible, create different groups of IPs and ports that make sense, which allows you to create a set of firewall rules, and primarily use groups where you can add/remove individual components. Ensure your rules specify the destination and source IP addresses (or sometimes ranges) and destination ports whenever possible.

Cleaning up the firewall rule base to remove any kind of unnecessary clutter can have a positive impact on network security.

To clean your firewall rule base, do the following:

- Eliminate redundant or duplicate rules. These may negatively impact firewall performance because the firewall has to process more rules than necessary.

- Remove the rules that are obsolete or no longer in use. These make the firewall management more complex and may even be a threat to network security if not updated.

- Remove shadowed rules that are not essential. These may lead to more critical rules being neglected.

- Eliminate conflicting rules.

- Eliminate any errors or inaccuracies in the rules. These may result in malfunctions.

2.4. Update your firewall software regularly

It is important to keep updating your firewall software to ensure that your network is secure and that there are no loopholes in the system that could pose a threat to security. From time to time, check if your firewall software is updated to the latest version.

2.5. Conduct regular firewall security audits

Security audits are necessary to ensure that the firewall rules comply with the organizational and external security regulations that apply to the network.

Unauthorized firewall configuration changes that are a policy violation can cause non-compliance. It is important for administrators and IT security staff to carry out regular security audits to ensure that no unauthorized changes have taken place.

3. Incident Response and Log Review Protocol

3.1. Information System Contingency Plan (ISCP)

An Information System Contingency Plan (ISCP) establishes comprehensive procedures to recover EDR quickly and effectively following a service disruption. Each clinic must have a robust ISCP that includes a Disaster Recovery Plan (DRP).

The following recovery plan objectives have been established by IHS:

- Maximize the effectiveness of contingency operations through an established plan that consists of the following phases:

  1. An activation and notification phase to activate the plan and determine the extent of damage.

  2. A recovery phase to restore EDR operations.

  3. A reconstitution phase to ensure that EDR is validated through testing and that normal operations are resumed.

- Identify the activities, resources, and procedures to carry out EDR processing requirements during prolonged interruptions to normal operations.

- Assign responsibilities to designated EDR personnel and provide guidance for recovering EDR during prolonged periods of interruption to normal operations.

- Ensure coordination with other internal personnel responsible for EDR contingency planning strategies.

- Ensure coordination with external points of contact (POC) and vendors associated with the execution of this ISCP.

The ISCP has the following three phases:

1. **Activation and Notification Phase** – Activation of the ISCP occurs after a disruption or outage that may reasonably extend beyond the Recovery Time Objective (RTO) established for a system.

2. **Recovery Phase** – The recovery phase details the activities and procedures for recovery of the affected system. Activities and procedures are written at a level that an appropriately skilled technician can recover the system without intimate system knowledge. This phase includes notification and awareness of escalation procedures for communication of recovery status to system owners and users.

3. **Reconstitution Phase** – The reconstitution phase defines the actions taken to test and validate system capability and functionality. This phase consists of two major activities: validating successful recovery and deactivating the plan. During validation, the system is tested and validated as operational prior to returning operation to its normal state. Validation procedures may include functionality or regression testing, concurrent processing, and/or data validation. The system is declared recovered and operational by system owners upon successful completion of validation testing. Deactivation includes activities to notify users of system operational status. This phase also addresses recovery effort documentation, activity log finalization, incorporation of lessons learned into plan updates, and readying resources for any future recovery events.

3.2. Security Alerts

Cybersecurity and Infrastructure Security Agency pushed the deployment of Falcon CrowdStrike in the government environment. This push trickled down from HHS to IHS for implementation to all endpoints running Windows and Linux operating systems. The agent is installed in a passive state and will not interfere with other agents or software running on your endpoints. Splunk is the data integrator for the CrowdStrike system logs.

To set up a procedure for handling security alerts, do the following:

- Assign someone to receive security alerts.

- Establish a timeframe for addressing security alerts.

- Establish an escalation process according to the severity of security alerts.

3.3. EDR Audit Logs

Review EDR audit logs regularly to ensure that there are no malicious activities occurring. Remove or inactivate users in Dentrix Enterprise when they are no longer actively working at the clinic. Adjust users' access rights when staff members change roles.

3.4. PHI/PII Breaches

The HIPAA Breach Notification Rule (45 CFR §§ 164.400-414) requires HIPAA-covered entities and their business associates to provide notification following a breach of unsecured protected health information. Ensure that a HIPAA breach incident response plan is included in your ISCP.

4. Potential Security Penalties and HIPAA Fines

4.1. Penalties for HIPAA Violations (PII/PHI Breaches)

Penalties for HIPAA violations vary significantly. Factors that affect penalties include how serious the offense was and if it was an accident. If a violation goes on without any correction, it can also lead to a harsher punishment. Everyone working in health care is responsible for following HIPAA rules.

There are four categories of violations and penalties:

- **Tier 1** – The covered entity could not prevent the violation. Usually, the covered entity is also not aware of the violation and couldn't do anything to stop it.

    Fines for violations in this category range from $100 to $50,000 per violation.

- **Tier 2** – The covered entity should have known of the violation. However, the violation still may have been inevitable even with enough care. Willful neglect of HIPAA rules does not fall into this category. You should do what you can to prevent the violation once you know it can happen.

    Fines for violations in this category range from $1,000 to $50,000 per violation.

- **Tier 3** – The covered entity willfully neglected HIPAA rules, which led to a violation, and then attempted to correct the issue.

   Fines for violations in this category range from $10,000 to $50,000 per violation. Factors, such as the level of harm, can affect the exact amount.

- **Tier 4** – The covered entity willfully neglected HIPAA rules, which led to a violation, but did not try to correct the issue. Consistently leaving patient records out or not logging out of electronic records may fall under this category.

   These types of HIPAA violations are the most serious, so they incur the biggest penalties. While other types of violations may qualify for a waiver, these types of violations do not.

   For violations in this category, there is a minimum fine of $50,000 per violation. Also, some of these violations may also result in jail time.

4.2. False Claims Act

The False Claim Act is a federal law that makes it a crime for any person or organization to knowingly make a false record or file a false claim regarding any federal health care program, which includes any plan or program that provides health benefits, whether directly, through insurance or otherwise, which is funded directly, in whole or in part, by the United States Government or any state healthcare system.

Penalties Under the False Claims Act:

- Violations under the federal False Claims Act can result in significant fines and penalties. Financial penalties to the person or organization includes recovery of three times the amount of the false claim(s), plus an additional penalty of $5,500 to $11,000 per claim.

- In addition to the federal law, states have adopted similar laws designed to prevent fraud, kickbacks, and conspiracies in connection with the Medicaid program. Examples of false claims include billing for services not provided, billing for the same service more than once, or making false statements to obtain payment for services. Violation of these laws can constitute a felony that is punishable by imprisonment, a fine of $50,000 or less for each violation, or both. A person who receives a benefit by reason of fraud, makes a fraudulent statement, or knowingly conceals a material fact is liable to the state for a civil penalty equal to the full amount received plus triple the damages.

4.3. Data breaches

Personal information in the United States is currently protected by a patchwork of industry-specific federal laws and state legislation whose scope (notification/remediation processes and fines) and jurisdiction vary.

4.4. Cost of remediation of breaches/incidents

Costs of remediation are more than just the imposed fines by laws. Costs can also include the followin:

- Increased cyber insurance and legal fees.
- Cost of recovering applications/programs/data.
- Reporting burden.

- Diminished trust.

- Lost revenue.

Schedule Optimization

Optimized scheduling balances provider preferences with your organization's needs and demand- creating the perfect schedule for each location. Schedule optimization management can help your practice meet its goals, bring in a steady revenue stream, and stay productive and busy.

1. Scheduling Templates

Scheduling templates allow you to define and maintain a schedule that supports your organization's specific goals. Your scheduling templates should be tailored to your organization and help you grow and improve toward your goals.

<<Insert Scheduling Templates decision support/SOP/guidance here>>

Define the desired goal of your schedule to help align best practices for using the software with your organization's needs. Some examples of various goals or guidance that are associated with scheduling strategies include the following: meeting capacity, having a healthy payor mix, maximizing patient acquisitions, managing re-care rates, meeting dental treatment acceptance, having production goals, and increasing encounter rates.

1.1. Maintaining Schedule Accuracy

Clearly define temporary changes using the following settings to reflect accurate availability in your schedule.

Operations Insight: The default Appointment Book settings for each clinic are established and maintained during database design. For information about making permanent changes to the default schedules for a clinic, refer to the "Database Design" section.

Clinic Schedules

For a clinic in Appointment Book, you can change the working hours for a single day or close the office entirely for a specific date or holiday. To change the clinic's schedule, do the following:

1. On the **Setup** menu, click **Clinic Schedule**.

    The **Schedule Calendar for Clinic** dialog box appears.

2. Do any of the following as needed:

    *   To close the office for a specific date, select the date, expand the **Office Closed** menu, and then click **Close Office on selected date**. You can use this option to close the office for a yearly holiday that does not occur on the same day of the month every year (for example, Thanksgiving).

    *   To set a yearly holiday for the office, select the date, expand the **Office Closed** menu, and then click **Set Yearly Holiday on selected day**. You can use this option to close the office for a yearly holiday that falls on the same day of the month every year (for example, Christmas is always on December 25).

- To update the office's working hours for a specific date, double-click the date, change the date ranges accordingly, select the **Update Op Schedules** checkbox to apply the time changes to the office's schedule for all operatories on this date (overriding but not changing the default availability), and then click **OK**.

3. Click **Close**.

Provider Schedules

For a provider in Appointment Book, you can change the working hours for a single day or set a vacation day. To change the provider's schedule, do the following:

1. On the **Setup** menu, click **Provider Setup**.

   The **Provider Setup** dialog box appears.

2. Select the **Clinic**.

3. Select the **Provider**.

4. Click **Schedule**.

   The **Schedule Calendar for** dialog box appears.

5. Do any of the following as needed:

   - To set a vacation day for a specific date, select the date, expand the **Options** menu, and then click **Set Vacation on selected date**.

   - To update the provider's working hours for a specific date, double-click the date, change the date ranges accordingly, select the **Update Op Schedules** checkbox to apply the time changes to the office's schedule for all operatories on this date (overriding but not changing the default availability), and then click **OK**.

6. Click **Close**.

Workflow Insight: Provider vacation days do not visually look different in Appointment Book. A pop-up message appears if a selected appointment time is outside of the clinic's or provider's working hours. Using the pre-visit workflow or Find Available Appointment feature supports the scheduling templates for the open clinic and provider times without eliminating wasted time reviewing temporary changes in the schedule visually each day.

Events

Events block out time and provide a visual indicator in Appointment Book that the schedule is unavailable. Scheduled events prevent appointments from being scheduled for the planned event date and time. You can schedule an event for a single day or an event that recurs for up to one year.

Operations Insight: You can prohibit users from deleting or editing events in the schedule to prevent them from scheduling appointments during the blocked time. You can assign these security right restrictions by individual user or by user group.

1.2. Procedure Times

With the average length of time necessary to perform procedures specified beforehand, when you schedule an appointment for a procedure or blend of procedures, the default length of time for the appointment is set automatically.

Individual Procedure Timing

A procedure code's time should meet the needs of all clinics that perform that procedure. When you schedule more than one procedure for an appointment, Dentrix Enterprise automatically sets the combined default times of those procedures as the appointment length.

Workflow insight: Getting these times accurate for your organization's needs significantly reduces scheduling errors and the number of steps required to schedule an appointment. Having procedure times set up is ideal for supporting call center operations or centralized scheduling processes.

Multi-code Timing

You can create multi-codes to assist with scheduling needs. A multi-codes is a set of procedures that are performed together. When you schedule a multi-code for an appointment, Dentrix Enterprise automatically sets the default time of that multi-code as the appointment length.

Time Patterns

Time patterns (X, /, and - symbols on the left edge of an appointment tile) can help you identify the intended allotment of provider (X), assistant (/), and chair (-) time. You can assign time patterns to procedure codes and multi-codes. Time patterns can be useful when you are scheduling an individual provider across multiple operatories. These patterns indicate when providers are available.

Workflow Insight: A warning message appears if you attempt to double-book a provider (schedule an appointment with that provider if the appointment has provider time that overlaps with the provider time of an appointment with the same provider in another operatory). Dentrix Enterprise prevents you from scheduling a provider's time that overlaps across three or more operatories.

Operations Insight: One thing you can do to optimize your schedule is to know how long specific procedures take. Conducting a time study to determine average procedure times will assist you in creating more accurate scheduling blocks and lead to less empty-chair time.

1.3. Perfect Day Scheduling

Maintain and update templates for the "perfect" daily schedule that meets the needs of the individual provider, clinic, and the organization.

<<Insert Perfect Day Scheduling decision support/SOP/guidance here>>

Sample guidelines:

- To allow for new patient's to be seen without extended wait times, use time blocks to reserve three new-patient appointments per week. Do not release these times for other patients until 48 hours before.

- To meet production goals, set up time blocks to ensure that each provider is scheduled to meet the daily goal. Use the blocks to search for the available times that align with the amount of production that you are scheduling.

- To identify emergency time and communicate the optimal time to schedule emergencies each day, use the emergency time block.

Provider Setup

Provider hours and time block templates create the framework for searching for available appointment times.

Appointment Types

Appointment types aid in decision support messages. Define appointment types that support the needed templates:

- New patients.
- Emergencies.
- Production goals.

Procedure Codes

Link appointment types to support the scheduled time block templates:

- Schedule with codes to support or avoid time blocks.
- Edit procedures codes to include a supporting appointment type:
  - "New patient" for D0150.
  - "Emergency" for D0140.
  - "Production" for D2750, D3310–D3330, D4341, and D5110–D5226.

Find New Appointment Time

Search by selected time blocks, incorporating the Next Available Appointment Time metric (third next appointment).

Time Blocks

Time blocks are set up per provider and operatory. Keep the following essentials in mind when you are setting up time blocks:

- The number of available time blocks is limited to six per provider and a total of 20 per view.
- The use of time blocks significantly enhances the process for identifying available appointment times that meet the needs of both the organization and the patients.
- You can adjust time blocks individually as needed. Time block flexibility provides a streamlined process for the teams to communicate scheduling changes or needs.
- There are no security rights that restrict the editing, overriding, or clearing of time blocks in the schedule.
- Time blocks appear only if Perfect Day Scheduling is active in Appointment Book.

Operations Insight*: Effective scheduling templates stabilize production from one day to the next and reduce stress due to inconsistency in schedules.*

2. Appointment Management

Manage, document, and communicate modifications to your schedule.

<<Insert Appointment Management decision support/SOP/guidance for scheduling policies>>

2.1. Broken Appointments

You can break appointments to keep track of patient care and document any no-shows or last-minute cancellations or modifications. To break an appointment, do the following:

1. In More Information, select the appointment in the **Next Appointments** list.

2. Click the **Locate Appointment** button to view the appointment in Appointment Book using the applicable view.

3. Right-click the appointment, and then click **Break Appointment**.

    The **Break Appointment** dialog box appears.

4. Select the **Reason** that you are breaking the appointment.

5. Click **OK**.

Breaking the appointment accomplishes the following:

*   Removes the appointment from Appointment Book and moves it to the Unscheduled List, which you can use for scheduling appointments in the future.

*   Updates the missed appointment information in the patient's Family File record to reflect the date of the broken appointment and the patient's total number of broken appointments.

*   Adds an Office Journal entry that shows the date, time, operator, and description of the broken appointment.

2.2. Wait/Will Call

You can mark an appointment as "Wait/Will Call" to place it on the Unscheduled List without having the appointment count towards the patient's broken appointment count. You can use this list for scheduling an appointment in the future when the patient initially contacts the office to schedule an appointment but cannot decide on a date or time yet.

<<Insert Wait/Will Call decision support/SOP/guidance here>>

Sample guidelines:

*   **Cancellation** – A fee could apply if the patient cancels an appointment with less than 48-hour notice. If the patient cancels an appointment 48 hours or more before, there is no fee.

*   **Rescheduling** – A fee could apply if the patient reschedules an appointment with less than 48-hour notice. If the patient reschedules an appointment 48 hours or more before, there is no fee.

*   **No Show** – A fee for 100% of the session amount could apply if the patient misses a scheduled appointment without canceling or rescheduling in advance. The appointment length and the provider determine the session amount.

    If a patient accumulates three no shows, he or she may be put on an emergency/wait call list and no longer allowed to reserve time in the schedule.

2.3. Rescheduling Appointments

Broken/No Show Appointments

If the appointment is considered broken, but the patient wants to reschedule, follow the process and internal guidelines for breaking the appointment to automate the system's ability to track the intended data before moving to the next step.

In More Information, use the pre-appointment workflow, and review unscheduled appointments and other clinical/financial readiness information according to your internal guidelines.

When you attempt to schedule an appointment for a patient who has an appointment on the Unscheduled List, a message appears. Click **Yes** to view the patient's appointment list and use the unscheduled appointment to schedule the new appointment. Clicking **No** and scheduling a new appointment will leave the unscheduled appointment on the Unscheduled List, and the message that indicates the patient has unscheduled appointments will continue to appear whenever you attempt to schedule future appointments for this patient.

Moving Scheduled Appointments

You can reschedule an appointment that isn't considered broken. To move an appointment, do the following:

1. In More Information, review the patient's financial and clinical readiness.

2. On the **Summary** tab, select the scheduled appointment in the **Next Appointments** list, and then click the **Locate Appointment** button to view the appointment in Appointment Book using the applicable view.

3. Double-click the appointment.

   The **Appointment Information** dialog box appears.

4. Click **Find** to locate available times, and move the appointment.

2.4. ASAP/Open/Fixed Schedule

Placing appointments on the ASAP/Open lists is ideal for sorting and strategically managing changes and requests for next available appointments in your schedule.

ASAP

If a patient requests a date and time this week, but the next opening isn't for two or more weeks, assign this status to the appointment. The patient will appear on a list of patients that you can contact when there are unexpected changes in the schedule.

Open

Assign this status to a patient's appointment if the patient is open to last-minute changes or doesn't require notice for shifting appointment times. The patient will appear on a list of patients that you can contact when there are unexpected changes in the schedule.

Note: Having an Open List separate from an ASAP List assists with targeting the correct patients with less research or wasted contact time.

Fixed

Assign this status to a patient's appointment if it is scheduled as intended, and the patient does not want to make changes to their appointment.

Workflow Insight: When adding an appointment to the ASAP or Open list, use the appointment note to annotate any specifics regarding the patient's ability to come in sooner (for example, time of day and frequency limitations). These lists can reduce the amount of time you spend trying to fill open times on your schedule.

3. Patient Communication

There are manual and automated processes for communication about patient appointments.

<<Insert Patient Communication decision support/SOP/guidance>>

3.1. Manual Communication

Use the lists and features within the system for communication needs.

Appointment Reminder System

Minimize the number of no-shows and broken appointments by implementing a system to contact patients at set intervals before their scheduled appointments.

- **Appointment statuses** – Labels placed on appointments to communicate non-verbally the status of reminder/confirmation efforts to all teams.

- **Due dates** – Treatment and continuing care due dates.

Documenting Communication

Use the following features for documenting communication:

- **Quick Letters** – You can generate individual letters or forms per patient, such as for school or work excuses.

- **Letters** – In Office Manager, you can perform a letter merge to generate batches of letters for multiple patients in the same clinic.

3.2. Appointment Lists

Maintain an optimal schedule utilizing the available scheduling lists and reports.

Scheduling Assistant

Simply and easily schedule appointments by combining the appointment managing lists into one window. The Scheduling Assistant includes quick access to a patient's More Information and Office Journal to easily start the pre-visit workflow or document your contact efforts.

- **ASAP List** – This list contains appointments for patients who want to come in sooner if a time slot opens up. Use this list to help you fill last-minute openings in your schedule.

- **Unscheduled List** – This list contains broken and wait/will call appointments. Use this list to help you keep patients active in their care and regain balance in your schedule.

- **Continuing Care List** – This list contains patients according to the specified continuing care due dates and types and other parameters.

- **Treatment Request Manager** – This list contains requests for treatment to be scheduled.

Patient List

Generate custom lists for focused strategies to fill your schedule.

- You can generate a patient list once for a unique need. When setting up the patient list, define the filters to narrow down the list of patients, and then identify the information that you want to see for each patient in the list.

- You can store the criteria for a patient list as a template if you want to generate that list as a standard report. To add a template, click **Add**, enter a **List name**, set up the necessary filters and data fields, click the **Run** button, click **Save**, and then click **OK**. To generate a patient list in the future using that saved template, select that template, and then click **Run**.

3.3. Automated Campaigns

Dentrix Enterprise works with communication systems, such as Demand Force. This arrangement allows for automated communication with the patients in your system and updating appointment statuses. Future development will include the ability to fully integrate with Patient Engage products.

Patient Records Management

Managing patient records is an organizational function for creating, maintaining, storing, and preserving administrative patient records. The electronic dental record (EDR) begins with the patient record where you enter patient and family demographics.

Note: Check with your state's dental society or board of dentistry for information on recordkeeping requirements in your state.

1. Patient Forms

You can use patient forms to record various types of data, such as patient information, medical history, billing information, and consent forms.

<<Insert Patient Forms decision support/SOP/guidance>>

1.1. Quick Letters

With these template letters and forms, you can use the Microsoft Word letter merge features to insert patient information from Dentrix Enterprise into a template. Use Quick Letters to quickly populate a patient form.

Workflow Insight: Use Quick Letters for correspondence, such as school excuse forms and revenue cycle letters. Generating a Quick Letter automatically adds an Office Journal entry that includes the date, time, and type of the letter.

1.2. Consent Forms

Consent forms are directly related to a patient's specific treatment-planned procedures and provide a method to inform a patient about planned treatment and capture signatures.

Workflow Insight: Capture consent form signatures during the patient visit lifecycle.

1.3. Questionnaires

Questionnaires are customizable forms that staff and patients can use to answer pre-defined questions. You can attach multiple questionnaires to a patient. Questionnaires have many uses, such as for emergency/pain evaluations, cosmetic rating scales, and new-patient experiences. You can easily access questionnaires from all patient-specific modules.

Workflow Insight: Questionnaires are designed as an "interview style" of data collection by a staff member. You can enter answers directly in Dentrix Enterprise or print the questionnaire for the patient to write answers on. Questionnaires do not integrate with any websites or kiosks that patients can use to complete forms.

2. Patient/Household File

Dentrix Enterprise provides comprehensive management of patient and household account information. Patient registration workflows can vary greatly depending upon the presence or absence of an interface with a medical product/software.

<<Insert Patient/Household File decision support/SOP/guidance>>

2.1. Patient Information

Individual or Family Accounts

In Dentrix Enterprise, patients are grouped into families. Family accounts allow for the sharing of insurance subscribers and benefit information across individual patients in the same family.

Workflow Insight: When you are deciding whether to use individual patient accounts or family accounts, it is important to define how your organization will assign subscriber information for current and non-patient subscribers in your system. Some HL7 restrictions require individual accounts instead of grouping patients by family. In this situation, sometimes you must enter a subscriber into the system multiple times to allow for proper assignment of insurance benefits.

Personal

When you are entering in the personal information for a patient, it is important to understand other workflows that may be affected by the data. The revenue cycle relies on complete and accurate information for each patient to achieve successful claim and billing processing results.

Workflow Insight: Global settings can help you make certain information required, such as a Social Security Number.

Demographics

The use and selection of demographics populated for each patient depends upon your organization's specific reporting and operational needs.

Operations Insight: Demographics in Family File are often used to populate UDS reports and for other government-related data reporting needs.

Office Info

- **First Visit** – It is important to identify the office requirement for a first visit. Unless you modify the first visit date to reflect the date of the patient's first visit, it is assumed that full registration occurred on the date the Family File record was created.

- **Prov1** – Dentrix Enterprise uses a patient's primary provider (provider 1) to create clinical records and for ease of future scheduling. Insurance claims may also use primary providers.

- **Clinic** – Assign a home clinic to a patient. Some reports, such as the Patient List, use the home clinic for calculations.

Family Edit

- **Merge Patients** – Combine duplicate patient records into one with little to no data loss.

- **Family Relations** – Allows for the handling of unique family relationships:

    - **Changing the head of house** – The head of household is also the guarantor (the person financially responsible for an account) in Dentrix Enterprise. Billing statements are generated based on a patient's guarantor and are addressed to that guarantor. Changing the head of household transfers all guarantor transactions (current and in history) from the original head of household to the new head of household and assigns the new head of household to the entire family.

    - **Combining families** – Combining families allows you to join two separate accounts into one account so they receive only one billing statement. You can combine families only if no current transactions are associated with those accounts.

    - **Separating families** – Separating a family allows you to take one or more patients from one account and move them to another account, such as when children age out of parental care. You can separate a family only if no current transactions are associated with the account.

Workflow Insight: Combining and separating families can result in "special adjustments" in situations where a payment was assigned to the family, assigned to the guarantor, or split between family members. Because a single family payment cannot exist in two different family accounts, Dentrix Enterprise adds special adjustments into the affected accounts to recognize the credit of that prior payment.

2.2. Continuing Care

As you schedule and reschedule a patient for a specific, routine service (such as a cleaning or X-rays) with the applicable continuing care flag assigned to it, Dentrix Enterprise automatically attaches that continuing care type to the patient and updates it accordingly.

Workflow Insight: You can manually assign continuing care types to a patient's record, such as if continuing care was not attached after an appointment. You may also need to manually update continuing care types in a patient's record, such as during an appointment preparation.

Do any of the following for a patient's continuing care type:

- **Override the defaults** – For each continuing care type, you can set up general default settings for all patients; however, in Family File, you can override any of the general defaults for a continuing care type after you attach it to a patient's record. You can also specify patient overrides for a continuing care type before you attach it to a patient's record.

- **Edit** – You can edit a continuing care type that is attached to a patient's record.

- **Clear** – You can remove a continuing care type from a patient if you no longer need to track or update that continuing care type for the patient.

2.3. Referral Information

To track the effectiveness of your referral sources, you must first add them to your Dentrix Enterprise database. Once you have added sources to the database, you can assign them to patients as they are referred to or from your office.

- **Incoming referral** – From the **Referred By** block in Family File, you can view and enter information about the individual or source that referred the current patient to your practice. An incoming referral can be either a "Referred By Patient" or a "Referred By Doctor/Other" referral type.

- **Outgoing referral** – From the **Referred To** block in Family File, you can view and enter information about other dental providers, professionals, and specialists to whom you refer treatment or services as referrals. You can attach an outgoing referral (a "Referred To" referral type) to treatment-planned procedures to have Dentrix Enterprise help you track the patients who have been referred to other doctors or specialists.

3. Patient Financial and Billing Information

The **Financial Information** block in the Family File displays certain financial details about the family account: billing type, balance, and payment details. You can also update this information, manage payment plans, and access guarantor notes.

Why is it important? Documenting patients and financial information is the foundation for a successful revenue cycle management system. Attention to detail with data entry will result in accurate patient reporting. Errors in the patient financial and billing workflows will negatively impact treatment plan estimates, collections, and financial and patient reporting.

3.1. Billing Types

Billing types are account specific, meaning that all patients within a family will be assigned the same billing type. You can assign billing types from either Family File or Ledger.

Benefits of using billing types:

- **Collection routines** – Using billing types in Dentrix Enterprise, you can target specific groups when applying finance charges, processing bills, and generating reports.

- **Financial assistance** – Using billing types that are meaningful to your organization, everyone can be on the same page. For example, if you attach a billing type to patients who are eligible for financial assistance from slides or grants, you can easily see that billing type in Family File and Ledger; then, as you check those patients out, you will know that you need to collect payment for services today or run reports specific to the funding/financial type.

3.2. Insurance

You can add insurance coverage to a head of household or patient in Family File. The insurance coverage that is attached to a head of household or patient appears in the **Insurance Information** block. If the dental insurance plan that you want to assign to a subscriber does not already exist, you can create a new dental insurance plan and assign it to the subscriber.

- **Group/plan** – To ensure that you can submit claims for patients covered by insurance plans to the correct insurance carriers, and to ensure that those claims have the correct information on them, you need to properly assign insurance to each patient's record. Before assigning insurance to dependents, make sure that the insurance plan has been assigned to the subscriber and that the subscriber is part of the same family as the patient to whom you are assigning the insurance plan. If the dental insurance plan that you want to assign to a subscriber does not already exist, you can create a new dental insurance plan and assign it to the subscriber.

- **Fee schedule** – If you attach a fee schedule to an insurance plan, Dentrix Enterprise uses that fee schedule instead of the fee schedule attached to the patient's primary provider. A fee schedule that is assigned to a patient overrides any other fee schedule that may be attached to the patient's insurance plan or provider.

- **Financial class type** – Financial class types are used for tracking types of patient insurance coverage. You can assign financial class types to insurance plans and use them for reporting purposes.

- **Verification of benefits** – Verifying benefits is a way to ensure that the services you render will result in payment from an insurance company. This is really the first step in ensuring payment from both the insurance company and, when applicable, the patient.

  Why is it important?

  - It allows you to gather any necessary authorizations before providing care or services.

  - It allows you to estimate what a patient will owe for rendered services, which helps you to collect payment at the time of service.

  - Accurate insurance verification ensures a higher number of accurate claims which speeds up approval and results in a faster billing cycle. Inadequate verification of eligibility and plan-specific benefits puts healthcare organizations at risk for claim rejections, denials, and bad debt.

  Verification of benefits consists of the following:

  - **Eligibility** – Enter a patient's eligibility for insurance benefits under any of his or her dental and medical insurance plans. Eligibility information is visible from Family File and on scheduled appointments.

    Why is it important?

    - By verifying eligibility, a patient's insurance coverage status can be determined prior to the appointment, and demographic information can be reported accurately on insurance claims. Additionally, prioritizing eligibility promotes proactive collection measures, and prevents payment delays.

    - Eligibility is also valuable for patient care outcomes by identifying when services are due or overdue.

- **Benefits remaining** – Under the applicable insurance plan, click **Ded/Benefits**. All insurance claim payments and deductibles that get posted to claims in Dentrix Enterprise will automatically update this information. You must manually update of this information when benefits are not applied to a claim in the system or a claim that is used with another provider/clinic that is not associated with your site.

  Why is it important? If you verify the benefits used and remaining and enter that information for an insurance plan, Treatment Planner and Ledger can use this information to generate more accurate estimates of insurance and patient responsibility.

4. Administrative/Patient Notes

Manage the documentation of all administrative patient communication. Many notes are text for reference only and are not part of structured data (reportable data).

4.1. Office Journal

The administrative/clerical team uses Office Journal as a notepad for patient communication. Journal entry types are hard coded and not customizable. Your team can add manual entries to document phone calls and other communications with the patient. Office Journal is great for historical tracking, so use it as a resource to identify team activity and confirm that the team is following internal guidelines.

- **Automatic entry types** – When staff perform certain tasks in Dentrix Enterprise, the system automatically adds journal entries with information that allows for easy tracking.

- **Manual entry types** – Staff can add journal entries to document conversations, set reminders for follow up, and so forth. Creating a standard description and note can make searching for information easier.

- **Filtering Office Journal entries** – You can generate and, if necessary, print a list of journal entries according to specified filters.

4.2. Patient Note

In the registration area, you can enter general patient notes, such as hobbies and preferences. A patient note has a 4000-character limit. Patient notes are not historical and can be deleted when they are no longer relevant. When patient notes are standardized, the first four lines can be reportable.

4.3. Decision Support

Dentrix Enterprise provides financial/administrative and clinical decision support.

Patient/Family Alerts

These are customizable alerts that can be attached to patients or families in case you need messages or alerts to appear when someone accesses specified areas of those patients' records. Also, a symbol can appear on the appointments of patients whose records are flagged with alerts. A patient alert is a "you don't want to miss this" type of note. Patient alerts are not historical and can be deleted when they are no longer relevant.

Global Alerts

These alerts appear based on specified criteria that patient records meet. You can use global alerts as clinical decision support to identify patients requiring premedication or as administrative decision support to identify patients with missing demographics.

Setting up a global alert consists of the following:

- **Alert Options** – Specify where the alert can appear. Use caution when deciding where alerts should appear as too many pop-up messages can be cumbersome and slow down workflows. Set up the alert so that it appears only where it is relevant to patient care based on the type of alert.

- **Patient Filters** – Specify what information to use as a filter. Filters identify if certain information exists or not. You can use a filter to check for the following:

  - **Patient information** – To check if a patient has missing information.

  - **Specialized groups** – To check if a patient is part of a certain group based on a billing type or patient tag.

  - **Clinical conditions** – To check if a patient has allergies or needs medication prior to an appointment.

Patient Tags

These are customizable definitions that can be assigned to patients. Patient tags provide visual notification when you are reviewing an account. Patient tags are reportable and available as a filter for many reports and features throughout the program. Be aware that patient tags are not historical and can be removed from patient records when they are no longer relevant.

4.4. Document Storage

Document Center is a place to organize and store documents that have been scanned or imported into Dentrix Enterprise. These items can be associated with patients, are easily accessed from all patient-specific modules, and are used for quick reference.

<<Insert Document Storage decision support/SOP/Guidance here>>

Document Center

Refer to the following processes for documents:

- **Acquiring**:

  - **Scan or acquire from a device** – You can add hard copy (paper) documents into Document Center is by capturing them with a WIA- or TWAIN-compliant scanner, camera, or other device. You can scan documents directly into each entity's Document Center, or you can scan documents in as unfiled documents and then attach them to the correct entities later.

    Workflow Insight: Set up Document Type Templates to standardize Document Center and for quicker and easier acquisitions.

- **Import** – You can add documents that were received electronically into Document Center by importing the electronic files from your computer, your office's network, or a removable storage device—even if the files did not originate from Dentrix Enterprise. When you import from a file, Document Center creates a single-page document. To acquire a multi-page document, you must acquire the first page and then add a page.

- **Send to Document Center** (virtual printer driver) – Dentrix Enterprise has a printer driver that allows you to save a copy of a document from any program that allows printing, such as a word processing program or a Web browser. The document will be saved as a .pdf file in Document Center. You can use this tool even without any Dentrix Enterprise modules open. The "Acquire Documents" security right is required to use the Document Center printer driver.

- **Accessing**:

  - The Document Center toolbar button changes if documents are available. You can access Document Center from all patient-specific modules.

  - The document tree displays saved items by folder types and then by date. Each description is preset for standardization and ease of use.

  - You can easily search through documents by using different views (such as family or staff) and filters (such as document type).

- **Modifying**:

  - **Attachments** – You can modify attachment associations for a specific document. Each document can be associated with a patient, provider/staff, employer, dental insurance plan, medical insurance plan, inbound referral, and/or outbound referral. Also, you can assign additional entities to a signed document.

  - **Signatures** – To prevent the changing or deleting of a document in Document Center, you can lock it with a signature. A signatures can be applied only to a document that is attached to patients, providers, and/or staff members. A signature for each patient, provider, or staff member who is attached to the document is allowed. Once a document has been signed, the document information cannot be changed, but you can attach the document to additional entities.

External Documents

Refer to the following details for external documents:

- **Mode**:

  - **Paper** – If records are maintained outside of the system in a paper chart or other hard copy method, access within Dentrix Enterprise is limited. Consider scanning the hard copies into the system or using patient tags to provide the ability to reference the documents or their locations.

  - **Medical system** – When using an interface, such as HL7, with your medical software, records are often shared between the two systems. Identify which records will be referenced chairside (or as part of a dental visit), and determine if they should be scanned into the dental and/or medical system to support your workflows.

- **Centralized records managers** – If records need to be requested prior to patient care, you can run a daily appointment list to provide as the list of records that have been requested from a central records manager or office. To identify a record has already been provided, you can select the **Chart Pulled** checkbox for an appointment. When you run the daily appointment list, there is an option to **Exclude 'Chart Pulled' Appointments** so the list includes appointments where records are still needed. This is a manual process for identifying when records are received or available within the clinic.

- **Availability**:

  - **Locating information** – Documents outside of the system can be supported using various features in the system. Dentrix Enterprise is not designed to be an external document tracking system but can assist with supporting reference information that identifies if a document or record is maintained outside the system.

  - **Document needs** – Patient tags, Family File consent dates, and Document Center are examples of features that you can use to identify which documents have been completed by a patient and which documents are needed.

- **Status**:

  - **Forms needed** – Patient tags, Family File consent dates, and Document Center are examples of features that you can use to communicate which documents have been completed by a patient and which documents are needed.

  - **Completed forms/data** (interfaced access) – Using an HL7 interface, Dentrix Enterprise can incorporate updated information from your medical software after changes have been made. Review HL7 options annually with support and your internal teams to identify updates to the interface that can be incorporated to support your workflows.

4.5. Patient Online Access (FUTURE)

For managing patient online experiences, some options are not available with Dentrix Enterprise. If you are converting to or adopting Dentrix Enterprise, and your current workflows utilize these options in your legacy system, consider switching to third-party options that integrate with Dentrix Enterprise for accommodating patient online access.

Clinical Records Management

The clinical record, also referred to as the patient chart, is the official office document that records all diagnostic information, clinical notes, treatment performed, and patient-related communications that pertain to medical and dental information in the dental office, including instructions for home care and consent to treatment. The clinical record is captured primarily during the patient visit lifecycle and patient records management. These processes help you maintain the accuracy and integrity of your clinical records.

Note: Check with your state's dental society or board of dentistry for information on record keeping requirements in your state.

1. Clinical Records Accuracy

The clinical record tracks what happens with every patient encounter. Complete and accurate records consist of the basic components for the routine management of clinical coding, documentation, supporting information, and notes.

1.1. Coding

Coding supports uniform, consistent, and accurate documentation of the services delivered and diagnosis.

<<Insert Coding decision support/SOP/guidance here>>

Dental CDT Codes

You can use the following features to assist providers with quick access to the codes that accurately represent the procedures that were performed or planned:

- **Procedure categories** – You can customize these lists to provide coding decision support for the clinical teams within your organization. This can limit the number of codes they need to search through to find the preferred codes.

- **Procedure button sets** – You can customize procedure button sets further to represent the codes that are used frequently by a provider.

Medical CPT Codes

Much like cross coding dental diagnostic codes, you can cross code medical CPT codes with CDT codes and CPT codes with ICD-10 codes. Using this cross-coding process supports coding decisions and internal clinical coding guidelines.

Medical claims require the cross coding of a medical code with a dental code and the attaching of the applicable diagnosis codes.

Workflow Insight: Procedure and diagnosis coding selection is recommended as part of the clinical workflow due to a provider's obligation to provide correct diagnosis and coding.

Supporting or Diagnostic Codes

Both ADA claim forms and HIPAA standard electronic claim transactions can report up to four diagnosis codes per dental procedure.

- **ICD-10** – There is no standard or fixed ICD code related to any procedure code. However, using the cross-coding settings in the system, you can assist with limiting searches for codes.

  - Cross code CDT codes with ICD-10 codes for supported dental diagnosis.

  - ICD codes can be limited to a short list available for specific CDT codes or automatically attached when an ADA code is posted.

- **Conditions** – Condition codes are not part of the official ADA code set. These codes are used in the system to show and attach conditions present to treatment diagnosed in the patient chart. This is simply part of the electronic dental record and will not be used for any third-party reporting or submission for reimbursement.

  Conditions can be used for reporting purposes and can be attached to treatment plans to further identify procedures that are connected to specific conditions.

Procedure Information

In addition to correct coding, each procedure's date of service, clinic, provider, and any additional modifiers make up the accurate coding process.

- Use provider overrides as necessary to ensure that accurate provider information is assigned to completed procedures that were treatment planned previously. For more information, see the "Database Design" section.

- If data entry is not completed on the date of service, it is important to record the accurate date of service for each code. The ability to edit this information depends on security and interface settings.

Operations Insight: There are alternative options for supporting the need to edit completed or posted codes. The ability to update a procedure's date without having to allow for edits is available from Ledger.

1.2. Clinical Notes

Comprehensive and accurate records are a vital part of a dental practice.

Clinical Note Provider and Clinic

When you add a clinical note, you assign a provider and clinic.

Clinical Note Locking

A provider can digitally sign a clinical note to indicate his or her approval of the note. Signing a clinical note locks it to prevent changes from being made to the text and to prevent the note from being deleted.

Workflow Insight: Depending upon certain global settings, clinical note locking can be accomplished automatically or during the month end process, or it can be removed as an option from the clinical notes.

Signature Manager

Providers and use Signature Manager to identify the clinical notes that have not been completed or that need to be signed.

Operations Insight: This tool can also be used for workflow accountability review. It allows you to proactively identify the clinics or providers that have clinical notes needing completion or signatures.

Addendums

Once a clinical note is signed and locked into history, you can record any changes or updates as an addendum to the original note. Addendums allow you to maintain the integrity of clinical notes as they are documented while allowing for updated information to be shown.

1.3. Perio Charting

Dentrix Enterprise provides tools for recording periodontal data.

<<Insert Perio charting decision support/SOP/guidelines here>>

Charting Data Capture

Perio exam methods and philosophies differ from provider to provider. To facilitate different charting styles, Perio Chart allows a provider to set up scripts and paths that represent his or her preferred method of examination.

Exam Order

You can specify how the perio exam progresses through the mouth. Path settings dictate the sequential order of movement through the probing areas of each individual tooth. Since each care provider will not take the same measurements in the same order, Dentrix Enterprise allows the path settings to be customized.

Measurement Calculations (CAL = PD + GM)

While performing a periodontal exam, it is important to remember that the pocket depth, gingival margin, and clinical attachment level measurements have a mathematical relationship. That relationship is such that, given any two of the three measurements, you can mathematically calculate the third. With that in mind, you can enter two measurements; and, based on your chosen calculation method, Dentrix Enterprise will automatically calculate and input the third measurement for you.

Exam Diagnostics

In addition to perio measurements, you can add other perio data to the current perio exam. You can use this data to create customized letters for insurance companies, patients, and clinical notes.

- **Notes** – This section has a predefined selection of options to identify the condition of the patient's gingiva, X-rays, oral hygiene, patient status, and perio status.

- **Summary** – The summary totals provide statistics about the patient's perio condition, probing depths, and clinical attachment levels.

- **Periodontal Case Type** – Types 1–5 are available to identify a patient's periodontal case type.

  Note: A new set of guidelines were released in 2017. These guidelines still reflect the previous classifications published in 1999.

Access / Review

Perio Chart stores all periodontal charting for historic review.

- **Internal** – A completed perio exam is stored in your database and is available for further review, patient education, and/or attaching to an insurance claim.

  - **Graphic chart** – The graphic chart view displays the numeric perio data in a graphical representation. A legend appears at the bottom of the chart to explain the chart symbols. You cannot add or change data in the graphic chart view.

  - **Exam comparison** – To help you educate your patients regarding periodontal disease progression, you can compare up to four saved perio exams with the current exam.

  - **Claims** – To attach a perio chart to a claim, open the include attachments window, and then click **Import Perio Chart** to select the date of the perio exam to attach.

    Operations Insight: All users must be pointed to the same letter template path to allow a person to attach a perio chart to a claim and then another person to submit that claim.

- **Referrals** – You can print custom reports, charts, and letters to provide for transitioning a patient's care to another provider.

1.4. Supporting Documentation

Maintaining supporting clinical documentation is required for proper diagnosis and treatment.

Radiographs

- **DEXIS** – If you purchase and install DEXIS, you can integrate this third-party digital imaging program with Dentrix Enterprise. With Dexis installed, you can access any images that were acquired or imported into DEXIS for a patient. You can attach images in DEXIS to a claim directly from the Dentrix Enterprise Ledger.

- **DentriXLink** – You can link Dentrix Enterprise with a third-party digital X-ray and imaging system. Depending on your imaging software, where and how you store your X-rays or images may vary.

Narratives

Narratives or remarks are notes that an office can write to an insurance company if the insurance company requires any sort of narrative or if the provider wants to provide expanded information about a patient's condition or treatment. You can add a narrative to a claim by opening the claim from Ledger and then clicking the **Note** menu.

<<Insert SOP/Guidance/Decision support on remarks/narratives>>

Sample guidelines can include a clinical team entering specific notes in the procedure notes for direct access by the revenue cycle or billing team. Alternatively, clinical teams can use clinical note templates to incorporate standard remarks or placement of the remarks within the body of the clinical notes.

Models/Digital Scans

If you have a DDX (Digital Dental Exchange) account, you can submit cases electronically to labs online. Signing up for a DDX account is free. The labs to which you want to send cases must also have a DDX account. Also, when you open DDX from Dentrix Enterprise to create a lab case, DDX can pre-populate the online prescription form with basic patient information. With DDX, you can attach a file to submit with the lab script or select the option to ship specific enclosures with the case.

Scanned Documentation

Any additional forms, documentation, or other manually obtained clinical information can be stored in Document Center, which you can access from all patient-specific modules (such as Chart and More Information).

Implantable Devices

You can now add implantable devices to a patient's medical alerts. There is a section in Medical Alerts that displays those devices. You can inactivate a device and specify a reason for doing so. If a procedure has been flagged as being for an implantable device, when you treatment plan that procedure, you can attach a device to the procedure by editing it, or you can wait to attach the device until you complete the procedure (when you post a completed procedure for an implantable device, Dentrix Enterprise automatically prompts you to attach a device).

Prescriptions

You can quickly create and accurately track medicines that are prescribed to your patients.

- **Patient Prescription** – When you enter a new prescription for a patient in Patient Prescription, it automatically appears in the **Medications/Prescriptions** list in Medical Alerts. While prescriptions that your office prescribes to a patient appear in Medical Alerts, medications are drugs that have not been prescribed by your office and are therefore separate from prescriptions.

- **ePrescribe** – ePrescribe allows you to enter, transmit, and manage prescriptions online. This service requires a subscription to be purchased that includes licenses for each individual provider that will be prescribing using this service.

  - **Decision Support** – One of the key benefits of ePrescribe is the ability to incorporate decision support into the prescribing workflow. Using ePrescribe improves patient safety with automatic drug interaction checking, dosage checks, adverse reaction checks, and duplicate therapy checks.

- **Tracking** – When you enter an electronic prescription in ePrescribe, a CCR file is downloaded and processed for the patient. You can then reconcile the document with the data already in the patient's record in Dentrix Enterprise. For each problem, medication, and allergy, select **Keep**, **Update**, **Inactivate**, or **Remove** from the **Action** list. Data that is removed from Dentrix Enterprise will be available only in an audit trail report.

2. Treatment Planning

In Dentrix Enterprise, you can manage the progress of planned patient care. To maximize the patient experience, you should make treatment planning customized and personal, but you should also maintain efficiency. When you post treatment-planned procedures in Ledger or Chart, Dentrix Enterprise automatically places those procedures into a default treatment plan case in Treatment Planner. However, you can create additional treatment plan cases to group and organize procedures. This allows you to, for example, track the status of or prioritize various courses of treatment, create alternative treatment options, or provide different patient payment estimates. You can create a customized patient experience all while maintaining an efficient workflow.

2.1. Case Visit Order

When more than one visit is required to complete a treatment plan case, you can organize the procedures in that case into visits so you know which procedures will be done in each visit.

Workflow Insight: Dentrix Enterprise bases insurance estimates for treatment cases on the assigned visits. Dentrix Enterprise assumes that the procedures in the first visit will be covered by insurance first, and then the procedures in the second visit, and so forth. If patients meet their maximum in the third visit for example, Dentrix Enterprise assumes that the procedures in the fourth visit will not be covered by insurance. So, insurance estimates may vary depending on how you arrange procedures into visits.

2.2. Alternate Treatment Options

You can create alternate cases for a treatment-planned procedure in order to provide the patient with multiple treatment options, such as root canal therapy and a crown versus an extraction, an implant, and a crown. When you create an alternate case, it is linked to the original case as an alternative treatment option.

2.3. Document Treatment Status

You can assign statuses to a treatment plan case during the course of treatment to help you track what has gone on with the case, such as when the case was proposed, referred, accepted, or rejected. The procedures in a rejected case don't appear in Chart, so Chart is not cluttered with irrelevant procedures. You can also record which procedures you have recommended and presented to the patient.

Case Status

Because the status of a case can be searched, selecting a status and adding a note regarding the status change can really help with team communication to get everyone on the same page.

- **Accepted** – You can use this status to specify that the case was accepted by the patient.

- **Rejected** – You can use this status to specify that the case was rejected by the patient.

- **Completed** – You can use this status to specify that the case was completed.

- **Referred** – You can use this status to specify that the case was referred out to a doctor or specialist.

*Workflow Insight: Selecting **Accepted**, **Rejected**, and **Completed** not only updates the case's status but causes a new default treatment plan case to be created. Additionally, selecting **Completed** sets all the procedures in the case "Complete," and the case can no longer be edited.*

Case Severity

You can assign severities to a patient's treatment plan cases to help you prioritize which treatment to perform next and which procedures are considered optional.

- **Immediate** – This case should be done immediately.

- **Eventual** – This case should be done eventually (in the future).

- **Optional** – This case is optional.

- **None** – No severity.

2.4. Consent Forms

The patient and provider can electronically sign consent forms that are attached to a treatment plan case. Once a signature is added to a consent form and the form is saved, the signature cannot be removed. The consent form is considered locked once both parties have signed it.

Workflow Insight: Depending upon certain global settings, a consent form can also be locked during the month end process, when saved with or without any signatures, or after a specified length of time.

3. Clinical Setup Integrity

Evaluate the clinical features and note templates for efficiency.

3.1. Maintaining Coding Connected Features

When changes are made to the CDT code sets, Dentrix Enterprise Support technicians can run the CDT Update utility to populate coding changes in your system. When this utility is run, there are additional places that these codes may be used, which you must review and update manually:

- **Appointment reasons** – You can set up appointment reasons in Practice Definitions. If CDT code changes include any codes in the Appointment Reasons definitions, you must remove or replace them to avoid using the outdated codes for future appointments.

- **Coverage tables** – Default coverage tables do not get updated with the latest codes. Manually editing a coverage table will ensure that the code changes are incorporated into insurance estimates that Dentrix Enterprise calculates.

- **Procedure buttons** – If any of the edited, removed, or added codes are in use or needed in your charting procedure buttons, you must update your button sets accordingly.

- **Multi-codes** – Review multi-codes for updated or inactivated CDT codes and update those multi-codes accordingly.

- **Note templates** – If updated or inactivated CDT codes are included in your clinical note templates or prompts, you must replace or update those templates or prompts accordingly.

- **Procedure Notes** – You can assign default notes to procedure codes and then have them copied automatically to a procedure note or clinical note. If changes are made to the CDT codes, you must review the automatic notes for accuracy.

- **Procedure / Treatment Area Flags** – These flags automatically correct the code for a procedure that you are posting or editing, according to the tooth number and surfaces selected. These flags to change the procedure code can be overridden when you are posting or editing procedures. To review or edit the flags for a procedure code's treatment area, in Procedure Code Setup, double-click a procedure code, and then click **Flags**. The name of the dialog box and available options vary depending on the selected **Treatment Area** for the procedure code.

3.2. Maintaining Code Sets and Access

Refer to the "Database Design" section for adding and updating codes in Dentrix Enterprise.

- **Dental CDT Codes** – The standard ADA-CDT dental codes list is automatically loaded with Dentrix Enterprise. You can add to and edit the procedure codes from Office Manager. For a custom list of current codes in your database, print the Procedure Code List from Office Manager. This printed list will include any additions or changes you've made to procedure codes.

  - **Inactive Codes** – You can inactivate procedure codes that you do not want to post in your practice. You cannot inactivate a procedure code that is in use (such as in an insurance plan's payment table). An inactive procedure code is not available throughout Dentrix Enterprise for any clinic. Inactivating a procedure code is not permanent; you can reactivate any inactive procedure code as needed.

  - **New Codes** – You can add and edit the procedure codes that you post in your practice. If you need a custom procedure code (for instance, a rate code or product code), you can add one, and it will be available for use the same as other codes.

- **Medical CPT Codes** - Due to licensing issues with the American Medical Association, Dentrix Enterprise does not pre-load the AMA-CPT, AMA-CPT Modifier, CPT-Place of Service, CPT-Type of Service, ICD-10CM, or ICD-9CM codes. These codes must be manually added to the database. You can obtain information on the codes and descriptions that can be added from reference books provided by the AMA.

  Note: With the Medical Cross Coding DataPak, you can add all the codes (except ICD-10 codes) into your database.

- **Supporting or Diagnostic Codes**:

  - **ICD-10** – Please contact Enterprise Support at 1-800-459-8067, Option 2 to have a technician run the ICD-10 codes script to enter the dental-related ICD-10 codes into your database.

  - **Dental Diagnoses** – Due to licensing issues, Dentrix Enterprise does not come with the dental diagnostic codes set up. These codes must be manually added to the database. You can obtain information on the codes and descriptions that can be added from reference books provided by the ADA.

  - **Conditions** – Condition codes in Dentrix Enterprise are not tied to specific ICD-10 or SNOMED code sets. These are not official ADA or AMA codes used for reporting or insurance purposes but system specific codes to use to identify present conditions in the odontogram. These codes can be updated or changed as needed for your organization.

    Operations Insight: Condition codes may be used for some of the reports in Dentrix Enterprise. Before making changes or deleting condition codes, verify that those condition codes are not used in necessary reports.

Revenue Cycle Management

Managing revenue cycle in Dentrix Enterprise consists of several independent but connected workflows and processes that are conducted within management routines and patient visit lifecycle workflows. This operations management overview for revenue cycle outlines the key components for dental billing and patient collections.

1. Insurance Plan Setup and Maintenance

There is more to managing your insurance plans than simply entering plan information into Dentrix Enterprise. Understanding the key settings used when building the insurance plans and routine maintenance of your insurance database provides a solid foundation for successful insurance processes.

The following table lists the components of Dentrix Enterprise insurance plan setup and maintenance.

Prerequisites	Defaults	Components
• Providers • Fee schedules • Definitions (Claim Form, Insurance Tags, Adjustment Types, and Financial Class Types) • eClaims enrollment (as needed)	• Claim setup • Default insurance coverage tables	• Insurance data • Insurance plan claim settings • Insurance coverage and estimates

Operations Insight: Insurance plan settings have a direct effect on many key revenue cycle and reporting outcomes.

You can add or edit insurance plans from Family File or Office Manager; however, you can assign a dental insurance plan to a subscriber only from Family File.

Workflow Insight: It is very important to search for existing insurance plans before adding a new insurance plan to prevent duplicate insurance plans in your database. Using descriptive, consistent, standard naming conventions is encouraged to assist with maintaining your insurance plan database.

1.1. Insurance Data

The following options are key items to understand when you are building or editing insurance data. Payor/state-specific claim regulations and organizational guidance will identify the settings needed for each insurance plan.

- **Carrier Name** – Enter the name for the insurance carrier as you would like to see it listed on the insurance plan. Avoid nicknames and internal references.

  Operations Insight: Even though insurance carriers, group plans, and group numbers are set up as independent records in the system, each plan is recognized and reported as an individual entity. Selecting financial class types, insurance tags, or a range of carriers can help when you are running reports. For example, if Delta Dental is the carrier, and there are seven plans for Delta Dental, reports will include seven Delta Dental carriers, and you can even select a range of only the Delta Dental carriers for reports to allow for reporting on their collective information.

- **Group Plan** – If the plan has a specific group, you can enter the group name. If you do not have a group name, you can use the employer name or other internal references. You can select if you want to include the group name on the claim.

  Note: This field is useful when you are searching through insurance plans that were entered previously so you can assign one to a patient.

- **Tags** – You can assign insurance tags to plans as a tool for grouping and searching for insurance plans. Insurance tags are completely customizable definitions to fit your organization's needs. A good example for an insurance tag would be the associated clinic; and if a plan is used for more than one clinic, multiple tags could be assigned.

- **Employer** – If an employer will be attached to the plan, you can select it. The employer must be in the system prior to attaching it to the plan.

- **Group #** – The group number often is the key identifying factor for insurance plans and is used when you are searching for insurance plans in the system. We recommended that you enter the full number as listed without abbreviations to assist with maintaining an accurate insurance plan database. Group numbers can be up to 30 characters.

- **Last Update** – This field is helpful for tracking when a plan was updated in the system. It is important to note that this field is not updated automatically, so you must manually populate it for each change.

- **Benefit Renewal** – This identifies the month that the yearly insurance benefits renew. Not including the accurate month could result in inaccurate insurance estimation calculations.

- **Claim Format** – This determines the type of claim format to use when a claim is generated for the plan:

  - **2019 ADA Claim Form** – The ADA Dental Claim Form provides a common format for reporting dental services to a patient's dental benefit plan. A claim is the formal payment request submitted by a dental care provider to the insurance carrier. The carrier then determines how much of the claim is covered by the patient's plan. Additional instructions for the ADA 2019 Claim Form can be found online.

    https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/publications/cdt/v2019adadentalclaimcompletioninstructions_v3_2022feb.pdf?rev=70d192ad312a47f285487c1d69de4190&hash=8EFBBD50FA335262C463823E1CA83DFE

  - **Health Care Finance Administration - HCFA 1500 Claim Form** – Created by Centers for Medicare & Medicaid Services (CMS), which initially was created to facilitate Medicare and Medicaid reimbursements.

  - **UB04, AKA CMS-1450 Form** – The UB04 uniform medical billing form is the standard claim form that any provider can use for the billing of inpatient or outpatient care. Refer to your state carriers for specific guidance on submitting the UBO4 dental claims. Sample carrier guidance can be found online.

    https://www.amerihealth.com/pdfs/providers/npi/ub04_form.pdf

  - **837** – An 837 file is an electronic file that contains patient claim information. This file is submitted to an insurance company or to a clearinghouse instead of a paper claim being printed and mailed. The 837 file can process patient claim information in different formats: 837D (dental), 837P (professional), or 837I (institutional).

  - **837i** – An 837i (institutional) file is the standard format used by institutional providers to transmit health care claims electronically. The Form CMS-1450, also known as the UB04, is the standard claim form to bill Medicare Administrative Contractors (MACs) when a paper claim is allowed. For additional information and guidance about 837i, refer to the IHS EDR Training Videos.

- **Fee Schedule** – Attaching the maximum allowable fee schedule to the plan is the preferred method to produce accurate insurance estimations throughout the system. For additional information see the "Estimate Components" section.

  Operations Insight: Using the contracted maximum allowable fee also supports workflow efficiency in other areas: reporting, insurance estimations, posting payments, and provider payroll. If there is not a fee schedule attached to the insurance plan, Dentrix Enterprise uses the fee schedule that is attached to the provider of procedures when it calculates the percentages from the coverage table.

- **Payor ID** – The payor ID is the "electronic address" for submitting claims electronically. Each payor has its own payor ID; however, some clearinghouses create their own specific payor ID. The list provided in Dentrix Enterprise includes the payor IDs that are specific to Henry Schein One's eClaims clearinghouse. If you do not use eClaims, you must enter the payor ID manually, and identify the correct payor IDs as directed by your clearinghouse.

  Workflow Insight: Having the payor ID list available in the system directly from the eClaims clearinghouse streamlines the workflow while improving accuracy. If a payor ID is not listed, select the "all payors not listed" ID, and the claim will be processed without any additional steps required. If possible, the clearinghouse updates the payor ID and sends the claim electronically; otherwise, the clearinghouse prints the claim and sends it to the payor. This process eliminates segregating claims that cannot be sent electronically.

- **Financial Class Types** – Financial class types allow you to group different payors into a similar category (such as Medicare, Medicaid, or self-pay) for billing and reporting purposes. The financial class types are set up in Practice Definitions.

1.2. Insurance Plan Claim Settings (Dental Form):

*Operations Insight: You can set up the default claim setup from Office Manager. Go to **Maintenance** > **Reference** > **Claim Setup**. Changing the default claim setup affects any new insurance plans that get created from that point on and does not affect existing plans; however, an option to copy the settings to selected or all insurance plans is available.*

Claim Setup

The ADA claim form DX2019 in Dentrix Enterprise provides additional settings that can be set per plan or as a default for new insurance plans.

- **Formatting Options** – **Font Size**, **Date Format**, and other options (if a carrier requires something non-standard, such as **No Special Characters**).

- **Provider and Fee Options** – The fee schedule to use for procedures on the entire claim: **Billing Provider**, **Insurance Plan**, or **Default** (use the fee schedule that is assigned to the subscriber; or if one is not assigned to the subscriber, the fee schedule that is assigned to the billing provider; or if one is not assigned to the billing provider, the fee schedule that is assigned to the insurance plan).

- **Provider Addresses** – The address to use for the **Billing Provider** and **Rendering Provider** on claims: **Billing Provider Address**, **Rendering Provider Address**, **Rendering Clinic Address**, or **Central Clinic Address**.

- **Advanced Settings** – Additional information that a carrier may require, such as the order of procedure codes or where to use the SSN on a claim.

Print/Send Options

The following options for printing or sending insurance claims are available:

- The **Diagnostic Code System** that is allowed on claims: **ICD 9**, **ICD 10**, or **Unspecified** (to not use diagnostic codes).

- Checkboxes for excluding or skipping items for claims.

- **Advanced** settings to support additional information that a carrier may require in specific boxes on claims.

Auto Adjustment Options

The **Auto Adjustment** options allow Dentrix Enterprise to automatically post adjustments based on the specified insurance coverage or fee schedules. These options are helpful for creating sliding fee scale discounts or other discount plans that provide a percentage discount as well as other variables (such as visit costs and different coverage per types of codes).

Rate Code Options

The **Rate Code Options** provide an automated process for billing rate codes and specific procedure information as directed by the payor. When creating a claim, Dentrix Enterprise includes the specified rate code, rate, and procedure information.

1.3. Insurance Plan Claim Settings (Medical Form):

The medical claim forms in Dentrix Enterprise provide additional settings that can be set per plan or as a default for new insurance plans.

- **HCFA212**:
  - **Diagnostic Code System** – The diagnostic coding system that is allowed on claims: **ICD 9**, **ICD 10**, or **Unspecified** (to <u>not</u> use diagnostic codes).
  - **Advanced** – Settings to support additional information that a carrier may require in specific boxes on claims.
  - **Claim Setup**:
    - **Provider and Fee Options** – The fee schedule to use for procedures on the entire claim: **Billing Provider**, **Insurance Plan**, or **Default** (use the fee schedule that is assigned to the subscriber; or if one is not assigned to the subscriber, the fee schedule that is assigned to the billing provider; or if one is not assigned to the billing provider, the fee schedule that is assigned to the insurance plan).
    - **Provider Addresses** – The address to use for the **Billing Provider** and **Rendering Provider** on claims: **Billing Provider Address**, **Rendering Provider Address**, **Rendering Clinic Address**, or **Central Clinic Address**.
    - **Advanced Settings** – Additional information that a carrier may require, such as anesthesia start and stop times or where to use the NPI on a claim.
- **UB04** (837i for institutional electronic claim submission):
  - **Diagnostic Code System** – The diagnostic coding system that is allowed on claims: **ICD 9**, **ICD 10**, or **Unspecified** (to <u>not</u> use diagnostic codes).
  - **Advanced** – Settings to support additional information that a carrier may require in specific boxes on claims. Refer to the IHS training video "837i: Medical Insurance Plan Setup" for information about the supported claim boxes.
  - **Claim Setup** – Whether box 38 is populated with guarantor or payor information.

1.4. Insurance Coverage and Estimates

Dentrix Enterprise uses standard formulas to provide insurance estimates. The formula used depends on the conditions that are applicable to the fee schedule, coverage table, co-pay, payment table, and insurance override.

Operations Insight: All ADA codes in the coverage table must start with an uppercase D. Codes may not register or calculate correctly if a lowercase d or a zero is used.

Estimate Components

Dentrix Enterprise uses the following factors to calculate insurance estimates:

- **Fee Schedule** – Fee schedules are lists of the maximum amount charged per service. Fees can be set by organization, office, insurance companies, and more.

  Why is it important? The fee schedule is the basis of all financial aspects for production and collection. The fee schedule is directly related to the insurance components and dictates all estimated outcomes.

  How is it used?

  - For treatment plan presentations, to provide good faith estimates (No Surprise Act).

  - In line-item accounting, to determine the insurance payment, patient payment, and provider collections.

- **Fee Schedule Assignment** – The fee that is used in the insurance estimate will be determined by where the fee schedule is assigned in the system. Fee assignment is handled in the following hierarchical order:

  - **Patient fee schedule** – A special fee schedule that must be assigned to the patient for any reason other than insurance purposes.

  - **Insurance plan fee schedule** – The breakdown of what the insurance company will pay for specific services, otherwise known as the contracted rate.

  - **Provider fee schedule** – Usually the office's UCR fee schedule.

  Workflow Insight: If two or more of any of the above fee schedules are selected, the system will always read the one higher on the list. For example, the patient fee schedule takes priority over the insurance plan fee schedule; and the insurance plan fee schedule takes priority over the provider fee schedule. Additionally, if the patient has multiple insurance plans, the primary insurance plan fee schedule takes priority over the secondary and any subsequent coverage.

- **Coverage Table** – You can add insurance benefit breakdowns for each plan as a coverage table. The coverage table includes deductible amounts, plan maximums, and the percentage covered. In the absence of an insurance override and payment tables, the fee schedule and coverage table will be used as the primary source for insurance estimates.

- **Payment Tables** – In the payment table, you can enter the exact dollar amount that an insurance plan pays towards a specific procedure code. Payment table codes override coverage table codes.

- **Co-Pays** – The co-pays in the coverage table are designed to support capitation plans. Using the Cap Plan coverage table that lists all procedures, you can enter a co-payment amount for each procedure that is covered by the plan.

Estimate Exceptions or Overrides

- **Insurance Override** – This option is available per procedure code if the patient has insurance coverage. It allows you to manually override what the system has estimated as the insurance portion for the procedure. Use an insurance override in limited, unique circumstances; you should not use it as a routine practice in your workflow.

- **Pre-Authorization Estimates** – Estimates that you itemize by procedure will update the insurance portion of the estimate accordingly using an insurance override. Use the pre-authorization management tools to assist your team with managing the process.

    - **Coverage Table** – Procedures can be identified as requiring a pre-authorization.

    - **Treatment Plan –** Flag or clear procedures as needing a pre-authorization from Treatment Planner. If a procedure was already flagged from the coverage table, the pre-estimate flag cannot be set or cleared.

        - **Pre-treatment authorization codes** – The **Pre-Est** column in Treatment Planner identifies the need and status of pre-authorizations:

            - **N** – Needed.

            - **S** – Sent.

            - **A** – Accepted.

            - **R** – Rejected.

        The **1** or **2** indicates primary or secondary insurance.

- **Payment Table** – As you post insurance payments, you can select the option to automatically update the payment table for that plan, storing what the insurance plan will pay for a specific procedure. This amount overrides any calculation from the coverage table.

Workflow Insight: Estimates use the following priority: Fee (patient, insurance, or provider), insurance override (manual or pre-auth), payment table, coverage table, and then co-pays.

2. Claim Management

In Dentrix Enterprise, you can manage the full cycle of insurance claims.

Operations Insight: A "clean" dental claim is one that contains all required information for claim adjudication, is free of errors, and is processed in a timely manner. A successful or "clean" claim submission in Dentrix Enterprise is achieved through the collective efforts of multiple operations and management workflows.

Prerequisites for successful Dentrix Enterprise claim management:

- **Patient Information** – Refer to the "Patient Records Management" section.

- **Clinical Information** – Refer to the "Clinical Records Management" section.

- **Provider/Plan Information** – Refer to other portions of the "Revenue Cycle Management" section and the "Database Design" section.

2.1. Claim Submission

<<Insert Successful Claim Submission decision support/SOP/guidance here>>

Claim Providers

- **Billing Dentist or Dental Entity** – The "Billing Dentist" or "Dental Entity" section provides information on the individual dentist's name, the name of the practitioner providing care, or the name of the group practice/corporation that is responsible for billing. Depending on the business relationship of the practice and the treating dentist, the information provided in this section may not be the treating dentist.

- **Treating Dentist and Treatment Location** – In this section, enter information that is specific to the dentist or practitioner acting within the scope of their state licensure who has provided treatment.

- **Pay-to** – This is the business or individual to whom a payment is made.

Primary Dental Claims

You can create primary dental claims per patient during the post visit workflow or as a batch of claims from Office Manager.

Workflow Insight: For procedures that require additional information or attachments, creating claims from Ledger is the most efficient way to identify the needs and complete the information. Batching insurance claims is an effective tool to avoid skipping claims that need to be created, and you can create batches of claims for multiple patients at one time.

Secondary, Tertiary, or Quaternary Dental Claims

When you post an insurance payment for a primary dental insurance claim, Dentrix Enterprise automatically prompts you to confirm if you want to create a secondary dental insurance claim. If you choose not to, or if you add the patient's secondary dental insurance plan after entering an insurance payment for the primary dental claim, you still can manually create a secondary dental insurance claim if needed. Tertiary and quaternary claims must always be created manually and are not shown in insurance estimates, treatment plans, or insurance reports.

Medical Claims

Medical Claims require a combination of AMA codes, ICD-10 diagnostic codes, modifier codes, and service codes added to the system. Entry of the necessary code sets utilized for medical coding can be accomplished manually or installed with the Medical Code Data Pak, which can be purchased from Henry Schein One Sales.

Operations Insight: Medical claims require manual cross coding for each dental procedure code listed on the claim. This process in Dentrix Enterprise is best suited for a limited volume of procedures and claims required for medical cross coding and submission.

Electronic Submission

Submitting Dental and Medical claims electronically with eClaims will simplify the insurance claims process. With eClaims, you can create, validate, and electronically send your insurance claims to payors. Claims can be centrally managed for the organization or by individual clinics.

Operations Insight: Sending claims electronically reduces the reimbursement time to days instead of weeks. Many claims can be adjudicated in real time, reducing the reimbursement time even further.

2.2. Claim Tracking

There are multiple resources to assist you with confirming all necessary claims are sent and tracking the status and data for submitted claims.

<<Insert Claim Tracking decision support/SOP/guidance here>>

eCentral Insurance Manager

The Insurance Manager allows you to track your electronic claims, view submission reports, and view claim statistics. The Insurance Manager cuts the wait time by giving you real-time access to a claim's status, which allows you to identify and begin resolving any "problem" claims within the first two weeks.

Procedures Not Attached

This report identifies any patient who has insurance and completed procedures not attached to a claim.

Workflow Insight: If there are procedures that are not sent on insurance claims, you can mark the individual code as "do not bill." This helps avoid having products and other elective items that should not be billed to insurance listed on the report.

Claims Not Sent

This report ensures claims are processed after being created. If a claim was not sent to the batch, printed, or sent electronically, it appears on this report.

Insurance Claims Aging

This report lists outstanding insurance claims, grouped by insurance carrier, along with the aged balances of each claim.

Claim Denials Management

Request for additional information versus a true denial.

- **Insurance Claim Statuses and Notes –** As you follow up on outstanding insurance claims, you can update an individual claim's status using one of the standard status options listed: **Tracer Sent**, **On Hold**, **Re-Sent**, or **Voided**. The claim status note will automatically be populated with status information, and you can manually type additional information.

- **Resubmit Reasons –** Resubmitting claims can help elevate your RCM effectiveness by reducing management efforts for a claim that has been addressed recently and by providing insight into trends with denied claims within your organization.

  Operations Insight: Resubmitting claims is recommended to maintain the integrity of data surrounding each claim. It is especially important if you are enrolled in eEOB import. Deleting the claim will also eliminate the internal data that links the claim to the eEOB. This simple step can enhance your electronic posting processes.

- **Split Primary Claim –** Splitting a primary claim is important for maintaining accuracy in claims tracking when the data within one claim needs alternative management tasks. This process allows you to single out the procedures you plan to resubmit to the insurance company and allows you to post payment to any procedures that were successfully adjudicated.

- **Zero Payment –** Posting a zero payment also closes the claim on the ledger. Before posting a zero payment to denied claims, we recommend that you review the circumstances to determine if resubmission, splitting, or updating data could warrant new denial management efforts.

- **Claims In History –** Once a claim has been closed, depending on security rights, you may be able to edit and correct the information to resend the original claim. If the claim is closed as well as the month, the claim will be placed into history. It isn't impossible to generate the necessary documentation in the system to resubmit or appeal a claim. The following steps could change based on your internal financial guidelines and account policies.

  - Post the original procedures with the backdated date of service in Ledger.

  - If you post the procedures for the second time, manually post an adjustment to offset the additional charge.

  - Create a claim with the new procedures to submit for payment.

  - If the insurance company sends an eEOB that is electronically linked to the original claim, post the payment manually.

2.3. Claim Payments

<<Insert Claim Payments and Adjustments decision support/SOP/guidance here>>

eEOB (Batch Insurance Payment)

When an insurance carrier sends your office one check or electronic funds transfer (EFT) to cover multiple claims for multiple patients, with Dentrix Enterprise, you can post the large insurance check to multiple patients without having to switch back and forth between different accounts and insurance claims.

- **eEOB –** Some payors provide an electronic Explanation of Benefits (EOB) as an Electronic Remittance Advice (ERA) for an electronic claim that you submit. With the 835 EOB import utility, you can import EOBs (in the 835 X12 4010 standard format) from eCentral into Dentrix Enterprise and post batches of insurance payments to multiple patients' accounts.

  Operations Insight: This feature is available as an add-on that you can purchase, and you must be submitting claims electronically through eClaims. Also, a global setting controls the availability of this feature.

  Workflow Insight: Do not import EOBs until you have received a check from the payor or verified that funds have been transferred through an EFT.

- **Check number** – The check number appears as part of a payment description on family walkouts (enhanced and plain forms), billing statements, the Family Ledger Report, and the Patient Ledger Report. For walkouts and statements, if the check number is longer than 14 characters, an ellipsis and the last 11 characters are displayed. For family and patient ledger reports, if the check number is longer than 13 characters, an ellipsis and the last 10 characters are displayed. Due to space limitations, the following reports, although they do list guarantor payments, do not show payment check numbers: Day Sheet (charges and receipts), Payment Summary Report, Suspended Credits Report, and Day Sheet-Receipts Report.

- **Insurance Overpayments –** A procedure is considered "overpaid" if the amount paid by the insurance company exceeds the estimated amount for an individual line item. When you are posting a batch insurance payment, the **Procedures Undercharged or Overpaid** dialog box appears so you can allocate the overpayment. The following actions are available:

  - **Add Charge Adjustment to Claim and apply remaining** – This option adds a charge adjustment to the claim and applies it to the remaining balance (up to the maximum allowed charge for the procedure).

  - **Suspend Credit for Refund or Credit to Patient** – This option adds offsetting adjustments to the claim to remove the balance and posts a suspended credit to the patient's ledger for a refund or credit.

  - **Allocate to procedure with remaining balance**.

  - **Allocate charge adjustment to claim and apply remaining**.

  - **Reduce Guarantor credit amount and apply to procedure**.

- **Insurance Underpayments –** A procedure is considered "underpaid" if the amount paid by the insurance payment is less than the estimated amount for an individual line item. When you are posting a batch insurance payment, the **Procedures Undercharged or Overpaid** dialog box appears so you can address the underpayment.

3. Posting Payments

In Dentrix Enterprise, you can manage patient payment allocations and adjustments.

<<Insert Patient Payment, Allocations and Credits decision support/SOP/guidance here>>

3.1. Patient Payments

Even if you apply a payment to charges for a family member other than the guarantor, all patient payments are classified as guarantor payments. Guarantor payments always appear in the ledger view, so you can easily see when the last time a payment was made to the account.

Payment Types

There are two general categories in the system for payments: Insurance payments and guarantor payments. Payments that are attached to an insurance claim generated in Dentrix Enterprise are categorized as insurance payments. Payments that are received from patients are categorized as guarantor payments. To assist you in classifying the different types of payments received from patients, you can add and customize guarantor payment types in Practice Definitions. You can define up to 99 payment types.

- Spelling and grammar are important for payment types. Be sure to make payment types understandable and professional as the description of a payment appears on billing and walkout statements.

- If you want to use a payment type for processing credit cards through Axia, select the **Associate with Axia CC Processing** checkbox. Also, if you want a copy of the details from a receipt to be included in the notes of the payment, select the **Copy receipt details to the notes** checkbox.

- You cannot delete a payment type definition if the payment type is associated with a payment that has been posted to any patient's ledger.

Family / Patient

For payments, the default selection for **Apply to charges for** can be set to the family or whomever is currently being viewed in Ledger. We recommend that the individual ledger view is used for easily maintaining individual patient balances within the families. Allocating the payment to the family, allocates the payment using FIFO to all balances for the family; if the patient should pay for only that individual's balance, using the family option could result in the need for manually adjusting allocations. When you are entering payments, you can select whether to apply payments to the family or other individual family members as needed.

Integrated / Automated

If the selected payment type has a "[cc]" at the end of the name, you can use Axia to process a credit card. Select the credit card terminal that you want to use for this payment (the selection will be saved for the user account currently logged in to Dentrix Enterprise).

You can refund a patient's credit card for the amount of payment that was posted in Ledger if the payment is associated with an Axia credit card transaction. If the transaction has not been settled yet by Axia (no money has been transferred yet; this usually happens at the end of the business day), the credit card transaction will not be handled as a refund but will be voided.

Workflow Insight: When a patient makes a payment, you can credit the payment to individual patient charges or to the entire family balance (oldest balance first). Also, you can post pre-payments and suspended payments that are not immediately allocated to a charge.

3.2. Adjustments

Dentrix Enterprise aligns itself with generally accepted accounting principles (GAAP), which recommends that you enter adjustments to correct posting errors, record refunds, and offer discounts. Posting adjustments instead of just editing procedure amounts will allow you to accurately track how those adjustments affect revenue.

Production Versus Collection

For reporting purposes, adjustments can be assigned as either Production adjustments or Collection adjustments. By default, all debit adjustments are in the production adjustments list, and all credit adjustments are in the collection adjustments list.

When you are adding adjustments to the system, it is helpful to include some sort of identifier in the name of the adjustments to assist with selecting the correct type of adjustment for adjusting production or collections.

Adjustment Types

- **Credit adjustments** – When you enter an amount, Dentrix Enterprise automatically allocates the adjustment to the oldest provider balances, according to the charges listed. The amount applied appears in the **Applied** column. If all or a portion of the adjustment has not been applied to any charges, a message appears and asks if you want to suspend the amount; the unapplied amount will be suspended but can be applied at a later time.

- **Charge adjustments** – Dentrix Enterprise assigns the selected patient's primary provider as the provider for the adjustment. When you are entering the adjustment, you can change the provider if necessary. For **Apply Charge**, select whether to apply the charge to the entire family's balance or to apply the charge to only the balance of the patient you specify.

3.3. Suspended Credits

Any payments or credits that are not allocated to a procedure or a debit adjustment are considered suspended credits. This is similar to a "credit balance"; the difference being that the ledger can have a balance and a suspended credit, whereas a credit balance is generally an overpayment.

Patient

If a payment or credit that is assigned to an individual patient results in a suspended credit, it is available to be allocated to that patient's balances. To apply a specific patient's suspended credit to another family member with a balance, in the **Apply Suspended Credits** dialog box you can right-click the suspended amount to change it from patient to family.

Family

Payments or credits that are assigned to family that result in a suspended credit can be applied to any family future balances. If the intent is to suspend the amount for a specific purpose, you can assign it to an individual patient, or you can mark it as "do not automatically allocate" and add a note to communicate the intended use of the credit.

Workflow Insight: If the option to apply a credit to the family is not available, the credit is from an insurance overpayment and cannot be applied to the family. To clear the suspended credit, you must post an adjustment on that patient's ledger.

Suspended Credits Manager

From the Suspended Credits Manager in Dentrix Enterprise, you can apply credits to charges without having to access each patient's ledger one at a time. The Suspended Credits Manager provides centralized management of suspended credits for all patients' accounts.

*Workflow Insight: If the payment amount exceeds the guarantor estimate, a dialog box will appear. Select either **Do not apply the remaining amount** (to only apply an amount equal to the guarantor estimate) or **Apply the remaining amount to the balances** (to apply the remaining amount but not exceed the total charge, which can be paid by insurance and will result in overpayment), and then click **OK**.*

Operations Insight: You can never purposefully suspend an insurance payment. If an insurance payment for more than the amount due is applied, a pair of offsetting adjustments are posted, and the overpayment is applied to the charge (debit) adjustment, leaving the credit adjustment on the account as a suspended credit. It is important that insurance plan setup is accurate to avoid excessive suspended credits being generated from insurance estimate inaccuracy.

4. Maintaining Insurance Database and Fees

4.1. Insurance Reference Utilities

A centralized location to manage insurance plans.

Why is it important?

- Eliminates duplicated insurance plans.

- Reduces operator error of selecting an incorrect plan (fewer to choose from).

- Ensures more accurate patient out-of-pocket estimated expenses (No Surprise Act).

Purge Plans

It is vital to have the most updated and accurate insurance plan information. Periodically you should purge your database of outdated or inactive insurance carriers that are no longer attached to any patients in your system.

Operations Insight: As a safeguard, Dentrix Enterprise allows you to purge only insurance plans that do not have subscribers attached or outstanding claims.

Join Plans

Another essential part of insurance maintenance is making sure that you are not cluttering up your insurance carrier database with multiple, identical plans. Joining plans reassigns patients between plans so you can purge the unwanted duplicates.

Workflow Insight: Following the recommended workflows, combined with your organizations guidelines for adding and updating insurance plans, reduces the duplication of plans in your database.

Note: When you are joining duplicate plans, sometimes due to outstanding claims, one of the plans cannot be purged from the system right away. Consider internal naming or identifiers to help prevent the plan from being used anymore.

4.2. Fee Schedule Maintenance

There are multiple sources and uses for fee schedules: usual and customary rates (UCR), if your site participates and is in-network with insurance companies, specialty services, dental discount plans, and more.

What is it? A centralized location to manage fee schedules. The fee schedule is the basis of line-item accounting and insurance estimate calculation.

Why is it important?

- You can automatically update your fee schedules quickly.

- You can quickly identify the number of patients, insurance plans, and providers that are assigned to each fee schedule.

- You can update your treatment plan fees for a patient from Treatment Planner to reflect any fee schedule changes.

Editing or Adding Fee Schedules

When you are adding fee schedules, you can enter the fees manually per code, copy from a base fee schedule, or import a fee schedule.

- **Attach** – With the fee schedule attached to a clinic, everywhere in the system that you can select a fee schedule, you can filter the list by clinic.

  Operations Insight: Dentrix Enterprise has one centralized database of fee schedules. Attaching fee schedules to a clinic allows you to sort the full list according to the applicable fees for the location. The system will allow 99,999 fee schedules to be entered, so we strongly recommend attaching fees to the applicable clinics.

- **Copy** – You can use an existing fee schedule as the basis for a new fee schedule. You can change any of the amounts as needed once the fee schedule is copied over.

- **Import** – Importing a fee schedule is the preferred method to add or update a fee schedule. Fee schedules must be saved in .csv, .xls, or .xlsx files.

- **Viewing Fee Schedule Associations** – In the **Fee Schedule Maintenance** dialog box, selecting **Attachments** allows you to view the number of patients, insurance plans, and providers that are attached to each fee schedule. Right-click in the **Provider**, **Patient**, or **Insurance** column to view the details.

Workflow Insight: Even if fee schedules are not provided in the required format, or any digital format, there are options for scanning a document, saving it as a .pdf file, and then converting the .pdf file to a .xlsx file. Work with your IT to identify options for importing fee schedules.

Updating Treatment Plan Fees

To maintain the integrity of treatment plan estimates, Dentrix Enterprise does not automatically update the fees for procedures that are assigned to a treatment plan. If the fees have changed since the time a treatment plan was given to a patient, you can manually update the fees in the treatment plan for that individual patient or for all patients from the **Fee Schedule Maintenance** dialog box.

Database Design

You can configure Dentrix Enterprise to meet your organization's specific needs. This section reviews the foundational setup for your organization's database and the configuration of individual modules to best support your workflows (centralized, location based, or a blend of both types).

The following table lists the components of database design.

Step 1: Enterprise Setup	Step 2: Clinic Resource Setup	Step 3: Dentrix Enterprise Configuration
• Creating Clinics • Configuring Clinic Information	• Provider Setup • Staff Setup • Operatory Setup	• Security Setup • Definitions • Procedure Code Setup • Continuing Care Setup • Appointment Book Setup • Clinical Setup • Prescriptions Setup • Ledger Setup • Document Center Setup • Customize Individual Modules and the Registry

1. Enterprise Setup

Customizations to meet your organizational needs start with defining the dental locations, so the Dentrix Enterprise setup process begins in the **Enterprise Setup** dialog box. In the **Enterprise Setup** dialog box, you can create a clinic and configure that clinic's information for operations and reporting. You must be logged in to the Central clinic to set up a clinic.

Operations Insight: Add each dental location as a clinic. You can filter reports for data output at the individual clinic level or grouped with other clinics. Additionally, the creation of clinics provides the opportunity to develop a unique Appointment Book for scheduling patients at each clinic.

Operations Insight: Adding a new clinic in an HL7 interface environment will require updates to the HL7 messaging with the Electronic Medical Record (EMR, such as RPMS).

What is a Clinic? Clinics are physical dental locations. A clinic could also be non-physical, such as a department. In Dentrix Enterprise, a clinic provides a space for unique data entry and tracking and should be considered anytime separation (or filtering) of data is desired.

Why is Clinic Information Important? Clinics are the key to allocation, or the assignment of resources to a location. For example, clinics are used to manage patients, services, staffing, and security assignments. A clinic can be reported on separately or in a group with other clinics. A clinic can have its own setup, including an Appointment Book for scheduling patients.

Because clinics are the base structure for many areas of Dentrix Enterprise configurations and workflows, be aware of how the following areas are dependent upon your clinics:

- Users (providers and staff).

- Security rights (for restricting access).

- Operatories (for scheduling).

- HL7 interface messages.

- Reporting.

1.1. Clinic Information – Clinic Settings Tab

On the **Clinic Settings** tab of the **Clinic Information** dialog box, you enter clinic-specific information. Combining these details with other settings throughout the system allows you to customize where a clinic's information will appear. The details alone do not establish how the information is used in Dentrix Enterprise.

- **Descriptive ID** – This Internal ID is a reference name for the clinic in Dentrix Enterprise and on reports. This is the site's short name or the abbreviated name for the clinic. The Descriptive ID can be a maximum of 11 characters long, and no spaces are allowed.

- **Clinic TIN** – You can link the Clinic TIN to a provider in the Clinic Resource Setup.

  What is a TIN? A Taxpayer Identification Number (Tax ID, or TIN) is a generic term used by the Internal Revenue Service to designate the types of numbers that it allows to be used for tax and identification purposes. It is primarily used to track payments for tax purposes. The Internal Revenue Service assigns a Tax Identifier Number (TIN) to each practice for tax purposes. A TIN can be assigned to the billing dentist if he or she is unincorporated.

  Who needs a TIN? A TIN is not required if you operate a sole proprietorship or an LLC with no employees. This person would simply use his or her own Social Security Number as a tax ID. A company getting a TIN is based on whether there are employees or not.

  Why is it important? A TIN is important for several reasons. It is how the IRS track payments made to agencies, and it is how agencies are identified on claim forms. More information on reporting the TIN on the ADA 2019 Claim Form can be found in the ADA Dental Claim Form Completion Instructions document.

  https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/publications/cdt/v2019adadentalclaimcompletioninstructions_v3_2022feb.pdf

  Operations Insight: Specifying the TIN and NPI for claims is part of the Revenue Cycle Management workflow.

- **Clinic NPI** – The clinic's NPI. You can specify an NPI for a provider as explained in the "Provider Setup" section.

    What is an NPI? A National Provider Identifier, or NPI, is a unique identification number for health care agencies and/or providers. All health care providers must apply for an NPI if they want to be reimbursed by insurance companies, refer patients to others, or write prescriptions.

    - **Types of NPIs:**

        - **Type 1 (Individual) NPI** – An NPI assigned to an individual healthcare provider.

        - **Type 2 (Group) NPI** – An NPI assigned to a healthcare provider group or organization.

    When does an agency need both? The purpose of the two types of NPIs is when a patient receives treatment from a large clinic. The insurance company not only wants to know which clinic the patient visited but also which of the many providers within the large clinic treated the patient.

    Why is it important? Without an NPI, agencies and their providers will not be able to be reimbursed by insurance companies. If a provider refers a patient to another provider who is paid by insurance companies, that referred provider needs the referring provider's NPI to get paid by insurance companies. A referred provider must report the referring provider's name and NPI number on a claim form. Pharmacies will no longer fill prescriptions without the NPI number of the referring provider.

    Operations Insight: In short, the TIN is the number the IRS uses to track money and identify a group with employees. The NPI is an ID number issued to physicians and others that provide medical/dental services. The TIN ensures that you receive accurate reporting of payments for tax purposes, and the NPI assures others that your credentials are legitimate.

- **Title** – The official practice name. The title will appear wherever specific clinics can be selected or wherever practice or clinic information is displayed.

- **Address** – The physical or mailing address of the individual clinic.

    Operations Insight: A P.O. Box or lock box address is not acceptable in these boxes because you can select an alternate address as an insurance claim provider's address.

- **Time Zone-** Each clinic in your organization can be in a different time zone. Access to ePrescribe from this clinic requires that the clinic have a time zone selected. Converting data into Dentrix Enterprise for this clinic requires that the clinic have a time zone selected.

- **Show/Hide/Mask SSN** – Select how Social Security Numbers (SSN) appear throughout areas of Dentrix Enterprise, such as reports, route slips, patient lists, and clinical charts.

    Operations Insight: By default, the Central clinic will mask all but the last four numbers, but other clinics that you add will show all the numbers, so change this setting so that the clinic will mask all but the last four numbers. This setting is recommended to ensure that patient information is secure and removed from or masked on reports, such as route slips, and computers that are visible to patients.

    Note: The SS# and Subscriber ID# boxes in Family File and some audit reports ignore the show/mask/hide selection.

The Social Security Number Fraud Prevention Act of 2017 (Pub. L. 115-59; 42 U.S.C. § 405 note) (the Act), prohibits federal agencies from mailing an unredacted Social Security Number (SSN) through regular USPS mail. This includes truncated SSN (last 4).

- To ensure that IHS personnel do not unwittingly violate the Act, it is required that effective September 15, 2022, any record released in response to any request or business function that contains an SSN and that will be sent by mail (meaning, through the U.S. Postal Service without delivery confirmation) must have the SSN redacted. "Mail" does not include an overnight delivery service, such as USPS Priority Mail® with Delivery Confirmation (DelCon). "Redacted" means fully redacted because truncation would require a regulation.

- All IHS clinics should configure Dentrix Enterprise to <u>not</u> display the entire SSN. The setting should be set to either not display the SSN or only display a portion of the SSN. If you are unsure how to verify or change the setting, search for "changing clinic settings" or "SSN" in the Dentrix Enterprise Help, or contact Dentrix Enterprise Support at <u>1-800-459-8067, Option 2, then Option 3</u>. When you contact Support, you will be asked for the Dentrix Customer ID the ZIP Code for the clinic.

- We all need to be aware that this prohibition on displaying/sharing SSNs includes any previously existing document that displays an SSN, and you must communicate this guideline to all personnel in your office, including contractor personnel, on an ongoing basis.

- **Administrative Contact** – The administrative contact is used for electronic service communication. Only primary providers entered into Dentrix Enterprise with a 10-digit phone number are available for selection.

- **Fiscal year's beginning month (1-12)** – The selected month applies to year-to-date (YTD) totals on reports.

  *Operations Insight: Each clinic can have a unique individual fiscal year beginning month if needed. To align with the federal fiscal year, the beginning month should be set to **10** (October).*

- **Appointment Book "Late Appt" Tracking** – To enable late appointment tracking, you must first identify the appointment status and number of minutes before your organization considers a patient late for an appointment. A "late appointment" will be indicated by a red dot in the upper-right corner of the scheduled appointment when the specified appointment status to watch for remains unchanged for more than the specified number of minutes.

  <<Insert late appointment and appointment status SOP/guideline here>>

  Workflow Insight: This option will only identify "late appointments" for a single appointment status used as the starting point for tracking. You should use the status that is most commonly applied to confirmed appointments, or you can use a reduced number of statuses that are applied to confirmed appointments.

- **Billing Statements** – The information you want to have appear on printed billing statements and walkouts:

    - **Use Central Office Info on Statements** – To print the name and address of the Central clinic on a statement that is sent to a patient of this clinic.

    - **Use Clinic Info on Statements** – To print this clinic's name and address on a statement that is sent to a patient of this clinic.

    - **Use Provider Info on Statements** – To print the name and address of the patient's primary provider (**Prov1**) on a statement that is sent to a patient of this clinic.

    - **Use Custom Settings on Statements** – To print a specified name, address, phone number, and message on a statement that is sent to a patient of this clinic. This option is available only if a certain global setting has been enabled by Support. With **Use Custom Settings on Statements** selected, you can specify the clinic or provider name, clinic address, clinic phone number, and statement message separately, and each clinic can have different settings.

    Operations Insight: This setting supports both centralized and de-centralized billing options. The billing statement's return address is clinic specific and can be set up with a central return address for all locations, with individual clinic information, or with a blend of the options using the global setting.

    Workflow Insight: When you are generating statements, there is an option to use either the default settings from the clinics selected or the settings from the logged in clinic for all statements being generated.

- **Change Provider Completion Options** – This setting automates the process for changing the rendering provider in circumstances when that provider is not the treatment-planning provider. You can specify whether the provider selected will be per patient or the provider selection should be retained until the user logs out.

    Operations Insight: If the completing provider for procedures is often different from the treatment-planning provider, automating the provider override options will reduce the manual process for changing providers on procedures. Even if the current process does not need this setting in place, it is good to think about future growth in the organization and having the setting support multiple providers treating common patients in the future.

    *Workflow Insight: This setting works in conjunction with the **Default Chart Provider** and **Provider from Selected Appointment** settings in the Practice Defaults. Combining these two options eliminates the need to select the chart provider per patient or session.*

    <<Insert Change Provider Completion Options SOP/guideline here>>

1.2. Clinic Information – Organization Settings Tab

On the **Organization Settings** tab of the **Clinic Information** dialog box, you enter organization-specific information (the settings affect all clinics) if you are logged in to the Central clinic.

Operations Insight: These settings are available only if you are logged in to the Central clinic, and these setting apply to all clinics.

- **Enable Patient Access Logging** – To enable the tracking of access to patient information, select the checkbox. When you are accessing a patient record multiple times the same way (in the same module, at the same clinic, on the same date, and by the same user) within the number of minutes specified in the **Minutes between identical records** box, Dentrix Enterprise will create only one entry for the Patient Information Accessed Report.

  Operations Insight: The number of minutes between identical records can be a value from 5 to 1440.

- **Enable Patient Print Logging** – Select this check box to enable the tracking of the following: when reports that contain patient information are generated (including the printing of the chart and the like); when patient records are accessed; additions, deletions, and modifications of patient information; and when patient health information is exported to a patient's portal. This audit information appears on the Audit - Combined Report. If you change this setting, the change is logged in the Audit - Audit Log Status Report.

  <<Insert Security Setting Options SOP/guideline here>>

- **Patient Birthdate/Age on Title Bar** – Select this checkbox to have a patient's birth date and age appear on the title bar of windows in Dentrix Enterprise when a patient is selected. This assists with confirmation of patient identification, especially in areas of scheduling and treatment.

- **Automatic Log Off** – These settings control the amount of "inactive" time that is allowed before a user is logged out of Dentrix Enterprise with the overall goal of securing patient data if a user is not actively engaged in the program. By default, the Dentrix Enterprise is set to automatically log off all users after 60 minutes of idle time. The warning message will appear 60 seconds prior to the user being logged out.

  Operations Insight: This setting is recommended to enhance the security of your system and the integrity of the audit reporting by reducing the potential for someone to leave a computer unsecured.

  << Insert Automatic Log Off security decision support/SOP/guideline here>>

- **Clinical Note Naming** – Clinical notes are organized by date in a "tree" format. Using clinical note naming allows for easy identification of a note origin by placing the template category and clinical note template names next to the note stamp in the tree.

  Workflow Insight: The clinical note naming occurs only when a clinical note is created from a template and only applies to the first template name. If you start a clinical note from the **Medical History Review** dialog box or by clicking the **New Clinical Note** button, the clinical note naming does not apply to that note.

- **Copy to Clinical Notes** – These options determine the information that will automatically be copied to a clinical note.

    - **Patient Health Assessment (Vitals) –** The summary of a health assessment. The full assessment data is outlined even if some of the information is not entered.

    - **Prescriptions –** The details (name, dosage, dispense, refill count, provider, clinic, sig, and notes) of a prescription.

    - **Medical Alerts –** Any changes made to a patient's medical alerts, including the alert, type of change, origin date, and notes.

        Workflow Insight: The summary of a medical history review is automatically copied to a clinical note and includes the full list of active medical alerts that are recorded for a patient and a summary of any changes that were made to medications, alerts, and/or allergies during the review.

    <<Insert copy to clinical notes SOP/guideline here>>

- **Close Claim –** The Close Claim feature allows a claim with impending insurance payments to remain open for tracking and additional payments.

    - **Claim Must Be Zero to Close –** If you enter an insurance payment that is more or less than what was expected from insurance, and you do not enter an adjustment to offset the difference, Dentrix Enterprise does not automatically mark the corresponding claim as being closed (although the claim's status still changes to Received). In this case, you would have to manually mark the claim as being closed by using the **Close Claim** menu option and choosing whether to credit or debit the patient's balance. Conversely, if the insurance payment is not the same as what was expected from insurance, once you enter an offsetting adjustment, Dentrix Enterprise does automatically mark the corresponding claim as being closed.

    - **Re-calculate Insurance Estimate** – Dentrix Enterprise will recalculate an insurance estimate if changes are made to the corresponding insurance plan's coverage table or payment table.

    - **Always Calculate Insurance Override –** With this check box selected, when you post a completed procedure, in the **Enter Procedure(s)** dialog box, Dentrix Enterprise does the following:

        - Displays the **Override Ins. Estimate** options.

        - Automatically selects the checkboxes to override the primary insurance estimate and the secondary insurance estimate according to the patient's insurance coverage.

        - Inserts the estimated insurance portion into the applicable boxes.

        Operations Insight: Review insurance setup as part of revenue cycle management to determine the full process for insurance estimates and plan settings.

- **Family File Settings**:

    - **Require Patient Email Address** – Select this checkbox to require that an email address be entered for each patient in Family File. If a patient declines to provide an email address, that can be specified instead of entering an email address.

    - **Require Referral for New Patients** – Select this checkbox to require that a referral source be selected when a new patient record is created in Family File.

- **Patient Education**:

    - **Use Spanish patient education if patient's preferred language is Spanish** – With this checkbox selected, if a patient's language preference is Spanish (in the **Patient Information** dialog box, under **Demographics**, **Spanish** is selected as the **Language**), when the **Patient Education** dialog box appears for that patient, the **Spanish** option is selected; otherwise, **English** is the default selection.

    - **Use description for finding patient education** – With this check box selected, you can enter a description instead of a code (SNOMED, NDC, or LOINC) when you search for patient education resources online with MedlinePlus.

- **Reject Old Treatment Plans** – You can have treatment-planned procedures archived automatically so they no longer appear as active treatment in Chart or Treatment Planner. Customize this feature by selecting the number of days a treatment plan case remains valid. When a treatment plan case is no longer valid, Dentrix Enterprise automatically rejects it and adds a note, stating why and when the case was rejected.

    Operations Insight: Rejected treatment is retained in the patient's record, and you can easily change the visibility and status of a case as needed.

1.3. Clinic Information - Subscriptions Tab

On the **Subscriptions** tab of the **Clinic Information** dialog box, you set up subscription-based features that require the purchase of licenses. A Support representative must activate the subscriptions and enter the license keys necessary to activate the features.

- **ePrescribe** – Allscripts is the third-party provider ePrescribe service. Prescribing electronically provides access to real-time patient clinical decision support information.

- **Outcome** – Quintiles is the third-party provider of the Outcome service. Outcome provides a caries risk assessment and reporting functionality, which you can access from Chart.

- **Updox** – Updox is the third-party provider of the Patient Portal service. You can use the patient portal to send secure messages to patients or referral sources and to transmit C-CDA files.

- **Meaningful Use** – The Meaningful Use features allow you to generate reports with the information needed to satisfy the attestation requirements for Meaningful Use. Dentrix Enterprise is a 2015 edition Certified Electronic Health Record Technology (CEHRT). CEHRT gives assurance to purchasers and other users that an EHR system or module offers the necessary technological capability, functionality, and security to help them meet the Meaningful Use criteria.

2. Clinic Resource Setup

In the **Clinic Resource Setup** dialog box, you can add or edit clinic information, operatory IDs, and provider and staff information.

2.1. Provider Setup

Each individual who can have an independent schedule and render a service for tracking or billing is considered a provider in Dentrix Enterprise.

Operations Insight: Dentrix Enterprise supports a single instance of each provider, even in organizations where a provider can render services in multiple locations.

Operations Insight: If your clinic is submitting electronic claims using Henry Schein One's eClaims, when you add a new billing provider to Dentrix Enterprise, you must submit an updated Practice Organization List (POL) to the eServices Support team.

- **Name and ID** – The ID can have a maximum of 10 characters.

   Operations Insight: Provider IDs are prevalent in selection lists and reports throughout Dentrix Enterprise. We recommend that you develop a naming convention for providers that will lend to easy identification of individual providers.

- **Non-Person** – If this provider is a billing entity, such as a corporation or association, select this checkbox.

- **Address** – Use this address if, for example, settings indicate that the provider address should be included on statements, letters, claims, and so forth.

   Operations Insight: It is important to enter a single line address into the top line as opposed to also using the second line because using the second line can cause an error when you attempt to submit claims. This error applies to all billing, pay-to, and rendering providers for a claim.

- **Specialty** – This is linked to a Taxonomy number (in the Practice Definitions).

   What is it? The Specialty Taxonomy is a unique 10-character number that describes your provider type, classification, or specialization. You need this to apply for an NPI.

   Why is it important? Taxonomy codes serve as a secondary identifier to ensure that a provider is accurately recognized.

   Why is it different from an NPI? An NPI identifies the provider to receive payment. Though both are unique codes, taxonomy codes are identifiers that describe the specialty field the provider is working and submitting claims for.

   Organizational Insight: Taxonomy codes are not applied for by providers; rather, they are designated for them depending on their healthcare field. These codes are required when individual providers apply for a National Provider Identifier (NPI) to designate provider type or specialty.

- **Class** –This setting will identify the specific class of the provider. This will determine the ability to select a provider in specific areas of the software including claims, prescriptions, Prov1 in the family file, and administrative contact.

  - Primary, for primary care providers, such as dentists

  - Secondary, for secondary care providers, such as hygienists or residents. Secondary providers are not eligible to include as a treating provider on Insurance claims.

  Operations Insight: Refer to the "Revenue Cycle Management" section for more insight into how provider class affects the claim process.

- **Log On User ID** – This is the ID that this provider will use to access Dentrix Enterprise. It is common for the **Log On User ID** to be the same as the provider's **ID**.

- **Password** – The password must be 7 to 11 characters long and meet three of the following four requirements: have at least one uppercase letter, have at least one lowercase letter, have at least one number, and have at least one special character (for example, #, %, or &).

- **Active Directory Single Sign On** – With the integration of Lightweight Directory Access Protocol (LDAP) with Dentrix Enterprise, after you sign on to Windows, you can log in to Dentrix Enterprise without entering a user name and password.

  Operations Insight: Once you turn on Single Sign On (SSO) you cannot go back to using Dentrix Enterprise without SSO.

  Workflow Insight: Even though you will no longer enter credentials to log in to Dentrix Enterprise, you will still be required to enter your AD credentials when signing clinical notes and when entering temporary overrides for users to do tasks that they do not have rights to do normally.

- **Fee Schedule** – This is the provider's default fee schedule.

  Operations Insight: Fee schedules can be attached to insurance plans, providers, and patients. Refer to the "Revenue Cycle Management" and "Patient Records Management" sections for more insight into fee schedule hierarchy and usage.

- **Clinic** – This is the primary clinic where the provider will work. If you are adding a new provider, the clinic that you are logged in to currently is selected by default. The assigned clinic will not limit the provider's ability to work in other clinics. Security and other settings determine access to data, scheduling, and which clinics a provider is available for selection in.

- **Identification/credentialing numbers** – These numbers identify who the provider is and are required for insurance processing, electronic prescriptions, and other forms as needed.

  - **TIN #** – Refer to the "Clinic Information – Clinic Settings Tab" section.

  - **State ID #, State, and State License Expiration** – License information to practice dentistry.

  - **Medicaid #**.

  - **DEA # and DEA License Expiration** – These are required for ePrescribe. Any dentist who prescribes controlled substances in Schedules II, III, IV, or V must register with the Drug Enforcement Administration (DEA) every three years.

  - **NPI** – An identifier assigned by the Federal government to all providers considered to be HIPAA-covered entities. Refer to the "Clinic Information – Clinic Settings Tab" section.

  - **Blue Cross ID # or Blue Shield ID #** – You must select one or the other.

- **Provider #, Office #, and Other #** – These are identifiers assigned to the billing dentist or dental entity other than a Social Security Number (SSN) or Tax Identification Number (TIN). The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be unique as they are assigned by different entities (such as a third-party payer or the federal government). Some Legacy IDs have an intrinsic meaning.

- **UPIN#** – This is a unique physician identification number (UPIN). It is a six-character alphanumeric identifier that was used by Medicare to identify doctors in the United States. UPINs were discontinued in June 2007 and replaced by National Provider Identifiers (NPI).

Operations Insight: Refer to the "Revenue Cycle Management" section for more insight into specific claim and billing setup needs.

2.2. Staff Setup

Staff members are employees who have not been entered as providers and anyone who will need access to Dentrix Enterprise. You set up a staff member in a single clinic no matter how many locations they may work in or need access to.

Operations Insight: Anyone (such as third-party venders, trainers, and IT) who needs to access Dentrix Enterprise should have a user ID and password. Do not use the Enterprise user as a "universal" log in for users. Also, for security purposes, we recommend that you do not share user ID and passwords between multiple users.

2.3. Operatory Setup

Operatories are columns in a schedule that allow for patient scheduling. Appointments cannot overlap in a column. Determine the number of columns you need based on the number of patients to be seen at any given time. Operatories appear from left to right alphabetically in Appointment Book. An operatory ID cannot be repeated even across other clinics. Consider prefixing the ID with the clinic ID.

3. Dentrix Enterprise Configuration

3.1. Security Setup

Passwords in Dentrix Enterprise serve many different functions. First, passwords can be used to prevent an unauthorized person from performing certain sensitive tasks, such as changing information, deleting transactions, and accessing financial information. Second, you can have the extra security of flagging certain operations to require additional user verification (the password must be re-entered) to perform those operations.

We recommended that you create user groups to group users by role or some other method that suits your needs. Having users in groups allows you to manage security rights for all users in a given group at the same time instead of having to manage rights per user.

In Dentrix Enterprise, each user is assigned "rights" to the tasks they need to complete. Dentrix Enterprise then allows access to each password-protected operation according to the security rights assigned to the logged-in user. If a user does not have rights to perform a certain function, he or she cannot access that particular area of the program or perform that particular task. Assigned rights are clinic-specific. Each user will need to be given rights for each clinic that he or she should have access to.

Operations Insight: We recommend that the owner, CIO, and/or appointed decision maker for system security who is familiar with all the available security settings read this section carefully, and be aware of who is given "Password Administration" rights in the organization.

<<Insert SOP/Guideline for security setup here>>

System Security Features

- **Secure User Password** – Set up a time interval that forces users to change their passwords regularly, as well as requirements that users cannot reuse any of their previous passwords.

    Operations Insight: We recommended that you use the available secure user password settings to promote maintaining individual user account integrity for your organization.

- **Password Expiration** – You can have passwords expire so that users have to change their passwords after a specified number of days. You can have users be forewarned of a pending password change a specified number of days before the expiration date. Or, you can choose to never have passwords expire.

- **Set Security Defaults**:

    - **Lock user out for** – You can select how many logon attempts a user has before that user is locked out of the system for a specified number of minutes.

    - **Do not allow use of the past** – You can prevent users from reusing a specific number of old passwords.

- **Verify User Before Access** – Certain situations may require additional protection. In these cases, the security options can be flagged as "Verify User Before Access." With this security flag enabled for a task, Dentrix Enterprise prompts users to re-enter a user name and password when they attempt to perform that task.

    Note: An asterisk (*) appears before a task that is flagged for the re-entry of credentials.

    Operations Insight: This added layer of security is very helpful to confirm that an area of your database is protected. It confirms that the correct user has rights to access that area of the software. This protects identified areas of the software even if someone leaves his or her computer unsecured.

    <<Insert SOP/Decision support/guideline for verify user before access>>

Adding User Groups

Group users by role or some other method.

<<Insert SOP/Guideline for user grouping>>

Set up the following options:

- **Group Name** – A name to identify the group.

- **Rights** – Select the checkboxes of the rights (categories and/or individual rights) that users in this security group should have by default.

    Operations Insight: There are four security rights in the "Central Clinic Only" category that are important for allowing or restricting access to all patients, providers, clinics, operatories, and appointment lists. When you are setting up groups or individual user rights, these must be set in the Central clinic.

Assigning Users to Groups

You can assign a user to multiple groups. Groups allow you to strategically assign user rights to a role that you assign to users. This allows for standard access in the system as well as simplifying the process for editing and adding user rights.

Set up the following options:

- **Groups** – Select the groups that you want to add users to.
- **Users** – Select the users that you want to add to the selected groups.
- **Clinics** – Select the clinics that you want the selected user groups to have rights in.

DXOne Reporting Security

You can control which reports can be generated by which users.

1. In DXOne Reporting, click the **Security** button.

    The **Report Security** dialog box appears.

2. Under **User List**, select a user.

3. In the **Report** list, select the report that you want to grant rights for.

4. In the **Rights** list, select the checkbox of each right that you want to grant.

5. In the **Clinics** list, select the checkbox of each clinic that you want to allow the user to generate the report for.

6. In the **Providers/Staff** list, select the checkbox of each provider or staff member that you want to allow the user to generate the report for.

    *Tip: To select the user selected under **User List**, click **Highlight Selected User**.*

    Workflow Insight: Due to DXOne security rights being able to add or remove clinics and providers from an individual's reporting rights, some report totals may be changed based on the rights assigned to the user running the report. Selecting "all clinics and all providers" gives the user the ability to see all current clinics and providers as well as any added in the future.

7. Click **Save**.

*Tip: If you have multiple employees with the same level of security, click **Copy User Security** to select the user from which you want to copy settings.*

3.2. Definitions

Definitions are user-defined options available throughout the system. There are over 45 pre-defined types you can customize. Definitions standardize what is selected and then reported on.

Operations Insight: Dentrix Enterprise assigns the definition number to a patient not the customizable description. Before customizing definitions be sure they have not been linked to patients. Modifying the text description of a definition will change that definition for all patients to whom the definition has been assigned. These pre-defined tables standardize what is selected and then reported on.

Note: Deleting a definition can cause skips in the definition numbering sequence, and these skips can lead to data corruption. Contact Support if you need assistance with changing or removing the definitions.

3.3. Procedure Code Setup

Dentrix Enterprise comes with all current ADA-CDT codes. You can customize certain options and add custom procedure codes for products and services to fit the needs of your organization. All codes and their settings are used for all clinics within the organization.

Review the following information:

- **Patient Friendly Description** – This patient-friendly language will be used in place of the dental terminology on treatment plans if the option to allow that is selected in the treatment plan setup. It can be helpful to customize this information and make it patient friendly to facilitate comprehension for patients.

- **ADA Code** – The standard ADA code is displayed for the procedure in most of the Dentrix Enterprise modules. It is also used to print some reports by procedure range. All ADA codes are included with Dentrix Enterprise when the program is first installed.

- **Abbrev Desc** – The abbreviated description is displayed in the Appointment Book as the description when a procedure is scheduled.

- **Treatment Area** – This regulates the information that is required for a procedure code. For example, if tooth is selected, a tooth number would be required when you use the code.

- **Treatment Flag**s – Select the applicable treatment flags for the procedure to indicate how the procedure will be handled in certain situations.

- **Show in Chart** – The procedure will be listed for the corresponding procedure code category button in Chart.

  *Workflow Insight: The **Show in Chart** option supports clinical workflows by sorting the procedure codes that are commonly used in your organization and making them easier to access in Chart.*

  Operation Insight: Running the Production Summary Report for all clinics, by ADA code, and for the last year or two provides helpful insight into which codes would support workflows across the organization.

- **Auto Continuing Car**e – When a procedure with a continuing care type attached to it is completed, Dentrix Enterprise automatically adds the continuing care type to the patient and/or updates that patient's continuing care due date.

- **Procedure Time** – This allows you to specify how many default units of time are assigned to a procedure code when it is scheduled.

  Workflow Insight: Set up the time pattern for each unit (chair time, assistant's time, or provider's time) to help you make use of all operatories when scheduling appointments and maximize your productivity.

- **Procedure Code Category** – Select the applicable category for this procedure code. In Practice Definitions, you can customize the procedure categories to fit your practice's needs.

  Operation Insight: You cannot delete a procedure code. If you no longer need or want to use a certain procedure code, you can invalidate it (this option is available for version 11.0 and later).

- **Appointment Type** – These work closely with time block scheduling. By giving each procedure a specific appointment type, you can schedule your work to meet daily and weekly goals and keep your office flowing smoothly.

- **Educational Video** – Add a hyperlink for an educational video specific to the procedure. The link will be available when the procedure has a treatment-planned status.

3.4. Continuing Care

You can use Continuing Care to track preventive care that is typically carried out in a cycle. Continuing care types are defined with an interval and then linked to a code to trigger the start or recurrence of the cycle. Prophy, Perio Maintenance, and diagnostic images are the most common types. You can run some reports by continuing care type.

You can customize Continuing Care by setting up Continuing Care views to create many different ways of looking at the continuing care information. You can also use Scheduling Assistant to manage patients on continuing care.

3.5. Appointment Book Setup

Design your schedule to maximize your organization's needs. Appointment Book setup consist of setting up standard defaults, such as hours of operation, and regular maintenance, such as holidays and vacation time. Review the "Schedule Optimization Management" section for strategic schedule maintenance.

<<Insert Scheduling SOP/Guideline here>>

Clinic Setup

You can customize your practice hours, appointment defaults, and the time block size that is used throughout the program.

Set up the following options for each clinic:

- **Default Schedule** – Select the checkbox next to each day of the week that the clinic is normally open. Also, you can break each day into three time ranges. To set the working hours for any day, click the day's search button, and then enter the start and end times of each range that you want for that day.

- **Time Block Size** – You can schedule your appointments in 5-minute, 10-minute, 15-minute, 20-minute, or 30-minute intervals.

  Workflow Insight: Time block size is used when setting up procedure codes to indicate how long a procedure will take to complete. Refer to the "Schedule Optimization" section when determining the best strategy for time block sizes to use for each clinic.

- **View Time at Right** – To have the time column appear on the right side of the window in addition to the left side, select this checkbox.

- **Default Appt. Settings** – Select the defaults for each new appointment:

  - **Status** – You can assign a status to an appointment. Each status can have a unique color for easy identification in Appointment Book. You can define up to 20 appointment statuses in the Practice Definitions.

  - **Schedule** – You can flag an appointment as Fixed, Open, or ASAP.

  - **Type** – You can classify an appointment for block scheduling. You can define up to 99 appointment types in the Practice Definitions.

Clinic Schedule

Dentrix Enterprise allows you to change your working hours for a single day or to close the office completely on a single day. Changing the hours of operation for a day or closing the office on a day does not make changes to any previously scheduled appointments.

- **Close Office on selected date** – Closes the office for the selected day. You can use this option to close the office for a yearly holiday that does not occur on the same day of the month every year (for example, Thanksgiving).

- **Open Office** – Opens the office for the selected day if it was previously closed.

- **Set Yearly Holiday on selected day** – Closes the office for a yearly holiday on the selected day. You can use this option to close the office for a yearly holiday that falls on the same day of the month every year (for example, Christmas is always on December 25).

- **Delete Holiday** – Opens the office for the selected day if it was previously closed for a yearly holiday.

- **Change working hours** – You can update the office's working hours for a specific date. A day can be separated into three time periods.

Provider Setup

You can customize work days, hours, and colors for all clinics the provider is available for scheduling in.

Operations Insight: You can set up providers in more than one clinic. The provider's available time can only include one clinic at a time.

When you are setting up the provider's default schedule, Dentrix Enterprise will warn you if the scheduled hours overlap in other clinics.

Set up the following options for each provider:

- **Default Schedule** – Select each day of the week that the provider normally works. You can separate each day into three time periods. To set the working hours for any day, enter the start and end times of each range that you want for that day.

- **Provider Color** – All appointments that are scheduled with that provider will use the designated color for the appointment tile. Each user should be assigned a unique color.

  Tip: Appointment information text is displayed in black, so choose a light color that contrasts with the black text for the provider's color.

Note: For information about time blocks, refer to the "Schedule Optimization" section.

Provider Schedule

For a provider in Appointment Book, you can change the working hours for a single day or set a vacation day. Refer to the "Schedule Optimization" section for information about managing temporary changes to provider schedules.

<<Insert provider schedule decision support/SOP/Guideline here>>

- **Set Vacation on selected date** – Makes the provider not available for the selected day. That box on the calendar turns purple.

- **Delete Vacation day** – Removes the provider's vacation day for the selected day if it was previously set.

- **Reset Hours to default on selected date** – Returns the selected day to the provider's default work day for that day of the week.

- **Change working hours** – You can update the provider's working hours for a specific date. A day can be separated into three time periods.

Operatory Setup

You can customize available hours for each operatory.

Workflow Insight: You can separate each day into three time period. This allows for adding lunch breaks, after hour open times, and so forth (for example, 8–12, 1–5, and 7–9).

Operations Insight: Appointment Book displays the default open and closed times for a clinic. The operatory settings can identify a specific operatory's available times if they are different from the clinic's hours (such as when a provider only works in operatory 3 on Fridays).

View Setup

A view is the visual schedule. The view is determined by the specified providers, operatories, and patient information. A clinic can have multiple views. By managing the views, you can control user access. This is separate from system security and is strictly used to control access to specific clinic schedules.

Operations Insight: You can have one view for when you are in the operatory and a different one for when you are at the front desk. For each view, you specify which providers, operatories, hours, and patient details appear in Appointment Book.

<<Insert SOP/guidelines here for appointment book views>>

Set up the following options:

- **Appt. View Name** – Type a name for the view.

- **Short-cut key to view** – Select the shortcut key that you want to use to access the view.

- **Clinic** – Select the clinic that you want to view.

- **Selected Providers** – Click **Modify List** to select the providers for the view.

- **Selected Operatories** – Click **Modify List** to select the operatories for the view.

- **View Options** – Select any of the following options:

  - **View Amount** – To have the scheduled production amount for the day, week, or month appear.

  - **View Appointment Notes** – To view a note symbol on any appointment with a note.

  - **View Alerts** – To view a red plus sign on any appointment for a patient with medical alerts.

  - **View Provider Columns** – To view the colored provider bar.

  - **View Ins Eligibility** – Select to see an insurance eligibility icon on any appointment for a patient with an insurance plan attached to his or her record.

- **Select Days** – Select the days of the week that the office is normally open. The week and month views will show only the selected days.

- **Month Time View** – For the month view, Dentrix Enterprise requires that a start and end time be entered. Type the earliest hour that you will see patients in the **Start Hr** box. Type the latest hour that appointments will last in the **End Hr** box. Click **am** or **pm** for both fields.

- **Appointment Display Info** – Depending on the length of an appointment, up to nine lines of information can appear on the face of an appointment tile. For each **Line**, select the information you want to have displayed on that line, or select **[None]** to leave that line blank.

   Tip: *On average, appointments will probably display 2–4 lines, so assign the most important items to the first lines.*

- **Default View** – Select this checkbox to have this view be your default for the current clinic.

Flip tab setup

A flip tab acts like a bookmark. It allows you to jump forward or backward several days, weeks, or months in Appointment Book, according to a specified length of time, such as seven days, two weeks, or six months. Flip tabs are workstation specific. You can add up to four flip tabs per daily, weekly, and monthly view on a computer.

Operations Insight: *Refer to the appendix that identifies all workstation-specific settings. Your IT may choose to use your operating system's settings to distribute workstation-specific settings to other workstations.*

Events

An event blocks out time for one or all operatories in Appointment Book so you have a visual reminder that you cannot schedule appointments during that time. An event can be for a single day or be a recurring event for up to one year.

<<Insert SOP/Guideline on blocks/events here>>

Operations Insights:

- *If you create a repeating event, be aware that, if you want to delete the whole series, you must delete each event in that series one at a time.*

- *If you attempt to schedule a single event that overlaps with an existing appointment or event, a message appears and states that the operatory is already scheduled at the requested time.*

- *If Dentrix Enterprise cannot create an event that is part of a series because that event overlaps with an existing appointment or event, a log file appears for your reference. You can correct the conflicts and then schedule events to match those in the series you created previously.*

Perfect Day Scheduling

Achieve a perfect balance of specific procedure types (for example, high production crown procedures and low production exams). Time blocks allow you to reserve certain times during the day to create your perfect day.

You must activate Perfect Day Scheduling to see the defined time blocks and for those who attempt to schedule appointments in the incorrect time blocks to see warnings. If Perfect Day Scheduling has not been activated, the defined time blocks do not appear in the Appointment Book, and no warning will appear if anyone tries to schedule appointments during reserved time blocks.

Workflow Insight: This feature is very helpful for identifying pre-defined time in Appointment Book for scheduling that works best for the clinical team. This is very helpful for organizations that have a call center. It allows for the individual sites to control the available times on their schedules.

Operations Insight: Each provider can have up to six time blocks assigned to them, and each view can show up to 20 individual time blocks at a time. Additional time blocks past the allowed 20 established for the view will not be visible.

3.6. Clinical Setup

The design elements discussed in this section will drive customization of your clinical modules to enhance your clinical records management workflows. Refer to the "Clinical Records Management" section for information about managing and maintaining all clinical records.

<<Insert Clinical SOP/Guideline here>>

Chart

- **Procedure Buttons** – You can assign a procedure code and images to each of the 24 buttons to quickly chart procedures for a patient.

    Operations Insight: Procedure button templates that you create are stored in the Dentrix Enterprise database.

    <<Insert Procedure Buttons SOP/guideline here>>

    - **Select Code** – Select **Procedure** or **Dental Diagnostic**. Then, select the desired procedure (ADA, administrative, in-house), condition, multi-code, or dental diagnostic code.

        Workflow Insight: While only a single code may be selected per procedure button, Dentrix Enterprise eliminates the need for unique buttons for like-procedures by automatically applying an alternate procedure code through a "smart-code" feature, called procedure flags. Procedure flags are assigned in Procedure Code Setup and control the automatic application (change) of a procedure code depending on the number of surfaces, tooth location, or roots present. For example, if you chart a one-surface amalgam (D2140) but select three surfaces, Dentrix Enterprise will automatically post the three-surface amalgam (D2160) procedure code.

- **Select Tooltip Text** – This selection controls the tooltip that appears when you position your mouse pointer over the button in Chart.

  Workflow Insight: The tooltip assigned to a procedure button will have a direct impact on your team's ability to easily identify which code is assigned to a particular procedure button. Efficient code selection = efficient clinical data entry.

  *Operations Insight: You can select **Procedure Description** or **Custom Text**. The **Procedure Description** displays the code description as assigned within the Procedure Code Setup, and **Custom Text** allows for unique identification based on naming conventions used by your organization.*

- **Select Button Face** – The selection controls the image that is assigned to the button face of the procedure button.

  Workflow Insight: Like the tooltip text, the strategic button face assignment to a procedure has an equal if not greater impact on your team's ability to easily identify which code is assigned to a particular procedure button.

  Operations Insight: The strategic placement of buttons into procedure groups and the organization of button images to allow for quick identification of a procedure will speed up data entry. Dentrix Enterprise provides 65 bitmap graphic images or the option to use code text. Code text displays the procedure code instead of an image and is often selected when a relevant image is not present, when users are proficient with codes, or to drive faster identification of a code.

- **Assign a Default Procedure Button Template to Users** – Dentrix Enterprise allows for the assignment of any procedure button template as the default for all users or as the template for specific users/user groups.

  Operations Insight: The procedure button template may be assigned to a user as a default or selected from Chart by the user when necessary. The customization of procedure button templates is commonly arranged by workstation, user, provider, specialty, and specific needs.

- **Procedure Categories** – Dentrix Enterprise comes with the ADA categories and codes. You can define and rename the categories in the Practice Definitions, and you reassign procedure codes to different categories in the Procedure Code Setup. Categories allow maximum efficiency in the clinical chart. You can select treatment to post from the procedure code category buttons.

- **Multi Codes** – Multi-codes are a combination of codes that make charting or posting fast and efficient. You can use multi-codes for services rendered as well as treatment plans. To add a procedure code to a multi-code, the procedure code must already exist in the system.

  Operations Insight: A multi-code may consist of one or more procedures that require additional treatment information to be entered, such as a tooth number. Multi-codes that require additional information are flagged with an asterisk (*) in the list. The additional information must be supplied when you post the multi-code. A single multi-code can have up to eight procedure codes, and you can combine multiple multi-codes together.

- **Chart colors** – See at a glance what work is existing, completed, or needed by assigning colors to statuses. Set up the following options for the graphical chart and progress notes:

    - **Paint Colors** - Each treatment status (Treatment Plan, Completed Work, Existing, Existing Other, and Conditions/Diagnoses) can be assigned a unique color. This color will be used to color code charting symbols in the graphical chart. As you select a color, the color change is not immediately visible in Chart; you must click **OK** to see the change.

        *Operations Insight: By default, Chart displays all progress notes in black. If you want items on the Progress Notes panel to be displayed in the status color, select **Use colors for progress notes**.*

    - **Screen Colors** – You can select the colors you want to use for the **Screen Background** and **Screen Gingiva** in the graphical chart. As you select a color, the color change is not immediately visible in Chart; you must click **OK** to see the change.

        Operations Insight: Chart colors are workstation-specific, meaning that different computers on the network can have their own colors. Also, the changes applied to a workstation will remain in effect even after Chart is closed and reopened. Refer to the appendix that identifies all workstation-specific settings.

- **Views** – W hen a condition or diagnosis is corrected or no longer exists, you can choose to invalidate the condition instead of deleting it to preserve a history of the condition or diagnosis. You can specify if you want invalidated conditions and diagnoses to appear in the progress notes.

    Select one of the following options:

    - **View Existing** – To display invalidated diagnoses when the **Existing** view option is selected.

    - **View Conditions** – To display invalidated conditions when the **Conditions** view option is selected.

    - **Do not display Invalidated Conditions/Diagnoses** – To hide invalidated conditions and diagnoses from your view in the progress notes, regardless of the selected view options.

Clinical Notes

Using a clinical note template as a guide, you can quickly and accurately document a patient's visit with minimal typing or editing. Templates are grouped by category. Also, each template can have any number of prompts, which are messages that prompt you to enter responses to user-defined questions.

Templates regulate clinical documentation with a defined question and answer format. Templates will guide the user and encourages comprehensive documentation of a patients' visits.

- **Clinical note categories** – To organize clinical note templates, do the following:

    1. Click **Category Setup**.

    2. Do the following:

        - Click **New Category**, and type the category name in the field.

        - Click **Move Up** or **Move Down** to change the order of the categories.

- **Clinical note prompts** – To customize the questions and answers that aid in building the clinical note, do the following:

  1. Click **Template Setup**.

  2. Set up the following options:

     - **Prompt Name** – Type a name for the prompt. The name is used to identify the prompt in the list and clinical note text. When you are setting up the template, the prompt appears in the text where it has been inserted and is set off by a tilde (˜) before and after the name.

     - **Prompt Text** – Type the text to be associated with the prompt. When you are adding a clinical note using a template with this prompt, you will see this text, which can be a question or statement, when a message appears and prompts you to enter a response.

     - **Response Type** – The response can consist of a confirmation only, one response from a list, check box responses, a date, a number/amount, text, selecting a tooth, selecting surfaces, selecting a quadrant, or selecting a sextant.

  Workflow Insight: Use an outline form for a clean, easy-to-audit note. Make sure you leave a space before and after the inserted prompt name so that the completed clinical note will be displayed properly.

Treatment Planner

Treatment Planner can help you provide your patients with easy-to-understand treatment options. When you open Treatment Planner for a selected patient, his or her entire treatment plan is used to create a default treatment plan case. You can set up additional cases and visits and view detailed treatment and insurance information. Also, you can group procedures in a treatment plan case by visit or organized by case to provide patients with different treatment options.

<<Insert SOP/Guideline for treatment plans here>>

Before treatment planning a case, set up the case default settings. Changes made to the default case settings affect all other computers on your practice's network, and the selected settings will be used for every new case that is created.

Set up the following default settings for new cases:

- **Estimate Expires** – Select the default expiration date for all cases: "1 year from current date," "3 months from current date," "1 month from current date," "Beginning of next calendar year," "Beginning of next fiscal year," "Beginning of next month," or "Prim. Ins. Benefit renewal month."

- **Default Case Note Template** – Select the default that will be used to create case notes from a template. By default, "[NONE]" is selected; no other options are available until at least one template has been set up. Do any of the following:

  - **Add** – To add a template, type a **Template Name** and the applicable **Template Text**.

  - **Modify** – To modify a template, select the template you want to change, make the necessary changes to the **Template Name** or **Template Text**, and then click **Modify** to save the changes.

  - **Delete** – To delete a template, select the template you want to delete, and then click **Delete**.

- **Automatic Case Status Updates** – Select the case statuses that you want to be added automatically to the case status history:

  - **Printed** – A selected cases will be updated with the "Printed" status when the case is printed.

  - **Proposed** – A selected case will be updated with the "Proposed" status to present or propose the case to the patient.

- **Case Financing Setup** – Case financing statuses must be set up before you can apply them to a case. If you want to add, rename, or delete a case financing status, click **Case Financing Setup** to open the **Case Financing Status Setup** dialog box and do any of the following:

  - **Add** – To add a case financing status, type a name in the **Case Financing Status** box, and then click **Add**. By default, the following case financing statuses are provided: In Progress, Needed, Not Necessary, and Pending More Information.

  - **Rename** – To rename a case financing status, select the status you want to rename, type the new name for the status, and then click **Rename**.

  - **Delete** – To delete a case financing status, select the status you want to delete, and then click **Delete**.

- **Patient-Friendly Description** – Patient-friendly descriptions can be entered and saved for any procedure code. When that code is selected, instead of displaying the technical description for the procedure, a less-technical description can be displayed so patients cab better understand the procedures in their treatment plans.

  1. Select a **Procedure** (the default description appears in the **Description** box).

  2. Type a **Patient-Friendly Description** (some procedures may already have patient-friendly descriptions, which can be edited).

  Note: You can also set up patient-friendly descriptions in the Procedure Code Setup.

- **Setup Consent Forms** – Any existing consent forms that will be used for new cases are shown in the list box. You can customize the list, choose the procedures that can appear on all forms, and select a signing device. Do the following:

  1. Either click **New** to add a form, or select a form and then click **Edit** to edit that form.

  2. Type or change the name and/or text of the consent form using the **Cut** ,**Copy**, and **Paste** buttons to manipulate text as needed. The form can be up to 5,000 characters long.

  3. Select **Do not include Procedure Codes on Consent Form** if you do not want to allow procedure information to show on the consent form (the default selections that indicate what procedure information can be shown on consent forms will be overridden).

  4. Click **Save**.

  5. From the **Select Electronic Signature Device** list, select the device that will be used to sign cases at this computer:

     - **Pointing Device** – Use for mice, touch screens, and writing tablets.

     - **Interlink ePad or Interlink ePad II** – Use if either of these devices are connected and set up at the computer from which a signature will be acquired.

Perio Chart

Because perio exam methods and philosophies differ from provider to provider, in Perio Chart you can set up scripts and paths that represent your preferred examination method.

<<Insert SOP/Guideline here>>

Set up the following options for **Perio Entry Setup**:

- **Auto Settings**:

  - **Path Advance** – You can control the order of movement through the probing areas of each tooth. To enable the use of the Path Settings, select this option. If the check box is clear, the automatic path advance will not work, and you must press the Enter key each time a measurement has been entered to advance to the next site.

  - **Tooth Advance** – You can control the order of movement from tooth to tooth. To enable the use of the **Script Settings**, select this option. If the check box is clear, the automatic tooth advance will not work, and you must move from tooth to tooth manually.

- **Calculation Options** – When you are performing a periodontal exam, it is important to remember that the pocket depth, gingival margin, and clinical attachment level measurements have a mathematical relationship. That relationship is such that, given any two of the three measurements, you can mathematically calculate the third. With that in mind, you can enter two measurements; and, based on your chosen calculation method, Dentrix Enterprise will automatically calculate and input the third measurement for you.

  *Workflow Insight: If you select any one of the calculation methods, Perio Chart will make the measurement options that are automatically calculated unavailable. For example, if you use the CAL calculation method, Perio Chart will make the **Clinical Att. Level** options unavailable. If you choose not to use a calculation, all of the fields will be available.*

- **Flag Red Limit** – You can choose to have a certain degree of pocket depth and clinical attachment level be displayed in red. As measurements are entered, if the pocket depth or CAL is equal to or greater than the selected red flag limit, the measurement will be displayed in red on the data chart.

  *Workflow Insight: Measurements can be flagged red in the graphic chart, as well. However, only the area on or above the selected limit is displayed in red. The area below the limit is displayed in green (the default color). If you want to display the area above and below the limit in red, select **All Red in Graphic Chart** to help you locate problem areas faster.*

- **Path Settings** – Path settings dictate the sequential order of movement through the probing areas of each individual tooth. Since each care provider will not take the same measurements in the same order, Dentrix Enterprise allows the path settings to be customized.

  *Workflow Insight: By default, Dentrix Enterprise has two paths: **P1** and **P2**. Both paths move you through entering pocket depths, bleeding, and suppuration measurements. **P1** charts from left (the provider's left) to right, and **P2** charts from right (the provider's right) to left.*

  You can customize the default paths or create up to two more paths. For a given path, in the **Name** field, type the name of the path to represent the measurements that will be charted (for example, PBSL might indicate Pocket Depth Bleeding Suppuration from Left to Right.) The name can be up to six characters long.

- **Script Settings** – Whereas path settings determine the entry method for the measurements, direction, and processes that will occur on each tooth that is examined, script settings dictate the sequential order of movement from tooth to tooth with the ability to designate the facial and lingual surfaces.

   Workflow Insight: The default Dentrix Enterprise script starts you on tooth number 1 on the facial side. The script advances from left to right, advancing from tooth 1 until reaching the end of the arch at tooth 16. At the end of the arch, the script reverses direction, advancing from tooth 16 back to tooth 1 on the lingual side. Next, the script drops down to the lower arch and advances from tooth 32 to 17 on the facial side. Finally, the script reverses again and advances from tooth 17 to tooth 32 on the lingual side.

   You can customize the default script or create up to two more scripts. The selected script will be used during the examination.

Set up the **Display Options** to choose which data elements to show and customize the color of certain objects on the graphic chart in Perio Chart:

1. Select or clear the check box of any of the following data elements you want to show or hide: **Gingival Margin**, **CAL**, **Probing Depth**, **Bleeding**, **Suppuration**, **MGJ**, **Mobility**, and/or **Furcation**.

2. **Red Flag Limit**, **Background**, and **Tooth Roots** are always shown.

3. If you want to change the color for any of the data elements that have a color, click the color swatch next to the corresponding element to open the **Colors** dialog box and choose the desired color.

4. To change the colors used for exam comparisons:

   a. Click the **Comparison Colors** button.

      The **Comparison Colors** dialog box appears.

   b. Click a color swatch to customize the color for that exam. Click **Defaults** if you want to return the comparison colors to the default colors when Dentrix Enterprise was originally installed. Click **OK** to save the color changes.

5. If you want to return the color settings for the data elements but not the comparison colors to the default colors when Dentrix Enterprise was originally installed, click **Defaults**.

3.7. Prescriptions

Patient Prescriptions can help you quickly create and accurately track medicines that providers prescribe to your patients.

Do any of the following:

- Click **New** to add a prescription. The **New Standard Prescription** dialog box appears.

- Select an existing prescription, and then click **Edit** to edit that prescription. The **Edit Standard Prescription** dialog box appears.

Operations Insight: You can enter prescriptions as they are prescribed to patients, or a list can be pre-populated in the database.

3.8. Ledger Setup

You can standardize the system settings that are used across the organization to support your revenue cycle workflows.

<<Insert SOP/Guideline for ledger settings here>>

Ledger Colors

To quickly identify different financial transaction types, you can assign each transaction type a unique color.

- From the **Color** dialog box, choose the desired color, click **OK**, and then assign colors to other transaction types, as appropriate.

- The Ledger view shows you all work completed for the patient. The Ledger-Treatment Plan view shows all recommended work not yet completed. To help you distinguish between the two views, you can assign one background color to the Ledger view and another background color to the Ledger-Treatment Plan view (choose a color that will contrast with the other colors).

Checkout Options

In most offices, three tasks are typically completed as a patient checks out after a visit. The **Fast Checkout** button combines these three tasks. With the click of a button, you can collect a payment, generate an insurance claim, and print a receipt. Also, you can have a patient's clinical summary uploaded automatically to his or her patient portal if you have a subscription to use Patient Portal.

Select the task options that you want to complete when you click the **Fast Checkout** button:

- **Enter Guarantor Payment** – To post a patient payment to the Ledger. When you click the **Fast Checkout** button, Dentrix Enterprise opens a dialog box that prompts you to enter a payment.

- **Create Insurance Claim** – To generate an insurance claim. Also, select whether you want to send the claim to the Batch Processor in the Office Manager (**Batch**) or print the claim immediately (**Print**) when you click the **Fast Checkout** button.

- **Walkout** – To print a receipt for the patient. Also, select whether you want to send the report to the Batch Processor in the Office Manager (**Batch**) or print the report immediately (**Print**) when you click the **Fast Checkout** button.

- **Send Clinical Summary to Portal** – To send a clinical summary for the patient for whom you perform a fast checkout to his or her patient portal.

   Notes:

   - *The patient for whom you perform a fast checkout must have an Updox patient portal account set up (the account is free of charge to the patient).*

   - *The user who is logged in when you click the **Fast Checkout** button must be licensed and set up to use Updox patient portal. The patient portal requires a paid subscription.*

- **Always Show Checkout Options** – Select this if the tasks you perform as a patient leaves vary. With this option selected the **Checkout Options** dialog box appears each time you click the **Fast Checkout** button so you can select the options you need for each patient individually.

Automatic Credit Allocation Options

Dentrix Enterprise can automatically apply suspended credits and post automatic adjustments for re-allocating credits according to selections you make. You can also set up options for handling negative payments and electronic EOBs.

Set up the following options:

- **Automatic Suspended Credit Allocation Options**:

  - **Automatically Allocate Suspended Credits when Applicable** – Select to automatically allocate any suspended credits to all charges that have a remaining balance. This applies all applicable suspended credits to all applicable charges, not just the recently posted charges.

  - **Do Not Automatically Allocate Suspended Credits** – Select to prevent Dentrix Enterprise from automatically allocating any suspended credits.

- **Automatic Insurance Payment Adjustment Options**:

  - **Credit Adjustment Type** – Click the search button to select the adjustment type that you want to use for the credit adjustment to offset a charge adjustment when a leftover insurance payment amount needs to be automatically allocated.

  - **Automatically Allocate** – Select **Use Automatic Suspended Credit Allocation Options** to default to the selection made under **Automatic Suspended Credit Allocation Options** for insurance credit adjustments. Select **Flag Adjustment "Do not automatically allocate"** to not have the insurance credit adjustment allocated automatically regardless of selection under **Automatic Suspended Credit Allocation Options**.

  - **Charge Adjustment Type** – Click the search button to select the adjustment type that you want to use for the charge adjustment when a leftover insurance payment amount needs to be automatically allocated.

  - **Itemize Automatic Adjustments for Billing Statements** – Select to itemize automatic adjustments on billing statements. We recommend that this option remain clear because automatic adjustments are always offsetting adjustments, so they will not affect an account balance and can be confusing if included on billing statements.

- **Adjustment Type for Negative Payments**:

  - **Enable Automatic Adjustments for Insurance Payments** – Select to post negative insurance payments to claims.

  - **Auto-post Refund adjustments to replace negative payments** – Select to automatically post refund adjustments to replace negative insurance payments to claims. A negative payment appears as a charge adjustment on the Ledger. Next, select the **Charge Adjustment Type** you want to use as the charge adjustment that automatically replaces a negative insurance payment.

    Tip: You may need to add a new adjustment type in the Practice Definitions for this charge adjustment.

- **Electronic EOB Options**:

  - **Default Provider for Non-Itemized eEOB Charges** - Select which provider to attach to a charge adjustment if an adjustment claim in an eEOB is not itemized. The provider can be the patient's primary provider (Prov1 from Family File), the pay-to provider on the claim, the rendering provider on the claim, or the billing provider on the claim.

  - **Copy Electronic EOBs to Document Center** - Select to copy electronic EOBs imported into Dentrix Enterprise to the Document Center.

Direct Print Options

You can print several reports from the Ledger: insurance claims, walkout statements, billing statements, and a family ledger report. A button for each of these reports is located on the toolbar. With the direct print options, you can indicate whether to print the report immediately or send it to the Batch Processor in the Office Manager to print it later.

For each report, select **Batch** or **Print** to indicate whether you want the report to go directly to your printer or to the Batch Processor.

*Tip: If your office will be sending claims electronically, click **Batch** for insurance claims so all insurance claims generated during the day will be sent to the Batch Processor and can be transmitted simultaneously at the end of the day.*

3.9. Document Center Setup

Create the standards for document storage management. Document Center is a place to store and organize documents that have been scanned or imported into Dentrix Enterprise. By setting up templates, Document Center is standardized and limits effort by the team.

<<Insert SOP/Guideline here>>

Document Types

You must assign a document type to all documents in Document Center. Document Types are the folders in which the scanned items are stored. This is a method to sort documents for standard storage processes as well as how information will be quickly accessed. With standard document types, all users should have a clear direction on where to store and find any documents stored in the system.

Document Type Templates

Templates assist with using the document types in a uniform way and help to define the descriptions that should be used when storing documents. The templates allow you to define a document type that will be stored, pre-select the document type, and enter a standard description or guidance for the description to make the process of storing and labeling documents streamlined and standard process.

<<Insert SOP/Guidelines for document storage here>>

Indian Health Manual (IHM)

Sections of IHM covered in this review for Electronic Health Records (EHR) (generically) and Electronic Dental Records (EDR) specifically:

[Indian Health] Manual Exhibit: 3-3-A

Chapter 3 Health Information Management

Part 3 – Professional Services

3-3.1 INTRODUCTION

A. Purpose. The purpose of the Health Information Management (HIM) chapter is to establish policy, objectives, staff responsibilities, operating relationships, and standards relating to health record services in the Indian Health Service (IHS).

B. Background. This chapter integrates current HIM practices with the regulatory requirements of the Health Insurance Portability and Accountability Act (HIPAA), implements an IHS electronic health record (EHR) system, and complies with the Centers for Medicare and Medicaid Services (CMS) regulations and other laws. The chapter also formally adopts the name change from Medical Records to HIM.

C. Policy. It is IHS policy that all health information professionals, health care providers, managers, and staff who are responsible for the creation, maintenance and disposition of health records will maintain and preserve the confidentiality of the patient's health record.

D. Authorities.
1. Privacy Act of 1974, as amended, 5 United States Code (U.S.C.) § 552a
2. General Administrative Requirements, 45 Code of Federal Regulations (CFR) Part 160.
3. Health Insurance Portability and Accountability Act, Privacy and Security Rule, 45 CFR Part 164
4. Confidentiality of Alcohol and Drug Abuse Patient Records Regulations, 42 CFR Part 2
5. Freedom of Information Act (FOIA), 45 CFR Part 5
6. Indian Health Service Records Disposition Schedule
7. Federal Information Security Management Act
8. Office of Management and Budget (OMB) Circulars A-123 and A-130
9. Indian Health Service Rules of Behavior for appropriate use of information systems and technology resources
10. Entry for negotiation of release or settlement, 42 CFR 35.13
11. Accrediting or certifying organizations such as the Joint Commission and CMS.

E. Goal. To support the IHS mission to raise the health status of American Indians and Alaska Natives (AI/AN) by maintaining a progressive HIM system that encompasses all aspects of a comprehensive health program.
F. Objectives. The IHS will:
    1. Maintain a readily available, complete, and accurate health record on all individuals evaluated and/or treated in an IHS facility or by IHS staff in a community health setting.
    2. Ensure to the maximum extent possible that patients rights to privacy are protected by all who use the health record or are aware of its contents in the course of supporting patient care activities or providing patient care.
    3. Facilitate the exchange of health information among health care providers within IHS facilities, contract facilities, or other facilities providing health care to IHS patients.
    4. Maintain secondary records and indexes (either manual or electronic) in order to provide vital statistics, statistical information, and research information.

3-3.2 HEALTH RECORD

A. Communication. The health record is a means of communication among the physicians, nurses, and allied health professionals who plan and conduct the care and treatment of the individual patient.
B. Definition. The health record is a chronological documentation of health care and medical treatment given to a patient by professional members of the health care team and includes all handwritten and electronic components of the documentation. It is an accurate, prompt recording of their observations including relevant information about the patient, the patient's progress, and the results of the treatment. The health record:
    1. may be paper or electronic or both (hybrid).
    2. creation, content, maintenance, management, processing, and expected quality measures must be standardized.
C. Division. The health record may be composed of two divisions:
    1. Documentation of all types of health care services provided to an individual, in any aspect of health care delivery. It includes individually identifiable health information, in any medium collected and directly used in and/or for documenting health care. The term includes records of care in any health-related setting used by health care professionals while providing patient care service, and to review patient data or to document their own observations, actions, and instructions.
    2. The administrative record is an official record pertaining to the administrative aspects involved in the care of a patient, including demographics, eligibility, billing, correspondence, and other business-related aspects.
D. Electronic Health Records. Electronic capture and storage of patient health information will be implemented to enhance access to patient data by health care practitioners and other authorized users. Electronically stored and/or printed health information is subject to the same medical and legal requirements as handwritten information in the health record.
E. Encumbered. An employee who currently occupies an official position.
F. Finances. The health record is the original source document for any financial activity involving patient care. Primary examples are the use of health records in audits of third-party collections by outside payers; in internal audits to verify allocation processes; and to develop and maintain cost management programs and cost management systems.
G. Legal Document. The health record is a legal document that benefits the patient, the physician, other health care providers, and the health care program.
H. Legal Health Record. The EHR and the paper record combined is the legal health record.
I. Station. An IHS health station is an ambulatory care facility (fixed or mobile) which is geographically separate from an inpatient hospital or health center, that provides one or more clinical services, and is operated less than 40 hours per week.

J. Statistics. The health record is the source document for statistical research, planning, and budgeting.

K. Training. The health record is a tool for training members of the medical and paramedical professions and for conducting medical research. It is the primary means for evaluating the quality and appropriateness of medical care rendered.

3-3.4 RESPONSIBILITIES

A. Chief, Health Information Management. The Chief, HIM, is responsible for:
   1. representing the HIM profession in planning and developing a comprehensive health program for the IHS;
   2. serving in a key role for all activities involving data systems, including planning, developing, implementing, and evaluating systems;
   3. advising the IHS Director and members of the Director's staff on policy formulation and activities involving HIM services, data quality, and third party reimbursement in all types of facilities;
   4. providing professional and technical guidance to Area HIM consultants in developing and administering HIM programs to enable IHS facilities to meet IHS goals and objectives;
   5. planning the recruitment, professional development, and effective use of professional and technical level HIM personnel throughout the IHS; and
   6. planning orientation and training activities for HIM personnel.

B. Area HIM Consultant. The Area HIM Consultant is responsible for:
   1. assisting in planning and developing a comprehensive health program for the Area that is consistent with IHS goals and objectives;
   2. advising the Area Director, Area staff, Chief Executive Officers (CEO), and their staffs on the implementation of policies and activities involving health records, data quality, third-party reimbursement, utilization review, and quality improvement;
   3. assisting Service Unit HIM Supervisors or Directors in meeting equal employment opportunity objectives;
   4. participating in planning, developing, implementing, and evaluating data systems;
   5. assisting Service Unit personnel in planning facilities construction/remodeling and procuring equipment;
   6. advising and assisting Service Unit HIM staff in performing quality review programs to meet requirements of the Joint Commission, CMS, the Accreditation Association for Ambulatory Health Care, and other regulatory and/or accrediting agencies;
   7. assisting in recruitment, use, and evaluation of professional and technical level Service Unit HIM staff;
   8. assisting in planning for career advancement and professional development of Area HIM staff using workshops, institutes, online courses, audio seminars, and college-based HIM courses;
   9. providing orientation to Area professional and administrative personnel on HIM policies and standards training;
   10. assisting the CEO and staff with orientation and indoctrination in HIM;
   11. providing guidance to Area and Service Unit staff in medico-legal matters, including compliance with the Privacy Act of 1974, HIPAA, FOIA, and Confidentiality of Alcohol and Drug Abuse Patient Records regulations;
   12. writing and submitting narrative reports for submission to the Chief Headquarters HIM Consultant and report at the biannual Area HIM Consultants meeting. The report should briefly discuss (as appropriate) the following:
       a. staffing levels in each facility for the following categories: Permanent, temporary, credential levels, and positions encumbered by credentialed professionals (Credentialed is defined as an active registration or accreditation by the AHIMA);
       b. changes in HIM positions, personnel components, and vacancies;
       c. accomplishments;
       d. proposed action for future quarter;
       e. recruiting activities;

     f.   problems and, if possible, recommended solutions; and

     g.   ongoing educational programs, regularly scheduled workshops, and outside training.

C. <u>Service Unit HIM Directors</u>. Service Unit HIM Directors are administratively responsible for all HIM activities within the Service Unit, hospitals, and clinics; they are responsible to:

   1. assist Service Unit staff in planning and developing a comprehensive health program to meet IHS goals and objectives;

   2. direct HIM department activities, implement IHS policies, and develop procedures to administer the facility HIM program;

   3. advise the CEO and staff in matters involving HIM policies, data quality, and third-party reimbursement;

   4. plan for recruiting, developing, and use of facility HIM personnel;

   5. assist in evaluating and analyzing statistical data for epidemiological or other studies, program planning, and budgeting;

   6. collaborate with the clinical application coordinator (CAC) on setting up, maintaining, accessing, and using the Resource and Patient Management System (RPMS) EHR;

   7. provide on-the-job training to HIM personnel;

   8. conduct HIM orientation for department heads and professional employees in HIM policies and procedures; and

   9. perform quality review studies with professional personnel from other disciplines in order to meet IHS requirements and those of certifying or accrediting organizations.

3-3.5 HEALTH INFORMATION MANAGEMENT DEPARTMENT

A. <u>Administrative Responsibilities</u>. The HIM department will maintain the facilities and services necessary to provide health records that are documented accurately and in a timely manner; that are readily accessible and contain all current information; and that permit prompt retrieval of information, including statistical data.

B. <u>Committee Responsibilities</u>. The HIM Director or Supervisor assists the Medical Record Review Committee with reviewing health records to ensure compliance with accreditation or certification standards; preparing meeting agendas; minutes, and reports; data collection and display; and appraisal of such department resources as equipment, physical environment, and staffing needs.

   1. Health Record Completion. The HIM staff must review a representative sample of charts from each inpatient and outpatient service or program to ensure documentation is adequate, timely, complete, and properly authenticated according to all accreditation/certification standards and all IHS directives. Staff must report inadequate records to the appropriate committees as outlined in the facility's Medical Staff Bylaws, Rules and Regulations.

   2. Minutes. Where committees are combined, separate headings for each committee function will be maintained in the minutes. Minutes will not contain direct patient identifiers such as name or unit health record number. Patient references will be used only when necessary and only in coded form. The key to patient identification codes will be maintained by a designated coordinator and destroyed when direct patient reference is no longer needed.

   3. Confidentiality of Committee Minutes. Committee actions will be maintained in strict confidence. The distribution and storage of minutes will be controlled. All persons receiving minutes will be held accountable for the document's security and its destruction when the minutes are no longer needed.

C. <u>Health Information Management Director</u>. The HIM Director is administratively responsible for ensuring that:

   1. Each individual treated within the facility or in the community by a member of the health care team will be registered. A health record is maintained for each individual who receives service as an outpatient, inpatient, newborn, emergency patient, community health patient, school student, and contract health service (CHS) beneficiary.

   2. The health record is maintained in strict confidence. Information from health records will be disclosed only in conformance with applicable Federal laws and regulations, policies of the IHS, and the laws of the State or Tribe in which the facility is located.

3. Only authorized personnel will have access to health records. Service Unit policy and procedures shall specify those employee positions within the Service Unit who are authorized to access health records on a "need-to-know" basis. A listing of specific individuals with health record access is maintained by the CEO or the Service Unit HIPAA Privacy Official and updated as necessary (Refer to Part 2, Chapter 7, IHM).

4. The HIM department will be secured at all times.

5. Health records will be removed from the facility only by court order from a court of competent jurisdiction in consultation with the Office of General Counsel (OGC), or for retirement to the Federal Records Center (FRC). A court order is necessary for removal of a record (other than for retirement) containing information about alcohol or drug abuse. See Section 3-3.12R, "Court Order and Subpoena Duces Tecum." (Refer to 45 CFR § 2.5 and 45 CFR § b9(b)(11) for discussion of a valid subpoena or court order.)

6. The HIM department assists in medical care evaluation by providing information needed to assess the quality and appropriateness of care provided by the facility. The specific role of the HIM department will be defined in the policies of each facility and will vary depending on organization and staffing.

7. The HIM department maintains a health records identification and filing system.

8. Statistical information is maintained to provide data as required by State, Federal, and accrediting/certifying organizations.

9. Policies and procedures regarding the responsibilities and functions of the HIM department are developed, implemented, and updated.

10. The HIM department maintains a permanent signature index for each provider who documents patient events in the health record. Providers include a medical doctor (MD), doctor of osteopathy (DO), registered nurse (RN), licensed practical nurse (LPN), registered pharmacist RPh), master social worker (M.S.W.), physician assistant (PA), and physician assistant certified (PA-C). The signature file shall be secured and maintained permanently in the office of the HIM Director or supervisor and shall contain the following:

   a. provider's name;
   b. provider's signature;
   c. provider's initials;
   d. provider's professional description;
   e. provider's entry on duty date; and
   f. provider's exit date.

D. Program Responsibilities

(14) Forms. Only standard forms (SF) and IHS clinical record forms are used in the health record. Proposed new or revised forms must be submitted through the Area Office to IHS Headquarters for approval in order to become an authorized part of the health record. Refer to Part 5, Chapter 24, IHM, TN No. 04-02, 07/16/04.

(15) Electronic Health Records and Patient Care Component + Templates. A local process for initiating, developing, and approving new electronic templates must be established under the auspices of the health record review function. As part of the health record review function, proposed templates must be reviewed for legal, policy, regulatory compliance, and ease of use. Requests must be approved prior to implementation of electronic health record templates. All components must reflect the health record number, date of documentation, date of service, and facility name. Paper forms are preferred for specific components of the record as a guideline for developing electronic templates.

3-3.8 HEALTH RECORD DOCUMENTATION

A. Description. The health record documents the care of the patient and is an important element contributing to high quality care. The documentation in a health record contains a compilation of scientific and subjective data from which conclusions or judgments are derived.

B. Purpose. Health record documentation is required to record pertinent facts, findings, and observations about a patient's health history including past and present illnesses, examinations, tests, treatments, and outcomes.

C. Facilitation. The health record facilitates the following:
   1. the physician and other health care professional's ability to evaluate and plan the patient's immediate treatment, and to monitor the patient's health care over time;
   2. the communication and continuity of care among physicians and other health care professionals involved in the patient's care;
   3. the accurate and timely claims review and payment;
   4. the appropriate utilization review and quality of care evaluations;
   5. the collection of data that may be useful for research and education;
   6. the accurate coding of diagnosis and procedures performed; and
   7. the source of aggregate data to be used as the basis for planning future health programs or initiatives.

D. Documentation Principles. Conducting reviews to evaluate clinical competency and support privileging activities.

E. Documentation Standards. Documentation standards include, but are not limited to, the following:
   1. A complete health record shall be maintained for each patient who receives direct or indirect health services at an IHS facility or field location, whether as an outpatient, inpatient, contract health patient, community health patient, school student, or emergency patient.
   2. The accreditation or certification standards regarding documentation pertinent to care and treatment records apply to both paper and electronic records.
   3. The RPMS (including the EHR) or the paper record are mediums for documentation of all patient care activities within the IHS.
   4. Attending providers are ultimately responsible for the accuracy of the health record for each patient under their care. The Clinical Director, or designee (equivalent), has oversight responsibility for health record timeliness, accuracy, and completion.
   5. Medical staff members and other individuals who have been granted such clinical privilege within their scope of practice must document or authenticate opinions requiring medical judgment.
   6. Health care practitioners must document according to regulatory standards and generally accepted documentation practices for completeness and timeliness.
   7. Health care practitioners involved in the patient's care must document each event of the patient's care in the health record.
   8. The practitioner who treats the patient is responsible for documenting and authenticating the care provided.

F. Prompt Documentation. Each clinical event, including history and physical examination (PE), shall be documented as soon as possible after the occurrence and within requirements set by the accreditation and/or certification standards for the type of facility or program. Health records of discharged or released patients shall be completed as specified in the facility's Medical Staff Bylaws, Rules and Regulations.
   1. Scope of Documentation. The health record must reflect candid statements but avoid derogatory or critical comments. Individual employee names are not included in health record documentation unless the purpose is to identify practitioners for continuing care. Emphasis is placed on relevant day-to-day entries. Timely entries must be made on appropriate documents following examination and treatment as specified in IHS and facility policies. Each patient event must include or refer to the following: the chief complaint and/or reason for visit and, as appropriate, relevant history, examination findings and prior diagnostic test results; assessment, clinical impression, or diagnosis; plan for care and date and legible identity of the health care professional; and identification of appropriate risk factors. The scope of documentation must be organized, complete, and comprehensive enough to:
      a. provide continuity of care;
      b. reflect all treatment;
      c. support health care provider's reported workload; and
      d. support services that are reimbursed by third-party payers.

G. <u>Signatures or Authentication</u>. All entries in the health record shall be dated and authenticated with full signatures. Also, MD, RN, RPh, or other professional designation shall be included with the signature to indicate essential or basic competencies of the person making an entry. Entries made by an extern or student shall be countersigned by the physician or other licensed independent practitioner in charge of the care. Signature stamps with original signature are authorized by the facility and must be kept in the signatory's complete control. Initials with professional designation may be used by providers for authentication purposes where those initials are readily recognized by other staff and where approved in the record of Medical Staff Executive Committee actions. A signature file listing must be maintained on all individuals who document in the health record, either electronic or on paper. See 3-3.5C(10).

H. <u>Electronic Signatures</u>.
    1. Electronic signatures may be used for Schedule II drug prescriptions for inpatient prescriptions.
    2. Electronic signatures cannot be used for Schedule II out-patient drug prescriptions according to the CFR pursuant to Drug Enforcement Agency (DEA) regulations. When the DEA permits such electronic authentication, it is permitted in the IHS health records.

I. <u>Time Frames</u>. Each entry in the record is completed (including authentication) within the time frames delineated by the facility's Medical Staff Bylaws, Rules and Regulations. A policy must include guidance on disciplinary action taken when time frames are not met. When a pertinent entry is missing or not written in a timely manner, a late entry is used to record the information in the health record with a notation giving the reason for the late entry. The entry of missing documentation or authentication is identified as "late entry" and must note the actual date the event occurred, not the date of documentation. In the EHR, the date of entry identifies the date the documentation actually occurred. Physicians and other health care providers must monitor computerized prompts for signature and take appropriate action.

J. <u>Record Content</u>. Health record content within the IHS will comply with: Requirements of the accreditation or certification standards for the type of facility or program, requirements for participation in third-party payment programs, and with licensure requirements of the providers or other special programs.

K. <u>General Requirements</u>. All written entries shall be made in permanent dark ink that does not soak through and obliterate information to ensure microfilmed or other copy media are legible. The health record shall contain sufficient information to:
    1. identify the patient;
    2. support the diagnoses/treatment
    3. justify the care, treatment, and services provided;
    4. document the course and results of selfcare, treatment, and services provided;
    5. describe the patient's condition upon release or discharge
    6. document instructions to patient regarding follow-up care, self care, home care, activity levels; necessary medications; and
    7. document environmental, family, and socioeconomic factors affecting the patient's health.

L. <u>Hospital Facilities Health Record Format</u> The patient's identification information and the facility's name must be on each page of the health record. This standardized IHS format facilitates authorized use of the health record for review or to make entries, and to retrieve patient information for administrative, statistical, and quality assurance purposes.
    1. <u>Outpatient Medical Record Format</u>. (Left side of medical record folder):
        a. PCC Health Summary
        b. Medication profile
        c. Chronic Medication Report or RPMS Chronic Medication List
        d. Ambulatory Care Record Brief
        e. PCC Encounter Record form (IHS-803) and other PCC forms (most recent visit date on top)

3-3.9 ELECTRONIC HEALTH RECORD PRINCIPLES

A. General. The RPMS EHR is intended to help providers electronically manage all aspects of patient care by providing a full range of functions for data retrieval and capture to support patient review, encounter, and follow-up. By moving data retrieval and documentation activities to the electronic environment, patient care activities and access to the record can occur simultaneously at multiple locations eliminating the need to depend on the availability of a paper chart.

The RPMS EHR combines the powerful database capabilities of the RPMS with a familiar and comfortable presentation layer, the graphical user interface (GUI). Integration of various RPMS components into the GUI allows providers to obtain a more comprehensive view of the clinical process. Also integrated into the RPMS EHR is VistA Imaging which allows the collection, storage, and display of radiologic images, electrocardiograph tracings, imaging from other sources, and document scanning.

As technology allows, all patient care documentation must be stored in the health information infrastructure via (a) direct data entry using RPMS and/or EHR, (b) Text Integration Utility (TIU), (c) VistA Imaging (or other VistA interfaces that facilitate dictation, transcription, uploading documents, voice recognition, document scanning), and (d) other technologies deemed appropriate by IHS.

B. Health Record Creation. A separate, unique health record is created and maintained for every individual assessed and treated by the IHS, as well as those receiving community ancillary care by the IHS, such as visits by Public Health Nurses, e.g., home visits, health fairs, etc. Printing and filing paper documents from electronic media for active records is not required.

C. Electronic Notes Standards. Electronically stored patient information is subject to the same medical and legal requirements as the hand-written information in the paper health record. Entries must be accurate, relevant, timely, and complete.
Viewing unsigned notes is not allowed because current technology does not provide an audit trail of the note status. Viewing unsigned notes poses a risk of clinical decision-making based on data that may be revised or deleted. However, limited access to unsigned notes may be determined by local policy.

Approved templates may be provided to complete the note text. Standardized note titles facilitate retrieval of specific patient information. Issues regarding note title standardization are part of the health record review function. Appropriate note titles must match note content and the credentials of the author to enhance the ability to find a note quickly and easily. Notes must be reviewed and signed promptly, as defined by facility policy.

D. Copy and Paste Functions. The electronic copy and paste function is a powerful tool; however, this functionality must be used with caution and according to strict enforceable policy. Each facility must develop a policy that ensures the elimination and/or judicious use of this electronic function.

E. Clinical Postings. Postings consist of crisis notes, clinical warnings, patient allergies, and advance directives. Postings are entered with an appropriately titled progress note and, if unsigned, may be rescinded by changing the note title.

F. Clinical Reminder. Clinical reminders are a clinical decision support tool to assist health care staff, but are not part of the clinical record. The reminders are recommendations based on clinical and administrative policy, and are always to be interpreted within the context of the practitioner's knowledge of the patient. If an inappropriate clinical reminder is triggered due to an improper code selection, corrections must be made based on facility policy.

G. Patient Flags. Patient Flags can be setup in the RPMS and added to a patient's record to notify the health care provider of a specific medical condition or situation. The flags are removed when the patient's condition or situation is resolved.

H. <u>Electronic Signatures</u>. Facility policy must provide adequate security measures to identify users (authors) who document in the health record by verifying the authenticity of electronic signatures. Authors are responsible for the sole use of their electronic signature.
    1. Authentication includes the identity and professional discipline of the author, and the date and time a document is signed. Notes made and authenticated by health care team members must be individually identified either by the use of the individual's title or by appropriate professional credential designation. Once affixed, authentication of electronic documents cannot be rescinded or repudiated.
    2. No editing or alteration of any documentation with a manual or electronic signature is permitted without approval of the Chief, Medical Information Services, or HIM Director.
    3. An electronic document in the health record may have more than one signature because each has a distinct and separate purpose depending on the role of the signer. For example, the signers may include the author, transcriptionist/recorder, supervising practitioner, or witness.
I. <u>Document Scanning</u>. Scanning, or imaging, is a process of converting a paper document to an electronic file. Scanned documents may be linked to TIU documents and displayed with the TIU document. Scanned documents do not require an electronic signature but are marked administratively complete. Only those documents that cannot be created in or interfaced with the EHR will be scanned. Development of document scanning policies is a shared responsibility among facility HIMs and other appropriate services.
J. <u>Health Record Alterations and Modification</u>. Electronic progress notes, operative reports, and discharge summaries are occasionally entered by practitioners in the TIU and the EHR software for the wrong patients, or the information within the document(s) may be erroneous. A local procedure, following the EHR for HIM Guide found at here, must be established for correcting erroneous patient information entered electronically. It is the responsibility of the HIM to ensure there is a process in place to correct erroneous health record information. (Refer to Manual Exhibit 3-3-A Comparison of Update, Administrative Correction, Addenda, and Amendment Requests.)

3-3.10 INTERDEPARTMENTAL RESPONSIBILITIES

This section defines for the responsibilities of the medical staff, nursing service, CEO, Privacy Act Liaison (PAL)/Privacy Official (PO), dental, pharmacy, behavioral health, nutrition/dietetics, optometry/ophthalmology, and committees.

J. <u>Dental</u>. Dental is responsible for compliance with their own standards regarding dental outpatient documentation. Dental film (X-ray) in the record must be removed prior to the retirement of the record to the FRC. (Refer to the IHS Records Disposition Schedule, Professional Services, Section 2, Dental Services.)

3-3.11 QUANTITATIVE ANALYSIS OF THE HEALTH RECORD

A. <u>Quantitative Analysis</u>. Quantitative analysis is a review of prescribed areas of the health record for identifying specific deficiencies in recording to ensure that it is complete, accurate, and timely. Items that do not meet the criteria should be on the deficiency form or in the EHR and completed by the responsible health care provider.
B. <u>Purpose</u>. The purpose of quantitative analysis is primarily to identify obvious and routine omissions that are easily corrected in the normal course of patient care. This ensures the health record is more complete for reference in continuing patient care; for protecting the legal interests of the patient, physician, and hospital; and for meeting provider licensing or regulatory and/or accrediting/certifying and IHS requirements.

C. <u>Quantitative Analysis of Outpatient Records</u>. The availability of a complete, accurate, and current outpatient record is as important as the inpatient record. It is a part of the total picture of the health status of the patient. The HIM personnel shall perform an initial review of the record following an outpatient visit. Procedures shall be developed at the IHS Service Unit to ensure that information is received from contract facilities and physicians. The following items of documentation shall be assessed as specified in IHS policy or in the facility's Medical Staff Bylaws, Rules and Regulations:

    1. <u>Clinic record</u>.
        a. completion of sociological data;
        b. diagnoses and clinical notes;
        c. use of standard terminology;
        d. approved abbreviations;
        e. <u>do not</u> use abbreviations;
        f. recording of pertinent dental and medical care;
        g. history and physical findings;
        h. date of visit;
        i. chief complaint or reason for visit;
        j. care and treatment;
        k. diagnosis;
        l. instructions to patient; and
        m. signatures/discipline.
    2. <u>Diagnostic tests, x-rays</u>. Reports for all tests and x-rays ordered are filed in the chart.
    3. <u>Types of treatment</u>. Documentation of various types of treatment.
        a. Operative Permit
        b. Report of Operation
        c. Pathology Report, if appropriate
        d. Copies of routine physical examinations maintained in record
        e. Obstetrical history, if appropriate
        f. Reports of CHS medical care
        g. Hospitalization summaries by referral hospital or physician

E. <u>Qualitative Analysis of Health Records</u>. Qualitative analysis is a review of health record entries for inconsistencies and omissions that signify the health record is inaccurate or incomplete. Such an analysis requires a knowledge of medical terminology, anatomy and physiology, fundamentals of disease processes, health record content, standards of provider licensing and other regulatory and/or accrediting/certifying agencies. It is usually performed by a qualified HIM professional.

    1. <u>Purpose</u>. As is true of quantitative analysis, the purposes of qualitative analysis include making the health record complete for reference in patient care, protecting legal interests, and meeting regulatory requirements. However, because it is more in-depth than quantitative analysis, it serves these purposes more fully. It also contributes background or supporting information for quality improvement and risk management activities. Qualitative analysis also assists in diagnosis and procedure coding specificity and sequencing that is important for ongoing health research, administrative studies, and reimbursement.
    2. <u>Components</u>. The components of qualitative analysis include a review of the health record content (assuming the completion of quantitative analysis) for the following:
        a. complete and consistent recording of diagnostic statements;
        b. consistency in entries by all health care providers;
        c. description and justification for the course of the patient's hospitalization;
        d. recording of all necessary instances of informed consents;
        e. application of good documentation practices; and
        f. occurrence of a potentially compensable event.

3. Examples of Qualitative Analysis. Review of records for indication of post-op wound infection; review of records for indication of postpartum infection; and review of physical exam for essential data items such as:
   a. pelvic and rectal exam prior to abdominal surgery and quality of documentation of findings;
   b. review of blood and component use against criteria established by the Tissue and Transfusion Committee;
   c. review of documentation items involved in quality review activities which are identified by the medical staff or medical staff body;
   d. review of potentially compensable events; and
   e. review and compare Pathology Reports with Operative Reports and Diagnoses to ensure compatibility and consistency.

4. Requirements. Qualitative analysis is not something that may be undertaken lightly. It requires an in-depth understanding of health record science and management. The qualitative analysis must be performed or directly supervised by a credentialed HIM professional who is experienced in record analysis and quality review activities.

5. Frequency. Qualitative analysis may be done routinely or on a sampling basis depending on facility needs and staffing patterns. However, the review of results should be a major part of the facility's Medical Record Review Committee activity.

3-3.12 MEDICO-LEGAL ASPECTS OF HEALTH RECORDS

A. Definition of Court of Competent Jurisdiction. The OGC, Department of Health and Human Services (HHS), has determined that only Federal courts are inherently courts of competent jurisdiction for Privacy Act purposes, whereas because of the doctrine of sovereign immunity, Tribal (and State) courts may be courts of competent jurisdiction only if the United States submits to the jurisdiction of such courts. The OGC advice and guidance is as follows: "The IHS, upon receipt of a Tribal court subpoena for Federal medical records, has the option of either complying with the subpoena (e.g., voluntarily submitting to the jurisdiction of the court) or processing it pursuant to 45 CFR § 2.5 under rules established in 45 CFR Part 5 (FOIA). The decision, however, should be made by IHS in consultation with the OGC."

B. Statement of Legal Liaison between Government Agencies.
   1. The Department of Justice (DOJ), through the OGC, is the legal representative of the HHS.
   2. All issues involving litigation shall be directed by the CEO to the Area Director, who shall refer the matter to the appropriate OGC attorney.

C. Characteristics of the Health Record as a Legal Document. The legal health record is the documentation of health care services provided to an individual during any aspect of health care delivery in any type of IHS facility for administrative, business, or payment purposes. The legal health record contains individually identifiable health information, stored on any medium, which is collected for documenting health care or health status. When the legal health record consists of information created as paper documents and information created in electronic media, it is considered to be in a hybrid environment.
   1. The significance of the health record as evidence in a court of law dictates that considerations be given to the following health record characteristics:
      a. All handwriting shall be in dark permanent ink (no red) that is legible when photocopied or microfilmed. The ink shall not be of the type that soaks through and obliterates information. Pencil entries in any part of the record are unacceptable. (Due to extended record retention periods, black permanent ink is preferred. No highlighters or white-out will be used in the record).
      b. All entries shall be dated and authenticated, including signature and title of the author. (Signature stamps with original signatures are authorized). Electronic signatures will be allowed pursuant to the facility's specific guidelines. Handwriting is deemed to be illegible if two people cannot read the handwriting.

    c. The electronic signature is a computer data compilation of any symbol or series of symbols executed, adopted, and/or authorized by an individual to be the legally binding equivalent of the individual's handwritten signature. The electronic signature is never shared.

    d. Each page within the health record shall contain the patient's identification information and the facility name.

    e. The health care provider shall sign those portions of the health record containing documentation of care for which that person is responsible, including countersignatures where appropriate.

    f. Transcription of dictated information shall be accurate, complete, and authenticated by appropriate signature.

    g. Correction of health record data shall be as follows:
        1. no erasure or other obliteration shall be made;
        2. incorrect data shall be lined out with a single line; and
        3. the date of correction, the signature of the person making the correction, the correct information, and the reason for the correction shall be added.

    h. Any request by the patient for correction/amendment of previously recorded PHI shall be handled by the Privacy Act/HIPAA Privacy Rule. Refer to Part 2, Chapter 7, IHM.

2. The health record shall not be removed from the facility at any time except by court order or retirement to a FRC. Restrictions concerning records removal are:

    a. Court orders must be signed by a judge and specify that the health record be presented for admission as evidence during a legal proceeding, such as, a court case, formal deposition, or grand jury investigation. All court orders received by the HIM Consultant must be forwarded to the OGC for review and the decision to comply is made by the IHS in consultation with the OGC.

    b. Discovery subpoenas (subpoenas issued to gain access to records for the purpose of examination) shall not be honored without the consent of the subject individual.

3. Health records shall be retained at the facility for the legally specified period of time and shall be transferred to the FRC in accordance with the National Archives and Record Administration regulation (usually after 3-7 years of inactivity). The [IHS Records Disposition Schedule 3-1, Medical Records File is found here](#).

F. Privacy and Confidentiality of the Health Record and Information Security.

    1. Confidentiality. Patient records are confidential regardless of medium. The privacy of patient information must be preserved, therefore, the information will not be made accessible to or discussed with unauthorized persons. All staff with access to patient information in the performance of their duties is informed of their responsibility to maintain the confidentiality of patient information. Every employee with access to patient records in any medium is responsible for proper handling of the patient records. Each employee is accountable for safeguarding patient confidentiality and privacy, and failure to do so may result in disciplinary or other adverse action up to, and including, termination.

    2. Access. Access to health care information is controlled to ensure its integrity, to minimize the risk of compromising confidentiality, and to increase reliability. Access to health records and health record file areas is limited to authorized personnel. (Refer to Part 2, Chapter 7, IHM.) Only authorized personnel are allowed to print extractions from the electronic health record or to make copies from the paper chart.

G. <u>Security</u>. Security measures for authorizing access to the patient's health record must be delineated in local policy. Only the Director, HIM, or his or her designee, may approve the physical removal of original health records from the treating facility. Health records in file areas and other areas where health records are temporarily stored (clinic or treatment areas, record review areas, quality assurance areas, release of information, etc.) must be secured when responsible personnel are not present to ensure the security of the area and to ensure records are not accessible to unauthorized individuals. Precautions must be taken by staff to ensure that patient records on computer screens cannot be seen by unauthorized individuals. The use of computer privacy screens is encouraged. All patient-identifiable waste paper and discarded materials from all departments must be shredded or disposed of in accordance with approved disposal policies and procedures of the facility. Locked containers or shredders must be provided in employee work areas for disposal of all sensitive patient identifiable information.

H. <u>Disaster Recovery Plan</u>. A disaster recovery plan for protecting and recovering health records damaged or destroyed by fire, flood, or by other means must be in place at all facilities. Staff must be knowledgeable of the overall plan, as well as their particular responsibility, in the event of natural or man-made disaster impacting normal operations. The disaster recovery plan must emphasize that the goal is to prevent damage, but to focus on recovery of lost, damaged, or destroyed records. The plan should include: preparation, response, and recovery with issues for consideration including, but not limited to:

   a. identification of possible disasters causing interruption of services, for example, loss of electricity, flood, fire, or earthquake;
   b. identification of key services (work processes) required to support patient care until normal operations are resumed, and the development of a contingency plan to provide these services;
   c. identification of contingency methods to provide access to records (e.g., back up MPI) stored on paper or electronically;
   d. identification of required immediate HIM staff action depending on the type of disaster, i.e., moving records, turning off electricity to areas, closing doors;
   e. coordinate with ancillary departments such as Admitting, ER, Risk Management, and Nursing;
   f. identification contract disaster recovery services vendors; and
   g. identification of equipment on hand or to be purchased, for example, back up generators for lighting, waterproof boxes, carts for transporting records to alternate location.

I. <u>Area Disaster Recovery Services</u>. Contact the Area disaster recovery vendor/contract staff and document the scope of their available services; advance arrangements must be made, with the disaster recovery vendor to provide priority service to the facility, if possible, for the facility to receive priority service.

   a. Staff must know the location of the disaster recovery manual materials.
   b. Routine disaster drills must be conducted.
   c. Following a disaster, document any portion(s) of patient records deemed lost, damaged, or destroyed, by noting date, data, and reason for loss in the patient record, or in a newly "created" patient record.

J. <u>Continuity of Operations Plan</u>. A continuity of operations plan for protecting and recovering health records damaged or destroyed by fire, flood, or by other means must be in place. Staff must be knowledgeable of the overall plan, as well as their particular responsibility, in the event of natural or man-made disaster impacting normal operations. The continuity of operations plan must emphasize that the goal is to prevent damage first, and then focus on recovery if records are damaged or destroyed. The plan should include: mitigation, preparedness, response, and recovery with issues for consideration including but not limited to:

   a. Identification of possible disasters causing interruption of services, such as loss of electricity, flood, fire, or earthquake;
   b. identification of key services (work processes) required to support patient care until normal operations can be resumed, and the development of contingency plans to provide these services;
   c. contingency methods to provide access to records, as in back up MPI, in electronically stored or paper form;

    d. identification of required immediate HIM staff action according to the disaster such as moving records, turning off electricity to areas, closing doors, etc.;

    e. coordination with ancillary departments such as Admitting, ER, Risk Management, and Nursing;

    f. identification of contract vendors offering disaster recovery services; and

    g. identification of equipment on hand or in need of purchase such as waterproof boxes, carts for transporting records to alternate location, etc.

K. <u>Area Incident Management Staff</u>. Area staff with designated responsibility for supporting incidents must be contacted and the scope of their offerings must be documented; advance arrangements must be made, where possible, for the facility to receive priority service.

    a. Staff must be oriented to the location of continuity of operations plans and emergency management plans.

    b. Health Information Management services should be part of routine disaster drills.

    c. Following a disaster, document any portion(s) of patient records deemed irretrievable or lost, by noting date, data, and reason for loss in the patient record, or in the newly "created" patient record, if disaster is of that proportion.

    d. The HIM portion of the continuity of operations plan should be reviewed at least annually along with the overall plan.

X. Privacy of the Patient - Patient Information.

1. <u>Responsibility for Privacy of the Patient</u>. The patient's right to privacy is the responsibility of all employees of each IHS facility, regardless of whether direct or contract care programs. The facility policies shall prescribe procedures that comply with the Privacy Act of 1974 and HIPAA Privacy Regulations. The procedure should specify the following:

    a. Persons officially authorized to provide information that may be released to news agencies on police cases.

    b. A listing of the type and amount of information that may be released to the press in other than law enforcement.

    c. All such policies shall be directed to promoting the well-being of the patient, protecting the patient's privacy, and assisting the press in covering the news. When in doubt, the patient's right to privacy takes precedence over the public's right to know.

2. <u>Newspaper Publicity of Patients</u>. Indian Health Service personnel shall not release detailed information to the press and shall not permit photographs of the patient without the signed authorization of the patient or his or her authorized representative. Such authorizations shall become a part of the patient's health record. Photographs shall be placed in an envelope and properly identified with patient name, health record number, and date photograph was taken.

    a. Information may be used or disclosed from the IHS hospital directory in response to an inquiry about a named individual from a member of the general public to establish the individual's presence (and location when needed for visitation purposes) or to report the individual's condition while hospitalized (e.g., satisfactory or stable), unless the individual objects to disclosure of this information. (Refer to IHS HIPAA P&P For Use and Disclosure for Directory Purposes.)

    b. The presence of a patient being treated for alcohol or drug abuse shall not be disclosed without the patient's consent. This prohibition includes evaluation, counseling, or treatment of abuse or addiction, and medical or surgical treatment of conditions that are a known direct result of alcohol or drug abuse.

3. Photographs of Patients. The signed authorization of the patient shall be obtained when the hospital or any person desires to take a photograph of a patient or any part of the body of a patient for any purpose whatsoever. The Authorization for Administration of Anesthesia and for Performance of Operations or Other Procedures form (IHS-515) is required for any pictures, films, etc., that are included in the health record. All media that capture and/or store patient health information are considered part of the health record and are, therefore, subject to confidentiality regulations. The original or copy of the signed consent becomes a part of the patient's health record.
   a. Clinical Photography. Permission is not required for photographing surgical or postmortem specimens, if the identity of the patient is not to be revealed.
   b. Television, Video, Motion Pictures. The Authorization to Produce and Use Audiovisual Materials form (IHS-859) is required for photographs, movies, video and audio tapes taken of the patient. Unless there is an express agreement to deliver the photograph or the negative to the patient, the patient has no basis for claiming possession of either, but has the right to a copy if Privacy Act and HIPAA Privacy policies are followed.

3-3.13 CONSENTS TO MEDICAL AND SURGICAL PROCEDURES

A. Characteristics of an Informed Consent. All health records must include evidence that informed consent was obtained from the patient or personal representative prior to undertaking any treatment or procedure. Separate, specific, and informed consent is required for any aspect of treatment or procedure that involves research. In addition, documentation in the health record must comply with accreditation/certification standards.
   1. Knowledge Before Signing. The procedure to be performed must be explained in laymen's terms to the patient by the health care provider, so that the patient knows which procedure is being consented to; knows specifically what is to be done; knows the expected results; understands the risks involved; knows the type of anesthesia involved; and is aware of alternative procedures. At the time of explanation and signing, the patient must not be under the influence of anesthetic or sedation. If the patient does not understand English, the consent should be explained by an interpreter who must sign as a witness.
   2. Content. An informed consent document must include the following information:
      a. Name of the facility in which the operation or procedure is to be performed, and the time and date the consent is signed;
      b. Name of provider to perform the procedure;
      c. Name of the patient on whom operation or procedure is to bed performed;
      d. Statement of the nature of the operation or procedure to be performed;
      e. Statement by patient, parent, or guardian, of procedure, risks, and alternatives as the patient understands it. If written by the provider, it must be in laymen's terms;
      f. Authorization to perform such additional operations or procedures considered necessary or desirable in the judgment of the surgeon or provider;
      g. Consent to dispose of tissues or amputated parts removed at operation;
      h. Authorization for taking photographs in the course of treatment for the purpose of advancing medical knowledge;
      i. Signature of patient or personal representative authorized to give consent on patient's behalf; and
      j. Signature of the witness.
   3. Length of Validity of Consent. Consents are considered to be valid for a reasonable time after signing. There is no specific limitation in hours or days after which a new consent must be obtained. As a matter of policy, no consent is deemed valid after the patient has been discharged.

4. Emergency Procedure Without Consent. A procedure may be performed when immediate surgery is necessary and the patient's state is such that he or she cannot rationally consent, or where delay in obtaining the consent of the parent or guardian poses a serious risk to the patient. Verbal or telephone consent, if obtained, shall be documented in the health record by the responsible practitioner. When a surgeon operates under such circumstances, the surgeon shall document in the patient's record:
   a. that an immediate operation was necessary;
   b. that consent could not be obtained from the patient or from any person authorized to act for the patient;
   c. that the operation performed was necessary to save the patient's life; or
   d. that delay might involve serious risk to the patient.

B. Consent Form. The Authorization for Administration of Anesthesia and For Performance of Operations or Other Procedures consent form (IHS-515) shall be used in all IHS facilities. The age of majority for consent to medical and surgical procedures is in accordance with State laws. Minors may consent to care and treatment in specific categories such as sexually transmitted disease, family planning (Refer to 3-13, Maternal Child Health, IHM), or alcohol/substance abuse counseling and treatment. Exception: Elective sterilization may not be consented to, or performed on, any patient prior to age 21 according to regulations regarding Federal funding of elective sterilizations. Patient consent shall be obtained for the following procedures:

1. Major and Minor Surgery. Anesthesia; non-surgical procedures that involve more than a slight risk of harm to the patient or that involve risk of a change in the patient's body structure; x-ray therapy; intravenous pyelograms; and all other procedures determined by the medical staff to require a specific explanation to the patient.

2. Outpatient and Inpatient Care. Competent adult patients who present themselves for treatment as either outpatients or inpatients consent to the ordinary diagnostic and therapeutic measures used by physicians and other medical personnel; it may be assumed that they know in general that their diagnosis and treatment may entail several procedures and that their request for treatment would include the willingness to submit to these ordinary procedures. It is recommended that each facility's medical staff create lists of invasive and non-invasive procedures performed at the respective facility requiring informed consent.

3. Immunizations. Where State or Federal law requires a written consent for administration of certain vaccines, the consent shall be obtained prior to vaccination of a patient.

4. Consent for Operative Procedures. The consent or refusal for consent shall be made a part of the health record.
   a. Consent for Surgery. Except in emergencies when the patient is physically or mentally incapable of consenting or when the delay required to obtain the consent of natural parents or legal guardians would seriously endanger the patient's health, no operative procedure shall be undertaken unless the patient (or in the case of a minor or incompetent, that person's natural or legal guardian) gives informed consent; nor shall any major operative procedure or the administration of preoperative medication or a general anesthetic be undertaken unless informed consent has been obtained in writing.
   b. Consent for Administration of Anesthesia. The patient's written informed consent is required for the administration of general or spinal anesthesia. The patient must be informed in laymen's terms of the procedure to be performed and the risks involved. The surgeon performing the procedure is responsible for obtaining the consent. The witness to the consent form shall not be a member of the operating team.
   c. Cesarean Section. Only the consent of the patient is necessary. The signed authorization becomes a part of the health record. In emergency cases where the life of the mother and/or child is threatened and the mother is unable to provide written consent, the provider should obtain oral consent from the mother and document the consent in the health record. If, in addition, the mother is unconscious or otherwise unable to provide informed consent, and a spouse or other appropriate family member is unavailable to provide consent, then no consent is required, however, the basis for proceeding with the cesarean section without consent should be documented in the health record.

d. <u>Sterilization</u>. An individual desiring sterilization that is not medically indicated because of specific pathology involving reproductive organs must be 21 years or older and mentally competent. A full explanation, both orally and in writing, shall be furnished of the procedure to be followed, risks and subsequent discomforts, benefits to be expected, and alternative methods of family planning. The individual shall be informed that a decision against sterilization will not prejudice future care or treatment. A sterilization procedure will not be performed for 30 days following execution of an informed consent nor more than 180 days after consent is executed (42 CFR 50.201,202,203). An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery. A separate Consent for Anesthesia and Surgery must be signed immediately prior to the surgery. This is an additional consent to meet requirements for the surgical procedure itself. (Refer to Part 3, Chapter 13, Section 12F(5), Maternal and Child Health IHM.)

e. <u>Special Therapy</u>. Consideration should be given to the need for consent in the event that the patient is given therapy that may be hazardous. The patient shall be informed and it should be documented in the health record.

f. <u>Special Situations</u>. In certain special situations, additional procedures and documentation are required. These include consent for unusual or extremely hazardous treatments or procedures, forced administration of psychotropic drugs, testing and treatment for HIV, and research. These are also specific notice and documentation requirements for medical emergencies and for the release of evidentiary information from the health record when the practitioner suspects the patient might have been subject to abuse or neglect.