IHS DENTRIX CLINIC MANAGER'S HANDBOOK

Updated: May 2022

Abstract

The IHS Dentrix Clinic Manager's Handbook is outlined with best practice guidance for the management and operation of Dentrix Enterprise within the IHS clinic. The chapters within this handbook are divided between specific clinic operation management workflows. From Dentrix Enterprise configuration to monthly closeout duties, the IHS Dentrix Clinic Manager's Handbook is the resource to outline dental clinic management processes within Dentrix Enterprise.

IHS Dentrix Clinic Manager's Handbook

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** New to this version.

Daily Clinic Closeout Duties

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Instructions: The Daily IHS Clinic Closeout Duties is designed to provide a comprehensive list of checks and balances to ensure the accuracy of today's entries recorded within Dentrix Enterprise, allow tracking and review 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. To produce the necessary reports, each row of the Daily Checklist table details the report (or checklist task) and suggested report filters you should utilize to complete the each of the identified objectives. When reviewing your report data, use the dependencies to complete any required tasks. The additional actions and corrections identify areas and tasks that may need to be performed if/when the report/task does not yield the expected result. Fields are provided within the table to indicate when the Checklist Task is complete: enter the review date, your name, recommended actions, target date and completion date in the designated fields for each task.

Checklist Task / Report	**Suggested Report Filters**	**Intent / Responsibility**	**Objective**	**Dependencies and Possible Actions or Corrections Needed to Meet Objective**	**WARNING:** *not following the recommendations in the checklists may yield the following unintended results*	**Reference Documentation** (all references are in the IHS Clinic Manager's Handbook unless noted as an *external reference*)	**Checklist Task / Report Completion**	
Day Sheet Report (All Clinics / All Providers)	Date Range: today, by entry date; All parameters for Clinic, Provider, Billing Type, Patient Tag	Dental Chief or Management Lead	Review of all transaction activity to gain an understanding of the care provided to patients, ability to identify gaps and pinpoint productivity of each provider.	Prior to running the Day Sheet Report, all appointments must be marked as <complete>, indicating that all procedures have been completed and reviewed for accuracy. Appointment Book: Confirm all appt status have been changed to COMPLETE; Cross check the schedule with the day sheet for missing patients Clinical Chart: Correct patient clinic, provider(s), and complete days services Ledger: Correct posting errors for payments/adjustments Family File: Assign 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 Guide*	Date Reviewed: Assigned Individual: Actions Required: Target Date: Completion Date:	
Day Sheet Report (Individual Provider)	Date Range: today, by entry date; All parameters for Clinic, Billing Type, Patient Tag; Filter by	Individual Provider	Individual provider reviews their completed procedures for accountability of patient care completed prior to filing of insurance claim.	Prior to running the Day Sheet Report, all appointments must be marked as <complete>, indicating that all procedures have been completed for the provider's patients. Appointment Book: Confirm all appt status have been changed to COMPLETE; Cross check the schedule with the day sheet for missing patients	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, insurance	Schedule Optimization Patient Records Clinical Records Revenue Cycle *Reports Reference Guide*	Date Reviewed: Assigned Individual: Actions Required:	

	Individual Provider			Clinical Chart: Correct patient clinic, provider(s), and complete days services Ledger: Correct posting errors for payments/adjustments Family File: Assign correct billing type	claims could be processed with information that is incorrect, leading to processing delays, need for resubmission, and claim payment delays.		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 desired)	Provider	Provider review of tomorrow's schedule to ensure provider availability for appointments scheduled, along with identifying patient treatment challenges, and treatment needs.	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-up 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 (i.e. appointments that are too short to provide needed care, provider out of the office for part of the day, etc.) that could have easily been avoided.	Schedule Optimization Patient Records Clinical Records	Date Reviewed: Assigned Individual: Actions Required: Target Date: Completion Date:	
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 appt. Color code for Eligibility Indicator on appointments: Yellow = Not Checked Green = Eligible Red = Not Eligible Family File: Attached insurance plan to patient file; Verify insurance eligibility; Enter eligibility dates and coverage detail	If the insurance information for the scheduled patient is not verified, the coverage/payment for services may be in jeopardy. 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 (version 8.0.9)	Select Appointment List: Continuing Care, Unscheduled Appointments, ASAP, Unscheduled Treatment or Unscheduled Treatment	Front Desk Staff	Compare scheduling lists with appointment opportunities to ensure timely patient care.	Continuing Care attached to patient. 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; Attach Continuing Care to appointments; Apply Break and Wait/Will Call to cancellations	Patient care opportunities are not optimized if those in need of appointments before provider availability occurs are not monitored. Cancellations in the clinic's schedule will not be as easily "filled" if	Schedule Optimization Patient Records Clinical Records	Date Reviewed: Assigned Individual: Actions Required:	

	Requests Select list filters, Clinic and Provider (as needed)			<u>Family File:</u> Assign appropriate Continuing Care types and intervals <u>Patient Chart:</u> Enter treatment plan <u>More Information:</u> Enter treatment request	the scheduling lists are not used.		Target Date: Completion Date:	
Signature Manager	Date Range: select date range, including today's date; Select Clinic and Provider; Status: Unsigned	Dental Chief & Individual Provider	Review and approve (sign) all open Clinical Notes.	Clinical Notes and electronic signatures (approvals) are being used in the EDR. <u>Clinical Notes:</u> Review note for completion; Add/modify Clinical Note as needed; Sign Clinical Note	Not using this fail-safe report leaves unsigned Clinical Notes open for editing/modification. Identifying those unsigned Clinical Notes via this report provides is a quick and easy way for Providers to find those patients 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, Patient Tag	Billing -OR- Front Desk Staff	Review of 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. <u>Ledger:</u> Correct posting errors for payments/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:	
Procedures Not Attached to Insurance	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 claim.	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 necessary	If procedures are completed yet not attached to the patient's claim for processing, this is revenue that may be lost or delayed. This report identifies missing claims so that the user may quickly and easily make corrections, adding procedures prior to claims being processed.	Revenue Cycle	Date Reviewed: Assigned Individual: Actions Required: Target Date: Completion Date:	

Insurance Claims Not Sent	Date Range: today; All parameters for Patient, Insurance Carrier, Clinic, Provider, Billing Type, Patient Tag	Billing -OR- Front Desk	Ensure that insurance claims have been processed/sent.	All claims have been electronically submitted or printed. <u>Ledger:</u> Confirm all documentation is attached to any held claims; Print or send claims electronically	Not using this report leaves unprocessed insurance claims unattended. Unlike the Procedures Not Attached to Insurance report, the Insurance Claims Not Sent identifies claims that do have all procedures correctly attached, but have not been sent to the Batch Processor for submission.	Revenue Cycle	Date Reviewed: Assigned Individual: Actions Required: Target Date: Completion Date:	
Secondary Insurance Claims Not Created	Date Range: today; All parameters for Patient, Insurance Carrier, Clinic, Provider, Billing Type, Patient Tag	Billing -OR- Front Desk Staff	To identify and process secondary insurance claims that have not yet been created.	Both Primary and Secondary Insurance plans have been attached to patient in the 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 or send claim electronically	When the patient's secondary insurance claim has not been created following the posting of payment or denial from the primary insurance, this report will catch that info and reveal. If the clinic does not routinely run this report, the information hangs in limbo and secondary insurance claims are not filed, effectively lowering revenue.	Revenue Cycle	Date Reviewed: Assigned Individual: Actions Required: Target Date: Completion Date:	
Pre-Estimates Not Sent	Date Range: today; All parameters for Patient, Insurance Carrier, Clinic, Provider, Billing Type and Patient Tag	Billing -OR- Front Desk Staff	To identify and process Pre-Treatment Insurance Estimate claims that have not been sent.	Clinical staff created treatment plan in the Patient Chart. FD/Billing Staff created a Pre-Treatment Estimate claim in the patient Ledger. <u>Patient Chart:</u> Confirm the Treatment Planned procedures on the claim are ready to be sent to insurance. Print or send claim electronically	If the patient (or the clinic) needs a pre-treatment estimate prior to proceeding with treatment recommended, this report will reveal those insurance estimates that have not yet been sent. If not generated, all will be awaiting information that has not even left the office via insurance processing.	Revenue Cycle	Date Reviewed: Assigned Individual: Actions Required: Target Date: Completion Date:	

Suspended Credits	Date Range: today, by entry date; All parameters for Guarantor, Clinic, Billing Type, Patient Tag	Billing -OR- Front Desk Staff	To 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 in suspension will have a direct impact on revenue totals within the Provider A/R Totals, 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

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Instructions: The Weekly IHS Checklist is designed to provide a comprehensive list of checks and balances to ensure the accuracy of this week's entries recorded within Dentrix Enterprise, allow tracking and review of internal key performance indicators, and verify the completion of this week's insurance revenue processes, where applicable. To produce the necessary reports, each row of the Weekly Checklist table details the report (or checklist task) and suggested report filters you should utilize to complete the each of the identified objectives. When reviewing your report data, use the dependencies to complete any required tasks. The additional actions and corrections identify areas and tasks that may need to be performed if/when the report/task does not yield the expected result. Fields are provided within the table to indicate when the Checklist Task is complete: enter the review date, your name, recommended actions, target date and completion date in the designated fields for each task.

Checklist Task / Report	**Suggested Report Filters**	**Intent / Responsibility**	**Objective**	**Dependencies and Possible Actions or Corrections Needed to Meet Objective**	**WARNING:** *not following the recommendations in the checklists may yield the following unintended results*	**Reference Documentation** (all references are in the IHS Clinic Manager's Handbook unless noted as an *external reference*)	**Checklist Task / Report Completion**	
Oral Health Status Report	Date Range: Last Week's Date Range	Dental Chief / CAC	Identify at 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 Metric.	If not completing the OHS Metric Tool at patient visits, along with running subsequent reports, identifying and following-up on high risk patients cannot effectively occur.	Clinical Records Patient Records *Reports Reference Guide*	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	
Signature Manager	Date Range: Last Week's Date to current Provider 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 note for completion; Add/modify Clinical Note as needed; Sign Clinical Note	Not using this fail-safe report leaves unsigned Clinical Notes open for editing/modification. Identifying those unsigned Clinical Notes via this report provides is a quick and easy way for Providers to find patient Clinical Notes that need attention and completion. **NOTE The OHS Metric Tool will not launch from this module.	Clinical Records	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	

Referral Recap Report	Last Week's Date Range	Dental Chief Front Desk/Scheduler	Used to 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.	Referred treatment by a doctor into the clinic must be recorded as such in the Patient Chart. Patient Chart: Document the patients Referred By 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 Guide*	Date Reviewed: Assigned Individual: Actions Required: Target Date: Completion Date:	
Treatment Plan Approval Report	Last Week's Date 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 be used to contact patients with unscheduled treatment plan procedures.	Insurance Pre-Treatment Insurance claim (or claims if Secondary insurance is applicable) was submitted and received. In the Treatment Planner, the case for the submitted treatment has been marked with either Accepted or Rejected. Ledger: Treatment Planned Procedures sent to Insurance for pre-approval. Document the notification from insurance company as accepted or rejected.	If this report is not used, approved, insurance estimated accepted treatment may remain unscheduled and the time invested in recording the info in EDR. Patient's oral care may be compromised and team member's time invested in this process will have been effectively wasted.	Schedule Optimization Patient Records Clinical Records Revenue Cycle *Reports Reference Guide*	Date Reviewed: Assigned Individual: Actions Required: Target Date: Completion Date:	
Treatment Plan Approval Status Report	Last Week's Date Range	Front Desk/Scheduler Clinical Manager, CAC or Dental Chief	Fully customizable internal status 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 for efforts with patient contact and appointment scheduling. Additionally, pre-treatment insurance information may also be used as a filter in this report.	Meaningful Approval Statuses must be added to Definitions in the Office Manager, Practice Setup. When treatment planned procedures are added in the Patient Chart, an Approval Status must be designated from those statuses available in the drop down menu. When the Approval Status changes, it must then be updated in the treatment planned procedure. Patient Chart: Mark appropriate status for treatment planned procedures.	Improper set up and use of status types will render this report useless. Not viewing the information on this report will leave patients who are in need of oral health care in an unscheduled state. Patient's oral care may be compromised and team member's time invested in this process will have been effectively wasted.	Database Design Schedule Optimization Patient Records Clinical Records Revenue Cycle *Reports Reference Guide*	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 attached to patient. 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; Attach Continuing Care to appointments; Apply Break and Wait/Will Call to cancellations Family File: Assign appropriate Continuing Care types and intervals Patient 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. Cancellations in the clinic's schedule 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:	
Referred By/To	Last Week's Date 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.	Family File: Document referred by/to within designated fields. Activate required 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	Last Week's Date Range	Dental Chief/Each Provider	This report reflects both production and collection net totals because it takes into account adjustments to production (i.e. patient discounts) and adjustments to collections (i.e. refunds to patients or insurance company, 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. Ledger: Ensure procedures, payments and adjustment are properly posted to providers of the rendered service.	Since this report is the only one in the EDR that contains all adjustments types and their relationship to Productions or Collections, not reviewing this report will leave the Dental Chief and/or the Providers without full information on the status of the clinic's Accounts Receivable totals.	Revenue Cycle *Reports Reference Guide*	Date Reviewed: Assigned Individual: Actions Required: Target Date: Completion Date:	

Analysis Summary	Last Week's Date Range	Dental Chief/Each Provider	The Analysis Summary provides and at-a-glance totals report, similar to day sheet "totals", used to oversee dental site patient, production, 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 providers of the rendered service.	When the Analysis Summary is not reviewed on a regular basis, the dental chief and providers have a reduced awareness for productivity within the dental clinic.	Revenue Cycle *Reports Reference Guide*	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, payment/credit must be allocated to a procedure/charge. Ledger: Allocate payments as they come in utilizing the FIFO method unless 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 Guide*	Date Reviewed: Assigned Individual: Actions Required: Target Date: Completion Date:	
Secondary Insurance Claims Not Created Report	Date Range: Last Week's Date to current	Front Desk/Billing Staff Review	To identify and process secondary insurance claims that have not been created.	Both Primary and Secondary Insurance plans have been attached to Patient in the 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 or send claims electronically.	When the patient's secondary insurance has not been created immediately following the posting of payment or denial from the primary insurance, this report will catch that info and reveal. If the clinic does not routinely run this report, the information hangs in limbo and secondary insurance claims are not filed, effectively lowering revenue.	Revenue Cycle	Date Reviewed: Assigned Individual: Actions Required: Target Date: Completion Date:	

Secondary Pre-Treatment Estimates Not Created Report	Date Range: Last Week's Date to current	Front Desk/Billing Staff Review	To identify and process secondary Pre-Treatment Estimates that have not yet been created.	Both Primary and Secondary Insurance plans have been attached to Patient in the Family File. Primary insurance Pre-Treatment Estimates were sent and estimates have been received and the estimated coverage has been entered in the Patient Ledger. Confirm the Treatment Planned procedures are ready to be sent to secondary insurance. Print or send electronically	If the patient - or the clinic - needs this information prior to proceeding with treatment, this report will identify those patients w/secondary insurance that has not been filed upon receipt of info from the primary carrier.	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 not possible.	Database Design Schedule Optimization Patient Records Clinical Records Revenue Cycle Monthly Checklist: Audit Reports *IHS Dentrix Enterprise User's Guide* *Reports Reference Guide*	Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	
							Completion Date:	

Monthly Clinic Closeout Duties

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Instructions: The IHS Checklist is designed to provide a comprehensive list of checks and balances to ensure the accuracy of entries recorded within Dentrix Enterprise, allow tracking and review of internal key performance indicators. When reviewing your report data, use the dependencies to complete any required tasks. The additional actions and corrections identify areas and tasks that may need to be performed if/when the report/task does not yield the expected result. Fields are provided within the table to indicate when the Checklist Task is complete: enter the review date, your name, recommended actions, target date and completion date in the designated fields for each task.

Checklist Task / Report	**Suggested Report Filters**	**Intent / Responsibility**	**Objective**	**Dependencies and Possible Actions or Corrections Needed to Meet Objective**	**WARNING:** *not following the recommendations in the checklists may yield the following unintended results*	**Reference Documentation** (all references are in the IHS Clinic Manager's Handbook unless noted as an *external reference*)	**Checklist Task / Report 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, 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 Guide*	Date Reviewed: Assigned Individual: Actions Required: Target Date: Completion Date:
Insurance Claims Aging Report	Since the report parameters include the ability to specify individual Clinics and/or Carriers it is possible to reveal more	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	Fees are being charged and claims billing processed in the EDR and via eServices/eClaims. Ledger: 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 Guide*	Date Reviewed: Assigned Individual: Actions Required: Target Date:

	targeted information.		of the aged claim, the user will discover what needs to be done to expedite processing so that the claim can be paid/adjudicated.				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.	Office Manager: Filters are used to focus on balances that are overdue and collectible. Ledger: Proper allocation of payments. DXOne: 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 Guide*	Date Reviewed: Assigned Individual: Actions Required: Target Date: Completion Date:	
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 Guide*	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	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	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	Database Design Revenue Cycle *Reports Reference Guide*	Date Reviewed: Assigned Individual: Actions Required:	

	specific procedure codes along with all or selected providers.		less providers needed based on volume.		needs based on volume of patient services.		Target Date: Completion Date:	
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 Guide*	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 Guide*	Date Reviewed: Assigned Individual: Actions Required: Target Date: Completion Date:	
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.	Ledger: 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 Guide*	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.	Ledger: 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 Guide*	Date Reviewed: Assigned Individual: Actions Required: Target Date: Completion Date:	
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 Guide*	Date Reviewed: Assigned Individual: Actions Required: Target Date: Completion Date:	

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) <u>Office Manager</u>: 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 Guide*	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 the Office Manager (MS Word integration with EDR). used in addition to scheduling assistant call list	<u>Office Manager</u>: Continuing Care types are setup and attached to appropriate procedure codes. <u>Appointment Book</u>: Continuing Care is attached to Patient appointments scheduled (procedure codes must be used in the Appt. Reasons). <u>Family File</u>: 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:	
Data Base Backup		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	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	Not having a data backup can be an extremely costly event in a situation where there is a hardware malfunction with the server, causing		Date Reviewed: Assigned Individual: Actions Required:	

			investment, a disaster recovery plan needs to be developed, implemented, maintained, and tested.	and qualified MCM or MCITP Database Administrator will already know how to accomplish the tasks	potentially significant data loss and down time.		Target Date:	
							Completion Date:	
Month End Update		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	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 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.		Date Reviewed:	
							Assigned Individual:	
							Actions Required:	
							Target Date:	

			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				Completion Date:	

Administrative Reports Checklist

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Instructions: The IHS Checklist is designed to provide a comprehensive list of checks and balances to ensure the accuracy of entries recorded within Dentrix Enterprise, allow tracking and review of internal key performance indicators. When reviewing your report data, use the dependencies to complete any required tasks. The additional actions and corrections identify areas and tasks that may need to be performed if/when the report/task does not yield the expected result. Fields are provided within the table to indicate when the Checklist Task is complete: enter the review date, your name, recommended actions, target date and completion date in the designated fields for each task.

Checklist Task / Report	**Objective**	**Dependencies and Possible Actions or Corrections Needed to Meet Objective**	**WARNING:** *not following the recommendations in the checklists may yield the following unintended results*	**Checklist Task / Report 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 show 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:	
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:	
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 dail , 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:	
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:	

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:	
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 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

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Instructions: The IHS Checklist is designed to provide a comprehensive list of checks and balances to ensure your EDR data backup job is completing successfully and your SQL server and associated servers/workstations are configured for optimal performance. Fields are provided within the table to indicate when the Checklist Task is complete: enter the review date, your name, recommended actions, target date and completion date in the designated fields for each task.

Task Interval	Checklist Task / Report	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	**WARNING:** *not following the recommendations in the checklists may yield the following unintended results*	Checklist Task / Report 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:	
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:	
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:	
Annual	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

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The following IT security protocols are a sequence of operations performed by an IT System Administrator or local office IT representative that helps mitigate potential EDR data loss and improve Server/Workstation operational performance.

In the event of data loss or malicious outside attack (Ex: Ransomware), your EDR data would be recoverable if the IT security protocols outlined below are executed successfully.

1. Systems Administration

a) Nightly Backup Verification
b) Data Recovery
c) SQL Maintenance Plan
d) Windows Updates/Patches
e) Windows System Logs
f) Hard/Virtual Drive Maintenance
g) Antivirus Scans

a. **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.

i. Backup critical system and application files on a nightly basis.
ii. 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.
iii. Every morning the backup logs should be reviewed (verified) to confirm a successful backup completed.
iv. Removable media (ex. tape, disk or external hard drive) should be disconnected and replaced with the next device.
v. Disconnected backup media should be stored in a fire-safe location or taken securely offsite.

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

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 backed up and add it to the backup process.

EDR Server/Image Server:

i. **DXONE** Folder (Shared Writeable folder containing customizations, report templates)
ii. **Original** Folder (all software and settings needed to reinstall the EDR implementation)
iii. **SQLBACKUPS** Folder (SQL Database backups for Dentrix, Dexis/MiPACS)
iv. **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 backup accordingly.

b. **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.

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

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

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

c. **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 above. The SQL BACKUPS folder should be part of your daily Backup Software job.

The SQL Maintenance plan is configured to keep the last 5 days of EDR data.

There are two ways to check the successful completion of a SQL Maintenance plan job.

SQL Management Console (Method 1)

i. Open the SQL Server Management Studio application.

ii. Login Credentials:

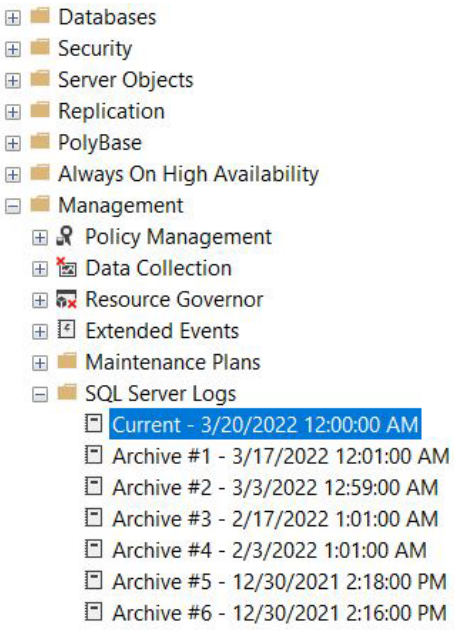
Server type: Database Engine
Server name: "EDR *server name*" \Dentrix_Live
Authentication: Windows Authentication

OR

Server type: Database Engine
Server name: "EDR *server name*" \Dentrix_Live
Authentication: SQL Server Authentication
User name: D1\"*D1 User name*"
Password: "*the SA password supplied to IT during installation*"

iii. Click the Connect tab.

iv. On the file tree on the left-hand side of the screen navigate to > management folder > SQL Server Logs > Current.



v. Click on “Current”.

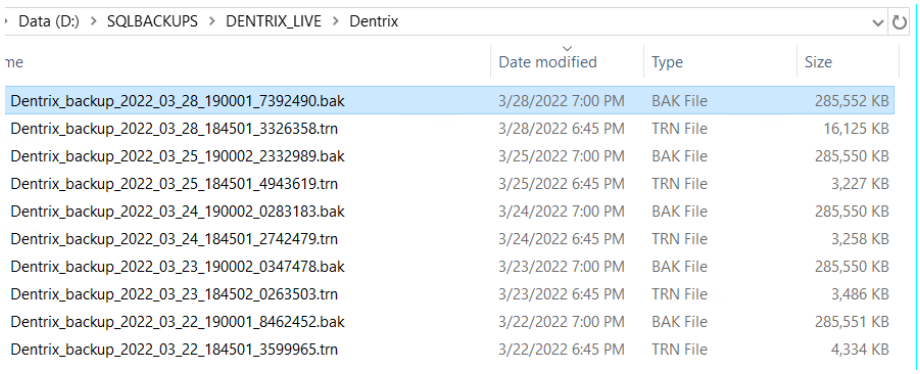
vi. The right side of the screen will display a Log File summary.

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

viii. If the Log File summary indicates that the SQL backup did not complete successfully, call EDR support at (800) 459-8067 or email ihs-support@henryscheinone.com.

SQL BACKUP Folder Review (Method 2)

i. On your EDR SQL server, navigate (using File Explorer) to D>SQLBACKUPS>Dentrix_Live>Dentrix



Note: *SQL Information: the .bak files are the database data files and the .trn files are the transaction*

log files.

ii. The last 5 days of SQL backups are listed (.bak and .trn). In example above the SQL maintenance backup plan is configured to run Monday through Friday.

iii. Each .bak and .trn file will list the date the file was backed up along with the files size.

iv. The dates listed should be the last 5 business days with a .bak files size that increases in size (as more data is input each day) or stays the same.

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

If the last 5 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 (800) 459-8067 or email ihs-support@henryscheinone.com.

d. 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.

e. 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 Log Errors/Events

a. Disk error messages referring to “bad blocks” that warn of likely drive failures – the event logs are often the first / only place you will learn of such problems.

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

c. Application errors relating to SQL connection errors.

f. Hard/Virtual Drive Maintenance: Optimizing your drives can help your Server/PC run smoother and increase performance. The process of defragmenting/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. That's because when your computer runs out of memory it will start to use the hard drive space for "virtual memory" to compensate.

a. It is recommended to defrag monthly.

b. Leave 15% free space on a drive. The free space is needed so Windows can defrag the drive efficiently.

Note Virtual Hard drives may not need to be defragged.

g. 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 and worms, as well as 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 Anti-Virus applications.*

2. General Firewall Rules

A network firewall is a crucial security tool that must be as robust as it can get while balancing security vs speed of performance for the users.

Network firewall configuration 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, here is a list of firewall best practices to adopt to secure the network from any existing or potential threat:

a. **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/URLs which the organization has deemed necessary for business. This helps to have control over who can access the network and prevents security breaches from occurring.

b. **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:

   i. Define the changes that are required and their objectives.
   ii. List the risks involved due to the policy changes, their impacts on the network, and a mitigation plan to minimize the risks.
   iii. Proper audit trails that record who made the change, why, and when.

c. **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 port whenever possible.

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

   <u>To clean your firewall rule base:</u>

   i. Eliminate redundant or duplicate rules that slow down the firewall performance as they require the firewall to process more rules in its sequence than necessary.

   ii. Remove the rules that are obsolete or no longer in use. These only make the firewall

management more complex and can even be a threat to network security if not updated.

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

iv. Conflicting rules must be eliminated.

v. Any errors or inaccuracies in the rules must be eliminated as these may result in malfunctions.

d. **Update your firewall software regularly**: It is important to keep updating your firewall software to ensure that your network is secure, and there are no loopholes in the system that could pose a threat to security. Check from time to time if your firewall software is updated to the latest version.

e. **Conduct regular firewall security audits**: Security audits are necessary to ensure that the firewall rules comply with the organizational, as well as 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 no unauthorized changes have taken place.

3. Incident Response and Log Review Protocol

a. **Information System Contingency Plan (ISCP):**

An Information System Contingency Plan (ISCP) establishes comprehensive procedures to recover EDR quickly and effectively following a service disruption.

The IHS requires a robust IS contingency planning process that includes both ISCPs and Disaster Recovery Plans (DRP) at each clinic.

i. **The following recovery plan objectives have been established by IHS:**

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

1. Activation and notification phase to activate the plan and determine the extent of damage;
2. Recovery phase to restore EDR operations; and
3. Reconstitution phase to ensure that EDR is validated through testing and that normal operations are resumed.

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

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

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

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

ii. **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.

b. **Security Alerts**

i. **Falcon CrowdStrike:** 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.

ii. **Take active actions on security alerts**:

1. Make sure someone is assigned to receive security alerts.
2. Make sure someone is assigned to address security alerts in an established timeframe.
3. Establish an escalation process depending on the severity of the alert.

c. **EDR audit logs:** Review EDR audit logs regularly to ensure there are no malicious activities occurring. Remove/inactivate users from Dentrix Enterprise when they are no longer actively working at the clinic. Adjust user-access rights when staff changes roles.

d. **PHI/PII breach:** 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 a HIPAA breach incident response plan is included in your ISCP.

4. Awareness of potential security penalties/HIPAA Fines

a. **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**:**

i. **Tier 1**

The first category of violations includes those where 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.

Violations in this category face fines of $100 up to $50,000 per violation.

ii. **Tier 2**

If a covered entity should have known of the violation, it falls under the second category. However, the violation still may have been inevitable 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.

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

iii. **Tier 3**

When a violation occurs as a result of willful neglect of HIPAA rules, it falls under this category. The other qualifier is that you have attempted to correct the issue.

If you have this type of violation, the penalty ranges from $10,000 to $50,000 per violation. Factors such as the level of harm can affect the exact amount.

iv. **Tier 4**

The most significant difference between the last category and this one is that violations in this group don't try to correct the issue. If you have a case of willful neglect and let the situation live on, that would fall into this category.

Consistently leaving patient records out or not logging out of electronic records may fall under this category.

This category is the most serious type of HIPAA violation, so it has the biggest penalty.

Each violation will face a minimum fine of $50,000. While other types may qualify for a waiver, these violations do not. Some of these violations may also result in jail time.

b. **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.

i. **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 can constitute a felony punishable by imprisonment, or a fine of $50,000 or less, or both, for each violation. 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 damages.

c. **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.

d. **Cost of remediation of breaches/incidents**: Costs of remediation are more than just the imposed fines by laws. Cost can also include:
    i. Increased cyber insurance and legal fees
    ii. Cost of recovering applications/programs/data
    iii. Reporting burden
    iv. Diminished trust
    v. Lost revenue

Schedule Optimization

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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** – Templates used for scheduling 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>>

   Defining the desired goal of your schedule to assist with aligning the best practice use of the software with your organization's needs. Some examples of the various goals or guidance associated with scheduling strategies include Meeting Capacity, Healthy Payor Mix, Maximizing Patient Acquisitions, Managing Re-Care Rates, Meeting Dental Treatment acceptance, production goals, and Increasing Encounter Rates.

   a. **Maintaining Schedule Accuracy:** Temporary changes should be clearly defined using the following settings to reflect accurate availability in your schedule.

      Operations Insight: The appointment book default settings for each clinic are established and maintained during Database Design. Refer to that overview if there are permanent changes to the default schedules for a clinic.

      i. **Close Office on Selected Date:** From the appointment book setup under Clinic Schedule, you can change your working hours for a single day or close the office entirely for an individual date. Use this option for yearly holidays that do not occur on the same day of the month each year (for example, Thanksgiving.)

      ii. **Holidays:** Use this option to close the office for yearly holidays that fall on the same day of the month every year (for example, Christmas is always on December 25th).

      iii. **Update Clinic Hours for selected days:** Double click on a date chosen to update the working hours. Select the checkbox "Update Op Schedules" to have the updated times reflected for each operatory in that clinic's view.

      iv. **Provider Schedules:** From the appointment book setup under Provider Setup, you can update individual provider's hours for a single day or set Vacation days like updating particular dates for the clinic. Select schedule and double click to make changes to the provider hours or select the menu options to indicate provider vacation days.

      Workflow Insight: Provider vacation days do not visually look different in the appointment book. A pop-up message the users if a selected appointment time is outside of the clinic or providers available time. 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 day-by-day for temporary changes in the schedule visually.

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

      Operations Insight: Event restrictions are available within an individual user or group security rights to restrict users from deleting or editing the events in the schedule and scheduling appointments during the

blocked time.

b. **Procedure Times** - Template the average time needed for specific procedure types and appointments. Procedure times provides the general amount of time necessary to schedule a procedure or blend of procedure codes.

i. **Individual procedure timing -** Procedure code time should be set to meet the needs of all clinics who use the specific code(s). When scheduling more than one procedure code for an appointment, the system will use the combined time assigned to each procedure code consecutively.

Workflow insight: Getting these times accurate to your organizations needs significantly reduces scheduling errors and the number of clicks required to schedule an appointment. Procedure times are ideal for supporting call center operations or centralized scheduling processes.

ii. **Time patterns** assist with identifying the intended use of provider, assistant, and chair time. (X, /, and – on the left of the scheduled appointments.) Time patterns can be useful when scheduling an individual provider across multiple operatories. These patterns indicate where providers are available.

1. Multi-codes can be created to assist with scheduling template needs. Multi-codes allow for multiple procedures to be combined and a default procedure time and time pattern assigned to the group for scheduling.

Workflow Insight: The system will warn the users when scheduling provider time in more than one operatory and prevent scheduling the same provider across three or more operatories.

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

c. **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 guidance:

1. To allow for New Patient's to be seen without extended wait times- Use time blocks to Reserve 3 New Patient appointments per week. Do not release these times for other patients until 48 hours essential the scheduled time.
2. To meet production goals- Time blocks are set to ensure 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 you are scheduling.
3. Emergency Time Communication- Clinical teams will use the emergency time block to identify and communicate the optimal time to schedule emergencies each day.
4.

i. **Provider setup** provider hours and time block templates create the frame work for the searching of time blocks

ii. **Appointment types** a definitions that aids in decision support messages

1. Build appointment types that support the needed templates

a. New patients

b. Emergencies

c. Production goals

iii. **Procedure codes** link appointment types to support the scheduled time block templates

1. Schedule with codes to support or avoid time blocks.
2. Edit procedures codes to include a supporting appointment type.
    a. D0150= new patient
    b. D0140 Emergency
    c. D2750, D3310-D3330, D4341, D5110-D5226=Production

iv. **Find new Appointment time** Search by selected time blocks
Incorporating the Next Available Appointment Time Metric (3rd next appointment)

v. **Time Blocks** are set up per provider and operatory. The following items are essential to keep in mind when setting up time blocks:

- The time blocks available are limited to 6-time blocks 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.
- Time Blocks can be individually adjusted as needed. Time block flexibility provides a streamlined process for the teams to communicate scheduling changes or needs.
- There are no security restrictions available to restrict editing, overriding, or clearing time blocks from the schedule.
- Perfect Day Scheduling must be activated to display the time blocks.

Operations Insight: Effective scheduling templates stabilize production from one day to the next and three 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>>

a. **Broken Appointments:** Broken appointments are designed to keep track of patient care and document any last-minute cancellations or modifications, and no-show appointments. From the More Information window, select the appointment from the *Next Appointments* list and select locate appointment icon to opens the view with the selected appointment.

i. Right-click the appointment you wish to break and select Break Appointment from the list. Select the reason you are breaking the appointment from the drop-down menu. This selection records the reason that the patient broke their appointment.

ii. Breaking the appointment does the following:

1. Removes the appointment from the appointment book and moves it to the Unscheduled List. This list is used for future scheduling.
2. Updates missed appointment information in the family file to reflect the date of the broken appointment and the number of broken appointments for this patient.
3. Adds a journal record that shows the date, time, operator, and description of the broken appointment.

b. **Wait/Will Call:** Wait/Will Call is a way to place an appointment on the unscheduled list without having it count towards a patient's broken appointment count. This list is used for future

scheduling, when scheduling at the time of appointment is not possible.

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

Sample guidelines:

1. Cancellation: A fee could apply if you cancel your appointment with less than 48 hours. If you cancel 48 hours or more before your appointment, there is no fee.
2. Rescheduling: If you move, or reschedule your appointment 48 hours before your meeting time is no rescheduling fee. A fee could apply if you reschedule with less than 48 hours.
3. A "no show" is someone who misses a scheduled appointment without canceling or rescheduling in advance of their scheduled appointment. No- shows could be charged 100% of the session amount. Appointment time and the provider determines the session amount.

- If a patient accumulates 3 no-shows, he or she may be on an emergency/wait call list only and no longer allowed to reserve time in the schedule.

c. **Rescheduling Appointments:**

i. **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.

1. More Info: Using the pre-appointment workflow, review unscheduled appointments, and other clinical/financial readiness information according to your internal guidelines.

a. When scheduling a patient with an appointment on the unscheduled list, you encounter a pop up indicating the patient had an unscheduled appointment. It is recommended to select "yes" to view the patient appointment list and use the appointment from the list. Clicking "no" and/or creating a new appointment will leave the original missed appointment on the list and continue to pop up for this patient when scheduled.

ii. **Moving Scheduled Appointments:** Rescheduling an appointment that isn't considered broken.

1. More Info: search for the patient from the more information window. Review patient financial and clinical readiness.
2. In the summary tab you will see any scheduled appointments for the patient. Select the intended appointment and locate appointment to take you to that date/time in the appointment book.
3. Double click on the appointment and select the "find" button on the right to locate the available times.

d. **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.

i. **ASAP:** If a patient requests a schedule this week, but your next opening isn't for 2+ weeks, use this status to populate a list of patients to contact when there are unexpected changes in your schedule.

ii. **Open:** Can be used similarly to ASAP to indicate patients who are open to last-minute changes or don't require notice for shifting appointment times. Generating two separate, distinct lists assist with targeting the correct patients with less research or wasted contact time.

iii. **Fixed:** this third option used for appointments scheduled as intended, and the patient does not desire to make changes to their appointment.

Workflow Insight: *When adding an appointment to the ASAP or open lists, use the appointment note to annotate if any specifics are surrounding the patient's ability to come in sooner. For example- Time of day, frequency limitations, wants an 8 am appointment. These lists reduce the amount of time spent using this list to fill the open times on your schedule.*

3. **Patient Communication –** Manual and Automated processes for communication surrounding patient appointments.

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

a. Manual Communication - Using the lists and features within the system for communication needs.

i. 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 appointment.

1. **Appointment Statuses** - label placed on appointments to communicate non-verbally to all teams the status of reminder/confirmation efforts.
2. **Treatment and Continuing Care Due Dates**

ii. Documenting Communication

iii. Letters - Quick Letters- Individual letters or forms generated per patient. (School/work excuse)

1. Letters – Letters function in the office manager and are used to create a letter merge for multiple patients in the same clinic.

b. **Appointment Lists -** Maintain an optimal schedule utilizing the available scheduling lists and reports.

i. Scheduling Assistant - Simply and easily schedule appointments by combining the appointment managing lists into one window. Includes quick access to a patient more information window and office journal to easily start the pre-visit workflow or document your contact efforts.

1. **ASAP list -** Pulls in all appointments that were identified as wanting to come in sooner in an easy to use list for filling last minute openings in your schedule.
2. **Unscheduled list -** Broken and Wait/Will Call patients are another quick access list to assist with keeping patients active in their care and regaining balance in your schedule.
3. **Continuing Care List -** Generate and sort lists of patients based on their due dates for continuing care, type, and other parameters.
4. **Treatment Request Manager –** Store and manage requests for treatment when an appointment still needs to be scheduled.

ii. Patient List - Generate custom lists for focused strategies when filling your schedule.

1. Patient lists can be run on an individual basis for a unique need. When running the patient list, simply define the filters you want to narrow your patient list by and then identify the information you want to see for the list of patients generated.
2. Patient lists can also be stored as a template if you want to use a specific list as a

standard report. When opening patient list, select add then define the filter and data fields needed. Once the list is created, select save and name the list generated for future use.

a. To run a list template in the future, the saved list will be available for selection in the template window when you open patient list report from the office manager.

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

Patient Records Management

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Patient Record Management is an organizational function responsible for the creation, maintenance, storage, and preservation of administrative patient records. The patient record is where the electronic dental record (EDR) begins, starting with the gathering of Patient and Family demographics.
**Check with your state dental society or state's board of dentistry for information on recordkeeping requirements in your state.*

1. **Patient Forms** – Patient forms are used for multiple purposes which include the recording of patient information, medical history, billing information, and consents.

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

   a. **Managing Forms** –

      i. **Quick Letters**: These template letters and forms use Microsoft Word letter merge and Dentrix Enterprise data to pull patient information into a form. Quick letters are used as a patient form generator that quickly populates patient information available in Dentrix Enterprise.

         Workflow Insight: Quick Letters can be utilized for correspondence such as school excuse forms and revenue cycle letters. The Office Journal automatically tracks the date, time and letter type that is generated for a patient.

      ii. **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: Consent form signatures are captured during the patient visit lifecycle.

      iii. **Questionnaires**: These are customizable forms where staff and patients can answer pre-defined questions. Multiple Questionnaires can be attached to a patient. They have many uses, such as emergency/pain evaluation, cosmetic rating scales, new patient experience, etc. Questionnaires are easily accessed from all patient specific modules.

         Workflow Insight: Questionnaires are designed for "interview style" data entry by a staff member. They are designed to be answered directly inside Dentrix Enterprise or printed. Questionnaires are not available for integration with websites or kiosk platforms for the patient to complete the form.

2. **Patient/Household File** – 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>>

   a. Patient Information –

i. **Individual or Family Accounts**: Dentrix Enterprise is designed to group patients into families. Family accounts allow for sharing of insurance subscribers and benefit information across individual patients within the same family.

Workflow Insight: If using individual patient vs. 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, it is sometimes required to enter a subscriber into the system multiple times to allow for proper assignment of insurance benefits.

ii. **Personal:** When entering in the personal information for a patient, it is important to understand other workflows that may be affected by the data. Revenue Cycle relies on complete and accurate information for each patient to achieve successful claim and billing process results.

Workflow Insight: Global settings can assist with making certain information required, such as the social security number.

iii. **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 the Family File are often used to populate UDS reports and other government type data reporting needs.

iv. **Office Info:**

1) First Visit Date: It is important to identify the office requirement for a first visit. Unless modified to reflect the date of first visit, it is assumed full registration occurred on the date the Family File was created.
2) Provider 1: A patient's primary provider (Provider 1) is used to create the clinical chart and ease of future scheduling. The Provider 1 may also be utilized for insurance claim providers (see Revenue Cycle Claim Form Templates).
3) Clinic Assignment: Each patient is assigned a home clinic, some reports use the home clinic for calculation, such as active patients.

v. **Family Edit:**

1) **Merge Patients**: Combine a duplicate patient records into one with little to no data loss.
2) **Family Relations**: Allows the handling of unique family relationships.
3) **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 and addressed based on a patient's guarantor.
4) **Combining Families**: This feature allows the joining of two separate accounts into one account. Use if two patient accounts would like to receive one balance billing statement.

5) **Separating Families:** This feature takes two or more patients from one account and moves them to another. This may be used for children who have aged out of parental care.

Workflow Insight: Combining and separating families can result in 'special adjustments' when there was a payment assigned to the family, guarantor or split between family members. Due to the fact that a single family payment cannot exist on two different family accounts, special adjustments are placed onto the affected accounts to recognize the credit of that prior payment.

vi. **Continuing Care** –

1) **Add Continuing Care:** As you schedule and reschedule a patient for a specific routine service (such as a cleaning or X-rays) with the appropriate Continuing Care flag assigned to it, Dentrix Enterprise automatically attaches that Continuing Care type to the patient and updates it accordingly.

Workflow Insight: Continuing Care types can be manually assigned and updated within a patient's record. The need to manually update a patient's record can arise in multiple scenarios, including appointment preparation or to add continuing care not attached to the patient's record after an appointment.

2) **Override CC Defaults:** You can set up general default settings (for all patients) for each Continuing Care type; however, from the Family File, you can override any general default with a patient override. Patient overrides occur when you assign a Continuing Care type to a patient using the general defaults, and then customize the settings. You can also specify patient overrides for Continuing Care settings before you assign a certain Continuing Care type to a particular patient.

3) **Edit/Clear:** As needed, you can remove or edit a Continuing Care type from a patient to no longer track or update that patient's Continuing Care for that type.

vii. **Referral Information** – To track the effectiveness of your referral sources, you need to 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.

1) **Incoming Referral:** From the Referred By block in the Family File, you can view and enter information about the individual or source that referred the current patient to your practice. There are Referred By Patient and Referred By Doctor/Other referral types.

2) **Outgoing Referral:** From the Referred To block in the Family File, you can view and enter information about other dental providers, professionals, and specialists to whom you refer treatment or services as referrals. The referral can be attached to treatment-planned procedures and Dentrix Enterprise can help you track the patients who have been referred to another doctor or specialist.

3. **Patient Financial & Billing Info** – 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 agreements and access guarantor notes.

<<Insert SOP/Guidance/Decision Support for assigning insurance plans to a subscriber/patient here>>

a. **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 the Family File or the Ledger.

   i. **Collection Routines** - Using Billing Types in Dentrix Enterprise, you can target specific groups when applying finance charges, processing bills, and generating reports.

   ii. **Financial Assistance** - When you use Billing Types that are meaningful to your organization, everyone can be on the same page. For example, if you attach a Billing Type to your patient eligible for financial assistance from slides or grants, you can easily see that Billing Type in the 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.

b. **Insurance –** You can add insurance coverage to a head of household or patient in the Family File. The insurance coverage 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.

   i. **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.

   ii. **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 assigned to a patient overrides any other fee schedule attached to the patient's insurance plan or provider.

   iii. **Financial Class Type** - Financial Class Types are used to track categories of patient insurance types. They are assigned to the insurance plans and can be used for reporting purposes.

   iv. **Verification and Benefits**

      1) **Eligibility** - You can enter a patient's eligibility for insurance benefits under any of his or her dental and medical insurance plans. This information is visible from the family file and on scheduled appointments.

      2) **Benefits Remaining** - Under the appropriate insurance plan, click Ded/Benefits button. All insurance claim payments and deductibles posted to claims within the system will automatically update this information. The manual update of this information is necessary when benefits were not applied to a claim in the system or used with another provider/clinic not associated with your organization.

4. **Administrative/Patient Notes** – Manage the documentation of all administrative patient communication. Many notes are text for visual information only and are not part of structured data (reportable data).

    a. **Patient Notes** -

        i. **Office Journal** - This note pad is designated for patient communication used by the administrative/clerical team. Journal entry types are hard coded and not customizable. Manual entries can be made by your team to document phone calls and other communications with the patient. Great for historical tracking. Use the Office Journal as a resource to identify team activity and confirm the team is following internal guidelines.

            1) **Automatic Entry Types** - When an entry is made in the Dentrix Enterprise system, the entry automates information to the journal for easy tracking.

            2) **Manual Entry Types** – Staff add entries to document conversations, set reminders for follow up, etc. Create a standard description and note to ease searching.

            3) **Filter Office Journal Entries** - Generate list of desired entries and print as needed.

        ii. **Patient Note** - Notes in the registration area can be used for general patient notes, such as hobbies and preferences. There is a character limit of 4000. This note is not historical and designed to be deleted when no longer relevant. When standardized the first 4 lines of this note area can be reportable.

    b. **Decision Support** -

        i. **Patient/Family Alerts** - Customizable alerts that can be attached to patients when a pop-up flag is needed. This alert will appear whenever information for a flagged patient is accessed, and a symbol is visible on the flagged patient's appointments. This is a *"don't want to miss"* note. This note is not historical and is designed to be deleted when no longer relevant. Alerts can be Patient or Family related.

        ii. **Global Alert** - These pop-up alerts identify items in the patient record and will display as defined in the setup. They can be used clinically as a decision support for Premed or administrative support for missing demographics.

            1) **Alert Options** - Allows for selection of where the alerts display. Use caution when deciding where alerts should display as too many pop-up messages can be cumbersome and slow down workflows. Alerts should only display where they are relevant to patient care based on the alert type.

            2) **Patient Filters** - Part of the setup includes deciding what information to use as a filter. Filters are used to identify if certain items are listed or missing.

            3) **Patient Information** - Check demographics for missing information.

            4) **Specialized Groups** - Display if a patient is part of certain group, such as Billing Types or Patient Tags.

            5) **Clinical Conditions** - Can alert if a patient has allergies or needs medication prior to appointments.

iii. **Patient Tags** are customizable definitions that can be assigned to a patient. Tags are used for visual notifications when reviewing an account. Patient Tags are reportable and available as filters in many reports and features throughout the program. Important to note they are utilized in real-time, there is no historical record.

5. **Document Storage** – The Document Center is a place to organize and store documents scanned or imported into Dentrix Enterprise. These items are patient related and are easily accessed from all patient specific modules and are used for quick reference.

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

a. **Document Center** – System storage and process surrounding documents placed into the system.

i. **Acquire -**

1) **Scan/Acquire from a Device** - A way to save hard copy (paper) documents. One way you can add files to the 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: By setting up Document Type Templates, the Document Center is standardized and reduces the acquisition efforts by the team.

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

3) **Send to Document Center (Virtual Printer)** - 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 the Document Center. You can use this tool even without any Dentrix Enterprise modules open. You must have security rights to "Acquire Documents" to use the Document Center printer driver.

ii. **Storage/Access -**

1) The Document Center icon changes when documents are available. Access is available from all patient specific modules.

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

3) Easily search through but using different views such as Family/Staff as well as filters such as different document types.

iii. **Document Information** –

1) **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.

2) **Signatures** – To prevent the changing or deleting of a document in the 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 sources.

b. External Documents -

i. **Mode** -

1) **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 location.

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

3) **Centralized Records Manager(s)** - If records need to be requested prior to patient care, you can run a daily appointment list to provide as the list of records requested from a central records manager/office. On each appointment, you can select the "chart pulled" check box to identify a record has already been provided. When running the daily appointment list, there is an option to exclude the "Chart pulled" appointments to only list the appointments where records are still needed. This is a manual process for identifying records are received/available within the clinic.

ii. **Availability** -

1) **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 of the system.

2) **Identifying Document Needs** - Patient Tags, family file consent dates, and Document Center are examples of features that can be incorporated to identify which documents have been completed by a patient, and which documents are needed.

iii. **Communicate Status** -

1) **Forms Needed** - Patient Tags, family file consent dates, and document center are examples of features that can be incorporated to communicate which documents have been completed by a patient, and which documents are needed.

2) **Completed Forms/Data** -

   i. **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.

6. (FUTURE FOR DXE) Patient Online Access – Manage the patient online experience – these items are not available for Dentrix Enterprise. If converting or adopting Dentrix Enterprise and your current workflows are using these items in your legacy system, consider third party options that integrate with Dentrix Enterprise for accommodating patient online access.

Clinical Records Management

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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.

**Check with your state dental society or state's 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. Basic components for the routine management of clinical coding, documentation, supporting information and notes for accuracy and completed records.
    a. **Coding –** Coding supports uniform, consistent, and accurate documentation of the services delivered and diagnosis.

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

        i. **Dental CDT codes** – Assisting providers with quick access to the codes that accurately represent the procedure performed or treatment planned.
            1. **Procedure categories:** Use customized 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 codes preferred.
            2. **Procedure button sets:** Procedure button sets can be customized further to represent the codes used frequently by provider.

        ii. **Medical CPT Codes** – Much like diagnosis cross-coding. You can cross code medical CPT codes with CDT codes, as well as CPT codes with ICD-10 codes. Using this cross-coding process in the system supports coding decisions and internal clinical coding guidelines.
            1. Medical claims require the selection of which medical code should be cross coded with the dental code as well as attaching the appropriate diagnosis code(s).

                Workflow Insight - Procedure and diagnosis coding selection is recommended as art of the clinical workflow due to the provider's obligation to the appropriate diagnosis and coding.

        iii. **Supporting or Diagnostic Codes -** Both ADA claim forms and HIPAA standard electronic claim transactions can report up to four diagnosis codes per dental procedure.
            1. **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 searching for codes.
                a. Cross Code CDT codes with ICD-10 codes for supported dental diagnosis.
                b. ICD codes can be limited to a short list available for specific CDT codes, or automatically attached when an ADA code is posted.
            2. **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 3rd party reporting or submission for reimbursement.

a. Conditions can be used for reporting purposes as well as attaching to treatment plans to further identify procedures connected to specific conditions.

iv. **Procedure Information** - In addition to the appropriate coding, each procedure's date of service, clinic, provider, and any additional modifiers make up the accurate coding process.

1. Use provider override as necessary to ensure accurate provider information is assigned to procedures completed that were treatment planned in the system. (see database design)
2. 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 necessity to edit completed or posted codes. The ability to update the procedures date without having to allow for edits is available from the Ledger.

b. **Clinical Notes -** Comprehensive and accurate records are a vital part of dental practice.

i. **Clinical Note Provider:** Notes are assigned to a provider and clinic when entered into the system.

ii. **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, during the month end process, or removed as an option from the clinical notes.

iii. **Signature Manager**: The signature manager can be used by the providers to identify the clinical notes that have not been completed or need to be signed.

Operations Insight: This tool can also be used for workflow accountability review. It provides the ability to proactively identify the clinics or providers that have outstanding notes for completion or signatures.

iv. **Addendums:** Once a clinical note is signed and locked into history, any changes or updates can be recorded as an addendum to the original note. Addendums allow you to maintain the integrity of the clinical notes as they are documented and show the updated information.

c. **Perio Charting** -

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

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

1. **Exam order:** Set 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.
2. **Measurement Calculations:** (i.e. CAL=PD + GM) - When 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.

ii. **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.

a. **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.
b. **Summary:** The summary totals provide statistics about the patient's perio condition, probing depths, and clinical attachment levels.
c. **Periodontal Case Type:** Types 1-5 are available to identify a patient's periodontal case type. (A new set of guidelines were released in 2017. These guidelines still reflect the previous classifications published in 1999.)

iii. **Access / Review** – The periodontal charting module stores all charting for historic review.

1. **Internal**: Once the perio exam is completed, the perio chart is stored directly in the Database for further review, patient education, and/or attaching to an insurance claim.

a. **Graphic Chart:** The graphic chart view displays the numeric perio data into a graphical representation. A legend appears at the bottom of the chart to explain the chart symbols. Data cannot be added or changed while in the graphic chart view.

b. **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.

c. To attach a perio chart to a claim, open the include attachments window and select the "import perio chart" button to select the perio exam date to attach to a claim.

<u>Operations insight-</u> All users must be pointed to the same letter template path for the perio chart to be attached to the claim by one person and then have the claim be submitted by a different user.

2. **Referrals:** Custom reports, charts, letters can be printed to provide when transitioning a patient's care to another provider.

d. **Supporting Documentation** - Maintaining complete documentation needed to support diagnosis, treatment, and required information as needed to support clinical documentation.

i. **Radiographs -**

1. **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. Images in Dexis can be attached to a claim directly from the ledger in Enterprise.

2. **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 differ.

ii. **Narratives -** Narratives or remarks are notes that an office can write to the insurance company if the insurance company requires any sort of narrative, or the provider wants to provide expanded information about the patient's condition or treatment. Narratives that populate

directly on the claim are entered in the ledger directly on the intended claim by selecting the "note" menu option.

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

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

iii. **Models/Digital Scans –** If you have a DDX (Digital Dental Exchange) account, you can submit cases electronically to labs through the internet. 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 have the option to attach a file to submit with the lab script or select the option to ship specific enclosures with the case.

iv. **Scanned Documentation –** Any additional forms, documentation, or other manually obtained clinical information can be stored in the document center. Access to these documents is available from all patient specific modules including the patient chart and the more information window.

v. **Implantable Devices -** You can now add implantable devices to a patient's medical alerts. There is a new section in the Medical Alerts window 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).

vi. **Prescriptions -** The Prescriptions module is designed to help you quickly create and accurately track medicines prescribed for your patients.

1. **Prescription Module:** While prescriptions that your office prescribes to the patient appear in the Medications/Prescriptions list as medical alerts, medications are drugs that have not been prescribed by your office and are therefore separate from prescriptions. Once a new prescription is created for a patient, the system will add it to the list of patient prescriptions in the patient prescription dialog box.

2. **ePrescribe:** ePrescribe provides the ability to manage prescriptions online. This service requires a subscription purchase and licenses for each individual provider that will be prescribing using this service.

   a. **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.

   b. **Tracking -** Once electronic prescriptions are entered into the ePrescribe module, a CCR file is downloaded and processed for the patient. This document is then reconciled with the data already in the patients 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 -** Managing the progress of planned patient care

   a. **Manage Treatment Cases -** To maximize the patient experience, you want make treatment planning customized and personal, but you also want to maintain efficiency. When you post treatment-planned

procedures in the Ledger or the Patient Chart, Dentrix automatically places those procedures into a default treatment plan case in the Treatment Planner. However, you can create additional treatment plan cases to group and organize procedures. This allows you to track the status of or prioritize various courses of treatment, create alternative treatment options, or provide different patient payment estimates, for example. You can create a customized patient experience all while maintaining an efficient workflow.

i. **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 visit 1 will be covered by insurance first, and then the procedures in visit 2, and so forth. If patients meet their maximum in visit 3, Dentrix Enterprise assumes that the procedures in visit 4 will not be covered by insurance. So insurance estimates may vary depending on how you arrange procedures within visits.

ii. **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.

iii. **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 the Patient Chart, so the Patient Chart is not cluttered with irrelevant procedures; while other statuses allow you to keep a record of the procedures you have recommended and presented to the patient. Since the status of a case can be searched once it's entered, this can really help with team communication to get everyone on the same page.

   1. **Case Status -**

      a. **Accepted:** You can use this to specify that the case was accepted by the patient.
      b. **Rejected:** You can use this to specify that the case was rejected by the patient.
      c. **Completed:** You can use this to specify that the case was completed.
      d. **Referred:** You can use this to specify that the case was referred out to a doctor or specialist.

      *Workflow Insight - Selecting **Accepted**, **Rejected**, and **Completed** will not only update the case's status but will cause a new default treatment plan case to be created. Selecting **Completed** will also set all the procedures in the case complete, and the case will no longer be able to be edited.*

   2. **Case Severity -** You can prioritize a patient's treatment plan cases to help you know what treatment to perform next and which procedures are considered optional. To do this, you assign a severity to each case.

      a. **Immediate:** This case should be done immediately.
      b. **Eventual:** This case should be done eventually (Future).
      c. **Optional:** This case is optional.
      d. **None:** No severity.

iv. **Consent Forms:** The patient and provider can electronically sign consent forms 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. (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 clinical module / note template for efficiency

    a. **Maintain Coding Connected Features -** When changes are made to the CDT code sets, Dentrix Enterprise support 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 that need to be reviewed for manual update needs.

        i. **Appointment Reasons -** Appointment reasons are set up manually in definitions. If CDT code changes include any codes listed in definitions for appointment reasons, they need to be removed or replaced to avoid using the outdated codes for future appointments.

        ii. **Coverage Tables -** Default coverage tables will not be updated with the latest codes. Manual edits of the coverage table will ensure that the code changes are incorporated into insurance estimates provided from the system.

        iii. **Procedure Buttons –** If any of the edited, removed, or added codes are in use or needed in your charting procedure buttons, you will need to update your button sets accordingly.

        iv. **Multi-Codes -** Multi-code sets should be reviewed for updated/inactivated CDT Codes and updated accordingly.

        v. **Note Templates -** If specific CDT codes are included in your clinical note templates or prompts, they will need to be replaced or updated according to the applicable changes to the CDT codes.

        vi. **Procedure Notes -** Default notes can be assigned to procedure codes and then automatically copied to the procedure note or clinical note. If changes are made to the CDT codes, the auto notes should be reviewed for accuracy.

        vii. **Procedure / Treatment Area Flags -** These flags automatically correct the procedure code when posting or changing the procedure, according to the tooth number and surfaces selected. (These flags to change the procedure code can be overridden when posting or editing procedures.) To review or edit the flags for the selected treatment area, click Flags. The name of the dialog box and code options that appear varies, depending on the selected Treatment Area.

    b. **Maintaining Code Sets and Access** - Refer to Database Design for adding and updating codes into your system.

        i. **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 in the office manager. For a custom list of current codes in your system, print the procedure code list from the office manager. This printed list will include any changes you've made when adding or editing the procedure codes listed in your system.

            a. **Inactivate Codes -** You can inactivate the 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.

            b. **New Codes -** You can add and edit the procedure codes you post in your practice. If you have the need for a custom procedure code (for instance, creating a rate code or coding for products sold) they can be added into the system and available for use the same as the other available codes in the system.

ii. **Medical CPT Codes -** Due to licensing issues with the American Medical Association, Dentrix Enterprise 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 system. Information on the codes and descriptions that can be added can be obtained using reference books provided by the AMA.

1. **Cross Code Pak -** Medical Cross Coding DataPak is available that will add all of the codes (except ICD-10-CM codes) for you.

iii. Supporting or Diagnostic Codes

1. **ICD-10 -** Please contact Enterprise Support to run the ICD-10 codes scripts (1-800-459-8067 option 2). The script that Support has will enter the dental related ICD-10 codes into your database.
2. **Dental Diagnosis -** Due to licensing issues, Dentrix Enterprise does not come with the dental diagnostic codes set up. These codes must be manually added to the program. Information on the codes and descriptions can be obtained using reference books provided by the ADA.
3. **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 when identifying conditions present in the odontogram. These codes can be updated or changed as needed by your organization.

   Operations Insight - Condition codes may be used for some of the specific reports in Dentrix Enterprise. Verify condition codes are not used in necessary reports before making changes or deleting condition codes from your system.

Revenue Cycle Management

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Managing revenue cycle in Dentrix Enterprise contains several independent but connected workflows and processes 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 plus routine maintenance of your insurance database provides a solid foundation for successful insurance processes.

   Operations Insight: *The settings within the insurance plans have a direct effect on many key Revenue Cycle and Reporting outcomes in the system.*

   a. **Insurance Plan Components** – You can add or edit insurance plans from the Family File and from the Office Manager; a dental insurance plan can only be assigned to a subscriber from the 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.*

      <<Insert Insurance Plan Components decision support/SOP/guidance here>> (Other State, Payor, or contractual requirements may need to be gathered to complete the insurance data needs for your organization)

      i) **Insurance Data:** The following options are key items to understand when building or editing your insurance data. Payor/state specific claim regulations and organizational guidance will identify the settings needed for each insurance plan's data.

         1) Carrier Name: Enter carrier name as you would like to see it listed on the insurance plan. Avoid nicknames and internal references in this section.

         2) Group Plan: If the plan has a specific group, you can enter the group name. If you do not have a group name, the employer name or other internal references for the plan can be listed here. You can select if you want to include the group name on the claim. (This field assists when you are searching or assigning insurances previously entered to patients.)

         3) Tags: Insurance Tags can be assigned to plans as a tool for grouping and searching insurance plans. Insurance Tags are added as definitions and can be completely custom for your organization's needs. A good example for an insurance Tag would be the associated clinic. If a plan is used for more than one clinic, multiple tags could be assigned.

         4) Employer: If an employer will be attached to the plan, you can select it from the list. The employer must be in the system prior to attaching it to the plan.

         5) Group #: The group number often is the key identifying factor for insurance plans and is used when searching insurance plans in the system. It is recommended to 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)

            Operations Insight: *Insurance plan carriers, group plans, and group numbers are set up as*

independent records in the system. Each plan is recognized and reported as an individual source. Financial class types, insurance tags, or selecting a range of carriers can assist in reporting needs. (I.e. Delta Dental is the Carrier. There are 7 plans in your system with Delta Dental listed as the carrier. When pulling reports by carrier in the system, there will be 7 "delta dental" carriers listed. Selecting the range of Delta carriers will allow for reporting on their collective information.)

6) 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 and needs to be manually populated for each change.

7) Benefit Renewal: This identifies the month that the yearly insurance benefits renew. Not including the accurate month could result in inaccurate insurance estimation calculations.

8) Claim Format**:** This will determine the type of claim format used when a claim is generated for the plan.

9) Fee Schedule: Attaching the insurance maximum allowable fee schedule to the plan is the preferred method to produce accurate insurance estimations throughout the system.

   *Operations Insight: Using the insurance contracted max allowable fee also supports workflow efficiency in other areas. (Reporting, insurance estimations, posting payments, provider payroll). If there is not a fee schedule attached to the insurance plan, the system will use the fee **s**chedule attached to the provider of procedures when calculating the percentages from the coverage table.*

10) Payor ID: The Payor ID is the "electronic address" for submitting claims electronically. Each payor has its own payor ID; however, some clearing houses create their own specific payor ID. The list provided in Dentrix Enterprise includes the list of payor IDs specific to our eClaims clearing house. If you do not use eClaims, you will need to enter the Payor ID manually, and identify the correct Payor IDs as directed by your clearing house.

    Workflow Insight: Having the Payor ID list available in the system directly from the eClaims clearing house 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 by eServices without any additional steps required. If they can update the Payor ID and send electronically, they will. If not, the claim will be dropped to paper and sent to the payor. This process eliminates segregating claims that cannot be sent electronically.

11) Financial Class Types**:** Financial Class Types allow you to group different payors into a similar category for billing and reporting purposes (I.e. Medicare, Medicaid, Self-Pay, etc.). The types available can be customized in definitions.

ii) Insurance Plan Claim Settings:

1) Claim Setup**:** The current ADA Dental claim (DX2012), and AMA Medical claim (HCFA212) forms in Dentrix Enterprise provide additional settings that can be set per plan, or as a default for new insurance plans.

   a. The provider/fee option will allow you to select where the procedure fees on the claim are determined- Billing Provider, Insurance Plan, or Default. ("Default" means that the fee schedule attached to the subscriber, the billing provider, or the insurance plan is used, in that order, as available. Rendering Provider is available for Medical Claims)

   b. Provider Address allows for the Billing and Rendering addresses to populate

on the claim based on the selection.

2) Claim Options: Options for printing or sending insurance claims

   a. Select the diagnostic coding system that you want to use for claims that are sent to this carrier: ICD 9, ICD 10, or Unspecified (to *not* include diagnostic codes).

   b. Select the applicable check boxes to select options to exclude or skip for dental billing.

3) Auto Adjustments**:** These settings can be used for automatically posting adjustments based on the insurance coverage or fee schedules as indicated in the settings. These options are helpful for creating Sliding Fee Scale discounts, or other discount plans in your system that provide a percentage discount as well as other variables. (Visit costs, different coverage per types of codes, etc.)

4) Rate Code Options: This provides an automated process for billing rate codes and the specific procedure information as directed by the payor. Once the claim is created, the system will include the rate code with the indicated rate and procedure information for the plan.

b. **Insurance Coverage and Estimates** – Dentrix Enterprise uses standard formulas to provide the insurance estimations in the system. The formula will use a combination of the following items, depending on the conditions applicable to the fee schedule, coverage table, co-pay, payment table, and insurance override.

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

<<Insert Insurance Estimate Components decision support/SOP/guidance here>>

i. **Estimate Components:** The following components will be factored into the insurance estimates generated in the system. Priority is placed in the following order:

1) Fee Schedule: The fee used in the insurance estimate will be determined by where the fee schedule is assigned into the system. Fee assignment will be utilized in the following order:

   a. Patient Fee Schedule
   b. Insurance Plan Fee Schedule
   c. Provider 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 Insurance Plan Fee Schedule. The Insurance Plan Fee Schedule ranks above Provider Fee Schedule. In situations of multiple insurances pull the primary insurance plan fee schedule first.

2) Coverage Table**:** Insurance benefit breakdowns for each plan can be added as a coverage table. The Coverage Tables include deductible amounts, plan maximums, and the percentage covered. In the absence of insurance override and payment tables the fee schedule and coverage table will be used as the primary source for insurance estimates.

3) 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.

ii. **Estimate Exceptions or Overrides** -

1) 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. Insurance Override should be used in limited unique circumstances and should not be used as a routine practice in your workflow.

2) Pre-Authorization Estimates: Estimates entered into the system itemized by procedure, will update the insurance portion of the estimate accordingly using "insurance override." Use the pre-authorization management tools to assist your team with managing the process.

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

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

i. Pre-treatment authorization codes: The Pre-Est column from the TX Plan, the following codes identify the need and status of pre-authorizations.

1. N- Needed, S- Sent, A- Accepted, R- Rejected. The 1 or 2 indicates primary or secondary insurance.

3) Payment Tables: As you post insurance payments, you can select the option to automatically update a payment table for that plan, storing what the insurance plan will pay for a specific procedure. This amount will override any calculation listed in the coverage table.

Workflow Insight: Between the Estimates/Overrides, the priority is placed in the following order: Fee, Insurance Override (manual or pre-auth), payment table, coverage table, co-pays.

2. **Claim Management –** Managing 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. Successful or "clean" claim submission in Dentrix Enterprise is achieved through the collective efforts of multiple operations and management workflows.

<<Insert Successful Claim Submission decision support/SOP/guidance here>> Sample guidance shown below:

- *Patient information (Patient Records Management)*
  - *The claim form includes all the required information (patient name, address, date of birth, identification number, and group number) in the correct fields, accurate, free of spelling errors.*
  - *Coverage was in effect on the date of service, and the patient's insurance covers the service provided.*
- *Clinical information (Clinical Records Management, Patient Visit Lifecycle)*
  - *Correct coding, including no expired or deleted codes. Codes meet the requirements for age, diagnosis, or treatment location.*
  - *Applicable procedure codes have the supporting documentation and information necessary.*
- *Provider/Plan Information (Database Design, Revenue Cycle, Patient Records Management)*
  - *The provider is licensed and credentialed to practice on the date of service.*

- *Place of service, date of service, and*
- *The form correctly identifies the payer and includes the right payer identification number and payer mailing address.*

- *Timely filing (Clinical Records Management, Revenue Cycle Management)*
  - *The claim is submitted on time.*

a. **Claim Submission**:

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

i. **Claim Providers**

ii. **Primary Dental Claims** – This can be accomplished per patient during the post visit workflow or as a batch of claims from the office manager.

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

iii. **Secondary, Tertiary, or Quaternary Dental Claims** - Posting an insurance payment for a primary dental insurance claim, will automatically prompt you to confirm if you want to create a secondary dental insurance claim. If you choose no, or if you add the patient's secondary dental insurance plan after the 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 will always be a manual creation, and are not shown in insurance estimates, treatment plans, or insurance reports.

iv. **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 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.

v. **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.

b. **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>>

i. **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 real time access to a claim's status, allowing you to identify and begin resolving any "problem" claims within the first two weeks.

ii. **Procedures Not Attached:** This report identifies any patient who has insurance and completed procedures not attached to a claim.

<u>Workflow Insight:</u> 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 not intended for insurance claims listed on the report.

iii. **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 will be identified with this report.

iv. **Insurance Claims Aging:** The Insurance Claim Aging report will list outstanding insurance claims, grouped by insurance carrier, along with the aged balances of each claim.

v. **Claim Denials Management:** Request for additional information vs. a true denial.

1) **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 populate status information, and you can free type information here as well.

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

<u>Operations insight:</u> Re-submitting 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.

3) **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 re-submit to the insurance company and allows you to post payment to any procedures that were successfully adjudicated.

4) **Zero Payment -** Posting a zero payment also closes the claim within the ledger. Before posting a zero to denied claims, it is recommended to review the circumstances to determine if re-submission, splitting, or updating data could warrant in new denial management efforts.

5) **Claims In History -**

a. 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 re-submit or appeal a claim. The following steps could change based on your internal financial guidelines and account policies.

i. Post the original procedures with the backdated date of service in the ledger.

ii. Posting the procedures for the second time then results in the need to manually post an adjustment to offset the additional charge.

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

iv. Manual posting may be necessary if the insurance company sends an eEOB that is electronically linked to the original claim.

c. **Claim Payments –**

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

i. **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.

   1) **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.

   2) **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.

ii. **Insurance Overpayments -** The system considers a procedure "overpaid" if the amount paid by the insurance company exceeds the estimated amount for an individual line item. When posting a batch insurance payment, the procedures undercharged or overpaid window can be used to allocate the overpayment. The following actions are available:

   1) 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).

   2) 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.

   3) Allocate to procedure with remaining balance

   4) Allocate charge adjustment to claim and apply remaining

   5) Reduce Guarantor credit amount and apply to procedure

iii. **Insurance Underpayments -** The system considers an "underpayment" as any instance when the amount paid by the insurance payment is less than the estimated amount for an individual line item. When posting a batch insurance payment, the procedures undercharged or overpaid window can be used to address the underpayment. The following actions are available are listed directly above in item ii.

3. **PAYMENT POSTING –** Manage patient payment allocation and adjustments

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

a. **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.

   i. **Payment Types:** There are two general categories in the system for payments: Insurance payments and guarantor payments. Payments attached to an insurance claim generated in Dentrix Enterprise are categorized as insurance payments. Payments received from patients are categorized as guarantor payments. To assist you in classifying the different types of payments received from patients, guarantor payment types can be customized and added. You can define up to 99 payment types.

      1) Spelling and grammar are important when creating payment types. Be sure to make payment types understandable and professional as they will be printed on billing and walkout statements as a description of any payments made.

      2) If you want to use a payment type for processing credit cards through Axia, select the "Associate with Axia CC Processing" check box. Then, 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" check box.

      3) Once a payment type is entered into the system, it cannot be deleted if it has been associated with a payment that has been posted to any patient's ledger.

   ii. **Family / Patient:** How the system defaults **Apply to charges for** can be set to <family> or whomever is currently being viewed in the ledger. It is recommended individual ledger view is used for easily maintaining individual patient balances within the families. Defaulting to family will allocate the payment using FIFO to all balances for the family. If the patient is intending to pay for only the individual's balance this setting could result in the need for manually adjusting allocations.

      1) When viewing a specific patient in the Ledger, you can simply select the dropdown in the payment window to apply payments to the family or other individual family members as needed.

   iii. **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 on to Dentrix Enterprise).

      1) You can refund a patient's credit card for the amount of payment that was posted in the 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.

   <u>Workflow Insight:</u> 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.

b. **Adjusting –** 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.

   i. **Production / 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.

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

ii. **Apply Adjustments –**

1) 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.

a. 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.

2) Charge Adjustments - The system assigns the selected patient's primary provider as the provider for the adjustment. The provider can be changed from the enter adjustment window if necessary. To apply the charge to the entire family's balance, from the apply charges list, select family. Or, to apply the charge to only a specific patient's balance, select that patient from the Apply Charges list.

c. **Suspended Credits -** Any payments or credits that is not allocated to a procedure or a debit adjustment is considered a suspended credit. 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.

i. **Patient -** If a payment or credit assigned to an individual patient results in a suspended credit, it is available to allocate to that patient's balances. To apply a specific patient's suspended credit to another family member with a balance you can right click on the suspended amount from the **Apply suspended credits** window and change it from patient to family. By changing it to family, it can now be applied to any member of that family.

ii. **Family –** Payments or credits assigned to family that result in a suspended credit will automatically be available to apply to any family future balances. If the intent is to suspend the amount for a specific purpose, it can be assigned to an individual patient or marked as "do not automatically allocate" with a specific note to indicate the intended use of the credit.

Workflow Insight If the option to remove patient (apply for family) is grayed out, this means the credit is from an insurance overpayment and cannot be applied to family. An adjustment on that patient ledger will be needed to clear the suspended credit.

iii. **Suspended Credits Manager -** From the Suspended Credits Manager window in Dentrix Enterprise, you can apply credits to charges without having to open 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: An insurance payment can never purposely be suspended. If an insurance payment for more than the amount due is applied, then a pair of offsetting adjustments will be created, and the overpayment will be 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 generated from insurance estimate inaccuracy.

4. **Maintaining Insurance Database and Fees -**

   a. **Insurance Reference Utilities –**

      <<Insert Insurance Reference Utilities decision support/SOP/guidance for here>>

      i. **Purge Plans**: It is vital to have the most updated and accurate insurance plan information in stored within your system. 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 only allows you to purge insurance plans that do not have subscribers attached, or outstanding claims.

      ii. **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 will reassign patients between plans, then the additional plan(s) can be purged.

         Workflow Insight: Following the recommended workflows, combined with your organizations guidelines for adding and updating insurance plans, will reduce duplications of the exact same plans in your database.
         ** If 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 avoid the plan being used further.*

   b. **Fee Schedule Maintenance** – There are multiple sources and uses for the fee schedules in the system. Usual and customary rates (UCR), if your organization participates and is in-network with insurance companies, specialty services, Dental Discount Plans, and more.

      i. **Edit or add fee schedules -** When adding fee schedules, you can enter the fees manually per code, copy from a base fee schedule, or import a fee schedule into your system.

         1) **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- it is strongly suggested to attach fees to the applicable clinics.

         2) **Copy -** Copy from fee schedule allows you to use an existing fee schedule as the basis for a new fee schedule. You can change any of the amounts as needed once the fees are copied.

         3) **Import-** Importing fee schedules is the preferred method to add or update fee schedules in the system. Fee Schedules must be saved as a .csv, .xls, or .xlsx file.

         4) **Viewing Fee Schedule Associations -** From the Fee Schedule Maintenance window, selecting Attachments will allow you to view the number of patients, insurance plans, and providers attached to each fee schedule. Right Click on 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 to PDF, then converting the PDF to Excel. Work with your IT to identify options with fee schedule import.

      ii. **Update Treatment Plan Fees -** To maintain the integrity of treatment plan estimates, Dentrix Enterprise does not automatically update the fees for procedures assigned to a treatment plan. If the fees have changed since the time the treatment plan was given to a patient, the

treatment plan can be manually updated for that individual patient or all patients from the Fee Schedule Maintenance Window.

Database Design

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Dentrix Enterprise is designed to be configured to your organization's specific needs. Database Design reviews the foundational setup and configuration processes for the database, users, and individual modules.

PRACTICE SETUP – Establishing the foundation for the organizational database design and determining how it best supports your workflows. In this process, you will define the main components of the organization settings and determine if the design of your database will support centralized workflows, individual location workflows, or a blend of the two.

1. **Enterprise Setup**: Enterprise Setup is the location where you create and define the individual clinic information for operations and reporting.

a. **Clinic Information**: You must be in the Central clinic to set up a clinic.

Operations Insight – Add each dental location as a clinic. Each clinic allows your organization to 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.

<<Insert Clinic decision support/SOP/Guideline here>> (How will clinics be initially established and maintained for the organization>>

i. **General Tab –** The detail housed within this tab will be the source for clinic specific identifying information. Combining these details with other settings throughout the system provides the opportunity to customize where the clinic information will display. The details alone do not establish *how* the information is used within Dentrix Enterprise.

1) **Descriptive ID** – This Internal ID is a reference name for the clinic in Dentrix Enterprise and on reports. This is the organization's "short name, or abbreviated name, for the clinic. The Descriptive ID is a maximum of 11 characters in length, no spaces allowed.
2) **Clinic TIN** – Tax Identification Number for the clinic. The Clinic TIN is accessible from the Provider Information dialogue box for quick setup of TIN for individual providers and/or billing entities.

Operations insight- The TIN/NPI intended for claims will be set up using the Revenue Cycle Management workflow.

<<Insert additional credentialing and/or TIN decision support/SOP/Guideline for TIN use for clinics and providers within the organization>>
3) **Title** – Formal practice name. The title will display when selecting a specific clinic or displaying practice/clinic information.
4) **Address** – Physical or mailing address of the individual clinic.

Operations Insight - P.O. Box, or lock box addresses are acceptable in this field, as alternate address fields in the system can be selected for the insurance claim provider address.

ii. **Settings Tab-** Most of the options on this tab are specific to the individual clinics settings. The settings listed below with an asterisk will affect all clinics.

1) **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.

2) **Show/Hide/Mask SSN** – Select how social security numbers (SSN) display throughout the system, including areas like reports, route slips, patient lists, and clinical charts. With any option, the full SSN is available in patient demographics.

   Operations Insight – The system default selection in Central clinic will mask all but the last four (4) numbers. This setting is recommended to ensure that patient information is secure and removed/masked from reports; family file, route slips, and visible computer workstations. Any subsequent new clinics added will default to show completely.
   Note- The SS#, Subscriber ID#, and some audit reports ignore the show/mask/hide selection.
   <<Insert security decision support/SOP/guidelines here for HIPAA compliance with PHI>>

3) **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 months if needed.
   <<Insert reporting fiscal year/calendar year reporting decision support/SOP/guideline here>>

4) **Time Zone-** This is set individually for each clinic in your organization. This is required if the clinic needs to access ePrescribe, or is converting data into Dentrix Enterprise.

5) **Billing Statements** – Select Title and Address to display on patient balance billing statements. There are three options for where the system pulls this information. This setting also applies to walkout statements.
   - Central office- pulls the information from the central clinic information.
   - Clinic- pulls the information from the clinic the user is logged into.
   - Provider-pulls the information from the primary provider (PROV1) on the account in the family file.
   - Custom- This is a global setting that support must activate. It allows for a custom selection of Name, address, and phone number to be used on statements pulling from the information available for all clinics and providers in the system.

   Operations Insight – This setting supports both centralized and de-centralized billing options. The Billing Statement return address is clinic specific and can be set up with a central return address for all locations or with individual clinic information or a blend of the options using the global setting.
   Workflow insight- When sending statements, there is an option to use the setting defaults for the clinics selected, or use the settings for the clinic logged into for all statements being sent at that time.

6) **Change Provider Completion Options** – This setting will automate the process for changing the rendering provider for circumstances when they were not the treatment-planning provider. You can specify if 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 / Provider from Selected Appointment setting in 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>>

7) ***Clinical Note Naming** – Clinical notes are organized by date in a "tree" format. The option to use 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.

Operations Insight - This setting is only available while logged in to Central clinic and applies to all clinics.
Workflow Insight – The Clinical Note Naming will only occur when the clinical note creation is initiated from a template and will only apply the first template name. If the clinical note was initiated from Medical History review or the 'New Clinical Note' icon, the Clinical Note Naming feature will not apply to that note.

8) **Close Claim –** The Close Claim features allows a claim with impending insurance payments to remain open for tracking and additional payments.
    1. **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.
    2. **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.
    3. **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 check boxes to override the primary insurance estimate and the secondary insurance estimate according to the patient's insurance coverage.
        - Inserts the estimated insurance portion in the respective boxes as applicable.

        Operations insight- Review insurance setup in revenue cycle management to determine the full process for insurance estimates and plan settings.

iii. **Optional Settings Tab -** Most of the options on this tab are available only for the Central clinic's optional settings tab. The settings listed below with an asterisk will affect all clinics.

1) ***Automatic Log Off** – These settings control the amount of 'inactive' time 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 new installation system setting is set to automatically log off all users after 60 minutes of idle time. The warning message will display 60 seconds prior to logging the user out of the system.

    Operations Insight – This setting is recommended to enhance the security of your system, and integrity of the audit reporting by reducing the potential for someone to leave a workstation unsecured.
    << Insert Automatic Log Off security decision support/SOP/guideline here>>

2) ***Enable Patient Access Logging** – To enable the tracking of access to patient information select the check box. When 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 field, 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

3) ***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 chart and the like.)

When patient records are accessed; additions, deletions, and modifications of patient information 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>>

4) ***Patient Birthdate/Age on Title Bar** – This setting will include the selected patient's birthday and age on the title bar in each module. This assists with confirmation of patient ID, especially in areas of scheduling and treatment.

5) ***Copy to Clinical Notes** – These options determine the information that will automatically copy to the clinical notes.

   i. **Patient Health Assessment (Vitals) -** The summary of the Health Assessment is listed in the clinical note. The full assessment data is outlined, even if some of the information is not entered.
   ii. **Prescriptions –** Details (name, dosage, dispense, refill count, provider, clinic, sig and notes) from prescriptions given are copied to the clinical note.
   iii. **Medical Alerts –** Any changes made to a patient's medical alerts will generate a note that includes the alert, type of change, origin date, and notes added to the alert.

   Workflow Insight- The medical history review is automatically copied to the clinical notes. This auto note does include the full list of active medical alerts recorded for a patient and gives a summary if there were any changes made to medications, alerts, and/or allergies during the review. The Specific copy medical alerts to clinical notes will provide the detail of changes in addition to the medical history review summary.

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

6) **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 the patient late for their 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 will want to use the status that is the most commonly applied to confirmed appointments, or reduce the multiple statuses used for confirmed.

7) **Patient Education** – If a patient's language preference is Spanish (in the Patient Information, 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.

   To have the description instead of the code (SNOMED, NDC, or LOINC) used when you search for patient education resources online with MedlinePlus.

8) ***Family File Settings** –

   Require Patient Email Address - Select this check box to require that an email address be entered for each patient in the 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 check box to require that a referral source be selected when a new patient record is created in the Family File.

9) ***Reject Old Treatment Plans** – You can have treatment-planned procedures archived automatically, so they no longer display as active treatment in the patient 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 editing the visibility and status of the case is easily controlled.

iv. **Subscriptions Tab** – Subscription-based features that require the purchase of licenses necessary for each module. A support representative must activate the subscriptions, and enter the license keys necessary to activate the features.

1) **Outcome Module-** Quintiles is the third-party provider of the Outcome service. The outcomes module provides a caries risk assessment and reporting functionality accessed from the patient chart.
2) **ePrescribe** – Allscripts is the third-party provider for electronic prescriptions. Prescribing electronically provides access to real time patient clinical decision support information.
3) **Updox (Patient Portal)-** Updox is the third-party provider of the Patient Portal service. The patient portal can be used for sending secure messages to patients or referral sources, and the transfer of C-CDA files.
4) **Meaningful Use** – The meaningful use module calculates the information needed to satisfy the attesting requirements. 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:** Add or edit clinic information, operatory IDs, provider and staff information.

<<Insert decision support/SOP/Guideline for Provider Setup and Credentialing>>

a. **Provider Setup:** Each individual that provides billable treatment to patients is considered a provider in Dentrix Enterprise.

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

i. **Name, ID** – Maximum of 10 characters

Operations Insight - Provider IDs prevalent in selection lists and reports throughout Dentrix Enterprise. It is recommended to develop a naming convention for providers that will lend to easy identification of individual providers.

ii. **Non-Person** – If this provider was set up to be utilized as a billing entity, such as a corporation or association, select this check box.

iii. **Address** –This address could be used if settings indicate the provider address should be included on statements, letters, claims etc.

Operations Insight- It is important to enter a single line address into the top line, as opposed to the second line. This can cause an error when submitting claims. This error would apply to all billing, pay to, and rendering providers listed on a claim.

iv. **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.

1) **Primary,** for primary care providers, such as dentists

2) **Secondary**, for secondary care providers, such as hygienists or residents.

Operations Insight- Reference Revenue Cycle management for more insight into how provider class affects the claim process.

v. **Log on User ID** –the ID that this provider will use to access Dentrix Enterprise. It is common to have the same User ID as ID discussed above.

vi. **Password** –The password must be 7 to 11 characters in length 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 &).

1) **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.

vii. **Fee Schedule** – fee schedule used as the default for the provider.

Operations insight- Fee schedules can be attached to insurance plans, providers, and patients. Reference Revenue Cycle Management and Patient Records Management for more insight into the fee schedule uses and hierarchy.

viii. **Clinic** – The primary clinic where a provider will work. Defaults to the clinic where the provider was first entered into the system. The assigned clinic will not limit the provider's ability work in other clinics. Security and other settings determine the access to data, scheduling, and which clinics a provider is available for selection.

ix. Many Numbers are used on insurance claims and other state forms. Add as needed**, TIN, State ID #, State, and State Expiration Date** ,**DEA #, License Expiration**, **Medicaid #**, **NPI**, **Blue Cross/Blue Shield ID #** (you must select one or the other), **Provider #**, **Office #**, **Other ID #**, and **UPIN#**.

Operations insight- Reference Revenue Cycle Management for more insight into specific claim/billing setup needs.
<<Insert Decision Support/SOP/Guideline on provider IDs>>

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

Operations insight- anyone who will access the system should have a user ID and password created. 3rd party venders, trainers, IT, etc. Enterprise should not be used as a "universal" log in for users, and it is not recommended for user ID and passwords be shared between multiple users for security purposes.

4. **Operatory Setup:** Operatories are columns in a schedule that will allow for patient scheduling. Each column can hold 1 patient at a time. Add the number of columns based on the number of patients to be seen at any given time. Operatories will be organized from left to right based on the naming convention, alpha numeric. An Operator Id's cannot be repeated even across other clinics. Consider prefixing with the clinic ID.

5. **Definitions:** Definitions are user-defined options available throughout the system. There are over 45 pre-defined types to be customized. 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. *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/removing the definitions.

6. **Procedure Code Setup:** Dentrix Enterprise comes with all current ADA-CDT codes. You have the ability to 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.

   i. Review the following information
      1. Patient Friendly Description – This patient friendly language will be used in place of the dental terminology on treatment plans, if the option 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.
      2. 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.)
      3. Abbrev Desc - The abbreviated description is displayed in the Appointment Book as the description when a procedure is scheduled.
      4. Treatment Area- This regulates the information required for a procedure code. For example, if tooth is selected, a tooth number would be required when using the code.
      5. Treatment Flags - Select the appropriate treatment flags for the procedure to indicate how the procedure will be handled in certain situations.
         a. Show in Chart - The procedure will be listed for the corresponding procedure code category button in the Patient Chart.

            Workflow insight- Show in chart supports clinical workflows by sorting the procedure codes that are commonly used in your organization and making them easier to access in the patient chart.
            Operation Insight- Running the production summary report for all clinics, by ADA code, for the last year or two provides helpful insight into which codes would support workflows across the organization.
      6. Auto Continuing Care – When a procedure with a continuing care type attached to is completed, Dentrix Enterprise automatically adds the continuing care type to the patient and/or updates that patient's continuing care due date.
      7. 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.
      8. Procedure Code Category - Select the appropriate 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 the codes starting in v11.0.
      9. 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.
      10. Educational Video – add a hyperlink for an educational video specific to the procedure. The link will be available when a procedure is in a treatment-planned status.

7. **Continuing Care:** Continuing Care is a way to track preventative care that is typically carried out in a cycle. CC 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 CC Types. Reports can be run by types

   i. Customize your Continuing Care view. You can set up Continuing Care views to create many different ways of looking at the continuing care information.
   ii. Scheduling Assistant can also be uses to manage Patients on a Continuing Care

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.

It is recommended to 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-on user. If a user does not have rights to perform a certain function, they 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 to which they have access.

> *Operations Insight- It is recommended that the owner, CIO, and/or appointed decision maker for system security familiar with all of 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>>

a. System Security Features

i. **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- It is recommended to use the available secure user password settings to promote maintaining individual user account integrity for your organization.

1. **Password Expiration** – If you want passwords to expire so that users have to change, their passwords after a certain length of time, click Expiration, and then select a password expiration date in days. If you want users to be forewarned of a pending password change, check Warn, and then select the days before the expiration date that you want the notification to appear. If you do not want passwords to expire, (users will never have to change passwords), click No Expiration.
2. **Set Security Defaults**
   a. Lock user out for – To select how many logon attempts a user has before that user is locked out of the system for a specific period of time, check this option, select the time interval for which a user will be locked out in minutes, and select the number of logon attempts users have.
   b. Do not allow use of the past – If you want to prevent users from reusing a specific number of old passwords, check this option, and then select how many previous passwords you want to block.

b. Verify User Before Access: certain situations may require additional protection. In these cases, the security options can be flagged to “Verify User Before Access.” With this security flag enabled for a task, users will be prompted to re-enter a user name and password when attempting to perform that task.

1. An asterisk (*) appears before a security option that is flagged to require re-entry of a password every time users attempt to perform that task.

Operations insight-This added layer of security is very helpful to confirm that an area of your database is protected. It confirms that the appropriate user has rights to access any area of the software. This protects identified areas of the software, even if someone leaves their workstation unsecured.

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

ii. Adding User Groups: group users by role or some other method.

<<Insert SOP/Guideline for user grouping>>

1. Set up the following options:
   a. Group Name – Type a name to identify the group.
   b. Rights – Select the check boxes of the rights (categories and/or individual rights) that users in this security group should have by default.

Operations insight- There are 4 security rights in the central clinic only group that are important for allowing or restricting access to all patients, providers, clinics, operatories, and appointment lists. When setting up groups or individual user rights, these must be set in the central clinic.

c. Assigning Users to Groups: A user can be assigned to multiple groups. Groups allow you to strategically assign user rights to a role and assign out to users. This allows for standard access in the system as well as simplifying the process for editing and adding new user rights.

1. Set up the following options:
   a. Groups – To select the groups that you want to add users to
   b. Users – To select the users that you want to add to the selected groups
   c. Clinics – To select the clinics that you want the selected user groups to have rights in

d. DXOne Reporting Security: control which reports can be generated by which users.

i. Under User List, select a user.
ii. Select the report for which you want to Set Security
iii. Set up the following options:
   1. Rights – Select the rights you want this user to have, or select all.

      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.
   2. Clinics – Select the clinics for which the user can generate reports, or select all.
   3. Provider/Staff – Select the providers and staff members for whom this user will have rights to generate reports, or select all.

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

Workflow insight- Due to DXOne security rights ability to add or remove clinics and providers from an individual's reporting rights, some report totals may be changed based by the rights assigned to the individual 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.

3. Appointment Book Setup – Design your schedule to maximize your organizations need. Appointment Book Setup consist of setting up standard default needs such as hours of operation, as well as regular maintenance such as Holidays and Vacation time. (Review Schedule Optimization Management for strategic schedule maintenance)

<<Insert Scheduling SOP/Guideline here>>

a. Clinic Setup: customize your practice hours, appointment defaults, and the time block size used throughout the program.

i. Set up the following options for each clinic:

1. Default Schedule – Select the check box next to each day of the week 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.
2. 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 Schedule Optimization when determining the best strategy for time block sizes used for each clinic.

3. 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 check box.
4. Default Appt. Settings: select the defaults for each new appointment:
    a. Status: Each appointment displayed in the Appointment Book can be assigned a status. Each status can be assigned a unique color that is displayed from the Appointment Book. 20 appointment statuses can be defined in Definitions.
    b. Schedule (Fixed, Open, or ASAP)
    c. Type: classify an appointment for block scheduling. 99 appointment types can be defined in Definitions.

b. 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.

1. Close Office on selected date – Closes the office on the selected day. The cell for that day will become light gray. Use this option to close the office for yearly holidays that do not occur on the same day of the month every year (for example, Thanksgiving).
2. Open Office – Opens the office on the selected day if it was previously closed.
3. Set Yearly Holiday on selected day – Closes the office on the selected day. Use this option to close the office for yearly holidays that fall on the same day of the month every year (for example, Christmas is always on December 25).
4. Delete Holiday – Opens the office on the selected day if it was previously closed for a yearly holiday.

c. Provider Setup: customize work days, hours and colors for all clinics the provider is available for scheduling.

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

i. Set up the following options for each provider:
    1. Default Schedule – Select each day of the week that the provider normally works. Also, you can break each day into three time ranges. To set the working hours for any day, enter the start and end times of each range that you want for that day.
    2. Provider Color – All appointments scheduled with that provider will use the designated color as the background for the appointment information. To assign the provider a unique color. Tip: Appointment information text is displayed in black, so choose a light color for the provider's color that contrasts with the black text. Provider Schedule

    **Time Blocks are reviewed in Schedule Optimization Management.*

d. Provider Schedule: In Dentrix Enterprise, you can change a single provider's hours for one day or to schedule the provider to be out of the office for one day. Refer to Schedule Optimization for managing temporary changes to provider schedules.

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

i. Set Vacation on selected date – Makes the provider not available on the selected day. The cell for that day will become purple.
ii. Delete Vacation day – Removes the provider's vacation day for the selected day if it was previously set.
iii. Reset Hours to default on selected date – Returns the selected day to the provider's default work day for that day of the week.

e. Operatory Setup: customize available hours for each operatory.

Workflow insight- you can break each day into three time ranges. This allows for adding lunch breaks, or adding after hour open times etc. For example- 8-12, 1-5, 7-9.
Operations insight- The appointment book will show the default clinic open and closed times. The operatory settings can identify a specific operatories available times if they are different from the clinic's hours. ie. A provider only works in op3 on Fridays.

f. View Setup: A view is the visual schedule which is controlled through a selection of Providers and Operatories and patient information. Multiple views can be set per Clinic. By managing the views you will be able to control user access. This is separate from system security, and is strictly a control of accessing 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 are shown in the Appointment Book.
<<Insert SOP/guidelines here for appointment book views>>

i. Set up the following options:

1. Appt. View Name – Type a name for the view.
2. Short-cut key to view – Select the shortcut key that you want to use to access the view.
3. Clinic – Select the clinic that you want to view.
4. Selected Providers – Click Modify List to select the providers for the view.
5. Selected Operatories – Click Modify List to select the operatories for the view.
6. View Options – Select any of the following:
    a. View Amount – To have the scheduled production amount for the day, week, or month appear.
    b. View Appointment Notes – To view a note symbol on any appointment with a note.
    c. View Alerts – To view a red plus sign on any appointment for a patient with medical alerts.
    d. View Provider Columns – To view the colored provider bar.
    e. 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.
7. 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.
8. 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 field. Type the latest hour that appointments will last in the End Hr field. Click am or pm for both fields.
9. Appointment Display Info – Depending on the length of an appointment, up to nine lines of information can be displayed on the face of an appointment. 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.
10. Default View – Select this check box to have this view be your default for the current clinic.

g. Flip tab setup: Acting as a bookmark, a flip tab allows you to jump forward or backward. Flip tabs are workstation-specific and must be set up on each workstation individually. You can have up to four flip tabs per daily, weekly, and monthly view on a computer.

Operations insight- See the workstation specific 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.

h. Events: an event blocks out time for one or all operatories in the Appointment Book, so you have a visual reminder that you cannot schedule 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 insight-

a. *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.*
b. *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.*
c. *If Dentrix could not 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.*

i. Perfect day scheduling: achieve a perfect balance of specific procedure types (for example, (High Production) Crowns) Time Blocks allow you to reserve certain times during the day, to create your Perfect Day.

Activating Perfect Day Scheduling: If Perfect Day 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 the appointment book for scheduling that works best for the clinical team. It is very helpful for organizations that have a call center. It allows for the individual site to control the available times on their schedules.

Operations insight- each provider can have up to 6 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.

4. **Clinical Setup** – The design elements found within this section will drive customization of your clinical modules to enhance your Clinical Records Management workflows. Review Clinical Records Management for managing and maintaining all clinical records.

<<Insert Clinical SOP/Guideline here>>

a. Patient Chart

i. **Procedure Buttons:** The assignment of procedure codes and images to a panel of 24 buttons allows for quick access to record patient clinical charting.

Operations Insight – Procedure Button Templates are created and stored on the Dentrix Enterprise database.
<<Insert Procedure Buttons SOP/guideline here>>

1. Select Code – Procedure or Dental Diagnostic – Select the desired procedure (ADA, administrative, in-house, condition or multi-codes) 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.

2. Select Tooltip Text – This selection controls the hover tooltip which displays within the Patient Chart when the mouse is held over a procedure button.

   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 - The options available include selecting the Procedure Description or Custom Text. Procedure Description will display the code description as assigned within the Procedure Code Setup, while Custom Text allows for unique identification based on naming conventions used by your organization.

3. Select Button Face – The selection controls the image assigned to the button face of the procedure button.

   Workflow Insight – Compared to 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 organization of button images allowing for quick distinction 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.

ii. 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 assign the template to specific users/user groups.

   Operations Insight - The procedure button template may be assigned to a user as a default, or selected from the Patient Chart by the user when necessary. The customization of procedure button templates is commonly arranged by workstation, user, provider, specialty specific needs.

iii. **Procedure Categories:** Dentrix Enterprise comes with the ADA categories and codes. Through definition setup the categories can be renamed and codes reassigned in procedure code set up. Allowing maximum efficiency in the clinical chart. You can select treatment to post from the procedure code category buttons.

iv. **Multi Codes:** Multi-Codes are a combination of codes stung together to make charting/posting fast and efficient. Multi codes can be used for services rendered as well as treatment plans. A code will have to exist prior to setting up multi-codes. See Procedure code set up.

   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 will be flagged with an asterisk (*) in the list box. The additional information must be supplied when posting the multi-code. A single multi code can have up to 8 codes, you can sting multiple multi-codes together.

v. **Chart colors:** See at a glance what work is existing, completed or is needed by assigning colors.

1. Set up the following options for the graphical chart and progress notes:

   a. 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 the Patient Chart; you must click OK to see the change.

      Operations insight- By default, the Patient 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.

   b. 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 the Patient Chart; you must click OK to see the change.

<u>Operations insight-</u> The Patient 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 the Patient Chart is closed and reopened. See the workstation specific appendix for all of the workstation specific settings.

vi. Views: When 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 show in the progress notes.

1. Select one of the following options:
   a. View Existing - To display invalidated diagnoses when the Existing view option is selected.
   b. View Conditions - To display invalidated conditions when the Conditions view option is selected.
   c. 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.

vii. 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.

1. Clinical Note Categories: Organize Clinical Note Templates
   a. Click Category Setup.
      i. New Category - Type the category name in the field
      ii. Move Up or Down - To change the order of the categories

2. Clinical note prompts: Customizable questions and answers that aid in building the clinical note.
   a. Template Setup
   b. Set up the following options:
      i. Prompt Name - Type a name for the prompt. The name is used to identify the prompt in the list and clinical note text (when 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).
      ii. Prompt Text - Type the text to be associated with the prompt. When 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.
      iii. Response types can consist of confirmation only, one response from a list, check box responses, date, number/amount, text, or select tooth, surfaces, quadrant, or sextant.

3. Clinical Note Templates: Regulate Clinical documentation with questions and answers. Templates will guide the user and encourages comprehensive documentation of a patients visit.
   <u>Workflow insight-</u> Use 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.

b. Treatment Planner: The Treatment Planner can help you provide your patients with easy-to-understand treatment options. When you open the 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>>

i. Customizing case settings: Before treatment planning a case, set up the case defaults. 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

1. Set up the following options:

a. Default Settings for New Cases

i. 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."

ii. 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.

1. Add - To add a template, type a Template Name and the appropriate Template Text
2. 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.
3. Delete - To delete a template, select the template you want to delete, and then click Delete.

iii. Automatic Case Status Updates - Select the case statuses that you want to be added automatically to the case status history

1. Printed - A selected cases will be updated with the "printed" status when the case is printed.
2. Proposed - A selected case will be updated with the "proposed" status to present or propose the case to the patient.

iv. Case Financing Setup - Case financing statuses must be set up before they can be applied 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.

1. Add - To add a case financing status, type a name in the Case Financing Status field, and then click Add. By default, the following case financing statuses are provided: In Progress, Needed, Not Necessary, and Pending More Information.
2. 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.
3. Delete - To delete a case financing status, select the status you want to delete, and then click Delete.

v. 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 may better understand the procedures in their treatment plans.

a. select a Procedure (the default description appears in the Description field),
b. type a Patient-Friendly Description (some procedures may already have patient-friendly descriptions, which can be edited.

Note: this is also available in Procedure Code Set up

vi. 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:

1. Form dialog box, 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 in length), 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),

vii. Select Electronic Signature Device - Select the device that will be used to sign cases at this computer:

1. Pointing Device - Use for mice, touch screens, and writing tablets.
2. 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.

c. **Perio Chart:** Because perio exam methods and philosophies differ from provider to provider, in the Perio Chart you can set up scripts and paths that represent your preferred examination method.

<<Insert SOP/Guideline here>>

i. Set up the following options:

1. Auto Settings
   a. 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.
   b. 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.
2. Calculation Options - When preforming 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, the Perio Chart will make the measurement fields on the Perio Chart that are automatically calculated unavailable. For example, if you use the CAL calculation method, the Perio Chart will make the Clinical Att. Level fields unavailable. If you choose not to use a calculation, all of the fields will be available.
3. 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, select this option to help you locate problem areas faster.
4. 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.

a. For a given path, in the Name field, type the name of the path to represent the measurements the will be charted (for example, PBSL might indicate Pocket Depth Bleeding Suppuration from Left to Right.) The name can be up to six characters in length.

5. 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.

d. Graphical Chart: choose which data elements to show and customize the color of certain objects on the graphic chart in the Perio Chart module.

i. 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.
ii. Red Flag Limit, Background, and Tooth Roots are always shown.
iii. 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.
iv. To change the colors used for exam comparisons, click the Comparison Colors button.
v. The Comparison Colors dialog box appears.
vi. 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.
vii. 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.

e. Prescriptions: The Prescriptions module can help you quickly create and accurately track medicines prescribed to your patients.

i. Do one of the following:
   1. Click New to add a prescription. The New Standard Prescription dialog box appears.
   2. Select an existing prescription, and then click Edit to edit that prescription. The Edit Standard Prescription dialog box appears.

Operations insight- Prescriptions can be entered as they are prescribed to patients, or a list can be pre-populated in the database.

5. Ledger Setup – Standardize the system settings used across the organization to support your revenue cycle workflows.

<<Insert SOP/Guideline for ledger settings here>>

a. Ledger Colors: quickly identify different financial transaction types, you can assign each transaction type a unique color.

i. From the Color dialog box, choose the desired color, click OK, and then assign colors to other transaction types, as appropriate.

ii. 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).

b. **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.

i. Select the task options that you want to complete when you click the Fast Checkout button:

1. Enter Guarantor Payment - Select 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.

2. Create Insurance Claim - Select 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.

3. Walkout - Select 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.

4. Send Clinical Summary to Portal - Select to send a clinical summary for the patient for whom you perform a fast checkout to his or her patient portal.
   a. Notes:
      i. 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).
      ii. 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.

5. Always Show Checkout Options - Select if the tasks you perform as a patient leaves vary, so that the Checkout Options dialog box appears each time you click the Fast Checkout button, thus allowing you to select the options you need for each patient individually.

c. **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.

i. Set up the following options:

1. Automatic Suspended Credit Allocation Options
   a. 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.

b. Do Not Automatically Allocate Suspended Credits - Select to prevent Dentrix Enterprise from automatically allocating any suspended credits.

2. Automatic Insurance Payment Adjustment Options
   a. 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.
   b. 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. Mark Flag Adjustment "Do not automatically allocate" to not have the insurance credit adjustment allocated automatically regardless of selection under Automatic Suspended Credit Allocation Options.
   c. 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.
   d. 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.

3. Adjustment Type for Negative Payments
   a. Enable Automatic Adjustments for Insurance Payments - Select to post negative insurance payments to claims.
   b. 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.

4. Electronic EOB Options
   a. 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.
   b. Copy Electronic EOBs to Document Center - Select to copy electronic EOBs imported into Dentrix Enterprise to the Document Center.

d. **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 later.

i. 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.

ii. The Direct Print Options dialog box appears.

6. Document Center Setup – Create the standards for document storage management. The Document Center is a place to organize and stored documents scanned or imported into Dentrix Enterprise. By setting up templates the Document Center is standardized and limits effort by the team.

<<Insert SOP/Guideline here>>

a. Document Types: You must assign a document type to all documents in the 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.

b. Document Type Templates: Templates assist with using the document types in a uniform way, and helps to define the decriptions 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)

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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. Service Unit HIM Directors. 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. Administrative Responsibilities. 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. Committee Responsibilities. 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. Health Information Management Director. 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. Signatures or Authentication. 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. Electronic Signatures.
    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. Time Frames. 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. Record Content. 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. General Requirements. 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. Hospital Facilities Health Record Format 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. Outpatient Medical Record Format. (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. Electronic Signatures. 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. Document Scanning. 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. Health Record Alterations and Modification. 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. Dental. 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. Quantitative Analysis. 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. Purpose. 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. Quantitative Analysis of Outpatient Records. 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. Clinic record.
        a. completion of sociological data;
        b. diagnoses and clinical notes;
        c. use of standard terminology;
        d. approved abbreviations;
        e. do not 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. Diagnostic tests, x-rays. Reports for all tests and x-rays ordered are filed in the chart.
3. Types of treatment. 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. Qualitative Analysis of Health Records. 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. Purpose. 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. Components. 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. Security. 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. Disaster Recovery Plan. 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. dentification of contingency methods to provide access to records (e.g., back up MPI) stored on paper or electronically;i
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. Area Disaster Recovery Services. 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. Continuity of Operations Plan. 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. Area Incident Management Staff. 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. Responsibility for Privacy of the Patient. 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. Newspaper Publicity of Patients. 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. Sterilization. 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. Special Therapy. 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. Special Situations. 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.