

**Clearinghouse Rule 14-011**

STATE OF WISCONSIN  
DENTISTRY EXAMINING BOARD

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IN THE MATTER OF RULE-MAKING : PROPOSED ORDER OF THE  
PROCEEDINGS BEFORE THE : DENTISTRY EXAMINING BOARD  
DENTISTRY EXAMINING BOARD : ADOPTING RULES  
: (CR )  
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PROPOSED ORDER

An order of the Dentistry Examining Board to create chapter DE 8 relating to patient dental records.

Analysis prepared by the Department of Safety and Professional Services.

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ANALYSIS

**Statutes interpreted:** ss. 146.81 (1) and (4), and 447.02, Stats

**Statutory authority:** ss. 15.08 (5) (b) and 227.11 (2) (a), Stats.

**Explanation of agency authority:**

Section 15.08 (5) (b), Stats., requires all examining boards to "...promulgate rules for its own guidance and for the guidance of the trade or profession to which it pertains, and define and enforce professional conduct and unethical practices not inconsistent with the law relating to the particular trade or profession."

Section 227.11 (2) (a), Stats., authorizes all agencies to promulgate rules interpreting the statutes it enforces or administers, when deemed necessary to effectuate the purpose of such statutes.

**Related statute or rule:** s. 146.81 (1) and (4), Stats.

**Plain language analysis:**

The primary purpose of the proposed rule is to develop minimum requirements for patient dental records. The rule considers ss. 146.81 (1) and (4), Stats., whereby "dentist"

is defined as a healthcare provider and consequently is required to maintain patient health records as specified in s. 146.81 (4). No additional requirements are proposed in this newly created chapter.

SECTION 1. This section creates a new chapter, DE 8 patient dental records and substantially mirrors the patient health records as specified in ch. Med 21, Wisc. Admin. Code. Specific areas of compliance include: retention, confidentiality, destruction and falsification of records.

SECTION 2. This section identifies when in the rule-making process the rule shall become effective.

**Summary of, and comparison with, existing or proposed federal regulation:**

An Internet-based search of the U.S. Code and Federal Register did not reveal any laws or proposals related to patient dental records, with the exception of the move to electronic records for Medicaid patients in 2016.

**Comparison with rules in adjacent states:**

An Internet-based search of the four adjacent states revealed the following:

**Illinois:** In Illinois Department of Financial and Professional Regulation oversees dentists; no rules requiring patient dental records were found.

**Iowa:** In Iowa, chapter 27 of the Iowa code, 650—27.11 (153,272C), relates to record keeping. Patient dental records must be maintained for a minimum of six years after the date of last examination, prescription, or treatment and for a minor 6 years after the age of majority. . Similar to other states, when electronic records are kept, a duplicate hard copy record or use an unalterable electronic record must be kept.

**Michigan:** In Michigan the Board of Dentistry rule, 1120 (R 338.11101 - 338.11821), requires records to be maintained for 10 years after the last treatment. In addition charting of dental procedures and a listing of medications administered are two additional requirements unlike proposed in this rule.

**Minnesota:** In Minnesota the related rule is 3100.9600 record keeping. This rule requires records to be maintained for 7 years after the last treatment. In the case of the patient being a minor, the records must be maintained for 7 years beyond the age of majority. In addition an emergency contact, information related to any insurance coverage, and providing an electronic backup are three additional requirements unlike proposed in this rule.

**Summary of factual data and analytical methodologies:**

No factual data and analytical methodologies were used to draft these rules.

**Analysis and supporting documents used to determine effect on small business or in preparation of economic impact analysis:**

The issue of patient dental records was raised in the context of not having a retention policy and the impact on associated costs related to the amount of storage dentist and firms are currently are maintaining. Section 146.81 (4), Stats., provides a period for destruction of records-- 5 years after the date of the last entry, or for such longer period as may be otherwise required by law.

It is expected that this proposed rule will decrease at least the cost of hard-copy record storage. No specific data was collected or analyzed to come to this conclusion.

**Fiscal Estimate and Economic Impact Analysis:**

The Fiscal Estimate and Economic Impact Analysis is attached.

**Effect on small business:**

These proposed rules do not have an economic impact on small businesses, as defined in s. 227.114 (1), Stats. The Department's Regulatory Review Coordinator may be contacted by email at Tom.Engels@wisconsin.gov, or by calling (608) 266-8608.

**Agency contact person:**

Jean MacCubbin, Administrative Rules Coordinator, Department of Safety and Professional Services, Division of Policy Development, 1400 East Washington Avenue, Room 151, P.O. Box 8366, Madison, Wisconsin 53708-8366; telephone 608-266-0955 or telecommunications rely at 711; email at Jean.MacCubbin@wisconsin.gov.

**Place where comments are to be submitted and deadline for submission:**

Comments may be submitted to Jean MacCubbin, Administrative Rules Coordinator, Department of Safety and Professional Services, Division of Policy Development, 1400 East Washington Avenue, Room 151, P.O. Box 8366, Madison, WI 53708-8366, or by email to Jean.MacCubbin@wisconsin.gov. Comments must be received on or before the

hearing to be held on March 5, 2014 to be included in the record of rule-making proceedings.

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TEXT OF RULE

SECTION 1. Chapter DE 8 is created to read:

**Chapter DE 8**  
**PATIENT DENTAL RECORDS**

**DE 8.01 Authority and purpose.** The rules in this chapter are adopted by the board under the authority of ss. 15.08 (5) (b), 227.11 (2) and ch. 447, Stats., to govern the practice of dentists in the preparation and retention of patient dental records.

**DE 8.02 Definitions.** In this chapter:

(1) "Patient" means a person who receives dental services from a licensed dentist or dental hygienist.

(2) "Patient dental record" or "patient health care record" has the meaning given in s. 146.81 (4), Stats.

**Note:** Section 146.81 (4) reads: "Patient health care records" means all records related to the health of a patient prepared by or under the supervision of a health care provider; ..."

**DE 8.10 Minimum standards for patient health care record retention. (1)** Patient health care records on every patient administered shall be maintained for a period of at least 10 years after the date of the last entry, unless otherwise required by state or federal law.

(2) A patient health care record prepared by a licensed dentist or dental hygienist shall contain the following health care information that applies to the patient's dental history and condition:

(a) Pertinent patient history.

(b) Pertinent objective findings related to examination and test results.

(c) Assessment or diagnosis.

(d) Plan of treatment for the patient.

\_\_\_\_\_ (3) Each patient dental record entry shall at least be dated, identify the practitioner, and be sufficiently legible to allow interpretation by other practitioners for the benefit of the patient.

(4) When patient dental records are maintained in an electronic format, a secure back up or duplicate file shall be maintained.

**DE 8.20 Confidentiality of patient health care records.** All patient health care records shall remain confidential as provided in s. 146.82, Stats.

**Note:** Section 146.82, Stats., reads: “**146.82 (1) CONFIDENTIALITY.** All patient health care records shall remain confidential. Patient health care records may be released only to the persons designated in this section or to other persons with the informed consent of the patient or of a person authorized by the patient. This subsection does not prohibit reports made in compliance with s. 253.12 (2), 255.40, or 979.01; records generated or disclosed pursuant to rules promulgated under s. 450.19; testimony authorized under s. 905.04 (4) (h); or releases made for purposes of health care operations, as defined in 45 CFR 164.501, and as authorized under 45 CFR 164, subpart E.

**DE 8.30 Preservation or destruction of patient health care records.** The preservation or destruction of patient health care records shall be in compliance with s. 146.819, Stats.

**Note:** Section 146.189, Stats., reads: “**146.819 Preservation or destruction of patient health care records.** (1) Except as provided in sub. (4), any health care provider who ceases practice or business as a health care provider or the personal representative of a deceased health care provider who was an independent practitioner shall do one of the following for all patient health care records in the possession of the health care provider when the health care provider ceased business or practice or died:

(a) Provide for the maintenance of the patient health care records by a person who states, in writing, that the records will be maintained in compliance with ss. 146.81 to 146.835.

(b) Provide for the deletion or destruction of the patient health care records.

(c) Provide for the maintenance of some of the patient health care records, as specified in par. (a), and for the deletion or destruction of some of the records, as specified in par. (b).

(2) If the health care provider or personal representative provides for the maintenance of any of the patient health care records under sub. (1), the health care provider or personal representative shall also do at least one of the following:

(a) Provide written notice, by 1st class mail, to each patient or person authorized by the patient whose records will be maintained, at the last-known address of the patient or person, describing where and by whom the records shall be maintained.

(b) Publish, under ch. 985, a class 3 notice in a newspaper that is published in the county in which the health care provider's or decedent's health care practice was located, specifying where and by whom the patient health care records shall be maintained.

(3) If the health care provider or personal representative provides for the deletion or destruction of any of the patient health care records under sub. (1), the health care provider or personal representative shall also do at least one of the following:

(a) Provide notice to each patient or person authorized by the patient whose records will be deleted or destroyed, that the records pertaining to the patient will be deleted or destroyed. The notice shall be provided at least 35 days prior to deleting or destroying the records, shall be in writing and shall be sent, by 1st class mail, to the last-known address of the patient to whom the records pertain or the last-known address of the person authorized by the patient. The notice shall inform the patient or person authorized by the patient of the date on which the records will be deleted or destroyed, unless the patient or person retrieves them before that date, and the location where, and the dates and times when, the records may be retrieved by the patient or person.

(b) Publish, under ch. 985, a class 3 notice in a newspaper that is published in the county in which the health care provider's or decedent's health care practice was located, specifying the date on which the records will be deleted or destroyed, unless the patient or person authorized by the patient retrieves them

before that date, and the location where, and the dates and times when, the records may be retrieved by the patient or person.

(4) This section does not apply to a health care provider that is any of the following:

(a) A community-based residential facility or nursing home licensed under s. 50.03.

(b) A hospital approved under s. 50.35.

(c) A hospice licensed under s. 50.92.

(d) A home health agency licensed under s. 50.49 (4).

(f) A local health department, as defined in s. 250.01 (4), that ceases practice or business and transfers the patient health care records in its possession to a successor local health department. “

**DE 8.31 Intentionally falsifying patient records.** Intentionally falsifying patient records shall be considered a violation of unprofessional conduct as specified in s. DE 5.02 (7).

SECTION 2. EFFECTIVE DATE. The rules adopted in this order shall take effect on the first day of the month following publication in the Wisconsin administrative register, pursuant to s. 227.22 (2) (intro.), Stats.

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(END OF TEXT OF RULE)  
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Dated \_\_\_\_\_

Agency \_\_\_\_\_

Board Chairperson  
Dentistry Examining Board