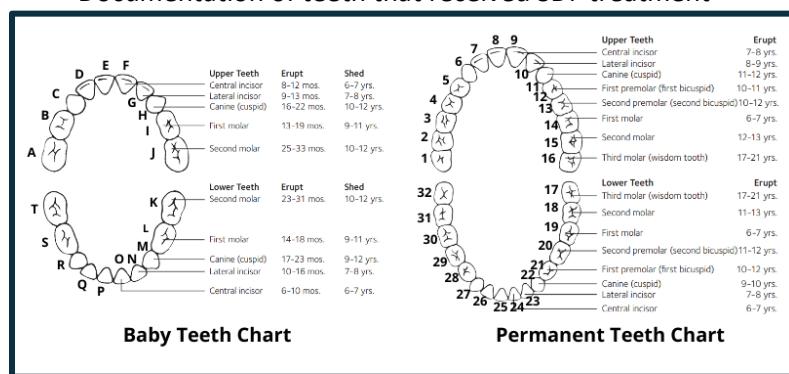


SDF Electronic Health Record Documentation

It's recommended that the electronic health record (EHR) capture the following information:

- Silver Diamine Fluoride application to treat active tooth decay?
 - Clinical staff to apply Silver Diamine Fluoride today
 - Clinical staff to schedule a separate appointment for application
 - Patient refused Silver Diamine Fluoride
 - Not discussed with patient
- SDF consent form reviewed with patient or legal guardian:
 - Patient or legal guardian accepted SDF treatment
 - Patient or legal guardian refused SDF treatment
- Is the pulp of the tooth exposed:
 - Yes - If yes, do not apply SDF
 - No
- Does the patient have a silver allergy:
 - Yes- If yes, do not apply SDF
 - No
- Has it been six months since prior application?
 - Yes
 - No
 - First application date: month/date/year
 - Second application date: month/date/year
- **SDF Procedure:** A protective drape was used. Teeth were wiped with cotton rolls to remove food or debris. The tooth/teeth being treated was dried thoroughly. Silver diamine fluoride was carefully applied to the lesion(s) with a microsponge applicator until saturated and allowed to absorb for up to 30 seconds. Excess SDF was dabbed away with gauze.
- Fluoride varnish was applied post SDF treatment
 - Yes – **Charge Capture using CPT 99188- This would also satisfy need for fluoride varnish prompted by oral health risk assessment.**
 - No
- Number of teeth that received SDF treatment -**Charge Capture using D1354 for patients with MaineCare insurance and CPT 0792T for patients with commercial insurance. If silver diamine fluoride is applied during the WCC, silver diamine fluoride should be coded as part of the visit. If a separate visit is scheduled the visit would be for SDF application only, unless the patient had other acute issues that were addressed.**
 - Documentation of teeth that received SDF treatment –



- Reminder to schedule an appointment in 6-months for reapplication and provide dental referral information