Health Net®

DENTAL

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Health Net Medi-Cal and Healthy Families Dental Operations Manual

The Health Net Medi-Cal and Healthy Families Dental Operations Manual was developed to ensure that dental practitioners have access to needed information and to ensure members enrolled in the Medi-Cal and Healthy Families managed care plans receive appropriate covered dental services when needed. Health Net's Medi-Cal and Healthy Families plans are underwritten by Health Net of California and is regulated by the California Department of Health Services (DHS) and the Department of Managed Health Care (DMHC).

As a Health Net contracting dental practitioner you are required to comply with applicable state laws and regulations and Health Net policies and procedures. The contents of the Health Net Medi-Cal and Healthy Families Dental Operations Manual are supplemental to your dental agreement. When the contents of the Health Net Medi-Cal and Healthy Families Dental Operations Manual conflict your dental agreement, your dental agreement takes precedence.

Except as noted, the policies, procedures and programs described in this manual are applicable to all Health Net Medi-Cal and Healthy Families participating dental providers.

Purpose

Health Net of California is a subsidiary of Health Net, Inc. and is one of the largest network-model health plans in California, serving more than 2.4 million members statewide and more than 2,700 associates. Health Net State Health Program's dental subsidiary, Health Net Dental, has been awarded a contract by the Department of Health Services (DHS) and the Managed Risk Medi-Cal Insurance Board (MRMIB) to provide dental coverage as part of the pre-paid health benefits provided by Health Net of California's Medi-Cal program in Los Angeles County and the Health Families program in Los Angeles, Orange, Riverside and San Bernardino counties.

Health Net Dental participating providers are paid monthly capitation for each member assigned to his or her practice, and receives a Health Net Dental eligibility roster identifying the assigned members and applicable capitation amounts. In return the provider is required to render all covered services that are within the provider's scope of practice to eligible members. A member is eligible to receive services if his or her name appears on the monthly eligibility roster or if eligibility is established either verbally or in writing by a Health Net Dental representative. Health Net Dental members choose the dental facility in which they will obtain care. The member selects the facility when he or she completes an enrollment form.

Prior authorization for dental services is not required; however, providers must request a referral for specialty services. All services provided to a member must be reported to Health Net Dental. This information is vitally important and is used to evaluate and report utilization statistics and trends as well as providing the physician's office with supplemental reimbursements.

Providers and their staff are expected to treat members promptly, fairly, and courteously when contacting the member by telephone, in person or in writing.

Los Angeles County Prepaid Health Plan Medi-Cal Dental Program Overview

Health Net Dental provides pre-paid dental coverage for individuals enrolled in the Los Angeles County Prepaid Health Plan (LAPHP) Medi-Cal Dental Program. LAPHP Medi-Cal Dental Program members are assigned to a primary care dentist (PCD) to receive general dental services. The PCD may refer the member to a specialist after obtaining authorization from Health Net Dental.

The benefit schedule available to LAPHP Medi-Cal Dental Program members is the same that is available to Denti-Cal (fee-for-service) members. The primary difference between the two programs is that members enrolled in the LAPHP Medi-Cal Dental Program are assigned to a PCD. The PCD is compensated through a capitation schedule and prior authorization is not required for covered services that are included in the scope of the PCD's responsibility. Members enrolled in the fee-for-service Denti-Cal program are required to obtain prior authorization for many services and procedures.

LAPHP Medi-Cal Dental Program members have access to an array of specialists, including pediatric dentistry, endodontics, and oral surgery. Health Net Dental contracts with specialists throughout Los Angeles County to ensure needed services are available to LAPHP Medi-Cal Dental Program members. Specialty services require prior authorization, except for emergency services. Emergency service referrals can be obtained by telephone or fax as outlined in the Referral section.

LAPHP Medi-Cal Dental Program members receive covered dental services from their PCD with no co-payment. Collection of co-payment amounts from a Medi-Cal member for covered dental services is strictly prohibited under the provisions of your provider agreement.

Healthy Families Program Overview

Health Net Dental provides pre-paid dental coverage for those enrolled in the Healthy Families Program in Los Angeles, Orange, San Bernardino, and Riverside counties. Healthy Families members are assigned to a PCD to obtain general dental services. The PCD may arrange for members to obtain care from a specialist after obtaining prior authorization from Health Net Dental.

Healthy Families members have access to an array of specialty services, including but not limited to pediatric dentistry, endodontics, and oral surgery. Orthodontic care is provided through the California Children Services (CCS) Program. Health Net Dental contracts with specialists throughout Los Angeles, Orange, San Bernardino, and Riverside counties.

Specialty services require prior authorization, except for emergency services. Emergency service referrals can be obtained by telephone or fax as outlined in the Referral section.

Unlike the LAPHP Medi-Cal Dental Program, Healthy Families members are responsible for co-payments for certain services. The PCD must collect member co-payments at the time of service, except when treating American Indians and Alaskan Native Children. An American Dental Association (ADA) claim form should be submitted by the PCD with the monthly encounters. The ADA form should be labeled, "American Indian or Alaskan Native requesting co-payments.

Capitation Guidelines

As a participating provider you are paid a monthly capitation for each member assigned to your office. Health Net Dental distributes an eligibility roster identifying those assigned members at the beginning of each month. A member is eligible to receive services if his or her name appears on the monthly eligibility roster or if eligibility is established either verbally or in writing by a Health Net representative. Covered services provided by the PCD do not require prior authorization. Specialty services must be prior authorized. All services (general or specialty) must be reported to Health Net Dental on a patient encounter form or equivalent reporting mechanism.

Members who change his or her PCD mid month and require services prior to being included in the new PCD's eligibility roster (and capitation calculation) may receive services from the new PCD. The new PCD will receive a pro-rated capitation amount, which is included in the following month's capitation check.

However, the PCD should contact the Health Net Dental Member Services Department to verify the change of PCD prior to providing services.

Member Assignment to PCD

Health Net Dental assigns each LAPHP and Healthy Families member to a PCD based on:

- Member request for a specific PCD
- The nearest PCD within 10 miles of member's residence
- The PCDs office should contact Health Net Dental Member Services Department if a member does not appear on the roster for eligibility and for members changing from PCD to another
- The capitation amount is prorated for members who change their PCDs mid-month

Member Transfer

- Provider may request that a member be transferred for any of the following reasons:
    - Member is repeatedly verbally abusive to the provider, auxiliary or staff or other plan members
    - Member physically assaults the provider or staff person or threatens another individual with a weapon on provider's premises. In this instance, the provider files a police report against the member
    - Member is disruptive to the provider's office operations
    - Member has allowed the fraudulent use of his or her coverage under Health Net Dental, which includes allowance of others to use the membership card to receive services from Health Net Dental providers
    - Member has failed to follow prescribed treatment (including failure to keep appointments). This is not, in and of itself, good cause for a request to transfer member unless the provider can demonstrated that, as a result of the failure, the provider is exposed to a substantially greater and unforeseeable risk than otherwise contemplated under Health Net Dental and the rate-setting assumptions
    - To request a member transfer, complete a Transfer Request Form (sample attached).

Transfer Request Form

☐ HFP ☐ LAPHP

Date _____

Member Name _____Dental Provider Number_____

Member Telephone _____ Office Telephone Number_____

Reason for request:

☐ Member is repeatedly verbally abusive to provider, auxiliary or staff or other plan members.

☐ Member physically assaults the provider or staff person or threatens another individual with a weapon on provider's premises. (Provider must file a police report against the member.)

☐ Member is disruptive to provider's office operations.

☐ Member has allowed the fraudulent use of his or her coverage under the plan, which includes his or her allowance of others to use his or her membership card to receive services from the plan's providers.

☐ Member has failed to follow prescribed treatment (including failure to keep appointments). This is not, in and of itself, good cause for a request to transfer member unless the provider can demonstrate that, as a result of the failure, the provider is exposed to a substantially greater and unforeseeable risk than otherwise contemplated under the plan and the rate-setting assumptions.

List missed appointments (if applicable): _____

Additional comments for transfer _____

_____

_____

_____ _____

Dentist Signature Date

Submit request by mail to:

HEALTH NET DENTAL
C/o LIBERTY Dental Plan of California, Inc.
3200 El Camino Real, Suite 290
Irvine, CA 92602

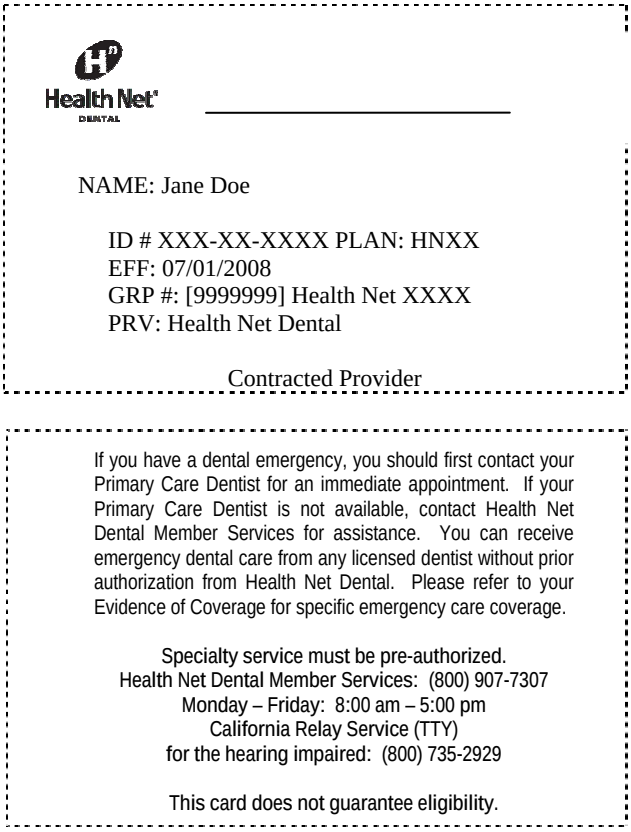
For Office Use Only
Name of person receiving complaint: _____
Date of action: _____

Member Identification Card and Eligibility

Health Net Dental members are issued an identification (ID) card at the time of enrollment. Members should present their Health Net Dental ID card at the time of service (except children who must show a photo ID). In addition, the member should present their Beneficiary ID Card (BIC) at each appointment.

Possession of a Health Net Dental ID card does not guarantee eligibility. PCDs must verify eligibility on the Health Net Dental roster or contact the Health Net Dental Member Services Department for questions on legibility, coverage, or the member's assigned PCD.

A sample of a Health Net Dental ID card is illustrated below. ID cards specify the program under which the member is eligible.


Health Net
DENTAL

NAME: Jane Doe

ID # XXX-XX-XXXX PLAN: HNXX
EFF: 07/01/2008
GRP #: [9999999] Health Net XXXX
PRV: Health Net Dental

Contracted Provider

If you have a dental emergency, you should first contact your Primary Care Dentist for an immediate appointment. If your Primary Care Dentist is not available, contact Health Net Dental Member Services for assistance. You can receive emergency dental care from any licensed dentist without prior authorization from Health Net Dental. Please refer to your Evidence of Coverage for specific emergency care coverage.

Specialty service must be pre-authorized.
Health Net Dental Member Services: (800) 907-7307
Monday – Friday: 8:00 am – 5:00 pm
California Relay Service (TTY)
for the hearing impaired: (800) 735-2929

This card does not guarantee eligibility.

Member Initiated Disenrollment Process

Members enrolled in the LAPHP may voluntarily disenroll from Health Net Dental at any time and can enroll in another plan or fee-for service Denti-Cal. Healthy Families members may change plans only during the annual open enrollment period.

Disenrollment is mandatory when a member:

- Requests disenrollment, and the request is not during any restricted disenrollment period for the member
- Requests disenrollment during the restricted disenrollment period and shows good cause
- Eligibility is terminated or member's eligibility for Medi-Cal is terminated, including the death of the eligible Beneficiary
- Requests disenrollment and meets the following criteria
    - To accommodate the needs of a foster child

  - To comply with travel distance standards
  - If new LAPHP or Healthy Families dental contractors become available
  - If Health Net Dental is decertified as a federally qualified plan
- There is a change of the member's place of residence outside the plan's service area
- It is determined that the member is enrolled as a commercial member of the plan

Plan Initiated Disenrollment

The plan may also request disenrollment of a member after every effort to resolve the problem with the member has been attempted. The plan will make every effort to reassign the member to another primary care dentist or educate the member on plan rules. Plan initiated disenrollments must be prior approved by DHS. A written request for disenrollment and the documentation supporting the request is submitted to DHS via Certified US Mail for approval. The supporting documentation establishes the pattern of behavior and the plan's efforts to resolve the problem. A notice is mailed to the member notifying them of the disenrollment for cause if DHS grants the plan-initiated request for disenrollment. The member continues to receive covered services until the effective date of the disenrollment.

Some of the reasons for disenrolling a member are:

1. Verbal Abuse
   a. Member is repeatedly verbally abusive to the Contracting Providers, ancillary or administrative staff, subcontractor staff or to other plan members
2. Physical Abuse
   a. Member physically assaults a Contracting Provider or staff person, subcontractor staff person, or other member, or threatens another individual with a weapon on the plan's premises. In this instance, the plan or the contracting provider will file a police report and file charges against the member
3. Disruptive Behavior
   a. Member is disruptive to the plan operations, in general, and the disruptive behavior is not a result of the member's special needs
4. Habitual Use of Non-Network Providers
   a. Member habitually uses providers not affiliated with the plan for non-emergency services without required authorizations (causing the plan to be subjected to repeated provider demands for payment for those services or other demonstrable degradation in the plan's relations with community providers)
5. Fraudulent Use of Medi-Cal Coverage
   a. Member has allowed the fraudulent use of Medi-Cal coverage under the plan, which includes allowing others to use the member's plan membership card to receive services from the plan
6. Noncompliance with Prescribed Treatment
   a. A member's failure to follow prescribed treatment (including failure to keep established dental appointment) will not, in and itself, be good cause for a plan-initiated disenrollment request unless it is demonstrable to DHS that, as a result of the failure, the plan is exposed to a substantially greater and unforeseeable risk than that otherwise contemplated under the Contract and rate negotiations.

Disenrollment Procedures

Requests Received via the Telephone

When a member service representative (MSR) receives a request from a member who wants to disenroll from the plan, they interview the member to see if they meet the disenrollment criteria listed under

member Initiated Disenrollment discussed above. The MSR will make every effort to resolve the problem with the member, by reassigning them to another primary care dentist or educating them on plan rules. If the member still wishes to disenroll from the plan, the MSR will inform the member that the plan cannot disenroll them, that the member will have to send a disenrollment form to HCO. The MSR will then inform the member that we send them a form within three (3) days and that if they need help filling the form out they should call the HCO at 800-430-4263.

The MSR logs the call and action in the plan's Management Information System (MIS). The action code will trigger the mailing of the enrollment/disenrollment form to the member.

Each day the member Services Coordinator receives the Daily member Services Report, which enlists all open communication responses. The report will list specific action such as mail member Disenrollment form. The Coordinator splits the report by function and distributes.

The member Service File Clerk receives the report listing the members to whom an enrollment/disenrollment form must be mailed with two (2) working days. The clerk mails the form and indicates on the report the action taken, this is returned to the Coordinator who has the report and will update it to closed, with the date the form was mailed.

Requests Received in Person

When a member visits the plan in person with a request for disenrollment from the plan, they will be referred to the Member Services Coordinator who will interview the member to see if they meet the disenrollment criteria listed under member Initiated Disenrollment above. The Coordinator will make every effort to resolve the problem with the member, by reassigning them to another primary care dentist or educating them on the plan rules. If the member still wants to disenroll from the plan the Coordinator will provide the member with the disenrollment form and tell them to call the HCO contractor if they need assistance filling out the form.

Requests Received in Writing

When a member Service Correspondence Specialist receives a written request from a member wanting to disenroll from the plan, they will send the member a disenrollment form and the written qualifying criteria. This action will be logged in the MIS and will be documented for audit trail.

Requests by the Plan for Prior Disenrollment Approval from DHS

The plan will make every effort to resolve problems with members before requesting disenrollment approval from DHS of a member who chronically displays one of the following behaviors:

1. Verbal Abuse
2. Physical Abuse
3. Disruptive Behavior
4. Habitual Use of Non-Network Providers
5. Fraudulent Use of Medi-Cal Coverage
6. Noncompliance with Prescribed Treatment

   If all attempts to resolve the problem fail, the plan will send a written request to DHS asking that the member be disenrolled from the plan's Sacramento GMC Medi-Cal Dental plan.

Member Rights and Responsibilities

Member Rights

Members have a right to:

- Access and availability to care
- Be provided information regarding contracting dentists
- Be provided information regarding Health Net Dental's services, benefits and specialty referral process
- Be treated with respect, dignity and recognition of the member's need for privacy and confidentially
- Express grievances and be informed of the grievance and appeal process

Member Responsibilities

Members are responsible for:

- Knowing and understanding the rules and regulations of Health Net Dental and abiding by these rules in the interest of quality dental care
- Learning about dental condition(s) and following prescribed treatment plans
- Contacting his or her PCD to make a dental appointment
- Arriving at the office five or ten minutes before the scheduled appointment to allow time for filling out any necessary paperwork
- Calling the dentist and rescheduling an appointment at least 24 hours in advance if they cannot keep a scheduled appointment
- Requesting individual counseling by the PCD to establish a healthy dental routine
- Adopting positive lifestyle choices such as brushing, flossing, checkups, good diet, avoiding tobacco, and using fluoride
- Being knowledgeable of community health fairs
- Reading health education materials available at the dentist's office

Provider Responsibilities

When the LAPHP Medi-Cal Dental Program or Healthy Families member enrolls with Health Net Dental, the member selects a PCD who is responsible for providing or coordinating all dental care for the member, including referrals to participating specialists. In order to ensure that the care rendered to members is provided under the appropriate requirements including covered benefits and referrals, PCD's and participating specialists are required to adhere to the following:

PCD Responsibilities

- Provide and/or coordinate all dental care for the member
- Perform an initial dental assessment
- Work closely with specialist to promote continuity of care
- Obtain prior authorization, when required for any specialty referral or supplemental payment
- Maintain adherence to Health Net Dental's Quality Management program
- Identify children with special health care needs and notify Health Net Dental
- Notify Health Net Dental of a member's death
- Arrange coverage by another provider when away from the office
- Ensure that emergency dental services are available and accessible 24 hours a day, 7 days a week through a PCD
- Maintain scheduled office hours
- Maintain dental records for a period of five years
- Provide updated credentialing information upon renewal dates
- Provide requested information upon receipt of a member grievance or complaint within 10 days of receiving a notification letter
- Provide encounter data on a standard ADA claim, Health Net Dental form or computer-generated form in a timely manner. Encounter data must be submitting no later than the 15th of each month
- Refer members who have CSS eligible conditions to Health Net Dental

Updating Provider Information

Providers are required to inform Health Net Dental of changes regarding their practice, including name, address, addition of associates, sale of the practice, or desire to terminate with Health Net Dental.

Initial Dental Assessment

PCDs are required to make a reasonable attempt to perform an initial dental assessment within 120 days of a member's enrollment unless the member has been treated within the last 12 months by his or her PCD. Periodic exams are a benefit once in 12-month period for adults and once in 6-month period for children. Members are instructed to contact their PCD as soon as possible.

The PCD must ensure that initial assessment appointments are scheduled with 120 days of the member's enrollment in Health Net Dental. If the member misses or cancels the appointment, the PCD office must contact the member at least two times to attempt to reschedule the appointment. The initial dental care assessment must include a dental history, clinical examination and radiographs as needed, in the judgment of the PCD. The PCD discusses general preventative care and follow-up treatment as necessary with members.

The initial or routine appointment must be provided within three weeks of the request. Plan providers are expected to provide necessary dental services within acceptable timeframes recommended by DHS and

Health Net Dental. If an access to care problem is identified, corrective action must be taken including, but not limited to the following:

- Additional education and assistance to the provider
- Provider counseling
- Provider probation
- Suspension of new assignments
- Transfer of member to another provider
- Contract termination for continuing noncompliance

Specialist Responsibilities

All specialty care must be prior authorized by Health Net Dental and documented through a referral form that is initiated by the PCD. If a member requires additional specialty care beyond the scope of the services authorized, the member must be referred back to the PCD for a new referral.

Specialists are responsible for:

- Providing specialty care to members
- Ensuring prior authorization has been obtained
- Working closely with the PCD to ensure continuity of care
- Maintaining adherence to Health Net Dental's Quality Management Program
- Billing Health Net Dental for all prior authorization dental services
- Maintaining dental records for five years;
- Providing credential information upon renewal dates

Encounter Data Requirements

Encounter date must be reported to reflect all services provided to LAPHP Medi-Cal Dental Program or Healthy Families members. Providers are encouraged to use an ADA claim form to report encounter information to Health Net Dental. Encounter information is required for all benefit programs.

Encounter information for services provided during one month should be submitted to Health Net Dental at:

HEALTH NET DENTAL
C/o LIBERTY Dental Plan of California, Inc.
3200 El Camino Real, Suite 290
Irvine, CA 92602

To be eligible for supplemental payments, encounter data must be received by Health Net Dental by the 15th of each month for services provided in the previous month. Encounters submitted after the 15th of the month will not be used for calculations for encounter payments.

Encounter payments will be paid on a monthly basis to the provider. Health Net Dental will reimburse within 30 days of the first week of each month when received by the 15th of the previous month. Health Net Dental monitors encounter submissions on a monthly basis and will conduct the following if a provider's office does not submit the monthly encounter information on a regular basis:

- Additional education and assistance to the provider
- Provider counseling
- Provider probation
- Suspension of new assignments
- Transfer of members to another provider

Referrals

Specialty Referrals

Specialty referral determinations are based on submitted documentation and member-covered benefits. Information provided by the provider is key to authorization requests. The Health Net Dental Director makes the final decisions regarding prior authorization requests for specialty services. The Dental Director or his or her designee, who is a California licensed dentist, reviews all referral decisions requiring professional judgment, including all potential denials.

All non-emergency referrals are valid for 30 days from the date of approval by Health Net Dental. The requesting PCD must complete the information, including procedure code and description of the services to be provided by the specialist and a statement regarding the need for a specialist. The referral must be signed and dated.

An emergency referral is available for members requiring immediate treatment. An emergency referral may be requested by telephone or fax:

Emergency Referral	
Telephone	**Fax**
(800) 907-7307	(800) 268-0154

Health Net Dental will respond to an emergency referral immediately from the time the referral is received. If the referral is approved, Health Net Dental will contact the specialty provider to inform him or her of the patient's urgent need for treatment and authorization. The PCD office must forward a written referral request to Health Net Dental after obtaining verbal approval.

Routine Specialty Referrals

A regular (non-emergency) referral is obtained by completing a referral form and mailing the form to Health Net Dental. Documentation supporting the reason for the referral must be included. Health Net Dental will respond to a referral request within five business days from the date of receipt. The referral form should be submitted to Health Net Dental at:

HEALTH NET DENTAL
C/o LIBERTY Dental Plan of California, Inc.
3200 El Camino Real, Suite 290
Irvine, CA 92602

Approved specialist referrals are based on submitted documentation and the benefit plan as outlined in Title 22 and the DHS Medi-Cal Manual of Criteria for Dental Services for referral of Medi-Cal members and the Health Net Healthy Families *Evidence of Coverage* (*EOC*) for Healthy Families members. A copy of a specialist referral is sent to the specialist, to the member, and to the PCD. In addition, the PCD is advised when appropriate, that follow-up treatment needs to be performed by the PCD.

Emergency Referrals

In the case of an emergency, the PCD should contact Health Net Dental for an immediate referral to a specialist. An emergency dental conditions is a dental condition which is manifested by acute symptoms of sufficient severity, including severe pain, severe swelling, bleeding, or for unforeseen dental conditions such as hemorrhage, infection, or trauma if not immediately diagnosed and treated, would lead to disability or harm to a member.

Emergency specialist referrals do not require prior authorization. Health Net Dental will respond to an emergency referral request immediately from the time the request is received. Specialty providers are requested should notify the claims coordinator prior to treating the member. This is done to ensure that the provider understands Health Net Dental program and does not provide routine non-emergency dental services for which the provider may not be reimbursed.

Denied Specialty Referrals

Specialist referrals may only be denied by a licensed dentist when the reason for denial is based in whole or in part on dental necessity. Specialist referrals may be denied for the following:

- Lack of eligibility
- Procedure not a benefit
- Insufficient documentation
- Dental necessity for procedure not evident
- Poor prognosis or longevity questionable
- Procedure requested is within the scope of the PCD

When a specialist referral is denied, the PCD and member are notified in writing within five business days of the denial. The PCD is informed within 24 hours by telephone or fax. Denial notification includes a clear and concise explanation of the rationale for the denial, a description of the criteria used, and the clinical benefit reason for the determination. Denial notification also includes the member's right to file a grievance and the grievance process, including timeframes for submitting a grievance. Members are also advised of their right to seek a second opinion at no charge.

When a referral for a member under the age of 21 is denied based on Medi-Cal benefits, the member's parent or legal guardian will be contacted and advised to seek assistance through the Child Health and Disability Program (CHDP), CCS Program or Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.

When a referral is denied because the services fall within the scope of the PCD, the member is instructed to return to his or her PCD to obtain treatment.

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Health Net Dental Specialist Referral Form

HEALTH NET DENTAL
c/o Liberty Dental Plan of California, Inc.
3200 El Camino Real, Suite 290
Irvine, CA 92602

Health Net DENTAL

☐ **Specialty Referral**
(Mail to LDP with xray & documents)

☐ **Emergency Referral**
(Call or Fax to LDP)

Provider		**Member**	
Prov License #	Phone	Member Name	ID#
Name		Patient Name	Phone
Address		Address	DOB
City		City	

CHECK ALL THAT APPLY IN EACH CATEGORY:

☐ **Endodontics** (must submit PA & BWX)

☐ **Prognosis** _____
☐ Pain
☐ Retreatment (date of original RCT ___)
☐ Calcification (circle one)
Canal involved M D B P
☐ Curved Canal (circle one)
Canal involved M D B P
☐ Internal/External Resorption
☐ Apicoectomy/Retrofiling
☐ Other _____

☐ **Oral Surgery** (must submit PA or Pano)

☐ Pain
☐ Swelling
☐ Periocornitis caused by exacerbated third molars
☐ Non-restorable – caries/internal resorption
☐ Resorption of roots of adjacent teeth
☐ Interference with prosthesis
of edentulous arches
☐ Other _____

- In absence of Pathology extractions of impacted teeth and roots are not a benefit

☐ **Periodontics** (must submit FMX & perio charting)

(circle one)
Case Type I, II, III, IV
Dates of Root Planing

UR _____ LL_____
LR _____ LR _____
☐Other _____

_____

☐ **Pedodontics**

☐ Uncooperative
Date of treatment attempt _____
☐ Medical Reason _____
☐ See MD attached note
☐Other _____

_____

☐ **Orthodontics** Notes:

TREATMENT REQUEST

Tooth #	Surface	ADA Code	Description	Fee	Co-Pay

Dentist Signature _____ **Date** _____

In office use only
Date Received _____ Eligibility _____ Plan # _____
Date Processed _____
Approved ☐ Denied ☐ Modified ☐
X-rays reviewed _____ Tracking # _____
Comments_____

Specialty Care Guidelines

Periodontics

Health Net Dental participating providers administer all phases of periodontal treatment, with the exception of surgery. This includes treatment planing, diagnosis, X-rays, pocket depth charting, emergency abscess treatment, scaling, root planing, curettage (with or without anesthesia), occlusal adjustment, prophylaxis and oral hygiene instructions. After healing is completed, if the PCD determines that oral hygiene is acceptable and pocket depths are unmaintainable, prior authorization to a specialty provider may be requested from
Health Net Dental. The PCD must submit the following documentation:

- A brief case description and history of periodontal services rendered
- All tooth numbers which may require surgery
- A pre- and post- pocket depth charting, dates or root planing/subgingival curettage
- Full mouth X-rays

Oral Surgery

Health Net Dental specialty providers deliver oral surgery care, including simple extractions, surgical extractions, tissue impactions, alveolectomies, post-operative care and all diagnostic X-rays. Providers are not required to perform partial or complete bony impactions or perform oral surgery on those patients whose physicians will not allow surgeries to be done in general practitioners' offices due to their health histories.

An oral surgery referral includes a diagnostic X-ray completely depicting the apical area of the tooth. If the X-ray is non-diagnostic, the X-ray charges from the specialist office will be charged back to the PCD's office. This referral covers the extractions of impacted teeth only with an existing pathology. This referral does not cover the extraction of immature, erupting third molars, which are currently impacted (usually on patients 18 years of age or younger) or extraction of impacted, asymptomatic teeth with no pathology on adult patients.

Endodontics

Health Net Dental expects its panel providers to perform standard endodontic therapy and palliative procedures on any tooth requiring such therapy, including all molars. Referral to an endondontist without prior authorization from Health Net Dental for non emergency services is the financial responsibility of the provider. The PCD must document the Health Net member's chart regarding the condition and why therapy cannot be rendered at the PCD's office. Inadequate access to perform endodontic therapy or lack of proper instruments is not acceptable reasons for a referral to an endodontist.

Health Net Dental is financial responsibility for endodontic treatment when:

- The tooth is critically important to the integrity of the oral condition of the patient
- Specific reasons exist for making the treatments by the PCD contradictory (e.g., failure of an existing root canal, calcified canals indicated through radiographs depicting an endodontic file in the blocked canal, broken instruments and periapical pathology remaining after standard therapy)

Endodontic referrals must include:

- The reason why the treatment cannot be performed at the PCD's office
- FMX or bilateral bite-wings
- Working X-rays with rubber dam and files in place demonstrating complications such as calcifications of the canals preventing proper access for instrumentation
- Prognosis of the tooth
- Date of previous root canal, if applicable

- Symptoms

Pedodontics

The following applies to pedodontic referrals:

- PCDs are responsible for providing all necessary and covered pedodontic care to assigned members, so long as that care rendered is within the PCDs clinical competency
- Pedodontic referrals are appropriate if the PCD is unable to provide appropriate pedodontic care due to any of the following:
    - Patient exhibits significant management or behavioral problems
    - Patient is medically compromised
    - Complexity of treatment required
    - Documentation in patient's record and of one attempt at treatment

Orthodontics

Facial growth management and orthodontic services are not covered, except in the treatment of handicapping malocclusion for persons under the age of 21 and in the treatment of cleft palate deformities under the case management of the CCS Program.

Orthodontic services for handicapping mal-occlusion is limited to Medi-Cal eligible individuals under 21 years of age by dentists qualified as orthodontists under the CCR, Title 22, Section 51233(c). Completion of the handicapping labiolingual deviation (HLD) Index is limited to the provider or provider group that performs the orthodontic examination with the intention of providing any subsequent medically necessary treatment under the orthodontic dental services program. The HLD Index is the preliminary measurement tool to determine the degree of handicapping mal-occlusion. The initial HLD Index does not require prior authorization. Once the HLD Index score is determined, a prior authorization request for is required to authorize study models then submitted to the orthodontic consultant. CCS will provide orthodontic treatment for Healthy Families members meeting the HLD Index. The PCD should refer for orthodontic treatment in the same manner as any other routine referral.

Determination Timeline

In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of dental care services to members, Health Net Dental adheres to the following timelines:

- Decisions are made in a timely manner and appropriate to the nature of the members condition, not to exceed five business days from Health Net Dental's receipt of the information requested by Health Net Dental to make the determination
- In cases where the review is retrospective, the decision is communicated to the member who received services within 30 days of the receipt of the information that is reasonably necessary to make the determination. This information is also be communicated to the provider
- When the member's condition is such that the member faces an imminent and serious threat to his or her health including, but not limited to, loss of life, or other major bodily function, the decision to approve, modify, or deny requests by providers is made in a timely manner appropriate for the nature of the members condition, not to exceed 24 hours after Health Net Dental's receipt of the information requested by Health Net Dental to make the determination
- Decision to approve, modify or deny requests by providers for authorization prior to, or concurrent with, the provision of dental care services to members is communicated to the requesting provider within 24 hours of the decision
- Except for concurrent review decisions pertaining to dental care that is underway, which is communicated to the member's treating provider within 24 hours, decisions resulting in denial, delay or modification of all or part of the requested dental services are communicated to the member in writing within two business days of the decision. In the cases of concurrent review,

dental care is not be discontinued until the member's treating provider has been notified of Health Net Dental's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the needs of the patient

- In the event that Health Net Dental cannot make a decision to approve, modify or deny the request for authorization within the timeframes specified above because Health Net Dental has not received all the needed information, Health Net Dental notifies the provider and the member in writing that Health Net Dental cannot make a decision to approve, modify, or deny the request for authorization within the specified timeframe. Health Net Dental will specify the reasons why the decision could not be made within the statutory timeframes. The reasons are limited to the following:
    - Health Net Dental is not in receipt of all of the information reasonably requested
    - Health Net Dental requires consultation by an expert reviewer
    - Health Net Dental requested that additional examination or test be performed upon the member provided the test is reasonable and consistent with good dental practice.

  Health Net Dental will also notify the provider and the member of the anticipated date on which a decision may be rendered.

Second Opinion

Requests for second opinions must be submitted to Health Net Dental by a member, a participating PCD or any other participating provider such as a specialist who is treating the member.

Second Opinion Process

The request is recorded in the Health Net Dental system and forward to the Member Services Manager

Health Net Dental claims coordinator and Dental Director will review and track the reason for the request and provide an authorization or a denial in an expeditious manner. The reason for a second opinion includes, but is not limited to, the following:

- Members can request a second opinion anytime
- Member questions the reasonableness or necessity of the recommended surgical procedures
- Member questions the diagnosis or plan of care for a condition that threatens loss of life, substantial impairment, including but not limited to, a serious chronic condition
- Member requests additional diagnosis if the clinical indications are not clear, the provider is unable to diagnose the condition, or the diagnosis is unclear due to conflicting test results
- Member treatment plan in progress is not improving the dental condition of the member within an appropriate period of time given the diagnosis and the member requests a second opinion regarding the diagnosis or continuance of the treatment
- Member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care

Health Net Dental will render the second opinion in a timely fashion appropriate for the nature of the member's condition, not to exceed 72 hours after Health Net Dental's receipt of the request for urgent care and routine cases, whenever possible. In the event of an emergency, emergency services will be rendered to members without prior authorization up to the point of stabilization. Upon request, members are mailed a copy of the timeline and second opinion procedures.

If a member is requesting a second opinion about care from his or her PCD, the second opinion is provided by an appropriately qualified health care dentist of the member's choice within Health Net Dental's network. An appropriately qualified health care professional is a PCD, specialist, or other licensed health care professional who meets these requirements.

If a member is requesting a second opinion about care from a specialist, the second opinion is provided by any provider of the member's choice within Health Net Dental's network of the same or comparable

specialty. If the specialist is not within Health Net Dental's network, Health Net Dental will incur the cost or negotiate the fee arrangements of that second opinion.

If there is no participating Health Net Dental provider within the network who is an appropriately qualified dentist, Health Net Dental will authorize a second opinion by an appropriately qualified dentist outside of the Health Net Dental provider network. Health Net Dental will take into account the ability of the member to travel to the provider.

Health Net Dental will require the provider who is rendering the second opinion to provide the member and the PCD with the consultation report, including any recommended procedures or tests that this second opinion provider deems appropriate.

In the event that Health Net Dental denies a request by a member for a second opinion, Health Net Dental will notify the member in writing of the reasons for the denial and inform the member of the right to file a grievance with Health Net Dental.

Referral Follow-Up

Approved specialty referrals are followed by the PCD to evaluate the need for follow-up treatment. Denied specialty referrals, the PCD must evaluate and schedule the appropriate treatment directly.

Case Management

Case management involves the timely coordination of dental and health care services, to meet a member's specific needs in a cost-effective manner that ensures continuity and quality of care, and promotes positive outcomes. Case Management also promotes the coordination of communication between medical providers and dental providers, to ensure that dental treatments do not interfere with medical treatment. The Specialty Referral/Claims Coordinator oversees members with multiple or complex dental and medical problems that need to be coordinated between medical HMO's and/or hospitals and dental providers.

Emergency Dental Care

Emergency dental care is:

> A dental screening, examination, evaluation by a dentist or dental specialist to determine if an emergency dental condition exists, and to provide care that would be acknowledged as within professionally recognized standards of care and in order to alleviate any emergency symptoms within the capability of the facility.

Emergency Condition

Emergency dental condition is:

> A dental condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that absence of immediate attention could reasonably be expected to result in any of the following:
>
> Placing the member's health in serious jeopardy
>
> Serious impairment to bodily function
>
> Serious dysfunction of any bodily organ or part

During regular office hours, providers must render emergency treatment. After hours, providers must make available to members the after-hours emergency care telephone number.

Out of Area Emergency Care

Members can obtain emergency treatment outside the coverage area by contacting any dentist in that area. Such treatment provided to the member must be directly related to treatment of the emergency condition.

> Providers outside of Health Net Dental's coverage area that provide emergency treatment will be paid by Health Net Dental on a Medi-Cal fee-for-service basis, when such claims include documentation that verifies the emergency. Health Net Dental is responsible for the cost of emergency treatment only.

Claims Processing

To ensure timely processing of claims, specialists must submit completed claim forms, including all pertinent information, to Health Net Dental after rendering treatment to a LAPHP Medi-Cal Program or Healthy Families members.

For out of area emergency services submit a standard claim form along with all pertinent information and an explanation of the emergency which prevented the member from receiving treatment from his or her PCD or obtaining prior authorization to receive the services from a panel specialist.

A notice is sent to the provider for claims that are denied and includes the reason(s) for denial and information about the provider's appeal rights.

Quality Management and Improvement Program

Program Description

Health Net Dental's Quality Management and Improvement (QMI) program is organized to ensure that the quality of care provided is being reviewed by dentists, quality of care problems are identified and corrected, and follow-up is planned when indicated. The QMI program addresses essential elements including quality of care, accessibility, availability, and continuity of care. The provision and utilization of services are closely monitored to ensure professionally recognized standards of care are met.

Policy

The purpose of Health Net Dental's QMI program is to ensure the highest quality, cost effective dental care is available to members, with an emphasis on dental prevention and the provision of exceptional customer service.

Scope

The scope of the QMI program activities includes continuous monitoring and evaluation of primary and specialty dental care provided throughout the dental network. In addition, the scope includes systematic processes for evaluating and monitoring all clinical and non-clinical aspects of dental care delivery.

Goals and Objectives

The Health Net Dental QMI program goals and objectives are comprehensive and support the overall organizational goal of providing the highest quality dental care to Health Net members in a cost effective manner. The QMI program focuses on a proactive problem solving and continuous monitoring and improvement approach to ensure access to quality dental care. The process includes:

- Standards and criteria development
- Problem and trend identification and assessment
- Development and implementation of quality improvement studies, performance, measure monitoring and member/provider surveys
- Credentialing and recredentialing of providers
- Monitoring of staff and provider performance
- Infection control monitoring
- Facility review audits
- Dental chart audits
- Utilization management and monitoring of over- and under-utilization
- Monitoring of member and provider grievance/appeals and follow-up
- Disenrollment, enrollment, and PCD transfer request tracking
- Provider/member education
- Staff orientation
- Corrective action plan development, implementation and monitoring effectiveness, including disciplinary actions and terminations of a provider for serious quality deficiencies and reporting the same to the appropriate authorities
- Complying with 805 reporting requirements for the Dental Board of California
- Other QMI program activities identified during monitoring process

The QMI program is comprised of the Dental Utilization Management/Quality Management and Peer Review Committees. These committees report to the State Health Programs Utilization Management/Quality Improvement Committee that reports to the Health Net Quality Committee. The Health Net Quality Committee reports to Health Nets Board of Directors.

Utilization Management/Quality Management Committee

The Utilization Management/Quality Management Committee reviews provider office quality assessment data, accessibility survey data, utilization data and provider related information. The Committee makes recommendations for development or changes in policies and procedures .The Committee reviews utilization data to determine norms, trends and practice patterns. In addition, the Committee recommends development of plan designs based on utilization patterns by monitoring and evaluating the following indicators:

- Access to care
- Availability of appointment
- Continuity of care
- Credentialing/re-credentialing of providers
- Outcome of care

Appeals and Grievance Process

Health Net Dental member appeal and grievance process encompasses investigation, review, and resolution of member issues to the plan and/or contracting providers. Members can submit a grievance via telephone, fax, e-mail, letter, or grievance form. Health Net Dental provides members whose primary language is not English with translation services. The plan currently provides translation services in 150 languages. Grievance forms can be obtained from Health Net Dental's Member Service Department, from a dental provider facility, or the plan's Web site. All contracting provider facilities are required to display member complaint forms. All member quality of care grievances, benefit complaints, and appeals are received and processed by the plan

In order to provide excellent service to our members, Health Net Dental maintains a process by which members can obtain timely resolution to their inquiries and complaints. This process allows for:

1. The receipt of correspondence from members, in writing or by telephone
2. Thorough research
3. Member education on plan provisions
4. Timely resolution

Health Net Dental resolves all complaints within 30 days of receipt. The Grievance Analyst mails notifications of the receipt of the grievance to the member and provider within five business days.

The Grievance Committee reviews member and provider disputes related to the plan, provider, or member. The Grievance Committee is responsible for hearing and resolving grievances by monitoring patterns or trends in order to formulate policy changes and generate recommendations as needed.

Appeals Process

Both provider and members may appeal any resolutions made by Health Net Dental. The request for appeal must be in writing and received by Health Net Dental within 45 days of receipt of the resolution. The Grievance Analyst will compile all the information used in the initial determination and any additional information received and forward to the Committee. Health Net Dental members determining a member's appeal must have no prior involvement in the decision and no vested interest in the case.

Standards and Guidelines

Access and Availability

Health Net Dental understands that high quality dental care is dependent, in part, on the ability of both the PCD and specialists to see patients promptly when they need care, and to spend sufficient amount of time with each patients. Member access and availability to dental care is monitored to ensure that members can:

- Select any network provider and obtain an initial, routine and hygiene appointment within three weeks of the request
- Obtain emergency services 24 hours a day and 7 seven days a week
- Be seen within thirty minutes by a PCD or specialty provider at a scheduled appointment

Access: Appointment Availability

1) Appointments must scheduled within Health Net Dental's Access Standards for appointment availability, which are as follows:
   a) Three weeks for an initial non-emergency appointment with a dentist
   b) Three weeks for a routine non-emergency appointment with a dentist
   c) Three weeks for appointments for dental hygiene appointments
   d) 24-hour availability for emergency care

Access to Specialists

Members with specialty care referral benefits are referred to network specialists within 25 miles of a member's residence. Health Net Dental tracks all referrals and payment to specialists.

Provider Access Surveys

Health Net Dental conducts quarterly random PCD office visits to access availability of appointments.

Member Satisfaction Surveys

Surveys can be generated to members in response to trending information or reports or potential access problems with specific dental offices.

Grievance System

Health Net Dental reports the summary of the quarterly findings of access issues reports by member's grievances or member transfers to alternate facilities.

Corrective Action

Negative findings resulting from the above activities may trigger further investigation of the provider facility by the Dental Director or designee. If an access to care problem is identified, corrective action will be taken including, but not limited to the following:

- Additional education and assistance to the provider.
- Provider counseling
- Closed to new membership enrollment
- Transfer of members to another provider
- Contract termination

Investigation results from subcommittees must be reported to Dental Utilization Management/Quality Improvement Committee.

Continuity and Coordination of Care

Health Net Dental ensures appropriate and timely continuity and coordination of care for all members.

A panel of network dentists are available in currently assigned counties from which members may select a provider to coordinate all of their dental care. All care rendered to Health Net members must be properly documented in the dental charts according to established documentation standards. Communication between the PCD and dental specialist occurs when members are referred for specialty dental care. Health Net Dental ensures that:

- An enrollment packet is provided to member upon enrollment and contains a lists of PCDs
- A current list of PCDs is maintained on the plans Web site
- Members that do not select a PCD are assigned a PCD within 30 days of enrollment, based on the member's geographic location
- A reminder postcard is sent 10 days after assignment of the member's PCD
- Dental chart documentation standards are included in the *Medi-Cal and Healthy Families Dental Provider Operations Manual*
- Dental chart audits verify compliance to documentation standards
- Guidelines for adequate communications between the referring and receiving providers when members are referred for specialty dental care is included in the *Medi-Cal and Healthy Families Dental Provider Operations Manual*
- Compliance with continuity and coordination of care standards is monitored during onsite facility audits
- When a referral to a specialist is authorized, the PCD evaluates the need for follow-up care after specialty services have been rendered and schedules the member for any appropriate follow-up care
- When a specialty referral is denied, the PCD evaluates the need to perform the services directly, and schedule the member for appropriate treatment

The results of onsite audits are reported to the Utilization Management/Quality Improvement Committee, and corrective action is implemented when deficiencies are identified.

Provider Credentialing and Recredentialing

A copy of the following information is provided and/or verified:

- Current state dental license for each participating dentist
- Current DEA license (except for orthodontists)
- Current evidence of malpractice insurance for at least $300,000 per incident and $600,000 aggregates for each participating dentist
- Current certificate of a recognized training residency program with completion (for specialists)
- Current permit of general anesthesia or conscious oral sedation, if administered, for the appropriate dentist
- Immediate notification of any professional liability claims, suits, or disciplinary actions
- Verification by California Dental Board and National Practitioner Data Bank

All provider credentials are continually monitored and updated on an on-going basis. Providers will receive notification of license/credential expiration from Health Net Dental, 30 – 60 days prior to expiration to allow time to submit current copies.

For all accepted providers, the local Provider Relations Representative presents a provider orientation within 30 days after activation at which time the provider receives a copy of the Health Net Dental Medi-Cal and Healthy Families Dental Provider Manual. The telephone number of the Health Net Operations Manager who coordinates with Health Net's Chief Dental Officer is provided to resolve any issues for the new provider.

Health Net Dental maintains two separate and distinct files for each provider. The first is the provider's quality improvement file, which is maintained with restricted access by the Quality Management Department. This file includes confidential credentialing information. The second file is the provider's facility file that is maintained by the Provider Relations Department, which also includes audit results. The latter contains copies of signed agreements, addenda, and related business correspondence. Within the first year of provider activation, Health Net Dental conducts the first periodic audit of the new office. This periodic audit includes facility and chart reviews.

The latter is based on a sample of assigned member's dental charts at the provider's office. For offices with no or very low assigned membership at that time, Health Net Dental may alternatively conduct a review of chart forms and charting procedures along with a facility review or postpone such a review until patient volume warrants such activity. Facilities that pass their periodic audit are scheduled for their next periodic audit.

Credentials and Calibration of Auditors

All consultants will be licensed dentists in California with credentials based on the same guidelines as general dental providers. Auditors will have current CADP certification, or be scheduled for CADP certification.

The objectives of calibration of general dental auditors are:

- To provide a review of quality of care guidelines
- To assess criteria and auditing methodology
- To verify inter-auditor and intra-auditor consistency in the review of treatment records
- To review the effectiveness of correction action plans

Compliance with Section 805

Purpose

In accordance with Californian Business Professions and Codes, Section 805 Reporting, it is the intent of Health Net Dental to establish a process that provides hearing and appellate review procedures of decisions that adversely affect dentists who contract with Health Net Dental.

> Section 805(a)(6) defines "medical disciplinary cause or reason" as that aspect of a licentiate's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care".

It is further the intent to establish flexible procedures, which do not create burdens that will discourage Health Net Dental or its Governing Board of Directors from carrying out peer review.

The Peer Review Committee will be responsible for collecting information from the Quality Management Committee, Provider Relation and the Appeals and Grievance department to identify the provider deficiency, evaluate if any the chronic emergent pattern relating to continuity and quality of care. Additionally, the Peer Review Committee will evaluate the Dental Director's decision.

Fair Procedure Process

The Fair Procedure Process is used when a provider is terminated with cause from the plan for repeat deficiency standards recognized as being contractual (e.g., charting documentation, optional treatment or other contractual deficiencies as listed in the Fair Procedure Process Criteria Guidelines).

The Fair Hearing Plan is used when a provider is terminated from the plan for medical cause or disciplinary reason that rises to the level of a Section 805 for failure to provide dental services that do not meet professionally recognized standards of quality of care.

The Health Net Dental Director reviews providers recommended for termination with cause. The Dental Director makes a determination whether to implement the Fair Procedure Process or the Fair Hearing Plan using the significant serious quality of care criteria and guidelines as listed in the revised Quality Management Guidelines and Standards. The Dental Director presents his findings and recommendations to the Peer Review Committee for review.

The Peer Review Committee reviews the findings and arrives at a recommendation if the provider agreement shall be terminated with cause and the format of the fair hearing to be offered the provider.

The recommendations of the Peer Review Committee are communicated to the provider and the Quality Management Committee. If the Peer Review Committee upholds the Dental Director's recommendation, the provider will be informed of the fair hearing process and applicable appellate review based on the Committee's recommended decision.

Definition of Detrimental

The definition of detrimental is:

- Injury or damage to ones health
- A cause of injury or damage and undesirable
- Exceedingly harmful
- Highly injurious or destructive

Anti-Fraud and Abuse

The purpose of Health Net Dental's Anti-Fraud Program is to effectively accomplish a review of activities of Health Net Dental and its' participating providers, subscribers and members to identify or detect and investigate incidents involving suspected fraudulent activity and to resolve incidents involving suspected fraudulent activity, including referrals to appropriate government agencies for prosecution.

Preventive Care Guidelines – Dental Health Education Program

Health Net Dental seeks to improve the oral health of its members by fostering good oral health preventive practices and thereby minimizing the need for more invasive, less conservative treatment. It is the policy of Health Net Dental to assist members in receiving preventive care services by providing a benefit for professionally recognized effective preventive services. Health Net Dental provides benefits for many preventive procedures when appropriate, subject to plan limitations. Check member plan information for specific coverage information, exclusions and limitations. Health Net Dental also provides supplemental payments for most preventative procedures. Payment is based on submitted encounter data. It is also the policy of Health Net Dental to inform members how to access services.

Health Net Dental provides for the following Clinical Care Guidelines designed for infants, children, adolescents, adults and older adults, and addresses prenatal educational efforts whenever appropriate:

Examinations

Contracting dentists are encouraged to provide periodic examination to identify dental concerns as early as possible to keep intervention as conservative as possible. Providers are encouraged to render a regular recall system to facilitate this early diagnosis and prevention. Health Net Dental recommends periodic examinations every six months.

Routine Prophylaxis

Providers are encouraged to render routine prophylaxis services in accordance with the definitions in the ADA's Current Dental Terminology. Providers should make decisions about the appropriateness of routine prophylaxis after screening or evaluating the periodontal status of the member. Health Net Dental recommends routine prophylaxis in conjunction with the periodic examination be established on a patient by patient basis taking into account the patients age, oral hygiene and dental condition and other pertinent factors.

Caries Prevention

Contracting dentists are encouraged to provide a comprehensive program of plaque control geared to the member's susceptibility to caries.

Contracting dentists are encouraged to provide recommendations for the use of systemic fluoride, fluoride toothpaste, and/or use of topical fluoride gels or rinses where indicated. Health Net Dental provides benefit for the topical application of fluoride, when appropriate.

Contracting dentists are encouraged to provide recommendations of sealants and treatment plans including sealants where there is evidence of potential pit and fissure caries in an otherwise healthy, non-filled tooth. Health Net Dental provides benefit for the placement of sealants, when appropriate, subject to Medi-Cal and Healthy Families dental criteria.

Periodontal Disease Prevention

Contracting dentists are encouraged to provide a comprehensive program of plaque control including, plaque removal to aid the member in maintaining a definitive, effective home care regimen. Other procedures, such as prophylaxis, dental health education, occlusal evaluation, correcting malocclusions and mal-posed teeth, restoring broken down and deformed teeth, and requiring the patient to practice thorough plaque control, are also encouraged by contracted dentists, as an integral part of periodontal disease prevention. Contracting dentists are encouraged to provide and document definitive evidence of plaque control instruction, evaluation, and follow-up occurring at member encounters. Contracting dentists are also encouraged to include supra-gingival and sub-gingival calculus removal as part of periodontal disease prevention and treatment.

Prevention of Other Oral Diseases and Diagnosis and Evaluation, of Oral Manifestation of Systemic Conditions

Recognition of potentially harmful tissue changes are the responsibility of the dental practitioner.

Other Preventive Concerns

Health Net Dental's Clinical Criteria and Guidelines include particular concern to preserving the primary teeth for masticating function and space maintenance, utilizing such procedures as pulpal therapy and stainless steel crowns. Prenatal nutritional supplements, counseling and education of expectant mothers and other family members to reduce the incidence of baby bottle tooth decay and to encourage proper dental examination and treatment of the infant is encouraged. It is appropriate for infants to have their first dental examination at age 1 – 3 years of age, in accordance with California Society of Pediatric Dentist's recommendations.

Health Net Dental provides benefit to preserve adequate space for the eruption of the permanent dentition. Space maintainers should be employed judiciously, with particular preference for fixed appliances, as deemed necessary and appropriate by contracting dentists.

Providers are encouraged to be familiar with adolescent dental health issues such as orthodontic malocclusion detection and treatment, periodontal concerns at this age group, and pre-eruption of third molars.

The dental needs of older adults, including periodontal concerns, partial or complete edentulism, root surface caries, and xerostomia should be evaluated and treated whenever appropriate.

Frequency of On-Site Quality Assurance Reviews

On-site facility and chart reviews are conducted for each provider by qualified dental professionals at least once every three years. Providers that fail to sufficiently comply with the QMI Guidelines will be reviewed more often, or until such time that the provider sufficiently complies with the guidelines. The frequency of follow-up reviews is dependent upon the severity and quantity of outstanding deficiencies. Providers who continually fail to correct major outstanding deficiencies and achieve sufficient compliances are subject to the termination of their provider agreement with Health Net Dental.

The scope of the QMI program activities includes continuous monitoring and evaluation of primary and specialty dental care provided in all settings and service locations. In addition, the scope includes systematic processes for evaluating and monitoring all clinical and non-clinical aspects of dental care delivery. The QMI program covers both individual and institutional providers, all major specialty areas, and all major delegated entities as applicable.

The Dental Director and his staff are responsible for identifying and referring to the Utilization Management/Quality Improvement committee all potential quality issues (PQIs) recognized through member/provider services, member/provider grievance/appeals, pre-authorization of specialty referrals and/or case management of complex and special needs cases. In addition, PQI's are identified through a review of aggregate quality and utilization data, including results of facility review and chart audits. Potential quality issues are tracked and trended by individual provider and by issues, and tracking and trending information is integrated into the UM/QI program quality of care assessments.

PQIs are referred to the Utilization Management/Quality Improvement Committee through a formal referral process within established timeframes. In addition, any potential risk management issue is reported to legal counsel through a similar referral process. Processes for PQI and legal counsel referrals are included in Health Net Dental's policies and procedures. The following are examples of clinical and non-clinical areas that are monitored for potential quality issues:

Clinical

- Quality of dental care provided
- Under- and over-utilization of services
- Dental procedures performed according to standards
- Infection control

Non-Clinical

- Accessibility of care
- Availability of care
- Continuity of care

Any time a clinical quality of care issue is suspected, the case is referred to the Dental Director. The Dental Director makes a determination whether the PQI requires further investigation based on available information and his or her own dental expertise. The Dental Director takes into consideration the following:

- Specific quality of care issue
- Source of the issue
- Provider associated with the issue
- Severity of the Issue

  Severity of the issue is determined by the threshold of the provider deficiency that precipitates investigation and/or actions by the plan, including the right of the Dental Director to place a provider on probation for category one or category two issues. Thresholds are classified into three categories, each reflecting a different level of severity and warranting a different corrective action plan (CAP).

  - **Category One** is a confirmed quality issue (deficiency) that does not jeopardize a member's health. Providers with these issues are place on probation by the Dental Director and must immediately correct the issue within 48 hours of identification.
  - **Category Two** is a confirmed quality issue (deficiency) that does not cause immediate harm to the health of a member. Providers with these issues are placed on probation and must correct the issue within 30 days of identification.
  - **Category Three** is a minor quality issue (deficiency) that does not pertain to the direct delivery of care. Providers with these issues are notified of the type of correction that needs to take place and are re-evaluated during the next annual evaluation.
- Referral to the Peer review Committee and/or the Utilization Management/Quality Improvement Committee as necessary
- Corrective action recommended (if indicated, the corrective action must be specific)
- Time frame for follow-up

If a potential problem is confirmed, the issue is referred to the Peer Review Committee for discussion and determination. If the Peer Review Committee determines quality issue does exist, corrective action is implemented based on the Committee's recommendation. This may include further investigation through focused review of studies, education to the provider or disciplinary actions. A quarterly report of issues identified, investigated, corrective actions implemented and follow-up actions being undertaken is submitted to the Quality Management Committee by the Peer Review Committee.

If an adverse determination is rendered, the Utilization Management/Quality Improvement Committee is notified of the circumstances surrounding the quality issue along with Peer Review Committee's determination and rationale. If the recommendation is to terminate the provider, the Utilization Management/Quality Improvement Committee notifies Health Net Dental's Chief Dental Officer who reports the recommendation to the Health Net, Inc. Programs Utilization Management/Quality Improvement Committee before proceeding with termination. Providers have the right to appeal adverse quality determinations.

In accordance with the California Business Professions and Codes, Section 805 Reporting, the plan has established a process that provides hearing and appellate review procedures of decisions procedures which do not create burdens that will discourage the plan or its Board of Directors from carrying out peer review.

Closure on Outstanding Quality Assurance Deficiencies

Providers who are found to have Category One through Category Three deficiencies will be given the opportunity and assistance to correct those deficiencies. The number of opportunities allowed for a provider to achieve a satisfactory level of compliance (e.g., the number of times follow-up reviews will be conducted for a provider) depends on the severity of the deficiencies and the degree of progress a provider shows with correcting outstanding deficiencies.

Process for Handling and Recording Dental Records

Health Net Dental has established and implemented strict guidelines concerning dental records maintenance in accordance to California Dental Practice Act. All participating providers are required and have agreed to comply with the plan's established guidelines for dental records maintenance. Provider compliance with the guidelines is routinely evaluated during chart audits.

Health Net Dental applies its current Confidentiality Policies and Procedures for handling and recording of all dental records. Health Net Dental maintains confidentiality and conflict of interest policies that meet state and federal statutes, and monitors staff and provider compliance with these policies.

Health Net Dental complies with the Health Insurance Portability and Accountability Act (HIPAA) regulations, and maintains a HIPAA manual of policies and procedures, staff training materials, notices to members and providers, and forms for providing consent for disclosure of protected information. All staff members receive training on HIPAA regulations. Members are educated regarding their rights pertaining to disclosure of protected information.

All participating and non-participating providers involved with the Utilization Management/Quality Improvement program, and Utilization Management/Quality Improvement Committees are required to review the plan's Confidential and Conflict of Interest policies and procedures, and sign a Confidentiality/Conflict of Interest Agreement form, prior to participating in the Quality Improvement activities.

Health Net Dental maintains copies of all minutes, reports and other data in a manner that ensures confidentiality of member or providers in any case.

Access to confidential reports and records is restricted to Utilization Management/Quality Improvement committee members and other personnel involved in Quality Improvement program and Quality Management activities. All sensitive information, such as patient dental charts and Utilization Management/Quality Improvement committee reports, are maintained in locked files.

When confidential information is no longer needed, it is shredded and disposed of in an appropriate manner to maintain privacy at all times.

Dental records are requested from the provider by the Dental Director or designee. Any requested dental record is recorded and tracked to completion by the Dental Director.

Dental records may be requested for the following reasons:

- Routine chart reviews/quality reviews
- Member complaint or grievance
- To assist a provider in applying appropriate member co-payments
- To assist a member in understanding recommended treatment and co-payments

All dental records are filed and locked for confidentiality purposes. Any dental record not kept as permanent record by Health Net Dental is destroyed and disposed of.

Chart Review Findings

The chart review will be based, whenever possible, on a minimum of 10 randomly selected charts (by Health Net Dental plan's auditor). The chart review findings will be reported as satisfactory or unsatisfactory for each category in the Audit Form. Results totaling more than 30% unsatisfactory for a single category will result in a written deficiency item response in the audit review letter sent to the provider If there are less than 10 chart findings for a single category, the 30% level will still apply.

All items marked unsatisfactory will be discussed at the exit interview. If there is a single gross deficiency, the auditor has the ability to classify the specific category, as deficient and a short narrative must be provided describing the deficiency.

Records Review

Health Net Dental has established guidelines for the delivery of dental care to members. All providers are expected to render dental care in accordance with community standards. The guidelines are listed below and followed by a form for use when evaluating a patient record.

Chart Selection

A minimum of 10 randomly selected patient charts are reviewed.

Elements of Record Review

The following criteria applies:

- Member identification must be on each page; personal/geographical data in the record
- Member's preferred language (if other than English) must be prominently noted in the record, as well as the request or refusal of language/interpretation services
- All entries must be dated and author identified; for member visits, the entries include at a minimum, the subjective complaints, the objective findings, and the plan for diagnosis and treatment as follows:
  - The record must contain a problem list, a complete record of preventive services rendered
  - Allergies and adverse reactions must be prominently noted in the record
  - All informed consents must be documented
  - All emergency care provided by the PCD directly, another contracting provider or non-contracting provider must be documented
  - Consultations, referrals, specialists' reports must be documented
  - Dental health education and referrals to dental health education services must be documented
  - Informed consent-should be comprehensive
    - Comprehensive consent is the provision of sufficient information regarding benefits and risks of treatment or non-treatment for specific conditions. This form must be sufficient to allow the member to make an informed decision. Comprehensive consent is required for all treatment and treatment recommendations.

1) Health History

   Comprehensive health history forms are used for every member. The health history form must include, at minimum, the following information:

   a) Present health status

   b) Dental history/problems. Also include dentists name and telephone number

   c) Systemic disease, such as:

      i) Cardiac diseases

      ii) History of rheumatic fever, prosthetic valves, pacemaker

      iii) History of prosthetic joints

      iv) Diabetes

      v) Hepatitis

      vi) Viral diseases

      vii) Venereal diseases

      viii) HIV status/AIDS

d) Allergies and sensitivity to medications or to dental anesthetics/latex gloves and products

e) Name of medical physician and telephone number

f) Bleeding disorder, hemophilia

g) Nervous disorder; epilepsy, seizures

h) Pregnancy status

i) History of substance abuse

j) Present medical treatment/medications

k) Family health history

l) Most current series of radiographs

m) History of Phen-fen use

2) Evaluation process

a) All questions on the history forms must be completed by each member

b) The questions should be in yes or no format

c) The patient initials or signs and dates the health history at the initial exam, and all subsequent updates

d) The doctor initials and dates the health history at the initial examination and all subsequent updates

e) There is written evidence of follow-up by the doctor for patients with significant positive medical findings

f) Medical alerts are prominently displayed on the treatment record, for every patient with significant medical problems. Confidentiality must always be maintained

g) The medical history is updated by both the patient and the doctor at appropriate recall visits

3) Intra-oral examination

Dental chart records the following information:

a) Dental caries

b) Defective restorations

c) Presence of removable prosthetics or appliances

d) Endodontic pathology

e) Soft tissue exam findings

f) Documentation of missing teeth

g) Periodontal evaluation, including pocket probing when indicated

h) Hard and soft tissue pathology

4) Radiographs: The following criteria applies:

a) The provider examines the patient before ordering radiographs at the initial examination.

b) The quality and quantity of radiographs taken, based on the needs of the patient, are sufficient for proper diagnosis and treatment planning. All teeth having root canal therapy have a periapical radiograph.

c) Radiographs are identified and dated. Current series are mounted. Original or baseline series are also mounted

d) Non-diagnostic radiographs, which are necessary to complete the diagnosis, should be retaken. Original radiographs should be maintained in the patient chart, and only radiograph copies mailed out of the office.

e) Refusal of radiographs by the patient is documented and the refusal should be signed by the patient.

f) Frequency of radiographs, for both adults and children, is in accordance with ADA recommendations and patients needs.

5) Diagnosis

a) Caries and defects in existing restorations should always be diagnosed carefully to avoid both over and under treatment.

b) Periodontal measurements is made as part of the periodontal diagnosis and documented in the treatment records.

c) Possible pathologic areas is noted.

6) Treatment Plans

a) Treatment plans are consistent with the findings of the clinical examination and diagnosis and include necessary treatment such as caries removal, treatment of periodontal disease, extraction, or root canal therapy.

b) Services such as replacement of missing teeth is listed; as well as alternative treatment plans.

c) Consultations and referrals should be indicated and documented when appropriate.

7) Treatment Sequencing: Treatment is prioritized and rendered in a logical treatment sequence as outlined in the following Dental Care Priority System

a) Very urgent - (functional and social disability)

i) Pain and acute infection

ii) Suspect cancer

iii) Caries into or near the pulp

iv) Teeth requiring extraction

v) Disfiguring conditions - (e.g., missing or badly decayed anterior teeth)

b) Moderately urgent (those conditions requiring care in the near future)

i) Chronic or subacute periodontal conditions

ii) Heavy calculus deposits

iii) Extensive penetration of caries into dentin

iv) Sufficient missing posterior teeth to require replacement - fewer than eight opposing posterior teeth present

v) Space maintenance for children

vi) Replacement of ill-fitting prosthetic appliances

c) Non-urgent (those conditions requiring care, but may be postponed for a period)

i) Periodontal surgery

ii) Beginning caries

iii) Replacement of missing teeth (where fewer than required for B4 priorities above

iv) Inlays or crowns on teeth previously restored with large amalgams, composites, or stainless-steel crowns

d) Maintenance (no special conditions requiring remedial treatment) patients placed on routine prophylaxis and recall care.

8) Preventive Procedures: Preventive procedures include:

a) Periodic prophylaxis and oral hygiene instructions (brushing, flossing, plaque control).

b) Removal of soft and calcified plaque (supragingival and subgingival calculus).

c) Fluoride treatment (systemic, professional or home topical application).

d) Sealants

e) Filings

9) Treatment Quality: Radiographs are used to evaluate treatment quality of:

a) Crowns and fixed bridges

b) Endodontics

c) Periodontics (removal of calculus)

d) Oral surgery

Treatment quality is evaluated relative to contour and marginal integrity of restorations, completeness of procedures rendered, and longevity (prognosis).

10) Progress Notes: Doctor's progress notes include the following:

a) Record entries and treatment progress notes are legible and comprehensive

b) Amount and type of anesthetic used if any, or if no anesthetic was used

c) Medications given or prescribed with strength, dosage, quantity, and instructions for use.

d) Description of treatment rendered on date of appointment such as prophy, oral hygiene instructions, fillings, bases, etc.

e) Refusal of recommended treatment.

f) Signature of treating dentist at the completion of progress notes.

11) Continuity and Coordination of Care

a) The treatment record shows evidence that the initial treatment was completed or have documentation indicating why the treatment was not completed.

b) The treatment is timely and efficient.

c) Recall and next visit appointments are documented in the treatment record.

d) Follow-up of broken or missed appointments are documented in the treatment record.

e) Specialty referral is documented in the treatment record and followed through, when indicated.

12) Case Management

a) Overall treatment indicates improvement in the health status of the member.

b) Risk status assessment of the oral health demonstrates an improvement from high to low risk over an extended period of treatment.

Facility Review Guidelines

1. Personal Protective Equipment (Infection Control and Occupation Safety and Health Association (OSHA) Requirements)
    a. Treatment Gloves: When treating patients, gloves must be worn by all treating dental personnel including all dentists, dental hygienist, dental assistants and X-ray technicians. Sterile gloves are worn in connection with surgical procedures involving soft tissue or bone. Gloves used for patient care are not to be reused. Wearing gloves in the business office or performing duties out of the operatory is inappropriate.
2. Changing Gloves
    a. Gloves must be changed after treatment of each patient or before leaving the operatory. In preparation for surgical procedures and prior to putting on new gloves, anti-microbial soap is used to wash hands. After each patient, hands are washed after removing and discarding gloves. Gloves are not to be washed before or after treatment and are not re-used. Jewelry should not be worn under gloves.
3. Masks and Shields
    a. When treating patients, surgical facemasks are to be worn by all treating personnel. Safety glasses chin length plastic face shields, or other protective eye wear is worn by all treating personnel when there is a potential for aerosol, spray or other airborne contamination risk. After treating each patient, masks are changed if moist or contaminated. Face shields are cleaned and disinfected if contaminated.
4. Operatories
    a. Operatories are disinfected after each use. Counter tops and dental units are cleaned with disposable towels followed by an intermediate level disinfectant. This may be accomplished by spray disinfections using such materials as iodophor, glutaraldehyde, or diluted bleach according to manufacturer's recommendations for disinfections. Low-level disinfectants are used for visibly soiled areas such as floors, walls, and other housekeeping surfaces.
5. Disinfectants
    a. Only approved disinfectants of appropriate strength will be utilized following manufacturer's recommendations. Classes of disinfectant used in dental offices include:
        i. High-level disinfectant can kill some bacterial spores, mycobacterium tuberculosis var bovis as well as bacteria, fungi, and viruses
        ii. Intermediate level disinfectants can kill mycobacterium tuberculosis var bovis and therefore, less resistant pathogens such as Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV).
        iii. Low-level disinfectants do not kill mycobacterium tuberculosis var bovis or bacterial spores, and their use is restricted to housekeeping surfaces.
6. Disposable and Barriers
    a. Use of barrier techniques including the use of plastic drapes and wraps, are removed, discarded and replaced between patients.
7. Hand Pieces Flushed after Use
    a. All high-speed hand pieces are flushed with air and water for 30 seconds into an appropriate receptacle. All dental unit water lines are equipped with anti-retraction (one-way) valves. At the beginning of each workday (prior to the attachment of hand pieces, ultrasonic scalers, or other devices), dental unit lines are purged with air or water for at least two minutes.
8. Cold Sterile Solution
    a. A record of cold sterile solution changes should be maintained and be available for review. Manufacturer's Recommendations: Disinfection solutions should be changed regularly according to

manufacturer's recommendations. Consideration should be given to volume usage when establishing change schedule. Logs should be maintained of these changes.

9) Decontamination Before Sterilization

   a) All contaminated instruments are decontaminated prior to sterilization. This may be accomplished by soaking, use of ultrasonic equipment, or washing contaminated instruments or reusable sharps in tuberculocidal disinfectant (an intermediate level or high level disinfecting solution) with a long handle brush and nitrile gloves.

10) Sterilization of Instruments

   a) All critical instruments (used to penetrate soft tissue or bone) or semi-critical instruments (not used to penetrate, but contact oral tissues) must be sterilized in a prescribed manner. For sterilization of heat-sensitive critical items, EPA-registered sterilants are used according to manufacturer's recommendations for sterilization. Sterilized instruments must be left in the cold sterile solution for at least 10 hours. Cold sterile solutions are changed after every 100 patient uses or bi-weekly, whichever comes first. All high-speed dental hand pieces, components of low speed hand pieces that are used intra-orally, and heat stable critical and semi-critical instruments and re-usable sharps are sterilized by:

      i) Autoclaving (steam under pressure)

      ii) Chemclaving (chemical vapor under pressure)

      iii) Dry heat

11) Monitoring Sterilization Cycle and Equipment

   a) For each sterilizer in the office, proper functioning of the sterilization cycle is verified by means of spore testing, which is complete weekly at minimum. Current laboratory verification must be available on the premises for review by the dental consultant. Regardless of how often a sterilizer is used, spore testing must be performed on a weekly basis.

12) Packaging and Storage of Instruments

   a) All critical and semi critical instruments, hand pieces, endodontic files, orthodontic pliers and lathe attachments are packaged or bagged before sterilization and remain packaged or bagged until ready for use. Bags or packages that are open, torn or otherwise not intact should be removed from storage, re-bagged, and sterilized again. Sterilized packages should be stored in dry, enclosed, low dust areas away from water and heat sources. Handling of sterilized packages should be kept to a minimum. Any package found to be open or torn shou1d be re-bagged and resterilized. There are special bags made specifically for dry heat sterilizers.

13) Sharps Containers

   a) Disposable needles, syringes, scalpel blades, burs, endodontic files and/or other sharp items and instruments are placed into puncture resistant sharps containers for disposal. Recapping of contaminated sharps should be avoided unless the scooping technique or a mechanical device is used to hold the needle sheath and/or eliminate the need for two-handed capping.

   b) Appropriate sharps containers are located in each operatory or in an acceptable alternative location that is near to the area of use to limit potential hazard of moving contaminated sharps.

14) Laboratory

   a) Laboratory materials including pumice wheels, splash shields, and trays are disinfected or sterilized between uses. Pumice, tray liners, and other disposables are removed, discarded, and replaced between uses. Dental impressions, bite registrations, prosthetic and orthodontic appliances are cleaned and disinfected with an intermediate level disinfectant before manipulation in the office laboratory or sending to an outside dental laboratory. Appliances are disinfected prior to placement in the patient's mouth.

15) Periodontal surgeries are performed only with a sterile water source.

Administrative

1) Hepatitis B Vaccinations
    a) Dentists: All dentists in the practice should be vaccinated for Hepatitis B or offered the series of vaccinations at the expense of the dentist/owner. A provider who has incorporated his or her practice must have vaccination records as well.
    b) Hygienists: All hygienists in the practice should be vaccinated for Hepatitis B or offered the series of vaccinations at the expense of the dentist/owner.
    c) Assistants: All dental assistants in the practice should be vaccinated for Hepatitis B or offered the series of vaccinations at the expense of the dentist/owner.
    d) Technicians: All radiographic and sterilization technicians in the practice should be vaccinated for Hepatitis B or offered the series of vaccinations at the expense of the dentist/owner.
    e) Refusals: If any of the above personnel declines the vaccination, there should be:
        i) A record of education regarding the risks of Hepatitis B exposure
        ii) A written and signed record of such refusal, even if a record or report is provided to attest that there is sufficient blood titer to negate the need for such vaccination.
2) Professional Licenses:
    a) Licenses for all dentists, hygienists, registered dental assistants, and X-ray technicians should be displayed or available for inspection upon request
    b) Identification of Licensed Personnel
    c) The California State Board of Dental Examiners requires the visible posting of pocket licenses or the visible posting of names and degrees of all licensed personnel and the use of name tags by licensed personnel.
3) Training Programs Subjects and Documentation
    a) Documentation of training programs for dental office personnel should be available for inspection. This training should be reported annually, when the job parameters change and when employment has just been initiated. Records of such training programs should be kept in an organized manner and available for inspection. This should include documentation regarding:
        i) Education in work practices
        ii) Housekeeping and disinfection
        iii) Sterilization procedures
        iv) Use of personnel protection equipment
        v) OSHA programs (including an Exposure Control Plan and Injury, Illness, and Prevention Program)
        vi) Universal Precautions
            (1) Universal precautions refer to an approach to infection control according to which all Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), and other blood-borne pathogens
4) Recall System Present
    a) Demonstrated process to recall patients. Ideally, there should be a method to follow-up on non-responding patients with documentation in the progress notes
5) Specialty Referrals Tracking System
    a) Either a computer or a manual record to track patients who have been referred to specialists. This is particularly important for patients requiring evaluation of suspicious interiorly lesions.

6) After Hours Contact System

   a) Answering service contacts the doctor or an answering machine provides contact numbers to reach the doctor. Regular monitoring of the system is needed to verify it is working.

Radiographic Safety

1) Shielding Patients
    a) Patients are draped with lead aprons with thyroid collars when radiographs are exposed. However, lead aprons without thyroid shield can be used for panographic films if the use of a thyroid collar would alter the diagnostic quality.
2) Equipment Registration and Inspection
    a) Registration is verified by viewing a copy of the bi-annual bill from DHS and payment for each X-ray unit. The regulators determine the inspection period and will make unannounced visits. Retroactive fees will be charged for each unregistered unit in addition to penalties. DHS oversees all matters pertaining to X-ray units, with the exception of San Diego and Los Angeles counties. These two counties oversee themselves. Los Angeles County has additional requirements relative to new office construction.
3) Licensed Personnel
    a) All responsible for exposing radiographs should be certified by the California Department of Consumer Affairs.
4) Dentist Prior Assessment
    a) As cited in the Business and Professions Code *1684.5,* prior to the patient's exposure to radiation, a licensed dentist is required to assess each new patient's need for radiographs. A radiograph may be taken without the dentist's assessment only during an emergency appointment.
5) Caution X-ray Signs
    a) Signs must be posted next to all exposure switches. Appearance is not regulated.
6) Additional Documents
    a) The following additional documents are required by the Department of Health Services
        i) Radiation Safety poster must be posted in plain view
        ii) Radiation Safety Guidelines
        iii) CCRs must be maintained in the office

Occupational Hazard Controls

1) Amalgam Safety
    a) Pre-Measured Amalgam Capsules or Amalgam Spill Kit
        i) A mercury spill kit is available.
    b) Covered Amalgamators
        i) All amalgamators should be covered during use.
    c) Storage of Scrap Amalgam
        i) All scrap amalgam should be stored under a layer of liquid in a plastic jar with a tightly fitting lid. Suitable liquids include, but are not limited to, water, glycerin, or mineral oil. The commercial HgX system is also acceptable.
2) Nitrous Oxide Scavenging System
    a) If nitrous oxide is used in the practice, then the equipment must include a scavenging system. Disposable nasal hoods may not accommodate scavenger system hoses.
3) Secured Gas Tanks
    a) All non-portable oxygen and nitrous oxide tanks must be properly secured.

4) Secured Storage of Controlled Medications

   a) If controlled prescription medications (Class II) are stored in the dental office for dispensing to patients, such mediations should be kept in a locked cabinet with restricted access. Logs of dispensing and expiration dates should be available.

5) Prescription Pads

   a) Prescription pads should not be readily accessible to patients.

6) Venting for Chemclaves

   a) A chemclave should be properly vented in accordance with manufacturer's recommendations. Ideally, air sampling should be conducted to monitor employee's exposure to formaldehyde to establish a baseline. Contact Ca1OSHA Consulting Division for help.

7) Fire Extinguisher

   a) All dental offices should have at least one fully charged fire extinguisher and office personnel should be trained in its use. Maintenance dates should be monitored.

Medical Emergency Procedures

1) CPR Certification: Adequate office personnel should be certified in Cardiopulmonary Resuscitation (CPR).

2) CPR Masks or Ambu-Bags

   a) If both adults and children are treated in the practice, then both pediatric and adult CPR masks with one-way valves should be readily available. Given adequate training in their use, ambu-bags are an acceptable alternative

3) Emergency Oxygen

   a) All dental offices must be equipped to provide emergency oxygen with a portable oxygen tank that includes a pressure valve, facemask, and reservoir bag (or other means of delivering oxygen with positive pressure). The portable oxygen should be full. Office staff must be trained in the use and maintenance of the equipment.

4) Medication Kit

   a) All dental offices must be equipped with an emergency medication kit that is easily located by all staff. The medication kit should include at minimum, the items listed below:

      i) Preloaded, injectable epinephrine

      ii) Injectable Benadryl®

      iii) Nitroglycerine (Tablets or spray required. Dermal patches are unacceptable)

      iv) An inhaler containing an accepted beta agonist, such as albuterol (Ventolin®)

      v) Two Sugar sources (orange juice or non-diet soft drink)

      vi) Chewable aspirin (161 or *325* grain), preferably baby aspirin

   A log should be kept of emergency medications present with their expiration dates. The kit should not contain any expired medications. Dentists and assisting staff should be trained in the use of these medications. If a more extensive medication kit is present, all dentists and staff must know how and when to administer these additional emergency medications.

5) First Aid Kit

   a) A first aid kit should be available in case of minor injuries. NOTE: Any facility delivery of anesthesia or sedation must remain in compliance with the Dental Board of California standards.

6) Blood Pressure Cuff and Stethoscope or Automatic Monitor

a) Baseline blood pressures must be recorded in the presence of a history of high blood pressure, and preferably, recorded for all patients.

Written Policies and Procedures

Written policies and procedures, readily accessible to all office personnel, should be available for inspection. The following subjects should be covered by specific written policies:

1) Radiographic safety
2) Fire safety, disaster, earthquake and emergency preparedness and plan
3) OSHA Standards for Infection Control, Occupational Hazard Communication, and Exposure Control should be contained in an OSHA Manual
4) Medical emergency procedures
5) Use of emergency oxygen

Overall Facility Appearance and Maintenance

1) Parking area and external areas of the office is adequately maintained and free of obvious avoidable hazards.
2) There is adequate parking available, including handicapped parking.
3) The office is easily identified with the provider's name on the entry door.
4) The provider's waiting room provides adequate seating (four chairs per full-time dentist and/or hygienist).
5) Reception, waiting room, operatories, and other rooms are clean and adequately maintained so that flooring does not appear to be dirty, permanently stained, or worn. Paint and wall coverings are not peeling, stained, discolored, or dirty. The internal areas of the office appear orderly, non-cluttered, and professional.
6) Dental, laboratory, radiographic, and other equipment at the office must be operating properly so that dental care can be provided in a safe and predictable manner.
7) Exit signs clearly indicate entrances and exits.

Continuity of Care

1) Verification of a system to track specialty referrals
2) Additional Considerations
   a) Eye Wash Station: The office must have at least one eye wash station with a dedicated line connected to the cold water. Office personnel should be trained in the use of the station.
   b) Hazardous Labels: A hazardous chemical labeling system should be used for all containers other than the original.
   c) MSDS Sheets: For all such chemicals used in the office, MSDS information sheets must be readily available and kept in an organized manner.
   d) Separate Cold Storage for Dental Materials: Dental materials requiring refrigeration should be stored in a designated refrigerator.
   e) Nitrile/Heavy Duty Utility Gloves: All contaminated instruments and sharps being processed before sterilization or high-level disinfection must be handled only by personnel wearing intact nitrile or other heavy-duty utility gloves.
   f) Protective Attire: Reusable protective clothing or disposable gowns is worn by treating personnel when clothing is likely to be soiled with blood or other bodily fluids. Protective attire must be removed when leaving the laboratories or work areas.

g) Laundry: For soiled or contaminated reusable protective clothing, onsite laundry facilities or laundry service must be provided by the dentist owner. Alternatively, the dentist owner may elect to furnish disposable gowns for use only in the dental office.

h) Infection Control – Infectious Waste: Infectious waste including contaminated sharps, blood soaked gauze or other similarly contaminated material, including extracted teeth, must be disposed of according to CDC, ADA and or other local and state ordinances and statutes, including Section 1005 of the Dental Practice Act.

   i) Leak-proof Receptacles: All infectious waste receptacles and sharps containers are leak-proof.

   ii) Receptacles with Tight Lids: All infectious waste receptacles and sharps containers have tight lids.

i) Red and Marked: All infectious waste receptacles and sharps containers must be red in color and labeled or marked with the universal biohazard symbol.

j) Waste Haulers: All infectious waste must be disposed of by a regular/hauler or by other special permit, as necessitated by applicable local, state, and or federal standards.

k) Illness and Injury Plan

l) Hazardous Communications Plan

m) Safety Needles

On Site Provider Facility Review Audit Tool-Sample

- Refer to the attached On Site Audit Facility and Chart Review Form for criteria and guidelines.

Quick Reference Guide

Claims

HEALTH NET DENTAL
C/o Liberty Dental Plan of California, Inc.
3200 El Camino Real, Suite 290
Irvine, CA 92602
Telephone: (800) 907-7307

Dental Director

(619) 445-2484
Robert.e.shechet@healthnet.com

Emergency Referrals

(800) 907-7307

General and Administrative

(800) 907-7307

Grievances

HEALTH NET DENTAL
C/o Liberty Dental Plan of California, Inc.
3200 El Camino Real, Suite 290
Irvine, CA 92602
Telephone: (800) 907-7307

Health Net Dental

(800) 907-7307

Member Enrollment

(800) 213-6991

Member Services

HEALTH NET DENTAL
C/o Liberty Dental Plan of California, Inc.
3200 El Camino Real, Suite 290
Irvine, CA 92602
Telephone: (800) 907-7307

Ordering Forms

HEALTH NET DENTAL
C/o Liberty Dental Plan of California, Inc.
3200 El Camino Real, Suite 290
Irvine, CA 92602
Telephone: (800) 907-7307

Provider Relations

(888) 273-2713

Specialty Referral

(800) 907-7307