VA Community Care Network Provider Manual

A Guide for Dental Office Staff

Welcome to VA Community Care Network

Dear Doctor,

Thank you for joining our network to treat Veterans in the U.S. Department of Veterans Affairs (VA) Community Care Network (CCN). Delta Dental Insurance Company (Delta Dental) underwrites and administers dental benefits for CCN, which provides comprehensive dental care for eligible Veterans. This provider manual serves as a “how to” guide for you and your staff and includes the following:

- Important contact information
- Instructions for claim processing
- Approved referrals/authorizations
- Training

This manual will be revised from time to time. If you print a paper copy for your office, please check Availity (availity.com) frequently to ensure you have the most current version.

Sincerely,

Daniel W. Croley, DMD

Vice President and Chief Dental Officer

Delta Dental of California

Important Contact Information

Provider Customer Service

Toll-Free 844-825-8111

Business Hours of Operation
Region 4: **Monday – Friday, 8 am – 6 pm, Local Provider Time**
Region 5: **Monday – Friday, 7 am – 6 pm, Local Provider Time**

Delta Office Toolkit (DOT)
dentalofficetoolkit.com

Claims

Mail to:

Delta Dental of California
Federal Government Programs
P. O. Box 537007
Sacramento, CA 95853-7007

Electronic Payor ID: **CDCA1**
Group Number for Region 4: **7000-0004**
Group Number for Region 5: **7000-0005**

Provider Disputes

Mail to:

Delta Dental of California
Federal Government Programs
Appeals/Grievances
P.O. Box 537015
Sacramento, CA 95853-7015

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Section 1 — VA Community Care Network

1.1 Overview

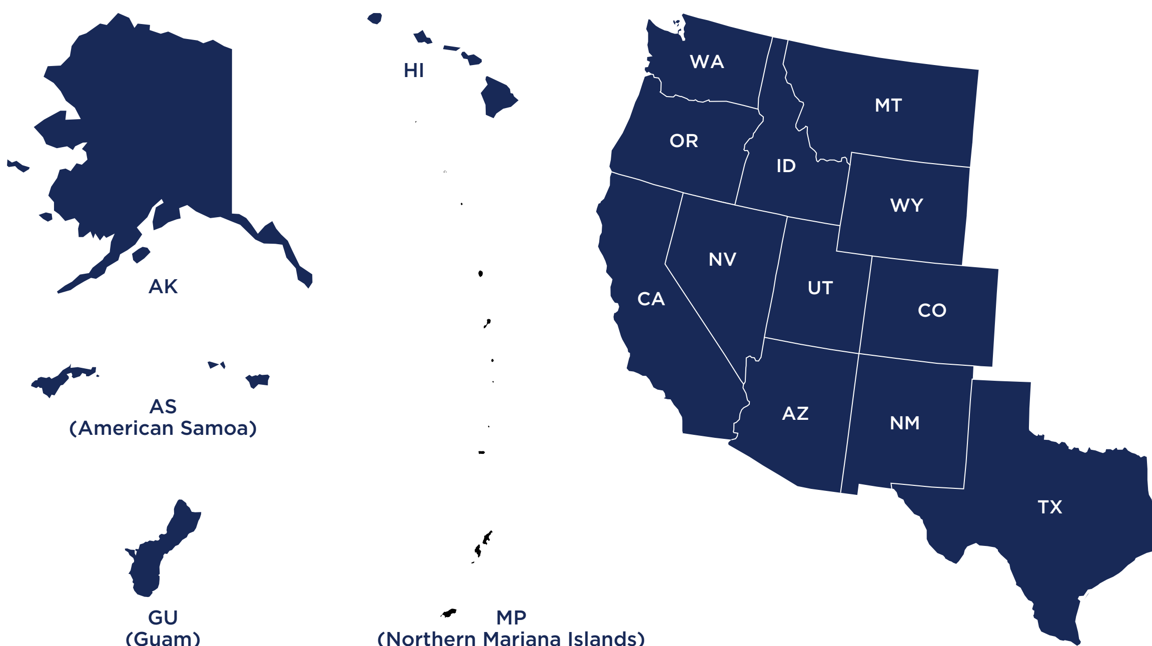
The Department of Veterans' Affairs (VA) Community Care Network (CCN) allows Veterans to receive health care services, including dental care, in their own community. VA developed CCN to expand Local VA Medical Centers' (VAMC) resources and availability of services for Veterans while ensuring Veterans receive timely high-quality care.

1.2 Region Coverage

VA CCN is currently divided into five separate regions. TriWest Healthcare Alliance is the Third Party Administrator for CCN Regions 4 and 5. Delta Dental serves as a subcontractor for dental services in CCN Regions 4 and 5.

- **Region 1 –** Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Rhode Island, West Virginia, Vermont and Virginia.
- **Region 2 –** Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Nebraska, North Dakota, Ohio, South Dakota and Wisconsin.
- **Region 3 –** Alabama, Arkansas, Florida, Georgia, Mississippi, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas and Virgin Island.
- **Region 4 –** Arizona, California, Colorado, Hawaii, Idaho, Montana, New Mexico, Nevada, Oregon, Texas, Utah, Washington, Wyoming, and the U.S. territories in the Pacific, including Guam, American Samoa, and the Northern Mariana Islands.
- **Region 5 –** Alaska

Community Care Network Regions 4 and 5



Section 2 — About Delta Dental's Network

2.1 Delta Dental Legion

Delta Dental's Legion network dentists are contracted dentists who are exclusive to national programs offered under federal contracts. Delta Dental Legion network dentists agree to provide services at contracted fees that meet cost-management criteria. The Delta Dental Legion network was formerly known as the Delta Dental Select USA network.

2.2 Delta Dental PPO™/DPO

Delta Dental's PPO preferred provider organization (PPO) network dentists are contracted dentists in Delta Dental's fee-for-service plans, which allow enrollees to visit any licensed dentist but may offer incentives when choosing PPO network dentists. Delta Dental PPO network dentists agree to provide services at fees that meet the plan's cost-management criteria. In Texas, this network is known as a dental provider organization (DPO).

2.3 Becoming A Contracted Network Provider

Delta Dental will provide a prospective contracting provider an enrollment packet, if requested. After Delta Dental receives the completed enrollment documents, Delta Dental staff will verify that all data fields have been completed prior to entering the information into Delta Dental's system of record. For more information about becoming a contracted network provider, please send an email to **FSPS@delta.org**

2.4 Credentialing

Credentialing involves gathering and reviewing information from regulatory agencies; professional associations and educational institutions to ensure that the prospective network provider is legally qualified to practice dentistry. Delta Dental uses the National Committee for Quality Assurance (NCQA) for credentialing criteria and guidelines to verify that the provider meets and maintains the standards required for participation. We verify the following for each prospective contracting provider:

- Presence of acceptable professional liability (malpractice) insurance coverage
- Valid permits and registration, including Drug Enforcement Administration, conscious sedation, oral conscious sedation and general anesthesia
- Possession of applicable certificates of specialty or proof of Board eligibility
- Provide a valid photo ID
- Absence of negative actions taken by the State Board of Dental Examiners and
- Curriculum vitae or work history

After the credentialing process has been completed and approved through the Credentialing Committee, Delta Dental will mail a welcome packet and counter-signed Contracting Provider Agreement to the provider facility. Monthly quality monitoring is performed for each provider. Delta Dental's credentialing process adheres to NCQA guidelines as the guidelines, as they apply to dentistry.

Appeal of Credentialing Committee Recommendations

If the Credentialing Committee recommends the denial of an application, the Committee will offer the applicant an opportunity to appeal the recommendation. We do not accept

participation with restrictions. We accept or deny based on our review criteria. Providers may be placed on a shortened credential cycle.

2.5 Qualifications Of Specialists

A specialist is one of the following:

- Diplomat of the appropriate American Board
- Listed as a specialist in the American Dental Directory of the American Dental Association section on "character of practice"
- Listed as a specialist on the roster of approved dental specialists of the State Department of Health

2.6 Re-Credentialing

The credentialing process is repeated every three years to verify that licenses and certifications remain current for each provider and that there are no adverse circumstances presented that would prevent continued participation in the program. Prior to expiration, Delta Dental's automated system generates reporting and reminder letters with credentialing documents for completion. The process should take no longer than 60 days to complete, pending a completed package with no missing information. The provider will be notified upon completion of the re-credentialing process.

2.7 National Provider Identifier

Contracted network providers must have a National Provider Identifier (NPI) in accordance with the timelines established in 45 Code of Federal Regulations (C.F.R.), Part 162, Subpart D. (An NPI was required to be in place for most providers by May 23, 2007).

Section 3 — Web Services

3.1 Availity

Availity is an online provider portal that TriWest utilizes to facilitate online health care management for Veterans. It also serves as a central location for CCN-related reference materials such as the Provider Handbook, quick reference guides (QRGs), training modules and more. Availity is a multi-payer site where you can use a single user ID and password to work with TriWest and other participating payers online. Availity is compliant with all Health Insurance Portability and Accountability Act (HIPAA) regulations, and there is no cost for providers to register or use any of the online tools such as access to all CCN dental information, QRGs and eSeminar Learning Path for dental training. To register for an account, please visit **availity.com**.

3.2 Dental Office Toolkit® (DOT)

The Dental Office Toolkit® (DOT) is designed to help decrease the time spent each day on the administrative tasks involved in providing care for Veterans covered under VA CCN. This dynamic online self-service tool allows you to:

- **Submit claims**
  With DOT, you can go paper-free by submitting your own claims, as well as avoid electronic submission fees from clearinghouses. Get your claims payments faster by signing up for direct deposit.
- **Check claims status**
  Find out the status of your claims submitted online through DOT.
- **Edit and delete submitted claims**
  Make same-day changes to your claims or delete claims even after you have submitted them for processing.

When you first register for DOT, you will need to create a username and unique password. To protect your password and authenticate each time you log in to the toolkit, you will be asked to select and answer a private security question used for identification should you need to change your password in the future.

After you register for DOT, we will send you an email including an attached letter with full instructions on how to activate your new account. Once you have activated your account, your office will be able to utilize all of DOT's features. If you register for DOT and do not receive an email or copy of the letter, contact Delta Dental at **844-825-8111**.

Transmission of private information is secure with DOT. Federal regulations that mandate the protection of individually identifiable patient information from public access, such as HIPAA, ensure that you and your patients' privacy is maintained in DOT. Transmissions between your computer system and DOT is secured using a 128-bit SSL (Secured Socket Layers) encryption program. This encryption nearly eliminates any possibility that personal information could be intercepted prior to its secure storage at Delta Dental. While it is impossible to guarantee absolute security, Delta Dental makes extraordinary efforts that surpass both industry standards and HIPAA requirements in order to protect your information throughout our operating systems.

With advanced security measures and no cost to submit claims or use any of the features of this self-service tool, there is no reason not to use DOT. You can use DOT for all your patients, regardless of what federal program they are enrolled in. Additional information about DOT, including a list of frequently asked questions, is available on any of the program websites.

Section 3 — Web Services

3.3 Direct Deposit

Once you have activated your DOT account, you will have the ability to sign up for direct deposit of your claim payments.

Signing up for direct deposit allows your claim payments to be transferred electronically from Delta Dental directly into your bank account. With direct deposit, there is no more waiting for the check to be delivered to your office by mail.

The advantages of direct deposit include:

- **Fast payments:** Payment is usually made within 48 hours of claims submission.
- **Safety:** There's less chance of lost or stolen checks. Simply view your claim payment information in your Dental Office Toolkit Activity Log or in your practice management system.
- **Efficiency:** With no mail to sort or checks to deposit, your office staff saves valuable time. Your claim payment remittance advice and Explanation of Benefits (EOB) statements are all online!

Claim payment checks and EOBs are mailed weekly to dental offices within a specific ZIP code range. Depending on the ZIP code range in which your office falls, you might have to wait several weeks before you receive your payment. Using direct deposit will eliminate long wait times and payments will be deposited automatically into your bank account within days of processing!

3.4 HealthShare Referral Manager (HSRM)

HealthShare Referral Manager (HSRM) is a secure, web-based system VA uses to generate and transfer referrals and authorizations to CCN providers. This new system simplifies and streamlines the referral and authorization process and facilitates information exchange — including images — through one easy-to-use and secure work platform. HSRM means less time faxing and emailing to VA, less time on hold with VA and shorter turnaround time for clinical utilization and care coordination processes. To register for an account, please visit **va.gov/COMMUNITYCARE/providers/Care_Coordination.asp**.

3.5 VA Storefront

The VA Storefront is VA's online hub for VA CCN. If you need to request additional services for a Veteran, or extend the timeframe of an existing approved referral or authorization, you can access the Request for Services (RFS) form at **va.gov/COMMUNITYCARE/providers**. The special webpage is referenced in provider authorization letters as the "VA Storefront."

3.6 Online Provider Directories

Delta Dental and TriWest may periodically include a provider's name, gender, work address, work fax number and work telephone number. The provider is responsible for notifying Delta Dental and TriWest of any changes of address, phone or fax number or specialty services rendered within 10 business days.

Section 4 — Training

4.1 Available Training

Delta Dental provides short, online training videos covering:

- Authorizations
- Dentist Treatment
- Overview for Dentists
- Submitting Claims
- Dental Office Toolkit

These videos are found on the TriWest Payer Space on Availity. To access the TriWest Payer Space, follow these steps:

1. Log into Availty
2. Under Payer Spaces, select TriWest Payer Space
3. Click on the TriWest Learning Center
4. On the "Learning Paths" tab
5. Enroll for the Delta Dental Learning Path for Dentists

Section 5 — Approved Referrals and Authorizations

The Veteran must have an approved referral or authorization from VA before an appointment can be set and an authorization letter will be sent to the provider. Eligibility and benefits are determined by VA directly. Prior to rendering care to a Veteran, the provider must have an approved referral or authorization on file.

5.1 How an Approved Referral or Authorization is Generated

There are three ways an approved referral or authorization can be triggered:

1. A provider who has seen a Veteran under an existing Approved Referral or Authorization and determines additional care is needed for the Veteran. A request is sent directly to VA by submitting an RFS form through VA's secure online system, or HSRM.
2. The Veteran contacts a local VAMC to confirm CCN eligibility. Once the Veteran's eligibility is determined and is eligible, VA either appoints the Veteran to a local VAMC or to a CCN provider.
3. VA evaluates the Veteran's needs and determines to refer the Veteran to the community. An approved referral or authorization is generated for the CCN provider.

5.2 Appointing After Authorization

Once the authorization is in the system, the VAMC or TriWest will contact the provider to make an appointment for the Veteran. When the appointment has been set, VAMC or TriWest will send the provider an approved referral or authorization letter.

Section 6 — Appointments

Prior to scheduling an appointment, VA must have issued an approved referral or authorization for the service. Only VAMCs or TriWest can schedule appointments for Veterans, including emergent and urgent care. If a Veteran calls the provider directly to schedule an appointment, the provider must notify VAMC immediately. Failure to do so may negatively impact claims processing.

6.1 Appointing — VAMC and TriWest

Below is the process scheduling an appointment for Veterans:

1. On behalf of the Veteran, VAMC or TriWest coordinator contacts the provider to schedule an appointment.
2. If an appointment can be made, then VAMC or TriWest coordinator schedules the appointment and sends the approved referral or authorization to the provider.

6.2 Participation Requirements for Appointments

Providers are responsible for the following requirements for appointments:

- Providers must honor all appointments with Veterans for covered services with an approved referral or authorization.
- The provider must notify the entity who scheduled the original appointment.
- The provider must submit an RFS form to VAMC for additional care beyond the current approved referral or authorization.
- The provider may not charge a Veteran for missing a scheduled appointment.

6.3 Maximum Appointment Availability Time

The following are VA standards:

- Primary care maximum appointment availability is 30 days.
- Specialty care maximum appointment availability is 30 days.
- Emergent care should be provided within 24 hours.
- Urgent care should be provided within 48 hours.

Section 7 — Treating the Veteran

VAMC or TriWest will send the provider an approved authorization or referral letter for the initial evaluation. This letter is the provider's playbook for any CCN appointment. The approved authorization/referral letters should be carefully read and retained. Providers should contact the referring VAMC or TriWest if a copy of approved authorization/referral is needed.

Providers may not collect copays, cost-shares or deductibles from the Veterans.

7.1 Approved Authorization or Referral

The approved authorization or referral identifies the scope of procedures a provider can perform for that specific appointment. An approved authorization or referral letter will be generated for all CCN appointments.

- Providers are not to perform any treatment on the Veteran if there is no approved authorization or referral for that appointment. Failure to do so will result in claims being denied.
- The provider listed on the approved authorization or referral needs to be the provider treating the Veteran. Claims may be denied if the treating provider is not the provider identified on the approved authorization or referral.
- Approved authorizations or referrals are valid for a specific amount of time. After the specific time-frame, the approved authorization or referral is void and a new one must be issued by VAMC or TriWest.
- The approved authorization or referral confirms the Veteran's eligibility for CCN. The provider does not need to perform an additional eligibility check.
- The approved authorization or referral included information on:
  - The treating provider
  - The Veteran
  - Claims submission
  - The referring VAMC
  - The authorization
  - Authorized care or procedures
- Make note of the referral or authorization number, as it is required for claims submission.

7.2 Standard Episodes of Care (SEOC)

When the VAMC authorizes care, they will attach a Standard Episode of Care or (SEOC) to the authorization. SEOCs are a more comprehensive model of ordering health care driven by the Department of Veterans Affairs (VA) to improve efficiency and consistency across all VA Medical Centers (VAMC). Delta Dental reviews claims based on the SEOC assigned to the referral. Procedures not listed on the SEOC will not be allowed and the veteran cannot be charged for these additional procedures.

There are multiple SEOC types that VA might assign to a referral, but the Initial Evaluation SEOC has special guidelines. Initial Evaluation SEOC's are assigned when there has been no treatment plan established by Veterans Affairs (VA). The Initial SEOC appointment allows the provider an opportunity to examine and evaluate the Veteran's oral health, provide limited

treatment and create a treatment plan for the VA to review for further treatment. **Care must not exceed $1,000 for Initial Evaluation SEOCs**. Further treatment must be reviewed and approved by the VA before treatment can be provided. Once approved a new referral and SEOC will be assigned.

A provider should only provide and bill what is needed/used. It is extremely important that you review the SEOC type, as care may be limited depending upon the SEOC submitted (especially with Initial SEOCs).

7.3 Initial Evaluations

The first appointment for most Veterans will be an initial evaluation. This allows the provider an opportunity to examine and evaluate the Veteran's oral health and provide limited treatment. Initial evaluations will have an Initial SEOC associated with it, and care must not exceed $1,000.

If a Veteran reschedules, cancels or does not show for an appointment, the provider should contact the referring VAMC or TriWest.

7.4 Developing a Plan of Care

Based on the initial evaluation, the provider is to develop a plan of care for additional medically necessary treatments. This plan needs to be submitted to the referring VAMC using HSRM and should be included in the dental records submission when the initial evaluation is completed. Treatment plans should not be submitted to Delta Dental.

VAMC will approve or deny the plan of care. If approved, VAMC will schedule subsequent appointments on behalf of the Veteran. Questions regarding approved/denied plans of care should be directed to the referring VAMC.

7.5 Dental Records Submission

After every CCN appointment, including the initial evaluation, dental records are to be sent within forty-five (45) days upon completion of the dental treatment plan. The following information needs to be submitted:

- The approved authorization or referral letter
- A completed RFS form
- Images or x-rays
- Initial evaluations
- If submitting a plan of care, any documentation justifying the plan of care's medical necessity

Please note that dental records are required to have:

- The provider's signature
- A second identifier associated with the patient's name (e.g., DOB, last 4 of SSN or VA authorization number)

VA will cover medically necessary medication that is part of an approved referral or authorization and follows the rules of VA National Formulary. More information on VA National Formulary can be found here: **www.pbm.va.gov/nationalformulary.asp**.

Please note that providers must be registered with their state prescription monitoring program and must check those prescription monitoring programs prior to writing prescriptions for controlled substances such as opioids.

Providers are prohibited from dispensing medication samples to Veterans.

Section 8 — Medication Process

8.1 Guidelines for Prescriptions

The following information about the provider is required for each prescription:

- Name (First, Middle, Last) and suffix (e.g., Sr., Jr., II., III.)
- National Provider Identifier (NPI1)
- Tax ID number (TIN)
- Personal DEA number and expiration date (not a generic facility number)
- Office address
- Office phone and additional phone number
- Fax number
- Discipline (e.g., dentist, oral surgeon)

8.2 Urgent and Emergent Medication Prescriptions

- In **urgent** and **emergent** situations when medication must be taken immediately and it is not possible to fill the prescription at a VA Pharmacy, the provider may prescribe up to a 14-day supply with no refills.
- Send the prescription and a copy of the approved authorization or referral to an ESI pharmacy using Surescripts e-Prescribing tool. To learn more about Surescripts and to register, go to **surescripts.com**.
- The medication must be listed on **www.pbm.va.gov/nationalformulary.asp**.
- If additional medication is needed after the 14-day supply due to medical necessity, a second prescription can be filled at a VA Pharmacy. The second prescription needs to be faxed to VA's authorizing facility pharmacy within one hour of seeing the Veteran.
- Veterans may fulfill the medication at any Express Scripts network pharmacy without having to pay out-of-pocket. Express Scripts network pharmacies can be found here: **express-scripts.com**.

8.3 General Medication Prescription

All prescriptions need to be made in accordance with VA's National Formulary.

- Fax both the prescription and a copy of the approved referral or authorization to your local VA Pharmacy for processing and fulfillment within one hour of seeing the Veteran.
- The Veteran may pick up the medicine at a VA Pharmacy, an ESI pharmacy, or have it mailed through ESI.
- Medication may be filled in-person at a VA pharmacy.
- If the Veteran needs a medication that's not on VA's National Formulary, the provider should follow these steps prior to writing the prescription:
  - Contact the local VAMC and request assistance with that VAMC's non-formulary request process and ask for a Formulary Request Review Form.
  - Wait for approval or denial. Turnaround time may take approximately 96 hours. If approved, providers may proceed with prescribing the medication.

Section 9 — Claims

9.1 Submitting Claims

When covered services are completed, providers should submit claims using Dental Office Toolkit (DOT) along with a copy of the Standardized Episodes of Care (SEOC) or approved referral or authorization received from VA. Authorized treatment should be submitted within 30 days after services have been rendered and no later than 180 days. VA requires providers to submit all supporting documents or records directly to the authorizing VAMC. Additionally, **providers may not collect copays, cost-shares or deductibles from the Veterans**.

Claims must be received by Delta Dental within 180 days from the date of service. Claims received late will not be paid and are not billable to the Veteran. If the claim was sent elsewhere in error the EOB from the other carrier can be submitted to Delta Dental for reconsideration if the EOB shows the date the claims was received.

9.2 Unauthorized Care

For care that is urgent or not authorized the provider must submit a new approved referral or authorization to VA and complete a new Request for Services (RFS) form. The RFS can be submitted to VAMC through the HSRM tool.

9.3 Veteran Payment of Non-Covered Benefits

A Veteran can agree to pay out of pocket for non-covered benefits. If a Veteran agrees to pay out of pocket for procedures not approved by the VA, the Veteran will need to provide their approval, in writing, to the provider for submission with the claim. The Veteran's approval must be given prior to the work being done, otherwise the procedure will remain disallowed and not billable to the veteran.

9.4 Claims Submission

Providers may submit claims electronically using DOT at no cost. Providers can also submit claims electronically through third-party clearing houses or by mail. When submitting claims, always include your VA Referral/Authorization Number on the claim. When submitting claims through DOT, enter VA Referral/Authorization Number in Box 35.

Do not submit claims by fax as they are often illegible.

For electronic claims, the payer ID is **CDCA1**, and the group number for Region 4 is **7000-0004** and for Region 5 is **7000-0005**.

Mail claims to:

> **Delta Dental of California**
> **Federal Government Programs**
> **P. O. Box 537007**
> **Sacramento, CA 95853-7007**

9.5 Claims Submission Tips

Here are a few tips to help ensure your claims are processed quickly and error-free:

- Always include VA Referral/Authorization Number on the Claim.

- When submitting Claims through DOT enter VA Referral/Authorization Number in Box 35.
- Include the VA Referral/Authorization number in Box 35 on the ADA claim form.
- Use black ink or printer toner.
- Use the same font style and size throughout the claim. All-cap, 10-point font is recommended.
- Dates should be in "MMDDYYYY" format with no spaces, dashes or slash marks.
- Use the "**Remarks**" or "**Comments**" field ONLY to document exceptional or unusual circumstances on the claim.
- Indicate fees with decimal points (e.g., $100.00, not $100).
- Indicate a quantity (e.g., radiographic images) in the field on the claim specifically for this purpose.
- Indicate the tooth number or letter, quadrant or arch in the appropriate fields.
- Use the correct indicator (tooth number, letter, quadrant or arch) for the corresponding CDT code.
- Use the same business name and associated tax identification number (TIN) as the IRS has on file for the billing entity for the service office location. The Type 2 National Provider Identifier (NPI) can be included with this information.
- Indicate the treating dentist's name, license number and issuing state, and the Type 1 National Provider Identifier (NPI) on the claim.
- Do not send study models. They are not reviewed.

Try to avoid these common errors, which can cause processing inaccuracies, delays and possible denial of a claim:

- Illegible handwritten claims
- Using ink colors other than black (preferred) or dark blue
- Using free-form text or stamped information in the body of the claim
- Using ditto marks or arrows to indicate duplicate information
- Making marks in spaces that should be left blank
- Putting a slash through zeroes or crossing sevens
- Writing on the top of lines or outside of boxes
- Using correction fluid or a highlighter pen
- Submitting photocopied claims that may be blurred or skewed
- Using nicknames

9.6 Checking Claim Status

You can check claim status anytime through DOT.

Section 9 — Claims

9.7 Coordination of Benefits (COB)

Coordination of Benefits (COB) is the process carriers follow to ensure that the combined benefits of all dental programs under which a Veteran is covered are utilized to their maximum benefit. Following are some basic claim submission guidelines to help maximize your Veteran's dental benefits. These guidelines will also ensure that the total payment does not exceed 100 percent of the combined fees allowed by all carriers:

- Determine which carrier is primary. An Authorization will indicate who is to be Primary or Secondary, VA is almost always going to be Primary.
- Submit the claim to the primary carrier and include complete information about the secondary carrier.
- Once the primary carrier has processed the claim, send a claim to the secondary carrier indicating the amount the primary carrier paid in the appropriate box on the claim form, even if the primary carrier paid zero.

9.8 Provider Disputes/Appeals:

Providers wishing to dispute or appeal a claim denial or modification can send an appeal to the address below. In the appeal, clearly state the nature of the appeal and the desired resolution.

Delta Dental of California
Federal Government Programs
Appeals/Grievances
P.O. Box 537015
Sacramento, CA 95853-7015

Section 10 — Quality Management

10.1 General Standards

1. Emergency care appointments shall be available 24 hours a day, seven days per week. An active after-hours mechanism, such as an answering machine, answering service, a cell phone number, or pager is available via 24/7 contact or other instructions.
2. Urgent care appointments shall be provided within 48 hours when consistent with the patient's individual needs and required by generally accepted standards for dentistry.
3. Routine care appointments shall be provided within 30 days.
4. Dental office facility and equipment must be clean, safe, well-maintained and in good repair.
5. Dental office must have written emergency protocols for fire and natural disasters; which include a plan indicating escape routes, staff member responsibilities and where to call for assistance.
6. Sterilization and infection control standards must conform to the current CDC Guidelines for Infection Control in Dental Healthcare Settings.
7. A comprehensive collection of medical history should be taken, including but not be limited to:
    a. General health and appearance, systemic disease, allergies and reactions for anesthetics
    b. Record of all current medications and medical treatment
    c. Record of current physician and contact in case of emergency
    d. Medical alerts (diabetes, high blood pressure, heart conditions, etc.) should be conspicuously located on a portion of the patient chart used during treatment and should reflect current medical history
    e. Periodic updates should occur in the patient chart at appropriate intervals, signed and dated by both patient and dentist.
8. Documentation of baseline dental conditions, including but not limited to:
    a. Existing restorations and conditions
    b. Missing teeth
    c. TMJ and occlusal evaluation
    d. Current existing prosthetics
    e. Periodontal condition
    f. Soft tissue – oral cancer exam
9. Documentation of patient's chief complaint or pertinent information relative to patient's dental history.

Section 10 — Quality Management

10. Progress notes – legible, detailed, in ink and in chronological order.
    a. Use of local anesthetic, type and volume or noted “no local anesthetic used”
    b. Medications prescribed or dispensed for the patient
    c. Quantity and frequency of radiographic images taken, or refusal of radiographic images to be taken.
    d. Written treatment plan
        i. Sequenced
        ii. Informed Consent Form
            a. Oral hygiene instructions
            b. Diagnosis and outcomes of treatment provided
            c. Specialty referrals

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