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HEALTH NET MEDI-CAL DENTAL OPERATIONS MANUAL

The Health Net Medi-Cal Dental Operations Manual was developed to ensure that dental practitioners have access to needed information and to ensure members enrolled in the Medi-Cal managed care plans receive appropriate covered dental services when needed. Health Net's Medi-Cal plans are underwritten by Health Net of California and is regulated by the California Department of Health Services (DHCS) 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 Dental Operations Manual are supplemental to your dental agreement. When the contents of the Health Net Medi-Cal 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 participating dental providers.

PURPOSE

Health Net, Inc. is one of the nation's largest publicly traded managed health care companies. The company's HNO, POS, insured PPO and government subsidiaries provide health benefits to approximately 6.4 million individuals in 27 states and the District of Columbia through group, individual, Medicare, Medicaid and TRICARE programs.

Health Net recognizes that there is strong evidence that oral health is critical to overall health, which is why Health Net has become a leader in providing medical and dental for State Health Program participants.

Health Net Dental offers a unique solution for eligible members: comprehensive medical and dental coverage under one health plan. Health Net of California participates in the following programs:

General Program Descriptions

Medi-Cal Program

- The State of California offers Medi-Cal (Medical and Dental) for low-income California residents who meet federal income and eligibility guidelines. This program covers most dental services at no charge for most Medi-Cal beneficiaries. Individuals, who are eligible for Medi-Cal through the State of California, may enroll with Health Net Dental in Los Angeles and Sacramento Counties.

Specific Programs Offered

Los Angeles Medi-Cal

The Los Angeles Medi-Cal Program is a California state-sponsored dental program for qualified residents in Los Angeles County.

Los Angeles PHP members are assigned to a Primary Care Dentist (PCD) for all of their general dental care needs. Los Angeles Medi-Cal members are also eligible to receive specialty care services with an authorized referral submitted by the member's PCD.

Sacramento Medi-Cal

The Sacrament Medi=Cal (GMC) Program is a California State-sponsored dental program for qualified residents in Sacramento County.

Sacramento Medi-Cal members are assigned to a Primary Care Dentist (PCD) for all of their general dental care needs. Sacramento Medi-Cal members are also eligible to receive specialty services with an authorized referral submitted by the member's PCD.

HIPAA AND ABBREVIATIONS

Health Insurance Portability and Accountability Act (HIPAA)

Health Net Dental Plan takes pride in the fact that we administer our dental plan in an effective and innovative manner while safeguarding our members' protected health information. We are committed to complying with the requirements and standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our commitment is demonstrated through our actions.

Health Net has appointed a Privacy Officer to develop, implement, maintain and provide oversight of our HIPAA Compliance Program, as well as assist with the education and training of our employees on the requirements and implications of HIPAA. As a health care provider and covered entity, you and your staff must follow HIPAA guidelines regarding Protected Health Information (PHI).

Health Net has created and implemented internal corporate-wide policies and procedures to comply with the provisions of HIPAA. Health Net has and will continue to conduct employee training and education in relation to HIPAA requirements. Health Net Dental Plan has disseminated its Notice of Privacy Practices to all required entities. Existing members were mailed a copy of the notice and all new enrollees are provided with a copy of the Notice with their member materials.

With the advent of new, faster and more efficient means of communications between health plans, hospitals and doctors/dentists through Electronic Data Interchange (EDI) concerns have been raised about ensuring that member information remains confidential and the member's privacy is protected. Health Net Dental Plan shares these concerns. Furthermore, Health Net Dental Plan is committed to ensuring that member-identifiable information or data is only reviewed by the professionals who treat patients, review and study the quality of care members receive and those who pay for and administer the services received.

Health Net Dental Plan is always striving to meet the latest standards and improve the security of confidentiality-protection systems. In addition to adhering to state and federal laws and regulations pertaining to confidentiality of individually identifiable information, Health Net Dental Plan utilizes the National Committee on Quality Assurance standards.

Dental information regarding a patient may only be released after Health Net Dental Plan has obtained appropriate prior written authorization from the patient or the patient's parent/legal guardian/conservator, or a valid court order or court-authorized subpoena requesting such records has been received by the company. 'Appropriate written authorization' means permission granted in accordance with Section 56.11 or 56.21 of the Confidentiality of Medical Information Act.

- The patient's name, address, age, and sex
- A general description of his/her reason for treatment, such as whether an injury, illness, etc., and the general nature of the condition
- The general condition of the patient (i.e. stable, not stable)
- Any information that is not medical information.

I. Protection of Member Privacy Confidentiality Process

WITHIN HEALTH NET DENTAL PLAN ADMINISTRATIVE FUNCTIONS:

Health Net Dental Plan will monitor/evaluate its processes for maintaining all confidential information, including its collection, use and disclosure, by use of an internal review process consisting of:

- The Corporate Compliance Committee
- The Policy Subcommittee
- The Quality Management Improvement Committee

These committees are responsible for the following::

A. The ongoing review of confidentiality policies and procedures;
B. The oversight of the development of corrective action plans; and
C. The responsibility for summary reporting to appropriate committees of senior management.

Health Net Dental Plan will maintain the confidentiality of all confidential information, including but not limited to: member-identifiable, provider-specific, business-transaction and information contained within all databases through:

A. The adoption, implementation, and on-going review/revision of policy, and
B. Any departmental specific policy and procedure.

Release of any member-identifiable, provider-specific, or business transaction information by the organization will be:

A. Subject to the criteria set forth in this policy and/or
B. In conjunction with the expressed written consent of the member or the legal guardian; excepting of those situations where such release of information is required by law or contract.

Member identifiable information or dental records, obtained for claims processing or benefit appeals, will be:

A. Stamped “Confidential” and forwarded or transported through the organization in a confidential manner (e.g., special confidential envelope, direct delivery to recipient, etc.)
B. Protected in locked files at the end of a business day.
C. Accessed only by employees as necessary to conduct appropriate processing.
D. Redacted to remove member/practitioner identifiers, whenever information is used for demonstration purposes.
E. Password protected for all systems data and laptop computer data.
F. Archived in accordance with all applicable federal, state, etc. laws.
G. Shredded when such materials are no longer needed.

On an annual basis, Health Net Dental Plan managers and/or supervisors provide employees with continuing education on data confidentiality through the employee appraisal process. Employees are required to renew their confidentiality statement at this time. This is accomplished through a signature acknowledgment on the employee's annual performance appraisal form. Health Net Dental Plan managers are accountable for compliance with these standards.

Health Net Dental Plan shall not disclose dental information regarding a patient without obtaining written authorization. The authorization must come from the patient, patient's guardian, or conservator. If the authorization is signed by a guardian or conservator, evidence such as a Power of Attorney, Court Order, or other appropriate legal document must be submitted to establish the authority to authorize the release of dental information.

EXCEPTIONS TO THIS PROCEDURE:

- Court Order
- Administrative Agency Order
- Investigative Subpoenas, issued by a judge
- Laws that require release of Protected Health Information

A valid authorization to release patient information shall include the following core elements:

- Name of the institution that is to release the information;
- Name of the individual or institution that is to receive the information;
- Patient's full name, address, and date of birth;
- Purpose of need for information;
- Extent or nature of information to be released;
- An expiration date or event statement;
- Date that the consent is signed. Date of signature must be later than the date of the information to be released; and
- Signature of the patient or legal representative.

RELEASE WITH PATIENT'S CONSENT:

A valid authorization, signed by the patient, is required to be completed before releasing dental information to the following:

- Other health care providers currently treating the patient (non-emergency)
- Sponsor, Insurer, administrator of a group insurance plan for purposes of evaluating the patient's application for coverage or benefits
- Patient's attorney

***RELEASE WITHOUT THE PATIENT'S CONSENT**:*

Health Net Dental Plan does not require signed authorization before releasing information to the following:

- Person or entity responsible for paying the patient's bill.
- Peer reviewers
- Licensing or Accreditation surveyors
- County Coroner
- Other health care providers currently treating the patient in emergency situations
- Public Health Department

Patients may receive a copy of their own records after completion of a valid authorization and payment is received to cover reasonable costs of providing the record and/or copies. Reasonable charges shall be billed to insurance companies, attorneys and photocopy services to cover reproduction costs and clerical costs incurred in locating and copying records.

Information contained in the dental records may be provided to Health Net Dental Plan employees in the course of completing Health Net Dental Plan business. All appropriate aspects of patient confidentiality shall be maintained by those employees/dentists reviewing the records.

Health Net Dental Plan maintains a fast, fair, cost effective HIPAA Provider Dispute Resolution (PDR) mechanism for contracted and non-contracted providers. Providers wishing to file a dispute will not be subject to discrimination. In processing provider disputes, Health Net Dental Plan will not charge the provider for costs incurred nor will expenses incurred by the disputing provider be reimbursed. All provider disputes must be received in writing. The Manager of Operations of Call Center Services is the appointed principal officer and is primarily responsible to review operations on an on-going basis and to prepare and submit required regulatory reports.

HIPAA Provider Dispute Resolution submission, receipt, processing and resolution must:

- Provide that the claim dispute be submitted using the original claim number
- Be processed and tracked in a manner allowing linkage with the original claim number
- Inform the provider of the availability of the PDR mechanism whenever contesting, adjusting or denying a claim, and the procedures for obtaining forms and instructions for filing a dispute including the mailing address.

Disputes regarding a claim or a request for overpayment return must:

- Clearly identify the disputed item
- Include the date of service (DOS)

- Provide clear explanation of the basis for the provider's reasons that the payment, request for overpayment return, request for additional information, contest, denial or adjustment is incorrect
- Include disputing providers name, identification number and contact information

For contracted providers only, if dispute is not regarding a claim or request for overpayment return (i.e. a contractual issue) it must include:

- Clear explanation of the issue
- Provider's position thereon

If dispute is submitted on behalf of the enrollee(s), Health Net Dental Plan will request the enrollee's written authorization to proceed. If received by the Contracted Provider, the Provider should forward to Health Net Dental Plan who will resolve it through the member grievance process and it must include:

- The name and identification number of the enrollee(s)
- A clear explanation of the disputed item(s)
- The Date Of Service (DOS)
- The provider's position thereon

Health Net Dental Plan will verify the enrollee(s) authorization to proceed with the grievance prior to submitting through the member grievance process.

- When a dispute is submitted on behalf of the enrollee(s), the provider will be deemed to be joining with or assisting the enrollee(s) with the meaning of Health and Safety Code Section 1368.

PROVIDER DISPUTE DEADLINES FOR SUBMISSION:

- A deadline is imposed for receipt of provider disputes. The deadline is 365 calendar days from the last date of action on the issue, or in the case of inaction, will not be less than 365 calendar days from the most recent time for contesting or denying claims has expired.
- If not received by the defined deadline, the dispute will be rejected and returned to the provider.

ACKNOWLEDGEMENT OF PROVIDER DISPUTES*:*

- Provider Disputes will be acknowledged in writing within 15 working days of receipt.

ABBREVIATIONS USED IN THIS REFERENCE GUIDE

Abbreviations used in this Reference Guide are shown below with their full text:

ADA	American Dental Association
CCS	California Children Services
CHDP	Child Health and Disability Prevention Program
CMS	Centers for Medicare and Medicaid Services
CVO	Certified Verification Organization
DHCS	California Department of Health Care Services
DHHS	Department of Health and Human Services
DHMO	Dental Healthcare Maintenance Organization
DHMO-EPO	Dental Healthcare Maintenance Organization – Exclusive Provider Organization
DMHC	Department of Managed Health Care
EPSDT	Early & Periodic Screening, Diagnosis and Treatment
GMC	Geographic Managed Care (Sacramento County)
HEDIS	Health Employers Data Information Set
HIPAA	Health Insurance Portability and Accountability Act
HN	Health Net
IVR	Interactive Voice Response System
LAPHP	Los Angeles Prepaid Health Plan
NPDB	National Practitioner Data Bank
OSHA	Occupational Safety and Health Administration
PCD	Primary Care Dentist
PHI	Private Health Information
PRC	Peer Review Committee
QM	Quality Management
QMIC	Quality Management and Improvement Committee
QMIP	Quality Management Improvement Program
UMC	Utilization Management Committee

LANGUAGE ASSISTANCE PROGRAM

Medi-Cal

Health Net Dental offers languages assistance services to members and providers. Contracting dental providers must ensure they are distributing dental health education materials and providing interpreter services to all members who require or request them. Linguistic services are available to all Medi-Cal beneficiaries at all key points of contact including, but not limited to, dental and non-dental care setting e.g. at dental provider site, member services, and appointment scheduling.

Federal and California state law require dental Medi-Cal providers to communicate in the primary language of their patients as a condition of participation under the Medi-Cal program.

Contracting dental providers must:

- Not subject people of limited English proficiency to unreasonable delays in the delivery of services
- Not require or encourage members to use family members or friends as interpreters (Health Net Dental strongly discourages the use of minors as interpreters)
- Not require members to pay for the services of an interpreter
- Not limited participation in a program or activity on the basis of limited English proficiency
- Not provide services to member with limited English proficiency that are not as effective as those provided to others
- Record the language preference of the member in the member's dental record
- Document the member's request or refusal of interpreter services in the member's dental record

Members have the right to:

- Receive interpreter services at no charge
- File a complaint or grievance if the language needs are not met
- Not be required to use family members or friends as interpreters

Language assistance services are available 24 hours a day, seven days a week To engage an interpreter once the member is ready to receive services, please call 1-888-703-6999. You will need the member's Health Net Dental ID number, date of birth and the member's full name to confirm eligibility and access interpretation services. It is not necessary to arrange for these services in advance.

Interpreter support is available 24 hours a day, seven days a week. The California Department of Management Health Care (DMHC) requires that interpreter services, according to Section 1367.04 of the Health and Safety Code and Section 1300.67.04 of Title 28 of the California Code of Regulations, are coordinated with scheduled appointments for dental care services in a manner that ensures the provision of interpreter services at the time of the appointment.

To comply with DMHC and applicable federal and state laws and regulations, Health Net Dental requires providers to document member's language preference in the dental record and to coordinate interpreter services with scheduled appointments for dental services to ensure the provision of interpreter services at the time of the appointment. If an appointment is rescheduled, it is very important to reschedule the interpreter services for the time of the new appointment to ensure the member is provided with these services.

Interpreter support may also assist in identifying the member's language need, even if Health Net Dental cannot identify the language. This service is provided at no charge to Health Net Dental participating providers. Dental providers should document the member's request or refusal of interpreter services in the member's dental record.

Additional complaint, grievance and Independent Medical Review information is available in English and Non-English languages on the Department of Managed Health Care's website: www.hmohelp.ca.gov. In addition, hard copies may be requested by submitting a written request to: Department of Managed Health Care, Attention: HMO Help Notices, 980 9th Street, Suite 500, Sacramento, CA 95814.

We appreciate your cooperation in this process, and your participation in the Health Net Dental network(s). If you have any questions regarding this update or the new California requirements, please call Professional Services at 1-800-268-9012.

LOS ANGELES PREPAID HEALTH AND SACRAMENTO COUNTY GEOGRAPHIC MANAGED CARE PLANS - 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 and California's Medi-Cal Geographic Managed Care Program in Sacramento County (GMC). LAPHP and GMC 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.

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.

The benefit schedule available to LAPHP AND GMC 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 AND GMC 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 AND GMC 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 and Sacramento Counties to ensure needed services are available to LAPHP AND GMC 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 AND GMC Medi-Cal Dental Program members receive covered dental services from their PCD with no copayment. Collection of copayment amounts from a Medi-Cal member for covered dental services is strictly prohibited under the provisions of your provider agreement.

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 GMC 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 or GMC

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
340 Commerce, Suite 100
Irvine, CA 92602

For Office Use Only

Name of person receiving complaint: _____

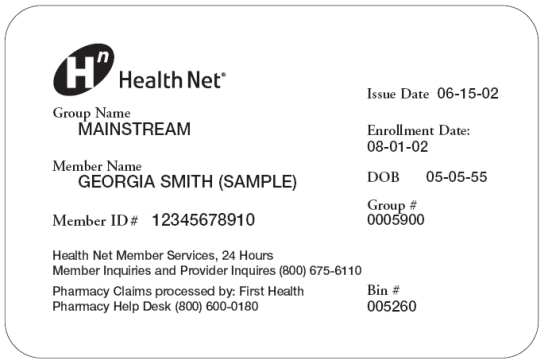
Date of action: _____

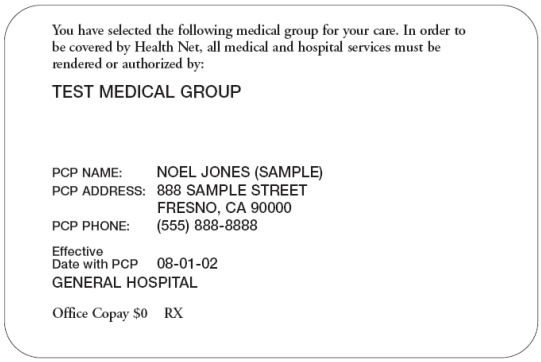
MEMBER IDENTIFICATION CARD AND ELIGIBILITY

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.





MEMBER INITIATED DISENROLLMENT PROCESS

Members enrolled in the LAPHP AND GMC may voluntarily disenroll from Health Net Dental at any time and can enroll in another plan or fee-for service Denti-Cal. 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 AND GMC 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 DHCS. A written request for disenrollment and the documentation supporting the request is submitted to DHCS 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 DHCS 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 DHCS 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 Health Care Options (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 DHCS

The plan will make every effort to resolve problems with members before requesting disenrollment approval from DHCS 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 DHCS asking that the member be disenrolled from the plan's LA-PHP Medi-Cal Dental Plan.

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 AND GMC Medi-Cal Dental Program 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
- Members who reside in the State of California have the right to an interpreter when receiving treatment and services.

- Health Net is offering free telephonic interpretation through our language service vendor. The member must be fully informed that an interpreter is available to him or her at no cost.
- To engage an interpreter once the member is ready to receive services, please call 1-800-977-7307. You will need the member's Health Net ID number, date of birth and the member's full name to confirm eligibility and access interpretation services. It is not necessary to arrange for these services in advance.
- Health Net discourages the use of family or friends as interpreters and strongly discourages the use of minors as interpreters for members except in an emergency situation if the minor demonstrates the ability to interpret complex dental information.
- Providers must also fully inform the member that he or she has the right not to use family and friends or minors as interpreters.
- If a member prefers not to use the interpretation services after he or she has been told that a trained interpreter is available free of charge, the member's refusal to use the trained interpreter shall be documented in the member's dental record, when in a provider setting, or the member's administrative file (call tracking record) in the Member Services setting.
- Language preferences of members will be available to directly contracted dentists upon request through telephone inquiries.

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.

ACCESSIBILITY STANDARDS

Health Net complies with standards of accessibility for members, as established by California State Law and Regulations. Adherence to these standards is reviewed during the dental facility audit and continually monitored through other Health Net Quality Management processes.

Health Net Dental Plan's standards for accessibility meet or exceed Title 28, of California Code of Regulations Division 1, from the Department of Managed Health Care, Chapter 2, for Health Services Plans, specifically Article 7, Standards.

Timely Access To Non-Emergency Health Care Services

Authority: Sections 1344, 1346 and 1367.03, Health and Safety Code.

Reference: Sections 1342, 1367, 1367.01, 1367.03, 1370, 1375.7 and 1380, Health and Safety Code.

The following is a summary of the pertinent items regarding timely access to dental services, as defined by Title 28. Should you wish a full copy of this legislation, contact the Professional Services Department and the document will be provided to you.

- Health Net Dental Plan shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the member's condition consistent with good professional practices.
- When it's necessary for a provider or a member to reschedule an appointment the appointment shall be promptly rescheduled in a manner that is appropriate for the member's health care needs and ensures continuity of care consistent with good professional practice.
- Interpreter services shall be coordinated with scheduled appointments for dental care services in a manner that ensures the provision of interpreter services at the time of the appointment.
- Urgent appointments within the dental plan network shall be offered within 72 hours of the time request for appointment when consistent with the members individual needs and as required by professionally recognized standards of dental practice.
- Non urgent appointments shall be offered within 36 business days of the request for appointment.
- Preventive dental care appointments shall be offered within 40 business days of the request for appointment
- Health Net Dental Plan shall ensure they have sufficient numbers of contracted providers to maintain compliance.
- Health Net Dental Plan shall ensure that contracted providers employ an answering service or a telephone answering machine during non business hours which provide instructions regarding how members may obtain urgent or emergency care including when applicable, how to contact another provider who has agreed to be on call to triage or screen by phone or if needed, deliver urgent or emergency care.

- Health Net Dental Plan shall ensure that during normal business hours, the waiting time for an member to speak by telephone with a customer service representative shall not exceed ten minutes

- Health Net Dental Plan shall have written quality assurance systems policies and procedures designed to ensure that the provider network is sufficient to provide accessibility, availability and continuity of covered health care services.

APPOINTMENT SCHEDULING

Appointments for an initial assessment, non-emergency routine services, and/or preventive care must be made available to members within three (3) weeks of the date a member requests for a specific time.

Appointments for acute/urgent care from a PCD or specialist shall not exceed one day (24 hours) from the date of the request for an appointment.

AFTER HOURS AND EMERGENCY SERVICES AVAILABILITY

The provider's after-hours response system must enable members to reach an on-call dentist 24 hours a day, seven days a week. Members may first attempt to contact their Primary Care Dentist (PCD) during regular office hours. Urgent appointments should be scheduled within 24 hours and the patient should be informed that only the emergency would be treated at that time. After-hours calls should be forwarded to an answering service or directly to the PCD. If the PCD is not on duty, an on-call provider should be available to act on his or her behalf.

Members requiring after-hours emergency dental services must receive an assessment by telephone from the provider within one hour of the time the member contacts the provider's “after hours” telephone service.

If the PCD or on-call dentist does not respond, the member may contact Health Net’s 24- hour answering service at 888-703-6999. Health Net will contact the provider who will be expected to call the member within one hour from the time the member's call is received by the answering service. If the member requires emergency care when outside the service area (greater than 50 miles from the PCD), the member may seek treatment from the nearest available dentist or emergency room as circumstances dictate.

WAITING TIME FOR SCHEDULED APPOINTMENTS

Member waiting time for scheduled appointments with their PCD or a specialty care provider must not exceed thirty (30) minutes. Provider offices must maintain records indicating when a member arrives for an appointment and when the provider sees the member.

Health Net sends an Accessibility Survey to every PCD office in the network on a regular basis to obtain information on appointment availability, waiting time, acceptance of new members and staffing changes. The survey must be completed and submitted to Health Net in a timely manner.

Accessibility	Goal/Standard
Total Compliant Initial Exam	3 weeks
Routine Exam	3 weeks
Hygiene Exam	3 weeks
Emergency Appointment	24 hours
Average wait-office	<30 minutes
Average wait-Operatory	<15 minutes

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 a 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 DHCS 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 AND GMC Medi-Cal Dental Program 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
340 Commerce, Suite 100
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

ON-LINE SERVICES

Health Net believes that establishing an easy to use multi-functional web presence is a key component in ensuring that all providers have the most efficient and up-to-the minute information available so that all Health Net Dental Plan members receive proper care. Integrated with our state of the art systems, Health Net's easy to navigate web portal ***iTransact***, provides effective, efficient tools for providers.

Health Net has a very comprehensive online solution, developed around the use of "smart technology." Providers may call, email, mail, and/or fax their information to customer service; or providers may initiate the process via the web portal. Health Net's system is designed to facilitate effective and efficient plan administration while improving the proper use of services by utilizing template-based authorizations and referrals. Health Net's system assures the review of services through pre-assigned workflows and case management integration. Utilization review, outcome assessments, and clinical benchmarking are facilitated. Health Net's system works to ensure that no documents are lost, data is 100% accurate, and efficiencies are gained. Credentialing information, such as provider's specialties, languages, board certifications, etc., is captured and available for reference.

Health Net is continually upgrading our web based functions and capability to improve the dental website and for all system enhancements and maintenance.

All providers, including rendering dentists, office administrators and auxiliary staff, receive initial on-site program orientation and are continually monitored through Health Net's comprehensive Provider Service Plan to evaluate the need for re-orientations due to program changes or dental office staff changes. The critical component of Health Net's Provider Education Program is training on our website capabilities, specifically the provider portal.

Health Net's web based system ensures a smooth process between Health Net and providers. Health Net's website capabilities and provider management functionality includes:

- On-line availability 24 hours a day, 7 days a week, 365 days a year
- Real Time Member Eligibility and Benefit information, including real time status of Annual Max and Deductibles
- Online Submission of Authorizations, Claims and Referrals
- Online Provider Applications
- Document (faxes, emails, correspondence)
- Immediate Access to All Documentation and Notes
- Immediate Authorizations Status Availability
- Submission of Clinical Data with Authorizations

- Automatic Response to Provider Authorization Requests
- Unique Identifiers
- History and Audit Trails
- Member Data Management
- Provider Data Management
- Viewing claims status, including viewing the adjudication results (the Explanation of Benefits), viewing the claim image, and filing an appeal

During the initial orientation, Health Net Dental's Professional Services Representative assists the provider with the specific profile information for the dental facility. The provider may use this screen to update their profile information when changes in office hours, contacts, languages, etc. All providers (dental facility locations) are issued a unique "access code" required for entry into the website portal. Upon initial log-in, providers are asked to select a password for all future log-ins.

The Provider website portal offers a "Contact Us" capability, allowing providers to send emails directly to the Professional Services Administrative area for response. All provider emails are triaged for immediate response whenever possible. In the event a Professional Services Representative needs to coordinate a response a Health Net Dental administrative staff member will forward the email directly to the appropriate representative who is more familiar with the dental office and it's dentst and staff members.

The i-Transact system is available to you 24 hours a day, 7 days a week!

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) 977-7307	**(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
340 Commerce, Suite 100
Irvine, CA 92602

Approved specialist referrals are based on submitted documentation and the benefit plan as outlined in Title 22 and the DHCS Medi-Cal Manual of Criteria for Dental Services for referral of Medi-Cal members *Evidence of Coverage* (*EOC*). 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 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.

Health Net Dental Specialist Referral Form

Health Net DENTAL

Health Net DENTAL

340 Commerce, Suite 100

Irvine, CA 92602

☐ **Specialty Referral**

(Mail to Health Net with x-ray & documents)

☐ **Emergency Referral**

(Call: (800) 977-7307 or Fax to Health Net)

Provider		**Member**	
Provider #ID	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)	☐ **Pedodontics**

(circle one) Case Type I, II, III, IV Dates of Root Planing UR _____ LL_____ LR _____ LR _____ ☐Other _____ _____	☐ 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 planning, 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 or 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 pediatric dentistry 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 are 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 form is required to authorize study models which are then reviewed by the orthodontic consultant. A referral authorization or denial will be sent per Health Net referral guidelines.

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/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 (refer to the attached sample of an ADA Claim Form), including all pertinent information, to Health Net Dental after rendering treatment to a LAPHP AND GMC Medi-Cal Program 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.

PREVENTIVE DENTISTRY GUIDELINES

PREVENTIVE CARE GUIDELINES – DENTAL HEALTH EDUCATION PROGRAM

Health Net Dental Plan 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 Plan to assist members in receiving preventive care services by providing a benefit for professionally recognized effective preventive services. Health Net Dental Plan provides benefits for many preventive procedures when appropriate, subject to plan limitations. Check individual plan information for exact coverage information, exclusions and limitations.

Dental preventive care guidelines are based on national/regional guidelines such as the American Dental Association, American Academy of Pediatrics, California Dental Association, Title 10, Title 22 and Denti-Cal guidelines.

It is also the policy of Health Net Dental Plan to inform members how to access services from the Plan.

Health Net Dental Plan provides for the following Clinical Care Guidelines aimed at infants, children, adolescents, adults, older adults and addresses pre-natal educational efforts whenever appropriate:

1. **Evaluations**
   Contracted dentists are encouraged to provide periodic evaluation to identify dental concerns as early as possible to keep intervention as conservative as possible. Providers are encouraged to provide a regular recall system to facilitate this early diagnosis and prevention. The Plan recommends periodic evaluations every six months.

2. **Routine Prophylaxis**
   Providers are encouraged to provide routine prophylaxis services in accordance with the definitions in the ADA's Current Dental Terminology (current version). 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 a periodic examination at the dentist's prescription every six months, except for periodontal maintenance.

3. **Caries Prevention**
   Contracted dentists are encouraged to provide a comprehensive program of plaque control geared to the individual patient's susceptibility to caries.

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

   Contracted dentists are encouraged to provide recommendations of sealants and treatment plans including sealants where there is evidence of potential pit and fissure carries in an

otherwise healthy, non-filled tooth. Health Net Dental provides benefit for the placement in sealants, when appropriate, subject to plan limitations.

4. **Periodontal Disease Prevention**
   Contracted 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 malposed 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.

   Contracted dentists are encouraged to provide and document definitive evidence of plaque control instruction, evaluation, and follow up occurring at member encounters. Contracted dentists are also encouraged to include supra-gingival and sub-gingival calculus removal as part of periodontal disease prevention and treatment.

5. **Prevention of Other Oral Diseases and Diagnosis and Evaluation, of Oral Manifestation of Systemic Conditions**
   Recognition of potentially harmful tissue changes shall be the responsibility of the dental practitioner.

6. **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. Pre-natal 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 in accordance with California Society of Pediatric Dentist recommendations.

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

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

CLINICAL DENTISTRY GUIDELINES

The clinical criteria in this Provider Reference Guide are partially based on respected dental organizations such as the American Dental Association (Dental Practice Parameters), the American Academy of Periodontology and the California Dental Association (Guidelines for the Assessment of Clinical Quality and Professional Performance). In addition, this Criteria was critiqued by a peer-based panel of licensed dentists. The procedure codes and nomenclature in this section of the Provider Reference Guide are from Current Dental Terminology, CDT 2009/2010, copyright the American Dental Association. This section of the Provider Reference Guide contains Health Net Dental Plan's Clinical Criteria and Guidelines. All enrollee benefits are subject to their specific plan designs.

NEW PATIENT INFORMATION

A. Registration information should minimally include:

1. Name, sex, birth date, address and telephone number, cell phone number, e-mail address, name of employer, work address and telephone number
2. Name and telephone number of person(s) to contact in an emergency
3. For minors, name of parent(s) or guardian(s) and telephone numbers, if different from above.

B. Pertinent information relative to the patient's chief complaint and dental history, including any problems or complications with previous dental treatment.

C. Medical History - There should be a detailed medical history form comprised of questions which require a "yes" or "no" responses or detail, minimally including:

1. Patient's current health status
2. Name and telephone number of physician and date of last visit
3. History of hospitalizations and/or surgeries
4. History of abnormal (high or low) blood pressure
5. Current medications, including dosages and indications
6. History of drug and medication use (including Fen-Phen/Redux and bisphosfonates)
7. Allergies and sensitivity to medications or materials (including latex)
8. Adverse reaction to local anesthetics
9. History of diseases:

a. Cardio-vascular disease, including heart attack, stroke, history of rheumatic fever, existence of pacemakers, valve replacements and/or stents and bleeding problems, etc.

b. Pulmonary disorders including tuberculosis, asthma and emphysema

c. Nervous disorders

d. Diabetes, endocrine disorders, and thyroid abnormalities

e. Liver or kidney disease, including hepatitis and kidney dialysis

f. Sexually transmitted diseases

g. Disorders of the immune system, including HIV status/AIDS

h. Other viral diseases

h. Musculoskeletal system, including prosthetic joints and when they were placed

10. Pregnancy

    a. Document the name of the patient's obstetrician and estimated due date.

    b. Follow current guidelines in the *ADA* publication, *Women's Oral Health Issues*.

11. History of cancer, including radiation or chemotherapy

12. The medical history form must be signed and dated by the patient or patient's parent or guardian.

13. Dentist's notes following up patient comments, significant medical issues and/or consultation with a physician should be documented on the medical history form or in the progress notes.

14. Medical alerts for significant medical conditions must be uniform and conspicuously located on a portion of the chart used and visible during treatment and should reflect current conditions.

15. The dentist must sign and date all baseline medical histories after review with the patient.

16. The medical history should be updated at appropriate intervals, dictated by the patient's history and risk factors, and must be done at least annually and signed by the patient and dentist.

BASELINE CLINICAL EVALUATION DOCUMENTATION

A. Observations of the initial evaluation are to be recorded in writing and charted graphically where appropriate, including missing or impacted teeth, existing restorations, prior endodontic treatment(s), fixed and removable appliances.

B. Assessment of TMJ status (necessary for adults) and/or classification of occlusion (necessary for minors) should be documented.

C. Full mouth periodontal probing and diagnosis must be documented, including an evaluation of bone levels, gingival recession, inflammation, etiologic factors (e.g., plaque and calculus), mobility, and furcation involvements.

D. A soft tissue/oral cancer examination of the lips, cheeks, tongue, gingiva, oral mucosal membranes, pharynx and floor of the mouth must be documented.

E. Periodontal evaluations and oral cancer screenings should be updated at appropriate intervals, dictated by the patient's history and risk factors, and must be done at least annually.

RADIOGRAPHS

A. An attempt should be made to obtain any recent radiographs from the previous dentist.

B. An adequate number of initial radiographs should be taken to make an appropriate diagnosis and treatment plan, per current FDA/ADA radiographic guidelines.

C. D0210 Intraoral – complete series (including bitewings)

A radiographic survey of the whole mouth, usually consisting of 14-22 periapical and posterior bitewing images intended to display the crowns and roots of all teeth, periapical areas and alveolar bone. *CDT 2009/2010, page 7.*

Benefits for this procedure are determined within each plan design.

Any combination of covered radiographs that meets or exceeds a provider's fee for a complete series will be adjudicated as a complete series, *for benefit purposes only.*

In addition, any panoramic film taken in conjunction with periapical and/or bitewing radiograph(s) will be considered as a complete series, *for benefit purposes only.*

D. Decisions about the types of recall films should also be made by the dentist and based on current FDA/ADA radiographic guidelines, including the complexity of previous and proposed care, caries, periodontal susceptibility, types of procedures and time since the patient's last radiographic examination.

E. A panoramic radiograph is a screening film and is not a substitute for periapical and/or bite wing radiographs when a dentist is performing a comprehensive evaluation.

F. Diagnostic radiographs should reveal contact areas without cone cuts or overlapping, and periapical films should reveal periapical areas and alveolar bone.

G. Radiographs should exhibit good contrast

H. Diagnostic digital radiographs should be printed on photographic quality paper and exhibit good clarity and brightness.

I. Recent radiographs must be mounted, labeled left/right and dated

J. Any patient refusal of radiographs should be documented

K. X-ray duplication fee

When a patient is transferred from one provider to another, diagnostic copies of all x-rays less than two years old should be duplicated for the second provider.

If the transfer is initiated by the provider, the patient may not be charged any X-ray duplication fees.

If the transfer is initiated by the patient, many plans allow the provider to charge for the actual cost of copying the X-rays up to a maximum fee of $25.

NOTE: X-ray duplication fees may not be allowed. Refer to specific plan designs.

PREVENTION

Preventive dentistry may include clinical tests, dental health education and other appropriate procedures to prevent caries and/or periodontal disease.

A. Caries prevention may include the following procedures where appropriate:

- patient education in oral hygiene and dietary instruction
- periodic evaluations and prophylaxis procedures
- topical or systemic fluoride treatment
- sealants

B. Periodontal disease prevention may include a comprehensive program of plaque removal and control in addition to the following procedures:

- oral and systemic health information

- oral hygiene and dietary instructions
- prophylaxis procedures on a regular basis
- occlusal evaluation
- correction of malocclusion and malposed teeth
- restoration and/or replacement of broken down, missing or deformed teeth

C. D1110 and D1120 – prophylaxis procedures

Plan policy- Procedure D1110 applies to patients who are 14 years old and older.

Plan Policy - Procedure D1120 applies to patients who are 13 years old and younger.

D. D1203 and D1204 – topical application of fluoride procedures

Plan Policy - Procedure D1203 applies to patients who are 13 years old and younger.

Plan Policy - Procedure D1204 applies to patients who are 14 years old and older.

E. Other areas of prevention may include:

- smoking cessation programs
- discontinuing the use of smokeless tobacco
- good dietary and nutritional habits for general health
- elimination of mechanical and/or chemical factors that cause irritation
- space maintenance in children where indicated for prematurely lost posterior teeth

F. Recognizing medical conditions that may contribute to or precipitate the need for additional prophylaxis procedures, supported by the patient's physician

TREATMENT PLANNING

A. Treatment plans should be comprehensive and documented in ink.

B. Treatment plans should be consistent with the clinical evaluation findings and diagnosis.

C. Procedures should be sequenced in an order of need consistent with diagnostic and evaluation findings and in compliance with accepted professional standards. Normal sequencing would include relief of pain, discomfort and/or infection, treatment of extensive caries and pulpal inflammation including endodontic procedures,

periodontal procedures, restorative procedures, replacement of missing teeth, prophylaxis and preventive care and establishing an appropriate recall schedule.

D. Informed Consent Process

a. Dentists must document that all recommended treatment options have been reviewed with the patient and that the patient understood the risks, benefits, alternatives, expectancy of success, the total financial responsibilities for all proposed procedures.

b. In addition, the patient should be advised of the likely results of doing no treatment.

c. Appropriate informed consent documentation must be signed and dated by the patient and dentist for the specific treatment plan that was accepted.

d. If a patient refuses recommended procedures, the patient must sign a specific "refusal of care" document.

E. Poor Prognosis

Procedures recommended for teeth with a guarded or poor prognosis (endodontic, periodontal or restorative) are not covered. When providers recommend endodontic, periodontal or restorative procedures (including crown lengthening), they should take into account and document the anticipated prognosis, restorability and/or maintainability of the tooth or teeth involved.

Health Net's licensed dental consultants adjudicate prognosis determinations for the above procedures on a case-by-case basis.

Health Net will reconsider poor prognosis determinations for the above procedures upon receipt of a new claim with appropriate documentation and new diagnostic x-ray(s) taken a minimum of six (6) months after the original date of service.

F. Some upgraded procedures (i.e. metals and porcelain on molars) may not be covered.

G. If more than one procedure would be considered appropriate in treating a dental condition, the Alternate Treatment Plan Formula should be utilized and presented: This formula credits the patient's benefited procedure against the cost of the alternative procedure and the patient's responsibility is calculated as follows: The usual total cost of the alternate treatment minus (–) the usual cost of the covered procedure plus (+) any listed copayment for the covered procedure.

H. If the dentist recommends or the patient chooses between two covered procedures, the chosen procedure would be covered. Example: if an extraction is agreed to instead of an endodontic procedure, the extraction would be covered.

I. Alternative treatment plans and options should be documented with a clear and concise indication of the treatment the patient has chosen. In such cases, the Alternate Treatment Plan Formula should be presented and documented.

J. Should a dentist not agree with a procedure requested by a patient, the dentist may decline to provide the procedure and request that the patient be transferred. In such cases, the dentist is responsible for completion of treatment-in-progress and emergencies until the transfer request is effective.

K. Consultations, referrals and their results should be documented.

PROGRESS NOTES

A. Progress notes constitute a legal record and must be detailed, legible and in ink.

B. All entries must be signed or initialed and dated by the person providing treatment.

C. Entries may be corrected, modified or lined out, but require the name of the person making any such changes and the date.

D. The names and amounts of all local anesthetics must be documented, including the amount of any vasoconstrictor present. If no local anesthetic is used for a procedure that normally requires it (i.e. scaling and root planing), the related rationale should be documented.

E. All prescriptions must be documented in the progress notes or copies kept in the chart, including the medication, strength, amount, directions and number of refills.

F. Copies of all lab prescriptions should be kept in the chart.

G. For paperless dental records, computer entries cannot be modified without identification of the person making the modification and the date of the change.

ENDODONTICS

Note: For benefit purposes providers should document endodontic dates of service as the dates when procedures have been entirely completed, subject to review.

1. Diagnostic techniques used when considering possible endodontic procedures may include an evaluation of:

    a. Pain and the stimuli that induce or relieve it by the following tests:

        i. Thermal

        ii. Electric

        iii. Percussion

iv. Palpation

v. Mobility

b. Non-symptomatic radiographic lesions

2. Treatment planning for endodontic procedures may include consideration of the following:

a. Strategic importance of the tooth or teeth

b. Prognosis – endodontic procedures for teeth with a guarded or poor 5-year prognosis (endodontic, periodontal or restorative) are not covered

c. Presence and severity of periodontal disease

d. Restorability and tooth fractures

e. Excessively curved or calcified canals

f. Following an appropriate informed consent process, if a patient elects to proceed with a procedure that is not covered, the member is responsible for the dentist's usual fee. The dentist should have the member sign appropriate informed consent documents and financial agreements.

g. Teeth that are predisposed to fracture following endodontic treatment should be protected with an appropriate restoration; most posterior teeth should be restored with a full coverage restoration.

h. Occlusion

3. Clinical Guidelines

a. Diagnostic pre-operative radiographs of teeth to be endodontically treated must reveal all periapical areas and alveolar bone.

b. A rubber dam should be used and documented (radiographically or in the progress notes) for most endodontic procedures. Documentation is required for any inability to use a rubber dam.

c. Gutta percha is the endodontic filling material of choice and should be densely packed and sealed. All canals should be obturated.

d. Post-operative radiograph(s), showing all canals and apices, must be taken immediately after completion of endodontic treatment.

e. In the absence of symptoms, post-operative radiographs should be taken at appropriate periodic intervals.

4. Endodontic Referral Necessity

In cases where a defect or decay is seen to be "approaching" the pulp of a tooth and the need for endodontic treatment is not clear, Health Net expects the General Dentist to proceed with the decay removal and possible temporization prior to any referral to an endodontist.

5. Endodontic Irrigation

Providers are contractually obligated to charge no more than the listed copayment for covered root canal procedures whether the dentist uses BioPure, diluted bleach, saline, sterile water, local anesthetic and/or any other acceptable alternative to irrigate the canal.

Providers may not unbundle dental procedures in an attempt to overcharge enrollees. The provider agreement and plan addenda determine what enrollees are to be charged for covered dental procedures. Even if the facility offered BioPure as an alternative to diluted bleach and the enrollee agreed to pay more for it, it would be an overcharge.

Note regarding inappropriate unbundling/coding for endodontic irrigation:

D9630 – Providers should not use this procedure code when reporting endodontic irrigation (BioPur).

The American Dental Association states that: "This procedure code would be used for material dispensed for home use, not to report drugs or medicaments used in the dental office." *CDT 2009/2010, page 174*

6. D3331 treatment of root canal obstruction; non-surgical access

Health Net Dental Plan acknowledges that procedure D3331 is a separate, accepted procedure code. However, this additional treatment is not automatically needed to complete every endodontic procedure. In addition, this procedure should not be submitted with endodontic retreatment procedures D3346, D3347 or D3348.

Health Net Dental Plan will not approve a benefit for this procedure when submitted as part of a predetermination request, prior to actual treatment. However, Health Net's licensed dental consultants will evaluate all available documentation on a case-by-case basis when this procedure is submitted for payment. Providers should submit brief narratives or copies of the patient's progress notes, in order to document that this additional treatment was needed and performed.

7. Pulpotomy

a. A pulpotomy may be indicated in a primary or permanent tooth when pulpal pathology is limited to the coronal pulp and the tooth has a reasonable period of retention and function.

b. Apexification may be indicated in a permanent tooth when there is evidence of a vital and normal pulp with an incompletely developed root or roots to allow maturation and completion of the root apex. Endodontic treatment should be completed when the root is fully formed.

8. Pulp Cap

a. This procedure is not to be used for bases and liners

b. Direct pulp capping is indicated for mechanical or accidental pulp exposures in relatively young teeth and may be indicated in the presence of a small, exposed vital or normal pulp

c. Indirect pulp capping (re-mineralization) is indicated to attempt to minimize the possibility of pulp exposure in very deep caries in vital teeth

9. Endodontic surgical treatment should be considered only in special circumstances, including:

a. The root canal system cannot be instrumented and treated non-surgically

b. There is active root resorption

c. Access to the canal is obstructed

d. There is gross over-extension of the root canal filling

e. Periapical or lateral pathosis persists and cannot be treated non-surgically

f. Root fracture is present or strongly suspected

g. Restorative considerations make conventional endodontic treatment difficult or impossible

10. Endodontic procedures may not be covered when a tooth or teeth have a poor prognosis due to:

a. untreated or advanced periodontal disease

b. gross destruction of the clinical crown and/or root decay at or below the alveolar bone

c. a poor crown/root ratio

ORAL SURGERY

A. Each dental extraction should be based on a clearly recorded diagnosis for which extraction is the treatment of choice of the dentist and the patient.

B. General Dentists are expected to provide routine oral surgery, including:

1. uncomplicated extractions
2. routine surgical extractions
3. incision and drainage of intra-oral abscesses
4. minor surgical procedures and postoperative services

C. Extractions may be indicated in the presence of non-restorable caries, untreatable periodontal disease, pulpal and periapical disease not amendable to endodontic therapy, to facilitate surgical removal of a cyst or neoplasm, or when overriding medical conditions exist, providing compelling justification to eliminate existing or potential sources of oral infection.

D. When teeth are extracted, all portions of the teeth should be removed. If any portion of a tooth (or teeth) is not removed, patient notification must be documented.

E. Local anesthesia is preferred in the absence of specific indications for the use of general anesthesia.

F. Minor contouring of bone and soft tissues during a surgical extraction is considered to be a part of and included in a surgical extraction, D7210.

G. Bone grafting (D7953) for ridge preservation may be indicated in preparation for implant placement or where alveolar contour is critical to planned prosthetic reconstruction.

H. Documentation of a surgical procedure should include: recording the tooth number, tissue removed and a description of the surgical method used; a record of unanticipated complications such as: failure to remove planned tissue/root tips; displacement of tissue to abnormal sites; unusual blood loss; presence of lacerations and other surgical or non-surgical defects.

I. Third molar extractions & benefit determinations

Health Net's licensed dental consultants adjudicate benefits on a case-by-case basis.

It is appropriate to report procedure D7220, D7230, D7240 or D7241 for the removal of an impacted tooth, with active pathology.

"Impacted tooth: An unerupted or partially erupted tooth that is positioned against another tooth, bone, or soft tissue so that complete eruption is unlikely." *CDT 2009/2010, page 204.*

The prophylactic removal of a tooth or teeth that appear to exhibit an unimpeded path of eruption and/or exhibit no active pathology is not covered.

The removal of third molars, or any other tooth, where pathology such as infection, non-restorable carious lesions, cysts, tumors, and damage to adjacent teeth is evident may be covered.

The extraction of third molars based on general and inconclusive findings such as crowding, headaches, pressure, earaches, or natural pains associated with eruption is not covered. The removal of asymptomatic, unerupted, third molars in the absence of active pathology may not be covered. By definition, completely covered and unerupted third molars cannot exhibit pericoronitis.

J. All suspicious lesions should be biopsied and examined microscopically.

K. D9220 – Deep sedation / General Anesthesia

When D9220 is listed as a covered procedure, benefits may be approved in conjunction with the following approved impaction extractions: D7230, D7240 and D7241.

Licensed dental consultants adjudicate D9220 benefits for other, simpler extractions on a case-by-case basis, with consideration for:

1. medical necessity and/or special needs patients
2. the extent and/or number of infected teeth
3. alveoloplasty and/or procedures involving the excision of bone

L. D7953 bone replacement graft for ridge preservation – per site

"Osseous autograft, allograft or non-osseous graft is placed in an extraction site at the time of the extraction to preserve ridge integrity (e.g., clinically indicated in preparation for implant reconstruction or where alveolar contour is critical to planned prosthetic reconstruction). *CDT 2009/2010, page 64*

Code D7953 should be reported when the bone graft is placed in an extraction site at the time of the extraction to preserve ridge integrity." (See above for indications.) *CDT 2009/2010, page 169.*

M. D4263 bone replacement graft – first site in quadrant

"This procedure involves the use of osseous autografts, osseous allografts or non-osseous grafts to stimulate periodontal regeneration when the disease process has lead to a deformity of the bone...". *CDT 2009/2010, page 25*

"Code D4263 should be reported when the bone graft is performed to stimulate periodontal regeneration when the disease process has led to deformity of the bone around an existing tooth." *CDT 2009/2010, page 169*

Note: Benefits for bone graft procedures are based on individual plan designs, including limitations and exclusions.

PERIODONTICS

All children, adolescents and adults should be evaluated for evidence of periodontal disease. If pocket depths do not exceed 3 mm and there is no bleeding on probing or evidence of radiographic bone loss, it is appropriate to document the patient's periodontal status as being within normal limits (WNL).

Comprehensive oral evaluations should include the quality and quantity of gingival tissues. Additional components of the evaluation would include documenting: six-point periodontal probing for each tooth, the location of bleeding, exudate, plaque and calculus, significant areas of recession, mucogingival problems, mobility, open or improper contacts, furcation involvement, and occlusal contacts or interferences. Following the completion of a comprehensive evaluation, a diagnosis and treatment plan should be completed.

PERIODONTAL TREATMENT SEQUENCING:

A. D4355 - Full mouth debridement to enable comprehensive evaluation and diagnosis

"The gross removal of plaque and calculus that interfere with the ability of the dentist to perform a comprehensive oral evaluation. This preliminary procedure does not preclude the need for additional procedures." *CDT 2009/2010, page 28*

In most cases, this procedure would be followed by the completion of a comprehensive evaluation at a subsequent appointment. This rescheduling may allow some initial soft tissue response and shrinkage prior to performing full mouth periodontal probing.

Note, this procedure:

1. must be supported by radiographic evidence of heavy calculus
2. is not a replacement code for procedure D1110
3. is not appropriate on the same day as procedure D0150 or D0180

B. D4341/D4342 - Scaling and root planing

Treatment involves the instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus, biofilm and stains from these surfaces. The absence of calculus should be evident on post treatment radiographs. These procedures are:

- considered to be within the scope of a General Dentist or a dental hygienist
- supported when full mouth periodontal pocket charting demonstrates at least 4 mm pocket depths. It is common for radiographs to reveal evidence of bone loss and/or the presence of interproximal calculus.
- Scaling and root planing procedures (D4341/D4342) are generally not performed in the same quadrants or areas for 2 years following initial completion of these services. In the interim, any localized scaling and root planning would be included within periodontal maintenance procedure D4910.

DEFINITIVE OR PRE-SURGICAL SCALING AND ROOT PLANING:

1. For early stages of periodontal disease, this procedure is used as definitive treatment and the patient may not need to be referred to a periodontist based upon tissue response and the patient's oral hygiene.

2. For later stages of periodontal disease, the procedure may be considered pre-surgical treatment and the patient may need to be referred to a periodontist, again based on tissue response and the patient's oral hygiene.

Note: Health Net Dental Plan requires that both definitive and pre-surgical scaling and root planing to be provided at a primary facility before considering referral requests to a periodontal specialist.

TWO QUADRANTS PER APPOINTMENT

Periodontal scaling and root planing is arduous and time consuming, involving instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus, and stains from these surfaces.

As a guideline, Health Net Dental Plan benefits only two quadrants per appointment. If a clinician recommends and/or completes more that two quadrants per appointment, documentation supporting the additional quadrant(s) must be included in the patient's records and/or progress notes.

- Local anesthesia is commonly used. If it is not used, the reason(s) should be documented. The use of topical anesthetics is considered to be a part of and included in this procedure.

- Home care oral hygiene techniques should be introduced and demonstrated.
- A re-evaluation following scaling and root planing should be performed. This re-evaluation should be performed at least 4-6 weeks later and include: a description of tissue response; pocket depths changes; sites with bleeding or exudate; evaluation of the patient's homecare effectiveness.

PROCEDURE CODES D1110 AND D4341

It is usually not appropriate to perform D1110 and D4341 on the same date of service. Health Net 's licensed dental consultants may review documented rationale for any such situations on a case-by-case basis.

- Adjunctive localized delivery antimicrobial agents may be used selectively for several residual pockets depths of at least 5 mm's, at least four weeks after completion of scaling and root planing.
- It may be appropriate to bypass scaling and root planing in certain limited circumstances and proceed directly to surgical treatment such as in the presence of severe acute infection, or where direct visualization of deep root areas is needed.
- Periodontal maintenance at regular intervals should be instituted following scaling and root planing if the periodontal condition has improved to a controllable level. Periodontal pocket depths and gingival status should be recorded periodically.
- The patient's homecare compliance and instructions should be documented.

IRRIGATION, PERIODONTAL - BY REPORT- D4999

If an enrollee elects not to have elective irrigation with other procedures (i.e. D1110, D4355, D4341, D4342 or D4910), contracted dentists may not limit the enrollee's access to other benefited procedures.

A patient's refusal of irrigation does not constitute grounds for requesting a patient transfer.

Notes on appropriate coding:

D4999 – The American Dental Association recommends using this generic procedure code when reporting irrigation (chlorhexidine). *CDT 2009/2010, page 158*

D9630 – The American Dental Association implies that providers should not use this procedure code when reporting irrigation (chlorhexidine).

"This procedure code would be used for material dispensed for home use, not to report drugs or medicaments used in the dental office." *CDT 2009/2010, page 174*

Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report - D4381

Benefits are not available when D4381 is performed with D4341 or D4342 in the same quadrant on the same date of service.

Dentists may consider the appropriate use of local delivery antimicrobials for chronic periodontitis patients as an adjunct to procedures D4341/D4342 (scaling and root planing) AFTER the following steps*:

1. A clinician has completed D4341/D4342 and allowed a minimum 4-week healing period. Then, the patient's pockets are re-probed and re-evaluated to determine the clinical response to the scaling and root planing.

2. Re-evaluation confirms that several teeth were non-responsive to scaling and root planing, with localized residual pocket depths of 5 mm's or deeper plus inflammation.

Health Net dental consultants may approve D4381 benefits for non-responsive cases following scaling and root planing on a *by report* basis:

1. In such cases, benefits may be approved for two teeth per quadrant in any twelve month period

2. Other procedures, such as systemic antibiotics** or surgery, should be considered when multiple teeth with 5 mm pockets or deeper exist in the same quadrant.

Treatment alternatives such as systemic antibiotics** or periodontal surgery instead of procedure D4381 may be considered when:

- Multiple teeth with pocket depths of 5 mm's or deeper exist in the same quadrant
- Procedure D4381 was completed at least 4-weeks after D4341 but a re-evaluation of the patient's clinical response confirms that D4381 failed to control periodontitis (i.e. a reduction of localized pocket depths)
- Anatomical defects are present (i.e. intrabony defects)

* *American Academy of Periodontology Statement on Local Delivery of Sustained or Controlled Release Antimicrobials as Adjunctive Therapy in the Treatment of Periodontitis. May, 2006*

** *American Academy of Periodontology Position Paper, Systemic Antibiotics in Periodontics. November, 2004*

WARNINGS/PRECAUTIONS: This procedure may be contra-indicated during pregnancy.

"May cause fetal harm during pregnancy." *ADA/PDR Guide to DENTAL THERAPEUTICS, Fourth Edition*

C. Periodontal surgical procedures

- The patient must exhibit a willingness to accept periodontal treatment and practice an appropriate oral hygiene regimen prior to consideration for periodontal surgical procedures.

- Case history, including patient motivation to comply with treatment and oral hygiene status, must be documented.

- Patient motivation may be documented in a narrative by the attending dentist and/or by a copy of patient's progress notes documenting patient follow through on recommended regimens.

- In most cases, there must be evidence of scrupulous oral hygiene for at least three months prior to the pre-authorization for periodontal surgery.

- Consideration for a direct referral to a periodontist would be considered on a by report basis.

- Periodontal surgical procedures are covered only in cases that exhibit a favorable long-term prognosis. Surgical procedures for the retention of teeth that are being used as prosthetic abutments is covered only when the teeth would exhibit adequate bone support for the forces to which they are, or will be, subjected.

- Periodontal pocket reduction surgical procedures may be covered in cases where the pocket depths are 5 mm's or deeper, following soft tissue responses to scaling and root planing.

- Osseous surgery procedures may not be covered if:

    1. pocket depths are 4 mm's or less and appear to be maintainable by non-surgical means (i.e. periodontal maintenance and root planing)

    2. patients are smokers or diabetics who's disease is not being adequately managed

- Periodontal pocket reduction surgical procedures should result in the removal of residual calculus and granulation tissue with improved physiologic form of the gingival tissues.

- Osseous surgery and regenerative procedures should also correct and reshape deformities in the alveolar bone where indicated.

- Soft tissue gingival grafting should be done to correct gingival deficiencies where appropriate.

CLINICAL CROWN LENGTHENING – HARD TISSUE - D4249

"This procedure is employed to allow restorative procedure or crown with little or no tooth structure exposed to the oral cavity. Crown lengthening requires reflection of a flap and is performed in a healthy periodontal environment, as opposed to osseous surgery, which is performed in the presence of periodontal disease. Where there are adjacent teeth, the flap design may involve a larger surgical area." *CDT 2009/2010, page 25*

Health Net considers the management of soft tissues performed during a restorative procedure or crown preparation with final impressions to be a part of and included in the fee for the related procedure. Providers may not charge Health Net or the patient a separate fee for D4249 if it is performed on the same tooth on the same day as preparation and final impressions for a crown.

D. Periodontal maintenance and supportive therapy intervals should be individualized, although three month recalls are common for many patients.

RESTORATIVE

DIAGNOSIS AND TREATMENT PLANNING

It is appropriate to restore teeth with radiographic evidence of caries, lost tooth structure, defective or lost restorations, and/or for post-endodontic purposes.

Restorative treatment must be identified using valid procedure codes as found in the current edition of the American Dental Association's Current Dental Terminology (CDT). This source includes nomenclature and descriptors for each procedure code.

Sequencing of treatment must be appropriate to the needs of the patient. Treatment results, including margins, contours and contacts, should be clinically acceptable. The long-term prognosis should be good (5 years or more). Guidelines for the Assessment of Clinical Quality and Professional Performance and standards set by the specialty boards shall apply.

A. Restorative dentistry includes the restoration of hard tooth structure lost as a result of caries, fracture, erosion, attrition, or trauma.

B. Restorative procedures in operative dentistry include amalgam, composites, inlays, onlays, crowns, as well as the use of various temporary materials.

AMALGAM FILLINGS, SAFETY & BENEFITS

American Dental Association Statement: Food and Drug Administration Action on Dental Amalgam

"WASHINGTON, July 28, 2009—The American Dental Association (ADA) agrees with the U.S. Food and Drug Administration's (FDA) decision not to place any restriction on the use of dental amalgam, a commonly used cavity filling material…

Dental amalgam is a cavity-filling material made by combining mercury with other metals such as silver, copper and tin. Numerous scientific studies conducted over the past several decades, including two large clinical trials published in the April 2006 Journal of the American Medical Association, indicate dental amalgam is a safe, effective cavity-filling material for children and others. And, in its 2009 review of the scientific literature on amalgam safety, the ADA's Council on Scientific Affairs reaffirmed that the scientific evidence continues to support amalgam as a valuable, viable and safe choice for dental patients…".

Amalgam free dental offices - If a dentist chooses not to provide amalgam fillings, alternative posterior fillings must be made available for Health Net patients. Any listed amalgam copayments would still apply.

Any alleged "allergies" to silver amalgam fillings must be supported in writing from a physician who is a board certified allergist. Any benefit issues related to dental materials and "allergies" will be adjudicated on a case-by-case basis by a licensed Health Net Dental Plan dental consultant.

C. The choice of restorative materials depends on the nature and extent of the defect to be restored, location in the mouth, stress distribution expected during mastication and esthetic requirements.

   i. The procedures of choice for treating caries or the replacement of an existing restoration not involving or undermining the cusps of posterior teeth is generally amalgam or composite.

   ii. The procedures of choice for treating caries or the replacement of an existing restoration not involving or undermining the incisal edges of an anterior tooth is composite.

   iii. Restorations for chipped teeth may be covered.

   iv. The replacement of clinically acceptable amalgam fillings with an alternative materials (composite, crown, etc.) is considered cosmetic and is not covered.

   v. Restorative procedures for teeth exhibiting a poor prognosis due to gross carious destruction of the clinical crown at/or below the bone level, advanced periodontal disease, untreated periapical pathology or poor restorability are not covered.

   vi. Pulpotomies and pre-formed crowns for primary teeth are covered only if the tooth is expected to be present for at least six months.

vii. For posterior primary teeth that have had extensive loss of tooth structure, the appropriate treatment is generally a prefabricated stainless steel crown or for anterior teeth, a stainless steel or prefabricated resin crown.

viii. When incisal edges of anterior teeth are undermined because of caries or replacement of a restoration undermining the incisal edges or a fracture, the procedures of choice may be veneers or crowns, either porcelain fused to metal or porcelain/ceramic substrate.

ix. An onlay should be considered when there is sufficient tooth structure, but cusp support is needed. An inlay is usually not a restoration of choice.

x. An inlay is usually not a restoration of choice.

PREVENTIVE RESIN RESTORATIONS

There is no accepted *CDT procedure code* for Preventive Resin Restorations. Such restorations must be reported as one of the following *CDT procedures*:

Sealant – per tooth - D1351

Mechanically and/or chemically prepared enamel surface sealed to prevent decay. If the resin restoration does not penetrate dentin, D1351 is appropriate.

Resin-based composites - D2330, D2391 or D2392

If the resin restoration does penetrate dentin, one of the resin-based composite codes is appropriate.

Desensitizing - D9910/D9911

Appropriate reporting of these procedures is clearly detailed below.

All acid etching, adhesives (including resin bonding agents), liners, bases and/or curing techniques are considered to be a part of and included in amalgam and composite restoration procedures. None of these included procedures may be unbundled and/or charged as a separate service.

Application of desensitizing medicament - D9910

Includes in-office treatment for root sensitivity. Typically reported on a “per visit” basis for application of topical fluoride. This code is not to be used for bases, liners or adhesives under restorations.

Application of desensitizing resin for cervical and/or root surface, per tooth - D9911

Typically reported on a “per tooth” basis for application of adhesive resins. This code is not to be used for bases, liners, or adhesives used under restorations.” *CDT 2009/2010, page 74*

CROWNS AND FIXED BRIDGES

Note: Providers may document the date of service for these procedures to be the date when final impressions are completed, subject to review.

UPGRADES

Plan designs limit the total maximum amount chargeable to a member for any combination of upgrades to $250 per unit.

Typical upgrades include:

- Choice of metal – noble, high noble, titanium alloy or titanium
- porcelain on molar teeth
- porcelain margins, by report

  (porcelain margin upgrades may be reported as D2999 for single crowns or as D6999 for abutment crowns)

SINGLE CROWNS

A. When bicuspid and anterior crowns are covered, the benefit is usually a porcelain fused to a base metal crown or a porcelain/ceramic substrate crown.

B. When molar crowns are indicated due to caries, an undermined or fractured off cusp or the necessary replacement of a restoration due to pathology, the benefit is usually a base metal crown.

C. Porcelain/ceramic substrate crowns on molars are susceptible to fracture and are generally not appropriate.

D. When anterior teeth have incisal edges/corners that are undermined or missing because of caries, a defective restoration or are fractured off, a labial veneer may not be sufficient. The treatment of choice may then become a porcelain fused to a base metal crown or porcelain/ceramic substrate crown.

E. Final crowns for teeth with a good prognosis should be sequenced after performing necessary endodontic and/or periodontic procedures and such teeth should exhibit a minimum crown/root ratio of 50%.

F. Crown services must be documented using valid procedure codes as found in the *American Dental Association's Current Dental Terminology (CDT).*

BRAND NAME DENTAL MATERIALS/ALTERNATIVES

While Health Net requires that its contracted dentists utilize accepted and approved dental materials approved by the FDA when treating eligible patients, it does not

require that they offer brand name restorations, crowns or bridges in lieu of generic alternatives.

However, if a contracted dentist elects to do so, appropriate American Dental Association (ADA) procedure codes listed in the current version of the Current Dental Terminology (CDT) reference manual must be presented to identify the alternate procedure(s) and the applicable Evidence of Coverage shall determine the patient's total financial responsibility.

For example, a patient's benefit and copayment responsibility for D2750 would apply whether the dentist offered a generic porcelain fused to high noble crown or a crown made of porcelain fused to either a precious foil coping (e.g. Sunrise) or composite metal coping (e.g. Captek).

Similarly, a patient's benefit and copayment for D2740 applies regardless of the technique or ceramic/porcelain materials used to produce a non-metallic crown. If a contracted dentist offers a covered, generic, all ceramic/porcelain crown or any brand name alternative (e.g., Vitadur-N, Hi-Ceram, Optec HSP, In-Ceram, Empress, Cerec, AllCeram, Procera, Lava, etc.), the same copayment would apply.

POST AND CORE PROCEDURES INCLUDING BUILDUPS

D2952 - Post and core in addition to crown, indirectly fabricated post and core are custom fabricated as a single unit.

D2954 prefabricated post and core in addition to crown core is built around a prefabricated post. This procedure includes the core material" *CDT 2009/2010, page 18.*

By CDT definitions, each of these procedures includes a "core". Therefore, providers may not unbundle procedure D2950 core buildup, including any pins and report it separately from either of these procedures for the same tooth during the same course of treatment.

K. Outcomes

- Margins, contours and contacts must be clinically acceptable
- Prognosis should be good for a minimum of 5-years
- *Guidelines for the Assessment of Clinical Quality and Professional Performance,* published by *The California Dental Association,* and standards set by the specialty boards shall apply.

FIXED BRIDGES

A. When a single posterior tooth is missing on one side of an arch and there are clinically adequate abutment teeth on each side of the missing tooth, the general choices to replace the missing tooth would be a fixed bridge or an implant.

If it is also necessary to replace teeth on the opposite side of the same arch, the benefit would be a removable partial denture instead of the fixed bridge.

B. Fixed bridges are not covered benefits in the presence of untreated moderate to severe periodontal disease, as evidenced in x-rays, or when a proposed abutment tooth or teeth have poor crown/root ratios.

C. When up to all four incisors are missing in an arch, the potential abutment teeth are clinically adequate and implants are not appropriate, possible benefits for a fixed bridge would will be evaluated on a *case-by-case* basis. Evaluation and diagnosis of any patient's periodontal status or active disease should be documented with recent full mouth periodontal probing and submitted with any benefit determination.

D. Bridge abutments would generally be full coverage crowns.

E. A distal cantilevered pontic is generally inappropriate for the replacement of a missing posterior tooth. However, a mesial cantilevered pontic but may be acceptable for the replacement of a maxillary lateral incisor when an adequate adjacent cuspid can be used for the abutment crown.

F. Third molars are generally not be replaced, particularly when there is no opposing occlusion

G. Outcomes

i. Margins, contours and contacts should be clinically acceptable

ii. Prognosis should be good for long term longevity

iii. Guidelines for the Assessment of Clinical Quality and Professional Performance of the California Dental Association shall apply.

I. Full Mouth Reconstruction

Full mouth reconstruction describes the process of restoring (rebuilding) the occlusion of a patient's remaining teeth. This treatment typically involves 10 or more units of fixed crown and bridge procedures, including the establishment of a new vertical dimension.

Most plans do not cover the crown and fixed bridge procedures involved in Full Mouth Reconstruction. However, this limitation does not exclude benefits for any other covered procedures (i.e. endodontic therapy, extractions, buildups or post & cores).

REMOVABLE PROSTHODONTICS

Note: Providers may document the date of service for these procedures to be the date when final impressions are completed, subject to review.

PARTIAL DENTURES

i. A removable partial denture is normally not indicated for a single tooth replacement of non-functional second or third molars.

ii. Partial dentures are covered when missing posterior teeth require functional replacements on both sides of the same arch.

iii. Full or partial dentures are not covered for replacement if an existing appliance can be made satisfactory by relining or repair.

iv. Full or partial dentures are not a covered if a clinical evaluation reveals the presence of a satisfactory appliance, even if a patient demands replacement due to their own perceived functional and/or cosmetic problems.

v. Unilateral removable partial dentures are rarely appropriate because if they are dislodged they may be swallowed or inhaled into the lungs.

vi. Abutment teeth should be restored prior to the fabrication of a removable appliance and would be covered if the teeth meet the same stand alone benefit requirements of a single crown.

vii. Partials should be designed so that they do not harm the remaining teeth.

viii. Materials used for removable partial dentures must be strong enough to resist breakage during normal function, nonporous, color stable, esthetically pleasing, non-toxic and non-abrading to the opposing or supporting dentition.

ix. Appliances should be designed to cause no damage to abutment teeth and/or periodontal tissues, and to facilitate oral hygiene.

x. Flexible partial dentures (D5225/D5226) include the following brands: *Valplast, Thermoflex, Flexite*, etc.

xi. *Combo Partials* – because these appliances may include cast metals, they would be appropriately reported as D5213/D5214.

COMPLETE DENTURES

xii. Complete dentures are the appliances of last resort, particularly in the mandibular arch. Patients should be fully informed of their significant limitations.

xiii. Establishing vertical dimension is considered to be a part of and included in the fee/process for fabricating a complete denture (standard, interim or

immediate). Therefore, benefits for a complete denture are not limited or excluded in any way simply because of the necessity to establish vertical dimension.

INTERIM COMPLETE DENTURES

These non-covered appliances are only intended to replace teeth during the healing period, prior to fabrication of a subsequent, covered complete denture.

IMMEDIATE COMPLETE DENTURES

These covered dentures are inserted immediately after a patient's remaining teeth are removed. While immediate dentures offer the benefit of never having to be without teeth, they must be relined (refitted on the inside) during the healing period after the extractions have been performed. The reason for such relining is that the shape of the supporting soft tissues and bone changes significantly during healing, causing the denture to become loose. In many cases, immediate dentures must be discarded and replaced with non-covered (limitation) standard complete dentures within the first six months.

REPAIRS AND RELINES

xiv. Repair of a partial or complete denture may be covered if it results in a serviceable appliance, subject to limitations. If the cost of repairing and/or relining an appliance is greater than a new appliance, the repair and/or reline would not be covered.

xv. Supporting soft tissues and bone shrink over time, resulting in decreased retention and/or stability of the appliance. A reline of a partial or complete denture would be covered (limitations may apply) if the procedure would result in a serviceable appliance.

IMPLANTS

GENERAL GUIDELINES

1. A thorough history and clinical examination leading to the evaluation of the patient's general health and diagnosis of his/her oral condition must be completed prior to the establishment of an appropriate treatment plan.

2. A conservative treatment plan should be considered prior to providing a patient with one or more implants. Crown(s) and fixed partial prosthetics for dental implants may be contraindicated for the following reasons:

   - Adverse systemic factors such as diabetes and smoking
   - Poor oral hygiene and tissue management by the patient
   - Inadequate osseo-integration (movable) of the dental implant(s)

- Excessive para-function or occlusal loading
- Poor positioning of the dental implant(s)
- Excessive loss of bone around the implant prior to its restoration
- Mobility of the implant(s) prior to placement of the prosthesis
- Inadequate number of implants or poor bone quality for long span prostheses
- Need to restore the appearance of gingival tissues in high esthetic areas
- When the patient is under 16 years of age, unless unusual conditions prevail

RESTORATION

i. The restoration of dental implants differs in many ways from the restoration of teeth, and as such, the restoration of dental implants has separate guidelines.

ii. Care must be exercised when restoring dental implants so that the occlusal and lateral loading of the prosthesis does not damage the integration of the dental implant system to the bone or affect the integrity of the implant system itself.

iii. Care must also be exercised when designing the prosthesis so that the hardness of the material used is compatible with that of the opposing occlusion.

iv. Jaw relationship and intra arch vertical distance should be considered in the initial treatment plan and selection of retentive and restorative appliances.

OUTCOMES

i. The appearance of fixed prosthetic appliances for implants may vary considerably depending on the location, position and number of implants to be restored.

ii. The appearance of the appliances must be appropriate to meet the functional and esthetic needs of the patient.

iii. The appearance and shape of the fixed prosthesis must exhibit contours that are in functional harmony with the remaining hard and soft tissues of the mouth.

iv. They must exhibit good design form to facilitate good oral hygiene, even in cases where the prosthesis may have a ridge lap form.

v. Fixed implant prostheses must incorporate a strategy for removal of the appliance without damage to the implant, or adjacent dentition, so that the implant can be utilized in cases where there is further loss of teeth, or where repair of the appliance is necessary.

vi. Multiple unit fixed prostheses for implants must fit precisely and passively to avoid damage to the implants or their integration to the bone.

vii. It is a contra-indication to have a fixed dental prosthesis abutted by both dental implant(s) and natural teeth (tooth) without incorporating a design to alleviate the stress from an osseo-integrated (non-movable) abutment to a natural tooth.

viii. It is the responsibility of the restoring dentist to evaluate the initial acceptability of the implants prior to proceeding with a restoration.

ix. It is the responsibility of the restoring dentist to instruct the patient in the proper care and maintenance of the implant system and to evaluate the patient's care initially following the final placement of the prosthetic restoration.

x. Fixed partial prostheses, as well as a single unit crowns, are expected to have a minimum prognosis for 5-years of service.

QUALTIY 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. Network Dentists are integral in the Program's development and implementation. 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 Improvement 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 Improvement 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, online 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.

FAIR HEARING.

Members have the right to request a fair hearing from the California Department of Social Services, at any time (whether or not a grievance has been submitted), by contacting the Public Inquiry and Response Unit at 1-800-952-5253, TDD 1-800-952-8349, or by writing:
California Department of Social Services State Hearing Division P.O. Box 944243, MS 19-37
Sacramento, CA 94244-2430

There is a 90-day deadline from the order or action complained of to file a fair hearing. The fair hearings are usually held within 90 days of request. However, the State is required to hold the hearing within three work days where the dental plan or the Member's provider indicates that taking the time for a standard resolution involving a denied health care service could seriously harm the Member's life or health, or ability to attain, maintain or regain maximum function. Members may receive continued benefits during the fair hearing process. You have the right to be represented by legal counsel, a friend or other spokesperson. A fair hearing can be

submitted regardless of whether or not a grievance has been submitted or resolved and when a health care service requested by member or provider has been denied, deferred or modified.

STANDARDS AND GUIDELINES

ACCESS AND AVAILABILITY (QM/QI PROGRAM OVERSIGHT)

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 be 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 is 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 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 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 RE-CREDENTIALING

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 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 (QM/QI PROGRAM OVERSIGHT)

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 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 copayments
- To assist a member in understanding recommended treatment and copayments

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 are 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 has 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 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), Hepetitis 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 DHCS 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. DHCS 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 Ssgar 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.

FORMS AND EXHIBITS

MEMBERS CAN SUBMIT A GRIEVANCE VIA TELEPHONE, FAX, E-MAIL, LETTER, ONLINE 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.

Health Net's Web Site – www.hndental.com, provides a form that allows the user to directly enter information. This form is provided online in multiple languages. This form may be accessed by going to the web sited www.hndental.com and clicking on GRIEVANCE FORM in the upper right corner.

Complaints may be directly faxed on the provided form or written out to Health Net – fax number 949-270-0109.

HEALTH NET DENTAL WRITTEN INQUIRY/COMPLAINT FORM-

Please return to:

HEALTH NET DENTAL

340 Commerce, Suite 100

Irvine, CA 92602

DATE RECEIVED_____

Date: _____ Member Name: _____

Subscriber ID: _____

Member Home Address: _____

Member Phone Number: Home: _____ _____ Work: _____

Patient Phone Number: Home: _____ _____ Work: _____

Employer Name: _____

Dental Facility Name: _____ Dentist Name: _____

Date: of last visit: _____ Location: _____

Inquiry/Grievance: _____

_____

_____

_____

_____

The California Department of Managed Health Care (DMHC) is responsible for regulating healthcare service plans. If you have a grievance against Health Net, you should first telephone Health Net Dental at **(800) 977-7307** [TDD/TTY for the hearing impaired at (**800) 880-3165**] and use Health Net Dental's grievance process before contacting the DMHC. Using this grievance procedure does not prohibit any legal rights or remedies that may be available to you. If you need help with a Grievance involving an emergency, a grievance that has not been satisfactorily resolved by Health Net Dental, or a grievance that remained unresolved for more than 30 days, you may call the DMHC for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial view of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency and urgent medical services. The DMHC has a toll-free telephone number at **(888) HMO-2219** to receive complaints regarding health plans. The hearing and speech impaired may use the DMHC's TDD line at (**877) 688-9891** to contact the DMHC. The DMHC's Web site at **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

HEALTH NET DENTAL SPECIALIST REFERRAL FORM

Health Net DENTAL

340 Commerce, Suite 100

Irvine CA 926902

☐ **Specialty Referral**
(Mail to Health Net with x-ray & documents)

☐ **Emergency Referral**
(Call: (800) 977-7307 or Fax to Health Net)

Provider		**Member**	
Prov #ID	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)	☐ **Oral Surgery** (must submit PA or Pano)
☐ **Prognosis** _____	☐ Pain
☐ Pain	☐ Swelling
☐ Retreatment (date of original RCT ___)	☐ Periocornitis caused by exacerbated third molars
☐ Calcification (circle one)	☐ Non-restorable – caries/internal resorption
Canal involved M D B P	☐ Resorption of roots of adjacent teeth
☐ Curved Canal (circle one)	☐ Interference with prosthesis
Canal involved M D B P	of edentulous arches
☐ Internal/External Resorption	☐ Other _____
☐ Apicoectomy/Retrofiling	• In absence of Pathology extractions of
☐ Other _____	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 # _____

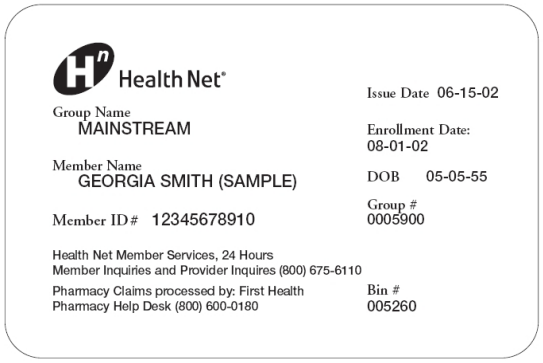
Date Processed _____

Approved ☐ Denied ☐ Modified ☐

X-rays reviewed _____ Tracking # _____

Comments_____

Sample Member Identification Card


Health Net

Group Name
MAINSTREAM

Issue Date 06-15-02

Enrollment Date:
08-01-02

Member Name
GEORGIA SMITH (SAMPLE)

DOB 05-05-55

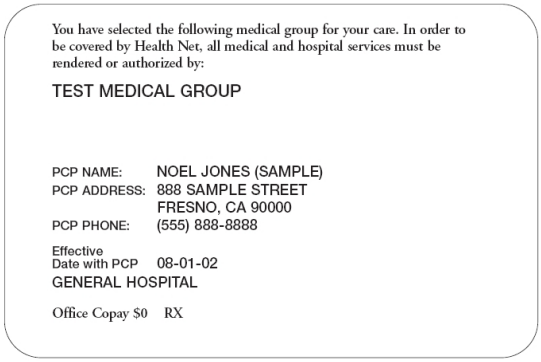
Member ID # 12345678910

Group #
0005900

Health Net Member Services, 24 Hours
Member Inquiries and Provider Inquires (800) 675-6110

Pharmacy Claims processed by: First Health
Pharmacy Help Desk (800) 600-0180

Bin #
005260


You have selected the following medical group for your care. In order to be covered by Health Net, all medical and hospital services must be rendered or authorized by:

TEST MEDICAL GROUP

PCP NAME: NOEL JONES (SAMPLE)
PCP ADDRESS: 888 SAMPLE STREET
FRESNO, CA 90000
PCP PHONE: (555) 888-8888

Effective
Date with PCP 08-01-02

GENERAL HOSPITAL

Office Copay $0 RX

TRANSFER REQUEST FORM

☐ LAPHP or GMC

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
340 Commerce, Suite 100
Irvine, CA 92602

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

Quick Reference Guide

Health Net Dental

(800) 977-7307

Member Enrollment

(800) 213-6991

General and Administrative

(800) 977-7307

Specialty Referral

(800) 977-7307

Claims

Health Net DENTAL

340 Commerce, Suite 100

Irvine, CA 92602

Telephone: (800) 977-7307

Provider Relations

(888) 273-2713

Emergency Referrals

(800) 977-7307

Grievances

Health Net Dental

340 Commerce, Suite 100

Irvine, CA 92602

Telephone: (800) 977-7307

Dental Director

(619) 445-2484

Robert.e.shechet@healthnet.com

Member Services

Health Net DENTAL

340 Commerce, Suite 100

Irvine, CA 92602

Telephone: (800) 977-7307

Ordering Forms

Health Net DENTAL

340 Commerce, Suite 100

Irvine, CA 92602

Telephone: (800) 977-7307

Faxing forms to Health Net

949-270-0109 fax number