

VETERANS  
ADMINISTRATION

DENTISTRY

December 23, 1987  
M-4

Department of  
Medicine and Surgery  
Washington, Dc 20420

M-4

Department of Medicine and Surgery  
Veterans Administration  
Washington, DC 20420

December 23, 1987

VA Department of Medicine and Surgery Manual M-4, Revised, "Dentistry," is published for the information and compliance of all concerned.

JOHN A. GRONVALL, M.D.  
Chief Medical Director

Distribution: RPC: 1043  
FD Plus 3-7225 (extra copy for each staff dentist)

Printing Date: June 10, 1988

## FOREWORD

Under current statutes codified in 38 U.S.C., as amended, the VA provides oral health services to eligible veterans therein specified. The Dental Program operates in conjunction with other elements of the Department of Medicine and Surgery, and in accordance with policies of the Administrator and the Chief Medical Director.

This manual promulgates the policies and mandatory procedures for implementation of the patient care programs of the Dental Services at VA health care facilities throughout the country. Dental examinations and treatment are provided at all VA medical centers and at selected VA outpatient clinics.

The policies and mandatory procedures prescribed reflect the objectives established for implementation by these facilities and provide the basic standards with which effective supervision will be maintained. As with other programs, the facility Director has ultimate responsibility for the conduct of Dental Service operations at the local facility. Organizationally, through the Chief of Staff, the Chief of Dental Service has primary responsibility for operation of the dental program and management of related professional and administrative obligations. It is essential that all dental professional personnel as well as management officials be familiar with the contents of this manual.

The policies and mandatory procedures related to research and education activities within the Dental Service are promulgated in VA Department of Medicine and Surgery manuals M-3 and M-8, respectively.

DECEMBER 29, 1987

RESCISSIONS

The following material is rescinded:

1. COMPLETE RESCISSIONS

a. **DM&S Manual**

M-4, dated August 12, 1963, and changes 1 through 9  
M-4, dated June 6, 1980

b. **Interim Issues**

II 10-72-25  
II 10-72-15  
II 10-73-8  
II 10-78-6  
II 10-79-10  
II 10-85-26

c. **DM&S Circulars**

10-81-257  
10-82-21  
10-83-173  
10-83-216  
10-83-203  
10-84-135  
10-86-61  
10-87-29

**CONTENTS**

**CHAPTER I. INPATIENT DENTAL PROGRAM**

**Section I. General**

| <b>PARAGRAPH</b>                               | <b>PAGE</b> |
|--|-------------|
| 1.01 Policy .....                              | 1-1         |
| 1.02 Hospitalization for Oral Conditions ..... | 1-1         |

**Section II. Examination and Treatment Procedures**

|  |      |
|--|------|
| 1.03 Oral Examination Procedures .....   | 1-1  |
| 1.04 Treatment Planning: Priorities for and Extent of Care .....   | 1-3  |
| 1.05 Information to be Furnished Patient Regarding Dental Treatment Phase of<br>Hospitalization .....    | 1-6  |
| 1.06 Refusal to Accept Dental Services .....   | 1-6  |
| 1.07 Physician/Dentist Interaction in the Management of Patients with Specified<br>Health Problems ..... | 1-6  |
| 1.08 Procedures Applicable to Treatment of Long-Term Patients .....                                      | 1-8  |
| 1.09 Medical Records: Criteria for Documentation .....   | 1-9  |
| 1.10 Completion or Termination of Treatment .....  | 1-11 |
| 1.11 Quality of Care: Dental Service Quality Assurance Program .....                                     | 1-12 |

**CHAPTER 2. EXTENDED CARE DENTAL PROGRAM**

**Section I. Eligibility for Dental Treatment**

|   |     |
|---|-----|
| 2.01 Type and Extent of Treatment Furnished .....         | 2-1 |
| 2.02 Eligibility Status While on Authorized Absence ..... | 2-1 |

**Section II. Examination and Treatment Procedures**

|   |     |
|---|-----|
| 2.03 Oral Examinations .....                                | 2-1 |
| 2.04 Treatment Procedures .....                             | 2-1 |
| 2.05 Coordination of Prescriptions for Selected Diets ..... | 2-1 |
| 2.06 Reporting Uncooperative Patients .....                 | 2-1 |
| 2.07 Community Nursing Home Care .....                      | 2-2 |
| 2.08 Quality of Care--HSRO: SERP AND SIR .....              | 2-2 |

**CHAPTER 3. OUTPATIENT DENTAL PROGRAM**

**Section I. General**

|   |     |
|---|-----|
| 3.01 Liaison and Professional Relations with Dental Associations,<br>Participating Dentists and Other Departments within the VA ..... | 3-1 |
| 3.02 Maximum Use of VA Dental Resources for Treatment of Eligible,<br>Service-Connected Veterans .....                                | 3-1 |

CONTENTS--Continued

| PARAGRAPH  | PAGE |
|--|------|
| 3.03 Persons Eligible for Outpatient Dental Care .....   | 3-1  |
| 3.04 Persons Not Eligible for Outpatient Dental Care .....   | 3-4  |
| 3.05 Emergency Dental Treatment Provided by VA Staff .....   | 3-5  |
| 3.06 Determinations of Eligibility .....   | 3-6  |
| 3.07 Compensable Service-Connected Dental Disabilities .....   | 3-8  |
| 3.08 One Episode of Class II Treatment .....   | 3-9  |
| 3.09 Certification of Inadequacy of Treatment .....  | 3-9  |
| 3.10 Disabilities Incurred During Subsequent Period of Service .....   | 3-9  |
| 3.11 Amended Ratings .....   | 3-9  |
| 3.12 Class II Beneficiaries Who Receive Care Under Other Than Class II<br>Episodes of Care .....                                     | 3-10 |
| <b>Section II. Examination and Treatment Procedures for Staff<br/>and Fee Outpatient Program</b>                                     |      |
| 3.13 Oral Examinations .....   | 3-10 |
| 3.14 Records .....   | 3-11 |
| 3.15 Radiographic Examinations .....   | 3-11 |
| 3.16 Treatment Recommendations .....   | 3-12 |
| 3.17 Oral Disability Evaluation Examinations for Compensation and Pension<br>Rating Purposes .....                                   | 3-12 |
| 3.18 Preoperative Oral Prophylaxis .....   | 3-13 |
| 3.19 Quality of Care--Review of VA Staff Treatment .....   | 3-13 |
| <b>Section III. Fee Jurisdictional Information</b>   |      |
| 3.20 Responsibility of Chief, Dental Service .....   | 3-14 |
| 3.21 Procedure for Recommending Changes to Schedule of Maximum Allowances for<br>Fee Dental Services .....                           | 3-15 |
| 3.22 Format for Schedule of Maximum Allowances for Fee Dental Services--Use<br>and Restrictions .....                                | 3-17 |
| 3.23 Requirements for Utilization of Private Dental Practitioner .....   | 3-17 |
| 3.24 Special Allowances for Needed and Unusual Dental Services Requiring<br>Treatment by a Dentist With Special Qualifications ..... | 3-17 |
| 3.25 Emergency Dental Treatment Provided by Fee Dentists .....   | 3-18 |
| 3.26 Requirement for Second-Opion Examination .....  | 3-18 |
| 3.27 Quality of Care--Spot Check of Fee Treatment .....  | 3-20 |
| <b>APPENDICES</b>  |      |
| 3A Example/Worksheet for Organization and Analysis of Data Summarized From<br>Dental Fee Survey .....                                | 3A-1 |
| 3B Veterans Administration Schedule of Maximum Allowances for Fee Dental<br>Services .....   | 3B-1 |

CONTENTS--Continued

CHAPTER 4. INSTRUCTIONS COMMON TO BOTH  
INPATIENT AND OUTPATIENT DENTAL PROGRAMS

Section I. General

| PARAGRAPH   | PAGE |
|---|------|
| 4.01 Local Dental Policies and Procedures .....   | 4-1  |
| 4.02 Officer of the Day--Dental .....   | 4-2  |
| 4.03 Supervision of Dental Residents and Other Dental Trainees .....  | 4-2  |
| 4.04 Dental Appointments and Records .....  | 4-3  |
| 4.05 Procedures Pertinent to Oral Surgery .....   | 4-4  |
| 4.06 Informed Consent for Performance of Dental Operations and Other<br>Procedures .....                            | 4-5  |
| 4.07 Diagnosis and Treatment of Oral Malignancies .....   | 4-8  |
| 4.08 Dental Care for Physically Handicapped Patients .....  | 4-8  |
| 4.09 Depletion of Masticatory Ability; Replacement of Missing Teeth by<br>Partial or Complete Prostheses .....      | 4-8  |
| 4.10 Dental Treatment in a Department of the Army, Navy, Air Force or U.S.<br>Public Health Service Hospitals ..... | 4-9  |
| 4.11 Dental Treatment in Non-Federal Hospitals .....  | 4-9  |
| 4.12 Sterilization .....  | 4-10 |
| 4.13 Mercury Contamination and Hygiene Practices .....  | 4-10 |
| 4.14 Radiation Protection Requirements .....  | 4-11 |

Section II Custody and Disposition of Expendable Dental Materials

|  |      |
|--|------|
| 4.15 Responsibility for Custody and Disposition of Artificial Teeth and<br>Precious Metals ..... | 4-12 |
| 4.16 Accounting for Precious Metals .....  | 4-13 |
| 4.17 Disposition of Unserviceable Prostheses .....   | 4-13 |
| 4.18 Dental Prostheses: Lost and Found .....   | 4-13 |

APPENDIX

|   |      |
|---|------|
| 4A Example/Center Memorandum: Authorized use of Dental Clinic Facilities .. | 4A-1 |
|---|------|

CHAPTER 5. DENTAL LABORATORIES

Section I. Establishment and Responsibilities

|                             |     |
|-----------------------------|-----|
| 5.01 Establishment .....    | 5-1 |
| 5.02 Responsibilities ..... | 5-1 |

Section II. Dental Laboratory Requirements and Procedures

|  |     |
|--|-----|
| 5.03 Requirements and Procedures Common to Both Dental Service Laboratories<br>and Central Dental Laboratories ..... | 5-3 |
|--|-----|

CONTENTS--Continued  
SECTION II -- Continued

| PARAGRAPH   | PAGE |
|---|------|
| 5.04 General Dental Service Requirements for Submission to a Central Dental Laboratory .....  | 5-3  |
| 5.05 Specific Dental Service Requirements for Submission to a Central Dental Laboratory ..... | 5-5  |
| 5.06 Central Dental Laboratory Requirements and Procedures .....                              | 5-7  |

## CHAPTER 1. INPATIENT DENTAL PROGRAM

### SECTION I. GENERAL

#### 1.01 POLICY

Dental services in health care facilities will be responsible for providing such dental care as is essential to the veterans' medical needs and treatment planning will be integrated to meet this objective. Dental treatment will include treatment of trauma, control of pain, elimination of acute infection and may be extended to provide definitive care to maintain or augment adequate masticatory function, improve appearance and correct speech deficiencies, as consistent with the priorities for dental care as outlined in paragraph 1.04c.

#### 1.02 HOSPITALIZATION FOR ORAL CONDITIONS

VA Beneficiaries. Hospitalization of VA beneficiaries for oral conditions will be accomplished in accordance with the prescribed policy for all admissions. The veteran will be referred to the dental service for consultation and a professional determination as to the need for admission. Patients admitted for dental care must be given the same careful medical evaluation as those admitted to other services. This evaluation may be provided by a physician-member of the medical staff or by a qualified dentist who has clinical privileges to render such service. A physician will be responsible for the care of any medical problem that may be present at the time of admission or arises during the course of hospitalization.

### SECTION II. EXAMINATION AND TREATMENT PROCEDURES

#### 1.03 ORAL EXAMINATION PROCEDURES

a. **Forms Involved.** The dental service will receive daily, for each patient admitted, VA Form 10-0001, Dental Index Card, with items 1 through 4 completed by Medical Administration Service. At the time of admission, an approved dental record (VA Form 10-7978f or other) will be placed in the patient's health care folder, as a permanent record, for recording the oral examination and, if applicable, the treatment plans. Special overprints on VA Form 10-7978g may be used when locally approved as supplements to the dental record.

b. **Oral Examination--Policy.** An oral examination by the dental service may be provided for any veteran admitted for hospitalization. Special emphasis will be given to those inpatients that have been identified by local protocols as requiring physician/dentist interaction for the management of medical conditions that are complicated by dental disease (see par. 1.07). It is expected that the examiner will have access to the medical record at the time of the examination. Long-term patients are to be reexamined at least every 6 months following the time of last examination or completion of last episode of treatment, whichever is applicable. For those patients who are admitted frequently, a review of the findings of an oral examination accomplished within the past 6 months may be substituted for a clinical examination.

#### c. **Oral Examination--Types**

(1) **Screening Examination.** Most inpatient examinations will be of this type. At a minimum,

DECEMBER 20, 1957

a screening examination will include a determination of the chief dental complaint (if any), a thorough oral and peri-oral soft tissue evaluation and a visual inspection of the teeth and investing structures. Charting of individual teeth is not considered essential. Significant oral findings and major medical diagnoses will be noted appropriately in the dental record. The purpose of the screening examination is to rule out serious oral disease and to establish profiles of patients' dental conditions as a basis for assigning priorities for treatment consistent with the availability of dental care resources. The screening examination does not supplant the complete oral examination as a prerequisite to definitive dental treatment planning and treatment.

(2) **Complete Oral Examination.** A complete oral examination is accomplished by a duly licensed dentist or a designated resident and is usually done only when there is indication that the veteran is to receive dental treatment. This indication may be provided on the basis of an earlier screening examination or from information made available in the medical record or on a consultation request. A complete oral examination will include a thorough oral and peri-oral soft tissue review, a charting of the teeth and periodontium, and an evaluative summary. As necessary, the examining dentist will use professionally indicated radiographs and other special diagnostic procedures. The patient's clinical, radiographic, and laboratory findings and case history will be correlated prior to the establishment of working diagnoses and a treatment plan. The number and type of dental x-ray exposures required will be a determination of the examining dentist. Transillumination of teeth is encouraged where it can be successfully employed to minimize the need for radiographs. However, since no tangible record remains, it will be necessary to carefully describe the findings identified by this method. Oral cytological examination may be used as an additional diagnostic tool, but should not be considered a substitute for biopsy. The routine use of the patient's medical record for diagnostic assistance and pertinent notation is expected. This requires that the medical record be sent to the dental service when the patient is being seen.

d. **Oral Examination as Prerequisite to Priority of Treatment.** Oral examinations are prerequisites to the establishment of priorities for dental treatment. Analyses of either complete examinations or screening examinations may serve for this purpose. However, no dental treatment other than emergency will be provided until a complete oral examination with treatment plan has been accomplished.

e. **Recording Pathologic Conditions.** Reports of oral examinations will be completed in detail and include laboratory results and radiographic findings when appropriate. Any abnormality or pathologic condition of the hard or soft tissues will be documented in the medical record. Oral manifestations indicating probable systemic conditions will be recorded and, as for all oral conditions considered to be of priority concern, brought directly to the physician's attention.

f. **Request for Dental Consultation.** A dental consultation for any inpatient may be requested by responsible health care personnel at any time with an SF 513, Medical Record--Consultation Sheet. Although the clinical evaluation should be comprehensive, the consultation response may be limited to positive findings. If complete oral examination and recommendations are indicated, the oral examination record will be completed.

g. **Information to Be Furnished to Patient at Time of Oral Examination.** Patients given an oral examination will be informed that such an examination is a diagnostic service provided as an integral part of their physical examination, not necessarily a basis for correction of dental disabilities, per se. The patient must not be left with the erroneous conception that the accomplishment of an oral examination and the discussion of dental problems or dental treatment needs by the examiner constitutes an obligation on the part of the VA to provide dental care. Caution must be taken through careful communication to avoid any commitment to dental care prior to the establishment of priorities based on medicodental findings or legal entitlement. Nevertheless, it is incumbent upon the examiner to provide the patient with a brief summary of the oral exam findings and an indication of the type of treatment, if any, that would be necessary to restore oral health.

#### **1.04 TREATMENT PLANNING: PRIORITIES FOR AND EXTENT OF CARE**

##### **a. Role of the Oral Examination**

(1) Following a screening examination, the Dental Service Chief or designee will review the medical/dental data and determine if further evaluation and/or treatment is indicated. If so, the patient will be scheduled for a complete oral examination.

(2) A complete oral examination usually implies that medical and/or dental conditions exist for which treatment by the Dental Service is to be considered. The type and extent of treatment recommended generally will be determined on the basis of the total hospitalization requirements. This may indicate treatment for all, some, or none of the dental conditions present.

b. **Policy for Establishing Priorities.** Most VA dental services examine and treat both inpatient and outpatient beneficiaries. It is not the established mission of the VA however, to provide dental care to all veterans or even to all those that are hospitalized. Title 38 U.S.C. chapter 17, sections 610, 611, and 612, as amended, prescribe the applicable authority and restrictions. Aside from emergency care, dental treatment for inpatients will relate to several factors, such as whether the dental condition is detrimentally affecting a medical problem, length of hospital stay, etc. dental treatment for outpatients relates to statutory eligibility granted to veteran beneficiaries, such as former POWs, those with service-connected dental conditions related to trauma, etc. Since VA dental resources are limited, and must be used judiciously, and since the law specifies that dental treatment will be provided on the basis of priorities, it is required that every Chief, Dental Service, develops and implements clinic policy to:

(1) Ensure that treatment recommendations for inpatients are correlated to the patient's medical profile and, as applicable, that this information is used as the basis for determining priorities for care. Policies will also ensure that outpatients have their eligibility established by Medical Administration Service.

(2) Organize and allocate existing dental resources to provide dental treatment in accordance with the priorities described in paragraph c.

(3) Ensure that the extent of care for each patient prescribed treatment is in accordance with paragraph d.

c. **Determination of Priorities for Dental Care.** The dental service's effectiveness in meeting the treatment needs of both inpatients and outpatients is critical. This effectiveness is cumulatively determined through careful consideration of each patient's particular circumstance (eligibility, dental problems, relationships to medical condition, emergency need, etc.). The degree of treatment commitment to the inpatient population and the extent of absorption of legally eligible outpatient cases must be determined through the firm establishment of PRIORITIES FOR CARE (described below) and EXTENT OF CARE (described in pars. d and e). Although there is not an ordered breakdown of priorities within a particular priority group (Priority I, Priority II, etc.). EACH PRIORITY GROUP'S DENTAL CARE NEEDS MUST BE PROCEEDING TOWARD RESOLUTION BEFORE TREATMENT IS PROVIDED TO ANY PATIENT IN A LOWER PRIORITY GROUP. To comply with this directive, the Chief, Dental Service, must limit delegation of authority for establishing the priorities of care to only those staff dentists who are thoroughly familiar with the mission of the VA and can maintain consistency based on fixed guidelines. The protocol for the provision of dental care will be established according to the assignment of approved treatment plans to the following priority groups:

(1) **Priority I**--Inpatients and outpatients whose statutory eligibility, dental emergencies, compelling medical needs and/or long-term hospitalization place them in top priority consideration for treatment. These are listed alphabetically, as follows:

(a) Classes I through VI legally eligible outpatient dental beneficiaries.

(b) Domiciliary patients.

(c) Emergency dental care.

(d) Inpatients (SC/NSC) with compelling medical need for dental treatment. (Reference par. 1.07 regarding the establishment of local protocols for the management of hospitalized patients with medical problems complicated by or related to oral conditions whose treatment is usually in the province of the dental service.)

(e) Inpatients who have been hospitalized continuously for 100 days or more (extended care).

(f) Nursing home care unit patients.

(g) Patients having a compelling medical need for continuation of dental care on a posthospital, outpatient basis.

(h) Specially designated inpatients and outpatients such as those provided for under approved sharing agreements, eligible allied beneficiaries, and employees officially authorized treatment for work related injuries or conditions, etc., as described in M-4, Dentistry, paragraph 3.03 d.

(2) **Priority II**--Hospitalized veterans whose dental conditions are not considered to be adjunct to their medical problems and who have no direct legal eligibility for outpatient dental care. In this category, service-connected veterans must be considered ahead of non-service-connected veterans.

(3) **Priority III**--Inpatients who do not qualify under Priority I and who are:

(a) **Active duty military personnel.** (Unless covered by the provisions of an approved sharing agreement.)

(b) **Military retirees.** (Unless covered by the provisions of an approved sharing agreement.)

(c) **Beneficiaries under CHAMPVA.**

d. **Determination of Extent of Care.** Once a patient has been properly categorized and the priority for dental care established, the EXTENT OF CARE must be determined. The extent of care is as important in properly allocating dental resources as establishing priorities for care, since over-treatment can dissipate these resources just as surely and quickly as improper priorities.

e. **Combining Priorities for Care and Extent of Care into an Equitable Treatment Protocol**

(1) The VA is obligated to fulfill the requirements of the statutes enacted by the Congress and to follow their intent with fidelity. Every Dental Service has the responsibility to provide dental care on the basis of controlled priority and individual prescription. Every Chief of Dental Service, every VA dentist who authorizes care, and every VA dentist who provides care share this responsibility. A clearly defined treatment plan that is in harmony with these precepts should be identifiable in the medical records of every patient receiving dental care.

(2) No authority exists, nor can there be any justification for providing non-emergent dental care for anyone in Priorities II or III until all the treatment needs of Priority I patients have been satisfied or are in the process of resolution (including those under treatment and transferred from other facilities for necessary continuation of treatment). Likewise, there is no authority to provide dental care to lower priority patients because it fulfills the criteria for a "teaching case." If a training program is overplanned in relation to resident staffing and the available and normally occurring clinical resources, either the scope of the training program must be adjusted or the Priority I cases must all be satisfied or be in the process of resolution, before treatment of lower priority patients, selected primarily for training purposes, can be undertaken.

(3) While the VA has the responsibility to provide dental care on a priority basis, it does not have the obligation to provide dental care in excess of that for which a veteran is eligible or which goes beyond the scope necessary to resolve a medical problem. For example, an inpatient's medical problem may require only the removal of foci of infection. Even though the VA may edentulate the patient to resolve the dental condition's impact on a medical problem, the VA is no more obligated to provide prostheses for this patient than a private dentist would be who had edentulated the patient. Unless the patient is a long-term inpatient or has specific legal eligibility to comprehensive care as a VA beneficiary or there remains a compelling medical need for the additional care, the VA will have discharged its obligation and the case should be closed. In addition, preventive measures will be undertaken on an ongoing basis only in those cases which they provide support for medical conditions such as head and neck radiation, renal dialysis, organ transplants, valvular disorders, etc., where continued control of infection is of paramount concern.

DECEMBER 20, 1987

f. **Review of Oral Examination Findings by the Physician.** A brief summary of oral examination findings will be written in the progress notes of the patient's medical record for review by the primary care physician. If dental treatment is planned, the progress note will direct the physician's attention to VA Form 10-7978f, the Oral Maxillofacial Defined Data Base (or other approved oral examination record), for a report of the complete exam and the treatment plan. In such case, the physician will also be expected to complete and sign the concluding portion of the oral examination record indicating whether or not the patient is physically able to have the planned dental treatment, the estimated duration of hospitalization, and any other comments concerning the patient's medical condition that are relevant to the proposed dental care.

#### **1.05 INFORMATION TO BE FURNISHED PATIENT REGARDING DENTAL TREATMENT PHASE OF HOSPITALIZATION**

Oral diagnosis, treatment recommendations and treatment limitations will be thoroughly discussed with the patient prior to treatment. It should be emphasized that the dental therapeutic measures recommended are not predicated on dental rehabilitation per se, but are to be performed as the dental phase of overall medical management. Each patient will be informed of the administrative procedures and limitations involved in furnishing the dental treatment during hospitalization and/or as posthospital care. Caution must be exercised by all personnel to avoid giving patients unrealistic expectations as to the amount and type of dental care they will receive. Questions concerning eligibility for alleged service-connected dental conditions will be referred to the Chief, Medical Administration Service, for resolution.

#### **1.06 REFUSAL TO ACCEPT DENTAL SERVICES**

In those instances where patients refuse to accept the dental services recommended or do not cooperate in receiving treatment, a statement of the facts will be entered in the progress notes and dental record for consideration and appropriate disposition by the patient's primary-care physician and the Chief, Dental Service.

#### **1.07 PHYSICIAN/DENTIST INTERACTION IN THE MANAGEMENT OF PATIENTS WITH SPECIFIED HEALTH PROBLEMS**

##### **a. Health Problems Involved**

(1) Some dental infections or intraoral diseases compromise the medical treatment of particular systemic health problems. In other cases, the patients medical problem(s) or medical treatment may complicate the provision of needed dental care. In the context of providing high quality medical care, it is imperative that each VA medical center establish and maintain a set of locally developed protocols and associated directives to assure identification, evaluation and necessary dental treatment of veterans hospitalized for specified medical conditions.

(2) Eleven diagnostic groups have been identified that include disease entities or conditions for which physician/dentist interaction is frequently necessary. The diagnostic groups are as follows:

(a) Head and Neck Malignancy

- (b) Cardiovascular Disorders
- (c) Advanced Liver Disease
- (d) Joint Prostheses
- (e) Nutritional and Metabolic Deficiencies
- (f) End Stage Renal Disease
- (g) Immunocompromised Patients
- (h) Pulmonary Disease
- (i) Patients with Mental Disorders
- (j) Substance Abuse
- (k) Physically Handicapped Patients

(3) A number of the diagnoses within these groups may require initial and continuous involvement of dentistry in the interdisciplinary team treatment planning and management of the patients involved. Most of those will be included in the following groups: head and neck malignancy, joint prostheses, cardiovascular disease, and immunocompromised patients. Others, because of (a) deleterious effects of oral infections on medically compromised patients or, (b) the effect of certain medical disorders and/or the side effects of treatment regimens on oral structures or tissues, will require special considerations, precautions, or management strategies. Also represented in these groups are patients with certain disorders and diseases who would be difficult to manage or be at significant risk if treated in a non-hospital setting.

**b. Responsibility for Implementation of Interdisciplinary Treatment Protocols**

(1) It is the responsibility of the Chief of Staff, or designee, to assure maintenance of locally developed interdisciplinary protocols and, through appropriate mechanisms, to monitor the quality of interdisciplinary care.

(2) Chiefs of Clinical Services having primary treatment responsibility for patients with diagnoses included in the diagnostic groupings will maintain procedures assuring that protocol patients are provided the opportunity for dental service evaluation and access to needed dental therapy.

(3) Physician and dentist members of the medical staff will coordinate the identification, referral, consultation and interdisciplinary management of patients in accordance with these protocols. In affiliated medical centers where residents rotate with some frequency throughout the training year, the Chiefs of Services to which the residents are assigned will assure that the residents maintain the continuity of interdisciplinary care.

(4) The Chief, Dental Service, will have primary responsibility for determining the appropriate level and extent of dental care for patients identified in the treatment protocols. The Chief will also establish dental staff responsibility for the coordination with the primary care physician(s) for the dental care of those patients.

(5) Chiefs of Dental Service will also ensure that their inpatient resources are directed toward meeting the needs of patients in established protocols. The Program Guide entitled Interdisciplinary Management of Patients Having Medically Compelling Needs for Dental Treatment provides related information and examples of content and format that may be helpful for local protocol development.

DECEMBER 29, 1957. . . .

c. **Procedural Guidance for Interdisciplinary Treatment Protocols**

(1) The examination program of the Dental Service and consultation requests from primary care physicians will be the chief operational mechanisms to identify patients who fall within the protocol groups. Identification by these means should be accomplished as soon after admission (or diagnosis of the applicable disease process) as possible so that the dental component of care will not impede primary medical care or prolong hospitalization. Pre-admission and post-discharge treatment planning will assure the most cost-effective approach as well as considerate, high quality care of these patients.

(2) Local policy, protocols, or directives must clearly state that, unless additional entitlement exists, dental care for patients in these diagnostic groups will be generally limited to treatment that is directly related to the medical problem. Presentation of interdisciplinary plans to patients should not give unrealistic expectations as to the amount and type of dental care they will be receiving.

(3) Quality assurance guidelines will be maintained to assure that patients are receiving dental evaluation and care consistent with the intent of this directive and in compliance with locally developed protocols.

**1.08 PROCEDURES APPLICABLE TO TREATMENT OF LONG-TERM PATIENTS**

a. **Responsibilities.** As indicated by the priorities listed in paragraph 1.04c, the VA assumes responsibility for dental care of patients hospitalized for long periods of time (over 100 days), including those admitted to Nursing Home Care Units and Domiciliaries. In addition to Dental Service personnel, the oral health of these patients must be a concern of physicians, nursing staff, dietitians, social workers and other therapists who come in contact with them on a day-to-day basis. Where interdisciplinary teams plan and implement care, a dentist should serve as an active participant or as a consultant and treatment plans for each long-term care patient should include a dental component.

b. **Oral Examination and Treatment Plan.** When it becomes evident that a veteran will be hospitalized or in the NHCU or domiciliary for over 100 days, a complete oral examination should be provided and a dental treatment plan formulated. The plan will be based on the patient's functional abilities as well as patient's medical problems and dento-oral status. Depending upon the patient's condition and prognosis, dental care may be limited to procedures eliminating pain and acute infection; or may be expanded to provide sufficient masticatory function to allow the patient to partake of a palatable as well as a nourishing diet. In any case, it will include preventive orientation and/or access to oral hygiene.

c. **Mental and Functional Disabilities.** The fabrication of commercially available or customized innovative devices to assist the oral hygiene practices of patients with functional disabilities is encouraged. This would include electric toothbrushes and oral irrigating appliances. Nursing personnel will be given instructions in the provision of daily oral hygiene procedures for patients who are unable to care for themselves. If the patient's mental state, age, or infirmity impair patient's ability to adequately comprehend, consent for any emergency dental care that is required will be obtained in accordance with paragraph 4.06f or g.

## 1.09 MEDICAL RECORDS: CRITERIA FOR DOCUMENTATION

a. Preparation and Use of VA Form 10-7978f, Oral Maxillofacial Defined Data Base, Part VI. This record will be an integral part of the consolidated health record. It is recognized that there will be variations in the ways this record format will be used because of the different methods employed by individual health care facilities. It is further recognized that for an interim period of time there will be opportunities for local facilities to develop and utilize alternative documentation methods which are approved by Central Office. However, for those Dental Services who are not granted exemption to the existing VA Form 10-7978f, the following general instructions will apply:

(1) **Item A, Chief Complaint.** List the patient's dental problems, if any, stated in the patients own words.

(2) **Item B, History of Present Illness.** Give a brief chronological description of the patient's chief dental complaints including date and mode of onset and symptoms such as pain, swelling, bleeding, past treatment if any, etc.

(3) **Item C, Past History.** Self-explanatory.

(4) **Item D, Clinical Examination.** This is a most important part of the patient's evaluation. Refer to paragraph 1.03c and e.

(5) **Special Dental Records.** If local facilities desire to use special records with a more extensive legend they may do so. However, any special forms used for this purpose will be used as an addition to VA Form 10-7978f, not in place of it. If at the completion of the episode of treatment there is need to retain the optional supplemental form for future reference, it may be filed with the patient's radiographs in the radiograph envelope, VA Form 10-2636 or VA Form 10-2536a.

(6) **Item G, Significant Laboratory and Radiographic Findings.** All significant diseases or other abnormal conditions revealed by the radiographic examination will be recorded. It is also desirable to note those laboratory findings that are relevant to the oral disease present or which may be significant to the course of dental treatment.

(7) **Initial Assessment and Plans.** Once the examination is complete, the dentist will, on the basis of the history, and the clinical, radiographic, laboratory and medical findings, assess the problem and record the assessment and plans on the dental form.

(a) **Assessment.** In the assessment, the type and extent of oral disease present is described, informing the physician what effect the oral condition may have on the patient's medical problem and general health.

(b) **Plans.** If, in the opinion of the dentist, the treatment of the dental condition(s) is not considered to be an essential part of the treatment for the patient's medical problem(s), a statement to this effect should be noted. If treatment is planned, it will be in accordance with the principles and guidelines given in paragraphs 1.04a and b and will be recorded according to following format as appropriate:

1. **Diagnostic (Dx).** Identifies any additional tests necessary to provide information regarding tentative or questionable diagnoses.

2. **Therapeutic (Rx).** Identifies the type of treatment planned for this episode of hospitalization such as extractions, restorations, periodontal treatment, etc.

3. **Patient Education.** Describes information provided patients concerning their oral conditions. All patients who receive treatment will be given instruction in proper oral hygiene practices and, if prostheses are furnished, instructions in their proper care. Patients should be advised of the relationship of their oral disease problems to their medical condition and general health. Patients having dental conditions for which treatment is not considered essential for care during hospitalization should also be advised of their dental problems and encouraged to seek private care.

(8) The examining dentist will sign and date the form in the space indicated.

b. **VA Form 10-1415, Problem List.** The patient's dental complaint, history of present dental problems, clinical examinations, roentgenograms, laboratory findings and review of the medical data will be correlated to establish the patient's oral maxillofacial problems. Those problems for which treatment is considered necessary will be entered on the problem list, VA Form 10-1415. All dental conditions that are entered on the problem list will have a date of onset, if known, and a date of entry followed by the problem. An arrow is drawn after the condition and when treatment is started the date is placed over the arrow. This date simplifies the index by allowing location of information in the progress notes. At this point, the dental record is ready for review by the patient's physician. (See par. 1.04c). In order to expedite dental care, it is recommended that the doctors orders be annotated to indicate that the dental record is ready for the physician's review. The record is flagged so the ward secretary will call this to the attention of the physician.

c. **Maintenance of Records.** Dental services performed will be entered in the progress notes and identified by the title of the problem. If desirable or indicated, the SOAP (subjective, objective, assessment, and plans) format may be used for entries in the progress notes. However, if the only dental progress note entry describes treatment of a specific problem, record only the pertinent aspects such as the problem title and the therapeutic procedure(s). When the dental treatment related to a problem has been completed, or the patient is being discharged, the date will be placed below the arrow on the problem list, and the dental summary completed. (See subpar. e.)

d. **Doctors Orders and Progress Notes.** Entries in the doctors orders will be made when indicated. As previously described, all dental treatment is recorded in the progress notes. When hospitalization is principally for dental care, the progress notes and doctors orders will be written primarily by the dentist caring for the patient. The dentist will also prepare and sign the final summary in such cases.

e. **Summary of Dental Care.** At the conclusion of dental treatment or on discharge, in order to assist the Medical Record Administrator in reviewing VA Form 10-1000, the dental service will list in the progress notes under the heading "Dental Summary" the diagnoses of the treated dental conditions. Services planned for completion on an outpatient status should also be

recorded. Any unusual circumstances or occurrences which the physician may want to include in the final summary should be stated briefly in the dental summary. The diagnoses will be consistent with the terminology from the latest available edition of the American Medical Association's "Current Medical Information and Terminology" as well as the terminology used in the International Classification of Diseases manual to allow for proper medical records ICD-9 coding. Treatment procedures should also be listed using the terminology from the latest edition of "Current Procedural Terminology" of the American Medical Association. Where utilization of these references is not feasible, then other approved references may be used.

f. **Security and Return of Medical Records.** The Chief, Dental Service, will be responsible for the security and prompt return of all medical records of patients referred to the dental service.

#### **1.10 CONTINUATION OR TERMINATION OF TREATMENT**

a. **Designation of Dental Treatment Status Prior to Discharge.** Prior to discharge, and as early during the hospital stay as possible, it will be incumbent upon the member of the medical staff having primary responsibility for the care of a hospitalized patient and the Chief, Dental Service (or designee), to coordinate the proper disposition of patients for whom dental care is in progress or is to be initiated during hospitalization. Proper planning should avoid extending inpatient status for the sole purpose of completing dental care. When discharge is imminent, a determination must be made whether or not the dental treatment provided has accomplished the intended objectives with relation to the medical condition of the patient. If essential dental treatment has been completed, inpatient dental care should be terminated. If essential care remains, the discharge planners must determine whether it will be continued with the patient as a bed occupant or as an outpatient. Except in unusual circumstances, patients being discharged to contract nursing homes or hospital-based home care should have all necessary care completed prior to discharge. If inpatient dental treatment has resulted in depletion of the patient's dentition, no commitment for prosthetic replacements will be made without applying the rationale and guidelines contained in paragraph 4.09a.

b. **Post-Discharge Treatment for Veterans with Statutory Eligibility for Outpatient Dental Care--Classes I through VI Status.**

(1) **Classification.** The Chief, Dental Service, in coordination with Medical Administration Service, will take appropriate action to ensure completion, on an outpatient basis, of the treatment planned for service-connected dental conditions for which the veteran has clear statutory eligibility (including dental conditions determined adjunct to a patient's service-connected medical disabilities) when such treatment cannot be completed prior to discharge. The patient's eligibility will be determined by Medical Administration Service and the veteran classified under one of the Classes I through VI categories. Any remaining uncompleted treatment for which the veteran is eligible will be recorded on VA Form 10-2570 as the outpatient treatment plan.

(2) **Referral.** When circumstances preclude treatment at the discharging facility due to geographic inaccessibility, Medical Administration Service will determine if there is another VA health care facility within reasonable distance from the veteran's residence and that that facility can provide the care in a timely manner (initiate treatment within 60 days). In such a case, the consolidated health record will be forwarded to the VA facility which will provide the

care. If another federal facility with which the VA has an established contract or sharing agreement is to provide the needed outpatient dental care, only copies of the pertinent records will be forwarded. If none of these options exist, Medical Administration Service will make arrangements with the appropriate VA clinic of jurisdiction to contract the dental care on a fee-basis. A VA beneficiary will not be referred for fee-dental care without a valid and justifiable reason. The decision for fee-dental care is not the prerogative of the veteran but is a VA decision based on the lack of availability of VA or other federal resources to provide the needed care. In all cases where referral takes place, the veteran will be notified and fully apprised of the action taken.

**c. Post-Discharge Outpatient Dental Treatment for Veterans Who Do Not Qualify Under Classes I-VI.**

(1) **Classification.** If a patient who does not have Class I through VI eligibility requires post-discharge dental care, the Chief of Dental Service, or designee, in coordination with the responsible staff physician, must arrange for the patient's return with the Medical Administration Service prior to discharge. For MAS purposes, the patient will be classified as either OPT/SC or OPT/NSC depending upon whether the medical treatment involves a service-connected disability. It should be noted, however, that the dental data system does not differentiate on this basis, and all such cases will be carried as "continuation of care."

(2) **Professional Considerations.** The commitment for post-hospital care to patients who would otherwise be ineligible for outpatient care must be restricted to only those individuals whose dental conditions are professionally determined to have a direct detrimental effect on the medical condition(s) of current concern. For whatever extent of dental care is to be provided, there must be an understandable and defensible position based on sound professional judgment relative to the dental impact on the medical problem. The patient's inability to defray the cost of private dental care cannot be a factor in determining the extent or limitation of dental treatment which will be provided by the VA. At time of discharge from the hospital, any remaining definitive dental care which does not significantly relate to a medical problem will be terminated. The only exceptions will be situations which would clearly constitute abandonment of a patient under treatment, such as need for post-operative evaluation, sutures in place, unrestored crown preparations, etc. Under these circumstances, those essential components of the dental treatment will be completed at the earliest possible opportunity. In cases where treatment is not to be continued, the veteran must be informed of any need for further care and counseled to seek it elsewhere. It is medico-legally important that such counseling be documented in the medical record.

(3) **Referral.** Patients who are to be followed on an outpatient basis and who reside long distances from the discharging facility may be treated at the VA health care facility closest to their homes. Advance arrangements must be made between Chiefs, Dental Services, of the facilities involved in accommodating reasonable requests for these patient care needs. Transfer of records will be accomplished by Medical Administration (M-1, part I, chapter 5).

**1.11 QUALITY OF CARE-DENTAL SERVICE QUALITY ASSURANCE PROGRAM**

a. **Integration with the Facility Quality Assurance Program.** With proper adherence to priority and extent of care, the primary responsibility of the dental service is to provide delivery of high quality cost-effective dental treatment. To such delivery, it is

imperative that appropriate procedures be established and implemented to review applicable aspects of the delivery system and resolve problems that are identified. The Dental Service Quality Assurance Program, while being specific for dental, must be integrated with and follow guidelines established for the facility QA Program. In most instances, the facility program will be carried out in the following areas:

- (1) Continuous Monitoring of Generic Screening Elements
- (2) Utilization Review
- (3) Peer Review
- (4) Risk Management and the Internal Control Program (A-123)
- (5) Credentialing and Privileging of Staff

**b. Dental Service Quality Assurance -- Responsibilities and Activities.**

(1) Each Chief, Dental Service is responsible for establishing adequate measures to:

(a) Monitor and evaluate the quality and appropriateness of dental care provided to VA beneficiaries.

(b) Review credentials of applicants for appointment, and grant or renew privileges of dental staff on the basis of their qualifications, current competence and clinical performance.

(c) Monitor and evaluate safety measures related to patients, patient care, staff activities and environment.

(d) Appropriately resolve or correct problems detected.

(e) Institute follow-up action to ascertain that corrective action has remedied such problems.

(2) Each dental service must have a written plan outlining specific QA procedures and maintain a file of QA activities and results which document operation of the program.

**c. References.** The VA Program Guide "Quality Assurance Program for Dentistry" provides detailed examples of implementation procedures and format and should serve as the basic reference guide for development of facility programs. The Chief, Dental Service, should also have access to the following references for added understanding and input to the overall facility QA program:

- (1) VA Manual, M-1, Part I, Chapter 5, Medical Records.
- (2) JCAH Accreditation Manual for Hospitals.
- (3) JCAH Long Term Care Standards Manual.
- (4) VA Regulation 6507(a)(4)i.
- (5) VA Manual, M-2, part I.
- (6) Confidentiality Regulations Title 38 U.S.C. 3305 and 38 CFR Part 17.
- (7) Information Bulletin "Oral Health for Long-Term Care Patients".
- (8) DM&S Circulars and Interim Issues on QA issues.



**CHAPTER 2. EXTENDED CARE DENTAL PROGRAM**

**SECTION I. ELIGIBILITY FOR DENTAL TREATMENT**

**2.01 TYPE AND EXTENT OF TREATMENT FURNISHED**

Patients in domiciliaries and VA nursing home care units will be provided such dental treatment as is considered reasonably necessary to protect and maintain health. Consideration may be given to speech and appearance as essential to their rehabilitation. A continuing preventive dental care program including education in self-care oral hygiene practices will be maintained for all these beneficiaries.

**2.02 ELIGIBILITY STATUS WHILE ON AUTHORIZED ABSENCE**

Patients may be provided any necessary dental treatment required while on authorized absence from a domiciliary by presenting the identification card, VA Form 10-5510, to any VA facility having resources available to furnish these services. The record of treatment provided under this authority will be furnished the domiciliary concerned for inclusion in their treatment files.

**SECTION II. EXAMINATION AND TREATMENT PROCEDURES**

**2.03 ORAL EXAMINATIONS**

As most patients in nursing home care units are in an age group most susceptible to cancer, a thorough, intensive extra-oral and intra-oral soft tissue examination is essential. They will be examined by a dentist as an integral part of their initial physical examination. The initial examination will be accomplished as soon as possible after admission. These beneficiaries will be scheduled for reexamination at 6-months intervals (or as soon thereafter as conditions permit), and treatment planned as indicated.

**2.04 TREATMENT PROCEDURES**

Long-term patients are eligible to receive dental treatment following initial or subsequent examination by the dental service and medical review. The requirements for informed patient consent and completion of SF 522, Medical Record--Request for Administration of Anesthesia and for Performance of Operations and Other Procedures, as outlined in paragraph 4.06, will apply for these patients. Dental treatment may be requested by patients through referral by the physician in attendance. Continuing dental care will be coordinated with the attending physician and the dental records will be incorporated in the appropriate treatment folder. The need for any remaining dental care will be fully considered prior to discharge.

**2.05 COORDINATION OF PRESCRIPTIONS FOR SELECTED DIETS**

The treating dentist will coordinate with the dietetic service all prescriptions for selected diets initiated in the dental service on behalf of patients.

**2.06 REPORTING UNCOOPERATIVE PATIENTS**

Persistent failure of a patient to cooperate during an episode of treatment will be documented and referred to the attending physician, Chief of Staff or Chief, Domiciliary Operations, as appropriate, for consideration and indicated action.

.. -

REVISION 10, 1981

## 2.07 COMMUNITY NURSING HOME CARE

a. A system of coordination with all services concerned will be established to assure that all needed dental treatment is accomplished before a beneficiary is discharged from a VA facility for placement in a community nursing home.

b. Emergency dental care for VA beneficiaries will be provided in accordance with the instructions outlined in M-1, part I, chapter 12, paragraphs 12.01c, 12.27 and/or 12.32.

c. VA beneficiaries requiring more than minor emergency dental care may be furnished such care under the provision of M-1, part I, chapter 12, paragraph 12.39.

## 2.08 QUALITY OF CARE--HSRO: SERP AND SIR

The same concerns for quality of care will apply for the Extended Care Dental Program as apply for the Inpatient Dental Program. Therefore, the same requirements and guidelines as set forth in paragraph 1.11 will be utilized.

(The provisions of ch. 2 are based on 38 U.S.C. 212 and 621.)

## CHAPTER 3. OUTPATIENT DENTAL PROGRAM

### SECTION I. GENERAL

#### 3.01 LIAISON AND PROFESSIONAL RELATIONS WITH DENTAL ASSOCIATIONS, PARTICIPATING DENTISTS AND OTHER DEPARTMENTS WITHIN THE VA

The Chief, Dental Service, will maintain close liaison and good professional relations with dental associations and dentists participating in the outpatient dental program. All professional correspondence will be signed by or for the Chief, Dental Service. Matters pertaining to interpretation of policy or mandatory procedures will be transmitted via a Director's letter to the Associate Deputy Chief Medical Director (16), VA Central Office, for clarification, when indicated. The administrative responsibilities of the Chief, Dental Service, in connection with the outpatient dental program, are contained in M-1, part I, chapter 19. VA dentists may be detailed to the Adjudication Division for part-time duty to serve as dental rating specialists where the dental rating activity does not justify the employment of a full-time dental rating specialist.

#### 3.02 MAXIMUM USE OF VA DENTAL RESOURCES FOR TREATMENT OF ELIGIBLE SERVICE-CONNECTED VETERANS

Outpatient dental treatment for eligible veterans will be provided in VA Dental Services by staff dentists to the maximum extent possible. This will be accomplished by strict adherence to the policies on priorities and extent of care put forth in paragraph 1.04 of this manual. Paragraph 3.13a outlines the limited instances in which referral to participating private sector dentists on a fee basis is permissible. All VA dentists are expected to be knowledgeable concerning dentistry's role in the mission of the VA and each dentist's responsibility in (a) establishing and maintaining priorities of care (b) understanding and exercising constraints in extent of care consistent with VA obligation, and (c) properly terminating care when indicated.

#### 3.03 PERSONS ELIGIBLE FOR OUTPATIENT DENTAL CARE

a. **Classes I Through VI Dental Beneficiaries.** Outpatient dental benefits will be furnished veterans in accordance with the provisions of existing legislation and regulations promulgated by the Administrator. Those specified as eligible to be authorized dental care on an outpatient basis are defined, and their entitlements described, in 38 CFR 17.123. Further vital references for the administration of the dental outpatient program are contained in 38 CFR 17.120, 17.123 (a)(b)(c), 17.124. The following definitions of classifications of eligible dental outpatients are not complete as to entitlements and restrictions. The actual statutes and VA regulations from which they are derived must be referred to in order to properly administer the program.

(1) **Class I.** Those having a service-connected compensable dental disability or condition are eligible for any needed dental care (38 U.S.C. 612(b)(1) as implemented by 38 CFR 17.123 (a).)

(2) **Class II.** Those having service-connected noncompensable dental conditions or disability shown to have been in existence at time of discharge or release from active duty (taking place after September 30, 1981) may be authorized any treatment as reasonably necessary for the one-time correction of the service-connection noncompensable condition, but only if:

(a) They are discharged or released under conditions other than dishonorable, from a period of active military service of not less than 180 days.

(b) Application for treatment is made within 90 days after such discharge or release.

(c) The certificate of discharge or release does not bear certification that the veteran was provided, within the 90-day period immediately before such discharge or release, a complete dental examination (including dental xrays) and all appropriate dental treatment indicated by the examination to be needed (38 U.S.C. 612(b)(2) as implemented by 38 CFR 17.123(B).)

(3) **Class II(a).** Those having a service-connected noncompensable dental condition or disability adjudicated as resulting from combat wounds or service trauma are eligible for repeat care for the service-connected condition(s) (38 U.S.C. 612(b)(3) as implemented by 38 CFR 17.123 (c).)

(4) **Class II(b).** Those having a service-connected noncompensable dental condition or disability and who were prisoners of war for less than 6 months are eligible for repeat care for the service-connected condition(s) (38 U.S.C. 612(b)(4) as implemented by 38 CFR 17.123 (d).)

(5) **Class II(c).** Those who were prisoners of war for 6 months or more are eligible for any needed dental care (38 U.S.C. 612(b)(7) as implemented by 38 CFR 17.123 (e).)

(6) **Class III.** Those having a dental condition professionally determined by the VA to be currently aggravating a service-connected medical condition are eligible for dental care to satisfactorily resolve the problem. Each episode of dental care must be predicated on application, followed by professional judgmental decision (38 U.S.C. 612(b)(4) as implemented by 38 CFR 17.121 (g).)

(7) **Class IV.** Those whose service-connected disabilities have been rated at 100 percent or who are receiving the 100 percent rate by reason of individual unemployability are eligible for any needed dental care (38 U.S.C. 612(b)(8) as implemented by 38 CFR 17.123 (H).)

(8) **Class V.** A service-connected, disabled veteran who has been approved by the VA for vocational rehabilitation training and for whom an objective has been selected, or who is pursuing this training, may be provided dental care to the extent it is professionally determined necessary to (a) make it possible to enter the course of training, (b) prevent interruption of the training, (c) hasten the return to training status which became interrupted because of a dental condition or, (d) overcome significant adverse esthetic or speech problems where specific goals of rehabilitation, including employability, would not be achievable due to the uncorrected dental handicap (38 CFR 17.123 (i).)

(9) **Class VI.** Those who served in the active military or naval forces during the Spanish-American War, including the Philippine Insurrection and the Boxer Rebellion or the Indian Wars are eligible for any needed dental care, on a repeat basis (38 U.S.C. 612(1)(F) as implemented by 38 CFR 17.123 (j).)

**b. Prioritization of Care and Use of VA Resources in the Treatment of Classes I-VI Dental Outpatients.** Veterans who are eligible for Classes I-VI outpatient dental benefits will be provided dental treatment by all VA Dental Services to the maximum extent practicable. This will be accomplished without compromise of emergency dental care and dental care having a direct bearing on the medical needs of inpatients. The resources of each facility's Dental Service must

be reserved and allocated primarily for its effective responsiveness to the inpatient and Classes I-VI outpatient needs. To this end, no commitment will be made for the continuation of inpatient dental care following discharge unless it is professionally determined to be essential or the veteran is eligible to receive the remaining care under Classes I-VI eligibility (38 U.S.C. 610(c).)

c. **Other Veteran Dental Beneficiaries.** Veterans who have no service-connected entitlement to outpatient dental care may be provided outpatient dental treatment on an OPT/NSC basis, within the limits of VA facilities, only when both of the following requirements are met:

(1) The treatment is a continuation of dental treatment which was begun while the veteran was receiving hospital care, and,

(2) The Chief, Dental Service, or professional designee, determines, at the time of hospital discharge, that the continuation or completion of such care remains necessary in relation to the medical problem(s) for which it was initially prescribed (38 U.S.C. 612(1)(E).)

d. **Other Beneficiaries.** Other beneficiaries who may be eligible for dental care in VA dental clinics on an outpatient basis, subject to and consistent with the provisions of existing laws, the stipulations of VA regulations and the availability of VA space, facilities and staff are:

(1) **Armed Forces Personnel on Active Duty** (38 U.S.C. 611 and 4115 as implemented by 38 CFR 17.60 (a), 17.62.)

(a) Authority from the Commanding Officer of the military installation should accompany the request for dental treatment. However, if extenuating circumstances are present, treatment of an emergent dental condition may be accomplished prior to the receipt of authority.

(b) Emergency dental treatment for members of the Armed Forces on active duty will be limited to such treatment as is found necessary for the relief of pain, and control of acute infection, trauma or hemorrhage.

(2) **Military Retirees.** Since there is no legal authorization for interagency reimbursement, retired members of the uniformed services are not to be provided outpatient dental care unless one of the following conditions applies:

(a) The retiree qualifies for dental treatment as an eligible veteran under the provisions cited in a or c of this paragraph (3.03 a,c).

(b) VA dental care of retirees is a provision of a jointly approved sharing agreement between a VA facility and a DoD unit.

(c) Treatment is specifically pre-authorized by DoD on DoD Form 2161.

(d) The retiree presents to a VA medical facility with an acute dental problem that qualifies for emergency dental treatment under the provisions of paragraph 3.05. In accordance with that paragraph, however, the retiree would be individually billed for any treatment rendered. Any effort to receive reimbursement from the DoD will be the responsibility of the retiree.

(3) **Allied Beneficiaries.** Dental care may be provided for persons who are pensioners of nations allied with the United States in World War I and World War II when they are properly referred by authorized officials under the conditions stipulated by the Administrator (38 U.S.C. 109(a) as implemented by 38 CFR 17.60.)

(4) **VA Employees.** Emergency dental treatment for VA employees may be provided only to the extent necessary to permit employees to remain on duty. Employees with emergency conditions for which followup care or complications would be anticipated will be advised to seek private care. Injuries incurred in performance of duty will receive necessary emergency treatment. Procedures applicable in obtaining such treatment and administrative limitations pertaining thereto are set forth in MP-5 part I, chapter 792, paragraph 7. (5 U.S.C. 7901 and 8103 as implemented by 38 CFR 17.60 (b))

(5) **Beneficiaries of Sharing Agreements.** Sharing resources with community facilities and other federal, state or local governmental agencies can enhance mutual efficiency and economy of operations. Entering into sharing arrangements on that basis is encouraged. Several generic arrangements are possible:

- (a) The non-VA agency provides services for which the VA facility pays.
- (b) The VA facility provides services for which the non-VA agency pays.
- (c) Combinations of the above.

Basic authority for sharing specialized medical resources is provided in Pub. L. 89-785; for VA/DoD agreements, in Pub. L. 97-174. Codification is in 38 U.S.C. 5011, and 5051 through 5053. A number of VA and DM&S directives provide implementation and guidance. Agreements are generally initiated and developed at VA facility level, but are subject to VA Central Office review and approval. In those instances where the VA is providing services for a non-VA agency, the beneficiaries of the care are considered legitimate workload for the VA, but it is emphasized that such care must not reduce or otherwise compromise the treatment services to veterans. The dental service chief or designee should be involved in the negotiations when dental care is part of a proposed sharing agreement and must be prepared to act upon workload estimates and to provide reasonable costing information in accordance with existing guidelines.

e. Notification of and Charges for Treatment Provided to Other Beneficiaries. The Federal agency concerned will be notified of the dental treatment provided and records of such services will be referred to Medical Administration Service for further administrative processing. (38 U.S.C. 4115 as implemented by 38 CFR 17.62)

### **3.04 PERSONS NOT ELIGIBLE FOR OUTPATIENT DENTAL CARE**

While the basic authorities for outpatient dental care are set forth in subsections (a), (e) and (f) of section 612, title 38, United States Code, subsection (b) describes the specifications for as well as limitations to these authorities. There is no legal authority to initiate dental care for any category of veterans discussed under section 612 (a) through (h) unless it is further described or specified under section 612(b); therefore, dental services are excluded from participation in VA PBC (Pre-Bed Care) program and dental treatment cannot be authorized

for purposes of preparation for hospitalization. The VA Ambulatory Health Care Program is designed to provide treatment on an outpatient basis which will serve to obviate or avoid the need for hospitalization. However, since there is no legal basis for dental services to participate in this program, there is no authority to provide outpatient dental treatment to avoid hospitalization. Anyone who is referred to a dental service for emergency dental treatment, without established legal eligibility to receive outpatient dental care, will be subject to the procedures and provisions of paragraph 3.05 which follows.

### **3.05 EMERGENCY OUTPATIENT DENTAL TREATMENT PROVIDED BY VA STAFF**

Under certain conditions, outpatient emergency dental care may be provided as a humanitarian service to individuals who do not have established dental eligibility. Such treatment will be restricted to the alleviation of acute pain, infection or trauma, or the remediation of any dental condition which is determined to be a serious threat to health or endangering life itself. The provision of emergency dental treatment will not entitle the applicant to further dental treatment unless the person is found to have eligibility for VA outpatient dental care. Individuals provided emergency dental treatment who are indeed ineligible for such care will be billed in accordance with paragraphs f and g (38 U.S.C. 210(c) as implemented by 38 CFR 17.124.) Procedures are as follows:

a. Veterans presenting at VA medical facilities requesting treatment for acute pain, infection or trauma of the dental/oral area will initially be seen in the reception/admission area for administrative processing and triage. Application procedures will be in accordance with relevant provisions of M-1, part I, chapters 16 and 19. Triage will include, if applicable, verification of any service-connected medical disability for which there is a potential for adjunct (Class III) dental care.

b. Except in cases of significant hemorrhage or similarly acute situations, appropriate MAS (Medical Administration Service) personnel will determine the applicant's eligibility for outpatient dental treatment prior to the referral of the patient to the Dental Service for clinical evaluation.

c. If the patient has no eligibility or limited eligibility for outpatient dental care, the patient will be informed of this fact by MAS personnel and advised that if emergency treatment is provided for which no entitlement exists, the patient will be billed for the treatment in accordance with M-1 part I chapter 15. Further, the patient will be informed that the VA is under severe restrictions with regard to the extent of emergency treatment that can be given, and that followup treatment or further remedial care must be sought out and received in the private sector. This information will be provided so the applicant seeking emergency dental care can make a judgment, prior to referral to the dental service, whether to seek emergency treatment from community resources or from the VA. If the applicant decides to seek treatment from the VA, the MAS eligibility clerk will sign the statement of ineligibility in Section I-A or limited eligibility in Section I-B on VA Form 10-2570g, Dental Outpatient Emergency Referral and Treatment Record. The applicant will complete the information requested in Section I-C and sign the statement of understanding about emergency dental care and billing.

d. The patient seeking VA emergency dental care will be referred for clinical evaluation to the dental service with Section I of VA Form 10-2570g completed. Dental service personnel will examine the patient to determine the action to be taken. Options are as follows:

(1) If the condition will require hospitalization for treatment and/or control, Section II-A of VA Form 10-2570g will be completed and the admission diagnosis will be entered. SF 513, Medical Record--Consultation Sheet, and/or VA Form 10-1158, Doctor's Orders, will be initiated, as appropriate. The patient will be returned to the admitting area with the necessary documents for admission.

(2) If it is determined that the dental condition is amenable to treatment on an outpatient basis and is of such nature that immediate attention is not required (cases not involving pulp, hypersensitive dentin, transient pulpitis, broken dentures, etc.,) Section II-B will be completed and the applicant will be returned to MAS personnel for possible referral to community resources through Social Work Service.

(3) If the dental condition is considered emergent because of severe and unabating pain, significant infection, hemorrhage, febrile course, etc., treatment will be provided but limited to emergency procedures such as opening and draining of root canal, extraction of tooth or root, removal of foreign body, arrest of hemorrhage, focal scaling for debridement, temporary sedative fillings, or other direct procedures for relief of symptoms.

e. Upon completion, a brief description of the emergency treatment provided will be entered on VA Form 10-2570g, section II-C. The form will be signed by the treating dentist and returned to MAS for billing purposes.

f. In most instances, no billing will be made for diagnostic procedures related to these emergency situations (i.e., there will be no charge for the clinical evaluation, required radiographs or biopsies). The exception is for eligible non-service-connected veterans who have been determined to be in Category C. Category C veterans must agree to pay the applicable outpatient co-payment in order to receive emergency examinations and/or diagnostic procedures.

g. Medical Administration Service will establish controls to ensure that a statement of charges for medical services is prepared and forwarded for any ineligible individual who receives emergency dental treatment on a humanitarian basis. The VA Form 10-2570g will be annotated with the number and date of VA Form 10-9014, Statement of Charges for Medical Care, and the completed copies of VA Form 10-2570g will be filed in both the administrative and medical portions of the Consolidated Health Record.

### **3.06 DETERMINATIONS OF ELIGIBILITY**

a. **Administrative.** Applications for outpatient dental treatment will be received and processed for legal eligibility by the MAS.

b. **Professional.** Veterans applying for outpatient dental care who have a service-connected medical condition(s) will be referred for medical evaluation to determine whether or not there is medical concern that a current dental problem might be aggravating the service-connected medical condition.

(1) **Dental Care as Adjunct to Service-Connected Medical Condition(s) (Class III Dental Outpatient).** In applicable situations, VA physicians who are responsible for the outpatient management of veterans with service-connected disabilities will identify the service-connected medical condition(s) they consider is being aggravated or compromised by the

current dental problem (38 U.S.C. 612(b)(1)(D).) The physician will provide certification of adjunctive eligibility for dental care by entering signature, date and pertinent medical diagnosis in the spaces provided in the lower right corner of VA Form 10-2570, VA Staff Dental Outpatient Record. Local policy may also allow use of SF 513, Consultation Sheet, for this purpose, in which case the physician must specify the service-connected medical problem(s) being aggravated or compromised and request dental care as adjunct thereto. Since this document serves as a certification, the signature cannot be delegated to a non-physician. A copy of the request and report should be attached to the outpatient dental record. Upon receipt of a request for adjunct care, the Chief, Dental Service, or professional designee, will then be responsible for diagnosing the dental problem(s) and for determining the specific indication for and extent of dental treatment to be provided. The extent of care will be related to only those dental conditions which, in sound professional judgment, are having a direct and materially detrimental effect upon the service-connected medical condition(s) cited by the VA physician. These determinations are equally appropriate whether the veteran is to be treated by VA staff dentists or if the veteran is to be treated on a fee basis. In either instance, the extent of dental care will be governed by the following considerations:

(a) Whether or not the current dental condition(s) is of sufficient magnitude to adversely affect the medical condition of concern or treatment thereof.

(b) Whether or not the medical condition of concern will require treatment of all the dental needs or completion of only a portion of a comprehensive dental treatment plan.

(2) **Consultations Between Medical and Dental Disciplines.** All necessary consultations will take place between the medical and dental disciplines to assure that each is adequately apprised of the other's concerns and conclusions so that meaningful professional determinations may be made and proper medical management of the patient will be carried out during dental treatment.

(3) **Dental Care as Adjunct to Service-Connected Dental Condition(s).** In outpatient cases where rated service-connected dental conditions serve as the only basis for dental treatment authorization, the Chief, Dental Service, will exercise sound professional judgment in determining the indication for and authorization of dental treatment for any non-service-connected dental condition considered to be essential in the assurance of successfully treating the service-connected dental condition(s). Any additional dental treatment authorized as adjunct under this provision must be identified on the applicable outpatient dental authorization record and the justification and rationale documented by the Chief, Dental Service.

(4) **Consistency in Professional Determinations for Adjunct Dental Care.** The determinations derived from professional judgment must be as consistent as possible. Whether or not the veteran would be treated by VA staff or would be authorized to a fee dentist should not be a factor in the decision. To provide unjustifiable dental care by VA staff is no more correct than to deny justifiable care because the case would have to be authorized for fee-basis care. The only basis for adjunct dental care is predicated on the medico-dental concerns under consideration. Under no circumstances should these determinations result from administrative action alone. Although the program guide, Interdisciplinary Management of Patients Having Compelling Needs for Dental Treatment, may provide some guidance, the use of listings of diseases and correlated eligibility factors should be avoided so that the variable interrelationships of acute and chronic diseases may be recognized and professionally

considered on an individual case basis.

(5) **Denial of Dental Care Based on Professional Determination.** When it has been professionally determined to deny authorization of Class III outpatient dental care, the veteran will be informed of the decision by a letter from the Chief, MAS. If no Class III dental treatment has been provided the veteran previously, the decision for denial may be established initially by the physician, based on noncorrelation between medical and dental problems, or by mutual agreement between the physician and Chief, Dental Service, following consultation. If the veteran has been provided Class III dental care previously, the same procedures may be followed; however, it may be advisable for an ad hoc committee to be convened, comprised of representative, involved professionals since precedent will seem to have been established by the prior authorization. Veterans commonly misunderstand subsequent denials to be a change in policy rather than changes in medico-dental circumstances or relationships. By this method of committee deliberation and action, the potential for complaint of personal bias may be overcome.

### **3.07 COMPENSABLE SERVICE-CONNECTED DENTAL DISABILITIES**

a. Veterans who have compensable service-connected dental disabilities (Class I dental beneficiaries) rated under the 9900 series of the Schedule for Rating Disabilities, by the nature of their service-connected disabilities, have special need for comprehensive programs of oral hygiene, preventive dentistry and periodic maintenance.

b. These Class I applicants will be fully informed of their eligibility for comprehensive dental care on a repeat basis.

c. These veterans should also be encouraged to receive periodic oral examinations, at least annually. A follow-up program should be established at the responsible VA facility, when feasible, or with a fee-basis dentist. However, each episode of dental care will be based on a separate claim and preauthorization.

d. Since many VA facilities are staffed with dental specialists or have consultants in dental specialties, it is desirable that these veterans be treated by VA staff.

e. There are times when there is confusion concerning dental authorization for outpatient dental care for veterans who have other rated, compensable service-connected conditions of the head and neck area. Such conditions as loss of soft tissue, scarring or cranial nerve involvement may have significant impact on oral function even though there may be no physical trauma to the dental structures, per se. These nondental conditions, which are rated under other series, are also designated under the Class I category. These should be considered as medical conditions and the decision as to whether or not dental care will be authorized, as Class III adjunct care, will be professionally determined on the basis of the following:

(1) The dental condition is aggravating the service-connected medical disability of the head and neck area, or, dental treatment is required in maxillofacial restoration of the medical disability, or

(2) The service-connected medical condition of the head and neck area is directly and adversely affecting the oral health status.

f. The only veterans who have direct legal entitlement to dental care on a repeat basis for compensable service-connected dental conditions are those who are rated under the 9900 series of the Schedule for Rating Disabilities. There is no basis for authorization of outpatient dental care for other compensable service-connected disabilities of the head and neck area unless the conditions and provisions of subparagraph e above apply.

### **3.08 ONE EPISODE OF CLASS II TREATMENT**

When Class II eligibility for one-time episode of dental care has been exhausted by satisfactory completion of the authorized treatment, or closed because no treatment was needed, no further Class II authorization may be issued.

a. **Dental Prostheses---Class II.** Following other aspects of authorized care, the furnishing of serviceable prostheses to replace missing service-connected teeth will terminate Class II eligibility to treatment. When required, immediate dentures may be authorized as an interim measure to be followed by the separate authorization for a relined of the immediate denture, if application for this additional procedure is filed by the veteran within a year from date of insertion. Both authorizations will be considered the same episode of treatment.

b. **Periodontal Conditions---Class II.** Specific treatment authorized for noncompensable service-connected or service-incurred periodontal conditions of Class II beneficiaries is expected to provide maximum benefit by the time that episode of care is completed. When that treatment is satisfactorily completed, as authorized, no further treatment or follow-up of the periodontal condition will be furnished by the VA.

### **3.09 CERTIFICATION OF INADEQUACY OF TREATMENT**

In providing outpatient dental services on a one-time episode of treatment basis, it is expected that the services provided for a beneficiary will be adequate in extent and professionally acceptable in quality. When it is professionally determined that additional treatment is necessary, the Chief, Dental Service, may so certify and authorize the additional dental treatment found necessary to properly discharge the VA's responsibility.

### **3.10 DISABILITIES INCURRED DURING SUBSEQUENT PERIOD OF SERVICE**

Beneficiaries who have had treatment completed for eligibility established on prior military service, or who did not file timely applications with the VA following prior military service, may be furnished Class II treatment only for the dental conditions incurred during their latest period of service. A prisoner of war who has had more than one period of service is entitled to repeated episodes of treatment for service-connected dental conditions incurred during all periods of service.

### **3.11 AMENDED RATINGS**

On reapplication, treatment may be authorized for additional service-connected dental disabilities or conditions granted by an amended rating subsequent to completion of the initial episode of treatment. Authorizations will be limited to treatment of the additional service-connected dental disabilities established by the amended rating.

.. -

SECRET 10, 1951

**3.12 CLASS II BENEFICIARIES WHO RECEIVE CARE UNDER OTHER THAN CLASS II EPISODES OF CARE**

Beneficiaries will be considered to have had one-time completion of Class II benefits and certification of exhaustion of those benefits will be annotated if all the dental care to which they were entitled was furnished during VA hospitalization or under Class III or Class V authorizations.

**SECTION II. EXAMINATION AND TREATMENT PROCEDURES FOR STAFF AND FEE OUTPATIENT PROGRAM**

**3.13 ORAL EXAMINATIONS**

An oral examination by a dentist will be accomplished as an integral part of annual or other complete physical examinations performed in VA facilities for service-connected beneficiaries entitled to outpatient medical treatment, as indicated. In addition, oral examinations will be completed for beneficiaries entitled to outpatient dental care when VA dental staff will provide the treatment. In those instances where the outpatient does not have a recent blood pressure determination recorded in the medical record, a blood pressure determination should be made and recorded. Patients with abnormal findings should be referred by consultation to the appropriate medical service for proper disposition.

a. **Beneficiaries Eligible for Outpatient Dental Treatment.** When it can be determined from available records that the beneficiary to be examined is eligible for outpatient dental treatment under any of the provisions of existing statutes and the local dental staff is able to provide the treatment, the oral examination will be recorded on VA Form 10-2570, VA Staff Dental Outpatient Record. If needed treatment cannot be furnished by local staff due to geographic inaccessibility, inability to provide the type of care required or to initiate treatment in a timely manner, MAS will determine if there is another VA health care facility within reasonable distance from the veteran's residence and, if so, ascertain if the dental staff at that facility can provide timely care (initiate treatment within 60 days). The local staff will then complete VA Form 10-2570 while the beneficiary is there, if possible. The VA Form 10-10 and allied papers will be forwarded to the VA facility which will provide the care. If none of these options exist and there are no contracts for the providing of dental care which have been established with other Federal facilities, MAS will forward the completed application for outpatient dental care, VA Form 10-10, to the VA facility for fee jurisdiction. A VA beneficiary will not be referred for fee dental care without justifiable reasons, however. The decision for fee dental care is not the prerogative of the veteran-beneficiary but a VA decision based on the criteria cited above. Of course, a veteran's severe physical infirmities which would make traveling hazardous to veteran's health could be considered an extenuating circumstance which would be both justifiable and documentable. In all cases where referral takes place the veteran will be notified and fully apprised of the action taken (38 U.S.C. 601(4)612 (a), (b) and (f).)

b. **Beneficiaries Referred for Dental Evaluation Prior to Determination of Eligibility for Outpatient Dental Treatment.** When it cannot be determined from available records that the beneficiary is eligible for outpatient dental treatment and the veteran has been referred to determine the need for dental care, the oral examination will consist of careful clinical evaluation. Radiographs will be obtained only when the examining dentist feels there is a

significant indication. A VA Form 10-2570 will not be accomplished but a brief statement regarding the oral findings will be made on SF 509 and signed by the dentist. When the oral examination reveals the need for routine dental care, the patient will be so advised and informed that the treatment cannot be furnished by the VA unless eligibility is established. An entry to this effect will be made on the SF 509. Emergent dental care, if needed, may be provided in accordance with the provisions of paragraph 3.05.

### **3.14 RECORDS**

a. **VA Form 10-2570a, Health Questionnaire for Dental Outpatients.** To avoid possible serious complications, it is essential that the examining and treating dentist have knowledge of a patient's general health status. The dentist must be aware of any past and/or current medical problems and of any medications which a patient is taking. When a dental outpatient examination is accomplished in a VA clinic, the patient should complete VA Form 10-2570a prior to the clinical examination unless adequate current medical records are available. The examining dentist should review the form, clarify any questionable items, make appropriate notes in the Dentist's Remarks section, and sign and date the form at the completion of the clinical examination. When the dental examination is authorized to a fee-basis dentist, the VA Form 10-2570a will accompany the VA Form 10-2570d. Although completion of VA Form 10-2570a is optional for fee basis dentists, they should be encouraged in its utilization. When a case is closed, VA Form 10-2570a will be filed in the treatment folder.

b. **VA Form 10-2570, VA Staff Dental Outpatient Record.** VA Form 10-2570 will be used to record examinations and treatment for all outpatient categories treated by VA staff except those in OPT-NSC status or OPT-SC status (where dental needs relate to medical conditions other than the veteran's service-connected conditions). The use of the form is self-explanatory. Generally, VA staff dental examinations will be completed within 2 weeks of application. Staff treatment workload will be limited to that number of beneficiaries for whom the staff can provide treatment on a timely basis (i.e., treatment to be initiated within 2 months after examination).

c. **VA Form 10-2570d, Dental Record, Authorization and Invoice for Outpatient Services.** VA Form 10-2570d will be used only for dental examination and treatment procedures by fee dentists. It will be used as a single document to authorize fee dental examination, record examination findings and treatment plan and record the treatment furnished. It will also serve as a voucher for payment of services provided by fee dentists. Instructions for administrative processing are contained in M-1, part I, chapter 19.

d. **VA Form 10-2570b, Examination Procedure Instructions for Participating Fee Dentist.** This self-explanatory form must accompany the VA Form 10-2570d when authorization is sent to a veteran-beneficiary to select a currently licensed dentist practicing general dentistry for dental examination and treatment plan.

e. **VA Form 10-2570c, Treatment Procedure Instructions for the Participating Fee Dentist.** This self-explanatory form must accompany VA Form 10-2570d when dental treatment is authorized to a fee-basis dentist.

### **3.15 RADIOGRAPHIC EXAMINATIONS**

Complete full mouth radiographic examinations of not less than 14 films or a single panoramic

view supplemented by necessary intra-oral films will be authorized for initial examination of all eligible beneficiaries. In circumstances where depleted dentition or edentulous status exists, the indication for radiographs should be modified by the examining dentist. On subsequent examinations, only radiographs necessary for proper diagnosis and/or treatment will be authorized. Radiographs will be interpreted and the findings incorporated in the report prior to establishing the treatment plan.

### **3.16 TREATMENT RECOMMENDATIONS**

The type and extent of treatment recommended and authorized must be of sufficient quantity and quality to meet the VA's responsibility of providing the beneficiary a satisfactory and professionally acceptable episode of treatment.

### **3.17 ORAL DISABILITY EVALUATION EXAMINATIONS FOR COMPENSATION AND PENSION RATING PURPOSES**

a. **Requirements for Oral Evaluation Examination.** In all cases for rating purposes of oral conditions and where a possibility exists that oral conditions may have a bearing on other conditions to be rated, a complete oral examination will be conducted by a dentist.

b. **Oral Evaluation Procedures.** Requests for an oral examination will be submitted to the Dental Service on VA Form 21-2507, Request for Physical Examination, or on SF 513, Consultation Request. Examination findings should be accurately and comprehensively reported on this form. If more space is required, SF 507, Continuation Sheet, will be used. Findings should be supported by both intra-oral and extra-oral radiographs and reports of any laboratory data, as required. The evaluation should include but not be limited to the following:

- (1) Pertinent history
- (2) Physical findings as related to pathoses, abnormalities and dysfunctions
  - (a) Loss of substance and extent (hard and soft tissue)
  - (b) Scarring and extent
  - (c) Deformity and extent
  - (d) Paresthesia. Location, degree and extent
  - (e) Limitation of motion and extent
  - (f) Abnormalities of speech
  - (g) Dysfunction and extent
- (3) Significant dental findings, i.e., malocclusion, periodontal disease, adequacy of masticatory function, serviceability of existing prostheses, etc., should be described.
- (4) In cases pertaining to gunshot wounds, fractures or other abnormalities of the mandible or maxilla where there is loss of substance, deformity, scars,

paralysis or any visible residuals, unretouched photographs showing the condition should be submitted. In cases where there is

.. -

SECURITY 49, 199.

limitation of motion of the temporomandibular articulation, or where there is deviation of the mandible, the extent of the limitation of motion or deviation will be recorded, including a description of any resulting malocclusion.

(5) Prognosis for successful restoration by means of corrective surgery or prostheses, including the apparent ability of the supporting tissues to tolerate the wearing of prostheses, should be reported. Options as to social acceptability should also be stated.

### **3.18 PREOPERATIVE ORAL PROPHYLAXIS**

Scaling of teeth sufficient to insure complete and accurate examination will be performed. Oral prophylaxis, if indicated, will be accomplished prior to the initiation of restorative and oral surgery procedures.

### **3.19 QUALITY OF CARE - REVIEW OF VA STAFF TREATMENT**

To assure that entitled beneficiaries have received the authorized dental treatment and that it meets acceptable professional standards, a representative number of Classes I-VI dental outpatients treated by VA staff will be reviewed as part of the Dental Service Quality Assurance program. A clinical examination with reference to the VA Form 10-2570 treatment plan will be performed by the Chief, Dental Service, or an appropriate designee. The examination will normally be accomplished at the last treatment visit for the authorized episode of care.

a. **Selection of Patients for Review.** Classes I-VI patients selected for review will be a random sampling of those treated.

b. **Identification of Discrepancies.** Any discrepancies requiring remedial action such as omissions, unsatisfactory treatment measures, unresolved conditions, etc., will be identified at the time of the evaluation and, if at all possible, a decision made for resolution. If local expertise (including consultants) is not sufficient to resolve the issues involved in a particular case, referral to another VA health care facility having appropriate expertise is recommended.

c. **Recordings of Findings and Decisions.** A brief summary of the findings of the review and any decision(s) for correction will be recorded on the veteran's VA Form 10-2570. If there is not sufficient space on this form, the entry will be made on SF 507, Continuation Sheet, which will be attached to the VA Form 10-2570. The entry will be dated and signed by the Chief, Dental Service, or his appointed designee.

d. **Record of Spot Check Activities.** All Chiefs, Dental Service, are responsible for maintaining a summary record of review activity. This record will include the name and social security number of the veteran, Classification (Classes I-VI), name of treating dentist, name of the examining dentist, date of examination and whether or not discrepancies are found. Decisions for action on discrepancies will be noted.

e. **Followup of Actions Taken.** Followup will be required for discrepancies in accordance with the quality assurance program. If a trend of discrepancies involving any staff dentist(s) becomes evident, a problem-focused SIR (Systematic Internal Review) may be indicated.

SECTION III. FEE JURISDICTIONAL INFORMATION

3.20 RESPONSIBILITY OF CHIEF, DENTAL SERVICE

In States where only one VA facility with fee-basis jurisdiction exists, the Chief, Dental Service, is authorized to act on all matters relative to participating fee dentists within that State. The term State, as used herein, includes the District of Columbia and the Commonwealth of Puerto Rico. In those States where two or more facilities have jurisdiction of a fee-basis program, the Chief, Dental Service, of the facilities listed below will assume the responsibility for coordinating the policies of outpatient fee dental administration and making revisions to the VA Schedule of Maximum Allowances for Fee Dental Services.

|               |   |
|---------------|---|
| Alaska        | Alaska has negotiated a program using the usual, customary and reasonable pre-filed fee concept which is administered by the Delta Dental Plan of Alaska. Contracts are negotiated annually with VA Central Office. This program is controlled and co-administered by VA Medical Center, Seattle, Washington.   |
| California    | California has negotiated a program using the usual, customary and reasonable pre-filed fee concept which is administered by the California Dental Service. Contracts are negotiated annually with VA Central Office. This program is controlled and co-administered by VA Outpatient Clinic, Los Angeles, VA Medical Center, San Diego, and VA Medical Center, San Francisco. VA Outpatient Clinic, Los Angeles, is designated as the responsible facility for policy coordination and revision of VA Schedule of Maximum Allowances for California. |
| Louisiana     | VA Medical Center, New Orleans  |
| Michigan      | VA Medical Center, Allen Park   |
| Missouri      | VA Medical Center, St. Louis  |
| New York      | VA Medical Center, New York   |
| Ohio          | VA Medical Center, Cleveland  |
| Pennsylvania  | VA Medical Center, Philadelphia   |
| Texas         | VA Medical Center, Dallas   |
| West Virginia | VA Medical Center, Huntington   |

.. -

FOIA b 7, D.C.

### 3.21 PROCEDURE FOR RECOMMENDING CHANGES TO SCHEDULE OF MAXIMUM ALLOWANCES FOR DENTAL SERVICES

#### a. Review Procedures for Analysis of Fees and Submission Protocol for Approval of Revisions by Central Office

(1) The Chief, Dental Service, of the fee jurisdictional facility, having the responsibility for revisions to the schedule of maximum allowances for that State will, at least annually, review the VA schedule with the responsible MAS dental representative. At this time a firsthand knowledge analysis will be made as to whether or not either official has experienced chronic deficiency problems associated with inadequate fees for any specific service. Criteria for identifying deficiencies will be based on:

(a) Unusual difficulties with veterans being unable to easily find private dentists who are willing to accept them as their patients within the current schedule of maximum allowable fees.

(b) Increased complaints from general practitioners over unacceptably low fees being authorized by the VA. (Reports of contact should be retained by the Chief, Dental Service, and the MAS representative to serve as documentation of these problems when a review is undertaken.)

(c) When the frequency of need to reduce usual and customary fees (so as to comply with the current maximum allowances) submitted by private dentists on VA Form 10-2570d for a specific service approximates or exceeds 25 percent, the service so affected is in need of being surveyed and analyzed for possible revision. Conversely, this review will identify when the maximum allowance for a specific service is too high. If the frequency of need to reduce a usual and customary fee approximates or is less than 10 percent, this service will also be incorporated in the survey.

(2) The Chief, Dental Service, will contact Chiefs of Dental Services of all other fee jurisdictional facilities in that particular State to ascertain if their experiences (using these criteria) are similar or if they have experienced other problems peculiar to their locale. This information will be incorporated into the preliminary decisionmaking process.

(3) The fee dental services (procedures) identified as deficient will be listed and a 2 months' survey will be conducted by the MAS dental representative recording the dollar amounts of the usual and customary fees submitted by the private dentists on VA Forms 10-2570d. Factors relating to the raw data collection survey are:

(a) The survey may include all, some, or only a single service, depending on the results of the preliminary decisionmaking process.

(b) Reviews and surveys may be conducted more frequently than once a year, depending on the acuteness of the situation.

(c) A high volume facility which can gather good broad-based data can compress the survey into a shorter time period. However, data that is not broad-based enough to be representative is invalid.

(d) The survey will be conducted so that every fee treatment plan is reviewed and recorded consecutively rather than on a geographic or pre-selection basis. Mini surveys may be conducted at the same time, for local information, but must not affect the consecutive order of the basic survey.

(e) No more than one entry (in dollar amount) will be recorded for each different service in a treatment plan. Example: A treatment plan recommends prophylaxis at \$18, three extractions at \$15 each, two crowns at \$180 each, two MO amalgams at \$22 each, and three MOD amalgams at \$30. The services and amounts recorded in the survey will be:

|                   |     |
|-------------------|-----|
| Prophylaxis       | 18  |
| Extraction        | 15  |
| Crown (full cast) | 180 |
| Amalgam MO        | 22  |
| Amalgam MOD       | 30  |

The next treatment plan will be recorded similarly.

(f) A survey format may be developed listing all the services which will be surveyed, leaving space opposite each for recording the applicable fee from each treatment plan, regardless as to whether the fee submitted is at, below or above the VA maximum allowable fee.

(g) Following completion of the survey, the raw data will be summarized and organized using VA Form 10-2507e, Worksheet for Organization and Analysis of Data Summarized From Dental Fee Survey. (See app. 3A.)

(4) When the percentiles and fees have been established, the fees corresponding to the 75th percentile will be entered (in red) alongside the applicable current "Maximum Allowances" in the VA Schedule of Maximum Allowances for Fee Dental Services.

(5) A packet will be formed containing the annotated schedule described in subparagraph (4) above, and copies of the completed worksheets described in subparagraph (3)(g) above. These will be submitted for approval to the ACMD for Dentistry (162) by a transmittal letter from that facility's Director.

(6) If the preliminary decisionmaking process described in subparagraph (1) above, or the fee dental survey described in subparagraph (3) above, confirm that no changes to the Schedule of Maximum Allowances are needed, a letter to this effect will be prepared for the Director's signature and sent to the ACMD for Dentistry (162).

(7) When the results of a survey demonstrate that a current maximum allowable fee is excessive (either due to prior error or due to the influence of economic recession), recommendation for a reduction to the current fee will be made.

**b. Distribution of Revised Schedules.** Following final approval of the revised schedules from Central Office, an effective date will be established which will allow time for the duplication and distribution of the revised schedules. All cases authorized prior to the effective date of the updated schedules will be paid in accordance with the allowances in effect at the time of authorization. Distribution of these schedules (with approved maximum allowances included) will be made by the Chief, Dental Service, and must be restricted to the following fiscal and

MAS at each fee jurisdiction facility on a "need to know" basis only.

c. **Communication to State Dental Association.** The appropriate representatives of the State Dental Association should be informed that the allowances of the VA schedule represent internal controls and that, in making a claim for payment of services, each dentist must not charge more than the usual and customary fees which are normally charged the general public. The requirement for specific knowledge of the VA maximum allowances, by outside parties, is not considered essential for the submission of their usual and customary fees and, to avoid any implication in price fixing, the revelation is prohibited. Negotiations with State dental associations will not be entered into for the establishment of VA maximum allowances. When revised Schedules of Maximum Allowances for Fee Dental Services are approved, they will be implemented on the effective date. Neither dentists, dental societies nor State dental associations will be notified when fee changes take place since it is the responsibility of each practitioner to submit their own usual and customary fees.

### **3.22 FORMAT FOR SCHEDULE OF MAXIMUM ALLOWANCES FOR FEE DENTAL SERVICES--USE AND RESTRICTIONS**

To assist Chiefs of Dental Services in developing a Schedule of Maximum Allowances for Fee Dental Services and to assure some uniformity, a format, which includes the elements most essential for a reasonably comprehensive schedule, is provided in appendix 3B. For VA internal use only, the approved maximum allowances may be added to the basic format in alignment with the services listed. Since the basic format contains specific guidance information which may be beneficial to participating dentists, appendix 3B may be duplicated (without specified maximum allowances or effective date included) and supplied to whomever may benefit from its information.

### **3.23 REQUIREMENTS FOR UTILIZATION OF PRIVATE DENTAL PRACTITIONER**

The policy of the VA is to utilize, on a fee basis, all ethically and professionally qualified dentists who are licensed to practice in the State where the services are to be furnished and who agree to provide dental services to veterans for preauthorized fees. This requires no application by the dentist for appointment. The veteran whose dental care will be authorized to a fee dentist is requested to select any currently licensed dentist practicing general dentistry.

### **3.24 SPECIAL ALLOWANCES FOR NEEDED AND UNUSUAL DENTAL SERVICES REQUIRING TREATMENT BY A DENTIST WITH SPECIAL QUALIFICATIONS**

a. Allowances in excess of the VA approved maximum allowances may be approved for dental services listed under items 6 and 8 and comparable services of Appendix 3B, VA Schedule of Maximum Allowances for Fee Dental Services, for unusual or difficult procedures which require treatment by a dentist having special qualifications. The need for a special fee must be fully documented and justified. Before approval of a special fee, the Chief, Dental Service, will determine:

(1) If the special fee is the usual and customary fee of the dentist providing the treatment which is routinely charged to other private patients for the same service.

(2) If the fee is reasonable and not in excess of that charged the general public for a similar service in the community concerned.

b. When a special fee has been approved, the service and special fee authorized will be identified by the use of asterisks in items 17 and 22 of VA Form 10-2570d. Any documents of justification from the fee dentist or annotations by the Chief, Dental Service, as bases for the special fees, will be forwarded to MAS with a copy of VA Form 10-2570d where they will be retained. These will be attached to the original VA Form 10-2570d at a later date following the completion of treatment and its final submission to the VA for payment.

### **3.25 EMERGENCY DENTAL TREATMENT PROVIDED BY FEE DENTISTS**

Payment may be provided for emergency dental treatment of eligible Classes I-VI dental beneficiaries without prior authorization provided notification is submitted to the VA fee jurisdictional facility not later than 15 days after the emergency treatment was initiated.

### **3.26 REQUIREMENT FOR SECOND-OPINION EXAMINATION**

Current statutes require that a "SECOND OPINION", by means of clinical reexamination of the veteran, be obtained in all cases where the total of a fee dental treatment plan exceeds \$500. MASs and Dental Services will coordinate in fulfilling the following procedures, as outlined:

a. A fee jurisdictional facility, having received a treatment plan which exceeds \$500, will determine if there are any VA health care facilities (having a dental service) within a 150 mile radius of the veteran's residence. The 150 mile radius may be exceeded in individual cases depending upon the extent and character of the treatment plan, the veterans medical condition and availability of suitable transportation.

b. Medical Administration Service will contact the veteran and inform the veteran that a second examination is necessary. The dental radiographs and VA Form 10-2570 (excluding the fee dentist's treatment plan) will be forwarded to a specified VA health care facility, which in turn, will establish a date and time for the examination with the veteran. Beneficiary travel will be provided by the facility conducting the second examination. All VA health care facilities will fully participate in this program.

c. A VA dentist will examine the veteran to determine dental problems and establish an independent treatment plan which, in the dentist's professional opinion, will provide a reasonable and satisfactory resolution. This treatment plan will be recorded on a new VA Form 10-2570 and, with the radiographs, will be sent back to the Chief, Dental Service, at the fee jurisdictional facility. The two treatment plans and radiographs will be reviewed there by the Chief, Dental Service, or professional designee, and a judgment made as to which plan is most reasonable and satisfactory. If the VA plan is selected, the following procedures will apply:

(1) If the veteran is geographically accessible to a VA facility for multiple visits, the veteran will be treated at that facility if treatment can be initiated in a timely fashion.

.. -

SECRET 10, 1991

(2) If the veteran cannot be provided timely care by the VA or if the veteran is not geographically accessible to a VA facility, the fee jurisdictional dentist will contact the fee dentist to reveal that a second opinion has determined that optional treatment would be satisfactory and more reasonable. If the fee dentist will treat according to the altered treatment plan (assuming fees are compatible with the VA fee schedule) then authorization can be made. If not, the veteran will be instructed and authorized to seek another dentist.

d. If a VA health care facility for conducting the second-opinion examinations is not available within a 150 mile radius of the veteran's place of residence, the Chief, Dental Service, or professional designee, of the VA fee jurisdictional facility will contact a second dentist in the private practice of general dentistry close to the veteran's residence. The VA dentist will explain about the legal need for a second dental examination. The veteran's radiographs (received from the first fee dentist and remounted by the VA for anonymity) will be forwarded to the second dentist with a VA Form 10-2570d containing authorization for examination only. The veteran will be informed by MAS that the veteran will be contacted by Dr. \_\_\_\_\_ for a second examination. Travel will be paid, as applicable, by the fee jurisdictional facility. Additional radiographs will be authorized when determined to be unavoidable. The second fee dentist will conduct a dental examination and generate an independent treatment plan (including fees) and submit it, with all radiographs, to the VA fee jurisdictional facility.

e. If the veteran refuses to participate in the second examination effort or to accept a treatment plan determined by the VA to be satisfactory, the case will be closed and the veteran so informed.

f. Both fee treatment plans will be reviewed at the fee jurisdictional facility. If both plans are satisfactory and there are no distinguishable advantages of one over the other and the fees of each dentist are within the VA Schedule of Maximum Allowances for Fee Dental Services, the first fee dentist (the one originally selected by the veteran) should be authorized to provide the dental care. If both plans are satisfactory but the first fee dentist's fees exceed the VA maximum allowances and the second dentist's fees are within the schedule, the Chief, Dental Service, will contact the first fee dentist to determine if the dentist is willing to provide the treatment for fees within the VA schedule. If not, the second fee dentist will be authorized to provide the treatment and the veteran will be so informed. If both plans are satisfactory but both dentists' fees exceed the VA maximum allowances, the first fee dentist will be contacted first to attempt satisfactory negotiation over the fees. If unsuccessful, negotiation will be instituted with the second fee dentist. If both negotiations fail and the Chief, Dental Service, does not feel optimistic that an additional authorization for a third fee dentist's examination would be productive of lower fees, the fee dentist with the less costly plan will be authorized to proceed with treatment. Whenever negotiations with the first fee dentist fail, the VA is obligated to communicate with the veteran providing explanation as to why the VA will be referring the veteran to the second fee dentist for treatment.

g. All of the foregoing paragraph is predicated upon the reviewing dentist's satisfaction that both treatment regimens would provide dental care of adequate quality and extent to resolve the dental problems for which the VA has responsibility. If there are significant differences in the type of treatment to be provided in the two plans, the VA reviewing dentist must determine

which plan will provide satisfactory resolution of the veteran's needs. When the decision is in favor of the second fee dentist's submission, tactful communication with the first fee dentist must take place with adequate explanation to avoid any implication of personal bias.

h. When the first fee dentist (who provided the dental radiographs) is not the one authorized to provide the treatment and the veteran desires that the radiographs be returned for his/her records, the VA will duplicate the radiographs and return the originals to the dentist, as requested.

i. If there is no VA health care facility nor a second fee dentist within a 150 mile radius of the veteran's residence to give a second opinion, the Chief, Dental Service, or his professional designee, without a clinical exam will render a judgment as to the extent and appropriateness of the proposed treatment as well as its compatibility with the VA fee schedule. If there are significant differences, the fee dentist will be contacted and negotiated with until a satisfactory resolution is attained.

### **3.27 QUALITY OF CARE--SPOT CHECK OF FEE TREATMENT**

a. To help assure that entitled beneficiaries receive the authorized dental treatment and that it meets acceptable professional standards, a percentage of patients treated by fee dentists will be spot checked. Each clinic of fee jurisdiction will arrange for the veteran's examination at the most convenient VA facility. Chiefs, Dental Services, of all designated facilities will participate in this program, as required. In order to accomplish this program on a meaningful and representative basis, the selection of fee patients for spot check will be, to the maximum extent possible, random samplings of patients who have been authorized routine dental care and reside in widely dispersed geographic locations. If a reasonable mix of patients who have been authorized extensive dental care does not surface by random sampling selection, then those patients will be spot checked in addition to the following random sampling:

(1) Fee jurisdictional facilities with projected fiscal year workloads of dental fee cases to be completed which exceed 200 cases will plan to accomplish post-treatment spot check evaluations for 5 percent of the cases actually completed in that fiscal year.

(2) Fee jurisdictional facilities with projected fiscal year workloads of dental fee cases to be completed which are 200 cases less will plan to accomplish post-treatment spot check evaluation for 10 percent of the cases actually completed in that fiscal year.

b. Other factors for spot check evaluations which should be considered and responded to, but which will be in addition to the requirements of subparagraph a (1) or (2) above, are:

(1) When a patient has indicated lack of satisfaction with the dental care received.

(2) When a patient has received treatment from a fee dentist with whom the VA has experienced previous problems.

(3) When a treatment plan from a fee dentist raises serious questions concerning the extent or type of care, The dentist will be contacted by the Chief, Dental Service, or professional

designee. If differences remain unresolved, then the patient will be examined, by the VA, prior to treatment authorization.

c. The request to the veteran for post-treatment examination should indicate that the examination is for the purpose of assuring that veterans receive all the treatment to which they are entitled.

(1) **Recording Findings.** A brief summary of the findings of the spot check examination will be recorded on the veteran's VA Form 10-2570d. If there is not sufficient space on this form, the entry will be made on SF 507, Continuation Sheet, which will be attached to VA Form 10-2570d. The entry will be dated and signed by the examining dentist. Nonjurisdictional facilities will return the records to the clinic of jurisdiction. All VA health care facilities will maintain a record of their spot check activities. This record will include the name and social security number of the veteran, classification (Classes I-VI), name of the fee dentist, date of examination and whether or not discrepancies are found. If found, the record will indicate the type of discrepancy as to:

(a) Minor.

(b) Major (involving either quality or misrepresentation). These discrepancies will be adequately documented as to detail and supported by evidence which would be beneficial in retrospective analysis (study casts, xrays, photographs, etc.). These items should be retained by the VA facility conducting the spot check until final disposition of the case is determined.

(2) **Action on Discrepancies.** Corrective action must be initiated within 2 weeks by the VA jurisdictional facility. One or more of the following options may apply:

(a) Arrange for the return of the veteran to the treating dentist for satisfactory completion of authorized services.

(b) Reauthorization of services, not satisfactorily performed, to a VA facility for treatment and recovery of monies from original fee dentist.

(c) Reauthorization of services, not satisfactorily performed, to another fee dentist and recovery of monies from the original fee dentist.

(d) Report of irresolvable, unsatisfactory treatment to the State Dental Association Peer Review Committee.

(e) Major discrepancies involving misrepresentation (including fraud) will be coordinated with MAS and reported in detail to the District Counsel for appropriate action. When an SF 1114, Bill of Collection, has been submitted by MAS to Fiscal Service, the report of final action taken or to be taken by the District Counsel should be sent to Fiscal Service to determine whether collection of the amount should be pursued, suspended or terminated.

(f) Followup will be accomplished in cases where action on discrepancies was determined necessary. This may take the form of telephone calls to or correspondence with the dentist or patient, or reexamination of the patient.

(Except as otherwise indicated, the provisions of Hh. 3 are based on 38 U.S.C. 212 and 621.)

Appendix 3A is not available on WANG; a copy may be Xeroxed in the VHA Library



**VETERANS ADMINISTRATION SCHEDULE  
OF MAXIMUM ALLOWANCES FOR FEE DENTAL SERVICES  
STATE OF \_\_\_\_\_  
EFFECTIVE \_\_\_\_\_**

The services listed are those for which maximum allowances have been designated and approved for veteran beneficiaries treated by dentists in the State of \_\_\_\_\_. A DENTIST MUST NOT MAKE CLAIM FOR PAYMENT OF FEES IN EXCESS OF THOSE CHARGED THE GENERAL PUBLIC AS USUAL AND CUSTOMARY FEES. Fees submitted, which are less than those of this schedule, will be honored as the individual's usual and customary fees. Those which are in excess will be reduced to comply with the schedule. Acceptance of a treatment case, which has been authorized by the VA, constitutes a contract to provide the authorized services for the stipulated amounts as payment in full. THE PATIENT MUST NOT BE REQUESTED TO PAY ANY DIFFERENCES BETWEEN THE AMOUNTS. AS AUTHORIZED, AND THE DENTIST'S USUAL AND CUSTOMARY FEES FOR THE SAME SERVICES. However, any dental treatment the veteran may need for non-service-connected conditions, for which the veteran has been determined ineligible and which has not been authorized by the VA, may then become a private matter between the dentist and patient. In order to avoid any misunderstanding concerning fraud, submission of completed VA Form 10-2570d (or other invoice) to the VA for payment should not take place until all the treatment for which claim is being made has been provided. The items listed in this schedule are limited to those procedures most often used in the authorization of outpatient dental treatment for general dental services. This does not preclude the authorization of other services when required. If there is need for services not listed or specified, recommendations with justification will be submitted to the Chief, Dental Service, at the VA issuing office for approval of a special fee. The VA conducts a program of post-treatment evaluation to assure satisfactory conclusion to the care authorized in behalf of the veteran.

**MAXIMUM**

**ALLOWANCES**

1. Examination and execution of VA Form 10-2570d.....

*(Sufficient scaling of teeth to ensure complete and accurate examination will be performed. Authorization for examination and xrays does not include any dental treatment (except emergency). If there are existing diagnostic radiographs, and professional judgment would contraindicate patient exposure to additional radiation, this service and its authorized fee should be crossed out on the VA Form 10-2570d and initialed. Recommended treatment, along with xrays, must be returned to VA issuing office for review, determination of veteran's extent of entitlement and authorization of that treatment which will be paid for by the VA.)*

2. Radiographs:

- a. Single periapical-first film .....
- b. Each additional film .....
- c. Maximum fee .....

d. Full-mouth xrays (minimum 14 films) .....

e. Full-mouth panoramic xray film (to be accompanied by supplemental periapical and/or bite-wing films when indicated) .....

f. Bite-wing films (only when full-mouth periapical xrays have not been accomplished)---only two interproximal or four periapical size films .....

g. Intra-oral film, occlusal view, maxillary or mandibular, each .....

h. Extra-oral film (mandible or maxillae and facial bones), each .....

3. Emergency treatment, palliative (for hard or soft tissue pathosis) .....  
(VA Regulations require that any emergency dental care provided an eligible VA beneficiary must be reported to the VA within 15 days of the date of treatment or it will be considered as unauthorized care. Since emergency dental needs cannot be anticipated nor preauthorized, the care provided must be reported promptly to determine eligibility and insure payment)

4. Prophylaxis treatment (to include scaling of teeth) .....

5. Periodontal treatment .....  
(Fees for periodontal care will be established on an individual case basis following submission of evidence of a thorough periodontal evaluation and complete treatment plan. Fees will depend upon extent of disease, type of treatment involved, etc. Normally, this will involve direct communication between the office of jurisdiction and the fee dentist.)

6. Oral Surgery:  
(Fees allowed for all dental surgical procedures include local anesthesia and routine postoperative care without additional charge.)

a. Extractions--per tooth .....

b. Impacted tooth .....  
(Fees within the allowable range to be determined by the authorizing dentist according to type and severity of impaction (soft tissue, partial bony, bony, disto-angular, etc.))

c. Alveoloplasty--(per quadrant or equivalent) .....  
(Alveoloplasty may be authorized, when indicated, for edentulous areas as a preprosthetic procedure. However, in a quadrant undergoing concurrent extractions, a fee for alveoplasty will be authorized only when it is necessary to lay a subperiosteal flap, recontour the alveolar bone, readapt the flap and suture. Mere ronguering of perialveolar or crestal bone following extraction(s) is not considered on alveoloplasty in this context.)

7. Postoperative treatment not covered by flat fee--on supplemental authorization with necessity shown .....

8. Root Canal Therapy:

a. Extirpation of pulp treatment, filling of root canal, single rooted tooth, radiographs .....  
*(Radiographs showing completed root canal filling must be submitted with completed VA Form 10-2570d at no additional charge.)*

b. For each additional canal filled .....

c. Apicoectomy (in addition to 8a above).....

9. Amalgam restorations:

*(All fees for tooth restorations will include local anesthesia and pulp protective media, where indicated, without additional charge. When an unforeseen need for a retentive device develops during authorized restorative dental treatment, this additional treatment may be performed prior to specific authorization. A pin amalgam restoration is a typical example of such treatment. The additional services rendered may be certified for payment by Chief, Dental Service, in accordance with M-1, part I, chapter 19.)*

a. Involving one tooth surface .....

b. Involving two tooth surfaces .....

c. Involving three or more tooth surfaces .....

d. Retention pin--only where extent of restoration requires its utilization--each .....

10. Gold restorations:

a. Involving one tooth surface .....

b. Involving two tooth surfaces .....

c. Involving three or more tooth surfaces .....

11. Composite restorations:

*(Fee will not be approved by the VA for posterior restorations which include occlusal surfaces. Proximal restorations of anterior teeth, not including incisal angles, are considered as single surface restorations.)*

a. Class I and V restoration .....

b. Class III restoration .....

c. Class IV restoration .....

12. Fixed prostheses: (Crowns, pontics, facings)  
(Correction of occlusion is considered a part of completed prosthodontics and multiple restorations involving occlusal surfaces.)

a. Crowns:

- (1) Porcelain jacket crown .....
- (2) Full cast gold crown .....
- (3) Cast gold crown with resin veneer\* .....
- (4) Porcelain fused to gold (Ceramco or equivalent)\* .....
- (5) Three quarter crown .....

(\*Crowns with esthetic veneers will not be authorized posterior to the maxillary and mandibular first molars. Unusual esthetic requirements will be justified on an individual case basis.)

b. Pontics:

- (1) Cast gold (sanitary) .....
- (2) Porcelain fused to gold (Ceramco or equivalent) .....
- (3) Steele's facing type .....
- (4) Tru-pontic type .....

13. Recementation:

- a. Inlay .....
- b. Crown .....
- c. Fixed partial denture (bridge) .....
- d. Facing or pontic .....

14. Removable Prostheses:

(Fees for all removable dentures include adjustments needed. Gold removable partials will be approved only as special fee items.)

a. Complete maxillary or mandibular denture: Resin .....

b. Immediate maxillary or mandibular denture: Resin .....

(The dentist inserting the immediate denture will advise the veteran that, when indicated, a one-time rebase (duplication) or reline will be authorized on the veteran's reapplication. The application, however, must be submitted not later than 12 months after insertion of the immediate denture.)

c. Partial maxillary or mandibular denture with two cast chrome-cobalt alloy clasps with rests: Resin Saddles .....

d. Partial maxillary denture with cast chrome-cobalt palatal major connector and two cast chrome-cobalt clasps with rests: Resin saddles .....

e. Partial mandibular dentist chrome-cobalt lingual bar or apron major connector and two cast chrome-cobalt clasps with rests: Resin saddles .....

f. Clasp with rest: Cast chrome-cobalt alloy .....  
 (Additional to 14c, d or e above)--each .....

g. Denture adjustment .....  
*(Fee for denture adjustment may be authorized, when indicated, but not to the dentist who constructed the appliance during the original authorization.)*

15. Repairs to prostheses:

a. Repair of broken denture--no teeth involved .....

b. Replacement of broken teeth on intact denture:

(1) First tooth .....

(2) Each additional tooth .....

c. Replacement of broken teeth on broken denture: Each replacement tooth (in addition to fee for 15a above) .....

d. Addition of teeth to partial denture to replace extracted natural teeth:

(1) First tooth .....

(2) Each additional tooth .....

e. Replacement of broken facing .....

f. Replacement of clasp on denture (clasp intact) .....

g. Replacement of clasp on denture with new clasp .....

16. Refabrication of existing removable dentures:

*(Fees for chairside "in the mouth" relines with self-curing rebase material will not be authorized. Both rebase and relines procedures must be generated from intra-oral border refinement (if indicated) and a new impression of the supporting tissues.)*

a. Rebase (duplication, replacement of entire base area of denture)--flask cured .....

b. Reline (addition of new denture material to base of denture) flask cured .....

17. Plaque control program:

*(Fee for plaque control (preventive dentistry) will be allowable only when supported by detailed documentation of a significant and acceptable program which is regularly provided as an integral part of the individual dentist's usual practice procedure.)*

a. Initial visit (to include prophylaxis, instruction, demonstration, etc. (Separate fee for oral prophylaxis will not be paid when Plaque Control Program has been authorized) .....

b. Followup visits (maximum of 3)--each .....

**CHAPTER 4. INSTRUCTIONS COMMON TO BOTH INPATIENT AND OUTPATIENT DENTAL PROGRAMS**

**SECTION I. GENERAL**

**4.01 LOCAL DENTAL POLICIES AND PROCEDURES**

Promulgation of local dental policies and procedures will take two forms. One form relates to matters that are internal to the dental service itself and will usually be referred to as the Dental Service Operations Manual. The other relates to matters that impact upon the operations of other individuals or services within the facility or require their cooperation. These will usually be published as facility memoranda over the signature of the facility Director.

a. **Dental Service Operations Manual.** The Chief, Dental Service, will be responsible for developing and maintaining currentness of an operations manual that details internal dental service policies and procedures essential to clinic function and delivery of dental care. The manual should serve to augment and implement VA and DM&S directives while maintaining consistency with their letter and intent. The following subjects are examples of those that may be covered:

Oral examinations and diagnostic procedures.  
Clinic dress code.  
Professional department.  
Supervision of dental residents.  
Collection of statistical data.  
Quality assurance procedures.  
Management of dental clinic records.  
Clinic infection control procedures.  
Housekeeping duties and responsibilities.  
Environmental hygiene (radiation, mercury, etc.).

b. **Facility Memoranda (or similarly named local directives).** The Chief, Dental Service, will be responsible for development, coordination, assuring publication, and maintaining currency of center memoranda that apply to the dental service but impact upon the activities or require the cooperation of other services. Examples are as follows:

Eligibility and priorities for dental care.  
Admission and discharge of dental patients.  
Procedures relating to dental emergency "drop-ins."  
Dental appointments for inpatients.  
Treatment of employee dental emergencies.  
On-ward preventive dentistry sessions.  
\*Authorized use of dental clinic facilities.

\*An example of format and style for a facility memorandum on this subject is provided as appendix 4A. Although local policy may require some variation in format, a local directive covering this subject is mandatory.

.. -

December 15, 1957

**c. Responsibilities of Dental Service Staff**

(1) Dental service personnel will be expected to be familiar with the provisions of all local policies and procedures, and to conduct their activities in accordance with those provisions. Similarly, they should be able to accurately explain them, as necessary, to patients, other VA employees, and the general public.

(2) The Chief of Dental Service must assure that any changes in local policies and procedures are promptly published and that all dental personnel are kept abreast of such changes. In addition to staff meeting discussions, a system of in-clinic circulation of the policy/procedure documents (with initialing by each individual attesting to their review and understanding) is considered a necessity.

**4.02 OFFICER OF THE DAY--DENTAL**

At all health care facilities where two or more dentists are assigned, a rotation roster of "Officer of the Day--Dental" will be maintained. The dental officer of the day will be subject to call for emergency dental care of VA beneficiaries and will keep the facility advised as to where to be contacted during the officer's tour of duty. At facilities with only one dentist, emergency dental coverage will be arranged for by the Chief, Dental Service, in cooperation with the Chief of Staff. The Director will promulgate instructions for the implementation of emergency dental coverage at VA outpatient clinics.

**4.03 SUPERVISION OF DENTAL RESIDENTS AND OTHER DENTAL TRAINEES**

a. Dental residents must be provided appropriate supervision during any and all clinical tours of duty in a VA medical facility. This supervision may be provided by the Program Director or a designated, appropriately credentialed physician or dentist member of the medical staff. The degree of such supervision is dependent upon demonstrated knowledge, skill, and judgment of the trainees as well as their level of professional attainment. A well-structured training program should permit and encourage increasing levels of clinical responsibility as defined in program objectives. In addition, all programs should endeavor to instill a sense of compassion for patients as human beings who must be treated with dignity and respect.

b. Supervision must include preceptor review of all treatment plans involving comprehensive care and for all procedures that are complex, involve increased patient risk, or with which the resident has limited experience. Such supervision should include a pre-treatment review of the dental/oral diagnosis, intended dental treatment, and relevant elements of the physical evaluation and medical history. Pre-treatment reviews should be documented in the medical records with comments and/or cosignature by the preceptor when appropriate.

c. Pre-treatment preceptor review is not required for short, uncomplicated procedures when the resident has demonstrated adequate professional knowledge, skill, and maturity of judgment in the VA milieu or, as applicable, in an affiliated hospital rotation. Designation of these residents will be on an individual basis by the Program Director and Service Chief (for dental specialty residents) or by the Program Director, Service Chief, and assigned preceptors (for dental general practice residents). Such designation will be based on careful monitoring and may be granted or withdrawn at any time during the residents' program. Implementation must

be accompanied by formal documentation in the resident's evaluation records.

d. During scheduled treatment, the degree of supervision and the physical proximity of the preceptor vary with the demonstrated knowledge, skill and judgment of the resident, the complexity of the procedure, and the condition of the patient. Based on these factors, treatment procedures may be accomplished under one of the following conditions:

(1) The preceptor present within the operatory or the clinic.

(2) The preceptor available within the medical complex, to include an affiliated institution, if geographically adjacent to the VA facility.

(3) Preceptor available on an "on-call" basis;---applicable to situations involving routine, low-risk procedures that a resident may wish to continue after normal clinic closing time.

e. Dental residents on an off-service rotation will be assigned to an appropriate member of the medical staff for supervision, and are subject to the supervisory directives applicable to that service. Dental residents providing dental or oral surgical treatment in the hospital surgical suite will usually be supervised in accordance with paragraph d by an appropriately credentialed member of the dental service staff. Supervisory directives of the surgical service will take precedence, however, if they are more restrictive or detailed.

f. Assignment of a dental resident to independent on-call status during evening, weekend, or holiday hours is permitted if, as in paragraph c, the resident has demonstrated clinical proficiency and judgment deemed sufficient to evaluate dental emergencies and, as indicated by the situation, to provide treatment or to request assistance; and either an appropriately credentialed attending staff member or, if applicable, a more experienced senior resident is assigned on-call as backup for consultation and/or assistance.

g. Undergraduate dental students, dental hygiene students, and dental assistant students (or any other trainees having direct patient contact during a dental clinic rotation in a VA medical facility) must be under the direct supervision of assigned faculty or appropriately designated members of the VA dental service staff. Complexity of assignments and proximity or participation of the instructor are dependent upon the objectives of the program, level of student attainment, demonstrated knowledge and skill, and condition of the patient. Students do not have the authority and they will not be assigned responsibility for providing independent patient care.

h. In a situation where serious or permanent harm could result to a patient or when the life of a patient is in immediate danger, dental service trainees, assisted by other personnel as available, shall be permitted to do everything possible to save the life of a patient or to save a patient from serious harm. Appropriate professional staff should be summoned for assistance without delay.

#### **4.04 DENTAL APPOINTMENTS AND RECORDS**

A system of scheduling dental appointments, consistent with the centralized scheduling program of the facility, will be established and maintained.

a. Unless a local automated system has been developed as an adequate substitute, VA Form 10-2679, Dental Appointment and Record Book, or a similar bound book, will be maintained by each dentist, hygienist and EFDA (expanded function dental auxiliary) to provide a daily record of appointments and services. Annotations will also be made concerning attendance at professional and/or administrative meetings and conferences and all other non-chairside duties.

b. The medico-dental terminology of the latest edition of the American Medical Association's "Current Medical Information and Terminology" and "Physicians' Current Procedural Terminology" and/or other approved references will be used in recording the oral diagnoses and treatment recommendations and procedures. The following abbreviations will be used in recording tooth surfaces:

| Simple       | Compound (Examples)                          |
|--------------|--|
| M (Mesial)   | MO (Mesio-occlusal)                          |
| I (Incisal)  | DO (Disto-occlusal)                          |
| F (Facial)   | MOD (Mesio-occluso-distal)                   |
| D (Distal)   | FO (Facio-occlusal) and similar combinations |
| O (Occlusal) |  |
| L (Lingual)  |  |

c. Periapical films will be mounted to orient the oral structures as they would be viewed from outside the mouth, facing the patient. This is in conformance with the system recommended for standardization by the American Dental Association.

d. The VA utilizes the numbering system for permanent teeth which starts with the maxillary right third molar as tooth No. 1 and proceeds sequentially to the maxillary left third molar as tooth No. 16. The mandibular left third molar is tooth No. 17 and the numbering proceeds sequentially, ending with the mandibular right third molar which is tooth No. 32.

e. Deciduous teeth are identified by capital letters starting with the maxillary right second molar, tooth A, and ending with the mandibular right second molar which is tooth T. The method of proceeding from A to T is similar to that for permanent teeth as outlined in subparagraph d above.

#### 4.05 PROCEDURES PERTINENT TO ORAL SURGERY

a. **Utilization of Operating Rooms for Oral Surgery Requiring General Anesthesia.** Normally the management of all oral conditions requiring the use of general anesthesia will take place only in hospital operating rooms. Allowances for extending this practice to a dental clinical area may be made where residency programs require trainees to obtain experience in general analgesia and/or sedation for ambulatory dental patients, or when the dental service is staffed by qualified personnel with appropriate clinical privileges. The implementation of such a program requires the approval of the Chief of Staff, Chief of Surgery, and the Chief of Anesthesiology.

b. **Fractures of the Zygomaticomaxillary Complex and/or Mandible.** Patients with fractures of the zygomaticomaxillary complex and/or mandible will be admitted to beds allocated to

the surgical service unless there are beds specifically allocated to the dental service. If there is another condition of priority concern, arrangements will be made to admit the patient to another service. Ordinarily, the dental service will be responsible for the treatment of fractures of the zygomaticomaxillary complex and/or mandible. In unusual or complicated cases, such as extensive fractures involving the middle third of the face, the orbits, the cranium, etc., consultation will be requested with the appropriate services. Thus, the care of the patient becomes a team effort assuring the best possible care for the veteran-beneficiary. In fact, consideration should always be given to bringing together the expertise of various professional disciplines where the application of these talents would serve to enhance treatment effectiveness, function restoration and esthetics. In facilities with approved training programs in oral surgery, the Chief, Dental Service, and the Chief of Staff, in cooperation with the Deans Committee, will be responsible for assuring that oral surgery residents are provided with adequate experience to meet the training requirements of the American Board of Oral and Maxillofacial Surgery and the Commission on Accreditation of the American Dental Association.

c. **Written Informed Consent.** It will be necessary, for the performance of all surgical procedures, that the patient be fully informed concerning the procedure(s) and sign consent prior to the initiation of treatment, as required by the applicable specifications contained in paragraph 4.06b through i.

#### **4.06 INFORMED CONSENT FOR PERFORMANCE OF DENTAL OPERATIONS AND OTHER PROCEDURES**

a. **Informed Consent--Verbal.** Except as specified under subparagraph b(1) it will not be necessary to obtain signature consent from an adult patient nor document SF 522, Medical Record-Request for Administration of Anesthesia and for Performance of Operations and Other Procedures, for low risk dental procedures which are commonly practiced by the dental profession and normally understood by dental patients (such as the administration of local anesthesia, preparation of teeth, restorations, oral prophylaxis, fabrication of prostheses, etc.). Prior to initiation of care, the dental care provider will explain to the patient (in language the patient can understand) the need for and the nature of the procedures to be performed, the attendant risks and discomforts, if any, and the extent of care for which the VA will be obligated. A notation documenting the explanation should be placed in the patient's medical record at the time it is given. No further consent(s) is required during the course of care unless there is a significant change in the treatment plan.

#### **b. Informed Consent--Written**

(1) All dental procedures involving higher risk or about which the average dental patient would not be familiar will require that the patient be fully informed concerning the nature, purpose and benefits of the procedure(s), possibility of complications and problems to be anticipated if no treatment is provided and the extent of dental care for which the VA will be obligated. This information must be attested to by the patient and the dentist on SF 522, Medical Record-Request for Administration of Anesthesia and for Performance of Operations and Other Procedures, prior to the initiation of dental treatment involving:

- (a) All surgical procedures.
- (b) All biopsies.

.. -

December 19, 1981

(c) Any dental procedure which would be considered to present unusual risk due to the health status of the patient or the risk factor of the procedure itself.

(d) Any dental procedure which is not commonly practiced by the dental profession whereby the average patient would not be expected to have knowledge of the procedure.

(e) Administration of relative anesthesia, general analgesia or intravenous sedation.

(2) If the treatment anticipated will involve multiple visits or procedures in following an authorized treatment plan, the treatment plan may be summarized, under item 1, part B of SF 522 and explained to the patient. Therefore, it will not be necessary, under this option, to obtain additional or subsequent signatures from the patient as long as the episode of care proceeds according to the following:

(a) There is no significant deviation from the treatment plan as originally outlined.

(b) The original treatment plan is not exceeded.

(c) The elapsed time for accomplishment of the episode of care does not become excessive in relation to the treatment involved and normal healing periods.

(d) No new or unusual problems or complications have arisen which will require alteration of the original treatment plan.

(3) If any of the conditions described under subparagraph above are breached during the course of dental treatment, the circumstances will be amended by the completion of a new SF 522.

(4) Written consent for multiple procedures constitutes only the permission to proceed with dental treatment on a continuing basis and must not be construed to be an obligation for the completion of care by either party (the patient or the VA). The patient is free to terminate treatment at any time, regardless of the treatment plan outlined on SF 522. Likewise, the VA must not be obligated for the completion of dental care on the basis of SF 522 alone. The commitment to complete treatment relates to factors other than the consent to proceed with treatment (i.e., legal eligibility, professional determination of priority of care, length of inpatient stay, occurrence of other intervening medical or dental problems which would contraindicate completion of the treatment plan, etc.).

c. Signatures Required by SF 522, Part C, Signatures, requires the following:

(1) Item 1, Signature of Counseling Physician/Dentist, should be the signature of the dentist who will perform the procedure. If the individual obtaining the written consent is not to be the treating dentist, the patient will be advised of the identity of the treating dentist. In the event that treatment will be provided by two or more dentists, then the procedures listed in the treatment plan in part B will be numbered. When the dentists who will treat the patient are listed, the numbers corresponding to the treatment each dentist is to provide will be indicated beside the dentist's name.

(2) Items 2 and 3, Signature of Witness, excluding members of operating team, are worded so as to prevent the witness from being an assistant surgeon or surgical consultant who might also be directly involved in performing the operation. In the case of a dentist/dental assistant team, the dental assistant (who will not be performing the operation, per se) may sign SF 522 as a witness.

(3) Item 2, Signature of Patient, and Item 3, Signature of Sponsor/Legal Guardian, are self-explanatory.

d. **Extraction of Teeth--Conditions for Waiver.** When extractions are indicated as emergency dental treatment and when prostheses to replace the tooth or teeth lost by the treatment procedure are not contemplated or intended, the patient will be required to sign a statement of understanding, stamped on the reverse of SF 522, which will read: "I understand and agree that the extraction of tooth number(s) \_\_\_\_\_ is being performed for my benefit and relief, and that such treatment does not obligate the VA to provide replacement for the lost tooth or teeth.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

e. **Extraction of Teeth--Conditions Not Requiring Waiver.** When extractions are indicated as part of the definitive treatment and it is assured that the tooth or teeth lost by the treatment procedure will be replaced by the VA, it will only be necessary to have the patient sign the front of SF 522. If there is any question as to whether the commitment to replace the missing teeth will be carried out or not, the requirements of subparagraphs b, c and d will be followed.

f. **Consent From Patient's Guardian or Next of Kin.** Consent of the patient's guardian or next of kin will be secured on an SF 522 when:

(1) The patient is unconscious or a minor (other than a minor member of the Armed Forces receiving treatment on official authorization).

(2) The patient has been adjudged legally incompetent or is deemed mentally incompetent such as to be incapable of comprehending the significance of such action or of exercising appropriate judgment.

g. **Consent From Director, or Chief of Staff.** When the patient is not competent to give consent, a physician Director, Chief of Staff or a physician acting for either will sign and date the SF 522 as the person authorized to consent for the patient when there is no known guardian or next of kin and oral surgery is necessary for the preservation of the patient's health or life. This procedure will also be used when time does not permit an effort to obtain consent from the patient's guardian or next of kin. The guardian or next of kin will be notified as soon as practicable and given reasons for furnishing the treatment without awaiting consent.

h. **Refusal To Consent.** Refusal by the patient or by the legal guardian to give consent for a recommended oral surgery, diagnostic or therapeutic procedure will be recorded in the patient's medical record.

.. -

December 19, 1951

i. **Disposition of SF 522.** SF 522, when signed and dated by the patient or by the person authorized to consent, will be filed in the patient's medical record. (Par. 4.06 is based on 38 U.S.C. 4131.)

#### **4.07 DIAGNOSIS AND TREATMENT OF ORAL MALIGNANCIES**

Effective treatment of oral malignancy often depends on early detection. When the clinical oral examination reveals a suspicious lesion, sound diagnostic, consultative, and/or operative procedures will be employed by the dentist commensurate with his/her experience and clinical privileges. Early diagnosis of oral malignancy can only be established by histopathological examination of representative tissue. All suspicious lesions which have not responded to therapy or resolved within a 2-week period should be biopsied. A tissue registry will be maintained by each dental service, documenting all tissue removed for histopathological examination. This registry will include the patient's name, hospital registry number or Social Security number, date of removal of the tissue, an accurate description of the site of the lesion, the histopathologic diagnosis, and the laboratory accession number (taken from SF 515, Tissue Examination), and the disposition of the patient. If the lesion is determined to be malignant, the patient will be referred to the Tumor Board or appropriate service chief for evaluation and treatment. The dentist is also obligated to examine the perioral and facial skin for abnormalities and a consultation request will be made to the surgical service for further evaluation and treatment if extra-oral malignancy is suspected.

#### **4.08 DENTAL CARE FOR PHYSICALLY HANDICAPPED PATIENTS**

Blind, paraplegic and/or patients who have sustained complete loss of both hands or use thereof will be given priority consideration for dental care when hospitalized. Those veterans who receive aid and attendance should be carefully evaluated for their dental needs related to their medical health status and provided with necessary dental care while hospitalized. Veteran-beneficiaries who are service connected for blindness, paraplegia, quadriplegia and/or complete loss of both hands, or use thereof, may be furnished outpatient dental care on an adjunct basis.

#### **4.09 DEPLETION OF DENTITION: REPLACEMENT OF MISSING TEETH BY PARTIAL OR COMPLETE PROSTHESES**

a. **Depleted Dentition and Replacement of Missing Teeth.** When a patient's dentition has been depleted as a result of VA treatment, it is not required that missing teeth be replaced with prostheses unless:

(1) There is a medical condition requiring improved masticatory function, or

(2) The veteran has eligibility for prostheses under Classes I-VI eligibility, or

(3) The veteran is a long-term (100 days or more) inpatient, being hospitalized for that period, or being carried as a patient in a VA NHCU (Nursing Home Care Unit) or Domiciliary.

b. **Maintenance or Replacement of Prostheses Provided by the VA.** Under conditions where the VA has previously provided satisfactory oral prostheses, there is no continuing obligation to maintain such dental prostheses or to replace them if they become unserviceable or lost, unless

the veteran has a service-connected medical condition which would require replacement or repair on the basis of professionally determined adjunct care, the veteran is a long-term inpatient, or has statutory eligibility to outpatient dental care. However, any denture lost while a veteran is an inpatient in a VA medical care facility may be replaced if the loss is verified by appropriate ward personnel and replacement is authorized by the Chief, Dental Service.

#### **4.10 DENTAL TREATMENT IN A DEPARTMENT OF THE ARMY, NAVY, AIR FORCE OR U.S. PUBLIC HEALTH SERVICE HOSPITAL**

a. **Prescription of Treatment.** When a VA beneficiary is receiving prescribed treatment in a Department of the Army, Navy, Air Force or U.S. Public Health Service Hospital, dental treatment, if indicated in the treatment for the condition necessitating hospitalization, should be furnished by that facility.

b. **Completion of Prescribed Treatment After Patient's Discharge.** When a VA beneficiary is discharged from a Department of the Army, Navy, Air Force, or U.S. Public Health Service Hospital with uncompleted dental treatment prescribed for a service-connected disability, the question of the necessity for furnishing further outpatient dental care for the treatment of the basic service-connected condition will be given consideration by the VA outpatient clinic of jurisdiction. Such cases will be handled without regard to what dental treatment may or may not have been prescribed for the basic service-connected condition while in such hospital, but the consideration will be based entirely on the treatment for which outpatient eligibility can be established. Exception will be made in cases where a sufficient number of teeth have been extracted to deplete mastication. In this instance, the provisions of paragraph 4.08 will be observed and the beneficiary referred to a VA facility for proper resolution. If the patient meets the eligibility requirements for class III dental treatment, the Chief, Dental Service, of the outpatient clinic of jurisdiction may authorize the treatment on an outpatient basis to a VA health care facility or to a fee dentist. (See M-1, part I, chapter 19.)

#### **4.11 DENTAL TREATMENT IN NON-FEDERAL HOSPITALS**

When a VA beneficiary is hospitalized in a non-federal contract hospital and it has been medically determined that dental care is required in the treatment of the condition for which the patient is hospitalized, the appropriate hospital official will communicate this need to the VA fee jurisdictional facility concerned with a statement as to their facility's capability for providing such treatment. If the VA facility Director considers the need for the dental treatment justified, the dentist will proceed as follows:

a. If the hospital cannot provide the treatment, arrangements will be made to transfer the patient to a VA inpatient facility, provided further hospitalization is necessary.

b. If the hospital has facilities for providing treatment, the VA facility Director will make authorization for such care.

c. If the hospital furnishes part of the treatment to the extent that depletion of dentition results and the patient has eligibility for replacement, the patient may be referred to a VA facility for completion of

.. .

EXAMPLE 19, 199.

treatment under OPT procedures as outlined in paragraph 1.10. If the patient meets the eligibility requirements for class III dental treatment, the Chief, Dental Service, of the facility of jurisdiction may refer the treatment to a VA health care facility or authorize fee-basis care according to the procedures outlined in paragraph 1.10b(2). (See also M-1, part I, ch. 19.)

#### **4.12 STERILIZATION**

a. The prevalence and transmissibility of bacterial and viral infections make it essential that VA Dental Services continually review their techniques for the sterilization of all dental instruments and supplies. Specific directions applicable to sterilization procedures will be included in the Dental Service Operations Manual at each VA facility.

b. Autoclaving, dry heat or ethylene oxide, when properly employed, will effectively accomplish sterilization of instruments and supplies. It is advised, however, that the use of ethylene oxide sterilization be confined to the SPD (Supply, Processing and Distribution) unit unless the dental service is especially equipped to deal with its environmental hazards. In all instances where instruments and supplies have been wrapped and sterilized, the applicable expiration date must be noted on each wrapping. When sterilized items become outdated, they must be resterilized prior to use.

c. It will be the responsibility of the Infection Control Committee at each VA facility to review, periodically, the techniques employed by the dental service for sterilization of instruments and supplies to assure that only effective procedures are being used.

#### **4.13 MERCURY CONTAMINATION AND HYGIENE PRACTICES**

a. There are serious concerns regarding the possibility of mercury intoxication of dental personnel. For this reason, each Chief of Dental Service, with the assistance of the Facility Safety Officer, will write and implement specific procedures for the safe handling of mercury and amalgam by the dental staff. Since appropriate precautions and proper equipment for the handling of amalgam are predominant factors in reducing the risks involved, it is essential that only sealed, pre-measured capsules of mercury and alloy be used by the dental service. Scrap amalgam will be collected, stored under fluid (water, glycerin), and periodically turned over to the Supply Service for disposition in accordance with VA Manual MP-2, subchapter H, section 108-43.414-51. Further recommendations on mercury hygiene are available from the Council on Dental Materials and Devices of the American Dental Association.

b. Environmentally safe levels of mercury vapor are determined by the OSHA (Occupational Health and Safety Administration) of the U.S. Department of Labor. VA medical regions have safety and fire protection engineers as well as Industrial Hygienists assigned that are available to assist facilities in the conduct of programs to test for mercury vapor levels and reduce the hazards thereof. Each Chief of Dental Service will ensure that testing for mercury vapor levels throughout the dental clinic is performed annually. A mercury vapor testing device must also be available to each dental service at times other than the annual test in order to monitor the mercury hygiene practices of new employees or trainees, and to check vapor levels following a mercury spill or other such accident.

c. Medical surveillance for mercury intoxication must be available as an element of a facility's industrial hygiene program. In the interests of safeguarding the health and safety of employees, annual medical screening of dental service personnel may be authorized as noted in MP-5, part I, chapter 792.

#### 4.14 RADIATION PROTECTION REQUIREMENTS

In the interest of protecting patients and employees from any harmful effects of unnecessary exposure to radiation, the following requirements will be implemented.

a. **Restricted Use.** Patient exposure to x-radiation will be guided by the following precautions and options:

(1) No radiographs will be taken unless it is professionally determined by a dentist or physician to be necessary.

(2) Indications for radiographs are usually limited to the following situations:

(a) A decision has been made to treat the patient and diagnostic radiographs are required.

(b) The radiographs are necessary to confirm clinical findings.

(3) No new radiographs will be requested (except in an emergency) without review of existing dental radiographs to determine if they will satisfactorily augment a thorough clinical evaluation. If duplicate radiographs are desired for any reason, they may be obtained by exposure of twin-pack films or by duplication of the original film. In no case will the patient be subjected to additional radiation for the purpose of creating a duplicate film.

(4) Transillumination is encouraged as an alternative to updating radiographs (particularly in the anterior areas) on a routine basis. If this method is used, clinical notations will be made concerning findings which deviate from earlier radiographs (such as incipient caries).

(5) The use of portable xray units will be avoided to the maximum extent practicable. The utilization of fixed xray units with built-in shielding features is the method of choice.

b. **Safety Requirements in the Use of X-Ray Equipment.** When operating dental xray equipment, unnecessary radiation exposure will be controlled by compliance with the following:

(1) Leaded aprons will be used routinely for shielding patients' gonadal areas. These aprons will be checked for defects, at least annually, and a record maintained.

(2) The operation of dental xray equipment will be restricted to individuals who have demonstrated proficiency in producing radiographs of diagnostic quality with the minimum exposure required. The need for re-exposure, due to evidence of continuing faulty technique, will be strictly avoided. Dental assistants hired after January 1, 1987, if they are to perform radiologic duties, must have successfully completed the Dental Radiation Health and Safety Examination administered by the Dental Assisting National Board.

(3) Proper collimation must be used to restrict the xray beam as closely as practicable to the clinical area of interest and as compatible with the dimensions of the xray film being utilized as good technique will allow.

(4) Long cone paralleling technique should be used to minimize the tissue area exposed to radiation. Position-indicating devices should be used with the paralleling technique in order to restrict the xray beam as nearly to the film size as possible.

(5) The shortest possible exposure time, while producing adequate diagnostic information, will be utilized.

(6) Dental xray equipment will be checked for radiation leakage and recalibrated, at least annually, and a record maintained.

(7) All individuals using xray generating apparatus and those closely positioned to it must wear film badges for monitoring individual radiation exposure.

(8) The exposure switch of each fixed xray unit will be arranged so that the operator must remain behind a shielded area in order to operate it. This will require one of the following modifications of a typical manufactured unit:

(a) The hand-held switch which activates the timer control must be fixed to the control panel so the operator cannot be free to move outside the shielded area during exposure.

(b) A floor-mounted or wall-mounted foot switch may be wired to the timer control as a substitute to the hand-held switch. This must be fixed in such a position as to require the operator to be located behind the shielded area during exposure.

(9) Only electronic timers, controlling the accuracy of exposure, will be utilized in the operation of dental xray units.

c. **Training in Radiation Health and Safety.** All dental auxiliaries whose job description calls for operation of radiology equipment are required to receive some measure of continuing education annually to reinforce their awareness of radiation health and safety, and, as necessary, to review operational techniques in that regard. The format and amount of time devoted to such education is optional and should be directed toward the experience and performance level of individual employees. The Chief, Dental Service, is encouraged to involve the Facility Safety Official in assessing individual needs and reviewing the program.

(The provisions of Sec. I are based on 38 U.S.C. 212 and 621.)

## **SECTION II. CUSTODY AND DISPOSITION OF EXPENDABLE DENTAL MATERIALS**

### **4.15 RESPONSIBILITY FOR CUSTODY AND DISPOSITION OF ARTIFICIAL TEETH AND PRECIOUS METALS**

The Chief, Dental Service, or Chief, Central Dental Laboratory, will have custody of all dental gold, platinum, chrome-cobalt, artificial teeth, bridge facings, and other expendable supplies in the dental clinic or Central Dental Laboratory, as applicable, and will be held responsible for their safekeeping. However, the Chief, Dental Service, or Chief, Central Dental Laboratory, may assign a responsible member of the staff to administer the system of controls for the issue and reissue of these items.

#### 4.16 ACCOUNTING FOR PRECIOUS METALS

a. **Basic Requirements.** All precious metals must be accounted for. Use of VA Forms 10-2936, Precious Metals Record Card, and 10-2609, Precious Metals Issue Slip, is optional. In any case, however, a ledger will be maintained to record:

- (1) The date precious metals were received from supply service.
- (2) The combined gross troy weight of all gold received excluding fabricated bars.
- (3) The number of fabricated gold bars received.
- (4) The weight of platinum received.
- (5) The date, name of patient and description of each appliance fabricated.
- (6) The date, name of patient and description of unserviceable gold appliances received.
- (7) The gross weight of all scrap gold turned over to the Chief, Supply Service.

b. **Procedures.** The employee having custody of precious metals will issue the amount and type needed by the dentist or technician and record the date, amount and type of appliance in the ledger. On completion of the appliance, all unused precious metal will be returned to the custodian for reissue (including uncontaminated gold of known quality received from patients). Buttons, crowns, etc., which are unserviceable for reissue, will be collected as scrap gold and melted into one ingot for subsequent turn-in to the Chief, Supply Service, as required by MP-2, subchapter H, section 108-43.313.51.

c. **Inventory Verification.** The Director will designate a responsible official, other than a Dental Service employee, to verify receipts and balances of precious metals annually.

#### 4.17 DISPOSITION OF UNSERVICEABLE PROSTHESES

A patient desiring to retain an unserviceable prosthesis containing gold, whether or not it was provided by the VA, may be allowed to do so. A notation that this appliance has been returned to the patient will be recorded in the ledger and signed by the patient. If the patient prefers not to accept the prosthesis, the appliance will be disposed of it accordance with paragraph 4.16 b above.

#### 4.18 DENTAL PROSTHESES: LOST AND FOUND

a. **Dental Prostheses Found on Station.** Dental prostheses recovered on VA property will be delivered to the Chief, Dental Service, for identification and appropriate disposition. There will be coordination between the Lost and Found activity of MAS and the Dental Service. If the dentures are not claimed within 90 days, they may be disposed of as unserviceable. Any dentures containing gold will have the gold recovered and disposed of as scrap gold, in accordance with paragraph 416 b.

b. **Dental Prostheses Lost by Patients.** Claims of lost prostheses by patients will not be honored for replacements unless the loss is substantiated through documentation by responsible VA officials who can attest as to their loss or destruction.

(The provisions of sec. II are based on 38 U.S.C. 4115.)

.. .

APPENDIX 4A A Sample Memorandum regarding "Authorized Use of Dental Clinic Facilities is not available on WANG. A copy may be Xeroxed in the VHA Library.

CHAPTER 5. DENTAL LABORATORIES

SECTION I. ESTABLISHMENT AND RESPONSIBILITIES

5.01 ESTABLISHMENT

Dental Service laboratories will be established and maintained at all VA health care facilities where inpatient and/or outpatient dental services are to be provided. Central Dental Laboratories will be established as authorized by the Chief Medical Director and maintained to the extent necessary for support of VA dental clinical activities in the fabrication of dental prostheses and other special appliances for which these laboratories are particularly equipped and staffed. Dental laboratories other than those classified as Central Dental Laboratories may be authorized by Central Office to provide limited dental laboratory services to selected facilities in isolated areas.

a. **Determination of Requirements.** The number, type, location, facilities and equipment required for Central Dental Laboratories will be determined on the basis of recommendations made by the Assistant Chief Medical Director for Dentistry. Amounts provided for operation of each Central Dental Laboratory, although not separately identified, are included in the recurring base of the primary fund allocation to the health care facility where they are located.

b. **Designation by Letter of Authorization.** Central Dental Laboratories, when established, will be designated by specific letter of authorization from Central Office. A copy of this assignment will be furnished to the appropriate Central Dental Laboratory.

c. **Utilization.** Unless unusual circumstances arise which are mutually resolved by agreements between the Chief, Dental Service, and the Chief, Central Dental Laboratory, only chrome-cobalt, porcelain-fused-to-metal and other special appliances will be referred to the Central Dental Laboratory for fabrication. All other oral prostheses will be processed and completed locally.

5.02 RESPONSIBILITIES

a. **Central Office.** The Assistant Chief Medical Director for Dentistry is responsible for the formulation of policies, standards and scope of Central Dental Laboratory activities, including, but not limited to, the provision of professional and technical assistance to the laboratories and participation in the development and recommendation of amounts that are included in the recurring base of the primary fund allocations for the operation of each Central Dental Laboratory.

b. **Directors of Health Care Facilities**

(1) Directors of facilities in which Central Dental Laboratories are located are responsible for assuring that other VA facilities receiving services from the Central Dental Laboratory are accorded fair and equitable priorities and that the requirements of any one facility do not take precedence over any other.

(2) Directors of facilities in which Central Dental Laboratories are located are responsible to the same degree for the successful operation of these activities as they are for activities that solely benefit their facility. Budgetary difficulties, workload backlogs, or other problems which cannot be resolved by local adjustment or action will be promptly called to the attention of the ACMD for Dentistry.

(3) Directors of facilities with Dental Services which utilize Central Dental Laboratories are responsible for providing adequate local laboratory facilities and dental laboratory technical staff to avoid inappropriate use of a Central Dental Laboratory. (See par. 5.01c.)

c. **Chiefs, Central Dental Laboratories.** The Chiefs, Central Dental Laboratories, are directly responsible to their directors for the administration and operation of the Central Dental Laboratories in accordance with prescribed policies and standards. It will be the responsibility of each Chief, Central Dental Laboratory, to:

(1) Make prompt decisions upon receipt of submitted cases as to whether they are acceptable for fabrication purposes or if they must be returned to the submitting Dental Service for necessary corrections.

(2) Implement and maintain quality control of all fabrications through inspection and review prior to their return to the submitting facility.

(3) Assure fabrication of prosthetic devices with minimum turn-around time, while maintaining satisfactory quality; attaining maximum productivity through the best possible organization of the resources available.

(4) Maintain liaison and effective communications concerning mutual problems through peer contact with dental personnel of submitting facilities.

(5) Assure that the Central Dental Laboratory technical staff possesses the capability and expertise to satisfactorily provide the full range of services requested, consistent with the mission of the VA.

d. **Chiefs, Dental Services.** It is the responsibility of each Chief, Dental Service, to:

(1) Assure that Dental Service laboratory technical staff possess the capability and expertise to fully fabricate most oral prostheses locally, including cast all-metal crown and fixed partial dentures; limiting the referrals to a Central Dental Laboratory to those specified in paragraph 5.01c.

(2) Assure that all staff dentists, residents and dental laboratory technicians are familiar with the contents of this chapter and understand requirements related to the use of the Central Dental Laboratory including allowing for adequate time for fabrication and transit.

(3) Personally, or by a professional designee, review all cases and prescriptions for completeness and adequacy relative to Central Dental Laboratory requirements prior to submission. (The responsibility for submission may be delegated to each staff dentist or resident clinician after the veteran has demonstrated, on a continuing basis, that submission requirements are being satisfactorily carried out and applicable procedures are understood.)

(4) Submit a roster of the staff dentists, residents and laboratory technicians to the Chief, Central Dental Laboratory, as of August 1, each year. The roster should also be updated as staff changes occur.

**December 23, 1987**

**M-4**

**M-4**

**December 23, 1987**

SECTION II. DENTAL LABORATORY REQUIREMENTS AND PROCEDURES

5.03 REQUIREMENTS AND PROCEDURES COMMON TO BOTH DENTAL SERVICE LABORATORIES AND CENTRAL DENTAL LABORATORIES

a. Recognized techniques and procedures will be followed by all Dental Services and laboratories to insure the successful fabrication of acceptable dental prostheses.

b. All VA dental laboratories engaged in processing dentures will identify the prosthesis under construction by the permanent placement of the beneficiary's name on the tissue-bearing area of the prosthesis. If the tissue-bearing area will not accommodate the beneficiary's full name, initials will suffice.

5.04 GENERAL DENTAL SERVICE REQUIREMENTS FOR SUBMISSION TO A CENTRAL DENTAL LABORATORY

a. Accepted dental procedures considered prerequisite to a dental prosthesis should be completed prior to preparing and submitting a case to a Central Dental Laboratory for fabrication. These procedures should include all necessary surgical, operative, endodontic and periodontic procedures, as well as individual tooth preparations.

b. VA Form 10-2804, Central Dental Laboratory is a packet of three chemically treated sheets attached by perforations to a large header. The top half (above the fold line) will be completed by the submitting dentist who will be responsible for:

(1) Reading, understanding and completing the requirements printed on the header of the form.

(2) Providing all information related to the case as requested on the form. If there is insufficient space in the "Instructions and Comments" section, a plain sheet of paper will be attached to the packet containing the continuation of instructions started on the VA Form 10-2804. Under no circumstances will the back of the packet be used for inscribing additional information since this will obscure the other data which was inscribed on the front of the chemically treated paper.

(3) Printing name legibly and signing as the official responsible for the prescription and mouth preparation, AS WELL AS THE QUALITY AND ACCURACY OF THE MATERIALS BEING SUBMITTED FOR FABRICATION.

(4) Removing Copy 3 (the back pink copy) from the packet after all entries and signatures have been completed on the form. Copies 1 and 2 (one pink and one white) will be left attached to the header and will be included with the case when shipped to the CDL. Copy 3 will be retained by the submitting Dental Service as the interim retention/reference copy while the case is in the CDL. It should be noted that the bottom half of this copy provides space where any contacts with the CDL, subsequent to shipment, can be annotated. When the prosthesis is returned from the CDL, it will be accompanied by completed Copy 2 (white copy). This copy then may be substituted for the interim (pink) copy in the reference file, thus indicating

(by color code) that the pink copies represent the cases in the CDL and the white copies those prescriptions which have been completed by the CDL and returned.

- c. Tooth shade selection must be indicated for all initial submissions to the Central Dental Laboratory.
- d. Proper packing for shipment of cases is extremely important. The following suggestions are recommended:
  - (1) Pack all items carefully using plastic bubble wrap or other suitable material.
  - (2) Carefully wrap removable dies separately and place them in plastic containers.
  - (3) Remove occlusal records from their casts and place them in an appropriate container.
  - (4) Disassemble articulators which can be broken down and wrap their parts separately.
  - (5) Pack articulators which cannot be disassembled as follows:
    - (a) Lock all movable parts.
    - (b) Remove casts (including rings and mounting plaster) and wrap them separately.
    - (6) Wrap any unmounted casts individually.
    - (7) Allow at least one-half inch between wrapped objects, and between objects and container walls.

(8) In certain instances, e.g., submission with two master casts, two preliminary casts, two denture trial bases, and an articulator; send the shipment in two boxes with a single copy of VA Form 10-2804 in each. VA Form 10-2804 can be annotated "part one of two" and "part two of two" or similarly.

- e. The following information will be typed or printed on the mailing label before being affixed to the shipping boxes:

Director (00/160L)  
VA Medical Center (where CDL is located)  
Street address  
City, State, ZIP Code  
ATTN: Chief, Central Dental Laboratory

- f. The name and return address of the submitting facility will be placed in the upper left corner of the mailing label.

g. Submission of request for remake of a prosthesis should be accompanied by the unsatisfactory prosthesis and a statement as to its deficiencies. The returned prosthesis will be beneficial to the Central Dental Laboratory for evaluation purposes and effecting quality controls.

**December 23, 1987**

**M-4**

**M-4**

**December 23, 1987**

5.05 SPECIFIC DENTAL SERVICE REQUIREMENTS FOR SUBMISSION TO A CENTRAL DENTAL LABORATORY

a. **Complete Dentures.** The fabrication of complete dentures will be routinely accomplished by the individual local Dental Service Laboratory. Only in unusual circumstances and with mutual agreement between the Chief, Dental Service, and the Chief, Central Dental Laboratory, will complete dentures be submitted for fabrication procedures. One-dentist Dental Services are exempt from this basic requirement.

(1) The molds, shades, and degree of cusps for denture teeth as well as other designated material for all submitted cases should be selected by the clinician and recorded in the appropriate space on VA Form 10-2804. The shade and mold guides used by the clinician should be from the same manufacturer of the artificial teeth that are stocked by the Central Dental Laboratory.

(2) Submissions for complete denture fabrication will include the following:

(a) Master cast, with minimum of one-half inch in the thinnest part, properly indexed and lubricated before mounting.

(b) Postpalatal seal (post dam), placed by the clinician. The laboratory will not make alterations to the master cast.

(c) Accurate base plate with attached occlusion rims.

(d) Mounted casts, when setup is requested. (Casts must be indexed, lubricated, mounted, and then removed from the mounting when sent for processing to the Central Dental Laboratory.

(e) Various types of diagnostic aids, if significant to the case.

(f) Specific instructions for tooth placement. This may be in the form of contoured rim, marks on master cast, or written instructions.

(3) Complete denture cases will be returned to the referring Dental Service for try-in after the teeth are positioned in wax.

b. **Rebasing Complete Dentures.** The processing of denture bases will be routinely accomplished by the individual local Dental Service laboratories. Only in unusual circumstances and with mutual agreement between the Chief, Dental Service, and the Chief, Central Dental Laboratory, will complete dentures be submitted for rebasing procedures. One-dentist Dental Services are exempt from this basic requirement. All undercuts must be removed from the tissue surface of these dentures prior to making a rebase impression. The impression must be post-dammed if post dam is desired. The impression will then be poured in stone at the facility but the cast should not be separated from the impression.

c. **Fabrication of Removable Partial Dentures**

(1) Diagnostic casts will be surveyed, tripoded and the desired design outlined by the clinician on all partial denture cases prior to the making of final impressions. Only after a careful survey, design and evaluation of the study cast can accurate determinations be made as to the proper

locations of rest preparations, modification of contour on certain remaining teeth for path of insertion, and/or other mouth and tooth conditions needing corrective attention.

(2) With questionable or unusually difficult cases, the designed study cast may be forwarded to the Chief, Central Dental Laboratory, to evaluate the contemplated design and plans for mouth preparation prior to clinical modifications or the making of the master cast.

(3) When a case is submitted to the Central Dental Laboratory for removable partial denture fabrication, the requirements will include the following:

(a) Diagnostic cast--surveyed, tripoded and design outlined.

(b) Master cast--unmarked, except for tripoding and the marking for distal extension where major connectors will extend to the post-palatal seal area; free of all wax.

(c) Articulator. All removable partial denture submissions, except those opposing an edentulous arch, will be prepared with indexed master casts mounted on a stable articulator. Prior to shipment, the mounting and casts should be removed, separated from each other, and all elements, including the articulator, carefully wrapped to prevent breakage.

(d) Shade selection--to be made with shade guides of the same manufacturer of artificial teeth or facings that are being stocked by the Central Dental Laboratory and noted in the appropriate space on the initial submission of VA Form 10-2804.

(4) Removable partial denture framework will be returned to the referring Dental Service for try-in prior to the processing of the denture base.

**d. Fabrication of Fixed Restorations.** Submissions for the fabrication of fixed restorations will adhere to the following requirements:

(1) The cast must be accurate, full arch, and have removable dies.

(2) The opposing cast must be an accurate and a bubble-free reproduction of the full arch occlusion.

(3) Surveyed abutment crowns.

(4) In those submissions where crowns are being fabricated to receive a RPD clasp later, an uncut master cast will be included along with the master cast. This may be a subsequent pour of the master impression. This is necessary to visualize soft tissue contours and relate planned clasps to hard and soft tissues.

(5) All casts will be submitted mounted on a stable articulator and steps must be taken to insure that:

(a) The mounted cast is checked for adequate tooth reduction and accurate registration by the clinician prior to submission.

(b) In opposing edentulous areas, an occlusal plane is established.

(c) The plaster mounting leaves the ends of the dowel pins exposed and accessible.

**December 23, 1987**

**M-4**

**M-4**

**December 23, 1987**

- (6) Only removable die-dowel systems are acceptable for submission and steps must be taken to insure that:
- (a) All dies are shallowly "ditched," trimmed, and that the margin is marked with a crayon-type pencil.
  - (b) The dies are keyed for proper repositioning.
  - (c) All dies are *free of undercuts* at the margins and that all undercuts above the margin are blocked out by the clinician, preferably before impression is taken.
  - (d) The dies are surveyed to determine that an acceptable path of removal/insertion is present for each individual tooth preparation and to determine that a common acceptable path is present for the two or more abutment teeth for the fixed partial denture. Attention must also be given concerning a survey path acceptable to the proximal surfaces of teeth adjacent to abutment teeth.
  - (e) Die systems which utilize an internal or external interlocking of the dies are not used.
  - (f) Interchangeable dies (the use of two dies for waxup of separate areas of a single crown or coping) are not used.
  - (g) Post and core castings for endodontically treated teeth are fabricated and cemented prior to crown construction.
  - (h) Only ADA approved die materials are used.
- (7) It is necessary that only shade guides of the type employed by the Central Dental Laboratory are used. Use only porcelain shade guides for shade selection for porcelain restorations, and acrylic shade guides for acrylic restorations.
- (8) Special pontic design or characterization should be indicated and illustrated.
- (9) A diagnostic waxup or setup, as well as pre-preparation cast, is highly desirable for all anterior restorations and should be included in the initial submission.

#### **5.06 CENTRAL DENTAL LABORATORY REQUIREMENTS AND PROCEDURES**

a. Authority is extended to the Chief, Central Dental Laboratory, to return cases submitted to the laboratory which, in the Chief's judgment, have master casts not suitable for the fabrication of the dental prosthesis requested. Defective casts or dies will be returned to the referring Dental Service so that corrections considered essential for the successful fabrication of the prescribed appliance can be accomplished. Mounted casts will be returned to the submitting dentist for evaluation when the opposing posterior teeth do not appear to be in centric relationship (intercuspal position), unless confirmation of the abnormality is annotated on VA Form 10-2804.

b. The Central Dental Laboratory will routinely fabricate porcelain-fused-to-metal fixed restorations, porcelain jacket crowns, and resin veneer restorations. Crowns posterior to the

maxillary first molars will be made completely of metal unless a porcelain veneered restoration is justified on VA Form 10-2804.

c. Articulated prostheses submitted to the Central Dental Laboratory for processing will be remounted and equilibrated to centric occlusion for processing error prior to finishing and polishing the prostheses.

d. Processed peripheral borders will not be polished by the Central Dental Laboratory.

e. Each submission handled by a Central Dental Laboratory will be assigned a case number by the laboratory. A new series of numbers beginning with the number "1" will be started on January 1 of each calendar year. If more than one appliance is to be constructed for the same patient, only one number will be assigned to the case.

f. When received by the CDL, an inventory of all parts of the submission (casts, dies, etc.) will be recorded on the VA Form 10-2804 along with the fabrication requirements of the prescription. When the inventory has been recorded, the remaining two copies of the form will be separated and Copy 2 filed. The original (Copy 1) will accompany the case through the laboratory. When the fabricated prosthesis is returned to the submitting facility, whether for try-in or insertion, Copy 2 will be retrieved from the CDL file and returned with the case. Copy 1 will be filed in its place. The CDL file will, by color differences between Copies 1 and 2, readily indicate the submissions under construction in the CDL as well as those which have been completed and returned to submitting facilities. Retained CDL files will be handled and eventually disposed of in accordance with DM&S Records Control Schedule 10-1.

g. When the Central Dental Laboratory has completed all phases of fabrication, as requested on VA Form 10-2804, it will be voided by an overprinting stamp prior to its return with the case. Any further steps necessary to complete the case will have to be resubmitted on a new VA Form 10-2804. This is necessary for accounting purposes and forms control within the Central Dental Laboratory.

h. When the case is completed, the composite lab values (CLVs) will be noted on the original VA Form 10-2804. CLVs used should be those that are standardized for all Central Dental Laboratories.

(The provisions of ch. 5 are based on 38 U.S.C. 4115.)

**December 23, 1987**

**M-4**

**M-4**

**December 23, 1987**