# PROCESS OF CARE EVALUATION

| Review Criteria | Reviewer Evaluation Measures |
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| **I. DOCUMENTATION** | |
| **A. Medical History** | |
| 1. Comprehensive information collection | General medical history with information pertaining to general health and appearance, systemic disease, allergies and reactions to anesthetics. Should include a list of any current medications and/or treatment. Proactive format is recommended. Name & telephone number of physician and person to contact in an emergency. Patient must sign and date all baseline medical histories. Must Questions: 1) Bisphosphonate Use and 2) Latex Sensitivity |
| 2. Medical follow-up | Patient comments, DDS/DMD notes, or consultation with a physician should be documented in the chart. |
| 3. Appropriate medical alert | Should be uniform and conspicuously located on the portion of the chart used during treatment and should reflect current medical history. |
| 4. Doctor signature and date | Dentist must sign and date all baseline medical histories after review with patient. |
| 5. Periodic update | Documentation of medical history updates at appropriate intervals. Must be signed by the patient and the provider. Acceptable on medical history form or in the progress notes. Should reflect changes or no changes. Recommend update be done at least annually. |
| **B. Dental History/Chief Complaint** | Documentation of chief complaint and pertinent information relative to patient's dental history. |
| **C. Documentation of Baseline Intra/Extra Oral Examination** | |
| 1. Status of teeth/existing conditions | Grid or narrative of existing restorations and conditions. |
| 2. TMJ/Occlusal evaluation | Evidence of TMJ exam or evaluation of occlusion (classification) should be determined. |
| 3. Prosthetics | Evaluation of existing appliance(s)(age, condition etc.), teeth replaced, clasps,etc. |
| 4. Status of periodontal condition | a. Condition of gingival tissue, calculus, plaque, bleeding on probing, etc.<br>b. Evidence of baseline probing should be documented (if indicated).<br>c. Case type of perio conditions (Type I-IV) or (Normal, Gingivitis, or Slight, Moderate or Severe Periodontitis). Should be verified with radiographs/ pocket documentation. |
| 5. Soft tissue/oral cancer exam | a. Evidence that soft tissue /oral cancer exam was performed initially and periodically (at least annually)<br>b. Notation of any anatomical abnormalities |
| **D. Progress Notes** | |
| 1. Legible and in ink | Provider should be reminded that progress notes are a legal document, all should be in ink, legible and should be in sufficient detail. Corrections should be made by lining-out.<br>Documentation of any follow-up instructions to the patient or recommendations for future care. Documentation of patient leaving the practice and reasons, if known. Documentation if any records forwarded, etc. |
| 2. Signed and dated by provider | All entries must be signed or initialed and dated by the treating provider. (Per CA. Dental Practice Act, Section 1683) |
| 3. Anesthetics | Notation in progress notes as to the type and amount of anesthetic used; or notation "no anesthesia used" for applicable situations. (Including info on vaso-constrictors used, if any) |
| 4. Prescriptions | Medications prescribed for the patient are documented and Sig., Rx, and Disp. in the progress notes or copies of all prescriptions are kept in the chart. Notation of an Rx given on phone. Recommended that dental lab prescriptions be documented in the progress notes or a copy kept in the chart. |

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| **II. QUALITY OF CARE** | |
| **A. Radiographs** | |
| 1. Quantity/Frequency | a. Adequate number of radiographs to make an appropriate diagnosis and treatment plan, per current FDA guidelines.<br>b. Recall x-rays should be based on current FDA guidelines. Depends on complexity of previous & proposed care, caries susceptibility, amount and type of treatment and time since last radiographic exposure.<br>c. Whenever possible, radiographs should not be taken if recent acceptable films are available from another source (previous Dentist).<br>d. Any refusal of radiographs should be documented. |
| 2. Technical Quality | a. No overlapping contacts, or cone cuts that affect diagnostic value; periapical films should show apices.<br>b. Good contrast, not over or underdeveloped; no chemical stains. |
| 3. Mounted, labeled and dated | Recent radiographs must be mounted, labeled and dated for reviewing and comparison with past radiographs. |
| **B. Treatment Plan** | |
| 1. Present and in ink | a. Comprehensive documentation of patient needs and treatment recommendations, all documentation in ink.<br>b. Consistent with diagnosis and clinical exam findings.<br>c. Alternative treatment plans and options should be documented with clear concise indication of what the patient has elected to have performed.<br>d. Consultations and referrals should be noted when necessary. |
| 2. Sequenced | Case should be sequenced in order of need and consistent with diagnostic and examination findings, and in compliance with recognized accepted professional standards. (Dental Practice Act, Section 1685) A possible sequence follows:<br>a. Relief of pain, discomfort and infection.<br>b. Prophylaxis and instructions in preventive care.<br>c. Treatment of extensive caries and pulpal inflammation. Endodontic therapy.<br>d. Periodontal treatment<br>e. Replacement of missing teeth, or restorative treatment<br>f. Placement of patient on recall schedule with documentation of progress notes. |
| 3. Informed Consent | a. Documentation that treatment plan has been reviewed with the patient and that the patient understands the risks, benefits and alternatives to care. Patient should also understand the financial component of the treatment proposed.<br>b. An appropriate form signed by the patient is recommended. Documentation that all patient's questions were answered. Evidence of a 'meeting of the minds'.<br>c. Documentation of any refusal of recommended care, including referrals. |
| **III. TREATMENT OUTCOMES OF CARE** | |
| **A. Preventive Services** | |
| 1. Diagnosis | Documentation that prophylaxis was performed in a timely manner. Documentation of fluoride treatments planned or rendered, as appropriate to age of patient and caries incidence. |
| 2. Oral Hygiene Instructions | Documentation of Home Care/ Oral Hygiene instructions given to patient. |
| 3. Recall | Documentation of timely, case appropriate recall of patient. |

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| **B. Operative Service** | |
| 1. Diagnosis | Recall and past radiographs used to evaluate proper diagnosis of caries and the need for treatment. Treatment performed in a timely manner. |
| 2. Restorative Outcome and Follow-Up | a. Margins, contours, and contacts appear radiographically acceptable.<br>b. Prognosis good for appropriate longevity. Minimal subsequent unplanned treatment. Unplanned treatment-redo of recent restorations due to fracture, extraction, RCT, etc. |
| 3. Specialist Referral | Referral to a specialist in appropriate circumstances and in a timely manner. |
| **C. Crown and Bridge Services** | |
| 1. Diagnosis | Recall and past radiographs used to evaluate the need for treatment. Treatment performed in a timely manner. |
| 2. Restorative Outcome and Follow-Up | a. Margins, contours, and contacts appear radiographically acceptable.<br>b. Prognosis good for appropriate longevity. Minimal subsequent unplanned treatment. Unplanned treatment-redo of recent restorations due to fracture, extraction, RCT, etc. |
| 3. Specialist Referral | Referral to a specialist in appropriate circumstances and in a timely manner. |
| **D. Endodontic Services** | |
| 1. Diagnosis | Signs and symptoms documented (if need not evident on radiographs). |
| 2. Rubber Dam Use | Evidence of rubber dam use on working images and/or documentation of use in progress notes. |
| 3. Endodontic Outcome and Follow-Up | a. Radiographic evaluation of treatment to determine that canal(s) is/are properly filled and well condensed.<br>b. Prognosis good for appropriate longevity. Minimal subsequent unplanned treatment, no eivdence of extraction of recently completed endo.<br>c. Documentation of final restoration.<br>d. Recall follow-up recommend with PA image. |
| 4. Specialist Referral | Referral to a specialist in appropriate circumstances and in a timely manner. |
| **E. Periodontal Services** | |
| 1. Diagnosis | Evidence that clinical examination including pocket charting and radiographs is available to determine proper type of treatment needed. |
| 2. Treatment per visit | Rationale for more than 2 quadrants of scaling/root planing per visit should be documented. |
| 3. Periodontal Follow-Up/Outcome | Recall follow-up recommended with radiographs or probing. |
| 4. Specialist Referral | Referral to a specialist in appropriate circumstances and in a timely manner. |
| **F. Prosthetic Services** | |
| 1. Diagnosis | Evaluation of form, fit, and function of existing prosthesis. Evaluation of need where no previous prosthesis exists. |
| 2. Prosthetic Outcome and Follow-Up | a. Treatment was done in a timely manner, including necessary adjustments.<br>b. Prognosis good for appropriate longevity. |
| 3. Specialist Referral | Referral to a specialist in appropriate circumstances and in a timely manner. |

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| **G. Surgical Services** | |
| 1. Diagnosis | Radiographic and/or soft tissue / clinical exam supports treatment rendered |
| 2. Surgical Outcome and Follow-Up | a. Comprehensive documentation of treatment done, materials used, and any noteworthy occurrences during the procedure.<br>b. Documentation of post-operative instructions to patient.<br>c. Documentation of any needed post-operative care, including suture removal. |
| 3. Specialist Referral | Referral to a specialist in appropriate circumstances and in a timely manner. |
| **IV. OVERALL PATIENT CARE** | Overall care is clinically acceptable (to the extent that it is possible to determine by x-rays and available information.) |