Cigna Dental
Periodic Quality Assessment (PQA)
Patient Record Form

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 required. Name and telephone number of physician and person to contact in an emergency as appropriate. Patient must sign and date all baseline medical histories. Required 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 (or initial) and date all baseline medical histories after review with patient.

5. Periodic update.
   Documentation of medical history updates at appropriate intervals. Evidence of periodic evaluations/update should be documented on a case specific basis. Must be signed by the patient and the provider. Acceptable for update to be on medical history form or in the progress notes. Should reflect changes or no changes. Recommend updates be done at least annually.

B. Dental History / Chief Complaint

1. Chief complaint / Reason for visit.
   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 (Existing restorations, missing teeth, impactions, caries, open or overhanging margins, open contacts, pathology).

2. TMJ/Occlusal evaluation.
   Evidence of TMJ exam and evaluation of occlusion (classification) should be determined. Evidence of periodic evaluation should be documented on a case specific basis.

3. Prosthetics.
   Evaluation of existing appliance(s) (age, condition, etc.), teeth replaced, clasps, etc. This section should include implants as well as removable appliances.
### C. Documentation of Baseline Intra/Extra Oral Examination (continued)

4. **Status of periodontal condition.**
   - a. Condition of gingival tissue, calculus, plaque, bleeding on probing, etc.
   - b. Evidence of baseline probing should be documented.
   - 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).
   - b. Note of any anatomical abnormalities.

### D. Progress Notes

1. **Legible and in ink.**
   - Provider should be reminded that written or electronic progress notes are a legal document. Written notes should all be in ink, legible, and should be in sufficient detail. Corrections should be made by line-through.
   - 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.

3. **Anesthetics.**
   - Notation in progress notes as to the type and amount of anesthetics used; or notation "no anesthesia used" for applicable situations. (Including info on vaso-constrictors used and concentration if any).

4. **Prescriptions.**
   - Medications prescribed for the patient are documented and sig., Rx, and Dsp. 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.
### B. Treatment Plan

1. **Present** and in ink.
   a. Comprehensive documentation of patient needs and treatment recommendations (all documentation in ink).
   b. Consistent with diagnosis and clinical exam findings.
   c. Alternative treatment plans and options should be documented with clear concise indication of what the patient has elected to have performed. Covered benefit and alternative or optional treatment should be clearly indicated.
   d. Consultations and referrals should be noted when necessary and appropriate.
   e. Chief complaint(s) addressed.

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. A possible sequence follows:
   a. Relief of pain, discomfort and infection.
   b. Prophylaxis and instructions in preventive care. (if appropriate for the patient’s condition)
   c. Treatment of extensive caries and pulpal inflammation. Endodontic therapy.
   d. Periodontal treatment
   e. Restorative treatment
   f. Replacement of missing teeth
   g. Placement of patient or 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.
   b. An appropriate form signed by the patient or parent/guardian is recommended. Documentation that all patient’s questions were answered. Consent signed by dentist. Evidence of “meeting of the minds.”
   c. Documentation of any refusal of recommended care, including specialty referrals.

### III. Treatment Outcomes of Care

#### A. Preventive Services

1. **Diagnosis.**
   Documentation that prophylaxis was performed in a timely manner (this may not apply to all patients, based on presenting conditions). Documentation of fluoride treatments planned or rendered, as appropriate to age of patient and caries incidence.

2. **Oral Hygiene Instructions.**
   Documentation of oral hygiene/home care instructions given to patient (either during periodontal treatment or preventive treatment appointments).

3. **Recall.**
   Documentation of timely case appropriate recall of patients (best practices would include the interval) (mark N/A if treatment is ongoing).

#### B. Operative Services

1. **Diagnosis.**
   Recall and past radiographs or images used to evaluate proper diagnosis of caries and the need for treatment. Treatment performed in a timely manner.
   - List tooth number(s) involved below the appropriate chart number if answered “U”.

2. **Restorative Outcome and Follow-Up.**
   a. Margins, contours, and contacts appear radiographically acceptable.
   b. Prognosis good for appropriate longevity. Minimal subsequent unplanned treatment. Example of unplanned treatment redo of recent restorations due to fracture, extraction, RCT, etc.
   - List tooth number(s) involved below the appropriate chart number if answered “U”.

3. **Specialist Referral.**
   Referral to a specialist in appropriate circumstances and in a timely manner documented.
   - List tooth number(s) involved below the appropriate chart number if answered “U”.
### C. Crown and Bridge Services

1. **Diagnosis.**
   - Recall and past radiographs or images used to evaluate the need for crown and bridge treatment. Treatment performed in a timely manner.
   - List tooth number(s) involved below the appropriate chart number if answered "U".

2. **Restorative Outcome and Follow-Up.**
   - Rationale for more than 2 quadrants of scaling/root planing per visit should be documented.

   - Margins, contours, and contacts appear radiographically acceptable.
   - Prognosis good for appropriate longevity. Minimal subsequent unplanned treatment. Examples of unplanned treatment-redo of recent restorations due to fracture, extraction, RCT, etc.
   - List tooth number(s) involved below the appropriate chart number if answered "U".

3. **Specialist Referral.**
   - Referral to a specialist in appropriate circumstances and in a timely manner documented.

### D. Endodontic Services

1. **Diagnosis.**
   - Signs and symptoms documented (if need not evident on radiographs or images). Initial radiographs included.
   - List tooth number(s) involved below the appropriate chart number if answered "U".

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.**
   - Radiographic evaluation of treatment to determine that canal(s) is/are properly filled and well condensed (final film or image).
   - Prognosis good for appropriate longevity. Minimal subsequent unplanned treatment, no evidence of extraction of recently completed endo.
   - Documentation of final restoration. (final film or image)
   - Recall follow-up recommend with PA image.
   - List tooth number(s) involved below the appropriate chart number if answered "U".

4. **Specialist Referral.**
   - Referral to a specialist in appropriate circumstances and in a timely manner documented.

### E. Periodontic Services

1. **Diagnosis.**
   - Evidence that clinical examination (including pocket charting and radiographs or images) 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, images or probing.

4. **Specialist Referral.**
   - Referral to a specialist in appropriate circumstances and in a timely manner documented.
### F. Prosthetic Services

1. **Diagnosis.**
   - Evaluation of form, fit, and function of existing prosthesis. Evaluation of need where no prosthesis exists. Prostheses over implants would be evaluated in this section.

2. **Prosthetic Outcome and Follow-Up.**
   - a. Treatment was done in a timely manner, including necessary adjustments.
   - b. Prognosis good for appropriate longevity.

3. **Specialist Referral.**
   - Referral to a specialist in appropriate circumstances and in a timely manner documented.

### G. Surgical Services

1. **Diagnosis.**
   - Radiographic and/or soft tissue clinical exam supports treatment rendered. Surgical phase of implant prosthesis can be evaluated in this section.

2. **Surgical Outcome and Follow-Up.**
   - a. Comprehensive documentation of treatment done, materials used, and any noteworthy occurrences during the procedure.
   - b. Notations on general anesthesia/sedation should be documented.
   - c. Documentation of post-operative instructions given to patient.
   - d. 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 documented.

### IV. Overall Patient Care & Outcome

**Overall professional assessment** of the patient record.

### V. Systemic (not isolated) Issues

1. **Potential clinical systemic issues** were identified with the office that require Cigna Dental Director Involvement. If "Yes (Y)", please check the appropriate items below.

   - a. Endodontic issues
   - b. Insufficient radiographs
   - c. Restorative, Crown/Bridge Issues
   - d. Medical treatment issues
   - e. Periodontal Issues
   - f. Informed consent issues
   - g. Continuity of, or access to, care
   - h. Other (please specify) _______________________

2. **Financial systemic issues** were identified with the office and will be addressed in a letter to the dental office requiring a signature confirming compliance.

   - a. BR1 - Brand Name Crowns
   - b. BR2 - Brand Name Prostheses
   - c. CL - Crown Lengthening With C/B
   - d. COS - Cosmetic Dentistry
   - e. DS - Desensitizer with Restorations
   - f. EQ - Use of Equipment - Laser / Cerec
   - g. FMD - Full Mouth Debridement
   - h. IC - Infection Control
   - i. IR - Irrigation
   - j. MC - Upgrade Charges for Gold and/or Porcelain on Crowns
   - k. PM - Porcelain Margins
   - l. TMP - Temporary Services
   - m. UCI - Upcoding
   - n. RCI - Root Canal Therapy Irrigation

Please add Comments on back of this sheet (required for "U" answers in IV a. and a "Y" answer for IV b.; attach a separate page if necessary):