VA Care in the Community (VACC)

Non-VA Medical Care Dental Program

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Version 4

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Introduction

A VA beneficiary may be referred for Non-VA Dental Care with a valid and justifiable reason. This justification may include, but is not limited to, the need for timely access to care, geographic considerations or the inability to provide required services within VA. In all cases where referral takes place, the Veteran must be notified and fully apprised of the action taken. The decision to provide dental benefits to a Veteran through a Non-VA dental provider is to be made by the Chief, Dental Service, or designee, after full consideration of all relevant factors including the patient's preference. This decision will often be based on current operational requirements such as those defined by the Veterans Access Choice and Accountability Act.

In such cases, non-VA dental care can be provided through a formal contract or an individual authorization and must be authorized in advance of treatment. Payment amounts for the treatment are summarized in Attachment A, Non-VA Dental Payment Methodology.

It is not the established mission of VA to provide dental care to all Veterans or even to all those who are hospitalized. Dental eligibility is determined in a different manner than medical eligibility. The scope of care is determined by the patient's dental classification. Eligibility for dental care is defined by statute and is to be provided in accordance with the provisions of existing law and VA regulations, i.e., 38 U.S.C. §§ 1710(c) and 1712 and 38 CFR 17.160-17.166. Please review Attachment B, Determining Veteran Eligibility for Non-VA Dental Care.

Process Handoff

The Dental ***referral/authorization*** handoff process begins when the VA dental provider submits a consult for non-VA dental care using the appropriate standardized Non-VA Care Coordination (NVCC) consult template in CPRS and the Non-VA Care (NVC) team receives the NVC Consult/Referral. Once eligibility and clinical necessity are confirmed, the Veteran is authorized for care in the community according to the appropriate hierarchy of care.

The Dental ***claims payment*** handoff process begins with the receipt of a claim by the NVC staff and/or claims processing staff. Dental claims may be received via hard copy on a VA Form 2570d, an ADA claim form, or via EDI. All claims must be date stamped when received prior to distribution for processing. EDI claims must be printed, then date stamped and distributed in the same manner.

Roles and Responsibilities

Each VA facility may be organized differently and is imperative for all entities in the process to build communication and engage in the process flows. Throughout the entire process it is vital that all staff, NVC, Dental and claims processing communicate throughout the entire episode of care (EOC). This ensures completion of the Dental treatment plan and reduces the risk that the Veteran is "lost to follow-up" when obtaining and completing non VA medical care services.

Authorizations will be entered using the Fee Basis Claims System (FBCS). However, FBCS does not recognize the American Dental Association (ADA) Dental claim form at this time. All claims associated with dental services should be processed under the VistA Fee Payment menu option in accordance with the VistA Fee User guidelines.

(NVCC Consult Templates)

- **VA Dental Chief/Designee**- The Chief, Dental Service, or designee, has the primary responsibility for the ***clinical oversight and determination*** of outpatient Non-VA Dental Care. This includes review of all proposed treatment plans for clinical appropriateness and the approval or disapproval of submitted fees consistent with the Schedule of Maximum Allowances for Non-VA Dental Care. VA Dental Service Chiefs or designees are responsible for all Class III and Class VI eligibility-determinations as they require and are based on review of the Veteran's medical history.
  - Veterans who do not accept a treatment plan determined by VA to be clinically appropriate must be informed of their rights to appeal through the Clinical Appeals Process. If a request for Non VA Care is denied, the Veteran must be informed of their right to appeal via the Health Benefits Appeals Process.
- **Eligibility and Enrollment/Business Office-** The VAMC facility Business Office is the first resource for administrative determination of dental eligibility. That office is to determine a Veteran's eligibility for all dental patient classifications, with the exception of Classes III and VI. When necessary, the second and final resource for administrative determinations of a Veteran's eligibility for dental care is the Health Eligibility Center (HEC). The HEC has final responsibility for verification of all administrative aspects of a Veteran's eligibility for dental care with the exception of determinations related to Classes III and VI.
- **Non-VA Care (NVC) Staff**-The NVC Staff is responsible for all administrative and care coordination functions relating to the episode of Non-VA Care:
  - Receiving the Non-VA Dental Care Consult, verifying administrative eligibility and confirm medical necessity per the Dental Chief or Designee.
  - Establishing the authorization for care in FBCS as determined by the Chief, Dental or Designee
  - Establishing appointments for the Veteran with the non-VA Dental provider and contacting the Veteran.
  - Enters appointments for the Veteran in VistA Appointment Management, non-count Non VA Care Dental clinic.
  - Receiving requests for additional services, transcribing to Non VA Care Dental Consult and/or scanning into VistA Imaging with communication to Dental Chief or designee for approval (unless other official Delegation of Authority for specific Dental program actions exist).
  - Routing requests/alerting VA Dental Chief or Designee regarding requests for additional services
  - Tracking the episode of care via Consult Management Reports and Appointment Management Lists, and information contained on non-VA Dental claims.
  - Consult management/ closure of Non-VA Dental Consult with use of the standardized Non VA Care Consult Result Note.
- **Claims Payment Staff-**The Claims Payment staff is primarily responsible for payment of non-VA claims, but may also assist with:

- Routing requests for additional services to the NVC staff
- Tracking the episode of care through completion
- Communicates with NVC Staff to accomplish completion of the consult once all claims are paid and episode of care is concluded.

Receiving & Scheduling Dental Services

The process begins when the Veteran presents to the VA Medical Center with a Dental complaint.

- A Non VA Care consult requesting Dental services is placed by the VA Provider, or a Dental note is entered by the VA staff dentist.
- The Veteran's Dental Class rating and eligibility for VA Dental care are reviewed and verified with assistance from the Enrollment and Eligibility Department/Business Office and with concurrence from Dental Service. For more information, please refer to Attachment B: Determining Veteran Eligibility for Non-VA Dental Treatment – Dental Classes.
- The **NVC staff** will alert the Chief, Dental Service, or Designee who will review the consult to determine:
  - If the care is clinically indicated
  - Can the care be provided within the VA
  - Does the request meet criteria for community referral
- If care ***can*** be provided within the VA, the NVC staff will Discontinue the consult with comments that care is available within VA, and place ordering VA provider/Dental staff on consult as additional signers and return to the Dental Clinic for scheduling with a comment that services are available in-house.
- If the referral does ***NOT*** meet criteria for community referral, the consult is Discontinued by the reviewer. The reviewer must include an explanation for discontinuing the consult and alert the referring provider.
- If the consult ***DOES*** meet criteria for community referral, the reviewing **clinician** (Dental Chief or Designee) will indicate if a contract or other predefined care option (i.e., VA/DoD sharing agreement, teaching affiliate agreement, contractual arrangement, etc.) exists for the services requested.
- If predefined care options ***DO*** exist, the **NVC staff** will contact the Veteran and inform them that the services will be scheduled with a specific facility.
- If predefined care options ***DO NOT*** exist, the **NVC staff** will contact the Veteran for their provider preference. The chosen provider must be checked against the The List of Excluded Individuals/Entities (LEIE). If a provider is found on the LEIE, the Compliance and Chief Fiscal Officers must be notified.
- If the **NVC staff** is unable to contact the Veteran within three business days, on two separate attempts, a standardized "Unable to Contact" letter must be sent to the

Veteran. The Veteran has 14 calendar days in which to respond. (Appointment Management SOP)

- If the Veteran refuses care, or if all efforts to contact the Veteran have been exhausted with no response, the consult is discontinued with an explanation of lack of response or refusal.

NOTE: For more specific instructions on consult actions, please refer to the NVCC Referral Review, and Appointment and Clinical Documentation Management SOP.

- Once the care option is established and accepted, the **NVC Staff** will coordinate a scheduled appointment for the Veteran with the contract provider or provider of choice.
- **NVC Staff** enters the initially scheduled Dental appointment in VistA in using a non-count clinic using VistA Appointment Management

NOTE: For more specific instructions on appointment management actions, please refer to the NVCC Appointment Procedure guide.

Authorizing Dental Services

- The **NVC staff** will establish the authorization for care, to include cost estimation, obligation of funds, and the appropriate Purpose of Visit (POV) codes. (Attachment C).
  - It is important to remember that cost estimations must be reasonable, and based on the reimbursement amount established for the region and the services to be provided.
  - Authorizations are entered using the Fee Basis Claims System (FBCS) Authorization Module.
- **NVC staff** creates Veteran and NVC provider correspondence using the NVC template (Non-VA Care Patient Appointment Letter and Non-VA Provider Authorization Letter).
- **NVC staff** will send any necessary medical documentation to the non-VA provider.
- **NVC staff** sends copies of the authorization and letters to the Veteran and non-VA provider.

Note: NVC staff may receive direct contact from non-VA provider regarding dental treatment question. Based on the urgency, **NVC Staff** will either contact VA Dental Chief or designee directly to discuss with non-VA Provider or send view alert on Non VA Care Dental Consult to answer questions and NVC staff will contact non-VA Provider with response.

- **NVC staff** sends copies of the authorization and letters to the Veteran and non-VA provider.
- **NVC Staff** must run daily Appointment List Reports to identify Veterans who should have attended the initial Non VA Care Appointment. After the appointment date, contact the Veteran to determine if services were rendered.

- If services were ***NOT*** provided:
  - Determine if the care is to be rescheduled.
    - If care ***IS*** to be rescheduled, update the appointment in VistA Appointment Management.
    - If care ***IS NOT*** to be rescheduled,
      - Discontinue the consult with comments documenting Veteran's refusal of care.
      - Amend the authorization by changing the "From" and "To" date to the same date, and amend the authorization remarks to reflect refusal and prevent future payments.
      - De-obligate funds
- If services ***WERE*** provided:
  - **NVC Staff** or **claims processing staff** determine if all authorized treatment was provided.

- If all treatment ***IS*** concluded, the claim may be processed for payment.

Note: There are times when treatment plans may be extensive requiring multiple visits for an episode of care. Claims should be processed as they arrive. It is not necessary to hold all claims until the entire episode of care is concluded. Even though claims are processed as they arrive, the consult will remain open until all services are rendered.

Treatment Plans

At times, Veterans may be authorized for non-VA Dental care that includes evaluation with the purpose of establishing a treatment plan for the episode of care. In such cases the process is as follows:

- **VA Dental Chief or Designee** will enter a Non-VA Consult authorizing evaluation for devising a treatment plan.
- **NVC Staff** establishes the authorization. Authorization remarks must clearly state:
  - That the initial authorization is for evaluation only
  - Precisely what type of evaluation (e.g., limited, problem focused; comprehensive oral evaluation, etc.) is authorized, to include necessary diagnostic imaging.
  - That **NO** treatment is to commence until after review and approval by VA Dental Chief.
  - Instructions for returning the treatment plan with the imaging studies to the **NVC** office.

Once the treatment plan is returned from the non-VA dentist:

- **NVC Staff** will scan the treatment plan and images into VistA Imaging and alert the VA Dental Chief or Designee.

- The **VA Dental Chief or Designee** will review the treatment plan and diagnostic images and indicate which elements of the submitted treatment plan are approved. Approved and disapproved elements are noted on the original consult.
- **NVC Staff** will enter the authorization for non-VA Dental care according to the notations from the consult and notify the Veteran and non-VA provider in writing using the Non-VA Care Patient Appointment Letter and Non-VA Provider Authorization Letter.

During the course of the episode of care, if additional requests for treatment are submitted, the same procedures will be used to process requests for further services.

Dental Guidance on Completing (Closing) Consult

Non VA Care **Dental** Consults are managed differently than **medical** Non VA Care Consults. If *treatments are still pending*, NVC and/or Claims staff does **NOT** close Non VA Care Dental Consult after the initial visit. The treatment plan may be scanned/uploaded, but **DO NOT** link the treatment plan to Non VA Care Consult Result Note (Dental) at this time. The NVC Consult remains open until all authorized services listed on the treatment plan are provided. Once ALL services on the treatment plan are provided, the consult is completed by the NVC MSA staff.

- When all authorized services outlined in the treatment plan are provided, NVC MSA Post-Appointment or Claims Processing staff may enter a comment on the Non VA Care Dental Consult.
- NVC MSA and/or Claims staff will retrieve the VistA Imaging number from the original treatment plan.
- NVC and/or claims staff will place the VistA Imaging number of the treatment plan document on the Non VA Care Consult Result Note, and note on the original consult.
- The Dental Provider and NVC Post Appointment MSA Staff receive alerts that the plan of care is concluded.

Throughout the course of the episode of care, documentation in the form of diagnostic images or requests for additional treatment may be received from the non-VA provider. These documents should be scanned and uploaded into VistA Imaging. The VistA Imaging number may be recorded on the Dental Progress note and the original consult. The consult must remain open until the entire episode of care is concluded.

- NVC and/or claims staff documents the completion date on the original Non VA Care Dental Consult.
  - NVC and/or claims staff documents the claim payment date on the original Non-VA Care Dental Consult.
  - NVC and/or claims staff documents and complete the consult with an alert to the referring provider.
- If treatment **CANNOT** be competed (due to non-compliance or other issues) or if additional care is requested by the community provider **NVC staff will**:

- Document the information on the original consult.
- If the treating provider is requesting additional care, outline the specific services requested (include tooth number and ADA code as well as proposed fees)
- View alert the Chief Dental Service or Designee for review and determination
- Document any additional authorized services in the original authorization.
- Contact the Veteran and provider and coordinate additional appointments.
- Establish the NVC Care appointment in non-count clinic using VistA Appointment Management.
- Maintain communications with both Veteran and provider to determine completion of all authorized services.
- Once all authorized care is provided, the consult may be completed.
    - Document the completion date on the original consult
    - Document the claim payment date on the original consult
    - Complete the consult, with an alert for the referring provider.

- If Clinical Review is required by Dental Chief or designee after receipt of Treatment plan (received by NVC and/or Claims staff), direct contact by NVC and/or Claims staff is required to reach out to Dental Chief or designee for review.
- Dental Chief or Designee will determine next steps and document on Non-VA Care Consult. May approve further treatment, may bring back to VA or Veteran may need a new Non-VA Care Consult Dental consult or other specialty consult. If new consult is required, the new consult would be submitted and would initiate a new NVCC handoff process.

Attachment A: Dental Payment Methodology

Key Points

- Payment processing for non-VA dental claims is performed in the VistA Fee Software, within VistA Fee medical batch.
- The local Dental Fee Schedule pricing methodology is based on the Schedule of Maximum Allowances for the VA facility geographic area.
- Consistent with Title 38 U.S.C. § 1712, a VA dentist must first confirm the reasonable necessity and appropriateness of a proposed treatment plan and associated fees in all cases where the total Non-VA Dental Care treatment plan exceeds $1,000. This confirmation may be obtained by any of the following:
  - An examination by a VA dentist to determine needs prior to Non-VA Dental Care authorization.
  - A second opinion examination by a VA dentist, or a designated, authorized, outside provider when no VA dentist is available, after submission of Non-VA dentist's treatment plan and associated fees.
  - A review of the clinical record, applicable images and supporting documentation by a VA dentist after submission of a Non-VA dentist's treatment plan and associated fees. This review does not necessarily require the Veteran to be present. Check with local procedure to see how to deal with other health insurance for the dental claim, if the Veteran carries it.

Payment Methodology Summary

- In the absence of a contract or negotiated agreement, payments approved under the non-VA medical care Program authority 38 U.S.C. 1712 are paid as follows:
  - Payment is the lesser of:
    - Schedule of maximum allowances for non-VA dental care
    - Usual and customary charge, or billed charges

Note: The VA schedule of Maximum Allowances for non-VA dental service is considered confidential, and will be distributed by the Chief, Dental Service, or designee. It is prohibited to provide a copy of this schedule to outside parties.

Relative Value Based Claims Payment Information for Dental

- Effective December 8, 2011, VHA contracted with Fair Health, Inc., to obtain relative value based claims payment information by geo-ZIP location for the majority of the 550 Dental CPT Procedure codes.
- The Office of Dentistry publishes information on the Dental Reporting and Analytics System website to aid facilities in determining the appropriate payment rates for non-VA dental care. This information is periodically updated as new data becomes available from Fair Health, Inc. (generally January and July of each year).
- Benefit schedules and payment rates may also be considered based on the following:

- By default, the benefit schedules are based on payment rates at the 50th percentile. It would be suggested that facilities consider setting payment rates at this level.
- If local dental care market conditions exist where payments must be higher than the 50th percentile rate to ensure timely access to quality non-VA dental care, then VA Medical Center Dental Service Chiefs and/or facility non-VA medical care program managers must document this necessity and obtain written approval for the alternative percentile schedule by their VISN Network Director through the local VA Medical Center director.
    - If local market conditions are such that quality and timely dental care at the default schedule is not available, the dental service chief and/or non-VA medical care program manager can use submitted non-VA dental care claims as a basis for determining prevailing market rates to substantiate an alternate schedule.
    - When an alternate schedule is required due to the market conditions, the schedule can be procedure-specific and does not have to adhere in total to a given percentile change. For any schedule change, document the need, the process used for determining the schedule, and have it approved as noted above.
    - For any unique ad-hoc clinical condition for a particular patient requiring a significant deviation from the schedule, the Dental Service Chief or designee, must document the clinical need and rationale for the deviation.
    - While it is not permissible to provide the Fair Health schedule to outside providers, it is permissible to poll or question non-VA providers for their fees to aid in determining an appropriate schedule as long as the inquiry is inclusive of a representative number of providers in the given specialty.

Attachment B: Determining Veteran Eligibility for Non-VA Dental Treatment – Dental Classes

Eligibility Criteria

Statutes and regulations establish VA's authority to provide dental benefits to specific categories of Veterans. Dental classes for outpatient dental care have been established by regulation and they define these patient categories. The dental regulations also identify other categories of Veterans eligible for specific dental care.

Eligibility for Veteran Classes III and VI

In the case of Class III and VI patients, consultation requests from non-dental providers must identify the medical condition being aggravated or the management of which is complicated by the dental problem. The Dental Service Chief, or designee, must review the consult and determine dental eligibility and scope of care.

Verifying Eligibility

The facility Business Office is the first resource for administrative determination of dental eligibility. That office is to determine a Veteran's eligibility for all dental patient classifications, with the exception of Classes III and VI. When necessary, the second and final resource for administrative determinations of a Veteran's eligibility for dental care is the Health Eligibility Center (HEC). The HEC has final responsibility for verification of all administrative aspects of a Veteran's eligibility for dental care with the exception of determinations related to Classes III and VI.

Note: If the Veteran's eligibility cannot be verified by any of these methods, the VA Form 10-7131, Exchange of Beneficiary Information and Request for Administrative and Adjudicative Action, should be sent to the appropriate VA Regional Office for determination.

Veteran Classes for Non-VA Dental Care

Veteran eligibility for non-VA dental care is based on the Veteran's classification. The following table outlines dental eligibility criteria and the associated dental benefits for each of the Veteran dental classification. POV codes are entered when processing the dental claim for the specific Veteran class. For a complete list of POV codes for each corresponding Dental Class, please refer to Attachment C Dental Purpose of Visit (POV) Codes.

Note:
Veterans eligible for outpatient comprehensive dental care include Classes I, II (a), II(c), IV. These Veterans receive any dental treatment that is reasonably necessary and clinically determined by the treating dentist to meet the Veteran's dental needs.

Dental Rating Class	*Description*
Class I	(1) **Class I** (a) Veterans having a compensable (10% or greater), service-connected dental disability or condition (combat or non-combat related) rated under VA's 9900 series of the Schedule for Rating Disabilities (see App. B) are eligible for any reasonably necessary dental care, whether related to the SC condition or not, to maintain or restore oral health and masticatory function, including repeat care. (b) Classification of Veterans having other service-connected conditions of the head and neck area is sometimes confusing. Non-dental conditions such as loss of soft tissue, scarring, or cranial nerve involvement are not rated under the 9900 series. These are considered medical conditions and Veterans with these conditions are not eligible under Class I. The decision to authorize dental care for these conditions as adjunctive care (either as Class III or Class VI) must be made by the Chief, Dental Service, or designee and based on the same criteria as for other medical conditions.

Class II	(2) **Class II** (a) Veterans having a noncompensable, service-connected dental disability or condition shown to have been in existence at the time of discharge or release from active service, which took place after 9/30/81, may be provided any treatment as reasonably necessary for the one-time correction of the noncompensable, service- connected dental condition if all of the following criteria are met: 1. In the case of Gulf War Veterans (which includes Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn Veterans), they must have served on active duty and been discharged or released, under conditions other than dishonorable, from a period of active military, naval, or air service of not less than 90 days. For others, they must have been discharged or released, under conditions other than dishonorable, from any other period of active military, naval, or air service of not less than 180 days. 2. Application for dental treatment is made within 180 days of such discharge or release. 3. The certificate of discharge or release does not bear a certification that the Veteran was provided, within the 90- day period immediately before discharge or release, a complete dental examination (including dental radiographs) and all appropriate dental treatment indicated by the examination was completed. This certification is found on the DD Form 214, Certificate of Release or Discharge from Active Duty, line 17. 4. For Class II patients, the VHA dental exam is completed within 180 days after discharge or release, unless delayed through no fault of the Veteran. (b) When Class II eligibility has been exhausted by satisfactory completion of the authorized treatment in accordance with good professional standards, no further care will be provided. (c) Class II dental beneficiaries who (through no fault of VA) have not completed authorized treatment within 3 years after filing the application will be presumed to have abandoned the claim for dental treatment (d) Limitations of Treatment Provided Under Class II.

Class II Continued	1. Dental Prostheses and Implants Provided by VA. Class II dental beneficiaries are not eligible to receive ongoing maintenance. Once adjustments are satisfactory, the episode of prosthetic care is considered to be complete and subsequent treatment is the responsibility of the Veteran. 2. Periodontal Conditions. Specific treatment authorized for periodontal conditions of Class II beneficiaries is expected to provide maximum benefit by the time that episode of overall care is completed. When that treatment is satisfactorily completed as authorized, further treatment or follow-up for the periodontal condition is not authorized. 3. Impacted Teeth. Impacted teeth are a developmental abnormality. Consideration for surgical extraction must be based on sound professional judgment to resolve existing disease or symptoms. 4. Malposed Teeth. Malposed teeth are considered a developmental abnormality and a pre-existing condition relative to the start of military service. Orthodontic care in this circumstance is not authorized. For cases in which trauma incurred in the line of duty resulted in malalignment of the teeth or when restorative procedures for which the Veteran is eligible require orthodontic intervention, orthodontic care may be provided. 5. Veterans with Orthodontic Appliances. When Veterans present at VA facilities with orthodontic appliances for the purpose of correcting developmental malocclusion and have not had their treatment completed by the military prior to discharge, they must be informed that VA does not assume the responsibility for any phase of the orthodontic care unless directly related to rehabilitation of combat trauma to the maxillofacial region. 6. Service Connection of Dental Conditions for Treatment Purposes. VBA may, upon request, provide documentation to the Dental Service defining service connection of specific teeth for dental treatment purposes. (See Title 38 CFR 3.381). The regulation provides for identification of teeth treated during military service, and applies only to Class II beneficiaries who have met the criteria as specified in Paragraph 7c1(a)-(f) and 7c2(a) and (b) of this Handbook. The Chief or designee can use the document in developing appropriate treatment recommendations. 7. United States Department of Defense (DoD) responsibilities. Under 38 U.S.C. 1712(a)(2), DoD must notify the Veteran at the time of discharge or release of the VA Class II- dental benefit available to newly discharged Veterans, including notice of the applicable time- limit for these benefits (i.e., including the need to apply for this benefit within 180 days of their discharge or release). If a Veteran requests dental treatment after that 180 day period and states the required notification was not provided to the Veteran upon discharge or release, the Chief Business Office should send a VA Form 10-7131 Exchange of Beneficiary Information to VBA to investigate. If no indication of notification was documented by DoD, or the DD-214 indicates dental treatment was not completed within 90 days of discharge and no Class II treatment has been provided, then Veteran may be provided a one-time course of dental care.

Class II(a)	(3) **Class II(a)** (a) Veterans having a service-connected noncompensable dental condition or disability adjudicated as resulting from combat wounds or service trauma may be authorized any treatment indicated as reasonably necessary for the correction of such service-connected noncompensable condition or disability. This includes any care necessary to provide and maintain a functioning dentition. (b) VA Form 10-564-D, Dental Trauma Rating or VA Regional Office Rating Decision letter identifies the service-connected noncompensable condition or disability, which establishes Class II(a) eligibility. (c) Prior to 1955, teeth that received routine dental care while the Veteran was on active duty were listed as "service connected," and therefore eligible for care. As a result of changes to Title 38 dental authorities in 1955, any Veteran who received a dental award letter from VBA dated before 1955 in which VBA determined the dental conditions to be noncompensable service connected is no longer eligible for Class II outpatient dental treatment based on such prior determination of service connection. Questions regarding eligibility may be referred to HEC.
Class II(b)	(4) **Class II (b)** (a) Outpatient dental services and treatment considered medically necessary are provided to certain homeless and other enrolled Veterans. These limited dental benefits defined in Title 38 U.S.C. § 2062 are to be provided a one-time course of dental care provided in the same manner as the dental benefits provided to a newly discharged veteran. Specifically, dental services and treatment provided to eligible Veterans under this authority are those that are: 1. Necessary for the Veteran to gain or regain employment; 2. Necessary to alleviate pain; or 3. Necessary to treat moderate, severe, or complicated and severe gingival and periodontal pathology. (b) Eligible Veterans are defined as those who are enrolled in VA's health care system; and the Veteran is receiving care (directly or by contract) for a period of 60 consecutive days, as verified by the facility Veterans Homeless Coordinator, in any of the following settings: 1. A Domiciliary, which includes Domiciliary Mental Health Residential Rehabilitation Treatment Programs. 2. A Compensated Work Therapy-Transitional Residence. 3. A Community Residential Care Program, if VA coordinated the placement. 4. A community-based residential treatment program serving homeless Veterans under the Health Care for Homeless Veterans (HCHV) program. 5. A setting operated by a provider to whom VA provides grant and per-diem funds under VA's Homeless Providers Grant and Per Diem Program.
Class II(c)	(5) **Class II(c)** Veterans who were Prisoners of War (POWs) are eligible for any needed dental care, including repeat care.

Class III	(6) **Class III** Veterans referred by a treating physician who have a dental condition professionally determined by the VA dentist(s) to be aggravating or complicating the management of a service-connected medical condition under active treatment are eligible for care to treat the dental condition. However, there is no provision granting eligibility for dental care under this classification in case of the opposite relationship, where a medical condition (e.g. Post-Traumatic Stress Disorder (PTSD)), may be contributing to a dental condition (e.g. bruxism) because the dental condition identified is not professionally determined to aggravate the medical condition. The goal is to provide focused care to treat only the oral conditions that directly impact the clinical management of the service-connected medical condition. Eligibility for each episode of dental care must be predicated on referral (consult), followed by a new dental evaluation.
Class IV	(7) **Class IV.** Veterans whose service connected disabilities have been rated at 100 percent (total) under the VA Schedule of Rating Disabilities (VASR-D) or who are receiving the 100 percent rate by reason of individual unemployability, are eligible for any needed dental care, including repeat care, with the following exception: Veterans awarded a temporary total disability rating by VBA but not as a VASR-D or individual employment eligibility rating (i.e. Prestabilization, Hospitalization or Convalescent Ratings) are not eligible for comprehensive outpatient dental services based on an opinion by VA General Counsel to the Under Secretary for Health, February 24, 2006, VAOPGCADV 2- 2006. These Veterans may be eligible for care under a different eligibility category. Determination of temporary status is the responsibility of the eligibility section of the Chief Business Office.
Class V	(8) **Class V** (a) A Veteran who is actively engaged in a Chapter 31 vocational rehabilitation program may receive dental care to the extent needed to meet any of the following goals: 1. Make possible the Veteran's entrance into a rehabilitation program; 2. Achieve the goals of the Veteran's vocational rehabilitation program; 3. Prevent interruption of a rehabilitation program; 4. Hasten the return to a rehabilitation program of a Veteran in interrupted or leave status; 5. Hasten the return to a rehabilitation program of a Veteran placed in discontinued status because of illness, injury or dental condition; 6. Secure and adjust to employment during the period of employment assistance; or 7. Enable the Veteran to achieve maximum independence in daily living. (b) Requests for Class V dental care must be forwarded to the Dental Service by the Chapter 31 Vocational Rehabilitation Program on VA Form 28-8861. This form needs to be provided for each episode of care requested. Dental care must not be provided beyond the anticipated rehabilitation date as specified on the form.
Class VI	(9) **Class VI.** Any Veteran scheduled for admission or who is receiving care under chapter 17 of title 38, U.S.C., may receive outpatient dental care if the dental condition is clinically determined to be complicating the medical condition currently under VA treatment. Eligibility for each episode of dental care will be predicated on referral and consultation, followed by a decision based upon clinical judgment. The goal is to provide focused care to treat only the oral conditions that are complicating impact the clinical management of the medical condition currently under treatment. This classification includes medically necessary dental care for Veterans receiving care for Military Sexual Trauma under Title 38 U.S.C. 1720D.

Other Beneficiaries	(10) **Other Beneficiaries.** Other beneficiaries who may be eligible for dental care in VA dental clinics on an outpatient basis to the extent consistent with law and applicable sharing agreements, subject to the availability of VA resources are: (a) Armed Forces Personnel on Active Duty. 1. Compensation and pension examinations must be performed for active duty personnel referred by VBA. 2. Active duty personnel may be provided treatment of emergent oral conditions. Authority from the Commanding Officer of the military installation must accompany the request for dental treatment. If extenuating circumstances are present, treatment of this condition may be accomplished prior to the receipt of authority. Emergency dental treatment for members of the Armed Forces on active duty must be limited to such treatment as is found necessary for the relief of pain and control of acute infection, trauma or hemorrhage. (b) Armed Forces Personnel in VA Polytrauma Centers. Active duty military personnel receiving treatment in a VA Polytrauma Center are eligible to receive any reasonably necessary dental care under the terms of the sharing agreement between the VA and Department of Defense (DOD) Memorandum of Agreement dated January 1, 2007, or any successive Memorandum of Agreements. (c) VA Employees. 1. VA employees may be provided emergent dental treatment and treatment to address injuries incurred in the performance of duty. Provision of care is predicated on referral from the employee health program. Employees with emergent conditions that may require follow-up care will be advised to seek private care at their expense. 2. VA employees may be provided dental treatment authorized by an approved Office of Workers' Compensation claim. (d) Beneficiaries of Sharing Agreements. Treatment provided must be dependent on the specific language of the agreement. (e). **Continuation or Termination of Dental Treatment Initiated as an Inpatient.** The Chief, Dental Service, or designee, is responsible for determining the proper disposition of inpatients who have received dental care. A determination must be made whether the provided dental treatment has accomplished the intended treatment goals. If essential dental treatment has been completed, the case must be closed. If essential dental care remains, the Chief, Dental Service or designee must collaborate with discharge planners to determine if dental care needs to be continued with the patient as a bed occupant or as an outpatient.

Disability Evaluation Examinations for Compensation and Pension Rating Purposes	(11) Disability Evaluation Examinations for Compensation and Pension Rating Purposes. Requests for an oral examination are submitted to the Dental Service by VBA. Veterans must be coded as “Special Provision (20)” unless established in another dental classification. Examinations must be completed in compliance with the Compensation and Pension program requirements.

Attachment C Dental Purpose of Visit (POV) Codes

Overview

When establishing authorizations for the use of non-VA medical services in the VistA Fee software modules, we use “Purpose of Visit” (POV) codes to identify the appropriate authority to expend VA funds for payment of the claims. It is very important in today’s data world to accurately use these codes to correctly identify not only the authority used to expend the funds, but to also capture workload and expenditures in the various health care programs that Non-VA Care (NVC) Offices typically process for payment. It is essential that NVC staff, as well as other VA employees who use the VistA Fee authorization menu options to process payments for non-VA care, enter data accurately to ensure the workload reports are associated with the appropriate NVC program and POV.

Background

As briefly discussed in the overview, the POV code may be assigned to authorizations entered into the VistA Fee system in various ways. There are times when you create a POV when you disposition an authorization, and there are times when you choose the actual POV code to be entered. There are even times when a POV code is automatically created in the authorization module by just choosing the appropriate program for which you are going to make a VistA Fee system payment. The current system gives the user the ability to enter many different choices. There is no editing logic built into the VistA Fee system to inform the user whether or not they have selected the appropriate POV. In short, the accuracy of NVC workload / expenditure data depends upon your decision as to which POV code is appropriate for each authorization.

In order to ensure the information passes through to Central Fee without rejection, the Dental authorization entry has different combinations of POV codes and other data entry fields. The POV table below explains when to use the additional data fields appropriately with the user’s choice of POV code. It is important to follow this information carefully to reduce the number of rejections related to the Veteran Master Record Listing.

Purpose of Visit Codes

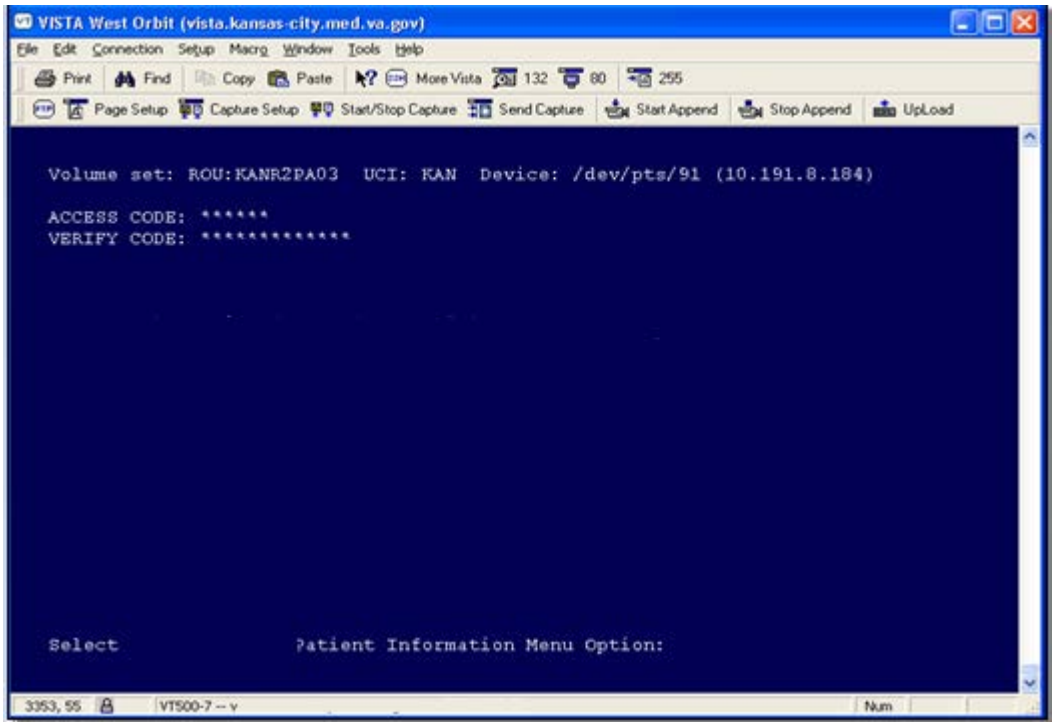
Dental Category Number	INPATIENT OR OUTPATIENT	POV CODE	TREATMENT TYPE CODE	NOTES / COMMENTS
Class I	Outpatient	15	1	Use when the dental treatment is for a Veteran with a service-connected, compensable dental disability.
Class II	Outpatient	16	1	Use when the dental treatment is for a Veteran who applied for and was authorized VA dental benefits within 180 days of discharge from Active Duty and has not been provided dental care upon discharge from Active Duty as cited on the Veteran's DD214.
Class IIa	Outpatient	17	1	Use when the dental treatment is for a Veteran with a service-connected, non-compensable dental condition resulting from combat wounds or dental trauma.
Class IIb	Outpatient	18	1	Use when the dental treatment is for a Veteran who may be homeless and receiving care under VHA Directive 2007-039.
Class IIc	Outpatient	19	1	Use when the dental treatment is for a Veteran who was a Prisoner of War (POW). They are eligible for any needed dental care, including repeat care.
Class IIr	Outpatient	20	1	No longer used.
Class III	Outpatient	21	1	Use when the dental treatment is for a Veteran with a service-connected adjunct medical condition. Each episode of dental care will be predicated on referral and consultation, followed by a clinical judgment decision.
Class IV	Outpatient	22	1	Use when the dental treatment is for a Veteran having service-connected disabilities rated 100% disabling, or are unemployable and paid at the 100% rate due to service-connected conditions.
Class V	Outpatient	23	1	Use when the dental treatment is for a Veteran under Vocational Rehabilitation/Chapter 31.
Class VI	Outpatient	24	1	Use when the dental treatment is for a Veteran receiving VA care and/or scheduled for inpatient care and requires dental care for a condition complicating a non service-connected medical condition currently under treatment. Each episode of dental care will be predicated on referral and consultation, followed by a clinical judgment decision.
Category 18	Outpatient	25	1	Use when the dental treatment is for a Veteran receiving emergent dental care and only when the Veteran is not eligible under Class I through VI Dental Treatment.
Category 19	Outpatient	26	1	Use when the dental treatment is for a Veteran receiving dental care continued after inpatient discharge and only when the Veteran is not eligible under Class I through VI Dental Treatment.
Category 20	Outpatient	27	1	Use when the dental treatment is for a Veteran receiving dental care under a special provision, such as Compensation and Pension exams or care provided under a Sharing Agreement, and only when the Veteran is not eligible under Class I through VI Dental Treatment.

Attachment D: Processing Payments on Dental Claims-Menu Navigation

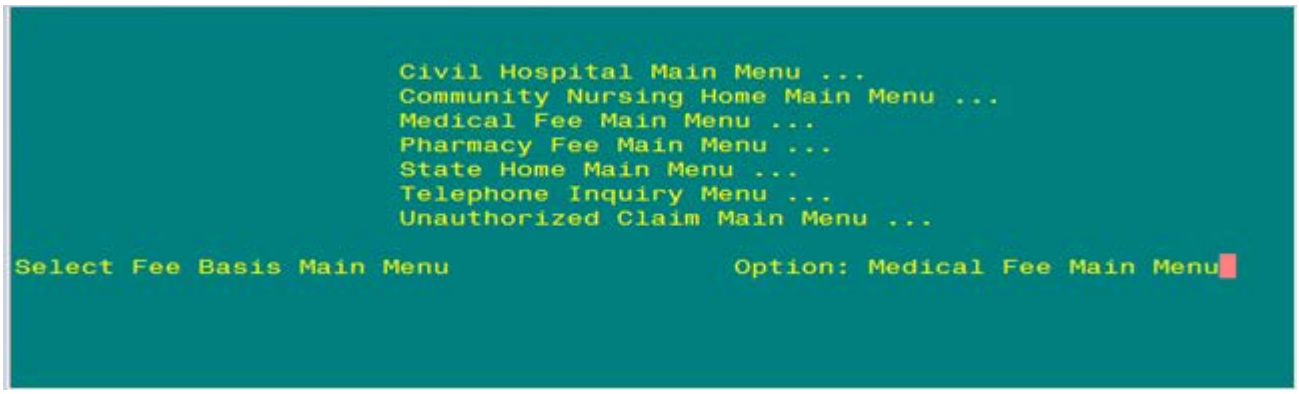
Log into VistA

NOTE: VistA provides the user with the ability to generate lists to answer the prompts. In order to navigate VistA, remember these tips:

- Selecting the 'Enter' key accepts the default action at the prompt and moves the list forward
- Selecting the '^' key stops the list from moving forward, or allows the user to move to a previous prompt by typing in the name of the prompt.
- Selecting an option moves the user to the next field.
- Typing "??" at a prompt will generate a list of options from which to choose an answer.



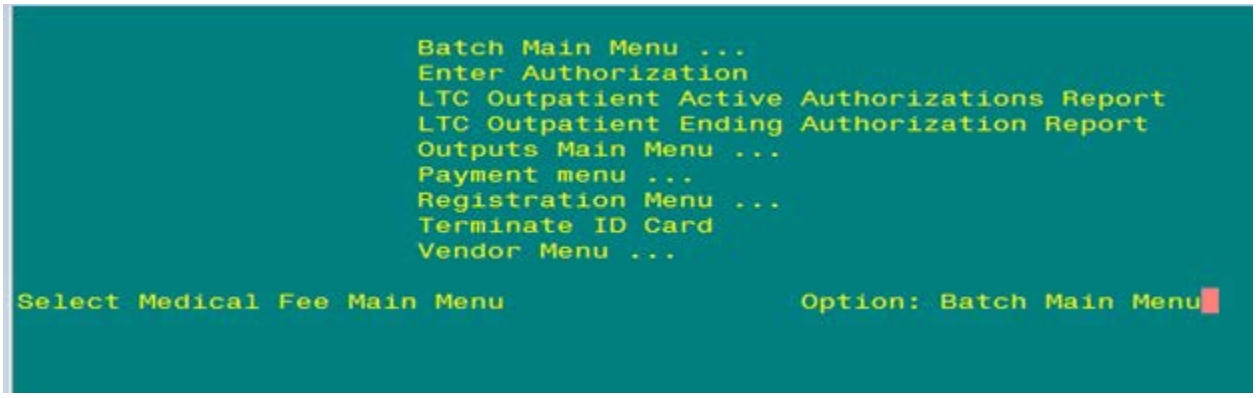
Navigate to the Medical Fee Main Menu



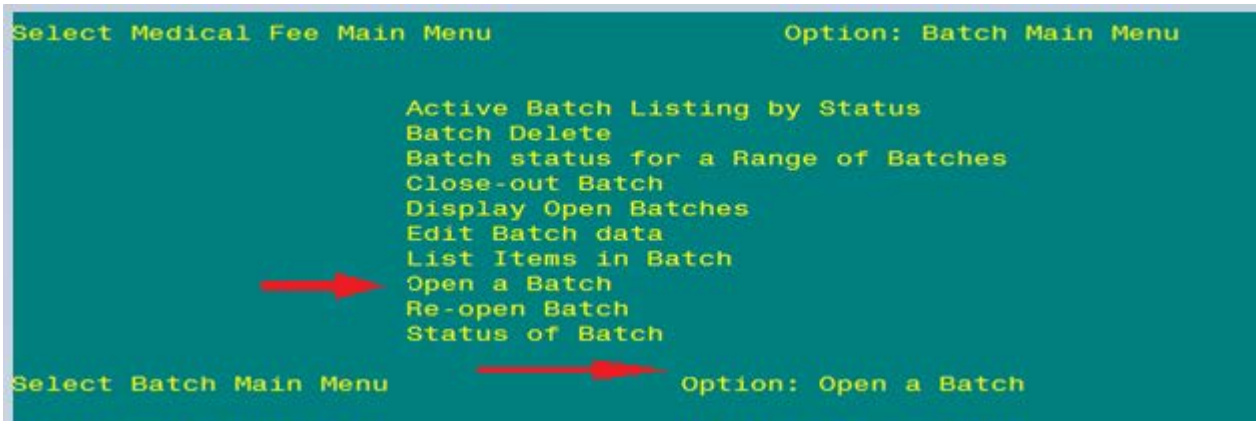
Establishing a Batch

From the Fee Basis Main Menu screen, enter Medical Fee Main Menu, when prompted.

Enter Batch Main Menu, when prompted.



The Open a Batch menu option allows the user to create a new Medical Fee Main Menu batch in VistA.



At the VistA Prompt “Want to Create a Medical Batch? Yes//” agree with the prompt by selecting ‘Enter’, or typing “Y” or “Yes”.

This will assign a new batch number and ask Are you adding ‘(Batch Number)’ as a new FEE BASIS BATCH?

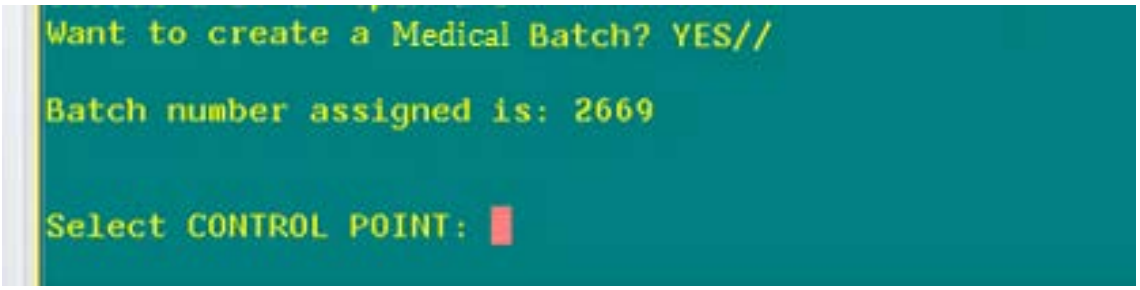
Type “Y” or “YES” and press the ‘Enter’ key for the next prompt

Select ‘Obligation Number’: Enter the appropriate Obligation number for Dental claims. Select ‘Enter’ to continue.

VistA will then display the obligation Fund Control Point (FCP) Number and the remaining funds obligated to that FCP

It is highly recommended that you write down the new batch number, as you will need to recall it later in the payment process.

NOTE: Depending on how your VistA Fee system is configured, it may ask you to Select Control Point number, rather than the Obligation number.



Enter the Fund Control Point (FCP) number for Dental payments.

Select 'Enter' to continue.

WARNING: If you select Enter or enter a <CTL 6> (also known as an up-carrot <^>), the batch will be deleted and you will be returned to the Batch Main Menu.

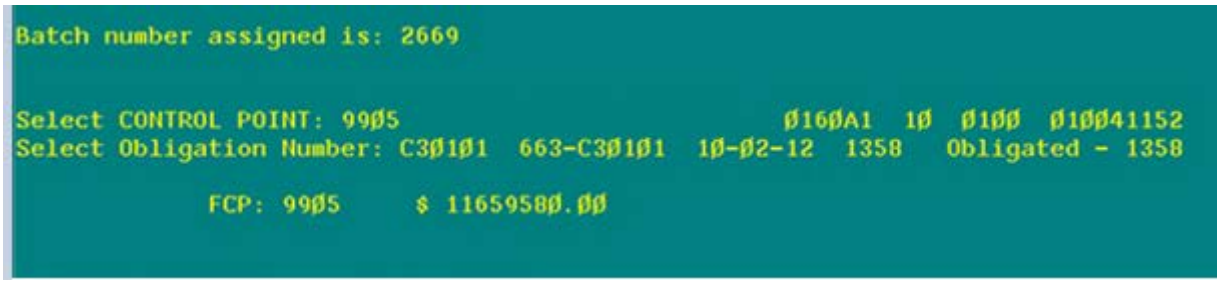
Along with the Control Point, you may be prompted to select 'Obligation Number'.

Enter the appropriate obligation number.

Select 'Enter' to continue.

WARNING: If you enter <CTL 6> (also known as an up-carrot <^>), the batch will be deleted and you will be returned to the Batch Main Menu.

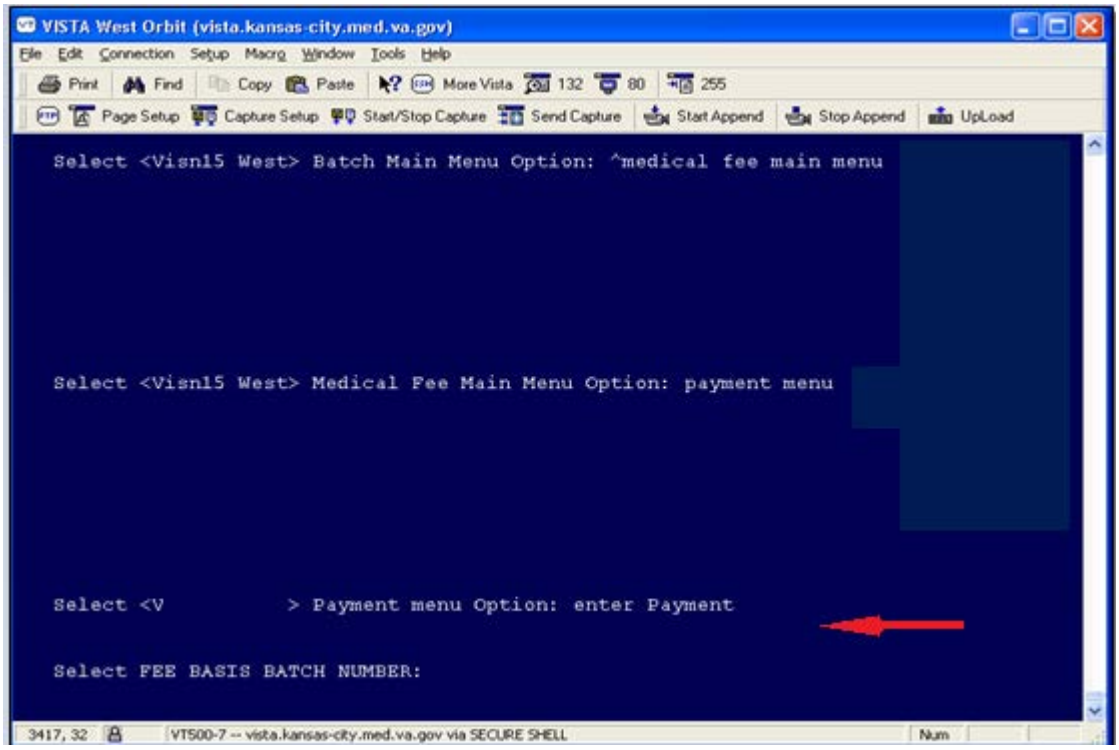
VistA will then display the obligation Fund Control Point (FCP) Number and the remaining funds obligated to that FCP, completing the Open Batch process.



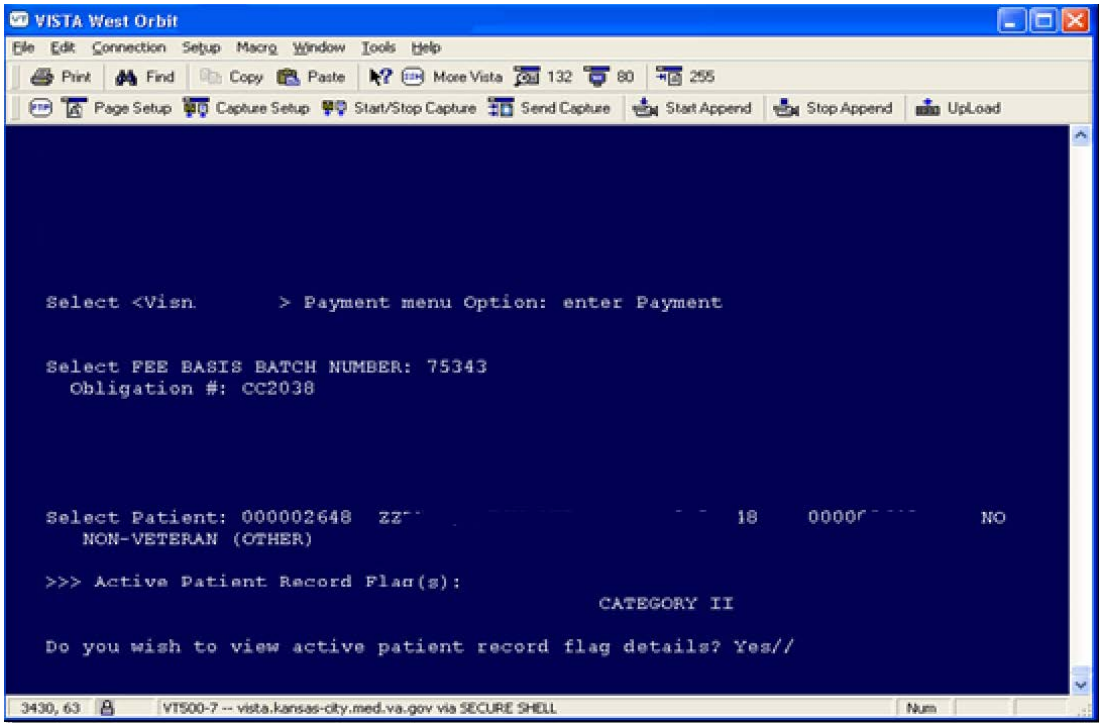
NOTE: Always refer to local policy and procedures to obtain your facility specific FCP/Obligation numbers for each type of care.

Processing the Claim for Payment

Once the batch is opened, the user may begin payment entry. Shortcuts allow the user to navigate to the payment menu by typing "^Enter Payment"

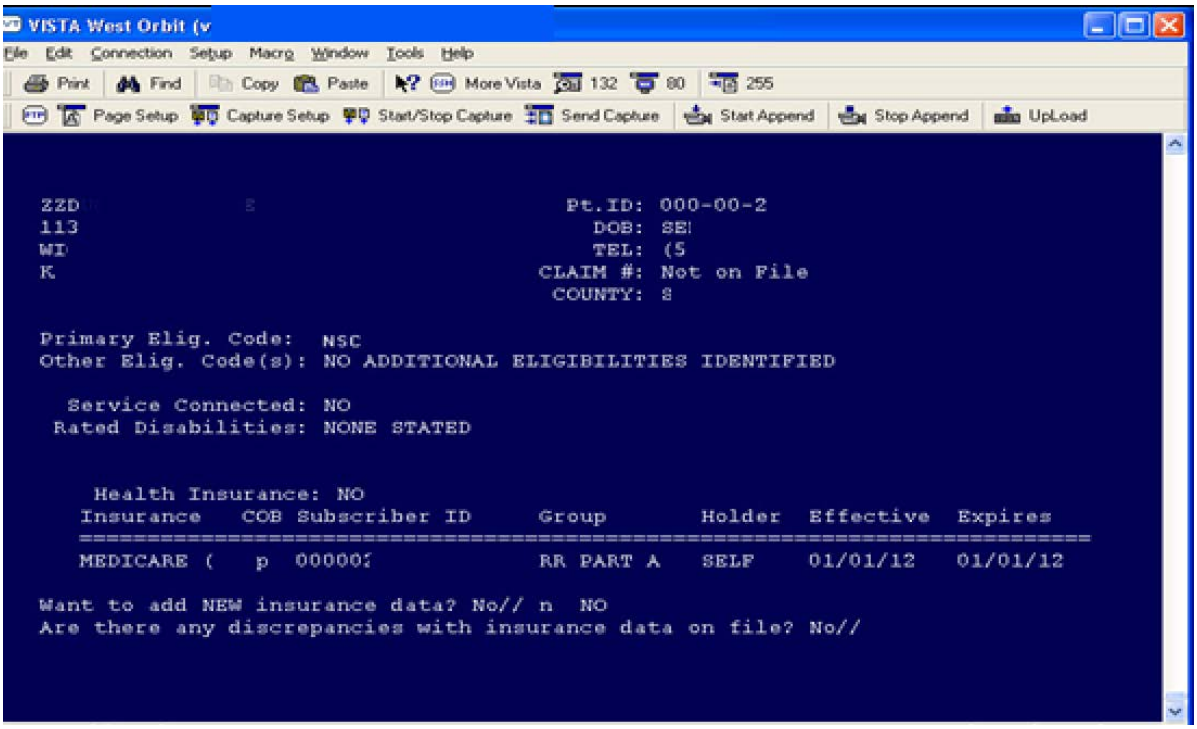


At the next prompt, enter the Veteran's full SSN. You might be prompted here to view the flag details— type "N" and continue



VistA will ask if there are any discrepancies in the insurance file. The user will select 'N' for this field.

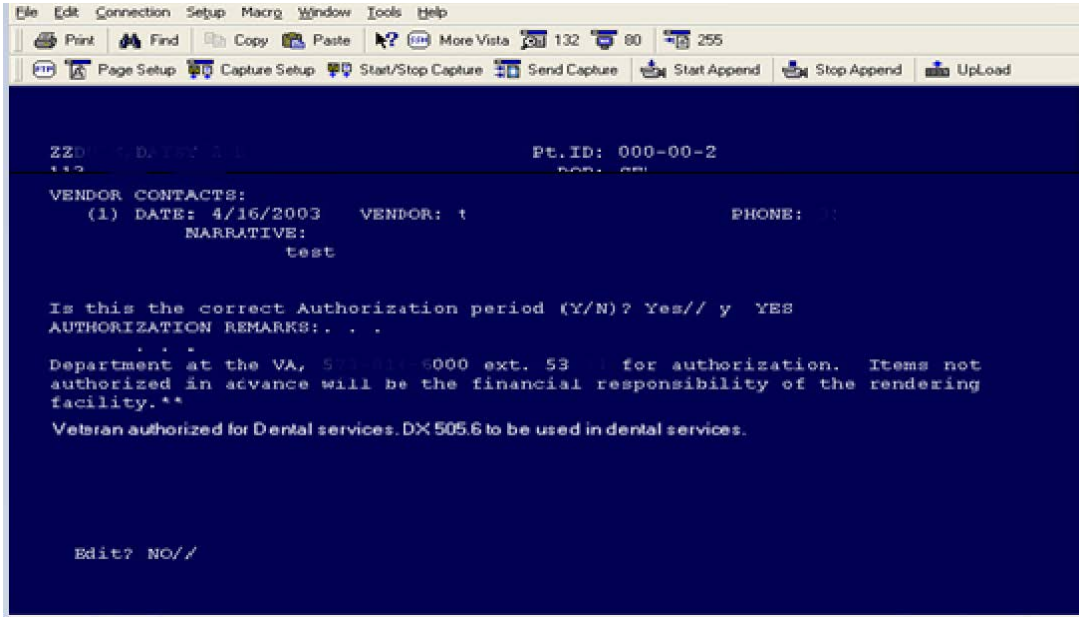
***NOTE*:** If insurance discrepancies are present notify the CPAC POC.



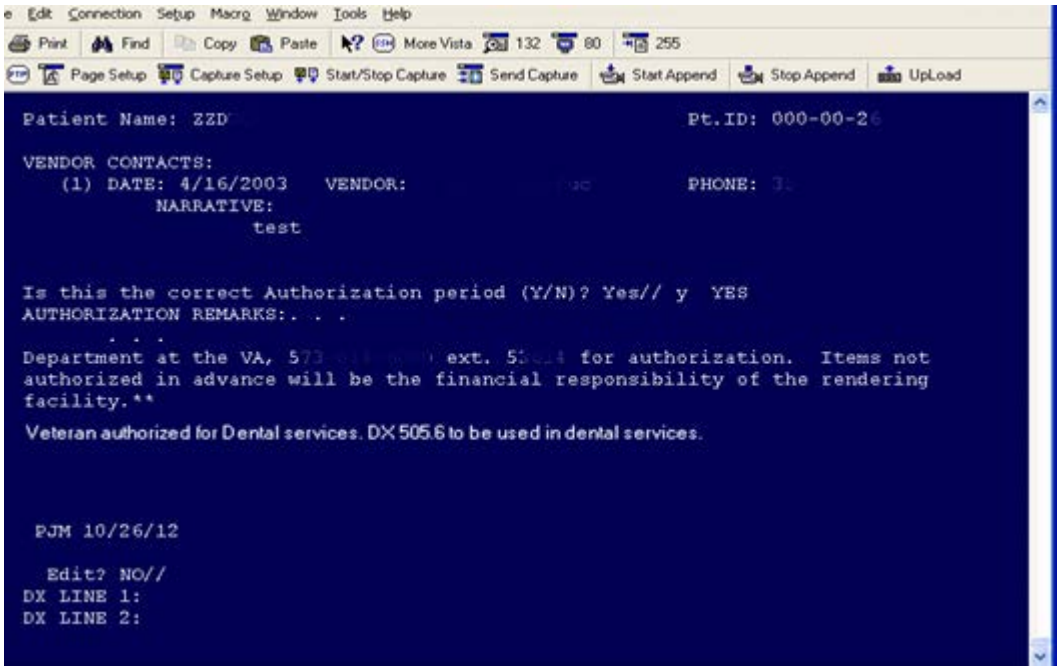
Next, the user must find an authorization; Vista will ask if this is the correct authorization period. If "No" the user would press 'Enter' to see all available authorizations and match it to the dental service on the claim.

If no dental authorization is present, research CPRS for further information:

- Log in to CPRS
- Select ‘Progress Note’
- Select the ‘Consult’ Tab
- Review the consults to determine if care was requested
- If the search is successful, enter the authorization and mark is as a delinquent obligation. Please review the Non-VA Medical Care Referral and Authorization Process Guide for additional details.



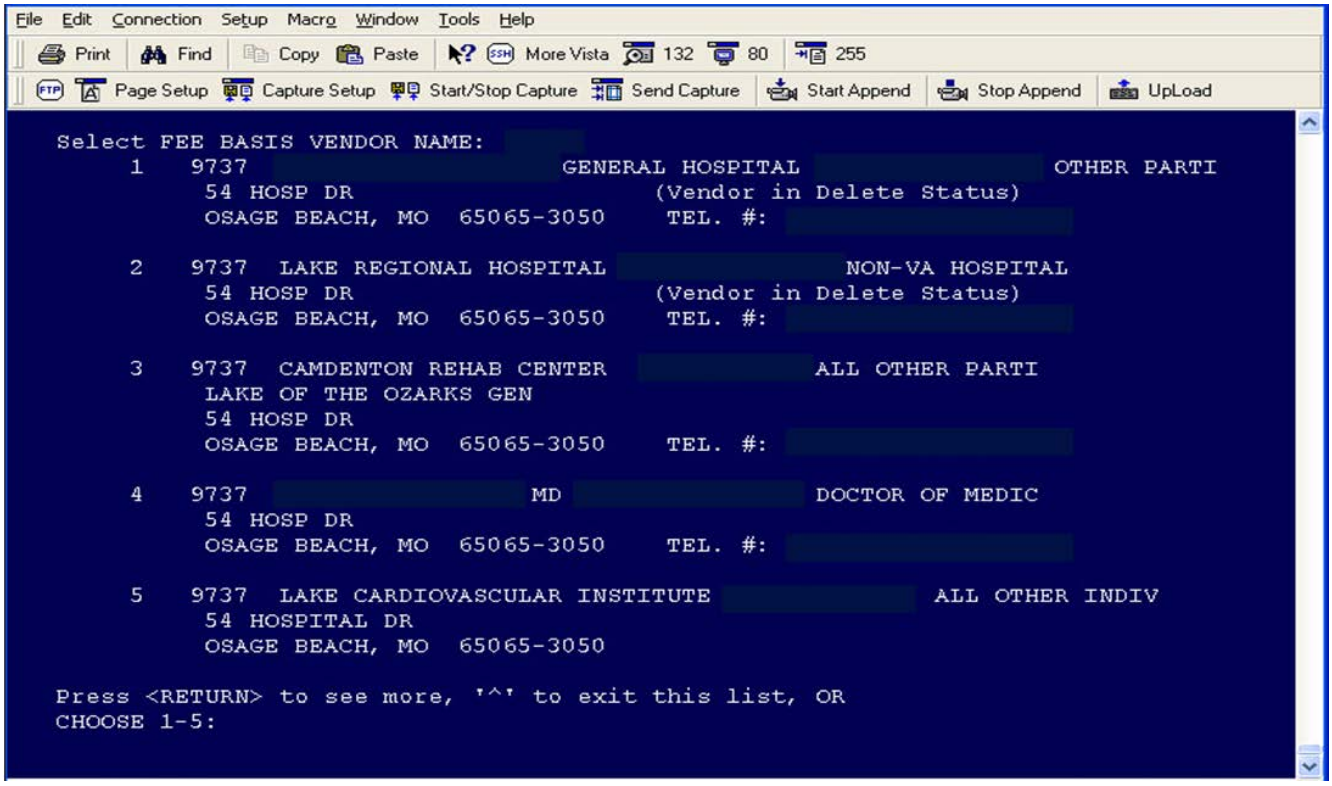
There is no need to enter/edit; press ‘Enter’ three times, one for each of the DX lines:



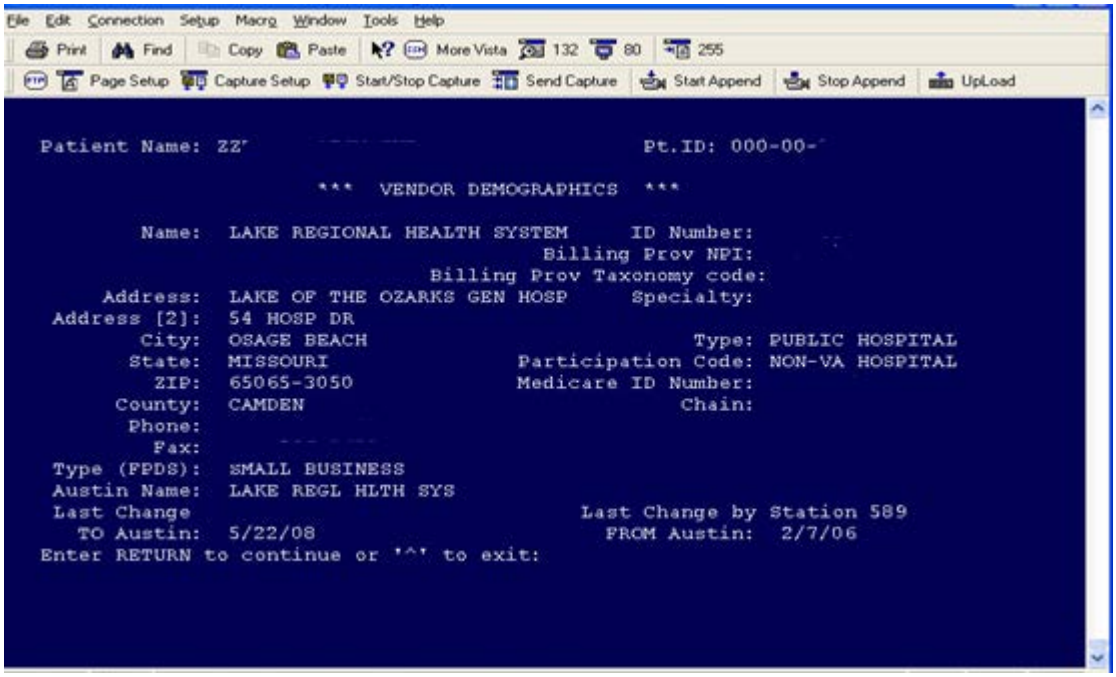
Select the correct vendor. The user may locate the vendor using either the Vendor’s federal tax ID number, or the last 4 of the TIN. Select ‘Enter’.

***NOTE*:** As a part of the dental claims review, verify that the non-VA provider is not on the List of Excluded Individuals/Entities (LEIE) database that is provided by the U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG).

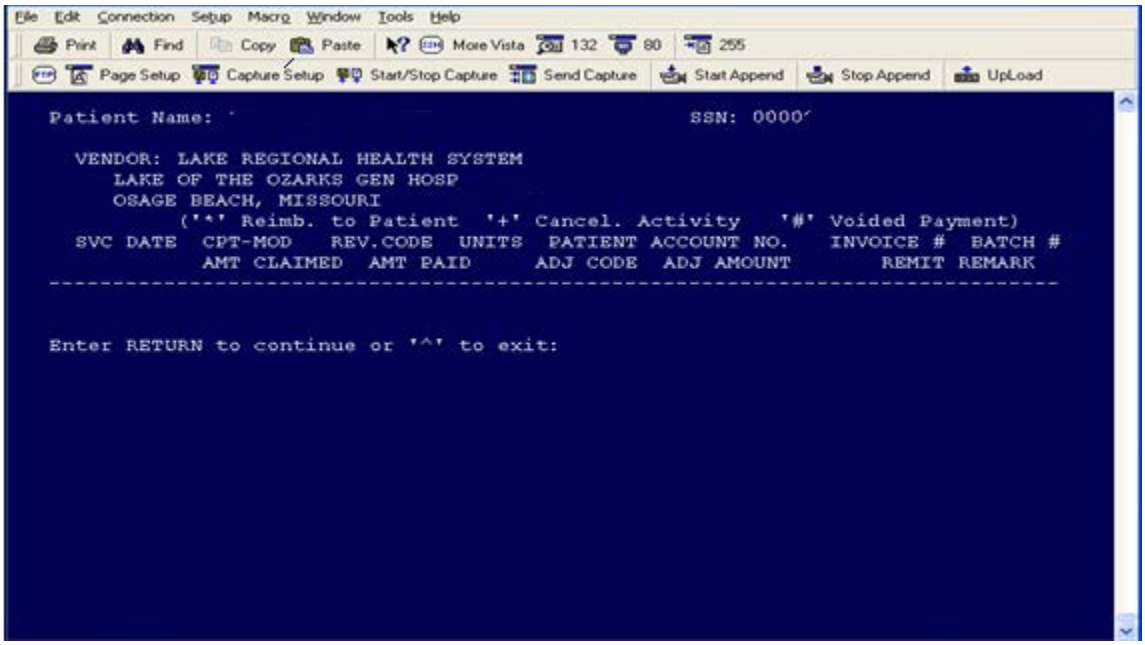
If a match is found, manually reject the claim.



Review the vendor demographic screen, to ensure selection of the correct vendor



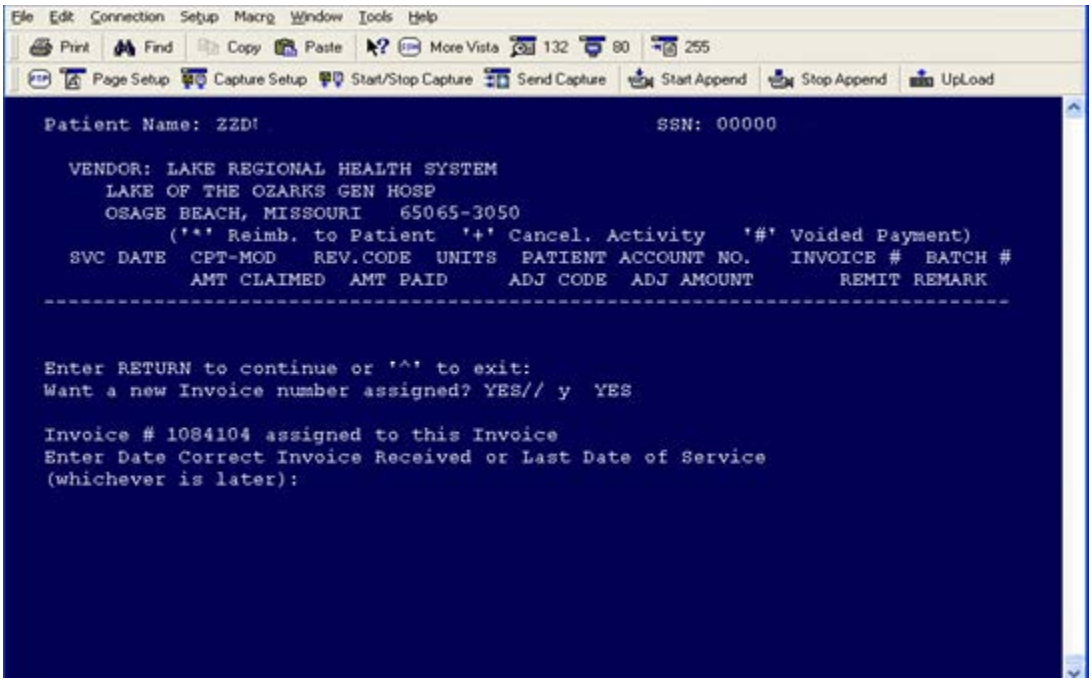
Review payment listing to determine if the payment is a duplicate.



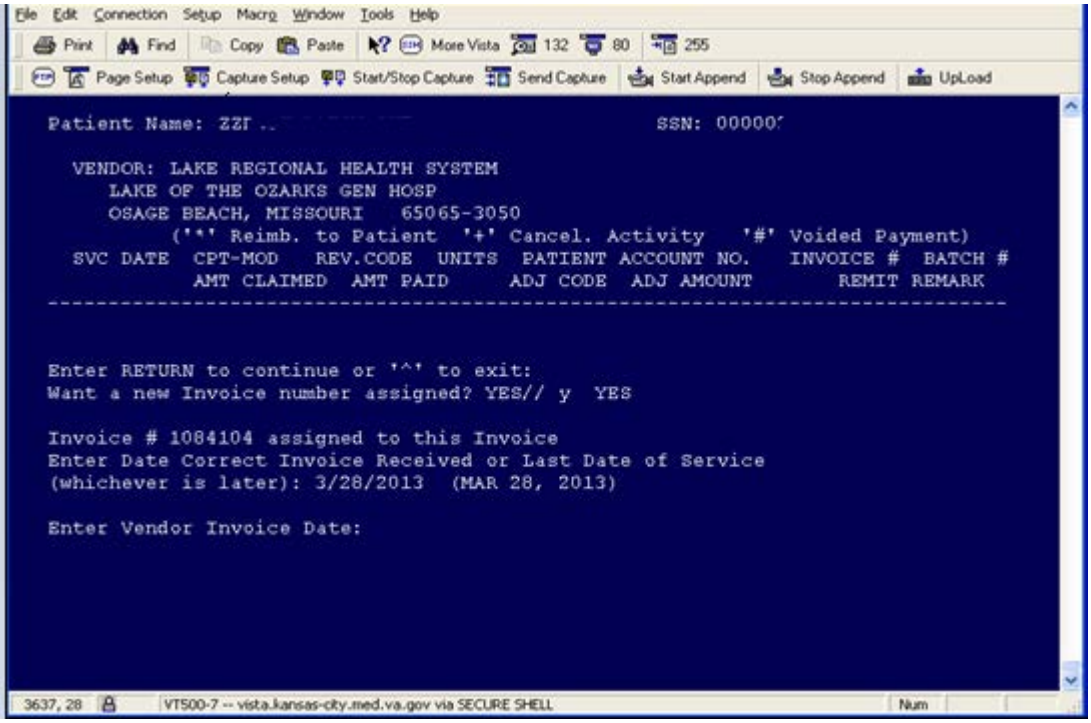
If no, proceed with payment.

If yes, enter claim information using the unauthorized menus and deny as a duplicate.

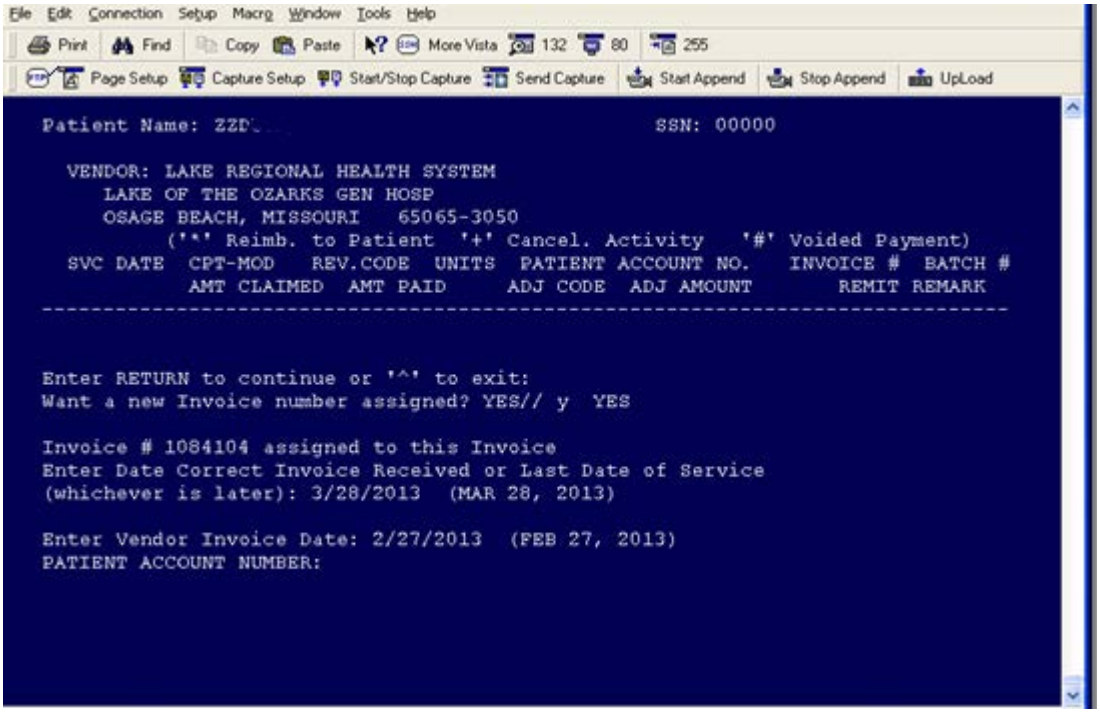
Enter the date the claim was received if available; if not available enter the last date of service. Press ‘Enter’ when finished.



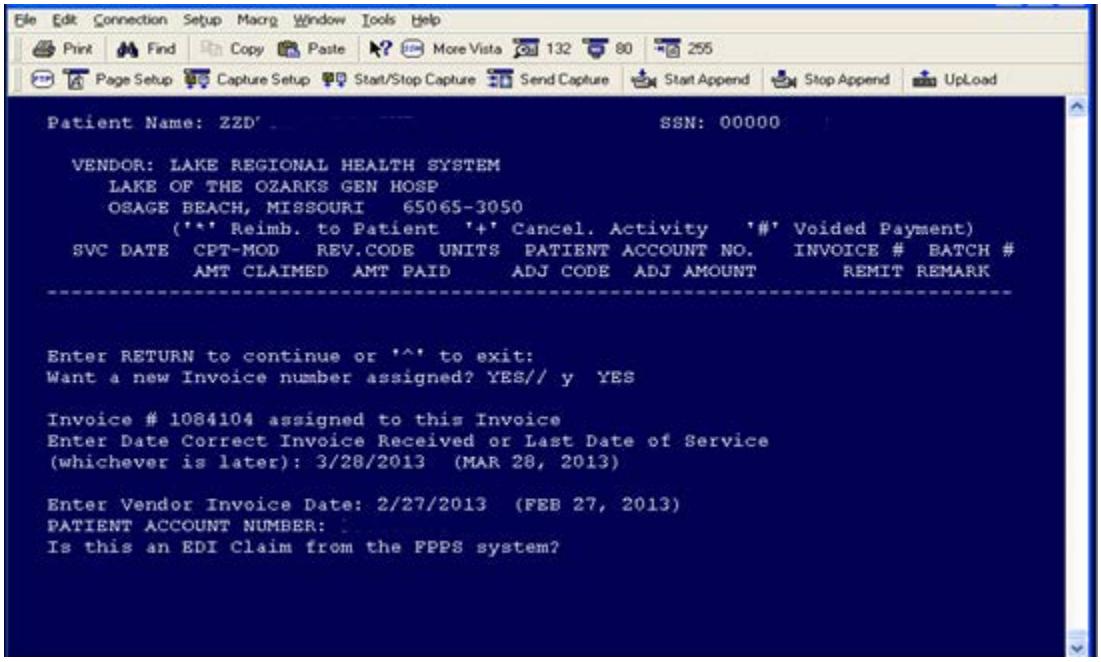
Enter the Vendor invoice date.



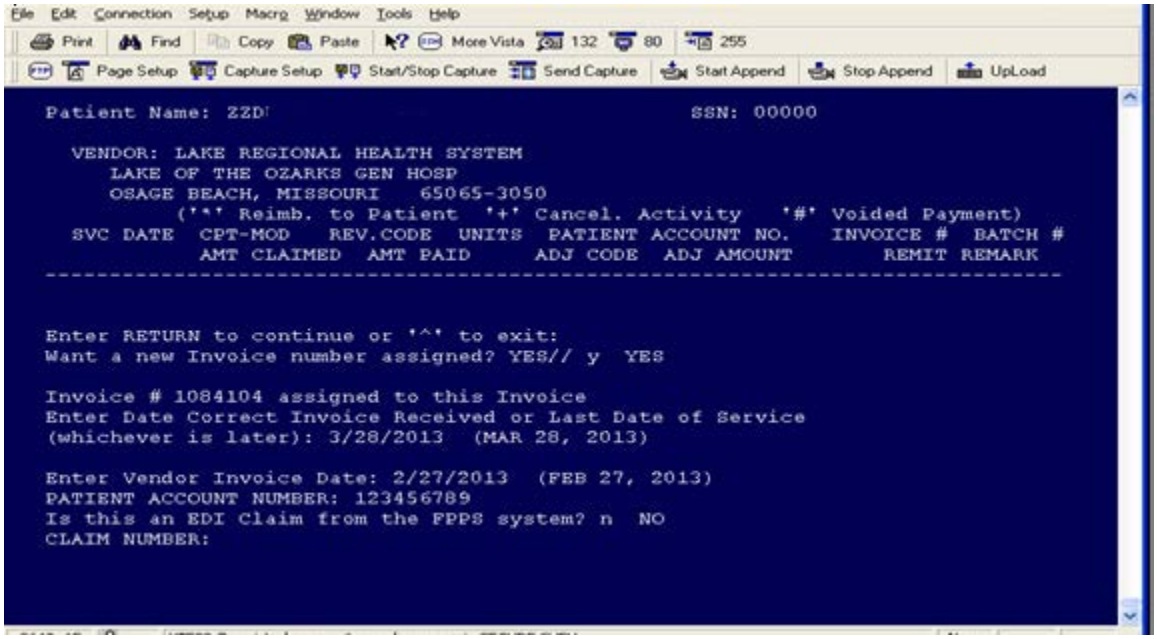
Enter the patient account number found on the ADA claim form.



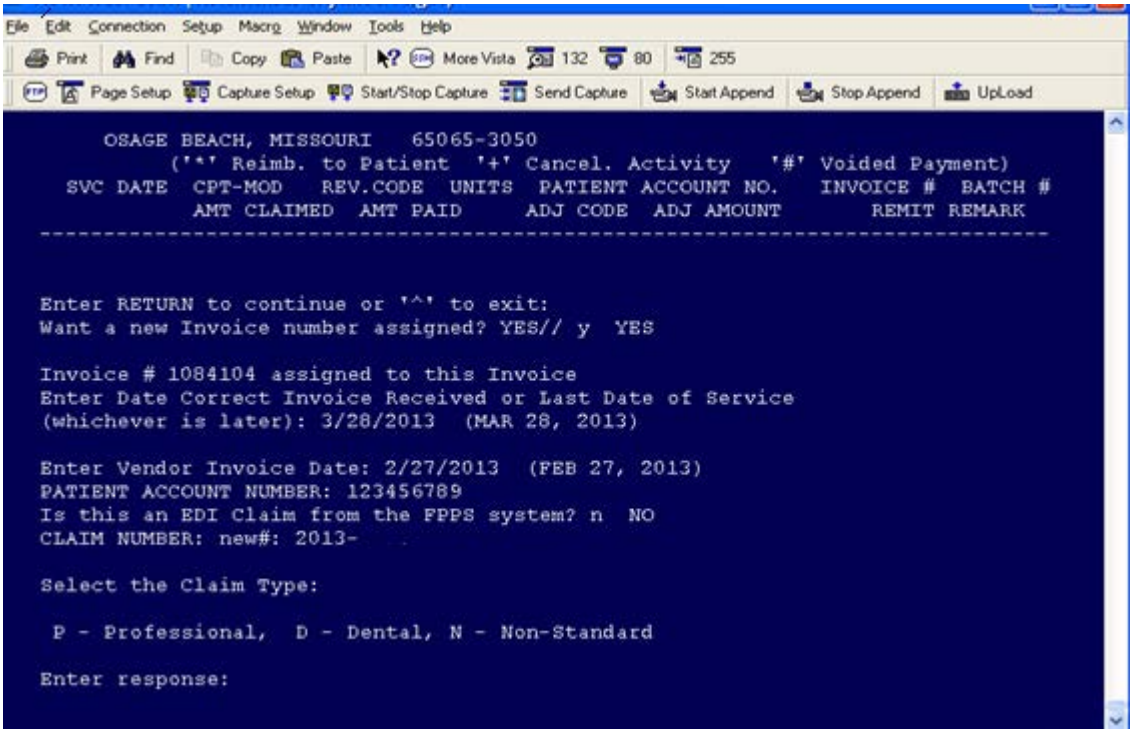
Indicate if this is an EDI claim or not.



To receive a system generated claim number, type “NEW” and press ‘Enter’.



Select ‘P’, ‘D’, or ‘N’ to indicate the Claim. For dental claims, press ‘D’.



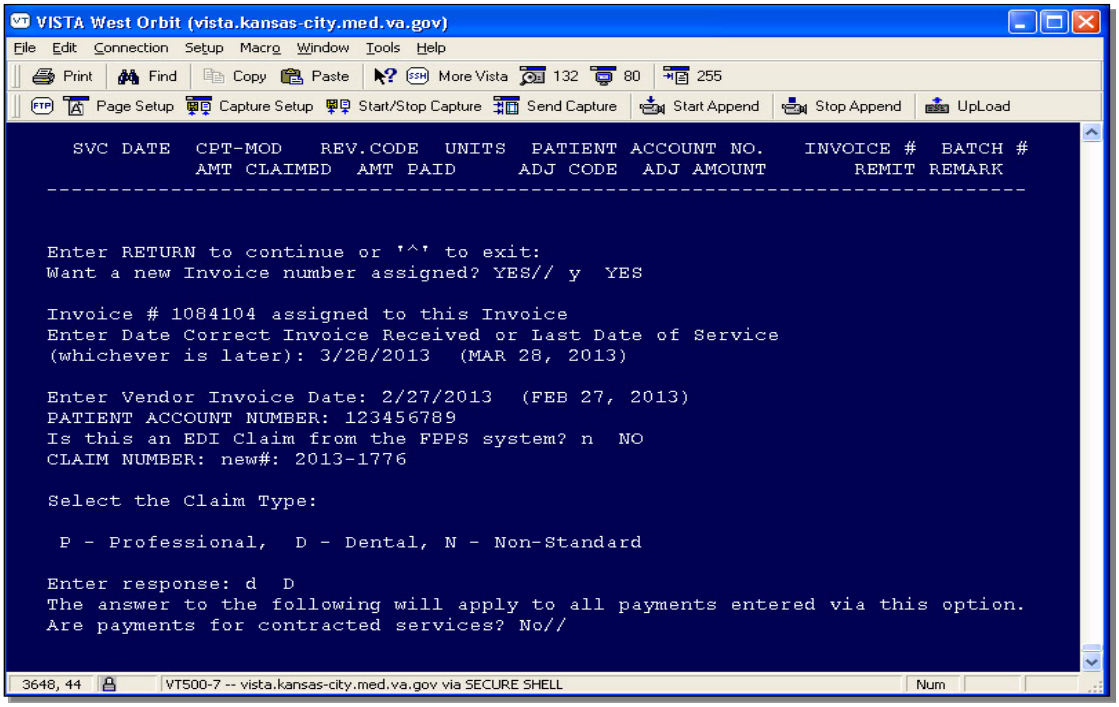
Is the claim for contracted provider?

If yes - type “Y”

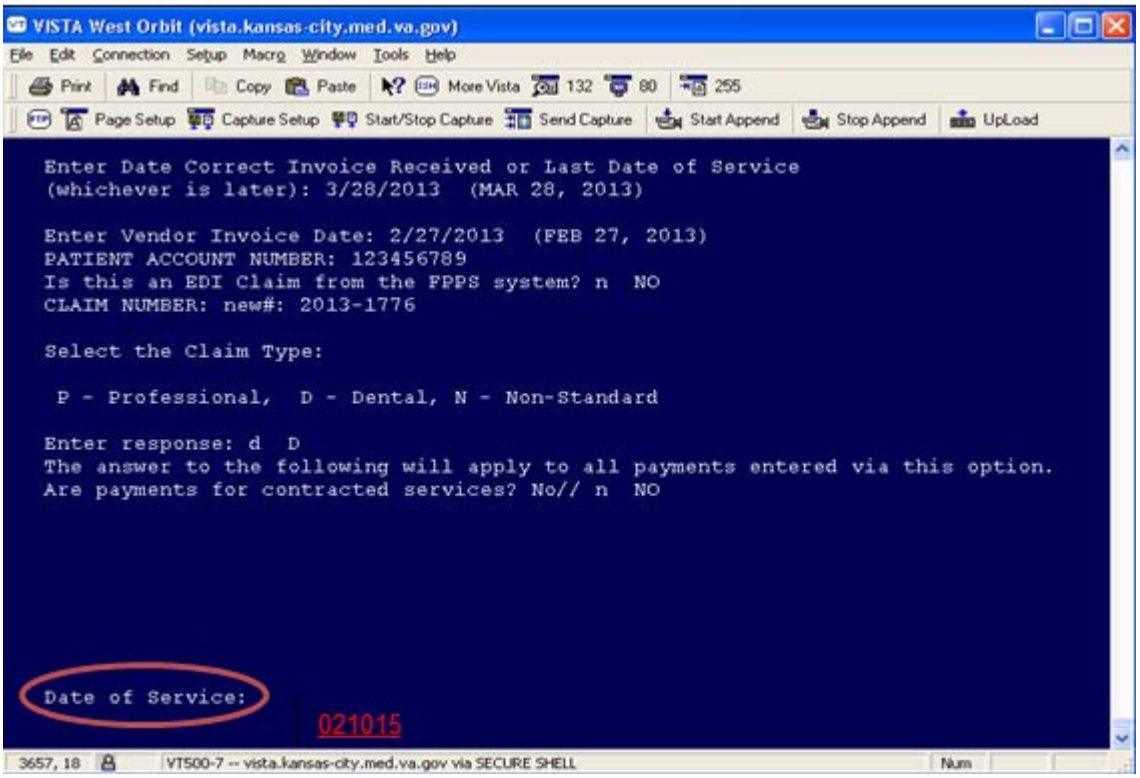
Enter the contract number.

Then select ‘Enter’

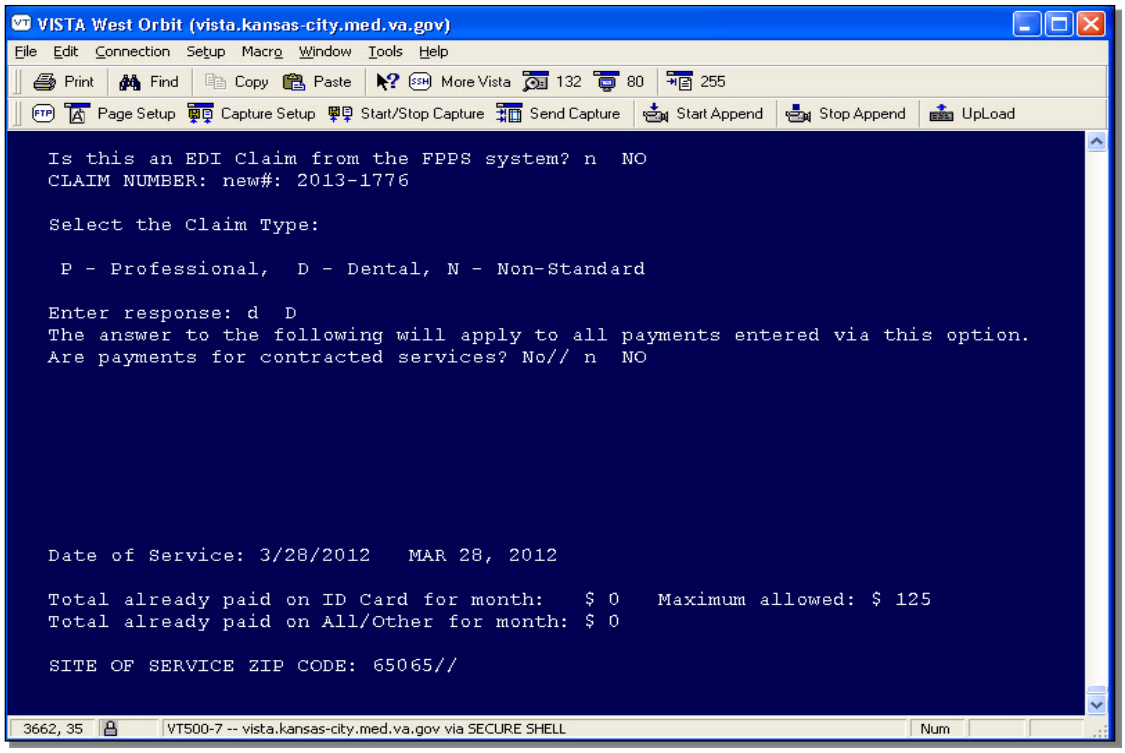
If no, type “N” here and press ‘Enter’.



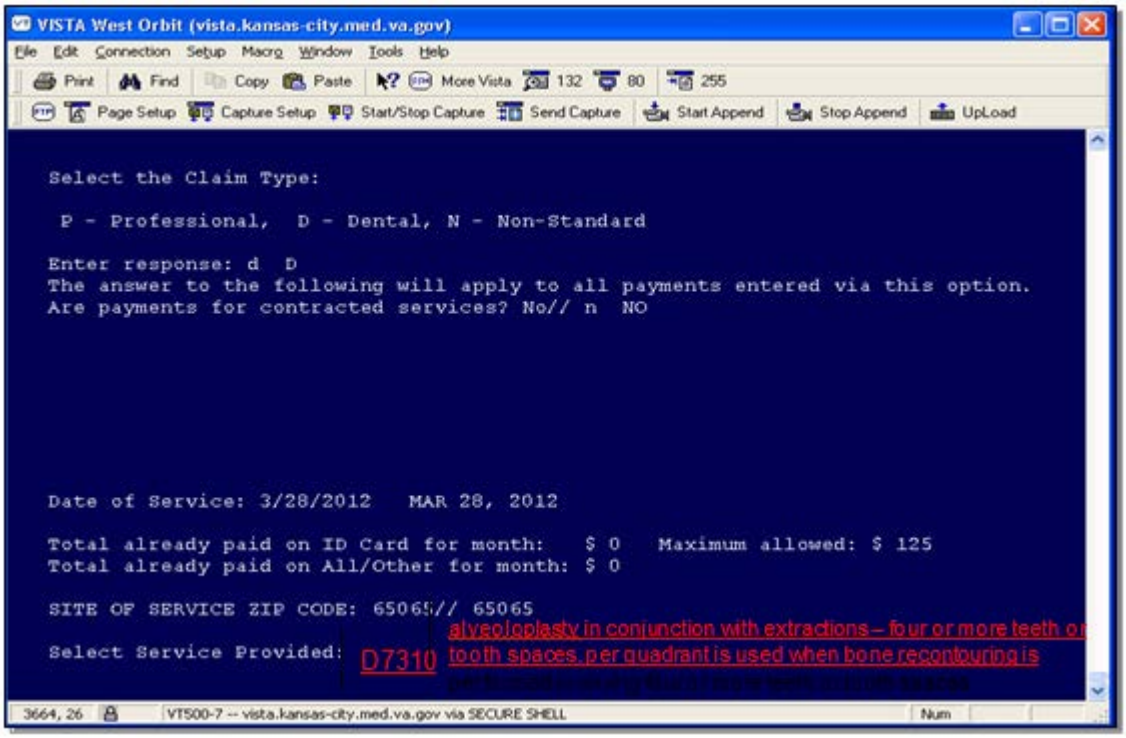
Enter the date of service.



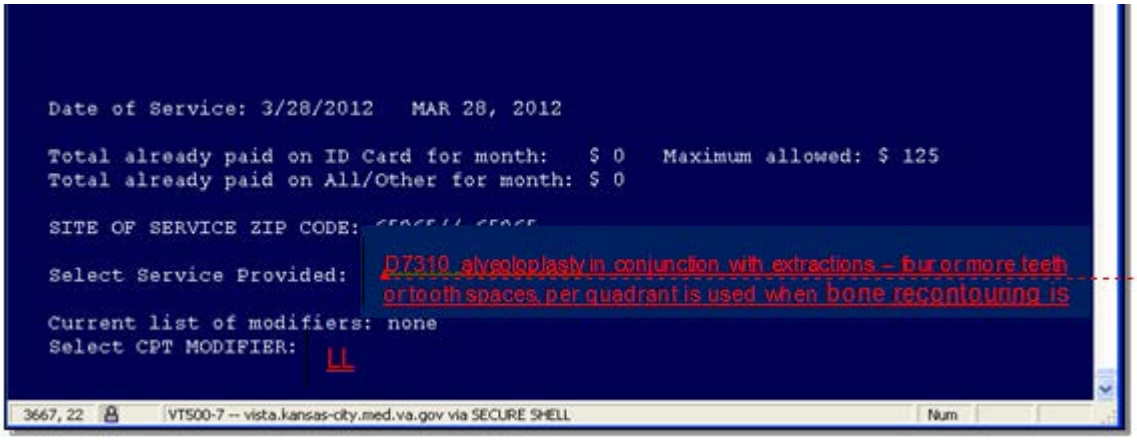
Enter the ZIP code where the services were performed. This information is found in the vendor address.



Enter the ADA codes found on the claim.

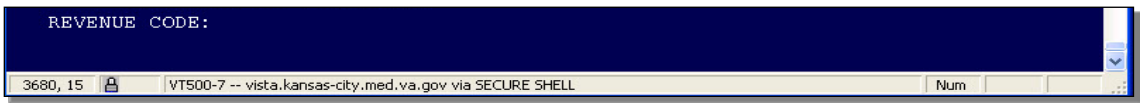


Make sure to also enter any modifiers on the claim.

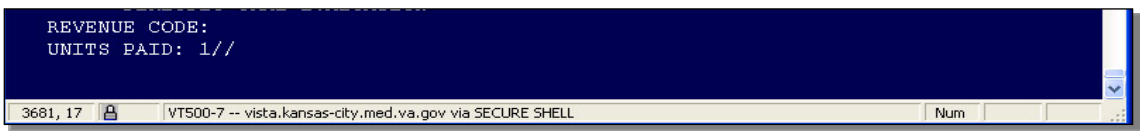


After each line is entered, press ‘Y’ if the information is correct and press ‘Enter’ one more time to lock in that line of service.

There are no revenue codes on a dental form so bypass this field by pressing ‘Enter’.



Enter the units for each service. If the services are performed by tooth then the units will default to 1.

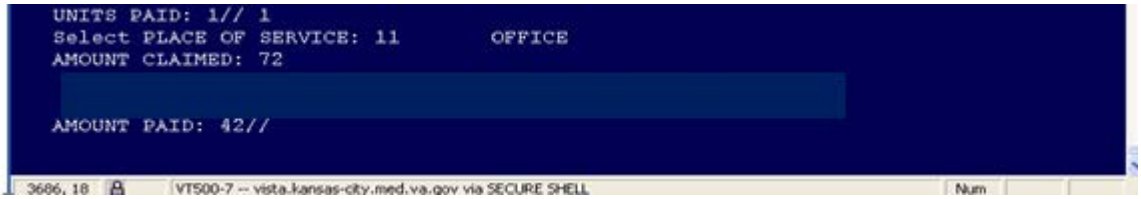


Select or enter the Place of Service. If you need a list of POS codes, type "??" at the prompt. This will generate a list of possible POS codes.

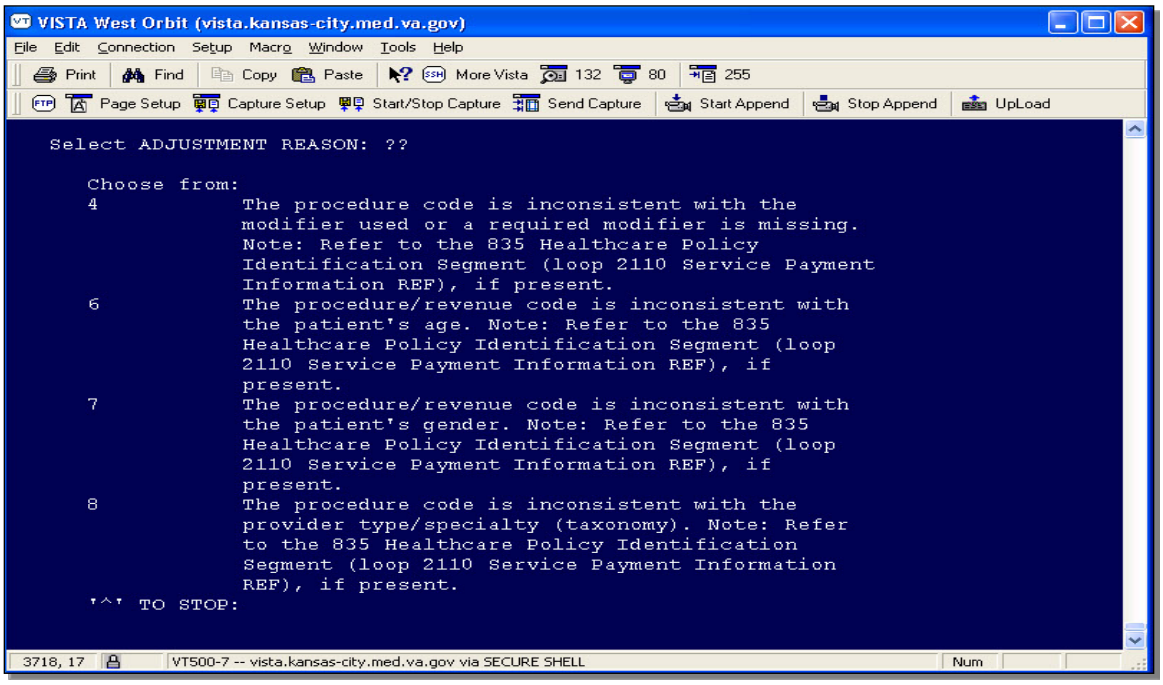
Next is a vital step, enter the dollar amount claimed by the vendor and press 'Enter'.

At the "Amount Paid" prompt input the lesser amount to be paid as described in Non-VA Dental Payment Methodology.

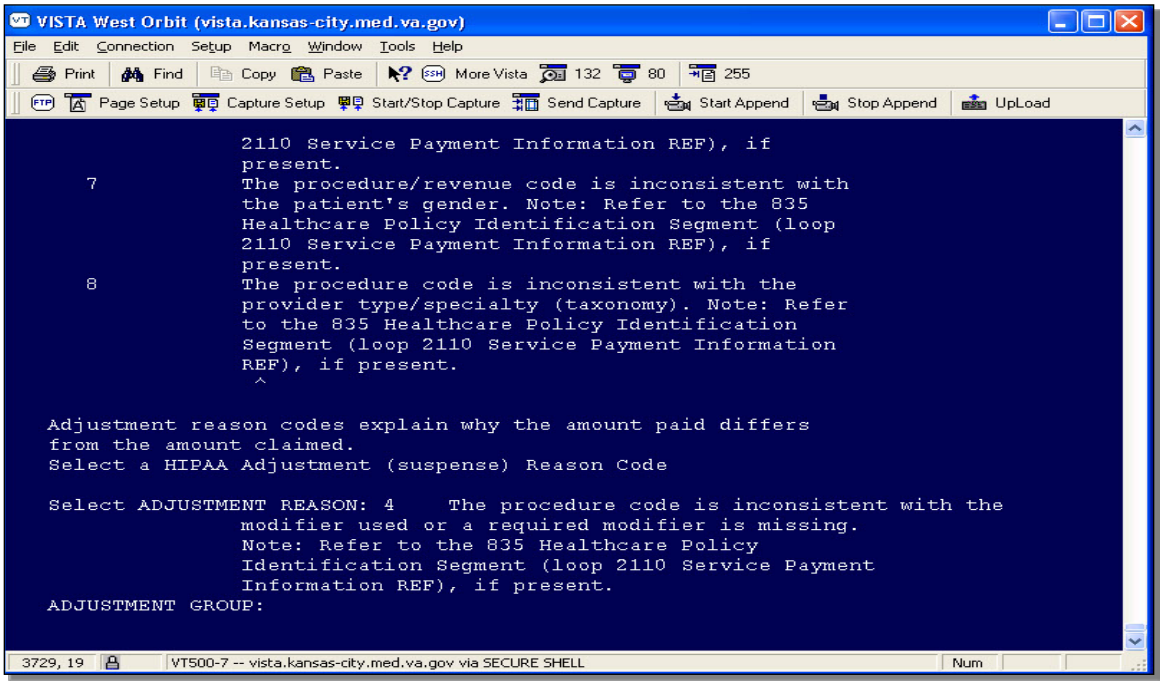
NOTE: Non-payable items must be input with $0.00 payment value with an appropriate adjustment code.



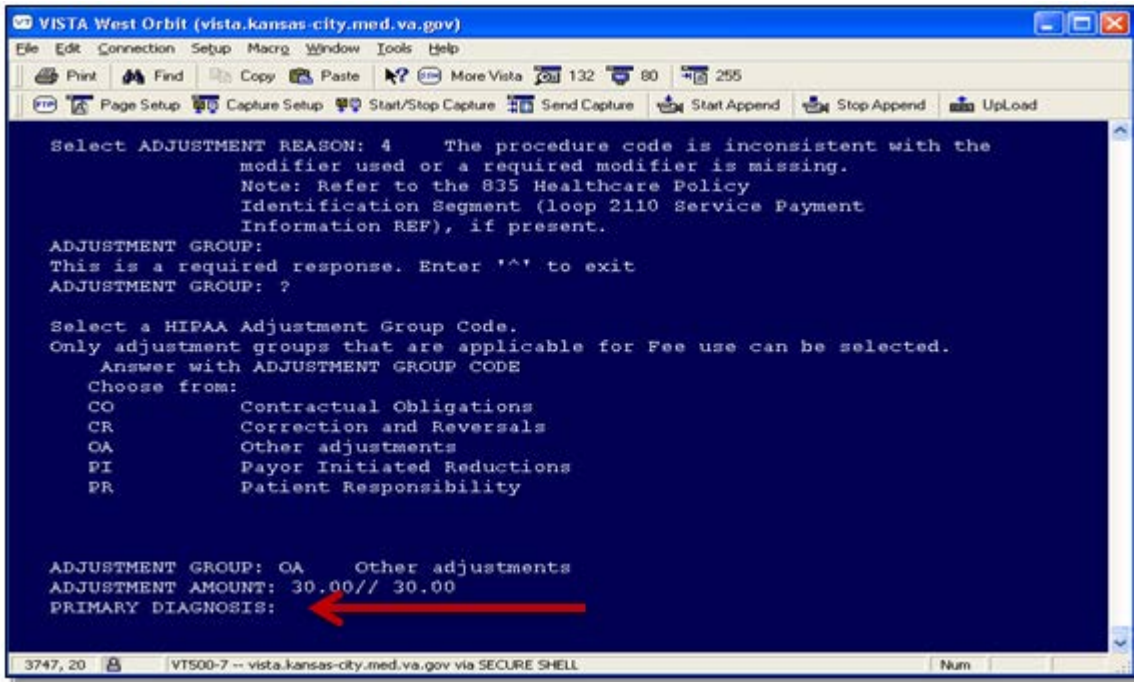
In cases where payment adjustments to the amount claimed are made the user will need to enter an adjustment reason. To obtain the list of adjustment reasons, type "??" at the prompt, and choose the appropriate reason.



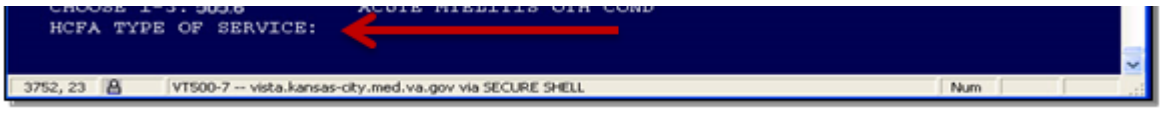
After entering or selecting the adjustment code, the user will be prompted to enter or select an adjustment group code. Type "??" at the prompt to generate a list of choices.



The user must enter a diagnostic code.

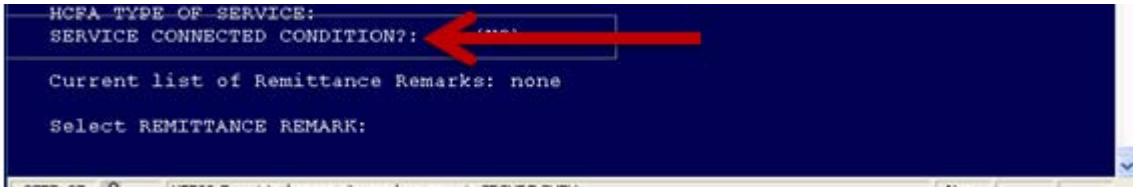


Dental claims are submitted on ADA forms, rather than HCFA forms. Bypass the HCFA"Type of Service" prompt by pressing 'Enter'.

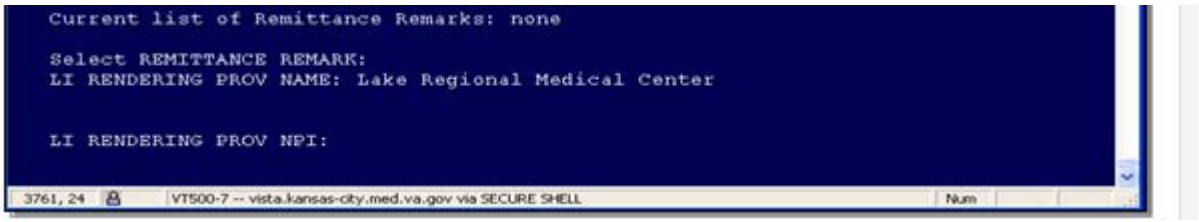


At the "Service Connect Condition" prompt, indicate whether the services were related to a service-connected condition by typing "Y" (yes) or "N" (no).

In the “Remittance Remark” field, enter the remark or type “??” to generate a list from which to choose.



Enter the NPI number found on the claim.

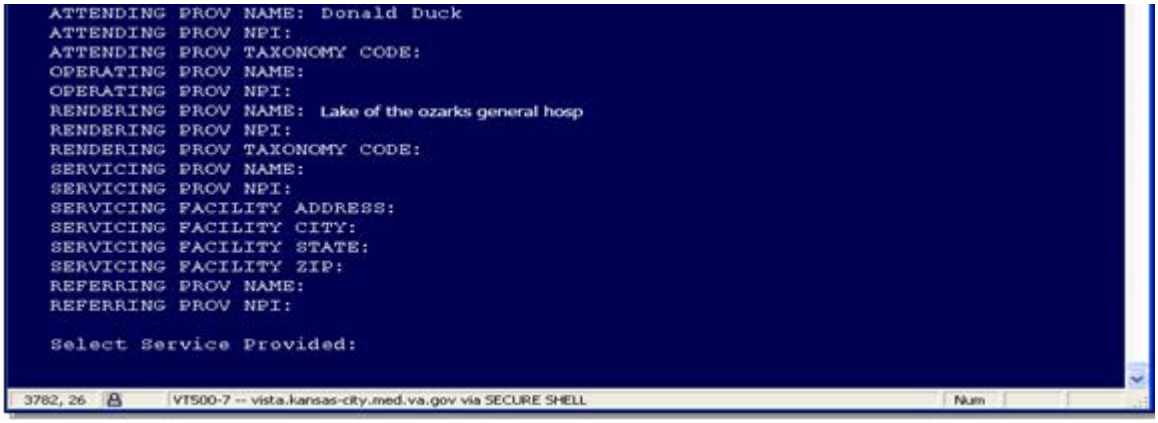


The next prompt asks for the provider taxonomy code. There are no taxonomy codes on dental claims, so the user will bypass this field by pressing ‘Enter’.

The user will enter the name of the person performing the service. The user will type the name of the non-VA provider.

The user would also enter the Servicing Facility demographics along with the Referring provider name and NPI number

After populating the fields, the user will enter the ADA code again.



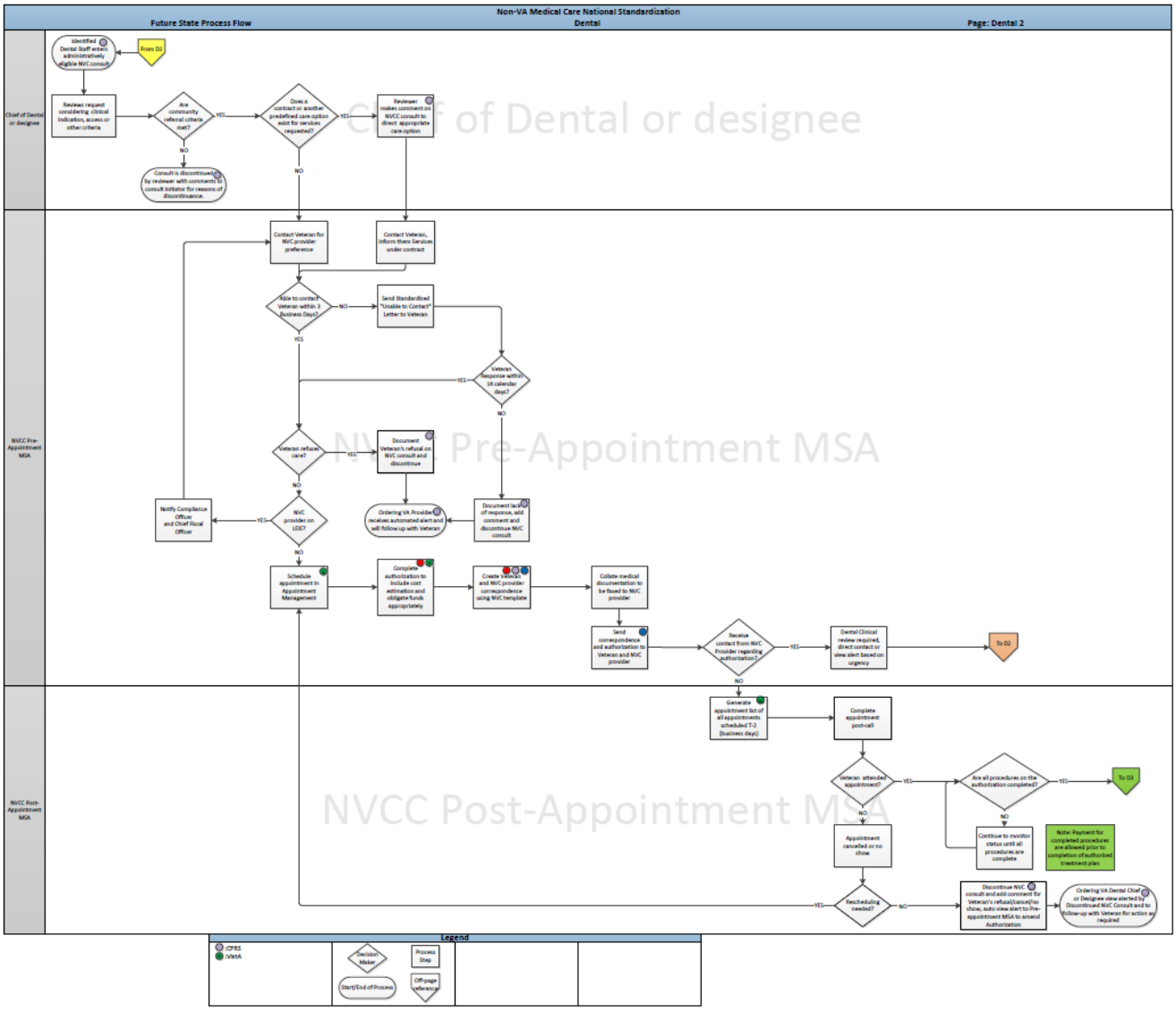
The line item information is now complete. The user must answer each of these prompts for each individual line item. Once all line items on the claim are entered, the user may move to the next claim.

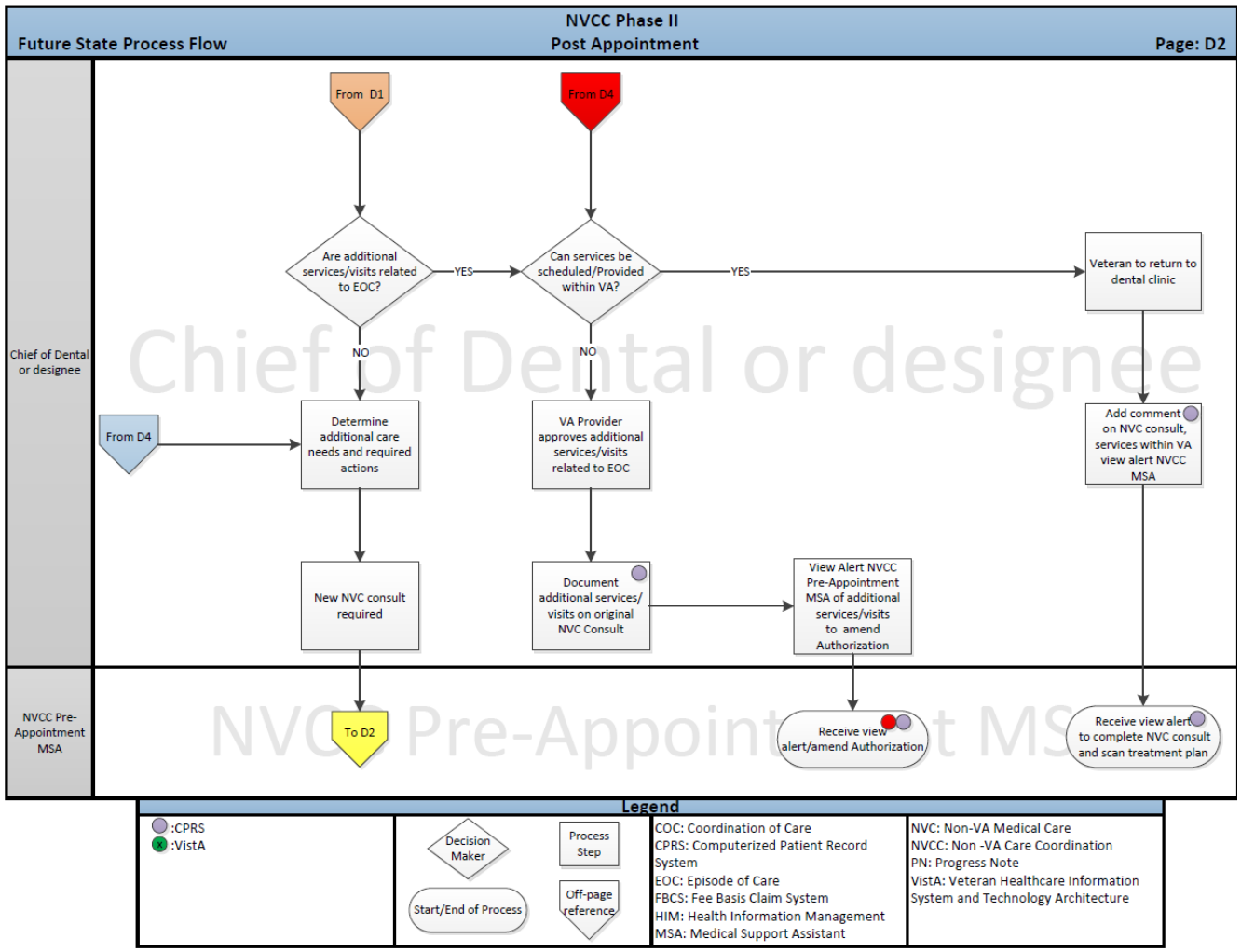
The user must review the claim to ensure all line items were entered appropriately, and none were missed.

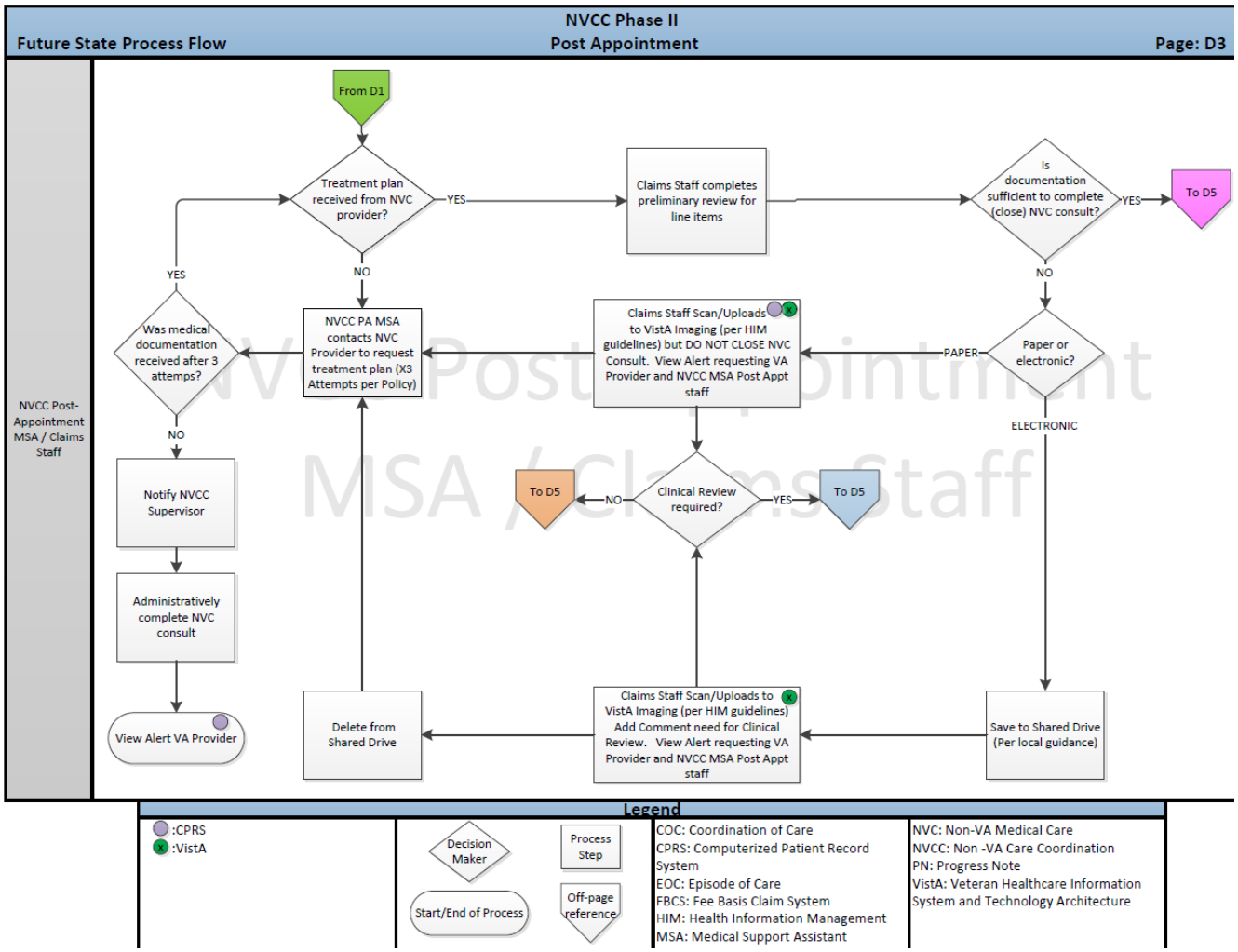
Once all line items are entered, the user may close the batch.

NOTE: It is important to note when finalizing batches, the batches must be finalized in the ***same*** system in *which they were created and released.* Dental batches are processed using the VistA Fee system, so the VistA Fee system must be used to flag rejects and finalize the batches.

Attachment E Dental Process Flow




NVCC Phase II
Future State Process Flow
Post Appointment
Page: D2
Chief of Dental or designee
NVCC Pre-Appointment MSA
From D1
From D4
Are additional services/visits related to EOC?
YES
Can services be scheduled/Provided within VA?
YES
Veteran to return to dental clinic
NO
NO
From D4
Determine additional care needs and required actions
VA Provider approves additional services/visits related to EOC
Add comment on NVC consult, services within VA view alert NVCC MSA
New NVC consult required
Document additional services/ visits on original NVC Consult
View Alert NVCC Pre-Appointment MSA of additional services/visits to amend Authorization
To D2
Receive view alert/amend Authorization
Receive view alert to complete NVC consult and scan treatment plan
Legend
:CPRS
:VistA
Decision Maker
Process Step
Start/End of Process
Off-page reference
COC: Coordination of Care
CPRS: Computerized Patient Record System
EOC: Episode of Care
FBCS: Fee Basis Claim System
HIM: Health Information Management
MSA: Medical Support Assistant
NVC: Non-VA Medical Care
NVCC: Non -VA Care Coordination
PN: Progress Note
VistA: Veteran Healthcare Information System and Technology Architecture


NVCC Phase II
Future State Process Flow
Post Appointment
Page: D3
NVCC Post-Appointment MSA / Claims Staff
From D1
Treatment plan received from NVC provider?
YES
NO
Claims Staff completes preliminary review for line items
Is documentation sufficient to complete (close) NVC consult?
YES
To D5
NO
Was medical documentation received after 3 attemps?
YES
NO
NVCC PA MSA contacts NVC Provider to request treatment plan (X3 Attempts per Policy)
Claims Staff Scan/Uploads to VistA Imaging (per HIM guidelines) but DO NOT CLOSE NVC Consult. View Alert requesting VA Provider and NVCC MSA Post Appt staff
PAPER
Paper or electronic?
ELECTRONIC
Notify NVCC Supervisor
Administratively complete NVC consult
View Alert VA Provider
To D5
NO
Clinical Review required?
YES
To D5
Delete from Shared Drive
Claims Staff Scan/Uploads to VistA Imaging (per HIM guidelines) Add Comment need for Clinical Review. View Alert requesting VA Provider and NVCC MSA Post Appt staff
Save to Shared Drive (Per local guidance)
Legend
:CPRS
:VistA
Decision Maker
Start/End of Process
Process Step
Off-page reference
COC: Coordination of Care
CPRS: Computerized Patient Record System
EOC: Episode of Care
FBCS: Fee Basis Claim System
HIM: Health Information Management
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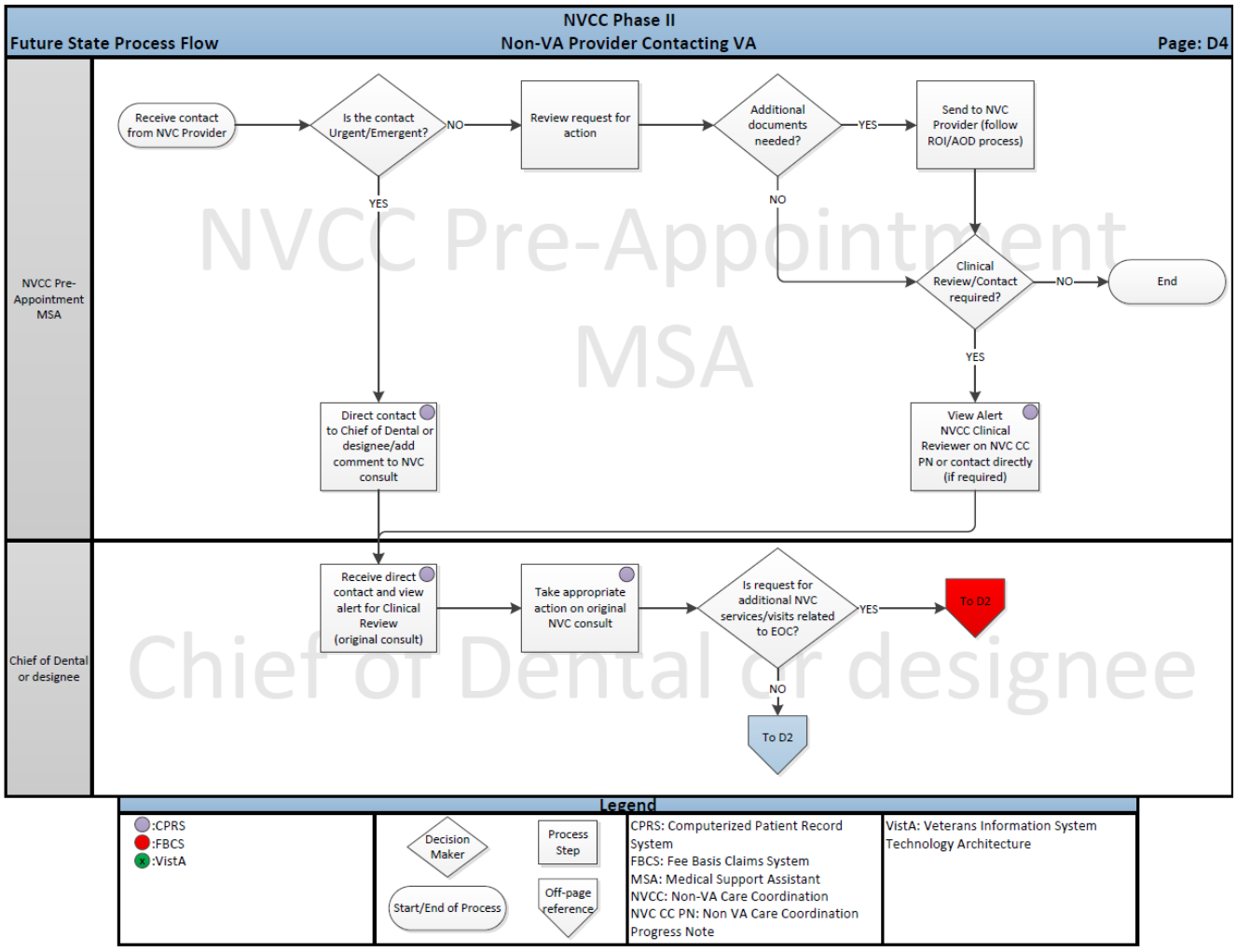
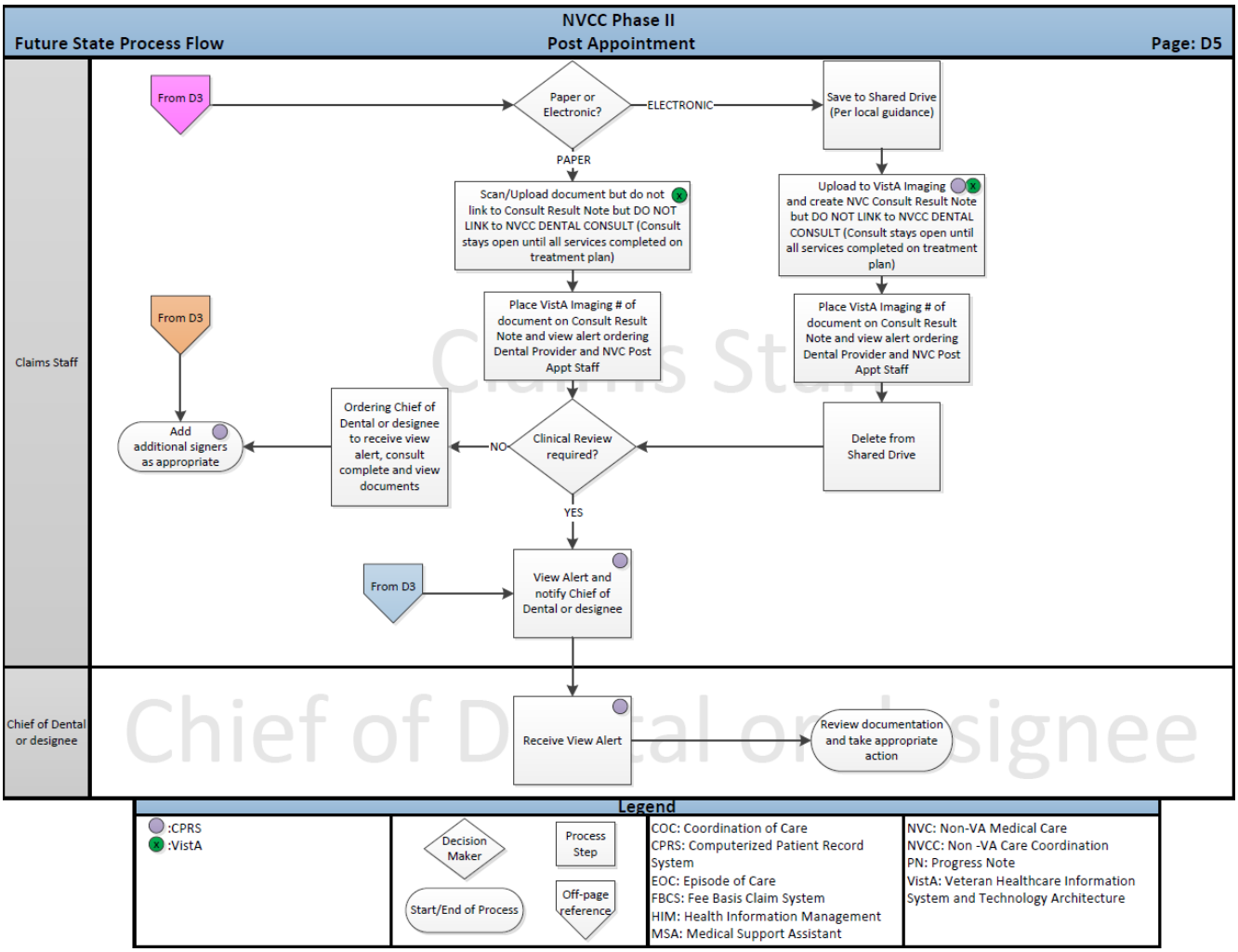

NVCC Phase II
Future State Process Flow
Non-VA Provider Contacting VA
Page: D4
NVCC Pre-Appointment MSA
Chief of Dental or designee
Receive contact from NVC Provider
Is the contact Urgent/Emergent?
NO
YES
Review request for action
Additional documents needed?
YES
NO
Send to NVC Provider (follow ROI/AOD process)
Clinical Review/Contact required?
NO
End
YES
Direct contact to Chief of Dental or designee/add comment to NVC consult
View Alert NVCC Clinical Reviewer on NVC CC PN or contact directly (if required)
Receive direct contact and view alert for Clinical Review (original consult)
Take appropriate action on original NVC consult
Is request for additional NVC services/visits related to EOC?
YES
To D2
NO
To D2
NVCC Pre-Appointment MSA
Chief of Dental or designee
Legend
:CPRS
:FBCS
:VistA
Decision Maker
Process Step
Start/End of Process
Off-page reference
CPRS: Computerized Patient Record System
FBCS: Fee Basis Claims System
MSA: Medical Support Assistant
NVCC: Non-VA Care Coordination
NVC CC PN: Non VA Care Coordination Progress Note
VistA: Veterans Information System Technology Architecture


NVCC Phase II
Future State Process Flow
Post Appointment
Page: D5
Claims Staff
Chief of Dental or designee
From D3
Paper or Electronic?
ELECTRONIC
PAPER
Save to Shared Drive (Per local guidance)
Upload to VistA Imaging and create NVC Consult Result Note but DO NOT LINK to NVCC DENTAL CONSULT (Consult stays open until all services completed on treatment plan)
Scan/Upload document but do not link to Consult Result Note but DO NOT LINK to NVCC DENTAL CONSULT (Consult stays open until all services completed on treatment plan)
Place VistA Imaging # of document on Consult Result Note and view alert ordering Dental Provider and NVC Post Appt Staff
Place VistA Imaging # of document on Consult Result Note and view alert ordering Dental Provider and NVC Post Appt Staff
From D3
Add additional signers as appropriate
Ordering Chief of Dental or designee to receive view alert, consult complete and view documents
NO
Clinical Review required?
Delete from Shared Drive
YES
From D3
View Alert and notify Chief of Dental or designee
Receive View Alert
Review documentation and take appropriate action
Legend
:CPRS
:VistA
Decision Maker
Process Step
Start/End of Process
Off-page reference
COC: Coordination of Care
CPRS: Computerized Patient Record System
EOC: Episode of Care
FBCS: Fee Basis Claim System
HIM: Health Information Management
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