California Dental Network

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NEWSLETTER FOR DENTAL PROVIDERS

Orthodontic Treatment

Orthodontic treatment for CDN Members must be rendered by a participating CDN Orthodontist and the Member must remain eligible during the 24 months of active treatment. Please make sure you have received an approved Specialty Referral form from CDN before Orthodontic treatment is started on a CDN Member. Orthodontic treatment competed by a General Provider is not a covered benefit for CDN Members. If you have any questions, please contact Provider Relations or Member Services.

UPGRADED AND OPTIONAL/NON-COVERED TREATMENT PLANS

CDN'S plans cover a wide range of basic services to treat most aspects of dental disease, with benefits available, by Plan, for specific list o covered services, and sub just to Plan Limitation and Guidelines. Because of the continuing development of new dental techniques and materials there are often a variety of ways to treat specific dental conditions. Many of these new techniques and materials are cosmetic in nature, and may not be listed in the CDT Procedure Codes and Nomenclature. Some dentally necessary but rarely occurring conditions (typically caused by changes to the dentition and periodontium caused by long term neglect or harmful habits) may require non-covered treatments.

When a Member wishes to upgrade his or her covered treatment (ex. have a composite resin filling instead of a dentally necessary amalgam filling on a basic plan, or a crown or metallic onlay instead of a large filling) the Member is responsible for the difference between the UCR of the covered service and the UCR of the upgraded service, plus the co-payment for the covered service. When the treatment being considered is optional (being performed for preventive or cosmetic reasons in the absence of symptoms, decay, or defective restorations) or the Member is electing an enhanced technique when informed of the covered technique, the Member is responsible for the provider's UCR fee for the procedure. The Member is also respon-

Prior Authorization vs Predeterminations for Specialty Care

The Plan requires prior authorization for all specialty care. Generally a preauthorization for oral surgery or endodontics shall be for specific treatment of a particular tooth (ex. extraction tooth #16), or type of care (endodontic referral for tooth #2 –with the endodontist to determine what type of treatment is to be performed.) In these cases the authorization allows the oral surgeon or endodontist to perform an examination and to provide treatment, subject to the listed covered benefits of the Benefit Plan and Plan Limitations and Exclusions. Periodontal and non-urgent pedodontic referrals (and sometimes certain oral surgery or endodontic referrals) are initially for "consultation" with the specialist to submit for a predetermination of benefits.

Predeterminations may be submitted by specialists who desire to know more details about what the Member's benefit is and what the provider may expect to be paid for the proposed treatment (the combination of the copayment paid by the Member, and compensation from the Plan up to the Member's annual limit), and are generally required for periodontal and non-urgent pediatric care.

Predeterminations are not a guarantee of payment; they are a "point in time" estimate. If the Member has received specialty care services elsewhere and the Plan has not yet received that claim, the Member may have already exceeded the maximum that the Plan will pay on the Member's behalf, in which case the Member would be responsible for the amount normally due from the Plan.

Non-urgent referral authorizations are handled by the Plan's Referral Department and must processed at the Plan within 5 business days of receipt.

Predeterminations are processed by the Claims Department and must be processed within 30 business days of receipt by the Plan. Although the Plan endeavors to process pre-determinations as soon as they are received at the Plan, the Plan cannot promise early processing.

To ensure processing and a response from the Plan please be sure to label all predeterminations as such by writing "Pre-determination" on the claim form. Claim forms not so labeled will be assumed to be encounter data, will be entered into the Plan's the encounter data program and then the form will be destroyed.

Don't forget to email or fax the 2 page Facility Survey to:

jlarson@caldental.net or 949-309-2674