California Dental Network

A DentaQuest company

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NEWSLETTER FOR DENTAL PROVIDERS

Emergency Referral Procedures

Emergency referrals, those for Members requiring urgent care for a single symptomatic tooth/area, same–day authorization may be obtained over the phone by contacting Member Services. Please be prepared to explain why the dentist cannot provide emergency pain relief so that a regular referral can be processed. Please note that the Plan does not process urgent referrals to the periodontist. The general dentist is expected to provide periodontal palliative care, including extraction of teeth with poor prognosis, and to complete Phase I therapy prior to referral.

ENCOUNTER SUBMISSION

We want your 2018 Encounter Data!

It is very important that your office submit 2018 Encounter Data for your CDN members.

- Submit Encounter Data on a Universal ADA Claim form. Specify ENCOUNTER on the form.
- Use a computer printout with data equivalent to a Claim Form Information.
- You can send the Encounter Data electronically to CDNClaims@caldental.net. Contact us for details on what file formats are acceptable.
- Mail Encounter Data to California Dental Network at P.O. Box 2428 Laguna Hills, CA 92654-9941.

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.