California Dental Network

A DentaQuest company

CLINICAL GUIDELINES

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Contents

CLINICAL GUIDELINES

GENERAL POLICIES

California Dental Network providers agree, by contract, to render services in accordance with the high standards of the dental profession for competence, care, and concern for the welfare and needs of each Member as set forth in the "Principles of Ethics of the American Dental Association" and the "Dental Practice Act" of the State of California. Dental providers agree not to discriminate in the treatment of Member patients and agree to provide services to Members equal in all respects to that provided to non-member patients of his/her practice. CDN expects dentists to provide services using the same quality and type of materials as used on non- Member patients, and to provide these services in a timely fashion, and properly sequenced.

In compliance with Federal HIPAA regulations, CDN defines benefits in terms of ADA- CDT codes. As codes are revised and updated, Member benefits may be modified to reflect the revised code, including a change in the actual code number when appropriate. In the case of changed code numbers the Member shall still have the appropriate procedure as a benefit, as long as the benefit provided is the same. (Examples: old CDT code 0130 "Emergency oral examination" has been replaced by code D0140 "Limited oral evaluation-problem focused" and codes D1203 "topical application of fluoride – child" and D1204 "topical application of fluoride – adult" have been replaced by D1208 "topical application of fluoride".)

CDN forbids denying benefits or collecting additional co-payments through the practices of upcoding/overcoding, unbundling, or surcharging. Upcoding/overcoding is the use of a procedure code that suggests a more difficult, costly procedure was actually performed (example: charging Member for procedure D7210 "Surgical removal of an erupted tooth that requires elevation of a soft tissue flap, bone removal and/or sectioning the tooth" when procedure D7110 "Uncomplicated single tooth extraction" was actually performed). Unbundling is the practice of dividing a dental procedure into component parts with separate CDT codes and charges so that when added together, the total charge is greater than the charge for the actual procedure (example: charging separately for suturing an extraction site, charging separately for temporary crowns or bridges during fabrication of a new crown or bridge, or charging separately for the routine application of local anesthetic). Surcharging is the practice of charging an additional fee not described by a specific CDT code for a procedure that is normally included in the underlying procedure (example: charging to remove sutures, charging to remove an existing filling or crown during restorative or endodontic procedures, or charging a sterilization/disinfection fee). Procedures found on retrospective review to have been upcoded/overcoded, unbundled, or surcharged will be subject to refund to the Member by the provider or reimbursement through CDN with deduction from the provider's capitation.

Advantage Plan, Advantage Plus, and Cosmetic Benefit Rider Polices supersede some of the Basic Plan Limitations and Exclusions. Offices that accept Members on these benefit programs agree to the modifications of the basic Limitations and Exclusions, and agree to abide with Plan policy regarding the interpretation of the Limitations and Exclusions as they apply to these Plans.

SPECIFIC POLICIES

The Plan provides coverage for dentally necessary treatment under all of its plan designs.

The Plan's basic Limitations and Exclusions are applicable to all basic plan designs (Group and Individual Plans 100 to 695 and UABT plans).

CDN's Advantage Series Plans (designated with the prefix "A") provide coverage for a range of procedures traditionally considered to be upgraded or optional/non covered at listed copayments.

Advantage Plus plans provide coverage for implants in addition to the regular Advantage Plan benefits.

CDN also offers a Cosmetic Benefit Rider to some of its basic plans. Providers who have agreed to accept the Advantage Plans, Advantage Plus plans, or plans with the Cosmetic Benefits Rider agree to perform the procedures or provide the alternative restorative/prosthetic materials listed on those schedules at the listed copayments, even when a less expensive alternative procedure could provide a satisfactory result. Please also refer to the separate section regarding Advantage Plans, Advantage Plus plans, and the Cosmetic Benefits Rider.

The following are clarifications of procedures which frequently are questioned by Plan Members and providers:

- Sterilization/disinfection fees may not be charged separately to Members. OSHA regulations and Dental Board of California regulations require that appropriate sterilization and disinfection protocols be adhered to for all treatments. Some benefit plans do allow for an office visit fee which will be listed on the benefit schedule.
- "Comprehensive periodontal evaluation– for new or established patients" (D0180) - This procedure is indicated for patients showing signs or symptoms of periodontal disease, or who have risk factors for periodontal disease (smoking, diabetes, etc.). It includes many of the same procedures performed in a "Comprehensive oral evaluation" (D0150): evaluation of periodontal conditions, including periodontal probing and charting, a dental and medical history and health assessment; and can include charting of existing conditions (restorations, missing and unerupted teeth, caries, occlusal relationships) and oral cancer evaluation. Therefore this procedure may not be charged separately when performed on the same day by the same provider as the provider performing the Comprehensive oral evaluation. Additionally, it is not chargeable for Members who do not show signs of, or risk factors for, periodontal disease.
- Screening of a patient (D0190), Assessment of a patient (D191), and Re-evaluation – post-operative visit D0171) – these procedures shall not be considered to be an exam for the purposes of Plan Limitations, whether performed in conjunction with, or separately from, other diagnostic procedures.
- Prophylaxis (D1110/20) - includes the removal of all calculus, and plaque to eliminate oral irritational factors, and coronal polishing for removing stains, for elimination of irritating oral factors. Calculus removal can only be performed by a licensed dentist or dental hygienist. Members may not be surcharged for calculus removal. Coronal polishing without the removal of all calculus does not constitute prophylaxis and is below the standard of care.
- "Topical Application of Fluoride" (D1208) vs. "Topical application of fluoride varnish" (D1206) – All children through age 14 are entitled to procedures D1206 or D1208 as part of routine preventive care and all adults are entitled to procedure D1206 or D1208 with no age limit when listed as a benefit on their plan once every six months.

- The topical fluoride must be prescription-strength designed solely for use in a dentist's office, and must be applied separately from prophylaxis paste. In conjunction with the CDT change to D1206 the copayment has been changed on most plans effective January 1, 2013. Check the current benefit schedule for the correct copayment.
- Sealant repair – per tooth (D1353) – may not be charged by the same treating office as placed the original sealant within 18 months of initial placement. GP is responsible for maintaining the integrity of all sealants placed for 18 months following placement.
- "Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis" (D4355) - is diagnostic in nature, not therapeutic. This procedure is performed on patients whose calculus and plaque is so heavy that it prevents the dentist from performing a comprehensive exam including periodontal pocket charting. It is not to be used in place of D1110/20 "prophylaxis" for patients who have heavy supragingival calculus. Members receiving procedure D4355 must have separate and subsequent appointments to provide appropriate therapy (prophylaxis and/or scaling and root planing); otherwise the service performed will be determined by the Plan to constitute "Prophylaxis" and must be charged at the appropriate Plan copayment.
- "Periodontal scaling and root planing, per quadrant" (D4341 and D4342) - includes the removal of plaque and calculus from crown and root surfaces, and smoothing of rough, contaminated dentin and cementum. This procedure is indicated only in patients with periodontal disease that has been documented by a comprehensive exam, including full pocket charting of the affected quadrants. It frequently requires the administration of local anesthetic and considerable time to perform. With the exception of partially edentulous quadrants, where a significant number of teeth are missing, the Plan expects that reasonable treatment should involve no more than two quadrants per visit. More than two quadrants per visit must be justified with appropriate documentation in the progress notes explaining the rationale; otherwise the Plan may, at its discretion, determine that only prophylaxis was performed, and Member may not be charged for root planing.
- D4346 – Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral examination. Requires documentation of qualifying conditions within the chart notes. Failure to have appropriate documentation will cause the Plan to find that D1110/D1120 – Prophylaxis has been performed and the appropriate copayment will apply. May not be performed in conjunction with (on same date of service as) D1110/D1120- Prophylaxis D4355 - Full mouth debridement, D4341/D4342 – Scaling and root planing, per quadrant, or D4910 – Periodontal maintenance.
- D6081- Scaling and debridement of a single implant crown – covered on Advantage Plus plans- is not to be separately charged if performed on the same date of service as prophylaxis or periodontal maintenance.
- "Periodontal maintenance" (D4910) - is only recognized when performed after completion of active periodontal therapy (root planing and/or surgery). Members who have not had root planing or surgery may only be maintained with "Prophylaxis" (D1110/D1120), or "Scaling" (D4346) (in presence of generalized moderate or severe gingival inflammation); which are covered once every 6 months (except as noted on Advantage plans). There is no frequency limitation on Periodontal maintenance therapy.
- "Gingival Irrigation" (D4921)- Shall not be charged when only a rinse is being provided. The listed copayment shall be applied on a per quadrant basis when performed during quadrant scaling and root planing (D4341 and D4342). When performed in conjunction with prophylaxis (D0110), periodontal maintenance (D4910), or full mouth debridement (D4355) the listed copayment shall apply on a per visit

basis, regardless of the number of teeth/areas irrigated. May not be surcharged during any oral surgical, endodontic, or periodontal surgical procedure.

- Clinical Crown Lengthening vs. Gingivectomy/Gingivoplasty to allow access for restorative dentistry. "Clinical Crown Lengthening-Hard Tissue" (D4249) requires reflection of a flap and removal of bone. The Plan allows a charge for crown lengthening only when chart documentation shows flap entry, closure, and bone removal was performed and the crown impression is done at a separate appointment. Soft tissue procedures done at the same appointment as the crown preparation and impression will be considered by the Plan to constitute "Gingivectomy /Gingivoplasty to allow access for restorative dentistry." (D4210 or D4211), and the appropriate co- payment will apply.
- Root canal treatment and retreatment – includes removal of existing restoration (filling, crown, bridge) and any posts pins and buildups, as needed, to perform the treatment. If a bridge must be sectioned to allow removal of only part of the bridge, then the appropriate copayment for procedure D9120 – "Sectioning of Fixed Partial Denture" shall apply.
- "Treatment of Root Canal Obstruction; Non-surgical Access" (D3331) - The Plan defines this procedure as formation of a pathway to achieve an apical seal without surgery when a root canal is blocked by foreign bodies such as separated instruments or broken posts that cannot be removed, or when a canal has at least 50% calcification, by length. This procedure is chargeable only when there is a radiograph showing the foreign body blockage, or a radiograph taken mid-treatment with file in place demonstrating the 50% by length calcification; a post-treatment radiograph demonstrating the achievement of apical seal; and specific progress notes documenting the special procedures performed to bypass the blockage or calcification. This procedure code does not apply to the routine retreatment of an existing root canal which includes routine removal of posts, pins, and old root canal filling material, or to the normal instrumentation of minor canal calcification. Providers using apex locator systems will still have to provide the aforementioned radiographic documentation in order for the charge to be considered valid by the Plan.
- Procedure D3910 "surgical procedure for isolation of tooth with rubber dam." This procedure is chargeable only when there is radiographic, photographic, or detailed narrative documentation of inadequate remaining clinical crown structure to allow placement of a rubber dam, and the procedure shall include reflection of a gingival flap with or without bone removal. Members may not be charged for procedure D3910 for soft tissue modifications (such as laser or electrosurgical cautery/gingivectomy, which appear to be for hemostasis/operator convenience rather than actual clamp placement and retention) in the absence of adequate radiographic or photographic and narrative documentation of need. Narrative documentation alone will be considered inadequate in questionable cases, where gingival flap procedures are not employed.
- For Members offered additional irrigants/medicaments and/or canal filling materials such as Biopure® or MTAD as part of a covered root canal: these materials are considered to be part of their "standard therapy" and the provider may not charge additionally for their use.
- Members may not be charged additionally for temporary closure of endodontic access openings – such temporary closure is considered to be part of the underlying endodontic procedure.
- Procedures to prepare for and/or place posts, and procedures to permanently close endodontic access through tooth structure, or existing restorations (crowns, bridges) are only covered when performed by the general dentist. Members requiring specialist endodontic treatment are to be returned to the referring general dentist to have these procedures performed. In the rare instance where, in the treating endodontist's opinion, it will be too risky for the general dentist to prepare for or place a post, separate

prior authorization must be obtained from the Plan. This will generally rule out performance of the procedure on the same day as the endodontic procedure. Treatment performed by the specialist without obtaining prior authorization will be denied and the Member may not be charged more than the copayment for treatment as performed by the general dentist.

- Root canal treatment vs. extraction – The Plan considers extraction to be a reasonable alternative to restoration of a tooth with root canal treatment, in the majority of treatment plans. When a Member and dentist agree that extraction is an acceptable alternative treatment option, then extraction shall be a covered benefit at the listed copayment. There may be rare instances where the treating dentist believes that saving a tooth or teeth is absolutely critical to the Member's present and future dental health, and that it would be unethical to extract the tooth/teeth. In that case the provider needs to explain this to the Member and if the Member insists on extraction then the provider should recommend the Member seek a second opinion and/or transfer to a new provider.
- Restorative and Prosthetic Procedures – Fillings, inlays, onlays, and crowns are covered benefits to restore teeth with caries, failing restorations (with or without decay), and fractures into dentin. There is no coverage for initial restoration of asymptomatic abrasion/erosion/attrition lesions; or for restorations placed for purely cosmetic reasons. Symptomatic abrasion/erosion/attrition lesions are covered for restoration at copayment if restoration is indicated to relieve the symptoms. Once an abrasion/erosion/attrition lesion has been restored, subsequent replacement of the restoration is a covered benefit. Dentally necessary composite resin restorations are a benefit on all anterior teeth and facial surfaces of bicuspids on basic plans; Members on Advantage Plans or those with the Cosmetic Benefit Rider have coverage for composite resin on all teeth/tooth surfaces, and also have coverage for dentally necessary veneers and porcelain/ceramic inlays and onlays. Porcelain is covered on all crowns and bridges with a separate co-payment for porcelain on molar crown and bridge units. There is no age or frequency limitation on fillings, crowns, inlays, onlays or fixed bridges.
- Restorative and Prosthetic treatment includes removal of the existing restoration (filling, crown, bridge) and any pins and buildups, as needed, to perform the treatment. If a bridge must be sectioned to allow removal of only part of the bridge, with the remainder to serve as a final restoration, then the appropriate copayment for procedure D9120 – "Sectioning of Fixed Partial Denture" shall apply. If a post must be removed, and it is not in conjunction with endodontic retreatment, then procedure D2955 "Post removal not in conjunction with endodontic therapy" shall apply.
- All bases, liners, adhesives, and desensitizing agents (ex. Gluma®), including amalgam and composite bonding agents, are included in the cost of the restoration (fillings, inlays, onlays crowns, bridges, veneers, posts, restorative foundations, and buildups) and Members may not be charged additionally for them.
- Providers may not charge for procedure D3950 – "Canal preparation and fitting of preformed dowel or post" in addition to the charge for the post if the same provider is also placing the post.
- Restorations performed solely to correct contour, contact, or occlusion are generally excluded from coverage. However when the restoration is necessary due to the failure of an existing restoration to provide proper contour, contact or occlusion, due to workmanship, then the restoration is a covered benefit. (Examples: existing filling or crown, improperly contoured, has resulted in an open contact – replacement is covered; Tooth is tipped and existing filling or crown follows the anatomical contour of the tooth, but the tipping must be corrected in a new crown to allow placement of a partial denture – replacement is not covered)

- Fillings - amalgam and resin/composite. Glass ionomer restorations are considered to be resin/composite restorations with identical coverage.
- Composite restorations are, by their nature, cosmetic in addition to functional, therefore, reasonable attempt to match the shade to patient's existing dentition is considered standard of care for a composite restoration. Members may not be surcharged for materials that will "match." Exception is made for documented extreme deviation from normal tooth color patterns (contact Plan prior to providing treatment). Members may not be charged additional for light-cured "bonded" composite. (Please refer to CDT guidelines for amalgam and composite/resin restorations.)
- Posterior composite resin restorations - On basic plans without a listed posterior composite resin benefit for other than the facial surface of bicuspids, posterior composite resins performed in place of dentally needed amalgam restorations are considered to be upgraded, not optional, treatment and Members may only be charged the difference between the office's UCR amalgam and UCR composite fee, plus any applicable co-payments for the covered amalgam filling. Members with Advantage Plans or the Cosmetic Benefits Rider have composite as a covered benefit, at the listed copayments on all tooth surfaces, when the procedure is dentally necessary, is recommended by the dentist, and is not for initial restoration of asymptomatic abrasion, attrition, or erosion. In offices where amalgam is not used, posterior composite resin becomes the covered benefit and must be provided at the co-payment for the equivalent amalgam restoration.
- Cast and indirectly fabricated single-unit restorations (inlays, onlays, and crowns) are a benefit when listed, and when, in the opinion of the treating dentist, the covered amalgam or composite restoration will no longer adequately restore the tooth. There is no frequency limitation on cast and indirectly fabricated restorations and there is no age limit for Members to receive a cast or indirectly fabricated restoration. Veneers, and porcelain/ceramic substrate or indirectly fabricated resin inlays and onlays are a benefit on Advantage Plans and under the Cosmetic Benefits Rider when dentally necessary and when recommended as a restorative option by the dentist.
- Porcelain is a covered benefit for crowns and bridges on all teeth, unless in the treating dentist's opinion porcelain cannot be used (due to lack of space/clearance or limiting condition such as bruxism, etc.). There is a separate (usually higher) co- payment for porcelain fused to metal on molars. Refer to the individual benefit listing for co-payment. Members are responsible for the actual laboratory cost for noble and high noble metals (as indicated by the lab invoice) on basic plans. Advantage Plan copayments include the cost for precious metal on noble and high noble crown and bridge materials. Advantage Plan Members also have porcelain/ceramic and trademarked esthetic crown and bridge materials as covered benefits at listed copayments for dentally necessary inlays, onlays, crowns and bridges. Members may elect to upgrade from a dentally needed filling to a cast or indirectly fabricated restoration (see upgrades). Members are responsible for the actual laboratory cost (as indicated by the laboratory invoice) of rest preparations or guide planes cast/lab fabricated into dentally necessary inlays, onlays, crowns, or bridges in preparation for removable partial denture procedures. Precision attachments and stress-breakers are not covered, nor are cast or indirectly fabricated restorations performed solely for the retention and support of removable partial dentures; and the Member is responsible for the office's UCR fee for these procedures.
- Crowns are covered benefits on endodontically treated teeth where decay or occlusal load indicates. Posterior teeth in occlusion with other natural teeth or fixed prosthetic restorations, or that support a removable prosthesis, are considered to have occlusal loading that requires cusp protection after endodontic therapy; therefore crowns are covered benefits on these teeth. Exception is made for teeth

that have no prior restoration, carious involvement, cracking or fracture, where endodontic therapy is performed solely to relieve symptoms, and the access opening is minimal and does not undermine the tooth structure.

- Crown and bridge unit coverage is limited to 5 units per arch per year. Time is considered to be one year from the placement of the first unit in the treatment plan (rather than per calendar year). Unit coverage is by tooth number in the arch, regardless of position in the arch for single phase treatment plans; for multiple phase treatment plans the first teeth/tooth positions, by tooth number, in each phase will be considered covered, up to 5 units per arch per treatment year.
- Porcelain failure on existing crowns or bridges-
    - With the exception of anterior crowns, if the porcelain failure is cosmetic in nature only, then replacement is not a covered benefit. Porcelain failure that results in a functional defect of a crown or bridge that cannot be repaired, and is not due to negligence or harmful habits, is covered for replacement.
    - A functional defect is considered to be a failure that prevents the crown or bridge from performing its intended function and/or providing adequate protection, including:
        - Maintaining contact to prevent shifting of neighboring or opposing teeth.
        - Preventing interproximal food entrapment.
        - Maintaining marginal integrity to prevent recurrent decay.
        - Permitting normal function: biting, chewing, and discluding, supporting or retaining an existing prosthesis.
    - Porcelain failure on anterior crowns is additionally covered when the metal substrate is exposed on visible (facial, incisal, and interproximal) surfaces.
- Repairs to inlays, onlays, veneers, and bridges due to restorative material failure (procedures D2981, D2982, D2983, D6980) – these procedures may not be charged by the same provider who placed the restoration within 24 months of the original restoration; the provider is responsible for repairs at no charge to the Member during the first 24 months following placement.
- Provisional crown (D2799) – is covered when the final impression cannot be taken the same day. Crown procedures include temporization so this code is not to be charged for routine restorative procedures. Only one provisional crown will be covered per incidence of tooth or restorative failure requiring a provisional crown.
- Dental Coping (D2975) - The CDT descriptor for procedure D2795 – Coping is: “A thin covering of the coronal portion of a tooth, usually devoid of anatomic contour, that can be used as a definitive restoration.” The common use for a coping is to protect an endodontically treated tooth that has had the coronal portion removed and is being used as support for an overdenture. Occasionally a coping is needed to correct the angulation of a tipped tooth so that the finished crown can be seated onto the tooth. The coping is cemented to the tooth and provides the marginal seal to the tooth to protect it. The finished crown is then separately cemented to the coping to complete the restoration process. In these or similar situations, a separate charge for the coping is appropriate. This is not to be confused with the use of the term coping for the substrate (metal or ceramic) of a crown or bridge that resin or porcelain is fused to. When a crown is fabricated by applying porcelain or resin to a coping such that the finished restoration is a single unit, the copayment for the crown includes the cost for both the coping/substrate, and the porcelain veneered to it. While some of the Plan’s benefit designs allow the provider to charge additionally for the lab cost of any high noble metal used in a crown or bridge (this would apply to porcelain fused to high noble and porcelain fused to noble metal crowns and bridge abutments and

pontics) others include the lab cost of high noble metal in the copayment, and the member may not be charged additionally. The Plan allows a separate charge for a coping only when the coping alone will be used as the definitive restoration, or when the coping will be cemented to the tooth, and then a complete crown will be separately cemented to the coping.

- Prosthetics - Generally the covered benefit to replace missing teeth is a removable partial denture. A fixed bridge is the covered benefit when replacing a defective bridge that has the same abutments and replaces the same teeth as the original bridge, and when no other teeth in the same arch must be replaced to restore arch integrity. (Arch integrity can be by existing sound prosthesis. Example: Member has a defective 4-unit anterior fixed bridge and also has a sound existing partial denture replacing 5 posterior teeth - the covered benefit is a new 4-unit bridge). A 3-unit fixed bridge is also the covered benefit for initial replacement of a single missing tooth, where appropriate abutment teeth are available. Covered fixed bridgework has no frequency or age limitation.
- Provisional abutments (D6793) and pontics (D6253)- are covered benefits when replacing anterior teeth one of which has been removed (by extraction or by removal of an existing failing apparatus) while covered by the Plan, or posterior teeth where an existing fixed bridge has been removed; when the final impression cannot be taken, and only when an existing prosthesis cannot be modified to function as an interim. All crown and bridge procedures include temporization so provisional pontics and abutments are not to be charged for routine restorative procedures. Only one interim prosthesis will be covered per incidence of lost anterior tooth, or lost existing bridge.
- Immediate, interim, or permanent complete and partial dentures–Routine post-delivery care is included, including all needed adjustments for 6 months following placement of the prosthesis. Members must be allowed reasonable and timely access to the office for adjustments during this post-delivery period. Interim partial dentures (“stayplate”, “flipper”) are a covered benefit only when replacing anterior teeth, one of which has been removed (by extraction or by removal of an existing failing apparatus) while covered by the Plan, and only when an existing prosthesis cannot be modified to function as an interim. Only one interim prosthesis will be covered per incidence of lost anterior tooth.
- The Plan covers one permanent, removable, complete or partial denture per arch every 5 years, including immediate dentures. The 5-year clause shall only apply to the subsequent replacement of a prosthesis made while the Member was covered by the Plan; it does not apply to the age of a prosthesis made prior to coverage by the Plan, therefore if a Member has a prosthesis made prior to coverage by the Plan that needs to be replaced, and that is less than 5 years old, replacement is covered at copayment. The same is true of lost or stolen prosthesis: the replacement exclusion only applies to lost or stolen prostheses that were made while covered by the Plan. Members receiving a provisional or interim partial denture, while enrolled in the Plan, are still entitled to placement of the permanent partial denture as a covered benefit, regardless of the condition (functional, relineable/repairable) of the interim prosthesis, once the dental/periodontal condition is considered stable to place it. Partial dentures may be replaced more frequently than 5 years if there is additional loss of natural teeth and the existing partial denture cannot be adequately modified to include the lost teeth.
- Members treatment-planned for an immediate full denture to be followed at a later date by a permanent full denture shall be entitled to have the first (immediate) prosthesis at the listed copayment. Interim complete dentures are not a covered benefit, however Members may not be charged for interim dentures when immediate dentures (those placed in conjunction with but not necessarily the same day as extractions) are being performed.

- Offices may charge the laboratory invoice cost difference for upgraded vs. basic teeth on covered partial and full dentures, as long as the Member is offered the option of having standard denture teeth at copayment. Alternative denture and partial denture materials are not a covered benefit on basic plans and, as long as the Member has been offered standard full/partial dentures at listed copayments, providers may offer alternative materials at UCR fees. Alternative denture and partial denture materials are a covered benefit on Advantage Plans at listed copayments. Contact the Plan for an updated list of currently covered materials and their applicable copayments for Advantage Plans.
- The California Dental Practice Act requires that every full upper or lower denture shall have the name or social security number of the patient permanently inscribed in the denture unless the patient objects, and that the patient may elect whether the name or the social security number is used. Providers may not charge additionally for this – it is included in the copayment for the denture.
- Members on basic plans are responsible for the cost of any pre-prosthetic tissue conditioning needed prior to placement of the permanent prosthesis, or during the healing phase of an immediately placed prosthesis. Members on Advantage Plans have tissue conditioning as a covered benefit at the listed copayments. Members on basic plans with existing standard resin base or metal framework partial dentures that cannot be repaired or relined are entitled to replacement with the same type of partial denture, as long as no additional teeth must be added (typically due to extraction). This means that Members with cast metal framework partials are entitled to replacement with cast metal framework partials; and Members with resin base partials are entitled to replacement with resin based partials, unless, in the treating dentist's opinion, the dental conditions will require a different type. In that case, the different type is covered, if listed on the benefit schedule.
- Members on basic plans may upgrade from a resin base partial to a cast metal framework partial. This does not apply to Members whose existing prosthesis is a type not normally covered by the basic plan, such as thermoplastic or precision attachment partials. Dentists must offer a covered benefit partial denture material to patients whose dental condition could be treated with a covered material; dentists who do not use traditional resin base or metal framework partials must honor the metal framework copayment for the material being used. (See separate Advantage Plan and Cosmetic Benefits Rider provisions)
- Custom tray impressions- Custom trays do not have a CDT code and custom tray impressions are considered to be a part of full/partial denture treatment, therefore dentists may not charge additionally for custom tray impressions.
- Unusual cases where a Member's dental condition cannot be treated by any Plan- covered partial or full denture material or technique, must be documented to the Plan and approved prior to treatment, and are subject to second opinion evaluation, as there is no benefit for Members whose physical or behavioral limitations preclude treatment with Plan-covered materials. Failure to do this prior to performing treatment may result in the Plan retrospectively determining that the dentist may charge for the non-covered material/procedure only the listed copayment for the Plan-covered full/part denture material/procedure.
- Members are responsible for the actual laboratory cost (as per the actual lab invoice) of any mesh, wire, or metal bar reinforcements incorporated into new partial or complete dentures. Members are also responsible for the actual lab cost of mesh, wire, or metal bar reinforcements placed as a repair or modification of an existing partial or complete denture in addition to the co-payment for the repair. Placement of, or repair of, precision attachments or stress breakers is not a Plan benefit. There is no coverage for repair or reline of existing non-covered thermoplastic partial or full dentures on basic plans

only – coverage is available on Advantage Plans (contact the Plan for allowed charges in excess of copayments listed for reline/repair of non-thermoplastic partial or full dentures). The Member is responsible for the office's UCR fee for those non-covered procedures.

- Oral surgical procedures—Include local anesthesia, suturing, if needed, and routine post- operative care. Dentist may not charge additionally, (or under D7999 code) for more difficult or time consuming extractions or other oral surgical procedures that do not involve other CDT-coded procedures. Extractions include "minor smoothing of socket bone."—Charges for alveolectomy or alveoplasty in conjunction with extractions, and not in preparation for partial or full dentures, require documentation of unusual circumstances. Members who refuse non-covered adjunctive procedures, such as socket preservation bone grafts, are still entitled to the underlying extraction at copayment. Socket preservation grafts must have a reasonable rationale for placement such as preservation of bone for a future prosthesis. The Plan is especially concerned when bone grafting is done in 3rd molar extraction sites when there is no evidence of bone loss on the adjacent tooth, and areas where no prosthesis is planned. In cases of disputed charges for bone grafting the Plan expects to see explanation for the rationale behind placement of the graft in the site; in the absence of such documentation the Plan may disallow the charge.
- Adjunct procedures - D9610 and D9612 – Therapeutic parenteral drug- is to be used to report medications delivered parenterally that will have a systemic effect. Examples would include antibiotics, anti-inflammatory, and other drugs that will have an effect outside of the confines of the tooth root canal system. D9630 "Other drugs and/or medicaments by report" – is to be used for drugs dispensed by the office for home use. These codes are not to be used for irrigants and disinfectants used inside the root canal system as part of the endodontic therapy, including, but not limited to Biopure® and MTAD. The claim for D9610 and D9612 must include a detailed narrative including the name of the medicament, indication for use, method and location of administration and intended systemic effect. Failure to submit the appropriate support documentation will cause the Plan to deny the procedure; and the Member may not be billed for the denied procedure(s).

"999" PROCEDURE CODES

The Plan discourages use of 999 miscellaneous procedure codes. Where there is a need to provide a service that can only be described by a 999 code, the Plan should be consulted prior to any work being done. Where the procedure involves additional materials or techniques to complete a Plan covered procedure, (examples: placement of clotting agents in an extraction site) the Plan will generally allow only the actual incremental cost of the material used at that time. If an additional lab procedure (rest seats on dentally necessary crowns or splinting of two dentally necessary crowns) is required, the Plan will allow the actual laboratory invoice charge for the additional procedure. In the case of disputed charges for "999" procedures that were not pre-authorized, the Plan reserves the right to determine the appropriate charge, and to direct offices to refund any inappropriate charges.

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 a specific list of covered services, and subject to Plan Limitations and Guidelines (see additional information regarding Advantage Plan and Cosmetic Benefits Rider provisions). 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.

Whenever a Plan Member and the treating Plan dentist are considering treatment plans with enhanced, cosmetic, or elective procedures, the Member must be clearly advised as to the availability and cost of the procedures that are covered by the Plan and those that are optional, so that an informed choice can be made.

In the event that a contracting provider does not provide certain covered services/materials in his or her practice and there is no alternative covered benefit, then the optional or enhanced service or material becomes the Plan-covered benefit, at the co-payment for the covered service/material. (Example: offices that do not provide amalgam restorations must provide posterior composite restorations at the amalgam co-payment to Members on basic plans; however offices that do not routinely do non-precious metal crowns even though they are listed on the benefit schedule may offer porcelain fused to gold as the listed, covered-benefit crown.)

A form for informed consent for upgraded and optional/non-covered treatment is included for your use. This form or an equivalent, clearly marked, alternative must be completed by the provider and signed by the Member, prior to the start of treatment for upgraded, optional, cosmetic, or enhanced material/technique procedures. In the event of disagreement or dispute about covered benefits, failure to have this form or its equivalent properly filled out, signed and dated, will result in the Plan determining all coverage and fees for the treatment rendered.

A Member's refusal of an upgraded, non-covered, or optional treatment plan will not preclude him or her from receiving covered services, except to the extent that lack of such procedures prevents adequate performance of subsequent procedures.

Examples:

- Members who decline periodontal irrigation or soft tissue management programs, or antimicrobial agents such as Arestin®, are still entitled to all covered periodontal procedures including root planing, prophylaxis, periodontal maintenance, and periodontal specialty referral, when indicated;
- Members who decline bone replacement grafts are still entitled to extraction at copayment;
- A Member who has a non-carious super-erupted tooth that prevents placement of an adequate removable partial denture unless the super-eruption is first corrected by a non-covered crown or by a covered extraction of the super- erupted tooth, may not insist on having the partial denture made without the corrective procedure;
- A Member who needs clinical crown lengthening to allow placement of a crown or bridge may not insist that the treatment be performed without it.

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 responsible for the cost of non-covered procedures.

Examples of Upgrades on basic plan types—Dentally necessary posterior filling upgraded from amalgam to composite or upgraded from amalgam to a cast metallic inlay, onlay, ¾ crown, or full coverage (full metal or porcelain-fused-to-metal) crown; dentally necessary acrylic partial denture upgraded to cast metal framework partial; dentally necessary partial upgraded to fixed bridge.

(Note: Prefabricated crowns (procedures D2929, D2930, D2931, D2932, D2933, D2934)– LEAT provisions shall not apply to these procedures if other Plan-covered crowns are a recommended alternative for dentally necessary treatment, and no upgrade fees will apply. For example – the dentist has recommended a porcelain fused to high noble crown (D2750) for a permanent tooth but has also listed a stainless steel crown D2931) as an alternative treatment. Either crown shall be covered at the listed copayment.

Examples of Optional Treatment (on basic plan types)—Dentally necessary filling or metallic inlay or onlay restored with a ceramic or lab-processed resin inlay or onlay. Dentally necessary partial denture covered in resin based material but Member opts for a thermoplastic material (such as Valplast®).

Examples of Non-Covered Treatment—Placement of a crown to improve retention/support of a partial denture; adding an additional, non-carious tooth to a fixed prosthesis (splinting solely for the purpose of support or retention).

GUIDELINES FOR ENHANCED TECHNIQUES AND MATERIALS

Crown and Bridge and Inlay/Onlay Materials/ Procedures - CDN's basic benefit plans provide for resin, resin to metal, full metal and porcelain fused to metal crown and bridge restorations. The type of metal used in these restorations does not change the way the tooth is prepared by the dentist, therefore the only additional fee that may be charged is the actual lab cost (as indicated by the actual laboratory invoice) for the additional cost of noble, high noble metals, or titanium. Porcelain margins and trademarked cosmetic or special feature porcelain or resin fused to metal crown and bridge materials such as Bio-2000®, Captek®., Golden Gate®, etc. are considered to be non-covered options on basic plans only if the Member is first offered the covered crown or bridge material as a treatment option, and has signed a covered/optional treatment form acknowledging his/her awareness of the availability and cost of the Plan-covered material. CDN basic plans provide for metallic inlays and onlays when indicated by the treating dentist, with the Member responsible for the lab cost of noble metals, high noble metals, or titanium. Porcelain/ceramic, resin-based indirect composite, and trademarked nonmetallic inlay and onlay materials such as Procera®, Lava®, Cerec®, E-Max®, are not covered on basic plans and the Member is responsible for the dentist's UCR fee if these materials are selected. If, in the opinion of the treating dentist, the covered tooth or area can only be treated with a non- conventional crown/bridge or inlay/onlay material (and this restriction is not due to some medical/physical/behavioral condition of the Member), then that material becomes the covered benefit and the Member may only be charged their co-payment plus that portion of the actual lab invoice fee that exceeds the lab's usual fee for a covered material. When a Member on a basic plan questions or disputes the fee charged for a crown, bridge, inlay, or onlay, only the actual lab invoice will considered when determining the Member's responsibility. If the office is unable to produce the actual lab invoice then CDN will determine a fee based on fees charged by labs in the area for those procedures and materials.

Removable Prosthetic Materials/Procedures-Members on basic plans who wish to upgrade the type of teeth in their conventional full or partial dentures are obligated for the difference between the laboratory cost of the

upgraded teeth and the basic teeth, as indicated by the actual lab invoice, plus their co-payment. In the case of treatments for Members on basic plans involving thermoplastic partial and full denture materials, "customized" dentures, or precision attachment and implant supported appliances, or overdentures, the provider may charge UCR only if the Member has been clearly advised of the available covered treatment and/or material and its cost, and has signed a covered/optional treatment acknowledgment form.

Treatments using enhanced techniques such as air abrasion, laser, and computer- assisted anesthetic delivery, etc. – CDN determines benefits by CDT-procedure codes, not by the technique used to perform the procedure. Offices may charge additionally for these and other techniques which are not, at present, widely adopted in the dental community to provide covered treatment, as long as the Member is given the option of receiving their covered treatment using accepted standard techniques. If the office only offers enhanced techniques and delivery methods, then the Member may not be charged additionally.

As particular advanced techniques and materials become widely adopted the covered procedures and co-payments will be adjusted as needed. (Example: Thirty years ago light-cured or "bonded" composite was considered an enhanced technique/material; now it is considered standard and offices may not surcharge for it.) The Plan reserves the right to determine when a technique or material moves from "enhanced" to "standard".

ADVANTAGE PLANS

Members on Advantage Plans (with an "A" prefix) have an expanded list of procedures and materials available for dentally necessary treatments at listed copayments. Offices seeing Advantage Plan Members agree to provide the listed procedures at the listed copayments, when the procedure is presented by the treating dentist as a recommended treatment option.

Specific Advantage Plan Policies in addition to those previously listed:

- The full range of inlay, onlay, crown and bridge options listed by CDT code on the benefit schedule is available to the Member at the listed copayment, with no additional fee for laboratory costs, when dentally necessary and when recommended by the dentist. Advantage Plan Members may also optionally select from a variety of trademarked crowns such as Captek®, Lava®, Procera®, E-Max®, etc., as well as trademarked inlay/onlay materials such as Empress®, E-max®, or Cerec®, when offered by the treating dentist. (The Plan is constantly updating its list of trademarked materials. Please call the Plan for copayment on any material not listed on the printed benefit schedule). Dentists may not insist on providing only trademarked crown and bridge/inlay-onlay materials. Dentists who offer only trademarked crown and bridge/inlay-onlay materials must offer those restorations at the copayment listed for the CDT-code described class of material being used, even if that material provided optionally would have a higher fee. (Example- Dentist only provides Lava® crowns in his/her practice. The applicable copayment would be that listed for procedure D2740-- porcelain/ceramic substrate – copayment range $225-$400, not that listed for Lava® [$650-$750]).
- Similarly, dentists may not insist on providing only trademarked denture and partial denture materials rather than materials that satisfy the CDT descriptions for covered materials. These trademarked materials (which like crown and bridge materials are constantly being updated – call the Plan for copayment on any unlisted material) are options available at listed copayments when the Member has also been offered the basic material described by the pertinent CDT code; when trademarked materials are the only material the practice uses then the basic copayment shall apply, even if that material offered optionally would have a higher fee.

- Advantage Plan Members who will be receiving initial placement of a 3-unit bridge that replaces a single missing tooth or replacement of a failing existing bridge with one of the same span and abutments/pontics as the original bridge are entitled to have the bridge performed in any of the listed standard or trademarked materials at the listed copayments, when recommended by the treating dentist.
- For Advantage Plan Members missing more than one tooth in the arch that will be prosthetically replaced for the first time, the covered benefit is a removable appliance in any of the listed standard or trademarked procedures at the listed copayment as recommended by the treating dentist. Advantage Plan Members may elect to upgrade from a covered removable partial denture to a fixed bridge. In this case the listed copayments do not apply and the standard upgrade calculation shall apply.
- Advantage Plan Members have subgingival antimicrobial irrigation as a covered benefit (under procedure code D4921 "Gingival Irrigation" The Plan's policy on irrigation is that the copayment for the procedure shall be on a "per quadrant" basis only when utilized in conjunction with scaling and root planning (D4341, D4342) and on a "per visit" basis when in conjunction with prophylaxis (D1110, D1120), full mouth debridement (D4385) or periodontal maintenance (D4910).
- Advantage Plan Members also have coverage for procedure code D9630 – "Drugs and medications dispensed in the office for home use" This does not include medications applied in the office or prescriptions written by the provider for medications to be purchased elsewhere.

Implants

Advantage Plus plans also include coverage for some implant related procedures. On these benefit plans single implants to replace single missing teeth shall be considered to be a covered benefit when recommended by the general dentist. Members who decline implants shall still be entitled to a 3-unit bridge to replace a single missing tooth.

COSMETIC BENEFITS RIDER

Some basic plans also have a Cosmetic Benefits Rider to their basic benefits package. Members on these plans are eligible for certain upgraded, optional, or cosmetic procedures at reduced fees, (at offices that accept those plans), when recommended by the dentist. Refer to the Cosmetic Benefit Rider for the list of covered procedures/materials and applicable co-payments. Contact the Plan for a list of benefit plans that include the Cosmetic Benefits Rider.

In general, Members with the Cosmetic Benefits Rider may not be forced to accept a procedure or material listed on the Rider in place of the covered treatment procedure or material listed on their basic Plan coverage. (Examples: in the case of fillings the Member may not be forced to accept composite fillings instead of amalgam; if the dentist does not use amalgam then the Member is entitled to the composite filling at the amalgam filling fee instead of the Cosmetic Rider fee for composite. In the case of inlays and onlays if the dentist is recommending a ceramic or resin inlay or onlay as an alternative to a metallic inlay or onlay, the Member may not be forced to accept the ceramic inlay or onlay, and the dentist is then obligated to perform the covered metallic inlay or onlay if the Member declines the ceramic or resin option. However, if the ceramic inlay or onlay is being offered as an alternative to a filling or crown, the Member may not insist on a metallic inlay or onlay if the dentist does not agree that this procedure is appropriate, but the dentist must agree to perform the alternative covered filling or crown at the listed copayment.)

The Cosmetic Benefit Rider fees apply only to treatment that is dentally necessary, and recommended as a treatment alternative by the dentist. With the exception of whitening, these fees do not apply to wholly cosmetic treatment such as optionally replacing dentally sound amalgam fillings with composite or placing veneers solely for contour, alignment, space closure, or color improvement (vs. restoring a decayed or damaged tooth with a veneer instead of a filling or crown).

WHITENING BENEFITS

Dental offices may offer alternative external in-office and take home tooth whitening treatments to the Advantage Plan and Cosmetic Benefits Rider covered whitening systems, but must offer a covered system if their office offers either in-office or take- home external tooth whitening. The Plan requires that the whitening system offered by the dentist must be of a prescription type, not available to the general public as an over-the-counter system, and that the system be offered in a manner and/or quantity/dosage determined by the manufacturer to be effective. There is no requirement that dentists who do not already offer either in-office or take-home whitening to other patients of their practices offer such whitening to Plan Members. The provider is responsible for determining the actual in-office or take-home system used in his or her office that will be considered the covered benefit, and what alternative systems of either type he or she may offer that would not be covered under the Plan.

INCOMPLETE TREATMENT

The dentist shall be entitled to retain part of the copayment for dental work, involving laboratory costs, that is not completed due to member-caused issues (non- compliance-i.e. multiple appointment failures, physical or behavioral changes, accident/death, member chooses to transfer out). The reasonable amount retained shall not exceed the dentist's actual costs (lab invoice costs plus reasonable office materials and labor determined by the plan), at the point where treatment is discontinued, nor shall it exceed the listed copayments, even if the listed copayment is lower than the lab cost.

WORK IN PROGRESS

The placement/presence of a sedative temporary filling, with or without the start of endodontic therapy (gross pulpal debridement, pulpotomy, pulpectomy) or a temporary crown or bridge (with or without an impression for final crown) will not be considered to be "work in progress" for the purposes of coverage determination at a subsequent provider office.