A summary of DENIS dental benefit management methodology for dental professionals, to be read in conjunction with the DENIS Benefit Guides for 2018 which describe individual scheme benefits.
Rationale for Benefit Management

Schemes have limited budgets for dental treatment and some form of management must be applied to remain within this budget. With DENIS, scheme dental benefits are limited by treatment definition and overall financial limits do not apply on our full cover options. The positive aspect of this approach is that members are not disadvantaged by financial limits which are affected by other treatment received during a given period or by treatment received by other family members or even other disciplines. For example, some schemes pay dental from a “day-to-day” limit. However, that financial pot also pays for other treatment such as acute medicine. Members will often forgo dental treatment and try to preserve their day-to-day limit for important medication. This is an effective and equitable way to ensure that members have reasonable access to dental treatment throughout the benefit year and which is paid for by the overall scheme risk pool. This must be seen in contrast to a medical savings account which is not scheme money; it is the members’ own funds.

Referral to Specialists

Benefits for specialists are usually only considered if there was a referral from a general dental practitioner. This excludes treatment for prescribed minimum benefit conditions (PMB). This is to ensure that the member is aware of possible benefit restrictions before they arrive at the specialist. If the scheme option does not offer specialised dental benefits, no benefits are available for treatment rendered by dental specialists.

Orthodontists
Most of our schemes offer orthodontic benefits. A needs analysis is done to ensure that deserving members receive orthodontic treatment. Patients must be aware that the benefit offered by the scheme is not automatic as it is subject to the outcome of the needs analysis. When referring a patient to an orthodontist, kindly request them to call the orthodontic line at DENIS before they see the orthodontist.

Maxillo-facial Surgeons
Admission to theatre, whether for conscious sedation or general anaesthetic, requires pre-authorisation and X-rays. Implant benefits are subject to pre-authorisation and hospital benefits are not available for implant placement. Benefits for all treatment are subject to published benefit guidelines.

NOTE: Please read through the Scheme Exclusions for certain surgical procedures.

Periodontists
The specialist consultation fee is covered but all other benefits are subject to approval of a treatment plan. Kindly submit the treatment plan and obtain approval before commencement of treatment. Benefits for treatment are subject to published benefit guidelines.

Prosthodontists
The specialist consultation fee is covered but all other benefits are subject to approval of a treatment plan. Kindly submit the treatment plan and obtain approval before commencement of treatment. Benefits for treatment are subject to published benefit guidelines.
**UNIQUE FUNDING DEFINITIONS AND EXCLUSIONS**

**Occlusal rehabilitation**
For funding purposes, we define *occlusal rehabilitation* as follows: The restoration of teeth with fixed prosthodontics where the primary cause of damage is bruxism and where this long-term “wear and tear” has resulted in reduced occlusal height and worn enamel. This type of damage to teeth does not qualify for funding. There is no benefit for fixed prosthodontics in such cases but this in no way implies that it is clinically inappropriate to restore such teeth with fixed prosthodontics.

**Orthodontic severity**
For funding purposes, all orthodontic cases are clinically assessed by using an orthodontic needs analysis. Benefit allocation is subject to the outcome of the needs analysis and the benefit may vary dependent on this analysis.

**General funding protocols on all schemes**
- Plastic dentures are limited to one per jaw (i.e. two per person) in a 4-year period.
- Benefits for crowns (where offered by the scheme option) will be granted once per tooth within a 5-year period.
- Benefits for endodontic treatment on deciduous teeth are limited to pulpotomies only.
- Metal frames for partial dentures are limited to one per jaw (i.e. two per person) within a 5-year period subject to published benefit guidelines.
- If a procedure does not attract benefit, it indicates that all treatment associated with the specific event also does not receive benefits. For example, if a crown is not covered then the laboratory costs, including models, are also not covered.
- In cases where a medical colleague is to administer sedatives intravenously or assist in difficult cases in the dental rooms, the fee charged by the second professional will be considered for funding, only if the event is pre-authorised.

**Compromised treatments**
For the purposes of benefit application, *compromised treatments* mean treatments which are done but where the outcome or prognosis is known to be questionable. There may be good reason for doing such compromised treatments, such as the patient’s inability to pay for the preferred treatment or the patient’s time constraints, etc. However, benefits will not be awarded for such treatment and the patient would be liable for interim treatment costs.

Please refer to the 2018 dental benefit tables for scheme/plan specific benefits as not all options have benefit for some procedures. Scheme specific benefit guides are available on the DENIS website: [www.denis.co.za](http://www.denis.co.za)

The scheme benefit guides also include details of the *Scheme Exclusions*. 

DENIS Chairside Guide 2018
In terms of the Medical Schemes Act, all scheme members have given permission for their health records to be shared with accredited managed care companies. Therefore, the managed care organisation is within its rights to see patient records provided that the same level of patient confidentiality is maintained.

**Benefit for specialised dental treatment is not automatic.** The member does not have a guaranteed number of crowns or implants per year, each item is reviewed and benefit allocated according to the criteria described below. The published **Scheme Benefit Guides** refer to a maximum benefit that can be awarded provided the criteria below are met.

**STANDARD PRE-AUTHORISATION INFORMATION**

With every authorisation the following **standard information** must be sent combined with the specific information for each type of authorisation described below:

- Membership number
- Dependent name
- Dependent date of birth
- Provider name
- Provider practice number
- ICD-10 codes
- Procedure codes

**DENTURES**

The following schemes and options have introduced pre-authorisation for denture effective from 2018:

- **Bonitas**—BonSave, Primary, Standard, Standard Select, BonCom, BonClassic and BonComplete
- **Thebemed**—Universal, Universal EDO, Energy: Core, Energy: Medium and Energy: Open, Fantasy
- **KeyHealth**—Equilibrium, Silver, Gold and Platinum
- **PG Group**
- **Enablemed**—Makoti Comprehensive, Malcor Option D and Sizwe Gomomo Care

The pre-authorisation applies to plastic dentures as well as partial metal frame dentures.

For denture authorisations, please provide the following information in addition to the **standard information** described above:

- Applicable missing tooth number for the denture application (this can also be in a tooth chart format)
- Primary laboratory code
- Primary clinical code

**CROWNS**

We only approve benefits for grossly broken down teeth, but where the alveolar bone and periodontal ligament are still healthy. The reason for this is to ensure that benefits are only awarded to teeth that have an acceptable chance of good long-term prognosis.

Where the primary reason for crowning is occlusal attrition due to long-term bruxism or other habits, no benefits will be awarded as this is a scheme exclusion and as such not eligible for funding.

Crowns are subject to radiographic evaluation and are not authorised if:

- The bone/root ratio is below minimum requirements
- A furcation lesion is present
- Root caries is present
- Active periodontitis is radiologically evident
- There are no teeth in occlusion
- The damage to the tooth is due to bruxism (see **UNIQUE FUNDING DEFINITIONS**)
- Third molars do not attract crown benefit
- Deciduous teeth do not attract crown benefit other than pre-formed crowns

Schemes options vary in the number of crowns offered from 0 to 3 per year, and this must be seen as a maximum benefit. See the **DENIS Benefit Guide** for this annual maximum. However, this maximum does not guarantee benefits, the above rules must be complied with on each crown request.
For crown authorisations please provide the following information in addition to the standard information:

- An X-ray clearly showing the entire clinical crown, the neck and the upper part of the alveolar bone – i.e. a periapical for anterior teeth
- The tooth number (FDI format)
- Primary clinical code to be used i.e. 8409, 8411, if a post is envisaged then the primary code for the post or core
- Primary laboratory codes to be used e.g. 9505

**BRIDGES AND IMPLANTS**

Where offered by the scheme, bridge pontics and implants will only attract benefit from the second molar forward. This does not imply that practitioners should not do bridges and implants to restore second molar function, the scheme will simply not pay for such treatment regardless of the clinical motivation.

Due to the excessive force caused by a class 1 lever effect, benefits are not available for cantilever bridges with a single abutment except where the abutment is a canine.

For bridge and implant authorisations please provide the following information in addition to the standard information and the information described under Crowns above:

- A panoramic X-ray
- A tooth charting listing all missing teeth and all crowned teeth
- The approximate implant position (FDI numbering)
- The prosthodontic treatment plan which is intended to follow the surgical phase

**ORTHODONTICS**

All cases are clinically assessed by using an orthodontic needs analysis. Benefit allocation is subject to the outcome of the needs analysis. We maintain orthodontic budget by only awarding benefits for severe cases up to a certain percentage of benefit which is specific to each scheme.

Benefits for Fixed Comprehensive Orthodontic treatment are limited to beneficiaries older than 9, but younger than 18. Treatment must commence before their 18th birthday.

Only one family member may commence orthodontic treatment in a calendar year.

Every case of orthodontics is pre-authorised and measured against the outcome of the needs analysis in order to reach a funding decision.

The member is responsible for the provision of either the original or copies of the following to DENIS in addition to the standard information which should be clearly labelled with the name of the member as well as the date:

- Photograph of:
  - Teeth in occlusion lips retracted
  - Teeth in occlusion from right
  - Teeth in occlusion from left
  - Occlusal view of both jaws
- Recent panoramic X-ray
- A traced cephalogram

**NOTE:** Original records will be returned via priority mail

**HOSPITALISATION**

- Hospitalisation cover is provided where an underlying medical condition creates a substantially increased risk of treating in the rooms and indicates that a higher level of care is required.
- Hospital benefits are considered for children younger than 5 years of age with multiple restorations and extractions where conscious sedation or other sedative is not appropriate. Hospital benefits for a child for restorative dentistry will only be granted once in that patient’s lifetime.
- Hospitalisation benefits are NOT granted where the primary reason is anxiety control.
- Hospital benefits are NOT available for dental implantology or any procedures associated with implantology e.g. sinus lifts and bone augmentation (which are also scheme exclusions).
- Hospital benefits are NOT available for apicectomies.
- Hospital benefits are NOT granted where the primary reason is for a sterile facility.
- Hospital benefits are NOT available for dentectomies.

For hospital authorisation please provide the following information in addition to the standard information:

- Treating provider practice number
- Hospital practice number
**Conscious Sedation**
Conscious sedation is subject to pre-authorisation as follows:
- Conscious sedation in hospital: the same criteria apply as for hospitalisation above
- If conscious sedation is performed in a hospital setting, the member will be liable for the hospital facility fee
- Conscious sedation in the dental rooms may be authorised for:
  - Surgical tooth removal or the removal of impactions
  - Minor procedures such as multiple extractions and multiple restorations in children under 8 years of age where anxiety is a major concern
  - Posterior apicectomies

For conscious sedation authorisation please provide the following information in addition to the standard information:
- Treating provider practice number
- Anaesthetist practice number
- Date of treatment
- Main complaint of patient
- Panoramic X-ray (for removal of wisdom teeth by a general dental practitioner)

**Nitrous Oxide**
The use of nitrous oxide in the rooms is not subject to pre-authorisation.

**Plastic Restorations (Amalgam, Composite, etc.)**
Authorisation must be obtained for any patient requiring more than five restorations in a benefit year. Access to healthcare for all is an important pillar at DENIS. Loss of teeth has far greater implications towards negatively impacting on oral health in South Africa. A request for motivation and radiographs will assist in providing better oral health care to all our members. The following scheme options are low cost options and restorative treatment is restricted to four restorations per year and no further benefits are allowed in the period:
- **Bonitas** — BonCap
- **Thebemed** — Universal
- **Enablemed** — Makoti Primary, Makoti Comprehensive, Malcor Option D and Sizwe Gomomo Care

For plastic restorations please provide the following information in addition to the standard information:
- Intraoral X-rays and written treatment plan which must include the following:
  - Tooth number
  - Surface
  - Diagnoses, e.g. caries, fracture, abrasion etc.

**Periodontics**
To access these benefits, patients have to be registered with the DENIS Periodontal Programme. In order to apply for the periodontal programme, members are requested to submit the following:
- Full treatment plan on a practice letterhead with the following information in addition to standard information—
  - CPITN score
  - Periapical X-rays showing affected areas
  - Full maintenance plan for the remainder of the benefit year

Members who fail to adhere to the maintenance plan following periodontal treatment will be removed from the DENIS Periodontal Programme, thus forfeiting the additional benefits. Further clinical information may be requested to support the authorisation request.
**IMPORTANT INFORMATION ABOUT PAYMENT OF CLAIMS**

Dental benefits and cover differ between the schemes and options under management; the **DENIS Benefit Guides** show detailed benefit tables for each scheme. These guides are available on the DENIS website [www.denis.co.za](http://www.denis.co.za).

DENIS reserves the right to request clinical records and radiographs to process and assess claims.

Payment of claims is subject to and governed by the registered scheme rules. In the event of a dispute, the registered scheme rules will prevail.

Payment of valid claims is subject to the membership fees being up to date on receipt of the claim. Payment of these fees is regarded as acknowledgement that the member and beneficiaries are bound by the registered rules of their scheme.

**WHAT DOES DENIS NEED IN ORDER TO PROCESS A CLAIM?**

When submitting a claim to DENIS, please ensure that the following information is clearly stipulated on the claim, since missing and/or inaccurate information will result in a rejection of the claim:

- Medical scheme
- Membership number
- Practice name
- Practice number
- Treatment date
- Dependant name
- Dependant code (please use the code as per the patient’s membership card)
- The relevant ICD-10 code per claim line
- Valid procedure codes
- Tooth numbers (if applicable)
- Authorisation number (if applicable)
- Assistant name and practice number (if applicable)
- Referring practitioner name and practice number (in the case of a dental laboratory claim)
- Dental technician registration number (required on laboratory claims)

**STALE CLAIMS**

Regulation 6 of the Medical Schemes Act of 1998

(1) A medical scheme must not in its rules or in any other manner in respect of any benefit to which a member or former member of such medical scheme or a dependant of such member is entitled, limit, exclude, retain or withhold, as the case may be, any payment to such member or supplier of service as a result of the late submission or late re-submission of an account or statement, before the end of the fourth month—

(a) from the last date of the service rendered as stated on the account, statement or claim; or

(b) during which such account, statement or claim was returned for correction

In terms of the Medical Schemes Act, all claims must be submitted within four months from the end of the month in which the service was provided. Claims that are not submitted and received within this time period will be regarded as stale, and will not be eligible for benefit. Payment of such an account will be the member’s liability.

**CLAIMING**

- Submit claims through one of the electronic claim clearing hubs (EDI)
- Emailing claims to DENIS: claims@DENIS.co.za
- Fax a clear copy of the claim to DENIS: 0866 770 336
- Posting original claims to DENIS:
  - DENIS Claims Department
  - Private Bag X1
  - Century City 7446
- Delivering original claims to DENIS offices:
  - Block D, The Forum
  - Northbank Lane
  - Century City 7441

If your practice does not submit via EDI per scheme/option managed by DENIS, a list of where to send your claims is available on the DENIS website: [www.denis.co.za](http://www.denis.co.za)