CareFirst
Family of health care plans

Part 11: Orthodontics

Comprehensive Dental Reference Guide

Please use the Comprehensive Dental Reference Guide when preparing your claims and pre-treatment estimates for CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc., (collectively, "CareFirst"), CareFirst BlueCross BlueShield Medicare Advantage, The Dental Network, and the Federal Employee Program®.

- **CDT code descriptions**
- **Utilization review perspectives on clinical presentations appropriate for benefit allowance**
- **CareFirst-required documentation to allow for processing**
- **Identification of codes that require a clinical review by our staff of licensed dentists**

Selecting the most appropriate code to describe treatment rendered and providing required documentation streamlines the claims submission process.

These descriptions and directions are based on standard plan designs. Individual patient plans may vary. Verify benefits and eligibility for each patient before the appointment.

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Orthodontics: D8000–D8999

The information provided is based on general clinical policy and can vary for each patient's plan. Verify benefits and eligibility for each patient before the appointment, as there are differences among plans. The following information gives generalized clinical requirements and guidance for each CDT code.

Orthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D8010	Limited orthodontic treatment of the primary dentition	Benefits are subject to the contractual lifetime maximum for orthodontics and are paid as a one-time benefit. This procedure is not covered under ACA pediatric embedded dental contracts. This service includes all required appliances, adjustments and observations. Requests for orthodontic services for members covered under CareFirst Dental Contracts are provided according to the contract. No Dental Director Review is required. Benefits are provided to members who meet the following criteria: Orthodontic coverage is provided in the member's contract. The member is eligible to receive orthodontic benefits. For example, a member's contract may provide coverage for orthodontic services but limited to dependents) and the orthodontic treatment is to reduce or eliminate an existing malocclusion.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Orthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D8020	Limited orthodontic treatment of the transitional dentition	Benefits are subject to the contractual lifetime maximum for orthodontics and are paid as a one-time benefit. This procedure is not covered under ACA pediatric embedded dental contracts. This service includes all required appliances, adjustments and observations. Requests for orthodontic services for members covered under CareFirst Dental Contracts are provided according to the contract. No Dental Director Review is required. Benefits are provided to members who meet the following criteria: Orthodontic coverage is provided in the member's contract. The member is eligible to receive orthodontic benefits. For example, a member's contract may provide coverage for orthodontic services but limited to dependents) and the orthodontic treatment is to reduce or eliminate an existing malocclusion.	n/a
D8030	Limited orthodontic treatment of adolescent dentition	Benefits are subject to the contractual lifetime maximum for orthodontics and are paid as a one-time benefit. This procedure is not covered under ACA pediatric embedded dental contracts. This service includes all required appliances, adjustments and observations. Requests for orthodontic services for members covered under CareFirst Dental Contracts are provided according to the contract. No Dental Director Review is required. Benefits are provided to members who meet the following criteria: Orthodontic coverage is provided in the member's contract. The member is eligible to receive orthodontic benefits. For example, a member's contract may provide coverage for orthodontic services but limited to dependents) and the orthodontic treatment is to reduce or eliminate an existing malocclusion.	n/a
D8040	Limited orthodontic treatment of adult dentition	Benefits are subject to the contractual lifetime maximum for orthodontics and are paid as a one-time benefit. This procedure is not covered under ACA pediatric embedded dental contracts. This service includes all required appliances, adjustments and observations. Requests for orthodontic services for members covered under CareFirst Dental Contracts are provided according to the contract. No Dental Director Review is required. Benefits are provided to members who meet the following criteria: Orthodontic coverage is provided in the member's contract. The member is eligible to receive orthodontic benefits. For example, a member's contract may provide coverage for orthodontic services but limited to dependents) and the orthodontic treatment is to reduce or eliminate an existing malocclusion.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Orthodontics	
Procedure Code	**Description**
D8070, D8080, D8090	Comprehensive orthodontic treatment of transitional dentition

Clinical Criteria and/or Policy and Supporting Documentation Requirements

Benefits are subject to the contractual lifetime maximum for orthodontics and are paid as a one-time benefit.

This service includes all required appliances, adjustments and observations.

Requests for orthodontic services for members covered under CareFirst Dental Contracts are provided according to the contract. Benefits are provided to members who meet the following criteria:

- Orthodontic coverage is provided in the member's contract.
- The member is eligible to receive orthodontic benefits. For example, a member's contract may provide coverage for orthodontic services but limited to dependents.
- The orthodontic treatment is to reduce or eliminate an existing malocclusion.
- One set of retainers is included in comprehensive orthodontics.
- One retainer replacement is allowed per arch per lifetime within 24 months of the date that active treatment ends (debanding, removal of active appliance).
- Rebonding or recementation of any fixed appliance is included during treatment.

Affordable Care Act (ACA) contracts:

Orthodontic benefits for members covered under ACA are limited to comprehensive orthodontic treatment (procedure codes D8070-D8090). All other orthodontic treatment procedure codes are excluded from the contract; therefore, a benefit will not be provided.

A Pre-Treatment Estimate (PTE) must be submitted and approved before any ACA benefits can be allowed and treatment begins. If treatment has started before receipt of an approved PTE, no benefits will be allowed. Benefits for orthodontic services will only be available until the end of the calendar year in which the member turns age 19 if the member:

- Has fully erupted permanent teeth with at least 1/2 to 3/4 of the clinical crown being exposed (unless the tooth is impacted or congenitally missing); and
- Has a severe, dysfunctional, handicapping malocclusion that meets a minimum score of 15 on the Handicapping Labio-Lingual Deviations Index (HLD) or a minimum score of 25 on the Salzmann Evaluation Index (form is dependent upon jurisdiction).
- Points are not awarded for aesthetics; therefore, additional points for aesthetic correction will not be considered part of the determination.

All other contracts (commercial):

The dentist should select the comprehensive ADA Procedure Code that is most appropriate to the patient's current stage of dentofacial development:

- D8070—Comprehensive orthodontic treatment of the transitional dentition
- D8080—Comprehensive orthodontic treatment of the adolescent dentition
- D8090—Comprehensive orthodontic treatment of the adult dentition

Benefits for orthodontic treatment are provided in quarterly or monthly installments, based on the group's specifications, and are determined by the anticipated length of treatment. When submitting the initial claim for orthodontia, include the following information:

- Banding date
- Length of treatment (in months)
- The total charge for the treatment

Dentists will submit one claim for the entire orthodontic course of treatment. An initial payment for comprehensive treatment is made upon banding and consists of the lesser of 25% of the Allowed Benefit or 25% of the member's orthodontia lifetime maximum.

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*Check patient eligibility including age and frequency limitations for each service.

Orthodontics

Clinical Criteria and/or Policy and Supporting Documentation Requirements

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Payments of the remaining allowance will be spread throughout the remaining months of treatment. CareFirst will automatically make quarterly or monthly payments based on the existing treatment plan. The benefit will continue to be paid until treatment is completed if the following conditions exist:

- The policy remains active
- The member remains covered under the policy
- The member has not reached the age of ineligibility as defined in the contract
- The member's lifetime maximum has not been exhausted
- The member continues to be under active treatment

CareFirst will provide a monthly benefit based on the patient's current eligibility and the orthodontic lifetime benefit available and is subject to all contractual provisions, exclusions and limitations.

Orthodontic benefits are based on the member's contract. The orthodontic lifetime maximum amount varies by account. To verify a member's eligibility and benefits, call using your Regional provider number or the appropriate Provider Service area.

Members seeking treatment from a Participating orthodontist are responsible for the co-insurance percentage associated with the treatment; the amount of member liability should not exceed the CareFirst Allowed Benefit. Participating providers are encouraged to verify their CareFirst fee schedule to determine the appropriate allowance for the procedure code. The allowance for the comprehensive treatment will be determined when the appliance is placed; any increase in allowances during treatment will not apply to orthodontic cases in progress.

Required documentation to accompany the PTE or claim:

For CareFirst Commercial Dental Contracts: No Dental Director Review is required; the claim form must include:

- Banding date
- Length of treatment (in months)
- The total charge for the treatment

ACA contracts:

Requires clinical review; pre-treatment estimate required. Panoramic and cephalometric radiographs, intraoral photographic series demonstrating occlusion, digital images of study models in centric bite registration and the State-mandated assessment form (HLD or Salzmann Index).

- Current ADA claim form with service code requested and fee
- Images of diagnostic study models, properly trimmed, with individual occlusal views, articulated profile and frontal views, clear enough to measure overjet, overbite, crowding, spacing, etc.
- High-quality facial photographs that equally illustrate the dentition and arch/tooth relationships are acceptable. (Plaster or stone models are no longer accepted.)
- Cephalometric head film with measurements and analysis
- Panoramic or full-series radiographs
- Clinical summary with diagnosis
- Appropriate State-mandated HLD or Salzmann Evaluation assessment form completed and signed by the treating provider
- Treatment plan including anticipated duration of active treatment

*Check patient eligibility including age and frequency limitations for each service.

Orthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy**	**Supporting Documentation Requirements**
D8091	Comprehensive orthodontic treatment with orthognathic surgery (Treatment of craniofacial syndromes or orthopedic discrepancies that require multiple phases of orthodontic treatment including monitoring growth and development between active phases of treatment.)	This procedure is not a covered service on most plans.	n/a
D8210	Removable appliance therapy	Benefits are typically allowed for commercial plans once per appliance per six months and apply to the orthodontic lifetime maximum. This procedure includes all required appliances, adjustments and observations.	No documentation is required.
D8220	Fixed appliance therapy	Benefits are typically allowed for commercial plans once per appliance per six months and apply to the orthodontic lifetime maximum. This procedure includes all required appliances, adjustments and observations.	No documentation is required.
D8660	Pre-orthodontic treatment visit	The benefit may be allowed once per six months for commercial plans, not to exceed 3 pre-orthodontic treatment visits before banding or delivery of the initial appliance. This code describes observational visits to determine when the patient can start orthodontic treatment.	No documentation is required.
D8670	Periodic orthodontic treatment visit (as part of the contract)	This procedure is considered inclusive to the orthodontic treatment rendered and cannot be billed to the member.	n/a
D8671	Periodic orthodontic treatment visit associated with orthognathic surgery	This procedure is not a covered service on most plans.	n/a
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	This procedure is considered inclusive to the orthodontic treatment rendered and cannot be billed to the member.	n/a
D8681	Removable orthodontic retainer adjustment	This procedure is considered inclusive to the orthodontic treatment rendered and cannot be billed to the member.	n/a
D8695	Removal of fixed orthodontic appliances for reasons other than completion of treatment	Typically not covered.	n/a
D8696	Repair of orthodontic appliance—maxillary	This procedure is considered inclusive to the orthodontic treatment rendered and cannot be billed to the member.	n/a
D8697	Repair of orthodontic appliance—mandibular	This procedure is considered inclusive to the orthodontic treatment rendered and cannot be billed to the member.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Orthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy**	**Supporting Documentation Requirements**
D8698	Re-cement or rebond fixed retainer—maxillary	This procedure is considered inclusive to the orthodontic treatment rendered and cannot be billed to the member.	n/a
D8699	Re-cement or rebond fixed retainer—mandibular	This procedure is considered inclusive to the orthodontic treatment rendered and cannot be billed to the member.	n/a
D8701	Repair of the fixed retainer includes reattachment—maxillary	Typically not covered.	n/a
D8702	Repair of the fixed retainer includes reattachment—mandibular	Typically not covered.	n/a
D8703	Replacement of lost or broken retainer—maxillary	Typically not covered.	n/a
D8704	Replacement of lost or broken retainer—mandibular	Typically not covered.	n/a
D8999	Unspecified orthodontic procedure, by report	A detailed narrative that describes the treatment provided, the rationale for the treatment, and any appropriate imaging or treatment notes are needed to review for benefits.	**Requires clinical review; pre-treatment estimate recommended;** A detailed narrative that describes the treatment provided and rationale for the treatment, and any appropriate imaging or treatment notes are needed to review for benefits.

*Check patient eligibility including age and frequency limitations for each service.