

Introduction

The clinical criteria are based upon procedure codes in the Current Dental Terminology® (CDT 2020), American Dental Association®.

CareFirst's Dental Clinical Criteria have been developed, revised and updated periodically. They are reviewed and approved by the CareFirst Dental Advisory Committee (DAC) and/or the Oral and Maxillofacial Surgery Advisory Committee (OMSFAC). The DAC is comprised of the Dental Director who acts as chairperson for the committee and 10 practicing network dentists. The OMSFAC is comprised of the Dental Director who acts as chairperson for the committee and four network oral surgeons.

The criteria are derived from reviews of the current dental literature, subject textbooks, other industry information, and

- Practice Parameters, American Association of Periodontology (www.perio.org)
- Parameters of Care, American Association of Oral and Maxillofacial Surgery (www.aaoms.org)
- Oral Health Policies and Clinical Guidelines, American Academy of Pediatric Dentistry (www.aapd.org)
- Position Statements, American Association of Dental Consultants (www.aadc.org)
- Dental Practice Parameters, American Dental Association (www.ada.org)

Dental benefits

Dental care benefits are provided as defined in the members' contracts. The members' contracts may exclude or impose frequency limits on certain procedures and may vary based on regulatory requirements and/or the level of coverage purchased by the employer group or individual. In-network dentists agree to CareFirst's Schedule of Allowances for covered services. Covered services are allowed a benefit only when dentally or medically necessary as determined by CareFirst.

Alternate benefits

Member contracts state "in the event there are alternative dental procedures that meet generally accepted standards of professional dental care for a Member's condition, benefits will be based upon the lowest cost alternative." If a Member elects to have a more expensive procedure performed, it is the Member's financial responsibility to pay the difference to the provider between the allowed amount for the alternate benefit and the contracted fee for the selected procedure.

The professional review process

- All review of clinical information is performed by licensed dental professionals.
- Only a licensed dentist may deny a procedure as "not medically or dentally necessary", "cosmetic in nature" or "experimental or investigational".
- Only a licensed dentist may consider a procedure or claim on appeal.
- Administrative denials are based on member contract provisions (i.e., benefit limitations, exclusions and annual contract period maximum) and do not require the review of a licensed professional.

Required clinical information

Procedures requiring professional review always require supporting clinical documentation. Please refer to the list of required documentation included as part of this document.

Sending your Clinical Information to CareFirst

Electronic claims: CareFirst prefers and accepts electronic dental claims from multiple third party vendors (NEA, Tesia/RSS, DentalXChange (DXC)) - use payer ID:00580.

Paper claims: Mail your claims to the address indicated on the back of the member's membership card.

Attachments and clinical documentation: The submission of electronic attachments (radiographs, progress notes, charting, photos, etc.) is highly recommended and may be submitted to CareFirst through an electronic attachment vendor of choice. Always be sure that your image is clear and diagnostic so as to expedite the clinical review process.