Introduction

The clinical criteria are based upon procedure codes in the Current Dental Terminology® (CDT 2018), 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 12 practicing network dentists. The OMSFAC is comprised of the Dental Director who acts as chairperson for the committee and six (6) network oral surgeons.

The criteria is derived from reviews of the current dental literature, subject textbooks, other insurance companies, 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. 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.”

The Professional Review Process

- All review of clinical information is performed by qualified dental staff.
- Only a licensed dentist may deny a procedure as “not medically or dentally necessary”, “cosmetic in nature”, “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
- **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.
- **Electronic claims:** CareFirst accepts electronic dental claims - use payer ID: 00580.