Dental Claims Processing Policies

Edits, Limitations and Billing Guidelines

To process claims accurately and consistently, CareFirst and CareFirst BlueChoice developed Dental Clinical and Policy Guidelines based on current community standards of dental care and are derived through consultation with the ADA® Dental Practice Parameters, dental practices, academic communities and current scientific literature.

The dental policy guidelines are supported by a system designed to adjudicate claims efficiently and accurately based on the member's contract. These edits use the most cost-effective, clinically appropriate claim reimbursement, based on clinical standards and contractual limitations. (See Dental Clinical Criteria.)

Mutually Exclusive Edits

This is defined as the billing for two or more procedures that, by dental care standards, would not usually be billed for the same patient on the same date of service.

Rebundling Edits

Unbundling occurs when two or more procedures are used to describe a service for which a single, more comprehensive procedure exists that more accurately describes the complete service performed. Unbundled procedures will be rebundled to the correct CDT procedure.

Incidental to/Included in/Integral part of

These terms are defined as procedures carried out at the same time as a primary procedure that are clinically integral to the performance of the primary procedure. Additional reimbursement is not provided for these incidental procedures, as they are included in the allowance for the primary procedure.
Common Limitations and Exclusions

Member contracts include limitations and exclusions, which may vary, based on regulatory requirements and/or the level of coverage purchased by the employer group. This is for informational purposes only.

Below are the most common limitations used in the administration of dental care, and may be combined with other policies and guidelines to ensure cost effectiveness and acceptable community standards of care. Use one of our self service options to verify specific benefit coverage.

General Criteria

Procedures should be performed based on dental necessity and as appropriate in the diagnosis, treatment and care of the member’s condition. Treatment rendered for cosmetic reasons, member convenience or services that do not meet standards of care are not eligible for benefits.

General criteria for members with Indemnity contracts are:

- If there is an alternative dental procedure(s) that meets generally accepted standards of professional dental care for a covered member’s condition, the benefit will be provided based upon the lowest cost alternative.
- CareFirst will provide benefits for covered services for a course of treatment up to 90 days after the date a member’s coverage terminates, if the treatment:
  - begins before the termination date of the member’s coverage
  - requires two or more visits to the dentist’s office on separate days (this provision does not apply to orthodontic services)

Diagnostic/Preventive Services

The following benefits are generally limited to twice per benefit plan year:

- oral exams (comprehensive oral evaluations are limited to one in a three year period per provider)
- routine prophylaxis
- bitewing radiographs (up to two bitewing procedures/benefit plan year)
- topical fluoride (age limit* applies)

The following benefits are limited to once per 36 months:

- one set of full mouth radiographs OR one panoramic film and one set of bitewing radiographs, in addition to those mentioned above
- one cephalometric radiograph
- sealants on permanent molars, one per tooth (age limit applies)*

The following benefits are limited to once per five years:

- space maintainers for prematurely lost cuspid to posterior deciduous teeth

Restorative Services

The following benefits are generally limited to once per twelve 12 months:

- silver amalgam and composite restorations, one restoration per surface

The following benefits are limited to once per five years:

- dentures, full and/or partials
- fixed bridges, including crowns, inlays and onlays used as abutments for or as a unit of the bridge
- crowns, inlays, onlays
- stainless steel crowns (age limit applies)*

Note: Specific requirements of a member’s Dental benefits vary and may differ from the general procedures outlined in this manual. If you have questions regarding a member’s eligibility, benefits, or claims status information, we encourage you to use one of our self-service channels CareFirst Direct or CareFirst on Call.

*Age limit – Benefits are provided until the end of the year in which the member turns 19.
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The benefit for regular denture adjustment and relining is limited to once per 36 months, but not within six months of the date of initial placement. Please note the following benefit limitations for immediate denture adjustment and relining:

- Initial adjustment/relining, three months after placement
- Second adjustment/relining, within the first year
- Third adjustment/relining, three years thereafter

The following benefits are limited to once per 12 months:

- Recementation of crowns, inlays and/or bridges
- Repair of prosthetic appliances per specific area of the appliance

The following services are contract exclusions:

- Replacement of a denture, bridge or crown as a result of loss or theft
- Replacement of an existing denture, bridge or crown that is satisfactory or that could be repaired
- Replacement of dentures, a bridge or a crown which were paid partially or fully under the terms of the policy and five years have not lapsed from the date of placement/replacement

Endodontic Services

The following contractual limitations generally apply:

- Pulpotomy is limited to deciduous teeth
- Root canal therapy is limited to permanent teeth
- Retreatment of a root canal is limited to one per tooth per lifetime

Periodontal Services

The following benefits are generally limited to a full mouth treatment once per 24 months:

- Periodontal scaling and root planing
- Gingival curettage

The following benefits are limited to once per five years:

- Osseous surgery, including flap entry and closure; one full mouth treatment
- Gingivectomy; one full mouth treatment
- Limited or complete occlusal adjustments in connection with periodontal treatment
- Mucogingival surgery limited to grafts and plastic procedures, one treatment per site

Oral Surgical Services

Some oral surgical procedures may have a benefit under a member’s medical policy, including:

- Services related to the treatment of temporomandibular disorder (TMD)
- Treatment of fractures, simple or compound
- Orthognathic surgery
- Accidental injury

The following benefits are available based on the dental policies outlined below:

- Both the extraction of a tooth and surgical removal of a cyst only if the cyst is > 1.25 cm. If the cyst measures < 0.5 cm, a benefit is provided for the extraction only; the cyst is considered inclusive
- Alveoloplasty, only if three or more teeth in a quadrant were extracted
- Frenulectomy and soft tissue graft performed on the same day. Please note: the benefit is provided for the graft only and the frenulectomy is considered inclusive

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Services rendered to members for the treatment of TMD, including radiographs and/or tomographic surveys, are not covered under the dental policy.

The following services are subject to professional review and the benefit is available based on individual consideration:

- Oroantral fistula closure
- Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus
- Tooth transplantation
- Surgical repositioning of teeth
- Vestibuloplasty, covered under ACA plans only
Anesthesia Services
A benefit for general anesthesia and intravenous sedation is provided if:
- required for oral surgery and,
- administered by a dentist who has a permit to administer conscious sedation or general anesthesia.

The following oral surgical services are eligible for general anesthesia and/or intravenous sedation if the oral surgery is covered under a member’s policy:
- apicoectomy
- surgical extractions (two or more) and soft tissue, partial/completely bony
- root resection
- hemisection
- surgical removal of residual tooth roots (cutting procedures)
- osseous surgery
- oroantral fistula closure
- bone replacement graft
- tooth reimplantation
- pedicle soft tissue graft
- free soft tissue graft
- surgical exposure of impacted or unerupted tooth
- alveoloplasty
- vestibuloplasty
- removal of odontogenic/nonodontogenic cyst or tumor
- removal of exostosis
- incision and drainage of abscess – intraoral/extraoral soft tissue
- excision of hyperplastic tissue

Benefits for local anesthesia are considered inclusive to the primary procedure(s) performed and a separate benefit is not provided.

Orthodontic Services
A benefit for orthodontic treatment is provided to members that meet the following criteria:
- orthodontic coverage is provided in the member’s contract and,
- the member is eligible to receive orthodontic benefit (for example, a member has orthodontic coverage in his contract, but only his dependent can take advantage of the benefit) and,
- the orthodontic treatment is to reduce or eliminate an existing malocclusion.

Initial Consultation
To facilitate a complete and comprehensive orthodontic treatment plan, the orthodontist documents a member’s medical/dental history, dental occlusion, overall dental condition, the relationship between the teeth and skeletal structure. Use ADA Consultation Procedure Code D9310.

Diagnostic Records
Pre-treatment records are important tools for orthodontists to make an accurate diagnosis and develop the treatment plan. The records include study models, diagnostic photographs, cephalometric and panoramic films. Use ADA Procedure Codes:
- Panoramic Radiograph – D0330
- Cephalometric Radiograph – D0340
- Diagnostic Casts – D0470
- Oral/Facial Images – D0350/D0351

Active Comprehensive Orthodontic Treatment
Active orthodontic treatment begins with the insertion of the appliance. (The banding date.) The comprehensive treatment procedure codes include the placement of the appliance, adjustments/follow-up (monthly visits), the removal of the appliance, construction of the retainer and any other follow-up treatment to maintain the achieved anatomical, functional and aesthetic results and/or stabilize the dentition after removal of the appliance.
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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

Benefit Guidelines for Traditional and Preferred Dental

For members covered under the Traditional and Preferred Dental plans, the benefit for the orthodontic treatment is provided in the quarterly or monthly installments, based on the group’s specifications and determined on the anticipated length of treatment. When submitting the initial claim for orthodontic treatment, include the following information:
- banding date
- length of treatment (in months)
- 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 percent of the Allowed Benefit or 25 percent of the member’s orthodontic lifetime maximum

Payments of the remaining allowance will be spread throughout the remaining months of treatment. We will automatically make quarterly or monthly payments based on the existing treatment plan for ACA ortho guidelines. For CFA patients, contact CFA customer service.

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

Billing Guidelines for Individual Select Preferred (ISP)

For members covered under the ISP plan, claims for the initial consultation and diagnostic records should be submitted to CareFirst for reimbursement. Claims should not be submitted for the comprehensive treatment. These services can be billed directly to the member at the time of banding.

Billing Guidelines for DHMO

For members covered under the Dental HMO, providers should charge the member the appropriate copayment for services based on the appropriate Member Copayment Schedule. Specialists should submit one claim for the entire orthodontic course of treatment and one payment will be made for the difference between the member’s copayment and the provider’s Orthodontic Guarantee.

Billing Guidelines for Patients with Dual Orthodontic Coverage

Health Insurance Exchanges in Maryland, the District of Columbia, and Virginia established under the Affordable Care Act (ACA) enroll individuals and families who purchase health insurance plans offered by CareFirst and other carriers. CareFirst’s medical plans offered in the individual and small group markets (both on and off of the Exchange) have the mandated 10 Essential Health Benefits (EHB), which include a pediatric dental benefit. They do not include an adult dental EHB; dental coverage for adults age 20 and older must be purchased through a separate dental plan.

Patient Qualifies for Dual Orthodontic Coverage

Once pediatric orthodontic medical necessity is determined using our Salzmann or HLD form, providers should submit a pre-treatment estimate (PTE) for review by the office of the CareFirst Dental Director. If the orthodontic treatment is approved, providers will receive an estimate of eligible benefits (EEB) detailing the approval. It is important to note that orthodontic cases started without an approval from CareFirst will not be given a benefit, regardless of the medical necessity. Providers should submit the approval EEB, along with the banding date,
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length of treatment, and total charge, to CareFirst for reimbursement.

Patient Does Not Qualify for Dual Orthodontic Coverage
If the provider’s assessment of an orthodontic case results in a low score, there is no requirement that the case must be submitted for review. In these cases, providers should expect to receive two Notices of Payment (NOPS): one reflecting a denial under the patient’s pediatric dental plan, and the second showing that the treatment has been processed.

Orthodontic Lifetime Maximum
Orthodontic benefits are based on the member’s contract. The orthodontic lifetime maximum amount varies by account. Use one of our self service options to verify specific benefit coverage.

Members seeking treatment from a Participating orthodontist are responsible for the coinsurance percentage associated with the treatment; the amount of member liability should not exceed the CareFirst Allowed Benefit. Participating providers are encouraged to review their CareFirst Fee Schedule to determine the appropriate allowance for the procedure code. The allowance for the comprehensive treatment will be determined at the time the appliance is placed; any increase in allowances that may occur during the course of treatment will not apply to orthodontic cases in progress.

Orthodontic Treatment in Progress
Members enrolled after the placement of the appliance may be eligible to receive orthodontic benefits for the treatment in progress. Use one of our self service options to verify specific benefit coverage.

Providers should submit the total charge, total length of treatment and original banding date. CareFirst will prorate the treatment plan and consider a benefit based on the cost of the remaining treatment. All expenses incurred prior to the effective date of the contract are not eligible for reimbursement and are considered to be the member’s responsibility.

Members Transferring from Another Orthodontist
New orthodontists must submit a claim indicating the anticipated number of months in the treatment plan and include the charge for the treatment and banding date, if appropriate.

A payment schedule will follow the monthly or quarterly installments; however, the initial allowance of 25 percent will not apply and the benefit will be limited to the remaining lifetime maximum amount.

Traditional and Preferred Dental Guidelines for Dental Implants
The dental implant policy applies only to members covered under the Standard Traditional and Preferred dental products. Some contracts may vary and, therefore, exclude dental implants or may limit coverage of dental implants to the replacement of one missing tooth as an Alternate Benefit in lieu of a 3-unit bridge.

Clinical Guidelines
- All dental implants and related services are subject to review by the Dental Director.
- A benefit is subject to medical necessity. The treatment must meet the criteria and be clinically appropriate based on accepted standards of dental care.
- Dental Implants are not recommended nor will a benefit be provided for young patients who have potential for future growth and development of their oral structures.
- A benefit applies only to the replacement of natural missing teeth.
- An implant must be necessary to restore the dental arch to form and function.
- A benefit may be considered only for teeth #2 – #15 and #18 – #31.
- An alternate benefit may be considered if there is a more conservative, less expensive treatment available that meets the standard of care.
- A benefit will not be provided to replace a supernumerary tooth.
- A benefit will not be provided to replace a tooth or teeth in space(s) not created by a missing natural tooth or teeth or created by a supernumerary tooth.
- A benefit may be considered only when the implant permits replacement of a functional tooth.

**Provider Guidelines**

- Providers are encouraged to file a request for a pre-treatment estimate. CareFirst strongly encourages providers to submit pre-treatment estimates and required attachments electronically or submit a current ADA claim form, check the box for “Dentist’s pre-treatment estimate” and leave the date of service blank.
- The appropriate supporting documentation must be submitted with the pre-treatment estimate or claim. (See the Dental Reference Guide for Required Attachments). Radiographs must be of diagnostic quality and properly labeled with the patient’s name, dentist’s name and address. Providers may also electronically transmit the supporting documentation via National Electronic Attachment, Inc. (NEA). Please include the NEA document number in the Remarks section on the ADA claim form. For more information, contact NEA at 800-782-5150 and select option #2.

**Member Contractual Limitations and Exclusions for Standard Traditional and Preferred Dental Members**

All existing contractual provisions, limitations and exclusions apply. Specifically:

- Major restorative – services limited to once per 60 months (five years) or as stated in the member’s contract.
- Replacement of an existing denture or bridge that is determined by CareFirst to be satisfactory or repairable.
- Implant services performed for elective and/or cosmetic reasons will not be covered.
- Benefit is subject to member’s annual contract maximums.

**Financial Responsibility**

Implants used to replace missing teeth can require considerable out of pocket costs for CareFirst members. Dentists must discuss financial arrangements with the member seeking any major services. Providers may request a pre-treatment estimate, along with the supporting required documents, for clinical review.

**Implant Quality Assurance**

Adherence to the Parameter on Placement and Management of the Dental Implant (American Academy of Periodontology) or Parameters of Care (American Association of Maxillofacial Surgeons – ParCare 07) is expected for all implants for which a benefit has been provided by CareFirst. Failure of an implant due to inadequate planning, placement and management as defined in the Parameter, will result in a Quality Improvement investigation.