CareFirst
Family of health care plans

Dental Claims Processing Policies

This manual provides information for CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and The Dental Network (CareFirst) Dental providers.

Per the terms of the Participating Agreement, all providers are required to adhere to all policies and procedures contained in this manual, as applicable. If we make any administrative or procedural changes, we will update the information in this manual and notify you through **email** and **BlueImpressions**, our online Dental provider newsletter.

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**. Through these channels, simple questions can be answered quickly.

ACA Pediatric Orthodontia

The pediatric dental orthodontic benefit requires pre-authorization for medical necessity before any treatment begins. Diagnostic records and the examination do not require a pre-treatment estimate (PTE). If the treatment does commence before authorization is received from CareFirst, no benefit will be allowed.

Orthodontic benefit provisions are slightly different in the ACA dental contracts for Maryland, the District of Columbia, and Virginia.

- **Maryland and the District of Columbia use the Handicapping Labiolingual Index (HLD)**
- **Virginia requires the Salzmann Deviation Index**

Providers may assess the patient prior to submitting a PTE. If the provider's assessment of the case results in a low score, there is no requirement to submit the case for review. If the parent insists or the score is close to passing, CareFirst recommends submitting the case for review.

Inquiries and Appeals

Claim Inquiry

An inquiry is a request for CareFirst to explain why a claim was paid a certain way or why it was rejected. It is an informal request for information and can normally be handled by calling the appropriate provider service area. Inquiries include: amount paid questions, coverage/eligibility questions, deductible/limitation questions, timely filing rejections, and claims resubmitted with required documentation. Claims inquiries can be made post-login on **CareFirst Direct**.

Claim Appeals

When CareFirst processes a claim and rejects it due to medical necessity or an adverse decision, providers may appeal the rejection in writing within six months or 180 days from the denial notification date.

An appeal is a formal written request to the Plan for reconsideration of a medical or contractual adverse decision. Appeals include: cosmetic rejections, experimental/investigational rejections, and medical necessity rejections.

A member, the member's authorized representative, or the dentist acting on behalf of the member, has the right to appeal the denial of a claim within 180 days from the date of notification of the denial or benefit determination though the internal review process.

A letter describing the reason(s) for the appeal and the clinical justification/rationale must include the following information:

- Patient name and membership identification number
- Claim number to be reviewed
- Dates of service
- Copy of original claim or Explanation of Benefits (EOB) denial information
- Supporting clinical notes or dental records
- CareFirst may require additional information from the provider

Appeals must be submitted in writing to the appropriate **Provider Service Correspondence Department** indicating the appeal reason and clearly stating that the request is an appeal.

The appeal will be reviewed by a dentist not involved in the initial denial. All appeal decisions are answered in writing.

Providers should first use the CareFirst internal appeals process before further complaints are made.

Appeal Resolution

Once the internal Appeal process is complete, you will receive a written decision that will include the following information:

- The specific reason for the Appeal decision
- A reference to the specific benefit provision, guideline protocol or other criteria on which the decision was based
- A statement regarding the availability of all documents, records or other information relevant to the Appeal decision, free of charge, including copies of the benefit provision, guideline, protocol or other decision was based
- Notification that the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning will be provided free of charge upon request
- Contact information regarding a State consumer assistance program, and n Information regarding the next level of Appeal, as appropriate

Other Requirements

The following describes circumstances under which the identified attachment is required for submission with the claim:

- A referral or consultant treatment plan may be required for support of specialty services
- An explanation of benefits (EOB) statement from a primary payer to CareFirst, if CareFirst is secondary
- A description of the procedure or service, which may include the dental record, if a procedure or service has no corresponding Current Dental Terminology (CDT) code
- Anesthesia records documenting the time spent on the service
- Appeal or Grievance: Submit a letter describing the reason for the appeal or grievance and the justification or rationale including supporting clinical notes or dental records (i.e. radiographs, treatment plans or office notes, etc.)
- Information related to a retrospective review and/or an audit, if a pattern of fraud, improper billing or coding is demonstrated
- Itemized bills
- Dental models
- Radiographs
- Photographs
- Diagnostic test results

When enclosing the appropriate attachments with the submitted claim, please remember to properly label the attachment with the patient's name, date, provider name and address, and ensure the radiographs are of diagnostic quality.

Dental offices may also electronically transmit radiographs and/or other supporting documentation to CareFirst through **National Electronic Attachment** (NEA). Please include the NEA document number in the Remarks section on the ADA claim form if you submit by mail. For additional information or to register with NEA, please call NEA at 800-782-5150 and select Option #2.

Refunding Erroneous Payments

If an overpayment from CareFirst is discovered the provider should call the appropriate **Provider Service Department** and alert the service representative that an adjustment is needed.

The service representative may instruct the provider to refund the amount of overpayment or initiate a voucher deduction. If the amount payable cannot be fully recovered on the next remittance schedule, the balance due is carried forward. Deductions are listed and identified on the final summary page of the remittance. CareFirst provides a chart following the NOP with recovery details about the original erroneous payment.

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 2 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 3 year period per provider)
- Routine prophylaxis
- Bitewing radiographs (up to 2 bitewing procedures/benefit plan year)
- Topical fluoride (age limit* applies)

The following benefits are generally 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 5 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)*

* Age limit—Benefits are provided until the end of the year in which the member turns 19.

The benefit for regular denture adjustment and relining is limited to once per 36 months, but not within 6 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 5 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 5 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 > 1.25cm. 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

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 (2 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.

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

Billing 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
- The member continues to be under active treatment

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, available on **CareFirst Direct**. 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.

Specialists should submit one claim for the entire orthodontic course of treatment and itemize all services, including diagnostic records. One payment will be made for the difference between the member's copayment on each service, and the provider's orthodontic pricing guarantee.

Billing Guidelines for CareFirst Administrators (CFA)

For members who hold dental insurance through CareFirst Administrators (CFA), our third party administrator, CFA processes orthodontic claims by paying out 25% of the entire benefit at banding. Orthodontists are then required to submit a monthly claim (using comprehensive codes, not D8670) for the remainder of the treatment.

This is an affiliate company of CareFirst, and an independent licensee of the Blue Cross and Blue Shield Association.

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, length of treatment, and total charge, to CareFirst for reimbursement.

Patient Does Not Qualify for Dual Orthodontic ACA 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 2 Notices of Payment (NOPs): one reflecting a denial under the patient's pediatric dental plan, and a second NOP showing that the treatment has been processed under the standalone dental plan.

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 using the current 2012© American Dental Association 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 if you submit by mail. 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 (5 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

CareFirst member contracts state that CareFirst has the right to allow the least costly alternative treatment to treat the presenting condition, if a professionally acceptable alternate exists. This limitation does not preclude the doctor or patient from a more expensive treatment plan, however, the doctor and patient must agree in advance how they are going to handle the additional cost and the member must be informed of and agree to the member liability. Providers may request a pre-treatment estimate along with supporting required documents for clinical review prior to starting the treatment.

Implant Quality Assurance

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**.

PM0017-1E (12/20)