CareFirst

Family of health care plans

DENTAL

PROVIDER MANUAL

CareFirst
Family of health care plans

Chapter 7: Policies and Procedures

Medical Policy and Technology Assessment

Medical Policies and Medical Policy Operating Procedures

The CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) evidence-based medical policies and medical policy operating procedures can be found in the Medical Policy Reference Manual. This manual is an informational database, which, along with other documentation, is used to assist CareFirst in reaching decisions on matters of medical policy and related member coverage. These policies and procedures are not intended to certify or authorize coverage availability and do not serve as an explanation of benefits or a contract. Medical policies are applicable to services covered under the patient's medical plan; several may apply to oral health care and are available for reference.

Member coverage will vary by contract and line of business. Benefits will only be available upon the satisfaction of all terms and conditions of coverage. Some benefits may be excluded from individual coverage contracts. In some instances, a patient's oral health care treatment may be covered under the medical policy. It is important to review the treatment considered, to determine whether the service provided may be covered under the medical benefit plan or the dental benefit plan.

Medical policies and medical policy operating procedures are not intended to replace or substitute for the independent clinical judgment of a practitioner or other health professional for the treatment of an individual. Medical technology is constantly changing, and CareFirst reserves the right to review and update its medical policy periodically and as necessary.

For specific reporting codes and instructions, refer to the appropriate and current coding manual, such as:

- The Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS Level II codes)
- The International Classification of Diseases (ICD)
- The American Medical Association's (AMA) Current Procedural Terminology (CPT®) (HCPCS Level I codes).
- The American Dental Association's® (ADA) Current Dental Terminology (CDT®)

The Medical Policy Reference Manual is organized according to specialty, and in some cases, subspecialty. There are search functions available online to help you identify any alignment of your treatment plan and the patient's presentation to an existing medical policy. Commonly reviewed medical policies by dental practitioners are:

- 1.03.001 – Orthotic Devices and Orthopedic Appliances
- 2.01.018 – Sleep Disorders
- 2.01.021 – Temporomandibular Joint (TMJ) Dysfunction
- 2.03.012 – Adjunctive Diagnostic Aids for Oral Cancer Screening
- 7.01.136 – Oral-Facial Trauma/Accidental Injury
- 7.01.137 – Oral-Facial Pathology
- 9.01.007A – General Anesthesia for Dental Care (Maryland and Virginia Mandates)

The introduction to the Medical Policy Reference Manual should be referenced prior to reviewing the medical policies and procedures. This section describes the medical policy process, format of documents, and definitions and interpretive guidelines of key terms such as medical necessity, cosmetic and experimental/investigational.

The medical policies and procedures located in the Medical Policy Reference Manual provide guidelines for most local lines of business. Many national accounts, processed through the National Account Service Company (NASCO) system, and members with Federal Employee Program (FEP) benefits, may defer to policies developed by the Blue Cross and Blue Shield Association (BCBSA). Therefore, there may be differences in medical policy and technology assessment determinations depending on the member contract. Benefits and coverage determinations should be verified prior to providing services.

Technology Assessments

A technology assessment is a process in which current or new/emerging technologies are thoroughly researched, evaluated and formulated, as appropriate, into evidence-based CareFirst medical policy. Technologies include drugs, devices, procedures and techniques. CareFirst has adopted the criteria of the BlueCross and BlueShield Association Technology Evaluation Center (TEC) for use in determining a technology's appropriateness for coverage. These criteria, along with an explanation of how they are applied, can be found in the introduction of the Medical Policy Reference Manual under Definitions and Interpretive Guidelines.

Technology assessments are presented with supportive data to the CareFirst technology assessment committee (TAC) on a regular basis. TAC is comprised of members of the healthcare policy department, CareFirst medical and dental directors and specialty consultants, as appropriate. Determinations of the status of the technology (i.e., whether the technology is experimental/investigational) are made by consensus of the TAC. TAC determinations are effective on the first day of the month following the meeting.

Dental Clinical Criteria

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 American Dental Association 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.

Dental Claims Adjudication Edits

Overview

Claim adjudication policies and associated edits are based on thorough reviews of a variety of sources including, but not limited to:

- CareFirst dental clinical guidelines
- ADA guidelines
- CMS policies

- Professional specialty organizations (e.g., American Association of Pediatric Dentists (AAPD), American Academy of Oral Maxillofacial Surgeons (AAOMS), American Association of Dental Consultants (AADC), etc.)
- State and/or federal mandates
- Member benefit contracts
- Provider contracts
- Current healthcare trends
- Clinical and technological advances
- Specialty expert consultants

Requests for Clinical Information

In order to accurately adjudicate claims and administer member benefits, it is sometimes necessary to request clinical records. The following is a list of some of the claims categories from which CareFirst may routinely require submission of clinical information, either before a service has been rendered, or before or after adjudication of a claim. Some of these specific modifiers are discussed in more detail throughout this manual. CareFirst maintains a dynamic list of required supporting documentation that must accompany a dental claim, and also may require information for the following categories:

- Procedures or services that require prior authorization.
- Procedures or services involving determination of medical necessity, including but not limited to those outlined in medical policies.
- Procedures or services that are or may be considered experimental/investigational.
- Claims involving review of clinical records.
- Procedures or services reported with unlisted, not otherwise classified or miscellaneous codes.
- Claims involving coordination of benefits.
- Claims being appealed.
- Claims being investigated for fraud and abuse or potential inappropriate billing practices.
- Claims that are being investigated for fraud or potential misinformation provided by a member during the application process.

This list is not intended to limit the ability of CareFirst to request clinical records. There may be additional individual circumstances when these records may be requested. By contract, these records are to be provided without charge.

Basic Claim Adjudication Policy Concepts

The following represent key coding methodologies, claims adjudication policies and reimbursement guidelines.

Note: These claim adjudication and associated reimbursement policies are applicable to local CareFirst lines of business. Adjudication edits/policies may differ for claims processed on the national processing system (NASCO) depending on the account's home plan and FEP.

Unbundled Procedures

Procedure unbundling occurs when two or more procedure codes are used to report a service when a single, more comprehensive procedure code exists that more accurately represents the service provided. Unbundled services are not separately reimbursed. If the more comprehensive code is not included on the claim, the unbundled services will be re-bundled into the comprehensive code; if it is a covered benefit, the more comprehensive service will be eligible for reimbursement. Always report the most comprehensive code(s) available to describe the services provided.

Incidental Procedures

An incidental procedure is carried out at the same time as a more complex primary procedure and/or is clinically integral to the successful outcome of the primary procedure. When procedures that are considered incidental are reported with related primary procedure(s) on the same date of service, they are not eligible for reimbursement.

Integral/Inclusive to Procedures

These are procedures that are considered integral to or included in the primary service. Integral or included in procedures are not eligible for reimbursement.

Duplicate Services and Multiple Reviews

Paying more than one provider for the same procedure or service represents duplicate procedure reimbursement.

CareFirst will reimburse only once for a service or procedure. Duplicate procedures, services and reviews, whether reported on the same or different claims, are not eligible for reimbursement.

Submissions of claims containing a miscellaneous code (DX999) are reviewed by our dental consultants. A reimbursement allowance is established based on this review using a variety of factors including, but not limited to, evaluating comparable procedures with an established fee. To be considered for reimbursement, a miscellaneous CDT code must be submitted with a complete description of the service or procedure provided. Any applicable records or reports must be submitted with the claim.

All applicable reimbursement policies will apply (i.e., incidental procedures, multiple procedures, etc.) in relation to claims submitted with miscellaneous codes.

General and Specialty Related Claim Adjudication Policies and Reimbursement Guidelines

New Patient Visit Frequency

According to CDT guidelines, a new patient is one who has not had services from the same practitioner or group in the same specialty in the past three years. An established patient periodic oral evaluation visit must be reported if the patient is seen, for any reason, by the same practitioner or member of the group with the same specialty, within the three-year timeframe. This also applies to dentists who are on-call for or covering for another dentist.

If a new patient comprehensive exam code is reported more than once by the same provider/group within the three-year timeframe, the code will automatically be denied and allowed an alternate benefit for a periodic examination.

Preventive Services

Preventive services, also known as health maintenance exams, include preventive oral examinations, related X-ray or imaging, laboratory or other diagnostic tests. Most CareFirst member contracts include a benefit for these preventive examinations, many of which are limited to twice per benefit year/annually.

For additional information, refer to the Dental Clinical Criteria, and always verify patient eligibility and benefits.

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 information 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 as follows:

- 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 limits may apply)

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 limits may apply)

The following benefits are limited to once per five years:

- Space maintainers for prematurely lost cuspid to posterior deciduous teeth

LabCorp for Dental Biopsies

LabCorp is the only national laboratory that CareFirst BlueChoice members can use when they require biopsies of the oral cavity or surrounding tissue. If pathology reports are reviewed by a lab other than LabCorp for these members, they will have unnecessary out-of-pocket expenses.

All dental laboratory work for members who have BlueChoice medical plans must be performed by LabCorp.

Teledentistry

Telemedicine services refers to the use of a combination of interactive audio, video or other electronic media used by a licensed healthcare provider for the purpose of diagnosis, consultation or treatment consistent with the provider's scope of practice. Use of e-mail, online questionnaires or fax is not considered a telemedicine service.

The ADA and CareFirst have defined synchronous teledentistry (D9995) as a real time encounter, interactive, with both audio and visual components. The use of asynchronous teledentistry (D9996) will not be a covered encounter when used without subsequent real time audio and visual encounters for encounters for emergencies and urgent dental care during this public health crisis.

The ADA has compiled information on how to perform these services and has provided additional guidance on how to bill for teledentistry services. We will not provide a benefit for photographs, streamed or recorded video or any other costs of the actual telemedicine technology. We consider this technology as equivalent to your in-office fixed costs.

CareFirst's coverage for audio-visual teledental visits will be limited to the problem-focused exam (D0140) and follow up (D0170), with D9995 considered inclusive to the telehealth service. If you and your patient determine that an office visit with you is necessary to resolve the problem, the in-person evaluation at your office on the same date of service will be considered inclusive to the telemedicine evaluation completed earlier in the day.

One evaluation will be covered per patient per date of service. For problem-focused telemedicine evaluations, please submit the appropriate code, D0140 or D0170, and your usual fee. Add D9995 to identify the synchronous telemedicine encounter and include a brief description of the patient's emergency problem in the remarks section. CareFirst will pay based on the contracted fees and the patient's plan design.

Note: D9995 is a non-reimbursable line item on the claim but allows you, your patient and CareFirst to distinguish that the examination/evaluation was performed using synchronous teledentistry means.

If your practice has its own telemedicine capability (audio/video), proceed with visits and bill CareFirst as normal with a place of service "02" and follow normal billing guidelines for both hard copy and electronic claim submissions. The Office for Civil Rights (OCR) at the HHS has stated that providers may use commercially available and third-party video chat services to provide telemedicine without risk that OCR might seek to impose a penalty for noncompliance with the Health Insurance Portability and Accountability Act (HIPAA) Rules. Guidance and frequently asked questions can be found on the OCR website.

The Maryland Preserve Telehealth Access Act

Effective July 1, 2021, the Maryland Preserve Telehealth Access Act expands the telehealth definition to include audio-only calls, which result in the appropriated delivery of a billable, covered healthcare service. All professional provider types are included in this mandate, but not all procedures. If a provider offers audio-only calls, they will be paid at the same rate as an in-person office screening visit (D0190), where applicable. This mandate expires June 30, 2025, and is applicable to patients enrolled in a fully insured Maryland benefit plan.

Dental providers should use D0190 with D9995 for audio-only dental telehealth visits. Audio-only teledentistry visits are covered when the patient is unable to participate in an audio-visual, synchronous visit in lieu of presenting in person to the office.

Restorative Services

The following benefits are generally limited to once per 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 limits may apply).

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
- TMJ

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 < 0.5cm, a benefit is provided for the extraction only; the cyst is considered inclusive.
- Alveoplasty, only if three or more teeth in a quadrant were extracted
- Frenulectomy and soft tissue graft performed on the same day.
  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 accidental 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 and will continue to be paid as long as the following criteria is met:

- Orthodontic coverage is provided in the member's contract.
- The member remains eligible to receive orthodontic benefit.
- The orthodontic treatment is to reduce or eliminate an existing malocclusion.

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 CDT 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 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 CDT 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

Standard Dental Billing Guidelines

For members covered under standard dental plans, the benefit for the orthodontic treatment is provided in quarterly or monthly installments, based on the employer 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. 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

For members covered under the Individual Select Preferred (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 (DHMO), 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. 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

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. Dentists 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 BCBS FEP Dental

BCBS FEP Dental recommends a pre-treatment estimate (PTE) be submitted prior to treatment for orthodontic services. A PTE is not a guarantee of benefits. PTEs can be sent directly to BCBS FEP Dental and do not need to be sent to the primary medical carrier first.

Dental Services Under the ACA

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.

As part of the ACA, certain dental services for children must be included as covered benefits for the member when using in-network providers.

ACA Pediatric Orthodontia

The pediatric dental orthodontic benefit requires prior authorization for medical necessity before any treatment begins. Diagnostic records and the examination do not require a 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) with a threshold value of 15 to qualify for benefits
- Virginia requires the Salzmann Deviation Index with a threshold value of 25 to qualify for benefits

The pediatric dental orthodontic benefit requires prior authorization for medical necessity before any treatment begins. However, 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.

Primary Carrier ACA Embedded Pediatric Dental

In cases where dual orthodontic coverage exists between a standalone dental benefit option and a medical plan which includes pediatric dental (ACA embedded pediatric dental), the provider should determine if the patient's orthodontia is medically necessary based on the requirements for the ACA embedded pediatric dental plan (HLD or Salzmann indices).

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 a second NOP showing that the treatment has been processed under the standalone dental plan.

Orthodontic Maximum

Orthodontic benefits are based on the member's contract. The orthodontic maximum amount(s) 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.

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.

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 three-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.

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.

Provider Guidelines

CareFirst strongly encourages providers to submit PTEs 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. 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 (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

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 PTE along with supporting required documents for clinical review prior to starting the treatment.

Billing for Services Rendered to Patients

Licensed providers may only report and submit claims for services rendered to patients that the practitioner individually and personally provides. CareFirst contracts with participating providers to perform services for an agreed upon fee. It is that provider, and only that provider, who can submit a claim and receive reimbursement.

As outlined in the CareFirst medical record documentation standards policy, 10.01.013A, in the Medical Policy Reference Manual, participating providers must accurately and completely document the medically necessary services they perform in the appropriate medical record and sign the document(s) attesting that they performed the service. Guidelines to create and maintain clinical and financial patient records are outlined by the ADA as well as notated in state regulations.

Special Services

Services rendered during off-hours, on weekends, on holidays, on an emergency basis when the office is typically closed and must be opened to treat the patient may be billed with a narrative using CDT code D9440. This service may not be covered under a patient's plan and would be the financial responsibility of the patient.

Sleep Disorders

CareFirst provides benefits for the diagnosis and management of sleep disorders, including oral appliances. Most sleep disorder services can be provided in the home setting. Refer to medical policy 2.01.018, Sleep Disorders in the Medical Policy Reference Manual for details and authorization requirements.

The D.C. Minor Consent for Vaccinations Amendment Act of 2020

CareFirst has implemented the D.C. Minor Consent for Vaccinations Amendment Act of 2020 (the Act). This legislation allows minors, 11 years of age or older, to receive a vaccine, if the minor is capable of meeting the informed consent standard and the vaccination is recommended by the United States Advisory Committee on Immunization Practices (ACIP) and provided in accordance with the United States Advisory Committee on Immunization Practices' recommended vaccinations schedule.

The Act applies to all age-appropriate vaccines including COVID-19. Vaccine(s) given under the Act must be administered in Washington, D.C.

Providers are not required to administer vaccines to minors without parental consent. However, should the elect to do so, the Act requires that providers notify CareFirst as well as seek reimbursement directly from the insurer for vaccinations given without parental consent, pursuant to the Act.

To support the Act, CareFirst developed the following process so we can suppress the EOB statement normally sent to the parent/guardian.

To ensure proper reimbursement and suppression of the corresponding EOB for vaccines administered under this Act, providers must complete both the D.C. Minor Consent Notification Form and the appropriate paper claim form.

Note: Claims for vaccines administered under this Act should not be sent electronically and must be sent on one of the paper forms below:

- Professional claims – please use the current version of the CMS-1500 form (version 02/12) on original red-ink-on-white-paper.
- Institutional claims – please use the current version of the UB-04 form on original red-in-on-white-paper.

Providers must submit both the completed notification form and correct paper claim form by mail to the following address:

CareFirst BlueCross BlueShield
Privacy Office
P.O. Box 14858
Lexington, KY 40512

Please note: Providers must follow this process exactly as outlined or CareFirst will not be able to suppress the EOB.

Refer to the Frequently Asked Questions and instructions for the paper claim form process for more information.

Radiology/Imaging

Dental X-rays (standard)

Dental x-rays are standard of care to visualize various parts of the dental complex that cannot be seen with the naked eye during an examination. While CareFirst has criteria for frequency and type of radiographs, it is imperative that the practitioner exposes the patient as little as clinically necessary to be able to diagnose and treat the patient. The ADA describes the need to take the individual patient, their clinical history, etc. into consideration when prescribing x-ray exposure. In general, if a procedure is being performed and radiographic verification of size, fit, etc. is necessary, subsequent radiographs of the same tooth/area will be considered inclusive, (e.g., during endodontic treatment, or crown seating with a test for marginal integrity).

Dental Cone Beam Computed Tomography (CBCT) imaging is currently not a covered procedure for dental benefit-covered services.

Intra and extraoral photography is considered inclusive to the primary service(s) performed and fees for those cannot be charged to the patient, except as part of the orthodontic case workup. Use of these photographs is helpful when submitting a claim on behalf of a patient if it most clearly demonstrates the clinical need for the primary procedure.