2023

CDT AND PEDIATRIC ESSENTIAL HEALTHCARE BENEFITS DENTAL PROCEDURE ADMINISTRATIVE GUIDELINES

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MASSACHUSETTS

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About This Guide

We've designed these administrative guidelines and policies to promote our members' long-term oral health. They are based on scientific research, documented professional standards, and the input of the Interspecialty Dental Advisory Committee (IDAC), which includes representatives of the American Dental Association's (ADA's) recognized clinical specialties and general practitioners from across Massachusetts. IDAC gives input regarding clinical parameters of care and helps to define the community "standard of care" when the ADA or recognized national specialty organizations have not specified national parameters of care. We review our policies on an ongoing basis to determine clinical appropriateness and to reflect significant technical advances.

This guide supports our online look-up tool for ADA Current Dental Terminology (CDT) procedure codes and pediatric Essential Healthcare Benefits (EHB). For each code, we note specific guidelines and recommendations with respect to time, age, or other contractual limitations or exclusions. We have also noted:

- When procedures are not covered benefits
- Codes that require radiographic (X-ray) imaging documentation and other supplementary documentation. **Note: Send x-rays and other diagnostic attachments *only* upon request. We will not return any attachments that are not requested or required.**
- Submission requirements for Affordable Care Act-qualifying pediatric dental services. These are available for ACA-qualifying members (small group dental plans with 1-50 eligible employees).

We accept only coding that is consistent with the verbal descriptors of CDT. However, the presence of a code in CDT does not mean that a subscriber has coverage available. We determine member benefits on the basis of our administrative policies and the terms of the subscriber's certificate. Also, some employers may customize benefits, so it's always important to check benefits and eligibility before performing services.

Some of the categories of service have introductory sections to explain what information you need to provide to facilitate our claim processing. For a more complete description of procedures, please refer to the *American Dental Association, Current Dental Terminology – 2022*. The 2022 Pediatric Essential Health Benefits CDT Guidelines are also included to comply with the requirements of the Affordable Care Act. These Guidelines are described separately. Please refer to the *Pediatric Essential Health Benefit CDT Guidelines and Submission Requirements* on our Provider Central website.

Please use our CDT look-up tools to determine the most accurate code to describe the service you provided to your patient. For additional information about billing, please refer to the Dental *Blue Book* Administrative Manual or call Dental Provider Service at **1-800-882-1178.**

Utilization Management

Utilization management activities including pre-treatment estimates, treatment review, and claim submission. Our dental utilization management team reviews certain types of procedures for quality of care, necessity, and appropriateness of treatment based on the documentation submitted. The team includes dentists, dental hygienists, and dental assistants.

While we continue to conduct utilization review on submitted claims, we don't routinely require submission of radiographs or periodontal charting from participating Dental Blue and Dental Blue PPO providers. Please refer to the *Submission Requirements for Participating Providers* column in our CDT and EHB look-up tool for any specific requirements needed when submitting claims for treatment.

What is "necessary and appropriate treatment?"

Our members' subscriber certificates specify that all dental care must be "necessary and appropriate to diagnose or treat your dental condition" and defines dental care as inclusive of services, procedures, supplies and appliances." The member's subscriber certificates identify the following criteria used to determine whether dental care is necessary and appropriate for the member. The dental care must be:

- Consistent with the prevention and treatment of oral disease or with the diagnosis and treatment of teeth that are decayed or fractured, or where the supporting structure is weakened by disease (including periodontal, endodontic, and related diseases).
- Furnished in accordance with standards of good dental practice.
- Not solely for the member's or dentist's convenience.

Based on a review of the submitted procedure documentation, our dental consultants determine available benefits for certain types of procedures, including, but not limited to, cast and milled restorations, periodontal services, oral surgery services, and fixed and removable prosthetics. A dental consultant reviews the treatment plan objectively and determines whether the services are within the scope of benefits, and whether these services appear to be necessary and appropriate for the member. Based on these findings, we may determine that a service is not *necessary and appropriate* for the member, even if a dentist has recommended, approved, prescribed, ordered, or furnished the service.

Services that are non-covered due to contractual limitations

There are situations in which specific services are not covered regardless of whether the procedure is a covered benefit. These are considered contractual limitations and are outlined in the Subscriber Certificate under "Limitations and Exclusions." Examples include a service performed for cosmetic purposes rather than for tooth decay or fracture or a service that is exploratory in nature.

Information we need to review a procedure

We review procedures including, but not limited to, cast and milled restorations, periodontal services, oral surgery services, and fixed and removable prosthetics. To thoroughly review a procedure, we may need pertinent documentation supporting your patient's treatment. This *Guide* identifies the information you must submit for each procedure that requires review. **Where we request a detailed narrative, please supply details about the patient's condition that will help us evaluate your claim and reimburse you appropriately.**

Individual consideration process

In general, we do not pay for any procedure that is not fully described by a CDT code. However, in some circumstances we will approve the unlisted procedure code or a procedure that does not otherwise meet guidelines for submission under our individual consideration process. To find out if we will apply individual consideration to cover the procedure for your patient, please:

- Submit a pre-treatment estimate request to determine if we will apply individual consideration to cover the non-covered procedure.

- Use a detailed narrative and CDT code D0999, D1999, D2999, D3999, D4999, D5899, D5999, D6199, D6999, D7999, D8999, or D9999 depending on the type of individual consideration being requested for review.

We'll review the claim and notify you of the outcome through a provider payment advisory (PPA) and provider detail advisory (PDA).

When documentation is requested

While we continue to conduct utilization review on submitted claims, we don't routinely require submission of radiographs or periodontal charting from participating Dental Blue and Dental Blue PPO providers. Please refer to the *Submission Requirements for Participating Providers* column for any specific requirements needed when submitting claims for treatment.

When we do request documentation, please remember that radiographs must be:

- Preoperative periapical images that are current and dated
- Images labeled "left" or "right" side if they are duplicates
- Mounted if they are a full series
- Diagnostic quality

Please remember to include:

- The member's name and ID
- The dentist's name and address

Refer to the specific code listing to determine what additional documentation is required.

***Massachusetts-contracted participating dentists should ONLY submit radiographs or other diagnostic attachments when requested. We will not return any radiographs or attachments that aren't required or requested**

Guidelines for specific services

Endodontic services

Endodontic procedures include exam, pulp test, pulpotomy, pulpectomy, extirpation of pulp, pre-operative, operative and post-operative radiographs, filling of canals, bacteriologic cultures, and local anesthesia. Endodontic therapy performed specifically for coping or overdenture are not covered benefits.

Claims for multiple-stage procedures should only be billed on date of completion/insertion. Benefits are not available for incomplete care. Payment for endodontic services does not mean that benefits will be available for subsequent restorative services. Coverage for those services is still subject to exclusions listed under major restorative guidelines.

Prosthodontic services

Bill claims for multiple stage procedures on the date of completion/insertion. Services may be non-covered for the following conditions:

- Untreated bone loss. An abutment tooth has poor-to-hopeless prognosis from either a restorative or periodontal perspective.
- Periapical pathology or unresolved, incomplete, or failed endodontic therapy.
- Treatment of TMJ to increase vertical dimension or restore occlusion.

Implant services

Benefits for single tooth endosteal dental implants, single tooth abutments, and single tooth implant/abutment supported crowns are now covered as a group 3 benefit up to the member's annual maximum. The surgical placement of implants to be used in the construction of an implant-supported bridge, or used as a component of an implant-supported overdenture or telescoping bridge is not a covered benefit. Also, the prosthetic abutments and pontics used in the construction of an implant supported fixed partial denture are not covered benefits.

Implant services may also be covered under a **special rider** that employer groups may purchase with their dental insurance policy. Please check the member's benefits to determine eligibility. The implant rider has a maximum lifetime dollar amount.

The rider covers the surgical placement of endosteal implants with a minimum age qualification of 16 for the replacement of teeth 2-15 and teeth 18-31. The implant rider does not cover the following services:

- Special preparatory radiographic or imaging studies (i.e., tomographic, CT, or MRI).
- Routine radiographs (i.e., periapical and panoramic.) May be covered under the member's general dental insurance policy to the same extent and under the same conditions and guidelines as those applied to a natural tooth.
- Adjunctive periodontal (D4000 series) or surgical (D7000 series) procedures in preparation for implant placement, in association with implant placement, or in association with salvage attempts

of a failing implant. These services are not covered under the rider, since the intent is to have benefits available for the implants themselves.

- Maxillofacial prosthetic procedure D5982, surgical stent (implant positioning type.) Coverage for this service will be denied, since the intent of the rider is to have benefits available for the implants themselves.
- Frequency limitation: once per tooth (replacement) per 60 months
- Prosthetic crowns for implants are not covered under the implant rider.
- Implant-supported fixed partial dentures.

Fixed prosthodontics

Bill claims for multiple stage procedures on the date of completion/insertion of the final restoration. Treatments must be generally accepted dental practice and must be necessary and appropriate for the dental condition. The foundation of generally accepted dental practice continues to be:

- Establishing periodontal health prior to final phase restoration prosthetic dentistry.
- Avoiding incomplete or technically deficient endodontic treatment which is detrimental to the long-term prognosis of the tooth and subsequent oral health.
- Cantilever pontic in the natural dentition is only covered for the replacement of a missing lateral incisor with a natural canine, or canine and bicuspid.

Fixed prosthodontics will not be covered if certain conditions are present:

- Untreated bone loss
- An abutment tooth has poor-to-hopeless prognosis from either a restorative or periodontal perspective
- Periapical pathology or unresolved, incomplete, or failed endodontic therapy
- Service meant to treat TMJ, increase vertical dimension, or restore occlusion
- A bridge where one or more of the abutments is an implant.

Orthodontic benefits

Limited Orthodontic Treatment. Use these codes for treatment utilizing any therapeutic modality with a limited objective or scale of treatment. Treatment may occur in any stage of dental development or dentition. For example: Treatment in one arch only to correct crowding, partial treatment to open spaces or upright a tooth for a bridge, implant, and partial treatment for closure of a space.

Comprehensive Orthodontic Treatment. Use these codes when there are multiple phases of treatment provided at different stages of dentofacial development. For example: The use of an activator is generally stage one of a two-stage treatment. In this situation, placement of fixed appliances will generally be stage two of a two-stage treatment. List both treatment phases as comprehensive treatment modified by the stage of dental development.

To request PA for:	Please:
Medically necessary orthodontic services	1. Submit the services requested on a dental claim form with the Pre-Treatment Estimate box checked. 2. Include the appropriate documentation for review of Comprehensive Orthodontics (D8080) including

	Pre-Treatment Claim Form, HLD Index Form, Orthodontic prior authorization form, cephalometric and panoramic images, and photographic prints showing lateral, occlusal, and frontal views for comprehensive orthodontic cases. 3. Include appropriate documentation for review of Limited Orthodontic (**D8010**, **D8020**) cases Pre-Treatment Claim Form, photographic prints, and the Orthodontic prior authorization form. 4. Send the prior authorization request electronically, if possible. If your Pre-Treatment Estimate has been approved, you can consider this to be your approved prior authorization.
Occlusal guards	1. Submit the services requested on a dental claim form with the Pretreatment Estimate box checked. . 2. Submit a narrative stating the necessity and appropriateness of an occlusal guard for prior authorization of this service. Do not enter a date of service on the claim. 3. Remember to: Enter an "X" in Box 1 of the claim form next to "Request for Predetermination/Preauthorization." List the services to be included in the prior authorization. 4. Send the prior authorization request electronically, if possible. If your Pre-Treatment Estimate has been approved, you can consider this to be your approved prior authorization..

Required documents for medically necessary prior authorization requests

Submit the following with the ADA Pre-Treatment Estimate form **(Note: Items 1, 4, and 5 are not required for Limited Orthodontic cases** (D8010/ D8020):

1. **Handicapping Labio-Lingual Deviations form**. Coverage for medically necessary orthodontics is determined by a minimum HLD Score of 22 or by an autoqualifier. Approval is based after consultant review of the appropriate documentation submitted.
2. **Pediatric Essential Health Benefits Prior Authorization form**
3. **Photographic Prints.** Photographic prints should be mounted, indicating the provider and patient names and the date.
   - Facial View: Be sure the patient's face is clearly discernible.
   - Lateral Views: Take views with sufficient soft tissue retraction to expose the buccal dentition, and as close to ninety degrees to the plane of the buccal dentition as possible (use of a mirror may be necessary.) The use of pediatric-size lip retractors facilitates sufficient soft tissue retraction. Photographs should allow evaluation of the antero-posterior relationship.
   - Occlusal Views: Take occlusal views with a mirror and retract so that the soft tissue of the lower lip does not cover the lower incisors. Try to include as many teeth as possible. Please measure the clinical widths of the maxillary and mandibular right central incisors, and enter the measurements on the HLD Recording Form.
4. **Cephalometric radiographic image**
5. **Panoramic radiographic image.** All teeth must be clearly visible.

We cannot prior authorize cases without complete information. We will return orthodontic records to the provider if submitted with a self-addressed, stamped return envelope.

How to submit claims for orthodontic treatment

Limited Treatment. Submit a claim with the appropriate CDT procedure code, including the total treatment fee and the placement date of the appliance. We will make payment after receipt of initial claim for treatment.

Comprehensive Treatment. For patients whose comprehensive treatment started after their orthodontic benefits became effective, submit the claim with the appropriate CDT procedure code, including the treatment charge and the date treatment began.

We will make monthly payments for comprehensive treatments. Initial monthly payment to you will be equal to 50% of the patients orthodontic benefit maximum for covered services less any member cost share. We will pay the rest in monthly installments until treatment plan is complete, or benefits exhausted. You do not need to submit a second claim; we will generate the payments automatically.

If comprehensive treatment began before the patient's orthodontic benefits became effective, submit the monthly visits and your monthly fee using the appropriate CDT procedure code. When submitting claims for the services included in orthodontic records, be sure to itemize listing the appropriate CDT procedure code for each service (e.g., radiographs, evaluation, study models) with your usual fee.

If you have questions regarding a patient's coverage, effective dates, or benefits, please call Dental Provider Service at **1-800-882-1178**.

How to bill for Essential Healthcare Benefits

These benefits will be administered under the subscriber's medical benefit and considered separate from any other Dental Blue product. To help you bill for dental EHB's under the member's **medical benefit**, please be aware of the following:

Check eligibility and benefits. Because these benefits have been added **only** to our small group and self-pay plans**,** it is important for you to verify eligibility and benefits before delivering services. To check eligibility and benefits, you can:

- Use Change Healthcare Dental Connect (available on our website under etools)
- Call Dental Provider Service at **1-800-882-1178**
- Call our **InfoDial** system (available 24 hours a day, seven days a week) at **1-800-882-1178** and follow the prompts for benefits and eligibility

Member benefits. Because these benefits are covered under the member's medical plan, Blue Cross Blue Shield of Massachusetts members who have EHB's through Blue Cross Blue Shield of Massachusetts will have a Blue Cross Blue Shield of Massachusetts medical ID card. Members who have dental benefits covered by Dental Blue will also have a Dental Blue ID card; in this case, both cards will have the same ID number with a different prefix.

How to bill for Essential Healthcare Benefits, *continued*

Maximums. The member's dental benefit maximums do not apply for services processed under the member's medical benefit. The provisions of the member's health plan govern coverage for these services. The member will have a separate maximum out of pocket (MOOP) benefit for pediatric dental benefits; after this maximum is met, coverage for pediatric dental benefits will not require a deductible, co-insurance, or a copayment.

Participating Dentists. You must be a participating dentist with Blue Cross Blue Shield of Massachusetts through the **Dental Blue** indemnity network to provide dental EHB's under the member's medical plan.

Reimbursement. We will reimburse Dental Blue participating dentists for pediatric dental EHB's using your submitted fee or the Dental Blue maximum allowable charge, whichever is less, minus the member's dental deductible, copayment, or co-insurance associated with the EHB plan.

Medical cost-share. When you provide services through the member's medical benefit, you must collect the member's cost-sharing (if applicable) to receive your whole reimbursement. The member's appropriate medical cost share may be a copayment (a fixed dollar amount), co-insurance (a percentage of the cost), or deductible (a first-dollar amount).