CareFirst
Family of health care plans

Part 2: Preventive

Comprehensive Dental Reference Guide

Please use the Comprehensive Dental Reference Guide when preparing your claims and pre-treatment estimates for CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc., (collectively, "CareFirst"), CareFirst BlueCross BlueShield Medicare Advantage, The Dental Network, and the Federal Employee Program®.

- **CDT code descriptions**
- **Utilization review perspectives on clinical presentations appropriate for benefit allowance**
- **CareFirst-required documentation to allow for processing**
- **Identification of codes that require a clinical review by our staff of licensed dentists**

Selecting the most appropriate code to describe treatment rendered and providing required documentation streamlines the claims submission process.

These descriptions and directions are based on standard plan designs. Individual patient plans may vary. Verify benefits and eligibility for each patient before the appointment.

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CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield Medicare Advantage is the shared business name of CareFirst Advantage, Inc. and CareFirst Advantage PPO, Inc. In the District of Columbia and Maryland, CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst Advantage, Inc., CareFirst Advantage PPO, Inc., CareFirst BlueChoice, Inc., First Care, Inc., and The Dental Network, Inc. are independent licensees of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD®, the Cross and Shield Symbols, and Federal Employee Program® are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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Preventive: D1000–D1999

The information provided is based on general clinical policy and can vary for each patient's plan. Verify benefits and eligibility for each patient before the appointment, as there are differences among plans. The following information gives generalized clinical requirements and guidance for each CDT code.

Preventive			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D1110	Prophylaxis—adult	Benefits are typically allowed (at least) two times per contract year. Benefits for a prophy within one day of perio cleaning procedures (D4341, D4342, D4355 or D4910) are not available as they are considered inclusive of the perio procedures. Benefits for a prophy are not available less than one month after scaling in the presence of gingival inflammation, D4346, is performed.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1120	Prophylaxis—child	Benefits are typically allowed (at least) two times per contract year. Benefits for a prophy within one day of perio cleaning procedures (D4341, D4342, D4355 or D4910) are not available as they are considered inclusive of the perio procedures. Benefits for a prophy are not available less than one month after scaling in the presence of gingival inflammation, D4346, is performed.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1206	Topical application of fluoride varnish	Benefits are typically allowed (at least) two times per contract year, which would be any combination of topical application of fluoride varnish (D1206) or topical application of fluoride (D1208). A fluoride benefit is provided for non-Risk members up to the end of the year in which the member turns 19. Effective 8/1/21, the age limit no longer applies to Risk members. Fluoride is available to all patients who have a Risk plan.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.

*Check patient eligibility including age and frequency limitations for each service.

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Preventive			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D1208	Topical application of fluoride	Benefits are typically allowed (at least) two times per contract year, which would be any combination of topical application of fluoride varnish (D1206) or topical application of fluoride (D1208). A fluoride benefit is provided for non-Risk members up to the end of the year in which the member turns 19. Effective 8/1/21, the age limit no longer applies to Risk members. Fluoride is available to all patients who have a Risk plan.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1310	Nutritional counseling for control of dental disease	This service is considered inclusive of other services submitted and is not a covered benefit.	n/a
D1320	Tobacco counseling for the control and prevention of oral disease	This service is considered inclusive of other services submitted and is not a covered benefit.	n/a
D1321	Counseling for the control and prevention of adverse oral, behavioral and systemic health effects associated with high-risk substance use	This service is considered inclusive of other services submitted and is not a covered benefit.	n/a
D1330	Oral hygiene instructions	This service is considered inclusive of other services submitted and is not a covered benefit.	n/a
D1351	Sealant—per tooth	Benefits are typically allowed every three years per permanent molar tooth. A sealant benefit is typically provided up to the end of the year when the member turns 19.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1353	Sealant repair, per tooth	This service is considered inclusive of the sealant procedure and is not a covered benefit.	n/a
D1354	Interim caries arresting medicament application—per tooth	This benefit is limited to one application per tooth surface/lifetime. It is allowed when there is no history of restoration, including Caries preventive medicament application (D1355), on the surface reported on the same service date or before the medicament placement.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1355	Caries preventive medicament application—per tooth	This benefit is limited to one application per tooth surface/lifetime. It is allowed when there is no history of restoration, or interim caries arresting medicament application (D1354), on the surface reported on the same service date or before the medicament placement.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1510	Space maintainer—fixed—unilateral	Check eligibility (including age limits) and frequency limitations for this service for each patient. Include the tooth number of the lost primary tooth/teeth on the claim form. The benefit is allowed for prematurely lost primary teeth only.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.

*Check patient eligibility including age and frequency limitations for each service.

Preventive			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D1516	Space maintainer—fixed—bilateral, maxillary	Check eligibility (including age limits) and frequency limitations for this service for each patient. Include the tooth number of the lost primary tooth/teeth on the claim form. The benefit is allowed for prematurely lost primary teeth only.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1517	Space maintainer—fixed—bilateral, mandibular	Check eligibility (including age limits) and frequency limitations for this service for each patient. Include the tooth number of the lost primary tooth/teeth on the claim form. The benefit is allowed for prematurely lost primary teeth only.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1520	Space maintainer—removable—unilateral	Check eligibility (including age limits) and frequency limitations for this service for each patient. Include the tooth number of the lost primary tooth/teeth on the claim form. The benefit is allowed for prematurely lost primary teeth only.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1526	Space maintainer—removable—bilateral, maxillary	Check eligibility (including age limits) and frequency limitations for this service for each patient. Include the tooth number of the lost primary tooth/teeth on the claim form. The benefit is allowed for prematurely lost primary teeth only.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1527	Space maintainer—removable—bilateral, mandibular	Check eligibility (including age limits) and frequency limitations for this service for each patient. Include the tooth number of the lost primary tooth/teeth on the claim form. The benefit is allowed for prematurely lost primary teeth only.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1551	Re-cement or rebond bilateral space maintainer—maxillary	This benefit is typically available one time per 12 months per tooth. It is not available until six months have elapsed from the insertion date. Include the tooth number of the lost primary tooth/teeth on the claim form.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1552	Re-cement or rebond bilateral space maintainer—mandibular	This benefit is typically available one time per 12 months per tooth. It is not available until six months have elapsed from the insertion date. Include the tooth number of the lost primary tooth/teeth on the claim form.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.

*Check patient eligibility including age and frequency limitations for each service.

Preventive			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D1553	Re-cement or re-bond unilateral space maintainer—per quadrant	This benefit is typically available one time per 12 months per tooth. It is not available until six months have elapsed from the insertion date. Include the tooth number of the lost primary tooth/teeth on the claim form.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1556	Removal of a fixed unilateral space maintainer—per quadrant	A benefit is only available if the appliance is removed by a dentist other than the dentist who originally placed the appliance. If submitted by the dentist who originally placed the appliance, the service is considered inclusive and is non-billable.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1557	Removal of fixed bilateral space maintainer—maxillary	A benefit is only available if the appliance is removed by a dentist other than the dentist who originally placed the appliance. If submitted by the dentist who originally placed the appliance, the service is considered inclusive and is non-billable.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1558	Removal of fixed bilateral space maintainer—mandibular	A benefit is only available if the appliance is removed by a dentist other than the dentist who originally placed the appliance. If submitted by the dentist who originally placed the appliance, the service is considered inclusive and is non-billable.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1575	Distal shoe space maintainer—fixed—unilateral	Check eligibility (including age limits) and frequency limitations for this service for each patient. Include the tooth number of the lost primary tooth/teeth on the claim form. The benefit is allowed for prematurely lost primary teeth only.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1701	Pfizer-BioNTech Covid-19 vaccine administration—first dose (SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 1)	Vaccine administration is typically considered a medical procedure. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D1702	Pfizer-BioNTech Covid-19 vaccine administration—second dose (SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 2)	Vaccine administration is typically considered a medical procedure. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D1703	Moderna Covid-19 vaccine administration—first dose (SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 1)	Vaccine administration is typically considered a medical procedure. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D1704	Moderna Covid-19 vaccine administration—second dose (SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 2)	Vaccine administration is typically considered a medical procedure. It may be billed under the patient's medical plan. It may or may not be covered.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Preventive			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D1720	Influenza vaccine administration	Vaccine administration is typically considered a medical procedure. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D1781	Vaccine administration—Human Papillomavirus—Dose 1	Vaccine administration is typically considered a medical procedure. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D1782	Vaccine administration—Human Papillomavirus—Dose 2	Vaccine administration is typically considered a medical procedure. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D1783	Vaccine administration—human papillomavirus—Dose 3	Vaccine administration is typically considered a medical procedure. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D1999	Unspecified preventive procedure, by report	D1999 was used during COVID-19 to pay for additional costs related to PPE. Effective 11/1/2020, this code is considered inclusive of other diagnostic or preventive procedures, and benefits are not available.	n/a

*Check patient eligibility including age and frequency limitations for each service.