

## **Washington Apple Health (Medicaid)**

# **Access to Baby and Child Dentistry Billing Guide**

**(For clients through age 5)**

**January 1, 2020**

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.

## About this guide\*

This publication takes effect January 1, 2020, and supersedes earlier guides to this program.

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People, who have hearing or speech disabilities, please call 711 for relay services.

Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

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\* This publication is a billing instruction.

## What has changed?

Subject	Change	Reason for Change
<b>COVID-19</b>	For the most current information regarding policy during the COVID-19 pandemic, please go to the <a href="#">COVID-19 webpage</a> .	Ease of finding information regarding dental changes related to COVID-19.
<a href="#">Definitions</a>	Added definition for “Current Procedural Terminology (CPT)”.	To align with updates regarding medical providers who use CPT codes for billing.
<a href="#">Are clients enrolled in an agency-contracted managed care organization (MCO) eligible?</a>	Added note box to clarify all ABCD program services provided by a non-dental provider must be billed through the client’s MCO.	Change in billing.
<a href="#">Coverage</a>	Under <i>What is covered</i> , changed “other agency-approved participating providers” to “ABCD non-dental provider.”	To align with changes in medical managed care.
	Updated note box to clarify Family Oral Health Education must be billed using CDT code D9999 for dental providers or CPT code 99429 with modifier DA for non-dental providers.	Billing update.
<a href="#">Coverage Table</a>	Added statement that the coverage table applies to ABCD dental providers	To clarify the first table applies to ABCD dental providers and the following newly added table applies to ABCD non-dental providers.
	Updated note box for code D1206 and D1208, clarifying the codes are equivalent and only one of the codes, not both, can be billed every four months.	Simplified language to make the code usage more clear.
	Added CDT codes D9222 and D9239 to list of codes not to be used in conjunction with billing for behavior management.	For clarification.
<a href="#">Coverage table non-dental providers</a>	Added new coverage table that applies to ABCD non-dental providers.	ABCD non-dental providers must bill using

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<b>ABCD-certified</b>	Removed “certified” language throughout guide.	CPT codes with modifier DA. ABCD is its own certification.
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## Additional Resources

To access provider alerts, go to the agency’s [Provider Alerts](#) webpage.

To access provider documents, go to the agency’s [Provider Billing Guides and Fee Schedules](#) webpage.

For additional resources, see the [Dental-Related Services Billing Guide](#).

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# Definitions

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This list defines terms and abbreviations, including acronyms, used in this guide.

**Access to Baby and Child Dentistry (ABCD)** – A program to increase access to dental services for Medicaid-eligible clients age five and younger.

**Anterior** – The maxillary and mandibular incisors, canines and tissue in the front of the mouth.

- Permanent maxillary anterior teeth include teeth 6, 7, 8, 9, 10, and 11.
- Permanent mandibular anterior teeth include teeth 22, 23, 24, 25, 26, and 27.
- Primary maxillary anterior teeth include teeth C, D, E, F, G, and H.
- Primary mandibular anterior teeth include teeth M, N, O, P, Q, and R.

**Current Dental Terminology (CDT®)** - A systematic listing of descriptive terms and identifying codes for reporting dental services and procedures performed by dental practitioners. CDT is published by the Council on Dental Benefit Programs of the American Dental Association (ADA).

**Current Procedural Terminology (CPT®)**  
A medical code set used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations.

**Dental Home** – The ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible,

coordinated and family-centered way. Establishment of a dental home begins no later than 12 months of age and includes referrals to specialists when appropriate.

**Interim therapeutic restoration (ITR)** – The placement of an adhesive restorative material following caries debridement by hand or other method for the management of early childhood caries. ITR is not considered a definitive restoration. (WAC [182-535-1050](#))

**Posterior** – The maxillary and mandibular incisors and canines and tissue in the front of the mouth.

- Permanent maxillary posterior teeth include teeth 1, 2, 3, 4, 5, 12, 13, 14, 15, and 16.
- Permanent mandibular posterior teeth include teeth 17, 18, 19, 20, 21, 28, 29, 30, 31, and 32.
- Primary maxillary posterior teeth include teeth A, B, I, and J.
- Primary mandibular posterior teeth include teeth K, L, S, and T.

# About the Program

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(WAC [182-535-1245](#))

## What is the ABCD program?

The Access to Baby and Child Dentistry (ABCD) program was established to increase access to dental services for Medicaid-eligible clients through age 5. The program's goal is to ensure that positive dental experiences in early childhood will lead to lifelong practices of good oral health. This is done in part by identifying and removing obstacles to early preventive treatment, such as the lack of transportation to a dental office, language interpretation issues, etc. (See [How does the ABCD program work?](#)).

The ABCD program is a partnership between the public and private sectors, including:

- The Health Care Authority.
- The Washington State Department of Health.
- The University of Washington School of Dentistry.
- Arcora (formerly known as The Washington Dental Service Foundation).
- The Washington State Dental Association.
- Local dental societies.
- Local health jurisdictions.
- Other funding sources.

The **mission** is to identify eligible infants and toddlers before age one and to match each child to an ABCD dentist (See [Who is eligible?](#)). Children will remain in the ABCD program until their sixth birthday (See WAC [182-535-1245\(1\)\(a\)](#)).

ABCD non-dental providers are also crucial to early intervention, as these providers typically see young children at least eight times before age 3 and opportunities exist to aid in early detection of dental health issues and promote dental preventive care. ABCD non-dental providers are encouraged to become credentialed and deliver dental disease prevention services.

Health care providers and community service programs identify and refer eligible clients to an ABCD provider.

Eligible clients and an adult family member may receive:

- Family oral health education.
- Anticipatory guidance.
- Assistance with transportation, interpreter services, and other issues related to dental services. (See WAC [182-535-1245\(2\)](#)).

**Note:** ABCD-eligible children are entitled to the full scope of care as described in the agency's [Dental-Related Services Billing Guide](#). This *Access to Baby and Child Dentistry (ABCD) Billing Guide* identifies specific services that are eligible for higher reimbursement.

## Who may provide ABCD dentistry?

(WAC [182-535-1245\(3\)](#))

- **Dentists** certified through the continuing education program at the University of Washington School of Pediatric Dentistry or graduate after 2006 from the University of Washington, School of Dentistry, are eligible for ABCD program enhanced reimbursement rates.
- **ABCD non-dental providers** (physicians, ARNPs, physician assistants) certified through Arcora (formerly known as The Washington Dental Service Foundation) are eligible for select ABCD program enhanced reimbursement rates (See the agency's [Physician-Related Services](#) billing guide).



## How does the ABCD program work?

The following chart lists the people/agencies involved in the ABCD program and shows how they interact to ensure eligible children receive restorative and preventive dental services.

Who	Responsibility
Community service programs including local health jurisdictions	<p>Identify Medicaid-eligible clients and refer them to an ABCD provider.</p> <p>Provide an orientation to the client or parent(s)/guardian(s) and prepare the family and child for the dental visit.</p> <p>Address obstacles to care, such as lack of transportation and limited English proficiency.</p> <p>Coordinate with local agencies in providing outreach and linkage services to eligible clients.</p>
ABCD Program Dentists	<p>Provide preventive and restorative treatment for an eligible client.</p> <p>Bill the agency for provided services according to this guide.</p>
ABCD non-dental Providers	<p>Provide periodic oral evaluation, family oral health education, and topical application of fluoride.</p> <p>Bill the agency for provided services according to this guide.</p>
Local Dental Societies	Encourage and support participation from members.
Health Care Authority	Reimburse ABCD program dentists for services covered under this program.
University of Washington School of Dentistry	Provide technical and procedural consultation on the enhanced treatments and conduct continued provider training and certification.
Arcora	<p>Provide management services and technical assistance to support client outreach, linkage, and provider recruitment.</p> <p>Provide training to primary care medical providers and certify them to receive enhanced reimbursement for delivering dental disease prevention services.</p>

# Client Eligibility

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## Who is eligible?

(WAC [182-535-1245\(1\)\(a\)\(b\)](#))

Clients age five and younger are eligible for ABCD services. Providers must verify that a patient has Washington Apple Health coverage for the date of service, and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

**Note:** See the agency [Dental-Related Services Billing Guide](#) for eligibility information regarding services other than those outlined in this guide.

## How can I verify a patient's eligibility?

Verifying eligibility is a two-step process:

**Step 1. Verify the patient's eligibility for Washington Apple Health.** For detailed instructions on verifying a patient's eligibility for Washington Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's [ProviderOne Billing and Resource Guide](#).

If the patient is eligible for Washington Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

**Step 2. Verify service coverage under the Washington Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Washington Apple Health client's benefit package, see the agency's [Program Benefit Packages and Scope of Services](#) webpage.

**Note:** Patients who wish to apply for Washington Apple Health can do so in the following ways:

1. By visiting the Washington Healthplanfinder's website at:  
[www.wahealthplanfinder.org](http://www.wahealthplanfinder.org).
2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY).
3. By mailing the application to:  
Washington Healthplanfinder  
PO Box 946  
Olympia, WA 98507

In person application assistance is also available. To get information about in-person application assistance available in their area, people may visit [www.wahealthplanfinder.org](http://www.wahealthplanfinder.org) or call the Customer Support Center.

## **Are clients enrolled in an agency-contracted managed care organization (MCO) eligible?**

(WAC [182-535-1245](#)(1)(c))

**Yes.** When verifying eligibility using ProviderOne, if the client is enrolled in an agency-contracted managed care organization, managed care enrollment will be displayed on the client benefit inquiry screen.

**Note:** Effective on and after January 1, 2020, ABCD program services provided by a non-dental provider for eligible clients who are enrolled in an agency-contracted managed care organization (MCO) previously paid through the fee-for-service payment system must now be billed directly through the client's MCO.

# Coverage

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(WAC [182-535-1245](#) (3))

## What is covered?

The agency pays enhanced fees only to ABCD dental providers and ABCD non-dental providers (e.g., ARNPs, physicians and PAs) for furnishing ABCD services. ABCD services include all of the following, when appropriate:

- Family oral health education. An oral health education visit must meet all of the following:
  - ✓ Be limited to one visit per day, per family, up to two visits per child in a 12-month period, per provider or clinic
  - ✓ Include documentation of all of the following in the client's record:
    - **"Lift the Lip" Training:** Show the "Lift Lip" flip chart or DVD provided at the certification workshop. Have the parent(s)/guardian(s) practice examining the child using the lap position. Ask if the parent(s)/guardian(s) feel comfortable doing this once per month.
    - **Oral hygiene training:** Demonstrate how to position the child to clean the teeth. Have the parent(s)/guardian(s) actually practice cleaning the teeth. Record the parent/guardian's response.
    - **Risk assessment for early childhood caries:** Assess the risk of dental disease for the child. Obtain a history of previous dental disease activity for this child and any siblings from the parent(s)/guardian(s). Also, note the dental health of the parent(s)/guardian(s).
    - **Dietary counseling:** Talk with the parent(s)/guardian(s) about the need to use a cup, rather than a bottle, when giving the child anything sweet to drink. Note any other dietary recommendations made.

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- **Discussion of fluoride supplements:** Discuss fluoride supplements with the parent(s)/guardian(s). The dentist, physician, or ARNP must write a fluoride prescription for the child, if appropriate. Let the parent/guardian know fluoride supplements are covered under the agency's Prescription Drug Program. Fluoride prescriptions written by the dentist, physician, or ARNP may be filled at any Medicaid-participating pharmacy. Ensure that the child is not already receiving fluoride supplements through a prescription written by the child's primary care medical provider.
- **Documentation** in the client's record to record the activities provided and duration of the oral education visit.

**Note:** Family oral health education is limited to one per day, per family, up to two visits per child in a 12-month period. The limit of one per day, per family also applies when multiple children in the family are seen on the same date of service.

**Do not use the parent's ProviderOne Client ID. For dental providers, Family Oral Health Education must be billed using CDT code D9999. Non-dental providers must bill using CPT code 99429 with modifier DA.**

- Application of fluoride varnish
- Periodic oral evaluations, once every 6 months. Six months must elapse between the comprehensive oral evaluation and the first periodic oral evaluation.
- Comprehensive oral evaluations, once per client, per provider or dental clinic, as an initial examination. The agency covers an additional comprehensive oral evaluation if the client has not been treated by the same provider or clinic within the past five years.
- Amalgam, resin, and glass ionomer restorations on primary teeth, as specified in current agency published documents

**Note:** The agency reimburses amalgam and resin restorations for a maximum of two surfaces for a primary first molar and a maximum of three surfaces for a primary second molar.

**Note:** The agency reimburses resin-based composite restorations for a maximum of three surfaces for a primary anterior tooth.

- Prefabricated porcelain/ceramic crowns for anterior primary teeth as specified in current agency published documents
- Therapeutic pulpotomy

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## Access to Baby and Child Dentistry

- Prefabricated stainless steel crowns on primary teeth, as specified in current agency published documents
- Resin-based composite crowns on anterior primary teeth
- Interim therapeutic restorations (ITRs) performed by ABCD, ITR-trained dentists
- Other dental-related services, as specified in current agency-published documents

**Note:** The client's record must show documentation of the ABCD services provided. (WAC [182-535-1245](#) (4))

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# Coverage Table

The following table applies to ABCD dental providers.

CDT® Code*	Nomenclature*	PA	Limitations
D0120	Periodic oral evaluation	No	One periodic evaluation allowed every 6 months, per provider.
D0150	Comprehensive oral evaluation	No	For agency purposes, this is to be considered an initial exam. One initial evaluation allowed per client, per provider or dental clinic.  Normally used by a general dentist or a specialist when evaluating a patient comprehensively.  <b>Six months must elapse before a periodic evaluation will be reimbursed.</b>
D1206	Topical application of fluoride varnish	No	Three times within a 12-month period with a minimum of 110 days between applications.  <b>Note:</b> CDT codes D1206 and D1208 are equivalent, and only one of the codes, not both, can be billed every four months.

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**Access to Baby and Child Dentistry**

CDT® Code*	Nomenclature*	PA	Limitations
D1208	Topical application of fluoride, excluding varnish	No	<p>Three times within a 12-month period with a minimum of 110 days between applications.</p> <p>Document in the client’s record which material (e.g., topical gel) is used.</p> <p><b>Note:</b> CDT codes D1206 and D1208 are equivalent, and only one of the codes, not both, can be billed every four months.</p>
D1575	Distal shoe space maintainer – fixed - unilateral	No	Quadrant designation required
D2140	Amalgam - one surface, primary or permanent	No	Tooth and surface designations required. Allowance includes polishing.
D2150	Amalgam - two surfaces, primary or permanent	No	Tooth and surface designations required. Allowance includes polishing.
D2160	Amalgam - three surfaces, primary or permanent	No	<p>Tooth and surface designations required.</p> <p><b>If billed on a primary first molar, the agency will reimburse at the rate for a two-surface restoration.</b></p>
D2330	Resin-based composite - one surface, anterior	No	Tooth and surface designations required. Allowed only on anterior teeth C through H and M through R.
D2331	Resin-based composite – two surfaces, anterior	No	Tooth and surface designations required. Allowed only on anterior teeth C through H and M through R.
D2332	Resin-based composite – three surfaces, anterior	No	Tooth and surface designations required. Allowed only on anterior teeth C through H and M through R.

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CDT® Code*	Nomenclature*	PA	Limitations
D2390	Resin-based composite crown, anterior – primary tooth	Yes*	Tooth designation required.  *Clients may meet EPA criteria: See EPA <a href="#">#870001348</a> .
D2391	Resin-based composite – one surface, posterior	No	Tooth and surface designations required.
D2392	Resin-based composite – two surfaces, posterior	No	Tooth and surface designations required.
D2393	Resin-based composite – three surfaces, posterior	No	Tooth designation required.  <b>If billed on a primary first molar, the agency will reimburse at the rate for a two-surface restoration.</b>
D2929	Prefabricated porcelain/ceramic crown – primary tooth	Yes*	Tooth designation required.  *Clients may meet EPA criteria: See EPA <a href="#">#870001348</a> and <a href="#">#870001347</a> .
D2930	Prefabricated stainless steel crown - primary tooth	Yes*	Tooth designation required.  *Clients may meet EPA criteria: See EPA <a href="#">#870001348</a> and <a href="#">#870001347</a> .
D2933	Prefabricated stainless steel crown with resin window	Yes*	Tooth designation required.  *Clients may meet EPA criteria: See EPA <a href="#">#870001348</a> and <a href="#">#870001347</a> .
D2941	Interim therapeutic restoration – primary dentition	Yes*	Tooth designation required. Covered for clients age 5 years and younger with a maximum of five teeth per visit. Restorations on a tooth can be done every 12 months through age 5 or until the tooth can be definitively treated for a permanent restoration. *See EPA <a href="#">#870001379</a> and <a href="#">#870001380</a> .

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CDT® Code*	Nomenclature*	PA	Limitations
D3220	Therapeutic pulpotomy	No	Covered only as complete procedure, once per tooth. Tooth designation required.
D9310	Professional consultation or diagnostic service provided by a practitioner other than the original practitioner	Yes	See <a href="#">Dental-Related Services billing guide</a> .
D9920	Behavior management	No	Involves a client whose documented behavior requires the assistance of at least <b>one additional professional staff</b> (six-handed dentistry) to protect the client and staff from injury while treatment is rendered; must be provided in a dental office or dental clinic
D9999	Family Oral Health Education	No	Limited to one visit per day, per family, up to two visits <b>per child</b> , per 12-month period, per provider or clinic.

**Note:** Do not bill Behavior management in conjunction with CDT codes D9222/D9223 or D9239/D9243 in any setting. For behavior management, the client’s record must include a description of the behavior being managed, the behavior management technique used, and identification of the additional professional staff used to manage the behavior to assist the delivery of dental treatment.

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## Access to Baby and Child Dentistry

The following table applies to ABCD **non-dental** providers.

CPT® Code*	ICD diagnosis Code	Description	Modifier	Limitations
99188	Z00.129	Topical application of fluoride varnish	DA	Three times within a 12-month period with a minimum of 110 days between applications.
99499	Z00.129	Periodic oral evaluation	DA	One periodic evaluation allowed every 6 months, per provider.
99429	Z00.129	Family oral health education	DA	Limited to one visit per day, per family, up to two visits <b>per child</b> , per 12-month period, per provider or clinic.

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# Expedited Prior Authorization

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## What is expedited prior authorization (EPA)?

The expedited prior authorization (EPA) process is designed to eliminate the need for prior authorization for selected dental procedure codes.

To use an EPA:

- Enter the EPA number on the claim form when billing the agency.
- When requested, provide documentation showing the client's condition meets **all** the EPA criteria.
- Prior authorization is required when a situation does not meet **all** the EPA criteria for selected dental procedure codes. See the agency's [Prior Authorization webpage](#) for details.

It is the provider's responsibility to determine if a client has already received the service allowed with the EPA criteria. If the client already received the service, a prior authorization request is required to provide the service again or to provide additional services.

**Note:** By entering an EPA number on your claim, you attest that **all** the EPA criteria are met and can be verified by documentation in the client's record. These services are subject to post payment review and audit by the agency or its designee.

The agency may recoup any payment made to a provider if the provider did not follow the required EPA process and if not all of the specified criteria were met.

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## EPA procedure code list

EPA #	CDT Code*	Description	Criteria
870001347	D2929	prefabricated porcelain/ceramic crown – primary tooth	<p>Allowed for a client age 12 and younger for a <b>primary posterior tooth</b> when determined to be medically necessary by a dental practitioner and one of the following conditions are met:</p> <ul style="list-style-type: none"> <li>Evidence of extensive caries</li> <li>Evidence of Class II caries with rampant decay</li> <li>Treatment of decay requires sedation or general anesthesia.</li> <li><b>First molar</b> requires a three or more surface restoration</li> <li><b>Second molar</b> requires a four or more surface restoration</li> <li>Tooth has a pulpotomy</li> </ul> <p>Allowed once every 3 years; allowed once every 2 years for clients of DDA.</p> <p>Medical justification (including preoperative x-rays (radiographs) or clinical documentation of findings when unable to take x-rays (radiographs) due to young age) must be present in the client record.</p>
	D2930	prefabricated stainless steel crown – primary tooth	
	D2933	prefabricated stainless steel crown with resin window	
870001348	D2390	resin-based composite crown, anterior (includes strip crowns)	<p>Allowed for a client age 12 and younger for a <b>primary anterior tooth</b> when determined to be medically necessary by a dental practitioner and one of the following conditions are met:</p> <ul style="list-style-type: none"> <li>Evidence of extensive caries</li> <li>Evidence of rampant decay</li> <li>Treatment of decay requires sedation or general anesthesia</li> <li>Requires a four or more surface restoration</li> </ul> <p>Allowed once every 3 years; allowed once every 2 years for clients of DDA.</p> <p>Medical justification (including preoperative x-rays (radiographs)) must be present in the client record.</p>
	D2929	prefabricated porcelain/ceramic crown – primary tooth	
	D2930	prefabricated stainless steel crown – primary tooth	
	D2933	prefabricated stainless steel crown with resin window	

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EPA #	CDT Code*	Description	Criteria
870001379	D2941	interim therapeutic restoration – primary dentition	<p>Interim therapeutic restoration (ITR) will be allowed in lieu of a definitive restoration as follows:</p> <ul style="list-style-type: none"> <li>• Child must be age 5 or younger</li> <li>• Has current decay</li> <li>• ABCD provider and has completed ITR training</li> <li>• ITR is expected to last a minimum of one year</li> <li>• Allowed for a maximum of 5 teeth per visit</li> <li>• Based on the treating dentist clinical judgement, will be allowed yearly until can be definitively treated or until the client’s 6<sup>th</sup> birthday.</li> </ul> <p>Not allowed in conjunction with general anesthesia (D9222, D9223, D9239, or D9243).</p> <p>NOT ALLOWED on the same day as other definitive restorations.</p>

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**Access to Baby and Child Dentistry**

EPA #	CDT Code*	Description	Criteria
870001380	D2941	interim therapeutic restoration – primary dentition	<p>Interim therapeutic restoration (ITR) will be allowed in lieu of a definitive restoration as follows:</p> <ul style="list-style-type: none"> <li>• Child must be age 5 or younger</li> <li>• Has current decay</li> <li>• ABCD provider and has completed ITR training</li> <li>• ITR is expected to last a minimum of one year</li> <li>• Allowed for a maximum of five teeth per visit</li> <li>• Based on the treating dentist clinical judgement, will be allowed yearly until can be definitively treated or until the client’s 6<sup>th</sup> birthday.</li> </ul> <p>Not allowed in conjunction with general anesthesia (D9222, D9223, D9239, or D9243).</p> <p>ALLOWED on the same day as definitive treatment if documentation that the child was not able to proceed with complete treatment once started.</p>

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# Billing

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All claims must be submitted electronically to the agency, except under limited circumstances. For more information, see the agency's [ProviderOne Billing and Resource](#) web page, *Paperless billing at HCA*. For providers approved to bill paper claims, see the *Paper Claim Billing Resource*.

## What are the general billing requirements?

Providers must follow the agency's [ProviderOne Billing and Resource Guide](#). These billing requirements include:

- What time limits exist for submitting and resubmitting claims and adjustments.
- When providers may bill a client.
- How to bill for services provided to primary care case management (PCCM) clients.
- How to bill for clients eligible for both Medicare and Medicaid.
- How to handle third-party liability claims.
- What standards to use for record keeping.

## How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on the agency's [Billers and Providers](#) webpage, under [Webinars](#).

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the [HIPAA Electronic Data Interchange \(EDI\)](#) web page.