Access to Baby and Child Dentistry(ABCD) Provider Guide

April 1, 2013

About this guide[*]

This publication takes effect as specified below and supersedes earlier guides to this program.

> 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.

What has changed?

Reason for Change	Effective Date	Subject	Change
Changes to Coverage Table PN 13-21	01/01/2013	Coverage	Added CDT code D1206 and a note to CDT code D1208.
Changes to Coverage Table PN 13-21	03/01/2013	Coverage	Added CDT code D2933.
Housekeeping PN 13-21	04/01/2013	Housekeeping	Reformatted and edited document for clarity.

Additional Resources

To download and print agency provider notices and provider guides, see the agency's Provider Publications website. For additional resources, see the agency's list of Available Resources and the Dental-Related Services Provider Guide.

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[*] This publication is a billing instruction.

Table of Contents

Alert! The page numbers in this table of contents are now "clickable"—do a "control + click" on a page number to go directly to a spot. As an Adobe (.pdf) document, the guide also is easily navigated by using bookmarks on the left side of the document. If you don't immediately see the bookmarks, right click on the gray area next to the document and select Page Display Preferences. Click on the bookmark icon on the left.)

Definitions

This list defines terms and abbreviations, including acronyms, used in this guide. For additional definitions, see the agency's [Washington Apple Health Glossary](#).

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 and 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).

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.

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

(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 five. 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.
- 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-certified dentist. (see Who is eligible?) Children will remain in the ABCD program until their sixth birthday. (See WAC 182-535-1245(1)(a)).

Primary care medical providers are also crucial to early intervention, as these providers typically see young children at least 8 times before age 3 and opportunities exist to aid in early detection of dental health issues and promote dental preventive care. Primary care medical 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 the ABCD program.

If enrolled in the ABCD program, the client 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 Provider Guide. This *Access to Baby and Child Dentistry (ABCD) Provider Guide* identifies specific services that are eligible for higher reimbursement.

Who may provide ABCD dentistry?
(WAC 182-535-1245(3))

Dentists who are 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.

Primary care medical providers who are certified through Washington Dental Service Foundation are eligible for select ABCD program enhanced reimbursement rates.

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 preventive dental services.

Who	Responsibility
Community service programs including local health jurisdictions	Identify Medicaid-eligible clients and refer them to the program.
Local community ABCD enrollment units This function may not be available in all counties	Provide an orientation to the client and/or parent(s)/guardian(s) and prepares the family and child for the dental visit. Enroll the client and family into the ABCD program and encourage timely and appropriate dental visits.

* The CDT Code and Nomenclature above have been obtained from *Current Dental Terminology* (including procedure codes, nomenclatures, descriptors and other data contained therein) ("CDT"). CDT is copyright © 2012 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Who	Responsibility
Local community ABCD enrollment units This function may not be available in all counties.	Provide the client with an ABCD program identification (ID) card. The client's parent(s)/guardian(s) must show this ID card to the dentist to prove the client is eligible for the program. Address obstacles to care, such as lack of transportation and limited English proficiency. Coordinate with local agencies in providing outreach and linkage services to eligible clients.
ABCD Program-Certified Dentists	Provide preventive and restorative treatment for an eligible client. Bill the agency for provided services according to this guide.
Certified Primary Care Medical Providers	Provide periodic oral evaluation, family oral health education, and topical application of fluoride. Bill the agency for provided services according to this guide.
Local Dental Societies	Encourage and support participation from members.
Health Care Authority	Reimburse program-certified 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.
Washington Dental Service Foundation	Provide management services, funding, and technical assistance to support client outreach, linkage, and provider recruitment. Provide training to primary care medical providers and certify them to receive enhanced reimbursement for delivering dental disease prevention services.

Client Eligibility

How can I verify a patient's eligibility?
(WAC 182-535-1245(1)(a)(b))

Clients five years of age and younger are eligible. 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.

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 Health Care Coverage—Program Benefit Packages and Scope of Service Categories web page.

> **Note:** Patients who are not Washington Apple Health clients may submit an application for health care coverage in one of the following ways:
>
> 1. By visiting the Washington Healthplanfinder's website at:
>   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 or call the Customer Support Center.

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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 plan, managed care enrollment will be displayed on the client benefit inquiry screen.

> **Note:** See the agency Dental-Related Services Provider Guide for eligibility information regarding services other than those outlined in this guide.

Coverage

(WAC 182-535-1245 (3))

What is covered?

The agency pays enhanced fees only to ABCD-certified dental providers and other agency-approved participating providers (e.g., ARNPs and physicians) 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 all of the following:

        ➢ **"Lift the Lip" Training:** Show the "Lift Lip" videotape or flip chart 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's/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.

> ➤ **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 file or the client's designated adult member's (family member or other responsible adult) file to record the activities provided and duration of the oral education visit.

Note: Bill the agency under the ProviderOne Client ID of the first child seen in the family. **Do not use the parent's ProviderOne Client ID.** Family Oral Health Education **must be billed using ADA/HCPCS code D9999**.

- Application of fluoride

- Periodic oral evaluations, once every six 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

- Amalgam and resin 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.

- Fabricated resin crowns for anterior primary teeth as specified in current agency published documents

- Therapeutic pulpotomy

- Prefabricated stainless steel crowns on primary teeth, as specified in current agency published documents

- Resin-based composite crowns on anterior primary teeth

- Glass ionomers used for Immediate Restorative Treatment (IRT) (allowed for children through five years of age when provided in the dental office or dental clinic)

- Other dental-related services, as specified in current agency-published documents

> **Note:** The client's file must show documentation of the ABCD services provided. (WAC 182-535-1245 (5))

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Coverage Table

CDT Code*	Nomenclature*	PA	Limitations	Maximum Allowable Fee
D0120	Periodic oral evaluation	No	One periodic evaluation is allowed every six months, per provider.	Fee Schedules
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 and/or a specialist when evaluating a patient comprehensively. **Six months must elapse before a periodic evaluation will be reimbursed.**	Fee Schedules
D1206	Topical application of fluoride varnish	No	Allowed up to 3 times in a 12-month period per client, per provider. **Note:** CDT codes D1206 and D1208 are not allowed on the same day. The fluoride limit per provider, per client, for CDT codes D1206 and D1208 is the combined total of the two; not per code. The codes are considered equivalent, and a total of 3 fluorides are allowed, not 3 of each.	Fee Schedules

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CDT Code*	Nomenclature*	PA	Limitations	Maximum Allowable Fee
D1208	Topical application of fluoride	No	Allowed up to 3 times in a 12-month period per client, per provider or clinic. Document in the client's file which material (e.g., topical gel) is used. **Note:** CDT codes D1206 and D1208 are not allowed on the same day. The fluoride limit per provider, per client, for CDT codes D1206 and D1208 is the combined total of the two; not per code. The codes are considered equivalent, and a total of 3 fluorides are allowed, not 3 of each.	Fee Schedules
D2140	Amalgam - one surface, primary or permanent	No	Tooth and surface designations required. Allowance includes polishing.	Fee Schedules
D2150	Amalgam - two surfaces, primary or permanent	No	Tooth and surface designations required. Allowance includes polishing.	Fee Schedules
D2160	Amalgam - three surfaces, primary or permanent	No	Tooth and surface designations required. **If billed on a primary first molar, the agency will reimburse at the rate for a two-surface restoration.**	Fee Schedules
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.	Fee Schedules
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.	Fee Schedules

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CDT Code*	Nomenclature*	PA	Limitations	Maximum Allowable Fee
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.	Fee Schedules
D2390	Resin-based composite crown, anterior – primary tooth	No	Tooth designation required.	Fee Schedules
D2391	Resin-based composite – one surface, posterior	No	Tooth and surface designations required.	Fee Schedules
D2392	Resin-based composite – two surfaces, posterior	No	Tooth and surface designations required.	Fee Schedules
D2393	Resin-based composite – three surfaces, posterior	No	Tooth designation required. **If billed on a primary first molar, the agency will reimburse at the rate for a two surface restoration.**	Fee Schedules
D2929	Prefabricated porcelain/ ceramic crown	No	Tooth designation required.	Fee Schedules
D2930	Prefabricated stainless steel crown - primary tooth	No	Tooth designation required.	Fee Schedules
D2933	Prefabricated stainless steel crown with resin window	No	Tooth designation required.	Fee Schedules
D3220	Therapeutic pulpotomy	No	Covered only as complete procedure, once per tooth. Tooth designation required.	Fee Schedules

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CDT Code*	Nomenclature*	PA	Limitations	Maximum Allowable Fee
D9920	Behavior management	No	Involves a patient whose documented behavior requires the assistance of at least **one additional dental professional staff** to protect the patient from self-injury while treatment is rendered.	[Fee Schedules](#)
D9999	Family Oral Health Education	No	Limited to 1 visit per day, per family, up to 2 visits **per child**, per 12-month period, per provider or clinic.	[Fee Schedules](#)

Billing and Claim Forms

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 complete claim forms?

See the agency's ProviderOne Billing and Resource Guide for instructions on completing the following claim forms:

- 2006 ADA
- CMS-1500

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