

**Washington Apple Health (Medicaid)**

# Orthodontic Services Billing Guide

**July 1, 2018**

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 July 1, 2018, and supersedes earlier billing 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.

Services, equipment, or both, related to any of the programs listed below must be billed using their program-specific billing guides:

- [Access to Baby and Child Dentistry \(ABCD\)](#)
- [Dental-Related 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.

## What has changed?

Subject	Change	Reason for Change
<a href="#">Cleft lip and palate, cleft palate, or cleft lip with alveolar process involvement</a>	Updated limitations and requirements for documentation.	Clarification
<a href="#">How do I complete and submit the Orthodontic Information (HCA 13-666) form?</a>	Updated the photographic evidence required for deep impinging overbite with soft tissue destruction.	Clarification of required evidence.

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\* This publication is a billing instruction.

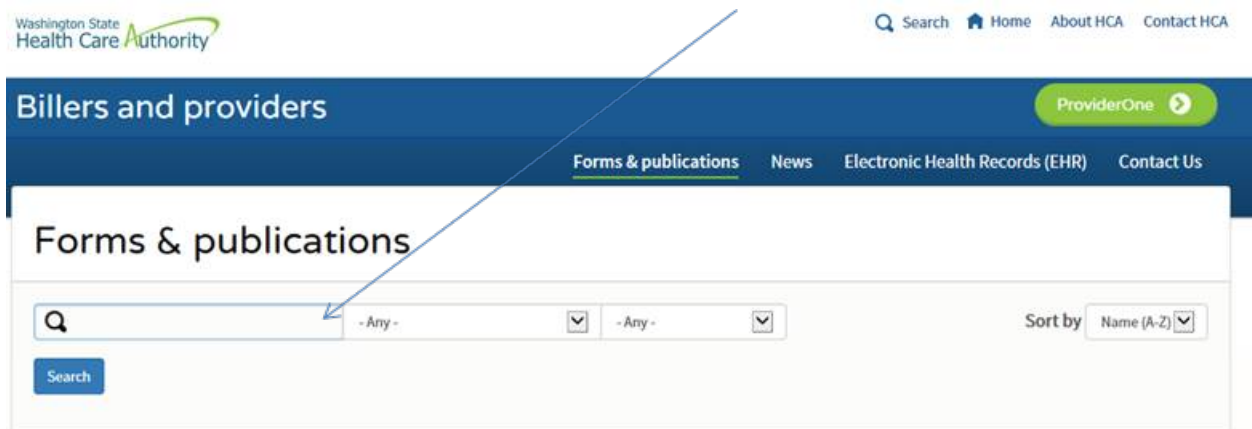
## How can I get agency provider documents?

To access provider alerts, go to the agency's [provider alerts](#) web page.

To access provider documents, go to the agency's [provider billing guides and fee schedules](#) web page.

## Where can I download agency forms?

To download an agency provider form, go to HCA's Billers and provider's web page, select [Forms & publications](#). Type the HCA form number into the **Search box** as shown below (Example: 13-835).



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# Definitions

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This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to [Chapter 182-500 WAC](#) for a complete list of definitions for Washington Apple Health. This list also uses definitions found in the current American Dental Association's Current Dental Terminology (CDT) and the current American Medical Association's Physician's Current Procedural Terminology (CPT®). **Where there is any discrepancy between this section and the current CDT or CPT, this section prevails.**

**Adolescent dentition** – The dentition that is present after the-loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment.

**Adult** – For the general purposes of the agency's dental program, means a client age 21 and older.

**Appliance placement** – The application of orthodontic attachments to the teeth for the purpose of correcting dentofacial abnormalities. ([WAC 182-535A-0010](#))

**Child** – For the general purposes of the agency's dental program, means a client age 20 and younger.

**Cleft** – An opening or fissure involving the dentition and supporting structures, especially those occurring in utero. These can be:

1. Cleft lips
2. Cleft palates (involving the roof of the mouth)
3. Facial clefts (e.g., macrostomia).  
(WAC 182-535A-0010)

**Comprehensive full orthodontic treatment** – Using fixed orthodontic appliances for treatment of adolescent dentition leading to the improvement of a client's severe handicapping craniofacial dysfunction and/or dentofacial deformity,

including anatomical and functional relationships. (WAC 182-535A-0010)

**Craniofacial anomalies** – Abnormalities of the head and face, either congenital or acquired, involving disruption of the dentition and supporting structures. (WAC 182-535A-0010)

**Craniofacial team** – A cleft palate/maxillofacial team or an American Cleft Palate Association-certified craniofacial team. These teams are responsible for the management (review, evaluation, and approval) of patients with cleft palate craniofacial anomalies to provide integrated case management, promote parent-professional partnerships, and make appropriate referrals to implement and coordinate treatment plans. (WAC 182-535A-0010)

**Crossbite** – An abnormal relationship of a tooth or teeth to the opposing tooth or teeth, in which normal buccolingual or labiolingual relations are reversed.

**Dental dysplasia** – An abnormality in the development of the teeth. (WAC 182-535A-0010)

**Ectopic eruption** – A condition in which a tooth erupts in an abnormal position or is 50% blocked out of its normal alignment in the dental arch.

**Early and periodic screening, diagnosis and treatment (EPSDT)** – The agency’s early and periodic screening, diagnosis, and treatment program for client twenty years of age and younger as described in chapter 182-534 WAC.

**Hemifacial microsomia** – A developmental condition involving the first and second brachial arch. This creates an abnormality of the upper and lower jaw, ear, and associated structures (half or part of the face is smaller in size).  
(WAC 182-535A-0010)

**Interceptive orthodontic treatment** – Procedures to lessen the severity or future effects of a malformation and to affect or eliminate the cause. Such treatment may occur in the primary or transitional dentition and may include such procedures as the redirection of ectopically erupting teeth, correction of isolated dental cross-bite, or recovery of recent minor space loss where overall space is adequate.  
(WAC 182-535A-0010)

**Limited orthodontic treatment** – Orthodontic treatment with a limited objective, not involving the entire dentition. It may be directed only at the existing problem, or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive therapy.  
(WAC 182-535A-0010)

**Malocclusion** – The improper alignment of biting or chewing surfaces of upper and lower teeth or abnormal relationship of the upper and lower dental arch. (WAC 182-535A-0010)

**Maxillofacial** – Relating to the jaws and face. (WAC 182-535A-0010)

**Occlusion** – The relation of the upper and lower teeth when in functional contact during jaw movement. (WAC 182-535A-0010)

**Orthodontics** – Treatment involving the use of any appliance, in or out of the mouth, removable or fixed, or any surgical procedure designed to redirect teeth and surrounding tissues. (WAC 182-535A-0010)

**Orthodontist** – A dentist who specializes in orthodontics, who is a graduate of a postgraduate program in orthodontics that is accredited by the American Dental Association, and who meets the licensure requirements of the Department of Health.  
(WAC 182-535A-0010)

**Permanent dentition** – Teeth that succeed the primary teeth and the additional molars that erupt.

**Primary dentition** – Teeth developed and erupted first in order of time, which are normally shed and replaced by permanent teeth.

**Transitional dentition** – The change from primary to permanent dentition in which the primary molars and canines are in the process of exfoliating and the permanent successors are emerging.

# Client Eligibility

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

([WAC 182-535A-0020](#), [WAC 182-501-0060](#))

The agency covers medically necessary orthodontic treatment and orthodontic-related services for severe handicapping malocclusions, craniofacial anomalies, or cleft lips or palates for clients age 20 and younger on a benefit package (BP) that covers such services.

Providers must verify that a patient has Washington Apple Health coverage for the date of service, and that the client's BP 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 current [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 BP.** To determine if the requested service is a covered benefit under the Washington Apple Health client's BP, see the agency's [Program Benefit Packages and Scope of Services](#) web page.

**Note:** Patients who wish to apply for Washington Apple Health can do so in one of 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 transferring from non-Medicaid or out-of-state providers eligible for continued orthodontic treatment?**

Eligible clients may receive the same orthodontic treatment and orthodontic-related services for continued orthodontic treatment when originally rendered by non-Medicaid or out-of-state providers as follows:

- The provider must submit the initial orthodontic case study and treatment plan records with the request for continued treatment.
- The agency evaluates the initial orthodontic case study and treatment plan to determine if the client met the agency's orthodontic criteria. See [When does the agency cover orthodontic treatment and related services?](#)
- The agency determines continued treatment duration based on the client's current orthodontic conditions.

The agency does not cover continued treatment if the client's initial condition did not meet the agency's criteria for the initial orthodontic treatment. The agency pays a deband and retainer fee if the client does not meet the initial orthodontic treatment criteria.

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

**Yes.** Washington Apple Health covers orthodontic and orthodontic-related services for eligible clients enrolled in an agency-contracted managed care organization (MCO). Bill the agency directly for all orthodontic and orthodontic-related services provided to eligible agency-contracted MCO clients.

# Provider Requirements

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## Who may provide and be paid for orthodontic treatment and orthodontic-related services?

[\(WAC 182-535A-0030\)](#)

The following provider types may furnish and be paid for providing covered orthodontic treatment and orthodontic-related services to eligible Washington Apple Health clients:

- Orthodontists
- Pediatric dentists
- General dentists
- Agency-recognized craniofacial teams or other orthodontic specialists approved by the agency

## What are the requirements for out-of-state providers?

[\(WAC 182-535A-0060\(8\)\)](#)

Orthodontic providers who are in agency-designated bordering cities must meet the following criteria:

- The licensure requirements of their state
- The same criteria for payment as in-state providers, including the requirements to contract with the agency

# Coverage

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## When does the agency cover orthodontic treatment and related services?

[\(WAC 182-535A-0040\)](#)

The agency covers orthodontic treatment and related services, subject to prior authorization requirements and the limitation list within this billing guide, for clients with one of the following medical conditions:

- Cleft lip and palate, cleft palate, or cleft lip with alveolar process involvement
- Other craniofacial anomalies including, but not limited to:
  - ✓ Hemifacial microsomia
  - ✓ Craniosynostosis syndromes
  - ✓ Cleidocranial dental dysplasia
  - ✓ Arthrogyryposis
  - ✓ Marfan syndrome
  - ✓ Treacher Collins syndrome
  - ✓ Ectodermal dysplasia
  - ✓ Achondroplasia

**Treatment and follow-up care must be performed only by an agency-recognized craniofacial team or an orthodontic specialist who has been approved by the agency.**

- Severe malocclusions with a Washington Modified Handicapping Labiolingual Deviation (HLD) Index Score of 25 or higher. (See [Where can I download agency forms?](#) to download the agency's *Orthodontic Information* (HCA 13-666) form, for scoring instructions.) The agency determines the final HLD Index Score based on documentation submitted by the provider.
- Dental malocclusions other than those listed on a case-by-case basis and when prior authorized.

# What orthodontic treatment and related services does the agency cover?

[\(WAC 182-535A-0040\)](#)

When deemed medically necessary with PA, the agency covers the following orthodontic treatments and related services for clients age 20 and younger:

- Interceptive orthodontic treatment
- Limited orthodontic treatment
  - ✓ The treatment includes up to 12 months of treatment from the date of the original appliance placement (see [Authorization](#) for information on limitation extensions).
  - ✓ The agency approves limited orthodontic treatment on transitional or adolescent dentition only.
  - ✓ The agency may approve a single impacted tooth for limited orthodontic treatment. When requesting PA for an impacted tooth, the agency requires the provider to submit a panoramic x-ray.
- Comprehensive full orthodontic treatment
  - ✓ The treatment must be completed within 30 months of the date of the original appliance placement (see [Authorization](#) for information on limitation extensions).
  - ✓ The agency approves comprehensive full orthodontic treatment on adolescent dentition only.
- Orthodontic appliance removal as a stand-alone service only when both:
  - ✓ The client's appliance was placed by a different provider or dental clinic, **and**
  - ✓ The provider removing the appliance has not furnished any other orthodontic treatment or orthodontic-related services to the client.
- On an individual basis, other orthodontic treatment and orthodontic-related services as determined medically necessary by the agency

## Treatment requirements

- If it is anticipated the client will require orthognathic surgery, a treatment plan must be submitted to the agency with the request for prior authorization confirming that an oral surgeon has been consulted and has committed to treat the client.
- The treatment must meet industry standards and correct the medical issue. If treatment is discontinued before completion, or treatment objectives were not obtained, clear documentation must be kept in the client's record explaining why treatment was not completed or why treatment goals were not obtained.

## What orthodontic treatment and orthodontic-related services are not covered by the agency?

[\(WAC 182-535A-0040\(4\)\)](#)

The agency does not cover the following orthodontic treatment and related services:

- Orthodontic treatment provided after the client's 21<sup>st</sup> birthday (treatment provided after the client's 21<sup>st</sup> birthday is the financial responsibility of the client)
- Case studies that do not include a definitive treatment plan
- Orthodontic treatment for cosmetic purposes
- Orthodontic treatment that is not medically necessary, as defined in [WAC 182-500-0070](#)
- Orthodontic treatment provided out-of-state (except out-of-state bordering cities according to [WAC 182-501-0175](#))

**Exception:** Providers in agency-designated bordering cities may be eligible for payment for services provided to agency clients. See [Provider Requirements](#) for information.

- Orthodontic treatment and related services that do not meet the requirements listed in this billing guide

**Note:** The agency evaluates a request for orthodontic treatment and related services that are:

- In excess of the limitations or restrictions listed in this section, according to [WAC 182-501-0169](#); and
- Listed as noncovered according to [WAC 182-501-0160](#).

## **What services are covered under the EPSDT program?**

**[\(WAC 182-535A-0040\(8\)\)](#)**

Under the Early Periodic Screening and Diagnostic Treatment (EPSDT) program, clients age 20 and younger may be eligible for orthodontic treatment and orthodontic-related services considered noncovered. The agency reviews requests for orthodontic treatment and orthodontic-related services for EPSDT clients, according to the provisions of [WAC 182-534-0100](#).

# Authorization

[\(WAC 182-535-1079 \(5\)\)](#)

## What is a limitation extension (LE)?

A limitation extension (LE) is an authorization of services beyond the designated benefit limit allowed in Washington Administration Code (WAC) and the agency's Washington Apple Health billing guides.

**Note:** A request for a limitation extension must be appropriate to the client's eligibility or program limitations. Not all eligibility groups cover all services.

The agency evaluates a request for dental-related services that are in excess of the Dental Program's limitations or restrictions, according to [WAC 182-501-0169](#).

## How to request an LE?

The agency requires a dental provider who is requesting an LE to submit sufficient, objective, clinical information to establish medical necessity.

**Providers must submit the request in writing on a completed *General Information for Authorization* form, HCA 13-835.** See [Where can I download agency forms?](#) See the agency's [ProviderOne Billing and Resource Guide](#) for more information.

### The agency may request additional information as follows:

- Additional x-rays (radiographs) (the agency returns x-rays only for approved requests and only if accompanied by self-addressed stamped envelope)
- Study model, if requested
- Photographs
- Any other information requested by the agency

**Note:** The agency may require second opinions and consultations before authorizing any procedure.

### Removable Dental Prosthetics

For nursing facility clients, the LE request must also include a completed copy of the *Denture/Partial Appliance Request for Skilled Nursing Facility Client* form, HCA 13-788. See [Where can I download agency forms?](#)

## What is an exception to rule (ETR)?

An exception to rule (ETR) is when a client or the client's provider requests the agency to pay for a noncovered service. The agency reviews these requests according to [WAC 182-501-0160](#).

## How to request an ETR

A noncovered service must be requested through ETR. To request a noncovered service, submit the request in writing on a completed *General Information for Authorization* form, HCA 13-835, and fax to the agency at: (866) 668-1214. See [Where can I download agency forms?](#)

Indicate in Box 30 on the form that you are requesting an ETR.

Be sure to provide all of the evidence required by [WAC 182-501-0160](#).



# Coverage Table

## General

### Clinical evaluations

CDT® Code	Description	PA? <sup>1</sup>	Limitations/ Requirements	Maximum Allowable Fee
D0160	Detailed and extensive oral evaluation – orthodontic only	No	Includes orthodontic oral examination, taking and processing clinical photographs, completing required form(s) and obtaining the agency’s authorization decision.  Allowed once per client, per billing provider	<a href="#">Online Fee Schedules</a>
D0170	Re-evaluation – limited, problem focused (established patient; not post-operative visit)	No	Not allowed in combination with periodic/limited/comprehensive oral evaluations.  Allowed once per client, per billing provider, per year until appliances are placed	

<sup>1</sup> PA-Prior Authorization

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## X-rays (radiographs)

CDT® Code	Description	PA?	Limitations/ Requirements	Maximum Allowable Fee
D0330	Panoramic film – maxilla and mandible	Yes	Included in case study. Additional films require prior authorization.  <b>Panoramic films</b> are not required when submitting prior authorization requests for orthodontic services unless the request indicates that the client has an impacted tooth or teeth. Therefore films are not covered prior to case study approval.	<a href="#">Online Fee Schedules</a>
D0340	Cephalometric film	Yes	Included in case study. Additional films require prior authorization.  <b>Cephalometric films</b> are not required when submitting prior authorization requests for orthodontic services unless the request indicates that the client has a negative overjet. Therefore films are not covered prior to case study approval.	

## Other orthodontic services

CDT® Code	Description	PA?	Limitations/ Requirements	Maximum Allowable Fee
D8220	Fixed appliance therapy	Yes	Considered for a Thumb Crib	<a href="#">Online Fee Schedules</a>
D8680	Appliance removal if placed by non-Medicaid provider	Yes	<b>Use this code for</b> a client whose appliance was placed by an orthodontic provider not participating with the agency, and/or whose treatment was previously covered by another third-party payer. Fee includes debanding and removal of cement.	
D8692	Replacement of lost or broken retainer	Yes	First replacement included in initial payment if within 6 months of deband date. Additional replacements require PA.	<a href="#">Online Fee Schedules</a>

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# Cleft lip and palate, cleft palate, or cleft lip with alveolar process involvement

**Note:** Providers must correctly indicate the appliance date on all orthodontic treatment claims.

CDT® Code	Description	PA?	Limitations/ Requirements	Maximum Allowable Fee
D8660	Cleft palate pre-orthodontic treatment visit	EPA	<p><b>Requires use of EPA # 870000970</b> when billing for cleft palate and craniofacial anomaly cases.</p> <p>Billable only by the treating orthodontic provider. Includes preparation of comprehensive diagnostic records (additional photos, study casts, cephalometric examination film, and panoramic film), formation of diagnosis and treatment plan from such records, and formal case conference.</p> <p>Treating provider <b>must</b> be an orthodontist <b>and either be</b> a member of a recognized craniofacial team <b>or</b> approved by the agency’s Dental Consultant to provide this service.</p> <p>Medically necessary ICD diagnosis codes associated with cleft palate, cleft uvula or cleft lip must be documented in the client’s record.</p>	<p><a href="#">Online Fee Schedules</a></p>

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## Limited orthodontic treatment for cleft palate

CDT® Code	Description	PA?	Limitations/ Requirements	Maximum Allowable Fee
D8020	Limited orthodontic treatment of the transitional dentition for cleft palate	EPA	<p><b>Requires the use of EPA #870001402</b> when billing for cleft palate and craniofacial anomaly cases.</p> <p>This reimbursement is for the <b>initial placement</b> when the appliance placement date and the date of service are the same. Includes first three months of treatment and appliance(s).</p>	<a href="#">Online Fee Schedules</a>
D8020	Limited orthodontic treatment of the transitional dentition for cleft palate	EPA	<p>This reimbursement is for each <b>subsequent three-month period</b> when the appliance placement date and the date of service are different. The agency reimburses a maximum of three follow-up visits.</p> <p><b>Requires use of EPA # 870001403</b> when billing for cleft palate and craniofacial anomaly cases.</p> <p><b>Note: To receive reimbursement for each subsequent three-month period:</b></p> <ul style="list-style-type: none"> <li>• The provider must examine the client in the provider’s office at least once during the three-month period. <i>*However, the agency prefers that the client be seen every eight to ten weeks, or as medically necessary.</i></li> <li>• Continuing treatment must be billed after each three-month interval.</li> <li>• Document the actual service dates in the client’s record.</li> </ul>	

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**Orthodontic Services**

CDT® Code	Description	PA?	Limitations/ Requirements	Maximum Allowable Fee
D8030	Limited orthodontic treatment of the adolescent dentition for cleft palate	EPA	<p><b>Requires use of EPA # 870000970</b> when billing for cleft palate and craniofacial anomaly cases.</p> <p>This reimbursement is for the <b>initial placement</b> when the appliance placement date and the date of service are the same. Includes first three months of treatment and appliance(s).</p>	<a href="#">Online Fee Schedules</a>
D8030	Limited orthodontic treatment of the adolescent dentition for cleft palate	EPA	<p>This reimbursement is for each <b>subsequent three-month period</b> when the appliance placement date and the date of service are different. The agency reimburses a maximum of three follow-up visits.</p> <p><b>Requires use of EPA # 870000970</b> when billing for cleft palate and craniofacial anomaly cases.</p> <p><b>Note: To receive reimbursement for each subsequent three-month period:</b></p> <ul style="list-style-type: none"> <li>• The provider must examine the client in the provider’s office at least once during the three-month period. <i>*However, the agency prefers that the client be seen every eight to ten weeks, or as medically necessary.</i></li> <li>• Continuing treatment must be billed after each three-month interval.</li> <li>• Document the actual service dates in the client’s record.</li> </ul>	

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## Interceptive orthodontics for cleft palate

CDT® Code	Description	PA?	Limitations/ Requirements	Maximum Allowable Fee
D8060	Interceptive orthodontic treatment of the transitional dentition for cleft palate	EPA	<p><b>Requires use of EPA # 870000980</b> when billing for cleft palate and craniofacial anomaly cases.</p> <p>Payable only once per client. The maximum allowance includes all professional fees, laboratory costs, and required follow-up. No allowance for lost or broken appliance.</p>	<a href="#">Online Fee Schedules</a>

## Comprehensive orthodontic treatment for cleft palate

CDT® Code	Description	PA?	Limitations/ Requirements	Maximum Allowable Fee
D8080	Comprehensive orthodontic treatment of the adolescent dentition for cleft palate	EPA	<p>This reimbursement is for the <b>initial placement</b> when the date of service and the appliance placement date are the same.</p> <p><b>Requires the use of EPA # 870000990.</b> This verifies that the client has a cleft palate or craniofacial anomaly.</p> <p>Includes first six months of treatment and appliances.</p> <p>Treating provider <b>must</b> be an orthodontist <b>and</b> be either a member of a recognized craniofacial team or approved by the agency's Dental Consultant to provide this service.</p>	<a href="#">Online Fee Schedules</a>

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**Orthodontic Services**

CDT® Code	Description	PA?	Limitations/ Requirements	Maximum Allowable Fee
D8080	Comprehensive orthodontic treatment of the adolescent dentition for cleft palate	EPA	<p>This reimbursement is for each <b>subsequent three-month period</b> when the appliance placement date and the date of service are different. The agency reimburses a maximum of eight follow-up visits.</p> <p><b>Requires the use of EPA # 870000990.</b> This verifies that the client has a cleft palate or craniofacial anomaly.</p> <p>Treating provider <b>must</b> be an orthodontist <b>and</b> be either a member of a recognized craniofacial team or approved by the agency’s Dental Consultant to provide this service.</p>	<a href="#">Online Fee Schedules</a>
			<p><b>Note: To receive reimbursement for each subsequent three-month period:</b></p> <ul style="list-style-type: none"> <li>• The provider must examine the client in the provider’s office at least once during the three-month period, with the first three-month interval beginning six months after the initial appliance placement. <i>* However, the agency prefers that the client be seen every eight to ten weeks, or as medically necessary.</i></li> <li>• Continuing treatment must be billed after each three-month interval.</li> <li>• Document the actual service dates in the client’s record.</li> </ul>	

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 © 2017 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

## Severe handicapping malocclusion

**Note:** You must correctly indicate the appliance date on all orthodontic treatment claims.

### Clinical evaluations

CDT® Code	Description	PA?	Limitations/ Requirements	Maximum Allowable Fee
D8660	Severe malocclusion pre-orthodontic visit	Yes	Use this code for Orthodontist Case Study. Billable only by the treating orthodontic provider. Includes preparation of comprehensive diagnostic records (additional photos, study casts, cephalometric examination film, and panoramic film), formation of diagnosis and treatment plan from such records, and formal case conference.	<a href="#">Online Fee Schedules</a>

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## Limited orthodontic treatment for severe malocclusion

CDT® Code	Description	PA?	Limitations/ Requirements	Maximum Allowable Fee
D8020	Limited orthodontic treatment of transitional dentition for severe malocclusion	Yes	This reimbursement is for the <b>initial placement</b> when the appliance placement date and the date of service are the same. Includes first three months of treatment and appliance(s).	<a href="#">Online Fee Schedules</a>
D8020	Limited orthodontic treatment of transitional dentition for severe malocclusion	Yes	<p>This reimbursement is for each <b>subsequent three-month period</b> when the appliance placement date and the date of service are different.</p> <p>The agency reimburses a maximum of three follow-up visits.</p> <p><b>Note: To receive reimbursement for each subsequent three-month period:</b></p> <ul style="list-style-type: none"> <li>The provider must examine the client in the provider’s office at least once during the three-month period. <i>* However, the agency prefers that the client be seen every eight to ten weeks, or as medically necessary.</i></li> <li>Continuing treatment must be billed after each three-month interval.</li> <li>Document the actual service dates in the client’s record.</li> </ul>	
D8030	Limited orthodontic treatment of the adolescent dentition for severe malocclusion	Yes	This reimbursement is for the <b>initial placement</b> when the appliance placement date and the date of service are the same. Includes first three months of treatment and appliance(s).	

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## Orthodontic Services

CDT® Code	Description	PA?	Limitations/ Requirements	Maximum Allowable Fee
D8030	Limited orthodontic treatment of the adolescent dentition for severe malocclusion	Yes	<p>This reimbursement is for each <b>subsequent three-month period</b> when the appliance placement date and the date of service are different.</p> <p>The agency reimburses a maximum of three follow-up visits.</p> <p><b>Note: To receive reimbursement for each subsequent three-month period:</b></p> <ul style="list-style-type: none"> <li>• The provider must examine the client in the provider’s office at least once during the three-month period. <i>* However, the agency prefers that the client be seen every eight to ten weeks, or as medically necessary.</i></li> <li>• Continuing treatment must be billed after each three-month interval.</li> <li>• Document the actual service dates in the client’s record.</li> </ul>	<a href="#">Online Fee Schedules</a>

### Interceptive orthodontics for severe malocclusion

CDT® Code	Description	PA?	Limitations/ Requirements	Maximum Allowable Fee
D8060	Interceptive orthodontic treatment of the transitional dentition for severe malocclusion	Yes	The maximum allowance includes all professional fees, laboratory costs, and required follow-up.	<a href="#">Online Fee Schedules</a>

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## Comprehensive orthodontic treatment for severe malocclusion

CDT® Code	Description	PA?	Limitations/ Requirements	Maximum Allowable Fee
D8080	Comprehensive orthodontic treatment of the adolescent dentition for severe malocclusion	Yes	This reimbursement is for the initial placement when the appliance placement date and the date of service are the same. Includes first six months of treatment and appliances.	
D8080	Comprehensive orthodontic treatment of the adolescent dentition for severe malocclusion	Yes	<p>This reimbursement is for each <b>subsequent three-month period</b> when the appliance placement date and the date of service are different. The agency reimburses a maximum of eight follow-up visits.</p> <p><b>Note: To receive reimbursement for each subsequent three-month period:</b></p> <ul style="list-style-type: none"> <li>The provider must examine the client in the provider's office at least once during the three-month period. <i>* However, the agency prefers that the client be seen every eight to ten weeks, or as medically necessary.</i></li> <li>Continuing treatment must be billed after each three-month interval, with the first three-month interval beginning six months after the initial appliance placement.</li> <li>Document the actual service dates in the client's record.</li> </ul>	

[Online Fee Schedules](#)

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# Authorization

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Prior authorization (PA) and expedited prior authorization (EPA) numbers do not override the client's eligibility or program limitations. Not all categories of eligibility receive all services.

## What orthodontic treatment and orthodontic-related services require authorization?

[\(WAC 182-535A-0050\)](#)

All orthodontic treatment and orthodontic-related services require either prior authorization or expedited prior authorization.

## General information about authorization

- For covered orthodontic-related services that require PA, the agency uses the payment determination process described in [WAC 182-501-0165](#).
- Authorization of an orthodontic-related service only indicates that the service is medically necessary. Authorization does not guarantee payment.

## When do I need to get prior authorization?

If prior authorization is required, it must be received from the agency **before** the service is provided.

Authorization is based on the establishment of medical necessity as determined by the agency on a case-by-case basis.

## How do I request written prior authorization?

**Note:** The agency requires an orthodontic provider who is requesting PA to submit sufficient, objective, clinical information to establish medical necessity.

To request prior authorization for orthodontic treatment and related services, submit all the following to the agency:

- **A completed *General Information for Authorization (HCA 13-835)* form** (See [Where can I download agency forms?](#)) – See the agency’s current [ProviderOne Billing and Resource Guide](#) for more information.
- ***Orthodontic Information (HCA 13-666)* form, with the following information:**
  - ✓ Client’s name and date of birth
  - ✓ Client’s ProviderOne client ID
  - ✓ Provider’s name and address
  - ✓ Provider’s telephone number (including area code)
  - ✓ Provider’s unique National Provider Identifier (NPI)
  - ✓ Physiological description of the disease, injury, impairment, or other ailment
  - ✓ Most recent and relevant radiographs (x-rays) as required. They must include the client name, provider name, and date the radiographs were taken. **Radiographs should be duplicates as originals are to be maintained in the client’s chart**
  - ✓ Proposed treatment
- Diagnostic color photographs
- A commitment letter from an oral surgeon when the request indicates that orthognathic surgery may be needed

### **Orthognathic surgery requests must be submitted with the following documents:**

- Treatment plan including expected surgical intervention CPT codes
- Cephalometric radiographs (x-rays)
- Color photographs (including five intraoral and three facial views)

**Note:** Prior authorization requests for orthognathic surgery must be submitted at least 12 months after the start of active orthodontic treatment. The agency will reject PA requests for orthognathic surgery that are submitted before the completion of 12 months of active orthodontic treatment.

**Note:** For billing information on billing CPT codes for oral surgery, refer to the agency's current [Physician-Related Services/Health Care Professional Billing Guide](#). The agency pays oral surgeons for only those CPT codes listed in the [Dental Fee Schedule](#) under Dental CPT Codes.

**The agency may request the following additional information:**

- **Additional x-rays (radiographs)** – The agency returns x-rays only for approved requests and if accompanied by self-addressed stamped envelope.
- **Study models** – Study models must be trimmed to sit on their backs in centric occlusion. Pack them carefully for shipping. Do not send study models with a wax bite between the models.
- Any other information requested by the agency

**Note:** The agency may require second opinions and consultations before authorizing any procedure.

## Medical justification

1. All information pertaining to medical necessity must come from the client's prescribing orthodontist. Information obtained from the client or someone on behalf of the client (e.g., family) will not be accepted.
2. Measurement, counting, recording, or consideration for treatment is performed only on teeth that have erupted and can be seen on the diagnostic study models. All measurements are made or judged on the basis equal to, or greater than the minimum requirement.
3. Only permanent natural teeth will be considered for comprehensive full orthodontic treatment of severe malocclusions.
4. A **single** impacted tooth alone is not considered a severe handicapping malocclusion.
5. Use either of the upper central incisors when measuring overjet, overbite (including reverse overbite), mandibular protrusion, and open bite. The upper lateral incisors or upper canines may not be used for these measurements.

## Where do I send requests for prior authorization?

Prior authorization (PA) requests must be faxed to the agency at 1-866-668-1214 using the *General Information for Authorization* (HCA 13-835) form. See [Where can I download agency forms?](#)

For information regarding submitting prior authorization requests to the agency, see the agency's [ProviderOne Billing and Resource Guide](#).

### With x-rays or photos

In order for the scanning and optical character recognition (OCR) functions to work, you **must** pick one of the following options for submitting x-rays or photos to the agency:

- Use the FastLook™ and FastAttach™ services provided by National Electronic Attachment, Inc. (NEA). You may register with NEA by visiting [www.nea-fast.com](http://www.nea-fast.com). On the dental registration page, enter “FastWDSHS” in the promotion code box. Contact NEA at 1-800-782-5150, ext. 2, with any questions.

When this option is chosen, you can fax your request to the agency and indicate the NEA# in the NEA field on the PA Request form. **There is a cost associated which will be explained by the NEA services.**

- Mail your request to:  
Authorization Services Office  
PO Box 45535  
Olympia, WA 98504-5535

#### **If you choose to mail your requests, the agency requires you to:**

1. Place x-rays in a large envelope.
2. Attach the PA request form and any other additional pages to the envelope (i.e. tooth chart, periodontal charting, etc.).
3. Put the client's name and ProviderOne ID# on the envelope.

**Note:** For orthodontics, write “orthodontics” on the envelope.

4. Place all materials in a larger envelope for mailing. You may mail multiple requests together.

**Note:** If study models are requested, include the client information and ID on **the models**. When mailing, indicate the provider's name, authorization reference #, and the word "orthodontics" on **the box**.

## Expedited Prior Authorization (EPA)

### What is expedited prior authorization (EPA)?

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

The agency allows for use of an EPA for selected dental procedure codes. The criteria for use of an EPA are explained below.

- The EPA number must be used when the provider bills the agency.
- Upon request, a provider must provide documentation to the agency showing how the client's condition meets **all** the criteria for EPA.
- A written request for prior authorization is required when a situation does not meet **all** the EPA criteria for selected dental procedure codes.
- 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.

**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.



## When do I need to bill with an EPA number?

Orthodontic services that require expedited prior authorization (EPA) in [Coverage](#) must list the assigned EPA number on the claim. By placing the appropriate EPA number on the claim, providers verify that the bill is for a cleft palate or craniofacial anomaly case.

**Note:** Only use the unique EPA number when indicated in [Coverage](#).

### Exceeding Limitations or Restrictions

A request to exceed stated limitations or other restrictions on covered services is called a limitation extension (LE), which is a form of prior authorization. The agency evaluates and approves requests for LE for orthodontic services when medically necessary, under the provisions of [WAC 182-501-0169](#).

The agency evaluates a request for any orthodontic service not listed as covered in this section under the provisions of [WAC 182-501-0070](#).

The agency reviews requests for orthodontic treatment for clients who are eligible for services under the EPSDT program according to the provisions of [WAC 182-534-0100](#).

([WAC 182-535A-0040](#))

**Note:** See the agency's [ProviderOne Billing and Resource Guide](#) for more information on requesting authorization.

# Orthodontic Information Form

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## When do I need to complete the Orthodontic Information (HCA 13-666) form?

Any time orthodontic services are requested for a client, you must complete the *Orthodontic Information* (HCA 13-666) form. See [Where can I download agency forms?](#)

**Note:** The agency updated the *Orthodontic Information* (HCA 13-666) form on January 1, 2017. Effective April 1, 2017, the agency will process prior authorization requests submitted on the updated form only.

This format follows requirements of the American Board of Orthodontics and the Orthodontic

## How do I complete and submit the Orthodontic Information (HCA 13-666) form?

(To be completed by the performing orthodontist or dentist. Otherwise, your requests will be returned unprocessed. Use blue or black ink **and** a highlighter.)

Applying for authorization to provide orthodontic services is a two-step process.

### Step 1. Complete the *Orthodontic Information* (HCA 13-666) form

- a) Fill in the provider information and patient information sections at the top of the form.
- b) In Part 1, fill in the information requested in each area that applies to the treatment being provided or enter N/A.

**Note:** Impacted tooth or teeth requires a recent panoramic x-ray.

- c) In Part 2, place an “X” for each condition that applies and provide the required justification

**Note:** If the following conditions apply, provide the indicated supporting documentation:

- Overjet greater than 9mm requires a color photograph using either a probe or ruler to demonstrate this condition.
- Reverse overjet greater than 3.5mm requires a color photograph using either a probe or ruler to demonstrate this condition.
- Negative overjet requires a recent cephalometric x-ray to confirm the condition.
- Deep impinging overbite with soft tissue destruction requires photographic evidence to confirm condition.

- d) In Part 3, calculate the Handicapping Labiolingual Deviation (HLD) index using the provided instructions.

If the client has mandibular protrusion, provide the indicated supporting documentation (i.e., cephalometric x-ray or periodontal probe that is seated in millimeters).

- e) Sign and date the form.

**Step 2. Submit** the following full set of eight dental color photographs to the agency:

- a) **Intraoral dental photographs:**
- 1) Front view (teeth in centric occlusion)
  - 2) Right lateral (teeth in centric occlusion)
  - 3) Left lateral (teeth in centric occlusion)
  - 4) Upper occlusal view (taken using a mirror/retractor to include second molars)
  - 5) Lower occlusal view (taken using a mirror/retractor to include second molars)

b) **Extraoral dental photographs:**

- 1) Front, full-face view
- 2) Front, full-face smiling
- 3) Profile, full-face view, facing to the right

**Note:** All photos are to be printed on one sheet of 8.5 X 11-inch paper. Fill the photo page as fully as possible. Position the photos on the page as follows:

**Top row:** facial views

**Middle row:** occlusal views with information about the client and provider between the two photos

**Bottom row:** three-teeth-together views

To match the orientation of the occlusal views to the client's left and right side of their face:

- Print the right-side view on the left of the sheet.
- Print the left-side view on the right side of the sheet.

This format follows requirements of the American Board of Orthodontics and the Orthodontic departments at the universities of Oregon and Washington.

**Mail the materials, with the client's ProviderOne Client ID number and name, to:**

**Health Care Authority  
PO Box 45535  
Olympia, WA 98504-5535**

**Note:** Always include the authorization number in the appropriate field on the electronic claim when submitting a claim.

## **Orthodontic information review**

The agency's orthodontic consultant will review the photos and all of the information submitted for each case. The agency's decision will be delivered through ProviderOne-generated correspondence.

## What if my request for client services is denied?

If your request for orthodontic treatment is not approved based on your initial submission, submit only the information requested by the agency for re-evaluation. Such information may include:

- The claim for the full case study attached to the *Orthodontic Information* (HCA 13-666) form. See [Where can I download agency forms?](#)
- Appropriate radiographs (e.g., panoramic and cephalometric radiographs).
- Diagnostic color photographs (eight).
- A separate letter with any additional medical information if it will contribute information that may affect the agency's final decision.
- Study models (do not send study models unless they are requested).
- Other information if requested.

# Payment

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The agency considers that a provider who furnishes covered orthodontic treatment and orthodontic-related services to an eligible client has accepted the agency's fees as published in the agency's fee schedules ([WAC 182-535A-0060\(2\)](#)).

The agency requires a provider to deliver services and procedures that are of acceptable quality to the agency. The agency may recoup payment for services that are determined to be below the standard of care or of an unacceptable product quality ([WAC 182-535A-0060\(3\)](#)).

## **How does the agency pay for interceptive orthodontic treatment?**

[\(WAC 182-535A-0060 \(4\)\)](#)

The agency pays for interceptive orthodontic treatment on primary or transitional dentition in one payment that includes all professional fees, laboratory costs, and required follow-up.

## How does the agency pay for limited orthodontic treatment?

[\(WAC 182-535A-0060 \(5\)\)](#)

The agency pays for limited orthodontic treatment as follows:

- ✓ The first three months of treatment starts on the date the initial appliance is placed and includes active treatment for the first three months. The provider must bill the agency with the date of service that the initial appliance is placed.
- ✓ The agency's initial payment includes replacement of brackets and lost or broken orthodontic appliances, appliance removal, initial and first replacement retainer fees within six months after debanding, and final records (photos, panoramic x-rays, cephalometric films, and final trimmed study models).

**Note:** If the client loses or breaks another retainer after the first replacement retainer within six months of debanding, a prior authorization request must be submitted to the agency.

If a second replacement retainer is required within 6 months of debanding, prior authorization is required. When requesting prior authorization, include the date of the debanding and a comment that the request is for a second replacement in box 30 of the *General Authorization* form (HCA 13-835).

- ✓ Follow-up treatment must be billed after each three-month treatment interval.
- ✓ Treatment must be completed within twelve months of the date of appliance placement. Treatment provided after one year from the date the appliance is placed requires a limitation extension (LE). The agency evaluates a request for orthodontic treatment and orthodontic-related services that are in excess of the limitations or restrictions listed within this billing guide, according to [WAC 182-501-0169](#).

## How does the agency pay for comprehensive full orthodontic treatment?

[\(WAC 182-535A-0060 \(6\)\)](#)

The agency pays for comprehensive full orthodontic treatment as follows:

- ✓ The first six months of treatment starts on the date the initial appliance is placed and includes active treatment for the first six months. The provider must bill the agency with the date of service that the initial appliance is placed.
- ✓ The agency's initial payment includes replacement of brackets and lost or broken orthodontic appliances, appliance removal, initial and first replacement retainer fees within six months after debanding, and final records (photos, panoramic x-rays, cephalometric films, and final trimmed study models).

**Note:** If the client loses or breaks another retainer after the first replacement retainer within six months of debanding, a prior authorization request must be submitted to the agency.

If a second replacement retainer is required within 6 months of debanding, prior authorization is required. When requesting prior authorization, include the date of the debanding and a comment that the request is for a second replacement in box 30 of the *General Authorization* form (HCA 13-835).

- ✓ Continuing follow-up treatment must be billed after each three-month treatment interval, with the first three-month interval beginning six months after the initial appliance placement.
- ✓ Treatment provided after thirty months from the date the appliance is placed requires a limitation extension. The agency evaluates a request for orthodontic treatment and orthodontic-related services that are in excess of the limitations or restrictions listed within this billing guide, according to [WAC 182-501-0169](#).



# Billing

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All claims must be submitted electronically to the agency, except under limited circumstances.  
For more information about this policy change, see [Paperless Billing at HCA](#).  
For providers approved to bill paper claims, see the agency's [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, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments.
- What fee to bill the agency for eligible clients.
- When providers may bill a client.
- Billing for services provided to primary care case management (PCCM) clients.
- Billing for clients eligible for both Medicare and Washington Apple Health (Medicaid).
- Third-party liability.
- Record-keeping requirements.

## Does the agency pay for orthodontic treatment beyond the client's eligibility period?

[\(WAC 182-535A-0060 \(9\), \(11\), and \(12\)\)](#)

**No.** If the client's eligibility for orthodontic treatment (see [Client Eligibility](#)) ends before the conclusion of the orthodontic treatment, payment for any remaining treatment is the individual's responsibility. The agency does not pay for these services.

The client is responsible for payment of any orthodontic service or treatment received during any period of ineligibility, even if the treatment was started when the client was eligible. The agency does not pay for these services.

The agency will pro-rate payment for the timeframe a client was eligible for orthodontic services if the client becomes ineligible during the three-month treatment sequence.

**Note:** When billing for a reduced follow-up period due to client ineligibility, use the last day of the final month the client is eligible as the date of service on the claim. Enter the following comment in the claim notes:

**Billing period [MONTH-MONTH], eligibility ended [MONTH/DAY], pro-rate for [MONTH(S)].**

Example: “Billing period Jan-Mar, eligibility ended 2/28, pro-rate for Jan-Feb.”

Refer to [WAC 182-502-0160](#) for the agency’s rules on billing a client when a provider or a client is responsible for paying a covered service.

## Where can I find the fee schedule for orthodontic treatment and related services?

See the agency’s [Dental Program Fee Schedule](#).

Payment for orthodontic treatment and orthodontic-related services is based on the agency’s published fee schedule. The maximum allowable cost includes all professional fees, laboratory costs, and required follow-up. ([WAC 182-535A-0060](#))