

Washington Apple Health (Medicaid)

Access to Baby and Child Dentistry Billing Guide

(For clients through age 5)

November 3, 2017

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 November 3, 2017, and supersedes earlier guides to this program.

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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.

* This publication is a billing instruction.

What has changed?

Subject	Change	Reason for Change
<u>Definitions</u>	Added the definition for interim therapeutic restoration (ITR).	Reflects revisions to WAC 182-535-1050
<u>What is covered?</u>	Removed designated adult member's file as place where documentation must be kept	Reflects revisions to WAC 182-535-1245
	Updated information in the "blue box" note regarding family oral health education.	Clarification
	Moved and updated information about glass ionomer restorations.	Reflects information in WAC 182-535-1245
	Replaced "fabricated resin" with "prefabricated porcelain/ceramic" crowns.	Reflects the current coverage
	Added interim therapeutic restorations (ITRs) as a covered service under the ABCD program.	Reflects revisions to WAC 182-535-1245
<u>Coverage Table</u>	Added limitations to CDT code D2941	Reflects revisions to WAC 182-535-1245
<u>EPA procedure code list</u>	Removed the restriction of one to two surfaces from both EPA numbers for CDT code D2941.	Policy change

Additional Resources

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.

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

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Table of Contents

About this guide	2
What has changed?	3
Additional Resources	3
Definitions.....	5
About the Program	6
What is the ABCD program?.....	6
Who may provide ABCD dentistry?.....	7
How does the ABCD program work?.....	7
Client Eligibility	9
Who is eligible?	9
How can I verify a patient’s eligibility?	9
Are clients enrolled in an agency-contracted managed care organization (MCO) eligible?.....	10
Coverage	11
What is covered?.....	11
Coverage Table.....	14
Expedited Prior Authorization	18
What is expedited prior authorization (EPA)?.....	18
EPA numbers	18
EPA procedure code list.....	19
Billing	20
What are the general billing requirements?	20
How do I bill claims electronically?	20

Alert! This Table of Contents is automated. Click on a page number to go directly to the page.



Definitions

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).

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

(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.

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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 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 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 (physicians, ARNPs, physician assistants) who are certified through the 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 restorative and 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	Provide an orientation to the client or parent(s)/guardian(s) and prepares the family and child for the dental visit.
This function may not be available in all counties	Enroll the client and family into the ABCD program and encourage timely and appropriate dental visits.

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Access to Baby and Child Dentistry

Who	Responsibility
<p>Local community ABCD enrollment units</p> <p>This function may not be available in all counties.</p>	<p>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.</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>
<p>ABCD Program-Certified Dentists</p>	<p>Provide preventive and restorative treatment for an eligible client.</p> <p>Bill the agency for provided services according to this guide.</p>
<p>Certified Primary Care Medical Providers</p>	<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>
<p>Local Dental Societies</p>	<p>Encourage and support participation from members.</p>
<p>Health Care Authority</p>	<p>Reimburse program-certified dentists for services covered under this program.</p>
<p>University of Washington School of Dentistry</p>	<p>Provide technical and procedural consultation on the enhanced treatments and conduct continued provider training and certification.</p>
<p>Washington Dental Service Foundation</p>	<p>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.</p>

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Client Eligibility

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](#) web page.

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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.
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.

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.

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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, 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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Access to Baby and Child Dentistry

- **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: When a family with multiple children receives family oral health education, bill the agency under the ProviderOne Client ID of the first child whose family member received the service. **Do not use the parent's ProviderOne Client ID.** Family Oral Health Education **must be billed using ADA/HCPCS code D9999.**

- Application of fluoride varnish
- 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. 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
- Prefabricated stainless steel crowns on primary teeth, as specified in current agency published documents

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Access to Baby and Child Dentistry

- Resin-based composite crowns on anterior primary teeth
- Interim therapeutic restorations (ITRs) performed by ABCD-certified, 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

CDT® Code*	Nomenclature*	PA	Limitations	Maximum Allowable Fee
D0120	Periodic oral evaluation	No	One periodic evaluation 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 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 once every four months - 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 one of codes, not both, can be billed every four months..	Fee Schedules

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Access to Baby and Child Dentistry

CDT® Code*	Nomenclature*	PA	Limitations	Maximum Allowable Fee
D1208	Topical application of fluoride, excluding varnish	No	<p>Allowed once every four months - per client, per provider or clinic.</p> <p>Document in the client’s record which material (e.g., topical gel) is used.</p> <p>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 one of codes, not both, can be billed every four months.</p>	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	<p>Tooth and surface designations required.</p> <p>If billed on a primary first molar, the agency will reimburse at the rate for a two-surface restoration.</p>	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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Access to Baby and Child Dentistry

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
D2941	Interim therapeutic restoration – primary dentition	Yes (See EPA)	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 five or until the client can be definitively treated for a restoration.	Fee Schedules

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Access to Baby and Child Dentistry

CDT® Code*	Nomenclature*	PA	Limitations	Maximum Allowable Fee
D3220	Therapeutic pulpotomy	No	Covered only as complete procedure, once per tooth. Tooth designation required.	Fee Schedules
D9920	Behavior management	No	Involves a client whose documented behavior requires the assistance of at least one additional professional staff to protect the client and staff from injury while treatment is rendered; must be provided in a dental office or dental clinic	Fee Schedules
D9999	Family Oral Health Education	No	Limited to one visit per day, per family, up to two visits per child , per twelve-month period, per provider or clinic.	Fee Schedules

Note: Do not bill Behavior management in conjunction with CDT codes D9223 or 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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Expedited Prior Authorization

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.

EPA numbers

1. If the client's medical condition does not meet **all** of the specified criteria, prior authorization (PA) must be obtained by submitting a request in writing to the agency (see [Dental services](#) web page).
2. It is the vendor's responsibility to determine whether the client has already been provided the service allowed with the EPA criteria. If the vendor determines that the client has already been provided the service, a written prior authorization request must be submitted to the agency.

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EPA procedure code list

CDT Code*	Description	EPA #	Criteria
D2941	interim therapeutic restoration – primary dentition	870001379	<p>Interim therapeutic restoration (ITR) will be allowed in lieu of a definitive restoration as follows:</p> <ul style="list-style-type: none"> • Child must be age 5 or younger • Has current decay • Provider is ABCD certified and has completed ITR training • ITR is expected to last a minimum of 1 year • Allowed for a maximum of 5 teeth per visit • Based on the treating dentist clinical judgement, will be allowed yearly until can be definitively treated or until the client’s 6th birthday. <p>Not allowed in conjunction with general anesthesia or on the same day as other definitive restorations.</p>
D2941	interim therapeutic restoration – primary dentition	870001380	<p>Interim therapeutic restoration (ITR) will be allowed in lieu of a definitive restoration as follows:</p> <ul style="list-style-type: none"> • Child must be age 5 or younger • Has current decay • Provider is ABCD certified and has completed ITR training • ITR is expected to last a minimum of 1 year • Allowed for a maximum of 5 teeth per visit • Based on the treating dentist clinical judgement, will be allowed yearly until can be definitively treated or until the client’s 6th birthday. <p>Not allowed in conjunction with general anesthesia. Allowed on same day as definitive treatment if documentation that child was not able to proceed with complete treatment once started.</p>

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Billing

Effective for claims billed on and after October 1, 2016

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:

- 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](#) web page, 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.

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