Washington State Health Care Authority

Washington Apple Health (Medicaid)

Orthodontic Services Billing Guide

October 1, 2025

Washington State Health Care Authority

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict arises between this document and a governing statute or Health Care Authority (HCA) rule, the governing statute or HCA rule applies.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If the broken link is in the most recent guide, please notify us at askmedicaid@hca.wa.gov.

About this guide*

This publication takes effect **October 1, 2025,** and supersedes earlier billing guides to this program. Unless otherwise specified, the program in this guide is governed by the rules found in Chapter 182-535A WAC.

The Health Care Authority 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.

Refer also to HCA's ProviderOne billing and resource guide for valuable information to help you conduct business with the Health Care Authority.

How can I get HCA Apple Health provider documents?

To access provider alerts, go to HCA's provider alerts webpage. To access provider documents, go to HCA's provider billing guides and fee schedules webpage.

---

* This publication is a billing instruction.

Health care privacy toolkit

The Washington Health Care Privacy Toolkit is a resource for providers required to comply with health care privacy laws.

Where can I download HCA forms?

To download an HCA form, see HCA's Forms & Publications webpage. Type only the form number into the Search box (Example: 13-835).

Copyright disclosure

What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the Subject column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
Client Eligibility - EPSDT	Added information regarding the services available through the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit.	To provide information about EPSDT services and accessibility.
What orthodontic treatment and related services does HCA cover	Added "e.g., clear aligners" to the note box	Clarification example of removable appliances
What orthodontic treatment and orthodontic-related services are not covered by HCA	Removed EPSDT language at end of section	Replaced with standard language under the Coverage section
Coverage Table – Clinical evaluations	Removed Note in the CDT® D0160 and moved to a note box stating "The following codes are not allowed for orthodontic treatment: CDT® D0140, D0120, and D9110.	Clarification
How do I request prior authorization	Added "or orthognathic surgery related to sleep apnea" too the note box	Clarification
EPA	Added "active" approval and "For clients age 21 and older, prior authorization is required" to EPA #870001539.	Clarification. PA is not a new requirement.

Washington State Health Care Authority

Table of Contents

Definitions

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 HCA'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.

Child – For the general purposes of HCA'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:

- Cleft lips
- Cleft palates (involving the roof of the mouth)
- Facial clefts (e.g., macrostomia)

Comprehensive 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.

Craniofacial anomalies – Abnormalities of the head and face, either congenital or acquired, involving disruption of the dentition, and supporting structures.

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.

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.

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) – HCA'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).

Limited orthodontic treatment – Utilizing any therapeutic modality with a limited objective or scale of treatment. Treatment may occur in any stage of dental development or dentition.

The treatment objective may be limited by:

- Not involving the entire dentition
- Not attempting to address the full scope of the existing or developing orthodontic problem
- Mitigating an aspect of a greater malocclusion (e.g., crossbite, overjet, overbite, arch length, anterior alignment, one phase of multi-phase treatment, treatment prior to the permanent dentition, etc.)
- A decision to defer or forgo comprehensive treatment

Malocclusion – The improper alignment of biting or chewing surfaces of upper and lower teeth or abnormal relationship of the upper and lower dental arch.

Maxillofacial – Relating to the jaws and face.

Occlusion – The relation of the upper and lower teeth when in functional contact during jaw movement.

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.

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.

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

How can I verify a client's eligibility?

(WAC 182-535A-0020, WAC 182-501-0060)

HCA 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 HCA 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 HCA'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 HCA's Program benefit packages and scope of services web page.

Note: Patients who are not Apple Health clients may apply for health care coverage in one of the following ways:

- **Online**: Go to **Washington Healthplanfinder** - select the "Let's Get Started" button. For patients age 65 and older, or on Medicare, go to **Washington Connections** – select the "Apply Now" button.
- **Mobile app:** Download the **WAPlanfinder app** – select "sign in" or "create an account".
- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 855-627-9604 (TTY).
- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form. To download an HCA form, see HCA's Free or Low Cost Health Care, **Forms & Publications** webpage. Type only the form number into the Search box (Example: **18-001P**). For patients age 65 and older, or on Medicare, complete the *Washington Apple Health Application for Age, Blind, Disabled/Long-Term Services and Supports (HCA 18-005)* form.
- **In-person**: Local resources who, at no additional cost, can help you apply for health coverage. See the **Health Benefit Exchange Navigator**.

Are clients enrolled in an HCA-contracted managed care organization eligible?

Yes. Washington Apple Health covers orthodontic and orthodontic-related services for eligible clients enrolled in an HCA-contracted managed care organization (MCO).

Dental providers – Bill HCA directly for all orthodontic, orthodontic-related services, and orthognathic surgeries provided for eligible HCA-contracted MCO clients.

Medical providers – Bill the HCA-contracted MCO directly for orthodontic-related services provided to eligible MCO clients.

Facility fees for services in an Ambulatory Surgery Center (ASC), outpatient setting, or inpatient setting for eligible clients who are enrolled in an HCA-contracted MCO must be billed directly through the client's MCO. Prior authorization continues to be the responsibility of the Health Care Authority (HCA). Requests are submitted to HCA and the authorization number is included on the claim submitted to the MCO.

Early Periodic Screening, Diagnosis, and Treatment (EPSDT)

Early periodic screening, diagnosis, and treatment (EPSDT) includes all services that are medically necessary to address health conditions for clients age 20 and younger. Providers may reference program-specific billing guides for services and equipment not covered by this billing guide and must follow the rules for the EPSDT program described in **chapter 182-534 WAC**. Published limits for services covered under EPSDT, if any, may be exceeded based on agency review of medical necessity described in **WAC 182-501-0165**.

Provider Requirements

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

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
- HCA-recognized craniofacial teams or other orthodontic specialists approved by HCA

Can substitute dentists (locum tenens) provide and bill for dental-related services?

(42 U.S.C. 1396a(32)(C))

Yes. Dentists may bill under certain circumstances for services provided on a temporary basis (i.e., locum tenens) to their patients by another dentist.

The dentist's claim must identify the substituting dentist providing the temporary services. Complete the claim as follows:

- Enter the provider NPI and taxonomy of the locum tenens dentist who performed the substitute services in the Servicing Provider section of the electronic claim.
- The locum tenens dentist must enroll as an Apple Health provider in order to treat an Apple Health client and submit claims. For enrollment information, go to the Enroll as a provider webpage.
- Enter the billing provider information in the usual manner.

An informal reciprocal arrangement, billing for temporary services is limited to a period of 14 continuous days, with at least one day elapsing between 14-day periods.

A locum tenens arrangement involving per diem or other fee-for-time compensation, billing for temporary services is limited to a period of 90 continuous days, with at least 30 days elapsing between 90-day periods.

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

Orthodontic providers who are in HCA-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 HCA.

Coverage

When does HCA cover orthodontic treatment and related services?

HCA covers orthodontic treatment and orthodontic-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.
- Other craniofacial anomalies including, but not limited to:
  - Hemifacial microsomia
  - Craniosynostosis syndromes
  - Cleidocranial dental dysplasia
  - Arthrogryposis
  - Marfan syndrome
  - Treacher Collins syndrome
  - Ectodermal dysplasia
  - Achondroplasia

Orthodontic treatment for clients with cleft lip and palate, cleft palate, or cleft lip or other craniofacial anomalies and follow-up care must be performed by a provider who is part of a craniofacial team that includes, but is not limited to, a general or pediatric dentist, orthodontist, and an oral maxillofacial surgeon or specialist.

- Severe malocclusions with a Washington Modified Handicapping Labiolingual Deviation (HLD) Index Score of 25 or higher and has established caries and plaque control. (See Where can I download HCA forms? to download HCA's *Orthodontic Information* (HCA 13-666) form, for scoring instructions.) HCA 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 HCA cover?

HCA covers the following orthodontic treatments and related services for clients age 20 and younger. Prior authorization is required.

- A case study when done in conjunction with limited or comprehensive orthodontic treatment.
- Limited orthodontic treatment as follows:
    - The treatment includes up to 12 months of treatment from the date of the original appliance placement (See **Authorization** for information on limitation extensions).
    - HCA approves limited orthodontic treatment on transitional or adolescent dentition only.
    - When requesting PA for an impacted tooth, HCA requires the provider to submit a panoramic x-ray.
- Comprehensive orthodontic treatment as follows:
    - Includes treatment up to 30 months from the date of the original appliance placement (See **Authorization** for information on limitation extensions).
    - HCA approves comprehensive orthodontic treatment on adolescent dentition only.
- Orthodontic appliance removal as a stand-alone service only when both of the following are true:
    - The client's appliance was placed by a different provider or dental clinic.
    - 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 HCA.

Note: Fixed appliances are the preferred method of orthodontic treatment. Removable appliances (e.g., clear aligners) can be requested as an Exception to Rule (ETR) to be reviewed for medical necessity.

Treatment requirements

- 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 achieved.
- Orthodontia will not be considered as the first course of treatment for speech, mental health, airway/obstructed sleep apnea, or any other underlying medical condition, without the express diagnosis of a treating medical

specialist who has the subject matter expertise appropriate and necessary for management of the specific condition indicated.

Transfer Cases

Clients transferring from non-Medicaid or out-of-state providers 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.
  - HCA evaluates the initial orthodontic case study and treatment plan to determine if the client met HCA's orthodontic criteria. **See When does HCA cover orthodontic treatment and related services**?
  - HCA determines continued treatment duration based on the client's current orthodontic conditions.
  - HCA may pay a deband and retainer fee.
- HCA does not cover continued treatment if the client's initial condition did not meet HCA's criteria for the initial orthodontic treatment.

Clients transferring from Medicaid 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 a different Medicaid provider as follows:
  - The provider must submit a letter, signed by the client's parent/guardian, indicating that the client is transferring care to the new provider.
  - HCA determines continued treatment duration based on the remaining units available from the previous authorization approval from the initial provider's office and the client's current orthodontic conditions.
  - HCA may pay a deband and retainer fee to the new provider.

Note: When billing for transfer cases, the appliance placement date must be the original banding date.

What orthodontic treatment and orthodontic-related services are not covered by HCA?

HCA does not cover the following orthodontic treatment and related services:

- Orthodontic treatment and related services provided after the client's 21st birthday (treatment provided after the client's 21st birthday is the financial responsibility of the client).
- 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 HCA-designated bordering cities may be eligible for payment for services provided to HCA clients. See Provider Requirements for information.

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

> **Note:** HCA evaluates a request for orthodontic treatment and related services for the following:
>
> - In excess of the limitations or restrictions listed in this section, according to WAC 182-501-0169
> - Listed as noncovered according to WAC 182-501-0160

Coverage Table

General

Clinical evaluations

CDT Code®	Description	PA?	Limitations/Requirements
D0160	Detailed and extensive oral evaluation – orthodontic only	No	Includes orthodontic oral examination, taking and processing clinical photographs/IO (intraoral) scans, completing required form(s) and obtaining HCA's authorization decision when clinically appropriate. Allowed once per client, per billing provider.
D0170	Reevaluation – limited, problem focused – orthodontic only (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. The intent of the code is for the provider to reevaluate if the client is ready for orthodontic treatment. After orthodontic treatment is completed, the code is not to be billed in lieu of periodic/limited/comprehensive oral evaluations.

Note: The following codes are not allowed for orthodontic treatment: CDT® D0140, D0120, and D9110.

X-rays (radiographs)

CDT Code®	Description	PA?	Limitations/Requirements
D0330	Panoramic image – maxilla and mandible	No	Included in case study. The agency covers panoramic images once every 3 years. **Panoramic images** are not required when submitting prior authorization requests for orthodontic services unless the request indicates that the client has an impacted tooth or teeth.

CDT Code®	Description	PA?	Limitations/Requirements
D0340	Cephalometric image	Yes	Included in case study. Additional images require prior authorization. **Cephalometric images** are not required when submitting prior authorization requests for orthodontic services unless the request indicates that the client has a negative overjet.

Note: HCA does not require PA for additional medically necessary panoramic x-rays (radiographs) ordered by oral surgeons and orthodontists.

Other orthodontic services

CDT Code®	Description	PA?	Limitations/Requirements
D8220	Fixed appliance therapy	Yes	Considered for a Thumb Crib. Fee includes placement and removal of appliance.
D8680	Appliance removal, construction, and placement of retainers	Yes	The client's appliance was placed by a different provider or dental clinic, an out-of-state provider, or a nonmedicaid provider. Fee includes debanding, removal of cement, and retainer(s). Not arch specific. Pays once for entire procedure. **Note**: Not payable to the provider who placed the appliance as this is considered part of the initial payment for limited and comprehensive orthodontic treatment.
D8695	Appliance removal	Yes	The client's appliance was placed by a different provider or dental clinic, an out-of-state provider, or a nonmedicaid provider. Fee includes debanding and removal of cement. Not arch specific. Pays once for entire procedure. **Note**: Not payable to the provider who placed the appliance as this is considered part of the initial payment for limited and comprehensive orthodontic treatment.

Severe handicapping malocclusion, cleft lip and palate, cleft palate, or cleft lip

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

Clinical evaluations

CDT Code®	Description	PA?	Limitations/Requirements
D8660	Pre-orthodontic visit	Y*	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 image, and panoramic image), formation of diagnosis and treatment plan from such records, and formal case conference. *See EPA #870000970 when billing cleft lip and/or palate and craniofacial anomaly cases. Prior authorization is required if the EPA criteria is not met.

Limited orthodontic treatment

CDT Code®	Description	PA?	Limitations/Requirements
D8020	Limited orthodontic treatment of transitional dentition	Y*	This reimbursement is for the **initial placement** when the appliance placement date and the date of service are the same. Includes first three months of treatment and appliance(s). *See EPA #870001402 when billing cleft lip and/or palate and craniofacial anomaly cases. Prior authorization is required if the EPA criteria is not met.

CDT Code®	Description	PA?	Limitations/Requirements
D8670	Limited orthodontic treatment of transitional dentition	Y*	This reimbursement is for each **subsequent three-month period** when the appliance placement date and the date of service are different. HCA reimburses a maximum of three follow-up visits. *See EPA #870001403 when billing for cleft lip and/or palate and craniofacial anomaly cases. Prior authorization is required if the EPA criteria is not met. **Note: To receive reimbursement for each subsequent three-month period**: • The provider must examine the client in the provider's office at least once during the three-month period. *However, HCA prefers that the client be seen every eight to ten weeks, or as medically necessary. • Continuing treatment must be billed after each three-month interval, with the first three-month interval beginning six months after the initial appliance placement. • Document the actual service dates in the client's record.
D8030	Limited orthodontic treatment of the adolescent dentition	Y*	This reimbursement is for the **initial placement** when the appliance placement date and the date of service are the same. Includes first three months of treatment, appliance/bracket removal and retainers. *See EPA #870000970 when billing cleft lip and/or palate and craniofacial anomaly cases. Prior authorization is required if the EPA criteria is not met.

CDT Code®	Description	PA?	Limitations/Requirements
D8670	Limited orthodontic treatment of the adolescent dentition	Y*	This reimbursement is for each **subsequent three-month period** when the appliance placement date and the date of service are different. HCA reimburses a maximum of three follow-up visits. *See EPA #870000970 when billing for cleft lip and/or palate and craniofacial anomaly cases. Prior authorization is required if the EPA criteria is not met. The four-column table has the CDT code, description, whether or prior authorization is required and limitations/requirements. **Note: To receive reimbursement for each subsequent three-month period**: • The provider must examine the client in the provider's office at least once during the three-month period. *However, HCA prefers that the client be seen every eight to ten weeks, or as medically necessary. • Continuing treatment must be billed after each three-month interval, with the first three-month interval beginning six months after the initial appliance placement. • Document the actual service dates in the client's record.

Note: Approval of limited orthodontic treatment is for 1 unit of CDT® code D8020 or D8030 and up to 3 units of CDT® code D8670. If treatment is completed prior to the utilization of all units, the provider is to bill only the units needed to complete the limited orthodontic treatment. The client record should reflect treatment beginning and end dates.

Comprehensive orthodontic treatment

CDT Code®	Description	PA?	Limitations/Requirements
D8070	Comprehensive orthodontic treatment of the transitional dentition	Y*	This reimbursement is for the initial placement when the appliance placement date and the date of service are the same. Includes first three months of treatment, appliance/bracket removal and retainers. *See EPA #870000990 when billing for cleft lip and/or palate and craniofacial anomaly cases. Prior authorization is required if the EPA criteria is not met.
D8080	Comprehensive orthodontic treatment of the adolescent dentition	Y*	This reimbursement is for the initial placement when the appliance placement date and the date of service are the same. Includes first three months of treatment, appliance/bracket removal and retainers. *See EPA #870000990 when billing for cleft lip and/or palate and craniofacial anomaly cases. Prior authorization is required if the EPA criteria is not met.

CDT Code®	Description	PA?	Limitations/Requirements
D8670	Comprehensive orthodontic treatment of the transitional dentition	Y*	This reimbursement is for each **subsequent three-month period** when the appliance placement date and the date of service are different. HCA reimburses a maximum of eight follow-up visits with the eighth unit of D8670 covering the last six months of treatment. *See EPA #870000990 when billing for cleft lip and/or palate and craniofacial anomaly cases. Prior authorization is required if the EPA criteria is not met. **Note: To receive reimbursement for each subsequent three-month period**: • The provider must examine the client in the provider's office at least once during the three-month period. *However, HCA prefers that the client be seen every eight to ten weeks, or as medically necessary. • Continuing treatment must be billed after each three-month interval, with the first three-month interval beginning six months after the initial appliance placement. • Document the actual service dates in the client's record.

CDT Code®	Description	PA?	Limitations/Requirements
D8670	Comprehensive orthodontic treatment of the adolescent dentition	Y*	This reimbursement is for each **subsequent three-month period** when the appliance placement date and the date of service are different. HCA reimburses a maximum of eight follow-up visits with the eighth unit of D8670 covering the last six months of treatment. *See EPA #870000990 when billing for cleft lip and/or palate and craniofacial anomaly cases. Prior authorization is required if the EPA criteria is not met. **Note: To receive reimbursement for each subsequent three-month period**: • The provider must examine the client in the provider's office at least once during the three-month period. *However, HCA prefers that the client be seen every eight to ten weeks, or as medically necessary. • Continuing treatment must be billed after each three-month interval, with the first three-month interval beginning six months after the initial appliance placement. • Document the actual service dates in the client's record.

Dental Codes

The Health Care Authority covers the following:

- Surgical access of unerupted permanent tooth
- Placement of device to facilitate eruption of impacted permanent tooth

CDT® Code	Description	PA?	Limitations/Requirements
D7280	Surgical access of unerupted permanent tooth	N	Tooth designation required.

CDT® Code	Description	PA?	Limitations/Requirements
D7283	Placement of device to facilitate eruption of impacted permanent tooth	N	Covered in conjunction with CDT® code D7280 and when medically necessary; tooth designation required.

Performing CDT® code D7283 does **not** indicate future approval of orthodontic treatment.

Orthognathic surgery

Note: It is the provider's responsibility to confirm place of service coverage for the following CPT® codes in the ASC, outpatient, and inpatient billing guides and fee schedules.

It is the provider's responsibility to confirm the appropriate taxonomy code when billing on either a dental or professional claim.

CPT Code	Description	Appropriate diagnosis code	PA?	Limitations/Requirements
21077, **21079,** **21080,** **21081,** **21082,** **21083,** **21084,** **21085,** **21086,** **21087,** **21088,** **21089**	Prepare face/oral prosthesis	M26220, M2604, M2603, M2602, M26213	EPA	See EPA #870001539 when billing for orthognathic surgery. Prior authorization is required if the EPA criteria is not met.

CPT Code	Description	Appropriate diagnosis code	PA?	Limitations/Requirements
21141, **21142,** **21143,** **21145,** **21146,** **21147,** **21150,** **21151,** **21154,** **21155,** **21159,** **21160**	Reconstruct midface, lefort	M26220, M2604, M2603, M2602, M26213	EPA	See EPA #870001539 when billing for orthognathic surgery. Prior authorization is required if the EPA criteria is not met.
21193, **21194,** **21195,** **21196,** **21198**	Reconstruct lower jaw	M26220, M2604, M2603, M2602, M26213	EPA	See EPA #870001539 when billing for orthognathic surgery. Prior authorization is required if the EPA criteria is not met.

Authorization

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?

All orthodontic treatment and orthodontic-related services require either prior authorization (PA) or expedited prior authorization (EPA).

General information about authorization

- For covered orthodontic-related services that require PA, HCA 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.

Providers must request PA from HCA when EPA criteria has not been met or the covered service requires PA. Services that require PA are listed in the fee schedule. HCA does not retrospectively authorize any health care services that require PA after they have been provided except when a client has delayed certification of eligibility.

When do I need to get prior authorization?

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

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

How do I request prior authorization?

Providers may submit a prior authorization request by direct data entry into ProviderOne (See HCA's prior authorization webpage for details).

Include all the following with the PA request:

- *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
  - Proposed treatment
- Most recent and relevant x-rays (radiograph) as required.
- They must include the client name, date of birth, and date the x-rays (radiograph) were taken.
- Diagnostic color photographs/IO (intraoral) scans that includes client name, date of birth, provider name, and date the photographs were taken.

> **Note**: HCA requires an orthodontic provider who is requesting PA to submit sufficient, objective, clinical information to establish medical necessity. Conditions, such as, but not limited to behavioral health, speech issues or sleep apnea, require a diagnosis by an appropriate specialist.
>
> Every photograph and x-ray (radiograph) must include client information and be current within 12 months.

Orthognathic surgery requests must be submitted with the following documents:

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

> **Note**: Prior authorization (PA) is required only if EPA criteria are not met. PA requests for orthognathic surgery are required at least 12 months after the start of active orthodontic treatment. HCA will reject PA requests for orthognathic surgery submitted before the completion of 12 months of active orthodontic treatment.

> For information on billing CPT codes for oral surgery or orthognathic surgery related to sleep apnea, refer to HCA's current Physician-related services/health care professional billing guide. HCA pays oral surgeons for only those CPT codes listed in the Dental fee schedule under Dental CPT Codes.

HCA may request the following additional information:

- **Additional x-rays (radiographs)**
- Second opinions and/or consultations
- Any other information requested by HCA

Medical justification

- 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.
- Measurement, counting, recording, or consideration for treatment is performed only on teeth that have erupted and can be seen in supporting documentation. All measurements are made or judged on the basis equal to or greater than the minimum requirement.
- Only permanent natural teeth will be considered for comprehensive orthodontic treatment of severe malocclusions.
- A single impacted tooth alone is not considered a severe handicapping malocclusion.
- A claim of palate soft tissue destruction reported to be the result of impinging overbite requires photographic evidence with adequate resolution and exposure to clearly show the area of reported tissue destruction.
    - Include a high-magnification, high-resolution open-mouth anterior palate photo of adequate exposure, clearly showing lingual aspects of all maxillary anterior teeth and surrounding soft tissues including the incisive papilla.
    - The provider must submit both a submental and open-mouth photo.
- For claims of cheek biting reported as the result of a specific feature or aspect of the client's malocclusion, a high resolution, high-magnification photo(s) of the affected cheek must be included demonstrating the said aspect and/or feature. These photos should cover a large enough area to show unaffected, healthy cheek tissue in addition to the injured cheek area(s). The specific numbered teeth involved in the recurring cheek bite injury must also be identified in the narrative portion of the PA request.

  In order to consider any medical condition as the primary condition for approval of medically necessary orthodontic treatment, the provider must submit the following required documentation established within the 12 months preceding the request:Specific recommendations for orthodontic treatment including:
    - The orthodontic condition to be addressed (e.g., overjet reduction, palatal expansion);
    - The specific medical condition contributing to the request (e.g., sleep apnea, speech issues), diagnosed by the client's treating medical specialist

whose subject matter expertise is appropriate and necessary for managing the specific condition indicated;

AND

- All medical diagnostic documentation, including tried and failed therapies utilized to address the condition.

Without the medical specialist's specific recommendation as to why the medical diagnosis should be considered as a contributing factor in the approval of orthodontic treatment, HCA cannot consider it as a basis for approval.

- 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.
- All photographs/IO (intraoral) scans and x-rays (radiographs) must be current (taken within the last 12 months) and include the client's name, date of birth, and provider name.

Note: Every photograph and x-ray (radiograph) must include client information.

What if treatment is discontinued prior to completion?

Orthodontic treatment must meet industry standards and correct the medical issue. If treatment is discontinued prior to completion, or treatment objectives are not achieved, the provider must:

- Keep clear documentation in the client's record explaining why treatment was discontinued or not completed, or explain why treatment goals were not achieved.
- Submit the *Orthodontic Discontinuation of Service* form, (HCA 13-0039) to HCA. See **Where can I download HCA forms**?
- If an extension of treatment is required, the Orthodontic Discontinuation of Service form should not be submitted. See the **What is a limitation extension (LE)** section of this guide.
- Reasons for discontinued services may be:
  - Client moves
  - Client transfers care to another provider
  - Client is non-compliant
  - Poor oral hygiene

How do I complete and submit the Discontinuation of Treatment (HCA 13-0039) form?

- Step 1: Enter client information (name and client ID number)

- Step 2: Enter the prior authorization number that was approved for orthodontic treatment
- Step 3: Enter the appliances placement date
- Step 4: Enter the deband date
- Step 5: Enter the last date of service for the client
- Step 6: Enter the reason treatment was discontinued prior to utilizing all approved units
- Step 7: Have the client's parent/guardian sign the form
- Step 8: Provider signature
- Step 9: Submit the form using the PA Pend Form Submission Cover Sheet (Barcode) for submitting additional information to an existing prior authorization request

For more information on submitting additional information to an existing prior authorization request, see Requesting Prior Authorization in HCA's **ProviderOne billing and resource guide** or HCA's **prior authorization webpage**.

How do I submit a PA request?

For information on submitting prior authorization requests to HCA, see Requesting Prior Authorization in HCA's **ProviderOne billing and resource guide** or HCA's **prior authorization webpage**.

How to submit a PA request, without x-rays (radiographs) or photos: For procedures that do not require x-rays (radiographs) or photos, submit by direct data entry (DDE) in the ProviderOne portal or fax the PA request to HCA at: (866) 668-1214.

How to submit a PA request, with x-rays (radiographs) or photos: Pick **one** of following options for submitting x-rays (radiographs) or photos to HCA:

- Submit request through ProviderOne by direct data entry and attach **x-rays (radiographs) or photos** to the PA request.
- Use the FastLook™ and FastAttach™ services provided by National Electronic Attachment, Inc. (NEA). You may register with NEA by visiting **http://www.nea-fast.com/** and entering "FastWDSHS" in the blue promotion code box. Contact NEA at 1-800-782-5150, ext. 2, with any questions.
- When choosing this option, you can fax your request to HCA and indicate the NEA# in the NEA field on the PA Request Form or in the comments if submitting request through Direct Data Entry. *There is a cost associated which will be explained by the NEA services*.

Expedited Prior Authorization (EPA)

What is expedited prior authorization (EPA)?

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

To use an EPA:

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

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

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

When do I need to bill with an EPA number?

Orthodontic services that require expedited prior authorization (EPA) as listed in the **Coverage Table** 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 the **Coverage Table**. Using an EPA when not indicated is subject to recoupment.
>
> See HCA's **ProviderOne billing and resource guide** or HCA's **prior authorization webpage** for more information on requesting authorization.

EPA Code List

Note: Prior authorization is required for all EPA numbers if the EPA criteria is not met.

EPA Number	CDT® Code	Description	Criteria
870000970	D8660	Pre-orthodontic treatment visit	Use when billing for cleft lip and/or palate and craniofacial anomaly cases. Treating provider must be a part of a craniofacial team that includes, but is not limited to, a general or pediatric dentist, orthodontist and an oral maxillofacial surgeon or specialist. Medically necessary ICD diagnosis codes associated with cleft lip and palate, cleft palate or cleft lip must be documented in the client's record. ICD diagnosis codes associated with craniofacial anomalies per WAC 182-535A-0040 need to be documented to use EPA.

EPA Number	CDT® Code	Description	Criteria
870000970	D8030	Limited orthodontic treatment of the adolescent dentition	Use when billing for cleft lip and/or palate and craniofacial anomaly cases. Treating provider must be a part of a craniofacial team that includes, but is not limited to, a general or pediatric dentist, orthodontist and an oral maxillofacial surgeon or specialist. Medically necessary ICD diagnosis codes associated with cleft lip and palate, cleft palate or cleft lip must be documented in the client's record. ICD diagnosis codes associated with craniofacial anomalies per WAC 182-535A-0040 need to be documented to use EPA. Limitations apply. EPA does not override the limitations/requirements for limited treatment. See **limited orthodontic treatment.** EPA does not apply for treatment beyond the initial limited treatment. **Limitation extension** must be submitted to HCA and approved. Client has established caries and plaque control.

EPA Number	CDT® Code	Description	Criteria
870000970	D8670	Limited orthodontic treatment of the adolescent dentition	Use when billing for cleft lip and/or palate and craniofacial anomaly cases. Treating provider must be a part of a craniofacial team that includes, but is not limited to, a general or pediatric dentist, orthodontist and an oral maxillofacial surgeon or specialist. Medically necessary ICD diagnosis codes associated with cleft lip and palate, cleft palate or cleft lip must be documented in the client's record. ICD diagnosis codes associated with craniofacial anomalies per WAC 182-535A-0040 need to be documented to use EPA. Limitations apply. EPA does not override the limitations/requirements for limited treatment. See limited orthodontic treatment. EPA does not apply for treatment beyond the initial limited treatment. **Limitation extension** must be submitted to HCA and approved. Client has established caries and plaque control.

EPA Number	CDT® Code	Description	Criteria
870000990	D8080	Comprehensive orthodontic treatment of the adolescent dentition	Use when billing for cleft lip and/or palate and craniofacial anomaly cases. Treating provider must be a part of a craniofacial team that includes, but is not limited to, a general or pediatric dentist, orthodontist and an oral maxillofacial surgeon or specialist. Medically necessary ICD diagnosis codes associated with cleft lip and palate, cleft palate or cleft lip must be documented in the client's record. ICD diagnosis codes associated with craniofacial anomalies per WAC 182-535A-0040 need to be documented to use EPA. Limitations apply. EPA does not override the limitations/requirements for comprehensive treatment. See comprehensive orthodontic treatment. EPA does not apply for treatment beyond the initial comprehensive orthodontic treatment. Limitation extension must be submitted to HCA and approved. Client has established caries and plaque control.

EPA Number	CDT® Code	Description	Criteria
870000990	D8670	Comprehensive orthodontic treatment of the adolescent dentition	Use when billing for cleft lip and/or palate and craniofacial anomaly cases. Treating provider must be a part of a craniofacial team that includes, but is not limited to, a general or pediatric dentist, orthodontist and an oral maxillofacial surgeon or specialist. Medically necessary ICD diagnosis codes associated with cleft lip and palate, cleft palate or cleft lip must be documented in the client's record. ICD diagnosis codes associated with craniofacial anomalies per WAC 182-535A-0040 need to be documented to use EPA. Limitations apply. EPA does not override the limitations/requirements for comprehensive treatment. See comprehensive orthodontic treatment. EPA does not apply for treatment beyond the initial comprehensive orthodontic treatment. Limitation extension must be submitted to HCA and approved. Client has established caries and plaque control.

EPA Number	CDT® Code	Description	Criteria
870001402	D8020	Limited orthodontic treatment of the transitional dentition	Use when billing for cleft lip and/or palate and craniofacial anomaly cases. Treating provider must be a part of a craniofacial team that includes, but is not limited to, a general or pediatric dentist, orthodontist and an oral maxillofacial surgeon or specialist. Medically necessary ICD diagnosis codes associated with cleft lip and palate, cleft palate or cleft lip must be documented in the client's record. ICD diagnosis codes associated with craniofacial anomalies per WAC 182-535A-0040 need to be documented to use EPA. Limitations apply. EPA does not override the limitations/requirements for limited treatment. See **limited orthodontic treatment**. EPA does not apply for treatment beyond the initial limited orthodontic treatment. **Limitation extension** must be submitted to HCA and approved. Client has established caries and plaque control.

EPA Number	CDT® Code	Description	Criteria
870001403	D8670	Limited orthodontic treatment of the transitional dentition	Use when billing for cleft lip and/or palate and craniofacial anomaly cases. Treating provider must be a part of a craniofacial team that includes, but is not limited to, a general or pediatric dentist, orthodontist and an oral maxillofacial surgeon or specialist. Medically necessary ICD diagnosis codes associated with cleft lip and palate, cleft palate or cleft lip must be documented in the client's record. ICD diagnosis codes associated with craniofacial anomalies per WAC 182-535A-0040 need to be documented to use EPA. Limitations apply. EPA does not override the limitations/requirements for limited treatment. See **limited orthodontic treatment** EPA does not apply for treatment beyond the initial limited orthodontic treatment. **Limitation extension** must be submitted to HCA and approved. Client has established caries and plaque control.

Note: Prior to utilizing EPA, it is the provider's responsibility to confirm place of service coverage for the following CPT® codes in the **ASC, outpatient, and inpatient billing guides and fee schedules**.

EPA Number	CPT® Code	Appropriate diagnosis code	Description	Criteria
870001539	21077, 21079, 21080, 21081, 21082, 21083, 21084, 21085, 21086, 21087, 21088, 21089	M26220, M2603, M2602, M26213	Prepare face/oral prosthesis	Use when billing for orthognathic surgery in an outpatient or inpatient setting. There must be an active approval in the system for full comprehensive orthodontic treatment for the client, plus all of the following in the client's record: • A treatment plan, including expected surgical intervention Current Procedural Terminology (CPT®) codes. • Cephalometric radiographs (x-rays). Color photographs/IO (intraoral) scans (including five intraoral and three facial views). For clients age 21 and older, prior authorization is required.

EPA Number	CPT® Code	Appropriate diagnosis code	Description	Criteria
870001539	21141, 21142, 21143, 21145, 21146, 21147, 21150,	M26220, M2603, M2602, M26213	Reconstruct midface lefort	Use when billing for orthognathic surgery in an outpatient or inpatient setting. There must be an active approval in the system for full comprehensive orthodontic treatment for the client, plus all of the following in the client's record: • A treatment plan, including expected surgical intervention Current Procedural Terminology (CPT®) codes. • Cephalometric radiographs (x-rays). Color photographs/IO (intraoral) scans (including five intraoral and three facial views). For clients age 21 and older, prior authorization is required.

EPA Number	CPT® Code	Appropriate diagnosis code	Description	Criteria
870001539	21193, 21195, 21196, 21198, 21199	M26220, M2603, M2602, M26213	Reconstruct lower jaw	Use when billing for orthognathic surgery in an outpatient or inpatient setting. There must be an active approval in the system for full comprehensive orthodontic treatment for the client, plus all of the following in the client's record: • A treatment plan, including expected surgical intervention Current Procedural Terminology (CPT®) codes. • Cephalometric radiographs (x-rays). Color photographs/IO (intraoral) scans (including five intraoral and three facial views). For clients age 21 and older, prior authorization is required.

EPA Number	CPT® Code	Appropriate diagnosis code	Description	Criteria
870001539	21151, 21154, 21155, 21159, 21160	M26220, M2603, M2602, M26213	Reconstruct midface lefort	Use when billing for orthognathic surgery in an inpatient hospital setting; NOT an outpatient setting. There must be an active approval in the system for full comprehensive orthodontic treatment for the client, plus all of the following in the client's record: • A treatment plan, including expected surgical intervention Current Procedural Terminology (CPT®) codes. • Cephalometric radiographs (x-rays). Color photographs/IO (intraoral) scans (including five intraoral and three facial views). For clients age 21 and older, prior authorization is required.

EPA Number	CPT® Code	Appropriate diagnosis code	Description	Criteria
870001539	21194	M26220, M2603, M2602, M26213	Reconstruct lower jaw	Use when billing for orthognathic surgery in an inpatient hospital setting; NOT an outpatient setting. There must be active approval in the system for full comprehensive orthodontic treatment for the client, plus all of the following in the client's record: • A treatment plan, including expected surgical intervention Current Procedural Terminology (CPT®) codes. • Cephalometric radiographs (x-rays). Color photographs/IO (intraoral) scans (including five intraoral and three facial views). For clients aged 21 and older, prior authorization is required.

NOTE: Providers are responsible for checking the Outpatient Hospital and ASC Billing Guides and fee schedules to confirm CPT® codes that are eligible for payment in an ASC, outpatient, or inpatient setting.

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 HCA'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.

HCA 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 do I request an LE?

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

Providers may submit a prior authorization request by direct data entry into ProviderOne (See HCA's prior authorization webpage for details).

Include all of the following with the orthodontic treatment LE request:

- *Orthodontic Information* (HCA 13-666) form, with the following information:"
  - Client's name and date of birth
  - 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 to establish need for the LE
  - Proposed treatment and explanation of why an LE is needed
- Most recent and relevant x-rays (radiographs) as required. They must include the client name, date of birth, and the date the x-rays (radiographs) were taken.
- Diagnostic color photographs/IO (intraoral) scans that include the client's name, date of birth, provider name, and the date the photographs were taken.

> **Note**: Radiographs and photographs must be current within 12 months.

HCA may request additional information as follows:

- Additional x-rays (radiographs).
- Photographs.
- Chart notes.
- Any other information requested by HCA.

> **Note**: HCA may require second opinions and consultations before authorizing any procedure.

What is an exception to rule (ETR)?

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

How do I request an ETR?

A noncovered service must be requested through an exception to rule (ETR).

To request an ETR, providers may submit a prior authorization request by direct data entry into ProviderOne (See HCA's prior authorization webpage for details).

Indicate in the comments box that you are requesting an ETR.

Be sure to provide all of the evidence required by WAC 182-501-0160.

Orthodontic Information Form

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 HCA forms?

> **Note**: HCA updated the *Orthodontic Information* (HCA 13-666) form on July 1, 2018.

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

- Fill in the provider information and patient information sections at the top of the form.
- 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.

- 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:

- Deep impinging overbite accompanied by soft tissue destruction of the palate requires photographic evidence displaying soft tissue destruction. Include a high-magnification, high-resolution open-mouth anterior palate photo of adequate exposure, clearly showing lingual aspects of all maxillary anterior teeth and surrounding soft tissues including the incisive papilla. The provider must submit a submental and open-mouth photo.

- Overjet 9mm or greater requires a color photograph using either a probe or ruler to demonstrate this condition. Refer to page three of the *Orthodontic Information* (HCA 13-666) form for criteria on measurement of overjet.

- Reverse overjet 3.5mm or greater 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.

- 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).

- Sign and date the form.

Step 2. Submit the following full set of eight dental color photographs/IO (intraoral) scans to HCA:

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

  - Lower occlusal view (taken using a mirror/retractor to include second molars)
- **Extraoral dental photographs**:
  - Front, full-face view
  - Front, full-face smiling
  - Profile, full-face view, facing to the right

Note: All photos submitted must be size 8.5 X 11.5-inch on a single page template. Patient's face must not be obscured or blacked out in any form. Position the photos on the template as follows:

Top row: facial views

Middle row: occlusal views, client name, date of birth, date photo was taken, and provider name

Bottom row: right lateral closed, left lateral closed, center closed

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

- Photos of the right-side view should be on the left of the sheet.

- Photos of the left-side view should be 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.

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

Orthodontic information review

HCA's orthodontic consultant will review the photos and all of the information submitted for each case. HCA's decision will be delivered through ProviderOne-generated correspondence. Providing additional information such as additional photographs, in addition to the ones required, may help HCA's orthodontic consultant determine medical necessity. Examples include:

- Submental photos to help confirm deep overbite with tissue destruction

- Cheek photos validating cheek biting in relation to a crossbite

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 HCA 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 HCA forms**?
- Appropriate x-rays (radiograph) (e.g., panoramic, and cephalometric radiographs).
- Diagnostic color photographs/IO (intraoral) scans (eight).
- A separate letter with any additional medical information if it will contribute information that may affect HCA's final decision.
- Other information if requested.

Payment

HCA considers that a provider who furnishes covered orthodontic treatment and orthodontic-related services to an eligible client has accepted HCA's fees as published in HCA's fee schedules.

HCA requires a provider to deliver services and procedures that are of acceptable quality to HCA. HCA may recoup payment for services that are determined to be below the standard of care or of an unacceptable product quality.

How does HCA pay for limited orthodontic treatment?

HCA 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 HCA with the date of service that the initial appliance is placed.
- HCA's initial payment includes placement of orthodontic appliances, appliance removal, retainer, and final records (photos, panoramic x-rays (radiographs), cephalometric images, and final trimmed study models).
- Follow-up treatment must be billed after each three-month treatment interval.
- Limited 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). HCA 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**.

Orthodontic treatment must meet industry standards and correct the medical issue. If treatment is discontinued prior to completion, or treatment objectives are not achieved, the provider must:

- Keep clear documentation in the client's record explaining why treatment was discontinued or not completed, or explain why treatment goals were not achieved.
- Submit the *Orthodontic Discontinuation of Service* form, (HCA 13-0039) to HCA. See **Where can I download HCA forms**?
- Use the PA Pend Form Submission Cover Sheet (Barcode) for submitting additional information to an existing prior authorization request.

How does HCA pay for comprehensive orthodontic treatment?

HCA pays for comprehensive 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 HCA with the date of service that the initial appliance is placed.

- HCA's initial payment includes placement of orthodontic appliances, appliance removal, fees, and final records (photos, panoramic x-rays (radiographs), cephalometric images, and final trimmed study models).
- Continuing follow-up treatment must be billed after each three-month treatment interval, with the first three-month interval beginning three months after the initial appliance placement.
- Comprehensive treatment provided after thirty months from the date of initial appliance placement requires a limitation extension (LE). HCA 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**.

Orthodontic treatment must meet industry standards and correct the medical issue. If treatment is discontinued prior to completion, or treatment objectives are not achieved, the provider must:

- Keep clear documentation in the client's record explaining why treatment was discontinued or not completed, or explain why treatment goals were not achieved.
- Submit the *Orthodontic Discontinuation of Service* form, (HCA 13-0039) to HCA. See **Where can I download HCA forms**?

Use the PA Pend Form Submission Cover Sheet (Barcode) for submitting additional information to an existing prior authorization request.

Billing

All claims must be submitted electronically to HCA, except under limited circumstances. For more information about this policy change, see Paperless billing at HCA. For providers approved to bill paper claims, see HCA's Paper claim billing resource.

What are the general billing requirements?

Providers must follow HCA'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 HCA 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 HCA pay for orthodontic treatment beyond the client's eligibility period?

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. HCA 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. HCA does not pay for these services.

HCA 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 the client was 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 HCA's rules on billing a client when a provider or a client is responsible for paying a covered service.

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA's Billers, providers, and partners webpage, under Learn how to use ProviderOne, select 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) webpage.

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

See HCA's Dental program fee schedule.

Payment for orthodontic treatment and orthodontic-related services is based on HCA's published fee schedule. The maximum allowable cost includes all professional fees, laboratory costs, and required follow-up.