Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Health and Recovery Services Administration (HRSA)

Orthodontic Services

Billing Instructions

[Chapter 388-535A WAC]

Copyright disclosure

About this publication

This publication supersedes all previous DSHS Orthodontics Billing Instructions materials published by the Washington State Department of Social and Health Services, Health and Recovery Services Administration.

Note: The effective date and publication date for any particular page of this document may be found at the bottom of the page.

Table of Contents

Table of Contents (cont.)

Section F: Orthodontic Information Sheet

Section G: Completing the 2006 ADA Claim Form

Important Contacts

How can I use the Internet to…

Find information on becoming a DSHS provider?

Visit Provider Enrollment at:
http://maa.dshs.wa.gov/provrel

Click ***Sign up to be a DSHS WA state Medicaid provider*** and follow the on-screen instructions.

Ask questions about the status of my provider application?

Visit Provider Enrollment at:
http://maa.dshs.wa.gov/provrel

- Click ***Sign up to be a DSHS WA state Medicaid provider***
- Click ***I want to sign up as a DSHS Washington State Medical provider***
- Click ***What happens once I return my application?***

Submit a change of address or ownership?

Visit Provider Enrollment at:
http://maa.dshs.wa.gov/provrel

- Click ***I'm already a current Provider***
- Click ***I want to make a change to my provider information***

Find out about payments, denials, claims processing, or DSHS managed care organizations?

Visit the Customer Service Center for Providers at:
http://maa.dshs.wa.gov/provrel

- Click ***I'm already a current Provider***
- Click ***Frequently Asked Questions***

or call/fax:
1-800-562-3022, Option 2 (toll free)
1-360-725-2144 (fax)

or write to:
Medical Assistance Customer Service Center (MACSC)
PO Box 45562
Olympia, WA 98504-5562

If I don't have access to the Internet, how do I find information on…

Becoming a DSHS provider, ask questions about the status of my provider application, or submit a change of address or ownership?

Call Provider Enrollment at:
1-800-562-3022 (toll free)

or write to:
Provider Enrollment
PO Box 45562
Olympia, WA 98504-5562

If I don't have access to the Internet, how do I find information on… (cont.)

Private insurance or third-party liability, other than DSHS managed care?

Office of Coordination of Benefits
PO Box 45565
Olympia, WA 98504-5565
1-800-562-6136 (toll free)

How do I find out about Internet billing (electronic claims submission)?

Call the DSHS/HIPAA E-Help Desk at:
1-800-562-3022 (toll free) and choose option #2, then option #4

or e-mail to:
hipaae-help@dshs.wa.gov

- or -

visit:
WinASAP and WAMedWeb:
http://www.acs-gcro.com

Click ***Medicaid*** then ***Washington State***.

All other HIPAA transactions:
https://wamedweb.acs-inc.com

To enroll with ACS EDI Gateway for HIPAA Transactions and/or WinASAP 2003, visit:
http://www.acs-gcro.com

Click ***Medicaid***, then ***Washington State***, then ***Enrollment***.

or call ACS EDI Gateway, Inc. at:
1-800-833-2051 (toll free)

After you submit the completed EDI Provider Enrollment form, ACS will send you the link and information necessary to access the web site. If you are already enrolled but cannot access the website, please call ACS toll free at 1-800-833-2051.

How can I access the DSHS Dental web site?

Visit:
http://maa.dshs.wa.gov/ProvRel/Dental/Dental.html

Where can I view and download DSHS fee schedules?

Visit:
http://maa.dshs.wa.gov/rbrvs

How do I check on a client's eligibility status?

Call ACS at:
1-800-833-2051 (toll free)

or call DSHS at:
1-800-562-3022 (toll free) and choose option #2

You may also access the WAMedWeb Online Tutorial at:
http://maa.dshs.wa.gov/wamedwebtutor

Where do I write to get prior authorization?

Program Management &
Authorization Section-Dental Program
PO Box 45506
Olympia WA 98504-5506

For procedures that do not require Radiographs - Fax: 1-360-725-2123

How do I obtain copies of billing instructions or numbered memoranda?

To view an electronic copy, visit:
http://maa.dshs.wa.gov

Click ***Billing Instructions/Numbered Memoranda***

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Definitions & Abbreviations

This section defines terms and abbreviations, including acronyms, used in these billing instructions. Please refer to DSHS's General Information Booklet (http://maa.dshs.wa.gov/download/BillingInstructions/General_Information_BI.pdf) for a more complete list of definitions.

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

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

Appliance placement – The application of orthodontic attachments to the teeth for the purpose of correcting dentofacial abnormalities. [WAC 388-535A-0010]

Child –For the general purposes of the DSHS Dental Program, means a client 20 years of age or younger

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

1. Cleft lip;
2. Cleft palate (involving the roof of the mouth); or
3. Facial clefts (e.g., macrostomia). [WAC 388-535A-0010]

Comprehensive full orthodontic treatment – Utilizing fixed orthodontic appliances for treatment of the permanent dentition leading to the improvement of a client's severe handicapping craniofacial dysfunction and/or dentofacial deformity, including anatomical and functional relationships. [WAC 388-535A-0010]

Craniofacial anomalies – Abnormalities of the head and face, either congenital or acquired, involving disruption of the dentition and supporting structures. [WAC 388-535A-0010]

Craniofacial team – A cleft palate/maxillofacial team or an American Cleft Palate Association-certified craniofacial team. These teams are responsible for the management (review, evaluation, and approval) of patients with cleft palate craniofacial anomalies to provider integrated case management, promote parent-professional partnership, and make appropriate referrals to implement and coordinate treatment plans. [WAC 388-535A-0010]

Dental dysplasia – An abnormality in the development of the teeth.[WAC 388-535A-0010]

EPA – Stands for Expedited Prior Authorization. See ***General Information Booklet***.

EPSDT – DSHS's Early and Periodic Screening, Diagnosis, and Treatment program for clients 20 years of age and younger as described in chapter 388-534 WAC. [WAC 388-535A-0010]

Health and Recovery Services Administration (HRSA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI State Children's Health Insurance Program (SCHIP), Title XVI Supplemental Security Income for the Aged, Blind, and Disabled (SSI), and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

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 appears smaller sized). [WAC 388-535A-0010]

Interceptive orthodontic treatment – Procedures to lessen the severity or future effects of a malformation and to affect or eliminate the cause. Such treatment may occur in the primary or transitional dentition and may include such procedures as the redirection of ectopically erupting teeth, correction of isolated dental cross-bite, or recovery of recent minor space loss where overall space is adequate. [WAC 388-535A-0010]

Limited transitional orthodontic treatment – Orthodontic treatment with a limited objective, not involving the entire dentition. It may be directed only at the existing problem, or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive therapy. [WAC 388-535A-0010]

Malocclusion – The improper alignment of biting or chewing surfaces of upper and lower teeth. [WAC 388-535A-0010]

Maxillofacial – Relating to the jaws and face. [WAC 388-535A-0010]

Medical Identification (ID) card – The document that identifies a client's eligibility for a medical program. This card was formerly known as the medical assistance identification (MAID) card or medical coupon.

Medically necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Occlusion – The relation of the upper and lower teeth when in functional contact during jaw movement. [WAC 388-535A-0010]

Orthodontics – Treatment involving the use of any appliance, in or out of the mouth, removable or fixed, or any surgical procedure designed to redirect teeth and surrounding tissues. [WAC 388-535A-0010]

Orthodontist – A dentist who specializes in orthodontics, who is a graduate of a postgraduate program in orthodontics that is accredited by the American Dental Association, and who meets the licensure requirements of the Department of Health. [WAC 388-535A-0010]

PA – Stands for Prior Authorization. See ***General Information Booklet***.

Primary Dentition – Teeth developed and erupted first in order of time.

Transitional Dentition – The final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

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Client Eligibility

Who Is Eligible? [Refer to WAC 388-535A-0020 (1) and (3)]

DSHS covers medically necessary orthodontic treatment and orthodontic-related services for severe handicapping malocclusions, craniofacial anomalies, or cleft lip or palate for clients whose Medical Identification (ID) Card lists one of the following medical program identifiers:

Medical Program Identifier	Medical Program
CNP	Categorically Needy Program – Clients may receive orthodontic treatment and orthodontic-related services through the age of 20. **Treatment must be completed before clients turns 21.**
CNP – CHIP	CNP – State Children's Health Insurance Program (SCHIP) (may receive orthodontic treatment and orthodontic-related services through the age of 18) See WAC 388-416-0015 for when certification periods may be extended.
MNP	Medically Needy Program – Clients may receive orthodontic treatment and orthodontic-related services through the age of 20. **Treatment must be completed before clients turns 21.**

Note: Clients who are eligible for services under the EPSDT program may receive orthodontic treatment and orthodontic-related services under the provisions of WAC 388-534-0100.

Eligible clients may receive the same orthodontic treatment and orthodontic-related services in recognized out-of-state bordering cities on the same basis as if provided in-state.
[See WAC 388-501-0175.]

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Provider Requirements

Who May Provide and Be Paid for Orthodontic Treatment and Orthodontic-Related Services? [Refer to WAC 388-535A-0030]

The following provider types may furnish and be paid for providing covered orthodontic treatment and orthodontic-related services to medical assistance clients:

- Orthodontists;
- Pediatric dentists;
- General dentists; and
- DSHS-recognized craniofacial teams or other orthodontic specialists approved by DSHS.

What Are the Requirements for out-of-State Providers? [Refer to WAC 388-535A-0060(6)]

Orthodontic providers who are in DSHS-designated bordering cities must meet:

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

What Are the Billing Requirements?

Providers must follow the general billing requirement in **DSHS's General Information Booklet** (http://maa.dshs.wa.gov/download/BillingInstructions/General_Information_BI.pdf). These billing requirements include, but are not limited to:

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

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Coverage

What Orthodontic Treatment and Orthodontic-Related Services Does DSHS Cover? [Refer to WAC 388-535A-0040 (1), (2), (3), and (5)]

DSHS covers:

- Orthodontic treatment and orthodontic-related services for a client who has a malocclusion associated with one of the following medical conditions. **Treatment and follow-up care must be performed only by an orthodontist or DSHS-recognized craniofacial team**:

  - ✓ Cleft lip and palate, cleft palate, or cleft lip with alveolar process involvement.

  - ✓ The following craniofacial anomalies:

    - ➢ Hemifacial microsomia;
    - ➢ Craniosynostosis syndromes;
    - ➢ Cleidocranial dental dysplasia;
    - ➢ Arthrogryposis; or
    - ➢ Marfan syndrome.

  Note: DSHS ***may*** cover orthodontic treatment for dental malocclusions other than those listed above on a case-by-case basis and when prior authorized. DSHS or the Office of Children with Special Health Care Needs (OCSHCN) does not require written prior authorization for services to a client with cleft palate and/or craniofacial anomalies when the client is case-managed by a DSHS-recognized craniofacial team that has a Special Agreement with DSHS.

- Medical conditions as indicated on the Washington Modified Handicapping Labiolingual Deviation (HLD) Index Score that result in a score of 25 or higher. DSHS reviews all requests for treatment for conditions that result in a score of less than 25 on a case-by-case basis, with consideration of medical necessity.

- The following orthodontic treatment and orthodontic-related services, subject to the limitations listed:

  - ✓ Panoramic radiographs (x-rays).

  - ✓ Interceptive orthodontic treatment once per a client's lifetime.

  - ✓ Limited transitional orthodontic treatment, up to one year from date of original appliance placement.

- ✓ Comprehensive full orthodontic treatment, up to 30 months from the date of original appliance placement.
- ✓ Orthodontic appliance removal only when:
  - ➢ The client's appliance was placed by a different provider or dental clinic; and
  - ➢ The provider removing the appliance has not furnished any other orthodontic treatment or orthodontic-related services to the client.
- ✓ Other medically necessary orthodontic treatment and orthodontic-related services as determined by DSHS.

What Orthodontic Treatment and Orthodontic-Related Services Does DSHS *Not* Cover? [Refer to WAC 388-535A-0040 (4)]

DSHS does not cover the following orthodontic treatment or orthodontic-related services:

- Lost or broken orthodontic appliances;
- Orthodontic treatment for cosmetic purposes;
- Orthodontic treatment that is not medically necessary (see *Definitions* section);
- Out-of-state orthodontic treatment; or

Exception: Providers in DSHS-designated bordering cities may be eligible for payment for services provided to DSHS clients. Refer to the *Provider Requirements* section for information.

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

Note: DSHS evaluates a request for orthodontic treatment and orthodontic-related services:

- That are in excess of the limitations or restrictions listed in this section, according to WAC 388-501-0169; and
- That are listed as noncovered according to WAC 388-501-0160.

What About Clients on the Early Periodic Screening, Diagnosis & Treatment (EPSDT) Program?

[Refer to WAC 388-535A-0040(8)]

DSHS reviews requests for orthodontic treatment and orthodontic-related services for clients who are eligible for services under the EPSDT program according to the provisions of WAC 388-534-0100.

Coverage Table

Clinical Evaluations

CDT Code	Description	PA?[1]	Limitations/ Requirements	Maximum Allowable Fee
D0160	Detailed and extensive oral evaluation – orthodontic only	No	Includes orthodontic oral examination, taking and processing clinical photographs, completing required form(s) and obtaining DSHS's authorization decision.	On line Fee Schedules
D0170	Re-evaluation – limited, problem focused (established patient; not post-operative visit)	No	• Allowed once per client, per visit; and • Not allowed in combination with periodic/limited/comprehensive oral evaluations.	

Radiographs

D0330	Panoramic Film – Maxilla and Mandible	No	Panoramic films are allowed once in a three-year period. A shorter interval between panoramic radiographs may be allowed when medically necessary. Doing both a panoramic film and an intraoral complete series is not allowed.	On line Fee Schedules
D0340	Cephalometric Film	No	Allowable for orthodontic purposes only. Cephalometric film allowed once in a two-year period.	

[1] PA-Prior Authorization

CDT Code	Description	PA?	Limitations/ Requirements	Maximum Allowable Fee

Other Orthodontic Services

D8680	Appliance Removal if placed by Non-Medicaid Provider	Yes	**Use this code for** a client whose appliance was placed by an orthodontic provider not participating with DSHS, and/or whose treatment was previously covered by another third-party payer. Fee includes debanding and removal of cement.	On line Fee Schedules

Cleft Lip and Palate, Cleft Palate, or Cleft Lip with Alveolar Process Involvement

D8660	Cleft Palate Pre-Orthodontic Treatment Visit	EPA	**Requires use of EPA number 870000950** when billing for cleft palate and craniofacial anomaly cases. Billable only by the treating orthodontic provider. Includes preparation of comprehensive diagnostic records (additional photos, study casts, cephalometric examination), formation of diagnosis and treatment plan from such records, and formal case conference. Treating provider **must** be an orthodontist **and** either be a member of a recognized craniofacial team or approved by DSHS's Dental Consultant to provide this service. One of the following medically necessary ICD-9-CM diagnosis codes must be documented in the client's record: 749.00-749.04, 749.10-14, 749.20-749.25, 754.0, 755.55	On line Fee Schedules

CDT Code	Description	PA?	Limitations/ Requirements	Maximum Allowable Fee

Limited Orthodontic Treatment for Cleft Palate

D8010 Limited orthodontic treatment of the primary dentition
D8020 Limited orthodontic treatment of the transitional dentition
D8030 Limited orthodontic treatment of the adolescent dentition

D8010 D8020 D8030	Limited Orthodontic Treatment for Cleft Palate	EPA	**Requires use of EPA number 870000950** when billing for cleft palate and craniofacial anomaly cases. This reimbursement is for the **initial placement** when the appliance placement date and the date of service are the same. Includes first 3 months of treatment and appliance(s).	
D8010 D8020 D8030	Limited Orthodontic Treatment for Cleft Palate	EPA	Reimbursement is for each **subsequent three month period** when the appliance placement date and the date of service are different. DSHS reimburses a maximum of 3 follow-up visits. **Requires use of EPA number 870000950** when billing for cleft palate and craniofacial anomaly cases. **Note: To receive reimbursement for each subsequent three-month period:** • The provider must examine the client in the provider's office at least twice during the 3-month period; • Continuing treatment must be billed after each 3-month interval; • Document the actual service dates in the client's record; • For billing purposes, use the last date of each 3-month billing interval as the date of service.	On line Fee Schedules

CDT Code	Description	PA?	Limitations/ Requirements	Maximum Allowable Fee

Interceptive Orthodontics for Cleft Palate

D8050 **Interceptive Orthodontic Treatment for Primary Dentition**
D8060 **Interceptive Orthodontic Treatment for Transitional Dentition**

D8050 D8060	Interceptive Orthodontic Treatment for Cleft Palate	EPA	**Requires use of EPA number 870000950** when billing for cleft palate and craniofacial anomaly cases. Payable only once per client. The maximum allowance includes all professional fees, laboratory costs, and required follow-up. No allowance for lost or broken appliance.	On line Fee Schedules

Comprehensive Orthodontic Treatment for Cleft Palate

D8070 **Comprehensive Orthodontic Treatment of the Transitional Dentition**
D8080 **Comprehensive Orthodontic Treatment of the Adolescent Dentition**

D8070 D8080	Comprehensive Orthodontic Treatment for Cleft Palate	EPA	This reimbursement is for the **initial placement** when the date of service and the appliance placement date are the same. **Requires the use of EPA number 870000950.** Use of the EPA number verifies that the client has a cleft palate or craniofacial anomaly. Includes first 6 months of treatment and appliances. Treating provider **must** be an orthodontist **and** be either a member of a recognized craniofacial team or approved by DSHS's Dental Consultant to provide this service.	On line Fee Schedules

CDT Code	Description	PA?	Limitations/ Requirements	Maximum Allowable Fee

Comprehensive Orthodontic Treatment for Cleft Palate (cont.)

D8070 Comprehensive Orthodontic Treatment of the Transitional Dentition
D8080 Comprehensive Orthodontic Treatment of the Adolescent Dentition

D8070 D8080	Comprehensive Orthodontic Treatment for Cleft Palate	EPA	This reimbursement is for each **subsequent three-month period** when the appliance placement date and the date of service are different. DSHS reimburses a maximum of 8 follow-up visits. **Requires the use of EPA number 870000950.** Use of the EPA number verifies that the client has a cleft palate or craniofacial anomaly. Treating provider **must** be an orthodontist **and** be either a member of a recognized craniofacial team or approved by DSHS's Dental Consultant to provide this service. **Note: To receive reimbursement for each subsequent three-month period:** • The provider must examine the client in the provider's office at least twice during the 3-month period, with the first 3-month interval beginning 6 months after the initial appliance placement; • Continuing treatment must be billed after each 3-month interval; • Document the actual service dates in the client's record; • For billing purposes, use the last date of each 3-month billing interval as the date of service.	On line Fee Schedules

CDT Code	Description	PA?	Limitations/ Requirements	Maximum Allowable Fee

Severe Handicapping Malocclusion

Clinical Evaluations

D8660	Severe Malocclusion Pre-orthodontic Visit	Yes	Use this code for Orthodontist Case Study. Billable only by the treating orthodontic provider. Includes preparation of comprehensive diagnostic records (additional photos, study casts, cephalometric examination), formation of diagnosis and treatment plan from such records, and formal case conference.	On line Fee Schedules

CDT Code	Description	PA?	Limitations/ Requirements	Maximum Allowable Fee

Limited Orthodontic Treatment for Severe Malocclusion

D8010 Limited orthodontic treatment of the primary dentition
D8020 Limited orthodontic treatment of the transitional dentition
D8030 Limited orthodontic treatment of the adolescent dentition

D8010 D8020 D8030	Limited Orthodontic Treatment for Severe Malocclusion	Yes	This reimbursement is for the **initial placement** when the appliance placement date and the date of service are the same. Includes first 3 months of treatment and appliance(s).	On line Fee Schedules
D8010 D8020 D8030	Limited Orthodontic Treatment for Severe Malocclusion	Yes	This reimbursement is for each **subsequent three-month period** when the appliance placement date and the date of service are the different. DSHS reimburses a maximum of 3 follow-up visits. **Note: To receive reimbursement for each subsequent three-month period:** • The provider must examine the client in the provider's office at least twice during the 3-month period; • Continuing treatment must be billed after each 3-month interval; • Document the actual service dates in the client's record; • For billing purposes, use the last date of each 3-month billing interval as the date of service.	On line Fee Schedules

CDT Code	Description	PA?	Limitations/ Requirements	Maximum Allowable Fee

Interceptive Orthodontics for Severe Malocclusion

D8050 Interceptive Orthodontic Treatment for Primary Dentition
D8060 Interceptive Orthodontic Treatment for Transitional Dentition

D8050 D8060	Interceptive Orthodontic Treatment for Severe Malocclusion	Yes	Payable only once per client. The maximum allowance includes all professional fees, laboratory costs, and required follow-up. No allowance for lost or broken appliance.	On line Fee Schedules

CDT Code	Description	PA?	Limitations/ Requirements	Maximum Allowable Fee

Comprehensive Orthodontic Treatment for Severe Malocclusion

D8070 Comprehensive Orthodontic Treatment of the Transitional Dentition
D8080 Comprehensive Orthodontic Treatment of the Adolescent Dentition

D8070 D8080	Comprehensive Orthodontic Treatment for Severe Malocclusion	Yes	This reimbursement is for the initial placement when the appliance placement date and the date of service are the same. Includes first 6 months of treatment and appliances.	On line Fee Schedules
D8070 D8080	Comprehensive Orthodontic Treatment for Severe Malocclusion	Yes	This reimbursement is for each **subsequent three-month period** when the appliance placement date and the date of service are different. DSHS reimburses a maximum of 6 follow-up visits.	
			Note: To receive reimbursement for each subsequent three-month period: • The provider must examine the client in the provider's office at least twice during the 3-month period; • Continuing treatment must be billed after each 3-month interval, with the first 3-month interval beginning 6 months after the initial appliance placement; • Document the actual service dates in the client's record; • For billing purposes, use the last date of each 3-month billing interval as the date of service.	

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Authorization

What Orthodontic Treatment and Orthodontic-Related Services Require Prior Authorization?

[Refer to WAC 388-535A-0050]

When DSHS authorizes an interceptive orthodontic treatment, limited orthodontic treatment, or full orthodontic treatment for a client, including a client eligible for services under the EPSDT program, that authorization indicates only that the specific service is medically necessary; it is not a guarantee of payment. The client must be eligible for the covered service at the time the service is provided.

For orthodontic treatment of a client with cleft lip, cleft palate, or other craniofacial anomaly, prior authorization (PA) is **not** required if the client **is being treated** by a DSHS-recognized craniofacial team, or an orthodontic specialist who has been approved by DSHS to treat cleft lip, cleft palate, or other craniofacial anomalies.

Subject to the conditions and limitations in this section and in applicable WAC, DSHS requires PA for orthodontic treatment and/or orthodontic-related services for other dental malocclusions that are not listed in the *Coverage* section of these billing instructions.

When Do I Need to Get Prior Authorization?

PA must be received from DSHS **before** the service is provided.

Authorization is based on the establishment of medical necessity as determined by DSHS. When PA is required for a service, DSHS considers these requests on a case-by-case basis.

DSHS may require second opinions and/or consultations before authorizing any procedure.

In an acute emergency, DSHS *may* authorize the service after it is provided when DSHS receives justification of medical necessity. This justification must be received by DSHS within 72 hours of the emergency service.

How Do I Obtain Written Prior Authorization?

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

The request must be submitted in writing on a completed Orthodontic Information sheet, DSHS 13-666, and include the following:

- The client's name and date of birth;
- The client's patient identification code (PIC);
- The provider's name and address;
- The provider's telephone number (including area code);
- The provider's assigned 7-digit DSHS provider number;
- The physiological description of the disease, injury, impairment, or other ailment;
- The most recent and relevant radiographs that are identified with client name, provider name, and date the radiographs were taken. *Radiographs should be duplicates as originals are to be maintained in the client's chart*;
- The proposed treatment; and
- Diagnostic color photographs.

To download available DSHS forms go to http://www1.dshs.wa.gov/msa/forms/index.html. Refer to Section F - Orthodontic Information Sheet for more information.

If DSHS approves your request, the ADA claim form will be returned to you with an authorization number.

Remember to include the authorization number on the ADA claim form.

Medical Justification

1. All information pertaining to medical necessity must come from the client's prescribing orthodontist. Information obtained from the client or someone on behalf of the client (e.g., family) will not be accepted.

2. Measurement, counting, recording, or consideration for treatment is performed only on teeth that have erupted and can be seen on the diagnostic study models. All measurements are made or judged on the basis equal to, or greater than, the minimum requirement.

3. Only permanent natural teeth will be considered for full orthodontic treatment of severe malocclusions.

4. 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.

5. Impacted teeth alone are not considered a severe handicapping malocclusion.

Documentation

The billing provider must keep documentation of the criteria in the client's file. This documentation must be readily available for review by DSHS staff on request.

Note: Upon audit, if specified criteria are not met, DSHS has the authority to recoup any payments made, based on RCW 74.02.050; 74.08.090; 74.09.290; WAC 388-502-0020; WAC 388-502-0230; and DSHS's Core Provider Agreement.

Where Do I Send Requests for Prior Authorization?

Mail your request to:

DSHS-Health and Recovery Services Administration
PO Box 45506
Olympia, WA 98504-5506

For procedures that do not require radiographs
Fax: 1-360-586-5299

Expedited Prior Authorization (EPA)

When do I need to bill with an EPA number?

Those orthodontic services listed in the Coverage section as **"Requires Expedited Prior Authorization"** must have the assigned EPA number for that procedure on the ADA claim form when billing. By placing the appropriate EPA number on the ADA claim form when billing DSHS, dental providers are verifying that the bill is for a cleft palate or craniofacial anomaly case. See pages C.4-C.7.

Note: The unique EPA number is to be used ONLY when indicated in the Coverage section.

EPA numbers will be discontinued upon implementation of the new DSHS ProviderOne payment system. Refer to the Coverage Table for billing protocol.

Exceeding Limitations or Restrictions

A request to exceed stated limitations or other restrictions on covered services is called a limitation extension (LE), which is a form of prior authorization. DSHS evaluates and approves requests for LE for orthodontic services when medically necessary, under the provisions of WAC 388-501-0169.

DSHS evaluates a request for any orthodontic service not listed as covered in this section under the provisions of WAC 388-501-0070.

DSHS reviews requests for orthodontic treatment for clients who are eligible for services under the EPSDT program according to the provisions of WAC 388-534-0100.

[WAC 388-535A-0040 (5),(6), and (7)]

Payment

Fee Schedule [Refer to WAC 388-535A-0060 (2) and (5)]

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

Payment for orthodontic treatment and orthodontic-related services is based on DSHS's published fee schedule.

You may access DSHS's Dental Fee Schedule at: http://maa.dshs.wa.gov/RBRVS/Index.html.

Payment for Interceptive Orthodontic Treatment

Payment for interceptive orthodontic treatment is based on DSHS's published fee schedule. Interceptive orthodontic treatment is payable only once per client. The maximum allowance includes all professional fees, laboratory costs, and required follow-up. No allowance for lost or broken appliance.

Payment for Limited Transitional Orthodontic Treatment
[Refer to WAC 388-535A-0060 (3)]

DSHS pays for limited transitional orthodontic treatment as follows:

- The first three months of treatment starts the date the initial appliance is placed and includes active treatment for the first three months. The provider must bill DSHS with the date of service that the initial appliance is placed.

- Continuing follow-up treatment must be billed after each three-month treatment interval during the treatment.

- Treatment must be completed within 12 months of the date of appliance placement. Treatment provided after one year from the date the appliance is placed requires a limitation extension. DSHS evaluates a request for orthodontic treatment and orthodontic-related services that are in excess of the limitations or restrictions listed in this section, according to WAC 388-501-0169.

Payment for Comprehensive Full Orthodontic Treatment
[Refer to WAC 388-535A-0060 (4)]

DSHS pays for comprehensive full orthodontic treatment as follows:

- The first six months of treatment starts the date the initial appliance is placed and includes active treatment for the first six months. The provider must bill DSHS with the date of service that the initial appliance is placed.

- Continuing follow-up treatment must be billed after each three-month treatment interval, with the first three-month interval beginning six months after the initial appliance placement.

- Treatment must be completed within 30 months of the date of appliance placement. Treatment provided after 30 months from the date the appliance is placed requires a limitation extension. DSHS evaluates a request for orthodontic treatment and orthodontic-related services that are in excess of the limitations or restrictions listed in this section, according to WAC 388-501-0169.

Does DSHS Pay for Orthodontic Treatment Beyond the Client's Eligibility Period? **[Refer to WAC 388-535A-0060 (7), (8), and (9)]**

If the client's eligibility for orthodontic treatment (see Client Eligibility section) ends before the conclusion of the orthodontic treatment, payment for any remaining treatment is the individual's responsibility. DSHS 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. DSHS does not pay for these services.

DSHS 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.

Refer to WAC 388-502-0160 for DSHS's rules on billing a client and WAC 388-501-0200 for DSHS's rules on when a provider or a client is responsible to pay for a covered service.

Orthodontic Information Sheet

When Do I Need to Complete the Orthodontic Information Sheet, DSHS 13-666?

When orthodontic services are requested for a DSHS client, you must complete the Orthodontic Information sheet, DSHS 13-666. To download copies of this form, go to: http://www1.dshs.wa.gov/msa/forms/eforms.html .

How Do I Complete and Submit the Orthodontic Information Sheet, DSHS 13-666?

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

Follow steps 1 and 2 below when applying for authorization to provide orthodontic services:

1. Complete the Orthodontic Information sheet [current version dated 6/2001]

a) Fill in the *provider information* and *patient information* sections at the top of the sheet.

b) In Part 1, fill in the information requested in each area that applies to the treatment being provided.

c) In Part 2, fill in as much as possible to assist DSHS's orthodontic consultant in determining medical necessity.

d) Phone number of provider.

2. **Submit** the following full set of 8 dental color photographs to DSHS:

a) **Intraoral Dental Photographs:**

1) Anterior (teeth in centric occlusion)
2) Right lateral (teeth in centric occlusion)
3) Left lateral (teeth in centric occlusion)
4) Upper Occlusal View (taken using a mirror)
5) Lower Occlusal View (taken using a mirror)

b) **Extraoral Photographs:**

1) Frontal
2) Frontal Smiling
3) Lateral Profile

Mail the materials, with the patient's PIC and name, to:

DSHS-Health and Recovery Services Administration
PO Box 45506
Olympia, WA 98504-5506

Remember to include the authorization number on the ADA claim form.

Orthodontic Information Review

DSHS's orthodontic consultant will review the photos and all of the information submitted for each case and will return the Orthodontic Information sheet to you with one of the following responses:

____ Orthodontic case study and treatment requests are authorized.

____ Orthodontic case study request authorized. *Requested treatment is not authorized at this time*. Resubmit with study models for evaluation, or see comments on the "Orthodontic Authorization" Sheet.

____ Request for orthodontic case study denied. See comments on the "Orthodontic Authorization" Sheet.

____ Pend for additional information.

Submitting Additional Information

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

- Claim for the full case study attached to the Orthodontic Information sheet, DSHS 13-666; and
- Appropriate radiographs (e.g., panoramic and cephalometric radiographs);
- Diagnostic color photographs (eight).
- A separate letter with any additional medical information if it will contribute information that may affect DSHS's final decision.
- Study models. (Do not send study models unless they are requested.)
- Other information if requested.

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Completing the ADA Claim Form

DSHS accepts **ONLY** the 2006 American Dental Association (ADA) dental claim form.

Any other dental claim forms will not be processed and will be returned to the provider.

Remember: If you submit your claims electronically, DSHS will be able to process them faster.

General Information

- Include any required expedited prior authorization number.
- Send only one claim form for payment. If the number of services exceeds one claim form, a second form can be submitted. Please make sure that all necessary claim information (provider number, patient identification code, etc.) is repeated on the second form. Each claim form should show the total charges for the services listed.
- Use either blue or black ink only. **Do not use red ink, highlighters, "post-it notes," stickers, correction fluid or tape** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process or will actually **black out** information. Do not write or use stamps or stickers on claim form.
- Please refer to billing instructions for indication of when a tooth/arch/quadrant/tooth surface is required to be billed with a code. If the billing instructions indicate that a tooth number is required, please bill with the appropriate tooth number. If the billing instructions indicate that a tooth number is required, it would be an error to bill with a quadrant designation. If the billing instructions indicate that a quadrant is indicated, please bill with a quadrant, not a tooth number. Claims billed with inappropriate data will be denied.

Send your claims for payment to:

Claims Processing
PO Box 9253
Olympia WA 98507-9253

2006 ADA Claim Form Instructions

Field No.	Name	Entry
HEADER INFORMATION		
1.	Type of transaction	Mark the appropriate box if billing a claim (statement of actual services) or requesting authorization (request for predetermination)
2.	Predetermination/Preauthorization Number	Place the required prior authorization number or EPA number in this field. Indicate the line(s) the number applies to.
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		
3.	Company/Plan Name, Address, City, State, Zip Code	Enter the address for DSHS that is listed in the shaded box on page G.1.
OTHER COVERAGE		
4.	Other Dental or Medical Coverage	If client has other insurance primary to Medical Assistance, check the appropriate response.
5.	Name of Policyholder/Subscriber (Last, First, Middle Initial, Suffix)	If different from the patient, enter the name of the subscriber.
6.	Date of Birth (MM/DD/CCYY)	Enter the subscriber's date of birth.
8.	Policyholder/Subscriber Identifier (SSN or ID#)	Enter the subscriber's SSN or other identifier assigned by the payer.
9.	Plan/Group Number	If the client has third party coverage, enter the dental plan # of the subscriber.
10.	Relationship to Primary Policyholder/Subscriber	Check the applicable box.
11.	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	Enter any other applicable third party insurance.
POLICYHOLDER/SUBSCRIBER INFORMATION		
12.	Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	If different from patient's (field 20), enter the legal name and address of the subscriber here.
13.	Date of Birth (MM/DD/CCYY)	If different from patient's, enter the subscriber's date of birth.
15.	Policyholder/Subscriber Identifier (SSN or ID#)	Enter the SSN or other identifier assigned by the payer.
16.	Plan/Group Number	Enter the subscriber's group Plan or Policy Number.
17.	Employer Name	Enter the name of the subscriber's employer.
PATIENT INFORMATION		
18.	Relationship to Policyholder/Subscriber	Check the appropriate box.

Field No.	Name	Entry
PATIENT INFORMATION (cont.)		
20.	Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code	Enter the client's legal name, address, and **Patient Identification Code (PIC)**.
21.	Date of Birth (MM/DD/CCYY)	Enter the client's date of birth.
23.	Patient ID/Account #	If you wish to use a medical record number, enter that number here.
RECORD OF SERVICES PROVIDED		
Each service performed must be listed as a separate, complete one-line entry. **Each extraction or restoration** must be listed as a separate line entry. If billing for removable prosthodontics, missing teeth must be noted on the tooth chart.		
24.	Procedure Date (MM/DD/CCYY)	Enter the six-digit date of service, indicating month, day, and year (e.g., September 1, 2008 = 090108).
25.	Area of Oral Cavity	If the procedure code requires an arch or a quadrant designation, enter the appropriate arch or quadrant as follows: 01 Maxillary area 02 Mandibular area 10 Upper right quadrant 20 Upper left quadrant 30 Lower left quadrant 40 Lower right quadrant
26.	Tooth system	Not used.
27.	Tooth Number(s) or Letter(s)	If the procedure code requires a tooth designation, enter the appropriate tooth number or letter (only one tooth may be billed per line). • 01 through 32 for permanent teeth • A through T for primary teeth • 51 through 82 or AS through TS for supernumerary teeth
28.	Tooth Surface	If the procedure code requires a tooth surface, enter the appropriate letter(s) from the list below to indicate the tooth surface. Up to five surfaces may be listed in this column: B = Buccal D = Distal F = Facial I = Incisal L = Lingual M = Mesial O = Occlusal

Field No.	Name	Entry
RECORD OF SERVICES PROVIDED (cont.)		
29.	Procedure Code	Enter the appropriate (2007 CDT) procedure code that represents the procedure or service performed. **The use of any other procedure code(s) will result in denial of payment.**
30.	Description	Give a brief written description of the services rendered. When billing for general anesthesia or IV sedation, enter the actual beginning and ending time.
31.	Fee	Enter **your usual and customary fee** (not DSHS's maximum allowable rate) for each service rendered. If fee schedule indicates to bill Acquisition Cost (AC), please bill your acquisition cost.
33.	Total Fee	Total of all charges.
34.	Missing Teeth Information	Place an "X" on the appropriate missing teeth.
35.	Remarks	Enter the provider number assigned by DSHS when you signed your Core Provider Agreement. It is the same seven-digit number that appears on the DSHS Remittance and Status Report in the ***Provider Number*** area at the top of the page. If performing provider is different than that listed in field 49, enter the rendering provider's Medicaid provider number here.
		To indicate a payment by another plan, enter "insurance payment" and the amount. Attach the insurance EOB to the claim.

Field No.	Name	Entry
ANCILLARY CLAIM/TREATMENT INFORMATION		
38.	Place of Treatment	DSHS defines the following places of service for paper claims when a place of treatment box is checked but no two-digit place of service is indicated: **Box checked** — **Place of Service** Office — Dental office (POS 11) Hospital — Outpatient hospital (POS 22) ECF — Skilled nursing facility (POS 31) Other — DSHS will not allow place of service "other" without a two digit place of service indicated. If the services rendered are not in one of the places of service as indicated above, then the two-digit POS **must** be indicated in field 38. DSHS considers the following places of service for dental claims (not all services are covered in all places of service) **Office** **11** dental office **Hosp** **21** inpatient hospital **22** outpatient hospital **23** hospital emergency room **ECF** **31** skilled nursing facility **32** nursing facility **54** intermediate care facility/mentally retarded **Other** **03** school-based services **12** client's residence **24** professional services in an ambulatory surgery center **50** federally qualified health center **71** state or public health clinic (department) DSHS requires that a valid two-digit place of service be indicated that accurately reflects the place of service. Inaccurate place of service designations will be denied.

Field No.	Name	Entry
ANCILLARY CLAIM/TREATMENT INFORMATION (cont.)		
39.	Number of Enclosures (00 to 99)	Check the appropriate box. **Note:** Do not send X-rays when billing for services.
40.	Is Treatment for Orthodontics?	Check appropriate box.
41.	Date Appliance Placed (MM/DD/CCYY)	This field ***must be completed*** for orthodontic treatment.
43.	Replacement of Prosthesis?	Check appropriate box. If "yes," enter reason for replacement in field 35 (Remarks).
44.	Date Prior Placement (MM/DD/CCYY)	Enter appropriate date if "yes" is check for field 43.
45.	Treatment Resulting from	Check appropriate box.
46.	Date of Accident (MM/DD/CCYY)	Enter date of accident.
BILLING DENTIST OR DENTAL ENTITY		
48.	Name, Address, City, State, Zip Code	Enter the dentist's name and address as recorded with DSHS.
49.	NPI	Enter your National Provider Identifier (NPI). It is this code by which providers are identified, not by provider name. **Without this number your claim will be denied.**
52.	Phone Number	Enter the billing dentist's phone number.
52a.	Additional provider ID	Medical Assistance billing ID number.
TREATING DENTIST AND TREATMENT LOCATION INFORMATION		
54.	NPI	Enter the performing provider's NPI if it is different from the one listed in field 49. If you are a dentist in a group practice, please indicate your unique NPI and/or name.
56.	Address, City, State, Zip Code	If different than field 48, enter the treating dentist's information here.
57.	Phone Number	If different from field 52, enter the treating dentist's phone number here.
58.	Additional provider ID	Medical Assistance rendering provider ID number.

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - ☐ Statement of Actual Services
   - ☐ Request for Predetermination / Preauthorization
   - ☐ EPSDT / Title XIX
2. Predetermination / Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender ☐ M ☐ F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
13. Date of Birth (MM/DD/CCYY)
14. Gender ☐ M ☐ F
15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other
19. Student Status ☐ FTS ☐ PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY)
22. Gender ☐ M ☐ F
23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)
33. Total Fee
35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X_____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other
39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)
44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
49. NPI
50. License Number
51. SSN or TIN
52. Phone Number ( ) –
52A. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X_____
Signed (Treating Dentist) Date

54. NPI
55. License Number
56. Address, City, State, Zip Code
56A. Provider Specialty Code
57. Phone Number ( ) –
58. Additional Provider ID

J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

To Reorder call 1-800-947-4746 or go online at www.adacatalog.org

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