Access to Baby and Child Dentistry/ABCD WA State HCA/Medicaid/Apple Health **Dental Fee Schedule Summary 04/2018;**

This reflects HCA/Medicaid fee schedule changes, retroactive to dates of service on-or-after **01/01/18** (subject to revision).

Disclaimer:

This summary is for quick reference purposes only & there is a possibility of omission & error. It is always superseded by the most current online HCA/Medicaid Provider Guides.

For further essential details on Claims & Billing, ProviderOne Resources, and Programs & Services, refer to: HCA BILLERS and PROVIDERS WEBPAGE for access to the most *current WA STATE HCA information and guides, including*: General ProviderOne Billing & Resource Guide; Dental Program Billing Guide& Fee Schedule ; Access to Baby and Child Dentistry (ABCD) Billing Guide; and ProviderOne Resources such as User Manuals and Training Webinars.

Procedures indicated in bold below, are eligible for ABCD-enhanced rate. ***Asterisk indicates provider guide billing revision as of January 1, 2018**.

Enhanced fees are allowable only for ABCD certified dental providers for current Medicaid patients from birth through age 5. Yellow highlight indicates ABCD-eligible only.
Note that ABCD children are entitled to the full scope of care, as described in HCA/Medicaid Dental Billing Instructions.

Procedure Code	Procedure Name	Frequency Allowable	ABCD Maximum Allowable	Non-ABCD Maximum Allowable
D0150	**Comprehensive (*initial*) Oral Evaluation**	1 per client per dentist or clinic, unless client has not been seen in 5 years or has a change in medical condition. See Dental Billing Guide for details.	**$40.38**	$33.64
D0120	**Periodic oral evaluation** *(six months must elapse since initial comp. exam)*	Every 6 months (180 days)	**$29.46**	$21.73
D0190 D0191	Limited Visual Oral Screening/ Assessment in *setting other than dental office or clinic*; child or adult. These codes are similar. *Choose one*. See billing instructions for more info.	Billable up to two per client, per year, per provider. Only one allowable per visit.	See non-ABCD	$10.20
D1120	Prophylaxis-Child through age 13 *(Note: for teens14-20 yrs, bill w/code D1110)*	Every 6 months (see ≤ 20 Dental B.I.)	See non-ABCD	$22.98
D1206* D1208*	**D1206 Topical fluoride varnish/ D1208 Topical application of fluoride, excluding varnish** *Note: D1206 and D1208 are not allowed on the same day. D1206 & D1208 cover both kids & adults. The limit per provider, per client, for D1206 and D1208 is the combined total of the two, not per code. The codes are considered equivalent, and one of codes, not both, can be billed every four months.	Allowed once every four months - per client, per provider, through age 6. (Or every six months for ages 7 to18.) *ADD'L applications w/ortho or prior auth.*	**$23.41**	$13.25
D1351	Topical application of sealant, per tooth. See Billing Instructions for details.	1x per tooth per 3 years or w/prior auth.	See non-ABCD	$21.98
D9999	**Family oral health education** *(Document FOHE in chart: see ABCD billing instructions)*	>Two times per 12-months *per child*, but only once per day *per family*!	**$27.58**	NA
D2941	**Interim therapeutic restoration– primary dentition; age 5 years & under; EPA #870001379**	Use current Billing Guide EPA criteria	**$63.61**	NA
D2140	**Amalgam–one surface**, primary or permanent *(allowance for all amalgams includes polishing.)* Tooth/surface designation required.	See Billing Instructions for more detail 1x per 2-years for same surface of same tooth or with written justification.	**$63.61**	$49.97
D2150	**Amalgam – two surfaces**, primary or permanent	"	**$69.97**	$61.97
D2160	**Amalgam –three or more surfaces**, primary or permanent *(Note: If billed on a primary first molar, payment is at the rate for a two-surface restoration.)*	"	**$85.87**	$69.96
D2161	Amalgam – four or more surfaces, primary or permanent *(Note: If billed on a primary 1st or 2nd molar, payment is at the rate for a two-surface restoration.)*	"	See non-ABCD	$69.96
----	**Note:** Glass ionomer restorations are only for primary teeth & 5 years of age or younger.	*Paid as one-surface resin-based composite restoration. See Billing Instructions*		
D2330	**Resin-based Composite- one surface,** anterior	See Billing Instructions for details.	**$63.61**	$59.37
D2331	**Resin-based Composite- two surfaces,** anterior	"	**$95.41**	$64.96
D2332	**Resin-based - three surfaces**, anterior	"	**$111.31**	$69.96
D2335	Resin-based Composite- 4+ surfaces or involving incisal angle (anterior); EPA# needed for anterior teeth.	See EPA details in Billing Instructions!!	See non-ABCD	$69.96
D2391	**Resin-based composite- 1 surface, posterior**	See Billing Instructions for details.	**$63.61**	$49.97
D2392	**Resin-based composite- 2 surface, posterior**	"	**$75.00**	$61.97
D2393	**Resin-based composite-3 surface, posterior** *(If billed on a primary 1st or 2nd molar, paid at D2392 rate)*	"	**$80.00**	$69.96
D2394	Resin-based composite- 4 surface, posterior *(If billed on a primary 1st or 2nd molar, paid at D2392 rate.)*	"	See non-ABCD	$69.96
D2390	**Resin-based composite crown, anterior; includes strip crowns.** *Medical justification required in record.*	See Billing Instructions for EPA# details	**$216.26**	$94.00
D2929	**Prefabricated non-stainless steel crowns;** *Medical justification required in client record.*	"	**$216.26**	$94.00
D2930	**Prefabricated stainless steel crown – primary tooth Medical** *justification required in client record.*	"	**$155.00**	$89.05
D2933	Prefabricated stainless steel crown with resin window- *Medical justification required in client record.*	"	**$155.00**	$103.90
D3220	**Therapeutic Pulpotomy;** *(Primary teeth only;* tooth designation required*)*	See Billing Instructions for details.	**$95.41**	$43.97
D9920	**Behavior management**-requires one add'tl staff person to protect patient. Doc. required. See billing info.	PA not needed for ages 8 and younger	**$28.10**	$26.72
D9230	Inhalation of nitrous oxide, analgesia, anxiolysis	Once per day.	See non-ABCD	$20.00

Billing Tips

A) NOTE: Change in frequency allowable for Codes 1206 & 1208; (changed from "3 times per year" to "once every four months").

B) NOTE: The Health Care Authority (HCA) browser support
For security purposes, HCA will support only the following four web browsers:(current & previous version):
--Google Chrome --Internet Explorer --Mozilla Firefox --Safari
What does this mean for you? HCA web applications may not work correctly on older browsers.
To ensure that you view the web applications properly, confirm that your browser will be supported and upgrade to (or install) the latest version .

C) NOTE: D2941 -Interim therapeutic restoration– primary dentition for age 5 and under. Must use EPA # & current criteria in Dental Billing Guide.

D) NOTE: For all dental providers **submitting a prior authorization request** using the *General Information for Authorization* form:
DO NOT put any info into FIELD 26 (Tooth or Quad #) unless the agency's Dental Program Billing Guide requires specific information to be entered.

E) Electronic claims are generally paid by Monday if submitted by 6pm Tuesday.
For training material on submitting electronic claims, please visit HCA/Medicaid ProviderOne Resources and Webinars.

F) Make sure to enter client ProviderOne ID # and provider taxonomy # correctly! The most common reasons for claim denial are an incorrect client ID or provider taxonomy.

G) If relevant, when contacting customer service state "I have looked at my Remittance Advice, and I don't understand_____",
otherwise they will tell you contact them after you have looked at your Remittance Advice.

H) If you have a Customer Relations Call Inquiry Issue:
> If not satisfied with answer, you may ask for a "lead" worker;
> If not satisfied with answer from "lead" worker, they can inquire with billing specialists (or ask to be referred if they do not);
> Make sure to get a call tracking number, in case you need to reference the call in the future.
> If you have made a good faith effort and are frustrated, you can contact Janice Tadeo, @ 360-725-1583 or Janice.tadeo@hca.wa.gov

I) You do not need to submit "coordination of Benefits" if you know that HCA will not pay. In that situation you only need to do it if your office wants to track it internally.

J) Remarks field: don't put notes in this field on the claim form unless needed. It will slow down processing because it will signal a human to review it.

K) Don't use "back" button when opening a page, use "CLOSE" button whenever there is that option.

L) For TPL, if a claim is partially denied (e.g. pays 2 services, denies D9999), break them out; submit one for the two services that were paid and a separate one for D9999 or you can just submit the denied claim (e.g. D9999) and don't bother with the rest.

M) D9999, Family Oral Health Education (FOHE), is billable two times per 12-months *per child*, but only once per day *per family*.
Note: Even if Medicaid is *secondary* insurance, it *will* pay for FOHE after denial by primary insurance.

N) If different, make sure to enter Billing (group) provider info & individual treating dentist info in correct fields. If solo practice, billing # & treating dentist are the same.

O) The Healthcare Authority provides a way for clients to directly see if Medicaid providers in their area are accepting new patients.
All active Medicaid providers that are loaded in the ProviderOne system will appear on this list unless they *actively choose* to remove themselves from the list.
If you wish to be removed from this listing, *your office* will need to request this through the provider file maintenance process within ProviderOne
by going to http://www.hca.wa.gov/medicaid/provider/documents/fs_removingacceptingnewpatientsfrombpw.pdf

P) ***NOTE: all claim denial and service limit requests submitted through*** ***Contact Us!*** (@ https://fortress.wa.gov/dshs/p1contactus/Provider_WebForm)
will be issued a confirmation page that includes a date and time stamp instead of a service request number.
There is a 48 hour turn-around for Service Limit checks: Be sure to include: Date of Service (DOS) • Procedure Code & date range for search • ProviderOne Domain **#**

At the Contact Us! "Request Form for Providers" screen, submit the claim denial or service limit request and the confirmation page will be displayed. A print button is provided at the lower right corner of the screen to print the confirmation for your records. The Claims Processing Office will reply to the request using an email address. This address is claimerror@hca.wa.gov. **NOTE:** Please be sure to add the claimerror@hca.wa.gov email address to the Safe Senders list in the email system you use so it will not be blocked or received in your junk email folder. Please do not send replies to this address.

Any additional or follow-up questions to your response should be submitted through Contact Us including confirmation # info entered into the **Other Comments field**.

Interim Therapeutic Restorations for ABCD providers

The Health Care Authority, in collaboration with the ABCD Program has developed criteria to provide reimbursement for the use of Interim Therapeutic Restorations in ABCD enrolled children. The criteria for the use of this procedure code is detailed in the January 2018 Provider Guide and is summarized in this document.

Reimbursement for this billing code (D2941) is only available to ABCD providers who have had the specific Phase II training provided by an ABCD Champion. The HCA has provided two different Expedited Prior Authorization (EPA) numbers that need to be used at the time of billing. Most of the time, EPA#870001379 will be the appropriate code. The second code (EPA#870001380) is provided in cases where definitive treatment was completed on one or more teeth and then the child's behavior deteriorated and an ITR needed to be placed on remaining teeth.

The process to prepare for using this code is as follows:

1. ABCD provider receives training from ABCD Champion;
2. ABCD Champion provides the UW Department of Pediatric Dentistry with documentation of individuals who have been trained;
3. UW Department of Pediatric Dentistry creates a certificate and letter with the provider's name and sends it to the provider;
4. UW Department of Pediatric Dentistry keeps a log of those trained and a file with copies of the certificates and letters;
5. Once training has occurred, ABCD provider can start billing for this procedure following guidelines below.
6. Reimbursement will be $63.61 per tooth regardless of the number of surfaces or the location (anterior vs posterior) of the tooth/teeth

Guidelines for Use

(As stated in ABCD Billing Guide <hca.wa.gov/assets/billers-and-providers/abcd-dental-bi-20180101.pdf>; always refer to most current ABCD Billing Guide.)

CDT CODE: D2941
DESCRIPTION: Interim Therapeutic Restoration – primary dentition
EPA #: 870001379

Interim therapeutic restoration (ITR) will be allowed in lieu of a definitive restoration as follows:

- Child must be age 5 or younger;
- Has current decay;
- Allowed for up to 1-2 surfaces;
- Provider is ABCD certified and has completed ITR training;
- ITR is expected to last a minimum of 1 year;
- Allowed for a maximum of 5 teeth per visit;
- Based on the treating dentist clinical judgment, will be allowed yearly until can be definitively treated or until the client's 6th birthday.
- Not allowed in conjunction with general anesthesia or on the same day as other definitive restorations.

Second EPA in cases where definitive treatment was started

Interim Therapeutic Restoration –
EPA# 870001380

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- ITR is expected to last a minimum of 1 year; • Allowed for a maximum of 5 teeth per visit;
- Based on the treating dentist clinical judgment, will be allowed yearly until can be definitively treated or until the client's 6th birthday.

Allowed on same day as definitive treatment with documentation that child was not able to proceed with complete treatment once started.

- not allowed in conjunction with general anesthesia

(As stated in Dental-Related Services Provider Guide 01/01/18; always refer to most current Provider Guide.)

What is Expedited Prior Authorization (EPA)?

Expedited prior authorization (EPA) process is designed to eliminate the need for written requests for prior authorization for selected dental procedure codes. The agency allows for use of an EPA for selected dental procedure codes. The criteria for use of an EPA are explained below.

- The EPA number must be used when the provider bills the agency.
- Upon request, a provider must provide documentation to the agency showing how the client's condition met the criteria for EPA.
- A written request for prior authorization is required when a situation does not meet the EPA criteria for selected dental procedure codes.
- The agency may recoup any payment made to a provider if the provider did not follow the required EPA process and criteria.

EPA numbers

1. If the client's medical condition does not meet all of the specified criteria, prior authorization (PA) must be obtained by submitting a request in writing to the agency (see Resources Available).

2. It is the vendor's responsibility to determine whether the client has already been provided the service allowed with the EPA criteria. If the vendor determines that the client has already been provided the service, a written prior authorization request must be submitted to the agency.