



Medical Assistance Administration



Orthodontic Services

Billing Instructions

[Chapter 388-535A WAC]

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About this publication

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Important Contacts

How find out about becoming a DSHS provider, submitting a change of address or ownership, or finding out the status of my provider application?

Provider Enrollment

<http://maa.dshs.wa.gov/ProvRel/Index.html>

(866) 545-0544 (toll free)

Where do I send my claims?

Electronic Claims:

Providers who would like to access the *free* WAMedWeb application can enroll now by contacting ACS EDI Gateway via telephone at (800) 833-2051 (toll free) or visit <https://wamedweb.acs-inc.com/wa/general/home.do>

Hardcopy Claims:

Division of Program Support
PO Box 9247
Olympia WA 98507-9247

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

To **view and download**, visit:
<http://maa.dshs.wa.gov> and click on *Billing Instructions/Numbered Memoranda*

To **have a hard copy sent** to you, visit:
<http://www.prt.wa.gov/> and click on *General Store*

Where do I call/look if I have questions regarding...

Policy, payments, denials, or general questions regarding claims processing, or MAA Managed Care?

Medical Assistance Customer Service

<http://maa.dshs.wa.gov/ProvRel/Index.html>

1-800-562-6188 (toll free)

Private insurance or third-party liability, other than MAA Managed Care?

Coordination of Benefits Section

1-800-562-6136 (toll free)

Electronic billing?

Electronic Media Claims Help Desk

(360) 725-1267

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: (360) 586-5299

Who do I call to request free in-office provider training?

Field Services Unit
(360) 725-1024
(360) 725-1027
(360) 725-1022
(360) 725-1023

How do I obtain DSHS forms?

To **download** DSHS forms, visit:
<http://www1.dshs.wa.gov/msa/forms/index.html>

To **have a hard copy sent** to you, visit:
<http://www.prt.wa.gov/> and click on
General Store.

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 MAA’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 MAA 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 Department of Health- and Medical Assistance Administration-recognized 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]

EPSDT – The department’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]

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]

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]

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.

Client Eligibility

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

MAA covers medically necessary orthodontic treatment for severe handicapping malocclusions, craniofacial anomalies, or cleft lip or palate for children only whose Medical Identification card lists one of the following medical program identifiers:

Medical Program Identifier	Medical Program
CNP	Categorically Needy Program (through age 20)
CNP – CHIP	CNP – State Children’s Health Insurance Program (SCHIP) (through age 18) See WAC 388-416-0015 for when certification periods may be extended.
MNP	Medically Needy Program – (through age 20)



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

Eligible clients may receive the same orthodontic services in designated bordering cities as if provided in-state. [See WAC 388-501-0175.]

Who is *not* eligible? [Refer to WAC 388-535A-0020 (2)]

MAA does not cover orthodontic services for adults (age 21 and older).

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Provider Requirements

Who may provide and be reimbursed for orthodontic services? [Refer to WAC 388-535A-0030 and 388-535A-0060(6)]

The following provider types may furnish and be reimbursed for providing covered orthodontic services to MAA clients:

- Orthodontists;
- Pediatric dentists;
- General dentists; and
- Department-recognized craniofacial teams or other orthodontic specialists approved by MAA's orthodontic consultant.

Orthodontic providers who are in department-designated bordering cities must meet the licensure requirements of their state; and meet the same criteria for payment as in-state providers, including the e requirements to contract with MAA.

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Coverage

What orthodontic treatment does MAA cover?

[Refer to WAC 388-535A-0040 (1) and (2)]

MAA covers orthodontic treatment for a client who has one of the following medical conditions:

- Cleft lip, cleft palate, or other craniofacial anomalies, when the client is treated by and receives follow-up care from a department-recognized craniofacial team for:
 - ✓ Cleft lip and palate, cleft palate, or cleft lip with alveolar process involvement;
 - ✓ Craniofacial anomalies, including but not limited to:
 - Hemifacial microsomia;
 - Craniosynostosis syndromes;
 - Cleidocranial dental dysplasia;
 - Arthrogyrosis; or
 - Marfan syndrome;
 - ✓ Other medical conditions with significant facial growth impact (e.g., juvenile rheumatoid arthritis (JRA)); or
 - ✓ Post-traumatic, post-radiation, or post-burn jaw deformity;
- Other severe handicapping malocclusions, including one or more of the following:
 - ✓ Deep impinging overbite when lower incisors are destroying the soft tissues of the palate;
 - ✓ Crossbite of individual anterior teeth when destruction of the soft tissue is present;
 - ✓ Severe traumatic malocclusion (e.g., loss of a premaxilla segment by burns or by accident; the result of osteomyelitis; or other gross pathology);
 - ✓ Overjet greater than 9mm with incompetent lips or reverse overjet greater than 3.5mm with reported masticatory and speech difficulties; or
 - ✓ Medical conditions as indicated on the Washington Modified Handicapping Labiolingual Deviation (HLD) Index Score that result in a score of 25 or higher. On a case-by-case basis, MAA reviews all requests for treatment for conditions that result in a score of less than 25, based on medical necessity.
- MAA may cover requests for orthodontic treatment for dental malocclusions other than those listed above when MAA determines that the treatment is medically necessary.



Note: MAA 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 an MAA-recognized craniofacial team that has a Special Agreement with MAA.

What orthodontic treatment does MAA *not* cover?

[Refer to WAC 388-535A-0040 (3)]

MAA does not cover:

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

Covered orthodontic treatment and orthodontic-related services

[Refer to WAC 388-535A-0040(4)]

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

- ✓ Panoramic radiographs (x-rays), once per client in a three-year period.
- ✓ Interceptive orthodontic treatment once per the client's lifetime,
- ✓ Limited transitional orthodontic treatment, up to one year from date of original appliance placement.
- ✓ Comprehensive full orthodontic treatment, up to two years from the date of original appliance placement.
- ✓ Orthodontic appliance removal only when:
 - The client's appliance was placed by a different provider; and
 - The provider has not furnished any other orthodontic treatment to the client.
- ✓ Other medically necessary orthodontic treatment and orthodontic-related services as determined by MAA.

Reimbursement for orthodontic treatment

[Refer to WAC 388-535A-0060 (5)]

Payment for orthodontic services is based on MAA's schedule of maximum allowances. Fees listed in the fee schedule are the maximum allowable fees.

Does MAA reimburse 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 (as listed on page A.1) ends before the conclusion of the orthodontic treatment, payment for any remaining treatment is the individual's responsibility. MAA does not reimburse 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. MAA does not reimburse for these services.

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

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Authorization

What orthodontic services require prior authorization?

[Refer to WAC 388-535A-0050]

When MAA 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.

Orthodontic providers **must** obtain prior authorization for those procedure codes listed in the Orthodontic Fee Schedule that have a “Yes” in the Prior Authorization column.

For orthodontic treatment of a client with cleft lip, cleft palate, or other craniofacial anomaly, prior authorization:

- Is **not** required if the client is **being treated** by a department-recognized craniofacial team, or an orthodontic specialist who has been approved by an MAA dental consultant to treat cleft lip, cleft palate, or other craniofacial anomalies; and
- Is required if the client is **not** being treated by a department-recognized craniofacial team, or an orthodontic specialist who has been approved by an MAA dental consultant to treat cleft lip, cleft palate, or other craniofacial anomalies.

Subject to the conditions and limitations in this section and in applicable WAC, MAA requires prior authorization for orthodontic treatment for other dental malocclusions that are not listed on page C.1.

When do I need to get prior authorization?

Prior authorization must be received from MAA **before** the service is provided.

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

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

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

How do I obtain written prior authorization?



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

The request must be submitted in writing on a completed Orthodontic Information [DSHS 13-666] form 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); and
- The provider's assigned 7-digit MAA provider number.

Also...

- 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;
- Study model (if requested); and
- Diagnostic color photographs (if requested).

(Refer to Section E - Orthodontic Information sheet.)

If MAA 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 MAA staff on request.



Note: Upon audit, if specified criteria are not met, MAA 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 MAA's Core Provider Agreement.

Where should I send requests for prior authorization?

Mail your request to:

Program Management and Authorization Section
PO Box 45506
Olympia, WA 98504-5506

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

Expedited Prior Authorization (EPA)

When do I need to bill with an EPA number?

Those orthodontic services listed in the Orthodontic Fee Schedule 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 MAA, dental providers are verifying that the bill is for a cleft palate or craniofacial anomaly case.



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

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. MAA evaluates and approves requests for LE for orthodontic services when medically necessary, under the provisions of WAC 388-501-0165.

MAA evaluates a request for any orthodontic service not listed as covered in this section under the provisions of WAC 388-501-0165.

MAA 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)]

Orthodontic Information Sheet

When do I need to fill out the Orthodontic Information sheet [DSHS 13-666]?

When orthodontic services are requested for an MAA client, you must complete the Orthodontic Information sheet [DSHS 13-666]. To download copies of DSHS 13-666, 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 MAA's orthodontic consultant in determining medical necessity.
2. **Submit** the following full set of 8 dental photographs to MAA:
 - 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

Mailing Address:

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

**Program Management and Authorization Section
PO Box 45506
Olympia, WA 98504-5506**

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

Orthodontic Information Review

MAA'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.

Submitting Additional Information

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

- Claim for the full case study attached to the Orthodontic Information sheet; and
- Appropriate radiographs (e.g., panoramic and cephalometric radiographs);
- Diagnostic color photographs (eight). (See page E.1/E.2).
- A separate letter with any additional medical information if it will contribute information that may affect MAA's final decision.
- Study models. (Do not send study models unless they are requested.)
- Other information if requested.

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Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- **Initial Claims**

- ✓ MAA requires providers to submit an **initial claim** to MAA and obtain an ICN within 365 days from any of the following:
 - The date the provider furnishes the service to the eligible client;
 - The date a final fair hearing decision is entered that impacts the particular claim;
 - The date a court orders MAA to cover the services; or
 - The date DSHS certifies a client eligible under delayed¹ certification criteria.



Note: If MAA has recouped a plan's premium, causing the provider to bill MAA, the time limit is 365 days from the date the plan recouped the payment from the provider.

¹ **Delayed Certification** - According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Retroactive Certification: An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider MAY refund payment made by the client and then bill MAA for the service. If the client has not paid for the service and the service is within the client's scope of benefits, providers must bill MAA.

- ✓ MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:
 - DSHS certification of a client for a retroactive period; or
 - The provider proves to MAA's satisfaction that there are other extenuating circumstances.
- ✓ MAA requires providers to bill known third parties for services. See page F.6 and/or WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

- **Resubmitted Claims**

- ✓ Providers may resubmit, modify, or adjust any timely initial claim, **except** prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.



Note: MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.
- The provider, or any agent of the provider, must not bill a client or a client's estate when:
 - ✓ The provider fails to meet these listed requirements; and
 - ✓ MAA does not pay the claim.

Refer to MAA's *General Information Booklet*, Section K, for instructions on how to correct any billing problems you experience (e.g., Adjustments/Rebillings).

When do I bill? [WAC 388-535A-0060(3) and (4)]

Limited Transitional Orthodontic Treatment

To be reimbursed for providing limited transitional orthodontic treatment, providers must bill MAA in intervals during the treatment and complete the treatment within 12 months of the date of the appliance placement:

1. First Billing:

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 should bill MAA with the date of service that the initial appliance is placed. **Indicate the date of the original appliance placement in field 41 of the ADA claim form.**

2. Subsequent Billing:

Continuing follow-up treatment must be billed after each 3-month treatment interval during the treatment. **Document the actual service dates in the client's record**, but for billing purposes use the last date of each 3 month billing interval as the date of service. Treatment provided after one year from the date the appliance is placed requires a limitation extension. (See *Exceeding Limitations or Restrictions* on page D.4) **Indicate the date of the original appliance placement in field 41 of the ADA claim form.**

Full Orthodontic Treatment

To be reimbursed for providing comprehensive full orthodontic treatment, providers must bill MAA in intervals during the treatment and complete treatment within 24 months of the date of the appliance placement:

1. First Billing:

The first six months of treatment starts the date the initial appliance is placed and includes active treatment within the six months. The provider should bill MAA with the date of service that the initial appliance is placed. **Indicate the date of the original appliance placement in field 41 of the ADA claim form.**

2. Subsequent Billing:

Continuing follow-up treatment must be billed after each 3-month interval, with the first 3-month treatment 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**, but for billing purposes use the last date of each 3-month billing interval as the date of service. Treatment provided after 2 years from the date the appliance is placed requires a limitation extension. (See *Exceeding Limitations or Restrictions* on page D.4.) **Indicate the date of the original appliance placement in field 41 of the ADA claim form.**

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary charge.

When can I bill an MAA client? [Refer to WAC 388-502-0160]

1. A provider may not bill, demand, collect, or accept payment from a client or anyone on the client's behalf for a covered service. The client is not responsible to pay for a covered service even if MAA does not pay for the service because the provider failed to satisfy the conditions of payment in MAA billing instructions, in chapter 388-502 WAC, and other chapters regulating the specific type of service provided.
2. The provider is responsible to verify whether the client has medical coverage for the date of service and to check the limitations of the client's medical program.
3. A provider may bill a client only if one of the following situations apply:
 - a. The client is enrolled in medical assistance managed care and the client and provider comply with the requirements outlined in WAC 388-538-095, "Scope of care for managed care enrollees;"
 - b. The client is not enrolled in medical assistance managed care, and the client and provider sign an agreement regarding payment for service. The agreement must be translated or interpreted into the client's primary language and signed before the service is rendered. The provider must give the client a copy and maintain the original in the client's file for department review upon request.

The agreement must include each of the following elements to be valid:

- i. A statement listing the specific service to be provided;
 - ii. A statement that the service is not covered by MAA;
 - iii. A statement that the client chooses to receive and pay for the specific service; and
 - iv. The client is not obligated to pay for the service if it is later found that the service was covered by MAA at the time it was provided, even if MAA did not pay the provider for the service because the provider did not satisfy MAA's billing requirements.
- c. The client or the client's legal guardian was reimbursed for the service directly by a third party (see WAC 388-501-0200);

- d. The client refuses to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill insurance for the service. This provision does not apply to coverage provided by MAA. [Medical Assistance is not insurance.];
- e. The provider has documentation that the client represented himself/herself as a private pay patient and not receiving Medical Assistance when the client is already eligible for and receiving benefits under an MAA medical program. The documentation must be signed and dated by the client or the client's representative. The provider must give a copy to the client and maintain the original documentation in the patient's file for department review upon request. In this case, the provider may bill the client without fulfilling the requirements in subsection 3.b. regarding the agreement to pay. However, if the patient later becomes eligible for MAA coverage of a provided service, the provider must comply with subsection 4 of this section for that service.
- f. The bill counts toward a spenddown liability, emergency medical expense requirement, deductible, or copayment required by MAA;
- g. The client received medical services in a hospital emergency room for a condition that was not an emergency medical condition. In such cases, a \$3.00 copayment may be imposed on the client by the hospital, except when:
 - i. Reasonable alternative access to care was not available;
 - ii. The "indigent person" criteria in WAC 246-453-040(1) applies;
 - iii. The client was 18 years of age or younger;
 - iv. The client was pregnant or within 60 days postpregnancy;
 - v. The client is an American Indian or Alaska Native;
 - vi. The client was enrolled in a MAA managed care plan, including Primary Care Case Management (PCCM);
 - vii. The client was in an institution such as a nursing facility or residing in an alternative living facility such as an adult family home, assisted living facility, or boarding home; or
 - viii. The client receives services under a waived program such as Community Options Program Entry System (COPES) and Division of Developmental Disabilities (DDD) waivers .

4. If a client becomes eligible for a covered service that has already been provided because the client:
 - a. Applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), the provider must:
 - i. Not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and
 - ii. Promptly refund the total payment received from the client or anyone on the client's behalf, and then bill MAA for the service;
 - b. Receives a delayed certification (see footer on page F.1), the provider must:
 - i. Not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and
 - ii. Promptly refund the total payment received from the client or anyone on the client's behalf, and then bill MAA for the service; or
 - c. Receives a retroactive certification (see footer on page F.1), the provider:
 - i. Must not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for any unpaid charges for the service; and
 - ii. May refund any payment received from the client or anyone on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.
5. Hospitals may not bill, demand, collect, or accept payment from a GA-U or ADATSA client, or anyone on the client's behalf, for inpatient or outpatient hospital services during a period of eligibility, except for spenddown and under the circumstances described on page F.5 (see 3.g.).



Note: Many people apply for a medical program **after** receiving covered medical services. The department may take as long as 45 to 90 days to process medical applications.

If eligible, the client receives a DSHS Medical ID card dated the first of the month of application. The Medical ID card is *NOT* noted with either the “retroactive certification” or “delayed certification” identifiers. Providers must treat these clients as the “delayed certification” procedure described above, even if the patient indicated he or she was private pay on the date of medical service.

6. A provider may not bill, demand, collect, or accept payment from a client, anyone on the client's behalf, or MAA for copying or otherwise transferring health care information, as that term is defined in chapter 70.02 RCW, to another health care provider.

This includes, but is not limited to:

- (a) Medical charts;
- (b) Radiological or imaging films; and
- (c) Laboratory or other diagnostic test results.

Third-Party Liability

For dental services for children and pregnant women, you may elect to bill MAA directly and MAA will recoup from the third party. If you know the third party carrier, you may choose to bill them directly. The client may not be billed for copays.

For all medical claims, you must bill the insurance carrier(s) indicated on the client's Medical ID card. An insurance carrier's time limit for claim submissions may be different from MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier code information is available on the DSHS-MAA web site at <http://maa.dshs.wa.gov/LTPR>. The information can be used as an on-line reference, downloaded, or printed. If you do not have access to MAA's web site, call 1-800-562-6136 and request that a hard copy or disk be mailed to you.

What general documentation must be kept in a client's record? [Refer to WAC 388-502- 0020]

In addition to the specific documentation required throughout this billing instruction, enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:
 - ✓ Patient's name and date of birth;
 - ✓ Dates of service(s);
 - ✓ Name and title of person performing the service, if other than the billing practitioner;
 - ✓ Chief complaint or reason for each visit;
 - ✓ Pertinent medical history;
 - ✓ Pertinent findings on examination;
 - ✓ Medications, equipment, and/or supplies prescribed or provided;
 - ✓ Description of treatment (when applicable);
 - ✓ Recommendations for additional treatments, procedures, or consultations;
 - ✓ Radiographs, tests, and results;
 - ✓ Dental photographs/teeth models;
 - ✓ Plan of treatment and/or care, and outcome; and
 - ✓ Specific claims and payments received for services.
- Assure charts are authenticated by the person who gave the order, provided the care, or performed the, examination, treatment or other service to which the entry pertains.
- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon request, **for six years from the date of service** or longer if required specifically by federal or state law or regulation.

MAA does not pay for the copying or otherwise transferring health care information to another health care provider. This includes, but it not limited to, medical charts, radiological or imaging films, and laboratory or other diagnostic test results. [Refer to WAC 388-502-0160(6)].

Medical justification is required for all procedures. Missing documentation in the client's record may result in payment recouped from the provider

CDT Code	Prior Auth Required?	Description	07/1/05 Maximum Allowable
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Fee Schedule

CLEFT PALATE AND CRANIOFACIAL ANOMALY CASES

Clinical Evaluations

D0160	N	<p>Detailed and extensive oral evaluation Orthodontic Only</p> <p>Use this code for orthodontic information (initial workup). Includes orthodontic oral examination, taking and processing clinical photographs, completing required form(s) and obtaining MAA's authorization decision.</p>	\$45.45
D0170	N	<p>Re-evaluation – limited, problem focused (established patient; not post-operative visit)</p> <p>The following limitations apply when billing for D0170:</p> <ul style="list-style-type: none"> • Allowed once per client, per visit; • Not allowed in combination with periodic/limited/comprehensive oral evaluations; • Treating provider must be an orthodontist and either a member of a recognized craniofacial team or approved by MAA's Dental Consultant; and • One of the following medically necessary diagnosis codes must be documented in the client's record: <p>213.1, 744.9, 749.0, 749.00-749.04, 749.10-749.14, 749.2, 749.20-749.25, 754.0, 755.55, 756.0, 802.2, 802.21-802.29, 802.3, 802.31-802.39, 802.4-802.6</p>	42.42

Orthodontic Services

CDT Code	Prior Auth Required?	Description	07/1/05 Maximum Allowable
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D8660	870000950	<p>Pre-orthodontic treatment visit Use this code when billing for Orthodontist Case Study</p> <p>Requires use of Expedited Prior Authorization number when billing for cleft palate and craniofacial anomaly cases.</p> <p>Billable only by the treating orthodontic provider. Includes preparation of comprehensive diagnostic records (additional photos, study casts, cephalometric examination), formation of diagnosis and treatment plan from such records, and formal case conference.</p> <p>Treating provider must be an orthodontist and either be a member of a recognized craniofacial team or approved by MAA's Dental Consultant to provide this service.</p>	\$202.00
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Interceptive Orthodontics

D8050	870000950	<p>Interceptive orthodontic treatment of the primary dentition</p> <p>Requires use of Expedited Prior Authorization number when billing for cleft palate and craniofacial anomaly cases.</p> <p>Payable only once per client. The maximum allowance includes all professional fees, laboratory costs, and required follow-up. No allowance for lost or broken appliance.</p>	525.20
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Orthodontic Services

CDT Code	Prior Auth Required?	Description	07/1/05 Maximum Allowable
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D8060	870000950	<p>Interceptive orthodontic treatment of the transitional dentition</p> <p>Requires use of Expedited Prior Authorization number when billing for cleft palate and craniofacial anomaly cases.</p> <p>Payable only once per client. The maximum allowance includes all professional fees, laboratory costs, and required follow-up. No allowance for lost or broken appliance.</p>	\$525.20
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CDT Code	Prior Auth Required?	Description	07/1/05 Maximum Allowable
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Limited Transitional Orthodontic Treatment

D8010	870000950	<p>Limited orthodontic treatment of the primary dentition.</p> <p>Requires use of Expedited Prior Authorization number when billing for cleft palate and craniofacial anomaly cases.</p> <p>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).</p>	\$676.70
D8010	870000950	<p>Limited orthodontic treatment of the primary dentition.</p> <p>Reimbursement is for each subsequent three month period when the appliance placement date and the date of service are different. Maximum of three units allowed.</p> <p>Requires the Expedited Prior Authorization Number listed when billing for cleft palate and craniofacial anomaly cases.</p> <p>Note: To receive reimbursement for each subsequent three-month period:</p> <ul style="list-style-type: none"> • 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. 	212.10

Orthodontic Services

CDT Code	Prior Auth Required?	Description	07/1/05 Maximum Allowable
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D8020	870000950	<p>Limited orthodontic treatment of the transitional dentition.</p> <p>Requires use of Expedited Prior Authorization number when billing for cleft palate and craniofacial anomaly cases.</p> <p>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).</p>	\$676.70
D8020	870000950	<p>Limited orthodontic treatment of the transitional dentition.</p> <p>Reimbursement is for each subsequent three month period when the appliance placement date and the date of service are different. Maximum of three units allowed.</p> <p>Requires the Expedited Prior Authorization Number listed when billing for cleft palate and craniofacial anomaly cases.</p> <p>Note: To receive reimbursement for each subsequent three-month period:</p> <ul style="list-style-type: none"> • 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. 	212.10

Orthodontic Services

CDT Code	Prior Auth Required?	Description	07/1/05 Maximum Allowable
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D8030	870000950	<p>Limited orthodontic treatment of the adolescent dentition.</p> <p>Requires use of Expedited Prior Authorization number when billing for cleft palate and craniofacial anomaly cases.</p> <p>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).</p>	\$676.70
D8030	870000950	<p>Limited orthodontic treatment of the adolescent dentition.</p> <p>Reimbursement is for each subsequent three month period when the appliance placement date and the date of service are different. Maximum of three units allowed.</p> <p>Requires the Expedited Prior Authorization Number listed when billing for cleft palate and craniofacial anomaly cases.</p> <p>Note: To receive reimbursement for each subsequent three-month period:</p> <ul style="list-style-type: none"> • 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. 	212.10

CDT Code	Prior Auth Required?	Description	07/1/05 Maximum Allowable
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Full Orthodontic Treatment

D8070	870000950	<p>Comprehensive orthodontic treatment of the transitional dentition.</p> <p>This reimbursement is for the initial placement when the date of service and the appliance placement date are the same.</p> <p>Requires Expedited Prior Authorization. Use of the EPA number verifies that the client has a cleft palate or craniofacial anomaly. Includes first 6 months of treatment and appliances.</p> <p>Treating provider must be an orthodontist and be either a member of a recognized craniofacial team or approved by MAA's Dental Consultant to provide this service.</p>	\$1,818.00
D8070	870000950	<p>Comprehensive orthodontic treatment of the transitional dentition.</p> <p>This reimbursement is for each subsequent three-month period when the appliance placement date and the date of service are different. Maximum of 6 units allowed.</p> <p>Requires Expedited Prior Authorization. Use of the EPA number verifies that the client has a cleft palate or craniofacial.</p> <p>Treating provider must be an orthodontist and be either a member of a recognized craniofacial team or approved by MAA's Dental Consult to provide this service.</p> <p>Continued on next page...</p>	454.50

Orthodontic Services

CDT Code	Prior Auth Required?	Description	07/1/05 Maximum Allowable
		<p>Note: To receive reimbursement for each subsequent three-month period:</p> <ul style="list-style-type: none"> • 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. 	
D8080	870000950	<p>Comprehensive orthodontic treatment of adolescent dentition.</p> <p>This reimbursement is for the initial placement when the date of service and the appliance placement date are the same.</p> <p>Requires Expedited Prior Authorization. Use of the EPA number verifies that the client has a cleft palate or craniofacial anomaly. Includes first 6 months of treatment and appliances.</p> <p>Treating provider must be an orthodontist and be either a member of a recognized craniofacial team or approved by MAA’s Dental Consultant to provide this service.</p>	\$1,818.00
D8080	870000950	<p>Comprehensive orthodontic treatment of adolescent dentition.</p> <p>This reimbursement is for each subsequent three-month period when the appliance placement date and the date of service are different. Maximum of 6 units allowed.</p> <p>Continued on next page...</p>	454.50

Orthodontic Services

CDT Code	Prior Auth Required?	Description	07/1/05 Maximum Allowable
		<p>Continued from previous page...</p> <p>Requires Expedited Prior Authorization. Use of the EPA number verifies that the client has a cleft palate or craniofacial anomaly.</p> <p>Treating provider must be an orthodontist and be either a member of a recognized craniofacial team or approved by MAA's Dental Consult to provide this service.</p> <p>Note: To receive reimbursement for each subsequent three-month period:</p> <ul style="list-style-type: none"> • 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. 	

CDT Code	Prior Auth Required?	Description	07/1/05 Maximum Allowable
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Other Orthodontic Services

D8680	Yes	<p>Orthodontic retention (removal of appliances, construction and placement of retainer(s))</p> <p>Use this code for a client whose appliance was placed by an orthodontic provider not participating with MAA, and/or whose treatment was previously covered by another third-party payor. Fee includes debanding and removal of cement.</p>	\$101.00
D8690	Yes	<p>Orthodontic treatment (alternative billing to a contract fee)</p> <p>Use this code for each three-month period of follow-up orthodontic care for a client who meets the criteria in WAC 388-535-1250, but whose banding, appliance placement and/or initial follow-up care was done by a provider not participating with MAA, or whose treatment was authorized and previously covered by another third-party payor. This follow-up care is for a period not to exceed one year, or the length of time remaining under the treatment plan authorized by the previous payor, whichever is shorter.</p> <p>One unit allowed every 3 months, up to a total of 4 units.</p>	121.20

CDT Code	Prior Auth Required?	Description	07/1/05 Maximum Allowable
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Radiographs

D0330	No	<p>Panoramic film – maxilla and mandible</p> <p>Documentation must be entered in the client’s file.</p> <p>Panoramic-type films are allowed once in a 3-year period.</p> <p>A shorter interval between panoramic radiographs may be allowed with written prior authorization from MAA.</p> <p>Doing <i>both</i> a panoramic film and an intraoral complete series is not allowed.</p>	\$43.43
D0340	No	<p>Cephalometric film</p> <p>Allowable for orthodontic purposes only. Cephalometric film allowed once in a three-year period.</p>	43.43

CDT Code	Prior Auth Required?	Description	07/1/05 Maximum Allowable
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SEVERE HANDICAPPING MALOCCLUSIONS

Clinical Evaluations

D0160	No	Detailed and extensive oral evaluation Orthodontic Only Use this code for Orthodontic information (initial workup). Includes orthodontic oral examination, taking and processing clinical photographs, completing required form(s) and obtaining MAA's authorization decision.	\$45.45
D8660	Yes	Pre-orthodontic treatment visit 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.	191.90

Interceptive Orthodontics

D8050	Yes	Interceptive orthodontic treatment of the primary dentition 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.	\$333.30
D8060	Yes	Interceptive orthodontic treatment of the transitional dentition 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.	333.30

CDT Code	Prior Auth Required?	Description	07/1/05 Maximum Allowable
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Limited Transitional Orthodontic Treatment

D8010	Yes	<p>Limited orthodontic treatment of the primary dentition.</p> <p>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).</p>	\$424.20
D8010	Yes	<p>Limited orthodontic treatment of the primary dentition.</p> <p>This reimbursement is for each subsequent three-month period when the appliance placement date and the date of service are the different.</p> <p>Maximum of three units allowed.</p> <p>Note: To receive reimbursement for each subsequent three-month period:</p> <ul style="list-style-type: none"> • 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. 	181.80
D8020	Yes	<p>Limited orthodontic treatment of the transitional dentition.</p> <p>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</p>	424.20

Orthodontic Services

CDT Code	Prior Auth Required?	Description	07/1/05 Maximum Allowable
D8020	Yes	<p>appliance(s).</p> <p>Limited orthodontic treatment of the transitional dentition.</p> <p>This reimbursement is for each subsequent three-month period when the appliance placement date and the date of service are different.</p> <p>Maximum of three units allowed.</p> <p>Note: To receive reimbursement for each subsequent three-month period:</p> <ul style="list-style-type: none"> • 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. 	\$181.80
D8030	Yes	<p>Limited orthodontic treatment of the adolescent dentition.</p> <p>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).</p>	424.20

Orthodontic Services

CDT Code	Prior Auth Required?	Description	07/1/05 Maximum Allowable
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D8030	Yes	<p>Limited orthodontic treatment of the adolescent dentition.</p> <p>This reimbursement is for each subsequent three-month period when the appliance placement date and the date of service are different.</p> <p>Maximum of three units allowed.</p> <p>Note: To receive reimbursement for each subsequent three-month period:</p> <ul style="list-style-type: none"> • 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. 	\$181.80
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CDT Code	Prior Auth Required?	Description	07/1/05 Maximum Allowable
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Full Orthodontic Treatment

D8070	Yes	<p>Comprehensive orthodontic treatment of the transitional dentition.</p> <p>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.</p>	\$1,212.00
D8070	Yes	<p>Comprehensive orthodontic treatment of the transitional dentition.</p> <p>This reimbursement is for each subsequent three-month period when the appliance placement date and the date of service are different. Maximum of 6 units allowed.</p> <p>Note: To receive reimbursement for each subsequent three-month period:</p> <ul style="list-style-type: none"> • 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. 	227.25
D8080	Yes	<p>Comprehensive orthodontic treatment of adolescent dentition.</p> <p>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.</p>	1,212.00

Orthodontic Services

CDT Code	Prior Auth Required?	Description	07/1/05 Maximum Allowable
D8080	Yes	<p>Comprehensive orthodontic treatment of adolescent dentition.</p> <p>This reimbursement is for each subsequent three-month period when the appliance placement date and the date of service are different. Maximum of 6 units allowed.</p> <p>Note: To receive reimbursement for each subsequent three-month period:</p> <ul style="list-style-type: none"> • 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. 	\$227.25

CDT Code	Prior Auth Required?	Description	07/1/05 Maximum Allowable
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Other Orthodontic Services

D8680	Yes	<p>Orthodontic retention (removal of appliances, construction and placement of retainer(s))</p> <p>Use this code for a client whose appliance was placed by an orthodontic provider not participating with MAA, and/or whose treatment was previously covered by another third-party payor. Fee includes debanding and removal of cement.</p>	\$101.00
D8690	Yes	<p>Orthodontic treatment (alternative billing to a contract fee)</p> <p>Use this code for each three-month period of follow-up orthodontic care for a client who meets the criteria on page A.1, but whose banding, appliance placement and/or initial follow-up care was done by a provider not participating with MAA, or whose treatment was authorized and previously covered by another third-party payor. This follow-up care is for a period not to exceed one year, or the length of time remaining under the treatment plan authorized by the previous payor, whichever is shorter.</p> <p>One unit allowed every 3 months, up to a total of 4 units.</p>	121.20

CDT Code	Prior Auth Required?	Description	07/1/05 Maximum Allowable
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Radiographs

D0330	No	<p>Panoramic film – maxilla and mandible</p> <p>Documentation must be entered in the client’s file.</p> <p>Panoramic-type films are allowed once in a 3-year period.</p> <p>A shorter interval between panoramic radiographs may be allowed with written prior authorization from MAA.</p> <p>Doing <i>both</i> a panoramic film and an intraoral complete series is not allowed.</p>	\$43.43
D0340	No	<p>Cephalometric film</p> <p>Allowable for orthodontic purposes only. Cephalometric film allowed once in a three-year period.</p>	43.43

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How to Complete the ADA Claim Form

These instructions are based on the ADA Dental Claim Form, 2002.

MAA encourages the use of the 2002 version of the ADA form to expedited claims processing. However, if using older versions of the ADA claim form, enter the required quadrant and arch designations in the “Tooth Surface” field (field 28).

See sample claim form, page H.6.

General Information

- Include any required prior authorization number. Prior authorized claim originals must be completed and returned as the billing document.
- 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 pens, 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.
- These instructions only address those fields that are required for billing MAA.

Send your claims for payment to:

Division of Program Support
PO Box 9253
Olympia WA 98507-9253

HEADER INFORMATION

2. **Predetermination/Preauthorization Number** – Place the required prior authorization number or EPA number in this field. Indicate the line(s) the number applies to.

PRIMARY PAYER INFORMATION

3. **Name, Address, City, State, Zip Code:** Enter the address for DSHS that is listed in the shaded box above.

OTHER COVERAGE

4. **Other Dental or Medical Coverage** – Check the appropriate response.
5. **Subscriber Name (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. **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 Subscriber** - Check the applicable box.
11. **Other Carrier Name, Address, City, State, Zip Code** – Enter any other applicable third party insurance.

PRIMARY SUBSCRIBER INFORMATION

12. **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. **Subscriber Identifier (SSN or ID#)** – Enter the SSN or other identifier assigned by the payer.
16. **Plan/Group Number** – Enter the subscriber’s group’s Plan or Policy Number.

17. **Employer Name** – Enter the name of the subscriber’s employer.

PATIENT INFORMATION

18. **Relationship to Primary Subscriber** – Check the appropriate box.
20. **Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code** – Enter the client’s legal name, address, and **Patient Identification Code (PIC)**. MAA identifies clients by this code, not by their name. This alphanumeric code is assigned to each MAA client and consists of:
 - First and middle initials (*or* a dash (-) must be entered if the middle initial is not indicated).
 - Six-digit birthdate, consisting of numerals only (MMDDYY).
 - First five letters of the last name (or fewer if the name is less than five letters).
 - Alpha or numeric character (tiebreaker).
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., February 1, 2005 = 020105).

25. Area of Oral Cavity – If the procedure code requires an arch or a quadrant designation, enter one of the following:

- 01 Maxillary area
- 02 Mandibular area
- 10 Upper right quadrant
- 20 Upper left quadrant
- 30 Lower left quadrant
- 40 Lower right quadrant

If you are using a claim form that does not include this column, enter one of the above codes in the tooth surface column (field 28).

27. Tooth Number(s) or Letter(s) –

Enter the appropriate tooth number, letter(s):

- 01 through 32 for permanent teeth
- A through T for primary teeth

28. Tooth Surface – Enter the appropriate code from the list below to indicate the tooth surface worked on. Up to **five codes** may be listed in this column:

- B = Buccal
- D = Distal
- F = Facial
- I = Incisal
- L = Lingual
- M = Mesial
- O = Occlusal

29. Procedure Code: Enter the procedure code from this fee schedule that represents the procedure or service performed. The use of any other procedure code(s) will result in denial of payment.

30. Description of Services - Give a brief written description of the services rendered. When billing for general anesthesia, enter the actual beginning and ending time. If billing for anesthesia, enter **only** the total # of minutes on the claim. To indicate a payment by another plan, write “insurance payment” in the description area and the amount in field 31. Attach the insurance EOB to the claim.

31. Fee - Enter your **usual and customary fee** (not MAA's maximum allowable rate) for each service rendered.

33. Total Fee – Total of all charges.

MISSING TEETH INFORMATION

34. Place an “X” on each missing tooth.

REMARKS

35. Remarks - This field may be used for justification for the services rendered, the name of any referring provider or facility, or the name of any provider who administered anesthesia.

Example of Remark: *“Jane Doe, CRNA administered anesthesia.”*

ANCILLARY CLAIM/ TREATMENT INFORMATION

38. Place of Treatment – Check the applicable box and enter one of the following codes to show the place of service at which the service was performed:

- Office** 11 dental office
- Hosp** 21 inpatient hospital
22 outpatient hospital
23 hospital emergency room
- ECF** 32 nursing facility
31 skilled nursing facility
54 intermediate care facility/mentally retarded
- Other** 12 client’s residence
24 professional services in an ambulatory surgery center
03 school-based services
50 federally qualified health center
71 state or public health clinic (department)

39. Number of Enclosures (00-99) – Check the appropriate box. If you check *yes*, indicate how many Radiographs are enclosed.

Note:

- Do not send Radiographs when billing for services.
- Radiographs are necessary **only when prior authorization is being requested.**
- Please write "Radiographs enclosed" on the mailing envelope and mail to the Program Management and Authorization Section (see “Authorization” in either Section D or Section E for address.)

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 MAA.
- 49. Provider ID** – Enter the provider number assigned by MAA when you signed your Core Provider Agreement. It is the same seven-digit number that appears on the MAA Remittance and Status Report in the *Provider Number* area at the top of the page. 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.

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

- 54. Provider ID** – Enter the performing provider number if it is different from the one listed in field 49. If you are a dentist in a group practice, please indicate your unique identification number 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.

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
 Statement of Actual Services – OR – Request for Predetermination/Preauthorization
 EPSDT/ Title XIX

2. Predetermination/Preauthorization Number
4810000

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? No (Skip 5-11) Yes (Complete 5-11)

PATIENT INFORMATION

5. Subscriber Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) 7. Gender M F 8. Subscriber Identifier (SSN or ID#)

9. Plan/Group Number 10. Relationship to Primary Subscriber (Check applicable box)
 Self Spouse Dependent Other

11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) 14. Gender M F 15. Subscriber Identifier (SSN or ID#)

16. Plan/Group Number 17. Employer Name

PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box)
 Self Spouse Dependent Child Other

19. Student Status FTS PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
**JS101189SMITHA
 SMITH, JOHN A**

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. <input type="checkbox"/> Tooth <input type="checkbox"/> System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	030105					D8660	Orthodontic Case Study	20000
2	040105					D8080	Initial Placement Severe Malocclusion	1,40000
3								
4								
5								
6								
7								
8								
9								
10								

****Note - these fees are samples - please use your usual and customary fees****

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)	Permanent																Primary										32. Other Fee(s)	33. Total Fee
	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		
																	T	S	R	Q	P	O	N	M	L	K		1,60000

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 (Check applicable box)
 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)
040105

42. Months of Treatment Remaining 43. Replacement of Prosthesis?
 No Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box)
 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

**Provider's Name
 Provider's Address**

49. Provider ID **5310000** 50. License Number 51. SSN or TIN

52. Phone Number () -

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 and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X _____
 Signed (Treating Dentist) Date

54. Provider ID **99999** 55. License Number

56. Address, City, State, Zip Code

57. Phone Number (**999**) **999** - **9999** 58. Treating Provider Specialty