



## **Health and Recovery Services Administration**



# **Dental Program for Clients Through Age 20 Billing Instructions**

**Chapter 388-535 WAC**

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## About this publication

This publication supersedes all previous HRSA Dental Billing Instructions and Numbered Memoranda and is 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.

## Fee Schedules

- You may access HRSA's Dental Fee Schedule at:  
<http://maa.dshs.wa.gov/RBRVS/Index.html>.
- To access HRSA's Oral Surgery Fee Schedule:
  - ✓ **Procedure codes** may be found in the Dental Fee Schedule at the above address.
  - ✓ **Maximum allowable fees** may be found in the Physician-Related Services Fee Schedule at the above address.

## HRSA's Billing Instructions and Numbered Memoranda

To obtain HRSA's provider numbered memoranda and billing instructions, go to HRSA's website at <http://maa.dshs.wa.gov/download/index.htm>.

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# Important Contacts

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A provider may contact HRSA with questions regarding its programs. However, HRSA's response is based solely on the information provided to HRSA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern HRSA's programs. [WAC 388-502-0020(2)]

## 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*

### Payments, denials, claims processing, or HRSA 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:  
800.562.3022, Option 2 (toll free)  
360.725.2144 (fax)

or write to:  
HRSA Customer Service Center  
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:  
800.562.3022 (toll free)

or write to:  
HRSA 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 HRSA managed care?**

Office of Coordination of Benefits  
PO Box 45565  
Olympia, WA 98504-5565  
800.562.6136 (toll free)

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

Call the HRSA/HIPAA E-Help Desk at: 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:**

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 800.833.2051.

**How can I access the HRSA Dental web site?**

Visit:

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

**Where can I view and download HRSA current and past fee schedules?**

Visit:

<http://maa.dshs.wa.gov/rbrvs/index.html>

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

Call ACS at:  
800.833.2051 (toll free)

or call HRSA at:  
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 send requests for prior authorization?**

Providers may choose to use the FastLook and FastAttach services provided by National Electronic Attachment, Inc. (NEA).

You may register with NEA by visiting [www.nea-fast.com](http://www.nea-fast.com) and entering "FastWDSHS" in the blue promotion code box. Contact NEA at 800.782.5150 ext. 2 with any questions. (See *Authorization* section for more details.)

Providers who do not register with NEA must send requests to:

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

For procedures that do not require Radiographs - Fax: 360.725.2123

**Where do I send paper claims?**

Claims Processing  
PO Box 9248  
Olympia, WA 98507-9248

**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*

**How do I obtain DSHS forms?**

To **view and download** DSHS forms, visit DSHS Forms and Records Management Service on the web:  
<http://www1.dshs.wa.gov/msa/forms/eforms.html>

To **have a paper copy sent** to you, contact DSHS Forms and Records Management Service:  
Phone: 360.664.6047  
Fax: 360.664.6186

Include in your request:

- Form number and name;
- Quantity you want;
- Your name;
- Your office/organization name; and
- Your complete mailing address.

# Definitions & Acronyms

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This section contains definitions of words and phrases that the Department of Social and Health Services (DSHS) uses in these billing instructions. HRSA also used dental definitions found in the current American Dental Association's Current Dental Terminology and the current American Medical Association's Physician's Current Procedural Terminology. **Where there is any discrepancy between the current CDT or CPT and this section, this section prevails.**

**Adjunctive** – A secondary treatment in addition to the primary therapy.

**Alternative Living Facility (ALF)** – Refer to WAC 388-513-1301.

**Ambulatory Surgery Center (ASC)** - Any distinct entity certified by Medicare as an ASC that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization.

**American Dental Association (ADA)** – The ADA is a national organization for dental professionals/dental societies.

**Anterior** – The maxillary and mandibular incisors and canines and tissue in the front of the mouth.

- Permanent maxillary anterior teeth include teeth 6, 7, 8, 9, 10, and 11.
- Permanent mandibular anterior teeth include teeth 22, 23, 24, 25, 26, and 27.
- Primary maxillary anterior teeth include teeth C, D, E, F, G, and H.
- Primary mandibular anterior teeth include teeth M, N, O, P, Q, and R.

**Asymptomatic** – Having or producing no symptoms.

**Authorization** - An official approval for action taken for or on behalf of an eligible Medical Assistance client. This approval is valid only if the client is eligible on the date of service.

**Authorization Number** - A nine-digit number, assigned by the Health and Recovery Services Administration (HRSA) that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pending, or denied.

**Base Metal** – Dental alloy containing little or no precious metals.

**Behavior Management** – Using the assistance of one additional dental professional staff to manage the behavior of a client to facilitate the delivery of dental treatment.

**Border Areas** - Refer to WAC 388-501-175.

**By Report (BR)** – A method of reimbursement in which HRSA determines the amount it will pay for a service when the rate for that service is not included in HRSA's published fee schedules. Upon request, the provider must submit a "report" which describes the nature, extent, time, effort, and/or equipment necessary to deliver the service.

**Caries** – Carious lesions or tooth decay through the enamel or decay of the root surface.

**Client** – An individual who has been determined eligible to receive medical or health care services under any HRSA program.

**Comprehensive Oral Evaluation** – A thorough evaluation and documentation of a client’s dental and medical history to include: extra-oral and intra-oral hard and soft tissues, dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, and oral cancer screening.

**Conscious Sedation** - A drug-induced depression of consciousness during which clients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, spontaneous ventilation is adequate, and cardiovascular function is maintained.

**Core Build-up** – Refers to building up of clinical crowns, including pins.

**Core Provider Agreement** - A basic contract that HRSA holds with medical providers serving HRSA clients. The provider agreement outlines and defines terms of participation in the Medicaid program.

**Coronal** – The portion of a tooth that is covered by enamel.

**Coronal Polishing** – A mechanical procedure limited to the removal of plaque and stain from exposed tooth surfaces.

**Crown** – A restoration covering or replacing part, or the whole, clinical crown of a tooth.

**Current Dental Terminology (CDT™)** - A systematic listing of descriptive terms and identifying codes for reporting dental services and procedures performed by dental practitioners. CDT is published by the Council on Dental Benefit Programs of the American Dental Association (ADA).

**Current Procedural Terminology (CPT™)** – A systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians and other practitioners who provide physician-related services. CPT is copyrighted and published annually by the American Medical Association (AMA).

**Decay** – A term for carious lesions in a tooth; and means decomposition of the tooth structure.

**Deep Sedation** – A drug-induced depression of consciousness during which a client cannot be easily aroused, ventilatory function may be impaired, but the client responds to repeated or painful stimulation.

**Denturist** – A person licensed under Chapter 18.30 RCW to make, construct, alter, reproduce, or repair a denture.

**Division of Developmental Disabilities (DDD)** - The division within DSHS responsible for administering and overseeing services and programs for clients with developmental disabilities.

**Endodontic** – The etiology, diagnosis, prevention, and treatment of diseases and injuries of the pulp and associated periradicular conditions.

**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.

**Extraction** – See “simple extraction” and “surgical extraction.”

**Federally Qualified Health Center (FQHC)** - A facility that is: 1) receiving grants under section 330 of the Public Health Services Act; OR 2) receiving such grants based on the recommendation of the Health Resources and Services Administration within the Public Health Service, as determined by the Secretary to meet the requirements for receiving such a grant, OR 3) a tribe or tribal organization operating outpatient health programs or facilities under the Indian Self Determination Act (PL93-638). Only Health Care Financing Administration designated FQHCs will be allowed to participate in the program.

**Flowable Composite** – A diluted resin-based composite dental restorative material that is used in cervical restorations and small, low stress bearing occlusal restorations.

**Fluoride Varnish, Rinse, Foam, or Gel** – A substance containing dental fluoride, which is applied to teeth.

**General Anesthesia** – A drug-induced loss of consciousness during which a client is not arousable even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Clients may require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

**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 (S-CHIP), Title XVI, and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

**High Noble Metal** – A dental alloy containing at least 60% pure gold.

**Limited Oral Evaluation** – An evaluation limited to a specific oral health condition or problem. Typically a client receiving this type of evaluation has a dental emergency, such as trauma or acute infection.

**Limited Visual Oral Assessment** – An assessment by a dentist or dental hygienist to determine the need for fluoride treatment and triage services when provided in settings other than dental offices or dental clinics.

**Major Bone Grafts** – A transplant of solid bone tissue(s).

**Managed Care** - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services.  
[WAC 388-538-050]

**Maximum Allowable** - The maximum dollar amount HRSA will pay a provider for specific services, supplies, or equipment.

**Medicaid** - The state and federally funded Title XIX program under which medical care is provided to persons eligible for the:

- Categorically needy program; or
- Medically needy program.

**Medical Identification (ID) Card** – The form the Department of Social and Health Services uses to identify clients of medical programs. Medical ID cards are good only for the dates printed on them. Clients will receive a Medical ID card in the mail each month they are eligible.

**Medically Necessary** - See WAC 388-500-0005.

**Medicare** - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare includes the following:

- “Part A” covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.

- “Part B” is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.
- “Part D” is the Medicare prescription drug insurance benefit, covering prescription drugs for a medically accepted indication; biological products; insulin; vaccines and some medical supplies associated with the injection of insulin.

**Minor Bone Grafts** – A transplant of nonsolid bone tissue(s), such as powdered bone, buttons, or plugs.

**Noble Metal** – A dental alloy containing at least 25% but less than 60% pure gold.

**Oral Hygiene Instruction** – Instruction for home oral hygiene care, such as tooth brushing techniques or flossing.

**Oral prophylaxis** – The dental procedure of scaling and polishing that includes removal of calculus, plaque, and stains from teeth.

**Partials or Partial Dentures** – A removable prosthetic appliance that replaces missing teeth in one arch.

**Patient Identification Code (PIC)** - An alphanumeric code that is assigned to each Medical Assistance client consisting of:

- a) First and middle initials (or a dash (-) must be entered if the middle initial is not indicated);
- b) Six-digit birthdate, consisting of *numerals only* (MMDDYY);
- c) First five letters of the last name (and spaces if the name is fewer than five letters); and
- d) Alpha or numeric character (tiebreaker).

**Periodic Oral Evaluation** – An evaluation performed on a patient of record to determine any changes in the client’s dental or medical status since a previous comprehensive or periodic evaluation.

**Periodontal Maintenance** – A procedure performed for clients who have previously been treated for periodontal disease with surgical or nonsurgical treatment. It includes the removal of supragingival and subgingival micro-organisms and deposits with hand and mechanical instrumentation, an evaluation of periodontal conditions, and a complete periodontal charting as appropriate.

**Periodontal Scaling and Root Planing** – A procedure to remove plaque, calculus, micro-organisms, and rough cementum and dentin from tooth surfaces. This includes hand and mechanical instrumentation, an evaluation of periodontal conditions, and a complete periodontal charting as appropriate.

**Permanent** – The permanent or adult teeth in the dental arch.

**Posterior** – The maxillary and mandibular premolars and molars and tissue towards the back of the mouth.

- Permanent maxillary posterior teeth include teeth 1, 2, 3, 4, 5, 12, 13, 14, 15, and 16.
- Permanent mandibular posterior teeth include teeth 17, 18, 19, 20, 21, 28, 29, 30, 31, and 32.
- Primary maxillary posterior teeth include teeth A, B, I, and J.
- Primary mandibular posterior teeth include teeth K, L, S, and T.

**Primary** – The first set of teeth.

**Provider or Provider of Service** - An institution, agency, clinic, or person:

- Who has a signed agreement with the department to furnish medical [dental] care, goods and/or services to clients; and
- Is eligible to receive payment from the department.

**Proximal** – The surface of the tooth near or next to the adjacent tooth.

**Radiographs** – an image or picture produced on a radiation sensitive film emulsion or digital sensor by exposure to ionizing radiation. Also known as X-ray.

**Reline** – To resurface the tissue side of a denture with new base material or soft tissue conditioner in order to achieve a more accurate fit.

**Revised Code of Washington (RCW)** - Washington State laws.

**Root Canal** - The chamber within the root of the tooth that contains the pulp.

**Root Canal Therapy** - The treatment of the pulp and associated periradicular conditions.

**Root Planing** – A procedure to remove plaque, calculus, micro-organisms, rough cementum, and dentin from tooth surfaces. This includes use of hand and mechanical instrumentation.

**Rural Health Clinic (RHC)** – See *Rural Health Clinic Billing Instructions*.

**Scaling** – A procedure to remove plaque, calculus, and stain deposits from tooth surfaces.

**Sealant** – A dental material applied to teeth to prevent dental caries.

**Simple Extraction** – The routine removal of tooth.

**Spenddown** – The amount of excess income DSHS has determined that a client has available to meet his or her medical expenses. The client becomes eligible for Medicaid coverage only after he or she meets the spenddown requirements.

**Standard of Care** – What reasonable and prudent practitioners would do in the same or similar circumstances.

**Surgical Extraction** – See definitions of dental procedures in the current CDT manual.

**Symptomatic** – Having symptoms (e.g., pain, swelling, and infection).

**Temporomandibular joint dysfunction (TMJ/TMD)** – An abnormal functioning of the temporomandibular joint or other areas secondary to the dysfunction.

**Therapeutic Pulpotomy** – The surgical removal of a portion of the pulp (inner soft tissue of a tooth), to retain the healthy remaining pulp.

**Third Party** - Any entity that is or may be liable to pay all or part of the medical cost of care of a medical program client.  
[WAC 388-500-0005]

**Usual and Customary** – The fee that the provider usually charges non-Medicaid customers for the same service or item. This is the maximum amount that the provider may bill HRSA.

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

**Wisdom Teeth** – The third molars, teeth 1, 16, 17, and 32.

**Xerostomia** – A dryness of the mouth due to decreased saliva.

# About the Program

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## What is the purpose of the Dental Program for Clients Through Age 20?

The purpose of the Dental Program is to provide quality dental and dental-related services to eligible clients.

## Becoming a DSHS Dental Provider [Refer to WAC 388-535-1070]

The following providers are eligible to enroll with the Health and Recovery Services Administration (HRSA) to furnish and bill for dental-related services provided to eligible clients:

- Persons currently licensed by the state of Washington to:
  - ✓ Practice dentistry or specialties of dentistry;
  - ✓ Practice medicine and osteopathy for:
    - Oral surgery procedures; or
    - Providing fluoride varnish under EPSDT.
  - ✓ Practice as a dental hygienist;
  - ✓ Practice as a denturist; or
  - ✓ Practice anesthesia according to Department of Health (DOH) regulations.
- Facilities that are:
  - ✓ Hospitals currently licensed by the Department of Health;
  - ✓ Federally-qualified health centers (FQHCs);
  - ✓ Medicare-certified ambulatory surgery centers (ASCs);
  - ✓ Medicare-certified rural health clinics (RHCs); or
  - ✓ Community health centers (CHC).
- Participating local health jurisdictions; and
- Border area or out-of-state providers of dental-related services who are qualified in their states to provide these services.

**Note:** HRSA pays licensed providers participating in the HRSA dental program for only those services that are within their scope of practice.  
[WAC 388-535-1070(2)]

# Client Eligibility

## Who is eligible? [Refer to WAC 388-535-1060]

Clients presenting DSHS Medical Identification Cards with the following medical program identifiers are eligible for covered dental services subject to the restrictions and specific limitations listed in the dental fee schedule:

Medical Program Identifier	Medical Program
CNP	Categorically Needy Program
CNP – CHIP	Categorically Needy Program - Children’s Health Insurance Program
CNP Emergency Medical Only	Categorically Needy Program – Alien Emergency Medical <b>Note:</b> Refer to <a href="#">WAC 388-438-0110</a> .
LCP-MNP	Limited Casualty Program/ Medically Needy Program
MNP-QMB	Medically Needy Program – QMB
GA-U No out of state care	General Assistance Unemployable ( <i>Limited coverage – see page C.2.</i> )
General Assistance No out of state care	Alcohol and Drug Abuse Treatment and Support Act (ADATSA) ( <i>Limited coverage – see page C.2.</i> )

## Are clients enrolled in an HRSA managed care plan eligible for services under HRSA’s Dental Program for Clients Through Age 20? [Refer to WAC 388-535-1060(4)]

**Yes!** Clients who are enrolled in an HRSA managed care plan are eligible for HRSA-covered dental services that are not covered by their plan.

Clients who are enrolled in an HRSA managed care plan should have a Health Maintenance Organization (HMO) identifier in the HMO column on their Medical ID Card.

# Coverage

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## When does HRSA pay for covered dental-related services for clients through age 20? [Refer to WAC 388-535-1079(1), (3), and (4)]

- Subject to coverage limitations, HRSA pays for dental-related services and procedures provided to clients through age 20 when the services and procedures:
  - ✓ Are within the scope of an eligible client's medical care program;
  - ✓ Are medically necessary;
  - ✓ Meet HRSA's prior authorization requirements, if any;
  - ✓ Are documented in the client's record (see the "What must I keep in a client's record" in the *Billing* section);
  - ✓ Are within accepted dental or medical practice standards;
  - ✓ Are consistent with a diagnosis of dental disease or condition;
  - ✓ Are reasonable in amount and duration of care, treatment, or service; and
  - ✓ Are listed as covered in these billing instructions (see Coverage section).
- Clients who are eligible for services through the Division of Developmental Disabilities (DDD) may receive dental-related services according to Section D.
- HRSA evaluates a request for dental-related services that are:
  - ✓ In excess of the dental program's limitations or restrictions, according to WAC 388-501-0169; and
  - ✓ Listed as noncovered, according to WAC 388-501-0160.

## Coverage Under the EPSDT Program [Refer to WAC 388-535-1079 (2)]

Under the Early Periodic Screening and Diagnostic Treatment (EPSDT) program, clients ages twenty and younger may be eligible for the dental-related services listed as noncovered in these billing instructions, if the services include those medically necessary services and other measures provided to correct or ameliorate conditions discovered during a screening performed under the EPSDT program. See HRSA's current *EPSDT Billing Instructions* for information about EPSDT.

## Coverage Under the GA-U and ADATSA Programs

[Refer to WAC 388-535-1065]

- Clients who receive medical care services under the following programs may receive the dental-related services described in the Coverage section of these billing instructions:
  - ✓ General Assistance Unemployable (GA-U); and
  - ✓ Alcohol and Drug Abuse Treatment and Support Act (ADATSA).
- HRSA covers the following dental-related services under the GA-U or ADATSA program:
  - ✓ Services provided only as part of dental treatment for:
    - Limited oral evaluation;
    - Periapical or bite-wing radiographs (x-rays) that are medically necessary to diagnose only the client's chief complaint;
    - Pulpal debridement to relieve dental pain;
    - Palliative treatment to relieve dental pain; or
    - Endodontic (root canal only) treatment for maxillary and mandibular anterior teeth (cuspids and incisors) when prior authorized).
  - ✓ Tooth extraction when at least one of the following apply:
    - The tooth has a radiographic apical lesion;
    - The tooth is endodontically involved, infected, or abscessed;
    - The tooth is not restorable; or
    - The tooth is not periodontally stable.
- Tooth extractions require prior authorization (PA) when:
  - ✓ The extraction of a tooth or teeth results in the client becoming edentulous in the maxillary arch or mandibular arch; and
  - ✓ A full mouth extraction is necessary because of radiation therapy for cancer of the head and neck.
- Each dental-related procedure described under this section is subject to the coverage limitations listed in Chapter 388-535 WAC for clients age 21 and older.
- HRSA does not cover any dental-related services not listed in the *Coverage* section of these billing instructions for clients eligible to receive services under the GA-U or ADATSA program, including any type of removable dental prosthesis.

**GA-U Covered Procedure Codes**

<b>Code</b>	<b>Description</b>	<b>PA?</b>	<b>Requirements/ Limitations</b>	<b>Maximum Allowable Fee</b>
D0140	limited oral evaluation – problem focused	N		<a href="#">On-line Fee Schedules</a>
D0220	intraoral – periapical first film	N		
D0230	intraoral – periapical each additional film	N		
D0270	bitewing – single film	N		
D0272	bitewings – two films	N		
D0273	bitewings – three films	N		
D0274	bitewings – four films	N		
D3221	pulpal debridement, primary and permanent teeth	N	Tooth designation required	
D3310	anterior (excluding final restoration)	N	Tooth designation required	
D7111	extraction, coronal remnants – deciduous tooth	N	Tooth designation required	
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	N	Tooth designation required	
D7210	surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	N	Tooth designation required	
D7220	removal of impacted tooth – soft tissue	N	Tooth designation required	
D7230	removal of impacted tooth – partially bony	N	Tooth designation required	
D7240	removal of impacted tooth – completely bony	N	Tooth designation required	
D7250	surgical removal of residual tooth roots (cutting procedure)	N	Tooth designation required	
D9110	palliative (emergency) treatment of dental pain – minor procedure	N		

## What diagnostic services are covered? [Refer to WAC 388-535-1080]

HRSA covers medically necessary dental-related diagnostic services, subject to the coverage limitations listed, for clients through age 20 as follows:

### Clinical Oral Evaluations

#### What is covered?

HRSA covers:

- Oral health evaluations and assessments. The services must be documented in the client's record in accordance with Chapter 388-502 WAC.
- Periodic oral evaluations, once every six months. Six months must elapse between the comprehensive oral evaluation and the first periodic oral evaluation.
- Limited oral evaluations, only when the provider performing the limited oral evaluation is not providing routine scheduled dental services for the client. The limited oral evaluation:
  - ✓ Must be to evaluate the client for a:
    - Specific dental problem or oral health complaint;
    - Dental emergency; or
    - Referral for other treatment.
  - ✓ When performed by a dentist, is limited to the initial examination appointment. HRSA does not cover any additional limited examination by a dentist for the same client until three months after a removable dental prosthesis has been seated.
- Comprehensive oral evaluations, once per client, per provider or clinic, as an initial examination. HRSA covers an additional comprehensive oral evaluation if the client has not been treated by the same provider or clinic within the past five years.

Code	Description	PA?	Maximum Allowable Fee
D0120	periodic oral evaluation – established patient	N	<a href="#">On-line Fee Schedules</a>
D0140	limited oral evaluation – problem focused	N	
D0150	comprehensive oral evaluation – new or established patient	N	

## Limited Visual Oral Assessment

### What is covered?

HRSA covers limited visual oral assessments, up to two per client, per year, per provider only when the assessment is:

- Performed by a dentist or dental hygienist to determine the need for sealants, fluoride treatment, and triage services when provided in **settings other than dental offices or dental clinics**. (e.g., school-based programs, alternative living facilities, etc.);
- Not performed in conjunction with other clinical oral evaluation services; and
- Provided by a licensed dentist or licensed dental hygienist.

**Note:** HRSA requires expedited prior authorization (EPA) for limited visual oral assessments. Use EPA code 870000998 (see EPA criteria on page E.4).

Code	Description	PA?	Maximum Allowable Fee
D9999	unspecified diagnostic procedure, by report	EPA #870000998 Refer to Section D for criteria.	<a href="#">On-line Fee Schedules</a>

## Radiographs (X-rays)

### What is covered?

**Note:** HRSA uses the prevailing standard of care to determine the need for dental radiographs.

HRSA covers:

- Radiographs that are of diagnostic quality, dated, and labeled with the client's name. HRSA requires original radiographs to be retained by the provider as part of the client's dental record, and duplicate radiographs to be submitted with prior authorization requests, or when copies of dental records are requested.
- An intraoral complete series (includes four bitewings), once in a three-year period only if HRSA has not paid for a panoramic radiograph for the same client in the same three-year period.

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- Periapical radiographs that are not included in a complete series. Documentation supporting the medical necessity for these must be included in the client's record.
- An occlusal intraoral radiograph once in a two-year period. Documentation supporting the medical necessity for these must be included in the client's record.
- A maximum of four bitewing radiographs once every 12 months.
- Panoramic radiographs in conjunction with four bitewings, once in a three-year period, only if HRSA has not paid for an intraoral complete series for the same client in the same three-year period.

**Note:** HRSA may cover panoramic radiographs for preoperative or postoperative surgery cases more than once in a three-year period, only on a case-by-case basis and when prior authorized.

Emergency treatment may be billed without PA. Indicate "Emergency" in the *Remarks* field on the ADA claim form.

- Cephalometric film:
  - ✓ For orthodontics, as described in chapter 388-535A WAC; or
  - ✓ Only on a case-by-case basis and when prior authorized.
- Radiographs not listed as covered in this subsection, only on a case-by-case basis and when prior authorized.

Code	Description	PA?	Maximum Allowable Fee
D0210	intraoral – complete series (including bitewings)	N	<a href="#">On-line Fee Schedules</a>
D0220	intraoral – periapical first film	N	
D0230	intraoral – periapical each additional film	N	
D0240	intraoral – occlusal film	N	
D0270	bitewing – single film	N	
D0272	bitewings – two films	N	
D0273	bitewings – three films	N	
D0274	bitewings – four films	N	
D0330	panoramic film	N	
D0340	cephalometric film (orthodontics only)	N	

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- Oral and facial photographic images, only on a case-by-case basis and when requested by HRSA.

Code	Description	PA?	Maximum Allowable Fee
D0350	oral/facial photographic images	Y	<a href="#">On-line Fee Schedules</a>

### Tests and Examinations

#### What is covered?

HRSA covers:

- One pulp vitality test per visit (not per tooth):
  - ✓ For diagnosis only during limited oral evaluations; and
  - ✓ When radiographs and/or documented symptoms justify the medical necessity for the pulp vitality test.

Code	Description	PA?	Maximum Allowable Fee
D0460	pulp vitality tests	N	<a href="#">On-line Fee Schedules</a>

- Diagnostic casts other than those included in an orthodontic case study, on a case-by-case basis, and when requested by HRSA.

Code	Description	PA?	Maximum Allowable Fee
D0470	diagnostic casts	Y	<a href="#">On-line Fee Schedules</a>

**Note:** HRSA covers viral cultures, genetic testing, caries susceptibility, and adjunctive pre-diagnostic tests only on a case-by-case basis and when requested by HRSA.

## What preventive services are covered? [Refer to WAC 388-535-1082]

HRSA covers medically necessary dental-related preventive services, subject to the coverage limitations listed, for clients through age 20 as follows:

### Dental Prophylaxis

#### What is covered?

HRSA covers prophylaxis:

- Which includes scaling and polishing procedures to remove coronal plaque, calculus, and stains when performed on primary, transitional, or permanent dentition, once every six months for clients through age 18.
- Which includes scaling and polishing procedures to remove coronal plaque, calculus, and stains when performed on transitional or permanent dentition, once every 12 months for clients ages 19-20.
- When the service is performed six months after periodontal scaling and root planing, or periodontal maintenance services, for clients ages 13-18.
- When the service is performed 12 months after periodontal scaling and root planing, or periodontal maintenance services for clients ages 19-20.
- Only when not performed on the same date of service as periodontal scaling and root planing, periodontal maintenance, gingivectomy or gingivoplasty.
- For clients of the Division of Developmental Disabilities (DDD) according to Section D.

Code	Description	PA?	Limitations	Maximum Allowable Fee
D1110	prophylaxis – adult	N	Clients ages 14-20	<a href="#">On-line Fee Schedules</a>
D1120	prophylaxis – child	N	Clients through age 13	

## Topical Fluoride Treatment

### What is covered?

HRSA covers:

- Fluoride varnish, rinse, foam or gel up to 3 times within a 12-month period per client, per provider or clinic for clients ages 6 and younger.
- Fluoride varnish, rinse, foam or gel up to 2 times within a 12-month period per client, per provider or clinic for clients ages 7 through 18.
- Fluoride varnish, rinse, foam or gel up to 3 times within a 12-month period per client, per provider or clinic during orthodontic treatment.
- Fluoride rinse, foam or gel once within a 12-month period per client, per provider or clinic for clients ages 19 through 20.
- Additional topical fluoride applications only on a case-by-case basis and when prior authorized.
- Topical fluoride treatment for clients of DDD according to Section D.

Code	Description	PA?	Limitations	Maximum Allowable Fee
D1203	topical application of fluoride (prophylaxis not included) – child	N	Clients through age 18	<a href="#">On-line Fee Schedules</a>
D1204	topical application of fluoride (prophylaxis not included) – adult	N	Clients ages 19-20	

## Oral Hygiene Instructions

### What is covered?

HRSA covers:

- Oral hygiene instructions only for clients through age eight.
- Oral hygiene instructions up to two times within a 12-month period.
- Individualized oral hygiene instructions for home care to include tooth brushing technique, flossing, and use of oral hygiene aides.
- Oral hygiene instructions only when not performed on the same date of service as prophylaxis.

**Note:** HRSA covers oral hygiene instructions only when provided by a licensed dentist or a licensed dental hygienist and the instruction is provided in a **setting other than a dental office or clinic.**

Code	Description	PA?	Maximum Allowable Fee
D1330	oral hygiene instructions	N	<a href="#">On-line Fee Schedules</a>

## Sealants

### What is covered?

HRSA covers:

- Sealants only when used on a mechanically and/or chemically prepared enamel surface.
- Sealants once per tooth in a three-year period for clients through age 18.
- Sealants only when used on the occlusal surfaces of:
  - ✓ Permanent teeth 2, 3, 14, 15, 18, 19, 30, and 31; and
  - ✓ Primary teeth A, B, I, J, K, L, S, and T.
- Sealants only on non-carious teeth or teeth with incipient caries.
- Sealants only when placed on a tooth with no pre-existing occlusal restoration, or any occlusal restoration placed on the same day.
- Additional sealants on a case-by-case basis and when prior authorized.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D1351	sealant – per tooth	N	Tooth designation required	<a href="#">On-line Fee Schedules</a>

## Space Maintenance

### What is covered?

HRSA covers:

- Fixed unilateral or fixed bilateral space maintainers for clients through age 18.
- Only one space maintainer per quadrant.
- Space maintainers only for missing primary molars A, B, I, J, K, L, S, and T.
- Replacement space maintainers only on a case-by-case basis and when prior authorized.
- Removal of fixed space maintainer for clients through age 18.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D1510	space maintainer – fixed – unilateral	N	Quadrant designation required	<a href="#">On-line Fee Schedules</a>
D1515	space maintainer – fixed – bilateral	N	Arch designation required	
D1550	re-cementation of space maintainer	N	Quadrant or arch designation required	
D1555	removal of fixed space maintainer	N		

## **What restorative services are covered? [Refer to WAC 388-535-1084]**

HRSA covers medically necessary dental-related restorative services, subject to the coverage limitations listed, for clients through age 20 as follows:

### **Restorative/Operative Procedures**

#### **Who is covered for hospitals or ambulatory surgical centers?**

HRSA covers restorative/operative procedures performed in a hospital or an ambulatory surgical center for:

- Clients ages eight and younger;
- Clients ages 9-20 only on a case-by-case basis and when prior authorized; and
- Clients of DDD according to Section D.

### **Amalgam Restorations for Primary and Permanent Teeth**

#### **Coverage Limitations**

HRSA considers:

- Tooth preparation, all adhesives (including amalgam bonding agents), liners, bases, and polishing as part of the amalgam restoration.
- The occlusal adjustment of either the restored tooth or the opposing tooth or teeth as part of the amalgam restoration.
- Buccal or lingual surface amalgam restorations, regardless of size or extension, as a one surface restoration. HRSA covers one buccal and one lingual surface per tooth.
- Multiple amalgam restorations of fissures and grooves of the occlusal surface of the same tooth as a one surface restoration.
- Amalgam restorations placed within six months of a crown preparation by the same provider or clinic to be included in the payment for the crown.

### Coverage for Primary Posterior Teeth

HRSA covers amalgam restorations for a maximum of two surfaces for a primary first molar and a maximum of three surfaces for a primary second molar. HRSA does not pay for additional amalgam restorations. (See “Other Restorative Surfaces” for restorations for a primary posterior tooth requiring an additional surface restoration.)

### Coverage for Permanent Posterior Teeth

HRSA covers:

- Two occlusal amalgam restorations for teeth 1, 2, 3, 14, 15, and 16, if the restorations are anatomically separated by sound tooth structure.
- Amalgam restorations for a maximum of five surfaces per tooth for a permanent posterior tooth, once per client, per provider or clinic, in a two-year period.
- Amalgam restorations for a maximum of six surfaces per tooth for teeth 1, 2, 3, 14, 15, and 16, once per client, per provider or clinic, in a two-year period.

HRSA does not pay for replacement of amalgam restoration on permanent posterior teeth within a two-year period unless the restoration has an additional adjoining carious surface. HRSA pays for the replacement restoration as one multi-surface restoration. The client's record must include radiographs and documentation supporting the medical necessity for the replacement restoration.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D2140	amalgam – one surface, primary or permanent	N	Tooth and surface designations required	<a href="#">On-line Fee Schedules</a>
D2150	amalgam – two surfaces, primary or permanent	N	Tooth and surface designations required	
D2160	amalgam – three surfaces, primary or permanent	N	Tooth and surface designations required. <b>Not allowed for primary first molars.</b>	
D2161	amalgam – four or more surfaces, primary or permanent	N	Tooth and surface designations required. <b>Not allowed for primary first or second molars.</b>	

## Resin-Based Composite Restorations for Primary and Permanent Teeth

### Coverage Limitations

HRSA considers:

- Tooth preparation, acid etching, all adhesives (including resin bonding agents), liners and bases, polishing, and curing as part of the resin-based composite restoration.
- The occlusal adjustment of either the restored tooth or the opposing tooth or teeth as part of the resin-based composite restoration.
- Buccal or lingual surface resin-based composite restorations, regardless of size or extension, as a one surface restoration. HRSA covers only one buccal and one lingual surface per tooth.
- Resin-based composite restorations of teeth where the decay does not penetrate the DEJ to be sealants (see “What Preventive Services are Covered?” for sealants coverage).
- Multiple preventive restorative resins, flowable composite resins, or resin-based composites for the occlusal, buccal, lingual, mesial, and distal fissures and grooves on the same tooth as a one surface restoration.
- Resin-based composite restorations placed within six months of a crown preparation by the same provider or clinic to be included in the payment for the crown.

### What is not covered?

HRSA does not cover preventive restorative resins or flowable composite resins on the interproximal surfaces (mesial and/or distal) when performed on posterior teeth or the incisal surface of anterior teeth.

## Coverage for Primary Teeth

HRSA covers:

- Resin-based composite restorations for a maximum of three surfaces for a primary anterior tooth. **HRSA does not pay for** additional composite or amalgam restorations on the same tooth after three surfaces. (See “Other Restorative Surfaces” for restorations for a primary anterior tooth requiring a four or more surface restoration).
- Resin-based restorations for a maximum of two surfaces for a primary first molar and a maximum of three surfaces for a primary second molar. **HRSA does not pay for** additional composite or amalgam restorations on the same tooth after two surfaces. (See “Other Restorative Surfaces” for restorations for a primary posterior tooth requiring an additional surface restoration.)
- Glass ionimer restorations only for primary teeth, and only for clients ages five and younger. HRSA pays for these restorations as a one surface resin-based composite restoration.

## Coverage for Permanent Teeth

HRSA covers:

- Two occlusal resin-based composite restorations for teeth 1, 2, 3, 14, 15, and 16 if the restorations are anatomically separated by sound tooth structure.
- Resin-based composite restorations for a maximum of five surfaces per tooth for a permanent posterior tooth, once per client, per provider or clinic, in a two-year period.
- Resin-based composite restorations for a maximum of six surfaces per tooth for permanent posterior teeth 1, 2, 3, 14, 15, and 16, once per client, per provider or clinic, in a two-year period.
- Resin-based composite restorations for a maximum of six surfaces per tooth for a permanent anterior tooth, once per client, per provider or clinic, in a two-year period.
- Replacement of resin-based composite restoration on permanent teeth within a two-year period only if the restoration has an additional adjoining carious surface. HRSA pays the replacement restoration as one multi-surface restorations. The client's record must include radiographs and documentation supporting the medical necessity for the replacement restoration.

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<b>Code</b>	<b>Description</b>	<b>PA?</b>	<b>Requirements</b>	<b>Maximum Allowable Fee</b>
D2330	resin-based composite – one surface, anterior	N	Tooth and surface designations required	<a href="#">On-line Fee Schedules</a>
D2331	resin-based composite – two surfaces, anterior	N	Tooth and surface designations required	
D2332	resin-based composite – three surfaces, anterior	N	Tooth and surface designations required	
D2335	resin-based composite – four or more surfaces or involving incisal angle (anterior)	N	Tooth and surface designations required. <b>Not allowed on primary anterior teeth.</b>	
D2390	resin-based composite crown, anterior	N	Tooth designation required	
D2391	resin-based composite – one surface, posterior	N	Tooth and surface designations required	
D2392	resin-based composite – two surfaces, posterior	N	Tooth and surface designations required	
D2393	resin-based composite – three surfaces, posterior	N	Tooth and surface designations required. <b>Not allowed on primary first molars.</b>	
D2394	resin-based composite – four or more surfaces, posterior	N	Tooth and surface designations required. <b>Not allowed on primary first and second molars.</b>	

## Crowns – Single Restorations Only

### What is covered?

HRSA covers:

- The following crowns for **permanent anterior teeth** for clients ages 12-20 when the crowns meet prior authorization (PA) criteria in the “Prior Authorization” section of these billing instructions and the provider follows the PA requirements in “Prior Authorization” on the following page:
  - ✓ Porcelain/ceramic crowns to include all porcelains, glasses, glass-ceramic, and porcelain fused to metal crowns; and
  - ✓ Resin crowns and resin metal crowns to include any resin-based composite, fiber, or ceramic reinforced polymer compound.

**Note:** HRSA does not cover permanent anterior crowns for clients through age 11.

- Full coverage metal crowns for **permanent posterior teeth** to include high noble, titanium, titanium alloys, noble, and predominantly base metal crowns for clients ages 18-20 when they meet PA criteria and the provider follows the PA requirements in “Prior Authorization” on the following page.

**Note:** HRSA does not cover permanent posterior crowns for clients through age 17.

### Payment

HRSA considers the following to be included in the payment for a crown:

- Tooth and soft tissue preparation;
- Amalgam and resin-based composite restoration, or any other restorative material placed within six months of the crown preparation. **Exception:** HRSA covers a one surface restoration on an endodontically treated tooth;
- Temporaries, including but not limited to, temporary restoration, temporary crown, provisional crown, temporary prefabricated stainless steel crown, ion crown, or acrylic crown;
- Packing cord placement and removal;
- Diagnostic or final impressions;

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- Crown seating, including cementing and insulating bases;
- Occlusal adjustment of crown or opposing tooth or teeth; and
- Local anesthesia.

### Billing

HRSA requires a provider to bill for a crown only after delivery and seating of the crown, not at the impression date.

### Prior Authorization

HRSA requires the provider to submit the following with each PA request:

- Radiographs to assess all remaining teeth;
- Documentation and identification of all missing teeth;
- Caries diagnosis and treatment plan for all remaining teeth, including a caries control plan for clients with rampant caries;
- Pre- and post-endodontic treatment radiographs for requests on endodontically treated teeth; and
- Documentation supporting a five-year prognosis that the client will retain the tooth or crown if the tooth is crowned.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D2710	crown – resin-based composite (indirect)	Y	Tooth designation required	<a href="#">On-line Fee Schedules</a>
D2720	crown – resin with high noble metal	Y	Tooth designation required	
D2721	crown – resin with predominantly base metal	Y	Tooth designation required	
D2722	crown – resin with noble metal	Y	Tooth designation required	
D2740	crown – porcelain/ceramic substrate	Y	Tooth designation required	
D2750	crown – porcelain fused to high noble metal	Y	Tooth designation required	
D2751	crown – porcelain fused to predominantly base metal	Y	Tooth designation required	

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Code	Description	PA?	Requirements	Maximum Allowable Fee
D2752	crown – porcelain fused to noble metal	Y	Tooth designation required	<a href="#">On-line Fee Schedules</a>
D2790	crown – full cast high noble metal	Y	Tooth designation required	
D2791	crown – full cast predominantly base metal	Y	Tooth designation required	
D2792	crown – full cast noble metal	Y	Tooth designation required	
D2794	crown – titanium	Y	Tooth designation required	

### Other Restorative Services

HRSA covers:

- All recementations of permanent indirect crowns.
- Prefabricated stainless steel crowns with resin window, resin-based composite crowns, prefabricated esthetic coated stainless steel crowns, and fabricated resin crowns for primary anterior teeth once every three years without PA if the tooth requires a four or more surface restoration.
- Prefabricated stainless steel crowns for primary posterior teeth once every three years without PA.
- Prefabricated stainless steel crowns for permanent posterior teeth once every three years when prior authorized.
- Prefabricated stainless steel crowns for clients of DDD according to Section D.
- Core buildup, including pins, only on permanent teeth, when prior authorized at the same time as the crown PA.
- Cast post and core or prefabricated post and core, only on permanent teeth, when prior authorized at the same time as the crown PA.

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Code	Description	PA?	Requirements	Maximum Allowable Fee
D2910	recement inlay, onlay, or partial coverage restoration	N	Tooth designation required	<a href="#">On-line Fee Schedules</a>
D2915	recement cast or prefabricated post and core	N	Tooth designation required	
D2920	recement crown	N	Tooth designation required	
D2930	prefabricated stainless steel crown – primary tooth	N	Tooth designation required	
D2931	prefabricated stainless steel crown – permanent tooth	Y	Tooth designation required	
D2932	prefabricated resin crown	N	Tooth designation required	
D2933	prefabricated stainless steel crown with resin window	Y	Tooth designation required	
D2934	prefabricated esthetic coated stainless steel crown – primary tooth	N	Tooth designation required	
D2950	core buildup, including any pins	Y	Tooth designation required	
D2954	post and core in addition to crown, indirectly fabricated	Y	Tooth designation required	

## What endodontic services are covered? [Refer to WAC 388-535-1086]

HRSA covers medically necessary dental-related endodontic services, subject to the coverage limitations listed, for clients through age 20 as follows:

### Pulp Capping

HRSA considers pulp capping to be included in the payment for the restoration.

### Pulpotomy/Pulpal Debridement

HRSA covers:

- Therapeutic pulpotomy on primary posterior teeth only; and
- Pulpal debridement on permanent teeth only, excluding teeth 1, 16, 17, and 32. HRSA does not pay for pulpal debridement when performed with palliative treatment for dental pain or when performed on the same day as endodontic treatment.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D3220	therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	N	Tooth designation required	<a href="#">On-line Fee Schedules</a>
D3221	pulpal debridement, permanent teeth	N	Tooth designation required	

### Endodontic Treatment on Primary Teeth

HRSA covers endodontic treatment with resorbable material for primary maxillary incisor teeth D, E, F, and G, if the entire root is present at treatment.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D3230	pulpal therapy (resorbable filling)-anterior, primary	N	Tooth designation required	<a href="#">On-line Fee Schedules</a>

## Endodontic Treatment on Permanent Teeth

HRSA:

- Covers endodontic treatment for permanent anterior, bicuspid, and molar teeth, excluding teeth 1, 16, 17, and 32.
- Considers the following included in endodontic treatment:
  - ✓ Pulpectomy when part of root canal therapy;
  - ✓ All procedures necessary to complete treatment; and
  - ✓ All intra-operative and final evaluation radiographs for the endodontic procedure.
- Pays separately for the following services that are related to the endodontic treatment:
  - ✓ Initial diagnostic evaluation;
  - ✓ Initial diagnostic radiographs; and
  - ✓ Post treatment evaluation radiographs if taken at least three months after treatment.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D3310	anterior (excluding final restoration)	N	Tooth designation required	<a href="#">On-line Fee Schedules</a>
D3320	bicuspid (excluding final restoration)	N	Tooth designation required	
D3330	molar (excluding final restoration)	N	Tooth designation required	

## Endodontic Retreatment on Permanent Anterior Teeth

- Requires PA for endodontic retreatment and considers endodontic retreatment to include:
  - ✓ The removal of post(s), pin(s), old root canal filling material, and all procedures necessary to prepare the canals;
  - ✓ Placement of new filling material; and
  - ✓ Retreatment for permanent anterior, bicuspid, and molar teeth, excluding teeth 1, 16, 17, and 32.

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- Pays separately for the following services that are related to the endodontic retreatment:
  - ✓ Initial diagnostic evaluation;
  - ✓ Initial diagnostic radiographs; and
  - ✓ Post treatment evaluation radiographs if taken at least three months after treatment.
- Does not pay for endodontic retreatment when provided by the original treating provider or clinic unless prior authorized by HRSA.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D3346	retreatment of previous root canal therapy – anterior	Y	Tooth designation required	<a href="#">On-line Fee Schedules</a>
D3347	retreatment of previous root canal therapy – bicuspid	Y	Tooth designation required	
D3348	retreatment of previous root canal therapy – molar	Y	Tooth designation required	

### Apexification/Apicoectomy

- Covers apexification for apical closures for **anterior permanent teeth only** on a case-by-case basis and when prior authorized. Apexification is limited to the initial visit and three interim treatment visits.
- Covers apicoectomy and a retrograde filling for **anterior teeth only**.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D3351	apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	N	Tooth designation required	<a href="#">On-line Fee Schedules</a>
D3352	apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	N	Tooth designation required	
D3410	apicoectomy/periradicular surgery – anterior	Y	Tooth designation required	
D3430	retrograde filling – per root	Y	Tooth designation required	

## What periodontic services are covered? [Refer to WAC 388-535-1088]

HRSA covers medically necessary periodontic services, subject to the coverage limitations listed, for clients through age 20 as follows:

### Surgical Periodontal Services

HRSA covers the following surgical periodontal services, including all postoperative care:

- Gingivectomy/gingivoplasty only on a case-by-case basis and when prior authorized; and
- Gingivectomy/gingivoplasty for clients of DDD according to Section D.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D4210	gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant	Y	Quadrant designation required	<a href="#">On-line Fee Schedules</a>
D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant	Y	Quadrant designation required	

### Nonsurgical Periodontal Services

HRSA:

- Covers periodontal scaling and root planing once per quadrant, per client in a two-year period on a case-by-case basis, when prior authorized for clients ages 13-18, and only when:
  - ✓ The client has radiographic evidence of periodontal disease;
  - ✓ The client's record includes supporting documentation for the medical necessity of the service, including complete periodontal charting and a definitive diagnosis of periodontal disease;
  - ✓ The client's clinical condition meets current published periodontal guidelines; and
  - ✓ Performed at least two years from the date of completion of periodontal scaling and root planing or surgical periodontal treatment.

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- Covers periodontal scaling and root planing once per quadrant, per client, in a two-year period for clients ages 19-20, and only when:
  - ✓ The client has radiographic evidence of periodontal disease;
  - ✓ The client's record includes supporting documentation for the medical necessity, including complete periodontal charting and a definitive diagnosis of periodontal disease;
  - ✓ The client's clinical condition meets current published periodontal guidelines; and
  - ✓ Performed at least two years from the date of completion of periodontal scaling and root planing or surgical periodontal treatment.
- Considers ultrasonic scaling, gross scaling, or gross debridement to be included in the procedure and not a substitution for periodontal scaling and root planing.
- Covers periodontal scaling and root planing only when the services are not performed on the same date of service as prophylaxis, periodontal maintenance, gingivectomy, or gingivoplasty.
- Covers periodontal scaling and root planing for clients of DDD according to Section D.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D4341	periodontal scaling and root planing – four or more teeth per quadrant	N	Quadrant designation required	<a href="#">On-line Fee Schedules</a>
D4342	periodontal scaling and root planing – one to three teeth per quadrant	N	Quadrant designation required	

### Periodontal Maintenance

#### HRSA:

- Covers periodontal maintenance once per client in a 12-month period on a case-by-case basis, when prior authorized, for clients ages 13-18, and only when:
  - ✓ The client has radiographic evidence of periodontal disease;
  - ✓ The client's record includes supporting documentation for the medical necessity, including complete periodontal charting and a definitive diagnosis of periodontal disease;

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- ✓ The client's clinical condition meets current published periodontal guidelines; and
- ✓ Performed at least 12 months from the date of completion of periodontal scaling and root planing, or surgical periodontal treatment.
- Covers periodontal maintenance once per client in a 12 month period for clients ages 19-20 only when:
  - ✓ The client has radiographic evidence of periodontal disease;
  - ✓ The client's record includes supporting documentation for the medical necessity, including complete periodontal charting and a definitive diagnosis of periodontal disease;
  - ✓ The client's clinical condition meets current published periodontal guidelines; and
  - ✓ Performed at least 12 months from the date of completion of periodontal scaling and root planing, or surgical periodontal treatment.
- Covers periodontal maintenance only if performed on a different date of service as prophylaxis, periodontal scaling and root planing, gingivectomy, or gingivoplasty.
- Covers periodontal maintenance for clients of DDD according to Section D.

Code	Description	PA?	Limitations	Maximum Allowable Fee
D4910	periodontal maintenance	Y	Clients ages 13-18	<a href="#">On-line Fee Schedules</a>
D4910	periodontal maintenance	N	Clients ages 19-20	

## What removable prosthodontic services are covered?

[Refer to WAC 388-535-1090]

HRSA covers medically necessary removable prosthodontic services, subject to the coverage limitations listed, for clients through age 20 as follows:

### Prior Authorization (PA)

HRSA requires PA for the removable prosthodontic and prosthodontic-related procedures listed in this section when noted. Documentation supporting the medical necessity for the service must be included in the client's file. PA requests must meet the criteria in the *Prior Authorization* section of these billing instructions. In addition, HRSA requires the dental provider to submit:

- Appropriate and diagnostic radiographs of all remaining teeth.
- A dental record which identifies:
  - ✓ All missing teeth for both arches;
  - ✓ Teeth that are to be extracted; and
  - ✓ Dental and periodontal services completed on all remaining teeth.
- The referring dentist's name and prescription when the PA request is submitted by a dentist for an immediate denture or a cast metal partial denture.

**Note:** If a client wants to change denture providers, HRSA must receive a statement from the client requesting the provider change. HRSA will check to make sure services haven't already been rendered by the original provider before cancelling the original authorization request for services. The new provider must submit another authorization request for services.

### Complete Dentures

HRSA covers complete dentures, as follows:

- A complete denture, including an immediate denture or overdenture, is covered when prior authorized.
- Three-month post-delivery care (e.g., adjustments, soft relines, and repairs) from the seat date of the complete denture is considered part of the complete denture procedure and is not paid separately.
- Replacement of an immediate denture with a complete denture if the complete denture is prior authorized at least six months after the seat date of the immediate denture.

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- Replacement of a complete denture or overdenture only if prior authorized at least five years after the seat date of the complete denture or overdenture being replaced. The replacement denture must be prior authorized.

Code	Description	PA?	Maximum Allowable Fee
D5110	complete denture – maxillary	Y	<a href="#">On-line Fee Schedules</a>
D5120	complete denture – mandibular	Y	
D5130	immediate denture – maxillary	Y	
D5140	immediate denture – mandibular	Y	

### Resin Partial Dentures

#### What is covered?

HRSA covers partial dentures, as follows:

- A partial denture, including a resin or flexible base partial denture, for anterior and posterior teeth when the partial denture meets the HRSA coverage criteria for resin partial dentures.
- PA of resin partial dentures:
  - ✓ Is required for clients ages nine and younger; and
  - ✓ Is not required for clients ages 10-20. Documentation supporting the medical necessity for the service must be included in the client's file.
- Three-month post-delivery care (e.g., adjustments, soft relines, and repairs) from the seat date of the partial denture, is considered part of the partial denture procedure and is not paid separately.
- Replacement of a resin or flexible base denture only if prior authorized at least three years after the seat date of the resin or flexible base partial denture being replaced. The replacement denture must be prior authorized and meet the HRSA coverage criteria for resin partial dentures.

### Coverage Criteria for Resin Partial Dentures

The following coverage criteria apply to resin partial dentures:

- The remaining teeth in the arch must have a reasonable periodontal diagnosis and prognosis;
- The client has established caries control;
- One or more anterior teeth are missing or four or more posterior teeth are missing;
- There are a minimum of four stable teeth remaining per arch; and
- There is a three-year prognosis for retention of the remaining teeth.

Code	Description	PA?	Limitations	Maximum Allowable Fee
D5211	maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	Y	Clients through age 9 only	<a href="#">On-line Fee Schedules</a>
D5211	maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	N*	Clients ages 10-20 only	
D5212	mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	Y	Clients through age 9 only	
D5212	mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	N*	Clients ages 10-20 only	
D5225	maxillary partial denture – flexible base (including any clasps, rests and teeth)	Y	Clients through age 9 only	
D5225	maxillary partial denture – flexible base (including any clasps, rests and teeth)	N*	Clients ages 10-20 only	
D5226	mandibular partial denture – flexible base (including any clasps, rests and teeth)	Y	Clients through age 9 only	
D5226	mandibular partial denture – flexible base (including any clasps, rests and teeth)	N*	Clients ages 10-20 only	

\* Replacement dentures must be prior authorized and meet the HRSA coverage criteria for resin partial dentures.

## Cast-metal Framework Partial Dentures

HRSA covers cast-metal framework partial dentures, as follows:

- Cast-metal framework with resin-based partial dentures, including any conventional clasps, rests, and teeth, for clients ages 18-20 only once in a five-year period, on a case-by-case basis, when prior authorized, and when the HRSA coverage criteria for partial dentures are met.

**Note:** Cast-metal framework partial dentures for clients ages 17 and younger are not covered.

- Three-month post-delivery care (e.g., adjustments, soft relines, and repairs) from the seat date of the cast metal partial denture is considered part of the partial denture procedure and is not paid separately.
- Replacement of a cast metal framework partial denture on a case-by-case basis and only if placed at least five years after the seat date of the partial denture being replaced. The replacement denture must be prior authorized and meet the HRSA coverage criteria for partial dentures.
- Authorization and payment for cast metal framework partial dentures is based on the HRSA coverage criteria for partial dentures.
- HRSA may consider resin partial dentures as an alternative if HRSA determines the criteria for cast metal framework partial dentures are not met.

## Coverage Criteria for Cast-metal Framework Partial Dentures

The following coverage criteria apply to cast-metal framework partial dentures:

- The remaining teeth in the arch must have a stable periodontal diagnosis and prognosis;
- The client has established caries control;
- All restorative and periodontal procedures must be completed before the request for PA is submitted;
- There are fewer than eight posterior teeth in occlusion;
- There are a minimum of four stable teeth remaining per arch; and
- There is a five-year prognosis for retention of the remaining teeth.

<b>Code</b>	<b>Description</b>	<b>PA?</b>	<b>Limitations</b>	<b>Maximum Allowable Fee</b>
D5213	maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	Y	Clients ages 18-20	<a href="#">On-line Fee Schedules</a>
D5214	mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	Y	Clients ages 18-20	

### **Other Requirements/Limitations**

HRSA:

- Requires a provider to bill for removable dental prosthetic procedures only after the seating of the prosthesis, not at the impression date. HRSA may pay for lab fees if the removable dental prosthesis is not delivered and inserted. Refer to “Other Services for Removable Prosthodontics.”
- Requires a provider to deliver services and procedures that are of acceptable quality to HRSA. HRSA may recoup payment for services that are determined to be below the standard of care or of an unacceptable product quality.

### **Alternative Living Facilities**

- Requires a provider to submit the following with a PA request for removable dental prosthetics for a client residing in a nursing facility, group home, or other facility:
  - ✓ The client's medical diagnosis or prognosis;
  - ✓ The attending physician's signature documenting medical necessity for the prosthetic service;
  - ✓ The attending dentist's or denturist's signature documenting medical necessity for the prosthetic service;
  - ✓ A written and signed consent for treatment from the client's legal guardian when a guardian has been appointed; and
  - ✓ A completed copy of the Denture/Partial Appliance Request for Skilled Nursing Facility Client form [DSHS 13-788]. For information on obtaining DSHS forms, refer to the *Important Contacts* section.

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- Limits removable partial dentures to resin-based partial dentures for all clients residing in a nursing facility, group home, or other facility. HRSA may consider cast metal partial dentures if coverage criteria are met.

### Adjustments to Dentures and Repairs to Complete and Partial Dentures

HRSA covers adjustments to complete and partial dentures three months after the seat date.

Code	Description	PA?	Maximum Allowable Fee
D5410	adjust complete denture – maxillary	N	<a href="#">On-line Fee Schedules</a>
D5411	adjust complete denture – mandibular	N	
D5421	adjust partial denture – maxillary	N	
D5422	adjust partial denture – mandibular	N	

### Repairs to Complete and Partial Dentures

HRSA covers repairs to complete and partial dentures once in a 12-month period. HRSA covers additional repairs on a case-by-case basis and when prior authorized.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D5510	repair broken complete denture base	N	Arch designation required	<a href="#">On-line Fee Schedules</a>
D5520	replace missing or broken teeth – complete denture (each tooth)	N	Tooth designation required	
D5610	repair resin denture base	N	Arch designation required	
D5620	repair cast framework	N	Arch designation required	
D5630	repair or replace broken clasp	N	Arch designation required	
D5640	replace broken teeth – per tooth	N	Tooth designation required	
D5650	add tooth to existing partial denture	N	Tooth designation required	
D5660	add clasp to existing partial denture	N	Tooth designation required	

## Denture Rebase Procedures

HRSA covers a laboratory rebase to a complete or cast-metal partial denture once in a three-year period when performed at least six months after the seating date. An additional rebase may be covered for complete or cast-metal partial dentures on a case-by-case basis when prior authorized.

Code	Description	PA?	Maximum Allowable Fee
D5710	rebase complete maxillary denture	N	<a href="#">On-line Fee Schedules</a>
D5711	rebase complete mandibular denture	N	
D5720	rebase maxillary partial denture	N	
D5721	rebase mandibular partial denture	N	

**Note:** HRSA does not allow a denture rebase and a reline in the same three-year period. HRSA covers rebases or relines only on cast-metal partials and complete dentures (CDT codes D5110, D5120, D5130, D5140, D5213, and D5214).

## Denture Reline Procedures

HRSA covers a laboratory reline to a complete or cast-metal partial denture once in a three-year period when performed at least six months after the seating date. An additional reline may be covered for complete or cast-metal partial dentures on a case-by-case basis when prior authorized.

Code	Description	PA?	Maximum Allowable Fee
D5750	reline complete maxillary denture (laboratory)	N	<a href="#">On-line Fee Schedules</a>
D5751	reline complete mandibular denture (laboratory)	N	
D5760	reline maxillary partial denture (laboratory)	N	
D5761	reline mandibular partial denture (laboratory)	N	

**Note:** HRSA does not allow a denture rebase and a reline in the same three-year period. HRSA covers rebases or relines only on cast-metal partials and complete dentures (CDT codes D5110, D5120, D5130, D5140, D5213, and D5214).

**Other Removable Prosthetic Services**

HRSA covers:

- Up to two tissue conditionings, and only when performed within three months after the seating date.
- Laboratory fees, subject to the following:
  - ✓ HRSA does not pay separately for laboratory or professional fees for complete and partial dentures; and
  - ✓ HRSA may pay part of billed laboratory fees when the provider obtains PA, and the client:
    - Is not eligible at the time of delivery of the prosthesis;
    - Moves from the state;
    - Cannot be located;
    - Does not participate in completing the complete, immediate, or partial dentures; or
    - Dies.

A provider must submit copies of laboratory prescriptions and receipts or invoices for each claim when billing for laboratory fees.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D5850	tissue conditioning, maxillary	N	Arch designation required	<a href="#">On-line Fee Schedules</a>
D5851	tissue conditioning, mandibular	N	Arch designation required	
D5860	overdenture – complete, by report	N	Arch designation required	
D5899	unspecified removable prosthodontic procedure, by report	Y	Arch designation required	
D6930	recement fixed partial denture	Y	Arch or quadrant designation required	

## What maxillofacial prosthetic services are covered?

[Refer to WAC 388-535-1092]

HRSA covers medically necessary maxillofacial prosthetic services, subject to the coverage limitations listed, for clients through age 20 as follows:

- Maxillofacial prosthetics are covered only on a case-by-case basis and **when prior authorized**; and
- HRSA **must pre-approve** a provider qualified to furnish maxillofacial prosthetics.

## What oral and maxillofacial surgery services are covered?

[Refer to WAC 388-535-1094]

### General Coverage

HRSA covers medically necessary oral and maxillofacial surgery services, subject to the coverage limitations listed, for clients through age 20 as follows:

- Requires enrolled providers who do not meet the conditions in Section A, “Becoming a DSHS Dental Provider” to bill claims for services that are listed in this subsection using only the Current Dental Terminology (CDT) codes.
- Requires enrolled providers (oral and maxillofacial surgeons) who meet the conditions in Section A, “Becoming a DSHS Dental Provider” to bill claims using Current Procedural Terminology (CPT) codes unless the procedure is specifically listed in HRSA's current published billing instructions as a CDT covered code (e.g., extractions).

**Note:** For billing information on billing CPT codes for oral surgery, refer to HRSA’s *Physician-Related Services Billing Instructions*. HRSA pays oral surgeons for only those CPT codes listed in the Dental Fee Schedule under “Dental CPT Codes.”

- Covers non-emergency oral surgery performed in a hospital or ambulatory surgery center only for:
  - ✓ Clients ages eight and younger;
  - ✓ Clients ages 9-20 only on a case-by-case basis and when prior authorized; and
  - ✓ Clients of DDD according to Section D.

## Documentation Requirements

HRSA requires the client's dental record to include supporting documentation for each type of extraction or any other surgical procedure billed to HRSA. The documentation must include:

- Appropriate consent form signed by the client or the client's legal representative;
- Appropriate radiographs;
- Medical justification with diagnosis;
- The client's blood pressure, when appropriate;
- A surgical narrative;
- A copy of the post-operative instructions; and
- A copy of all pre- and post-operative prescriptions.

## Extractions and Surgical Extractions

HRSA covers routine and surgical extractions (includes local anesthesia, suturing, if needed, and routine postoperative care).

HRSA includes debridement of a granuloma or cyst that is less than five millimeters as part of the global fee for the extraction.

**Note:** For surgical extractions, documentation supporting the medical necessity of the billed procedure code must be in the client's record.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D7111	extraction, coronal remnants – deciduous tooth	N	Tooth designation required	<a href="#">On-line Fee Schedules</a>
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	N	Tooth designation required	
D7210	surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	N	Tooth designation required	
D7220	removal of impacted tooth – soft tissue	N	Tooth designation required	
D7230	removal of impacted tooth – partially bony	N	Tooth designation required	
D7240	removal of impacted tooth – completely bony	N	Tooth designation required	
D7241	removal of impacted tooth – completely bony, with unusual surgical complications	Y	Tooth designation required	
D7250	surgical removal of residual tooth roots (cutting procedure)	N	Tooth designation required	

### Other Surgical Procedures

- HRSA covers surgical access of an unerupted tooth.
- Biopsy of soft oral tissue or brush biopsy does not require PA. All biopsy reports or findings must be kept in the client's dental record.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D7280	surgical access of an unerupted tooth	N	Tooth designation required	<a href="#">On-line Fee Schedules</a>
D7286	biopsy of oral tissue – soft	N		
D7288	brush biopsy – transepithelial sample collection	N		

### Alveoloplasty – Surgical Preparation of Ridge for Dentures

HRSA covers alveoloplasty only on a case-by-case basis and when prior authorized. HRSA covers alveoloplasty only when not performed in conjunction with extractions.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D7320	alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	Y	Quadrant designation required	<a href="#">On-line Fee Schedules</a>

### Surgical Excision of Soft Tissue Lesions

HRSA covers surgical excision of soft tissue lesions only on a case-by-case basis and when prior authorized.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D7410	excision of benign lesion up to 1.25 cm	Y	Quadrant designation required	<a href="#">On-line Fee Schedules</a>

## Excision of Bone Tissue

HRSA covers only the following excisions of bone tissue in conjunction with placement of immediate, complete, or partial dentures when prior authorized:

- Removal of lateral exostosis;
- Removal of mandibular or palatal tori; and
- Surgical reduction of soft tissue or osseous tuberosity.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D7471	removal of lateral exostosis (maxilla or mandible)	Y	Arch designation required	<a href="#">On-line Fee Schedules</a>
D7472	removal of torus palatinus	Y		
D7473	removal of torus mandibularis	Y		
D7485	surgical reduction of osseous tuberosity	Y	Quadrant designation required	

## Surgical Incision

HRSA covers the following surgical incision-related services:

- Uncomplicated dental-related intraoral and extraoral soft tissue incision and drainage of abscess. HRSA does not cover this service when combined with an extraction or root canal treatment. Documentation supporting medical necessity must be in the client's record.

**Note:** Providers must not bill drainage of abscess (D7510 or D7520) in conjunction with palliative treatment (D9110).

- Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue when prior authorized. Documentation supporting the medical necessity for the service must be in the client's record.
- Frenuloplasty/frenulectomy for clients through age six. HRSA covers frenuloplasty/frenulectomy for clients ages 7-12 only on a case-by-case basis and when prior authorized. Documentation supporting the medical necessity for the service must be in the client's record.

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<b>Code</b>	<b>Description</b>	<b>PA?</b>	<b>Requirements</b>	<b>Maximum Allowable Fee</b>
D7510	incision and drainage of abscess – intraoral soft tissue	N		<a href="#">On-line Fee Schedules</a>
D7520	incision and drainage of abscess – extraoral soft tissue	N		
D7530	removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	Y		
D7960	frenulectomy (frenectomy or frenotomy) – separate procedure	N	Clients through age six. Arch designation required.	
D7960	frenulectomy (frenectomy or frenotomy) – separate procedure	Y	Clients ages 7-12. Arch designation required.	
D7963	frenuloplasty	N	Clients through age six. Arch designation required.	
D7963	frenuloplasty	Y	Clients age 7-12. Arch designation required.	

**Occlusal Orthotic Devices**

HRSA covers:

- Occlusal orthotic devices for clients ages 12-20 only on a case-by-case basis and when prior authorized.
- An occlusal orthotic device only as a laboratory processed full arch appliance.

**Note:** Refer to “What adjunctive general services are covered?” for occlusal guard coverage and limitations on coverage.

<b>Code</b>	<b>Description</b>	<b>PA?</b>	<b>Maximum Allowable Fee</b>
D7880	occlusal orthotic device, by report	Y	<a href="#">On-line Fee Schedules</a>

**What orthodontic services are covered?** [Refer to WAC 388-535-1096]

HRSA covers orthodontic services, subject to the coverage limitations listed, for clients through age 20 according to HRSA's *Orthodontic Services Billing Instructions*.

## What adjunctive general services are covered?

[Refer to WAC 388-535-1098]

HRSA covers medically necessary dental-related adjunctive general services, subject to the coverage limitations listed, for clients through age 20 as follows:

### Unclassified Treatment

HRSA covers palliative (emergency) treatment, not to include pulpal debridement (D3221), for treatment of dental pain, limited to once per day, per client, as follows:

- The treatment must occur during limited evaluation appointments;
- A comprehensive description of the diagnosis and services provided must be documented in the client's record; and
- Appropriate radiographs must be in the client's record supporting the medical necessity of the treatment.

Code	Description	PA?	Maximum Allowable Fee
D9110	palliative (emergency) treatment of dental pain – minor procedure	N	<a href="#">On-line Fee Schedules</a>

### Anesthesia

HRSA:

- Covers local anesthesia and regional blocks as part of the global fee for any procedure being provided to clients.
- Covers office-based oral or parenteral conscious sedation, deep sedation, or general anesthesia, as follows:
  - ✓ The provider's current anesthesia permit must be on file with HRSA.
  - ✓ For clients of DDD, the services must be performed according to Section D.
  - ✓ For clients ages eight and younger, documentation supporting the medical necessity of the anesthesia service must be in the client's record.

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- ✓ For clients ages 9-20, deep sedation or general anesthesia services are covered on a case-by-case basis and when prior authorized, **except for oral surgery services**. Office-based general anesthesia for oral surgery services listed in “What oral and maxillofacial surgery services are covered?” does not require PA.
  - ✓ PA is not required for oral or parenteral conscious sedation for any dental service. Documentation supporting the medical necessity of the service must be in the client's record.
  - ✓ For clients ages 9-18 who have a diagnosis of oral facial cleft, HRSA does not require PA for deep sedation or general anesthesia services when the dental procedure is directly related to the oral facial cleft treatment.
  - ✓ For clients through age 20, the provider must bill anesthesia services using the CDT codes listed in this section.
- Covers inhalation of nitrous oxide for clients through age 20, once per day.
  - Requires providers of oral or parenteral conscious sedation, deep sedation, or general anesthesia to meet:
    - ✓ The prevailing standard of care;
    - ✓ The provider's professional organizational guidelines;
    - ✓ The requirements in Chapter 246-817 WAC; and
    - ✓ Relevant department of health (DOH) medical, dental, or nursing anesthesia regulations.
  - Pays for anesthesia services according to WAC 388-535-1350.

Code	Description	PA?	Maximum Allowable Fee
D9220	deep sedation/general anesthesia	*	<a href="#">On-line Fee Schedules</a>
D9230	analgesia, anxiolysis, inhalation of nitrous oxide	N	
D9241	intravenous conscious sedation/analgesia	N	
D9248	non-intravenous conscious sedation	N	

**Note:** When general anesthesia (including deep sedation) is administered by:

- The attending dentist, HRSA reimburses at the rate of 50% of the maximum allowable rate.
- A provider other than the attending dentist, HRSA reimburses at the maximum allowable rate.

\*See coverage criteria.

## Billing Anesthesia

- When billing for general anesthesia, show the beginning and ending times on the claim form in the Description of Service field on the ADA Claim Form. State the total number of minutes on the claim. Anesthesia time begins when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent) and ends when the anesthesiologist or CRNA is no longer in constant attendance (e.g., when the patient can be safely placed under post-operative supervision).
- You must enter the name of the provider who administered the anesthesia in the *Remarks* field of the claim form, if that provider is different from the billing provider.

## Non-emergency Dental Services

HRSA covers non-emergency dental services performed in a hospital or ambulatory surgical center only for:

- Clients ages eight and younger.
- Clients ages 9-20 only on a case-by-case basis and when prior authorized.
- Clients of DDD according to Section D.

## Professional Visits

HRSA covers:

- A consultation – diagnostic service provided by a dentist or physician other than the requesting dentist or physician when requested by HRSA.
- Up to two house/extended care facility (alternate living facility) calls (visits) per facility, per provider. HRSA limits payment to two facilities per day, per provider.
- One hospital call (visit), including emergency care, per day, per provider, per client.
- An emergency office visit after regularly scheduled hours. HRSA limits payment to one emergency visit per day, per provider.

## Dental Program for Clients Through Age 20

Code	Description	PA?	Maximum Allowable Fee
D9310	consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	N	<a href="#">On-line Fee Schedules</a>
D9410	house/extended care facility call	N	
D9420	hospital call	N	
D9440	office visit – after regularly scheduled hours	N	

### Drugs

HRSA covers drugs and/or medicaments only when used with parenteral conscious sedation, deep sedation, or general anesthesia. HRSA's dental program does not pay for oral sedation medications.

Code	Description	PA?	Maximum Allowable Fee
D9610	therapeutic parenteral drug, single administration	N	<a href="#">On-line Fee Schedules</a>
D9612	therapeutic parenteral drugs, two or more administrations, different medications	N	
D9630	other drugs and/or medicaments, by report	N	

### Miscellaneous Services

HRSA covers:

- Behavior management when the assistance of one additional dental staff other than the dentist is required, for:
  - ✓ Clients ages eight and younger;
  - ✓ Clients ages 9-20, only on a case-by-case basis and when prior authorized; and
  - ✓ **Clients of DDD (refer to Section D) or clients residing in an alternative living facility.**

**Note:** For clients residing in an alternative living facility, documentation supporting the medical necessity of the billed procedure code must be in the client's record.

- Treatment of post-surgical complications (e.g., dry socket). Documentation supporting the medical necessity of the service must be in the client's record.

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- Occlusal guards when medically necessary and prior authorized. (Refer to “What oral and maxillofacial surgery services are covered?” for occlusal orthotic device coverage and coverage limitations.) HRSA covers:
  - ✓ An occlusal guard only for clients ages 12-20 when the client has permanent dentition; and
  - ✓ An occlusal guard only as a laboratory processed full arch appliance.

Code	Description	PA?	Maximum Allowable Fee
D9920	behavior management	N	<a href="#">On-line Fee Schedules</a>
D9930	treatment of complications (post-surgical) – unusual circumstances	N	
D9940	occlusal guard, by report	Y	

## What dental-related services are not covered for clients through age 20? [Refer to WAC 388-535-1100(1) (2)]

### What is not covered?

HRSA does not cover the following for clients through age 20:

- The dental-related services described in “Noncovered Services by Category” unless the services include those medically necessary services and other measures provided to correct or ameliorate conditions discovered during a screening performed under the early periodic screening, diagnosis and treatment (EPSDT) program. See HRSA’s *EPSDT Billing Instructions* for information about the EPSDT program.
- Any service specifically excluded by statute.
- More costly services when less costly, equally effective services as determined by HRSA are available.
- Services, procedures, treatments, devices, drugs, or application of associated services:
  - ✓ Which HRSA or the Centers for Medicare and Medicaid Services (CMS) considers investigative or experimental on the date the services were provided; or
  - ✓ That are not listed as covered in one or both of the following:
    - Washington Administrative Code (WAC); or
    - HRSA's current published documents.

### Noncovered Services by Category

HRSA does not cover dental-related services listed under the following categories of service for clients through age 20 (see “What is not covered?” (see above) for services provided under the EPSDT program):

#### Diagnostic Services

HRSA does not cover:

- Extraoral radiographs, excluding panoramic or cephalometric films; or
- Comprehensive periodontal evaluations.

## Preventive Services

HRSA does not cover:

- Nutritional counseling for control of dental disease;
- Tobacco counseling for the control and prevention of oral disease;
- Removable space maintainers of any type;
- Sealants placed on a tooth with the same-day occlusal restoration, pre-existing occlusal restoration, or a tooth with occlusal decay;
- Space maintainers for clients ages 19-20; or
- Fluoride trays of any type.

## Restorative Services

HRSA does not cover:

- Gold foil restorations;
- Metallic, resin-based composite, or porcelain/ceramic inlay/onlay restorations;
- Crowns for cosmetic purposes (e.g., peg laterals and tetracycline staining);
- Crowns for third molars 1, 16, 17, and 32;
- Temporary or provisional crowns (including ion crowns);
- Labial veneer resin or porcelain laminate restorations;
- Sedative fillings;
- Any type of coping;
- Crown repairs; or
- Polishing or recontouring restorations or overhang removal for any type of restoration.

## Endodontic Services

HRSA does not cover:

- Indirect or direct pulp caps;
- Any endodontic therapy on primary teeth, except endodontic treatment with resorbable material for primary maxillary incisor teeth D, E, F, and G, if the entire root is present at treatment;
- Apexification/recalcification for root resorption of permanent anterior teeth;
- Any apexification/recalcification procedures for bicuspid or molar teeth;
- Any apicoectomy/periradicular services for bicuspid or molar teeth; or
- Any surgical endodontic procedures including, but not limited to, retrograde fillings (except for anterior teeth), root amputation, reimplantation, and hemisections.

## Periodontic Services

HRSA does not cover:

- Surgical periodontal services including, but not limited to:
  - ✓ Gingival flap procedures;
  - ✓ Clinical crown lengthening;
  - ✓ Any type of periodontal osseous surgery;
  - ✓ Bone or soft tissue grafts;
  - ✓ Biological material to aid in soft and osseous tissue regeneration;
  - ✓ Guided tissue regeneration;
  - ✓ Pedicle, free soft tissue, apical positioning, subepithelial connective tissue, soft tissue allograft, combined connective tissue and double pedicle, or any other soft tissue or osseous grafts; or
  - ✓ Distal or proximal wedge procedures.

- Nonsurgical periodontal services including, but not limited to:
  - ✓ Intracoronal or extracoronar provisional splinting.
  - ✓ Full mouth debridement.
  - ✓ Localized delivery of chemotherapeutic agents.
  - ✓ Any other type of nonsurgical periodontal service.

### **Removable Prosthodontics**

HRSA does not cover:

- Removable unilateral partial dentures;
- Any interim complete or partial dentures;
- Precision attachments; or
- Replacement of replaceable parts for semi-precision or precision attachments.

### **Implant Services**

HRSA does not cover:

- Any type of implant procedures, including, but not limited to, any tooth implant abutment (e.g., periosteal implant, eposteal implant, and transosteal implant), abutments or implant supported crown, abutment supported retainer, and implant supported retainer.
- Any maintenance or repairs to the implant procedures listed in above bullet.
- The removal of any implant as described in the above bullets.

### **Fixed Prosthodontics**

HRSA does not cover:

- Any type of fixed partial denture pontic or fixed partial denture retainer.
- Any type of precision attachment, stress breaker, connector bar, coping, cast post, or any other type of fixed attachment or prosthesis.

## Oral and Maxillofacial Surgery

HRSA does not cover:

- Any oral surgery service that is not listed in HRSA's list of covered dental CPT codes published in HRSA's current rules or billing instructions; or
- Any oral surgery service not listed in “What oral and maxillofacial surgery services are covered?”

## Adjunctive General Services

HRSA does not cover:

- Anesthesia, including, but not limited to:
  - ✓ Local anesthesia as a separate procedure;
  - ✓ Medication for oral sedation, or therapeutic intramuscular (IM) drug injections, including antibiotic and injection of sedative;
  - ✓ Regional block anesthesia as a separate procedure; or
  - ✓ Trigeminal division block anesthesia as a separate procedure.
- Other general services including, but not limited to:
  - ✓ Application of any type of desensitizing medicament or resin;
  - ✓ Dental supplies, including but not limited to items such as toothbrushes;
  - ✓ Dentist's or dental hygienist's time writing or calling in prescriptions;
  - ✓ Dentist's time consulting with clients on the phone;
  - ✓ Educational supplies;
  - ✓ Enamel microabrasion;
  - ✓ Fabrication of athletic mouthguard, occlusal guard, or nightguard;
  - ✓ Fees for no-show, cancelled, or late arrival appointments;
  - ✓ Nonmedical equipment or supplies;
  - ✓ Occlusal adjustment or odontoplasties;
  - ✓ Occlusion analysis;
  - ✓ Office supplies used in conjunction with an office visit;
  - ✓ Personal comfort items or services;
  - ✓ Provider mileage or travel costs;
  - ✓ Service charges of any type, including fees to create or copy charts; or
  - ✓ Teeth whitening services or bleaching, or materials used in whitening or bleaching.

# Clients of the Division of Developmental Disabilities

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## Clients Eligible for Enhanced Services

Clients of the Division of Developmental Disabilities (DDD) may be entitled to more frequent services.

These individuals will have an "XX" in the "DD" column of their Medical ID Card. Individuals lacking the DD information on their Medical ID Card are not eligible for the additional services. If you believe that a patient may qualify for these services, refer the individual or the patient's guardian to the nearest Developmental Disabilities Office (see list below).

### Division of Developmental Disabilities Field Offices

#### **Region 1**

1611 West Indiana Ave  
MS: B32-28  
Spokane WA 99205-4221  
509.456.2893  
509.456.4256 FAX  
800.462.0624

#### **Region 2**

1002 N. 16<sup>th</sup> Avenue  
MS: B39-7  
Yakima WA 98909-2500  
509.225.7970  
509.575.2326 FAX  
800.822.7840

#### **Region 3**

840 N. Broadway  
Building A, Suite 100  
MS: N31-11  
Everett, WA 98201-1296  
425.339.4833  
425.339.4856 FAX  
800.788.2053

#### **Region 4**

1700 East Cherry Street  
MS: N46-6  
Seattle WA 98122-4695  
206.568.5700  
206.720.3334 FAX  
800.314.3296

#### **Region 5**

1305 Tacoma Avenue S., Suite 300  
MS: N27-6  
Tacoma WA 98402  
253.593.2812  
253.597.4368 FAX  
800.248.0949

#### **Region 6**

Airustrial Park, Bldg. 6  
MS: 45315  
PO Box 45315  
Olympia, WA 98504-5315  
360.753.4673  
360.586.6502 FAX  
800.339.8227

*If you have any problems contacting these field offices, call Connie Mix-Clark DDD state office, at 360.725.3455 or email at [clarkcl@dshs.wa.gov](mailto:clarkcl@dshs.wa.gov).*

## What additional dental-related services are covered for clients of the Division of Developmental Disabilities (DDD)?

[Refer to WAC 388-535-1099]

HRSA pays for dental-related services under the categories of services listed in this section for clients of DDD, subject to the coverage limitations listed. HRSA's *Dental Program for Clients Through Age 20 Billing Instructions* apply to clients of DDD unless otherwise stated in this section.

### Preventive Services

#### Dental Prophylaxis

HRSA covers dental prophylaxis up to three times in a 12-month period (see "Periodontic Services" in this section for limitations on periodontal scaling and root planing).

#### Topical Fluoride Treatment

HRSA covers topical fluoride varnish, rinse, foam or gel, up to three times within a 12-month period per client, per provider or clinic.

#### Sealants

HRSA covers sealants:

- Only when used on the occlusal surfaces of:
  - ✓ Primary teeth A, B, I, J, K, L, S, and T; or
  - ✓ Permanent teeth 2, 3, 4, 5, 12, 13, 14, 15, 18, 19, 20, 21, 28, 29, 30, and 31.
- Once per tooth in a two-year period.

### Crowns

HRSA covers stainless steel crowns every two years for the same tooth and only for primary molars and permanent premolars and permanent molars for clients through age 20. Documentation supporting the medical necessity of the service must be in the client's record.

## Periodontic Services

### Surgical Periodontal Services

HRSA covers:

- Gingivectomy/gingivoplasty once every three years. Documentation supporting the medical necessity of the service must be in the client's record (e.g., drug induced gingival hyperplasia).
- Gingivectomy/gingivoplasty with periodontal scaling and root planing or periodontal maintenance when the services are performed:
  - ✓ In a hospital or ambulatory surgical center; or
  - ✓ For clients under conscious sedation, deep sedation, or general anesthesia.

### Nonsurgical Periodontal Services

HRSA covers:

- Periodontal maintenance up to 3 times in a 12-month period; and
- Periodontal scaling and root planing, up to two times per quadrant in a 12-month period.

**Note:** If a periodontal maintenance or oral prophylaxis occurs in a 12-month period, it replaces an allowed periodontal scaling and root planing (four quadrants).

**Note:** A maximum of three procedures of any combination of prophylaxis, periodontal scaling and root planing, or periodontal maintenance are allowed in a 12-month period.

## Adjunctive General Services

HRSA covers:

- Oral parenteral conscious sedation, deep sedation, or general anesthesia for any dental services performed in a dental office or clinic. Documentation supporting the medical necessity must be in the client's record.
- Sedation services according to “What adjunctive general services are covered?”

## Non-emergency Dental Services

**Note:** A maximum of three procedures of any combination of prophylaxis, periodontal scaling and root planing, or periodontal maintenance are allowed in a 12-month period.

Documentation supporting the medical necessity of the service must be included in the client's record.

## Miscellaneous Services-Behavior Management

HRSA covers behavior management provided in dental offices, dental clinics, or alternative living facilities for clients of any age. Documentation supporting the medical necessity of the service must be included in the client's record.

# Authorization

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**Prior authorization (PA) and expedited prior authorization (EPA) numbers do not override the client's eligibility or program limitations. Not all categories of eligibility receive all services.**

## General Information about Authorization

[Refer to WAC 388-535-1220 (1) and (5)]

- For clients through age 20, HRSA uses the determination process for payment described in WAC 388-501-0165 for covered dental-related services that require PA.
- When HRSA authorizes a dental-related service for a client, that authorization indicates only that the specific service is medically necessary; it is not a guarantee of payment.
- The authorization is valid for six months and only if the client is eligible for covered services on the date of service.

## When do I need to get PA?

Authorization must take place *before* the service is provided.

In an acute emergency, HRSA *may* authorize the service after it is provided when HRSA receives justification of medical necessity. This justification must be received by HRSA within seven business days of the emergency service.

## When does HRSA deny a PA request? [Refer to WAC 388-535-1220 (6)]

HRSA denies a request for a dental-related service when the requested service:

- Is covered by another DSHS program;
- Is covered by an agency or other entity outside DSHS; or
- Fails to meet the program criteria, limitations, or restrictions in these billing instructions.

## How do I obtain written PA?

[Refer to WAC 388-535-1220 (2)-(4)]

HRSA requires a dental provider who is requesting PA to submit sufficient, objective, clinical information to establish medical necessity.

**Providers must submit the request in writing on a completed ADA Claim Form and include the following:**

- The client's patient identification code (PIC);
- Provider's name and address;
- Provider's telephone number (including area code); and
- Provider's assigned 7-digit HRSA provider number.

**Note:** Refer to Section G, Completing the ADA Claim Form.

**HRSA may request additional information as follows:**

- Additional radiographs (x-rays). HRSA returns radiographs only for approved requests and if accompanied by self-addressed stamped envelope;
- Study model, if requested;
- Photographs; and
- Any other information requested by HRSA.

**Note:** HRSA may require second opinions and/or consultations before authorizing any procedure.

If HRSA approves the request, HRSA will return the ADA Dental Claim Form to the provider with an authorization number. ***Complete this original form*** and submit it for payment. Providers should keep a copy for their records.

## Removable Dental Prosthetics

For nursing facility clients, the PA request must also include a completed copy of the Denture/Partial Appliance Request for Skilled Nursing Facility Client form [DSHS 13-788].

**Note:** For information on obtaining DSHS forms, refer to the Important Contacts section.

## Where do I send requests for PA?

**Starting April 1, 2007**, HRSA will accept all requests for dental PA by fax or mail without radiographs from providers who utilize the data storage services offered by National Electronic Attachment, Inc. (NEA).

Once enrolled with NEA, submit all requests with the NEA claim number noted in the remarks section of the ADA claim form. This will allow HRSA to access and review the radiographs electronically.

### **FastAttach™**

**FastAttach** enables dental offices to electronically transmit x-rays, periodontal charts, intraoral photos, EOBs and any other required information for insurance carriers to view in support of electronic claims.

Register by visiting [www.nea-fast.com](http://www.nea-fast.com) and entering “FastWDSHS” in the blue promotion code box. Contact NEA at 800.782.5150 ext. 2 with any questions.

### **Providers who do not register with NEA must send requests and documentation to:**

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

### **For procedures that do not require radiographs:**

Fax: 360.725.2123

## EPA Criteria for Limited Visual Oral Assessment (D9999)

When billing for this code (D9999) and placing the assigned EPA # **870000998** onto the ADA claim form, a provider is verifying that the assessment is:

- Performed to determine the need for sealants, fluoride treatment, and triage services when provided in **settings other than dental offices or clinics** (e.g., school-based programs, alternative living facilities, etc.);
- Not performed in conjunction with other clinical oral evaluation services; and
- Provided by a licensed dentist or licensed dental hygienist.

This procedure also includes appropriate referrals, charting, patient data and oral health status, and informing the client, parent, or guardian of the results.

# Billing

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## Hospital Billing

HRSA covers medically necessary dental-related services provided to an eligible client in a hospital-based dental clinic when the services:

- Are provided in accordance with Chapter 388-535 WAC; and
- Are billed on an ADA or 1500 Claim Form.

HRSA pays a hospital for covered dental-related services, including oral and maxillofacial surgeries, that are provided in the hospital's operating room when:

- The covered dental-related services are medically necessary and provided in accordance with Chapter 388-535 WAC;
- The covered dental-related services are billed on a UB claim form; and
- At least one of the following is true:
  - ✓ The dental-related service(s) is provided to an eligible medical assistance client on an emergency basis;
  - ✓ The client is eligible under the DDD program;
  - ✓ The client is age eight or younger; or
  - ✓ The dental service is prior authorized by HRSA.

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

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

- **Initial Claims**

- ✓ HRSA requires providers to submit an **initial claim** to HRSA 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 HRSA to cover the services; or
  - The date DSHS certifies a client eligible under delayed<sup>1</sup> certification criteria.

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

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<sup>1</sup> **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 HRSA 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 HRSA for the service.

## Dental Program for Clients Through Age 20

- ✓ HRSA 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<sup>2</sup> period; or
  - The provider proves to HRSA's satisfaction that there are other extenuating circumstances.
- ✓ HRSA requires providers to bill known third parties for services. See page F6 and/or WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to HRSA'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:** HRSA 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 HRSA by claim adjustment. The provider must refund overpayments to HRSA 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
  - ✓ HRSA does not pay the claim.

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

## What fee should I bill HRSA for eligible clients?

Bill HRSA your usual and customary charge.

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<sup>2</sup> **Retroactive Certification:** An applicant receives a service, then applies to HRSA 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 HRSA 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 HRSA.

## How do I bill for clients eligible for both Medicare and Medicaid?

Medicare does not cover *dental procedures*. **Surgical** CPT procedure codes 10000-69999 must be billed to Medicare first. After receiving Medicare's determination, submit a claim to HRSA. Attach a copy of the Medicare determination.

## When can I bill an HRSA 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 HRSA does not pay for the service because the provider failed to satisfy the conditions of payment in HRSA 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 HRSA;
  - 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 HRSA at the time it was provided, even if HRSA did not pay the provider for the service because the provider did not satisfy HRSA'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);

## Dental Program for Clients Through Age 20

- 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 HRSA. [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 HRSA 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 HRSA 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 HRSA;
- 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 HRSA 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 community alternatives program (CAP).

## Dental Program for Clients Through Age 20

4. If a client becomes eligible for a covered service that has already been provided because the client:
    - a. Applied to HRSA 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 HRSA for the service;
    - b. Receives a delayed certification (see footer on page G.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 HRSA for the service; or
- 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.
- c. Receives a retroactive certification (see footer on page G.2), 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 HRSA for the service.
5. Hospitals may not bill, demand, collect, or accept payment from a medically indigent, 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 in subsection 3.g. of this section.

6. A provider may not bill, demand, collect, or accept payment from a client, anyone on the client's behalf, or HRSA 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, you may elect to bill HRSA directly and HRSA 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 HRSA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as HRSA's, prior to any payment by HRSA.

You must meet HRSA'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 HRSA 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 HRSA, or if you have reason to believe that HRSA may make an additional payment:

- Submit a completed dental claim form to HRSA;
- Attach the insurance carrier's statement or EOB;
- If rebilling, also attach a copy of the HRSA 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-HRSA web site at <http://maa.dshs.wa.gov>. The information can be used as an on-line reference, downloaded, or printed. If you do not have access to HRSA's web site, call 800.562.6136 and request that a hard copy or disk be mailed to you.

## What must I keep in a client's record?

[Refer to WAC 388-502-0020]

In addition to the specific documentation required for the Dental Program that is listed throughout this billing instruction, enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client according to Chapter 388-502 WAC
- 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.

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

**Note:** Medical justification is required for all procedures. Missing documentation in the client's record may result in HRSA recouping payment(s) from the provider.

## Notifying Clients of their Rights (Advance Directives)

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

## Fee Schedules

- You may access HRSA's Dental Fee Schedule at:  
<http://maa.dshs.wa.gov/RBRVS/Index.html>.
- To access HRSA's Oral Surgery Fee Schedule:
  - ✓ **Procedure codes** may be found in the Dental Fee Schedule at the above address.
  - ✓ **Maximum allowable fees** may be found in the Physician-Related Services Fee Schedule at the above address.

**Note:** Bill HRSA your usual and customary charge.

# 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
<b>HEADER INFORMATION</b>		
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.
<b>INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION</b>		
3.	Company/Plan Name, Address, City, State, Zip Code	Enter the address for DSHS that is listed in the shaded box on page D.1.
<b>OTHER COVERAGE</b>		
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.
<b>POLICYHOLDER/SUBSCRIBER INFORMATION</b>		
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.
<b>PATIENT INFORMATION</b>		
18.	Relationship to Policyholder/Subscriber	Check the appropriate box.

## Dental Program for Clients Age 21 and Older

Field No.	Name	Entry
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### PATIENT INFORMATION (cont.)

20.	Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code	Enter the client's legal name, address, and <b>Patient Identification Code (PIC)</b> .
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

<b>Each service performed</b> must be listed as a separate, complete one-line entry. <b>Each extraction or restoration</b> 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	<p>If the procedure code requires an arch or a quadrant designation, enter the appropriate arch or quadrant as follows:</p> <p>01 Maxillary area            02 Mandibular area            10 Upper right quadrant            20 Upper left quadrant            30 Lower left quadrant            40 Lower right quadrant</p>
26.	Tooth system	Not used.
27.	Tooth Number(s) or Letter(s)	<p>If the procedure code requires a tooth designation, enter the appropriate tooth number or letter (only one tooth may be billed per line).</p> <ul style="list-style-type: none"> <li>• 01 through 32 for permanent teeth</li> <li>• A through T for primary teeth</li> <li>• 51 through 82 or AS through TS for supernumerary teeth</li> </ul>
28.	Tooth Surface	<p>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:</p> <p>B = Buccal            D = Distal            F = Facial            I = Incisal            L = Lingual            M = Mesial            O = Occlusal</p>

**Dental Program for Clients Age 21 and Older**

Field No.	Name	Entry
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<b>RECORD OF SERVICES PROVIDED (cont.)</b>		
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29.	Procedure Code	Enter the appropriate (2007 CDT) procedure code that represents the procedure or service performed. <b>The use of any other procedure code(s) will result in denial of payment.</b>
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 <b>your usual and customary fee</b> (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	<p>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 <b><i>Provider Number</i></b> 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.</p> <p>To indicate a payment by another plan, enter "insurance payment" and the amount. Attach the insurance EOB to the claim.</p>

**Dental Program for Clients Age 21 and Older**

Field No.	Name	Entry
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**ANCILLARY CLAIM/TREATMENT INFORMATION**

38.	Place of Treatment	<p>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:</p> <table border="0"> <thead> <tr> <th align="left"><u>Box checked</u></th> <th align="left"><u>Place of Service (POS)</u></th> </tr> </thead> <tbody> <tr> <td>Office</td> <td>Dental office (POS 11)</td> </tr> <tr> <td>Hospital</td> <td>Outpatient hospital (POS 22)</td> </tr> <tr> <td>ECF</td> <td>Skilled nursing facility (POS 31)</td> </tr> <tr> <td>Other</td> <td>DSHS will not allow place of service "other" without a two digit place of service indicated.</td> </tr> </tbody> </table> <p>If the services rendered are not in one of the places of service as indicated above, then the two-digit POS <b>must</b> be indicated in field 38.</p> <p>DSHS considers the following places of service for dental claims (not all services are covered in all places of service)</p> <table border="0"> <tbody> <tr> <td><b>Office</b></td> <td><b>11</b></td> <td>dental office</td> </tr> <tr> <td rowspan="3"><b>Hosp</b></td> <td><b>21</b></td> <td>inpatient hospital</td> </tr> <tr> <td><b>22</b></td> <td>outpatient hospital</td> </tr> <tr> <td><b>23</b></td> <td>hospital emergency room</td> </tr> <tr> <td rowspan="3"><b>ECF</b></td> <td><b>31</b></td> <td>skilled nursing facility</td> </tr> <tr> <td><b>32</b></td> <td>nursing facility</td> </tr> <tr> <td><b>54</b></td> <td>intermediate care facility/mentally retarded</td> </tr> <tr> <td rowspan="5"><b>Other</b></td> <td><b>03</b></td> <td>school-based services</td> </tr> <tr> <td><b>12</b></td> <td>client's residence</td> </tr> <tr> <td><b>24</b></td> <td>professional services in an ambulatory surgery center</td> </tr> <tr> <td><b>50</b></td> <td>federally qualified health center</td> </tr> <tr> <td><b>71</b></td> <td>state or public health clinic (department)</td> </tr> </tbody> </table> <p>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.</p>	<u>Box checked</u>	<u>Place of Service (POS)</u>	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.	<b>Office</b>	<b>11</b>	dental office	<b>Hosp</b>	<b>21</b>	inpatient hospital	<b>22</b>	outpatient hospital	<b>23</b>	hospital emergency room	<b>ECF</b>	<b>31</b>	skilled nursing facility	<b>32</b>	nursing facility	<b>54</b>	intermediate care facility/mentally retarded	<b>Other</b>	<b>03</b>	school-based services	<b>12</b>	client's residence	<b>24</b>	professional services in an ambulatory surgery center	<b>50</b>	federally qualified health center	<b>71</b>	state or public health clinic (department)
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## Dental Program for Clients Age 21 and Older

Field No.	Name	Entry
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### ANCILLARY CLAIM/TREATMENT INFORMATION (cont.)

39.	Number of Enclosures (00 to 99)	Check the appropriate box.  <b>Note:</b> 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 <i>must be completed</i> 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. <b>Without this number your claim will be denied.</b>
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.

