COMMUNITY HEALTH PLAN of Washington™

# Apple Health Dental Services

Prior to January 1, 2020, all dental services for Apple Health enrollees were billed to the Washington State Health Care Authority (HCA) as fee-for-service (FFS).

Effective with dates of service on and after January 1, 2020, some services are billed to the Apple Health enrollee's managed care organization.

Bill to CHPW:

- Hospital facility charges for inpatient dental services must be billed directly to CHPW. Authorization is required. See the authorization requirements below.
- Hospital facility charges for outpatient and emergency room department for dental services, must be on the HCA Outpatient Prospective Payment System (OPPS) fee schedule. Allowed CDT codes are included in the schedule and must be billed to CHPW. CDT codes not in the OPPS fee schedule are not covered and will be denied.
- Ambulatory Surgery Center (ASC) charges for dental services, must be on the HCA ASC fee schedule and billed to CHPW. Allowed CDT codes are included in the ASC fee schedule. CDT codes not in the ASC fee schedule are not covered and will be denied.
- CHPW covers one primary care provider (PCP) pre-operative evaluation and management (E/M) visit for medical clearance when the member will be under anesthesia when receiving the dental services.
- Dental prescriptions must be billed directly to CHPW.
- Access to Baby & Child Dentistry (ABCD)/Mouth Matters program services provided by a non-dental provider for eligible members must be billed directly to CHPW. **See "Access to Baby & Child Dentistry (ABCD)" below for coding information.**

The following will continue to be billed to the HCA via FFS:

- Dental professional fees billed using CDT codes.
- Dental and/or oral surgeon professional fees using a CPT code and provider taxonomy starting with 12.
- Dental services performed by tribal health providers, both Indian Health Service facilities and tribally operated clinics.

Enrollees of the Apple Health FFS (HCA) program have no billing changes.

## Authorizations

HCA requires authorization for inpatient admission for dental diagnosis. Providers can include the authorization number in the claim or send a copy of the authorization with their claim.

Authorizations are not required for facility charges related to the following common, routine dental services:

- Members age eight (8) years old and younger at date of service.
- Members identified in ProviderOne with a Developmental Disabilities Administration (DDA) indicator.
- These specific cleft palate surgeries/CPT codes performed in an inpatient, outpatient, or Ambulatory Service Center (ASC) setting: 42200, 42205, 42210, 42215, 42225, 42226, 42227, 42235, 42260, 42280, and 42281 with a diagnosis of cleft palate.

Refer to the Procedure Code Lookup Tool and Prior Authorization List for complete information.

## Access to Baby & Child Dentistry (ABCD)/Mouth Matters Program

The Access to Baby & Child Dentistry (ABCD)/Mouth Matters program is for Medicaid-eligible clients ages five (5) years old and younger, and for clients of the Developmental Disabilities Administration (DDA) through age 12.

ABCD certified, primary care providers must bill Family Oral Health Education (FOHE), application of topical fluoride, and periodic oral evaluations with the following CPT codes and modifier:

- 99188 with modifier DA: Application of Topical Fluoride Varnish
- 99499 with modifier DA: Unlisted E&M Service – to be used for Periodic Oral Evaluations
- 99429 with modifier DA: Unlisted preventative service – to be used for FOHE by PCP

For more information about becoming a certified Mouth Matters provider, please email or call the Arcora Foundation, mcaplow@arcorafoundation.org or 206-473-9542.

## Questions?

If you have questions about the changes for dental services, please call CHPW Apple Health Customer Service at 800-440-1561.