Washington State Health Care Authority

Washington Apple Health (Medicaid)

Access to Baby and Child Dentistry/Mouth Matters Billing Guide

(For clients through age 5 and for clients age 0 through 12 with disabilities)

January 1, 2022

Washington State Health Care Authority

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and a Health Care Authority rule arises, the rule applies.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If this is the most recent guide, please notify us at askmedicaid@hca.wa.gov.

About this guide*

This publication takes effect **January 1, 2022,** and supersedes earlier billing guides to this program. Unless otherwise specified, the program in this guide is governed by the rules found in WAC 182-535-1245.

The Health Care Authority is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

> Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

Refer also to HCA's ProviderOne billing and resource guide for valuable information to help you conduct business with the Health Care Authority.

> * To align with WAC 182-535-1245, the expansion of the ABCD program is specific to clients age 0 through 12 with disabilities and have a Developmental Disabilities Administration (DDA) indicator.

How can I get HCA Apple Health provider documents?

To access provider alerts, go to HCA's provider alerts webpage.

To access provider documents, go to HCA's provider billing guides and fee schedules webpage.

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* This publication is a billing instruction.

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Where can I download HCA forms?

To download an HCA form, see HCA's **Forms & Publications** webpage. Type only the form number into the Search box (Example: 13-835).

Copyright disclosure

What has changed?

Subject	Change	Reason for Change
Title	Added "and clients age 0 through 12 with disabilities" Added MouthMatters to the title of the guide	To align with ABCD expansion program and WAC 182-535-1245 This is the medical extension of ABCD
Note box	Added note box for clients age 0 through 12 with disabilities	To clarify the ABCD expansion program is specific to clients who have a Developmental Disabilities Administration (DDA) indicator
Definitions	Added definition for the Developmental Disabilities Administration (DDA)	ABCD expansion program includes eligible clients with a DDA indicator – definition is a reference for the DDA program

Subject	Change	Reason for Change
What is the ABCD/MouthMatters Program	Added language "and clients of the Developmental Disabilities Administration (DDA) through age 12"	To align with ABCD expansion program and WAC 182-535-1245
Note box	Added note box with explanation of eligible children	To clarify ABCD expansion is inclusive of clients age 0 through 12 enrolled in DDA waiver program and possess a DDA indicator
What is the ABCD/MouthMatters Program	Added The Washington State Dental Hygiene Association to list of partnerships	Aligns with legislation that added dental hygienists as allowed providers
Who may provide ABCD dentistry	Added dental hygienists to the list and in the table	To align with legislation to add dental hygienists as allowed providers
Who is eligible	Added "and DDA clients through age 12"	To align with ABCD expansion program and WAC 182-535-1245
	Added a note box to explain where to find if the client as a DDA indicator – added link to the ProviderOne Billing and Resource Guide	Clarification for providers
EPA procedure code list	Added "or a DDA client through age 12 or younger"	To align with ABCD expansion program and WAC 182-535-1245

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Definitions

This list defines terms and abbreviations, including acronyms, used in this guide.

Access to Baby and Child Dentistry (ABCD) – A program to increase access to dental services for Medicaid-eligible clients age five and younger.

Anterior – The maxillary and mandibular incisors, 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.

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 medical code set used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations.

Dental Home – The ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated and family-centered way. Establishment of a dental home begins no later than 12 months of age and includes referrals to specialists when appropriate.

Developmental Disabilities Administration (DDA) – The administration within the Department of Social and Health Services responsible for administering and overseeing services and programs for clients with developmental disabilities. Formerly known as the Division of Developmental Disabilities.

Interim therapeutic restoration (ITR) – The placement of an adhesive restorative material following caries debridement by hand or other method for the management of early childhood caries. ITR is not considered a definitive restoration. (WAC 182-535-1050)

MouthMatters – The name of the medical extension of the ABCD program.

Posterior – The maxillary and mandibular incisors and canines and tissue in the front 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.

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About the Program

(WAC 182-535-1245)

What is the ABCD/MouthMatters Program?

The Access to Baby and Child Dentistry (ABCD)/MouthMatters program was established to increase access to dental services for Medicaid-eligible clients through age 5 and clients of the Developmental Disabilities Administration (DDA) through age 12. The program's goal is to ensure that positive dental experiences in early childhood will lead to lifelong practices of good oral health. This is done in part by identifying and removing obstacles to early preventive treatment, such as the lack of transportation to a dental office, language interpretation issues, etc. (See How does the ABCD program work?).

> **Note**: For the purpose of this program, children with disabilities are defined as children age 0 through 12 who are enrolled in the Developmental Disabilities Administration (DDA) waiver program and possess a DDA indicator.

The ABCD/MouthMatters program is a partnership between the public and private sectors, including:

- The Health Care Authority.
- The Washington State Department of Health.
- The University of Washington School of Dentistry.
- Arcora Foundation.
- The Washington State Dental Association.
- The Washington State Dental Hygiene Association
- Local dental and hygiene societies.
- Local health jurisdictions.
- Other funding sources.

The mission is to identify eligible infants and toddlers before age one and to match each child to an ABCD dentist (See **Who is eligible?**). Children will remain in the ABCD program until their sixth birthday. Clients of the Developmental Disabilities Administration (DDA) will remain in the ABCD program until their 13th birthday

Medical providers are also crucial to early intervention, as these providers typically see young children at least eight times before age 3 and opportunities exist to aid in early detection of dental health issues and promote dental preventive care. ABCD/MouthMatters medical providers are encouraged to become credentialed and deliver dental disease prevention services.

Health care providers and community service programs identify and refer eligible clients to an ABCD provider.

Eligible clients and an adult family member may receive:

- Family oral health education.
- Anticipatory guidance.
- Assistance with transportation, interpreter services, and other issues related to dental services.

> **Note**: ABCD-eligible children are entitled to the full scope of care as described in HCA's Dental-Related Services Billing Guide. This Access to Baby and Child Dentistry (ABCD) Billing Guide identifies specific services that are eligible for higher reimbursement.

Who may provide ABCD dentistry?

- **Dentists** certified through the continuing education program at the University of Washington School of Pediatric Dentistry or graduate after 2006 from the University of Washington, School of Dentistry, are eligible for ABCD program enhanced reimbursement rates. Contact your local **ABCD program** for questions about current certifications or for scheduling certification training.
- **Dental hygienists** certified through the continuing education program at the University of Washington School of Pediatric Dentistry. Contact the local **ABCD program** for questions about current certifications or for scheduling certification training.
- **Medical providers** (physicians, ARNPs, physician assistants, naturopaths) certified through Arcora Foundation are eligible for select ABCD program enhanced reimbursement rates. ABCD medical providers are referred to as MouthMatters providers. Contact Arcora at mcaplow@arcorafoundation.org or (206) 473-9542 for questions about current certification or for scheduling certification training.

How does the ABCD/MouthMatters program work?

The following chart lists the people/agencies involved in the ABCD program and shows how they interact to ensure eligible children receive restorative and preventive dental services.

Who	Responsibility
Community service programs including local health jurisdictions	Identify Medicaid-eligible clients and refer them to an ABCD or MouthMatters provider. Provide an orientation to the client or parent(s)/guardian(s) and prepare the family and child for the dental visit. Address obstacles to care, such as lack of transportation and limited English proficiency. Coordinate with local agencies in providing outreach and linkage services to eligible clients.
ABCD Program Dentists or dental hygienists	Provide preventive and restorative treatment for an eligible client. Bill HCA for provided services according to this guide.
ABCD/MouthMatters medical Providers	Provide periodic oral evaluation, family oral health education, and topical application of fluoride. Bill HCA for provided services according to this guide.
Local Dental Societies	Encourage and support participation from members
Health Care Authority	Reimburse ABCD program dentists for services covered under this program
University of Washington School of Dentistry	Provide technical and procedural consultation on the enhanced treatments and conduct continued provider training and certification.
Arcora Foundation	Provide management services and technical assistance to support client outreach, linkage, and provider recruitment. Provide training to dental and medical providers and certify them to receive enhanced reimbursement for delivering dental disease prevention services.

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Client Eligibility

Who is eligible?

Clients age five and younger and DDA clients through age 12 are eligible for ABCD/MouthMatters services. Providers must verify that a patient has Washington Apple Health coverage for the date of service, and that the client's benefit package covers the applicable service. This helps prevent delivering a service the Health Care Authority will not pay for.

> **Note**: See the Dental-Related Services Billing Guide for eligibility information regarding services other than those outlined in this guide.

How do I verify a client's eligibility?

Check the client's services card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service HCA will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Apple Health**. For detailed instructions on verifying a patient's eligibility for Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in HCA's ProviderOne Billing and Resource Guide.

If the patient is eligible for Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

Step 2. **Verify service coverage under the Apple Health client's benefit package**. To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see HCA's Program Benefit Packages and Scope of Services webpage.

> **Note**: To determine if the client has the DDA indictor, see the ProviderOne Billing and Resource Guide.

Note: Patients who are not Apple Health clients may submit an application for health care coverage in one of the following ways:

1. By visiting the Washington Healthplanfinder's website.
2. By calling the Customer Support Center toll-free at: 855-WAFINDER

(855-923-4633) or 855-627-9604 (TTY)

3. By mailing the application to: Washington Healthplanfinder, PO Box 946, Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit the **Washington Healthplanfinder's website** or call the Customer Support Center.

Are clients enrolled in an HCA-contracted managed care organization (MCO) eligible?

Yes. Most Medicaid-eligible clients are enrolled in one of HCA's contracted managed care organizations (MCOs). For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

> **Note**: Effective on and after January 1, 2020, MouthMatters program services provided by a medical provider for eligible clients who are enrolled in an HCA-contracted managed care organization (MCO) previously paid through the fee-for-service payment system must be billed directly through the client's MCO.

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Coverage

What is covered?

The Health Care Authority (HCA) pays enhanced fees only to ABCD dental providers and ABCD/MouthMatters medical providers (i.e., ARNPs, physicians and PAs) for furnishing ABCD/MouthMatters services. ABCD/MouthMatters services include all of the following, when appropriate:

- Family oral health education. An oral health education visit must meet all of the following:
  - Be limited to one visit per day, per family, up to two visits per child in a 12-month period, per provider or clinic.
  - Include documentation of the following in the client's record:
    - "Lift the Lip" Training: Show the "Lift Lip" flip chart or DVD provided at the certification workshop. Have the parent(s)/guardian(s) practice examining the child using the lap position. Ask if the parent(s)/guardian(s) feel comfortable doing this once per month.
    - Oral hygiene training: Demonstrate how to position the child to clean the teeth. Have the parent(s)/guardian(s) actually practice cleaning the teeth. Record the parent/guardian's response.
    - Risk assessment for early childhood caries: Assess the risk of dental disease for the child. Obtain a history of previous dental disease activity for this child and any siblings from the parent(s)/guardian(s). Also, note the dental health of the parent(s)/guardian(s).
    - Dietary counseling: Talk with the parent(s)/guardian(s) about the need to use a cup, rather than a bottle, when giving the child anything sweet to drink. Note any other dietary recommendations made.
    - Discuss the benefits of fluoride: Discuss fluoride supplements with the parent(s)/guardian(s). The dentist or medical provider must write a fluoride prescription for the child, if appropriate. Let the parent/guardian know fluoride supplements are covered under HCA's Prescription Drug Program. Fluoride prescriptions written by the dentist or medical provider may be filled at any Medicaid-participating pharmacy. Ensure that the child is not already receiving fluoride supplements through a prescription written by the child's primary care medical provider.
    - Documentation in the client's record of the activities provided.

Note: Family oral health education is limited to one per day, per family, up to two visits per child in a 12-month period. The limit of one per day, per family also applies when multiple children in the family are seen on the same date of service. Providers are to provide this service one family at a time and not in a group setting with multiple families. The Health Care Authority does not pay for family oral health education in a school setting unless provided with a family one-on-one.

Do not use the parent's ProviderOne Client ID. For dental providers, Family Oral Health Education **must be billed using CDT® code D9999. Medical providers must bill using CPT® code 99429 with modifier DA**.

- Application of fluoride varnish
- Periodic oral evaluations, once every 6 months. Six months must elapse between the comprehensive oral evaluation and the first periodic oral evaluation.
- Comprehensive oral evaluations, once per client, per provider or dental clinic, as an initial examination. HCA covers an additional comprehensive oral evaluation if the client has not been treated by the same provider or clinic within the past five years.
- Amalgam, resin, and glass ionomer restorations on primary teeth, as specified in the current Dental-related services billing guide

Note: HCA reimburses amalgam and resin restorations for a maximum of two surfaces for a primary first molar and a maximum of three surfaces for a primary second molar.

Note: HCA reimburses resin-based composite restorations for a maximum of three surfaces for a primary anterior tooth.

- Prefabricated porcelain/ceramic crowns for anterior primary teeth as specified in the current Dental-related services billing guide
- Therapeutic pulpotomy
- Prefabricated stainless steel crowns on primary teeth, as specified in the current Dental-related services billing guide

- Resin-based composite crowns on anterior primary teeth
- Interim therapeutic restorations (ITRs) performed by ABCD, ITR-trained dentists
- Other dental-related services, as specified in the current **Dental-related services billing guide**

> **Note**: The client's record must show documentation of the ABCD services provided.

Coverage Table

The following table applies to ABCD **dental** providers.

CDT® Code	Nomenclature	PA	Limitations
D0120	Periodic oral evaluation	No	One periodic evaluation allowed every 6 months, per provider
D0150	Comprehensive oral evaluation	No	For HCA purposes, this is to be considered an initial exam. One initial evaluation allowed per client, per provider or dental clinic. Normally used by a general dentist or a specialist when evaluating a patient comprehensively. **Six months must elapse before a periodic evaluation will be reimbursed.**
D1206	Topical application of fluoride varnish	No	Three times within a 12-month period with a minimum of 110 days between applications. **Note**: CDT codes D1206 and D1208 are equivalent, and only one of the codes, not both, can be billed every four months.
D1208	Topical application of fluoride, excluding varnish	No	Three times within a 12-month period with a minimum of 110 days between applications. Document in the client's record which material (e.g., topical gel) is used. **Note**: CDT codes D1206 and D1208 are equivalent, and only one of the codes, not both, can be billed every four months.
D1575	Distal shoe space maintainer – fixed - unilateral	No	Quadrant designation required
D2140	Amalgam - one surface, primary or permanent	No	Tooth and surface designations required. Allowance includes polishing.
D2150	Amalgam - two surfaces, primary or permanent	No	Tooth and surface designations required. Allowance includes polishing.

CDT® Code	Nomenclature	PA	Limitations
D2160	Amalgam - three surfaces, primary or permanent	No	Tooth and surface designations required. **If billed on a primary first molar, HCA will reimburse at the rate for a two-surface restoration.**
D2330	Resin-based composite - one surface, anterior	No	Tooth and surface designations required. Allowed only on anterior teeth C through H and M through R.
D2331	Resin-based composite – two surfaces, anterior	No	Tooth and surface designations required. Allowed only on anterior teeth C through H and M through R.
D2332	Resin-based composite – three surfaces, anterior	No	Tooth and surface designations required. Allowed only on anterior teeth C through H and M through R.
D2390	Resin-based composite crown, anterior – primary tooth	No	Tooth designation required.
D2391	Resin-based composite – one surface, posterior	No	Tooth and surface designations required.
D2392	Resin-based composite – two surfaces, posterior	No	Tooth and surface designations required.
D2393	Resin-based composite – three surfaces, posterior	No	Tooth designation required. **If billed on a primary first molar, HCA will reimburse at the rate for a two-surface restoration**.
D2929	Prefabricated porcelain/ ceramic crown – primary tooth	No	Tooth designation required.

CDT® Code	Nomenclature	PA	Limitations
D2930	Prefabricated stainless steel crown - primary tooth	No	Tooth designation required.
D2933	Prefabricated stainless steel crown with resin window	No	Tooth designation required.
D2941	Interim therapeutic restoration – primary dentition	Yes*	Tooth designation required. Covered for clients age 5 years and younger with a maximum of five teeth per visit. Restorations on a tooth can be done every 12 months through age 5 or until the tooth can be definitively treated for a permanent restoration. *See EPA #870001379 and #870001380.
D3220	Therapeutic pulpotomy	No	Covered only as complete procedure, once per tooth. Tooth designation required.
D9310	Professional consultation or diagnostic service provided by a practitioner other than the original practitioner	Yes	See Dental-Related Services billing guide
D9920	Behavior management	No	Involves a client whose documented behavior requires the assistance of at least **one additional professional staff** (six-handed dentistry) to protect the client and staff from injury while treatment is rendered; must be provided in a dental office or dental clinic
D9999	Family Oral Health Education	No	Limited to one visit per day, per family, up to two visits **per child**, per 12-month period, per provider or clinic.

Note: Do not bill Behavior management in conjunction with CDT® codes D9222/D9223 or D9239/D9243 in any setting. For behavior management, the client's record must include a description of the behavior being managed, the behavior management technique used, and identification of the additional professional staff used to manage the behavior to assist the delivery of dental treatment.

The following table applies to ABCD/MouthMatters **medical** providers including Federally Qualified Health Centers (FQHC)/Rural Health Clinics (RHC) medical providers.

CPT® Code	ICD diagnosis Code	Description	Modifier	Limitations	FQHC/RHC Billing
99188	Z00.129	Topical application of fluoride varnish	DA	Three times within a 12-month period with a minimum of 110 days between applications.	Not encounter eligible. When fluoride treatment and sealants are provided on the same day as an encounter-eligible service, they must be billed on the same claim. If they are not provided on the same day as an encounter-eligible service, they may be billed for fee-for-service reimbursement. For clients enrolled in managed care, claims must be billed according to each MCO's billing guidelines.

CPT® Code	ICD diagnosis Code	Description	Modifier	Limitations	FQHC/RHC Billing
99499	Z00.129	Periodic oral evaluation	DA	One periodic evaluation allowed every 6 months, per provider.	Encounter eligible. Like encounter-eligible services, HCA will pay for one encounter, per client, per day unless the periodic evaluation is performed by a provider of a different specialty or there is an unrelated diagnosis. See HCA's Rural Health Clinics Billing Guide or the Federally Qualified Health Centers Billing Guide. See WAC 182-549-1450(1) and 182-548-1450(1) which states: • (1) The medicaid agency pays for one encounter, per client, per day, except in the following circumstances: • (a) The visits occur with different health care professionals with different specialties; or • (b) There are separate visits with unrelated diagnoses.
99429	Z00.129	Family oral health education	DA	Limited to one visit per day, per family, up to two visits **per child**, per 12-month period, per provider or clinic.	Encounter eligible. Like encounter-eligible services, HCA will pay for one encounter, per client, per day unless the periodic evaluation is performed by a provider of a different specialty or there is an unrelated diagnosis. See HCA's Rural Health Clinics Billing Guide or the Federally Qualified Health Centers Billing Guide. See WAC 182-549-1450(1) and 182-548-1450(1) which states: • (1) The medicaid agency pays for one encounter, per client, per day, except in the following circumstances: • (a) The visits occur with different health care professionals with different specialties; or • (b) There are separate visits with unrelated diagnoses.

*Previously due to a system limitation, CDT® codes D9999 and D0120 were required to be billed fee-for-service on a claim type K rather than to the client's HCA-contracted managed care organization (MCO) when performed in a medical setting. When CPT® codes 99429 and 99499 are billed to the client's MCO, the

codes must be billed according to existing FQHC and RHC policy regarding two encounters in one day. HCA's ProviderOne system is set up to follow the policy outlined in WAC **182-549-1450(1)** and **182-548-1450(1)** for two encounters.

For any questions, please email FQHCRHC@hca.wa.gov.

> **Note**: Effective on and after January 1, 2020, MouthMatters program services provided by a medical provider for eligible clients who are enrolled in an HCA-contracted managed care organization (MCO), previously paid through the fee-for-service payment system, must be billed directly through the client's MCO.

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Expedited Prior Authorization

What is expedited prior authorization (EPA)?

The expedited prior authorization (EPA) process is designed to eliminate the need for prior authorization for selected dental procedure codes.

To use an EPA:

- Enter the EPA number on the claim form when billing HCA.
- When requested, provide documentation showing the client's condition meets all the EPA criteria.
- Prior authorization is required when a situation does not meet all the EPA criteria for selected dental procedure codes. See HCA's Prior Authorization webpage for details.

It is the provider's responsibility to determine if a client has already received the service allowed with the EPA criteria. If the client already received the service, a prior authorization request is required to provide the service again or to provide additional services.

Note: By entering an EPA number on your claim, you attest that **all** the EPA criteria are met and can be verified by documentation in the client's record. These services are subject to post payment review and audit by HCA or HCA's designee.

HCA may recoup any payment made to a provider if the provider did not follow the required EPA process and if not all of the specified criteria were met.

EPA procedure code list

EPA #	CDT® Code	Description	Criteria
870001379	D2941	interim therapeutic restoration – primary dentition	Interim therapeutic restoration (ITR) will be allowed in lieu of a definitive restoration as follows: • Child must be age 5 or younger or a DDA client through age 12 or younger. • Has current decay • ABCD provider and has completed ITR training • ITR is expected to last a minimum of one year • Allowed for a maximum of 5 teeth per visit • Based on the treating dentist clinical judgement, will be allowed yearly until can be definitively treated or until the client's 6th birthday. Not allowed in conjunction with general anesthesia (D9222, D9223, D9239, or D9243). NOT ALLOWED on the same day as other definitive restorations.
870001380	D2941	interim therapeutic restoration – primary dentition	Interim therapeutic restoration (ITR) will be allowed in lieu of a definitive restoration as follows: • Child must be age 5 or younger or a DDA client through age 12 or younger • Has current decay • ABCD provider and has completed ITR training • ITR is expected to last a minimum of one year • Allowed for a maximum of five teeth per visit • Based on the treating dentist clinical judgement, will be allowed yearly until can be definitively treated or until the client's 6th birthday. Not allowed in conjunction with general anesthesia (D9222, D9223, D9239, or D9243). D1354 (silver diamine fluoride) is not payable on the same tooth, same visit as ITR. ALLOWED on the same day as definitive treatment if documentation that the child was not able to proceed with complete treatment once started.

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Billing

All claims must be submitted electronically to HCA.

For more information, see HCA's ProviderOne Billing and Resource web page, *Paperless billing at HCA*.

What are the general billing requirements?

Providers must follow HCA's ProviderOne Billing and Resource Guide. These billing requirements include:

- What time limits exist for submitting and resubmitting claims and adjustments.
- When providers may bill a client.
- How to bill for services provided to primary care case management (PCCM) clients.
- How to bill for clients eligible for both Medicare and Medicaid.
- How to handle third-party liability claims.
- What standards to use for record keeping.

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA's Billers and Providers webpage, under Webinars.

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the HIPAA Electronic Data Interchange (EDI) web page.