

Access for Baby Care for Early Dental Examination and Fluoride Varnish Placement “ABC Program”

Policy Limitations, Billing and Claims Adjudication

Effective with the implementation date of November 1, 2008 for the “ABC Program”, two (2) dental codes will be added to the Medicaid Physician Fee Schedule. These codes are the American Dental Association’s (ADA) Current Dental Terminology (CDT) codes, which must be used in order to be compliant with the Health Insurance Portability and Accountability Act (HIPAA). The two (2) additional codes are noted below:

D0145 (\$25)	Oral evaluation for a patient under three (3) years of age and counseling with the primary caregiver.
D1206 (\$20)	Topical therapeutic fluoride varnish application for moderate to high caries risk patients.

The first oral examination may be performed on children at 6 months of age. The CDT nomenclature designates D0145 (Oral evaluation) as the code to be used. If it is determined that the child is at risk of caries then fluoride varnish may be applied and the code D1206 utilized. The fluoride varnish may be applied at a subsequent visit but must be submitted on the same billing form as the original D0145 code with the separate dates of service appropriately indicated.

The following are required components of the oral evaluation visit (code D0145):

- An oral evaluation, including assessment for early childhood decay, with documentation of noteworthy findings;
- Preventive counseling including dietary recommendations and oral hygiene instructions;
- Prescribing fluoride supplements if required;
- Assessment for the need of fluoride varnish and application if indicated (or application at subsequent visit);
- Referral to a dental provider (if necessary);

The oral evaluation may be performed and billed for beginning at six (6) months of age and at every well child care visit through 40 months of age (i.e. 6,9,12,15,18 and 36 month visits).

Fluoride varnish may not be applied and billed for without initial completion of the oral evaluation.

The service is not eligible for third party reimbursement.

Claim filing Process

Prior authorization is not necessary but providers must have attended and passed Continuing Medical Education Credits offered through Dr. Douglass at the University of Connecticut School of Dental Medicine in conjunction with various continuing education providers including the CT chapter of the AAP’s teleconference series and the Child Health and Development Institute of Connecticut EPIC program. Only providers who have completed the training course may bill and be reimbursed for the components of the “ABC Program”. Primary care providers who have attended the CME course may place the aforementioned codes on the CMS 1500. The information relevant to the service which includes date of service, place of service, type of service (procedure code beginning with the letter “D” followed by a four (4) digit number), procedure, charge and units of service rendered are to be placed on line 24 sections “A”, “B”, “C”, “D” “F” and “G” respectively. For instructions on how to complete an entire CMS 1500, please refer to the policy manual, Chapter Eight (8) which discusses the form in general terms in further detail.

The claim may be submitted either electronically or by hard copy through EDS or through the Medical Care Organization (MCO) that the provider is enrolled and credentialed.