WAC 182-535-1079 Dental-related services—General. (1) Clients described in WAC 182-535-1060 are eligible to receive the dental-related services described in this chapter, subject to coverage limitations, restrictions, and client age requirements identified for a specific service. The medicaid agency pays for dental-related services and procedures provided to eligible clients when the services and procedures:

(a) Are part of the client's dental benefit package;

(b) Are within the scope of an eligible client's Washington apple health program;

(c) Are medically necessary;

(d) Meet the agency's authorization requirements, if any;

(e) Are documented in the client's dental record in accordance with chapter 182-502 WAC and meet the department of health's requirements in WAC 246-817-305 and 246-817-310;

(f) Are within accepted dental or medical practice standards;

(g) Are consistent with a diagnosis of a dental disease or dental condition;

(h) Are reasonable in amount and duration of care, treatment, or service; and

(i) Are listed as covered in the agency's rules and published billing instructions and fee schedules.

(2) For orthodontic services, see chapter 182-535A WAC.

(3) The agency requires site-of-service prior authorization, in addition to prior authorization of the procedure, if applicable, for nonemergency dental-related services performed in a hospital or an ambulatory surgery center when:

(a) A client is not a client of the developmental disabilities administration of the department of social and health services (DSHS) according to WAC 182-535-1099;

(b) A client is age nine or older;

(c) The service is not listed as exempt from the site-of-service authorization requirement in the agency's current published dental-related services fee schedule or billing instructions; and

(d) The service is not listed as exempt from the prior authorization requirement for deep sedation or general anesthesia (see WAC 182-535-1098 (1)(c)(v)).

(4) To be eligible for payment, dental-related services performed in a hospital or an ambulatory surgery center must be listed in the agency's current published outpatient fee schedule or ambulatory surgery center fee schedule. The claim must be billed with the correct procedure code for the site-of-service.

(5) Under the early and periodic screening, diagnostic, and treatment (EPSDT) program, clients age twenty and younger may be eligible for dental-related services listed as noncovered. The standard for coverage for EPSDT is found in chapter 182-534 WAC.

(6) The agency evaluates a request for dental-related services that are:

(a) In excess of the dental program's limitations or restrictions, according to WAC 182-501-0169; and

(b) Listed as noncovered, according to WAC 182-501-0160.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-20-097, § 182-535-1079, filed 10/3/17, effective 11/3/17; WSR 16-18-033, § 182-535-1079, filed 8/26/16, effective 9/26/16. Statutory Authority: RCW 41.05.021 and 2013 2nd sp.s. c 4 § 213. WSR 14-08-032, §

182-535-1079, filed 3/25/14, effective 4/30/14. Statutory Authority: RCW 41.05.021. WSR 12-09-081, § 182-535-1079, filed 4/17/12, effective 5/18/12. WSR 11-14-075, recodified as § 182-535-1079, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. WSR 07-06-042, § 388-535-1079, filed 3/1/07, effective 4/1/07.]