

Chapter 182-535 WAC

DENTAL-RELATED SERVICES

WAC

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GENERAL

WAC 182-535-1050 Dental-related definitions. The following definitions and abbreviations and those found in WAC 388-500-0005 apply to this chapter. The department also uses dental definitions found in the American Dental Association's Current Dental Terminology (CDT) and the American Medical Association's Physician's Current Procedural Terminology (CPT). Where there is any discrepancy between the CDT or CPT and this section, this section prevails. (CPT is a trademark of the American Medical Association.)

"Access to baby and child dentistry (ABCD)" is a program to increase access to dental services in targeted areas for medicaid eligible infants, toddlers, and preschoolers up through the age of five. See WAC 388-535-1300 for specific information.

"American Dental Association (ADA)" is a national organization for dental professionals and dental societies.

"Anterior" refers to teeth (maxillary and mandibular incisors and canines) and tissue in the front of the mouth. Permanent maxillary anterior teeth include teeth six, seven, eight, nine, ten, and eleven. Permanent mandibular anterior teeth include teeth twenty-two, twenty-three, twenty-four, twenty-five, twenty-six, and twenty-seven. 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" means having or producing no symptoms.

"Base metal" means dental alloy containing little or no precious metals.

"Behavior management" means using the assistance of one additional dental professional staff to manage the behavior of a client to facilitate the delivery of dental treatment.

"By report" - a method of reimbursement in which the department determines the amount it will pay for a service when the rate for that service is not included in the department'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" means carious lesions or tooth decay through the enamel or decay of the root surface.

"Comprehensive oral evaluation" means 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" is a drug-induced depression of consciousness during which a client responds purposefully to verbal commands, either alone or accompanied by light tac-

tile stimulation. No interventions are required to maintain a patent airway, spontaneous ventilation is adequate, and cardiovascular function is maintained.

"Core buildup" refers to building up of clinical crowns, including pins.

"Coronal" is the portion of a tooth that is covered by enamel.

"Coronal polishing" is a mechanical procedure limited to the removal of plaque and stain from exposed tooth surfaces.

"Crown" means a restoration covering or replacing part or the whole clinical crown of a tooth.

"Current dental terminology (CDT)" is 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)" is 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" is a term for caries or carious lesions and means decomposition of tooth structure.

"Deep sedation" is 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.

"Dental general anesthesia" see **"general anesthesia."**

"Dentures" means an artificial replacement for natural teeth and adjacent tissues, and includes complete dentures, immediate dentures, overdentures, and partial dentures.

"Denturist" means a person licensed under chapter 18.30 RCW to make, construct, alter, reproduce, or repair a denture.

"Endodontic" means the etiology, diagnosis, prevention and treatment of diseases and injuries of the pulp and associated periradicular conditions.

"EPSDT" means the department's early and periodic screening, diagnosis, and treatment program for clients twenty years of age and younger as described in chapter 388-534 WAC.

"Extraction" see **"simple extraction"** and **"surgical extraction."**

"Flowable composite" is 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" is a substance containing dental fluoride which is applied to teeth.

"General anesthesia" is 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.

"High noble metal" is a dental alloy containing at least sixty percent pure gold.

"Limited oral evaluation" is 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" is an assessment by a dentist or dental hygienist to determine the need for fluoride treatment and/or when triage services are provided in settings other than dental offices or dental clinics.

"Major bone grafts" is a transplant of solid bone tissue(s).

"Medically necessary" see WAC 388-500-0005.

"Minor bone grafts" is a transplant of nonsolid bone tissue(s), such as powdered bone, buttons, or plugs.

"Noble metal" is a dental alloy containing at least twenty-five percent but less than sixty percent pure gold.

"Oral evaluation" see **"comprehensive oral evaluation."**

"Oral hygiene instruction" means instruction for home oral hygiene care, such as tooth brushing techniques or flossing.

"Oral prophylaxis" is the dental procedure of scaling and polishing which includes removal of calculus, plaque, and stains from teeth .

"Partials" or **"partial dentures"** are a removable prosthetic appliance that replaces missing teeth in one arch.

"Periodic oral evaluation" is 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" is 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 microorganisms and deposits with hand and mechanical instrumentation, an evaluation of periodontal conditions, and a complete periodontal charting as appropriate.

"Periodontal scaling and root planing" is a procedure to remove plaque, calculus, microorganisms, 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.

"Posterior" refers to the teeth (maxillary and mandibular premolars and molars) and tissue towards the back of the mouth. Permanent maxillary posterior teeth include teeth one, two, three, four, five, twelve, thirteen, fourteen, fifteen, and sixteen. Permanent mandibular posterior teeth include teeth seventeen, eighteen, nineteen, twenty, twenty-one, twenty-eight, twenty-nine, thirty, thirty-one, and thirty-two. Primary maxillary posterior teeth include teeth A, B, I, and J. Primary mandibular posterior teeth include teeth K, L, S, and T.

"Proximal" is the surface of the tooth near or next to the adjacent tooth.

"Radiograph" is an image or picture produced on a radiation sensitive film emulsion or digital sensor by exposure to ionizing radiation.

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

"Root canal" is the chamber within the root of the tooth that contains the pulp.

"Root canal therapy" is the treatment of the pulp and associated periradicular conditions.

"Root planing" is a procedure to remove plaque, calculus, microorganisms, and rough cementum and dentin from tooth surfaces. This includes hand and mechanical instrumentation.

"Scaling" is a procedure to remove plaque, calculus, and stain deposits from tooth surfaces.

"Sealant" is a dental material applied to teeth to prevent dental caries.

"Simple extraction" is the routine removal of a tooth.

"Standard of care" means what reasonable and prudent practitioners would do in the same or similar circumstances.

"Surgical extraction" is the removal of a tooth by cutting of the gingiva and bone. This includes soft tissue extractions, partial boney extractions, and complete boney extractions.

"Symptomatic" means having symptoms (e.g., pain, swelling, and infection).

"Temporomandibular joint dysfunction (TMJ/TMD)" is an abnormal functioning of the temporomandibular joint or other areas secondary to the dysfunction.

"Therapeutic pulpotomy" is the surgical removal of a portion of the pulp (inner soft tissue of a tooth), to retain the healthy remaining pulp.

"Usual and customary" means the fee that the provider usually charges nonmedicaid customers for the same service or item. This is the maximum amount that the provider may bill the department.

"Wisdom teeth" are the third molars, teeth one, sixteen, seventeen, and thirty-two.

"Xerostomia" is a dryness of the mouth due to decreased saliva.

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WAC 182-535-1060 Clients who are eligible for dental-related services. The following clients who receive services under the medical assistance programs listed in this section are eligible for covered dental-related services, subject to the restrictions and specific limitations described in this chapter and other applicable WAC:

(1) Children eligible for the:

(a) Categorically needy program (CN or CNP);

(b) Children's health insurance program (CNP-CHIP); and

(c) Limited casualty program - medically needy program (LCP-MNP).

(2) Adults eligible for the:

(a) Categorically needy program (CN or CNP); and

(b) Limited casualty program - medically needy program (LCP-MNP).

(3) Clients eligible for medical care services under the following state-funded only programs are eligible only for the limited dental-related services described in WAC 388-535-1065:

(a) General assistance - Unemployable (GA-U); and

(b) General assistance - Alcohol and Drug Abuse Treatment and Support Act (ADATSA) (GA-W).

(4) Clients who are enrolled in a managed care plan are eligible for medical assistance administration (MAA)-covered dental services that are not covered by their plan, under fee-for-service, subject to the provisions of chapter 388-535 WAC and other applicable WAC.

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WAC 182-535-1065 Coverage limits for dental-related services provided under the GA-U and ADATSA programs. (1) Clients who receive medical care services under the following programs may receive the dental-related services described in this section:

(a) General assistance unemployable (GA-U); and

(b) Alcohol and Drug Abuse Treatment and Support Act (ADATSA).

(2) The department covers the following dental-related services for a client eligible under the GA-U or ADATSA program:

(a) Services provided only as part of dental treatment for:

(i) Limited oral evaluation;

(ii) Periapical or bite-wing radiographs that are medically necessary to diagnose only the client's chief complaint;

(iii) Palliative treatment to relieve dental pain;

(iv) Pulpal debridement to relieve dental pain; or

(v) Endodontic (root canal only) treatment for maxillary and mandibular anterior teeth (cuspids and incisors) when prior authorized).

(b) Tooth extraction when at least one of the following apply:

(i) The tooth has a radiograph apical lesion;

(ii) The tooth is endodontically involved, infected, or abscessed;

(iii) The tooth is not restorable; or

(iv) The tooth is not periodontally stable.

(3) Tooth extractions require prior authorization when:

(i) The extraction of a tooth or teeth results in the client becoming edentulous in the maxillary arch or mandibular arch; and

(ii) A full mouth extraction is necessary because of radiation therapy for cancer of the head and neck.

(4) Each dental-related procedure described under this section is subject to the coverage limitations listed in chapter 388-535 WAC.

(5) The department does not cover any dental-related services not listed in this section for clients eligible under the GA-U or ADATSA program, including any type of removable prosthesis (denture).

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WAC 182-535-1070 Dental-related services provider information. (1) The following providers are eligible to enroll with the medical assistance administration (MAA) to furnish and bill for dental-related services provided to eligible clients:

(a) Persons currently licensed by the state of Washington to:

- (i) Practice dentistry or specialties of dentistry.
- (ii) Practice as dental hygienists.
- (iii) Practice as denturists.
- (iv) Practice anesthesia by:

(A) Providing conscious sedation with parenteral or multiple oral agents, deep sedation, or general anesthesia as an anesthesiologist or dental anesthesiologist;

(B) Providing conscious sedation with parenteral or multiple oral agents, deep sedation, or general anesthesia as a certified registered nurse anesthetist (CRNA) under WAC 246-817-180; or

(C) Providing conscious sedation with parenteral or multiple oral agents as a dentist, when the dentist has a conscious sedation permit issued by the department of health (DOH) that is current at the time the billed service(s) is provided; or

(D) Providing deep sedation or general anesthesia as a dentist when the dentist has a general anesthesia permit issued by DOH that is current at the time the billed service(s) is provided.

(v) Practice medicine and osteopathy for:

- (A) Oral surgery procedures; or
 - (B) Providing fluoride varnish under EPSDT.
- (b) Facilities that are:

(i) Hospitals currently licensed by the DOH;

(ii) Federally qualified health centers (FQHCs);

(iii) Medicare-certified ambulatory surgical centers (ASCs);

(iv) Medicare-certified rural health clinics (RHCs); or

(v) Community health centers.

(c) Participating local health jurisdictions.

(d) Bordering city or out-of-state providers of dental-related services who are qualified in their states to provide these services.

(2) Subject to the restrictions and limitations in this section and other applicable WAC, MAA pays licensed providers participating in the MAA dental program for only those services that are within their scope of practice.

(3) For the dental specialty of oral and maxillofacial surgery:

(a) MAA requires a dentist to:

(i) Be currently entitled to such specialty designation (to perform oral and maxillofacial surgery) under WAC 246-817-420; and

(ii) Meet the following requirements in order to be reimbursed for oral and maxillofacial surgery:

(A) The dentist must have participated at least three years in a maxillofacial residency program; and

(B) The dentist must be board certified or designated as "board eligible" by the American Board of Oral and Maxillofacial Surgery.

(b) A dental provider who meets the requirements in (3)(a) of this section must bill claims using appropriate current dental terminology (CDT) codes or current procedural terminology (CPT) codes for services that are identified as covered in WAC and MAA's published billing instructions or numbered memoranda.

(4) See WAC 388-502-0020 for provider documentation and record retention requirements. MAA requires additional dental documentation under specific sections in this chapter and as required by chapter 246-817 WAC.

(5) See WAC 388-502-0100 and 388-502-0150 for provider billing and payment requirements. Enrolled dental providers who do not meet the conditions in (3)(a) of this section must bill all claims using only the CDT codes for services that are identified in WAC and MAA's published billing instructions or numbered memoranda. MAA does not reimburse for billed CPT codes when the dental provider does not meet the requirements in subsection (3)(a) of this section.

(6) See WAC 388-502-0160 for regulations concerning charges billed to clients.

(7) See WAC 388-502-0230 for provider review and appeal.

(8) See WAC 388-502-0240 for provider audits and the audit appeal process.

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WAC 182-535-1079 Dental-related services for clients through age twenty—General. (1) Subject to coverage limitations, the department pays for dental-related services and procedures provided to clients through age twenty when the services and procedures:

(a) Are within the scope of an eligible client's medical care program;

(b) Are medically necessary;

(c) Meet the department's prior authorization requirements, if any;

(d) Are documented in the client's record in accordance with chapter 388-502 WAC;

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

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

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

(h) Are listed as covered in the department's published rules, billing instructions and fee schedules.

(2) Under the early periodic screening and diagnostic treatment (EPSDT) program, clients ages twenty and younger may be eligible for dental-related services listed as noncovered.

(3) Clients who are eligible for services through the division of developmental disabilities may receive dental-related services according to WAC 388-535-1099.

(4) The department evaluates a request for dental-related services:

(a) That are in excess of the dental program's limitations or restrictions, according to WAC 388-501-0169; and

(b) That are listed as noncovered according to WAC 388-501-0160.

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WAC 182-535-1080 Covered dental-related services for clients through age twenty—Diagnostic. The department covers medically necessary dental-related diagnostic services, subject to the coverage limitations listed, for clients through age twenty as follows:

(1) **Clinical oral evaluations.** The department covers:

(a) Oral health evaluations and assessments.

(b) Periodic oral evaluations as defined in WAC 388-535-1050, once every six months. Six months must elapse between the comprehensive oral evaluation and the first periodic oral evaluation.

(c) Limited oral evaluations as defined in WAC 388-535-1050, only when the provider performing the limited oral evaluation is not providing routine scheduled dental services for the client. The limited oral evaluation:

(i) Must be to evaluate the client for a:

(A) Specific dental problem or oral health complaint;

(B) Dental emergency; or

(C) Referral for other treatment.

(ii) When performed by a denturist, is limited to the initial examination appointment. The department does not cover any additional limited examination by a denturist for the same client until three months after a removable prosthesis has been seated.

(d) Comprehensive oral evaluations as defined in WAC 388-535-1050, once per client, per provider or clinic, as an initial examination. The department covers an additional comprehensive oral evaluation if the client has not been treated by the same provider or clinic within the past five years.

(e) Limited visual oral assessments as defined in WAC 388-535-1050, up to two per client, per year, per provider only when the assessment is:

(i) Not performed in conjunction with other clinical oral evaluation services;

(ii) Performed to determine the need for sealants or fluoride treatment and/or when triage services are provided in settings other than dental offices or clinics; and

(iii) Provided by a licensed dentist or licensed dental hygienist.

(6/30/11)

(2) **Radiographs (X rays).** The department:

(a) Covers radiographs that are of diagnostic quality, dated, and labeled with the client's name. The department 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.

(b) Uses the prevailing standard of care to determine the need for dental radiographs.

(c) Covers an intraoral complete series (includes four bitewings), once in a three-year period only if the department has not paid for a panoramic radiograph for the same client in the same three-year period.

(d) Covers 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.

(e) Covers 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.

(f) Covers a maximum of four bitewing radiographs once every twelve months for clients through age eleven.

(g) Covers a maximum of four bitewing radiographs once every twelve months for clients ages twelve through twenty.

(h) Covers panoramic radiographs in conjunction with four bitewings, once in a three-year period, only if the department has not paid for an intraoral complete series for the same client in the same three-year period.

(i) 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.

(j) Covers cephalometric film:

(i) For orthodontics, as described in chapter 388-535A WAC; or

(ii) Only on a case-by-case basis and when prior authorized.

(k) Covers radiographs not listed as covered in this subsection, only on a case-by-case basis and when prior authorized.

(l) Covers oral and facial photographic images, only on a case-by-case basis and when requested by the department.

(3) **Tests and examinations.** The department covers:

(a) One pulp vitality test per visit (not per tooth):

(i) For diagnosis only during limited oral evaluations; and

(ii) When radiographs and/or documented symptoms justify the medical necessity for the pulp vitality test.

(b) Diagnostic casts other than those included in an orthodontic case study, on a case-by-case basis, and when requested by the department.

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WAC 182-535-1082 Covered dental-related services for clients through age twenty—Preventive services. The department covers medically necessary dental-related preventive services, subject to the coverage limitations listed, for clients through age twenty as follows:

(1) **Dental prophylaxis.** The department covers prophylaxis:

(a) 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 twenty.

(b) Only when the service is performed six months after periodontal scaling and root planing, or periodontal maintenance services, for clients ages thirteen through twenty.

(c) Only when not performed on the same date of service as periodontal scaling and root planing, periodontal maintenance, gingivectomy or gingivoplasty.

(d) For clients of the division of developmental disabilities according to WAC 388-535-1099.

(2) **Topical fluoride treatment.** The department covers:

(a) Fluoride varnish, rinse, foam or gel for clients ages six and younger, up to three times within a twelve-month period.

(b) Fluoride varnish, rinse, foam or gel for clients ages seven through eighteen, up to two times within a twelve-month period.

(c) Fluoride varnish, rinse, foam or gel, up to three times within a twelve-month period during orthodontic treatment.

(d) Fluoride rinse, foam or gel for clients ages nineteen through twenty, once within a twelve-month period.

(e) Additional topical fluoride applications only on a case-by-case basis and when prior authorized.

(f) Topical fluoride treatment for clients of the division of developmental disabilities according to WAC 388-535-1099.

(3) **Oral hygiene instruction.** The department covers:

(a) Oral hygiene instruction only for clients through age eight.

(b) Oral hygiene instruction up to two times within a twelve-month period.

(c) Individualized oral hygiene instruction for home care to include tooth brushing technique, flossing, and use of oral hygiene aides.

(d) Oral hygiene instruction only when not performed on the same date of service as prophylaxis.

(e) Oral hygiene instruction 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.

(4) **Sealants.** The department covers:

(a) Sealants only when used on a mechanically and/or chemically prepared enamel surface.

(b) Sealants once per tooth in a three-year period for clients through age eighteen.

(c) Sealants only when used on the occlusal surfaces of:

(i) Permanent teeth two, three, fourteen, fifteen, eighteen, nineteen, thirty, and thirty-one; and

(ii) Primary teeth A, B, I, J, K, L, S, and T.

(d) Sealants on noncarious teeth or teeth with incipient caries.

(e) Sealants only when placed on a tooth with no preexisting occlusal restoration, or any occlusal restoration placed on the same day.

(f) Additional sealants on a case-by-case basis and when prior authorized.

(5) **Space maintenance.** The department covers:

(a) Fixed unilateral or fixed bilateral space maintainers for clients through age eighteen.

(b) Only one space maintainer per quadrant.

(c) Space maintainers only for missing primary molars A, B, I, J, K, L, S, and T.

(d) Replacement space maintainers only on a case-by-case basis and when prior authorized.

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WAC 182-535-1084 Covered dental-related services for clients through age twenty—Restorative services. The department covers medically necessary dental-related restorative services, subject to the coverage limitations listed, for clients through age twenty as follows:

(1) **Restorative/operative procedures.** The department covers restorative/operative procedures performed in a hospital or an ambulatory surgical center for:

(a) Clients ages eight and younger;

(b) Clients ages nine through twenty only on a case-by-case basis and when prior authorized; and

(c) Clients of the division of developmental disabilities according to WAC 388-535-1099.

(2) **Amalgam restorations for primary and permanent teeth.** The department considers:

(a) Tooth preparation, all adhesives (including amalgam bonding agents), liners, bases, and polishing as part of the amalgam restoration.

(b) The occlusal adjustment of either the restored tooth or the opposing tooth or teeth as part of the amalgam restoration.

(c) Buccal or lingual surface amalgam restorations, regardless of size or extension, as a one surface restoration. The department covers one buccal and one lingual surface per tooth.

(d) Multiple amalgam restorations of fissures and grooves of the occlusal surface of the same tooth as a one surface restoration.

(e) 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.

(3) **Amalgam restorations for primary posterior teeth only.** The department covers amalgam restorations for a maximum of two surfaces for a primary first molar and maximum of three surfaces for a primary second molar. (See subsection (9)(c) of this section for restorations for a primary posterior tooth requiring additional surfaces.) The department does not pay for additional amalgam restorations.

(4) **Amalgam restorations for permanent posterior teeth only.** The department:

(a) Covers two occlusal amalgam restorations for teeth one, two, three fourteen, fifteen, and sixteen, if the restorations are anatomically separated by sound tooth structure.

(b) Covers 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.

(c) Covers amalgam restorations for a maximum of six surfaces per tooth for teeth one, two, three, fourteen, fifteen, and sixteen, once per client, per provider or clinic, in a two-year period (see (a) of this subsection).

(d) 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. The department 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.

(5) Resin-based composite restorations for primary and permanent teeth. The department:

(a) 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.

(b) Considers the occlusal adjustment of either the restored tooth or the opposing tooth or teeth as part of the resin-based composite restoration.

(c) Considers buccal or lingual surface resin-based composite restorations, regardless of size or extension, as a one surface restoration. The department covers only one buccal and one lingual surface per tooth.

(d) Considers resin-based composite restorations of teeth where the decay does not penetrate the DEJ to be sealants (see WAC 388-535-1082(4) for sealants coverage).

(e) Considers multiple preventive restorative resin, flowable composite resin, or resin-based composites for the occlusal, buccal, lingual, mesial, and distal fissures and grooves on the same tooth as a one surface restoration.

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

(g) Considers 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.

(6) Resin-based composite restorations for primary teeth only. The department covers:

(a) Resin-based composite restorations for a maximum of three surfaces for a primary anterior tooth (see subsection (9)(b) of this section for restorations for a primary anterior tooth requiring a four or more surface restoration). The department does not pay for additional composite or amalgam restorations on the same tooth after three surfaces.

(b) Resin-based composite restorations for a maximum of two surfaces for a primary first molar and a maximum of three surfaces for a primary second molar. (See subsection (9)(c) of this subsection for restorations for a primary posterior tooth requiring additional surfaces.) The department does not pay for additional composite restorations on the same tooth.

(c) Glass ionomer restorations only for primary teeth, and only for clients ages five and younger. The department pays for these restorations as a one surface resin-based composite restoration.

(7) Resin-based composite restorations for permanent teeth only. The department covers:

(a) Two occlusal resin-based composite restorations for teeth one, two, fourteen, fifteen, and sixteen if the restorations are anatomically separated by sound tooth structure.

(b) 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.

(c) Resin-based composite restorations for a maximum of six surfaces per tooth for permanent posterior teeth one, two, three, fourteen, fifteen, and sixteen, once per client, per provider or clinic, in a two-year period (see (a) of this subsection).

(d) 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.

(e) Replacement of resin-based composite restoration on permanent teeth within a two-year period only if the restoration has an additional adjoining carious surface. The department pays the replacement restoration as a one multi-surface restoration. The client's record must include radiographs and documentation supporting the medical necessity for the replacement restoration.

(8) Crowns. The department:

(a) Covers the following crowns once every five years, per tooth, for permanent anterior teeth for clients ages twelve through twenty when the crowns meet prior authorization criteria in WAC 388-535-1220 and the provider follows the prior authorization requirements in (d) of this subsection:

(i) Porcelain/ceramic crowns to include all porcelains, glasses, glass-ceramic, and porcelain fused to metal crowns; and

(ii) Resin crowns and resin metal crowns to include any resin-based composite, fiber, or ceramic reinforced polymer compound.

(b) Covers full coverage metal crowns once every five years, per tooth, for permanent posterior teeth to include high noble, titanium, titanium alloys, noble, and predominantly base metal crowns for clients ages eighteen through twenty when they meet prior authorization criteria and the provider follows the prior authorization requirements in (d) and (e) of this subsection.

(c) Considers the following to be included in the payment for a crown:

(i) Tooth and soft tissue preparation;

(ii) Amalgam and resin-based composite restoration, or any other restorative material placed within six months of the crown preparation. Exception: The department covers a one surface restoration on an endodontically treated tooth, or a core buildup or cast post and core;

(iii) Temporaries, including but not limited to, temporary restoration, temporary crown, provisional crown, temporary prefabricated stainless steel crown, ion crown, or acrylic crown;

(iv) Packing cord placement and removal;

(v) Diagnostic or final impressions;

(vi) Crown seating, including cementing and insulating bases;

(vii) Occlusal adjustment of crown or opposing tooth or teeth; and

(viii) Local anesthesia.

(d) Requires the provider to submit the following with each prior authorization request:

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

(e) Requires a provider to bill for a crown only after delivery and seating of the crown, not at the impression date.

(9) **Other restorative services.** The department covers:

- (a) All recementations of permanent indirect crowns.
- (b) 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 prior authorization if the tooth requires a four or more surface restoration.

(c) Prefabricated stainless steel crowns for primary posterior teeth once every three years without prior authorization if:

- (i) Decay involves three or more surfaces for a primary first molar;
- (ii) Decay involves four or more surfaces for a primary second molar; or
- (iii) The tooth had a pulpotomy.

(d) Prefabricated stainless steel crowns for permanent posterior teeth once every three years when prior authorized.

(e) Prefabricated stainless steel crowns for clients of the division of developmental disabilities according to WAC 388-535-1099.

(f) Core buildup, including pins, only on permanent teeth, when prior authorized at the same time as the crown prior authorization.

(g) Cast post and core or prefabricated post and core, only on permanent teeth, when prior authorized at the same time as the crown prior authorization.

[11-14-075, recodified as § 182-535-1084, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-042, § 388-535-1084, filed 3/1/07, effective 4/1/07.]

WAC 182-535-1086 Covered dental-related services for clients through age twenty—Endodontic services. The department covers medically necessary dental-related endodontic services, subject to the coverage limitations listed, for clients through age twenty as follows:

(1) **Pulp capping.** The department considers pulp capping to be included in the payment for the restoration.

(2) **Pulpotomy.** The department covers:

(a) Therapeutic pulpotomy on primary posterior teeth only; and

(b) Pulpal debridement on permanent teeth only, excluding teeth one, sixteen, seventeen, and thirty-two. The department does not pay for pulpal debridement when performed with palliative treatment of dental pain or when performed on the same day as endodontic treatment.

(3) **Endodontic treatment.** The department:

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

(b) Covers endodontic treatment for permanent anterior, bicuspid, and molar teeth, excluding teeth one, sixteen, seventeen, and thirty-two.

(c) Considers the following included in endodontic treatment:

- (i) Pulpotomy when part of root canal therapy;
- (ii) All procedures necessary to complete treatment; and
- (iii) All intra-operative and final evaluation radiographs for the endodontic procedure.

(d) Pays separately for the following services that are related to the endodontic treatment:

- (i) Initial diagnostic evaluation;
- (ii) Initial diagnostic radiographs; and
- (iii) Post treatment evaluation radiographs if taken at least three months after treatment.

(e) Requires prior authorization for endodontic retreatment and considers endodontic retreatment to include:

- (i) The removal of post(s), pin(s), old root canal filling material, and all procedures necessary to prepare the canals;
- (ii) Placement of new filling material; and
- (iii) Retreatment for permanent anterior, bicuspid, and molar teeth, excluding teeth one, sixteen, seventeen, and thirty-two.

(f) Pays separately for the following services that are related to the endodontic retreatment:

- (i) Initial diagnostic evaluation;
- (ii) Initial diagnostic radiographs; and
- (iii) Post treatment evaluation radiographs if taken at least three months after treatment.

(g) Does not pay for endodontic retreatment when provided by the original treating provider or clinic unless prior authorized by the department.

(h) 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.

(i) Covers apicoectomy and a retrograde fill for anterior teeth only.

[11-14-075, recodified as § 182-535-1086, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-042, § 388-535-1086, filed 3/1/07, effective 4/1/07.]

WAC 182-535-1088 Covered dental-related services for clients through age twenty—Periodontic services. The department covers medically necessary periodontic services, subject to the coverage limitations listed, for clients through age twenty as follows:

(1) **Surgical periodontal services.** The department covers the following surgical periodontal services, including all postoperative care:

(a) Gingivectomy/gingivoplasty only on a case-by-case basis and when prior authorized; and

(b) Gingivectomy/gingivoplasty for clients of the division of developmental disabilities according to WAC 388-535-1099.

(2) Nonsurgical periodontal services. The department:

(a) 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 thirteen through eighteen, and only when:

(i) The client has radiographic evidence of periodontal disease;

(ii) The client's record includes supporting documentation for the medical necessity, including complete periodontal charting and a definitive diagnosis of periodontal disease;

(iii) The client's clinical condition meets current published periodontal guidelines; and

(iv) Performed at least two years from the date of completion of periodontal scaling and root planing or surgical periodontal treatment.

(b) Covers periodontal scaling and root planing once per quadrant, per client, in a two-year period for clients ages nineteen through twenty. Criteria in (a)(i) through (iv) of this subsection must be met.

(c) Considers ultrasonic scaling, gross scaling, or gross debridement to be included in the procedure and not a substitution for periodontal scaling and root planing.

(d) 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.

(e) Covers periodontal scaling and root planing for clients of the division of developmental disabilities according to WAC 388-535-1099.

(3) Other periodontal services. The department:

(a) Covers periodontal maintenance once per client in a twelve-month period on a case-by-case basis, when prior authorized, for clients ages thirteen through eighteen, and only when:

(i) The client has radiographic evidence of periodontal disease;

(ii) The client's record includes supporting documentation for the medical necessity, including complete periodontal charting and a definitive diagnosis of periodontal disease;

(iii) The client's clinical condition meets current published periodontal guidelines; and

(iv) Performed at least twelve months from the date of completion of periodontal scaling and root planing, or surgical periodontal treatment.

(b) Covers periodontal maintenance once per client in a twelve month period for clients ages nineteen through twenty. Criteria in (a)(i) through (iv) of this subsection must be met.

(c) Covers periodontal maintenance only if performed on a different date of service as prophylaxis, periodontal scaling and root planing, gingivectomy, or gingivoplasty.

(d) Covers periodontal maintenance for clients of the division of developmental disabilities according to WAC 388-535-1099.

[11-14-075, recodified as § 182-535-1088, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-042, § 388-535-1088, filed 3/1/07, effective 4/1/07.]

WAC 182-535-1090 Covered dental-related services for clients through age twenty—Prosthodontics (removable). The department covers medically necessary prosth-

odontics (removable) services, subject to the coverage limitations listed, for clients through age twenty as follows:

(1) Prosthodontics. The department:

(a) Requires prior authorization for all removable prosthodontic and prosthodontic-related procedures, except as stated in (c)(ii)(B) of this subsection. Prior authorization requests must meet the criteria in WAC 388-535-1220. In addition, the department requires the dental provider to submit:

(i) Appropriate and diagnostic radiographs of all remaining teeth.

(ii) A dental record which identifies:

(A) All missing teeth for both arches;

(B) Teeth that are to be extracted; and

(C) Dental and periodontal services completed on all remaining teeth.

(iii) A prescription written by a dentist when a denturist's prior authorization request is for an immediate denture or a cast metal partial denture.

(b) Covers complete dentures, as follows:

(i) A complete denture, including an immediate denture or overdenture, is covered when prior authorized.

(ii) 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.

(iii) Replacement of an immediate denture with a complete denture is covered if the complete denture is prior authorized at least six months after the seat date of the immediate denture.

(iv) Replacement of a complete denture or overdenture is covered 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.

(c) Covers partial dentures, as follows:

(i) A partial denture, including a resin or flexible base partial denture, is covered for anterior and posterior teeth when the partial denture meets the following department coverage criteria.

(A) The remaining teeth in the arch must have a reasonable periodontal diagnosis and prognosis;

(B) The client has established caries control;

(C) One or more anterior teeth are missing or four or more posterior teeth are missing;

(D) There is a minimum of four stable teeth remaining per arch; and

(E) There is a three-year prognosis for retention of the remaining teeth.

(ii) Prior authorization of partial dentures:

(A) Is required for clients ages nine and younger; and

(B) Not required for clients ages ten through twenty.

Documentation supporting the medical necessity for the service must be included in the client's file.

(iii) 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.

(iv) Replacement of a resin or flexible base denture is covered 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 department coverage criteria in (c)(i) of this subsection.

(d) Covers cast-metal framework partial dentures, as follows:

(i) Cast-metal framework with resin-based partial dentures, including any conventional clasps, rests, and teeth, are covered for clients ages eighteen through twenty only once in a five-year period, on a case-by-case basis, when prior authorized and department coverage criteria listed in subsection (d)(v) of this subsection are met.

(ii) Cast-metal framework partial dentures for clients ages seventeen and younger are not covered.

(iii) 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.

(iv) Replacement of a cast metal framework partial denture is covered 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 department coverage criteria listed in (d)(v) of this subsection.

(v) Department authorization and payment for cast metal framework partial dentures is based on the following criteria:

(A) The remaining teeth in the arch must have a stable periodontal diagnosis and prognosis;

(B) The client has established caries control;

(C) All restorative and periodontal procedures must be completed before the request for prior authorization is submitted;

(D) There are fewer than eight posterior teeth in occlusion;

(E) There is a minimum of four stable teeth remaining per arch; and

(F) There is a five-year prognosis for the retention of the remaining teeth.

(vi) The department may consider resin partial dentures as an alternative if the department determines the criteria for cast metal framework partial dentures listed in (d)(v) of this subsection are not met.

(e) Requires a provider to bill for removable prosthetic procedures only after the seating of the prosthesis, not at the impression date. Refer to subsection (2)(e) and (f) for what the department may pay if the removable prosthesis is not delivered and inserted.

(f) Requires a provider to submit the following with a prior authorization request for removable prosthetics for a client residing in an alternate living facility (ALF) as defined in WAC 388-513-1301 or in a nursing facility:

(i) The client's medical diagnosis or prognosis;

(ii) The attending physician's request for prosthetic services;

(iii) The attending dentist's or denturist's statement documenting medical necessity;

(iv) A written and signed consent for treatment from the client's legal guardian when a guardian has been appointed; and

(v) A completed copy of the denture/partial appliance request for skilled nursing facility client form (DSHS 13-788) available from the department's published billing instructions.

(g) Limits removable partial dentures to resin-based partial dentures for all clients residing in one of the facilities listed in (f) of this subsection. The department may consider cast metal partial dentures if the criteria in subsection (1)(d) are met.

(h) Requires a provider to deliver services and procedures that are of acceptable quality to the department. The department may recoup payment for services that are determined to be below the standard of care or of an unacceptable product quality.

(2) **Other services for removable prosthodontics.** The department covers:

(a) Adjustments to complete and partial dentures three months after the date of delivery.

(b) Repairs to complete and partial dentures, once in a twelve month period. The department covers additional repairs on a case-by-case basis and when prior authorized.

(c) A laboratory reline or 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 reline or rebase may be covered for complete or cast-metal partial dentures on a case-by-case basis when prior authorized.

(d) Up to two tissue conditionings, and only when performed within three months after the seating date.

(e) Laboratory fees, subject to the following:

(i) The department does not pay separately for laboratory or professional fees for complete and partial dentures; and

(ii) The department may pay part of billed laboratory fees when the provider obtains prior authorization, and the client:

(A) Is not eligible at the time of delivery of the prosthesis;

(B) Moves from the state;

(C) Cannot be located;

(D) Does not participate in completing the complete, immediate, or partial dentures; or

(E) Dies.

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

[11-14-075, recodified as § 182-535-1090, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-042, § 388-535-1090, filed 3/1/07, effective 4/1/07.]

WAC 182-535-1092 Covered dental-related services for clients through age twenty—Maxillofacial prosthetic services. The department covers medically necessary maxillofacial prosthetic services, subject to the coverage limitations listed, for clients through age twenty as follows:

(1) Maxillofacial prosthetics are covered only on a case-by-case basis and when prior authorized; and

(2) The department must preapprove a provider qualified to furnish maxillofacial prosthetics.

[11-14-075, recodified as § 182-535-1092, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-042, § 388-535-1092, filed 3/1/07, effective 4/1/07.]

WAC 182-535-1094 Covered dental-related services for clients through age twenty—Oral and maxillofacial surgery services. The department covers medically neces-

sary oral and maxillofacial surgery services, subject to the coverage limitations listed, for clients through age twenty as follows:

(1) **Oral and maxillofacial surgery services.** The department:

(a) Requires enrolled providers who do not meet the conditions in WAC 388-535-1070(3) to bill claims for services that are listed in this subsection using only the current dental terminology (CDT) codes.

(b) Requires enrolled providers (oral and maxillofacial surgeons) who meet the conditions in WAC 388-535-1070(3) to bill claims using current procedural terminology (CPT) codes unless the procedure is specifically listed in the department's current published billing instructions as a CDT covered code (e.g., extractions).

(c) Covers nonemergency oral surgery performed in a hospital or ambulatory surgery center only for:

- (i) Clients ages eight and younger;
- (ii) Clients ages nine through twenty only on a case-by-case basis and when prior authorized; and
- (iii) Clients of the division of developmental disabilities according to WAC 388-535-1099.

(d) Requires the client's dental record to include supporting documentation for each type of extraction or any other surgical procedure billed to the department. The documentation must include:

- (i) Appropriate consent form signed by the client or the client's legal representative;
- (ii) Appropriate radiographs;
- (iii) Medical justification with diagnosis;
- (iv) Client's blood pressure, when appropriate;
- (v) A surgical narrative;
- (vi) A copy of the post-operative instructions; and
- (vii) A copy of all pre- and post-operative prescriptions.

(e) Covers routine and surgical extractions.

(f) Covers debridement of a granuloma or cyst that is five millimeters or greater in diameter. The department includes debridement of a granuloma or cyst that is less than five millimeters as part of the global fee for the extraction.

(g) Covers biopsy, as follows:

- (i) Biopsy of soft oral tissue or brush biopsy do not require prior authorization; and
- (ii) All biopsy reports or findings must be kept in the client's dental record.

(h) Covers alveoloplasty only on a case-by-case basis and when prior authorized. The department covers alveoloplasty only when not performed in conjunction with extractions.

(i) Covers surgical excision of soft tissue lesions only on a case-by-case basis and when prior authorized.

(j) Covers only the following excisions of bone tissue in conjunction with placement of immediate, complete, or partial dentures when prior authorized:

- (i) Removal of lateral exostosis;
- (ii) Removal of torus palatinus or torus mandibularis; and
- (iii) Surgical reduction of soft tissue or osseous tuberosity.

(2) **Surgical incisions.** The department covers the following surgical incision-related services:

(a) Uncomplicated intraoral and extraoral soft tissue incision and drainage of abscess. The department 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.

(b) 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.

(c) Frenuloplasty/frenulectomy for clients through age six. The department covers frenuloplasty/frenulectomy for clients ages seven through twelve only on a case-by-case and when prior authorized. Documentation supporting the medical necessity for the service must be in the client's record.

(3) **Occlusal orthotic devices.** (Refer to WAC 388-535-1098 (5)(c) for occlusal guard coverage and limitations on coverage.) The department covers:

(a) Occlusal orthotic devices for clients ages twelve through twenty only on a case-by-case basis and when prior authorized.

(b) An occlusal orthotic device only as a laboratory processed full arch appliance.

[11-14-075, recodified as § 182-535-1094, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-042, § 388-535-1094, filed 3/1/07, effective 4/1/07.]

WAC 182-535-1096 Covered dental-related services for clients through age twenty—Orthodontic services.

The department covers orthodontic services, subject to the coverage limitations listed, for clients through age twenty according to chapter 388-535A WAC.

[11-14-075, recodified as § 182-535-1096, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-042, § 388-535-1096, filed 3/1/07, effective 4/1/07.]

WAC 182-535-1098 Covered dental-related services for clients through age twenty—Adjunctive general services.

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

(1) **Adjunctive general services.** The department:

(a) Covers palliative (emergency) treatment, not to include pupal debridement (see WAC 388-535-1086 (2)(b)), for treatment of dental pain, limited to once per day, per client, as follows:

(i) The treatment must occur during limited evaluation appointments;

(ii) A comprehensive description of the diagnosis and services provided must be documented in the client's record; and

(iii) Appropriate radiographs must be in the client's record supporting the medical necessity of the treatment.

(b) Covers local anesthesia and regional blocks as part of the global fee for any procedure being provided to clients.

(c) Covers office based oral or parenteral conscious sedation, deep sedation, or general anesthesia, as follows:

(i) The provider's current anesthesia permit must be on file with the department.

(ii) For clients of the division of developmental disabilities, the services must be performed according to WAC 388-535-1099.

(iii) For clients ages eight and younger, documentation supporting the medical necessity of the anesthesia service must be in the client's record.

(iv) For clients ages nine through twenty, deep sedation or general anesthesia services are covered on a case-by-case basis and when prior authorized, except for oral surgery services. Oral surgery services listed in WAC 388-535-1094 do not require prior authorization.

(v) Prior authorization 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.

(vi) For clients ages nine through eighteen who have a diagnosis of oral facial cleft, the department does not require prior authorization for deep sedation or general anesthesia services when the dental procedure is directly related to the oral facial cleft treatment.

(vii) For clients through age twenty, the provider must bill anesthesia services using the CDT codes listed in the department's current published billing instructions.

(d) Covers inhalation of nitrous oxide for clients through age twenty, once per day.

(e) Requires providers of oral or parenteral conscious sedation, deep sedation, or general anesthesia to meet:

(i) The prevailing standard of care;

(ii) The provider's professional organizational guidelines;

(iii) The requirements in chapter 246-817 WAC; and

(iv) Relevant department of health (DOH) medical, dental, or nursing anesthesia regulations.

(f) Pays for anesthesia services according to WAC 388-535-1350.

(g) Covers professional consultation/diagnostic services as follows:

(i) A dentist or a physician other than the practitioner providing treatment must provide the services; and

(ii) A client must be referred by the department for the services to be covered.

(2) **Nonemergency dental services.** The department covers nonemergency dental services performed in a hospital or ambulatory surgical center only for:

(a) Clients ages eight and younger.

(b) Clients ages nine through twenty only on a case-by-case basis and when prior authorized.

(c) Clients of the division of developmental disabilities according to WAC 388-535-1099.

(3) **Professional visits.** The department covers:

(a) Up to two house/extended care facility calls (visits) per facility, per provider. The department limits payment to two facilities per day, per provider.

(b) One hospital call (visit), including emergency care, per day, per provider, per client.

(c) Emergency office visits after regularly scheduled hours. The department limits payment to one emergency visit per day, per provider.

(4) **Drugs and/or medicaments (pharmaceuticals).** The department covers drugs and/or medicaments only when used with parenteral conscious sedation, deep sedation, or general anesthesia. The department's dental program does not pay for oral sedation medications.

(5) **Miscellaneous services.** The department covers:

(a) Behavior management when the assistance of one additional dental staff other than the dentist is required, for:

(i) Clients ages eight and younger;

(ii) Clients ages nine through twenty, only on a case-by-case basis and when prior authorized;

(iii) Clients of the division of developmental disabilities according to WAC 388-535-1099; and

(iv) Clients who reside in an alternate living facility (ALF) as defined in WAC 388-513-1301 or in a nursing facility.

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

(c) Occlusal guards when medically necessary and prior authorized. (Refer to WAC 388-535-1094(3) for occlusal orthotic device coverage and coverage limitations.) The department covers:

(i) An occlusal guard only for clients ages twelve through twenty when the client has permanent dentition; and

(ii) An occlusal guard only as a laboratory processed full arch appliance.

[11-14-075, recodified as § 182-535-1098, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-042, § 388-535-1098, filed 3/1/07, effective 4/1/07.]

WAC 182-535-1099 Covered dental-related services for clients of the division of developmental disabilities.

The department pays for dental-related services under the categories of services listed in this section for clients of the division of developmental disabilities, subject to the coverage limitations listed. Chapter 388-535 WAC applies to clients of the division of developmental disabilities unless otherwise stated in this section.

(1) Preventive services.

(a) **Dental prophylaxis.** The department covers dental prophylaxis or periodontal maintenance up to three times in a twelve-month period (see subsection (3) of this section for limitations on periodontal scaling and root planing).

(b) **Topical fluoride treatment.** The department covers topical fluoride varnish, rinse, foam or gel, up to three times within a twelve-month period.

(c) **Sealants.** The department covers sealants:

(i) Only when used on the occlusal surfaces of:

(A) Primary teeth A, B, I, J, K, L, S, and T; or

(B) Permanent teeth two, three, four, five, twelve, thirteen, fourteen, fifteen, eighteen, nineteen, twenty, twenty-one, twenty-eight, twenty-nine, thirty, and thirty-one.

(ii) Once per tooth in a two-year period.

(2) **Crowns.** The department covers stainless steel crowns every two years for the same tooth and only for primary molars and permanent premolars and molars, as follows:

(a) For clients ages twenty and younger, the department does not require prior authorization for stainless steel crowns. Documentation supporting the medical necessity of the service must be in the client's record.

(b) For clients ages twenty-one and older, the department requires prior authorization for stainless steel crowns.

(3) Periodontic services.

(a) **Surgical periodontal services.** The department covers:

(i) 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).

(ii) Gingivectomy/gingivoplasty with periodontal scaling and root planing or periodontal maintenance when the services are performed:

(A) In a hospital or ambulatory surgical center; or

(B) For clients under conscious sedation, deep sedation, or general anesthesia.

(b) **Non-surgical periodontal services.** The department covers:

(i) Periodontal scaling and root planing, up to two times per quadrant in a twelve-month period.

(ii) Periodontal scaling (four quadrants) substitutes for an eligible periodontal maintenance or oral prophylaxis, twice in a twelve-month period.

(4) Adjunctive general services.

(a) **Adjunctive general services.** The department covers:

(i) 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.

(ii) Sedations services according to WAC 388-535-1098 (1)(c) and (e).

(b) **Nonemergency dental services.** The department covers nonemergency dental services performed in a hospital or an ambulatory surgical center for services listed as covered in WAC 388-535-1082, 388-535-1084, 388-535-1086, 388-535-1088, and 388-535-1094. Documentation supporting the medical necessity of the service must be included in the client's record.

(5) Miscellaneous services—Behavior management.

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

[11-14-075, recodified as § 182-535-1099, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520, 07-06-042, § 388-535-1099, filed 3/1/07, effective 4/1/07.]

WAC 182-535-1100 Dental-related services not covered for clients through age twenty. (1) The department does not cover the following for clients through age twenty:

(a) The dental-related services described in subsection (2) of this section unless the services are covered under the early periodic screening, diagnosis and treatment (EPSDT) program. See WAC 388-534-0100 for information about the EPSDT program.

(b) Any service specifically excluded by statute.

(c) More costly services when less costly, equally effective services as determined by the department are available.

(d) Services, procedures, treatment, devices, drugs, or application of associated services:

(i) Which the department or the Centers for Medicare and Medicaid Services (CMS) considers investigative or experimental on the date the services were provided.

(ii) That are not listed as covered in one or both of the following:

(A) Washington Administrative Code (WAC).

(B) The department's current published documents.

(2) The department does not cover dental-related services listed under the following categories of service for clients through age twenty (see subsection (1)(a) of this section for services provided under the EPSDT program):

(a) **Diagnostic services.** The department does not cover:

(i) Extraoral radiographs.

(ii) Comprehensive periodontal evaluations.

(b) **Preventive services.** The department does not cover:

(i) Nutritional counseling for control of dental disease.

(ii) Tobacco counseling for the control and prevention of oral disease.

(iii) Removable space maintainers of any type.

(iv) Sealants placed on a tooth with the same-day occlusal restoration, preexisting occlusal restoration, or a tooth with occlusal decay.

(v) Space maintainers for clients ages nineteen through twenty.

(c) **Restorative services.** The department does not cover:

(i) Gold foil restorations.

(ii) Metallic, resin-based composite, or porcelain/ceramic inlay/onlay restorations.

(iii) Crowns for cosmetic purposes (e.g., peg laterals and tetracycline staining).

(iv) Crowns for third molars one, sixteen, seventeen, and thirty-two.

(v) Temporary or provisional crowns (including ion crowns).

(vi) Labial veneer resin or porcelain laminate restorations.

(vii) Any type of coping.

(viii) Crown repairs.

(ix) Polishing or recontouring restorations or overhang removal for any type of restoration.

(d) **Endodontic services.** The department does not cover:

(i) Any endodontic therapy on primary teeth, except as described in WAC 388-535-1086 (3)(a).

(ii) Apexification/recalcification for root resorption of permanent anterior teeth.

(iii) Any apexification/recalcification procedures for bicuspid or molar teeth.

(iv) Any apicoectomy/periradicular services for bicuspid or molar teeth.

(v) Any surgical endodontic procedures including, but not limited to, retrograde fillings (except for anterior teeth), root amputation, reimplantation, and hemisections.

(e) **Periodontic services.** The department does not cover:

(i) Surgical periodontal services including, but not limited to:

(A) Gingival flap procedures.

(B) Clinical crown lengthening.

(C) Osseous surgery.

(D) Bone or soft tissue grafts.

(E) Biological material to aid in soft and osseous tissue regeneration.

(F) Guided tissue regeneration.

(G) 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.

(H) Distal or proximal wedge procedures.

(ii) Nonsurgical periodontal services including, but not limited to:

(A) Intracoronal or extracoronal provisional splinting.

(B) Full mouth or quadrant debridement.

(C) Localized delivery of chemotherapeutic agents.

(D) Any other type of nonsurgical periodontal service.

(f) **Removable prosthodontics.** The department does not cover:

(i) Removable unilateral partial dentures.

(ii) Any interim complete or partial dentures.

(iii) Precision attachments.

(iv) Replacement of replaceable parts for semi-precision or precision attachments.

(g) **Implant services.** The department does not cover:

(i) 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.

(ii) Any maintenance or repairs to procedures listed in (g)(i) of this subsection.

(iii) The removal of any implant as described in (g)(i) of this subsection.

(h) **Fixed prosthodontics.** The department does not cover:

(i) Any type of fixed partial denture pontic or fixed partial denture retainer.

(ii) Any type of precision attachment, stress breaker, connector bar, coping, cast post, or any other type of fixed attachment or prosthesis.

(i) **Oral and maxillofacial surgery.** The department does not cover:

(i) Any oral surgery service not listed in WAC 388-535-1094.

(ii) Any oral surgery service that is not listed in the department's list of covered current procedural terminology (CPT) codes published in the department's current rules or billing instructions.

(j) **Adjunctive general services.** The department does not cover:

(i) Anesthesia, including, but not limited to:

(A) Local anesthesia as a separate procedure.

(B) Regional block anesthesia as a separate procedure.

(C) Trigeminal division block anesthesia as a separate procedure.

(D) Medication for oral sedation, or therapeutic intramuscular (IM) drug injections, including antibiotic and injection of sedative.

(E) Application of any type of desensitizing medicament or resin.

(ii) Other general services including, but not limited to:

(A) Fabrication of an athletic mouthguard.

(B) Occlusion analysis.

(C) Occlusal adjustment or odontoplasties.

(D) Enamel microabrasion.

(E) Dental supplies such as toothbrushes, toothpaste, floss, and other take home items.

(F) Dentist's or dental hygienist's time writing or calling in prescriptions.

(G) Dentist's or dental hygienist's time consulting with clients on the phone.

(H) Educational supplies.

(I) Nonmedical equipment or supplies.

(J) Personal comfort items or services.

(K) Provider mileage or travel costs.

(L) Fees for no-show, cancelled, or late arrival appointments.

(M) Service charges of any type, including fees to create or copy charts.

(N) Office supplies used in conjunction with an office visit.

(O) Teeth whitening services or bleaching, or materials used in whitening or bleaching.

[11-14-075, recodified as § 182-535-1100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-042, § 388-535-1100, filed 3/1/07, effective 4/1/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191. 03-19-078, § 388-535-1100, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1100, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1100, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1100, filed 12/6/95, effective 1/6/96.]

WAC 182-535-1220 Obtaining prior authorization for dental-related services for clients through age twenty.

(1) The department uses the determination process for payment described in WAC 388-501-0165 for covered dental-related services for clients through age twenty that require prior authorization.

(2) The department requires a dental provider who is requesting prior authorization to submit sufficient objective clinical information to establish medical necessity. The request must be submitted in writing on an American Dental Association (ADA) claim form, which may be obtained by writing to the American Dental Association, 211 East Chicago Avenue, Chicago, Illinois 60611.

(3) The department may request additional information as follows:

(a) Additional radiographs (X rays) (refer to WAC 388-535-1080(2)).;

(b) Study models;

(c) Photographs; and

(d) Any other information as determined by the department.

(4) The department may require second opinions and/or consultations before authorizing any procedure.

(5) When the department 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.

(6) The department denies a request for a dental-related service when the requested service:

- (a) Is covered by another department program;
- (b) Is covered by an agency or other entity outside the department; or
- (c) Fails to meet the program criteria, limitations, or restrictions in chapter 388-535 WAC.

[11-14-075, recodified as § 182-535-1220, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-042, § 388-535-1220, filed 3/1/07, effective 4/1/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191. 03-19-078, § 388-535-1220, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1220, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1220, filed 3/10/99, effective 4/10/99.]

ABCD DENTAL PROGRAM

WAC 182-535-1245 Access to baby and child dentistry (ABCD) program. The access to baby and child dentistry (ABCD) program is a program established to increase access to dental services for medicaid-eligible clients ages five and younger.

(1) Client eligibility for the ABCD program is as follows:

(a) Clients must be age five and younger. Once enrolled in the ABCD program, eligible clients are covered until their sixth birthday.

(b) Clients eligible under one of the following medical assistance programs are eligible for the ABCD program:

- (i) Categorically needy program (CNP);
- (ii) Limited casualty program-medically needy program (LCP-MNP);
- (iii) Children's health program; or
- (iv) State children's health insurance program (SCHIP).

(c) ABCD program services for eligible clients enrolled in a managed care organization (MCO) plan are paid through the fee-for-service payment system.

(2) Health care providers and community service programs identify and refer eligible clients to the ABCD program. If enrolled, the client and an adult family member may receive:

- (a) Oral health education;
- (b) "Anticipatory guidance" (expectations of the client and the client's family members, including the importance of keeping appointments); and
- (c) Assistance with transportation, interpreter services, and other issues related to dental services.

(3) The department pays enhanced fees only to ABCD-certified dentists and other department-approved certified providers for furnishing ABCD program services. ABCD program services include, when appropriate:

(a) Family oral health education. An oral health education visit:

- (i) Is limited to one visit per day per family, up to two visits per child in a twelve-month period, per provider or clinic; and
- (ii) Must include all of the following:
 - (A) "Lift the lip" training;
 - (B) Oral hygiene training;

(C) Risk assessment for early childhood caries;

(D) Dietary counseling;

(E) Discussion of fluoride supplements; and

(F) Documentation in the client's file or the client's designated adult member's (family member or other responsible adult) file to record the activities provided and duration of the oral education visit.

(b) Periodic oral evaluation, up to two visits per client, per calendar year, per provider or clinic;

(c) Topical application of fluoride varnish;

(d) Amalgam, resin, and glass ionomer restorations on primary teeth, as specified in current department-published documents;

(e) Therapeutic pulpotomy;

(f) Prefabricated stainless steel crowns on primary teeth, as specified in current department-published documents;

(g) Resin-based composite crowns on anterior primary teeth; and

(h) Other dental-related services, as specified in current department-published documents.

(4) The client's file must show documentation of the ABCD program services provided.

[11-14-075, recodified as § 182-535-1245, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.08.090. 08-16-009, § 388-535-1245, filed 7/24/08, effective 8/24/08. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-042, § 388-535-1245, filed 3/1/07, effective 4/1/07. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and .225. 02-11-136, § 388-535-1245, filed 5/21/02, effective 6/21/02.]

ADULTS' DENTAL-RELATED SERVICES

WAC 182-535-1247 Dental-related services for clients age twenty-one and older—General. (1) Subject to coverage limitations, the department pays for dental-related services and procedures provided to clients age twenty-one and older when the services and procedures:

(a) Are within the scope of an eligible client's medical care program;

(b) Are medically necessary as defined in WAC 388-500-0005;

(c) Meet the department's prior authorization requirements, if any;

(d) Are documented in the client's record in accordance with chapter 388-502 WAC;

(e) Are within prevailing standard of care accepted dental or medical practice standards;

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

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

(h) Are listed as covered in the department's published rules, billing instructions and fee schedules.

(2) Clients who are eligible for services through the division of developmental disabilities may receive dental-related services under the provisions of WAC 388-535-1099.

(3) The department evaluates a request for dental-related services:

(a) That are in excess of the dental program's limitations or restrictions, according to WAC 388-501-0169; and

(b) That are listed as noncovered under the provisions in WAC 388-501-0160.

[11-14-075, recodified as § 182-535-1247, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-041, § 388-535-1247, filed 3/1/07, effective 4/1/07.]

WAC 182-535-1255 Covered dental-related services—Adults. The department covers dental-related diagnostic services only as listed in this section for clients age twenty-one and older (for dental-related services provided to clients eligible under the GA-U or ADATSA program, see WAC 388-535-1065).

(1) **Clinical oral evaluations.** The department covers:

(a) Oral health evaluations and assessments. The services must be documented in the client's record in accordance with WAC 388-502-0020;

(b) Periodic oral evaluations as defined in WAC 388-535-1050, once every twelve months. Twelve months must elapse between the comprehensive oral evaluation and the first periodic oral evaluation;

(c) Limited oral evaluations as defined in WAC 388-535-1050, only when the provider performing the limited oral evaluation is not providing routine scheduled dental services for the client. The limited oral evaluation:

(i) Must be to evaluate the client for a:

(A) Specific dental problem or oral health complaint;

(B) Dental emergency; or

(C) Referral for other treatment.

(ii) When performed by a dentist, is limited to the initial examination appointment. The department does not cover an additional limited oral examination by a dentist for the same client until three months after the removable prosthesis has been seated.

(d) Comprehensive oral evaluations as defined in WAC 388-535-1050, once per client, per provider or clinic, as an initial examination. The department covers an additional comprehensive oral evaluation if the client has not been treated by the same provider or clinic within the past five years;

(e) Limited visual oral assessments as defined in WAC 388-535-1050, up to two per client, per year, per provider only when the assessment is:

(i) Not performed in conjunction with other clinical evaluation services;

(ii) Performed to determine the need for fluoride treatment and/or when triage services are provided in settings other than dental offices or clinics; and

(iii) Provided by a licensed dentist or licensed dental hygienist.

(2) **Radiographs (X rays).** The department:

(a) Covers radiographs that are of diagnostic quality, dated, and labeled with the client's name. The department 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 required.

(b) Uses the prevailing standard of care to determine the need for dental radiographs.

(c) Covers intraoral complete series (includes four bitewings), once in a three-year period only if the department has not paid for a panoramic radiograph for the same client in the same three-year period.

(d) Covers periapical radiographs that are not included in a complete series. Documentation supporting the medical necessity for these must be in the client's record.

(e) Covers up to four bitewing radiographs once in a twelve month period.

(f) Covers panoramic radiographs in conjunction with four bitewings, once in a three-year period, only if the department has not paid for an intraoral complete series for the same client in the same three-year period.

(g) 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.

[11-14-075, recodified as § 182-535-1255, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-041, § 388-535-1255, filed 3/1/07, effective 4/1/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191. 03-19-079, § 388-535-1255, filed 9/12/03, effective 10/13/03.]

WAC 182-535-1257 Covered dental-related services for clients age twenty-one and older—Preventive services. The department covers dental-related preventive services only as listed in this section for clients age twenty-one and older (for dental-related services provided to clients eligible under the GA-U or ADATSA program, see WAC 388-535-1065).

(1) **Dental prophylaxis.** The department covers dental prophylaxis:

(a) Which includes scaling and polishing procedures to remove coronal plaque, calculus, and stains once every twelve months;

(b) Only when the service is performed twelve months after periodontal scaling and root planing, or periodontal maintenance services;

(c) Only when not performed on the same date of service as periodontal scaling and root planing, or periodontal maintenance, gingivectomy or gingivoplasty; and

(d) For clients of the division of development disabilities according to WAC 388-535-1099.

(2) **Topical fluoride treatment.** The department covers:

(a) Fluoride rinse, foam or gel, once within a twelve-month period;

(b) Fluoride varnish, rinse, foam or gel for clients who are age sixty-five and older, or clients who reside in alternative living facilities, up to three times within a twelve-month period;

(c) Additional topical fluoride applications when prior authorized; and

(d) Topical fluoride treatment for clients of the division of developmental disabilities according to WAC 388-535-1099.

[11-14-075, recodified as § 182-535-1257, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-041, § 388-535-1257, filed 3/1/07, effective 4/1/07.]

WAC 182-535-1259 Covered dental-related services for clients age twenty-one and older—Restorative services. The department covers dental-related restorative services only as listed in this section for clients age twenty-one and older (for dental-related services provided to clients eli-

gible under the GA-U or ADATSA program, see WAC 388-535-1065).

(1) **Amalgam restorations for permanent teeth.** The department:

(a) Considers tooth preparation, all adhesives (including amalgam bonding agents), liners, bases, and polishing as part of the amalgam restoration;

(b) Considers the occlusal adjustment of either the restored tooth or the opposing tooth or teeth as part of the restoration;

(c) Considers buccal or lingual surface amalgam restorations, regardless of size or extension, as a one surface restoration. The department covers only one buccal and one lingual surface per tooth;

(d) Considers multiple amalgam restorations of fissures and grooves of the occlusal surface of the same tooth as a one surface restoration;

(e) Covers two occlusal amalgam restorations for teeth one, two, three, fourteen, fifteen, and sixteen, if the restorations are anatomically separated by sound tooth structure;

(f) Covers 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;

(g) Covers amalgam restorations for a maximum of six surfaces per tooth for teeth one, two, three, fourteen, fifteen and sixteen, once per client, per provider or clinic, in a two-year period. See also (e) of this subsection; and

(h) Does not pay for replacement of an amalgam restoration by the same provider on a permanent posterior tooth within a two-year period unless the restoration has an additional adjoining carious surface. The department 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.

(2) **Resin-based composite restorations for permanent teeth.** The department:

(a) 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;

(b) Considers the occlusal adjustment of either the restored tooth or the opposing tooth or teeth as part of the resin-based composite restoration;

(c) Considers buccal or lingual surface resin-based composite restorations, regardless of size or extension, as a one surface restoration. The department covers only one buccal and one lingual surface per tooth;

(d) Considers resin-based composite restorations of teeth where the decay does not penetrate the DEJ to be sealants. The department does not cover sealants for clients age twenty-one and older;

(e) Considers multiple preventive restorative resins or flowable composite resins for the occlusal, buccal, lingual, mesial, and distal fissures and grooves on the same tooth as a one surface restoration;

(f) Does not cover preventive restorative resin or flowable composite resin on the interproximal surfaces (mesial and/or distal) of posterior teeth or the incisal surface of anterior teeth;

(g) Covers two occlusal resin-based composite restorations for teeth one, two, three, fourteen, fifteen, and sixteen if the restorations are anatomically separated by sound tooth structure;

(h) Covers 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;

(i) Covers resin-based composite restorations for a maximum of six surfaces per tooth for permanent posterior teeth one, two, three, fourteen, fifteen and sixteen, once per client, per provider or clinic, in a two-year period. See also (g) of this subsection;

(j) Covers 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; and

(k) Does not pay for replacement of resin-based composite restorations by the same provider on permanent teeth within a two-year period unless the restoration has an additional adjoining carious surface. The department 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.

(3) **Crowns.** The department:

(a) Does not cover permanent crowns for clients age twenty-one and older, except for prefabricated stainless steel crowns for posterior permanent teeth on a case-by-case basis when prior authorized; and

(b) Covers crowns for clients of the division of developmental disabilities according to WAC 388-535-1099.

[11-14-075, recodified as § 182-535-1259, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-041, § 388-535-1259, filed 3/1/07, effective 4/1/07.]

WAC 182-535-1261 Covered dental-related services for clients age twenty-one and older—Endodontic services. The department covers dental-related endodontic services only as listed in this section for clients age twenty-one and older (for dental-related services provided to clients eligible under the GA-U or ADATSA program, see WAC 388-535-1065).

(1) **Pulpal debridement.** The department covers pulpal debridement on permanent teeth. Pulpal debridement is not covered when performed with palliative treatment or when performed on the same day as endodontic treatment.

(2) **Endodontic treatment.** The department:

(a) Covers endodontic treatment for permanent anterior teeth only;

(b) Considers the following included in endodontic treatment:

(i) Pulpectomy when part of root canal therapy;

(ii) All procedures necessary to complete treatment; and

(iii) All intra-operative and final evaluation radiographs for the endodontic procedure.

(c) Pays separately for the following services that are related to the endodontic treatment:

(i) Initial diagnostic evaluation;

(ii) Initial diagnostic radiographs; and

(iii) Post treatment evaluation radiographs if taken at least three months after treatment.

(d) Requires prior authorization for endodontic retreatment and considers endodontic retreatment to include:

- (i) The removal of post(s), pin(s), old root canal filling material, and all procedures necessary to prepare the canals;
- (ii) Placement of new filling material; and
- (iii) Retreatment for permanent maxillary and mandibular anterior teeth only.

(e) Pays separately for the following services that are related to the endodontic retreatment:

- (i) Initial diagnostic evaluation;
- (ii) Initial diagnostic radiographs; and
- (iii) Post treatment evaluation radiographs if taken at least three months after treatment.

(f) Does not pay for endodontic retreatment when provided by the original treating provider or clinic.

[11-14-075, recodified as § 182-535-1261, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-041, § 388-535-1261, filed 3/1/07, effective 4/1/07.]

WAC 182-535-1263 Covered dental-related services for clients age twenty-one and older—Periodontic services. The department covers dental-related periodontic services only as listed in this section for clients age twenty-one and older (for dental-related services provided to clients eligible under the GA-U or ADATSA program, see WAC 388-535-1065).

(1) **Surgical periodontal services.** The department covers surgical periodontal services, including all postoperative care for clients of the division of development disabilities according to WAC 388-535-1099.

(2) **Nonsurgical periodontal services.** The department:

(a) Covers periodontal scaling and root planing once per quadrant, per client, in a two-year period when:

- (i) The client has radiographic evidence of periodontal disease;
- (ii) The client's record includes supporting documentation for the medical necessity, including complete periodontal charting and a definitive diagnosis of periodontal disease;
- (iii) The client's clinical condition meets current published periodontal guidelines; and
- (iv) Performed at least two years from the date of completion of periodontal scaling and root planing or surgical periodontal treatment.

(b) Considers ultrasonic scaling, gross scaling, or gross debridement to be included in the procedure and not a substitution for periodontal scaling and root planing.

(c) 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.

(d) Covers periodontal scaling and root planing for clients of the division of developmental disabilities according to WAC 388-535-1099.

(3) **Other periodontal services.** The department:

(a) Covers periodontal maintenance once per client in a twelve-month period when:

- (i) The client has radiographic evidence of periodontal disease;

(ii) The client's record includes supporting documentation for medical necessity, including complete periodontal charting and a definitive diagnosis of periodontal disease;

(iii) The client's clinical condition meets existing published periodontal guidelines; and

(iv) Performed at least twelve months from the date of completion of periodontal scaling and root planing or surgical periodontal treatment.

(b) Covers periodontal maintenance only if performed on a different date of service as prophylaxis, periodontal scaling and root planing, gingivectomy, or gingivoplasty.

(c) Covers periodontal maintenance for clients of the division of developmental disabilities according to WAC 388-535-1099.

[11-14-075, recodified as § 182-535-1263, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-041, § 388-535-1263, filed 3/1/07, effective 4/1/07.]

WAC 182-535-1266 Covered dental-related services for clients age twenty-one and older—Prosthodontics (removable). The department covers dental-related prosthodontics (removable) services only as listed in this section for clients age twenty-one and older (for dental-related services provided to clients eligible under the GA-U or ADATSA program, see WAC 388-535-1065).

(1) **Removable prosthodontics.** The department:

(a) Requires prior authorization requests for all removable prosthodontics and prosthodontic-related procedures listed in this subsection. Prior authorization requests must meet the criteria in WAC 535-1280. In addition, the department requires the dental provider to:

(i) Submit:

(A) Appropriate and diagnostic radiographs of all remaining teeth.

(B) A dental record that identifies:

(I) All missing teeth for both arches;

(II) Teeth that are to be extracted; and

(III) Dental and periodontal services completed on all remaining teeth.

(C) A prescription written by a dentist when a denturist's prior authorization request is for an immediate denture or cast metal partial denture.

(ii) Obtain a signed agreement of acceptance from the client at the conclusion of the final denture try-in for a department authorized complete denture or a cast-metal denture described in this section. If the client abandons the complete denture or the cast-metal partial denture after signing the agreement of acceptance, the department will deny subsequent requests for the same type dental prosthesis if the request occurs prior to the dates specified in this section. A copy of the signed agreement that documents the client's acceptance of the dental prosthesis must be submitted to the department's dental prior authorization section before the department pays the claim.

(b) Covers a complete denture, as follows:

(i) A complete denture, including an immediate denture or overdenture, is covered when prior authorized and the complete denture meets department coverage criteria;

(ii) Post-delivery care (e.g., adjustments, soft relines, and repairs) provided within three months of the seat date of a

complete denture, is considered part of the complete denture procedure and is not paid separately;

(iii) Replacement of an immediate denture with a complete denture is covered only when the replacement occurs at least six months from the seat date of the immediate denture. The replacement complete denture must be prior authorized; and

(iv) Replacement of a complete denture or overdenture is covered only when the replacement occurs at least five years from the seat date of the complete denture or overdenture being replaced. The replacement denture must be prior authorized.

(c) Covers partial dentures as follows:

(i) Department authorization and payment for a resin or flexible base partial denture for anterior and posterior teeth is based on the following criteria:

(A) The remaining teeth in the arch must have a reasonable periodontal diagnosis and prognosis;

(B) The client has established caries control;

(C) One or more anterior teeth are missing, or four or more posterior teeth per arch are missing;

(D) There is a minimum of four stable teeth remaining per arch; and

(E) There is a three-year prognosis for retention of all remaining teeth.

(ii) Post-delivery care (e.g. adjustments, soft relines, and repairs) provided after three months from the seat date of the partial denture, is considered part of the partial denture and is not paid separately; and

(iii) Replacement of a resin or flexible base denture is covered only when the replacement occurs at least three years from the seat date of the partial denture being replaced. The replacement denture must be prior authorized and meet department coverage criteria.

(d) Covers cast metal framework partial dentures as follows:

(i) A cast metal framework with resin-based denture, including any conventional clasps, rests, and teeth, is covered on a case-by-case basis when prior authorized and department coverage criteria listed in (d)(iv) of this subsection are met.

(ii) Post-delivery care (e.g., adjustments, soft relines, and repairs) provided within three months of the seat date of the cast metal partial denture, is considered part of the partial denture procedure and is not paid separately.

(iii) Replacement of a cast metal framework partial denture is covered on a case-by-case basis and only when the replacement occurs at least five years from the seat date of the partial denture being replaced. The replacement denture must be prior authorized and meet department coverage criteria listed in (d)(iv) of this subsection.

(iv) Department authorization and payment for cast metal framework partial dentures is based on the following criteria:

(A) The remaining teeth in the arch must have a stable periodontal diagnosis and prognosis;

(B) The client has established caries control;

(C) All restorative and periodontal procedures must be completed before the request for prior authorization is submitted;

(D) There are fewer than eight posterior teeth in occlusion;

(E) There is a minimum of four stable teeth remaining per arch;

(F) There is a five-year prognosis, based on the sole discretion of the department, for retention of all remaining teeth.

(v) The department may consider resin partial dentures as an alternative if the criteria for cast metal framework partial dentures listed in (d)(iv) of this subsection do not meet department specifications.

(e) Requires the provider to bill for covered removable prosthetic procedures only after the seating of the prosthesis, not at the impression date. Refer to (2)(c) and (d) of this subsection if the removable prosthesis is not delivered and inserted.

(f) Requires a provider to submit the following with prior authorization requests for removable prosthetics for a client residing in a nursing home, group home, or other facility:

(i) The client's medical diagnosis and prognosis;

(ii) The attending physician's request for prosthetic services;

(iii) The attending dentist's or denturist's statement documenting medical necessity;

(iv) A written and signed consent from the client's legal guardian when a guardian has been appointed; and

(v) A completed copy of the Denture/Partial Appliance Request for Skilled Nursing Facility Client form (DSHS 13-788) available from the department.

(g) Limits removable partial dentures to resin based partial dentures for all clients who reside in one of the facilities listed in (f) of this subsection. The department may consider cast metal partial dentures if the criteria in (d) of this subsection are met.

(h) Requires a provider to deliver services and procedures that are of acceptable quality to the department. The department may recoup payment for services that are determined to be below the standard of care or of an unacceptable product quality.

(2) **Other services for removable prosthetics.** The department covers:

(a) Repairs to complete and partial dentures;

(b) A laboratory reline or rebase to a complete or cast metal partial denture, once in a three-year period when performed at least six months after the seat date; and

(c) Laboratory fees, subject to all of the following:

(i) The department does not pay laboratory and professional fees for complete and partial dentures, except as stated in (ii) of this subsection;

(ii) The department may pay part of billed laboratory fees when the provider has obtained prior authorization from the department, and:

(A) At the time of delivery of the prosthesis, the patient is no longer an eligible medical assistance client (see also WAC 388-535-1280(3));

(B) The client moves from the state; or

(C) The client dies.

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

[11-14-075, recodified as § 182-535-1266, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-041, § 388-535-1266, filed 3/1/07, effective 4/1/07.]

WAC 182-535-1267 Covered dental-related services for clients age twenty-one and older—Oral and maxillofacial surgery services. The department covers oral and maxillofacial surgery services only as listed in this section for clients age twenty-one and older (for dental-related services provided to clients eligible under the GA-U or ADATSA program, see WAC 388-535-1065).

(1) **Oral and maxillofacial surgery services.** The department:

(a) Requires enrolled dental providers who do not meet the conditions in WAC 388-535-1070(3) to bill claims for services that are listed in this subsection using only the current dental terminology (CDT) codes.

(b) Requires enrolled providers (oral and maxillofacial surgeons) who meet the conditions in WAC 388-535-1070(3) to bill claims using current procedural terminology (CPT) codes unless the procedure is specifically listed in the department's current published billing instructions as a CDT covered code (e.g., extractions).

(c) Does not cover oral surgery services described in WAC 388-535-1267 that are performed in a hospital operating room or ambulatory surgery center.

(d) Requires the client's record to include supporting documentation for each type of extraction or any other surgical procedure billed to the department. The documentation must include:

(i) An appropriate consent form signed by the client or the client's legal representative;

(ii) Appropriate radiographs;

(iii) Medical justification with diagnosis;

(iv) Client's blood pressure, when appropriate;

(v) A surgical narrative;

(vi) A copy of the post-operative instructions; and

(vii) A copy of all pre- and post-operative prescriptions.

(e) Covers routine and surgical extractions.

(f) Covers debridement of a granuloma or cyst that is five millimeters or greater in diameter. The department includes debridement of a granuloma or cyst that is less than five millimeters as part of the global fee for the extraction.

(g) Covers biopsy, as follows:

(i) Biopsy of soft oral tissue or brush biopsy do not require prior authorization; and

(ii) All biopsy reports must be kept in the client's record.

(h) Covers alveoloplasty only when three or more teeth are extracted per arch.

(i) Covers surgical excision of soft tissue lesions only on a case-by-case basis and when prior authorized.

(j) Covers only the following excisions of bone tissue in conjunction with placement of immediate, complete, or partial dentures when prior authorized:

(i) Removal of lateral exostosis;

(ii) Removal of torus palatinus or torus mandibularis; and

(iii) Surgical reduction of soft tissue or osseous tuberosity.

(2) **Surgical incision-related services.** The department covers the following surgical incision-related services:

(a) Uncomplicated intraoral and extraoral soft tissue incision and drainage of abscess. The department 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; and

(b) Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue when prior authorized. Documentation supporting medical necessity must be in the client's record.

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WAC 182-535-1269 Covered dental-related services for clients age twenty-one and older—Adjunctive general services. The department covers dental-related adjunctive general services only as listed in this section for clients age twenty-one and older (for dental-related services provided to clients eligible under the GA-U or ADATSA program, see WAC 388-535-1065).

(1) **Adjunctive general services.** The department:

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

(i) The treatment must occur during limited evaluation appointments;

(ii) A comprehensive description of diagnosis and services provided must be documented in the client's record; and

(iii) Appropriate radiographs must be in the client's record to support medical necessity for the treatment.

(b) Covers local anesthesia and regional blocks as part of the global fee for any procedure being provided to clients.

(c) Covers office based oral or parenteral sedation:

(i) For services listed as covered in WAC 388-535-1267;

(ii) For all current published current procedural terminology (CPT) dental codes;

(iii) When the provider's current valid anesthesia permit is on file with the department; and

(iv) For clients of the division of developmental disabilities according to WAC 388-535-1099.

(d) Covers office based general anesthesia for:

(i) Extraction of three or more teeth;

(ii) Services listed as covered in WAC 388-535-1267 (1)(h) and (j);

(iii) For all current published CPT dental codes;

(iv) When the provider's current valid anesthesia permit is on file with the department; and

(v) For clients of the division of developmental disabilities, according to WAC 388-535-1099.

(e) Covers inhalation of nitrous oxide, once per day.

(f) Requires providers of oral or parenteral conscious sedation, or general anesthesia to meet:

(i) The prevailing standard of care;

(ii) The provider's professional organizational guidelines;

(iii) The requirements in chapter 246-817 WAC; and

(iv) Relevant department of health (DOH) medical, dental, and nursing anesthesia regulations;

(g) Pays for anesthesia services according to WAC 388-535-1350;

(h) Covers professional consultation/diagnostic services as follows:

(i) A dentist or a physician other than the practitioner providing treatment must provide the services; and

(ii) A client must be referred by the department for the services to be covered.

(2) **Nonemergency dental services.** The department covers nonemergency dental services performed in a hospital or ambulatory surgical center for clients of the division of developmental disabilities according to WAC 388-535-1099.

(3) **Professional visits.** The department covers:

(a) Up to two house/extended care facility calls (visits) per facility, per provider. The department limits payment to two facilities per day, per provider.

(b) One hospital call (visit), including emergency care, per day, per provider, per client. The department does not pay for additional hospital calls if billed for the same client on the same day.

(c) Emergency office visits after regularly scheduled hours. The department limits payment to one emergency visit per day, per provider.

(4) **Drugs and/or medicaments (pharmaceuticals).** The department covers drugs and/or medicaments (pharmaceuticals) only when used with parenteral conscious sedation, deep sedation, or general anesthesia. The department's dental program does not pay for oral sedation medications.

(5) **Miscellaneous services.** The department covers:

(a) Behavior management that requires the assistance of one additional dental staff other than the dentist only for clients of the division of developmental disabilities. See WAC 388-535-1099.

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

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WAC 182-535-1271 Dental-related services not covered for clients age twenty-one and older. (1) The department does not cover the following for clients age twenty-one and older (see WAC 388-535-1065 for dental-related services for clients eligible under the GA-U or ADATSA program):

(a) The dental-related services and procedures described in subsection (2) of this section;

(b) Any service specifically excluded by statute;

(c) More costly services when less costly, equally effective services as determined by the department are available; and

(d) Services, procedures, treatment, devices, drugs, or application of associated services:

(i) Which the department or the Centers for Medicare and Medicaid Services (CMS) considers investigative or experimental on the date the services were provided.

(ii) That are not listed as covered in one or both of the following:

(A) Washington Administrative Code (WAC).

(B) The department's published documents (e.g., billing instructions).

(2) The department does not cover dental-related services listed under the following categories of service for clients age twenty-one and older:

(a) **Diagnostic services.** The department does not cover:

(i) Detailed and extensive oral evaluations or reevaluations;

(ii) Comprehensive periodontal evaluations;

(iii) Extraoral or occlusal intraoral radiographs;

(iv) Posterior-anterior or lateral skull and facial bone survey films;

(v) Sialography;

(vi) Any temporomandibular joint films;

(vii) Tomographic survey;

(viii) Cephalometric films;

(ix) Oral/facial photographic images;

(x) Viral cultures, genetic testing, caries susceptibility tests, adjunctive prediagnostic tests, or pulp vitality tests; or

(xi) Diagnostic casts.

(b) **Preventive services.** The department does not cover:

(i) Nutritional counseling for control of dental disease;

(ii) Tobacco counseling for the control and prevention of oral disease;

(iii) Oral hygiene instructions (included as part of the global fee for oral prophylaxis);

(iv) Removable space maintainers of any type;

(v) Sealants;

(vi) Space maintainers of any type or recementation of space maintainers; or

(vii) Fluoride trays of any type.

(c) **Restorative services.** The department does not cover:

(i) Restorative/operative procedures performed in a hospital operating room or ambulatory surgical center for clients age twenty-one and older. For clients of the division of developmental disabilities, see WAC 388-535-1099;

(ii) Gold foil restorations;

(iii) Metallic, resin-based composite, or porcelain/ceramic inlay/onlay restorations;

(iv) Prefabricated resin crowns;

(v) Temporary or provisional crowns (including ion crowns);

(vi) Any type of permanent or temporary crown. For clients of the division of developmental disabilities see WAC 388-535-1099;

(vii) Recementation of any crown, inlay/onlay, or any other type of indirect restoration;

(viii) Sedative fillings;

(ix) Preventive restorative resins;

(x) Any type of core buildup, cast post and core, or prefabricated post and core;

(xi) Labial veneer resin or porcelain laminate restoration;

(xii) Any type of coping;

(xiii) Crown repairs; or

(xix) Polishing or recontouring restorations or overhang removal for any type of restoration.

(d) **Endodontic services.** The department does not cover:

(i) Indirect or direct pulp caps;

(ii) Endodontic therapy on any primary teeth for clients age twenty-one and older;

(iii) Endodontic therapy on permanent bicuspid or molar teeth;

(iv) Any apexification/recalcification procedures;

(v) Any apicoectomy/periradicular service; or

(vi) Any surgical endodontic procedures including, but not limited to, retrograde fillings, root amputation, reimplantation, and hemisections.

(e) **Periodontic services.** The department does not cover:

(i) Surgical periodontal services that include, but are not limited to:

(A) Gingival or apical flap procedures;

(B) Clinical crown lengthening;

(C) Any type of osseous surgery;

(D) Bone or soft tissue grafts;

(E) Biological material to aid in soft and osseous tissue regeneration;

(F) Guided tissue regeneration;

(G) 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

(H) Distal or proximal wedge procedures; or

(ii) Nonsurgical periodontal services, including but not limited to:

(A) Intracoronal or extracoronal provisional splinting;

(B) Full mouth debridement;

(C) Localized delivery of chemotherapeutic agents; or

(D) Any other type of nonsurgical periodontal service.

(f) **Prosthodontics (removable).** The department does not cover any type of:

(i) Removable unilateral partial dentures;

(ii) Adjustments to any removable prosthesis;

(iii) Chairside complete or partial denture relines;

(iv) Any interim complete or partial denture;

(v) Precision attachments; or

(vi) Replacement of replaceable parts for semi-precision or precision attachments.

(g) **Oral and maxillofacial prosthetic services.** The department does not cover any type of oral or facial prosthesis other than those listed in WAC 388-535-1266.

(h) **Implant services.** The department does not cover:

(i) Any 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;

(ii) Any maintenance or repairs to procedures listed in (h)(i) of this subsection; or

(iii) The removal of any implant as described in (h)(i) of this subsection.

(i) **Prosthodontics (fixed).** The department does not cover any type of:

(i) Fixed partial denture pontic;

(ii) Fixed partial denture retainer;

(iii) Precision attachment, stress breaker, connector bar, coping, or cast post; or

(iv) Other fixed attachment or prosthesis.

(j) **Oral and maxillofacial surgery.** The department does not cover:

(i) Any nonemergency oral surgery performed in a hospital or ambulatory surgical center for current dental terminology (CDT) procedures;

(ii) Vestibuloplasty;

(iii) Frenuloplasty/frenulectomy;

(iv) Any oral surgery service not listed in WAC 388-535-1267;

(v) Any oral surgery service that is not listed in the department's list of covered current procedural terminology (CPT) codes published in the department's current rules or billing instructions;

(vi) Any type of occlusal orthotic splint or device, bruxing or grinding splint or device, temporomandibular joint splint or device, or sleep apnea splint or device; or

(vii) Any type of orthodontic service or appliance.

(k) **Adjunctive general services.** The department does not cover:

(i) Anesthesia to include:

(A) Local anesthesia as a separate procedure;

(B) Regional block anesthesia as a separate procedure;

(C) Trigeminal division block anesthesia as a separate procedure;

(D) Analgesia or anxiolysis as a separate procedure except for inhalation of nitrous oxide;

(E) Medication for oral sedation, or therapeutic drug injections, including antibiotic or injection of sedative; or

(F) Application of any type of desensitizing medicament or resin.

(ii) Other general services including, but not limited to:

(A) Fabrication of athletic mouthguard, occlusal guard, or nightguard;

(B) Occlusion analysis;

(C) Occlusal adjustment or odontoplasties;

(D) Enamel microabrasion;

(E) Dental supplies, including but not limited to, toothbrushes, toothpaste, floss, and other take home items;

(F) Dentist's or dental hygienist's time writing or calling in prescriptions;

(G) Dentist's or dental hygienist's time consulting with clients on the phone;

(H) Educational supplies;

(I) Nonmedical equipment or supplies;

(J) Personal comfort items or services;

(K) Provider mileage or travel costs;

(L) Missed or late appointment fees;

(M) Service charges of any type, including fees to create or copy charts;

(N) Office supplies used in conjunction with an office visit; or

(O) Teeth whitening services or bleaching, or materials used in whitening or bleaching.

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WAC 182-535-1280 Obtaining prior authorization for dental-related services for clients age twenty-one and older. (1) The department uses the determination process described in WAC 388-501-0165 for covered dental-related

services for clients age twenty-one and older that require prior authorization.

(2) The department requires a dental provider who is requesting prior authorization to submit sufficient objective clinical information to establish medical necessity. The request must be submitted in writing on an American Dental Association (ADA) claim form, which may be obtained by writing to the American Dental Association, 211 East Chicago Avenue, Chicago, Illinois 60611.

(3) The department may request additional information as follows:

(a) Additional radiographs (X rays) (refer to WAC 388-535-1255(2));

(b) Study models;

(c) Photographs; and

(d) Any other information as determined by the department.

(4) The department may require second opinions and/or consultations before authorizing any procedure.

(5) When the department 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.

(6) The department denies a request for a dental-related service when the requested service:

(a) Is covered by another department program;

(b) Is covered by an agency or other entity outside the department; or

(c) Fails to meet the program criteria, limitations, or restrictions in chapter 388-535 WAC.

[11-14-075, recodified as § 182-535-1280, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520, 07-06-041, § 388-535-1280, filed 3/1/07, effective 4/1/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191. 03-19-080, § 388-535-1280, filed 9/12/03, effective 10/13/03.]

PAYMENT

WAC 182-535-1350 Payment methodology for dental-related services. The medical assistance administration (MAA) uses the description of dental services described in the American Dental Association's Current Dental Terminology, and the American Medical Association's Physician's Current Procedural Terminology (CPT).

(1) For covered dental-related services provided to eligible clients, MAA pays dentists and other eligible providers on a fee-for-service or contractual basis, subject to the exceptions and restrictions listed under WAC 388-535-1100 and 388-535-1400.

(2) MAA sets maximum allowable fees for dental services provided to children as follows:

(a) MAA's historical reimbursement rates for various procedures are compared to usual and customary charges.

(b) MAA consults with representatives of the provider community to identify program areas and concerns that need to be addressed.

(c) MAA consults with dental experts and public health professionals to identify and prioritize dental services and

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procedures for their effectiveness in improving or promoting children's dental health.

(d) Legislatively authorized vendor rate increases and/or earmarked appropriations for children's dental services are allocated to specific procedures based on the priorities identified in (c) of this subsection and considerations of access to services.

(e) Larger percentage increases may be given to those procedures which have been identified as most effective in improving or promoting children's dental health.

(f) Budget-neutral rate adjustments are made as appropriate based on the department's evaluation of utilization trends, effectiveness of interventions, and access issues.

(3) MAA reimburses dental general anesthesia services for eligible clients on the basis of base anesthesia units plus time. Payment for dental general anesthesia is calculated as follows:

(a) Dental procedures are assigned an anesthesia base unit of five;

(b) Fifteen minutes constitute one unit of time. When a dental procedure requiring dental general anesthesia results in multiple time units and a remainder (less than fifteen minutes), the remainder or fraction is considered as one time unit;

(c) Time units are added to the anesthesia base unit of five and multiplied by the anesthesia conversion factor;

(d) The formula for determining payment for dental general anesthesia is: $(5.0 \text{ base anesthesia units} + \text{time units}) \times \text{conversion factor} = \text{payment}$.

(4) When billing for anesthesia, the provider must show the actual beginning and ending times on the claim. Anesthesia time begins when the provider starts to physically prepare the client for the induction of anesthesia in the operating room area (or its equivalent), and ends when the provider is no longer in constant attendance (i.e., when the client can be safely placed under postoperative supervision).

(5) MAA pays eligible providers listed in WAC 388-535-1070 for conscious sedation with parenteral and multiple oral agents, or for general anesthesia when the provider meets the criteria in this chapter and other applicable WAC.

(6) Dental hygienists who have a contract with MAA are paid at the same rate as dentists who have a contract with MAA, for services allowed under The Dental Hygienist Practice Act.

(7) Licensed denturists who have a contract with MAA are paid at the same rate as dentists who have a contract with MAA, for providing dentures and partials.

(8) MAA makes fee schedule changes whenever the legislature authorizes vendor rate increases or decreases.

(9) MAA may adjust maximum allowable fees to reflect changes in services or procedure code descriptions.

(10) MAA does not pay separately for chart or record setup, or for completion of reports, forms, or charting. The fees for these services are included in MAA's reimbursement for comprehensive oral evaluations or limited oral evaluations.

[11-14-075, recodified as § 182-535-1350, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191. 03-19-080, § 388-535-1350, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1350, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC

1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1350, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1350, filed 12/6/95, effective 1/6/96.]

WAC 182-535-1400 Payment for dental-related services. (1) The medical assistance administration (MAA) considers that a provider who furnishes covered dental services to an eligible client has accepted MAA's rules and fees.

(2) Participating providers must bill MAA their usual and customary fees.

(3) Payment for dental services is based on MAA's schedule of maximum allowances. Fees listed in the MAA fee schedule are the maximum allowable fees.

(4) MAA pays the provider the lesser of the billed charge (usual and customary fee) or MAA's maximum allowable fee.

(5) MAA pays "by report" on a case-by-case basis, for a covered service that does not have a set fee.

(6) Participating providers must bill a client according to WAC 388-502-0160, unless otherwise specified in this chapter.

(7) If the client's eligibility for dental services ends before the conclusion of the dental treatment, payment for any remaining treatment is the client's responsibility. The exception to this is dentures and partial dentures as described in WAC 388-535-1240 and 388-535-1290.

[11-14-075, recodified as § 182-535-1400, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191. 03-19-080, § 388-535-1400, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1400, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1400, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1400, filed 12/6/95, effective 1/6/96.]

WAC 182-535-1450 Payment for denture laboratory services. The medical assistance administration (MAA) does not directly reimburse denture laboratories. MAA's reimbursement for complete dentures, immediate dentures, partial dentures, and overdentures includes laboratory fees. The provider is responsible to pay a denture laboratory for services furnished at the request of the provider.

[11-14-075, recodified as § 182-535-1450, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191. 03-19-080, § 388-535-1450, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1450, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1450, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1450, filed 12/6/95, effective 1/6/96.]

WAC 182-535-1500 Payment for dental-related hospital services. The medical assistance administration (MAA) pays for medically necessary dental-related hospital inpatient and outpatient services in accord with WAC 388-550-1100.

[11-14-075, recodified as § 182-535-1500, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-

1500, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1500, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1500, filed 12/6/95, effective 1/6/96.]

WAC 182-535-1550 Payment for dental care provided out-of-state. See WAC 388-501-0180, 388-501-0182, and 388-501-0184 for services provided outside the state of Washington. See WAC 388-501-0175 for designated bordering cities.

[11-14-075, recodified as § 182-535-1550, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.035. 08-08-064, § 388-535-1550, filed 3/31/08, effective 5/1/08. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1550, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1550, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1550, filed 12/6/95, effective 1/6/96.]