

Chapter 182-535 WAC

DENTAL-RELATED SERVICES

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182-535-1247	Dental-related services for clients age twenty-one and older—General. [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.] Repealed by 12-09-081, filed 4/17/12, effective 5/18/12. Statutory Authority: RCW 41.05.021.	182-535-1269	Covered dental-related services for clients age twenty-one and older—Adjunctive general services. [11-14-075, recodified as § 182-535-1269, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-041, § 388-535-1269, filed 3/1/07, effective 4/1/07.] Repealed by 12-09-081, filed 4/17/12, effective 5/18/12. Statutory Authority: RCW 41.05.021.
182-535-1255	Covered dental-related services—Adults. [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.] Repealed by 12-09-081, filed 4/17/12, effective 5/18/12. Statutory Authority: RCW 41.05.021.	182-535-1271	Dental-related services not covered for clients age twenty-one and older. [11-14-075, recodified as § 182-535-1271, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-041, § 388-535-1271, filed 3/1/07, effective 4/1/07.] Repealed by 12-09-081, filed 4/17/12, effective 5/18/12. Statutory Authority: RCW 41.05.021.
		182-535-1280	Obtaining prior authorization for dental-related services for clients age twenty-one and older. [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.] Repealed by 12-09-081, filed 4/17/12, effective 5/18/12. Statutory Authority: RCW 41.05.021.

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 tactile 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. (1) The clients described in this section are eligible to receive the dental-related services described in this chapter, subject to limitations, restrictions, and client-age requirements identified for a specific service.

(a) Clients who are eligible under one of the following medical assistance programs:

(i) Categorically needy (CN);

(ii) Children's health care as described in WAC 388-505-0210;

(iii) Medically needy (MN);

(iv) Medical care services (MCS) as described in WAC 182-508-0005;

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

(b) Clients who are eligible under one of the medical assistance programs in subsection (a) of this section and are one of the following:

- (i) Twenty years of age and younger;
- (ii) Twenty years of age and younger enrolled in an agency-contracted managed care organization (MCO). MCO clients are eligible under fee-for-service for covered dental-related services not covered by their MCO plan, subject to the provisions of this chapter and other applicable agency rules;
- (iii) For dates of service on and after July 1, 2011, clients who are verifiably pregnant;
- (iv) For dates of service on and after July 1, 2011, clients residing in one of the following:
 - (A) Nursing home;
 - (B) Nursing facility wing of a state veteran's home;
 - (C) Privately operated intermediate care facility for the intellectually disabled (ICF/ID); or
 - (D) State-operated residential habilitation center (RHC).
- (v) For dates of service on and after July 1, 2011, clients who are eligible under an Aging and Disability Services Administration (ADSA) 1915 (c) waiver program;
- (vi) For dates of service prior to October 1, 2011, clients of the division of developmental disabilities; or
- (vii) For dates of service on and after October 1, 2011, clients of the division of developmental disabilities who also qualify under (b)(i), (iii), (iv), or (v) of this subsection.

(2) See WAC 388-438-0120 for rules for clients eligible under an alien emergency medical program.

(3) The dental services discussed in this chapter are excluded from the benefit package for clients not eligible for comprehensive dental services as described in subsection (1) of this section. Clients who do not have these dental services in their benefit package may be eligible only for the emergency oral health care benefit according to WAC 182-531-1025.

(4) Exception to rule procedures as described in WAC 182-501-0169 are not available for services that are excluded from a client's benefit package.

[Statutory Authority: RCW 41.05.021, 12-09-081, § 182-535-1060, filed 4/17/12, effective 5/18/12. 11-14-075, recodified as § 182-535-1060, 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. 03-19-077, § 388-535-1060, 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, § 388-535-1060, 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 U.S.C. 1396d(a), C.F.R. 440.100 and 440.225. 99-07-023, § 388-535-1060, filed 3/10/99, effective 4/10/99.]

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 cer-

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

- (a) Are part of the client's dental benefit package;
 - (b) Are within the scope of an eligible client's medical care program;
 - (c) Are medically necessary;
 - (d) Meet the agency's prior authorization requirements, if any;
 - (e) Are documented in the client's record in accordance with chapter 182-502 WAC;
 - (f) Are within accepted dental or medical practice standards;
 - (g) Are consistent with a diagnosis of dental disease or condition;
 - (h) Are reasonable in amount and duration of care, treatment, or service; and
 - (i) Are listed as covered in the agency's rules and published billing instructions and fee schedules.
- (2) The agency requires site-of-service prior authorization, in addition to prior authorization of the procedure, if applicable, for nonemergency dental-related services performed in a hospital or an ambulatory surgery center when:
- (a) A client is not a client of the division of developmental disabilities according to WAC 182-535-1099;
 - (b) A client is nine years of age or older;
 - (c) The service is not listed as exempt from the site-of-service authorization requirement in the agency's current published dental-related services fee schedule or billing instructions; and
 - (d) The service is not listed as exempt from the prior authorization requirement for deep sedation or general anesthesia (see WAC 182-535-1098 (1)(c)(v)).

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

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

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

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

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

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

WAC 182-535-1080 Covered dental-related services—Diagnostic. Clients described in WAC 182-535-1060 are eligible to receive the dental-related diagnostic services listed in this section, subject to coverage limitations, restrictions, and client-age requirements identified for a specific service.

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

- (a) Oral health evaluations and assessments.
- (b) Periodic oral evaluations as defined in WAC 182-535-1050, 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 182-535-1050, 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 agency does not cover any additional limited examination by a dentist for the same client until three months after a removable prosthesis has been seated.

(d) Comprehensive oral evaluations as defined in WAC 182-535-1050, once per client, per provider or clinic, as an initial examination. The agency 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 182-535-1050, 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 by a licensed dentist or dental hygienist 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.

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

- (a) Covers radiographs that are of diagnostic quality, dated, and labeled with the client's name. The agency requires:
 - (i) Original radiographs to be retained by the provider as part of the client's dental record; and
 - (ii) Duplicate radiographs to be submitted:
 - (A) With requests for prior authorization; and
 - (B) When the agency requests copies of dental records.
- (b) Uses the prevailing standard of care to determine the need for dental radiographs.

(c) Covers an intraoral complete series once in a three-year period only if the agency has not paid for a panoramic radiograph for the same client in the same three-year period. The intraoral complete series includes fourteen through twenty-two periapical and posterior bitewings. The agency limits reimbursement for all radiographs to a total payment of no more than payment for a complete series.

(d) Covers medically necessary periapical radiographs for diagnosis in conjunction with definitive treatment, such as root canal therapy. Documentation supporting medical necessity must be included in the client's record.

(e) Covers an occlusal intraoral radiograph once in a two-year period, for clients twenty years of age and younger.

(f) Covers oral facial photo images, only on a case-by-case basis when requested by the agency, for clients twenty years of age and younger.

(g) Covers a maximum of four bitewing radiographs (once per quadrant) once every twelve months.

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

(i) May reimburse for 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, except when required by an oral surgeon. For orthodontic services, see chapter 182-535A WAC.

(j) Covers cephalometric films once in a two-year period for clients twenty years of age and younger, 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 agency.

(3) **Tests and examinations.** The agency covers the following for clients who are twenty years of age and younger:

(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 agency.

[Statutory Authority: RCW 41.05.021, 12-09-081, § 182-535-1080, filed 4/17/12, effective 5/18/12. 11-14-075, recodified as § 182-535-1080, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520, 07-06-042, § 388-535-1080, 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, § 388-535-1080, 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, § 388-535-1080, 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 U.S.C. 1396d(a), C.F.R. 440.100 and 440.225. 99-07-023, § 388-535-1080, filed 3/10/99, effective 4/10/99.]

WAC 182-535-1082 Covered dental-related services—Preventive services. Clients described in WAC 182-535-1060 are eligible for the dental-related preventive services listed in this section, subject to coverage limitations and client-age requirements identified for a specific service.

(1) **Dental prophylaxis.** The agency covers prophylaxis as follows. Prophylaxis:

(a) Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains when performed on primary or permanent dentition.

(b) Is limited to once every:

(i) Six months for clients eighteen years of age and younger; and

(ii) Twelve months for clients nineteen years of age and older.

(c) Is reimbursed only when the service is performed:

(i) At least six months after periodontal scaling and root planing, or periodontal maintenance services, for clients from thirteen to eighteen years of age; and

(ii) At least twelve months after periodontal scaling and root planing, periodontal maintenance services, for clients nineteen years of age and older.

(d) Is not reimbursed separately when performed on the same date of service as periodontal scaling and root planing, periodontal maintenance, gingivectomy, or gingivoplasty.

(e) Is covered for clients of the division of developmental disabilities according to (a), (c), and (d) of this subsection and WAC 182-535-1099.

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

(a) Fluoride rinse, foam or gel, including disposable trays, for clients six years of age and younger, up to three times within a twelve-month period.

(b) Fluoride rinse, foam or gel, including disposable trays, for clients from seven to eighteen years of age, up to two times within a twelve-month period.

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

(d) Fluoride rinse, foam or gel, including disposable trays, for clients from nineteen to sixty-four years of age, once within a twelve-month period.

(e) Fluoride rinse, foam or gel, including disposable trays, for clients sixty-five years of age and older who reside in alternate living facilities, up to three times within a twelve-month period.

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

(g) Topical fluoride treatment for clients of the division of developmental disabilities according to WAC 182-535-1099.

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

(a) Oral hygiene instruction only for clients eight years of age and younger.

(b) Oral hygiene instruction, no more than once every six months, 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 agency covers:

(a) Sealants for clients eighteen years of age and younger and clients of the division of developmental disabilities of any age.

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

(c) Sealants once per tooth:

(i) In a three-year period for clients eighteen years of age and younger; and

(ii) In a two-year period for clients any age of the division of developmental disabilities according to WAC 182-535-1099.

(d) 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.

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

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

(g) Additional sealants not described in this subsection on a case-by-case basis and when prior authorized.

(5) **Space maintenance.** The agency:

(a) Covers fixed unilateral or fixed bilateral space maintainers for clients twelve years of age and younger, subject to the following:

(i) Only one space maintainer is covered per quadrant.

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

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

(b) Covers removal of fixed space maintainers for clients eighteen years of age and younger.

[Statutory Authority: RCW 41.05.021, 12-09-081, § 182-535-1082, filed 4/17/12, effective 5/18/12. 11-14-075, recodified as § 182-535-1082, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520, 07-06-042, § 388-535-1082, filed 3/1/07, effective 4/1/07.]

WAC 182-535-1084 Covered dental-related services—Restorative services. Clients described in WAC 182-535-1060 are eligible for the dental-related restorative services listed in this section, subject to coverage limitations, restrictions, and client-age requirements identified for a specific service.

(1) **Amalgam and resin restorations for primary and permanent teeth.** The agency considers:

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

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

(c) Restorations placed within six months of a crown preparation by the same provider or clinic to be included in the payment for the crown.

(2) **Limitations for all restorations.** The agency:

(a) Considers multiple restoration involving the proximal and occlusal surfaces of the same tooth as a multisurface restoration, and limits reimbursement to a single multisurface restoration.

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

(c) Considers multiple restorations of fissures and grooves of the occlusal surface of the same tooth as a one-surface restoration.

(d) Considers resin-based composite restorations of teeth where the decay does not penetrate the dentoenamel junction (DEJ) to be sealants. (See WAC 182-535-1082(4) for sealant coverage.)

(e) Reimburses proximal restorations that do not involve the incisal angle on anterior teeth as a two-surface restoration.

(f) Covers only one buccal and one lingual surface per tooth. The agency reimburses buccal or lingual restorations, regardless of size or extension, as a one-surface restoration.

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

(h) Does not pay for replacement restorations within a two-year period unless the restoration has an additional adjoining carious surface. The agency pays for the replacement restoration as one multisurface restoration. The client's record must include X rays and documentation supporting the medical necessity for the replacement restoration.

(3) **Additional limitations on restorations on primary teeth.** The agency covers:

(a) A maximum of two surfaces for a primary first molar. (See subsection (6) of this section for a primary first molar that requires a restoration with three or more surfaces.) The agency does not pay for additional restorations on the same tooth.

(b) A maximum of three surfaces for a primary second molar. (See subsection (6) of this section for a primary posterior tooth that requires a restoration with four or more surfaces.) The agency does not pay for additional restorations on the same tooth.

(c) A maximum of three surfaces for a primary anterior tooth. (See subsection (6) of this section for a primary anterior tooth that requires a restoration with four or more surfaces.) The agency does not pay for additional restorations on the same tooth after three surfaces.

(d) Glass ionomer restorations for primary teeth, only for clients five years of age and younger. The agency pays for these restorations as a one-surface, resin-based composite restoration.

(4) **Additional limitations on restorations on permanent teeth.** The agency covers:

(a) (b) Two occlusal restorations for the upper molars on teeth one, two, three, fourteen, fifteen, and sixteen if, the restorations are anatomically separated by sound tooth structure.

(c) A maximum of five surfaces per tooth for permanent posterior teeth, except for upper molars. The agency allows a maximum of six surfaces per tooth for teeth one, two, three, fourteen, fifteen, and sixteen.

(d) A maximum of six surfaces per tooth for resin-based composite restorations for permanent anterior teeth.

(5) **Crowns.** The agency:

(a) Covers the following indirect crowns once every five years, per tooth, for permanent anterior teeth for clients from twelve to twenty years of age when the crowns meet prior authorization criteria in WAC 182-535-1220 and the provider follows the prior authorization requirements in (c) 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) 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 agency 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 (placement), including cementing and insulating bases;

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

(viii) Local anesthesia.

(c) 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.

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

(6) **Other restorative services.** The agency covers the following restorative services:

(a) All recementations of permanent indirect crowns only for clients from twelve to twenty years of age.

(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 only for clients twenty years of age and younger as follows:

(i) For ages twelve and younger without prior authorization if the tooth requires a four or more surface restoration; and

(ii) For ages thirteen to twenty with prior authorization.

(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 excluding one, sixteen, seventeen, and thirty-two once every three years, for clients twenty years of age and younger, without prior authorization.

(e) Prefabricated stainless steel crowns for clients of the division of developmental disabilities without prior authorization according to WAC 182-535-1099.

(f) Core buildup, including pins, only on permanent teeth, only for clients twenty years of age and younger, and only allowed in conjunction with indirect crowns and 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, only for clients twenty years of age and younger, and only when in conjunction with a crown and when prior authorized.

[Statutory Authority: RCW 41.05.021, 12-09-081, § 182-535-1084, filed 4/17/12, effective 5/18/12. 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—Endodontic services. Clients described in WAC 182-535-1060 are eligible to receive the dental-related endodontic services listed in this section, subject to coverage limitations, restrictions, and client-age requirements identified for a specific service.

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

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

(a) Therapeutic pulpotomy on primary teeth only for clients twenty years of age and younger.

(b) Pulpal debridement on permanent teeth only, excluding teeth one, sixteen, seventeen, and thirty-two. The agency 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 agency:

(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 for clients twenty years of age and younger.

(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) Covers endodontic retreatment for clients twenty years of age and younger when prior authorized.
- (f) The agency 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.
- (g) 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.
- (h) Does not pay for endodontic retreatment when provided by the original treating provider or clinic unless prior authorized by the agency.
- (i) 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 and limited to clients twenty years of age and younger, per tooth.
- (j) Covers apicoectomy and a retrograde fill for anterior teeth only for clients twenty years of age and younger.

[Statutory Authority: RCW 41.05.021, 12-09-081, § 182-535-1086, filed 4/17/12, effective 5/18/12. 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—Periodontic services. Clients described in WAC 182-535-1060 are eligible to receive the dental-related periodontic services listed in this section, subject to coverage limitations, restrictions, and client-age requirements identified for a specified service.

(1) **Surgical periodontal services.** The agency 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 only for clients twenty years of age and younger; and
- (b) Gingivectomy/gingivoplasty for clients of the division of developmental disabilities according to WAC 182-535-1099.

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

- (a) Covers periodontal scaling and root planing for clients from thirteen to eighteen years of age, once per quadrant, per client, in a two-year period, on a case-by-case basis, when prior authorized, 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, or at least twelve calendar months from the completion of periodontal maintenance.

(b) Covers periodontal scaling and root planing once per quadrant, per client, in a two-year period for clients nineteen years of age and older. 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 182-535-1099.

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

(a) Covers periodontal maintenance for clients from thirteen to eighteen years of age once per client in a twelve-month period on a case-by-case basis, when prior authorized, 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 with location of the gingival margin and clinical attachment loss and a definitive diagnosis of periodontal disease;

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

(iv) The client has had periodontal scaling and root planing but not within twelve months of 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 nineteen years of age and older. Criteria in (a)(i) through (iv) of this subsection must be met.

(c) Covers periodontal maintenance only if performed at least twelve calendar months after receiving prophylaxis, periodontal scaling and root planing, gingivectomy, or gingivoplasty.

(d) Covers periodontal maintenance for clients of the division of developmental disabilities according to WAC 182-535-1099.

[Statutory Authority: RCW 41.05.021, 12-09-081, § 182-535-1088, filed 4/17/12, effective 5/18/12. 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—Prosthodontics (removable). Clients described in WAC 182-535-1060 are eligible to receive the prosthodontics (removable) and related services, subject to the coverage limitations, restrictions, and client-age requirements identified for a specific service.

(1) **Prosthodontics.** The agency:

(a) Requires prior authorization for all removable prosthodontic and prosthodontic-related procedures. Prior authori-

zation requests must meet the criteria in WAC 182-535-1220. In addition, the agency 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.

(b) Covers complete dentures, as follows:

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

(ii) Three-month post-delivery care (e.g., adjustments, soft relines, and repairs) from the seat (placement) 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) Complete dentures are limited to:

(A) One initial maxillary complete denture and one initial mandibular complete denture per client, per the client's lifetime; and

(B) One replacement maxillary complete denture and one replacement mandibular complete denture per client, per client's lifetime.

(v) Replacement of a complete denture or overdenture is covered only if prior authorized, and only if the replacement occurs at least five years after the seat date of the complete denture or overdenture being replaced. The replacement denture must be prior authorized.

(vi) The provider must obtain a signed denture agreement of acceptance (#13-809) from the client at the conclusion of the final denture try-in for an agency-authorized complete denture. If the client abandons the complete denture after signing the agreement of acceptance, the agency will deny subsequent requests for the same type of dental prosthesis if the request occurs prior to the dates specified in this section. A copy of the signed agreement must be kept in the provider's files and be available upon request by the agency.

(c) Covers resin partial dentures, as follows:

(i) A partial denture is covered for anterior and posterior teeth when the partial denture meets the following agency 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 (excluding teeth one, two, fifteen, sixteen, seventeen, eighteen, thirty-one, and thirty-two);

(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 is required for partial dentures.

(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-based denture with any prosthetic 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 agency coverage criteria in (c)(i) of this subsection.

(d) Does not cover replacement of a cast-metal framework partial denture, with any type of denture, within five years of the initial seat date of the partial denture.

(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) of this section for what the agency 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 agency'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.

(h) Requires a provider to deliver services and procedures that are of acceptable quality to the agency. The agency 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 agency covers:

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

(b) Repairs:

(i) To complete dentures, once in a twelve-month period. The cost of repairs cannot exceed the cost of the replacement denture. The agency covers additional repairs on a case-by-case basis and when prior authorized.

(ii) To partial dentures, once in a twelve-month period. The cost of the repairs cannot exceed the cost of the replacement partial denture. The agency covers additional repairs on a case-by-case basis and when prior authorized.

(c) A laboratory reline or rebase to a complete or 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 partial dentures on a case-by-case basis when prior authorized.

(d) Up to two tissue conditionings, only for clients twenty years of age and younger, and only when performed within three months after the seating date.

(e) Laboratory fees, subject to the following:

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

(ii) The agency 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.

[Statutory Authority: RCW 41.05.021, 12-09-081, § 182-535-1090, filed 4/17/12, effective 5/18/12. 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—Maxillofacial prosthetic services. Clients described in WAC 182-535-1060 are eligible to receive the maxillofacial prosthetic services listed in this section, subject to the following:

(1) Maxillofacial prosthetics are covered only for clients twenty years of age and younger on a case-by-case basis and when prior authorized; and

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

[Statutory Authority: RCW 41.05.021, 12-09-081, § 182-535-1092, filed 4/17/12, effective 5/18/12. 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—Oral and maxillofacial surgery services. Clients described in WAC 182-535-1060 are eligible to receive the oral and maxillofacial surgery services listed in this section, subject to the coverage limitations, restrictions, and client-age requirements identified for a specific service.

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

(a) Requires enrolled providers who do not meet the conditions in WAC 182-535-1070(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 182-535-1070(3) to bill claims using current procedural terminology (CPT) codes unless the procedure is specifically listed in the agency'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 eight years of age and younger;

(ii) Clients from nine to twenty years of age only on a case-by-case basis and when the site-of-service is prior authorized by the agency; and

(iii) Clients any age of the division of developmental disabilities.

(4/17/12)

(d) For site-of-service and oral surgery CPT codes that require prior authorization, the agency requires the dental provider to submit:

(i) Documentation used to determine medical appropriateness;

(ii) Cephalometric films;

(iii) X rays;

(iv) Photographs; and

(v) Written narrative.

(e) Requires the client's dental record to include supporting documentation for each type of extraction or any other surgical procedure billed to the agency. 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 and complete description of each service performed beyond surgical extraction or beyond code definition;

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

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

(f) Covers routine and surgical extractions.

(g) Requires prior authorization for unusual, complicated surgical extractions.

(h) Covers tooth reimplantation/stabilization of accidentally evulsed or displaced teeth for clients twenty years of age and younger.

(i) Covers surgical extraction of unerupted teeth for clients twenty years of age and younger.

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

(k) Covers the following without prior authorization:

(i) Biopsy of soft oral tissue;

(ii) Brush biopsy for clients twenty years of age and younger.

(l) Requires providers to keep all biopsy reports or findings in the client's dental record.

(m) Covers alveoloplasty for clients twenty years of age and younger only on a case-by-case basis and when prior authorized. The agency covers alveoloplasty only when not performed in conjunction with extractions.

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

(o) Covers only the following excisions of bone tissue in conjunction with placement of complete or partial dentures for clients twenty years of age and younger when prior authorized:

(i) Removal of lateral exostosis;

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

(iii) Surgical reduction of soft tissue osseous tuberosity.

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

(a) Uncomplicated intraoral and extraoral soft tissue incision and drainage of abscess. The agency 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 for clients twenty years of age and younger when prior authorized. Documentation supporting the medical necessity for the service must be in the client's record.

(c) Frenuloplasty/frenulectomy for clients six years of age and younger without prior authorization.

(d) Frenuloplasty/frenulectomy for clients from seven to twelve years of age 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 182-535-1098 (4)(c) for occlusal guard coverage and limitations on coverage.) The agency covers:

(a) Occlusal orthotic devices for clients from twelve to twenty years of age only on a case-by-case basis and when prior authorized.

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

[Statutory Authority: RCW 41.05.021, 12-09-081, § 182-535-1094, filed 4/17/12, effective 5/18/12. 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—Orthodontic services. (1) The agency covers orthodontic services, subject to the coverage limitations listed, for clients twenty years of age and younger, according to chapter 182-535A WAC.

(2) The agency does not cover orthodontic services for clients twenty-one years of age and older.

[Statutory Authority: RCW 41.05.021, 12-09-081, § 182-535-1096, filed 4/17/12, effective 5/18/12. 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—Adjunctive general services. Clients described in WAC 182-535-1060 are eligible to receive the adjunctive general services listed in this section, subject to coverage limitations, restrictions, and client-age requirements identified for a specific service.

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

(a) Covers palliative (emergency) treatment, not to include pupal debridement (see WAC 182-535-1086 (2)(b)), for treatment of dental pain, for clients twenty years of age and younger, 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 agency.

(ii) For clients eight years of age and younger, and for clients any age of the division of developmental disabilities, documentation supporting the medical necessity of the anesthesia service must be in the client's record.

(iii) For clients from nine to twenty years of age, deep sedation or general anesthesia services are covered on a case-by-case basis and when prior authorized, except for oral surgery services. For oral surgery services listed in WAC 182-535-1094, deep sedation or general anesthesia services do not require prior authorization.

(iv) Prior authorization is not required for oral or parenteral conscious sedation for any dental service for clients twenty years of age and younger, and for clients any age of the division of developmental disabilities. Documentation supporting the medical necessity of the service must be in the client's record.

(v) For clients from nine to twenty years of age who have a diagnosis of oral facial cleft, the agency 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.

(vi) A provider must bill anesthesia services using the CDT codes listed in the agency's current published billing instructions.

(d) Covers administration of nitrous oxide, 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 dental anesthesia services according to WAC 182-535-1350.

(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 agency for the services to be covered.

(2) **Professional visits.** The agency covers:

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

(b) One hospital call (visit), including emergency care, per day, per provider, per client, and not in combination with a surgical code unless the decision for surgery is a result of the visit.

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

(3) **Drugs and/or medicaments (pharmaceuticals).** The agency covers drugs and/or medicaments only when used with parenteral conscious sedation, deep sedation, or general anesthesia for clients twenty years of age and younger. The agency's dental program does not pay for oral sedation medications.

(4) Miscellaneous services. The agency covers:

(a) Behavior management when the assistance of one additional dental staff other than the dentist is required for the following clients and documentation supporting the need for the behavior management must be in the client's record:

- (i) Clients eight years of age and younger;
- (ii) Clients from nine to twenty years of age, only on a case-by-case basis and when prior authorized;
- (iii) Clients any age of the division of developmental disabilities; 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 182-535-1094(3) for occlusal orthotic device coverage and coverage limitations.) The agency covers:

- (i) An occlusal guard only for clients from twelve to twenty years of age when the client has permanent dentition; and
- (ii) An occlusal guard only as a laboratory processed full arch appliance.

[Statutory Authority: RCW 41.05.021, 12-09-081, § 182-535-1098, filed 4/17/12, effective 5/18/12. 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.

Subject to coverage limitations, restrictions, and client-age requirements identified for a specific service, the agency pays for the dental-related services listed under the categories of services in this section that are provided to clients of the division of developmental disabilities. This chapter also applies to clients of the division of developmental disabilities, regardless of age, unless otherwise stated in this section.

(1) Preventive services.

(a) Dental prophylaxis. The agency 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 agency covers topical fluoride varnish, rinse, foam or gel, up to three times within a twelve-month period.

(c) Sealants. The agency 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 agency 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 agency does not require prior authorization for stainless steel crowns. Documentation supporting the medical necessity of the service must be in the client's record.

(4/17/12)

(b) For clients twenty-one years of age and older, the agency requires prior authorization for stainless steel crowns when the tooth has had a pulpotomy and only for:

- (i) Primary first molars when the decay involves three or more surfaces; and
- (ii) Second molars when the decay involves four or more surfaces.

(3) Periodontic services.

(a) **Surgical periodontal services.** The agency 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) **Nonsurgical periodontal services.** The agency covers:

(i) Periodontal scaling and root planing, one time per quadrant in a twelve-month period.

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

(iii) Periodontal maintenance allowed six months after scaling or root planing.

(4) Adjunctive general services. The agency covers:

(a) 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.

(b) Sedations services according to WAC 182-535-1098 (1)(c) and (e).

(5) **Nonemergency dental services.** The agency covers nonemergency dental services performed in a hospital or an ambulatory surgical center for services listed as covered in WAC 182-535-1082, 182-535-1084, 182-535-1086, 182-535-1088, and 182-535-1094. Documentation supporting the medical necessity of the service must be included in the client's record.

(6) **Miscellaneous services—Behavior management.** The agency covers behavior management provided in dental offices or dental clinics. Documentation supporting the medical necessity of the service must be included in the client's record.

[Statutory Authority: RCW 41.05.021, 12-09-081, § 182-535-1099, filed 4/17/12, effective 5/18/12. 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. (1) The agency does not cover the following:

(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 182-534-0100 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 agency are available.

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

(i) That the agency 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 agency's current published documents.

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

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

(i) Detailed and extensive oral evaluations or reevaluations.

(ii) Extraoral radiographs.

(iii) Posterior-anterior or lateral skull and facial bone survey films.

(iv) Any temporomandibular joint films.

(v) Tomographic surveys.

(vi) Cephalometric films, for clients twenty-one years of age and older.

(vii) Oral/facial photographic images, for clients twenty-one years of age and older.

(viii) Comprehensive periodontal evaluations.

(ix) Occlusal intraoral radiographs, for clients twenty-one years of age and older.

(x) Viral cultures, genetic testing, caries susceptibility tests, or adjunctive prediagnostic tests.

(xi) Pulp vitality tests, for clients twenty-one years of age and older.

(xii) Diagnostic casts, for clients twenty-one years of age and older.

(b) **Preventive services.** The agency 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) Oral hygiene instructions for clients nine years of age and older. This is included as part of the global fee for oral prophylaxis.

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

(vi) Sealants, for clients twenty years of age and older. For clients of the division of developmental disabilities, see WAC 182-535-1099.

(vii) Space maintainers, for clients nineteen years of age and older.

(viii) Recementation of space maintainers, for clients twenty-one years of age and older.

(ix) Custom fluoride trays of any type.

(x) Bleach trays.

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

(i) Restorations for wear on any surface of any tooth without evidence of decay through the dentoenamel junction (DEJ) or on the root surface.

(ii) Gold foil restorations.

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

(iv) Prefabricated resin crowns, for clients twenty-one years of age and older.

(v) Preventive restorations.

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

(vii) Permanent indirect crowns for molar teeth.

(viii) Permanent indirect crowns on permanent anterior teeth for clients fourteen years of age and younger.

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

(x) Labial veneer resin or porcelain laminate restorations.

(xi) Recementation of any crown, inlay/onlay, or any other type of indirect restoration, for clients twenty-one years of age and older.

(xii) Sedative fillings.

(xiii) Any type of core buildup, cast post and core, or prefabricated post and core, for clients twenty-one years of age and older.

(xiv) Any type of coping.

(xv) Crown repairs.

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

(xvii) Amalgam restorations of primary posterior teeth for clients sixteen years of age and older.

(xviii) Crowns on teeth one, sixteen, seventeen, and thirty-two.

(xix) Any services other than extraction on supernumerary teeth.

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

(i) The following endodontic services for clients twenty-one years of age and older:

(A) Endodontic therapy on permanent bicuspid;

(B) Any apexification/recalcification procedures; or

(C) Any apicoectomy/periradicular service.

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

(iii) The following endodontic services:

(A) Indirect or direct pulp caps.

(B) Any endodontic therapy on primary teeth, except as described in WAC 182-535-1086 (3)(a).

(C) Endodontic therapy on molar teeth.

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

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

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

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

(i) Removable unilateral partial dentures.

(ii) Adjustments to any removable prosthesis.

(iii) Any interim complete or partial dentures.

(iv) Flexible base partial dentures.

(v) Any type of permanent soft relines (e.g., molloplast).

(vi) Precision attachments.

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

(viii) Replacement of second or third molars for any removable prosthesis.

(ix) Immediate dentures.

(x) Cast-metal framework partial dentures.

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

(i) Any type of implant procedures, including, but not limited to, any tooth implant abutment (e.g., periosteal implants, eosteal implants, and transosteal implants), abutments or implant supported crowns, abutment supported retainers, and implant supported retainers.

(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 agency does not cover any type of:

(i) Fixed partial denture pontic.

(ii) Fixed partial denture retainer.

(iii) Precision attachment, stress breaker, connector bar, coping, cast post, or any other type of fixed attachment or prosthesis.

(iv) Occlusal orthotic splint or device, bruxing or grinding splint or device, temporomandibular joint splint or device, or sleep apnea splint or device.

(v) Orthodontic service or appliance, for clients twenty-one years of age and older.

(i) **Oral maxillofacial prosthetic services.** The agency does not cover any type of oral or facial prosthesis other than those listed in WAC 182-535-1092.

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

(i) Any oral surgery service not listed in WAC 182-535-1094.

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

(iii) Vestibuloplasty.

(iv) Frenuloplasty/frenulectomy, for clients twenty-one years of age and older.

(k) **Adjunctive general services.** The agency 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) General anesthesia for clients twenty-one years of age and older.

(iii) Oral or parenteral conscious sedation for clients twenty-one years of age and older.

(iv) Analgesia or anxiolysis as a separate procedure except for administration of nitrous oxide for clients twenty-one years of age and older.

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

(A) Fabrication of an athletic mouthguard.

(B) Occlusal guards for clients twenty-one years of age and older.

(C) Nightguards.

(D) Occlusion analysis.

(E) Occlusal adjustment, tooth or restoration adjustment or smoothing, or odontoplasties.

(F) Enamel microabrasion.

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

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

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

(J) Educational supplies.

(K) Nonmedical equipment or supplies.

(L) Personal comfort items or services.

(M) Provider mileage or travel costs.

(N) Fees for no-show, canceled, or late arrival appointments.

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

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

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

[Statutory Authority: RCW 41.05.021, 12-09-081, § 182-535-1100, filed 4/17/12, effective 5/18/12. 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 U.S.C. 1396d(a), C.F.R. 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. (1) The agency uses the determi-

nation process for payment described in WAC 182-501-0165 for covered dental-related services that require prior authorization.

(2) The agency 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 DSHS form 13-835, available on the agency's web site.

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

(a) Additional radiographs (X rays) (refer to WAC 182-535-1080(2));

(b) Study models;

(c) Photographs; and

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

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

(5) When the agency 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 agency denies a request for a dental-related service when the requested service:

(a) Is covered by another agency program;

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

(c) Fails to meet the program criteria, limitations, or restrictions in this chapter.

[Statutory Authority: RCW 41.05.021, 12-09-081, § 182-535-1220, filed 4/17/12, effective 5/18/12. 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 U.S.C. 1396d(a), C.F.R. 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.]

PAYMENT

WAC 182-535-1350 Payment methodology for dental-related services. The agency uses the description of dental services described in the American Dental Association's Current Dental Terminology (CDT), and the American Med-

ical Association's Physician's Current Procedural Terminology (CPT).

(1) For covered dental-related services provided to eligible clients, the agency pays dentists and other eligible providers on a fee-for-service or contractual basis, subject to the exceptions and restrictions listed under WAC 182-535-1100 and 182-535-1400.

(2) The agency sets maximum allowable fees for dental services as follows:

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

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

(c) The agency consults with dental experts and public health professionals to identify and prioritize dental services and procedures for their effectiveness in improving or promoting dental health.

(d) Legislatively authorized vendor rate increases and/or earmarked appropriations for 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 dental health.

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

(3) The agency 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) The agency pays eligible providers listed in WAC 182-535-1070 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 the agency are paid at the same rate as dentists who have a contract with the agency, for services allowed under The Dental Hygienist Practice Act.

(4/17/12)

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

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

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

(10) The agency 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 the agency's reimbursement for comprehensive oral evaluations or limited oral evaluations.

[Statutory Authority: RCW 41.05.021, 12-09-081, § 182-535-1350, filed 4/17/12, effective 5/18/12. 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 U.S.C. 1396d(a), C.F.R. 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 agency considers that a provider who furnishes covered dental services to an eligible client has accepted the agency's rules and fees.

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

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

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

(5) The agency 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 182-502-0160, 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 182-535-1240 and 182-535-1290.

[Statutory Authority: RCW 41.05.021, 12-09-081, § 182-535-1400, filed 4/17/12, effective 5/18/12. 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 U.S.C. 1396d(a), C.F.R. 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. This section applies to payment for denture laboratory services. The agency does not directly reimburse denture laboratories. The agency's reimbursement for complete dentures, partial dentures, and overdentures includes labora-

tory fees. The provider is responsible to pay a denture laboratory for services furnished at the request of the provider.

[Statutory Authority: RCW 41.05.021, 12-09-081, § 182-535-1450, filed 4/17/12, effective 5/18/12. 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 U.S.C. 1396d(a), C.F.R. 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 agency pays for medically necessary dental-related services provided in an inpatient or outpatient hospital setting according to WAC 182-550-1100.

[Statutory Authority: RCW 41.05.021, 12-09-081, § 182-535-1500, filed 4/17/12, effective 5/18/12. 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 U.S.C. 1396d(a), C.F.R. 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 U.S.C. 1396d(a), C.F.R. 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.]