

Chapter 182-535 WAC

DENTAL-RELATED SERVICES

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		182-535-1269	Covered dental-related services for clients age twenty-one and older—Adjunctive general services. [WSR 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. WSR 07-06-041, § 388-535-1269, filed 3/1/07, effective 4/1/07.] Repealed by WSR 12-09-081, filed 4/17/12, effective 5/18/12. Statutory Authority: RCW 41.05.021.
182-535-1247	Dental-related services for clients age twenty-one and older—General. [WSR 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. WSR 07-06-041, § 388-535-1247, filed 3/1/07, effective 4/1/07.] Repealed by WSR 12-09-081, filed 4/17/12, effective 5/18/12.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. [WSR 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. WSR 07-06-041, § 388-535-1271, filed 3/1/07, effective 4/1/07.] Repealed by WSR 12-09-081, filed 4/17/12, effective 5/18/12.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. [WSR 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. WSR 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. WSR 03-19-080, § 388-535-1280, filed 9/12/03, effective 10/13/03.] Repealed by WSR 12-09-081, filed 4/17/12, effective 5/18/12. Statutory Authority: RCW 41.05.021.

GENERAL

WAC 182-535-1050 Dental-related services—Definitions. The following definitions and abbreviations and those found in chapter 182-500 WAC apply to this chapter. The medicaid agency 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 for medicaid eligible infants, toddlers, and preschoolers through age five. See WAC 182-535-1245 for specific information.

"Alternate living facility" is defined in WAC 182-513-1100.

"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.

"Behavior management" means using one additional professional staff, who is employed by the dental provider or clinic and who is not delivering dental treatment to the client, to manage the client's behavior to facilitate dental treatment delivery.

"By-report" means 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 agency's published fee schedules. Upon request the provider must submit a "report" that 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 on the root surface.

- **"Incipient caries"** means the beginning stages of caries or decay, or subsurface demineralization.

- **"Rampant caries"** means a sudden onset of widespread caries that affects most of the teeth and penetrates quickly to the dental pulp.

"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" means 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" means the building up of clinical crowns, including pins.

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

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

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

"Deep sedation" means 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.

"Edentulous" means lacking teeth.

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

"EPSDT" means the agency's early and periodic screening, diagnostic, and treatment program for clients age twenty and younger as described in chapter 182-534 WAC.

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

"Flowable composite" means a diluted low-viscosity-filled 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" means a substance containing dental fluoride which is applied to teeth, not including silver diamine fluoride.

"General anesthesia" means 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 pres-

sure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

"Interim therapeutic restoration (ITR)" means the placement of an adhesive restorative material following caries debridement by hand or other method for the management of early childhood caries. It is not considered a definitive restoration.

"Limited oral evaluation" means 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" means an assessment by a dentist or dental hygienist provided in a setting other than a dental office or dental clinic to identify signs of disease and the potential need for referral for diagnosis.

"Medically necessary" see WAC 182-500-0070.

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

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

"Partials" or **"partial dentures"** mean a removable prosthetic appliance that replaces missing teeth on either arch.

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

"Periodontal scaling and root planing" means 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" means 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.

"Prophylaxis" means the dental procedure of scaling and polishing which includes removal of calculus, plaque, and stains from teeth.

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

"Radiograph (X-ray)" means 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" means the chamber within the root of the tooth that contains the pulp.

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

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

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

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

"Simple extraction" means the extraction of an erupted or exposed tooth to include the removal of tooth structure, minor smoothing of socket bone, and closure, as necessary.

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

"Surgical extraction" means the extraction of an erupted or impacted tooth requiring removal of bone and/or sectioning of the tooth, and including elevation of mucoperiosteal flap if indicated. This includes related cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone, and closure.

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

"Therapeutic pulpotomy" means 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 agency.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-20-097, § 182-535-1050, filed 10/3/17, effective 11/3/17; WSR 16-13-110, § 182-535-1050, filed 6/20/16, effective 8/1/16. Statutory Authority: RCW 41.05.021 and 2013 2nd sp.s. c 4 § 213. WSR 14-08-032, § 182-535-1050, filed 3/25/14, effective 4/30/14. WSR 11-14-075, recodified as § 182-535-1050, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. WSR 07-06-041, § 388-535-1050, filed 3/1/07, effective 4/1/07. Statutory Authority: RCW 74.04.050, 74.04.057, and 74.09.530. WSR 04-14-100, § 388-535-1050, filed 7/6/04, effective 8/6/04. 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. WSR 03-19-077, § 388-535-1050, 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. WSR 02-13-074, § 388-535-1050, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090. WSR 01-02-076, § 388-535-1050, filed 12/29/00, effective 1/29/01. 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. WSR 99-07-023, § 388-535-1050, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. WSR 96-01-006 (Order 3931), § 388-535-1050, filed 12/6/95, effective 1/6/96.]

WAC 182-535-1060 Dental-related services—Client eligibility. (1) Refer to WAC 182-501-0060 to see which apple health programs include dental-related services in their benefit package.

(2) Managed care clients are eligible under apple health fee-for-service for covered dental-related services not covered by their managed care organization (MCO), subject to

the provisions of this chapter and other applicable agency rules.

(3) See WAC 182-507-0115 for rules for clients eligible under the alien emergency medical program.

(4) Exception to rule procedures as described in WAC 182-501-0160 are not available for services that are excluded from a client's benefit package.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-20-097, § 182-535-1060, filed 10/3/17, effective 11/3/17. Statutory Authority: RCW 41.05.021 and 2013 2nd sp.s. c 4 § 213. WSR 14-08-032, § 182-535-1060, filed 3/25/14, effective 4/30/14. Statutory Authority: RCW 41.05.021. WSR 12-09-081, § 182-535-1060, filed 4/17/12, effective 5/18/12. WSR 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. WSR 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. WSR 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. WSR 99-07-023, § 388-535-1060, filed 3/10/99, effective 4/10/99.]

WAC 182-535-1066 Dental-related services—Medical care services clients (formerly general assistance (GA)).

(1) The medicaid agency covers the following dental-related services for a medical care services client under WAC 182-501-0060 when the services are provided by a dentist to assess, diagnose, and treat pain, infection, or trauma of the mouth, jaw, or teeth, including treatment of postsurgical complications, such as dry socket:

- (a) Limited oral evaluation;
 - (b) Periapical or bitewing radiographs (X-rays) that are medically necessary to diagnose only the client's chief complaint;
 - (c) Palliative treatment to relieve dental pain or infection;
 - (d) Pulpal debridement to relieve dental pain or infection; and
 - (e) Tooth extraction.
- (2) Tooth extractions require prior authorization when:
- (a) The extraction of a tooth or teeth results in the client becoming edentulous in the maxillary arch or mandibular arch; or
 - (b) A full mouth extraction is necessary because of radiation therapy for cancer of the head and neck.

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

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-20-097, § 182-535-1066, filed 10/3/17, effective 11/3/17. Statutory Authority: RCW 41.05.021 and 2013 2nd sp.s. c 4 § 213. WSR 14-08-032, § 182-535-1066, filed 3/25/14, effective 4/30/14.]

WAC 182-535-1070 Dental-related services—Provider information.

(1) The following providers are eligible to enroll with the medicaid agency 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 qualified professional under chapter 246-817 WAC; 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, the agency pays licensed providers participating in the agency's dental program for only those services that are within their scope of practice.

(3) For the dental specialty of oral and maxillofacial surgery, the agency requires a dentist to meet the following requirements in order to be reimbursed for oral and maxillofacial surgery:

- (a) The provider's professional organization guidelines;

- (b) The department of health (DOH) requirements in chapter 246-817 WAC; and

- (c) Any applicable DOH medical, dental, and nursing anesthesia regulations.

(4) See WAC 182-502-0020 for provider documentation and record retention requirements. The agency requires additional dental documentation under specific sections in this chapter and as required by DOH under chapter 246-817 WAC.

(5) See WAC 182-502-0100 and 182-502-0150 for provider billing and payment requirements. Enrolled dental providers who do not meet the conditions in subsection (3) of this section must bill all claims using only the CDT codes for services that are identified in WAC and the agency's published billing instructions and provider notices. The agency 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 182-502-0160 for regulations concerning charges billed to clients.

(7) See WAC 182-502-0230 for provider payment reviews and dispute rights.

(8) See chapter 182-502A WAC for provider audits and the audit appeal process.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-20-097, § 182-535-1070, filed 10/3/17, effective 11/3/17. Statutory Authority: RCW 41.05.021 and 2013 2nd sp.s. c 4 § 213. WSR 14-08-032, § 182-535-1070, filed 3/25/14, effective 4/30/14. WSR 11-14-075, recodified as § 182-535-1070, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. WSR 05-06-092, § 388-535-1070, filed 3/1/05, effective 4/1/05. 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. WSR 03-19-077, § 388-535-1070, 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. WSR 02-13-074, § 388-535-1070, filed 6/14/02, effective 7/15/02.]

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 medicare agency pays for dental-related services and procedures provided to eligible clients when the services and procedures:

- (a) Are part of the client's dental benefit package;
- (b) Are within the scope of an eligible client's Washington apple health program;
- (c) Are medically necessary;
- (d) Meet the agency's authorization requirements, if any;
- (e) Are documented in the client's dental record in accordance with chapter 182-502 WAC and meet the department of health's requirements in WAC 246-817-305 and 246-817-310;
- (f) Are within accepted dental or medical practice standards;
- (g) Are consistent with a diagnosis of a dental disease or dental condition;
- (h) Are reasonable in amount and duration of care, treatment, or service; and
- (i) Are listed as covered in the agency's rules and published billing instructions and fee schedules.

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

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

- (a) A client is not a client of the developmental disabilities administration of the department of social and health services (DSHS) according to WAC 182-535-1099;
- (b) A client is age nine or older;
- (c) The service is not listed as exempt from the site-of-service authorization requirement in the agency's current published dental-related services fee schedule or billing instructions; and
- (d) The service is not listed as exempt from the prior authorization requirement for deep sedation or general anesthesia (see WAC 182-535-1098 (1)(c)(v)).

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

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

(10/3/17)

noncovered. The standard for coverage for EPSDT is found in chapter 182-534 WAC.

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

- (a) In excess of the dental program's limitations or restrictions, according to WAC 182-501-0169; and
- (b) Listed as noncovered, according to WAC 182-501-0160.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-20-097, § 182-535-1079, filed 10/3/17, effective 11/3/17; WSR 16-18-033, § 182-535-1079, filed 8/26/16, effective 9/26/16. Statutory Authority: RCW 41.05.021 and 2013 2nd sp.s. c 4 § 213. WSR 14-08-032, § 182-535-1079, filed 3/25/14, effective 4/30/14. Statutory Authority: RCW 41.05.021. WSR 12-09-081, § 182-535-1079, filed 4/17/12, effective 5/18/12. WSR 11-14-075, recodified as § 182-535-1079, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. WSR 07-06-042, § 388-535-1079, filed 3/1/07, effective 4/1/07.]

WAC 182-535-1080 Dental-related services—Covered—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 medicare agency covers the following oral health evaluations and assessments, per client, per provider or clinic:

(a) 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.

(b) 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 on the same day. 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 delivered.

(c) 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.

(d) Limited visual oral assessments as defined in WAC 182-535-1050, once every six months only when the assessment is:

- (i) Not performed in conjunction with other clinical oral evaluation services; and
- (ii) Performed by a licensed dentist or dental hygienist to determine the need for sealants or fluoride treatment or when triage services are provided in settings other than dental offices or clinics.

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

(a) Covers radiographs per client, per provider or clinic, 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; or

(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 for clients age fourteen and older 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 at least fourteen to 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, per arch, once in a two-year period, for clients age twenty and younger.

(f) Covers a maximum of four bitewing radiographs once every twelve months.

(g) 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.

(h) Covers one preoperative and postoperative panoramic radiograph per surgery without prior authorization. The agency considers additional radiographs on a case-by-case basis with prior authorization. For orthodontic services, see chapter 182-535A WAC.

(i) Covers one preoperative and postoperative cephalometric film per surgery without prior authorization. The agency considers additional radiographs on a case-by-case basis with prior authorization. For orthodontic services, see chapter 182-535A WAC.

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

(k) 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 age twenty and younger:

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

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

(ii) When radiographs 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, 41.05.160. WSR 16-18-033, § 182-535-1080, filed 8/26/16, effective 9/26/16. Statutory Authority: RCW 41.05.021 and 2013 2nd sp.s. c 4 § 213. WSR 14-08-032, § 182-535-1080, filed 3/25/14, effective 4/30/14. Statutory Authority: RCW 41.05.021. WSR 12-09-081, § 182-535-1080, filed 4/17/12, effective 5/18/12. WSR 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. WSR 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. WSR 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. WSR 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. WSR 99-07-023, § 388-535-1080, filed 3/10/99, effective 4/10/99.]

WAC 182-535-1082 Dental-related services—Covered—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) **Prophylaxis.** The medicaid 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 age eighteen and younger;

(ii) Twelve months for clients age nineteen and older; or

(iii) Six months for a client residing in an alternate living facility or nursing facility.

(c) Is reimbursed according to (b) of this subsection when the service is performed:

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

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

(iii) At least six months after periodontal scaling and root planing, or periodontal maintenance services for clients who reside in an alternate living facility or nursing facility.

(d) Is not reimbursed separately when performed on the same date of service as periodontal scaling and root planing, periodontal maintenance, gingivectomy, gingivoplasty, or scaling in the presence of generalized moderate or severe gingival inflammation.

(e) Is covered for clients of the developmental disabilities administration of the department of social and health services (DSHS) according to (a), (c), and (d) of this subsection and WAC 182-535-1099.

(2) **Topical fluoride treatment.** The agency covers the following per client, per provider or clinic:

(a) Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, for clients age six and younger, three times within a twelve-month period with a minimum of one hundred ten days between applications.

(b) Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, for clients from age seven through eighteen, two times within a twelve-month period with a minimum of one hundred seventy days between applications.

(c) Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, every three times within a twelve-month period during orthodontic treatment with a minimum of one hundred ten days between applications.

(d) Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, for clients age nineteen and older, once within a twelve-month period.

(e) Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, for clients who reside in alternate living facilities or nursing facilities, every two times within a

twelve-month period with a minimum of one hundred seventy days between applications.

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

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

(3) **Oral hygiene instruction.** Includes instruction for home care such as tooth brushing technique, flossing, and use of oral hygiene aids. Oral hygiene instruction is included as part of the global fee for prophylaxis for clients age nine and older. The agency covers individualized oral hygiene instruction for clients age eight and younger when all of the following criteria are met:

(a) Only once per client every six months within a twelve-month period.

(b) Only when not performed on the same date of service as prophylaxis or within six months from a prophylaxis by the same provider or clinic.

(c) 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) **Tobacco cessation counseling for the control and prevention of oral disease.** The agency covers tobacco cessation counseling for pregnant women only. See WAC 182-531-1720.

(5) **Sealants.** The agency covers:

(a) Sealants for clients age twenty and younger and clients any age of the developmental disabilities administration of DSHS.

(b) Sealants, other than glass ionomer cement, only when used on a mechanically or chemically prepared enamel surface.

(c) Sealants once per tooth:

(i) In a three-year period for clients age twenty and younger; and

(ii) In a two-year period for clients any age of the developmental disabilities administration of DSHS 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) Sealants are included in the agency's payment for occlusal restoration placed on the same day.

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

(6) **Space maintenance.** The agency covers:

(a) One fixed unilateral space maintainer per quadrant or one fixed bilateral space maintainer per arch, including re-plantation, for missing primary molars A, B, I, J, K, L, S, and T, when:

(i) Evidence of pending permanent tooth eruption exists; and

(ii) The service is not provided during approved orthodontic treatment.

(b) Replacement space maintainers on a case-by-case basis when authorized.

(c) The removal of fixed space maintainers when removed by a different provider.

(i) Space maintainer removal is allowed once per appliance.

(ii) Reimbursement for space maintainer removal is included in the payment to the original provider that placed the space maintainer.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-20-097, § 182-535-1082, filed 10/3/17, effective 11/3/17; WSR 16-18-033, § 182-535-1082, filed 8/26/16, effective 9/26/16. Statutory Authority: RCW 41.05.021 and 2013 2nd sp.s. c 4 § 213. WSR 14-08-032, § 182-535-1082, filed 3/25/14, effective 4/30/14. Statutory Authority: RCW 41.05.021. WSR 12-09-081, § 182-535-1082, filed 4/17/12, effective 5/18/12. WSR 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. WSR 07-06-042, § 388-535-1082, filed 3/1/07, effective 4/1/07.]

WAC 182-535-1084 Dental-related services—Covered—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 medicaid agency considers:

(a) Tooth preparation, acid etching, all adhesives (including bonding agents), liners and bases, indirect and direct pulp capping, 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 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 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 dentinoenamel junction (DEJ) to be sealants. (See WAC 182-535-1082 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 is cracked or broken or 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 or documentation supporting the medical necessity for the replacement restoration.

(3) Additional limitations for 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.

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

(a) 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.

(b) 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.

(c) 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 age fifteen through twenty 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.

(b) Prefabricated stainless steel crowns, including stainless steel crowns with resin window, resin-based composite crowns (direct), prefabricated esthetic coated stainless steel crowns, and prefabricated resin crowns for primary anterior teeth once every three years only for clients age twenty and younger as follows:

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

(ii) For age thirteen through twenty with prior authorization.

(c) Prefabricated stainless steel crowns, including stainless steel crowns with resin window, resin-based composite crowns (direct), prefabricated esthetic coated stainless steel crowns, and prefabricated resin 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, including stainless steel crowns with resin window, and prefabricated resin crowns, for permanent posterior teeth excluding one, sixteen, seventeen, and thirty-two once every three years, for clients age twenty and younger, without prior authorization.

(e) Prefabricated stainless steel crowns for clients of the developmental disabilities administration of the department of social and health services (DSHS) without prior authorization according to WAC 182-535-1099.

(f) Core buildup, including pins, only on permanent teeth, only for clients age twenty and younger, and only allowed in conjunction with crowns and when prior authorized. For indirect crowns, prior authorization must be obtained from the agency at the same time as the crown. Providers must submit pre- and post-endodontic treatment radiographs to the agency with the authorization request for endodontically treated teeth.

(g) Cast post and core or prefabricated post and core, only on permanent teeth, only for clients age twenty and younger, and only when in conjunction with a crown and when prior authorized.

(7) **Silver diamine fluoride.** The agency covers silver diamine fluoride per application as follows:

(a) When used for stopping the progression of caries only;

(b) May be provided two times per client in a twelve-month period; and

(c) Cannot be performed and billed with interim therapeutic restoration on the same tooth.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-20-097, § 182-535-1084, filed 10/3/17, effective 11/3/17; WSR 16-18-033, § 182-535-1084, filed 8/26/16, effective 9/26/16; WSR 15-10-043, § 182-535-1084, filed 4/29/15, effective 5/30/15. Statutory Authority: RCW 41.05.021 and 2013 2nd sp.s. c 4 § 213. WSR 14-08-032, § 182-535-1084, filed 3/25/14, effective 4/30/14. Statutory Authority: RCW 41.05.021. WSR 12-09-081, § 182-535-1084, filed 4/17/12, effective 5/18/12. WSR 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. WSR 07-06-042, § 388-535-1084, filed 3/1/07, effective 4/1/07.]

WAC 182-535-1086 Dental-related services—Covered—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 medicaid 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 age twenty 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 on primary teeth.** The agency covers endodontic treatment with resorbable material for primary teeth, if the entire root is present at treatment.

(4) **Endodontic treatment on permanent teeth.** The agency:

(a) Covers endodontic treatment for permanent anterior teeth for all clients.

(b) Covers endodontic treatment for permanent bicuspid and molar teeth, excluding teeth one, sixteen, seventeen, and thirty-two for clients age twenty 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 (X-rays) 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.

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(5) **Endodontic retreatment on permanent anterior teeth.** The agency:

(a) Covers endodontic retreatment for clients age twenty and younger when prior authorized.

(b) Covers endodontic retreatment of permanent anterior teeth for clients twenty-one years of age and older when prior authorized.

(c) 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.

(d) 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.

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

(6) **Apexification/apicoectomy.** The agency covers:

(a) Apexification for apical closures for anterior permanent teeth only. Apexification is limited to the initial visit and three interim treatment visits per tooth and is limited to clients age twenty and younger.

(b) Apicoectomy and a retrograde fill for anterior teeth only for clients age twenty and younger.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-20-097, § 182-535-1086, filed 10/3/17, effective 11/3/17. Statutory Authority: RCW 41.05.021 and 2013 2nd sp.s. c 4 § 213. WSR 14-08-032, § 182-535-1086, filed 3/25/14, effective 4/30/14. Statutory Authority: RCW 41.05.021. WSR 12-09-081, § 182-535-1086, filed 4/17/12, effective 5/18/12. WSR 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. WSR 07-06-042, § 388-535-1086, filed 3/1/07, effective 4/1/07.]

WAC 182-535-1088 Dental-related services—Covered—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 medicaid agency covers the following surgical periodontal services, including all postoperative care:

(a) Gingivectomy/gingivoplasty (does not include distal wedge procedures on erupting molars) only on a case-by-case basis and when prior authorized and only for clients age twenty and younger; and

(b) Gingivectomy/gingivoplasty (does not include distal wedge procedures on erupting molars) for clients of the developmental disabilities administration of the department of social and health services (DSHS) according to WAC 182-535-1099.

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

(a) Covers periodontal scaling and root planing for clients age thirteen through eighteen, 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 and subgingival calculus;

(ii) The client's record includes supporting documentation for the medical necessity, including complete periodontal charting done within the past twelve months from the date of the prior authorization request 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 age nineteen 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 developmental disabilities administration of DSHS according to WAC 182-535-1099.

(f) Covers periodontal scaling and root planing, one time per quadrant in a twelve-month period for clients residing in an alternate living facility or nursing facility.

(3) Other periodontal services. The agency:

(a) Covers periodontal maintenance for clients age thirteen through eighteen 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 done within the past twelve months 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 age nineteen 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 developmental disabilities administration of DSHS according to WAC 182-535-1099.

(e) Covers periodontal maintenance for clients residing in an alternate living facility or nursing facility:

(i) Periodontal maintenance (four quadrants) substitutes for an eligible periodontal scaling or root planing once every six months.

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

(f) Covers full-mouth scaling in the presence of generalized moderate or severe gingival inflammation and only:

(i) For clients age nineteen and older once in a twelve-month period after an oral evaluation; and

(ii) For clients age thirteen through eighteen once in a twelve-month period after an oral evaluation and when prior authorized.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-20-097, § 182-535-1088, filed 10/3/17, effective 11/3/17; WSR 16-18-033, § 182-535-1088, filed 8/26/16, effective 9/26/16. Statutory Authority: RCW 41.05.021 and 2013 2nd sp.s. c 4 § 213. WSR 14-08-032, § 182-535-1088, filed 3/25/14, effective 4/30/14. Statutory Authority: RCW 41.05.021. WSR 12-09-081, § 182-535-1088, filed 4/17/12, effective 5/18/12. WSR 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. WSR 07-06-042, § 388-535-1088, filed 3/1/07, effective 4/1/07.]

WAC 182-535-1090 Dental-related services—Covered—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 medicaid agency requires prior authorization for removable prosthodontic and prosthodontic-related procedures, except as otherwise noted in this section. Prior authorization requests must meet the criteria in WAC 182-535-1220. In addition, the agency requires the dental provider to submit:

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

(b) A dental record which identifies:

(i) All missing teeth for both arches;

(ii) Teeth that are to be extracted; and

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

(2) Complete dentures. The agency covers complete dentures, including overdentures, when prior authorized, except as otherwise noted in this section.

The agency considers three-month post-delivery care (e.g., adjustments, soft relines, and repairs) from the delivery (placement) date of the complete denture as part of the complete denture procedure and does not pay separately for this care.

(a) The agency covers complete dentures only as follows:

(i) One initial maxillary complete denture and one initial mandibular complete denture per client.

(ii) Replacement of a partial denture with a complete denture only when the replacement occurs three or more years after the delivery (placement) date of the last resin partial denture.

(iii) One replacement maxillary complete denture and one replacement mandibular complete denture per client, per client's lifetime. The replacement must occur at least five years after the delivery (placement) date of the initial com-

plete denture or overdenture. The replacement does not require prior authorization.

(b) The agency reviews requests for replacement that exceed the limits in this subsection (2) under WAC 182-501-0050(7).

(c) The provider must obtain a current signed Denture Agreement of Acceptance (HCA 13-809) form from the client at the conclusion of the final denture try-in and at the time of delivery 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. Failure to submit the completed, signed Denture Agreement of Acceptance form when requested may result in recoupment of the agency's payment.

(3) **Resin partial dentures.** The agency covers resin partial dentures only as follows:

(a) For anterior and posterior teeth only when the following criteria are met:

(i) The remaining teeth in the arch must be free of periodontal disease and have a reasonable prognosis.

(ii) The client has established caries control.

(iii) The client has one or more missing anterior teeth or four or more missing posterior teeth (excluding teeth one, two, fifteen, and sixteen) on the upper arch to qualify for a maxillary partial denture. Pontics on an existing fixed bridge do not count as missing teeth. The agency does not consider closed spaces of missing teeth to qualify as a missing tooth.

(iv) The client has one or more missing anterior teeth or four or more missing posterior teeth (excluding teeth seventeen, eighteen, thirty-one, and thirty-two) on the lower arch to qualify for a mandibular partial denture. Pontics on an existing fixed bridge do not count as missing teeth. The agency does not consider closed spaces of missing teeth to qualify as a missing tooth.

(v) There is a minimum of four functional, stable teeth remaining per arch.

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

(b) Prior authorization is required.

(c) The agency considers three-month post-delivery care (e.g., adjustments, soft relines, and repairs) from the delivery (placement) date of the resin partial denture as part of the resin partial denture procedure and does not pay separately for this care.

(d) Replacement of a resin-based partial denture with a new resin partial denture or a complete denture if it occurs at least three years after the delivery (placement) date of the resin-based partial denture. The replacement partial or complete denture must be prior authorized and meet agency coverage criteria in (a) of this subsection.

(e) The agency reviews requests for replacement that exceed the limits in this subsection (3) under WAC 182-501-0050(7).

(f) The provider must obtain a signed Partial Denture Agreement of Acceptance (HCA 13-809) form from the client at the time of delivery for an agency-authorized partial denture. A copy of the signed agreement must be kept in the

provider's files and be available upon request by the agency. Failure to submit the completed, signed Partial Denture Agreement of Acceptance form when requested may result in recoupment of the agency's payment.

(4) **Provider requirements.**

(a) The agency requires a provider to bill for a removable partial or complete denture only after the delivery of the prosthesis, not at the impression date. Refer to subsection (5)(e) of this section for what the agency may pay if the removable partial or complete denture is not delivered and inserted.

(b) The agency requires a provider to submit the following with a prior authorization request for a removable resin partial or complete denture for a client residing in an alternate living facility or 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 (HCA 13-788) form available from the agency's published billing instructions which can be downloaded from the agency's web site.

(c) The agency limits removable partial dentures to resin-based partial dentures for all clients residing in one of the facilities listed in (b) of this subsection.

(d) The agency 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.

(5) **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, per arch. 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, per arch. 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 relines or rebase to a complete or partial denture, once in a three-year period when performed at least six months after the delivery (placement) date. The agency does not pay for a denture relines and a rebase in the same three-year period. An additional relines or rebase may be covered for complete or partial dentures on a case-by-case basis when prior authorized.

(d) 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 partial or complete denture;

- (B) Moves from the state;
 - (C) Cannot be located;
 - (D) Does not participate in completing the partial or complete denture; or
 - (E) Dies.
- (iii) 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 and 41.05.160. WSR 17-20-097, § 182-535-1090, filed 10/3/17, effective 11/3/17; WSR 16-18-033, § 182-535-1090, filed 8/26/16, effective 9/26/16; WSR 15-10-043, § 182-535-1090, filed 4/29/15, effective 5/30/15. Statutory Authority: RCW 41.05.021 and 2013 2nd sp.s. c 4 § 213. WSR 14-08-032, § 182-535-1090, filed 3/25/14, effective 4/30/14. Statutory Authority: RCW 41.05.021. WSR 12-09-081, § 182-535-1090, filed 4/17/12, effective 5/18/12. WSR 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. WSR 07-06-042, § 388-535-1090, filed 3/1/07, effective 4/1/07.]

WAC 182-535-1092 Dental-related services—Covered—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 on a case-by-case basis and when prior authorized; and
- (2) The medicaid agency must preapprove a provider qualified to furnish maxillofacial prosthetics.

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-18-033, § 182-535-1092, filed 8/26/16, effective 9/26/16. Statutory Authority: RCW 41.05.021 and 2013 2nd sp.s. c 4 § 213. WSR 14-08-032, § 182-535-1092, filed 3/25/14, effective 4/30/14. Statutory Authority: RCW 41.05.021. WSR 12-09-081, § 182-535-1092, filed 4/17/12, effective 5/18/12. WSR 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. WSR 07-06-042, § 388-535-1092, filed 3/1/07, effective 4/1/07.]

WAC 182-535-1094 Dental-related services—Covered—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 medicaid 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 guide 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 age eight and younger;
 - (ii) Clients age nine through twenty only on a case-by-case basis and when the site-of-service is prior authorized by the agency; and

- (ii) Clients any age of the developmental disabilities administration of the department of social and health services (DSHS).

- (d) For site-of-service and oral surgery CPT codes that require prior authorization, the agency requires the dental provider to submit current records (within the past twelve months), including:

- (i) Documentation used to determine medical appropriateness;
 - (ii) Cephalometric films;
 - (iii) Radiographs (X-rays);
 - (iv) Photographs; and
 - (v) Written narrative/letter of medical necessity, including proposed billing codes.

- (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 simple and surgical extractions. Authorization is required for the following:

- (i) Surgical extractions of four or more teeth per arch over a six-month period, resulting in the client becoming edentulous in the maxillary arch or mandibular arch;
- (ii) Simple extractions of four or more teeth per arch over a six-month period, resulting in the client becoming edentulous in the maxillary arch or mandibular arch; or
- (iii) Tooth number is not able to be determined.
- (g) Covers unusual, complicated surgical extractions with prior authorization.
- (h) Covers tooth reimplantation/stabilization of accidentally evulsed or displaced teeth.
- (i) Covers surgical extraction of unerupted teeth for clients.
 - (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; and
 - (iii) Surgical excision of soft tissue lesions.
 - (l) Requires providers to keep all biopsy reports or findings in the client's dental record.
 - (m) Covers the following with prior authorization (photos or radiographs, as appropriate, must be submitted to the agency with the prior authorization request):
 - (i) Alveoloplasty on a case-by-case basis.
 - (ii) Only the following excisions of bone tissue in conjunction with placement of complete or partial dentures:
 - (A) Removal of lateral exostosis;

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

(C) Surgical reduction of osseous tuberosity.

(iii) Surgical access of unerupted teeth for clients age twenty and younger.

(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 the medical necessity must be in the client's record.

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

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

(d) Frenuloplasty/frenulectomy for clients age seven through twelve only on a case-by-case basis and when prior authorized. Photos must be submitted to the agency with the prior authorization request. 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 age twelve through twenty only on a case-by-case basis and when prior authorized.

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

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-20-097, § 182-535-1094, filed 10/3/17, effective 11/3/17; WSR 16-18-033, § 182-535-1094, filed 8/26/16, effective 9/26/16; WSR 15-10-043, § 182-535-1094, filed 4/29/15, effective 5/30/15. Statutory Authority: RCW 41.05.021 and 2013 2nd sp.s. c 4 § 213. WSR 14-08-032, § 182-535-1094, filed 3/25/14, effective 4/30/14. Statutory Authority: RCW 41.05.021. WSR 12-09-081, § 182-535-1094, filed 4/17/12, effective 5/18/12. WSR 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. WSR 07-06-042, § 388-535-1094, filed 3/1/07, effective 4/1/07.]

WAC 182-535-1096 Dental-related services—Covered—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 and 2013 2nd sp.s. c 4 § 213. WSR 14-08-032, § 182-535-1096, filed 3/25/14, effective 4/30/14. Statutory Authority: RCW 41.05.021. WSR 12-09-081, § 182-535-1096, filed 4/17/12, effective 5/18/12. WSR 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. WSR 07-06-042, § 388-535-1096, filed 3/1/07, effective 4/1/07.]

WAC 182-535-1098 Dental-related services—Covered—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.

(10/3/17)

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

(a) Covers palliative (emergency) treatment, not to include pupal debridement (see WAC 182-535-1086 (2)(b)), for treatment of dental pain, limited to once per day, per client, as follows:

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

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

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

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

(c) Covers office-based deep sedation/general anesthesia services:

(i) For all eligible clients age eight and younger and clients any age of the developmental disabilities administration of the department of social and health services (DSHS). Documentation supporting the medical necessity of the anesthesia service must be in the client's record.

(ii) For clients age nine through twenty 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 (1)(f) through (m) and clients with cleft palate diagnoses, deep sedation/general anesthesia services do not require prior authorization.

(iii) For clients age twenty-one and older when prior authorized. The agency considers these services for only those clients:

(A) With medical conditions such as tremors, seizures, or asthma;

(B) Whose records contain documentation of tried and failed treatment under local anesthesia or other less costly sedation alternatives due to behavioral health conditions; or

(C) With other conditions for which general anesthesia is medically necessary, as defined in WAC 182-500-0070.

(d) Covers office-based intravenous moderate (conscious) sedation/analgesia:

(i) For any dental service for clients age twenty and younger, and for clients any age of the developmental disabilities administration of DSHS. Documentation supporting the medical necessity of the service must be in the client's record.

(ii) For clients age twenty-one and older when prior authorized. The agency considers these services for only those clients:

(A) With medical conditions such as tremors, seizures, or asthma;

(B) Whose records contain documentation of tried and failed treatment under local anesthesia, or other less costly sedation alternatives due to behavioral health conditions; or

(C) With other conditions for which general anesthesia or conscious sedation is medically necessary, as defined in WAC 182-500-0070.

(e) Covers office-based nonintravenous conscious sedation:

(i) For any dental service for clients age twenty and younger, and for clients any age of the developmental disabilities administration of DSHS. Documentation supporting the medical necessity of the service must be in the client's record.

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(ii) For clients age twenty-one and older, only when prior authorized.

(f) Requires providers to bill anesthesia services using the current dental terminology (CDT) codes listed in the agency's current published billing instructions.

(g) Requires providers to have a current anesthesia permit on file with the agency.

(h) Covers administration of nitrous oxide once per day, per client per provider.

(i) 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.

(j) Pays for dental anesthesia services according to WAC 182-535-1350.

(k) 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 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 medicaments (pharmaceuticals).**

(a) The agency covers oral sedation medications only when prescribed and the prescription is filled at a pharmacy. The agency does not cover oral sedation medications that are dispensed in the provider's office for home use.

(b) The agency covers therapeutic parenteral drugs as follows:

(i) Includes antibiotics, steroids, anti-inflammatory drugs, or other therapeutic medications. This does not include sedative, anesthetic, or reversal agents.

(ii) Only one single-drug injection or one multiple-drug injection per date of service.

(c) For clients age twenty and younger, the agency covers other drugs and medicaments dispensed in the provider's office for home use. This includes, but is not limited to, oral antibiotics and oral analgesics. The agency does not cover the time spent writing prescriptions.

(4) **Miscellaneous services.** The agency covers:

(a) Behavior management provided by a dental provider or clinic. The agency does not cover assistance with managing a client's behavior provided by a dental provider or staff member delivering the client's dental treatment.

(i) Documentation supporting the need for behavior management must be in the client's record and including the following:

(A) A description of the behavior to be managed;

(B) The behavior management technique used; and

(C) The identity of the additional professional staff used to provide the behavior management.

(ii) Clients, who meet one of the following criteria and whose documented behavior requires the assistance of one additional professional staff employed by the dental provider or clinic to protect the client and the professional staff from injury while treatment is rendered, may receive behavior management:

(A) Clients age eight and younger;

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

(C) Clients any age of the developmental disabilities administration of DSHS;

(D) Clients diagnosed with autism;

(E) Clients who reside in an alternate living facility (ALF) as defined in WAC 182-513-1301, or in a nursing facility as defined in WAC 182-500-0075.

(iii) Behavior management can be performed in the following settings:

(A) Clinics (including independent clinics, tribal health clinics, federally qualified health centers, rural health clinics, and public health clinics);

(B) Offices;

(C) Homes (including private homes and group homes); and

(D) Facilities (including nursing facilities and alternate living facilities).

(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 age twelve through twenty 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 and 41.05.160. WSR 17-20-097, § 182-535-1098, filed 10/3/17, effective 11/3/17; WSR 16-18-033, § 182-535-1098, filed 8/26/16, effective 9/26/16; WSR 15-10-043, § 182-535-1098, filed 4/29/15, effective 5/30/15. Statutory Authority: RCW 41.05.021 and 2013 2nd sp.s. c 4 § 213. WSR 14-08-032, § 182-535-1098, filed 3/25/14, effective 4/30/14. Statutory Authority: RCW 41.05.021. WSR 12-09-081, § 182-535-1098, filed 4/17/12, effective 5/18/12. WSR 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. WSR 07-06-042, § 388-535-1098, filed 3/1/07, effective 4/1/07.]

WAC 182-535-1099 Dental-related services for clients of the developmental disabilities administration of the department of social and health services. Subject to coverage limitations and restrictions identified for a specific service, the medicaid agency pays for the additional dental-related services listed in this section that are provided to clients of the developmental disabilities administration of the department of social and health services (DSHS), regardless of age.

(1) **Preventive services.** The agency covers:

(a) Periodic oral evaluations once every four months per client, per provider.

(b) Prophylaxis once every four months.

(c) Periodontal maintenance once every six months (see subsection (3) of this section for limitations on periodontal scaling and root planing).

(d) Topical fluoride varnish, rinse, foam or gel, once every four months, per client, per provider or clinic.

(e) 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) **Other restorative services.** The agency covers:

(a) All recementations of permanent indirect crowns.

(b) Prefabricated stainless steel crowns, including stainless steel crowns with resin window, resin-based composite crowns (direct), prefabricated esthetic coated stainless steel crowns, and prefabricated resin crowns for primary anterior teeth once every two years only for clients age twenty and younger without prior authorization.

(c) Prefabricated stainless steel crowns, including stainless steel crowns with resin window, resin-based composite crowns (direct), prefabricated esthetic coated stainless steel crowns, and prefabricated resin crowns for primary posterior teeth once every two years for clients age twenty and younger 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, including stainless steel crowns with resin window, and prefabricated resin crowns for permanent posterior teeth excluding one, sixteen, seventeen, and thirty-two once every two years without prior authorization for any age.

(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.

(iv) Full-mouth or quadrant debridement allowed once in a twelve-month period.

(v) Full-mouth scaling in the presence of generalized moderate or severe gingival inflammation.

(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) Sedation 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 according to WAC 182-535-1098.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-20-097, § 182-535-1099, filed 10/3/17, effective 11/3/17; WSR 16-18-033, § 182-535-1099, filed 8/26/16, effective 9/26/16; WSR 15-10-043, § 182-535-1099, filed 4/29/15, effective 5/30/15. Statutory Authority: RCW 41.05.021 and 2013 2nd sp.s. c 4 § 213. WSR 14-08-032, § 182-535-1099, filed 3/25/14, effective 4/30/14. Statutory Authority: RCW 41.05.021. WSR 12-09-081, § 182-535-1099, filed 4/17/12, effective 5/18/12. WSR 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. WSR 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 medicaid agency does not cover the following under the dental program:

(a) The dental-related services described in subsection (2) of this section unless the services are covered under the early periodic screening, diagnostic, and treatment (EPSDT) program. When EPSDT applies, the agency evaluates a non-covered service, equipment, or supply according to the process in WAC 182-501-0165 to determine if it is medically necessary, safe, effective, and not experimental.

(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) Posterior-anterior or lateral skull and facial bone survey films.
- (iii) Any temporomandibular joint films.
- (iv) Tomographic surveys/3-D imaging.
- (v) Comprehensive periodontal evaluations.
- (vi) Viral cultures, genetic testing, caries susceptibility tests, or adjunctive prediagnostic tests.
- (b) **Preventive services.** The agency does not cover:
 - (i) Nutritional counseling for control of dental disease.
 - (ii) Removable space maintainers of any type.
 - (iii) Sealants placed on a tooth with the same-day occlusal restoration, preexisting occlusal restoration, or a tooth with occlusal decay.
 - (iv) Custom fluoride trays of any type.
 - (v) 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 dentinoenamel junction (DEJ) or on the root surface.
 - (ii) Preventative restorations.
 - (iii) Labial veneer resin or porcelain laminate restorations.
 - (iv) Sedative fillings.
 - (v) Crowns and crown related services.
 - (A) Gold foil restorations.
 - (B) Metallic, resin-based composite, or porcelain/ceramic inlay/onlay restorations.
 - (C) Crowns for cosmetic purposes (e.g., peg laterals and tetracycline staining).
 - (D) Permanent indirect crowns for posterior teeth.
 - (E) Permanent indirect crowns on permanent anterior teeth for clients age fourteen and younger.
 - (F) Temporary or provisional crowns (including ion crowns).
 - (G) Any type of coping.
 - (H) Crown repairs.
 - (I) Crowns on teeth one, sixteen, seventeen, and thirty-two.
 - (vi) Polishing or recontouring restorations or overhang removal for any type of restoration.
 - (vii) Any services other than extraction on supernumerary teeth.
- (d) **Endodontic services.** The agency does not cover:
 - (i) Indirect or direct pulp caps.
 - (ii) Any endodontic treatment on primary teeth, except as described in WAC 182-535-1086(3).
- (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 (except for clients of the developmental disabilities administration).
 - (C) Localized delivery of chemotherapeutic agents.
 - (D) Any other type of surgical periodontal service.
- (f) **Removable prosthodontics.** The agency does not cover:
 - (i) Removable unilateral partial dentures.
 - (ii) Any interim complete or partial dentures.
 - (iii) Flexible base partial dentures.
 - (iv) Any type of permanent soft relines (e.g., molloplast).
 - (v) Precision attachments.
 - (vi) Replacement of replaceable parts for semi-precision or precision attachments.
 - (vii) Replacement of second or third molars for any removable prosthesis.
 - (viii) Immediate dentures.
 - (ix) Cast-metal framework partial dentures.
 - (x) Replacement of agency-purchased removable prosthodontics that have been lost, broken, stolen, sold, or destroyed as a result of the client's carelessness, negligence, recklessness, deliberate intent, or misuse as described in WAC 182-501-0050.
- (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.
 - (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) Vestibuloplasty.
 - (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) Other general services including, but not limited to:

(A) Fabrication of an athletic mouthguard.

(B) Sleep apnea devices or splints.

(C) Occlusion analysis.

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

(E) Enamel microabrasion.

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

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

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

(I) Educational supplies.

(J) Nonmedical equipment or supplies.

(K) Personal comfort items or services.

(L) Provider mileage or travel costs.

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

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

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

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

(Q) Botox or dermal fillers.

(3) The agency does not cover the following dental-related services for clients age twenty-one and older:

(a) The following diagnostic services:

(i) Occlusal intraoral radiographs;

(ii) Diagnostic casts;

(iii) Sealants (for clients of the developmental disabilities administration, see WAC 182-535-1099);

(iv) Pulp vitality tests.

(b) The following restorative services:

(i) Prefabricated resin crowns;

(ii) Any type of core buildup, cast post and core, or prefabricated post and core.

(c) The following endodontic services:

(i) Endodontic treatment on permanent bicuspid or molar teeth;

(ii) Any apexification/recalcification procedures;

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

(d) The following adjunctive general services:

(i) Occlusal guards, occlusal orthotic splints or devices, bruxing or grinding splints or devices, or temporomandibular joint splints or devices; and

(ii) Analgesia or anxiolysis as a separate procedure except for administration of nitrous oxide.

(4) The agency evaluates a request for any dental-related services listed as noncovered in this chapter under the provisions of WAC 182-501-0160.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-20-097, § 182-535-1100, filed 10/3/17, effective 11/3/17; WSR 15-10-043, § 182-535-1100, filed 4/29/15, effective 5/30/15. Statutory Authority: RCW 41.05.021 and 2013 2nd sp.s. c 4 § 213. WSR 14-08-032, § 182-535-1100, filed

3/25/14, effective 4/30/14. Statutory Authority: RCW 41.05.021. WSR 12-09-081, § 182-535-1100, filed 4/17/12, effective 5/18/12. WSR 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. WSR 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. WSR 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. WSR 02-13-074, § 388-535-1100, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), C.F.R. 440.100 and 440.225. WSR 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. WSR 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 medicaid agency uses the determination 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, current (within the past twelve months), objective clinical information to establish medical necessity. The request must be submitted in writing on the General Information for Authorization (HCA 13-835) form, 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 by a licensed independent doctor of dental surgery (DDS)/doctor of dental medicine (DMD) 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 to twelve months as indicated in the agency's authorization letter 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 state agency program;

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

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

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-20-097, § 182-535-1220, filed 10/3/17, effective 11/3/17; WSR 16-18-033, § 182-535-1220, filed 8/26/16, effective 9/26/16. Statutory Authority: RCW 41.05.021 and 2013 2nd sp.s. c 4 § 213. WSR 14-08-032, § 182-535-1220, filed 3/25/14, effective 4/30/14. Statutory Authority: RCW 41.05.021. WSR 12-09-081, § 182-535-1220, filed 4/17/12, effective 5/18/12. WSR 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. WSR 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. WSR 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. WSR 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. WSR 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 medicaid agency pays enhanced fees only to ABCD-certified dentists and other agency-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 documentation of all of the following in the client's record:

- (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 record to record the activities provided and duration of the oral education visit.

(b) 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;

(c) 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;

(d) Topical application of fluoride varnish;

(e) Amalgam, resin, and glass ionomer restorations on primary teeth, as specified in the agency's current published documents;

(f) Interim therapeutic restorations (ITRs) for primary teeth, only for clients age five and younger. The agency pays an enhanced rate for these restorations to ABCD-certified, ITR-trained dentists as follows:

(i) A one-surface, resin-based composite restoration with a maximum of five teeth per visit; and

(ii) Restorations on a tooth can be done every twelve months through age five, or until the client can be definitively treated for a restoration.

(g) Therapeutic pulpotomy;

(h) Prefabricated stainless steel crowns on primary teeth, as specified in the agency's current published documents;

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

(j) Other dental-related services, as specified in the agency's current published documents.

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

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-20-097, § 182-535-1245, filed 10/3/17, effective 11/3/17; WSR 16-13-110, § 182-535-1245, filed 6/20/16, effective 8/1/16. Statutory Authority: RCW 41.05.021 and 2013 2nd sp.s. c 4 § 213. WSR 14-08-032, § 182-535-1245, filed 3/25/14, effective 4/30/14. WSR 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. WSR 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. WSR 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. WSR 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 Medical 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 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.

(4) 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.

(5) 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.

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

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

(8) 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 and 2013 2nd sp.s. c 4 § 213. WSR 14-08-032, § 182-535-1350, filed 3/25/14, effective 4/30/14. Statutory Authority: RCW 41.05.021. WSR 12-09-081, § 182-535-1350, filed 4/17/12, effective 5/18/12. WSR 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. WSR 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. WSR 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. WSR 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. WSR 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 dental general anesthesia services for eligible clients as follows:

(a) Fifteen-minute increments are billed as one unit of time. When a dental procedure requires multiple fifteen-minute units and there is a remainder (less than fifteen minutes), the remainder is considered one unit.

(b) When billing for anesthesia, the provider must show the actual beginning and ending times in the client's medical record. 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).

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

(7) Participating providers must bill a client according to WAC 182-502-0160, unless otherwise specified in this chapter.

(8) 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 exceptions to this are complete dentures and resin partial dentures as described in WAC 182-535-1090.

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-13-110, § 182-535-1400, filed 6/20/16, effective 8/1/16. Statutory Authority: RCW 41.05.021 and 2013 2nd sp.s. c 4 § 213. WSR 14-08-032, § 182-535-1400, filed 3/25/14, effective 4/30/14. Statutory Authority: RCW 41.05.021. WSR 12-09-081, § 182-535-1400, filed 4/17/12, effective 5/18/12. WSR 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. WSR 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. WSR 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. WSR 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. WSR 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 laboratory 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. WSR 12-09-081, § 182-535-1450, filed 4/17/12, effective 5/18/12. WSR 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. WSR 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. WSR 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. WSR 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. WSR 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. WSR 12-09-081, § 182-535-1500, filed 4/17/12, effective 5/18/12. WSR 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. WSR 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. WSR 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. WSR 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 182-501-0180, 182-501-0182, and 182-501-0184 for services provided outside the state of Washington. See WAC 182-501-0175 for designated bordering cities.

[Statutory Authority: RCW 41.05.021 and 2013 2nd sp.s. c 4 § 213. WSR 14-08-032, § 182-535-1550, filed 3/25/14, effective 4/30/14. WSR 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. WSR 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. WSR 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. WSR 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. WSR 96-01-006 (Order 3931), § 388-535-1550, filed 12/6/95, effective 1/6/96.]