WAC 182-535-1080 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 medicaid 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 denturist, is limited to the initial examination appointment. The agency does not cover any additional limited examination by a denturist 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, two times per client, per provider in a twelve-month period 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 typically includes 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:

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

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

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

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 21-14-055, § 182-535-1080, filed 7/1/21, effective 8/1/21. Statutory Authority: RCW 41.05.021, 41.05.160 and 2017 3rd sp.s. c 1 § 213 (1)(c). WSR 19-09-058, § 182-535-1080, filed 4/15/19, effective 7/1/19. 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.]