WSR 25-21-017
PROPOSED RULES
HEALTH CARE AUTHORITY
[Filed October 3, 2025, 9:47 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 25-17-012.

Title of Rule and Other Identifying Information: WAC 182-535-1094 Dental-related services—Covered—Oral and maxillofacial surgery services.

Hearing Location(s): On November 25, 2025, at 10:00 a.m. The health care authority (HCA) holds public hearings virtually without a physical meeting place. To attend the virtual public hearing, you must register in advance at https://us02web.zoom.us/webinar/register/WN_WMYVCpvnRxav53MDSaRk-g#/registration. If the link above opens with an error message, please try using a different browser. After registering, you will receive a confirmation email containing information about joining the public hearing.

Date of Intended Adoption: Not sooner than November 26, 2025.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, beginning October 4, [2025,] 8:00 a.m., by November 25, 2025, 11:59 p.m.

Assistance for Persons with Disabilities: Contact Jessica Nguyen, phone 360-725-1174, fax 360-586-9727, telecommunication relay service 711, email arc@hca.wa.gov, by November 7, 2025.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: HCA is revising this rule to clarify language in subsection (3)(c) and remove subsection (3)(d) to make it less prescriptive based on a review of evidence provided by the health technology clinical committee (HTCC) decision findings. Additionally, HCA is updating the developmental disabilities administration (DDA) name to align with the name change initiated by the department of social and health services. DDA is now developmental disabilities community services division.

Reasons Supporting Proposal: See purpose.

Statutory Authority for Adoption: RCW 41.05.021 and 41.05.160.

Statute Being Implemented: RCW 41.05.021 and 41.05.160.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Valerie Freudenstein, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-1344; Implementation and Enforcement: Jayson Diaz, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-9967.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to HCA rules unless requested by the joint administrative rules review committee or applied voluntarily.

Scope of exemption for rule proposal from Regulatory Fairness Act requirements:

Is not exempt.

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. This rule is being revised to be less prescriptive based on a review of evidence provided by HTCC decision findings.

HCA does not anticipate these rules to add any new costs to providers. Therefore, these rules do not impose more-than-minor costs on small businesses. Other revisions to the rules are only housekeeping changes.

October 3, 2025
Wendy Barcus
Rules Coordinator

RDS-6608.2

AMENDATORY SECTION (Amending WSR 21-14-055, filed 7/1/21, effective 8/1/21)

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~~)) 20. Prior authorization is required for the site of service; and

(iii) Clients any age of the developmental disabilities ((~~administration~~)) community services division 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~~)) 12 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.

(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.

(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 biopsy of soft oral tissue, brush biopsy, and surgical excision of soft tissue lesions. Providers must keep all biopsy reports or findings in the client's dental record.

(l) Covers only the following excisions of bone tissue in conjunction with placement of complete or partial dentures:

(i) Removal of lateral exostosis;

(ii) Removal of torus palatinus or torus mandibularis;

(iii) Surgical reduction of osseous tuberosity.

(2) **Alveoloplasty.** The agency covers alveoloplasty only in conjunction with the preparation of dentures or partials. Documentation supporting the medical necessity for the procedure must be maintained in the client's record. Supporting documentation must include current radiographs and medical justification narrative.

(3) **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~~)) 12 and younger((~~, without~~)). Prior authorization is required.

(d) ((~~Frenuloplasty/frenulectomy for clients age seven through twelve. Prior authorization is required. 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.~~

~~(e)~~)) Surgical access of unerupted teeth for clients age ((~~twenty~~)) 20 and younger. Prior authorization is required.

(4) **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~~)) 12 through 20. Prior authorization is required.

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