

## WSR 26-05-030

## PERMANENT RULES

## HEALTH CARE AUTHORITY

[Filed February 11, 2026, 10:06 a.m., effective March 14, 2026]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The health care authority (agency) removed CDT® code D9630 from coverage under the dental benefit as these drugs and medications are available under the client's pharmacy benefit when prescribed and the prescription is filled at a pharmacy. As a result, the agency revised WAC 182-535-1098 to reflect this change and to also clarify that these services are still available under the client's pharmacy benefit. Additionally, the agency updated the term "conscious sedation" to "moderate sedation" to align with industry standard language.

Citation of Rules Affected by this Order: Amending WAC 182-535-1098.

Statutory Authority for Adoption: RCW 41.05.021 and 41.05.160.

Adopted under notice filed as WSR 26-02-059 on January 6, 2026.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 1, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 1, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 1, Repealed 0.

Date Adopted: February 11, 2026.

Wendy Barcus  
Rules Coordinator

**RDS-6885.1**

AMENDATORY SECTION (Amending WSR 25-22-083, filed 11/4/25, effective 12/5/25)

**WAC 182-535-1098 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.

(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 community services division 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 20 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 (1) and clients with cleft palate diagnoses, the agency does not require prior authorization for deep sedation/general anesthesia services.

(iii) For clients age 21 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~~) moderate sedation with parenteral agents:

(i) For any dental service for clients age 20 and younger, and for clients any age of the developmental disabilities community services division of DSHS. Documentation supporting the medical necessity of the service must be in the client's record.

(ii) For clients age 21 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~~) moderate sedation is medically necessary, as defined in WAC 182-500-0070.

(e) Covers (~~office-based nonintravenous conscious~~) moderate sedation with enteral agents:

(i) For any dental service for clients age 20 and younger, and for clients any age of the developmental disabilities community services division of DSHS. Documentation supporting the medical necessity of the service must be in the client's record.

(ii) For clients age 21 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~~) minimal sedation, enteral, or parenteral (~~conscious~~) moderate 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 20 and younger,~~) The agency covers other drugs and medicaments (dispensed in the provider's office for home use) under the client's pharmacy benefit. This includes, but is not limited to, oral antibiotics and oral analgesics. The agency does not cover the time spent writing prescriptions.

(d) For clients enrolled in an agency-contracted managed care organization (MCO), the client's MCO pays for dental 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 profes-

sional 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 20, only on a case-by-case basis and when prior authorized;

(C) Clients any age of the developmental disabilities community services division of DSHS;

(D) Clients diagnosed with autism;

(E) Clients who reside in an alternate living facility (ALF) as defined in WAC (~~(182-513-1301)~~) 182-513-1100, 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(4) for occlusal orthotic device coverage and coverage limitations.) The agency covers:

(i) An occlusal guard only for clients age 12 through 20 when the client has permanent dentition; and

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

(5) **Nonclinical procedures.**

(a) The agency covers teledentistry according to the department of health, health systems quality assurance office of health professions, current guidelines, appropriate use of teledentistry, and as follows (see WAC 182-531-1730 for coverage limitations not listed in this section):

(i) Synchronous teledentistry at the distant site for clients of all ages; and

(ii) Asynchronous teledentistry at the distant site for clients of all ages.

(b) The client's record must include the following supporting documentation regarding teledentistry:

(i) Service provided via teledentistry;

(ii) Location of the client;

(iii) Location of the provider; and

(iv) Names and credentials of all persons involved in the teledentistry visit and their role in providing the service at both the originating and distant sites.