Health Care Authority

Dental Program for Clients Through Age 20

Billing Instructions

Chapter 182-535 WAC

Copyright Disclosure

About this publication

This publication supersedes all previous Agency Dental Billing Instructions and Numbered Memoranda and is published by the Washington State Health Care Authority.

Note: The Agency now reissues the entire billing manual when making updates, rather than just a page or section. The effective date and revision history are now at the front of the manual. This makes it easier to find the effective date and version history of the manual.

Effective Date

The effective date of this publication is: **05/09/2010**.

2010 Revision History

This publication has been revised by:

Document	Subject	Issue Date	Pages Affected

Fee Schedules

- You may access the Agency Dental Fee Schedule at: http://hrsa.dshs.wa.gov/RBRVS/Index.html.
- To access the Agency Oral Surgery Fee Schedule:
  - ✓ **Procedure codes** may be found in the Dental Fee Schedule at the above address.
  - ✓ **Maximum allowable fees** may be found in the Physician-Related Services Fee Schedule at the above address.

How Can I Get Agency Provider Documents?

To download and print Agency provider numbered memos and billing instructions, go to the Agency website at http://hrsa.dshs.wa.gov (click the ***Billing Instructions and Numbered Memorandum*** link).

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Section E: Authorization

Section F: Billing and Claim Forms

Important Contacts

Note: This section contains important contact information relevant to the Dental Program for Clients Through Age 20. For more contact information, see the Agency *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the Agency *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html
Finding out about payments, denials, claims processing, or Agency managed care organizations	
Electronic or paper billing	
Finding Agency documents (e.g., billing instructions, # memos, fee schedules)	
Private insurance or third-party liability, other than Agency managed care	
Prior authorization, limitation extensions, or exception to rule	
Accessing the Agency Dental web site	Visit: http://hrsa.dshs.wa.gov/DentalProviders/DentalIndex.html

Definitions & Abbreviations

This section contains definitions of words and phrases that the Health Care Authority (the Agency) uses in these billing instructions. The Agency also used dental definitions found in the current American Dental Association's Current Dental Terminology and the current American Medical Association's Physician's Current Procedural Terminology. **Where there is any discrepancy between the current CDT or CPT and this section, this section prevails.** Please refer to the Agency *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for a more complete list of definitions.

Adjunctive – A secondary treatment in addition to the primary therapy.

Alternative Living Facility (ALF) – Refer to WAC 182-513-1301.

Ambulatory Surgery Center (ASC) - Any distinct entity certified by Medicare as an ASC that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization.

American Dental Association (ADA) – The ADA is a national organization for dental professionals/dental societies.

Anterior – The maxillary and mandibular incisors and canines and tissue in the front of the mouth.

- Permanent maxillary anterior teeth include teeth 6, 7, 8, 9, 10, and 11.
- Permanent mandibular anterior teeth include teeth 22, 23, 24, 25, 26, and 27.
- Primary maxillary anterior teeth include teeth C, D, E, F, G, and H.
- Primary mandibular anterior teeth include teeth M, N, O, P, Q, and R.

Asymptomatic – Having or producing no symptoms.

Authorization Number - A nine-digit number, assigned by the Agency that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pended, or denied.

Base Metal – Dental alloy containing little or no precious metals.

Behavior Management – Using the assistance of one additional dental professional staff to manage the behavior of a client to facilitate the delivery of dental treatment.

Benefit Service Package - A grouping of benefits or services applicable to a client or group of clients.

Border Areas - Refer to WAC 182-501-175.

Caries – Carious lesions or tooth decay through the enamel or decay of the root surface.

Comprehensive Oral Evaluation – 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 - A drug-induced depression of consciousness during which clients respond 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 Build-up – Refers to building up of clinical crowns, including pins.

Coronal – The portion of a tooth that is covered by enamel.

Coronal Polishing – A mechanical procedure limited to the removal of plaque and stain from exposed tooth surfaces.

Crown – A restoration covering or replacing part, or the whole, clinical crown of a tooth.

Current Dental Terminology (CDT™) - 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™) – 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 – A term for carious lesions in a tooth; and means decomposition of the tooth structure.

Deep Sedation – 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.

Denturist – A person licensed under Chapter 18.30 RCW to make, construct, alter, reproduce, or repair a denture.

Division of Developmental Disabilities (DDD) - The division within the Agency responsible for administering and overseeing services and programs for clients with developmental disabilities.

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

EPSDT – The Agency's early and periodic screening, diagnosis, and treatment program for clients 20 years of age and younger as described in chapter 182-534 WAC.

Extraction – See "simple extraction" and "surgical extraction."

Federally Qualified Health Center (FQHC) - A facility that is: 1) receiving grants under section 330 of the Public

Health Services Act; OR 2) receiving such grants based on the recommendation of the Health Resources and Services Administration within the Public Health Service, as determined by the Secretary to meet the requirements for receiving such a grant, OR 3) a tribe or tribal organization operating outpatient health programs or facilities under the Indian Self Determination Act (PL93-638). Only Health Care Financing Administration designated FQHCs will be allowed to participate in the program.

Flowable Composite – A diluted resin-based composite dental restorative material that is used in cervical restorations and small, low stress bearing occlusal restorations.

Fluoride Varnish, Rinse, Foam, or Gel – A substance containing dental fluoride, which is applied to teeth.

General Anesthesia – A drug-induced loss of consciousness during which a client is not arousable even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Clients may require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

High Noble Metal – A dental alloy containing at least 60% pure gold.

Immediate Denture - A prosthesis constructed for placement immediately after removal of remaining natural teeth on the day of extractions.

Limited Oral Evaluation – 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 – An assessment by a dentist or dental hygienist to determine the need for fluoride treatment and triage services when provided in settings other than dental offices or dental clinics.

Major Bone Grafts – A transplant of solid bone tissue(s).

Medical Identification card(s) – See *Services Card*.

Medically Necessary - See WAC 182-500-0005.

Minor Bone Grafts – A transplant of nonsolid bone tissue(s), such as powdered bone, buttons, or plugs.

National Provider Identifier (NPI) – A federal system for uniquely identifying all providers of health care services, supplies, and equipment.

Noble Metal – A dental alloy containing at least 25% but less than 60% pure gold.

Oral Hygiene Instruction – Instruction for home oral hygiene care, such as tooth brushing techniques or flossing.

Oral prophylaxis – The dental procedure of scaling and polishing that includes removal of calculus, plaque, and stains from teeth.

Partials or Partial Dentures – A removable prosthetic appliance that replaces missing teeth in one arch.

Patient Identification Code (PIC) – See ProviderOne Client ID.

Periodic Oral Evaluation – 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 – 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 micro-organisms and deposits with hand and mechanical instrumentation, an evaluation of periodontal conditions, and a complete periodontal charting as appropriate.

Periodontal Scaling and Root Planing – A procedure to remove plaque, calculus, micro-organisms, and rough cementum and dentin from tooth surfaces. This includes hand and mechanical instrumentation, an evaluations of periodontal conditions, and a complete periodontal charting as appropriate.

Permanent – The permanent or adult teeth in the dental arch.

Posterior – The maxillary and mandibular premolars and molars and tissue towards the back of the mouth.

- Permanent maxillary posterior teeth include teeth 1, 2, 3, 4, 5, 12, 13, 14, 15, and 16.
- Permanent mandibular posterior teeth include teeth 17, 18, 19, 20, 21, 28, 29, 30, 31, and 32.
- Primary maxillary posterior teeth include teeth A, B, I, and J.
- Primary mandibular posterior teeth include teeth K, L, S, and T.

Primary – The first set of teeth.

Proximal – The surface of the tooth near or next to the adjacent tooth.

Radiographs – an image or picture produced on a radiation sensitive film emulsion or digital sensor by exposure to ionizing radiation. Also known as X-ray.

Reline – 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 - The chamber within the root of the tooth that contains the pulp.
Root Canal Therapy - The treatment of the pulp and associated periradicular conditions.

Root Planing – A procedure to remove plaque, calculus, micro-organisms, rough cementum, and dentin from tooth surfaces. This includes use of hand and mechanical instrumentation.

Rural Health Clinic (RHC) – See *Rural Health Clinic Billing Instructions*.

Scaling – A procedure to remove plaque, calculus, and stain deposits from tooth surfaces.

Sealant – A dental material applied to teeth to prevent dental caries.

Simple Extraction – The routine removal of tooth.

Spenddown – The amount of excess income the Agency has determined that a client has available to meet his or her medical expenses. The client becomes eligible for Medicaid coverage only after he or she meets the spenddown requirements.

Standard of Care – What reasonable and prudent practitioners would do in the same or similar circumstances.

Surgical Extraction – See definitions of dental procedures in the current CDT manual.

Symptomatic – Having symptoms (e.g., pain, swelling, and infection).

Temporomandibular joint dysfunction (TMJ/TMD) – An abnormal functioning of the temporomandibular joint or other areas secondary to the dysfunction.

Therapeutic Pulpotomy – The surgical removal of a portion of the pulp (inner soft tissue of a tooth), to retain the healthy remaining pulp.

Transaction Control Number (TCN) - A unique field value that identifies a claim transaction assigned by ProviderOne.

Usual and Customary – The fee that the provider usually charges non-Medicaid customers for the same service or item. This is the maximum amount that the provider may bill the Agency.

Wisdom Teeth – The third molars, teeth 1, 16, 17, and 32.

Xerostomia – A dryness of the mouth due to decreased saliva.

About the Program

What Is the Purpose of the Dental Program for Clients Through Age 20?

The purpose of the Dental Program is to provide quality dental and dental-related services to eligible clients.

Becoming a Agency Dental Provider [Refer to WAC 182-535-1070]

The following providers are eligible to enroll with the Agency to furnish and bill for dental-related services provided to eligible clients:

- Persons currently licensed by the state of Washington to:
  - ✓ Practice dentistry or specialties of dentistry;
  - ✓ Practice medicine and osteopathy for:
    - ➢ Oral surgery procedures; or
    - ➢ Providing fluoride varnish under EPSDT.
  - ✓ Practice as a dental hygienist;
  - ✓ Practice as a denturist; or
  - ✓ Practice anesthesia according to Department of Health (DOH) regulations.
- Facilities that are:
  - ✓ Hospitals currently licensed by the Department of Health;
  - ✓ Federally-qualified health centers (FQHCs);
  - ✓ Medicare-certified ambulatory surgery centers (ASCs);
  - ✓ Medicare-certified rural health clinics (RHCs); or
  - ✓ Community health centers (CHC).
- Participating local health jurisdictions; and
- Border area or out-of-state providers of dental-related services who are qualified in their states to provide these services.

Note: The Agency pays licensed providers participating in the Agency Dental Program for only those services that are within their scope of practice. [WAC 182-535-1070(2)]

Client Eligibility

Who Is Eligible? [Refer to WAC 182-535-1060]

Please see the Agency *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Note: Refer to the *Scope of Coverage Chart* web page at: http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html for an up-to-date listing of Benefit Service Packages.

Are Clients Enrolled in a Agency Managed Care Plan Eligible? [Refer to WAC 182-535-1060(4)]

Yes! Clients who are enrolled in a Agency managed care plan are eligible for Agency-covered dental services that are not covered by their plan, under fee-for-service.

When verifying eligibility using ProviderOne, if the client is enrolled in a Agency managed care plan, managed care enrollment will be displayed on the Client Benefit Inquiry screen. All services must be requested directly through the client's Primary Care Provider (PCP). Clients can contact their managed care plan by calling the telephone number provided to them.

All medical services covered under a managed care plan must be obtained by the client through designated facilities or providers. The managed care plan is responsible for:

- Payment of covered services; and
- Payment of services referred by a provider participating with the plan to an outside provider.

Note: To prevent billing denials, please check the client's eligibility **prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the plan. See the Agency *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Coverage

When Does the Agency Pay for Covered Dental-Related Services for Clients Through Age 20? [Refer to WAC 182-535-1079(1), (3), and (4)]

- Subject to coverage limitations, the Agency pays for dental-related services and procedures provided to clients through age 20 when the services and procedures:

  - ✓ Are within the scope of an eligible client's medical care program;
  - ✓ Are medically necessary;
  - ✓ Meet the Agency's prior authorization requirements, if any;
  - ✓ Are documented in the client's record (see the "What must I keep in a client's record" in the *Billing and Claim Forms* section);
  - ✓ Are within accepted dental or medical practice standards;
  - ✓ Are consistent with a diagnosis of dental disease or condition;
  - ✓ Are reasonable in amount and duration of care, treatment, or service; and
  - ✓ Are listed as covered in these billing instructions (see the *Coverage* section).

- Clients who are eligible for services through the Division of Developmental Disabilities (DDD) may receive dental-related services according to Section D.

- The Agency evaluates a request for dental-related services that are:

  - ✓ In excess of the Dental Program's limitations or restrictions, according to WAC 182-501-0169; and
  - ✓ Listed as noncovered, according to WAC 182-501-0160.

Coverage Under the EPSDT Program [Refer to WAC 182-535-1079 (2)

Under the Early Periodic Screening and Diagnostic Treatment (EPSDT) program, clients ages twenty and younger may be eligible for the dental-related services listed as noncovered in these billing instructions, if the services include those medically necessary services and other measures provided to correct or ameliorate conditions discovered during a screening performed under the EPSDT program. See the current Agency *Early Periodic Screening, Diagnosis & Treatment (EPSDT) Billing Instructions* for information about EPSDT.

Coverage Under the GA-U and ADATSA Programs

[Refer to WAC 182-535-1065]

- Clients who receive medical care services under the following programs may receive the dental-related services described in the Coverage section of these billing instructions:

  - ✓ General Assistance Unemployable (GA-U); and
  - ✓ Alcohol and Drug Abuse Treatment and Support Act (ADATSA).

- The Agency covers the following dental-related services under the GA-U or ADATSA program:

  - ✓ Services provided only as part of dental treatment for:

    - ➢ Limited oral evaluation;
    - ➢ Periapical or bite-wing radiographs (x-rays) that are medically necessary to diagnose only the client's chief complaint;
    - ➢ Pulpal debridement to relieve dental pain;
    - ➢ Palliative treatment to relieve dental pain; or
    - ➢ Endodontic (root canal only) treatment for maxillary and mandibular anterior teeth (cuspids and incisors) when prior authorized.

  - ✓ Tooth extraction when at least one of the following apply:

    - ➢ The tooth has a radiographic apical lesion;
    - ➢ The tooth is endodontically involved, infected, or abscessed;
    - ➢ The tooth is not restorable; or
    - ➢ The tooth is not periodontally stable.

- Tooth extractions require prior authorization (PA) when:

  - ✓ The extraction of a tooth or teeth results in the client becoming edentulous in the maxillary arch or mandibular arch; and

  - ✓ A full mouth extraction is necessary because of radiation therapy for cancer of the head and neck.

- Each dental-related procedure described under this section is subject to the coverage limitations listed in Chapter 182-535 WAC for clients age 21 and older.

- The Agency does not cover any dental-related services not listed in the *Coverage* section of these billing instructions for clients eligible to receive services under the GA-U or ADATSA program, including any type of removable dental prosthesis.

GA-U Covered Procedure Codes

Code	Description	PA?	Requirements/ Limitations	Maximum Allowable Fee
D0140	limited oral evaluation – problem focused	N		On-line Fee Schedules
D0220	intraoral – periapical first film	N		
D0230	intraoral – periapical each additional film	N		
D0270	bitewing – single film	N		
D0272	bitewings – two films	N		
D0273	bitewings – three films	N		
D0274	bitewings – four films	N		
D3221	pulpal debridement, primary and permanent teeth	N	Tooth designation required	
D3310	anterior (excluding final restoration)	N	Tooth designation required	
D7111	extraction, coronal remnants – deciduous tooth	N	Tooth designation required	
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	N	Tooth designation required	
D7210	surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	N	Tooth designation required	
D7220	removal of impacted tooth – soft tissue	N	Tooth designation required	
D7230	removal of impacted tooth – partially bony	N	Tooth designation required	
D7240	removal of impacted tooth – completely bony	N	Tooth designation required	
D7250	surgical removal of residual tooth roots (cutting procedure)	N	Tooth designation required	
D9110	palliative (emergency) treatment of dental pain – minor procedure	N		

PA for Services Performed in a Hospital or Ambulatory Surgery Center (ASC)

- **Dental Providers**

  ✓ The Agency requires PA for non-emergency dental services performed in a hospital and dental services performed in an ASC for clients age 9 and older (except for clients of the division of developmental disabilities according to WAC 182-543-1099).

  ✓ The place of service (POS) on the submitted claim form **must** match the setting where the service is performed. The Agency may audit claims with an incorrect POS and payment may be recouped.

  ✓ The dentist providing the service must send in a request for authorization to perform the procedure in this setting. The request must:

    ➢ Contain all procedure codes, including procedure codes that require PA according to these billing instructions;

    Note: Authorization for a client to be seen in a hospital or ASC setting does not automatically authorize any specific code that requires PA. If the specific code requires PA, also include the rationale for the code.

    ➢ Be on the appropriate claim form(s) for the services requested; and

    ➢ Include a letter that clearly describes the medical necessity of performing the service in the requested setting.

Note: Any PA request submitted without the above information will be returned as incomplete.

  ✓ The Agency requires providers to report dental services, including oral and maxillofacial surgeries, using CDT codes.

    Exception: Oral surgeons may use CPT codes **listed in the Agency Dental Program Fee Schedule *only*** when the procedure performed is not listed as a covered CDT code in the Agency published Dental Program Fee Schedule. CPT codes must be billed on an 837P/CMS-1500 claim form.

- **Facilities**

  - ✓ Hospitals and ASCs must use CDT codes for dental procedures. Hospitals and ASCs may bill with a CPT code ***only*** if there is no CDT code that covers the service performed.

  - ✓ Coverage and payment is limited to those CDT and select CPT codes listed in the Agency Dental Program Fee Schedule.

  - ✓ ASCs are paid only for the codes listed in the Agency *Ambulatory Surgery Centers Billing Instructions*.

  - ✓ The Agency considers anesthesia to be included in the payment made to the facility. The Agency does not pay separately when a facility bills CDT code D9220/D9221 or D9241/D9242.

  - ✓ If requesting anesthesia time that is significantly greater than the normal anesthesia time for the procedure, include the medical justification for this in the documentation.

  - ✓ Hospitals and ASCs may only use procedure code 41899 when there is no existing national code that describes the services being provided. The Agency considers this code ***only*** when the performing dentist submits a PA request with justification explaining that there is no existing national code describing the services being provided.

  - ✓ The place of service (POS) on the submitted claim form must match the setting being requested:

Place of Service	Setting
21	Inpatient Hospital
22	Outpatient Hospital
24	Ambulatory Surgery Center

What Diagnostic Services Are Covered? [Refer to WAC 182-535-1080]

The Agency covers medically necessary dental-related diagnostic services, subject to the coverage limitations listed, for clients through age 20 as follows:

Clinical Oral Evaluations

What Is Covered?

The Agency covers:

- Oral health evaluations and assessments. The services must be documented in the client's record in accordance with Chapter 182-502 WAC.

- Periodic oral evaluations, once every six months. Six months must elapse between the comprehensive oral evaluation and the first periodic oral evaluation.

- Limited oral evaluations, only when the provider performing the limited oral evaluation is not providing routine scheduled dental services for the client. The limited oral evaluation:

  ✓ Must be to evaluate the client for a:

  - ➢ Specific dental problem or oral health complaint;
  - ➢ Dental emergency; or
  - ➢ Referral for other treatment.

  ✓ 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 dental prosthesis has been seated.

- Comprehensive oral evaluations (see *Definitions & Abbreviations*), 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.

Note: The Agency does not pay separately for chart or record set-up. The fees for these services are included in the Agency's reimbursement for comprehensive oral evaluations.

Code	Description	PA?	Maximum Allowable Fee
D0120	periodic oral evaluation – established patient	N	On-line Fee Schedules
D0140	limited oral evaluation – problem focused	N	
D0150	comprehensive oral evaluation – new or established patient	N	

Limited Visual Oral Assessment

What Is Covered?

The Agency covers limited visual oral assessments, up to two per client, per year, per provider only when the assessment is:

- Performed by a dentist or dental hygienist to determine the need for sealants, fluoride treatment, and triage services when provided in **settings other than dental offices or dental clinics.** (e.g., school-based programs, alternative living facilities, etc.);
- Not performed in conjunction with other clinical oral evaluation services; and
- Provided by a licensed dentist or licensed dental hygienist.

Code	Description	PA?	Maximum Allowable Fee
D9999	unspecified diagnostic procedure, by report	N	On-line Fee Schedules

Radiographs (X-rays)

What Is Covered?

Note: The Agency uses the prevailing standard of care to determine the need for dental radiographs.

The Agency covers:

- Radiographs that are of diagnostic quality, dated, and labeled with the client's name. The Agency requires original radiographs to be retained by the provider as part of the client's dental record, and duplicate radiographs to be submitted with prior authorization requests, or when copies of dental records are requested.
- An intraoral complete series (includes four bitewings), once in a three-year period only if the Agency has not paid for a panoramic radiograph for the same client in the same three-year period.
- Periapical radiographs that are not included in a complete series. Documentation supporting the medical necessity for these must be included in the client's record.
- An occlusal intraoral radiograph once in a two-year period. Documentation supporting the medical necessity for these must be included in the client's record.

- A maximum of four bitewing radiographs once every 12 months.

- 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.

> **Note:** The Agency may cover panoramic radiographs for preoperative or postoperative surgery cases more than once in a three-year period, only on a case-by-case basis and when prior authorized.
>
> Emergency treatment may be billed without PA. Indicate "Emergency" in the *Remarks* field on the ADA claim form.

- Cephalometric film:

  ✓ For orthodontics, as described in chapter 182-535A WAC; or
  ✓ Only on a case-by-case basis and when prior authorized.

- Radiographs not listed as covered in this subsection, only on a case-by-case basis and when prior authorized.

Code	Description	PA?	Maximum Allowable Fee
D0210	intraoral – complete series (including bitewings)	N	On-line Fee Schedules
D0220	intraoral – periapical first film	N	
D0230	intraoral – periapical each additional film	N	
D0240	intraoral – occlusal film	N	
D0270	bitewing – single film	N	
D0272	bitewings – two films	N	
D0273	bitewings – three films	N	
D0274	bitewings – four films	N	
D0330	panoramic film	N	
D0340	cephalometric film (orthodontics only)	N	

- Oral and facial photographic images, only on a case-by-case basis and when requested by the Agency.

Code	Description	PA?	Maximum Allowable Fee
D0350	oral/facial photographic images	Y	On-line Fee Schedules

> **Note:** The Agency does not require PA for additional medically necessary panoramic x-rays by oral surgeons and orthodontists.

Tests and Examinations

What Is Covered?

The Agency covers:

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

  ✓ For diagnosis only during limited oral evaluations; and
  ✓ When radiographs and/or documented symptoms justify the medical necessity for the pulp vitality test.

Code	Description	PA?	Maximum Allowable Fee
D0460	pulp vitality tests	N	On-line Fee Schedules

- Diagnostic casts other than those included in an orthodontic case study, on a case-by-case basis, and when requested by the Agency.

Code	Description	PA?	Maximum Allowable Fee
D0470	diagnostic casts	Y	On-line Fee Schedules

Note: The Agency covers viral cultures, genetic testing, caries susceptibility, and adjunctive pre-diagnostic tests only on a case-by-case basis and when requested by the Agency.

What Preventive Services Are Covered? [Refer to WAC 182-535-1082]

The Agency covers medically necessary dental-related preventive services, subject to the coverage limitations listed, for clients through age 20 as follows:

Dental Prophylaxis

What Is Covered?

The Agency covers prophylaxis:

- Which includes scaling and polishing procedures to remove coronal plaque, calculus, and stains when performed on primary, transitional, or permanent dentition, once every six months for clients through age 18.
- Which includes scaling and polishing procedures to remove coronal plaque, calculus, and stains when performed on transitional or permanent dentition, once every 12 months for clients ages 19-20.
- Only when the service is performed six months after periodontal scaling and root planing, or periodontal maintenance services, for clients ages 13-18.
- When the service is performed 12 months after periodontal scaling and root planing, or periodontal maintenance services for clients ages 19-20.
- Only when not performed on the same date of service as periodontal scaling and root planing, periodontal maintenance, gingivectomy or gingivoplasty.
- For clients of the Division of Developmental Disabilities (DDD) according to Section D.

Code	Description	PA?	Limitations	Maximum Allowable Fee
D1110	prophylaxis – adult	N	Clients ages 14-20	On-line Fee Schedules
D1120	prophylaxis – child	N	Clients through age 13	

Topical Fluoride Treatment

What Is Covered?

The Agency covers:

- Fluoride varnish, rinse, foam or gel up to 3 times within a 12-month period per client, per provider or clinic for clients ages 6 and younger.
- Fluoride varnish, rinse, foam or gel up to 2 times within a 12-month period per client, per provider or clinic for clients ages 7 through 18.
- Fluoride varnish, rinse, foam or gel up to 3 times within a 12-month period per client, per provider or clinic during orthodontic treatment.
- Fluoride rinse, foam or gel once within a 12-month period per client, per provider or clinic for clients ages 19 through 20.
- Additional topical fluoride applications only on a case-by-case basis and when prior authorized.
- Topical fluoride treatment for clients of DDD according to Section D.

Code	Description	PA?	Limitations	Maximum Allowable Fee
D1203	topical application of fluoride (prophylaxis not included) – child	N	Clients through age 18	On-line Fee Schedules
D1204	topical application of fluoride (prophylaxis not included) – adult	N	Clients ages 19-20	

Oral Hygiene Instructions

What Is Covered?

The Agency covers:

- Oral hygiene instructions only for clients through age eight.
- Oral hygiene instructions up to two times within a 12-month period.
- Individualized oral hygiene instructions for home care to include tooth brushing technique, flossing, and use of oral hygiene aides.
- Oral hygiene instructions only when not performed on the same date of service as prophylaxis.

Note: The Agency covers oral hygiene instructions 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**.

Code	Description	PA?	Maximum Allowable Fee
D1330	oral hygiene instructions	N	On-line Fee Schedules

Sealants

What Is Covered?

The Agency covers:

- Sealants only when used on a mechanically and/or chemically prepared enamel surface.
- Sealants once per tooth in a three-year period for clients through age 18.
- Sealants only when used on the occlusal surfaces of:
  - ✓ Permanent teeth 2, 3, 14, 15, 18, 19, 30, and 31; and
  - ✓ Primary teeth A, B, I, J, K, L, S, and T.
- Sealants only on non-carious teeth or teeth with incipient caries.
- Sealants only when placed on a tooth with no pre-existing occlusal restoration, or any occlusal restoration placed on the same day.
- Additional sealants on a case-by-case basis and when prior authorized.
- Sealants for DDD according to the guidelines and limitations in Section D.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D1351	sealant – per tooth	N	Tooth designation required	On-line Fee Schedules

Space Maintenance

What Is Covered?

The Agency covers:

- Fixed unilateral or fixed bilateral space maintainers for clients through age 18.
- Only one space maintainer per quadrant.
- Space maintainers only for missing primary molars A, B, I, J, K, L, S, and T.
- Replacement space maintainers only on a case-by-case basis and when prior authorized.
- Removal of fixed space maintainer for clients through age 18.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D1510	space maintainer – fixed – unilateral	N	Quadrant designation required	On-line Fee Schedules
D1515	space maintainer – fixed – bilateral	N	Arch designation required	
D1550	re-cementation of space maintainer	N	Quadrant or arch designation required	
D1555	removal of fixed space maintainer	N		

What Restorative Services Are Covered? [Refer to WAC 182-535-1084]

The Agency covers medically necessary dental-related restorative services, subject to the coverage limitations listed, for clients through age 20 as follows:

Restorative/Operative Procedures

Who Is Covered for Hospitals or Ambulatory Surgical Centers?

The Agency covers restorative/operative procedures performed in a hospital or an ambulatory surgical center for:

- Clients ages eight and younger;
- Clients ages 9-20 only on a case-by-case basis and when prior authorized; and
- Clients of DDD according to Section D.

Amalgam Restorations for Primary and Permanent Teeth

Coverage Limitations

The Agency considers:

- Tooth preparation, all adhesives (including amalgam bonding agents), liners, bases, and polishing as part of the amalgam restoration.
- The occlusal adjustment of either the restored tooth or the opposing tooth or teeth as part of the amalgam restoration.
- Buccal or lingual surface amalgam restorations, regardless of size or extension, as a one surface restoration. The Agency covers one buccal and one lingual surface per tooth.
- Multiple amalgam restorations of fissures and grooves of the occlusal surface of the same tooth as a one surface restoration.
- Amalgam restorations placed within six months of a crown preparation by the same provider or clinic to be included in the payment for the crown.

Coverage for Primary Posterior Teeth

The Agency covers amalgam restorations for a maximum of two surfaces for a primary first molar and a maximum of three surfaces for a primary second molar. The Agency does not pay for additional amalgam restorations. (See "Other Restorative Surfaces" for restorations for a primary posterior tooth requiring an additional surface restoration.)

Coverage for Permanent Posterior Teeth

The Agency covers:

- Two occlusal amalgam restorations for teeth 1, 2, 3, 14, 15, and 16, if the restorations are anatomically separated by sound tooth structure.
- Amalgam restorations for a maximum of five surfaces per tooth for a permanent posterior tooth, once per client, per provider or clinic, in a two-year period.
- Amalgam restorations for a maximum of six surfaces per tooth for teeth 1, 2, 3, 14, 15, and 16, once per client, per provider or clinic, in a two-year period.

The Agency does not pay for replacement of amalgam restoration on permanent posterior teeth within a two-year period unless the restoration has an additional adjoining carious surface. The Agency pays for the replacement restoration as one multi-surface restoration. The client's record must include radiographs and documentation supporting the medical necessity for the replacement restoration.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D2140	amalgam – one surface, primary or permanent	N	Tooth and surface designations required	On-line Fee Schedules
D2150	amalgam – two surfaces, primary or permanent	N	Tooth and surface designations required	
D2160	amalgam – three surfaces, primary or permanent	N	Tooth and surface designations required. **If billed on a primary first molar, the Agency will reimburse at the rate for a two-surface restoration.**	

Code	Description	PA?	Requirements	Maximum Allowable Fee
D2161	amalgam – four or more surfaces, primary or permanent	N	Tooth and surface designations required. **If billed on a primary first or second molar, the Agency will reimburse at the rate for a two-surface restoration.**	

Resin-Based Composite Restorations for Primary and Permanent Teeth

Coverage Limitations

The Agency considers:

- Tooth preparation, acid etching, all adhesives (including resin bonding agents), liners and bases, polishing, and curing as part of the resin-based composite restoration.
- The occlusal adjustment of either the restored tooth or the opposing tooth or teeth as part of the resin-based composite restoration.
- Buccal or lingual surface resin-based composite restorations, regardless of size or extension, as a one surface restoration. The Agency covers only one buccal and one lingual surface per tooth.
- Resin-based composite restorations of teeth where the decay does not penetrate the DEJ to be sealants (see "What Preventive Services are Covered?" for sealants coverage).
- Multiple preventive restorative resins, flowable composite resins, or resin-based composites for the occlusal, buccal, lingual, mesial, and distal fissures and grooves on the same tooth as a one surface restoration.
- Resin-based composite restorations placed within six months of a crown preparation by the same provider or clinic to be included in the payment for the crown.

What Is Not Covered?

The Agency does not cover preventive restorative resins or flowable composite resins on the interproximal surfaces (mesial and/or distal) when performed on posterior teeth or the incisal surface of anterior teeth. The Agency does not cover glass ionomer restorations on permanent teeth and for clients five years of age and older.

Coverage for Primary Teeth

The Agency covers:

- Resin-based composite restorations for a maximum of three surfaces for a primary anterior tooth. **The Agency does not pay for** additional composite or amalgam restorations on the same tooth after three surfaces. (See "Other Restorative Surfaces" for restorations for a primary anterior tooth requiring a four or more surface restoration).

- Resin-based restorations for a maximum of two surfaces for a primary first molar and a maximum of three surfaces for a primary second molar. **The Agency does not pay for** additional composite or amalgam restorations on the same tooth after two surfaces. (See "Other Restorative Surfaces" for restorations for a primary posterior tooth requiring an additional surface restoration.)

- Glass ionimer restorations only for primary teeth, and only for clients ages five and younger. The Agency pays for these restorations as a one surface resin-based composite restoration.

Coverage for Permanent Teeth

The Agency covers:

- Two occlusal resin-based composite restorations for teeth 1, 2, 3, 14, 15, and 16 if the restorations are anatomically separated by sound tooth structure.

- Resin-based composite restorations for a maximum of five surfaces per tooth for a permanent posterior tooth, once per client, per provider or clinic, in a two-year period.

- Resin-based composite restorations for a maximum of six surfaces per tooth for permanent posterior teeth 1, 2, 3, 14, 15, and 16, once per client, per provider or clinic, in a two-year period.

- Resin-based composite restorations for a maximum of six surfaces per tooth for a permanent anterior tooth, once per client, per provider or clinic, in a two-year period.

- Replacement of resin-based composite restoration on permanent teeth within a two-year period only if the restoration has an additional adjoining carious surface. The Agency pays the replacement restoration as one multi-surface restorations. The client's record must include radiographs and documentation supporting the medical necessity for the replacement restoration.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D2330	resin-based composite – one surface, anterior	N	Tooth and surface designations required	On-line Fee Schedules
D2331	resin-based composite – two surfaces, anterior	N	Tooth and surface designations required	
D2332	resin-based composite – three surfaces, anterior	N	Tooth and surface designations required	
D2335	resin-based composite – four or more surfaces or involving incisal angle (anterior)	N	Tooth and surface designations required. **Not allowed on primary teeth.**	
D2390	resin-based composite crown, anterior	N	Tooth designation required	
D2391	resin-based composite – one surface, posterior	N	Tooth and surface designations required	
D2392	resin-based composite – two surfaces, posterior	N	Tooth and surface designations required	

Code	Description	PA?	Requirements	Maximum Allowable Fee
D2393	resin-based composite – three surfaces, posterior	N	Tooth and surface designations required. **If billed on a primary first or second molar, the Agency will reimburse at the rate for a two-surface restoration.**	
D2394	resin-based composite – four or more surfaces, posterior	N	Tooth and surface designations required. **If billed on a primary first or second molar, the Agency will reimburse at the rate for a two-surface restoration.**	

Crowns – Single Restorations Only

What Is Covered?

The Agency covers:

- The following crowns for **permanent anterior teeth** for clients ages 12-20 when the crowns meet prior authorization (PA) criteria in the "Prior Authorization" section of these billing instructions and the provider follows the PA requirements in "Prior Authorization" on the following page:

  ✓ Porcelain/ceramic crowns to include all porcelains, glasses, glass-ceramic, and porcelain fused to metal crowns; and

  ✓ Resin crowns and resin metal crowns to include any resin-based composite, fiber, or ceramic reinforced polymer compound.

Note: The Agency does not cover permanent anterior crowns for clients through age 11.

Payment

The Agency considers the following to be included in the payment for a crown:

- Tooth and soft tissue preparation;
- 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;
- Temporaries, including but not limited to, temporary restoration, temporary crown, provisional crown, temporary prefabricated stainless steel crown, ion crown, or acrylic crown;
- Packing cord placement and removal;
- Diagnostic or final impressions;
- Crown seating, including cementing and insulating bases;
- Occlusal adjustment of crown or opposing tooth or teeth; and
- Local anesthesia.

Billing

The Agency requires a provider to bill for a crown only after delivery and seating of the crown, not at the impression date.

Prior Authorization

The Agency requires the provider to submit the following with each PA request:

- Radiographs to assess all remaining teeth;
- Documentation and identification of all missing teeth;
- Caries diagnosis and treatment plan for all remaining teeth, including a caries control plan for clients with rampant caries;
- Pre- and post-endodontic treatment radiographs for requests on endodontically treated teeth; and
- Documentation supporting a five-year prognosis that the client will retain the tooth or crown if the tooth is crowned.

Code	Description	PA?	Requirments	Maximum Allowable Fee
D2710	crown – resin-based composite (indirect)	Y	Tooth designation required	On-line Fee Schedules
D2720	crown – resin with high noble metal	Y	Tooth designation required	
D2721	crown – resin with predominantly base metal	Y	Tooth designation required	
D2722	crown – resin with noble metal	Y	Tooth designation required	
D2740	crown – porcelain/ceramic substrate	Y	Tooth designation required	
D2750	crown – porcelain fused to high noble metal	Y	Tooth designation required	
D2751	crown – porcelain fused to predominantly base metal	Y	Tooth designation required	
D2752	crown – porcelain fused to noble metal	Y	Tooth designation required	

Note: The Agency does not pay for procedure codes D2710 through D2752 when billed for posterior teeth.

Other Restorative Services

The Agency covers:

- All recementations of permanent indirect crowns.
- Prefabricated stainless steel crowns with resin window, resin-based composite crowns, prefabricated esthetic coated stainless steel crowns, and fabricated resin crowns for primary anterior teeth once every three years without PA if the tooth requires a four or more surface restoration. Radiographic justification is required.
- Prefabricated stainless steel crowns for primary posterior teeth once every three years without PA. Radiographic justification is required.
- Prefabricated stainless steel crowns for permanent posterior teeth once every three years. Radiographic justification is required.
- Prefabricated stainless steel crowns for clients of DDD according to Section D. Radiographic justification is required.
- Core buildup, including pins, only on permanent teeth.
- Cast post and core or prefabricated post and core, only on permanent teeth.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D2910	recement inlay, onlay, or partial coverage restoration	N	Tooth designation required	On-line Fee Schedules
D2915	recement cast or prefabricated post and core	N	Tooth designation required	
D2920	recement crown	N	Tooth designation required	
D2930	prefabricated stainless steel crown – primary tooth	N	Tooth designation required	
D2931	prefabricated stainless steel crown – permanent tooth	N	Tooth designation required	
D2932	prefabricated resin crown	N	Tooth designation required	
D2933	prefabricated stainless steel crown with resin window	N	Tooth designation required	
D2934	prefabricated esthetic coated stainless steel crown – primary tooth	N	Tooth designation required	
D2950	core buildup, including any pins	N	Tooth designation required	
D2952	Post and core in addition to crown, indirectly fabricated	N	Tooth designation required	
D2954	Prefabricated post and core in addition to crown	N	Tooth designation required	

What Endodontic Services Are Covered? [Refer to WAC 182-535-1086]

The Agency covers medically necessary dental-related endodontic services, subject to the coverage limitations listed, for clients through age 20 as follows:

Pulp Capping

The Agency considers pulp capping to be included in the payment for the restoration.

Pulpotomy/Pulpal Debridement

The Agency covers:

- Therapeutic pulpotomy on primary posterior teeth only; and
- Pulpal debridement on permanent teeth only, excluding teeth 1, 16, 17, and 32.

The Agency does not pay for pulpal debridement when performed with palliative treatment for dental pain or when performed on the same day as endodontic treatment.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D3220	therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	N	Tooth designation required	On-line Fee Schedules
D3221	pulpal debridement, permanent teeth	N	Tooth designation required	

Endodontic Treatment on Primary Teeth

The Agency covers endodontic treatment with resorbable material for primary maxillary incisor teeth D, E, F, and G, if the entire root is present at treatment.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D3230	pulpal therapy (resorbable filling)-anterior, primary	N	Tooth designation required	On-line Fee Schedules

Endodontic Treatment on Permanent Teeth

The Agency:

- Covers endodontic treatment for permanent anterior, bicuspid, and molar teeth, excluding teeth 1, 16, 17, and 32.
- Considers the following included in endodontic treatment:
  - ✓ Pulpectomy when part of root canal therapy;
  - ✓ All procedures necessary to complete treatment; and
  - ✓ All intra-operative and final evaluation radiographs for the endodontic procedure.
- Pays separately for the following services that are related to the endodontic treatment:
  - ✓ Initial diagnostic evaluation;
  - ✓ Initial diagnostic radiographs; and
  - ✓ Post treatment evaluation radiographs if taken at least three months after treatment.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D3310	anterior (excluding final restoration)	N	Tooth designation required	On-line Fee Schedules
D3320	bicuspid (excluding final restoration)	N	Tooth designation required	
D3330	molar (excluding final restoration)	N	Tooth designation required	

Endodontic Retreatment on Permanent Anterior Teeth

- Requires PA for endodontic retreatment and considers endodontic retreatment to include:
  - ✓ The removal of post(s), pin(s), old root canal filling material, and all procedures necessary to prepare the canals;
  - ✓ Placement of new filling material; and
  - ✓ Retreatment for permanent anterior, bicuspid, and molar teeth, excluding teeth 1, 16, 17, and 32.

- Pays separately for the following services that are related to the endodontic retreatment:
  - ✓ Initial diagnostic evaluation;
  - ✓ Initial diagnostic radiographs; and
  - ✓ Post treatment evaluation radiographs if taken at least three months after treatment.
- Does not pay for endodontic retreatment when provided by the original treating provider or clinic unless prior authorized by the Agency.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D3346	retreatment of previous root canal therapy – anterior	Y	Tooth designation required	On-line Fee Schedules
D3347	retreatment of previous root canal therapy – bicuspid	Y	Tooth designation required	
D3348	retreatment of previous root canal therapy – molar	Y	Tooth designation required	

Apexification/Apicoectomy

- Covers apexification for apical closures for **anterior permanent teeth only** on a case-by-case basis and when prior authorized. Apexification is limited to the initial visit and three interim treatment visits.
- Covers apicoectomy and a retrograde filling for **anterior teeth only**.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D3351	apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	N	Tooth designation required	On-line Fee Schedules
D3352	apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	N	Tooth designation required	
D3410	apicoectomy/periradicular surgery – anterior	Y	Tooth designation required	
D3430	retrograde filling – per root	Y	Tooth designation required	

What Periodontic Services Are Covered? [Refer to WAC 182-535-1088]

The Agency covers medically necessary periodontic services, subject to the coverage limitations listed, for clients through age 20 as follows:

Surgical Periodontal Services

The Agency covers the following surgical periodontal services, including all postoperative care:

- Gingivectomy/gingivoplasty only on a case-by-case basis and when prior authorized; and
- Gingivectomy/gingivoplasty for clients of DDD according to Section D.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D4210	gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant	Y	Quadrant designation required	On-line Fee Schedules
D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant	Y	Quadrant designation required	

Nonsurgical Periodontal Services

The Agency:

- Covers periodontal scaling and root planing for the number of teeth scaled that are periodontically involved once per quadrant, per client in a two-year period on a case-by-case basis, when prior authorized for clients ages 13-18, and only when:
  - ✓ The client has radiographic evidence of periodontal disease;
  - ✓ The client's record includes supporting documentation for the medical necessity of the service, including complete periodontal charting and a definitive diagnosis of periodontal disease;
  - ✓ The client's clinical condition meets current published periodontal guidelines; and
  - ✓ Performed at least two years from the date of completion of periodontal scaling and root planing or surgical periodontal treatment.

- Covers periodontal scaling and root planing once per quadrant, per client, in a two-year period for clients ages 19-20, and only when:

  ✓ The client has radiographic evidence of periodontal disease;

  ✓ The client's record includes supporting documentation for the medical necessity, including complete periodontal charting and a definitive diagnosis of periodontal disease;

  ✓ The client's clinical condition meets current published periodontal guidelines; and

  ✓ Performed at least two years from the date of completion of periodontal scaling and root planing or surgical periodontal treatment.

- Considers ultrasonic scaling, gross scaling, or gross debridement to be included in the procedure and not a substitution for periodontal scaling and root planing.

- 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.

- Covers periodontal scaling and root planing for clients of DDD according to Section D.

Code	Description	PA?	Limitations	Requirements	Maximum Allowable Fee
D4341	periodontal scaling and root planing – four or more teeth per quadrant	Y	Clients ages 13-18	Quadrant designation required	On-line Fee Schedules
D4341	periodontal scaling and root planing – four or more teeth per quadrant	N	Clients ages 19-20	Quadrant designation required	On-line Fee Schedules
D4342	periodontal scaling and root planing – one to three teeth per quadrant	Y	Clients ages 13-18	Quadrant designation required	
D4342	periodontal scaling and root planing – one to three teeth per quadrant	N	Clients ages 19-20	Quadrant designation required	

Periodontal Maintenance

The Agency:

- Covers periodontal maintenance once per client in a 12-month period on a case-by-case basis, when prior authorized, for clients ages 13-18, and only when:
  - ✓ The client has radiographic evidence of periodontal disease;
  - ✓ The client's record includes supporting documentation for the medical necessity, including complete periodontal charting and a definitive diagnosis of periodontal disease;
  - ✓ The client's clinical condition meets current published periodontal guidelines; and
  - ✓ Performed at least 12 months from the date of completion of periodontal scaling and root planing, or surgical periodontal treatment.
- Covers periodontal maintenance once per client in a 12 month period for clients ages 19-20 only when:
  - ✓ The client has radiographic evidence of periodontal disease;
  - ✓ The client's record includes supporting documentation for the medical necessity, including complete periodontal charting and a definitive diagnosis of periodontal disease;
  - ✓ The client's clinical condition meets current published periodontal guidelines; and
  - ✓ Performed at least 12 months from the date of completion of periodontal scaling and root planing, or surgical periodontal treatment.
- Covers periodontal maintenance only if performed on a different date of service as prophylaxis, periodontal scaling and root planing, gingivectomy, or gingivoplasty.
- Covers periodontal maintenance for clients of DDD according to Section D.

Code	Description	PA?	Limitations	Maximum Allowable Fee
D4910	periodontal maintenance	Y	Clients ages 13-18	On-line Fee Schedules
D4910	periodontal maintenance	N	Clients ages 19-20	

What Removable Prosthodontic Services Are Covered?

[Refer to WAC 182-535-1090]

The Agency covers medically necessary removable prosthodontic services, subject to the coverage limitations listed, for clients through age 20 as follows:

Prior Authorization (PA)

The Agency requires PA for the removable prosthodontic and prosthodontic-related procedures listed in this section when noted. Documentation supporting the medical necessity for the service must be included in the client's file. PA requests must meet the criteria in the *Prior Authorization* section of these billing instructions. In addition, the Agency requires the dental provider to submit:

- Appropriate and diagnostic radiographs of all remaining teeth.
- A dental record which identifies:
  - ✓ All missing teeth for both arches;
  - ✓ Teeth that are to be extracted; and
  - ✓ Dental and periodontal services completed on all remaining teeth.
- The referring dentist's name and prescription when the PA request is submitted by a denturist for an immediate denture or a cast metal partial denture.

> **Note:** If a client wants to change denture providers, the Agency must receive a statement from the client requesting the provider change. The Agency will check to make sure services haven't already been rendered by the original provider before cancelling the original authorization request for services. The new provider must submit another authorization request for services.

The Agency requires a provider to:

- Obtain a signed agreement of acceptance from the client at the conclusion of the final denture try-in for a Agency-authorized complete denture or a cast-metal denture described in this section. If the client abandons the complete or partial 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 time limitations specified in this section.
- Retain in your records a completed copy of the signed Agreement of Acceptance, 13-809, that documents the client's acceptance of the dental prosthesis along.

Complete Dentures

The Agency covers complete dentures, as follows:

- A complete denture, including an immediate denture or overdenture, is covered when prior authorized.
- Three-month post-delivery care (e.g., adjustments, soft relines, and repairs) from the seat date of the complete denture is considered part of the complete denture procedure and is not paid separately.
- Replacement of an immediate denture with a complete denture if the complete denture is prior authorized at least six months after the seat date of the immediate denture.
- Replacement of a complete denture or overdenture only if prior authorized at least five years after the seat date of the complete denture or overdenture being replaced. The replacement denture must be prior authorized.

Code	Description	PA?	Maximum Allowable Fee
D5110	complete denture – maxillary	Y	On-line Fee Schedules
D5120	complete denture – mandibular	Y	
D5130	immediate denture – maxillary	Y	
D5140	immediate denture – mandibular	Y	

The Agency requires the "Agreement of Acceptance" form for all complete dentures (CDT codes D5110 and D5120). Complete this form at the time of the final try-in, and retain in your records.

Resin Partial Dentures

What Is Covered?

The Agency covers partial dentures, as follows:

- A partial denture, including a resin partial denture, for anterior and posterior teeth when the partial denture meets the Agency coverage criteria for resin partial dentures.
- PA of resin partial dentures:
  - ✓ Is required for clients ages nine and younger; and
  - ✓ Is not required for clients ages 10-20. Documentation supporting the medical necessity for the service must be included in the client's file.

- Three-month post-delivery care (e.g., adjustments, soft relines, and repairs) from the seat date of the partial denture, is considered part of the partial denture procedure and is not paid separately.

- Replacement of a resin or flexible base denture only if prior authorized at least three years after the seat date of the resin or flexible base partial denture being replaced. The replacement denture must be prior authorized and meet the Agency's coverage criteria for resin partial dentures.

Coverage Criteria for Resin Partial Dentures

The following coverage criteria apply to resin partial dentures:

- The remaining teeth in the arch must have a reasonable periodontal diagnosis and prognosis;

- The client has established caries control;

- One or more anterior teeth are missing or four or more posterior teeth are missing;

- There are a minimum of four stable teeth remaining per arch; and

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

Code	Description	PA?	Limitations	Maximum Allowable Fee
D5211	maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	Y	Clients through age 9 only	On-line Fee Schedules
D5211	maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	N*	Clients ages 10-20 only	
D5212	mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	Y	Clients through age 9 only	
D5212	mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	N*	Clients ages 10-20 only	

* Replacement dentures must be prior authorized and meet the Agency's coverage criteria for resin partial dentures.

Cast-metal Framework Partial Dentures

The Agency covers cast-metal framework partial dentures, as follows:

- Cast-metal framework with resin-based partial dentures, including any conventional clasps, rests, and teeth, for clients ages 18-20 only once in a five-year period, on a case-by-case basis, when prior authorized, and when the Agency's coverage criteria for partial dentures are met.

  Note: Cast-metal framework partial dentures for clients ages 17 and younger are not covered.

- Three-month post-delivery care (e.g., adjustments, soft relines, and repairs) from the seat date of the cast metal partial denture is considered part of the partial denture procedure and is not paid separately.

- Replacement of a cast metal framework partial denture on a case-by-case basis and only if placed at least five years after the seat date of the partial denture being replaced. The replacement denture must be prior authorized and meet the Agency's coverage criteria for partial dentures.

- Authorization and payment for cast metal framework partial dentures is based on the Agency's coverage criteria for partial dentures.

- The Agency may consider resin partial dentures as an alternative if the Agency determines the criteria for cast metal framework partial dentures are not met.

Coverage Criteria for Cast-metal Framework Partial Dentures

The following coverage criteria apply to cast-metal framework partial dentures:

- The remaining teeth in the arch must have a stable periodontal diagnosis and prognosis;
- The client has established caries control;
- All restorative and periodontal procedures must be completed before the request for PA is submitted;
- There are fewer than eight posterior teeth in occlusion;
- There are a minimum of four stable teeth remaining per arch; and
- There is a five-year prognosis for retention of the remaining teeth.

Code	Description	PA?	Limitations	Maximum Allowable Fee
D5213	maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	Y	Clients ages 18-20	On-line Fee Schedules
D5214	mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	Y	Clients ages 18-20	

The Agency requires the "Agreement of Acceptance" form for all cast metal partial dentures (CDT codes D5213 and D5214). Complete this form at the time of the final try-in, and retain in your records.

Other Requirements/Limitations

The Agency:

- Requires a provider to bill for removable dental prosthetic procedures only after the seating of the prosthesis, not at the impression date. The Agency may pay for lab fees if the removable dental prosthesis is not delivered and inserted. Refer to "Other Services for Removable Prosthodontics**."**
- 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.

Alternative Living Facilities

- Requires a provider to submit the following with a PA request for removable dental prosthetics for a client residing in a nursing facility, group home, or other facility:

  ✓ The client's medical diagnosis or prognosis;

  ✓ The attending physician's signature documenting medical necessity for the prosthetic service;

  ✓ The attending dentist's or denturist's signature documenting medical necessity for the prosthetic service;

  ✓ A written and signed consent for treatment from the client's legal guardian when a guardian has been appointed; and

  ✓ A completed copy of the Denture/Partial Appliance Request for Skilled Nursing Facility Client form, 13-788. For information on obtaining Agency forms, refer to the *Important Contacts* section.

- Limits removable partial dentures to resin-based partial dentures for all clients residing in a nursing facility, group home, or other facility. The Agency may consider cast metal partial dentures if coverage criteria are met.

Adjustments to Dentures and Repairs to Complete and Partial Dentures

Adjustments to complete and partial dentures are included in the global fee for the denture for the first 90 days after the seat date.

Code	Description	PA?	Maximum Allowable Fee
D5410	adjust complete denture – maxillary	N	On-line Fee Schedules
D5411	adjust complete denture – mandibular	N	
D5421	adjust partial denture – maxillary	N	
D5422	adjust partial denture – mandibular	N	

Repairs to Complete and Partial Dentures

The Agency covers repairs to complete and partial dentures once per arch in a 12-month period. The Agency covers additional repairs on a case-by-case basis and when prior authorized.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D5510	repair broken complete denture base	N	Arch designation required	On-line Fee Schedules
D5520	replace missing or broken teeth – complete denture (each tooth)	N	Tooth designation required	
D5620	repair cast framework	N	Arch designation required	
D5650	add tooth to existing partial denture	N	Tooth designation required	
D5660	add clasp to existing partial denture	N	Tooth designation required	

Denture Rebase Procedures

The Agency covers a laboratory rebase to a complete or cast-metal partial denture once in a three-year period when performed at least six months after the seating date. An additional rebase may be covered for complete or cast-metal partial dentures on a case-by-case basis when prior authorized.

Code	Description	PA?	Maximum Allowable Fee
D5710	rebase complete maxillary denture	N	On-line Fee Schedules
D5711	rebase complete mandibular denture	N	
D5720	rebase maxillary partial denture	N	
D5721	rebase mandibular partial denture	N	

Note: The Agency does not allow a denture rebase and a reline in the same three-year period. The Agency covers rebases or relines only on cast-metal partials and complete dentures (CDT codes D5110, D5120, D5130, D5140, D5213, and D5214).

Denture Reline Procedures

The Agency covers a laboratory reline to a complete or cast-metal partial denture once in a three-year period when performed at least six months after the seating date. An additional reline may be covered for complete or cast-metal partial dentures on a case-by-case basis when prior authorized.

Code	Description	PA?	Maximum Allowable Fee
D5750	reline complete maxillary denture (laboratory)	N	On-line Fee Schedules
D5751	reline complete mandibular denture (laboratory)	N	
D5760	reline maxillary partial denture (laboratory)	N	
D5761	reline mandibular partial denture (laboratory)	N	

Note: The Agency does not allow a denture rebase and a reline in the same three-year period. The Agency covers rebases or relines only on cast-metal partials and complete dentures (CDT codes D5110, D5120, D5130, D5140, D5213, and D5214).

Other Removable Prosthetic Services

The Agency covers:

- Up to two tissue conditionings, and only when performed within three months after the seating date.

- Laboratory fees, subject to the following:

  - ✓ The Agency does not pay separately for laboratory or professional fees for complete and partial dentures; and

  - ✓ The Agency may pay part of billed laboratory fees when the provider obtains PA, and the client:

    - ➢ Is not eligible at the time of delivery of the prosthesis;
    - ➢ Moves from the state;
    - ➢ Cannot be located;
    - ➢ Does not participate in completing the complete, immediate, or partial dentures; or
    - ➢ Dies.

Note: Use the impression date as the date of service in the above instance.

A provider must submit copies of laboratory prescriptions and receipts or invoices for each claim when submitting for prior authorization of code D5899 for laboratory fees.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D5850	tissue conditioning, maxillary	N	N/A	On-line Fee Schedules
D5851	tissue conditioning, mandibular	N	N/A	
D5860	overdenture – complete, by report	Y	Arch designation required	
D5899	unspecified removable prosthodontic procedure, by report	Y	Arch designation required	
D6930	recement fixed partial denture	Y	Arch or quadrant designation required	

What Maxillofacial Prosthetic Services Are Covered?

[Refer to WAC 182-535-1092]

The Agency covers medically necessary maxillofacial prosthetic services, subject to the coverage limitations listed, for clients through age 20 as follows:

- Maxillofacial prosthetics are covered only on a case-by-case basis and **when prior authorized**; and

- The Agency **must pre-approve** a provider qualified to furnish maxillofacial prosthetics.

What Oral and Maxillofacial Surgery Services Are Covered?

[Refer to WAC 182-535-1094]

General Coverage

The Agency covers medically necessary oral and maxillofacial surgery services, subject to the coverage limitations listed, for clients through age 20 as follows:

- Requires enrolled providers who do not meet the conditions in Section A, "Becoming an Agency Dental Provider" to bill claims for services that are listed in this subsection using only the Current Dental Terminology (CDT) codes.

- Requires enrolled providers (oral and maxillofacial surgeons) who meet the conditions in Section A, "Becoming a Agency Dental Provider" to bill claims using Current Procedural Terminology (CPT) codes unless the procedure is specifically listed in the Agency's current published billing instructions as a CDT covered code (e.g., extractions).

  Note: For billing information on billing CPT codes for oral surgery, refer to the current n/MPA *Physician-Related Services Billing Instructions*. The Agency pays oral surgeons for only those CPT codes listed in the Dental Fee Schedule under "Dental CPT Codes."

- Covers non-emergency oral surgery performed in a hospital or ambulatory surgery center only for:

  ✓ Clients ages eight and younger;
  ✓ Clients ages 9-20 only on a case-by-case basis and when prior authorized; and
  ✓ Clients of DDD according to Section D.

Documentation Requirements

The Agency 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:

- Appropriate consent form signed by the client or the client's legal representative;
- Appropriate radiographs;
- Medical justification with diagnosis;
- The client's blood pressure, when appropriate;
- A surgical narrative;
- A copy of the post-operative instructions; and
- A copy of all pre- and post-operative prescriptions.

Extractions and Surgical Extractions

The Agency covers routine and surgical extractions (includes local anesthesia, suturing, if needed, and routine postoperative care).

The Agency includes debridement of a granuloma or cyst that is less than five millimeters as part of the global fee for the extraction.

Note: For surgical extractions, documentation supporting the medical necessity of the billed procedure code must be in the client's record.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D7111	extraction, coronal remnants – deciduous tooth	N	Tooth designation required	On-line Fee Schedules
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	N	Tooth designation required	
D7210	surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	N	Tooth designation required	
D7220	removal of impacted tooth – soft tissue	N	Tooth designation required	
D7230	removal of impacted tooth – partially bony	N	Tooth designation required	
D7240	removal of impacted tooth – completely bony	N	Tooth designation required	

Code	Description	PA?	Requirements	Maximum Allowable Fee
D7241	removal of impacted tooth – completely bony, with unusual surgical complications	Y	Tooth designation required	
D7250	surgical removal of residual tooth roots (cutting procedure)	N	Tooth designation required	

Other Surgical Procedures

- The Agency covers surgical access of an unerupted tooth.
- Biopsy of soft oral tissue or brush biopsy does not require PA. All biopsy reports or findings must be kept in the client's dental record.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth			On-line Fee Schedules
D7280	surgical access of an unerupted tooth	N	Tooth designation required	
D7286	biopsy of oral tissue – soft	N		
D7288	brush biopsy – transepithelial sample collection	N		

Alveoloplasty – Surgical Preparation of Ridge for Dentures

The Agency covers alveoloplasty only on a case-by-case basis and when prior authorized. The Agency covers alveoloplasty only when not performed in conjunction with extractions.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D7310	Alveoloplasty in conjunction with extractions – four or more teeth, per quadrant	Y	Quadrant designation required	On-line Fee Schedules

Surgical Excision of Soft Tissue Lesions

The Agency covers surgical excision of soft tissue lesions only on a case-by-case basis and when prior authorized.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D7410	excision of benign lesion up to 1.25 cm	Y	Quadrant designation required	On-line Fee Schedules

Excision of Bone Tissue

The Agency covers only the following excisions of bone tissue in conjunction with placement of immediate, complete, or partial dentures when prior authorized:

- Removal of lateral exostosis;
- Removal of mandibular or palatal tori; and
- Surgical reduction of soft tissue or osseous tuberosity.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D7471	removal of lateral exostosis (maxilla or mandible)	Y	Arch designation required	On-line Fee Schedules
D7472	removal of torus palatinus	Y		
D7473	removal of torus mandibularis	Y		
D7485	surgical reduction of osseous tuberosity	Y	Quadrant designation required	

Surgical Incision

The Agency covers the following surgical incision-related services:

- Uncomplicated dental-related intraoral and extraoral soft tissue incision and drainage of abscess. The Agency does not cover this service when combined with an extraction or root canal treatment. Documentation supporting medical necessity must be in the client's record.

Note: Providers must not bill drainage of abscess (D7510 or D7520) in conjunction with palliative treatment (D9110).

- Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue when prior authorized. Documentation supporting the medical necessity for the service must be in the client's record.

- Frenuloplasty/frenulectomy for clients through age six. The Agency covers frenuloplasty/frenulectomy for clients ages 7-12 only on a case-by-case basis and when prior authorized. Documentation supporting the medical necessity for the service must be in the client's record.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D7510	incision and drainage of abscess – intraoral soft tissue	N		On-line Fee Schedules
D7520	incision and drainage of abscess – extraoral soft tissue	N		
D7530	removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	Y		
D7960	frenulectomy (frenectomy or frenotomy) – separate procedure	N	Clients through age six. Arch designation required.	
D7960	frenulectomy (frenectomy or frenotomy) – separate procedure	Y	Clients ages 7-12. Arch designation required.	
D7963	frenuloplasty	N	Clients through age six. Arch designation required.	
D7963	frenuloplasty	Y	Clients age 7-12. Arch designation required.	

Occlusal Orthotic Devices

The Agency covers:

- Occlusal orthotic devices for clients ages 12-20 only on a case-by-case basis and when prior authorized.
- An occlusal orthotic device only as a laboratory processed full arch appliance.

> **Note:** Refer to "What adjunctive general services are covered?" for occlusal guard coverage and limitations on coverage.

Code	Description	PA?	Maximum Allowable Fee
D7880	occlusal orthotic device, by report	Y	On-line Fee Schedules
D7972	Surgical reduction of fibrous tuberosity	Y	

What Orthodontic Services Are Covered? [Refer to WAC 182-535-1096]

The Agency covers orthodontic services, subject to the coverage limitations listed, for clients through age 20 according to the current Agency *Orthodontic Services Billing Instructions*.

What Adjunctive General Services Are Covered?

[Refer to WAC 182-535-1098]

The Agency covers medically necessary dental-related adjunctive general services, subject to the coverage limitations listed, for clients through age 20 as follows:

Unclassified Treatment

The Agency covers palliative (emergency) treatment, not to include pulpal debridement (D3221), for treatment of dental pain, limited to once per day, per client, as follows:

- The treatment must occur during limited evaluation appointments;
- A comprehensive description of the diagnosis and services provided must be documented in the client's record; and
- Appropriate radiographs must be in the client's record supporting the medical necessity of the treatment.

Code	Description	PA?	Maximum Allowable Fee
D9110	palliative (emergency) treatment of dental pain – minor procedure	N	On-line Fee Schedules

Anesthesia

The Agency:

- Covers local anesthesia and regional blocks as part of the global fee for any procedure being provided to clients.
- Covers office-based oral or parenteral conscious sedation, deep sedation, or general anesthesia, as follows:
  - ✓ General Anesthesia is only covered when performed in an office setting.
  - ✓ The provider's current anesthesia permit must be on file with the Agency.
  - ✓ For clients of DDD, the services must be performed according to Section D.
  - ✓ For clients ages eight and younger, documentation supporting the medical necessity of the anesthesia service must be in the client's record.

- ✓ For clients ages 9-20, deep sedation or general anesthesia services are covered on a case-by-case basis and when prior authorized, **except for oral surgery services**. Office-based general anesthesia for oral surgery services listed in "What oral and maxillofacial surgery services are covered?" does not require PA.

- ✓ PA is not required for oral or parenteral conscious sedation for any dental service. Documentation supporting the medical necessity of the service must be in the client's record.

- ✓ For clients ages 9-18 who have a diagnosis of oral facial cleft, the Agency does not require PA for deep sedation or general anesthesia services when the dental procedure is directly related to the oral facial cleft treatment.

- ✓ For clients through age 20, the provider must bill anesthesia services using the CDT codes listed in this section.

- ✓ For medically necessary office-based general anesthesia, the Agency does not require PA when one of the following applies. The client is:

  - ➢ Age eight or younger;
  - ➢ A client of the Division of Developmental Disabilities; or
  - ➢ Age 20 or younger and has a diagnosis of oral facial cleft and the treatment is directly related to the oral facial cleft.

  Note: Providers must document medical necessity for these services.

- ✓ For clients age nine and older, the Agency requires PA for office-based general anesthesia unless criteria listed in this section is satisfied.

  Note: Providers must submit medical justification for these services when requesting PA.

- Covers inhalation of nitrous oxide for clients through age 20, once per day.

- Requires providers of oral or parenteral conscious sedation, deep sedation, or general anesthesia to meet:

  - ✓ The prevailing standard of care;
  - ✓ The provider's professional organizational guidelines;
  - ✓ The requirements in Chapter 246-817 WAC; and
  - ✓ Relevant department of health (DOH) medical, dental, or nursing anesthesia regulations.

- Pays for anesthesia services according to WAC 182-535-1350.

Code	Description	PA?	Maximum Allowable Fee
D9220	deep sedation/general anesthesia–first 30 minutes	*	On-line Fee Schedules
D9221	deep sedation/general anesthesia—each additional 15 minutes	*	
D9230	analgesia, anxiolysis, inhalation of nitrous oxide	N	
D9241	intravenous conscious sedation/analgesia-first 30 minutes	N	
D9242	Intravenous conscious sedation/analgesia—each additional 15 minutes	N	
D9248	non-intravenous conscious sedation	N	

*See coverage criteria.

Billing Anesthesia

- When billing for general anesthesia, show the beginning and ending times on the claim form in the Description of Service field on the ADA Claim Form. State the total number of minutes on the claim. Anesthesia time begins when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent) and ends when the anesthesiologist or CRNA is no longer in constant attendance (e.g., when the patient can be safely placed under post-operative supervision).

- You must enter the name of the provider who administered the anesthesia in the *Remarks* field of the claim form, if that provider is different from the billing provider.

- **Bill for general anesthesia as follows:**

  Bill one unit of D9220 for the first 30 minutes of deep sedation/general anesthesia. Each additional 15 minute increment of deep sedation/general anesthesia is equal to one unit of D9221. **For example:** 60 minutes of general anesthesia would be billed as 1 unit of D9220 and 2 units of D9221.

- **Bill for intravenous conscious sedation/analgesia as follows:**

  Bill one unit of D9241 for the first 30 minutes of deep sedation/general anesthesia. Each additional 15 minute increment of intravenous conscious sedation/analgesia is equal to one unit of D9242. **For example:** 60 minutes of intravenous conscious sedation/analgesia would be billed as 1 unit of D9241 and 2 units of D9242.

Non-emergency Dental Services

The Agency covers non-emergency dental services performed in a hospital or ambulatory surgical center only for:

- Clients ages eight and younger.
- Clients ages 9-20 only on a case-by-case basis and when prior authorized.
- Clients of DDD according to Section D.

Professional Visits

The Agency covers:

- A consultation – diagnostic service provided by a dentist or physician other than the requesting dentist or physician when requested by the Agency.
- Up to two house/extended care facility (alternate living facility) calls (visits) per facility, per provider. The Agency limits payment to two facilities per day, per provider.
- One hospital call (visit), including emergency care, per day, per provider, per client.
- An emergency office visit after regularly scheduled hours. The Agency limits payment to one emergency visit per day, per provider.

Code	Description	PA?	Maximum Allowable Fee
D9310	consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	N	On-line Fee Schedules
D9410	house/extended care facility call	N	
D9420	hospital call	N	
D9440	office visit – after regularly scheduled hours	N	

Drugs

The Agency covers drugs and/or medicaments only when used with parenteral conscious sedation, deep sedation, or general anesthesia. The Agency's Dental Program does not pay for oral sedation medications.

Code	Description	PA?	Maximum Allowable Fee
D9610	therapeutic parenteral drug, single administration **Note:** Refer to your CDT manual for more information.	N	On-line Fee Schedules
D9612	therapeutic parenteral drugs, two or more administrations, different medications **Note:** Refer to your CDT manual for more information.	N	
D9630	other drugs and/or medicaments, by report **Note:** Refer to your CDT manual for more information.	N	

Miscellaneous Services

The Agency covers:

- Behavior management when the assistance of one additional dental staff other than the dentist is required, for:

  ✓ Clients ages eight and younger;

  ✓ Clients ages 9-20, only on a case-by-case basis and when prior authorized; and

  ✓ **Clients of DDD (refer to Section D) or clients residing in an alternative living facility**.

  Note: For clients residing in an alternative living facility, documentation supporting the medical necessity of the billed procedure code must be in the client's record.

- Treatment of post-surgical complications (e.g., dry socket). Documentation supporting the medical necessity of the service must be in the client's record.

- Occlusal guards when medically necessary and prior authorized. (Refer to "What oral and maxillofacial surgery services are covered?" for occlusal orthotic device coverage and coverage limitations.) The Agency covers:

  ✓ An occlusal guard only for clients ages 12-20 when the client has permanent dentition; and

  ✓ An occlusal guard only as a laboratory processed full arch appliance.

Code	Description	PA?	Maximum Allowable Fee
D9920	behavior management	N	On-line Fee Schedules
D9930	treatment of complications (post-surgical) – unusual circumstances	N	
D9940	occlusal guard, by report	Y	

What Dental-Related Services Are Not Covered for Clients through Age 20? [Refer to WAC 182-535-1100(1) (2)]

What Is Not Covered?

The Agency does not cover the following for clients through age 20:

- The dental-related services described in "Noncovered Services by Category" unless the services include those medically necessary services and other measures provided to correct or ameliorate conditions discovered during a screening performed under the early periodic screening, diagnosis and treatment (EPSDT) program. See the current Agency *Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Billing Instructions* for information about the EPSDT program.

- Any service specifically excluded by statute.

- More costly services when less costly, equally effective services as determined by the Agency are available.

- Services, procedures, treatments, devices, drugs, or application of associated services:

  - ✓ Which the Agency or the Centers for Medicare and Medicaid Services (CMS) considers investigative or experimental on the date the services were provided; or

  - ✓ That are not listed as covered in one or both of the following:

    - ➢ Washington Administrative Code (WAC); or
    - ➢ Current Agency published documents.

Noncovered Services by Category

The Agency does not cover dental-related services listed under the following categories of service for clients through age 20 (see "What is not covered?" (see above) for services provided under the EPSDT program):

Diagnostic Services

The Agency does not cover:

- Extraoral radiographs, excluding panoramic or cephalometric films; or
- Comprehensive periodontal evaluations.

Preventive Services

The Agency does not cover:

- Nutritional counseling for control of dental disease;
- Tobacco counseling for the control and prevention of oral disease;
- Removable space maintainers of any type;
- Sealants placed on a tooth with the same-day occlusal restoration, pre-existing occlusal restoration, or a tooth with occlusal decay;
- Space maintainers for clients ages 19-20; or
- Fluoride trays of any type.

Restorative Services

The Agency does not cover:

- Restorations for wear on any surface of any tooth without evidence of decay peneatrating the DEJ or on the root surface;
- Gold foil restorations;
- Metallic, resin-based composite, or porcelain/ceramic inlay/onlay restorations;
- Crowns for cosmetic purposes (e.g., peg laterals and tetracycline staining);
- Permanent crowns for bicuspids or molar teeth;
- Temporary or provisional crowns (including ion crowns);
- Labial veneer resin or porcelain laminate restorations;
- Sedative fillings;
- Any type of coping;
- Crown repairs; or
- Polishing or recontouring restorations or overhang removal for any type of restoration.

Endodontic Services

The Agency does not cover:

- Indirect or direct pulp caps;
- Any endodontic therapy on primary teeth, except endodontic treatment with resorbable material for primary maxillary incisor teeth D, E, F, and G, if the entire root is present at treatment;
- Apexification/recalcification for root resorption of permanent anterior teeth;
- Any apexification/recalcification procedures for bicuspid or molar teeth;
- Any apicoectomy/periradicular services for bicuspid or molar teeth; or
- Any surgical endodontic procedures including, but not limited to, retrograde fillings (except for anterior teeth), root amputation, reimplantation, and hemisections.

Periodontic Services

The Agency does not cover:

- Surgical periodontal services including, but not limited to:
  - ✓ Gingival flap procedures;
  - ✓ Clinical crown lengthening;
  - ✓ Any type of periodontal osseous surgery;
  - ✓ Bone or soft tissue grafts;
  - ✓ Biological material to aid in soft and osseous tissue regeneration;
  - ✓ Guided tissue regeneration;
  - ✓ 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; or
  - ✓ Distal or proximal wedge procedures.

- Nonsurgical periodontal services including, but not limited to:

  - ✓ Intracoronal or extracoronal provisional splinting.
  - ✓ Full mouth debridement.
  - ✓ Localized delivery of chemotherapeutic agents.
  - ✓ Any other type of nonsurgical periodontal service.

Removable Prosthodontics

The Agency does not cover:

- Removable unilateral partial dentures;
- Any interim complete or partial dentures;
- Flexible base partial dentures;
- Any type of permanent soft reline (e.g., molloplast);
- Precision attachments; or
- Replacement of replaceable parts for semi-precision or precision attachments.

Implant Services

The Agency does not cover:

- Any type of implant procedures, including, but not limited to, any tooth implant abutment (e.g., periosteal implant, eposteal implant, and transosteal implant), abutments or implant supported crown, abutment supported retainer, and implant supported retainer.

- Any maintenance or repairs to the implant procedures listed in above bullet.

- The removal of any implant as described in the above bullets.

Fixed Prosthodontics

The Agency does not cover:

- Any type of fixed partial denture pontic or fixed partial denture retainer.

- Any type of precision attachment, stress breaker, connector bar, coping, cast post, or any other type of fixed attachment or prosthesis.

Oral and Maxillofacial Surgery

The Agency does not cover:

- Any oral surgery service that is not listed in the Agency's list of covered dental CPT codes published in the Agency's current rules or billing instructions; or
- Any oral surgery service not listed in "What oral and maxillofacial surgery services are covered?"

Adjunctive General Services

The Agency does not cover:

- Anesthesia, including, but not limited to:
  - ✓ Local anesthesia as a separate procedure;
  - ✓ Medication for oral sedation, or therapeutic intramuscular (IM) drug injections, including antibiotic and injection of sedative;
  - ✓ Regional block anesthesia as a separate procedure; or
  - ✓ Trigeminal division block anesthesia as a separate procedure.
- Other general services including, but not limited to:
  - ✓ Application of any type of desensitizing medicament or resin;
  - ✓ Dental supplies, including but not limited to items such as toothbrushes;
  - ✓ Dentist's or dental hygienist's time writing or calling in prescriptions;
  - ✓ Dentist's time consulting with clients on the phone;
  - ✓ Educational supplies;
  - ✓ Enamel microabrasion;
  - ✓ Fabrication of athletic mouthguard, occlusal guard, or nightguard;
  - ✓ Fees for no-show, cancelled, or late arrival appointments;
  - ✓ Nonmedical equipment or supplies;
  - ✓ Occlusal adjustment, tooth or restoration adjustment or smoothing or odontoplasties;
  - ✓ Occlusion analysis;
  - ✓ Office supplies used in conjunction with an office visit;
  - ✓ Personal comfort items or services;
  - ✓ Provider mileage or travel costs;
  - ✓ Service charges of any type, including fees to create or copy charts; or
  - ✓ Teeth whitening services or bleaching, or materials used in whitening or bleaching.

Clients of the Division of Developmental Disabilities

Clients Eligible for Enhanced Services

Clients of the Division of Developmental Disabilities (DDD) may be entitled to more frequent services.

These individuals will be identified in ProviderOne as clients of the Division of Developmental Disabilities. Individuals not identified as such are not eligible for the additional services. If you believe that a patient may qualify for these services, refer the individual or the patient's guardian to the nearest Developmental Disabilities Office (see list below).

Division of Developmental Disabilities Field Offices

Region 1
1611 West Indiana Ave
MS: B32-28
Spokane WA 99205-4221
1-509-456-2893
1-509-456-4256 FAX
1-800-462-0624

Region 2
1002 N. 16th Avenue
MS: B39-7
Yakima WA 98909-2500
1-509-225-7970
1-509-575-2326 FAX
1-800-822-7840

Region 3
840 N. Broadway
Building A, Suite 100
MS: N31-11
Everett, WA 98201-1296
1-425-339-4833
1-425-339-4856 FAX
1-800-788-2053

Region 4
1700 East Cherry Street
MS: N46-6
Seattle WA 98122-4695
1-206-568-5700
1-206-720-3334 FAX
1-800-314-3296

Region 5
1305 Tacoma Avenue S., Suite 300
MS: N27-6
Tacoma WA 98402
1-253-593-2812
1-253-597-4368 FAX
1-800-248-0949

Region 6
Airdustrial Park, Bldg. 6
MS: 45315
PO Box 45315
Olympia, WA 98504-5315
1-360-753-4673
1-360-586-6502 FAX
1-800-339-8227

If you have any problems contacting these field offices, call Alan McMullen, DDD state office, at 360-725-3451 or email at mcmular@dshs.wa.gov.

What Additional Dental-Related Services Are Covered for Clients of the Division of Developmental Disabilities (DDD)?

[Refer to WAC 182-535-1099]

The Agency pays for dental-related services under the categories of services listed in this section for clients of DDD, subject to the coverage limitations listed. The Agency *Dental Program for Clients Through Age 20 Billing Instructions* apply to clients of DDD unless otherwise stated in this section.

Preventive Services

Dental Prophylaxis

The Agency covers dental prophylaxis up to three times in a 12-month period (see "Periodontic Services" in this section for limitations on periodontal scaling and root planing).

Topical Fluoride Treatment

The Agency covers topical fluoride varnish, rinse, foam or gel, up to three times within a 12-month period per client, per provider or clinic.

Sealants

The Agency covers sealants:

- Only when used on the occlusal surfaces of:
  - ✓ Primary teeth A, B, I, J, K, L, S, and T; or
  - ✓ Permanent teeth 2, 3, 4, 5, 12, 13, 14, 15, 18, 19, 20, 21, 28, 29, 30, and 31.
- Once per tooth in a two-year period.

Crowns

The Agency covers stainless steel crowns every two years for the same tooth and only for primary molars and permanent premolars and permanent molars for clients through age 20. Documentation supporting the medical necessity of the service must be in the client's record.

Periodontic Services

Surgical Periodontal Services

The Agency covers:

- 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).

- Gingivectomy/gingivoplasty with periodontal scaling and root planing or periodontal maintenance when the services are performed:

  ✓ In a hospital or ambulatory surgical center; or
  ✓ For clients under conscious sedation, deep sedation, or general anesthesia.

Nonsurgical Periodontal Services

The Agency covers:

- Periodontal maintenance up to 3 times in a 12-month period; and

- Periodontal scaling and root planing, up to two times per quadrant in a 12-month period.

Note: If a periodontal maintenance or oral prophylaxis occurs in a 12-month period, it replaces an allowed periodontal scaling and root planing (four quadrants).

Note: A maximum of three procedures of any combination of prophylaxis, periodontal scaling and root planing, or periodontal maintenance are allowed in a 12-month period.

Adjunctive General Services

The Agency covers:

- 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.

- Sedation services according to “What adjunctive general services are covered?”

Non-emergency Dental Services

> **Note:** A maximum of three procedures of any combination of prophylaxis, periodontal scaling and root planing, or periodontal maintenance are allowed in a 12-month period.

Documentation supporting the medical necessity of the service must be included in the client's record.

Miscellaneous Services-Behavior Management

The Agency covers behavior management provided in dental offices, dental clinics, or alternative living facilities for clients of any age. Documentation supporting the medical necessity of the service must be included in the client's record.

Authorization

Prior authorization (PA) and expedited prior authorization (EPA) numbers do not override the client's eligibility or program limitations. Not all categories of eligibility receive all services.

General Information about Authorization

[Refer to WAC 182-535-1220 (1) and (5)]

- For clients through age 20, the Agency uses the determination process for payment described in WAC 182-501-0165 for covered dental-related services that require PA.
- When the Agency authorizes a dental-related service for a client, that authorization indicates only that the specific service is medically necessary; it is not a guarantee of payment.
- The authorization is valid for six months and only if the client is eligible for covered services on the date of service.

When Do I Need To Get PA?

Authorization must take place ***before*** the service is provided.

In an acute emergency, the Agency *may* authorize the service after it is provided when the Agency receives justification of medical necessity. This justification must be received by the Agency within seven business days of the emergency service.

When Does the Agency Deny a PA Request? [Refer to WAC 182-535-1220 (6)]

The Agency denies a request for a dental-related service when the requested service:

- Is covered by another Agency program;
- Is covered by an agency or other entity outside the Agency; or
- Fails to meet the program criteria, limitations, or restrictions in these billing instructions.

How Do I Obtain Written PA? [Refer to WAC 182-535-1220 (2)-(4)]

The Agency requires a dental provider who is requesting PA to submit sufficient, objective, clinical information to establish medical necessity.

Providers must submit the request in writing on a completed General Information for Authorization form, 13-835. See the Agency *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for more information.

The Agency may request additional information as follows:

- Additional radiographs (x-rays). The Agency returns radiographs only for approved requests and if accompanied by self-addressed stamped envelope;
- Study model, if requested;
- Photographs; and
- Any other information requested by the Agency.

Note: The Agency may require second opinions and/or consultations before authorizing any procedure.

Removable Dental Prosthetics

For nursing facility clients, the PA request must also include a completed copy of the Denture/Partial Appliance Request for Skilled Nursing Facility Client form, 13-788.

Note: For information on obtaining Agency forms, refer to the Important Contacts section.

Where Do I Send Requests for PA?

Without Radiographs or Photos

For procedures that do not require radiographs, fax the PA request to the Agency at: 1-866-668-1214.

With Radiographs or Photos

In order for the scanning & optical character recognition (OCR) functions to work you ***must*** pick one of following options for submitting radiographs or photos to the Agency:

- Use the FastLook™ and FastAttach™ services provided by National Electronic Attachment, Inc. (NEA). You may register with NEA by visiting www.nea-fast.com and entering "FastWDSHS" in the blue promotion code box. Contact NEA at 1-800-782-5150, ext. 2, with any questions.

  When this option is chosen, you can fax your request to the Agency and indicate the NEA# in the NEA field on the PA Request Form. *There is a cost associated which will be explained by the NEA services.*

- Submit digital images via e-mail to DESDASO@dshs.wa.govwith your PA request form and any other required documentation. The reference number will be available after your fax is received, scanned by the Agency, and the reference number is generated. You may obtain your reference number by calling 1-800-562-3022 and using the IVR function.

- Continue to mail your request to:

  Authorization Services Office
  P.O. Box 45535
  Olympia, WA 98504-5535

  If You Choose to Mail Your Requests, the Agency requires you to:

  - Place x-rays in an 8x11 sealed envelope.
  - Place your provider ID & the ProviderOne Client ID on the outside of the envelope. For items too big for an envelope, such as models, use a box and place your provider ID on the outside.
  - Place the envelope and the PA request form (or cover sheet if submitting information for an already existing PA#) into a larger envelope.
  - Mail to the Agency.

Note: Please see the Agency *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for more information on requesting authorization.

Billing and Claim Forms

What Are the General Billing Requirements?

Providers must follow the Agency *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments;
- What fee to bill the Agency for eligible clients;
- When providers may bill a client;
- How to bill for services provided to primary care case management (PCCM) clients; and
- Record keeping requirements.

Hospital Billing

The Agency covers medically necessary dental-related services provided to an eligible client in a hospital-based dental clinic when the services:

- Are provided in accordance with Chapter 182-535 WAC; and
- Are billed on a 2006 ADA or CMS-1500 Claim Form or appropriate electronic transaction.

The Agency pays a hospital for covered dental-related services, including oral and maxillofacial surgeries, that are provided in the hospital's operating room when:

- The covered dental-related services are medically necessary and provided in accordance with Chapter 182-535 WAC;
- The covered dental-related services are billed on a UB-04 claim form; and
- At least one of the following is true:
  - ✓ The dental-related service(s) is provided to an eligible medical assistance client on an emergency basis;
  - ✓ The client is eligible under the DDD program;
  - ✓ The client is age eight or younger; or
  - ✓ The dental service is prior authorized by the Agency.

How Do I Bill for Clients Eligible for Both Medicare and Medicaid?

Medicare currently does not cover ***dental procedures***. **Surgical** CPT procedure codes 10000-69999 must be billed to Medicare first. After receiving Medicare's determination, submit a claim to the Agency. Attach a copy of the Medicare determination.

Third-Party Liability

For dental services you may elect to bill the Agency directly and the Agency will recoup from the third party. If you know the third party carrier, you may choose to bill them directly. The client may not be billed for copays.

For all medical claims, refer to the Agency *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html.

Notifying Clients of their Rights (Advance Directives)

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

Fee Schedules

- You may access the Agency's Dental Fee Schedule at: http://hrsa.dshs.wa.gov/RBRVS/Index.html.

- To access the Agency's Oral Surgery Fee Schedule:

  ✓ **Procedure codes** may be found in the Dental Fee Schedule at the above address.
  ✓ **Maximum allowable fees** may be found in the Physician-Related Services Fee Schedule at the above address.

Note: Bill the Agency your usual and customary charge.

Completing the ADA Claim Form

Note: Refer to the Agency *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for general instructions on completing the ADA Claim Form.