RULE-MAKING ORDER
PERMANENT RULE ONLY

CR-103P (December 2017)
(Implements RCW 34.05.360)

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STATE OF WASHINGTON
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DATE: April 15, 2019
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WSR 19-09-058

Agency: Health Care Authority

Effective date of rule:

Permanent Rules

☐ 31 days after filing.

☒ Other (specify) July 1, 2019 **(If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)**

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?

☐ Yes ☐ No If Yes, explain:

Purpose: The agency revised these rules to comply with legislation in Substitute Senate Bill 5883 for providing dental services through managed care, adding coverage for teledentistry, and revising limitations on visual oral assessments.

Citation of rules affected by this order:

New:
Repealed:
Amended: 182-535-1050, 182-535-1060, 182-535-1080, 182-535-1082, 182-535-1084, 182-535-1098, 182-535-1245, 182-535A-0010, 182-535A-0020, 182-500-0070
Suspended:

Statutory authority for adoption: RCW 41.05.021, 41.05.160, SSB 5883, Laws of 2017, Chapter 1, Sec. 213 (1)(c)

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 19-06-044 on March 4, 2019 (date).

Describe any changes other than editing from proposed to adopted version:

Proposed/Adopted	WAC Subsection	Reason
Original WAC # 182-535-1082 (Covered—Preventive services.)		
Proposed	(5) **Tobacco/nicotine cessation counseling for the control and prevention of oral disease.** The agency covers tobacco/nicotine cessation counseling ~~for pregnant women only~~. See WAC 182-531-1720.	The agency proposed to remove "for pregnancy women only" but is keeping the original language at this time.
Adopted	(5) **Tobacco/nicotine cessation counseling for the control and prevention of oral disease.** The agency covers tobacco/nicotine cessation counseling for pregnant women only. See WAC 182-531-1720.	

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name:
Address:
Phone:
Fax:
TTY:

Email:
Web site:
Other:

Note: If any category is left blank, it will be calculated as zero. No descriptive text.

Count by whole WAC sections only, from the WAC number through the history note. A section may be counted in more than one category.

The number of sections adopted in order to comply with:

	New	Amended	Repealed
Federal statute:			
Federal rules or standards:			
Recently enacted state statutes:			

The number of sections adopted at the request of a nongovernmental entity:

New	Amended	Repealed

The number of sections adopted on the agency's own initiative:

New	Amended	Repealed

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

New	Amended	Repealed
	10	

The number of sections adopted using:

	New	Amended	Repealed
Negotiated rule making:			
Pilot rule making:			
Other alternative rule making:		10	

Date Adopted: April 15, 2019

Name: Wendy Barcus

Title: HCA Rules Coordinator

Signature:

AMENDATORY SECTION (Amending WSR 17-11-136, filed 5/24/17, effective 7/1/17)

WAC 182-500-0070 ((~~Medical assistance~~)) Definitions—M. "Managed care organization (MCO)" see WAC 182-538-050.

"Medicaid" means the federal medical aid program under Title XIX of the Social Security Act that provides health care to eligible people.

"Medicaid agency" means the state agency that administers the medicaid program. The Washington state health care authority (HCA) is the state's medicaid agency.

"Medicaid transformation project" refers to the demonstration granted to the state by the federal government under section 1115 of the Social Security Act. Under this demonstration, the federal government allows the state to engage in a five-year demonstration to support health care systems, to implement reform, and to provide new targeted medicaid services to eligible clients with significant needs.

"Medical assistance" is the term the agency and its predecessors use to mean all federal or state-funded health care programs, or both, administered by the agency or its designees. Medical assistance programs are referred to as Washington apple health.

"Medical care services (MCS)" means the limited scope health care program financed by state funds for clients who are eligible for the aged, blind, or disabled (ABD) cash assistance (see WAC 388-400-0060) or the housing and essential needs (HEN) referral program (see WAC 388-400-0065) and not eligible for other full-scope programs due to their citizenship or immigration status.

"Medical consultant" means a physician employed by or contracted with the agency or the agency's designee.

"Medical facility" means a medical institution or clinic that provides health care services.

"Medical institution" See "institution" in WAC 182-500-0050.

"Medical services card" or **"services card"** means the card the agency issues at the initial approval of a person's Washington apple health benefit. The card identifies the person's name and medical services identification number but is not proof of eligibility. The card may be replaced upon request if it is lost or stolen, but is not required to access health care through Washington apple health.

"Medically necessary" is a term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purposes of this section, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all.

"Medically needy (MN)" or **"medically needy program (MNP)"** means the state and federally funded health care program available to specific groups of people who would be eligible as categorically needy (CN), except their monthly income is above the CN standard. Some long-term care clients with income or resources above the CN standard may also qualify for MN.

"Medically needy income level (MNIL)" means the standard the agency uses to determine eligibility under the medically needy program. See WAC 182-519-0050.

"Medicare" is the federal government health insurance program under Titles II and XVIII of the Social Security Act. For additional information, see www.Medicare.gov.

"Medicare assignment" means the process by which a provider agrees to provide services to a medicare beneficiary and accept medicare's payment for the services.

"Medicare cost-sharing" means out-of-pocket medical expenses related to services provided by medicare. For clients enrolled in medicare, cost-sharing may include Part A and Part B premiums, co-insurance, deductibles, and copayments for medicare services. See chapter 182-517 WAC.

"Minimum essential coverage" means coverage under 26 U.S.C. Sec. 5000A(f).

"Modified adjusted gross income (MAGI)" means the adjusted gross income as determined by the Internal Revenue Service under the Internal Revenue Code of 1986 (IRC) increased by:

((~~(1)~~)) (a) Any amount excluded from gross income under 26 U.S.C. Sec. 911;

((~~(2)~~)) (b) Any amount of interest received or accrued by the client during the taxable year which is exempt from tax; and

((~~(3)~~)) (c) Any amount of Title II Social Security income or Tier 1 railroad retirement benefits excluded from gross income under 26 U.S.C. Sec. 86. See chapter 182-509 WAC for additional rules regarding MAGI.

AMENDATORY SECTION (Amending WSR 17-20-097, filed 10/3/17, effective 11/3/17)

WAC 182-535-1050 ((~~Dental-related services~~))Definitions. The following definitions and abbreviations and those found in chapter 182-500 WAC apply to this chapter. The medicaid agency also uses dental definitions found in the American Dental Association's Current Dental Terminology (CDT) and the American Medical Association's Physician's Current Procedural Terminology (CPT). Where there is any discrepancy between the CDT or CPT and this section, this section prevails. (CPT is a trademark of the American Medical Association.)

"Access to baby and child dentistry (ABCD)" is a program to increase access to dental services for medicaid eligible infants, toddlers, and preschoolers through age five. See WAC 182-535-1245 for specific information.

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

"American Dental Association (ADA)" is a national organization for dental professionals and dental societies.

"Anterior" refers to teeth (maxillary and mandibular incisors and canines) and tissue in the front of the mouth. Permanent maxillary anterior teeth include teeth six, seven, eight, nine, ten, and eleven. Permanent mandibular anterior teeth include teeth twenty-two, twenty-three, twenty-four, twenty-five, twenty-six, and twenty-seven. Primary maxillary anterior teeth include teeth C, D, E, F, G, and H. Primary mandibular anterior teeth include teeth M, N, O, P, Q, and R.

"Asynchronous" means two or more events not happening at the same time.

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

"By-report" means a method of reimbursement in which the department determines the amount it will pay for a service when the rate for that service is not included in the agency's published fee schedules. Upon request the provider must submit a "report" that describes the nature, extent, time, effort and/or equipment necessary to deliver the service.

"Caries" means carious lesions or tooth decay through the enamel or decay on the root surface.

- **"Incipient caries"** means the beginning stages of caries or decay, or subsurface demineralization.
- **"Rampant caries"** means a sudden onset of widespread caries that affects most of the teeth and penetrates quickly to the dental pulp.

"Comprehensive oral evaluation" means a thorough evaluation and documentation of a client's dental and medical history to include extra-oral and intra-oral hard and soft tissues, dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, and oral cancer screening.

"Conscious sedation" means a drug-induced depression of consciousness during which a client responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, spontaneous ventilation is adequate, and cardiovascular function is maintained.

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

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

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

"Current dental terminology (CDT)" means a systematic listing of descriptive terms and identifying codes for reporting dental services and procedures performed by dental practitioners. CDT is published by the Council on Dental Benefit Programs of the American Dental Association (ADA).

"Current procedural terminology (CPT)" means a systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians and other practitioners who provide physician-related services. CPT is copyrighted and published annually by the American Medical Association (AMA).

"Decay" means a term for caries or carious lesions and means decomposition of tooth structure.

"Deep sedation" means a drug-induced depression of consciousness during which a client cannot be easily aroused, ventilatory function may be impaired, but the client responds to repeated or painful stimulation.

"Dental general anesthesia" see **"general anesthesia."**

"Dentures" means an artificial replacement for natural teeth and adjacent tissues, and includes complete dentures, immediate dentures, overdentures, and partial dentures.

"Denturist" means a person licensed under chapter 18.30 RCW to make, construct, alter, reproduce, or repair a denture.

"Distant site (location of dental provider)" means the physical location of the dentist or authorized dental provider providing the dental service to a client through teledentistry.

"Edentulous" means lacking teeth.

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

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

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

"Flowable composite" means a diluted low-viscosity-filled resin-based composite dental restorative material that is used in cervical restorations and small, low stress bearing occlusal restorations.

"Fluoride varnish, rinse, foam or gel" means a substance containing dental fluoride which is applied to teeth, not including silver diamine fluoride.

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

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

"Limited oral evaluation" means an evaluation limited to a specific oral health condition or problem. Typically a client receiving

this type of evaluation has a dental emergency, such as trauma or acute infection.

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

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

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

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

"Originating site (location of client)" means the physical location of the medicaid client as it relates to teledentistry.

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

"Periodic oral evaluation" means an evaluation performed on a patient of record to determine any changes in the client's dental or medical status since a previous comprehensive or periodic evaluation.

"Periodontal maintenance" means a procedure performed for clients who have previously been treated for periodontal disease with surgical or nonsurgical treatment. It includes the removal of supragingival and subgingival microorganisms, calculus, and deposits with hand and mechanical instrumentation, an evaluation of periodontal conditions, and a complete periodontal charting as appropriate.

"Periodontal scaling and root planing" means a procedure to remove plaque, calculus, microorganisms, and rough cementum and dentin from tooth surfaces. This includes hand and mechanical instrumentation, an evaluation of periodontal conditions, and a complete periodontal charting as appropriate.

"Posterior" means the teeth (maxillary and mandibular premolars and molars) and tissue towards the back of the mouth. Permanent maxillary posterior teeth include teeth one, two, three, four, five, twelve, thirteen, fourteen, fifteen, and sixteen. Permanent mandibular posterior teeth include teeth seventeen, eighteen, nineteen, twenty, twenty-one, twenty-eight, twenty-nine, thirty, thirty-one, and thirty-two. Primary maxillary posterior teeth include teeth A, B, I, and J. Primary mandibular posterior teeth include teeth K, L, S, and T.

"Prepaid ambulatory health plan (PAHP)" see WAC 182-538-050. For the purpose of this chapter, dental managed care contractors are considered PAHPs.

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

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

"Radiograph (X-ray)" means an image or picture produced on a radiation sensitive film emulsion or digital sensor by exposure to ionizing radiation.

"Reline" means to resurface the tissue side of a denture with new base material or soft tissue conditioner in order to achieve a more accurate fit.

"Root canal" means the chamber within the root of the tooth that contains the pulp.

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

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

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

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

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

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

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

"Synchronous" means existing or occurring at the same time.

"Teledentistry" means the variety of technologies and tactics used to deliver HIPAA-compliant, interactive, real-time audio and video telecommunications (including web-based applications) or store-and-forward technology to deliver covered services within the dental care provider's scope of practice to a client at a site other than the site where the provider is located.

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

"Therapeutic pulpotomy" means the surgical removal of a portion of the pulp (inner soft tissue of a tooth), to retain the healthy remaining pulp.

"Usual and customary" means the fee that the provider usually charges nonmedicaid customers for the same service or item. This is the maximum amount that the provider may bill the agency.

AMENDATORY SECTION (Amending WSR 17-20-097, filed 10/3/17, effective 11/3/17)

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

(2) ((~~Managed care clients are eligible under apple health fee-for-service for covered dental-related services not covered by their managed care organization (MCO), subject to the provisions of this chapter and other applicable agency rules.~~

~~(3)~~)) Clients whose benefit package includes dental services are assigned a dental managed care plan. If a client is not eligible for a dental managed care plan, they receive services on a fee-for-service basis.

(3) Clients enrolled in an agency-contracted managed care organization (MCO) or prepaid ambulatory health plan (PAHP) must receive their dental services through that MCO or PAHP, except as described under WAC 182-538-095.

(a) All clients are eligible for dental managed care benefits with the exception of clients receiving apple health benefits under a state-only program.

(b) Clients eligible for dental managed care on a voluntary basis include:

(i) American Indian/Alaska native (AI/AN) clients; and

(ii) Clients who reside in a county that has only one MCO or PAHP.

(c) See WAC 182-538-060 for more details regarding managed care choice and assignment.

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

((~~(4)~~)) (5) Exception to rule procedures as described in WAC 182-501-0160 are not available for services that are excluded from a client's benefit package.

AMENDATORY SECTION (Amending WSR 16-18-033, filed 8/26/16, effective 9/26/16)

WAC 182-535-1080 ((~~Dental-related services~~))Covered—Diagnostic. Clients described in WAC 182-535-1060 are eligible to receive the dental-related diagnostic services listed in this section, subject to coverage limitations, restrictions, and client age requirements identified for a specific service.

(1) **Clinical oral evaluations.** The medicaid agency covers the following oral health evaluations and assessments, per client, per provider or clinic:

(a) Periodic oral evaluations as defined in WAC 182-535-1050, once every six months. Six months must elapse between the comprehensive oral evaluation and the first periodic oral evaluation.

(b) Limited oral evaluations as defined in WAC 182-535-1050, only when the provider performing the limited oral evaluation is not providing routine scheduled dental services for the client on the same day. The limited oral evaluation:

(i) Must be to evaluate the client for a:

(A) Specific dental problem or oral health complaint;

(B) Dental emergency; or

(C) Referral for other treatment.

(ii) When performed by a denturist, is limited to the initial examination appointment. The agency does not cover any additional limited examination by a denturist for the same client until three months after a removable prosthesis has been delivered.

(c) Comprehensive oral evaluations as defined in WAC 182-535-1050, once per client, per provider or clinic, as an initial examination. The agency covers an additional comprehensive oral evaluation if the client has not been treated by the same provider or clinic within the past five years.

(d) Limited visual oral assessments as defined in WAC 182-535-1050, ((~~once every six months~~)) two times per client, per provider in a twelve-month period only when the assessment is:

(i) Not performed in conjunction with other clinical oral evaluation services; and

(ii) Performed by a licensed dentist or dental hygienist to determine the need for sealants or fluoride treatment or when triage services are provided in settings other than dental offices or clinics.

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

(a) Covers radiographs per client, per provider or clinic, that are of diagnostic quality, dated, and labeled with the client's name. The agency requires:

(i) Original radiographs to be retained by the provider as part of the client's dental record; and

(ii) Duplicate radiographs to be submitted:

(A) With requests for prior authorization; or

(B) When the agency requests copies of dental records.

(b) Uses the prevailing standard of care to determine the need for dental radiographs.

(c) Covers an intraoral complete series once in a three-year period for clients age fourteen and older only if the agency has not paid for a panoramic radiograph for the same client in the same three-year period. The intraoral complete series includes at least fourteen to twenty-two periapical and posterior bitewings. The agency limits reimbursement for all radiographs to a total payment of no more than payment for a complete series.

(d) Covers medically necessary periapical radiographs for diagnosis in conjunction with definitive treatment, such as root canal therapy. Documentation supporting medical necessity must be included in the client's record.

(e) Covers an occlusal intraoral radiograph, per arch, once in a two-year period, for clients age twenty and younger.

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

(g) Covers panoramic radiographs in conjunction with four bitewings, once in a three-year period, only if the agency has not paid for an intraoral complete series for the same client in the same three-year period.

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

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

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

(k) Covers oral and facial photographic images, only on a case-by-case basis and when requested by the agency.

(3) **Tests and examinations.** The agency covers the following for clients who are age twenty and younger:

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

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

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

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

AMENDATORY SECTION (Amending WSR 17-20-097, filed 10/3/17, effective 11/3/17)

WAC 182-535-1082 ((~~Dental-related services —~~))Covered—Preventive services. Clients described in WAC 182-535-1060 are eligible for the dental-related preventive services listed in this section, subject to coverage limitations and client-age requirements identified for a specific service.

(1) **Prophylaxis.** The medicaid agency covers prophylaxis as follows. Prophylaxis:

(a) Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains when performed on primary or permanent dentition.

(b) Is limited to once every:

(i) Six months for clients age eighteen and younger;

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, for clients who reside in alternate living facilities or nursing facilities, every two times within a twelve-month period with a minimum of one hundred seventy days between applications.

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

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

(3) **Silver diamine fluoride.**

(a) The agency covers silver diamine fluoride as follows:

(i) When used for stopping the progression of caries or as a topical preventive agent;

(ii) Allowed two times per client per tooth in a twelve-month period; and

(iii) Cannot be billed with interim therapeutic restoration on the same tooth when arresting caries or as a preventive agent.

(b) The dental provider or office must have a signed informed consent form on file for each client receiving a silver diamine fluoride application. The form must include the following:

(i) Benefits and risks of silver diamine fluoride application;

(ii) Alternatives to silver diamine fluoride application; and

(iii) A color photograph example that demonstrates the post-procedure blackening of a tooth with silver diamine fluoride application.

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

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

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

(c) Only when provided by a licensed dentist or a licensed dental hygienist and the instruction is provided in a setting other than a dental office or clinic.

((~~(4)~~)) (5) **Tobacco/nicotine cessation counseling for the control and prevention of oral disease.** The agency covers tobacco/nicotine cessation counseling for pregnant women only. See WAC 182-531-1720.

((~~(5)~~)) (6) **Sealants.** The agency covers:

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

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

(c) Sealants once per tooth:

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

(ii) In a two-year period for clients any age of the developmental disabilities administration of DSHS according to WAC 182-535-1099.

(d) Sealants only when used on the occlusal surfaces of:

(i) Permanent teeth two, three, fourteen, fifteen, eighteen, nineteen, thirty, and thirty-one; and

(ii) Primary teeth A, B, I, J, K, L, S, and T.

(e) Sealants on noncarious teeth or teeth with incipient caries.

(f) Sealants only when placed on a tooth with no preexisting occlusal restoration, or any occlusal restoration placed on the same day.

(g) Sealants are included in the agency's payment for occlusal restoration placed on the same day.

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

((~~(6)~~)) (7) **Space maintenance.** The agency covers:

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

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

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

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

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

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

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

AMENDATORY SECTION (Amending WSR 18-12-033, filed 5/29/18, effective 7/1/18)

WAC 182-535-1084 Dental-related services—Covered—Restorative services. Clients described in WAC 182-535-1060 are eligible for the dental-related restorative services listed in this section, subject to coverage limitations, restrictions, and client age requirements identified for a specific service.

(1) **Amalgam and resin restorations for primary and permanent teeth.** The medicaid agency considers:

(a) Tooth preparation, acid etching, all adhesives (including bonding agents), liners and bases, indirect and direct pulp capping, polishing, and curing as part of the restoration.

(b) Occlusal adjustment of either the restored tooth or the opposing tooth or teeth as part of the restoration.

(c) Restorations placed within six months of a crown preparation by the same provider or clinic to be included in the payment for the crown.

(2) **Limitations for all restorations.** The agency:

(a) Considers multiple restoration involving the proximal and occlusal surfaces of the same tooth as a multisurface restoration, and limits reimbursement to a single multisurface restoration.

(b) Considers multiple restorative resins, flowable composite resins, or resin-based composites for the occlusal, buccal, lingual, mesial, and distal fissures and grooves on the same tooth as a one-surface restoration.

(c) Considers multiple restorations of fissures and grooves of the occlusal surface of the same tooth as a one-surface restoration.

(d) Considers resin-based composite restorations of teeth where the decay does not penetrate the dentinoenamel junction (DEJ) to be sealants. (See WAC 182-535-1082 for sealant coverage.)

(e) Reimburses proximal restorations that do not involve the incisal angle on anterior teeth as a two-surface restoration.

(f) Covers only one buccal and one lingual surface per tooth. The agency reimburses buccal or lingual restorations, regardless of size or extension, as a one-surface restoration.

(g) Does not cover preventive restorative resin or flowable composite resin on the interproximal surfaces (mesial or distal) when performed on posterior teeth or the incisal surface of anterior teeth.

(h) Does not pay for replacement restorations within a two-year period unless the restoration is cracked or broken or has an additional adjoining carious surface. The agency pays for the replacement restoration as one multisurface restoration. The client's record must include X rays or documentation supporting the medical necessity for the replacement restoration.

(3) **Additional limitations for restorations on primary teeth.** The agency covers:

(a) A maximum of two surfaces for a primary first molar. (See subsection (6) of this section for a primary first molar that requires a restoration with three or more surfaces.) The agency does not pay for additional restorations on the same tooth.

(b) A maximum of three surfaces for a primary second molar. (See subsection (6) of this section for a primary posterior tooth that requires a restoration with four or more surfaces.) The agency does not pay for additional restorations on the same tooth.

(c) A maximum of three surfaces for a primary anterior tooth. (See subsection (6) of this section for a primary anterior tooth that requires a restoration with four or more surfaces.) The agency does not pay for additional restorations on the same tooth after three surfaces.

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

(a) Two occlusal restorations for the upper molars on teeth one, two, three, fourteen, fifteen, and sixteen if, the restorations are anatomically separated by sound tooth structure.

(b) A maximum of five surfaces per tooth for permanent posterior teeth, except for upper molars. The agency allows a maximum of six surfaces per tooth for teeth one, two, three, fourteen, fifteen, and sixteen.

(c) A maximum of six surfaces per tooth for resin-based composite restorations for permanent anterior teeth.

(5) **Crowns.** The agency:

(a) Covers the following indirect crowns once every five years, per tooth, for permanent anterior teeth for clients age fifteen through twenty when the crowns meet prior authorization criteria in WAC 182-535-1220 and the provider follows the prior authorization requirements in (c) of this subsection:

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

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

(b) Considers the following to be included in the payment for a crown:

(i) Tooth and soft tissue preparation;

(ii) Amalgam and resin-based composite restoration, or any other restorative material placed within six months of the crown preparation. Exception: The agency covers a one-surface restoration on an endodontically treated tooth, or a core buildup or cast post and core;

(iii) Temporaries, including but not limited to, temporary restoration, temporary crown, provisional crown, temporary prefabricated stainless steel crown, ion crown, or acrylic crown;

(iv) Packing cord placement and removal;

(v) Diagnostic or final impressions;

(vi) Crown seating (placement), including cementing and insulating bases;

(vii) Occlusal adjustment of crown or opposing tooth or teeth; and

(viii) Local anesthesia.

(c) Requires the provider to submit the following with each prior authorization request:

(i) Radiographs to assess all remaining teeth;

(ii) Documentation and identification of all missing teeth;

(iii) Caries diagnosis and treatment plan for all remaining teeth, including a caries control plan for clients with rampant caries;

(iv) Pre- and post-endodontic treatment radiographs for requests on endodontically treated teeth; and

(v) Documentation supporting a five-year prognosis that the client will retain the tooth or crown if the tooth is crowned.

(d) Requires a provider to bill for a crown only after delivery and seating of the crown, not at the impression date.

(6) **Other restorative services.** The agency covers the following restorative services:

(a) All recementations of permanent indirect crowns.

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

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

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

(c) Prefabricated stainless steel crowns, including stainless steel crowns with resin window, resin-based composite crowns (direct), prefabricated esthetic coated stainless steel crowns, and prefabricated resin crowns, for primary posterior teeth once every three years without prior authorization if:

(i) Decay involves three or more surfaces for a primary first molar;

(ii) Decay involves four or more surfaces for a primary second molar; or

(iii) The tooth had a pulpotomy.

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

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

(f) Core buildup, including pins, only on permanent teeth, only for clients age twenty and younger, and only allowed in conjunction with crowns and when prior authorized. For indirect crowns, prior authorization must be obtained from the agency at the same time as the

crown. Providers must submit pre- and post-endodontic treatment radiographs to the agency with the authorization request for endodontically treated teeth.

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

((~~(7)~~ **~~Silver diamine fluoride~~.** ~~The agency covers silver diamine fluoride, as follows:~~

~~(a) Allowed only when used:~~

~~(i) For stopping the progression of caries; or~~

~~(ii) As a topical preventive agent.~~

~~(b) Allowed two times per client, per tooth, in a twelve-month period.~~

~~(c) Cannot be billed with interim therapeutic restoration on the same tooth when arresting caries or as a preventive agent.~~))

AMENDATORY SECTION (Amending WSR 17-20-097, filed 10/3/17, effective 11/3/17)

WAC 182-535-1098 ((~~Dental-related services—~~))Covered—Adjunctive general services. Clients described in WAC 182-535-1060 are eligible to receive the adjunctive general services listed in this section, subject to coverage limitations, restrictions, and client-age requirements identified for a specific service.

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

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

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

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

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

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

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

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

(ii) For clients age nine through twenty on a case-by-case basis and when prior authorized, except for oral surgery services. For oral surgery services listed in WAC 182-535-1094 (1)(f) through (m) and clients with cleft palate diagnoses, deep sedation/general anesthesia services do not require prior authorization.

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

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

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

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

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

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

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

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

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

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

(e) Covers office-based nonintravenous conscious sedation:

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

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

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

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

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

(i) Requires providers of oral or parenteral conscious sedation, deep sedation, or general anesthesia to meet:

(i) The prevailing standard of care;

(ii) The provider's professional organizational guidelines;

(iii) The requirements in chapter 246-817 WAC; and

(iv) Relevant department of health (DOH) medical, dental, or nursing anesthesia regulations.

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

(k) Covers professional consultation/diagnostic services as follows:

(i) A dentist or a physician other than the practitioner providing treatment must provide the services; and

(ii) A client must be referred by the agency for the services to be covered.

(2) **Professional visits.** The agency covers:

(a) Up to two house/extended care facility calls (visits) per facility, per provider. The agency limits payment to two facilities per day, per provider.

(b) One hospital visit, including emergency care, per day, per provider, per client, and not in combination with a surgical code unless the decision for surgery is a result of the visit.

(c) Emergency office visits after regularly scheduled hours. The agency limits payment to one emergency visit per day, per client, per provider.

(3) **Drugs and medicaments (pharmaceuticals).**

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

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

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

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

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

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

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

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

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

(B) The behavior management technique used; and

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

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

(A) Clients age eight and younger;

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

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

(D) Clients diagnosed with autism;

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

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

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

(B) Offices;

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

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

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

(c) Occlusal guards when medically necessary and prior authorized. (Refer to WAC 182-535-1094(3) for occlusal orthotic device coverage and coverage limitations.) The agency covers:

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

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

(5) **Nonclinical procedures.**

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

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

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

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

(i) Service provided via teledentistry;

(ii) Location of the client;

(iii) Location of the provider; and

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

AMENDATORY SECTION (Amending WSR 17-20-097, filed 10/3/17, effective 11/3/17)

WAC 182-535-1245 Access to baby and child dentistry (ABCD) program. The access to baby and child dentistry (ABCD) program is a program established to increase access to dental services for medicaid-eligible clients ages five and younger.

(1) Client eligibility for the ABCD program is as follows:

(a) Clients must be age five and younger. Once enrolled in the ABCD program, eligible clients are covered until their sixth birthday.

(b) Clients eligible under one of the following medical assistance programs are eligible for the ABCD program:

(i) Categorically needy program (CNP);

(ii) Limited casualty program-medically needy program (LCP-MNP);

(iii) Children's health program; or

(iv) State children's health insurance program (SCHIP).

((~~(c) ABCD program services for eligible clients enrolled in a managed care organization (MCO) plan are paid through the fee-for-service payment system.~~))

(2) Health care providers and community service programs identify and refer eligible clients to the ABCD program. If enrolled, the client and an adult family member may receive:

(a) Oral health education;

(b) "Anticipatory guidance" (expectations of the client and the client's family members, including the importance of keeping appointments); and

(c) Assistance with transportation, interpreter services, and other issues related to dental services.

(3) ((~~The medicaid agency pays enhanced fees only to~~)) Only ABCD-certified dentists and other agency-approved certified providers are paid an enhanced fee for furnishing ABCD program services. ABCD program services include, when appropriate:

(a) Family oral health education. An oral health education visit:

(i) Is limited to one visit per day per family, up to two visits per child in a twelve-month period, per provider or clinic; and

(ii) Must include documentation of all of the following in the client's record:

(A) "Lift the lip" training;

(B) Oral hygiene training;

(C) Risk assessment for early childhood caries;

(D) Dietary counseling;

(E) Discussion of fluoride supplements; and

(F) Documentation in the client's record to record the activities provided and duration of the oral education visit.

(b) Comprehensive oral evaluations as defined in WAC 182-535-1050, once per client, per provider or clinic, as an initial examination. The agency covers an additional comprehensive oral evaluation if the client has not been treated by the same provider or clinic within the past five years;

(c) Periodic oral evaluations as defined in WAC 182-535-1050, once every six months. Six months must elapse between the comprehensive oral evaluation and the first periodic oral evaluation;

(d) Topical application of fluoride varnish;

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

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

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

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

(g) Therapeutic pulpotomy;

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

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

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

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

AMENDATORY SECTION (Amending WSR 17-20-097, filed 10/3/17, effective 11/3/17)

WAC 182-535A-0010 ((~~Orthodontic services~~))Definitions. The following definitions and those found in chapter 182-500 WAC apply to this chapter.

"Adolescent dentition" means teeth that are present after the loss of primary teeth and prior to the cessation of growth that affects orthodontic treatment.

"Appliance placement" means the application of orthodontic attachments to the teeth for the purpose of correcting dentofacial abnormalities.

"Cleft" means an opening or fissure involving the dentition and supporting structures, especially one occurring in utero. These can be:

(a) Cleft lip;

(b) Cleft palate (involving the roof of the mouth); or

(c) Facial clefts (e.g., macrostomia).

"Comprehensive full orthodontic treatment" means utilizing fixed orthodontic appliances for treatment of adolescent dentition leading to the improvement of a client's severe handicapping craniofacial dysfunction and/or dentofacial deformity, including anatomical and functional relationships.

"Craniofacial anomalies" means abnormalities of the head and face, either congenital or acquired, involving disruption of the dentition and supporting structures.

"Craniofacial team" means a cleft palate/maxillofacial team or an American Cleft Palate Association-certified craniofacial team. These teams are responsible for the management (review, evaluation, and approval) of patients with cleft palate craniofacial anomalies to provide integrated management, promote parent-professional partnership, and make appropriate referrals to implement and coordinate treatment plans.

"Crossbite" means an abnormal relationship of a tooth or teeth to the opposing tooth or teeth, in which normal buccolingual or labiolingual relations are reversed.

"Dental dysplasia" means an abnormality in the development of the teeth.

"Ectopic eruption" means a condition in which a tooth erupts in an abnormal position or is fifty percent blocked out of its normal alignment in the dental arch.

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

"Hemifacial microsomia" means a developmental condition involving the first and second brachial arch. This creates an abnormality of the upper and lower jaw, ear, and associated structures (half or part of the face is smaller in size).

"Interceptive orthodontic treatment" means procedures to lessen the severity or future effects of a malformation and to affect or eliminate the cause. Such treatment may occur in the primary or transitional dentition and may include such procedures as the redirection of ectopically erupting teeth, correction of isolated dental crossbite, or recovery of recent minor space loss where overall space is adequate.

"Limited orthodontic treatment" means orthodontic treatment with a limited objective, not involving the entire dentition. It may be directed only at the existing problem, or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive therapy.

"Malocclusion" means improper alignment of biting or chewing surfaces of upper and lower teeth or abnormal relationship of the upper and lower dental arches.

"Maxillofacial" means relating to the jaws and face.

"Occlusion" means the relation of the upper and lower teeth when in functional contact during jaw movement.

"Orthodontics" means treatment involving the use of any appliance, in or out of the mouth, removable or fixed, or any surgical procedure designed to redirect teeth and surrounding tissues.

"Orthodontist" means a dentist who specializes in orthodontics, who is a graduate of a postgraduate program in orthodontics that is accredited by the American Dental Association, and who meets the licensure requirements of the department of health.

"Permanent dentition" means those teeth that succeed the primary teeth and the additional molars that erupt.

"Prepaid ambulatory health plan" or **"PAHP"** see WAC 182-538-050. For the purpose of this chapter, dental managed care contractors are considered PAHPs.

"Primary dentition" means teeth that develop and erupt first in order of time and are normally shed and replaced by permanent teeth.

"Transitional dentition" means the final phase from primary to permanent dentition, in which most primary teeth have been lost or are in the process of exfoliating and the permanent successors are erupting.

AMENDATORY SECTION (Amending WSR 17-20-097, filed 10/3/17, effective 11/3/17)

WAC 182-535A-0020 ((~~Orthodontic treatment and orthodontic services—~~))Client eligibility. (1) Subject to the limitations of this chapter, the medicaid agency covers medically necessary orthodontic treatment and orthodontic-related services for severe handicapping malocclusions, craniofacial anomalies, or cleft lip or palate, for eligible clients through age twenty. Refer to WAC 182-501-0060 to see which Washington apple health programs include orthodontic services in their benefit package.

(2) Clients enrolled in an agency-contracted managed care organization (MCO) or prepaid ambulatory health plan (PAHP) must receive their orthodontic services through that MCO or PAHP, except as described under WAC 182-538-095. Clients whose benefit package includes dental services are assigned a dental managed care plan. If a client is not eligible for a dental managed care plan, they receive services on a fee-for-service basis.

(a) All clients are eligible for dental managed care benefits with the exception of clients receiving apple health benefits under a state-only program.

(b) Clients eligible for dental managed care on a voluntary basis include:

(i) American Indian/Alaska native (AI/AN) clients; and

(ii) Clients who reside in a county that has only one MCO or PAHP.

(c) See WAC 182-538-060 for more details regarding managed care choice and assignment.

(d) If a client receiving orthodontic services through an MCO or PAHP chooses to transfer to another MCO or PAHP or to fee-for-service (FFS) during active orthodontic treatment, the MCO or PAHP that initiated the orthodontic treatment remains responsible for payment until completion of the orthodontic treatment.

(e) If an FFS client transfers to an MCO or PAHP during active orthodontic treatment, the MCO or PAHP assumes payment responsibility until completion of the orthodontic treatment.

(3) Eligible clients may receive the same orthodontic treatment and orthodontic-related services in recognized out-of-state bordering cities on the same basis as if provided in-state. See WAC 182-501-0175.

((~~(3)~~)) (4) Eligible clients may receive the same orthodontic treatment and orthodontic-related services for continued orthodontic treatment when originally rendered by a nonmedicaid or out-of-state provider as follows:

(a) The provider must submit the initial orthodontic case study and treatment plan records with the request for continued treatment.

(b) The agency evaluates the initial orthodontic case study and treatment plan to determine if the client met the agency's orthodontic criteria per WAC 182-535A-0040 (1) through (3).

(c) The agency determines continued treatment duration based on the client's current orthodontic conditions.

(d) The agency does not cover continued treatment if the client's initial condition did not meet the agency's criteria for the initial orthodontic treatment. The agency pays a deband and retainer fee if the client does not meet the initial orthodontic treatment criteria.