RULE-MAKING ORDER
PERMANENT RULE ONLY

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

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: March 30, 2020
TIME: 2:16 PM

WSR 20-08-103

Agency: Health Care Authority

Effective date of rule:

Permanent Rules

☒ 31 days after filing.

☐ Other (specify) _____ **(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 is amending these rules to align with recent dental policy changes for dental services for clients enrolled in an agency-contracted managed care organization (MCO). Beginning in January 2020, these charges became the responsibility of the client's MCO.

Citation of rules affected by this order:

New:
Repealed:
Amended: 182-535-1098; 182-535-1350
Suspended:

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 20-04-088 on February 05, 2020 (date).

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

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:

Federal statute:	New	____	Amended	____	Repealed	____
Federal rules or standards:	New	____	Amended	____	Repealed	____
Recently enacted state statutes:	New	____	Amended	____	Repealed	____

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	New	____	Amended	____	Repealed	____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	New	____	Amended	____	Repealed	____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	New	____	Amended	1	Repealed	____

The number of sections adopted using:

Negotiated rule making:	New	____	Amended	____	Repealed	____
Pilot rule making:	New	____	Amended	____	Repealed	____
Other alternative rule making:	New	____	Amended	1	Repealed	____

Date Adopted: March 30, 2020	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

AMENDATORY SECTION (Amending WSR 19-09-058, filed 4/15/19, effective 7/1/19)

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

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

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

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

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

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

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

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

(i) For all eligible clients age eight and younger and clients any age of the developmental disabilities 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, the agency does not require prior authorization for 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 anal-

gesics. The agency does not cover the time spent writing prescriptions.

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

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

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

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

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

(B) The behavior management technique used; and

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

(ii) Clients, who meet one of the following criteria and whose documented behavior requires the assistance of one additional 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 14-08-032, filed 3/25/14, effective 4/30/14)

WAC 182-535-1350 Payment methodology for dental-related services. The agency uses the description of dental services described in the American Dental Association's Current Dental Terminology (CDT), and the American Medical Association's Physician's Current Procedural Terminology (CPT).

(1) For covered dental-related services provided to eligible clients, the agency pays dentists and other eligible providers on a fee-for-service or contractual basis, subject to the exceptions and restrictions listed under WAC 182-535-1100 and 182-535-1400.

(2) The agency sets maximum allowable fees for dental services as follows:

(a) The agency's historical reimbursement rates for various procedures are compared to usual and customary charges.

(b) The agency consults with representatives of the provider community to identify program areas and concerns that need to be addressed.

(c) The agency consults with dental experts and public health professionals to identify and prioritize dental services and procedures for their effectiveness in improving or promoting dental health.

(d) Legislatively authorized vendor rate increases and/or earmarked appropriations for dental services are allocated to specific procedures based on the priorities identified in (c) of this subsection and considerations of access to services.

(e) Larger percentage increases may be given to those procedures which have been identified as most effective in improving or promoting dental health.

(f) Budget-neutral rate adjustments are made as appropriate based on the agency's evaluation of utilization trends, effectiveness of interventions, and access issues.

(3) The agency pays eligible fee-for-service providers listed in WAC 182-535-1070 for conscious sedation with parenteral and multiple oral agents, or for general anesthesia when the provider meets the criteria in this chapter and other applicable WAC. For clients enrolled in an agency-contracted managed care organization (MCO), the client's MCO pays for dental prescriptions.

(4) Dental hygienists who have a contract with the agency are paid at the same rate as dentists who have a contract with the agency, for services allowed under the Dental Hygienist Practice Act.

(5) Licensed denturists who have a contract with the agency are paid at the same rate as dentists who have a contract with the agency, for providing dentures and partials.

(6) The agency makes fee schedule changes whenever the legislature authorizes vendor rate increases or decreases.

(7) The agency may adjust maximum allowable fees to reflect changes in services or procedure code descriptions.

(8) The agency does not pay separately for chart or record setup, or for completion of reports, forms, or charting. The fees for these services are included in the agency's reimbursement for comprehensive oral evaluations or limited oral evaluations.