RULE-MAKING ORDER
PERMANENT RULE ONLY

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

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DATE: July 01, 2021
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WSR 21-14-055

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: 182-535-1050 Added definitions for alveoloplasty, mobile anesthesiologist, and resin-based composite restorations. Amended definition for comprehensive oral evaluation to "may include periodontal charting" to align with CDT definition. Amended definition of prophylaxis to remove "tooth" and replace with "tooth structures and implants and is intended to control local irritation factors" to align with CDT definition. Removed definition of flowable composite as it is now described in the newly added definition of resin-based composite restorations.

182-535-1080(2)(c) Removed "at least" and replaced with "typically" to make the amount of films necessary for full mouth set of x-rays less restrictive.

182-535-1080(3)(b) Removed subsection. The agency no longer accepts study models.

182-535-1082(1)(a) Removed "primary or permanent dentition" and replace with "tooth structures and implants" to align with CDT definition.

182-535-1082(1)(b)(i)(B) and (1)(c)(i)(B) Added "Of any age" to residing in an alternate living facility or nursing facility to clarify there is no age limits. Restructured subsection to remove redundant language and provide clearer reading.

182-535-1082(2) Restructured subsection to remove redundant language and provide clearer reading. No policy change.

182-535-1082(6)(b) Removed subsection. Glass ionomer cements have improved and are considered a suitable material to be used as sealants.

182-535-1084(1), (2)(b) Added glass ionomer to listed restorations.

182-535-1084(2)(e) Removed subsection. Dental providers use letters to identify tooth surfaces and no longer use the term "incisal angle."

182-535-1084(2)(f) Amended subsection to only say "Does not cover preventative restorations." This amendment reflects the improved properties of current composite materials and no longer require the restrictions.

182-535-1084(2)(g) Amended subsection to allow for coverage of replacement restorations that are cracked or broken, between 6 and 24 months of original placement, with approved prior authorization.

182-535-1084(2)(h) Amended subsection to clarify that replacement of a cracked or broken restoration within a 6-month period by the same provider is considered part of the global payment of the initial restoration and is not paid separately. HCA expects restorations to last a minimum of two years. Providers must guarantee their work, at their cost, for at least 6 months to ensure a quality restoration. Removed last sentence in previous (2)((h) "The agency pays for the replacement restoration as one multisurface restoration." Restorations are commonly paid for as surfaces billed.

182-535-1084(3) Removed subsection titled "Additional limitations for restorations on primary teeth." Surfaces treated are surfaces that can be billed. This removes the limits.

182-535-1084(5)(b)(i) and (ii) Removed subsections and combine into subsection (5)(c).

182-535-1084(5)(c). Revised to include "…for clients ages 0 through 12 and with prior authorization for clients age 13 through 20" for prefabricated stainless steel crowns. Revised (i)-(iv) to include decay information.

182-535-1084(5)(e) Added new subsection "Prefabricated stainless-steel crowns, for permanent posterior teeth, excluding one, 16, 17, and 32 for clients age 21 and older in lieu of a restoration requiring three or more surfaces." Coverage is no longer restricted to clients age 21 and younger.

182-535-1090(1)(b)(iii) Added "restorative" and "in the arch(es) being request" for clarification to specify arch designation for prosthodontics.

182-535-1090(2)(a)(iii) Added "and the replacement is medically necessary. Prior authorization is required for replacement dentures with evidence of medical necessity" to clarify the intent for replacement dentures is that they are medically necessary and not just replaced because a specific time frame has gone by. Remove "the replacement does not require prior authorization."

182-535-1090(3)(a)(i) Removed "free of periodontal disease" and replaced with "periodontally stable" and "periodontal" prognosis. The agency is aware that the expectation is not to cure periodontal disease but rather the periodontal disease is managed in order to provide a stable foundation and the required three-year prognosis for a resin partial denture.
182-535-1090(3)(d) Added that the replacement must be medically necessary. Prior authorization is required for replacement dentures with evidence of medical necessity. The intent for replacement dentures is that they are medically necessary and not just replaced because a specific time frame has gone by.

182-535-1094(2) Revised alveoplasty policy. Removed "prior authorization is not required" language.

182-535-1098(1)(c)(ii) Corrected cross reference - housekeeping

182-535-1099(1)(e) Added cross reference for sealant coverage.

182-535-1099(3)(b)(v) Added "allowed once in a 12-month period" to establish a limitation for full mouth scaling.

182-535-1220(3)(b) Removed "study models" as they are no longer used.

182-535-1220(4) Amended doctor of dental medicine to "medicine in dentistry" for clarification.

182-535-1245(1)(d) Amended "nondental" to "medical" provider to clarify nondental providers are medical providers.

182-535-1245(3)(a)(ii)(F) Amended "and duration of" to "at" for clarification of reading.

182-535-1245(3)(f)(i) Added "glass ionomer" to clarify this is a covered service

Citation of rules affected by this order:
New:
Repealed:
Amended: 182-535-1050, 182-535-1080, 182-535-1082, 182-535-1084, 182-535-1090, 182-535-1094, 182-535-1098, 182-535-1099, 182-535-1220, 182-535-1245
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 21-10-095 on May 5, 2021 (date).
Describe any changes other than editing from proposed to adopted version:

WAC 182-535-1082(5)		
Proposed	((~~**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 is not striking this language.
Adopted		

	Tobacco/nicotine cessation counseling for the control and prevention of oral disease. The agency covers tobacco/nicotine cessation counseling for pregnant people 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:

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 10 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	10	Repealed	____

Date Adopted: July 1, 2021	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

AMENDATORY SECTION (Amending WSR 19-20-047, filed 9/25/19, effective 10/26/19)

WAC 182-535-1050 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.

"Alveoloplasty" means a distinct (separate procedure) from extractions. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery.

"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~~)), (may include periodontal screening and/or 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.

"Mobile anesthesiologist" means a provider qualified to deliver moderate and deep sedation in an office setting other than their own. The mobile anesthesiologist is a separate provider from the clinician delivering dental treatment.

"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.

"Prophylaxis" means the dental procedure of scaling and polishing which includes removal of calculus, plaque, and stains from ((~~teeth~~)) tooth structures and implants and is intended to control local irritation factors.

"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.

"Resin-based composite restorations" means resin-based composite refers to a broad category of materials including, but not limited to, composites. The category may include bonded composite, light-cured composite, etc. Tooth preparation, acid-etching, adhesives (including resin-bonding agents), liners and bases, and curing are included as part of the restoration. Glass ionomers, when used as definitive restorations, should be reported with resin-based composite codes.

"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 19-09-058, filed 4/15/19, effective 7/1/19)

WAC 182-535-1080 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, 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 typically 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)~~)) (a) For diagnosis only during limited oral evaluations; and

((~~(ii)~~)) (b) 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 19-09-058, filed 4/15/19, effective 7/1/19)

WAC 182-535-1082 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~~)) tooth structures and implants.

(b) Is limited to once every:

(i) Six months for clients ((~~age eighteen and younger~~)):

(A) Age eighteen and younger; or

(B) Of any age residing in an alternate living facility or nursing facility;

(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~~)):

(A) Age thirteen through eighteen; or

(B) Of any age residing in an alternate living facility or nursing facility; or

(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 for clients:

(i) Age six and younger;

(ii) During orthodontic treatment.

(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 for clients:

(i) From age seven through eighteen; or

(ii) Of any age residing in alternate living facilities or nursing facilities.

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

((~~(g)~~)) (e) 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.

(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.~~

~~(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)~~)) (c) 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)~~)) (d) Sealants on noncarious teeth or teeth with incipient caries.

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

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

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

((~~(7)~~)) (6) **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 19-09-058, filed 4/15/19, effective 7/1/19)

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, and glass ionomer 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, or glass ionomer restorations 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.~~)) (f) Does not cover preventative restorations.

(g) Covers replacement restorations between six and twenty-four months of original placement, with approved prior authorization, if the restoration is cracked or broken. The client's record must include

X-rays or documentation supporting the medical necessity for the replacement restoration.

(h) Replacement of a cracked or broken restoration within a six-month period by the same provider is considered part of the global payment of the initial restoration and will not pay separately.

(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)~~)) (4) **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)~~)) (5) **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 for clients ages zero through twelve and with prior authorization for clients age thirteen through twenty 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; or

(ii) Evidence of Class II caries with rampant decay; or

(iii) Evidence of extensive caries; or

(iv) Treatment of decay requires sedation or general anesthesia.

(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 permanent posterior teeth, excluding one, sixteen, seventeen, and thirty-two for clients age twenty-one and older in lieu of a restoration requiring three or more surfaces.

(f) 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~~)) in accordance with WAC 182-535-1099.

((~~(f)~~)) (g) 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)~~)) (h) 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.

AMENDATORY SECTION (Amending WSR 18-04-028, filed 1/30/18, effective 3/2/18)

WAC 182-535-1090 Dental-related services—Covered—Prosthodontics (removable). Clients described in WAC 182-535-1060 are eligible to receive the prosthodontics (removable) and related services, subject to the coverage limitations, restrictions, and client-age requirements identified for a specific service.

(1) **Prosthodontics.** The medicaid agency requires prior authorization for removable prosthodontic and prosthodontic-related procedures, except as otherwise noted in this section. Prior authorization requests must meet the criteria in WAC 182-535-1220. In addition, the agency requires the dental provider to submit:

(a) Appropriate and diagnostic radiographs of all remaining teeth.

(b) A dental record which identifies:

(i) All missing teeth for both arches;

(ii) Teeth that are to be extracted; and

(iii) Dental restorative and periodontal services completed on all remaining teeth in the arch(es) being requested.

(2) **Complete dentures.** The agency covers complete dentures, including overdentures, when prior authorized, except as otherwise noted in this section.

The agency considers three-month post-delivery care (e.g., adjustments, soft relines, and repairs) from the delivery (placement) date of the complete denture as part of the complete denture procedure and does not pay separately for this care.

(a) The agency covers complete dentures only as follows:

(i) One initial maxillary complete denture and one initial mandibular complete denture per client.

(ii) Replacement of a partial denture with a complete denture only when the replacement occurs three or more years after the delivery (placement) date of the last resin partial denture.

(iii) One replacement maxillary complete denture and one replacement mandibular complete denture per client, per client's lifetime. The replacement must occur at least five years after the delivery (placement) date of the initial complete denture or overdenture((~~. The replacement does not require prior authorization~~)) and the replacement is medically necessary. Prior authorization is required for all replacement dentures with evidence of medical necessity.

(b) The agency reviews requests for replacement that exceed the limits in this subsection (2) under WAC 182-501-0050(7).

(c) The provider must obtain a current signed Denture Agreement of Acceptance (HCA 13-809) form from the client at the conclusion of the final denture try-in and at the time of delivery for an agency-authorized complete denture. If the client abandons the complete denture after signing the agreement of acceptance, the agency will deny subse-

quent requests for the same type of dental prosthesis if the request occurs prior to the dates specified in this section. A copy of the signed agreement must be kept in the provider's files and be available upon request by the agency. Failure to submit the completed, signed Denture Agreement of Acceptance form when requested may result in recoupment of the agency's payment.

(3) **Resin partial dentures.** The agency covers resin partial dentures only as follows:

(a) For anterior and posterior teeth only when the following criteria are met:

(i) The remaining teeth in the arch must be ((~~free of periodontal disease~~)) periodontally stable and have a reasonable periodontal prognosis.

(ii) The client has established caries control.

(iii) The client has one or more missing anterior teeth or four or more missing posterior teeth (excluding teeth one, two, fifteen, and sixteen) on the upper arch to qualify for a maxillary partial denture. Pontics on an existing fixed bridge do not count as missing teeth. The agency does not consider closed spaces of missing teeth to qualify as a missing tooth.

(iv) The client has one or more missing anterior teeth or four or more missing posterior teeth (excluding teeth seventeen, eighteen, thirty-one, and thirty-two) on the lower arch to qualify for a mandibular partial denture. Pontics on an existing fixed bridge do not count as missing teeth. The agency does not consider closed spaces of missing teeth to qualify as a missing tooth.

(v) There is a minimum of four functional, stable teeth remaining per arch.

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

(b) Prior authorization is required.

(c) The agency considers three-month post-delivery care (e.g., adjustments, soft relines, and repairs) from the delivery (placement) date of the resin partial denture as part of the resin partial denture procedure and does not pay separately for this care.

(d) Replacement of a resin-based partial denture with a new resin partial denture or a complete denture if it occurs at least three years after the delivery (placement) date of the resin-based partial denture((~~. The replacement partial or complete denture must be prior authorized~~)) and is medically necessary. Prior authorization is required for all replacement dentures with evidence of medical necessity and meet agency coverage criteria in (a) of this subsection.

(e) The agency reviews requests for replacement that exceed the limits in this subsection (3) under WAC 182-501-0050(7).

(f) The provider must obtain a signed Partial Denture Agreement of Acceptance (HCA 13-965) form from the client at the time of delivery for an agency-authorized partial denture. A copy of the signed agreement must be kept in the provider's files and be available upon request by the agency. Failure to submit the completed, signed Partial Denture Agreement of Acceptance form when requested may result in recoupment of the agency's payment.

(4) **Provider requirements.**

(a) The agency requires a provider to bill for a removable partial or complete denture only after the delivery of the prosthesis, not at the impression date. Refer to subsection (5)(e) of this section for what the agency may pay if the removable partial or complete denture is not delivered and inserted.

(b) The agency requires a provider to submit the following with a prior authorization request for a removable resin partial or complete denture for a client residing in an alternate living facility or nursing facility:

(i) The client's medical diagnosis or prognosis;

(ii) The attending physician's request for prosthetic services;

(iii) The attending dentist's or denturist's statement documenting medical necessity;

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

(v) A completed copy of the Denture/Partial Appliance Request for Skilled Nursing Facility Client (HCA 13-788) form available from the agency's published billing instructions which can be downloaded from the agency's website.

(c) The agency limits removable partial dentures to resin-based partial dentures for all clients residing in one of the facilities listed in (b) of this subsection.

(d) The agency 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.

(5) **Other services for removable prosthodontics.** The agency covers:

(a) Adjustments to complete and partial dentures three months after the date of delivery.

(b) Repairs:

(i) To complete dentures, once in a twelve-month period, per arch. The cost of repairs cannot exceed the cost of the replacement denture. The agency covers additional repairs on a case-by-case basis and when prior authorized.

(ii) To partial dentures, once in a twelve-month period, per arch. The cost of the repairs cannot exceed the cost of the replacement partial denture. The agency covers additional repairs on a case-by-case basis and when prior authorized.

(c) A laboratory reline or rebase to a complete or partial denture, once in a three-year period when performed at least six months after the delivery (placement) date. The agency does not pay for a denture reline and a rebase in the same three-year period. An additional reline or rebase may be covered for complete or partial dentures on a case-by-case basis when prior authorized.

(d) Laboratory fees, subject to the following:

(i) The agency does not pay separately for laboratory or professional fees for complete and partial dentures; and

(ii) The agency may pay part of billed laboratory fees when the provider obtains prior authorization, and the client:

(A) Is not eligible at the time of delivery of the partial or complete denture;

(B) Moves from the state;

(C) Cannot be located;

(D) Does not participate in completing the partial or complete denture; or

(E) Dies.

(iii) A provider must submit copies of laboratory prescriptions and receipts or invoices for each claim when billing for laboratory fees.

AMENDATORY SECTION (Amending WSR 19-06-003, filed 2/21/19, effective 3/24/19)

WAC 182-535-1094 Dental-related services—Covered—Oral and maxillofacial surgery services. Clients described in WAC 182-535-1060 are eligible to receive the oral and maxillofacial surgery services listed in this section, subject to the coverage limitations, restrictions, and client-age requirements identified for a specific service.

(1) **Oral and maxillofacial surgery services.** The medicaid agency:

(a) Requires enrolled providers who do not meet the conditions in WAC 182-535-1070(3) to bill claims for services that are listed in this subsection using only the current dental terminology (CDT) codes.

(b) Requires enrolled providers (oral and maxillofacial surgeons) who meet the conditions in WAC 182-535-1070(3) to bill claims using current procedural terminology (CPT) codes unless the procedure is specifically listed in the agency's current published billing guide as a CDT covered code (e.g., extractions).

(c) Covers nonemergency oral surgery performed in a hospital or ambulatory surgery center only for:

(i) Clients age eight and younger;

(ii) Clients age nine through twenty. Prior authorization is required for the site of service; and

(iii) Clients any age of the developmental disabilities administration of the department of social and health services (DSHS).

(d) For site-of-service and oral surgery CPT codes that require prior authorization, the agency requires the dental provider to submit current records (within the past twelve months), including:

(i) Documentation used to determine medical appropriateness;

(ii) Cephalometric films;

(iii) Radiographs (X-rays);

(iv) Photographs; and

(v) Written narrative/letter of medical necessity, including proposed billing codes.

(e) Requires the client's dental record to include supporting documentation for each type of extraction or any other surgical procedure billed to the agency. The documentation must include:

(i) Appropriate consent form signed by the client or the client's legal representative;

(ii) Appropriate radiographs;

(iii) Medical justification with diagnosis;

(iv) Client's blood pressure, when appropriate;

(v) A surgical narrative and complete description of each service performed beyond surgical extraction or beyond code definition;

(vi) A copy of the post-operative instructions; and

(vii) A copy of all pre- and post-operative prescriptions.

(f) Covers simple and surgical extractions.

(g) Covers unusual, complicated surgical extractions with prior authorization.

(h) Covers tooth reimplantation/stabilization of accidentally evulsed or displaced teeth.

(i) Covers surgical extraction of unerupted teeth ((~~for clients~~)).

(j) Covers debridement of a granuloma or cyst that is five millimeters or greater in diameter. The agency includes debridement of a

granuloma or cyst that is less than five millimeters as part of the global fee for the extraction.

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

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

(i) Removal of lateral exostosis;

(ii) Removal of torus palatinus or torus mandibularis;

(iii) Surgical reduction of osseous tuberosity.

(2) **Alveoloplasty.** The agency covers alveoloplasty((~~. Prior authorization is not required~~)) only in conjunction with the preparation of dentures or partials. Documentation supporting the medical necessity for the procedure must be maintained in the client's record. Supporting documentation must include current radiographs and medical justification narrative.

(3) **Surgical incisions.** The agency covers the following surgical incision-related services:

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

(b) Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue. Documentation supporting the medical necessity for the service must be in the client's record.

(c) Frenuloplasty/frenulectomy for clients age six and younger, without prior authorization.

(d) Frenuloplasty/frenulectomy for clients age seven through twelve. Prior authorization is required. Photos must be submitted to the agency with the prior authorization request. Documentation supporting the medical necessity for the service must be in the client's record.

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

(4) **Occlusal orthotic devices.** (Refer to WAC 182-535-1098 (4)(c) for occlusal guard coverage and limitations on coverage.) The agency covers:

(a) Occlusal orthotic devices for clients age twelve through twenty. Prior authorization is required.

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

AMENDATORY SECTION (Amending WSR 20-08-103, filed 3/30/20, effective 4/30/20)

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

(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.

(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 17-20-097, filed 10/3/17, effective 11/3/17)

WAC 182-535-1099 Dental-related services for clients of the developmental disabilities administration of the department of social and health services. Subject to coverage limitations and restrictions identified for a specific service, the medicaid agency pays for the additional dental-related services listed in this section that are provided to clients of the developmental disabilities administration of the department of social and health services (DSHS), regardless of age.

(1) **Preventive services.** The agency covers:

(a) Periodic oral evaluations once every four months per client, per provider.

(b) Prophylaxis once every four months.

(c) Periodontal maintenance once every six months (see subsection (3) of this section for limitations on periodontal scaling and root planing).

(d) Topical fluoride varnish, rinse, foam or gel, once every four months, per client, per provider or clinic.

(e) Sealants (see WAC 182-535-1082 for sealant coverage):

(i) Only when used on the occlusal surfaces of:

(A) Primary teeth A, B, I, J, K, L, S, and T; or

(B) Permanent teeth two, three, four, five, twelve, thirteen, fourteen, fifteen, eighteen, nineteen, twenty, twenty-one, twenty-eight, twenty-nine, thirty, and thirty-one.

(ii) Once per tooth in a two-year period.

(2) **Other restorative services.** The agency covers:

(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 two years only for clients age twenty and younger without 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 two years for clients age twenty and younger 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 two years without prior authorization for any age.

(3) **Periodontic services.**

(a) **Surgical periodontal services.** The agency covers:

(i) 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).

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

(A) In a hospital or ambulatory surgical center; or

(B) For clients under conscious sedation, deep sedation, or general anesthesia.

(b) **Nonsurgical periodontal services.** The agency covers:

(i) Periodontal scaling and root planing, one time per quadrant in a twelve-month period.

(ii) Periodontal maintenance (four quadrants) substitutes for an eligible periodontal scaling or root planing, twice in a twelve-month period.

(iii) Periodontal maintenance allowed six months after scaling or root planing.

(iv) Full-mouth or quadrant debridement allowed once in a twelve-month period.

(v) Full-mouth scaling in the presence of generalized moderate or severe gingival inflammation allowed once in a twelve-month period.

(4) **Adjunctive general services.** The agency covers:

(a) 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.

(b) Sedation services according to WAC 182-535-1098 (1)(c) and (e).

(5) **Nonemergency dental services.** The agency covers nonemergency dental services performed in a hospital or an ambulatory surgical center for services listed as covered in WAC 182-535-1082, 182-535-1084, 182-535-1086, 182-535-1088, and 182-535-1094. Documentation supporting the medical necessity of the service must be included in the client's record.

(6) **Miscellaneous services - Behavior management.** The agency covers behavior management according to WAC 182-535-1098.

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

WAC 182-535-1220 Obtaining prior authorization for dental-related services. (1) The medicaid agency uses the determination process for payment described in WAC 182-501-0165 for covered dental-related services that require prior authorization.

(2) The agency requires a dental provider who is requesting prior authorization to submit sufficient, current (within the past twelve months), objective clinical information to establish medical necessity. The request must be submitted in writing on the General Information for Authorization (HCA 13-835) form, available on the agency's website.

(3) The agency may request additional information as follows:

(a) Additional radiographs (X-rays) (refer to WAC 182-535-1080(2));

(b) ((~~Study models;~~

~~(c)~~)) Photographs; and

((~~(d)~~)) (c) Any other information as determined by the agency.

(4) The agency may require second opinions and/or consultations by a licensed independent doctor of dental surgery (DDS)/doctor of ((~~dental medicine~~)) medicine in dentistry (DMD) before authorizing any procedure.

(5) 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 to twelve months as indicated in the agency's authorization letter and only if the client is eligible for covered services on the date of service.

(6) The agency denies a request for a dental-related service when the requested service:

(a) Is covered by another state agency program;

(b) Is covered by an entity outside the agency; or

(c) Fails to meet the program criteria, limitations, or restrictions in this chapter.

AMENDATORY SECTION (Amending WSR 20-04-096, filed 2/5/20, effective 3/7/20)

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 provided by a dental provider for eligible clients who are enrolled in an agency-contracted managed care organization (MCO) are paid through the fee-for-service payment system.

(d) ABCD program services provided by a ((~~nondental~~)) medical provider for eligible clients who are enrolled in an agency-contracted managed care organization (MCO) must be billed directly through the client's MCO.

(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) 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~~)) at 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, or glass ionomer 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.