EXPEDITED RULE MAKING

CR-105 (June 2024)
(Implements RCW 34.05.353)

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DATE: August 18, 2025
TIME: 12:50 PM

WSR 25-17-066

Agency: Health Care Authority

Title of rule and other identifying information: (describe subject)
182-500-0030, Definitions-E. Early periodic screening, diagnosis and treatment (EPSDT);
182-501-0050, Health care general coverage;
182-530-2100, Noncovered – Outpatient drugs and pharmaceutical supplies;
182-531-0100, Scope of coverage for physician-related and health care professional services-General and administrative;
182-531-0150, Noncovered physician-related and health care professional services – General and administrative;
182-531-0250, Who can provide and bill for physician-related services and health care professional services;
182-531-1600, Bariatric surgery;
182-531-1675 Washington apple health – Gender affirming interventions for gender dysphoria;
182-535-1050, Definitions;
182-535-1079, Dental-related services – General;
182-535-1100, Dental-related services – Not covered;
182-535A-0010, Definitions;
182-535A-0040, Orthodontic treatment and orthodontic-related services – Covered, noncovered, and limitations to coverage;
182-538-180, Rights and protections;
182-544-0575, Vision care-Noncovered eyeglasses and contact lenses;
182-552-0450, Mandibular advancement device;
182-554-800, Noncovered – Enteral nutrition products, equipment, and related supplies;
182-556-0200, Chiropractic services for children;
Other related rules as appropriate.

Purpose of the proposal and its anticipated effects, including any changes in existing rules: The Health Care Authority is updating the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) rules across applicable agency programs. The revised language aligns with guidance from the Centers for Medicare & Medicaid (CMS) and will refer to the EPSDT Chapter (182-534 WAC), recently amended under WSR 25-13-048.

Reasons supporting proposal: The revised EPSDT rules in Title 182 WAC will have consistent language, and the agency will only need to update the EPSDT chapter for any subsequent changes to EPSDT program rules.

Statutory authority for adoption: RCW 41.05.021, RCW 41.05.160

Statute being implemented: RCW 41.05.021, RCW 41.05.160

Is rule necessary because of a:

Federal Law?	☐ Yes	☒ No
Federal Court Decision?	☐ Yes	☒ No
State Court Decision?	☐ Yes	☒ No

If yes, CITATION:

Name of proponent: (person or organization) Health Care Authority

☐ Private
☐ Public
☒ Governmental

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting:	Melinda Froud	PO Box 42716, Olympia, WA 98504-2716	360-725-1408
Implementation:	Christine Cole	PO Box 45502, Olympia, WA 98504-5502	360-725-1368
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Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters: None

Expedited Adoption - Which of the following criteria was used by the agency to file this notice:

☐ Relates only to internal governmental operations that are not subject to violation by a person;

☐ Adopts or incorporates by reference without material change federal statutes or regulations, Washington state statutes, rules of other Washington state agencies, shoreline master programs other than those programs governing shorelines of statewide significance, or, as referenced by Washington state law, national consensus codes that generally establish industry standards, if the material adopted or incorporated regulates the same subject matter and conduct as the adopting or incorporating rule;

☒ Corrects typographical errors, make address or name changes, or clarify language of a rule without changing its effect;

☐ Content is explicitly and specifically dictated by statute;

☐ Have been the subject of negotiated rule making, pilot rule making, or some other process that involved substantial participation by interested parties before the development of the proposed rule; or

☐ Is being amended after a review under RCW 34.05.328.

Expedited Repeal - Which of the following criteria was used by the agency to file notice:

☐ The statute on which the rule is based has been repealed and has not been replaced by another statute providing statutory authority for the rule;

☐ The statute on which the rule is based has been declared unconstitutional by a court with jurisdiction, there is a final judgment, and no statute has been enacted to replace the unconstitutional statute;

☐ The rule is no longer necessary because of changed circumstances; or

☐ Other rules of the agency or of another agency govern the same activity as the rule, making the rule redundant.

Explanation of the reason the agency believes the expedited rule-making process is appropriate pursuant to RCW 34.05.353(4): The proposed rules do not change any benefits of, or requirements for, EPSDT services. Instead of including EPSDT rules in multiple sections of Title 182 WAC, HCA has centralized them in Chapter 182-534 WAC, and the proposed rules refer to that chapter.

NOTICE

THIS RULE IS BEING PROPOSED UNDER AN EXPEDITED RULE-MAKING PROCESS THAT WILL ELIMINATE THE NEED FOR THE AGENCY TO HOLD PUBLIC HEARINGS, PREPARE A SMALL BUSINESS ECONOMIC IMPACT STATEMENT, OR PROVIDE RESPONSES TO THE CRITERIA FOR A SIGNIFICANT LEGISLATIVE RULE. IF YOU OBJECT TO THIS USE OF THE EXPEDITED RULE-MAKING PROCESS, YOU MUST EXPRESS YOUR OBJECTIONS IN WRITING AND THEY MUST BE SENT TO

Name: Wendy Barcus, HCA Rules Coordinator

Agency: Health Care Authority

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Other:

BEGINNING (date/time) 8/19/2025 8:00 AM **AND RECEIVED BY** (date/time) 10/20/2025 11:59 PM

Date: August 18, 2025	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

AMENDATORY SECTION (Amending WSR 19-04-095, filed 2/5/19, effective 3/8/19)

WAC 182-500-0030 Definitions—E. "Early ((~~and~~)) periodic screening, diagnosis, and treatment (EPSDT)" is ((~~a comprehensive child health program that entitles infants, children, and youth to preventive care and treatment services. EPSDT is available to people age twenty and younger who are eligible for any agency health care program. Access and services for EPSDT are governed by federal rules at 42 C.F.R., Part 441, Subpart B. See chapter 182-534 WAC~~)) defined under WAC 182-534-0050.

"Early elective delivery" means any nonmedically necessary induction or cesarean section before ((~~thirty-nine~~)) 39 weeks of gestation. Thirty-nine weeks of gestation is greater than ((~~thirty-eight~~)) 38 weeks and six days.

"Electronic signature" means a signature in electronic form attached to or associated with an electronic record including, but not limited to, a digital signature.

"Emergency medical condition" means the sudden onset of a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

(a) Placing the patient's health in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of any bodily organ or part.

"Employer-sponsored dependent coverage" means creditable health coverage for dependents offered by a family member's employer or union, for which the employer or union may contribute in whole or in part towards the premium. Extensions of such coverage (e.g., COBRA extensions) also qualify as employer-sponsored dependent coverage as long as there remains a contribution toward the premiums by the employer or union.

"Evidence-based medicine (EBM)" means the application of a set of principles and a method for the review of well-designed studies and objective clinical data to determine the level of evidence that proves to the greatest extent possible, that a health care service is safe, effective, and beneficial when making:

(a) Population-based health care coverage policies (WAC 182-501-0055 describes how the agency or its designee determines coverage of services for its health care programs by using evidence and criteria based on health technology assessments); and

(b) Individual medical necessity decisions (WAC 182-501-0165 describes how the agency or its designee uses the best evidence available to determine if a service is medically necessary as defined in WAC 182-500-0030).

"Exception to rule." See WAC 182-501-0160 for exceptions to noncovered health care services, supplies, and equipment. See WAC 182-503-0090 for exceptions to program eligibility.

"Expedited prior authorization (EPA)" means the process for obtaining authorization for selected health care services in which providers use a set of numeric codes to indicate to the agency or the agency's designee which acceptable indications, conditions, or agency or agency's designee-defined criteria are applicable to a particular request for authorization. EPA is a form of "prior authorization."

"Extended care services" means nursing and rehabilitative care in a skilled nursing facility provided to a recently hospitalized medicare patient.

AMENDATORY SECTION (Amending WSR 13-15-044, filed 7/11/13, effective 8/11/13)

WAC 182-501-0050 Health care general coverage. WAC 182-501-0050 through 182-501-0065 describe the health care services available to a client on a fee-for-service basis or to a client enrolled in a managed care organization (MCO) (defined in WAC 182-538-050). For the purposes of this section, health care services includes treatment, equipment, related supplies, and drugs. WAC 182-501-0070 describes noncovered services.

(1) Health care service categories listed in WAC 182-501-0060 do not represent a contract for health care services.

(2) For the provider to receive payment, the client must be eligible for the covered health care service on the date the health care service is performed or provided.

(3) Under the agency's fee-for-service programs, providers must be enrolled with the agency or its designee and meet the requirements of chapter 182-502 WAC to be paid for furnishing health care services to clients.

(4) The agency or its designee pays only for the health care services that are:

(a) Included in the client's health care benefits package as described in WAC 182-501-0060;

(b) Covered - See subsection (9) of this section;

(c) Ordered or prescribed by a health care provider who meets the requirements of chapter 182-502 WAC;

(d) Medically necessary as defined in WAC 182-500-0070;

(e) Submitted for authorization, when required, in accordance with WAC 182-501-0163;

(f) Approved, when required, in accordance with WAC 182-501-0165;

(g) Furnished by a provider according to chapter 182-502 WAC; and

(h) Billed in accordance with agency or its designee program rules and the agency's current published billing instructions.

(5) The agency does not pay for any health care service requiring prior authorization from the agency or its designee, if prior authorization was not obtained before the health care service was provided; unless:

(a) The client is determined to be retroactively eligible for medical assistance; and

(b) The request meets the requirements of subsection (4) of this section.

(6) The agency does not reimburse clients for health care services purchased out-of-pocket.

(7) The agency does not pay for the replacement of agency-purchased equipment, devices, or supplies which have been sold, gifted, lost, broken, destroyed, or stolen as a result of the client's carelessness, negligence, recklessness, deliberate intent, or misuse unless:

(a) Extenuating circumstances exist that result in a loss or destruction of agency-purchased equipment, devices, or supplies, through no fault of the client that occurred while the client was exercising reasonable care under the circumstances; or

(b) Otherwise allowed under specific agency program rules.

(8) The agency's refusal to pay for replacement of equipment, device, or supplies will not extend beyond the limitations stated in specific agency program rules.

(9) **Covered health care services.**

(a) Covered health care services are either:

(i) "Federally mandated" - Means the state of Washington is required by federal regulation (42 C.F.R. 440.210 and 220) to cover the health care service for medicaid clients; or

(ii) "State-option" - Means the state of Washington is not federally mandated to cover the health care service but has chosen to do so at its own discretion.

(b) The agency may limit the scope, amount, duration, and/or frequency of covered health care services. Limitation extensions are authorized according to WAC 182-501-0169.

(10) **Noncovered health care services.**

(a) The agency does not pay for any health care service listed as noncovered in WAC 182-501-0070 or in any other agency program rule, unless the agency grants a request for an exception to rule allowing payment for the noncovered service. The agency evaluates a request for a noncovered health care service only if an exception to rule is requested according to the provisions in WAC 182-501-0160.

(b) ((~~When a noncovered health care service is recommended during the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) exam and then ordered by a provider, the agency evaluates the health care service according to the process in WAC 182-501-0165 to determine if it is medically necessary, safe, effective, and not experimental (see WAC 182-534-0100 for EPSDT rules).~~)) For children age 20 and younger, providers must follow the rules for the early periodic screening, diagnosis, and treatment (EPSDT) program; see chapter 182-534 WAC.

AMENDATORY SECTION (Amending WSR 21-02-004, filed 12/23/20, effective 1/23/21)

WAC 182-530-2100 Noncovered—Outpatient drugs and pharmaceutical supplies. (1) The medicaid agency does not cover:

(a) A drug that is:

(i) Not approved by the Food and Drug Administration (FDA); or

(ii) Prescribed for a nonmedically accepted indication, including diagnosis, dose, or dosage schedule that is not evidenced-based.

(b) A drug prescribed:

(i) For weight loss or gain;

(ii) For infertility, frigidity, impotency;

(iii) For sexual or erectile dysfunction;

(iv) For cosmetic purposes or hair growth; or

(v) For treatment of cough or cold symptoms, except as listed in WAC 182-530-2000 (1)(h).

(c) Drugs used to treat sexual or erectile dysfunction, in accordance with section 1927 (d)(2)(K) of the Social Security Act, unless such drugs are used to treat a condition other than sexual or erectile dysfunction, and these uses have been approved by the Food and Drug Administration.

(d) Drugs listed in the federal register as "less-than-effective" ("DESI" drugs) or which are identical, similar, or related to such drugs.

(e) Outpatient drugs for which the manufacturer requires as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or manufacturer's designee.

(f) A product:

(i) With an obsolete National Drug Code (NDC) for more than two years;

(ii) With a terminated NDC;

(iii) Whose shelf life has expired; or

(iv) Which does not have an eleven-digit NDC.

(g) Over-the-counter (OTC) drugs, vitamins, and minerals, except as allowed under WAC 182-530-2000 (1)(h).

(h) Any drug regularly supplied by other public agencies as an integral part of program activity (e.g., immunization vaccines for children).

(i) Free pharmaceutical samples.

(2) A noncovered drug can be requested through the exception to rule process as described in WAC 182-501-0160.

(3) ((~~If a noncovered drug is prescribed through the early and periodic screening, diagnosis, and treatment (EPSDT) process, an authorization request may be submitted indicating that the request is EPSDT related, and the request will be evaluated according to the process in WAC 182-501-0165. (See WAC 182-534-0100 for EPSDT rules.)~~)) For clients age 20 and younger, providers must follow the rules for the early periodic screening, diagnosis, and treatment program; see chapter 182-534 WAC.

AMENDATORY SECTION (Amending WSR 23-04-048, filed 1/26/23, effective 2/26/23)

WAC 182-531-0100 Scope of coverage for physician-related and health care professional services—General and administrative. (1) The medicaid agency covers health care services, equipment, and supplies listed in this chapter, according to agency rules and subject to the limitations and requirements in this chapter, when they are:

(a) Within the scope of an eligible client's Washington apple health program. Refer to WAC 182-501-0060 and 182-501-0065; and

(b) Medically necessary as defined in WAC 182-500-0070.

(2) The agency evaluates a request for a service that is in a covered category under the provisions of WAC 182-501-0165.

(3) The agency evaluates requests for covered services that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions as described in WAC 182-501-0169.

(4) For children age 20 and younger, providers must follow the rules for the early periodic screening, diagnosis, and treatment (EPSDT) program, see chapter 182-534 WAC.

(5) The agency covers the following physician-related services and health care professional services, subject to the conditions in subsections (1), (2), ((~~and~~)) (3), and (4) of this section:

(a) Alcohol and substance misuse counseling (refer to WAC 182-531-1710);

(b) Allergen immunotherapy services;

(c) Anesthesia services;

(d) Dialysis and end stage renal disease services (refer to chapter 182-540 WAC);

(e) Emergency physician services;

(f) ENT (ear, nose, and throat) related services;

(g) ((~~Early and periodic screening, diagnosis, and treatment (EPSDT) services (refer to WAC 182-534-0100);~~

~~(h)~~)) Habilitative services (refer to WAC 182-545-400);

((~~(i)~~)) (h) Reproductive health services (refer to chapter 182-532 WAC);

((~~(j)~~)) (i) Hospital inpatient services (refer to chapter 182-550 WAC);

((~~(k)~~)) (j) Maternity care, delivery, and newborn care services (refer to chapter 182-533 WAC);

((~~(l)~~)) (k) Office visits;

((~~(m)~~)) (l) Vision-related services (refer to chapter 182-544 WAC for vision hardware for clients 20 years of age and younger);

((~~(n)~~)) (m) Osteopathic treatment services;

((~~(o)~~)) (n) Pathology and laboratory services;

((~~(p)~~)) (o) Physiatry and other rehabilitation services (refer to chapter 182-550 WAC);

((~~(q)~~)) (p) Foot care and podiatry services (refer to WAC 182-531-1300);

((~~(r)~~)) (q) Primary care services;

((~~(s)~~)) (r) Psychiatric services;

((~~(t)~~)) (s) Psychotherapy services (refer to WAC 182-531-1400);

((~~(u)~~)) (t) Pulmonary and respiratory services;

((~~(v)~~)) (u) Radiology services;

((~~(w)~~)) (v) Surgical services;

((~~(x)~~)) (w) Cosmetic, reconstructive, or plastic surgery, and related services and supplies to correct physiological defects (e.g., congenital or as a result of illness or physical trauma), or for mastectomy reconstruction for post cancer treatment;

((~~(y)~~)) (x) Telemedicine (refer to WAC 182-501-0300);

((~~(z)~~)) (y) Tobacco/nicotine cessation counseling (refer to WAC 182-531-1720);

((~~(aa)~~)) (z) Vaccines for adults, adolescents, and children in the United States administered according to the current advisory committee on immunization practices (ACIP) recommended immunization schedule published by the Centers for Disease Control and Prevention (CDC). Vaccines outside the regular schedule may be covered if determined to be medically necessary;

((~~(bb)~~)) (aa) Other outpatient physician services.

((~~(5)~~)) (6) The agency covers physical examinations for Washington apple health clients only when the physical examination is for one or more of the following:

(a) A ((~~screening exam~~)) well-child checkup covered by the EPSDT program (see WAC 182-534-0100);

(b) An annual exam for clients of the division of developmental disabilities; or

(c) A screening pap smear, mammogram, or prostate exam.

((~~(6)~~)) (7) By providing covered services to a client eligible for Washington apple health, a provider who meets the requirements in WAC 182-502-0005(3) accepts the agency's rules and fees which includes federal and state law and regulations, billing instructions, and provider notices.

AMENDATORY SECTION (Amending WSR 23-23-058, filed 11/8/23, effective 12/9/23)

WAC 182-531-0150 Noncovered physician-related and health care professional services—General and administrative. (1) The medicaid agency evaluates a request for noncovered services in this chapter under WAC 182-501-0160. In addition to noncovered services found in WAC 182-501-0070, except as provided in subsection (2) of this section, the agency does not cover:

(a) Acupuncture, massage, or massage therapy;

(b) Any service specifically excluded by statute;

(c) Care, testing, or treatment of infertility or sexual dysfunction. This includes procedures for donor ovum, donor sperm, gestational carrier, and reversal of vasectomy or tubal ligation;

(d) Hysterectomy performed solely for the purpose of sterilization;

(e) Cosmetic treatment or surgery, except as provided in WAC 182-531-0100 ((~~(4)(x)~~)) (5)(w);

(f) Experimental or investigational services, procedures, treatments, devices, drugs, or application of associated services, except when the individual factors of an individual client's condition justify a determination of medical necessity under WAC 182-501-0165;

(g) Hair transplantation;

(h) Marital counseling or sex therapy;

(i) More costly services when the medicaid agency determines that less costly, equally effective services are available;

(j) Vision-related services as follows:

(i) Services for cosmetic purposes only;

(ii) Group vision screening for eyeglasses; and

(iii) Refractive surgery of any type that changes the eye's refractive error. The intent of the refractive surgery procedure is to reduce or eliminate the need for eyeglass or contact lens correction. This refractive surgery does not include intraocular lens implantation following cataract surgery;

(k) Payment for body parts, including organs, tissues, bones and blood, except as allowed in WAC 182-531-1750;

(l) Physician-supplied medication, except those drugs which the client cannot self-administer and therefore are administered by the physician in the physician's office;

(m) Physical examinations or routine checkups, except as provided in WAC 182-531-0100;

(n) Foot care, unless the client meets criteria and conditions outlined in WAC 182-531-1300, as follows:

(i) Routine foot care including, but not limited to:

(A) Treatment of tinea pedis;

(B) Cutting or removing warts, corns and calluses; and

(C) Trimming, cutting, clipping, or debriding of nails.

(ii) Nonroutine foot care including, but not limited to, treatment of:

(A) Flat feet;

(B) High arches (cavus foot);

(C) Onychomycosis;

(D) Bunions and tailor's bunion (hallux valgus);

(E) Hallux malleus;

(F) Equinus deformity of foot, acquired;

(G) Cavovarus deformity, acquired;

(H) Adult acquired flatfoot (metatarsus adductus or pes planus);

(I) Hallux limitus.

(iii) Any other service performed in the absence of localized illness, injury, or symptoms involving the foot;

(o) Except as provided in WAC 182-531-1600, weight reduction and control services, procedures, treatments, devices, drugs, products, gym memberships, equipment for the purpose of weight reduction, or the application of associated services;

(p) Nonmedical equipment;

(q) Nonemergent admissions and associated services to out-of-state hospitals or noncontracted hospitals in contract areas; and

(r) Early elective deliveries as defined in WAC 182-500-0030.

(2) The medicaid agency covers excluded services listed in (1) of this subsection if those services are mandated under and provided to a client who is eligible for one of the following:

(a) The EPSDT program, see chapter 182-534 WAC;

(b) A Washington apple health program for qualified **medicare** beneficiaries (QMBs); or

(c) A waiver program.

AMENDATORY SECTION (Amending WSR 23-21-061, filed 10/12/23, effective 11/12/23)

WAC 182-531-0250 Who can provide and bill for physician-related and health care professional services. (1) The health care professionals and health care entities listed in WAC 182-502-0002 and enrolled with the medicaid agency can bill for physician-related and health care professional services that are within their scope of practice.

(2) The agency pays for services provided by, or in conjunction with, a resident physician when:

(a) The services are billed under the teaching hospital's national provider identifier (NPI) or the supervising physician's NPI;

(b) The servicing provider is identified on the claim under the teaching or resident physician's NPI; and

(c) The services are provided and billed according to this chapter and chapters 182-501 and 182-502 WAC.

(3) The agency does not pay for services performed by any of the health care professionals listed in WAC 182-502-0003.

(4) The agency pays eligible providers for physician-related services and health care professional services if those services are mandated by, and provided to clients who are eligible for, one of the following:

(a) The early ((~~and~~)) periodic screening, diagnosis, and treatment (EPSDT) program, see chapter 182-534 WAC;

(b) A Washington apple health program for qualified medicare beneficiaries (QMB); or

(c) A waiver program.

AMENDATORY SECTION (Amending WSR 13-14-016, filed 6/21/13, effective 7/22/13)

WAC 182-531-1600 Bariatric surgery. (1) The agency covers medically necessary bariatric surgery for eligible clients.

(2) Bariatric surgery must be performed in a hospital with a bariatric surgery program, and the hospital must be:

(a) Located in the state of Washington or approved border cities (see WAC 182-501-0175); and

(b) Meet the requirements of WAC 182-550-2301.

(3) ((~~If bariatric surgery is requested or prescribed under the EPSDT program, the agency evaluates it as a covered service under EPSDT's standard of coverage that requires the service to be:~~

~~(a) Medically necessary;~~

~~(b) Safe and effective; and~~

~~(c) Not experimental.~~)) For clients age 20 and younger, providers must follow the rules for the early periodic screening, diagnosis, and treatment (EPSDT) program, see chapter 182-534 WAC.

(4) The agency authorizes payment for bariatric surgery and bariatric surgery-related services in three stages:

(a) Stage one - Initial assessment of client;

(b) Stage two - Evaluations for bariatric surgery and successful completion of a weight loss regimen; and

(c) Stage three - Bariatric surgery.

Stage one - Initial assessment

(5) Any agency-enrolled provider who is licensed to practice medicine in the state of Washington may examine a client requesting bariatric surgery to ascertain if the client meets the criteria listed in subsection (6) of this section.

(6) The client meets the preliminary conditions of stage one when:

(a) The client is:

(i) Twenty-one through ((~~fifty-nine~~)) 59 years of age; or

(ii) Eighteen through ((~~twenty~~)) 20 years old for laparoscopic adjustable gastric banding (LAGB) only;

(b) The client has a body mass index (BMI) of ((~~thirty-five~~)) 35 or greater;

(c) The client is not pregnant. (Pregnancy within the first two years following bariatric surgery is not recommended. When applicable, a family planning consultation is highly recommended prior to bariatric surgery);

(d) The client is diagnosed with one of the following:

(i) Diabetes mellitus;

(ii) Degenerative joint disease of a major weight bearing joint(s) (the client must be a candidate for joint replacement surgery if weight loss is achieved); or

(iii) Other rare comorbid conditions (such as pseudo tumor cerebri) in which there is medical evidence that bariatric surgery is medically necessary and that the benefits of bariatric surgery outweigh the risk of surgical mortality; and

(e) The client has an absence of other medical conditions such as multiple sclerosis (MS) that would increase the client's risk of surgical mortality or morbidity from bariatric surgery.

(7) If a client meets the criteria in subsection (6) of this section, the provider must request prior authorization from the agency before referring the client to stage two of the bariatric surgery authorization process. The provider must attach a medical report to the request for prior authorization with supporting documentation that the client meets the stage one criteria in subsections (5) and (6) of this section.

(8) The agency evaluates requests for covered services that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions when medically necessary, under the provisions of WAC 182-501-0165 and 182-501-0169.

Stage two - Evaluations for bariatric surgery and successful completion of a weight loss regimen

(9) After receiving prior authorization from the agency to begin stage two of the bariatric surgery authorization process, the client must:

(a) Undergo a comprehensive psychosocial evaluation performed by a psychiatrist, licensed psychiatric ARNP, or licensed independent social worker with a minimum of two years postmasters' experience in a mental health setting. Upon completion, the results of the evaluation must be forwarded to the agency. The comprehensive psychosocial evaluation must include:

(i) An assessment of the client's mental status or illness to:

(A) Evaluate the client for the presence of substance abuse problems or psychiatric illness which would preclude the client from participating in presurgical dietary requirements or postsurgical lifestyle changes; and

(B) If applicable, document that the client has been successfully treated for psychiatric illness and has been stabilized for at least

six months and/or has been rehabilitated and is free from any drug and/or alcohol abuse and has been drug and/or alcohol free for a period of at least one year.

(ii) An assessment and certification of the client's ability to comply with the postoperative requirements such as lifelong required dietary changes and regular follow-up.

(b) Undergo an internal medicine evaluation performed by an internist to assess the client's preoperative condition and mortality risk. Upon completion, the internist must forward the results of the evaluation to the agency.

(c) Undergo a surgical evaluation by the surgeon who will perform the bariatric surgery (see subsection (13) of this section for surgeon requirements). Upon completion, the surgeon must forward the results of the surgical evaluation to the agency and to the licensed medical provider who is supervising the client's weight loss regimen (refer to WAC 182-531-1600 (9)(d)(ii)).

(d) Under the supervision of a licensed medical provider, the client must participate in a weight loss regimen prior to surgery. The client must, within ((~~one hundred and eighty~~)) 180 days from the date of the agency's stage one authorization, lose at least five percent of his or her initial body weight. If the client does not meet this weight loss requirement within ((~~one hundred and eighty~~)) 180 days from the date of the agency's initial authorization, the agency will cancel the authorization. The client or the client's provider must reapply for prior authorization from the agency to restart stage two. For the purpose of this section, "initial body weight" means the client's weight at the first evaluation appointment.

(i) The purpose of the weight loss regimen is to help the client achieve the required five percent loss of initial body weight prior to surgery and to demonstrate the client's ability to adhere to the radical and lifelong behavior changes and strict diet that are required after bariatric surgery.

(ii) The weight loss regimen must:

(A) Be supervised by a licensed medical provider who has a core provider agreement with the agency;

(B) Include monthly visits to the medical provider;

(C) Include counseling twice a month by a registered dietician referred to by the treating provider or surgeon; and

(D) Be at least six months in duration.

(iii) Documentation of the following requirements must be retained in the client's medical file. Copies of the documentation must be forwarded to the agency upon completion of stage two. The agency will evaluate the documentation and authorize the client for bariatric surgery if the stage two requirements were successfully completed.

(A) The provider must document the client's compliance in keeping scheduled appointments and the client's progress toward weight loss by serial weight recordings. The client must lose at least five percent of his or her initial body weight and must maintain the five percent weight loss until surgery;

(B) For diabetic clients, the provider must document the efforts in diabetic control or stabilization;

(C) The registered dietician must document the client's compliance (or noncompliance) in keeping scheduled appointments, and the client's weight loss progress;

(D) The client must keep a journal of active participation in the medically structured weight loss regimen including the activities un-

der (d)(iii)(A), (d)(iii)(B) if appropriate, and (d)(iii)(C) of this subsection.

(10) If the client fails to complete all of the requirements of subsection (9) of this section, the agency will not authorize stage three - Bariatric surgery.

(11) If the client is unable to meet all of the stage two criteria, the client or the client's provider must reapply for prior authorization from the agency to reenter stage two.

Stage three - Bariatric surgery

(12) The agency may withdraw authorization of payment for bariatric surgery at any time up to the actual surgery if the agency determines that the client is not complying with the requirements of this section.

(13) A surgeon who performs bariatric surgery for medical assistance clients must:

(a) Have a signed core provider agreement with the agency;

(b) Have a valid medical license in the state of Washington; and

(c) Be affiliated with a bariatric surgery program that meets the requirements of WAC 182-550-2301.

(14) For hospital requirements for stage three - Bariatric surgery, see WAC 182-550-2301.

AMENDATORY SECTION (Amending WSR 24-21-072, filed 10/14/24, effective 11/14/24)

WAC 182-531-1675 Washington apple health—Gender affirming interventions for gender dysphoria. (1) **Overview of treatment program.**

(a) **Medicaid agency coverage.** The medicaid agency covers the services listed in (b) of this subsection to treat gender dysphoria (also referred to as gender incongruence) under WAC 182-501-0050 and 182-531-0100. These services include life-changing procedures that may not be reversible.

(b) **Medical services covered.** Medical services covered by the agency include, but are not limited to:

(i) Presurgical and postsurgical hormone therapy;

(ii) Puberty suppression therapy;

(iii) Behavioral health services;

(iv) Gender affirming hair removal services; and

(v) Surgical and ancillary services including, but not limited to:

(A) Anesthesia;

(B) Labs;

(C) Pathology;

(D) Radiology;

(E) Hospitalization;

(F) Physician services; and

(G) Hospitalizations and physician services required to treat postoperative complications of procedures performed under this section.

(c) **Diagnosis of gender dysphoria/gender incongruence.** A diagnosis of gender dysphoria/gender incongruence is required to obtain services under this program and must be made by a provider who meets the qualifications outlined in chapter 182-502 WAC.

(d) **Medical necessity.** The agency authorizes and pays for only medically necessary services. Medical necessity is defined in WAC 182-500-0070 and is determined under WAC 182-501-0165 and limitation extensions in accordance with WAC 182-501-0169.

(e) **Provider requirements.** Providers should be knowledgeable of gender-nonconforming identities and expressions, and the assessment and treatment of gender dysphoria/gender incongruence, including experience utilizing standards of care that include the World Professional Association for Transgender Health (WPATH) Standards of Care.

(f) **Clients age 20 and younger.** ((~~The agency evaluates requests for clients age 20 and younger according to the early and periodic screening, diagnosis, and treatment (EPSDT) program described in chapter 182-534 WAC. Under the EPSDT program, the agency pays for a service if it is medically necessary, safe, effective, and not experimental.~~)) For clients age 20 and younger, providers must follow the rules for the early periodic screening, diagnosis, and treatment program, see chapter 182-534 WAC.

(g) **Transportation services.** The agency covers transportation services under the provisions of chapter 182-546 WAC.

(h) **Out-of-state care.** Any out-of-state care, including a presurgical consultation, must be prior authorized as an out-of-state service under WAC 182-501-0182.

(i) **Corrective surgeries for intersex traits.** The agency covers corrective or reparative surgeries for people with intersex traits who received surgeries that were performed without the person's consent.

(2) **Prior authorization.**

(a) **Prior authorization requirements for surgical services.** As a condition of payment, the agency requires prior authorization for all surgical services to treat gender dysphoria/gender incongruence, except as provided in subsection (3) of this section. This includes modifications or revisions to, or correcting complications from, a previous surgery related to infections or impairment of a function.

(b) **Required documentation.** The provider must include the following documentation with the prior authorization request:

(i) **Behavioral health assessment.** Documentation of a behavioral health assessment performed within 18 months preceding surgery by a qualified behavioral health professional as defined in WAC 182-531-1400. This provider must be a licensed health care professional who is eligible under chapter 182-502 WAC, as follows:

(A) Psychiatrist;

(B) Psychologist;

(C) Psychiatric advanced practice registered nurse (APRN);

(D) Psychiatric mental health nurse practitioner-board certified (PMHNP-BC);

(E) Mental health counselor (LMHC);

(F) Independent clinical social worker (LICSW);

(G) Advanced social worker (LASW); or

(H) Marriage and family therapist (LMFT).

(ii) **Evaluation requirements.** The comprehensive behavioral health assessment must:

(A) Confirm the diagnosis of gender dysphoria, or gender incongruence, or both, as defined by the *Diagnostic Statistical Manual of Mental Disorders;*

(B) Document that:

(I) The client's experience of gender incongruence is marked and sustained;

(II) The client has the desire to make their body as congruent as possible with a desired gender through surgery, hormone treatment, or other medical therapies;

(III) Gender incongruence causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; and

(IV) The client has no contraindicating behavioral health conditions that would impair the ability to give informed consent, as described in (c) of this subsection. If a client has a behavioral health condition that interferes with their ability to give informed consent and the client understands the risks, benefits, and alternatives to gender affirming treatment, the provider must facilitate treatment of the underlying behavioral health condition to support the client's ability to provide informed consent.

(iii) **Hormone therapy.** Documentation from the primary care provider or the provider prescribing hormone therapy that the client has:

(A) As appropriate to the client's gender goal for the following procedures:

(I) Had six continuous months of hormone therapy immediately preceding a request for genital surgery; or

(II) Twelve continuous months of continuous hormone therapy immediately preceding a request for breast augmentation surgery, unless:

• Hormones are not clinically indicated for the client or hormones are not aligned with the client's gender health care plan, or both; or

• The client has requested a mastectomy or reduction mammoplasty; or

• The client has a medical contraindication to hormone therapy; and

• The client has a medical necessity for surgery and the client is adherent with current gender dysphoria treatment.

(B) Gender dysphoria/gender incongruence that is not a symptom of another medical condition; and

(C) Had no medical conditions that would impair the client's ability to give informed consent.

(iv) **Surgical.** Documentation from the surgeon of the client's:

(A) Medical history and physical examination(s) performed within the 12 months preceding surgery;

(B) Medical necessity for surgery and surgical plan; and

(C) For hysterectomies, a completed agency hysterectomy consent form must be submitted.

(c) **Informed consent.** The surgeon must provide documentation showing that they informed the client of:

(i) The nature of the proposed care, treatment, services, medications, and procedures;

(ii) Potential benefits, risks, or side effects, including potential problems that might occur during recuperation;

(iii) The likelihood of achieving the client's treatment goals;

(iv) Reasonable alternatives;

(v) Relevant risks, benefits, and side effects related to alternatives, including the possible results of not receiving care, treatment, and services;

(vi) Any limitations on the confidentiality of information learned from or about the patient;

(vii) The effect of gender-affirming treatment on reproduction; and

(viii) Reproductive options before having gender-affirming surgeries that have the potential to create iatrogenic infertility.

(d) **Requirements for hair removal.** For facial or body hair removal, a client must submit:

(i) A letter written within the past 18 months from the provider managing the client's gender-affirming hormone therapy describing the client's attempted hair removal techniques that failed, for each affected part of the body.

(ii) A letter of medical necessity from the client's dermatologist or primary care provider written within the past 18 months that includes:

(A) The size and location of the area to be treated; and

(B) For each area of the body, the number of expected units needed to complete treatment.

(iii) Photographs of the areas to be treated, if requested by the agency.

(e) **Other requirements.** If the client fails to complete all of the requirements in (b) of this subsection, the agency will not authorize gender affirming surgery unless:

(i) The clinical decision-making process is provided in the referral letter and attachments described in (b) of this subsection; and

(ii) The agency has determined that the request is medically necessary in accordance with WAC 182-501-0165 based on review of all submitted information.

(f) **Behavioral health provider requirements.** The behavioral health provider who performs the behavioral health assessment described in (b)(i) of this subsection must:

(i) Meet the provisions of WAC 182-531-1400;

(ii) Be competent in using the *Diagnostic Statistical Manual of Mental Disorders*, and the *International Classification of Diseases* for diagnostic purposes;

(iii) Be able to recognize and diagnose coexisting behavioral health conditions and to distinguish these from gender dysphoria/gender incongruence;

(iv) Be knowledgeable of gender-nonconforming identities and expressions, and the assessment and treatment of gender dysphoria; and

(v) Have completed continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a behavioral health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

(g) **Clients age 17 and younger.** Clients age 17 and younger must meet the requirements for prior authorization identified in (a) through (d) of this subsection, except that the comprehensive behavioral health assessment required in (b)(i) of this subsection must be a biopsychosocial behavioral health assessment performed by a behavioral health provider who specializes in adolescent transgender care and meets the qualifications outlined in WAC 182-531-1400.

(3) **Expedited prior authorization (EPA).**

(a) **Approved EPA procedures.** The agency allows a provider to use the EPA process for clients age 17 and older for the following medically necessary procedures:

(i) Bilateral mastectomy or reduction mammoplasty with or without chest reconstruction; and

(ii) Genital or donor skin graft site hair removal when medically necessary to prepare for genital reassignment.

(b) **Clinical criteria and documentation.** To use the EPA process for procedures identified in (a) of this subsection, the following clinical criteria and documentation must be kept in the client's record and made available to the agency upon request:

(i) One comprehensive biopsychosocial behavioral health assessment performed by a licensed behavioral health provider within the 18 months preceding surgery that meets the requirements identified in subsection (2) of this section;

(ii) Documentation from the primary care provider or the provider prescribing hormone therapy of the medical necessity for surgery and confirmation that the client is adherent with current gender dysphoria treatment; and

(iii) Documentation from the surgeon of the client's:

(A) Medical history and physical examinations performed within the 12 months preceding surgery; and

(B) Medical necessity for surgery and surgical plan.

(c) **Documentation exception.** When the requested procedure is for genital or donor skin graft site hair removal to prepare for bottom surgery, there is an exception to the requirements in (b) of this subsection. The only documentation required is either a:

(i) Letter of medical necessity from the treating surgeon that includes the size and location of the area to be treated, and expected date of planned genital surgery; or

(ii) Letter of medical necessity from the provider who will perform the hair removal that includes the surgical consult for bottom surgery and addresses the need for hair removal prior to gender affirming surgery.

(d) **Prior authorization required for other surgeries.** All other surgeries to treat gender dysphoria, including modifications to, or complications from a previous surgery require prior authorization to determine medical necessity.

(e) **Recoupment.** The agency may recoup any payment made to a provider for procedures listed in this subsection if the provider does not follow the EPA process outlined in WAC 182-501-0163 or if the provider does not maintain the documentation required by this subsection.

AMENDATORY SECTION (Amending WSR 21-14-055, filed 7/1/21, effective 8/1/21)

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, and CDT is a trademark of the American Dental 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~~)) 10, and 11. Permanent mandibular anterior teeth include teeth ((~~twenty-two, twenty-three, twenty-four, twenty-five, twenty-six, and twenty-seven~~)) 22, 23, 24, 25, 26, and 27. Primary maxillary anterior teeth include teeth C, D, E, F, G, and H. Primary mandibular anterior teeth include teeth M, N, O, P, Q, and R.

"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, (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 com-

mands, 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.

"Early periodic screening, diagnosis, and treatment (EPSDT)" is defined under WAC 182-534-0050.

"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."**

"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~~)) 12, 13, 14, 15, and 16. Permanent mandibular posterior teeth include teeth ((~~seventeen, eighteen, nineteen, twenty, twenty-one, twenty-eight, twenty-nine, thirty, thirty-one, and thirty-two~~)) 17, 18, 19, 20, 21, 28, 29, 30, 31, and 32. Primary maxillary posterior teeth include teeth A, B, I, and J. Primary mandibular posterior teeth include teeth K, L, S, and T.

"Prophylaxis" means the dental procedure of scaling and polishing which includes removal of calculus, plaque, and stains from 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 17-20-097, filed 10/3/17, effective 11/3/17)

WAC 182-535-1079 Dental-related services—General. (1) Clients described in WAC 182-535-1060 are eligible to receive the dental-related services described in this chapter, subject to coverage limitations, restrictions, and client age requirements identified for a specific service. The medicaid agency pays for dental-related services

and procedures provided to eligible clients when the services and procedures:

(a) Are part of the client's dental benefit package;

(b) Are within the scope of an eligible client's Washington apple health program;

(c) Are medically necessary;

(d) Meet the agency's authorization requirements, if any;

(e) Are documented in the client's dental record in accordance with chapter 182-502 WAC and meet the department of health's requirements in WAC 246-817-305 and 246-817-310;

(f) Are within accepted dental or medical practice standards;

(g) Are consistent with a diagnosis of a dental disease or dental condition;

(h) Are reasonable in amount and duration of care, treatment, or service; and

(i) Are listed as covered in the agency's rules and published billing instructions and fee schedules.

(2) For orthodontic services, see chapter 182-535A WAC.

(3) The agency requires site-of-service prior authorization, in addition to prior authorization of the procedure, if applicable, for nonemergency dental-related services performed in a hospital or an ambulatory surgery center when:

(a) A client is not a client of the developmental disabilities ((~~administration~~)) community services division of the department of social and health services (DSHS) according to WAC 182-535-1099;

(b) A client is age nine or older;

(c) The service is not listed as exempt from the site-of-service authorization requirement in the agency's current published dental-related services fee schedule or billing instructions; and

(d) The service is not listed as exempt from the prior authorization requirement for deep sedation or general anesthesia (see WAC 182-535-1098 (1)(c)(v)).

(4) To be eligible for payment, dental-related services performed in a hospital or an ambulatory surgery center must be listed in the agency's current published outpatient fee schedule or ambulatory surgery center fee schedule. The claim must be billed with the correct procedure code for the site-of-service.

(5) ((~~Under the early and periodic screening, diagnostic, and treatment (EPSDT) program, clients age twenty and younger may be eligible for dental-related services listed as noncovered. The standard for coverage for EPSDT is found in~~)) For clients age 20 and younger, providers must follow the rules for the early periodic screening, diagnosis, and treatment (EPSDT) program, see chapter 182-534 WAC.

(6) The agency evaluates a request for dental-related services that are:

(a) In excess of the dental program's limitations or restrictions, according to WAC 182-501-0169; and

(b) Listed as noncovered, according to WAC 182-501-0160.

AMENDATORY SECTION (Amending WSR 23-08-080, filed 4/5/23, effective 5/6/23)

WAC 182-535-1100 Dental-related services—Not covered. (1) The medicaid agency does not cover the following under the dental program:

(a) The dental-related services described in subsection (2) of this section unless the services are covered under the early periodic screening, diagnostic, and treatment (EPSDT) program described in chapter 182-534 WAC. ((~~When EPSDT applies, the agency evaluates a noncovered service, equipment, or supply according to the process in WAC 182-501-0165 to determine if it is medically necessary, safe, effective, and not experimental.~~))

(b) Any service specifically excluded by statute.

(c) More costly services when less costly, equally effective services as determined by the agency are available.

(d) Services, procedures, treatment, devices, drugs, or application of associated services:

(i) That the agency or the Centers for Medicare and Medicaid Services (CMS) considers investigative or experimental on the date the services were provided.

(ii) That are not listed as covered in one or both of the following:

(A) Washington Administrative Code (WAC).

(B) The agency's current published documents.

(2) The agency does not cover dental-related services listed under the following categories of service (see subsection (1)(a) of this section for services provided under the EPSDT program):

(a) **Diagnostic services.** The agency does not cover:

(i) Detailed and extensive oral evaluations or reevaluations.

(ii) Posterior-anterior or lateral skull and facial bone survey films.

(iii) Any temporomandibular joint films.

(iv) Tomographic surveys/3-D imaging.

(v) Comprehensive periodontal evaluations.

(vi) Viral cultures, genetic testing, caries susceptibility tests, or adjunctive prediagnostic tests.

(b) **Preventive services.** The agency does not cover:

(i) Nutritional counseling for control of dental disease.

(ii) Removable space maintainers of any type.

(iii) Sealants placed on a tooth with the same-day occlusal restoration, preexisting occlusal restoration, or a tooth with occlusal decay.

(iv) Custom fluoride trays of any type.

(v) Bleach trays.

(c) **Restorative services.** The agency does not cover:

(i) Restorations for wear on any surface of any tooth without evidence of decay through the dentinoenamel junction (DEJ) or on the root surface.

(ii) Preventative restorations.

(iii) Labial veneer resin or porcelain laminate restorations.

(iv) Sedative fillings.

(v) Crowns and crown related services.

(A) Gold foil restorations.

(B) Metallic, resin-based composite, or porcelain/ceramic inlay/onlay restorations.

(C) Crowns for cosmetic purposes (e.g., peg laterals and tetracycline staining).

(D) Permanent indirect crowns for posterior teeth.

(E) Permanent indirect crowns on permanent anterior teeth for clients age 14 and younger.

(F) Temporary or provisional crowns (including ion crowns).

(G) Any type of coping.

(H) Crown repairs.

(I) Crowns on teeth one, 16, 17, and 32.

(vi) Polishing or recontouring restorations or overhang removal for any type of restoration.

(vii) Any services other than extraction on supernumerary teeth.

(d) **Endodontic services.** The agency does not cover:

(i) Indirect or direct pulp caps.

(ii) Any endodontic treatment on primary teeth, except as described in WAC 182-535-1086(3).

(e) **Periodontic services.** The agency does not cover:

(i) Surgical periodontal services including, but not limited to:

(A) Gingival flap procedures.

(B) Clinical crown lengthening.

(C) Osseous surgery.

(D) Bone or soft tissue grafts.

(E) Biological material to aid in soft and osseous tissue regeneration.

(F) Guided tissue regeneration.

(G) Pedicle, free soft tissue, apical positioning, subepithelial connective tissue, soft tissue allograft, combined connective tissue and double pedicle, or any other soft tissue or osseous grafts.

(H) Distal or proximal wedge procedures.

(ii) Nonsurgical periodontal services including, but not limited to:

(A) Intracoronal or extracoronal provisional splinting.

(B) Full mouth or quadrant debridement (except for clients of the developmental disabilities ((~~administration~~)) community services division of the department of social and health services (DSHS)).

(C) Localized delivery of chemotherapeutic agents.

(D) Any other type of surgical periodontal service.

(f) **Removable prosthodontics.** The agency does not cover:

(i) Removable unilateral partial dentures.

(ii) Any interim complete or partial dentures.

(iii) Flexible base partial dentures.

(iv) Any type of permanent soft reline (e.g., molloplast).

(v) Precision attachments.

(vi) Replacement of replaceable parts for semi-precision or precision attachments.

(vii) Replacement of second or third molars for any removable prosthesis.

(viii) Immediate dentures.

(ix) Cast-metal framework partial dentures.

(g) **Implant services.** The agency does not cover:

(i) Any type of implant procedures, including, but not limited to, any tooth implant abutment (e.g., periosteal implants, eposteal implants, and transosteal implants), abutments or implant supported crowns, abutment supported retainers, and implant supported retainers.

(ii) Any maintenance or repairs to procedures listed in (g)(i) of this subsection.

(iii) The removal of any implant as described in (g)(i) of this subsection.

(h) **Fixed prosthodontics.** The agency does not cover any type of:

(i) Fixed partial denture pontic.

(ii) Fixed partial denture retainer.

(iii) Precision attachment, stress breaker, connector bar, coping, cast post, or any other type of fixed attachment or prosthesis.

(i) **Oral maxillofacial prosthetic services.** The agency does not cover any type of oral or facial prosthesis other than those listed in WAC 182-535-1092.

(j) **Oral and maxillofacial surgery.** The agency does not cover:

(i) Any oral surgery service not listed in WAC 182-535-1094.

(ii) Vestibuloplasty.

(k) **Adjunctive general services.** The agency does not cover:

(i) Anesthesia, including, but not limited to:

(A) Local anesthesia as a separate procedure.

(B) Regional block anesthesia as a separate procedure.

(C) Trigeminal division block anesthesia as a separate procedure.

(D) Medication for oral sedation, or therapeutic intramuscular (IM) drug injections, including antibiotic and injection of sedative.

(E) Application of any type of desensitizing medicament or resin.

(ii) Other general services including, but not limited to:

(A) Fabrication of an athletic mouthguard.

(B) Sleep apnea devices or splints.

(C) Occlusion analysis.

(D) Occlusal adjustment, tooth or restoration adjustment or smoothing, or odontoplasties.

(E) Enamel microabrasion.

(F) Dental supplies such as toothbrushes, toothpaste, floss, and other take home items.

(G) Dentist's or dental hygienist's time writing or calling in prescriptions.

(H) Dentist's or dental hygienist's time consulting with clients on the phone.

(I) Educational supplies.

(J) Nonmedical equipment or supplies.

(K) Personal comfort items or services.

(L) Provider mileage or travel costs.

(M) Fees for no-show, canceled, or late arrival appointments.

(N) Service charges of any type, including fees to create or copy charts.

(O) Office supplies used in conjunction with an office visit.

(P) Teeth whitening services or bleaching, or materials used in whitening or bleaching.

(Q) Botox or dermal fillers.

(3) The agency does not cover the following dental-related services for clients age 21 and older:

(a) The following diagnostic services:

(i) Occlusal intraoral radiographs;

(ii) Diagnostic casts;

(iii) Sealants (for clients of the developmental disabilities administration, see WAC 182-535-1099);

(iv) Pulp vitality tests.

(b) The following restorative services:

(i) Prefabricated resin crowns;

(ii) Any type of core buildup, cast post and core, or prefabricated post and core.

(c) The following endodontic services:

(i) Endodontic treatment on permanent bicuspids or molar teeth;

(ii) Any apexification/recalcification procedures;

(iii) Any apicoectomy/periradicular surgical endodontic procedures including, but not limited to, retrograde fillings (except for anterior teeth), root amputation, reimplantation, and hemisections.

(d) The following adjunctive general services:

(i) Occlusal guards, occlusal orthotic splints or devices, bruxing or grinding splints or devices, or temporomandibular joint splints or devices; and

(ii) Analgesia or anxiolysis as a separate procedure except for administration of nitrous oxide.

(4) The agency evaluates a request for any dental-related services listed as noncovered in this chapter under the provisions of WAC 182-501-0160.

AMENDATORY SECTION (Amending WSR 21-18-006, filed 8/18/21, effective 1/1/22)

WAC 182-535A-0010 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.

"Early periodic screening, diagnosis, and treatment (EPSDT)" is defined under WAC 182-534-0050.

"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).

"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.

"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 23-24-099, filed 12/6/23, effective 1/6/24)

WAC 182-535A-0040 Orthodontic treatment and orthodontic-related services—Covered, noncovered, and limitations to coverage. Orthodontic treatment and orthodontic-related services require prior authorization.

(1) The medicaid agency covers orthodontic treatment and orthodontic-related services for a client who has one of the medical conditions listed in (a) and (b) of this subsection. Treatment and follow-up care must be performed by a provider who is part of a craniofacial team that includes, but is not limited to, a general or pediatric dentist, orthodontist, and an oral maxillofacial surgeon or specialist.

(a) Cleft lip and palate, cleft palate, or cleft lip.

(b) The following craniofacial anomalies including, but not limited to:

(i) Hemifacial microsomia;

(ii) Craniosynostosis syndromes;

(iii) Cleidocranial dental dysplasia;

(iv) Arthrogryposis;

(v) Marfan syndrome;

(vi) Treacher Collins syndrome;

(vii) Ectodermal dysplasia; or

(viii) Achondroplasia.

(2) The agency authorizes orthodontic treatment and orthodontic-related services when the following criteria are met:

(a) Severe malocclusions with a Washington Modified Handicapping Labiolingual Deviation (HLD) Index Score of 25 or higher as determined by the agency;

(b) The client has established caries control; and

(c) The client has established plaque control.

(3) The agency covers orthodontic treatment for dental malocclusions other than those listed in subsections (1) and (2) of this section on a case-by-case basis when the agency determines medical necessity based on documentation submitted by the provider.

(4) The agency does not cover the following orthodontic treatment or orthodontic-related services:

(a) Orthodontic treatment for cosmetic purposes;

(b) Orthodontic treatment that is not medically necessary;

(c) Orthodontic treatment provided out-of-state, except as stated in WAC 182-501-0180 (see also WAC 182-501-0175 for medical care provided in bordering cities); or

(d) Orthodontic treatment and orthodontic-related services that do not meet the requirements of this section or other applicable WAC.

(5) The agency covers the following orthodontic treatment and orthodontic-related services:

(a) Limited orthodontic treatment.

(b) Comprehensive full orthodontic treatment on adolescent dentition.

(c) A case study when done in conjunction with orthodontic treatment.

(d) Other orthodontic treatment subject to review for medical necessity as determined by the agency.

(6) The agency covers the following orthodontic-related services:

(a) Clinical oral evaluations according to WAC 182-535-1080.

(b) Cephalometric films that are of diagnostic quality, dated, and labeled with the client's name.

(c) Orthodontic appliance removal as a stand-alone service only when:

(i) The client's appliance was placed by a different provider or dental clinic; and

(ii) The provider has not furnished any other orthodontic treatment or orthodontic-related services to the client.

(7) The treatment must meet industry standards and correct the medical issue. If treatment is discontinued prior to completion, or treatment objectives are not achieved, the provider must:

(a) Document in the client's record why treatment was discontinued or not completed, or why treatment goals were not achieved.

(b) Notify the agency by submitting the Orthodontic Discontinuation of Service form (HCA 13-0039).

(8) The agency evaluates a request for orthodontic treatment or orthodontic-related services:

(a) That are in excess of the limitations or restrictions listed in this section, according to WAC 182-501-0169; and

(b) That are listed as noncovered according to WAC 182-501-0160.

(9) ((~~The agency reviews requests for orthodontic treatment or orthodontic-related services for clients who are eligible for services under the EPSDT program according to the provisions of WAC 182-534-0100.~~)) For children age 20 and younger, providers must follow the rules for the early periodic screening, diagnosis, and treatment (EPSDT) program, see chapter 182-534 WAC.

AMENDATORY SECTION (Amending WSR 19-24-063, filed 11/27/19, effective 1/1/20)

WAC 182-538-180 Rights and protections. (1) People have medicaid-specific rights when applying for, eligible for, or receiving medicaid-funded health care services.

(2) All applicable statutory and constitutional rights apply to all medicaid people including, but not limited to:

(a) The participant rights under WAC 246-341-0600;

(b) Applicable necessary supplemental accommodation services including, but not limited to:

(i) Arranging for or providing help to complete and submit forms to the agency;

(ii) Helping people give or get the information the agency needs to decide or continue eligibility;

(iii) Helping to request continuing benefits;

(iv) Explaining the reduction in or ending of benefits;

(v) Assisting with requests for administrative hearings; and

(vi) On request, reviewing the agency's decision to terminate, suspend, or reduce benefits.

(c) Receiving the name, address, telephone number, and any languages offered other than English of providers in a managed care organization (MCO);

(d) Receiving information about the structure and operation of the MCO and how health care services are delivered;

(e) Receiving emergency care, urgent care, or crisis services;

(f) Receiving poststabilization services after receiving emergency care, urgent care, or crisis services that result in admittance to a hospital;

(g) Receiving age-appropriate and culturally appropriate services;

(h) Being provided a qualified interpreter and translated material at no cost to the person;

(i) Receiving requested information and help in the language or format of choice;

(j) Having available treatment options and explanation of alternatives;

(k) Refusing any proposed treatment;

(l) Receiving care that does not discriminate against a person;

(m) Being free of any sexual exploitation or harassment;

(n) Making an advance directive that states the person's choices and preferences for health care services under 42 C.F.R. Sec. 489 Subpart I;

(o) Choosing a contracted health care provider;

(p) Requesting and receiving a copy of health care records;

(q) Being informed the cost for copying, if any;

(r) Being free from retaliation;

(s) Requesting and receiving policies and procedures of the MCO as they relate to health care rights;

(t) Receiving services in an accessible location;

(u) Receiving medically necessary services in accordance with the early ((~~and~~)) periodic screening, diagnosis, and treatment (EPSDT) program under ((~~WAC 182-534-0100~~)) chapter 182-534 WAC, if the person is age ((~~twenty~~)) 20 or younger;

(v) Being treated with dignity, privacy, and respect;

(w) Receiving treatment options and alternatives in a manner that is appropriate to a person's condition;

(x) Being free from seclusion and restraint;

(y) Receiving a second opinion from a qualified health care professional within an MCO provider network at no cost or having one arranged outside the network at no cost, as provided in 42 C.F.R. Sec. 438.206(b)(3);

(z) Receiving medically necessary health care services outside of the MCO if those services cannot be provided adequately and timely within the MCO;

(aa) Filing a grievance with the MCO if the person is not satisfied with a service;

(bb) Receiving a notice of action so that a person may appeal any decision by the MCO that:

(i) Denies or limits authorization of a requested service;

(ii) Reduces, suspends, or terminates a previously authorized service; or

(iii) Denies payment for a service, in whole or in part.

(cc) Filing an appeal if the MCO fails to provide health care services in a timely manner as defined by the state or act within the time frames in 42 C.F.R. Sec. 438.408(b); and

(dd) Requesting an administrative hearing if an appeal is not resolved in a person's favor.

AMENDATORY SECTION (Amending WSR 17-14-067, filed 6/29/17, effective 7/30/17)

WAC 182-544-0575 Vision care—Noncovered eyeglasses and contact lenses. (1) The agency does not cover the following:

(a) Executive style eyeglass lenses;

(b) Bifocal contact lenses;

(c) Daily and two week disposable contact lenses;

(d) Extended wear soft contact lenses, except when used as therapeutic contact bandage lenses or for aphakic clients;

(e) Custom colored contact lenses;

(f) Glass lenses;

(g) Nonglare or anti-reflective lenses;

(h) Progressive lenses;

(i) Sunglasses and accessories that function as sunglasses (e.g., "clip-ons");

(j) Upgrades at private expense to avoid the medicaid agency's contract limitations (e.g., frames that are not available through the agency's contract or noncontract frames or lenses for which the client or other person pays the difference between the agency's payment and the total cost).

(2) A noncovered service may be requested as an exception to rule (ETR) as described in WAC 182-501-0160.

(3) ((~~When a noncovered service is recommended based on the early and periodic screening, diagnosis, and treatment (EPSDT) program, the agency evaluates the request for medical necessity based on the definition in WAC 182-500-0070 and the process in WAC 182-501-0165.~~)) For clients age 20 and younger, providers must follow the rules for the early periodic screening, diagnosis, and treatment (EPSDT) program, see chapter 182-534 WAC.

AMENDATORY SECTION (Amending WSR 19-18-049, filed 8/30/19, effective 10/1/19)

WAC 182-552-0450 Mandibular advancement device. The agency covers the purchase of a mandibular advancement device for a client when the provider determines that the use of a continuous positive airway pressure (CPAP) device is medically contraindicated or the client cannot medically tolerate a CPAP device. Prior authorization is required for all eligible clients.

(1) The agency considers a mandibular advancement device to be medical equipment subject to the same billing requirements, restrictions, and limitations as other medical equipment according to chapter 182-543 WAC.

(2) For clients:

(a) Who have natural dentition, the agency pays for one custom-made mandibular advancement device every five years. The client must:

(i) Complete a face-to-face evaluation with a sleep medicine physician in an agency-designated center of excellence (COE) prior to sleep testing;

(ii) Be diagnosed with obstructive sleep apnea (OSA) using a clinical evaluation and positive attended polysomnogram (PSG); and

(iii) Meet the sleep testing criteria described in WAC 182-552-0400.

(b) ((~~For clients age twenty or younger, the agency evaluates requests for a mandibular advancement device according to the early periodic screening, diagnosis, and treatment (EPSDT) criteria found in WAC 182-534-0100. Under EPSDT, the agency will pay for a service if it is medically necessary, safe, effective, and not experimental.~~)) Age 20 and younger, providers must follow the rules for the early periodic screening, diagnosis, and treatment (EPSDT) program, see chapter 182-534 WAC.

(3) The prescriber must keep the following in the client's record:

(a) Documentation of a CPAP trial lasting at least six consecutive months; and

(b) A description of why CPAP failed or an explanation of why CPAP is not the appropriate treatment.

(4) The mandibular advancement device must be titrated by a licensed provider who has documented experience in titrating these devices.

(5) The mandibular advancement device must be provided and billed by a licensed dentist who:

(a) Holds a certification in dental sleep medicine from the American Board of Dental Sleep Medicine (ABDSM); or

(b) Is the dental director of a dental sleep medicine facility accredited by the ABDSM; or

(c) Has completed agency-recognized continuing education in dental sleep medicine provided by the ABDSM or a comparable organization within the two years prior to providing the mandibular advancement device.

(6) The agency evaluates requests for authorization for mandibular advancement devices that exceed the limitations in this section on a case-by-case basis in accordance with WAC 182-501-0169.

AMENDATORY SECTION (Amending WSR 17-08-009, filed 3/24/17, effective 5/1/17)

WAC 182-554-800 Noncovered—Enteral nutrition products, equipment, and related supplies. (1) The medicaid agency does not cover the following:

(a) Nonmedical equipment, supplies, and related services (for example, backpacks, pouches, bags, baskets, or other carrying containers); and

(b) Orally administered enteral nutrition products for any client age ((~~twenty-one~~)) 21 and older.

(2) A provider may request an exception to rule under WAC 182-501-0160 for a noncovered service.

(3) ((~~When early and periodic screening, diagnosis, and treatment (EPSDT) applies, the agency evaluates a request for a noncovered service, equipment, or related supplies under WAC 182-501-0165. See WAC 182-534-0100 for EPSDT rules.~~)) For children age 20 and younger, providers must follow the rules for the early periodic screening, diagnosis, and treatment (EPSDT) program, see chapter 182-534 WAC.

AMENDATORY SECTION (Amending WSR 15-10-018, filed 4/24/15, effective 5/25/15)

WAC 182-556-0200 Chiropractic services for children. (1) The medicaid agency ((~~pays only for~~)) covers chiropractic services((~~:~~

~~(a) For clients who are:~~

~~(i) Under age twenty-one; and~~

~~(ii) Referred by a screening provider under the healthy kids/early and periodic screening, diagnosis, and treatment (EPSDT) program.~~

~~(b) That are:~~

~~(i) Medically necessary under WAC 182-500-0070, safe, effective, and not experimental;~~

~~(ii)~~)) for clients age 20 and younger only. Providers must follow the rules for the early period screening, diagnosis, and treatment (EPSDT) program, see chapter 182-534 WAC.

(2) To be paid, chiropractic services must be:

(a) Provided by a chiropractor licensed in the state where services are provided; ((~~and~~

~~(iii)~~)) (b) Within the scope of the chiropractor's license((~~.~~));

and

(c) Limited to:

(i) Chiropractic manipulative treatments of the spine; and

(ii) X-rays of the spine.

((~~(2)~~)) (3) Chiropractic services are paid according to fees established by the agency using methodology set out in WAC 182-531-1850.