Washington State Health Care Authority

Washington Apple Health (Medicaid)

Dental-Related Services Program Billing Guide

July 1, 2026

Washington State Health Care Authority

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict arises between this document and a governing statute or Health Care Authority (HCA) rule, the governing statute or HCA rule applies.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If the broken link is in the most recent guide, please notify us at askmedicaid@hca.wa.gov.

About this guide*

This publication takes effect **July 1, 2026,** and supersedes earlier billing guides to this program. Unless otherwise specified, the program in this guide is governed by the rules found in Chapter 182-535 WAC.

The Health Care Authority is committed to providing equal access to our services. If you need accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

> Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by HCA.

Refer also to HCA's ProviderOne billing and resource guide for valuable information to help you conduct business with the Health Care Authority.

You must bill services, equipment, or both, related to any of the programs listed below using the Health Care Authority's Washington Apple Health program-specific billing guides:

- Access to baby and child dentistry (ABCD)
- Orthodontic services

How can I get HCA Apple Health provider documents?

To access provider alerts, go to HCA's provider alerts webpage.

To access provider documents, go to HCA's provider billing guides and fee schedules webpage.

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Health care privacy toolkit

The **Washington Health Care Privacy Toolkit** is a resource for providers required to comply with health care privacy laws.

Where can I download HCA forms?

To download an HCA form, see HCA's **Forms & Publications** webpage. Type only the form number into the Search box (Example: 13-835).

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What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item is the Subject column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
Throughout guide	Changed all references to DDCS back to DDA.	DSHS reunited developmental disabilities services back under the Development Disabilities Administration (DDA). No change in policy.
X-rays (radiographs)	Added criteria language for oral and facial photographic images EPA # assigned to CDT® code D0350	To provide specific information regarding asynchronous teledentistry
Oral hygiene instruction	Added dental therapist	New provider type who can provide this service
Crowns – single restorations only	Added language – "Placement is encouraged to occur after physical maturity has occurred (17-18 years of age) to reduce gingival margin changes resulting in exposed crown margins. If function requires crown placement at an earlier age, HCA will consider that in review of request."	Additional recommendation

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Subject	Change	Reason for Change
Endodontic retreatment on permanent teeth – prior authorization	Changed "diagnosis" to "pulp and periapical diagnosis for tooth/teeth"	Added specificity for clarity
Apexification/apicoectomy	Changed "diagnosis" to "pulp and periapical diagnosis for tooth/teeth"	Added specificity for clarity
Surgical excision of soft tissue and soft tissue lesions	Moved CDT® codes D7970 and D7971 to this section from Excision of bone tissue section	To place codes in the appropriate section - these codes are related to soft tissue excision
Surgical incision	Added "or palliative treatment (CDT® D9110)" and removed the note box referencing this	Simplification
Occlusal orthotic devices	Added "splints"	To clarify that occlusal orthotic devices may be referred to as "splints"
Palliative treatment	Updated language with additional criteria	Clarification regarding when this treatment cannot be billed

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Subject	Change	Reason for Change
Anesthesia	Added language to CDT® codes D9223 and D9225 "Age 9 through 20 and in foster care/kinship care" Added EPA numbers Added additional criteria language Added additional language for documentation requirements for prior authorization	Clarification for those clients eligible for foster care Clarification regarding documentation from the provider
Is teledentistry covered?	Added language for training website and teledentistry guidelines	To provide additional information
What is teledentistry?	Added dental therapists	New provider type
Documentation – teledentistry	Added language regarding radiographs	Additional documentation requirement
What is not covered through teledentistry	Added examples of appointment scheduling and patient registration	Clarification of what is not covered
What dental-related services are not covered?	Added under restorative services "Restorations for noncavitated, initial lesions on any surface of any tooth"	Clarification that aligns with HCA's restorative policy

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Subject	Change	Reason for Change
EPA Code list	Added additional criterial RAC codes for CDT® codes D9222, D9223, D9224, and D9225 Added EPA # for CDT® code D0350 Oral/facial photo images	Added for clients who need general anesthesia and are enrolled in foster care Reduce administrative burden

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Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to chapter 182-500 WAC for a complete list of definitions for Washington Apple Health. The Health Care Authority also used dental definitions found in the current American Dental Association's Current Dental Terminology (CDT®) and the current American Medical Association's Physician's Current Procedural Terminology (CPT®). **Where there is any discrepancy between this section and the current CDT or CPT, this section prevails**.

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

Alternate Living Facility (ALF) – Refer to WAC 182-513-1100.

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

Amalgam restorations (including polishing) – Tooth preparation, all adhesives (including amalgam bonding agents). Liners and bases are included as part of the restoration.

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

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

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

- Permanent maxillary anterior teeth include teeth 6, 7, 8, 9, 10, and 11
- Permanent mandibular anterior teeth include teeth 22, 23, 24, 25, 26, and 27
- Primary maxillary anterior teeth include teeth C, D, E, F, G, and H
- Primary mandibular anterior teeth include teeth M, N, O, P, Q, and R (WAC 182-535-1050)

Asynchronous – Two or more events not happening at the same time.

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

Behavior management – 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 the dental treatment delivery.

Border areas – See WAC 182-501-0175.

By-report – A method of reimbursement where Health Care Authority determines the amount it will pay for a service when the rate for that service is not included in the Health Care Authority'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.

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

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

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

Conscious sedation – 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 build-up – Refers to building up of clinical crowns, including pins.

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

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

Current Dental Terminology (CDT®) – A systematic listing of descriptive terms and identifying codes for reporting dental services and procedures performed by dental practitioners. CDT is by the Council on Dental Benefit Programs of the American Dental Association (ADA).

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

Decay – A term for carious lesions in a tooth and means decomposition of the tooth structure.

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

Dentures – An artificial replacement for natural teeth and adjacent tissues, and includes complete dentures, overdentures, and partial dentures.

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

Developmental Disabilities Administration (DDA) – The administration within the Department of Social and Health Services that provides services to adults and children with intellectual and developmental disabilities.

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Distant site (location of dentist) – The physical location of the dentist or authorized dental provider providing the dental service to an eligible Medicaid client through teledentistry. (WAC 182-531-1730)

Endodontic – The etiology, diagnosis, prevention, and treatment of diseases and injuries of the pulp and associated periradicular conditions. (WAC 182-535-1050)

Edentulous – Lacking teeth.

EPSDT – The Health Care Authority'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 – A substance containing dental fluoride, which is applied to teeth, not including silver diamine fluoride.

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

High noble metal – A dental alloy containing at least 60% pure gold.

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

Intraoral comprehensive series of radiographic images – A radiographic survey of the whole mouth intended to display the crowns and roots of all teeth, periapical areas, interproximal areas and alveolar bone including edentulous areas.

Limited oral evaluation – An evaluation limited to a specific oral health condition or problem. Typically, a client receiving this type of evaluation has a dental emergency, such as trauma or acute infection.

Limited visual oral assessment – An assessment by a dentist or dental hygienist provided in settings other than dental offices or dental clinics to identify signs of disease and the potential need for referral for diagnosis.

Mobile anesthesiologist – 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.

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

Nursing facility – An institution that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.

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

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Originating site (location of client) – The physical location of the eligible Medicaid client. (WAC 182-531-1730)

Overdenture – Type of complete denture that is supported by a few remaining teeth or dental implants and attached by specialized dental attachments secured on the roots or implants.

Palliative treatment – Treatment that relieves pain but is not curative; services provided do not have distinct procedure codes.

Partials or partial dentures – A removable prosthetic appliance that replaces missing teeth on either arch.

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

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

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

Posterior – The teeth (maxillary and mandibular premolars and molars) and tissue towards the back of the mouth:

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

Primary – The first set of teeth.

Prophylaxis – Removal of calculus, plaque, and stains from tooth structures and implants in the permanent and transitional dentition. It is intended to control local irritational factors.

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

Radiograph (x-ray) – An image or picture produced on a radiation sensitive film emulsion or digital sensor by exposure to ionizing radiation.

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

Resin-based composite restorations – 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

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are included as part of the restoration. Glass ionomers, when used as definitive restorations, should be reported with these codes.

Root canal – The chamber within the root of the tooth that contains the pulp.

Root canal therapy – The treatment of the pulp and associated periradicular conditions.

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

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

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

Silver Diamine Fluoride – An odorless liquid that contains silver particles and fluoride, applied to teeth to arrest caries.

Simple extraction – 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 – What reasonable and prudent practitioners would do in the same or similar circumstances.

Supernumerary teeth – Extra erupted or unerupted teeth that resemble teeth of normal shape designated by the number series 51 through 82 and AS through TS.

Surgical extraction – The extraction of an erupted or impacted tooth requiring the removal of bone and/or sectioning of 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 – Existing or occurring at the same time.

Teledentistry – 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 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) – An abnormal functioning of the temporomandibular joint or other areas secondary to the dysfunction.

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

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About the Program

What is the purpose of the Dental-Related Services program?

The purpose of the Dental-Related Services program is to provide quality dental and dental-related services to eligible Washington Apple Health clients, subject to the limitations, restrictions, and age requirements identified in this billing guide.

Who is eligible to become a Health Care Authority-contracted provider?

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

- Persons currently licensed by the state of Washington to:
  - Practice dentistry or specialties of dentistry
  - Practice medicine and osteopathy for either of the following:
    - Oral surgery procedures.
    - Providing fluoride varnish under the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Well-Child Program Billing Guide.
  - Practice as a dental hygienist
  - Practice as a denturist
  - Practice as a dental therapist
  - Practice anesthesia by any of the following:
    - Providing conscious sedation with parenteral or multiple oral agents, deep sedation, or general anesthesia as an anesthesiologist, dental anesthesiologist, or qualified professional under **chapter 246-817 WAC**.
    - Providing minimal sedation which is limited to a single dose of a single oral agent with or without nitrous oxide as outlined by the Department of Health (DOH). See **WAC 246-817-745**.
    - Providing moderate sedation with parenteral or enteral agents, as a dentist with a moderate sedation permit issued by DOH that is current at the time the billed service is provided. See **WAC 246-817-755** and **246-817-760**.
    - Providing moderate sedation with enteral or parenteral agents to pediatric patients as a dentist with a pediatric sedation endorsement issued by DOH that is current at the time the billed service is provided. See **WAC 246-817-765**.

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  - Providing deep sedation or general anesthesia as a dentist with a deep sedation or general anesthesia permit issued by DOH that is current at the time the billed service is provided.
  - Providing anesthesia services in a mobile setting as an anesthesiologist, dental anesthesiologist, or qualified professional who holds a current mobile anesthesia contract with HCA.

- Facilities that are one of the following:
  - Hospitals currently licensed by DOH.
  - Federally qualified health centers (FQHCs).
  - Medicare-certified ambulatory surgery centers (ASCs).
  - Medicare-certified rural health clinics (RHCs).
  - Community health centers (CHC).
- Participating local health jurisdictions.
- Border area providers of dental-related services who are qualified in their states to provide these services.

Note: HCA pays licensed providers participating in HCA's Dental-Related Services program for only those services that are within their scope of practice. (WAC 182-535-1070(2))

Can substitute dentists (locum tenens) provide and bill for dental-related services?

(42 U.S.C. 1396a(32)(I))

Yes. Dentists may bill under certain circumstances for services provided on a temporary basis (i.e., locum tenens) to their patients by another dentist.

The dentist's claim must identify the substituting dentist providing the temporary services. Complete the claim as follows:

Enter the provider's National Provider Identifier (NPI) and taxonomy of the locum tenens dentist who performed the substitute services in the Servicing Provider section of the electronic claim.

The locum tenens dentist must enroll as a Washington Apple Health provider in order to treat a Washington Apple Health client and submit claims. For enrollment information, go to the Enroll as a provider webpage.

Enter the billing provider information in the usual manner.

An informal reciprocal arrangement, billing for temporary services is limited to a period of 14 continuous days, with at least one day elapsing between 14-day periods.

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A locum tenens arrangement involving per diem or other fee-for-time compensation, billing for temporary services is limited to a period of 90 continuous days, with at least 30 days elapsing between 90-day periods.

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Client Eligibility

How do I verify a client's eligibility?

Check the client's services card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service HCA will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Apple Health**. For detailed instructions on verifying a patient's eligibility for Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in HCA's ProviderOne Billing and Resource Guide.

If the patient is eligible for Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

Step 2. **Verify service coverage under the Apple Health client's benefit package**. To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see HCA's Program Benefit Packages and Scope of Services webpage.

Note: To determine if the client has the DDA indicator, see the ProviderOne Billing and Resource Guide.

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Note: Patients who are not Apple Health clients may apply for health care coverage in one of the following ways:

- **Online**: Go to **Washington Healthplanfinder** - select the "Let's get started" button. For patients age 65 and older, or on Medicare, go to **Washington Connections** – select the "Apply Now" button.
- **Mobile app:** Download the **WAPlanfinder app** – select "sign in" or "create an account".
- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 855-627-9604 (TTY).
- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form. To download an HCA form, see HCA's Free or Low Cost Health Care, **Forms & Publications** webpage. Type only the form number into the Search box (Example: **18-001P**). For patients age 65 and older, or on Medicare, complete the *Washington Apple Health Application for Age, Blind, Disabled/Long-Term Services and Supports (HCA 18-005)* form.
- **In-person**: Local resources who, at no additional cost, can help you apply for health coverage. See the **Health Benefit Exchange Navigator**.

Are clients enrolled in an HCA-contracted managed care organization (MCO) eligible?

Yes. Dental-related services, including surgical services with a dental-related diagnosis, for eligible clients enrolled in an HCA-contracted managed care organization (MCO) are covered under Washington Apple Health fee-for-service. Bill HCA directly for all dental-related services provided to eligible MCO clients.

Reentry Initiative

The Reentry Demonstration Initiative (Reentry Initiative) is a new Apple Health (Medicaid) initiative under the Medicaid Transformation Project (MTP). Under this initiative, incarcerated people who are Apple Health-eligible may receive a limited set of health care services through fee-for-service (FFS) or their HCA-contracted managed care organization (MCO) for up to 90 days before their release from carceral facilities within Washington State. These services will ensure a person's healthy and successful reentry into their community. For more information, visit **Reentry from a carceral setting**.

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Early Periodic Screening, Diagnosis, and Treatment (EPSDT)

Early periodic screening, diagnosis, and treatment (EPSDT) includes all services that are medically necessary to address health conditions for clients age 20 and younger. Providers may reference program-specific billing guides for services and equipment not covered by this billing guide; see also the rules for the EPSDT program described in **chapter 182-534 WAC**. Published limits for services covered under EPSDT, if any, may be exceeded based on agency review of medical necessity described in **WAC 182-501-0165**.

To request a noncovered service, see the **Well-Child Program (EPSDT) Billing Guide**.

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Coverage

When does HCA pay for covered dental-related services?

Subject to coverage limitations and client-age requirements identified for a specific service, HCA pays for dental-related services and procedures when the services are all of the following:

- Part of the client's benefit package.
- Within the scope of an eligible client's Washington Apple Health program.
- Medically necessary.
- Meet HCA's authorization requirements, if any.
- Documented in the client's record per chapter 182-502 WAC and meet the Department of Health's (DOH) requirements in WAC 246-817-305 and WAC 246-817-310.
- Within accepted dental or medical practice standards.
- Consistent with a diagnosis of dental disease or dental condition in alignment with current evidence-based guidelines.
- Reasonable in amount and duration of care, treatment, or service.
- Listed as covered in this billing guide.

For orthodontic services, see chapter 182-535A WAC and HCA's Orthodontic services billing guide.

What services performed in a hospital or ambulatory surgery center (ASC) are covered?

Dental providers

- HCA covers evaluation and management (E/M) codes (formerly hospital visits and consults) when an oral surgeon is called to the hospital or receives a client from the hospital for an emergency condition (i.e., infection, fracture, or trauma).
- When billing for E/M codes in facility settings, oral surgeons must use CPT® codes and follow CPT® rules, including the use of modifiers. When billing for emergency hospital visits, oral surgeons must bill:
  - On an electronic professional claim.
  - Using the appropriate CPT® code and modifiers, if appropriate.
- HCA requires prior authorization (PA) for CDT® dental services performed in a hospital or an ASC for clients age 9 and older (except for clients of the

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Developmental Disabilities Administration (DDA) division). HCA reviews requests for PA in accordance with **WAC 182-501-0165**.

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

Place of Service	Setting
19	Outpatient hospital clinic – off campus
21	Inpatient hospital
22	Outpatient hospital clinic – on campus
24	Ambulatory surgery center

- The dentist providing the service must send in a request for PA to perform the procedure in these settings. The request must:
  - Contain at least one procedure code.
  - List all applicable codes that require PA.

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

  - Be submitted on the General Information for Authorization form, HCA 13-835. See Where can I download HCA forms?
  - Include a letter that clearly describes the medical necessity of performing the service in the requested setting.

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

- HCA requires providers to report dental services, including oral and maxillofacial surgeries, using CDT® codes.

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Exception: Oral surgeons may use CPT® codes listed in HCA's Physician-related/professional services fee schedule only when the procedure performed is not listed as a covered CDT® code in HCA's Dental program fee schedule. CPT® codes must be billed on an electronic professional claim.

- HCA pays dentists and oral surgeons for hospital visits using only the CPT® codes listed in the oral surgery section of the Physician-related services/health care professional services billing guide. In accordance with CPT guidelines, evaluation and management codes (visit codes) are not allowed on the same day as a surgery code (CPT® or CDT®) unless the decision to do the surgery was made that day and appropriate modifiers are used.
- HCA follows the National Correct Coding Initiative (NCCI) policy. The Centers for Medicare and Medicaid Services (CMS) created this policy to promote national correct coding methods. NCCI assists HCA to control improper coding that may lead to inappropriate payment. For more information about HCA's policy to follow NCCI rules, see the National correct coding initiative section of the Physician-related services/health care professional services billing guide.
- If requesting anesthesia time that is significantly greater than the normal anesthesia time for the procedure, include the medical justification for this in the documentation.

Facilities

- Hospitals and ASCs must use CDT® codes for dental procedures. Hospitals and ASCs may bill with a CPT® code only if there is no CDT® code that covers the service performed.
- Coverage and payment are limited to those CDT® and select CPT® codes listed in the Health Care Authority's Dental program fee schedule.
- ASCs are paid only for the codes listed in the Health Care Authority's Ambulatory surgery centers billing guide.
- A mobile anesthesia facility fee may be billed only by mobile anesthesiologists who hold a mobile anesthesia contract with the Health Care Authority.
- Professional anesthesia fees are billable by the anesthesia provider only, not by the facility.

Note: Hospital and ASC facility fees for eligible clients enrolled in an HCA-contracted managed care organization (MCO) must be billed directly through the client's MCO.

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Site-of-service prior authorization

HCA requires site-of-service PA in addition to PA of the procedure, if applicable, for nonemergency dental-related services performed in a hospital or an ASC when all of the following are true:

- The client is not a client of the DDA.
- The client is age 9 or older.
- The service is not listed as exempt from the site-of-service PA requirement in this billing guide or HCA's Dental-related services fee schedule.
- The service is not listed as exempt from the PA requirement for deep sedation or general anesthesia (see What adjunctive general services are covered?).

To be eligible for payment, dental-related services performed in a hospital, or an ASC, must be listed in HCA's Outpatient fee schedule or ASC fee schedule. The claim must be billed with the correct procedure code for the site-of-service.

What is a limitation extension (LE) or exception to rule (ETR)?

What is a limitation extension?

A limitation extension (LE) is an authorization of services beyond the designated benefit limit allowed in Washington Administration Code (WAC) and HCA's Washington Apple Health billing guides.

> **Note**: A request for a limitation extension must be appropriate to the client's eligibility or program limitations. Not all eligibility groups cover all services.

HCA evaluates a request for dental-related services that are in excess of the Dental Program's limitations or restrictions, according to WAC 182-501-0169.

How do I request an LE?

HCA requires a dental provider who is requesting a limitation extension (LE) to submit sufficient, objective, clinical information to establish medical necessity.

Providers may submit an LE request by direct data entry into ProviderOne or by fax (see HCA's prior authorization webpage for details).

HCA may request additional information as follows:

- Additional x-rays (radiographs).
- Photographs.
- Any other information considered necessary.

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Note: HCA may require second opinions and consultations before authorizing any procedure.

Removable Dental Prosthetics

For nursing facility clients, the LE request must also include a completed copy of the *Denture/Partial Prosthesis Request for Skilled Nursing Facility and Alternate Living Facility Client* form, HCA #13-788. See Where can I download HCA forms?

How do I request a noncovered service?

For clients age 0 through 20, send a completed *Fax/Written Request Basic Information* form (HCA 13-756) to the address or fax listed on the form. (See Where can I download HCA forms?). For more information, see the **Well-Child Program (EPSDT) Billing Guide** or **Chapter 182-534 WAC**.

For clients age 21 and older, providers may request a noncovered service through an **Exception to Rule** (ETR).

What is an exception to rule?

An Exception to Rule (ETR) is a request for payment by HCA for a noncovered service. HCA reviews these requests according to WAC 182-501-0160.

Any item or service for which an ETR is requested must be submitted to the agency or the agency's designee in writing within 90 days of the date of the written notification denying authorization for the noncovered service.

To request an ETR, providers may submit their request by direct data entry into ProviderOne or by fax (see HCA's prior authorization webpage for details).

Indicate in the comments box that you are requesting an ETR.

Be sure to provide all the evidence required by WAC 182-501-0160.

What diagnostic services are covered?

Subject to coverage limitations, restrictions, and client-age requirements identified for a specific service, HCA covers the following dental-related diagnostic services:

Oral health evaluations and assessments

HCA covers per client, per provider or clinic:

- **Periodic oral evaluations**, once every 6 months. Six months must elapse between the comprehensive oral evaluation and the first periodic oral evaluation. Exception to limits, see **Clients of the Developmental Disabilities Administration** (DDA) division, Preventive Services.
- **Limited oral evaluations**, only when the provider performing the limited oral evaluation is not providing routine scheduled dental services for the client on the same day.

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Note: Any post-operation evaluations are covered as part of the original procedure's global fee and are not considered as a limited oral evaluation.

- The limited oral evaluation:
  - Must evaluate the client for one of the following:
    - A specific dental problem or oral health complaint
    - A dental emergency
    - A referral for other treatment
  - When performed by a denturist, is limited to the initial examination appointment. HCA does not cover any additional limited examination by a denturist for the same client until 3 months after the delivery of a removable dental prosthesis.
- **Comprehensive oral evaluations** as an initial examination includes:
  - A complete dental and medical history and general health assessment.
  - A thorough evaluation of extra-oral and intra-oral hard and soft tissue.
  - The evaluation and recording of dental caries, missing or unerupted teeth, restoration, occlusal relationships, periodontal evaluation, hard and soft tissue anomalies, and oral cancer screening.

  HCA covers comprehensive oral evaluation per provider/same clinic once every 5 years or sooner for established patients who have a significant health change. (See EPA).

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

CDT® Code	Short Description	PA?
D0120	Periodic oral evaluation	N*
D0140	Limited oral eval problm focus	N*
D0150	Comprehensive oral evaluation	N*

*Oral surgeons may bill E/M codes (CPT® 99201-99215) on an electronic professional claim to represent these services instead of CDT® codes.

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Note: CDT® code D0150 is to be used for all ages. For clients ages 0 through 3, **do not** bill CDT® code D0145. Use CDT® code D0150.

Limited visual oral assessment (pre-diagnostic services)

HCA covers limited visual oral assessments or screening, allowed two times per client, per provider in a calendar year as follows:

- When not performed in conjunction with other clinical oral evaluation services.
- When performed by a licensed dentist, dental therapist, or dental hygienist to determine the need for sealants, fluoride treatment, or when triage services are provided in **settings other than dental offices or dental clinics** (*e.g.*, alternate living facilities, etc.).

CDT® Code	Short Description	PA?
D0190	Screening of a patient	N
D0191	Assessment of a patient	N

See the **limitation extension (LE)** section of this billing guide for requesting additional units of the service.

Alcohol and substance misuse counseling

HCA covers alcohol and substance misuse counseling through Screening, Brief Interventions, and Referral to Treatment (SBIRT) services when provided by, or under the supervision of, a certified physician or other certified licensed health care professional, such as a dentist or a dental hygienist, within the scope of their practice. See HCA's Physician-Related Services/Health Care Professional Services Billing Guide.

X-rays (radiographs)

HCA uses the prevailing standard of care to determine the need for dental x-rays (radiographs). The request for x-rays must be an individual assessment for each client and follow the "**As Low As Reasonably Achievable (ALARA)**" principle.

HCA covers:

- X-rays (radiographs), per client, per provider or clinic, that are of diagnostic quality, dated, and labeled with the client's name. HCA requires:
  - Retention of original x-rays (radiographs) in the client's dental record.
  - Submission of duplicate x-rays (radiographs) with prior authorization requests and when copies of dental records are requested by HCA.

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- An intraoral complete series, once in a 3-year period for clients age 14 and older:
  - Only if HCA has not paid for a panoramic x-ray (radiograph) for the same client in the same 3-year period.
  - The intraoral comprehensive series of radiographic images typically includes 14 to 22 periapical and posterior bitewings (radiographs).
  - HCA limits reimbursement for all x-rays (radiographs) to a total payment of no more than the payment for a complete series.
- Medically necessary periapical x-rays (radiographs) that are not included in a complete series for diagnosis in conjunction with definitive treatment, such as root canal therapy. Documentation supporting medical necessity for the procedure must be included in the client's record.
- An occlusal intraoral x-ray (radiograph), per arch, once in a 2-year period, for clients age 20 and younger.
- A maximum of four bitewing x-rays (radiographs) once every 12 months.
- Panoramic x-rays (radiographs) (for dental only) in conjunction with four bitewings, once in a 3-year period:
  - Only if HCA has not paid for an intraoral complete series for the same client in the same 3-year period.
  - Preoperative and postoperative panoramic x-rays (radiographs), one per surgery without PA.
  - For orthodontic services, see the Orthodontic services billing guide.
- Cephalometric films – One preoperative and postoperative cephalometric film per surgery without PA for providers with taxonomy of 1223S0112X.
- Additional x-rays (radiographs) will be considered on a case-by-case basis with PA.
- X-rays (radiographs) not listed as covered, only on a case-by-case basis with PA.
- Oral and facial photographic images are allowed when taken to facilitate an examination (CDT® D0140, D0150, D0120) via asynchronous teledentistry. It must be billed in conjunction with asynchronous teledentistry and is only allowed in the following settings: skilled nursing facility (SNF), adult family homes, group homes, and schools. Oral and facial photographic images are not allowable for synchronous teledentistry. All other photographic images will be reviewed on a case-by-case basis and require PA.
- HCA reviews requests for PA in accordance with WAC 182-501-0165.

CDT® Code	Short Description	PA?	Requirements
D0210	Intraor complete film series	N	Clients age 14 and older

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CDT® Code	Short Description	PA?	Requirements
D0220	Intraoral periapical first	N	
D0230	Intraoral periapical ea add	N	
D0240	Intraoral occlusal film	N	Clients age 20 and younger only
D0270	Dental bitewing single image	N	
D0272	Dental bitewings two images	N	
D0273	Bitewings – three images	N	
D0274	Bitewings four images	N	
D0330	Panoramic image	N	
D0340	2d cephalometric image	Y	Clients age 20 and younger only
D0350	Oral/facial photo images	Y	See EPA #870001741

Note: HCA does not require PA for additional medically necessary panoramic x-rays (radiographs) ordered by oral surgeons and orthodontists.

Tests and examinations

HCA covers the following for clients age 20 and younger:

- One pulp vitality test per visit (not per tooth):
  - For diagnosis only during limited oral evaluations.
  - When x-rays (radiographs) or documented symptoms, or both, justify the medical necessity for the pulp vitality test.

CDT® Code	Short Description	PA?
D0460	Pulp vitality test	N

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

What preventive services are covered?

Prophylaxis

HCA:

- Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains when performed on a primary or permanent dentition or implants as part of the prophylaxis service.
- Limits prophylaxis to once every:
  - Six months for a client:
    - Age 18 and younger; or
    - Of any age residing in an alternate living facility (ALF) or skilled nursing facility (SNF).
  - Twelve months for a client age 19 and older.
  - Four months for a client of the Developmental Disabilities Administration (DDA).
- Reimburses only when the prophylaxis is performed:
  - At least 6 months after periodontal scaling and root planing, or periodontal maintenance services, for clients:
    - Age 13 to 18;
    - Of any age residing in an alternative living facility (ALF) or skilled nursing facility (SNF)
  - At least 12 months after periodontal scaling and root planing, or periodontal maintenance services, for clients age 19 and older.
  - At least 4 months after periodontal scaling and root planing or periodontal maintenance services for a **Developmental Disabilities Administration** (DDA) client.
- Does not reimburse for prophylaxis separately when any of the following are performed:
  - Periodontal scaling and root planing
  - Periodontal maintenance
  - Scaling in the presence of generalized moderate or severe gingival inflammation
  - Full mouth debridement

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- Gingivectomy
- Gingivoplasty
- On the same date of service
- Within 6 months for clients:
  - Age 13 to 18; or
  - Of any age residing in an alternative living facility (ALF) or skilled nursing facility (SNF)
- Within 12 months for clients age 19 and older
- Within 4 months for clients of the **Developmental Disabilities Administration** (DDA)

CDT® Code	Short Description	PA?	Age Limitation
D1110	Dental prophylaxis adult	N	Clients age 14 and older only
D1120	Dental prophylaxis child	N	Clients through age 13 only

See the **limitation extension (LE)** section of this billing guide for requesting additional units of the service.

Topical fluoride treatment

HCA covers fluoride rinse, foam or gel, or fluoride varnish, including disposable trays, per client, per provider or clinic as follows:

Clients who are . . .	Frequency
Age 6 and younger or all ages for clients of DDA	Three times within a 12-month period with a minimum of 110 days between applications
Age 7 through 18 or residing in ALFs or nursing facilities	Two times within a 12-month period with a minimum of 170 days between applications
Age 7 through 20 receiving orthodontic treatment	Three times within a 12-month period during orthodontic treatment with a minimum of 110 days between applications The provider must bill with the initial appliance placement date.
Age 19 and older	Once within a 12-month period

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Note: Additional topical fluoride applications are approved only on a case-by-case basis with PA. HCA reviews requests for PA in accordance with WAC 182-501-0165.

CDT® Code	Short Description	PA?
D1206	Topical fluoride varnish	N
D1208	Topical app fluorid ex vrnsh	N

Note: CDT® codes D1206 and D1208 are not allowed on the same day. The fluoride limit per provider, per client, for CDT® codes D1206 and D1208 is the combined total of two, not per code. The codes are equivalent, and a total of three or two fluorides are allowed, not three or two of each.

Oral hygiene instruction

HCA covers oral hygiene instruction only for clients who are age 8 and younger. Oral hygiene instruction includes individualized instruction for home care such as tooth brushing techniques, flossing, and use of oral hygiene aids.

HCA covers oral hygiene instruction as follows:

- Only two times per client, per provider, in a calendar year.
- Only when not performed on the same date of service as prophylaxis or within 6 months from a prophylaxis by the same provider or clinic.

Note: HCA covers oral hygiene instruction provided by a licensed dentist, dental therapist, or dental hygienist only when the instruction is in a setting other than a dental office or clinic.

CDT® Code	Short Description	PA?	Age Limitation
D1330	Oral hygiene instruction	N	Clients age 8 and younger only

Note: For clients age 9 and older, oral hygiene instruction is included as part of the global fee for prophylaxis.

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Tobacco cessation counseling

HCA covers tobacco cessation counseling for all Washington Apple Health clients. Refer to the **Physician-related services/health care professional services billing guide**.

Sealants

HCA covers sealants for the occlusal surfaces of permanent teeth 2, 3, 14, 15, 18, 19, 30, 31 and primary teeth A, B, I, J, K, L, S, and T when the following criteria are met:

- Clients are age 20 and younger or people of any age who are clients of the **Developmental Disabilities Administration** (DDA).
- Once per tooth:
  - In a 3-year period for clients age 20 and younger.
  - In a 2-year period for people of any age who are clients of DDA.
- Only when used on a mechanically and/or chemically prepared enamel surface.
- On non-carious teeth or teeth with non-cavitated initial caries lesions.
- Only when placed on a tooth with no pre-existing occlusal restoration, or any occlusal restoration placed on the same day.

Use of either resin-based or glass ionomer material for sealants is allowed.

Additional sealants are allowed on a case-by-case basis and when prior authorized.

CDT® Code	Short Description	PA?	Requirements	Age Limitation
D1351	Dental sealant per tooth	N	Tooth designation	Clients age 20 and younger; **DDA clients** of any age

See the **limitation extension (LE)** section of this billing guide for requesting additional units of the service.

Silver Diamine Fluoride

HCA covers the use of 38% silver diamine fluoride (SDF) per application as follows:

- When used for stopping the progression of caries (D1354) or as a topical preventive agent (D1354)
- Two times per client, per tooth, in a 12-month period

General Clinical Considerations:

- Treatment using SDF should follow evidence informed guidance found in:

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  - Evidence-based clinical practice guidelines on nonrestorative treatments for carious lesions – The Journal of the American Dental Association, and
  - SFD Indications and Technique: When and How to Use SDF to Manage Caries Lesions
- SDF should be used as part of a comprehensive caries management program
- The dental provider or office should have a signed informed consent form

Limitations:

- SDF must not be billed with interim therapeutic restoration on the same tooth, on the same date of service, when arresting caries or as a preventive agent.
- SDF application is included in the global payment for a restoration when done on the same tooth on the same day.
- SDF must not be billed in conjunction with any endodontic therapy codes or utilized in any situation where there is suspected or confirmed pulp exposure or involvement.
- HCA does not currently allow nano silver fluoride for CDT® code D1354. Evidence and recommendations will be monitored and updated as needed.

Note: For more information, see the SDF fact sheet on the Center for Evidence Based Policy website. The Center for Evidence Based Policy allows for the reprinting and distribution of the fact sheet.

CDT® Code	Short Description	PA?	Requirements	Age Limitation
D1354	Int caries med app per tooth	N	Tooth number	All ages

Space maintenance

HCA covers:

- One fixed unilateral space maintainer per quadrant or one fixed bilateral space maintainer per arch, for missing primary molars A, B, I, J, K, L, S, and T, subject to the following:
  - Evidence of pending permanent tooth eruption exists.
  - Initial space maintainers do not require PA.
  - Replacement space maintainers covered on a case-by-case basis with PA.
  - Space maintainer removal is included in the initial payment to the original provider who placed the space-maintainer.
- The removal of fixed space maintainers when removed by a different billing provider/clinic. Space maintainer removal allowed once per appliance.

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CDT® Code	Short Description	PA?	Requirements
D1510	Space maintainer fxd unilat	N*	Quadrant designation required *Replacement requires PA
D1516	Fixed bilat space maint, max	N*	No PA for initial placement. *Replacement requires PA.
D1517	Fixed bilat space maint, man	N*	No PA for initial placement. *Replacement requires PA.
D1551	Recement space maint - max	N	No PA required
D1552	Recement space maint - man	N	No PA required
D1553	Recement unilat space maint	N	No PA required
D1556	Rem fixed unilat space maint	N	Only allowed once by a different billing provider/clinic
D1557	Remove fixed bilat maint max	N	Only allowed once by a different billing provider/clinic
D1558	Remove fixed bilat man	N	Only allowed once by a different billing provider/clinic
D1575	Dist space maint, fixed unil	N	Quadrant designation required

Note: HCA does not pay for space maintainers (CDT® codes D1510, D1516, D1517, D1575) for clients during orthodontic treatment.

What restorative services are covered?

Amalgam, resin, and glass ionomer restorations for primary and permanent teeth

HCA considers:

- Tooth preparation, acid etching, all adhesives (including bonding agents), liners and bases, polishing, indirect and direct pulp capping, and curing as part of the restoration.
- Occlusal adjustment of either the restored tooth or the opposing tooth or teeth as part of the restoration.

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- Restorations placed within 6 months of a crown preparation by the same provider or clinic to be included in the payment for the crown.

Limitations for all restorations

HCA:

Considers restorative treatment for caries lesions to align with current evidence-based standards:

- **Evidence-Based Clinical Practice Guideline on Restorative Treatments for Caries Lesions** | American Dental Association (ada.org)
- **The American Dental Association Caries Classification System for Clinical Practice** – The Journal of the American Dental Association (ada.org)
- Considers multiple restorative resin, flowable composite resin, glass ionomer, or resin-based composite for the occlusal, buccal, lingual, mesial, and distal fissures and grooves on the same tooth as a one-surface restoration.
- Considers multiple restorations of fissures and grooves of the occlusal surface of the same tooth as a one-surface restoration.
- Considers resin-based composite restorations of teeth where the decay does not penetrate the dentinoenamel junction (DEJ) to be sealants. (See Sealants.)
- Does not pay for silver diamine fluoride application if a restoration is done on the same tooth on the same day.
- Covers only one buccal/facial and one lingual surface per tooth. The Health Care Authority reimburses buccal or lingual restorations, regardless of size or extension, as a one-surface restoration.
- Covers replacement restorations between 6 and 24 months of original placement if the restoration is cracked or broken. Requires prior authorization.
    - The client's record must include x-rays (radiographs) or documentation supporting the medical necessity for the replacement restoration.
    - 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 HCA does not pay separately.

Covers an additional restorative surface to a tooth or a buildup if original restoration was placed within 24 months. Prior authorization is required for teeth needing a buildup or additional restorative surfaces when the new restoration includes the original restorative surface. (Example: #19O is placed. Provider is requesting #19OB.) HCA reviews requests for PA in accordance with **WAC 182-501-0165**.

See the **limitation extension (LE)** section of this billing guide for requesting additional units of the service.

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Note: HCA does not cover any services, other than extractions, on supernumerary teeth. See How do I request a noncovered service?

Additional limitations for restorations on primary teeth

HCA covers:

- A maximum of three surfaces for a primary anterior tooth. (See Other restorative services for a primary anterior tooth that requires a restoration with four or more surfaces.) HCA does not pay for additional restorations on a primary anterior tooth after three surfaces unless EPA criteria are met (See EPA #870001307).

Additional limitations for restorations on permanent teeth

HCA covers:

- Two occlusal restorations for the upper molars on teeth 1, 2, 3, 14, 15, and 16, only if the restorations are anatomically separated by sound tooth structure.
  - To be paid for both restorations placed on the same tooth providers must bill on separate lines on the same claim.
- A maximum of five surfaces per tooth for permanent posterior teeth, except for upper molars. The Health Care Authority allows a maximum of six surfaces per tooth for teeth 1, 2, 3, 14, 15, and 16.
- A maximum of six surfaces per tooth for resin-based composite restorations for permanent anterior teeth.

CDT® Code	Short Description	PA?	Requirements
D2140	Amalgam one surface permanen	N	Tooth and surface designations required
D2150	Amalgam two surfaces permane	N	Tooth and surface designations required
D2160	Amalgam three surfaces perma	N	Tooth and surface designations required.
D2161	Amalgam 4 or > surfaces perm	N	Tooth and surface designations required.
D2330	Resin one surface - anterior	N	Tooth and surface designations required

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CDT® Code	Short Description	PA?	Requirements
D2331	Resin two surfaces - anterior	N	Tooth and surface designations required
D2332	Resin three surfaces - anterio	N	Tooth and surface designations required
D2335	Resin 4/> surf or w incis an	Y*	Tooth and surface designations required. Permanent teeth do not require EPA/PA. Primary teeth may meet EPA criteria. *See EPA #870001307.
D2390	Ant resin-based cmpst crown	Y*	Tooth designation required. Clients age 20 and younger only. Client's age 0-12 and DDA clients age 0-20 do not require EPA/PA. *Clients age 13-20 require PA.
D2391	Post 1 srfc resinbased cmpst	N	Tooth and surface designations required
D2392	Post 2 srfc resinbased cmpst	N	Tooth and surface designations required
D2393	Post 3 srfc resinbased cmpst	N	Tooth and surface designations required.
D2394	Post >=4srfc resinbase cmpst	N	Tooth and surface designations required.

Crowns – single restorations only

HCA covers:

- The following indirect crowns, per tooth, once every 5 years for permanent anterior teeth for clients age 15 through 20 when the crowns meet prior authorization (PA) criteria in Prior Authorization and the provider follows the PA requirements on the following page (HCA reviews requests for PA in accordance with **WAC 182-501-0165**):
    - Porcelain/ceramic crowns to include all porcelains, glasses, glass ceramic, and porcelain fused to metal crowns.
    - Resin crowns and resin metal crowns to include any resin-based composite, fiber, or ceramic reinforced polymer compound.

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  - Placement is encouraged to occur after physical maturity has occurred (17-18 years of age) to reduce gingival margin changes resulting in exposed crown margins. If function requires crown placement at an earlier age, HCA will consider that in review of request.
- General clinical considerations:
  - Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma and must involve four or more surfaces and at least 50% of the incisal edge.
  - If anterior tooth with endodontics:
    - Dated diagnostic post-endodontic radiograph
    - Tooth must be filled within 2 mm of apex unless there is a curvature or calcification of the canal that limits the ability to fill the canal to apex
    - Must be properly condensed/obturated and not overfilled

Payment

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

- Tooth and soft tissue preparation.
- Amalgam and resin-based composite restoration, or any other restorative material placed within 6 months of the crown preparation.

> **Exception**: HCA covers a one-surface restoration on an endodontically treated tooth, or a core buildup or cast post and core.

- Placement of filler to eliminate any undercut, box form, or irregularity.
- Temporaries, including but not limited to, temporary restoration, temporary crown, provisional crown, temporary prefabricated stainless-steel crown, ion crown, or acrylic crown.
- Packing cord placement and removal.
- Diagnostic or final impressions, conventional or digital.
- Crown seating (placement), including cementing and insulating bases.
- Occlusal adjustment of crown or opposing tooth or teeth.
- Local anesthesia.

Billing

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

Post-operative radiographs are required in the client record for permanent crown placement to confirm quality of care.

Prior authorization (PA)

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HCA requires the provider to submit the following with each PA request for crowns:

- Current (within the past 12 months) dated x-rays (radiographs) to assess all remaining teeth.
- Documentation and identification of all missing teeth.
- Caries diagnosis and treatment plan for all remaining teeth, including a caries control plan for clients with rampant caries.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma and must involve four or more surfaces and at least 50% of the incisal edge.
- Pre- and post-endodontic treatment dated x-rays (radiographs) for requests on endodontically treated teeth.
    - Tooth must be filled within 2 mm of apex unless there is a curvature or calcification of the canal that limits the ability to fill the canal to apex
    - Must be properly condensed/obturated and not overfilled
- Documentation supporting a 5-year prognosis that the client will retain the tooth or crown if the tooth is crowned.

HCA reviews requests for PA in accordance with WAC 182-501-0165.

CDT® Code	Short Description	PA?	Requirements	Age Limitation
D2710	Crown resin-based indirect	Y	Anterior teeth only. Tooth designation required	Clients age 15 to 20 only
D2720	Crown resin w/ high noble me	Y	Anterior teeth only. Tooth designation required	Clients age 15 to 20 only
D2721	Crown resin w/ base metal	Y	Anterior teeth only. Tooth designation required	Clients age 15 to 20 only
D2722	Crown resin w/ noble metal	Y	Anterior teeth only. Tooth designation required	Clients age 15 to 20 only

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CDT® Code	Short Description	PA?	Requirements	Age Limitation
D2740	Crown porcelain/ceramic	Y	Anterior teeth only. Tooth designation required	Clients age 15 to 20 only
D2750	Crown porcelain w/ h noble m	Y	Anterior teeth only. Tooth designation required	Clients age 15 to 20 only
D2751	Crown porcelain fused base m	Y	Anterior teeth only. Tooth designation required	Clients age 15 to 20 only
D2752	Crown porcelain w/ noble met	Y	Anterior teeth only. Tooth designation required	Clients age 15 to 20 only

Other restorative services

HCA reviews requests for PA in accordance with WAC 182-501-0165.

HCA covers:

- All re-cementations of permanent indirect crowns.
- Prefabricated stainless-steel crowns, including stainless-steel crowns with resin window, prefabricated porcelain/ceramic crowns, resin-based composite crowns (direct), prefabricated esthetic coated stainless-steel crowns, and prefabricated resin crowns for primary anterior teeth once every 3 years without PA for clients age 20 and younger. X-ray (radiograph) justification is required.
- Prefabricated stainless-steel crowns, including stainless-steel crowns with resin window, prefabricated porcelain/ceramic crowns, resin-based composite crowns (direct), prefabricated esthetic coated stainless-steel crowns, and prefabricated resin crowns for primary posterior teeth once every 3 years:
  - Without PA for clients ages 0 through 12. X-ray (radiograph) justification is required.
  - With PA for clients ages 13 to 20, if:
    - The tooth had a pulpotomy; or
    - Evidence of Class II caries with rampant decay; or

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  - Evidence of extensive caries; or
  - Treatment of decay requires sedation or general anesthesia.
- Prefabricated stainless-steel crowns, including stainless-steel crowns with resin window, and prefabricated resin crowns for permanent posterior teeth excluding 1, 16, 17, and 32 once every 3 years without PA for clients age 20 and younger. X-ray (radiograph) justification is required.
- Prefabricated stainless-steel crowns for permanent posterior teeth, excluding 1, 16, 17, and 32 for clients ages 21 and older in lieu of a restoration requiring three or more surfaces.

> **Note**: If unable to take x-rays (radiographs) due to the client's young age or disability, the client's record must contain documentation of medical necessity justification for the procedure.

- Prefabricated stainless-steel crowns without PA for clients of the Developmental Disabilities Administration (DDA). X-ray (radiograph) justification is required.
- Core buildup, including pins, as follows:
  - Only on permanent teeth and only when all of the following apply:
    - For clients age 20 and younger.
    - Allowed in conjunction with crowns.
  - Clinical criteria required for core buildup:
    - A major part of the tooth's structure (50% or more) is fractured or carious, specifically:
      - Anterior: involve four or more surfaces and at least 50% of the incisal edge
      - Bicuspid: One cusp or 3+ surfaces involved
      - Molar: Two cusps or 4+ surfaces involved
    - The preparation is at or below the gingival crest.
    - Less than 3 mm of sound dentin remains vertically above the preparation line in opposing walls where the crown margins will be located.
- Cast post and core or prefabricated post and core as follows:
  - Only on permanent teeth and only when all of the following apply:
    - For clients age 20 and younger.
    - When in conjunction with a crown.
  - Clinical criteria required for post and core build-up:

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- In endodontically treated teeth that have significant loss of coronal tooth structure, and an indirect restoration cannot be adequately retained
- Same as listed for core buildups

Prior Authorization (PA) requests for other restorative services require the following documentation:

Periapical and bitewing x-rays

Final restorative treatment plan

- If endodontically treated, a post-treatment radiograph is required
  - The tooth must be filled within 2 mm of apex unless there is a curvature; or
  - Calcification of the canal that limits the ability to fill the canal to apex
    - Must be properly condensed/obturated and not overfilled

CDT® Code	Short Description	PA?	Requirements	Age Limitation
D2910	Recement inlay onlay or part	N	Tooth designation required	Clients age 20 and younger only
D2915	Recement cast or prefab post	N	Tooth designation required	Clients age 20 and younger only
D2920	Re-cement or re-bond crown	N	Tooth designation required	All ages
D2390	Ant resin-based cmpst crown	*Y	Tooth designation and x-ray (radiograph) justification are required	Clients age 20 and younger only. Client's age 0-12 and DDA clients age 0-20 do not require EPA/PA. *Clients age 13-20 require PA.
D2929	Prefab porc/eram crown pri	Y*	Tooth designation required and x-ray (radiograph) justification required.	Clients age 0-12 and DDA clients age 0-20 do not require PA/EPA. *Clients age 13-20 require PA.

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CDT® Code	Short Description	PA?	Requirements	Age Limitation
D2930	Prefab stnlss steel crwn pri	Y*	Tooth designation required and x-ray (radiograph) justification required.	Clients age 0-12 and DDA clients age 0-20 do not require PA/EPA. *Clients age 13-20 require PA.
D2931	Prefab stnlss steel crown pe	N	Tooth designation required and x-ray (radiograph) justification required. For posterior teeth excluding 1, 16, 17, and 32 once every 3 years.	All ages.
D2932	Prefabricated resin crown	Y*	Tooth designation required and x-ray (radiograph) justification required.	Clients age 0-12 and DDA clients age 0-20 do not require PA/EPA. *Clients age 13-20 require PA.
D2933	Prefab stainless steel crown	N	Tooth designation required and x-ray (radiograph) justification required. For permanent posterior teeth excluding 1, 16, 17, and 32 once every 3 years.	Clients age 20 and younger only
D2934	Prefab steel crown primary	N	Tooth designation required and x-ray (radiograph) justification required.	Clients age 20 and younger only
D2950	Core build-up incl any pins	N	Tooth designation required; must be billed in conjunction with CDT® codes for crowns (CDT® code D2710, D2740, or D2752 for permanent anterior teeth or CDT® code D2931 for permanent posterior teeth)	Clients age 20 and younger only
D2952	Post and core cast + crown	N	Tooth designation required; must be billed in conjunction with CDT® codes for crowns (CDT® code D2710, D2740, or D2752 for permanent anterior teeth or CDT® code D2931 for permanent posterior teeth)	Clients age 20 and younger only

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CDT® Code	Short Description	PA?	Requirements	Age Limitation
D2954	Prefab post/core + crown	N	Tooth designation required; must be billed in conjunction with CDT® codes for crowns (CDT® code D2710, D2740, or D2752 for permanent anterior teeth or CDT® code D2931 for permanent posterior teeth)	Clients age 20 and younger only

What endodontic services are covered?

Pulp capping

HCA considers pulp capping included in the payment for the restoration.

Pulpotomy/pulpal debridement

HCA covers:

- Therapeutic pulpotomy on primary teeth only for clients age 20 and younger.
- Pulpal debridement on permanent teeth only, excluding teeth 1, 16, 17, and 32.

HCA does not pay for pupal debridement when performed:

- With palliative treatment for dental pain
- On the same day or the day after endodontic treatment.

CDT® Code	Short Description	PA?	Requirements	Age Limitation
D3220	Therapeutic pulpotomy	N	Tooth designation required	Clients age 20 and younger only, primary teeth only
D3221	Gross pulpal debridement	N	Tooth designation required	All ages, permanent teeth only

Endodontic treatment on primary teeth

HCA covers endodontic treatment with resorbable material for primary teeth if the entire root is present at treatment.

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CDT® Code	Short Description	PA?	Requirements
D3230	Pulpal therapy anterior prim	N	Tooth designation required
D3240	Pulpal therapy posterior pri	N	Tooth designation required

Endodontic treatment on permanent teeth

HCA:

- Covers endodontic treatment for permanent anterior teeth for all clients.
- Covers endodontic treatment for permanent bicuspid and molar teeth, excluding teeth 1, 16, 17, and 32 for clients age 20 and younger.
- Covers endodontic treatment for primary teeth without succedaneous molar teeth. For teeth A, B, I, J, K, L, S, and T. Requires prior authorization. For clients age 20 and younger.
- Considers the following included in endodontic treatment:
  - Pulpectomy when part of root canal therapy.
  - All procedures necessary to complete treatment.
  - All intra-operative and final evaluation x-rays (radiographs) for the endodontic procedure.
- Pays separately for the following services that are related to the endodontic treatment:
  - Initial diagnostic evaluation.
  - Initial diagnostic radiographs.
  - Post treatment evaluation radiographs if taken at least 3 months after treatment.
- Determines PA requests for medical necessity when the following requirements are true
  - Teeth must be restorable and have mature or fully formed apices
  - Teeth must not have sub-crestal caries or caries extending in to the furcation
  - Teeth must not have advanced or untreated periodontal disease or inadequate bone support
  - Tooth must have final restorative treatment plan, inclusive of cuspal coverage, if indicated
  - Tooth must be filled within 2 mm of apex unless there is a curvature or calcification of the canal that limits the ability to fill the canal to apex
  - Tooth must be properly condensed/obturated and not overfilled

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HCA reviews requests for PA in accordance with WAC 182-501-0165.

CDT® Code	Short Description	PA?	Requirements	Age Limitation
D3310	End thxpy, anterior tooth	N	Tooth designation required	All ages
D3320	End thxpy, premolar tooth	Y*	Tooth designation required	Clients age 20 and younger PA required only for primary teeth (A, B, I, J, K, L, S, and T) without succedaneous premolar teeth.
D3330	End thxpy, molar tooth	N	Tooth designation required	Clients age 20 and younger

Endodontic retreatment on permanent teeth

HCA:

- Covers endodontic retreatment for a client age 20 and younger when prior authorized.
- Covers endodontic retreatment of permanent anterior teeth for a client age 21 and older when prior authorized.
- Considers endodontic retreatment to include:
  - The removal of post(s), pin(s), old root canal filling material, and all procedures necessary to prepare the canals.
  - Placement of new filling material.
  - Retreatment for permanent anterior, bicuspid, and molar teeth, excluding teeth 1, 16, 17, and 32.
- Pays separately for the following services that are related to the endodontic retreatment:
  - Initial diagnostic evaluation.
  - Initial diagnostic x-rays (radiographs).
  - Post treatment evaluation x-rays (radiographs) if taken at least 3 months after treatment.
- Does not pay for endodontic retreatment when:
  - Provided by the original treating provider or clinic during the two years since the initial treatment.

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  - Provided by the original treating provider or clinic unless prior authorized by the Health Care Authority.
- Determines PA requests for medical necessity when the following requirements are true
  - Teeth must be restorable and have mature or fully formed apices
  - Teeth must not have sub-crestal caries or caries extending in to the furcation
  - Teeth must not have advanced or untreated periodontal disease or inadequate bone support
  - Tooth must have final restorative treatment plan, inclusive of cuspal coverage, if indicated
    - Canal fill: Appears to extend to a point shorter than 2 millimeters from the apex, or extends significantly beyond the apex, or appears to be incomplete

Prior Authorization:

Additional documentation requirements for PA:

- Pulp and periapical diagnosis for tooth/teeth
- Dated periapical and bitewing radiograph to evaluate restorability
- Final restorative treatment plan

HCA reviews requests for PA in accordance with WAC 182-501-0165.

CDT® Code	Short Description	PA?	Requirements	Age Limitation
D3346	Retreat root canal anterior	Y	Tooth designation required	All ages
D3347	Retreat root canal premolar	Y	Tooth designation required	Clients age 20 and younger
D3348	Retreat root canal molar	Y	Tooth designation required	Clients age 20 and younger

Apexification/apicoectomy

HCA covers:

Apexification for apical closures of anterior permanent teeth for clients age 20 and younger. Apexification is limited to the initial visit and three interim treatment visits per tooth.

HCA determines PA requests for medical necessity when the following requirements are true for apexification:

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- Incomplete apical closure in a permanent tooth with necrotic pulp; irreversible pulpits, or periapical disease
- External root resorption; arrent of resorption
- Perforations or root fractures that do not communicate with oral cavity
- Apicoectomy and a retrograde filling for anterior teeth only for clients age 20 and younger when prognosis supports treatment

HCA determines PA requests for medical necessity when the following requirements are true for apicoectomy:

- Failed retreatment of endodontic therapy
- When the apex of tooth cannot be accessed due to calcification or other anomaly
- When perforation or root fracture is suspected and visualization is necessary
- When there is a gross overextension of filling materials and healing is impaired

HCA determines PA requests for medical necessity when the following requirements are true for retrograde fillings:

- Periradicular pathosis resulting from an adequate apical seal or from a blockage of the root canal system that could not addressed with nonsurgical root canal treatment
- Root perforations or resorptive defects

Prior Authorization:

Additional documentation requirements for PA requests:

- Pulp and periapical diagnosis for tooth/teeth
- Dated periapical and bitewing radiograph to evaluate restorability
- Final restorative treatment plan

CDT® Code	Short Description	PA?	Requirements	Age Limitation
D3351	Apexification/recalc initial	N	Tooth designation required	Clients age 20 and younger Anterior permanent teeth only
D3352	Apexification/recalc interim	N	Tooth designation required	Clients age 20 and younger Anterior permanent teeth only

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CDT® Code	Short Description	PA?	Requirements	Age Limitation
D3410	Apicoectomy - anterior	*Y	Tooth designation required *Initial treatment requires no PA. Subsequent treatment requires PA	Clients age 20 and younger
D3430	Retrograde filling	*Y	Tooth designation required *Initial treatment requires no PA. Subsequent treatment requires PA	Clients age 20 and younger

What periodontic services are covered?

Surgical periodontal services

HCA covers gingivectomy/gingivoplasty (does not include distal wedge procedures on erupting molars), including all postoperative care for:

- Clients age 20 and younger only, on a case-by-case basis, and when prior authorized.
- Clients of the Developmental Disabilities Administration (DDA).

CDT® Code	Short Description	PA?	Requirements	Age Limitation
D4210	Gingivectomy/plasty 4 or mor	Y	Quadrant designation required	Clients age 20 and younger
D4211	Gingivectomy/plasty 1 to 3	Y	Quadrant designation required	Clients age 20 and younger

Nonsurgical periodontal services

HCA:

- Covers periodontal scaling and root planing for the number of teeth scaled that are periodontally involved once per quadrant, for clients age 13 through

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18, per client in a 2-year period on a case-by-case basis, when prior authorized, and only when:

  - The client has x-rays (radiographs) evidence of periodontal disease.
  - The client's record includes supporting documentation for the medical necessity of the service, including complete periodontal charting done within 12 months with location of the gingival margin and clinical attachment loss and a definitive diagnosis of periodontal disease prior to the date of the prior authorization request.
  - The client's clinical condition meets current periodontal guidelines.
  - Performed at least 2 years from the date of completion of periodontal scaling and root planing or surgical periodontal treatment, or at least 12 months from the completion of periodontal maintenance.

- Covers periodontal scaling and root planing once per quadrant, per client, in a 2-year period for clients age 19 and older and only when:
  - The client has x-rays (radiographs) evidence of periodontal disease.
  - The client's record includes supporting documentation for the medical necessity, including complete periodontal charting and a definitive diagnosis of periodontal disease.
  - The client's clinical condition meets current periodontal guidelines.
  - Performed at least 2 years from the date of completion of periodontal scaling and root planing or surgical periodontal treatment, or at least 12 months from the completion of periodontal maintenance.
- Considers ultrasonic scaling, gross scaling, or gross debridement to be included in the procedure and not a substitution for periodontal scaling and root planing.
- Covers periodontal scaling and root planing only when the services are not performed on the same date of service as prophylaxis, periodontal maintenance, scaling in the presence of generalized moderate or severe gingival inflammation, gingivectomy, or gingivoplasty.
- Covers periodontal scaling and root planing, one time per quadrant in a 12-month period for clients of DDA.
- Covers periodontal scaling and root planing, one time per quadrant in a 12-month period for clients residing in an ALF or nursing facility.
- Covers full mouth scaling in the presence of generalized moderate or severe gingival inflammation (CDT® code D4346) for clients age 13 and older, once in a 12-month period after an oral evaluation only when:
  - The client's record includes written documentation describing gingival condition, generalized suprabony pockets, and moderate to severe bleeding on probing.
  - The service is not billed on the same date of service as periodontal scaling and root planning, periodontal maintenance, prophylaxis, full mouth debridement, gingivectomy, or gingivoplasty.

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CDT® Code	Short Description	PA?	Requirements	Age Limitation
D4341	Periodontal scaling & root	Y	Quadrant designation required	Clients age 13 through 18 only
D4341	Periodontal scaling & root	N	Quadrant designation required	Clients age 19 and older only
D4342	Periodontal scaling 1-3teeth	Y	Quadrant designation required	Clients age 13 through 18 only
D4342	Periodontal scaling 1-3teeth	N	Quadrant designation required	Clients age 19 and older only
D4346	Scaling gingiv inflammation	N		Clients age 13 and older only
D4355	Full mouth debridement	N	Covered only for clients of DDA	All ages

Note: Clients age 19 and older are eligible for CDT® code D1110 or D4346 once in a 12-month period. If the client has used either CDT® code D1110 or D4346, they are ineligible for another unit of D1110 or D4346 until 12 months have lapsed. Do not bill CDT® code D4346 with CDT® codes D4341, D4342, D4355, or D4910 for the same date of service. If CDT® code D4346 has been used, the client is ineligible for any units of CDT® codes D4341, D4342, D4355, and D4910 until 12 months have lapsed.

Clients age 13 to 18 are eligible for CDT® codes D1110 and D1120 once in a 6-month period. CDT® code D4346 may be substituted for one D1110 /D1120 in the 12-month period. If D4346 has been used, the client is ineligible until 6 months have lapsed for D1110/D1120 or 12 months have lapsed for D4346.

Periodontal maintenance

HCA covers periodontal maintenance:

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- Only after the client has received periodontal scaling and root planing, gingivectomy, or gingivoplasty. The periodontal maintenance must be done at least 12 months after the periodontal scaling and root planing.
- When the client has x-ray (radiograph) evidence of periodontal disease.
- When the client's record includes supporting documentation for the medical necessity, including complete periodontal charting with location of the gingival margin and clinical attachment loss and a definitive diagnosis of periodontal disease.
- When the client's clinical condition meets current periodontal guidelines.
- For clients age 13 through 18, once per client in a 12-month period following completion of HCA-approved scaling and root planing. See **Staging and Grading Periodontitis**.
- Once per client in a 12-month period for clients age 19 and older.
- For clients of DDA.

> **Note**: Covers periodontal scaling and root planing, one time per quadrant in a 12-month period for clients residing in an ALF or nursing facility. HCA will cover scaling and root planing 6 months after periodontal maintenance if 12 months have elapsed since last SRP.

- For clients residing in an alternative living facility (ALF) or skilled nursing facility (SNF):
  - Periodontal maintenance (four quadrants) substitutes for an eligible periodontal scaling or root planing once every 6 months.
  - Periodontal maintenance is allowed 6 months after scaling or root planning.

> **Note**: Increased frequency for clients with a diagnosis of diabetes. Effective January 1, 2024, clients age 21 and older with a diagnosis of periodontal disease and Type I, II, or gestational diabetes are eligible for more frequent periodontal maintenance procedures.

- For clients 21 and older with a diagnosis of diabetes:
  - Periodontal maintenance (four quadrants) substitutes for an eligible periodontal scaling or root planing once every 3 months.
  - Periodontal maintenance allowed three months after scaling and root planing.
  - Scaling and root planing may substitute for an eligible periodontal maintenance when medically necessary.

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  - Covers periodontal scaling and root planing once per quadrant, per client, in a 2-year period.
  - The provider performing the procedure must keep documentation in their records of the client's diabetes diagnosis.
  - CDT® code D4910 must be billed with EPA 870001655 for clients who meet this criteria.
  - Documented current health history with a confirmed diagnosis of diabetes is required.
- Only if the service is not billed on the same date of service as prophylaxis, periodontal scaling and root planning, scaling in the presence of generalized moderate or severe gingival inflammation, full mouth debridement, gingivectomy, or gingivoplasty.

CDT® Code	Short Description	PA?	Age Limitations
D4910	Periodontal maint procedures	N	Clients 13-18 *After completion of an HCA-approved scaling and root planing
D4910	Periodontal maint procedures	N	Clients age 19 and older only
D4910	Periodontal maint procedures	Y*	Clients age 21 and older with a diagnosis of diabetes. *See EPA #870001655.

What prosthodontic (removable) services are covered?

For complete authorization criteria, see Prior authorization for removable prosthodontic and prosthodontic-related procedures.

Complete dentures

HCA:

- Covers a limited exam (CDT® D0140) as follows:
  - When performed by a denturist, is limited to the initial examination appointment. HCA does not cover any additional limited examination by a denturist for the same client until 3 months after the delivery of a removable dental prosthesis.
- Covers complete dentures, including overdentures only as follows:
  - One initial maxillary complete denture and one initial mandibular complete denture per client.

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- All materials used in the fabrication of dentures (e.g., digital vs analogue) must be repairable/adjustable.
- One replacement maxillary complete and one replacement mandibular complete denture per client's lifetime, if medically necessary and a minimum of 5 years has elapsed. Requires PA. HCA reviews requests for PA in accordance with WAC 182-501-0165.

> **Note**: It is the responsibility of the provider, through client limit inquiry, to confirm the client qualifies for an initial set of dentures and has not previously received an initial set of dentures paid for by HCA.

- Replacement of a partial denture with a complete denture only when the replacement occurs 3 or more years after the delivery (placement) date of the last resin partial denture. If replacement occurs within three years after the delivery (placement) date of the last resin partial denture, providers must submit a PA request to determine medical necessity. HCA reviews requests for PA in accordance with WAC 182-501-0165.
- Replacement of a complete denture requires PA regardless of whether 5 years have elapsed or not.
  - The prior authorization request must have documentation of medical necessity.
  - Photos of the current appliance, when applicable to show medical necessity. Photos must include:
    - Client name
    - Client date of birth
    - Date of when photo taken
    - Provider name
  - Replacement of HCA-purchased removable prosthodontics that have been lost, broken, stolen, sold, or destroyed as a result of the client's carelessness, negligence, recklessness, deliberate intent, or misuse is not covered unless extenuating circumstances exist through no fault of the client. (See WAC 182-501-0050.)
- HCA reviews requests for PA in accordance with WAC 182-501-0165.

- Considers 3-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 is not paid separately.
- Requires that each complete denture and removable partial denture be marked with the name of the client for whom the prosthesis is intended. (See WAC 246-812-360 and RCW 18.32.695).

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CDT® Code	Short Description	PA?
D5110	Dentures complete maxillary	No PA for initial placement. *Replacement requires PA.
D5120	Dentures complete mandible	No PA for initial placement. *Replacement requires PA.

The provider must obtain a completed, signed Denture Agreement of Acceptance form, HCA 13-809, from the client at the conclusion of the final denture try-in and at the time of delivery for a Health Care Authority-authorized complete denture. See Where can I download HCA forms?

If the client abandons the complete denture after signing the agreement of acceptance, the Health Care Authority will deny subsequent requests for the same type of dental prosthesis if the request occurs before the time limitations 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 Health Care Authority. Failure to submit the completed, signed Denture Agreement of Acceptance form when requested may result in recoupment of the Health Care Authority's payment.

Resin partial dentures

HCA covers resin partial dentures with prior authorization as follows:

- For anterior and posterior teeth only when the following criteria are met:
  - The remaining teeth in the arch must be periodontally stable and have a reasonable periodontal prognosis.
  - The client has established caries control.
  - For a maxillary partial denture, the client has either of the following:
    - One or more missing anterior teeth.
    - Four or more missing posterior teeth (excluding teeth 1, 2, 15, and 16) on the upper arch.
  - For a mandibular partial denture, the client has either of the following:
    - One or more missing anterior teeth.
    - Four or more missing posterior teeth (excluding teeth 17, 18, 31, and 32) on the lower arch.

Note: Pontics on an existing fixed bridge do not count as missing teeth. HCA does not consider closed spaces of missing teeth to qualify as a missing tooth.

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- There are a minimum of four functional, stable teeth remaining per arch (excluding 1, 16, 17, and 32).
- There is a three-year prognosis for retention of the remaining teeth.
- For replacement of a resin-based partial denture with a new resin-based partial denture if it occurs at least 3 years from the delivery (placement) date of the resin-based partial denture when medically necessary. The replacement denture must be prior authorized.
  - PA is required and must have documentation of medical necessity
  - Photos of the current appliance when applicable to show medical necessity and meet the Health Care Authority's coverage criteria. Photos must include:
    - Client name
    - ProviderOne ID
    - Date photos were taken
    - Provider name
  - HCA does not cover replacement of HCA-purchased removable prosthodontics that have been lost, broken, stolen, sold, or destroyed as a result of the client's carelessness, negligence, recklessness, deliberate intent, or misuse. (See **WAC 182-501-0050**).
  - If the appliances were lost, broken, stolen, sold, or destroyed as a result of extenuating circumstances, submit a PA with documentation describing how the appliances were lost, broken, stolen, sold, or destroyed (see WAC 182-501-0050(7)(a)). Documentation should be in the form of a responding official report (e.g., original policy, fire marshal, healthcare facility).
  - HCA reviews requests for PA in accordance with **WAC 182-501-0165**.
- HCA considers 3-month post-delivery care (e.g., adjustments, soft relines, and repairs) from the delivery (placement) date of the partial denture as part of the resin partial denture procedure. This is not paid separately.

CDT® Code	Short Description	PA?
D5211	Dentures maxilla part resin	Y
D5212	Dentures mand part resin	Y

- The provider must obtain a completed, signed Partial Denture Agreement of Acceptance form, HCA 13-965, from the client at the conclusion of the final denture try-in and at the time of delivery for a Health Care Authority-authorized partial denture. See Where can I download HCA forms?

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- If the client abandons the partial denture after signing the agreement of acceptance, the Health Care Authority will deny subsequent requests for the same type of dental prosthesis if the request occurs before the time limitations 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 Health Care Authority. Failure to submit the completed, signed Partial Denture Agreement of Acceptance form when requested may result in recoupment of the Health Care Authority's payment.

Other requirements/limitations

Providers must:

- Bill for removable partial or complete denture only after the delivery (placement) of the prosthesis, not at the impression date. The Health Care Authority may pay for lab fees if the removable partial or complete denture is not delivered.
- Deliver services and procedures that are of acceptable quality to the Health Care Authority. The Health Care Authority may recoup payment for services that are determined to be below the standard of care or of an unacceptable product quality.

Adjustments to dentures

Adjustments to complete and partial dentures are included in the global fee for the denture for the first 90 days after the delivery (placement) date. The Health Care Authority covers adjustments to complete and partial dentures once in a 90-day period, per appliance.

CDT® Code	Short Description	PA?
D5410	Dentures adjust cmplt maxil	N
D5411	Dentures adjust cmplt mand	N
D5421	Dentures adjust part maxill	N
D5422	Dentures adjust part mandbl	N

Repairs to complete and partial dentures

HCA covers repairs to complete and partial dentures once in a 12-month period, per arch. The cost of repairs cannot exceed the cost of a replacement denture or a partial denture. HCA covers additional repairs on a case-by-case basis with PA. HCA reviews requests for PA in accordance with WAC 182-501-0165.

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CDT® Code	Short Description	PA?	Requirements
D5511	Rep broke comp dent base man	N	
D5512	Rep broke comp dent base max	N	
D5520	Replace denture teeth complt	N	Tooth designation required
D5611	Rep resin part dent base man	N	
D5612	Rep resin part dent base max	N	
D5621	Rep cast part frame man	N	
D5622	Rep cast part frame max	N	
D5630	Rep partial denture clasp	N	Tooth designation required
D5640	Replace part denture teeth	N	Tooth designation required
D5650	Add tooth to partial denture	N	Tooth designation required
D5660	Add clasp to partial denture	N	Tooth designation required

Denture rebase procedures

HCA covers a laboratory rebase to a complete or partial denture once in a 3-year period when performed at least 6 months after the delivery (placement) date. Rebase prior to 3 years may be covered for complete or partial dentures on a case-by-case basis when requested as a limitation extension through prior authorization.

CDT® Code	Short Description	PA?
D5710	Dentures rebase cmplt maxil	N
D5711	Dentures rebase cmplt mand	N
D5720	Dentures rebase part maxill	N
D5721	Dentures rebase part mandbl	N

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Note: HCA covers rebases or relines only on partials and complete dentures (CDT® codes D5110, D5120, D5211, D5212, D5213, and D5214).

Denture reline procedures

HCA covers a laboratory reline to a complete or partial denture once in a 3-year period when performed at least 6 months after the delivery (placement) date. Reline prior to 3 years may be covered for complete or partial dentures on a case-by-case basis when prior authorized.

CDT® Code	Short Description	PA?
D5750	Denture reln cmplt max indir	N
D5751	Denture reln cmplt mand ind	N
D5760	Denture reln part max indir	N
D5761	Denture reln part mand indir	N

Note: HCA covers rebases or relines only on partials and complete dentures (CDT® codes D5110, D5120, D5211, D5212, D5213, and D5214). The Health Care Authority does not cover chairside relines.

Other removable prosthetic services

HCA:

- Covers laboratory fees, subject to the following:
  - The Health Care Authority does not pay separately for laboratory or professional fees for complete and partial dentures.
  - The Health Care Authority may pay part of billed laboratory fees when the provider obtains PA, and the client:
    - Is not eligible at the time of delivery of the partial or complete denture.
    - Moves from the state.
    - Cannot be located.
    - Does not participate in completing the partial or complete dentures.
    - Dies.

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

- Requires providers to submit copies of laboratory prescriptions and receipts or invoices for each claim when submitting for PA of code D5899 for laboratory fees.
- HCA reviews requests for PA in accordance with WAC 182-501-0165.

Overdenture

- An overdenture is a type of complete denture that is supported by a few remaining teeth or dental implants and attached by specialized dental attachments secured on the roots or implants.
  - Teeth or dental implants that are not modified for an overdenture are considered a partial denture and must be billed as such.

CDT® Code	Short Description	PA?	Requirements	Age Limitation
D5863	Overdenture complete max	Y	Arch designation required	
D5865	Overdenture complete mandib	Y	Arch designation required	
D5899	Removable prosthodontic proc	Y	Arch designation required	
D6930	Recement/bond part denture	N	Arch or quadrant designation required	

Prior authorization (PA) for removable prosthodontic and prosthodontic-related procedures

HCA requires PA for the removable prosthodontic and prosthodontic-related procedures listed in this section when noted. PA requests must meet the prior authorization criteria. In addition, HCA requires the dental provider to submit current, within the last 12 months:

- Appropriate diagnostic x-rays (radiographs) of all remaining teeth, except for nursing facility clients when x-rays (radiographs) are unavailable. In this case, the provider must submit a completed Tooth Chart form (HCA 13-863). See Where can I download HCA forms?
- Photographs of the client's current appliance if replacement is due to wear or breakage.
- A dental record which contains:

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  - A restorative and periodontal treatment plan indicating the client's treatment needs. If the client is being referred to a separate dental provider for appliance fabrication, the referring dentist must provide all supporting documentation to the servicing dental provider to expedite the PA request.
  - Chart notes indicating the client has completed a prophylaxis or nonsurgical periodontal services within the last twelve months, and all restorative treatment needs have been completed.
- Completed *Tooth Chart* (HCA 13-863) form. The tooth chart must be completed as follows:
  - All missing teeth for both arches. Missing teeth must be marked with an | |
  - Teeth that are to be extracted. Extracted teeth must be marked with an X.

A provider must:

- Obtain a signed Denture Agreement of Acceptance (HCA 13-809) form and/or Partial Denture Agreement of Acceptance (HCA 13-965) from the client at the final denture or partial denture try-in and at the time of delivery (placement) for a Health Care Authority-authorized complete or partial denture described in this section. See Where can I download HCA forms? If the client abandons the complete or partial denture after signing the agreement of acceptance, the Health Care Authority will deny subsequent requests for the same type of dental prosthesis if the request occurs prior to the time limitations specified in this section (WAC 182-535-1090).
- Retain in the client's record the completed copy of the signed Denture Agreement of Acceptance (HCA #13-809) form and/or Partial Denture Agreement of Acceptance (HCA 13-965) form, which documents the client's acceptance of the dental prosthesis.

> **Note**: If a client wants to change denture providers, HCA must receive a statement from the client requesting the provider change. HCA will confirm the original provider has not already rendered services before cancelling the original authorization request for services. The new provider must submit another authorization request for services.

Alternate living facilities or skilled nursing facilities

HCA requires a provider, who is providing services within an alternative living facility (ALF) or in a skilled nursing facility (SNF), group home, or other facility, to submit the following with a PA request for a removable partial or complete denture for a client residing in these settings:

- The client's medical diagnosis or prognosis.
- A qualified medical provider (e.g., physician, ARNP/PA, director of nursing) request documenting medical necessity for the prosthetic service.

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- The attending dentist or denturist's signature documenting medical necessity for the prosthetic service.
- A written and signed consent for treatment from the client's legal guardian when a guardian has been appointed.
- A completed copy of the *Denture/Partial Prosthesis Request for Skilled Nursing Facility and Alternate Living Facility Client* form, HCA 13-788 (see Where can I download HCA forms?).
- If the request is for a denture that was lost by the facility, an official report or statement from the facility must be included with the prior authorization request.

What maxillofacial prosthetic services are covered?

HCA covers maxillofacial prosthetics on a case-by-case basis with PA. HCA reviews requests for PA in accordance with **WAC 182-501-0165**.

HCA must preapprove a provider qualified to furnish maxillofacial prosthetics.

What oral and maxillofacial surgery services are covered?

General coverage

All coverage limitations and age requirements apply to clients of the Developmental Disabilities Administration (DDA) unless otherwise noted.

- HCA-enrolled dental providers who are not specialized to perform oral and maxillofacial surgery must use only the Current Dental Terminology (CDT®) codes to bill claims for services that are listed as covered.
- HCA-enrolled dental providers who are specialized to perform oral and maxillofacial surgery can bill using Current Procedural Terminology (CPT®) codes unless the procedure is specifically listed in this billing guide as a CDT® covered code (e.g., extractions).

> **Note**: For billing information on billing CPT® codes for oral surgery, refer to HCA's Physician-related services/health care professional billing guide. HCA pays oral surgeons for only those CPT® codes listed in the Dental fee schedule under Dental CPT® Codes.

- HCA covers nonemergency oral surgery performed in a hospital or ambulatory surgery center only for clients:
  - Age 8 and younger
  - Age 9 through 20 on a case-by-case basis and when the site-of-service is prior authorized by the Health Care Authority

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  - Any age for clients of the DDA
- HCA requires the dental provider to submit current records (within the last 12 months) all of the following for site-of-service and oral surgery CPT® codes that require PA:
  - Documentation used to determine medical necessity. **Please note**: Only documentation that pertains to medical necessity needs to be submitted, not the entire client record.
  - Cephalometric films.
  - X-rays (radiographs).
  - Photographs.
  - Written narrative/letter submitted by the requesting practitioner, providing explanation of medical necessity to include proposed billing codes.

Services exempt from site of service prior authorization

HCA does not require site-of-service authorization for cleft palate surgeries:

Documentation requirements

HCA requires the client's dental record to include supporting documentation for each type of extraction or any other surgical procedure billed to HCA. The documentation must include:

- Appropriate consent form signed by the client or the client's legal representative
- Appropriate radiographs
- Medical justification with diagnosis
- The client's blood pressure, when appropriate
- A surgical narrative and complete description of each service performed beyond surgical extraction or beyond code definition
- A copy of the post-operative instructions
- A copy of all pre- and post-operative prescriptions

Extractions

HCA covers:

- Simple and surgical extractions
- Unusual, complicated surgical extractions
- Extraction of unerupted teeth
- Coronectomy is covered for teeth #1, 16, 17, and 32, when medical necessity for extraction of impacted teeth is met and if the removal of the complete tooth would result in damage to the neurovascular bundle.

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  - Coronectomy is not indicated for teeth with the following conditions:
    - Mobility
    - Caries into the pulp
    - Periapical pathology or teeth associated with tumors/cysts
    - Horizontal impactions in direct contact with nerves
- One limited exam per extraction case. Covers both pre and post evaluation.
- Debridement of a granuloma or cyst that is five millimeters or greater in diameter. The Health Care Authority includes debridement of a granuloma or cyst that is less than five millimeters as part of the global fee for the extraction.

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

When making the client edentulous, current photographs or radiographs are required in the supporting documentation with a medical justification narrative demonstrating:

- Extensive caries/rampant decay. This is defined by the Health Care Authority as widespread caries that affects 67% or greater of the teeth (per arch) and penetrates quickly to the dental pulp.
- There are less than four teeth per arch with a favorable 3-year prognosis.
- Generalized periodontal disease (per arch).
- The structural or periodontal health of the remaining teeth (per arch) is insufficient to support a partial denture.
- The need to address oral disease for clients preparing for a medical procedure, such as organ transplant, joint replacement, heart surgery, or head and neck radiation.

CDT® Code	Short Description	PA?	Requirements
D7111	Extraction coronal remnants	N	Tooth designation required. Primary teeth only.
D7140	Extraction erupted tooth/exr	N	Tooth designation required
D7210	Rem imp tooth w mucoper flp	N	Tooth designation required

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CDT® Code	Short Description	PA?	Requirements
D7220	Impact tooth remov soft tiss	N	Tooth designation required
D7230	Impact tooth remov part bony	N	Tooth designation required
D7240	Impact tooth remov comp bony	N	Tooth designation required
D7241	Impact tooth rem bony w/comp	Y	Tooth designation required
D7250	Tooth root removal	N	Tooth designation required. The fee for this service is included in the initial extraction fee when performed by the original treating dentist or clinic and may not be billed to the client.
D7251	Coronectomy	N	Tooth designation required. Only allowed for teeth 1, 16, 17, and 32.

Other surgical procedures

HCA covers the following without prior authorization (PA):

- Biopsy of soft oral tissue.
- Brush biopsy.
- Surgical excision of soft tissue lesions.
- Tooth reimplantation/stabilization of accidentally avulsed or displaced teeth.
- Surgical access of unerupted permanent tooth
- Placement of device to facilitate eruption of impacted permanent tooth

Providers must keep all biopsy reports or findings in the client's dental record. Surgical access of an unerupted permanent tooth and placement of a device to facilitate eruption of an impacted permanent tooth cannot be billed with an excision of pericoronal gingiva on the same tooth, on the same date of service.

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CDT® Code	Short Description	PA?	Requirements	Age Limitation
D7270	Tooth reimplantation	N	Tooth designation required for permanent teeth only	
D7280	Exposure of unerupted tooth	N	Tooth designation required.	Clients age 20 and younger only
D7283	Place device impacted tooth	N	Covered in conjunction with D7280 and when medically necessary; tooth designation required.	Clients age 20 and younger only
D7285	Biopsy of oral tissue hard	N		
D7286	Biopsy of oral tissue soft	N		
D7288	Brush biopsy	N		

Alveoloplasty – surgical preparation of ridge for dentures

HCA covers alveoloplasty only in conjunction with the preparation of dentures or partials. Alveoloplasty is a distinct and separate procedure from an extraction or surgical extraction. Documentation supporting the medical necessity for the procedure must be maintained in the client's record. Supporting documentation must include current photographs or x-rays (radiographs) and medical justification narrative.

CDT® Code	Short Description	PA?	Requirements
D7310	Alveoplasty w/ extraction	N	Quadrant designation required
D7311	Alveoloplasty w/extract 1-3	N	Quadrant designation required
D7320	Alveoplasty w/o extraction	N	Quadrant designation required
D7321	Alveoloplasty not w/extracts	N	Quadrant designation required

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Surgical excision of soft tissue and soft tissue lesions

HCA covers surgical excision of soft tissue. Documentation supporting the medical necessity of the procedure must be maintained in the client's record. All biopsy reports and/or findings must be documented in the client's dental record.

HCA covers excision of pericoronal gingiva for teeth #1, 16, 17, and 32. Excision of pericoronal gingiva is not allowed on the same day as extraction of the same tooth and cannot be billed with D7280 and D7283.

CDT® Code	Short Description	PA?	Requirements	
D7410	Rad exc lesion up to 1.25 cm	N		
D7970	Excision hyperplastic tissue	Y	Arch designation required	
D7971	Excision pericoronal gingiva	N	Tooth designation required, #1, 16, 17, and 32.	Clients age 20 and younger only

Excision of bone tissue

HCA covers only the following excisions of bone tissue in conjunction with placement of complete or partial dentures:

- Removal of lateral exostosis.
- Removal of mandibular or palatal tori.
- Surgical reduction of osseous tuberosity.

Documentation supporting the medical necessity for the procedure must be maintained in the client's record. Supporting documentation must include current photographs or x-rays (radiographs) and medical justification narrative.

CDT® Code	Short Description	PA?	Requirements	Age Limitation
D7471	Rem exostosis any site	N	Arch designation required	
D7472	Removal of torus palatinus	N		
D7473	Remove torus mandibularis	N	Quadrant designation required	

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CDT® Code	Short Description	PA?	Requirements	Age Limitation
D7485	Surg reduct osseoustuberosit	N	Quadrant designation required	
D7972	Surg redct fibrous tuberosit	Y		

Surgical incision

HCA covers:

- Uncomplicated dental-related intraoral and extraoral soft tissue incision and drainage of abscess. HCA does not cover this service when combined with extraction or root canal treatment or palliative treatment (CDT® code D9110).
- Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.
- Frenuloplasty/frenulectomy.

> **Note**: See the Health Technology Clinical Committee (HTCC) decision 20250613A regarding frenotomy and frenectomy.

  - HCA will not approve treatment without a specific recommendation from the medical specialist
    - For clients age 0 to 12 only on a case-by-case basis and when prior authorized. Photos must be submitted with the PA request.
  - In order to consider any medical condition as medically necessary for treatment, the provider must submit, current within the past 12 months:
    - A specific recommendation for treatment, that includes the condition needing to be addressed (e.g., breastfeeding support, speech pathology issues, etc.), from the treating medical specialist who has the subject matter expertise appropriate and necessary for management of the specific condition indicated.
    - All medical diagnostic documentation, including tried and failed therapies utilized to address the condition.
- Documentation supporting the medical necessity of procedures must be maintained in the client's record.

CDT® Code	Short Description	PA?	Requirements	Age Limitation
D7510	I&d absc intraoral soft tiss	N	Tooth designation required	
D7520	I&d abscess extraoral	N		

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CDT® Code	Short Description	PA?	Requirements	Age Limitation
D7530	Removal fb skin/areolar tiss	N		
D7961	Buccal/labial frenectomy	Y*	Once per client's lifetime	Clients age 0 to 12 only For clients requiring treatment for periodontal defects, see EPA#870001686 For clients requiring service for speech language disorders, see EPA#870001685
D7962	Lingual frenectomy	Y*		Clients age 0 to 12 only For clients requiring breast feeding support, see 870001683 For clients requiring service for speech language disorders, see EPA#870001685
D7963	Frenuloplasty	Y*	Arch designation required	Clients age 0 to 12 only For clients requiring breast feeding support, see 870001683 For clients requiring service for speech language disorders, see EPA#870001685

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Occlusal orthotic devices

HCA covers occlusal orthotic devices (splints):

- For clients from age 12 through 20 only on a case-by-case basis with PA.
- Only as a laboratory processed full arch appliance.
- For treatment of temporomandibular disorders (TMD)

The following documentation must be submitted with the PA request:

- Letter of medical necessity, and
- Supporting documentation (radiographs, IO photos, etc.).

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

CDT® Code	Short Description	PA?	Age Limitation
D7880	Occlusal orthotic appliance	Y	Clients age 12 through 20 only

What orthodontic services are covered?

HCA covers orthodontic services, subject to the coverage limitations listed, for clients age 20 and younger according to HCA's Orthodontic services billing guide.

What adjunctive general services are covered?

Palliative treatment

HCA covers palliative (emergency) treatment for treatment of dental pain, limited to once per day, per client, as follows:

- The treatment must occur during limited evaluation appointments.
- Is not allowed on same day as definitive treatment (example: root canal treatment is being performed.)
- A comprehensive description of the diagnosis and services provided must be documented in the client's record.
- Appropriate radiographs must be in the client's record supporting the medical necessity of the treatment.

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- Cannot be used to code for a service or activity that is listed as noncovered as specified in WAC 182-535-1100 (examples include but are not limited to an occlusal adjustment or writing a prescription.)
- Cannot be used for services rendered that already have a distinct CDT® procedure code (examples include but are not limited to pulpotomy or a denture adjustment.)
- Is not allowed in conjunction with pulpal debridement (CDT® D3221) incision and drainage (CDT® D7510 and D7520) or any oral surgery codes.

CDT® Code	Short Description	PA?	Requirement
D9110	Tx dental pain minor proc	N	Tooth designation required

Anesthesia

HCA:

- Covers local anesthesia and regional blocks as part of the global fee for any procedure provided to clients.
- Requires the provider's current Department of Health (DOH) anesthesia permit to be on file with the Health Care Authority.
- Covers office-based minimal, moderate, and deep sedation, or general anesthesia.
- Covers administration of nitrous oxide once per day, per client, per provider.

To review maximum allowable fees, see the Health Care Authority's Fee Schedule.

ANESTHESIA PRIOR AUTHORIZATION

CDT® Code	Short Description	Ages	PA?
D9222	Deep anest, ,1st 15 min	Age 8 and younger, age 9 through 20 with diagnosis of cleft palate, or any age clients of DDA	N

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CDT® Code	Short Description	Ages	PA?
D9222	Deep anest, 1st 15 min	Age 9 through 20 without diagnosis of cleft palate and age 21 and older. See EPA #870001387 Age 9 through 20 and in foster care/kinship care. See EPA # 870001740	Y*
D9223	General anesth ea addl 15 mi	Age 8 and younger, age 9 through 20 with diagnosis of cleft palate, or any age **clients of DDA**	N
D9223	General anesth ea addl 15 mi	Age 9 through 20 without diagnosis of cleft palate and age 21 and older. See EPA #870001387 Age 9 through 20 and in foster care/kinship care. See EPA # 870001740	Y*
D9224	Gen anes adv air – 15 min	Age 8 and younger, age 9 through 20 with diagnosis of cleft palate, or any age for clients of DDA	N
D9224	Gen anes adv air – 15 min	Age 9 through 20 without diagnosis of cleft palate and age 21 and older. See EPA# 870001387. Age 9 through 20 and in foster care/kinship care. See EPA # 870001740	Y*

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CDT® Code	Short Description	Ages	PA?
D9225	Gen anes adv air – sub 15 min	Age 8 and younger, age 9 through 20 with diagnosis of cleft palate, or any age for clients of DDA	N
D9225	Gen anes adv air – sub 15 min	Age 9 through 20 without diagnosis of cleft palate and age 21 and older. See EPA# 870001387. Age 9 through 20 and in foster care/kinship care. See EPA # 870001740	Y*
D9230	Analgesia	All ages	N
D9239	Iv mod sedation, 1st 15 min	Age 20 and younger Any age clients of DDA	N
D9239	Iv mod sedation, 1st 15 min	Age 21 and older	Y
D9243	Iv sedation ea addl 15m	Age 20 and younger Any age clients of DDA	N
D9243	Iv sedation ea addl 15m	Age 21 and older	Y
D9244	Office min sed drug enteral	Age 20 and younger Any age clients of DDA	N
D9244	Office min sed drug enteral	Age 21 and older	Y
D9245	Admin mod sedation-enteral	Age 20 and younger Any age clients of DDA	N
D9245	Admin mod sedation-enteral	Age 21 and older	Y
D9246	Mod sedation noniv-15 min	Age 20 and younger Any age clients of DDA	N
D9246	Mod sedation noniv-15 min	Age 21 and older	Y

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CDT® Code	Short Description	Ages	PA?
D9247	Mod sedation noniv-sub15min	Age 20 and younger Any age clients of DDA	N
D9247	Mod sedation noniv-sub15min	Age 21 and older	Y

Note: Letters of medical necessity for anesthesia must clearly describe the medical need for anesthesia and what has been tried and failed.

HCA:

- Requires providers performing any type of sedation to meet:
  - The prevailing standard of care.
  - The provider's professional organizational guidelines.
  - The requirements in chapter 246-817 WAC.
  - Relevant DOH medical, dental, or nursing anesthesia regulations.
  - The provider must document evidence of disease or rationale that demonstrates that:
    - The clinical need for treatment outweighs the risk of sedation/anesthesia and/or
    - Demonstrates clinical decision making/treatment planning that will mitigate the need for future sedation/anesthesia and/or
    - Delay the need for repeat sedation/anesthesia.
- Requires providers to complete current treatment plan in one visit and/or minimize the number of appointments required for treatment. If one appointment is not feasible, rationale for multiple requests must be based on clinical need and/or medical necessity, not provider or practice factors (i.e., scheduling, no-show policies).
- Does not pay a separate fee for anesthesia monitoring. Monitoring is included in the global payment for rendering anesthesia.

Note: Per CDT® 2026, all anesthesia codes with or without administration of nitrous oxide; nitrous oxide must be billed with CDT® code D9230 if administered as a single agent.

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> **Note**: For clients age 21 and older, prior authorization will be considered for those clients with other conditions for which general anesthesia or conscious sedation is medically necessary, as defined in WAC 182-500-0070.

Documentation required for prior authorization:

- Current (within the past 12 months) dated x-rays (radiographs)
- Must include diagnostic periapical and bitewing for teeth with any planned endodontic procedures
- Relevant treatment plan
- If proposed treatment will exceed a single sedation visit, the provider must include proposed number of visits and medical necessity rationale for multiple sedation visits
- Letter that clearly describes the medical necessity of performing the dental procedure with sedation
- Medical history or conditions, if pertinent and not addressed in the letter of medical necessity

Mobile anesthesia

To receive payment for a facility fee for mobile anesthesia services, the mobile anesthesiologist must have a core provider agreement and a mobile anesthesia contract with HCA. See HCA's Eligible provider types and requirements webpage for more information.

> **Note**: Mobile anesthesiologist must be a separate provider than the provider delivering treatment.

Billing for anesthesia

Billing time for anesthesia begins when the qualified anesthesiology provider starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent) and ends when the qualified anesthesiology provider is no longer in constant attendance (e.g., when the patient can be safely placed under post-operative supervision).

HCA pays for anesthesia services according to WAC 182-535-1400(5).

- **Bill for deep sedation/general anesthesia as follows:**
  - For CDT® codes D9222 and D9223
    - Bill one unit of CDT® code D9222 for first 15-minute increment.
    - Bill one or more units of CDT® code D9223 for each additional 15-minute increment.
  - For CDT® codes D9224 and D9225

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- Bill one unit of CDT® code D9224 for the first 15-minute increment
- Bill one or more units of CDT® code D9225 for each additional 15-minute increment

Note: Maximum number of units (21 total – 1 unit for D9222/D9224 and up to 20 units for D9223/D9225)

- **Bill for intravenous moderate sedation/analgesia as follows:**
  - Bill one unit of CDT® code D9239 for first 15-minute increment.
  - Bill one or more units of CDT® code D9243 for each additional 15-minute increment.
- **Bill for non-intravenous moderate sedation/analgesia as follows**:
  - Bill on unit of CDT® code D9246 for the first 15-minute increment
  - Bill one or more units of CDT® code D9247 for each additional 15-minute increment

Example: You are billing for 60 minutes of deep sedation (CDT® codes D9222/D9223), complete the claim as follows:

- Claim line one – D9222 one unit (first 15 minutes)

- Claim line two – D9223 three units (additional 45 minutes)

In ProviderOne, there is a box in which the provider submits how many **units** of anesthesia were delivered for that visit. You must put **units** in this box even though the direction (in parenthesis) next to the box says to enter in minutes. The direction on the screen in parenthesis is wrong. Please enter **units** in the box.

Professional visits and consultations

HCA covers:

- A referral for professional consultation or diagnostic services provided by a dentist or a physician other than the referring practitioner providing treatment.
  - PA request must include the following referral documentation:
    - Referring provider's name
    - Client's name

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    - Client ProviderOne ID (or date of birth)
    - Date of the referral
    - Description of the chief complaint
  - HCA reviews requests for PA in accordance with WAC 182-501-0165.
- Up to two house/extended care facility calls (visits) per facility, per provider. HCA limits payment to two facilities per day, per provider.
- One hospital call (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. This is for care provided outside the servicing provider's office to a client who is in a hospital or ambulatory surgical center. Services delivered to the client on the date of service are documented separately using the applicable procedure codes.
- Emergency office visits after regularly scheduled hours. HCA limits payment to one emergency visit per day, per client, per provider.

CDT® Code	Short Description	PA?
D9310	Dental consultation	N
D9410	Dental house call	N
D9420	Hospital/asc call	N
D9440	Office visit after hours	N

Note: CDT® code D9310 is only allowable for pediatric dentist, endodontist, periodontist, and oral surgeon taxonomies

When billing for evaluation and management (E/M) codes, all of the following must be true:

- Services must be billed on an electronic professional claim.
- Services must be billed using one of the following CPT® codes and modifiers must be used if appropriate.
- E/M codes may not be billed for the same client, on the same day as surgery unless the E/M visit resulted in the decision for surgery.

CPT® Code	Short Description	PA?
99211	Off/op est may x req phy/qhp	N

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CPT® Code	Short Description	PA?
99231	Subsequent hospital care	N
99242	Office consultation	N
99252	Inpatient consultation	N

Drugs and medicaments (pharmaceuticals)

HCA covers oral sedation medications only when prescribed and the prescription is filled at a pharmacy. HCA does not cover oral sedation medications that are dispensed in the provider's office for home use. HCA covers other drugs and medicaments for home use through the client's pharmacy benefit. This includes, but is not limited to, oral antibiotics, oral analgesics, and prescription fluoride paste. HCA does not cover the time spent writing prescriptions.

HCA does not cover over-the-counter dental supplies, see WAC 182-535-1100.

HCA covers therapeutic parenteral drugs as follows:

- Includes antibiotic, steroids, anti-inflammatory drugs, or other therapeutic medications
- Only one single-drug injection or one multiple-drug injection per date of service

Coverage for therapeutic parenteral drugs does not include sedative, anesthetic, or reversal agents.

CDT® Code	Short Description	PA?	Age Limitation
D9610	Dent therapeutic drug inject	N	
D9612	Thera par drugs 2 or > admin	N	

Note: Prescription fees for eligible clients enrolled in an HCA-contracted managed care organization (MCO) must be billed directly to the client's MCO.

Behavior management

HCA covers behavior management under the following conditions: At least **one additional professional staff (six-handed dentistry)**, employed by the dental provider or clinic, is needed to protect the client and staff from injury while treatment is rendered for clients:

- Age 8 and younger.
- Age 9 through 20, only on a case-by-case basis and when prior authorized.

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- Any age of the **Developmental Disabilities Administration** (DDA).
- Residents who reside in an ALF or nursing facility.
- Diagnosed with autism.

HCA does not pay a separate fee for behavior management when the assistance is provided by a parent (legal guardian) or family member, or a provider or staff member (four-handed dentistry) already delivering the client's dental treatment.

Note: Documentation supporting the medical necessity for the procedure must be maintained in the client's record. It must include a description of the behavior to be managed, the behavior management technique used, and identification of the additional professional staff to manage the behavior to assist the delivery of dental treatment.

CDT® Code	Short Description	PA?	Age Limitation
D9920	Behavior management	N	• Clients age 8 and younger; or • DDA clients; or • Clients residing in an ALF or nursing facility; or • Clients diagnosed with autism
D9920	Behavior management	Y	Clients age 9 through 20 and not a DDA client

Note: Do not bill behavior management in conjunction with CDT® codes D9222, D9223, D9224, D9225, D9239, D9243, D9246, or D9247 in any setting.

HCA pays for behavior management when performed in the following settings only:

- Clinics (including independent clinics, tribal health clinics, federally qualified health centers, rural health clinics, and public health clinics).
- Offices.
- Homes (including private homes and group homes).
- Facilities (including alternate living facilities and nursing facilities).

Postsurgical complications

HCA covers treatment of post-surgical complications (e.g., dry socket). This treatment can be billed only one time per visit and used only for an unusual circumstance, not for a routine postoperative visit. Documentation supporting the medical necessity for the procedure must be maintained in the client's record.

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CDT® Code	Short Description	PA?	Requirement
D9930	Treatment of complications	N	Tooth designation required

Occlusal guards

HCA covers occlusal guards when medically necessary and with PA. (See What oral and maxillofacial surgery services are covered? for occlusal orthotic device coverage and coverage limitations.) HCA covers an occlusal guard only:

- For clients age 12 through 20 when the client has permanent dentition.
- As a laboratory processed full arch appliance.
- To treat bruxism and clenching.

The following documentation must be submitted with the PA request:

- Letter of medical necessity, and
- Supporting documentation (radiographs, IO photos, etc.).

HCA does not cover occlusal guards for the treatment of Temporomandibular Dysfunction (TMD) or sleep apnea. See **Occlusal Orthotic Device** for treatment of TMD

CDT® Code	Short Description	PA?	Age Limitation
D9944	Occ guard, hard, full arch	Y	Clients age 12 through 20 only
D9945	Occ guard, soft, full arch	Y	Clients age 12 through 20 only

Is teledentistry covered?

(**WAC 182-535-1098**, Chapter 18.29 RCW, Chapter 18.32 RCW)

Yes. Washington Apple Health clients are eligible for medically necessary covered dental services delivered through teledentistry. The dental provider is responsible for determining and documenting that teledentistry is medically necessary and within the Department of Health's Dental Quality Assurance Commission's **teledentistry guidelines**.

Health care professionals, including dentists and credentialed dental staff, are now required to obtain telehealth training if providing clinical telehealth services. Complete the free and publicly available telemedicine training at the **Washington State Health Care Professional Telemedicine Training website**.

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What is teledentistry?

Teledentistry is not a specific procedure, but a broad variety of technologies and tactics used to deliver dental services. Health care practitioners use HIPAA-compliant, interactive, real-time audio and video telecommunications (including web-based applications) or store-and-forward technology to deliver covered services that are within their scope of practice, to a client at a site other than the site where the provider is located.

A dentist or authorized dental provider may delegate allowable tasks to Washington State Registered Dental Therapists, Dental Hygienists (RDHs) and Expanded Function Dental Assistants (EFDAs) through teledentistry. Delegation of tasks to dental hygienists and EFDA's through teledentistry must be under the general supervision described in WAC 246-817-525 and WAC 246-817-550. Teledentistry does not meet the definition of close supervision.

There are two ways to use teledentistry:

- **Synchronous** meaning the dental provider and the client are in separate locations virtually interacting in real time through real-time audio and video.
- **Asynchronous** meaning store-and-forward technology where the client and the dental provider do not interact in real time. Asynchronous is when a dentist reviews client health information and records previously gathered by another professional at a different time and location than where the records were initially obtained.

The authorized dental provider uses teledentistry, when it is medically necessary and performed within the Department of Health Dental (DOH) Quality Assurance Commission's, Appropriate Use of Teledentistry Guideline.

This mode of care enables the dental provider and the client to interact either synchronously or asynchronously. Teledentistry allows clients, particularly those in medically underserved areas of the state, to have improved access to essential dental services that may not otherwise may not be available without traveling long distances. The Health Care Authority does not cover email or facsimile transmissions as teledentistry services.

When does HCA cover teledentistry?

HCA covers teledentistry as a substitute for an in-person, face-to-face, hands-on visit only for services that are medically necessary, within the scope of practice of the performing HCA-contracted providers, and DOH teledentistry guidelines.

For synchronous (real-time encounter) teledentistry, the client is present at the originating site and participates in the visit with the dentist or authorized dental provider at the distant site.

For asynchronous (a not in real-time encounter) teledentistry, the client's dental clinical information is gathered at the originating site the information is sent via store-and-forward technology to a dentist or authorized dental provider (distant site) for review and subsequent intervention at a later point in time.

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Documentation

The client's record must include supporting documentation for the medical necessity of the service including the following:

- Any radiographs or intraoral photos captured during visit (see **radiograph section** for information on intraoral photos and asynchronous teledentistry visits)
- Service(s) provided via teledentistry.
- Location of the client.
- Location of the provider.
- Names and credentials (MD, DDS/DMD, DT, RDH, EFDA) of all persons involved in the teledentistry visit and their role in the encounter at both the originating and the distant sites.

Note: Place of Service (POS) for teledentistry must be added to the claim. POS 2 (telehealth provided other than the patient's home) or POS 10 (telehealth provided in patient's home).

CDT® Code	Short Description	PA?
D9995	Teledentistry real-time	N
D9996	Teledentistry dent review	N

What is not covered through teledentistry?

- Training
- Intake/administrative services that would normally be done by telephone, (e.g., appointment scheduling, patient registration).

What dental-related services are not covered?

General – All ages

HCA does not cover:

- The dental-related services listed under By category – for clients age 21 and older unless the services include those medically necessary services where there is not a less costly, equally effective service available as determined by HCA.
- Other measures provided to correct or ameliorate conditions discovered during a screening performed under the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

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- Any service specifically excluded by statute.
- More costly services when less costly, equally effective services as determined by HCA are available.
- Services, procedures, treatments, devices, drugs, or application of associated services:
    - That HCA or the Centers for Medicare and Medicaid Services (CMS) considers investigative or experimental on the date the services were provided.
    - That are not listed as covered in one or both of the following:
        - Washington Administrative Code (WAC).
        - HCA's current documents.

By category – For all ages

HCA does not cover the following dental-related services under the dental program for any age:

Diagnostic services

- Detailed and extensive oral evaluations or reevaluations.
- Posterior-anterior or lateral skull and facial bone survey films.
- Any temporomandibular joint films.
- Tomographic surveys/3-D imaging.
- Viral cultures, genetic testing, caries susceptibility tests, or adjunctive prediagnostic tests.
- Comprehensive periodontal evaluations.

Preventive services

- Nutritional counseling for control of dental disease.
- Removable space maintainers of any type.
- Sealants placed on a tooth with the same-day occlusal restoration, preexisting occlusal restoration, or a tooth with occlusal decay.
- Custom fluoride trays of any type.
- Bleaching trays.

Restorative services

- Restorations for wear on any surface of any tooth without evidence of decay through the dentinoenamel junction (DEJ) or on the root surface.
- Restorations for noncavitated, initial lesions on any surface of any tooth.
- Preventive restorations.

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- Labial veneer resin or porcelain laminate restorations.
- Sedative fillings.
- Crowns and crown related services
  - Gold foil restorations.
  - Metallic, resin-based composite, or porcelain/ceramic inlay/onlay restorations.
  - Crowns for cosmetic purposes (e.g., peg laterals and tetracycline staining).
  - Permanent indirect crowns for posterior teeth.
  - Permanent indirect crowns on permanent anterior teeth for clients age 14 and younger.
  - Temporary or provisional crowns (including ion crowns).
  - Any type of coping.
  - Crown repairs.
  - Crowns on teeth 1, 16, 17, and 32.
- Polishing or recontouring restorations or overhang removal for any type of restoration.
- Any services other than extraction on supernumerary teeth.

Endodontic services

- Indirect or direct pulp caps
- Any endodontic treatment on primary teeth, except endodontic treatment with resorbable material for primary maxillary incisor teeth D, E, F, and G, if the entire root is present at treatment.

Periodontic services

- Surgical periodontal services including, but not limited to:
  - Gingival flap procedures.
  - Clinical crown lengthening.
  - Osseous surgery.
  - Bone or soft tissue grafts.
  - Biological material to aid in soft and osseous tissue regeneration.
  - Guided tissue regeneration.
  - Pedicle, free soft tissue, apical positioning, subepithelial connective tissue, soft tissue allograft, combined connective tissue and double pedicle, or any other soft tissue or osseous grafts.
  - Distal or proximal wedge procedures.
- Other periodontal services including, but not limited to:
  - Intracoronal or extracoronal provisional splinting.

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- Full mouth or quadrant debridement (except for clients of the Developmental Disabilities Administration (DDA).
- Localized delivery of chemotherapeutic agents.
- Any other type of surgical periodontal service.

Removable prosthodontics

- Removable unilateral partial dentures.
- Any interim complete or partial dentures.
- Flexible base partial dentures.
- Any type of permanent soft reline (e.g., molloplast).
- Precision attachments.
- Replacement of replaceable parts for semi-precision or precision attachments.
- Replacement of second or third molars for any removable prosthesis.
- Immediate dentures.
- Cast-metal framework partial dentures.

> **Note**: HCA does not cover replacement of HCA-purchased removable prosthodontics that have been lost, broken, stolen, sold, or destroyed as a result of the client's carelessness, negligence, recklessness, deliberate intent, or misuse. See WAC 182-501-0050.

Implant services

- 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.
- Any maintenance or repairs to the above implant procedures.
- The removal of any implant as described above.

Fixed prosthodontics

- Fixed partial denture pontic.
- Fixed partial denture retainer.
- Precision attachment, stress breaker, connector bar, coping, cast post, or any other type of fixed attachment or prosthesis.

Oral maxillofacial prosthetic services

Any type of oral or facial prosthesis other than those listed in What maxillofacial prosthetic services are covered?

Oral and maxillofacial surgery

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- Any oral surgery service not listed in What oral and maxillofacial surgery services are covered?
- Any oral surgery service that is not listed in WAC 182-535-1094.
- Vestibuloplasty.

Adjunctive general services

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

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By category – for clients age 21 and older

HCA does not cover the dental-related services listed under the following categories of service for clients age 21 and older:

Diagnostic services

- Occlusal intraoral radiographs.
- Diagnostic casts.
- Pulp vitality tests.

Preventive services

- Sealants (except for clients of DDA).

Restorative services

- Prefabricated resin crowns.
- Any type of core buildup, cast post and core, or prefabricated post and core.

Endodontic services

- Endodontic treatment on permanent bicuspids or molar teeth.
- Any apexification/recalcification procedures.
- Any apicoectomy/perioradicular surgical endodontic procedures including, but not limited to, retrograde fillings (except for anterior teeth), root amputation, reimplantation, and hemisections.

Adjunctive general services

- Occlusal guards, occlusal orthotic splints or devices, bruxing or grinding splints or devices, or temporomandibular joint splints or devices.
- Analgesia or anxiolysis as a separate procedure except for administration of nitrous oxide.

HCA evaluates a request for dental-related services that are listed as noncovered under the provisions in WAC 182-501-0160.

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Washington State Health Care Authority

Clients of the Developmental Disabilities Administration (DDA)

Are clients of the DDA eligible for enhanced services?

Yes. Clients identified in ProviderOne as clients of the DDA, regardless of age, are eligible for increased frequency of some services. Clients not identified as such are not eligible for the additional services. If you believe that a patient may qualify for these services, refer the patient or the patient's guardian to the nearest DDA Field Office. You may find current contact information for DDA on the DDA website.

What additional dental-related services are covered for clients of DDA?

Subject to coverage limitations, restrictions, and client age requirements identified for a specific service, HCA pays for the following dental-related services under the following categories of services that are provided to clients of DDA. This billing guide also applies to clients of DDA, regardless of age, unless otherwise stated in this section.

Preventive Services

CDT® Code	Short Description	PA?	Requirements	Age Limitation	Frequency
D0120	Periodic oral evaluation	N		All ages	Once every 4 months
D1110	Dental prophylaxis adult	N		Clients age 14 and older only	Once every 4 months. See limitations on periodontal scaling and root planning.
D1120	Dental prophylaxis child	N		Clients age 13 and under only	Once every 4 months. See limitations on periodontal scaling and root planning.

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CDT® Code	Short Description	PA?	Requirements	Age Limitation	Frequency
D1206	Topical fluoride varnish	N	CDT® codes D1206 and D1208 are not allowed on the same day	All ages	Once every 4 months
D1208	Topical app fluorid ex vrnsh	N	CDT® codes D1206 and D1208 are not allowed on the same day	All ages	Once every 4 months
D1351	Dental sealant per tooth	N	Tooth designation required	All ages	Once per tooth in a 2-year period on the occlusal surfaces of: Primary teeth A, B, I, J, K, L, S, and T Permanent teeth 2, 3, 4, 5, 12, 13, 14, 15, 18, 19, 20, 21, 28, 29, 30, and 31

Other Restorative Services

CDT® Code	Short Description	PA?	Requirements	Age Limitation	Frequency
D2910	Recement inlay onlay or part	N	Tooth designation required	All ages	
D2915	Recement cast or prefab post	N	Tooth designation required	All ages	
D2920	Re-cement or re-bond crown	N	Tooth designation required	All ages	

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CDT® Code	Short Description	PA?	Requirements	Age Limitation	Frequency
D2929	Prefab porc/ceram crown pri	Y*	Tooth designation required and x-ray (radiograph) justification required.	Clients age 0-12 and DDA clients age 0-20 do not require PA/EPA. *Clients age 13-20 require PA.	Once every 2 years for **primary** anterior teeth. Once every 2 years for **primary** posterior teeth if criteria Other Restorative Services is met.
D2930	Prefab stnlss steel crwn pri	Y*	Tooth designation required and x-ray (radiograph) justification required.	Clients age 0-12 and DDA clients age 0-20 do not require PA/EPA. *Clients age 13-20 require PA.	Once every 2 years for **primary** anterior teeth. Once every 2 years for **primary** posterior teeth if criteria Other Restorative Services is met.
D2931	Prefab stnlss steel crown pe	N	Tooth designation required	All ages	Once every 2 years for **permanent** posterior teeth, excluding 1, 16, 17 and 32.

HCA reviews requests for PA in accordance with WAC 182-501-0165.

Periodontic Services

CDT® Code	Short Description	PA?	Requirements	Age Limitation	Frequency
D4210	Gingivectomy/plasty 4 or mor	N	Quadrant designation required	All ages	Once every 3 years
D4211	Gingivectomy/plasty 1 to 3	N	Quadrant designation required	All ages	Once every 3 years
D4341	Periodontal scaling and root	N	Quadrant designation required	Clients age 13 and older	One time per quadrant in a 12-month period

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CDT® Code	Short Description	PA?	Requirements	Age Limitation	Frequency
D4342	Periodontal scaling 1-3teeth	N	Quadrant designation required	Clients age 13 and older	One time per quadrant in a 12-month period
D4346	Scaling gingiv inflammation	N		Clients age 13 and older	Once in a 12-month period
D4355	Full mouth debridement	N		All ages	Once in a 12-month period
D4910	Periodontal maint procedures	N		Clients age 13 and older	Twice in a 12-month period *must be 6 months after last root planing

Adjunctive General Services/Miscellaneous

CDT® Code	Short Description	PA?	Requirements	Age Limitation	Frequency
D9222	Deep anest, 1st 15 min	N		All ages	
D9223	General anesth ea addl 15 mi	N		All ages	
D9224	Gen anes adv air – 15 min	N		All ages	
D9225	Gen anes adv air – sub 15 min	N		All ages	
D9239	Iv mod sedation, 1st 15 min	N		All ages	
D9243	Iv sedation ea addl 15m	N		All ages	
D9244	Office min sed drug enteral	N		All ages	
D9245	Admin mod sedation-enteral	N		All ages	

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CDT® Code	Short Description	PA?	Requirements	Age Limitation	Frequency
D9246	Mod sedation noniv – 15 min	N		All ages	
D9247	Mod sedation noniv - sub 15 min	N		All ages	
D9920	Behavior management	N		All ages	

Note: Do not bill behavior management in conjunction with CDT® codes D9222, D9223, D9224, D9225 D9239, D9243, D9246, or D9247 in any setting.

Other restorative services

Prefabricated stainless-steel crowns, including stainless-steel crowns with resin window, resin-based composite crowns (direct), prefabricated esthetic coated stainless crowns, and prefabricated resin crowns for primary posterior teeth once every 2 years only for clients age 20 and younger without prior authorization if one of the following applies:

- Evidence of extensive caries.
- Evidence of Class II caries with rampant decay.
- Treatment of decay requires sedation or general anesthesia.
- Decay involves three or more surfaces for a primary first molar.
- Decay involves four or more surfaces for a primary second molar.
- The tooth had a pulpotomy.

Periodontic services

Surgical periodontal services

HCA covers gingivectomy/gingivoplasty (does not include distal wedge procedures on erupting molars):

- Once every 3 years. Documentation supporting the medical necessity of the service must be in the client's record (e.g., drug induced gingival hyperplasia).
- With periodontal scaling and root planing or periodontal maintenance when the services are performed:
  - In a hospital or ambulatory surgical center.
  - For clients under conscious sedation, deep sedation, or general anesthesia.

Nonsurgical periodontal services

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HCA covers:

- Periodontal scaling and root planing, one time per quadrant in a 12-month period.
- Periodontal maintenance (four quadrants) substitutes for an eligible periodontal scaling or root planing, twice in a 12-month period.
- Periodontal maintenance allowed 6 months after scaling or root planing.
- Full-mouth or quadrant debridement allowed once in a 12-month period.
- Scaling in the presence of generalized moderate or severe gingival inflammation allowed once in a 12-month period.
- Gingivectomy is not a covered service in conjunction with the above listed procedures.

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

Nonemergency dental services

HCA covers nonemergency dental services performed in a hospital or an ambulatory surgery center for services listed as covered in the following sections in this billing guide:

- What preventative services are covered?
- What restorative services are covered?
- What endodontic services are covered?
- What periodontic services are covered?
- What oral and maxillofacial surgery services are covered?

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

Miscellaneous services-behavior management

HCA covers behavior management provided by a dental provider or clinic. Documentation supporting the medical necessity of the service must be included in the client's record. See behavior management.

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Note: Documentation supporting the medical necessity of the billed procedure code must be in the client's record. It must include a description of the behavior managed, the behavior management technique used, and identification of the additional professional staff employed by the dental provider or clinic to manage the behavior to assist the delivery of dental treatment. HCA does not pay a separate fee for behavior management when assistance is provided by a parent (legal guardian) or family member, provider, or staff member already delivering the client's dental treatment.

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Washington State Health Care Authority

Authorization

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

Prior authorization (PA)

For dental-related services that require PA, HCA reviews requests for PA according to WAC 182-501-0165.

Authorization of a dental-related service indicates only that the specific service is medically necessary. Authorization does not guarantee payment.

The authorization is valid for 6 to 12 months as indicated in HCA's authorization letter and only if the client is eligible for covered services on the date of service. Valid dates are based on the date HCA approves the request regardless of the date of PA submission.

When do I need to get PA?

PA must be obtained **before** the service is provided.

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

When does HCA deny a PA request?

HCA denies a PA request for a dental-related service when the requested service:

- Is covered by another state agency program.
- Is covered by an entity outside HCA.
- Fails to meet the program criteria, limitations, or restrictions in this billing guide.

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How do I obtain a PA?

Providers may submit a PA request by direct data entry into ProviderOne or fax (see HCA's prior authorization webpage for details).

HCA may request additional information as follows:

- Additional x-rays (radiographs).
- Photographs.
- Second opinions and/or consultations.
- Arch/quadrant designation:

Code	Area
00	Entire oral cavity
01	Maxillary arch
02	Mandibular arch
10	Upper right quadrant
20	Upper left quadrant
30	Lower left quadrant
40	Lower right quadrant

- Any other information requested by HCA.

Note: HCA requires a dental provider who is requesting PA to submit sufficient, current (within the past 12 months), objective, clinical information to establish medical necessity.

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> **Note**: All images must include both of the following:
>
> - The date the images were taken.
> - The client's name and date of birth or their ProviderOne Client ID number.

Removable dental prosthetics: For nursing facility clients, the PA request must also include a completed copy of the Denture/Partial Appliance Request for Skilled Nursing Facility Client form, HCA #13-788. See Where can I download HCA forms?

> **Note**: For information on obtaining HCA forms, see HCA's Forms & Publications webpage.

How do I submit a PA request?

For information on submitting prior authorization requests to HCA, see Requesting Prior Authorization in HCA's ProviderOne billing and resource guide or HCA's prior authorization webpage.

How to submit a PA request, without x-rays (radiographs) or photos: For procedures that do not require x-rays (radiographs) or photos, submit by direct data entry (DDE) in the ProviderOne portal or fax the PA request to HCA at: (866) 668-1214.

How to submit a PA request, with x-rays (radiographs) or photos: Pick one of following options for submitting x-rays (radiographs) or photos to HCA:

- Submit request through ProviderOne by direct data entry and attach x-rays (radiographs) or photos to the PA request.
- Use the FastLook™ and FastAttach™ services provided by National Electronic Attachment, Inc. (NEA). You may register with NEA by visiting www.nea-fast.com and entering "FastWDSHS" in the blue promotion code box. Contact NEA at 1-800-782-5150, ext. 2, with any questions.

  When choosing this option, you can fax your request to HCA and indicate the NEA# in the NEA field on the PA Request Form or in the comments if submitting request through Direct Data Entry. There is a cost associated which will be explained by the NEA services.

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Note: HCA does not accept any documentation on CDs, thumb drives, or any device that requires downloading on state equipment.

What is expedited prior authorization (EPA)?

Expedited Prior Authorization (EPA) eliminates the need for PA for selected dental procedure codes.

To use an EPA:

- Enter the EPA number on the claim form when billing HCA.
- When requested, provide documentation showing the client's condition meets all the EPA criteria.

PA is required when a situation does not meet all the EPA criteria for selected dental procedure codes. See HCA's Prior Authorization webpage for details.

It is the provider's responsibility to determine if a client has already received the service allowed with the EPA criteria and if the provider has already rendered the service for the client. If the client already received the service, a PA request is required to provide the service again or to provide additional services. For claim inquiries, or to check for service limitations, contact the Medical Assistance Customer Service Center (MACSC):

- Phone: 1-800-562-3022
- Online: https://fortress.wa.gov/hca/p1contactus/

Note: By entering an EPA number on your claim, you attest that all the EPA criteria are met and can be verified by documentation in the client's record. These services are subject to post payment review and audit by HCA or its designee.

HCA may recoup any payment made to a provider if the provider did not follow the required EPA process and if not all of the specified criteria were met.

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EPA code list

EPA#	CDT® Code	Short Description	Criteria
870001741	D0350	Oral/facial photo images	Must occur in SNF, group home/adult family home, school when using asynchronous teledentistry (D9996) to conduct an exam (D0150, D0120, D0140) and must be billed with CDT® code D9996. Not allowable with a screening (D0190/D0191) Not allowable with synchronous teledentistry Not allowable in assisted or independent living facilities or dental clinics 1 time per 12 months Photos must be retained in the client's chart Photos must be of diagnostic quality and include all teeth/arches that were examined
870001307	D2335	Resin 4/> surf or w incis an	Allowed for primary anterior teeth (CDEFGHMNOPQR) when determined medically necessary by a dental practitioner and a more appropriate alternative to a crown. *The Health Care Authority does not pay for a crown on the same tooth if a restoration has been done within the past 6 months. **Note** - In addition to the EPA # on your claim, you must enter a claim note "Pay per authorization - see EPA information"
870001327	D0150	Comprehensive oral evaluation	Allowed for established patients who have a documented significant change in health conditions.
870001387	D9222	Deep anest, 1st 15 min	Allowed for clients age 9 through 20 receiving oral surgery services listed in WAC 182-535-1094(1)(f-l) and clients with cleft palate diagnoses. Only anesthesiology providers who have a core provider agreement with the Health Care Authority can bill this code.

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EPA#	CDT® Code	Short Description	Criteria
870001740	D9222	Deep anest, 1st 15 min	For clients age 9 – 20 with the following RAC codes: 1014-1017, 1019-1022 - 1196, and - 1279 – 1281. When treatment is medically necessary.
870001387	D9223	General anesth ea addl 15 min	Allowed for clients age 9 through 20 receiving oral surgery services listed in WAC 182-535-1094(1)(f-l) and clients with cleft palate diagnoses. Only anesthesiology providers who have a core provider agreement with the Health Care Authority can bill this code.
870001740	D9223	General anesth ea addl 15 min	For clients age 9 – 20 with the following RAC codes: 1014-1017, 1019-1022 - 1196, and - 1279 – 1281. When treatment is medically necessary.
870001387	D9224	Gen anes adv air – 15 min	Allowed for clients age 9 through 20 receiving oral surgery services listed in WAC 182-535-1094(1)(f-l) and clients with cleft palate diagnoses. Only anesthesiology providers who have a core provider agreement with the Health Care Authority can bill this code.
870001740	D9224	Gen anes adv air – 15 min	For clients age 9 – 20 with the following RAC codes: 1014-1017, 1019-1022 - 1196, and - 1279 – 1281. When treatment is medically necessary.

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EPA#	CDT® Code	Short Description	Criteria
870001387	D9225	Gen anes adv air – sub 15 min	Allowed for clients age 9 through 20 receiving oral surgery services listed in WAC 182-535-1094(1)(f-l) and clients with cleft palate diagnoses. Only anesthesiology providers who have a core provider agreement with the Health Care Authority can bill this code.
870001740	D9225	Gen anes adv air – sub 15 min	For clients age 9 – 20 with the following RAC codes: 1014-1017, 1019-1022 - 1196, and - 1279 – 1281. When treatment is medically necessary.
870001655	D4910	Periodontal maint procedures	Clients age 21 and older with a diagnosis of diabetes. Provider performing the procedure must keep documentation (in their records) of the client's diabetes diagnosis.
870001683	D7962	Lingual frenectomy	Clients age 0 – 12 months requiring breast feeding support. Referral by a primary care provider with expertise in caring for newborns and providing ongoing infant care that diagnoses symptomatic ankyloglossia that is not improving with lactation support or other measures and recommends frenectomy
870001683	D7963	Frenuloplasty	Clients age 0 – 12 months requiring breast feeding support. Referral by a primary care provider with expertise in caring for newborns and providing ongoing infant care that diagnoses symptomatic ankyloglossia that is not improving with lactation support or other measures and recommends frenectomy

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EPA#	CDT® Code	Short Description	Criteria
870001685	D7961	Buccal/labial frenectomy	Clients age 0 – 6 years old diagnosed with speech disorders. HCA considers a frenotomy/frenectomy for speech language disorders when all the following are met: - Multi-disciplinary team has supported non-surgical interventions, including evaluation and treatment by a speech language pathologist in the last 12 months, and - Non-surgical modalities have failed and - The frenum attachment is diagnosed by a physician as requiring surgical intervention given all other treatments have failed HCA does not consider a lingual frenotomy/frenectomy to prevent a future speech or feeding disorder to be medically necessary.
870001685	D7962	Lingual frenectomy	Clients age 0 – 6 years old diagnosed with speech disorders. HCA considers a frenotomy/frenectomy for speech language disorders when all the following are met: - Multi-disciplinary team has supported non-surgical interventions, including evaluation and treatment by a speech language pathologist in the last 12 months, and - Non-surgical modalities have failed and - The frenum attachment is diagnosed by a physician as requiring surgical intervention given all other treatments have failed HCA does not consider a lingual frenotomy/frenectomy to prevent a future speech or feeding disorder to be medically necessary.

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EPA#	CDT® Code	Short Description	Criteria
870001685	D7963	Frenuloplasty	Clients age 0 – 6 years old diagnosed with speech disorders. HCA considers a frenotomy/frenectomy for speech language disorders when all the following are met: - Multi-disciplinary team has supported non-surgical interventions, including evaluation and treatment by a speech language pathologist in the last 12 months, and - Non-surgical modalities have failed and - The frenum attachment is diagnosed by a physician as requiring surgical intervention given all other treatments have failed HCA does not consider a lingual frenotomy/frenectomy to prevent a future speech or feeding disorder to be medically necessary.
870001686	D7961	Buccal/labial frenectomy	For clients age 0 – 6 years old diagnosed with periodontal defects. HCA considers a labial frenotomy to be medically necessary when all of the following are met: - Factors causing gingival/periodontal inflammation are controlled and - Oral hygiene measures are inadequate to reduce accumulation of plaque, food, and therefore, periodontal defects (eg recession) may occur Chart notes and photographs that outline all of the above MN is met and they are inadequate to prevent periodontal pockets or defects

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Washington State Health Care Authority

Billing

All claims must be submitted electronically to HCA, except under limited circumstances. For more information about this policy change, see Paperless billing at HCA. For providers approved to bill paper claims, see HCA's Paper claim billing resource.

What are the general billing requirements?

Providers must follow HCA's ProviderOne billing and resource guide. These billing requirements include:

- What time limits exist for submitting and resubmitting claims and adjustments.
- When providers may bill a client.
- How to bill for services provided to primary care case management (PCCM) clients.
- How to bill for clients eligible for both Medicare and Medicaid.
- How to handle third-party liability claims.
- What standards to use for record keeping.

Note: If an ICD diagnosis code is entered on the dental billing and it is an invalid diagnosis code, the claim will be denied.

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA's Billers, providers, and partners webpage, under Learn how to use ProviderOne, select Webinars.

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the HIPAA electronic data interchange (EDI) webpage.

How do facilities bill?

Ambulatory Surgical Centers (ASC) and hospitals must bill for surgical services according to their billing guides. See the ASC Billing Guide, Inpatient Hospital Services Billing Guide and the Outpatient Hospital Services Billing Guide for how to bill for surgical services.

HCA pays the hospital or ASC professional fees. The Health Care Authority-contracted managed care organization (MCO) pays the facility fees for covered dental-related services.

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Note: If a client is not enrolled in an HCA-contracted managed care organization (MCO), bill the Health Care Authority for services.

How do I bill for clients eligible for both Medicare and Medicaid?

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

What are the advance directives requirements?

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

Clients have the right to:

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

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Washington State Health Care Authority

Fee Schedules

Where can I find dental fee schedules?

For CDT®/dental codes – see HCA's Dental fee schedule.

For dental oral surgery codes, see HCA's Physician-related/professional services fee schedule.

Note: Bill HCA your usual and customary charge.

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