

Washington State Health Care Authority

Medicaid Provider Guide

Dental-Related Services
[Refer to Chapter 182-535 WAC]



Washington State
Health Care Authority

A Billing Instruction

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About this Guide

This guide supersedes all previous Agency Dental Medicaid Provider Guides and Numbered Memoranda and is published by the Medicaid Program of the Washington State Health Care Authority.

What Has Changed?

Reason for Change	Effective Date	Section/ Page No.	Subject	Change
Provider Notice 12-85	Retroactive to October 1, 2012.	Authorization Page 74	Expedited Prior Authorization	Clarify the EPA Process for Dental Services.
Provider Notice 12-85	Retroactive to October 1, 2012.	Authorization Page 75	Expedited Prior Authorization	Update information to the criteria for procedure codes D1204, D1515, D2335, D3120, and D7971 in the Expedited Prior Authorization Procedure Code List.

Fee Schedules

- You may access the Agency's Dental Fee Schedule at:
<http://hrsa.dshs.wa.gov/RBRVS/Index.html>.
- To access the Agency's Oral Surgery Fee Schedule:
 - ✓ **Procedure codes** may be found in the Dental Fee Schedule at the above address.
 - ✓ **Maximum allowable fees** may be found in the Physician-Related Services Fee Schedule at the above address.

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Important Contacts

Note: This section contains important contact information relevant to Dental-Related Services. For more contact information, see the Agency’s *Resources Available* web page at:
http://hrsa.dshs.wa.gov/Download/Resources_Available.html

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	<p>See the Agency’s <i>Resources Available</i> web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html</p>
Finding out about payments, denials, claims processing, or Agency managed care organizations	
Electronic or paper billing	
Finding Agency documents (e.g., Medicaid provider guides, Provider Notices, fee schedules)	
Private insurance or third-party liability, other than Agency managed care	
Prior authorization, limitation extensions, or exception to rule	
Accessing the Agency Dental web site	<p>Visit: http://hrsa.dshs.wa.gov/DentalProviders/DentalIndex.html</p>

Definitions & Abbreviations

Below are definitions of words and phrases that the Health Care Authority (the Agency) uses in this Medicaid provider guide. The Agency 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 the current CDT or CPT and what is located here the definitions in this Medicaid Provider Guide prevails.** Please refer to the Agency *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for a more complete list of definitions.

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

Alternative Living Facility (ALF) – Refer to WAC 182-513-1301.

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/dental societies. [WAC 182-535-1050]

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]

Asymptomatic – Having or producing no symptoms. [WAC 182-535-1050]

Base Metal – Dental alloy containing little or no precious metals. [WAC 182-535-1050]

Behavior Management – Using the assistance of one additional dental professional staff to manage the behavior of a client to facilitate the delivery of dental treatment. [WAC 182-535-1050]

Border Areas - Refer to WAC 182-501-175.

Caries – Carious lesions or tooth decay through the enamel or decay of the root surface. [WAC 182-535-1050]

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 conditions (including periodontal charting), hard and soft tissue anomalies, and oral cancer screening. [WAC 182-535-1050]

Conscious Sedation - A drug-induced depression of consciousness during which clients respond 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. [WAC 182-535-1050]

Core Build-up – Refers to building up of clinical crowns, including pins. [WAC 182-535-1050]

Coronal – The portion of a tooth that is covered by enamel. [WAC 182-535-1050]

Coronal Polishing – A mechanical procedure limited to the removal of plaque and stain from exposed tooth surfaces. [WAC 182-535-1050]

Crown – A restoration covering or replacing part, or the whole, clinical crown of a tooth. [WAC 182-535-1050]

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 published by the Council on Dental Benefit Programs of the American Dental Association (ADA). [WAC 182-535-1050]

Decay – A term for carious lesions in a tooth; and means decomposition of the tooth structure. [WAC 182-535-1050]

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. [WAC 182-535-1050]

Denturist – A person licensed under Chapter 18.30 RCW to make, construct, alter, reproduce, or repair a denture. [WAC 182-535-1050]

Division of Developmental Disabilities (DDD) - The division within the Department of Social and Health Services responsible for administering and overseeing services and programs for clients with developmental disabilities.

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

Extraction – See “simple extraction” and “surgical extraction.”

Flowable Composite – A diluted resin-based composite dental restorative material that is used in cervical restorations and small, low stress bearing occlusal restorations.

Fluoride Varnish, Rinse, Foam, or Gel – A substance containing dental fluoride, which is applied to teeth.

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. [WAC 182-535-1050]

High Noble Metal – A dental alloy containing at least 60% pure gold. [WAC 182-535-1050]

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

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.
[WAC 182-535-1050]

Limited Visual Oral Assessment – An assessment by a dentist or dental hygienist to determine the need for fluoride treatment and triage services when provided in settings other than dental offices or dental clinics.
[WAC 182-535-1050]

Major Bone Grafts – A transplant of solid bone tissue(s). [WAC 182-535-1050]

Minor Bone Grafts – A transplant of non-solid bone tissue(s), such as powdered bone, buttons, or plugs.
[WAC 182-535-1050]

Noble Metal – A dental alloy containing at least 25% but less than 60% pure gold.
[WAC 182-535-1050]

Oral Hygiene Instruction – Instruction for home oral hygiene care, such as tooth brushing techniques or flossing.
[WAC 182-535-1050]

Oral prophylaxis – The dental procedure of scaling and polishing that includes removal of calculus, plaque, and stains from teeth.
[WAC 182-535-1050]

Partials or Partial Dentures – A removable prosthetic appliance that replaces missing teeth in one arch.
[WAC 182-535-1050]

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.
[WAC 182-535-1050]

Periodontal Maintenance – A procedure performed for clients who have previously been treated for periodontal disease with surgical or nonsurgical treatment. It includes the removal of supragingival and subgingival micro-organisms and deposits with hand and mechanical instrumentation, an evaluation of periodontal conditions, and a complete periodontal charting as appropriate. [WAC 182-535-1050]

Periodontal Scaling and Root Planing – A procedure to remove plaque, calculus, micro-organisms, and rough cementum and dentin from tooth surfaces. This includes hand and mechanical instrumentation, an evaluation of periodontal conditions, and a complete periodontal charting as appropriate. [WAC 182-535-1050]

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

Posterior – The 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. [WAC 182-535-1050]

Primary – The first set of teeth.

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

Radiograph – an image or picture produced on a radiation sensitive film emulsion or digital sensor by exposure to ionizing radiation. Also known as X-ray. [Refer to WAC 182-535-1050]

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. [WAC 182-535-1050]

Root Canal - The chamber within the root of the tooth that contains the pulp. [WAC 182-535-1050]

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. [WAC 182-535-1050]

Scaling – A procedure to remove plaque, calculus, and stain deposits from tooth surfaces. [WAC 182-535-1050]

Sealant – A dental material applied to teeth to prevent dental caries. [WAC 182-535-1050]

Simple Extraction – The routine removal of tooth. [WAC 182-535-1050]

Standard of Care – What reasonable and prudent practitioners would do in the same or similar circumstances. [WAC 182-535-1050]

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 – See definitions of dental procedures in the current CDT manual. [WAC 182-535-1050]

Symptomatic – Having symptoms (e.g., pain, swelling, and infection). [WAC 182-535-1050]

Temporomandibular joint dysfunction (TMJ/TMD) – An abnormal functioning of the temporomandibular joint or other areas secondary to the dysfunction. [WAC 182-535-1050]

Therapeutic Pulpotomy – The surgical removal of a portion of the pulp (inner soft tissue of a tooth), to retain the healthy remaining pulp. [WAC 182-535-1050]

Wisdom Teeth – The third molars, teeth 1, 16, 17, and 32. [WAC 182-535-1050]

Xerostomia – A dryness of the mouth due to decreased saliva. [WAC 182-535-1050]

About the Program

Scope of Program

The Health Care Authority (the Agency) covers comprehensive dental services, according to Agency rules and subject to the limitations and requirements in this Medicaid provider guide, when they are:

- Within the scope of an eligible client's medical assistance program.
- Included in the client's benefit package. Refer to WAC [182-535-1060](#) and [182-501-0050](#).

All clients are subject to the limitations, restrictions, and age requirements identified for the specific service, unless otherwise noted.

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 Medicaid clients.

Becoming an Agency Dental Provider

[Refer to WAC 182-535-1070]

The following providers are eligible to enroll with the Agency 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 EPSDT.
 - ✓ Practice as a dental hygienist.
 - ✓ Practice as a denturist.
 - ✓ Practice anesthesia according to Department of Health (DOH) regulations.

Dental-Related Services

- Facilities that are one of the following:
 - ✓ Hospitals currently licensed by the Department of Health (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: The Agency pays licensed providers participating in the Agency's Dental-Related Services Program for only those services that are within their scope of practice. [WAC 182-535-1070(2)]

Client Eligibility

Who Is Eligible?

[Refer to WAC 182-535-1060]

The clients described in this section are eligible to receive the dental-related services described in this Medicaid provider guide subject to limitations, restrictions, and client-age requirements identified for a specific service. Clients must be covered under a Benefit Package that includes dental-related services and must be one of the following:

- 20 years of age and younger.
- 20 years of age and younger enrolled in an agency-contracted managed care organization (MCO). See “Are Clients Enrolled in Managed Care Eligible?” for more details.
- **For dates of service on and after July 1, 2011, verifiably pregnant.**
- **For dates of service on and after July 1, 2011, residing in one of the following:**
 - ✓ Nursing home.
 - ✓ Nursing facility wing of a state veteran’s home.
 - ✓ Privately operated intermediate care facility for the intellectually disabled (ICF/ID).
 - ✓ State-operated residential habilitation center (RHC).
- **For dates of service on and after July 1, 2011, eligible under an Aging and Disability Services Administration (ADSA) 1915 (c) waiver program.**
- **For dates of service prior to October 1, 2011, clients of the Division of Developmental Disabilities.**

- **For dates of service on and after October 1, 2011**, clients of the Division of Developmental Disabilities who also qualify as follows:
 - ✓ Are 20 years of age and younger.
 - ✓ **For dates of service on and after July 1, 2011**, clients who are verifiably pregnant.
 - ✓ **For dates of service on and after July 1, 2011**, clients residing in one of the following:
 - Nursing home.
 - Nursing facility wing of a state veteran's home.
 - Privately operated intermediate care facility for the intellectually disabled (ICF/ID).
 - State-operated residential habilitation center (RHC).

Eligibility Determination Resources

- Refer to the *Scope of Categories of Healthcare Services Table* web page at: <http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html> for an up-to-date listing of Benefit Packages.
- In addition to using the Scope of Healthcare Services Table mentioned above, providers must use the Eligibility Determination Flowchart to determine client eligibility for dental-related services. The flowchart is located on the Agency's Dental Services webpage at: <http://hrsa.dshs.wa.gov/DentalProviders/DentalIndex.html>.
- Please see the Agency's *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/billing/providerone_billing_and_resource_guide.html for further instructions on how to verify a client's eligibility.

Are Clients Enrolled in Managed Care Eligible?

[Refer to WAC 182-535-1060(1)(b)(ii)]

Yes! Eligible clients who are enrolled in an Agency-contracted managed care organization are eligible under fee-for-service for covered services that are NOT covered by their plan. In fact, with the exception of some oral surgeries, most dental services are not covered by managed care plans. Therefore, fee- for- service rules apply. Medical services covered under a managed care plan must be obtained by the client through designated facilities or providers.

When verifying eligibility using ProviderOne, if the client is enrolled in an Agency managed care plan, managed care enrollment will be displayed on the Client Benefit Inquiry screen. All services must be requested directly through the client's Primary Care Provider (PCP). Clients can contact their managed care plan by calling the telephone number provided to them.

Note: To prevent billing denials, please check the client's eligibility **prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the plan. See the Agency's *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/billing/providerone_billing_and_resource_guide.html for instructions on how to verify a client's eligibility.

Coverage

When Does the Agency Pay for Covered Dental-Related Services?

[Refer to WAC [182-535-1079](#) (1)]

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

- Are part of the client's benefit package.
- Are within the scope of an eligible client's medical care program.
- Are medically necessary.
- Meet the Agency's prior authorization requirements, if any.
- Are documented in the client's record.
- Are within accepted dental or medical practice standards.
- Are consistent with a diagnosis of dental disease or condition.
- Are reasonable in amount and duration of care, treatment, or service.
- Are listed as covered in this Medicaid provider guide.

Services Performed in a Hospital or Ambulatory Surgery Center (ASC)

Dental Providers

- The Agency covers Evaluation and Management (E&M) Codes (formerly hospital visits and consults) when an oral surgeon is called to the hospital or is sent 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 837P HIPAA compliant claim form, Professional claim billed via Direct Data Entry (DDE), or CMS-1500 paper claim form.
 - ✓ Using the appropriate CPT procedure code and modifiers, if appropriate.
- The Agency 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 Division of Developmental Disabilities, see [Coverage](#) in this Medicaid provider guide).

Dental-Related Services

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

Place of Service	Setting
21	Inpatient Hospital
22	Outpatient Hospital
24	Ambulatory Surgery Center

- The dentist providing the service must send in a request for authorization to perform the procedure in this setting. The request must:
 - ✓ Contain all procedure codes, including procedure codes that require PA according to this Medicaid provider guide.

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 on the General Information for Authorization form, HCA 13-835.
- ✓ Include a letter that clearly describes the medical necessity of performing the service in the requested setting.
- ✓ Include the client eligibility authorization number if client is 21 years of age and older.

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

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

Exception: Oral surgeons may use CPT codes **listed in the Agency's [Physician-Related/Professional and Emergent Oral Healthcare Services Fee Schedule](#)** only when the procedure performed is not listed as a covered CDT code in the Agency's [Dental Program Fee Schedule](#). CPT codes must be billed on an 837P/CMS-1500 claim form.

The Agency pays dentists and oral surgeons for hospital visits using only the CPT codes listed in Section B of the [Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide](#). Per 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.

- 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 is limited to those CDT and select CPT codes listed in the Agency's [Dental Program Fee Schedule](#).
- ASCs are paid only for the codes listed in the Agency's [Ambulatory Surgery Centers Medicaid Provider Guide](#).
- The Agency considers anesthesia to be included in the payment made to the facility. The Agency does not pay separately, even if a facility bills CDT code D9220/D9221 or D9241/D9242.

Hospitals and ASCs may only use procedure code 41899 when there is no existing national code that describes the services being provided. The Agency considers this code for payment *only* when the performing dentist submits a PA request with justification explaining that there is no existing national code describing the services being provided.

Site-of-Service Prior Authorization [Refer to WAC [182-535-1079](#) (2) (3)]

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

- The client is not a client of the Division of developmental Disabilities according to the “Clients of the Division of Developmental Disabilities” section in this Medicaid provider guide.
- The client is nine years of age or older.
- The service is not listed as exempt from the site-of-service authorization requirement in this Medicaid provider guide or the Agency's current published [Dental-Related Services Fee Schedule](#).
- The service is not listed as exempt from the prior authorization requirement for deep sedation or general anesthesia (see “[What Adjunctive General Services Are Covered?](#)” in this section).

To be eligible for payment, dental-related services performed in a hospital or an ASC must be listed in the Agency's current published [Outpatient Fee Schedule](#) or [ASC Fee Schedule](#). The claim must be billed with the correct procedure code for the site-of-service.

Coverage Under the EPSDT Program

[Refer to WAC [182-535-1079](#) (4)]

Under the Early Periodic Screening and Diagnostic Treatment (EPSDT) program, clients 20 years of age and younger may be eligible for the dental-related services listed as noncovered. See the Agency's current [Early Periodic Screening, Diagnosis & Treatment \(EPSDT\) Medicaid Provider Guide](#) for information about EPSDT.

Limitation Extension and Exception to Rule

[Refer to WAC [182-535-1079](#) (5)]

What Is an LE?

LE is an authorization of services beyond the designated benefit limit allowed in Washington Administration Code (WAC) and Agency Medicaid provider guides.

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

The Agency 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?

The Agency requires a dental provider who is requesting an LE to submit sufficient, objective, clinical information to establish medical necessity.

Providers must submit the request in writing on a completed General Information for Authorization form, 13-835. See the Agency's current [ProviderOne Billing and Resource Guide](#) for more information.

The Agency may request additional information as follows:

- Additional X-rays (radiographs). The Agency returns X-rays only for approved requests and only if accompanied by self-addressed stamped envelope.
- Study model, if requested.
- Photographs.
- Any other information requested by the Agency.

Note: The Agency may require second opinions and/or 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 Appliance Request for Skilled Nursing Facility Client form, 13-788.

Note: For information on obtaining Agency forms, refer to the Important Contacts section.

What Is an Exception to Rule?

A client and/or the client's provider may request the Agency to pay for a noncovered service. This is called an Exception to Rule. The Agency reviews these requests according to WAC 182-501-0160.

How Do I Request a Noncovered Service?

To request a noncovered service, submit the request in writing on a completed General Information for Authorization form, 13-835, to the Agency at: 1-866-668-1214.

Indicate in Box 30 on the form that you are requesting an Exception to Rule.

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

What Diagnostic Services Are Covered?

[Refer to WAC [182-535-1080](#)]

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

Clinical Oral Evaluations

What Is Covered?

The Agency covers:

- Oral health evaluations and assessments. The services must be documented in the client's record in accordance with Chapter [182-502](#) WAC.
- Periodic oral evaluations, once every six months. Six months must elapse between the comprehensive oral evaluation and the first periodic oral evaluation.
- Limited oral evaluations, only when the provider performing the limited oral evaluation is not providing routine scheduled dental services for the client. The limited oral evaluation:
 - ✓ Must be to evaluate the client for a:
 - Specific dental problem or oral health complaint.
 - Dental emergency.
 - Referral for other treatment.
 - ✓ When performed by a dentist, is limited to the initial examination appointment. The Agency does not cover any additional limited examination by a dentist for the same client until three months after a removable dental prosthesis has been seated.
- Comprehensive oral evaluations once per client, per provider or clinic, as an initial examination that must include:
 - ✓ A complete dental and medical history and general health assessment.
 - ✓ A complete 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 conditions (including periodontal charting), hard and soft tissue anomalies, and oral cancer screening.

The Agency covers an additional comprehensive oral evaluation if the client has not been treated by the same provider or clinic within the past five years.

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

Code	Description	PA?	Maximum Allowable Fee
D0120	periodic oral evaluation – established patient*	N	On-line Fee Schedules
D0140	limited oral evaluation – problem focused*	N	
D0150	comprehensive oral evaluation – new or established patient*	N	

*Oral surgeons may bill E&M codes (CPT 99201-99215) on an 837P/CMS-1500 claim to represent these services instead of CDT codes.

Limited Visual Oral Assessment

What Is Covered?

The Agency covers limited visual oral assessments, up to two per client, per year, per provider only when the assessment is:

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

Code	Description	PA?	Maximum Allowable Fee
D9999	unspecified diagnostic procedure, by report	N	On-line Fee Schedules

X-rays (Radiographs)

What Is Covered?

Note: The Agency uses the prevailing standard of care to determine the need for dental X-rays (radiographs).

The Agency covers:

- X-rays that are of diagnostic quality, dated, and labeled with the client's name. The Agency requires:
 - ✓ Original X-rays to be retained by the provider as part of the client's dental record.
 - ✓ Duplicate X-rays to be submitted with requests for prior authorization and when the Agency requests copies of dental records.
- An intraoral complete series, once in a three-year period only if the Agency has not paid for a panoramic X-ray for the same client in the same three-year period. The intraoral complete series includes 14-22 periapical and posterior bitewings. The Agency limits reimbursement for all x-rays to a total payment of no more than the payment for a complete series.
- Medically necessary periapical X-rays that are not included in a complete series for diagnosis in conjunction with definitive treatment, such as root canal therapy. Documentation supporting medical necessity must be included in the client's record.
- An occlusal intraoral X-ray once in a two-year period, for clients 20 years of age and younger.
- A maximum of four bitewing X-rays (once per quadrant) once every twelve months.
- Panoramic X-rays in conjunction with four bitewings, once in a three-year period, only if the Agency has not paid for an intraoral complete series for the same client in the same three-year period.

Note: The Agency may reimburse for additional medically necessary panoramic X-rays for preoperative or postoperative surgery cases more than once in a three-year period, only on a case-by-case basis and when prior authorized, except when required by an oral surgeon. For orthodontic services, refer to the Agency's current published [Orthodontic Services Medicaid Provider Guide](#). Emergency treatment may be billed without prior authorization. Indicate emergency in the remarks field on the ADA claim form.

Dental-Related Services

- Cephalometric films once in a two-year period for clients 20 years of age and younger, only on a case-by-case basis, and when prior authorized.
- X-rays not listed as covered in this subsection, only on a case-by-case basis and when prior authorized.

Code	Description	PA?	Age Limitation	Maximum Allowable Fee
D0210	intraoral – complete series (including bitewings)	N		On-line Fee Schedules
D0220	intraoral – periapical first film	N		
D0230	intraoral – periapical each additional film	N		
D0240	intraoral – occlusal film	N	Clients 20 years of age and younger only.	
D0270	bitewing – single film	N		
D0272	bitewings – two films	N		
D0273	bitewings – three films	N		
D0274	bitewings – four films	N		
D0330	panoramic film	N		
D0340	cephalometric film (orthodontics only)	N	Clients 20 years of age and younger only.	

- Oral and facial photographic images, for clients age 20 and younger only on a case-by-case basis and when requested by the Agency.

Code	Description	PA?	Age Limitation	Maximum Allowable Fee
D0350	oral/facial photographic images	Y	Clients 20 years of age and younger only.	On-line Fee Schedules

Note: The Agency does not require PA for additional medically necessary panoramic x-rays by oral surgeons and orthodontists.

Tests and Examinations

What Is Covered?

The Agency covers the following for clients 20 years of age and younger:

- One pulp vitality test per visit (not per tooth):
 - ✓ For diagnosis only during limited oral evaluations.
 - ✓ When X-rays and/or documented symptoms justify the medical necessity for the pulp vitality test.

Code	Description	PA?	Age Limitation	Maximum Allowable Fee
D0460	pulp vitality tests	N	Clients 20 years of age and younger only.	On-line Fee Schedules

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

Code	Description	PA?	Age Limitation	Maximum Allowable Fee
D0470	diagnostic casts	Y	Clients 20 years of age and younger only.	On-line Fee Schedules

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

What Preventive Services Are Covered?

[Refer to WAC 182-535-1082]

Subject to coverage limitations and client-age requirements identified for a specific service, the Agency covers the following dental-related preventive services.

Dental Prophylaxis

What Is Covered?

The Agency covers prophylaxis as follows. Prophylaxis:

- Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains when performed on primary or permanent dentition.
- Is limited to once every:
 - ✓ 6 months for a client 18 years of age and younger.
 - ✓ 12 months for a client from 19 years of age and older.
- **Exception:** Clients of the Division of Developmental Disabilities (Refer to section D of this Medicaid provider guide).
- Is reimbursed only when the service is performed:
 - ✓ At least 6 months after periodontal scaling and root planing, or periodontal maintenance services, for clients from 13 to 18 years of age.
 - ✓ At least 12 months after periodontal scaling and root planing, or periodontal maintenance services, for clients from 19 years of age and older.
- Is not reimbursed separately when performed on the same date of service as periodontal scaling and root planing, periodontal maintenance, gingivectomy, or gingivoplasty.
- Is covered for clients of the Division of Developmental Disabilities according to Section D in this Medicaid provider guide.

Code	Description	PA?	Age Limitation	Maximum Allowable Fee
D1110	prophylaxis – adult	N	Clients 14 years of age and older only.	On-line Fee Schedules
D1120	prophylaxis – child	N	Clients through age 13 only.	

Topical Fluoride Treatment

What Is Covered?

The Agency covers:

- Fluoride rinse, foam or gel, including disposable trays, for clients 6 years of age and younger, up to 3 times within a 12-month period per client, per provider or clinic.
- Fluoride rinse, foam or gel, including disposable trays, for clients from 7 to 18 years of age, up to 2 times within a 12-month period per client, per provider or clinic.
- Fluoride rinse, foam or gel, including disposable trays, up to 3 times within a 12-month period per client, per provider or clinic during orthodontic treatment.
- Fluoride rinse, foam or gel, including disposable trays, for clients from 19 to 64 years of age, once within a 12-month period per client, per provider or clinic.
- Fluoride rinse, foam or gel, including disposable trays, for clients 65 years of age and older who reside in alternate living facilities, up to 3 times within a 12-month period per client, per provider or clinic.
- Additional topical fluoride applications only on a case-by-case basis and when prior authorized.
- Topical fluoride treatment for clients of the Division of Developmental Disabilities according to Section D of this Medicaid provider guide.

Code	Description	PA?	Age Requirement	Maximum Allowable Fee
D1203	topical application of fluoride (prophylaxis not included) – child	N	Clients 18 years of age and younger only.	On-line Fee Schedules
D1204	topical application of fluoride (prophylaxis not included) – adult	N	Clients 19 years of age and older only.	

Oral Hygiene Instruction

What Is Covered?

The Agency covers oral hygiene instruction only for clients who are eight years of age and younger. Individualized oral hygiene instruction for home care includes tooth brushing techniques, flossing, and use of oral hygiene aids. Oral hygiene instruction is covered:

- No more than once every 6 months, up to 2 times within a 12-month period.
- Only when not performed on the same date of service as prophylaxis.

Note: The Agency covers oral hygiene instruction only when provided by a licensed dentist or a licensed dental hygienist and the instruction is provided in a **setting other than a dental office or clinic.**

Code	Description	PA?	Age Limitation	Maximum Allowable Fee
D1330	oral hygiene instructions	N	Clients 8 years of age and younger only.	On-line Fee Schedules

Sealants

What Is Covered?

The Agency covers:

- Sealants for clients 18 years of age and younger and clients of the Division of Developmental Disabilities of any age.
- Sealants only when used on a mechanically and/or chemically prepared enamel surface.
- Sealants once per tooth:
 - ✓ In a 3-year period for clients 18 years of age and younger.
 - ✓ In a two-year period for clients any age of the Division of Developmental Disabilities according to Section D of this Medicaid provider guide.
- Sealants only when used on the occlusal surfaces of:
 - ✓ Permanent teeth 2, 3, 14, 15, 18, 19, 30, and 31.
 - ✓ Primary teeth A, B, I, J, K, L, S, and T.

Dental-Related Services

- Sealants on non-carious teeth or teeth with incipient caries.
- Sealants only when placed on a tooth with no pre-existing occlusal restoration, or any occlusal restoration placed on the same day.
- Additional sealants on a case-by-case basis and when prior authorized.

Code	Description	PA?	Requirements	Age Limitation	Maximum Allowable Fee
D1351	sealant – per tooth	N	Tooth and surface designation required	Clients 18 years of age and younger only, except for clients of the Division of Developmental Disabilities.	On-line Fee Schedules

Space Maintenance

What Is Covered?

The Agency:

- Covers fixed unilateral or fixed bilateral space maintainers for clients 12 years of age and younger, subject to the following:
 - ✓ Only one space maintainer is covered per quadrant.
 - ✓ Space maintainers are covered only for missing primary molars A, B, I, J, K, L, S, and T.
 - ✓ Replacement space maintainers are covered only on a case-by-case basis and when prior authorized.
- Covers the removal of fixed space maintainers for clients 18 years of age or younger.

Dental-Related Services

Code	Description	PA?	Requirements	Age Limitation	Maximum Allowable Fee
D1510	space maintainer – fixed – unilateral	N	Quadrant designation required.	Clients 12 years of age and younger only.	On-line Fee Schedules
D1515	space maintainer – fixed – bilateral	N	Arch designation required.	Clients 12 years of age and younger only.	
D1550	re-cementation of space maintainer	N	Quadrant or arch designation required.	Clients 12 years of age and younger only.	
D1555	removal of fixed space maintainer	N		Clients 18 years of age and younger only.	

What Restorative Services Are Covered?

[Refer to WAC [182-535-1084](#)]

Subject to coverage limitations, restrictions, and client-age requirements identified for a specific service, the Agency covers the following dental-related restorative services.

Amalgam and Resin Restorations for Primary and Permanent Teeth

The Agency considers:

- Tooth preparation, acid etching, all adhesives (including bonding agents), liners and bases, polishing, and curing as part of the restoration.
- Occlusal adjustment of either the restored tooth or the opposing tooth or teeth as part of the amalgam restoration.
- Restorations placed within six months of a crown preparation by the same provider or clinic to be included in the payment for the crown.

Limitations for All Restorations

The Agency:

- Considers multiple restorations involving the proximal and occlusal surfaces of the same tooth as a multisurface restoration, and limits reimbursement to a single multisurface restoration.
- Considers multiple preventive restorative resins, flowable composite resins, or resin-based composites for the occlusal, buccal, lingual, mesial, and distal fissures and grooves on the same tooth as a one-surface restoration.
- 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 dentoenamel junction (DEJ) to be sealants. (See “[What Preventive Services Are Covered?](#)” for sealant coverage.)
- Reimburses proximal restorations that do not involve the incisal angle on anterior teeth as a two-surface restoration.
- Covers only one buccal and one lingual surface per tooth. The Agency reimburses buccal or lingual restorations, regardless of size or extension, as a one-surface restoration.

- Does not cover preventive restorative resin or flowable composite resin on the interproximal surfaces (mesial or distal) when performed on posterior teeth or the incisal surface of anterior teeth.
- Does not pay for replacement restorations within a two-year period unless the restoration has an additional adjoining carious surface. The Agency pays for the replacement restoration as one multisurface restoration. The client's record must include x-rays and documentation supporting the medical necessity for the replacement restoration.

Additional Limitations for Restorations on Primary Teeth

The Agency covers:

- A maximum of two surfaces for a primary first molar. (See “[Other Restorative Services](#)” in this section for a primary first molar that requires a restoration with three or more surfaces.) The Agency does not pay for additional restorations on the same tooth.
- A maximum of three surfaces for a primary second molar. (See “[Other Restorative Services](#)” in this section for a primary posterior tooth that requires a restoration with four or more surfaces.) The Agency does not pay for additional restorations on the same tooth.
- A maximum of three surfaces for a primary anterior tooth. (See “[Other Restorative Services](#)” in this section for a primary anterior tooth that requires a restoration with four or more surfaces.) The Agency does not pay for additional restorations on the same tooth after three surfaces.
- Glass ionomer restorations for primary teeth, only for clients five years of age and younger. The Agency pays for these restorations as a one-surface, resin-based composite restoration.

Additional Limitations for Restorations on Permanent Teeth

The Agency covers:

- Two occlusal restorations for the upper molars on teeth one, two, three, fourteen, fifteen, and sixteen if, the restorations are anatomically separated by sound tooth structure.
- A maximum of five surfaces per tooth for permanent posterior teeth, except for upper molars. The Agency allows a maximum of six surfaces per tooth for teeth one, two, three, fourteen, fifteen, and sixteen.
- A maximum of six surfaces per tooth for resin-based composite restorations for permanent anterior teeth.

Dental-Related Services

Code	Description	PA?	Requirements	Maximum Allowable Fee
D2140	amalgam – one surface, primary or permanent	N	Tooth and surface designations required	On-line Fee Schedules
D2150	amalgam – two surfaces, primary or permanent	N	Tooth and surface designations required	
D2160	amalgam – three surfaces, primary or permanent	N	Tooth and surface designations required. If billed on a primary first molar, the Agency will reimburse at the rate for a two-surface restoration.	
D2161	amalgam – four or more surfaces, primary or permanent	N	Tooth and surface designations required. If billed on a primary first molar, the Agency will reimburse at the rate for a two-surface restoration. If billed on a primary second molar, the Agency will reimburse at the rate for a three-surface restoration.	
D2330	resin-based composite – one surface, anterior	N	Tooth and surface designations required	
D2331	resin-based composite – two surfaces, anterior	N	Tooth and surface designations required	
D2332	resin-based composite – three surfaces, anterior	N	Tooth and surface designations required	
D2335	resin-based composite – four or more surfaces or involving incisal angle (anterior)	N	Tooth and surface designations required. Not allowed on primary teeth.	
D2390	resin-based composite crown, anterior	N	Tooth designation required	
D2391	resin-based composite – one surface, posterior	N	Tooth and surface designations required	
D2392	resin-based composite – two surfaces, posterior	N	Tooth and surface designations required	

Dental-Related Services

Code	Description	PA?	Requirements	Maximum Allowable Fee
D2393	resin-based composite – three surfaces, posterior	N	Tooth and surface designations required. If billed on a primary first molar, the Agency will reimburse at the rate for a two-surface restoration. If billed on a primary second molar, the Agency will reimburse at the rate for a three-surface restoration.	On-line Fee Schedules
D2394	resin-based composite – four or more surfaces, posterior	N	Tooth and surface designations required. If billed on a primary first molar, the Agency will reimburse at the rate for a two-surface restoration. If billed on a primary second molar, the Agency will reimburse at the rate for a three-surface restoration.	

Crowns – Single Restorations Only

What Is Covered?

The Agency covers:

- The following indirect crowns once every five years, per tooth, for **permanent anterior teeth** for clients from 12 to 20 years of age when the crowns meet prior authorization (PA) criteria. (See “[Authorization](#)”) in this Medicaid provider guide and follow the provider [PA requirements](#) on the following page:
 - ✓ 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.

Note: The Agency does not cover permanent anterior crowns for clients through age 11.

Payment

The Agency 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 six months of the crown preparation. **Exception:** The Agency covers a one-surface restoration on an endodontically treated tooth, or a core buildup or cast post and core.
- 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.
- Crown seating (placement), including cementing and insulating bases.
- Occlusal adjustment of crown or opposing tooth or teeth.
- Local anesthesia.

Billing

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

Prior Authorization

The Agency requires the provider to submit the following with each PA request:

- X-rays 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.
- Pre- and post-endodontic treatment X-rays for requests on endodontically treated teeth.
- Documentation supporting a five-year prognosis that the client will retain the tooth or crown if the tooth is crowned.

Code	Description	PA?	Requirements	Age Limitation	Maximum Allowable Fee
D2710	crown – resin-based composite (indirect)	Y	Tooth designation required.	Clients 12 to 20 years of age only.	On-line Fee Schedules
D2720	crown – resin with high noble metal	Y	Tooth designation required.	Clients 12 to 20 years of age only.	
D2721	crown – resin with predominantly base metal	Y	Tooth designation required.	Clients 12 to 20 years of age only.	
D2722	crown – resin with noble metal	Y	Tooth designation required.	Clients 12 to 20 years of age only.	
D2740	crown – porcelain/ceramic substrate	Y	Tooth designation required.	Clients 12 to 20 years of age only.	

Dental-Related Services

Code	Description	PA?	Requirements	Age Limitation	Maximum Allowable Fee
D2750	crown – porcelain fused to high noble metal	Y	Tooth designation required.	Clients 12 to 20 years of age only.	
D2751	crown – porcelain fused to predominantly base metal	Y	Tooth designation required.	Clients 12 to 20 years of age only.	
D2752	crown – porcelain fused to noble metal	Y	Tooth designation required.	Clients 12 to 20 years of age only.	

Note: The Agency does not pay for procedure codes D2710 through D2752 when billed for posterior teeth.

Other Restorative Services

The Agency covers the following restorative services:

- All recementations of permanent indirect crowns only for clients from 12 to 20 years of age.
- Prefabricated stainless steel crowns with resin window, resin-based composite crowns, prefabricated esthetic coated stainless steel crowns, and fabricated resin crowns for primary anterior teeth once every three years only for clients 20 years of age and younger as follows:
 - ✓ For ages 12 and younger without PA if the tooth requires a four or more surface restoration.
 - ✓ For ages 13 to 20 with PA. X-ray justification is required.
- Prefabricated stainless steel crowns for primary posterior teeth once every three years without PA if:
 - ✓ 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.

X-ray justification is required.
- Prefabricated stainless steel crowns for permanent posterior teeth excluding 1, 16, 17, and 32 once every 3 years, for clients 20 years of age and younger, without PA. X-ray justification is required.

Dental-Related Services

- Prefabricated stainless steel crowns for clients of the Division of Developmental Disabilities without PA (See [Clients of the Division of Developmental Disabilities](#)) within this Medicaid provider guide. X-ray justification is required.
- Core buildup, including pins, only on permanent teeth, only for clients 20 years of age and younger and allowed only when in conjunction with a crown and when prior authorized.
- Cast post and core or prefabricated post and core, only on permanent teeth, only for clients 20 years of age and younger, and only when in conjunction with a crown and when prior authorized.

Code	Description	PA?	Requirements	Age Limitation	Maximum Allowable Fee
D2910	recement inlay, onlay, or partial coverage restoration	N	Tooth designation required.	Clients 20 years of age and younger only.	On-line Fee Schedules
D2915	recement cast or prefabricated post and core	N	Tooth designation required.	Clients 20 years of age and younger only.	
D2920	recement crown	N	Tooth designation required.	Clients 12 through 20 years of age only.	
D2930	prefabricated stainless steel crown – primary tooth	*	Tooth designation required.	Clients 20 years of age and younger only.	
D2931	prefabricated stainless steel crown – permanent tooth	N	Tooth designation required.	Clients 20 years of age and younger only.	
D2932	prefabricated resin crown	N	Tooth designation required.	Clients 12 to 20 years of age only.	
D2933	prefabricated stainless steel crown with resin window	N	Tooth designation required.	Clients 12 to 20 years of age only.	

* For ages 12 and younger without PA if the tooth requires a four or more surface restoration. For ages 13 to 20 with PA. X-ray justification is required.

Dental-Related Services

Code	Description	PA?	Requirements	Age Limitation	Maximum Allowable Fee
D2933	prefabricated stainless steel crown with resin window	N	Tooth designation required.	Clients 12 to 20 years of age only.	On-line Fee Schedules
D2934	prefabricated esthetic coated stainless steel crown – primary tooth	N	Tooth designation required.	Clients 12 to 20 years of age only.	
D2950	core buildup, including any pins	Y	Tooth designation required.	Clients 20 years of age and younger only.	
D2952	Post and core in addition to crown, indirectly fabricated	Y	Tooth designation required.	Clients 20 years of age and younger only.	
D2954	Prefabricated post and core in addition to crown	Y	Tooth designation required.	Clients 20 years of age and younger only.	

What Endodontic Services Are Covered?

[Refer to WAC 182-535-1086]

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

Pulp Capping

The Agency considers pulp capping to be included in the payment for the restoration.

Pulpotomy/Pulpal Debridement

The Agency covers:

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

The Agency does not pay for pulpal debridement when performed with palliative treatment for dental pain or when performed on the same day as endodontic treatment.

Code	Description	PA?	Requirements	Age Limitation	Maximum Allowable Fee
D3220	therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	N	Tooth designation required.	Clients 20 years of age and younger.	On-line Fee Schedules
D3221	pulpal debridement, permanent teeth	N	Tooth designation required.		

Endodontic Treatment on Primary Teeth

The Agency covers endodontic treatment with resorbable material for primary maxillary incisor teeth D, E, F, and G, if the entire root is present at treatment.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D3230	pulpal therapy (resorbable filling)-anterior, primary	N	Tooth designation required	On-line Fee Schedules

Endodontic Treatment on Permanent Teeth

The Agency:

- Covers endodontic treatment for permanent anterior, bicuspid, and molar teeth, excluding teeth 1, 16, 17, and 32 for clients 20 years of age 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 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 three months after treatment.

Code	Description	PA?	Requirements	Age Limitation	Maximum Allowable Fee
D3310	anterior (excluding final restoration)	N	Tooth designation required.	Client 20 years of age and younger.	On-line Fee Schedules
D3320	bicuspid (excluding final restoration)	N	Tooth designation required.	Client 20 years of age and younger.	
D3330	molar (excluding final restoration)	N	Tooth designation required.	Clients 20 years of age and younger.	

Endodontic Retreatment on Permanent Anterior Teeth

The Agency:

- Covers endodontic retreatment for a client 20 years of age or younger 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.
 - ✓ Post treatment evaluation X-rays if taken at least three months after treatment.
- Does not pay for endodontic retreatment when provided by the original treating provider or clinic unless prior authorized by the Agency.

Code	Description	PA?	Requirements	Age Limitation	Maximum Allowable Fee
D3346	retreatment of previous root canal therapy – anterior	Y	Tooth designation required.	Clients age 20 and younger.	On-line Fee Schedules
D3347	retreatment of previous root canal therapy – bicuspid	Y	Tooth designation required.	Clients age 20 and younger.	
D3348	retreatment of previous root canal therapy – molar	Y	Tooth designation required.	Clients age 20 and younger.	

Apexification/Apicoectomy

- Covers apexification for apical closures for **anterior permanent teeth only** on a case-by-case basis and when prior authorized. Apexification is limited to the initial visit and three medication replacements and limited to clients 20 years of age and younger, per tooth.
- Covers apicoectomy and a retrograde filling for **anterior teeth only** for clients 20 years of age and younger.

Code	Description	PA?	Requirements	Age Limitation	Maximum Allowable Fee
D3351	apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	Y	Tooth designation required.	Clients age 20 and younger.	On-line Fee Schedules
D3352	apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	Y	Tooth designation required.	Clients age 20 and younger.	
D3410	apicoectomy/periradicular surgery – anterior	N	Tooth designation required.	Clients age 20 and younger.	
D3430	retrograde filling – per root	N	Tooth designation required.	Clients age 20 and younger.	

What Periodontic Services Are Covered?

[Refer to WAC 182-535-1088]

Subject to coverage limitations, restrictions, and client-age requirements identified for specific service, the Agency covers the following dental-related periodontic services.

Surgical Periodontal Services

The Agency covers the following surgical periodontal services, including all postoperative care:

- Gingivectomy/gingivoplasty, for clients 20 years of age and younger, only on a case-by-case basis and when prior authorized.
- Gingivectomy/gingivoplasty for clients of the Division of Developmental Disabilities according to Section D of this Medicaid provider guide.

Code	Description	PA?	Requirements	Age Limitation	Maximum Allowable Fee
D4210	gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant	Y	Quadrant designation required.	Clients age 20 and younger.	On-line Fee Schedules
D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant	Y	Quadrant designation required.	Clients age 20 and younger.	

Nonsurgical Periodontal Services

The Agency:

- Covers periodontal scaling and root planing for the number of teeth scaled that are periodontically involved once per quadrant, for clients from 13 to 18 years of age, per client in a two-year period on a case-by-case basis, when prior authorized, and only when:
 - ✓ The client has X-ray evidence of periodontal disease.
 - ✓ The client's record includes supporting documentation for the medical necessity of the service, including complete periodontal charting and a definitive diagnosis of periodontal disease.

Dental-Related Services

- ✓ The client's clinical condition meets current published periodontal guidelines.
- ✓ Performed at least two years from the date of completion of periodontal scaling and root planing or surgical periodontal treatment, or at least 12 calendar months from the completion of periodontal maintenance.
- Covers periodontal scaling and root planing once per quadrant, per client, in a two-year period for clients ages 19 years of age and older and only when:
 - ✓ The client has X-ray 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 published periodontal guidelines.
 - ✓ Performed at least two years from the date of completion of periodontal scaling and root planing or surgical periodontal treatment.
- 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, gingivectomy, or gingivoplasty.
- Covers periodontal scaling and root planing for clients of the Division of Developmental Disabilities PA (See [Clients of the Division of Developmental Disabilities](#)) within this Medicaid Provider Guide.

Code	Description	PA?	Requirements	Age Limitations	Maximum Allowable Fee
D4341	periodontal scaling and root planing – four or more teeth per quadrant	Y	Quadrant designation required	Clients 13 to 18 years of age only.	On-line Fee Schedules
D4341	periodontal scaling and root planing – four or more teeth per quadrant	N	Quadrant designation required	Clients 19 years of age and older only.	
D4342	periodontal scaling and root planing – one to three teeth per quadrant	Y	Quadrant designation required	Clients 13 to 18 years of age only.	
D4342	periodontal scaling and root planing – one to three teeth per quadrant	N	Quadrant designation required	Clients 19 years of age and older only.	

Periodontal Maintenance

The Agency:

- Covers periodontal maintenance for clients from 13 to 18 years of age, once per client in a 12-month period on a case-by-case basis, when prior authorized, and only when:
 - ✓ The client has X-ray evidence of periodontal disease.
 - ✓ 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.
 - ✓ The client's clinical condition meets current published periodontal guidelines.
 - ✓ The client has had periodontal scaling and root planing but not within 12 months of the date of completion of periodontal scaling and root planing, or surgical periodontal treatment.

- Covers periodontal maintenance once per client in a 12 month period for clients 19 years of age and older only when:
 - ✓ The client has X-ray 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 published periodontal guidelines.
 - ✓ The client has had periodontal scaling and root planing after but not within 12 months from the date of completion of periodontal scaling and root planing, or surgical periodontal treatment.

- Covers periodontal maintenance only if performed at least 12 calendar months after receiving prophylaxis, periodontal scaling and root planing, gingivectomy, or gingivoplasty.

- Covers periodontal maintenance for clients of DDD according to Section D of this Medicaid provider guide.

Code	Description	PA?	Age Limitations	Maximum Allowable Fee
D4910	periodontal maintenance	Y	Clients 13 to 18 years of age only.	On-line Fee Schedules
D4910	periodontal maintenance	N	Clients 19 years of age and older only.	

What Removable Prosthodontic Services Are Covered?

[Refer to WAC 182-535-1090]

Subject to coverage limitations, restrictions, and client-age requirements identified for a specific service, the Agency covers the following prosthodontic (removable) services:

Prior Authorization (PA)

The Agency requires PA for the removable prosthodontic and prosthodontic-related procedures listed in this section when noted. Documentation supporting the medical necessity for the service must be included in the client's file. PA requests must meet the criteria in the *Prior Authorization* section of this Medicaid provider guide. In addition, the Agency requires the dental provider to submit:

- Appropriate and diagnostic X-rays of all remaining teeth.
- A dental record which identifies:
 - ✓ All missing teeth for both arches.
 - ✓ Teeth that are to be extracted.
 - ✓ Dental and periodontal services completed on all remaining teeth.

Note: If a client wants to change denture providers, the Agency must receive a statement from the client requesting the provider change. The Agency will check to make sure services haven't already been rendered by the original provider before cancelling the original authorization request for services. The new provider must submit another authorization request for services.

The Agency requires a provider to:

- Obtain a signed agreement of acceptance from the client at the conclusion of the final denture try-in for an Agency-authorized complete denture or a cast-metal denture described in this section. If the client abandons the complete or partial denture after signing the agreement of acceptance, the Agency will deny subsequent requests for the same type of dental prosthesis if the request occurs prior to the time limitations specified in this section.
- Retain in your records a completed copy of the signed Denture or Partial Denture Agreement of Acceptance form, HCA 13-809 that documents the client's acceptance of the dental prosthesis.

Complete Dentures

The Agency covers complete dentures, as follows:

- A complete denture, including an overdenture, is covered when prior authorized and meets the Agency’s coverage criteria.
- Three-month post-delivery care (e.g., adjustments, soft relines, and repairs) from the seat (placement) date of the complete denture is considered part of the complete denture procedure and is not paid separately.
- Replacement of an immediate denture with a complete denture is covered, if the complete denture is prior authorized at least six months after the seat date of the immediate denture.
- Complete dentures are limited to:
 - ✓ One initial maxillary complete denture and one initial mandibular complete denture per client, per the client’s lifetime.
 - ✓ One replacement maxillary complete denture and one replacement mandibular complete denture per client, per the client’s lifetime.
- Replacement of a complete denture or overdenture only if prior authorized, and only if the replacement occurs at least five years after the seat date of the complete denture or overdenture being replaced. The replacement denture must be prior authorized.

Code	Description	PA?	Age Limitations	Maximum Allowable Fee
D5110	complete denture – maxillary	Y	Lifetime Max for clients 21 years of age and older.	On-line Fee Schedules
D5120	complete denture – mandibular	Y	Lifetime Max for clients 21 years of age and older.	
D5130	immediate denture – maxillary	Y	Clients 20 years of age and younger only.	
D5140	immediate denture – mandibular	Y	Clients 20 years of age and younger only.	

The provider must obtain a signed Denture or Partial Denture Agreement of Acceptance form, HCA 13-809, from the client at the conclusion of the final denture try-in for an Agency-authorized complete denture. If the client abandons the complete denture after signing the agreement of acceptance, the Agency will deny subsequent requests for the same type of dental prosthesis if the request occurs prior to the dates specified in this section. A copy of the signed agreement must be kept in the provider's files and be available upon request by the Agency.

Resin Partial Dentures

What Is Covered?

The Agency covers resin partial dentures, as follows:

- A partial denture is covered for anterior and posterior teeth when the partial denture meets the Agency coverage criteria for resin partial dentures.
- Prior authorization is required for partial dentures.
- Three-month post-delivery care (e.g., adjustments, soft relines, and repairs) from the seat date of the partial denture is considered part of the partial denture procedure and is not paid separately.
- Replacement of a resin-based denture, with any prosthetic, is covered only if prior authorized, at least three years after the seat date of the resin partial denture being replaced. The replacement denture must be prior authorized and meet the Agency's coverage criteria for resin partial dentures.

Coverage Criteria for Resin Partial Dentures

A partial denture, including a resin partial denture, is covered for anterior and posterior teeth when the partial denture meets the following agency coverage criteria:

- The remaining teeth in the arch must have a reasonable periodontal diagnosis and prognosis.
- The client has established caries control.
- One or more anterior teeth are missing or four or more posterior teeth (excluding teeth 1, 2, 15, 16, 17, 18, 31, and 32).
- There are a minimum of four stable teeth remaining per arch.
- There is a three-year prognosis for retention of the remaining teeth.

Code	Description	PA?	Limitations	Maximum Allowable Fee
D5211	maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	Y		On-line Fee Schedules
D5212	mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	Y		

Other Requirements/Limitations

The Agency:

- Does not cover replacement of a cast metal framework partial denture, with any type of denture, within five years of the initial seat date of the partial denture.
- Requires a provider to bill for removable dental prosthetic procedures only after the seating of the prosthesis, not at the impression date. The Agency may pay for lab fees if the removable dental prosthesis is not delivered and inserted.
- Requires a provider to deliver services and procedures that are of acceptable quality to the Agency. The Agency may recoup payment for services that are determined to be below the standard of care or of an unacceptable product quality.

Alternative Living Facilities

- Requires a provider to submit the following with a PA request for removable dental prosthetics for a client residing in a nursing facility, group home, or other facility:
 - ✓ The client's medical diagnosis or prognosis.
 - ✓ The attending physician's signature documenting medical necessity for the prosthetic service.
 - ✓ The attending dentist's 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 Appliance Request for Skilled Nursing Facility Client form, 13-788. For information on obtaining Agency forms, refer to the *Important Contacts* section.

- Limits removable partial dentures to resin-based partial dentures for all clients residing in a nursing facility, group home, or other facility. The Agency may consider cast metal partial dentures if coverage criteria are met.

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 seat date.

Code	Description	PA?	Maximum Allowable Fee
D5410	adjust complete denture – maxillary	N	On-line Fee Schedules
D5411	adjust complete denture – mandibular	N	
D5421	adjust partial denture – maxillary	N	
D5422	adjust partial denture – mandibular	N	

Repairs to Complete and Partial Dentures

The Agency covers repairs:

- To complete and partial dentures once in a 12-month period, per arch. The cost of repairs cannot exceed the cost of the replacement denture. The Agency covers additional repairs on a case-by-case basis and when prior authorized.
- To partial dentures, once in a 12-month period, per arch. The cost of the repairs cannot exceed the cost of the replacement partial denture. The Agency covers additional repairs on a case-by-case basis and when prior authorized.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D5510	repair broken complete denture base	N	Arch designation required	On-line Fee Schedules
D5520	replace missing or broken teeth – complete denture (each tooth)	N	Tooth designation required	
D5620	repair cast framework	N	Arch designation required	
D5650	add tooth to existing partial denture	N	Tooth designation required	
D5660	add clasp to existing partial denture	N	Tooth designation required	

Denture Rebase Procedures

The Agency covers a laboratory rebase to a complete or partial denture once in a three-year period when performed at least six months after the seating date. An additional rebase may be covered for complete or cast-metal partial dentures on a case-by-case basis when prior authorized.

Code	Description	PA?	Maximum Allowable Fee
D5710	rebase complete maxillary denture	N	On-line Fee Schedules
D5711	rebase complete mandibular denture	N	
D5720	rebase maxillary partial denture	N	
D5721	rebase mandibular partial denture	N	

Note: The Agency does not allow a denture rebase and a reline in the same three-year period. The Agency covers rebases or relines only on partials and complete dentures (CDT codes D5110, D5120, D5130, D5140, D5213, and D5214).

Denture Reline Procedures

The Agency covers a laboratory reline to a complete or cast-metal partial denture once in a three-year period when performed at least six months after the seating date. An additional reline may be covered for complete or cast-metal partial dentures on a case-by-case basis when prior authorized.

Code	Description	PA?	Maximum Allowable Fee
D5750	reline complete maxillary denture (laboratory)	N	On-line Fee Schedules
D5751	reline complete mandibular denture (laboratory)	N	
D5760	reline maxillary partial denture (laboratory)	N	
D5761	reline mandibular partial denture (laboratory)	N	

Note: The Agency does not allow a denture rebase and a reline in the same three-year period. The Agency covers rebases or relines only on partials and complete dentures (CDT codes D5110, D5120, D5130, D5140, D5213, and D5214).

Other Removable Prosthetic Services

The Agency covers:

- Up to two tissue conditionings, for a client 20 years of age or younger, and only when performed within three months after the seating date.
- Laboratory fees, subject to the following:
 - ✓ The Agency does not pay separately for laboratory or professional fees for complete and partial dentures.
 - ✓ The Agency 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 prosthesis.
 - Moves from the state.
 - Cannot be located.
 - Does not participate in completing the complete, immediate, or partial dentures.
 - Dies.

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

- A provider must submit copies of laboratory prescriptions and receipts or invoices for each claim when submitting for prior authorization of code D5899 for laboratory fees.

Code	Description	PA?	Requirements	Age Limitations	Maximum Allowable Fee
D5850	tissue conditioning, maxillary	N		Clients 20 years of age and younger only.	On-line Fee Schedules
D5851	tissue conditioning, mandibular	N		Clients 20 years of age and younger only.	
D5860	overdenture – complete, by report	Y	Arch designation required.		
D5899	unspecified removable prosthodontic procedure, by report	Y	Arch designation required.		
D6930	recent fixed partial denture	Y	Arch or quadrant designation required.		

What Maxillofacial Prosthetic Services Are Covered?

[Refer to WAC [182-535-1092](#)]

The Agency covers maxillofacial prosthetic services subject to the following:

- Maxillofacial prosthetics are covered only for clients twenty years of age and younger, on a case-by-case basis and when prior authorized.
- The Agency must pre-approve a provider qualified to furnish maxillofacial prosthetics.

What Oral and Maxillofacial Surgery Services Are Covered?

[Refer to WAC [182-535-1094](#)]

General Coverage

Subject to coverage limitations, restrictions, and client-age requirements identified for a specific service, the Agency covers the following oral and maxillofacial surgery services listed in this section. All coverage limitations and age requirements apply to clients of the Division of Developmental Disabilities, unless otherwise stated:

- Requires enrolled providers who do not meet the conditions in Section A, “Becoming a Agency Dental Provider” to bill claims for services that are listed in this subsection using only the Current Dental Terminology (CDT) codes.
- Requires enrolled providers (oral and maxillofacial surgeons) who meet the conditions in Section A, “Becoming an Agency Dental Provider” to bill claims using Current Procedural Terminology (CPT) codes unless the procedure is specifically listed in the Agency’s current published Medicaid provider guide as a CDT covered code (e.g., extractions).

Note: For billing information on billing CPT codes for oral surgery, refer to the Agency’s current [Physician-Related Services/Healthcare Professional Medicaid Provider Guide](#). The Agency pays oral surgeons for only those CPT codes listed in the Dental Fee Schedule under “Dental CPT Codes.”

- Covers non-emergency oral surgery performed in a hospital or ambulatory surgery center only for:
 - ✓ Clients eight years of age and younger.
 - ✓ Clients from 9 to 20 years of age only on a case-by-case basis and when the site-of-service is prior authorized by the Agency.

- ✓ Clients any age of the Division of Developmental Disabilities.
- For site-of-service and oral surgery CPT codes that require PA, the Agency requires the dental provider to submit all of the following:
 - ✓ Documentation used to determine medical appropriateness.
 - ✓ Cephalometric films.
 - ✓ X-rays.
 - ✓ Photographs.
 - ✓ Written narrative.

Services exempt from site of service prior authorization

The Agency does not require site-of-service authorization for any of the following surgeries:

Cleft palate surgeries (CPTs 42200, 42205, 42210, 42215, 42225, 42226, 42227, 42235, 42260, 42280, and 42281) with a diagnosis of cleft palate.

Documentation Requirements

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

- 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 and Surgical Extractions

The Agency:

- Covers routine and surgical extractions (includes local anesthesia, suturing, if needed, and routine postoperative care).
- Requires PA for unusual, complicated surgical extractions.
- Covers surgical extraction of unerupted teeth for clients 20 years of age and younger.
- Covers debridement of a granuloma or cyst that is five millimeters or greater in diameter. The Agency includes debridement of a granuloma or cyst that is less than five millimeters as part of the global fee for the extraction.

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

Code	Description	PA?	Requirements	Maximum Allowable Fee
D7111	extraction, coronal remnants – deciduous tooth	N	Tooth designation required	On-line Fee Schedules
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	N	Tooth designation required	
D7210	surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	N	Tooth designation required	
D7220	removal of impacted tooth – soft tissue	N	Tooth designation required	
D7230	removal of impacted tooth – partially bony	N	Tooth designation required	
D7240	removal of impacted tooth – completely bony	N	Tooth designation required	
D7241	removal of impacted tooth – completely bony, with unusual surgical complications	Y	Tooth designation required	
D7250	surgical removal of residual tooth roots (cutting procedure)	N	Tooth designation required	

Other Surgical Procedures

The Agency:

- Covers tooth reimplantation/stabilization of accidentally evulsed or displaced teeth for clients 20 years of age and younger.
- Covers the following without prior authorization:
 - ✓ Biopsy of soft oral tissue.
 - ✓ Brush biopsy for clients 20 years of age and younger.
- Requires providers to keep all biopsy reports or finding in the client’s dental record.

Code	Description	PA?	Requirements	Age Limitations	Maximum Allowable Fee
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	N		Clients 20 years of age and younger only.	On-line Fee Schedules
D7280	surgical access of an unerupted tooth	N	Tooth designation required.	Clients 20 years of age and younger only.	
D7283	placement of device to facilitate eruption of impacted tooth	Y	Covered in conjunction with D7280 and when medically necessary.	Clients 20 years of age and younger only.	
D7285	biopsy of oral tissue – Hard	Y	<i>Retroactive to dates of service on and after March 1, 2012.</i>	Clients 20 years of age and younger only.	
D7286	biopsy of oral tissue – soft	N			
D7288	brush biopsy – transepithelial sample collection	N		Clients 20 years of age and younger only.	

Alveoloplasty – Surgical Preparation of Ridge for Dentures

The Agency covers alveoloplasty only:

- For clients 20 years of age and younger.
- On a case-by-case basis and when prior authorized.
- When not performed in conjunction with extractions.

Code	Description	PA?	Requirements	Age Limitations	Maximum Allowable Fee
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth, per quadrant	Y	Quadrant designation required.	Clients 20 years of age and younger only.	On-line Fee Schedules

Surgical Excision of Soft Tissue Lesions

The Agency covers surgical excision of soft tissue lesions only on a case-by-case basis and when prior authorized.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D7410	excision of benign lesion up to 1.25 cm	Y	Quadrant designation required.	On-line Fee Schedules

Excision of Bone Tissue

The Agency covers only the following excisions of bone tissue in conjunction with placement of immediate, complete, or partial dentures, for clients 20 years of age and younger when prior authorized:

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

Code	Description	PA?	Requirements	Age Limitations	Maximum Allowable Fee
D7471	removal of lateral exostosis (maxilla or mandible)	Y	Arch designation required.	Clients 20 years of age and younger only.	On-line Fee Schedules
D7472	removal of torus palatinus	Y		Clients 20 years of age and younger only.	
D7473	removal of torus mandibularis	Y		Clients 20 years of age and younger only.	
D7485	surgical reduction of osseous tuberosity	Y	Quadrant designation required.	Clients 20 years of age and younger only.	On-line Fee Schedules
D7970	Excision of hyperplastic tissue – per arch	Y		Clients 20 years of age and younger only.	
D7971	Excision of Pericoronal Gingiva	Y		Clients 20 years of age and younger only.	
D7972	Surgical reduction of fibrous tuberosity	Y		Clients 20 years of age and younger only.	

Surgical Incision

The Agency covers the following surgical incision-related services:

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

Note: Providers must not bill drainage of abscess (D7510 or D7520) in conjunction with palliative treatment (D9110).

- Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue for clients 20 years of age and younger when prior authorized. Documentation supporting the medical necessity for the service must be in the client's record.
- Frenuloplasty/frenulectomy for clients six years of age and younger, without prior authorization.
- The Agency covers frenuloplasty/frenulectomy for clients from 7 to 12 years of age only on a case-by-case basis and when prior authorized.
- Documentation supporting the medical necessity, including photographs, for the service must be in the client's record.

Code	Description	PA?	Requirements	Age Limitations	Maximum Allowable Fee
D7510	incision and drainage of abscess – intraoral soft tissue	N			On-line Fee Schedules
D7520	incision and drainage of abscess – extraoral soft tissue	N			
D7530	removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	Y		Clients 20 years of age and younger only.	
D7960	frenulectomy (frenectomy or frenotomy) – separate procedure	Y	Arch designation required.	Clients 7 to 12 years of age only.	
D7960	frenulectomy (frenectomy or frenotomy) – separate procedure	N	Arch designation required.	Clients six years of age and younger only.	

Dental-Related Services

Code	Description	PA?	Requirements	Age Limitations	Maximum Allowable Fee
D7963	frenuloplasty	Y	Arch designation required.	Clients 7 to 12 years of age only.	
D7963	frenuloplasty	N	Arch designation required.	Clients six years of age and younger only.	

Occlusal Orthotic Devices

The Agency covers:

- Occlusal orthotic devices for clients from 12 to 20 years of age only on a case-by-case basis and when prior authorized.
- An occlusal orthotic device only as a laboratory processed full arch appliance.

Note: Refer to “[What Adjunctive General Services are Covered?](#)” for occlusal guard coverage and limitations on coverage.

Code	Description	PA?	Age Limitations	Maximum Allowable Fee
D7880	occlusal orthotic device, by report	Y	Clients 12 to 20 years of age only.	On-line Fee Schedules

What Orthodontic Services Are Covered?

[Refer to WAC [182-535-1096](#)]

The Agency covers orthodontic services, subject to the coverage limitations listed, for clients 20 years of age and younger according to the Agency’s current [Orthodontic Services Medicaid Provider Guide](#).

What Adjunctive General Services Are Covered?

[Refer to WAC [182-535-1098](#)]

Subject to coverage limitations and client age requirements identified for a specific service, the Agency covers the following dental-related adjunctive general services listed in this section.

Unclassified Treatment

The Agency covers palliative (emergency) treatment, not to include pulpal debridement (D3221), for treatment of dental pain, for clients 20 years of age and younger, limited to once per day, per client, as follows:

- The treatment must occur during limited evaluation appointments.
- 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.

Code	Description	PA?	Requirement	Age Limitations	Maximum Allowable Fee
D9110	palliative (emergency) treatment of dental pain – minor procedure	N	Tooth Designation Required.	Clients 20 years of age and younger.	On-line Fee Schedules

Anesthesia

The Agency:

- Covers local anesthesia and regional blocks as part of the global fee for any procedure being provided to clients
- Covers office-based oral or parenteral conscious sedation, deep sedation, or general anesthesia, as follows:
 - ✓ General Anesthesia is only covered when performed in an office setting.
 - ✓ The provider's current anesthesia permit must be on file with the Agency.
 - ✓ For clients eight years of age and younger, and for clients any age of the Division of Developmental Disabilities, documentation supporting the medical necessity of the anesthesia service must be in the client's record.
 - ✓ For clients from 9 to 20 years of age, deep sedation or general anesthesia services are covered on a case-by-case basis and when prior authorized, **except for oral surgery services**. For oral surgery services listed in the “What oral and maxillofacial surgery services are covered?” section, deep sedation or general anesthesia services do not require PA.
 - ✓ PA is not required for oral or parenteral conscious sedation for any dental service for clients 20 years of age or younger, and for clients any age of the Division of Developmental Disabilities. Documentation supporting the medical necessity of the service must be in the client's record.
 - ✓ For clients from 9 to 20 years of age who have a diagnosis of oral facial cleft, the Agency does not require PA for deep sedation or general anesthesia services when the dental procedure is directly related to the oral facial cleft treatment.
 - ✓ Providers must bill anesthesia services using the CDT codes listed in this section.
- Covers administration of nitrous oxide for clients once per day.
- Requires providers of oral or parenteral conscious sedation, deep sedation, or general anesthesia to meet:
 - ✓ The prevailing standard of care.
 - ✓ The provider's professional organizational guidelines.
 - ✓ The requirements in Chapter [246-817](#) WAC.
 - ✓ Relevant Department of Health (DOH) medical, dental, or nursing anesthesia regulations.

- Pays for anesthesia services according to WAC [182-535-1350](#).

Code	Description	PA?	Maximum Allowable Fee
D9220	deep sedation/general anesthesia—first 30 minutes	*	On-line Fee Schedules
D9221	deep sedation/general anesthesia—each additional 15 minutes	*	
D9230	analgesia, anxiolysis, inhalation of nitrous oxide	N	
D9241	intravenous conscious sedation/analgesia—first 30 minutes	N	
D9242	Intravenous conscious sedation/analgesia—each additional 15 minutes	N	
D9248	non-intravenous conscious sedation	N	

*See coverage criteria.

Billing Anesthesia

- The anesthesia time begins when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent) and ends when the anesthesiologist or CRNA is no longer in constant attendance (e.g., when the patient can be safely placed under post-operative supervision).
- **Bill for general anesthesia as follows:**
 Bill one unit of D9220 for the first 30 minutes of deep sedation/general anesthesia. Each additional 15 minute increment of deep sedation/general anesthesia is equal to one unit of D9221. **For example:** 60 minutes of general anesthesia would be billed as 1 unit of D9220 and 2 units of D9221.
- **Bill for intravenous conscious sedation/analgesia as follows:**
 Bill one unit of D9241 for the first 30 minutes of deep sedation/general anesthesia. Each additional 15 minute increment of intravenous conscious sedation/analgesia is equal to one unit of D9242. **For example:** 60 minutes of intravenous conscious sedation/analgesia would be billed as 1 unit of D9241 and 2 units of D9242.
- For clients of the Division of Developmental Disabilities, always use an EPA number when billing for services.

Professional Visits and Consults

- The Agency covers professional consultation/diagnostic services as follows:
 - ✓ A dentist or a physician other than the practitioner providing treatment must provide the services.
 - ✓ A client must be referred by the Agency for the services covered.
- The Agency covers:
 - ✓ Up to two house/extended care facility calls (visits) per facility, per provider. The Agency 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.
 - ✓ Emergency office visits after regularly scheduled hours. The Agency limits payment to one emergency visit per day, per client, per provider.

(See procedure codes on next page)

Code	Description	PA?	Maximum Allowable Fee
D9410	house/extended care facility call	N	
D9420	hospital call	N	
D9440	office visit – after regularly scheduled hours	N	

- When billing for Evaluation and Management (E&M) codes, all of the following must be true:
 - ✓ Services must be billed on an 837P HIPAA compliant claim form, Professional claim via the Direct Data Entry (DDE) system, or a paper CMS-1500.
 - ✓ Services must be billed using one of the following CPT procedure 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.

Code	Description	PA?	Maximum Allowable Fee
99201	Office/outpatient visit, new*	N	On-line Fee Schedules
99211	Office/outpatient visit, est*	N	
99231	Subsequent hospital care*	N	
99241	Office Consultation*	N	
99251	Inpatient Consultation*	N	

*See CPT manual for long descriptions.

Drugs

The Agency covers drugs and/or medicaments (pharmaceuticals) only when used with parenteral conscious sedation, deep sedation, or general anesthesia for clients 20 years of age and younger.

The Agency's Dental Program does not pay for oral sedation medications.

Code	Description	PA?	Maximum Allowable Fee
D9610	therapeutic parenteral drug, single administration	N	On-line Fee Schedules
D9612	therapeutic parenteral drugs, two or more administrations, different medications	N	
D9630	other drugs and/or medicaments, by report	N	

Behavior Management

The Agency covers behavior management when the assistance of one additional dental staff other than the dentist is required, (documentation of medical necessity of the service must be included in the client’s record) for:

- ✓ Clients eight years of age and younger.
- ✓ Clients from 9 to 20 years of age, only on a case-by-case basis and when prior authorized.
- ✓ Clients any age of the Division of Developmental Disabilities.
- ✓ Clients who reside in an alternative living facility.

Note: For clients residing in an alternative living facility, documentation supporting the medical necessity of the billed procedure code must be in the client’s record.

EPA is only required for eligibility purposes (i.e., clients of the Division of Developmental Disabilities).

Code	Description	PA?	Limitations
D9920	behavior management	EPA	

Post Surgical Complications

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

Code	Description	PA?	Requirement	Limitations
D9930	treatment of complications (post-surgical) – unusual circumstances	N	Tooth designation required.	

Occlusal Guards

The Agency covers occlusal guards when medically necessary and prior authorized. (Refer to “What oral and maxillofacial surgery services are covered?” for occlusal orthotic device coverage and coverage limitations.) The Agency covers:

- ✓ An occlusal guard only for clients from 12 to 20 years of age when the client has permanent dentition.
- ✓ An occlusal guard only as a laboratory processed full arch appliance.

Code	Description	PA?	Age Limitations	Maximum Allowable Fee
D9940	occlusal guard, by report	Y	Clients 12 to 20 years of age only.	

How Do I Indicate to the Agency that a Client 21 Years of Age and Older Is Eligible for the Comprehensive Dental Benefit?

The Agency requires an eligibility expedited prior authorization (EPA) number at the claim level of a claim for every adult client receiving care under the comprehensive dental benefit. Go the following link to choose an eligibility EPA:

<http://hrsa.dshs.wa.gov/DentalProviders/documents/epa.pdf>

How Do I Indicate to the Agency that my Client Qualifies for the Emergency Oral Healthcare Benefit?

The Agency requires a medical expedited prior authorization (EPA) number at the claim level of a claim for every client that does not qualify for the comprehensive dental benefit but qualifies and is receiving limited dental services under the Emergency Oral Healthcare Benefit. Go the following link to choose an eligibility EPA:

<http://hrsa.dshs.wa.gov/DentalProviders/documents/epa.pdf>

Note: Failure to use an appropriate EPA number will result in claim denial.

What Dental-Related Services Are Not Covered?

[Refer to WAC [182-535-1100](#)]

The Agency does not cover the following:

- The dental-related services described in “Noncovered Services by Category” unless the services include those medically necessary services and other measures provided to correct or ameliorate conditions discovered during a screening performed under the early periodic screening, diagnosis and treatment (EPSDT) program. See the Agency’s current [Early Periodic Screening, Diagnosis, and Treatment \(EPSDT\) Medicaid Provider Guide](#) for information about the EPSDT program.
- Any service specifically excluded by statute.
- More costly services when less costly, equally effective services as determined by the Agency are available.
- Implant services.
- Services, procedures, treatments, devices, drugs, or application of associated services:
 - ✓ That the Agency 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).
 - Current Agency published documents.

The Agency does not cover dental-related services listed under the following categories of service:

Diagnostic Services

The Agency does not cover:

- Detailed and extensive oral evaluations or reevaluations.
- Extraoral radiographs.
- Posterior-anterior or lateral skull and facial bone survey films.
- Any temporomandibular joint films.
- Tomographic surveys.
- Cephalometric films, for clients 21 years of age and older.
- Oral/facial photographic images, for clients 21 years of age and older.
- Comprehensive periodontal evaluations.
- Occlusal intraoral radiographs, for clients 21 years of age and older.
- Viral cultures, genetic testing, caries susceptibility tests, or adjunctive prediagnostic tests.
- Pulp vitality tests, for clients 21 years of age and older.
- Diagnostic casts, for clients 21 years of age and older.

Preventive Services

The Agency does not cover:

- Nutritional counseling for control of dental disease.
- Tobacco counseling for the control and prevention of oral disease.
- Removable space maintainers of any type.
- Oral hygiene instructions for clients nine years of age and older. This is included as part of the global fee for oral prophylaxis.

Dental-Related Services

- Sealants placed on a tooth with the same-day occlusal restoration, preexisting occlusal restoration, or a tooth with occlusal decay.
- Sealants, for clients twenty years of age and older. For clients of the Division of Developmental Disabilities, see Section D of this Medicaid provider guide.
- Space maintainers, for clients nineteen years of age and older.
- Recementation of space maintainers, for clients 21 years of age and older.
- Custom fluoride trays of any type, for clients 21 years of age and older.
- Bleaching trays.

Restorative Services.

The Agency does not cover:

- Restorations for wear on any surface of any tooth without evidence of decay through the dentoenamel junction (DEJ) or on the root surface.
- Gold foil restorations.
- Metallic, resin-based composite, or porcelain/ceramic inlay/onlay restorations.
- Prefabricated resin crowns, for clients 21 years of age and older.
- Preventive restorations.
- Crowns for cosmetic purposes (e.g., peg laterals and tetracycline staining).
- Permanent indirect crowns for molar teeth.
- Permanent indirect crowns on permanent anterior teeth for clients 14 years of age and younger.
- Temporary or provisional crowns (including ion crowns).
- Labial veneer resin or porcelain laminate restorations.
- Recementation of any crown, inlay/onlay, or any other type of indirect restoration, for clients 21 years of age and older.
- Sedative fillings.

Dental-Related Services

- Any type of core buildup, cast post and core, or prefabricated post and core, for clients 21 years of age and older.
- Any type of coping.
- Crown repairs.
- Polishing or recontouring restorations or overhang removal for any type of restoration.
- Amalgam restorations of primary posterior teeth for clients 16 years of age and older.
- Crowns on teeth 1,16, 17, and 32.
- Any services other than extraction on supernumerary teeth.

Endodontic Services

The Agency does not cover:

- The following endodontic services for clients 21 years of age and older:
 - ✓ Endodontic therapy on permanent bicuspid.
 - ✓ Any apexification/recalcification procedures.
 - ✓ Any apicoectomy/periradicular service.
- Apexification/recalcification for root resorption of permanent anterior teeth.
- The following endodontic services:
 - ✓ Indirect or direct pulp caps.
 - ✓ Any endodontic therapy 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.
 - ✓ Endodontic therapy on molar teeth.
 - ✓ Any apexification/recalcification procedures for bicuspid or molar teeth.
 - ✓ Any apicoectomy/periradicular services for bicuspid teeth or molar teeth.
 - ✓ Any surgical endodontic procedures including, but not limited to, retrograde fillings (except for anterior teeth), root amputation, reimplantation, and hemisections.

Periodontic Services

The Agency does not cover:

- 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.
- Nonsurgical periodontal services including, but not limited to:
 - ✓ Intracoronary or extracoronary provisional splinting.
 - ✓ Full mouth or quadrant debridement.
 - ✓ Localized delivery of chemotherapeutic agents.
 - ✓ Any other type of nonsurgical periodontal service.

Removable Prosthodontics

The Agency does not cover:

- Removable unilateral partial dentures.
- Adjustments to any removable prosthesis.
- 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.
- Repairs to any partial denture for clients 21 years of age and older.
- Immediate dentures.
- Cast-metal framework partial dentures.

Implant Services

The Agency does not cover:

- 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

The Agency does not cover any type of:

- 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.
- Occlusal orthotic splint or device, bruxing or grinding splint or device, temporomandibular joint splint or device, or sleep apnea splint or device.
- Orthodontic service or appliance, for clients 21 years of age and older.

Oral Maxillofacial Prosthetic Services

The Agency does not cover any type of oral or facial prosthesis other than those listed in “What Maxillofacial Prosthetic Services Are Covered?”

Oral and Maxillofacial Surgery

The Agency does not cover:

- Any oral surgery service not listed in “What Oral and Maxillofacial Surgery Services Are Covered?”
- Any oral surgery service that is not listed in the agency's list of covered current procedural terminology (CPT) codes published in the agency's current rules or Medicaid provider guides.
- Vestibuloplasty.
- Frenuloplasty/frenulectomy, for clients 21 years of age and older.

Adjunctive General Services

The Agency does not cover:

- 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.
- General anesthesia for clients 21 years of age and older.
- Oral or parenteral conscious sedation for clients 21 years of age and older.
- Analgesia or anxiolysis as a separate procedure except for administration of nitrous oxide for clients 21 years of age and older.
- Other general services including, but not limited to:
 - ✓ Fabrication of an athletic mouthguard.
 - ✓ Occlusal guards for clients 21 years of age and older.
 - ✓ Nightguards.
 - ✓ 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.

Dental-Related Services

- ✓ 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.

The Agency evaluates a request for dental-related services that are listed as noncovered under the provisions in WAC [182-501-0160](#).

Clients of the Division of Developmental Disabilities

How Do Providers Indicate to the Agency that Clients Are Served by the Division of Developmental Disabilities?

[Refer to WAC [182-535-1099](#) (6)]

Refer to “Expedited Prior Authorization (EPA) in Section E.

Clients Eligible for Enhanced Services

Clients of the Division of Developmental Disabilities may be entitled to more frequent services.

These individuals will be identified in ProviderOne as clients of the Division of Developmental Disabilities. Individuals not identified as such are not eligible for the additional services. If you believe that a patient may qualify for these services, refer the individual or the patient’s guardian to the nearest Division of Developmental Disabilities Field Office. You may find current contact information for the Division of Developmental Disabilities at:

<http://www.dshs.wa.gov/ddd/contacts.shtml>.

What Additional Dental-Related Services Are Covered for Clients of the Division of Developmental Disabilities?

[Refer to WAC [182-535-1099](#)]

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

Preventive Services

Dental Prophylaxis

The Agency covers dental prophylaxis up to three times in a 12-month period (see “Periodontic Services” in this section for limitations on periodontal scaling and root planing).

Topical Fluoride Treatment

The Agency covers topical fluoride varnish, rinse, foam or gel, up to three times within a 12-month period per client, per provider or clinic.

Sealants

The Agency covers sealants:

- Only when used on the occlusal surfaces of:
 - ✓ Primary teeth A, B, I, J, K, L, S, and T; or
 - ✓ Permanent teeth 2, 3, 4, 5, 12, 13, 14, 15, 18, 19, 20, 21, 28, 29, 30, and 31.
- Once per tooth in a two-year period.

Crowns

The Agency covers stainless steel crowns every two years for the same tooth and only for primary molars and permanent premolars and permanent molars, as follows:

- For clients age 20 and younger, the Agency does not require prior authorization for stainless steel crowns. Documentation supporting the medical necessity of the service must be in the client's record.
- For clients 21 years of age and older, the Agency requires prior authorization for stainless steel crowns when the tooth has had a pulpotomy and only for:
 - ✓ Primary first molars when the decay involves three or more surfaces.
 - ✓ Second molars when the decay involves four or more surfaces.

Periodontic Services

Surgical Periodontal Services

The Agency covers:

- Gingivectomy/gingivoplasty once every three years. Documentation supporting the medical necessity of the service must be in the client's record (e.g., drug induced gingival hyperplasia).
- Gingivectomy/gingivoplasty 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

The Agency 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 six months after scaling or root planing.

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.

Adjunctive General Services

The Agency covers:

- Oral parenteral conscious sedation, deep sedation, or general anesthesia for any dental services performed in a dental office or clinic. Documentation supporting the medical necessity must be in the client's record.
- Sedation services according to [“What Adjunctive General Services are Covered?”](#)

Nonemergency Dental Services

The Agency covers nonemergency dental services performed in a hospital or an ambulatory surgery center for services listed as covered in the following sections in this Medicaid provider 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?

Miscellaneous Services-Behavior Management

The Agency covers behavior management provided in dental offices or dental clinics. Documentation supporting the medical necessity of the service must be included in the client's record.

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.

General Information about Authorization

[Refer to WAC [182-535-1220](#) (1) and (5)]

- The Agency uses the determination process for payment described in WAC [182-501-0165](#) for covered dental-related services that require prior authorization (PA).
- When the Agency authorizes a dental-related service for a client, that authorization indicates only that the specific service is medically necessary; it is not a guarantee of payment.
- The authorization is valid for six months and only if the client is eligible for covered services on the date of service.

When Do I Need To Get PA?

Authorization must take place *before* the service is provided.

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

When Does the Medicaid Agency Deny a PA Request?

[Refer to WAC [182-535-1220](#) (6)]

The Medicaid Agency denies a request for a dental-related service when the requested service:

- Is covered by another Medicaid Agency program.
- Is covered by an agency or other entity outside the Medicaid Agency.
- Fails to meet the program criteria, limitations, or restrictions in this Medicaid Provider Guide.

How Do I Obtain Written PA?

[Refer to WAC [182-535-1220](#) (2)-(4)]

The Agency requires a dental provider who is requesting PA to submit sufficient, objective, clinical information to establish medical necessity.

Providers must submit the request in writing on a completed General Information for Authorization form, 13-835. See the Agency's current [ProviderOne Billing and Resource Guide](#) for more information.

The Agency may request additional information as follows:

- Additional X-rays (radiographs). The Agency returns X-rays only for approved requests and if accompanied by self-addressed stamped envelope.
- Study model, if requested.
- Photographs.
- Any other information requested by the Agency.

Note: The Agency may require second opinions and/or consultations before authorizing any procedure.

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, available at: <http://hrsa.dshs.wa.gov/forms/>.

Note: For information on obtaining Agency forms, refer to the Important Contacts section.

Where Do I Send Requests for PA?

PA requests must be faxed to the Agency at 1-866-668-1214 using the General Information for Authorization form, HCA 13-835, available at: <http://hrsa.dshs.wa.gov/forms/>.

For information regarding submitting prior authorization requests to the Agency see: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide/PA_Chapter.pdf.

Without X-rays or Photos

For procedures that do not require X-rays, fax the PA request to the Agency at: 1-866-668-1214.

With X-rays or Photos

In order the scanning & optical character recognition (OCR) functions to work you *must* pick one of following options for submitting X-rays or photos to the Agency:

- 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 this option is chosen, you can fax your request to the Agency and indicate the NEA# in the NEA field on the PA Request Form. *There is a cost associated which will be explained by the NEA services.*

- Continue to mail your request to:
Authorization Services Office
P.O. Box 45535
Olympia, WA 98504-5535

If You Choose to Mail Your Requests, the Agency requires you to:

1. Place x-rays in an large envelope.
2. Attach the PA request form and any other additional pages to the envelope (i.e. tooth chart, perio charting etc.)
3. Put the client’s name, ProviderOne ID#, and section the request is for on the envelope.

Note: For orthodontics- write “orthodontics on the envelope.”

4. Place in a larger envelope for mailing. Multiple sets of requests can be mailed together.
5. Mail to the Agency.

Expedited Prior Authorization (EPA)

The EPA process is designed to eliminate the need for written requests for prior authorization for selected dental procedure codes.

The Agency allows for use of an EPA for selected dental procedure codes. The criteria for use of an EPA are explained below.

- The EPA number must be used when the provider bills the Agency.
- Upon request, a provider must provide documentation to the Agency showing how the client's condition met the criteria for EPA.
- A written request for prior authorization is required when a situation does not meet the EPA criteria for selected dental procedure codes.
- The Agency may recoup any payment made to a provider if the provider did not follow the required EPA process and criteria.

Expedited Prior Authorization (EPA) Numbers

1. If the client's medical condition does not meet **all** of the specified criteria, prior authorization (PA) must be obtained by submitting a request in writing to the Agency (see the *Important Contacts* section).
2. It is the vendor's responsibility to determine whether the client has already been provided the service allowed with the EPA criteria. If the vendor determines that the client has already been provided the service, a written prior authorization request must be submitted to the Agency.

For eligibility expedited prior authorization criteria, go to the Agency's Dental webpage at: <http://hrsa.dshs.wa.gov/DentalProviders/documents/epa.pdf>.

Note: Failure to bill with the appropriate EPA number at the header level will result in claim denial.

Expedited Prior Authorization Procedure Code List

Procedure Code	Description	EPA #	Criteria
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	870001307	<p>Allow for primary anterior teeth (CDEFGHMNOPQR) when determined medically necessary by a dental practitioner and a more appropriate alternative to a crown.</p> <p>*If a bill for a crown on the same tooth is received within 6 months the amount paid for this treatment will be recouped.</p> <p>**NOTE - In addition to the EPA # on your claim, you will need to enter a claim note "Pay per authorization - see EPA information"</p>
D1515	Space maintainer - fixed - bilateral	870001308	Allow to replace an existing Unilateral fixed space maintainer when teeth 3 & 14 or 19 & 30 have erupted
D3120	Pulp cap - indirect (excluding final restoration)	870001309	Allow for a primary tooth when determined medically necessary by a dental practitioner and a less costly alternative to a therapeutic pulpotomy.
D7971	Excision of pericoronal gingiva	870001310	Allow when determined to be medically necessary by a dental practitioner for treatment of a newly erupting tooth.
D1204	Topical application of fluoride (prophylaxis not included) - adult	870001311	Allow for an eligible adult 65 years of age or older 1/time in a 12 month period

Billing and Claim Forms

What Are the General Billing Requirements?

Providers must follow the Agency's current [ProviderOne Billing and Resource Guide](#). These billing requirements include, but are not limited to:

- 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.
- What standards to use for record keeping.

Note: Effective for claims received on or after January 1, 2012, if an ICD9 diagnosis code is entered on the dental billing and it is an invalid diagnosis code, the claim will be denied.

Facility Billing

The Agency covers medically necessary dental-related services provided to an eligible client in a hospital-based dental clinic when the services:

- Are provided in accordance with Chapter 182-535 WAC.
- Are billed on a 2006 ADA or UB 04 Claim Form or appropriate electronic transaction.

The Agency pays a hospital for covered dental-related services, including oral and maxillofacial surgeries, that are provided in the hospital's operating room when:

- The covered dental-related services are medically necessary and provided in accordance with Chapter 182-535 WAC.
- The covered dental-related services are billed on a UB-04 claim form.

The Agency pays an Ambulatory Surgery Center for covered dental-related services, including oral and maxillofacial surgeries that are provided in the facilities operating room, when:

- The covered dental-related services are medically necessary and provided in accordance with Chapter 182-535 WAC.
- The covered dental-related services are billed on a CMS-1500 claim form.

How Do I Bill for Clients Eligible for Both Medicare and Medicaid?

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

Third-Party Liability

For dental services you may elect to bill the Agency directly and the Agency will recoup from the third party. If you know the third party carrier, you may choose to bill them directly. The client may not be billed for copays.

For all medical claims, refer to the Agency's current [*ProviderOne Billing and Resource Guide*](#).

Notifying Clients of their Rights (Advance Directives)

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.

Fee Schedules

- You may access the Agency's Dental Fee Schedule at:
<http://hrsa.dshs.wa.gov/RBRVS/Index.html>.
- To access the Agency's Oral Surgery Fee Schedule:
 - ✓ **Procedure codes** may be found in the Dental Fee Schedule at the above address.
 - ✓ **Maximum allowable fees** may be found in the Physician-Related Services Fee Schedule at the above address.

Note: Bill the Agency your usual and customary charge.

Completing the ADA Claim Form

Note: Refer to the Agency's current [ProviderOne Billing and Resource Guide](#) for general instructions on completing the ADA Claim Form.