Washington State Health Care Authority

Washington Apple Health (Medicaid)

Dental-Related Services Program Billing Guide

November 1, 2016

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.

About this guide*

This publication takes effect November 1, 2016, and supersedes earlier billing guides to this program.

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Services, equipment, or both, related to any of the programs listed below must be billed using the agency's Washington Apple Health program-specific billing guides:

- Access to Baby and Child Dentistry (ABCD)
- Orthodontic Services

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

* This publication is a billing instruction.

What has changed?

Subject	Change	Reason for Change
Definitions	Updated the definition of "Behavior management" to reflect that any professional staff may assist in behavior management	Aligns with recent updates to Chapter 182-535 WAC Dental-related services
When does the agency pay for covered dental-related services?	Added information to the requirement of documenting dental-related services in a client's record.	Aligns with recent updates to Chapter 182-535 WAC Dental-related services
Limited visual oral assessment	Changed the frequency of limited visual oral assessments from two per year per client to every six months.	Aligns with recent updates to Chapter 182-535 WAC Dental-related services
	Removed repeated information: "Provided by a licensed dentist or licensed dental hygienist."	Aligns with recent updates to Chapter 182-535 WAC Dental-related services
X-rays (radiographs)	Added "per arch" to the coverage of occlusal intraoral x-rays.	Aligns with recent updates to Chapter 182-535 WAC Dental-related services
Topical fluoride treatment	Changed the frequency of topical fluoride treatments for clients age 6 and younger from three times per year to every four months.	Aligns with recent updates to Chapter 182-535 WAC Dental-related services
	Changed the frequency of topical fluoride treatments for clients age 7 through 18 from two times per year to every six months.	Aligns with recent updates to Chapter 182-535 WAC Dental-related services
Oral hygiene instruction	Added "or within six months from a prophylaxis by the same provider or clinic" to the coverage of oral hygiene instruction.	Aligns with recent updates to Chapter 182-535 WAC Dental-related services
Space maintenance	Added "per quadrant" to fixed unilateral space maintainer; added "per arch" to fixed bilateral space maintainer.	Aligns with recent updates to Chapter 182-535 WAC Dental-related services
	Changed information that space maintainer removal is allowed once per appliance, rather than once per quadrant.	Aligns with recent updates to Chapter 182-535 WAC Dental-related services

Subject	Change	Reason for Change
What restorative services are covered?	Removed the word "amalgam" from information about occlusal adjustment.	Aligns with recent updates to Chapter 182-535 WAC Dental-related services
Limitations for all restorations	Removed "per client, per provider or clinic" from information about replacement restorations; updated information required for the client's record for replacement restorations	Aligns with recent updates to Chapter 182-535 WAC Dental-related services
Complete dentures	Removed "or at least five years after the seat date of the last cast metal partial denture" from coverage of replacement of partial dentures with complete dentures	Aligns with recent updates to Chapter 182-535 WAC Dental-related services
	Updated the form name to *Denture Agreement of Acceptance*; added "and at the time of delivery" to the requirement of getting a client's signature on the form	Aligns with recent updates to Chapter 182-535 WAC Dental-related services
Resin partial dentures	Added that "The agency does not consider closed spaces of missing teeth to qualify as a missing tooth" in coverage of resin partial dentures.	Aligns with recent updates to Chapter 182-535 WAC Dental-related services
Repairs to complete and partial dentures	Corrected CDT code D5630 to show the requirement of a tooth designation, rather than an arch designation	Correction
What maxillofacial prosthetic services are covered?	Removed "only for clients age 20 and younger" from coverage of maxillofacial prosthetic services.	Aligns with recent updates to Chapter 182-535 WAC Dental-related services
Behavior management	Added "provided in dental offices or dental clinics" to the coverage of behavior management; removed the word "dental" from the requirement of needing professional staff to assist in order for behavior management to be covered	Aligns with recent updates to Chapter 182-535 WAC Dental-related services
What additional dental-related services are covered for clients of DDA?	Changed the frequency of periodic oral evaluations for DDA clients from three times per year to every four months.	Aligns with recent updates to Chapter 182-535 WAC Dental-related services
	Changed the frequency of prophylaxes for DDA clients age 14 and older from three times per year to every four months.	Aligns with recent updates to Chapter 182-535 WAC Dental-related services

Subject	Change	Reason for Change
	Changed the frequency of prophylaxes for DDA clients age 13 and younger from three times per year to every four months.	Aligns with recent updates to Chapter 182-535 WAC Dental-related services
	Changed the frequency of topical fluoride varnish for DDA from three times per year to every four months.	Aligns with recent updates to Chapter 182-535 WAC Dental-related services
	Changed the frequency of topical fluoride application (excluding varnish) for DDA clients from three times per year to every four months.	Aligns with recent updates to Chapter 182-535 WAC Dental-related services
General information about authorization	Added clarification that authorizations are valid from six to twelve months; this information is indicated on the agency's authorization letter	Aligns with recent updates to Chapter 182-535 WAC Dental-related services
How do I bill claims electronically?	Added section to direct providers to a resource for electronic billing.	Housekeeping
How do I complete the 2012 ADA claim form?	Removed section. Effective October 1, 2016, all claims must be filed electronically. For providers approved to bill paper, see agency's Paper Claim Billing Resource for general information about paper billing.	Policy change to improve efficiency in processing claims.

How can I get agency provider documents?

To access provider alerts, go to the agency's provider alerts web page.

To access provider documents, go to the agency's provider billing guides and fee schedules web page.

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Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to Chapter 182-500 WAC for a complete list of definitions for Washington Apple Health. The 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 this section and the current CDT or CPT, this section prevails.**

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

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

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 and 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 professional staff to manage the behavior of a client to facilitate the delivery of dental treatment. (WAC 182-535-1050)

Border areas – See WAC 182-501-0175.

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 a client responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, spontaneous ventilation is adequate, and cardiovascular function is maintained. (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 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)

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

Developmental Disabilities Administration (DDA) – The administration within the Department of Social and Health Services responsible for administering and overseeing services and programs for clients with developmental disabilities. Formerly known as the Division of 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, or when triage services are provided in settings other than dental offices or dental clinics. (WAC 182-535-1050)

Major bone grafts – A transplant of solid bone tissue. (WAC 182-535-1050)

Minor bone grafts – A transplant of nonsolid bone tissue, 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)

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

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

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

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

- Permanent maxillary posterior teeth include teeth 1, 2, 3, 4, 5, 12, 13, 14, 15, and 16
- Permanent mandibular posterior teeth include teeth 17, 18, 19, 20, 21, 28, 29, 30, 31, and 32

- Primary maxillary posterior teeth include teeth A, B, I, and J
- Primary mandibular posterior teeth include teeth K, L, S, and T (WAC 182-535-1050)

Primary – The first set of teeth.

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

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

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 a tooth. (WAC 182-535-1050)
Six months – Equal to 180 days.

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 – The removal of a tooth by cutting of the gingiva and bone. This includes soft tissue extractions, partial boney extractions, and complete boney extractions. (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

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

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

Who is eligible to become an agency-contracted provider?

(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 the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program
  - ✓ Practice as a dental hygienist
  - ✓ Practice as a denturist
  - ✓ Practice anesthesia according to Department of Health (DOH) regulations
- Facilities that are one of the following:
  - ✓ Hospitals currently licensed by the DOH
  - ✓ Federally-qualified health centers (FQHCs)
  - ✓ Medicare-certified ambulatory surgery centers (ASCs)
  - ✓ Medicare-certified rural health clinics (RHCs)
  - ✓ Community health centers (CHC)

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- 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))

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Client Eligibility

How can I verify a patient's eligibility?

Providers must verify that a patient has Washington Apple Health coverage for the date of service, and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Verifying eligibility is a two-step process:

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

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

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

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

1. By visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org.

2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY).

3. By mailing the application to:
   Washington Healthplanfinder
   PO Box 946
   Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.

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

(WAC 182-535-1060(2))

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

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Coverage

When does the agency pay for covered dental-related services?

(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:

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

For orthodontic services, see Chapter 182-535A WAC and the agency's Orthodontic Services Billing Guide.

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

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 receives a client from the hospital for an emergency condition (i.e., infection, fracture, or trauma).

  When billing for E/M codes in facility settings, oral surgeons must use CPT codes and follow CPT rules, including the use of modifiers. When billing for emergency hospital visits, oral surgeons must bill:

  - ✓ On an 837P HIPAA compliant claim form, Professional claim billed via Direct Data Entry (DDE), or CMS-1500 paper claim form.

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- ✓ Using the appropriate CPT 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 Developmental Disabilities Administration (DDA)).

- 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 at least one procedure code.

  - ✓ List **all** applicable codes that require PA.

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

  - ✓ Be submitted on the *General Information for Authorization* form, HCA 13-835.

  - ✓ Include a letter that clearly describes the medical necessity of performing the service in the requested setting.

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

- 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 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.

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- The agency pays dentists and oral surgeons for hospital visits using only the CPT codes listed in the oral surgery section of the Physician-Related Services/Health Care Professional Services Billing Guide. In accordance with CPT guidelines, evaluation and management codes (visit codes) are not allowed on the same day as a surgery code (CPT® or CDT®) unless the decision to do the surgery was made that day and appropriate modifiers are used.

- 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 Billing 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 D9223 or D9243.

Site-of-service prior authorization

(WAC 182-535-1079 (3), (4))

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 ASC when all of the following are true:

- The client is not a client of the DDA.

- The client is age 9 or older.

- The service is not listed as exempt from the site-of-service authorization requirement in this billing guide or the agency's current 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?).

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

What services are covered under the Early Periodic Screening and Diagnostic Treatment program?

(WAC 182-535-1079 (5))

Under the Early Periodic Screening and Diagnostic Treatment (EPSDT) program, clients age 20 and younger may be eligible for the dental-related services listed as noncovered. The agency reviews requests for dental-related services for clients who are eligible for services under the EPSDT program when a referral for services is the result of an EPSDT exam, according to the provisions of WAC 182-534-0100.

Which services are covered for medical care services clients?

(WAC 182-535-1066)

The agency covers the following dental-related services for a medical care services (MCS) client as listed in WAC 182-501-0060 when the services are provided by a dentist to assess and treat pain, infection, or trauma of the mouth, jaw, or teeth, including treatment of post-surgical complications, (e.g., dry socket):

- Limited oral evaluation
- Periapical or bite-wing radiographs (x-rays) that are medically necessary to diagnose only the client's chief complaint
- Palliative treatment to relieve dental pain
- Pulpal debridement to relieve dental pain

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- Tooth extraction. Tooth extractions require prior authorization (PA) when one of the following applies:

  - ✓ The extraction of a tooth or teeth results in the client becoming edentulous in the maxillary arch or mandibular arch.
  - ✓ A full mouth extraction is necessary because of radiation therapy for cancer of the head and neck.

Each dental-related procedure described under this section is subject to the coverage limitations listed in this billing guide.

The agency does not cover any dental-related services not listed in this section for MCS clients, including any type of removable dental prosthesis.

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Covered procedure codes for MCS clients

Code	Description	PA?	Requirements/ Limitations	Maximum Allowable Fee
D0140	limited oral evaluation – problem focused	N		Fee Schedule
D0220	intraoral – periapical first film	N		
D0230	intraoral – periapical each additional film	N		
D0270	bitewing – single film	N		
D0272	bitewings – two films	N		
D0273	bitewings – three films	N		
D0274	bitewings – four films	N		
D3221	pulpal debridement, primary and permanent teeth	N	Tooth designation required	
D3310	endodontic therapy, anterior tooth (excluding final restoration)	N	Tooth designation required	
D7111	extraction, coronal remnants – deciduous tooth	N	Tooth designation required	
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	N	Tooth designation required	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	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	
D7250	surgical removal of residual tooth roots (cutting procedure)	*	Tooth designation required	
D9110	palliative (emergency) treatment of dental pain – minor procedure	N	Tooth designation required	

*This service must be prior authorized by the agency if provided by the original treating provider or clinic.

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Are limitation extensions and exceptions to rule available?

(WAC 182-535-1079 (5))

What is a limitation extension?

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

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

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, HCA 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 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, HCA 13-788.

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What is an exception to rule?

An exception to rule (ETR) is when a client or the client's provider requests the agency to pay for a noncovered service. The agency reviews these requests according to WAC 182-501-0160.

How do I request a noncovered service?

A noncovered service must be requested through ETR. To request a noncovered service, submit the request in writing on a completed *General Information for Authorization* form, HCA 13-835, and fax to the agency at: (866) 668-1214.

Indicate in Box 30 on the form that you are requesting an ETR.

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

What diagnostic services are covered?

(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:

Oral health evaluations and assessments

The agency covers per client, per provider or clinic:

- **Periodic oral evaluations**, once every six months. Six months must elapse between the comprehensive oral evaluation and the first periodic oral evaluation. **Exception to limits, s**ee Clients of the Developmental Disabilities Administration (DDA), Preventive Services.

- **Limited oral evaluations**, only when the provider performing the limited oral evaluation is not providing routine scheduled dental services for the client on the same day. The limited oral evaluation:

  - ✓ Must evaluate the client for a:

    - ➢ Specific dental problem or oral health complaint,
    - ➢ Dental emergency, or
    - ➢ Referral for other treatment.

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- ✓ When performed by a denturist, is limited to the initial examination appointment. The agency does not cover any additional limited examination by a denturist for the same client until three months after a removable dental prosthesis has been delivered.

- **Comprehensive oral evaluations** as an initial examination that must include:

  - ✓ A complete dental and medical history and general health assessment.
  - ✓ A thorough evaluation of extra-oral and intra-oral hard and soft tissue.
  - ✓ The evaluation and recording of dental caries, missing or unerupted teeth, restoration, occlusal relationships, periodontal 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 or for established patients who have a documented significant change in health conditions (see EPA).

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.

CDT® Code	Description	PA?	Maximum Allowable Fee
D0120	periodic oral evaluation – established patient*	N	On-line Fee Schedule
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.

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Limited visual oral assessment

The agency covers limited visual oral assessments or screening, per provider only when the assessment or screening is:

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

CDT® Code	Description	PA?	Maximum Allowable Fee
D0190	screening of a patient	N	Fee Schedule
D0191	assessment of a patient	N	

Alcohol and substance misuse counseling

The agency covers alcohol and substance misuse counseling through screening, brief interventions, and referral to treatment (SBIRT) services when provided by, or under the supervision of, a certified physician or other certified licensed health care professional, such as a dentist or a dental hygienist, within the scope of their practice. See the agency's current Physician-Related Services/Health Care Professional Services Billing Guide.

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X-rays (radiographs)

The agency uses the prevailing standard of care to determine the need for dental x-rays (radiographs).

The agency covers:

- X-rays, per client, per provider or clinic, 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 for clients age 14 and older. The agency will only cover the intraoral series 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 at least 14 to 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, per arch, once in a two-year period, for clients age 20 and younger.

- A maximum of four bitewing x-rays once every 12 months.

- Panoramic x-rays (for dental only) 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.

- Preoperative and postoperative panoramic x-ray, one per surgery without prior authorization. The agency considers additional x-rays on a case-by-case basis with prior authorization. For orthodontic services, see the Orthodontic Services Billing Guide.

- Cephalometric films - One preoperative and postoperative cephalometric film per surgery without prior authorization. Additional x-rays will be considered on a case-by-case basis with prior authorization.

- X-rays not listed as covered, only on a case-by-case basis and when prior authorized.

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CDT® Code	Description	PA?	Age Limitation	Maximum Allowable Fee
D0210	intraoral – complete series (including bitewings)	N	Clients age 14 and older	Fee Schedule
D0220	intraoral – periapical first film	N		
D0230	intraoral – periapical each additional film	N		
D0240	intraoral – occlusal film	N	Clients age 20 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 (oral surgeons only)	N		

- Oral and facial photographic images on a case-by-case basis and when requested by the agency.

CDT® Code	Description	PA?	Age Limitation	Maximum Allowable Fee
D0350	2D oral/facial photographic images obtained intraorally or extraorally	Y	Clients age 20 and younger only	Fee Schedule

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

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Tests and examinations

The agency covers the following:

- One pulp vitality test per visit (not per tooth) for clients age 20 and younger:
  - ✓ For diagnosis only during limited oral evaluations
  - ✓ When x-rays and/or documented symptoms justify the medical necessity for the pulp vitality test

CDT® Code	Description	PA?	Maximum Allowable Fee
D0460	pulp vitality tests	N	Fee Schedule

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

CDT® Code	Description	PA?	Maximum Allowable Fee
D0470	diagnostic casts	Y	Fee Schedule

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.

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What preventive services are covered?

(**WAC 182-535-1082**)

Dental prophylaxis

The agency:

- Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains when performed on a primary or permanent dentition as part of the prophylaxis service.

- Limits prophylaxis once every:

  ✓ Six months for a client age 18 and younger.
  ✓ Twelve months for a client age 19 and older.
  ✓ Four months for a client residing in a nursing facility.

  Exception: Clients of the Developmental Disabilities Administration (DDA) may exceed these limits.

- Reimburses only when the prophylaxis is performed:

  ✓ At least six months after periodontal scaling and root planing, or periodontal maintenance services, for clients age 13 to 18.

  ✓ At least 12 months after periodontal scaling and root planing, or periodontal maintenance services, for clients age 19 and older.

  ✓ At least six months after periodontal scaling and root planing, or periodontal maintenance services for clients who reside in a nursing facility.

- Does not reimburse for prophylaxis separately when it is performed on the same date of service as periodontal scaling and root planing, periodontal maintenance, gingivectomy, or gingivoplasty.

- Covers prophylaxis for clients of DDA.

CDT® Code	Description	PA?	Age Limitation	Maximum Allowable Fee
D1110	prophylaxis – adult	N	Clients age 14 and older only	Fee Schedule
D1120	prophylaxis – child	N	Clients through age 13 only	

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Topical fluoride treatment

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

Clients who are…	Frequency
Age 6 and younger OR Receiving orthodontic treatment OR Residing in alternate living facilities	Every four months within a 12-month period
Age 7 through 18	Every six months within a 12-month period
Age 19 and older	Once within a 12-month period

- Additional topical fluoride applications only on a case-by-case basis and when prior authorized
- Topical fluoride treatment for clients of DDA

CDT® Code	Description	PA?	Maximum Allowable Fee
D1206*	topical fluoride varnish	N	Fee Schedule
D1208*	topical application of fluoride, excluding varnish	N	

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

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Oral hygiene instruction

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

The agency covers oral hygiene instruction as follows:

- Once every six months (up to two times within a 12-month period)
- Only when not performed on the same date of service as prophylaxis or within six months from a prophylaxis by the same provider or clinic

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**.

CDT® Code	Description	PA?	Age Limitation	Maximum Allowable Fee
D1330	oral hygiene instructions	N	*Clients age 8 and younger only	Fee Schedule

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

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Tobacco cessation counseling

The agency covers tobacco cessation counseling for clients age 18 and older and pregnant women any age for the control and prevention of oral disease. Refer to the Physician Related Services/Health Care Professional Services Billing Guide.

Sealants

The agency covers sealants as follows:

- For clients age 20 and younger and people of any age who are clients of the Developmental Disabilities Administration (DDA), Department of Social and Health Services (DSHS)
- Only when used on a mechanically and/or chemically prepared enamel surface
- Once per tooth:
  - ✓ In a three-year period for clients age 20 and younger
  - ✓ In a two-year period for people of any age who are clients of DDA, DSHS

  Additional sealants are allowed on a case-by-case basis and when prior authorized
- 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
- On noncarious teeth or teeth with incipient caries
- Only when placed on a tooth with no pre-existing occlusal restoration, or any occlusal restoration placed on the same day

Sealants are included in the agency's payment for occlusal restoration placed on the same day

CDT® Code	Description	PA?	Requirements	Age Limitation	Maximum Allowable Fee
D1351	sealant – per tooth	N	Tooth and surface designation required	Clients age 20 and younger; DDA/DSHS clients of any age	Fee Schedule

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Space maintenance

The agency covers:

- One fixed unilateral space maintainer per quadrant or one fixed bilateral space maintainer per arch, including re-cementation, for missing primary molars A, B, I, J, K, L, S, and T, subject to the following:
  - ✓ Evidence of pending permanent tooth eruption exists
  - ✓ Replacement space maintainers are covered on a case-by-case basis and when prior authorized
- The removal of fixed space maintainers when removed by a different provider. Space maintainer removal is allowed once per appliance.

CDT® Code	Description	PA?	Requirements	Maximum Allowable Fee
D1510	space maintainer – fixed – unilateral	N	Quadrant designation required	Fee Schedule
D1515	space maintainer – fixed – bilateral	N	Arch designation required	
D1550	re-cement or re-bond space maintainer	N	Quadrant or arch designation required	Fee Schedule
D1555	removal of fixed space maintainer	N	Quadrant designation required	

Note: The agency does not pay for space maintainers (D1510 and D1515) for clients during approved orthodontic treatment.

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What restorative services are covered?

(WAC 182-535-1084)

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 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.
- Replacements of restorations to be covered when:
  - ✓ Cracked or broken, **and**
  - ✓ Justification is documented in the client's record.

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 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?)

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- 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 or 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 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 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 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 age 5 and younger. The agency pays for these restorations as a one-surface, resin-based composite restoration.

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Additional limitations for restorations on permanent teeth

The agency covers:

- Two occlusal restorations for the upper molars on teeth 1, 2, 3, 14, 15, and 16, only if the restorations are anatomically separated by sound tooth structure.
- 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 1, 2, 3, 14, 15, and 16.
- A maximum of six surfaces per tooth for resin-based composite restorations for permanent anterior teeth.

CDT® Code	Description	PA?	Requirements	Maximum Allowable Fee
D2140	amalgam – one surface, primary or permanent	N	Tooth and surface designations required	Fee Schedule
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	N	Tooth and surface	

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CDT® Code	Description	PA?	Requirements	Maximum Allowable Fee
	surfaces, anterior		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 (includes strip crowns)	N*	Tooth designation required. Clients age 20 and younger only.	Fee Schedule
D2391	resin-based composite – one surface, posterior	N	Tooth and surface designations required.	

* For primary anterior teeth, once every three years as follows: Clients age 12 and younger without PA if the tooth requires a four or more surface restoration. Clients age 13 through 20 with PA. X-ray justification is required.

CDT® Code	Description	PA?	Requirements	Maximum Allowable Fee
D2392	resin-based composite – two surfaces, posterior	N	Tooth and surface designations required	
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.	Fee Schedule

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CDT® Code	Description	PA?	Requirements	Maximum Allowable Fee
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.	Fee Schedules

Crowns – single restorations only

The agency covers:

- The following indirect crowns once every five years, per tooth, for **permanent anterior teeth** for clients age 15 through 20 when the crowns meet prior authorization (PA) criteria in Prior Authorization and the provider follows the PA requirements on the following page:
  - ✓ 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 under age 15.

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

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Exception: The agency covers a one-surface restoration on an endodontically treated tooth, or a core buildup or case 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 for crowns:

- 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

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CDT® Code	Description	PA?	Requirements	Age Limitation	Maximum Allowable Fee
D2710	crown – resin-based composite (indirect)	Y	Tooth designation required	Clients age 15 to 20 only	Fee Schedule
D2720	crown – resin with high noble metal	Y	Tooth designation required	Clients age 15 to 20 only	
D2721	crown – resin with predominantly base metal	Y	Tooth designation required	Clients age 15 to 20 only	
D2722	crown – resin with noble metal	Y	Tooth designation required	Clients age 15 to 20 only	
D2740	crown – porcelain/ceramic substrate	Y	Tooth designation required	Clients age 15 to 20 only	
D2750	crown – porcelain fused to high noble metal	Y	Tooth designation required	Clients age 15 to 20 only	

CDT® Code	Description	PA?	Requirements	Age Limitation	Maximum Allowable Fee
D2751	crown – porcelain fused to predominantly base metal	Y	Tooth designation required	Clients age 15 to 20 only	
D2752	crown – porcelain fused to noble metal	Y	Tooth designation required	Clients age 15 to 20 only	

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

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Other restorative services

The agency covers:

- All re-cementations of permanent indirect crowns.

- Prefabricated stainless steel crowns, including stainless steel crowns with resin window, resin-based composite crowns (direct), prefabricated esthetic coated stainless steel crowns, and prefabricated resin crowns for primary anterior teeth once every three years only for clients age 20 and younger as follows:

  - ✓ For clients age 12 and younger without PA if the tooth requires a four or more surface restoration

  - ✓ For clients age 13 through 20 with PA (x-ray justification is required)

- Prefabricated stainless steel crowns, including stainless steel crowns with resin window, resin-based composite crowns (direct), prefabricated esthetic coated stainless steel crowns, and prefabricated resin crowns for primary posterior teeth once every three years without 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, including stainless steel crowns with resin window, and prefabricated resin crowns for permanent posterior teeth excluding 1, 16, 17, and 32 once every three years, for clients age 20 and younger, without PA. X-ray justification is required.
- Prefabricated stainless steel crowns for clients of the Developmental Disabilities Administration (DDA) without PA. X-ray justification is required.

- Core buildup, including pins, only on permanent teeth, only for clients age 20 and younger, and only allowed in conjunction with crowns and when prior authorized. For indirect crowns, prior authorization must be obtained from the agency at the same time as the crown. Providers must submit pre- and post-endodontic treatment radiographs to the agency with the authorization request for endodontically treated teeth.

- Cast post and core or prefabricated post and core, only on permanent teeth, only for clients age 20 and younger, and only when in conjunction with a crown and when prior authorized.

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CDT® Code	Description	PA?	Requirements	Age Limitation	Maximum Allowable Fee
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	N	Tooth designation required	Clients age 20 and younger only	Fee Schedule
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	N	Tooth designation required	Clients age 20 and younger only	
D2920	Re-cement or re-bond crown	N	Tooth designation required	All ages	
D2929	prefabricated porcelain/ceramic crown – primary tooth	*	Tooth designation required	Clients age 20 and younger only	
D2930	prefabricated stainless steel crown – primary tooth	*	Tooth designation required	Clients age 20 and younger only	Fee Schedule
D2931	prefabricated stainless steel crown – permanent tooth	N	Tooth designation required	Clients age 20 and younger only	
D2932	prefabricated resin crown	N	Tooth designation required	Clients age 20 and younger only	

* For clients age 12 and younger without PA if the tooth requires a four or more surface restoration. For clients age 13 through 20 with PA. x-ray justification is required.

CDT® Code	Description	PA?	Requirements	Age Limitation	Maximum Allowable Fee
D2933	prefabricated stainless steel crown with resin window	N	Tooth designation required	Clients age 20 and younger only	Fee Schedule
D2934	prefabricated esthetic coated stainless steel crown – primary tooth	N	Tooth designation required	Clients age 20 and younger only	
D2950	core buildup, including any pins when required	Y	Tooth designation required	Clients age 20 and younger only	
D2952	post and core in addition to crown, indirectly fabricated	Y	Tooth designation required	Clients age 20 and younger only	
D2954	prefabricated post and core in addition to crown	Y	Tooth designation required	Clients age 20 and younger only	

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What endodontic services are covered?

(WAC 182-535-1086)

Pulp capping

The agency considers pulp capping to be included in the payment for the restoration, unless the client meets the EPA criteria or has PA.

CDT® Code	Description	PA?	Requirements	Age Limitation	Maximum Allowable Fee
D3120	pulp cap – indirect (excluding final restoration)	Y	Tooth designation required	Clients age 20 and younger	Fee Schedule

Pulpotomy/pulpal debridement

The agency covers:

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

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.

CDT® 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 age 20 and younger	Fee Schedule
D3221	pulpal debridement, primary and permanent teeth	N	Tooth designation required	All ages	

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Endodontic treatment on primary teeth

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

CDT® Code	Description	PA?	Requirements	Maximum Allowable Fee
D3230	pulpal therapy (resorbable filling)-anterior, primary	N	Tooth designation required	Fee Schedule
D3240	pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restorations)	N	Tooth designation required	

Endodontic treatment on permanent teeth

The agency:

- Covers endodontic treatment for permanent anterior teeth for all clients.
- Covers endodontic treatment for permanent bicuspid and molar teeth, excluding teeth 1, 16, 17, and 32 for clients age 20 and younger.
- 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 (x-rays) 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

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CDT® Code	Description	PA?	Requirements	Age Limitation	Maximum Allowable Fee
D3310	anterior (excluding final restoration)	N	Tooth designation required	All ages	Fee Schedule
D3320	bicuspid (excluding final restoration)	N	Tooth designation required	Client age 20 and younger	
D3330	molar (excluding final restoration)	N	Tooth designation required	Clients age 20 and younger	

Endodontic retreatment on permanent teeth

The agency:

- Covers endodontic retreatment for a client age 20 and younger when prior authorized.
- Covers endodontic retreatment of permanent anterior teeth for a client age 21 and older when prior authorized.
- Considers endodontic retreatment to include:
  - ✓ The removal of post(s), pin(s), old root canal filling material, and all procedures necessary to prepare the canals.
  - ✓ Placement of new filling material.
  - ✓ Retreatment for permanent anterior, bicuspid, and molar teeth, excluding teeth 1, 16, 17, and 32.
- Pays separately for the following services that are related to the endodontic retreatment:
  - ✓ Initial diagnostic evaluation
  - ✓ Initial diagnostic x-rays
  - ✓ 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.

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CDT® Code	Description	PA?	Requirements	Age Limitation	Maximum Allowable Fee
D3346	retreatment of previous root canal therapy – anterior	Y	Tooth designation required	All ages	Fee Schedule
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

The agency 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 per tooth to clients age 20 and younger.

- Apicoectomy and a retrograde filling for **anterior teeth only** for clients age 20 and younger.

CDT® 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	Fee Schedule
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 anterior	N	Tooth designation required	Clients age 20 and younger	
D3430	retrograde filling – per root	N	Tooth designation required	Clients age 20 and younger	

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What periodontic services are covered?

(WAC 182-535-1088)

Surgical periodontal services

The agency covers the following, including all postoperative care:

- Gingivectomy/gingivoplasty (does not include distal wedge procedures on erupting molars), for clients age 20 and younger only, on a case-by-case basis, and when prior authorized

- Gingivectomy/gingivoplasty (does not include distal wedge procedures on erupting molars) for clients of the Developmental Disabilities Administration (DDA)

CDT® 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	Fee Schedule
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 age 13 through 18, 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 and subgingival calculus.

  - ✓ 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.

  - ✓ The client's clinical condition meets current periodontal guidelines.

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- ✓ Performed at least two years from the date of completion of periodontal scaling and root planing or surgical periodontal treatment, or at least 12 months from the completion of periodontal maintenance.

- Covers periodontal scaling and root planing once per quadrant, per client, in a two-year period for clients age 19 and older and only when:
  - ✓ The client has x-ray evidence of periodontal disease and subgingival calculus.
  - ✓ The client's record includes supporting documentation for the medical necessity, including complete periodontal charting and a definitive diagnosis of periodontal disease.
  - ✓ The client's clinical condition meets current periodontal guidelines.
  - ✓ Performed at least two years from the date of completion of periodontal scaling and root planing or surgical periodontal treatment, or at least 12 months from the completion of periodontal maintenance.

- Considers ultrasonic scaling, gross scaling, or gross debridement to be included in the procedure and not a substitution for periodontal scaling and root planing.

- Covers periodontal scaling and root planing only when the services are not performed on the same date of service as prophylaxis, periodontal maintenance, gingivectomy, or gingivoplasty.

- Covers periodontal scaling and root planing for clients of DDA.

- Covers periodontal scaling and root planing, one time per quadrant in a 12-month period for clients residing in a nursing facility.

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CDT® 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 age 13 through 18 only	Fee Schedule
D4341	periodontal scaling and root planing – four or more teeth per quadrant	N	Quadrant designation required	Clients age 19 and older only	
D4342	periodontal scaling and root planing – one to three teeth per quadrant	Y	Quadrant designation required	Clients age 13 through 18 only	
D4342	periodontal scaling and root planing – one to three teeth per quadrant	N	Quadrant designation required	Clients age 19 and older only	
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	N	Covered only for clients of DDA	All ages	

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Periodontal maintenance

- The agency covers periodontal maintenance for clients age 13 through 18, 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 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.
- The agency covers periodontal maintenance once per client in a 12-month period for clients age19 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 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 months after receiving prophylaxis, periodontal scaling and root planing, gingivectomy, or gingivoplasty.
- Covers periodontal maintenance for clients of DDA.
- Covers periodontal maintenance for clients residing in a nursing facility:
  - ✓ Periodontal maintenance (four quadrants) substitutes for an eligible periodontal scaling or root planing once every six months
  - ✓ Periodontal maintenance allowed six months after scaling or root planing

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CDT® Code	Description	PA?	Age Limitations	Maximum Allowable Fee
D4910	periodontal maintenance	Y	Clients age 13 through 18 only	Fee Schedules
D4910	periodontal maintenance	N	Clients age 19 and older only	Fee Schedules

What prosthodontic (removable) services are covered?

(WAC 182-535-1090)

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

Complete dentures

The agency covers:

- A complete denture, including an overdenture, when prior authorized and meeting the agency's coverage criteria.
- Three-month post-delivery care (e.g., adjustments, soft relines, and repairs) from the delivery (placement) date of the complete denture. This is considered part of the complete denture procedure and is not paid separately.
- Complete dentures, which are limited to:
  - ✓ One initial maxillary complete denture and one initial mandibular complete denture per client, per the client's lifetime.
    - ➢ Replacement of a partial denture with a complete denture is covered only when the replacement occurs three or more years after the seat date of the last resin partial denture.
  - ✓ 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 is covered only if prior authorized, and only if the replacement occurs at least five years after the seat date of the initial complete denture or overdenture.

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CDT® Code	Description	PA?	Maximum Allowable Fee
D5110	complete denture – maxillary	Y	Fee Schedule
D5120	complete denture – mandibular	Y	

The provider must obtain a signed *Denture Agreement of Acceptance* form, HCA 13-809, from the client at the conclusion of the final denture try-in and at the time of delivery for 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 before the time limitations specified in this section. A copy of the signed agreement must be kept in the provider's files and be available upon request by the agency.

Resin partial dentures

The agency covers resin partial dentures with prior authorization as follows:

- For anterior and posterior teeth **only** when the following criteria are met:
  - ✓ The remaining teeth in the arch must be free of periodontal disease and have a reasonable prognosis.
  - ✓ The client has established caries control.
  - ✓ The client has one or more missing anterior teeth or four or more missing posterior teeth (excluding teeth 1, 2, 15, 16, 17, 18, 31, and 32). Pontics on an existing fixed bridge do not count as missing teeth. The agency does not consider closed spaces of missing teeth to qualify as a missing tooth.
  - ✓ There are a minimum of four stable teeth remaining per arch.
  - ✓ There is a three-year prognosis for retention of the remaining teeth.

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

- The agency covers replacement of a resin-based partial denture with a new resin partial denture or a complete denture if it occurs at least three years from the seat date of the

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resin-based partial denture. The replacement denture must be prior authorized and meet the agency's coverage criteria for resin partial dentures.

- The agency does not cover replacement of a cast metal framework partial denture with any type of denture within five years of the seat date of the cast metal partial denture.

CDT® Code	Description	PA?	Limitations	Maximum Allowable Fee
D5211	maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	Y*		Fee Schedule
D5212	mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	Y*		

*See prior authorization for prosthodontic and prosthodontic-related services.

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 delivery (placement) date of the partial denture.

- Requires a provider to bill for removable partial or complete denture only after the delivery of the prosthesis, not at the impression date. The agency may pay for lab fees if the removable partial or complete denture 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.

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.

CDT® Code	Description	PA?	Maximum Allowable Fee
D5410	adjust complete denture – maxillary	N	Fee Schedule
D5411	adjust complete denture – mandibular	N	
D5421	adjust partial denture – maxillary	N	
D5422	adjust partial denture – mandibular	N	

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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 a replacement denture or a partial denture. The agency covers additional repairs on a case-by-case basis and when prior authorized.

CDT® Code	Description	PA?	Requirements	Maximum Allowable Fee
D5510	repair broken complete denture base	N	Arch designation required	Fee Schedules
D5520	replace missing or broken teeth – complete denture (each tooth)	N	Tooth designation required	
D5610	repair resin denture base	N	Arch designation required	
D5620	repair cast framework	N	Arch designation required	
D5630	repair or replace broken clasp – per tooth	N	Tooth designation required	
D5640	replace broken teeth – per tooth	N	Tooth designation required	
D5650	add tooth to existing partial denture	N	Tooth designation required	
D5660	add clasp to existing partial denture – per tooth	N	Tooth designation required	

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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 partial dentures on a case-by-case basis when prior authorized.

CDT® Code	Description	PA?	Maximum Allowable Fee
D5710	rebase complete maxillary denture	N	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, D5211, D5212, D5213, and D5214).

Denture reline procedures

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

CDT® Code	Description	PA?	Maximum Allowable Fee
D5750	reline complete maxillary denture (laboratory)	N	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, D5211, D5212, D5213, and D5214).

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Other removable prosthetic services

The agency:

- Covers up to two tissue conditionings, for a client age 20 and younger, and only when performed within three months after the delivery (placement) date.

- Covers 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 partial or complete denture.
    - ➢ Moves from the state.
    - ➢ Cannot be located.
    - ➢ Does not participate in completing the partial or complete dentures.
    - ➢ Dies.

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

- Requires providers to submit copies of laboratory prescriptions and receipts or invoices for each claim when submitting for prior authorization of code D5899 for laboratory fees.

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CDT® Code	Description	PA?	Requirements	Age Limitations	Maximum Allowable Fee
D5850	tissue conditioning, maxillary	N		Clients age 20 and younger only	Fee Schedule
D5851	tissue conditioning, mandibular	N		Clients age 20 and younger only	
D5863	overdenture – complete maxillary	Y	Arch designation required		
D5865	overdenture – complete mandibular	Y	Arch designation required		
D5899	unspecified removable prosthodontic procedure, by report	Y	Arch designation required		
D6930	Re-cement or re-bond fixed partial denture	Y	Arch or quadrant designation required		

Prior authorization for removable prosthodontic and prosthodontic-related procedures

The agency requires prior authorization (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 prior authorization criteria. 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.

- For complete dentures or resin partials:

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- ✓ X-rays if teeth are present. The exception is for nursing facility clients when X-rays are unavailable. In this case, the provider must submit a completed *Tooth Chart*, HCA 13-863 form.

- ✓ If edentulous, a complete *Tooth Chart*, HCA 13-863 form.

The tooth chart must be completed as follows: missing teeth must be marked with an | | and those teeth to be extracted must be marked with an X.

The agency requires a provider to:

- 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 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 the client's record the completed copy of the signed *Denture or Partial Denture Agreement of Acceptance* form, HCA 13-809, which documents the client's acceptance of the dental prosthesis.

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Alternative living facilities

- The agency requires a provider to submit the following with a PA request for a removable partial or complete denture for a client residing in an alternate living facility or 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, HCA 13-788
- The agency limits removable partial dentures to resin-based partial dentures for all clients residing in a nursing facility.

What maxillofacial prosthetic services are covered?

(**WAC 182-535-1092**)

The agency:

- Covers maxillofacial prosthetics on a case-by-case basis and when prior authorized.
- Must pre-approve a provider qualified to furnish maxillofacial prosthetics.

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What oral and maxillofacial surgery services are covered?

(WAC 182-535-1094)

General coverage

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

- Agency-enrolled dental providers who are not specialized to perform oral and maxillofacial surgery must use only the current dental terminology (CDT) codes to bill claims for services that are listed as covered.

- Agency-enrolled dental providers who are specialized to perform oral and maxillofacial surgery can bill using Current Procedural Terminology (CPT®) codes unless the procedure is specifically listed in this billing guide as a CDT® covered code (e.g., extractions).

> **Note:** For billing information on billing CPT codes for oral surgery, refer to the agency's current Physician-Related Services/Health Care Professional Billing Guide. The agency pays oral surgeons for only those CPT codes listed in the Dental Fee Schedule under Dental CPT Codes.

- The agency covers nonemergency oral surgery performed in a hospital or ambulatory surgery center only for:

  - ✓ Clients age 8 and younger
  - ✓ Clients age 9 through 20 on a case-by-case basis and when the site-of-service is prior authorized by the agency
  - ✓ Clients any age of the Developmental Disabilities Administration

- The agency requires the dental provider to submit all of the following for site-of-service and oral surgery CPT codes that require PA:

  - ✓ Documentation used to determine medical appropriateness
  - ✓ Cephalometric films
  - ✓ Radiographs (x-rays)
  - ✓ Photographs
  - ✓ Written narrative/letter of medical necessity

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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 (CPT® codes 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). Prior authorization is required when one of the following applies:
    - ✓ Extractions of four or more teeth per arch over a six-month period, resulting in the client becoming edentulous in the maxillary arch or mandibular arch
    - ✓ Tooth number is not able to be determined
- Covers unusual, complicated surgical extractions with prior authorization.
- Covers surgical extraction of unerupted teeth.

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- 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.

CDT® Code	Description	PA?	Requirements	Maximum Allowable Fee
D7111	extraction, coronal remnants – deciduous tooth	N	Tooth designation required	Fee Schedule
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)	*	Tooth designation required	

*If provided by the original treating provider or clinic, this service must receive PA from the agency.

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Other surgical procedures

The agency:

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

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

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Alveoloplasty – surgical preparation of ridge for dentures

The agency covers alveoloplasty on a case-by-case basis when prior authorized. Photos must be submitted to the agency with the prior authorization request.

CDT® Code	Description	PA?	Requirements	Maximum Allowable Fee
D7310	alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	Y	Quadrant designation required	Fee Schedule
D7311	alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	Y	Quadrant designation required	
D7320	alveoloplasty not in conjunction with extractions – four or more teeth, per quadrant	Y	Quadrant designation required	
D7321	alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	Y	Quadrant designation required	

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. Photos or radiographs (x-rays), as appropriate, must be submitted to the agency with the prior authorization request.

CDT® Code	Description	PA?	Requirements	Maximum Allowable Fee
D7410	excision of benign lesion up to 1.25 cm	Y	Quadrant designation required	Fee Schedule

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Excision of bone tissue

The agency covers only the following excisions of bone tissue in conjunction with placement of complete or partial dentures, when prior authorized. Photos or radiographs, as appropriate, must be submitted to the agency with the prior authorization request.

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

CDT® Code	Description	PA?	Requirements	Age Limitations	Maximum Allowable Fee
D7471	removal of lateral exostosis (maxilla or mandible)	Y	Arch designation required		Fee Schedule
D7472	removal of torus palatinus	Y			
D7473	removal of torus mandibularis	Y	Quadrant designation required		
D7485	surgical reduction of osseous tuberosity	Y	Quadrant designation required		
D7970	excision of hyperplastic tissue – per arch	Y		Clients age 20 and younger only	
D7971	excision of pericoronal gingiva	Y		Clients age 20 and younger only	
D7972	surgical reduction of fibrous tuberosity	Y		Clients age 20 and younger only	

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Surgical incision

The agency:

- Covers 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).

- Covers removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue when prior authorized. Documentation supporting the medical necessity for the service must be in the client's record.

- Covers frenuloplasty/frenulectomy for clients age 6 and younger, without prior authorization.

- Covers frenuloplasty/frenulectomy for clients age 7 to 12 only on a case-by-case basis and when prior authorized. Photos must be submitted to the agency with the prior authorization request.

- Requires documentation supporting the medical necessity, including photographs, for the service to be in the client's record.

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

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CDT® Code	Description	PA?	Requirements	Age Limitations	Maximum Allowable Fee
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure	N	Arch designation required	Clients age 6 and younger only	Fee Schedule
D7963	Frenuloplasty	Y	Arch designation required	Clients age 7 to 12 only	
D7963	Frenuloplasty	N	Arch designation required	Clients age 6 and younger only	

Occlusal orthotic devices

The agency covers:

- Occlusal orthotic devices for clients from age 12 through 20 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.

CDT® Code	Description	PA?	Age Limitations	Maximum Allowable Fee
D7880	occlusal orthotic device, by report	Y	Clients age 12 through 20 only	Fee Schedules

What orthodontic services are covered?

(WAC 182-535-1096)

The agency covers orthodontic services, subject to the coverage limitations listed, for clients age 20 and younger according to the agency's current Orthodontic Services Billing Guide.

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What adjunctive general services are covered?

(WAC 182-535-1098)

Palliative treatment

The agency covers palliative (emergency) treatment, not to include pulpal debridement (D3221), for treatment of dental pain, 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

Palliative treatment is not allowed on same day as definitive treatment.

CDT® Code	Description	PA?	Requirement	Maximum Allowable Fee
D9110	palliative (emergency) treatment of dental pain – minor procedure	N	Tooth designation required	Fee Schedule

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Anesthesia

The agency:

- Covers local anesthesia and regional blocks as part of the global fee for any procedure being provided to clients.
- The provider's current Department of Health (DOH) anesthesia permit must be on file with the agency.
- Covers office-based oral or parenteral conscious sedation, deep sedation, or general anesthesia, as follows:

ANESTHESIA PRIOR AUTHORIZATION		
Type	**Ages**	**PA?**
General anesthesia (Office-based only)	Age 8 and younger Any age clients of DDA	No
	Age 9 through 20	Yes*
	Age 9 through 20 with diagnosis of cleft palate	No
	Age 21 and older	Yes
Oral conscious sedation (Office-based only)	Age 20 and younger Any age clients of DDA	No
	Age 21 and older	Yes
Parenteral conscious sedation (Office-based only)	Age 20 and younger Any age clients of DDA	No
	Age 21 and older	Yes

*Unless providing one of the services listed in WAC 182-535-1094(1)(f)-(m).

Note: Letters of medical necessity for anesthesia must clearly describe the medical need for anesthesia and what has been tried and failed. Dental phobia and fear of needles is not specific enough information.

- 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.

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- ✓ For clients age 21 and older, prior authorization will be considered only for those clients with medical conditions such as tremors, seizures, behavioral health conditions, breathing difficulties, and other conditions for which general anesthesia is medically necessary, as defined in WAC 182-500-0070.

- Requires providers to bill anesthesia services using the CDT codes listed in the table below.

- Pays for anesthesia services according to WAC 182-535-1350 (3) and WAC 182-535-1400 (5).

CDT® Code	Description	PA?	Maximum Allowable Fee
D9223	deep sedation/general anesthesia—15-minute increments	See Anesthesia Prior Authorization Table	Fee Schedule
D9230	analgesia, anxiolysis, inhalation of nitrous oxide		
D9243	intravenous moderate (conscious) sedation/analgesia—15-minute increments		
D9248	non-intravenous conscious sedation (this includes non-IV minimal and moderate sedation)		

Billing for anesthesia

- Billing time for anesthesia 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 CDT code D9223 for each 15-minute increment.

- **Bill for intravenous conscious sedation/analgesia as follows:**

  Bill one unit of CDT code D9243 for each 15-minute increment.

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Professional visits and consultations

- The agency:
  - ✓ Covers professional consultation or diagnostic services only when provided by a dentist or a physician other than the practitioner providing treatment.
  - ✓ Requires the client to be referred by the agency for the services.
  - ✓ 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.
  - ✓ Covers 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.
  - ✓ Covers emergency office visits after regularly scheduled hours. The agency limits payment to one emergency visit per day, per client, per provider.

CDT® Code	Description	PA?	Maximum Allowable Fee
D9410	house/extended care facility call	N	Fee Schedule
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.

CDT® Code	Description *Refer to CPT manual for long descriptions.	PA?	Maximum Allowable Fee
99201	Office/outpatient visit, new*	N	Fee Schedules
99211	Office/outpatient visit, est*	N	
99231	Subsequent hospital care*	N	
99241	Office Consultation*	N	
99251	Inpatient Consultation*	N	

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Drugs and medicaments (pharmaceuticals)

- The agency covers oral sedation medications only when prescribed and the prescription is filled at a pharmacy. The agency does not cover oral sedation medications that are dispensed in the provider's office for home use.

- The agency covers therapeutic parenteral drugs as follows:

  ✓ Includes antibiotic, steroids, anti-inflammatory drugs, or other therapeutic medications
  ✓ Does not include sedative, anesthetic, or reversal agents
  ✓ Only one single-drug injection or one multiple-drug injection per date of service

- For clients age 20 and younger, the agency covers other drugs and medicaments dispensed in the provider's office for home use. This includes, but is not limited to, oral antibiotics and oral analgesics. The agency does not cover the time spent writing prescriptions.

CDT® Code	Description	PA?	Age Limitations	Maximum Allowable Fee
D9610	therapeutic parenteral drug, single administration	N		Fee Schedule
D9612	therapeutic parenteral drugs, two or more administrations, different medications	N		
D9630	other drugs and/or medicaments, by report	N	Clients age 20 and younger only	

Behavior management

The agency covers behavior management provided in dental offices or dental clinics when the assistance of at least **one additional professional staff** is needed to protect the client and staff from injury while treatment is rendered for:

✓ Clients age 8 and younger.
✓ Clients age 9 through 20, only on a case-by-case basis and when prior authorized.
✓ Clients any age of the Developmental Disabilities Administration (DDA).
✓ Clients who reside in an alternate living facility.
✓ Clients diagnosed with autism.
✓ Clients who reside in a skilled nursing facility.

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Note: Documentation supporting the medical necessity of the billed procedure code must be in the client's record.

CDT Code	Description	PA?	Age Limitations	Maximum Allowable Fee
D9920	behavior management	N	Clients age 8 and younger and any age for clients of DDA, clients residing in alternate living facility, and clients diagnosed with autism	Fee Schedule
D9920	behavior management	Y	Clients age 9 through 20	

Postsurgical 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.

CDT® Code	Description	PA?	Requirement	Maximum Allowable Fee
D9930	treatment of complications (post-surgical) – unusual circumstances	N	Tooth designation required	Fee Schedule

Occlusal guards

The agency covers occlusal guards when medically necessary and prior authorized. (See 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 age 12 through 20 when the client has permanent dentition.
- ✓ An occlusal guard only as a laboratory processed full arch appliance.

CDT® Code	Description	PA?	Age Limitations	Maximum Allowable Fee
D9940	occlusal guard, by report	Y	Clients age 12 through 20 only	Fee Schedules

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What dental-related services are not covered?

(WAC 182-535-1100)

General – All ages

The agency does not cover:

- The dental-related services listed under 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. When EPSDT applies, the agency evaluates a noncovered service, equipment, or supply according to the process in WAC 182-501-0165 to determine if it is medically necessary, safe, effective, and not experimental.

- Any service specifically excluded by statute.

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

- 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).
    - ➢ Agency's current documents.

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By category – For all ages

The agency does not cover the dental-related services listed under the following categories of service for any age:

Diagnostic services

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

Preventive services

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

Restorative services

- Restorations for wear on any surface of any tooth without evidence of decay through the dentoenamel junction (DEJ) or on the root surface
- Preventive restorations
- Labial veneer resin or porcelain laminate restorations
- Sedative fillings
- Crowns and crown related services
    - ✓ Gold foil restorations
    - ✓ Metallic, resin-based composite, or porcelain/ceramic inlay/onlay restorations
    - ✓ Crowns for cosmetic purposes (e.g., peg laterals and tetracycline staining)
    - ✓ Permanent indirect crowns for posterior teeth
    - ✓ Permanent indirect crowns on permanent anterior teeth for clients age 14 and younger
    - ✓ Temporary or provisional crowns (including ion crowns)
    - ✓ Any type of coping
    - ✓ Crown repairs
    - ✓ Crowns on teeth 1, 16, 17, and 32

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- Polishing or recontouring restorations or overhang removal for any type of restoration
- Any services other than extraction on supernumerary teeth

Endodontic services

- Indirect or direct pulp caps
- Any endodontic 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

Periodontic services

- Surgical periodontal services including, but not limited to:

  - ✓ Gingival flap procedures
  - ✓ Clinical crown lengthening
  - ✓ Osseous surgery
  - ✓ Bone or soft tissue grafts
  - ✓ Biological material to aid in soft and osseous tissue regeneration
  - ✓ Guided tissue regeneration
  - ✓ Pedicle, free soft tissue, apical positioning, subepithelial connective tissue, soft tissue allograft, combined connective tissue and double pedicle, or any other soft tissue or osseous grafts
  - ✓ Distal or proximal wedge procedures

- Other periodontal services including, but not limited to:

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

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Removable prosthodontics

- Removable unilateral partial dentures
- Any interim complete or partial dentures
- Flexible base partial dentures
- Any type of permanent soft reline (e.g., molloplast)
- Precision attachments
- Replacement of replaceable parts for semi-precision or precision attachments
- Replacement of second or third molars for any removable prosthesis
- Immediate dentures
- Cast-metal framework partial dentures
- Replacement of upper and lower prosthodontic no sooner than every five years for complete dentures and every three years for resin partial dentures
- More than one replacement of complete denture upper and lower arch per lifetime

Implant services

- Any type of implant procedures, including, but not limited to, any tooth implant abutment (e.g., periosteal implants, eposteal implants, and transosteal implants), abutments or implant supported crowns, abutment supported retainers, and implant supported retainers
- Any maintenance or repairs to the above implant procedures
- The removal of any implant as described above

Fixed prosthodontics

- Fixed partial denture pontic
- Fixed partial denture retainer
- Precision attachment, stress breaker, connector bar, coping, cast post, or any other type of fixed attachment or prosthesis
- Occlusal orthotic splint or device, bruxing or grinding splint or device, temporomandibular joint splint or device, or sleep apnea splint or device

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

- Any oral surgery service not listed in What oral and maxillofacial surgery services are covered?

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- Any oral surgery service that is not listed in the agency's list of covered current procedural terminology (CPT®) codes in the agency's current rules or Washington Apple Health billing guides
- Vestibuloplasty

Adjunctive general services

- Anesthesia, including, but not limited to:
  - ✓ Local anesthesia as a separate procedure
  - ✓ Regional block anesthesia as a separate procedure
  - ✓ Trigeminal division block anesthesia as a separate procedure
  - ✓ Medication for oral sedation, or therapeutic intramuscular (IM) drug injections, including antibiotic and injection of sedative
  - ✓ Application of any type of desensitizing medicament or resin
- Other general services including, but not limited to:
  - ✓ Fabrication of an athletic mouthguard
  - ✓ 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
  - ✓ Educational supplies
  - ✓ Nonmedical equipment or supplies
  - ✓ Personal comfort items or services
  - ✓ Provider mileage or travel costs
  - ✓ Fees for no-show, canceled, or late arrival appointments
  - ✓ Service charges of any type, including fees to create or copy charts
  - ✓ Office supplies used in conjunction with an office visit
  - ✓ Teeth whitening services or bleaching, or materials used in whitening or bleaching
  - ✓ Botox or derma-fillers

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By category – for clients age 21 and older

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

Diagnostic services

- Occlusal intraoral radiographs
- Diagnostic casts
- Pulp vitality tests

Preventive services

- Sealants (except for clients of DDA)

Restorative services

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

Endodontic services

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

Adjunctive general services

- Occlusal guards
- Analgesia or anxiolysis as a separate procedure except for administration of nitrious oxide

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

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Clients of the Developmental Disabilities Administration

Are clients of the Developmental Disabilities Administration eligible for enhanced services?

Note: Clients of the Developmental Disabilities Administration (DDA) of the Department of Social and Health Services (DSHS) may be entitled to more frequent services.

Yes. These clients will be identified in ProviderOne as clients of the Developmental Disabilities Administration (DDA). Clients not identified as such are not eligible for the additional services. If you believe that a patient may qualify for these services, refer the patient or the patient's guardian to the nearest DDA Field Office. You may find current contact information for DDA on the DDA website.

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

(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 DDA. This billing guide also applies to clients of DDA, **regardless of age**, unless otherwise stated in this section.

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Preventative Services

CDT® Code	Description	PA?	Requirements	Age Limitation	Frequency
D0120	periodic oral evaluation – established patient	N		All ages	Once every four months
D1110	prophylaxis – adult	N		Clients age 14 and older only	Once every four months. See limitations on periodontal scaling and root planning.
D1120	prophylaxis – child	N		Clients age 13 and under only	Once every four months. See limitations on periodontal scaling and root planning.
D1206	topical fluoride varnish.	N	CDT codes D1206 and D1208 are not allowed on the same day	All ages	Once every four months
D1208	topical application of fluoride, excluding varnish	N	CDT codes D1206 and D1208 are not allowed on the same day	All ages	Once every four months
D1351	sealant – per tooth	N	Tooth and surface designation required	All ages	Once per tooth in a two-year period on the occlusal surfaces of: Primary teeth A, B, I, J, K, L, S, and T Permanent teeth 2, 3, 4, 5, 12, 13, 14, 15, 18, 19, 20, 21, 28, 29, 30, and 31

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Other Restorative Services

CDT® Code	Description	PA ?	Requirements	Age Limitation	Frequency
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	N	Tooth designation required	All ages	
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	N	Tooth designation required	All ages	
D2920	Re-cement or re-bond crown	N	Tooth designation required	All ages	
D2929	prefabricated porcelain/ ceramic crown – primary tooth	N	Tooth designation required	Clients age 20 and younger only	Once every two years for **primary** anterior teeth. Once every two years for **primary** posterior teeth if criteria Other Restorative Services is met.
D2930	prefabricated stainless steel crown – primary tooth	N	Tooth designation required	Clients age 20 and younger only	Once every two years for **primary** anterior teeth. Once every two years for **primary** posterior teeth if criteria Other Restorative Services is met.
D2931	prefabricated stainless steel crown – permanent tooth	N	Tooth designation required	All ages	Once every two years for **permanent** posterior teeth, excluding 1, 16, 17 and 32.

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Periodontic Services

CDT® Code	Description	PA?	Requirements	Age Limitation	Frequency
D4210	gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant	N	Quadrant designation required	All ages	Once every three years
D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant	N	Quadrant designation required	All ages	Once every three years
D4341	periodontal scaling and root planing – four or more teeth per quadrant	N	Quadrant designation required	Clients age 13 and older	One time per quadrant in a 12-month period
D4342	periodontal scaling and root planing – one to three teeth per quadrant	N	Quadrant designation required	Clients age 13 and older	One time per quadrant in a 12-month period
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	N		All ages	Once in a 12-month period
D4910	periodontal maintenance	N		Clients age 13 and older	Twice in a 12-month period *must be six months after last root planing * see limitations in Clients of the Developmental Disabilities Administration

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Adjunctive General Services/Miscellaneous

CDT® Code	Description	PA?	Requirements	Age Limitation	Frequency
D9223	deep sedation/general anesthesia–15-minute increments	N		All ages	
D9243	intravenous moderate (conscious) sedation/analgesia – 15-minute increments	N		All ages	
D9248	non-intravenous moderate (conscious) sedation	N		All ages	
D9920	behavior management	N		All ages	

Other restorative services

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

  - ✓ 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 pulptomy.

Periodontic services

Surgical periodontal services

The agency covers:

- Gingivectomy/gingivoplasty (does not include distal wedge procedures on erupting molars) 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).

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- Gingivectomy/gingivoplasty (does not include distal wedge procedures on erupting molars) 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 allowed six months after scaling or root planing.

- Full-mouth or quadrant debridement allowed once in a 12-month period.

The items listed above are not covered in conjunction with gingivectomy.

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

Nonemergency dental services

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 billing guide:

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

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

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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.

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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

(WAC 182-535-1220 (1) and (5))

- For dental-related services that require PA, the agency uses the payment determination process described in WAC 182-501-0165.
- Authorization of a dental-related service indicates only that the specific service is medically necessary. Authorization does not guarantee payment.
- The authorization is valid for six to twelve months as indicated in the agency's authorization letter and only if the client is eligible for covered services on the date of service.

When do I need to get prior authorization?

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 agency deny a prior authorization request?

(WAC 182-535-1220 (6))

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

- Is covered by another Washington Apple Health program.
- Is covered by an agency or other entity outside the Medicaid agency.
- Fails to meet the program criteria, limitations, or restrictions in this billing guide.

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How do I obtain written PA?

(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, HCA 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.

Note: For information on obtaining agency forms, see the agency's Forms & Publications web page.

Where do I send requests for PA?

PA requests must be faxed to the agency at (866) 668-1214 using the *General Information for Authorization* form, HCA 13-835.

For information regarding submitting prior authorization requests to the agency, see Requesting Prior Authorization in the current ProviderOne Billing and Resource Guide.

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Without x-rays or photos

For procedures that do not require x-rays, fax the PA request to the agency at:
(866) 668-1214.

With x-rays or photos

In order for 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 requests to:
  Authorization Services Office
  PO Box 45535
  Olympia, WA 98504-5535

If you choose to mail your requests, the agency requires you to:

1. Place x-rays in a 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.

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What is expedited prior authorization?

The expedited prior authorization (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.

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 Dental services web page).
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.

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EPA procedure code list

CDT Code*	Description	EPA #	Criteria
D0150	comprehensive oral evaluation – new or established patient	870001327	Allowed for established patients who have a documented significant change in health conditions.
D1515	space maintainer - fixed - Bilateral	870001308	Allowed to replace an existing unilateral fixed space maintainer when teeth 3 & 14 or 19 & 30 have erupted
D2929	prefabricated porcelain or ceramic crown, posterior	870001347	Allowed for a client age 12 and younger for a primary posterior tooth when determined to be medically necessary by a dental practitioner and one of the following conditions are met: • Evidence of extensive caries • Evidence of Class II carries with rampant decay • Treatment of decay requires sedation or general anesthesia. Medical justification must be present in the client record.
D2930	prefabricated stainless steel crown, posterior	870001347	
D2929	prefabricated porcelain or ceramic crown, anterior	870001348	Allowed for a client age 12 and younger for a primary anterior tooth when determined to be medically necessary by a dental practitioner and one of the following conditions are met: • Evidence of extensive caries • Evidence of rampant decay • Treatment of decay requires sedation or general anesthesia Medical justification must be present in the client record.
D2930	prefabricated stainless steel crown, anterior	870001348	

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CDT Code*	Description	EPA #	Criteria
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	870001307	Allowed for primary anterior teeth (CDEFGHMNOPQR) when determined medically necessary by a dental practitioner and a more appropriate alternative to a crown. *If a bill for a crown on the same tooth is received within six months the amount paid for this treatment will be recouped. **Note** - In addition to the EPA # on your claim, you must enter a claim note "Pay per authorization - see EPA information"
D2390	resin-based composite crown, anterior	870001348	Allowed for a client age 12 and younger for a primary anterior tooth when determined to be medically necessary by a dental practitioner and one of the following conditions are met: • Evidence of extensive caries • Evidence of rampant decay • Treatment of decay requires sedation or general anesthesia Medical justification must be present in the client record.
D3120	pulp cap - indirect (excluding final restoration)	870001309	Allowed for a primary tooth when determined medically necessary by a dental practitioner and a less costly alternative to a therapeutic pulpotomy.

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CDT Code*	Description	EPA #	Criteria
D7111, D7140, D7210, D7220, D7230, D7240	extractions of four or more teeth per arch over a six-month period, resulting in the client becoming edentulous in the maxillary arch or mandibular arch	870001383	Allowed when client is diagnosed with a medical condition that requires radiation to head/neck area
D7111, D7140, D7210, D7220, D7230, D7240	extractions of four or more teeth per arch over a six-month period, resulting in the client becoming edentulous in the maxillary arch or mandibular arch	870001384	Allowed for a client on a transplant list. Has clinical evidence of infected teeth or gums. Extractions are recommended by the transplant surgeon.
D7111, D7140, D7210, D7220, D7230, D7240	extractions of four or more teeth per arch over a six-month period, resulting in the client becoming edentulous in the maxillary arch or mandibular arch	870001385	Allowed for a client requiring joint replacement. Has clinical evidence of infected teeth or gums. Extractions are recommended by the joint replacement physician/surgeon.
D7111, D7140, D7210, D7220, D7230, D7240	extractions of four or more teeth per arch over a six-month period, resulting in the client becoming edentulous in the maxillary arch or mandibular arch	870001388	Allowed for a client requiring heart surgery. Has clinical evidence of infected teeth or gums. Extractions are recommended by the physician/surgeon.
D7280	surgical access of an unerupted tooth	870001366	Allowed when client is in active orthodontic treatment. Allowed one time per client, per tooth.
D7283	placement of device to facilitate eruption of impacted tooth	870001366	Allowed when client is in active orthodontic treatment. Allowed one time per client, per tooth.
D7971	excision of pericoronal gingiva	870001310	Allowed when determined to be medically necessary by a dental practitioner for treatment of a newly erupting tooth.

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Billing

Effective for claims billed on and after October 1, 2016
All claims must be submitted electronically to the agency, except under limited circumstances.
For more information about this policy change, see Paperless Billing at HCA.
This billing guide still contains information about billing paper claims.
This information will be updated effective January 1, 2017.

What are the general billing requirements?

Providers must follow the agency's ProviderOne Billing and Resource Guide. These billing requirements include:

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

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

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims electronically can be found on the agency's Billers and Providers web page, under Webinars. See Dental provider workshop.

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

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How do facilities bill?

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 2012 ADA or an 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 and WAC 182-535-1079.
- 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 and WAC 182-535-1079.
- The covered dental-related services are billed on a CMS-1500 claim form.

When hospitals/ASCs bill for the facility fee, the procedures represented on their bill must match the professional dental bill.

Note: The agency does not cover CPT code 41899 for dental services.

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.

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What are the advance directives requirements?

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

Clients have the right to:

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

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Fee Schedules

Where can I find dental fee schedules?

- For CDT®/dental codes – see the agency's Dental Fee Schedule.
- For dental oral surgery codes, see the agency's Physician-Related/Professional Services Fee Schedule.

Note: Bill the agency your usual and customary charge.

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