



PROPOSED RULE MAKING

CR-102 (June 2012)

(Implements RCW 34.05.320)

Do NOT use for expedited rule making

Agency: Health Care Authority, Washington Apple Health

- Preproposal Statement of Inquiry was filed as WSR 16-09-071; or
- Expedited Rule Making--Proposed notice was filed as WSR _____; or
- Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1).

- Original Notice
- Supplemental Notice to WSR _____
- Continuance of WSR _____

Title of rule and other identifying information:

- WAC 182-535-1079 Dental-related services – General
- WAC 182-535-1080 Dental-related services – Covered – Diagnostic
- WAC 182-535-1082 Dental-related services – Covered – Preventative services
- WAC 182-535-1084 Dental-related services – Covered – Restorative services
- WAC 182-535-1088 Dental-related services – Covered – Periodontic services
- WAC 182-535-1090 Dental-related services – Covered – Prosthodontics (removable)
- WAC 182-535-1092 Dental-related services – Covered – Maxillofacial prosthetic services
- WAC 182-535-1094 Dental-related services – Covered – Oral and maxillofacial surgery services
- WAC 182-535-1098 Dental-related services – Covered – Adjunctive general services
- WAC 182-535-1099 Dental-related services for clients of the developmental disabilities administration of the department of social and health services
- WAC 182-535-1220 Obtaining prior authorization for dental-related services

Hearing location:

Health Care Authority
 Cherry Street Plaza Building; Sue Crystal Conf Rm 106A
 626 - 8th Avenue, Olympia WA 98504

Metered public parking is available street side around building. A map is available at:
http://www.hca.wa.gov/documents/directions_to_csp.pdf
 or directions can be obtained by calling: (360) 725-1000

Date: **August 23, 2016** Time: **10:00 a.m.**

Date of intended adoption: Not sooner than August 24, 2016
(Note: This is **NOT** the **effective** date)

Submit written comments to:

Name: HCA Rules Coordinator
 Address: PO Box 45504, Olympia WA, 98504-5504
 Delivery: 626 – 8th Avenue, Olympia WA 98504
 e-mail arc@hca.wa.gov
 fax (360) 586-9727

by **5:00 pm on August 23, 2016**

Assistance for persons with disabilities: Contact Amber Lougheed by August 19, 2016
 e-mail: amber.lougheed@hca.wa.gov or (360) 725-1349
 TTY (800) 848-5429 or 711

Purpose of the proposal and its anticipated effects, including any changes in existing rules:

The agency is amending these rules to add a cross-reference in regards to documentation of client's dental records, to clarify limitations of covered services, and to clarify the time period that an authorization is valid. Other housekeeping changes were made to improve language.

Reasons supporting proposal: See Purpose

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Statute being implemented: RCW 41.05.021, 41.05.160

Is rule necessary because of a:

- Federal Law? Yes No
 - Federal Court Decision? Yes No
 - State Court Decision? Yes No
- If yes, CITATION:

DATE
July 20, 2016

NAME
Wendy Barcus

SIGNATURE

TITLE
HCA Rules Coordinator

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
 STATE OF WASHINGTON
 FILED

DATE: July 20, 2016

TIME: 11:23 AM

WSR 16-15-101

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters: N/A

Name of proponent: Health Care Authority

- Private
 Public
 Governmental

Name of agency personnel responsible for:

Name	Office Location	Phone
Drafting..... Katie Pounds	PO Box 42716, Olympia, WA 98504-2716	(360) 725-1346
Implementation....April Minton	PO Box 45511, Olympia, WA 98504-5511	(360) 725-1590
Enforcement.....April Minton	PO Box 45511, Olympia, WA 98504-5511	(360) 725-1590

Has a small business economic impact statement been prepared under chapter 19.85 RCW or has a school district fiscal impact statement been prepared under section 1, chapter 210, Laws of 2012?

Yes. Attach copy of small business economic impact statement or school district fiscal impact statement.

A copy of the statement may be obtained by contacting:

Name:

Address:

phone ()

fax ()

e-mail

No. Explain why no statement was prepared.

The agency has determined that the proposed filing does not impose a disproportionate cost impact on small businesses or nonprofits.

Is a cost-benefit analysis required under RCW 34.05.328?

Yes A preliminary cost-benefit analysis may be obtained by contacting:

Name:

Address:

phone ()

fax ()

e-mail

No: Please explain:

RCW 34.05.328 does not apply to Health Care Authority rules unless requested by the Joint Administrative Rules Review Committee or applied voluntarily.

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

- (a) Are part of the client's dental benefit package;
- (b) Are within the scope of an eligible client's Washington apple health ((~~WAH~~)) program;
- (c) Are medically necessary;
- (d) Meet the agency's prior authorization requirements, if any;
- (e) Are documented in the client's dental record in accordance with chapter 182-502 WAC and meet the department of health's requirements in WAC 246-817-305 and 246-817-310;
- (f) Are within accepted dental or medical practice standards;
- (g) Are consistent with a diagnosis of a dental disease or dental condition;
- (h) Are reasonable in amount and duration of care, treatment, or service; and
- (i) Are listed as covered in the agency's rules and published billing instructions and fee schedules.

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

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

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

(b) A client is age nine ((~~years of age~~)) or older;

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

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

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

(5) Under the early periodic screening and diagnostic treatment (EPSDT) program, clients age twenty ((~~years of age~~)) and younger may be eligible for dental-related services listed as noncovered.

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

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

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

WAC 182-535-1080 Dental-related services—Covered—Diagnostic.

Clients described in WAC 182-535-1060 are eligible to receive the dental-related diagnostic services listed in this section, subject to coverage limitations, restrictions, and client age requirements identified for a specific service.

(1) **Clinical oral evaluations.** The medicaid agency covers the following oral health evaluations and assessments, per client, per provider or clinic:

(a) Periodic oral evaluations as defined in WAC 182-535-1050, once every six months. Six months must elapse between the comprehensive oral evaluation and the first periodic oral evaluation.

(b) Limited oral evaluations as defined in WAC 182-535-1050, only when the provider performing the limited oral evaluation is not providing routine scheduled dental services for the client on the same day. The limited oral evaluation:

(i) Must be to evaluate the client for a:

(A) Specific dental problem or oral health complaint;

(B) Dental emergency; or

(C) Referral for other treatment.

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

(c) Comprehensive oral evaluations as defined in WAC 182-535-1050, once per client, per provider or clinic, as an initial examination. The agency covers an additional comprehensive oral evaluation if the client has not been treated by the same provider or clinic within the past five years.

(d) Limited visual oral assessments as defined in WAC 182-535-1050, (~~up to two per year~~) once every six months only when the assessment is:

(i) Not performed in conjunction with other clinical oral evaluation services; and

(ii) Performed by a licensed dentist or dental hygienist to determine the need for sealants or fluoride treatment (~~and/or~~) or when triage services are provided in settings other than dental offices or clinics(~~;~~~~and~~

~~(iii) Provided by a licensed dentist or licensed dental hygienist)).~~

(2) **Radiographs (X rays).** The agency:

(a) Covers radiographs per client, per provider or clinic, that are of diagnostic quality, dated, and labeled with the client's name. The agency requires:

(i) Original radiographs to be retained by the provider as part of the client's dental record; and

(ii) Duplicate radiographs to be submitted:

(A) With requests for prior authorization; or

(B) When the agency requests copies of dental records.

(b) Uses the prevailing standard of care to determine the need for dental radiographs.

(c) Covers an intraoral complete series once in a three-year period for clients age fourteen (~~years of age~~) and older only if the

agency has not paid for a panoramic radiograph for the same client in the same three-year period. The intraoral complete series includes at least fourteen to twenty-two periapical and posterior bitewings. The agency limits reimbursement for all radiographs to a total payment of no more than payment for a complete series.

(d) Covers medically necessary periapical radiographs for diagnosis in conjunction with definitive treatment, such as root canal therapy. Documentation supporting medical necessity must be included in the client's record.

(e) Covers an occlusal intraoral radiograph, per arch, once in a two-year period, for clients age twenty (~~(years of age)~~) and younger.

(f) Covers a maximum of four bitewing radiographs once every twelve months.

(g) Covers panoramic radiographs in conjunction with four bitewings, once in a three-year period, only if the agency has not paid for an intraoral complete series for the same client in the same three-year period.

(h) Covers one preoperative and postoperative panoramic radiograph per surgery without prior authorization. The agency considers additional radiographs on a case-by-case basis with prior authorization. For orthodontic services, see chapter 182-535A WAC.

(i) Covers one preoperative and postoperative cephalometric film per surgery without prior authorization. The agency considers additional radiographs on a case-by-case basis with prior authorization. For orthodontic services, see chapter 182-535A WAC.

(j) Covers radiographs not listed as covered in this subsection, only on a case-by-case basis and when prior authorized.

(k) Covers oral and facial photographic images, only on a case-by-case basis and when requested by the agency.

(3) **Tests and examinations.** The agency covers the following for clients who are age twenty (~~(years of age)~~) and younger:

(a) One pulp vitality test per visit (not per tooth):

(i) For diagnosis only during limited oral evaluations; and

(ii) When radiographs (~~(and/or)~~) or documented symptoms justify the medical necessity for the pulp vitality test.

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

AMENDATORY SECTION (Amending WSR 14-08-032, filed 3/25/14, effective 4/30/14)

WAC 182-535-1082 Dental-related services—Covered—Preventive services. Clients described in WAC 182-535-1060 are eligible for the dental-related preventive services listed in this section, subject to coverage limitations and client-age requirements identified for a specific service.

(1) **Dental prophylaxis.** The medicaid agency covers prophylaxis as follows. Prophylaxis:

(a) Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains when performed on primary or permanent dentition.

(b) Is limited to once every:

- (i) Six months for clients age eighteen (~~((years of age))~~) and younger;
 - (ii) Twelve months for clients age nineteen (~~((years of age))~~) and older; or
 - (iii) Four months for a client residing in a nursing facility.
- (c) Is reimbursed only when the service is performed:
- (i) At least six months after periodontal scaling and root planing, or periodontal maintenance services, for clients from age thirteen (~~((to))~~) through eighteen (~~((years of age))~~);
 - (ii) At least twelve months after periodontal scaling and root planing, periodontal maintenance services, for clients age nineteen (~~((years of age))~~) and older; or
 - (iii) At least six months after periodontal scaling and root planing, or periodontal maintenance services for clients who reside in a nursing facility.
- (d) Is not reimbursed (~~((for))~~) separately when performed on the same date of service as periodontal scaling and root planing, periodontal maintenance, gingivectomy, or gingivoplasty.
- (e) Is covered for clients of the developmental disabilities administration of the department of social and health services (DSHS) according to (a), (c), and (d) of this subsection and WAC 182-535-1099.
- (2) **Topical fluoride treatment.** The agency covers the following per client, per provider or clinic:
- (a) Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, for clients age six (~~((years of age))~~) and younger, (~~((up to three times within a twelve month period))~~) every four months.
 - (b) Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, for clients from age seven through eighteen (~~((years of age, up to two times))~~), every six months within a twelve-month period.
 - (c) Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, (~~((up to three times))~~) every four months within a twelve-month period during orthodontic treatment.
 - (d) Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, for clients age nineteen (~~((years of age))~~) and older, once within a twelve-month period.
 - (e) Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, for clients who reside in alternate living facilities as defined in WAC 182-513-1301, (~~((up to three times))~~) every four months within a twelve-month period.
 - (f) Additional topical fluoride applications only on a case-by-case basis and when prior authorized.
 - (g) Topical fluoride treatment for clients of the developmental disabilities administration of DSHS according to WAC 182-535-1099.
- (3) **Oral hygiene instruction.** Includes (~~((individualized))~~) instruction for home care such as tooth brushing technique, flossing, and use of oral hygiene aids. The agency covers individualized oral hygiene instruction, per client, as follows:
- (a) For clients age eight (~~((years of age))~~) and younger. For clients age nine (~~((years of age))~~) and older, oral hygiene instruction is included as part of the global fee for oral prophylaxis.
 - (b) Once every six months (~~((, up to two times))~~) within a twelve-month period.
 - (c) 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.

(d) 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.

(4) **Tobacco cessation counseling for the control and prevention of oral disease.** The agency covers tobacco cessation counseling for pregnant women only. See WAC 182-531-1720.

(5) **Sealants.** The agency covers:

(a) Sealants for clients age twenty (~~((years of age))~~) and younger and clients any age of the developmental disabilities administration of DSHS.

(b) Sealants only when used on a mechanically (~~((and/or))~~) or chemically prepared enamel surface.

(c) Sealants once per tooth:

(i) In a three-year period for clients age twenty (~~((years of age))~~) and younger; and

(ii) In a two-year period for clients any age of the developmental disabilities administration of DSHS according to WAC 182-535-1099.

(d) Sealants only when used on the occlusal surfaces of:

(i) Permanent teeth two, three, fourteen, fifteen, eighteen, nineteen, thirty, and thirty-one; and

(ii) Primary teeth A, B, I, J, K, L, S, and T.

(e) Sealants on noncarious teeth or teeth with incipient caries.

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

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

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

(6) **Space maintenance.** The agency covers:

(a) One fixed unilateral space maintainer per quadrant or one fixed bilateral space maintainer(~~((s))~~) per arch, including recementation, for missing primary molars A, B, I, J, K, L, S, and T, (~~((subject to the following))~~) when:

(i) (~~((Only when there is))~~) Evidence of pending permanent tooth eruption(~~((-))~~) exists; and

(ii) (~~((Only one space maintainer is covered per quadrant.))~~) The service is not provided during approved orthodontic treatment.

(b) Replacement space maintainers (~~((are covered only))~~) on a case-by-case basis (~~((and))~~) when prior authorized.

~~((b))~~ (c) The removal of fixed space maintainers when removed by a different provider. Space maintainer removal is allowed once per (~~((quadrant))~~) appliance.

AMENDATORY SECTION (Amending WSR 15-10-043, filed 4/29/15, effective 5/30/15)

WAC 182-535-1084 Dental-related services—Covered—Restorative services. Clients described in WAC 182-535-1060 are eligible for the dental-related restorative services listed in this section, subject to coverage limitations, restrictions, and client age requirements identified for a specific service.

(1) **Amalgam and resin restorations for primary and permanent teeth.** The medicaid agency considers:

(a) Tooth preparation, acid etching, all adhesives (including bonding agents), liners and bases, polishing, and curing as part of the restoration.

(b) Occlusal adjustment of either the restored tooth or the opposing tooth or teeth as part of the ((amalgam)) restoration.

(c) Restorations placed within six months of a crown preparation by the same provider or clinic to be included in the payment for the crown.

(2) **Limitations for all restorations.** The agency:

(a) Considers multiple restoration involving the proximal and occlusal surfaces of the same tooth as a multisurface restoration, and limits reimbursement to a single multisurface restoration.

(b) Considers multiple restorative resins, flowable composite resins, or resin-based composites for the occlusal, buccal, lingual, mesial, and distal fissures and grooves on the same tooth as a one-surface restoration.

(c) Considers multiple restorations of fissures and grooves of the occlusal surface of the same tooth as a one-surface restoration.

(d) Considers resin-based composite restorations of teeth where the decay does not penetrate the dentoenamel junction (DEJ) to be sealants. (See WAC 182-535-1082(4) for sealant coverage.)

(e) Reimburses proximal restorations that do not involve the incisal angle on anterior teeth as a two-surface restoration.

(f) Covers only one buccal and one lingual surface per tooth. The agency reimburses buccal or lingual restorations, regardless of size or extension, as a one-surface restoration.

(g) Does not cover preventive restorative resin or flowable composite resin on the interproximal surfaces (mesial or distal) when performed on posterior teeth or the incisal surface of anterior teeth.

(h) Does not pay for replacement restorations within a two-year period unless the restoration has an additional adjoining carious surface. The agency pays for the replacement restoration as one multisurface restoration ((~~per client, per provider or clinic~~)). The client's record must include X rays ((~~and~~)) or documentation supporting the medical necessity for the replacement restoration.

(3) **Additional limitations on restorations on primary teeth.** The agency covers:

(a) A maximum of two surfaces for a primary first molar. (See subsection (6) of this section for a primary first molar that requires a restoration with three or more surfaces.) The agency does not pay for additional restorations on the same tooth.

(b) A maximum of three surfaces for a primary second molar. (See subsection (6) of this section for a primary posterior tooth that requires a restoration with four or more surfaces.) The agency does not pay for additional restorations on the same tooth.

(c) A maximum of three surfaces for a primary anterior tooth. (See subsection (6) of this section for a primary anterior tooth that requires a restoration with four or more surfaces.) The agency does not pay for additional restorations on the same tooth after three surfaces.

(d) Glass ionomer restorations for primary teeth, only for clients age five ((~~years of age~~)) and younger. The agency pays for these restorations as a one-surface, resin-based composite restoration.

(4) **Additional limitations on restorations on permanent teeth.** The agency covers:

(a) Two occlusal restorations for the upper molars on teeth one, two, three, fourteen, fifteen, and sixteen if, the restorations are anatomically separated by sound tooth structure.

(b) A maximum of five surfaces per tooth for permanent posterior teeth, except for upper molars. The agency allows a maximum of six surfaces per tooth for teeth one, two, three, fourteen, fifteen, and sixteen.

(c) A maximum of six surfaces per tooth for resin-based composite restorations for permanent anterior teeth.

(5) **Crowns.** The agency:

(a) Covers the following indirect crowns once every five years, per tooth, for permanent anterior teeth for clients age fifteen (~~((to))~~) through twenty (~~((years of age))~~) when the crowns meet prior authorization criteria in WAC 182-535-1220 and the provider follows the prior authorization requirements in (c) of this subsection:

(i) Porcelain/ceramic crowns to include all porcelains, glasses, glass-ceramic, and porcelain fused to metal crowns; and

(ii) Resin crowns and resin metal crowns to include any resin-based composite, fiber, or ceramic reinforced polymer compound.

(b) Considers the following to be included in the payment for a crown:

(i) Tooth and soft tissue preparation;

(ii) Amalgam and resin-based composite restoration, or any other restorative material placed within six months of the crown preparation. Exception: The agency covers a one-surface restoration on an endodontically treated tooth, or a core buildup or cast post and core;

(iii) Temporaries, including but not limited to, temporary restoration, temporary crown, provisional crown, temporary prefabricated stainless steel crown, ion crown, or acrylic crown;

(iv) Packing cord placement and removal;

(v) Diagnostic or final impressions;

(vi) Crown seating (placement), including cementing and insulating bases;

(vii) Occlusal adjustment of crown or opposing tooth or teeth; and

(viii) Local anesthesia.

(c) Requires the provider to submit the following with each prior authorization request:

(i) Radiographs to assess all remaining teeth;

(ii) Documentation and identification of all missing teeth;

(iii) Caries diagnosis and treatment plan for all remaining teeth, including a caries control plan for clients with rampant caries;

(iv) Pre- and post-endodontic treatment radiographs for requests on endodontically treated teeth; and

(v) Documentation supporting a five-year prognosis that the client will retain the tooth or crown if the tooth is crowned.

(d) Requires a provider to bill for a crown only after delivery and seating of the crown, not at the impression date.

(6) **Other restorative services.** The agency covers the following restorative services:

(a) All recementations of permanent indirect crowns.

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

(i) For age((s)) twelve and younger without prior authorization if the tooth requires a four or more surface restoration; and

(ii) For age((s)) thirteen ((tø)) through twenty with prior authorization.

(c) Prefabricated stainless steel crowns, including stainless steel crowns with resin window, resin-based composite crowns (direct), prefabricated esthetic coated stainless steel crowns, and prefabricated resin crowns, for primary posterior teeth once every three years without prior authorization if:

(i) Decay involves three or more surfaces for a primary first molar;

(ii) Decay involves four or more surfaces for a primary second molar; or

(iii) The tooth had a pulpotomy.

(d) Prefabricated stainless steel crowns, including stainless steel crowns with resin window, and prefabricated resin crowns, for permanent posterior teeth excluding one, sixteen, seventeen, and thirty-two once every three years, for clients age twenty ((years-of-age)) and younger, without prior authorization.

(e) Prefabricated stainless steel crowns for clients of the developmental disabilities administration of the department of social and health services (DSHS) without prior authorization according to WAC 182-535-1099.

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

(g) Cast post and core or prefabricated post and core, only on permanent teeth, only for clients age twenty ((years-of-age)) and younger, and only when in conjunction with a crown and when prior authorized.

AMENDATORY SECTION (Amending WSR 14-08-032, filed 3/25/14, effective 4/30/14)

WAC 182-535-1088 Dental-related services—Covered—Periodontic services. Clients described in WAC 182-535-1060 are eligible to receive the dental-related periodontic services listed in this section, subject to coverage limitations, restrictions, and client-age requirements identified for a specified service.

(1) **Surgical periodontal services.** The medicaid agency covers the following surgical periodontal services, including all postoperative care:

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

(b) Gingivectomy/gingivoplasty (does not include distal wedge procedures on erupting molars) for clients of the developmental disa-

bilities administration of the department of social and health services (DSHS) according to WAC 182-535-1099.

(2) **Nonsurgical periodontal services.** The agency:

(a) Covers periodontal scaling and root planing for clients (~~(from)~~) age thirteen (~~(to)~~) through eighteen (~~(years of age)~~), once per quadrant per client, in a two-year period on a case-by-case basis, when prior authorized, and only when:

(i) The client has radiographic evidence of periodontal disease and subgingival calculus;

(ii) The client's record includes supporting documentation for the medical necessity, including complete periodontal charting and a definitive diagnosis of periodontal disease;

(iii) The client's clinical condition meets current published periodontal guidelines; and

(iv) Performed at least two years from the date of completion of periodontal scaling and root planing or surgical periodontal treatment, or at least twelve calendar months from the completion of periodontal maintenance.

(b) Covers periodontal scaling and root planing once per quadrant per client in a two-year period for clients age nineteen (~~(years of age)~~) and older. Criteria in (a)(i) through (iv) of this subsection must be met.

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

(d) 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.

(e) Covers periodontal scaling and root planing for clients of the developmental disabilities administration of DSHS according to WAC 182-535-1099.

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

(3) **Other periodontal services.** The agency:

(a) Covers periodontal maintenance for clients (~~(from)~~) age thirteen through eighteen (~~(years of age)~~) once per client in a twelve-month period on a case-by-case basis, when prior authorized, and only when:

(i) The client has radiographic evidence of periodontal disease;

(ii) 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;

(iii) The client's clinical condition meets current published periodontal guidelines; and

(iv) The client has had periodontal scaling and root planing but not within twelve months of the date of completion of periodontal scaling and root planing, or surgical periodontal treatment.

(b) Covers periodontal maintenance once per client in a twelve month period for clients age nineteen (~~(years of age)~~) and older. Criteria in (a)(i) through (iv) of this subsection must be met.

(c) Covers periodontal maintenance only if performed at least twelve calendar months after receiving prophylaxis, periodontal scaling and root planing, gingivectomy, or gingivoplasty.

(d) Covers periodontal maintenance for clients of the developmental disabilities administration of DSHS according to WAC 182-535-1099.

(e) Covers periodontal maintenance for clients residing in a nursing facility:

(i) Periodontal maintenance (four quadrants) substitutes for an eligible periodontal scaling or root planing once every six months.

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

AMENDATORY SECTION (Amending WSR 15-10-043, filed 4/29/15, effective 5/30/15)

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

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

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

(b) A dental record which identifies:

(i) All missing teeth for both arches;

(ii) Teeth that are to be extracted; and

(iii) Dental and periodontal services completed on all remaining teeth.

(2) **Complete dentures.** The agency covers complete dentures, including overdentures, when prior authorized.

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

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

(i) One initial maxillary complete denture and one initial mandibular complete denture per client, per the client's lifetime.

~~((A))~~ (ii) Replacement of a partial denture with a complete denture ~~((is covered:~~

~~(I) At least)) only when the replacement occurs three or more years after the seat date of the last resin partial denture((; or~~

~~(II) At least five years after the seat date of the last cast-metal partial denture)).~~

~~((ii))~~ (iii) One replacement maxillary complete denture and one replacement mandibular complete denture per client, per client's lifetime.

(b) The agency covers replacement of a complete denture or overdenture ((is covered)) only if prior authorized, and only when the replacement occurs at least five years after the seat date of the initial complete denture or overdenture.

(c) The provider must obtain a signed Denture Agreement of Acceptance (HCA 13-809) form from the client at the conclusion of the

final denture try-in and at the time of delivery for an agency-authorized complete denture. If the client abandons the complete denture after signing the agreement of acceptance, the agency will deny subsequent requests for the same type of dental prosthesis if the request occurs prior to the dates specified in this section. A copy of the signed agreement must be kept in the provider's files and be available upon request by the agency.

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

(a) ~~((A resin partial denture is covered))~~ For anterior and posterior teeth only when the following criteria are met:

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

(ii) The client has established caries control.

(iii) The client has one or more missing anterior teeth or four or more missing posterior teeth (excluding teeth one, two, fifteen, sixteen, seventeen, eighteen, thirty-one, and thirty-two). Pontics on an existing fixed bridge do not count as missing teeth. The agency does not consider closed spaces of missing teeth to qualify as a missing tooth.

(iv) There is a minimum of four stable teeth remaining per arch.

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

(b) Prior authorization is required ~~((for resin partial dentures))~~.

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

(d) Replacement of a resin-based partial denture with a new resin partial denture or a complete denture ~~((is covered))~~ if it occurs at least three years ~~((since))~~ after the seat date of the resin-based partial denture. The replacement denture must be prior authorized and meet agency coverage criteria in (a) of this subsection.

(e) 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.

(4) **Provider requirements.**

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

(b) The agency requires a provider to submit the following with a prior authorization request for a removable resin partial or complete denture for a client residing in an alternate living facility (ALF) as defined in WAC 182-513-1301 or in a nursing facility as defined in WAC 182-500-0075:

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

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

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

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

(v) A completed copy of the Denture/Partial Appliance Request for Skilled Nursing Facility Client (HCA 13-788) form available from the

agency's published billing instructions which can be downloaded from the agency's web site.

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

(d) The agency requires a provider to deliver services and procedures that are of acceptable quality to the agency. The agency may recoup payment for services that are determined to be below the standard of care or of an unacceptable product quality.

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

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

(b) Repairs:

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

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

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

(d) Up to two tissue conditionings, only for clients age twenty (~~(years of age)~~) and younger, and only when performed within three months after the delivery (placement) date.

(e) Laboratory fees, subject to the following:

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

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

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

(B) Moves from the state;

(C) Cannot be located;

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

(E) Dies.

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

AMENDATORY SECTION (Amending WSR 14-08-032, filed 3/25/14, effective 4/30/14)

WAC 182-535-1092 Dental-related services—Covered—Maxillofacial prosthetic services. Clients described in WAC 182-535-1060 are eligible to receive the maxillofacial prosthetic services listed in this section, subject to the following:

(1) Maxillofacial prosthetics are covered (~~only for clients twenty years of age and younger~~) on a case-by-case basis and when prior authorized; and

(2) The medicaid agency must preapprove a provider qualified to furnish maxillofacial prosthetics.

AMENDATORY SECTION (Amending WSR 15-10-043, filed 4/29/15, effective 5/30/15)

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

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

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

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

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

(i) Clients age eight (~~years of age~~) and younger;

(ii) Clients (~~from~~) age nine through twenty (~~years of age~~) only on a case-by-case basis and when the site-of-service is prior authorized by the agency; and

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

(d) For site-of-service and oral surgery CPT codes that require prior authorization, the agency requires the dental provider to submit:

(i) Documentation used to determine medical appropriateness;

(ii) Cephalometric films;

(iii) Radiographs (X rays);

(iv) Photographs; and

(v) Written narrative/letter of medical necessity.

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

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

(ii) Appropriate radiographs;

(iii) Medical justification with diagnosis;

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

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

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

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

(f) Covers routine and surgical extractions. Prior authorization is required when the:

(i) 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; or

(ii) Tooth number is not able to be determined.

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

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

(i) Covers surgical extraction of unerupted teeth for clients age twenty (~~(years of age)~~) and younger.

(j) Covers debridement of a granuloma or cyst that is five millimeters or greater in diameter. The agency includes debridement of a granuloma or cyst that is less than five millimeters as part of the global fee for the extraction.

(k) Covers the following without prior authorization:

(i) Biopsy of soft oral tissue;

(ii) Brush biopsy.

(l) Requires providers to keep all biopsy reports or findings in the client's dental record.

(m) Covers the following with prior authorization (photos or radiographs, as appropriate, must be submitted to the agency with the prior authorization request):

(i) Alveoloplasty on a case-by-case basis (~~(only when not performed in conjunction with extractions)~~).

(ii) Surgical excision of soft tissue lesions only on a case-by-case basis.

(iii) Only the following excisions of bone tissue in conjunction with placement of complete or partial dentures:

(A) Removal of lateral exostosis;

(B) Removal of torus palatinus or torus mandibularis; and

(C) Surgical reduction of osseous tuberosity.

(iv) Surgical access of unerupted teeth for clients age twenty (~~(years of age)~~) and younger.

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

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

(b) 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.

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

(d) Frenuloplasty/frenulectomy for clients (~~(from)~~) age seven (~~(to)~~) through twelve (~~(years of age)~~) only on a case-by-case basis and when prior authorized. Photos must be submitted to the agency with the prior authorization request. Documentation supporting the medical necessity for the service must be in the client's record.

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

(a) Occlusal orthotic devices for clients (~~(from)~~) age twelve through twenty (~~(years of age)~~) only on a case-by-case basis and when prior authorized.

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

AMENDATORY SECTION (Amending WSR 15-10-043, filed 4/29/15, effective 5/30/15)

WAC 182-535-1098 Dental-related services—Covered—Adjunctive general services. Clients described in WAC 182-535-1060 are eligible to receive the adjunctive general services listed in this section, subject to coverage limitations, restrictions, and client-age requirements identified for a specific service.

(1) **Adjunctive general services.** The medicaid agency:

(a) Covers palliative (emergency) treatment, not to include pupal debridement (see WAC 182-535-1086 (2)(b)), for treatment of dental pain, limited to once per day, per client, as follows:

(i) The treatment must occur during limited evaluation appointments;

(ii) A comprehensive description of the diagnosis and services provided must be documented in the client's record; and

(iii) Appropriate radiographs must be in the client's record supporting the medical necessity of the treatment.

(b) Covers local anesthesia and regional blocks as part of the global fee for any procedure being provided to clients.

(c) Covers office-based (~~oral or parenteral conscious sedation, deep sedation, or general anesthesia, as follows~~) deep sedation/general anesthesia services:

(i) (~~The provider's current anesthesia permit must be on file with the agency.~~

~~(ii))~~ For all eligible clients age eight (~~(years of age)~~) and younger(~~(7)~~) and (~~(for)~~) clients any age of the developmental disabilities administration of the department of social and health services (DSHS)(~~(7)~~). Documentation supporting the medical necessity of the anesthesia service must be in the client's record.

~~((iii))~~ (ii) For clients age nine (~~(years of age to)~~) through twenty (~~(years of age, deep sedation or general anesthesia services are covered)~~) on a case-by-case basis and when prior authorized, except for oral surgery services. For oral surgery services listed in WAC 182-535-1094 (1)(~~(b)~~) (f) through (m) and clients with cleft palate diagnoses, deep sedation ((or)) general anesthesia services do not require prior authorization.

~~((iv) Prior authorization is not required for oral or parenteral conscious sedation)~~ (iii) For clients age twenty-one and older when prior authorized. The agency considers these services for only those clients:

(A) With medical conditions such as tremors, seizures, or asthma;

(B) Whose files contain documentation of tried and failed treatment under local anesthesia or other less costly sedation alternatives due to behavioral health conditions; or

(C) With other conditions for which general anesthesia is medically necessary, as defined in WAC 182-500-0070.

(d) Covers office-based intravenous moderate (conscious) sedation/analgesia:

(i) For any dental service for clients age twenty ((years of age)) and younger, and for clients any age of the developmental disabilities administration of DSHS. Documentation supporting the medical necessity of the service must be in the client's record.

~~((v))~~ For clients from nine to twenty years of age who have a diagnosis of oral facial cleft, the agency does not require prior authorization for deep sedation or general anesthesia services when the dental procedure is directly related to the oral facial cleft treatment.

~~(vi)~~ A)) (ii) For clients age twenty-one and older when prior authorized. The agency considers these services for only those clients:

(A) With medical conditions such as tremors, seizures, or asthma;

(B) Whose files contain documentation of tried and failed treatment under local anesthesia, or other less costly sedation alternatives due to behavioral health conditions; or

(C) With other conditions for which general anesthesia or conscious sedation is medically necessary, as defined in WAC 182-500-0070.

(e) Covers office-based nonintravenous conscious sedation:

(i) For any dental service for clients age twenty and younger, and for clients any age of the developmental disabilities administration of DSHS. Documentation supporting the medical necessity of the service must be in the client's record.

(ii) For clients age twenty-one and older, only when prior authorized.

(f) Requires providers ((must)) to bill anesthesia services using the current dental terminology(CDT) codes listed in the agency's current published billing instructions.

~~((vii))~~ For clients twenty one years of age and older, prior authorization is required for general anesthesia and 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.

~~(d))~~ (g) Requires providers to have a current anesthesia permit on file with the agency.

(h) Covers administration of nitrous oxide, once per day.

~~((e))~~ (i) Requires providers of oral or parenteral conscious sedation, deep sedation, or general anesthesia to meet:

(i) The prevailing standard of care;

(ii) The provider's professional organizational guidelines;

(iii) The requirements in chapter 246-817 WAC; and

(iv) Relevant department of health (DOH) medical, dental, or nursing anesthesia regulations.

~~((f))~~ (j) Pays for dental anesthesia services according to WAC 182-535-1350.

~~((g))~~ (k) Covers professional consultation/diagnostic services as follows:

(i) A dentist or a physician other than the practitioner providing treatment must provide the services; and

(ii) A client must be referred by the agency for the services to be covered.

(2) **Professional visits.** The agency covers:

(a) Up to two house/extended care facility calls (visits) per facility, per provider. The agency limits payment to two facilities per day, per provider.

(b) One hospital visit, including emergency care, per day, per provider, per client, and not in combination with a surgical code unless the decision for surgery is a result of the visit.

(c) Emergency office visits after regularly scheduled hours. The agency limits payment to one emergency visit per day, per client, per provider.

(3) **Drugs and medicaments (pharmaceuticals).** (~~The agency covers drugs and medicaments, such as antibiotics, steroids, anti-inflammatories, or other therapeutic medications for clients twenty years of age and younger. The agency's dental program does not pay for oral sedation medications.~~)

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

(b) The agency covers therapeutic parenteral drugs as follows:

(i) Includes antibiotics, steroids, anti-inflammatory drugs, or other therapeutic medications. This does not include sedative, anesthetic, or reversal agents.

(ii) Only one single-drug injection or one multiple-drug injection per date of service.

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

(4) **Miscellaneous services.** The agency covers:

(a) Behavior management (~~when~~) provided in dental offices or dental clinics. Documentation supporting the need for behavior management (~~is~~) must be in the client's record. Behavior management is for the following clients whose documented behavior requires the assistance of one additional professional (~~dental~~) staff employed by the billing provider to protect the client and the professional staff from injury while treatment is rendered(-):

(i) Clients age eight (~~years of age~~) and younger;

(ii) Clients (~~from~~) age nine through twenty (~~years of age~~), only on a case-by-case basis and when prior authorized;

(iii) Clients any age of the developmental disabilities administration of DSHS;

(iv) Clients diagnosed with autism; and

(v) Clients who reside in an alternate living facility (ALF) as defined in WAC 182-513-1301, or in a nursing facility as defined in WAC 182-500-0075.

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

(c) Occlusal guards when medically necessary and prior authorized. (Refer to WAC 182-535-1094(3) for occlusal orthotic device coverage and coverage limitations.) The agency covers:

(i) An occlusal guard only for clients (~~from~~) age twelve through twenty (~~years of age~~) when the client has permanent dentition; and

(ii) An occlusal guard only as a laboratory processed full arch appliance.

WAC 182-535-1099 Dental-related services for clients of the developmental disabilities administration of the department of social and health services. Subject to coverage limitations(~~(,)~~) and restrictions(~~(, and client age requirements)~~) identified for a specific service, the medicaid agency pays for the additional dental-related services listed (~~(under the categories of services)~~) in this section that are provided to clients of the developmental disabilities administration of the department of social and health services (DSHS)(~~(. This chapter also applies to clients any age of the developmental disabilities administration of DSHS, unless otherwise stated in this section)~~), regardless of age.

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

(a) Periodic oral evaluations(~~(. The agency covers periodic oral evaluations up to three times in a twelve month period)~~) once every four months per client, per provider.

(b) Dental prophylaxis(~~(. The agency covers dental prophylaxis~~) once every four months.

(c) Periodontal maintenance (~~(up to three times in a twelve month period)~~) once every six months (see subsection (3) of this section for limitations on periodontal scaling and root planing).

(~~(e)~~) (d) Topical (~~(fluoride treatment. The agency covers topi-~~ cal) fluoride varnish, rinse, foam or gel, (~~(up to three times within a twelve month period)~~) once every four months, per client, per provider or clinic.

(~~(d)~~) (e) Sealants(~~(. The agency covers sealants)~~):

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

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

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

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

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

(a) All recementations of permanent indirect crowns.

(b) Prefabricated stainless steel crowns, including stainless steel crowns with resin window, resin-based composite crowns (direct), prefabricated esthetic coated stainless steel crowns, and prefabricated resin crowns for primary anterior teeth once every two years only for clients age twenty (~~(years of age)~~) and younger without prior authorization.

(c) Prefabricated stainless steel crowns, including stainless steel crowns with resin window, resin-based composite crowns (direct), prefabricated esthetic coated stainless steel crowns, and prefabricated resin crowns for primary posterior teeth once every two years for clients age twenty (~~(years of age)~~) and younger without prior authorization if:

(i) Decay involves three or more surfaces for a primary first molar;

(ii) Decay involves four or more surfaces for a primary second molar; or

(iii) The tooth had a pulpotomy.

(d) Prefabricated stainless steel crowns, including stainless steel crowns with resin window, and prefabricated resin crowns for

permanent posterior teeth excluding one, sixteen, seventeen, and thirty-two once every two years without prior authorization for any age.

(3) **Periodontic services.**

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

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

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

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

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

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

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

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

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

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

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

(a) Oral parenteral conscious sedation, deep sedation, or general anesthesia for any dental services performed in a dental office or clinic. Documentation supporting the medical necessity must be in the client's record.

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

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

(6) **Miscellaneous services - Behavior management.** The agency covers behavior management provided in dental offices or dental clinics. Documentation supporting the medical necessity of the service must be included in the client's record.

AMENDATORY SECTION (Amending WSR 14-08-032, filed 3/25/14, effective 4/30/14)

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

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

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

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

(b) Study models;

(c) Photographs; and

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

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

(5) When the agency authorizes a dental-related service for a client, that authorization indicates only that the specific service is medically necessary; it is not a guarantee of payment. The authorization is valid for six to twelve months as indicated in the agency's authorization letter and only if the client is eligible for covered services on the date of service.

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

(a) Is covered by another agency program;

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

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