

Medicaid Purchasing Administration



Dental Program For Clients Age 21 and Older Billing Instructions

Chapter 388-535 WAC

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About this Publication

This publication supersedes all previous Department/Medicaid Purchasing Administration (MPA) Dental Billing Instructions and Numbered Memoranda and is published by the Washington State Department of Social and Health Services, Medicaid Purchasing Administration

Note: The Department now reissues the entire billing manual when making updates, rather than just a page or section. The effective date and revision history are now at the front of the manual. This makes it easier to find the effective date and version history of the manual.

Effective Date

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Fee Schedules

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

How Can I Get Department/MPA Provider Documents?

To download and print Department/MPA provider numbered memos and billing instructions, go to the Department/MPA website at <http://hrsa.dshs.wa.gov> (click the *Billing Instructions and Numbered Memorandum* link).

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Important Contacts

Note: This section contains important contact information relevant to the Dental Program for Clients Age 21 and Older. For more contact information, see the Department/**MPA** *Resources Available* web page at:
http://hrsa.dshs.wa.gov/Download/Resources_Available.html

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

Definitions & Abbreviations

This section contains definitions of words and phrases that the Department of Social and Health Services (the Department) uses in these billing instructions. The Department also used dental definitions found in the current American Dental Association's Current Dental Terminology and the current American Medical Association's Physician's Current Procedural Terminology.

Where there is any discrepancy between the current CDT or CPT and this section, this section prevails.

Please refer to the Department/MPA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for a more complete list of definitions.

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

Alternative Living Facility (ALF) – Refer to WAC 388-513-1301.

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

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

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.

Asymptomatic – Having or producing no symptoms.

Authorization Number - A nine-digit number, assigned by the **Medicaid Purchasing Administration (MPA)** that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pended, or denied.

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

Behavior Management – Using the assistance of one additional dental professional staff to manage the behavior of a client to facilitate the delivery of dental treatment.

Benefit Service Package - A grouping of benefits or services applicable to a client or group of clients.

Border Areas - Refer to WAC 388-501-175.

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

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.

Conscious Sedation - A drug-induced depression of consciousness during which clients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, spontaneous ventilation is adequate, and cardiovascular function is maintained.

Core Build-up – Refers to building up of clinical crowns, including pins.

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

Coronal Polishing – A mechanical procedure limited to the removal of plaque and stain from exposed tooth surfaces.

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

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

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

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

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

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

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

Endodontic – The etiology, diagnosis, prevention, and treatment of diseases and injuries of the pulp and associated periradicular conditions.

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

Federally Qualified Health Center (FQHC) - A facility that is: 1) receiving grants under section 330 of the Public Health Services Act; OR 2) receiving such grants based on the recommendation of the Health Resources and Services Administration within the Public Health Service, as determined by the Secretary to meet the requirements for receiving such a grant, OR 3) a tribe or tribal organization operating outpatient health programs or facilities under the Indian Self Determination Act (PL93-638). Only Health Care Financing Administration designated FQHCs will be allowed to participate in the program.

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.

High Noble Metal – A dental alloy containing at least 60% pure gold.

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

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

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

Major Bone Grafts – A transplant of solid bone tissue(s).

Medical Identification card(s) – See *Services Card*.

Medically Necessary - See WAC 388-500-0005.

Minor Bone Grafts – A transplant of nonsolid bone tissue(s), such as powdered bone, buttons, or plugs.

National Provider Identifier (NPI) – A federal system for uniquely identifying all providers of health care services, supplies, and equipment.

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

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

Oral Prophylaxis – The dental procedure of scaling and polishing that includes removal of calculus, plaque, and stains from teeth.

Partials or Partial Dentures – A removable prosthetic appliance that replaces missing teeth in one arch

Patient Identification Code (PIC) – See ProviderOne Client ID.

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

Periodontal Maintenance – A procedure performed for clients who have previously 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.

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

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

Posterior – The maxillary and mandibular premolars and molars and tissue towards the back of the mouth.

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

Primary – The first set of teeth.

ProviderOne – Department of Social and Health Services (the Department) primary provider payment processing system.

ProviderOne Client ID- A system-assigned number that uniquely identifies a single client within the ProviderOne system; the number consists of nine numeric characters followed by WA.

For example: 123456789WA.

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

Radiographs – an image or picture produced on a radiation sensitive film emulsion or digital sensor by exposure to ionizing radiation. Also known as X-ray.

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.

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.

Rural Health Clinic (RHC) – See *Rural Health Clinic Billing Instructions*.

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

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

Services Card – A plastic “swipe” card that the Department issues to each client on a “one- time basis.” Providers have the option to acquire and use swipe card technology as one method to access up-to-date client eligibility information.

- The Services Card replaces the paper Medical Assistance ID Card that was mailed to clients on a monthly basis.
- The Services Card will be issued when ProviderOne becomes operational.
- The Services Card displays only the client’s name and ProviderOne Client ID number.
- The Services Card does not display the eligibility type, coverage dates, or managed care plans.
- The Services Card does not guarantee eligibility. Providers are responsible to verify client identification and complete an eligibility inquiry.

Simple Extraction – The routine removal of tooth structure, minor smoothing of socket bone and closure, as necessary.

Spenddown – The amount of excess income the Department has determined that a client has available to meet his or her medical expenses. The client becomes eligible for Medicaid coverage only after he or she meets the spenddown requirements.

Standard of Care – What reasonable and prudent practitioners would do in the same or similar circumstances.

Surgical Extraction – See definitions of dental procedures in the current CDT manual.

Symptomatic – Having symptoms (e.g., pain, swelling, and infection).

Temporomandibular Joint Dysfunction (TMJ/TMD) – An abnormal functioning of the temporomandibular joint or other areas secondary to the dysfunction.

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

Transaction Control Number (TCN) - A unique field value that identifies a claim transaction assigned by ProviderOne.

Usual and Customary – The fee that the provider usually charges non-Medicaid customers for the same service or item. This is the maximum amount that the provider may bill the Department.

Wisdom Teeth – The third molars, teeth 1, 16, 17, and 32.

Xerostomia – A dryness of the mouth due to decreased saliva.

About the Program

What Is the Purpose of the Dental Program for Clients Age 21 and Older?

The purpose of the Dental Program is to provide quality dental and dental-related services to eligible clients age 21 and older.

Becoming a Department Dental Provider [Refer to WAC 388-535-1070]

The following providers are eligible to enroll with the Department of Social and Health Services (the Department) 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:
 - Oral surgery procedures; or
 - Providing fluoride varnish under EPSDT.
 - ✓ Practice as a dental hygienist;
 - ✓ Practice as a denturist; or
 - ✓ Practice anesthesia according to Department of Health (DOH) regulations.
- Facilities that are:
 - ✓ Hospitals currently licensed by the Department of Health;
 - ✓ Federally-qualified health centers (FQHCs);
 - ✓ Medicare-certified ambulatory surgery centers (ASCs);
 - ✓ Medicare-certified rural health clinics (RHCs); or
 - ✓ Community health centers (CHC).
- Participating local health jurisdictions; and
- Border area or out-of-state providers of dental-related services who are qualified in their states to provide these services.

Note: The Department pays licensed providers participating in the Department dental program for only those services that are within their scope of practice.
[WAC 388-535-1070(2)]

Client Eligibility

Who Is Eligible? [Refer to WAC 388-535-1060]

Please see the Department/MPA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Note: Refer to the *Scope of Coverage Chart* web page at: <http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html> for an up-to-date listing of Benefit Service Packages.

Are Clients Enrolled in a Department Managed Care Plan Eligible? [Refer to WAC 388-535-1060(4)]

Yes! Clients who are enrolled in a Department managed care plan are eligible for Department-covered dental services that are not covered by their plan, under fee-for-service.

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

All medical services covered under a managed care plan must be obtained by the client through designated facilities or providers. The managed care plan is responsible for:

- Payment of covered services; and
- Payment of services referred by a provider participating with the plan to an outside provider.

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

Coverage

When Does the Department Pay for Covered Dental-Related Services for Clients 21 and Older? [Refer to WAC 388-535-1247]

- Subject to coverage limitations, the Department pays for dental-related services and procedures provided to clients age 21 and older when the services and procedures:
 - ✓ Are within the scope of an eligible client's medical care program;
 - ✓ Are medically necessary;
 - ✓ Meet the Department's prior authorization requirements, if any;
 - ✓ Are within prevailing standard of care accepted dental or medical practice standards;
 - ✓ Are consistent with a diagnosis of dental disease or condition;
 - ✓ Are reasonable in amount and duration of care, treatment, or service; and
 - ✓ Are listed as covered in these billing instructions (see *Coverage* section).
- Clients who are eligible for services through the Division of Developmental Disabilities (DDD) may receive dental-related services according to Section D.
- The Department evaluates a request for dental-related services that are:
 - ✓ In excess of the dental program's limitations or restrictions, according to WAC 388-501-0169; and
 - ✓ Listed as noncovered, according to WAC 388-501-0160.

Coverage under the **Disability Lifeline** and ADATSA Programs [Refer to WAC 388-535-1065]

- Clients who receive medical care services under the following programs may receive the dental-related services described in the *Coverage* section of these billing instructions:
 - ✓ **Disability Lifeline**; and
 - ✓ Alcohol and Drug Abuse Treatment and Support Act (ADATSA).
- The Department covers the following dental-related services under the **Disability Lifeline** or ADATSA program:
 - ✓ Services provided only as part of dental treatment for:
 - Limited oral evaluation;
 - Periapical or bite-wing radiographs (x-rays) that are medically necessary to diagnose only the client's chief complaint;
 - Pulpal debridement to relieve dental pain; or
 - Endodontic (root canal only) treatment for maxillary and mandibular anterior teeth (cuspids and incisors) when prior authorized.
 - ✓ Tooth extraction when at least one of the following apply:
 - The tooth has a radiographic apical lesion;
 - The tooth is endodontically involved, infected, or abscessed;
 - The tooth is not restorable; or
 - The tooth is not periodontally stable.
- Tooth extractions require prior authorization (PA) when:
 - ✓ The extraction of a tooth or teeth results in the client becoming edentulous in the maxillary arch or mandibular arch; and
 - ✓ 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 Chapter 388-535 WAC for clients age 21 and older.
- The Department does not cover any dental-related services not listed in the *Coverage* section of these billing instructions for clients eligible to receive services under the **Disability Lifeline** or ADATSA program, including any type of removable dental prosthesis.

Disability Lifeline Covered Procedure Codes

Code	Description	PA?	Requirements/ Limitations	Maximum Allowable Fee
D0140	limited oral evaluation – problem focused	N		On-line Fee Schedules
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	anterior (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 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	
D7250	surgical removal of residual tooth roots (cutting procedure)	N	Tooth designation required	

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

- **Dental Providers**

- ✓ The Department requires PA for non-emergency dental services performed in a hospital and dental services performed in an ASC for clients age 9 and older (except for clients of the division of developmental disabilities according to WAC 388-543-1099).
- ✓ The place of service (POS) on the submitted claim form **must** match the setting where the service is performed. The Department may audit claims with an incorrect POS and payment may be recouped.
- ✓ The dentist providing the service must send in a request for authorization to perform the procedure in this setting. The request must:

- Contain all procedure codes, including procedure codes that require PA according to these billing instructions;

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

- Be on the appropriate claim form(s) for the services requested; and
- 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 Department requires providers to report dental services, including oral and maxillofacial surgeries, using CDT codes.

Exception: Oral surgeons may use CPT codes **listed in the Department's Dental Program Fee Schedule** *only* when the procedure performed is not listed as a covered CDT code in the Department's published Dental Program Fee Schedule. CPT codes must be billed on an 837P/CMS-1500 claim form.

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- **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 Department's Dental Program Fee Schedule.
- ✓ ASCs are paid only for the codes listed in the Department/**MPA** *Ambulatory Surgery Centers Billing Instructions*.
- ✓ The Department considers anesthesia to be included in the payment made to the facility. The Department does not pay separately when a facility bills CDT code D9220/D9221 or D9241/D9242.
- ✓ 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.
- ✓ Hospitals and ASCs may only use procedure code 41899 when there is no existing national code that describes the services being provided. The Department considers this code *only* when the performing dentist submits a PA request with justification explaining that there is no existing national code describing the services being provided.
- ✓ The place of service (POS) on the submitted claim form must match the setting being requested:

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

What Diagnostic Services Are Covered? [Refer to WAC 388-535-1255]

The Department covers only the dental-related diagnostic services listed in this section for clients age 21 and older.

Clinical Oral Evaluations

What Is Covered?

The Department covers:

- Oral health evaluations and assessments. The services must be documented in the client's record in accordance with Chapter 388-502 WAC.
- Periodic oral evaluations, once every 12 months. 12 months must elapse between the comprehensive oral evaluation and the first periodic oral evaluation.
- Limited oral evaluations, only when the provider performing the limited oral evaluation is not providing routine scheduled dental services for the client. The limited oral evaluation:
 - ✓ Must be to evaluate the client for a:
 - Specific dental problem or oral health complaint;
 - Dental emergency; or
 - Referral for other treatment.
 - ✓ When performed by a dentist, is limited to the initial examination appointment. The Department does not cover an additional limited examination by a dentist for the same client until three months after the removable dental prosthesis has been seated.
- Comprehensive oral evaluations, once per client, per provider or clinic, as an initial examination that must include:
 - ✓ A complete dental and medical history and a general health assessment;
 - ✓ A complete thorough evaluation of extra-oral and intra-oral hard and soft tissue; and
 - ✓ The evaluation and recording of dental caries, missing or erupted teeth, restoration, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, and oral cancer screening.

Note: The Department does **not** pay separately for chart or record set-up. The fees for these services are included in the Department's reimbursement for Comprehensive Oral Evaluations.

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

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

Limited Visual Oral Assessment

What Is Covered?

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

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

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

Radiographs (X-rays)

What Is Covered?

Note: The Department uses the prevailing standard of care to determine the need for dental radiographs.

The Department covers:

- Radiographs that are of diagnostic quality (clearly confirms the condition), dated, and labeled with the client's name. The Department requires original radiographs to be retained by the provider as part of the client's dental record, and duplicate radiographs to be submitted with prior authorization requests or when copies of dental records are requested.
- An intraoral complete series (includes four bitewings), once in a three-year period only if the Department has not paid for a panoramic radiograph for the same client in the same three-year period.
- Periapical radiographs that are not included in a complete series. Documentation supporting the medical necessity for these must be included in the client's record.
- A maximum of four bitewing radiographs every 12 months.
- Panoramic radiographs in conjunction with four bitewings, once in a three-year period, only if the Department has not paid for an intraoral complete series for the same client in the same three-year period.

Note: The Department may cover panoramic radiographs for preoperative or postoperative surgery cases more than once in a three-year period, only on a case-by-case basis and when prior authorized. Emergency treatment may be billed without PA. Indicate “Emergency” in the *Remarks* field on the ADA claim form.

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

Code	Description	PA?	Maximum Allowable Fee
D0210	intraoral – complete series (including bitewings)	N	On-line Fee Schedules
D0220	intraoral – periapical first film	N	
D0230	intraoral – periapical each additional film	N	
D0270	bitewing – single film	N	
D0272	bitewings – two films	N	
D0273	bitewings – three films	N	
D0274	bitewings – four films	N	
D0330	panoramic film	N	

What Preventive Services Are Covered? [Refer to WAC 388-535-1257]

The Department covers only the dental-related preventive services listed in this section for clients age 21 and older.

Dental Prophylaxis

What Is Covered?

The Department covers prophylaxis:

- Which includes scaling and polishing procedures to remove coronal plaque, calculus, and stains once every 12 months.
- When the service is performed 12 months after periodontal scaling and root planing or periodontal maintenance services.
- Only when not performed on the same date of service as periodontal scaling and root planing, periodontal maintenance, gingivectomy or gingivoplasty.
- For clients of the Division of Developmental Disabilities (DDD) according to Section D.

Code	Description	PA?	Maximum Allowable Fee
D1110	prophylaxis – adult	N	On-line Fee Schedules

Topical Fluoride Treatment

What Is Covered?

The Department covers:

- Fluoride rinse, foam, or gel once within a 12-month period per client, per provider or clinic.
- Fluoride varnish, rinse, foam, or gel up to three times within a 12-month period per client, per provider or clinic for clients who are age 65 and older or clients who reside in alternative living facilities. If client resides in an alternate living facility, indicate “client resides in an alternate living facility” on the claim.
- Additional topical fluoride applications only on a case-by-case basis and when prior authorized.
- Topical fluoride treatment for clients of DDD according to Section D.

Code	Description	PA?	Maximum Allowable Fee
D1204	topical application of fluoride (prophylaxis not included) – adult	N	On-line Fee Schedules

What Restorative Services Are Covered? [Refer to WAC 388-535-1259]

The Department covers only the dental-related restorative services listed in this section for clients age 21 and older.

For clients of DDD, refer to Section D.

Amalgam Restorations for Permanent Teeth

What Is Covered?

The Department covers:

- Two occlusal amalgam restorations for teeth 1, 2, 3, 14, 15, and 16, if the restorations are anatomically separated by sound tooth structure.
- Amalgam restorations for a maximum of five surfaces per tooth for a permanent posterior tooth, once per client, per provider or clinic, in a two-year period.
- Amalgam restorations for a maximum of six surfaces per tooth for teeth 1, 2, 3, 14, 15, and 16, once per client, per provider or clinic, in a two-year period.

Coverage Limitations

The Department considers:

- Tooth preparation, all adhesives (including amalgam bonding agents), liners, bases, and polishing as part of the amalgam restoration.
- The occlusal adjustment of either the restored tooth or the opposing tooth or teeth as part of the amalgam restoration.
- Buccal or lingual surface amalgam restorations, regardless of size or extension, as a one surface restoration. The Department covers one buccal and one lingual surface per tooth.
- Multiple amalgam restorations of fissures and grooves of the occlusal surface of the same tooth as a one surface restoration.

What Is Not Covered?

The Department does not pay for replacement of an amalgam restoration by the same provider on a permanent posterior tooth within a two-year period unless the restoration has an additional adjoining carious surface. The Department pays for the replacement restoration as one multi-surface restoration. The client’s record must include radiographs and documentation supporting the medical necessity for the replacement restoration.

Code	Description	PA?	Maximum Allowable Fee
D2140	amalgam – one surface, primary or permanent	N	On-line Fee Schedules
D2150	amalgam – two surfaces, primary or permanent	N	
D2160	amalgam – three surfaces, primary or permanent	N	
D2161	amalgam – four or more surfaces, primary or permanent	N	

Resin-Based Composite Restorations for Permanent Teeth

What Is Covered?

The Department covers:

- Two occlusal resin-based restorations for teeth 1, 2, 3, 14, 15, and 16, if the restorations are anatomically separated by sound tooth structure.
- Resin-based restorations for a maximum of five surfaces per tooth for a permanent posterior tooth, once per client, per provider or clinic, in a two-year period.
- Resin-based composite restorations for a maximum of six surfaces per tooth for teeth 1, 2, 3, 14, 15, and 16, once per client, per provider or clinic, in a two-year period.
- Resin-based composite restorations for a maximum of five surfaces per tooth for a permanent posterior tooth, once per client, per provider or clinic, in a two-year period.

Coverage Limitations

The Department considers:

- Tooth preparation, acid etching, all adhesives (including resin bonding agents), liners and bases, polishing, and curing as part of the resin-based composite restoration.
- The occlusal adjustment of either the restored tooth or the opposing tooth or teeth as part of the resin-based composite restoration.

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- Buccal or lingual surface resin-based composite restorations, regardless of size or extension, as a one surface restoration. The Department covers only one buccal and one lingual surface per tooth.
- Resin-based composite restorations of teeth where the decay does not penetrate the DEJ, to be sealants.
- Multiple preventive restorative resins, flowable composite resins, or resin-based composites for the occlusal, buccal, lingual, mesial, and distal fissures and grooves on the same tooth as a one surface restoration.

What Is Not Covered?

- The Department does not cover preventive restorative resins or flowable composite resins on the interproximal surfaces (mesial and/or distal) of posterior teeth or the incisal surface of anterior teeth.
- The Department does not cover sealants for clients age 21 and older. Except for clients of DDD, refer to section D (please wordsmith)
- The Department does not pay for replacement of resin-based composite restorations by the same provider on permanent teeth within a two-year period unless the restoration has an additional adjoining carious surface. The Department pays for the replacement restoration as one multi-surface restoration. The client's record must include radiographs and documentation supporting the medical necessity for the replacement restoration.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D2330	resin-based composite – one surface, anterior	N	Tooth and surface designations required	<u>On-line Fee Schedules</u>
D2331	resin-based composite – two surfaces, anterior	N	Tooth and surface designations required	
D2332	resin-based composite – three surfaces, anterior	N	Tooth and surface designations required	
D2335	resin-based composite – four or more surfaces or involving incisal angle (anterior)	N	Tooth and surface designations required	
D2391	resin-based composite – one surface, posterior	N	Tooth and surface designations required	

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Code	Description	PA?	Requirements	Maximum Allowable Fee
D2392	resin-based composite – two surfaces, posterior	N	Tooth and surface designations required	On-line Fee Schedules
D2393	resin-based composite – three surfaces, posterior	N	Tooth and surface designations required	
D2394	resin-based composite – four or more surfaces, posterior	N	Tooth and surface designations required	

Crowns

The Department covers crowns for clients of DDD according to Section D.

Note: The Department does not cover permanent crowns for clients of any age. Radiograph justification is required.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D2931	prefabricated stainless steel crown – permanent tooth	N	Tooth designation required	On-line Fee Schedules

What Endodontic Services Are Covered? [Refer to WAC 388-535-1261]

The Department covers only the dental-related endodontic services listed in this section for clients age 21 and older. For dental-related services provided to clients of the Division of Developmental Disabilities (DDD), see Section D.

Pulp Capping

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

Pulp Debridement

The Department covers pulpal debridement on permanent teeth only, excluding teeth 1, 16, 17, and 32. The Department does not pay for pulpal debridement when performed on the same day as endodontic treatment.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D3221	pulpal debridement, permanent teeth	N	Tooth designation required	On-line Fee Schedules

Endodontic Treatment on Permanent Anterior Teeth

The Department:

- Covers endodontic treatment for permanent **anterior teeth** only.
- Considers the following included in endodontic treatment:
 - ✓ Pulpectomy when part of root canal therapy;
 - ✓ All procedures necessary to complete treatment; and
 - ✓ All intra-operative and final evaluation radiographs for the endodontic procedure.
- Pays separately for the following services that are related to the endodontic treatment:
 - ✓ Initial diagnostic evaluation;
 - ✓ Initial diagnostic radiographs; and
 - ✓ Post treatment evaluation radiographs if taken at least three months after treatment.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D3310	anterior (excluding final restoration)	N	Tooth designation required	On-line Fee Schedules

What Periodontic Services Are Covered? [Refer to WAC 388-535-1263]

The Department covers only the dental-related periodontic services listed in this section for clients age 21 and older.

Surgical Periodontal Services

The Department covers surgical periodontal services, including all postoperative care for clients of DDD according to Section D.

Nonsurgical Periodontal Services

The Department:

- Covers periodontal scaling and root planing for the number of teeth scaled that are periodontically involved once per quadrant, per client in a two-year period when:
 - ✓ The client has radiographic evidence of periodontal disease;
 - ✓ The client's record includes supporting documentation for the medical necessity of the service, including complete periodontal charting and a definitive diagnosis of periodontal disease;
 - ✓ The client's clinical condition meets current published periodontal guidelines; and
 - ✓ Performed at least two years from the date of completion of periodontal scaling and root planing or surgical periodontal treatment.
- Considers ultrasonic scaling, gross scaling, or gross debridement to be included in the procedure and not a substitution for periodontal scaling and root planing.
- Covers periodontal scaling and root planing only when the services are not performed on the same date of service as prophylaxis, periodontal maintenance, gingivectomy, or gingivoplasty.
- Covers periodontal scaling and root planing for clients of DDD according to Section D.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D4341	periodontal scaling and root planing – four or more teeth per quadrant	N	Quadrant designation required	On-line Fee Schedules
D4342	periodontal scaling and root planing – one to three teeth per quadrant	N	Quadrant designation required	

Periodontal Maintenance

The Department:

- Covers periodontal maintenance once per client in a 12-month period when:
 - ✓ The client has radiographic evidence of periodontal disease;
 - ✓ The client's record includes supporting documentation for the medical necessity, including complete periodontal charting and a definitive diagnosis of periodontal disease;
 - ✓ The client's clinical condition meets current published periodontal guidelines; and
 - ✓ Performed at least 12 months from the date of completion of periodontal scaling and root planing, or surgical periodontal treatment.
- Covers periodontal maintenance only if performed on a different date of service as prophylaxis, periodontal scaling and root planing, gingivectomy, or gingivoplasty.
- Covers periodontal maintenance for clients of DDD according to Section D.

Code	Description	PA?	Maximum Allowable Fee
D4910	periodontal maintenance	N	On-line Fee Schedules

What Removable Prosthodontic Services Are Covered?

[Refer to WAC 388-535-1266]

The Department covers only the dental-related removable prosthodontic services listed in this section for clients age 21 and older. For dental-related services provided to clients of the Division of Developmental Disabilities (DDD), see Section D.

Prior Authorization

The Department requires PA for all removable prosthodontics and prosthodontic-related procedures listed in this section. PA requests must meet the criteria in the *Prior Authorization* section of these billing instructions.

In addition, the Department requires the dental provider to submit:

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

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

The Department requires a provider to:

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

Complete Dentures

The Department covers a complete denture **or overdenture**, as follows:

- The Department covers an initial complete denture or overdenture for a client only when prior authorized and the complete denture or overdenture meets Department coverage criteria;
- Post-delivery care (e.g., adjustments, soft relines, and repairs) provided within three months of the seat date of the complete denture, is considered part of the complete denture procedure and is not paid separately; and
- The Department pays for a replacement complete denture or overdenture only when the replacement occurs at least five years from the seat date of the previous complete denture or overdenture paid for by the Department. The replacement denture must be prior authorized; and
- The Department limits payment for complete dentures to 2 maxillary complete dentures and 2 mandibular complete dentures per a client's lifetime.

Code	Description	PA?	Maximum Allowable Fee
D5110	complete denture – maxillary	Y	On-line Fee Schedules
D5120	complete denture – mandibular	Y	

The Department requires the “Agreement of Acceptance” form for all complete dentures (CDT codes D5110 and D5120). Complete this form at the time of the final try-in, and retain in your records.

Resin Partial Dentures

What Is Covered?

The Department covers partial dentures, as follows:

- A partial denture, including a resin base partial denture, for anterior and posterior teeth when the partial denture meets the Department's coverage criteria for resin partial dentures.
- Post-delivery care (e.g., adjustments, soft relines, and repairs) provided after three months from the seat date of the partial denture is considered part of the partial denture procedure and is not paid separately.

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- Replacement of a resin base denture only when the replacement occurs at least three years from the seat date of the partial denture being replaced. The replacement denture must be prior authorized and meet the Department’s coverage criteria for resin partial dentures and cast-metal framework partial dentures.
- Authorization and payment for a resin base partial denture for anterior and posterior teeth is based on the following criteria:
 - ✓ The remaining teeth in the arch must have a **stable** periodontal diagnosis and prognosis;
 - ✓ The client has established caries control;
 - ✓ One or more anterior teeth are missing or four or more posterior teeth (excluding second and third molars) per arch are missing (the Department does not pay for replacement of second or third molars);
 - ✓ There are a minimum of four stable teeth remaining per arch; and
 - ✓ There is a three-year prognosis for retention of the remaining teeth.

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

Other Requirements/Limitations

The Department:

- Requires a provider to bill for removable dental prosthetic procedures only after the seating of the prosthesis, not at the impression date. The Department may pay for lab fees if the removable dental prosthesis is not delivered and inserted. Refer to “Other Services for Removable Prosthodontics.”
- Requires a provider to deliver services and procedures that are of acceptable quality to the Department. The Department may recoup payment for services that are determined to be below the standard of care or of an unacceptable product quality.

Alternative Living Facilities

- Requires a provider to submit the following with a PA request for removable dental prosthetics for a client residing in a nursing facility, group home, or other facility:
 - ✓ The client's medical diagnosis or prognosis;
 - ✓ The attending physician's signature documenting medical necessity for the prosthetic service;
 - ✓ The attending dentist's or denturist's signature documenting medical necessity for the prosthetic service;
 - ✓ A written and signed consent for treatment from the client's legal guardian when a guardian has been appointed; and
 - ✓ A completed copy of the Denture/Partial Appliance Request for Skilled Nursing Facility Client form, DSHS 13-788. For information on obtaining Department forms, refer to the *Important Contacts* section.
- Limits removable partial dentures to resin-based partial dentures for all clients residing in a nursing facility, group home, or other facility.

Adjustments to Dentures and Repairs to Complete and Partial Dentures

Adjustments to complete dentures are included in the global fee for the denture for the first 90 days after the seat date.

Repairs to Complete Dentures

The Department covers repairs to complete dentures once in a 12-month period. The Department covers additional repairs on a case-by-case basis and when prior authorized.

Code	Description	PA?	Requirements	Maximum Allowable Fee
D5510	repair broken complete denture base	N	Arch designation required	On-line Fee Schedules
D5520	replace missing or broken teeth – complete denture (each tooth)	N	Tooth designation required	

Denture Rebase Procedures

The Department covers a laboratory rebase **to a complete denture** once in a three-year period when performed at least six months after the seating date.

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

Note: The Department does not allow a denture rebase and a relines in the same three-year period. The Department covers rebases or relines **only on complete** dentures (CDT codes **D5110 and D5120**).

Denture Reline Procedures

The Department covers a laboratory relines to a complete or cast-metal partial denture once in a three-year period when performed at least six months after the seating date.

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

Note: The Department does not allow a denture rebase and a relines in the same three-year period. The Department covers rebases or relines only **on complete** dentures (CDT codes **D5110 and D5120**).

Other Removable Prosthetic Services

The Department covers laboratory fees, subject to the following:

- The Department does not pay separately for laboratory or professional fees for complete and partial dentures; and
- The Department may pay part of billed laboratory fees when the provider obtains PA, and the client:
 - ✓ Is not eligible at the time of delivery of the prosthesis;
 - ✓ Moves from the state; or
 - ✓ Dies.

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

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

Code	Description	PA?	Requirements	Maximum Allowable Fee
D5860	overdenture – complete, by report	Y	Arch designation required	On-line Fee Schedules
D5899	unspecified removable prosthodontic procedure, by report (lab fees)	Y	Arch designation required	

What Oral and Maxillofacial Surgery Services Are Covered?

[Refer to WAC 388-535-1267]

General Coverage

The Department covers only the oral and maxillofacial surgery services listed in this section for clients age 21 and older. For dental-related services provided to clients of the Division of Developmental Disabilities (DDD), see Section D.

The Department:

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

Note: For billing information on billing CPT codes for oral surgery, refer to the Department/MPA *Physician-Related Services Billing Instructions*. The Department pays oral surgeons for only those CPT codes listed in the Dental Fee Schedule under “Dental CPT Codes.”

Documentation Requirements

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

- An 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;
- A copy of the post-operative instructions; and
- A copy of all pre- and post-operative prescriptions.

Extractions and Surgical Extractions

The Department covers routine and surgical extractions (includes local anesthesia, suturing, if needed, and routine postoperative care).

The Department considers debridement of a granuloma or cyst that is less than five millimeters as part of the global fee for the extraction.

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

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

Other Surgical Procedures

Biopsy of soft oral tissue does not require PA. All biopsy reports or findings must be kept in the client's dental record.

Code	Description	PA?	Maximum Allowable Fee
D7286	biopsy of oral tissue – soft	N	On-line Fee Schedules

Surgical Excision of Soft Tissue Lesions

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

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

Surgical Incision

The Department covers uncomplicated dental-related intraoral and extraoral soft tissue incision and drainage of abscess. The Department 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.

Code	Description	PA?	Maximum Allowable Fee
D7510	incision and drainage of abscess – intraoral soft tissue	N	On-line Fee Schedules
D7520	incision and drainage of abscess – extraoral soft tissue (dental-related)	N	

What Adjunctive General Services Are Covered?

[Refer to WAC 388-535-1269]

The Department covers oral and adjunctive general services only as listed in this section for clients age 21 and older. For dental-related services provided to clients of the Division of Developmental Disabilities (DDD), see Section D.

Anesthesia

The Department covers:

- Local anesthesia and regional blocks as part of the global fee for any procedure being provided to clients.
- Administration of nitrous oxide, one visit per day.

Code	Description	PA?	Maximum Allowable Fee
D9230	analgesia, anxiolysis, inhalation of nitrous oxide	N	On-line Fee Schedules

Non-emergency Dental Services

The Department covers non-emergency dental services performed in a hospital or ambulatory surgical center only for clients of DDD according to Section D.

Professional Visits

The Department covers:

- A consultation – diagnostic service provided by a dentist or physician other than the requesting dentist or physician when requested by the Department. A client must be referred by the Department for the services to be covered.
- Up to two house/extended care facility (alternate living facility) calls (visits) per facility, per provider. The Department limits payment to two facilities per day, per provider.
- One hospital call (visit), including emergency care, per day, per provider, per client. The Department does not pay for additional hospital calls if billed for the same client on the same day.

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- Emergency office visits after regularly scheduled hours. The Department limits payment to one emergency visit per day, per provider.

Code	Description	PA?	Maximum Allowable Fee
D9310	consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	N	On-line Fee Schedules
D9410	house/extended care facility call	N	
D9420	hospital call	N	
D9440	office visit – after regularly scheduled hours	N	

Drugs

The Department covers drugs and/or medications (pharmaceuticals) only when used for therapeutic purposes such as antibiotics, steroids, or anti-inflammatories. The Department's dental program does not pay for oral sedation medications.

Code	Description	PA?	Maximum Allowable Fee
D9610	therapeutic parenteral drug, single administration Note: Refer to your CDT manual for more information.	N	On-line Fee Schedules
D9612	therapeutic parenteral drugs, two or more administrations, different medications Note: Refer to your CDT manual for more information.	N	
D9630	other drugs and/or medicaments, by report Note: Refer to your CDT manual for more information.	N	

Miscellaneous Services

The Department covers:

- Behavior management requiring the assistance of one additional dental staff other than the dentist **only for clients of DDD (refer to Section D) or clients residing in an alternative living facility.**

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

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

Code	Description	PA?	Limitations	Maximum Allowable Fee
D9920	behavior management	N	DDD clients or clients residing in an alternative living facility only	On-line Fee Schedules
D9930	treatment of complications (post-surgical) – unusual circumstances	N		

What Dental-Related Services Are Not Covered for Clients Age 21 and Older? [Refer to WAC 388-535-1271]

What Is Not Covered?

The Department does not cover the following for clients age 21 and older (see the “Coverage under the Disability Lifeline and ADATSA Programs” section for dental-related services for clients eligible under the Disability Lifeline or ADATSA program and the “Clients of the Division of Developmental Disabilities” section for clients of the Division of Developmental Disabilities):

- The dental-related services described in “Noncovered Services by Category.”
- Any service specifically excluded by statute.
- More costly services when less costly, equally effective services as determined by the Department are available.
- Services, procedures, treatment, devices, drugs, or application of associated services:
 - ✓ Which the Department or the Centers for Medicare and Medicaid Services (CMS) considers investigative or experimental on the date the services were provided; or
 - ✓ That are not listed as covered in one or both of the following:
 - Washington Administrative Code (WAC); or
 - The Department's current published documents.

Noncovered Services by Category

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

Diagnostic Services

The Department does not cover:

- Detailed and extensive oral evaluations or re-evaluations;
- Comprehensive periodontal evaluations;
- Extraoral, excluding panoramic films, or occlusal intraoral radiographs;
- Posterior-anterior or lateral skull and facial bone survey films;
- Sialography;
- Any temporomandibular joint films (TMJ);

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- Tomographic survey;
- Cephalometric films;
- Oral/facial photographic images;
- Viral cultures, genetic testing, caries susceptibility tests, adjunctive pre-diagnostic tests, or pulp vitality tests; or
- Diagnostic casts.

Preventive Services

The Department does not cover:

- Nutritional counseling for control of dental disease;
- Tobacco counseling for the control and prevention of oral disease;
- Oral hygiene instructions (included as part of the global fee for oral prophylaxis);
- Removable space maintainers of any type;
- Sealants. For clients of DDD, refer to Section D;
- Space maintainers of any type or recementation of space maintainers; or
- Fluoride trays of any type.

Restorative Services

The Department does not cover:

- Restorative/operative procedures performed in a hospital operating room or ambulatory surgical center for clients age 21 and older. For clients of DDD, refer to Section D;
- Restorations for wear on any surface of any tooth without evidence of decay penetrating the DEJ or on the root surface;
- Gold foil restorations;
- Metallic, resin-based composite, or porcelain/ceramic inlay/onlay restorations;
- Prefabricated restorations;
- Temporary or provisional crowns (including ion crowns);
- Any type of permanent or temporary crown. For clients of DDD, refer to Section D;
- Recementation of any crown, inlay/onlay, or any other type of indirect restoration;
- Sedative fillings;
- Preventive restorations;

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- Any type of core buildup, cast post and core, or prefabricated post and core;
- Labial veneer resin or porcelain laminate restoration;
- Any type of coping;
- Crown repairs; or
- Polishing or recontouring restorations or overhang removal for any type of restoration.

Endodontic Services

The Department does not cover:

- Indirect or direct pulp caps;
- Endodontic therapy on any primary teeth for clients age 21 and older;
- Endodontic therapy on permanent bicuspid or molar teeth;
- Endodontic retreatment of permanent anterior, bicuspid, or molar teeth;
- Any apexification/recalcification procedures;
- Any apicoectomy/periradicular service; or
- Any surgical endodontic procedures including, but not limited to, retrograde fillings, root amputation, reimplantation, and hemisections.

Periodontic Services

The Department does not cover:

- Surgical periodontal services that include, but are not limited to:
 - ✓ Gingival or apical flap procedures;
 - ✓ Clinical crown lengthening;
 - ✓ Any type of periodontal osseous surgery;
 - ✓ Bone or soft tissue grafts;
 - ✓ Biological material to aid in soft and osseous tissue regeneration;

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- ✓ 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; or
- ✓ Distal or proximal wedge procedures.
- Nonsurgical periodontal services to include:
 - ✓ Intracoronaral or extracoronaral provisional splinting;
 - ✓ Full mouth debridement;
 - ✓ Localized delivery of chemotherapeutic agents; or
 - ✓ Any other type of nonsurgical periodontal service.

Removable Prosthodontics

The Department does not cover:

- Immediate dentures;
- Cast metal framework partial dentures;
- Adjustments to any removal prosthesis;
- Repairs to any partial denture;
- Flexible base partial dentures;
- Replacement of second or third molars for any removable partial prosthesis;
- Any type of permanent soft relin (e.g., molloplast);
- Chairside complete or partial denture relines;
- Any interim complete or partial denture;
- Precision attachments; or
- Replacement of replaceable parts for semi-precision or precision attachments.

Oral and Maxillofacial Prosthetic Services

The Department's Dental Program for Clients Age 21 and Older does not cover any type of oral or facial prosthesis other than those listed in "What removable prosthodontic services are covered?"

Implant Services

The Department does not cover:

- Any implant procedures, including, but not limited to, any tooth implant abutment (e.g., periosteal implant, eosteal implant, and transosteal implant), abutments or implant supported crown, abutment supported retainer, and implant supported retainer;
- Any maintenance or repairs to the implant procedures listed above; or
- The removal of implants as described in the above bullets.

Fixed Prosthodontics

The Department does not cover:

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

Oral and Maxillofacial Surgery

The Department does not cover:

- Any nonemergency oral surgery performed in a hospital or ambulatory surgical center for Current Dental Terminology (CDT) procedures;
- Brush biopsy;
- Any type of alveoplasty;
- Any type of excisions of bone tissue including, but not limited to:
 - ✓ Removal of lateral exostosis;
 - ✓ Removal of torus palatinus or torus mandibularis; and
 - ✓ Surgical reduction of osseous tuberosity.
- Any type of surgical reduction of fibrous tuberosity;

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- Removal of foreign body from mucosa, skin, or subcutaneous tissue;
- Vestibuloplasty;
- Frenuloplasty/frenulectomy;
- Any oral surgery service that is not listed in the department's list of covered dental CPT codes published in the department's current billing instructions;
- Any oral surgery service not listed in "What oral and maxillofacial surgery services are covered"; or
- Any type of occlusal orthotic splint or device, bruxing or grinding splint or device, or temporomandibular joint (TMJ) splint or device.

Orthodontic Services

The Department does not cover any type of orthodontic service or appliance for clients age 21 and older.

Adjunctive General Services

The Department does not cover:

- Anesthesia **in any setting, to include:**
 - ✓ Analgesia or anxiolysis as a separate procedure except for **administration** of nitrous oxide;
 - ✓ **General anesthesia sedation;**
 - ✓ Local anesthesia as a separate procedure;
 - ✓ Medication for **oral sedation or injection of sedative.**
 - ✓ **Oral or parenteral conscious sedation;**
 - ✓ Regional block anesthesia as a separate procedure; or
 - ✓ Trigeminal division block anesthesia as a separate procedure;

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- Other general services including, but not limited to:
 - ✓ Application of any type of desensitizing medicament or resin;
 - ✓ Dental supplies, including but not limited to items such as toothbrushes;
 - ✓ Dentist's or dental hygienist's time writing or calling in prescriptions;
 - ✓ Dentist's time consulting with clients on the phone;
 - ✓ Educational supplies;
 - ✓ Enamel microabrasion;
 - ✓ Fabrication of athletic mouthguard, occlusal guard, or nightguard;
 - ✓ Missed or late appointment fees;
 - ✓ Nonmedical equipment or supplies;
 - ✓ Occlusal adjustment, tooth or restoration adjustment or smoothing, or odontoplasties;
 - ✓ Occlusion analysis;
 - ✓ Office supplies used in conjunction with an office visit;
 - ✓ Personal comfort items or services;
 - ✓ Provider mileage or travel costs;
 - ✓ Service charges of any type, including fees to create or copy charts; or
 - ✓ Teeth whitening services or bleaching, or materials used in whitening or bleaching.

The Department evaluates a request for dental-related services that are listed as noncovered under the provisions in WAC 388-501-0160.

Clients of the Division of Developmental Disabilities

Clients Eligible for Enhanced Services

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

These individuals will be identified in ProviderOne as clients of the Division of Developmental Disabilities. Individuals not identified as such are not eligible for the additional services. If you believe that a patient may qualify for these services, refer the individual or the patient's guardian to the nearest Developmental Disabilities Office (see list below).

Division of Developmental Disabilities Field Offices

Region 1

1611 West Indiana Ave
MS: B32-28
Spokane WA 99205-4221
1-509-456-2893
1-509-456-4256 FAX
1-800-462-0624

Region 2

1002 N. 16th Avenue
MS: B39-7
Yakima WA 98909-2500
1-509-225-7970
1-509-575-2326 FAX
1-800-822-7840

Region 3

840 N. Broadway
Building A, Suite 100
MS: N31-11
Everett, WA 98201-1296
1-425-339-4833
1-425-339-4856 FAX
1-800-788-2053

Region 4

1700 East Cherry Street
MS: N46-6
Seattle WA 98122-4695
1-206-568-5700
1-206-720-3334 FAX
1-800-314-3296

Region 5

1305 Tacoma Avenue S., Suite 300
MS: N27-6
Tacoma WA 98402
1-253-593-2812
1-253-597-4368 FAX
1-800-248-0949

Region 6

Airindustrial Park, Bldg. 6
MS: 45315
PO Box 45315
Olympia, WA 98504-5315
1-360-753-4673
1-360-586-6502 FAX
1-800-339-8227

*If you have any problems contacting these field offices, call Alan McMullen,
DDD state office, at 360-725-3451 or email at mcmular@dshs.wa.gov.*

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

[Refer to WAC 388-535-1099]

The Department pays for dental-related services under the categories of services listed in this section for clients of DDD, subject to the coverage limitations listed. The Department/MPA *Dental Program for Clients Age 21 and Older Billing Instructions* apply to clients of DDD unless otherwise stated in this section.

Preventive Services

Dental Prophylaxis

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

Topical Fluoride Treatment

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

Sealants

The Department covers sealants:

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

Crowns

The Department covers stainless steel crowns every two years for the same tooth and only for primary molars and permanent premolars and permanent molars for clients ages 21 and older. Documentation supporting the medical necessity of the service must be in the client's record.

Periodontic Services

Surgical Periodontal Services

The Department covers:

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

Code	Description	PA?	Requirements	Maximum Allowable Fee
D4210	gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant	Y	Quadrant designation required. DDD clients only.	On-line Fee Schedules
D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant	Y	Quadrant designation required. DDD clients only.	

Nonsurgical Periodontal Services

The Department covers:

- Periodontal maintenance up to 3 times in a 12-month period; and
- Periodontal scaling and root planing, up to 2 times per quadrant in a 12-month period.

Note: If a periodontal maintenance or oral prophylaxis occurs in a 12-month period, it replaces an allowed periodontal scaling and root planing (four quadrants).

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

Adjunctive General Services

The Department covers:

- Oral parenteral conscious sedation, deep sedation, or general anesthesia for any dental services performed in a dental office or clinic. Documentation supporting the medical necessity must be in the client's record.
- Sedation services according to “What adjunctive general services are covered?”

Non-emergency Dental Services

Note: The Department covers medically necessary, non-emergency dental services performed in a hospital or an ambulatory surgical center.

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

Miscellaneous Services-Behavior Management

The Department covers behavior management provided in dental offices, dental clinics, or alternative living facilities for clients of any age. Documentation supporting the medical necessity of the service must be included in the client's record.

Authorization

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

General Information about Authorization

[Refer to WAC 388-535-1280 (1) and (5)]

- For clients age 21 and older, the Department uses the determination process for payment described in WAC 388-501-0165 for covered dental-related services that require PA.
- When the Department authorizes a dental-related service for a client, that authorization indicates only that the specific service is medically necessary; it is not a guarantee of payment.
- The authorization is valid for six months and only if the client is eligible for covered services on the date of service.

When Do I Need To Get PA?

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

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

When retroactive eligibility is established, the Department may authorize the service if the provider submits a request for authorization with the required information and indicates “retro eligibility” on the request.

When Does the Department Deny a PA Request?

[Refer to WAC 388-535-1280 (6)]

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

- Is covered by another Department program;
- Is covered by an agency or other entity outside the Department; or
- Fails to meet the program criteria, limitations, or restrictions in these billing instructions.

How Do I Obtain Written PA? [Refer to WAC 388-535-1280 (2)-(4)]

The Department 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, DSHS 13-835. See the DSHS/MPA *ProviderOne Billing and Resource Guide* at:

http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for more information.

The Department may request additional information as follows:

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

Note: The Department 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, DSHS 13-788.

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

Where Do I Send Requests for PA?

Without Radiographs or Photos

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

With Radiographs or Photos

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

- 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 Department 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.*

- Submit digital images via e-mail to DESDASO@dshs.wa.gov with your PA request form and any other required documentation. The reference number will be available after your fax is received, scanned by the Department, and the reference number is generated. You may obtain your reference number by calling 1-800-562-3022 and using the IVR function.
- Continue to mail your request to:

Authorization Services Office
P.O. Box 45535
Olympia, WA 98504-5535

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

- Place x-rays in an 8x11 sealed envelope.
- Place your provider ID & the ProviderOne Client ID on the outside of the envelope. For items too big for an envelope, such as models, use a box and place your provider ID on the outside.
- Place the envelope and the PA request form (or cover sheet if submitting information for an already existing PA#) into a larger envelope.
- Mail to the Department.

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You may also send multiple prior authorization requests if you attach the form to the prepared envelope with a paper clip, creating one packet per client. Put all packets in one larger envelope for mailing.

Note: Please see the Department/MPA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for more information on requesting authorization.

Billing and Claim Forms

What Are the General Billing Requirements?

Providers must follow the Department/**MPA** *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments;
- What fee to bill the Department for eligible clients;
- When providers may bill a client;
- How to bill for services provided to primary care case management (PCCM) clients; and
- Record keeping requirements.

Hospital Billing

The Department 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 388-535 WAC; and
- Are billed on a 2006 ADA or CMS-1500 Claim Form or appropriate electronic transaction.

The Department 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 388-535 WAC;
- The covered dental-related services are billed on a UB-04 claim form; and
- At least one of the following is true:
 - ✓ The dental-related service(s) is provided to an eligible medical assistance client on an emergency basis;
 - ✓ The client is eligible under the DDD program; or
 - ✓ The dental service is prior authorized by the Department.

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

Medicare does not currently 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 Department. Attach a copy of the Medicare determination.

Third-Party Liability

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

For all medical claims, refer to the Department/MPA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html.

Notifying Clients of their Rights (Advance Directives)

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

Clients have the right to:

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

Fee Schedules

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

Note: Bill **MPA** your usual and customary charge.

Completing the ADA Claim Form

Note: Refer to the Department/**MPA** *ProviderOne Billing and Resource Guide* at:
http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for general instructions on completing the ADA Claim Form.