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 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 and younger;

(ii) Clients age nine through twenty. Prior authorization is required for the site of service; 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 current records (within the past twelve months), including:

(i) Documentation used to determine medical appropriateness;

(ii) Cephalometric films;

(iii) Radiographs (X-rays);

(iv) Photographs; and

(v) Written narrative/letter of medical necessity, including proposed billing codes.

(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 simple and surgical extractions.

(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.

(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 biopsy of soft oral tissue, brush biopsy, and surgical excision of soft tissue lesions. Providers must keep all biopsy reports or findings in the client's dental record.

(l) Covers only the following excisions of bone tissue in conjunction with placement of complete or partial dentures:

(i) Removal of lateral exostosis;

(ii) Removal of torus palatinus or torus mandibularis;

(iii) Surgical reduction of osseous tuberosity.

(2) **Alveoloplasty.** The agency covers alveoloplasty only in conjunction with the preparation of dentures or partials. Documentation supporting the medical necessity for the procedure must be maintained in the client's record. Supporting documentation must include current radiographs and medical justification narrative.

(3) **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 the medical necessity must be in the client's record.

(b) Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue. Documentation supporting the medical necessity for the service must be in the client's record.

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

(d) Frenuloplasty/frenulectomy for clients age seven through twelve. Prior authorization is required. 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.

(e) Surgical access of unerupted teeth for clients age twenty and younger. Prior authorization is required.

(4) **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 age twelve through twenty. Prior authorization is required.

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

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 21-14-055, § 182-535-1094, filed 7/1/21, effective 8/1/21; WSR 19-06-003, § 182-535-1094, filed 2/21/19, effective 3/24/19; WSR 17-20-097, § 182-535-1094, filed 10/3/17, effective 11/3/17; WSR 16-18-033, § 182-535-1094, filed 8/26/16, effective 9/26/16; WSR 15-10-043, § 182-535-1094, filed 4/29/15, effective 5/30/15. Statutory Authority: RCW 41.05.021 and 2013 2nd sp.s. c 4 § 213. WSR 14-08-032, § 182-535-1094, filed 3/25/14, effective 4/30/14. Statutory Authority: RCW 41.05.021. WSR 12-09-081, § 182-535-1094, filed 4/17/12, effective 5/18/12. WSR 11-14-075, recodified as § 182-535-1094, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. WSR 07-06-042, § 388-535-1094, filed 3/1/07, effective 4/1/07.]