wisconsin Medicaid update
and BadgerCare

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Wisconsin Medicaid and BadgerCare Information for Providers

To:
Dentists

New ADA claim form and Medicaid billing instructions

Wisconsin Medicaid began accepting the new American Dental Association (ADA) claim form on January 1, 2000. Wisconsin Medicaid will accept the old claim form until June 30, 2000.

For claims received on or after **July 1, 2000**, dentists currently billing on the ADA claim form are required to use the new ADA claim form – Version 2000 – exclusively.

Note: Dentists (i.e., oral surgeons and oral pathologists) who currently use the HCFA 1500 claim form, should continue to use the HCFA 1500 claim form.

Dentists should use the enclosed Wisconsin Medicaid instructions (Attachment 1 of this *Update*) to complete the new ADA claim form – Version 2000. The Wisconsin Medicaid instructions have minor variations from the ADA instructions. The variations are needed to process claims in the Wisconsin Medicaid claims system. Providers should complete only the elements listed in these instructions as appropriate. No other elements are required. In addition, providers are not required to include attachments to the claim form unless instructed to do so as outlined in the Medicaid Dental Handbook.

In addition to the claim form instructions, refer to Attachment 2 for a completed example of the claim form.

Medicaid HMO network providers

The information and procedures in this *Update* apply to fee-for-service Medicaid claims only. If you are a Medicaid HMO network provider, contact your managed care organization for more information about their procedures. Wisconsin Medicaid HMOs are required to provide at least the same benefits provided under fee-for-service arrangements.

Obtaining copies of the new claim form

The new ADA claim forms are not provided by Wisconsin Medicaid. To obtain a supply of the new forms, contact your normal ADA supplier and software vendor.

Verifying recipient eligibility and insurance information

Medicaid recipients receive a Medicaid ID card upon initial enrollment into Wisconsin Medicaid. Medicaid ID cards may be in any of the following formats:

- Plastic Forward cards.
- Green temporary paper cards.
- Beige Presumptive Eligibility paper cards.

Please use the information exactly as it appears on the Medicaid ID card or as indicated on Medicaid's Eligibility Verification System (EVS) to complete the patient information section on the claim. Recipient information available through the EVS includes:

- Dates of Medicaid eligibility.
- Medicaid managed care program name and telephone number and if the managed care program covers dental services.
- Private managed care or other commercial health insurance coverage.
- Information describing limitation of benefits.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *www.dhfs.state.wi.us/medicaid/*.

Resources available to verify recipient eligibility

Wisconsin Medicaid's EVS consists of the following resources available to verify recipient eligibility:

Service	Description	Telephone number	Hours
Automated Voice Response (AVR) System	Computerized voice response to provider inquiries.	(800) 947-3544 (outside Madsion area and out-of-state) (608) 221-4247 (Madison area)	24 hours a day / 7 days a week
Personal Computer Software and Magnetic Stripe Card Readers	Computer software. ID card reader.	Call Provider Services for a list of commercial eligibility verification vendors.	24 hours a day / 7 days a week
Provider Services	Correspondents assist with questions.	(800) 947-9627 (outside Madsion area and out-of-state) (608) 221-9883 (Madison area)	Policy, Billing, and Eligibility information: 8:30 a.m. - 4:30 p.m. (M, W-F) 9:30 a.m. - 4:30 p.m. (T)
Direct Information Access Line with Updates for Providers (Dial-Up)	Software communications package and modem.	Call (608) 221-4746 for more information.	7:00 a.m. - 6:00 p.m. (M-F)

Attachment 1
American Dental Association Claim Form Completion Instructions
-Version 2000-

Use the following claim form instructions to complete the ADA claim form – Version 2000. To avoid denial or inaccurate claim payment, do ***not*** follow the claim form's printed instructions. The Wisconsin Medicaid instructions have minor variations needed to process claims in the Wisconsin Medicaid claims system.

Complete the elements listed below as appropriate. No other elements are required. In addition, do not include attachments unless instructed to do so in the Medicaid Dental Handbook.

Element 2: Medicaid Claim, EPSDT, Prior Authorization # *(Required, if applicable)*

EPSDT (HealthCheck): HealthCheck is Wisconsin Medicaid's federally mandated program known nationally as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). If the services were performed as a result of a HealthCheck/EPSDT exam, check the EPSDT box.

Prior authorization #: Enter the seven-digit prior authorization (PA) number from the approved Prior Authorization Dental Request Form (PA/DRF), if applicable. Do not attach a copy of the PA/DRF to the claim. Services authorized under different PA numbers must be billed on separate claim forms.

Element 8: Patient Name (Last, First, Middle)

Enter the recipient's last name, first name, and middle initial as they appear on the Medicaid ID card or indicated by Medicaid's Eligibility Verification System (EVS). If the name or spelling of the name on the Medicaid ID card and the EVS do not match, use the spelling from the EVS.

Element 12: Date of Birth (MMDDYYYY)

Enter the recipient's date of birth in MMDDYYYY format (e.g., March 27, 1972, would be 03271972).

Element 13: Patient ID

Enter the recipient's ***10-digit*** Medicaid ID number as indicated on the Medicaid ID card or the EVS. Do not enter any other numbers or letters.

Element 33: Other Subscriber's Name *(Required, if applicable)*

Wisconsin Medicaid uses this element for Medicare and commercial health insurance information, whether the recipient has commercial insurance coverage, Medicare coverage, or both.

Recipients with commercial health insurance coverage

Dental commercial insurance coverage must be billed prior to billing Wisconsin Medicaid. Dental commercial insurance coverage is indicated by the EVS under "Other Commercial Health Insurance."

When a recipient's eligibility is confirmed, one of seven "other insurance" indicators may be indicated. The following chart lists the seven insurance indicators, along with the corresponding tables to use when each indicator appears.

Medicaid Insurance Indicators		
Commercial Insurance Indicator	**Meaning**	**Table**
DEN	Commercial Dental Insurance	Table 1
HMO	Health Maintenance Organization (non-Medicaid)	Table 2
BLU	BlueCross & BlueShield	Table 3
WPS	Wisconsin Physicians Service	Table 3
CHA	TriCare	Table 3
HPP	Wausau Health Protection Plan	Table 3
OTH	All other commercial health or dental insurance plans	Table 3

In addition, Table 4 lists examples of special circumstances to consider when billing commercial health or dental insurance prior to billing Wisconsin Medicaid.

Table 1 – Insurance indicator "DEN" is indicated on the recipient's eligibility file

Bill the following procedure codes to commercial dental insurance *prior* to billing these procedures to Medicaid.

Service type	Service	Procedure codes
Diagnostic	Exams	00120, 00150, 00160
	X-rays	00270, 00272, 00274
Preventive	Prophylaxis, Fluoride	01110-01205
	Sealants	01351
	Space maintainers	01510, 01515, 01550
Restorative	Fillings	02110-02387
	Crowns	02920-02933
Endodontic	Root canals	03310, 03320, 03330
Periodontic	Gingivectomy	04210, 04211
	Scaling	04341
	Full-mouth debridement	04355
Prosthodontic	Dentures	05110-05212, 05510-05761
	Bridges	06930, 06940, 06980
Extractions	Extractions	07110-07250
Surgical - Current Dental Terminology	Surgeries	07260-07780, 07840, 07850, 07910-07991
Orthodontic	Orthodontia	08110-08650, 08750

Medicaid's insurance explanation codes

To file a claim with Medicaid containing one or more of the procedure codes listed in Table 1, indicate one of the following codes in this element.

Code	When to use code
OI-P (other insurance paid)	If claim is paid entirely or in part by commercial health or dental insurance. Indicate the amount paid by commercial health or dental insurance to the provider or the insured in Element 59, under "Payment by other plan."
OI-D (other insurance denied)	If claim is denied by commercial health or dental insurance following submission of a correct and complete claim, or payment was applied toward the coinsurance and deductible. Do not use this code unless the claim in question was billed to and denied by the commercial health or dental insurer.
OI-Y (other insurance yes)	If commercial health or dental insurance coverage was indicated, but it was not billed for reasons including, but not limited to: - Recipient denies coverage or will not cooperate. - The provider knows the carrier does not cover the service in question. - Commercial insurance failed to respond to initial and follow-up claims. - Benefits are not assignable or cannot get an assignment.
None. Providers may leave this element blank.	If none of the procedure codes on the claim are listed in Table 1.

Table 2 – Insurance indicator "HMO" is indicated on the recipient's eligibility file

Bill the following procedure codes to commercial dental insurance *prior* to billing these procedures to Medicaid.

Service type	Service	Procedure codes
Diagnostic	Exams	00120, 00150, 00160
Preventive	Cleanings	01110-01120
Restorative	Fillings	02110-02160
Extractions	Extractions	07210-07250
Surgical - Current Dental Terminology	Surgeries	07260-07780, 07840, 07850, 07910-07991

Medicaid's insurance explanation codes

To file a claim with Medicaid containing one or more of the procedure codes listed in Table 2, indicate one of the following codes in this element.

Code	When to use code
OI-P (other insurance paid)	If claim is paid entirely or in part by the (non-Medicaid) HMO. Indicate the amount paid by the HMO to the provider or the insured in Element 59, under "Payment by other plan."
OI-H (other insurance HMO)	If claim is not covered by the HMO or the billed amount does not exceed the coinsurance or deductible amount. Do not use OI-H if an otherwise covered service was rendered by a provider outside of the network.
None. Providers are not required to bill other dental insurance and may leave this element blank.	If none of the procedure codes on the claim are listed in Table 2.
None. Providers must be members of the recipient's HMO to receive Medicaid reimbursement.	If providers are not members of the recipient's HMO. Medicaid may not be billed.

Table 3 –Other insurance indicator "BLU," "WPS," "CHA," "HPP," or "OTH" is indicated on the recipient's eligibility file

Bill the following procedure codes to commercial health or dental insurance *prior* to billing these procedures to Medicaid.

Service type	Service	Procedure codes
Surgical - Current Dental Terminology	Surgeries	07260-07780, 07840, 07850, 07910-07991

Medicaid's insurance explanation codes

To file a claim with Medicaid containing one or more of the procedure codes listed in Table 3, indicate one of the following codes in this element.

Code	When to use code
OI-P (other insurance paid)	If claim is paid entirely or in part by commercial health or dental insurance. Indicate the amount paid by commercial health or dental insurance to the provider or the insured in Element 59, under "Payment by other plan."
OI-D (other insurance denied)	If claim is denied by commercial health or dental insurance following submission of a correct and complete claim, or payment was applied toward the coinsurance and deductible. Do not use this code unless the claim in question was billed to and denied by the commercial health or dental insurer.
OI-Y (other insurance yes)	If commercial health or dental insurance coverage was indicated, but it was not billed for reasons including, but not limited to: - Recipient denies coverage or will not cooperate. - The provider knows the carrier does not cover the service in question. - Commercial insurance failed to respond to initial and follow-up claims. - Benefits are not assignable or cannot get an assignment.
None. Providers may leave this element blank.	If none of the procedure codes on the claim are listed above.

Table 4 – Special Circumstances

Special circumstances when billing commercial health or dental insurance prior to billing Wisconsin Medicaid

Situation	Appropriate response
No insurance indicator is indicated by Medicaid's Eligibility Verification System (EVS).	Leave this element blank.
An insurance indicator is present, but none of the services are listed on the appropriate Table (1, 2, or 3).	Leave this element blank.
Provider: - Is aware of other commercial health or dental insurance not indicated on the EVS. - Bills the insurance. - Receives reimbursement from the insurer.	- Place "OI-P" in this element. - Place the amount paid by commercial health or dental insurance in the "Payment by other plan" box in Element 59. - Complete the TPL-17 form found in Appendix 19 of the All-Provider Handbook to correct Medicaid files.
Provider: - Is aware of other commercial health or dental insurance not indicated on the EVS. - Bills the insurance. - Does not receive reimbursement from that insurer.	- Leave this element and the "Payment by other plan" box in Element 59 blank. - Complete the TPL-17 form found in Appendix 19 of the All-Provider Handbook to correct Medicaid files.

When commercial dental or health insurance paid for some services

When commercial dental or health insurance only paid for some services and denied payment for the others, Wisconsin Medicaid recommends submitting two separate Medicaid claim forms. To maximize Medicaid reimbursement, one claim should be submitted for the partially paid services and another for the services denied by commercial dental or health insurance.

Recipients with Medicare coverage

Medicare must be billed for covered services before billing Wisconsin Medicaid if Medicare covers the service. *Refer to Appendix 17 of the All-Provider Handbook for further information regarding the submission of claims for dual entitlees.* When the recipient has Medicare coverage, but Medicare does not allow any charges, one of the following Medicare disclaimer codes (e.g., "M-5") must be indicated in this element:

Code	Description
M-5	Provider is not Medicare certified. This code can be used when providers are identified in Wisconsin Medicaid files as being Medicare certified, but are billing for dates of service before or after their Medicare certification effective dates.
M-6	Recipient not Medicare eligible. This code can be used when Medicare denies payment for services related to ***chronic renal failure*** (diagnosis code 585) because the recipient is not eligible for Medicare. Medicare must be billed first, even when the recipient is identified in Wisconsin Medicaid files as not eligible for Medicare.
M-7	Medicare disallowed or denied payment. This code applies when Medicare denies the claim for reasons related to policy, not billing errors.
M-8	Noncovered Medicare service. This code can be used when Medicare was not billed because the service, under certain circumstances related to the recipient's diagnosis, is not covered.

A Medicare disclaimer code should *not* be indicated when one or more of the following statements are true:

- Medicare never covers the procedure in any circumstance.
- The provider's Wisconsin Medicaid file shows he or she is not Medicare certified.
- Medicaid's Eligibility Verification System (EVS) shows the recipient does not have any Medicare coverage for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A coverage. Services related to a diagnosis of chronic renal failure are the only exceptions.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits (EOMB), but do not indicate on the claim form the amount Medicare paid.

If none of the above statements are true, a Medicare disclaimer code is necessary in this element.

Recipients with both Medicare and commercial dental or health insurance

Use both a Medicare disclaimer code (e.g., "M-5") and other insurance explanation code (e.g., "OI-P") when applicable.

Element 42: Name of Billing Dentist or Dental Entity

Enter the billing provider's complete name as it appears on the Medicaid certification letter. If the billing provider is a group or clinic, enter the group or clinic name in this element.

Element 44: Provider ID

Enter the billing provider's eight-digit Medicaid provider number. If the billing provider is a group or clinic, enter the group or clinic billing number in this element.

Element 46: Address

Enter the billing provider's complete street address as it appears on the Medicaid certification letter. If providers move or are at a different address, they should complete Appendix 34 of the All-Provider Handbook, to notify Wisconsin Medicaid that an address change has occurred.

Element 49: Place of treatment

Place of treatment	What to enter in this element
Office	Check the "Office" box with an "X" only.
Hospital	Check the "Hospital" box with an "X" and enter: **1** for Inpatient hospital **2** for Outpatient hospital
ECF (Extended Care Facility)	Check the "ECF" box with an "X" and enter: **7** for Nursing home **8** for Skilled nursing facility
Other	Check the "Other" box with an "X" and enter: **4** for Home **9** for Other **B** for Ambulatory surgical center

Elements 50-52: City, State, ZIP code

Enter the billing provider's complete city, state, and ZIP code as they appear on the Medicaid certification letter.

Element 54: Is treatment for orthodontics? *(Required, if applicable.)*

Check yes or no to indicate whether the treatment is for orthodontics, and enter the date the appliances were placed if yes is indicated.

Element 56: Is treatment result of occupational illness or injury? *(Required, if applicable.)*

Specify if the dental services were the result of an occupational illness or injury. Check yes or no. If yes is indicated, write a brief explanation in the space provided.

Element 57: Is treatment result of: auto accident? other accident? neither? *(Required, if applicable.)*

Specify if the dental services were the result of an auto accident or other accident. Write a brief description including dates if appropriate.

Element 59: Examination and treatment plans

Date (MMDDYYYY): Enter the date of service in MMDDYYYY format (e.g., July 1, 1999, would be 07011999) for each detail.

Tooth: If the procedure applies to only one tooth, the tooth modifier (i.e., tooth number or tooth letter) is entered here. If the procedure applies to only one denture repair, the modifier (i.e., UU or LL) is entered here. Refer to Section IV-E of the Dental Handbook for more modifier information.

Surface: Enter the tooth surface(s) restored for each restoration.

Diagnosis Index #: Not required by Wisconsin Medicaid.

Procedure Code: Enter the procedure code for the dental service provided. Refer to appendices 9 through 19 of the Dental Handbook, for a complete list of covered codes.

Qty: Enter the exact quantity billed. When multiple quantities of a single type of service are provided on the same day, list the code only once with the appropriate quantity indicated at the end of the description. (This does not apply to codes that require modifiers.)

Description: Write a brief description of each procedure.

Fee: Enter the usual and customary charge for each detail line of service.

Total Fee: Enter the total of all detail charges.

Payment by other plan: Enter the total dollar amount paid by any other commercial health insurance plan. Do not include the copayment amount. *If the commercial insurance plan paid on only some services, those partially paid services should be billed on a separate claim from the unpaid services.* This allows Wisconsin Medicaid to appropriately credit the payments. Do not enter payments made by Medicare.

Max. Allowable: Not required by Wisconsin Medicaid.

Deductible: Not required by Wisconsin Medicaid.

Carrier pays: Not required by Wisconsin Medicaid.

Patient pays: If a patient is eligible for Medicaid with a spenddown, enter the spenddown amount, when applicable. Write "spenddown" to the left of the *Patient pays* box. Refer to the All-Provider Handbook for more information on recipient spenddown. Do not enter recipient copayment amounts.

Admin. Use Only: Enter an "E" after each procedure code's detail line that was an emergency service. Wisconsin Medicaid's claims processing system only accepts the letter "E," with no other letters, as an indication of an emergency.

Element 61: Remarks for unusual services *(Required, if applicable)*

List any unusual services, including reasons why limitations were exceeded. For example, include an explanation demonstrating medical necessity for replacing a properly completed filling, crown, or adding a restoration on any tooth surface. Another example includes indicating medical necessity for non-prior authorized crowns.

Element 62: Dentist's signature block

If the performing provider is not part of a clinic or group biller, then the provider, or his or her representative, must sign in Element 62. Also enter the month, day, and year that the form is signed.

Note: This may be a computer-printed name and date, or a signature stamp.

If elements 42 and 44 indicate a clinic or group biller, indicate the Medicaid-certified performing provider's name and eight-digit Medicaid provider number in this element.

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Attachment 2 - Sample ADA Claim Form

Dental Claim Form

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1 ☐Dentist's pre-treatment estimate ☐Dentist's statement of actual services — Specialty (see backside)
2 ☐Medicaid Claim ☐EPSDT — Prior Authorization # 1234567
3. Carrier Name
4. Carrier Address
5. City | 6. State | 7. Zip

PATIENT

8. Patient Name (Last, First, Middle): Recipient, Im A.
9. Address | 10. City | 11. State
12. Date of Birth (MM/DD/YYYY): 03 / 27 / 1972
13. Patient ID #: 1234567890
14. Sex ☐M ☐F
15. Phone Number ( )
16. Zip Code
17. Relationship to Subscriber/Employee: ☐Self ☐Spouse ☐Child ☐Other_____
18. Employer/School Name_____ Address_____

SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID#/SSN#
20. Employer Name
21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address
24. Phone Number ( )
25. City | 26. State | 27. Zip Code
28. Date of Birth (MM/DD/YYYY) / /
29. Marital Status ☐Married ☐Single ☐Other
30. Sex ☐M ☐F

39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

X_____ Signed (Patient/Guardian) Date (MM/DD/YYYY)

OTHER POLICIES

31. Is Patient covered by another plan ☐No (Skip 32–37) ☐Yes ☐Dental or ☐ Medical
32. Policy #
33. Other Subscriber's Name: OI-P M-6
34. Date of Birth (MM/DD/YYYY) / /
35. Sex ☐M ☐F
36. Plan/Program Name
37. Employer/School Name_____ Address_____
38. Subscriber/Employee Status ☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student
40. Employer/School Name_____ Address_____
41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

X_____ Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity: I.M. Billing
43. Phone Number ( )
44. Provider ID #: 12345678
45. Dentist Soc. Sec. or T.I.N.
46. Address: 1 W. Williams St.
47. Dentist License #
48. First visit date of current series:
49. Place of treatment ☐Office ☐Hosp. ☐ECF ☒Other B
50. City: Anytown | 51. State: WI | 52. Zip Code: 55555
53. Radiographs or models enclosed? ☐Yes, How many?_____ ☐No
54. Is treatment for orthodontics? ☐Yes ☒No If service already commenced: Date appliances placed _____ Total mos. of treatment remaining _____
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No — If no, reason for replacement: _____ Date of prior placement: _____
56. Is treatment result of occupational illness or injury? ☒No ☐ Yes Brief description and dates_____
57. Is treatment result of: ☐auto accident? ☐other accident? ☒neither Brief description and dates_____

58. Diagnosis Code Index (optional) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee	Admin. Use Only
MM DD YYYY				05110	1	Complete upper denture	XXX.XX	
MM DD YYYY	28	MOD		02160	1	Amalgam	XX.XX	
MM DD YYYY	25			W7116	1	Open tooth for drainage	XX.XX	E

60. Identify all missing teeth with "X"

Permanent									Primary								
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

Total Fee	XXX.XX
Payment by other plan	XX.XX
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

61. Remarks for unusual services

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

x *I.M. Provider* Signed (Treating Dentist) License # MM/DD/YYYY Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City | 65. State | 66. Zip Code

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J588 (Same as ADA Dental Claim Form) – J589, J590, J591

To Reorder, call 1-800-947-4746