wisconsin Medicaid update and BadgerCare

June 2001 ● No. 2001-16
PHC 1799

Wisconsin Medicaid and BadgerCare Information for Providers

To:
Dentists
HealthCheck Providers
HMOs and Other Managed Care Programs

# Dental sealants are now a covered HealthCheck service for all Medicaid recipients under age 21

Effective for dates of service on and after February 1, 2001, Wisconsin Medicaid covers dental sealants provided by certified HealthCheck nursing agencies to all Medicaid recipients under age 21, regardless of whether the recipient is covered by Medicaid fee-for-service or enrolled in a Medicaid HMO. This includes recipients enrolled in a Medicaid HMO that provides dental coverage.

## Background

Wisconsin Medicaid covers dental sealants and other dental services provided by Medicaid-certified dental providers. In addition, many local health departments hold dental clinics in which paid or volunteer dentists or dental hygienists provide sealants and other dental services. Since most local health departments are also certified HealthCheck providers, Wisconsin Medicaid will now reimburse certified HealthCheck nursing agencies for providing dental sealants to Medicaid recipients under age 21 when billed as a HealthCheck service.

Medicaid coverage for sealants in HealthCheck nursing agencies is limited to tooth numbers 02, 03, 14, 15, 18, 19, 30, and 31. Refer to the prior authorization (PA) segment of this *Update* for information on other teeth which require PA for sealants.

## Dentists or dental hygienists may provide sealants

For dates of service on and after February 1, 2001, Wisconsin Medicaid covers sealants that are provided by a dentist or a dental hygienist at a certified HealthCheck nursing agency. For a dental hygienist to apply a sealant, a prescription from a licensed dentist is required. This must be retained in the recipient's HealthCheck file. Because the HealthCheck nursing agency is Medicaid certified, Medicaid does not require that the dentist or dental hygienist providing the sealants be Medicaid certified.

## Submit all dental sealant claims to Wisconsin Medicaid fee-for-service

Like environmental inspections for lead poisoning done under HealthCheck, dental sealants are covered on a fee-for-service basis for *all* Wisconsin Medicaid recipients, including recipients enrolled in a Medicaid HMO. This includes recipients enrolled in a Medicaid HMO that provides dental coverage.

## Claim submission

When submitting claims for dental sealants, HealthCheck providers are required to:

- Use the HCFA 1500 claim form.
- Indicate American Dental Association *Current Dental Terminology* code D1351.
- Indicate type of service G.

- Indicate the tooth numbers that received sealants as modifiers on the claim form. Tooth numbers must be entered in a two-character format, such as "02," with only one tooth per line.
- Submit the claim to Medicaid fee-for-service, even if the recipient is enrolled in a Medicaid HMO.

Refer to the Attachment of this *Update* for a completed sample HCFA 1500 claim form for dental sealants submitted by a HealthCheck nursing agency.

There is a once-per-three-year limitation on sealants for permanent first and second molars. To exceed the once-per-three-year limitation, a narrative must be attached to the claim explaining why the limitation was exceeded. The narrative must be signed by a licensed dentist.

## Prior authorization

Prior authorization is required for tooth numbers/letters 01, 04-13, 16, 17, 20-29, 32, A-T, and SN. For these teeth, HealthCheck providers must refer the recipient to a Medicaid-certified dentist to request PA and provide these services. If the PA is approved, Wisconsin Medicaid will reimburse the dentist for the services.

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/*.

# ATTACHMENT

## Sample HCFA 1500 claim form for dental sealants submitted by a HealthCheck nursing agency

APPROVED OMB-0938-0008

PICA

**HEALTH INSURANCE CLAIM FORM**

PICA

1. MEDICARE ☐ (Medicare #) | MEDICAID ☐ (Medicaid #) **P** | CHAMPUS ☐ (Sponsor's SSN) | CHAMPVA ☐ (VA File #) | GROUP HEALTH PLAN ☐ (SSN or ID) | FECA BLK LUNG ☐ (SSN) | OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): **1234567890**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **Recipient, Ima A.**

3. PATIENT'S BIRTH DATE MM DD YY: **MM DD YY** SEX M ☐ F **X**

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): **609 Willow**

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: **Anytown** STATE: **WI**

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY: STATE:

ZIP CODE: **55555** TELEPHONE (Include Area Code): **(XXX)XXX-XXXX**

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. **V70.0** 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 **MM DD YY** | **3** | **G** | **D1351** | **02** | **1** | **XX XX** | **1.0** | | | | |
| 2 **MM DD YY** | **3** | **G** | **D1351** | **03** | **1** | **XX XX** | **1.0** | | | | |
| 3 **MM DD YY** | **3** | **G** | **D1351** | **18** | **1** | **XX XX** | **1.0** | | | | |
| 4 **MM DD YY** | **3** | **G** | **D1351** | **19** | **1** | **XX XX** | **1.0** | | | | |
| 5 | | | | | | | | | | | |
| 6 | | | | | | | | | | | |

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.: **1234JED**

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $ **XXX XX**

29. AMOUNT PAID $

30. BALANCE DUE $ **XXX XX**

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

**I.M. Authorized MM/DD/YY**

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

**I.M. Billing**
**1 W. Williams**
**Anytown, WI 55555** **87654321**

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500