wisconsin Medicaid update
and BadgerCare
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Wisconsin Medicaid and BadgerCare Information for Providers

To:
Dentists
HMOs and Other Managed Care Programs

Claims submission simplified for emergency dental procedure codes

Effective immediately, both electronic and paper claims will no longer require an "E" indicator for certain procedure codes. This change in dental claims submission *does not* modify Wisconsin Medicaid limitations or documentation requirements for services covered only in an emergency, including coverage of surgical extractions.

Emergency "E" indicator no longer required for claims submitted for certain emergency procedures

Effective immediately, both electronic and paper claims will no longer require an "E" indicator for certain dental procedure codes that Wisconsin Medicaid covers only in emergencies. This change in claims submission procedures applies to dental claims submitted on either the American Dental Association (ADA) claim form or the HCFA 1500 claim form; it does not change policy regarding emergency procedures. Previously, Wisconsin Medicaid required that dental providers place an "E" indicator in the "Administrative Use Only" box of the ADA claim form or in Element 24I of the HCFA 1500 claim form in order to receive reimbursement for dental procedures covered only in an emergency. The "E" indicator requirement caused problems for dentists submitting claims using electronic billing vendors.

For a list of *Current Dental Terminology* (CDT) and *Current Procedural Terminology* codes which no longer require an "E" indicator when submitting claims, refer to Attachments 1 and 2 of this *Wisconsin Medicaid and BadgerCare Update.* While the "E" indicator is no longer required, the following conditions still apply to the procedure codes listed in Attachments 1 and 2:

- Wisconsin Medicaid will reimburse claims for these procedures only if they are provided in an emergency.
- In non-emergency situations, Wisconsin Medicaid requires the dentist to explain to the recipient prior to providing the services that the service is not covered by Wisconsin Medicaid and that the recipient is responsible for payment. Providers may not bill recipients if they do not give the required explanation to recipients before providing services. Refer to Attachment 3 and to the All-Provider Handbook for information on billing recipients for non-covered services.

Submitting claims for emergency dental services

When submitting a claim to Wisconsin Medicaid for emergency dental services, complete and submit the ADA (either version) or HCFA 1500 claim form. Refer to the Wisconsin Medicaid Dental Handbook for detailed instructions on the HCFA 1500 claim form and the 1994 version of the ADA claim form. Refer to the March 2000 *Update* (2000-10), titled "New ADA claim form and Medicaid billing instructions," for information on the ADA Version 2000 claim form.

Documentation of emergency dental procedures

Document the nature of the emergency in the recipient's **dental record**. This documentation shall include a diagnosis with signs and symptoms, description of the treatment provided and post-operative instructions and prescriptions.

For example, the documentation of a surgical extraction shall include signs, symptoms, and a description of the procedure that may include:

- Elevation of a mucoperiosteal flap.
- Removal of bone.
- Sectioning of a tooth.
- Suturing.

Post-operative instructions and prescriptions should also be included in the record. **Writing "surgical extraction" or "SE" in the treatment notes is not sufficient documentation.**

Wisconsin Medicaid may recoup reimbursement for emergency dental procedures if a post pay audit finds insufficient documentation of the emergency procedure.

Wisconsin Medicaid coverage of surgical extractions

As directed by the 1991-93 Biennial Budget and HFS 107.07(3)(m), Wis. Admin. Code, Wisconsin Medicaid covers surgical extractions of impacted or erupted teeth or surgical removal of residual tooth root only in the following circumstances:

- An emergency situation, when an immediate service must be provided to relieve the recipient from pain, an acute infection, trismus, swelling, fever, or trauma.
- Orthodontia for children up to age 21. In this situation, Wisconsin Medicaid requires the provider to request prior authorization for the surgical extraction of a tooth in a non-emergency situation.
- If, during the extraction of any tooth, an extraction unexpectedly becomes a surgical extraction, the surgical extraction is considered a dental emergency. In this situation, a provider is required to submit a claim for this procedure as an emergency. Even if a recipient has indicated that he or she will pay for a non-surgical extraction, retain documentation of the emergency circumstances in the recipient's records.

The procedure codes for surgical extractions affected by these conditions are: D7210, D7220, D7230, D7240, D7250, and their corresponding zero codes. Refer to Attachment 1 for descriptions of these CDT codes.

Medicaid-contracted HMOs and dental coverage

Some recipients enrolled in Medicaid-contracted HMOs have dental coverage through their HMOs. Before providing any non-emergency dental services, a dentist should always check whether a Medicaid recipient is enrolled in an HMO and whether the HMO provides dental coverage. Dental providers are paid on a fee-for-service basis for managed care program enrollees if the managed care program does not offer dental 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 1
CDT procedure codes that no longer require an "E" indicator

Wisconsin Medicaid no longer requires an "E" indicator on the claim form for these *Current Dental Terminology* procedure codes if the procedure was provided in an emergency. Wisconsin Medicaid considers a situation to be an emergency when immediate service must be provided to relieve the recipient from pain, an acute infection, trismus, swelling, fever, or trauma.

Code	Description of Service		Code	Description of Service
D0250 00250	Extraoral — first film		D7270 07270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus
D0260 00260	Extraoral — each additional film		D7910 07910	Suture of recent small wounds up to 5 cm
D0330* 00330*	Panoramic film		D7911 07911	Complicated suture — up to 5 cm
D7210* 07210*	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth		D7912 07912	Complicated suture — greater than 5 cm
D7220* 07220*	Removal of impacted tooth — soft tissue		D9110 09110	Palliative (emergency) treatment of dental pain — minor procedure
D7230* 07230*	Removal of impacted tooth — partially bony		D9910 09910	Application of desensitizing medicament
D7240* 07240*	Removal of impacted tooth — completely bony		W7116	Open tooth for drainage
D7250* 07250*	Surgical removal of residual tooth roots (cutting procedure)		W7118	Treat periodontal abscess

*Wisconsin Medicaid may reimburse for these services in conjunction with an orthodontic treatment plan or with prior authorization for unusual non-emergency situations.

ATTACHMENT 2
CPT procedure codes that no longer require an "E" indicator

Wisconsin Medicaid no longer requires an "E" indicator on the claim form for these *Current Procedural Terminology* codes if the procedure was provided in an emergency. Wisconsin Medicaid considers a situation to be an emergency when immediate service must be provided to relieve the recipient from pain, an acute infection, trismus, swelling, fever, or trauma.

Code	Description of Service	Code	Description of Service	Code	Description of Service
12011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less	12053	5.1 cm to 7.5 cm	13133	Each additional 5 cm or less
12013	2.6 cm to 5.0 cm	12054	7.6 cm to 12.5 cm	13150	Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less
12014	5.1 cm to 7.5 cm	12055	12.6 cm to 20.0 cm	13151	1.1 cm to 2.5 cm
12015	7.6 cm to 12.5 cm	12056	20.1 cm to 30.0 cm	13152	2.6 cm to 7.5 cm
12016	12.6 cm to 20.0 cm	12057	Over 30.0 cm	13153	Each additional 5 cm or less
12017	20.1 cm to 30.0 cm	13102	Repair, complex, trunk; each additional 5 cm or less	14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
12018	Over 30.0 cm	13122	Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less	14041	Defect 10.1 sq cm to 30.0 sq cm
12051	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less	13131	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm	14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
12052	2.6 cm to 5.0 cm	13132	2.6 cm to 7.5 cm	14061	Defect 10.1 sq cm to 30.0 sq cm

Code	Description of Service		Code	Description of Service		Code	Description of Service
14300	Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated, any area		15240	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less		15820	Blepharoplasty, lower eyelid
15000	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); first 100 sq cm or one percent of body area of infants and children		15241	Each additional 20 sq cm		15822	Blepharoplasty, upper eyelid
15120	Split graft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children (except 15050)		15260	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less		15824	Rhytidectomy; forehead
15121	Each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof		15261	Each additional 20 sq cm		15825	Neck with platysmal tightening (platysmal flap, P-flap)

Code	Description of Service		Code	Description of Service		Code	Description of Service
15826	Glabellar frown lines		21215	Mandible (includes obtaining graft)		37615	Ligation, major artery (eg, post-traumatic, rupture); neck
15828	Cheek, chin, and neck		21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)		40650	Repair lip, full thickness; vermilion only
20900	Bone graft, any donor area; minor or small (eg, dowel or button)		21235	Ear cartilage, autogenous, to nose or ear (includes obtaining graft)		40652	Up to half vertical height
20902	Major or large		21497	Interdental wiring, for condition other than fracture		40654	Over one-half vertical height, or complex
20926	Tissue grafts, other (eg, paratenon, fat, dermis)		31600	Tracheostomy, planned (separate procedure)		40818	Excision of mucosa of vestibule of mouth as donor graft
21110	Application of interdental fixation device for conditions other than fracture or dislocation, includes removal		31603	Tracheostomy, emergency procedure; transtracheal		40830	Closure of laceration, vestibule of mouth; 2.5 cm or less
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)		31605	Cricothyroid membrane		40831	Over 2.5 cm or complex

Code	Description of Service		Code	Description of Service		Code	Description of Service
41250	Repair of laceration 2.5 cm or less; floor of mouth and/or anterior two-thirds of tongue		42180	Repair, laceration of palate; up to 2 cm		42962	With secondary surgical intervention
41251	Posterior one-third of tongue		42182	Over 2 cm or complex		42970	Control of nasopharyngeal hemorrhage, primary or secondary (eg, postadenoidectomy); simple, with posterior nasal packs, with or without anterior packs and/or cauterization
41252	Repair of laceration of tongue, floor of mouth, over 2.6 cm or complex		42900	Suture pharynx for wound or injury		42971	Complicated, requiring hospitalization
41500	Fixation of tongue, mechanical, other than suture (eg, K-wire)		42960	Control oropharyngeal hemorrhage, primary or secondary (eg, post-tonsillectomy); simple		42972	With secondary surgical intervention
41821	Operculectomy, excision pericoronal tissues		42961	Complicated, requiring hospitalization			

ATTACHMENT 3
Billing recipients for noncovered services

As stated in HFS 101.03(103), Wis. Admin. Code, a noncovered service is a service, item, or supply for which Medicaid reimbursement is not available. This includes the following:

- A service listed as noncovered in HFS 107, Wis. Admin. Code.
- A service for which prior authorization has been denied.
- A service considered by consultants to the Department of Health and Family Services to be medically unnecessary, unreasonable, or inappropriate.

In some cases, a recipient may request a noncovered service. No part of the charge for a noncovered service is reimbursable by Wisconsin Medicaid and the provider may instead bill the recipient. However, dentists may bill the recipients for a noncovered service only if certain conditions are met prior to the delivery of that service:

- Wisconsin Medicaid requires the dentist to explain to the recipient prior to providing the service that the service is not covered by Wisconsin Medicaid and that the recipient is responsible for payment.
- The noncovered service must be separate or distinct from a related, covered service.
- If the recipient still requests the service after being told that it is not Medicaid-covered, the recipient and the dentist need to decide whether the service should be provided and make payment arrangements. Before providing the service, dentists are encouraged to obtain a written statement from the recipient verifying that the recipient has accepted liability for the service.

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