wisconsin Medicaid update
and BadgerCare
February 2002 • No. 2002-04
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Wisconsin Medicaid and BadgerCare Information for Providers

To:
Dentists
HMOs and Other Managed Care Programs

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/*.

# Introducing the new Prior Authorization Dental Attachment 1

This *Wisconsin Medicaid and BadgerCare Update* introduces the new Prior Authorization Dental Attachment 1 (PA/DA1) which is designed to make PA easier for dentists who perform certain procedures. Dentists use the PA/DA1 in conjunction with the Prior Authorization Dental Request Form (PA/DRF).

Providers have the option of using the revised PA/DA1 included with this *Update* or the Prior Authorization Dental Attachment (PA/DA) from the 1998 Dental Services Handbook. Dentists who provide oral surgery, orthodontics, and fixed prosthetics are required to continue to use the PA/DA from the 1998 Dental Services Handbook.

## Improvements made to the Prior Authorization Dental Attachment

Improvements for the new Prior Authorization Dental Attachment 1 (PA/DA1) include the following formatting and organizational changes:

- It has been condensed into a check-box format and requires minimal narrative.
- It is organized by category and offers the treatment plan justifications for each category.
- It lists supporting documentation required for each procedure. Note that the documentation requirements have not changed.

Refer to Attachment 1 of this *Wisconsin Medicaid and BadgerCare Update* for PA/DA1 completion instructions (HCF 11010A). Refer to Attachment 2 for a copy of the PA/DA1 (HCF 11010).

### *Oral surgery, orthodontics, and fixed prosthetic services*

The PA/DA1 does not include all services. Dentists who provide the following services are required to continue to use the old Prior Authorization Dental Attachment (PA/DA) from the Dental Services Handbook. Wisconsin Medicaid will issue a Prior Authorization Dental Attachment 2 for the following services in the future:

- Oral surgery.
- Orthodontics.
- Fixed prosthetics.

## How the Prior Authorization Dental Attachment 1 was designed

The PA/DA1 was designed by a Medicaid-certified dentist with support and suggestions from the Wisconsin Dental Association. It was piloted in four dental offices. Dentists who have used the new check-box format agree that the PA/DA1 is easier to use compared to the PA/DA published in the 1998 Dental Services Handbook. Medicaid-certified dentists may now choose to use either the new PA/DA1 or the 1998 PA/DA.

## Obtaining copies of the Prior Authorization Dental Attachment 1 and instructions

The following options are available to providers for obtaining the PA/DA1:

- Photocopy the PA/DA1 in Attachment 2.
- Refer to the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* to print a Portable Document Format (PDF) copy or to obtain a copy providers may complete electronically. (See the "Electronic Prior Authorization Dental Attachment 1" section of this *Update* for more information on obtaining a fillable PDF version.)
- Order paper copies of the PA/DA1 (and Prior Authorization Dental Request Form) by writing to Wisconsin Medicaid. Include a return address, the number of copies needed, and the form number. Mail the request to the following address:

  Wisconsin Medicaid
  Forms Reorder
  6406 Bridge Rd
  Madison WI 53784-0003

Providers may create a template on their computer that includes the same information as the PA/DA1 included with this *Update*.

### *Electronic Prior Authorization Dental Attachment 1*

Providers may obtain a fillable PDF version of the PA/DA1 from the Medicaid Web site. The fillable PDF version allows providers to complete the PA/DA1 on their computer using Adobe Acrobat Reader® and then print it.* To obtain this version, follow these steps:

- Go to the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/*.
- Click on "Medicaid and BadgerCare Provider Updates."
- Select this *Update* (2002-04) by choosing "2002" under "Updates by Year" and finding "2002-04." Providers may also find it under "Publications listed by provider type."
- Select Attachment 2 within the text of the *Update* and save it to your computer.
- Click on the light gray boxes with the hand tool to enter information in each field. Press the "Tab" key to get to each field.

## Submitting prior authorization requests

Dentists may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616 if X-rays or models are not required for documentation purposes. Refer to the January 2002 *Update* for more information on faxing PA requests. Dentists who wish to continue submitting PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

Dentists may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616 if X-rays or models are not required for documentation purposes.

## Managed care providers

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

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* The Medicaid Web site provides instructions on how to obtain Adobe Acrobat Reader® at no charge from the Adobe® Web site. Adobe Acrobat Reader® does not allow users to save completed fillable PDFs to their computer. Refer to the Adobe® Web site for more information on fillable PDFs.

# ATTACHMENT 1
# Prior Authorization Dental Attachment 1 (PA/DA1) Completion Instructions

(A copy of the Prior Authorization Dental Attachment 1 [PA/DA1] Completion Instructions is located on the reverse side of this page.)

# WISCONSIN MEDICAID
# PRIOR AUTHORIZATION DENTAL ATTACHMENT 1 (PA/DA1) COMPLETION INSTRUCTIONS

The Wisconsin Medicaid Program requires information to enable the Medicaid program to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information shall include but is not limited to information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02 (4), Wis. Admin. Code).

Under s. 49.45 (4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to the Medicaid program administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

When completing PA requests, answer all elements as thoroughly as possible. Provide enough information (check all boxes that apply) for Wisconsin Medicaid dental consultants to make a reasonable judgement about the case.

**Submitting Prior Authorization Requests**
Dentists may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616 if X-rays or models are not required for documentation purposes. Dentists who wish to continue submitting PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

**HEADER COMPLETION INSTRUCTIONS:** Complete the numeric information at the top of **each** page of the Prior Authorization Dental Attachment 1 (PA/DA1). This information ensures accurate tracking of the PA/DA1 with the Prior Authorization Dental Request Form (PA/DRF) through the PA review process. This attachment will be returned to the provider if the numeric information is not completed at the top of each page submitted.

**PA Number —** Indicate the preprinted number stamped at the top of the PA/DRF.

**Recipient's Medicaid Number —** Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

**Billing Provider Number —** Enter the eight-digit provider number. Use the billing number you will use on Medicaid claims.

**Performing Provider Number (if different) —** Enter the eight-digit provider number of the dentist who will actually provide the service if the performing provider is different from the billing provider.

## SERVICE SECTION COMPLETION INSTRUCTIONS

**Category —** Select the category that describes the requested service(s).

**Procedure Codes —** Check the box for the appropriate procedure code(s) that represents the service(s) being requested.

**Treatment Plan Justification —** Check all boxes that apply for the appropriate reason(s) the procedure(s) is to be performed.

**Required Documentation —** This column lists the documentation that must be submitted with the PA request.

# ATTACHMENT 2
# Prior Authorization Dental Attachment 1 (PA/DA1)

(A copy of the Prior Authorization Dental Attachment 1 [PA/DA1] is located on the following pages.)

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**DEPARTMENT OF HEALTH AND FAMILY SERVICES**
Division of Health Care Financing
HCF 11010 (01/02)

**STATE OF WISCONSIN**
107.07(2), Wis. Admin. Code

# WISCONSIN MEDICAID
# PRIOR AUTHORIZATION DENTAL ATTACHMENT 1 (PA/DA1)
# CHECK BOX VERSION

Requested identifying information will only be used to process the prior authorization (PA) request. Failure to supply any of the requested information may result in a denial of the PA.

| PA Number | Recipient's Medicaid Number | Billing Provider Number | Performing Provider Number |
|---|---|---|---|
| | | | |

| CATEGORY | PROCEDURE CODES (CHECK ALL THAT APPLY) | | TREATMENT PLAN JUSTIFICATION (CHECK ALL THAT APPLY) | REQUIRED DOCUMENTATION |
|---|---|---|---|---|
| Diagnostic Services | ❑ D0210<br>❑ D0330<br>❑ D0340<br>❑ D0350<br>❑ D0470 | | ❑ Frequency limitation needs to be exceeded<br>❑ Ortho ❑ Department of Health and Family Services request<br>❑ Date of models_____<br>❑ HealthCheck referral | Explanation to exceed frequency limitation. |
| Preventive Services | ❑ D1110<br>❑ D1120<br>❑ D1201<br>❑ D1203<br>❑ D1204<br>❑ D1205 | | ❑ Permanent disability, describe_____<br>❑ Rampant decay ❑ Xerostomia<br>❑ Radiation therapy to head and neck<br>❑ Root caries/recession ❑ Medication<br>❑ Other_____<br>❑ Quantity requested_____<br>Years requested ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 (check one) | |
| | ❑ D1351 | | ❑ Congenital malformation<br>❑ Newly erupted tooth<br>Tooth numbers_____<br>❑ Medical condition_____ | No PA needed under age 20 for first and second molars. |
| Restorative Services | ❑ W7126* | Tooth No. | ❑ Signed Provision of Upgraded Partial Denture and Crowns to Medicaid Recipients | One periapical X-ray. |
| | ❑ D2932<br>❑ D2933 | Tooth No. | ❑ Older than age 20 — 6-11, 22-27, D-G, SN<br>❑ Successful endo tx[1]<br>❑ More than 50% tooth involved in trauma/caries<br>❑ Cannot be restored with composite<br>❑ AAP[2] I or II | One periapical X-ray. |
| Endodontic Services | ❑ D3310<br>❑ D3320<br>❑ D3330 | Tooth No. | ❑ AAP I or II ❑ Restorative tx completed<br>❑ Restorative tx in process<br>❑ Extractions last three years<br>Tooth number and date_____<br>❑ Pathology, describe_____ | • Two bitewing and one periapical X-rays.<br>• Intra-oral charting.<br>• Document pathology, abcesses, carious exposure, non-vital, etc. |
| | ❑ D3410<br>❑ D3430 | Tooth No. | ❑ Periapical pathology ❑ Failed root canal<br>❑ Root fx[3] ❑ Existing porcelain crown<br>❑ 6-11, 22-27 ❑ Other_____ | • One periapical X-ray.<br>• Include both codes on PA. |
| Periodontic Services | ❑ D4210<br>❑ D4211 | | ❑ Medication induced hyperplasia<br>❑ Irritation ortho bands ❑ Hyperplasia<br>❑ More than 25% crown involved<br>❑ D4211 tooth numbers_____<br>❑ Other_____ | • Periodontal charting.<br>• Comprehensive periodontal treatment plan. |
| | ❑ D4341 | | ❑ Older than age 12 — Pockets 4 to 6 mm<br>❑ History of periodontal abcess<br>❑ Early bone loss ❑ Moderate bone loss ❑ AAP II or III<br>❑ Oral hygiene: ❑ Good ❑ Fair ❑ Poor | • Periodontal charting.<br>• Comprehensive periodontal treatment plan. |
| | ❑ D4355 | | ❑ Excess calculus on X-ray ❑ AAP I or II<br>❑ No dental tx in multiple years<br>❑ Oral hygiene: ❑ Good ❑ Fair ❑ Poor | • Bitewing or full mouth X-rays.<br>• Calculus must be visible on X-rays. |
| | ❑ D4910 | | ❑ Recent history of periodontal scale/surgery<br>❑ Oral hygiene: ❑ Good ❑ Fair ❑ Poor<br>Years requested ❑ 1 ❑ 2 ❑ 3 (check one) | • Periodontal charting.<br>• Comprehensive periodontal treatment plan once per 12 months. |

[1]tx — treatment [2]AAP — American Association of Periodontists [3]fx — fracture

| PA Number | Recipient's Medicaid Number | Billing Provider Number | Performing Provider Number |
|---|---|---|---|
| | | | |

| CATEGORY | PROCEDURE CODES (CHECK ALL THAT APPLY) | TREATMENT PLAN JUSTIFICATION (CHECK ALL THAT APPLY) | REQUIRED DOCUMENTATION |
|---|---|---|---|
| Prosthodontic Services — Complete Dentures | ❑ D5110<br>❑ D5120 | ❑ Age of existing denture(s) Max_____ Mand_____<br>❑ New denture request because:<br>❑ Worn base/broken teeth ❑ Poor fit<br>❑ Vertical dimension<br>❑ This is initial placement of dentures<br>❑ Date(s) last teeth extracted_____<br>❑ Has not worn existing dentures for more than three years<br>❑ Edentulous more than 5 years without dentures<br>❑ Lost/stolen/broken dentures<br>❑ Reline/repair not appropriate<br>❑ Additional justification_____ | • New dentures limited to one per five years, per arch.<br>• Document early requests.<br>• Six weeks healing period required unless special circumstances documented.<br>• Document reasons for not wearing dentures, or for not having ever had dentures.<br>• Submit medical documentation to support special requests.<br>• Document loss and plan for prevention of future mishaps. |
| Prosthodontic Services — Partial Dentures | ❑ D5211<br>❑ D5212<br>❑ W7127*<br>❑ W7128* | ❑ Age of existing denture(s) Max_____ Mand_____<br>❑ New denture partial request because:<br>❑ Worn base/broken teeth ❑ Poor fit<br>❑ Vertical dimension<br>❑ This is initial placement of dentures<br>❑ Date(s) last teeth extracted_____<br>❑ Missing at least one anterior tooth and/or has fewer than two posterior teeth in any one quadrant in occlusion with opposing arch<br>❑ AAP type I or II<br>❑ Non-restorable teeth have been extracted<br>❑ Restorative procedures completed or scheduled<br>❑ Unusual clinical circumstances — document (needed for employment, etc.)<br>❑ Recommendation of speech therapist<br>❑ Lost/stolen/broken dentures<br>❑ Reline/repair not appropriate<br>❑ Additional justification_____ | • X-rays to show entire arch.<br>• Periodontal charting.<br>• New partials limited to one per five years, per arch.<br>• Document early requests.<br>• Six weeks healing period required unless special circumstances documented.<br>• Document reasons for not wearing partial dentures, or reasons for not having ever had partial dentures.<br>• Submit medical documentation to support special requests.<br>• Document loss and plan for prevention of future mishaps. |
| Prosthodontic Services — Denture Reline | ❑ D5750<br>❑ D5751<br>❑ D5760<br>❑ D5761 | ❑ Loose or ill-fitting<br>❑ Tissue shrinkage or weight loss<br>❑ Recipient is wearing denture | • Relines limited to one per three years, per arch.<br>• Document special circumstances or early requests. |
| Anesthesia/ Professional Visit | ❑ D9220<br>❑ D9241<br>❑ D9248<br>❑ D9420 | ❑ Behavior ❑ Disability (describe)<br>❑ Geriatric ❑ Physician consult<br>❑ Complicated medical history_____<br>❑ Extensive restoration ❑ Maxillofacial surgery | • Submit medical documentation to support special circumstances.<br>• Prior authorization not required for recipients five years and under for procedure D9420. |

Additional comments:

*No dentist obligated to provide this service.

RESET FORM