wisconsin Medicaid update
and BadgerCare

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Wisconsin Medicaid and BadgerCare Information for Providers

To:
Dentists
HMOs and Other Managed Care Programs

# Wisconsin Medicaid adds procedure codes to dental coverage

Effective for dates of service on and after June 1, 2002, Wisconsin Medicaid will cover two additional dental procedure codes.

## Wisconsin Medicaid adds two dental procedure codes to covered dental services

Wisconsin Medicaid will cover two additional *Current Dental Terminology* (CDT) procedure codes at the reimbursement rates listed in the Attachment of this *Wisconsin Medicaid and BadgerCare Update* effective for dates of service on and after June 1, 2002.

For more information on CDT procedure codes and dental claims submission, refer to the Wisconsin Medicaid Dental Handbook.

All recipients are responsible for paying a copayment, which is part of the cost involved in obtaining dental services. However, in some situations, such as emergencies, recipients are exempt from copayment. For more information on collecting copayments and copayment exemptions, refer to the Dental Handbook.

This *Update* contains Medicaid fee-for-service policy and applies to dentists who provide 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.

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
# Procedure codes added to dental coverage
## Effective for dates of service on and after June 1, 2002

| CDT procedure code | Description of service | PA required? | Allowable Age | Limitations | Child maximum fee (0-20 years) | Adult maximum fee (21+ years) | Copayment |
|---|---|---|---|---|---|---|---|
| D0140 or 00140 | Limited oral evaluation — problem focused. This code is typically used for recipients referred for a specific problem and/or dental emergencies, trauma, or acute infection. | No | All | One evaluation per three years per provider. | $19.61 | $18.13 | $1.00 |
| D7120 or 07120 | Extractions (includes local anesthesia, suturing, if needed, and routine postoperative care); each additional tooth | No | All | One extraction per tooth (tooth numbers 1-32, A-T, SN). Not reimbursable if procedure code D7250 or 07250 is performed on the same date of service for the same tooth number. | $40.91 | $38.53 | $2.00 |