wisconsin Medicaid update
and BadgerCare

July 2003 ● No. 2003-50
PHC 1982

Wisconsin Medicaid and BadgerCare Information for Providers

To:

Dentists

HMOs and Other Managed Care Programs

Changes to local codes, paper claims, and prior authorization for dental services as a result of HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces important changes to local codes, paper claims, and prior authorization (PA) for dental services effective October 2003, as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). These changes include:

- **Adopting nationally recognized codes to replace currently used Wisconsin Medicaid local codes.**
- **Revising ADA 2000 paper claim instructions.**
- **Revising Medicaid PA request forms and instructions.**

A future *Update* will notify providers of the specific effective dates for the various changes.

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/*.

Changes as a result of HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces important billing and prior authorization (PA) changes for dental services. These changes will be implemented in **October 2003** as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

A future *Update* will notify providers of the specific effective dates for the various changes. These changes are *not* policy or coverage related (e.g., PA requirements, documentation), but include:

- Adopting nationally recognized procedure codes, modifiers, and place of service (POS) (place of treatment) codes to replace currently used Wisconsin Medicaid local codes.
- Revising ADA 2000 paper claim instructions.
- Revising PA request forms and instructions.

Note: Use of the national codes that will replace Wisconsin Medicaid local codes, revised claim instructions, or revised PA forms and instructions prior to implementation dates may result in claim denials and returned PA requests. Specific implementation dates will be published in a future *Update.*

Adoption of national codes

Wisconsin Medicaid will adopt nationally recognized codes to replace currently used Wisconsin Medicaid local codes for dental services.

Replacement of local procedure codes with Current Dental Terminology 4 procedure codes

Wisconsin Medicaid will adopt *Current Dental Terminology 4* (CDT-4) procedure codes to replace currently used Wisconsin Medicaid local procedure codes (W7060-W7998) for dental services. Refer to Attachment 1 of this *Update* for a procedure code conversion chart. Providers must choose the CDT-4 procedure code that best describes the service performed.

Providers should continue to refer to their service-specific *Updates* and handbooks for other nationally recognized procedure codes Wisconsin Medicaid covers. Wisconsin Medicaid will no longer reimburse for "0" codes after the implementation of HIPAA. If the code listed in the Dental Services Handbook begins with "0," replace the "0" with "D."

Wisconsin Medicaid will discontinue use of CDT-3 procedure codes with the implementation of HIPAA. Providers are encouraged to begin using CDT-4 codes as soon as possible. A maximum fee schedule that includes allowable CDT-4 codes is available from the Wisconsin Medicaid Web site.

If the provider's office does not have a CDT-4 manual, one can be ordered from the American Dental Association.

Coverage for dental services

Medicaid coverage and documentation requirements for dentists will remain unchanged. Refer to the Dental Services Handbook and *Updates* for complete Medicaid policies and procedures.

Areas of the oral cavity

Dentists will be required to use nationally recognized indicators for areas of the oral cavity. Refer to Attachment 2 for a conversion crosswalk from local modifiers to nationally recognized areas of the oral cavity, used when designating repairs of upper and lower dentures and partials.

Supernumerary teeth

Effective with the implementation of HIPAA, the supernumerary modifier, "SN," will be indicated in the following manner:

- For primary teeth, an "S" will be placed after the applicable tooth letter (values "AS" through "TS").
- For permanent teeth, enter the sum of the value of the tooth number closest to the supernumerary tooth and 50. For example, if the tooth number closest to the supernumerary tooth has a value of 12, the provider will indicate supernumerary with the number 62 (12 + 50 = 62).

Place of service (place of treatment) codes

Nationally recognized two-digit POS (place of treatment) codes will replace the one-digit Wisconsin Medicaid POS codes. Refer to Attachment 3 for a list of allowable POS codes for dental services.

Elimination of the ADA 1994 paper claim form

Effective for claims received by Wisconsin Medicaid on and after September 1, 2003, Wisconsin Medicaid will no longer process claims submitted on the ADA 1994 paper claim form. Providers are encouraged to begin using the ADA 2000 paper claim form as soon as possible.

Revision of ADA 2000 paper claim instructions

With the implementation of HIPAA, Medicaid-certified dentists will be required to follow the revised instructions for the ADA 2000 paper claim form in this *Update,* even though the actual ADA 2000 claim form is not being revised at this time. Refer to Attachments 4 and 6-13 for the revised instructions. Attachment 5

Wisconsin Medicaid will no longer reimburse for "0" codes after the implementation of HIPAA. If the code listed in the Dental Services Handbook begins with "0," replace the "0" with "D."

is a sample of a claim for dental services that reflects the changes to the billing instructions. Circled fields on the claim form example indicate changes in claim form instructions.

Failure to follow the revised ADA 2000 paper claim instructions for claims received by Wisconsin Medicaid after the implementation of HIPAA will result in claim denials.

Note: In some instances, paper claim instructions are different from electronic claim instructions. Providers should refer to their software vendor's electronic billing instructions for completing electronic claims.

Wisconsin Medicaid will return any PA requests submitted using the previous version of the PA/DA to providers.

Revisions made to the ADA 2000 claim form instructions

Revisions made to the ADA 2000 paper claim form instructions include the following:

- Other insurance indicators were revised (Element 33).
  Note: OI-H and OI-Y are no longer acceptable for claims submitted on the ADA 2000 claim form. Refer to Attachment 6 for correct usage of OI-D.
- Medicare disclaimer codes were revised (Element 33).
  Note: M-6 is no longer acceptable. Refer to Attachment 7 for revised descriptions of Medicare disclaimer codes.
- Place of service (place of treatment) codes revised (Element 49). Refer to Attachment 3 for a list of allowable POS codes for dental services.
- Spenddown amount should no longer be entered (Element 59 "Patient Pays"). Wisconsin Medicaid will automatically reduce the provider's reimbursement by the recipient's spenddown amount.

Revision of prior authorization request forms and instructions

With the implementation of HIPAA, dentists will be required to use the revised Prior Authorization Dental Request Form (PA/DRF), HCF 11035, dated 06/03. Instructions for completion of this revised form are located in Attachment 14. A sample PA/DRF is in Attachment 15. The PA/DRF has been revised to include more space for additional modifiers in Element 15.

Prior authorization attachments

Dentists will be required to use either the revised Prior Authorization/Dental Attachment 1 (PA/DA1), HCF 11010, dated 06/03, or the Prior Authorization/Dental Attachment 2 (PA/DA2), HCF 11014, dated 06/03, for PA requests received by Wisconsin Medicaid on and after September 1, 2003. Wisconsin Medicaid will return any PA requests submitted using the previous version of the PA/DA to providers.

Dentists are required to use the PA/DA1 for the prior authorized services in the following categories:

- Anesthesia/professional visits.
- Diagnostic services.
- Endodontic services.
- Periodontic services.
- Preventive services.
- Prosthodontic services.
- Restorative services.

Dentists are required to use the PA/DA2 for the prior authorized services in the following categories:

- Fixed prosthetic services.
- Oral surgery services.
- Orthodontic services.

Refer to Attachment 16 for a copy of the completion instructions for the PA/DA1. Attachment 17 is a copy of the PA/DA1 for providers to photocopy, and Attachment 18 is a copy of the PA/DA2 for providers to photocopy.

Obtaining prior authorization request forms

The PA/DA1 and PA/DA2 are available in a fillable Portable Document Format (PDF) from the forms page of the Wisconsin Medicaid Web site. (Providers cannot obtain copies of the PA/DRF from the Medicaid Web site since each form has a unique preprinted PA number on it.) To access the PA/DA1, PA/DA2, and other Medicaid forms, follow these instructions:

1. Go to *www.dhfs.state.wi.us/medicaid/*.
2. Choose "Providers" from the options listed in the Wisconsin Medicaid main menu.
3. Select "Provider Forms" under the "Provider Publications and Forms" topic area.

The fillable PDF may be accessed using Adobe Acrobat Reader®* and may be completed electronically. Providers may then include the printed version of the attachment with the PA/RF. To use the fillable PDF, click on the dash-outlined boxes to enter information. Press the "Tab" key to move from one box to the next.

To request paper copies of the PA/DA1, PA/DA2, or PA/DRF, call Provider Services at (800) 947-9627 or (608) 221-9883. Questions about the forms may also be directed to Provider Services at the telephone numbers previously mentioned.

In addition, all PA forms and attachments are available by writing to Wisconsin Medicaid. Include a return address, the name of the form, and the HCF number of the form (if applicable) and send the request to:

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

General HIPAA information

Refer to the following Web sites for more HIPAA-related information:

- *www.cms.gov/hipaa/* — Includes links to the latest HIPAA news and federal Centers for Medicare and Medicaid Services HIPAA-related links.
- *aspe.hhs.gov/admnsimp/* — Contains links to proposed and final rules, links to download standards and HIPAA implementation guides, and frequently asked questions regarding HIPAA and the Administrative Simplification provisions.
- *www.dhfs.state.wi.us/hipaa/* — Contains Wisconsin Department of Health and Family Services HIPAA-related publications, a list of HIPAA acronyms, links to related Web sites, and other valuable HIPAA information.

Providers cannot obtain copies of the PA/DRF from the Medicaid Web site since each form has a unique preprinted PA number on it.

Information regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients who receive their dental benefits on a fee-for-service basis. Since HIPAA impacts all health care payers, it is important to know that HIPAA changes, including changes from local procedure codes to national procedure codes, will also have an impact on Medicaid HMOs. For questions related to Medicaid HMOs or managed care HIPAA-related changes, contact the appropriate managed care organization.

---

* The Medicaid Web site provides instructions on how to obtain Adobe Acrobat Reader® at no charge from the Adobe® Web site at *www.adobe.com/*. 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
Procedure code conversion chart for dental services

The following table lists the *Current Dental Terminology 4* (CDT-4) procedure codes that providers will be required to use when submitting claims for dental services. A future *Wisconsin Medicaid and BadgerCare Update* will notify providers of the specific effective dates for Wisconsin Medicaid's implementation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).Wisconsin Medicaid will no longer reimburse for "0" codes after the implementation of HIPAA.

Before HIPAA implementation		After HIPAA implementation	
Local procedure code	**Local procedure code description**	**CDT-4 procedure code**	**CDT-4 procedure code description**
W7060	Periodic oral exam (additional) — HealthCheck Other Services	**D0999**	unspecified diagnostic procedure, by report
W7062	Single unit crown — HealthCheck Other Services	**D2999**	unspecified restorative procedure, by report
W7063	Non-surgical procedure — HealthCheck Other Services	**D9999**	unspecified adjunctive procedure, by report
W7064	Surgical procedure — HealthCheck Other Services	**D4999**	unspecified periodontal procedure, by report
W7116	Open tooth for drainage	**D9110**	palliative (emergency) treatment of dental pain — minor procedure
W7118	Treat periodontal abscess		
W7126	Upgraded crown	**D2791**	crown — full cast predominantly base metal
W7127	Upgraded upper partial denture (including any conventional clasps, rests, and teeth)	**D5211**	maxillary partial denture — resin base (including any conventional clasps, rests and teeth)
W7128	Upgraded lower partial denture (including any conventional clasps, rests, and teeth)	**D5212**	mandibular partial denture — resin base (including any conventional clasps, rests and teeth)
W7130	TMJ office visit	**D0140**	limited oral evaluation — problem focused
W7310*	Fixed prosthodontic retainer	**D6751**	crown — porcelain fused to predominantly base metal
		D6791	crown — full cast predominantly base metal
W7320*	Fixed prosthodontic pontic	**D6211**	pontic — cast predominantly base metal
		D6241	pontic — porcelain fused to predominantly base metal
W7910	Examination, models, consultation — orthodontic	**D8660**	pre-orthodontic treatment visit
W7920*	Initial orthodontic treatment — banding service	**D8010**	limited orthodontic treatment of the primary dentition
		D8020	limited orthodontic treatment of the transitional dentition
		D8030	limited orthodontic treatment of the adolescent dentition
		D8040	limited orthodontic treatment of the adult dentition
		D8050	interceptive orthodontic treatment of the primary dentition
		D8060	interceptive orthodontic treatment of the transitional dentition
		D8070	comprehensive orthodontic treatment of the transitional dentition
		D8080	comprehensive orthodontic treatment of the adolescent dentition
		D8090	comprehensive orthodontic treatment of the adult dentition
W7995	Initial consultation, TMJ (TMJ multi-disciplinary evaluation program use only)	**D0160**	detailed and extensive oral evaluation — problem focused, by report
W7996	Follow-up consultation, TMJ (TMJ multidisciplinary evaluation program use only)	**D0170**	re-evaluation — limited, problem focused (established patient; not post-operative visit)
W7998	TMJ assistant surgeon	**D7899**	unspecified TMD therapy, by report

*Providers should choose the most appropriate CDT-4 procedure code for local codes replaced by multiple procedure codes.

ATTACHMENT 2
Local modifier code conversion chart for dental services

The following table lists the nationally recognized areas of the oral cavity that providers will be required to use instead of local modifiers "UU" and "LL" when submitting claims for repairs of upper and lower dentures and partials. A future *Wisconsin Medicaid and BadgerCare Update* will notify providers of the specific effective dates for Wisconsin Medicaid's implementation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Before HIPAA implementation	**After HIPAA implementation**
Local modifier and description	**Areas of the oral cavity**
UU Upper	**01** Maxillary
LL Lower	**02** Mandibular

ATTACHMENT 3
Place of service (place of treatment) codes for dental services

The following table lists the nationally recognized two-digit place of service (POS) (place of treatment) codes providers will be required to use when submitting claims for dental services. A future *Wisconsin Medicaid and BadgerCare Update* will notify providers of the specific effective dates for Wisconsin Medicaid's implementation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

When submitting claims on the ADA 2000 paper claim form, providers are required to enter one of the following POS codes under "Place of Treatment," Element 49. Refer to Attachment 4 of this *Update* for ADA 2000 paper claim completion instructions.

Place of treatment	Enter the following in Element 49
Office	Check the "Office" box with an "X" and enter: • **"05"** for Indian Health Service Free-Standing Facility. • **"06"** for Indian Health Service Provider-Based Facility. • **"07"** for Tribal 638 Free-Standing Facility. • **"08"** for Tribal 638 Provider-Based Facility. • **"11"** for Office. • **"50"** for Federally Qualified Health Center. • **"71"** for State or Local Public Health Clinic. • **"72"** for Rural Health Clinic.
Hospital	Check the "Hospital" box with an "X" and enter: • **"21"** for Inpatient Hospital. • **"22"** for Outpatient Hospital. • **"23"** for Emergency Room — Hospital. • **"51"** for Inpatient Psychiatric.
Extended Care Facility (ECF)	Check the ECF box with an "X" and enter: • **"31"** for Skilled Nursing Facility. • **"32"** for Nursing Facility. • **"54"** for Intermediate Care Facility/Mentally Retarded.
Other	Check the "Other" box with an "X" and enter: • **"12"** for Home. • **"15"** for Mobile Unit. • **"24"** for Ambulatory Surgical Center.

ATTACHMENT 4
ADA 2000 claim form completion instructions for dental services

(For claims submitted after HIPAA implementation)

Use the following claim form completion instructions, ***not*** the element descriptions printed on the claim form, to avoid denied claims or inaccurate claim payment. Complete all required elements as appropriate. Do not include attachments unless instructed to do so in the Wisconsin Medicaid Dental Services Handbook.

Wisconsin Medicaid recipients receive a Medicaid identification card upon being determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Eligibility Verification System (EVS) to determine if there are any limitations on covered services and obtain the correct spelling of the recipient's name. Refer to the Provider Resources section of the All-Provider Handbook or the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* for more information about the EVS.

Element 1 — Dentist's Pre-Treatment Estimate, Dentist's Statement of Actual Services, Specialty (not required)

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 multiple PA requests must be submitted on separate claim forms with their respective PA numbers. Wisconsin Medicaid will only accept one PA number per claim.

Elements 3-7 — Carrier Name, Carrier Address, City, State, ZIP (not required)

Element 8 — Patient Name

Enter the recipient's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Elements 9-11 — Patient's Address, City, State (not required)

Element 12 — Date of Birth (MM/DD/YYYY)

Enter the recipient's birth date in MM/DD/YYYY format (e.g., March 27, 1972, would be 03/27/1972).

Element 13 — Patient ID

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

Elements 14-16 — Sex, Phone Number, Zip Code (not required)

Element 17 — Relationship to Subscriber/Employee (not required)

Element 18 — Employer/School (not required)

Element 19 — Subs./Emp. ID#/SSN# (not required)

Element 20 — Employer Name (not required)

Element 21 — Group# (not required)

Element 22-30 — Subscriber/Employer Name (Last, First, Middle), Address, Phone Number, City, State, ZIP Code, Date of Birth (MM/DD/YYYY), Marital Status, Sex (not required)

Element 31 — Is Patient Covered by Another Plan (not required)

Element 32 — Policy # (not required)

Element 33 — Other Subscriber's Name (required, if applicable)

Except for a few instances, Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service. This means the provider is required to make a reasonable effort to exhaust all existing commercial health insurance sources before billing Wisconsin Medicaid unless the service is not covered by commercial health insurance. Wisconsin Medicaid uses Element 33 to identify Medicare and commercial health insurance information, whether the recipient has commercial health insurance coverage, Medicare coverage, or both. Refer to Attachments 6-13 of this *Wisconsin Medicaid and BadgerCare Update* for the following information:

- Wisconsin Medicaid commercial health or dental insurance explanation codes for use in Element 33 (Attachment 6).
- Medicare disclaimer codes (Attachment 7).
- A key to Wisconsin Medicaid's seven commercial health insurance indicators for use when a recipient's eligibility is confirmed in EVS (Attachment 8).
- When the EVS indicates the code "DEN" for "Other Coverage," a list of procedure codes for claims for which commercial dental insurance must be billed prior to billing Wisconsin Medicaid (Attachment 9).
- When the EVS indicates the code "HMO" for "Other Coverage," a list of procedure codes for claims for which commercial dental insurance must be billed prior to billing Wisconsin Medicaid (Attachment 10).
- When the EVS indicates the code "VIS" for "Vision Only," providers are not required to bill private insurance.
- When the EVS indicates the codes "BLU," "WPS," "CHA," "HPP," or "OTH" for "Other Coverage," a list of procedure codes for claims for which commercial dental insurance must be billed prior to billing Wisconsin Medicaid (Attachment 12).
- When the EVS indicates the code "SUP" for "Medicare Supplement," providers must bill commercial insurance for Medicare-allowed services only (Attachment 11).
- Appropriate provider responses to special circumstances when billing commercial health or dental insurance prior to billing Wisconsin Medicaid (Attachment 13).

Recipients with commercial health or dental insurance coverage

Commercial health or dental insurance coverage must be billed prior to submitting claims to Wisconsin Medicaid, unless the service does not require commercial health insurance billing as determined by Wisconsin Medicaid. Commercial health insurance coverage is indicated by the EVS under "Other Commercial Health Insurance."

When commercial dental or health insurance paid for some services

When commercial dental or health insurance paid only for some services and denied payment for the others, Wisconsin Medicaid recommends providers submit 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

Submit claims to Medicare before submitting claims to Wisconsin Medicaid.

Do not enter a Medicare disclaimer code in Element 33 when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- Wisconsin Medicaid indicates the recipient does *not* have any Medicare coverage including Medicare Cost ("MCC") or Medicare + Choice ("MPC") for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A.
- Wisconsin Medicaid indicates that the provider is not Medicare enrolled.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits, but do not indicate on the claim form the amount Medicare paid.

If none of the previous statements are true, a Medicare disclaimer code is necessary. Refer to Attachment 7 for a list of Medicare disclaimer codes.

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 34 — Date of Birth (MM/DD/YYYY) (not required)

Element 35 — Sex (not required)

Element 36 — Plan/Program Name (not required)

Element 37 — Employer/School (not required)

Element 38 — Subscriber/Employer Status (not required)

Element 39 — Subscriber/Employee Signature (not required)

Element 40 — Employer/School (not required)

Element 41 — Employee/Subscriber Signature Authorizing Payment (not required)

Element 42 — Name of Billing Dentist or Dental Entity

Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider's name, city, state, and Zip code. If the billing provider is a group or clinic, enter the group or clinic name in this element. The name in Element 42 must correspond with the provider identification number in Element 44.

Element 43 — Phone Number (not required)

Element 44 — Provider ID

Enter the billing provider's eight-digit Medicaid provider number. The provider number in this element must correspond with the provider name indicated in Element 42.

Element 45 — Dentist Soc. Sec. or T.I.N. (not required)

Element 46 — Address

Enter the billing provider's complete street address. If providers move or are at a different address, they should complete the Wisconsin Medicaid Provider Change of Address or Status form (HCF 1181), dated 09/02, to notify Wisconsin Medicaid that an address change has occurred. The form is located on the forms section of the Wisconsin Medicaid Web site at *www.dhfs.state.wi.us/medicaid/*. Providers without Internet access may request a copy by calling Provider Services at (800) 947-9627 or (608) 221-9883.

Element 47 — Dentist License # (not required)

Element 48 — First Visit Date of Current Series (not required)

Element 49 — Place of Treatment

Enter the appropriate two-digit place of service (place of treatment) code for each service as indicated in Attachment 3.

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 53 — Radiographs or Models Enclosed? (not required)

Element 54 — Is Treatment for Orthodontics? (required, if applicable)

Check yes or no to indicate whether or not the treatment is for orthodontics, and enter the date the appliances were placed if "yes" is indicated.

Element 55 — If Prosthesis (Crown, Bridge Dentures), Is This Initial Placement? (not required)

Element 56 — Is Treatment Result of Occupational Illness or Injury? (required, if applicable)

Check yes or no to specify if the dental services were the result of an occupational illness or injury. 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 58 — Diagnosis Code Index (not required)

Element 59 — Examination and Treatment Plans

Date (MM/DD/YYYY): Enter the date of service in MM/DD/YYYY format (e.g., November 1, 2003, would be 11/01/2003) for each detail.

Tooth: If the procedure applies to only one tooth, the tooth number or tooth letter is entered here. If the procedure applies to only one repair of dentures or partials, the area of the oral cavity is entered here.

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

Diagnosis Index #: Not required by Wisconsin Medicaid.

Procedure Code: Enter the appropriate procedure code and modifier for the dental service provided.

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 actual amount paid by commercial health or dental insurance. (If the dollar amount indicated in Element 59 is greater than zero, "OI-P" must be indicated in Element 33.) Do not include the Wisconsin Medicaid copayment amount. *If the commercial health or dental insurance plan paid on only some services, those partially paid services should be submitted on a separate claim from the unpaid services to maximize reimbursement.* This allows Wisconsin Medicaid to appropriately credit the payments. If the commercial health or dental insurance denied the claim, enter "000." Do **not** enter Medicare-paid amounts in this field.

Max. Allowable: Not required by Wisconsin Medicaid.

Deductible: Not required by Wisconsin Medicaid.

Carrier %: Not required by Wisconsin Medicaid.

Patient Pays: Not required by Wisconsin Medicaid. Do not enter recipient copayment amounts.

Admin. Use Only: Not required by Wisconsin Medicaid.

Element 60 — Identify All Missing Teeth With "X" (not required)

Element 61 — Remarks for Unusual Services (required, if applicable)

List any unusual services, including reasons why limitations were exceeded.

Element 62 — Dentist's Signature Block

The provider or the authorized representative must sign in Element 62. The month, day, and year the form is signed must also be entered in MM/DD/YYYY format.

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

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.

Elements 63-65 — Address Where Treatment Was Performed, City, ZIP Code (not required)

ATTACHMENT 5
Sample ADA 2000 claim form for dental services

(Changes in claim form instructions are circled)

Dental Claim Form

©American Dental Association, 1999 version 2000

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): **MM / DD / YYYY** | 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-5**

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. Provider** | 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 **11**

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
MM DD YYYY				D5110	1	Complete upper denture	XXX.XX
MM DD YYYY	28	MOD		D2160	1	Amalgam	XX.XX

Admin. Use Only

60. Identify all missing teeth with "X"

Permanent: 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16 | 32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17

Primary: A B C D E | F G H I J | 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 **87654321** **MM/DD/YYYY**

Signed (Treating Dentist) License # Date (MM/DD/YYYY)

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

©American Dental Association, 1999

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

To Reorder, call 1-800-947-4746

ATTACHMENT 6
Wisconsin Medicaid commercial health or dental insurance explanation codes for dental services

When submitting a claim to Wisconsin Medicaid containing one or more of the procedure codes listed in Attachments 9-12 of this *Wisconsin Medicaid and BadgerCare Update,* indicate one of the following commercial health or dental insurance codes in Element 33 of the ADA 2000 paper claim form.

Code	When to use code
OI-P (other insurance paid)	PAID in part or in full by commercial health insurance or commercial HMO. In Element 59, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D (other insurance denied)	Use OI-D for dental claims in either of the following situations: • DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, *or* payment was applied towards the coinsurance and deductible. • YES, the recipient has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to: ✓ The recipient denied coverage or will not cooperate. ✓ The provider knows the service in question is not covered by the carrier. ✓ The recipient's commercial health insurance failed to respond to initial and follow-up claims. ✓ Benefits are not assignable or cannot get assignment. ✓ Benefits are exhausted.
None	Providers may leave this element blank if none of the procedure codes on the claim are listed in Attachments 9-12.
Note: The provider may not use OI-D if the recipient is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not bill Wisconsin Medicaid for services that are included in the capitation payment.	

ATTACHMENT 7
Medicare disclaimer codes for dental services

The following table indicates appropriate Medicare disclaimer codes for use in Element 33 on the ADA 2000 paper claim form when billing Medicare prior to billing Wisconsin Medicaid.

Code	Description
M-5	**Provider is not Medicare certified.** This code may 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. Use M-5 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part A. ✓ The procedure provided is covered by Medicare Part A. *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part B. ✓ The procedure provided is covered by Medicare Part B.
M-7	**Medicare disallowed or denied payment.** This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use M-7 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted. *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted.
M-8	**Noncovered Medicare service.** This code may be used when Medicare was not billed because the service is not covered in this circumstance. Use M-8 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is usually covered by Medicare Part A but not in this circumstance (e.g., recipient's diagnosis). *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is usually covered by Medicare Part B but not in this circumstance (e.g., recipient's diagnosis).

ATTACHMENT 8
Key to Wisconsin Medicaid's commercial health insurance indicators for dental services

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

Commercial insurance indicator	Description	Table
DEN	Commercial Dental Insurance	Attachment 9
HMO	Health Maintenance Organization (non-Medicaid)	Attachment 10
SUP	Medicare Supplement	Attachment 11
BLU	BlueCross and BlueShield	Attachment 12
WPS	Wisconsin Physician's Service	Attachment 12
CHA	TriCare	Attachment 12
HPP	Wausau Health Protection Plan	Attachment 12
OTH	All other commercial health or dental insurance plans	Attachment 12

ATTACHMENT 9
Insurance indicator "DEN"

When the Eligibility Verification System indicates the code "DEN" for "Other Coverage," providers are required to submit claims for the following procedure codes to commercial dental insurance prior to billing these procedures to Wisconsin Medicaid.

Service type	**Service**	**Before HIPAA implementation** *(Current Dental Terminology 3)*	**After HIPAA implementation** *(Current Dental Terminology 4)*
Diagnostic	Exams	D0120, D0150, D0160	D0120-D0170
	X-rays	D0270, D0272, D0274	D0270-D0274
Preventive	Prophylaxis, Fluoride	D1110-D1205	D1110-D1205
	Sealants	D1351	D1351
	Space maintainers	D1510, D1515, D1550	D1510-D1515, D1550
Restorative	Fillings	D2110-D2387	D2140-D2394
	Crowns	D2920-D2933	D2390, D2920-D2933
Endodontic	Root canals	D3310, D3320, D3330	D3310-D3330
Periodontic	Gingivectomy	D4210, D4211	D4210-D4211
	Scaling	D4341	D4341-D4342
	Full-mouth debridement	D4355	D4355
Prosthodontic	Dentures	D5110-D5212, D5510-D5761	D5110-D5212, D5510-D5761
	Bridges	D6930, D6940, D6980	D6930-D6940, D6980-D6985
Extractions	Extractions	D7110-D7250	D7111-D7250
Surgical	Surgeries	D7260-D7780, D7840, D7850, D7910-D7991	D7260-D7780, D7840-D7850, D7910-D7991
Orthodontic	Orthodontia	D8010-D8650, D8750	D8010-D8680, D8692

ATTACHMENT 10
Insurance indicator "HMO"

When the Eligibility Verification System indicates the code "HMO" for "Other Coverage," providers are required to submit claims for the following procedure codes to the commercial HMO prior to billing these procedures to Wisconsin Medicaid. The provider must be a member of the recipient's commercial HMO to receive Wisconsin Medicaid reimbursement.

Service type	**Service**	**Before HIPAA implementation** *(Current Dental Terminology 3)*	**After HIPAA implementation** *(Current Dental Terminology 4)*
Diagnostic	Exams	D0120, D0150, D0160	D0120-D0170
Preventive	Cleanings	D1110-D1120	D1110-D1120
Restorative	Fillings	D2110-D2160	D2140-D2394
Oral and Maxillofacial Surgery	Extractions	D7210-D7250	D7111-D7250
Surgical	Surgeries	D7260-D7780, D7840, D7850, D7910-D7991	D7260-D7780, D7840-D7850, D7910-D7991

ATTACHMENT 11
Insurance indicator "SUP"

When the Eligibility Verification System indicates the code "SUP" for "Other Coverage," the provider is required to submit claims for the following procedure codes to the recipient's commercial dental or health insurance prior to billing these procedures to Wisconsin Medicaid.

Service type	**Service**	**Before HIPAA implementation** *(Current Dental Terminology 3)*	**After HIPAA implementation** *(Current Dental Terminology 4)*
Adjunctive/General Services	Anesthesia	None	D9220, D9241

ATTACHMENT 12
Insurance indicators "BLU," "WPS," "CHA," "HPP," or "OTH"

When the Eligibility Verification System indicates either "BLU," "WPS," "CHA," "HPP," or "OTH" codes for "Other Coverage," the provider is required to submit claims for the following procedure codes to the recipient's commercial dental or health insurance prior to billing these procedures to Wisconsin Medicaid.

Service type	**Service**	**Before HIPAA implementation** *(Current Dental Terminology 3)*	**After HIPAA implementation** *(Current Dental Terminology 4)*
Adjunctive/General Services	Anesthesia	None	D9220, D9241

ATTACHMENT 13
Special circumstances when billing commercial health or dental insurance prior to billing Wisconsin Medicaid for dental services

The following table indicates appropriate provider responses on the ADA 2000 paper claim form to 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 Element 33 blank.
Insurance indicator "VIS" is present.	Leave Element 33 blank.
An insurance indicator is present, but none of the services are listed in Attachments 9-12.	Leave Element 33 blank.
The 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 Element 33. • Place the amount paid by commercial health or dental insurance in the "Payment by other plan" box in Element 59. • Complete the Other Coverage Discrepancy Report (HCF 1159), dated 10/02, located in the forms section of the Wisconsin Medicaid Web site at *www.dhfs.state.wi.us/medicaid/*. Providers without Internet access may request a copy by calling Provider Services at (800) 947-9627 or (608) 221-9883.
The 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 Element 33 and the "Payment by other plan" box in Element 59 blank. • Complete the Other Coverage Discrepancy Report to update Medicaid files.

ATTACHMENT 14
Prior Authorization Dental Request Form (PA/DRF) Completion Instructions

(For prior authorizations submitted after HIPAA implementation)

(A copy of the "Prior Authorization Dental Request Form [PA/DRF] Completion Instructions" is located on the following pages.)

[This page intentionally left blank.]

WISCONSIN MEDICAID
PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for dental 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 should 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 Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. The Prior Authorization Dental Request Form (PA/DRF) is mandatory when requesting PA. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Providers may submit PA requests, along with the Prior Authorization/Dental Attachment 1 (PA/DA1) or the Prior Authorization/Dental Attachment 2 (PA/DA2), by fax to Wisconsin Medicaid at (608) 221-8616. This option is available only when the PA request does not include additional documentation, such as models or X-rays. Providers may submit PA requests with attachments by mail to:

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

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — PROVIDER INFORMATION

Element 1 — Name and Address — Billing Provider
Enter the name and complete address (street, city, state, and Zip code) of the billing provider. The name listed in this element must correspond with the Medicaid provider number listed in Element 4. *No other information should be entered in this element, since it also serves as a return mailing label.*

Element 2 — Telephone Number — Billing Provider
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

Element 3 — Processing Type
Check the appropriate box to indicate the processing type for either dental services (124) or orthodontic services (125).

Element 4 — Billing Provider's Medicaid Provider No.
Enter the eight-digit Medicaid provider number of the billing provider. The provider number in this element must correspond with the provider name listed in Element 1.

Element 5 — Performing Provider's Medicaid Provider Number
Enter the eight-digit Medicaid provider number of the performing provider, if it is different from the number in Element 4. This is the provider who will actually perform the service.

SECTION II — RECIPIENT INFORMATION

Element 6 — Recipient Medicaid ID Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the recipient's Medicaid identification card or the Eligibility Verification System (EVS) to obtain the correct identification number.

Element 7 — Date of Birth — Recipient
Enter the recipient's date of birth in MM/DD/YY format (e.g., September 8, 1966, would be 09/08/66).

Element 8 — Address — Recipient
Enter the complete address of the recipient's place of residence, including the street, city, state, and Zip code. If the recipient is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 9 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 10 — Sex — Recipient
Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 11 — Place of Service
Check the appropriate place of service code designating where the requested service/procedure/item would be provided/performed/ dispensed.

Element 12 — Dental Diagram
For partials, endodontics, and periodontics, circle the periodontal case type. On the dental diagram, cross out ("X") missing teeth (including extractions). Circle teeth to be extracted only when requesting endodontic or partial denture services. At the bottom of the element, indicate the number and type of X-rays submitted with this PA request. Staple the X-ray envelope to the PA/DRF to the right of Element 12.

Element 13 — Tooth No.
Using the numbers and letters on the dental diagram in Element 12, identify the tooth number or letter for the service requested.

Element 14 — Procedure Code
Enter the appropriate procedure code for each service/procedure/item requested.

Element 15 — Modifier
Enter the modifier corresponding to the procedure code listed if a modifier is required by Wisconsin Medicaid.

Element 16 — Description of Service
Enter a written description corresponding to the appropriate procedure code for each service/procedure/item requested.

Element 17 — QR
Enter the appropriate quantity requested (e.g., number of services) for each procedure code listed.

Element 18 — Charge
Enter the usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1.0," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

Note: The charges indicated on the PA/DRF should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to *Terms of Provider Reimbursement* issued by the Department of Health and Family Services.

Element 19 — Total Charges
Enter the anticipated total charge for this request.

Element 20 — Signature — Performing Provider
The original signature of the provider requesting this service/procedure must appear in this element.

Element 21 — Date Signed
Enter the month, day, and year the PA/DRF was signed (in MM/DD/YY format).

Element 22 — Signature — Recipient / Guardian (if applicable)
If desired, the recipient or recipient's guardian may sign the PA request.

Element 23 — Date Signed
Enter the month, day, and year the recipient or recipient's guardian signed the PA request.

Detach and keep the bottom copy of the PA/DRF. Leave the top two forms attached.

Provider checklist: *The bottom copy of the PA/DRF features a provider checklist to assist with requests for periodontics, endodontics, and services requiring enclosures. For additional information, consult the Dental Provider Handbook.*

ATTACHMENT 15
Sample Prior Authorization Dental Request Form (PA/DRF) for dental services

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11035 (Rev. 06/03)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code

WISCONSIN MEDICAID
PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.
Instructions: Type or print clearly. Before completing this form, read the Prior Authorization Dental Request Form (PA/DRF) Completion Instructions (HCF 11035A).

FOR MEDICAID USE — ICN	AT	Prior Authorization Number
		1234567

SECTION I — PROVIDER INFORMATION

1. Name and Address — Billing Provider (Street, City, State, Zip Code)
I. M. Provider
1 W. Williams St.
Anytown, WI 55555

2. Telephone Number ? Billing Provider
(XXX) XXX-XXXX

4. Billing Provider's Medicaid Provider No.
12345678

3. Processing Type (Check one)
☒ 124 (Dental)
☐ 125 (Ortho)

5. Performing Provider's Medicaid Provider Number

SECTION II — RECIPIENT INFORMATION

6. Recipient Medicaid ID Number
1234567890

7. Date of Birth — Recipient
MM/DD/YYYY

8. Address — Recipient (Street, City, State, Zip Code)
609 Willow St.
Anytown, WI 55555

9. Name — Recipient (Last, First, Middle Initial)
Im A. Recipient

10. Sex — Recipient
☐ M ☒ F

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

11. Place of Service
☒ Dental Office (POS 11) ☐ Outpatient Hospital (POS 22) ☐ Ambulatory Surgical Center (POS 24)
☐ Skilled Nursing Facility (POS 31) ☐ Other (please specify): _____

13. Tooth No.	14. Procedure Code	15. Modifier	16. Description of Service	17. QR	18. Charge
20	D3320		Root canal therapy bicuspid	1	XXX.XX
11	D2932		Resin crown	1	XXX.XX
			19. **Total Charges**		XXX.XX

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

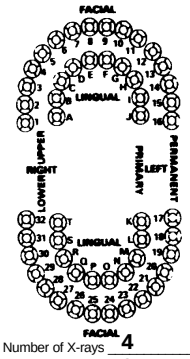
20. **SIGNATURE** — Performing Provider: I.M. Provider

21. Date Signed
MM/DD/YY

22. **SIGNATURE** — Recipient / Guardian (if applicable)

23. Date Signed

12. Dental Diagram
- Circle periodontal case type if applicable. I II III IV V
- Cross out missing teeth.
- Circle teeth to be extracted.



Staple X-Ray Envelope Here

Number of X-rays: 4
Type of X-rays: 2 BW, 2 PA

FOR MEDICAID USE

Procedure(s) Authorized:

Quantity Authorized:

☐ Approved _____ Grant Date _____ Expiration Date

☐ Modified — Reason:

☐ Denied — Reason:

☐ Returned — Reason:

_____ **SIGNATURE** — Consultant / Analyst _____ Date Signed

ATTACHMENT 16
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 following pages.)

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

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for dental 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 should 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 Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. The Prior Authorization/ Dental Attachment 1 (PA/DA1) is mandatory when requesting PA for anesthesia/professional visits, diagnostic services, endodontic services, periodontic services, preventive services, prosthodontic services, and restorative services. 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 or who are submitting PA requests that require X-rays or models 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 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 Medicaid Identification Number — Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the recipient's Medicaid identification card or the Eligibility Verification System (EVS) to obtain the correct identification number.

Billing Provider's Medicaid Provider Number — Enter the eight-digit Medicaid provider number of the billing provider. Use the billing number used for Medicaid claims.

Performing Provider's Medicaid 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 17
Prior Authorization / Dental Attachment 1 (PA/DA1) Check Box Version

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

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11010 (Rev. 06/03)

STATE OF WISCONSIN
HFS 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 Medicaid Identification Number	Billing Provider's Medicaid Provider Number	Performing Provider's Medicaid Provider Number

CATEGORY	PROCEDURE CODES (CHECK ALL THAT APPLY)		TREATMENT PLAN JUSTIFICATION (CHECK ALL THAT APPLY)	REQUIRED DOCUMENTATION
Diagnostic Services	❑ D0210 ❑ D0330 ❑ D0340 ❑ D0350 ❑ D0470		❑ Frequency limitation needs to be exceeded ❑ Ortho ❑ Department of Health and Family Services request ❑ Date of models_____ ❑ HealthCheck referral	Explanation to exceed frequency limitation.
Preventive Services	❑ D1110 ❑ D1120 ❑ D1201 ❑ D1203 ❑ D1204 ❑ D1205		❑ Permanent disability, describe_____ ❑ Rampant decay ❑ Xerostomia ❑ Radiation therapy to head and neck ❑ Root caries / recession ❑ Medication ❑ Other_____ ❑ Quantity requested_____ Years requested ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 (check one)	
	❑ D1351		❑ Congenital malformation ❑ Newly erupted tooth Tooth numbers_____ ❑ Medical condition_____	• No PA needed under age 21 for first and second molars. • Sealants are not covered after age 20.
Restorative Services	❑ D2791*	Tooth No.	❑ Signed Provision of Upgraded Partial Denture and Crowns to Medicaid Recipients	One periapical X-ray.
	❑ D2930 ❑ D2932 ❑ D2933	Tooth No.	❑ Tooth numbers 6-11, 22-27, D-G, supernumerary ❑ Successful endo tx[1] ❑ More than 50% tooth involved in trauma / caries ❑ Cannot be restored with composite ❑ AAP[2] I or II	• One periapical X-ray. • No PA needed under age 21. • D2933 is not allowed on teeth numbers 22-27.
Endodontic Services	❑ D3310 ❑ D3320 ❑ D3330	Tooth No.	❑ AAP I or II ❑ Restorative tx completed ❑ Restorative tx in process ❑ Extractions last three years Tooth number and date_____ ❑ Pathology, describe_____	• Two bitewing and one periapical X-rays. • Intra-oral charting. • Document pathology, abcesses, carious exposure, non-vital, etc.
	❑ D3410 ❑ D3430	Tooth No.	❑ Periapical pathology ❑ Failed root canal ❑ Root fx[3] ❑ Existing porcelain crown ❑ 6-11, 22-27 ❑ Other_____	• One periapical X-ray. • Include both codes on PA.
Periodontic Services	❑ D4210 ❑ D4211		❑ Medication induced hyperplasia ❑ Irritation ortho bands ❑ Hyperplasia ❑ More than 25% crown involved ❑ D4211 tooth numbers_____ ❑ Other_____	• Periodontal charting. • Comprehensive periodontal treatment plan.
	❑ D4341		❑ Older than age 12 — Pockets 4 to 6 mm ❑ History of periodontal abcess ❑ Early bone loss ❑ Moderate bone loss ❑ AAP II or III ❑ Oral hygiene: ❑ Good ❑ Fair ❑ Poor	• Periodontal charting. • Comprehensive periodontal treatment plan.
	❑ D4355		❑ Excess calculus on X-ray ❑ AAP I or II ❑ No dental tx in multiple years ❑ Oral hygiene: ❑ Good ❑ Fair ❑ Poor	• Bitewing or full mouth X-rays. • Calculus must be visible on X-rays.
	❑ D4910		❑ Recent history of periodontal scale / surgery ❑ Oral hygiene: ❑ Good ❑ Fair ❑ Poor Years requested ❑ 1 ❑ 2 ❑ 3 (check one)	• Periodontal charting. • Comprehensive periodontal treatment plan. Allowed once per 12 months.

*No dentist obligated to provide this service [1]tx — treatment [2]AAP — American Association of Periodontists [3]fx — fracture

Continued

PA Number	Recipient Medicaid Identification Number	Billing Provider's Medicaid Provider Number	Performing Provider's Medicaid Provider Number

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

Additional comments:

ATTACHMENT 18
Prior Authorization / Dental Attachment 2 (PA/DA2) Oral Surgery, Orthodontic, and Fixed Prosthetic Services

(A copy of the "Prior Authorization/Dental Attachment 2 [PA/DA2] Oral Surgery, Orthodontic, and Fixed Prosthetic Services" is located on the following pages.)

[This page intentionally left blank.]

WISCONSIN MEDICAID

PRIOR AUTHORIZATION / DENTAL ATTACHMENT 2 (PA/DA2) ORAL SURGERY, ORTHODONTIC, AND FIXED PROSTHETIC SERVICES

INSTRUCTIONS: Complete Section I for all orthodontics, oral surgery, and fixed prosthetic services. Complete Section II when anesthesia or a professional visit is necessary. Complete Section III for orthodontic services only. Requested identifying information will only be used to process the prior authorization (PA) request. If necessary, attach additional pages for provider responses. **Refer to the Dental Services Handbook and *Wisconsin Medicaid and BadgerCare Updates* for service restrictions and additional documentation requirements.** Provide enough information for Wisconsin Medicaid dental consultants to make a reasonable judgement about the request. The use of this form is voluntary and providers may develop their own form as long as it includes all the information and is formatted exactly like this form.

Prior Authorization Dental Request Form (PA/DRF) Number	Recipient's Medicaid Identification Number	Billing Provider Medicaid Provider Number	Performing Provider Medicaid Provider Number

SECTION I — ORAL SURGERY, ORTHODONTIC, AND FIXED PROSTHETIC SERVICES

1. Diagnosis

2. Treatment plan

3. Treatment prognosis (Check one. If Poor, explain the reason for requested treatment.)

❑ Excellent ❑ Good ❑ Fair ❑ Poor

4. Indicate if the recipient is physically, psychologically, or otherwise indefinitely disabled, or has a medical condition that impacts the treatment requested

SECTION II — ANESTHESIA / PROFESSIONAL VISIT

5. PROCEDURE CODES (CHECK ALL THAT APPLY)	6. TREATMENT PLAN JUSTIFICATION (CHECK ALL THAT APPLY)	7. REQUIRED DOCUMENTATION
❑ D9220 ❑ D9241 ❑ D9248 ❑ D9420	❑ Behavior ❑ Disability (describe)_____ ❑ Geriatric ❑ Physician consult ❑ Complicated medical history_____ ❑ Extensive restoration ❑ Maxillofacial surgery (describe)_____	• Submit medical documentation to support special circumstances. • Prior authorization not required for recipients five years and under for procedure D9420.

SECTION III — ORTHODONTIC SERVICES ONLY

8. Anticipated number of monthly adjustments

Continued

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 or who are submitting PA requests that require X-rays or models may do so by submitting them to the following address:

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

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for dental 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 should 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 Medicaid administration such as determining eligibility of the applicant, processing prior PA requests, or processing provider claims for reimbursement. The Prior Authorization/Dental Attachment 2 (PA/DA2) is mandatory when requesting PA for fixed prosthetic services, oral surgery services, and orthodontic services. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.