wisconsin Medicaid update
and BadgerCare

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Wisconsin Medicaid and BadgerCare Information for Providers

To:
Dentists Billing CPT Oral Surgery Codes
HMOs and Other Managed Care Programs

Changes to local codes, paper claims, and prior authorization for oral surgery 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 oral surgery 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 CMS 1500 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.

Changes as a result of HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces important billing and prior authorization (PA) changes for oral surgery 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 requirements), but include:

- Submitting claims for procedures that require a tooth number or surface information must be billed on the ADA 2000 claim form.
- Adopting nationally recognized place of service (POS) codes to replace currently used Wisconsin Medicaid local codes.
- Revising CMS 1500 paper claim instructions.
- Revising PA request forms and instructions.

Note: Use of the national POS codes, revised paper 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*.

Claim forms

Providers billing *both Current Procedural Terminology* and *Current Dental Terminology* procedure codes may continue to bill on the CMS 1500 claim form, *except* when billing for a procedure that requires a tooth number or surface information. Procedures that require a tooth number or surface information

will need to be billed on the ADA 2000 claim form.

Adoption of national codes

Wisconsin Medicaid will adopt nationally recognized medical codes to replace currently used Wisconsin Medicaid local codes for oral surgery services.

Allowable procedure codes

Providers should continue to refer to their service-specific *Updates* and handbooks for nationally recognized procedure codes Wisconsin Medicaid covers.

Type of service codes

Type of service codes will no longer be required on Medicaid claims or PA requests.

Place of service codes

Nationally recognized two-digit POS codes will replace the one-digit Wisconsin Medicaid POS codes. Refer to Attachment 1 of this *Update* for a list of allowable POS codes for oral surgery services.

Coverage for oral surgery services

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

Revision of CMS 1500 paper claim instructions

With the implementation of HIPAA, Medicaid-certified oral surgery providers will be required to follow the revised instructions for the CMS 1500 paper claim form in this *Update*, even though the actual CMS 1500 claim form is not being revised at this time. Refer to Attachment 2 for the revised instructions. Attachment 3 is a sample of a claim for oral surgery services that reflects the changes to the billing instructions.

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

Type of service codes will no longer be required on Medicaid claims or PA requests.

Revisions made to the CMS 1500 claim form instructions

Revisions made to the CMS 1500 paper claim form instructions include the following:

- Other insurance indicators were revised (Element 9).
  Note: OI-H is no longer acceptable for claims submitted on the CMS 1500 claim form. Refer to Attachment 2 for correct usage of OI-D.
- Medicare disclaimer codes were revised (Element 11).
  Note: M-6 is no longer acceptable.
- Place of service codes were revised (Element 24B).
- Type of service codes are no longer required (Element 24C).
- Up to four modifiers per procedure code may be entered (Element 24D).
- HealthCheck indicator "H" is no longer required (Element 24H).
- Spenddown amount should no longer be entered (Element 24K). 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, oral surgery providers 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

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

are located in Attachment 4. A sample PA/DRF is in Attachment 5. The PA/DRF has been revised to include more space for additional modifiers in Element 15.

Prior authorization attachments

Oral surgery providers will be required to use either the new 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 August 1, 2003. Wisconsin Medicaid will return any PA requests submitted after August 1, 2003, using the previous version.

Oral surgery providers will be required to use the PA/DA1 for the prior authorized services in the following categories:

- Diagnostic services.
- Endodontic services.
- Periodontic services.
- Preventive services.
- Prosthodontic services.
- Restorative services.

Oral surgery providers will be required to use the PA/DA2 for the prior authorized services in the following categories:

- Anesthesia/professional visits.
- Fixed prosthetic services.
- Oral surgery services.
- Orthodontic services.

Refer to Attachment 6 for a copy of the completion instructions for the PA/DA1. Attachments 7 and 8 are copies of the PA/DA1 and 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

* 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.

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.

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 *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
Place of service codes for oral surgery services

The following table lists the nationally recognized place of service (POS) codes that providers will be required to use when submitting claims for oral surgery 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).

POS code	Description
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
12	Home
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room — Hospital
24	Ambulatory Surgical Center
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
50	Federally Qualified Health Center
51	Inpatient Psychiatric
54	Intermediate Care Facility/Mentally Retarded
61	Comprehensive Inpatient Rehabilitation Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic

ATTACHMENT 2
CMS 1500 claim form instructions for oral surgery 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.

If a provider is billing services for which both *Current Procedural Terminology* and *Current Dental Terminology* (CDT) procedure codes will be used, providers may bill both on the CMS 1500 claim form. **The exception is that procedures requiring a tooth number or surface information must be billed on the ADA 2000 claim form.**

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 to 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 — Program Block/Claim Sort Indicator

Enter claim sort indicator "P" in the Medicaid check box for the service billed.

Element 1a — Insured's I.D. Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the Medicaid identification card or the EVS to obtain the correct identification number.

Element 2 — Patient's 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.

Element 3 — Patient's Birth Date, Patient's Sex

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify whether the recipient is male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name (not required)

Element 5 — Patient's Address

Enter the complete address of the recipient's place of residence, if known.

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name

Commercial health or dental insurance must be billed prior to submitting claims to Wisconsin Medicaid, unless the service does not require commercial health or dental insurance billing as determined by Wisconsin Medicaid.

If the EVS indicates that the recipient has dental ("DEN") insurance only or has no commercial health or dental insurance, leave Element 9 blank.

If the EVS indicates that the recipient has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"), Medicare Supplement ("SUP"), TriCare ("CHA"), Vision only ("VIS"), a health maintenance organization ("HMO"), or some other ("OTH") commercial health insurance, **and** the service requires other insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three other insurance (OI) explanation codes **must** be indicated in the **first** box of Element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part or in full by commercial health insurance or commercial HMO. In Element 29 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	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. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	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.

Note: The provider may not use OI-D or OI-Y 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.

Element 10 — Is Patient's Condition Related to (not required)

Element 11 — Insured's Policy, Group, or FECA Number

Use the **first** box of this element for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Submit claims to Medicare before submitting claims to Wisconsin Medicaid.

Element 11 should be left blank 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. The following Medicare disclaimer codes may be used when appropriate:

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 (DOS) 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).

Elements 12 and 13 — Authorized Person's Signature (not required)

Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 — If Patient Has Had Same or Similar Illness (not required)

Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

Elements 17 and 17a — Name and I.D. Number of Referring Physician or Other Source (not required)

Element 18 — Hospitalization Dates Related to Current Services (not required)

Element 19 — Reserved for Local Use

If a provider bills an unlisted (or not otherwise specified) procedure code, a description of the procedure must be indicated in this element. If Element 19 does not provide enough space for the procedure description, or if a provider is billing multiple unlisted procedure codes, documentation must be attached to the claim describing the procedure(s). In this instance, indicate "See Attachment" in Element 19.

Element 20 — Outside Lab? (not required)

Element 21 — Diagnosis or Nature of Illness or Injury

Enter the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. The diagnosis description is not required.

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number

Enter the seven-digit prior authorization (PA) number from the approved Prior Authorization Dental Request Form (PA/DRF). Services authorized under multiple PA requests must be billed on separate claim forms with their respective PA numbers. Wisconsin Medicaid will only accept one PA number per claim.

Element 24A — Date(s) of Service

Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one DOS, enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- When billing for two, three, or four DOS on the same detail line, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the "From" field and enter subsequent DOS in the "To" field by listing **only** the date(s) of the month. For example, for DOS December 1, 8, 15, and 22, 2003, indicate 12/01/03 or 12/01/2003 in the "From" field and indicate 08/15/22 in the "To" field.

It is allowable to enter up to four DOS per line if:

- All DOS are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All procedures have the same place of service (POS) code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge **per detail line** in Element 24F.)
- The number of services performed on each DOS is identical.
- All procedures have the same family planning indicator, if applicable.
- All procedures have the same emergency indicator, if applicable.

Element 24B — Place of Service

Enter the appropriate two-digit POS code for each service. Refer to Attachment 1 of this *Wisconsin Medicaid and BadgerCare Update* for allowable place of service codes.

Element 24C — Type of Service (not required)

Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character procedure code. Wisconsin Medicaid denies claims received without an appropriate procedure code.

Modifiers

Enter the appropriate modifier in the "Modifier" column of Element 24D. Please note that Wisconsin Medicaid has not adopted all national modifiers. The only modifier valid for oral surgery services is "80." If using CDT codes that require tooth modifiers, providers must use the ADA 2000 claim form.

Element 24E — Diagnosis Code

Enter the number (1, 2, 3, or 4) that corresponds to the appropriate ICD-9-CM diagnosis code listed in Element 21.

Element 24F — $ Charges

Enter the total charge for each line item. Providers are required to bill Wisconsin Medicaid their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to Medicaid benefits.

Element 24G — Days or Units

Enter the appropriate number of units for each line item. Always use a decimal (e.g., 2.0 units).

Element 24H — EPSDT/Family Plan

Enter an "F" for each family planning procedure. If family planning does not apply, leave this element blank.

Element 24I — EMG

Enter an "E" for **each** procedure performed as an emergency. If the procedure is not an emergency, leave this element blank.

Element 24J — COB (not required)

Element 24K — Reserved for Local Use

Enter the eight-digit Medicaid provider number of the performing provider for each procedure if that number is different than the billing provider number in Element 33. Any other information entered in this element may cause claim denial.

Element 25 — Federal Tax I.D. Number (not required)

Element 26 — Patient's Account No. (not required)

Optional — Providers may enter up to 20 characters of the patient's internal office account number. This number will appear on the Remittance and Status Report and/or the 835 Health Care Claim Payment/Advice transaction.

Element 27 — Accept Assignment (not required)

Element 28 — Total Charge

Enter the total charges for this claim.

Element 29 — Amount Paid

Enter the actual amount paid by commercial health or dental insurance. (If the dollar amount indicated in Element 29 is greater than zero, "OI-P" must be indicated in Element 9.) If the commercial health or dental insurance denied the claim, enter "000." Do **not** enter Medicare-paid amounts in this field.

Element 30 — Balance Due

Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28.

Element 31 — Signature of Physician or Supplier

The provider or the authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/YYYY format.

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

Element 32 — Name and Address of Facility Where Services Were Rendered (not required)

If the services were provided to a recipient in a nursing home (POS code "31," "32," "33," or "54"), indicate the nursing home's eight-digit Medicaid provider number.

Element 33 — Physician's, Supplier's Billing Name, Address, ZIP Code, and Phone

Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider's name, address, city, state, and Zip code. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.

ATTACHMENT 3
Sample CMS 1500 claim form for oral surgery services

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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

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

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

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY SEX M [ ] F [X]

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

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

CITY: Anytown STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: STATE:

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

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M-8

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

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

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

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

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

1. 750.0 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 20 03		11		41010		1	XXX XX	1.0				12345678
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 1234JED

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

28. TOTAL CHARGE: $ XXX XX

29. AMOUNT PAID: $ XX XX

30. BALANCE DUE: $ XX XX

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

J.M. Authorized MM/DD/YY

SIGNED DATE

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

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

I.M. Provider
1 W. Williams
Anytown, WI 55555 87654321

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE*

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

ATTACHMENT 4
Prior Authorization Dental Request Form (PA/DRF) Completion Instructions

(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 5
Sample Prior Authorization Dental Request Form (PA/DRF) for oral surgery 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)	2. Telephone Number ? Billing Provider	3. Processing Type (Check one)
I.M. Provider **1 W. Williams** **Anytown, WI 55555**	**(XXX) XXX-XXXX**	☒ 124 (Dental) ☐ 125 (Ortho)
	4. Billing Provider's Medicaid Provider No. **12345678**	
	5. Performing Provider's Medicaid Provider Number **12345678**	

SECTION II — RECIPIENT INFORMATION

6. Recipient Medicaid ID Number	7. Date of Birth — Recipient	8. Address — Recipient (Street, City, State, Zip Code)
1234567890	**MM/DD/YY**	**609 Willow** **Anytown, WI 55555**
9. Name — Recipient (Last, First, Middle Initial) **Recipient, Ima**	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
	41010		**Incision of lingual frenum**	**1**	**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.

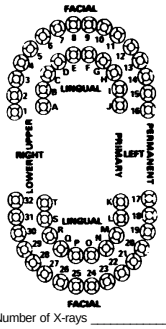
19. **Total Charges** **xxx.xx**

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 _____
Type of X-rays _____

FOR MEDICAID USE — Procedure(s) Authorized: — Quantity Authorized:

☐ Approved — Grant Date — Expiration Date

☐ Modified — Reason:

☐ Denied — Reason:

☐ Return — Reason:

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

ATTACHMENT 6
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 7
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 8
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.)

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DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11014 (Rev. 06/03)

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

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.