wisconsin Medicaid update and BadgerCare

November 2006 ● No. 2006-88

Wisconsin Medicaid and BadgerCare Information for Providers

To:

Dental Hygienists

Dentists

HMOs and Other Managed Care Programs

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *dhfs.wisconsin.gov/medicaid/*.

PHC 1250

Changes to Dental Prior Authorization Attachments

Recent changes in dental prior authorization (PA) requirements were announced in the August 2006 *Wisconsin Medicaid and BadgerCare Update* (2006-73), titled "Changes to Dental Prior Authorization Requirements and Coverage." As a result, the Prior Authorization/Dental Attachment 1 (PA/DA1), HCF 11010 (11/06), and the Prior Authorization/Dental Attachment 2 (PA/DA2) Oral Surgery, Orthodontic, and Fixed Prosthetic Services, HCF 11014 (11/06), have been revised.

Recent changes in dental prior authorization (PA) requirements were announced in the August 2006 *Wisconsin Medicaid and BadgerCare Update* (2006-73), titled "Changes to Dental Prior Authorization Requirements and Coverage." As a result, the Prior Authorization/Dental Attachment 1 (PA/DA1), HCF 11010 (11/06), and the Prior Authorization/Dental Attachment 2 (PA/DA2) Oral Surgery, Orthodontic, and Fixed Prosthetic Services, HCF 11014 (11/06), have been revised. Changes to the attachments primarily include removing procedure codes for services that no longer require PA and revising required documentation notes, where appropriate.

A copy of the revised Prior Authorization/Dental Attachment 1 (PA/DA1) Completion Instructions, HCF 11010A (11/06), and the PA/DA1 form may be obtained from Attachments 1 and 2 of this *Update*. A copy of the revised PA/DA2 is located in Attachment 3. Copies of the PA/DA1 and PA/DA2 may also be requested from Provider Services at (800) 947-9627 or (608) 221-9883 or downloaded from the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/*.

Providers are strongly encouraged to begin using the revised PA/DA1 and PA/DA2 for all future PA requests. No changes were made to the Prior Authorization Dental Request Form (PA/DRF), HCF 11035 (Rev. 10/03).

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. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

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

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

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11010A (11/06)

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

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

Wisconsin Medicaid requires certain 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 judgment 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), HCF 11035, 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.

Prior Authorization Dental Request Form (PA/DRF) 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 Medicaid Eligibility Verification System 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) to the procedure(s) being performed.

Required Documentation
Refer to this column to determine the documentation that must be submitted with the PA request.

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

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

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11010 (11/06)

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

WISCONSIN MEDICAID

PRIOR AUTHORIZATION / DENTAL ATTACHMENT 1 (PA/DA1)
CHECK BOX FORMAT

The 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 denial of the PA.

Prior Authorization Dental Request Form (PA/DRF) 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 ❑ D0470 (Prior authorization only required in certain circumstances.)		❑ Frequency limitation to be exceeded (D0210 and D0330) ❑ Recipient over age 20 (D0470) ❑ Department of Health and Family Services request ❑ Date of models (MM/DD/YY) _____	• Explanation to exceed frequency limitation. • Document number and type of X-rays taken (for D0210 and D0330).
Restorative Services	❑ D2390 ❑ D2932 ❑ D2933 (For recipients ages 0-20, PA is *not* required.)	Tooth No.	❑ Tooth numbers 6-11, 22-27, D-G, supernumerary (56-61, 72-77) ❑ Successful endodontic treatment ❑ More than 50 percent tooth involved in trauma / caries ❑ Cannot be restored with composite ❑ American Association of Periodontists (AAP) I or II ❑ Frequency limitation to be exceeded ❑ Recipient over age 20	• One periapical X-ray. • Explanation to exceed frequency limitation. • D2933 is not allowed on teeth numbers 22-27.
Endodontic Services	❑ D3310 ❑ D3320	Tooth No.	❑ Involves root canal therapy on four or more teeth (PA not required for three or fewer teeth)	All documentation listed below and a treatment plan that indicates all indicated teeth meet clinical criteria.
	❑ D3330 (For recipients ages 0-20, PA is *not* required.)	Tooth No.	❑ AAP I or II ❑ Evidence visible on radiographs that at least 50 percent of the clinical crown is intact ❑ Restorative treatment completed ❑ Restorative treatment in process ❑ Extractions completed in last three years (Indicate tooth number, date, and reason for any extractions) _____ _____ ❑ Pathology, describe _____ ❑ Involves root canal therapy on four or more teeth (PA not required for three or fewer teeth)	• Full-mouth series X-rays to include bitewing X-rays. • Intra-oral charting. • Document pathology, abcesses, carious exposure, non-vital, etc.
Periodontic Services	❑ D4210 ❑ D4211		❑ Medication-induced hyperplasia ❑ Irritation from orthodontic bands ❑ Hyperplasia ❑ More than 25 percent crown involved ❑ Other _____	• Periodontal charting. • Comprehensive periodontal treatment plan. • Include Area of Oral Cavity code(s) on PA/DRF: 10 (upper right), 20 (upper left), 30 (lower left), and 40 (lower right).
	❑ D4341 ❑ D4342		❑ Recipient over age 12 — pockets 4 to 6 mm ❑ History of periodontal abcess ❑ Early bone loss ❑ Moderate bone loss ❑ AAP II or III ❑ Oral hygiene (choose one) — ❑ Good ❑ Fair ❑ Poor ❑ Full-mouth debridement completed in last 12 months. Date of service for D4355 (MM/DD/YY) _____	• Periodontal charting. • Comprehensive periodontal treatment plan. • Include Area of Oral Cavity code(s) on PA/DRF: 10 (upper right), 20 (upper left), 30 (lower left), and 40 (lower right).
	❑ D4355 (For recipients ages 13 and older, PA is *not* required.)		❑ Excess calculus on X-ray ❑ AAP I or II ❑ No dental treatment in multiple years ❑ Oral hygiene (choose one) — ❑ Good ❑ Fair ❑ Poor ❑ Recipient under age 13	• Bitewing or full mouth X-rays. • Calculus must be visible on X-rays.
	❑ D4910		❑ Recent history of periodontal scale / surgery ❑ Oral hygiene (choose one) — ❑ Good ❑ Fair ❑ Poor Years requested (check one) — ❑ 1 ❑ 2 ❑ 3	• Periodontal charting. • Comprehensive periodontal treatment plan. • Allowed once per 12 months.

Continued

PA/DRF 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	❑ Initial placement of dentures (year) Max _____ Mand ____ ❑ Age of existing denture(s) (years) Max _____ Mand _____ ❑ New denture request because of the following (choose all that apply) ❑ Worn base / broken teeth ❑ Poor fit ❑ Vertical dimension ❑ Date(s) last teeth extracted (MM/DD/YY) _____ ❑ Reason for edentulation _____ _____ ❑ Lost / stolen / broken dentures ❑ Reline / repair not appropriate ❑ Has not worn existing dentures for more than three years ❑ Edentulous more than five years without dentures ❑ Additional justification _____ _____ ❑ Frequency limitation must be exceeded.	• New dentures limited to one per five years, per arch. • 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. • Explanation to exceed frequency limitation.
Prosthodontic Services — Partial Dentures	❑ D5211 ❑ D5212 ❑ D5213 ❑ D5214 ❑ D5225 ❑ D5226 ❑ D5670 ❑ D5671	❑ Initial placement of dentures (year) Max _____ Mand _____ ❑ Age of existing denture(s) (years) Max _____ Mand _____ ❑ New denture partial request because of the following (choose all that apply) ❑ Worn base / broken teeth ❑ Poor fit ❑ Vertical dimension ❑ Date(s) last teeth extracted _____ ❑ Tooth numbers extracted _____ ❑ Missing at least one anterior tooth and/or has fewer than two posterior teeth in any one quadrant in occlusion with opposing arch ❑ Has at least six missing teeth per arch ❑ AAP I or II ❑ Nonrestorable teeth have been extracted ❑ Restorative procedures scheduled ❑ Restorative procedures completed ❑ Unusual clinical circumstances — must be documented (e.g., needed for employment) ❑ Lost / stolen / broken dentures ❑ Reline / repair not appropriate ❑ Additional justification _____ ❑ Frequency limitation must be exceeded.	• X-rays to show entire arch. • Periodontal charting. • New partials limited to one per five years, per arch. • 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. • Explanation to exceed frequency limitation.
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 _____ ❑ Frequency limitation must be exceeded.	• Relines limited to one per three years, per arch. • Document special circumstances. • Explanation to exceed frequency limitation.
Adjunctive General Services — Anesthesia	❑ D9220 ❑ D9241 ❑ D9248 (Prior authorization not required for the following: • Services performed in a hospital or ambulatory surgery center. • Services for recipients ages 0-20 when performed by a pediatric dentist or oral surgeon.)	❑ Behavior ❑ Disability (describe) _____ ❑ Geriatric ❑ Physician consult ❑ Complicated medical history _____ ❑ Extensive restoration ❑ Maxillofacial surgery (describe)_____ ❑ Three or more extractions in more than one quadrant.	Submit medical documentation to support special circumstances.
HealthCheck Other Services	❑ D0999 ❑ D2999 ❑ D4999 ❑ D9999	❑ Periodic oral evaluation (additional) ❑ Single unit crown. Tooth number _____ ❑ Surgical procedure ❑ Non-surgical procedure	• Submit medical documentation to support special requests. • HealthCheck referral required.

Additional Comments

ATTACHMENT 3
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 (11/06)

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. The 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 publications for service restrictions and additional documentation requirements.* Provide enough information for Wisconsin Medicaid dental consultants to make a reasonable judgment about this 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 Medicaid Identification Number	Billing Provider's Medicaid Provider Number	Performing Provider's Medicaid Provider Number

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

Diagnosis

Treatment Plan

Treatment Prognosis (Check one. If "poor," explain the reason for the requested treatment.)

❑ Excellent ❑ Good ❑ Fair ❑ Poor

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

SECTION II — ANESTHESIA

PROCEDURE CODES (Check All That Apply)	**TREATMENT PLAN JUSTIFICATION (Check All That Apply)**	**REQUIRED DOCUMENTATION**
❑ D9220 ❑ D9241 ❑ D9248 (Prior authorization not required for the following: • Services performed in a hospital or ambulatory surgery center. • Services for recipients ages 0-20 when performed by a pediatric dentist or oral surgeon.)	❑ Behavior ❑ Disability (describe)_____ ❑ Geriatric ❑ Physician consult ❑ Complicated medical history_____ ❑ Extensive restoration ❑ Maxillofacial surgery (describe)_____ ❑ Three or more extractions in more than one quadrant	Submit medical documentation to support special circumstances.

SECTION III — ORTHODONTIC SERVICES ONLY

Anticipated Number of Monthly Adjustments	HealthCheck referral for orthodontic treatment.

Continued

Submitting Prior Authorization Requests
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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 PA requests, or processing provider claims for reimbursement. The Prior Authorization/Dental Attachment 2 (PA/DA2) Oral Surgery, Orthodontic, and Fixed Prosthetic Services 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.

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:

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Prior Authorization
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6406 Bridge Rd
Madison WI 53784-0088