BADGERCARE+
BadgerCare Plus Information for Providers

Update
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To: Dentists, HMOs and Other Managed Care Programs

Dental Services Under BadgerCare Plus

BadgerCare Plus, the new state-sponsored health care program, will be implemented in February 2008. This *Update* describes the policies for dental services under BadgerCare Plus.

BadgerCare Plus Overview

In January 2007, Governor Jim Doyle included in his 2007-09 Biennial Budget proposal an innovative state-sponsored health care program to expand coverage to Wisconsin residents and ensure that all children in Wisconsin have access to affordable health care. This new program is called BadgerCare Plus, and it will start on February 1, 2008.

BadgerCare Plus merges family Medicaid, BadgerCare, and Healthy Start into a single program. BadgerCare Plus will expand enrollment to:

- All uninsured children.
- More pregnant women.
- More parents and caretaker relatives.
- Parents with children in foster care who are working to reunify their families.
- Young adults exiting out-of-home care, such as foster care, because they have turned 18 years of age.
- Certain farmers and other self-employed parents and caretaker relatives.

All individuals enrolled in BadgerCare Plus and Wisconsin Medicaid will be referred to as "members."

BadgerCare Plus is comprised of two benefit plans, the Standard Plan and the Benchmark Plan. The services covered under the BadgerCare Plus Standard Plan are the same as the current Wisconsin Medicaid program; therefore, the term "Standard Plan" will be used in all future *Updates* to describe the shared policy and billing information. The BadgerCare Plus Benchmark Plan is a more limited plan, modeled after commercial insurance.

New services covered under BadgerCare Plus and Wisconsin Medicaid include over-the-counter tobacco cessation products for all members and mental health and substance abuse screening, preventive mental health counseling, and substance abuse intervention services for pregnant women at risk of mental health or substance abuse problems. Future *Updates* will describe these new benefits in detail.

Refer to the November 2007 *Update* (2007-79), titled "Introduction to BadgerCare Plus — Wisconsin's New Health Care Program," for general information on covered and noncovered services, copayments, and enrollment.

Covered and Noncovered Services

Standard Plan

Dental services covered under the Standard Plan are the same as they are under the current Wisconsin Medicaid program.

Benchmark Plan

Certain dental services are covered under the Benchmark Plan only for the following members:

- Children under 18 years of age.
- Pregnant women.

Coverage under the Benchmark Plan is limited to specific services within the following categories:

- Diagnostic.
- Preventive.
- Simple restorative.
- Periodontics.
- Surgical procedures.

See Attachment 1 of this *Update* for a detailed list of services covered under the Benchmark Plan.

Temporomandibular Joint Dysfunctions

Diagnosis and treatment for Temporomandibular Joint (TMJ) dysfunctions covered under the Benchmark Plan are the same as they are under the current Wisconsin Medicaid program.

Traumatic Injury

Services provided by a dentist for traumatic injuries may be covered — subject to review by a dental consultant — under the Benchmark Plan for children under 18 years of age and for pregnant women. Claims submitted for services that are not listed in Attachment 1 will be reviewed for reimbursement as a traumatic injury-related service.

Prior Authorization

Prior authorization (PA) policy and procedures are the same under the Standard Plan and the Benchmark Plan as they are under the current Wisconsin Medicaid program. Refer to dental-specific publications for PA requirements.

Reimbursement and Cost Sharing

Standard Plan

Reimbursement and copayment amounts for services under the Standard Plan are the same as they are under the current Wisconsin Medicaid program. Reimbursement is considered to be payment in full. Providers should refer to previously published service-specific publications for more information on copayment amounts.

Policy regarding members who are subject to copayments and members who are exempt from copayments is different than that of the current Wisconsin Medicaid program.

Providers should note that the following Standard Plan members **are subject to copayment** for services where copayment applies:

- Members enrolled in BadgerCare Plus Standard Plan HMOs (previously referred to as Medicaid HMOs).
- Members under 18 years of age with incomes above 100 percent of the Federal Poverty Level (FPL).

Providers are prohibited from collecting copayments from the following Standard Plan members:

- Nursing home residents.
- Pregnant women.
- Members under 18 years of age who are members of a federally recognized tribe.
- Members under 18 years of age with incomes at or below 100 percent of the FPL.

Under the Standard Plan, providers **cannot** deny services if a member fails to make his or her copayment.

Benchmark Plan

Maximum allowable fees for the Benchmark Plan are set at the 50th percentile of the *American Dental Association 2005 Survey of Dental Fees — East North Central Region.* The maximum allowable fees for the Benchmark Plan are listed in Attachment 1.

Benchmark Plan members do not have copayments.

Benchmark Plan members who are children under 18 years of age are responsible for payments for the following:

- A deductible of the first $200.00 for covered services per enrollment year, based on the Benchmark Plan maximum allowable fee schedule.
- Fifty percent of the maximum allowable fee for each service once the $200.00 deductible is met.

Preventive and diagnostic services are exempt from the $200.00 deductible but are subject to the 50 percent cost-sharing requirement.

All pregnant women are exempt from cost-sharing, including the deductible and the 50 percent cost-sharing requirement.

Total benefits are limited for all Benchmark Plan members to $750.00 per enrollment year, based on the amount paid by the Benchmark Plan. Any services provided in an enrollment year after the $750.00 annual limit is met are considered noncovered services.

Providers are **not** required to accept members in the Benchmark Plan.

Under the Benchmark Plan, a provider has the right to deny services if the member fails to pay any required cost sharing.

Examples of Cost Sharing Under the Benchmark Plan

In the first example, a child enrolled in the Benchmark Plan sees a dentist for a limited exam (D0140), a panoramic X-ray (D0330), a periapical X-ray (D0220), and a subsequent extraction (D7140). The maximum allowable fees for these services are as follows:

- Limited exam, $47.00.
- Panoramic X-ray, $82.00.
- Periapical X-ray, $19.00.
- Extraction, $100.00.

The total for these services is $248.00.

Because the exam and X-rays are considered **preventive and diagnostic**, they are **exempt** from the $200.00 annual deductible but not from the $750.00 annual limit. These services are reimbursed by BadgerCare Plus to the provider at 50 percent of the maximum allowable fee with the member responsible for the balance. The provider would receive $23.50 from BadgerCare Plus for the limited exam, $41.00 for the panoramic X-ray, and $9.50 for the periapical X-ray for a total of $74.00, which is applied to the member's $750.00 annual limit. The member is responsible for the remaining $74.00 for these services.

The extraction is subject to the $200.00 annual deductible, so the member is responsible for the full $100.00. This amount is not applied to the member's $750.00 annual limit.

In the second example, a dental provider sees a child enrolled in the Benchmark Plan as a new patient. This member receives a new patient exam (D0150), a full mouth X-ray (D0210), an adult prophylaxis (D1110), and restoration (D2140, D2150, D2160).

The maximum allowable fees for these services are as follows:

- New patient exam, $50.00.
- Full mouth X-ray, $90.00.
- Adult Prophylaxis, $60.00.
- Restorations, $313.00.

The total for these services is $513.00.

Because the exam, X-ray, and prophylaxis are considered **preventive and diagnostic**, they are **exempt** from the $200.00 annual deductible but not from the $750.00 annual limit. These services are reimbursed by BadgerCare Plus to the provider at 50 percent of the maximum allowable fee with the Benchmark Plan member responsible for the balance. The provider would receive $25.00 from BadgerCare Plus for the new patient exam, $45.00 for the full mouth X-ray, and $30.00 for the adult prophylaxis. The member is responsible for the remaining $100.00 for these services.

The restorations are subject to the $200.00 annual deductible, so the member is responsible for the first $200.00 and then 50 percent of the $113.00 balance for a total of $256.50 ($200.00 deductible plus 50 percent, or $56.50, of the remainder). BadgerCare Plus would reimburse the remaining $56.50.

Revised Terms of Reimbursement

Dental terms of reimbursement (TOR) are revised effective February 1, 2008. Refer to Attachment 2 for the Dental/Dental Hygienists Terms of Reimbursement. The attached TOR replaces the previous version and will automatically take effect.

Billing Benchmark Plan Members for Services

Benchmark Plan members are responsible only up to the Benchmark Plan maximum allowable fee for dental services once a provider collects the $200.00 deductible or the remaining 50 percent of the maximum allowable fee if the deductible has already been met. Services received in an enrollment year that exceed the $750.00 limit per enrollment year are considered noncovered services. Noncovered services can be billed directly to the member at the provider's usual and customary charge. Dental service providers are strongly urged to obtain from the member a written and signed waiver of liability for noncovered services.

Providers should contact **Provider Services** toll free at **(800) 947-9627** or at **(608) 221-9883** for information on a member's status relative to the $750.00 limit per enrollment year.

Enrollment Year Under BadgerCare Plus

An enrollment year is defined as the continuous 12-month period beginning the first day of the calendar month in which a member is enrolled in the Benchmark Plan and ending on the last day of the 12th calendar month.

For example, a member completes his or her BadgerCare Plus application materials by September 25, 2008. During the month of October, the Department of Health and Family Services (DHFS) reviews the application materials and determines that the member is **eligible** for the Benchmark Plan effective September 1, 2008, the first day of the calendar month that the application materials were completed; however, the enrollment year for this member will not begin until October 1, 2008, the first day of the calendar month in which the DHFS actively enrolled the member in the Benchmark Plan. The Benchmark Plan enrollment year for this member is defined as October 1, 2008, through September 30, 2009. **Services received after eligibility is established and before the enrollment year begins are covered under the Benchmark Plan but do not count toward the service limitations.**

Subsequent enrollment years begin on the first day of the calendar month immediately following the end of the previous enrollment year, if there is no coverage gap. If there is a coverage gap for more than one day, the enrollment year will reset to begin on the first day of the month in which the DHFS re-enrolls the member into the Benchmark Plan.

If a member switches from the Benchmark Plan to the Standard Plan, the Benchmark Plan enrollment year does not reset. For example, a member's enrollment year under the Benchmark Plan begins March 1, 2008. During the third month, the member's income status changes and he or she is now eligible for the Standard Plan effective June 1, 2008. During August, the DHFS determines that the member is no longer eligible for the Standard Plan and effective September 1, 2008, the member returns to the Benchmark Plan. Since there is not a gap in coverage, the initial Benchmark Plan enrollment year is still active. The member must adhere to limits for services received while covered under the Benchmark Plan during the enrollment year period March 1, 2008, through February 28, 2009.

The Benchmark Plan enrollment year is the time period used to determine service limitations for members in the Benchmark Plan. **Services received while covered under the Standard Plan do not count toward the enrollment year service limitations in the Benchmark Plan and vice versa.** If a member switches between the two plans during

one enrollment year, service limitations will accumulate separately under each plan.

Information Regarding BadgerCare Plus HMOs

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

The *BadgerCare Plus Update* is the first source of program policy and billing information for providers. All information applies to Medicaid and BadgerCare Plus unless otherwise noted in the *Update*.

Wisconsin Medicaid and BadgerCare Plus are administered by the Division of Health Care Access and Accountability, 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/*.

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ATTACHMENT 1
Dental Services Covered Under the BadgerCare Plus Benchmark Plan

The following tables list procedure codes that are reimbursed under the BadgerCare Plus Benchmark Plan's Dental Services benefit.

Dental services are only available for children under 18 years of age and pregnant women under the Benchmark Plan. A deductible of $200.00 applies to services other than preventive and diagnostic services and 50 percent cost-sharing applies after payment of the deductible. Only children are subject to the deductible and cost-sharing. Pregnant women are exempt from all cost-sharing. The benefit is limited to $750.00 per enrollment year based on the amount paid by the Benchmark Plan.

D0100-D0999 Diagnostic

Covered diagnostic services are identified by the allowable *Current Dental Terminology* (CDT) procedure codes listed in the following table. BadgerCare Plus reimbursement is allowable only for services that meet all program requirements. This includes documenting the medical necessity of services in the member's medical record.

Code	Description of Service	Limitations and Requirements	Benchmark Plan Maximum Fee	Subject to $200.00 Deductible
Clinical Oral Examinations				
D0120	Periodic oral evaluation — established patient	One per 12-month period, per provider, for members ages 13 and older. One per six-month period, per provider, for members up to age 12.	$32.00	No
D0140	Limited oral evaluation — problem focused	One per six months, per provider.	$47.00	No
D0150	Comprehensive oral evaluation — new or established patient	One per three years, per provider.	$50.00	No
D0160	Detailed and extensive oral evaluation — problem focused, by report	One per three years, per provider.	$65.00	No
D0170	Re-evaluation — limited, problem focused (established patient; not post-operative visit)	Allowed once per year, per provider. Allowable in office or hospital places of service (POS).	$38.00	No

Code	Description of Service	Limitations and Requirements	Benchmark Plan Maximum Fee	Subject to $200.00 Deductible
Radiographs/Diagnostic Imaging (Including Interpretation)				
D0210	Intraoral; complete series (including bitewings)	One per three years, per provider. Not billable within six months of other X-rays including D0220, D0230, D0240, D0270, D0272, D0274, and D0330 except in an emergency.[1] Panorex plus bitewings may be billed under D0210.	$90.00	No
D0220	periapical — first film	One per day. Not payable with D0210 on same date of service (DOS) or up to six months after.[2]	$19.00	No
D0230	periapical — each additional film	Up to three per day. Must be billed with D0220. Not payable with D0210 on same DOS or up to six months after.[2]	$15.00	No
D0240	occlusal film	Up to two per day. Not payable with D0210 on same DOS.	$25.00	No
D0250	Extraoral; first film	Emergency only, one per day.[1]	$30.00	No
D0260	each additional film	Emergency only, only two per day.[1] Must be billed with D0250.	manual	No
D0270	Bitewing(s); single film	One per day, up to two per six-month period, per provider. Not payable with D0210, D0270, D0272, D0273, or D0274 on same DOS or up to six months after.[2]	$20.00	No
D0272	two films	One set of bitewings per six-month period, per provider. Not payable with D0210, D0270, D0272, D0273, or D0274 on same DOS or up to six months after.[2]	$30.00	No
D0273	three films	One set of bitewings per six-month period, per provider. Not payable with D0210, D0270, D0272, D0273, or D0274 on same DOS or up to six months after.[2]	$36.00	No

Code	Description of Service	Limitations and Requirements	Benchmark Plan Maximum Fee	Subject to $200.00 Deductible
Radiographs/Diagnostic Imaging (Including Interpretation) (Continued)				
D0274	four films	One set of bitewings per six-month period, per provider. Not payable with D0210, D0270, D0272, D0273, or D0274 on same DOS or up to six months after.[2]	$42.00	No
D0330	Panoramic film	One per day when another radiograph is insufficient for proper diagnosis. Not payable with D0210, D0270, D0272, D0273, or D0274.	$82.00	No
D0340	Cephalometric film	Orthodontia diagnosis only. Allowable for members up to age 20.	$80.00	No
D0350	Oral/facial photographic images	Allowable for members up to age 20. Allowable for orthodontia or oral surgery.	$35.00	No
Tests and Examinations				
D0470	Diagnostic casts	Orthodontia diagnosis only. Allowed with prior authorization (PA) for members ages 21 and over, at BadgerCare Plus' request (e.g., for dentures).	$66.00	No
D0486	Accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	None	$175.00	No
D0999*	Unspecified diagnostic procedure, by report	Use this code for up to two additional oral exams per year with a HealthCheck referral. Allowable for members ages 13-20. Use for dental hygienists to report oral screening or preliminary exam. Limited to one per member, per provider, per year. No age restrictions.	$38.00	No

* Indicates procedure reimbursable to Medicaid-certified dental hygienist.

1 Retain records in member files regarding nature of emergency.

2 Six-month limitation may be exceeded in an emergency.

D1000-D1999 Preventive

Covered preventive services are identified by the allowable CDT procedure codes listed in the following table. BadgerCare Plus reimbursement is allowable only for services that meet all program requirements. This includes documenting the medical necessity of services in the member's medical record.

Code	Description of Service	Limitations and Requirements	Benchmark Plan Maximum Fee	Subject to $200.00 Deductible
Dental Prophylaxis				
D1110*	Prophylaxis; adult	One per 12-month period, per provider, for members ages 21 and older. One per six-month period, per provider, for members ages 13-20. Allowable for members ages 13 and older. Not payable with periodontal scaling and root planing or periodontal maintenance procedure. *Special Circumstances:* Up to four per 12-month period, per provider, for permanently disabled members. Retain documentation of disability that impairs ability to maintain oral hygiene. Allowable for Medicaid-certified dental hygienists.	$60.00	No
D1120*	child	One per six-month period, per provider. Allowable for members up to age 12. *Special Circumstances:* Up to four per 12-month period, per provider, for permanently disabled members. Retain documentation of disability that impairs ability to maintain oral hygiene. Allowable for Medicaid-certified dental hygienists.	$45.00	No

Code	Description of Service	Limitations and Requirements	Benchmark Plan Maximum Fee	Subject to $200.00 Deductible
Topical Fluoride Treatment (Office Procedure)				
D1203+	Topical application of fluoride (prophylaxis not included); child	Two per 12-month period, per provider. Allowable for members up to age 12. *Special Circumstances:* Up to four per 12-month period, per provider, for cases of demonstrated high need, or for permanently disabled members. Retain documentation of disability that impairs ability to maintain oral hygiene or demonstrated high need. Allowable for Medicaid-certified dental hygienists, physicians, and nurses.	$26.00	No
D1204*	adult	Two per 12-month period, per provider, for members ages 13-20. Covered only in special circumstances for members ages 21 and older: Up to four per 12-month period, per provider, for permanently disabled members. Retain documentation of disability that impairs ability to maintain oral hygiene. Allowable for members age 13 or older. Allowable for Medicaid-certified dental hygienists.	$27.00	No
D1206*	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	Up to four per 12-month period, per provider, for at risk children ages 0-20. Up to two per 12-month period, per provider, for children up to age 12. Up to four per 12-month period, per provider, for children up to age 12 for cases of demonstrated high need or permanently disabled members. Covered only in special circumstances for members ages 21 and older: Up to four per 12-month period, per provider, for permanently disabled members. Retain documentation of disability that impairs ability to maintain oral hygiene. Not payable with periodontal scaling and root planing. Allowable for Medicaid-certified dental hygienists. Per CDT, not used for desensitization.	$27.00	No

Code	Description of Service	Limitations and Requirements	Benchmark Plan Maximum Fee	Subject to $200.00 Deductible
Other Preventive Services				
D1351*	Sealant — per tooth	Retain documentation regarding medical necessity of sealants placed on teeth other than permanent molars (1, 4-13, 16, 17, 20-29, 32, 51-82, A-T, AS-TS). Allowable for members up to age 20. Narrative required in order to exceed once per three-year limitation. Allowable for Medicaid-certified dental hygienists.	$35.00	No
Space Maintenance (Passive Appliances)				
D1510	Space maintainer; fixed-unilateral	First and second primary molar only (tooth letters A, B, I, J, K, L, S, and T only). Limited to four per DOS; once per year, per tooth. Narrative required to exceed frequency limitation. Allowable for members up to age 20.	$210.00	No
D1515	fixed-bilateral	Once per year, per arch. Narrative required to exceed frequency limitation. Allowable for members up to age 20.	$300.00	No
D1550	Recementation of space maintainer	Limited to two per DOS. Allowable for members up to age 20.	$46.00	No

* Indicates procedure reimbursable to Medicaid-certified dental hygienist.

D2000-D2999 Restorative

Covered restorative services are identified by the allowable CDT procedure codes listed in the following table. BadgerCare Plus reimbursement is allowable only for services that meet all program requirements. This includes documenting the medical necessity of services in the member's medical record.

Code	Description of Service	Limitations and Requirements	Benchmark Plan Maximum Fee	Subject to $200.00 Deductible
Amalgam Restorations (Including Polishing)				
D2140	Amalgam; one surface, primary or permanent	Primary teeth: Once per tooth, per year, per provider[1] (tooth letters A-T and AS-TS only). Permanent teeth: Once per tooth, per three years, per provider[1] (tooth numbers 1-32 and 51-82 only).	$85.00	Yes
D2150	Two surfaces, primary or permanent	Primary teeth: Once per tooth, per year, per provider[1] (tooth letters A-T and AS-TS only). Permanent teeth: Once per tooth, per three years, per provider[1] (tooth numbers 1-32 and 51-82 only).	$103.00	Yes
D2160	Three surfaces, primary or permanent	Primary teeth: Once per tooth, per year, per provider[1] (tooth letters A-T and AS-TS only). Permanent teeth: Once per tooth, per three years, per provider[1] (tooth numbers 1-32 and 51-82 only).	$125.00	Yes
D2161	Four or more surfaces, primary or permanent	Primary teeth: Once per tooth, per year, per provider[1] (tooth letters A-T and AS-TS only). Permanent teeth: Once per tooth, per three years, per provider[1] (tooth numbers 1-32 and 51-82 only).	$150.00	Yes

Code	Description of Service	Limitations and Requirements	Benchmark Plan Maximum Fee	Subject to $200.00 Deductible
Resin-Based Composite Restorations — Direct				
D2330	Resin-based composite; one surface, anterior	Primary teeth: Once per tooth, per year, per provider.[1] Permanent teeth: Once per tooth, per three years, per provider.[1] Allowed for Class I and Class V only (tooth numbers 6-11, 22-27, C-H, M-R, 56-61, 72-77, CS-HS, and MS-RS only).	$100.00	Yes
D2331	two surfaces, anterior	Primary teeth: Once per tooth, per year, per provider.[1] Permanent teeth: Once per tooth, per three years, per provider.[1] Allowed for Class III only (tooth numbers 6-11, 22-27, C-H, M-R, 56-61, 72-77, CS-HS, and MS-RS only).	$125.00	Yes
D2332	three surfaces, anterior	Primary teeth: Once per tooth, per year, per provider.[1] Permanent teeth: Once per tooth, per three years, per provider.[1] Allowed for Class III and Class IV only (tooth numbers 6-11, 22-27, C-H, M-R, 56-61, 72-77, CS-HS, and MS-RS only).	$151.00	Yes
D2335	four or more surfaces or involving incisal angle (anterior)	Primary teeth: Once per tooth, per year, per provider.[1] Permanent teeth: Once per tooth, per three years, per provider.[1] Allowed for Class IV only (tooth numbers 6-11, 22-27, C-H, M-R, 56-61, 72-77, CS-HS, and MS-RS only). Must include incisal angle. Four surface resins may be billed under D2332, unless an incisal angle is included.	$184.00	Yes

Code	Description of Service	Limitations and Requirements	Benchmark Plan Maximum Fee	Subject to $200.00 Deductible
Resin-Based Composite Restorations — Direct (Continued)				
D2390	Resin-based composite crown, anterior	Primary teeth: Once per year, per tooth (tooth letters D-G, DS-GS only). Permanent teeth: Once per five years, per tooth (tooth numbers 6-11, 22-27, 56-61, 72-77 only.) Limitation can be exceeded with narrative for children[1], and with PA for adults greater than age 20.[2]	$250.00	Yes
D2391	Resin-based composite — one surface, posterior	Primary teeth: Once per year, per provider, per tooth[1] (tooth letters A, B, I, J, K, L, S, T, AS, BS, IS, JS, KS, LS, SS, and TS only). Permanent teeth: Once per three years, per provider, per tooth[1] (tooth numbers 1-5, 12-21, 28-32, 51-55, 62-71, and 78-82 only).	$111.00	Yes
D2392	Resin-based composite — two surfaces, posterior	Primary teeth: Once per year, per provider, per tooth[1] (tooth letters A, B, I, J, K, L, S, T, AS, BS, IS, JS, KS, LS, SS, and TS only). Permanent teeth: Once per three years, per provider, per tooth[1] (tooth numbers 1-5, 12-21, 28-32, 51-55, 62-71, and 78-82 only).	$145.00	Yes
D2393	Resin-based composite — three surfaces, posterior	Primary teeth: Once per year, per provider, per tooth[1] (tooth letters A, B, I, J, K, L, S, T, AS, BS, IS, JS, KS, LS, SS, and TS only). Permanent teeth: Once per three years, per provider, per tooth[1] (tooth numbers 1-5, 12-21, 28-32, 51-55, 62-71, and 78-82 only).	$175.00	Yes

Code	Description of Service	Limitations and Requirements	Benchmark Plan Maximum Fee	Subject to $200.00 Deductible
Resin-Based Composite Restorations — Direct (Continued)				
D2394	Resin-based composite — four or more surfaces, posterior	Primary teeth: Once per year, per provider, per tooth[1] (tooth letters A, B, I, J, K, L, S, T, AS, BS, IS, JS, KS, LS, SS, and TS only). Permanent teeth: Once per three years, per provider, per tooth[1] (tooth numbers 1-5, 12-21, 28-32, 51-55, 62-71, and 78-82 only).	$204.00	Yes

1 Limitation may be exceeded if narrative on claim demonstrates medical necessity for replacing a properly completed filling, crown, or adding a restoration on any tooth surface. Limitation may be exceeded for non-prior authorized crowns by indicating medical necessity.

2 Frequency limitation may be exceeded only with PA.

D4000-D4999 Periodontics

Covered periodontic services are identified by the allowable CDT procedure codes listed in the following table. BadgerCare Plus reimbursement is allowable only for services that meet all program requirements. This includes documenting the medical necessity of services in the member's medical record.

Code	Description of Service	Limitations and Requirements	Benchmark Plan Maximum Fee	Subject to $200.00 Deductible
Surgical Services (Including Usual Postoperative Care)				
D4210	Gingivectomy or gingivoplasty — four or more contiguous teeth or bounded teeth spaces per quadrant	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), and 40 (lower right).	$400.00	Yes
D4211	one to three contiguous teeth or bounded teeth spaces per quadrant	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), and 40 (lower right).	$151.00	Yes

Code	Description of Service	Limitations and Requirements	Benchmark Plan Maximum Fee	Subject to $200.00 Deductible
Non-Surgical Periodontal Services				
D4341*	Periodontal scaling and root planing — four or more teeth per quadrant	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), and 40 (lower right). Allowable for members ages 13 and older. Limited in most circumstances to once per three years per quadrant. Up to four quadrants per DOS are allowed when provided in hospital or ambulatory surgical center POS. Limited to two quadrants per DOS when provided in an office, home, Extended Care Facility (ECF), or other POS, unless the PA request provides sound medical or other logical reasons, including long distance travel to the dentist or a disability that makes travel to the dentist difficult. Not payable with prophylaxis.	$175.00	Yes
D4342*	Periodontal scaling and root planing — one to three teeth, per quadrant	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), and 40 (lower right). Allowable for members ages 13 and older. Limited in most circumstances to once per three years per quadrant. Up to four quadrants per DOS are allowed when provided in a hospital or ambulatory surgical center POS. Limited to two quadrants per DOS when provided in an office, home, ECF, or other POS, unless the PA request provides sound medical or other logical reasons, including long-distance travel to the dentist or a disability that makes travel to the dentist difficult. Not payable with prophylaxis.	$105.00	Yes

Code	Description of Service	Limitations and Requirements	Benchmark Plan Maximum Fee	Subject to $200.00 Deductible
Non-Surgical Periodontal Services (Continued)				
D4355*	Full mouth debridement to enable comprehensive evaluation and diagnosis	Full mouth code. Excess calculus must be evident on an X-ray. One per three years, per provider. Billed on completion date only. May be completed in one long appointment. No other periodontal treatment (D4341, D4342, or D4910) can be authorized immediately after this procedure. Includes tooth polishing. Not payable with prophylaxis. Allowable for members ages 13 and older. Allowable with PA for members ages 0-12.	$123.00	Yes
Other Periodontal Services				
D4910*	Periodontal maintenance	Prior authorization may be granted up to three years. Not payable with prophylaxis. Once per year in most cases. Allowable for members ages 13 and older.	$95.00	Yes

* Indicates procedure reimbursable to Medicaid-certified dental hygienist.

D7000-D7999 Oral and Maxillofacial Surgery

Covered oral and maxillofacial surgery services are identified by the allowable CDT procedure codes listed in the following table. BadgerCare Plus reimbursement is allowable only for services that meet all program requirements. This includes documenting the medical necessity of services in the member's medical record.

Code	Description of Service	Limitations and Requirements	Benchmark Plan Maximum Fee	Subject to $200.00 Deductible
Extractions (Includes Local Anesthesia, Suturing, if Needed, and Routine Postoperative Care)				
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	Allowed only once per tooth (tooth numbers 1-32, A-T, 51-82, and AS-TS).	$100.00	Yes
Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions				
D7810	Open reduction of dislocation	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.	Manual	Yes
D7820	Closed reduction of dislocation	Once per DOS. Operative report required.	$486.00	Yes
D7830	Manipulation under anesthesia	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.	$339.00	Yes
D7840	Condylectomy	Only allowable in hospital, office, or ambulatory surgical center POS. No operative report required.	Manual	Yes
D7850	Surgical discectomy, with/without implant	Only allowable in hospital, office, or ambulatory surgical center POS. No operative report required.	Manual	Yes
D7860	Arthrotomy	Only allowable in hospital, office, or ambulatory surgical center POS. No operative report required.	$4,058.00	Yes
D7871	Non-arthroscopic lysis and lavage	Allowable only once per side (right and left) per three years.	$766.00	Yes

Code	Description of Service	Limitations and Requirements	Benchmark Plan Maximum Fee	Subject to $200.00 Deductible
Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions (Continued)				
D7899	Unspecified TMD therapy, by report	Use this code for billing temporomandibular joint assistant surgeon. Procedure must be included in PA request for the surgery itself. Only allowable in hospital or ambulatory surgical center POS.	Manual	Yes
20605	Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)	None	$82.00	Yes
21050	Condylectomy, temporomandibular joint (separate procedure)	None	Manual	Yes
21060	Meniscectomy, partial or complete, temporomandibular joint (separate procedure)	None	TBD	Yes
21070	Coronoidectomy (separate procedure)	None	$2,565.00	Yes
21240	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)	None	Manual	Yes
21242	Arthroplasty, temporomandibular joint, with allograft	None	Manual	Yes
21243	Arthroplasty, temporomandibular joint, with prosthetic joint replacement	None	$6,567.00	Yes
21480	Closed treatment of temporomandibular dislocation; initial or subsequent	None	$369.00	Yes
21485	complicated (eg, recurrent requiring intermaxillary fixation or splinting), initial or subsequent	None	Manual	Yes

Code	Description of Service	Limitations and Requirements	Benchmark Plan Maximum Fee	Subject to $200.00 Deductible
Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions (Continued)				
21490	Open treatment of temporomandibular dislocation	None	Manual	Yes
29800	Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)	None	Manual	Yes
29804	Arthroscopy, temporomandibular joint, surgical	None	$3,530.00	Yes

* Indicates procedure reimbursable to Medicaid-certified dental hygienist.

+ Indicates procedure reimbursable to Medicaid-certified physicians, nurse practitioners, physician's assistants, HealthCheck providers, and federally qualified health centers.

Claims for traumatic injury will be reviewed on a case-by-case basis. Maximum allowable fees will be established at the time of approval.

ATTACHMENT 2
Dental/Dental Hygienist Terms of Reimbursement

(A copy of the "Dental/Dental Hygienist Terms of Reimbursement" is located on the following page.)

Jim Doyle
Governor

Kevin R. Hayden
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF HEALTH CARE ACCESS AND ACCOUNTABILITY
WISCONSIN MEDICAID AND BADGERCARE
PROVIDER SERVICES
6406 BRIDGE ROAD
MADISON WI 53784

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DENTAL/DENTAL HYGIENISTS TERMS OF REIMBURSEMENT

The Department of Health and Family Services (DHFS) will establish maximum allowable fees for certified dental providers for the provision of covered services provided to Medicaid recipients who are covered under Medicaid or are members of the BadgerCare Plus Standard Plan. The DHFS will establish separate maximum allowable fees for the provision of covered services provided to recipients who are members of the BadgerCare Plus Benchmark Plan.

The DHFS shall pay the lesser of a provider's usual and customary charges or a maximum rate established by the DHFS. The maximum allowable fee shall be based on various factors including a review of usual and customary charges submitted to Wisconsin Medicaid, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations.

Providers are required to bill their usual and customary charges for services provided, that charge being the amount charged by the provider for the same service when provided to non-Medicaid patients. For providers using a sliding fee scale for specific services, usual and customary means the median of the individual provider's charge for the service when provided to non-Medicaid patients.

The DHFS shall adjust payments made to providers to reflect the amounts of any allowable copayments or deductibles that providers are required to collect pursuant to ch. 49, Wis. Stats.

Payments for deductibles and coinsurance payable on an assigned Medicare claim shall be made in accordance with s. 49.46(2)(c), Wis. Stats.

In accordance with federal regulations contained in 42 CFR 447.205, the DHFS will provide public notice in advance of the effective date of any significant proposed change in its methods and standards for setting payment rates for services.

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