wisconsin Medicaid update
and BadgerCare

April 2007 ● No. 2007-33

Wisconsin Medicaid and BadgerCare Information for Providers

To:
Dental Hygienists
Dentists
HMOs and Other Managed Care Programs

Procedure Code and Certification Requirement Changes for Dental Hygienists

Effective for dates of service on and after January 17, 2007, Wisconsin Medicaid has expanded reimbursement for dental hygienists to include five additional *Current Dental Terminology* procedure codes (D0999, D4341, D4342, D4355, and D4910).

In addition, effective January 1, 2007, Wisconsin Medicaid has eliminated the requirements that dental hygienists have 3,200 hours of practicing experience in order to receive certification as a Medicaid provider and that dental hygienists employed or contracted by a public health entity are required to submit the date(s) of sealant clinic programs to the contract agency for the Wisconsin Seal-A-Smile Dental Sealant Program at least 20 days before each program clinic.

Certification Requirement Changes

Pursuant to a change in Wisconsin Administrative Code, effective January 17, 2007, Wisconsin Medicaid no longer requires that dental hygienists demonstrate a minimum of 3,200 hours of active practice experience in order to become certified as a Medicaid provider. The requirement will be removed from the certification packets used by dental hygienists. Furthermore, effective January 17, 2007, dental hygienists employed or contracted by a public health entity are no longer required to submit the date(s) of sealant clinic programs to the contract agency for the Wisconsin Seal-A-Smile Dental Sealant Program at least 20 days before each program date.

Dental hygienists must be licensed by the Department of Regulation and Licensing (DR&L) and operate within their scope of practice as defined by DR&L regulations. Refer to the August 2006 *Wisconsin Medicaid and BadgerCare Update* (2006-74), titled "Dental Hygienists May Become Medicaid Certified," for additional information about certification requirements. This *Update* can be found on the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/updates/2006/2006-74.htm*.

Expansion of Allowable Services for Dental Hygienists

Effective for dates of service on and after January 17, 2007, Medicaid-certified dental hygienists may be reimbursed for additional services using the following *Current Dental Terminology* (CDT) procedure codes:

- D0999 (Unspecified diagnostic procedure, by report).
- D4341 (Periodontal scaling and root planing — four or more teeth per quadrant).
- D4342 (Periodontal scaling and root planing — one to three teeth, per quadrant).
- D4355 (Full mouth debridement to enable comprehensive evaluation and diagnosis).
- D4910 (Periodontal maintenance).

Procedure code D0999 must be used to indicate an oral screening or preliminary examination. The words "preliminary examination" or "oral screening" must be written in Element 30 of the ADA 2002 and 2006 claim forms or Element 59 of the ADA 2000 form. The reason these terms must be used on the claim form is because D0999 is also used to indicate a HealthCheck "Other Service." On occasion, a HealthCheck screening may identify the need for health care services that are not otherwise covered by Wisconsin Medicaid or that exceed Medicaid limitations. These services are called HealthCheck "Other Services." HealthCheck "Other Services" require prior authorization (PA). Use of the terms "preliminary examination" or "oral screening" indicates that services are not HealthCheck "Other Services" and do not require PA or a HealthCheck referral.

Providers are required to obtain PA for certain specified services before delivery of that service. The procedure codes that always require PA are D4341, D4342, and D4910. Procedure code D4355 requires PA only when performed on children up to the age of 12. Refer to the PA section of this *Update* for PA information regarding these procedure codes.

See Attachment 1 of this *Update* for the full list of reimbursable services for dental hygienists and the restrictions attached to them. Reimbursement for dental hygienists using these procedure codes is the same as for dentists. The maximum allowable fee schedule is available on the Wisconsin Medicaid Web site at *dhfs.wisconsin.gov/medicaid4/maxfees/txt/maxfee08_dental.txt*.

Prior Authorization

Providers are required to obtain PA for certain specified services before delivery of that service. The CDT procedure codes that require PA are D4341, D4342, and D4910. Procedure code D4355 requires PA only when performed on children up to the age of 12.

When PA is required, Wisconsin Medicaid will not reimburse for the following:

- Services provided prior to the grant date indicated on the Prior Authorization Dental Request Form (PA/DRF), HCF 11035 (Rev. 10/03).
- Services provided after the expiration date indicated on the PA/DRF.
- Services rendered without first obtaining PA. The provider is responsible for the cost of these services.

Provider eligibility, recipient eligibility, and medical status on the date of service, as well as all other Wisconsin Medicaid requirements, must be met prior to payment of the claim. Providers are advised that PA does not guarantee payment.

Provider eligibility, recipient eligibility, and medical status on the date of service, as well as all other Wisconsin Medicaid requirements, must be met prior to payment of the claim.

Required Prior Authorization Forms

The PA/DRF and the Prior Authorization Dental Attachment 1 (PA/DA1), HCF 11010 (11/06), are required for PA requests. The PA/DRF serves as the cover page of a paper PA request. Providers are required to complete the basic provider, recipient, and service information on the PA/DRF.

Each PA request is assigned a unique seven-digit number located on the PA/DRF. This PA number must be indicated on a claim for the service because it identifies the service as one that has been prior authorized. The PA/DA1 allows a provider to document the clinical information used to determine whether the

standards of medical necessity are met for the requested service(s).

The completion instructions and a sample PA/DRF are located in Attachments 2 and 3. The completion instructions and a reproducible copy of the PA/DA1 are located in Attachments 4 and 5. Copies of the PA/DA1 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/*. The PA/DRF cannot be downloaded and printed in its original format from the Web site because it is a uniquely numbered multi-part form. Providers may request paper copies of the PA/DRF and all other PA forms and PA attachments by writing to Wisconsin Medicaid. Include a return address, the name of the form, the form number, and number of forms desired and send the request to the following address:

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

Provider Questions

Providers and billing staff who are experiencing difficulties or have questions may call the following:

- Provider Services at (800) 947-9627 or (608) 221-9883. Press "6" for a dental correspondent when prompted.
- Dental professional relations representative Joan Buntin at (715) 675-3190 for complex billing issues.

Information Regarding Medicaid HMOs

Services performed by a Medicaid-certified dental hygienist are considered dental services for the purposes of Medicaid HMO coverage. 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.

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/*.

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ATTACHMENT 1
Allowable Dental Hygienist Services and Limitations

This attachment lists procedure codes for which dental hygienists may be reimbursed with limitations. This list completely replaces previously published lists of dental hygienist procedure codes. Providers and billing staff who have questions about coverage may call Provider Services at (800) 947-9627 or (608) 221-9883 (press "6" for a dental correspondent when prompted).

Diagnostic Procedures

Code	Description of Service	Prior Authorization?	Limitations and Requirements
Tests and Examinations			
D0999	unspecified diagnostic procedure, by report	No	Oral screening and preliminary examination. "Preliminary examination" or "oral screening" must be written in Element 30 of the ADA 2002 and 2006 claim forms or Element 59 of the ADA 2000 form. Wisconsin Medicaid will reimburse only one instance of D0999 per recipient, per provider, per date of service.

Preventive

Code	Description of Service	Prior Authorization?	Limitations and Requirements
Dental Prophylaxis			
D1110	prophylaxis – adult	No	One per 12-month period, per provider, for ages 21 and older. One per six-month period, per provider, for ages 13-20. **Allowable for recipients ages 13 or 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 recipients. Retain documentation of disability that impairs ability to maintain oral hygiene.* *Allowable for Medicaid-certified dental hygienists.*
D1120	prophylaxis – child	No	One per six-month period, per provider. **Allowable for recipients up to age 12.** *Special Circumstances: Up to four per 12-month period, per provider, for permanently disabled recipients. Retain documentation of disability that impairs ability to maintain oral hygiene.* *Allowable for Medicaid-certified dental hygienists.*
Topical Fluoride Treatment (Office Procedure)			
D1203	topical application of fluoride (prophylaxis not included) – child	No	Two per 12-month period, per provider. **Allowable for recipients 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 recipients. Retain documentation of disability that impairs ability to maintain oral hygiene or demonstrated high need.* *Allowable for Medicaid-certified dental hygienists, physicians, and nurses.*
D1204	topical application of fluoride (prophylaxis not included) – adult	No	Two per 12-month period, per provider, for ages 13-20. **Allowable for recipients age 13 or older.** *Covered only in special circumstances for ages 21 and older: Up to four per 12-month period, per provider, for permanently disabled recipients. Retain documentation of disability that impairs ability to maintain oral hygiene.* *Allowable for Medicaid-certified dental hygienists.*
D1206	topical fluoride varnish – therapeutic application for moderate to high caries risk patients	No	Two per 12-month period, per provider. **Allowable for recipients 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 recipients. Retain documentation of disability that impairs ability to maintain oral hygiene or demonstrated high need.* *Allowable for Medicaid-certified dental hygienists, physicians, and nurses.*

Preventive (continued)

Code	Description of Service	Prior Authorization?	Limitations and Requirements
Other Preventive Services			
D1351	Sealant – per tooth	No	Retain documentation regarding medical necessity of sealants placed on teeth *other than* primary or secondary molars (1, 4-13, 16, 17, 20-29, 32, 51-82, A-T, AS-TS). **Allowable for recipients up to age 20.** Narrative required to exceed once per three-year limitation. *Allowable for Medicaid-certified dental hygienists.*

Periodontics

Code	Description of Service	Prior Authorization?	Limitations and Requirements
Non-Surgical Periodontal Service			
D4341	periodontal scaling and root planing – four or more teeth per quadrant	Yes	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), and 40 (lower right). **Allowable for recipients ages 13 and older.** Limited in most circumstances to once per three years per quadrant. Up to four quadrants per date of service (DOS) are allowed when provided in hospital or ambulatory surgical center place of service (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, which explains why travel to the dentist is difficult. Not payable with prophylaxis.
D4342	periodontal scaling and root planing – one to three teeth, per quadrant	Yes	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), and 40 (lower right). **Allowable for recipients 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, which explains why travel to the dentist is difficult. Not payable with prophylaxis.
D4355	full mouth debridement to enable comprehensive evaluation and diagnosis	No (see limitations)	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 recipients ages 13 and older.** **Allowable with PA for recipients ages 0-12.**
Other Periodontal Service			
D4910	periodontal maintenance	Yes	Prior authorization may be granted up to three years. Not payable with prophylaxis. Once per year in most cases. **Allowable for recipients ages 13 and older.**

ATTACHMENT 2
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.)

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 will 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 your 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 your PA/DRF features a provider checklist to assist with requests for periodontics, endodontics, and services requiring enclosures. For additional information, consult your Dental Provider Handbook.*

ATTACHMENT 3
Prior Authorization Dental Request Form (PA/DRF)

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11035 (Rev. 10/03)

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)
	4. Billing Provider's Medicaid Provider No. **87654321**	❑ 125 (Ortho)
	5. Performing Provider's Medicaid Provider Number	

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**	**1234 Street St.**
9. Name — Recipient (Last, First, Middle Initial)	10. Sex — Recipient	**Anytown, WI 55555**
Im A. 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
	D4341	**10**	**Periodontal scaling and root planning – four or more teeth per quadrant**	**1**	**XXX.XX**

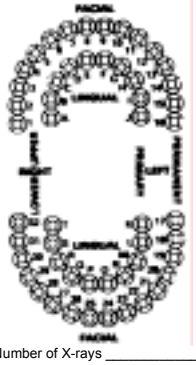
An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization 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:

❑ Returned — Reason:

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

ATTACHMENT 4
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.)

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 5
Prior Authorization/Dental Attachment 1 (PA/DA1)
(for photocopying)

(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