ForwardHealth
Wisconsin serving you

Update
March 2015

No. 2015-11

Affected Programs: BadgerCare Plus, Medicaid
To: Dentists, HMOs and Other Managed Care Programs

Revised Prior Authorization Requirements for Periodontal Scaling and Root Planing

This *ForwardHealth Update* announces revised prior authorization (PA) requirements for periodontal scaling and root planing effective for PA requests received on and after April 13, 2015.

Effective for prior authorization (PA) requests received on and after April 13, 2015, ForwardHealth has revised the PA requirements for periodontal scaling and root planing.

Coverage Information

ForwardHealth covers periodontal scaling and root planing when traditional, less intensive dental services have not been effective in treating pain and infection. Periodontal scaling and root planing always require PA in order to be covered by ForwardHealth.

Allowable Procedure Codes

The following are allowable *Current Dental Terminology* (CDT) procedure codes for periodontal scaling and root planing:

- D4341 (Periodontal scaling and root planing — four or more teeth per quadrant).
- D4342 (Periodontal scaling and root planing — one to three teeth, per quadrant).

Approval Criteria

According to DHS 107.02(3)(a), Wis. Admin. Code, ForwardHealth has the authority to require and define the terms of PA for dental services.

All of the following criteria must be met before PA requests for periodontal scaling and root planing can be approved:

- The member has bone loss or excess calculus that is visible on X-rays.
- The member has more than 50 percent bony support intact for the teeth being treated.
- The member has inflamed gingiva with at least one pocket five or more millimeters deep on three or more teeth. For PA requests indicating procedure code D4342 to be approved, at least three teeth in a quadrant must be affected. Periodontal scaling and root planing may be approved for a single quadrant.
- The member has received *one* of the following:
  - ✓ A full-mouth debridement within the last year.
  - ✓ Routine dental care performed by the provider requesting PA for periodontal scaling and root planing.

Allowable Quadrants per Date of Service

In most circumstances, periodontal scaling and root planing are limited to two quadrants per date of service (DOS). In the following circumstances, periodontal scaling and root planing may be completed for all four quadrants per DOS:

- If the member has been hospitalized for another service(s) and periodontal scaling and root planing may be provided concurrently with that service.
- If the member has to travel long distances (more than 60 miles one way) to an appointment with the requesting provider.

- If the member has a disability that makes traveling to the dentist difficult.

The above exceptions must be indicated on the PA request and must be specifically approved by the ForwardHealth dental consultant.

Submission of Prior Authorization Requests

Providers are required to submit the following when requesting PA for periodontal scaling and root planing:

- A completed Prior Authorization Dental Request Form (PA/DRF), F-11035 (07/12).
- A completed Prior Authorization/Dental Attachment 1 (PA/DA1), F-11010 (04/15).
- Supporting clinical documentation.

As stated in DHS 106.02(9)(e)1., Wis. Admin. Code, providers are responsible for the truthfulness, accuracy, timeliness, and completeness of PA requests and any supporting clinical documentation regardless of the submission method. Incomplete PA requests will be returned to providers.

Prior Authorization/Dental Attachment 1

The Periodontal Services section of the PA/DA1 has been updated as a result of the revised PA requirements. Additionally, requesting providers are now required to sign and date the PA/DA1.

Providers should refer to Attachment 1 of this *ForwardHealth Update* for a copy of the Prior Authorization/Dental Attachment 1 (PA/DA1) Completion Instructions, F-11010A (04/15), and to Attachment 2 for a copy of the updated PA/DA1 form. Current versions of the PA/DA1 completions instructions and form are available on the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/content/provider/forms/index.htm.spage.*

Required Supporting Clinical Documentation

Prior authorization requests for periodontal scaling and root planing must include the following supporting clinical documentation:

- Clinical notes stating that the member has been informed of the etiology of periodontal disease and methods of treatment and prevention.
- Clinical notes stating that a long-term plan for maintenance, including annual re-evaluations and a review of the periodontal disease, has been established.
- Documentation that the member has received one of the following:
  - ✓ A full-mouth debridement in the last year and has had three months to recover.
  - ✓ Routine dental care from the requesting provider.
- A complete periodontal charting of the oral cavity (not including the tooth [teeth] to be extracted) that was completed within six months of requesting PA for periodontal scaling and root planing (after a full-mouth debridement, if applicable).
- Full-mouth X-rays with a current set of four bitewing X-rays (two each side). (*Note:* Full-mouth X-rays are only reimbursable once every three years per provider. A set of four bitewing X-rays is only reimbursable once every six months per provider.)
- The dentist's statement of need requesting treatment of more than two quadrants per day, if applicable.

Submission Options

Providers may submit PA requests for periodontal scaling and root planing via any of the following:

- Portal.
- Fax.
- Mail.
- 278 Health Care Services Review — Request for Review and Response Transaction.

For specific information about each of these submission options, providers should refer to the Submission Options chapter of the Prior Authorization section of the Dental service area of the ForwardHealth Online Handbook.

Providers are reminded that if they fax or mail a PA request to ForwardHealth, they are required to include *all* documentation with the request, including the PA/DRF, PA/DA1, and required supporting clinical documentation.

Follow-up Care

Follow-up cleanings and maintenance for periodontal scaling and root planing may be provided to members; however, standard limitations apply. Prophylactic services are limited to one per six-month period for members 20 years of age and younger and one per 12-month period for members 21 years of age and older. For members with a permanent physical or developmental disability that impairs their ability to maintain their own oral hygiene, prophylactic services are limited to four per 12-month period.

Providers may request one additional prophylactic service for periodontal scaling and root planing per member per year if that member has already reached his or her annual limit for prophylactic services but requires an additional prophylactic service for periodontal scaling and root planing. Providers are required to use CDT procedure code D4910 (Periodontal maintenance) to indicate the additional prophylactic service. The additional prophylactic service may be included on the PA request for periodontal scaling and root planing. The PA request must include documentation that justifies the additional prophylactic service.

Note: Providers should use the same procedure codes that are used for routine prophylactic services when submitting claims. For additional information about procedures codes for prophylactic services, providers should refer to the Standard Plan/Medicaid Diagnostic, Preventive, Restorative, Endodontics, Periodontics, General Codes topic (topic #2808) in the Codes chapter of the Covered and Noncovered Services section of the Dental service area of the Online Handbook.

Circumstances in Which Periodontal Scaling and Root Planing Is Not Covered

Periodontal scaling and root planing is not covered by ForwardHealth in the following circumstances:

- The requested start date for periodontal scaling and root planing is within three months of a full-mouth debridement.
- Clinical notes submitted with the PA request explicitly indicate that a failure to attend appointments, poor dental hygiene, or other negative behavioral factors as reported by a clinician contributed to the member's condition.
- Periodontal scaling and root planing was provided in the last three years.

Information Regarding Managed Care Organizations

This *Update* contains fee-for-service policy and applies to members who receive their dental benefits on a fee-for-service basis. For managed care policy, contact the appropriate managed care organization. Managed care organizations are required to provide at least the same benefits as those provided under fee-for-service arrangements.

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

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin AIDS Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *www.forwardhealth.wi.gov/*.

P-1250

This *ForwardHealth Update* was issued on 03/13/2015, and information contained in this *Update* was incorporated into the Online Handbook on 04/13/2015.

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 pages.)

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

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (DHS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is mandatory when requesting PA for certain services. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. When completing PA requests, answer all elements as thoroughly as possible. Provide enough information (check all boxes that apply) for ForwardHealth to make a determination about the request.

Submitting Prior Authorization Requests
Dentists may submit PA requests that include the Prior Authorization/Dental Attachment 1 (PA/DA1), F-11010, in one of the following ways:

1) For requests submitted on the ForwardHealth Portal, dentists may access *www.forwardhealth.wi.gov/*.

2) For requests submitted by fax, dentists should submit the completed Prior Authorization Dental Request Form (PA/DRF), F-11035, and PA/DA1 to ForwardHealth at (608) 221-8616 *if X-rays or models are not required for documentation purposes.*

3) For PA requests submitted by mail, dentists should submit the PA/DRF and PA/DA1 to the following address:

   ForwardHealth
   Prior Authorization
   Ste 88
   313 Blettner Blvd
   Madison WI 53784

Providers should make duplicate copies of all paper documents mailed to ForwardHealth.

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 — MEMBER AND PROVIDER INFORMATION
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 PA/DRF through the PA review process. This attachment will be returned to the provider if the numeric information is not completed at the top of each page submitted.

Member Identification Number
Enter the member ID. Do not enter any other numbers or letters.

National Provider Identifier (NPI) — Billing Provider
Enter the National Provider Identifier (NPI) of the billing provider.

NPI — Rendering Provider (If Different)
Enter the NPI of the rendering provider who will actually provide the service if the rendering provider is different from the billing provider.

SECTION II — DENTAL SERVICES

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 of the boxes that apply to the appropriate reason(s) for the procedure(s) being performed.

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

SECTION III — AUTHORIZED SIGNATURE

Signature — Requesting Provider
The requesting provider is required to complete and sign this form.

Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION IV — ADDITIONAL INFORMATION

Indicate any additional information (e.g., diagnostic and clinical information) in the space provided.

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

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

(This page was intentionally left blank.)

FORWARDHEALTH
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.

SECTION I — MEMBER AND PROVIDER INFORMATION		
Member Identification Number	National Provider Identifier (NPI) — Billing Provider	NPI — Rendering Provider

SECTION II — DENTAL SERVICES

CATEGORY	PROCEDURE CODES (Check All That Apply)		TREATMENT PLAN JUSTIFICATION (Check All That Apply)	REQUIRED DOCUMENTATION
Diagnostic Services	❑ D0210 ❑ D0330 ❑ D0470 (Prior authorization is only required in certain circumstances.)		❑ Frequency limitation to be exceeded (D0210 and D0330). ❑ Member over age 20 (D0470). ❑ Department of Health Services request. ❑ Date of models (MM/DD/CCYY). ________________	• Explanation to exceed frequency limitation. • Document number and type of X-rays taken (for D0210 and D0330).
Restorative Services	❑ D2390 ❑ D2932 ❑ D2933 (For members who are age 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. ❑ Member 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. (Prior authorization is 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 members who are age 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. (Prior authorization 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.
Periodontal Services	❑ D4210 ❑ D4211		❑ Medication-induced hyperplasia. ❑ Irritation from orthodontic bands. ❑ Hyperplasia. ❑ More than 25 percent crown involved. ❑ Other. (Describe.) ________________	• 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).

Continued

Member Identification Number	NPI — Billing Provider	NPI — Rendering Provider

SECTION II — DENTAL SERVICES (Continued)

<table>
<tr><th>CATEGORY</th><th>PROCEDURE CODES
(Check All That Apply)</th><th>TREATMENT PLAN JUSTIFICATION
(Check All That Apply)</th><th>REQUIRED DOCUMENTATION</th></tr>
<tr><td>Periodontal Services (Continued)</td><td>❑ D4341
❑ D4342</td><td>❑ Member 13 years of age and older.
❑ Early bone loss.
❑ Moderate bone loss.
❑ At least one pocket five or more millimeters deep on three or more teeth.
❑ Oral hygiene. (Check one.)
❑ Good ❑ Fair ❑ Poor
❑ Full-mouth debridement completed in last 12 months. Date of service for D4355 (MM/DD/CCYY).
____________________</td><td>• Periodontal charting.
• Comprehensive periodontal treatment plan.
• Full mouth X-rays with current bitewing X-rays.
• Clinical notes indicating member education on periodontal disease.
• Documentation of full-mouth debridement and/or routine dental care.</td></tr>
<tr><td></td><td>❑ D4355
(For members who are age 13 and older, PA is not required.)</td><td>❑ Excess calculus on X-ray.
❑ AAP I or II.
❑ No dental treatment in multiple years.
❑ Oral hygiene. (Check one.)
❑ Good ❑ Fair ❑ Poor
❑ Member under age 13.</td><td>• Bitewing or full mouth X-rays.
• Calculus must be visible on X-rays.</td></tr>
<tr><td></td><td>❑ D4910</td><td>❑ Recent history of periodontal scale / surgery.
❑ Oral hygiene. (Check one.)
❑ Good ❑ Fair ❑ Poor
❑ Years requested. (Check one.)
❑ 1 ❑ 2 ❑ 3</td><td>• Periodontal charting.
• Comprehensive periodontal treatment plan.
• Allowed once per 12 months.</td></tr>
<tr><td>Prosthodontic Services — Complete Dentures</td><td>❑ D5110
❑ D5120</td><td>❑ Initial placement of dentures (year).
Max __________ Mand __________
❑ Age of existing denture(s) (years).
Max __________ Mand __________
❑ New denture request because of the following. (Check all that apply.)
❑ Worn base / broken teeth.
❑ Poor fit.
❑ Vertical dimension.
❑ Date(s) last teeth extracted (MM/DD/CCYY).
____
❑ 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.</td><td>• 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.</td></tr>
</table>

Continued

Member Identification Number	NPI — Billing Provider	NPI — Rendering Provider

SECTION II — DENTAL SERVICES (Continued)

CATEGORY	PROCEDURE CODES (Check All That Apply)	TREATMENT PLAN JUSTIFICATION (Check All That Apply)	REQUIRED DOCUMENTATION
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. (Check 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. ❑ Member 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 members ages 0-20 when performed by a pediatric dentist or oral surgeon.)	❑ Behavior. ❑ Disability. (Describe.) ____ ❑ Geriatric. ❑ Physician consult. ❑ Complicated medical history. (Describe.) ____ ❑ 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.

Continued

SECTION III — AUTHORIZED SIGNATURE	
SIGNATURE — Requesting Provider	Date Signed

SECTION IV — ADDITIONAL INFORMATION

Indicate any additional information (e.g., diagnostic and clinical information) in the space provided.