ForwardHealth
Wisconsin serving you

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Affected Programs: BadgerCare Plus, Medicaid
To: Community Health Centers

Dental Claims Submission Guidelines for Community Health Centers

Overview

As part of changes related to the implementation of a prospective payment system (PPS) reimbursement structure, global billing is not allowed under PPS reimbursement for dental services. Instead, community health centers (CHCs) will be reimbursed an encounter rate for each allowed dental visit. There may be situations where certain dental services require more than one face-to-face visit for completion of the service; this *ForwardHealth Update* provides claim submission instructions and reimbursement information for those situations.

Prospective Payment System Encounters

Under the PPS, ForwardHealth will reimburse CHCs a PPS rate for each allowable CHC encounter type (medical, dental, and behavioral health) per date of service (DOS). A CHC encounter is defined as a face-to-face visit on a single DOS between a member and a Medicaid-enrolled CHC provider to provide diagnosis, treatment, or preventive service(s) at the Health Resources and Services Administration (HRSA)-approved CHC location including main and off-site locations.

CHC providers shall be reimbursed for each allowable face-to-face visit for dental services requiring more than one visit under the PPS reimbursement payment structure. As part of the CHC PPS implementation, the February 2018 *ForwardHealth Update* (2018-08), titled "New Reimbursement Methodology for Community Health Centers," instructed CHC providers to bill global dental services per DOS. These billing instructions are consistent with the previous reimbursement methodology, which reimbursed multiple visits for the completion and delivery of certain dental services. For example, the reimbursement rate for *Current Dental Terminology* (CDT) procedure code D5110 (Complete denture — maxillary) was multiplied by a factor of five, based on the average number of encounters reimbursable under the federally qualified health center cost-settlement process. CHC providers will be reimbursed an encounter rate when all other conditions for coverage, as outlined in *Update* 2018-08, have been met.

Procedure Codes for Additional Visits

For reimbursement to CHCs for dental services requiring multiple visits, the procedure code that represents the final prosthesis or dental service is referred to as the base code, and each additional visit is referred to as the associated code. Base codes and associated codes will be considered direct services for PPS reimbursement purposes.

ForwardHealth has identified the following CDT procedure codes to represent the associated codes:

- **D1999** (unspecified preventive procedure, by report): For preventive services that require additional visits. Coverage is limited to a maximum of 1 unit per member per preventive procedure.

- **D2999** (unspecified restorative procedure, by report): For restorative services that require additional visits. Coverage is limited to a maximum of 1 allowable unit per member per restorative procedure.
- **D3999** (unspecified endodontic procedure, by report): For endodontic services that require additional visits. Coverage is limited to a maximum of 1 allowable unit per member per endodontic procedure.
- **D5899** (unspecified removable prosthodontic procedure, by report): For complete and partial denture services that require additional visits. Coverage is limited to a maximum of 4 allowable units per member per denture procedure.

Refer to Attachment 1 of this *Update* for examples of base codes and associated codes and allowable units for dental services requiring multiple visits.

Note: Providers are required to document the specific service(s) performed for each dental visit in the member's dental record.

Prior Authorization Requirements

All prior authorization (PA) requirements for dental services remain the same; CHC providers are required to continue to submit PA requests as established prior to PPS implementation.

Codes designated as associated codes do not require PA.

Previously Submitted Prior Authorization Requests

When an existing PA request's effective dates span dates before and after May 1, 2018, providers are required to submit claims for multiple visits according to the multiple visit claim submission process outlined in this *Update* using the appropriate associated procedure codes for DOS on and after May 1, 2018.

For DOS before May 1, 2018, providers should not indicate the associated procedure code for additional dental visits. These visits will be accounted for under the previous reimbursement process in place prior to May 1, 2018.

For DOS on and after May 1, 2018, providers are required to indicate the associated procedure code for each additional dental visit as appropriate on a single claim with the base code and associated codes listed as separate details.

Claims Submission and Reimbursement

When billing for dental services requiring additional visits using the above dental procedure codes, CHCs must submit all face-to-face visits related to the dental service on a single claim on or after the date of completion or delivery.

CHCs must submit a single claim for the dental services requiring additional visits as follows:

- Include the base code and associated code(s) with their respective DOS as separate details.
- Include Healthcare Common Procedure Coding System (HCPCS) code T1015 (Clinic visit/encounter, all-inclusive), when applicable, for the base code and each associated code per the PPS claims submission guidelines.

When a dental visit qualifies for a PPS rate by meeting all defined program requirements, providers will be reimbursed the PPS rate for the encounter (indicated by HCPCS procedure code T1015) for the base code and for each associated code. Refer to Attachment 2 for sample claims submission details for dental procedures requiring multiple visits.

Denture repair, relines (excluding six-month post-care period), and tooth re-implantation base codes can be used to represent the service once per DOS per member per provider. There will not be associated codes for these services.

If a provider would like consideration when a base code is not rendered or is processed in a denied status (such as when the base code does not meet program requirements for reimbursement), the Wisconsin Department of Health

Services (DHS) will require a review of each associated code service for compliance. Refer to information under the Subsequent Encounters section of *Update* 2018-08 for instructions on submitting additional documentation for review. Provider reimbursement for the associated codes will be dependent on DHS review.

Information Regarding Managed Care Organizations

Refer to the Managed Care Impact section of *Update* 2018-08 for related managed care claims submission and reimbursement information.

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 Medicaid Services, the 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, DHS.

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

P-1250

This Update was issued on 06/19/2018 and information in this Update was incorporated into the Online Handbook on 01/07/2021.

ATTACHMENT 1
Examples of Base and Associated Procedure Codes and Allowable Units

Base codes that qualify for additional reimbursement are listed in the following table.

Base Code	Description	Associated Code	Description	Total Number of Allowed Visits/ Encounters	
D1510	Space maintainer — fixed, unilateral	D1999	Unspecified preventive procedure, by report	Maximum of two encounters	One base code and one associated code
D2791	Crown — full cast predominantly base metal	D2999	Unspecified restorative procedure, by report	Maximum of two encounters	One base code and one associated code
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	D3999	Unspecified endodontic procedure, by report	Maximum of two encounters	One base code and one associated code
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	D3999	Unspecified endodontic procedure, by report	Maximum of two encounters	One base code and one associated code
D3330	Endodontic therapy, molar tooth (excluding final restoration)	D3999	Unspecified endodontic procedure, by report	Maximum of two encounters	One base code and one associated code
D5110	Complete denture — maxillary	D5899	Unspecified removable prosthodontic procedure, by report	Maximum of five encounters	One base code and four associated codes
D5120	Complete denture — mandibular	D5899	Unspecified removable prosthodontic procedure, by report	Maximum of five encounters	One base code and four associated codes
D5211	Maxillary partial denture — resin base (including any conventional clasps, rests and teeth)	D5899	Unspecified removable prosthodontic procedure, by report	Maximum of five encounters	One base code and four associated codes
D5212	Mandibular partial denture — resin base (including any conventional clasps, rests and teeth)	D5899	Unspecified removable prosthodontic procedure, by report	Maximum of five encounters	One base code and four associated codes

Base Code	Description	Associated Code	Description	Total Number of Allowed Visits/ Encounters	
D5213	Maxillary partial denture — cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5899	Unspecified removable prosthodontic procedure, by report	Maximum of five encounters	One base code and four associated codes
D5214	Mandibular partial denture — cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5899	Unspecified removable prosthodontic procedure, by report	Maximum of five encounters	One base code and four associated codes
D5225	Maxillary partial denture — flexible base (including any conventional clasps, rests and teeth)	D5899	Unspecified removable prosthodontic procedure, by report	Maximum of five encounters	One base code and four associated codes
D5226	Mandibular partial denture — flexible base (including any conventional clasps, rests and teeth)	D5899	Unspecified removable prosthodontic procedure, by report	Maximum of five encounters	One base code and four associated codes

ATTACHMENT 2
Sample Claims Submission Details for Multiple Visits

When submitting claims for a member receiving maxillary complete denture services represented by *Current Dental Terminology* (CDT) procedure code D5110 (Complete denture — maxillary), claims should include the following procedures codes.

Appointment	Service Date/ Description	Claim Detail	Reimbursement Structure (Subject to Program Requirements)
First Appointment	05/01/2018	Detail 1: T1015	Prospective payment system (PPS) rate
	05/01/2018	Detail 2: D5899	$0.00
Second Appointment	05/05/2018	Detail 3: T1015	PPS rate
	05/05/2018	Detail 4: D5899	$0.00
Third Appointment	05/10/2018	Detail 5: T1015	PPS rate
	05/10/2018	Detail 6: D5899	$0.00
Fourth Appointment	05/20/2018	Detail 7: T1015	PPS rate
	05/20/2018	Detail 8: D5899	$0.00
Fifth Appointment	05/21/2018	Detail 9: T1015	No payable direct service
	05/21/2018	Detail 10: D5899	Exceeds unit limit for D5899 (0–4 per member/per base code)
Sixth Appointment	06/05/2018	Detail 11: T1015	PPS rate
	06/05/2018	Detail 12: D5110	$0.00

When submitting claims for a member receiving a crown represented by CDT procedure code D2791 (Crown — full cast predominantly base metal), claims should include the following procedure codes.

Appointment	Service Date/ Description	Claim Detail	Reimbursement Structure (Subject to Program Requirements)
First Appointment	05/01/2018	Detail 1: T1015	PPS rate
	05/01/2018	Detail 2: D2999	$0.00
Second Appointment	05/05/2018	Detail 3: T1015	PPS rate
	05/05/2018	Detail 4: D2791	$0.00