Tommy G. Thompson
Governor

Joe Leean
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF HEALTH

1 WEST WILSON STREET
P. O. BOX 309
MADISON WI 53701-0309

MEMORANDUM

DATE: December 7, 1998

TO: All Medicaid-Certified Dental Providers

FROM: Peggy L. Bartels, Administrator
Division of Health Care Financing

SUBJECT: Part B Dental Handbook Replacement

I. Introduction

The purpose of this mailing is to provide you with a new Part B Dental handbook, which incorporates the most recent Wisconsin Medicaid Updates, clarifies existing policy, and separates sections with tabs for easier use.

II. Part B Provider Handbook Replacement

Enclosed you will find a replacement for your Part B Dental Handbook. This handbook takes the place of the current handbook. Following is an overview of the revised information.

- **Sealants:** This handbook reasserts that sealants no longer require a HealthCheck referral.
- **Tabs:** The dental handbook is now separated into sections by tabs, making it easier to use.
- **New prior authorization forms:** Wisconsin Medicaid has revised its prior authorization forms, considering provider input and common reasons prior authorization request forms were returned to providers.
- **Tables:** Tables, particularly the tables that identify Medicaid coverage by procedure code (Appendix 5.2), have been redesigned for easier use.
- **Improved language:** Some areas of this handbook have been rewritten for clarity.

III. The Part B Dental Handbook Replacement Includes Information From Past Updates

This new handbook includes information that was previously sent in updates. Please throw away all updates issued before August 1, 1998.

If you have questions about any of the policy, billing, or prior authorization requirements referred to in this memo, please call the Medicaid fiscal agent Correspondence Unit at (608) 221-9883 or (800) 947-9627.

Enclosures

Introduction

HFS 101 through 108, Wis. Admin. Code, state statutes, and federal laws govern Wisconsin Medicaid. Medicaid provider handbooks identify the regulations and assist Medicaid providers to comply with requirements. Use the following handbooks when providing services:

- Part A, the all-provider handbook, includes general policy guidelines, regulations, and billing information applicable to all types of certified providers.
- Part B, the provider-specific handbook, includes information on provider eligibility criteria, covered services, payment methodology, prior authorization, and billing instructions.
- The Provider Section of the Wisconsin Medicaid Managed Care Guide includes information on policy guidelines and regulations for AFDC-related/Healthy Start recipients enrolled in a Medicaid HMO. The AFDC program no longer exists, but the Wisconsin Medicaid program still bases eligibility on AFDC criteria as of July 16, 1996.

Each provider is sent a copy of Part A, the all-provider handbook, the appropriate provider-specific handbook, and the Wisconsin Medicaid Managed Care Guide at the time of certification. Purchase additional copies of provider handbooks by using the order form in Appendix 36 of Part A, the all-provider handbook.

Read all materials before initiating services to ensure a thorough understanding of Medicaid policy and billing procedures.

Note: Refer to HFS 101 through 108, Wis. Admin. Code, for a complete source of Medicaid regulations and policies. In the event of any conflict between HFS 101 through 108, Wis. Admin. Code, and the handbook, the intent of the Wisconsin Administrative Code holds. For additional copies of HFS 101 through 108, Wis. Admin. Code, write to Document Sales at the address in Appendix 3 of Part A, the all-provider handbook.

Additional laws and regulations relating to Wisconsin Medicaid include the following:

- Sections 49.43 - 49.497, Wisconsin Statutes.
- Title XIX, federal Social Security Act and its enabling regulations, Title 42 - Public Health, Parts 430-456.

Definitions for common Medicaid terms and abbreviations are in Appendix 30 of Part A, the all-provider handbook, and in HFS 101 through 108, Wis. Admin. Code.

Wisconsin Medicaid is administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing (DHCF) is directly responsible for managing Wisconsin Medicaid. The DHFS contracts with an outside fiscal agent to provide health claims processing services including:

- Provider certification.
- Claims payment.
- Provider services.
- Recipient services.

The current Wisconsin Medicaid fiscal agent is EDS.

DENTAL SERVICES
TABLE OF CONTENTS

Page #

I. GENERAL INFORMATION
- A. TYPE OF HANDBOOK B1
- B. PROVIDER INFORMATION B1
  - Provider Eligibility and Certification B1
    - Certification Determines Oral Surgery Billing B1
  - Certification for Laboratory Services B1
  - Scope of Services B2
  - Reimbursement B2
  - Provider Responsibilities B2
  - Advisory Committee B2
  - Reducing the Number of Missed Appointments B2
- C. RECIPIENT INFORMATION B3
  - Verifying Recipient Eligibility B3
  - Recipient Loss of Eligibility at Any Time During Treatment B4
    - Orthodontic Exception B4
    - Prosthodontic Exception B5
  - Benefit Category B5
  - Recipients Enrolled in Managed Care Programs B5
  - Copayment B6
  - HealthCheck/Early and Periodic Screening, Diagnosis, and Treatment Requirements B7
  - Specialized Medical Vehicle Transportation for Disabled Recipients B7

II. COVERED SERVICES & RELATED LIMITATIONS
- A. INTRODUCTION B9
  - Education in Preventive Care B9
  - Infection Control Charges B9
  - Take-Home Supplies B9
  - Tooth Numbers and Letters B9
  - Denture Repair Modifiers B9
  - Surgery Modifiers B9
  - Emergency Services B10
- B. PRESCRIPTIONS B10
  - Prescription Requirements B10
  - "Brand Medically Necessary" Requirements for Innovator Drugs B11
    - Nursing Home Orders B11
    - Over-the-Counter Drugs B11
  - Drug Rebate System B11
    - Documentation for Drugs Manufactured by Companies That Have Not Signed a Rebate Agreement B12
- C. COVERED SERVICES B12
  - Covered Services Information Handout B12
- D. HEALTHCHECK B13
- E. HEALTHCHECK "OTHER SERVICES" B14
- F. INPATIENT AND OUTPATIENT HOSPITAL SERVICES B14
- G. NONCOVERED SERVICES B15

DENTAL SERVICES
TABLE OF CONTENTS
(continued)

Page #

III. PRIOR AUTHORIZATION
A. GENERAL PRIOR AUTHORIZATION GUIDELINES B17
Emergency Services B17
Traumatic Loss of Teeth for Children Under Age 21 ..... B17
B. PRIOR AUTHORIZATION REQUEST FORM B17
Sample Prior Authorization Forms B18
Prior Authorization Number B18
Re-Authorization of a Prior Authorization to a New Provider Number B18
Supporting Material Requirements B19
C. HEALTHCHECK "OTHER SERVICES" B19

IV. BILLING INFORMATION
A. COORDINATION OF BENEFITS B21
Other Insurance Billing Information - Paper Claims B21
Claim Showing Health Insurance Payment Made B21
Claim Showing Health Insurance Denied Payment B21
B. MEDICARE/ MEDICAID DUAL ENTITLEMENT B21
C. MEDICARE QMB-ONLY B22
D. BILLED AMOUNTS B22
E. MODIFIERS B22
Tooth Numbers and Letters B22
Denture Repair Modifiers B22
Surgery Modifiers B22
F. PLACE-OF-SERVICE CODES B23
G. CLAIM FORM B23
Paper Claim Submission B23
American Dental Association Claim Form for CDT Billing B23
HCFA 1500 Claim Form for Current Procedural Terminology Billing B24
Paperless Claim Submission B24
H. EMERGENCY SERVICES B24
I. HEALTHCHECK B25
J. RECIPIENT LOSS OF ELIGIBILITY DURING TREATMENT B25
K. OCCUPATIONAL ILLNESS OR INJURY B26
L. COPAYMENT B26
Copayment Billing Procedures B26
M. FOLLOW-UP TO CLAIM SUBMISSION B26
Claims Submission Deadline B26
N. CLAIMCHECK® FOR ORAL SURGERY B27
How ClaimCheck® Affects Billing Inconsistencies B27
Unbundling (Code Splitting) B27
Incidental/Integral Procedures B28
Mutually Exclusive B28
Periodic Review of Previously Submitted Claims B28
Requesting Adjustments B28

V. APPENDICES B29

A. Type of Handbook

Part B is the provider-specific Medicaid handbook for dental services. Part B includes information for providers on provider eligibility criteria, recipient eligibility, covered services, payment method, and billing instructions. Use this handbook in conjunction with Part A, the all-provider handbook, which includes general policy guidelines, regulations, and billing information applicable to all types of certified providers. Refer to the Provider Section of the Wisconsin Medicaid Managed Care Guide for general policy and regulation information for AFDC-related/Healthy Start recipients enrolled in a Medicaid HMO.

B. Provider Information

Provider Eligibility and Certification

To be eligible for Wisconsin Medicaid certification, dentists practicing in the state of Wisconsin are required to maintain an active license with the state Dental Examining Board according to section 447.05, Wis. Stats. Dentists practicing outside the state of Wisconsin who provide services to Wisconsin Medicaid recipients must be licensed by the Dental Examining Board in their own state.

Certification Determines Oral Surgery Billing

Wisconsin Medicaid uses provider specialties to determine which procedure coding system dentists will use in billing for oral surgeries. During the certification process, Wisconsin Medicaid asks dental providers to identify their practice specialties:

- Endodontics.
- Oral Pathology.
- Orthodontics.
- Periodontics.
- General Practice.
- Oral Surgery.
- Pedodontics.
- Prostdontics.

Dental providers who choose the oral surgery and oral pathology specialty use the American Medical Association's *Physicians' Current Procedural Terminology* (CPT) procedure codes for billing most oral surgeries. Dental providers with all other specialties use American Dental Association (ADA) Current Dental Terminology (CDT) procedure codes for billing most oral surgeries, as described in this handbook. Dentists who want different oral surgery billing than assigned to their specialty must complete a form requesting a change. Refer to Appendices 2 and 16 of this handbook for further information.

Certification for Laboratory Services

All laboratories which test human specimens to determine health status are covered by the federal Clinical Laboratory Improvement Amendments (CLIA) of 1988. CLIA governs every aspect of laboratory operation, including tests performed, personnel qualifications, quality control, quality assurance, proficiency testing, patient test management, and records and information systems. Every provider who performs laboratory tests must obtain a CLIA identification number *and* a certificate of waiver or a certificate of registration from the federal Health Care Financing Administration (HCFA). HCFA may grant a certificate of waiver to a laboratory that restricts its testing to the eight waived tests. This applies to clinics and individual provider offices that perform laboratory tests. Clinics

B. Provider Information (continued)

with laboratories located at more than one location must have a Wisconsin Medicaid billing provider number for every laboratory that has a CLIA identification number in order to receive the correct reimbursement for laboratory services.

Scope of Services

The policies in this handbook govern all dental services provided within the scope of the practice of the profession as defined in section 447.02, Wis. Stats., and HFS 107.07, Wis. Admin. Code. The covered services and related limitations are listed in Section II and in Appendices 9 through 19 of this handbook.

Reimbursement

The rate of reimbursement is based on the Medicaid dental maximum fee schedule. A provider is reimbursed the lesser of either the billed amount or the maximum fee allowable established by Wisconsin Medicaid (refer to Section IV-D of this handbook for more information). Wisconsin Medicaid has a maximum payment for all radiographs provided to a single recipient on a single day; for selected oral surgery emergency services provided to a single recipient on a single day; and for all dental services provided to a single recipient on a single day.

Provider Responsibilities

Refer to Section IV of Part A, the all-provider handbook, for information about the responsibilities of Medicaid-certified providers, including all of the following:

- Fair treatment of the recipient.
- Maintenance of records.
- Recipient requests for noncovered services.
- Services rendered to a recipient during periods of retroactive eligibility.
- Grounds for provider sanctions.
- Additional state and federal requirements.

Advisory Committee

The Wisconsin Dental Association (WDA) Access to Care Committee advises the Department of Health and Family Services (DHFS) and acts as a communication link between the DHFS and the provider community. The membership listing of the committee is available through the WDA.

Reducing the Number of Missed Appointments

The following suggestions will reduce missed appointments for all patients, including Medicaid recipients. When you schedule appointments, explain to patients the importance of keeping appointments and the office rules regarding missed appointments. Wisconsin Medicaid offers the following suggestions to decrease the “no show” rate:

- Contact the patient by telephone or postcard prior to the appointment and remind the

B. Provider Information (continued)

patient of the time and place of the appointment and the importance of canceling scheduled appointments in advance.

- Require patients to verify their appointment by calling the dental office, using the following procedures:
  1. Explain the policy carefully to your patients when they make appointments.
  2. Send postcards to remind them of their appointments, of the office policy regarding confirming their appointments, and of the need to call immediately to confirm the upcoming appointment.
  3. If they do not call by a given day before their appointment, give the appointment to another patient.
- If the appointment is made through the HealthCheck screening or targeted case management programs, encourage staff from those programs to ensure that scheduled appointments are kept.
- Call the local city/county health department or the HealthCheck Hotline at (800) 722-2295 for information about HealthCheck services in your area. Individual dentists may agree only to accept referrals from HealthCheck providers, such as the local public health agencies and physicians. Some health departments have outreach staff who might be able to assist recipients in getting to their dental appointments.
- Contact programs and agencies, such as HeadStart, sheltered workshops, or human service departments, to develop a referral system. Some of these agencies may assist recipients in finding transportation and keeping dental appointments.
- If a recipient needs assistance in paying for transportation to a medical appointment, encourage the recipient to call the county department of social or human services before the appointment.
- If a recipient is physically or mentally disabled, unable to take public transportation, and has a physician prescription verifying the disability, the recipient may call a Medicaid-certified specialized medical vehicle (SMV) provider for transportation.

WDA has distributed papers describing community models for delivery of dental emergency services and additional suggestions to reduce the “no-show” rate. Contact your local association for more information.

C. Recipient Information

Verifying Recipient Eligibility

Recipient eligibility information is available to providers from Wisconsin Medicaid’s Eligibility Verification System (EVS). Providers can access EVS in a number of ways, including:

- Automated Voice Response (AVR) System.
- Eligibility Hotline.
- Dial-Up (Direct Information Access Line with Updates for Providers).

C. Recipient Information (continued)

Refer to Section I-C of Part A, the all-provider handbook, for more information about these methods of verifying recipient eligibility. For more information about recipient eligibility itself, refer to Section V of Part A.

Recipient Loss of Eligibility at Any Time During Treatment

If a recipient loses Medicaid eligibility at any time during treatment, Wisconsin Medicaid does *not* reimburse those services provided after eligibility has lapsed. (Refer to the exceptions for fixed and removable prosthodontics and orthodontic treatment noted later in this section.)

Note: For purposes of this section, loss of eligibility includes:

(a) Termination of coverage.
(b) Change in medical status.
(c) Change in age (e.g., the recipient exceeding the allowable age limitation for orthodontia).
(d) Enrollment in a Medicaid-contracted managed care program.

The recipient should present a valid Medicaid identification card to providers at each visit. Federal regulations deny federal matching funds for any services provided to ineligible recipients.

Recipients are financially responsible for any services received after their Medicaid eligibility is terminated. If the recipient wishes to continue treatment, it then becomes a decision between provider and patient whether the service should be provided and how payment will be made.

To avoid misunderstanding, Wisconsin Medicaid recommends that the provider remind recipients that they are responsible for any continued care.

To avoid potential reimbursement problems that can arise when a recipient loses eligibility during treatment, Wisconsin Medicaid encourages providers to follow these important procedures:

- When a recipient requires more than one office visit to complete treatment, the provider must verify the recipient's eligibility *on each visit*. Ask to see the recipient's Medicaid identification card each time.
- After the provider receives an approved prior authorization (PA) for a requested service, again verify the recipient's eligibility before proceeding with the approved service. *An approved PA does not guarantee recipient eligibility*. The recipient must be eligible on the day the service is provided, except as noted below.

Orthodontic Exception

The date of band placement for orthodontic treatment is the determination date for reimbursement. If a recipient becomes ineligible while receiving orthodontic treatment, Wisconsin Medicaid will continue to reimburse the dentist for completion of orthodontic

C. Recipient Information (continued)

services when bands are placed during the recipient's period of eligibility. If the recipient was eligible on the date the bands were placed, Wisconsin Medicaid will reimburse dentists *only for those services for which PA was granted*.

Prosthodontic Exception

The date of the final impression for prosthodontic services is the determination date for reimbursement. If a recipient becomes ineligible while receiving fixed or removable prosthodontic treatment, Wisconsin Medicaid will continue to reimburse the dentist for completion of prosthodontic services when final impressions were taken during the recipient's period of eligibility. If the recipient was eligible on the date the final impression was made, Wisconsin Medicaid will reimburse dentists *only for those services for which PA was granted*,

Wisconsin Medicaid makes these exceptions due to the complexity, cost, and long-term nature of prosthodontic and orthodontic treatment.

Benefit Category

Some Wisconsin Medicaid recipients do not have dental coverage or have very limited dental coverage due to their benefit category. Refer to Appendix 36 of this handbook or to Section V of Part A, the all-provider handbook, for additional information on benefit categories.

Recipients Enrolled in Managed Care Programs

Some recipients enrolled in Medicaid-contracted HMOs have dental coverage through their HMO. If a dentist without HMO affiliation provides *non-emergency* dental care to a Medicaid recipient with HMO dental coverage, neither the HMO nor Wisconsin Medicaid will reimburse the dentist for those services. Neither can the dentist hold the recipient liable.

Therefore, *before* providing any non-emergency dental services, a dentist should always check whether a Medicaid recipient is enrolled in an HMO and whether the HMO provides dental coverage. Eligibility information, including HMO dental coverage, is available through the Voice Response System, Dial-Up (the Wisconsin Medical Assistance Automated Information System), or the Eligibility Hotline. Refer to Section I-C of Part A, the all-provider handbook, for more information regarding these information systems.

If a dentist without HMO affiliation provides *emergency* dental care to a recipient with HMO dental coverage, the HMO will reimburse the dentist according to conditions of payment established in the HMO's contract with Wisconsin Medicaid. Refer to page B10 of this handbook for the definition of emergency dental care.

Dental providers are paid on a fee-for-service basis for managed care program enrollees if the managed care program does not offer dental services, or if the prosthodontia or orthodontia treatment began before the recipient was enrolled in a Wisconsin Medicaid-contracted managed care program. The determination dates for

C. Recipient Information (continued)

fee-for-service reimbursement for such treatments are as described under "Recipient Loss of Eligibility at Any Time During Treatment" in this section.

Refer to the Provider Section of the Wisconsin Medicaid Managed Care Guide for more information about managed care program noncovered services, emergency services, and hospitalizations.

Copayment

Except as noted below, all recipients are responsible for paying part of the cost involved in obtaining dental services. Refer to the maximum allowable fee schedule for procedure codes and their applicable copayment.

Wisconsin Medicaid bases the following copayment limitations on its maximum allowable fee for each code and not on the provider's billed amount:

Each service reimbursed at:	Copay:
• Up to $10.00	$0.50
• From $10.01 to $25.00	$1.00
• From $25.01 to $50.00	$2.00
• Over $50.00	$3.00

• Copayments for most CPT oral surgery codes is $3.00.

Refer to the maximum allowable fee schedule to determine the amount of copayment to charge for specific procedures.

Copayment exemptions include:

- Emergency services.
- Services provided to nursing home residents.
- Services provided to recipients under 18 years of age.
- Pregnant women who receive medical services related to the pregnancy or to another medical condition that may complicate the condition.
- Services covered by Medicaid-contracted managed care programs to enrollees of the managed care program.

All providers who perform services that require recipient copayment must make a reasonable attempt to collect that copayment from the recipient. Providers shall not, at their discretion, waive the recipient copayment requirement, unless the provider determines that the cost of collecting the payment, coinsurance, or deductible exceeds the amount to be collected. However, providers may not deny services to a recipient for failing to make a copayment.

Wisconsin Medicaid automatically deducts applicable copayment amounts from Medicaid

C. Recipient Information (continued)

payments. Do not reduce the billed amount on the claim by the amount of recipient copayment.

HealthCheck/Early and Periodic Screening, Diagnosis, and Treatment Requirements

HealthCheck is Wisconsin Medicaid's federally mandated program known nationally as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Through HealthCheck, children receive routine preventive medical check-ups, immunizations, and referrals. Certain dental services, such as orthodontia, are available to Wisconsin Medicaid recipients only after HealthCheck has been performed. Refer to Appendices 9 through 19 of this handbook for information on procedures that require HealthCheck. Refer to Section II-D and II-E of this handbook for more information on HealthCheck.

Specialized Medical Vehicle Transportation for Disabled Recipients

Wisconsin Medicaid covers necessary transportation to and from Wisconsin Medicaid-covered services. County human services departments and tribal agencies approve and pay for common carrier transportation by taxi, bus, or private car. Wisconsin Medicaid covers specialized medical vehicle (SMV) transportation for recipients who are temporarily or indefinitely physically or mentally disabled with conditions that contraindicate travel by common carrier.

The state Legislature adopted changes in HFS 107.23, Wis. Admin. Code, to reduce the costly and inappropriate use of SMVs by recipients. One of these changes requires a prescription signed by a referring health care provider, such as a dentist, for all SMV trips (except hospital or nursing home discharges) that exceed SMV one-way upper mileage limits.

A prescription is needed for trips that exceed 40 miles one-way and originate in one of the following counties:

- Brown.
- Dane.
- Fond du Lac.
- Kenosha.
- La Crosse.
- Manitowoc.
- Milwaukee.
- Outagamie.
- Sheboygan.
- Racine.
- Rock.
- Winnebago.

Wisconsin Medicaid requires a prescription for trips that exceed 70 miles one-way and originate in *any other* Wisconsin county.

If you refer a recipient who needs SMV transportation to a dental service that you suspect is farther away than the Wisconsin Medicaid one-way upper mileage limits, write a prescription for the recipient to show the SMV provider.
All recipients must have the physician SMV certification form on file before receiving SMV transportation.

The prescription should include the name of the health care provider or facility, the city

C. Recipient Information (continued)

where it is located, the service the recipient requires, and the amount of time the recipient needs transportation to the service. (Indicate time in days, not to exceed 365 days.)

Providers who may refer recipients and write SMV prescriptions are dentists, physicians, physician assistants, nurse midwives, nurse practitioners, optometrists, opticians, chiropractors, podiatrists, HealthCheck agencies, and family planning clinics.

Appendix 7 of this handbook provides an example of an SMV transportation prescription.

A. Introduction

Wisconsin Medicaid covers basic dental services within the categories of diagnostic, preventive, restorative, endodontic, periodontic, removable and fixed prosthodontic, oral and maxillofacial surgery, orthodontic, and adjunctive general services. These services are covered when provided by a Medicaid-certified dentist to an eligible Wisconsin Medicaid recipient according to the policies and procedures in this handbook.

Education in Preventive Care

Education of a Wisconsin Medicaid recipient in preventive care and the provision of dental health information is a component of all Medicaid-covered dental services, whenever appropriate. When provided, preventive training and information sharing should be documented in the recipient's dental records. Wisconsin Medicaid does not seperately reimburse these services.

Infection Control Charges

Providers should note that all Occupational Safety and Health Administration-mandated and other infection-control charges are included in Wisconsin Medicaid reimbursement. These costs may not be separately reimbursed or billed to the recipient.

Take-Home Supplies

Routine take-home supplies (e.g., gauze) are not separately reimbursable. Wisconsin Medicaid reimbursement of dental procedures includes routine take-home supplies needed before or after the procedure is performed. Recipients may not be charged for routine supplies.

Tooth Numbers and Letters

Wisconsin Medicaid recognizes tooth letters "A" through "T" for primary teeth and tooth numbers "1" through "32" for permanent teeth. Wisconsin Medicaid also recognizes "SN" (super numerary) for teeth that cannot be classified under "A" through "T" or "1" through "32". Whenever a procedure applies to a specific tooth, these modifiers must be used in element 37 of the American Dental Association (ADA) claim form.

Denture Repair Modifiers

When billing the denture repair procedure codes, providers must indicate which denture is being repaired. Use the procedure code modifier "UU" for upper and "LL" for lower denture in element 37 of the ADA claim form.

Surgery Modifiers

Oral surgeons and oral pathologists billing *Current Procedural Technology* (CPT) codes for oral surgeries are to use modifier 80 in element 24D of the HCFA 1500 claim form to designate when a provider assists at surgery. Refer to the CPT code chart in Appendix 19 of this handbook to identify the services that allow reimbursement for assistance at surgery. Refer to Appendix 16 of this handbook for information on assisting at surgery using the ADA Current Dental Terminology (CDT) codes.

A. Introduction (continued)

Emergency Services

Wisconsin Medicaid covers emergency dental services. Certain dental services are covered only when they are provided under emergency circumstances (refer to Appendices 9 through 19 of this handbook).

Emergency dental care is defined as immediate service that must be provided to relieve the patient from pain, acute infection, swelling, trismus, fever, or trauma. In all emergency situations, the recipient's dental records must document the nature of the emergency and the treatment provided.

In emergency situations, Wisconsin Medicaid waives prior authorization (PA) requirements. For example, treatment of an abscessed tooth by opening the tooth for drainage is considered an emergency service, but completion of root canal therapy is *not* considered an emergency service. Wisconsin Medicaid also may waive PA for a hospital call, general anesthesia, and IV sedation.

Refer to Section III-A of this handbook for additional information on PA for emergency services. Emergency services are exempt from copayment. In addition, Wisconsin Medicaid has established a maximum reimbursement per patient per day for specific emergency services.

Refer to Section IV-H of this handbook for instructions on billing for emergency procedures.

B. Prescriptions

Within their scope of practice, dentists may prescribe drugs for Medicaid recipients. Before administering or prescribing any Schedule II, III, IV, or V pharmaceutical agents, the provider must also obtain a Drug Enforcement Administration (DEA) certification of registration. Wisconsin Medicaid does not reimburse providers for any charges associated with writing the prescription or for take-home drugs dispensed by a dentist.

Prescription Requirements

It is vital that the prescriber provide information sufficient for the dispensing provider to fill the prescription.

Except as otherwise provided in federal or state law, either the prescriber must write the prescription, or the pharmacist must take the prescription verbally from the prescriber. If the pharmacist takes the prescription verbally from the prescriber, the pharmacist must later put the prescription in writing. The prescription must include:

- The name and quantity of the drug or item prescribed.
- The date of issue of the prescription.
- The prescriber's name and address.
- The recipient's name and address.
- The prescriber's signature (if prescriber writes the prescription).
- The directions for use of the prescribed drug or item.

B. Prescriptions (continued)

For hospital and nursing home recipients, orders must be entered into the medical and nursing charts and must include the above information. Prescription orders are valid for no more than one year from the date of the prescription (except for controlled substances and prescriber-limited refills).

"Brand Medically Necessary" Requirements for Innovator Drugs

For a pharmacy to be reimbursed for a legend brand drug at a rate higher than that allowed for a generic equivalent, the prescribing provider must certify that a brand name drug is medically necessary by using the phrase "BRAND MEDICALLY NECESSARY" or "MEDICALLY NECESSARY" (instead of "NO SUBSTITUTES" or "N.S."). *This certification must be in the prescribing practitioner's own handwriting directly on the prescription order or on a separate authorization which is attached to the original prescription. Pharmacy orders must have this documentation prior to submitting claims to Wisconsin Medicaid.* In addition, the prescriber must document the reason in the recipient's medical record why the brand drug is medically necessary.

Typed certification, signature stamps, or certification handwritten by someone other than the prescriber does not satisfy this requirement. "Blanket" authorization for an individual recipient, drug, or prescriber is not acceptable documentation. A letter of certification is acceptable as long as the notation is handwritten, is for specified drugs for an individual recipient, and is valid for no more than one year. *While it is the pharmacy's responsibility to have this written documentation, it is the prescriber's responsibility to provide the pharmacy with the required documentation.*

Nursing Home Orders

Prescriber certification that the brand is medically necessary must be made on *each* prescription order written for nursing home recipients. This certification is good only for the length of time that the order is valid. Updated written certification is required for each new prescription order written.

Over-the-Counter Drugs

The "Brand Medically Necessary" provisions described for legend drugs do not apply to over-the-counter (OTC) drugs. Using a maximum allowable cost (MAC) formula based on generic prices, Wisconsin Medicaid reimburses providers who dispense OTCs described in Appendix 3 of this handbook. (Reimbursement for insulin and OTC ophthalmic lubricants is not limited to this MAC formula.) Higher reimbursement is not available for brand name OTC drugs when prescribers indicate "Brand Medically Necessary." Since Wisconsin Pharmacy Examining Board rules prohibit dispensing generic OTCs when brand name versions are prescribed, prescribers are encouraged to prescribe OTC drugs by their generic descriptions to prevent confusion.

Drug Rebate System

Wisconsin Medicaid utilizes a drug rebate system. The drug rebate system is the result of the federal Omnibus Budget Reconciliation Act of 1990. Manufacturers that have signed rebate agreements have their prescription drugs covered by Wisconsin Medicaid if the

B. Prescriptions (continued)

drugs meet Wisconsin Medicaid guidelines. Wisconsin Medicaid does not cover drugs produced by manufacturers that did not sign a rebate agreement, except as noted in Appendix 3 of this handbook. Under the drug rebate system, drug manufacturers that choose to participate in state Medicaid programs are required to sign rebate agreements with the federal Health Care Financing Administration (HCFA). Participation in the Medicaid program is voluntary on the part of the drug manufacturers. Rebate agreements are valid for one year. At the end of one year, manufacturers may choose whether or not to continue participation in the rebate program. Non-participating manufacturers have the option each quarter of signing a rebate agreement which is effective for the following quarter.

The prescriber may wish to contact a local Medicaid-certified pharmacy to confirm that Wisconsin Medicaid covers a particular drug or product.

Appendix 3 of this handbook is a list of the types of drugs that are covered by Wisconsin Medicaid, including those which require PA. Appendix 4 of this handbook lists *noncovered* drugs, including drugs sold by manufacturers that did not sign rebate agreements.

Documentation for Drugs Manufactured by Companies That Have Not Signed a Rebate Agreement

Wisconsin Medicaid recognizes that there are a few cases where it is medically necessary to provide a drug that is produced by a manufacturer that did not sign a rebate agreement. These drugs may be provided to the recipient when the *pharmacy* completes a PA request.

In this case, the prescriber must provide the following documentation to the pharmacy:

- A statement indicating that no other drug produced by a manufacturer that signed a rebate agreement is medically appropriate for the recipient.
- A statement indicating that Wisconsin Medicaid coverage of the drug is cost-effective for Wisconsin Medicaid.

A recipient request for a particular drug is not considered adequate justification for granting approval without the prescriber demonstrating medical necessity.

C. Covered Services

For a list of Medicaid-covered basic dental services, refer to Appendices 9 through 19 of this handbook.

Covered Services Information Handout

Dentists are encouraged to use the "Wisconsin Medicaid Covered Dental Services" informational handout when explaining Wisconsin Medicaid dental services to recipients (refer to Appendix 5 of this handbook).

D. HealthCheck

HealthCheck is Wisconsin Medicaid's federally-mandated program known nationally as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Through HealthCheck, children receive preventive medical check-ups, immunizations, and referrals.

To be eligible for a HealthCheck referral, a recipient must:

- Have a current Medicaid identification card.
- Be under 21 years of age.

When a recipient is enrolled in a Medicaid-contracted managed care program (indicated by a yellow Medicaid card), only the managed care program or its affiliated providers may provide the HealthCheck screening for that recipient.

Dentists can encourage recipients to obtain their HealthCheck screenings before their dental visits. This is particularly helpful when recipients have a medical need for orthodontia.

A dentist should refer the recipient to the HealthCheck Hotline telephone number listed in Appendix 1 of Part A, the all-provider handbook, to obtain a list of HealthCheck providers. A HealthCheck flyer is provided in Appendix 35 of this handbook for distribution to Wisconsin Medicaid recipients, or the HealthCheck referral form may be obtained by writing to:

Wisconsin Medicaid Claim Reorder
EDS
6406 Bridge Road
Madison, WI 53784-0003

Upon completion of a HealthCheck screening, eligible recipients may be given a HealthCheck Verification Card. This card assists the recipient in obtaining some Wisconsin Medicaid dental services because it verifies that a HealthCheck screening has been performed.

When providing a service that needs a HealthCheck screening (refer to HealthCheck "Other Services" below), dentists should make a photocopy of the card or keep in the recipient files signed and written evidence that a HealthCheck screening has occurred in the past year. The HealthCheck provider signature is required. No additional statement from the HealthCheck provider is needed. This evidence must be submitted with PA requests, but is not required for billing.

All Wisconsin Medicaid services resulting from a HealthCheck screening must be provided within one year of the screening date. A new HealthCheck screening must be performed if more than one year has passed since the previous screening.

E. HealthCheck "Other Services"

Wisconsin Medicaid covers orthodontia and some other dental services only if the child has received a HealthCheck exam. As a result of the federal Omnibus Budget Reconciliation Act of 1989 (OBRA), Wisconsin Medicaid considers requests for coverage of medically necessary dental services which are not specifically listed as covered services, or which are listed in this section as noncovered services, when all of the following conditions are met:

- The provider verifies that a comprehensive HealthCheck screening has been performed in the past year through a signed written document from the HealthCheck provider.
- The service is allowed under the Social Security Act as a "medical service."
- The service is "medically necessary" and "reasonable" to correct or ameliorate a condition or defect which is discovered during a HealthCheck screening.
- The service is noncovered under Wisconsin Medicaid.
- A service currently covered by Wisconsin Medicaid is not appropriate to treat the identified condition.

All requests for HealthCheck "Other Services" require PA. Refer to Section III of this handbook for information on requesting PA.

F. Inpatient and Outpatient Hospital Services

Inpatient and outpatient hospitalization is allowed on an emergency and non-emergency (elective) basis for some dental services.

Hospitalization for the express purpose of controlling apprehension is not a Medicaid-covered service. This policy applies to inpatient or outpatient hospital and ambulatory surgical centers.

If the request for hospitalization is for an institutionalized recipient, a physician's statement or order and an informed consent signed either by the recipient or the recipient's legal guardian is required.

Non-emergency hospitalization is appropriate in the following situations:

- Children with uncontrollable behavior in the dental office or with psychosomatic disorders that require special handling. Children needing extensive operative procedures such as multiple restorations, abscess treatments, or oral surgery procedures.
- Developmentally disabled recipients with a history of uncooperative behavior in the dental office, even with premedication.
- Hospitalized recipients who need extensive restorative or surgical procedures, or whose physician has requested a dental consultation.
- Geriatric recipients or other recipients whose medical history indicates that monitoring of vital signs or availability of resuscitative equipment is necessary during dental procedures.

F. Inpatient and Outpatient Hospital Services (continued)

- Medical history of uncontrolled bleeding, severe cerebral palsy, or other medical conditions that render in-office treatment impossible.
- Medical history of uncontrolled diabetes where oral and maxillofacial surgical procedures are being performed.
- Extensive oral and maxillofacial surgical procedures are being performed (e.g., Orthognathic, Cleft Palate, temporomandibular joint (TMJ) surgery).

For elective procedures, hospital calls are limited to two visits per stay and require PA.

All elective, non-emergency hospital services require PA if they require PA in other places of service, unless otherwise noted.

Hospital calls are limited to two visits per stay and require PA.

Emergency hospitalizations, hospital calls, and emergency outpatient services (emergency room and day surgery) do not require PA.

G. Noncovered Services

Under s. 49.46(2)(b), Wis. Stats., and under HFS 107.07(4), Wis. Admin. Code, Wisconsin Medicaid does not cover the following dental services:

- Dental implants and transplants.
- Fluoride mouth rinse.
- Services for purely aesthetic or cosmetic purposes.
- Overlay dentures, duplicate dentures, and related adjustments.
- Training in preventive dental care is not separately reimbursable.
- Cement bases as a separate item.
- Single unit crowns, except under HFS 107.07(1)(d)4 and HFS 107.07(a)5, Wis. Admin. Code.
- Precision attachments.
- Cast and prefabricated post and core.
- Professional visits, other than for the annual examination of a nursing home resident.
- Dispensing of drugs.
- Diagnostic casts, except when required for PA.
- Adjunctive periodontal services.
- Surgical removal of erupted teeth, except in emergency situations as stated in HFS 107.07(3), Wis. Admin. Code.
- Alveoplasty and stomatoplasty.
- All non-surgical medical or dental treatment for a TMJ condition.
- Osteoplasty, except as otherwise stated in HFS 107.07(2), Wis. Admin. Code.

G. Noncovered Services (continued)

In certain unusual circumstances, the Department of Health and Family Services (DHFS) may request that a noncovered service be performed, including, but not limited to, diagnostic casts in order to substantiate a PA request. In these cases the requested services can be reimbursed.

A. General Prior Authorization Guidelines

Providers must have prior authorization (PA) for certain specified services before delivery of that service, unless the service is provided on an emergency basis.

A summary of PA polices and guidelines for specific covered services are in Appendices 9 through 19 of this handbook.

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).
- 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.

Emergency Services

Emergency dental care is immediate service that must be provided to relieve the recipient from pain, an acute infection, swelling, trismus, fever, or trauma.

PA is not required in emergency situations.

Wisconsin Medicaid waives the PA requirement for hospital calls, general anesthesia, and IV sedation. These procedures are the only procedures for which PA is waived in an emergency.

Certain services are covered only when they are provided under emergency circumstances. Refer to Appendices 9 through 19 of this handbook for more information.

The recipient's records must include documentation of the nature of the emergency. Emergency services are exempt from copayment.

Traumatic Loss of Teeth for Children Under Age 21

When a child experiences a traumatic loss of teeth, removable prostheses may be provided by backdating a PA request. Refer to Appendix 14 of this handbook for more information.

B. Prior Authorization Request Form

The PA/DRF and the Prior Authorization Dental Attachment (PA/DA) are required for PA requests. Sample forms and instructions are given in Appendices 20 through 23 of this handbook.

B. Prior Authorization Request Form (continued)

Both the PA/DRF and PA/DA must be completed and submitted to:

Prior Authorization Unit, Suite 88
EDS
6406 Bridge Road
Madison, WI 53784-0088

PA forms may be obtained by submitting a written request to:

Wisconsin Medicaid Claim Reorder
EDS
6406 Bridge Road
Madison, WI 53784-0003

Please be specific when identifying the forms requested and the quantity needed. Reorder forms are included in the mailing of each request for forms. Please do not telephone the Correspondence Unit to request forms.

Sample Prior Authorization Forms

Refer to Appendices 20 through 23 of this handbook for sample PA forms and instructions.

Prior Authorization Number

A preprinted seven-digit PA number appears in red at the top of the PA/DRF form. This is a very important number for billing as it identifies the service on the claim form as a service that has been prior authorized.

Re-Authorization of a Prior Authorization to a New Provider Number

Sometimes another dentist has already received PA for the service you are requesting. A PA may be re-authorized to your provider number if:

- You receive the following message in response to your PA request: *"A current authorization for this service is on file for another provider. If the service was not provided, a statement of that fact is required."*
- The recipient has not received the service from the initial provider and does not expect to.

To re-authorize a PA:

- Obtain a signed written statement from the Wisconsin Medicaid recipient or the originally authorized provider that the services were not received from the initial provider.
- Submit the recipient or originally authorized provider statement, along with the PA request and a brief statement about the situation, to the Wisconsin Medicaid fiscal agent.

B. Prior Authorization Request Form (continued)

The fiscal agent will contact the initial provider to terminate the existing PA and to allow you to obtain a new PA.

Refer to Section VIII of Part A, the all-provider handbook, for more information on re-authorizing PAs.

Supporting Material Requirements

In certain instances, supporting material (in addition to the request form) is required to document the need for services (such as specific x-rays). Supporting material requirements are detailed in this section and in Appendix 24 of this handbook. The Medicaid program dental consultant may request additional documentation if necessary to substantiate a PA request.

When providers submit supporting material, the material must be clearly labeled, identified, and securely packaged. Wisconsin Medicaid does not reimburse for charges for duplication of materials (e.g., copies of x-rays, study models). All materials are returned to the provider in the condition they are received.

If the quality of the supporting material is such that a determination of authorization cannot be made, the material is returned to the provider and any new materials must be provided at the provider's expense.

C. HealthCheck "Other Services"

A PA request for HealthCheck "Other Services" must include a copy of a signed HealthCheck verification card, statement, or other indication that the recipient received a HealthCheck screen. The statement or other indication must be signed by the provider who performed the HealthCheck, and it must indicate the date of the screen. The screen must be performed within one year of the date of receipt of the PA request.

Additional information documenting the individual's need for the service and the appropriateness of the service being delivered may be requested by the BHCF dental consultant.

Refer to Sections II-D and II-E of this handbook for further information on HealthCheck "Other Services."

A. Coordination of Benefits

Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service. If the recipient is covered under other health insurance (including Medicare), Wisconsin Medicaid pays that portion of the allowable cost remaining after exhausting all other health insurance sources. Refer to Section IX of Part A, the all-provider handbook, for more detailed information on services requiring health insurance billing, exceptions, and the "Other Coverage Discrepancy Report."

Other Insurance Billing Information - Paper Claims

Refer to Appendices 26 through 29 of this handbook for American Dental Association (ADA) claim form and HCFA 1500 claim form completion instructions and samples.

Note: When a claim is submitted to commercial insurance and the commercial insurance pays on some of the services, and denies payment on some of the services, two separate claim forms must be submitted to Wisconsin Medicaid (so the correct reimbursement is made) by processing a claim for the partially paid services separately from the services denied by "other insurance."

Claim Showing Health Insurance Payment Made

- Submit a claim form with the services the health insurance allowed and reimbursed.
- Enter OI-P in element 15A of the ADA claim form or in element 9 of the HCFA 1500 claim form, and enter the amount paid by the health insurance in element 42 of the ADA claim form or in element 29 of the HCFA 1500 claim form.

Claim Showing Health Insurance Denied Payment

- Submit a claim form with the services the health insurance denied and did not reimburse.
- Enter OI-D in element 15A of the ADA claim form or in element 9 of the HCFA 1500 claim form.

Electronic claims use different fields to indicate other health insurance billing. Refer to your electronic media claims (EMC) manual for more information.

Refer to Part A, the all-provider handbook, for more detailed information on services requiring health insurance billing exceptions and the insurance explanation codes.

Note: When a recipient's Medicaid identification card indicates DEN (dental insurance) under "Other Coverage," all dental services must be billed to the dental insurance prior to submitting a claim to Wisconsin Medicaid.

B. Medicare/ Medicaid Dual Entitlement

Recipients covered under both Medicare and Medicaid are referred to as dual entitlees. Claims for Medicare-covered services provided to dual entitlees must be billed to Medicare prior to billing Medicaid if Medicare usually pays for the service, such as oral surgery. Wisconsin Medicaid pays the allowable coinsurance on Medicare-allowed items and any deductible that is applied to those Medicare allowed items in s. 49.46(2)(c), Wis.

B. Medicare/ Medicaid Dual Entitlement (continued)

Stats. Refer to Appendix 17 of Part A, the all-provider handbook, for specific information on Medicare/Medicaid dual entitlement. Appendix 16 of Part A, the all-provider handbook, identifies services not covered by Medicare.

C. Medicare QMB-Only

Qualified Medicare Beneficiary-only (QMB-only) recipients are only eligible for Medicaid payment of the coinsurance and the deductibles for Medicare-covered services. (Because Medicare only covers a few dental services, most services provided for QMB-only recipients are not covered by Wisconsin Medicaid.)

D. Billed Amounts

Providers must bill Wisconsin Medicaid their usual and customary charge for services provided, which is the amount charged by the provider for the same service when provided to private pay 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. Providers may not discriminate against Medicaid recipients by charging a higher fee for the service than is charged to a private pay patient.

The billed amount should not be reduced by the amount of Wisconsin Medicaid recipient copayment. The applicable copayment will automatically be deducted from the payment allowed by Wisconsin Medicaid. Refer to Section I of this handbook for general information about dental service copayments.

A Wisconsin Medicaid Dental Maximum Allowable Fee Schedule is available. The fee schedule consists of the dental procedure code, a prior authorization (PA) indicator, a brief narrative description, the maximum fee, and the copayment amount associated with the service.

Copies of the Wisconsin Medicaid Dental Maximum Allowable Fee Schedule may be purchased by submitting the order form located in Appendix 38 of Part A, the all-provider handbook.

E. Modifiers

Tooth Numbers and Letters

Wisconsin Medicaid recognizes tooth letters "A" through "T" for primary teeth and tooth numbers "1" through "32" for permanent teeth. Wisconsin Medicaid also recognizes "SN" (super numerary) for teeth that cannot be classified under "A" through "T" or "1" through "32". Whenever a procedure applies to a specific tooth, these modifiers must be used in element 37 of the ADA claim form.

Denture Repair Modifiers

When billing the denture repair procedure codes, providers must indicate which denture is being repaired. Use the procedure code modifier "UU" for upper and "LL" for lower denture in element 37 of the ADA claim form.

Surgery Modifiers

Oral surgeons and oral pathologists billing *Physicians' Current Procedural Technology* (CPT) codes for oral surgeries must use modifier 80 in element 24D of the HCFA 1500

E. Modifiers (continued)

claim form to designate when a provider assists at surgery. Refer to the CPT code chart in Appendix 19 of this handbook to identify the services that allow assistance at surgery. Refer to Appendix 16 of this handbook for information on assisting at surgery using the ADA Current Dental Terminology (CDT) codes.

Only specific modifiers which are appropriate to the procedure billed are accepted by Wisconsin Medicaid. Claim details with modifiers which Wisconsin Medicaid has not designated as allowable are denied.

F. Place-of-Service Codes

Wisconsin Medicaid uses place-of-service codes to indicate where the service was provided. Many dental procedure codes have place-of-service restrictions. Below is a list of place-of-service codes and their descriptions:

Place of Service (POS) Description	HCFA POS
Other	0
Inpatient Hospital	1
Outpatient Hospital	2
Doctor's Office	3
Home	4
NH/Extended Care Facility	7
Skilled Nursing Facility	8
Ambulatory Surgery Center	B

Refer to Appendices 8 through 19 of this handbook for information on specific place-of-service requirements.

G. Claim Form

Paper Claim Submission

American Dental Association Claim Form for CDT Billing

Dental services provided by dentists billing with ADA (CDT) codes are submitted on the ADA claim form. A sample form and completion instructions are in Appendices 26 and 27 of this handbook.

ADA claim forms are not provided by Wisconsin Medicaid or its fiscal agent. They may be obtained by contacting:

ADA Catalog Sales
211 East Chicago Avenue
Chicago, IL 60611
1-800-947-4746

G. Claim Form (continued)

HCFA 1500 Claim Form for Current Procedural Terminology Billing

Dental services provided by dentists billing with CPT codes are submitted on the HCFA 1500 claim form. When dentists provide both ADA and CPT code services to the same patient, both may be billed on the HCFA 1500 claim form, unless the ADA code requires a tooth modifier. A sample form and completion instructions are in Appendices 28 and 29 of this handbook.

The HCFA 1500 claim form is not provided by Wisconsin Medicaid or the Medicaid fiscal agent, EDS. It may be obtained from a number of forms suppliers including:

State Medical Society Services, Inc.
Post Office Box 1109
Madison, WI 53701
(608) 257-6781
1-800-362-9080

Paperless Claim Submission

As an alternative to submission of paper claims, the fiscal agent is able to process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem.

The fiscal agent also offers a product called the Reformatter. This product is designed for providers who use an IBM-compatible computer to generate ADA claims on paper. Instead of printing claim information on paper, the claim data is transmitted via modem to the fiscal agent. The fiscal agent reformats the data into the required electronic format for processing. Claims submitted through these systems have the same legal requirements as those submitted on paper and are subject to the same processing requirements as those submitted on paper.

Software for electronic submissions may be obtained free of charge. Electronic submissions have substantial advantages in reducing clerical effort and errors, reducing mailing costs and delays, and improving processing time. Additional information on alternative claim submission is available by contacting the Electronic Media Claims (EMC) Department at:

Wisconsin Medicaid EMC Department
EDS
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

H. Emergency Services

Emergency services are defined as services that must be provided immediately to relieve pain, swelling, acute infection, trismus, fever, or trauma. Because the ADA claim form does not have an element to designate emergency treatment, all claims for emergency services must be identified by an "E" in the "For Administrative Use Only" box on the line

H. Emergency Services (continued)

item for the emergency service of the ADA claim form or element 24-I of the HCFA 1500 claim form in order to exempt the services from copayment deduction. Only the letter "E" without any additional letters is accepted. The definition of a dental emergency is in Section II-A of this handbook.

EMC claims use a different field to indicate an emergency. Refer to your EMC manual for more information.

I. HealthCheck

Certain services are covered for recipients 20 years old and under when they result from a HealthCheck screening.

In addition, other medically necessary dental services which are not normally covered by Wisconsin Medicaid may be covered for children under age 21 if they have had a HealthCheck screening. These services always require prior authorization (PA).

Refer to Section II-D and II-E of this handbook for additional HealthCheck information.

Evidence that a HealthCheck screening has occurred in the past year, such as a photocopy of the recipient's current HealthCheck card, must be included with the PA request. Check the EPSDT box in element 2 of the ADA claim form or mark "H" in element 24H of the HCFA 1500 claim form if the service requires a HealthCheck screening and a HealthCheck screening has occurred. Do not attach evidence that a HealthCheck screening has occurred with the claim form. Refer to Appendices 27 and 29 of this handbook for billing instructions when a HealthCheck screening prior to dental services is required.

EMC claims use a different field to indicate a HealthCheck screen has occurred. Refer to your EMC manual for more information.

J. Recipient Loss of Eligibility During Treatment

Prior authorized services for fixed or removable prosthodontic and orthodontic treatment may be paid by Wisconsin Medicaid after the recipient becomes ineligible as long as authorized services began when the recipient was eligible, as defined below.

If a recipient becomes enrolled in a Medicaid HMO mid-treatment, the dental provider must submit orthodontia claims following the HMO extraordinary claims billing procedures. Refer to Section IX of Part A, the all-provider handbook, for instructions.

Fixed or removable prosthodontic services provided to recipients who have become ineligible mid-treatment are covered if the recipient was eligible on the date the final impressions were made. Always use the date of the final impression as the date of service when billing for prosthodontics.

Orthodontic services provided to recipients who have become ineligible mid-treatment are covered if the recipient was eligible on the date the initial orthodontic bands were placed. These orthodontic services should be submitted according to routine procedures.

K. Occupational Illness or Injury

All claims submitted which relate to an occupational illness or an injury must be clearly identified and explained. Element 30 of the ADA claim form or elements 14, 15, and 16 of the HCFA 1500 claim form must be marked "yes" and a brief narrative relating to that response must be presented in the space provided.

EMC claims use a different field to indicate occupational illness or injury. Please refer to your EMC manual for more information.

L. Copayment

Copayment Billing Procedures

Providers should bill Wisconsin Medicaid their usual and customary charges for all services rendered. Copayment amounts collected from recipients should not be deducted from charges billed to Wisconsin Medicaid, nor should these Wisconsin Medicaid copayment amounts be indicated in the "paid by other" element on claims submitted. The appropriate copayment amount is automatically deducted by the fiscal agent from payments allowed by Wisconsin Medicaid. Remittance and Status Reports from the fiscal agent reflect the automatic deduction of applicable copayment amounts.

Providers must make a reasonable attempt to collect copayment from a Medicaid recipient. However, providers may not refuse to provide services to a recipient solely for failure to make this copayment.

Recipients cannot be held responsible for copayment established by commercial health insurance carriers. Additional information about Medicaid copayment is available in Section V-E of Part A, the all-provider handbook.

M. Follow-up to Claim Submission

Claims Submission Deadline

The fiscal agent must receive all claims for services provided to eligible recipients within 365 days from the date of service. This policy applies to all initial claim submissions, resubmissions, and adjustment requests.

Providers are responsible for initiating follow-up procedures on claims submitted to the fiscal agent. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. Wisconsin Medicaid advises providers that the fiscal agent takes no further action on a denied claim until the information is corrected and the provider resubmits the claim for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to the fiscal agent. Section X of Part A, the all-provider handbook, includes detailed information about:

- The Remittance and Status Report.
- Adjustments to paid claims.
- Return of overpayments.
- Duplicate payments.
- Denied claims.
- Good faith claims filing procedures.

M. Follow-up to Claim Submission (continued)

In cases where a tooth number is questioned by the fiscal agent and results in a claim denial, a pre-operative radiograph is required to be resubmitted with a new claim, which is reviewed by the dental consultant.

Refer to Section IX of Part A, the all-provider handbook, for exceptions to the claim submission deadline and requirements for submission to Late Billing Appeals.

Section X of Part A, the all-provider handbook, also includes information related to appropriate claim follow-up procedures.

N. ClaimCheck® for Oral Surgery

Wisconsin Medicaid uses automated procedure coding review software (GMIS ClaimCheck®) to review claims submitted by oral surgeons billing for oral surgery services with CPT procedure codes. Insurance companies and other state Medicaid programs also use similar software. This enhanced claims processing system reflects and monitors current Medicaid reimbursement policy. The enhancement incorporates coding generally consistent with the CPT, although, it has been customized to reflect Wisconsin Medicaid reimbursement policies.

Only CPT codes are reviewed. Claims are reviewed for several categories of billing inconsistencies and errors. Reviews include the unbundling of procedure codes, separate billing for incidental or integral procedures, and billing mutually exclusive codes.

ClaimCheck® affects claims in any of the following ways:

- The claim may pass through unchanged.
- The procedure codes may be rebundled into one or more appropriate codes.
- One or more of the codes may be denied as incidental/integral or mutually exclusive (the remaining codes continue processing).

How ClaimCheck® Affects Billing Inconsistencies

Unbundling (Code Splitting)

Unbundling occurs when two or more CPT codes are used to describe a procedure that may be better described by a single, more comprehensive code. For example, ClaimCheck® will add the lengths of individual wound repairs on the same anatomical site. A wound repair of 2.5 cm or less (procedure code 12011) coupled with a wound repair of 5.1 cm to 7.5 cm (procedure code 12014) will be rebundled to procedure code 12015 - wound repair 7.6 cm to 12.5 cm.

GMIS ClaimCheck® considers the single, most appropriate code for reimbursement when unbundling is detected.

GMIS ClaimCheck® totals billed amounts for individual procedures. For example, if three procedures billed at $20, $25, and $30 are rebundled into a single procedure code, GMIS ClaimCheck® adds the three amounts and calculates the billed amount for the rebundled code at $75. However, Wisconsin Medicaid reimburses the provider either the lesser of the billed amount or the maximum allowable fee for that procedure code.

N. ClaimCheck® for Oral Surgery (continued)

Incidental/Integral Procedures

Incidental procedures are those performed at the same time as a more complex primary procedure. They require few additional oral surgeon resources and are generally not considered necessary to the performance of the primary procedure. For example, the removal of jaw joint cartilage (procedure code 21060) is incidental to the extensive jaw surgery (procedure code 21045).

Integral procedures are those performed as a part of a more complex primary procedure. For example, when a recipient undergoes a diagnostic arthroscopy of the temporomandibular joint (procedure code 29800) and a surgical arthrotomy of the same joint, the diagnostic procedure is considered integral to the performance of the arthrotomy.
When a procedure is considered either incidental or integral to a more complex procedure, only the primary procedure is considered for payment.

Mutually Exclusive

Mutually exclusive procedures are those that are not usually performed at the same operative session on the same date of service. This also pertains to different procedure codes billed for the same type of procedure when only one of the codes should be billed. For example, if an oral surgeon bills a closed treatment of a palatal or maxillary fracture (LeFort I type) and an open treatment of the same fracture (procedure codes 21421 and 21422), one of the procedures will be found mutually exclusive to the other.

When ClaimCheck® finds two or more procedures mutually exclusive, only the code with the highest billed usual and customary charge is considered for reimbursement.

Periodic Review of Previously Submitted Claims

Periodically, the claims processing system reviews claims history to identify related procedures or separate claims that have been billed for services rendered by the same performing provider, to the same recipient, on the same date of service. These claims are reviewed to detect unbundling, mutually exclusive and incidental/integral coding errors. Providers will be notified by letter of these billing errors with a request for repayment.

Requesting Adjustments

Providers may request adjustments to paid claims by submitting an adjustment request form with documentation that explains why the procedure review should not be followed. Documentation might include operative reports, descriptions of special circumstances, or other information that justifies overruling the denial. Write “dental review requested” on the adjustment form. For the adjustment form and instructions, refer to Part A, the all-provider handbook, Appendices 27 and 27a.

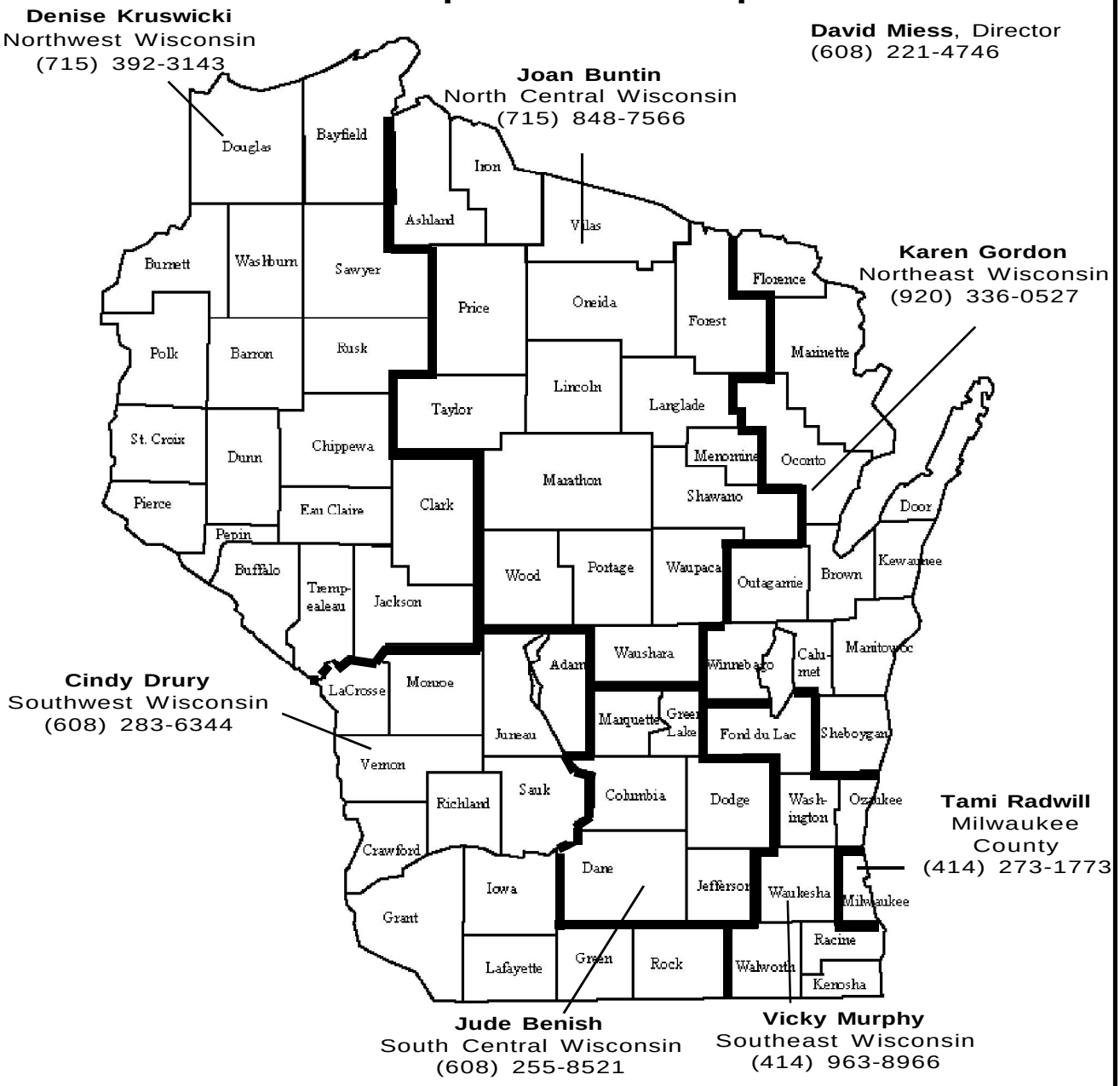
Dental Services Handbook
Appendices

Page #

1. Quick Access Guide to Wisconsin Medicaid Information B31
2. Dental Certification Form B33
3. Wisconsin Medicaid Covered Drugs B37
4. Wisconsin Medicaid Noncovered Drugs B41
5. Wisconsin Medicaid Covered Dental Services B43
6. Multidisciplinary Temporomandibular Joint Evaluation Programs Approved By the Wisconsin Department of Health and Family Services Medicaid Program B47
7. Example of Prescription for Specialized Medical Vehicle Trips That Exceed Upper Mileage Limits B49
8. Place of Service Codes B51
9. Diagnostic Services B53
10. Preventive Services B57
11. Restorative Services B65
12. Endodontic Services B71
13. Periodontic Services B79
14. Removable Prosthodontic Services B85
15. Fixed Prosthodontic Services B95
16. Oral and Maxillofacial Surgery Services B97
17. Orthodontic Services B115
18. Adjunctive/General Services B121
19. Current Procedural Terminology Codes for Dentists Billing as Oral Surgeons B125
20. Sample Prior Authorization Dental Request Form (PA/DRF) B151
21. Prior Authorization Dental Request Form (PA/DRF) Completion Guidelines B153
22. Sample Prior Authorization Dental Attachment Request Form (PA/DA) B155
23. Prior Authorization Dental Attachment Request Form (PA/DA) Completion Guidelines B159
24. Wisconsin Medicaid Information Needed For Prior Authorization Requests B161
25. Provision of Upgraded Partial Denture and Crowns to Medicaid Recipients B163
26. American Dental Association Claim Form Example B165
27. American Dental Association Claim Form Completion Instructions B167
28. HCFA 1500 Claim Form Example B173
29. HCFA 1500 Claim Form Instructions For Dental Services B175
30. Wisconsin Medicaid Allowable Place of Service Table and Allowable Type of Service Table B181
31. Wisconsin Medicaid Dental Billing Requiring Additional Documentation B183
32. Sample Electronic Claims Submission Screen B185
33. Electronic Media Claims Questionnaire B187
34. Understanding Explanation of Benefits Messages on the American Dental Association Claim Form B189
35. HealthCheck Screening Information Chart B191
36. Dental Coverage Limits for Special Recipient Eligibility Categories B193

Appendix 1
Quick Access Guide to Wisconsin Medicaid Information

Wisconsin Medicaid Professional Relations Representatives Map



Questions from Recipients about Medicaid Eligibility and Services?

Providers may refer recipients who have questions about their Medicaid eligibility to the Recipient Services hotline. This hotline is not for provider use.

- **Recipient Services** ***(recipient use only)***
  (800) 362-3002
  Hours: 8:00 a.m. to 4:30 p.m.,
  Monday–Friday

Here's Help!

A Quick Access Guide for Medicaid Providers on Wisconsin Medicaid Information

Policy/Billing Questions?

- **EDS Correspondence Unit for Policy/Billing Information**
  (608) 221-9883
  (800) 947-9627
  Hours: 8:30 a.m. to 4:30 p.m., Monday, Wednesday–Friday
  9:30 a.m. to 4:30 p.m., Tuesday
  Not available on holidays

- **Medicaid Managed Care Contract Monitors**
  (800) 760-0001
  Hours: 8:30 a.m. to 4:30 p.m., Monday, Wednesday–Friday
  9:30 a.m. to 4:30 p.m., Tuesday

- **Stat P.A.**
  (*for limited services*)
  (800) 947-1197
  (608) 221-2096
  Hours: 8:00 a.m. to 9:00 p.m.
  Monday–Friday

Questions about Medicaid Recipient Eligibility?

- **The Voice Response System**
  (608) 221-4247
  Hours: 24 hours a day, seven days a week
  Including holidays

- **The Eligibility Hotline**
  (608) 221-9254
  Hours: 8:30 a.m. to 4:30 p.m., Monday, Wednesday–Friday
  9:30 a.m. to 4:30 p.m., Tuesday
  Not available on holidays

(800) WIS-ELIG (947-3544)
Hours: 7:30 a.m. to 5:00 p.m.,
Monday–Friday
Not available on holidays

Professional Relations Representatives

for help with complex Medicaid provider questions
(*see map on other side*)

- **Milwaukee County**
  Tami Radwill
  (414) 273-1773

- **Northwest Wisconsin**
  Denise Kruswicki
  (715) 392-3143

- **North Central Wisconsin**
  Joan Buntin
  (715) 848-7566

- **Northeast Wisconsin**
  Karen Gordon
  (920) 336-0527

- **Southwest Wisconsin**
  Cindy Drury
  (608) 283-6344

- **South Central Wisconsin**
  Jude Benish
  (608) 255-8521

- **Southeast Wisconsin**
  Vicky Murphy
  (414) 963-8966

Remember...

- ✓ Policy and billing information lines answer policy and billing questions only, including prior authorization information.
- ✓ Check the recipient's Wisconsin Medicaid identification card first to avoid calls to Voice Response and the Eligibility Hotline. Refer to Appendix 31 of Part A, the all-provider handbook, for instructions on how to access Voice Response.
- ✓ 800 phone numbers are toll-free in Wisconsin only.

Post this by your telephone for easy reference.

Appendix 2
Dental Certification Form

Determining Your Oral Surgery Billing

Wisconsin Medicaid dentists can select the procedure code billing system they want to use for billing all oral surgery codes that do not require a tooth letter or number. Dentists can select either:

- The American Dental Association (ADA) Current Dental Terminology (CDT).
- The *Physicians' Current Procedural Terminology* (CPT).

If you are unsure whether you are certified by Wisconsin Medicaid to bill with CDT codes or CPT codes, please contact Correspondence Unit for Policy/Billing Information at (800) 947-9627.

This document outlines the way that oral surgery procedure code billing is automatically assigned to dentists and provides an opportunity for dentists to choose a different billing system than they are assigned.

Assignment of Oral Surgery Billing

Assignment of oral surgery billing depends on the dental specialty chosen during Medicaid certification. This assignment is necessary because it provides the computers of the Medicaid fiscal agent, EDS, both a systematic way to identify the oral surgery procedure codes a provider can bill and a way to ensure accurate reimbursement.

Specialties Billing CPT Codes for Most Oral Surgeries

Dentists with the following specialties on the certification file are to bill CPT procedure codes for most oral surgeries:

- Oral surgeons.
- Oral pathologists.
- Other dentists selecting CPT code billing (using the attached form).

Specialties Billing ADA CDT Codes for All Oral Surgeries

The following dental specialties are to bill ADA procedure codes for all oral surgeries:

- Endodontic.
- Orthodontics.
- Periodontics.
- Oral surgeons/pathologists selecting ADA code billing (using the attached form).
- General Practice.
- Pedodontics.

General Policies Regarding Oral Surgery Billing

All dentists, regardless of specialty:

- Receive the same reimbursement for the same procedures.
- Have virtually the same program limitations, such as prior authorization requirements, for the same procedures.

- Bill all other dental (non-surgical) procedures using ADA procedure codes and a few Wisconsin Medicaid HCFA Common Procedure Coding System (HCPCS) local procedure codes ("W" codes).
- Must bill for all oral surgeries using the codes assigned at certification or chosen by completing the attached form.
- Cannot temporarily alternate between coding systems, using different procedure codes on different days.
- Can change their oral surgery billing anytime by completing the attached form, "Selecting a Different Oral Surgery Billing Method."

Oral Surgery Procedure Code Billing
Determined By Provider Certification

Provider Type and Specialty on EDS File	Procedure Codes Allowed to Bill	Procedure Codes Not Allowed to Bill
Dentist (provider type 27) *Specialties* - Endodontic - General Practice - Oral Surgery/Pathology billing all ADA codes* - Orthodontics - Pedodontics - Periodontics - Prosthodontics	- American Dental Association (ADA) Current Dental Terminology (CDT) and - Local HCPCS or "W" procedure codes	- Any *Physicians' Current Procedural Terminology* (CPT) codes for oral surgeries
Dentist (provider type 27) *Specialties* - Oral Pathology - Oral Surgery - Any other type of dentist billing CPT oral surgery codes*	- All ADA codes except those noted - Local HCPCS or "W" procedure codes except those noted - Selected CPT codes for selected oral surgeries	- ADA codes 07260, 07285-07999 - Local HCPCS code W7998
Physicians (Provider types 19-20) *Specialties* - All physician specialties	- All ADA codes except those noted - HCPCS codes except those noted - Physicians CPT codes for oral surgeries	- ADA codes 07260, 07285-07999 - Local HCPCS code W7998 - Dental CPT codes for oral surgeries

* Providers who have completed the application for selecting a different oral surgery billing method.

Appendix 2
Dental Certification Form (cont.)

Selecting a Different Oral Surgery Billing Method

Complete this form if you want to bill with different oral surgery procedure codes than are currently assigned to your dental specialty (refer to chart on previous page). If you are currently certified in Wisconsin Medicaid and do not want to change your oral surgery billing, do not complete this form. If you are applying for certification and wish to choose the alternate method, complete this form and submit with your application.

Send the completed form to: Provider Maintenance, EDS, 6406 Bridge Road, Madison, WI 53784-0006.

Name _____

Address _____

_____

_____

Medicaid
Provider Number (if assigned) _____

Desired Future Effective
Date for Billing Change _____
(Allow two weeks for computer file changes.)

Providers will be notified when the selected specialty is ready for use. Claims submitted with dates of service on or after the effective date in the notice will use the new billing method.

Current Specialty (required, must mark one)

___Endodontic
___Oral Pathology
___Orthodontics
___Periodontics
___General Practice
___Oral Surgery
___Pedodontics
___Prosthodontics

Oral Surgery Billing Specialties

Indicate the specialty that you choose, based on your choice of procedure codes for oral surgery billing. (Do not complete if you are satisfied with the oral surgery billing codes assigned to your specialty.) ***NOTE:*** *If you are a member of a group, encourage all members of the group to use the same oral surgery billing method.*

___Oral surgeons/pathologists billing ADA codes for all oral surgeries
___Any other dental specialty choosing CPT oral surgery billing

_____ _____
Signature Date

(***NOTE:*** On the fiscal agent's computer files, your oral surgery billing specialty will be listed, but records will be kept as to your actual dental specialty.)

A. COVERED DRUGS - LEGEND DRUGS

Wisconsin Medicaid uses an Open Formulary for legend drugs with few restrictions. Restrictions include: Drugs Which Require Prior Authorization (refer to Sections C and D below), Noncovered Manufacturer Drugs (refer to Section A of Appendix 4 of this handbook), Less-Than-Effective Drugs (refer to Section B of Appendix 4 of this handbook) and Negative Formulary Drugs (refer to Section C of Appendix 4 of this handbook).

B. COVERED DRUGS - OVER-THE-COUNTER DRUGS

The general categories are:

ANALGESICS-ORAL/RECTAL[1] ANTACIDS ANTIBIOTIC OINTMENTS ANTIFUNGALS-TOPICAL ANTIFUNGALS-VAGINAL BISMUTH SUBSALICYLATE CAPSAICIN CONTRACEPTIVE SUPPLIES	COUGH SYRUPS[2] DIPHENHYDRAMINE FERROUS GLUCONATE/ SULFATE FOR PREGNANT WOMEN (AND FOR A 60-DAY PERIOD BEYOND THE END OF THE PREGNANCY)	HYDROCORTISONE PRODUCTS-TOPICAL INSULIN LICE CONTROL PRODUCTS AND PINWORM TREATMENT PRODUCTS	MECLIZINE OPHTHALMIC LUBRICANTS PSEUDOEPHEDRINE PYRIDOXINE TABLETS THERAPEUTIC ORAL ELECTROLYTE REPLACEMENT SOLUTIONS

(Note: Coverage is limited to generic drugs for most covered OTC drugs [excluding the OTC product categories of insulin, ophthalmic lubricants, and contraceptive supplies]. Some products in these categories are *not* covered because the manufacturer did not sign a rebate agreement. Examples of noncovered brand name products include Mylanta, Rolaids, Clear Tears, Lyteers, Neo Tears, Maalox, Titralac, Ecotrin, Robitussin, Tylenol, Ascriptin, Riopan and Advil.)

B. COVERED DRUGS - OVER-THE-COUNTER DRUGS (HealthCheck "Other Services")

Effective with dates of service beginning January 1, 1994, the following drug categories are covered through HealthCheck "Other Services" without prior authorization but with a written prescription, as well as verification that a comprehensive HealthCheck screen occurred within the last year. Pharmacies are required to maintain this documentation. HealthCheck is a preventive health care program for children under the age of 21. Refer to Appendix 25 of the pharmacy handbook for more specific information on covered categories.

ANTI-DIARRHEALS IRON SUPPLEMENTS	LACTASE PRODUCTS LAXATIVES	MULTIVITAMINS	TOPICAL PROTECTANTS

[1] Limited to single entity aspirin, acetaminophen, ibuprofen products only. These analgesics remain in the daily rate for nursing home recipients.

[2] Covered "cough syrups" are limited to products for treatment of coughs only. Covered products include those containing a single component (terpin hydrate or guaifenesin), a single cough suppressant (codeine or dextromethorphan), or a combination of an expectorant and cough suppressant. Multiple ingredient cough/cold combination products are noncovered.

C. COVERED NON REBATED DRUGS - PRIOR AUTHORIZATION REQUIRED

These drugs require prior authorization because the manufacturer did not sign a rebate agreement. Prescribers are requested to provide a statement regarding the nature of the medical need for these specific brand drugs, as well as a statement which asserts that failure to cover the drug will result in costs to Wisconsin Medicaid which exceed the cost of the drug. This list may change if the manufacturer signs a rebate agreement.
Generic equivalents of these drugs are not included in this requirement and may be billed without prior authorization if the generic manufacturer has signed a rebate agreement.

DALMANE LIBRITABS	LIBRIUM MELANEX	MENRIUM QUARZAN	RIMSO 50 VALIUM

D. COVERED REBATED DRUGS - PRIOR AUTHORIZATION REQUIRED

1. Paper Submission
These drugs are produced by manufacturers which have signed rebate agreements but require prior authorization to determine medical necessity. Diagnosis and information regarding the medical requirements for these drugs must be provided on the prior authorization request.

ALGLUCERASE (11/1/92) Ceredase* ALPHA-1-PROTEINASE INHIBITOR Prolastin*	CS III & IV STIMULANTS (Excludes Mazindol) Benzphetamine, Diethylpropion, Fenfluramine, Phendimetrazine, Phentermine	ENTERAL NUTRITIONALS Ensure, Pediasure Meritine, Enrich, MCT Sustacal, Pregestimil, etc. EPOETIN ALFA Epogen,* Procrit*	FERTILITY ENHANCEMENT DRUGS (when used to treat conditions other than infertility) Chorionic Gonadotropin, Menotropins, Clomiphene, Urofollitropin, Gonadorelin
HUMAN GROWTH HORMONE Humatrope,* Protropin* Serostim™ HYPERALIMENTATION Total Parenteral Nutrition Peripheral Parenteral Nutrition	IMPOTENCE TREATMENT DRUGS (When used for a condition other than impotence) Alprostadil Systemic (Prostin VR Pediatric, Vasoprost), Phentolamine, Systemic (Regitine), Phentolamine Oral (Vasomax), Sildenafil (Viagra)	INTERFERONS Alferon N,* Intron-A,* Infergen, Roferon-A,* Betaseron* (10/01/93) Avonex (07/01/96)	MUPIROCIN (02/01/94) Bactroban* MUROMONAB-CD3 Orthoclone OKT3*
	UNLISTED/ INVESTIGATIONAL DRUGS Biopterin (tetrahydrobiopterin), Somogard (deslorelin)	WEIGHT LOSS AGENTS Meridia (2/1/98)	

D. COVERED REBATED DRUGS - PRIOR AUTHORIZATION REQUIRED			
2. Specialized Transmission Approval Technology (STAT) PA.			
ORAL ULCER TREATMENT DRUGS (07/01/94) Axid, Carafate, Cytotec, Pepcid, Prilosec, Tagamet, Zantac Prevacid (10/01/95), Tritec (8/26/96), Arthrotec (1/1/98), Prevpac (1/20/98)	SMOKING CESSATION PRODUCTS (07/01/94) Habitrol, ProStep, Zyban (6/23/97) (OTC products not covered.)	COLONY STIMULATING FACTORS (07/01/94) Neupogen, Leukine, Prokine	

* Providers will receive a response within 24 hours from Wisconsin Medicaid for these drug products produced by manufacturers who have signed rebate agreements. Providers must have properly submitted the prior authorization requests.

Appendix 4
Wisconsin Medicaid Noncovered Drugs

A. Noncovered Drugs - No Manufacturer Rebate Agreement

Manufacturers of the following drugs have chosen not to participate in the Medicaid program. This is *not* a complete list of noncovered drugs. This list may change if manufacturers sign rebate agreements. Wisconsin Medicaid does not grant prior authorization for these drugs. Wisconsin Medicaid may cover the generic alternatives for these drugs if the manufacturer signed a rebate agreement. The noncovered drugs are:

Asthmanephrine	Duolube	Karigel	Nafrinse
Bichloracetic Acid	Eppy N Opth Soln	Lyteers	Neo-Tears
Clear Tears	Eppy Sol Oph	Moisture Drops	Tinver Lotion
Drysol	Karidium	Monoject Insulin Jel	Xerac AC
			Yodoxin

B. Medicaid Noncovered Drugs - FDA Less-Than-Effective Drugs

Wisconsin Medicaid does not grant prior authorization for these drugs nor for any generic alternatives identified by the Food and Drug Administration (FDA) as identical, related or similar to these drugs. This list represents only the most commonly prescribed less-than-effective drugs.

Amesec	Deprol	Kinesed	Mudrane	Quibron Plus
Arlidin	Donnatal	Levsin W Phenobarb	Naldecon	Rautrax
Bellabarb	Donnatal Extentabs	Librax	Nylidrin	Theofed
Belladenal	Entex	Lufyllin EPG	Pentaerythritol TN	Tigan Oral/rectal
Belladenals	Entex Liq	Marax	Peritrate	Tuss Ornade
Butibel	Fedrinal	Mepergan Fortis	Phenobarb & Belladonna	Vasodilan
Cyclandelate	Isolate Comp	Midrin	Priscoline	Vioform W HC
	Isoxuprine	P.V. Tussin	Quadrinal	Vytone

C. Medicaid Noncovered Drugs - Wisconsin Negative Formulary. Prior Authorization Will Not Be Granted for These Drugs:

Alginate
Gaviscon
Minoxidil Topical
Non-rebated Drugs Ineligible for Prior Authorization
Progesterone for PMS
Legend Multi-vitamins (Non-prenatal) - Excludes HealthCheck

FERTILITY ENHANCEMENT DRUGS (when used to treat infertility)

Chorionic Gonadotropin
Menotropins
Clomiphene
Urofollitroping
Gonadorelin

IMPOTENCE TREATMENT DRUGS

Alprostadil Intracavernosal (Caverject, Edex)
Phetolamine Intracavernosal (Regitine)
Sildenafil (Viagra)
Urethral Suppository (Muse)
Yohimbine

Any Drug Determined to Be Experimental in Nature or Not Proven as an Effective Treatment for the Condition for Which it Is Prescribed (See HFS 107.035).

Appendix 5
Wisconsin Medicaid
Covered Dental Services

This table should be used as a *general* guideline. For specific procedure codes and limitations, please see Appendices 9 through 19 of this handbook.

COVERED SERVICES	LIMITATIONS	NONCOVERED SERVICES
Diagnostic Services:		
Exams	-Two times a year (ages 1-12 years) -One time a year (ages 13 yrs. and over)	
Most X-rays	-Limits on frequency and type	
Office visit		-Not covered separately, provider should bill for treatment
Preventive Services:		
Cleanings (Prophylaxis)	-Two times a year (ages 1-12 yrs.) -One time a year (ages 13 yrs. and over) -Fluoride treatment for children without prior authorization	
Sealants	-Prior authorization required for some teeth -One time every three years	
Space Maintainer	-For children only, prior authorization required for ages 13-20	
Restorative Services:		
Fillings	-One time a year for baby teeth, if needed -One time every three years for permanent teeth, if needed	
Crowns	-Prefabricated stainless steel crowns -Other prefabricated crowns for front teeth -Prior authorization required for adults for non-stainless steel prefabricated crowns for front teeth	-Single unit crowns, not prefabricated
Endodontic Services:		
Anterior, Bicuspid Root Canals	-Adults require prior authorization -Only covered if good oral health, good attendance record, few missing teeth	
Molar Root Canals	-Prior authorization required for everyone -Only covered if good oral health, good attendance record, few missing teeth	

Appendix 5
Wisconsin Medicaid
Covered Dental Services
(continued)

Covered Services	Limitations	Noncovered Services
Periodontal Services:		
Gingivectomy	-Prior authorization required	-Osseous surgery and all other adjunctive periodontal services
Scaling and Planing	-Prior authorization required	-Osseous surgery and all other adjunctive periodontal services
Full-mouth debridement	-Prior authorization required	-Osseous surgery and all other adjunctive periodontal services
Periodontal maintenance procedure	-Prior authorization required	-Osseous surgery and all other adjunctive periodontal services
Dentures-Bridges:		
Partial Dentures	-Require prior authorization -Covered only if good oral health and specific teeth missing -Six-week healing period after extraction -Only resin base partials -Replacement once per five years, if needed	-Cast metal base partial dentures
Full Dentures	-Prior authorization required -Replacements only once per five years, if needed -Six-week healing period after extraction	-Duplicate, overlay, cu-sil dentures
Denture Reline	-Prior authorization required -Only once per three years	
Denture Repair	-Limited reimbursement for repair -Repair only if denture is repairable	
Bridges	-Fixed bridge requires prior authorization -Fixed bridge coverage extremely limited	
Oral Surgery:		
Tooth Extraction	-Surgical tooth removal covered only in medical emergency	-Surgical tooth removal without emergency conditions
Oral Surgeries	-Some require prior authorization	-Alveoplasty, vestibuloplasty, and osteoplasty after age 20
TMJ Surgery	-Covered only if non-surgical treatment was unsuccessful	-Non-surgical treatment of TMJ
General or IV Anesthesia	-Requires prior authorization -Covered only when medically necessary	
Orthodontia:		
Orthodontia	-Requires prior authorization -Children up through age 20 -HealthCheck referral required -Covered only in cases of severe malocclusion	-Adult orthodontia

Appendix 5
Wisconsin Medicaid
Covered Dental Services
(continued)

The following services are not Wisconsin Medicaid covered services:

- Cast metal base partial denture
- Overlay, cu-sil, duplicate dentures and adjustments.
- Dental implants and transplants.
- Services for purely aesthetic or cosmetic purposes .
- Cast and prefabricated post and core.
- Professional visits including office visits in which no treatment occurs.
- Single unit cast crowns.
- Adult orthodontia.
- Dispensing of drugs.
- Adjunctive periodontal services.
- Alveoplasty, vestibuloplasty, and most osteoplasty.
- Non-surgical medical or dental treatment for a TMJ condition.
- Service for which prior authorization was denied.

Copayment

Copayments are an important part of reimbursement for dental services. Recipients are encouraged to make every effort to pay their copayment.

Appendix 6
Multidisciplinary Temporomandibular Joint Evaluation Programs Approved By The Wisconsin Department of Health and Family Services Medicaid Program

The following programs have been approved as multidisciplinary Temporomandibular Joint (TMJ) Evaluation Programs for Wisconsin Medicaid:

A. Thomas Indresano, D.D.S.
Professor and Chairman
Oral and Maxillofacial Surgery
Medical College of Wisconsin
Milwaukee County Medical Complex
9200 W. Wisconsin Avenue
Milwaukee, WI 53226
(414) 454-5760

Michael P. Banasik, D.D.S.
Department of Dental Specialist
Gundersen Clinic, Ltd.
1836 South Avenue
LaCrosse, WI 54601
(608) 782-7300, extension 2260

Daniel J. D'Angelo, D.D.S.
Oral and Maxillofacial Surgery
Associates of Waukesha, Ltd.
1111 Delafield Street #321
Waukesha, WI 53188
(414) 547-8665

William J. Nelson, D.D.S.
Oral and Maxillofacial Surgery
Associates of Green Bay, S.C.
704 Webster Avenue
Green Bay, WI 54301
(920) 468-3400

John F. Doyle, D.D.S.
University of Wisconsin Hospital and Clinics
600 Highland Avenue
Madison, WI 53705
(608) 263-7502

Appendix 7
Example of Prescription for Specialized Medical Vehicle Trips That Exceed Upper Mileage Limits

Specialized medical vehicle (SMV) providers must obtain prior authorization for all SMV trips (except for hospital and nursing home discharges) that:

- Originate in one of the urban counties listed below and exceed 40 miles one-way.
- Originate in any other county and exceed 70 miles one-way. [1]

Prior authorization requires a prescription from the referring provider. [2]

Urban counties are: Brown, Dane, Fond du Lac, Kenosha, LaCrosse, Manitowoc, Milwaukee, Outagamie, Sheboygan, Racine, Rock, and Winnebago.

If you refer a recipient who needs SMV transportation to a medical service that you suspect is farther away than the Wisconsin Medicaid upper mileage limits, write a prescription for the recipient to show the SMV provider.

Your prescription should include the name of the health care provider or facility, city where it is located, the service the recipient requires, and the amount of time the recipient needs transportation to the service (indicate time in days, not to exceed 365 days).

Anytown Clinic
1 W. Wilson
Anytown, WI 55555

Name *I. M. Recipient*

Address *609 Willow Anytown, WI 55555*
Regional Clinic, Anytown
Emergency Dental Services
Round trip--Recipient's home to Regional Clinic, Anytown
95 miles

Prescriber's Signature *I. M. Referring, D.D.S.* Date *MM/DD/YY*

[1] HFS 107.23(2)(f), Wisconsin Administrative Code
[2] Providers who may refer recipients and write SMV prescriptions are physicians, physician assistants, nurse midwives, nurse practitioners, dentists, optometrists, opticians, chiropractors, podiatrists, HealthCheck agencies, and family planning clinics.

Appendix 8
Place of Service Codes

Wisconsin Medicaid uses place of service codes to indicate where the service was provided. Many dental procedure codes have place of service restrictions. Below is a list of place of service codes and their descriptions:

Place of Service (POS) Description	HCFA POS
Other	0
Inpatient Hospital	1
Outpatient Hospital	2
Doctor's Office	3
Home	4
NH/Extended Care Facility	7
Skilled Nursing Facility	8
Ambulatory Surgery Center	B

Refer to the individual appendices within this section for information on specific place-of-service requirements.

Appendix 9
Diagnostic Services

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
Clinical Oral Examinations:				
00120	Periodic Oral Examination	No	All	One per 12-month period per provider for ages 13 and older. One per six months per provider for ages 0 through 12.
00150	Comprehensive Oral Evaluation	No	All	One per three years per provider.
00160	Detailed and extensive oral evaluation-problem focused, by report	No	All	One per three years per provider.
W7060	Periodic Oral Exam (Additional) - HealthCheck other services	Yes	13-20	Up to two additional oral exams per year with a HealthCheck referral.
W7130	TMJ Office Visit	No	All	One per year per provider.
Radiographs:				
00210	Intraoral, complete series (including bitewings)	No*	All	One per three years per provider Not billable within six months of other x-rays including 00220, 00230, 00240, 00270, 00272, 00274, 00330 except in an emergency.[1] (Panorex plus bitewings may be billed under 00210.)^
00220	Intraoral - periapical, first film	No	All	One per day Not billable for same date as, or six months after, 00210.^
00230	Intraoral - periapical, each additional film	No	All	Up to three per day Must be billed with 00220 Not billable for same date as, or six months after, 00210.^

Key:

[1] - Retain records in recipient files regarding nature of emergency.
* - Frequency limitation may be exceeded only with prior authorization.
^ - Six-month limitation may be exceeded in an emergency as indicated by "E" on the claim form. The same date of service limitation may *not* be exceeded in an emergency.

Appendix 9
Diagnostic Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
00240	Intraoral - occlusal film	No	All	Up to two per day Not billable for same date as 00210.
00250	Extraoral - first film	No	All	*Emergency only*, one per day.[1]
00260	Extraoral - each additional film	No	All	*Emergency only*, only two per day.[1] Must be billed with 00250.
00270	Bitewing - single film	No	All	One per day, up to two per six-month period, per provider. Not billable for same day as, and for six months after, 00210, 00270, 00272, or 00274.^
00272	Bitewings - two films	No	All	One set of bitewings per six-month period, per provider. Not billable for same day as, and for six months after, 00210, 00270, 00272, or 00274.^
00274	Bitewings - four films	No	All	One set of bitewings per six-month period, per provider. Not billable for same day as, and for six months after, 00210, 00270, 00272, or 00274.^
00330	Panoramic Film	No*	All	*Emergency only*, or orthodontia diagnostic only with prior authorization.[1] One per day when another radiograph is insufficient for proper diagnosis Not billable with 00210, 00270, 00272, or 00274.
00340	Cephalometric Film	Yes	All	Orthodontia diagnosis only.
Tests and Laboratory Examinations:				
00470	Diagnostic Casts	Yes	All	Only upon DHFS request.

Key:

[1] - Retain records in recipient files regarding nature of emergency.
* - Frequency limitation may be exceeded only with prior authorization.
^ - Six-month limitation may be exceeded in an emergency as indicated by "E" on the claim form. The same date of service limitation may not be exceeded in an emergency.

Appendix 9
Diagnostic Services
(continued)

COVERED SERVICES

DEFINITION

Diagnostic services include oral evaluations, selected radiographs, and diagnostic casts to:
- Assess oral health.
- Diagnose oral pathology.
- Develop an adequate treatment plan for the recipient's oral health.

Dentists are required to bill the oral evaluation procedure appropriate to the level of service provided.

Children ages 13-20 may receive up to two additional oral evaluations per year through HealthCheck. These additional evaluations must be prior authorized.

ORAL EVALUATION DOCUMENTATION

Dentists must document and maintain oral evaluation information in the same manner as they do for other patients. Wisconsin Medicaid regulations and accepted standards of dental care require documentation of:

Periodic Oral Evaluation
- Changes in dental and medical health since the last oral evaluation.
- Diagnosis of dental diseases.
- Interpretation of information acquired through additional diagnostic procedures.

Comprehensive Oral Evaluation
Documents:
- Review of medical and dental history including chief complaint.
- Blood pressure; baseline and additional, if appropriate.
- Intra-and extra-oral soft and hard tissue examination.
- Charting of the dentition, restorations, and periodontal conditions (including periodontal charting and tooth mobility).
- Occlusal relationships.
- Dental diagnosis and treatment plan.
- Interpretation of information acquired through additional diagnostic procedures.

Detailed and Extensive Oral Evaluation
- Problem-focused findings of comprehensive evaluation.
- Integration of more extensive diagnostic modalities.
- Diagnosis, prognosis, and treatment plan.

RADIOGRAPHS

Only a limited number and variety of radiographs are covered. Reimbursement for radiographs includes exposure of the radiograph, developing, mounting, and radiographic interpretation.

An intraoral complete series may include either a periapical series plus bitewings or a panorex plus bitewings. Individual panoramic radiographs are covered in emergency situations or for orthodontia diagnosis only.

Appendix 9
Diagnostic Services
(continued)

ORAL EVALUATIONS DONE IN NURSING HOMES OR FOR CHILDREN

To provide greater flexibility in scheduling when oral exams are provided to an adult nursing home resident or to children, the time period between oral evaluations may be as few as 330 days for adult nursing home residents and 160 days for children.

DETAILED AND EXTENSIVE ORAL EVALUATION

Examples of conditions requiring this type of evaluation may include dentofacial anomolies, complex temporomandibular dysfunction, facial pain of unknown origin, or severe systemic diseases requiring multi-disciplinary consultation.

PRIOR AUTHORIZATION

FULL MOUTH RADIOGRAPHS

Additional full mouth (intraoral complete series) radiographs or panoramic x-rays can receive prior authorization in cases of trauma or other unusual medical or dental clinical histories, such as cancer or rampant decay.

CEPHALOMETRIC RADIOGRAPHS

Cephalometric radiographs are allowed only for orthodontic cases and always require prior authorization (PA) and a HealthCheck exam.

PANORAMIC RADIOGRAPHS

Panoramic radiographs for orthodontic cases also require a PA and a HealthCheck exam.

BILLING

BILLING RADIOGRAPHS

All x-rays provided on the same date of service are required to be billed on the same claim form. Duplicate billings are denied.

DETAILED AND EXTENSIVE ORAL EVALUATION

Claims for detailed and extensive oral evaluation are required to be filed on paper with a copy of the office progress notes to document the medical necessity for an extensive problem-focused evaluation.

EMERGENCY SERVICES

Emergency services are defined as services that must be provided immediately to relieve pain, swelling, acute infection, trismus, or trauma. Because the American Dental Association (ADA) claim form does not have a means to designate emergency treatment by procedure, all claims for emergency services must be identified by an “E” in the “For Administrative Use Only” box on the line item for the emergency service of the ADA claim form or element 24I of the HCFA 1500 claim form in order to exempt the services from copayment deduction. Only the letter “E” without any additional letters is accepted. Information relating to the definition of a dental emergency is in Section II-A of this handbook.

EMC claims use a different field to indicate an emergency. Refer to your EMC manual for more information.

ADDITIONAL INFORMATION

In addition to this summary, refer to:

- The preceding pages for a complete listing of Wisconsin Medicaid covered diagnostic services, procedure codes, and related limitations.
- Appendix 31 for a summary of required billing documentation.
- Appendix 24 for a summary of required documentation needed for PA requests.

Appendix 10
Preventive Services

Please note that local anesthesia is included in the fee for procedures requiring anesthesia and is not separately billable. When a provider uses anesthesia, the anesthesia charge should be included in the amount billed for the procedure.

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
Dental Prophylaxis:				
01110	Prophylaxis - adult	No* (see limitations)	>12	One per 12-month period per provider. Three additional per year allowable with prior authorization. Not billable with periodontal scaling and root planing or periodontal maintenance procedure or periodontal scaling performed in presence of gingival inflammation. (Prior authorization may be granted for up to five years for permanently disabled recipients.)
01120	Prophylaxis - child	No* (see limitations)	<13	One (01120 or 01201) per six months per provider. Up to two additional per year allowable with prior authorization. Not billable with 01201. (Prior authorization may be granted for up to five years for permanently disabled recipients.)
Topical Fluoride Treatment (office procedure):				
01201	Topical application of fluoride (including prophylaxis) - child	No* (see limitations)	<13	One (01120 or 01201) per six months per provider. Up to two additional allowable per year with prior authorization. Not billable with 01120. (Prior authorization may be granted for up to five years for permanently disabled recipients.)

Key:
* - Frequency limitation may be exceeded only with prior authorization.

Appendix 10
Preventive Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
01203	Topical application of fluoride (prophylaxis not included) - child	Yes (see limitations)	<13	Up to four per year with prior authorization. (Prior authorization may be granted for up to five years for permanently disabled recipients.)
01204	Topical application of fluoride (prophylaxis not included) - adult	Yes (see limitations)	>12	Up to four per year with prior authorization. (Prior authorization may be granted for up to five years for permanently disabled recipients.)
01205	Topical application of fluoride (including prophylaxis) - adult	Yes (see limitations)	>12	Up to four per year with prior authorization. Not billable with periodontal scaling and root planing. (Prior authorization may be granted for up to five years for permanently disabled recipients.) One per six-month period, per provider.
Other Preventive Services:				
01351	Sealant - per tooth	Yes (see limitations)	< 21	Prior authorization *is not* required for tooth numbers 2, 3, 14, 15, 18, 19, 30, 31. Prior authorization *is* required for tooth numbers 1, 4-13, 16, 17, 20-29, 32, A-T, SN. Narrative required in order to exceed once per three-year limitation on permanent first and second molars.

Key:
* - Frequency limitation may be exceeded only with prior authorization.

Appendix 10
Preventive Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
Space Maintenance (passive appliances):				
01510	Space maintainer - fixed - unilateral	No	< 21	First and second primary molar only (tooth letters A, B, I, J, K, L, S, T only). Limited to four per day; once per year per tooth. A narrative is required to exceed the limitation.
01515	Space maintainer - fixed - bilateral	Yes (see limitations)	< 21	Once per year, per arch. Prior authorization is required only for ages 13-20. Narrative required to exceed frequency limitation, before age 13.
01550	Recementation of space maintainer	No	< 21	Limited to two per day.

Key:
* - Frequency limitation may be exceeded only with prior authorization.

Appendix 10
Preventive Services
(continued)

PROPHYLAXES

COVERED SERVICES

ROUTINE PROPHYLAXIS SERVICES

Preventive services include routine prophylaxes (which includes scaling and polishing) for adults and children.

Wisconsin Medicaid covers routine prophylaxes including scaling and polishing:

- Once every six months for children through age 12.
- Once per year for recipients over the age of 12.
- Children ages 13-20 may receive one additional prophylaxis per year with prior authorization (PA).

PROPHYLAXIS SERVICES DONE IN A NURSING HOME OR FOR CHILDREN

To provide greater flexibility in scheduling when oral exams are provided to an adult nursing home resident or to children, the time period between oral evaluations may be as few as 330 days for adult nursing home residents and 160 days for children.

PROPHYLAXES AND FLUORIDE

When prophylaxes and fluoride are provided on the same date of service, they must be billed under a single procedure code rather than as two separate procedure codes.

PRIOR AUTHORIZATION

ADDITIONAL PROPHYLAXES COVERAGE

Additional prophylaxes are a covered benefit for recipients only with PA. The criteria for approval of additional prophylaxes require one or more of the following conditions:

- Mental or physical handicaps which impair oral hygiene.
- Recipient is taking medication which causes gingival hyperplasia.
- Recipient has another medical condition requiring additional prophylaxes.

A plan of care regimen with additional prophylaxes is routinely granted for 12 months, unless a longer period is specified in the PA request.

EXTENDED PRIOR AUTHORIZATION

PA for additional prophylaxes treatments for disabled recipients can be granted for up to five years if:

- The disability is permanent.
- The provider expects to see the recipient over an extended period of time.

DOCUMENTATION FOR PROPHYLAXES

The following information must be submitted on the PA request:

- Complete description of the recipient's oral condition.
- Past dental and medical history.
- Etiologic factors affecting the recipient's oral condition.
- Anticipated treatment plan and fees, including additional prophylaxes and fluoride treatment.

Appendix 10
Preventive Services
(continued)

PRIOR AUTHORIZATION
(continued)

To obtain PA for more than 12 months, indicate (in addition to the information required on all PAs listed above) on the Prior Authorization Dental Request Form (PA/DRF) and Prior Authorization Dental Attachment (PA/DA):

- The period of time for which you are seeking PA.
- A statement to explain the permanency of the disability.
- The total number of annual and semi-annual prophylaxes requested. For example, if the recipient is a regular patient with a permanent disability, you can request three additional prophylaxes per year for five years (a quantity of 15 on the PA/DRF).

TOPICAL FLUORIDE TREATMENT

COVERED SERVICES

DEFINITION

Topical fluoride treatment is a covered benefit for children and adult recipients.

The application of topical fluoride treatment is allowed for children:

- Up to age 13.
- Once every six months.
- In conjunction with a prophylaxis.
- Without PA.

PRIOR AUTHORIZATION

DEFINITION

PA is required for fluoride services for children under age 13 in excess of one treatment per six months and for any fluoride treatment for recipients age 13 and over.

ADDITIONAL FLUORIDE TREATMENT FOR CHILDREN

Up to two additional fluoride treatments per year may be approved for recipients under age 13 with PA.

FLUORIDE TREATMENT FOR ADULTS

Fluoride treatments for recipients age 13 and over are covered if approved with PA.

CRITERIA FOR COVERAGE

The criteria for approval of topical fluoride treatment require one or more of the following conditions:

- Rampant decay.
- Xerostomia.
- Radiation therapy to the head and neck.
- Cemental or root surface caries secondary to gingival recession.

Appendix 10
Preventive Services
(continued)

- Mental and physical handicaps which impair oral hygiene resulting in high incidence of caries.

A plan of care regimen for topical fluoride treatment is routinely granted for 12 months, unless a longer period is specified in the prior authorization (PA) request.

EXTENDED PRIOR AUTHORIZATION

PA for topical fluoride treatment for disabled recipients can be granted for up to five years if:

- The disability is permanent.
- The provider expects to see the recipient over an extended period of time.

The following information must be submitted on the PA request:

- Complete description of the recipient's oral condition.
- Past dental and medical history.
- Etiologic factors affecting the recipient's oral condition.
- Anticipated treatment plan and fees, including additional prophylaxes and fluoride treatments.

To obtain PA for more than 12 months, in addition to the information required on all PA requests listed above, indicate on the PA/DRF and PA/DA:

- The period of time for which you are seeking PA.
- A statement to explain the permanency of the disability.
- The total number of fluoride treatments requested. For example, if the recipient is a regular patient with a permanent disability, you could request four fluoride treatments per year for five years (a quantity of 20 on the PA/DRF)

SEALANTS

COVERED SERVICES

HEALTHCHECK NO LONGER REQUIRED

Sealants are a covered service for recipients under 21 years of age. As of January 1, 1998, Wisconsin Medicaid no longer requires a HealthCheck exam before a recipient receives sealants.

Wisconsin Medicaid covers sealants (ADA procedure code 01351) for a child once every three years.

PRIOR AUTHORIZATION

DEFINITION

Sealants on the first and second permanent molars do not require PA. PA is required for sealants on all other teeth.

PA is required for tooth numbers 1, 4-13, 16, 17, 20-29, 32, A-T, SN.

Appendix 10
Preventive Services
(continued)

SPACE MAINTAINERS

COVERED SERVICES

DEFINITION

Space maintainers are a covered Wisconsin Medicaid service. Space maintenance therapy is covered to enable children to develop normal dental occlusion. This service includes coverage of missing anterior teeth, bilateral missing posterior teeth, and unilateral missing posterior teeth.

A space maintainer which includes a stainless steel crown (loop or distal shoe types) is reimbursed as a spacer plus a stainless steel crown. When a stainless steel crown is used instead of a band, the stainless steel crown must be separately identified.

PA is required for the space maintainer, fixed bilateral type, for children ages 13-20.

SPACE MAINTAINERS DOCUMENTATION

The PA request for space maintainers must include:

- Two bitewing radiographs.
- Anterior periapical radiograph for anterior space maintainers.
- A dentist's statement documenting one of the following:
  1. Evidence of premature loss of one or more primary teeth on both sides of the arch.
  2. Congenital absence of permanent teeth.
  3. Delayed eruption pattern due to certain medical conditions.
  4. Presence of supernumerary teeth.

ADDITIONAL INFORMATION

In addition to this summary, refer to:

- The preceding pages for a complete listing of Wisconsin Medicaid covered preventive services, procedure codes, and related limitations.
- Appendix 31 for a summary of required billing documentation.
- Appendix 24 for a summary of required documentation needed for PA requests.

Appendix 11
Restorative Services

Please note that local anesthesia is included in the fee for procedures requiring anesthesia and is not separately billable. When a provider uses anesthesia, the anesthesia charge should be included in the amount billed for the procedure.

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
Amalgam Restorations (including polishing):				
02110	Amalgam - 1 surface, primary	No	All	Once per tooth, per year, per provider. + (tooth letters A-T, SN only)
02120	Amalgam - 2 surfaces, primary	No	All	Once per tooth, per year, per provider. + (tooth letters A-T, SN only)
02130	Amalgam - 3 surfaces, primary	No	All	Once per tooth, per year, per provider. + (tooth letters A-T, SN only) (Four surface amalgams may be billed under this code.)
02140	Amalgam - 1 surface, permanent	No	All	Once per tooth, per 3 years, per provider.+ (tooth numbers 1-32, SN only)
02150	Amalgam - 2 surfaces, permanent	No	All	Once per tooth, per 3 years, per provider.+ (tooth numbers 1-32, SN only)
02160	Amalgam - 3 surfaces, permanent	No	All	Once per tooth, per 3 years, per provider.+ (tooth numbers 1-32, SN only) (Four surface amalgams may be billed under this code.)

Key:

+ - 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 in a narrative on the claim.

Appendix 11
Restorative Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
Resin Restorations:				
02330	Resin - 1 surface, anterior	No	All	Once per three years, per provider, per permanent tooth. + Once per year, per provider, per primary tooth.+ Allowed for Class I and Class V only. (tooth numbers 6-11, 22-27, C-H, M-R, SN only)
02331	Resin - 2 surfaces, anterior	No	All	Once per three years, per provider, per permanent tooth. + Once per year, per provider, per primary tooth.+ Allowed for Class III only. (tooth numbers 6-11, 22-27, C-H, M-R, SN only)
02332	Resin - 3 surfaces, anterior	No	All	Once per three years, per provider, per permanent tooth. + Once per year, per provider, per primary tooth.+ Allowed for Class III and Class IV only. (tooth numbers 6-11, 22-27, C-H, M-R, SN only)
02335	Resin - 4 or more surfaces or involving incisal angle (anterior)	No	All	Once per three years, per provider, per permanent tooth. + Once per year, per provider, per primary tooth.+ Allowed for Class IV only. (tooth numbers 6-11, 22-27, C-H, M-R, SN only) Must include incisal angle. Four surface resins may be billed under 02332, unless an incisal angle is included.

Key:

+ - 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 in a narrative on the claim.

Appendix 11
Restorative Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
02380	Resin - 1 surface, posterior primary	No	All	Once per year, per provider, per tooth. + (tooth letters A, B, I, J, K, L, S, T, SN)
02381	Resin - 2 surfaces, posterior primary	No	All	Once per tooth, per year, per provider. + (tooth letters A, B, I, J, K, L, S, T, SN only) This resin code will be paid at the same rate as an equivalent amalgam.
02382	Resin - 3 or more surfaces, posterior primary	No	All	Once per tooth, per year, per provider. + (tooth letters A, B, I, J, K, L, S, T, SN only) This resin code will be paid at the same rate as an equivalent amalgam.
02385	Resin - 1 surface, posterior permanent	No	All	Once per three years, per provider, per tooth.+ (tooth numbers 1-5, 12-21, 28-32, SN)
02386	Resin - 2 surfaces, posterior permanent	No	All	Once per tooth, per 3 years, per provider.[1] (tooth numbers 1-5, 12-21, 28-32, SN) This resin code will be paid at the same rate as an equivalent amalgam.
02387	Resin - 3 or more surfaces, posterior permanent	No	All	Once per tooth, per 3 years, per provider.[1] (tooth numbers 1-5, 12-21, 28-32, SN) This resin code will be paid at the same rate as an equivalent amalgam.
Other Restorative Services:				
02910	Recement inlay	No	All	Tooth numbers 1-32, SN only.
02920	Recement crown	No	All	Tooth numbers 1-32, A-T, SN.
02930	Prefabricated stainless steel crown (SSC) primary tooth	No	All	Tooth letters A-T, SN only (once per year, per tooth).+
02931	Prefabricated stainless steel crown (SSC) permanent tooth	No	All	Tooth numbers 1-32, SN only (once per five years, per tooth)+

Key:

[1] - Retain records in recipient files regarding nature of emergency.

\+ - 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 in a narrative on the claim.

Appendix 11
Restorative Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
02932	Prefabricated resin crown	Yes (> age 20)	All	Tooth numbers 6-11, 22-27, D-G, SN (once per year, per primary tooth; once per five years, per permanent tooth). (Composite crown may be billed under this code). Limitation exceeded with narrative for children+, and with prior authorization for adults > age 20.*
02933	Prefabricated stainless steel crown with resin window	Yes (> age 20)	All	Tooth numbers 6-11, D-G, SN only (once per year, per primary tooth; once per five years, per permanent tooth). Limitation exceeded with narrative for children+, and with prior authorization for adults > age 20.*
Upgraded Cast Crown:				
W7126	Upgraded crown	Yes	All	Tooth numbers 1-32, A-T, SN (once per year, per primary tooth; once per five years, per permanent tooth*). No dentist is obligated to provide this service.
02940	Sedative filling	No	All	Not allowed with pulpotomies, permanent restorations, or endodontic procedures (tooth numbers 1-32, A-T, SN only).
02951	Pin retention - per tooth, in addition to restoration	No	All	Tooth numbers 1-32, SN only (once per three years per tooth). +

Key:

* - Frequency limitation may be exceeded only with prior authorization.

\+ - 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 in a narrative on the claim.

Appendix 11
Restorative Services
(continued)

COVERED SERVICES

FREQUENCY LIMITATIONS

Wisconsin Medicaid limits the frequency of restorations on each tooth. The limitations may be exceeded only if a narrative on the claim demonstrates the medical necessity for replacing a properly completed restoration. Claims for a replacement restoration done in less than the allowable time frame that fail to include a statement indicating why the restoration was replaced are denied.

STANDARDS AND GUIDELINES

The standards and guidelines listed below, along with any limitations listed in the preceding pages, are required to be followed when providing restorative services:

- A restoration is considered a two or more surface restoration when two or more actual tooth surfaces are involved, *whether they are connected or not*.
- Any single or combination of restorations on one surface of a tooth is considered as one surface for reimbursement purposes.
- For billing purposes, count the total number of tooth surfaces restored and list the surface letters on the claim, *even when unrelated surfaces are restored*.
- Services not reimbursable as separate procedures are:
  1. Services considered part of the restoration, including:
     a. Base, copalite, or calcium hydroxide liners placed under a restoration.
     b. The acid etching procedure for composite restorations.
  2. Local anesthesia which is included in the restorative service fee.
- Charges for pulpotomies must be itemized separately on the dental claim form. They are not included in the reimbursement for restorations.

AMALGAM RESTORATIONS

Amalgam restorations:

- Are a covered service of Wisconsin Medicaid.
- Can be placed on any primary or permanent tooth.

RESIN RESTORATIONS

Wisconsin Medicaid covers resin restorations and reimburses most resin codes at the same rate as an equivalent amalgam.

TEMPORARY SEDATIVE FILLINGS

Temporary sedative fillings in conjunction with root canal procedures are paid for as part of the root canal procedure and are not separately billable. They are not considered to be a small base before placement of a permanent restoration.

TOOTH SURFACES

The following letters are the only ones accepted by Wisconsin Medicaid for the identification of tooth surfaces:

Anterior Teeth (Centrals, Laterals, Cuspids)

Mesial	(M)	Facial	(F)
Incisal	(I)	Lingual	(L)
Distal	(D)	Gingival	(G)

Appendix 11
Restorative Services
(continued)

Posterior Teeth (Pre-molars/Bicuspids, Molars)

Mesial	(M)	Buccal	(B)
Occlusal	(O)	Lingual	(L)
Distal	(D)	Gingival	(G)

Wisconsin Medicaid only pays per unique surface regardless of location. When gingival (G) is listed with a second surface, such as BG, BFG, DG, FG, LG, MG, they are considered a single surface. Also, "FB" is considered one surface since the two letters describe the same tooth surface.

PRIOR AUTHORIZATION

CROWNS

PA is required for recipients 21 years of age and older for composite/prefabricated resin crowns or stainless steel crowns with resin windows on specific anterior teeth.

UPGRADED CROWNS

Wisconsin Medicaid reimburses dentists for providing upgraded crowns. Due to fiscal limitations, and federal and state regulations, the following policy regarding these services has been established:

- PA is always required.
- Reimbursement is at the maximum fee for the "standard" stainless steel crown.
- Reimbursement must be accepted as payment in full.
- Each dental office that provides the service must have written criteria based on medical necessity to determine who will receive the upgraded service.
- The form in Appendix 25 of this handbook must be completed and attached to the PA/DRF and PA/DA.
- All criteria must be applied consistently to all Medicaid recipients.

No dentist is under any obligation to provide upgraded crowns.

RADIOGRAPH DOCUMENTATION

Providers must include a periapical radiograph of the involved tooth or teeth with any request for PA for crowns.

ADDITIONAL INFORMATION

In addition to this summary, a provider needs to refer to:

- The preceding pages for a complete listing of Wisconsin Medicaid covered restorative services, procedure codes, and related limitations.
- Appendix 31 for a summary of required billing documentation.
- Appendix 24 for a summary of required documentation needed for PA requests.

Appendix 12
Endodontic Services

Please note that local anesthesia is included in the fee for procedures requiring anesthesia and is not separately billable. When a provider uses anesthesia, the anesthesia charge should be included in the amount billed for the procedure.

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
Pulpotomy:				
03220	Therapeutic pulpotomy (excluding final restoration)	No	All	Once per tooth per lifetime. Primary teeth only. (tooth letters A-T, SN only)
Root Canal Therapy (including treatment plan, clinical procedures, and follow-up care:				
03310	Anterior (excluding final restoration)	Yes, > age 20	All	Normally for permanent anterior teeth. May be used to bill a single canal on a bicuspid or molar (tooth numbers 2-15, 18-31, SN only, once per tooth, per lifetime). Not allowed with sedative filling.
03320	Bicuspid (excluding final restoration)	Yes, > age 20	All	Normally for permanent bicuspid teeth May be used for two canals on a molar (tooth numbers 2-5, 12-15, 18-21, 28-31, SN only, once per tooth, per lifetime). Not allowed with sedative filling.
03330	Molar (excluding final restoration)	Yes	All	Not covered for third molars. Permanent teeth only (tooth numbers 2, 3, 14, 15, 18, 19, 30, 31, SN only, once per tooth, per lifetime). Not allowed with sedative filling.
03351	Apexification/recalcification - (apical closure/calcific repair of perforations, root resorption, etc.)	No	< 21	Permanent teeth only (tooth numbers 2-15, 18-31, SN only). Not allowable with root canal therapy. Bill the entire procedure under this code.

Appendix 12
Endodontic Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
W7116	Open tooth for drainage	No	All	Tooth numbers 2-15, 18-31, SN. *Emergency only.* Limit of $50.00 reimbursement per day for all emergency procedures done on a single day. Narrative required to override the limitations. Not billable with root canal therapy or pulpotomy on same date of service. Should be followed with a prior authorization request for a root canal.
Periapical Services:				
03410	Apicoectomy/periradicul-ar surgery - anterior	Yes, unless provided to a hospital inpatient	All	Permanent anterior teeth only (tooth numbers 6-11, 22-27, SN only). Not payable with root canal therapy on the same date of service. Code does not include retrograde filling. Include retrograde filling on prior authorization request for apicoectomy and on claim for billing.
03430	Retrograde filling - per root	Yes, unless provided to a hospital inpatient		Permanent anterior teeth only (tooth numbers 6-11, 22-27, SN only). Not payable with root canal therapy for the same date of service. Include retrograde filling on prior authorization request for apicoectomy and on claim for billing. Apicoectomy does not include retrograde filling.

Appendix 12
Endodontic Services
(continued)

COVERED SERVICES

STANDARDS FOR ROOT CANAL THERAPY

The following guidelines must be followed when providing endodontic services:

- The standard of acceptability employed by Wisconsin Medicaid for endodontic procedures requires that the canal(s) be completely filled apically and laterally.
- Root canal therapy for permanent teeth includes:

1. Diagnosis.
2. Extirpation.
3. Treatment.
4. Progress radiographs.
5. Filling and obliteration of root canals.
6. Temporary fillings.

NONCOVERED SERVICES

When the root canal filling does not meet Wisconsin Medicaid treatment standards:

- Wisconsin Medicaid can require the procedure to be redone at no additional Wisconsin Medicaid reimbursement.
- Any reimbursement already made may be recouped after the Wisconsin Medicaid dental consultant reviews the circumstances.

Sargenti filling material and other materials not accepted by the federal Food and Drug Administration are not accepted by Wisconsin Medicaid.

RADIOGRAPHS

A post-treatment radiograph *is required* for all root canal therapy and can be reimbursed separately.

OPEN TOOTH FOR DRAINAGE

Emergency treatment for recipients needing root canal therapy can be provided without prior authorization (PA) using code W7116, (Open Tooth for Drainage). This allows the dentist to relieve pain and/or extirpate the tooth in anticipation of proceeding with a root canal. A PA request for a root canal should be sent immediately.

INTERRUPTED ROOT CANAL THERAPY

A dentist may bill "open tooth for drainage" and "sedative filling" to receive reimbursement when root canal therapy begins and the recipient fails to return for subsequent visits or becomes ineligible.

REFERRALS

General dentists should not refer Medicaid recipients to endodontists, unless the recipient has a restorative dentist to provide restoration of the teeth.

General dentists referring a root canal procedure to an endodontist should complete the appropriate sections of the Prior Authorization Dental Attachment (PA/DA) form and send it to the endodontist with the referral.

General dentists referring Medicaid recipients to endodontists need to supply the endodontist with:

- Minimum of two bitewing x-rays.
- Oral charting of missing teeth.
- Treatment plan including plan for involved tooth.
- Oral hygiene status.

Appendix 12
Endodontic Services
(continued)

- Attendance information.
- Date and reason for any extractions within the past three years.

PRIOR AUTHORIZATION

PRIOR AUTHORIZED ROOT CANAL SERVICES

PA is required for all anterior, bicuspid, and molar teeth for recipients 21 years old and older. For recipients under age 21, PA is only required for molar endodontic procedures.

Up to three root canals can be approved, based on clinical appropriateness and restorability of the teeth. Root canals are limited to once per tooth, per lifetime, unless extenuating circumstances exist. Root canal therapy is not covered on third molars.

APICOECTOMY AND RETROGRADE FILLING

Apicoectomy and retrograde fillings are limited to anterior teeth only.

Providers must include a periapical with any request for PA for apicoectomy and retrograde filling.

Providers must include a request for a retrograde filling separately with the PA requests for an apicoectomy.

PA is not required when the apicoectomy and retrograde filling services are provided to a hospital inpatient.

CRITERIA FOR APPROVAL

The recipient qualifies for root canal therapy if:

For procedure code 03310

1. No more than three anterior teeth require root canal therapy, and no anterior tooth in the same arch is missing or indicated for extraction. The recipient must have adequate posterior occlusion per Wisconsin Medicaid criteria and would not be a partial denture candidate. If the recipient already qualifies for a partial denture due to missing anterior teeth in the same arch, or inadequate posterior occlusion, the request for root canal therapy is denied and the provider is asked to submit a request for a partial denture. The provider has the option to complete the root canal therapy on the indicated tooth or teeth at the recipient's expense.

2. The tooth is an abutment tooth for a fixed bridge or an anchor tooth for a partial denture and the bridge or partial is serviceable and functional, as determined by the Wisconsin Medicaid dental consultant.

3. Good recipient attendance record.

For procedure codes 03320 and 03330

1. No more than two posterior teeth require root canal therapy, and no anterior tooth in the same arch is missing or indicated for extraction. The recipient must have adequate posterior occlusion per Wisconsin Medicaid criteria and would not be a partial denture candidate. If the recipient already qualifies for a partial denture due to missing anterior

Appendix 12
Endodontic Services
(continued)

teeth in the same arch or inadequate posterior occlusion, the request for root canal therapy is denied and the provider is asked to submit a request for a partial denture. The provider has the option to complete the root canal therapy on the indicated tooth or teeth at the recipient's expense.

2. The tooth is an abutment tooth for a fixed bridge or an anchor tooth for a partial denture and the bridge or partial is serviceable and functional, as determined by the Wisconsin Medicaid dental consultant.

3. One posterior tooth requires root canal therapy and no other anterior tooth or teeth are missing in the same arch, no other tooth or teeth are in need of root canal therapy, and no other tooth or teeth are indicated for extraction. If the denial of the root canal and the resultant tooth extraction qualifies the recipient for a partial denture, and the recipient did not previously qualify for a partial denture, the root canal can be approved.

4. Good recipient attendance record.

Exceptions can be made in the following cases, as determined by the dental consultant:

- Recipients who have post-radiation necrosis potential.
- Blood diseases or disorders where extractions are contraindicated.
- Medically compromised or handicapped recipients.
- Recipients unable to wear complete or partial denture for documented psychiatric reasons.
- Unusual clinical situation where an endodontic procedure appears appropriate based on comprehensive review of the dental plan and medical history. (For example, an irreversible pulpotomy caused by a deep restoration with no other tooth loss within the last three years.).
- Recipients under age 21 who may require more than two molar root canals.
- Recipients under age 21 who may also require a partial denture to replace a missing anterior tooth or teeth.
- To preserve the integrity of an intact arch or quadrant.

CRITERIA USED FOR EVALUATION OF ROOT CANAL THERAPY PRIOR AUTHORIZATION REQUEST

The following criteria are used to evaluate PA requests for root canal therapy:

- Root canal therapy should not be considered for a Medicaid recipient if restoration requires a post and core unless the recipient pays for the post and core. Post and core is not a covered service. If the recipient is unable to pay for the post and core, root canal therapy should not be requested.
- Oral health status and x-rays do not indicate rampant decay; only three anterior teeth or only one bicuspid or molar root canal is necessary.
- Root canal therapy is *not* covered on third molars.
- Root canals performed in anticipation of overlay dentures are not covered.

CRITERIA FOR APICOECTOMY

- An apicoectomy procedure can be approved when an anterior tooth with a failing root canal can be made clinically functional by the procedure.

Appendix 12
Endodontic Services
(continued)

MISSING TEETH EXCLUSIONS

Wisconsin Medicaid's definition of missing teeth *excludes*:

- Wisdom teeth.
- Teeth previously extracted for orthodontic reasons.
- Congenitally missing teeth.
- Teeth lost due to trauma, cancer, or rare tumor.

PRIOR AUTHORIZATION DOCUMENTATION

The provider must submit the following information for root canal therapies:

- Complete intraoral tooth charting and periodontal case type.
- Minimum of two bitewing x-rays and periapical x-ray of involved tooth or teeth.
- Attendance information.
- Indication of oral hygiene status.
- Date and reason for any extractions within the past three years.
- A treatment plan including plan for involved tooth or teeth.
- A good success potential for:
  1. Proper completion of the procedure.
  2. Restoration of the tooth.
  3. Maintenance of the endodontically treated tooth (recipients will maintain their oral health).

DENIAL OF ROOT CANAL THERAPY REQUESTS

If the PA request for root canal therapy is denied, the service is noncovered. The recipient:

- Must be informed in advance of treatment that the service is noncovered.
- May be billed for the service only if PA has been denied and the recipient agrees to pay for the service before the service is provided.

Refer to Section VIII of Part A, the all-provider handbook, for more information.

WISCONSIN MEDICAID NONCOVERED MATERIAL AND SERVICES

Wisconsin Medicaid does not cover the following:

- Filling material not accepted by the federal Food and Drug Administration (FDA) (e.g., Sargenti filling material).
- Root canals performed in anticipation of overlay dentures.
- Post and core. Wisconsin Medicaid covers a root canal needing a post and core only if the recipient agrees in advance to pay for the post and core.

Appendix 12
Endodontic Services
(continued)

BILLING

EMERGENCY SERVICES

Emergency services are defined as services that must be provided immediately to relieve pain, swelling, acute infection, trismus, or trauma. Because the ADA claim form does not have an element to designate emergency treatment, all claims for emergency services must be identified by an "E" in the "For Administrative Use Only" box on the line item for the emergency service of the ADA claim form or element 24I of the HCFA 1500 claim form in order to exempt the services from copayment deduction. *Only the letter "E" without any additional letters is accepted.* Information relating to the definition of a dental emergency is in Section II-A of this handbook.

EMC claims use a different field to indicate an emergency. Refer to your EMC manual for more information.

ADDITIONAL INFORMATION

In addition to this summary, refer to:

- The preceding pages for a complete listing of Medicaid-covered endodontic services, procedure codes, and related limitations.
- Appendix 31 for a summary of required billing documentation.
- Appendix 24 for a summary of required documentation needed for PA requests.

Appendix 13
Periodontic Services

Please note that local anesthesia is included in the fee for procedures requiring anesthesia and is not separately billable. When a provider uses anesthesia, the anesthesia charge should be included in the amount billed for the procedure.

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
Surgical Services (including usual postoperative services):				
04210	Gingivectomy or gingivoplasty - per quadrant	Yes	All	Per quadrant of six teeth or more.
04211	Gingivectomy or gingivoplasty, per tooth	Yes	All	Less than six teeth (tooth numbers 1-32, A-T, SN).
04341	Periodontal scaling and root planing, per quadrant	Yes	>12	Per quadrant of eight teeth. (Limited in most circumstances to once per three years per quadrant.) Limited to two quadrants per day in place of service 0, 3, 4, 7, or 8, unless the PA request provides sound medical or other logical reasons, including long distance travel to the dentist or disability makes travel to dentist difficult. Up to four quadrants per day, per recipient in place of service 1, 2, or B. Not billable with prophylaxis.
04355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis	Yes	>12	Full mouth code. Excess calculus must be evident in x-ray. Billed on completion date only. Can be completed in one long appointment. No other periodontal treatment (04341 or 04910) can be authorized immediately after this procedure. Includes tooth polishing. Not billable with prophylaxis. (Once per three years in most circumstances.)

Appendix 13
Periodontic Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
04910	Periodontal maintenance procedures (following active therapy)	Yes	>12	Prior authorization may be granted up to three years. Not billable with prophylaxis. Once per year in most cases.
W7117	Treat ANUG (acute necrotizing ulcerative gingivitis/Vincent's disease)	No	All	Treatment for any or all portions of the mouth. Not tooth specific. *Emergency only.* Limit of $50.00 per day for all emergency procedures done on a single day. Narrative required to override the limitation.
W7118	Treat periodontal abscess	No	All	Tooth numbers 1-32, A-T, SN. *Emergency only.* Limit of $50.00 per day for all emergency procedures done on a single day. Narrative required to override limitation.

Appendix 13
Periodontic Services
(continued)

COVERED SERVICES

GINGIVECTOMY SERVICES

Gingivectomy/gingivoplasty procedures include:

- All pre-operative diagnosis.
- Periodontal charting.
- Surgery, including local anesthetic, post-operative dressings, and follow-up appointments.

PERIODONTAL SCALING AND ROOT PLANING

The procedure includes all pre-operative diagnosis, periodontal charting, treatment, local anesthetic, and post-operative follow-up.

FULL MOUTH DEBRIDEMENT

This scaling procedure is more precise in describing therapy for generalized gingivitis and is not meant to be performed on a routine basis. On completion of treatment, the gingival tissues should be normal and can be maintained by adult prophylaxes on a regular basis. The procedure includes tooth polishing. It is not allowed on the same day as prophylaxes.

PERIODONTAL MAINTENANCE PROCEDURES (FOLLOWING ACTIVE THERAPY)

This procedure follows active periodontal treatment. It includes:

- An update of the medical and dental histories.
- Radiographic review.
- Extraoral and intraoral soft tissue examination.
- Dental examination.
- Periodontal evaluation.
- Removal of the bacterial flora from crevicular and pocket areas.
- Scaling and root planing where indicated.
- Polishing of the teeth.
- A review of the recipient's plaque control efficiency.

Periodontal maintenance is not allowed on the same day as prophylaxes but can be alternated with the prophylaxis procedure to allow the patient to be seen every six months for prophylaxes following active therapy for up to three years following active periodontal treatment.

QUADRANTS

Wisconsin Medicaid defines one quadrant of periodontal procedures as involving eight teeth, regardless of their actual location. For example, periodontal scaling and root planing of two teeth in each of four anatomic quadrants (mandibular left, mandibular right, etc.) constitutes one quadrant of periodontal therapy for approval and reimbursement guidelines.

Four quadrants per day are allowed in inpatient and outpatient hospital and ambulatory surgical center settings. In other settings, only two quadrants are allowed in a day. However, if the recipient has difficulty traveling to dental appointments or if medical or other reasons are *indicated on the prior authorization (PA) request*, then PA for scaling and root planing may be approved up to four quadrants per day, per recipient.

Appendix 13
Periodontic Services
(continued)

PRIOR AUTHORIZATION

PRIOR AUTHORIZATION FOR PERIODONTIC SERVICES

Generally, gingivectomy procedures are approved if greater than 25 percent of the crown is covered with hyperplastic gingiva, and the recipient has a history of medication-induced hyperplasia, puberty gingivitis, familial hereditary hyperplasia, or irritation from orthodontic treatment.

Periodontal scaling and root planing procedures are approved when the periodontal charting demonstrates periodontal pocketing between 4mm and 6mm in depth and history of bleeding, swollen, or infected periodontium (gums). A dental history of long-standing chronic inflammation is not an acceptable criteria for periodontal scaling and root planing.

Periodontal maintenance procedures can be prior authorized:

- Along with the request for scaling and root planing.
- After scaling and root planing has been completed.

Periodontal maintenance procedures are to be alternated with prophylaxes to maintain good oral health for a period of three years following active periodontal therapy.

PRIOR AUTHORIZATION DOCUMENTATION

When submitting PA requests for periodontic services, the following information needs to be included:

- Complete periodontal charting of oral cavity.
- Significant medical and dental history.
- Comprehensive treatment plan for periodontal disease, including treatment, surgery, and postoperative care, including additional prophylaxes as needed.

BILLING

All services done on the same day must be billed on the same claim form. If two claims are submitted, one claim will be denied as a duplicate.

BILLING

EMERGENCY SERVICES

Emergency services are defined as services that must be provided immediately to relieve pain, swelling, acute infection, trismus, or trauma. All claims for emergency services must be identified by an "E" in the "For Administrative Use Only" box on the line item for the emergency service of the ADA claim form or element 24I of the HCFA 1500 claim form in order to exempt the services from copayment deduction. *Only the letter "E" without any additional letters is accepted.* Information relating to the definition of a dental emergency is in Section II-A of this handbook.

Claims submitted electronically use a different field to indicate an emergency. Refer to your Electronic Media Claims (EMC) manual for more information.

Appendix 13
Periodontic Services
(continued)

ADDITIONAL INFORMATION

In addition to this summary, refer to:

- The preceding pages for a complete listing of Medicaid-covered periodontic services, procedure codes, and related limitations.
- Appendix 31 for a summary of required billing documentation.
- Appendix 24 for a summary of required documentation needed for PA requests.

Appendix 14
Removable Prosthodontic Services

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
Complete Dentures (including routine post-delivery care):				
05110	Complete denture - maxillary	Yes	All	Allowed once per five years.*** @
05120	Complete denture - mandibular	Yes	All	Allowed once per five years.*** @
Partial Dentures (including routine post-delivery care):				
05211	Maxillary partial denture - resin base (including any conventional clasps, rests, and teeth)	Yes	All	Allowed once per five years.*** @
05212	Mandibular partial denture - resin base (including any conventional clasps, rests, and teeth)	Yes	All	Allowed once per five years.*** @
W7127	Upgraded upper partial denture (including any conventional clasps, rests, and teeth)	Yes	All	Allowed once per five years.*** @ *No dentist is obligated to provide this service.*
W7128	Upgraded lower partial denture (including any conventional clasps, rests, and teeth)	Yes	All	Allowed once per five years.*** @ *No dentist is obligated to provide this service.*
Repairs to Complete Dentures:				
05510	Repair broken complete denture base	No	All	Combined maximum reimbursement limit per six months for repairs. Requires modifier (UU=Upper, LL=Lower).

Key:

*** - Frequency limitation may be exceeded in exceptional circumstances.

@ - Healing period of six weeks required after last extraction prior to taking impressions for dentures, unless shorter period approved in prior authorization.

Appendix 14
Removable Prosthodontic Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
05520	Repair missing or broken teeth - complete denture (each tooth)	No	All	Combined maximum reimbursement limit per six months for repairs. Requires modifier (UU=Upper, LL=Lower.)
Repairs to Partial Dentures:				
05610	Repair resin denture base	No	All	Limited to once per day. Combined maximum reimbursement limit per six months for repairs. Requires modifier (UU=Upper, LL=Lower).
05620	Repair cast framework	No	All	Combined maximum reimbursement limit per six months for repairs. Requires modifier (UU=Upper, LL=Lower).
05630	Repair or replace broken clasp	No	All	Combined maximum reimbursement limit per six months for repairs. Requires modifier (UU=Upper, LL=Lower).
05640	Replace broken teeth - per tooth	No	All	Combined maximum reimbursement limit per six months for repairs. Requires modifier (UU=Upper, LL=Lower).
05650	Add tooth to existing partial denture	No	All	Combined maximum reimbursement limit per six months for repairs. Requires modifier (UU=Upper, LL=Lower).

Key:

*** - Frequency limitation may be exceeded in exceptional circumstances.

@ - Healing period of six weeks required after last extraction prior to taking impressions for dentures, unless shorter period approved in prior authorization.

Appendix 14
Removable Prosthodontic Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
05660	Add clasp to existing partial denture	No	All	Combined maximum reimbursement limit per six months for repairs. Requires modifier (UU=Upper, LL=Lower).
Denture Reline Procedures:				
05750	Reline complete maxillary denture (laboratory)	Yes	All	Allowed once per three-year period.***
05751	Reline complete mandibular denture (laboratory)	Yes	All	Allowed once per three-year period.***
05760	Reline maxillary partial denture (laboratory)	Yes	All	Allowed once per three-year period.***
05761	Reline mandibular partial denture (laboratory)	Yes	All	Allowed once per three-year period.***
Maxillofacial Prosthetics:				
05932	Obturator prosthesis, definitive	Yes	All	Allowed once per six months.***
05955	Palatal lift prosthesis, definitive	Yes	All	Allowed once per six months.***
05999	Unspecified maxillofacial prosthesis, by report	Yes	All	For medically necessary removable prosthodontic procedures not covered in Appendix 14. Lab bills and narrative required.

Key:

*** - Frequency limitation may be exceeded in exceptional circumstances.

@ - Healing period of six weeks required after last extraction prior to taking impressions for dentures, unless shorter period approved in prior authorization.

Appendix 14
Removable Prosthodontic Services
(continued)

COVERED SERVICES

FREQUENCY LIMITATIONS

Removable prosthodontic services are limited to one new full or partial denture per five years unless unusual circumstances are documented with the prior authorization (PA) request.

LIFE EXPECTANCY OF PROSTHESIS

Generally, given reasonable care and maintenance, a prosthesis should last at least five years.

Unusual circumstances must be documented in the PA request to allow the DHFS to override the five-year limitation. Providers and recipients cannot expect to receive approval for a replacement prosthesis without adequate justification and documentation.

DENTURE INSTRUCTIONS TO RECIPIENTS

As part of any removable prosthetic service, dentists are expected to instruct the recipient on the proper care of the prostheses. Six months of post-insertion follow-up care is included for complete and partial dentures and relining complete and partial dentures.

LOST, STOLEN, OR SEVERELY DAMAGED POLICY

Removable prosthodontic services are provided at considerable program expense. Wisconsin Medicaid does not intend to repeatedly replace lost, severely damaged, or stolen prostheses. PA requests for lost, severely damaged, or stolen prostheses are only approved when:

- The recipient has exercised reasonable care in maintaining the denture.
- The prosthesis was being used up to the time of loss or theft.
- The loss or theft is *not* a repeatedly occurring event.
- A reasonable explanation is given for the loss or theft of the prosthesis.
- A reasonable plan to prevent future loss is outlined by the recipient or the facility where the recipient lives.

HEALING PERIOD AFTER A TOOTH EXTRACTION

The DHFS requires a minimum of six weeks healing after the last tooth extraction occurs before a final impression is made.

A PA request for dentures *can be approved before all teeth are removed*. The six-week healing period must still take place. *If the six-week waiting period does not take place, payment for dentures is denied or recouped*

SHORTER HEALING PERIOD AFTER TOOTH EXTRACTION

A shorter healing period after an extraction may be approved or no healing period may be required if the PA request demonstrates that such approval is appropriate due to medical necessity, an unusual medical condition, that only a few teeth are extracted, or that extracted teeth are in noncritical areas such as the opposing arch.

Wisconsin Medicaid may grant a shortened healing period or require no healing period in limited situations for recipients who are employed with job duties that require public contact. In this situation, a statement from the employer indicating the job duties that require public contact must be included in the PA request.

To have a shorter healing period, a provider must request the shorter period at the same

Appendix 14
Removable Prosthodontic Services
(continued)

time the PA request for dentures is made.

EDENTULOUS RECIPIENT

If a recipient has been totally edentulous for more than five years and has never worn a prosthesis, then no denture is ordinarily approved unless the dentist submits:

- A favorable prognosis.
- An analysis of the oral tissue status (e.g., muscle tone, ridge height, muscle attachments, etc.).
- Justification indicating why a recipient has been without a prosthesis.

If a recipient has not worn an existing prosthesis for three years, no new prosthesis will usually be authorized unless unusual mitigating circumstances are documented and verified.

When a recipient has a history of an inability to tolerate and wear a prosthetic appliance due to psychological or physiological reasons, then a new prosthesis will not be approved.

DENTURE REPAIR/RELINING COVERAGE

REPAIR SERVICES

Wisconsin Medicaid requests that dentists use discretion with denture repairs. Old, worn dentures with severely worn teeth or fractures due to age, should be replaced. A PA request with appropriate documentation must be submitted for replacement dentures.

RELINING DENTURES

Relining complete and partial upper and lower dentures is limited to once every three years. Six months of post-insertion follow-up care is included in reimbursement for complete and partial dentures and relining complete and partial dentures.

COMPLETE DENTURE REPAIRS

Complete denture repairs include:

- Repair of major fractures.
- Repair of broken flanges.
- Replacement of one or two lost denture teeth.

PARTIAL DENTURE REPAIRS

Repairs to damaged partial dentures include:

- Repair of fractured flanges.
- Repair of major fractures.
- Replacing a broken clasp with wrought wire clasps.
- Selective repair or addition of teeth.
- Adding teeth and/or a clasp to a partial denture if it makes the denture functional.

NONCOVERED REPAIRS

The following repairs are not covered by Wisconsin Medicaid:

- Extensive repairs of marginally functional dentures.
- Repairs to a denture when a new denture would be better for the health of the recipient.

Appendix 14
Removable Prosthodontic Services
(continued)

PRIOR AUTHORIZATION

PRIOR AUTHORIZED SERVICES

All removable prosthodontic services, except the repair of a denture, require PA.

MAXILLOFACIAL PROSTHESIS

Palatal lifts prosthesis, obturators for cleft palate, and other maxillofacial prosthesis are covered services with PA. These services should be requested on the PA request in addition to a complete or removable partial denture when clinically appropriate.

INITIAL DENTURES

Providers should note that most PA requests for initial dentures are approved for *eligible* providers and recipients, *unless* the recipient cannot function with dentures due to a medical condition.

FULL DENTURES WITH FEW REMAINING TEETH

Wisconsin Medicaid will consider paying for full dentures when a recipient has only one or two remaining teeth per arch if this treatment would maintain proper anchorage and if the denture could be converted to a full denture by a simple repair in the event of tooth loss. The Medicaid dental consultant determines the appropriateness of this situation.

PARTIAL DENTURES

Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP type I or II), and a favorable prognosis where continuous deterioration of periodontal health is not expected. *Partial dentures are resin based.*

A recipient qualifies for a partial denture if the following criteria are met:

- One or more anterior teeth are missing.
- The recipient has less than two posterior teeth per quadrant in occlusion with the opposing quadrant.
- A combination of one or more anterior teeth are missing, and recipient has less than two posterior teeth per quadrant in occlusion with the opposing quadrant.
- The recipient can accommodate the partial and properly maintain the partial (e.g., no gag reflex, no potential for swallowing the partial, recipient not severely handicapped).
- AAP Type I or II.
- The recipient requires replacement of anterior teeth for employment reasons.
- Medically necessary for nutritional reasons documented by health history or physician.
- Unusual clinical situations where a partial is determined to be necessary based on a comprehensive review of the dental and medical histories.
- Good recipient attendance record.

If placement of a partial denture in an arch provides at least two posterior teeth (posterior teeth are bicuspids and molars only) per quadrant in occlusion with the opposing quadrant, then the opposing partial, if requested, would not be authorized unless recipient also has an anterior tooth missing in that arch.

Partial dentures can be granted to recipients needing partials for employment opportunities

Appendix 14
Removable Prosthodontic Services
(continued)

(refer to qualifications for partial).

DOCUMENTATION

Each PA request for removable prosthesis or relines should explain the individual needs of the recipient, and include the following information:

1. Complete and Partial Dentures.
   - The age of existing prosthesis (if applicable).
   - The date(s) of surgery or edentulation or verification.
   - The adaptability of the recipient. When appropriate, specifically document why a patient is not wearing an existing prosthesis, and why a new prosthesis will eliminate the problem.
   - Speech functions and phonetics documented by a speech therapist.
   - The appropriateness of repairing or relining the existing prosthesis or other alternative service.
   - Occlusal changes as vertical dimension.
   - Any misutilization practice of the recipient.
   - Documented loss or damage of prosthesis requiring replacement, if applicable, and how future loss will be prevented.

2. Partial Dentures
   - Complete periodontal charting and x-rays sufficient to show entire arch in question; the consultant can request additional information such as diagnostic casts on a case-by-case basis.
   - Periodontal status (AAP Type I-V).
   - Oral hygiene status.
   - Attendance record of recipient.
   - Verification that all abscessed or non-restorable teeth have been extracted or are scheduled to be extracted (or the PA request will be returned for extraction dates and appropriate healing period).
   - Verification that all remaining teeth are decay-free or the recipient is scheduled for all restorative procedures.
   - Success potential for proper completion and long-term maintenance of the partial denture.

The DHFS may request additional documentation including a *physician's* statement to verify:

- The medical necessity and appropriateness of the PA request.
- The prosthesis is necessary for proper nourishment and digestion.
- The recipient is physically and psychologically able to wear and maintain the prosthesis.
- The previous dentures have become unserviceable or lost.

Appendix 14
Removable Prosthodontic Services
(continued)

DOCUMENTATION FOR LOST, STOLEN, OR SEVERELY DAMAGED DENTURES

When submitting a PA request involving a lost, stolen, or severely damaged prosthesis, please give special attention to the need for the prosthesis. The request must include a police report, accident report, fire report, or hospital, nursing home, or group home (community-based residential facility) administrator statement or recipient statement on the loss. Such statements should include how, when, and where the prosthesis was lost or damaged, and what attempts were made to recover the loss and plans to prevent future loss.

PALATAL LIFT PROSTHESIS DOCUMENTATION

PA requests for palatal lift prostheses must include a speech pathologist's or physician's statement to document that a speech impediment exists.

MAXILLOFACIAL PROSTHESIS DOCUMENTATION

All maxillofacial prostheses require PA. Maxillofacial prostheses are approved based on medical necessity and appropriateness on a case-by-case basis.

UPGRADED PARTIAL DENTURES DOCUMENTATION

In response to requests by some dentists for coverage of higher quality partial dentures, Wisconsin Medicaid reimburses dentists for providing upgraded partial dentures. Due to fiscal limitations, and federal and state regulations, the following policy regarding these services has been established:

- PA is always required.
- Reimbursement is at the maximum fee for the "standard" resin-base partial denture.
- Reimbursement must be accepted as payment in full.
- Each dental office that provides the service must have written criteria based on medical necessity to determine who receives the upgraded service.
- The form in Appendix 25 of this handbook must be completed and attached to the Prior Authorization Dental Request Form (PA/DRF) and Prior Authorization Dental Attachment (PA/DA).
- All criteria must be applied consistently to all Medicaid recipients.

No dentist is under any obligation to provide upgraded partial dentures.

TRAUMATIC LOSS OF TEETH FOR RECIPIENTS UNDER AGE 21

When traumatic loss of one or more anterior teeth (tooth numbers 6-11, 22-27) occurs and partial dentures are required, a PA must be submitted.

BACKDATING PRIOR AUTHORIZATION REQUESTS

Where the service is identified as urgent in character, backdating the PA request to the date the request is received by the fiscal agent may be appropriate.

A request for backdating will be approved only if:

- The PA request specifically requests backdating.
- The clinical justification for beginning the service before PA is included.
- The request is received by the fiscal agent within 14 calendar days of the start of provision of services.

Appendix 14
Removable Prosthodontic Services
(continued)

BILLING INFORMATION

BILLING FOR PARTIAL AND COMPLETE DENTURES

When billing for partial and complete dentures:

- Dentists are required to list the date that the final impressions were taken as the date of service.
- Recipients must be eligible on the date the final impressions are taken in order for the denture service to be covered. Providers will be asked to verify this date through progress notes if eligibility issues arise.

REIMBURSEMENT FOR REPAIRS

Wisconsin Medicaid reimburses a maximum amount per recipient, per denture, per six-month period for the repair of partial or complete dentures.

If laboratory costs exceed the maximum reimbursement allowed, dentists may submit a claim or adjustment request with laboratory bills.

ADDITIONAL INFORMATION

In addition to this summary, refer to:

- The preceding pages for a complete listing of Medicaid-covered removable prosthodontic services, procedure codes, and related limitations.
- Appendix 31 for a summary of required billing documentation.
- Appendix 24 for a summary of required documentation needed for PA requests.

Appendix 15
Fixed Prosthodontic Services

Please note that local anesthesia is included in the fee for procedures requiring anesthesia and is not separately billable. When a provider uses anesthesia, the anesthesia charge should be included in the amount billed for the procedure.

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
Other Fixed Prosthetic Services:				
06545	Retainer - cast metal for resin-bonded fixed prosthesis	Yes	All	Tooth numbers 1-32, SN only.
06930	Recement fixed partial denture	No	All	
06940	Stress breaker	Yes	All	Copy of lab bill required.
06980	Fixed partial denture repair, by report	Yes	All	Copy of lab bill required.
W7310	Fixed prosthodontic retainer	Yes	All	Tooth numbers 1-32, SN only.
W7320	Fixed prosthodontic pontic	Yes	All	Tooth numbers 1-32, SN only.

Appendix 15
Fixed Prosthodontic Services
(continued)

COVERED SERVICES

DEFINITION

Fixed prosthodontic services include fixed prosthodontic or acid etch retainers, pontics, repairing damaged fixed bridges, and permanently recementing fixed bridges.

The recementing of a fixed bridge, either of acid-etch retainer type or conventional crown/inlay/onlay retainers, is limited to permanent cementation.

PRIOR AUTHORIZATION

FIXED PROSTHODONTIC SERVICES

Prior authorization (PA) is required for fixed bridge retainers, pontics, and acid etch retainers. Coverage is limited to recipients who cannot safely wear a removable partial denture due to a preexisting medical condition.

PA requests for fixed prosthetic services are only considered when the following criteria can be documented:

- The recipient cannot wear a removable partial or complete denture.
- The recipient has periodontally healthy teeth.
- The recipient has good oral hygiene.

BRIDGE REPAIR

Repairing a fixed bridge requires PA. The PA requests for the repair of a fixed prosthetic device are only considered when the following criteria can be documented:

- The fixed bridge is functional.
- The recipient has periodontally healthy teeth.
- The recipient has good oral hygiene.

FIXED PROSTHODONTIC PRIOR AUTHORIZATION REQUEST DOCUMENTATION

The following documentation must be submitted with a PA request for a fixed prosthodontic appliance:

- A minimum of periodontal charting and periapical radiographs of all abutment teeth.
- A periodontal status and oral hygiene status.
- An explanation of unsuccessful wearing or attempt to wear a removable prosthetic appliance.

If necessary, a study cast may be requested by Wisconsin Medicaid.

ADDITIONAL INFORMATION

In addition to this summary, refer to:

- The preceding pages for a complete listing of Medicaid-covered fixed prosthodontic services, procedure codes, and related limitations.
- Appendix 31 for a summary of required billing documentation.
- Appendix 24 for a summary of required documentation needed for PA requests.

Appendix 16
Oral and Maxillofacial Surgery Services

Please note that local anesthesia is included in the fee for procedures requiring anesthesia and is not separately billable. When a provider uses anesthesia, the anesthesia charge should be included in the amount billed for the procedure.

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
Extractions (includes local anesthesia and routine postoperative care):				
07110	Single tooth	No	All	Allowed only once per tooth (tooth numbers 1-32, A-T, SN). Not billable same day as 07250.
Surgical Extractions (includes local anesthesia and routine postoperative care):				
07210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	No	All	Allowed only once per tooth. Covered when performing an *emergency* service or with PA for orthodontia (tooth numbers 1-32, A-T, SN).[1] Not billable same day as 07250.
07220	Removal of impacted tooth - soft tissue	No	All	Allowed only once per tooth. Covered when performing an *emergency service* or with PA for orthodontia (tooth numbers 1-32, A-T, SN).[1] Not billable same day as 07250.
07230	Removal of impacted tooth - partial bony	No	All	Allowed only once per tooth. Covered when performing an *emergency service* or with PA for orthodontia (tooth numbers 1-32, A-T, SN).[1] Not billable same day as 07250.
07240	Removal of impacted tooth - completely bony	No	All	Allowed only once per tooth. Covered when performing an *emergency service* or with PA for orthodontia (tooth numbers 1-32, A-T, SN).[1] Not billable same day as 07250.

Key:

[1] - Retain records in recipient files regarding nature of emergency.

[2] - Providers who are Wisconsin Medicaid certified as oral surgeons or oral pathologists or choose CPT billing must use a CPT code to bill for this procedure. Refer to Appendix 19 for a list of covered CPT procedure codes.

** - Frequency limitation may be exceeded if a narrative on the claim demonstrates medical necessity for additional services.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
07250	Surgical removal of residual tooth roots (cutting procedure)	No	All	*Emergency only* (tooth numbers 1-32, A-T, SN).[1] Allowed only once per tooth. Not allowed on the same day as tooth extraction of same tooth number.
Other Surgical Procedures:				
07260 or CPT[2]	Oroantral fistula closure	No	All	
07270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus	No	All	*Emergency only*(tooth numbers 1-32, C-H, M-R, SN).[1]
07280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments)	Yes	< 21	HealthCheck referral is required. Not allowed for primary or wisdom teeth (tooth numbers 2-15, 18-31, SN only).
07281	Surgical exposure of impacted or unerupted tooth to aid eruption	Yes	< 21	HealthCheck referral is required. Not allowed for wisdom teeth (tooth numbers 2-15, 18-31, A-T, SN only).
07285 or CPT[2]	Biopsy of oral tissue - hard	No	All	Once per day.**
07286 or CPT[2]	Biopsy of oral tissue - soft	No	All	Once per day.**

Key:

[1] - Retain records in recipient files regarding nature of emergency.

[2] - Providers who are Wisconsin Medicaid certified as oral surgeons or oral pathologists or choose CPT billing must use a CPT code to bill for this procedure. Refer to Appendix 19 for a list of covered CPT procedure codes.

** - Frequency limitation may be exceeded if a narrative on the claim demonstrates medical necessity for additional services.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
Removal of Tumors, Cysts, and Neoplasms:				
07430 or CPT[2]	Excision of benign tumor - lesion diameter up to 1.25 cm	No	All	Once per day.**
07431 or CPT[2]	Excision of benign tumor - lesion diameter greater than 1.25 cm	No	All	Once per day.**
07440 or CPT[2]	Excision of malignant tumor - lesion diameter up to 1.25 cm	No	All	Pathology report required.
07441 or CPT[2]	Excision of malignant tumor - lesion diameter greater than 1.25 cm	No	All	Pathology report required.
07450 or CPT[2]	Removal of odontogenic cyst or tumor - lesion diameter up to 1.25 cm	No	All	Pathology report required.
07451 or CPT[2]	Removal of odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	No	All	Pathology report required.
07460 or CPT[2]	Removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	No	All	Pathology report required.
07461 or CPT[2]	Removal of nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	No	All	Pathology report required.

Key:

[1] - Retain records in recipient files regarding nature of emergency.

[2] - Providers who are Wisconsin Medicaid certified as oral surgeons or oral pathologists or choose CPT billing must use a CPT code to bill for this procedure. Refer to Appendix 19 for a list of covered CPT procedure codes.

** - Frequency limitation may be exceeded if a narrative on the claim demonstrates medical necessity for additional services.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
Excision of Bone Tissue:				
07470 or CPT[2]	Removal of exostosis - maxilla or mandible	Yes	All	Operative report required.
07480 or CPT[2]	Partial ostectomy (guttering or saucerization)	No	All	Operative report required.
07490 or CPT[2]	Radical resection of mandible with bone graft	No	All	Operative report required. Only allowable in place of service 0, 1, 2, or B.
Surgical Incision:				
07510 or CPT[2]	Incision and drainage of abscess - intraoral soft tissue	No	All	Operative report required. Not to be used for periodontal abscess - use W7118.
07520 or CPT[2]	Incision and drainage of abscess - extraoral soft tissue	No	All	Operative report required.
07530 or CPT[2]	Removal of foreign body, skin, or subcutaneous areolar tissue	Yes, unless provided to hospital inpatient	All	Not allowed for root fragments or bone spicules. Operative report required.
07540 or CPT[2]	Removal of reaction-producing foreign bodies - musculoskeletal system	Yes, unless provided to hospital inpatient	All	Not allowed for root fragments or bone spicules. Operative report required.
07550 or CPT[2]	Sequestrectomy for osteomyelitis	No	All	Operative report required.
07560 or CPT[2]	Maxillary sinusotomy for removal of tooth fragment or foreign body	No	All	Operative report required.

Key:

[1] - Retain records in recipient files regarding nature of emergency.

[2] - Providers who are Wisconsin Medicaid certified as oral surgeons or oral pathologists or choose CPT billing must use a CPT code to bill for this procedure. Refer to Appendix 19 for a list of covered CPT procedure codes.

** - Frequency limitation may be exceeded if a narrative on the claim demonstrates medical necessity for additional services.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
Treatment of Fracture - Simple:				
07610 or CPT[2]	Maxilla - open reduction (teeth immobilized, if present)	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.
07620 or CPT[2]	Maxilla - closed reduction (teeth immobilized, if present)	No	All	Operative report required.
07630 or CPT[2]	Mandible - open reduction (teeth immobilized, if present)	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.
07640 or CPT[2]	Mandible - closed reduction (teeth immobilized, if present)	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.
07650 or CPT[2]	Malar and/or zygomatic arch - open reduction	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.
07660 or CPT[2]	Malar and/or zygomatic arch - closed reduction	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.
07670 or CPT[2]	Alveolus - stabilization of teeth, open reduction splinting	No	All	Operative report required.
07680 or CPT[2]	Facial bones - complicated reduction with fixation and multiple surgical approaches	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.

Key:

[1] - Retain records in recipient files regarding nature of emergency.

[2] - Providers who are Wisconsin Medicaid certified as oral surgeons or oral pathologists or choose CPT billing must use a CPT code to bill for this procedure. Refer to Appendix 19 for a list of covered CPT procedure codes.

** - Frequency limitation may be exceeded if a narrative on the claim demonstrates medical necessity for additional services.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
Treatment of Fractures - Compound:				
07710 or CPT[2]	Maxilla - open reduction	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.
07720 or CPT[2]	Maxilla - closed reduction	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.
07730 or CPT[2]	Mandible - open reduction	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.
07740 or CPT[2]	Mandible - closed reduction	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.
07750 or CPT[2]	Malar and/or zygomatic arch - open reduction	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.
07760 or CPT[2]	Malar and/or zygomatic arch - closed reduction	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.
07770 or CPT[2]	Alveolus - stabilization of teeth, open reduction splinting	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.
07780 or CPT[2]	Facial bones - complicated reduction with fixation and multiple surgical approaches	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.

Key:

[1] - Retain records in recipient files regarding nature of emergency.

[2] - Providers who are Wisconsin Medicaid certified as oral surgeons or oral pathologists or choose CPT billing must use a CPT code to bill for this procedure. Refer to Appendix 19 for a list of covered CPT procedure codes.

** - Frequency limitation may be exceeded if a narrative on the claim demonstrates medical necessity for additional services.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
Reduction of Dislocation and Management of Other TMJ Dysfunctions:				
07810 or CPT[2]	Open reduction of dislocation	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.
07820 or CPT[2]	Closed reduction of dislocation	No	All	Once per day.**
07830 or CPT[2]	Manipulation under anesthesia	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.
07840 or CPT[2]	Condylectomy	Yes	All	Multidisciplinary TMJ evaluation required. Only allowable in place of service 1, 2, or B. No operative report required.
07850 or CPT[2]	Surgical discectomy; with/without implant	Yes	All	Multidisciplinary TMJ evaluation required. Only allowable in place of service 1, 2, or B. No operative report required.
07860 or CPT[2]	Arthrotomy	Yes	All	Multidisciplinary TMJ evaluation required. Only allowable in place of service 1, 2, or B. No operative report required.
W7995	Initial consultation, TMJ (TMJ multi-disciplinary evaluation program use only)	No	All	Multidisciplinary TMJ evaluation required. Only allowable in place of service 1, 2, or B. No operative report required.
W7996	Follow-up consultation, TMJ (TMJ multidisciplinary evaluation program use only)	No	All	Allowed once per year, per multidisciplinary TMJ evaluation program. Allowable in place of service 1, 2, or 3.

Key:

[1] - Retain records in recipient files regarding nature of emergency.

[2] - Providers who are Wisconsin Medicaid certified as oral surgeons or oral pathologists or choose CPT billing must use a CPT code to bill for this procedure. Refer to Appendix 19 for a list of covered CPT procedure codes.

** - Frequency limitation may be exceeded if a narrative on the claim demonstrates medical necessity for additional services.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
W7998 or CPT[2]	TMJ assistant surgeon	Yes	All	Procedure must be included in PA request for the surgery itself. Only allowable in place of service 1, 2, or B.
Repair of Traumatic Wounds:				
07910 or CPT[2]	Suture of recent small wounds up to 5 cm	No	All	*Emergency only* -operative report required.
Complicated Suturing (reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure):				
07911 or CPT[2]	Complicated suture - up to 5 cm	No	All	Covered for *trauma (emergency) situations only*[1]. Operative report required.
07912 or CPT[2]	Complicated suture - greater than 5 cm	No	All	Covered for *trauma (emergency) situations* only.[1] Once per day.** No operative report required, unless same day as surgery.
Other Repair Procedures				
07940 or CPT[2]	Osteoplasty - for orthognathic deformities	Yes	< 21	HealthCheck referral required. Only allowable in place of service 1, 2, or B. No operative report required.
07950 or CPT[2]	Osseous, osteo-periosteal, or cartilage graft of the mandible or facial bones - autogenous or nonautogenous, by report	Yes	All	Multidisciplinary TMJ evaluation required. Only allowable in place of service 1, 2, 3, or B. No operative report needed.

Key:

[1] - Retain records in recipient files regarding nature of emergency.

[2] - Providers who are Wisconsin Medicaid certified as oral surgeons or oral pathologists or choose CPT billing must use a CPT code to bill for this procedure. Refer to Appendix 19 for a list of covered CPT procedure codes.

** - Frequency limitation may be exceeded if a narrative on the claim demonstrates medical necessity for additional services.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
07960 or CPT[2]	Frenulectomy (frenectomy or frenotomy) - separate procedure	Yes	< 21	HealthCheck referral required. No operative report needed.
07970 or CPT[2]	Excision of hyperplastic tissue - per arch	Yes	All	No operative report needed.
07980 or CPT[2]	Sialolithotomy	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.
07991 or CPT[2]	Coronoidectomy	Yes	All	Multidisciplinary TMJ evaluation required. Only allowable in place of service 1, 2, or B. No operative report needed.
07999 or CPT[2]	Unspecified oral surgery procedure, by report	Yes	All	For medically necessary oral and maxillofacial procedures not included in Appendix 16. Does not include alveoplasty, vestibuloplasty, or other procedures not covered by Wisconsin Medicaid. Operative report required.

Key:

[1] - Retain records in recipient files regarding nature of emergency.

[2] - Providers who are Wisconsin Medicaid certified as oral surgeons or oral pathologists or choose CPT billing must use a CPT code to bill for this procedure. Refer to Appendix 19 for a list of covered CPT procedure codes.

** - Frequency limitation may be exceeded if a narrative on the claim demonstrates medical necessity for additional services.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

ORAL AND MAXILLOFACIAL SURGERY EXCEPT TMJ

COVERED SERVICES

DEFINITION

Wisconsin Medicaid may cover oral and maxillofacial surgical services due to trauma or congenital malformations such as clefts, or the removal of pathologic, painful, or non-restorable teeth. Corrective congenital surgery, such as orthognathic surgery, is limited to specific cases due to severe handicapping malocclusions.

SURGICAL EXTRACTION OF A TOOTH

Surgical extraction of a tooth is covered only when an extraction is necessary due to:

- An emergency which is a situation when an immediate service must be provided to relieve the recipient from pain, an acute infection, swelling, fever, or trauma.
- Orthodontia (for children up to age 21). In this case, prior authorization (PA) should be requested for the surgical extraction of a tooth in a non-emergency situation.

If during the routine extraction of any tooth the extraction unexpectedly becomes a surgical extraction, the surgical extraction is considered a dental emergency and will be covered. The procedure should be billed as an emergency and documentation of the circumstances must be kept in the recipient's records.

REPLANTATION AND SPLINTING

The replantation and splinting of a traumatically avulsed or subluxated tooth:

- Includes the post-operative follow-up.
- Includes the removal of any splints and wires.
- *Does not include any root canal therapy for the involved teeth*

SUTURING

Suturing is:

- A covered benefit only when it is a result of a trauma.
- Not separately reimbursable when it is part of the surgery. In this case, it is included in the surgical procedure and fee.

When billing for suturing, the provider must include an operative report accurately describing the procedure, complexity of closure, location of laceration, and length of laceration(s) repaired.

PRIOR AUTHORIZATION

GENERAL INFORMATION

A study model may be requested by the dental consultant to aid in evaluating any PA request.

SURGICAL EXPOSURE OF AN IMPACTED OR UNERUPTED TOOTH

The surgical exposure of an impacted or unerupted tooth for orthodontic reasons includes placement of any hooks, wires, pins, etc., to aid eruption through orthodontics. This service includes placement of any orthodontic appliance on the impacted tooth.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

The documentation required for submitting the PA request is:

- A HealthCheck exam (the HealthCheck provider signature is required).
- A periapical radiograph of the tooth.

SURGICAL EXPOSURE OF A TOOTH TO AID ERUPTION

For the surgical exposure of a tooth to aid eruption, the tooth must be impacted by an adjacent tooth and not close to natural eruption. This service can be requested for primary and permanent teeth.

This service does *not* include placement of any hooks, wires, pins, etc., to aid eruption through orthodontics.

The documentation required for submitting the PA request is:

- A HealthCheck referral.
- A periapical radiograph of the tooth.

REMOVAL OF EXOSTOSIS MAXILLAE OR MANDIBLE

Criteria for PA approval include one of the following:

- The exostosis presents an undesirable undercut.
- The exostosis presents problems with insertion or stability of prosthesis.
- Medically necessary due to the presence of pain caused by the insertion or wearing of a removable prosthesis.

REMOVAL OF FOREIGN BODY

Removal of foreign body requires one periapical x-ray to accompany the PA request.

OSTEOPLASTY/ OSTEOTOMY

Osteoplasty/osteotomy for orthognathic deformities is provided for only the most severe orthodontic skeletal malocclusion. PA requests for correction of orthognathic deformities require a HealthCheck referral. Criteria for approval include one of the following:

- To correct the most severe cases of protruding or retruding mandible or maxillae where conventional orthodontics cannot provide a stable and acceptable outcome.
- To correct the most severe cases of open bite where conventional orthodontics cannot provide a stable and acceptable outcome.
- To correct a significant skeletal malocclusion where conventional orthodontics cannot provide a stable and acceptable outcome.
- To correct severe malocclusions caused by disease or injury where conventional orthodontics cannot provide a stable and acceptable outcome.

If the deformity has been caused by disease or injury, a physician's statement is required.

A HealthCheck referral is required for PA approval. The criteria for approval include a frenum which creates a central incisor diastema, ankyloglossia, periodontal defects, removable prosthodontic impairment, or is necessary to complete orthodontic services.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

EXCISION OF HYPERPLASTIC TISSUE

For the excision of hyperplastic tissue (per arch), the recipient must have an edentulous ridge and have difficulty wearing a prosthesis. The recipient must have adequate healing after tooth extraction before requesting this service. The service includes all local anesthetic, suturing, post-operative care, and soft tissue conditioning of any appliances at the time of surgery.

TMJ SURGERY

DEFINITION

The TMJ office visit requires detailed and extensive examination and documentation of the recipient's TMJ dysfunction.

A TMJ office visit consists of:

- A comprehensive history.
- Clinical examination.
- Diagnosis.
- Treatment planning.

INITIAL TREATMENT

The initial treatment of a TMJ dysfunction must consist of non-surgical treatments which include:

- Short-term medication.
- Home therapy (e.g., soft diet).
- Splint therapy.
- Physical therapy, including correction of myofunctional habits.
- Relaxation or stress management techniques.
- Psychological evaluation or counseling.

The non-surgical TMJ treatments are not covered by Wisconsin Medicaid

EVALUATION FOR TMJ SURGERY

When non-surgical TMJ therapy has failed to reduce TMJ dysfunction and pain, the recipient may request TMJ surgery. An oral and maxillofacial surgeon or physician surgeon can submit a PA request for TMJ surgery. The request must include an evaluation by a Department of Health and Family Services (DHFS)-approved Multidisciplinary TMJ Evaluation Program. A listing of the approved TMJ multi-disciplinary evaluation program sites is in Appendix 6 of this handbook. The initial TMJ consultation can be billed by the dentist performing the dental evaluation component of the evaluation program.

A follow-up consultation may be billed if necessary to clarify or review the findings and conclusions of the initial consultation.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

This evaluation must be provided by a facility not previously involved with the treatment of the recipient. The multi-disciplinary evaluation includes:

- A dental evaluation conducted by an oral and maxillofacial surgeon, orthodontist, or general practice dentist.
- A physical evaluation conducted by a neurologist, psychiatrist, or other physician knowledgeable regarding TMJ therapies.
- A psychological evaluation conducted by a psychiatrist or psychologist.

PRIOR AUTHORIZATION

TMJ EVALUATION

Documentation of the evaluation conclusions (including dentist's and physician's) must be included when the PA request is being submitted. All PA requests submitted for TMJ surgery must include a second opinion evaluation by a DHFS-approved multidisciplinary center. A PA request received without a multi-disciplinary evaluation will be returned. Only TMJ surgeries with favorable prognosis for surgery are considered for approval.

To adequately provide a second opinion, the multidisciplinary center must have the necessary dental records on hand before seeing the recipient. The following materials must be at the second opinion location *before* the recipient's consultation visit:

- Any imaging procedures completed (MRI reports, x-rays, etc.).
- Operative notes addressing symptoms, findings, and diagnosis.
- Documentation of conservative care performed, including any occupational or physical therapy notes.
- Operative plan.
- Three to six-month postoperative plan of care.

TMJ CRITERIA FOR APPROVAL

PA criteria for approval include:

- Documentation of American Association of Oral and Maxillofacial Surgeries criteria.
- Documentation of second opinion.
- Favorable prognosis for surgery verified by second opinion.

ALL ORAL AND MAXILLOFACIAL SURGERY SERVICES BILLING

PRE- AND POST-CARE DAYS

Reimbursement for procedures directly related to an oral surgery is incorporated into reimbursement for the oral surgery procedure.

Palliative treatment, application of desensitizing medicaments, and other related procedures are not allowed at least three days before and 10 or more days after the surgery. Other procedures that are directly related to the surgery are not to be billed separately, no matter when the procedure is billed.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

However, if the procedure is not directly related to oral surgery, the limitation can be overridden with a narrative demonstrating that fact on the claim form. For example, the procedure may be done on a separate section of the mouth than the oral surgery.

ONE PER DAY LIMITATION

Many oral surgeries are limited to once per day. This limitation may be exceeded if narrative on the claim form demonstrates the additional services were medically necessary.

ADA/CPT ORAL SURGERY BILLING OPTIONS

Medicaid-certified dentists can select the procedure coding system they want to use for billing all oral surgery codes that do not require a tooth letter or number. Dentists can select either:

- The American Dental Association (ADA) Current Dental Terminology.
- The *Physicians' Current Procedural Terminology* (CPT).

The narrative below outlines the way that oral surgery procedure code billing is automatically assigned to dentists and provides an opportunity for dentists to choose a different billing system than they are assigned.

ASSIGNMENT OF ORAL SURGERY BILLING

Assignment of oral surgery billing depends on the dental specialty chosen during Medicaid certification. This assignment is necessary because it provides the fiscal agent's computers both a systematic way to identify the oral surgery procedure codes a provider can bill and a way to ensure accurate reimbursement.

SPECIALTIES BILLING CPT

This means that dentists with the following specialties are required to bill CPT procedure codes for oral surgeries that do not require tooth modifiers:

- Oral surgeons.
- Oral pathologists.
- Other dentists who indicate they want to bill CPT codes (using the form in Appendix 2 of this handbook).

SPECIALTIES BILLING ADA

The following specialties are required to bill ADA procedure codes for all oral surgeries:

- Endodontic.
- Orthodontics.
- Periodontics.
- Oral surgeons/pathologists who indicate they want to use ADA codes (using the form in Appendix 2 of this handbook).
- General practice.
- Pedodontics.
- Prosthodontics.

The chart in Appendix 2 of this handbook provides further clarification of this policy.

CHOOSING DIFFERENT BILLING

Any dentist who wants to elect a different billing specialty than currently chosen may do so by completing the form in Appendix 2 of this handbook.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

MD/DDS

When a provider is licensed as both a D.D.S. and M.D., Wisconsin Medicaid encourages the provider to enroll as a dentist (provider type 27 - oral surgery specialty 041).

IDENTICAL POLICIES AND REIMBURSEMENT FOR ALL DENTISTS

All dentists, regardless of specialty:

- Receive the same reimbursement for the same procedures.
- Have virtually the same program limitations, such as PA requirements, for the same procedures.
- Will bill all other dental (non-surgical) procedures using ADA procedure codes and a few Wisconsin Medicaid HCPCS local procedure codes (W codes).
- Must bill for all oral surgeries using the code system assigned at certification or chosen by completing the attached form.
- Cannot temporarily alternate between coding systems, using different procedure codes on different days.
- Can change their designated coding system anytime by completing the attached form.
- Will find that CPT billing requires fewer attachments and is easier to bill electronically.

DECREASED ATTACHMENTS AND CLAIMS PROCESSING TIME

The CPT coding system is more precise than the ADA coding system for describing the same oral surgery procedures. Therefore, most CPT codes do not require operative and pathology reports for manual pricing by the Medicaid dental consultant as well as the additional time needed for processing manually priced claims. This will facilitate electronic billing.

ORAL SURGERY BILLING USING ADA PROCEDURE CODES

ADA PROCEDURE CODES

The ADA and local HCPCS oral surgery procedure codes that are covered by Wisconsin Medicaid are listed in Appendix 16 of this handbook.

WISCONSIN MEDICAID CLAIM FORM

When ADA and HCPCS codes are used to bill Wisconsin Medicaid, the ADA claim form must be used.

ASSISTING SURGEON

Dentists billing ADA procedure codes will need to bill for the assisting surgeon as follows:

- If a procedure requires PA and an assisting surgeon will be used, request approval for both at the same time.
- Use the prior authorized TMJ assisting surgeon code (W7998) for TMJ surgery.
- With PA, surgical assistance may be paid under procedure code 07999.

ORAL SURGERY BILLING USING CPT PROCEDURE CODES FOR PROCEDURES THAT ARE NOT TOOTH SPECIFIC

CPT PROCEDURES

Appendix 19 of this handbook contains a complete list of all the CPT procedure codes that are covered in Wisconsin Medicaid dental benefit. Oral surgeons, oral pathologists, and dentists electing CPT billing use these codes instead of the ADA oral surgery codes that do not require tooth modifiers.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

HCFA 1500

The HCFA 1500 claim form must be used when using a CPT procedure code for billing. If a dentist provides both ADA and CPT procedures for a single patient, both may be billed on the HCFA 1500 claim form. The only ADA codes that cannot be billed on the HCFA 1500 claim form are restorative codes that require tooth surface information. Appendix 29 of this handbook contains HCFA 1500 billing instructions.

DIAGNOSIS

An *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code is always required in element 21 when using CPT codes on the HCFA 1500 claim form.

ASSISTING SURGEON

An assisting surgeon is allowed for some complex surgery procedures as noted on the chart in Appendix 19 of this handbook. To bill for an assisting surgeon, put the modifier "80" in element 24I of the HCFA 1500. If a procedure requires PA and an assisting surgeon will be used, request approval for both at the same time.

TMJ SURGERY PROCEDURES AND MANAGED CARE PROGRAMS

Medicaid-contracted managed care programs that cover dental services are responsible for providing a multidisciplinary evaluation at a facility of their choice to determine the necessity of TMJ surgery. If the surgery is approved, the managed care program may designate the facility at which the surgery is performed. The managed care program is responsible for paying the cost of the surgery and all related services (e.g., hospitalization, anesthesiology).

Wisconsin Medicaid does not reimburse for a TMJ surgery billed by a dentist on a fee-for-service basis when provided to a Medicaid recipient enrolled in a Medicaid-contracted managed care program which covers dentistry. Therefore, dentists must participate in or obtain a referral from the recipient's managed care program since the managed care program is responsible for paying the cost of all services. Failing to obtain a managed care program referral may result in a denial of payment for services by the managed care program. Refer to the Wisconsin Medicaid Managed Care Guide for more information.

If a Medicaid-contracted managed care program does *not* cover dental services, the multidisciplinary evaluation must be performed at a multidisciplinary evaluation facility designated by the DHFS. The dentist may submit a PA request to the fiscal agent and, if approved, the dental surgeon is reimbursed for the evaluation on a fee-for-service basis.

- Refer to the Wisconsin Medicaid Managed Care Guide and Appendices 20, 21, and 22 of Part A, the all-provider handbook, for a list of Medicaid-contracted managed care programs and services that can be billed fee-for-service.
- If surgery is recommended and the PA is approved, the managed care program is responsible for paying the cost of all related medical and hospital services and may therefore designate the facility at which the surgery is performed.
- The dentist must work closely with the managed care program to ensure continuity of coverage.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

EMERGENCY SERVICES

Emergency services are defined as services that must be provided immediately to relieve pain, swelling, acute infection, trismus, or trauma. Because the ADA claim form does not have an element to designate emergency treatment, all claims for emergency services must be identified by an "E" in the "For Administrative Use Only" box on the line item for the emergency service of the ADA claim form or element 24I of the HCFA 1500 claim form in order to exempt the services from copayment deduction. *Only the letter "E" without any additional letters is accepted.* Information relating to the definition of a dental emergency is in Section II-A of this handbook.

EMC claims use a different field to indicate an emergency. Refer to your EMC manual for more information.

ADDITIONAL INFORMATION

In addition to this summary, refer to:

- The preceding pages for a complete listing of Medicaid-covered oral and maxillofacial surgery services, procedure codes, and related limitations.
- Appendix 31 of this handbook for a summary of required billing documentation.
- Appendix 24 of this handbook for a summary of required documentation needed for PA requests.

Appendix 17
Orthodontic Services

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
08110	Removable appliance therapy, minor treatment for tooth guidance	Yes	< 21	HealthCheck referral required.
08120	Fixed appliance therapy, minor treatment for tooth guidance	Yes	< 21	HealthCheck referral required.
08210	Removable appliance therapy	Yes	< 21	HealthCheck referral required.
08220	Fixed appliance therapy	Yes	< 21	HealthCheck referral required.
08360	Interceptive orthodontic treatment, removable appliance therapy	Yes	< 21	HealthCheck referral required.
08370	Fixed appliance therapy, interceptive orthodontic treatment	Yes	< 21	HealthCheck referral required.
08560	Monthly treatment - comprehensive orthodontic treatment - permanent dentition, Class I malocclusion	Yes	< 21	HealthCheck referral required.
08570	Monthly treatment - comprehensive orthodontic treatment - permanent dentition, Class II malocclusion	Yes	< 21	HealthCheck referral required.
08580	Monthly treatment - comprehensive orthodontic treatment - permanent dentition, Class III malocclusion	Yes	< 21	HealthCheck referral required.

Appendix 17
Orthodontic Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
08650	Monthly treatment of atypical or extended skeleton cases, orthodontic	Yes	< 21	HealthCheck referral required.
W7910	Examination, models, consultation - orthodontic	Yes	< 21	HealthCheck referral required.
W7920	Initial orthodontic treatment - banding service	Yes	< 21	HealthCheck referral required.
08750	Post-treatment stabilization	Yes	< 21	HealthCheck referral required.

Appendix 17
Orthodontic Services
(continued)

COVERED SERVICES

DEFINITION

Orthodontic services are covered for interceptive orthodontic services to minimize future malocclusion during the developmental phases of the mixed dentition and to provide comprehensive orthodontic service due to handicapping malocclusion causing speech, eating/ mastication, or psychological problems.

HEALTHCHECK REQUIREMENT

Orthodontia treatment is available only through the HealthCheck program and is not available to adults over age 20 (the HealthCheck provider signature is required).

RECIPIENT ELIGIBILITY FOR COMPLETION OF ORTHODONTIC TREATMENT

Regardless of recipient eligibility, all approved orthodontic services, once started (bands placed during a period of eligibility) are reimbursed to completion of the approved services performed by a certified provider.

If an orthodontia patient becomes Medicaid-eligible in mid-treatment, Wisconsin Medicaid will approve a prior authorization (PA) request for continued services if all PA criteria are met.

FIXED OR REMOVABLE APPLIANCE THERAPY SERVICES

MINOR TOOTH GUIDANCE

This service is for correction of a minor malocclusion in which one to four teeth are involved. The service is considered especially for children under the age of 12 in the mixed dentition stage of development.

HARMFUL HABIT CORRECTING

This service is for correction of harmful habit such as thumb, finger, tongue or lip sucking and is considered especially for children under the age of 12 in the mixed dentition stage of development.

If this procedure is coordinated with any behavioral modification, either by the dentist or by another health care provider, it must be documented on the PA request.

INTERCEPTIVE ORTHODONTIC TREATMENT

This service is for the correction of a minor malocclusion in which one to four teeth are involved and is considered especially for children under the age of 12 in the mixed dentition stage of development. The correction of cross bites, orthopedic orthodontics, and 2 x 4 interceptive procedures are allowed services under this procedure. Interceptive procedures are not inclusive of permanent teeth Phase II orthodontic treatment of this malocclusion.

PRIOR AUTHORIZATION

GENERAL REQUIREMENTS

All orthodontic services require PA and a HealthCheck referral. For orthodontic records reimbursement, the following guidelines are applicable: examination, models, cephalometric x-ray, panoramic x-ray, or consultation are reimbursed if there is a HealthCheck exam (the HealthCheck provider signature is required). These procedures may be reimbursed even if the remaining orthodontic treatment is denied. Orthodontic services are not available to adults over age 20.

Appendix 17
Orthodontic Services
(continued)

Procedure W7910 (examination models, consultation—orthodontic) includes an examination of the recipient, a consultation, and the obtaining of study models. This procedure must be performed and an orthodontic treatment plan must be included with any PA request for orthodontic treatment. Although this procedure requires PA, the procedure must be done to obtain PA. The PA request will be backdated to include date of record.

Before submitting a PA request for any orthodontic treatment, the provider must:

- Perform a clinical examination of the patient.
- Obtain orthodontic study models.
- Complete the PA dental request forms (PA/DRF and PA/DA).
- Submit the models with the PA request for orthodontic services.
- Obtain a written, signed verification that a HealthCheck exam has occurred. It must be dated within one year of the date the PA request is received by the fiscal agent.

SEVERE MALOCCLUSION CRITERIA FOR APPROVAL

The criteria for approving orthodontia are summarized below:

- A severe and handicapping malocclusion determined by a minimum Salzmann Index of 30.
- In extenuating circumstances, the dental consultant may, after comprehensive review of the case, determine that a severe handicapping malocclusion does exist and approve the orthodontia treatment even though the Salzmann score is less than 30.
- Transfer cases from out-of-state or within state must fulfill Medicaid criteria of age and Salzmann Index at time of initial treatment (banding).
- Certain cases of minor treatment (1-4 teeth) can be approved for minor fixed or removable orthodontic treatment
- If the request for orthodontic services is the result of a personality or psychological problem or condition and a patient does not meet the criteria listed above, then a referral from a mental health professional is required.

A copy of the Salzmann Index can be obtained by writing to:

Provider Maintenance
EDS
6406 Bridge Road
Madison, WI 53784-0006

Orthodontic treatment is *not* authorized for cosmetic reasons.

TERMINATED ORTHODONTIC TREATMENT

If any orthodontic treatment is terminated prior to completion, the provider must notify the prior authorization unit in writing within 30 day of termination. The notification must include the reason(s) for termination and treatment progress notes. This must be done before a new dentist can get a PA.

Appendix 17
Orthodontic Services
(continued)

ORTHODONTIC INITIAL TREATMENT AND BILLING DATE

When billing for the initial orthodontic banding service, the date used is the day the treatment started. This is defined as the date when the bands, brackets, or appliances are placed in the recipient's mouth. The recipient must be Medicaid eligible on this date of service.

RETAINERS

Providers can request retainers as part of any comprehensive orthodontic service. If retainers are separately identified on an approved PA for orthodontic service, they may be separately reimbursed. However, when submitting the PA request, the provider may normally include the placement, fees, and follow-up for retainers in the initial fee and monthly adjustments. In this case, a separate request for retainers will not be granted. Using either way of billing, the maximum fee for orthodontic treatment will be the same.

LOST OR DAMAGED RETAINERS

In the cases of lost or damaged retainers, the provider should submit a new PA request for a new retainer. New orthodontic records do not need to be submitted with the new PA. However, multiple lost retainers (due to recipient negligence) will *not* be replaced.

The following documentation must be submitted with all requests for orthodontic PA:

1. Orthodontic records of the exam, consultation, and study models. Study models must be securely packed, clearly labeled to identify the provider and the recipient, and must include a centric occlusion bite registration.
2. A completed PA/DRF.
3. Signed and dated evidence that a HealthCheck exam has occurred in the past year.
4. A treatment plan.

Although not covered by Wisconsin Medicaid, intraoral camera-ready photographs *may* be included in the request.

ADDITIONAL INFORMATION

In addition to this summary, refer to:

- The preceding pages for a complete listing of Medicaid-covered orthodontic services, procedure codes, and related limitations.
- Appendix 31 of this handbook for a summary of required billing documentation.
- Appendix 24 of this handbook for a summary of required documentation needed for PA requests.

Appendix 18
Adjunctive/General Services

Please note that local anesthesia is included in the fee for procedures requiring anesthesia and is not separately billable. When a provider uses anesthesia, the anesthesia charge should be included in the amount billed for the procedure.

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
Unclassified Treatment:				
09110	Palliative (emergency) treatment of dental pain - minor procedure	No	All	Not billable immediately before or after surgery.[3] *Emergency only.*
Anesthesia:				
09220	General anesthesia	Yes	All	Prior authorization not required for place of service 1, 2, B. Prior authorization not required in an emergency. Not billable with 09240.
09240	Intravenous sedation	Yes	All	Prior authorization not required in an emergency or for place of service 1, 2, or B. Not billable with 09220.
Professional Visits:				
09420	Hospital call	Yes	All	Up to two visits per stay. Only allowable in place of service 1, 2, B. Prior authorization not required in an emergency.
Miscellaneous Services:				
09910	Application of desensitizing medicament	No	All	Tooth numbers 1-32, A-T, SN. Limit of $50 reimbursement per day for all emergency procedures done on a single day. Not billable immediately before or after surgery.[3] Cannot be billed for routine fluoride treatment. *Emergency only.*

- Refer to Endodontic Services, Appendix 12 of this handbook, for information on W7116 - Open Tooth for Drainage.
- Refer to Periodontic Services, Appendix 13 of this handbook, for information on W7117 - Treat ANUG and W7118 Treat Periodontal Abscess.

Key:

[3] - $50 limitation per day for all emergency procedures applies to 09110, 09910, W7116, W7117, and W7118. Narrative required to override the limitations.

Appendix 18
Adjunctive/General Services
(continued)

COVERED SERVICES

DEFINITION

Adjunctive general services include hospitalization, general anesthesia, intravenous sedation, and emergency services provided for relief of dental pain.

PALLIATIVE (EMERGENCY) TREATMENT

For Wisconsin Medicaid purposes, palliative (emergency) treatment is treatment of dental pain - minor procedures that do not fit into the restorative, periodontic, or oral and maxillofacial surgery covered services described in this handbook. Refer to Section II-A of this handbook for a detailed explanation of emergency services. Palliative treatment and definitive treatment cannot be performed on the same tooth on the same date of service.

INPATIENT AND OUTPATIENT HOSPITAL SERVICES

Inpatient and outpatient hospitalization is allowed on an emergency and non-emergency (elective) basis for all dental services.

Hospitalization for the express purpose of controlling apprehension is not a Medicaid-covered service. This policy applies to inpatient or outpatient hospital and ambulatory surgical centers.

Non-emergency hospitalization is appropriate in the following situations:

- Children with uncontrollable behavior in the dental office or with psychosomatic disorders that require special handling. Children needing extensive operative procedures such as multiple restorations, abscess treatments, or oral surgery procedures.
- Developmentally disabled recipients with a history of uncooperative behavior in the dental office, even with premedication.
- Hospitalized recipients who need extensive restorative or surgical procedures or whose physician has requested a dental consultation.
- Geriatric recipients or other recipients whose medical history indicates that monitoring of vital signs or that the availability of resuscitative equipment is necessary during dental procedures.
- Medical history of uncontrolled bleeding, severe cerebral palsy, or other medical conditions that render in-office treatment impossible.
- Medical history of uncontrolled diabetes where oral and maxillofacial surgical procedures are being performed.
- Extensive oral and maxillofacial surgical procedures are being performed (e.g., Orthognathic, Cleft Palate, TMJ surgery).

If the request for hospitalization is for an institutionalized recipient, a physician's statement or order and an informed consent signed either by the recipient or the recipient's legal guardian is required.

PRIOR AUTHORIZATION

GENERAL REQUIREMENTS

General anesthesia or intravenous sedation requires prior authorization (PA) except when it is provided in an inpatient hospital, outpatient hospital, or an ambulatory surgical center.

Appendix 18
Adjunctive/General Services
(continued)

GENERAL ANESTHESIA AND INTRAVENOUS SEDATION

The criteria for approval of a PA include:

- A physician's statement indicating the recipient is allergic to local anesthetics.
- The recipient is unmanageable and belligerent with premedication attempts.
- Medical history indicates surgical procedures would require the monitoring of vital signs.
- Medical history of uncontrolled bleeding.
- The request is accompanied with elective major oral and maxillofacial surgery requiring general anesthesia.
- Inability to gain local anesthesia after the recipient has been on antibiotic therapy to control infection for five to seven days or if a life-threatening infection is present.

General anesthesia and intravenous conscious sedation administered by a dental provider is separately billable and requires PA. General anesthesia and intravenous conscious sedation is not allowed simply to control apprehension, even when providing emergency services. Intravenous sedation includes pharmacological management.

NON-EMERGENCY HOSPITALIZATION FOR DENTAL SERVICES

All elective, non-emergency hospital services require PA if they require PA in other places of service, unless otherwise noted.

Hospital calls are limited to two visits per stay and require PA.

EMERGENCY HOSPITALIZATION AND OUTPATIENT DENTAL SERVICES

Emergency hospitalizations and emergency outpatient services (emergency room and day surgery) do not require PA.

BILLING

EMERGENCY SERVICES

Emergency services are defined as services that must be provided immediately to relieve pain, swelling, acute infection, trismus, or trauma. Because the ADA claim form does not have an element to designate emergency treatment, *all claims for emergency services must be identified by an "E"* in the "For Administrative Use Only" box on the line item for the emergency service of the ADA claim form or element 24I of the HCFA 1500 claim form in order to exempt the services from copayment deduction. *Only the letter "E" without any additional letters is accepted*. Information relating to the definition of a dental emergency is in Section II-A of this handbook.

Claims submitted electronically use a different field to indicate an emergency. Refer to your Electronic Media Claims (EMC) manual for more information.

ADDITIONAL INFORMATION

In addition to this summary, refer to:

- The preceding pages for a complete listing of Medicaid-covered adjunctive/general services, procedure codes, and related limitations.
- Appendix 31 of this handbook for a summary of required billing documentation.
- Appendix 24 of this handbook for a summary of required documentation needed for PA requests.

Appendix 19
Current Procedural Terminology Codes for Dentists Billing as Oral Surgeons

This appendix summarizes CPT codes for dentists billing as oral surgeons on the HCFA 1500 claim form.

GENERAL POLICIES

- Copayment for most CPT oral surgeries is $3.00
- Most services are limited to once per day. Limitation may be exceeded if operative report, pathology report, attachment, or narrative on claim justifies multiple procedures on the same day based on medical necessity.
- Sutures cannot be billed the same day as other oral surgeries, unless an operative report attached to the claim demonstrates the sutures were not part of the surgery.
- The definitions of the column titles for the CPT code tables are listed below.

DEFINITIONS OF THE COLUMN TITLES	
CPT Code and Description:	These codes and descriptions are taken from the 1998 *Physicians' Current Procedural Terminology* (CPT), published by the American Medical Association.
Emergency Only:	The checked procedure codes are covered only in an emergency. When billing, emergency must be indicated in element 24 I of the HCFA 1500 claim form and records on the emergency must be kept in the patient files. Emergency is defined as that immediate service that must be provided to relieve the patient from pain, an acute infection, swelling, trismus, fever, or trauma.
Age Limitations:	These procedure codes have no age limitations, unless otherwise marked.
Operative/Pathology Report Required:	An operative or pathology report must be submitted with the claims for the procedure codes that are checked.
Prior Authorization (PA) Required:	Checked procedures require PA. When noted by an asterisk, some procedures require PA except in an emergency or in inpatient hospital setting. When noted, some procedures require that evidence of a HealthCheck examination be submitted with the PA.
Place of Service Limits:	All procedure codes can be provided in places of service (POS) 0-4, 7, 8, B, unless otherwise noted.
2nd Opinion Required:	A multidisciplinary Temporomandibular Joint Dysfunction (TMJ) evaluation is required to provide the procedures that are checked. Information on this evaluation must be submitted in the PA request.
Surgical Assist. Allowed:	Surgical assistants are allowed for the checked procedure codes. The modifier "80" is to be used on the claim in element 24D to indicate assist at surgery. When a surgery requires PA and an assistant will be used, PA is required for payment of the assistance.

Appendix 19
CPT Codes for Dentists Billing as Oral Surgeons
(continued)

CPT Code	Description	Emergency Only	Age Limitations	Operative/ Path Report Required	PA Required	Place of Service Limits	2nd Opinion Required	Surg. Assist. Allowed
10120	Incision and removal of foreign body, subcutaneous tissues; simple				✓*			
10121	Incision and removal of foreign body, subcutaneous tissues; complicated				✓*			
10140	Incision and drainage of hematoma, seroma or fluid collection				✓*			
10160	Puncture aspiration of abscess, hematoma, bulla, or cyst				✓*			
10180	Incision and drainage, complex, postoperative wound infection				✓*			
11100	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed (separate procedure); single lesion							
11101	each separate/additional lesion							
11440	Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less							
11441	lesion diameter 0.6 to 1.0 cm							
11442	lesion diameter 1.1 to 2.0 cm							
11640	Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 0.5 cm or less							
11641	lesion diameter 0.6 to 1.0 cm							
11642	lesion diameter 1.1 to 2.0 cm							
11643	lesion diameter 2.1 to 3.0 cm							
11644	lesion diameter 3.1 to 4.0 cm							
11646	lesion diameter over 4.0 cm							

* Prior authorization required except in an emergency and in an inpatient hospital (POS 1).
** Recipient must have HealthCheck prior to receiving the dental service.

Appendix 19
CPT Codes for Dentists Billing as Oral Surgeons
(continued)

CPT Code	Description	Emergency Only	Age Limitations	Operative/ Path Report Required	PA Required	Place of Service Limits	2nd Opinion Required	Surg. Assist. Allowed
12011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less	✓						
12013	2.6 cm to 5.0 cm	✓						
12014	5.1 cm to 7.5 cm	✓						
12015	7.6 cm to 12.5 cm	✓						
12016	12.6 cm to 20.0 cm	✓						
12017	20.1 cm to 30.0 cm	✓						
12018	over 30.0 cm	✓						✓80
12051	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less	✓						
12052	2.6 cm to 5.0 cm	✓						
12053	5.1 cm to 7.5 cm	✓						
12054	7.6 cm to 12.5 cm	✓						
12055	12.6 cm to 20.0 cm	✓						
12056	20.1 cm to 30.0 cm	✓						
12057	over 30.0 cm	✓						✓80
13151	Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm	✓						
13152	2.6 cm to 7.5 cm	✓						
13300	Repair, unusual, complicated, over 7.5 cm, any area	✓						
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq. cm or less	✓						
14041	defect 10.1 sq. cm to 30.0 sq. cm	✓						

* Prior authorization required except in an emergency and in an inpatient hospital (POS 1).
** Recipient must have HealthCheck prior to receiving the dental service.

Appendix 19
CPT Codes for Dentists Billing as Oral Surgeons
(continued)

CPT Code	Description	Emergency Only	Age Limitations	Operative/ Path Report Required	PA Required	Place of Service Limits	2nd Opinion Required	Surg. Assist. Allowed
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less	✓						
14061	defect 10.1 sq cm to 30.0 sq cm	✓						
14300	Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated, any area	✓						
15000	Excisional preparation or creation of recipient site by excision of essentially intact skin (including subcutaneous tissues), scar, or other lesion prior to repair with free skin graft (list as separate service in addition to skin graft)	✓						
15120	Split graft, face, eyelids, mouth, neck, ears, orbits, genitalia, and/or multiple digits; 100 sq cm or less, or each one percent of body area of infants and children (except 15050)	✓						
15121	each additional 100 sq cm, or each one percent of body area of infants and children, or part thereof	✓						✓80
15240	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less	✓						
15241	each additional 20 sq cm	✓						
15260	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less	✓						
15261	each additional 20 sq cm	✓						
15574	Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet				✓*			✓80
15576	eyelids, nose, ears, lips, or intraoral				✓*			✓80

* Prior authorization required except in an emergency and in an inpatient hospital (POS 1).
** Recipient must have HealthCheck prior to receiving the dental service.

Appendix 19
CPT Codes for Dentists Billing as Oral Surgeons
(continued)

CPT Code	Description	Emergency Only	Age Limitations	Operative/ Path Report Required	PA Required	Place of Service Limits	2nd Opinion Required	Surg. Assist. Allowed
15620	Delay of flap or sectioning of flap (division and inset); at forehead, cheeks, chin, neck, axillae, genitalia, hands (except 15625), or feet				✓*			
15630	at eyelids, nose, ears, or lips				✓*			
15732	Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter, sternocleidomastoid, levator scapulae)				✓*			✓80
15740	Flap; island pedicle				✓*			
15750	neurovascular pedicle				✓*			
15760	Graft; composite (eg, full thickness of external ear or nasal ala), including primary closure, donor area				✓*			
15770	derma-fat-fascia				✓*			✓80
15820	Blepharoplasty, lower eyelid;	✓						
15822	Blepharoplasty, upper eyelid;	✓						
15824	Rhytidectomy; forehead	✓						
15825	neck with platysmal tightening (platysmal flap, "P-flap")	✓						
15826	glabellar frown lines	✓						
15828	cheek, chin, and neck	✓						
15838	Excision, excessive skin and subcutaneous tissue (including lipectomy); submental fat pad				✓*			
17000	Destruction by any method, including laser, with or without surgical curettement, all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions, including local anesthesia; first lesion							

* Prior authorization required except in an emergency and in an inpatient hospital (POS 1).
** Recipient must have HealthCheck prior to receiving the dental service.

Appendix 19
CPT Codes for Dentists Billing as Oral Surgeons
(continued)

CPT Code	Description	Emergency Only	Age Limitations	Operative/ Path Report Required	PA Required	Place of Service Limits	2nd Opinion Required	Surg. Assist. Allowed
17280	Destruction, malignant lesion, any method, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less							✓80
17281	lesion diameter 0.6 to 1.0 cm							✓80
17282	lesion diameter 1.1 to 2.0 cm							✓80
17283	lesion diameter 2.1 to 3.0 cm							✓80
17284	lesion diameter 3.1 to 4.0 cm							✓80
17286	lesion diameter over 4.0 cm							✓80
20000	Incision of soft tissue abscess (eg, secondary to osteomyelitis); superficial							
20005	deep or complicated							
20200	Biopsy, muscle; superficial							
20205	deep							
20206	Biopsy, muscle, percutaneous needle							
20220	Biopsy, bone, trocar, or needle; superficial (eg, ilium, sternum, spinous process, ribs)							
20240	Biopsy, excisional; superficial (eg, ilium, sternum, spinous process, ribs, trochanter of femur)							
20245	deep (eg, humerus, ischium, femur)							
20520	Removal of foreign body in muscle or tendon sheath; simple				✓*			

* Prior authorization required except in an emergency and in an inpatient hospital (POS 1).
** Recipient must have HealthCheck prior to receiving the dental service.

Appendix 19
CPT Codes for Dentists Billing as Oral Surgeons
(continued)

CPT Code	Description	Emergency Only	Age Limitations	Operative/ Path Report Required	PA Required	Place of Service Limits	2nd Opinion Required	Surg. Assist. Allowed
20525	Removal of foreign body in muscle or tendon sheath; deep or complicated				✓*			
20550	Injection, tendon sheath, ligament, trigger points or ganglion cyst				✓			
20605	Arthrocentesis, aspiration and/or injection; intermediate joint, bursa or ganglion cyst (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)				✓	1,2,3,B		
20615	Aspiration and injection for treatment of bone cyst							
20670	Removal of implant; superficial, (eg, buried wire, pin or rod) (separate procedure)				✓*			
20680	deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)				✓*			
20693	Adjustment or revision of external fixation system requiring anesthesia (eg, new pin(s) or wire(s) and/or new ring(s) or bar(s))			✓				
20694	Removal, under anesthesia, of external fixation system				✓			
20900	Bone graft, any donor area; minor or small (eg, dowel or button)	✓				1,2,3,B		✓80
20902	major or large	✓				1,2,3,B		✓80
20910	Cartilage graft; costochondral				✓	1,2,B	✓	✓80
20926	Tissue grafts, other (eg, paratenon, fat, dermis)	✓				1,2,3,B		
20962	Bone graft with microvascular anastomosis; other than fibula, iliac crest, or metatarsal			✓	✓*	1,2,B	✓	✓80

* Prior authorization required except in an emergency and in an inpatient hospital (POS 1).
** Recipient must have HealthCheck prior to receiving the dental service.

Appendix 19
CPT Codes for Dentists Billing as Oral Surgeons
(continued)

CPT Code	Description	Emergency Only	Age Limitations	Operative/ Path Report Required	PA Required	Place of Service Limits	2nd Opinion Required	Surg. Assist. Allowed
21010	Arthrotomy, temporomandibular joint				✓	1,2,B	✓	
21025	Excision of bone (eg, for osteomyelitis or bone abscess); mandible							
21026	facial bone(s)							
21029	Removal by contouring of benign tumor of facial bone (eg, fibrous dysplasia)							
21030	Excision of benign tumor or cyst of facial bone other than mandible							
21031	Excision of torus mandibularis				✓			
21032	Excision of maxillary torus palatinus				✓			
21034	Excision of malignant tumor of facial bone other than mandible							✓80
21040	Excision of benign cyst or tumor of mandible; simple							
21041	complex							
21044	Excision of malignant tumor of mandible;							✓80
21045	radical resection					0,1,2,B		✓80
21050	Condylectomy, temporomandibular joint (separate procedure)				✓	1,2,B	✓	✓80
21060	Meniscectomy, partial or complete, temporomandibular joint (separate procedure)				✓	1,2,B	✓	✓80
21070	Coroniodectomy (separate procedure)				✓	1,2,B	✓	✓80
21082	Impression and custom preparation; palatal augmentation prosthesis			✓	✓	0,1,2,3,B		
21085	oral surgical splint			✓	✓*	0,1,2,3,B		
21086	auricular prosthesis			✓	✓	0,1,2,3,B		

* Prior authorization required except in an emergency and in an inpatient hospital (POS 1).
** Recipient must have HealthCheck prior to receiving the dental service.

Appendix 19
CPT Codes for Dentists Billing as Oral Surgeons
(continued)

CPT Code	Description	Emergency Only	Age Limitations	Operative/ Path Report Required	PA Required	Place of Service Limits	2nd Opinion Required	Surg. Assist. Allowed
21100	Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure)							
21110	Application of interdental fixation device for conditions other than fracture or dislocation, includes removal	✓						
21121	Genioplasty; sliding osteotomy, single piece		0-20**		✓**	1, 2, B		✓80
21122	Genioplasty; sliding osteotomies, two or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)		0-20**		✓**	1, 2, B		✓80
21123	sliding, augmentation with interpositional bone grafts (includes obtaining autografts)		0-20**		✓**	1, 2, B		✓80
21125	Augmentation, mandibular body or angle; prosthetic material		0-20**		✓**	1, 2, B		✓80
21127	with bone graft, onlay or interpositional (includes obtaining autograft)		0-20**		✓**	1, 2, B		✓80
21141	Reconstruction midface, LeFort 1; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft		0-20**		✓**	1, 2, B		✓80
21142	two pieces, segment movement in any direction, without bone graft		0-20**		✓**	1, 2, B		✓80
21143	three or more pieces, segment movement in any direction, without bone graft		0-20**		✓**	1, 2, B		✓80
21145	single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)		0-20**		✓**	1, 2, B		✓80
21146	two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)		0-20**		✓**	1, 2, B		✓80
21147	three or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)		0-20**		✓**	1, 2, B		✓80

* Prior authorization required except in an emergency and in an inpatient hospital (POS 1).
** Recipient must have HealthCheck prior to receiving the dental service.

Appendix 19
CPT Codes for Dentists Billing as Oral Surgeons
(continued)

CPT Code	Description	Emergency Only	Age Limitations	Operative/ Path Report Required	PA Required	Place of Service Limits	2nd Opinion Required	Surg. Assist. Allowed
21150	Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome)		0-20**		✓**	1, 2, B		✓80
21151	any direction, requiring bone grafts (includes obtaining autografts)		0-20**		✓**	1, 2, B		✓80
21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I		0-20**		✓**	1, 2, B		✓80
21155	with LeFort I		0-20**		✓**	1, 2, B		✓80
21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I		0-20**		✓**	1, 2, B		✓80
21160	with LeFort I		0-20**		✓**	1, 2, B		✓80
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)		0-20**		✓**	1, 2, B		✓80
21193	Reconstruction of mandibular rami, horizontal, vertical, "C", or "L" osteotomy; without bone graft		0-20**		✓**	1, 2, B		✓80
21194	with bone graft (includes obtaining graft)		0-20**		✓**	1, 2, B		✓80
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation		0-20**		✓**	1, 2, B		✓80
21196	with internal rigid fixation		0-20**		✓**	1, 2, B		✓80
21198	Osteotomy, mandible, segmental		0-20**		✓**	1, 2, B		✓80
21206	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)		0-20**		✓**	1, 2, B		✓80
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)		0-20**		✓**	1, 2, B		✓80
21209	reduction		0-20**		✓**	1, 2, B		✓80

* Prior authorization required except in an emergency and in an inpatient hospital (POS 1).
** Recipient must have HealthCheck prior to receiving the dental service.

Appendix 19
CPT Codes for Dentists Billing as Oral Surgeons
(continued)

CPT Code	Description	Emergency Only	Age Limitations	Operative/ Path Report Required	PA Required	Place of Service Limits	2nd Opinion Required	Surg. Assist. Allowed
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)	✓				1, 2, B		
21215	mandible (includes obtaining graft)	✓				1, 2, B		✓80
21230	Graft, rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)	✓				1, 2, B		
21235	ear cartilage, autogenous, to nose or ear (includes obtaining graft)	✓				1, 2, B		
21240	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)				✓	1, 2, B	✓	✓80
21242	Arthroplasty, temporomandibular joint, with allograft				✓	1, 2, B	✓	✓80
21243	Arthroplasty, temporomandibular joint, with prosthetic joint replacement				✓	1, 2, B	✓	✓80
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)		0-20**		✓**	1, 2, B		✓80
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial		0-20**		✓**	1, 2, B		✓80
21246	complete		0-20**		✓**	1, 2, B		✓80
21247	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia)		0-20**		✓**	1, 2, B		✓80
21248	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial		0-20**		✓**	1, 2, B		✓80
21249	complete		0-20**		✓**	1, 2, B		✓80
21255	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)		0-20**		✓**	1, 2, B		✓80

* Prior authorization required except in an emergency and in an inpatient hospital (POS 1).
** Recipient must have HealthCheck prior to receiving the dental service.

Appendix 19
CPT Codes for Dentists Billing as Oral Surgeons
(continued)

CPT Code	Description	Emergency Only	Age Limitations	Operative/ Path Report Required	PA Required	Place of Service Limits	2nd Opinion Required	Surg. Assist. Allowed
21260	Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach		0-20**		✓**	1, 2, B		✓80
21261	combined intra- and extracranial approach		0-20**		✓**	1, 2, B		✓80
21263	with forehead advancement		0-20**		✓**	1, 2, B		✓80
21267	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach		0-20**		✓**	1, 2, B		✓80
21268	combined intra- and extracranial approach		0-20**		✓**	1, 2, B		✓80
21270	Malar augmentation, prosthetic material		0-20**		✓**	1, 2, B		✓80
21295	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); extraoral approach					1, 2, B		
21296	intraoral approach					1, 2, B		
21299	Unlisted craniofacial and maxillofacial procedure				✓			✓80
21310	Closed treatment of nasal bone fracture without manipulation					0,1,2,3,B		
21315	Closed treatment of nasal bone fracture; without stabilization					0,1,2,3,B		
21320	with stabilization					0,1,2,3,B		
21325	Open treatment of nasal fracture; uncomplicated					0,1,2,3,B		
21330	complicated, with internal and/or external skeletal fixation					0,1,2,3,B		
21335	with concomitant open treatment of fractured septum					0,1,2,3,B		

* Prior authorization required except in an emergency and in an inpatient hospital (POS 1).
** Recipient must have HealthCheck prior to receiving the dental service.

Appendix 19
CPT Codes for Dentists Billing as Oral Surgeons
(continued)

CPT Code	Description	Emergency Only	Age Limitations	Operative/ Path Report Required	PA Required	Place of Service Limits	2nd Opinion Required	Surg. Assist. Allowed
21336	Open treatment of nasal septal fracture, with or without stabilization					0,1,2,3,B		✓80
21337	Closed treatment of nasal septal fracture, with or without stabilization					0,1,2,3,B		
21338	Open treatment of nasoethmoid fracture; without external fixation					0,1,2,3,B		
21339	with external fixation					0,1,2,3,B		✓80
21340	Percutaneous treatment of nasoethmoid complex fracture, with splint, wire or headcap fixation, including repair of canthal ligaments and/or the nasolacrimal apparatus					0,1,2,3,B		
21343	Open treatment of depressed frontal sinus fracture					0,1,2,3,B		✓80
21345	Closed treatment of nasomaxillary complex fracture (LeFort II type), with interdental wire fixation or fixation of denture or splint					0,1,2,3,B		
21346	Open treatment of nasomaxillary complex fracture (LeFort II type); with wiring and/or local fixation					0,1,2,3,B		✓80
21347	requiring multiple open approaches					0,1,2,3,B		✓80
21348	with bone grafting (includes obtaining graft)					0,1,2,3,B		✓80
21355	Percutaneous treatment of fracture of malar area, including zygomatic arch and malar tripod, with manipulation					0,1,2,3,B		
21356	Open treatment of depressed zygomatic arch fracture (eg, Gilles approach)					0,1,2,3,B		✓80
21360	Open treatment of depressed malar fracture, including zygomatic arch and malar tripod					0,1,2,3,B		
21365	Open treatment of complicated (eg, comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with internal fixation and multiple surgical approaches					0,1,2,3,B		✓80
21366	with bone grafting (includes obtaining graft)					0,1,2,3,B		✓80

* Prior authorization required except in an emergency and in an inpatient hospital (POS 1).
** Recipient must have HealthCheck prior to receiving the dental service.

Appendix 19
CPT Codes for Dentists Billing as Oral Surgeons
(continued)

CPT Code	Description	Emergency Only	Age Limitations	Operative/ Path Report Required	PA Required	Place of Service Limits	2nd Opinion Required	Surg. Assist. Allowed
21385	Open treatment of orbital floor "blowout" fracture; transantral approach (Caldwell-Luc type operation)					0,1,2,3,B		✓80
21386	periorbital approach					0,1,2,3,B		
21387	combined approach					0,1,2,3,B		
21390	periorbital approach, with alloplastic or other implant					0,1,2,3,B		✓80
21395	periorbital approach with bone graft (includes obtaining graft)					0,1,2,3,B		✓80
21400	Closed treatment of fracture of orbit, except "blowout"; without manipulation					0,1,2,3,B		
21401	with manipulation					0,1,2,3,B		
21406	Open treatment of fracture of orbit, except "blowout"; without implant					0,1,2,3,B		✓80
21407	with implant							✓80
21408	with bone grafting (includes obtaining graft)							✓80
21421	Closed treatment of palatal or maxillary fracture (LeFort I type), with interdental wire fixation or fixation of denture or splint					0,1,2,3,B		
21422	Open treatment of palatal or maxillary fracture (LeFort I type);					0,1,2,3,B		✓80
21423	complicated (comminuted or involving cranial nerve foramina), multiple approaches					0,1,2,3,B		✓80
21431	Closed treatment of craniofacial separation (LeFort III type) using interdental wire fixation of denture or splint					0,1,2,3,B		
21432	Open treatment of craniofacial separation (LeFort III type); with wiring and/or internal fixation					0,1,2,3,B		✓80
21433	complicated (eg, comminuted or involving cranial nerve foramina), multiple surgical approaches					0,1,2,3,B		✓80
21435	complicated, utilizing internal and/or external fixation techniques (eg, head cap, halo device, and/or intermaxillary fixation)					0,1,2,3,B		✓80

* Prior authorization required except in an emergency and in an inpatient hospital (POS 1).
** Recipient must have HealthCheck prior to receiving the dental service.

Appendix 19
CPT Codes for Dentists Billing as Oral Surgeons
(continued)

CPT Code	Description	Emergency Only	Age Limitations	Operative/ Path Report Required	PA Required	Place of Service Limits	2nd Opinion Required	Surg. Assist. Allowed
21436	Open treatment of craniofacial separation (LeFort III type); complicated, multiple surgical approaches, internal fixation, with bone grafting (includes obtaining graft)					0,1,2,3,B		✓80
21440	Closed treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)							
21445	Open treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)					0,1,2,3,B		
21450	Closed treatment of mandibular fracture; without manipulation					0,1,2,3,B		
21451	with manipulation					0,1,2,3,B		
21452	Percutaneous treatment of mandibular fracture, with external fixation					0,1,2,3,B		
21453	Closed treatment of mandibular fracture with interdental fixation					0,1,2,3,B		
21454	Open treatment of mandibular fracture with external fixation					0,1,2,3,B		✓80
21461	Open treatment of mandibular fracture; without interdental fixation					0,1,2,3,B		✓80
21462	with interdental fixation					0,1,2,3,B		✓80
21465	Open treatment of mandibular condylar fracture					0,1,2,3,B		
21470	Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints					0,1,2,3,B		✓80
21480	Closed treatment of temporomandibular dislocation; initial or subsequent							
21485	complicated (eg, recurrent requiring intermaxillary fixation or splinting), initial or subsequent			✓				
21490	Open treatment of temporomandibular dislocation			✓		0,1,2,3,B		✓80
21497	Interdental wiring, for condition other than fracture	✓						
21499	Unlisted musculoskeletal procedure, head			✓	✓			✓80

* Prior authorization required except in an emergency and in an inpatient hospital (POS 1).
** Recipient must have HealthCheck prior to receiving the dental service.

Appendix 19
CPT Codes for Dentists Billing as Oral Surgeons
(continued)

CPT Code	Description	Emergency Only	Age Limitations	Operative/ Path Report Required	PA Required	Place of Service Limits	2nd Opinion Required	Surg. Assist. Allowed
29800	Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)				✓	1,2,B	✓	
29804	Arthroscopy, temporomandibular joint, surgical				✓	1,2,B	✓	✓80
30130	Excision turbinate, partial or complete				✓			
30140	Submucous resection turbinate, partial or complete				✓			
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip				✓*			
30410	complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip				✓*			
30420	including major septal repair				✓*			
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)				✓*			
30435	intermediate revision (bony work with osteotomies)				✓*			
30450	major revision (nasal tip work and osteotomies)				✓*			
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only				✓*			✓80
30462	tip, septum, osteotomies				✓*			✓80
30580	Repair fistula; oromaxillary (combine with 31030 if antrotomy is included)							
30600	oronasal							
31000	Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium)							
31020	Sinusotomy, maxillary (antrotomy); intranasal							
31030	radical (Caldwell-Luc) without removal of antrochoanal polyps							

* Prior authorization required except in an emergency and in an inpatient hospital (POS 1).
** Recipient must have HealthCheck prior to receiving the dental service.

Appendix 19
CPT Codes for Dentists Billing as Oral Surgeons
(continued)

CPT Code	Description	Emergency Only	Age Limitations	Operative/ Path Report Required	PA Required	Place of Service Limits	2nd Opinion Required	Surg. Assist. Allowed
31032	Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) with removal of antrochoanal polyps							
31225	Maxillectomy; without orbital exenteration							✓80
31600	Tracheostomy, planned (separate procedure);	✓						
31603	Tracheostomy, emergency procedure; transtracheal	✓						
31605	cricothyroid membrane	✓						
37615	Ligation, major artery (eg, post-traumatic, rupture); neck	✓						✓80
40490	Biopsy of lip							
40500	Vermilionectomy (lip shave), with mucosal advancement							
40510	Excision of lip; transverse wedge excision with primary closure							
40520	V-excision with primary direct linear closure							
40525	full thickness, reconstruction with local flap (eg, Estlander or fan)							
40527	full thickness, reconstruction with cross lip flap (Abbe-Estlander)							
40530	Resection of lip, more than one-fourth, without reconstruction							
40650	Repair lip, full thickness; vermilion only	✓						
40652	up to half vertical height	✓						
40654	over one-half vertical height, or complex	✓						

* Prior authorization required except in an emergency and in an inpatient hospital (POS 1).
** Recipient must have HealthCheck prior to receiving the dental service.

Appendix 19
CPT Codes for Dentists Billing as Oral Surgeons
(continued)

CPT Code	Description	Emergency Only	Age Limitations	Operative/ Path Report Required	PA Required	Place of Service Limits	2nd Opinion Required	Surg. Assist. Allowed
40700	Plastic repair of cleft lip/nasal deformity; primary, partial or complete, unilateral				✓			
40701	primary bilateral, one stage procedure				✓			
40702	primary bilateral, one of two stages				✓			
40720	secondary, by recreation of defect and reclosure				✓			✓80
40761	with cross lip pedicle flap (Abbe-Estlander type), including sectioning and inserting of pedicle				✓			
40799	Unlisted procedure, lips			✓	✓			✓80
40800	Drainage of abscess, cyst, hematoma, vestibule of mouth; simple							
40801	complicated			✓				
40804	Removal of embedded foreign body, vestibule of mouth; simple			✓	✓*			
40805	complicated			✓	✓*			
40806	Incision of labial frenum (frenotomy)		0-20**		✓**			
40808	Biopsy, vestibule of mouth							
40810	Excision of lesion of mucosa and submucosa, vestibule of mouth; without repair							
40812	with simple repair							
40814	with complex repair							
40816	complex, with excision of underlying muscle							
40818	Excision of mucosa of vestibule of mouth as donor graft	✓						
40819	Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frenectomy)		0-20**		✓**			

* Prior authorization required except in an emergency and in an inpatient hospital (POS 1).
** Recipient must have HealthCheck prior to receiving the dental service.

Appendix 19
CPT Codes for Dentists Billing as Oral Surgeons
(continued)

CPT Code	Description	Emergency Only	Age Limitations	Operative/ Path Report Required	PA Required	Place of Service Limits	2nd Opinion Required	Surg. Assist. Allowed
40820	Destruction of lesion or scar of vestibule of mouth by physical methods (eg, laser, thermal, cryo, chemical)							
40830	Closure of laceration, vestibule of mouth; 2.5 cm or less	✓						
40831	over 2.5 cm or complex	✓						
40899	Unlisted procedure, vestibule of mouth			✓	✓			✓80
41000	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; lingual							
41005	sublingual, superficial							
41006	sublingual, deep, supramylohyoid							
41007	submental space							
41008	submandibular space							
41009	masticator space							
41010	Incision of lingual frenum (frenotomy)		0-20**		✓**			
41015	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; sublingual							
41016	submental							
41017	submandibular							
41018	masticator space							
41100	Biopsy of tongue; anterior two-thirds							
41105	posterior one-third							
41108	Biopsy of floor of mouth							

* Prior authorization required except in an emergency and in an inpatient hospital (POS 1).
** Recipient must have HealthCheck prior to receiving the dental service.

Appendix 19
CPT Codes for Dentists Billing as Oral Surgeons
(continued)

CPT Code	Description	Emergency Only	Age Limitations	Operative/ Path Report Required	PA Required	Place of Service Limits	2nd Opinion Required	Surg. Assist. Allowed
41110	Excision of lesion of tongue without closure							
41112	Excision of lesion of tongue with closure; anterior two-thirds							
41113	posterior one-third							
41114	with local tongue flap							
41115	Excision of lingual frenum (frenectomy)		0-20**		✓**			
41116	Excision, lesion of floor of mouth							
41120	Glossectomy; less than one-half tongue							✓80
41130	hemiglossectomy							✓80
41135	partial, with unilateral radical neck dissection							✓80
41140	complete or total, with or without tracheostomy, without radical neck dissection							✓80
41145	complete or total, with or without tracheostomy, with unilateral radical neck dissection							✓80
41150	composite procedure with resection floor of mouth and mandibular resection, without radical neck dissection							✓80
41153	composite procedure with resection floor of mouth, with suprahyoid neck dissection							✓80
41155	composite procedure with resection floor of mouth, mandibular resection, and radical neck dissection (Commando type)							✓80
41250	Repair of laceration 2.5 cm or less; floor of mouth and/or anterior two-thirds of tongue	✓						
41251	posterior one-third of tongue	✓						
41252	Repair of laceration of tongue, floor of mouth, over 2.6 cm or complex	✓						
41500	Fixation of tongue, mechanical, other than suture (eg, K-wire)	✓		✓				✓80

* Prior authorization required except in an emergency and in an inpatient hospital (POS 1).
** Recipient must have HealthCheck prior to receiving the dental service.

Appendix 19
CPT Codes for Dentists Billing as Oral Surgeons
(continued)

CPT Code	Description	Emergency Only	Age Limitations	Operative/ Path Report Required	PA Required	Place of Service Limits	2nd Opinion Required	Surg. Assist. Allowed
41510	Suture of tongue to lip for micrognathia (Douglas type procedure)			✓				
41520	Frenoplasty (surgical revision of frenum, eg. with Z-plasty)		0-20**		✓**			
41599	Unlisted procedure, tongue, floor of mouth			✓	✓			✓80
41800	Drainage of abscess, cyst, hematoma from dentoalveolar structures							
41805	Removal of embedded foreign body from dentoalveolar structures; soft tissues			✓	✓*			
41806	bone			✓	✓*			
41820	Gingivectomy, excision gingiva, each quadrant				✓			
41821	Operculectomy, excision pericoronal tissues	✓			✓			
41822	Excision of fibrous tuberosities, dentoalveolar structures				✓			
41823	Excision of osseous tuberosities, dentoalveolar structures				✓			
41825	Excision of lesion or tumor (except listed above), dentoalveolar structures; without repair							
41826	with simple repair							
41827	with complex repair							
41828	Excision of hyperplastic alveolar mucosa, each quadrant (specify)			✓	✓			
41850	Destruction of lesion (except excision), dentoalveolar structures							
41872	Gingivoplasty, each quadrant (specify)				✓			
41899	Unlisted procedure, dentoalveolar structures			✓	✓			
42000	Drainage of abscess of palate, uvula							

* Prior authorization required except in an emergency and in an inpatient hospital (POS 1).
** Recipient must have HealthCheck prior to receiving the dental service.

Appendix 19
CPT Codes for Dentists Billing as Oral Surgeons
(continued)

CPT Code	Description	Emergency Only	Age Limitations	Operative/ Path Report Required	PA Required	Place of Service Limits	2nd Opinion Required	Surg. Assist. Allowed
42100	Biopsy of palate, uvula							
42104	Excision, lesion of palate, uvula; without closure							
42106	with simple primary closure							
42107	with local flap closure							
42120	Resection of palate or extensive resection of lesion							✓80
42140	Uvulectomy, excision of uvula							
42145	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)							
42160	Destruction of lesion, palate or uvula (thermal, cryo or chemical)							
42180	Repair, laceration of palate; up to 2 cm	✓						
42182	over 2 cm or complex	✓						
42200	Palatoplasty for cleft palate, soft and/or hard palate only				✓			
42205	Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only				✓			
42210	with bone graft to alveolar ridge (includes obtaining graft)				✓			
42215	Palatoplasty for cleft palate; major revision				✓			
42220	secondary lengthening procedure				✓			
42225	attachment pharyngeal flap				✓			
42226	Lengthening of palate, and pharyngeal flap				✓			
42227	Lengthening of palate, with island flap				✓			

* Prior authorization required except in an emergency and in an inpatient hospital (POS 1).
** Recipient must have HealthCheck prior to receiving the dental service.

Appendix 19
CPT Codes for Dentists Billing as Oral Surgeons
(continued)

CPT Code	Description	Emergency Only	Age Limitations	Operative/ Path Report Required	PA Required	Place of Service Limits	2nd Opinion Required	Surg. Assist. Allowed
42235	Repair of anterior palate, including vomer flap				✓			
42260	Repair of nasolabial fistula							
42280	Maxillary impression for palatal prosthesis			✓	✓**			
42299	Unlisted procedure, palate, uvula			✓	✓**			✓80
42300	Drainage of abscess; parotid, simple							
42305	parotid, complicated							
42310	Drainage of abscess; submaxillary or sublingual, intraoral							
42320	submaxillary, external							
42325	Fistulization of sublingual salivary cyst (ranula);					0,1,2,3,B		
42326	with prosthesis			✓	✓	0,1,2,3,B		
42330	Sialolithotomy; submandibular (submaxillary), sublingual or parotid, uncomplicated, intraoral					0,1,2,3,B		
42335	submandibular (submaxillary), complicated, intraoral					0,1,2,3,B		
42340	parotid, extraoral or complicated intraoral					0,1,2,3,B		
42400	Biopsy of salivary gland; needle							
42405	incisional							
42408	Excision of sublingual salivary cyst (ranula)							
42409	Marsupialization of sublingual salivary cyst (ranula)							

* Prior authorization required except in an emergency and in an inpatient hospital (POS 1).
** Recipient must have HealthCheck prior to receiving the dental service.

Appendix 19
CPT Codes for Dentists Billing as Oral Surgeons
(continued)

CPT Code	Description	Emergency Only	Age Limitations	Operative/ Path Report Required	PA Required	Place of Service Limits	2nd Opinion Required	Surg. Assist. Allowed
42410	Excision of parotid tumor or parotid gland; lateral lobe, without nerve dissection							✓80
42415	lateral lobe, with dissection and preservation of facial nerve							✓80
42420	total, with dissection and preservation of facial nerve							✓80
42425	total, en bloc removal with sacrifice of facial nerve							✓80
42426	total, with unilateral radical neck dissection							✓80
42440	Excision of submandibular (submaxillary) gland							✓80
42450	Excision of sublingual gland							
42500	Plastic repair of salivary duct, sialodochoplasty; primary or simple							
42505	secondary or complicated							
42507	Parotid duct diversion, bilateral (Wilke type procedure);							
42508	with excision of one submandibular gland							
42509	with excision of both submandibular glands							✓80
42510	with ligation of both submandibular (Wharton's) ducts							✓80
42550	Injection procedure for sialography							
42600	Closure salivary fistula							
42650	Dilation salivary duct							
42660	Dilation and catheterization of salivary duct, with or without injection							✓80
42665	Ligation salivary duct, intraoral							
42699	Unlisted procedure, salivary glands or ducts			✓	✓			✓80

* Prior authorization required except in an emergency and in an inpatient hospital (POS 1).
** Recipient must have HealthCheck prior to receiving the dental service.

Appendix 19
CPT Codes for Dentists Billing as Oral Surgeons
(continued)

CPT Code	Description	Emergency Only	Age Limitations	Operative/ Path Report Required	PA Required	Place of Service Limits	2nd Opinion Required	Surg. Assist. Allowed
42700	Incision and drainage abscess; peritonsillar							
42720	retropharyngeal or parapharyngeal, intraoral approach							
42725	retropharyngeal or parapharyngeal, external approach							✓80
42800	Biopsy; oropharynx							
42808	Excision or destruction of lesion of pharynx, any method							
42809	Removal of foreign body from pharynx				✓*			
42890	Limited pharyngectomy							✓80
42892	Resection of lateral pharyngeal wall or pyriform sinus, direct closure by advancement of lateral and posterior pharyngeal walls							✓80
42894	Resection of pharyngeal wall requiring closure with myocutaneous flap							✓80
42900	Suture pharynx for wound or injury	✓						
42950	Pharyngoplasty (plastic or reconstructive operation on pharynx)				✓			✓80
42960	Control oropharyngeal hemorrhage, primary or secondary (eg, post-tonsillectomy); simple	✓						
42961	complicated, requiring hospitalization	✓				1,2,B		
42962	with secondary surgical intervention	✓				1,2,B		
42970	Control of nasopharyngeal hemorrhage, primary or secondary (eg, postadenoidectomy); simple, with posterior nasal packs, with or without anterior packs and/or cauterization	✓						
42971	complicated, requiring hospitalization	✓				1,2,B		
42972	with secondary surgical intervention	✓				1,2,B		
42999	Unlisted procedure, pharynx, adenoids, or tonsils			✓	✓			✓80

* Prior authorization required except in an emergency and in an inpatient hospital (POS 1).
** Recipient must have HealthCheck prior to receiving the dental service.

Appendix 19
CPT Codes for Dentists Billing as Oral Surgeons
(continued)

CPT Code	Description	Emergency Only	Age Limitations	Operative/ Path Report Required	PA Required	Place of Service Limits	2nd Opinion Required	Surg. Assist. Allowed
64400	Injection, anesthetic agent; trigeminal nerve, any division or branch							
64505	Injection, anesthetic agent; sphenopalatine ganglion							
64510	stellate ganglion (cervical sympathetic)							
64600	Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch							
64605	second and third division branches at foramen ovale							
64610	second and third division branches at foramen ovale under radiologic monitoring							
64716	Neuroplasty and/or transposition; cranial nerve (specify)			✓				✓80
64722	Decompression; unspecified nerve(s) (specifiy)			✓				✓80
64727	Internal neurolysis, requiring use of operating microscope (list separately in addition to code for neuroplasty) (Neuroplasty includes external neurolysis)							
64734	Transection or avulsion of; infraorbital nerve							
64736	mental nerve							
64738	inferior alveolar nerve by osteotomy							
64740	lingual nerve							
64742	facial nerve, differential or complete							
99070	Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)							

* Prior authorization required except in an emergency and in an inpatient hospital (POS 1).
** Recipient must have HealthCheck prior to receiving the dental service.

Appendix 20
SAMPLE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF)

DO NOT DETACH TOP 2 FORMS - Reminder: ENCLOSE PA/DA with PA/DRF

MAIL TO
EDS
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PA/DRF
WISCONSIN MEDICAID DENTAL
PRIOR AUTHORIZATION REQUEST FORM
(DO NOT WRITE IN THIS SPACE)
A.T. #
P.A. # 1271692

ICN #

1. PROCESSING TYPE (MARK ONE)
DENTAL - 124 ☐
ORTHO - 125 ☐

2. RECIPIENT'S MEDICAID ID NUMBER

3. RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)
(Write name exactly as it appears on the Medicaid ID card)

4. RECIPIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

5. DATE OF BIRTH ___/___/___

6. SEX M ☐ F ☐

7. BILLING PROVIDER NO.

8. PERFORMING PROVIDER NO. (if different)

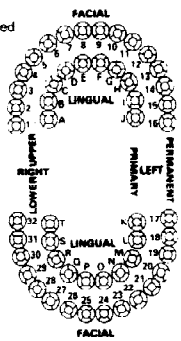
9. BILLING PROVIDER NAME, ADDRESS, ZIP CODE
(If stamped, please stamp every copy)

10. PROVIDER TELEPHONE NO.

11. INDICATE IF THE SERVICE WILL BE PERFORMED IN:
- INPATIENT HOSPITAL (POS 1) ☐
- OUTPATIENT HOSPITAL (POS 2) ☐
- AMBULATORY SURG. CENTER (POS 8) ☐
- DENTAL OFFICE (POS 3) ☐

12. TOOTH #	13. PROCEDURE CODE	14. QUAN.	15. DESCRIPTION	16. FEE	
			18. TOTAL FEES		

17.
- Circle periodontal case type if applicable to the service requested
  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 _____

An approved prior authorization does not guarantee payment. Prior authorized services: 1) are subject to the applicable terms of reimbursement issued by the Department; 2) must be provided consistent with a prior authorization, as approved or modified by the Department or its fiscal agent; and 3) are reimbursable only if and to the extent the provisions of s. HFS 107.02(3), Wis. Admin. Code, are met. Payment will not be made for services initiated prior to the approval or after the authorization expiration date. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, reimbursement will be allowed only if the service is not covered by the HMO and all other program requirements are met.

19. RECIPIENT/GUARDIAN SIGNATURE (*Optional*)
Date

20. PERFORMING PROVIDER SIGNATURE
(If stamped, please stamp every copy)
Date

MEDICAID CONSULTANT USE ONLY - DO NOT WRITE IN THIS SPACE

AUTHORIZATION: PROCEDURE(S) AUTHORIZED: QUANTITY AUTHORIZED:

☐ APPROVED GRANT DATE EXPIRATION DATE

☐ MODIFIED REASON

☐ DENIED REASON

☐ RETURN REASON

DATE MEDICAID CONSULTANT/ANALYST SIGNATURE

Appendix 20
SAMPLE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF)
(continued)

MAIL TO:
EDS
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PA/DRF
WISCONSIN MEDICAID DENTAL
PRIOR AUTHORIZATION REQUEST FORM
(DO NOT WRITE IN THIS SPACE)
A.T. #
P.A. # 1271692

ICN #

1. PROCESSING TYPE (MARK ONE)
DENTAL - 124 ☐
ORTHO - 125 ☐

2. RECIPIENT'S MEDICAID ID NUMBER

3. RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)
(Write name exactly as it appears on the Medicaid ID card)

4. RECIPIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

5. DATE OF BIRTH ___/___/___

6. SEX M ☐ F ☐

7. BILLING PROVIDER NO.

8. PERFORMING PROVIDER NO. (If different)

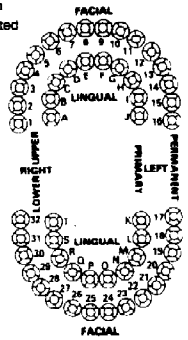
9. BILLING PROVIDER NAME, ADDRESS, ZIP CODE
(If stamped, please stamp every copy)

10. PROVIDER TELEPHONE NO.

11. INDICATE IF THE SERVICE WILL BE PERFORMED IN:
- INPATIENT HOSPITAL (POS 1) ☐
- OUTPATIENT HOSPITAL (POS 2) ☐
- AMBULATORY SURG. CENTER (POS 8) ☐
- DENTAL OFFICE (POS 3) ☐

12. TOOTH #	13. PROCEDURE CODE	14. QUAN.	15. DESCRIPTION	16. FEE	
			18. TOTAL FEES		

17.
- Circle periodontal case type if applicable to the service requested
  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 _____

An approved prior authorization does not guarantee payment. Prior authorized services: 1) are subject to the applicable terms of reimbursement issued by the Department; 2) must be provided consistent with a prior authorization, as approved or modified by the Department or its fiscal agent; and 3) are reimbursable only if and to the extent the provisions of s. HFS 107.02(3), Wis. Admin. Code, are met. Payment will not be made for services initiated prior to the approval or after the authorization expiration date. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, reimbursement will be allowed only if the service is not covered by the HMO and all other program requirements are met.

19. RECIPIENT/GUARDIAN SIGNATURE (*Optional*)

Date

20. PERFORMING PROVIDER SIGNATURE
(If stamped, please stamp every copy)

Date

PROVIDER CHECKLIST
REQUESTS FOR PERIODONTICS, ENDODONTICS, AND SERVICES REQUIRING ENCLOSURES

HAVE YOU ENCLOSED?

X-rays for any of the following:
- Space maintainer ____
- Resin window SSC/resin crown ____
- Endodontics ____
- Partials and fixed prosthetics ____
- Surgical exposure of unerupted tooth ____
- Removal of foreign body ____

Periodontal charting required for any of the following procedures:
- Periodontal scaling and root planing ____
- Full mouth debridement ____
- Periodontal maintenance ____
- Partials *(for perio case types II, III, IV, and V only)* ____
- Fixed prosthodontics (abutment teeth) ____

HealthCheck referral for any of the following:
- Osteoplasty/Orthognathic surgery ____
- Surgical exposure of unerupted tooth ____
- Frenulectomy ____
- Orthodontics ____

When requesting upgraded crowns and upgraded partial dentures, the form "Provision of Upgraded Partial Denture and Crowns to Medicaid Recipients" in the Dental Provider Handbook (Part B) must be completed, signed, and attached to this form.

Statement on speech impediment for:
- Palatal lift ____

TMJ surgery requirements - Enclose each of the following:
- Second surgical opinion ____
- Document non-surgical treatment ____
- Operative and post-operative plan of care ____
- X-ray report ____

PROVIDER COPY - RETAIN FOR YOUR RECORDS
DISCARD UPON RECEIPT OF PROCESSED PRIOR AUTHORIZATION REQUEST

Appendix 21
PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF) COMPLETION GUIDELINES

The Prior Authorization Dental Request Form (PA/DRF) is to be used by all dentists requesting prior authorization (PA) for dental or orthodontic services.

All dentists requesting PA need to complete the following:

Service requested	Pages to complete
Additional dental visits or cleanings	PA/DRF and PA/DA page 1
Orthodontia	PA/DRF and PA/DA page 1
Endodontics, Periodontics, Partial dentures	PA/DRF and PA/DA pages 1 and 2
Partials, Dentures	PA/DRF and PA/DA pages 1, 2, and 3

Photocopy the necessary pages of the PA/DA form from Appendix 22 of this handbook.

Submit the PA/DRF and the appropriate page(s) of the PA/DA to the following address:

Prior Authorization Unit
EDS
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/DRF COMPLETION INSTRUCTIONS

BOX #	DESCRIPTION	INSTRUCTIONS
1	PROCESSING TYPE	Mark the appropriate box.
2	RECIPIENT'S MEDICAID ID NUMBER	Enter the recipient's 10-digit Medicaid number exactly as it appears on the Medicaid identification card.
3	RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)	Enter the recipient's name exactly as it appears on the Medicaid identification card.
4	RECIPIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	Enter the address of the recipient's place of residence. The street, city, state, and zip code must be included. If the recipient is a resident of a nursing home or other facility, enter the name of the nursing home or facility.
5	RECIPIENT'S DATE OF BIRTH	Enter the recipient's date of birth in MM/DD/YY format.
6	RECIPIENT'S SEX	Specify male or female.
7	BILLING PROVIDER NUMBER	Enter the billing provider's 8-digit Medicaid provider number. Use the billing number you will use on Medicaid claims.
8	PERFORMING PROVIDER NUMBER (if different)	**The performing provider is the dentist who will actually provide the service. Complete this section if the performing provider is different from the billing provider.** Enter the performing provider's 8-digit Medicaid provider number.
9	BILLING PROVIDER'S ADDRESS (if stamped, please stamp every copy.)	Enter the name and the address of the billing provider. The street, city, state, and zip code must be included. If you use a stamp for the name and address, please stamp all three copies of the PA/DRF form. No other information should be included in this section because it also serves as a return mailing label.

Appendix 21
PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF) COMPLETION GUIDELINES
(continued)

BOX #	DESCRIPTION	INSTRUCTIONS
10	PROVIDER TELEPHONE NUMBER	Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the provider.
11	INDICATE IF THE SERVICE WILL BE PERFORMED IN:	Mark the proper place of service code which desginates where the requested service/procedure will be provided. Do not mark any of these boxes if the requested service will be performed in a location other than inpatient hospital, outpatient hospital, ambulatory surgery center, or dental office.
12	TOOTH NUMBER (*or letter*)	Using the numbers and letters on the Tooth Chart in box 17, identify the tooth number or letter for the service requested.
13	PROCEDURE CODE	Enter the appropriate procedure code for each service/procedure requested on each line.
14	QUANTITY (*of service requested*)	Dentists: Enter the number of services requested for each service/procedure requested. If requesting five years of prophylaxes or fluoride services for permanently disabled recipients, with four services requested each year, request 20 units of service. Orthodontists: Enter a quantity of "1" in this box.
15	DESCRIPTION (*of service*)	Enter a written description corresponding to the appropriate procedure code for each service/procedure.
16	FEE	Enter your usual and customary charge for each service/procedure requested (the amount charged to non-Medicaid patients).
17	PERIODONTAL CASE TYPE, TOOTH CHART, & X-RAYS	For Partials, Endodontics, and Periodontics, circle the periodontal case type. On the diagram, cross out ("X") missing teeth (including extractions). Circle teeth to be extracted only when requesting endodontic or partial denture services. Indicate the number and type of x-rays submitted with this prior authorization request. (We request this information to ensure we receive all the x-rays sent with the PA/DRF.)
18	TOTAL FEES	Enter the anticipated total charge for this request.
19	RECIPIENT/GUARDIAN SIGNATURE (*Optional*)	The recipient or the recipient's guardian can sign and date the prior authorization request so they are informed about the request.
20	PROVIDER SIGNATURE (*If stamped, please stamp every copy.*)	The provider must sign and date the prior authorization request. If you use a stamp for the provider signature, please stamp all three copies of the PA/DRF form.

DETACH AND KEEP THE BOTTOM COPY OF THE PA/DRF.
LEAVE THE TOP TWO FORMS ATTACHED.

Keep the bottom copy of the PA/DRF. You can discard this copy once you receive the processed prior authorization request.

PROVIDER CHECKLIST: The bottom copy features a Provider Checklist to assist with requests for periodontics, endodontics, and services requiring enclosures. For additional information, consult Appendix 24 of this handbook.

Appendix 22
SAMPLE PRIOR AUTHORIZATION DENTAL ATTACHMENT REQUEST FORM (PA/DA)

DENTAL AND ORTHODONTICS PRIOR AUTHORIZATION (PA/DA) FORM
(Attach to PA/DRF form)

WRITE IN P.A. # *(preprinted in red ink on PA/DRF form)*	RECIPIENT'S MEDICAID ID #	BILLING PROVIDER #	PERFORMING PROVIDER # *(if different)*

PA/DA PAGE 1

COMPLETE THIS PAGE FOR ALL DENTAL AND ORTHODONTIC PRIOR AUTHORIZATION REQUESTS

Please answer all questions on this page. If necessary, attach additional pages for your responses.

1. **Complete for all dental services.** Dental diagnosis / Description of present condition:

2. **Complete for Orthodontics .** Type of malocclusion:

3. **Complete for all dental services.** Dental indications, dental history, or medical need pertinent to treatment requested:

4. **Complete for all dental services.** Specific treatment plan:

5. **Complete for Orthodontics.** Anticipated number of monthly adjustments:

6. **Complete for all dental services.** Overall treatment prognosis (circle one)

EXCELLENT	GOOD	FAIR	POOR

If POOR, please explain the reason for the requested treatment.

7. **Complete for all dental services.** Indicate if the recipient is physically, psychologically, otherwise indefinitely disabled, or has a medical condition that impacts the treatment requested.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

Appendix 22
SAMPLE PRIOR AUTHORIZATION DENTAL ATTACHMENT REQUEST FORM (PA/DA)
(continued)

PA/DA PAGE 2

COMPLETE THIS PAGE FOR:

ENDODONTICS (Questions 1, 2, 3, 4, 5, 6 and 8)

PERIODONTICS (Questions 1, 2, 3 and 7)

PARTIAL DENTURES (Questions 1, 2, 3, 8 and 9 – also complete Page 3)

If necessary, attach additional pages for your responses.

1. **Complete for Endodontics, Periodontics, or Partial Dentures.** Condition of caries control:
   a. Restorative treatment plan has not been started. ☐
   b. Restorative treatment plan is in progress. ☐
   c. Restorative treatment plan has been completed. ☐

2. **Complete for Endodontics, Periodontics, or Partial Dentures.** Oral hygiene status (circle one):

EXCELLENT	GOOD	FAIR	POOR

3. **Complete for Endodontics, Periodontics, or Partial Dentures.** Recipient attendance (circle one):

EXCELLENT	GOOD	FAIR	POOR	NEW PATIENT

4. **Complete for Endodontics.** Have recipient provide reasons and estimated dates for any extractions within the past three years.

5. **Complete for Endodontics.** Is the requested tooth an abutment for a partial/bridge?

   Yes ☐ No ☐

   If yes, indicate age and condition of partial/bridge.

6. **Complete for Endodontics.** For endodontic treatment, indicate if the tooth can be restored.

   ☐ I am able to restore the tooth using Medicaid-covered services.

Medicaid does not cover post and core or a permanent crown. If restoration requires the use of services not covered by Medicaid, please indicate whether the recipient has agreed to pay for services necessary to complete the restoration which are not covered by Medicaid.	Yes, the recipient has agreed to pay for restorative services not covered by Medicaid. ☐ No, the recipient has not agreed to pay for restorative services not covered by Medicaid. ☐

7. **Complete for Periodontics.** Describe a comprehensive periodontal treatment plan, including pre- and post-operative care.

8. **Complete for Endodontics or Partial Dentures.** Are all remaining teeth decay-free, properly restored, and periodontally healthy to ensure a good five-year prognosis?

   Yes ☐ No ☐

   If no, please explain restorations in progress.

9. **Complete for Partial Dentures.** If all necessary extractions have not been completed, please explain why.

Appendix 22
SAMPLE PRIOR AUTHORIZATION DENTAL ATTACHMENT REQUEST FORM (PA/DA)
(continued)

DENTAL AND ORTHODONTICS PRIOR AUTHORIZATION (PA/DA) FORM
(Attach to PA/DRF form)

WRITE IN P.A. # (preprinted in red ink on PA/DRF form)	RECIPIENT'S MEDICAID ID #	BILLING PROVIDER #	PERFORMING PROVIDER # (if different)

PA/DA PAGE 3

COMPLETE THIS PAGE FOR:
PARTIALS
DENTURES

Respond to all applicable questions if the recipient has and/or is requesting a removable complete or partial denture. Mark appropriate boxes.

If necessary, attach additional pages for your responses.

1. Does the recipient have a partial or denture(s)?

   Yes ☐ No ☐

   If yes, *please indicate:*

   Full ☐ Max. ☐ Mand. ☐

   Partial ☐ Max. ☐ Mand. ☐

2. Does the recipient wear his/her partial or denture(s)?

   Yes ☐ No ☐

   If no, answer question 3.

   If yes, *please indicate:*

   Max. ☐ Mand. ☐

3. If the recipient is no longer wearing the partial or denture(s), when did the recipient stop wearing it?

   Max _____ Mand _____

   Reason why the recipient stopped wearing existing partial / denture(s):

4. How old is the existing partial or denture(s)?

   Max _____ Mand _____

   Reason why the partial or denture(s) cannot be relined:

5. If the recipient is edentulous, how long edentulous?

   Max _____ Mand _____

Policy on Lost, Stolen or Severely Damaged Dentures	Documentation for Lost, Stolen or Severely Damaged Dentures
Wisconsin Medicaid does not routinely replace lost, severely damaged, or stolen prostheses. These prior authorization requests are only approved when: • The recipient has exercised reasonable care in maintaining the denture; • The prosthesis was being used up to the time of loss or theft; • The loss or theft is *not* a repeatedly occurring event; • A reasonable explanation is given for the loss or theft of the prosthesis; and • A reasonable plan to prevent future loss is outlined by the recipient or the facility where the recipient lives.	The dentist must attach documentation of the loss of dentures from the appropriate source. Documentation may include: • Police report, accident report, or fire report; • Hospital, nursing home, or group home/community based residential facility administrator statement on the loss; • Recipient statement on the loss.

See Wisconsin Medicaid Provider Handbook, Part B (Dental) for more information.

Appendix 23
PRIOR AUTHORIZATION DENTAL ATTACHMENT REQUEST FORM (PA/DA) COMPLETION GUIDELINES

When completing prior authorization (PA) requests, thoroughly answer all appropriate questions. Provide enough key information for Wisconsin Medicaid dental consultants to make a reasonable judgement about the case. This will decrease the number of resubmissions and prevent denials due to inadequate information.

All dentists requesting PA need to complete the following:

Service requested	Pages to complete
Additional dental visits or cleanings	PA/DRF and PA/DA page 1
Orthodontia	PA/DRF and PA/DA page 1
Endodontics, Periodontics, Partial dentures	PA/DRF and PA/DA pages 1 and 2
Partials, Dentures	PA/DRF and PA/DA pages 1, 2, and 3

Attach the appropriate pages of the completed PA/DA form to the Prior Authorization Dental Request Form (PA/DRF) and submit to the following address:

Prior Authorization Unit
EDS
Suite 88
6406 Bridge Road
Madison WI 53784-0088

HEADER COMPLETION INSTRUCTIONS – ALL PA/DA PAGES

The numeric information in the boxes at the top of each page of the PA/DA form must be completed. This information ensures accurate tracking of the PA/DA form with the PA/DRF form through the PA review process. This form will be returned to you for completion if this numeric information is not provided at the top of each page of the PA/DA form you submit.

DESCRIPTION	INSTRUCTIONS
WRITE IN PA #	Write in the red, preprinted number stamped at the top of the PA/DRF form.
RECIPIENT'S MEDICAID ID #	Enter the recipient's 10-digit Medicaid number exactly as it appears on the Medicaid identification card.
BILLING PROVIDER #	Enter the billing provider's 8-digit Medicaid provider number.
PERFORMING PROVIDER # *(if different)*	The performing provider is the dentist who will actually provide the service. You only need to complete this section if the performing provider is different from the billing provider.

PA/DA COMPLETION INSTRUCTIONS

PAGE 1 — Complete all questions on Page 1 of the PA/DA for all dental or orthodontic PA requests.

PAGE 2 — For endodontic PA requests, complete questions 1, 2, 3, 4, 5, 6, 8.
For periodontic PA requests, complete questions 1, 2, 3, and 7.
For partial denture PA requests, complete questions 1, 2, 3, 8, and 9.

PAGE 3 — Complete all questions on Page 3 for partials and dentures.

Appendix 24
Wisconsin Medicaid Information Needed For Prior Authorization Requests

When completing prior authorization (PA) requests, please:

- Thoroughly answer all appropriate questions.
- Provide all the key information about the recipient's case.
- Give enough information for Wisconsin Medicaid dental consultants to make a reasonable judgment about the request. This is the only information they have on which to base their decision.

Careful completion of all necessary PA questions will:

- Decrease the number of resubmissions.
- Prevent denials due to inadequate information.

ADA PROCEDURE CODE	SERVICE	INFORMATION NEEDED
Preventive Services		
01351	Sealants	PA required for most teeth but not required for first and second permanent molars.
01515	Space maintainer	Two bitewing x-rays (PA required ages 13-20).
Restorative Services		
02932, 02933	Composite/prefabricated resin crown, prefabricated stainless steel crown with resin window	One periapical x-ray (PA required for adults over age 20 only).
W7126	Upgraded crown	One periapical x-ray.
Endodontic Services		
03310, 03320, 03330	Anterior, bicuspid, and molar root canal therapy	- One periapical x-ray. - Two bitewing x-rays. - Intraoral charting (PA/DRF Element 17). (PA always required for adults over age 20 on all teeth and for children on molar teeth.)
03410	Apicoectomy (anterior only)	- One periapical x-ray.
03430	Retrograde filling	- One periapical x-ray.
Periodontic Service		
04341	Periodontal scaling and root planing	- Periodontal charting.
04355	Full mouth debridement	- Periodontal charting. - Minimum of 4 bitewing x-rays or a full mouth x-ray.
04910	Periodontal maintenance	- Periodontal charting.

ADA PROCEDURE CODE	SERVICE	INFORMATION NEEDED
Prosthodontic Services		
05110-05120	Denture	- If replacing lost/stolen prosthesis, include official explanation of loss and a plan to prevent future loss.
05211-05212 W7127-W7128	Partial denture Upgraded partial denture	- X-rays sufficient to show entire arch plus bitewings, if appropriate. - Periodontal charting. - Intraoral charting (PA/DRF Element 17). - If replacing lost/stolen prosthesis, include official explanation of loss and a plan to prevent future loss.
05955	Palatal lift	- If replacing lost/stolen prosthesis, include official explanation of loss and a plan to prevent future loss. - Physician or speech pathologist statement documenting speech impediment.
Fixed Prosthodontic Services		
06545, 06940-06980 W7310-W7320	Fixed prosthodontics	- Periapical x-rays sufficient to show treatment area. - Periodontal charting of abutment teeth.
Oral and Maxillofacial Surgery Services		
07280-07281	Surgical exposure	- One periapical x-ray. - HealthCheck referral.
07530-07540 and equivalent CPT codes	Removal foreign body	- One periapical x-ray. (PA not required for POS 1 or in an emergency.)
07840-07860, 07950, 07991 07992 and equivalent CPT codes	TMJ surgery	- TMJ second surgical opinion. - Document non-surgical treatment. - Operative and post-op plan of care. - X-ray report.
07940, 07960 and equivalent CPT codes	Orthognathic surgery, frenulectomy	- HealthCheck.
Orthodontic Services		
08110-08750 W7910-W7920 00340	Orthodontic service	- HealthCheck referral. - Study models. Pack study models securely in packing material to prevent breakage.

All PA requests require:

- A statement from the dentist regarding the reasons for the requested treatment.
- Answers to all appropriate questions on all PA forms.
- Signatures and dates on each form.

When appropriate, include the following information:

- A description of the recipient's oral health.
- Any physical or mental disability that affects the recipient's dental health and hygiene.
- Any state/federal law that requires the recipient to receive treatment (such as when a child is in foster care).
- Any medical condition that affects the recipient's dental health.
- The relationship between the prior authorized treatment and other dental treatment in progress.
- Trauma situations that have affected the treatment needed.
- Efforts to date to correct the problem.
- Additional X-rays or intraoral pictures if they are needed to better document the situation.

Appendix 25
Provision of Upgraded Partial Denture and Crowns to Medicaid Recipients

A dentist/dental clinic must submit the following form or another written document with the same information upon submission of the first prior authorization (PA) request to provide an upgraded partial denture and/or crown (higher quality than currently covered by Medicaid) to a Medicaid recipient. All subsequent PA requests to provide an upgraded crown or partial denture *under the same dental clinic/dentist provider number* must either contain the same form or reference as the previously submitted document.

1. All Medicaid patients who receive services from the dentist/dental clinic listed below are eligible to receive upgraded crowns and/or partial dentures based on the following medical criteria established by the dental office:

2. All Medicaid recipients who receive upgraded crowns and/or partial dentures are charged no more than $3 copayment, unless the recipient is exempt from copayment charges as based on Medicaid copayment exemptions outlined in Part A, the all-provider handbook.

3. Medicaid payment along with the $3 recipient copayment is accepted as payment in full for the upgraded procedures.

Dentist/Dental Clinic (printed)_____

Dentist/Dental Clinic (signature)_____

Medicaid Provider Number _____ Date _____

Appendix 26
American Dental Association Claim Form Example

Dental Claim Form See reverse for instructions

1. ☐ Dentist's pre-treatment estimate
☐ Dentist's statement of actual services
Provider ID # 12345678

2. ☐ Medicaid Claim
☐ EPSDT
Prior Authorization # 1234567
Patient ID # 1234567890

3. Carrier name and address

PATIENT COVERAGE INFORMATION

4. Patient name: first Im; m.i. A.; last Recipient
5. Relationship to employee: ☐ self ☐ child ☐ spouse ☐ other
6. Sex: m f X
7. Patient birthdate: MM DD YYYY MM DD YY
8. If full time student: school; city 1234JED
9. Employee/subscriber name and mailing address
10. Employee/subscriber dental plan I.D. number
11. Employee/subscriber birthdate: MM DD YYYY
12. Employer (company) name and address
13. Group number
14. Is patient covered by another dental plan: yes no. If yes, complete 15-a. Is patient covered by a medical plan? yes no
15-a. Name and address of carrier(s): M-6 OI-P
15-b. Group no.(s)
16. Name and address of other employer(s)
17-a. Employee/subscriber name (if different from patient's)
17-b. Employee/subscriber dental plan I.D. number
17-c. Employee/subscriber birthdate: MM DD YYYY
18. Relationship to patient: ☐ self ☐ parent ☐ spouse ☐ other

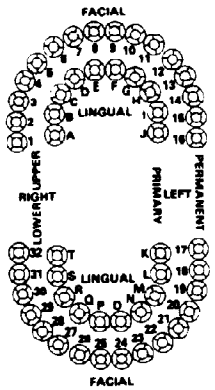
19. I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.
› Signed (Patient* – see reverse) Date

20. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.
› Signed (Employee/subscriber) Date

BILLING DENTIST

21. Name of Billing Dentist or Dental Entity: IM Billing
22. Address where payment should be remitted: 1 W. Williams
23. City, State, Zip: Anytown, WI 55555
24. Dentist Soc. Sec. or T.I.N. (see reverse**)
25. Dentist license no.
26. Dentist phone no.
27. First visit date current series
28. Place of treatment: Office Hosp. ECF Other 3
29. Radiographs or models enclosed? No Yes How many?
30. Is treatment result of occupational illness or injury? No X Yes
31. Is treatment result of auto accident? No X Yes
32. Other accident? No X Yes
33. If prosthesis, is this initial placement? (If no, reason for replacement)
34. Date of prior placement
35. Is treatment for orthodontics? If service already commenced enter: Date appliances placed Mos. treatment remaining

36. Identify missing teeth with "x"



37. Examination and treatment plan – List in order from tooth no. 1 through tooth no. 32 – Using charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year	Procedure number	Fee	For administrative use only
		Complete upper denture	MM DD YY	05110	xxx xx	
		Amalgam	MM DD YY	02160	xx xx	
		Open tooth for drainage	MM DD YY	W7118	xx xx	E

38. Remarks for unusual services

39. I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.
› IM Authorized MMDDYY
Signed (Treating Dentist) License Number Date

40. Address where treatment was performed
IM Performing Provider 87654321 City State Zip

41. Total Fee Charged xxx xx
42. Payment by other plan xx xx
Max. Allowable
Deductible
Carrier %
Carrier pays
Patient pays

©American Dental Association, 1994
J510 (Same as ADA Dental Claim Form - J504, J511, J512)

Appendix 27
American Dental Association Claim Form Completion Instructions

To avoid unnecessary denial or inaccurate claim payment, providers must use the following claim form completion instructions. Enter all required data on the face of the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless "optional" or "not required" is specified.

Wisconsin Medicaid recipients receive a Medicaid identification card upon initial enrollment into Wisconsin Medicaid and at the beginning of each month thereafter. This card must always be presented prior to rendering the service. Please use the information exactly as it appears on the Medicaid identification card to complete the information in the patient information section.

Element 1 - Provider ID #
Enter the billing provider's eight-digit provider number. (*Note*: A group billing provider number must be entered in this element if a performing provider number is entered in element 40.)

Element 2 - EPSDT/Prior authorization #/Patient ID#
HealthCheck is Wisconsin Medicaid's federally mandated program known nationally as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

> *EPSDT*: If the services were performed as a result of a HealthCheck/EPSDT exam, check the EPSDT box.
>
> *Prior authorization #*: Enter the seven-digit prior authorization (PA) number from the approved prior authorization form. Do not attach a copy of the PA form to the claim. Services authorized under different PA numbers must be billed on separate claim forms.
>
> *Patient ID#*: Enter the recipient's 10-digit Medicaid identification number from the Medicaid identification card.

Element 3 - Carrier name and address (not required)

Element 4 - Patient name
Enter the recipient's first name, middle initial, and last name as they appear on the current Medicaid identification card.

Element 5 - Relationship to employee (not required)

Element 6 - Sex
Check "M" for male or "F" for female.

Element 7 - Patient birthdate
Enter the recipient's date of birth in MMDDYY format (e.g., June 18, 1964, would be 061864) as it appears on the Medicaid identification card.

Element 8 - If full time student (optional)
You may enter the patient's internal office account number here. This number will appear on the fiscal agent Remittance and Status report (maximum of 14 characters).

Element 9 - Employee/subscriber name and mailing address (not required)

Element 10 - Employee/subscriber dental plan ID number (not required)

Element 11 - Employee/subscriber birthdate (not required)

Element 12 - Employer (company) name and address (not required)

Element 13 - Group number (not required)

Element 14 - If patient covered by another dental plan... (not required)

Element 15a - Name and address of carriers
Medicare must be billed for covered services before billing Wisconsin Medicaid if Medicare covers the service. When the recipient's Medicaid identification card indicates Medicare coverage, but Medicare does not allow any charges, one of the following Medicare disclaimer codes must be indicated. The description is not required.

Code	Description
M-1	Medicare benefits exhausted. This disclaimer code may be used by hospitals, nursing homes, and home health agencies when Medicare has made payment up to the lifetime limits of its coverage.
M-5	Provider not Medicare certified for the benefits provided.
M-6	Recipient not Medicare eligible.
M-7	Medicare disallowed (denied) payment. Medicare claim cannot be corrected and resubmitted.
M-8	Medicare was not billed because Medicare never covers this service.

If Medicare is not billed because the recipient's Medicaid identification card indicated no Medicare coverage, this element must be left blank.

If Medicare allows an amount on the recipient's claim, the Explanation of Medicare Benefits (EOMB) must be attached to the claim and this element must be left blank. Do not enter Medicare paid amounts on the claim form. Refer to Appendix 17 of Part A, the all-provider handbook, for further information regarding the submission of claims for dual entitlees.

Dental Only third party coverage (commercial insurance coverage) must be billed prior to billing Wisconsin Medicaid. This new billing policy applies only to dentists using the ADA claim form. Dental Only third party insurance will be indicated in the "Other Coverage" space on the recipient's Medicaid identification card as "DEN".

If a recipient has only Dental Only third party insurance, then DEN will appear on the Medicaid identification card as a separate code. If a recipient has other third party insurance in addition to Dental Only third party insurance, then multiple insurance indicators will appear on the Medicaid identification card: for example, BLU, DEN.

When the dental provider has not billed other insurance because the "Other Coverage" of the recipient's Medicaid identification is blank, this element must be left blank.

When the "Other Coverage" space shows HPP, BLU, WPS, CHA, OTH, HMO, or HPP, but *not DEN*, and the service is not dental surgery, this element must be left blank.

When the "Other Coverage" space of the recipient's Medicaid identification card indicates BLU, WPS, CHA, or OTH, *but not DEN*, and the service requires third party billing according to Appendix 18a of Part A, the all-provider handbook, one of the following codes MUST be indicated in element 15a. The description of the code is not required, nor is policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID in part by other insurance. The amount paid by private insurance to the provider or the insured is indicated on the claim.
OI-D	DENIED by private insurance following submission of a correct and complete claim. Do NOT use this code unless the claim in question was actually billed to and denied by the private insurer.
OI-Y	Yes, card indicates other coverage, but it was not billed for reasons including, but not limited to: - Recipient denies coverage or will not cooperate. - Service in question is known to be noncovered. - Insurance failed to respond to initial and follow-up claim. - Benefits not assignable or cannot get an assignment.

When "Other Coverage" space of the recipient's Medicaid identification card indicates HMO or HMP,*but not DEN*, and the service requires third party billing according to Appendix 18a of Part A, the all-provider handbook, one of the following codes MUST be indicated in element 15a. The description of the code is not required, nor is policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID by HMO or HMP. The amount paid is indicated on the claim.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may *not* use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by an HMO or HMP are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill Wisconsin Medicaid for services which are included in the capitation payment.

Element 15b - Group no.(s) (not required)

Element 16 - Name and address of other employer(s) (not required)

Element 17a - Employee/subscriber name (not required)

Element 17b - Employee/subscriber dental plan ID number (not required)

Element 17c - Employee/subscriber birthdate (not required)

Element 18 - Relationship to patient (not required)

Element 19 - Patient signature block (not required)

Element 20 - Employee/subscriber block (not required)

Element 21, 22, and 23 - Name and address of billing dentist or dental entity
Enter the billing provider's complete address.

Element 24 - Dentist's Social Security number or tax identification number (not required)

Element 25 - Dentist license number (not required)

Element 26 - Dentist phone no. (not required)

Element 27 - First visit date (not required)

Element 28 - Place of treatment
Enter the appropriate HCFA place of service code in the "Other" column. If the place of service entered is "Other," describe the place of service. Enter only one place of service code.

Code	Description
1	Inpatient hospital
2	Outpatient hospital
3	Office
4*	Home
7	Nursing home
8	Skilled nursing facility
0**	Other
B	Ambulatory surgical center

* = Enter the reason for performing dental service in the recipient's residence in element 38.
** = Enter the place of service's location and the reason for performing the dental procedure in an outside location in element 38.

Element 29 - Radiographs or models enclosed? (not required)

Element 30 - Is treatment result of occupational illness or injury?
Specify if the dental services were the result of an occupational illness, injury, or accident. Check no or yes. If yes is indicated for any one of the conditions, write a brief explanation in the space provided.

Element 31 - Is treatment result of auto accident? (required if applicable)

Element 32 - Other accident? (required if applicable)

Element 33 - If prosthesis, is this initial placement? (not required)

Element 34 - Date of prior placement (not required)

Element 35 - Is treatment for orthodontics? (not required)

Element 36 - Specify missing teeth with an "X" (optional)
Identify any missing or extracted teeth with an X" on the tooth chart.

Element 37 - Examination and treatment plan

Tooth # or letter: If the procedure applies to only one tooth, the tooth modifier (i.e., tooth number or tooth letter) is entered in element 37. If the procedure applies to only one denture repair, the modifier (i.e., UU or LL) is entered in element 37. Refer to Section IV-E of this handbook for more modifier information.

Surface: Enter the tooth surface(s) restored for each restoration.

Description of service: Write a brief description of each procedure. An exact quantity is entered in this element for procedure codes 00230, 00240, 00260, 04211, and 09220 only. When multiple quantities of a single type of service are provided on the same day, list the code only once with the appropriate quantity indicated at the end of the description. (This does not apply to codes that require modifiers.)

Date service performed: Enter the date of service in MMDDYY format (e.g., July 1, 1995, would be 070195) for each detail.

Procedure number: Enter the procedure code for the dental service provided. Refer to Appendices 9 through 19 of this handbook for a complete list of covered codes.

Fee: Enter the total charge for each detail.

For administrative use only: Enter an "E" in this element if the service is an emergency. Wisconsin Medicaid's claims processing system only accepts the letter "E," with no other letters, as an indication of an emergency.

Element 38 - Remarks for unusual services (not required)

Element 39 - Dentist's signature block

The provider, or an authorized representative, must sign in element 39. Also enter the month, day, and year that the form is signed.

Note: This may be a computer-printed name and date or a signature stamp.

Element 40 - Address where treatment was performed

If the dentist who performed the service is different than the billing provider, enter the performing provider's name and eight-digit provider number.

Element 41 - Total fee charged

Enter the total of all detail charges.

Element 42 - Payment by other plan

Enter the total dollar amount paid by any other insurance. Do not include the copayment amount.

If other insurance paid on only some services, those partially paid services should be billed on a separate claim from the unpaid services. This allows the fiscal agent to appropriately credit the payments.

Patient pays: Enter the spenddown amount, when applicable. Write "Spenddown" to the left of the *patient pays* box. Refer to Part A, the all-provider handbook, for information on recipient spenddown.

Appendix 28
HCFA 1500 Claim Form Example

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) P | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY — SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 609 Willow St.

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown — STATE: WI

8. PATIENT STATUS: Single | Married | Other — Employed | Full-Time Student | Part-Time Student

CITY — STATE

ZIP CODE: 55555 — TELEPHONE (Include Area Code): (xxx) xxx-xxxx

ZIP CODE — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-D

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M-8

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY — SEX: M | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX: M | F

b. AUTO ACCIDENT? YES | NO — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO — *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM MM DD YY — TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM MM DD YY — TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 802.35 3. ___.__

2. ___.__ 4. ___.__

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 MM DD YY		1	G	07230	17	1	xx	xx	1.0		E	
2 MM DD YY		1	G	07220	16	1	xx	xx	1.0		E	
3 MM DD YY		1	G	21230		1	xx	xx	1.0		E	
4 MM DD YY		1	G	21346	80	1	xx	xx	1.0			
5												
6												

25. FEDERAL TAX I.D. NUMBER: SSN | EIN

26. PATIENT'S ACCOUNT NO.: 1234ABCD

27. ACCEPT ASSIGNMENT? (For govt. claims, see back): YES | NO

28. TOTAL CHARGE: $ xx xx

29. AMOUNT PAID: $

30. BALANCE DUE: $ xx xx

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I. M. Authorized

SIGNED — DATE: MM/DD/YY

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I. M. Billing Provider
1 W. Williams
Anytown, WI 55555

PIN# — GRP# 76543210

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

Appendix 29
HCFA 1500 Claim Form Instructions
For Dental Services

To avoid denial or inaccurate claim payment, providers must use the following claim form completion instructions. Enter all required data on the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless "not required" is specified.

If a dentist is providing both CPT and ADA dental procedures, both may be billed on the HCFA 1500 claim form. The only exception to this is that restorative services requiring tooth number and surface information must be billed on the dental claim form.

Wisconsin Medicaid recipients receive a Medicaid identification card upon initial enrollment into Wisconsin Medicaid and at the beginning of each month thereafter. Providers should always see this card before rendering services. Please use the information exactly as it appears on the Medicaid identification card to complete the patient and insured information.

Element 1 - Program block/claim sort indicator
Enter claim sort indicator "P" for the service billed in the Medicaid check box. Claims submitted without this indicator are denied.

Element 1a - Insured's I.D. number
Enter the recipient's 10-digit Medicaid identification number as found on the current Medicaid identification card. This element must contain no other numbers, unless the claim is a Medicare crossover claim, in which case the recipient's Medicare number may also be indicated.

Element 2 - Patient's name
Enter the recipient's last name, first name, and middle initial as it appears on the current Medicaid identification card.

Element 3 - Patient's birth date, patient's sex
Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) as it appears on the Medicaid identification card. Specify if male or female with an "X."

Element 4 - Insured's name (not required)

Element 5 - Patient's address
Enter the complete address of the recipient's place of residence.

Element 6 - Patient relationship to insured (not required)

Element 7 - Insured's address (not required)

Element 8 - Patient status (not required)

Element 9 - Other insured's name
Third-party insurance (commercial insurance coverage) must be billed prior to billing Wisconsin Medicaid, unless the service does not require third-party billing according to Appendix 18a of Part A, the all-provider handbook.

- When the provider has not billed other insurance because the "Other Coverage" of the recipient's Medicaid identification card is blank, the service does not require third party billing according to Appendix 18a of Part A, the all-provider handbook, or the recipient's Medicaid identification card indicates "DEN" only, this element must be left blank.

- When "Other Coverage" of the recipient's Medicaid identification card indicates HPP, BLU, WPS, CHA, or OTH, and the service requires third party billing according to Appendix 18a of Part A, the all-provider handbook, one of the following codes MUST be indicated in the *first* box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part by other insurance. The amount paid by private insurance to the provider or the insured is indicated on the claim.
OI-D	DENIED by private insurance following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do NOT use this code unless the claim in question was actually billed to and denied by the private insurer.
OI-Y	YES, card indicates other coverage but it was not billed for reasons including, but not limited to:

- Recipient denies coverage or will not cooperate.
- The provider knows the service in question is noncovered by the carrier.
- Insurance failed to respond to initial and follow-up claim.
- Benefits not assignable or cannot get an assignment.
- When "Other Coverage" of the recipient's Medicaid identification card indicates "HMO" or "HMP," one of the following disclaimer codes must be indicated if applicable:

Code	Description
OI-P	PAID by HMO or HMP. The amount paid is indicated on the claim.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may *not* use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by an HMO or HMP are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill Wisconsin Medicaid for services which are included in the capitation amount.

Element 10 - Is patient's condition related to (not required)

Element 11 - Insured's policy, group, or FECA number

The *first* box of this element is used by Wisconsin Medicaid for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed prior to billing to Wisconsin Medicaid. When the recipient's Medicaid identification card indicates Medicare coverage, but Medicare does not pay, one of the following Medicare disclaimer codes MUST be indicated. The description is not required.

Code	Description
M-1	Medicare benefits exhausted. This disclaimer code may be used by hospitals, nursing homes, and home health agencies when Medicare has made payment up to the lifetime limits of its coverage.
M-5	Provider not Medicare certified for the benefits provided.

M-6 Recipient not Medicare eligible.

M-7 Medicare disallowed (denied) payment. Medicare claim cannot be corrected and resubmitted.

M-8 Medicare was not billed because Medicare never covers this service.

If Medicare is not billed because the recipient's Medicaid identification card indicates no Medicare coverage, this element must be left blank.

If Medicare allows an amount on the recipient's claim, the Explanation of Medicare Benefits (EOMB) must be attached to the claim and this element must be left blank. Do not enter Medicare paid amounts on the claim form. Refer to Appendix 17 of Part A, the all-provider handbook, for further information regarding the submission of claims for dual entitlees.

Elements 12 and 13 - Authorized person's signature
(Not required since the provider automatically accepts assignment through Medicaid certification.)

Element 14 - Date of current illness, injury, or pregnancy (not required)

Element 15 - If patient has had same or similar illness (not required)

Element 16 - Dates patient unable to work in current occupation (not required)

Element 17 - Name of referring physician or other source (not required)

Element 17a - I.D. number of referring physician (not required)

Element 18 - Hospitalization dates related to current services (not required)

Element 19 - Reserved for local use
If an unlisted procedure code is billed, providers must describe the procedure. If element 19 does not provide sufficient space for the procedure description, or if multiple unlisted procedure codes are being billed, providers must attach documentation to the claim describing the procedure(s). In this instance, providers must indicate "See Attachment" in element 19. This element may be used for narratives required to exceed limitations.

Element 20 - Outside lab (not required)

Element 21 - Diagnosis or nature of illness or injury
The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code must be entered for each symptom or condition related to the services provided. Manifestation ("M") codes are not acceptable. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis. The diagnosis description is not required.

Element 22 - Medicaid resubmission (not required)

Element 23 - Prior authorization
Enter the seven-digit prior authorization (PA) number from the approved PA request form. Services authorized under multiple PAs must be billed on separate claim forms with their respective PA numbers.

Element 24a - Date(s) of service

Enter the month, day, and year for each procedure when billing for one date of service, enter the date in MM/DD/YY format in the "FROM" field. It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.
- All services are billed using the same procedure code and modifier if applicable.
- All procedures have the same type of service code.
- All procedures have the same place of service code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge *per detail line* in element 24F.)
- The number of services performed on each date of service is identical.
- All procedures have the same HealthCheck indicator.
- All procedures have the same emergency indicator.

Element 24b - Place of service

Enter the appropriate Wisconsin Medicaid *single-digit* place of service code for each service. Refer to Appendix 30 of this handbook for Wisconsin Medicaid allowable place of service codes.

Element 24c - Type of service code

Enter the type of service "G."

Element 24d - Procedures, services, or supplies

Enter the appropriate five-character procedure code and, if applicable, a maximum of two, two-character modifiers under the "Modifier" column. The only modifier valid for these CPT procedure codes is "80." If using ADA codes that require tooth modifiers, the tooth numbers or letters must be indicated.

Element 24e - Diagnosis code

When multiple procedures related to different diagnoses are submitted, column E must be used to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) that corresponds to the appropriate diagnosis in element 21.

Element 24f - Charges

Enter the total charge for each line item.

Element 24g - Days or units

Enter the total number of services billed for each line item.

Element 24h - EPSDT/family planning

HealthCheck is Wisconsin Medicaid's federally mandated program known nationally as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

Enter an "H" for each procedure that was performed as a result of a HealthCheck exam. If HealthCheck does not apply, leave this element blank.

Element 24i - EMG

Enter an "E" for *each* procedure performed as an emergency, regardless of the place of service. If the procedure is not an emergency, leave this element blank.

Element 24j - COB (not required)

Element 24k - Reserved for local use

Enter the eight-digit, Medicaid provider number of the performing provider *for each procedure*, if it is different than the billing provider number indicated in element 33.

When applicable, enter the word "spenddown" and, under it, the spenddown amount on the last detail line of element 24K directly above element 30. Refer to Section IX of Part A, the all-provider handbook, for information on recipient spenddown.

Any other information entered in this element may cause claim denial.

Element 25 - Federal tax ID number (not required)

Element 26 - Patient's account number

Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the fiscal agent Remittance and Status Report.

Element 27 - Accept Assignment

(Not required, provider automatically accepts assignment through Medicaid certification.)

Element 28 - Total charge

Enter the total charges for this claim.

Element 29 - Amount paid

Enter the amount paid by other insurance. If other insurance denied the claim, enter $0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

Element 30 - Balance due

Enter the balance due as determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

Element 31 - Signature of physician or supplier

The provider or the authorized representative must sign in element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY format.

NOTE: This may be a computer-printed or typed name and date or a signature stamp with the date.

Element 32 - Name and address of facility where services rendered

If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit Medicaid provider number.

Element 33 - Physician's, supplier's billing name, address, zip code, and phone

Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit Medicaid provider number.

Appendix 30
Wisconsin Medicaid Allowable Place Of Service Table

Place of Service (POS) Code	Description
1	Inpatient Hospital
2	Outpatient Hospital
3	Office
4	Home
7	Nursing Home (ICF)
8	Skilled Nursing Facility
0	Other
B	Ambulatory Surgical Center

Wisconsin Medicaid Allowable Type Of Service Table

Type of Service (TOS) Code	Description
G	Dental Services

Appendix 31
Wisconsin Medicaid Dental Billing Requiring Additional Documentation

CATEGORY	ADA CODE RANGE	REQUIRED DOCUMENTATION
Diagnostic	00160 00250-00260 00330	- Copy of the office progress notes to document the medical necessity for a detailed and extensive problem-focused evaluation. - Covered only in dental emergency. - Mark "E" on claim form to indicate emergency.*
Restorative	02110-02387 02930-02933, 02951	- Time limitations (such as coverage of the procedure only once every 3 years) may be exceeded if narrative on claim justifies medical necessity for replacing a properly completed filling, non-prior authorized crown, or adding a restoration on any surface tooth.
Removable Prosthodontic	05510-05660	- Required modifier "UU" or "LL."
	05999	- Narrative. - Lab bill.
Fixed Prosthodontic	06545, 06940, 06980	- Lab bill.
Oral/Max Surgery	07210-07250, 07270	- Covered only in dental emergency. - Mark "E" on claim form to indicate emergency.*
	07280-07281, 07960	- HealthCheck referral required. For billing, check element 2 EPSDT (HealthCheck) on claim form.**
	07285-07431, 07820	- Frequency limitation of once per day may be exceeded if narrative on claim justifies medical necessity for additional services.
	07440-07461	- Pathology report.
	07470-07810, 07830	- Operative report.
	07910-07911	- Operative report. - Covered only in dental emergency. - Mark "E" on claim form to indicate emergency.*
	07912	- Operative report required if same day as surgery.
	07940, 07960	- HealthCheck referral required. For billing, check element 2, EPSDT (HealthCheck) on claim form.**
	07980, 07999	- Operative report.
Orthodontic	08110-08750 W7910-W7920	- HealthCheck referral required. For billing, check element 2, EPSDT (HealthCheck) on claim form.**
Adjunctive	09910 W7116-W7118	- Covered only in dental emergency. - Mark "E" on claim form to indicate emergency.*

* Put "E" in element "For Admin. Use Only." Retain documentation of emergency in patient's records. Emergency dental care is immediate service that *must* be provided to relieve the patient from pain, an acute infection, swelling, trismus, fever, or trauma.

** HealthCheck referral form, copy of HealthCheck card, or any other signed, dated documentation that a HealthCheck exam has occurred in the past year is required with prior authorization request only. Retain evidence of HealthCheck in patient files. (Do not submit HealthCheck form with claim.)

DO NOT SUBMIT THIS CHART WITH YOUR CLAIM. THIS IS FOR DENTAL OFFICE USE ONLY.

Appendix 32
Sample Electronic Claims Submission Screen

DENTAL Electronic Claims Submission (ECS) SCREEN
The field numbers on the ECS screen correspond with the numbered data elements on the dental claim form.

WELCOME TO ELECTRONIC CLAIMS SUBMISSION
EDS-WISCONSIN MEDICAID

BP NBR 1 L NAME 4 F NAME 4 MID 2
PCN 8 OI 15a TPL 32 MSC 15a
PA NBR 2 DIAG 1 V722

DTL	FDOS	POS	PROC	M1	PP NBR	CHARGE	UNIT	EMG	HC	SURF
1	37	28	37	37	40	37	37	37	2	37
2										
3										
4										
5										
6										
7										
8										
9										
10										

TOT BILL 41 OI PAID 42 PAT PAID 42 NET BILL 31

1 Page # 1 Field # 6 Form: DENTAL 02-18-1998 11:48:29

Appendix 33
Electronic Media Claims Questionnaire

PAPERLESS CLAIMS REQUEST FORM

Please complete this form if you want additional information on electronic billing.

Name: _____

Address: _____

_____

_____

Medicaid Number: _____ **Phone #:** _____

Contact Person: _____

Type of Service(s) Provided: _____

Estimated Monthly Medicaid Claims Filed: _____

• • • •

Appendix 34
Understanding Explanation of Benefits Messages on the American Dental Association Claim Form

Use this chart to better understand EOB messages you receive. The second column indicates the EOB message, the place in the handbook to find clarifying information, and the claim form element that triggered the message. This chart references only the dental claim form, although the same messages may be received when using the HCFA 1500 claim form.

EOB Code	Message, Resource, and Related Claim Form Element
29	Recipient's last name does not match number. Wisconsin Medicaid card or other eligibility resource - Part A, Section I.C. Element 4
614	Recipient's first name does not match number. Wisconsin Medicaid card or other eligibility resource - Part A, Section I.C. Element 4
281	Recipient MA number incorrect. Wisconsin Medicaid card or other eligibility resource - Part A, Section I.C. Element 2
10	Recipient eligible for Medicare. Bill Medicare first. (Surgical Procedures) Part A, Appendix 17 If Medicare allowed charges - Attach Medicare EOMB If Medicare denied charges - Element 15A - use M-code and do not attach EOMB.
273	Resubmit Wisconsin Medicaid covered services denied by Medicare. Part A, Appendix 17 Element 15A - Use M-Code. Do not attach EOMB.
278	Wisconsin Medicaid files show recipient has other commercial ins. Part A, Appendix 18 - Bill denied services on separate claim from paid services to maximize benefits. Element 15A and 42
192	Prior authorization required for this service. Part B, Appendix 9 through 19 (Limitations) Element 2
424	Billing provider name/number missing, mismatched, or invalid. Element 1 & 21
425	Performing provider name/number missing, mismatched, or invalid. Element 40
177	Place of service invalid or not payable. Part B, Appendix 30 Element 28

EOB Code	Message, Resource, and Related Claim Form Element
93	Procedure code modifier (tooth letter, number, UU/LL) invalid. Part B, Appendix 9 (Limitations) Element 37
388	Procedure code is incorrect (not on EDS file). Part B, Appendix 9 through 19 (not all ADA codes are valid for Wisconsin Medicaid) Element 37
116	Procedure not a benefit on date of service. Part B, Appendix 9 through 19 Elements 37
247	Procedure code obsolete for date of service. Part B, Appendix 9 through 19 Element 37
172	Recipient not eligible for DOS billed. Element 37
171	Claim/adjustment received after 12 months from date of service. Part A, Section 9 F Element 37
865	Service covered only in emergency. Indicate with "E" - definition p.B10 - Keep documentation in recipient record Element - For Administrative Use Only
84	Signature or date missing. Element 39
100	Claim previously/partially paid on (claim number and R & S date). Part A, Appendix 27 Adjustment Request Form

NOTE: ADA Claim Form Completion Instructions are found in the Part B Provider Handbook, Appendix 27.

Appendix 35
HealthCheck Screening Information Chart

SPECIAL DENTAL CARE FOR YOUR CHILD IS AVAILABLE THROUGH A HEALTHCHECK SCREENING

Special dental care is available for children who are Medicaid recipients, such as:

- A SECOND CLEANING EACH YEAR..... for children over age 13.
- ORTHODONTIA (BRACES)..... for severe problems.

All your child needs is a HealthCheck screening!

HealthCheck is a preventive health screening that all kids should have once a year. And, if a child is under 4, the screening should be more often.

A HealthCheck screening offers all kinds of services:

- Complete check-ups.
- Hearing and eye tests.
- Shots.

And much more...

Through the HealthCheck screen, you can get a HealthCheck verification card to give to your dentist. Your dentist then determines the need for additional services, such as additional cleanings and braces.

For more information, contact your HMO, primary care physician, or the HealthCheck hotline at 1-800-722-2295.

Appendix 36
Dental Coverage Limits for Special Recipient Eligibility Categories

The following recipient eligibility categories have limited or no Medicaid dental coverage. Providers can identify recipients in these categories through information on their Medicaid identification card or by contacting EDS' Voice Response System, the Eligibility Hotline, or Dial-Up. Refer to Appendix 2 of Part A, the all-provider handbook, for the appropriate telephone numbers.

Special Benefit Category	Medicaid Identification Card Indicator	Medicaid Dental Coverage
Qualified Medicare Beneficiary Only	"QMB-only" or "QMB-only NH" written on card	Limited to payment of coinsurance and deductible for the few services that Medicare covers
Presumptive Eligibility	Beige card or blue card with message "Ambulatory Prenatal Services Only"	Limited to pregnancy-related services, including dental
Tuberculosis-related	Blue card with medical status code of "TR" and message: "Limited Services. Call EDS Voice Response."	Limited to tuberculosis-related services, including dental
Illegal (undocumented) aliens	No card	Limited to emergency services only
Specified Low Income Medicare Beneficiary Only	No card	No dental coverage
Qualified Working Disabled Individual	No card	No dental coverage