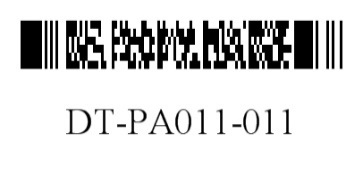
****DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services Wis. Admin. Code § DHS 107.07(2)

F-11010 (01/2019)

**ForwarDhealth**

**PRIOR AUTHORIZATION / DENTAL ATTACHMENT 1 (PA/DA1)**

**check box FORMAT**

The requested identifying information will only be used to process the prior authorization (PA) request. Failure to supply any of the requested information may result in denial of the PA.

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| **SECTION I – MEMBER AND PROVIDER INFORMATION** | | | | | |
| Member ID Number | | | National Provider Identifier (NPI) – Billing Provider | NPI – Rendering Provider | |
| **SECTION II – DENTAL SERVICES** | | | | | |
| **Category** | **Procedure Codes (Check all that apply.)** | | **Treatment Plan Justification  (Check all that apply.)** | | **Required Documentation** |
| Diagnostic Services | D0210  D0330  D0470  (PA is only required in certain circumstances.) | | Frequency limitation to be exceeded (D0210 and D0330)  Member over age 20 (D0470)  Wisconsin Department of Health Services request  Date of models (MM/DD/CCYY) | | * Explanation to exceed frequency limitation * Document number and type of X-rays taken (for D0210 and D0330) |
| Preventive Services | D1351  (21 years and older) | Tooth No. | Disability  Risk Factor (Describe) | | Explanation of medical necessity |
| Restorative Services | D2390  D2932  D2933  (For members who are age 0–20, PA is **not** required.) | Tooth No. | Tooth numbers 6–11, 22–27, D–G, supernumerary (56–61, 72–77)  Successful endodontic treatment  More than 50 percent tooth involved in trauma / caries  Cannot be restored with composite  American Association of Periodontists (AAP) I or II  Frequency limitation to be exceeded  Member over age 20 | | * One periapical X-ray * Explanation to exceed frequency limitation * D2933 is not allowed on teeth numbers 22–27 |
| Endodontic Services | D3310  D3320 | Tooth No. | Involves root canal therapy on four or more teeth (PA is not required for three or fewer teeth.) | | All documentation listed below and a treatment plan that indicates all indicated teeth meet clinical criteria |
| D3330  (For members who are age 0–20, PA is **not** required.) | Tooth No. | AAP I or II  Evidence visible on radiographs that at least 50 percent of the clinical crown is intact  Restorative treatment completed  Restorative treatment in process  Extractions completed in last three years (Indicate tooth number, date, and reason for any extractions.)    Pathology (Describe.)  Involves root canal therapy on four or more teeth (PA is not required for three or fewer teeth.) | | * Full-mouth series X-rays to include bitewing X-rays * Intra-oral charting * Document pathology, abcesses, carious exposure, nonvital, etc. |
| Periodontal Services | D4210  D4211 | | Medication-induced hyperplasia  Irritation from orthodontic bands  Hyperplasia  More than 25 percent crown involved  Other (Describe.) | | * Periodontal charting * Comprehensive periodontal treatment plan * Include Area of Oral Cavity code(s) on PA/DRF: 10 (upper right), 20 (upper left), 30 (lower left), and 40 (lower right) |

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## PRIOR AUTHORIZATION / DENTAL ATTACHMENT 1 (PA/DA1) 2 of 4

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| **SECTION II – DENTAL SERVICES (Continued)** | | | |
| **Category** | **Procedure Codes (Check all that apply.)** | **Treatment Plan Justification  (Check all that apply.)** | **Required Documentation** |
| Periodontal Services (Continued) | D4341  D4342 | Member 13 years of age and older  Early bone loss  Moderate bone loss  At least one pocket five or more millimeters deep on three or more teeth  Oral hygiene (Check one.)  Good  Fair  Poor  Full-mouth debridement completed in last 12 months Date of service for D4355 (MM/DD/CCYY). | * Periodontal charting * Comprehensive periodontal treatment plan * Full mouth X-rays with current bitewing X-rays * Clinical notes indicating member education on periodontal disease * Documentation of full-mouth debridement and/or routine dental care |
| D4355  (For members who are age 13 and older, PA is **not** required.) | Excess calculus on X-ray  AAP I or II  No dental treatment in multiple years  Oral hygiene (Check one.)  Good  Fair  Poor  Member under age 13 | * Bitewing or full mouth X-rays * Calculus must be visible on X-rays |
| D4910 | Recent history of periodontal scale / surgery  Oral hygiene (Check one.)  Good  Fair  Poor  Years requested (Check one.)  1  2  3 | * Periodontal charting * Comprehensive periodontal treatment plan * Allowed once per 12 months |
| Prosthodontic Services –Complete Dentures | D5110  D5120 | Initial placement of dentures (year)  Max       Mand  Age of existing denture(s) (years)  Max       Mand  New denture request because of the following (Check all that apply.)  Worn base / broken teeth  Poor fit  Vertical dimension  Date(s) last teeth extracted (MM/DD/CCYY)  Reason for edentulation    Lost / stolen / broken dentures  Reline / repair not appropriate  Has not worn existing dentures for more than three years  Edentulous more than five years without dentures  Additional justification    Frequency limitation must be exceeded | * New dentures limited to one per five years, per arch. * Six weeks healing period required unless special circumstances documented. * Document reasons for not wearing dentures or for not having ever had dentures. * Submit medical documentation to support special requests. * Document loss and plan for prevention of future mishaps. * Explanation to exceed frequency limitation. |

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## PRIOR AUTHORIZATION / DENTAL ATTACHMENT 1 (PA/DA1) 3 of 4

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| **SECTION II – DENTAL SERVICES (Continued)** | | | |
| **Category** | **Procedure Codes (Check all that apply.)** | **Treatment Plan Justification  (Check all that apply.)** | **Required Documentation** |
| Prosthodontic Services – Partial Dentures | D5211  D5212  D5213  D5214  D5225  D5226  D5670  D5671 | Initial placement of dentures (year)  Max       Mand  Age of existing denture(s) (years)  Max       Mand  New denture partial request because of the following (Check all that apply.)  Worn base / broken teeth  Poor fit  Vertical dimension  Date(s) last teeth extracted  Tooth numbers extracted  Missing at least one anterior tooth and/or has fewer than two posterior teeth in any one quadrant in occlusion with opposing arch  Has at least six missing teeth per arch  AAP I or II  Nonrestorable teeth have been extracted  Restorative procedures scheduled  Restorative procedures completed  Unusual clinical circumstances – must be documented (e.g., needed for employment)  Lost / stolen / broken dentures  Reline / repair not appropriate  Additional justification    Frequency limitation must be exceeded | * X-rays to show entire arch. * Periodontal charting. * New partials limited to one per five years, per arch. * Six weeks healing period required unless special circumstances documented. * Document reasons for not wearing partial dentures or reasons for not having ever had partial dentures. * Submit medical documentation to support special requests. * Document loss and plan for prevention of future mishaps. * Explanation to exceed frequency limitation. |
| Prosthodontic Services – Denture Reline | D5750  D5751  D5760  D5761 | Loose or ill-fitting  Tissue shrinkage or weight loss  Member is wearing denture  Age of the denture or partial  Frequency limitation must be exceeded | * Relines limited to one per three years, per arch. * Document special circumstances. * Explanation to exceed frequency limitation. |
| Adjunctive General Services – Anesthesia | D9222  D9223  D9230  D9239  D9243  D9248  (PA is not required for the following:   * Services performed in a hospital or ambulatory surgery center. * Services for members ages 0–20 when performed by a pediatric dentist or oral surgeon.) | Behavior  Disability (Describe.)    Geriatric  Physician consult  Complicated medical history (Describe.)    Extensive restoration  Maxillofacial surgery (Describe.)    Three or more extractions in more than one quadrant | Submit medical documentation to support special circumstances. |
| Adjunctive General Services – Miscellaneous | D9944  D9945  D9946 | Has bruxism or clenching of teeth  Tolerates prosthesis | Submit documentation to support request. |

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| **SECTION II – DENTAL SERVICES (Continued)** | | | | |
| **Category** | **Procedure Codes (Check all that apply.)** | **Treatment Plan Justification  (Check all that apply.)** | | **Required Documentation** |
| HealthCheck Other Services | D0999  D2999  D4999  D5999  D7999  D9999 | Periodic oral evaluation (additional)  Single unit crown. Tooth number  Surgical procedure  Nonsurgical procedure | | * Submit medical documentation to support special requests. * HealthCheck referral required. |
| **SECTION III – AUTHORIZED SIGNATURE** | | | | |
| **SIGNATURE** – Requesting Provider | | | Date Signed | |
| **SECTION IV – ADDITIONAL INFORMATION** | | | | |
| Indicate any additional information (e.g., diagnostic and clinical information) in the space provided. | | | | |