pennsylvania
DEPARTMENT OF HUMAN SERVICES

MEDICAL ASSISTANCE BULLETIN

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SUBJECT

Dental Benefit Limit Exception Process Update

BY

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IMPORTANT REMINDER: All providers must revalidate the Medical Assistance (MA) enrollment of each service location every 5 years. Providers should log into PROMISe to check the revalidation dates of each service location and submit revalidation applications at least 60 days prior to the revalidation dates. Enrollment (revalidation) applications may be found at: http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994.

PURPOSE:

The purpose of this bulletin is to inform dentists, federally qualified health centers (FQHCs) and rural health clinics (RHCs) of changes to the dental benefit limit exception (BLE) process for adult Medical Assistance (MA) Program beneficiaries, 21 years of age and older, effective March 1, 2021.

SCOPE:

This bulletin applies to all dentists, FQHCs and RHCs rendering dental services to MA beneficiaries in the Fee-for-Service delivery system. Dentists, FQHCs and RHCs rendering dental services in the managed care delivery system should address any questions regarding the dental benefit limits and payment for dental services to the appropriate managed care organization.

BACKGROUND/DISCUSSION:

The Department of Human Services (Department) implemented limits to certain dental benefits for adult MA beneficiaries 21 years of age and older on September 30, 2011. The Department issued MA Bulletin 27-11-47, titled "Medical Assistance Dental Benefit Changes," on September 26, 2011, to inform dentists, FQHCs and RHCs of the limits as well as the criteria and procedure to request an exception to the limits. The Department evaluates BLEs for the following dental services: dentures, oral evaluations and prophylaxis that exceed

Dental Fee Schedule limits, crowns, and adjunctive services, as well as periodontal and endodontic services.

As set forth in MA Bulletin 27-11-47, the Department developed a BLE process. The Department will grant benefit limits exceptions to the dental benefit limits when one of the following criteria is met:

1. The Department determines the recipient has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the recipient.

2. The Department determines the recipient has a serious chronic systemic illness or other serious health condition and denial of the exception will result in the rapid, serious deterioration of the health of the recipient.

3. The Department determines that granting a specific exception is a cost-effective alternative for the MA Program.

4. The Department determines that granting an exception is necessary in order to comply with Federal law.

Dental providers and stakeholders requested that the Department streamline the dental BLE review process. In response to their request, the Department now advises dental providers of the supporting medical/dental record information needed to review a BLE request and will consider additional information received within 15 days before making a decision on the BLE request.

The Department also examined the dental BLE process in an attempt to identify additional efficiencies. As part of that review, the Department determined that since the process was implemented, the Department has approved the majority of BLE requests for requesting beneficiaries who presented with certain medical conditions. Therefore, the Department has implemented an operational change. The Department will review BLE requests, without requiring supporting medical record documentation of the underlying medical condition(s), when the Department identifies through its claims history that a beneficiary has the health condition(s) listed below.

NOTE: The dental benefit limits do not apply to children under 21, or adults who reside in a nursing facility, an intermediate care facility for individuals with intellectual disabilities (ICF/ID) or an intermediate care facility for persons with other related conditions (ICF/ORC). However, dental providers must continue to secure prior authorization, as required by the Department and identified on the MA Program's Dental Fee Schedule, for crowns, periodontal services and dentures provided to a MA beneficiary who resides in a nursing facility, an ICF/ID, or an ICF/ORC. Dental providers must secure an 1150 Administrative Waiver, i.e., Program Exception approval, from the Department in instances when a MA beneficiary, who resides in one of these settings, is requesting a service that exceeds the fee schedule limits for dental services.

PROCEDURE:

If the dental BLE request identifies that the beneficiary has one of the conditions set forth below, as part of the dental BLE review process, the Department will review the MA beneficiary's claim history to determine if the condition was previously identified on a claim:

1. Diabetes.

2. Coronary Artery Disease or risk factors for the disease.

3. Cancer of the Face, Neck, and Throat (does not include stage 0 or stage 1 non-invasive basal or sarcoma cell cancers of the skin).

4. Intellectual Disability.

5. Current Pregnancy including post-partum period.

If the condition was previously identified on a claim, the Department will not require supporting medical record documentation of the condition. If the condition was not previously identified on a claim, the Department will notify the dental provider that supporting medical record documentation is needed to review the BLE request. The supporting medical record documentation if the condition was not previously identified on a claim, and any additional information requested, must be submitted to the Department within 15 days of the date of the Department's request to the dental provider. Upon receipt of the medical record documentation or additional information, the Department will review the request for a dental BLE to confirm that one of the criteria for the granting of a BLE is met. The dental provider and MA beneficiary will be informed of the Department's determination by written Notice of Decision. If the BLE request is approved, the services can be provided and paid for as long as the beneficiary maintains MA eligibility.

The Department updated Pennsylvania PROMISe™ Provider Handbook, 837 Professional/CMS-1500 Claim Form; and the Pennsylvania PROMISe™ Provider Handbook, 837 Dental/ADA – Version 2012 Claim Form to reflect the process set forth above.

https://www.dhs.pa.gov/providers/PROMISe_Guides/Pages/PROMISe-Handbooks.aspx