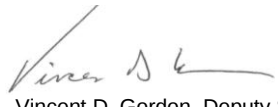




ISSUE DATE September 26, 2011	EFFECTIVE DATE September 30, 2011	NUMBER 27-11-47 08-11-51
SUBJECT Medical Assistance Dental Benefit Changes		BY  Vincent D. Gordon, Deputy Secretary Office of Medical Assistance Programs

IMPORTANT REMINDER: If you submit HIPAA compliant electronic healthcare claim transactions to the Department, you need to be prepared for the ANSI X12 v5010 and NCPDP vD.0 upgrades in order to prevent the rejection of your claims. The CMS mandated compliance date for all covered entities to use the new standards is January 1, 2012. For additional information, visit the DPW website at:
<http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/softwareandservicevendors/hipaa5010d.0upgradeinformation/index.htm>

PURPOSE:

The purposes of this bulletin are to:

1. Inform dentists, federally qualified health centers (FQHCs) and rural health clinics (RHCs) of changes in specific dental service benefits for adult Medical Assistance (MA) recipients, 21 years of age and older, effective September 30, 2011.
2. Inform providers of revised provider handbook pages, which include instructions for providers to request exceptions to the dental benefit limits.

SCOPE:

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

BACKGROUND/DISCUSSION

The MA Program provides a continuum of physical and behavioral health services, including long-term care, inpatient hospital, pharmacy, and outpatient services to approximately 2.2 million Pennsylvanians.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate toll-free number for your provider type.

Visit the Office of Medical Assistance Programs Web site at
<http://www.dpw.state.pa.us/provider/healthcaremedicalassistance/index.htm>

Currently, eligible adult MA recipients receive a broad array of dental services, which range from oral evaluations and preventive dental services to surgical extractions, crowns and dentures. Under Federal law, 42 U.S.C.A. § 1396d(a)(10); 1396a(a)(10)(A), states are not required to include dental services in their State Plan. Adult dental services may be furnished at the state's option.

States across the country, including Pennsylvania, are struggling to maintain their Medicaid programs as state revenues continue to lag, failing to keep pace with ever-increasing caseloads and health care costs. While the caseload of persons eligible for the MA program in the Commonwealth continues to grow in State Fiscal Year (SFY) 2011-2012; the General Fund Budget is 4.1 percent less than SFY 2010-2011 amounts, to near SFY 2008-2009 levels.

The Department of Public Welfare (Department) has taken steps to identify cost containment initiatives that will have the least detrimental impact on the health care needs of the MA population.

Rather than eliminating all dental services for the MA adult population, for example, the Department closely evaluated the utilization of and payments for particular dental services to determine which services could be limited with minimal impact. Based on MA utilization and claims data from SFY 2009-2010, the most recent year for which complete data is available, the changes to the dental benefits would have had no impact on over 96 percent of the total MA eligible adult population eligible for dental benefits who received services in that fiscal year. The Department will therefore realize significant cost savings while maintaining core preventive dental services as well as some other dental services for recipients.

Effective September 30, 2011, adult MA recipients, 21 years of age and older, will be eligible for the following:

- One partial upper denture or one full upper denture and one partial lower denture or one full lower denture per lifetime. Additional dentures will require a benefit limit exception (BLE).
- One oral evaluation and prophylaxis per 180 days, per adult recipient. Additional oral evaluations and prophylaxis will require a BLE.
- Crowns and adjunctive services, periodontal and endodontic services if the recipient receives a BLE.

The Department will grant benefit limit exceptions to the dental benefits 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.

The MA Program's MCOs have the option to impose the same or lesser limits for dental services. If the MA Program's MCOs decide to impose the same or lesser dental limits, they will issue individual notices to their members and notify network providers, at least 30 days in advance of the changes.

NOTE: The dental benefit changes do not apply to children under 21 years of age or to adults who reside in a nursing facility, an intermediate care facility for persons with mental retardation (ICF/MR) or an intermediate care facility for persons with other related conditions (ICF/ORC).

The dental benefit changes apply to adult recipients 21 years of age and older who reside in personal care homes and assisted living facilities.

PROCEDURE:

Effective September 30, 2011, the Department will limit the following dental services for adult recipients 21 years of age and older:

- Periodic oral evaluation (D0120) will be limited to one (1) per 180 days, per recipient. Additional oral evaluations will require a benefit limit exception (BLE).
NOTE: Providers will not be paid for a periodic oral evaluation (D0120) and a comprehensive oral evaluation (D0150) within the same 180 day time period.
- Prophylaxis, adult (D1110) will be limited to one (1) per 180 days, per recipient. Additional prophylaxis will require a BLE.
- Dentures will be limited to one per upper arch, full or partial, regardless of procedure code (D5110, D5130, D5211, D5213) and one per lower arch, full or partial, regardless of procedure code (D5120, D5140, D5212, D5214), per lifetime. The Department will review claims payment history for dates of service on and after March 1, 2004, to determine if the recipient previously received a denture for the arch. Additional dentures will require a BLE.

Effective September 30, 2011, adult recipients 21 years of age and older will be eligible for the following services only if the Department approves a BLE request:

- Crowns and adjunctive services (D2710, D2721, D2740, D2751, D2791, D2910, D2915, D2920, D2952, D2954, D2980)
- Periodontic services (D4210, D4341, D4355, D4910)
- Endodontic services (D3310, D3320, D3330, D3410, D3421, D3425, D3426)

Services provided beyond a recipient's benefit limits are not covered, unless a BLE is requested and approved by the Department.

If the recipient is enrolled in the managed care delivery system and receives a prior authorization approval for a dental service and subsequently enrolls in the Fee-for-Service (FFS) delivery system, the provider must request a BLE for the dental service if it is one of the dental services specified in this MA Bulletin that is subject to the dental benefit limits.

Dental Benefit Limit Exception Process

Dentist's Instructions:

In order to request a dental BLE, dentists must submit to the Department:

1. An American Dental Association (ADA) Claim Form completed in compliance with the MA Program's Dental Provider Handbook instructions. Field #1 on the ADA Claim Form must be checked to indicate "Request for Predetermination/Preauthorization"; and
2. A completed Dental BLE Request Form MA 549, which must be attached to the ADA Claim Form. Providers must indicate if the request is prospective or retrospective in the appropriate check box. If the request is retrospective, providers must indicate the applicable date(s) of service. The Dental BLE Request Form MA 549 must include documentation supporting the need for the service, including but not limited to dental record documentation, diagnostic study results, radiographs (if applicable), and a comprehensive medical and dental history.

Providers must submit the completed forms and supporting documentation to the Department at:

Office of Medical Assistance Programs
Bureau of Fee-for-Service Programs
Dental Benefit Exception Review
PO Box 8187
Harrisburg, Pennsylvania 17105-8187

The Dental BLE Request Form MA 549 is downloadable and available on the Department's website at:

<http://www.dpw.state.pa.us/findaform/ordermedicalassistanceforms/index.htm>.

A BLE request may be made prospectively, before the dental service is provided to the recipient, or retrospectively, after the dental service is provided to the recipient. A retrospective BLE request must be submitted no later than 60 days from the date the Department denies the claim because the service is over the benefit limit. Retrospective BLE requests received on or after the 61st day from the claim rejection date will be denied.

Instructions for requesting a prospective or retrospective dental BLE can be found in the MA Program's Dental Provider Handbook or by contacting the Medical Assistance Service

Center at 1-800-537-8862. The MA Program's Dental Provider Handbook may be viewed by accessing the Department's website at:

<http://www.dpw.state.pa.us/publications/forproviders/promiseproviderhandbooksandbillingguides/index.htm>

FQHC and RHC Instructions

In order to request a dental BLE, FQHCs and RHCs must submit to the Department:

1. An ADA Claim Form that reflects procedure code T1015/U9 (all inclusive dental clinic visit); and, the dental procedure code(s); and;
2. A completed Dental BLE Request Form MA 549, which must be attached to the ADA Claim Form, as set forth in the Dentist's Instructions above. The Dental BLE Request Form MA 549 must include documentation supporting the need for the service, including but not limited to dental record documentation, diagnostic study results, radiographs (if applicable), and a comprehensive medical and dental history.

Although the Department will assign a Dental BLE authorization number when it approves a BLE request, the FQHC and RHC must not include this number on any claims submission, i.e., electronic, internet or CMS 1500 Claim Form. FQHCs and RHCs must submit the claim for the approved procedure as a dental clinic visit (T1015/U9). If the Dental BLE authorization number is submitted on the claim, the claim will deny.

FQHCs and RHCs must maintain the Department's Dental BLE authorization number in the patient's record and make the record available for review and copying by the Department as required under 55 Pa.Code § 1101.51(e).

Instructions for requesting a prospective or retrospective dental BLE can be found in the MA Program's RHC/FQHC Provider Handbook or by contacting the MA Service Center at 1-800-537-8862. The MA Program's RHC/FQHC Provider Handbook may be viewed by accessing the Department's website at:

<http://www.dpw.state.pa.us/publications/forproviders/promiseproviderhandbooksandbillingguides/index.htm>

Decisions on Requests for a Benefit Limit Exception

The Department will respond to a request for a prospective dental BLE request within 21 days after the Department receives the request. For prospective dental BLE requests, if the provider or recipient is not notified of the decision within 21 days of the date the request is received by the Department, the dental BLE will be automatically approved. The Department will respond to a retrospective dental BLE request within 30 days after receiving the request.

The provider and the recipient will receive written notice of the approval or denial of the dental BLE request. When the Department denies a dental BLE request, the recipient and the provider receive a written Notice of Decision that explains the reason for the denial.

Consistent with 55 Pa.Code § 1101.31(f)(2)(viii), the provider may not bill the MA recipient for payment for services rendered in excess of the dental limits unless:

1. The provider informs the recipient before the service is rendered that the service requires a BLE and the recipient is liable for the payment if the request for an exception is denied; and,
2. The provider requests an exception to the limit and the Department denies the request.

Appeal Process for Benefit Limit Exception Request Denials

The Department will issue a written Notice of Decision for BLE requests to the recipient and the provider. Recipients have the right to appeal both prospective and retrospective BLE request denials. If a BLE request is denied by the Department, a recipient may file an appeal within 30 days from the date of the denial notice by submitting an appeal in writing to the address listed on the notice.

Providers may only appeal the Department's denial of a retrospective BLE request. Providers may file an appeal of a denial of a retrospective BLE request within 30 days from the date of the denial notice to the address listed on the notice.

Previously Approved Prior Authorizations

Crowns and denture services that were previously approved through the Department's prior authorization (PA) process must be initiated prior to the end-date of the approved authorization period, provided that the recipient remains eligible for MA dental benefits.

- A denture is considered initiated with the date of the dental impression (not the date of extraction).
 - Dentists are to use the date of the denture impression as the date of service and indicate the date of delivery of the denture in the "Remarks" section of the ADA Claim Form.
- A crown is considered initiated with the date of the preparation of the tooth.
 - Dentists are to use the date of tooth preparation as the date of service and indicate the date of cementation in the "Remarks" section of the ADA Claim Form.

Periodontal services must be completed prior to the end-date of the approved authorization period.

NOTE: Endodontic treatments do not require prior authorization. However, in order for the Department to pay a claim for endodontic treatments that are initiated prior to, but not completed by, September 30, 2011, providers must use the date of tooth access as the date of service.

- Dentists must indicate the date of completion of the endodontic service in the “Remarks” section of the ADA Claim Form.

FQHCs and RHCs are not subject to prior authorization requirements for dental services. FQHCs and RHCs must follow the directions above regarding the initiation of services; however, FQHCs and RHCs will continue to bill as usual with the T1015 procedure code/U9 modifier combination on the CMS 1500 in order to ensure appropriate claims payment.

Oral Evaluations and Prophylaxis

Providers may contact the Medical Assistance Service Center at 1-800-537-8862 and ask a Department representative to check the paid claims history in PROMIS[™] in order to help providers determine if an adult MA recipient had a paid claim for an oral evaluation (D0120 or D0150) or prophylaxis (D1110) in the last 180 days. It is important for providers to understand that this verification is just a snapshot in time. It is not a guarantee that another oral evaluation or prophylaxis was or was not rendered and is not a guarantee of payment.

Providers may view the Dental Fee Schedule and Dental Narrative by accessing the following website link: <http://services.dpw.state.pa.us/olddpw/OutpatientFeeSchedule.aspx>.

Dentists, FQHCs and RHCs who do not have internet access may request a hard copy of their Provider Handbook by writing to the Department at the following address:

Office of Medical Assistance Programs
Bureau of Fee-for-Service Programs
PO Box 8050
Harrisburg, Pennsylvania 17105
Attention: Division of Provider Services.

ATTACHMENT:

[Dental BLE Request Form](#)