Managed Care Operations Memorandum
General Operations
MCOPS Memo 06/2025-008

Date: June 25, 2025

Subject: Dental Benefit Limit Exception (BLE) Process Clarification

To: All Physical Health (PH) HealthChoices Managed Care Organizations (MCOs) – and All Community Health Choices (CHC) MCOs - Statewide

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A. Purpose
The purpose of this memorandum is to clarify the Department of Human Services' (Department) requirements and MCO responsibilities with regard to the dental BLE process for HealthChoices PH-MCO members and Community HealthChoices MCO members under the Medical Assistance (MA) Program in Pennsylvania.

B. Background
On September 26, 2011, the Department issued MA Bulletin 27-11-47, effective September 30, 2011, which conveyed restrictions established by notice in the PA Bulletin that limited eligibility for dental services covered by MA for adult beneficiaries 21 years of age and older to one partial upper denture or one full upper denture and one partial lower denture or one full lower denture per lifetime, and one oral evaluation and prophylaxis per 180 days. The bulletin also established a process by which dental providers could submit BLE requests which, if approved by the Department, would make an adult MA beneficiary eligible for additional dentures, oral evaluations and prophylaxis, crowns and adjunctive services, or periodontal and endodontic services.

Under the BLE process established by this bulletin, exceptions to these adult dental benefit limits would be granted when the Department determined that one of the following four criteria was met:

1. The beneficiary has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the beneficiary.
2. The beneficiary 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 beneficiary.
3. Granting a specific exception is a cost-effective alternative for the MA Program.
4. Granting an exception is necessary in order to comply with Federal law.

In order to request a dental BLE, the bulletin requires dentists to complete an American Dental Association (ADA) Claim Form for the necessary services, attach a completed Dental BLE Request Form MA-549 to identify the criteria met, as well as any supporting medical record documentation, and submit the package to the Department's Bureau of Fee-for-Service Program for review and approval.

On April 15, 2021, in response to requests from dental providers and stakeholders, the Department issued MA Bulletin 08-21-01, to streamline and improve the efficiency of the dental BLE review process. Under this new streamlined process, the Department reviews and approves 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 any of the following health condition(s):

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 Department identifies one of these five conditions in a beneficiary's claim history, the Department does not require the provider to submit supporting medical record documentation of the condition(s). The Department has determined that the documented presence of one of these five conditions, either through review of claims history or by submission of medical records, constitutes sufficient evidence that the request has met one or more of the four criteria listed in MA Bulletin 27-11-47, and a BLE will be granted. If one of these five conditions is not identified in a beneficiary's claim history, the Department requires the dental provider to submit supporting medical record documentation from a physician to establish the existence of one or more of the five conditions, or any other condition that would warrant a BLE request. In either case, as with any request for prior or retroactive authorization, **the specific services requested or provided must also be medically necessary**, as determined by the Department's clinical review. Put another way, the documented existence of conditions which meet BLE criteria does not constitute sufficient evidence for the medical necessity of the specific services requested or provided to address such conditions. The granting of a benefit limit exception is not equivalent to the authorization of the service; it is a prerequisite to continue the process of evaluating the medical necessity of the service.

C. Discussion

MCOs are required, under the terms of the HealthChoices PH Agreement, Section V.A.1, as well as under the terms of the CHC Agreement, to provide, at a minimum, In-Plan Services in the amount, duration and scope set forth in the MA fee-for-service (FFS) Program, based on the beneficiary's benefit package, unless otherwise specified by the Department. This includes quantitative and non-quantitative treatment limits as indicated in state statutes and regulations, the Medicaid State Plan and other state policies and procedures. As explained in

Section V.A.18 of the PH HealthChoices Agreement, in Section V.A.21 of the CHC Agreement, and Provider Quick Tip #273, PH-MCOs and CHC-MCOs have the option to impose the same or lesser [*emphasis added*] limits for dental services as imposed by MA FFS. Therefore, for those services that are covered in a member's benefit package only with an approved BLE, the MCO must either use the same criteria as the Department, or criteria that are less restrictive, for its review of BLE requests.

With regard to BLE approval for the five listed conditions, the Department has determined, based on review of the relevant literature, that the documented presence of any of these five conditions constitutes sufficient evidence that a member has met one or more BLE criteria and the BLE should be approved. If a provider submits a BLE request with an MA 549 form that indicates the presence of any of the five listed conditions, MCOs must review the beneficiary's claims history, and if this review documents the presence of any of these conditions, the MCO may not require the submission of additional medical records to document these conditions, or any additional information to qualify for the BLE, such as a demonstration that the requested dental service would ameliorate the underlying condition that qualifies for the BLE. **If the claims history does not document the presence of any of these five conditions, the MCO must reach out to the dental provider to explain the need to submit supporting documentation from a medical provider. Once the presence of one of the qualifying conditions has been established, the request should then move to clinical review for medically necessary dental services, and the MCO has discretion and authority to approve or deny authorization for the service on that basis.**

However, neither BLE nor clinical review may result in a requirement to provide alternate or less expensive services (such as extraction) when the member has been documented through claims or submitted medical records to have any of the five conditions listed in MA Bulletin 08-21-01, and the requested services have been determined to be medically necessary and clinically appropriate. The MCO may only consider alternative or less costly services if the requested service has been determined not to be medically necessary.

MCOs may not automatically deny a BLE request due to a procedural defect on the BLE form submitted by a provider. If an incomplete BLE form is received from a dental provider, the MCO should first investigate internal records to determine whether any missing information is available. For example, if a provider fails to indicate which condition the member has, the MCO should review available claims data to attempt to make that determination. If the form contained erroneous information or if the MCO is unable to obtain the missing information through its own systems, the MCO should contact the provider to obtain the missing information or correct the defect.

MCOs may elect to require providers to include Diagnosis Code Z98.818 or other MCO-specified codes in the ADA Claim Form accompanying the BLE request but may not deny the request due to the lack of this diagnosis code, and MCOs may instruct

providers to include only procedure codes which require a BLE on the accompanying ADA Claim Form but may not deny a BLE request due to the presence of service codes which do not require a BLE. In these situations, MCOs should still investigate internal records and available claims and work with providers to correct such defects, as described above.

The Dental BLE flow chart in Attachment 3 to this memorandum is a general illustration of the appropriate BLE review process as designed and intended by the Department in MA Bulletin 08-21-01. This chart does not formally address all scenarios and circumstances in which a BLE form may be missing or incomplete, or formally require specific actions, but is intended as a general description of how the BLE process should work in most instances.

D. Next Steps

1. HealthChoices PH-MCOs and CHC-MCOs must provide a list of ICD-10 diagnosis codes used to identify the presence of each of the five conditions referred to in this Ops Memo and submit that list of codes to the Department for approval. PH-MCOs and CHC-MCOs are encouraged to coordinate with other PH-MCOs and CHC-MCOs to establish a common set of diagnosis codes.

2. PH-MCOs and CHC-MCOs must review their dental BLE policies, processes procedures and forms, including those utilized by subcontracted Dental Benefits Managers on behalf of the PH-MCO or CHC-MCO, to determine whether any revisions are required to align with this memorandum. If revisions are required, they must be submitted to the Department for review and approval within 30 days of the effective date of this memorandum.

3. PH-MCOs and CHC-MCOs must review the revised version of the MA-549 FFS BLE form in Attachment 2 and consider adding any appropriate revised language and the additional checkboxes for providers to indicate the five qualifying conditions to their individual MCO BLE forms to help guide providers as to the intent and required steps of the BLE request process, as well as to clarify the respective roles of the five conditions and four criteria as set forth in the relevant MA Bulletins and Quick Tip, as discussed above.

4. PH-MCOs and CHC-MCOs who have questions regarding the content of this memorandum or the required BLE process should contact the DHS Chief Dental Officer or their respective contract monitoring teams in OMAP's Bureau of Managed Care Operations or OLTL's Division of Managed Care Operations.

E. Attachments

Attachment 1: MA-549 (revised 06/24/2025)

Dental Benefit Limit Exception Request Fo

Attachment 2: Flow Chart

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