

<b>ISSUE DATE</b>  April 15, 2021	<b>EFFECTIVE DATE</b>  April 15, 2021	<b>NUMBER</b>  08-21-01 27-21-01
<b>SUBJECT</b>  Dental Benefit Limit Exception Process Update	<b>BY</b>   Sally A. Kozak, Deputy Secretary Office of Medical Assistance Programs	

**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](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

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.dhs.pa.gov/provider/healthcaremedicalassistance/index.htm>.

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

## 6 Prior Authorization

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The Prior Authorization process for dental providers is described in this section. Along with the general information, this section includes the services that require prior authorization as well as the procedures to obtain prior authorization. Special guidelines for specific services are outlined here, as well as instructions on how to complete the ADA Claim Form – Version 2012 to obtain prior authorization. The final sections detail the procedure to transfer previously approved dental treatment to another MA enrolled dentist and examples of completed dental prior authorization requests.

### 6.1 General Information

Services and procedures that require prior authorization are identified in the Medical Assistance Program Fee Schedule with the suffix "PA" following the MA fee.

#### 6.1.1 DENTAL FEE SCHEDULE AND BENEFITS

The Department limits the following dental services for beneficiaries 21 years of age and older, **who do not reside** in a nursing facility, an ICF/ID or ICF/ORC:

1. Periodic oral evaluation will be limited to one (1) per 180 days, per beneficiary. Additional oral evaluations will require a Department approved BLE request.  
**NOTE:** Comprehensive oral evaluation will not be paid if rendered within the same 180-day time period.
2. Prophylaxis, adult will be limited to one (1) per 180 days, per beneficiary. Additional prophylaxis will require a Department approved BLE request.
3. Dentures will be limited to one per upper arch, regardless of procedure code (full or partial denture) and one per lower arch, regardless of procedure code (full or partial denture) **per lifetime**. The lifetime limit for dentures will begin with claims payment history on and after dates of service April 27, 2015. Additional dentures will require a Department approved BLE request.

Beneficiaries over 21 years of age, **who do not reside** in a nursing facility, an ICF/ID or ICF/ORC, will only be eligible for the following services if the Department approves a Benefit Limit Exception (BLE) request:

1. Crowns and adjunctive services;
2. Periodontic services;
3. Endodontic services.

Services requiring prior authorization include:

1. Orthodontics;
2. Complete and partial dentures;
3. Surgical extractions;

4. Placement of device to facilitate eruption of impacted tooth;
5. Crowns; and
6. Periodontal services except full mouth debridement, which requires post-operative review.

(See Section 6.3 for a comprehensive listing of services requiring prior authorization by category and procedure code.)

This section of the handbook explains the process for obtaining prior authorization for the above services. Orthodontic prior authorization is explained in Section 7 of this handbook.

**NOTE:** An approved prior authorization request means only that the “service” was determined medically necessary. The prior authorization is for the service only, not for the place of service. If providing service in an inpatient hospital, hospital short procedure unit or free-standing ambulatory surgical center, payment is dependent upon the Department’s authorization approval of the admission.

An approved request does not guarantee the beneficiary’s continued MA eligibility. **It is the responsibility of the provider to verify the beneficiary’s eligibility; not only on the date the service is requested, but also on the date the service is performed.**

MA does not cover restorations, procedures or appliances done to alter vertical dimension. Such procedures include, but are not limited to, those done primarily for replacement of tooth structure lost by attrition, realignment of teeth, splinting, equilibration, full mouth rehabilitation, and treatment of temporal mandibular joint syndrome. The beneficiary must be informed prior to service delivery that the Department does not cover the service. If performed, the service must be done with agreement from the beneficiary to assume all costs.

## 6.2 Authorization Process

Described briefly, the process for obtaining Department authorization for services is as follows:

Request – The dentist completes the ADA Claim Form - Version 2012, for any services that require prior authorization.

The dentist submits the ADA claim form, all required radiographs and information to justify medical necessity for the requested service(s) in the ENV 320 envelope or an envelope large enough to accommodate all of the required documentation without folding to:

Department of Human Services  
Office of Medical Assistance Programs  
P.O. Box 8050  
Harrisburg, PA 17105-8187

All radiographs should be placed in the X-ray envelope (ENV 98) prior to mailing.

Determination - Upon receipt of the required documents, the Department will either approve or disapprove the request for prior authorization. The dentist is notified of the approval or denial on the “Prior Authorization Notice” (MA 328).

Payment - After the service is approved and rendered, the provider may bill the Department. The ADA Claim Form - Version 2012 is completed in accordance with the instructions for completing claim forms in this handbook.

### 6.3 Services Requiring Prior Authorization

The following procedures require prior authorization.

<b>Services Requiring Prior Authorization</b>			
Procedure	Procedure Code	Procedure	Procedure Code
Crowns	D2710	Surgical Extractions	D7220
	D2721		D7230
	D2740		D7240
	D2751		D7250
	D2791		
Periodontics	D4210	Other Surgical Procedures	D7280
	D4341		
	D4355 **		
	D4910		
Complete Dentures	D5110	Partial Dentures	D5211
	D5120		D5212
	D5130		D5213
	D5140		D5214
Placement of device to facilitate eruption of impacted tooth	D7283	Orthodontics	D8080
			D8210
			D8220
			D8670
			D8680

The above services must be accompanied by a full mouth periapical or a panorex and current radiograph(s) of the affected area(s). Exceptions to this rule are noted in Section 6.4, Special Guidelines, which follows.

\*\*The Department requires the dentist to secure post-operative review approval for procedure code D4355. The dentist is to submit for post-operative review through the prior authorization program. The procedure name and procedure code must match and accurately describe the requested service(s).

## **6.4 Special Guidelines**

### **6.4.1 Crowns**

- a. Radiological films for proposed crowns or abutment teeth must have acceptable views of adjacent and opposing teeth.
- b. Molars must have pathological destruction to the tooth by caries or trauma, and must involve four (4) or more surfaces and two (2) or more cusps.

Anterior teeth must have pathological destruction to the tooth by caries or trauma, and must involve four (4) or more surfaces and at least 50% of the incisal edge.

Bicuspid (premolars) must have pathological destruction to the tooth by caries or trauma and must involve three (3) or more surfaces and one (1) cusp.

- c. When submitting a request for a crown following a root canal, the following conditions must be met:
  1. a one month period of time must elapse between the date a root canal is completed and the date that the request for a crown is submitted;
  2. a periapical film must be taken and submitted to show the root and crown of the natural tooth;
  3. the tooth is filled within two millimeters of the radiological apex; and
  4. the root canal filling material is not filled beyond the radiographical apex.
- d. The beneficiary must be free from active and advanced periodontal disease.
- e. Crowns must be opposed by teeth in the opposite jaw or be a support for a partial.
- f. Crowns for primary teeth will not be covered if the radiograph indicates imminent exfoliation.
- g. Crowns will not be approved when lesser means of restoration is possible.
- h. The dentist should impress upon the beneficiary the importance of taking care of a crown. Crowns that are dislodged, broken, or lost are not sufficient justification for replacement.

### **6.4.2 Complete Dentures**

- a. A Prior Authorization Request for a denture(s) should be based on:
  1. the total condition of the mouth;
  2. the ability of the beneficiary to adjust to a denture(s); and
  3. the desire of the beneficiary to wear a denture(s).

- b. Where essential preparatory services of any type are a part of an approved complete or partial denture treatment plan, those services must be completed before the denture service itself is initiated, including prior authorization of any teeth requiring extraction.
- c. The dentist should impress upon the beneficiary the importance of taking care of dentures. Stolen, lost or broken dentures are not sufficient justification for replacement.
- d. Dentures must be fabricated for a specific beneficiary with individually positioned teeth, wax up of the entire denture body and conventional laboratory processing.

**NOTE:** Complete dentures for nursing facility beneficiaries - This procedure is to be used for requesting complete denture only:

When a beneficiary is a resident of a nursing facility and the medical condition is such that the beneficiary cannot be moved from a room of the facility to obtain the needed radiographs, a Dental Services Certification form (available through the nursing facility) can be submitted, in lieu of radiographs, with the ADA Claim Form - Version 2012. When submitting a request with a certification form, the treatment plan should contain sufficient detail for a thorough diagnostic review. The Dental Services Certification form must be completed and signed. Enter the statement "DENTAL SERVICES CERTIFICATION FORM SUBMITTED IN LIEU OF RADIOGRAPHS" in the Remarks section of the ADA Claim Form - Version 2012.

### **6.4.3 Partial Dentures**

- a. The treatment plan must identify all teeth that are going to be placed on the partial denture.
- b. Abutment teeth must be at least 50% supported by bone.
- c. The dentist should impress upon the beneficiary the importance of taking care of dentures. Stolen, lost or broken dentures are not sufficient justification for replacement.

### **6.4.4 Extractions**

- a. Surgical
  - 1. The surgical extraction is not a simple extraction. Surgical extractions require an incision of overlying soft tissue, elevation of flap, and/or removal of bone, the removal of teeth, and possibly sectioning of the teeth.
  - 2. Surgical extraction will be for fully developed permanent teeth causing or threatening to cause irreversible damage.
  - 3. Routine removal of impacted or unerupted teeth must be supported by pathology.
    - A. Lesions associated with impaction.

B. Threat of resorption of root of permanent adjacent tooth.

b. Procedure Code Identification

1. Refer to the following illustrations to determine the appropriate MA Procedure Code for prior authorization.

A. Complete Bony Impaction

The occlusal surface of the crown of the tooth is completely encased in bone, and requires bone removal and/or sectioning of the tooth in order to remove the tooth.



B. Partial Bony Impaction

The occlusal surface of the crown of the tooth is sufficiently covered with bone to require removal of bone and/or sectioning to remove it from its bony crypt. In this case, the crown is partially covered by bone.



C. Soft Tissue Impaction

The occlusal surface of the crown of the tooth is partially or completely covered by soft tissue, which is incised and/or retracted from bone to remove the tooth.



D. Root Recovery

Surgical removal of a residual root completely covered by bone. A root remains with bony tissue grown over the space, which was once occupied by the coronal portion of the tooth.



**NOTE:** If a fee for tooth extraction was previously paid, no additional payment will be made for a subsequent root recovery involving the same tooth.

#### **6.4.5 Periodontal Services**

- a. Gingivectomy or Gingivoplasty - per quadrant
  1. The procedure is medically necessary for the correction of severe gingival hyperplasia or hypertrophy associated with drug therapy. Severe gingival hyperplasia interferes with or restricts the ability to perform effective daily oral hygiene procedures.
  2. If the following criteria are met in the professional judgment of the reviewer, this service will be approved:
    - A. Comprehensive periodontal evaluation (e.g., description of periodontal tissues, pocket depth chart, tooth mobility, mucogingival relationships); and
    - B. Pertinent medical and dental history (e.g., medications); and
    - C. Objective evidence of severe gingival hyperplasia restricting the ability to perform effective daily oral hygiene procedures; or
    - D. Other documentation of objective evidence of clinical condition whose severity is consistent with above criteria.
    - E. Exceptions to established limits may be granted if documentation presented indicates recurrence of severe gingival hyperplasia within a two-year period due to inability to alter medications.
- b. Periodontal scaling and root planing - per quadrant
  1. The procedure is medically necessary to:
    - A. Reduce clinical inflammation as evidenced by edema, erythema of the gingival, generalized bleeding on probing, spontaneous bleeding reported by beneficiary, or by purulent gingival discharge;
    - B. Effectuate microbial shifts to a less pathogenic, subgingival flora;
    - C. Reduce probing depths when pocket depth is equal to or greater than 5mm or in the presence of clinical inflammation (see a above) following routine prophylaxis; and/or
    - D. Gain clinical attachment.
  2. If the following criteria are met in the professional judgment of the reviewer, this service will be approved:
    - A. Comprehensive periodontal evaluation (e.g., description of periodontal tissue, pocket depth chart, tooth mobility, mucogingival relationships); and
    - B. Current diagnostic radiographs demonstrating evidence of bone loss; and
    - C. Narrative/documentation of clinical information, including pocket depth(s) of 5mm or greater except in cases of medication related gingival hyperplasia or persistent inflammation characterized by generalized bleeding on probing (multiple bleeding points present per tooth on at least ½ of remaining dentition per quadrant); or

- D. Other documentation of objective evidence of clinical condition whose severity is consistent with above criteria.
  - E. Exceptions to established limitations will not be granted due to lack of beneficiary compliance and/or continued poor oral hygiene.
- c. Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis - **the dentist is required to secure post-operative review and approval from the Department through the prior authorization program.**
- 1. The procedure is medically necessary for removal of subgingival and/or supragingival plaque and calculus which obstructs the ability to perform an oral evaluation. A preliminary procedure that does not preclude need for other procedures.
  - 2. If the following criteria are met in the professional judgment of the reviewer, this service will be approved:
    - A. Radiographs for diagnostic purposes demonstrating evidence of gross calculus buildup (radiographically visible calculus involving at least 75% of remaining dentition); or
    - B. In lieu of radiographs, documentation is presented indicating treatment was provided under general anesthesia or intravenous sedation, or radiographs were not obtainable due to the beneficiary's medical status; or
    - C. Other documentation of objective evidence of clinical condition whose severity is consistent with above criteria.
    - D. Exception to established limitations may be granted if objective evidence is presented indicating beneficiary is unable to perform effective daily oral hygiene procedures due to medical status.
- d. Periodontal maintenance procedures following active treatment (this excludes full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit)
- 1. The procedure is medically necessary to:
    - A. Prevent or minimize the recurrence and progression of periodontal disease in beneficiaries who have been previously treated for periodontitis;
    - B. Prevent or reduce the incidence of tooth loss by monitoring the dentition and any prosthetic replacements of the natural teeth; and
    - C. Increase the probability of locating and treating, in a timely manner, other diseases or conditions found within the oral cavity.
  - 2. If the following criteria are met in the professional judgment of the reviewer, this service will be approved:
    - A. Documentation of previous periodontal treatment; and
    - B. Continuous documentation of significant hard and soft tissue changes (e.g., changes in pocket depth greater than or equal to 2mm); or

- C. Other documentation of objective evidence of clinical condition whose severity is consistent with above criteria.
- D. Exceptions to established limitations will not be granted due to lack of beneficiary compliance and/or continued poor oral hygiene.

#### **6.4.6 Endodontic Therapy (Root Canals)**

- a. Payment for root canals no longer requires post-operative review for prior authorization approval.
- b. Root canals are not covered in the following situations:
  - 1. Intentional (elective) endodontics;
  - 2. Third molar (unless it is an abutment tooth);
  - 3. Teeth with advanced periodontal disease;
  - 4. Teeth with subosseous and/or furcation carious involvement;
  - 5. Teeth which cannot be restored with conventional methods (i.e., amalgam, composite or crowns); or
  - 6. Teeth, which have received prior endodontics treatment.

### **6.5 How to Complete the ADA Claim Form - Version 2012 for a Prior Authorization and a Dental BLE Request**

Please click the following link for detailed instructions on completing the ADA Claim Form – Version 2012 for Prior Authorization and a Dental BLE Request:

[https://www.dhs.pa.gov/providers/PROMISe\\_Guides/Documents/ADA%20Claim%20Form%20Version%202012%20Completion%20Aid%20for%20Dentist.pdf](https://www.dhs.pa.gov/providers/PROMISe_Guides/Documents/ADA%20Claim%20Form%20Version%202012%20Completion%20Aid%20for%20Dentist.pdf)

### **6.6 Administrative Waiver (Program Exception)**

The Department, under extraordinary circumstances, will pay for a medical service or item that is not one for which the MA Program has an established fee, or will expand the limits for services or items that are listed on the MA Program Fee Schedule. If a provider concludes that lack of the service or item would impair the beneficiary's health, the provider may request an 1150 Administrative Waiver or Program Exception (PE).

#### **6.6.1 Services and Items Requiring 1150 Administrative Waiver**

Services and items not listed on the MA Program Fee Schedule require an 1150 Administrative Waiver. An 1150 Administrative Waiver is also required for the expansion of the limits for services and items that are listed on the MA Program Fee Schedule.

### **6.6.2 Procedure for Obtaining 1150 Administrative Waiver**

When an MA beneficiary has the need for a service(s) or item(s) requiring a 1150 Administrative Waiver, the dentist completes the 1150 Waiver section of the Outpatient Service Authorization Request (MA 97).

The dentist submits the MA-97 form, all required radiographs and information to justify medical necessity for the services in an envelope large enough to accommodate all of the required documentation without folding to:

Outpatient  
PA/1150 Waiver Services  
P.O. Box 8187  
Harrisburg, PA 17105-8187

All radiographs should be placed in the X-ray envelope (ENV 98) prior to mailing.

Upon receipt of the required documentation, the Department will either approve or disapprove the request for a program exception. The dentist is notified of the approval or denial on the “Program Exception Notice” (MA 481).

If the request is approved, the dentist may bill the Department after the service is rendered. The ADA Claim Form - Version 2012 is completed in accordance with the instructions for completing claim forms in this handbook.

### **6.7 How to Complete the Outpatient Service Authorization Request Form (MA 97) for a 1150 Administrative Waiver**

The MA 97 is a snapset form. The original (Department Copy) is to be submitted for processing, while the copy (Provider Copy) is to be retained in the beneficiary’s dental record. Instructions for completing the form can also be found on the back of the MA 97 cover page.

- Item 1. Prior Authorization (LEAVE BLANK)
- Item 2. 1150 Waiver (Program Exception) (MUST) Place a checkmark in this block.

#### **PATIENT INFORMATION**

Items 3 through 6 are to be completed using information obtained from the Eligibility Verification System (EVS)

- Item 3. Beneficiary Number (MUST)  
Enter the 10-digit beneficiary identification number.
- Item 4. Patient’s Name (Last, First, MI) (MUST)  
Enter the beneficiary’s last name, first name, and middle initial.
- Item 5. Birthdate (MMDDCCYY) (MUST)  
Enter the beneficiary’s birthdate in an 8-digit format.
- Item 6. Sex (OPTIONAL)

Check the appropriate box, “M” (male) or “F” (female).

### **PROVIDER/PRESCRIBER INFORMATION**

Items 7 through 10 are to be completed using the information found on the provider’s Medical Assistance “Provider Notice Information Form.”

Item 7. Provider Name (MUST)

Enter the provider’s last name, first name, and middle initial.

Item 8. Provider Number/Service Location (MUST)

Enter the provider’s 9-digit Provider Identification Number and 4-digit Service Location.

Item 9. Provider’s Own Reference No. (OPTIONAL)

Enter your own reference number or beneficiary’s name to comply with the provider’s filing system.

Items 10 and 11 will only be completed if the payment for services will be sent to someone other than the dentist providing the services. A group/payee must be enrolled with the Department.

Item 10. Group Name (IF APPLICABLE)

Enter the name of the person, group, or organization designated to receive payment.

Item 11. Group Number/Service Location (IF APPLICABLE)

Enter the group/payee’s 9-digit Provider Identification Number and 4-digit Service Location.

Items 12 through 16 refer to the Referring Practitioner, if applicable.

Item 12. Name of Referring Practitioner or Prescriber (IF APPLICABLE)

Enter the name of the referring practitioner, if applicable. Enter the first name, middle initial and last name, followed by degree.

Item 13. License Number (IF APPLICABLE)

Enter the referring practitioner’s professional license number.

Item 14. Specialty (IF APPLICABLE)

Enter the referring practitioner’s area of professional specialty.

Item 15. Telephone Number (IF APPLICABLE)

Enter the referring practitioner’s telephone number, including area code. The referring practitioner may be contacted if additional information is needed by the Department.

Item 16. Practitioner’s/Prescribing Physician’s Street Address (IF APPLICABLE)

Enter the referring practitioner's street address to which the approval or denial notice is to be mailed. Make sure the address is correct and complete.

- Item 17. Primary Diagnosis (LEAVE BLANK)
- Item 18. ICD-10-CM Diagnosis (LEAVE BLANK)
- Item 19. Secondary Diagnosis (LEAVE BLANK)
- Item 20. ICD-10-CM Diagnosis (LEAVE BLANK)

**REQUESTED SERVICES (Items 21A through 26G)**

- Item 21A Description of Services/Supplies Requested (MUST)

Enter a description of the service or item or use CDT-4 procedure name terminology. If a CDT-4 procedure code is available, please include it in the description.

- Item 21B Procedure Code (LEAVE BLANK)

- Item 21C Modifier (LEAVE BLANK)

- Item 21D Quantity (LEAVE BLANK)

- Item 21E Amount Per Unit (MUST)

Enter the exact dollar amount requested for each service.

- Item 21F Quantity per Month (MUST)

Enter the exact quantity of services requested.

- Item 21G Number of Months (LEAVE BLANK)

Related items 22A through 26G MUST be completed when additional services are requested. Complete as described in Items 21A through 21G.

- Item 27A Estimated Length of Need (No. of Months) (IF APPLICABLE)  
If the service will be needed over a period of months, enter the number of months the beneficiary is expected to need the service (Enter 1-99; 99=Lifetime).

- Item 27B Initial Date of Service (MMDDCCYY) (LEAVE BLANK)

- Item 27C Beginning Date of Service for This Request (MMDDCCYY) (MUST)

Enter the date that the service being requested is scheduled to begin using an 8-digit format. If the service will be provided only once, enter the date the service will be provided.

- Item 28 What Other Alternatives Have Been Tried or Used to Meet This Patient's Needs? (MUST)

Attach documentation of alternatives which have been tried and justify the need for the service(s) requested in Items 21A through 26G. If no alternatives have been tried or used, indicate "N/A."

Item 29 Check the Box Which Applies to This Patient's Current Residential Status (MUST)

Check the appropriate box to indicate where the beneficiary resides.

Item 30 Justification Needed for the Evaluation of This Request (MUST)

Give a narrative description of the specific symptoms or abnormalities the services/equipment/supplies are intended to alleviate.

This item must contain sufficient documentation to justify the medical necessity for all requested services. If additional space is needed, please attach additional sheets of paper. The additional pages should be 8 ½" X 11".

The Program Exception request for dental services must be performed as part of a complete dental treatment program and must be accompanied by a detailed treatment plan. The treatment plan must include all of the following:

- pertinent dental history;
- pertinent medical history, if applicable;
- the strategic importance of the tooth;
- the condition of the remaining teeth;
- the existence of all pathological conditions;
- preparatory services performed and completion date(s);
- documentation of all missing teeth in the mouth;
- the oral hygiene of the mouth;
- all proposed dental work;
- identification of existing crowns, periodontal services, etc.
- identification of the existence of full and/or partial denture(s), with the date of initial insertion;
- the periodontal condition of the teeth, including pocket depth, mobility, osseous level, vitality and prognosis; and
- identification of abutment teeth by number.

**Note:** For those Service Programs where dental services are limited to services provided in an inpatient hospital, hospital short procedure unit or ambulatory surgical center, please include a statement identifying where the service will be provided.

Item 31. Number of Attachments (IF APPLICABLE)

Indicate the number of attachments, including radiographs that are being submitted with the MA 97. For example, if you attached two additional pages to include additional treatment plan information and a Panorex, you would enter a "3."

- Item 32. Resubmission of Previously Denied Request (IF APPLICABLE)  
If this is a resubmission of a previously denied request, enter an “X” in this field and the previously denied Program Exception (PE) Reference Number from the “Program Exception Notice” (MA 481) in the space provided.
- Item 33. Initial Request (IF APPLICABLE)  
If this is the initial request, enter an “X” in this field.
- Item 34. Signature of Patient/Authorized Representative (MUST)  
The patient or authorized representative MUST sign the MA 97.
- Item 35. Date (MMDDCCYY) (MUST)  
The patient or authorized representation must enter the date the MA 97 was signed in 8-digit format.
- Item 36. Practitioner’s/Prescriber’s Signature (MUST)  
It is essential that the practitioner requesting the service/item sign or use his/her signature stamp on the MA 97.
- Item 37. Date (MMDDCCYY) (MUST)  
The practitioner must enter the date the MA 97 was completed in 8-digit format.

## 6.8 Dental Benefit Limit Exception (BLE) Request

### 6.8.1 Services and Items Requiring a BLE Request

The Department limits the following dental services for beneficiaries 21 years of age and older, **who do not reside** in a nursing facility, an ICF/ID or ICF/ORC:

1. Periodic oral evaluation is limited to one (1) per 180 days, per beneficiary. Additional oral evaluations will require a Department approved BLE request.
2. Prophylaxis, adult is limited to one (1) per 180 days, per beneficiary. Additional prophylaxis will require a Department approved BLE request.
3. Dentures will be limited to one per upper arch, regardless of procedure code (full or partial denture) and one per lower arch, regardless of procedure code (full or partial denture) **per lifetime**. The lifetime limit for dentures will begin with claims payment history on and after dates of service April 27, 2015. Additional dentures will require a Department approved BLE request.

Beneficiaries over 21 years of age, **who do not reside** in a nursing facility, an ICF/ID or ICF/ORC, will only be eligible for the following services if the Department approves a BLE request.

1. Dentures (when the limit has been exceeded)
2. Crowns and adjunctive services
3. Periodontic services

4. Endodontic services

The Department will approve a BLE request to any of the dental limits described above when one of the following circumstances applies:

1. The Department determines 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 Department determines 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. The Department determines that approving a specific exception is a cost-effective alternative for the MA Program; or,
4. The Department determines that approving an exception is necessary in order to comply with Federal law.

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

### **6.8.2 Procedure for Obtaining Benefit Limit Exception**

The provider must submit an ADA Claim Form completed in compliance with the instructions in Section 6.5, as the provider would when requesting prior authorization, and attach a completed Dental Benefit Limit Exception (BLE) Request Form (MA 549). Instructions on how to order this form may be found at the following link: [https://www.dhs.pa.gov/docs/Documents/OMAP/s\\_002142.pdf](https://www.dhs.pa.gov/docs/Documents/OMAP/s_002142.pdf).

The provider must indicate "Dental BLE Attached" in Box 35 - Remarks Section.

The request must include documentation supporting the need for the service, including but not limited to chart/record documentation, diagnostic study results, radiographs (if applicable), comprehensive medical and dental history.

The Department will notify the provider and beneficiary of its decision within 21 days after receiving a prospective BLE request, or within 30 days after receipt of a retrospective BLE request. A retrospective request for a dental benefit limit exception must be submitted no later than 60 days from the date the Department rejects the claim because the service is over the benefit limit. Retrospective exception requests made after 60 days from the claim rejection date will be denied.

Providers can submit the completed forms and supporting documentation by mail to the Department at:

Office of Medical Assistance Programs  
Fee-for-Service Program  
Dental Benefit Exception Review  
P.O. Box 8187  
Harrisburg, PA 17105

Providers can also submit dental BLE requests and supporting documentation to the Department via secure email to the following email address at [RA-FFS\\_Dental@pa.gov](mailto:RA-FFS_Dental@pa.gov). It is the provider's responsibility to send the information via secure and encrypted email.

The Department will notify the provider and beneficiary of its decision within 21 days after receiving a prospective BLE request, or within 30 days after receipt of a retrospective BLE request. A retrospective request for a dental benefit limit exception must be submitted no later than 60 days from the date the Department rejects the claim because the service is over the benefit limit. Retrospective exception requests made after 60 days from the claim rejection date will be denied.

Dental providers **MUST INCLUDE** the BLE authorization number in the appropriate field of the claim.

### **6.8.3 Dental Benefit Limit Exceptions Review Process**

The Department will review the BLE request and supporting documentation to determine if one of the criteria for the granting of a BLE is met. If additional information is needed to review the BLE request, the Department will notify the provider of the supporting dental/medical record information needed and will consider additional information received within 15 days before making a decision on the BLE request.

If the BLE request identifies that the beneficiary has one of the conditions set forth below, as part of the BLE review process the Department will review the MA beneficiary's claim history. If the condition was previously identified on a claim, the Department will review the BLE request to determine if one of the criteria is met without requiring supporting medical record documentation of the condition.

1. Diabetes.
2. Coronary Artery 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.

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 Department will issue a written Notice of Decision for BLE requests to the beneficiary and provider.

**NOTE:** The provider may not seek payment from the MA beneficiary for a service that is over a benefit limit unless:

1. The provider informed the beneficiary before providing the service that the service may be above the benefit limit, in which case it would not be covered unless the Department grants an exception;
2. The provider submitted a request for an exception to the benefit limit; and
3. The Department denied the BLE request.

#### **6.8.4 Appeals Process**

The Department will issue a written Notice of Decision for BLE requests to the beneficiary and provider. 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 of decision.

### **6.9 Transfer of Previously Approved Dental Treatment**

- Within a Group Practice

If a dental service has been approved for one provider in a group and now another provider within the same group wants to perform the service, the new provider must submit a new ADA Claim Form - Version 2012, including the prior authorization number of the previously approved request and stating the reason for the requested transfer. X-rays are not required when requesting the exact services previously approved. Enter the statement "TRANSFER OF PREVIOUSLY APPROVED DENTAL TREATMENT" in the Remarks section of the ADA Claim Form - Version 2012.

- Transfer Between Unrelated Providers

If a dental service has been approved for one provider and beneficiary goes to a new provider for the service, the new provider must submit a new ADA Claim Form - Version 2012, stating the reason for the new request. Include the previous provider's name, if known, and the previous prior authorization number. X-rays are not required when requesting the exact service previously approved. Enter the statement "TRANSFER OF PREVIOUSLY APPROVED DENTAL TREATMENT" in the Remarks section of the ADA Claim Form - Version 2012.

#### **Important - Please Note:**

If new services, in addition to those previously approved are being requested as part of a transfer, a treatment plan justifying all requested services and radiographs must be submitted.

If more than 180 days has passed from the date of the original approval and/or the original approval has expired, the new request must include an updated treatment plan and the required radiographs.

### **6.9.1 Treatment**

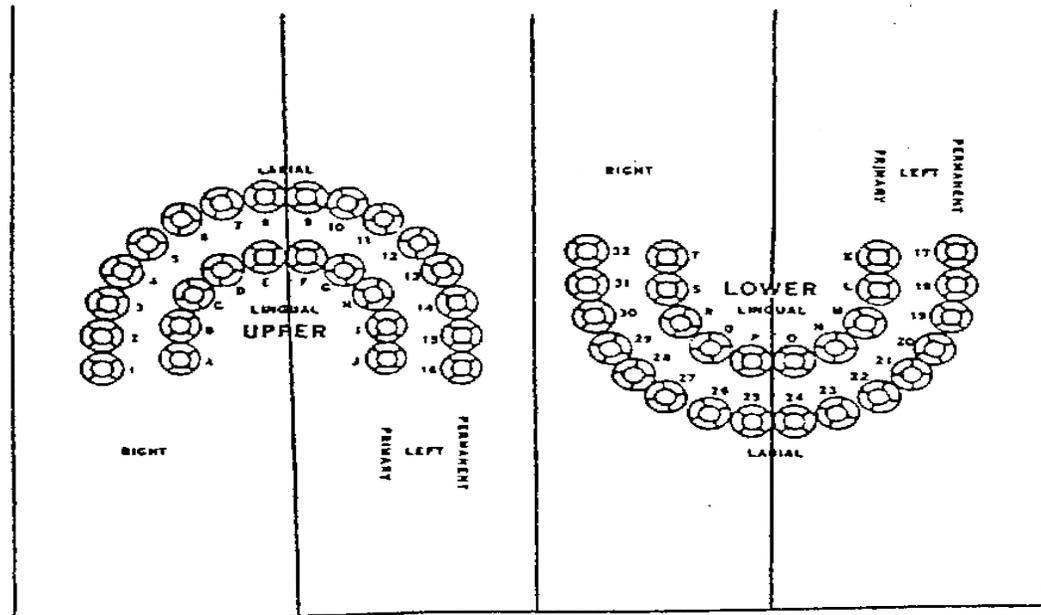
For each approved quarter of orthodontic treatment, the orthodontist must submit an original ADA Claim Form - Version 2012 for payment. Providers should retain a copy of the submitted claim form for their records.

### **6.9.2 Diagnostic Aids**

An orthodontist can bill for diagnostic aids (Procedure Code D8999) *only if* the beneficiary meets all of the requirements for orthodontic treatment listed on page 81, but the Department determined the beneficiary is ineligible for orthodontic treatment.

Bill for diagnostic aids *after* receiving the denial notification. When billing for diagnostic aids, **enter the Prior Authorization Reference Number from the MA 328 in the “Remarks” section of the ADA Claim Form - Version 2012.**

## **HOW TO IDENTIFY QUADRANTS**



EACH AREA EQUALS 1 QUADRANT