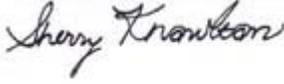


	MEDICAL ASSISTANCE BULLETIN COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF PUBLIC WELFARE	
	SUBJECT General Assistance Restructure as a Result of Act No. 1994-49	BY  Sherry Knowlton Deputy Secretary for Medical Assistance Programs
NUMBER:	99-94-14, 1101-94-01	
ISSUE DATE:	August 31, 1994	
EFFECTIVE DATE:	September 6, 1994	

PURPOSE:

The purpose of this bulletin is to notify providers of changes in medical assistance benefits for some adult general assistance (GA) cash recipients and GA-related medical assistance recipients as a result of Act No. 1994-49.

SCOPE:

This bulletin applies to all providers enrolled in the Medical Assistance Program.

BACKGROUND:

On June 16, 1994, Governor Robert P. Casey signed into law Act No. 1994-49. This law changed the eligibility requirements for Transitionally Needy and Chronically Needy status under the GA Program. The law also changes medical assistance benefits for certain GA recipients age 21 and over.

DISCUSSION:

Effective September 6, 1994, GA cash recipients and GA-related medical assistance recipients age 21 and older whose medical benefits are solely state-funded will no longer be eligible for the following services:

- Dental Services - except when the patient's medical condition or handicap requires the dental services be provided in an Ambulatory Surgical Center (ASC), Short Procedure Unit (SPU), or inpatient hospital setting;
- Medical supplies - except when prescribed for the purpose of family planning or in conjunction with the home health agency services; and
- Pharmaceutical services - except legend birth control drugs.

Exception: Chronically Needy GA recipients, age 21 and older are eligible for pharmaceutical services.

Limits on services under the GA Basic Healthcare Package continue to apply to GA recipients whose medical assistance benefits are funded solely by state funds, with no federal financial participation.

Some recipients of GA cash benefits receive medical assistance benefits funded in part by the federal government. Those individuals will continue to receive pharmaceutical services, dental services, and medical equipment and supplies.

Recipients receiving medical assistance benefits through an HMO, HIO or Community Health Center managed care program, should be referred to the plan to learn the effect the changes have on the benefits available to them. Providers affiliated with an HMO, HIO or Community Health Center managed care program who provide services to medical assistance recipients should contact the plan directly with benefit and reimbursement questions.

As a result of the changes noted above, the Department has issued revised Healthcare Benefits Packages to all providers under Medical Assistance Bulletin 99-94-12, issued August 3, 1994.

PROCEDURE:

SERVICES THAT WILL CHANGE EFFECTIVE SEPTEMBER 6, 1994

Effective September 6, 1994, the following changes in medical assistance benefits for GA recipients age 21 and older whose medical benefits are solely state-funded will occur:

- Some recipients will move from Healthcare Benefits Package 3 to Package 5.
- Dental - Recipients covered under Health Benefits Package 3 or 5 will not receive dental services, except when the patient's medical condition or handicap requires the dental services to be provided in an ASC/SPU or inpatient hospital setting.

BILLING PROCEDURES FOR SERVICES INITIATED PRIOR TO SEPTEMBER 6, 1994;

1. ENDODONTICS - If a recipient's tooth was endodontically treated (accessed and/or filled) prior to September 6, 1994, please submit a Dental Prior Authorization Request form (MA 98) for post-op review upon completion of the endodontic treatment, in accordance with current medical assistance guidelines. For teeth accessed prior to September 6, 1994, please use the date of access as the date of service and place the date of completion in the remarks section of the MA-300D
2. CROWNS - If a recipient has an approved prior authorization, the tooth was prepared and an impression taken prior to September 6, 1994, but the crown cannot be cemented until on or after September 6, 1994, please use the date of impression as the date of service and place the date of cementation in the remarks section of the MA-300D.

DENTURES - If a recipient has an approved prior authorization for the denture and an impression was taken prior to September 6, 1994, but the denture cannot be delivered until on or after September 6, 1994, please use the date of impression as the date of service and place the date of delivery in the remarks section of the MA-300D.

EXTRACTIONS - Extractions requiring prior authorization performed on an emergency basis prior to September 6, 1994, must be submitted for prior authorization review, with the date of service included in the treatment plan, in accordance with current medical assistance guidelines.

- Medical Supplies - Recipients covered under HealthCare Benefits Package 3 or 5 will not receive medical supplies, except when prescribed for the purpose of family planning or in conjunction with home health agency services.

NOTE: Recipients who received prior authorization for medical supplies must be eligible to receive medical supplies on the date of service. Prior authorization does not supersede eligibility. Providers must verify eligibility for medical supplies using the Eligibility Verification System (EVS) before providing a service.

- Pharmaceuticals - Recipients covered under HealthCare Benefit Package 5 will not receive pharmaceutical services, except legend birth control drugs.

EXCEPTION: Chronically needy GA recipients are eligible to receive pharmaceutical services. These recipients will be identified as being covered under HealthCare Benefits Package 3.

SERVICES WITH LIMITS UNDER THE GA BASIC HEALTHCARE PACKAGE WHICH REMAIN IN EFFECT

Limits placed on services provided by the following enrolled providers to recipients covered under the GA Basic HealthCare Package (HealthCare Benefits Packages 3 and 5), remain in effect:

- Practitioner's Office and Clinic Visits - Limited to a combined maximum of 18 visits per year. (Practitioners include: physicians, podiatrists, chiropractors, optometrists, and certified registered nurse practitioners) (Clinics include: independent medical clinics, rural health clinics, general and rehabilitation hospital clinics, family planning clinics, and federally qualified health centers. Not included are visits to emergency rooms, outpatient drug and alcohol clinics, outpatient psychiatric clinics, and psychiatric partial hospitalization facilities.)
- Pharmaceuticals - The Department will pay for all classes of legend drugs and insulin included on the Department's Drug Reference File, prescribed or ordered by a physician, not to exceed a maximum of six prescriptions, including originals and refills, per calendar month.

EXCEPTION: Recipients covered under HealthCare Benefits Package 5 are eligible to receive only legend birth control drugs.

Compensability of drugs can be verified through the Electronic Claims Management (ECM) System or the Drug Verification System (DVS).

NOTE: Multisource brand name drugs that have therapeutically equivalent or "A" rated generics available for substitution require prior authorization for dispensing brand name drugs.

- Home Health Agency Visits - Limited to a maximum of 30 visits per year.
- Freestanding Drug and Alcohol Rehabilitation Hospitals and Drug and Alcohol Detoxification/Rehabilitation Units of General Hospitals - Up to 30 days per year.
- Freestanding Medical Rehabilitation Hospitals and Medical Rehabilitation Units of General Hospitals - Up to 30 days per year.
- Emergency Room - Emergency services only.
- Ambulance - Emergency transportation only.

NOTE: For purposes of tallying annual limits, a year is defined as the state fiscal year, July 1 through June 30.

POLICY:

The legal bases for the changes described in this bulletin are as follows:

- Change in eligibility requirements for Transitionally Needy and Chronically Needy Status:

Section 5 of Act No. 1994-49, amending

Section 432(3) of the Public Welfare Code.

- Changes in medical assistance benefits:

Sections 6 and 7 of Act No. 1994-49, amending

Sections 442.1 and 442.2 of the Public Welfare Code,

62 P.S. § 442.1 and § 442.2.

The Department will amend 55 Pa. Code Chapter 1101, § 1101.31(e) and will add new subsections (f) and (g), which will describe the benefits that certain GA recipients receive in addition to the medically needy benefits package.

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 website at www.dpw.state.pa.us/omap.