

## MEDICAL ASSISTANCE HANDBOOK

### **PA PROMISe™ Provider Handbook 837 Professional/CMS-1500 Claim Form**

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### Section 7. PRIOR AUTHORIZATION

#### 7.5 Benefit Limit Exception Criteria and Process

Effective January 1, 1993, DPW implemented modifications to the MA Program to provide medical services, to include six prescriptions per month for adult General Assistance (GA) recipients, ages 21 to 65.

Effective August 10, 2005, DPW established criteria and a process to grant exceptions to the benefit limit for

- GA adult recipients for
  - 18 practitioner/clinic visits per fiscal year (July 1 through June 30);
  - 30 home health visits per fiscal year
  - Six prescriptions per month
- Categorically needy adult MA recipients for 18 practitioner/clinic visits per fiscal year (July 1 through June 30).

Effective September 30, 2011, DPW established limits to the dental benefit package for adult MA recipients, 21 years of age and older, as well as criteria and a process to grant exceptions to the dental benefit package limits. Information related to dental services is found in the MA Program's Dental Provider Handbook:

[http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/form/s\\_001847.pdf](http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/form/s_001847.pdf)

Effective January 3, 2012, DPW established a limit of six pharmacy prescriptions per month for categorically needy adult MA recipients, 21 years of age and older, as well as criteria and a process to grant exceptions to the pharmacy benefit package limit. The criteria and exceptions process to the benefit package limit of six prescriptions per month for adult GA eligible recipients are revised to meet the same criteria and process established for categorically needy MA eligible recipients.

##### 7.5.1 Criteria for a Benefit Limit Exception

Exceptions to the numerical limits on prescription drugs, practitioner/clinic visits, home health visits and dental services may be granted when:

1. DPW 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; or
2. DPW 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; or

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3. DPW determines that granting a specific exception is a cost effective alternative for the MA Program; or,
4. DPW determines that granting an exception is necessary in order to comply with Federal law.

### 7.5.2 Types of Conditions that Qualify for a Benefit Limit Exception

- Hypertensive/Cardiovascular Disease
- Multi-system Diseases:
  - Hypertensive/Cardiovascular Disease
  - Pulmonary
  - Gastrointestinal
  - Musculoskeletal
  - Renal/Urinary
  - Central Nervous System
  - Endocrine
- Post Transplant
- Trauma Combined with any of the following diseases:
  - Hypertensive/Cardiovascular Disease
  - Pulmonary
  - Gastrointestinal
  - Musculoskeletal
  - Renal/Urinary
  - Central Nervous System
  - Endocrine
- Acute Systemic or Recurrent Infections
- Post Emergency Room Follow-up Treatment
- Post Operative Care, Incident to the Operation
- Multiple Trauma
- Major Organ System Illness
- HIV/AIDS
- Vaccines

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- The recipient's condition is not covered by the list above, but it is the practitioner's opinion that the recipient's condition meets the regulatory criteria for an exception to the limits and warrants an exception.

### 7.5.3 Process to Request a Benefit Limit Exception for Medical and Home Health Visits

- Practitioner determines that recipient meets criteria for an exception.
- Practitioner requests additional services and provides the following information:
  - Clinical presentation
  - Is condition acute or chronic
  - If chronic, how treated previously
  - Is recipient compliant with treatment recommendations
  - Services requested
  - Diagnosis

Requests can be made by contacting the Exceptions Unit at 1-800-637-7840.

Written requests can be sent to: Department of Public Welfare  
GA Exceptions Unit  
P.O. Box 8171  
Harrisburg, Pennsylvania 17105-8171

- DPW medical staff determines whether the request should be approved or denied. If the provider/practitioner indicates the request is urgent, the response will be made no later than 48 hours after the request is received. If the practitioner indicates the request is non-urgent, the response will be made no longer than 21 days after the request is received. If the practitioner is not notified of a decision on an exception within 21 days, the request is deemed approved.
- DPW may request additional medical documentation to determine the need for an exception. If additional information is requested, the 48-hour response to an urgent request is extended for the time required to receive the information.
- If the exception request is denied, DPW will send written notice of denial to the practitioner and the recipient. Only the recipient has the right to appeal the denial.
- If the exception request is approved, DPW will provide the practitioner with an authorization number for submission on the claim.
- All correspondence related to an exception must include:
  - Provider's name and medical license number;

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- Provider type;
- Provider's address;
- Provider's telephone number;
- Recipient's name and identification number;
- 10-digit exception number, if one has been assigned.

### **7.5.4 Process to Request a Benefit Limit Exception for Home Health Visits after Receiving a Denial on the Remittance Advice**

Home health providers who are aware that a recipient is reaching the limit of 30 home health visits per fiscal year should follow the process outlined in Section 7.5.3. However, if the home health provider unknowingly provided service beyond the 30-day limit and received a denial on the Remittance Advice statement, the provider may request a benefit limit exception following the regular process if the recipient appears to meet the exception criteria defined in Section 7.5.1.1. DPW's response for this request will be made no longer than 21 days after the request is received.

### **7.5.5 Process to Request a Benefit Limit Exception for a Drug Prescription**

- The prescribing provider may submit a request for approval of an exception for a prescription which exceeds the limit of six prescriptions per month, is not approved under the automatic exceptions process, and will be dispensed on or after January 3, 2012 for a categorically needy adult MA recipient, or, on or after August 10, 2005 for a GA recipient.
- Practitioners may dispense up to a 5-day emergency supply of a prescribed medication without a BLE approval, if, in the professional judgment of the practitioner, the recipient has an immediate need for the medication and not supplying the medication would result in serious impairment to a recipient's health. A prescription for a pharmacy item dispensed as an emergency supply does not count toward the six prescriptions per month limit.
- The prescriber requests approval for a BLE by submitting the Pharmacy Benefit Limit Exception Request Form to MA Pharmacy Services at 1-866-327-0191. The following information is required from the medical prescriber:
  - Recipient name, address, date of birth, and ACCESS card ID number
  - The prescriber's name, specialty, National Provider Number (NPI), state medical license number, address, telephone and fax numbers
  - Information about the drug that is being requested including the drug name, strength, quantity, directions, day supply, and anticipated duration of the regimen.
  - Copies of documentation from the recipient's medical record supporting the criterion for the benefit limit exception.

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- Additional information may be required to determine the need for an exception. A determination is made, usually within 24 to 72 hours, once DPW receives all of the required medical documentation.
- DPW will notify the prescribing provider by return fax indicating whether the request for an exception to the pharmacy benefit limit is approved or denied.
- DPW will also send a written Notice of Decision to the prescribing provider and the recipient.
- Only the recipient has the right to appeal the denial.
- If the exception request is approved, the prescriber obtains an authorization number that he writes on the prescription. The prescription is filled by the pharmacy or the practitioner dispenses the approved medication to the recipient. The authorization number must be included on the claim submission.
- When a PA for a drug is required for a reason other than an exception to the six prescriptions per month benefit limit, such as for an excessive quantity, a clinical review, or medical necessity for a non-preferred drug, the prescribing provider must still obtain approval from the Department that specifically addresses all PA requirements.