

Pennsylvania
PROMIS_eTM
Provider Handbook



pennsylvania
DEPARTMENT OF HUMAN SERVICES

837 Dental/ADA –
Version 2023
Claim Form

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1 Introduction

1.1 PA PROMIS_eTM Provider Handbook for the 837 Dental/ADA - Version 2012 Claim Form

The following PA PROMIS_eTM providers should access the PA PROMIS_eTM Provider Handbook for the ADA Claim Form – Version 2012 to obtain provider specific policies, eligibility information, remittance advice interpretation and billing instructions:

- Cleft Palate Providers
- Dental Anesthesiologists
- Endodontists
- General Dentists
- Oral/Maxillofacial Pathologists
- Oral/Maxillofacial Radiologists
- Oral/Maxillofacial Surgeons
- Orthodontists/Dentofacial Orthopedists
- Pediatric Dentists
- Periodontists
- Prosthodontists
- Public Health Dentists

1.2 PA PROMIS^e™ Provider Handbook for the 837 Dental/ADA – Version 2012 Claim Form Sections

This handbook contains the following sections:

Section 2 – General Information

This section contains a high-level introduction for PA PROMIS^e™ providers, which includes information on Nondiscrimination, Freedom of Choice, invoicing options, time limits for claim submission, 180-Day Exception Request instructions, claim adjustment instructions, inquiries, PA PROMIS^e™ Internet Applications, and claim form ordering procedures.

Section 3 – Policies

This section contains links to regulations pertaining to PA PROMIS^e™ providers.

For example, the PA PROMIS^e™ Provider Handbook for the ADA Claim Form – Version 2012 will contain a link to the Pennsylvania Code, which houses Department of Human Services (DHS) regulations. If a dentist needs to access Medical Assistance (MA) policies specific to dental services, a link to 55 Pa. Code Chapters 1101 (General Provisions), 1149 (Dentists' Services) and 1150 (MA Program Payment Policies) will be provided to ensure that the dentist is submitting claim forms in accordance with MA policy.

Section 4 – Beneficiary Eligibility

This section reviews how to determine if a beneficiary is eligible for service(s). It describes the Pennsylvania ACCESS Cards, the Beneficiary Restriction/Lock-In Program, and Third Party Liability and Medicare.

Section 5 – Provider Enrollment Information

This section contains information for a provider to understand how to enroll in PA PROMIS^e™. Provider information such as enrollment/provider agreements, provider notice information, changes to enrollment, and provider responsibilities are also included in this section.

Section 6 – Prior Authorization and Dental Benefit Limit Exception (BLE) Process

This section reviews the Prior Authorization (PA) requirements and includes instructions and information regarding the Program Exception (PE) process and the Dental Benefit Limit

Exception (BLE) Process

Section 7 – Orthodontics

This section reviews PA requirements for orthodontics, an overview of the orthodontic process, special forms and diagnostic aids, special situations, and billing for orthodontic services.

Section 8 – Special Billing Information

This section includes billing requirements for specific dental services and special situations.

Section 9 – Remittance Advice

This section describes how to read and understand the contents of the Remittance Advice (RA) Statement for claims and claim adjustments. It also includes a sample claim reconciliation method.

Section 10 – HIPAA Requirements

This section presents an overview of the Health Insurance Portability and Accountability Act (HIPAA).

Section 11 – Fee Schedule

This section includes billing requirements for dental services and anesthesia/sedation services.

Section 12 – Provider Preventable Conditions

This section describes the reporting requirements and procedures for Provider Preventable Conditions (PPC), Other Provider Preventable Conditions (OPPC), and Health Care Acquired Conditions (HCAC).

Appendix A

This appendix contains provider specific and/or service specific Billing Guides. Each Billing Guide provides comprehensive instructions on the proper completion of each block contained on the ADA Claim Form – Version 2012.

Appendix B

This appendix contains MA Bulletins applicable to providers using this handbook.

Appendix C

This section contains instructions for Providers who will use the PA PROMIS^e™ Internet Applications.

Appendix D

This section contains DHS required forms along with instructions for proper form completion.

Appendix E

This section contains a glossary of PA PROMIS^e™ terms, acronyms and phrases with their definitions.

2 General Information

The General Information section provides a high-level overview of the Pennsylvania Provider Reimbursement and Operations Management Information System (PA PROMIS^eTM). This PA PROMIS^eTM Provider Handbook - ADA Claim Form/Version 2012 was written for dental providers serving beneficiaries receiving Medical Assistance (MA) services through the Fee-For-Service (FFS) delivery system. It presents an overview of the MA Program in Pennsylvania, including administration by the Department of Human Services (DHS), nondiscrimination, freedom of choice, invoicing options, payment process, inquiries, time limits for claim submission, the 180-Day Exception Request Process, claim adjustments, prescription procedures, and MA forms and ADA Claim Form – Version 2012 ordering instructions.

2.1 Overview for PA PROMIS^eTM

PA PROMIS^eTM is the name of DHS's claims processing and management information system. PROMIS^eTM stands for **Provider Reimbursement and Operations Management Information System**. PA PROMIS^eTM incorporates the claims processing and information activities of the following DHS program areas:

- Office of Medical Assistance Programs (OMAP)
 - Healthy Beginnings Plus (HBP)
- Office of Developmental Programs (ODP)
- Office of Mental Health and Substance Abuse Services (OMHSAS)
- Office of Long Term Living (OLTL)

2.1.1 Office of Medical Assistance Programs

The Office of Medical Assistance Programs (OMAP) administers the joint state/federal Medical Assistance Program that purchases health care for needy Pennsylvania residents. Based on an individual's eligibility category, covered services may include physician and clinic visits; inpatient hospital care; home health care; medical supplies and equipment; nursing facility care; inpatient and outpatient psychiatric and drug and alcohol services; prescription drugs; dental and other medically necessary services.

The Office of Income Maintenance's local county assistance offices determine eligibility for Medical Assistance. These offices also determine eligibility for Temporary Assistance for Needy Families (TANF), food stamps, and energy assistance. Family and individual eligibility criteria for Medical Assistance include income and resources.

MA purchases services through contracts with managed-care organizations and under an indemnity, or traditional, Fee-For-Service (FFS) system. A medical provider is required

to enroll in the program and must meet applicable national, federal, and state licensing and credential requirements.

OMAP is also responsible for enrolling providers, processing provider claims, establishing rates and fees, contracting and monitoring of managed care organizations (MCOs), detecting and deterring provider and beneficiary fraud and abuse, and administering some waiver services.

2.1.1.1 Healthy Beginnings Plus

Healthy Beginnings Plus (HBP) is Pennsylvania's effort to assist low-income pregnant women who are eligible for Medical Assistance (MA) to have a positive prenatal care experience. HBP significantly expands maternity services that can be reimbursed by the MA Program. The intent of HBP is to render services that meet pregnant beneficiary's psychosocial needs in addition to rendering traditional medical/obstetric services. Federal legislation permits Pennsylvania to extend MA eligibility to pregnant women with family incomes up to 185% of federal poverty guidelines. Pregnant beneficiaries may elect to participate in HBP or receive their prenatal care in the traditional MA system.

For detailed HBP provider information, please visit DHS's website at:

<https://www.dhs.pa.gov/providers/Providers/Pages/Medical/Healthy-Beginnings.aspx>

2.1.2 Office of Developmental Programs

The Office of Developmental Programs (ODP) provides a comprehensive array of services and supports for people with intellectual disabilities of all ages. Services include, but are not limited to, supports coordination, residential, day and support services administered or operated by county mental health and intellectual disabilities (MH/ID) programs and contracted private and state operated intermediate care facilities for beneficiaries with intellectual disabilities. Funding is provided through federal, state, and county resources.

Community residential supports include small homes and apartments or family living settings. Additionally, individuals are offered the opportunity to participate in home-based services, provided in their own home or that of a family member. Day services, such as supported employment and vocational training are provided to individuals living at home or in community residential facilities. A wide array of services and supports are also available to families caring for a child or beneficiary sibling with intellectual disabilities. Many services are available for funding under the Medicaid Home and Community Based Waiver Program.

2.1.3 Office of Child Development and Early Learning (OCDEL)

The Office of Child Development and Early Learning (OCDEL) focuses on creating opportunities for the commonwealth's youngest children to develop and learn to their fullest potential. This goal is accomplished through a framework of supports and systems that help ensure that children and their families have access to high quality services.

OCDEL works with many partners to create opportunities for the commonwealth's children. Parents, schools, child care, early intervention, Head Start, libraries, community organizations and other stakeholders have joined with the Office of Child Development and Early Learning to provide high quality early childhood programs and effective prevention strategies to mitigate challenges faced by families that affect school readiness and academic success.

OCDEL strives to build a strong foundation for children, starting in infancy, through the establishment of a statewide standard for excellence in early care and education and the creation of financial and technical supports to achieve that goal. The success of the commonwealth's efforts today will be seen in the development of Pennsylvania citizens who are strong, independent and well prepared for the future.

DHS is the lead agency responsible for administering the Early Intervention (EI) (birth to age three) Program through OCDEL/Bureau of Early Intervention Services. OCDEL administers the EI Program for children from birth through age three who are eligible for Early Intervention services and supports through the County MH/ID programs.

2.1.4 Office of Mental Health and Substance Abuse Services

The Office of Mental Health and Substance Abuse Services (OMHSAS) administers a comprehensive array of behavioral health services throughout the state. Community resources are emphasized, with a goal of developing a full array of services and supports as alternatives to hospitalization. Behavioral health services range from community to hospital programs with emphasis on helping children, adolescents, and adults remain in their communities. Community-based services are emphasized, with the goal to help people who have serious mental illness or serious emotional disturbance break the cycle of repeated hospital or residential admissions. The range of services include outpatient, psychiatric partial hospitalization, residential, short-term inpatient hospital care, emergency crisis intervention services, counseling, information referral, mobile mental health treatment, peer support services and case management services.

Services provided to beneficiaries are based on the Community Support Program (CSP) Principles: consumer-centered, consumer-empowered, be racially and culturally appropriate, be flexible, be normalized and incorporate natural supports, meet special needs, be accountable, and be coordinated.

2.1.5 Office of Long-Term Living

The Office of Long Term Living is comprised of program and administrative offices under the direction of a Deputy Secretary. The Deputy Secretary oversees the Office of Policy and Strategic Planning, the Bureau of Individual Support, the Bureau of Provider Supports, and the Office of Quality Management, Metrics and Analytics.

The Office of Policy and Strategic Planning acts as a "clearinghouse" for all policy development activity within the agency. This Office is responsible for developing, coordinating, planning, assessing and evaluating policies across OLTL to ensure consistency in content, direction and application. Examples include coordination of the development of waiver renewals, waiver amendments, state plan documents, regulations

and legislation. Its staff also assists other bureaus in developing policy, evaluating policy impact and establishing and improving strategic direction. When solicited, the Office provides direction to field staff and service providers for the implementation of OLTL policies. The Policy Office serves as a liaison with other DHS programs and policy offices, other state agencies and external stakeholder groups. The Policy Office is comprised of three divisions: the Division of Policy, the Division of Planning and the Division of Research, Development and Innovation.

The Bureau of Individual Support is comprised of two Divisions – Direct Services and Nursing Home Transition and Diversion. The Division of Direct Services provides services to individuals with disabilities through the Attendant Care Act 150 Program, the Attendant Care Medicaid Waiver Program, the administration of the Aging Attendant Care Waiver Program, the COMMCARE Waiver for individuals who experience a medically determinable diagnosis of traumatic brain injury, the OBRA Waiver for individuals with physical developmental disabilities, and the Independence Waiver. The Division of Nursing Home Transition and Diversion oversees the Commonwealth’s transition and diversion programs by working with key stakeholders, including consumers, advocates, and providers. This Division also reviews and approves special needs funding requests, provides oversight of Specialized Services provided to individuals “targeted” through the Pre-Admission Screening Process, and coordinates with the Bureau of Fee-for-Service (FFS) and managed care plans for people aging out of Early Periodic Screening and Diagnostic Treatment (EPSDT).

The Bureau of Provider Support serves as liaison to the provider community serving the long-term living continuum, including nursing facilities, Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID) facilities, and Home and Community Based Services (HCBS) providers. Through the operations of three divisions, responsibilities include management of field operations staff that conduct Utilization Management Review, clinical and fiscal reviews in nursing facilities to ensure compliance with applicable state and federal regulations, including compliance with Minimum Data Set completion and submission accuracy. Responsibilities include licensing of Assisted Living. Additional responsibilities include certification and enrollment of nursing facilities, ICFs/ID and HCBS providers.

The Office of Quality Management, Metrics and Analytics (QMMA) conducts quality management and improvement monitoring of long-term living programs and services to ensure compliance with federal and state regulations and the delivery of quality programs to assure the health and welfare of consumers. Through the operations of two divisions, the QMMA staff ensures that program and service delivery systems achieve desired outcomes. This includes working closely with the Office of Policy and Strategic Planning to use data analysis to measure the effectiveness of program design and operations, recommend strategies for improvement, ensure fiscal accountability, and prepare financial reports as appropriate, including reports required by the Centers for Medicare and Medicaid Services (CMS) and other regulatory agencies.

2.2 Medical Assistance (MA) Delivery Systems

All eligible beneficiaries presenting for services in Pennsylvania receive Medical Assistance (MA) services through either the fee-for-service or managed care delivery system. The instructions in this Provider Handbook for the 837 Dental/ADA Claim Form – Version 2012 apply to the FFS Program administered by DHS.

2.2.1 Fee-For-Service (FFS)

The traditional FFS delivery system provides payment on a per-service basis for health care services provided to eligible MA beneficiaries.

2.2.2 Managed Care

Under the managed care delivery system, MA beneficiaries receive physical and behavioral health care through a managed care organization (MCO) under contract with DHS or the county government.

2.2.2.1 HealthChoices

HealthChoices is the name of Pennsylvania's mandatory managed care program for eligible MA beneficiaries. Through Physical Health MCOs, beneficiaries receive quality medical care and timely access to all appropriate physical health services, whether the services are delivered on an inpatient or outpatient basis. The Office of Medical Assistance Programs oversees the Physical Health component of the HealthChoices Program.

Through Behavioral Health MCOs, beneficiaries receive quality behavioral health services and timely access to appropriate mental health and/or drug and alcohol services. The behavioral health component is overseen by DHS's Office of Mental Health and Substance Abuse Services (OMHSAS).

Most of the Medical Assistance population is enrolled in the Physical Health HealthChoices program, which is responsible to provide the dental benefit. The FFS program covers the remainder of the MA population, which includes beneficiaries who are newly eligible (and in the process of selecting an MCO to serve them), beneficiaries institutionalized for more than 30 days, and beneficiaries age 21 and older who are dually eligible for Medicare and Medicaid.

If an enrolled MA provider wants to participate in a HealthChoices MCO network, the provider must contact the participating MCO(s) directly. A provider can enroll with more than one MCO. Providers must submit documentation to the MCO verifying that they are an enrolled MA provider or have applied with DHS to be enrolled in the MA Program, and agree to meet the requirements and conditions for network participation set forth by the MCO.

For additional information on HealthChoices, visit the Managed Care section of the DHS Internet site at:

2.3 Nondiscrimination

The provider agrees to comply with the Commonwealth's Contract Compliance Regulations which are set forth at 16 Pa. Code, §49.101, as follows:

- a. Provider shall not discriminate against any employee, applicant for employment, independent contractor, or any other person because of race, color, religious creed, ancestry, national origin, age or gender. Provider shall take affirmative action to ensure that applicants are employed, and that employees or agents are treated during employment, without regard to their race, color, religious creed, ancestry, national origin, age or gender. Such affirmative action shall include, but is not limited to the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training. Provider shall post in conspicuous places, available to employees, agents, applicants for employment and other persons, a notice to be provided by the contracting agency setting forth the provisions of this nondiscrimination clause.
- b. Provider shall in advertisements or requests for employment placed by it or on its behalf state all qualified applicants will receive consideration for employment without regard to race, color, religious creed, ancestry, national origin, age or gender.
- c. Provider shall send each labor union or workers' representative with which it has a collective bargaining agreement or other contract or understanding, a notice advising said labor union or workers' representative of its commitment to this nondiscrimination clause. Similar notice shall be sent to every other source of recruitment regularly utilized by Provider.
- d. It shall be no defense to a finding of noncompliance with Contract Compliance Regulations issued by the Pennsylvania Human Relations Commission or this nondiscrimination clause that Provider had delegated some of its employment practices to any union, training program or other source of recruitment, which prevents it from meeting its obligations. However, if the evidence indicated that the Contractor was not on notice of the third-party discrimination or made a good faith effort to correct it, such factors shall be considered in mitigation in determining appropriate sanctions.
- e. Where the practices of a union or any training program or other source of recruitment will result in the exclusion of minority group persons, so that Provider will be unable to meet its obligations under the Contract Compliance Regulations issued by the Pennsylvania Human Relations Commission or this nondiscrimination clause, Provider shall then employ and fill vacancies through other nondiscriminatory employment procedures.
- f. Provider shall comply with the Contract Compliance Regulations of the Pennsylvania Human Relations Commission, 16 Pa. Code Chapter 49, and with all laws prohibiting

discrimination in hiring or employment opportunities. In the event of Provider's noncompliance with the nondiscrimination clause of this contract or with any such laws, this contract may, after hearing and adjudication, be terminated or suspended, in whole or in part, and Provider may be declared temporarily ineligible for further Commonwealth contracts, and such other sanctions may be imposed and remedies invoked as provided by the Contract Compliance Regulations.

- g. Provider shall furnish all necessary employment documents and records to, and permit access to its books, records and accounts by the contracting agency and the Human Relations Commission, for purposes of investigation to ascertain compliance with the provisions of the Contract Compliance Regulations, pursuant to §49.35 of this title (relating to information concerning compliance by contractors). If Provider does not possess documents or records reflecting the necessary information requested, it shall furnish such information on reporting forms supplied by the contracting agency or the Commission.
- h. Provider shall actively recruit minority subcontractors or subcontractors with substantial minority representation among their employees.
- i. Provider shall include the provisions of the nondiscrimination clause in every subcontract, so that such provisions will be binding upon each subcontractor.
- j. The terms used in this nondiscrimination clause shall have the same meaning as in the Contract Compliance Regulations issued by the Pennsylvania Human Relations Commission, 16 Pa. Code Chapter 49.
- k. Provider obligations under this clause are limited to the Provider's facilities within Pennsylvania, or where the contract is for purchase of goods manufactured outside of Pennsylvania, the facilities at which such goods are actually produced.

2.4 Freedom of Choice of MA Beneficiaries

Title XIX of the Social Security Act, §1902(a)(23) [42 U.S.C. 1396(a)(23)], requires that a State Plan for medical assistance must provide that any individual eligible for MA may obtain such assistance from any MA enrolled institution, agency or person qualified to perform the service or services required. This freedom of choice provision allows MA beneficiaries the same opportunities to choose among available MA enrolled providers of covered health care as are normally offered to the general public. For beneficiaries enrolled in a mandatory managed care program, the freedom of choice provision is limited to providers enrolled in the managed care network.

As an exception to this policy, DHS may restrict certain beneficiaries to specified providers (refer to [Section 4.6, Beneficiary Restriction/Centralized Lock-In Program](#)).

The following explanations provide an overview of how freedom of choice applies to each delivery system.

2.4.1 Fee-for-Service (FFS)

MA beneficiaries are permitted to select the providers from whom they receive medical services. Therefore, there will be no service referral arrangements, profit sharing or rebates among providers who serve MA beneficiaries.

Although providers may use the services of a single pharmacy, laboratory, or other providers in the community, they are prohibited from making oral and written agreements that would interfere with an MA beneficiary's freedom of choice of providers.

2.4.2 Mandatory Managed Care (HealthChoices)

Beneficiaries residing in a HealthChoices County in Pennsylvania maintain their freedom of choice by choosing one of the HealthChoices physical health plans to use for their MA covered health care services as well as a provider who works within that plan, to be their primary care practitioner (PCP).

Under the HealthChoices Behavioral Health Program, beneficiaries will be assigned a behavioral health plan based on their county of residence; however, a beneficiary maintains the freedom to choose from among the providers in the behavioral health MCOs provider network. With regards to the behavioral health component of the HealthChoices program, counties are required to ensure high quality medical care and timely access to appropriate mental health and substance abuse services and facilitate effective coordination with other needed services.

2.5 Invoicing Options

Providers can submit claims to DHS via the ADA Claim Form – Version 2012, via the PROMIS^e™ Provider Portal or through electronic media claims (EMC).

2.5.1 PROMIS^e™ Provider Portal

The PROMIS^e™ Provider Portal allows providers, alternates, and billing agents with the proper security access to submit claims, verify beneficiary eligibility, check on claim status, and update enrollment information.

Note: Out-of-Network (OON) providers can only check eligibility via the PROMIS^e™ Provider Portal.

Specifically, users can use the Portal to:

- File claims for all claim types and adjustments in either real-time or an interactive mode from any location connected to the Internet
- View the status of any claim or adjustment regardless of its method of submission
- Access computer-based training programs that lets users complete training courses from their desktops at their convenience

- Update specific provider enrollment information via ePEAP
- Verify beneficiary eligibility within seconds of querying
- Transmit outpatient drug prescriptions and renewals

For information on submitting claims via the PROMIS^e™ Provider Portal, please go to [Appendix C, Provider Internet User Manual](#).

2.5.2 Electronic Media Claims (EMC)

PA PROMIS^e™ can accept billing submitted through Direct Connect, through a Clearinghouse, Bulletin Board or Provider Electronic Solutions (PES) software. It can be downloaded, free-of-charge at:

<http://promise.dpw.state.pa.us/ePROM/ProviderSoftware/softwareDownloadMain.asp>

For more information on these invoicing options, please refer to the Billing Information Page at:

<https://www.dhs.pa.gov/providers/Billing-Info/Pages/default.aspx>

Or contact:

Gainwell Technologies/PA PROMIS^e™
 1250 Camp Hill Bypass Suite 100
 Mail Stop 2-200
 Camp Hill, PA 17011-3700
Telephone: 800-248-2152 (in state only)
717-975-4100 (local)

For information on submitting claims electronically via the Internet, please refer to Appendix C, Internet User Manual for Providers, in this handbook.

2.5.2.1 EMC Billing and Attachments

For claims that require an attachment(s) and are submitted using any electronic media, you will need to obtain a Batch Cover Letter and an Attachment Control Number (ACN). Batch Cover Letters and ACNs can be obtained via the DHS PROMIS^e™ Website <http://promise.dpw.state.pa.us> by accessing the Provider Claim Attachment Control Window. For more information on accessing the Provider Claim Attachment Control Window, refer to the Provider Internet User Manual found in Appendix C of the 837 Dental/ADA Version 2012 Claim Form Handbook.

- Attachment Control Number (ACN)

When submitting a claim electronically that requires a paper attachment, providers must obtain an Attachment Control Number (ACN) from the PA PROMIS^e™ website. The purpose of the ACN is to provide DHS with a means of matching paper attachments to electronic claims. (For detailed instructions on obtaining an ACN, see Appendix C, Internet User Manual for Providers, of this handbook.

An ACN must be obtained prior to completing the electronic claim requiring an attachment.

The Provider Claim Attachment Number Request window of the PA PROMIS^e™ Internet Applications allows providers to submit and view requests for an ACN.

A Batch Cover Form with the ACN must be present on all paper attachment batches. The ACN on the paper batch must match the ACN entered on the related electronic claim. The Batch Cover Form can be located in Appendix D, Special Forms, of this handbook.

The provider must follow the billing requirements defined in the provider handbook in addition to the electronic billing instructions.

2.5.2.2 ADA Claim Form – Version 2012 (Hardcopy Submission)

Mail completed claim forms and claim adjustments to:

Department of Human Services
Office of Medical Assistance Programs
P.O. Box 8015
Harrisburg, PA 17105-8015

Please see Appendix A, Billing Guides, of this handbook for detailed instructions on the proper completion of the ADA Claim Form – Version 2012.

2.5.2.2.1 Special Notes for Submitting the ADA Claim Form – Version 2012

- Signature Transmittal Form (MA 307)

The MA 307 must have a handwritten signature or signature stamp of a Service Bureau representative, the provider, or his/her designee.

When submitting claims, you must include individual provider numbers in the spaces provided on the MA 307. The MA 307 must then be submitted with the corresponding batches of individual provider's claims.

2.5.2.2.2 Optical Character Recognition (OCR)

DHS has optical scanning as an alternative mechanism for claims processing. Optical scanning is a process whereby special equipment reads typewritten or computer-printed information on a claim form. Since image scanning eliminates the need for data entry, providers can expect improvement in the accuracy and timeliness of claims processed.

- Guidelines for OCR Processing

To take advantage of OCR processing, claim forms must be typed or computer-printed in black or blue ink. Change the ribbon frequently to obtain clear and readable information. Center the data in each block using 10 or 12 character per

inch font. Do not combine handwriting (other than signatures) and machine print on a claim form. Additionally, do not use special characters, such as periods, \$, etc., or space between data in the blocks. Do not use script or compressed print. Claim forms must not be folded.

For more information concerning the OCR billing mode, contact:

Gainwell Technologies/PA PROMIS^eTM
1250 Camp Hill Bypass Suite 100
Mail Stop 2-200
Camp Hill, PA 17011-3700
Telephone: 800-248-2152 (in state only)
717-975-4100 (local)

2.5.2.2.3 Beneficiary Signature Requirements

Providers who bill via electronic media must retain the beneficiary's signature on file using the Encounter Form (MA 91). (See Appendix D, Special Forms, of this handbook.) The purpose of the beneficiary's signature is to certify that the beneficiary received the service from the provider indicated on the claim form and that the beneficiary listed on the Pennsylvania ACCESS Card is the individual who received the service.

When keeping beneficiary signatures on file, the following procedures shall be followed:

- Obtain the signature of the beneficiary or his/her agent for each date for which outpatient services were furnished and billing is being submitted to DHS for payment. Obtain the signature on the MA 91 with the patient's 10-digit beneficiary ID number, taken from his/her Pennsylvania ACCESS Card.
- The MA 91 containing the beneficiary's signatures must be retained on file for a period of *at least four years*, independently from other medical records, and must be available for reviewing and copying by State and Federal officials or their duly authorized agents.
- Providers may photocopy and use the sample MA 91 in Appendix D, Special Forms, of this handbook. A separate MA 91 must be used for each beneficiary (HIPAA Privacy). Currently, the MA 91 can be obtained via the MA Provider Order Form (MA 300X) or a printable version is available on DHS's website at:

<https://www.dhs.pa.gov/docs/Documents/MA%20Response%20Forms/Encounter%20Form.pdf>

Situations, which do not require a beneficiary's signature, also do not require the MA 91 (See Section 5, Provider Enrollment Information, for a complete list of DHS's exemptions to the signature requirements.

- Provider Responsibility

DHS will hold the provider, not the Service Bureau or billing agent, if one is used, responsible for any errors, omissions, and resulting liabilities, which are related to any claim form(s) submitted to DHS for payment under the provider's name or PA PROMIS^e™ (ID) identification number.

2.6 Payment Process

PA PROMIS^e™ processes financial information up to the point of payment. PA PROMIS^e™ does not generate actual payments to providers. The payment process is managed by the Commonwealth Treasury Department's Automated Bookkeeping System (TABS). PA PROMIS^e™ requests payments to be made by generating a file for payment that is sent to TABS. From there, payments can take the form of checks or Electronic Funds Transfers (EFTs). PA PROMIS^e™ will produce a Remittance Advice (RA) Statement for each provider who has had claims adjudicated and/or financial transactions processed during the payment cycle.

Providers have the option of receiving a check via the mail from the Treasury Department or they may utilize a direct deposit service known as the Automated Clearinghouse (ACH) Program. This service decreases the turnaround time for payment and reduces administrative costs. Provider payments are deposited via electronic media to the bank account of the provider's choice. ACH is an efficient and cost effective means of enhancing practice management accounts receivable procedures. ACH enrollment information can be obtained from DHS's website at:

<https://www.dhs.pa.gov/providers/Providers/Pages/Electronic-Funds-Transfer.aspx>

2.7 Time Limits for Claim Submission

DHS must receive claim forms for submissions, resubmissions, and adjustment of claim forms within specified time frames; otherwise, the claim will reject on timely filing related edits and will not be processed for payment.

2.7.1 Office of Medical Assistance Programs (OMAP)

<https://www.dhs.pa.gov/docs/For-Providers/Pages/Medical-Assistance-Regulations.aspx>

2.7.2 180-Day Exception Request Process

DHS will consider a request for a 180-day exception if it meets *at least one* of the following criteria:

1. An eligibility determination was requested from the County Assistance Office (CAO) within 60 days of the date the service was provided. DHS must receive the provider's 180-day exception request within 60 days of the CAO's eligibility determination processing date; and/or

2. The provider requested payment from a third party insurer within 60 days of the date of service. DHS must receive the provider's 180-day exception request within 60 days of the date indicated on the third party denial or approval.

To submit a 180-day exception request, the provider must take the following steps:

- Step 1. Review the claim to verify that it meets at least one of the above cited criteria.
- Step 2. Complete a claim form correctly (the claim form must be a signed original – no file copies or photocopies will be accepted).
- Step 3. Include all supporting documentation along with documentation to and from the CAO (dated eligibility notification) and/or third party insurer (explanation of benefits statement).
- Step 4. Complete a <https://www.dhs.pa.gov/providers/FAQs/Documents/180-Day%20Exception%20Request%20Detail%20Page.pdf> * and submit it to DHS with each exception request. (See Appendix D, Special Forms, for instructions on completing the 180-Day Exception Request Detail Page)

Please do not fold or staple your exception request documentation. Please use an “8½ by 11” envelope for mailing purposes.

Supporting documentation must consist of any or all of the following:

- Evidence that the MA application was submitted to the CAO within 60 days of the end date of service and a copy of the eligibility notification; and/or
- Evidence that a payment request was submitted to a third party insurer within 60 days of the end date of service and a copy of the third party's explanation of benefits statement or Remittance Advice.

Note: The provider will identify and use all patient medical resources before billing DHS.

DHS may request additional documentation to justify approval of an exception. If the requested information is not received within 30 days from the date of DHS's request, a decision will be made, based on the available information.

Exceptions will be granted on a one-time basis. Claims granted an exception that reject due to provider error may be resubmitted for payment up to 365 days from the end date of service (see 180-Day Exception Approval letter for resubmission procedure).

Medical Assistance (MA) providers must send the 180-Day Exception Request Detail Page, supporting documentation, and the original claim form(s) to:

Department of Human Services
180-Day Claims Exception Unit
P.O. Box 8042
Harrisburg, PA 17105-8042

Providers will receive a letter stating DHS's decision. The fact that DHS approves a 180-day exception does not guarantee that the claim will not be rejected for reasons other than time requirements.

When a request for an exception is denied by the 180-Day Exception Unit, the provider has a right to appeal. **All appeals must be requested in writing within 30-days of the date of DHS's Notice of Denial.**

If the provider wishes to appeal the denial:

1. Complete all denied claims correctly.
2. Attach a copy of all documentation supporting your position to your appeal.
3. Include a cover letter stating that you **wish to appeal** and the basis on which your appeal is being made. (The words "wish to appeal" must appear in the letter.)
4. Send all of the above information along with a copy of DHS's Notice of Denial to:

PA Department of Human Services
Bureau of Hearings and Appeals
2330 Vartan Way
Harrisburg, PA 17110

Please see [MA Bulletin 99-03-08](#) – "Change to Protocol for Certain Provider Appeals".

NOTE: A copy of the appeal request and supporting documentation must also be sent to the program office that denied the 180-day exception request.

2.8 Internal Control Number (ICN)

Paper claims with attachments, paper claims without attachments and Special Handle claims processed via PA PROMISe™ will be assigned a 13-digit Internal Control Number (ICN) upon receipt. The ICN is returned to providers in the first column of the Remittance Advice (RA) Statement. The ICN consists of the following elements.

Internal Control Number (ICN) Format			
Region Code RR	Year and Julian Day YY JJJ	Batch Number BBB	Claim Sequence SSS
10	04 001	301	023

The first two-digits of the ICN are the [region code](#). This code is used by PA PROMISe™ to denote the type of claim being processed.

The third and fourth digits of the ICN denote the year the claim was received into PROMISe™. For example, if the claim was received into PROMISe™ in 2004, the third and fourth digits will be “04”.

The fifth, sixth, and seventh digits denote the Julian Day. In this example 001 is January 1st.

The eighth through 10th digits are the Batch Number, and the 11th and 13th digits are the Claim Sequence. The Batch Number and Claim Sequence are used internally by DHS.

When submitting a previously rejected claim, it is imperative that you use the two-digit RA Number with the **original rejected ICN** in the Remarks Section of the ADA Claim Form – Version 2012.

Electronic, internet, Point of Service (POS), and single adjustments submitted electronically through BES or Internet and all Mass Adjustments will be assigned a 13-digit Internal Control Number (ICN) upon receipt. The ICN is returned to providers in the first column of the Remittance Advice (RA) Statement. The ICN consists of the following elements (This new format was effective 06/26/2015):

Internal Control Number (ICN) Format		
Region Code RR	Year and Julian Day YY JJJ	Claim Sequence SSSSSS
20	04 001	321654

The first two digits of the ICN are the [region code](#). This code is used by PA PROMISe™ to denote the type of claim being processed.

The year and Julian day (**YY JJJ**) comprise the next five digits, with the first two digits being the year and the next three being the Julian day.

The last six digits represent the claim sequence number (**SSSSSS**).

Sequences for all applicable regions will start at 000001 with the following exceptions:

- Region 77 will start at 2000
- Region 87 will start at 10000

2.9 Inquiries

Providers across the Commonwealth have multiple ways to make general inquiries, including the PA PROMIS^e™ Internet Applications and the Provider Inquiry Unit. The following sections explain the various tools providers have at their disposal.

2.9.1 PA PROMIS^e™ Internet Applications

The PROMIS^e™ Provider Portal allows providers, alternates, billing agents, and out-of-network (OON) providers with the proper security access to submit claims, verify beneficiary eligibility, check on claim status, and update enrollment information. Specifically, users can use the Internet to:

- View the status of any claim or adjustment regardless of its method of submission, along with error status codes and HIPAA adjustment reason codes for rejected claims
- Information on specific procedure
- Access computer-based training programs that will let users complete training courses from your desktop at your convenience
- Update specific provider enrollment information electronically
- Verify beneficiary eligibility within seconds of querying
- Electronically transmit outpatient drug prescriptions and renewals

Providers can review and download remittance advice statements for the past two years and print an Adobe Acrobat (.PDF) copy of their original paper Remittance Advice (RA) Statement.

Providers can download or review Provider Handbooks and Billing Guides, forms, etc., from the DHS website. For more information on the Internet tools available and instructions on accessing the tools, please refer to Appendix C, Provider Internet User Manual, of this handbook.

2.9.2 Provider Services Inquiry Lines

To obtain further assistance, please refer to the Contact Information/Help for MA Providers page for the appropriate telephone number.

2.9.2.1 Fee-for-Service Provider Service Center

The Provider Service Center will be open from 8:00 a.m. to 4:30 p.m., Monday through Friday, to assist providers with their questions/inquiries.

All questions regarding claim form completion or billing procedures and policy, plus questions regarding claim status or inappropriate payments should be directed to:

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

2.10 Claim Adjustments

There will be times when it is necessary to correct a paid claim (i.e., claim that has appeared on your RA Statement as “Paid”) when payment was received in error.

When a claim is paid in error (overpaid or underpaid), DHS will offset/adjust future payment(s) to the provider to either:

- Recoup any money owed; or
- Compensate a provider if the provider was underpaid.

Claim adjustments **can** be used to:

- Adjust a Paid or Approved Claim.
- Change a procedure code, total billed amount, and/or units

You **cannot** use a claim adjustment to:

- Correct a denied claim.
- Correct a suspended claim.
- Correct a beneficiary number or provider number.

For Claim Voids:

- Void only a paid or approved claim, if:
 - the claim has an incorrect beneficiary or provider ID

- the claim was incorrectly submitted and should never have been filed originally
- a procedure code was submitted incorrectly (for ODP providers only)

2.10.1 Completing a Claim Adjustment

The ADA Claim Form – Version 2012 is used to submit claims for payment as well as to submit claim adjustments when you are in receipt of an overpayment or underpayment. It is important to note that when submitting a claim adjustment on the ADA Claim Form – Version 2012, the claim adjustment will be completed using the provider and beneficiary information exactly as entered on the original claim being adjusted. For claim line information, copy the corresponding information from the original claim for all items that remain unchanged. Where a correction is necessary, enter the correct information.

When completing the ADA Claim Form – Version 2012 to adjust a claim that was paid in error, in addition to using the corresponding information from the paid claim, complete Item 32 (Remarks for unusual services) as follows:

- When submitting a claim adjustment of a previously approved claim, enter the letters “ADJ” and the 13-digit ICN of the **last approved claim**.
- When submitting a claim adjustment for a previously approved claim adjustment, enter the letters “ADJ” and the 13-digit ICN of the **last approved adjustment**.

2.11 Ordering Forms

The following sections detail the various forms providers may need when billing PA PROMIS^e™ and the addresses, telephone numbers, and website, when available, for obtaining these forms.

2.11.1 Medical Assistance Forms

You may order billing material through the Medical Assistance Forms Page of the DHS website at <https://www.dhs.pa.gov/docs/Publications/Pages/Medical-Assistance-Provider-Forms.aspx> by using the Medical Assistance Provider Order Form (MA 300X). For providers who do not have access to the Internet, the MA 300X can be ordered directly from DHS’s printing contractor:

Department of Human Services
 MA Forms Contractor
 P.O. Box 60749
 Harrisburg, PA 17106-0749

Additionally, providers can obtain an order form by submitting a request for the MA 300X, in writing, to:

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

You can expect to receive your forms within two weeks from the time you submit your order. This quick turnaround time on delivery is designed to eliminate the need for most emergencies. You should keep a three to six month supply of extra forms, including order forms, on hand and plan your ordering well in advance of exhausting your supply.

The MA 300X can be typed or handwritten. Photocopies and/or carbon copies of the MA 300X are not acceptable. *Orders must be placed on an original MA 300X.*

The MA 300X is continually being revised as forms are added or deleted. Therefore, you may not always have the most current version of the MA 300X form from which to order. You need to be cognizant of MA Bulletins and manual releases for information on new, revised, or obsolete forms so that you can place your requisitions correctly. If a new MA form is not on your version of the MA 300X, you are permitted to add the form to the MA 300X.

2.11.2 ADA Claim Form – Version 2012

The ADA Claim Form - Version 2012 is not available for order on the MA 300X. You can order the ADA Claim Form – Version 2012 by calling the American Dental Association (ADA) at 1-800-947-4746 or by accessing the ADA website at: <http://www.ada.org/>

You must use original claim forms. Providers are not permitted to submit laser and/or dot matrix produced claim forms. Laser and/or dot matrix produced claim forms will be returned by DHS.

2.12 Prescriptions

The following information shall be required on all MA prescriptions, which have been either written or verbally ordered by a licensed prescriber:

1. Prescriber's license number
2. Name and address of the beneficiary
3. Name of the licensed prescriber
4. Name, strength and quantity of the medication
5. Directions for use

6. Refills, if any
7. Indication for "brand medically necessary", when applicable
8. The DEA number of the licensed prescriber when controlled substances have been prescribed.

3 Policies

Policies are located on the Pennsylvania (PA) Code Website. Listed below are the hyperlinks to the applicable regulations and PA PROMISe™ policies.

3.1 Policy Hyperlinks

Dentists Chapters [1101](#), [1149](#), [1150](#)

4 Beneficiary Eligibility

This section explains the Eligibility Verification System (EVS) and how to verify beneficiary eligibility. It describes identification cards; all relevant beneficiary information supplied to providers and details each eligibility verification access method available and how to use it.

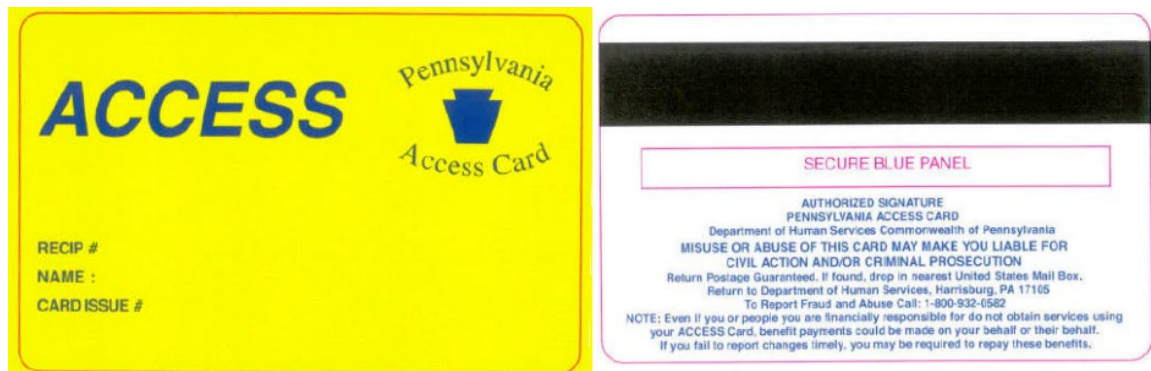
Individuals eligible for Medical Assistance (MA) in Pennsylvania may have medical coverage under one of two delivery systems; through a traditional Fee-for-Service (FFS) system or a Managed Care Organization (MCO). Pennsylvania ACCESS Card

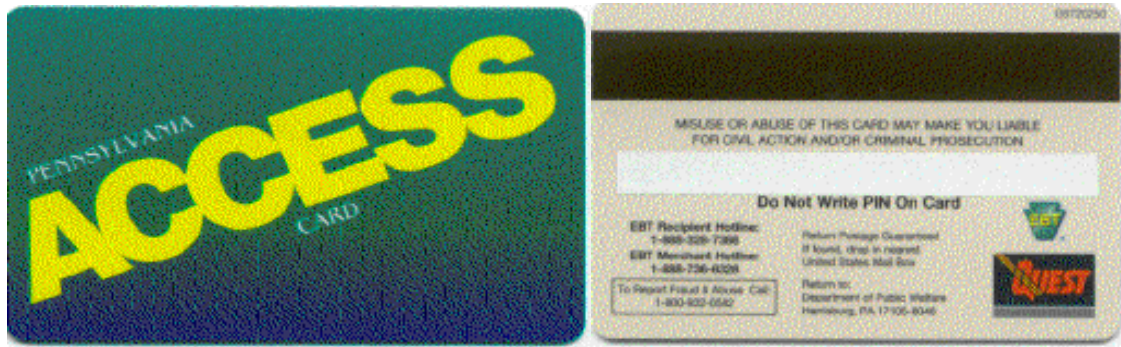
4.1 Pennsylvania ACCESS Card

4.1.1 Pennsylvania ACCESS Card (Medical Benefits Only)

Eligible beneficiaries (including beneficiaries enrolled in an MCO) will have a permanent plastic identification card that identifies their eligibility for covered MA services. The plastic card, known as the "Pennsylvania ACCESS Card", resembles a yellow credit card with the word "ACCESS" printed across it in blue letters. Beneficiary information is listed on the front of the card and includes the full name of the beneficiary, a 10-digit beneficiary number and a 2-digit card issue number. The back of the ACCESS card has a magnetic stripe designed for "swiping" through a personal computer (PC) with an attached card reader to access eligibility information through the Eligibility Verification System (EVS). The back of the card also has a signature strip, a return address for lost cards and a misuse or abuse warning.

Beneficiaries who are eligible for medical benefits only will receive the yellow ACCESS card.

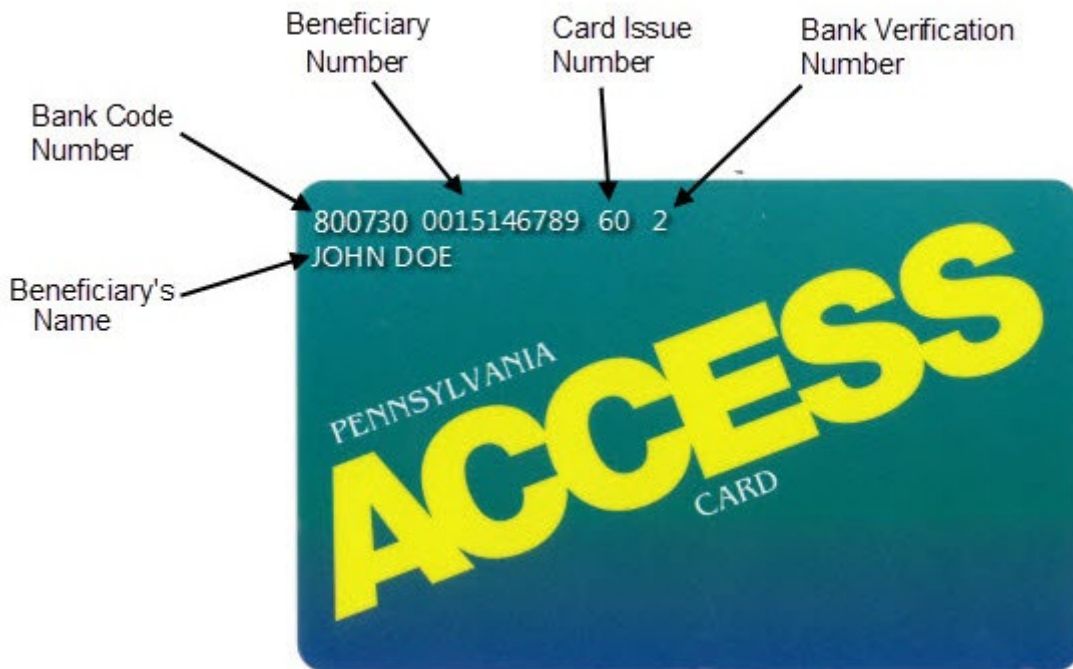




4.1.2 Electronic Benefits Transfer (EBT) ACCESS Card

The Electronic Benefits Transfer (EBT) ACCESS card is blue and green in color with the word “ACCESS” printed in yellow letters. This card is issued to MA beneficiaries who receive cash assistance and/or SNAP (Supplemental Nutritional Assistance Program) as well as medical services, if eligible. The card is issued to individuals who are the payment names for cash and/or SNAP benefits. Remaining household members are issued the yellow ACCESS card, as well as beneficiaries who are eligible for MA only.

Providers must verify eligibility through EVS when presented with either card to ensure beneficiary is eligible prior to rendering services.



4.1.3 Beneficiary Number and Card Issue Number

The Pennsylvania ACCESS card contains a 10-digit beneficiary number followed by a 2-digit card issue number. The 10-digit beneficiary number is a number permanently assigned to each beneficiary. The beneficiary number and card issue number is the preferred method to access DHS's Eligibility Verification System (EVS).

Providers must use the 10-digit beneficiary number when billing for services. The card issue number is used as a security measure to deter fraudulent use of a lost or stolen card.

4.1.4 Lost, Stolen or Defective Cards

When a Pennsylvania ACCESS card is lost or stolen, the beneficiary should contact his/her County Assistance Office (CAO) caseworker to request a replacement card. The card issue number is voided to prevent misuse when the new card is issued. A replacement card should be received in seven to ten days of request. If a card is needed immediately, an interim paper card can be issued by the CAO. This ensures beneficiaries of uninterrupted medical services. The interim card contains the same Beneficiary Number and Card Issue Number as the previous ACCESS card. It is advisable that you request additional identification when presented with an interim card.

To accurately determine whether the card presented is valid, a provider will need to check the beneficiary's eligibility via the Beneficiary ID and Card Issue number search. EVS will not notify the provider if the presented card is lost or stolen.

The EVS will return an error response if a wrong or previous card issue number is submitted. Use of alternative search methods, while acceptable, will not confirm the card presented is valid, lost or stolen. If the ACCESS card is damaged or defective, e.g., if the magnetic stripe does not swipe, instruct the beneficiary to return the defective card to the CAO and request a replacement card.

4.2 Eligibility Verification System

The Eligibility Verification System (EVS) enables providers to determine an MA beneficiary's eligibility as well as their scope of coverage. Please do not assume that the beneficiary is eligible because he/she has an ACCESS card. It is vital that you verify the beneficiary's eligibility through EVS each time the beneficiary is seen. EVS should be accessed on the date the service is provided, since the beneficiary's eligibility is subject to change. Payment will not be made for ineligible beneficiaries.

4.3 Methods to Access EVS

Providers or approved agencies can access EVS through one of four access methods.

4.3.1 Automated Voice Response System (AVRS)

You may access EVS via the AVRS through a touch-tone telephone. The EVS telephone access system is available 24 hours a day, seven days a week. The toll-free telephone number is 1-800-766-5387.

4.3.2 Batch Submissions

Batch EVS transactions in ANSI 5010 270/271 format can be submitted to the Batch Bulletin Board System (BBS). The BBS maintained by Gainwell Technologies enables providers to upload eligibility requests and download eligibility responses. Currently, the Provider Electronic Solutions Software (PES) utilizes the bulletin board to provide eligibility responses upon receipt of a request. Providers can create their own solution or purchase commercial available software however any software utilized must be certified by Gainwell Technologies prior to accessing the production BBS.

4.3.3 PROMISe™ Provider Portal (Web Interactive)

The PROMISe Portal allows registered users to conduct interactive eligibility checks from a computer terminal. User's complete the required data fields on the eligibility screen and then submit the request for an immediate response.

4.3.4 Value Added Networks (VAN)

VAN (PC/POS) collects requests for eligibility information in a real-time interactive processing mode. Both personal computer (PC) software and point-of-service (POS) devices will use this method to gather eligibility information.

4.4 HIPAA 270/271 - Health Care Eligibility Benefit Inquiry/Response

EVS will accept and return the standardized electronic transaction formats for eligibility requests and responses as mandated by HIPAA. The eligibility **request** format is called the HIPAA 270 Health Care Eligibility Benefit Inquiry format (also known as 270 Eligibility Inquiry). The eligibility **response** format is called the HIPAA 271 Health Care Eligibility Benefit Response (also known as 271 Eligibility Response). Both formats may also be referenced by the 3-digit transaction number: 270 and 271. Providers and other approved agencies that submit electronic requests in the 270 format will receive an EVS response with eligibility information in the 271 format.

4.4.1 User Identification (ID) and Password

4.4.1.1 Internet Interactive

When accessing EVS via the PROMISe™ Provider Portal, providers must create a User ID and Password. In addition, users will need to create challenge questions and select both a site key and associated passphrase. After the initial setup, providers must utilize their User ID, password and challenge questions every time the PROMISe™ Provider Portal is accessed.

For more information on use of the PROMISe™ Provider Portal, please refer to the PROMISe™ Provider Internet User Manual at:

<http://promise.dpw.state.pa.us/promisehelp/manuals/PROMISeProviderInternetUserManual.pdf>

4.4.2 BBS User Identification and BBS Password

4.4.2.1 BBS

When accessing the EVS via the Batch method, BBS, providers/users will need a BBS User ID and a BBS password

4.4.3 EVS Access Options

Providers have four options to search for beneficiary eligibility information. You must use your 9 – digit provider number and 4-digit service location to obtain eligibility information.

To search for beneficiary information, you may use the:

- 10-digit Beneficiary Identification number and the 2-digit card issue number from the beneficiary's ACCESS card,
- 10-digit Beneficiary Identification number and beneficiary's DOB. (Not available with the AVRS),
- Beneficiary's social security number (SSN) and the beneficiary's date of birth (DOB) or,
- Beneficiary's first and last name and the beneficiary's DOB (not available with the AVRS)

You must identify the date of service for which you wish to verify eligibility. Eligibility can be searched for a single day or span-dates for a maximum of 30 days. A query can request eligibility for future dates up to the end of the current month. EXAMPLE: If today's date is 6/14/2014, a provider could submit an eligibility query for dates of

services 6/1/14 through 6/30/14. The EVS would return all eligibility segments for the entire month of June.

4.4.4 Eligibility Requests within Two Years of the Date of Service

If an MA beneficiary is eligible for medical benefits, EVS will provide a comprehensive eligibility response. Although you have the ability to verify eligibility for beyond two years from the current date, you must access EVS on the date you intend to provide service to the beneficiary. The eligibility response will include the following information:

Beneficiary Demographics

- Name
- Beneficiary ID
- Gender
- Date of Birth

Eligibility Segments

- Begin date and end date
- Eligibility status (as defined by HIPAA)
- Category of assistance
- Program status code
- Service program description

Managed Care Organization (MCO) (Physical), Family Care Network (FCN), and Long Term Care Capitated Assistance Program (LTCCAP)

- Plan name/code and phone number
- Primary Care Provider (PCP) name and phone number, begin and end dates (up to 3 PCPs will be returned)
- Primary Care Case Manager (PCCM) name and phone number
- Begin and end date (if different from inquiry dates)
- Managed Care Organization (MCO) (Behavioral)
- Plan name/code and phone number
- Begin and end date (if different from inquiry dates)

Third Party Liability (TPL)

- Carrier name/type
- Address of carrier
- Policyholder name and number (except for Medicare Part A or Part B)
- Group number
- Patient pay amount associated to a beneficiary and provider during a given time period
- Court ordered indicator
- Begin and end dates (if different from inquiry dates)
- Lock In or Restricted Beneficiary Information

- Status (Y = Yes/N = No)
- Provider type
- Provider name and phone number
- Narrative (restrictions do not apply to emergency services)
- Begin and end date (if different from inquiry dates)
- Limitations.
- Procedure code and NDC (FFS only, not available when accessing EVS using the AVRS)

EPSDT

- Last screen date (for under 21 only)

Dental

- Last dental visit (for under 21 only)

Patient Financial Responsibility

- Co-payment
- Deductible

This information will be available to the provider for two years following the date of service.

4.4.5 Eligibility Requests More Than Two Years from the Date of Service

For eligibility inquiries on information older than two years, EVS will return a reduced list of basic eligibility information. The basic eligibility information provided when inquiring about a beneficiary's eligibility more than two years from the date of service is as follows:

Beneficiary Demographics

- Name
- Beneficiary ID
- Gender
- Date of Birth

Eligibility Segments

- Begin date and end date
- Eligibility status (as defined by HIPAA)
- Category of assistance
- Program status code
- Service program description

4.5 Provider Assistance for EVS Hardware/Software Problems

Gainwell Technologies maintains and staffs an inquiry unit called the "Provider Assistance Center" (PAC), to provide you with quick responses to inquiries and resolution of problems associated with the EVS hardware and software function of the Provider Electronic Solutions Software. This service is available from 8:00 a.m. until 5:00 p.m., Eastern Standard Time, Monday through Friday (except holidays), at 1-800-248-2152.

4.6 Beneficiary Restriction/Centralized Lock-In Program

DHS's Beneficiary Restriction/Centralized Lock-In Program restricts those beneficiaries who have been determined to be abusing and/or misusing MA services, or who may be defrauding the MA Program. The restriction process involves an evaluation of the degree of abuse, a determination as to whether or not the beneficiary should be restricted, notification of the restriction, and evaluation of subsequent MA services. DHS may not pay for a service rendered by any provider other than the one to whom the beneficiary is restricted, unless the services are furnished in response to an emergency or a Medical Assistance Restricted Beneficiary Referral Form (MA 45) is completed and submitted with the claim. The MA 45 must be obtained from the dentist to whom the beneficiary is restricted.

A beneficiary placed in this program can be locked-in to any number of providers at one time. Restrictions are removed after a period of five years if improvement in use of services is demonstrated.

If a beneficiary is restricted to a provider within your provider type, the EVS will notify you if the beneficiary is locked into you or another provider. The EVS will also indicate all type(s) of provider(s) to which the beneficiary is restricted.

NOTE: Valid emergency services are excluded from the lock-in process.

4.7 Patient Financial Responsibility

The Eligibility Verification System will return patient financial responsibility information to the provider for transactions submitted with dates of service on or after 1/1/2013. This information will be displayed for up to two years from the date of service searched (unless the date searched is prior to 1/1/2013). Please reference Quick Tip #148 for additional information.

4.7.1 Collection of Medical Assistance Beneficiary Copayment

Federal law permits the MA Program to require beneficiaries (FFS only) to pay a small copayment for most medical services. Providers will ask for the copayment when the medical service is rendered.

A beneficiary is obligated to pay a copayment for each unit of service provided; however, if the beneficiary is unable to pay, the service may not be denied. If copayment applies to

the service provided, MA will automatically compute and deduct the copayment from the provider's payment, even if it is not collected.

For most medical services, the amount of the copayment is determined by the MA fee for the service, as indicated in the PA PROMISE™ Program Fee Schedule. Some services provided to beneficiaries contain a fixed copayment, some are based on a sliding scale, and others do not require a copayment. Please refer to the https://www.dhs.pa.gov/providers/Documents/Billing%20Information/c_268951.pdf for details.

4.7.1.1 Copayment Exemptions

There are a number of exemptions to the copayment requirement, such as emergencies, services to pregnant women, residents of nursing facilities, and beneficiaries under the age of 18. Please refer to the https://www.dhs.pa.gov/providers/Documents/Billing%20Information/c_268951.pdf for a complete list of exemptions.

4.7.2 Deductibles

Adult GA beneficiaries have a \$150 deductible per state fiscal year for certain MA compensable services. If applicable, the EVS will return both the beneficiary's GA deductible amount per year (\$150.00) and the outstanding GA deductible left considering the beneficiary's past billing history. Please refer to 55 Pa.Code § 1101.63(b) for more information.

4.7.3 Patient Pay

While determining eligibility for a beneficiary, there may be an amount of income considered available to pay the unpaid, incurred medical expenses for the beneficiary. If this is the case the beneficiary will have a patient pay liability indicated in their file and the specific amount of the patient pay liability will be returned on an EVS transaction. This amount may be linked to a specific provider or facility so it's important to check to see if a beneficiary is responsible. It is important to note that payment will be made to the provider only after this amount has been paid.

4.8 Third Party Liability, Other Insurance and Medicare

Medical Assistance is considered the payer of last resort. All other insurance coverage must be exhausted before billing MA. The MA Program is responsible only for payment of the unsatisfied portion of the bill, up to the maximum allowable MA fee for the service as listed in the Medical Assistance Program Fee Schedule.

It is your responsibility to ask if the beneficiary has other coverage not identified through the EVS (i.e., Worker's Compensation, Medicare, etc.). When a beneficiary is eligible for both Medicare and MA benefits, the Medicare program must be billed first if the service is

covered by Medicare. Payment will be made by MA for the Medicare Part B deductible and coinsurance up to the MA fee.

When beneficiaries, their personal representative who can consent to medical treatment, or an attorney or insurer with signed authorization request a duplicate copy of the claim forms, the provider may release a copy to the requestor, but shall submit a copy of the invoice and the request to the following address:

Department of Human Services
TPL - Casualty Unit
P.O. Box 8486
Harrisburg, PA 17105-8486 (717) 772-6604

The TPL Casualty Unit will follow-up and take appropriate action for recovery of any MA payment recouped in a settlement action.

This procedure **MUST** be followed by **ALL** providers enrolled in the MA Program for **ALL** requests for payment information about MA beneficiaries. This includes beneficiaries enrolled in a Managed Care Organization (MCO).

The Medical Assistance Early Intervention (MA EI) Program has additional requirements regarding the use of private insurance coverage for eligible children. Use of private health insurance for EI services is strictly voluntary. The family must give written consent for a provider to bill the child's private insurance. If the family does not consent to the use of their private insurance, the agency or independent provider of EI services should bill their County MH/ID program for the child's MA EI services.

You may NOT bill a child's private insurance program or private managed care plan/HMO before billing MA. EI services must be provided at no cost to parents or children as required by the Individuals with Disabilities Education Act (IDEA). A state may use any available fiscal source to meet this requirement. Thus, private health insurance proceeds may be used to meet the cost of EI services as long as financial losses are not imposed on the parents or child.

Potential financial impact/consequences:

1. A decrease in available lifetime coverage or any other benefit under an insurance policy;
2. An increase in premiums under an insurance policy; or
3. Out of pocket expenses, such as the payment of a deductible amount incurred in filing an insurance claim.

Targeted Service Management – ID (TSM-ID) providers should refer to ODP Bulletin #00-94-14, Targeted Service Management and Third Party Liability, in Appendix B of this handbook. TSM-ID providers may discontinue submitting claims to third party insurers prior to sending the claim to PROMISe™ for processing. TSM-ID providers are not required to attach insurance statements to their claim forms. However, the statements must be maintained on file.

4.8.1 Third Party Resource Identification and Recovery Procedures

When DHS discovers a potential third party resource after a claim was paid, a notification letter will be sent to the provider with detailed claim/resource billing information and an explanation of scheduled claim adjustment activity. Providers must submit documentation relevant to the claim within the time limit specified in the recovery notification. If difficulty is experienced in dealing with the third party, notify DHS at the address indicated on the recovery notice within 30 days of the deadline for resubmission. If the provider fails to respond within the time limit, the funds will be administratively recovered and the claims cannot be resubmitted for payment.

4.9 Medical Assistance Managed Care

HealthChoices is Pennsylvania's mandatory MA managed care program. As part of DHS's commitment to ensure access to care for all MA eligible beneficiaries, it is important that providers understand that there will always be some MA beneficiaries in the Fee-For-Service (FFS) Program and that all MA beneficiaries are issued an ACCESS card, even those in managed care. A small number of beneficiaries are exempt from HealthChoices and will continue to access health care through the FFS Program. In addition, there is a time lag between initial eligibility determination and MCO enrollment. During that time period, beneficiaries must use the FFS delivery system to access care.

All HealthChoices providers are required to have a current FFS agreement and an active Provider Identification Number as part of the HealthChoices credentialing process. Therefore, HealthChoices providers need not take any special steps to bill DHS for FFS beneficiaries. They may simply use the current FFS billing procedures, forms, and their Provider Identification Number and service location.

For questions concerning enrollment or billing the MA MCOs, providers should contact the specific MCO they are credentialed with or plan to be credentialed with.

4.10 Service Programs

When an individual qualifies for Medical Assistance benefits, they are placed in one of two options to pay for their medical services:

- Health Choices Managed Care Organization
- Fee for Services (FFS)

If enrolled in the FFS delivery system, a beneficiary will be placed in a particular health care benefits package. Each package covers specific services. Medical Assistance Bulletin 99-06-10 is a comprehensive list of services covered under each package. The link below gives a brief description of what each package covers.

[Service Programs for PA PROMISE™ Medical Assistance Providers Reference Chart](#)

If a beneficiary is enrolled in a Managed Care Organization (MCO), the provider will need to contact the appropriate MCO for specific coverage.

4.11 Beneficiary Specific Requirements

The beneficiary specific requirements section will include information on how to access waiver services and base programs.

4.11.1 Home and Community Based Waivers

Medicaid-funded home and community based services are a set of medical and non-medical services designed to help persons with disabilities and older Pennsylvanians live independently in their homes and communities. The following sections highlight the various home and community based waivers.

4.11.1.1 Office of Developmental Programs (ODP) Waivers and Office of Child Development & Early Learning (OCDEL) Waivers

ODP administers, The Person/Family Directed Support Waiver and the Consolidated Waiver for Individuals with diagnosed intellectual disabilities. OCDEL administers Infants, Toddlers and Families Waivers. The following provides an overview of the waiver services available.

Person/Family Directed Support Waiver (PFDS) – The Pennsylvania Person/Family waiver is designed to help persons with intellectual disabilities live more independently in their homes and communities and to provide a variety of services that promote community living, including self-directed service models and traditional, agency-based service models.

Consolidated Waiver for Individuals Diagnosed with Intellectual Disability – The Pennsylvania Consolidated Waiver for individuals diagnosed with intellectual disabilities is designed to help persons with intellectual disabilities live more independently in their homes and communities and to provide a variety of services that promote community living, including self-directed service models and traditional, agency-based models.

For more detailed information on eligibility requirements and services provided under each waiver please click the following link:

[Office of Developmental Program Specific Waivers](#)

4.11.1.2 Office of Long Term Living (OLTL) Waivers

OLTL administers the Aging Waiver, the AIDS Waiver, the Attendant Care Waiver/Act 150, the COMMCARE Waiver, the Independence Waiver and the OBRA Waiver. The following provides an overview of the waiver services available.

Aging Waiver – The Aging Waiver provides long-term care services to older Pennsylvanians living in their homes and communities.

Aids Waiver – The AIDS Waiver Program is a federally approved special program which allows the Commonwealth of Pennsylvania to provide certain home and community-based services not provided under the regular fee-for-service program to persons with symptomatic HIV disease or AIDS.

Attendant Care Waiver/ACT 150 – The Attendant Care Waiver/Act 150 provides services to eligible persons with physical disabilities in order to prevent institutionalization and allows them to remain as independent as possible.

COMMCARE Waiver – The COMMCARE Waiver was designed to prevent institutionalization of individuals with traumatic brain injury (TBI) and to allow them to remain as independent as possible.

Independence Waiver – The Independence Waiver provides services to eligible persons with physical disabilities in order to prevent institutionalization and allows them to remain as independent as possible.

OBRA Waiver – The OBRA Waiver is a Home and Community Based Waiver program that may help people with a developmental physical disability to allow them to live in the community and remain as independent as possible.

For more detailed information on eligibility requirements and services provided under each waiver please click the following link:

[Support Services Waivers](#)

4.11.2 Medical Assistance Early Intervention (MA EI)

Early Intervention (EI) – Infants and toddlers between the ages of birth and their third birthday are eligible for EI services as determined by one or more of the following:

- A twenty-five percent (25%) delay in one or more areas of development compared to other children of the same age.
- A physical disability, such as hearing or vision loss
- An informed clinical opinion
- Known physical or mental conditions which have a high probability for developmental delays

In order to obtain MA EI funding, the child must:

1. Be referred through the County MH/ID program
2. Be determined either eligible for EI or “at risk tracking” (see below)
3. Be MA eligible
4. Receive services from an MA EI enrolled agency/group or independent provider.
5. Receive services which are MA EI eligible

“At risk tracking” – If a child is found ineligible for EI services by the screening/evaluation, they may still be eligible for follow-up screening and tracking. Children eligible for screening and tracking include:

- A birth weight under 3.5 pounds or 1500 grams
- Cared for in a neonatal intensive care unit
- Born to chemically dependent mothers
- Seriously abused or neglected as substantiated pursuant to the Child Protective Services Law of 1975, as amended.
- Confirmed to have dangerous blood lead levels as set by the Department of Health Service Coordinators are the only MA EI qualified professionals who can bill for “At risk tracking” services.

Infants, Toddlers, and Families (ITF) Waiver

The Infants, Toddlers, and Families Waiver (Early Intervention) provides habilitation services to children from birth to age three who are in need of early intervention services and would otherwise require the level of care provided in an intermediate care facility for persons with intellectual disabilities or other related conditions (ICF/ID-ORC).

Functional Eligibility:

Children, ages 0 – 3 (Birth until the 3rd birthday), may be eligible for ITF Waiver services if there is a need for early intervention services and the child is eligible for the ICF/MR (Intermediate Care Facility for Persons with Intellectual Disabilities) level of care for intellectual disabilities and related conditions.

Services:

The ITF Waiver provides habilitation services by qualified professionals with family/caregiver participation in the child’s natural environment.

Please note that income limitations may apply. To ensure that a child is eligible for waiver services, access EVS and review his/her service.

4.11.3 Targeted Services Management – Intellectual Disabilities (TSM-ID)

The MA Program provides payment for specific TSM-ID services provided to eligible beneficiaries by enrolled providers. These services are covered when provided in accordance with the approved Medicaid State Plan Amendment for Targeted Service Management – ID and applicable state regulations and policies.

Individuals served in a psychiatric or general medical hospital are eligible for TSM-ID services provided the stay is no longer than 180 calendar days. TSM may work with individuals on their caseload that are in psychiatric units of general hospitals or in public

or private psychiatric hospitals for a period not to exceed 30 calendar days from the estimated date of discharge. In these instances, the TSM person's activities are limited to monitoring the individual's progress, locating and obtaining services for the individual after discharge. These activities provided by the TSM person during this transition may not duplicate or replace the institution's responsibility to provide discharge planning and continuity of care provided by the hospital. Reference sections 3.1A and 3.1B of the Pennsylvania Medicaid State Plan.

4.12 Procedures for Birth Centers and Nurse Midwives to Expedite Newborn Eligibility

Birth Centers and nurse midwives must immediately notify the County Assistance Office (CAO) of a child's birth when the mother is eligible for MA at the time of delivery. This contact must be done by telephone or fax to the appropriate CAO. Providers that have a high volume of MA births may wish to make arrangements with the local CAO to expedite this process.

In addition, within three working days of the baby's birth, birth centers and midwives must submit a Newborn Eligibility Form (MA 112) to the appropriate CAO. The CAO authorizes eligibility for the newborn under the mother's record, enters the newborn's identifying information on the MA 112 and returns it to the birth center or nurse midwife.

The MA 112 form may be obtained by completing the MA Provider Order Form (MA 300X) and submitting it to DHS.

PLEASE NOTE: If the birth occurs on a weekend or holiday, contact the CAO by telephone or fax on the next workday. The MA 112 must be submitted to the appropriate CAO within three workdays of the baby's birth.

4.12.1 Completion of the MA 112

The MA 112 must be completed with the assistance of the newborn's mother or the mother's authorized representative before the mother leaves the hospital or is discharged from the provider's care. Instructions for completing the form are located on the reverse side of the form. In addition to those instructions, the following information must be entered on the form:

Item 12 – Mother's Name

Enter the mother's name (last name, first name, M.I.) as shown on her ACCESS card. Allow enough space after the mother's name to enter the mother's Beneficiary Identification Number, as shown on her ACCESS card, or through accessing EVS.

Item 16 – Newborn Name

Enter the newborn's name, if available. If the newborn has not been named, enter "Baby Girl" or "Baby Boy" followed by the mother's last name.

Item 28 – For Notary Use

Do not complete this item.

Item 30 – Applicant’s Signature

The mother or her authorized representative must sign the MA 112.

Item 31 – Date

Enter the date the application was signed.

Item 32 – ID Verification

Do not complete this item.

Items 33-37 – Hospital Information

Enter the appropriate information to identify the birth center or nurse midwife completing the form.

4.12.2 Instructions for Billing Without the Newborn’s Beneficiary Number

You may bill MA immediately after contacting the CAO by phone or fax and after submitting the MA 112 to the CAO. It is not necessary to wait for the MA 112 to be returned to you before submitting your invoice. However, in order for PA PROMIS^e™ to process your claim, the newborn invoice must be completed with the following modifications:

Block 1a (Insured’s I.D. Number) - **Use the mother’s 10-digit ID number found on her ACCESS Card or by accessing EVS.**

Blocks 2 (Patient’s Name (Last Name, First Name, and Middle Initial) and 3 (Patient’s Birth Date) - **Use the newborn’s identifying information (i.e., name, birthdate, sex, etc.).**

Block 19 (Reserved for Local Use) - Enter Attachment Type Codes AT26 (which indicates that you are billing for a newborn using the mother’s ID number) and AT99 (which indicates that you have an 8½ by 11 sheet of paper attached to the claim form). Enter the mother’s name, social security number, and date of birth on the 8½ by 11 sheet of paper. *Include your provider’s name, 9-digit provider number and 4-digit service location on the attachment.*

Multiple Births

Complete a separate claim form for each child.

Remittance Advice Statement

When a claim appears on your remittance advice, it will be listed with the correct beneficiary information for the newborn. Please keep the newborn's ID number in your records for subsequent billings.

Billing with the Newborn's Beneficiary Number

If you have the newborn's ID number at the time of billing, complete the claim form in the usual manner using the ID number designated by the CAO for the newborn. You will not use the mother's ID number nor will you need to indicate Attachment Code AT26 or AT99.

5 Provider Enrollment Information

This section contains information for providers of services under PA PROMIS_eTM.

5.1 Provider Participation Requirements

5.1.1 Licensure/Registration/Certification

To be eligible to enroll in PA PROMIS_eTM, practitioners in Pennsylvania must be licensed and currently registered by the appropriate State agency. Out-of-state practitioners must be licensed and currently registered by the appropriate agency in their state.

Other providers must be approved, licensed, issued a permit or certified by the appropriate State agency and, if applicable, certified under Medicare.

For more information please refer to the following website:

<https://www.dhs.pa.gov/Services/Disabilities-Aging/Pages/MA-and-payment-of-Long-Term-Care.aspx>

5.1.2 Enrollment/Provider Agreement

The provider is considered the legal entity and can be either a business or an individual doing business with DHS. Legal entities can complete the enrollment process in one of two ways:

1. Complete a paper enrollment form and send changes on letterhead.
2. Use the Internet and the Provider Enrollment Automation Project, known as ePEAP to request changes to enrollment information.

5.1.2.1 Paper Enrollment Forms

Providers must complete a PA PROMIS_eTM Provider Enrollment Form, PA PROMIS_eTM Provider Agreement, and be approved by DHS. Upon successful enrollment, the provider will receive a Provider Enrollment Letter (PRV-9008-R). (Refer to Section 5.2 for information on the Provider Enrollment Letter.)

Provider enrollment forms can be found on the DHS website at:

<https://www.dhs.pa.gov/providers/Providers/Pages/PROMISe-Enrollment.aspx>

Provider application requests or applications in process: (800) 537-8862 between 8:00 a.m. – 12:00 p.m. and 12:30 p.m. – 4:00 p.m., Monday through Friday excluding holidays.

5.1.2.2 ePEAP

Through the electronic Provider Enrollment Automation Project (ePEAP) providers with Internet access can review and request changes to their provider information via the Internet. Providers are required to register and create a four-digit password in order to use ePEAP. Please go to:

<https://promise.dpw.state.pa.us/promisehelp/manuals/PROMISeProviderInternetUserManual.pdf>

and follow the directions to use ePEAP. Current limitations to ePEAP are:

1. The website cannot be used to enroll a new provider or to re-enroll a provider. It is to be used by currently enrolled providers to request changes to their provider information.
2. Certain provider types are not able to use ePEAP at this time. Please refer to: https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OMAP/d_004253.pdf for the complete list.

5.1.3 PA PROMISe™ Provider Identification

PA PROMISe™ provides the ability to enroll providers in various programs and record their demographics, certification and rate information. PA PROMISe™ maintains a single unique number to identify a provider. PA PROMISe™ supports the ability to uniquely identify locations, provider types, specialties, authorization/certification/licensing information for services and other required data within the unique provider identification number.

DHS initiated a Master Provider Index (MPI) in conjunction with PA PROMISe™. MPI is a central repository of provider profiles and demographic information that registers and identifies providers uniquely within DHS. Under MPI and PA PROMISe™, a provider is considered a unique legal entity and can be either a business or an individual provider doing business with DHS. Additionally, providers can be assigned only one MPI provider identification number for a given Federal Employee Identification Number (FEIN) or Social Security Number.

Each enrolled PA PROMISe™ provider will be assigned a nine-digit MPI identification number. In addition, each provider will be assigned one or more four-digit service locations as the unique provider identification for the claim.

NOTE: When submitting claims to DHS, providers must use their nine-digit provider identification number and the appropriate four-digit service location as the unique provider identification for the claim.

5.2 Provider Enrollment Letter

Once a provider has been approved by DHS, PA PROMIS^e™ will generate a Provider Enrollment Letter (PRV- 9008-R) to be sent, with the appropriate documentation, to the provider announcing his/her acceptance. Pertinent information is printed on the front and back of the letter for provider verification.

(CURRENT DATE) (PROVIDER NAME)

(STREET ADDRESS 1)

(STREET ADDRESS 2)

(CITY/STATE/ZIP)

Provider ID / Service Location: XXXXXXXXXXX XXXX

Dear Provider:

Your contract as a medical provider under programs administered by the Pennsylvania Department of Human Services has been approved.

Your program and expiration dates are listed below. Prior to expiration, you will receive a notification to extend your contract.

As an approved provider, you may submit claims for reimbursement under the medical programs within the scope of coverage of your services for eligible individuals.

The nine (09) digit identification provider number, and four (04) digit service location listed above have been assigned to you for billing purposes. In order to assure prompt reimbursement, it is imperative that these numbers be shown on each claim.

We are pleased to welcome you as a participating provider. For additional information regarding the Pennsylvania Department of Human Services Programs, please access our website at <http://www.dhs.state.pa.us>. Sincerely,

Provider Enrollment Unit

Provider Information

Provider ID: XXXXXXXXXXX

Service Location: XXXX

Provider Name: XX Provider
Address: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

XX

Provider Type: XX XX Provider
Specialty: XXX XX Provider
Sub-Specialty: XXX XX Provider
Taxonomy: XXXXXXXXXXXXX

(Only if multiple specialties or sub-specialties)

Provider Specialty: XXX XX

Provider Sub-Specialty: XXX XX

Provider Taxonomy: XXXXXXXXXXXXX

Current Programs

Program: XXXXXXXXXXXXXXXXXXXXXXXX Status: XXXXXXXXXXXXXXXX Expiration Date: MM/DD/CCYY

{Only if multiple programs}

Program: XXXXXXXXXXXXXXXXXXXXXXXX

Status: XXXXXXXXXXXXXXXX

Expiration Date: MM/DD/CCYY

Rates Information

Effective Date: MM/DD/CCYY End Date: MM/DD/CCYY Total Rate: \$9999999.99

{Only if multiple rates}

Effective Date: MM/DD/CCYY

5.3 How to Complete the ADA Claim Form – Version 2012

Please click the following link for detailed instructions on completing the ADA Claim Form Version 2012:

https://www.dhs.pa.gov/providers/PROMISE_Guides/Pages/PROMISE-Handbooks.aspx

5.4 Submitting Claim Forms

Providers who have been assigned a provider identification number can submit claims either on hard copy or by Electronic Media Claims (EMC).

- ADA Claim Form – Version 2012 submission to:

Department of Human Services
Office of Medical Assistance Programs
P.O. Box 8015
Harrisburg, PA 17105-8015

5.4.1 Claim Forms through PA PROMIS_eTM

The provider will use his/her provider ID number and password to log into PA PROMIS_eTM and will be able to perform the following functions:

1. Review messages and informational notices from DHS that are displayed upon logon to the secure website. Once read, the message can be marked “read” and will no longer appear on the initial window.
2. Maintain passwords and, if authorized, can create and manage user accounts for others in his/her organization.
3. Review the status of claims submitted to DHS for payment and can review specific Error Status Codes (ESC) and HIPAA Adjustment Reason Codes for rejected claims.
4. Submit claims directly for payment or adjustment for services and prescriptions.
 - Pharmacy claims are automatically reviewed for ProDUR (Prospective Drug Utilization Review) alerts and overrides at the time of entry and corrections can be made before final submission.
 - Assuming successful completion of a claim submission, the total allowed amount of the claim, plus any adjustment information, will be displayed to the submitting provider. Although this response will be available upon submission, the claim will be held in a “Suspend” status for later processing. This prompt response to the claim submission will significantly reduce the time required for providers to submit properly completed claims and allow faster processing.
5. Review information for specific procedures, drugs and diagnoses.
6. Check pricing and eligibility limitation information.
7. Verify the eligibility status of beneficiaries. Inquiries can be made by Beneficiary ID/Card Issue Number, SSN/Date of Birth, or Beneficiary Name/Date of Birth combinations.

8. Review and download records of payments (Remittance Advice) from DHS for the past two years.
 - The provider can search for, download, and print an Adobe Acrobat (.PDF) copy of his/her original paper Remittance Advice
9. Download or review provider handbooks, billing guides, fee schedules, bulletins, etc., from the DHS website.

All claims, regardless of media, are translated into a common file structure for PA PROMIS_eTM that allows them to be communicated in a common format between different computer systems. Electronic Fee-For-Service claims and adjustments are accepted in the HIPAA-compliant ANSI 837 Dental format.

PA PROMIS_eTM supports the input of claims through multiple media, including:

- CD
- Bulletin Board via PC modem dial up
- Internet

5.5 Beneficiary Signatures

Providers must obtain applicable beneficiary signatures either on the claim form or on the Encounter Form (MA 91). The purpose of the beneficiary's signature is to certify that the beneficiary received the service and that the person listed on the PA ACCESS Card is the individual who received the service provided.

A parent, legal guardian, relative, or friend may sign his or her own name on behalf of the beneficiary. The provider or an employee of the provider does not qualify as an agent of the beneficiary; however, children who reside in the custody of a County children and youth agency may have a representative or legal custodian sign the claim form or the MA 91 on behalf of the child.

The following situations do not require that the provider obtain the beneficiary's signature:

- When billing for inpatient hospital, short procedure unit, ambulatory surgical center, nursing home, and emergency room services.
- When billing for services which are paid in part by another third party resource, such as Medicare, Blue Cross, or Blue Shield.
- When billing for services provided to a beneficiary who is unable to sign because of a physical condition such as palsy.
- When resubmitting a rejected claim form.

- When billing on computer-generated claims. *In this instance, you must obtain the beneficiary's signature on the Encounter Form (MA 91).*

5.6 Record Keeping and Onsite Access

Providers must retain, for at least four years, unless otherwise specified in the provider regulations, medical and fiscal records that fully disclose the nature and extent of the services rendered to PA PROMIS^e™ beneficiaries and that meet the criteria established in regulations.

Please refer to [55 Pa. Code Chapter 1101, §1101.51\(e\)](#) to review DHS regulations regarding record retention requirements.

6 Prior Authorization

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:

- 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.
- Prophylaxis, adult will be limited to one (1) per 180 days, per beneficiary. Additional prophylaxis will require a Department approved BLE request.
- 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. Endodontics

Services requiring prior authorization include:

1. Orthodontics;
2. Endodontics
3. Complete and partial dentures;
4. Surgical extractions;
5. Placement of device to facilitate eruption of impacted tooth;
6. Crowns; and
7. Periodontal services except full mouth debridement, which requires post-operative review.

(See Section 6.3 for more information concerning prior authorization)

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 2019, 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.

The dental unit is accepting electronic PA / BLE through the Department's resource account (RA-FFS_Dental@pa.gov). Providers must submit the following documentation with the BLE request.

- Completed ADA Claim Form
- Completed BLE Request Form (MA 549)
- Digital x-rays
- Treatment plan

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 2019 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.

Services Requiring Prior Authorization			
Procedure	Procedure Code	Procedure	Procedure Code
Crowns	D2710	Surgical	D7220
	D2721	Extractions	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.

Bicuspids (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 overlaying 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.

6.4.7 Sleep Apnea Appliance

- a. Payment for the fabrication and placement of a sleep apnea appliance requires prior authorization. The prior authorization request must include:

1. Prescription from a physician,
2. A panoramic x-ray, and
3. A letter of medical necessity including criteria explaining the necessity of the appliance.

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

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.

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. 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

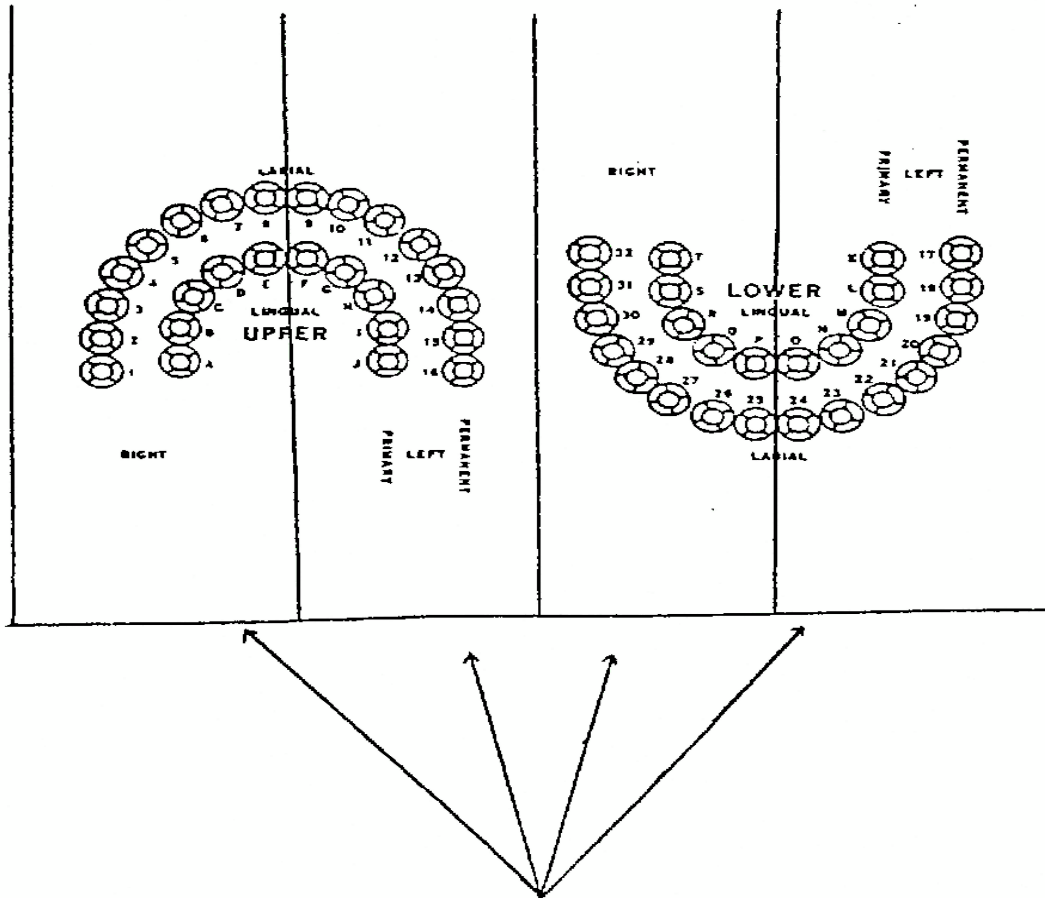
For each approved quarter of orthodontic treatment, the orthodontist must submit an original ADA Claim Form - Version 2012 for payment. Providers should retain a copy of the submitted claim form for their records.

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

7.1 General Information

In order to bill Medical Assistance (MA) and/or request prior authorization for orthodontic services, the dental practitioner must be a board certified or board eligible orthodontist. This section of the handbook will provide the necessary information for the enrolled orthodontist to request prior authorization and successfully bill DHS for approved services.

7.1.1 Orthodontic Prior Authorization

All prior authorization materials (ADA Claim Form - Version 2012, Orthodontic Decision Checklist, and diagnostic aids) are sent to:

Department of Human Services
Office of Medical Assistance Programs
Orthodontic Prior Authorization Unit
P.O. Box 8187
Harrisburg, PA 17105-8187

7.2 Overview of the Orthodontic Process

7.2.1 Qualifying Restrictions

The beneficiary must meet the following regulatory qualifications in order for the request to be considered:

a. Permanent Dentition (fully erupted)

Orthodontic services are only considered for those beneficiaries with permanent dentition. The beneficiary should present with a fully erupted set of permanent teeth. At least $\frac{1}{2}$ to $\frac{3}{4}$ of the clinical crown of the tooth must be visible, unless the tooth is congenitally missing or impacted/blocked out.

b. Age

The beneficiary must be under 21 years of age.

c. Orthodontic Decision Checklist

The Orthodontic Decision Checklist consists of eight areas for consideration in determining a handicapping malocclusion. If the beneficiary meets one or more considerations in Items 2 through 8, the orthodontist must submit the ADA Claim Form - Version 2012, diagnostic study models and X-rays to the Prior Authorization Unit who will determine if the request meets the requirements established in MA regulations.

Orthodontic services for cosmetic/esthetic purposes are not compensable under the Medical Assistance Program (see Chapter 1149, §1149.57(3)).

Consideration for orthodontic services may be requested if *all* of the above conditions have been met.

7.2.2 Submission for Consideration

a. Complete forms

1. The Orthodontic Decision Checklist (refer to Section 7.3.1 for completion instructions)
2. The ADA Claim Form - Version 2012 (refer to Section 7.3.2 for completion instructions)

b. Prepare acceptable diagnostic aids

Diagnostic study models and full mouth X-rays must be prepared following the instructions in Section 7.3.4.

c. Submission

Place the Orthodontic Decision Checklist, ADA Claim Form - Version 2012, and the ENV 98 containing the beneficiary's radiographs, in the MA 320 envelope or an envelope large enough to accommodate the materials without folding. Orthodontic diagnostic study models should be sent at the same time under separate cover. Mail **all** of the above to:

Department of Human Services
Office of Medical Assistance Programs
Orthodontic Prior Authorization Unit
P.O. Box 8187
Harrisburg, PA 17105-8187

7.2.3 Determination

DHS will make a decision to approve or disapprove orthodontic services within 21 days of receipt of the request.

If the services are denied, the orthodontist may bill for diagnostic aids unless prohibited by the denial message on the Prior Authorization Notice.

DHS will notify the orthodontist, the beneficiary and the County Assistance Office (CAO) whether the services are approved or denied on the Prior Authorization Notice (MA 328).

7.2.4 Billing

The orthodontist may bill for any orthodontic services prior authorized by DHS and provided to the beneficiary. Diagnostic aids may be billed separately on the invoice only

if the treatment has been denied and the Prior Authorization Notice does not preclude billing for the aids.

The total allowable payment for orthodontic treatment will not exceed \$3,450 for eight quarters of treatment. Diagnostic aids and the retention period following active treatment are included in the above payments.

7.3 Special Forms and Diagnostic Aids

7.3.1 Orthodontic Decision Checklist

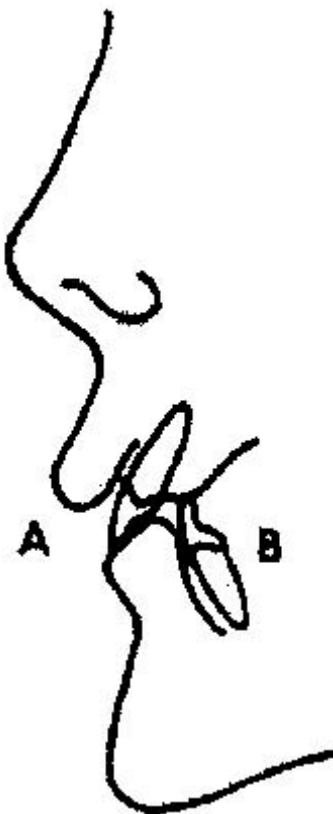
INTER-ARCH DEVIATION

7.3.1.1 Anterior Segment

OVERBITE refers to the occlusion of the maxillary incisors on or opposite the labial gingival mucosa of the mandibular incisors, or the mandibular incisors occlude directly on the palatal mucosa back of the maxillary incisors.

DO NOT CONSIDER OVERBITE unless the LOWER INCISORS IMPINGE ON THE PALATE or the UPPER INCISORS IMPINGE ON OR ARE OPPOSITE THE LOWER GINGIVA.

Fig. 1



OPEN-BITE OF INCISORS refers to vertical interarch dental separation between the maxillary and mandibular incisors when the posterior teeth are in terminal occlusion. Open-bite is recorded in addition to overjet if the incisal edges of the labially protruding maxillary incisors are above the incisal edges of the mandibular incisors when the posterior teeth are in terminal occlusion.

EDGE-TO-EDGE OCCLUSION IS NOT ASSESSED AS OPEN-BITE

Fig. 2



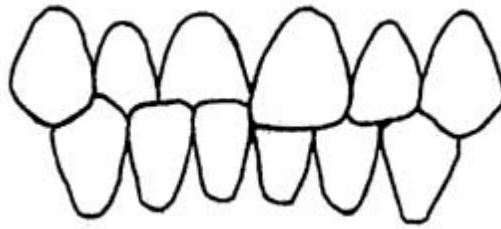
DO NOT CONSIDER OVERJET if distance is less than NINE (9) MILLIMETERS.

Fig. 3



CROSS-BITE OF INCISORS refers to the maxillary incisors that are in lingual relation to their opposing teeth in the mandible when the maxillary and mandibular dental arches are in terminal occlusion

Fig. 4

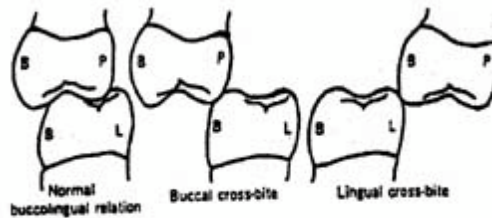


7.3.1.2 Posterior Segment

CROSS-BITE OF POSTERIOR TEETH refers to teeth in the buccal segment that are positioned lingually or buccally out of ENTIRE OCCLUSAL CONTACT with the teeth in the opposing jaw when the rest of the teeth in the dental arches are in terminal occlusion.

EDGE-TO-EDGE OCCLUSION IS NOT ASSESSED AS CROSS-BITE.

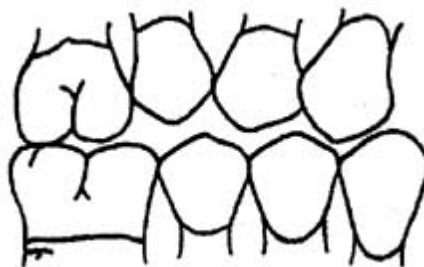
Fig. 5



OPEN-BITE OF POSTERIOR TEETH refers to the vertical interdental separation between upper and lower canines, bicuspids, and first molars when the rest of the teeth in the dental arches are in terminal occlusion.

CUSP-TO-CUSP OCCLUSION IS NOT ASSESSED AS AN OPEN-BITE.

Fig. 6



Complete the reverse side of the Orthodontic Decision Checklist as follows.

1. Include in DESCRIPTION OF PATIENT'S CONDITION AND DIAGNOSIS
 - a. All preliminary dental services completed.
 - b. Clinical description of beneficiary's general oral condition.
 - c. Classification of malocclusion.
2. Include in TREATMENT PLAN
 - a. List your projected treatment plans including the techniques to be used.
 - b. Tooth extraction(s), if any.
 - c. Indicate active treatment time: months.
 - d. Indicate retention time: months.
 - e. Special treatment(s) required (i.e., surgical exposures, surgery, etc.)
3. Include in REMARKS
 - a. Any conditions relating to the handicapping malocclusion.

7.3.2 How to Complete the ADA Claim Form - Version 2012 for an Orthodontic Prior Authorization Request

Please click the following link for detailed instructions on completing the ADA Claim Form – Version 2012 for an Orthodontic Prior Authorization Request:

https://www.dhs.pa.gov/providers/PROMISE_Guides/Pages/PROMISE-Handbooks.aspx

7.4 Special Situations

7.4.1 Transfer Procedure

7.4.1.1 If the beneficiary is transferring to another provider and orthodontic treatment was previously approved, do the following:

- A. Complete the Orthodontic Prior Authorization Request using the ADA Claim Form - Version 2012.

Under "SIGNIFICANT MEDICAL HISTORY" write "TRANSFER" and the name of the previous provider, if known.

- B. Mail the ADA Claim Form - Version 2012 to:

Department of Human Services
Office of Medical Assistance Programs
Orthodontic Prior Authorization Unit
P.O. Box 8187
Harrisburg, PA 17105-8187

7.4.1.2 If the beneficiary was receiving services as a private pay patient:

- A. Complete the Orthodontic Prior Authorization Request using the ADA Claim Form - Version 2012.

Under "SIGNIFICANT MEDICAL HISTORY" write "PRIVATE PAY TRANSFER FROM: ".

- B. Complete only the reverse side of the Orthodontic Decision Checklist.
 - a) Under "DESCRIPTION OF PATIENT'S CONDITION AND DIAGNOSIS", include the description of the oral cavity prior to treatment (if known) and the condition at the time of the request.
 - b) Under "TREATMENT PLAN", include the diagnostic procedures used prior to treatment (if known) and ones used at present (if any). Describe the plan to be used to continue and complete treatment. Also, describe the system in use at the present time.
 - c) Under "REMARKS", include any known information of the past treatment (i.e., name of doctor, place of treatment, the date active treatment began, circumstances of private pay insurance [guardian, foster care program, etc.], periods of inactive treatment, reason for pay status change, etc.). Also, include any relevant information regarding present circumstances of beneficiary.
- C. Submit a current set of orthodontic diagnostic study models and radiograph(s) (full mouth).

- D. Mail the ADA Claim Form - Version 2012, radiographs and orthodontic diagnostic study models to:

Department of Human Services
Office of Medical Assistance Programs
Orthodontic Prior Authorization Unit
P.O. Box 8187
Harrisburg, PA 17105-8187

7.4.1.3 Continuity of care from managed care to Fee-for-Service (FFS)

- A. When a provider is informed via EVS that a beneficiary is no longer enrolled in a managed care organization (MCO), but is covered by FFS, the provider and DHS are responsible for ensuring continuing services that were previously prior authorized by the MCO until the end of the time period previously authorized by the MCO.

- B. If the provider is enrolled in the MA Program, he or she must submit the Orthodontia Prior Authorization Request Form using the ADA Claim Form - Version 2012 the MCO's Prior Authorization Notice to:

Department of Human Services
Office of Medical Assistance Programs
Orthodontic Prior Authorization Unit
P.O. Box 8187
Harrisburg, PA 17105-8187

- C. The Prior Authorization Unit will review ADA Claim Form - Version 2012 and attachments submitted. Based on that information, the Prior Authorization Unit will issue an MA Prior Authorization Notice indicating the approved quarters of treatment to the provider. The remaining quarters of treatment will be honored as initially approved by the MCO.

- D. For payment, the provider must submit an invoice for each approved quarter of treatment with the MA Prior Authorization Number indicated in Item 2 (Prior Authorization No.) of the ADA Claim Form - Version 2012.

If the provider is not enrolled in the MA Program and wishes to perform the orthodontia treatment and receive payment for the treatment, he or she must enroll by submitting a Dental Enrollment Form and Provider Agreement to DHS. Enrollment information and forms are available on the DHS website at [Provider Enrollment Information](#). The non-enrolled provider may not invoice DHS for the treatment until after the enrollment process is completed. The provider who meets all MA requirements will be enrolled retroactive to the date the treatment was first delivered after the beneficiary disenrolled from managed care. Enrollment forms must be submitted within thirty (30) days of the initial treatment to avoid extended delay. The ADA Claim Form - Version 2012 with the MCO's Prior Authorization Notice and documentation showing quarters of treatment reimbursed by the MCO must be submitted to DHS at the address listed in Step 2 above.

7.4.1.4 Lost Beneficiary Eligibility

If the beneficiary loses eligibility during orthodontic treatment, DHS's final payment will be made for the quarter in which the beneficiary becomes ineligible. The beneficiary has the option to continue treatment at his/her own expense. The beneficiary must be informed that he/she is responsible for payment before further services are provided.

7.5 Billing

Compensable orthodontic services can be found in the Medical Assistance Program Fee Schedule.

Invoices for approved orthodontic services must be completed following the instructions in this handbook.

7.5.1 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.

7.5.2 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 DHS 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.** 2.3

8 Special Billing Information

8.1 Dental Anesthesia/Sedation

A dentist is eligible for payment only for deep sedation general anesthesia), intravenous (I.V.) conscious sedation/analgesia, non-intravenous conscious sedation and analgesia, anxiolysis, inhalation of nitrous oxide provided in the dentist's office or a dental clinic in conjunction with a compensable surgical procedure.

Inhalation of nitrous oxide and non-intravenous conscious sedation are only compensable for eligible beneficiaries under 21 years of age. These procedure codes are compensable in conjunction with the dental treatment of the mentally, physically, or medically compromised beneficiary or those whose psychological or emotional maturity limits the ability to undergo successful dental treatment.

The person responsible for the administration of the deep sedation general anesthesia, inhalation of nitrous oxide, conscious I.V. sedation/analgesia and non-intravenous conscious sedation must be in compliance with all rules, regulations, certifications and licensure as indicated by the Pennsylvania State Board of Dentistry. **A current copy of the dentist's anesthesia permit must be on file with the Department.**

8.1.1 Inpatient Anesthesia/Sedation

A dentist is not eligible for payment for anesthesia/sedation services provided in a hospital short procedure unit, a hospital emergency room, an ambulatory surgical center or on an inpatient basis.

The Department will pay a physician for anesthesia services when dental services are provided in a hospital short procedure unit, ambulatory surgical center, emergency room or inpatient hospital.

8.1.2 Outpatient Anesthesia/Sedation

Payment of the management fee precludes payment for outpatient deep sedation/general anesthesia, intravenous conscious sedation, non-intravenous conscious sedation, or analgesia, anxiolysis, inhalation of nitrous oxide on the same date of service.

8.1.2.1 General Information

Payment for outpatient anesthesia/sedation is made to the dental provider or the dental clinic only if:

- a. The condition of the beneficiary and/or the nature of the oral surgery is such that the use of local anesthesia is not practical;
- b. It is medically necessary;

- c. The qualifications of the dentist and the office facilities are such that the administration of anesthesia/sedation will not cause undue risk to the beneficiary; *and*
- d. The general anesthesia was administered by a properly supervised Certified Registered Nurse Anesthetist.

8.1.2.2 Documentation

A statement must be included in the Remarks section of the invoice justifying the use of anesthesia/sedation on the basis of the beneficiary's condition and/or the nature of the oral surgery plus medical necessity. If the procedure performed is one of the surgical procedures identified in the MA Program Fee Schedule, medical necessity does not have to be documented.

The following procedures are considered "surgical procedures" in the MA Program Fee Schedule:

- D3410 through D3426
- D7450 through D7970
- 10060 through 10140
- 11010 through 11012
- 11310 through 20150
- 20520 through 20525
- 20661 through 21088
- 21116 through 21510
- 21555 through 23930
- 29804 through 30020
- 30110 through 31267
- 40500 through 40805
- 40810 through 41018
- 41110 through 42000
- 42104 through 42340
- 42408 through 42510

- 42600 through 42955
- 64600 through 64872
- 67840 through 67966

Pedodontists and Oral Surgeons must also adhere to the guidelines specified above. However, the only documentation required is a statement in the Remarks section, explaining that the dentist is a Pedodontist or Oral Surgeon.

8.1.2.3 What constitutes acceptable documentation for the condition of the beneficiary or the nature of the oral surgery to justify anesthesia/sedation?

- a. Child is under 5 years of age and more than one simple extraction or surgical extraction is performed.
- b. Beneficiary has medical conditions that preclude the use of local anesthesia.
- c. Severe infection at the injection site.
- d. Beneficiaries with intellectual disability, other mental health or physical conditions and who are unmanageable using local anesthesia.
- e. Multiple extractions in more than one quadrant. If the treatment is simple or surgical extractions, two or more quadrants must have had at least two teeth extracted per quadrant *or* three or more quadrants had at least one tooth extracted per quadrant. Medical Assistance uses the diagram on page 89 to identify quadrants.

8.1.2.4 What constitutes acceptable documentation to justify medical necessity?

- a. Severe infection at the injection site.
- b. Severe cerebral palsy, unmanageable.
- c. Severe intellectual disability, unmanageable.

NOTE: A DEFINITIVE DIAGNOSIS AND SECONDARY DIAGNOSIS ALONG WITH DOCUMENTATION OF THE STATEMENTS UNDER THE REMARKS SECTION MUST BE SUBSTANTIATED IN THE BENEFICIARY'S MEDICAL RECORD. THESE CLAIMS ARE SUBJECT TO REVIEW FOR MEDICAL NECESSITY.

8.1.2.5 Examples of unacceptable documentation:

- a. Beneficiary unable to tolerate the procedure.
- b. Beneficiary prefers or requests general anesthesia.

c. Beneficiary wants to be asleep.

d. Additional invoicing requirements

Dental practitioners who administer and bill the Department for anesthesia/sedation when performing outpatient surgical procedures or tooth extractions (warranting anesthesia/ sedation) *must* bill for the surgical extractions and the anesthesia/sedation on the same invoice.

Any substantiating documentation to justify payment for the anesthesia must be included in the Remarks section of the claim form.

8.2 Outpatient Surgical Services

8.2.1 Alveolectomy/Alveoloplasty

Alveolectomy/alveoplasty services) are billed *per quadrant*. For MA billing purposes, a quadrant equals 5 - 8 teeth.

Alveolectomy/alveoplasty services involving less than five teeth are not compensable.

8.2.2 Excision of Hyperplastic Tissue

Excision of hyperplastic tissue, per arch, is *not* intended to be used for simple corrective tissue removal associated with extractions. Use of this code is reserved for removal of abnormal, extraneous tissue that is interfering with the normal function of the teeth and/or prosthetic appliances.

8.3 Medications, Palliative Treatment and Prescriptions

a. Medications and supplies furnished by the dentist during the course of an examination or treatment are **not** paid for by the Department in addition to the regular fees listed in the Medical Assistance Program Fee Schedule.

b. Palliative (emergency) treatment of dental pain may not be billed in addition to any other treatment or dental service (excluding dental radiographs used to determine appropriate dental care), on the same day.

c. The Department requests that you put your license number on prescriptions/orders for MA beneficiaries. This information is needed to meet federal surveillance and utilization review standards, which require the Department to identify practitioners who order or prescribe goods, services or drugs. Your license number will be submitted to the Department by the provider dispensing the goods, services or drugs that you prescribe.

8.4 Supernumerary Teeth

Permanent dentition - Supernumerary teeth are identified by the numbers 51 through 82, beginning with the area of the upper right third molar, following around the upper arch and continuing on the lower arch to the area of the lower right third molar (for example, supernumerary number 51 is adjacent to the upper right molar number 1; supernumerary number 82 is adjacent to the lower right third molar number 32).

Primary dentition - Supernumerary teeth are identified by the placement of the letter "S" following the letter identifying the adjacent primary tooth (for example, supernumerary "AS" is adjacent to "A"; supernumerary "TS" is adjacent to "T").

The appropriate supernumerary tooth number/letters should be placed in the Tooth Number or Letter(s) field (Item 27) of the [ADA Claim Form - Version 2012](#).

8.5 Homebound, Nursing Facilities

Dental services are available for eligible beneficiaries in the home or nursing facility.

When completing the claim form, be certain to indicate the appropriate place of service (Item 38 on the ADA Claim Form - Version 2012).

8.6 Transportation (Mileage)

Procedure Code S0215 may be billed when service is provided in the beneficiary's home or a nursing facility outside of the city, borough or unincorporated community in which the dentist's office is located.

Mileage calculation begins at the city, borough or community limits.

When several beneficiaries in the same relative vicinity are visited on a continuous trip, the mileage allowed is for the call to the beneficiary whose home is the most distant from the defined limit of the community in which the dentist's office is located.

Mileage is paid beginning at the limits defined above, to the farthest destination and return.

8.7 Dental Procedures for Special Situations

8.7.1 Beneficiary fails to return for completion of service

When the dentist has received prior authorization for crowns or dentures and the beneficiary does not return to have the appliance inserted or the work is not completed, the dentist must request payment through the 1150 Administrative Waiver process.

- a. When the item is completed, the dentist must notify the beneficiary and make an appointment. If the dentist is unable to contact the beneficiary after thirty (30)

days, in spite of repeated attempts, which must be documented in the beneficiary's treatment record, the dentist must send a letter to the beneficiary and the appropriate County Assistance Office.

- b. If after sixty (60) days neither the dentist nor the County Assistance Office can locate the beneficiary or the work cannot be completed, the dentist may submit an 1150 Administrative Waiver request to the Department.

8.7.2 Beneficiary loses eligibility

When billing the Department for a prior authorized custom-made crown or denture for which the impression was taken while the beneficiary was eligible, but was not inserted in the beneficiary's mouth before the beneficiary became ineligible, the dentist must use the date of impression for the date of service. Include the date the appliance was inserted in the Remarks Section of the [ADA Claim Form - Version 2012](#).

8.8 Inpatient Hospital/Short Procedure Unit (SPU)/Ambulatory Surgical Center (ASC) Dental Care

8.8.1 Surgical procedures

The fee paid by the Department for inpatient surgical services includes all preoperative and postoperative visits. When two or more surgical procedures are performed by the same dentist, during the same period of hospitalization, the dentist will be reimbursed for up to 100% of the highest allowable payment for one procedure, and 25% for the second procedure, with no payment for any additional procedures.

8.8.2 Inpatient visit(s)

Payment may be made to dentists for daily inpatient medical care under the following conditions:

- a. Dentist is responsible for care:

The beneficiary was hospitalized in anticipation of dental surgery that was not performed because medical treatment was successful. In addition, a physician was not responsible for the daily medical care of the beneficiary. Finally, the condition of the beneficiary required hospitalization.

- b. Another practitioner is responsible for the care:

The dentist must provide care for a condition or diagnosis unrelated to any daily medical care provided by the primary physician.

- c. Inpatient consultation(s)

Any professional consultation requested for any beneficiary is limited to one such consultation per hospital admission. The consultation must be requested by the primary dentist or physician and must be provided by a dental or medical

specialist other than the dentist providing the treatment. A consultation report must be made in writing and is considered to be a part of the beneficiary's dental treatment and hospital records.

d. Limited compensable services

All dental procedures listed in the Medical Assistance Program Fee Schedule are considered outpatient procedures. Outpatient procedures are not compensable on an inpatient basis unless there is medical justification documented in the beneficiary's medical record and on the invoice.

Generally, the following services are compensable on an inpatient basis when properly invoiced:

1. Oral surgery procedures when the condition of the beneficiary and/or the nature of the oral surgery may entail undue risk to the beneficiary if performed on an outpatient basis.
2. Extractions of teeth only when:
 - A. The teeth are impacted (i.e., soft tissue, complete bony and partial bony impactions where the surgical procedure would constitute undue risk to the beneficiary without hospitalization); or
 - B. A beneficiary presents a medically compromising condition that would endanger the physical health of the beneficiary without hospitalization; or
 - C. Beneficiary is unmanageable in a dental office because of a severe mental and/or physical condition and requires general anesthesia.
3. The procedure is a secondary, necessary procedure.
4. Dental restorative services performed for a beneficiary who is unmanageable in a dental office because of a severe physical and/or mental condition that necessitates the use of general anesthesia. (Payment for the administration of general anesthesia will be made to the anesthesiologist, *not* the dentist.)

NOTE: ALL REQUESTS FOR REIMBURSEMENT FOR COMPENSABLE DENTAL SERVICES PERFORMED ON AN INPATIENT/SPU/ASC BASIS MUST BE DOCUMENTED BY SUBSTANTIATING INFORMATION IN THE "REMARKS" SECTION OF THE CLAIM FORM.

8.9 Consultations

A referral to another practitioner does not constitute a consultation. For example, when a dentist refers a beneficiary to the oral surgeon who then performs oral surgery, the oral surgeon would bill for the surgical procedure(s). A consultation will not be reimbursed in this case. When a beneficiary is referred to another practitioner, the medical record must indicate the name of the practitioner and the reason for the referral.

8.9.1 Procedure codes

Consultation procedure codes **99241** through **99275** are located in the Medical Assistance Program Fee Schedule.

8.9.2 Payment limitations

- a. Payment will not be made for a self-referred consultation. A consultation must be requested by another practitioner.
- b. A practitioner will not be reimbursed for a consultation and an oral examination on the same date of service.
- c. Payment will not be made for a consultation when it is performed by a surgeon or assistant surgeon regarding the advisability of definitive surgery and surgery subsequently is performed by that surgeon.
- d. Payment will not be made for a consultation if the consultation occurs between members of the same group, shared facility, or providers sharing common records.
- e. Payment will not be made for a dental consultation in a nursing facility when provided by a dentist who has a contract or agreement to provide dental exams and follow-up care to residents of the facility. A dentist may bill for an initial or periodic oral exam for these services.
- f. Payment for an inpatient consultation includes payment for follow-up care. Therefore, the consultant is not eligible to bill for daily medical care. Only the attending practitioner is entitled to bill for daily medical care.

8.10 Assistant Surgeon Services

The maximum payment to an assistant surgeon will be an amount equal to 20% of the maximum allowable payment made to the surgeon for the surgery performed.

The assistant surgeon should bill using procedure code **D7999**. This code should be placed under "Procedure Code" (Field 29) on the ADA Claim Form - Version 2012. The letters "**ASST SURG**" and the **procedure code indicating the actual surgery performed** *must* be entered in the "Remarks" (Field 35) section of the ADA Claim Form - Version 2012.

8.11 Other Billing Information

8.11.1 General Policies

Children under 21 years of age are eligible for all medically necessary dental services. For children under 21 years of age who require medically necessary dental services beyond the fee schedule limits, the dentist should request a waiver of the limits, as

applicable, through the 1150 Administrative Waiver (Program Exception) process.

8.11.2 Preventive Services

Treatment guidelines for “Interim Caries arresting medicament application – per tooth” are as follows:

- High caries-risk patients with anterior or posterior active cavitated lesions;
- Cavitated caries lesions in individuals presenting with behavioral or medical management challenges;
- Patients with multiple cavitated caries lesions that may not all be treated in one visit;
- Difficult to treat cavitated dental caries lesions; or
- Active cavitated caries lesions with no clinical signs of pulp involvement.

The number of teeth treated should be based on the clinical evaluation. The presence of an active cavitated carious lesion in the tooth is required for treatment.

8.11.3 Restorations

The Department considers two or more restorations on the same surface of a tooth to be one restoration. Providers are to bill for only one restoration per tooth.

The Department’s payment for restoration and filling include local anesthesia, polishing, bonding agents, cement bases, acid etch, light cured material and the necessary medications when indicated.

8.11.4 Sealants

The Department limits sealants to children under 21 years of age as follows:

1. 1st premolars (tooth numbers 5, 12, 21, 28) and 2nd premolars (tooth numbers 4, 13, 20, 29);
2. permanent first molar (tooth numbers 3, 14, 19, 30) and permanent second molars (tooth numbers 2, 15, 18, 31).

NOTE: Application of sealants includes the occlusal surface of 1st and 2nd molars where a buccal restoration may exist.

Payment is limited to one application per caries-free and restoration-free permanent molar, per lifetime.

8.11.5 Space Maintainers

Space maintainers are passive appliances designed to prevent tooth movement for posterior teeth only. A bilateral space maintainer must maintain spaces for permanent successors to prematurely lost posterior deciduous teeth occurring bilaterally in the maxillary or mandibular arch.

8.11.6 Tobacco Cessation Counseling

In order to provide tobacco cessation counseling services, a dentist must be pre-approved by the Department of Health (DOH) as a Tobacco Cessation Program. The Fee Schedule defines one unit of a tobacco cessation counseling session as greater than 10 minutes, limited to one visit (unit of service) per day and a maximum of 70 units per individual, per calendar year. Providers must provide a full 10-minute counseling session in order to submit a claim for one unit of service. Providers are not permitted to round the unit of service to the next higher unit when providing a partial unit of time. Providers are not permitted to combine partial time units to equal a full unit of service.

Additional information on pre-approval by the Department of Health may be found Medical Assistance Bulletin, 99-18-10, titled “Enrollment of Tobacco Cessation Providers,” effective June 18, 2018.

8.11.7 Cleft Palate Services

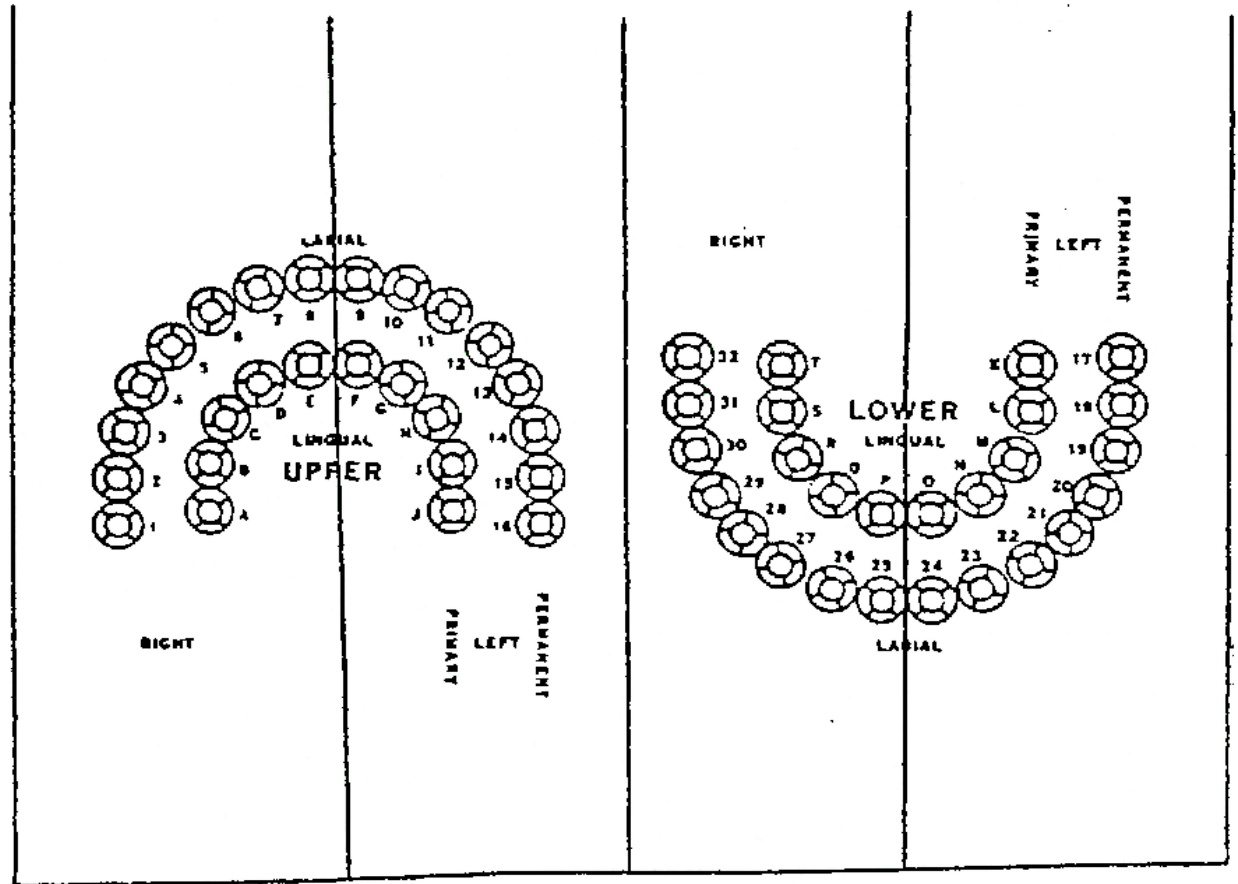
(Beneficiaries 20 Years of Age and Under)

Evaluations -

Cleft Palate Clinic providers are to submit a copy of the completed initial evaluation to the address below for prior authorization for cleft palate services. The evaluation must be updated on a yearly basis as long as the beneficiary is covered by the Medical Assistance Cleft Palate Program.

Orthodontic services covered under this program must not be done solely for cosmetic purposes, but must be done in conjunction with craniofacial reconstruction and/or the correction of a severe handicapping malocclusion. Orthodontic services will not be limited to eight quarters of treatment and/or permanent dentition only for Cleft Palate Treatment.

Department of Human Services
Office of Medical Assistance Programs/Bureau of Fee-for-Service Programs
Cleft Palate Services
P.O. Box 8050



EACH AREA EQUALS 1 QUADRANT

9 Remittance Advice

The Remittance Advice Statement explains the actions taken and the status of claims and claim adjustments processed by DHS during a daily cycle. The processing date on the RA statement is the computer processing date for the cycle. Checks corresponding to each cycle are mailed separately by the Treasury Department.

The first page of the RA is used as a mailing label and contains the "Address" where the RA is being sent. This is followed by the "Detail" page(s) that list all of the claim forms processed during the PA PROMIS^e™ daily cycle. The next page is a "Summary" of activity from the detail page(s). Finally, the last page(s) is the Explanation of Edits Set This Cycle page(s).

9.1 Remittance Advice Address Page

The RA address page contains the address where the RA Statement is to be mailed and is used as a mailing label.

Providers may also find a Remittance Advice (RA) Alert on this page. From time to time, DHS may need to disseminate information quickly to the provider community. Consequently, an alert may be contained on the "address" page of the RA statement or in the form of an insert contained within the RA statement.

9.2 Remittance Advice Detail Page(s)

The detail pages of the RA statement contain information about the claim forms and claim adjustments processed during the daily cycle.

Claim form information contained on the detail pages is arranged alphabetically by beneficiary last name. If there is more than one provider *service location code*, claims will be returned on separate RA Statements as determined by each service location.

9.3 PA PROMIS^e™ Remittance Advice Summary Page*

This page contains information summarizing all action taken on your claims during the daily cycle.

9.4 PA PROMIS^e™ "Explanation of Edits Set This Cycle" Page*

This is always the last page(s) of the RA Statement. This page contains a list of the Explanation Codes or Comments that appear on the RA Detail page(s) for the weekly cycle. To the right of each Explanation Code is the description of the code.

9.5 Claim Form Reconciliation Method

The daily RA statement reconciles submitted claim forms with PA PROMISe™ claims processing activities. By itself, the RA statement will not serve as an accounts receivable report because:

- Suspended claims will be processed in more than one daily computer run. Therefore, the difference between claims processed over a certain time period and the paid/rejected claims during the same period may not equal outstanding submitted invoices.
- The amount billed by the provider indicates the usual and customary charges and will ordinarily not equal the paid-in-full amount for services as determined by the PA PROMISe™ Program Fee Schedule.

To determine the "accounts receivable", you should develop a "reconciliation" system. As an example, some providers use the following method:

Step 1. Your copy of claim forms that were submitted to DHS is placed in a "submitted" or "suspended" file. They are filed by date of submission to DHS. Within each submission date batch, the files copies are in alphabetical order by the beneficiary's last name.

If you have made arrangements with DHS to use different service locations or payees, then you should have a separate submitted invoice file for each service location or payee. Your RA statement will be organized first by service location, then by beneficiary name in alphabetical order.

Step 2. Each additional batch of invoices that is submitted is added to the back of the submitted/suspended file so that the oldest file copies are in the front and the most recent are in the back.

Step 3. Each time you receive an RA statement from DHS, the "submitted file" is compared to the RA statement.

A. If a claim form has been approved and "paid", that claim form is removed from the submitted file and placed with the provider's permanent financial records.

B. If there was an overpayment or underpayment, a claim adjustment is submitted. The file copy of the claim adjustment is added to the submitted file.

C. If a claim form has been identified as "denied", the file copy of that claim form is removed from the submitted file.

1. If the denied claim is one that DHS should not pay, (for example, the beneficiary is ineligible or the service is not covered), then the claim form is placed in your permanent record.

2. If the denied claim is one you believe DHS should pay, then prepare and submit a new claim form with the correct information. Correct information may be found in the provider's records or secured from the beneficiary. If the Explanation Code indicates that it is a beneficiary eligibility related problem, access EVS to verify beneficiary eligibility. For all other problems, contact DHS. The provider copy of the resubmitted claim form is added to the resubmitted file as a regular claim form under the new date of submission.

Step 4. All file copies of submitted claims that are identified on the RA statement as suspended are left in your submitted file for comparison with future RA statements.

Step 5. If a claim form does not appear on an RA Statement as approved, denied, or suspended within 45 - 50 days after submission, resubmit the claim immediately. If you have Internet access, go to the PA PROMIS^e™ Internet site at: <http://promise.dpw.state.pa.us/> to check the status of the claim or contact the Provider Inquiry Unit and request claim status.

This reconciliation system will not only make it easier to reconcile your submitted claims with DHS's processing actions, but it will give you a quick indicator of the number of outstanding claims. It will also give you an approximate age (by submission date) of the outstanding claims.

10 HIPAA Requirements

This section includes how the Health Insurance Portability and Accountability Act (HIPAA) requirements were implemented and applied in the PA PROMIS^e™ Program. This section also describes how providers can become certified to submit HIPAA transactions and code sets. Additionally, the handbook will provide information on how the HIPAA security rules will protect private information in the PA PROMIS^e™ Program.

10.1 Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) became public law on August 21, 1996. It is a federal bi-partisan law based on the Kennedy-Kassebaum bill. The Department of Health and Human Services assigned the Centers for Medicare & Medicaid Services (CMS) the task of implementing HIPAA. The primary goal of the law was to make it easier for people to keep health insurance, and help the industry control administrative costs.

HIPAA is divided into five Titles or sections. Title I is Portability and has been fully implemented. Portability allows individuals to carry their health insurance from one job to another so that they do not have a lapse in coverage. It also restricts health plans from imposing pre-existing condition limitations on individuals who switch from one health plan to another.

Title II is called Administrative Simplification. Title II is designed to:

- Reduce health care fraud and abuse;
- Guarantee security and privacy of health information;
- Enforce standards for health information and transactions; and
- Reduce the cost of healthcare by standardizing the way the industry communicates information.

Titles III, IV, and V have not yet been defined.

The main benefit of HIPAA is standardization. HIPAA requires the adoption of industry-wide standards for administrative health care transactions; national code sets; and privacy protections. Standards have also been developed for unique identifiers for providers, health plans and employers; security measures; and electronic signatures.

10.1.1 Administrative Simplification

The goal of administrative simplification is to reduce health care administrative costs and promote quality and continuity of care by facilitating electronic data interchange (EDI). HIPAA establishes standards for 10 electronic health care transactions, national code

sets, and unique identifiers for providers, health plans, employers, and individuals. It also establishes standards for ensuring the security of electronic health care transactions.

Although industry use of EDI is growing, health care transactions are transported and processed in various file structures and record layouts.

It is important to remember two things:

- a. HIPAA does not require providers to submit claims or receive remittance advice statements electronically.
- b. It also does not directly address paper claims.

10.1.2 Transactions Adopted

837 Professional	NCPDP 5.1 Claim	270 Eligibility Request
837 Institutional Inpatient	NCPDP 5.1 Reversal	271 Eligibility Response
837 Institution Nursing Home	NCPDP 5.1 Eligibility	
837 Dental	NCPDP 1.1 Batch	
835 Remittance Advice		

10.1.3 Code Sets Adopted

International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)	Diagnoses (all services) and Inpatient Hospital Procedures
National Drug Codes (NDC)	Drugs, Biologicals
Current Dental Terminology, fourth edition (CDT-4)	Dental Services
Current Procedural Terminology, fourth edition (CPT-4)	Physician and all other services
CPT-4 – Healthcare Common Procedure Coding System	Medical equipment, injectable drugs, transportation services, and other services not found in CPT-4
CMS Health Care Claim Adjustment Reason Codes and Remittance Advice Remark Codes	

10.1.4 Software Options Available

Providers have four options for selecting software used to submit HIPAA-ready transactions to Pennsylvania Medical Assistance.

1. Request Provider Electronic Solutions (PES) software (provided free-of-charge).
2. Purchase certified HIPAA software from your vendor of choice.
3. Program your own system software.
4. Use a clearinghouse that uses HIPAA certified software.

All providers planning to submit HIPAA-ready claims, regardless of the origin of their software, need to register and be certified by Gainwell Technologies, DHS's claims processing contractor, prior to submitting their first claim. To register, please go to <https://promise.dpw.state.pa.us/ePROM/ProviderSoftware/softwareCertificationForm.asp> and complete the registration form. If you do not have Internet access, please call 717-975-6085, and leave your name and telephone number. A certification expert will contact you to complete the registration process.

10.1.5 HIPAA Claim Transaction Certification

For HIPAA-compliant transactions to be submitted, there is a certification process that involves registration and testing. When you register for certification, you must indicate the type of transactions you will be sending/receiving.

It is vital that you complete the certification process and become certified to exchange HIPAA transactions. Without certification, your files will not be accepted and your claims will not be processed.

Certification does not insure that claims will be paid.

10.1.5.1 Provider Electronic Solutions Software

If you are looking for a way to send and receive HIPAA-ready electronic transactions and determine beneficiary eligibility, consider the Provider Electronic Solutions software. You can submit the following transaction types:

- EVS transactions (interactive and batch)
- Professional Claims (837P)
- Dental Claims (837D)
- Institutional Claims (837I)
- Long Term Care Claims (837I)
- Electronic Remittance Advice (835)
- Pharmacy Claims, Eligibility, and Extended Reversals (NCPDP 5.1)

NOTE: For more information on Provider Electronic Solutions software click on http://promise.dpw.state.pa.us/ePROM/_ProviderSoftware/softwareDownloadMain.asp

Follow the directions to download the software.

NOTE: This software is available to you free-of-charge, and runs on Microsoft Windows operating systems on IBM compatible computers.

10.1.5.2 PA PROMISe™ Internet Providers

Providers who submit claim transactions directly through the PA PROMISe™ Internet Application do *not* require certification because this application is built to be HIPAA compliant. However, you are required to be an active provider in PA PROMISe™. You will also need a valid log on ID and a username and password to access PA PROMISe™.

10.1.5.3 Software Vendors/Developers

Clearinghouses, software vendors and developers distributing software to providers are required to certify through Gainwell Technologies. Upon successful certification, each vendor/developer will be assigned a Terminal ID. The software vendor/developer will provide this number to their users when distributing software. Providers who submit claims through a clearinghouse are covered under the clearinghouse's certification.

10.1.5.3.1 837/835 submitters:

- Clearinghouses and providers/submitters directly interacting electronically with the Gainwell Technologies clearinghouse must certify (this also includes providers using certified software purchased from a vendor).
- Providers submitting claims through a clearinghouse are covered under the clearinghouse's certification,

10.1.5.3.2 NCPDP 5.1 vendors:

- Software vendors and developers distributing software to providers must certify.
- Vendors of interactive software are also required to certify with Emdeon Business Services.

10.1.5.3.3 NCPDP 5.1 interactive submitters:

- Submitters using certified software are covered under the software vendor's certification.

- Interactive submitters using certified vendor software will not be required to obtain a Gainwell Technologies HIPAA clearinghouse ID but will be required to register with Emdeon Business Services.

10.1.5.3.4 NCPDP 1.1 batch submitters:

- Submitters using certified software are covered under the software vendor's certification.
- Each provider who submits batch transactions using certified vendor software is responsible for obtaining a Gainwell Technologies HIPAA clearinghouse ID that grants access to the Gainwell Technologies clearinghouse system.

10.1.5.3.5 270/271 vendors:

- Software vendors and developers distributing software to providers must certify.

10.1.5.3.6 270/271 interactive submitters:

- Submitters using certified software are covered under the software vendor's certification.

10.1.5.3.7 270/271 batch submitters:

- Submitters using certified software are covered under the software vendor's certification.
- Each submitter is responsible for obtaining a Gainwell Technologies HIPAA clearinghouse ID that grants access to the Gainwell clearinghouse system.

10.1.5.3.8 278 Prior Authorization

- Submitters using certified software are covered under the software vendor's certification.
- Each submitter is responsible for obtaining a Gainwell Technologies HIPAA clearinghouse ID that grants access to the Gainwell clearinghouse system.

Register for HIPAA certification by visiting the DHS website:

https://promise.dpw.state.pa.us/eprom/_ProviderCertification/softwareCertificationForm.aspx

Click on the "PROMISE™ Transaction Certification Registration Form" link. After you complete and electronically submit the registration form, a Gainwell Technologies representative will contact you to explain the certification process. If

you do not have Internet access or need help completing the PROMIS^e™ Transaction Certification Registration Form, call the Gainwell Technologies Provider Assistance Center's toll-free telephone line at 1-800-248-2152 (Harrisburg area residents may call 717-975- 4100).

10.2 HIPAA Privacy

The HIPAA Privacy Rule became effective on April 14, 2001 and was amended on August 14, 2002. It creates national standards to protect medical records and other protected health information (PHI) and sets a minimum standard of safeguards of PHI.

The regulations impact covered entities that are health care plans, health care clearinghouses and health care providers. Most covered entities, except for small health plans, must comply with the requirements by April 14, 2003. DHS performs functions as a health care plan and health care provider. Any entity having access to PHI must do an analysis to determine whether it is a covered entity and, as such, subject to the HIPAA Privacy Regulations.

10.2.1 Requirements

Generally, the HIPAA Privacy Rule prohibits disclosure of PHI except in accordance with the regulations. All organizations, which have access to PHI must do an analysis to determine whether or not it is a covered entity. The regulations define and limit the circumstances under which covered entities may use or disclose PHI to others. Permissible uses under the rules include three categories:

- a. Use and disclosure for treatment, payment and healthcare operations;
- b. Use and disclosure with individual authorization; and
- c. Use and disclosure without authorization for specified purposes.

The HIPAA Privacy Regulations require Covered Entities to:

- Appoint a privacy officer charged with creating a comprehensive Privacy Policy.
- Develop minimum necessary policies.
- Amend Business Associate contracts.
- Develop accounting of disclosures capability.
- Develop procedures to request alternative means of communication.
- Develop procedures to request restricted use of PHI.
- Develop complaint procedures.
- Develop amendment request procedures.

- Develop individual access procedures.
- Develop an anti-retaliation policy.
- Train the workforce.
- Develop and disseminate the Privacy Notice.

10.2.2 Business Associate Relationships

As a covered entity, DHS must have safeguards in place when it shares information with its Business Associates. A Business Associate is defined by the HIPAA Privacy Regulation as a person or entity, not employed by the covered entity, who performs a function for the covered entity that requires it to use, disclose, create or receive PHI. The covered entity may disclose PHI to a Business Associate if it receives satisfactory assurances that the Business Associate will appropriately safeguard the information in accordance with the HIPAA requirements. These assurances are memorialized in a Business Associate Agreement that may or may not be part of a current contract or other agreement. The Business Associate language must establish permitted and required uses and disclosures and must require Business Associates to:

- a. Appropriately, safeguard PHI.
- b. Report any misuse of PHI.
- c. Secure satisfactory assurances from any subcontractor.
- d. Grant individuals access to and the ability to amend their PHI.
- e. Make available an accounting of disclosures.
- f. Release applicable records to the covered entity and the Secretary of Health and Human Services.
- g. Upon termination of the Business Associate relationship, return or destroy PHI.

DHS's Business Associates include, but are not limited to Counties, Managed Care Organizations, Children and Youth Agency Contractors, and certain Contractors/Grantees. DHS's agreements with its Business Associates must be amended (or otherwise modified) to include the Business Associate language required for HIPAA compliance. DHS will discontinue sharing information and/or discontinue a relationship with a Business Associate who fails to comply with the Business Associate language.

10.2.3 Notice of Privacy Practice

A covered entity must provide its consumers with a plain language notice of individual rights with respect to PHI maintained by the covered entity. Beginning April 15, 2003, health care providers must provide the notice to all individuals on their first day of service, and must post the notice at the provider's delivery site, if applicable. Except in an

emergency treatment situation, a provider must make a good faith effort to obtain a written acknowledgement of receipt of the notice. Health plans must provide the notice to each individual enrolled in the plan as of April 14, 2003, and to each new enrollee thereafter at the time of enrollment, and within sixty days of any material revision to the notice. A covered entity with a web site must post its notice on the web site. A covered entity must document compliance with the notice requirements and must keep a copy of notices issued.

The specific elements of the notice include:

- a. Header: "This notice describes how medical information about you may be used and how you can get access to this information. Please review it carefully."
- b. A description, including at least one example, of the types of uses and disclosures the covered entity may make for treatment, payment or health care operations.
- c. A description of each of the other purposes for which the covered entity is required or permitted to use or disclose individually identifiable health information without consent or authorization.
- d. If appropriate, a statement that the covered entity will contact the individual to provide information about health-related benefits or services.
- e. A statement of the individual's rights under the privacy regulations.
- f. A statement of the covered entity's duties under the privacy regulations.
- g. A statement informing individuals how they may complain about alleged violations of the privacy regulations.

10.2.4 Employee Training and Privacy Officer

Providers must train their employees in their privacy procedures and must designate an individual to be responsible for ensuring the procedures are followed.

10.2.5 Consent and Authorization

10.2.5.1 Consent

The HIPAA Privacy Regulations permit (not require) a covered entity to obtain a consent from a patient to use and disclose PHI for treatment, payment and health care operations. DHS will be obtaining consent for treatment, payment, and health care operations from its clients, where practicable.

10.2.5.2 Authorization

The HIPAA Privacy Regulations make a clear distinction between consents and authorizations. Consents are used only for disclosures related to treatment, payment and health care operations. The covered entity is required to have an authorization

from an individual for any disclosure that is not for treatment, payment, or health care operations or exempted under the regulations. An authorization must clearly and specifically describe the information that may be disclosed, provide the name of the person or entity authorized to make the disclosure and to whom the information may be disclosed. An authorization must also contain an expiration date or event, a statement that the authorization may be revoked in writing, a statement that the information may be subject to re-disclosure and be signed and dated.

10.2.6 Enforcement

DHS is not responsible for the enforcement of the HIPAA privacy requirements. This responsibility lies with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR). The enforcement activities of OCR will involve:

- Conducting compliance review;
- Providing technical assistance to covered entities to assist them in achieving compliance with technical assistance;
- Responding to questions and providing guidance;
- Investigating complaints; and, when necessary,
- Seeking civil monetary penalties and making referrals for criminal prosecution

10.3 HIPAA Security Rule

The HIPAA Security Rule sets guidelines for the protection of private information. Security is the policies, procedures, technical services, and mechanisms used to protect electronic information. It mandates computer systems, facility, and user security safeguards. These safeguards are intended to minimize unauthorized disclosures and lost data.

10.4 Penalties for Noncompliance

The penalties outlined for the two rules released to date are as follows:

Penalties for the Transactions and Code Sets are aimed at the health plans, billing services and providers who submit claims electronically. They are:

- \$100 per violation (defined as each claim element)
- Maximum of \$25,000 per year.

Privacy affects all covered entities, such as health plans, billing services, providers and business associates who receive and use protected health information. The penalties for wrongful disclosures are:

- Up to \$250,000 AND 10 years in prison.

For more information on penalties, please go to

<http://www.hhs.gov/ocr/privacy/>

11 Medical Assistance Program Dental Fee Schedule

The Medical Assistance (MA) Program Dental Fee Schedule is posted on the Department of Human Services website at the following website link:

https://www.dhs.pa.gov/providers/Documents/Dental%20Care/p_002906.pdf

Providers should refer to the MA Program Dental Fee Schedule for information on specific provider types, provider specialties, places of service, limits and prior authorization requirements. The procedure codes that require prior authorization are identified by a “Yes” under the “Prior Authorization” heading.

12 Provider Preventable Conditions (PPCs)

This section is for:

- Practitioners, including dentists paid from the MA Program Fee Schedule.

Note: For specific billing requirements, please refer to the Billing Guide for your specific provider type.

The Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), enacted March 23, 2010, required the United States Department of Health and Human Services to prohibit payment by state Medicaid programs for health care acquired conditions (HCACs), effective July 1, 2011.

12.1 Requirements

On June 6, 2011, the Centers for Medicare and Medicaid Services (CMS), the agency within HHS that administers the Medicare program and works in partnership with states to administer Medicaid programs, established an umbrella term of provider preventable conditions (PPCs), which encompasses HCACs and other provider preventable conditions (OPPCs), and promulgated regulations regarding Medicaid program payment prohibitions for PPCs. While the statutory effective date is July 1, 2011, CMS delayed compliance action on these provisions until July 1, 2012. (See Federal Register (FR), Vol.76, No. 108, 32816-32838).

A HCAC is defined as “a condition occurring in any inpatient hospital setting, identified currently or in the future, as a hospital-acquired condition (HAC) by the Secretary of HHS under section 1886(d)(4)(D) of the Social Security Act (Act), other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients”. On August 16, 2010, the Centers for Medicare and Medicaid Services published the list of Medicare HACs for FY 2011. (See FR, Vol. 75, No. 157, 50042-50677). Section 5001(c) of the Deficit Reduction Action provides for the revision of the list of (HAC) conditions from time to time. (See FR, Vol. 76, No. 160, 51476-51846).

An OPPC is defined as “a condition occurring in any health care setting that meets the following criteria:

- is identified in the state’s Medicaid State Plan;
- has been found by the state, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
- has a negative consequence for the beneficiary;
- is auditable;

- includes, at a minimum,
 - wrong surgical or other invasive procedure performed on a patient;
 - surgical or other invasive procedure performed on the wrong body part; and
 - surgical or other invasive procedure performed on the wrong patient.

A state's Medicaid State Plan must prohibit payment for PPCs, including Medicaid payments for services received by individuals dually eligible for Medicare and Medicaid. The state must ensure that the non-payment for PPCs does not prevent access to services for its Medicaid beneficiaries. Additionally, state's Medicaid State Plan must require that providers identify PPCs that are associated with claims for Medicaid payment or with courses of treatment furnished to Medicaid beneficiaries for which Medicaid program payment is otherwise available.

A state may not reduce a MA payment to a provider for a PPC if the PPC existed prior to the initiation of treatment of the patient by that provider. Further, a state is required to reduce payments only to the extent that the PPC results in an increased payment to the provider and the portion of the payment directly related to treatment for, and related to the PPC can be reasonably isolated. Finally, Federal Financial Participation (FFP) will not be available for state expenditures for PPCs.

The Department is committed to ensuring that quality health care is provided to eligible MA beneficiaries in all healthcare settings. Although not specifically naming PPCs as such services, the Department has long prohibited payment for services that are harmful to beneficiaries, of inferior quality or medically unnecessary. More specifically, the MA program has the following relevant payment limitations:

- 62 PS. 1407 (a)(6) and 55 Pa.Code §1101.77(a)(10) prohibits the submission of claims for the provision of MA services which the Department's medical professionals have determined to be harmful or of little or no benefit to the beneficiary, of inferior quality, or medically unnecessary;
- 55 Pa.Code §1101.71 relating to utilization control sets forth the MA Program's responsibility to establish procedures for reviewing the utilization of and payment for, MA services in accordance with section 1902(a)(3) of the Act (42 U.S.C.A. §1396a(a)(30)) as well as the provider's responsibility to cooperate with such reviews;
- 55 Pa.Code § 1101.83 relating to restitution and repayment, sets forth the Department's right to restitution for noncompensable services; and 55 Pa.Code §1150.61 relating to general payment policy, sets forth that the Department will pay for covered services that comply with applicable regulations.

On September 30, 2011, the Department submitted a State Plan Amendment (SPA) to the CMS assuring compliance with the federal statutory requirements for non-payment of PPCs. Upon CMS approval of the SPA, the Department will implement the provision for prohibition of payment for PPCs, i.e., HCACs and the required OPPCs, which consist of the wrong surgical or other invasive procedure performed on a patient, surgical or other invasive

procedure performed on the wrong body part, and surgical or other invasive procedure performed on the wrong patient.

12.2 Procedure

In order to comply with the above federal and state statutory requirements and MA Program payment regulations, affected providers are required to report PPCs, including HCACs and OPPCs on or attached to their claims to the Department.

The Department will adjust affected provider payments for HCACs and OPPCs in accordance with federal and state statutory requirements and MA Program payment regulations in the following manner:

12.2.1 Health Care Acquired Conditions (HCACs)

Acute care general hospitals and inpatient rehabilitation and psychiatric hospitals and excluded rehabilitation and psychiatric units of acute care general hospitals must report a “Present On Admission” (POA) indicator for each diagnosis code on their claim(s). POA indicators include the following:

- Y – described as “Diagnosis was present at the time of inpatient admission”.
- N – described as “Diagnosis was not present at the time of inpatient admission”.
- U – described as “Documentation insufficient to determine if condition was present at the time of admission”.
- W – described as “Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission”.
- Blank - described as “Exempt from POA reporting” (electronic or internet claims, must be reported with POA Exempt Diagnosis).
- 1 – described as “Exempt from POA reporting” (paper claims only, must be reported with POA Exempt Diagnosis)

Acute care general hospitals and inpatient rehabilitation and psychiatric hospitals and excluded rehabilitation and psychiatric units of acute care general hospitals are required to report HCACs by using the applicable POA indicator on their claims. Additionally, rehabilitation and psychiatric hospitals and excluded rehabilitation and psychiatric units of acute care general hospitals are required to report HCACs through the Department’s Concurrent Hospital Review (CHR) Process.

The Department will exclude any HCAC diagnosis code or HCAC diagnosis code/procedure code combination associated with the applicable POA indicator from grouping of the acute care general hospital’s inpatient claim. The Department then will be able to reasonably isolate costs associated with the HCAC and thereby ensure that the hospital receives the appropriate All Patient Refined-Diagnosis Related Group (APR-DRG) payment and does not receive payment for a higher paying APR-DRG or an APR-DRG with a higher severity level.

The Department will deny days associated with HCACs and reduce the number of inpatient covered days by the denied number of days on inpatient rehabilitation and psychiatric hospitals' and excluded rehabilitation and psychiatric units of acute care general hospitals' inpatient claims, as determined through physician review under the Department's CHR process and as reported by the POA indicator on the claim.

12.2.2 Other Provider Preventable Conditions (OPPCs)

When an OPPC occurs, acute care general hospitals and inpatient rehabilitation and psychiatric hospitals and excluded rehabilitation and psychiatric units of acute care general hospitals are required to complete the OPPC Self Reporting Form (MA 551) according to directions and submit the form as an attachment to their claim following the directions for submitting a claim attachment according to the applicable provider's billing guidelines. Acute care general hospitals and inpatient rehabilitation and psychiatric hospitals and excluded rehabilitation and psychiatric units of acute care general hospitals are reminded that they must identify all practitioners involved and provide details relating to the OPPC event.

The Department developed a new claims processing edit to post on inpatient claims when one or more of the following diagnosis codes are indicated on the OPPC Self Reporting attachment to the claim:

- E8765 defined as "Performance of wrong operation (procedure) on correct patient";
- E8766 defined as "Performance of operation (procedure) on patient not scheduled for surgery"; or
- E8767 defined as "Performance of correct operation (procedure) on wrong side/body part".

The Department will manually review acute care general hospital claims to determine whether the identified OPPC will result in a higher APR-DRG or increases severity associated with the APR-DRG. If so, the payment will be reduced to the appropriate APR-DRG and severity level and payment will be made to the hospital accordingly. If the acute care general hospitalization is solely the result of an OPPC that occurred upon admission, the Department will not make an APR-DRG payment to the hospital.

The Department will not make a per diem payment to inpatient rehabilitation and psychiatric hospitals and excluded rehabilitation and psychiatric units of acute care general hospitals when an OPPC is reported with the claim as denied through the CHR process.

All other providers, except dentists, are required to report the applicable procedure code(s) with one or more of the following modifiers on the claim when an OPPC occurs:

- PA defined as "Surgical or other invasive procedure on the wrong body part"
- PB defined as "Surgical or the invasive procedure on the wrong patient"
- PC defined as "Wrong surgery or other invasive procedure on the patient".

The Department will deny the nursing facilities', county nursing facilities', state operated nursing facilities', ICF/MRs', and ICF/ORCs' per diem payment when an OPPC is reported on the claim.

The Department will deny the ambulatory surgical centers', hospital short procedure units', clinics', and practitioners' MA Fee Schedule payment when an OPPC is reported on the claim. In instances when an OPPC occurs during an operation involving multiple surgical procedures, anesthesiologists are to submit two separate claims and adhere to the following instructions:

- Submit a claim and report the anesthesia time (in minutes) associated with the procedure code that **is not related** to the OPPC.
- Submit a second claim and report the anesthesia time (in minutes) associated with procedure code and modifiers PA, PB, and/or PC that **are related** to the OPPC.

Dentists are to report OPPCs using modifiers PA, PB, and/or PC in the "Remarks" section of the ADA claim form or in the "Billing Note" of the electronic dental (837-D) or Internet dental claim media. The Department will deny the dentist's payment when an OPPC is reported on the claim.

Providers may download the OPPC Self Reporting Form by accessing the following website link:

<https://expressforms.pa.gov/apps/pa/DHS/MA-Provider>

MA beneficiaries and/or their families are held harmless and **the affected provider and/or facility are not permitted to bill the MA beneficiary or their families for PPCs, which includes the billing of any applicable MA copayment, deductible or coinsurance amount.**

Providers are required to report PPCs to the Department as directed in their MA Program Provider Handbooks.

Providers are to refer to MA Bulletin 01-12-30 03-12-27 09-12-32 18-12-01 31-12-32 33-12-31 02-12-27 08-12-30 14-12-27 27-12-28 32-12-27 47-12-01 titled "Provider Preventable Conditions", issued June 15, 2012 and effective July 1, 2012, and any subsequent MA Bulletins for information regarding PPCs.

Appendix A – Billing Guides

This section contains a list of the Billing Guides for the 837 Dental/ADA-Version 2012 Claim Form Provider Handbook.

Cleft Palate Providers
Dental Anesthesiologists
Dentists (General)
Endodontists
Oral/Maxillofacial Pathologists
Oral/Maxillofacial Radiologists
Oral/Maxillofacial Surgeons
Orthodontists/Dentofacial Orthopedists
Pediatric Dentists
Periodontists
Prosthodontists
Public Health Dentists

https://www.dhs.pa.gov/providers/PROMISE_Guides/Pages/PROMISE-Handbooks.aspx

Appendix B - Bulletins

This section contains the link to Bulletins for the 837 Dental/ADA-Version 2012 Claim Form Provider Handbook:

<https://www.dhs.pa.gov/docs/For-Providers/Pages/Bulletin-Search.aspx>

Appendix C – Provider Internet User Manual

This section contains the link to the Internet User Manual for Providers for the 837 Dental/ADA-Version 2012 Claim Form Provider Handbook:

https://www.dhs.pa.gov/providers/Documents/Billing%20Information/s_002302.pdf

Appendix D – Special Forms

This section contains the Special Forms for the 837 Dental/ADA-Version 2012 Claim Form Provider Handbook. Please note that these forms are created and updated by the Department of Human Services. Please contact them with any questions concerning these forms or any forms you may think should be listed here:

<https://expressforms.pa.gov/apps/pa/DHS/MA-Provider>

Appendix E – Glossary

This section contains a link to the list of Terminology/Description of Services (glossary) that is included in the 837 Dental/ADA-Version 2012 Claim Form Provider Handbook. Please use this glossary to find a word or phrase that you may not understand. Please contact the Department of Human Services with any questions concerning this list or any word or phrase you may think should be listed here:

<http://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/055/chapter1149/s1149.2.html&d=reduce>