Prior Authorization Review Panel
MCO Policy
Submission

A separate copy of this form must accompany each policy submitted for review.

Policies submitted without this form will not be considered for review.

Plan: Keystone First (KF), AmeriHealth Caritas Pennsylvania (ACP)	**Submission Date 5/23/2024**
Policy Number: 152.101	**Effective Date:9/17/11** **Revision Date:11/13/2024**
Policy Name: Dental Benefit Limit Exceptions	

Type of Submission – Check all that apply:

- ☐ **New Policy**
- ☐ **Annual Review – No Revisions**
- **×Revision of Currently "Passed" Policy**
- ☐ **Revision of a Previously "Failed" Policy**
- ☐ **Base Policy**
- ☐ **Attachment to Base Policy**
- ☐ **Attestation of unchanged policies**

Removal of need for a diagnosis code on BLE submissions

Removal of picture of provider portal (as it was discovered it was Skygen's portal.

Removal of criteria in bullet 8 regarding periodontal services.

Name of Authorized Individual (Please type or print): **Peter Madden, DDS**	**Signature of Authorized Individual:** 

Keystone First

AmeriHealth Caritas Pennsylvania

POLICY AND PROCEDURE

Supersedes:

Policy No: 152.101

Subject: Dental Benefit Limit Exceptions

Department: Medical Management

Last Review Date: 5/23/24

Original Effective Date: November 17, 2011

Next Review Date: April 14, 2025

Unit: Dental

Stakeholder(s): Dental, Medical Management, Provider Network Management

Applicable Party(s):

Review Cycle: Annual

Line(s) of Business: 100/500/530/540/550

Policy: To establish a process for requesting exceptions to the dental benefit limits for adults ages twenty-one (21) and over. Attachment A contains the list of dental benefit limitations applicable to Members age twenty-one (21 and over.

The dental benefit changes do not apply to children under twenty-one (21) years of age or to adults who reside in a nursing facility, an
ICF/ID — Intermediate Care Facility for the Intellectually Disabled
or an intermediate care facility for persons with other related conditions (ICF/ORC).

Purpose: Institute policy and procedure for application of Benefit Limit Exceptions (BLE) to dental benefit limits for Members twenty-one (21) years of age and older

Definitions:

Administrator: DentaQuest is the claims administrator acting on behalf of the Plan and shall hereafter be referred to as "Administrator".

Complaint —

A dispute or objection regarding a particular Provider or the coverage, operations, or management of a Physical Health Managed Care Organization (PH-MCO), which has not been resolved by the PH-MCO and has been filed with the PH-MCO or with Pennsylvania Insurance Department's (PID's) Bureau of Managed Care (BMC), including, but not limited to:

- a denial because the requested service or item is not a covered service; which does not include BLE
- the failure of the PH-MCO to provide a service or item in a timely manner, as defined by the Department;
- the failure of the PH-MCO to decide a Complaint or Grievance within the specified time frames;

- a denial of payment by the PH-MCO after a service or item has been delivered because the service or item was provided without authorization by a Provider not enrolled in the Medical Assistance (MA) Program;

- a denial of payment by the PH-MCO after a service or item has been delivered because the service or item provided is not a covered service for the Member; or

- a denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

This term does not include a Grievance.

DHS Fair Hearing: A hearing conducted by the Department of Human Services (DHS), Bureau of Hearings and
Appeals or its subcontractor.

Grievance —
A request to a PH-MCO by a Member or a member's authorized representative to have the PH-MCO reconsider a decision solely concerning the medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered service/item. If the PH-MCO is unable to resolve the matter, a Grievance may be filed regarding the decision that:

1) disapproves full or partial payment for a requested health care service/item;
2) approves the provision of a requested health care service/item for a lesser scope or duration than requested; or
3) disapproves payment for the provision of a requested health care service/item but approves payment for the provision of an alternative health care service/item.

This term does not include a Complaint.

Procedure:

To request a Benefit Limit Exception (BLE) for a dental service for a Member, providers must submit the following documentation to the Health Plan:

1. Dental Benefit Exception Request Form (see Attachments B).
    - The appropriate Benefit Limit Criteria to be reviewed must be checked, as well as the "Request Type" of retrospective or prospective.
        i. See Attachment A for a list of services for which the BLE may be submitted
    - A request for an exception to a dental benefit limit may be made prospectively, before the service is provided to the member or retrospectively, after the service is provided.
        i. Provider will check the appropriate box on the BLE form to indicate whether the request is prospective or retrospective

2. The provider must also complete an American Dental Association (ADA) claim form in full (see Attachment C).
    - The form should indicate "Request for Predetermination/Preauthorization" in Field #1.

3. ***When submitting the BLE request, only those codes requiring BLE should be on the ADA claim form submitted for prior authorization or retro authorization requests. Inclusion of non-BLE codes on authorization requests may result in denials of those requests.***

4. Documentation supporting the need for the service must be submitted, including:
    - dental record and treatment notes,
    - diagnostic study results,
    - radiographs and photos, if applicable
    - medical and dental history, and
    - supporting correspondence from the member's treating physician-*exceptions apply. Refer to bullet 7 for details*

5. For Keystone First Members, providers must submit the completed forms and supporting documentation to the Health Plan at:

Request for Benefit Limit Exception
Keystone First — Prior Authorizations
c/o DentaQuest — Authorizations
P.O. Box 2906, Milwaukee, WI 53201-2906

6. For AmeriHealth Caritas Pennsylvania Members, providers must submit the completed forms and supporting documentation to the Health Plan at:

Request for Benefit Limit Exception
AmeriHealth Caritas Pennsylvania — Prior Authorizations
c/o DentaQuest — Authorizations
P.O. Box 2906, Milwaukee, WI 53201-2906

7. All documents and forms will be scanned into the system for availability.

If the BLE request identifies that the Member has one of these conditions (diabetes, coronary artery disease, cancer of the face, neck, and throat (not to include stage 0 and stage 1 non-invasive basal or sarcoma cancers of the skin) intellectual disability, and current pregnancy), as part of the review process, the Administrator will review the Member's MA claims history provided by the Health Plan. If the condition(s) are identified in the Member's claims history, the Administrator should review the BLE request to determine if one of the criteria is met without requiring medical record documentation. If the condition is not identified in the Member's claims history, the Administrator will inform the provider that additional supporting medical documentation is required and must be received within fourteen (14) days. Upon receipt of the medical documentation, the request will be reviewed to determine if one of the BLE criteria is met. If additional information is not received, a determination will be made based upon the information received. Reference to any conditions outside the five cohorts included in this clause will require physician documentation.

8. BLE Requests will be managed in a similar fashion as other authorization requests, with approval decisions made using the following criteria:
   - Member has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the Member
   - Member 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 member
   - Granting the exception is a cost effective alternative for the Health Plan
   - Granting the exception is necessary to comply with Federal law
   - Member does not meet any of the benefit limit exception criteria Benefit Limit Exception
   -

9. The Administrator, under direction of the Dental Director, will apply BLE criteria, for decision.

10. A request for a BLE made prospectively, before the service is rendered, requires a response within two (2) days of the receipt of the request. If the provider or Member is not notified of the decision within 21 days of the date the request is received by the Health Plan, the dental BLE and dental services in question will be automatically approved. When additional information is required and received, the exception request and dental services in question will be approved or denied within two (2) business days after receipt of the information.

11. A request for a BLE made retrospectively, or after the service is rendered, must be made no later than sixty (60) days from the date the claim is denied because the service is over the benefit limit. Retrospective exception requests made on or after the sixty-first (61st) day from the claim rejection date will be denied. The Plan will respond to a retrospective exception request within thirty (30) days after the receipt of the request.

12. The Administrator will issue a written notice of the decision of the approval or denial for BLE requests to the Member and provider. The denial notice will include the denial rationale and the Member's appeal rights. (See Attachment D for Member BLE Denial Notice Template.)
    - In accordance with Act 68 and Plan Policy # AP 700P Medical Assistance Member Complaint, Grievance and DHS Fair Hearing Policy and Procedures, Members have the right to appeal both prospective and retrospective denials. Members may file a complaint or a grievance within 45 days from the date of the denial notice or request a fair hearing in writing that must be postmarked within 30 days from the date of the denial notice. Members may file a first level Complaint that disputes one of the following, the Member must file a Complaint within sixty (60) days from the date of the incident complained of or the date the Member receives written notice of a decision:

    A Member must file a Grievance within sixty (60) calendar days from the date the Member receives written notice of decision.

    The Member or Member's representative may file a request for a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the Delegate 's first level Complaint decision.

    The Member or Member's representative may file a request for a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the Delegate 's Grievance decision.

    Please refer to Attachment D.

13. The Administrator will segment the BLE requests from conventional authorization requests, and utilize reporting capabilities to indicate the numbers of such requests, approval and denial rates, and associated reasons.

14. Consistent with 55 PA Code § 1101.31(f)(2)(viii) A provider may not hold a recipient liable for payment for services rendered in excess of the limits established in subsections (b) and (e) unless both of the following conditions are met: (A) The provider has requested an exception to the limit and the Department has denied the request. (B) The provider informed the recipient

before the service was rendered that the recipient is liable for the payment as specified in § 1101.63(a) (relating to payment in full) if the exception is not granted.

15. The Health Plan, under extraordinary circumstances, will consider payment for services for which the MA Program has no established fees, or will expand the limits for services or items that are listed on the MA Program fee schedule (but ordinarily do not require a BLE form) through the appeals process. If a provider concludes that an additional or more frequent service or lack of the service or item would impair the Member's health, a benefitted service would not suffice and feels the service meets standard of care criteria, the provider should include such information when requesting reconsideration.

16. Each BLE request will be reviewed for BLE criteria along with medical and dental necessity. Denial language should reflect the appropriate reason for the determination,

Related Policies and Procedures:

152.100 Review Process for Dental Services Subject to Prior Authorization (Pre-service) or Retrospective Review
AP.700P Medical Assistance Member Complaint, Grievance and DHS Fair Hearing Policy and Procedures

Superseded Policies and Procedures:

Source Documents and References:
Act 68

Attachments:

Attachment A –Dental Benefit Limitations for Adult Members
Attachment B – Benefit Limit Exception Request Form
Attachment C – Sample ADA Dental Claim Form
Attachment D – Member BLE denial notice template

Approved By:

Date: May 23, 2024

Peter Madden, DDS
Corporate Dental
Director

ATTACHMENT A
Dental Benefit Limitations for Adult Members

1. Dentures will be limited to one per upper arch, regardless of procedure code (D5110, D5130, D5211, D5213) (full or partial denture), and one per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) (full or partial denture) per lifetime. The lifetime limit for dentures will begin with claims payment history on or after dates of service April 27, 2015. Additional dentures will require an approved BLE request

2. Crowns and all associated adjunctive services (D2710, D2740, D2721, D2751, D2752, D2791, , D2952, D2954,) will only be eligible if the Plan approves a BLE request. Code D2920 (Re-cement crown) will continue to be covered.

3. Periodontal services (D4210, D4341, D4342, D4355,) will only be eligible if the Plan approves a BLE request. Indicate in the appropriate field of the BLE request and provide documentation if the member is pregnant; or if the member has diabetes; or has coronary artery disease; assuming existing service-specific dental criteria are met coverage will continue.

4. Endodontic services (D3310, D3320, D3330, D3410, D3421, D3425, D3426, D3471, D3472, D3473, D3501, D3502, D3503, D3921) will only be
eligible if the Plan approves a BLE request. Code D3220 will be covered for members 21 years of age and older.

5. Oral evaluations (D0120 are limited to one per 180 days per provider/group per member. Additional oral evaluations will require a BLE.

6. Prophylaxis (D1110) is limited to one per 180 days per provider/group per member. Additional prophylaxis will require a BLE.

NOTE: The benefit limit exception does not apply to children under 21 years of age or to adults who reside in a nursing facility, an
ICF/ID — Intermediate Care Facility for the Intellectually Disabled
or an intermediate care facility for persons with other related conditions (ICF/ORC).

Policy No: 152.101, Attachment B

Dental Benefit Limit Exception (BLE) Request Form

This form must be attached to a completed ADA dental claim form. All fields must be legibly completed, and all required documentation provided.

Keystone First

Coverage by Vista Health Plan,
an independent licensee of the Blue Cross and Blue Shield Association.

Please print.

Member information
Last name:
First name:
Date of birth (mm/dd/yyyy):
Member ID number:
Phone:

Provider information
Last name:
First name:
NPI number:
Keystone First ID number:
Phone:

Benefit exception request type: □ Prospective □ Retrospective — Dates of Service: _____

Benefit limit criteria to be reviewed (check all that apply or do not check any boxes if none apply):

□ Patient has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the patient.

□ Patient 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 patient.

□ Granting the exception is a cost-effective alternative for Keystone First.

□ Granting the exception is necessary in order to comply with federal law.

Explain below why the patient meets the criteria for a benefit limit exception. The explanation should be in narrative form and include a comprehensive justification (attach additional pages if necessary).

Keystone First will notify the provider and recipient of its decision within 21 days of our receipt of the request or within 30 days after receipt of a retrospective request. BLE retrospective requests must be submitted no later than 60 days from the date Keystone First rejects the claim because the service is over the benefit limit. Retrospective exception requests made on or after the 61st day from the claim rejection date will be denied.

I attest that the information provided and statements made herein are true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Provider signature: _____ Date: _____

Mail to:
Request for Benefit Limit Exception
Keystone First Health Plan
c/o DentaQuest — Authorizations
P.O. Box 2906, Milwaukee, WI 53201-2906

Dental Benefit Limit Exception (BLE) Request Form

This form must be attached to a completed ADA dental claim form. All fields must be legibly completed, and all required documentation provided.

AmeriHealth Caritas Pennsylvania

Please print

Member information
Last name:
First name:
Date of birth (mm/dd/yyyy):
Member ID number:
Phone:

Provider information
Last name:
First name:
NPI number:
AmeriHealth Caritas ID number:
Phone:

Benefit exception request type: □ Prospective □ Retrospective - Dates of Service: _____

Benefit limit criteria to be reviewed (check all that apply or do not check any boxes if none apply):

□ Patient has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the patient.

□ Patient 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 patient.

□ Granting the exception is a cost-effective alternative for AmeriHealth Caritas Pennsylvania.

□ Granting the exception is necessary in order to comply with federal law.

Explain below why the patient meets the criteria for a benefit limit exception. The explanation should be in narrative form and include a comprehensive justification (attach additional pages if necessary).

AmeriHealth Caritas Pennsylvania will notify the provider and recipient of its decision within 21 days of our receipt of the request or within 30 days after receipt of a retrospective request. When additional information is required and received, the exception request will be approved or denied within 21 business days after our receipt of the information. BLE retrospective requests must be submitted no later than 60 days from the date AmeriHealth Caritas Pennsylvania rejects the claim because the service is over the benefit limit. Retrospective exception requests made on or after the 61st day from the claim rejection date will be denied.

I attest that the information provided and statements made herein are true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Provider signature: _____ Date: _____

Mail to:
Request for Benefit Limit Exception
AmeriHealth Caritas Pennsylvania
c/o DentaQuest — Authorizations
P.O. Box 2906
Milwaukee, WI 53201-2906

Policy No.: 152.101, Attachment C

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes) ☐ Request for Predetermination/Preauthorization ☐ Statement of Actual Services ☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

3a. Payer ID

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F ☐U | 8. Policyholder/Subscriber ID (Assigned by Plan)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

11a. Other Payer ID

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F ☐U | 15. Policyholder/Subscriber ID (Assigned by Plan)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐M ☐F ☐U | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____ Patient/Guardian Signature _____ Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____ Subscriber Signature _____ Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) - | 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION (alll dates in MM/DD/CCYY format)

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) | 39a. Date Last SRP

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____ Signed (Treating Dentist) _____ Date

53a. Locum Tenens Treating Dentist? ☐

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID

J43024 (Same as ADA Dental Claim Form – J43124, J43224, J43424, J43024T)

J43D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J436)

Policy No: 152.101, Attachment D
EXHIBIT N (4)

STANDARD BENEFIT LIMIT EXCEPTION (BLE) DENIAL NOTICE – COMPLETE DENIAL

[DATE] [This MUST be the date the notice is mailed]

[Member's Name]
[Address]
[City, State, Zip]

RE: [Member's name and DOB]

Dear **[Member Name]:**

This is an important notice about your services. Read it carefully.
Call **[PH-MCO Name]** at **[PH-MCO Phone # & Toll-free TTY/PA RELAY]** if you have any questions or need help.

[PH-MCO Name] has reviewed the benefit limit exception request for **[identify SPECIFIC service/item, along with frequency/level/duration]** submitted by **[prescriber's name]** for you on **[date]**. After physician review, the request is: Denied

Your request was **denied completely** because **[Explain in detail, at a 6th grade level, every reason for denial. In addition to the explanation for the decision, include specific references to approved medical necessity guidelines, rules, and/or protocols on which the decision was based. If denied because of insufficient information, identify all additional information needed to render a decision.]**

[If the service/item requested were previously authorized, in any amount, include the following:]
The **[identify SPECIFIC service/item]** you have been getting will end on **[date services will end]**, unless you file a Complaint or Grievance by **[DATE+15]**. If you file a Complaint or Grievance by **[DATE+15]**, your services will continue until a decision is made on your Complaint or Grievance.

What if I disagree with the decision to deny my request for services?

- You may file a Complaint or Grievance with **[PH-MCO Name]** by **[DATE+60].**
- You may ask for the medical necessity guidelines or other rules **[PH MCO Name]** used to make this decision, at no cost to you. To ask for a copy of the medical necessity guidelines or other rules that **[PH-MCO Name]** used to make the decision, call **[PH MCO Name]** at **[PH-MCO Phone # & Toll-free TTY/PA RELAY #]** or write a letter. If you file a Complaint or Grievance, you can ask for a copy of this information by checking **Box 2** on the "Complaint/Grievance Request Form."
- You may get a second opinion from another provider in **[PH-MCO Name]**'s network. Call **[PH-MCO Name]** at **[PH-MCO Phone # & Toll-free TTY/PA RELAY]** to get a referral for a second opinion. Asking for a second opinion will not give you more time to file a Complaint or Grievance. It will not continue any service or item that you have been getting.

How do I file a Complaint or Grievance?

You can file a Complaint or Grievance by phone, by using the "Complaint/Grievance Request Form," or by writing a letter.

To file a Complaint or Grievance:
By Phone: Call **[PH-MCO Name]** at **[Phone# & Toll-free TTY/PA RELAY #]**;
By Fax: Fax the "Complaint/Grievance Request Form" or a letter to **[PH-MCO FAX #]**; or
By Mail: Mail the "Complaint/Grievance Request Form" or a letter to the following address:

[PH-MCO ADDRESS FOR FILING COMPLAINT/GRIEVANCE]

How long will it take to decide my Complaint or Grievance?
[PH-MCO Name] will send you a written notice of the decision on your Complaint or Grievance within **[30, unless the PH-MCO will be using a shorter time frame to provide notice of 1st level Complaints and Grievance decisions]** days from when **[PH-MCO Name]** received your Complaint or Grievance.

How do I ask for an early decision on my Complaint or Grievance?
If you or your doctor or dentist thinks waiting **[30, unless the PH-MCO will be use using a shorter time frame]** days for a decision could harm your health, call **[PH-MCO Name]** at **[Phone# & Toll-free TTY/PA RELAY #]** to ask for an early decision on your Complaint or Grievance.

You should also ask your doctor or dentist to fax a signed letter to **[PH-MCO FAX #]** within 72 hours of when you asked for an early decision on your Complaint or Grievance. The letter should explain why waiting **[30, unless the PH-MCO will be use using a shorter time frame]** days for a decision could harm your health.

[PH-MCO Name] will tell you the decision within 48 hours from when **[PH-MCO Name]** gets your doctor's letter, or within 72 hours from when you asked **[PH-MCO Name]** for an early decision, whichever is sooner, unless you ask **[PH-MCO Name]** to take more time to decide your Complaint or Grievance. You can ask **[PH-MCO Name]** to take up to 14 more days to decide your Complaint or Grievance.

What happens after I file my Complaint or Grievance?
[PH-MCO Name] will hold a meeting within **[30, unless the PH-MCO will be use using a shorter time frame]** days of when you filed your Complaint or Grievance to review your Complaint or Grievance. You may attend the meeting either in person or by phone. **[OR if video conference is available:** You may attend the meeting either in person, by phone, or by videoconference.**]** You may also bring a family member, friend, or lawyer to help you during the meeting.

Once you have completed **[PH-MCO Name]**'s internal process, if you disagree with **[PH-MCO Name]**'s decision on your Complaint or Grievance, you may ask for an external Grievance review or a Fair Hearing or you may ask for both an external Grievance review and a Fair Hearing. Information about external Grievance reviews and Fair Hearings can be found in the member handbook.

How can I get help with my Complaint or Grievance?
If you need help filing a Complaint or Grievance, you can call **[PH-MCO Name]** at **[PH-MCO Phone # & Toll-free TTY/PA RELAY]**.

To ask for free legal help with your Complaint or Grievance, contact:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org); or
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

Sincerely,

[PH-MCO Name]

cc: **[Prescribing Provider]**
[PCP]

COMPLAINT/GRIEVANCE REQUEST FORM

Member: _____ **Member ID:** _____

Parent/Guardian: _____**Phone number:** _____

Address: _____

Date on the Notice of Decision: _____

1. **Check how you would like to be present at the review of your Complaint/Grievance:**
   ☐ **BY TELEPHONE** (You will be sent the date and time of the review. You will be called at the phone number you provided above.)
   ☐ **BY VIDEOCONFERENCE [PH-MCO to include only if available]** (You will be sent the date, time, and location of the review.)
   ☐ **IN PERSON** (You will be sent the date, time, and location of the review.)
   ☐ **NOT BE PRESENT** (You can change your mind at any time. You will be sent the date and time of the review. The decision on your Complaint/Grievance will not be affected if you are not present.)

2. **Would you like a copy of the information [PH-MCO Name] used to make the decision you are filing a Complaint/Grievance about? Yes ☐ No ☐**

3. **Do you need an interpreter or language services? Yes ☐ No ☐ Language?**_____
   (Interpreter and language services will be provided free of charge.)

4. **Why do you disagree with [PH-MCO Name]'s decision?** (Attach more pages if needed. You will be able to explain why you disagree during the review.)
   _____
   _____
   _____
   _____

5. **If someone will be helping you with your Complaint/Grievance, please provide his or her information:** (If you do not yet have anyone helping you, just leave this blank and you can let **[PH-MCO Name]** know later if someone will be helping you.)
   Representative's name and phone number: _____
   Representative's address: _____
   Relation to Member: _____

Member's Signature: _____Date:_____

Send to: **[PH-MCO Complaint/Grievance address and PH-MCO Complaint/Grievance fax #]**

[NONDISCRIMINATION NOTICE/LEP/LANGUAGE ACCESS INFORMATION HERE]

EXHIBIT N (5)
STANDARD BENEFIT LIMIT EXCEPTION (BLE) DENIAL NOTICE – PARTIAL APPROVAL OF REQUESTED SERVICE/ITEM

[DATE] [This MUST be the date the notice is mailed]

[Member's Name]
[Address]
[City, State, Zip]

RE: [Member's name and DOB]

Dear **[Member Name]:**

This is an important notice about your services. Read it carefully.
Call **[PH-MCO Name]** at **[PH-MCO Phone # & Toll-free TTY/PA RELAY]** if you have any questions or need help.

[PH-MCO Name] has reviewed the benefit limit exception request for **[identify SPECIFIC service/item, along with frequency/level/duration]** submitted by **[prescriber's name]** for you on **[date]**. After physician review, the request is:

Approved other than as requested as follows:

[Describe the level, frequency, and duration of service approved.]

[Describe the level, frequency, and duration of service denied.]

Your request was **not approved as requested** because **[Explain in detail, at a 6th grade level, every reason for denial. In addition to the explanation for the decision, include specific references to approved medical necessity guidelines, rules, and/or protocols on which the decision was based. If denied because of insufficient information, identify all additional information needed to render a decision.]**

[If the service/item requested were previously authorized, in any amount, include the following:]
The **[identify SPECIFIC service/item]** you have been getting will end on **[date services will end]**, unless you file a Complaint or Grievance by **[DATE+15]**. If you file a Complaint or Grievance by **[DATE+15]**, your services will continue until a decision is made on your Complaint or Grievance.

What if I disagree with the decision to deny my request for services?

- You may file a Complaint or Grievance with **[PH-MCO Name]** by **[DATE+60].**
- You may ask for the medical necessity guidelines or other rules **[PH MCO Name]** used to make this decision, at no cost to you. To ask for a copy of the medical necessity guidelines or other rules that **[PH-MCO Name]** used to make the decision, call **[PH MCO Name]** at **[PH-MCO Phone # & Toll-free TTY/PA RELAY #]** or write a letter. If you file a Complaint or

Grievance, you can ask for a copy of this information by checking **Box 2** on the "Complaint/Grievance Request Form."
- You may get a second opinion from another provider in **[PH-MCO Name]**'s network. Call **[PH-MCO Name]** at **[PH-MCO Phone # & Toll-free TTY/PA RELAY]** to get a referral for a second opinion. Asking for a second opinion will not give you more time to file a Complaint or Grievance. It will not continue any service or item that you have been getting.

How do I file a Complaint or Grievance?
You can file a Complaint or Grievance by phone, by using the "Complaint/Grievance Request Form," or by writing a letter.

To file a Complaint or Grievance:
By Phone: Call **[PH-MCO Name]** at **[Phone# & Toll-free TTY/PA RELAY #]**;
By Fax: Fax the "Complaint/Grievance Request Form" or a letter to **[PH-MCO FAX #]**; or
By Mail: Mail the "Complaint/Grievance Request Form" or a letter to the following address:

[PH-MCO ADDRESS FOR FILING COMPLAINT/GRIEVANCE]

How long will it take to decide my Complaint or Grievance?
[PH-MCO Name] will send you a written notice of the decision on your Complaint or Grievance within **[30, unless the PH-MCO will be using a shorter time frame to provide notice of 1st level Complaints and Grievance decisions]** days from when **[PH-MCO Name]** received your Complaint or Grievance.

How do I ask for an early decision on my Complaint or Grievance?
If you or your doctor or dentist thinks waiting **[30, unless the PH-MCO will be use using a shorter time frame]** days for a decision could harm your health, call **[PH-MCO Name]** at **[Phone# & Toll-free TTY/PA RELAY #]** to ask for an early decision on your Complaint or Grievance.

You should also ask your doctor or dentist to fax a signed letter to **[PH-MCO FAX #]** within 72 hours of when you asked for an early decision on your Complaint or Grievance. The letter should explain why waiting **[30, unless the PH-MCO will be use using a shorter time frame]** days for a decision could harm your health.

[PH-MCO Name] will tell you the decision within 48 hours from when **[PH-MCO Name]** gets your doctor's letter, or within 72 hours from when you asked **[PH-MCO Name]** for an early decision, whichever is sooner, unless you ask **[PH-MCO Name]** to take more time to decide your Complaint or Grievance. You can ask **[PH-MCO Name]** to take up to 14 more days to decide your Complaint or Grievance.

What happens after I file my Complaint or Grievance?
[PH-MCO Name] will hold a meeting within **[30, unless the PH-MCO will be use using a shorter time frame]** days of when you filed your Complaint or Grievance to review your Complaint or Grievance. You may attend the meeting either in person or by phone. **[OR if video conference is available:** You may attend the meeting either in person, by phone, or by videoconference.**]** You may also bring a family member, friend, or lawyer to help you during the meeting.

Once you have completed **[PH-MCO Name]**'s internal process, if you disagree with **[PH-MCO Name]**'s decision on your Complaint or Grievance, you may ask for an external Grievance review or a Fair Hearing or you may ask for both an external Grievance review and a Fair Hearing. Information about external Grievance reviews and Fair Hearings can be found in the member handbook.

How can I get help with my Complaint or Grievance?

If you need help filing a Complaint or Grievance, you can call **[PH-MCO Name]** at **[PH-MCO Phone # & Toll-free TTY/PA RELAY]**.

To ask for free legal help with your Complaint or Grievance, contact:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org); or
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

Sincerely,

[PH-MCO Name]

cc: **[Prescribing Provider]**
[PCP]

COMPLAINT/GRIEVANCE REQUEST FORM

Member: _____ **Member ID:** _____

Parent/Guardian: _____**Phone number:** _____

Address: _____

Date on the Notice of Decision: _____

6. **Check how you would like to be present at the review of your Complaint/Grievance:**
   ☐ **BY TELEPHONE** (You will be sent the date and time of the review. You will be called at the phone number you provided above.)
   ☐ **BY VIDEOCONFERENCE [PH-MCO to include only if available]** (You will be sent the date, time, and location of the review.)
   ☐ **IN PERSON** (You will be sent the date, time, and location of the review.)
   ☐ **NOT BE PRESENT** (You can change your mind at any time. You will be sent the date and time of the review. The decision on your Complaint/Grievance will not be affected if you are not present.)

7. **Would you like a copy of the information [PH-MCO Name] used to make the decision you are filing a Complaint/Grievance about? Yes ☐ No ☐**

8. **Do you need an interpreter or language services? Yes ☐ No ☐ Language?**_____
   (Interpreter and language services will be provided free of charge.)

9. **Why do you disagree with [PH-MCO Name]'s decision?** (Attach more pages if needed. You will be able to explain why you disagree during the review.)

   _____

   _____

   _____

   _____

10. **If someone will be helping you with your Complaint/Grievance, please provide his or her information:** (If you do not yet have anyone helping you, just leave this blank and you can let **[PH-MCO Name]** know later if someone will be helping you.)
    Representative's name and phone number: _____

    Representative's address: _____

    Relation to Member: _____

Member's Signature: _____Date:_____

Send to: **[PH-MCO Complaint/Grievance address and PH-MCO Complaint/Grievance fax #]**

EXHIBIT N (6)
STANDARD BENEFIT LIMIT EXCEPTION (BLE) DENIAL NOTICE – APPROVAL OF DIFFERENT SERVICE/ITEM

[DATE] [This MUST be the date the notice is mailed]

[Member's Name]
[Address]
[City, State, Zip]

RE: [Member's name and DOB]

Dear **[Member Name]:**

This is an important notice about your services. Read it carefully.
Call **[PH-MCO Name]** at **[PH-MCO Phone # & Toll-free TTY/PA RELAY]** if you have any questions or need help.

[PH-MCO Name] has reviewed the benefit limit exception request for **[identify SPECIFIC service/item, along with frequency/level/duration]** submitted by **[prescriber's name]** for you on **[date]**. After physician review, the request is:

Denied as requested, but the following service or item is approved: **[Describe the specific service/item approved, including the level, frequency, and duration of service.]**

A different service or item is approved because **[Explain in detail, at a 6th grade level, every reason for denial. In addition to the explanation for the decision, include specific references to approved medical necessity guidelines, rules, and/or protocols on which the decision was based. If denied because of insufficient information, identify all additional information needed to render a decision.]**

[If the service/item requested were previously authorized, in any amount, include the following:]
The **[identify SPECIFIC service/item]** you have been getting will end on **[date services will end]**, unless you file a Complaint or Grievance by **[DATE+15]**. If you file a Complaint or Grievance by **[DATE+15]**, your services will continue until a decision is made on your Complaint or Grievance.

What if I disagree with the decision to deny my request for services?

- You may file a Complaint or Grievance with **[PH-MCO Name]** by **[DATE+60].**
- You may ask for the medical necessity guidelines or other rules **[PH MCO Name]** used to make this decision, at no cost to you. To ask for a copy of the medical necessity guidelines or other rules that **[PH-MCO Name]** used to make the decision, call **[PH MCO Name]** at **[PH-MCO Phone # & Toll-free TTY/PA RELAY #]** or write a letter. If you file a Complaint or Grievance, you can ask for a copy of this information by checking **Box 2** on the "Complaint/Grievance Request Form."
- You may get a second opinion from another provider in **[PH-MCO Name]**'s network. Call **[PH-MCO Name]** at **[PH-MCO Phone # & Toll-free TTY/PA RELAY]** to get a referral for a second opinion. Asking for a second opinion will not give you more time to file a Complaint or Grievance. It will not continue any service or item that you have been getting.

How do I file a Complaint or Grievance?
You can file a Complaint or Grievance by phone, by using the "Complaint/Grievance Request Form," or by writing a letter.

To file a Complaint or Grievance:
By Phone: Call **[PH-MCO Name]** at **[Phone# & Toll-free TTY/PA RELAY #]**;
By Fax: Fax the "Complaint/Grievance Request Form" or a letter to **[PH-MCO FAX #]**; or
By Mail: Mail the "Complaint/Grievance Request Form" or a letter to the following address:

[PH-MCO ADDRESS FOR FILING COMPLAINT/GRIEVANCE]

How long will it take to decide my Complaint or Grievance?
[PH-MCO Name] will send you a written notice of the decision on your Complaint or Grievance within **[30, unless the PH-MCO will be using a shorter time frame to provide notice of 1st level Complaints and Grievance decisions]** days from when **[PH-MCO Name]** received your Complaint or Grievance.

How do I ask for an early decision on my Complaint or Grievance?
If you or your doctor or dentist thinks waiting **[30, unless the PH-MCO will be use using a shorter time frame]** days for a decision could harm your health, call **[PH-MCO Name]** at **[Phone# & Toll-free TTY/PA RELAY #]** to ask for an early decision on your Complaint or Grievance.

You should also ask your doctor or dentist to fax a signed letter to **[PH-MCO FAX #]** within 72 hours of when you asked for an early decision on your Complaint or Grievance. The letter should explain why waiting **[30, unless the PH-MCO will be use using a shorter time frame]** days for a decision could harm your health.

[PH-MCO Name] will tell you the decision within 48 hours from when **[PH-MCO Name]** gets your doctor's letter, or within 72 hours from when you asked **[PH-MCO Name]** for an early decision, whichever is sooner, unless you ask **[PH-MCO Name]** to take more time to decide your Complaint or Grievance. You can ask **[PH-MCO Name]** to take up to 14 more days to decide your Complaint or Grievance.

What happens after I file my Complaint or Grievance?
[PH-MCO Name] will hold a meeting within **[30, unless the PH-MCO will be use using a shorter time frame]** days of when you filed your Complaint or Grievance to review your Complaint or Grievance. You may attend the meeting either in person or by phone. **[OR if video conference is available:** You may attend the meeting either in person, by phone, or by videoconference.**]** You may also bring a family member, friend, or lawyer to help you during the meeting.

Once you have completed **[PH-MCO Name]**'s internal process, if you disagree with **[PH-MCO Name]**'s decision on your Complaint or Grievance, you may ask for an external Grievance review or a Fair Hearing or you may ask for both an external Grievance review and a Fair Hearing. Information about external Grievance reviews and Fair Hearings can be found in the member handbook.

How can I get help with my Complaint or Grievance?

If you need help filing a Complaint or Grievance, you can call **[PH-MCO Name]** at **[PH-MCO Phone # & Toll-free TTY/PA RELAY]**.
To ask for free legal help with your Complaint or Grievance, contact:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org); or
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

Sincerely,

[PH-MCO Name]

cc: **[Prescribing Provider]**
[PCP]

COMPLAINT/GRIEVANCE REQUEST FORM

Member: _____ **Member ID:** _____

Parent/Guardian: _____**Phone number:** _____

Address: _____

Date on the Notice of Decision: _____

11. Check how you would like to be present at the review of your Complaint/Grievance:

☐ **BY TELEPHONE** (You will be sent the date and time of the review. You will be called at the phone number you provided above.)

☐ **BY VIDEOCONFERENCE [PH-MCO to include only if available]** (You will be sent the date, time, and location of the review.)

☐ **IN PERSON** (You will be sent the date, time, and location of the review.)

☐ **NOT BE PRESENT** (You can change your mind at any time. You will be sent the date and time of the review. The decision on your Complaint/Grievance will not be affected if you are not present.)

12. Would you like a copy of the information [PH-MCO Name] used to make the decision you are filing a Complaint/Grievance about? Yes ☐ No ☐

13. Do you need an interpreter or language services? Yes ☐ No ☐ Language?_____
(Interpreter and language services will be provided free of charge.)

14. Why do you disagree with [PH-MCO Name]'s decision? (Attach more pages if needed. You will be able to explain why you disagree during the review.)

_____

_____

_____

_____

15. If someone will be helping you with your Complaint/Grievance, please provide his or her information: (If you do not yet have anyone helping you, just leave this blank and you can let **[PH-MCO Name]** know later if someone will be helping you.)

Representative's name and phone number: _____

Representative's address: _____

Relation to Member: _____

Member's Signature: _____Date:_____

Send to: **[PH-MCO Complaint/Grievance address and PH-MCO Complaint/Grievance fax #]**

[NONDISCRIMINATION NOTICE/LEP/LANGUAGE ACCESS INFORMATION HERE]

TEMPLATE N (7)
REQUEST FOR ADDITIONAL INFORMATION LETTER

[Date Letter Mailed (Date of Request for additional information)]

[Member's Name]
[Address]
[City, State, Zip]

RE: [Member's name and DOB]

Member ID: **********

Subject: Request for Additional Information from Your Provider

Dear **[Member Name]:**

This is an important notice about your services. Read it carefully.
Call **[PH-MCO Name]** at **[PH-MCO Phone # & Toll-free TTY/PA RELAY]** if you have any questions or need help.

[PH-MCO or Vendor name on behalf of PH-MCO] received a request for **[identify SPECIFIC service/item/frequency/level/duration]** from **[provider name]** on **[date received].**

In order to decide if this service is Medically Necessary for you, **[PH-MCO Name]** needs more information. **[PH-MCO Name]** has asked your provider to send us the following information by **[date]**:

[List specific information requested]

[PH-MCO Name] will make a decision on the requested services within 2 business days after getting the information from your provider. **[PH-MCO Name]** will tell you the decision in writing within 2 business days after making its decision.

If we do not receive the additional information within 14 days, **[PH-MCO Name]** will make the decision to approve or deny the service based on the information it already has. **[PH-MCO Name]** will tell you the decision in writing within 2 business days after it should have gotten the additional information.

If you have any questions, please contact Member Services at **[CCH-MCO Phone #/Toll-free TTY #]**.

Sincerely,

[PH-MCO Name]

cc: **[Prescribing Provider]**
[PCP]

[NONDISCRIMINATION NOTICE/LEP/LANGUAGE ACCESS INFORMATION HERE]