

UnitedHealthcare Community Plan of Pennsylvania — Benefit limit exception form process

This guide is designed to help you with properly submitting UnitedHealthcare/SKYGEN dental benefit limit exception (BLE) forms.

Regulatory information

Section 6.8 of the Pennsylvania Promise Provider Handbook states that there are certain benefits offered to recipients ages 21 and older outside of the standard benefit allowances. In order to access these additional benefits, you must use the standard UnitedHealthcare/SKYGEN BLE form and each submission must meet the following criteria:

- **Members eligible for BLE**

Pennsylvania Medicaid members ages 21 and older

- **Procedures eligible for BLE**

Use the following table to add the correct procedures and codes to BLE forms:

| Code | Procedure | Frequency allowed without a BLE |
|-------|--|---------------------------------|
| D0120 | Periodic oral evaluation | 1/180 days |
| D1110 | Prophylaxis - adult | 1/180 days |
| D5110 | Complete denture - maxillary | 1/1 lifetime |
| D5130 | Immediate denture - maxillary | 1/1 lifetime |
| D5211 | Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth) | 1/1 lifetime regardless of code |
| D5213 | Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | 1/1 lifetime regardless of code |
| D5120 | Complete denture - mandibular | 1/1 lifetime regardless of code |
| D5140 | Immediate denture - mandibular | 1/1 lifetime regardless of code |

| Code | Procedure | Frequency allowed without a BLE |
|--------------|---|--|
| D5212 | Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth) | 1/1 lifetime regardless of code |
| D5214 | Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | 1/1 lifetime regardless of code |
| D2710 | Crown - resin-based composite (indirect) | None |
| D2721 | Crown - resin with predominantly base metal | None |
| D2740 | Crown - porcelain/ceramic | None |
| D2751 | Crown - porcelain fused to predominantly base metal | None |
| D2791 | Crown - full cast predominantly base metal | None |
| D2910 | Recement or re-bond inlay, onlay, veneer or partial coverage restoration | None |
| D2915 | Recement or re-bond cast indirectly fabricated or prefabricated post and core | None |
| D2920 | Recement or re-bond crown | None |
| D2952 | Cast post and core in addition to crown | None |
| D2954 | Prefabricated post and core in addition to crown | None |
| D2980 | Crown repair necessitated by restorative material failure | None |
| D4210 | Gingivectomy or gingivoplasty - 4 or more contiguous teeth- or tooth-bounded spaces per quadrant | None |
| D4341 | Periodontal scaling and root planing - 4 or more teeth per quadrant | None |
| D4342 | Periodontal scaling and root planing for 1 to 3 teeth per quadrant | None |
| D4355 | Periodontal scaling and root planing for 1 to 3 teeth per quadrant | None |
| D4910 | Periodontal maintenance | None |
| D3310 | Endodontic therapy, anterior tooth (excluding final restoration) | None |
| D3320 | Endodontic therapy, premolar tooth (excluding final restoration) | None |

| Code | Procedure | Frequency allowed without a BLE |
|-------|---|---------------------------------|
| D3330 | Endodontic therapy, molar tooth (excluding final restoration) | None |
| D3410 | Apicoectomy - anterior | None |
| D3421 | Apicoectomy - premolar (first root) | None |
| D3425 | Apicoectomy - molar (first root) | None |
| D3426 | Apicoectomy (each additional root) | None |

BLE process

- **Authorization:** To access procedures that are eligible for BLE, you must submit an authorization on the standard American Dental Association (ADA) form and attach the UnitedHealthcare/SKYGEN BLE form. This may be an electronic or a paper authorization. Without an approved authorization, BLE claims will be denied.

Note: It is not required that you have denied authorization before seeking a BLE service. BLE services are initiated when you submit authorization along with a BLE form.

- **Diagnosis code:** To request BLE services, you must use diagnosis code Z98.818 in the diagnosis code field on the standard ADA form. This will enable the claims system to allow the additional BLE service(s). Without this diagnosis code, procedures will be subject to standard limitations.

Note: The diagnosis code must be present on both the authorization request and the claim for BLE services to be paid.

- **UnitedHealthcare BLE form:** You must attach the approved UnitedHealthcare/SKYGEN BLE form to the authorization request. You'll use this form to indicate the reason the BLE is necessary according to the state criteria. You must also check the appropriate box and include a description of the medical needs that require the requested service(s) in the appropriate section. Without a complete UnitedHealthcare/SKYGEN BLE form, your request will be denied.
- A UnitedHealthcare dental consultant will review the authorization request along with the attached BLE form and make a determination. That determination will be sent to you in writing and a copy will be added online, within the UnitedHealthcare Dental provider portal at **Dental Hub™**. See the "Member and Provider Communication" section at the bottom of this document.
- **Claim:** If the BLE authorization request is approved, you may perform the requested treatment and submit corresponding claim documentation.
 - **Diagnosis code:** The same diagnosis code (**Z98.818**) must be included in the diagnosis code field on the standard ADA claim form. This will enable the claims system to allow the additional BLE services. Without this diagnosis code, procedures will be subject to standard limitations.

Note: The diagnosis code must be included on both the authorization request and the claim in order to be paid for as BLE services.



Dental Benefit Providers®

Criteria for approval

Upon receipt of the BLE authorization request, UnitedHealthcare dental consultants will review the documentation submitted to determine if the BLE is approved. Consultants use the criteria defined by the State of Pennsylvania, as reflected on the UnitedHealthcare/ SKYGEN BLE form.

The following qualifiers will be evaluated:

- The BLE request will be reviewed to determine if one of the criteria is met without requiring supporting medical record documentation of the condition.
 - Diabetes
 - Coronary artery disease
 - Cancer of the face, neck and throat (does not include stage 0 or stage 1 noninvasive basal or sarcoma cell cancers of the skin)
 - Intellectual disability
 - Current pregnancy
- Does the member have a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the member?
- Does the member have a serious chronic systemic illness or other serious health condition and denial of the exception will result in the serious deterioration of the health of the member?
- Would granting the exception be a cost-effective alternative for the medical assistant (MA) program?
- Would granting the exception be necessary in order to comply with federal law?

Along with checking the appropriate boxes, you must include a description of the medical needs that require the requested services in the appropriate field. You should also include supplemental information to substantiate the selected qualifier.

Member and care provider communication

We'll inform you, in writing, of our determination of the BLE request. We'll also notify the member. That communication will be mailed to the member and faxed to the care provider. It'll also be made available online via the [Dental Hub™](#).



Questions?

Call Provider Customer Service at **800-508-4876** 8 a.m.-9 p.m. ET, Monday-Friday.

Pennsylvania plans dental benefit limit exception request form



Failure to complete this form in its entirety will result in this form being returned unprocessed. This form must be attached to a completed ADA dental claim form and mailed to:

SKYGEN, Attn: UPMC Health Plan BLE Authorizations, P.O. Box 351, Milwaukee, WI 53201

| | |
|--|-----------------------|
| Member last name: | First name: |
| Member ID number: | Member date of birth: |
| Provider last name: | First name: |
| Provider National Provider Identifier (NPI) number: | |
| Provider telephone: | |
| Benefit request type: Prospective Retrospective - Date(s) of service | |

Benefit limit criteria to be reviewed (check all that apply):

| | |
|--------------------------|--|
| <input type="checkbox"/> | Member has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the member. |
| <input type="checkbox"/> | Member has a serious chronic illness or other serious health condition and denial of the exception will result in the serious deterioration of the health of the member. |
| <input type="checkbox"/> | Granting the exception is a cost-effective alternative for the plan. |
| <input type="checkbox"/> | Granting the exception is necessary in order to comply with federal law. |

This request must include documentation supporting the need for the service, including but not limited to chart documentation to include a treatment plan, radiographs (if applicable), medical and dental history.

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

SKYGEN will notify the care provider and member of its decision **within 2 business days of receiving the request or within 2 business days of receiving additional information, if requested by SKYGEN.**

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

Care provider signature:

Date:

