BENEFITS

§ 1101.31. Scope.

(a) *Scope*. The scope of benefits for which MA recipients are eligible differs according to recipients' categories of assistance, as described in this section.

(1) Recipients under 21 years of age are eligible for all medically necessary services.

(2) The benefit limits specified in subsections (b), (c), and (e) apply only to adults, with the exception of pregnant women, including throughout the postpartum period.

(3) Recipients shall exhaust other available medical resources prior to receiving MA benefits.

(b) *Categorically needy*. The categorically needy are eligible for all of the following benefits:

(1) Inpatient hospital services other than services in an institution for mental disease, as specified in Chapter 1163 (relating to inpatient hospital services), including one medical rehabilitation hospital admission per fiscal year.

(2) Up to a combined maximum of 18 clinic, office and home visits per fiscal year by physicians, podiatrists, optometrists, CRNPs, chiropractors, outpatient hospital clinics, independent medical clinics, rural health clinics, and FQHCs.

(3) Outpatient hospital services as follows:

(i) Short procedure unit services as specified in Chapter 1126 (relating to ambulatory surgical center services and hospital short procedure unit services).

(ii) Psychiatric partial hospitalization services as specified in Chapter 1153 (relating to outpatient psychiatric services) up to one hundred and eighty three-hour sessions, 540 total hours, per recipient per fiscal year.

(iii) Outpatient hospital clinic services as specified in Chapter 1221 (relating to clinic and emergency room services) and in paragraph (2).

(iv) Rural health clinic services and FQHC services as specified in Chapter 1129 (relating to rural health clinic services) and in paragraph (2).

(4) Laboratory and X-ray services as specified in Chapter 1243 (relating to outpatient laboratory services) and Chapter 1230 (relating to portable X-ray services).

(5) Nursing facility care as specified in Chapter 1181 (relating to nursing facility care) and Chapter 1187 (relating to nursing facility services).

(6) Intermediate care.

(7) Inpatient psychiatric care as specified in Chapter 1151 (relating to inpatient psychiatric services), up to 30 days per fiscal year.

(8) Physicians' services as specified in Chapter 1141 (relating to physicians' services) and in paragraph (2).

(9) Optometrists' services as specified in Chapter 1147 (relating to optometrists' services) and in paragraph (2).

(10) Home health care as specified in Chapter 1249 (relating to home health agency services).

(11) Clinic services as follows:

(i) Independent medical clinic services as specified in Chapter 1221 and in paragraph (2).

(ii) Ambulatory surgical center services as specified in Chapter 1126.

(iii) Psychiatric clinic services as specified in Chapter 1153, including up to 5 hours or 10 one-half hour sessions of psychotherapy per recipient in a 30 consecutive day period.

(iv) Drug and alcohol clinic services, including methadone maintenance, as specified in Chapter 1223 (relating to outpatient drug and alcohol clinic services).

(12) Ambulance services as specified in Chapter 1245 (relating to ambulance transportation).

(13) Dental services as specified in Chapter 1149 (relating to dentists' services).

(14) Medical equipment, supplies, prostheses, orthoses and appliances as specified in Chapter 1123 (relating to medical supplies).

(15) EPSDT services, for recipients under 21 years of age as specified in Chapter 1241 (relating to early and periodic screening, diagnosis, and treatment program).

(16) Family planning services and supplies as specified in Chapter 1245.

(17) Drugs as specified in Chapter 1121 (relating to pharmaceutical services).

(18) Chiropractic services as specified in Chapter 1145 (relating to chiropractors' services) limited to the visits specified in paragraph (2).

(19) Podiatrists' services as specified in Chapter 1143 (relating to podiatrists' services) and in paragraph (2).

(20) CRNP services as specified in Chapter 1144 (relating to certified registered nurse practitioner services) and in paragraph (2).

(c) *Medically needy*. The medically needy are eligible for the benefits in subsection (b) with the exception of the following:

(1) Medical equipment, supplies, prostheses, orthoses and appliances.

(2) Drugs.

(d) *State Blind Pension*. State Blind Pension recipients are eligible for the following benefits:

(1) Outpatient hospital services as follows:

(i) Psychiatric partial hospitalization services as specified in Chapter 1153 up to 240 three-hour sessions, 720 total hours, per recipient in a 365 consecutive day period.

(ii) Rural health clinic services and FQHC services, as specified in Chapter 1129.

(2) Physicians' services as specified in Chapter 1141.

(3) Optometrists' services as specified in Chapter 1147.

(4) Home health care as specified in Chapter 1249.

(5) Clinic services as follows:

(i) Psychiatric clinic services as specified in Chapter 1153, including up to 7 hours or 14 one-half hour sessions of psychotherapy per recipient in a 30 consecutive day period.

(ii) Drug and alcohol clinic services, including methadone maintenance, as specified in Chapter 1223.

(6) Ambulance services as specified in Chapter 1245.

(7) Dental services as specified in Chapter 1149.

(8) Family planning services and supplies as specified in Chapter 1245.

(9) Drugs as specified in Chapter 1121.

(10) Chiropractors' services as specified in Chapter 1145.

(e) *GA recipients*. GA recipients are eligible for benefits as follows:

(1) GA chronically needy and nonmoney payment recipients are eligible for all of the following benefits:

(i) Up to a combined maximum of 18 clinic, office, and home visits per fiscal year by physicians, podiatrists, optometrists, CRNPs, chiropractors, outpatient hospital clinics, independent medical clinics, rural health clinics and FQHCs.

(ii) Home health care as specified in Chapter 1249, up to a maximum of 30 visits per fiscal year.

(iii) Legend and nonlegend drugs as specified in Chapter 1121 not to exceed a maximum of six prescriptions and refills per month.

(iv) Inpatient hospital services other than services in an institution for mental disease as specified in Chapter 1163, as follows:

(A) One acute care inpatient hospital admission per fiscal year.

(B) One medical rehabilitation hospital admission per fiscal year.

(C) Up to 30 days of drug and alcohol inpatient hospital care per fiscal year.

(v) Outpatient hospital services as follows:

(A) Short procedure unit services as specified in Chapter 1126.

(B) Psychiatric partial hospitalization services as specified in Chapter 1153, up to 180 three-hour sessions, 540 total hours, per recipient per fiscal year.

(C) Outpatient hospital clinic services as specified in Chapter 1221 and in subparagraph (i).

(D) Rural health clinic services and FQHC services as specified in Chapter 1129 and in subparagraph (i).

(vi) Ambulance services as specified in Chapter 1245, for medically necessary emergency transportation and transportation to a nonhospital drug and alcohol detoxification and rehabilitation facility from a hospital when a recipient presents to the hospital for inpatient drug and alcohol treatment and the hospital has determined that the required services are not medically necessary in an inpatient facility.

(vii) Emergency room care as specified in Chapter 1221, limited to emergency situations as defined in § § 1101.21 and 1150.2 (relating to definitions; and definitions).

(viii) Laboratory and X-ray services as specified in Chapter 1243 and Chapter 1230.

(ix) Nursing facility care as specified in Chapter 1181 and Chapter 1187.

(x) Intermediate care.

(xi) Inpatient psychiatric care as specified in Chapter 1151, up to 30 days per fiscal year.

(xii) Clinic services as follows:

(A) Independent medical clinic services as specified in Chapter 1221 and in subparagraph (i).

(B) Ambulatory surgical center services as specified in Chapter 1126.

(C) Psychiatric clinic services as specified in Chapter 1153, including a total of 5 hours or 10 one-half hour sessions of psychotherapy per recipient in a 30 consecutive day period.

(D) Drug and alcohol clinic services, including methadone maintenance, as specified in Chapter 1223.

(xiii) Physicians' services as specified in Chapter 1141 and in subparagraph (i).

(xiv) Dental services as specified in Chapter 1149.

(xv) Podiatrists' services as specified in Chapter 1143 and in subparagraph (i).

(xvi) Chiropractic services as specified in Chapter 1145 limited to the visits specified in subparagraph (i)

(xvii) CRNP services as specified in Chapter 1144 and in subparagraph (i).

(xviii) Medical equipment, supplies, prostheses, orthoses and appliances as specified in Chapter 1123.

(xix) Family planning services and supplies as specified in Chapter 1225.

(2) GA medically needy only recipients are eligible for the benefits described in paragraph (1) of subsection (e), with the following exceptions:

(i) Medical equipment, supplies, prostheses, orthoses and appliances.

(ii) Drugs.

(3) The Department will inform recipients subject to the limits established in this subsection and medical service providers of these limits and the recipient's current usage of limited services. When the Department determines that a recipient's usage of services is likely to exceed the limits established by this subsection, it will review the case to determine whether the recipient should be referred to the Disability Advocacy Program.

(f) *Exceptions*.

(1) The Department is authorized to grant exceptions to the limits specified in subsections (b) and (e) when it determines that one of the following criteria applies:

(i) The recipient has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of or result in the serious deterioration of the health of the recipient.

(ii) Granting the exception is a cost-effective alternative for the MA Program.

(iii) Granting the exception is necessary in order to comply with Federal law.

(2) The process for requesting an exception is as follows:

(i) A recipient or a provider on behalf of a recipient may request an exception.

(ii) A request for an exception may be made to the Department in writing, by telephone, or by facsimile.

(iii) A request for an exception may be made prospectively, before the service has been delivered, or retrospectively, after the service has been delivered.

(iv) The Department will respond to a request for an exception no later than:

(A) For prospective exception requests, within 21 days after the Department receives the request.

(B) For prospective exception requests when the provider indicates an urgent need for quick response, within 48 hours after the Department receives the request.

(C) For retrospective exception requests, within 30 days after the Department receives the request.

(v) A retrospective request for an 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.

(vi) Both the recipient and the provider will receive written notice of the approval or denial of the exception request. For prospective exception requests, if the provider or recipient is not notified of the decision within 21 days of the date the request is received, the exception will be automatically granted.

(vii) Departmental denials of requests for exception are subject to the right of appeal by the recipient in accordance with Chapter 275 (relating to appeal and fair hearing and administrative disqualification hearings).

(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.

Authority

The provisions of this § 1101.31 amended under sections 201(2), 403(b), 443.1, 443.3, 443.6, 448 and 454 of the Public Welfare Code (62 P. S. § § 201(2), 403(b), 443.1, 443.6, 448 and 454).

Source

The provisions of this § 1101.31 amended December 11, 1992, effective January 1, 1993, 22 Pa.B. 5995; amended November 24, 1995, effective November 25, 1995, and apply retroactively to November 1, 1995, 25 Pa. B. 5240; amended August 26, 2005, effective August 29, 2005, 35 Pa.B. 4811. Immediately preceding text appears at serial pages (286984), (204503) to (204504) and (266133) to (266135).

Notes of Decisions

Services

The provisions of 55 Pa. Code § 1101.31 contemplate the availability of non-medically necessary as well as medically necessary services for eligible participants. *Leader Nursing Centers, Inc. v. Department of Public Welfare*, 475 A.2d 859 (Pa. Cmlth. 1984).

Cross References

This section cited in 55 Pa. Code § 1121.24 (relating to scope of benefits for GA recipients); 55 Pa. Code § 1123.21 (relating to scope of benefits for the categorically needy); 55 Pa. Code § 1123.24 (relating to scope of benefits for GA recipients); 55 Pa. Code § 1126.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1127.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1128.24 (relating to scope of benefits for GA recipients); 55 Pa. Code § 1129.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1130.23 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1141.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1142.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1143.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1144.24 (relating to scope of benefits for GA recipients); 55 Pa. Code § 1145.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1147.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1151.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1153.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1151.43 (relating to limitation on payment); 55 Pa. Code § 1153.53 (relating to limitations on payment); 55 Pa. Code § 1163.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1163.424 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1181.25 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1221.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1223.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1225.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1230.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1243.24 (relating to

scope of benefits for General Assistance recipients); 55 Pa. Code § 1245.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1249.24 (relating to scope of benefits for General Assistance recipients); and 55 Pa. Code § 1251.24 (relating to scope of benefits for General Assistance recipients).
