

9055.0320 STATE SOLDIERS ASSISTANCE PROGRAM DENTAL AND OPTICAL PROGRAM ACTIVITIES.

Subpart 1. Program purpose.

A. Upon application approval, the commissioner must provide needed dental and optical care to a veteran and the veteran's dependents.

B. An applicant for dental and optical benefits must meet the requirements of this part and must be a veteran, the surviving spouse of a veteran, or the authorized representative of a surviving dependent of a veteran.

C. This part applies only to the dental and optical program activities.

Subp. 2. Income and asset limits for dental and optical.

A. An applicant's monthly household income and household assets are determinants of eligibility for the dental and optical program activities.

B. Maximum monthly household income limits and maximum household asset limits for the dental and optical program activities are provided in the schedule of maximum monthly allowances for the dental and optical program activity.

C. The commissioner must calculate the monthly household income and household assets of an applicant according to parts 9055.0300 and 9055.0310.

D. To be eligible for benefits under this part, an applicant's monthly household income and household assets must be under the maximum limits.

Subp. 3. Dental and optical benefit periods.

A. The commissioner must establish dental and optical benefit periods not to exceed 150 calendar days during which a recipient of dental or optical benefits is authorized to receive treatment.

B. A recipient may request an extension of a dental or optical benefit period to complete treatment that began before the final day of the benefit period.

C. A recipient must request to extend a dental or optical benefit period through a county veterans service officer, a department field operations claim representative, or a department Tribal veterans service officer.

D. A recipient making a request under this subpart to extend a dental or optical benefit period must submit a written statement to the commissioner not more than 30 days after the current benefit period has ended that explains the need for extending the benefit period.

E. The commissioner must extend the length of a dental or optical benefit period for any of the following reasons that are preventing a recipient from completing dental or optical treatment:

(1) medical conditions that prohibit the recipient from receiving dental or optical treatment;

- (2) required wait times between specific dental or optical procedures;
- (3) lack of appointment availability with the authorized dental or optical provider; or
- (4) unforeseen circumstances that prevent the recipient from completing dental or optical treatment.

F. A recipient must reapply for dental or optical benefits if the current benefit period ended before the recipient began receiving dental or optical treatment.

Subp. 4. Dental and optical authorization letters.

A. The commissioner must issue a dental or optical authorization letter to each recipient of dental or optical benefits.

B. The dental and optical authorization letters must explain:

- (1) the first and final days of the benefit period;
- (2) the maximum dental or optical benefit amounts; and
- (3) the authorized dental or optical provider.

C. A recipient of benefits under this part is authorized to receive treatment only from the provider stated on the current dental or optical authorization letter.

D. The commissioner must issue authorization letters for the dental and optical program activities only for dental and optical providers in Minnesota.

Subp. 5. Dental and optical denial letter.

A. The commissioner must issue a dental or optical denial letter to an applicant who is denied dental or optical benefits.

B. The dental or optical denial letter must explain the reasons for denial and the applicant's right to appeal under part 9055.0290, subpart 8.

C. The commissioner must provide an applicant who is over the maximum monthly household income limit or maximum household asset limit for dental and optical benefits a written explanation of how the applicant's monthly household income and household assets were calculated.

Subp. 6. Provider participation.

A. For a dental or optical provider participating in the dental or optical program activities, the dental or optical provider must:

- (1) comply with this part;
- (2) coordinate treatment and follow-up care with the commissioner for each recipient of dental or optical benefits;
- (3) bill only for the treatment provided; and

(4) report any conflicts of interest that arise out of providing dental or optical treatment to a person.

B. The commissioner must temporarily suspend a provider's participation in the dental or optical program activities upon initiation of an investigation into provider misconduct.

Subp. 7. Changing providers.

A. A recipient of dental and optical benefits under this part may request to change providers if there is a conflict with the original provider or other circumstances prevent the recipient from completing treatment with the original provider.

B. A recipient requesting to change dental or optical providers must submit the request with a written statement explaining the reasons for changing providers to the commissioner through a county veterans service officer, a department field operations claims representative, or a department Tribal veterans service officer.

C. A recipient may request to change dental or optical providers once during the first benefit period approved under the current application and before treatment has begun. The following conditions apply when changing providers under this item:

(1) the commissioner must void the current dental or optical authorization letter and terminate the current benefit period of the recipient;

(2) the commissioner must issue a new dental or optical authorization letter to the recipient, which begins a new benefit period; and

(3) any additional requests to change providers during a new benefit period require approval by the commissioner under items A and B.

D. A recipient may request to change dental or optical providers once during the first benefit period approved under the current application after treatment has begun. The following conditions apply when changing dental or optical providers under this item:

(1) the commissioner must provide written notice to the original provider and the new provider that the request to change providers is approved;

(2) the commissioner must inform the new provider of the benefit amount remaining on the dental or optical authorization letter;

(3) payment for treatment from a new provider is prohibited before commissioner approval under subitems (1) and (2);

(4) retroactive payment for treatment from a new provider before commissioner approval under subitems (1) and (2) is prohibited;

(5) charges incurred at the original provider before the request to change providers is approved have payment priority over charges incurred at a new provider;

(6) once all charges from the original provider are paid, only the remaining balance of the initial benefit amount is available for use with a new provider;

(7) the length of a benefit period remains the same when changing dental or optical providers but can be extended according to subpart 3, items B to E, if necessary;

(8) additional treatment from the original provider is prohibited once a new provider is approved by the commissioner under subitems (1) and (2); and

(9) any additional requests to change providers require approval by the commissioner under items A and B.

Subp. 8. Adding providers. A recipient of dental or optical benefits or the dental or optical provider may request to add an additional provider to a current authorization letter. The following conditions apply when adding a dental or optical provider under this subpart:

A. the current provider must submit a written referral for treatment from the added provider to the commissioner before the end of the current benefit period;

B. the commissioner must provide written notice to the current provider and the added provider that the request is approved;

C. the commissioner must inform the current provider and the added provider of the benefit amount remaining on the dental or optical authorization letter and that the remaining benefit amount must be shared between the current provider and the added provider;

D. the commissioner must approve an added provider under items A to C before treatment from the added provider is authorized;

E. retroactive payment for treatment from an added provider before commissioner approval under items A to C is prohibited;

F. the length of the benefit period remains the same when adding a dental or optical provider but can be extended according to subpart 3, items B to E, if necessary; and

G. treatment from the current provider is still authorized if a provider is added to an authorization letter.

Subp. 9. Dental and optical program activities are not insurance.

A. The commissioner must be the last to pay for dental and optical treatment when a recipient of dental and optical benefits is covered by insurance. An applicant for dental or optical benefits must disclose to the commissioner dental or optical insurance coverage.

B. A dental or optical provider must submit an explanation of benefits from the insurance carrier with the corresponding dental or optical claims to the commissioner if a recipient has dental or optical insurance.

C. The commissioner must only pay the amount the covered person is responsible for paying under the terms and conditions of the insurance contract and the laws of Minnesota.

D. The commissioner must pay up to the maximum amount allowed under the dental or optical program activities for treatment not covered by insurance or denied in full by the insurance carrier.

Subp. 10. **Benefits provided.** The commissioner must administer the dental benefit in two tiers:

A. the first tier of the dental benefit pays up to a maximum benefit amount on an annual basis for specific dental treatment; and

B. the second tier of the dental benefit pays up to a maximum per-lifetime benefit amount for specific types of dental treatment.

Subp. 11. **First-tier dental benefit.**

A. The commissioner must issue a dental authorization letter to each recipient of the first-tier dental benefit.

B. The maximum annual benefit amount for the first tier of the dental benefit is provided in the schedule of maximum monthly allowances for the dental program activity.

C. The maximum benefit amount is authorized at the start of each first-tier dental benefit period for which a recipient is approved.

D. First-tier dental benefit amounts remaining at the end of a benefit period do not carry over for future use. First-tier dental benefit amounts must not be combined or transferred among household members.

E. The first-tier dental benefit allows for payment of the following treatments:

- (1) examinations, cleanings, and screenings;
- (2) diagnostic procedures;
- (3) fillings and tooth repairs;
- (4) restorative procedures to include bonding, sealants, and veneers;
- (5) crowns, caps, and bridges;
- (6) root canals and other endodontic treatment;
- (7) periodontal treatment;
- (8) prescription medications prescribed by a dental provider; and
- (9) tooth extractions including tissue and bone removal and restoration that are not in preparation for dentures, partial dentures, or a flipper.

F. Dental treatment not covered under the first-tier dental benefit includes:

- (1) orthodontia and orthodontic procedures;

- (2) tooth whitening and cosmetic procedures;
- (3) occlusal guards;
- (4) specialized toothbrushes and other hardware; and
- (5) dental implants.

Subp. 12. Frequency of the first-tier dental benefit.

- A. A recipient is limited to one first-tier dental benefit every 12 months.
- B. A previous recipient is eligible for the first-tier dental benefit 12 months after the first date of service paid for by the commissioner in the recipient's previous benefit period.
- C. A previous recipient must complete a new application for each benefit period and must meet all eligibility requirements for each benefit period.

Subp. 13. Second-tier dental benefit.

A. The commissioner must issue the second-tier dental benefit to a recipient as a maximum per-lifetime benefit amount for specific types of treatment. The second-tier dental benefit allows for payment of:

- (1) tooth extractions including tissue and bone removal and restoration in preparation for dentures, partial dentures, or a flipper; and
- (2) full dentures, partial dentures, or a flipper.

B. The maximum lifetime benefit amount for the second-tier dental benefit is provided in the schedule of maximum monthly allowances for the dental program activity.

C. The maximum benefit amount is authorized at the start of the first second-tier benefit period a recipient is approved for. Second-tier benefit amounts remaining at the end of the first benefit period carry over for future use in subsequent benefit periods until the lifetime benefit amount is exhausted.

D. A previous recipient of a second-tier dental benefit must complete and submit to the commissioner a new application for each second-tier benefit period and meet all eligibility requirements for each benefit period.

E. The commissioner must issue a separate authorization letter each time a recipient is approved for a second-tier dental benefit. Each authorization letter must show the amount that is remaining for the benefit.

F. Second-tier benefit amounts must not be combined or transferred among household members.

G. The maximum benefit amounts for each second-tier dental benefit are exclusive and must not be combined with each other or with the first-tier dental benefit amount.

H. A second-tier dental benefit must be preauthorized by the commissioner before treatment is provided. The original or current dental provider must submit a written request for preauthorization of a second-tier benefit to the commissioner before the end of a current first-tier dental benefit period and before second-tier treatment is provided.

I. A recipient may use the first-tier dental benefit on an annual basis to receive second-tier dental treatment if the maximum lifetime benefit amount for the second-tier dental benefit is exhausted.

Subp. 14. Optical benefits.

A. The optical benefit allows for payment of specific optical treatment under a single tier on an annual basis. The commissioner must issue an optical authorization letter to each recipient of the optical benefit.

B. The maximum annual benefit amount for the optical benefit is provided in the schedule of maximum monthly allowances for the optical program activity.

C. The maximum benefit amount is authorized at the start of each optical benefit period for which a recipient is approved.

D. Optical benefit amounts remaining at the end of a benefit period do not carry over for future use. Optical benefit amounts must not be combined or transferred among household members.

E. Optical treatment covered annually under this subpart is limited to:

- (1) examinations and screenings;
- (2) diagnostic procedures;
- (3) prescription medications prescribed by an ophthalmologist or optometrist; and
- (4) eyewear to include prescription glasses, prescription sunglasses, and contact lenses.

F. Optical treatment not covered under this subpart includes:

- (1) eye surgery;
- (2) eyewear accessories to include carrying cases, cleaning kits, and cleaning solutions;

and

- (3) eyewear warranty or membership programs.

Subp. 15. Frequency of optical benefits.

A. A recipient is limited to one optical benefit every 12 months.

B. A previous recipient is eligible for the optical benefit 12 months after the first date of service paid for by the commissioner in the recipient's previous benefit period.

C. A previous recipient must complete a new application for each benefit period. The person must meet all eligibility requirements for each benefit period.

Subp. 16. Dental and optical payments.

A. Dental and optical providers must submit dental and optical claims with the information required in item C to the commissioner for payment.

B. The commissioner must make payments for dental and optical treatment directly to the dental or optical provider.

C. Dental and optical claims submitted to the commissioner for payment of dental or optical benefits must include and confirm:

- (1) the name of the recipient receiving treatment;
- (2) the name of the recipient who applied for benefits;
- (3) a copy of the dental or optical authorization letter;
- (4) the dates of service and the treatment provided;
- (5) the amount charged for each treatment;
- (6) the provider's name, location, and payment address; and
- (7) an explanation of benefits from the insurance carrier if the recipient has insurance.

Statutory Authority: *MS s 14.06; 196.04; 196.05; 197.03; 197.05; 197.06; 197.75*

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