



Provider Relations Outreach Specialist

- **220.000** **Benefit Limits**

7-1-15

Benefit limits are the limits on the *quantity* of covered services Medicaid-eligible beneficiaries may receive. Medicaid-eligible beneficiaries are responsible for payment for services beyond the established benefit limits, unless the Division of Medical Services (DMS) authorizes an extension of a particular benefit

If a service is denied for exceeding the benefit limit, and the Medicaid beneficiary had elected to receive the service by written informed consent prior to the delivery of the service, the Medicaid beneficiary is responsible for the payment, unless that service has been deemed not medically necessary.

Benefit extensions are considered after the service has been rendered and the provider has received a denial for "benefits exhausted." DMS considers requests for benefit extensions based on the medical necessity of the service. If a Medicaid provider chooses to file for an extension of benefits and is denied due to the service not being medically necessary, the beneficiary is not responsible for the payment. Once the extension of benefits request has been initiated on a particular service, the provider cannot abort the process before a final decision is rendered.

Please see Section 229.000 through Section 229.120 and Section 131.000 points A and C for benefit extension request procedures. DMS reviews extension of benefits requests for Home Health, personal care, diapers and medical supplies. AFMC reviews extension of benefits requests for physician, lab, radiology and machine tests, using form DMS-671. All personal care services for beneficiaries under age 21 are reviewed by the contracted Quality Improvement Organization (QIO). [View or print AFMC contact information.](#)