



MEDICAL ASSISTANCE BULLETIN

COMMONWEALTH OF PENNSYLVANIA • DEPARTMENT OF PUBLIC WELFARE

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SUBJECT

180-Day Exception Requests and
Invoice Submission Time Frames

BY

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Deputy Secretary for Medical Assistance Programs

PURPOSE: The purpose of this bulletin is to alert providers to significant changes in the 180-day exception process. This bulletin replaces Medical Assistance Bulletin No. 99-83-05.

SCOPE: This bulletin applies to all Medical Assistance providers except those who bill on the Inpatient Invoice (MA 310C) and those providers who bill on the Long Term Care Invoice (MA 309C).

BACKGROUND: On December 15, 1990, Medical Assistance Regulation, Section 1101.68, was published in the Pennsylvania Bulletin. This revised regulation establishes criteria for submitting invoices for services rendered to medical assistance recipients.

Under the above cited regulation, all providers of medical assistance services are required to submit original invoices no later than 180 days from the end date of service unless the invoice meets specific criteria of the 180-day exception process.

DISCUSSION: An invoice which is submitted within the 180 day deadline, and is rejected due to provider error, may be resubmitted. Providers must include the Claim Reference Number (CRN) and the Remittance Advice number (RA) number in the Remarks Section of the resubmitted invoice in order for payment to be made. All resubmitted invoices, including claim adjustments must be received for final adjudication within 365 days of the end date of service.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:
Division of Outpatient Operations or Practitioners 1-800-537-8862
Claims Exception Unit call Pharmacy/Medical Suppliers
P.O. Box 8044 1-800-932-0938
Harrisburg, PA 17105 Ancillary Providers
1-800-537-8861

Providers can verify the Department's receipt of an invoice by noting the assignment of a ten digit CRN which appears in the second column of the RA. The CRN number contains the julian calendar date on which the claim was received. If an invoice fails to appear on an RA within 45 days from the date of submission it must be resubmitted. Likewise, if an invoice is pended and does not appear on the RA as approved or rejected, the claim may be resubmitted after 45 days from the RA date.

Effective January 1, 1991, original invoices received after 180 days from the end date of service will be rejected unless they meet specific criteria for a 180-day exception.

PROCEDURE: The Department will consider a request for a 180-day exception if it meets one or both of the following criteria:

1. An eligibility determination was requested from the county assistance office (CAO) within 60 days of the end date of service. The Department must receive the provider's 180-day exception request within 60 days of the CAO's eligibility determination processing date; and/or
2. The provider requested payment from a third party insurer within 60 days of the end date of service. The Department must receive the provider's 180-day exception request within 60 days of the date indicated on the third party denial or approval.

To submit a 180-day request, the provider must take the following steps:

1. check the claim to verify that it meets one or both of the above cited criteria;
2. complete an invoice correctly (The invoice must be a signed original - no file copies or photocopies will be accepted);
3. include all supporting documentation along with documentation to and from the CAO and third party insurer;
4. complete a 180-day Exception Request Detail Page and submit it to the Department with each exception request. (Instructions for its completion are attached); and
5. do not fold or staple the forms (use a large envelope).

Supporting documentation under #3 above must consist of any or all of the following:

- evidence that the medical assistance application was submitted to the CAO within 60 days of the end date of service; and/or

- evidence that a payment request was submitted to a third party insurer within 60 days of the end date of service. (The provider is responsible for identifying and using all the patient's medical resources before billing the Department).

The Department must receive a properly completed invoice within 60 days of the CAO documentation or the third party statement.

The Department may request additional documentation to justify approval of an exception. If the requested information is not received within 30 days from the date of the Department's request, a decision will be made, based on available information.

Exceptions will be granted on a one time basis. Claims granted an exception and rejected due to provider error may be resubmitted for payment up to 365 days from the end date of service (see the 180-Day Exception Approval letter for resubmission procedure).

Providers will receive a letter stating the Department's decision. The fact that the Department approves a 180-day exception does not guarantee that the claim will not be rejected for reasons other than time requirements.

Although regulations are effective January 1, 1991, the Office of Medical Assistance Programs (OMAP) is allowing time for providers to adjust to the revised time frames. Therefore, OMAP will apply the new time frame to 180-day exception requests received after April 1, 1991.

Send the 180-day exception request detail page, supporting documentation, and a correctly completed invoice to:

Department of Public Welfare
Division of Outpatient Operations
P.O. Box 8044
Harrisburg, Pennsylvania 17105
ATTENTION: Claims Exception Unit

180-day exception requests that are denied will be returned to the provider with a letter of explanation. The provider has the right to appeal within 30 days of the date on the denial letter. Each appeal must contain a concise statement explaining the basis for the appeal along with a copy of the denial letter. Send the appeal to:

Department of Public Welfare
Director, Office of Hearings and Appeals
P.O. Box 2675
Harrisburg, Pennsylvania 17105