

Pennsylvania
PROMIS*e*TM
Provider Handbook



pennsylvania
DEPARTMENT OF HUMAN SERVICES

**837 Professional/CMS-
1500 Claim Form**

January 2017, Version 2.27

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[APPENDIX B – BULLETINS](#)

[APPENDIX C – PROVIDER INTERNET USER MANUAL](#)

[APPENDIX D – SPECIAL FORMS](#)

[APPENDIX E – FQHC/RHC](#)

[APPENDIX F – GLOSSARY](#)

1 Introduction

The PA PROMIS^e™ Provider Handbooks were written for the Pennsylvania Provider Reimbursement and Operations Management Information System (PA PROMIS^e™) providers who submit claims via the 837 Professional format or the CMS-1500 Claim Form, the 837 Institutional format or the UB-04 Claim Form, the NCPDP Version 5.1 Pharmacy transactions, and the 837 Dental format or the ADA Claim Form – Version 2012.

Four handbooks have been designed to assist PA PROMIS^e™ providers:

- PA PROMIS^e™ Provider Handbook for the 837 Professional/CMS-1500 Claim Form
- PA PROMIS^e™ Provider Handbook for the 837 Institutional/UB-04 Claim Form
- PA PROMIS^e™ Provider Handbook for the 837 Dental/ADA Claim Form – Version 2012
- PA PROMIS^e™ Provider Handbook for NCPDP 5.1/Pharmacy Billing

The following sections detail the PA PROMIS^e™ providers who should access the PA PROMIS^e™ Provider Handbook for the 837 Professional/CMS-1500 Claim Form, a general overview of each section of the handbook, and how to obtain a hardcopy PA PROMIS^e™ Provider Handbook for the CMS-1500 Claim Form.

NOTE: The PA PROMIS^e™ Provider Handbooks have been designed to be fully functional as paper-based documents; however, providers will realize the full benefit of the handbooks when they access them in their online version.

1.1 PA PROMIS^e™ Provider Handbook for the 837 Professional/CMS-1500 Claim Form

The following PA PROMIS^e™ providers should access the PA PROMIS^e™ Provider Handbook for the 837 Professional/CMS-1500 Claim Form to obtain general information, eligibility verification instructions, Remittance Advice (RA) Interpretation, and billing instructions:

Adult Autism Waiver
Aging Waiver Services Providers
Ambulance Companies
Attendant Care Providers
Audiologists
Behavioral Specialist Consultants
Birth Centers
Case Managers

Certified Registered Nurse Anesthetists (CRNAs)
Certified Registered Nurse Practitioners (CRNPs)
Chiropractors
Clinics
COMMCARE Waiver Services Providers
Department of Health (DOH) Providers
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services
Employment Competitive Providers
Extended Care Facilities (ECFs) for Respite Care Services
Family Planning Clinics - Title XIX Only
Funeral Directors
Healthy Beginnings Plus (HBP) Providers
Home and Community Habitation Services Providers
Home Health Agency Providers
Home Residential Rehabilitation Providers
Homemaker Agency Providers
Hospice Providers
Independence & OBRA Waiver Providers
Intermediate Service Organizations (ISOs)
Laboratories
LTC Exceptional Grant Payment Providers
LTC Medicare Deductible and Coinsurance Payments
MA Early Intervention (EI) Providers
Medical Suppliers

Medically Fragile Foster Care Providers
Mental Health & Substance Abuse Providers
Midwives
Mobile Therapy Providers
Non-JCAHO Residential Treatment Facilities (RTFs)
Nurses
Nutritionists
Office of Developmental Programs (ODP) Base Services, P/FDS and Consolidated Waiver Services
Office of Developmental Programs (ODP) Financial Management Services (FMS)
Optometrists
Personal Care Services Providers
Physicians
Podiatrists
Psychologists
Public Schools
Rehabilitation Facilities (CORF)
Renal Dialysis Centers
Rural Health Clinics (RHCs) & Federally Qualified Health Centers (FQHCs)
School Corporations
Targeted Case Management Providers
Therapeutic Staff Support
Therapists
Tobacco Cessation Providers
Vendors

1.2 PA PROMIS^e™ Provider Handbook for the 837 Professional/CMS-1500 Claim Form Sections

This handbook contains the following sections:

- | | |
|--|--|
| Section 2 –
General Information | This section contains a high-level introduction for PA PROMIS ^e ™ providers, which includes information on the Commonwealth’s delivery systems, Freedom of Choice, invoicing options, time limits for claim submission, 180-Day Exception Request instructions, claim adjustment instructions, inquiries, Internet functions, and claim form reordering procedures. |
| Section 3 -- Policies | This section contains links to the Regulations, which pertain to PA PROMIS ^e ™ providers.

<i>For example, the PA PROMIS^e™ Provider Handbook for the CMS-1500 Claim Form will contain a link to the Pennsylvania Code, which houses Department of Human Services (DHS) Regulations. If a physician needs to access Medical Assistance (MA) policies specific to physicians, a link to 55 Pa. Code, Chapters 1101 (General Provisions), 1141 (Physicians’ Services), and 1150 (MA Program Payment Policies) will be provided to ensure that the physician is submitting claim forms in accordance with MA policy.</i> |
| Section 4 -- Beneficiary Eligibility | This section reviews how to determine if a beneficiary is eligible for service(s), describes the Pennsylvania ACCESS Cards, reviews program specific requirements for waivers and base programs, the Beneficiary Restriction/Lock-In Program, as well as Third Party Liability (TPL) and Medicare. |
| Section 5 –
Special Requirements for PA PROMIS^e™ Providers | This section contains information on Federally Required Forms and State Required Forms. It contains links to PA PROMIS ^e ™ policies surrounding the proper completion of these forms, when applicable, as well as links to the forms and their instructions. |
| Section - 6
Provider Enrollment Information | This section contains information for a provider to understand how to enroll in the PA PROMIS ^e ™ Program. Provider information such as enrollment/provider agreements, provider notice information, changes to enrollment, provider certification, and provider |

responsibilities.

**Section 7 –
Prior Authorization**

This section reviews Prior Authorization (PA) requirements, and includes instructions and information regarding Program Exception (PE), the Automated Utilization Review (AUR) Admission Certification Process, Place of Service Review (PSR), and administrative items.

**Section 8 - Remittance
Advice**

This section describes how to read and understand the contents of the Remittance Advice (RA) Statement for claims and adjustments, as well as a sample claim reconciliation method.

**Section 9 – HIPAA
Requirements**

This section presents an overview of the Health Insurance Portability and Accountability Act (HIPAA).

**Section 10 – Provider
Preventable Conditions**

This section describes the reporting requirements and procedures for Provider Preventable Conditions (PPC), Other Provider Preventable Conditions (OPPC), and Health Care Acquired Conditions (HCAC).

Appendix A – Billing Guides

This section contains provider-specific and/or service-specific Billing Guides. Each Billing Guide provides comprehensive instruction on the proper completion of each block contained on the CMS-1500 Claim Form.

Appendix B

This section contains MA Bulletins applicable to each provider using this handbook.

Appendix C

This section contains instructions for Providers who will use the functions on the PA PROMISE™ Internet.

Appendix D

This section contains DHS forms and federally required forms, along with instructions for proper completion.

Appendix E

This section contains the guidelines, procedures, and standards for Federally Qualified Health Centers (FQHCs), their cost reporting instructions, worksheets, and settlement reports.

Appendix F

This section contains a glossary of PA PROMISE™ terms, acronyms, and phrases with their definitions.

2 General Information

The General Information section provides a high-level overview of the Pennsylvania (PA) Provider Reimbursement and Operations Management Information System (PROMIS^e[™]) and the various Offices and Programs whose providers will utilize PA PROMIS^e[™] for claims processing. This section also provides an overview of Nondiscrimination, Freedom of Choice, Medical Assistance (MA) Delivery Systems, invoicing options, payment process, inquiries, time limits for claim submission, the 180-Day Exception Request Process, claim adjustments, and MA forms and CMS-1500 ordering instructions.

2.1 Overview for PA PROMIS^e[™]

PA PROMIS^e[™] is the name of the Pennsylvania Department of Human Services' (DHS) claims processing and management information system. PROMIS^e[™] stands for Provider Reimbursement and Operations Management Information System in an electronic format. PA PROMIS^e[™] incorporates the claims processing and information activities of the following DHS program areas:

- Office of Medical Assistance Programs (OMAP)
- Office of Developmental Programs (ODP)
- Office of Mental Health and Substance Abuse Services (OMHSAS)
- Office of Long-Term-Living (OLTL)
- Special Pharmaceutical Benefits Program (SPBP)
- Healthy Beginnings Plus (HBP)

In addition, PA PROMIS^e[™] processes claims for the Departments of Aging, Education, and Health. Each program area is described in this section of the handbook.

2.1.1 Office of Medical Assistance Programs

The Office of Medical Assistance Programs (OMAP) administers the joint state/federal Medical Assistance Program that purchases health care for needy Pennsylvania residents. Based on an individual's eligibility category, covered services may include physician and clinic visits; inpatient hospital care; home health care; medical supplies and equipment; nursing facility care; inpatient and outpatient psychiatric and drug and alcohol services; prescription drugs; dental and other medically necessary services.

The Office of Income Maintenance's local county assistance offices determine eligibility for Medical Assistance. These offices also determine eligibility for Temporary Assistance for Needy Families (TANF), food stamps, and energy assistance. Family and individual eligibility criteria for Medical Assistance include income and resources.

MA purchases services through contracts with managed-care organizations and under an indemnity, or traditional, Fee-for-Service (FFS) system. Facility-based services are reimbursed under case-mix for long-term care for the elderly, while other facilities are paid on a prospective, or cost, basis. A medical provider is required to enroll in the program and must meet applicable national, federal, and state licensing and credential requirements.

OMAP is also responsible for enrolling providers, processing provider claims, establishing rates and fees, contracting and monitoring of managed care organizations (MCO), detecting and deterring provider and beneficiary fraud and abuse, and administering some waiver services.

2.1.2 Office of Developmental Programs

The Office of Developmental Programs (ODP) provides a comprehensive array of services and supports for people with development disabilities of all ages. Services include, but are not limited to, supports coordination, residential, day and support services administered or operated by county mental health and intellectual disabilities (MH/ID) programs and contracted private and state operated intermediate care facilities for beneficiaries with developmental disabilities. Funding is provided through federal, state, and county resources.

Community residential supports include small homes and apartments or family living settings. Additionally, individuals are offered the opportunity to participate in home-based services, provided in their own home or that of a family member. Day services, such as supported employment and vocational training are provided to individuals living at home or in community residential facilities. A wide array of services and supports are also available to families caring for a child or beneficiary sibling with developmental disabilities. Many services are available for funding under the Medicaid Home and Community Based Waiver Program.

OCDEL administers the EI Program for children from birth through age two who are eligible for Early Intervention services and supports through the County MH/ID programs. All EI services are coordinated through a service coordinator who assists the family in gaining access to EI services and other services identified on the child's Individual Family Support Plan (IFSP). The MA EI program is operated in concert with OMAP following all MA regulations. Early Intervention is services and supports designed to help families with children with developmental delays. Early Intervention is the total effort of a statewide coordinated, comprehensive multidisciplinary, interagency system of appropriate developmental and support services designed to meet the needs of eligible infants, toddlers and their families. EI services can include, among other things, information on how children develop, early childhood education and intervention services which can help a child with hearing, seeing, talking, moving or learning, ideas for how a family can help their child at home or in the community, and designs intervention plans to help a family enhance their child's growing and learning. The EI Program is currently implemented through three funding sources: Medical Assistance Early Intervention (MA EI), the Infants, Toddlers and Families Waiver (ITF Waiver) and County Base funds.

2.1.3 Office of Mental Health and Substance Abuse Services

The Office of Mental Health and Substance Abuse Services (OMHSAS) administers a comprehensive array of behavioral health services throughout the state. Community resources are emphasized, with a goal of developing a full array of services and supports as alternatives to hospitalization. Behavioral health services range from community to hospital programs with emphasis on helping children, adolescents, and adults remain in their communities. Community-based services are emphasized, with the goal to help people who have serious mental illness or serious emotional disturbance break the cycle of repeated hospital or residential admissions. The range of services include outpatient, psychiatric partial hospitalization, residential, short-term inpatient hospital care, emergency crisis intervention

services, counseling, information referral , mobile mental health treatment, peer support services and case management services. These services are provided for all ages.

Services provided to beneficiaries are based on the Community Support Program (CSP) Principles: consumer-centered, consumer-empowered, be racially and culturally appropriate, be flexible, be normalized and incorporate natural supports, meet special needs, be accountable, and be coordinated.

2.1.4 Office of Long-Term Living

The Office of Long-Term Living is comprised of program and administrative offices under the direction of a Deputy Secretary. The Deputy Secretary oversees the Office of Policy and Strategic Planning, the Bureau of Individual Support, the Bureau of Provider Supports, and the Office of Quality Management, Metrics and Analytics.

The Office of Policy and Strategic Planning acts as a “clearinghouse” for all policy development activity within the agency. This Office is responsible for developing, coordinating, planning, assessing and evaluating policies across OLTL to ensure consistency in content, direction and application. Examples include coordination of the development of waiver renewals, waiver amendments, state plan documents, regulations and legislation. Its staff also assists other bureaus in developing policy, evaluating policy impact and establishing and improving strategic direction. When solicited, the Office provides direction to field staff and service providers for the implementation of OLTL policies. The Policy Office serves as a liaison with other DHS programs and policy offices, other state agencies and external stakeholder groups. The Policy Office is comprised of three divisions: the Division of Policy, the Division of Planning and the Division of Research, Development and Innovation.

The Bureau of Individual Support is comprised of two Divisions – Direct Services and Nursing Home Transition and Diversion. The Division of Direct Services provides services to individuals with disabilities through the Attendant Care Act 150 Program, the Attendant Care Medicaid Waiver Program, the administration of the Aging Attendant Care Waiver Program, the COMM CARE Waiver for individuals who experience a medically determinable diagnosis of traumatic brain injury, the OBRA Waiver for individuals with physical developmental disabilities, and the Independence Waiver. The Division of Nursing Home Transition and Diversion oversees the Commonwealth’s transition and diversion programs by working with key stakeholders, including consumers, advocates, and providers. This Division also reviews and approves special needs funding requests, provides oversight of Specialized Services provided to individuals “targeted” through the Pre-Admission Screening Process, and coordinates with the Bureau of Fee-For-Service (FFS) and managed care plans for people aging out of Early Periodic Screening and Diagnostic Treatment (EPSDT).

The Bureau of Provider Support serves as liaison to the provider community serving the long-term living continuum, including nursing facilities, Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) facilities, and Home and Community Based Services (HCBS) providers. Through the operations of three divisions, responsibilities include management of field operations staff that conduct Utilization Management Review, clinical and fiscal reviews in nursing facilities to ensure compliance with applicable state and federal regulations, including compliance with Minimum Data Set completion and submission accuracy. Responsibilities

include licensing of Assisted Living. Additional responsibilities include certification and enrollment of nursing facilities, ICFs/MR and HCBS providers.

The Office of Quality Management, Metrics and Analytics conducts quality management and improvement monitoring of long-term living programs and services to ensure compliance with federal and state regulations and the delivery of quality programs to assure the health and welfare of consumers. Through the operations of two divisions, the QMMA staff ensures that program and service delivery systems achieve desired outcomes. This includes working closely with the Office of Policy and Strategic Planning to use data analysis to measure the effectiveness of program design and operations, recommend strategies for improvement, ensure fiscal accountability, and prepare financial reports as appropriate, including reports required by the Centers for Medicare and Medicaid Services (CMS) and other regulatory agencies.

2.1.5 Special Pharmaceutical Benefits Program

The Special Pharmaceutical Benefits Program (SPBP) is a program for low and moderate-income individuals and families that helps pay for specific drug therapies used for the treatment of beneficiaries with HIV/AIDS or a DSM IV diagnosis for schizophrenia. The HIV/AIDS side of the SPBP is usually called AIDS Drug Assistance Program (ADAP) in other states.

The Department of Human Services, Office of Medical Assistance Programs (OMAP), administers SPBP. The HIV/AIDS portion of the program is funded through a combination of Ryan White Emergency Care Act Title II funds and state funds. The mental health drug component is funded exclusively through state funds. The SPBP is not an entitlement program.

For additional information on SPBP, please visit DHS's website at:

<http://www.health.pa.gov/My%20Health/Diseases%20and%20Conditions/E-H/HIV%20And%20AIDS%20Epidemiology/Pages/Special-Pharmaceutical-Benefits-Program.aspx>

2.1.6 Healthy Beginnings Plus

Healthy Beginnings Plus (HBP) is Pennsylvania's effort to assist low-income pregnant women who are eligible for Medical Assistance (MA) to have a positive prenatal care experience. HBP significantly expands maternity services that can be reimbursed by the MA Program. The intent of HBP is to render services that meet pregnant beneficiaries' psychosocial needs in addition to rendering traditional medical/obstetric services. Federal legislation permits Pennsylvania to extend MA eligibility to pregnant women with family incomes up to 185% of federal poverty guidelines. Pregnant beneficiaries may elect to participate in HBP or receive their prenatal care in the traditional MA system.

For detailed HBP provider information, please visit DHS's Website at:

<http://www.dhs.state.pa.us/provider/doingbusinesswithdhs/medicalassistance/healthybeginningsplus/index.htm>

2.2 Medical Assistance (MA) Delivery Systems

All eligible beneficiaries presenting for services in Pennsylvania receive Medical Assistance (MA) services through either the Fee-for-Service (FFS) or managed care delivery system. The

instructions in this Provider Handbook for the CMS-1500 Claim Form apply to the FFS Program administered by DHS.

2.2.1 Fee-For-Service (FFS)

The traditional FFS delivery system provides payment on a per-service basis for health care services provided to eligible MA beneficiaries.

2.2.2 Managed Care

Under the managed care delivery system, MA beneficiaries receive physical and behavioral health care through a managed care organization (MCO) under contract with DHS or the county government.

2.2.2.1 HealthChoices

HealthChoices is the name of Pennsylvania's mandatory managed care program for eligible MA beneficiaries. Through Physical Health MCOs, beneficiaries receive quality medical care and timely access to all appropriate physical health services, whether the services are delivered on an inpatient or outpatient basis. The Office of Medical Assistance Programs oversees the Physical Health component of the HealthChoices Program.

Through Behavioral Health MCOs, beneficiaries receive quality behavioral health services and timely access to appropriate mental health and/or drug and alcohol services. The behavioral health component is overseen by DHS's Office of Mental Health and Substance Abuse Services (OMHSAS).

When HealthChoices is fully implemented statewide, it will include approximately 90% of the total statewide MA population. The remaining 10%, who will remain in the FFS program, includes beneficiaries who are newly eligible (and in the process of selecting a managed care organization to serve them) and beneficiaries institutionalized for more than 30 days.

If an enrolled MA provider wants to participate in a HealthChoices MCO network, the provider must contact the participating MCO(s) directly. A provider can enroll with more than one MCO. Providers must submit documentation to the MCO verifying that they are an enrolled MA provider or have applied with DHS to be enrolled in the MA Program, and agree to meet the requirements and conditions for network participation set forth by the MCO.

For additional information on HealthChoices, visit the Managed Care Section of the DHS Website at:

<http://www.dhs.state.pa.us/provider/healthcaremedicalassistance/managedcareinformation/index.htm>

2.3 Nondiscrimination

The provider agrees to comply with the Commonwealth's Contract Compliance Regulations which are set forth at 16 Pa. Code, §49.101, as follows:

1. Provider shall not discriminate against any employee, applicant for employment, independent contractor, or any other person because of race, color, religious creed, ancestry, national origin, age, or gender. Provider shall take affirmative action to ensure

that applicants are employed, and that employees or agents are treated during employment, without regard to their race, color, religious creed, ancestry, national origin, age or gender. Such affirmative action shall include, but is not limited to the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training. Provider shall post in conspicuous places, available to employees, agents, applicants for employment and other persons, a notice to be provided by the contracting agency setting forth the provisions of this nondiscrimination clause.

2. Provider shall, in advertisements or requests for employment placed by it or on its behalf, state all qualified applicants will receive consideration for employment without regard to race, color, religious creed, ancestry, national origin, age or gender.
3. Provider shall send each labor union or workers' representative with which it has a collective bargaining agreement or other contract or understanding, a notice advising said labor union or workers' representative of its commitment to this nondiscrimination clause. Similar notice shall be sent to every other source of recruitment regularly utilized by Provider.
4. It shall be no defense to a finding of noncompliance with Contract Compliance Regulations issued by the Pennsylvania Human Relations Commission or this nondiscrimination clause that Provider had delegated some of its employment practices to any union, training program or other source of recruitment that prevents it from meeting its obligations. However, if the evidence indicated that the Contractor was not on notice of the third-party discrimination or made a good faith effort to correct it, such factors shall be considered in mitigation in determining appropriate sanctions.
5. Where the practices of a union or any training program or other source of recruitment will result in the exclusion of minority group persons, so that Provider will be unable to meet its obligations under the Contract Compliance Regulations issued by the Pennsylvania Human Relations Commission or this nondiscrimination clause, Provider shall then employ and fill vacancies through other nondiscriminatory employment procedures.
6. Provider shall comply with the Contract Compliance Regulations of the Pennsylvania Human Relations Commission, 16 Pa. Code Chapter 49, and with all laws prohibiting discrimination in hiring or employment opportunities. In the event of Provider's noncompliance with the nondiscrimination clause of this contract or with any such laws, this contract may, after hearing and adjudication, be terminated or suspended, in whole or in part, and Provider may be declared temporarily ineligible for further Commonwealth contracts, and such other sanctions may be imposed and remedies invoked as provided by the Contract Compliance Regulations.
7. Provider shall furnish all necessary employment documents and records to, and permit access to its books, records and accounts by the contracting agency and the Human Relations Commission, for purposes of investigation to ascertain compliance with the provisions of the Contract Compliance Regulations, pursuant to §49.35 of this title (relating to information concerning compliance by contractors). If Provider does not possess documents or records reflecting the necessary information requested, it shall

furnish such information on reporting forms supplied by the contracting agency or the Commission.

8. Provider shall actively recruit minority subcontractors or subcontractors with substantial minority representation among their employees.
9. Provider shall include the provisions of the nondiscrimination clause in every subcontract, so that such provisions will be binding upon each subcontractor.
10. Terms used in this nondiscrimination clause shall have the same meaning as in the Contract Compliance Regulations issued by the Pennsylvania Human Relations Commission, 16 Pa. Code Chapter 49.
11. Provider obligations under this clause are limited to the Provider's facilities within Pennsylvania, or where the contract is for purchase of goods manufactured outside of Pennsylvania, the facilities at which such goods are actually produced.

2.4 Freedom of Choice of MA Beneficiaries

Title XIX of the Social Security Act, §1902(a)(23) [42 U.S.C. 1396(a)(23)], requires that a State Plan for medical assistance must provide that any individual eligible for MA may obtain such assistance from any MA enrolled institution, agency or person qualified to perform the service or services required. This freedom of choice provision allows MA beneficiaries the same opportunities to choose among available MA enrolled providers of covered health care as are normally offered to the general public. For beneficiaries enrolled in a mandatory managed care program, the freedom of choice provision is limited to providers enrolled in the managed care network.

As an exception to this policy, DHS may restrict certain beneficiaries to specified providers (refer to Section 4.6, Beneficiary Restriction/Centralized Lock-In Program).

The following explanations provide an overview of how freedom of choice applies to each delivery system.

2.4.1 Fee-for-Service

MA beneficiaries are permitted to select the providers from whom they receive medical services. Therefore, there will be no service referral arrangements, profit sharing or rebates among providers who serve MA beneficiaries.

Although providers may use the services of a single pharmacy, laboratory, or other providers in the community, they are prohibited from making oral and written agreements that would interfere with an MA beneficiary's freedom of choice of providers.

2.4.2 Mandatory Managed Care (HealthChoices)

Beneficiaries residing in a HealthChoices County in Pennsylvania maintain their freedom of choice by choosing one of the HealthChoices physical health plans to use for their MA covered health care services as well as a provider who works within that plan, to be their primary care practitioner (PCP).

Under the HealthChoices Behavioral Health Program, beneficiaries will be assigned a behavioral health plan based on their county of residence; however, a beneficiary maintains the freedom to choose from among the providers in the behavioral health MCOs provider network. With regards to the behavioral health component of the HealthChoices program, counties are required to ensure high quality medical care and timely access to appropriate mental health and substance abuse services and facilitate effective coordination with other needed services.

2.5 Invoicing Options

Providers can submit claims to DHS via the CMS-1500 Claim Form or through electronic media claims (EMC).

Electronic Media Claims (EMC)

PA PROMISE™ can accept billing submitted through Direct Connect, through a Clearinghouse, or Bulletin Board via Personal Computer (PC). For more information on these invoicing options, please contact:

HPE/PA PROMIS^e[™]
1250 Camp Hill Bypass Suite 100
Mail Stop 2-200
Camp Hill, PA 17011-3700
Telephone: 800-248-2152 (in-state only)
717-975-4100 (local)

For information on submitting claims electronically via the Internet, please go to Appendix C, *Provider Internet User Manual*, of this document.

1. Electronic Media Claims (EMC)

For claims submitted via any electronic media that require an attachment or attachments, you will need to obtain a Batch Cover Letter and an Attachment Control Number (ACN). Batch Cover Letters and ACNs can be obtained via the DHS PROMIS^e[™] Website <http://promise.dpw.state.pa.us/>, from the Provider Claim Attachment Control Window. For more information on accessing the Provider Claim Attachment Control Window, refer to the Provider Internet User Manual found in Appendix C of the 837 Professional/CMS-1500 Claim Form Handbook.

- Attachment Control Number (ACN)

When submitting a claim electronically that requires a paper attachment, providers must obtain an Attachment Control Number (ACN) from the PA PROMIS^e[™] Website. The purpose of the ACN is to provide DHS with a means of matching paper attachments to electronic claims. (For detailed instructions on obtaining an Attachment Control Number, see Appendix C, Provider Internet User Manual, of this handbook.

An ACN must be obtained prior to completing the electronic claim requiring an attachment, such as the Sterilization Patient Consent Form (MA 31), Patient Acknowledgement for Hysterectomy (MA 30), or Physician Certification for an Abortion (MA 3). You will need to enter the ACN on your electronic claim prior to transmission.

The Provider Claim Attachment Number Request window of the PA PROMIS^e[™] Internet allows providers to submit and view requests for an ACN.

A batch cover form with the ACN must be present on all paper attachment batches. The ACN on the paper batch must match the ACN entered on the related electronic claim. The Batch Cover Form can be located in Appendix D (Special Forms) of this handbook.

- Handbook

The provider must follow the billing requirements defined in the provider handbook in addition to the electronic billing instructions.

- Claim Status

Electronic Media Claims

Providers submitting claims can download an electronic Remittance Advice (RA)

from the PROMIS^e™ Website after each weekly cycle in which the provider's claim forms were processed.

Providers can elect to opt out of receiving electronic RAs and instead receive hardcopy Remittance by changing their settings for the PROMIS^e™ Website or by contacting the appropriate Provider Assistance Center.

For questions concerning the information contained on the RA Statement, access Section 8 (Remittance Advice). If additional assistance is needed, contact the appropriate Provider Service Center at DHS.

CMS-1500 Claims (Hardcopy Submission)

Mail completed CMS-1500 Claim Forms (claim forms and claim adjustments) to:

Department of Human Services
Office of Medical Assistance Programs
P.O. Box 8194
Harrisburg, PA 17105-8194

Please see Appendix A, Billing Guides. Click on the top link to go to the main list of Billing Guides. Once there, click on the provider/specialty-appropriate link on the Billing Guide page to find detailed instructions on the proper completion of the CMS-1500 Claim Form.

1. Special Notes for Submitting the CMS-1500
 - Signature Transmittal Form (MA 307)

Providers billing on continuous print claim forms must follow DHS's regular billing requirements with the exception of the following items. No special enrollment arrangements are necessary to utilize this billing mode.

The MA 307 must have a handwritten signature or signature stamp of a Service Bureau representative, the provider, or his/her designee.

- Before submitting continuous-fed claims for payment, the claims must be separated and batched according to the individual provider who rendered the services
- When submitting claims, you must include individual provider numbers in the spaces provided on the MA 307. The MA 307 must then be submitted with the corresponding batches of individual provider's claims
- The MA 307 contains ten spaces for ten different provider numbers. If you are submitting more than ten batches of continuous-fed claim forms, for more than ten individual providers, more than one signed MA 307 should accompany the batches of claim forms

2. Optical Character Recognition (OCR)

DHS has optical scanning as an alternative mechanism for claims processing.

Optical scanning is a process whereby special equipment reads typewritten or computer-printed information on a claim form. Since image scanning eliminates the need for data entry, providers can expect improvement in the accuracy and timeliness of claims processed.

- Guidelines for OCR Processing

To take advantage of OCR processing, claim forms must be typed or computer-printed in black or blue ink. Change the ribbon frequently to obtain clear and readable information. Center the data in each block using 10 or 12 character per inch font. Do not combine handwriting (other than signatures) and machine print on the claim form. Additionally, do not use special characters, such as periods, \$, etc., or space between data in the blocks. Do not use script or compressed print. Claim forms must not be folded.

For more information concerning the OCR billing mode, contact:

HPE/PA PROMIS^e[™]
1250 Camp Hill Bypass Suite 100
Mail Stop 2-200
Camp Hill, PA 17011-3700
Telephone: 800-248-2152 (in-state only)
717-975-4100 (local)

3. Beneficiary Signature Requirements

Providers who bill via continuous print claim forms (pinned) or electronic media must retain the beneficiary's signature on file using the Encounter Form (MA 91). (See Appendix D, Special Forms, of this handbook.) The purpose of the beneficiary's signature is to certify that the beneficiary received the service from the provider indicated on the claim form and that the beneficiary listed on the Pennsylvania ACCESS Card is the individual who received the service.

When keeping beneficiary signatures on file, the following procedures shall be followed:

- Obtain the signature of the beneficiary or his/her agent for each date for which services were furnished and billing is being submitted to DHS for payment. Obtain the signature on the Encounter Form with the patient's 10-digit beneficiary number, taken from his/her Pennsylvania ACCESS Card
- The Encounter Forms containing the beneficiary's signatures must be retained on file for a period of at least four years, independently from other medical records, and must be available for reviewing and copying by State and Federal officials or their duly authorized agents
- Fee-for Service and OLTL providers may photocopy and use the sample Encounter Form in Appendix D, Special Forms, of this

handbook. A separate Encounter Form must be used for each beneficiary (HIPAA Privacy). Currently, the Encounter Form can be obtained via the MA Provider Order Form (MA 300X) or a printable version is available on DHS's Website at

<http://www.dhs.state.pa.us/dhsassets/maforms/index.htm>

- The Encounter Form for services administered by the Office of Mental Health and Substance Abuse Services is not available for ordering using the MA 300X from Medical Assistance. Providers may photocopy the Encounter Form from Appendix D, Special Forms, from this handbook or make their own forms, which must include all necessary information as illustrated in Appendix D.

Situations, which do not require a beneficiary's signature, also do not require the Encounter Form (See Section 6, Provider Information, for a complete list of DHS's exemptions to the signature requirements)

- Provider Responsibility

DHS will hold the provider, not the Service Bureau or billing agent, if one is used, responsible for any errors, omissions, and resulting liabilities which are related to any claim form(s) submitted to DHS for payment under the provider's name or PA PROMIS^e™ identification (ID) number.

2.6 Payment Process

PA PROMIS^e™ processes financial information up to the point of payment. PA PROMIS^e™ does not generate actual payments to providers. The payment process is managed by the Commonwealth's Treasury Department. Payments can take the form of checks or Electronic Funds Transfers (EFTs). PA PROMIS^e™ will produce a Remittance Advice (RA) Statement for each provider who has had claims adjudicated and/or financial transactions processed during the payment cycle.

Providers have the option of receiving a check via the mail from the Treasury Department or they may utilize a direct deposit service known as the Automated Clearinghouse (ACH) Program. This service decreases the turnaround time for payment and reduces administrative costs. Provider payments are deposited via electronic media to the bank account of the provider's choice. ACH is an efficient and cost effective means of enhancing practice management accounts receivable procedures. ACH enrollment information can be obtained from DHS's Website at:

<http://www.dhs.pa.gov/provider/doingbusinesswithdhs/electronicfundstransferdirectdepositinformation/index.htm>

2.7 Time Limits for Claim Submission

DHS must receive claim forms for submissions, resubmissions, and adjustment of claim forms within specified time frames; otherwise, the claim will reject on timely filing related edits and will not be processed for payment.

2.7.1 Office of Medical Assistance Programs (OMAP), Office of Mental Health and Substance Abuse Services (OMHSAS), and Office of Long-Term Living (OLTL)

<http://www.pacode.com/secure/data/055/chapter1101/s1101.68.html>

2.7.2 Office of Developmental Programs (ODP) Base and Waiver Services

ODP requires direct service providers that render and bill for Consolidated and Person/Family Directed Support (P/FDS) Waiver-funded services to submit original claims within 180 calendar days of the initial date of service. Providers who submit base-funded claims are not subject to the timely filing regulations. Providers who render base funded services should consult with the applicable county program regarding local policies.

Original Targeted Services Management (TSM) and Supports Coordination (SC) claims must be marked as billable in the Home and Community Services Information System within seven (7) calendar days from the date of contact with the individual. See Bulletin # 00-10-06 for the policy and requirements specific to ODP.

2.7.2.1 ODP 180 calendar day exception request criteria for base and waiver services

ODP will consider a request for a 180 calendar day exception if it meets one of the following criteria:

- An individual's waiver eligibility determination was requested within 60 calendar days of the date of service and the Department has received an invoice exception request from the provider within 60 calendar days of receipt of the eligibility determination.
- ODP waiver-funded services that require prior authorization in the Medicaid Management Information System (PROMIS^eTM) were retroactively prior authorized in PROMIS^eTM, which caused the invoice submission to occur 180 calendar days after the service was rendered. Retroactive prior authorizations may occur in PROMIS^eTM when additional documentation is requested from the provider, Supports Coordination Organization (SCO), or Administrative Entity (AE) before a prior authorization determination decision can be made.
- A claim denial has occurred because the service was not authorized on the Individual Supports Plan (ISP) prior to invoice submission. In order for a prior authorized service to be paid, it must first be authorized in PROMIS^eTM then authorized on the ISP, located in the Home and Community Services Information System (HCSIS), by the AE.
- The provider requested payment from a third party insurer within 60 calendar days from the date of service. ODP must receive the provider's 180 calendar day exception request within 60 calendar days of the date indicated on the third party denial or approval. (Refer to ODP Bulletin #00-94-14, TSM and Third Party Liability, in Appendix B of this handbook.)
- Due to a delay in the establishment of a provider's fiscal year rate.
- The provider is conducting transitional planning.

- A TSM or SC provider enrolls in the Medical Assistance (MA) Program to receive federal reimbursement for TSM or SC services and the service begin date is retroactive. The submission of billable service notes, via Home and Community Information System, for all days beyond the 180 calendar day limit, **due to late provider enrollment**, must be submitted within 90 calendar days of the actual provider enrollment date.

2.7.2.2 180-Day Exception Request for Process for Targeted Case Service Management ID (TSM-ID)

To submit a 180-day exception request for TSM-ID services, the provider must:

1. Verify that one or more of the criteria listed in Section 2.7.4 have been met.
2. Submit a completed claim form with the appropriate documentation along with the request to the appropriate ODP Regional Office. The Regional Office will forward the request along with its recommendation to ODP's Central Office. The ODP/TSM Regional Representatives are identified below:

ODP Central Region

Office of Mental Retardation
Harrisburg State Hospital
Willow Oak Building
Harrisburg, PA 17105
Telephone: (717) 772-6498

ODP Western Region

Office of Mental Retardation
300 Liberty Avenue
Pittsburgh, PA 15222
Telephone: (412) 565-5144

ODP Northeast Region

Office of Mental Retardation
100 Lackawanna Avenue
Scranton, PA 18503
Telephone: (570) 963-4749

ODP Southeastern Region

Office of Mental Retardation
1400 Spring Garden Street
Philadelphia, PA 19130-4064
Telephone: (215) 560-2247

Providers will receive a letter indicating DHS's decision

2.7.3 180 Day Exception Request Process (*Except OMHSAS Providers – See 2.7.4*)

DHS will consider a request for a 180-day exception if it meets at least one of the following criteria:

1. An eligibility determination was requested from the County Assistance Office (CAO) within 60 days of the date the service was provided. DHS 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 date of service. DHS 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 exception request, the provider must take the following

steps:

- Step 1 Review the claim to verify that it meets at least one of the above cited criteria.
- Step 2 Complete a claim form correctly (the claim form must be a signed original – no file copies or photocopies will be accepted).
- Step 3 Include all supporting documentation along with documentation to and from the CAO (dated eligibility notification) and/or third party insurer (explanation of benefits statement).
- Step 4 Complete a [180-Day Exception Request Detail Page](#) and submit it to DHS with each exception request. Instructions for completing the 180-Day Exception Request Detail Page can be found in Appendix D, Special Forms.

Please do not fold or staple your exception request documentation. Please use an “8½ by 11” envelope for mailing purposes.

Supporting documentation 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 a copy of the PA 162 form; and/or
- Evidence that a payment request was submitted to a third party insurer within 60 days of the end date of service and a copy of the third party’s explanation of benefits statement or Remittance Advice.

NOTE: The provider will identify and use all patient medical resources before billing DHS.

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

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

Medical Assistance (MA) providers must send the 180-Day Exception Request Detail Page, supporting documentation, and the original claim form(s) to:

Department of Human Services
180-Day Claims Exception Unit
P.O. Box 8042
Harrisburg, PA 17105-8042

Providers will only receive a letter stating DHS's decision if their exception was returned or denied. The fact that DHS approves a 180-day exception does not guarantee that the claim will not be rejected for reasons other than time requirements.

When a request for an exception is denied by the 180-Day Exception Unit, the provider will receive a Notice of Denial which includes appeal rights. **All appeals must be requested in writing within 33-days of the date of DHS's Notice of Denial.**

If the provider wishes to appeal the denial:

1. Complete all denied claims correctly.
2. Attach a copy of all documentation supporting your position to your appeal.
3. Include a cover letter stating that you hereby appeal the denial and the basis on which your appeal is being made. (The words "wish to appeal" must appear in the letter.)
4. Send all of the above information along with a copy of DHS's Notice of Denial to:

Bureau of Hearings and Appeals
2330 Vartan Way
Harrisburg, PA 17110
Attn: Provider Appeals

Please see [MA Bulletin 99-03-08](#), "Change to Protocol for Certain Provider Appeals".

NOTE: A copy of the appeal request and supporting documentation must also be sent to the program office that denied that 180-day exception request.

2.7.4 180-Day Exception Request Process for Office of Mental Health and Substance Abuse Services Providers

DHS's Office of Mental Health and Substance Abuse Services (OMHSAS) will consider a request for a 180-day exception if it meets one 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;
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; and/or
3. A provider enrolls in the MA Program, through OMHSAS, to receive federal reimbursement for mental health services when service delivery began prior to the enrollment date. Within six months of the enrollment date, the provider must complete and submit all claims in excess of 180 days. The claims must be submitted in one complete package for special processing.

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

1. Check the claim in question to determine if it meets one or more of the above-cited criteria;
2. Complete an original claim form (the claim form must be signed – no file copies or photocopies will be accepted);

3. Include all supporting documentation along with documentation to and from the third party insurer. Supporting documentation consists of the following:
 - a. Evidence that the Medical Assistance application was submitted to the CAO within 60 days of the end date of service, and/or
 - b. 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 of the patient's medical resources before billing the Department.)
4. Complete the 180-Day Exception Request Detail Page and submit it to the Department with each exception request. Instructions for completing the 180-Day Exception Request Detail Page can be found in Appendix D, Special Forms.
5. Do not fold or staple the forms (use a large envelope).

The Department may request additional documentation to justify approval of an exception. If the request is not received within 30 days of 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. Acceptance of claims is not an indication of approval for payment. Normal processing edits will still occur prior to payment.

Send the 180-Day Exception Request Detail Page, for MA funded mental health services only, supporting documentation and an original claim form(s) to:

Department of Human Services
Shamrock Hall, Building 31
112 East Azalea Drive
Harrisburg, PA 17110-3594
Attn: Business Partner Support Unit

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

When a request for an exception is denied by the 180-Day Exception Unit, the provider will receive a Notice of Denial which includes appeal rights. **All appeals must be requested in writing within 33-days of the date of DHS's Notice of Denial.**

If the provider wishes to appeal the denial:

1. Complete all denied claims correctly.
2. Attach a copy of all documentation supporting your position to your appeal.
3. Include a cover letter stating that you hereby appeal the denial and the basis on which your appeal is being made. (The words "wish to appeal" must appear in the letter.)
4. Send all of the above information along with a copy of DHS's Notice of Denial to:

Bureau of Hearings and Appeals
2330 Vartan Way
Harrisburg, PA 17110
Attn: Provider Appeals

Please see [MA Bulletin 99-03-08](#), “Change to Protocol for Certain Provider Appeals”.

2.7.5 OLTL Waiver Provider Handbook Guidelines:

OLTL will consider a request for a 180-day exception if it meets one of the following criteria:

- An individual’s waiver eligibility determination was requested within 60 calendar days of the date of service and OLTL has received an invoice exception from the provider within 60 calendar days of receipt of the eligibility determination.
- A claim denial has occurred because the service was not authorized on the Individual Service Plan (ISP) prior to invoice submission. In order for a prior authorized service to be paid, it must first be authorized on the ISP. OLTL must receive an invoice exception from the provider within 60 calendar days of the service authorization.
- The provider requested payment from a third party insurer within 60 calendar days from the date of service. OLTL must receive the provider’s 180-day exception request within 60 calendar days of the date indicated on the third party denial or approval.

OLTL 180-Day Exception requests should be submitted to the following address for consideration:

Department of Human Services
Office of Long Term Living
Provider Operations Section
P.O. Box 8025
Harrisburg, PA 17105-8025
Attn: 180 Day Exceptions

2.8 Internal Control Number (ICN)

Paper claims with attachments, paper claims without attachments and Special Handle claims processed via PA PROMIS^e™ will be assigned a 13-digit Internal Control Number (ICN) upon receipt. The ICN is returned to providers in the first column of the Remittance Advice (RA) Statement. The ICN consists of the following elements:

Internal Control Number (ICN) Format			
Region Code RR	Year and Julian Day YY JJJ	Batch Number BBB	Claim Sequence SSS
10	11 096	612	023

The first two digits of the ICN are the [region code](#). This code is used by PA PROMIS^e™ to denote the type of claim being processed.

The third and fourth digits of the ICN denote the year the claim was received into PROMIS^e™. For example, if the claim was received in 2011, the third and fourth digits will be “11”.

The fifth, sixth, and seventh digits denote the Julian Day. In this example 096 is April 6th.

The eighth through 10th digit is the Batch Number and the 11th through the 13th digit is the Claim Sequence. The Batch Number and Claim Sequence are used internally by DHS.

When resubmitting a previously rejected claim, it is imperative that you use the original rejected ICN in Block 22 (Medicaid Resubmission) of the CMS-1500 Claim Form.

Electronic, internet, Point of Service (POS), and single adjustments submitted electronically through BES or Internet and all Mass Adjustments will be assigned a 13-digit Internal Control Number (ICN) upon receipt. The ICN is returned to providers in the first column of the Remittance Advice (RA) Statement. The ICN consists of the following elements (This new format was effective 06/26/2015):

Internal Control Number (ICN) Format

Region Code RR	Year and Julian Day YY JJJ	Claim Sequence # SSSSSS
20	11 096	321654

The first two digits of the ICN are the [region code](#). This code is used by PA PROMIS^e™ to denote the type of claim being processed.

The year and Julian day (**YY JJJ**) comprise the next five digits, with the first two digits being the year and the next three being the Julian day.

The last six digits represent the claim sequence number (**SSSSSS**).

Sequences for all applicable regions will start at 000001 with the following exceptions:

- Region 77 will start at 2000
- Region 87 will start at 10000

2.9 Inquiries

Providers across the Commonwealth have multiple ways to make general inquiries, such as the PA PROMIS^e™ Internet Applications and the Provider Service Center. The following sections explain the various tools providers have at their disposal.

2.9.1 PA PROMIS^e™ Internet Applications

Via the PA PROMIS^e™ Internet Applications, providers can review information for specific procedures, drugs and diagnoses, and eligibility limitation information. Providers can review and download remittance advice statements for the past two years and print an Adobe Acrobat (.PDF) copy of their original paper Remittance Advice (RA) Statement.

Providers can download or review Provider manuals, forms, etc., from the DHS website. Additionally, providers can electronically file claims from any location connected to the Internet, retrieve electronic copies of RA statements, and verify beneficiary eligibility. Providers can review the status of claims submitted to DHS for payment and can review specific Error Status Codes (ESC) and HIPAA Adjustment Reason Codes for rejected claims.

For more information on the Internet tools available and instructions on accessing the tools, please refer to Appendix C, Provider Internet User Manual, of this handbook..

2.9.2 Medical Assistance Program Provider Inquiry

2.9.2.1 Provider Service Center

The Provider Service Center will be open from 8:00 a.m. to 4:30 p.m., Monday through Friday, to assist providers with their questions/inquiries. Please contact the [appropriate toll-free telephone number](#) for assistance. All questions regarding claim form completion or billing procedures and policy plus questions regarding claim status or inappropriate payments should be directed to:

Department of Human Services
Office of Medical Assistance Programs
Provider Service Center
P.O. Box 8050
Harrisburg, PA 17105-8050

2.9.2.2 Long Term Care Provider Services Inquiry Lines

The Long Term Care Provider Services Inquiry Lines are available from 9:00 a.m. 12:00 noon and 1:00 p.m. to 4:00 p.m., Monday through Thursday, to assist providers with their questions/inquiries. Please see Important Telephone Numbers and Addresses on the DHS Website for the appropriate toll-free telephone number for your provider type.

2.9.3 Office of Mental Health and Substance Abuse Services – Technical Assistance

OMHSAS operates a provider inquiry line which is operational 24 hours a day, seven days a week. The inquiry line is intended to assist providers of Medicaid funded mental health services, HealthChoices counties, HealthChoices Managed Care Organizations, and behavioral health HealthChoices providers in billing and daily operations. Calls are answered live Monday through Friday 8:30 a.m. until 4:00 p.m. Calls received outside of normal business hours will be directed to voice mail. Please utilize the appropriate e-mail address or the appropriate toll-free telephone number for your provider type.

For additional information on OMHSAS related services, you can e-mail OMHSAS at HC-Services@pa.gov or via US Postal Service at the following address:

Department of Human Services
Office of Mental Health and Substance Abuse Services
Shamrock Hall, Building 31
112 East Azalea Drive
Harrisburg, PA 17110-3594
Attn: Medicaid Business Partner Support Unit

2.9.4 Targeted Services Management – Intellectual Disabilities (TSM-ID) Technical Assistance

The TSM-ID Program offers assistance with PA PROMISE™ invoicing procedures and policy questions. Periodically, optional seminars may be offered to familiarize new providers with the PA PROMISE™ Program and to present information on program changes to the provider community.

For information on TSM training, please call or write to:

Department of Human Services

Office of Developmental Disabilities
Targeted Service Management Program
P.O. Box 2675
Harrisburg, PA 17105-2675
Telephone: (717) 705-3760
Fax: (717) 787-6583

2.9.5 MA Tele-Response System

The MA Tele-Response System provides voice-recorded messages to the most frequently asked questions, which do not require dialogue with a service representative.

The MA Tele-Response System is available 24-hours a day, seven days a week. You must have a touch-tone telephone or tone generator pad to use it.

For General Information, providers may call the MA Tele-Response System at **1-877-787-6397**.

When you call the MA Tele-Response System, you will hear the following options:

- Press 1 For information on the last three Remittance Advice Cycles and Check mail date information.
- Press 2 For information on how to report non-receipt of a check or Remittance Advice Statement.
- Press 3 For information regarding provider enrollment in the PA PROMIS^e™ Program, or how to report practice address or personnel changes.
- Press 4 For information on invoice submission time frames and reconciling claims.
- Press 5 For information on where to submit claim forms and information on billing electronically.
- Press 6 For information on NDC compensability, or information on how to determine beneficiary eligibility.

2.10 Claim Adjustments/Claim Voids

There will be times when it is necessary to correct an approved claim (i.e., a claim that has appeared on your RA Statement as “Paid”) when payment was received in error.

When a claim is paid in error (overpaid or underpaid), DHS will offset/adjust future payment(s) to the provider to either:

- Recoup any money owed; or
- Compensate a provider if the provider was underpaid

Claim adjustments **can** be used to:

- Adjust only a paid claim

- Use claim frequency – 7 for adjustment
- Insert the last paid claim ICN in original claim # field
- Complete claim as it should have been submitted originally

You **cannot** use a claim adjustment to:

- Correct a rejected claim
- Correct a pended/suspended claim
- Correct a claim that never appeared on an RA Statement
- Correct a beneficiary number or provider number

Claim voids **can** be used to:

- Void only a paid claim
 - The claim has wrong beneficiary or provider ID
 - Claim was incorrectly submitted and should never have been filed originally
 - A procedure code was submitted incorrectly (for ODP providers Only)
 - Claim frequency – 8 for void
- Insert paid claim ICN in original claim # field

2.10.1 Completing a Claim Adjustment

The CMS-1500 Claim Form is used to submit claims for payment as well as to submit claim adjustments when you are in receipt of an overpayment or underpayment. It is important to note that when submitting a claim adjustment on the CMS-1500, the claim adjustment will be completed using the provider and beneficiary information exactly as entered on the original claim being adjusted. For claim line information, copy the corresponding information from the original claim for all items, which remain unchanged. Where a correction is necessary, enter the correct information.

When completing the CMS-1500 to adjust a claim that was paid in error, in addition to using the corresponding information from the paid claim, complete the following blocks:

- Block 19 (Reserved for Local Use) – Enter Attachment Code AT99 to indicate that remarks are attached. Attach an 8½ by 11 sheet of paper to the CMS-1500 containing an explanation as to why you are submitting a claim adjustment (e.g., the claim was paid under the wrong provider number or you billed for an incorrect number of units, etc.) Be sure to list the beneficiary’s name and beneficiary identification number and the provider’s name and 9-digit provider number and 4-digit service location in the upper left corner of the attachment. This information will provide assistance in the event that the attachment becomes separated from the claim. This will assist the claims processor in matching the attachment back to the claim.
- Block 22 (Medicaid Resubmission) – Enter the letters “ADJ” in the left portion of this block. Enter the 13-digit internal control number (ICN), a space, and the line number of the

claim, which paid in error. If your claim was submitted prior to the implementation of PA PROMIS^e™, enter the 10-digit claim reference number (CRN) in place of the ICN.

You may claim adjust more than one claim line on a single claim adjustment. Keep in mind that all claim lines associated with the original claim processed will be assigned a new, adjusted Internal Control Number (ICN). Consequently, you may only be adjusting one claim line on a claim where you had originally submitted three claim lines. Although you may be adjusting only one claim line, the new adjusted ICN is assigned to all of the lines appearing on the last paid claim form. If you are adjusting multiple claim lines from a single claim form, again, all of the claim lines associated with the last paid claim form will receive the new, adjusted ICN.

If you need to submit a claim adjustment on a previously adjusted claim, you must use the *last approved ICN* to adjust another claim line on a previously adjusted claim.

2.10.2 Examples of Claim Adjustments/Voids Using the CMS-1500

Example #1 Adjustment If you have billed for 1 unit totaling \$55.00 and the claim was paid but should have billed for 2 units totaling \$110.00, then you should adjust the claim. Change the units to 2 and change the amount to \$110.00. Make sure everything else is as you originally wanted it to be, and resubmit the claim, referencing the last paid claim number.

Example #2 Adjustment If you have billed using one specific procedure code and the claim was paid, but you realized that you used the wrong procedure code, then you should adjust the claim. Change incorrect procedure code to the correct procedure code, making sure that everything else is correct and as you originally wanted it to be. Then resubmit the claim, making sure to reference the last paid claim in the reference field.

Example #1 Void If you have billed the wrong billing provider service location, but the claim paid, then you need to void the claim. You need to bill the claim again, using the correct service location.

Example #2 Void If you see twins, and you billed for seeing one twin but really saw the other twin, but the claim paid, then you need to void the claim. Once you void the claim, you need to rebill it using the correct twin's beneficiary ID number.

Please note that DHS **does not require** providers to submit claim adjustments for an amount **less than one dollar**.

2.11 Ordering Forms

The following sections detail the various forms providers may need when billing PA PROMIS^e™ and the addresses, telephone numbers, and Website, when available, for obtaining these forms.

2.11.1 Medical Assistance Forms

Providers may order MA forms via the MA 300X (MA Provider Order Form) or by accessing DHS's website site at:

<http://www.dhs.state.pa.us/dhsassets/maforms/index.htm>

For providers who do not have access to the Internet, the MA 300X can be ordered directly from DHS's printing contractor:

Department of Human Services
MA Forms Contractor
P.O. Box 60749
Harrisburg, PA 17106-0749

Additionally, providers can obtain an order form by submitting a request for the MA 300X, in writing, to:

Department of Human Services
Office of Medical Assistance Programs
Division of Operations
P.O. Box 8050
Harrisburg, PA 17105

You can expect to receive your forms within two weeks from the time you submit your order. This quick turnaround time on delivery is designed to eliminate the need for most emergencies. You should keep a three to six month supply of extra forms, including order forms, on hand and plan your ordering well in advance of exhausting your supply.

The MA 300X can be typed or handwritten. Photocopies and/or carbon copies of the MA 300X are not acceptable. *Orders must be placed on an original MA 300X.*

The MA 300X is continually being revised as forms are added or deleted. Therefore, you may not always have the most current version of the MA 300X form from which to order. You need to be cognizant of MA Bulletins and manual releases for information on new, revised, or obsolete forms so that you can place your requisitions correctly. If a new MA form is not on your version of the MA 300X, you are permitted to add the form to the MA 300X.

Please note that forms specific to services administered by the Office of Mental Health and Substance Abuse Services may not be available for ordering using the MA 300. Please contact OMHSAS via email at HC-Services@state.pa.usa or you may call OMHSAS Provider Inquiry at 800-433-4459.

2.11.2 CMS-1500 Claim Form

DHS does not provide CMS-1500 claim forms. Providers may review the information listed below to obtain CMS-1500 claim forms for paper claim form submission.

To obtain copies of the CMS-1500 claim form:

- Contact the US Government Printing Office at (202) 512-1800 or your local Medicare carrier. You may access the Website at <http://bookstore.gpo.gov>. For a list of local Medicare carriers in your state, including their telephone number, please go to the Medicare Regional Homepage
- Contact the American Medical Association Unified Service Center at 800-621-8335.

3 Policies

Policies are located on the Pennsylvania (PA) Code Website. Listed below are the hyperlinks to the applicable regulations and PA PROMISE™ policies.

Attendant Care	Chapters 1101 , 1150 , 1249 , & 1153
Audiologist	Chapters 1101 and 1150
Birthing Centers	Chapters 1101 , 1150 , & 1127
Case Manager	HIV Case Management – Chapters 1101 , 1150 , & 1247
Certified Registered Nurse Anesthetist (CRNA)	Chapters 1101 & 1150
Certified Registered Nurse Practitioner (CRNP)	Chapters 1101 , 1150 , & 1144
Chiropractor	Chapters 1101 , 1150 , & 1145
Clinic	Independent Medical/Surgical Clinic – Chapters 1101 , 1150 , & 1221 Outpatient Drug & Alcohol Clinic – Chapters 1101 , 1150 , & 1223 Outpatient Psychiatric Clinic – Chapters 1101 , 1150 , & 1153
COMMCARE Waiver	Chapters 1101 , 1150 , & TBD
Department of Health	To Be Determined
Employment Competitive	To Be Determined
EPSDT Screen Instructions for Outpatient Hospitals	Chapters 1101 , 1150 , 1241 , & 1221
Extended Care Facilities (Respite Care)	To Be Determined
Family Planning (Title XIX Only)	Chapters 1101 , 1150 , & 1225
Funeral Director	Chapters 1101 , 1150 , & 1251

Healthy Beginnings Program (HBP)	Chapters 1101 , 1150 , & 1140
Home and Community Habilitation	Chapters 1101 & 1150
Home Health Agency	Chapters 1101 , 1150 , & 1249
Home Residential Rehab	Chapters 6400 & 6500
Homemaker Agency	Chapters 1101 , 1150 , & 1249
Hospice	Chapters 1101 , 1150 , & 1130
Independence & OBRA Waiver	To Be Determined
Intermediate Service Organization (ISO)	Chapters 1101 & 1150
Laboratory	Chapters 1101 , 1150 , & 1243
Long Term Care (LTC) Facility – Medicare Deductible and Coinsurance	Chapters 1101 , 1150 , & 1187
LTC Exceptional Grant Payment	Chapters 1101 , 1150 , & 1187
Medical Assistance Early Intervention (MA EI), EI Base, and Infants, Toddlers & Families (ITF) Waiver	Chapters 1101 & 1150
Medical Suppliers	Chapters 1101 , 1150 , & 1123
Medically Fragile Foster Care	Chapters 1101 & 1150
Mental Health & Substance Abuse Services	Outpatient Psychiatric Partial Hospitalization Facility – Chapters 1101 , 1150 , & 1153 Family Based Mental Health & Crisis Intervention – Chapter 1101 & To Be Determined
Mental Retardation Targeted Services Managements (MR-TSM)	To Be Determined
Michael Dallas Waiver	Chapters 1101 & 1150
Midwives	Chapters 1101 , 1150 , & 1142

Non-JCAHO Residential Treatment Facilities (RTFs)	Chapters 1101 & 1150
Nurse	Chapters 1101 , 1241 & 1150
Nutritionist	Chapters 1101 & 1150
ODP Base Services	To Be Determined
ODP Consolidated Waiver	To Be Determined
ODP Person/Family Directed Supports (P/FDS) Waiver	To Be Determined
Optometrists	Chapters 1101 , 1150 , & 1147
PDA Waiver & BRIDGE	Chapters 1101 & 1150
Physicians	Chapters 1101 , 1141 , & 1150
Podiatrists	Chapters 1101 , 1143 , & 1150
Psychologists	Chapters 1101 & 1150
Public Schools	To Be Determined
Rehab Facility	Chapters 1101 & 1150
Renal Dialysis Center	Chapters 1101 , 1128 , & 1150
Rural Health Clinic (RHC)/Federally Qualified Health Center (FQHC)	Chapters 1101 , 1150 , & 1129
School Corporation	To Be Determined
Special Pharmaceutical Benefits Program (SPBP)	To Be Determined
Targeted Case Management	Chapters 1101 , 1247 , & 1150
Therapist	Chapters 1101 & 1150
Tobacco Cessation	Chapters 1101 & 1150

Transportation (Ambulance)	Chapters 1101 , 1245 , & 1150
Transportation (Medical Assistance Transportation (MATP))	To Be Determined
Vendor	To Be Determined
X-Ray Clinic	Chapters 1101 , 1230 , & 1150

4 Beneficiary Eligibility

This section explains the Eligibility Verification System (EVS), and how to verify beneficiary eligibility. It describes identification cards; all relevant beneficiary information supplied to providers and also details each eligibility verification access method available and how to use it.

Individuals eligible for Medical Assistance (MA) in Pennsylvania may have medical coverage under one of two delivery systems; through a traditional Fee-for-Service (FFS) system or a Managed Care Organization (MCO).

4.1 Pennsylvania ACCESS Card

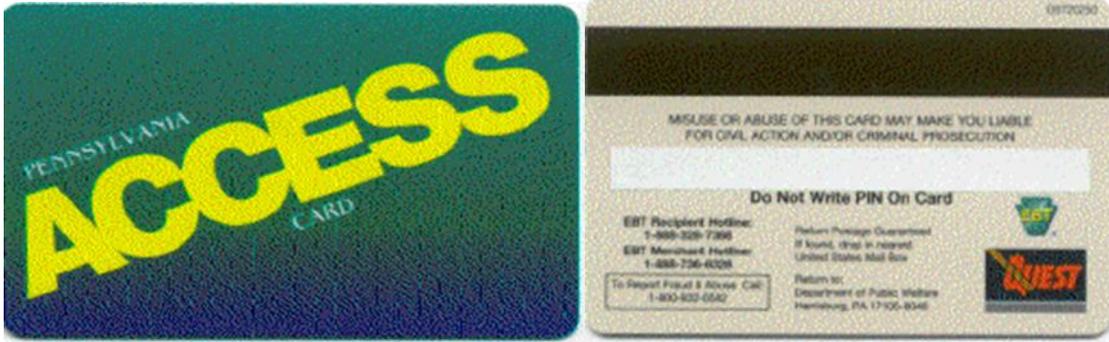
The following details the two types of Pennsylvania ACCESS cards providers may encounter.

4.1.1 Pennsylvania ACCESS Card (Medical Benefits Only)

Eligible beneficiaries (including those beneficiaries enrolled in an MCO) will have a permanent plastic identification card that identifies their eligibility for covered MA services. The plastic card, known as the “Pennsylvania ACCESS Card”, resembles a yellow credit card with the word “ACCESS” printed across it in blue letters. Beneficiary information is listed on the front of the card and includes the full name of the beneficiary, a 10-digit beneficiary number, and a 2-digit card issue number. The back of the ACCESS card has a magnetic stripe for “swiping” through a personal computer (PC) with an attached card reader to access eligibility information through the Eligibility Verification System (EVS). The back of the card also has a signature strip, a return address for lost cards and a misuse or abuse warning.

Beneficiaries who are eligible for medical benefits only will receive the yellow ACCESS card.

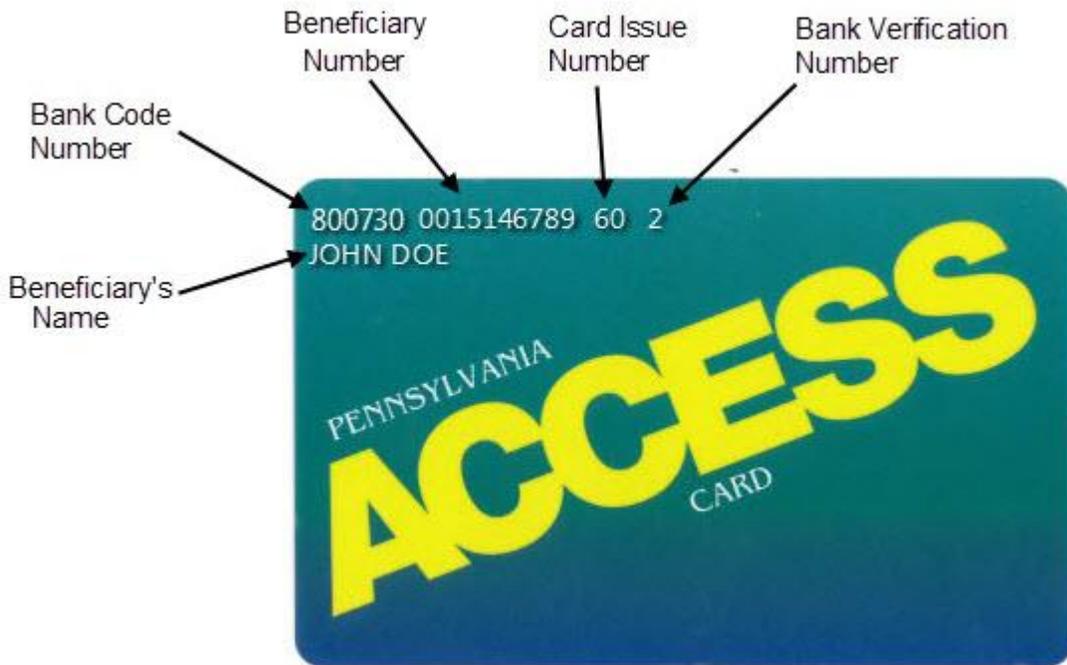




4.1.2 Electronic Benefits Transfer (EBT) ACCESS Card

The Electronic Benefits Transfer (EBT) ACCESS card is blue and green in color with the word “ACCESS” printed in yellow letters. This card is issued to MA beneficiaries who receive cash assistance and/or SNAP (Supplemental Nutritional Assistance Program) as well as medical services, if eligible. The card is issued to individuals who are the payment names for cash and/or SNAP benefits. Remaining household members are issued the yellow ACCESS card, as well as beneficiaries who are eligible for MA only.

Providers must verify eligibility through EVS when presented with either card to ensure beneficiary is eligible prior to rendering services.



4.1.3 Beneficiary Number and Card Issue Number

The Pennsylvania ACCESS cards contain a 10-digit beneficiary number followed by a 2-digit card issue number. The 10-digit beneficiary number is a number permanently assigned to each

beneficiary. The beneficiary number and card issue number is the preferred method to access DHS's Eligibility Verification System (EVS).

Providers must use the 10-digit beneficiary number when billing for services. The card issue number is used as a security measure to deter fraudulent use of a lost or stolen card.

4.1.4 Lost, Stolen or Defective Cards

When a Pennsylvania ACCESS card is lost or stolen, the beneficiary should contact his/her County Assistance Office (CAO) caseworker to request a replacement card. The card issue number is voided to prevent misuse when the new card is issued. A replacement card should be received in seven to ten business days of request. If a card is needed immediately, an interim paper card can be issued by the CAO. This ensures beneficiaries of uninterrupted medical services. The interim card contains the same Beneficiary Number and Card Issue Number as the previous ACCESS card. It is advisable that you request additional identification when presented with an interim card.

To accurately determine whether the card presented is valid, a provider will need to check the beneficiary's eligibility via the RID (Beneficiary ID) and Card Issue number search—Other search methods, if correct information is supplied, will not notify the provider if the presented card is lost or stolen.

The EVS will return an error response if a wrong or previous card issue number is submitted. Use of alternative search methods, while acceptable, will not confirm the card presented is valid. If the ACCESS card is damaged or defective, e.g., if the magnetic stripe does not swipe, instruct the beneficiary to return the defective card to the CAO and request a replacement card.

4.2 Eligibility Verification System

The Eligibility Verification System (EVS) enables providers to determine an MA beneficiary's eligibility as well as their scope of coverage. Please do not assume that the beneficiary is eligible because he/she has an ACCESS card. It is vital that you verify the beneficiary's eligibility through EVS each time the beneficiary is seen. EVS should be accessed on the date the service is provided, since the beneficiary's eligibility is subject to change. Payment will not be made for ineligible beneficiaries.

4.3 Methods to Access EVS

Providers or approved agencies can access EVS through one of four access methods.

4.3.1 Automated Voice Response System (AVRS)

You may access EVS via the AVRS through a touch-tone telephone. The EVS telephone access system is available 24 hours a day, seven days a week. The toll-free number is 1-800-766-5387.

The EVS Response Worksheet (MA 464) is a form designed to capture beneficiary information obtained through an EVS verification inquiry. A copy of the form is illustrated in Appendix D, Special Forms, of this handbook. The form can be printed from the Medical Assistance Forms page of the DHS website at:

<http://www.dhs.state.pa.us/dhsassets/maforms/index.htm>

4.3.2 Value Added Networks (VAN)

VAN (PC/POS) collects requests for eligibility information in a real-time interactive processing mode. Both personal computer (PC) software and point-of-service (POS) devices will use this method to gather eligibility information.

4.3.3 PROMIS^e™ Provider Portal (Web Interactive)

The PROMIS^e™ Portal allows registered users to conduct interactive eligibility checks from a computer terminal. User's complete the required data fields on the eligibility screen and then submit the request for an immediate response.

4.3.4 Batch Submissions

Batch EVS transactions in ANSI 5010 270/271 format can be submitted to the Batch Bulletin Board System (BBS). The BBS maintained by Hewlett Packard Enterprises enables providers to upload eligibility requests and download eligibility responses. Currently, the Provider Electronic Solutions Software (PES) utilizes the bulletin board to provide eligibility responses upon receipt of a request. Providers can create their own solution or purchase commercial available software however any software utilized must be certified by HPE prior to accessing the production BBS.

4.4 HIPAA 270/271 – Health Care Eligibility Benefit Inquiry/Response

EVS will accept and return the standardized electronic transaction formats for eligibility requests and responses as mandated by the Health Insurance Portability and Accountability Act (HIPAA). The eligibility *request* format is called the HIPAA 270 Health Care Eligibility Benefit Inquiry format (also known as 270 Eligibility Inquiry). The eligibility *response* format is called the HIPAA 271 Health Care Eligibility Benefit Response (also known as 271 Eligibility Response). Both formats may also be referenced by the 3-digit transaction number: 270 and 271. Providers and other approved agencies that submit electronic requests in the 270 format will receive an EVS response with eligibility information in the 271 format.

4.4.1 User Identification (ID) and Password

4.4.1.1 Internet Interactive

When accessing EVS via the PROMIS^e™ Provider Portal, providers must create a User ID and Password. In addition, users will need to create challenge questions and select both a site key and associated passphrase. After the initial setup, providers must utilize their User ID, password and challenge questions every time the PROMIS^e™ Provider Portal is accessed.

For more information on use of the PROMIS^e™ Provider Portal, please refer to the PROMIS^e™ Provider Internet User Manual at:

<http://promise.dpw.state.pa.us/promisehelp/manuals/PROMISeProviderInternetUserManual.pdf>

4.4.2 BBS User Identification and BBS Password

4.4.2.1 BBS

When accessing the EVS via the Batch method, BBS, providers/users will need a BBS User ID and a BBS password.

4.4.3 EVS Search Options

You have four options to search for beneficiary eligibility information. You must use your 9 – digit provider number and 4-digit service location to obtain eligibility information.

To search for beneficiary information, you may use the:

- 10-digit Beneficiary Identification number (RID) and the 2-digit card issue number from the beneficiary's ACCESS card,
- 10-digit Beneficiary Identification number (RID) and beneficiary's DOB. (not available with the AVRS),
- Beneficiary's social security number (SSN) and the beneficiary's date of birth (DOB) or,
- Beneficiary's first and last name and the beneficiary's DOB (not available with the AVRS)

You must identify the date of service for which you wish to verify eligibility. Eligibility can be searched for a single day or span-dates for a maximum of 30 days. A query can request eligibility for future dates up to the end of the current month. EXAMPLE: If today's date is 6/14/2014, a provider could submit an eligibility query for dates of services 6/1/14 through 6/30/14. The EVS would return all eligibility segments for the entire month of June.

4.4.4 Eligibility Requests within Two Years of the Date of Service

If an MA beneficiary is eligible for medical benefits, EVS will provide a comprehensive eligibility response. Although you have the ability to verify eligibility for beyond two years from the current date, you must access EVS on the date you intend to provide service to the beneficiary. The eligibility response will include the following information:

Beneficiary Demographics

- Name
- Beneficiary ID
- Gender
- Date of birth

Eligibility Segments

- Begin date and end date
- Eligibility status (as defined by HIPAA)
- Category of assistance
- Program status code
- Service program description

Managed Care Organization (MCO) (Physical), Family Care Network (FCN), and the Long Term Care Capitated Assistance Program (LTCCAP)

- Plan name/code and phone number
- Primary Care Provider (PCP) name and phone number, begin and end dates (up to 3 PCPs will be returned)
- Primary Care Case Manager (PCCM) name and phone number

- Begin and end date (if different from inquiry dates)
- Managed Care Organization (MCO) (Behavioral)
- Plan name/code and phone number
- Begin and end date (if different from inquiry dates)

Third Party Liability (TPL)

- Carrier name/type
- Address of carrier
- Policyholder name and number (except for Medicare Part A or Part B)
- Group number
- Patient pay amount associated to a beneficiary and provider during a given time period
- Court ordered indicator
- Begin and end dates (if different from inquiry dates)
- Lock In or Restricted Beneficiary Information
- Status (Y = Yes/N = No)
- Provider type
- Provider name and phone number
- Narrative (restrictions do not apply to emergency services)
- Begin and end date (if different from inquiry dates)
- Limitations.
- Procedure code and NDC (FFS only, not available when accessing EVS using the AVRS)

EPSDT

- Last screen date (for under 21 only)

Dental

- Last dental visit (for under 21 only)

Patient Financial Responsibility

- Co-payment
- Deductible

This information will be available to the provider for two years following the date of service.

4.4.5 Eligibility Requests More Than Two Years from the Date of Service

For eligibility inquiries on information older than two years, EVS will return a reduced list of basic eligibility information. The basic eligibility information provided when inquiring about a beneficiary's eligibility more than two years from the date of service is as follows:

Beneficiary Demographics

- Name
- Beneficiary ID
- Gender
- Date of birth

Eligibility Segments

- Begin date and end date
- Eligibility status (as defined by HIPAA)
- Category of assistance
- Program status code
- Service program description

4.5 Provider Assistance for EVS Software Problems

HPE maintains and staffs an inquiry unit called the "Provider Assistance Center" (PAC), to provide you with swift responses to inquiries and resolution of problems associated with the EVS function of the Provider Electronic Solutions Software. This service is available from 8:00 a.m. until 5:00 p.m., Eastern Standard Time, Monday through Friday (except holidays), at 1-800-248-2152.

4.6 Beneficiary Restriction/Centralized Lock-In Program

DHS's Beneficiary Restriction/Centralized Lock-In Program restricts those beneficiaries who have been determined to be abusing and/or misusing MA services, or who may be defrauding the MA Program. The restriction process involves an evaluation of the degree of abuse, a determination as to whether or not the beneficiary should be restricted, notification of the restriction, and evaluation of subsequent medical assistance services. DHS may not pay for a service rendered by any provider other than the one to whom the beneficiary is restricted, unless the services are furnished in response to an emergency or a Medical Assistance Beneficiary Referral Form (MA 45) is completed and submitted with the claim. The MA 45 must be obtained from the practitioner to whom the beneficiary is restricted.

A beneficiary placed in this program can be locked-in to any number of providers at one time. Restrictions are removed after a period of five years if improvement in use of services is demonstrated.

If a beneficiary is restricted to a provider within your provider type, the EVS will notify you if the beneficiary is locked into you or another provider. The EVS will also indicate all type(s) of provider(s) to which the beneficiary is restricted.

NOTE: Valid emergency services are excluded from the lock-in process.

4.7 Patient Financial Responsibility

The Eligibility Verification System will return patient financial responsibility information to the provider for transactions submitted with dates of service on or after 1/1/2013. This information will be displayed for up to two years from the date of service searched (unless the date searched is prior to 1/1/2013). Please reference [Quick Tip #148](#) for additional information.

4.7.1 Collection of Medical Assistance Beneficiary Copayment

Federal law permits the MA Program to require beneficiaries (FFS only) to pay a small copayment for most medical services. Providers will ask for the copayment when the medical service is rendered.

A beneficiary is obligated to pay a copayment for each unit of service provided; however, if the beneficiary is unable to pay, the service may not be denied. If copayment applies to the service provided, MA will automatically compute and deduct the copayment from the provider's payment, even if it is not collected.

For most medical services, the amount of the copayment is determined by the MA fee for the service, as indicated in the PA PROMIS^e™. Some services provided to beneficiaries contain a fixed copayment, some are based on a sliding scale, and others do not require a copayment. Please refer to the [Copayment Desk Reference](#) for details.

4.7.1.1 Copayment Exemptions

There are a number of exemptions to the copayment requirement, such as emergencies, services to pregnant women, residents of nursing facilities, and beneficiaries under the age of 18. Please refer to the [Copayment Desk Reference](#) for a complete list of exemptions.

4.7.2 Deductibles

Adult GA beneficiaries have a \$150 deductible per state fiscal year for certain MA compensable services. If applicable, the EVS will return both the beneficiary's GA deductible amount per year (\$150.00) and the outstanding GA deductible left considering the beneficiary's past billing history. Please refer to 55 Pa.Code § 1101.63(b) for more information.

4.7.3 Patient Pay

While determining eligibility for a beneficiary, there may be an amount of income considered available to pay the unpaid, incurred medical expenses for the beneficiary. If this is the case the beneficiary will have a patient pay liability indicated in their file and the specific amount of the patient pay liability will be returned on an EVS transaction. This amount may be linked to a specific provider or facility so it's important to check to see if a beneficiary is responsible. It is important to note that payment will be made to the provider only after this amount has been paid.

4.8 Third Party Liability, Other Insurance and Medicare

Medical Assistance is the payor of last resort. All other insurance coverage must be exhausted before billing MA. You would only bill MA for unsatisfied deductible or coinsurance amounts, or if the payment you receive from the other insurance coverage is less than the MA fee for that service. The MA Program is responsible only for payment of the unsatisfied portion of the bill, up to the maximum allowable MA fee for the service as listed in the Medical Assistance Program Fee Schedule.

It is your responsibility to ask if the beneficiary has other coverage not identified through the EVS (i.e., Worker's Compensation, Medicare, etc.)

When billing DHS after billing the other insurance, indicate the resource on the claim form as indicated in the detailed claim form instructions. It is also important to note that when a CMS 1500 paper claim form is submitted, attachment form MA 538 must be included with the claim. This form will list the beneficiary's commercial insurance and how much they have paid for a particular service. For additional information on the MA 538 form please follow the link below:

<http://www.dhs.state.pa.us/publications/bulletinsearch/bulletinselected/index.htm?bn=99-06-16&o=N&po=OMAP&id=12/18/2006>

When a beneficiary is eligible for both Medicare and MA benefits, the Medicare program must be billed first if the service is covered by Medicare. Payment will be made by MA for the Medicare Part B deductible and coinsurance up to the MA fee.

DHS does not require that you attach insurance statements to the claim form, with the exception of Medicare claims. However, the statements must be maintained in your files. If the beneficiary has coverage through Medicare Part B and MA, the claim may automatically cross over to PA PROMIS^e™ for payment of any deductible and/or co-insurance amounts. If the claim does not cross over from Medicare and you are submitting the claim directly to PA PROMIS^e™, enter **AT05** in Block 19 of the CMS-1500 Claim Form, attach the Explanation of Medicare Benefits and the Medical Assistance form MA 539. For additional information on the MA 539 form please follow the link below:

<http://www.dhs.state.pa.us/publications/bulletinsearch/bulletinselected/index.htm?bn=99-06-16&o=N&po=OMAP&id=12/18/2006>

When beneficiaries, their personal representative who can consent to medical treatment, or an attorney or insurer with a signed authorization request a duplicate copy of the claim forms, the provider may release a copy to the requester, but shall submit a copy of the claim form and the request to the following address:

Department of Human Services
TPL – Casualty Unit
P.O. Box 8486
Harrisburg, PA 17105-8486
(717) 772-6604

The TPL Casualty Unit will follow-up and take appropriate action for recovery of any MA payment recouped in a settlement action.

This procedure **MUST** be followed by **ALL** providers enrolled in the MA Program for **ALL** requests for payment information about MA beneficiaries. This includes beneficiaries enrolled in an MCO.

The Medical Assistance Early Intervention (MA EI) Program has additional requirements regarding the use of private insurance coverage for eligible children. Use of private health insurance for EI services is strictly voluntary. The family must give written consent for a provider to bill the child's private insurance. **If the family does not consent to the use of their private insurance, the agency or independent provider of EI services should bill their County MH/ID program for the child's MA EI services.**

You may NOT bill a child's private insurance program or private managed care plan/HMO before billing MA. EI services must be provided at no cost to parents or children as required by the Individuals with Disabilities Education Act (IDEA). A state may use any available fiscal source to meet this requirement. Thus, private health insurance proceeds may be used to meet the cost of EI services as long as **financial losses are not imposed** on the parents or child.

Potential financial impact/consequences:

1. A decrease in available lifetime coverage or any other benefit under an insurance policy;

2. An increase in premiums under an insurance policy; or
3. Out of pocket expenses, such as the payment of a deductible amount incurred in filing an insurance claim.

Targeted Service Management – ID (TSM-ID) providers should refer to ODP Bulletin #00-94-14, Targeted Service Management and Third Party Liability, in Appendix B of this handbook. TSM-ID providers may discontinue submitting claims to third party insurers prior to sending the claim to PROMIS^e™ for processing. TSM-ID providers are not required to attach insurance statements to their claim forms. However, the statements must be maintained on file.

4.8.1 Third Party Resource Identification and Recovery Procedures

When DHS discovers a potential third party resource after a claim was paid, a notification letter will be sent to the provider with detailed claim/resource billing information and an explanation of scheduled claim adjustment activity. Providers must submit documentation relevant to the claim within the time limit specified in the recovery notification. If difficulty is experienced in dealing with the third party, notify DHS at the address indicated on the recovery notice within 30 days of the deadline for resubmission. If the provider fails to respond within the time limit, the funds will be administratively recovered and the claims cannot be resubmitted for payment.

4.9 Medical Assistance Managed Care

HealthChoices is Pennsylvania’s mandatory MA managed care program. As part of DHS’s commitment to ensure access to care for all MA eligible beneficiaries, it is important that providers understand that there will always be some MA beneficiaries in the Fee-For-Service (FFS) delivery system and that all MA beneficiaries are issued an ACCESS card, even those in managed care. A small number of beneficiaries are exempt from HealthChoices and will continue to access health care through the FFS delivery system. In addition, there is a time lag between initial eligibility determination and managed care organization (MCO) enrollment. During that time period, beneficiaries must use the FFS delivery system to access care.

All HealthChoices providers are required to have a current FFS agreement and an active PA PROMIS^e™ Provider Identification Number as part of the HealthChoices credentialing process. Therefore, HealthChoices providers need not take any special steps to bill DHS for FFS beneficiaries. They may simply use the current FFS billing procedures, forms and their Provider Identification Number and Service Location.

For questions concerning enrollment or billing the HealthChoices MCOs, providers should contact the specific MCO they are credentialed with or plan to be credentialed with.

4.10 Service Programs

When an individual qualifies for Medical Assistance benefits, they are placed in one of two options to pay for their medical services:

- Health Choices Managed Care Organization
- Fee for Services (FFS)

If enrolled in the FFS delivery system, a beneficiary will be placed in a particular health care benefits package. Each package covers specific services. Medical Assistance Bulletin 99-06-10 is

a comprehensive list of services covered under each package. The link below gives a brief description of what each package covers.

[Service Programs for PA PROMISe™ Medical Assistance Providers Reference Chart](#)

If a beneficiary is enrolled in a Managed Care Organization (MCO), the provider will need to contact the appropriate MCO for specific coverage.

4.11 Client Specific Requirements

The beneficiary specific requirements section will include information on how to access waiver services and base programs.

4.11.1 Waivers

Medicaid-funded home and community based services are a set of medical and non-medical services designed to help persons with disabilities and older Pennsylvanians live independently in their homes and communities. The following sections highlight the various home and community based waivers.

4.11.1.1 Office of Developmental Programs (ODP) Waivers and Office of Child Development & Early Learning (OCDEL) Waivers

ODP administers, The Person/Family Directed Support Waiver and the Consolidated Waiver for Individuals with diagnosed Intellectual Disabilities. OCDEL administers the Infants, Toddlers and Families Waiver. The following provides an overview of the waiver services available.

Person/Family Directed Support Waiver (PFDS) – The Pennsylvania Person/Family waiver is designed to help persons with intellectual disabilities live more independently in their homes and communities and to provide a variety of services that promote community living, including self-directed service models and traditional, agency-based service models.

Consolidated Waiver for Individuals Diagnosed with Mental Retardation – The Pennsylvania Consolidated Waiver for individuals diagnosed with mental retardation is designed to help persons with intellectual disabilities live more independently in their homes and communities and to provide a variety of services that promote community living, including self-directed service models and traditional, agency-based models.

For more detailed information on eligibility requirements and services provided under each waiver please click the following link:

[Office of Developmental Program Specific Waivers](#)

4.11.1.2 Office of Long Term Living (OLTL) Waivers

OLTL administers the Aging Waiver, the AIDS Waiver, the Attendant Care Waiver/Act 150, the COMMCARE Waiver, the Independence Waiver and the OBRA Waiver. The following provides an overview of the waiver services available.

Aging Waiver – The Aging Waiver provides long-term care services to older Pennsylvanians living in their homes and communities.

Aids Waiver – The AIDS Waiver Program is a federally approved special program which allows the Commonwealth of Pennsylvania to provide certain home and community-based services not provided under the regular fee-for-service program to persons with symptomatic HIV disease or AIDS.

Attendant Care Waiver/ACT 150 – The Attendant Care Waiver/Act 150 provides services to eligible persons with physical disabilities in order to prevent institutionalization and allows them to remain as independent as possible.

COMMCARE Waiver – The COMMCARE Waiver was designed to prevent institutionalization of individuals with traumatic brain injury (TBI) and to allow them to remain as independent as possible.

Independence Waiver – The Independence Waiver provides services to eligible persons with physical disabilities in order to prevent institutionalization and allows them to remain as independent as possible.

OBRA Waiver – The OBRA Waiver is a Home and Community Based Waiver program that may help people with a developmental physical disability to allow them to live in the community and remain as independent as possible.

For more detailed information on eligibility requirements and services provided under each waiver please click the following link:

[Support Services Waivers](#)

4.11.2 Medical Assistance Early Intervention (MA EI)

Early Intervention (EI) – Infants and toddlers between the ages of birth and their third birthday are eligible for EI services as determined by one or more of the following:

- A twenty-five percent (25%) delay in one or more areas of development compared to other children of the same age.
- A physical disability, such as hearing or vision loss
- An informed clinical opinion
- Known physical or mental conditions which have a high probability for developmental delays

In order to obtain MA EI funding, the child must:

1. Be referred through the County MH/ID program
2. Be determined either eligible for EI or “at risk tracking” (see below)
3. Be MA eligible
4. Receive services from an MA EI enrolled agency/group or independent provider.
5. Receive services which are MA EI eligible

“At risk tracking” – If a child is found ineligible for EI services by the screening/evaluation, they may still be eligible for follow-up screening and tracking. Children eligible for screening and tracking include:

- A birth weight under 3.5 pounds or 1500 grams
- Cared for in a neonatal intensive care unit
- Born to chemically dependent mothers

- Seriously abused or neglected as substantiated pursuant to the Child Protective Services Law of 1975, as amended.
- Confirmed to have dangerous blood lead levels as set by the Department of Health Service Coordinators are the only MA EI qualified professionals who can bill for “At risk tracking” services.

Infants, Toddlers, and Families (ITF) Waiver

The Infants, Toddlers, and Families Waiver (Early Intervention) provides habilitation services to children from birth to age three who are in need of early intervention services and would otherwise require the level of care provided in an intermediate care facility for persons with mental retardation or other related conditions (ICF/ID-ORC).

Functional Eligibility:

Children, ages 0 – 3 (Birth until the 3rd birthday), may be eligible for ITF Waiver services if there is a need for early intervention services and the child is eligible for the ICF/ID (Intermediate Care Facility for Persons with Intellectual Disabilities) level of care for intellectual disabilities and related conditions.

Services:

The ITF Waiver provides habilitation services by qualified professionals with family/caregiver participation in the child’s natural environment.

Please note that income limitations may apply. To ensure that a child is eligible for waiver services, access EVS and review his/her service

4.11.3 Targeted Services Management – Intellectual Disabilities (TSM-ID)

The MA Program provides payment for specific TSM-ID services provided to eligible beneficiaries by enrolled providers. These services are covered when provided in accordance with the approved Medicaid State Plan Amendment for Targeted Service Management – ID and applicable state regulations and policies.

Individuals served in a psychiatric or general medical hospital are eligible for TSM-ID services provided the stay is no longer than 180 calendar days. TSM may work with individuals on their caseload that are in psychiatric units of general hospitals or in public or private psychiatric hospitals for a period not to exceed 30 calendar days from the estimated date of discharge. In these instances, the TSM person’s activities are limited to monitoring the individual’s progress, locating and obtaining services for the individual after discharge. These activities provided by the TSM person during this transition may not duplicate or replace the institution’s responsibility to provide discharge planning and continuity of care provided by the hospital. Reference sections 3.1A and 3.1B of the Pennsylvania Medicaid State Plan.

4.12 Procedures for Birth Centers and Nurse Midwives to Expedite Newborn Eligibility

Birth Centers and nurse midwives must immediately notify the County Assistance Office (CAO) of a child's birth when the mother is eligible for MA at the time of delivery. This contact must be done by telephone or fax to the appropriate CAO. Providers that have a high volume of MA births may wish to make arrangements with the local CAO to expedite this process.

In addition, within three working days of the baby's birth, birth centers and midwives must submit a Newborn Eligibility Form (MA 112) to the appropriate CAO. The CAO authorizes eligibility for the newborn under the mother's record, enters the newborn's identifying information on the MA 112 and returns it to the birth center or nurse midwife.

The MA 112 form may be obtained by completing the MA Provider Order Form (MA 300X) and submitting it to DHS.

PLEASE NOTE: If the birth occurs on a weekend or holiday, contact the CAO by telephone or fax on the next workday. The MA 112 must be submitted to the appropriate CAO within three workdays of the baby's birth.

4.12.1 Completion of the MA 112

The MA 112 must be completed with the assistance of the newborn's mother or the mother's authorized representative before the mother leaves the hospital or is discharged from the provider's care. Instructions for completing the form are located on the reverse side of the form. However, in addition to those instructions, the following information must be entered on the form:

Item 12 – Mother's Name

Enter the mother's name (last name, first name, M.I.) as shown on her ACCESS card. Allow enough space after the mother's name to enter the mother's Beneficiary Identification Number, as shown on her ACCESS card, or through access EVS.

Item 16 – Newborn Name

Enter the newborn's name, if available. If the newborn has not been named, enter "Baby Girl" or "Baby Boy" followed by the mother's last name.

Item 28 – For Notary Use

Do not complete this item.

Item 30 – Applicant's Signature

The mother or her authorized representative must sign the MA 112.

Item 31 – Date

Enter the date the application was signed.

Item 32 – ID Verification

Do not complete this item.

Items 33-37 – Hospital Information

Enter the appropriate information to identify the birth center or nurse midwife completing the form.

4.12.2 Instructions for Billing Without the Newborn's Beneficiary Number

You may bill MA immediately after contacting the CAO by phone or fax and after submitting the MA 112 to the CAO. It is not necessary to wait for the MA 112 to be returned to you before submitting your invoice. However, in order for PA PROMISE™ to process your claim, the newborn invoice must be completed with the following modifications:

Block 1a (Insured's I.D. Number) - **Use the mother's 10-digit ID number found on her ACCESS Card or by accessing EVS.**

Blocks 2 (Patient's Name (Last Name, First Name, and Middle Initial) and 3 (Patient's Birth Date) - **Use the newborn's identifying information (i.e., name, birthdate, sex, etc.).**

Block 19 (Reserved for Local Use) - Enter Attachment Type Codes AT26 (which indicates that you are billing for a newborn using the mother's ID number) and AT99 (which indicates that you have an 8½ by 11 sheet of paper attached to the claim form). Enter the mother's name, social security number, and date of birth on the 8½ by 11 sheet of paper. *Include your provider's name, 9-digit provider number and 4-digit service location on the attachment.*

Multiple Births

Complete a separate claim form for each child.

Remittance Advice Statement

When a claim appears on your remittance advice, it will be listed with the correct beneficiary information for the newborn. Please keep the newborn's ID number in your records for subsequent billings.

Billing With the Newborn's Beneficiary Number

If you have the newborn's ID number at the time of billing, complete the claim form in the usual manner using the ID number designated by the CAO for the newborn. You will not use the mother's ID number nor will you need to indicate Attachment Code AT26 or AT99.

5 Special Requirements For PA PROMISe™ Providers

This section provides an overview of waiver services, behavioral health services, and services (i.e., sterilizations, hysterectomies, and abortions), with attachments required by the Federal government, as well as links to their policies and instructions for the proper completion of these forms. In addition, information regarding Medical Assistance Early Intervention (MA EI) is contained in this section.

5.1 Special Forms and Instructions

All special forms and their related instructions have been hyperlinked throughout this Provider Handbook. The hyperlinked version of these special forms and instructions are located in Appendix D, Special forms.

5.2 MA Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) Providers

In accordance with the Benefits Improvement and Protection Act (BIPA) 2000 requirements, for the period January 1, 2001 through September 30, 2001, DHS paid FQHCs/RHCs on a per visit basis, 100% of the average of their audited reasonable costs related to the provision of MA covered services during Fiscal Years 1999 and 2000, adjusted to account for any increase or decrease in the scope of services furnished by the FQHC/RHC. Beginning October 1, 2001, DHS paid, on a per visit basis, the amount paid for the preceding Federal Fiscal Year (FFY), increased by the percentage increase in the Medicare Economic Index (MEI) applicable to primary care services.

Beginning October 1, 2002, and for each FFY thereafter, DHS pays, on a per visit basis, the amount paid for the preceding FFY, increased by the percentage increase in the MEI applicable to primary care services effective October 1.

DHS will adjust an FQHC's or RHC's rate to account for any increase or decrease in the scope of services any time that the FQHC/RHC has received approval for a change in the scope of services from the United States Department of Health and Human Services, Public Health Service. Additionally, DHS will consider extraordinary circumstances or unusual one-time occurrences that might have substantial cost effects in the current or future years. For subsequent FYs following any adjustment for change in scope of services, payment will be set by using the MEI method used for other centers/clinics.

For FQHCs/RHCs that are newly qualified as an FQHC or RHC after FY 2000, DHS will pay for the initial year, on a per visit basis, 100 percent of the reasonable cost related to the provision of Medicaid covered services of other centers/clinics located in the same or adjacent areas with a similar caseload. In the absence of such other centers/clinics, cost reporting methods will be used to establish the initial rate. For subsequent FYs following the clinic's enrollment, any adjustment for payment will be set using the MEI method used for other centers/clinics.

DHS will pay FQHCs and RHCs directly, on a quarterly basis, an amount which represents the difference, if any, between the amounts paid by managed care organizations (MCOs) to FQHCs and RHCs for approved services provided to MCO eligible MA beneficiaries and the payment to which the FQHC/RHC would be entitled for these services under the Prospective Payment System (PPS) method. DHS will use the PPS rates, as derived from FQHCs and RHCs audited cost reports

to reconcile the amount of these supplemental payments, and for FQHCs only, to reconcile the amount paid for dental services.

5.3 Continued Submission of Cost Reports

BIPA 2000 provides for the rebasing of PPS rates paid to FQHCs and RHCs subsequent to a study or survey conducted by the Comptroller General of the United States on the need for any such rebase or refinement of rates. To this end, DHS continues to require all FQHCs and RHCs enrolled in the MA Program to submit annual cost reports to the Office of MA Programs, Bureau of Fee-For-Service Programs in order to ensure the availability of data required for any such federal study or rebase of rates. FQHC and RHC Cost Reports, in the format prescribed by DHS, continue to be due 90 days after the end of the clinic's own fiscal year.

To access "Guidelines, Procedures and Standards for FQHCs", "Cost Report Form and Instructions", "PA MA Program FQHC Provider Questionnaire", and "FQHC/RHC Monthly MCO Settlement Report Instructions" click the following link:

http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/s_001850.pdf

5.4 Waiver Funded Services

Medicaid-funded home and community based services are medical and non-medical services designed to help persons with disabilities and older Pennsylvanians live independently in their homes and communities. Medicaid-funded home and community based services available in Pennsylvania are:

- Personal Support Services: Assistance needed for the beneficiary to plan, organize, and manage community resources.
- Residential Habilitation Services: Assistance with acquisition, retention, or improvement in skills related to activities of daily living.
- Day Habilitation Services: Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills, which take place in a non-residential setting, separate from where the beneficiary resides.
- Prevocational Services: Services aimed at preparing an individual for paid or unpaid employment.
- Supported Employment: Paid employment services for people who need intensive ongoing support to perform in a work setting.
- Homemaker/Chore Services: General household activities provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself and others in the home.
- Adaptive Appliances and Equipment: Specially designed appliances and equipment needed for the beneficiary to live as independently as possible.
- Respite Services: Services that are provided on a short-term basis because of the absence or need for relief of primary care givers.
- Transportation: Transportation needed to enable beneficiaries to gain access to waiver and other community services.
- Visual/Mobility Therapy, Behavior Therapy, and Visiting Nurse Services.

- Respite Care Services: Services provided to beneficiaries unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing care.
- Skilled Nursing: Provided by either a registered nurse (RN) or a licensed practical nurse (LPN) that is employed by an MA home health agency. The number of hours approved will be based on medical necessity criteria and certification from the individual's physician.

5.5 Mental Health Services

The following sections detail mental health services available through PA PROMISE™.

5.5.1 Family Based Mental Health Services for Children and Adolescents (FBMHS)

This is a team delivered service rendered in the home and community, which is designed to integrate mental health treatment, family support services and casework so that families may continue to care for their children and adolescents with serious mental illness or emotional disturbance at home. This service is intended to be an intensive and comprehensive service which reduces the need for psychiatric hospitalization and out-of-home placements.

5.5.2 Mental Health Crisis Intervention Services (MHCI)

Crisis intervention services are immediate, crisis-oriented services designed to resolve precipitating stress. The services are provided to adults, children, adolescents, and their families who exhibit an acute problem of disturbed thought, behavior, mood, or social relationships. The services provide rapid response to crisis situations that threaten the wellbeing of the individual or others. MHCI services include the intervention, assessment, counseling, screening and disposition services which are commonly considered appropriate to the provision of MHCI. The variance of the crisis intervention program services can be rendered include telephone crisis service, walk-in crisis service, mobile individual crisis service, mobile team crisis service, medical mobile crisis team service, and crisis residential service.

5.5.3 Mental Health Intensive Case Management

Intensive case management is targeted to adults with serious and persistent mental illness and children with serious mental illness and emotional disorders. It is designed to insure access to community agencies, services, and people whose functions are to provide the support, training and assistance required for a stable, safe, and healthy community life. Activities of the case management staff shall include: (1) linking with services; (2) monitoring of service delivery; gaining access to services; (3) assessment and service planning; (4) problem resolution; and (5) informal support network building, and use of community services.

5.5.4 Resource Coordination

Resource coordination services are targeted to adults with serious and persistent mental illness and children and adolescents with mental illness or serious emotional disturbance, and their families, who do not need the intensity and frequency of contacts provided through intensive case management, but who do need assistance in accessing, coordinating, and monitoring of resources and services. Services are provided to assess an individual's strengths and meet needs in order to achieve stability in the community. Resource coordination is similar to intensive case management

in that the activities are the same. However, caseload limits are larger and there is no requirement for 24-hour service availability. Resource coordination is established as an additional level of case management and is not intended to replace intensive case management.

5.6 Federally Required Forms

When providers perform certain services, there are instances when a federally required form must accompany a claim for payment, regardless of its mode of transmission (electronically or hardcopy on the CMS-1500 claim form). The Sterilization Patient Consent Form (MA 31), Patient Acknowledgement for Hysterectomy (MA 30), and the Physician's Certification for an Abortion (MA 3) are forms that are required by the Federal Government.

Payment for sterilizations, abortions, and hysterectomies will only be made if the appropriate form(s) are completed and accurate, and the procedures were performed within any time frames specified within the regulations. It is therefore important that providers be aware of the regulations surrounding the sterilizations, abortions, and hysterectomies, as well as how to complete the federally required forms accurately.

Providers frequently experience rejections for claims submitted with federally required forms, which were incomplete or incorrect. It is important to note that the MA 30, MA 31, and the MA 3, are scrutinized by federal auditors and, in order to maintain federal financial participation for the cost of these services, the Commonwealth must insure that the forms are completed correctly in every detail. The federal requirements are complex and many providers have complained to DHS that the forms must be completed numerous times before they are accepted. This problem is made more difficult because providers do not know specifically why a form has been rejected.

DHS recognizes the complexity of the federal requirements relating to these forms. In response to providers' requests, claims with federal attachments (i.e., MA 30, MA 31, or MA 3) will suspend with a special Remittance Advice (RA) Explanation Codes 4511, 4061, 4018, and 4022, and DHS will manually review each attachment for correct completion.

IF ERRORS ARE FOUND ON THE ATTACHMENT, THE CLAIM WILL BE DENIED. THE CLAIM FORM AND THE FEDERALLY REQUIRED FORM WILL BE RETURNED TO YOU WITH THE APPROPRIATE FORM LETTER. ERRORS WILL BE CIRCLED IN RED.

The following details which services require submission of a claim form and its applicable federal form:

5.6.1 Sterilization Patient Consent Form (MA 31)

This Sterilization Patient Consent Form (MA 31) must be attached to the claim when a provider is submitting a claim form for a beneficiary who received a sterilization service, such as a tubal ligation or a vasectomy. (See Appendix D, Special Forms, of this handbook.)

Please review 55 Pa Code Chapter 1141, §1141.55 (Payment Conditions for Sterilizations) prior to completing the MA 31. (See Section 3, Policies, of this handbook.)

5.6.2 Patient Acknowledgement for Hysterectomy (MA 30)

The Patient Acknowledgement for Hysterectomy (MA 30) must be attached to the claim when a provider is submitting a claim form for a beneficiary who received a hysterectomy (See Appendix D, Special Forms, of this handbook).

Please review 55 Pa Code Chapter 1141, §1141.56 (Payment Conditions for Hysterectomies) prior to completing the MA 30. (See Section 3, Policies, of this handbook.)

5.6.3 Physician Certification for an Abortion (MA 3)

The Physician Certification for an Abortion (MA 3) must be attached to the claim when a provider is submitting a claim form for a beneficiary who received an elective abortion. Please note that MA will only pay for abortion services when the mother's life is endangered by the pregnancy or when pregnancy is the result of rape or incest. (See Appendix D, Special Forms, of this handbook.)

Please review MA Bulletin 1141-95-01 - "Payment Policy for Abortion Services" carefully for DHS's policy regarding payment for abortions. (See Appendix B, Bulletins, of this handbook.)

5.7 State Required Forms

5.7.1 Medical Evaluation

Medical evaluation (MA 51) must be completed by the attending physician before admission or before authorization for payment to a nursing facility, intermediate care facility for the individuals with intellectual disabilities (ICF-ID), intermediate care facility for other related conditions (ICF-ORC), or a psychiatric hospital. Some home and community based services also require the completion of the MA 51. A copy of the MA 51 must be kept in the beneficiary's medical record. Failure to complete the MA 51 in its entirety may result in its return to you.

5.8 Medical Assistance Early Intervention (MA EI) Requirements

Referral of a child for MA EI services must be through the County MH/ID Program. An agency or independent provider cannot provide services to a child without this referral.

5.8.1 Determination of Medical Necessity

In order to be reimbursed for MA EI services, the agency/provider must secure a determination of medical necessity from a physician, licensed by the Commonwealth. The authorization should include:

- Indication that EI services are medically necessary (the statement can be generalized or prescriptive based upon the physician's preference)
- It must specify the length of time the authorization covers (to/from dates)
- Length of the authorization can be up to the child's third birthday; however, this authorization should be qualified by including "or until EI services are no longer needed."

It is recommended that this determination be obtained from the child's primary physician, but can be obtained from any Commonwealth licensed physician.

5.8.2 Service Coordination

Service coordination (EI Case Management) differs from other MA EI services as follows:

- Services can either be direct (face to face) or indirect.
- Service coordination is not a reimbursable service with any third party insurer in Pennsylvania. Agencies providing service coordination need not secure a denial from other third party insurers but may directly bill MA EI.
- Travel time related to eligible activities provided to the child/family is eligible for reimbursement.
- Service Coordinators are permitted to bill for EI children who are eligible for one of the five mandated “At risk tracking” categories. (Refer to Section 4.11.2, Medical Assistance Early Intervention, for additional information on “at risk tracking”.)

5.8.3 MA EI Documentation Requirements

The following documentation is required in order to seek reimbursement from MA EI for eligible services:

1. Parental Authorization: A written signature on the child’s Individual Family Service Plan (IFSP) and/or any EI service authorization.
2. Determination of Medical Necessity
3. Current IFSP listing each service in the program summary section using EI terminology, location of service and frequency/duration/intensity defined in units per month.
4. Service Support Plan: For each MA EI service identified, a corresponding service support plan should be developed by the appropriate MA qualified professional. The “Service Support Plan” becomes part of the child’s record. It should be specific to the identified service(s) listed on the IFSP (i.e., Occupational Therapy). The plan should document the outcome expected from the service and any other specific needed to understand what this service is intended to do for the child. It should have specific outcomes and objectives.
5. Progress Notes: Each time the MA qualified provider provides service to the child/family, a written entry must be made in the child’s progress notes or service log, including:
 - Date
 - Length of time spent
 - Place of service
 - Summary of activities provided that clearly reflects the appropriate activity
 - Signature of the MA qualified provider

Progress notes should be written when planned service delivery is not completed (i.e., the family was not at home). Progress notes provide a summary of activities provided the child/family response to the treatment/intervention, and progress/purpose of each visit/interaction. They should link back to the child's service support plan. Ideally, the notes should be completed during the normal service visit with the parent/caregiver's participation. The parent/caregiver should also sign and date the progress note.

The progress notes are part of the child's record.

5.8.4 Early Intervention and Managed Care

Eligible services delivered through the Early Intervention (birth to age three) Program are not included in the HealthChoices managed care program rates. If a child is covered under HealthChoices managed care plan and receives MA EI services from an enrolled MA EI agency/group or independent provider, the agency/group or independent provider is permitted to invoice PROMISE™ for payment of the MA EI eligible services.

6 Provider Enrollment Information

This section contains information for providers of services under PA PROMIS^e™.

6.1 Provider Participation Requirements

6.1.1 Licensure/Registration/Certification

To be eligible to enroll in PA PROMIS^e™, practitioners in Pennsylvania must be licensed and currently registered by the appropriate State agency. Out-of-state practitioners must be licensed and currently registered by the appropriate agency in their state.

Other providers must be approved, licensed, issued a permit or certified by the appropriate State agency and, if applicable, certified under Medicare.

For more information please refer to the following website:

<http://www.dhs.state.pa.us/provider/longtermcareservices/index.htm>

6.1.2 Enrollment/Provider Agreement

The provider is considered the legal entity and can be either a business or an individual, doing business with DHS. Legal entities can complete the enrollment process in one of two ways:

- Complete a paper enrollment form and send changes on letterhead.
- Use the Internet and the Provider Enrollment Automation Project, known as ePEAP, to request changes to enrollment information.

6.1.2.1 Paper Enrollment Forms

Providers must complete a PA PROMIS^e™ Provider Enrollment Form, PA PROMIS^e™ Provider Agreement, and be approved by DHS. Upon successful enrollment, the provider will receive a Provider Enrollment Letter (PRV-9008-R). (Refer to Section 6.2 for information on the Provider Enrollment Letter.)

Provider enrollment forms can be found on the DHS website at:

<http://www.dhs.state.pa.us/provider/promise/enrollmentinformation/index.htm>

NOTE: If you are unable to log into the Internet, you can telephone the following:

CATEGORY	TELEPHONE NUMBER	HOURS OF OPERATION
Application Requests (Inpatient and Outpatient)	(717) 772-6456 (Messages only)	24 hours/day 7 days/week
Applications In-Process (Inpatient and Outpatient)	(717) 772-6140	Monday – Friday 8:30 a.m. – 12:00 noon 1:00 p.m. – 3:30 p.m.

CATEGORY	TELEPHONE NUMBER	HOURS OF OPERATION
Long Term Care Provider Enrollment Applications	(717) 772-2571	Monday – Friday 8:30 a.m. – 5:00 p.m.
OMHSAS – MA Mental Health Funded Services (Outpatient Enrollment Applications)	800-433-4459	24 hours/day 7 days/week
Behavioral Health Supplemental Service Provider Applications	Contact the County/BH-MCO which credentialed the program or 800-433-4459	

6.1.2.2 ePEAP

Through the electronic Provider Enrollment Automation Project (ePEAP) providers with Internet access can review and request changes to their provider information via the Internet. Providers are required to register and create a 4-digit password in order to use ePEAP. Please go to the following web site and follow the directions to use ePEAP.

http://www.dhs.state.pa.us/cs/groups/webcontent/documents/manual/s_001933.pdf

Current limitations to ePEAP are:

- This website cannot be used to enroll a new provider or to re-enroll a provider. It is to be used by currently enrolled providers to request changes to their provider information.
- Certain provider types are not able to use ePEAP at this time. Please refer to http://www.dhs.state.pa.us/cs/groups/webcontent/documents/bulletin_admin/d_004253.pdf for the complete list.

6.1.2.3 Medical Assistance Early Intervention (MA EI) Program Enrollment Requirements

In order to participate in the MA EI Program, the agency or independent provider must hold a contract/agreement with the County Mental Health/Intellectual Disabilities (MH/ID) Program Office to provide EI services.

The County MH/ID Program Office designee will provide the essential enrollment materials that the agency or provider will need to complete in order to enroll in the MA EI Program. The following are the specific enrollment procedures.

1. All agencies and individual providers, either group members or independent providers, who wish to provide EI services must send their enrollment applications to the Office of Mental Retardation, through the County EI Contact personnel.
2. **Initial enrollments for agencies and individuals who are not PA PROMISE™ enrolled:**
The County MH/ID Program must provide a letter on County letterhead, signed by the County Administrator, which documents the Early Intervention Contract/ Agreement with the

agency or independent provider, a cost based fee schedule which includes the name of service(s), the applicable procedure code(s), location(s) of service, the 15 minute unit rate(s) and the effective date. This date will be the enrollment date.

3. **PA PROMIS^e™ enrolled providers.**

PA PROMIS^e™ enrolled providers who will be providing EI services must submit a completed copy of the Enrollment Information and Fee Assignment Change Form to ODP. In addition, the provider must have a direct contract with the County MH/ID Program to provide EI services in that county or county joinder, and must submit a letter on county letterhead signed by the County Administrator which documents the Early Intervention Contract/Agreement with the agency or independent provider and a cost based fee schedule.

4. **Multiple County MH/ID Agencies or Independent Providers**

Agencies or providers who contract with more than one County MH/ID Program or County MH/ID joinder to provide EI services, and are already enrolled to provider EI services do not need to complete another enrollment package. The County MH/ID Program should submit a letter on County letterhead and signed by the County Administrator that documents:

- Recognition of the EI contract/agreement
- A cost base fee schedule which includes service(s), procedure code(s), location(s) of services, applicable modifiers and the 15 minute unit rate(s) and effective date of implementation.

NOTE: ODP will only participate up to the maximum rates as defined in the current MA EI Program Fee Schedule. (Please refer to the MA EI Fee Schedule in Section 3, Policies, of this handbook.)

5. **Service Coordination Enrollment**

Agencies providing EI service coordination are required to enroll in PROMIS^e™. The individual service coordinator need not enroll. ODP will enroll agencies to provide EI intervention coordination. MR Bulletin #00-94-22, Early Intervention Medical Assistance Eligible Service Coordination, issued August 12, 1994, sets forth the minimum qualifications for service coordinators in the MA EI Program, the types of service coordination activities eligible for reimbursement, and the billing procedures. (See Appendix B, Bulletins, of this handbook.)

Once the initial enrollment of the agency/independent provider or the addition of another County MH/ID Program/County joinder is completed, ODP will send a letter to the agency or independent provider notifying them of the enrollment completion and/or revisions to their file.

6.1.2.4 Targeted Service Management – ID (TSM-ID) Enrollment Requirements

Eligible providers of TSM-ID services must be enrolled in PA PROMIS^e™. In addition, eligible providers are:

1. County MH/ID Programs which provide Targeted Service Management directly.
 - a. County Programs that provide direct services and support coordination shall submit to their appropriate ODP Regional Office of Mental Retardation a proposal that will describe the administrative procedures which will ensure that supports coordinators are free to identify problems in a person's services and that consumers have access to conflict free support coordination services. Direct services are defined as:

- i. All licensed and unlicensed ID residential services provided to people with mental retardation.
 - ii. All non-residential services provided to people with mental retardation.
 - iii. Services provided under all Intellectual Disabilities Medicaid waivers.
 - iv. Services provided by Health Care Quality Units and Independent Monitoring Teams.
2. Private providers of supports coordination under contract with county MH/ID Programs that are not also providers of “direct” services for individuals with mental retardation. For purposes of this agreement, providers who contract for or coordinate family support services (outside the Medicaid waiver(s), early intervention services, or services involving representative payee services and payment agent services are not considered to be “direct” providers of other services for individuals with mental retardation.
 - a. In cases where a County has a question about whether a contract arrangement is conflicted or whether an activity falls within the definition of a conflicted service, the County must submit a description of the arrangement or the services to their appropriate ODP Regional Office. The Regional Office will make a determination on an individual basis and forward their recommendation to ODP’s Central Office for review.

To enroll:

- A potential provider must first contract with the County in which he/she wishes to provide TSM-ID services.
- Providers must complete a Provider Enrollment Form and two copies of the Provider Agreement and send them to:

Department of Human Services
Office of Developmental Programs
Targeted Service Management Program
P.O. Box 2675
Harrisburg, PA 17105-2675

Upon enrollment, the provider will receive a Provider Notice containing enrollment information. All address, telephone changes and group membership changes must be submitted in writing to the previous address. No changes will be made to a provider’s file unless written notification is received. The appropriate ODP Regional Office should also be copied with the correspondence.

6.1.2.5 Office of Mental Health and Substance Abuse Services (OMHSAS) Enrollment Requirements

When a provider requests to provide one of the services under OMHSAS, a package is sent to them to tell them about the program and a site visit is scheduled with an OMHSAS licensing representative. This same package includes the enrollment package. When the visit is completed and the Certificate of Compliance is issued, the enrollment package can be completed and sent from the provider to the County and the local OMHSAS Field Office. These entities must sign off in their respective capacity. From the Field Office, the package is checked for completeness and forwarded to OMHSAS Headquarters for enrollment.

6.1.3 PA PROMIS^e™ Provider Identification

PA PROMIS^e™ provides the ability to enroll providers in various programs and record their demographic, certification and rate information. PA PROMIS^e™ maintains a single unique number to identify a provider. PA PROMIS^e™ supports the ability to uniquely identify locations, provider types, specialties, authorization/certification/licensing information for services and other required data within the unique provider identification number.

DHS initiated a Master Provider Index (MPI) in conjunction with PA PROMIS^e™. MPI is a central repository of provider profiles and demographic information that registers and identifies providers uniquely within DHS. Under MPI and PA PROMIS^e™, a provider is considered a unique legal entity and can be either a business or an individual provider, doing business with DHS. Additionally, providers can be assigned only one MPI provider identification number for a given Federal Employee Identification Number (FEIN) or Social Security Number.

Each enrolled PA PROMIS^e™ provider will be assigned a 9-digit MPI provider identification number. In addition, each provider will be assigned one or more 4-digit service locations that identify the physical address where service is provided, the provider type and at least one specialty.

NOTE: When submitting claims to DHS, providers must use their 9-digit provider identification number and the appropriate 4-digit service location as the unique provider identification for the claim.

6.1.4 Hearing Aid Dispensing Certification

In accordance with the policy direction set forth in MA Bulletin 01-07-07 et al., “Provider Specialty 220 (Hearing Aid Dispenser) Requirement and Updated MA Program Fee Schedule for Hearing Aid Supplies,” providers who dispense hearing aid supplies must submit yearly updated proof of Department of Health (DOH) certification. Upon annual renewal of the DOH certification, a copy of the renewed certification must be submitted to MA Provider Enrollment to ensure an active status of Provider Specialty 220 (Hearing Aid Dispenser) on your enrollment files. Please refer to the instructions as outlined in the Procedure section of MA Bulletin 01-07-07 et al. for adding Provider Specialty 220 to your provider file and for instruction on submitting the required DOH annual certification renewals. Effective August 1, 2007, failure to submit proof of DOH certification and yearly renewals will result in claim denials and inability to bill for hearing aid supplies.

6.2 Provider Enrollment Letter

Once a provider has been approved by DHS, PA PROMIS^e™ will generate a Provider Enrollment Letter (PRV-9008-R) to be sent, with the appropriate documentation, to the provider announcing the acceptance. Pertinent information is printed on the front and back of the letter for provider verification.

(CURRENT DATE)

(PROVIDER NAME)

(STREET ADDRESS 1)

(STREET ADDRESS 2)

(CITY/STATE/ZIP)

Provider ID / Service Location: XXXXXXXXXX XXXX

Dear Provider:

Your contract as a medical provider under programs administered by the Pennsylvania Department of Human Services has been approved.

Your program and expiration dates are listed below. Prior to expiration, you will receive a notification to extend your contract.

As an approved provider, you may submit claims for reimbursement under the medical programs within the scope of coverage of your services for eligible individuals.

The nine (09) digit identification provider number, and four (04) digit service location listed above have been assigned to you for billing purposes. In order to assure prompt reimbursement, it is imperative that these numbers be shown on each claim.

We are pleased to welcome you as a participating provider. For additional information regarding the Pennsylvania Department of Human Services Programs, please access our website at

http://www.dhs.state.pa.us/cs/groups/webcontent/documents/manual/s_001933.pdf

Sincerely,

Provider Enrollment Unit

Provider Information

Provider ID: XXXXXXXXXX
Service Location: XXXX
Provider Name: XXX
Provider Address: XXX
XX
XX

Provider Type: XX XXX
Provider Specialty: XXX XXX
Provider Sub-Specialty: XXX
Provider Taxonomy: XXXXXXXXXX

(Only if multiple specialties or sub-specialties)

Provider Specialty: XXX XXX
Provider Sub-Specialty: XXX XXX
Provider Taxonomy: XXXXXXXXXX

Current Programs

Program: XXXXXXXXXXXXXXXXXXXXXXX

Status: XXXXXXXXXXXX
Expiration Date: MM/DD/CCYY
{Only if multiple programs}
Program: XXXXXXXXXXXXXXXXXXXX
Status: XXXXXXXXXXXX
Expiration Date: MM/DD/CCYY

Rates Information

Effective Date: MM/DD/CCYY
End Date: MM/DD/CCYY
Total Rate: \$9999999.99
{Only if multiple rates}
Effective Date: MM/DD/CCYY

6.3 Submitting Claim Forms

Providers who have been assigned a provider identification number can submit claims either on hard copy or by Electronic Media Claims (EMC).

- CMS-1500 hard-copy submission to:
Department of Human Services
Office of Medical Assistance
P.O. Box 8194
Harrisburg, PA 17105-8194

6.3.1 Claim Forms through PA PROMIS^eTM

The provider will use his/her provider ID number and password to log into PA PROMIS^eTM and will be able to perform the following functions:

- Review messages and informational notices from DHS that are displayed upon logon to the secure website. Once read, the message can be marked “read” and will no longer appear on the initial window.
- Maintain passwords and, if authorized, can create and manage user accounts for others in his/her organizations.
- Review the status of claims submitted to DHS for payment and can review specific Error Status Codes (ESC) and HIPAA Adjustment Reason Codes for rejected claims.
- Submit claims directly for payment or adjustments for services and prescriptions.

Pharmacy claims are automatically reviewed for ProDUR (Prospective Drug Utilization Review) alerts and overrides at the time of entry and corrections can be made before final submission.

Assuming successful completion of a claim submission, the total allowed amount of the claim, plus any adjustment information, will be displayed to the submitting provider. Although this response will be available upon submission, the claim will be held in a "Suspend" status for later processing.

This prompt response to the claim submission will significantly reduce the time required for providers to submit properly completed claims and allow faster processing.

- Review information for specific procedures, drugs and diagnoses.
- Check pricing and eligibility limitation information.
- Verify the eligibility status of beneficiaries. Inquiries can be made by Beneficiary ID/Card Issue Number, SSN/Date of Birth, or Beneficiary Name/Date of Birth combinations.
- Review and download records of payments (Remittance Advice) from DHS for the past two years.
- The provider can search for, download, and print an Adobe Acrobat (.PDF) copy of their original paper remittance advice.
- Download or review provider handbooks, billing guides, fee schedules, MA bulletins, etc., from the DHS website.

All claims, regardless of media, are translated into a common file structure for PA PROMIS^e™ that allows them to be communicated in a common format between different computer systems. Electronic fee-for-service claims and adjustments are accepted in the HIPAA-compliant 837 Professional (X12 837 5010) format.

PA PROMIS^e™ supports the input of claims through multiple media, including:

- CD
- Bulletin Board via PC modem dial up
- Internet
- CMS-1500 Claim Form

6.4 Beneficiary Signatures

Providers must obtain applicable beneficiary signatures either on the claim form or on the MA Encounter Form (MA 91). The purpose of the beneficiary's signature is to certify that the beneficiary received the service and that the person listed on the PA ACCESS Card is the individual who received the services provided.

A parent, legal guardian, relative, or friend may sign his or her own name on behalf of the beneficiary. The provider or an employee of the provider does not qualify as an agent of the beneficiary; however, children who reside in the custody of a County children and youth agency may have a representative or legal custodian sign the claim form or the MA 91 for the child.

The following situations do not require that the provider obtain the beneficiary's signature:

- When billing for inpatient hospital, short procedure unit, ambulatory surgical center, nursing home, and emergency room services.
- When billing for services which are paid in part by another third party resource, such as Medicare, Blue Cross, or Blue Shield.
- When billing for services provided to a beneficiary who is unable to sign because of a physical condition such as palsy.
- When billing for services provided to a beneficiary who is physically absent, such as laboratory services or the interpretation of diagnostic services.
- When resubmitting a rejected claim form.

- When billing on computer-generated claims. In this instance, you must obtain the beneficiary's signature on the Encounter Form (MA 91).

6.4.1 Beneficiary Signature Requirements for Targeted Services Management – ID (TSM-ID)

An individual does not have to sign the Encounter Form (MA 91) in order for the provider to receive payment for TSM-ID services. However, the individual or his/her representative (i.e., legal guardian, family member, or advocate) must sign a current service plan or addendum to the plan, which states that he/she chooses to receive TSM. The County or its delegate is responsible to ensure that this statement is maintained and appropriately updated on an annual basis.

The provider may only sign for an individual when he/she cannot sign, make a mark, or indicate his/her intent, or have a representative sign on his/her behalf.

The service plan or addendum containing the individual's signature must be preserved until the expiration of four years and give full and free access to:

- a. The Commonwealth;
- b. The U.S. Comptroller General;
- c. The U.S. Department of Health and Human Services and their authorized representatives.

6.5 Record Keeping and Onsite Access

Providers must retain, for at least 4 years, unless otherwise specified in the provider regulations, medical and fiscal records that fully disclose the nature and extent of the services rendered to MA beneficiaries and that meet the criteria established in regulations.

Please refer to 55 Pa Code Chapter 1101, §1101.51(e) <http://www.pacode.com/secure/data/055/chapter1101/s1101.51.html> to review DHS regulations regarding record retention requirements.

6.6 Provider Specific Rate Setting

6.6.1 MA EI Services

The County MH/MR Program negotiates the unit rate up to the maximum of the ODP MA EI Program Fee Schedule. Rates can vary by contract and by agency.

6.6.2 TSM-ID Services

Each County MH/ID Program calculates and forwards a TSM maximum rate to ODP for consideration each year of participation. A County which contracts for TSM provision may establish the maximum rate for all of its TSM providers or may negotiate individual rates which may not exceed the County's approved maximum rate. Rates are to be negotiated between the County and provider in accordance with the County Mental Health/Mental Retardation Fiscal Manual, 55 Pa. Code Chapter 4300 (see Section 3, Policies, of this handbook). ODP reviews and updates the Provider Rate Record for billing purposes based on providers' annual rates. A declaration of the TSM rate a County agrees to pay a contracted provider (or several) signed by both the County Administrator and the private provider's Executive Director (or legal representative) must be submitted to ODP, TSM Program annually as part of the rate setting process. This may be in statement or letterform and can accompany the provider's rate-setting package or come within the specified timeframe during the rate setting process.

7 Prior Authorization

The Prior Authorization process and 1150 Administrative Waiver (Program Exception) process are automated systems that enable providers to obtain prior approval for reimbursement of specific services and items and those services or items not listed on the PA PROMIS^e™ Fee Schedule.

7.1 Prior Authorization in PA PROMIS^e™

Prior authorization is required for those services and items so designated in the PA PROMIS^e™ Fee Schedule with the prior authorization (PA) indicator.

The automated system ensures that a decision must be rendered on the prior authorization request within *21 days* of receipt of the Outpatient Service Authorization Request Form (MA 97), or the request is automatically approved.

7.1.1 Services and Items Requiring Prior Authorization

Services and items requiring prior authorization are identified in the PA PROMIS^e™ Fee Schedule with the prior authorization (PA) indicator. Prior authorization is also required when a single item costing **under** \$100 per item is requested in quantities totaling **more** than \$100.

Prior authorization is required after ***three months*** of rental on ***any*** item.

7.1.2 Procedures for Obtaining Prior Authorization

When an MA beneficiary has the need for a service(s) or item(s) requiring prior authorization, the ***prescribing practitioner*** completes ***two*** copies of a prescription. The original prescription is given to the beneficiary. The ***prescriber*** completes the prior authorization section of the MA 97.

NOTE: For Shift Nursing, a letter of medical necessity from the physician and a CMS-485 Form are acceptable in place of the two copies of a prescription.

The ***prescriber*** submits the completed MA 97 with a copy of the beneficiary's prescription in the envelope (ENV 320) provided by DHS. For shift nursing services, send the completed MA 97 and prescription to:

Department of Human Services
Outpatient PA/1150 Waiver Services
P.O. Box 8044
Harrisburg, PA 17105-8044

For all other outpatient services, send the completed MA 97 and prescription to:

Department of Human Services
Outpatient PA/1150 Waiver Services
P.O. Box 8188
Harrisburg, PA 17105-8188

DHS will either approve or deny the request and notify accordingly the ***prescriber*** and the beneficiary by means of the Prior Authorization Notice (MA 328).

NOTE: AN APPROVED PRIOR AUTHORIZATION REQUEST MEANS ONLY THAT THE SERVICE WAS DETERMINED MEDICALLY NECESSARY, BUT IT DOES NOT GUARANTEE THE BENEFICIARY'S ELIGIBILITY. IT IS THE RESPONSIBILITY OF THE PROVIDER, AS WELL AS THE PRESCRIBER, TO VERIFY THE BENEFICIARY'S ELIGIBILITY THROUGH THE ELIGIBILITY VERIFICATION SYSTEM (EVS), NOT ONLY ON THE DATE THE SERVICE IS REQUESTED, BUT ALSO ON THE DATE THE SERVICE IS PERFORMED/PROVIDED.

7.1.2.1 Prior Authorization and Program Exception Review of Hyperbaric Oxygen Therapy in Full Body Chamber

- I. General Requirements for Prior Authorization and Program Exception Requests for Hyperbaric Oxygen Therapy in a Full Body Chamber
 - A. Hyperbaric Oxygen Therapy services in a Full Body Chamber That Requires Prior Authorization
 - B. Hyperbaric Oxygen Therapy Services in a Full Body Chamber That Require a Program Exception
 - C. Emergency Services
 - D. Retrospective Reviews
- II. Procedures for Requesting Prior Authorization or a Program Exception for Hyperbaric Oxygen Therapy Services in a Full Body Chamber
 - A. Initiating the Prior Authorization or Program Exception Request
 - B. Information and Supporting Documentation that Must Be Available for the Prior Authorization or Program Exception Review
 - C. Documentation Supporting the Need for a Service That Requires Prior Authorization or a Program Exception
 - D. Review of Documentation for Medical Necessity
 - E. Clinical Review Processes
 - F. Timeframe of Review
 - G. Notification of Decision
 - H. Denials
 - I. Prior Authorization or Program Exception Number
- III. Procedures to Submit Claims
 - A. Submission of Claims
 - B. Claims for Emergency Room Services

I. GENERAL REQUIREMENTS FOR PRIOR AUTHORIZATION AND PROGRAM EXCEPTION REQUESTS FOR HYPERBARIC OXYGEN THERAPY SERVICES IN A FULL BODY CHAMBER

A. Hyperbaric Oxygen Therapy Services in a Full Body Chamber That Require Prior Authorization

1. Hyperbaric oxygen therapy services provided in a full body chamber in the hospital outpatient setting.
2. Hyperbaric oxygen therapy services provided in a full body chamber on an outpatient basis to a Medical Assistance (MA) beneficiary who is admitted to an inpatient facility.

B. Hyperbaric Oxygen Therapy Services in a Full Body Chamber That Require a Program Exception (1150 Waiver)

1. A request for hyperbaric oxygen therapy services in a full body chamber that exceeds the MA Program Fee Schedule limit of 4 units per day.

C. Emergency Services

Retrospective authorization or program exception is required for hyperbaric oxygen therapy services in a full body chamber that is provided in the hospital outpatient setting on an emergency basis. The request must be submitted within thirty (30) days of the date of service, following the procedure in Section II. If it is determined that the service was not provided to treat an emergency medical condition or was not found to be medically necessary, as set forth in Department regulations and program bulletins, the prior authorization or program exception request will be denied.

D. Retrospective Reviews

Retroactive MA Eligibility

A prescriber may request authorization for outpatient hospital claims for hyperbaric oxygen therapy services in a full body chamber provided to individuals who are determined to be eligible for MA retroactively (“late pickups”). The request must be submitted within thirty (30) days of the date the provider receives notice of the eligibility determination, following the procedure in Section II. If it is determined that the service was not medically necessary, the authorization request will be denied.

Individuals with Third Party Resources

For those individuals with Third Party Resources, including Medicare and private insurance, the Department will not require PA or PE approval of hyperbaric oxygen therapy services prior to the service being performed. In these instances, the rendering provider will submit its claim for cost sharing to the MA Program in the usual manner as set forth in the CMS 1500 Billing Guide for PROMIS[™]. If the Third Party Resource denies payment for the hyperbaric oxygen therapy service or pays less than the MA Program fee, the prescriber may request retrospective approval from the Department within 30 days of the date of the Third Party Resource Explanation of Benefits (EOB).

II. PROCEDURE FOR REQUESTING PRIOR AUTHORIZATION OR A PROGRAM EXCEPTION FOR HYPERBARIC OXYGEN THERAPY SERVICES IN A FULL BODY CHAMBER

A. Initiating the Prior Authorization or Program Exception Request

1. Who May Initiate the Request

The prescribing practitioner must request prior authorization or a program exception.

2. How to Initiate the Request

The Department accepts prior authorization requests for prior authorization by telephone at 1-800-537-8862, choose Option 1, then choose Option 3, and then choose Option 2, between 7:30 a.m. - 12 p.m. and 1:00 p.m. - 4:00 p.m. Monday through Friday.

B. Information and Supporting Documentation that Must Be Available for the Prior Authorization Review

The information required at the time prior authorization is requested includes the following:

1. Prescribing practitioner's name, address, and office telephone number, or prescribing practitioner's Medical Assistance Identification (MAID) number and National Provider Identifier (NPI) number/taxonomy/zip code
2. Rendering provider's or facility's MAID number and NPI number/taxonomy/zip code
3. Beneficiary's name and Medical Assistance Identification number
4. Procedure code of the requested service
5. Diagnosis and ICD-9 or ICD-10, as applicable, diagnosis code
6. Clinical information to support the medical necessity for the requested service, including:
 - a. Symptoms and their duration
 - b. Physical examination findings
 - c. Corresponding laboratory and/or imaging reports
 - d. Treatments the beneficiary has received
 - e. Reason the service is being requested
 - f. Specialist reports or evaluations
 - g. Clinical notes

C. Documentation Supporting the Need for a Service that Requires Prior Authorization or a Program Exception

The clinical information provided during the course of the prior authorization or program exception review must be verifiable within the patient's medical record. Upon retrospective review, the Department may seek restitution for the payment of the service and any applicable restitution penalties from the prescriber if the medical record does not support the medical necessity for the service. See 55 Pa.Code § 1101.83(b).

D. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of hyperbaric oxygen therapy services in a full body chamber (HBOT), the determination of whether the requested service is medically necessary will take into account whether the beneficiary:

1. Has a diagnosis of Type I or Type II Diabetes.

AND

2. Chronic, severe, or gangrenous diabetic lower extremity wound(s) that is (are) a Wagner grade 3 or higher.

AND

3. The wound(s) have no documented measurable improvement in the last 30 days of standard wound therapy.

OR

4. Has compromised skin grafts or flaps (not for the primary management of wounds) and the graft or flap has no documented measurable improvement of the wound(s) in the last 30 days of standard wound therapy.

OR

5. Has a diagnosis of active radionecrosis (osteoradionecrosis, myoradionecrosis, brain radionecrosis, and other soft tissue radiation necrosis).

OR

6. Has a diagnosis of radiation proctitis.

OR

7. Is undergoing dental surgery of a radiated jaw and requires prophylactic pre- and post-treatment.

OR

8. Has a diagnosis of idiopathic sudden deafness, acoustic trauma or noise-induced hearing loss within the past 3 months.

OR

9. Chronic refractory osteomyelitis that has been unresponsive to conventional medical and surgical management.

E. Clinical Review Process

Prior authorization nurse reviewers will review the request for prior authorization and apply the clinical guidelines in Section D. above, to assess the medical necessity of the requested service. If the nurse reviewer determines that the requested service meets the medical necessity guidelines, then the nurse reviewer will approve the request. If the nurse reviewer determines that the guidelines are not met, then the request will be referred to a physician reviewer for a medical

necessity determination. Such a request for prior authorization or a program exception may be approved when, in the professional judgment of the physician reviewer, the service is medically necessary to meet the medical needs of the beneficiary.

F. Timeframe for Review

The Department will make a decision on the prior authorization request within two (2) business days of receiving all information reasonably needed to make a decision regarding the medical necessity of the services. A decision may be made during the call if sufficient information is provided at that time. If additional information is requested and not received by the 15th day of the date of initial request, the request will be denied for lack of sufficient information.

The Department will make a decision on a program exception request based on the regulations set forth at 55 Pa.Code § 1150.63 within 21 days of receiving the request for a beneficiary less than 21 years of age.

G. Notification of Decision

The Department will issue a written notice of the decision to the beneficiary, the prescribing provider and the rendering provider (if applicable).

NOTE: An approved prior authorization or program exception request means only that the service has been determined to be medically necessary. It does not address the beneficiary's eligibility for the service on the date of service. It is the responsibility of the rendering provider to verify the beneficiary's eligibility through the Eligibility Verification System (EVS) on the date the service is provided.

H. Denials

If a prior authorization or program exception request is denied or approved other than as requested, the beneficiary has the right to appeal the Department's decision. The beneficiary has thirty (30) days from the date on the prior authorization notice to submit an appeal in writing to the address listed on the notice.

I. Prior Authorization or Program Exception Number

If the prior authorization or program exception request is approved, the Department will issue a prior authorization or program exception number, which is valid for the time period not to exceed a maximum of thirty (30) calendar days.

J. Duration of Approvals

A prior authorization or program exception approval is valid for a maximum of thirty (30) calendar days.

K. Subsequent Approvals

If the treatment period exceeds thirty (30) calendar days, the provider must contact the Department by telephone at 1-800-537-8862 to request reevaluation and update the prior authorization or program exception every thirty (30) days.

III. PROCEDURES TO SUBMIT CLAIMS

A. Submission of Claims

Follow the instructions for submitting a claim for approved hyperbaric oxygen therapy under pressure found in the General Hospitals (including Outpatient Hospital Clinic, Emergency Room, Hospital Short Procedure Unit (SPU), and Outpatient Rehabilitation Hospital providers) billing guide on the Department's website at the following address:

http://www.dhs.state.pa.us/cs/groups/webcontent/documents/manual/s_001877.pdf

Follow the instructions for submitting a claim for approved hyperbaric oxygen therapy under pressure as a program exception found in the Claims Submission Instructions for Services Approved via the 1150 Administrative Waiver on the Department's website at the following address:

http://www.dhs.state.pa.us/cs/groups/webcontent/documents/manual/s_001859.pdf

Providers who are unable to access the billing guide online may obtain a hard copy by calling 1-800-537-8862, prompt 4.

Follow the instructions for submitting an internet claim for approved hyperbaric oxygen therapy under pressure found in the PROMIS^e™ Provider Internet User Manual on the Department's website at the following address:

<http://promise.dpw.state.pa.us/promisehelp/manuals/promiseproviderinternetusermanual.pdf>

B. Claims for Emergency Room Services

When hyperbaric oxygen therapy under pressure is provided as part of an emergency room treatment where the beneficiary is admitted directly to the inpatient setting from the emergency room, the service must be included on the inpatient invoice rather than being billed as an outpatient claim.

7.1.3 Exceptions

In the event that a beneficiary is in immediate need of a service or item requiring prior authorization, and the situation ***is an emergency***, the prescriber may indicate that the prescription be filled by the provider before submitting the MA 97. The prescriber must still complete and submit the MA 97 for review. This request will be examined in the same manner as an initial request for prior authorization.

If DHS determines that the beneficiary's circumstances did not constitute an emergency situation and the MA 97 is denied, the ***provider will not be compensated*** for the service or item provided.

7.1.4 Steps for Payment

When the ***provider*** is presented with the beneficiary's prescription, the ***provider*** fills the prescription and completes a claim form in accordance with existing instructions for completion of the 837 Professional/CMS-1500 Claim Form.

Upon completion, the ***provider*** submits the original claim form to DHS for processing, while retaining a file copy. The ***provider*** should submit the CMS-1500 to the regular address for claim submission:

Department of Human Services
Office of Medical Assistance Programs
P.O. Box 8194
Harrisburg, PA 17105-8194

7.2 Prior Authorization of Home Health Services

Home Health Agencies must call **1-800-558-4477** to request prior authorization of home health services.

7.2.1 Requests

Prior authorization requests for home health services may not exceed any existing limits established by the MA Program as defined in 55 Pa. Code, Chapter 1249 (relating to Home Health Agency Services), §1249.59 (relating to Limitations on payment).

When requesting prior authorization, the home health agency must indicate all disciplines prescribed by the practitioner:

- Nurse (RN or LPN)
- Home Health Aide
- Occupational Therapist
- Speech Therapist
- Physical Therapist
- Audiologist

The home health agency must specify the number of visits for each discipline.

7.2.2 Department Approval

DHS will approve or deny any request on the telephone, followed by a Prior Authorization Notice that identifies the procedure code(s) for the services approved, the number of visits approved, and any modifiers that are applicable. The Prior Authorization Notice will also identify those services DHS denied, including the reason for the denial, and the services approved other than requested.

DHS's prior authorization system has the capability to approve multiple lines of medically necessary services per authorization number. Each line item approved is for a procedure code and includes the number of visits approved for that code, plus the approved modifiers.

The Prior Authorization Number consists of ten numeric digits.

In most instances, DHS will attempt to list approved services under one Prior Authorization Number.

DHS may assign a second Prior Authorization Number:

- When there is a change in the beneficiary's diagnosis, or
- After each sixty-day period.

7.2.3 Claim Submission

You may submit claims as frequently as you wish. If you choose to submit claims monthly or at the end of an approval period, use the last date of service for the approval period listed on the Prior Authorization Notice, even if services were not provided on consecutive days.

You must use the procedure code listed on the approval.

You must complete the modifier fields (Block 24D of the CMS-1500) with the modifiers supplied by DHS. DHS will assign modifiers as follows:

- When services extend across two consecutive months,
- When services extend beyond the first 28 days of service,
- The home health agency needs to extend services for an approved service line which the home health agency has already billed DHS, or
- When requesting additional services after the initial approval period.
- Information and pricing modifiers may also be assigned, if applicable.

Enter the 10-digit Prior Authorization Number in Block 23 of the CMS-1500.

7.2.4 Examples

DHS's Prior Authorization System has the capacity to include multiple procedure codes under one Prior Authorization Number. Examples 7.2.4.1 and 7.2.4.2 are intended to demonstrate that multiple services, or disciplines, may be prior authorized under one number.

NOTE: All examples assume that the services are medically necessary and meet all other payment conditions.

DHS recognizes that most home health agencies bill on a monthly basis and that these agencies do not wish to change their billing schedules. Example 7.2.4.3 is intended to demonstrate that when prior authorized services cross over two consecutive calendar months, DHS may authorize all of the services under one Prior Authorization Number but, on the initial call to DHS, may assign a 2-digit alpha modifier to the procedure codes to allow for monthly billing.

There may be situations where the practitioner determines that the beneficiary requires an additional home health service that was not included in the original Plan of Treatment. DHS may include the additional services under the original Prior Authorization Number, and the approved service *will have at least two modifiers*. Example 7.2.4.4 is intended to demonstrate this type of situation.

NOTE: The home health agency has the option to request that all procedure codes for the additional service be assigned under one separate Prior Authorization Number for up to a 60-day period.

Example 7.2.4.5 addresses a situation where the practitioner determines that the beneficiary needs an increase in the quantity of services included in the plan of treatment, which were already prior authorized by DHS. When this occurs, DHS may authorize the increased visits under the original Prior Authorization Number, and will assign a procedure code *with at least two modifiers*.

7.2.4.1 Multiple Services Authorized Under One Prior Authorization Number

The practitioner orders the following services for an eligible beneficiary. The beneficiary is being discharged from the hospital on March 1, 2004. Services are to begin on the date of discharge.

- One RN visit per day for two weeks; followed by,
- One RN visit per week for the next two weeks; and
- One aide visit per day for two weeks; followed by,
- One aide visit per week for the next two weeks.

DHS will prior authorize these services under one Prior Authorization Number. The Prior Authorization Notice will have the following information:

Procedure Code	Modifier	Description	# Visits
G0154	ZC	Home Health Visit (Days 1 – 28) by RN or LPN 3/1-3/28/2004 daily visit X 2 weeks, once/week X 2 weeks	16
G0156	ZC	Home Health Visit (Days 1 – 28) by Aide 3/1-3/28/2004 daily visit X 2 weeks, once/week X 2 weeks	16

7.2.4.2 Multiple Services Authorized Under One Prior Authorization Number

The practitioner orders the same services as described in Example 7.2.4.1. The practitioner also orders the beneficiary to receive physical therapy once a day for four weeks. The beneficiary is discharged on March 1, 2004, and physical therapy will start on the day of discharge.

DHS will prior authorize these services under one Prior Authorization Number. The Prior Authorization Notice will have the following information:

Procedure Code	Modifier	Description	# Visits
G0154	ZC	Home Health Visit (Days 1 – 28) by RN or LPN 3/1-3/28/2004 daily visit X 2 weeks, once/week X 2 weeks	16
G0156	ZC	Home Health Visit (Days 1 – 28) by Aide 3/1-3/28/2004 daily visit X 2 weeks, once/week X 2 weeks	16
G0151	ZC	Physical Therapy (Days 1 – 28) by Physical Therapist 33/1-3/28/2004 1 visit daily for 4 weeks	28

7.2.4.3 Services Cross Over Two Consecutive Months, Modifiers Required

The practitioner orders the same services as described in Example 7.2.4.1. The beneficiary is being discharged from the hospital on March 22, 2004. Services are to begin on the date of discharge.

The home health agency wishes to bill monthly. DHS will prior authorize these services under one Prior Authorization Number, even though the services cross over two consecutive months. The Prior Authorization Notice will have the following information:

Procedure Code	Modifier	Description	# Visits
G0154	ZC	Home Health Visit (Days 1 – 28) by RN or LPN 3/22-3/31/2004 daily visit X 2 weeks	10
G0154	ZD	Home Health Visit (Days 1 – 28) by RN or LPN 4/1-4/18/2004 daily visit X 6 days	6
G0156	ZC	Home Health Visit (Days 1 – 28) by Aide 3/22-3/31/2004 daily visit X 2 weeks	10
G0156	ZD	Home Health Visit (Days 1 – 28) by Aide 4/1-4/18/2004 daily visit X 6 days	6

7.2.4.4 Request for Additional Services After Original Authorization

The beneficiary was receiving the prior authorized services as described in Example 7.2.4.1. The practitioner examines the beneficiary and determines that in addition to the services already prior authorized; the beneficiary requires occupational therapy once a day for two weeks.

DHS approved the services as described in Example 7.2.4.1. The home health agency calls in the new order and provides the original Prior Authorization Number. DHS will change the original prior authorization screen by adding the additional procedure code for occupational therapy. The additional services will be approved using *at least two modifiers* for that time period.

CHANGE TO ORIGINAL AUTHORIZATION*

Procedure Code	Modifier	Description	# Visits
G0152	ZC/01	Occupational Therapy (Days 1 – 28) by Occupational Therapist 3/1-3/14/2004 daily visit for 2 weeks	14

The Home Health Agency will receive a second notice from DHS. DHS's records will reflect the change.

7.2.4.5 Request for an Increase in the Quantity of Services Already Prior Authorized

The practitioner orders the services described in Example 7.2.4.2. However, after one week of therapy, the practitioner increases physical therapy to two times per day for the next three weeks.

DHS will prior authorize these services under one Prior Authorization Number. The home health agency calls in the order change and provides the original Prior Authorization Number. DHS will approve the additional services using *at least two modifiers* for that time period.

ORIGINAL AUTHORIZATION

Procedure Code	Modifier	Description	# Visits
G0154	ZC	Home Health Visit (Days 1 – 28) by RN or LPN 3/1-3/28/2004 daily visit X 2 weeks, once/week X 2 weeks	16
G0156	ZC	Home Health Visit (Days 1 – 28) by Aide 3/1-3/28/2004 daily visit X 2 weeks, once/week X 2 weeks	16
G0151**	ZC	Physical Therapy (Days 1 – 28) by Physical Therapist 3/1-3/28/2004 1 visit daily for 4 weeks	28

** Due to the change in the physician’s orders, the previously approved Physical Therapy visits will be closed and approved as listed below.

CHANGE TO ORIGINAL AUTHORIZATION***

Procedure Code	Modifier	Description	# Visits
G0151	ZC/01	Physical Therapy (Days 1 – 28) by Physical Therapist 3/1-3/7/2004 daily visit for one week	7
G0151	ZC/01	Physical Therapy (Days 1 – 28) by Physical Therapist 3/1-3/28/2004 two visits/day for 3 weeks	42

The home health agency will receive a second Prior Authorization Notice from DHS. DHS’s records will reflect the change.

7.3 1150 Administrative Waiver (Program Exception)

The Department may, under extraordinary circumstances, pay for an item which is not on the MA Program Fee Schedule through the PE process. See 55 Pa.Code §1150.63(b). In addition, providers may request a PE when seeking an exception to the rate for an item on the MA Program Fee

Schedule or when seeking to provide an item in a quantity that exceeds the limits on the MA Program Fee Schedule.

In order to assist the Department in establishing a price for an item that is not on the MA Program fee schedule, or to evaluate a request for a PE seeking an exception to the established rate, PE requests must include documentation, more fully described below, of the Manufacturer's Suggested Retail Price (MSRP) and the adjusted acquisition cost.

The MSRP is the price at which the manufacturer recommends retailers sell their product(s).

The adjusted acquisition cost is the actual cost of an item, after discounts and rebates, to the medical supplier/manufacturer. It does not include the following costs:

- Delivery or shipping costs (including postage and handling)
- Labor costs (including assembly, repair or fitting)
- Operating expenses (including insurance costs)

PE requests to exceed the quantity limits will be approved if determined medically necessary by the Department and will be paid at the established MA Program fee schedule rate and, therefore, are not subject to the documentation requirements set forth in subsection 7.3.2 below.

7.3.1 Procedures for Obtaining an 1150 Administrative Waiver

When a MA beneficiary is in need of an item requiring a PE, the physician prescriber completes two copies of a prescription detailing all components of the item prescribed for the MA beneficiary. One prescription is given to the MA beneficiary to provide to the medical supplier. The submitting physician prescriber completes the *1150 Waiver (Program Exception)* section of the Outpatient Services Authorization Request (MA 97) form in accordance with form directions and places a check mark in block number 2 on the form, which identifies the request as an 1150 Waiver (Program Exception) request.

The physician prescriber or medical supplier (on behalf of the physician prescriber) submits the completed MA 97 form, with a copy of the MA beneficiary's prescription, documentation supporting medical necessity, and information required to determine pricing, in the envelope (ENV K-320) provided by the Department to the appropriate address listed on the cover sheet of the MA 97 form. The nationally recognized procedure code for the service or item for the Program Exception request must be reflected on the MA-97 Form. If the service or item being requested does not have a nationally recognized code, then a thorough description of the service or item being requested must be provided. Medical justification must be provided for the item or limit expansion being requested and the request must include a reason why the item or limit on the MA Program Fee Schedule is not adequate. The provider places an additional copy of the prescription in the recipient's medical file kept in the provider's office.

Once the Program Exception request is received, the Department will approve, approve other than requested, or deny the request. Notification of the Department's decision will be sent to the physician prescriber and the MA beneficiary by means of a Notice of Decision.

Please note: An approved 1150 Administrative Waiver/PE request means only that the service or item was determined medically necessary; it does not guarantee the beneficiary's eligibility. It is the responsibility of the prescriber, as well as the provider, to verify the beneficiary's eligibility through the eligibility verification system

(EVS); not only on the date the service or item is requested, but also on the date the service or item is performed or provided.

7.3.2 Documentation Requirements for 1150 Administrative Waiver Requests for Durable Medical Equipment and Medical Supplies

Providers must include documentation of the adjusted acquisition cost and the MSRP with PE requests.

- Providers that have already purchased the item must submit an invoice for the item with the PE request.
- Providers that have not purchased the item, but have received a cost quote from the manufacturer, must submit the cost quote with the PE request.
- If the PE request is being submitted by a medical supplier that is not the manufacturer, the documentation should be submitted on the letterhead of the manufacturer or distributor from whom the medical supplier ordered the item.
- If the PE request is being submitted by a manufacturer, the documentation should be submitted on its own letterhead with a statement that it is the manufacturer.
- If the PE request is being submitted by a distributor, the distributor should submit the documentation on the letterhead of the company from which the requested item was acquired.

This information, along with the information provided to establish medical necessity, must be provided in order for the Department to process PE requests for DME, medical supplies, prosthetics and orthotics.

All invoices for PE requests to the Department must be unaltered, fully legible, on the medical supplier, manufacturer, or distributor letterhead, and must include the following:

1. The supplier/manufacturer/distributor letterhead must include the following:
 - Supplier/manufacturer/distributor name
 - Complete address
 - Customer Service telephone number
 - Customer Service fax number
2. Complete “Invoice to” information
3. Complete “Ship To” information which includes name of the beneficiary/supplier receiving the item, street address, city, state and zip code
4. The date of the invoice
5. The invoice number
6. Product name
7. Serial number (if applicable)
8. Product model number
9. Item number
10. Full item description
11. The unit of measure and quantity of defined unit (examples: pair= 2, set= 3, case= 35, box= 10, and package= 60)
12. The MSRP per unit of measure

13. The adjusted acquisition cost per unit of measure for each item purchased, including any and all other discount(s), rebates, refunds or other price-reducing allowances (e.g. full payment terms)
14. Sales tax, shipping, handling, delivery, postage, insurance costs, labor costs, operating expenses and any other charges imposed shall be individually identified

Acceptable documentation for all cost quotes for PE requests to the Department must be unaltered, fully legible, on the medical supplier, manufacturer, or distributor letterhead from which the item(s) are being ordered and must include the following:

1. The supplier/manufacturer/distributor letterhead must include the following:
 - Supplier/manufacturer/distributor name
 - Complete address
 - Customer Service telephone number
 - Customer Service fax number
2. Complete “Quote To” information
3. Complete “Ship To” information which includes the name of the supplier receiving the item, street address, city, state and zip code
4. The date of the quote
5. The date the quote expires
6. Quote number
7. Product name
8. Serial number (if applicable)
9. Product model number
10. Item number
11. Full item description
12. The unit of measure and quantity of defined unit (e.g. pair = 2, set = 3, case = 35, box = 10 & package = 60)
13. The MSRP per unit of measure
14. The adjusted acquisition cost per unit of measure for each item purchased, including any and all other discount(s), rebates, refunds or other price-reducing allowances (e.g. full payment terms)
15. Sales tax, shipping, handling, delivery, postage, insurance costs, labor costs, operating expenses and any other charges imposed shall be individually identified
16. Customer number
17. Applicable national procedure code(s)

For all PE requests approved based upon a cost quote, providers must submit the final paid invoice depicting the above (1–17) information to the Department at the following address within 30 days after the item is purchased:

Commonwealth of Pennsylvania
Department of Human Services
Office of Medical Assistance Programs
Bureau of Fiscal Management
Division of Hospital and Outpatient Rate Setting
Commonwealth Tower, 6th Floor
P.O. Box 2675

Harrisburg, Pennsylvania 17105

The MSRP may be incorporated into the document that contains the invoice or cost quote. All MSRPs, invoices or cost quotes submitted to the Department as required documentation in association with a PE request must be personally signed (including printed name) and dated by an authorized representative of the medical supplier, manufacturer or distributor.

7.3.3 Exceptions

In the event that a beneficiary is in immediate need of a service or item requiring an 1150 Administrative Waiver, and the situation *is an emergency*, the prescriber may indicate that the prescription be filled by the provider before submitting the MA 97. The prescriber must still complete and submit the MA 97 for regular review. This request will be examined in the same manner as an initial request for an 1150 Administrative Waiver.

If DHS determines that the beneficiary's circumstances did not constitute an emergency situation and the MA 97 is denied, the *provider will not be compensated* for the service or item dispensed.

7.3.4 Steps for Payment

When the provider is presented with the beneficiary's prescription, the provider fills the prescription and completes a claim form in accordance with existing instructions for completion of the CMS-1500 Claim Form. Upon completion, the provider submits the original claim form to DPW for processing. (The provider should make a copy of the claim form for his/her file.) The provider should submit the CMS-1500 to the regular address for claim submission:

Department of Public Welfare
Office of Medical Assistance Programs
P.O. Box 8194
Harrisburg, PA 17105-8194

NOTE: PRIOR AUTHORIZED AND 1150 ADMINISTRATIVE WAIVER SERVICES CANNOT BE BILLED ON THE SAME CLAIM FORM.

7.4 Automated Utilization Review (AUR) Admission Certification

DHS automated the admission certification process for urgent and emergency admissions to acute care hospitals, hospital short procedure units, free-standing ambulatory surgical centers, and for all admissions to rehabilitation hospitals, rehabilitation units of general hospitals, drug and alcohol detoxification rehabilitation units, drug and alcohol treatment rehabilitation hospitals, psychiatric hospitals, psychiatric units of general hospitals, extended acute care psychiatric units of general hospitals and residential treatment facilities. This admission certification process was merged with the already automated Place of Service Review (PSR) Program for elective admissions to acute care hospitals, freestanding ambulatory surgical centers and hospital short procedure units. This merger is now known as the Automated Utilization Review (AUR) process.

The AUR process will affect claims submitted by physicians, dentists, and podiatrists.

7.4.1 Types of Admissions

- ELECTIVE** A preplanned admission to a hospital, hospital short procedure unit or ambulatory surgical center. The term includes an admission in which scheduling options may be exercised by the attending practitioner, facility or beneficiary without unfavorably affecting the outcome of the treatment.
- URGENT** An admission wherein medical care must be administered promptly and cannot be delayed.
- EMERGENCY** An admission to a hospital for a condition in which immediate medical care is necessary to prevent death, serious impairment, or significant deterioration of the health of the beneficiary.

ELECTIVE ADMISSIONS to acute care hospitals; freestanding ambulatory surgical centers and hospital short procedure units require a PSR number. **THE PRACTITIONER OR FACILITY MUST REQUEST THE NUMBER PRIOR TO ADMISSION.** (Refer to Section 7.4.2.)

URGENT AND EMERGENCY ADMISSIONS to all facilities and all admissions to cost-reimbursed facilities (rehabilitation hospitals/units, private psychiatric hospitals/units or extended acute psychiatric inpatient facilities) require an admission certification number. **THE FACILITY MUST REQUEST THE ADMISSION CERTIFICATION WITHIN TWO WORKING DAYS FOLLOWING ADMISSION.** (Refer to Section 7.4.3.)

7.4.2 Place of Service Review Program

The Place of Service Review (PSR) Program applies to all *elective* admissions to acute care hospitals, freestanding ambulatory surgical centers, and hospital short procedure units.

The PSR Program applies to physicians, dentists and podiatrists and determines:

1. Whether the proposed setting is appropriate; and
2. Whether the procedure is compensable under the MA Program.

The PSR takes place *prior* to admission and applies *only to elective* admissions to acute care hospitals, freestanding ambulatory surgical centers, and hospital short procedure units.

7.4.2.1 Admissions Exempt from PSR

The only exemptions to the requirement that PSR must be requested prior to admission are:

- A. URGENT or EMERGENCY ADMISSIONS – For urgent and emergency admissions, refer to the Admission Certification Process (Section 7.4.3)
- B. MATERNITY ADMISSIONS – Primary diagnosis codes must be entered in Block 21 of the CMS-1500 Claim Form. If a PSR Number is entered on the claim form, the claim form will reject.
- C. MEDICARE PART A ADMISSIONS – A PSR number will not be required for inpatient admissions if the beneficiary has Medicare Part A only. The practitioner must note in the Remarks Section of the claim form that the beneficiary has “Medicare Part A Only.” This

Medicare Part A exemption does not apply for hospital short procedure unit and freestanding ambulatory surgical center admissions.

D. MEDICARE PART B ADMISSIONS

E. NEWBORNS – As defined in 55 Pa. Code Chapter 1150, including newborns transferred from another hospital on the date of birth. The primary diagnosis code in Block 21 of the CMS-1500 Claim Form must indicate newborn.

F. ADMISSIONS TO REHABILITATION HOSPITALS, REHABILITATION UNITS OF GENERAL HOSPITALS, DRUG AND ALCOHOL DETOXIFICATION REHABILITATION UNITS AND DRUG AND ALCOHOL TREATMENT AND REHABILITATION HOSPITALS, PRIVATE PSYCHIATRIC HOSPITALS AND PSYCHIATRIC UNITS OF GENERAL HOSPITALS AND JCAHO CERTIFIED EXTENDED ACUTE PSYCHIATRIC UNITS OF GENERAL HOSPITALS AND RESIDENTIAL TREATMENT FACILITIES – ADMISSIONS TO THESE FACILITIES REQUIRE ADMISSION CERTIFICATION, REFER TO Section 7.4.3.

G. HMO BENEFICIARYS

7.4.2.2 Places of Service

A PSR number is required and must be entered in Block 23 of the CMS-1500 Claim Form when billing for elective surgical, surgical diagnostic, obstetrical, medical, or psychiatric service, when the service is provided in an inpatient hospital, ambulatory surgical center or short procedure unit.

NOTE: SERVICES THAT REQUIRE A PSR NUMBER SHOULD NOT BE INCLUDED ON THE SAME CLAIM FORM WITH SERVICES THAT DO NOT REQUIRE A PSR NUMBER. For example, an office visit rendered two weeks prior to an elective admission should be billed on a separate claim form. DO NOT enter a PSR number in Block 23 for the office visit.

7.4.2.3 The PSR Process

The attending practitioner has the primary responsibility for initiating Place of Service Review requests. However, requests may be initiated by either the attending practitioner or the facility where the procedure will be performed.

The practitioner or facility requests PSR by calling 1-800-558-4PSR (4777) between 7:30 a.m. and 4:00 p.m., Monday through Friday except Commonwealth holidays. You must provide the following information when requesting a PSR number:

1. Name and telephone number of the person initiating the request
2. 10-digit Beneficiary Number
3. Practitioner's 9-digit Provider Number and 4-digit Service Location
4. Practitioner's License Number
5. Facility's 9-digit Provider Number and 4-digit Service Location
6. ICD-9-CM Diagnosis Code for dates of service prior to October 1, 2015; or ICD-10-CM Diagnosis Code for dates of service on and after October 1, 2015
7. Procedure code from the MA Program Fee Schedule

8. Medical indications justifying the medical necessity for the procedure and the proposed setting
9. A brief medical history describing the previous treatment and/or diagnostic testing
10. Prior admission information if the beneficiary was admitted to a facility within the last 30 days
11. Admission and discharge dates
12. Provider Number and type
13. Transfer information on elective transfers from one facility to another – the provider type and MA ID Number of the transferring facility.

A form has been developed to simplify the request process. The form is titled “*Information For Place Of Service Review (PSR) Request*”. The provider cannot order this form. You may photocopy the blank form included in this section.

7.4.2.4 Place of Service Review (PSR) Notice

Practitioners may receive verbal certification of their PSR request during the telephone conversation with the nurse or physician reviewer. ***On all PSR certification requests, a written notification of the decision will be issued to the admitting practitioner, the facility, and the beneficiary.*** The approval is valid for 60 days from the date appearing in the DATE OF NOTICE field on the PSR Notice. The expiration date also appears on the PSR Notice.

NOTE: It is the provider’s responsibility to verify the beneficiary’s eligibility not only on the date of the PSR certification request but also on the date the service is rendered. A PSR certification does not guarantee payment if the service is not covered under the beneficiary’s Service Program or if the beneficiary is ineligible on the date of service. Please access the Eligibility Verification System (EVS) prior to rendering service.

The reverse side of the PSR Certification Notice contains additional information for providers and beneficiaries. To avoid confusion, the information for providers will not appear on the beneficiary’s copy.

7.4.2.5 Cases Involving Extended Courses of Treatment

An extended course of treatment is any plan of treatment that includes the same services repeated over an extended period of time (i.e., chemotherapy). For extended courses of treatment in short procedure units or freestanding ambulatory surgical centers, the PSR Program will certify up to ten treatments per request. The services must begin within 60 days of the certification, but do not have to be completed within 60 days of the certification.

Only one PSR certification will be necessary for those ten services unless the treatment plan changes. If the service being provided is altered (i.e., medication change), the change will be considered a new treatment plan and course of treatment and a new PSR certification will be required. For extended courses of treatment on an inpatient basis, each admission must be certified through the PSR process.

7.4.2.6 Re-evaluation and Appeals Process

If the attending practitioner disagrees with the decision made by DHS, the provider may request a re-evaluation of the decision. The re-evaluation may be requested by calling the PSR toll-free lines within **10 calendar days** of the date on the PSR notification letter.

The re-evaluation phase does not replace the formal appeal process. If a provider is not in agreement with the decision made by DHS, and if this was not resolved satisfactorily at the re-evaluation step, a formal appeal may be filed.

The facility, practitioner, or beneficiary has the right to file an appeal. A formal appeal must be submitted in writing within **30 calendar days** of the date on the PSR Certification Notice (MA 324). The appeal request should contain a copy of the MA 324 and information to support the reason for the appeal and should be sent to:

Bureau of Hearings and Appeals
Federal Hearings and Appeals Services
117 West Main Street
Plymouth, PA 18651-2926

Beneficiaries may request an appeal within **30 calendar days** of the date on the PSR Certification Notice by submitting a short letter to the address listed on the Notice. Hospitals, practitioners, and beneficiaries do not have the right to a separate appeal on the same case.

7.4.2.7 Late Pickups

There are certain circumstances where DHS will allow providers to request Place of Service Review certification after performing the procedure. Cases that fall into this category are termed “LATE PICKUPS”.

To qualify for late pickup status, one of the following situations must exist and be certified by the provider:

A. AN ELECTIVE PROCEDURE IS PERFORMED BEFORE MA ELIGIBILITY IS DETERMINED.

1. An individual is admitted for an elective procedure and does not have MA coverage at the time of admission. The county assistance office later determines the beneficiary was eligible on the date of service. The provider may apply for PSR certification within **30 calendar days** of the date notified of MA eligibility.
2. An individual applied for MA and has not received notification of eligibility by the time the provider feels the procedure needs to be performed. A late pickup can be requested within **30 calendar days** of the date notified of MA eligibility.

B. THIRD PARTY COVERAGE FAILS TO MATERIALIZE

1. An individual has private insurance **and MA** and the private insurance is expected to pay. The private insurance company rejects the claim. A PSR request must be made within **30 calendar days** of the date the practitioner was notified of the insurance rejection, because the individual is a known MA beneficiary. If the request is not made within the specified time period, the claim is denied. If the beneficiary has MA and private insurance, the provider has the option of requesting PSR **before** the service is provided and before receiving the Explanation of Benefits (EOB); however, all other insurance benefits must be exhausted before billing MA.

When calling PSR on a late pickup case, please advise the PSR nurse reviewer of the date the service was rendered and/or the admission date.

7.4.2.8 PSR Toll-Free Telephone Number

1-800-558-4777 – Monday through Friday – 7:30 a.m. to 4:00 p.m.

NOTE: Providers and facilities located in bordering states are not subject to PSR. However, if an adjacent state provider renders services in a Pennsylvania hospital, he/she must enter the PSR number on his/her claim form. ***There is no toll-free telephone number for out-of-state providers;*** therefore, you may call PSR at **(717) 772-6020**. If an in-state provider renders services in an out-of-state facility, the PSR number is not required.

7.4.2.9 Penalty for By-passing PSR

The practitioner or facility must request PSR ***prior*** to admitting an MA beneficiary to an acute care hospital, freestanding ambulatory surgical center, or hospital short procedure unit.

Under certain circumstances, DHS allows providers to request PSR after the procedure has been performed. These cases are “late pickups” and, if billed correctly, providers will receive the appropriate MA reimbursement payment on the claims.

However, when an admission requires PSR and the provider attempts to by-pass the PSR requirement by requesting PSR subsequent to the service, or if the provider erroneously designates an admission as urgent or an emergency, DHS will pay **50%** of the MA approved reimbursement amount for a correctly invoiced service.

7.4.3 Urgent and Emergency Admissions to DRG Facilities and All Admissions to CHR Facilities

Urgent and emergency admissions to Diagnosis Related Group (DRG) facilities and all admissions to Concurrent Hospital Review (CHR) facilities require Admission Certification. The Admissions Certification review must take place within ***two working days*** of admission and must be requested by the facility.

7.4.3.1 Exempt Admissions

The only exemptions to the Admission Certification process are:

1. **MATERNITY ADMISSIONS** – A primary diagnosis code of O10.011 through 09A.53 must be entered in Block 21 of the CMS-1500 Claim form. If an Admission Certification Number is entered on the claim form, the claim form will reject.
2. **MEDICARE PART A ADMISSIONS** – An Admission Certification Number is not required for inpatient admissions if the beneficiary has Medicare Part A only. The practitioner must note in the Remarks Section of the claim form that the beneficiary has Medicare Part A only. This Medicare Part A exemption does not apply for hospital short procedure unit and freestanding ambulatory surgical center admissions.
3. **MEDICARE PART B ADMISSIONS**
4. **NEWBORNS** – As defined in 55 Pa. Code Chapter 1150, including newborns transferred from another hospital on the date of birth. The primary diagnosis code in Item 26 of the MA 319/MA319C must indicate newborn (Z38.00 through Z38.8).

5. HMO beneficiaries*

*Admission certification is required for HMO beneficiaries admitted to extended acute care psychiatric units (inpatient) or to residential treatment facilities

7.4.3.2 Places of Service

An Admission Certification Number is required and must be entered in Block 23 of the CMS-1500 Claim Form when billing for surgical, surgical diagnostic, obstetrical, medical, or psychiatric services, in an inpatient hospital, ambulatory surgical center, or short procedure unit.

NOTE: SERVICES THAT REQUIRE AN ADMISSION CERTIFICATION NUMBER SHOULD NOT BE INCLUDED ON THE SAME CLAIM FORM WITH SERVICES THAT DO NOT REQUIRE AN ADMISSION CERTIFICATION NUMBER.

For example, an office visit rendered two weeks prior to an urgent admission should be billing on a separate claim form. Do not enter an admission certification number in Block 23 for the office visit.

Providers and facilities located in bordering states are not subject to the Admission Certification process. However, if the adjacent state providers render services in a Pennsylvania hospital, they must enter the Admission Certification Number on their claim form.

7.4.3.3 The Certification Process

The facility is responsible for initiating Admission Certification requests for urgent and emergency admissions to DRG facilities, hospital short procedure units, ambulatory surgical center and all admissions to CHR facilities. The facility must initiate the request via a telephone call to DHS within *two working days* of admission. When a nurse reviewer approves the admission, a 10-digit Admission Certification Number will be generated and will be listed on the Certification Notice sent to the physician. The facility will also receive a DRG/CHR Certification Notice.

Practitioners providing surgical, surgical diagnostic, non-delivery related obstetrical, medical, or psychiatric services for urgent or emergency admissions, or elective admissions to rehabilitation hospitals/units, private psychiatric hospitals/units, or extended acute psychiatric inpatient facilities, must enter the 10-digit Admission Certification Number in Block 23 of the CMS-1500.

Any physician claim form for urgent or emergency services provided in an inpatient hospital, ambulatory surgical center or short procedure unit, or for services in a rehabilitation hospital/unit, private psychiatric hospital/unit, or extended acute psychiatric inpatient facility, that does not contain an Admission Certification Number will be rejected unless the admission is exempt from the Admission Certification process.

NOTE: Only the facility can request certification for urgent or emergency admissions or for any admissions to CHR facilities, although the notification will be sent to the facility and the practitioner. The facility will be given the Certification Number at the time of the request. An exception to this process is as follows:

The practitioner may call the appropriate toll-free telephone number to certify an admission when the facility does not need to certify the admission because the hospital received payment from a third party insurance.

When an individual has private insurance *and MA*, and the private insurance is expected to pay but rejects the claim or makes partial payment, the MA Admission Certification request must be made

within 30 calendar days of the date the practitioner was notified of the insurance rejection or partial payment. If the request is not made within the specified time-period, payment will be denied. When calling on a late pickup case, you must advise the nurse reviewer of the date the service was rendered and/or the admission date. The required medical, beneficiary and provider information for requests must be on hand for discussion.

In the event that a facility does not certify an admission, the toll-free telephone number a practitioner may call to certify urgent or emergency admissions to acute care hospitals, hospital short procedure units, or free-standing ambulatory surgical centers is: **1-800-558-4DRG (4374)**.

The toll-free telephone number a practitioner may call to certify elective, urgent, or emergency admissions to cost reimbursed hospitals and units is: **1-800-558-4CHR (4247)**.

An Admission Certification Number does not guarantee payment if the beneficiary is not eligible or the service is not covered under the beneficiary's category of assistance. It is the provider's responsibility to verify the beneficiary's eligibility on the date of service and to ensure that the service provided is covered under the beneficiary's Service Program.

7.4.3.4 Denied Admissions

If the admission is not approved, DHS will deny payment to both the facility and the practitioner.

The facility or the practitioner has the right to file an appeal on any denied admission.

7.4.3.5 Readmissions within 31 Days of Discharge

If the beneficiary is readmitted to a facility within 31 days of discharge for a continuation of care, the practitioner will need a new Admission Certification Number in order to bill for services rendered on the admission or continuation of care admission.

The facility, not the practitioner, is responsible for contacting DHS to provide information necessary for certification of the admission.

The practitioner will receive a Hospital Admission DRG/CHR Certification Notice with a new Admission Certification Number to be used for services provided during the continuation of care admission.

NOTE: The facility will not receive an additional DRG payment for continuation of care admissions.

If the Admission Certification Unit determines that the readmission is the result of a premature discharge, payment for the readmission will be denied to both the facility and the practitioner.

NOTE: IF THE READMISSION IS AN ELECTIVE ADMISSION TO AN ACUTE CARE HOSPITAL, AMBULATORY SURGICAL CENTER, OR SHORT PROCEDURE UNIT, THE READMISSION WILL REQUIRE PSR CERTIFICATION PRIOR TO ADMISSION.

7.4.3.6 Appeals Process

If Admission Certification is denied and the attending practitioner disagrees with the decision made by DHS, the provider may file an appeal. A formal appeal must be submitted in writing within **30 calendar days** of the date on the Hospital Admission DRG/CHR Certification Notice. The appeal request should contain information to support the reason for the appeal and should be sent to:

Bureau of Hearings and Appeals

Federal Hearings and Appeals Services
117 West Main Street
Plymouth, PA 18651-2926

Hospitals and practitioners do not have the right to a separate appeal on the same care.

7.4.3.7 Late Pickups

There are certain circumstances where DHS will allow facilities to request Admission Certification after *two working days* from the date of admission. Cases that fall into this category are termed "LATE PICKUPS".

To qualify for late pickup status, one of the following situations must exist and be certified by the provider:

- A. An urgent or emergency admission to a short procedure unit, free standing ambulatory surgical center or inpatient hospital, or an admission to a rehabilitation hospital/unit, drug and alcohol detoxification rehabilitation hospital/unit, psychiatric hospital/unit, extended acute care psychiatric unit or residential treatment facility that occurred before MA eligibility was determined.
 - 1. An individual is admitted on an urgent or emergency basis and does not have MA coverage at the time of admission. The county assistance office later determines the beneficiary was eligible on the date of service. The facility may apply for Admission Certification within *30 calendar days* of the date notified of MA eligibility.
- B. Third party coverage fails to materialize.
 - 1. The individual has private insurance *and MA* and the private insurance is expected to pay. The private insurance company rejects the claim. An Admission Certification request must be made within *30 calendar days* of the date the facility was notified of the insurance rejection, because the individual is a known MA beneficiary. If the request is not made within the specified time period, payment will be denied.

When calling for DRG/CHR Admission Certification on a late pickup case, please advise the DRG/CHR nurse reviewer of the date the service was rendered and/or the admission date.

7.5 Benefit Limit Exceptions Criteria and Process

Effective January 1, 1993, DHS implemented modifications to the MA Program to provide medical services, to include six prescriptions per month for adult General Assistance (GA) beneficiaries, ages 21 to 65.

Effective August 10, 2005, DHS established criteria and a process to grant exceptions to the benefit limit for

- GA adult beneficiaries for
 - 18 practitioner/clinic visits per fiscal year (July 1 through June 30);
 - 30 home health visits per fiscal year
 - Six prescriptions per month
- Categorically needy adult MA beneficiaries for 18 practitioner/clinic visits per fiscal year (July 1 through June 30).

Effective September 30, 2011, DHS established limits to the dental benefit package for adult MA beneficiaries, 21 years of age and older, as well as criteria and a process to grant exceptions to the dental benefit package limits. Information related to dental services is found in the MA Program's Dental Provider Handbook:

http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/p_035985.pdf

Effective January 3, 2012, DHS established a limit of six outpatient legend and non-legend prescription drugs per month for categorically needy adult MA beneficiaries, 21 years of age and older, as well as criteria and a process to grant exceptions to the pharmacy benefit package limit. The six prescription drug limit does not apply to beneficiaries who are pregnant, including throughout the postpartum period, or reside in a nursing facility or intermediate care facility. The criteria and exceptions process to the benefit package limit of six prescriptions per month for adult GA eligible beneficiaries are revised to meet the same criteria and process established for categorically needy MA eligible beneficiaries.

7.5.1 Criteria for a Benefit Limit Exception

Exceptions to the numerical limits on prescription drugs, practitioner/clinic visits, home health visits and dental services may be granted when:

1. DHS determines the beneficiary has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the beneficiary; or
2. DHS determines the beneficiary has a serious chronic systemic illness or other serious health condition and denial of the exception will result in the rapid, serious deterioration of the health of the beneficiary; or
3. DHS determines that granting a specific exception is a cost effective alternative for the MA Program; or,
4. DHS determines that granting an exception is necessary in order to comply with Federal law.

7.5.2 Conditions that Qualify for a Benefit Limit Exception

- Hypertensive/Cardiovascular Disease
- Multi-system Diseases:
 - Hypertensive/Cardiovascular Disease
 - Pulmonary
 - Gastrointestinal
 - Musculoskeletal
 - Renal/Urinary
 - Central Nervous System
 - Endocrine
- Post Transplant
- Trauma Combined with any of the following diseases:

- Hypertensive/Cardiovascular Disease
- Pulmonary
- Gastrointestinal
- Musculoskeletal
- Renal/Urinary
- Central Nervous System
- Endocrine
- Acute Systemic or Recurrent Infections
- Post Emergency Room Follow-up Treatment
- Post Operative Care, Incident to the Operation
- Multiple Trauma
- Major Organ System Illness
- HIV/AIDS
- The beneficiary's condition is not covered by the list above, but it is the practitioner's opinion that the beneficiary's condition meets the regulatory criteria for an exception to the limits and warrants an exception.

7.5.3 Process to Request a Benefit Limit Exception for Medical and Home Health Visits

Practitioner determines that beneficiary meets criteria for an exception.

Practitioner requests additional services and provides the following information:

- Clinical presentation
- Is condition acute or chronic
- If chronic, how treated previously
- Is beneficiary compliant with treatment recommendations
- Services requested
- Diagnosis

Requests can be made by contacting the Exceptions Unit at 1-800-537-8862.

Written requests can be sent to:

Department of Human Services
GA Exceptions Unit
P.O. Box 8171
Harrisburg, Pennsylvania 17105-8171

DHS medical staff determines whether the request should be approved or denied. If the provider/practitioner indicates the request is urgent, the response will be made no later than 48 hours after the request is received. If the practitioner indicates the request is non-urgent, the

response will be made no longer than 21 days after the request is received. If the practitioner is not notified of a decision on an exception within 21 days, the request is deemed approved.

DHS may request additional medical documentation to determine the need for an exception. If additional information is requested, the 48-hour response to an urgent request is extended for the time required to receive the information.

If the exception request is denied, DHS will send written notice of denial to the practitioner and the beneficiary. Only the beneficiary has the right to appeal the denial.

If the exception request is approved, DHS will provide the practitioner with an authorization number for submission on the claim.

All correspondence related to an exception must include:

- Provider's name and medical license number;
- Provider type;
- Provider's address;
- Provider's telephone number;
- Beneficiary's name and identification number;
- 10-digit exception number, if one has been assigned.

7.5.4 Process to Request a Benefit Limit Exception for Home Health Visits After Receiving a Denial on the Remittance Advice

Home health providers who are aware that a beneficiary is reaching the limit of 30 home health visits per fiscal year should follow the process outlined in Section 7.5.3. However, if the home health provider unknowingly provided service beyond the 30-day limit and received a denial on the Remittance Advice statement, the provider may request a benefit limit exception following the regular process if the beneficiary appears to meet the exception criteria defined in Section 7.5.1. DHS's response for this request will be made no later than 21 days after the request is received.

7.5.5 Process to Request a Benefit Limit Exception for a Drug Prescription

- The prescribing provider may submit a request for approval of a benefit limit exception for a prescription which exceeds the limit of six prescriptions per month, is not approved under the automatic exceptions process, and will be dispensed on or after January 3, 2012 for a categorically needy adult MA beneficiary, or, on or after August 10, 2005 for a GA beneficiary.
- Practitioners may dispense up to a 5-day emergency supply of a prescribed medication without a benefit limit exception approval, if, in the professional judgment of the practitioner, the beneficiary has an immediate need for the medication and not supplying the medication would result in serious impairment to a beneficiary's health. A prescription for a pharmacy item dispensed as an emergency supply does not count toward the six prescriptions per month limit.
- The prescriber requests approval for a benefit limit exception by submitting the Pharmacy Benefit Limit Exception Request Form to MA Pharmacy Services at 1-866-327-0191; or, if

the prescriber does not have access to a fax machine, by calling MA Pharmacy Services at 1-800-537-8862. The following information is required from the medical prescriber:

- Beneficiary name, address, date of birth, and ACCESS card ID number
 - The prescriber's name, specialty, National Provider Number (NPI), state medical license number, address, telephone and fax numbers
 - Information about the drug that is being requested including the drug name, strength, quantity, directions, day supply, and anticipated duration of the regimen.
 - Copies of documentation from the beneficiary's medical record supporting the criterion for the benefit limit exception.
- Additional information may be required to determine the need for an exception. A determination is made, usually within 24 to 72 hours, once DHS receives all of the required medical documentation.
 - DHS will notify the prescribing provider by return fax indicating whether the request for an exception to the pharmacy benefit limit is approved or denied.
 - DHS will also send a written Notice of Decision to the prescribing provider and the beneficiary.
 - Only the beneficiary has the right to appeal the denial.
 - If the exception request is approved, the prescriber obtains an authorization number that he writes on the prescription. The prescription is filled by the pharmacy or the practitioner dispenses the approved medication to the beneficiary. The authorization number must be included on the claim submission.
 - When a PA for a drug is required for a reason other than an exception to the six prescriptions per month benefit limit, such as for an excessive quantity, a clinical review, or medical necessity for a non-preferred drug, the prescribing provider must still obtain approval from the Department that specifically addresses all PA requirements.

7.6 General Requirements for Prior Authorization and Program Exception Requests for Advanced Radiologic Imaging Services

7.6.1 Services That Require Prior Authorization or a Program Exception

The following advanced radiologic imaging services require prior authorization or a program exception, as described below:

- Computerized Tomography (CT) Scans
- Magnetic Resonance Angiogram (MRA) Scans
- Magnetic Resonance Imaging (MRI) Scans
- Magnetic Resonance Spectroscopy (MRS) Scans
- Nuclear Medicine Cardiology Scans
- Positron Emission Tomography (PET) Scans
- Single Photon Emission Computed Tomography (SPECT) Scans

7.6.1.1 Prior Authorization

A. Prior authorization is required for the following advanced radiologic imaging services:

- A non-emergency service listed on the MA Program Fee Schedule that is provided in an outpatient setting.
- A non-emergency service listed on the MA Program Fee Schedule that is provided in an outpatient setting to a Medical Assistance (MA) beneficiary who is in an inpatient facility.

B. Prior authorization is not required for the following advanced radiologic imaging services:

- A non-emergency service listed on the MA Program Fee Schedule that is provided in an inpatient setting.
- A service listed on the MA Program Fee Schedule that is provided on an emergency basis.

7.6.1.2 Program Exception (1150 Waiver)

A program exception requested through the administrative waiver process authorized by 55 Pa. Code § 1150.63 is required for the following advanced radiologic imaging services:

- A non-emergency service not listed on the MA Program Fee Schedule that is provided in an outpatient setting.
- The professional component of a non-emergency service not listed on the MA Program Fee Schedule that is provided in an inpatient setting.

7.6.1.3 Retrospective Review

A. Emergency Services Not on the MA Program Fee Schedule

A program exception is required for the following advanced radiologic imaging services provided on an emergency basis:

- A service not listed on the MA Program Fee Schedule that is provided in an outpatient setting.
- The professional component of a service not listed on the MA Program Fee Schedule that is provided in an inpatient setting.
- The request must be submitted within thirty days of the date of service, following the procedure in 7.6.2. If it is determined that the service was not provided to diagnose or treat an emergency medical condition, as set forth in Department regulations and program bulletins, the program exception request will be denied

B. Retroactive MA Eligibility

A prescriber may request authorization for claims for advanced radiologic imaging services provided to individuals who are determined to be eligible for MA retroactively (“late pickups”). The request must be submitted within thirty days of the date the prescriber or rendering provider receives notice of the eligibility determination. If it is determined that the service was not medically necessary, the authorization request will be denied.

C. Individuals with Third Party Resources

For those individuals with Third Party Resources, including Medicare and private insurance, the Department will not require PA or PE approval of advanced radiologic imaging services prior to the service being performed. In these instances, the rendering provider will submit

its claim for cost sharing to the MA Program in the usual manner as set forth in the CMS 1500 Billing Guide for PROMIS^e. If the Third Party Resource denies payment for the advanced radiologic imaging service or pays less than the MA Program fee, the prescriber may request retrospective approval from the Department within 30 days of the date of the Third Party Resource Explanation of Benefits.

D. Documentation Supporting the Need for a Service That Requires Prior Authorization or a Program Exception

The clinical information provided during the course of the prior authorization or program exception review must be verifiable within the patient's medical record. Upon retrospective review, the Department may seek restitution for the payment of the service and any applicable restitution penalties from the prescriber if the medical record does not support the medical necessity for the service. See 55 Pa. Code § 1101.83(b).

7.6.2 Procedure for Requesting Prior Authorization or a Program Exception for Advanced Radiologic Imaging Services

7.6.2.1 Initiating the Prior Authorization or Program Exception Request

A. Who May Initiate the Request

The prescribing practitioner must request prior authorization or a program exception.

B. How to Initiate the Request

The Department accepts prior authorization and program exception requests for advanced radiologic imaging services performed in an outpatient setting by telephone. Prescribers are to call 1-800-537-8862, (select Option # 1, then select Option # 3, then select Option # 3 again) between 7:30 a.m. and 4:00 p.m. (Eastern Standard Time), Monday through Friday.

7.6.2.2 Information and Supporting Documentation that Must Be Available for the Prior Authorization or Program Exception Review

The information required at the time prior authorization or a program exception is requested includes the following:

- Prescribing practitioner's name, address, and office phone number
- Rendering provider's or facility's Medical Assistance Identification (MAID) number and/or National Provider Identifier (NPI) number/taxonomy/zip code

NOTE: For a program exception request for an advanced radiologic imaging service not listed on the MA Program Fee Schedule, when the rendering provider and the reading physician are different providers, the MAID or NPI number is required for both providers.

- Beneficiary's name and Medical Assistance identification number
- Procedure code of the requested service
- Diagnosis and diagnosis code
- Clinical information to support the medical necessity of the requested service, including:
 - Symptoms and their duration
 - Physical examination findings

- o Actions previously taken to determine the beneficiary's diagnosis (e.g., X-rays, CT scans, lab work, ultrasound, scoped procedures, referrals to specialist, specialist evaluation)
- o Treatments that the beneficiary received (e.g., physical therapy, chiropractic or osteopathic manipulation, hot pads, massage, ice packs, medications)
- o Reason the service is being requested (e.g., further evaluation, rule out a disorder)

The following documentation from the medical record may also be requested:

- Clinical notes
- Specialist reports or evaluations
- Reports from previously completed diagnostic procedures (e.g., X-ray, CT, MRI, ultrasound reports)

7.6.2.3 Documentation for Medical Necessity

In evaluating a prior authorization or program exception request for an advanced radiologic imaging service performed in an outpatient setting, the determination of whether the requested service is medically necessary will take into account the elements specified in the most current version of the InterQual Clinical Content – Imaging guidelines.

7.6.2.4 Clinical Review Process

Requests for advanced radiologic imaging services will be reviewed by applying the clinical guidelines identified in 7.6.2.3 above, to assess the medical necessity of the requested service. If the reviewer determines that the requested service meets the clinical guidelines, the reviewer will approve the request. If the reviewer determines that the guidelines are not met, or is unable to determine whether the guidelines are met, the request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization or a program exception may be approved when, in the professional judgment of the physician reviewer, the advanced radiologic imaging service is medically necessary to meet the needs of the beneficiary.

7.6.2.5 Timeframe of Review and Notification of Decision

The Department will make a decision on the prior authorization or program exception request within two business days of receiving all information reasonably needed to make a decision regarding the medical necessity of the service. A decision may be made during the call, if sufficient information is provided at that time. If additional information is requested and not received by the 15th day of the date of initial request, the request will be denied for lack of sufficient information.

The Department will issue a written notice of the decision to the beneficiary, the prescribing provider and the rendering provider (if applicable). If a prior authorization or program exception request is denied or approved other than as requested, the beneficiary has the right to appeal the decision within thirty days from the date on the notice by submitting an appeal in writing to the address listed on the notice.

NOTE: An approved prior authorization or program exception request means only that the service has been determined to be medically necessary. It does not address the beneficiary's eligibility for the service on the date of service. It is the responsibility of the rendering provider to verify the beneficiary's eligibility through the Eligibility Verification System (EVS) on the date the service is provided.

7.6.2.6 Prior Authorization or Program Exception Number

If the prior authorization or program exception request is approved, the Department will issue a prior authorization or program exception number, which is valid for sixty days from the date the request. If the service appointment is rescheduled to a date beyond the sixty-day period, the prescribing practitioner must call 1-800-537-8862 (select Option #1, then select Option # 3, then select Option # 3 again) between 7:30 a.m. and 4:00 p.m. (Eastern Standard Time), Monday through Friday to request the authorization period be adjusted.

7.6.3 Procedures to Submit Claims

7.6.4 Submission of Claims

Follow the instructions for submitting a claim for an approved advanced radiologic imaging service found in the provider-specific billing guides on the Department's website at the following address:

<http://www.dhs.state.pa.us/publications/forproviders/promiseproviderhandbooksandbillingguides/index.htm>

Providers who are unable to access the billing guides online may obtain a hard copy by calling the Provider Service Center at 1-800-537-8862, Option # 1.

7.6.4.1 Submission of Physician Claims

- A. A physician claim submitted for the professional component of an advanced radiologic imaging service listed on the MA Program Fee Schedule that is provided in an outpatient or emergency room setting need not include the prior authorization number.
- B. A physician claim submitted for the professional component of an advanced radiologic imaging service not listed on the MA Program Fee Schedule that is provided in an outpatient, emergency room or inpatient setting must include the program exception number.
- C. When the rendering provider and reading provider are permitted to submit separate claims for a service provided in an outpatient setting approved through the program exception process, the MAID or NPI number of both providers must be included on both claims.

7.6.4.2 Claims for Emergency Room Services

When an advanced radiologic imaging service is provided in the emergency room and the beneficiary is admitted directly to the inpatient setting from the emergency room, the service must be included on the inpatient invoice rather than being billed as an outpatient claim.

8 Remittance Advice

The Remittance Advice (RA) Statement explains the actions taken and the status of claims and claim adjustments processed by DHS during a daily cycle. The processing date on the RA statement is the computer processing date for the cycle. Checks corresponding to each cycle are mailed separately by the Treasury Department.

The first page of the RA is used as a mailing label and contains the “Address” where the RA is being sent. This is followed by the “Detail” page(s) that list all of the claim forms processed during the PA PROMIS^e™ daily cycle. The next page is a “Summary” of activity from the detail page(s). Finally, the last page(s) is the Explanation of Edits Set This Cycle page(s).

8.1 Remittance Advice Address Page

The RA Address Page contains the address where the RA Statement is to be mailed and is used as a mailing label.

Providers may also find a Remittance Advice (RA) Alert on this page. From time to time, DHS may need to disseminate information quickly to the provider community. Consequently, an alert may be contained on the “Address” page of the RA Statement or in the form of an insert contained within the RA Statement.

The image shows a sample Remittance Advice Address Page from the Commonwealth of Pennsylvania Department of Public Welfare. It includes a header, a table with provider and processing information, a text alert, and a mailing address. Annotations 1, 2, 3, and 4 are placed around the form to highlight specific elements.

Commonwealth of Pennsylvania Department of Public Welfare		PA PROMIS ^e ™ Remittance Advice	
PROVIDER			
Provider ID	Service Location	Processing Date	Page
001456123	0001	04/14/2004	1

Cycles 50, 51, 01 & 02

The purpose of this alert is to make you aware that effective April 14, 2003, the Office of Medical Assistance Programs discontinued printing the recipient's Social Security Number on the yellow ACCESS Card.

The ACCESS card will still have the ten-digit recipient number, the recipient name and the two-digit card issue number printed on it. The card issue number is used for eligibility verification and for processing online pharmacy claims.

Until the old card stock is depleted, some recipient's may receive an ACCESS card that lists "SS#", but will have blank spaces after it.

The elimination of the Social Security Number from the ACCESS card should have no impact on providers and this action will not change key elements required to access services or eligibility information.

Send to Service Bureaus
5/26/03

Date:

31 001456123
Seaman, Joseph C
278 Main Street
Yourtown, PA 15000

Definitions of items circled on the above sample Remittance Advice Address Page:

1. **Provider Identification** Provider's 9-digit PA PROMIS^e™ provider number.
2. **Service Location** Provider's 4-digit service location.
3. **Name and Address of the Provider** Address on DHS's provider files that denotes where the RA statement will be mailed.
4. **Alert** From time to time, DHS may need to disseminate information quickly to providers. Unless specifically designated for a particular provider type, the information applies to all providers.

8.2 Remittance Advice Detail Page(s)

The detail pages of the RA statement contain information about the claim forms and claim adjustments processed during the daily cycle.

Claim form information contained on the detail pages is arranged alphabetically by beneficiary last name. If there is more than one provider *service location code*, claims will be returned on separate RA Statements as determined by each service location.

1 PROVIDER NUMBER 123456789
 2 LOC 0003
 3 TYPE 31
 4 NPI NUMBER 0123456789

COMMONWEALTH OF PENNSYLVANIA
 DEPARTMENT OF HUMAN SERVICES
 PA PROMISE
 PROVIDER REMITTANCE ADVICE

Processing Date: 06/29/2015
 Page: 63

5	ICN	LINE NUMBER	QTY	BEGIN DATE OF SERVICE	END DATE OF SERVICE	PROCEDURE CODE MODIFIER or DRUG ID	AMOUNT BILLED	AMOUNT PAID	STATUS	EXPLANATION CODES OR COMMENTS
7	RID: 5681935036					RECIPIENT NAME: HPP (Prod), YBTEYPY M				
	6915174001033	0					300.00	0.00	D	9010 D
	6915174001033	1	1	06/17/2015	06/17/2015	99213	300.00	0.00	D	
	6915174001033	98	0	06/17/2015	06/17/2015		300.00	35.00	CR	2715174002384/0001 (03)
17	COPAY:	0.00								
18	PATIENT ACCT NBR:	CO 15509	TC F6E	DATE OF CLAIM:	06/23/2015		CLAIM TOTAL BILLED:	0.00		35.00 CR
	6915174001034	0					300.00	0.00	D	9010 D
	6915174001034	1	1	06/18/2015	06/18/2015	99213	300.00	0.00	D	
	6915174001034	98	0	06/18/2015	06/18/2015		300.00	35.00	CR	2715170002277/0001 (02)
	COPAY:	0.00								
	PATIENT ACCT NBR:	CO 15509	TC F6F	DATE OF CLAIM:	06/23/2015		CLAIM TOTAL BILLED:	0.00		35.00 CR
	6915174001035	0					300.00	0.00	D	9010 D
	6915174001035	1	1	06/18/2015	06/18/2015	99213	300.00	0.00	D	
	6915174001035	98	0	06/18/2015	06/18/2015		300.00	35.00	CR	2715174002386/0001 (03)
	COPAY:	0.00								
	PATIENT ACCT NBR:	CO 15509	TC F6F	DATE OF CLAIM:	06/23/2015		CLAIM TOTAL BILLED:	0.00		35.00 CR

21 Central PA Medical Associates LLP
 PO BOX 9999
 1234 W East Street N
 Sampleville, PA 17777-9999

22 RA NUMBER 03/00041

1. **Provider Identification Number** Provider's 9-digit PA PROMIS^e™ provider number.
2. **Service Location** Provider's 4-digit service location.
3. **Provider Type** Provider type listed on the "Provider Notice Information Form".
4. **NPI Number** The 10-digit National Provider Identification number of the referring provider, ordering provider, or other source.
5. **Beneficiary Identification Number (RID)** Beneficiary's 10-digit ID number from Block 1a of the CMS-1500.
6. **Beneficiary Name** Beneficiary's name as identified by the beneficiary ID Number. Beneficiaries are listed alphabetically within each service location. If the beneficiary ID on the claim form does not match with a number in the system's files, a blank space appears instead of name.
7. **Internal Control Number (ICN)** The 13-digit number assigned by DHS to the claim form. For a paper claim the first two digits represent the Region Code, the third through the seventh digits represent the Year and Julian Date, the eighth through the tenth digits represent the Batch Number, and the eleventh through the thirteenth digits represent the Claim Sequence within the batch. For an electronic, POS or internet claim the first two digits represent the Region Code, the next five digits represent the year and Julian day with the first two digits being the year and the next three being the Julian day. The claim sequence number (SSSSSS) for all regions will start with 000001 with the exception of Region 77 which will start at 2000 and Region 87 which will start at 10000.
8. **Line Number** Number of the claim line on the claim form. The claim line may be 1 through 6.
9. **Quantity** Number of services provided as indicated on the claim line.
10. **Begin Date of Service** Beginning date that the service was performed, as indicated on the claim form.
11. **End Date of Service** Ending date that the service was performed, as indicated on the claim form.
12. **Procedure Codes, Modifier, Drug ID, and** Codes entered in Block 24D of the CMS-1500 claim form used to identify the types of services that were rendered.

Drug Code	Please consult your provider specific fee schedule for compensable procedure code/modifier combinations.
13. Amount Billed	Your usual charge less any third party payments for the service/item provided, as indicated on the claim form.
14. Amount Paid	Amount approved by MA for payment. Please note that MA pays the lesser of the following: the provider's usual charge or the established MA fee for the service/item.
15. Status	Disposition of the claim line as of the processing date. The Status Column of the RA indicates whether the claim has been paid, denied, or suspended: <ul style="list-style-type: none"> <li style="margin-top: 10px;">(P) Paid A claim, or claim line, that is approved for payment. The amount paid by the Commonwealth is listed. If the amount paid is not correct, follow the instructions in the Billing Guide to submit a Claim Adjustment. <li style="margin-top: 10px;">(D) Denied A claim or claim line that is rejected (denied.) Explanation code for the denial will be listed in the Explanation Code column. Look up the code's meaning on the Explanation of Edits Set This Cycle page(s) at the end of the RA. <ul style="list-style-type: none"> <li style="margin-top: 5px;">• Check the file copy of the claim form submitted to locate the error. <li style="margin-top: 5px;">• If the service is compensable, submit a new corrected claim form for the denied claim. Include the Internal Control Number (ICN) (or the Claim Reference Number (CRN) if the claim was submitted prior to 03/01/2004) of the rejected claim. Please refer to the appropriate billing guide for location on the claim form to enter the ICN or CRN or enter the applicable are when electronically billing

(S)
Suspended

A claim or claim line that is suspended is being held for manual review by DHS. The explanation code for the suspended claim will be listed in the Explanation Code column. Look up the code's meaning on the "Explanation of Edits Set This Cycle" pages(s) found at the end of the RA. *If a claim is suspended and does not appear on an RA as approved or rejected within 45 days, resubmit the claim.* If your claim has multiple lines the following should be taken in to consideration when reviewing your RA.

- If you see that some of the lines have an "S" for suspend, that means the whole claim is in a Suspend status. Please wait until the claim has been fully adjudicated (paid or denied) before deciding to take further action.
- If you see that line 0 (claim header line) is "D" denied, that means the entire claim is denied. If you believe the claim should not have denied, you may resubmit the claim. **[Note: Do not submit a denied claim as an adjustment. A denied claim cannot be adjusted since no payment was made.]**
- If you see that line 0 (claim header line) is "P" (Paid) and some lines have a "D" (denied,) the claim is considered paid, but the specific line(s) with the status "D" are denied. If you believe the claim or claim line should not have denied, you may resubmit that denied claim line. **[Note: If you resubmit the whole claim, the lines that previously paid on the first claim will be denied as a duplicate.]**

16. Explanation Codes or Comments

Messages to the provider. The code numbers help identify what was incorrect on the claim form (denial codes) or explain why DHS is manually reviewing the claim

8.3 PA PROMISe™ Remittance Advice Summary Page

This page contains information summarizing all action taken on your claims during the daily cycle.

COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE PA PROMISe PROVIDER REMITTANCE ADVICE			Processing Date: 05/21/2004 Page: 42,037			
PROVIDER NUMBER 123456789	LOC 0001	TYPE 24				
	①	②	③	④	⑤	⑥
	-----NUMBER-----				-----AMOUNT-----	
SUMMARY	PROCESSED	DENIED	SUSPENDED	APPROVED	BILLED	PAID
CLAIM / ADJUSTMENTS ⑦	2	2	0	0	149.00	0.00
CLAIM DETAILS ⑧	1	1	0	0	0.00	0.00
ADJUSTMENT DETAILS ⑨	1	1	0	0	149.00	6.99
SYSGEN CLAIM ADJ DETAILS ⑩	0	0	0	0	0.00	0.00
CREDITS ⑪	1	1	0	0	149.00	6.99 (CR)
NET GROSS ADJUSTMENT ⑫	0			0		0.00
LIEN PAYMENT ⑬	0			0		0.00
BEGINNING CREDIT BALANCE ⑭						0.00
PAYMENT AMOUNT ⑮						0.00
COPAY DEDUCTED ⑯						0.00
GA DEDUCTIBLE ⑰						0.00
UPDATE TO CR BALANCE ⑱						0.00
NEW CREDIT BALANCE ⑲						0.00
BEGINNING YTD BALANCE ⑳						87.49
NEW YTD TOTAL ㉑						87.49

CENTRAL PA MEDICAL ASSOCIATES LLP PO BOX 9999 1234 W EAST ST N SAMPLEVILLE, PA 17777-9999	RA NUMBER 43/01234 VT/ITEM NUMBER 31207777/000000
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1. **Number Processed** Total of all claim line items, adjustment line items, claim details, system-generated adjusted line items, credits and/or net gross adjustments and lien payments that were acted upon by PA PROMISe™ during the daily cycle.
2. **Number Rejected** Number of line items and number of adjustments denied.
3. **Number Suspended** Number of claim line items or adjustment claim line items held for further processing. These claims are awaiting approval or

rejection.

- 4. Number Approved** Number of items that were accepted for payment during the daily cycle.
- 5. Amount Billed** Total of the usual charges less third party payments billed as shown on the claim lines and/or claim adjustments.
- 6. Amount Paid** Dollar amount authorized for payment.
- 7. Claim/Adjustments** Total number of processed and billed amount on all claims and claim adjustment for this cycle.
- 8. Claim Detail** Number of line items and actual dollar amounts on processed, denied, approved, suspended, billed and paid claim line items.
- 9. Adjustment Details** Number of claim adjustment line and actual dollar amounts for the daily cycle.
- 10 Systems Generated Adjustment Line Items** Number of systems generated claim adjustment line and actual dollar amounts for the daily cycle. Usually the items relate to DHS initiated Third Party Liability (TPL) recoveries.
- 11 Credits** Amount originally paid on claims that are being adjusted during the daily cycle.
- 12 Net Gross Adjustment** Amounts debited (DB) and credited (CR) to a provider's account. CR indicates an amount of money owed to the Commonwealth, and this amount will be subtracted from the approved claim amount. DB indicates an amount of money owed to the provider and this amount will be added to the approved claim amount. Gross adjustments are transactions affecting a provider's account that are not processed by way of a claim form.
- 13 Lien Payment** Amount of the payment taken from a provider to pay the lien holder for this cycle.
- 14 Beginning Credit Balance** Amount owed to the Commonwealth as of the last Remittance Advice (RA) Statement.
- 15 Payment Amount** Actual dollar amount the provider will receive for the RA.
- 16 Copay Deducted** Amount of copayment deducted during this daily cycle.
- 17 GA Deductible** Amount a General Assistance beneficiary is required to pay toward his/her healthcare. GA Deductible (\$150.00 per year, assessed on a fiscal year basis) may be applied to general

hospitals (inpatient and outpatient, non-diagnostic services), hospital short procedure units (SPUs), ambulatory surgical centers (ASCs), rehabilitation hospitals (inpatient and outpatient), private psychiatric hospitals, and extended acute psychiatric inpatient care providers claims. Not applicable to providers who submit claims on the 837P or CMS-1500 Claim Form

- 18 Update to Credit Balance** Dollar amount on the Remittance Advice to be applied against the “Beginning Credit Balance”. This may be a positive or negative amount.
- 19 New Credit Balance** Balance owed to the Commonwealth by the provider after this weekly financial cycle.
- 20 Beginning Year to Date Balance** Cumulative amount paid to the provider in the current calendar year, not including this weekly financial cycle.
- 21 New Year to Date Total** Cumulative amount paid to the provider for the current calendar year, including the current RA Check Amount.

8.4 PA PROMISE™ “Explanation of Edits Set This Cycle” Page

This is always the last page(s) of the RA Statement. This page contains a list of the Explanation Codes or Comments that appear on the RA Detail page(s) for this weekly cycle. To the right of each Explanation Code is the description of the code.

COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES PA PROMISE PROVIDER REMITTANCE ADVICE	Processing Date: 08/24/2015 Page: 19,472 14
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PROVIDER NUMBER	LOC	TYPE	NPI NUMBER
012345678	0001	31	1234567890

EXPLANATION OF EDITS SET THIS CYCLE

1013	INVALID RELATIONSHIP BETWEEN BILL & REND PROVIDER
1019	INVALID RELATIONSHIP BETWEEN BILL & REND PROVIDER
1149	RENDERING TAXONOMY DOES NOT MATCH ANY REGISTERED.
2018	RECIPIENT IS BH MCO ELIGIBLE ON DATE OF SERVICE
204	RECIPIENT ID INVALID OR NOT FOUND ON CIS
2502	RECIP HAS MED B, NO MED DENIAL OR PMT INDICATED
2999	PENDED CLAIM TO DETERMINE RECIPIENT ELIGIBILITY
4021	RECIPIENT NOT ELIGIBLE FOR SERVICE PROVIDED
4036	PROCEDURE CODE/MODIFIER VS POS RESTRICTION
4045	PROV TYPE/SPEC/PROC CODE/MODIFIER INVALID
4046	PT/SPECIALTY/PLACE OF SERVICE COMBO IS INVALID
487	CLAIM SUBMITTED TO THE DEPT AS A MEDICARE CROSSOVER
830	SEQUESTRATION CARC REPORTED ON THE CLAIM LINE
9000	BILLED AMOUNT EXCEEDS ALLOWED AMOUNT

***** For complete Edit Descriptions, please click on the link below or visit the following web site: *****

<http://www.dhs.state.pa.us/provider/promise/errorstatuscodesanddescriptions/index.htm>

Definitions of the items circled on the above sample “Explanation of Edits Set This Cycle” page:

- | | |
|--|--|
| 1 Explanation Code or Comments | Messages to the provider. The reason code(s) are also found in the Explanation Codes or Comments column of the Remittance Advice Detail page(s). |
| 2 Messages to the provider Explanation Code Description | Description of the Explanation Codes or Comments found on the Remittance Advice Detail page(s) for this daily cycle. |

8.5 Claim Form Reconciliation Method

The daily RA statement reconciles submitted claim forms with MA claims processing activities. By itself, the RA statement will not serve as an accounts receivable report because:

- Suspended claims will be processed in a daily computer run. Therefore, the difference between claims processed over a certain time period and the paid/rejected claims during the same period may not equal outstanding submitted claim forms.
- The amount billed by the provider indicates the usual and customary charges and will ordinarily not equal the paid-in-full amount for services as determined by the PA PROMIS^e™ Program Fee Schedule.

To determine the “accounts receivable”, you should develop a “reconciliation” system. As an example, some providers use the following method:

Step 1 Your copies of claim forms that were submitted to DHS are placed in a “submitted” or “suspended” file. They are filed by date of submission to DHS. Within each submission date batch, the file copies are in alphabetical order by the beneficiary’s last name.

If you have made arrangements with DHS to use different service locations or payees, then you should have a separate submitted claim form file for each service location or payee. Your RA statement will be organized first by service location, then by beneficiary name in alphabetical order.

It is very important that you enter your own reference number (i.e., patient account number) or patient’s name in Block 26 (Patient’s Account Number) of the CMS-1500 to comply with your own filing system. The information entered into this box is listed in the first column of the RA statement. This information can be used to identify the patient on claims whenever the name of the beneficiary does not appear on the RA statement. If DHS cannot identify the patient due to an inaccurate beneficiary number, a blank space will appear on the RA Statement where the beneficiary’s name usually appears. When this situation occurs, the information entered on the claim form in Block 26 of the CMS-1500, will enable you to identify the patient and keep your own records up to date.

Step 2 Each additional batch of claim forms that is submitted is added to the back of the submitted/pending file so that the oldest file copies are in the front and the

most recent are in the back.

Step 3

Each time you receive an RA statement from DHS, the “submitted file” is compared to the RA statement.

- A. If a claim form has been “approved” and paid, that claim form is removed from the submitted file and placed with the provider’s permanent financial records.
- B. If there was an overpayment or underpayment, a claim adjustment is submitted. The file copy of the claim adjustment is added to the submitted file.
- C. If a claim form has been identified as “denied”, the file copy of that claim form is removed from the submitted file.
 - 1. If the denied claim form is one that DHS should not pay, (for example, the beneficiary is ineligible or the service is not covered), then the claim form is placed in your permanent record.
 - 2. If the denied claim form is one you believe DHS should pay, then prepare and submit a new claim form with the correct information. Correct information may be found in the provider’s records or secured from the beneficiary. If the Explanation Code indicates that it is a beneficiary eligibility related problem, access EVS to verify beneficiary eligibility. For all other problems, contact DHS. The provider copy of the resubmitted claim form is added to the resubmitted file as a regular claim form under the new date of submission.

Step 4

All file copies of submitted claims that are identified on the RA statement as suspended are left in your submitted file for comparison with future RA statements.

Step 5

If a claim form does not appear on an RA Statement as paid, denied, or suspended within 45 - 50 days after submission, resubmit the claim immediately. If you have Internet access, go to the PA PROMISE™ Internet site at promise.dhs.state.pa.us, to check the status of the claim or contact the Provider Inquiry Unit and request claim status. In most cases, claim forms will appear on an RA Statement 25-35 calendar days after submission.

This reconciliation system will not only make it easier to reconcile your submitted claims with DHS’s processing actions, but it will give you a quick indicator of the number of outstanding claims. It will also give you an approximate age (by submission date) of the outstanding claims.

9 HIPAA Requirements

This section includes how the Health Insurance Portability and Accountability Act (HIPAA) requirements were implemented and applied in the PA PROMIS^e™ Program. This section also describes how providers can become certified to submit HIPAA transactions and code sets. Additionally, the handbook will provide information on how the HIPAA security rules will protect private information in the PA PROMIS^e™ Program.

9.1 Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) became public law on August 21, 1996. It is a federal bi-partisan law based on the Kennedy-Kassebaum bill. The Department of Health and Human Services assigned the Centers for Medicare & Medicaid Services (CMS) the task of implementing HIPAA. The primary goal of the law was to make it easier for people to keep health insurance, and help the industry control administrative costs.

HIPAA is divided into five Titles or sections. Title I is Portability and has been fully implemented. Portability allows individuals to carry their health insurance from one job to another so that they do not have a lapse in coverage. It also restricts health plans from imposing pre-existing condition limitations on individuals who switch from one health plan to another.

Title II is called Administrative Simplification. Title II is designed to:

- Reduce health care fraud and abuse;
- Guarantee security and privacy of health information;
- Enforce standards for health information and transactions; and
- Reduce the cost of healthcare by standardizing the way the industry communicates information.

Titles III, IV, and V have not yet been defined.

The main benefit of HIPAA is standardization. HIPAA requires the adoption of industry-wide standards for administrative health care transactions; national code sets; and privacy protections. Standards have also been developed for unique identifiers for providers, health plans and employers; security measures; and electronic signatures.

9.1.1 Administrative Simplification

The goal of administrative simplification is to reduce health care administrative costs and promote quality and continuity of care by facilitating electronic data interchange (EDI). HIPAA establishes standards for 10 electronic health care transactions, national code sets, and unique identifiers for providers, health plans, employers, and individuals. It also establishes standards for ensuring the security of electronic health care transactions.

Although industry use of EDI is growing, health care transactions are transported and processed in various file structures and record layouts.

It is important to remember two things:

1. HIPAA does not require providers to submit claims or receive remittance advice statements electronically.
2. It also does not directly address paper claims.

9.1.2 Transactions Adopted

837 Professional	NCPDP 5.1 Claim	270 Eligibility Request
837 Institutional Inpatient	NCPDP 5.1 Reversal	271 Eligibility Response
837 Institution Nursing Home	NCPDP 5.1 Eligibility	
837 Dental	NCPDP 1.1 Batch	
835 Remittance Advice		

9.1.3 Code Sets Adopted

International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)	Diagnoses (all services) and Inpatient Hospital Procedures
National Drug Codes (NDC)	Drugs, Biologicals
Current Dental Terminology, fourth edition (CDT-4)	Dental Services
Current Procedural Terminology, fourth edition (CPT-4)	Physician and all other services
CPT-4 – Healthcare Common Procedure Coding System	Medical equipment, injectable drugs, transportation services, and other services not found in CPT-4
HCFA Health Care Claim Adjustment Reason Codes and Remittance Advice Remark Codes	

9.1.4 Software Options Available

Providers have four options for selecting software used to submit HIPAA-ready transactions to Pennsylvania Medical Assistance.

1. [Request Provider Electronic Solutions \(PES\)](#) software (provided free-of-charge).
2. Purchase certified HIPAA software from your vendor of choice.
3. Program your own system software.
4. Use a clearinghouse that uses HIPAA certified software.

All providers planning to submit HIPAA-ready claims, regardless of the origin of their software, need to register and be certified by HPE, DHS's claims processing contractor, prior to submitting their first claim. To register, please go to <https://promise.dpw.state.pa.us/ePROM/ProviderSoftware/softwareCertificationForm.asp> and complete the registration form. If you do not have Internet access, please call 717-975-6085, and leave your name and telephone number. A certification expert will contact you to complete the registration process.

9.1.5 HIPAA Claim Transaction Certification

For HIPAA-compliant transactions to be submitted, there is a certification process that involves registration and testing. When you register for certification, you must indicate the type of transactions you will be sending/receiving.

It is vital that you complete the certification process and become certified to exchange HIPAA transactions. Without certification, your files will not be accepted and your claims will not be processed.

Certification does not insure that claims will be paid.

9.1.5.1 Provider Electronic Solutions software

If you are looking for a way to send and receive HIPAA-ready electronic transactions and determine beneficiary eligibility, consider the Provider Electronic Solutions software. You can submit the following transaction types:

- EVS transactions (interactive and batch)
- Professional Claims (837P)
- Dental Claims (837D)
- Institutional Claims (837I)
- Long Term Care Claims (837I)
- Electronic Remittance Advice (835)
- Pharmacy Claims, Eligibility, and Extended Reversals (NCPDP 5.1)

NOTE: For more information on Provider Electronic Solutions software click on <http://promise.dpw.state.pa.us/ePROM/ProviderSoftware/softwareDownloadMain.asp>

Follow the directions to download the software.

NOTE: This software is available to you free-of-charge, and runs on Microsoft Windows operating systems on IBM compatible computers.

9.1.5.2 PA PROMIS^e™ Internet Providers

Providers who submit claim transactions directly through the PA PROMIS^e™ Internet Application do *not* require certification because this application is built to be HIPAA compliant. However, you are required to be an active provider in PA PROMIS^e™. You will also need a valid log on ID and a username and password to access PA PROMIS^e™.

9.1.5.3 Software Vendors/Developers

Clearinghouses, software vendors and developers distributing software to providers are required to certify through HPE. Upon successful certification, each vendor/developer will be assigned a Terminal ID. The software vendor/developer will provide this number to their users when distributing software. Providers who submit claims through a clearinghouse are covered under the clearinghouse's certification.

9.1.5.3.1 837/835 submitters:

- Clearinghouses and providers/submitters directly interacting electronically with the HPE clearinghouse must certify (this also includes providers using certified software purchased from a vendor).
- Providers submitting claims through a clearinghouse are covered under the clearinghouse's certification.

9.1.5.3.2 NCPDP 5.1 vendors:

- Software vendors and developers distributing software to providers must certify.
- Vendors of interactive software are also required to certify with WebMD.

9.1.5.3.3 NCPDP 5.1 interactive submitters:

- Submitters using certified software are covered under the software vendor's certification.
- Interactive submitters using certified vendor software will not be required to obtain an HPE HIPAA clearinghouse ID but will be required to register with WebMD.

9.1.5.3.4 NCPDP 1.1 batch submitters:

- Submitters using certified software are covered under the software vendor's certification.
- Each provider who submits batch transactions using certified vendor software is responsible for obtaining an HPE HIPAA clearinghouse ID that grants access to the HPE clearinghouse system.

9.1.5.3.5 270/271 vendors:

- Software vendors and developers distributing software to providers must certify.

9.1.5.3.6 270/271 interactive submitters:

- Submitters using certified software are covered under the software vendor's certification.

9.1.5.3.7 270/271 batch submitters:

- Submitters using certified software are covered under the software vendor's certification.
- Each submitter is responsible for obtaining an HPE HIPAA clearinghouse ID that grants access to the HPE clearinghouse system.

9.1.5.3.8 278 Prior Authorization

- Submitters using certified software are covered under the software vendor's certification.
- Each submitter is responsible for obtaining an HPE HIPAA clearinghouse ID that grants access to the HPE clearinghouse system.

Register for HIPAA certification by visiting the DHS website: http://promise.dpw.state.pa.us/ePROM/_ProviderSoftware/softwareDownloadMain.asp

Click on the "HIPAA Certification Registration Form" link. After you complete and electronically submit the registration form, an HPE representative will contact you to explain the certification process. If you do not have Internet access or need help completing the HIPAA Certification Registration Form, call the HPE Provider Assistance Center's toll-free telephone line at 1-800-248-2152 (Harrisburg area residents may call 717-975-6173).

9.2 HIPAA Privacy

The HIPAA Privacy Rule became effective on April 14, 2001 and was amended on August 14, 2002. It creates national standards to protect medical records and other protected health information (PHI) and sets a minimum standard of safeguards of PHI.

The regulations impact covered entities that are health care plans, health care clearinghouses and health care providers. Most covered entities, except for small health plans, must comply with the requirements by April 14, 2003. DHS performs functions as a health care plan and health care provider. Any entity having access to PHI must do an analysis to determine whether it is a covered entity and, as such, subject to the HIPAA Privacy Regulations.

9.2.1 Requirements

Generally, the HIPAA Privacy Rule prohibits disclosure of PHI except in accordance with the regulations. All organizations, which have access to PHI must do an analysis to determine whether or not it is a covered entity. The regulations define and limit the circumstances under which covered entities may use or disclose PHI to others. Permissible uses under the rules include three categories:

1. Use and disclosure for treatment, payment and healthcare operations;
2. Use and disclosure with individual authorization; and
3. Use and disclosure without authorization for specified purposes.

The HIPAA Privacy Regulations require Covered Entities to:

- Appoint a privacy officer charged with creating a comprehensive Privacy Policy.
- Develop minimum necessary policies.
- Amend Business Associate contracts.
- Develop accounting of disclosures capability.
- Develop procedures to request alternative means of communication.

- Develop procedures to request restricted use of PHI.
- Develop complaint procedures.
- Develop amendment request procedures.
- Develop individual access procedures.
- Develop an anti-retaliation policy.
- Train the workforce.
- Develop and disseminate the Privacy Notice.

9.2.2 Business Associate Relationships

As a covered entity, DHS must have safeguards in place when it shares information with its Business Associates. A Business Associate is defined by the HIPAA Privacy Regulation as a person or entity, not employed by the covered entity, who performs a function for the covered entity that requires it to use, disclose, create or receive PHI. The covered entity may disclose PHI to a Business Associate if it receives satisfactory assurances that the Business Associate will appropriately safeguard the information in accordance with the HIPAA requirements. These assurances are memorialized in a Business Associate Agreement that may or may not be part of a current contract or other agreement. The Business Associate language must establish permitted and required uses and disclosures and must require Business Associates to:

1. Appropriately, safeguard PHI.
2. Report any misuse of PHI.
3. Secure satisfactory assurances from any subcontractor.
4. Grant individuals access to and the ability to amend their PHI.
5. Make available an accounting of disclosures.
6. Release applicable records to the covered entity and the Secretary of Health and Human Services.
7. Upon termination of the Business Associate relationship, return or destroy PHI.

DHS's Business Associates include, but are not limited to Counties, Managed Care Organizations, Children and Youth Agency Contractors, and certain Contractors/Grantees. DHS's agreements with its Business Associates must be amended (or otherwise modified) to include the Business Associate language required for HIPAA compliance. DHS will discontinue sharing information and/or discontinue a relationship with a Business Associate who fails to comply with the Business Associate language.

9.2.3 Notice of Privacy Practice

A covered entity must provide its consumers with a plain language notice of individual rights with respect to PHI maintained by the covered entity. Beginning April 15, 2003, health care providers must provide the notice to all individuals on their first day of service, and must post the notice at the provider's delivery site, if applicable. Except in an emergency treatment situation, a provider must make a good faith effort to obtain a written acknowledgement of receipt of the

notice. Health plans must provide the notice to each individual enrolled in the plan as of April 14, 2003, and to each new enrollee thereafter at the time of enrollment, and within sixty days of any material revision to the notice. A covered entity with a web site must post its notice on the web site. A covered entity must document compliance with the notice requirements and must keep a copy of notices issued.

The specific elements of the notice include:

- Header: “This notice describes how medical information about you may be used and how you can get access to this information. Please review it carefully.”
- A description, including at least one example, of the types of uses and disclosures the covered entity may make for treatment, payment or health care operations.
- A description of each of the other purposes for which the covered entity is required or permitted to use or disclose individually identifiable health information without consent or authorization.
- If appropriate, a statement that the covered entity will contact the individual to provide information about health-related benefits or services.
- A statement of the individual’s rights under the privacy regulations.
- A statement of the covered entity’s duties under the privacy regulations.
- A statement informing individuals how they may complain about alleged violations of the privacy regulations.

9.2.4 Employee Training and Privacy Officer

Providers must train their employees in their privacy procedures and must designate an individual to be responsible for ensuring the procedures are followed.

9.2.5 Consent and Authorization

9.2.5.1 Consent

The HIPAA Privacy Regulations permit (not require) a covered entity to obtain a consent from a patient to use and disclose PHI for treatment, payment and health care operations. DHS will be obtaining consent for treatment, payment, and health care operations from its clients, where practicable.

9.2.5.2 Authorization

The HIPAA Privacy Regulations make a clear distinction between consents and authorizations. Consents are used only for disclosures related to treatment, payment and health care operations. The covered entity is required to have an authorization from an individual for any disclosure that is not for treatment, payment, or health care operations or exempted under the regulations. An authorization must clearly and specifically describe the information that may be disclosed, provide the name of the person or entity authorized to make the disclosure and to whom the information may be disclosed. An authorization must also contain an expiration date or event, a statement that the authorization may be revoked in writing, a statement that the information may be subject to redisclosure and be signed and dated.

9.2.6 Enforcement

DHS is not responsible for the enforcement of the HIPAA privacy requirements. This responsibility lies with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR). The enforcement activities of OCR will involve:

- Conducting compliance review;
- Providing technical assistance to covered entities to assist them in achieving compliance with technical assistance;
- Responding to questions and providing guidance;
- Investigating complaints; and, when necessary,
- Seeking civil monetary penalties and making referrals for criminal prosecution

9.3 HIPAA Security Rule

The HIPAA Security Rule sets guidelines for the protection of private information. Security is the policies, procedures, technical services, and mechanisms used to protect electronic information. It mandates computer systems, facility, and user security safeguards. These safeguards are intended to minimize unauthorized disclosures and lost data.

9.4 Penalties for Noncompliance

The penalties outlined for the two rules released to date are as follows:

Penalties for the Transactions and Code Sets are aimed at the health plans, billing services and providers who submit claims electronically.

They are:

\$100 per violation (defined as each claim element) Maximum of \$25,000 per year.

Privacy affects all covered entities, such as health plans, billing services, providers and business associates who receive and use protected health information. The penalties for wrongful disclosures are:

Up to \$250,000 AND 10 years in prison.

For more information on penalties, please go to <http://www.hhs.gov/ocr/hipaa>

9.5 Additional HIPAA Information

Located below are some links to pages of the HIPAA section of the DHS Internet site that you can visit for the most up-to-date information on HIPAA.

For General HIPAA information:

<http://www.dhs.state.pa.us/yourprivacyrightshipaa/index.htm>

For Office of Medical Assistance HIPAA information:

<http://www.dhs.state.pa.us/yourprivacyrightshipaa/index.htm>

For HIPAA Compliant Provider Billing Guides:

<http://www.dhs.state.pa.us/publications/forproviders/promisecompanionguides/index.htm>

For information on HIPAA Certification:

<http://www.dhs.state.pa.us/provider/promise/certification/index.htm>

10 Provider Preventable Conditions (PPCs)

This section is for:

- Clinics, including hospital based medical-surgical clinics, independent medical-surgical clinics, and family planning clinics paid from the MA Program Fee Schedule;
- Rural health clinics, federally qualified health centers and birth centers paid under a prospective payment rate; and
- Practitioners, including physicians, dentists, podiatrists, certified registered nurse practitioners, optometrists and midwives paid from the MA Program Fee Schedule.

Note: For specific billing requirements, please refer to the Billing Guide for your specific provider type.

The Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), enacted March 23, 2010, required the United States Department of Health and Human Services to prohibit payment by state Medicaid programs for health care acquired conditions (HCACs), effective July 1, 2011.

10.1 Requirements

On June 6, 2011, the Centers for Medicare and Medicaid Services (CMS), the agency within HHS that administers the Medicare program and works in partnership with states to administer Medicaid programs, established an umbrella term of provider preventable conditions (PPCs), which encompasses HCACs and other provider preventable conditions (OPPCs), and promulgated regulations regarding Medicaid program payment prohibitions for PPCs. While the statutory effective date is July 1, 2011, CMS delayed compliance action on these provisions until July 1, 2012. (See Federal Register (FR), Vol.76, No. 108, 32816-32838).

A HCAC is defined as “a condition occurring in any inpatient hospital setting, identified currently or in the future, as a hospital-acquired condition (HAC) by the Secretary of HHS under section 1886(d)(4)(D) of the Social Security Act (Act), other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients”. On August 16, 2010, the Centers for Medicare and Medicaid Services published the list of Medicare HACs for FY 2011. (See FR, Vol. 75, No. 157, 50042-50677). Section 5001(c) of the Deficit Reduction Act provides for the revision of the list of (HAC) conditions from time to time. (See FR, Vol. 76, No. 160, 51476-51846).

An OPPC is defined as “a condition occurring in any health care setting that meets the following criteria:

- is identified in the state’s Medicaid State Plan;
- has been found by the state, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
- has a negative consequence for the beneficiary;
- is auditable;

- includes, at a minimum,
 - wrong surgical or other invasive procedure performed on a patient;
 - surgical or other invasive procedure performed on the wrong body part; and
 - surgical or other invasive procedure performed on the wrong patient.

A state's Medicaid State Plan must prohibit payment for PPCs, including Medicaid payments for services received by individuals dually eligible for Medicare and Medicaid. The state must ensure that the non-payment for PPCs does not prevent access to services for its Medicaid beneficiaries. Additionally, state's Medicaid State Plan must require that providers identify PPCs that are associated with claims for Medicaid payment or with courses of treatment furnished to Medicaid beneficiaries for which Medicaid program payment is otherwise available.

A state may not reduce a MA payment to a provider for a PPC if the PPC existed prior to the initiation of treatment of the patient by that provider. Further, a state is required to reduce payments only to the extent that the PPC results in an increased payment to the provider and the portion of the payment directly related to treatment for, and related to the PPC can be reasonably isolated. Finally, Federal Financial Participation (FFP) will not be available for state expenditures for PPCs.

The Department is committed to ensuring that quality health care is provided to eligible MA beneficiaries in all healthcare settings. Although not specifically naming PPCs as such services, the Department has long prohibited payment for services that are harmful to beneficiaries of inferior quality or medically unnecessary. More specifically, the MA program has the following relevant payment limitations:

- 62 PS. 1407 (a)(6) and 55 Pa.Code §1101.77(a)(10) prohibits the submission of claims for the provision of MA services which the Department's medical professionals have determined to be harmful or of little or no benefit to the beneficiary, of inferior quality, or medically unnecessary;
- 55 Pa.Code §1101.71 relating to utilization control sets forth the MA Program's responsibility to establish procedures for reviewing the utilization of and payment for, MA services in accordance with section 1902(a)(3) of the Act (42 U.S.C.A. §1396a(a)(30)) as well as the provider's responsibility to cooperate with such reviews;
- 55 Pa.Code § 1101.83 relating to restitution and repayment, sets forth the Department's right to restitution for noncompensable services; and 55 Pa.Code §1150.61 relating to general payment policy, sets forth that the Department will pay for covered services that comply with applicable regulations.

On September 30, 2011, the Department submitted a State Plan Amendment (SPA) to the CMS assuring compliance with the federal statutory requirements for non-payment of PPCs. Upon CMS approval of the SPA, the Department will implement the provision for prohibition of payment for PPCs, i.e., HCACs and the required OPPCs, which consist of the wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, and surgical or other invasive procedure performed on the wrong patient.

10.2 Procedure

In order to comply with the above federal and state statutory requirements and MA Program payment regulations, affected providers are required to report PPCs, including HCACs and OPPCs on or attached to their claims to the Department.

The Department will adjust affected provider payments for HCACs and OPPCs in accordance with federal and state statutory requirements and MA Program payment regulations in the following manner:

10.2.1 Health Care Acquired Conditions (HCACs)

Acute care general hospitals and inpatient rehabilitation and psychiatric hospitals and excluded rehabilitation and psychiatric units of acute care general hospitals must report a “Present On Admission” (POA) indicator for each diagnosis code on their claim(s). POA indicators include the following:

- Y – described as “Diagnosis was present at the time of inpatient admission”.
- N – described as “Diagnosis was not present at the time of inpatient admission”.
- U – described as “Documentation insufficient to determine if condition was present at the time of admission”.
- W – described as “Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission”.
- Blank - described as “Exempt from POA reporting” (electronic or internet claims, must be reported with POA Exempt Diagnosis).
- 1 – described as “Exempt from POA reporting” (paper claims only, must be reported with POA Exempt Diagnosis)

Acute care general hospitals and inpatient rehabilitation and psychiatric hospitals and excluded rehabilitation and psychiatric units of acute care general hospitals are required to report HCACs by using the applicable POA indicator on their claims. Additionally, rehabilitation and psychiatric hospitals and excluded rehabilitation and psychiatric units of acute care general hospitals are required to report HCACs through the Department’s Concurrent Hospital Review (CHR) Process.

The Department will exclude any HCAC diagnosis code or HCAC diagnosis code/procedure code combination associated with the applicable POA indicator from grouping of the acute care general hospital’s inpatient claim. The Department then will be able to reasonably isolate costs associated with the HCAC and thereby ensure that the hospital receives the appropriate All Patient Refined-Diagnosis Related Group (APR-DRG) payment and does not receive payment for a higher paying APR-DRG or an APR-DRG with a higher severity level.

The Department will deny days associated with HCACs and reduce the number of inpatient covered days by the denied number of days on inpatient rehabilitation and psychiatric hospitals’ and excluded rehabilitation and psychiatric units of acute care general hospitals’ inpatient claims, as determined through physician review under the Department’s CHR process and as reported by the POA indicator on the claim.

10.2.2 Other Provider Preventable Conditions (OPPCs)

When an OPPC occurs, acute care general hospitals and inpatient rehabilitation and psychiatric hospitals and excluded rehabilitation and psychiatric units of acute care general hospitals are required to complete the OPPC Self Reporting Form (MA 551) according to directions and submit the form as an attachment to their claim following the directions for submitting a claim attachment according to the applicable provider's billing guidelines. Acute care general hospitals and inpatient rehabilitation and psychiatric hospitals and excluded rehabilitation and psychiatric units of acute care general hospitals are reminded that they must identify all practitioners involved and provide details relating to the OPPC event.

The Department developed a new claims processing edit to post on inpatient claims when one or more of the following diagnosis codes are indicated on the OPPC Self Reporting attachment to the claim:

- Y65.51 defined as "Performance of wrong operation (procedure) on correct patient";
- Y65.52 defined as "Performance of operation (procedure) on patient not scheduled for surgery"; or
- Y65.53 defined as "Performance of correct operation (procedure) on wrong side/body part".

The Department will manually review acute care general hospital claims to determine whether the identified OPPC will result in a higher APR-DRG or increases severity associated with the APR-DRG. If so, the payment will be reduced to the appropriate APR-DRG and severity level and payment will be made to the hospital accordingly. If the acute care general hospitalization is solely the result of an OPPC that occurred upon admission, the Department will not make an APR-DRG payment to the hospital.

The Department will not make a per diem payment to inpatient rehabilitation and psychiatric hospitals and excluded rehabilitation and psychiatric units of acute care general hospitals when an OPPC is reported with the claim as denied through the CHR process.

All other affected providers are required to report the applicable procedure code(s) with one or more of the following modifiers on the claim when an OPPC occurs:

- PA defined as "Surgical or other invasive procedure on the wrong body part"
- PB defined as "Surgical or the invasive procedure on the wrong patient"
- PC defined as "Wrong surgery or other invasive procedure on the patient".

The Department will deny the nursing facilities', county nursing facilities', state operated nursing facilities', ICF/IDs', and ICF/ORCs' per diem payment when an OPPC is reported on the claim.

The Department will deny the ambulatory surgical centers', hospital short procedure units', clinics', and practitioners' MA Fee Schedule payment when an OPPC is reported on the claim. In instances when an OPPC occurs during an operation involving multiple surgical procedures, anesthesiologists are to submit two separate claims and adhere to the following instructions:

- Submit a claim and report the anesthesia time (in minutes) associated with the procedure code that **is not related** to the OPPC.
- Submit a second claim and report the anesthesia time (in minutes) associated with procedure code and modifiers PA, PB, and/or PC that **are related** to the OPPC.

FQHCs and RHCs are to report the applicable procedure code with one or more of the modifiers PA, PB or PC on the CMS 1500 claims form or the 837P electronic claim form when an OPPC occurs. The Department will deny the FQHC's or RHC's provider specific prospective encounter payment when an OPPC is reported on the claim.

Dentists are to report OPPCs using modifiers PA, PB, and/or PC in the "Remarks" section of the ADA claim form or in the "Billing Note" of the electronic dental (837-D) or Internet dental claim media. The Department will deny the dentist's payment when an OPPC is reported on the claim.

Providers may download the OPPC Self Reporting Form by accessing the following website link:

<http://www.dhs.state.pa.us/findaform/ordermedicalassistanceforms/index.htm>.

MA beneficiaries and/or their families are held harmless and **the affected provider and/or facility are not permitted to bill the MA beneficiary or their families for PPCs, which includes the billing of any applicable MA copayment, deductible or coinsurance amount.**

Providers are required to report PPCs to the Department as directed in their MA Program Provider Handbooks.

Providers are to refer to MA Bulletin 01-12-30 03-12-27 09-12-32 18-12-01 31-12-32 33-12-31 02-12-27 08-12-30 14-12-27 27-12-28 32-12-27 47-12-01 titled "Provider Preventable Conditions", issued June 15, 2012 and effective July 1, 2012, and any subsequent MA Bulletins for information regarding PPCs.

10.2.3 Ordering and Prescribing Requirements

The Patient Protection and Affordable Care Act (ACA) added requirements for provider screening and enrollment, including a requirement that states require physicians and other practitioners who order or prescribe items or services for MA beneficiaries to enroll as MA providers. The Department of Health and Human Services regulation implementing this requirement can be found at 42 CFR § 455.410.

Providers should check their PROMISe™ billing guide for further directions on including the NPI of the MA enrolled provider who ordered or prescribed the item or service on the claim. The billing guides will instruct providers where to populate the NPI of the ordering or prescribing MA enrolled provider on the claim. Below is the link to the billing guides.

<http://www.dhs.pa.gov/publications/forproviders/promiseproviderhandbooksandbillingguides/index.htm>

PLEASE NOTE: This requirement applies only to the following Provider Types:

- **Provider Type 03** – Extended Care Facilities for Respite Care Services
- **Provider Type 05** – Home Health Agency
- **Provider Type 06** – Hospice
- **Provider Type 08** – Clinic
- **Provider Type 09** – Certified Registered Nurse
- **Provider Type 11** – Mental Health/Substance Abuse Services Provider
- **Provider Type 16** – Nurse
- **Provider Type 17** – Therapist
- **Provider Type 19** – Psychologist
- **Provider Type 20** – Audiologist
- **Provider Type 21** – Case Manager
- **Provider Type 25** – Durable Medical Equipment and Medical Supplies
- **Provider Type 28** – Laboratory
- **Provider Type 29** – X-Ray Clinic
- **Provider Type 30** – Renal Dialysis Clinic
- **Provider Type 31** – Physician
- **Provider Type 33** – Certified Nurse Midwife
- **Provider Type 35** – Public Schools
- **Provider Type 59** – Home & Community Based Waiver Services