



MEDICAL ASSISTANCE BULLETIN
COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF PUBLIC WELFARE

NUMBER: 99-03-08

ISSUE DATE:
July 29, 2003

EFFECTIVE DATE:
July 1, 2003

SUBJECT: Change of Protocol for Certain Provider Appeals.
Appeals must be sent to Bureau of Hearing and Appeals.

BY:

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Acting Deputy Secretary
Office of Medical Assistance Programs

PURPOSE:

The purpose of this bulletin is to inform providers that, effective July 1, 2003, the Department requires that certain provider appeals (including those pertaining to Diagnosis Related Group (DRG), Concurrent Hospital Review (CHR), 180-Day Exception, Pre-Certification, and Retrospective Review) must be filed directly and exclusively with the Bureau of Hearings and Appeals.

SCOPE:

This bulletin applies to all providers enrolled in the Medical Assistance (M A) Program's fee-for-service (FFS) delivery system and is applicable to the **fee-for-service delivery system only**. Providers enrolled in managed care organizations (MCOs) should contact their individual MCO for guidance relating to appeal requests.

BACKGROUND:

Previously, in some circumstances, certain provider appeals were filed with the program office that issued the denial. The program office, in turn, forwarded the appeal to the Bureau of Hearings and Appeals. Due to passage of Act 2002-142, 67 Pa. C.S.A. § 1101 et seq., effective July 1, 2003, and the resulting Standing Practice Order ("SPO"), 33 Pa.B. ____ (No. 26, June 28, 2003), all provider appeals (including those pertaining to Diagnosis Related Group, Concurrent Hospital Review, 180-Day Exception, Pre-Certification, and Retrospective Review) must be filed directly and exclusively with the Bureau of Hearings and Appeals.

These appeals, which were previously filed with the program office, will be handled pursuant to SPO Rule 32 relating to expedited disposition of certain appeals. Provider appeals may be filed with the Bureau of Hearings and Appeals only in response to written denials of the program office. All provider appeals must be submitted in accordance with all applicable rules, including the instructions on the notice of agency action (pertaining to the timeliness and other requirements of SPO Rule 19) and must include all appropriate documentation (as set forth in SPO Rule 18(b)). If the program office's denial is based on the lack of medical necessity, the provider must include a copy of the complete medical record.

The provider must also send an **exact and complete copy** of its appeal and **all attached documents** to the program office that issued the notice of the agency action. The copy must be sent to the program office at the same time the provider files its appeal with the Bureau of Hearings and Appeals. In order for the appeal to be processed in a timely manner, it is important that all required information be submitted to both the Bureau of Hearings and Appeals and the program office at the time of the appeal.

PROCEDURE:

All provider appeals (including those pertaining to Diagnosis Related Group, Concurrent Hospital Review, 180-Day Exception, Pre-Certification, and Retrospective Review) must be filed directly and exclusively with the Bureau of Hearings and Appeals at the following address:

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

The provider must also send an exact and complete copy of its appeal and all attached documents to the program office that issued the notice of the agency action. The copy must be sent to the program office at the same time the provider files its appeal with the Bureau of Hearings and Appeals.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate toll-free telephone number for your provider type.

Visit the Office of Medical Assistance Programs website at www.dpw.state.pa.us/omap.