



ISSUE DATE	EFFECTIVE DATE	NUMBER
May 25, 2018	May 25, 2018	99-18-08
SUBJECT	BY	
Update to 180-Day Exception Requests and Invoice Submission Time Frames		 Sally A. Kozak, Acting Deputy Secretary Office of Medical Assistance Programs

**IMPORTANT REMINDER:** All providers must revalidate the Medical Assistance (MA) enrollment of each service location every 5 years. Providers should log into PROMISE to check the revalidation dates of each service location and submit revalidation applications at least 60 days prior to the revalidation dates. Enrollment (revalidation) applications may be found at:  
[http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S\\_001994](http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994).

**PURPOSE:**

The purpose of this bulletin is to alert Medical Assistance (MA) providers to updated information related to the 180-day exception process.

**SCOPE:**

This bulletin applies to MA enrolled providers rendering services and submitting claims for payment in the physical health and behavioral health Fee-for-Service delivery system. It does not apply to providers submitting 180-day exception requests for Home and Community Based Waiver Services or to providers rendering services in the managed care delivery system.

**BACKGROUND:**

The regulation at 55 Pa. Code § 1101.68 (relating to invoicing for services) established requirements for submitting claims for services rendered to MA beneficiaries.

Under the above cited regulation, providers of MA services are required to submit initial claims no later than 180 days from the date the service was rendered or the compensable item was provided unless the claim meets the invoice exception criteria, referred to as a 180-day exception.

**COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:**

The appropriate toll free number for your provider type

Visit the Office of Medical Assistance Programs Web site at  
<http://www.dhs.pa.gov/provider/healthcaremedicalassistance/index.htm>

Since the release of MA bulletin 99-91-02, “180-Day Exception Requests and Invoice Submission Timeframes,” the Department has made operational changes that impact the 180-day exception process.

### **DISCUSSION:**

Providers can verify the Department’s receipt of a claim by noting the assignment of a 13-digit Internal Control Number (ICN), which appears on the Remittance Advice (RA). The ICN number contains the Julian calendar date on which the claim was received. If a claim fails to appear on an RA within 45 days of the date of submission, it should be resubmitted. Likewise, if a claim is pending and does not appear on the RA as approved or rejected, the claim should be resubmitted after 45 days.

A claim that was submitted within the 180-day deadline and denied can be resubmitted with corrected information. Providers must include the 13-digit ICN and the RA number in the Remarks section of the resubmitted claim in order for payment to be made. **All resubmitted claims must be received within 365 days** from the date the service was rendered or the compensable item was provided.

Initial claims received after 180 days from the date the service was rendered or the compensable item was provided will be denied unless they meet specific criteria for a 180-day exception and the process described below is followed.

### **PROCEDURE:**

The Department 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 from the date the service was rendered or the compensable item was provided. The Department must receive the provider's 180-day exception request within 60 days of the CAO's eligibility determination.
2. The provider requested payment from a third party insurer within 60 days from the date the service was rendered or the compensable item was provided. 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.
3. A Prior Authorization, Benefit Limit Exception, Program Exception, Place of Service Review, Diagnosis Related Group or a Concurrent Hospital Review was approved by the Department. The Department must receive the provider's 180-day exception request within 60 days of the date of the notice of decision.

If the claim meets one of the criteria, the provider must take the following steps to submit a request for a 180-day exception:

1. Complete a paper claim form as specified in the billing guide. The claim must be an original. No file copies or photocopies will be accepted.
2. Complete a 180-day Exception Request Detail Page and submit it to the Department with each exception request. **Do not fold or staple the forms. Use a large envelope.**
3. Include all supporting documentation. Supporting documentation must include the following, depending on which of the criteria is the basis for the request for a 180-day exception:
  - A copy of the PA162 (Notice of Eligibility) from the CAO.
  - A copy of the Explanation of Benefits, RA or a denial from the third party insurer. The provider is responsible for identifying and using all the patient's medical resources before billing the Department.
  - If the provider received a notice of decision issued by the Department, a copy of the notice should be submitted.

Send the paper claim form, the 180-day Exception Request Detail Page and supporting documentation to:

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

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

**Exceptions will be granted on a one-time basis.** Providers will receive a notice stating the Department's decision if the exception request is denied. If an exception request is granted, the claim form and its required documentation will be submitted for processing. The appearance of the claim on the provider's RA will be the provider's notification that the exception request was granted.

The fact that the Department approves a 180-day exception does not guarantee that the claim will not be rejected for reasons other than timeliness requirements. **Claims granted an exception and subsequently rejected due to provider error may be resubmitted for payment up to 365 days** from the date the service was rendered or the compensable item was provided.

If the exception request is denied, the provider can appeal the decision to the Bureau of Hearings and Appeals. Information about how to file an appeal will be included in the notice.

**OBSOLETE BULLETIN:**

This bulletin obsoletes MA bulletin 99-91-02, "180-Day Exception Requests and Invoice Submission Timeframes," issued on March 1, 1991.