Pennsylvania PROMIS*e*™ Provider Handbook

pennsylvania

DEPARTMENT OF HUMAN SERVICES

837 Institutional/UB-04 Claim Form

October 2017, Version 2.23

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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 on the 837 Professional/CMS-1500 Claim Form, the 837 Institutional/UB-04 Claim Form, the NCPDP Version 5.1/Pharmacy transactions, and the 837 Dental/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 Institutional/UB-04 Claim Form, a general overview of each section of the handbook, and how to obtain a hardcopy PA PROMIS*e*™ Provider Handbook for the 837 Institutional/UB-04 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 Institutional/UB-04 Provider Handbook

The following PA PROMIS*e*™ providers should access the PA PROMIS*e*™ Handbook for the 837 Institutional/UB-04 Claim Form to obtain general information, provider specific policies, eligibility information, and billing instructions:

- General Hospitals (including Outpatient Hospital Clinic, Emergency Room, and Hospital Short Procedure Unit (SPU) providers);
- Inpatient Hospitals;
- Ambulatory Surgical Centers (ASCs);
- Inpatient Rehabilitation Hospitals/Rehabilitation Facilities;
- Inpatient Psychiatric Hospitals/Psychiatric Facilities;
- Nursing Facilities (including general nursing and county nursing facilities);
- State Mental Retardation Centers;
- Intermediate Care Facilities for the Mentally Retarded (ICF/MR);
- Intermediate Care Facilities for Other Related Conditions (ICF/ORC);
- State Restoration Centers;

- Long-Term Care (LTC) Units Located at State Mental Hospitals.

1.2 PA PROMIS*e*™ Provider Handbook for the 837 Institutional/UB-04 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, inquiries, Internet functions, and claim form reordering procedures.
Section 3 -- Policies	This section contains links to Regulations, which pertain to PA PROMIS*e*™ providers. *For example,* this handbook will contain a link to the Pennsylvania Code, which houses Department of Human Services (DHS) Regulations. Hospitals will need to access 55 Pa. Code Chapters 1101, 1221, 1126 and 1163 to ensure that they are submitting claims in accordance with MA policy for hospital clinic, emergency room, short procedure unit, and inpatient hospital services.
Section 4 -- Beneficiary Eligibility	This section reviews how to determine if a beneficiary is eligible for services, describes the beneficiary ACCESS plastic identification cards; defines client-specific requirements including waivers and base programs, as well as third party liability, other insurance 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 policies surrounding the proper completion of these forms, when applicable, as well as links to the forms and their instructions. Information regarding waiver services, behavioral health services, and MA Early Intervention is included in this section as well.
Section - 6 Provider Enrollment Information	This section contains information necessary for a provider to understand how to enroll in PA PROMIS*e*™. Provider information such as enrollment/provider agreements, termination information, provider notice information, changes to

	enrollment, provider certification, provider-specific rate settings, and provider responsibilities.
Section 7 – Prior Authorization	This section reviews Prior Authorization (PA) requirements and includes instructions and information regarding Program Exception (PE), Automated Utilization Review Admission Certification Process, Place of Service Review (PSR), Beneficiary Restriction/Lock-In, administrative items, and special guidelines.
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	This section contains provider specific and/or service specific Billing Guides, which provide instruction on the proper completion of each block of the UB-04 Claim Form.
Appendix B	This section contains MA Bulletins.
Appendix C	This section contains instructions for the PROMIS*e*™ Internet functions.
Appendix D	This section contains DHS forms and federally required forms with their instructions.
Appendix E	This section contains the Diagnosis Related Group (DRG) Manual for inpatient hospitals.
Appendix F	This section contains the Concurrent Hospital Review (CHR) Manual for inpatient rehabilitation and inpatient psychiatric hospitals.

Appendix G	This section contains the Place of Service Review (PSR) Manual for inpatient hospitals.
Appendix H	This section contains the Utilization Management Review (UMR) Process for long term care facilities.
Appendix I	This section contains the APR DRG pricing manual.
Appendix J	This section contains the APR DRG manual.
Appendix K	This section contains a glossary of PA PROMIS*e*™ terms and phrases.

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 UB-04 Claim Form 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. 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 Social Programs (OSP)
- Special Pharmaceutical Benefits Program (SPBP)
- Healthy Beginnings Plus (HBP)

In addition, PA PROMIS*e*™ processes some 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.

2.1.1.1 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 clients' 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 clients 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

2.1.2 Office of Developmental Programs

The Office of Developmental Programs (ODP) provides a comprehensive array of services and supports for people with intellectual 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 intellectual 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 intellectual disabilities. Many services are available for funding under the Medicaid Home and Community Based Waiver Program.

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 includes outpatient, partial, residential, short-term inpatient hospital care, emergency crisis intervention services, counseling, information referral and case management services. These services are provided for all ages.

Services provided to adults are based on the Community Support Program (CSP) Principles: consumer-centered, consumer-empowered, culturally appropriate, flexible, strengths-based, community-based, natural supports, needs based and coordinated. In accordance with these principles, vocational/employment services, psychiatric rehabilitation services, community treatment teams, housing supports, consumer-run drop-in centers, social/recreational services as well as other locally designed services for special needs and populations also are available to adults.

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 directs the Bureaus of Program Management, Home and Community Based Services and Supportive Services.

The Bureau of Program Management consists of the Division of Budget and Fiscal Evaluation and the Division of Program Evaluation and Development. The Bureau's responsibility is to provide facilitation, liaison, coordination, assistance, and support to all of the Office of Social Programs' (OSP) programs. The Division of Budget and Fiscal Evaluation is responsible for financial management and oversight, financial monitoring, budgeting and providing operational support in the areas of procurement, personnel, audit and information systems. The Division of Program Evaluation and Development is responsible for providing assistance and support to program offices in the evaluation, analysis, and quality assurance of existing programs, and in the development and refinement of new programs. The Division conducts reviews of program effectiveness, standards, protocols, procedures, instructions and requirements, and waiver applications. It assists in the development of program standards and strategies, and it coordinates new program design and development, as well as program reengineering.

The Bureau of Home and Community Based Services, Division of Home Care 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 COMMCARE Waiver for individuals who experience a medically determinable diagnosis of traumatic brain injury, and through other new programs that are being developed. The new programs are intended to expand home and community based opportunities for persons with physical and cognitive disabilities. In addition, the Division of Home Care Services provides services to individuals with disabilities through the Community Services Program for Persons with Physical Disabilities, which includes the Omnibus Budget Reconciliation Act-87 (OBRA-87) Waiver and the Independence Waiver. Also under the Bureau of Home and Community Based Services is the Division of Adult Residential Facilities, which manages the inspection, licensing, and enforcement activities of personal care homes statewide.

Services provided by the Bureau of Supportive Services through its Divisions of Contract Programs and County Based Programs include Homeless Assistance, Medical Assistance

Transportation, Human Services Development Fund, Domestic Violence, Legal Services, Rape Crisis, Family Planning, Breast Cancer Screening, Women's Medical Services, Women's Service Programs Providing Alternatives to Abortion and Refugee Programs.

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 or managed care delivery system. The instructions in this Provider Handbook for the 837 Institutional/UB-04 Claim Form applies to the Fee-for-Service 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 persons who are newly eligible (and in the process of selecting a managed care organization to serve them) and persons 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 Internet site at:

http://www.dhs.state.pa.us/foradults/healthcaremedicalassistance/healthchoicesgeneralinformation/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:

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.

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.

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.

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 factor shall be considered in mitigation in determining appropriate sanctions.

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.

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.

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.

Provider shall actively recruit minority subcontractors or subcontractors with substantial minority representation among their employees.

Provider shall include the provisions of the nondiscrimination clause in every subcontract, so that such provisions will be binding upon each subcontractor.

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.

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 programs, 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).

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 837 Institutional/UB-04 Claim Form or through electronic media claims (EMC).

2.5.1 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:

DXC Technology/PA PROMIS*e*™
225 Grandview Avenue, 1st Floor
Mail Stop A-20
Camp Hill, PA 17011
Telephone: 800-248-2152 (in-state only)
717-975-4100 (local)

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

2.5.2 EMC Billing and Attachments

For claim forms 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 Website (add specific information), from the Provider Claim Attachment Control Window. For more information on accessing the Provider Claim Attachment Control Window on the Website, refer to Appendix C, Provider Internet User Manual of this handbook.

2.5.2.1 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 Form 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.

2.5.2.2 Handbook

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

2.5.2.3 Claim Status

Electronic Media Claims, except Modem-to-Modem

Providers submitting claims electronically will receive an electronic Remittance Advice (RA) in the Health Care Payment and Remittance Advices (ANSI 835) format as well as a hardcopy RA Statement after each weekly cycle in which the provider's claim forms were processed. For questions concerning the information contained on the RA Statement, access Section 8 (Remittance Advice). If additional assistance is needed, contact the appropriate Provider Inquiry Unit at DHS at:

http://www.dhs.state.pa.us/foradults/helpfultelephonenumbers/contactinformationhelpformaproviders/index.htm

Modem to Modem

For modem-to-modem claim submissions, all electronic payments and RAs (Medicare, MA, and private insurance) are returned in the Health Care Payment and Remittance Advices (ANSI 835) format. This provides the ability to standardize claims reconciliation.

2.5.2.4 Signature Transmittal Form (MA 307)

The Signature Transmittal Form (see Appendix D, Special Forms, in this handbook) must have a handwritten signature or signature stamp of a Service Bureau representative, the provider, or his/her designee.

2.5.3 UB-04 Claim Form (Hardcopy Submission)

Mail completed UB-04 Claim Forms for inpatient hospitals, outpatient hospital clinics, emergency rooms, short procedure units and ambulatory surgical centers to:

Department of Human Services

Office of Medical Assistance Programs
P.O. Box 8150
Harrisburg, PA 17105-8150

Mail completed UB-04 Claim Forms for nursing facilities, State Mental Retardation Centers, ICF/MRs, ICF/ORCs, State Restoration Centers and Long Term Care Units of State Mental Hospitals to:

Department of Human Services
Office of Medical Assistance Programs
P.O. Box 8248
Harrisburg, PA 17105-8248

Please see Appendix A, Billing Guides, of the handbook for detailed instructions on the proper completion of the UB-04 Claim form.

2.5.3.1 Signature Transmittal Form

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 designees.

- 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 continuous-fed 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.

2.5.3.2 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 keypunching, 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 a 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

DXC Technology/PA PROMIS*e*™
225 Grandview Avenue, 1st Floor
Mail Stop A-20
Camp Hill, PA 17011
Telephone: 800-248-2152 (in-state only)
717-975-4100 (local)

2.5.3.3 Beneficiary Signature Requirements

Providers who bill via continuous print claim forms (pinfed) 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 outpatient 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.
- 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

  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.)

2.5.3.4 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 MA identification 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 Treasury Department's Automated Bookkeeping System (TABS). PA PROMIS*e*™ requests payments to be made by generating a file of payments that is sent to TABS. From there, 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. ACH reduces the time it takes to receive payment from the Pennsylvania MA Program. 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.state.pa.us/provider/doingbusinesswithdhs/electronicfundstransferdirectdepositinformation/index.htm

2.7 Time Limits for Claim Submission

DHS must receive claims for submission, resubmission, or adjustment 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)

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*e*™) were retroactively prior authorized in PROMISe™, which caused the invoice submission to occur 180 calendar days after the service was rendered. Retroactive prior authorizations may occur in PROMISe™ 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*e*™ 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.

2.7.3 180 Day Exception Request Process for Hospitals and Facilities

In making allowance for 180-day exceptions, DHS must be assured that the facility made every possible effort to bill DHS in a timely manner. No exceptions will be granted when the claim should have been submitted through the normal billing mechanism within 180 days from the end date of service.

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

- The Medical Assistance application was submitted to the County Assistance Office within 60 days from the date of discharge or 60 days from the date of a third party rejection or partial payment, if applicable; and/or

- The facility requested payment from a third party insurer within 60 days of the date of discharge.

NOTE: DHS must receive the provider's 180-day exception request within 60 days of the date indicated on the third party denial or approval or within 60 calendar days of the date on the PA 162 from the County Assistance Office.

A properly completed 837 Institutional/UB-04 Claim form must be received by DHS within 60 days of the date of the PA 162 or the third party payment statement when a DRG/PSR/CHR certification is **not** required.

For stays which require a DRG/PSR/CHR (MA 424) or PSR (MA 324) certification, a properly completed 837 Institutional/UB-04 must be received by DHS within 60 days of the "Date of Notice" on the DRG/PSR/CHR Certification Notice.

Inpatient rehabilitation facilities/hospitals, inpatient psychiatric facilities/hospitals, and JCAHO Residential Treatment (RTF) facilities are reminded to submit two separate claim forms if the service covers two fiscal years.

In order to document that the above time frames were met by the facility, the 180-Day Exception Request Detail Page must be completed and submitted to DHS with each exception request. In addition, each exception request must be accompanied by documentation to support the dates listed on the exception request form. Providers are responsible for maintaining a supply of 180-Day Exception Request Detail Pages.

A request for exception, which consists of the 180-Day Exception Request Detail Page, supporting documentation, and a correctly completed 837 Institutional/UB-04 Claim form, must be submitted to:

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

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

An exception will be granted only if the deadline date for submission of the claim could not be met due to a delay caused by a third party resource or delay by the County Assistance Office in determining the beneficiary's eligibility according to the regulation time frames.

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.

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 has a right to appeal. **All appeals must be requested in writing within 30-days of the date of DHS's Notice of Denial**.

If the provider wishes to appeal the denial:

- Complete all denied claims correctly. Replacements of prior claims (claim adjustments) must show the Internal Control Number (ICN) (if submitted prior to PA PROMISe™, enter the claim reference number (CRN) of the last approved claim in Form Locator 37C.
- Attach a copy of all documentation supporting your position to your appeal.
- Include a cover letter stating that you wish to appeal and the basis on which your appeal is being made. (The words "wish to appeal" must appear in the letter.)
- 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, 2nd Floor
  Harrisburg, PA 17110
  Attn: Provider Appeals Unit

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 Process for Long Term Care (LTC) Facilities

DHS will consider a request for a 180-day exception for nursing facility services if it meets one or both of the following criteria:

- An eligibility determination was requested from the County Assistance Office (CAO) within 60 days of the date of service. DHS must receive the provider's 180-day exception request within 60 days of the CAO's eligibility determination processing date, and/or
- 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 of the third party denial or approval.

To submit a request for an exception, the following must be included:

- All supporting documentation, including documentation to and from the CAO and third party.
- A correctly completed claim form.
- A 180-Day Exception Request Detail Page must be completed and submitted to DHS with each exception request. A copy of the detail page, which should be photocopied, and instructions for its completion are found in Appendix D, Special Forms, of this handbook.

Please note that only claims meeting the criteria in Section 1101.68 are appropriate for review under this procedure. Untimely claims due to provider's failure to bill, to bill correctly or due

to billing problems, in general, will not be granted an exception. Only requests for exceptions due to CAO or third party delays will be processed.

A request for an exception to any of the above time frames must accompany the claim form(s) and be submitted to:

Department of Human Services
Office of Medical Assistance Programs
Bureau of Long Term Care Programs
Division of Long Term Care Provider Services
PO Box 8025
Harrisburg, PA 17105-8025
Attn: 180-Day Exception Request

Please use envelopes supplied by DHS or envelopes large enough to accommodate the claim forms without folding. Attachments should be paper-clipped to the claim form. Please do not use staples. Folding or stapling claim forms interferes with the scanning process. Please be sure to include your return address on the envelope.

Providers who complete their claim forms by hand need to be certain that the information is legible and that black or dark blue ink is used.

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

Nursing facilities will receive a letter stating DHS's decision. For approved claims, the fact that DHS agrees to process the claim does not guarantee that the claim will not be rejected for reasons other than the time requirements.

Exceptions will be granted on a one-time basis. Exception claims rejected due to provider error will not be granted additional exceptions.

If the request for an exception is denied, LTC facilities will receive a denial letter from DHS. The denial letter provides a "Notice of Appeal". To appeal DHS's decision:

- Complete the Notice of Appeal on the back of the denial letter.
- Make a copy of the letter for your files.

Mail the letter with the signed Notice of Appeal and supporting documentation to:

Bureau of Hearings and Appeals
2330 Vartan Way, 2nd Floor
Harrisburg, PA 17110

Please see MA Bulletin 99-03-08, "Change to Protocol for Certain Provider Appeals."

A copy of the appeal request and supporting documentation must also be sent to the program office that denied that 180-day exception request. Long Term Care Facilities must send a copy of the appeal request and supporting documentation to:

Department of Human Services
Long Term Care Provider Services
P.O. Box 8025, Appeals Documents

Harrisburg, PA 17105-8025

2.7.5 180-Day Exception Request Process for Nursing Facilities Submitting Claims for the Long Term Care - Exceptional Payment Program

Long-term care facilities have 180 days from the date of service to submit the initial claim for payment of an LTC Exceptional Payment (i.e., exceptional and/or specially adapted wheelchairs, air fluidized beds, power air flotation beds, augmentative communication devices, and ventilator services). If you are unable to submit a claim form(s) for exceptional payment within 180-days of the date of service, you may submit a request for an exception to the time limits for claim submission. Please forward an original, properly completed 837 Institutional/UB-04 Claim form to:

Department of Human Services
Bureau of Long Term Care Programs
Division of Long Term Care Provider Services
P.O. Box 8025
Harrisburg, PA 17105-8025
Attn: Exceptional Payment Section

If the claim was submitted within 180-days of the date of service and rejected, do not use the address above. Claims that are received within 180-days of the date of service and subsequently reject, may be resubmitted up to 365-days from the original date of service. Please refer to your Billing Guide in Appendix A for detailed instruction on the proper completion of the claim form when resubmitting rejected claims.

2.8 Internal Control Number (ICN)

Paper claims with attachments, paper claims without attachments and Special Handle claims processed via PA PROMISe™ 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:

Region Code RR	Year and Julian Day YY JJJ	Batch Number BBB	Claim Sequence SSS
10	04 001	612	023

The first 2-digits of the ICN are the region code. This code is used by PA PROMISe™ 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 into PROMIS*e*™ in 2004, the third and fourth digits will be "04".

The fifth, sixth, and seventh digits denote the Julian Calendar Day. In this example 001 is January 1st.

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.

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):

Region Code RR	Year and Julian Day YY JJJ	Claim Sequence # SSSSSS
20	04 001	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 Inquiry Unit. The following sections explain the various tools providers have at their disposal.

2.9.1 PA PROMIS*e*™ Internet Applications

The PROMISe™ Provider Portal allows providers, alternates, billing agents, and out-of-network (OON) providers with the proper security access to submit claims, verify beneficiary eligibility, check on claim status, and update enrollment information. Specifically, users can use the Internet to:

- Electronically file claims for all claim types and adjustments in either a real-time or an interactive mode from any location connected to the Internet
- View the status of any claim or adjustment regardless of its method of submission, along with error status codes and HIPAA adjustment reason codes for rejected claims
- Information on specific procedure
- Access computer-based training programs that will let users complete training courses from your desktop at your convenience
- Update specific provider enrollment information electronically
- Verify beneficiary eligibility within seconds of querying
- Electronically transmit outpatient drug prescriptions and renewals

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 Handbooks and Billing Guides, forms, etc., from the DHS website. 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 Services Inquiry Lines

To obtain further assistance, please refer to the Contact Information/Help for MA Providers page for the appropriate telephone number.

2.9.2.2 Fee-for-Service 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.

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

2.9.2.3 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.

2.9.3 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 Voiding/Canceling Claims on the UB-04 Claim Form

The UB-04 Claim Form is used to submit claims for payment as well as to void (back-out) claims when you are in receipt of an incorrect payment. It is important to note that when submitting a claim adjustment on the UB-04 Claim Form, the claim adjustment will be completed using the provider and beneficiary information exactly as entered on the original claim being adjusted.

When completing the UB-04 to adjust a claim that was paid in error, in addition to using the corresponding information from the paid claim, complete the following Form Locators:

- Form Locator 4 (Type of Bill) – Utilize Frequency Code "8" when you must void a previously paid claim (return all monies paid by DHS). Frequency Code "8" reflects the elimination or the "backing-out" in its entirety of a previously submitted bill for a specific provider, patient, payer, insured, and statement covers period dates.
- Form Locator 37C (MA ICN) - Enter the 13-digit Internal Control Number (ICN) for the last approved claim adjustment or last approved claim.
- *If your claim was submitted prior to the implementation of PA PROMISe™, enter the 10-digit Claim Reference Number (CRN) in place of the ICN.*
- Form Locator 42 (Revenue Code) – When using Frequency Code "8" to return all monies paid, enter Revenue Code "0001" (Total Charges).
- Form Locator 43 (Revenue Description 1-23) – Enter the words "Total Charges".

- Form Locator 47 (Total Charges) – When using Frequency Code "8" to return all monies paid, enter "000".

2.11 Ordering Forms

Sections 2.11.1 and 2.11.2 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, inpatient hospital, outpatient hospital clinic, emergency room, short procedure unit and ambulatory surgical center 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 17105-8050

LTC 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
LTC Provider Services
P.O. Box 8025
Harrisburg, PA 17105-8025

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.

2.11.2 UB-04 Claim Form

DHS does not provide UB-04 Claim Forms. The provider can review the information listed below to obtain UB-04 Claim Forms for paper claim form submission.

To obtain UB-04 Claim Forms:

- Contact the U.S. Government Printing Office at (202) 512-1800 or your local Medicare carrier.
- For a list of local Medicare carriers in your state, including their telephone number, access the Centers for Medicare and Medicaid Services at:
  http://www.cms.hhs.gov/ElectronicBillingEDITrans/
  and go to the Medicare Regional Homepage.

3 Policies

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

Hyperlinks to DHS Policies are currently under construction.

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 six 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 C, 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 PROMISe™ Provider Portal (Web Interactive)

The PROMISe 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 DXC Technology 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 DXC Technology 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 PROMISe™ 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 PROMISe™ Provider Portal is accessed.

For more information on use of the PROMISe™ Provider Portal, please refer to the PROMISe™ 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

DXC Technology 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

MA is considered the payor of last resort. All other insurance coverage must be exhausted before billing MA. 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 MA 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.)

If other insurance coverage exists, you must bill it first. 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. In either case, MA will limit its payment to the MA fee for that service. When billing DHS after billing the other insurance, indicate the resource on the claim form as indicated in the detailed claim form instructions.

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. However, the statements must be maintained in your files.

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 requestor, 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.

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 PROMIS*e*™ 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 & 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 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 Intellectual Disabilities – The Pennsylvania Consolidated Waiver for individuals diagnosed with intellectual disabilities 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 intellectual disabilities 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 leave 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 after contacting the CAO by telephone or fax, and after submitting the MA 112 to the CAO. It is no longer necessary to wait for the MA 112 to be returned to you prior to submitting your claim form. However, in order for MA to process your claim, the newborn claim form must be submitted under the mother's beneficiary number. Please note the following modifications to the 837 Institutional/UB-04 Claim Form:

Form Locator 60 – (Certificate – Social Security Number – Health Insurance Claim – ID Number [A, B, C])

Enter the mother's beneficiary number from the ACCESS card. If the ACCESS card is not available, access EVS, utilizing the mother's social security number and date of birth. EVS will return the mother's beneficiary number.

Form Locator 12 – (Patient's Name)

Enter the newborn's first and last name. If the newborn's first name is not available, you may enter "Baby Boy" or "Baby Girl".

Form Locator 14 – (Birthdate)

Enter the newborn's date of birth.

Form Locator 15 – (Sex)

Enter an "M" for male or an "F" for female.

Form Locators 24 through 30 – (Condition Codes)

Enter Condition Code YO (Newborn Eligibility).

Form Locator 84 – (Remarks)

Enter the mother's full name, her date of birth, and her social security number.

NOTE: DHS defines a newborn as an infant who was born in the hospital or who was born on the way to the hospital, and has not been discharged or transferred from the hospital since birth.

Multiple Births

Complete a separate claim form for each child.

Automated Utilization Review (AUR) Process

If a newborn requires an admission certification number and does not have a beneficiary number, you cannot use the mother's beneficiary number to obtain admission certification. Handle this admission as a late pick-up when the newborn is assigned a beneficiary number. See the Hospital DRG/CHR/PSR Manuals of this handbook for additional information. See Appendices E, F, and G of this handbook.

Remittance Advice (RA) Statement

When the claim appears on your RA Statement, it will be listed with the correct beneficiary information for the newborn.

You will not be paid for the newborn under the mother's beneficiary number.

Please keep the newborn's beneficiary number in your records for subsequent billings.

Billing with the Newborn's Beneficiary Number

If you have the newborn's beneficiary number at the time of claim submission, complete the 837 Institutional/UB-04 Claim Form as per your billing guide using the newborn's beneficiary number designated by the CAO for the newborn.

5 Special Requirements For PA PROMISe™ Providers

This section reviews 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, of this handbook.

5.2 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 person 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 person 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 person to live as independently as possible.
- Transportation: Transportation needed to enable persons to gain access to waiver and other community services.
- Visual/Mobility Therapy, Behavior Therapy, and Visiting Nurse Services.
- Respite Care Services: Services provided to individuals 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: Skilled nursing must be provided by either a registered nurse (RN) or a licensed practical nurse (LPN) that is employed by an MA enrolled home health agency. The number of hours approved will be based on medical necessity criteria and certification from the individual's physician.

5.3 Mental Health Services

The following sections detail mental health services available through PA PROMIS*e*™.

5.3.1 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.

5.3.2 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, which threaten the well-being 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 that 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.

5.3.3 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. Services will be offered within parameters imposed by funding and other resources.

5.3.4 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.

5.4 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 UB-04 claim forms). 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 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 special Remittance Advice (RA) Explanation Codes 4061, 4074, 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:

5.4.1 Sterilization Patient Consent Form (MA 31)

The 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.)

5.4.2 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 prior to completing the MA 30. (See Section 3, Policies, of this handbook.)

5.4.3 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 1163-95-02, "Payment Policy for Abortion Services" carefully for DHS's policy regarding payment for abortions. (See Appendix B, Bulletins, of this handbook.)

5.5 Interim and Straddle Billing

5.5.1 Interim Billing (Acute Care Hospitals)

DRG payment is based on the entire stay, and payment to the hospital is usually made after the beneficiary is discharged, using Type of Bill 111, (billing admission through discharge).

Under certain circumstances, beneficiaries may be hospitalized for extensive periods of time. In order to help hospitals deal with these situations, DHS will allow interim bills for beneficiaries who remain hospitalized 90 days or longer.

DRG hospitalizations of 90 days or longer may be billed on an interim basis. After the hospital is paid for the initial interim bill (using Type of Bill 112), additional interim bills (using Type of Bill 117), may be submitted after each 30-day period. These additional bills for continued hospitalization must be submitted as a claim adjustment for the preceding paid bill. Type of Bill 117 is an accumulation of the total stay from the date of admission to the date specified in the "through" section of Form Locator 6 – Statement Covers Period.

When the patient is discharged, the final claim MUST be submitted showing the entire stay using Type of Bill 117. Day outlier claims must be sent to the Division of Medical Review, DRG Outlier Review Section (see section 5.6.1 for information on day outlier requests). The Division will evaluate the day outlier request. Payments made as a result of the interim billing will be adjusted up or down based upon the final review determination of allowable days.

5.5.2 Interim Billing (Inpatient Rehabilitation, Inpatient Psychiatric, & JCAHO Residential Treatment Facilities "RTFs")

Interim bills should be submitted in no less than 30-day increments. After the initial interim claim (Type of Bill 112) is submitted and paid, additional interim claims must be completed as "Replacements of Prior Claims" using Type of Bill 117.

Each replacement is an accumulation of the total stay appearing in the Statement Covers Period and should be billed in 30-day increments reflecting all ancillary information for covered days during the identified Statement Covers Period.

5.5.3 Straddle Billing (Inpatient Rehabilitation Hospitals/Facilities, Inpatient Psychiatric Hospitals/Facilities, and JACHO RTFs)

If the patient is admitted in one fiscal year and discharged in the next, the hospital must submit separate invoices for both fiscal years.

For example, if the patient is admitted June 1 and discharged July 30, you would submit one invoice for the June 1 through June 30 period using a Type of Bill 112 and another claim for the remainder of the stay in the next fiscal year using another Type of Bill 112. Remember to show the same admission date on both claims (admission date, Form Locator 17). When straddle billing at the beginning of a new fiscal year, Type of Bill 112 must be used.

Providers billing after a third party insurance (other than Medicare) which has exhausted for a patient who has MA coverage or received MA coverage retroactive to the date of admission, must have the complete stay certified through Concurrent Hospital Review (CHR) and bill for the entire stay.

If the patient remains in the hospital (Patient Status 30) and you submit an interim or straddle bill, it is not necessary for you to subtract a discharge day since the patient has not been discharged.

5.6 Outliers

5.6.1 Day Outlier Requirements

When a day outlier is due, Edit Code 4261, which notifies you that you are eligible for a day outlier, will appear on a Remittance Advice (RA) Statement. Upon receipt of Edit Code 4261, you must submit a properly completed claim, using Type of Bill 117, and Condition Code 60 with the following information:

1. Day Outlier Request Form, a copy of the "PSR/DRG Certification Notice" or "Day Outlier Request for Cases Exempt from the PSR/DRG Process", with the requested number of outlier days completed.
2. Copy of the third party statement, when applicable.
3. Copy of the RA Statement showing either the base DRG payment.
4. UR Coordinator comments on hospital letterhead stationery. Any days denied by the coordinator must be identified by the date in the comments section.
5. Copy of the complete inpatient medical record.

Mail the information to:

Department of Human Services
Division of Medical Review
DRG Outlier Review Section
P.O. Box 8171
Harrisburg, PA 17105-8171

Failure to follow the above instructions could result in nonpayment of a day outlier.

5.6.2 Cost Outliers

Cost Outliers are automatically paid to the facility when treating neonates and burn cases. For additional information, see MA Bulletin 11-97-10, "Cost Outlier Payments for Certain Burn and Neonate Cases, issued August 11, 1997, for additional information.

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 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 (See Section 4.11.2, Medical Assistance Early Intervention, for additional information).

5.8.3 Medical Assistance Early Intervention (MA EI) Documentation Requirements

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

- Parental Authorization: A written signature on the child's Individual Family Service Plan (IFSP) and/or any EI service authorization.
- Determination of Medical Necessity
- 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.
- 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 is 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.
- 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 3) Program are not included in the HealthChoices managed care programs rates. If a child who is covered under HealthChoices managed care plan receives MA EI services from an enrolled MA EI agency/group or independent provider, the agency/group or independent provider is permitted to invoice PA PROMIS*e*™ 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:

1. Complete a paper enrollment form and send changes on letterhead.
2. 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 6.3 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.
Long Term Care Provider Enrollment Applications	(717) 772-2571	Monday – Friday 8:30 a.m. – 5:00 p.m.

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:

http://www.dhs.state.pa.us/cs/groups/webcontent/documents/manual/s_001933.pdf and follow the directions to use ePEAP.

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.dpw.state.pa.us/cs/groups/webcontent/documents/bulletin_admin/d_004253.pdf for a complete list.

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: XXXXXXXXX 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
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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.

Sincerely,

Provider Enrollment Unit

Provider Information

Provider ID: XXXXXXXXX

Service Location: XXXX

Provider Name: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Provider Address: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Provider Type: XX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Provider Specialty: XXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Provider Sub-Specialty: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Provider Taxonomy: XXXXXXXXXX

(Only if multiple specialties or sub-specialties)

Provider Specialty: XXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Provider Sub-Specialty: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Provider Taxonomy: XXXXXXXXXX

Current Programs

Program: XXXXXXXXXXXXXXXXXXXX

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}

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).

Mail completed UB-04 Claim Forms for inpatient hospitals, outpatient hospital clinics, emergency rooms, short procedure units and ambulatory surgical centers to:

Department of Human Services
Office of Medical Assistance Programs
P.O. Box 8150
Harrisburg, PA 17105-8150

Mail completed UB-04 Claim Forms for nursing facilities, State Mental Retardation Centers, ICF/MRs, ICF/ORCs, State Restoration Centers and Long Term Care Units of State Mental Hospitals to:

Department of Human Services
Office of Medical Assistance Programs
P.O. Box 8248
Harrisburg, PA 17105-8248

6.3.1 Claim Forms through PA PROMIS*e*™

The provider will use their provider ID number and password to log into PA PROMIS*e*™ and will be able to perform the following functions:

- Review messages and informational notices from DHS that are displayed upon log on to the secure web site. 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 their 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 web site.

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

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 beneficiary 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).

6.5 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) for more information.

http://www.pacode.com/secure/data/055/chapter1101/s1101.51.html

7 Prior Authorization

The Prior Authorization process and 1150 Administrative Waiver (Program Exception) process 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*™ Program Fee Schedule.

7.1 Prior Authorization in PA PROMIS*e*™

Prior authorization is required for those services and items so designated in the MA Program 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*™ Program 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.

The ***prescriber*** submits the completed MA 97 with a copy of the beneficiary's prescription in the envelope (ENV 320) provided by DHS.

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*e*™. 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 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.

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 Institutional/UB-04 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 837 Institutional/UB-04 to the regular address for claim submission:

Department of Human Services
Office of Medical Assistance Programs
P.O. Box 8150
Harrisburg, PA 17105-8150

7.1.5 Department Approval

DHS will approve or deny any request, 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 service or item approved for that code, plus the approved modifiers.

The Prior Authorization Number consists of ten numeric digits. The numbers are as follows:

1st – 5th digits	Julian calendar date DHS received the request
6th digit	Origin Code
7th – 10th digits	Sequential number of the request for that day

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

DHS will assign a second Prior Authorization Number:

- When there is a change in the beneficiary's diagnosis, or
- After each 60-day period.

7.1.6 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 (Form Locator 44 of the 837 Institutional/UB-04 Claim Form) with the modifiers supplied by DHS. DHS will assign modifiers as follows:

- When services extend across two consecutive months, or
- When requesting additional services after the initial approval period.

Enter the 10-digit Prior Authorization Number in Form Locator 63 of the 837 Institutional/UB-04 Claim Form.

7.2 1150 Administrative Waiver (Program Exception)

DHS, under extraordinary circumstances, will pay for a medical service or item that is not one for which the PA PROMIS*e*™ Program has an established fee, or will expand the limits for services or items that are listed on the PA PROMIS*e*™ Program Fee Schedule. If a provider concludes that lack of the service or item would impair the beneficiary's health, the provider may request an 1150 Administrative Waiver or Program Exception (PE).

7.2.1 Services and Items Requiring 1150 Administrative Waiver

Services and items not listed on the PA PROMIS*e*™ Program Fee Schedule require an 1150 Administrative Waiver.

An 1150 Administrative Waiver is also required for the expansion of the limits for services and items that ***are listed*** on the PA PROMIS*e*™ Program Fee Schedule.

7.2.2 Procedure for Obtaining 1150 Administrative Waiver

When an MA beneficiary has the need for a service(s) or item(s) requiring an 1150 Administrative Waiver, the ***prescribing practitioner*** completes ***two copies*** of a prescription. The original prescription is given to the beneficiary. The ***prescriber*** completes the 1150 Waiver section of the MA 97.

The ***prescriber*** submits the completed MA 97 with a copy of the beneficiary's prescription in the envelope (ENV 320) provided by DHS to the appropriate address listed on the cover sheet of the MA 97 form.

DHS will either approve or deny the request and notify accordingly the ***prescriber***, provider, and the beneficiary by means of the Program Exception Notice (MA 481).

NOTE: ***AN APPROVED 1150 ADMINISTRATIVE WAIVER 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, NOT ONLY ON THE DATE THE SERVICE IS***

REQUESTED, BUT ALSO ON THE DATE THE SERVICE IS PERFORMED/PROVIDED.

7.2.3 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.

7.2.4 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 Institutional/UB-04 Claim Form.

Upon completion, the ***provider*** submits the original claim form to DHS for processing. (The provider should make a copy of the claim form for his/her file.) The ***provider*** should submit the 837 Institutional/UB-04 Claim Form to the regular address for claim submission:

Department of Human Services
Office of Medical Assistance Programs
P.O. Box 8150
Harrisburg, PA 17105-8150

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

7.3 1150 Administrative Waiver Request Review Requirements for JCAHO Accredited Residential Treatment Facilities (RTFs)

To have a beneficiary approved for JCAHO RTF services:

1. A completed MA 325 Form (1150 Administrative Waiver Request) signed by the prescribing physician or designee.
2. A copy of the most recent psychiatric evaluation (within 30 days) signed by the treating psychiatrist that includes a recommendation for mental health residential treatment.
3. A copy of the individual's current or proposed mental health treatment plan, which specifies the goals for the residential treatment, the service to be provided, how those services will achieve the goals, and expected outcomes.
4. The Plan Care Summary, when available.
5. A copy of the completed form, Community-Based Mental Health Services – Alternative to Mental Health Residential Treatment Services.

Submit all of the above documentation in a complete package to:

Department of Human Services
Office of Medical Assistance Programs
Division of Medical Review/Concurrent Hospital Review Section – RTF
P.O. Box 8171
Harrisburg, PA 17105-8171

7.4 DRG Manual

The "Manual for Diagnosis Related Group (DRG) Review of Inpatient Hospital Services" is included in Appendix E of this handbook.

7.5 CHR Manual

The "Manual for Current Hospital Review (CHR) of Inpatient Hospital Services" is included in Appendix F of this handbook.

7.6 PSR Manual

The "Manual for Place of Service Review (PSR) of Inpatient Hospital Services" is included in Appendix G of this handbook.

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.

Commonwealth of Pennsylvania **PA PROMIS*e*™**

Department of Human Servic **Remittance Advice**

2

1

PROVIDER

Provider ID	Service Location
001456123	0001

Processing Date	Page
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 Date: 5/26/03

4

3

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.

```
                                   COMMONWEALTH OF PENNSYLVANIA                          Processing Date: 06/29/2015
                                   DEPARTMENT OF HUMAN SERVICES                                   Page:          28
                                          PA PROMISe
                                   PROVIDER REMITTANCE ADVICE                                                     3

PROVIDER NUMBER   LOC   TYPE   NPI NUMBER
   123456789      0079   01    0123456789

                                                   PROCEDURE CODE
                   LINE          BEGIN DATE  END DATE     MODIFIER          AMOUNT        AMOUNT        EXPLANATION CODES
      ICN         NUMBER   QTY   OF SERVICE  OF SERVICE   or DRUG ID        BILLED         PAID     STATUS OR COMMENTS

RID: 4503172159                RECIPIENT NAME: EPSDT CO 11479, LEANN

2715169002109      0       3   06/28/2014  07/01/2014                      26,589.45        0.00     S   4512 S
                                                                                                        5004 S 5015139101001(26)
                                                                                                        546  P 822  P 2551 P 9000 P
COPAY:       0.00     PATIENT STATUS: 01     DRG: 0541     SOI: 2                    PATIENT AGE:  11 PATIENT SEX: F
DIAGNOSIS CODES: O151     F0630    T2600XA
PROCEDURE CODES: 0UB67ZZ
GA DEDUCTIBLE:     0.00
PATIENT ACCT NBR: ICD-10B1          DATE OF CLAIM:  06/18/2015     CLAIM TOTAL BILLED:     26,589.45

2715169002110      0       3   06/28/2014  07/01/2014                      26,589.45        0.00     S   4512 S
                                                                                                        5004 S 5015139101001(26)
                                                                                                        546  P 822  P 2551 P 9000 P
COPAY:       0.00     PATIENT STATUS: 01     DRG: 0541     SOI: 2                    PATIENT AGE:  11 PATIENT SEX: F
DIAGNOSIS CODES: O151     F0630    T2660XA
PROCEDURE CODES: 0UB67ZZ
GA DEDUCTIBLE:     0.00
PATIENT ACCT NBR: ICD-10B1          DATE OF CLAIM:  06/18/2015     CLAIM TOTAL BILLED:     26,589.45

Central PA Medical Associates, LLP
PO Box 9999
2284 W East Street N
Samplevilla, PA 17777-9999

RA NUMBER 03/00052
```

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 services was performed, as indicated on the claim form.
12.	**Amount Billed**	Your usual charge less any third party payments for the service/item provided, as indicated on the claim form.
13.	**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.

14. 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:

(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.

(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.

- Check the file copy of the claim form submitted to locate the error.
- 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" page(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.]**

15. 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 (suspended codes.) The description of each code is found on the "Explanation of Edits Set This Cycle" page(s) at the end of the RA. These messages used in conjunction with the claim status notify you what happened to your claim and if there are actions that need to be taken. Please note that there are several codes that are for informational purposes only. These explanation codes do not cause your claim to deny. For example, you may see the code 9000 (Billed Amount Exceed Allowed Amount) setting with the status of "P" for paid on your claim. This is letting you know that the claim or claim line has been paid and that the system has reduced the payment to correspond to the Medical Assistance Fee Schedule. You do not need to take any action when receiving these informational related explanation codes.

		Please review the sample reconciliation method found in the Remittance Advice section of each Provider Handbook for information on setting up your own accounts receivable method.
16.	**Copay Deducted**	The amount of beneficiary copayment deducted for the service.
17.	**Patient Status**	Indicates the status of the beneficiary as of the ending service date of the period covered on an institutional claim
18.	**DRG**	Identifies a diagnosis related grouping. The DRG code is used to determine the amount for hospital inpatient claims.
19.	**SOI**	Identifies the severity of the beneficiary's illness.
20	**Patient Age**	Identifies the age of the beneficiary.
21	**Patient Sex**	Identifies the sex of the beneficiary.
22.	**GA Deductible**	General Assistance Deductible amount. This is the dollar amount for this claim that was applied to the General Assistance deductible set for this client by DHS.
23.	**Patient Account Number**	Alpha and/or numeric identifier entered in Block 26 of the CMS-1500 claim form. This information is especially helpful to you in identifying a patient if the Beneficiary's Name appears as a blank space.
24.	**Date of Claim Form**	Date the claim form was signed by the provider or date the claim was transmitted electronically.
25.	**Claim Total Billed**	Total amount billed for the claim.
26.	**Diagnosis Codes**	Codes entered on the claim form used to identify the diagnosis
27.	**Procedure Codes**	Codes entered on the claim form used to identify the types of services that were rendered. Please consult your provider specific fee schedule for compensable procedure code/modifier combinations.
28.	**Name and Mailing Address of Provider**	Address on DHS's provider files designated to receive payment for services.
29.	**RA Number XX/00000**	First two digits identify the processing cycle. The five digits following the slash (/) identify the particular RA within the cycle.

The RA number should be used when making inquiries about the information contained on the RA Statement.

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                    Processing Date: 05/21/2004
                          DEPARTMENT OF PUBLIC WELFARE                              Page:     42,037
                                  PA PROMISe
                            PROVIDER REMITTANCE ADVICE                                            9

PROVIDER NUMBER  LOC  TYPE
  123456789      0001  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                          RA NUMBER 43/01234
PO BOX 9999                                                VT/ITEM NUMBER 31207777/000000
1234 W EAST ST N
SAMPLEVILLE, PA 17777-9999
```

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 on 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

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 CROSSOVE
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 MA paid-in-full amount for services as determined by the MA 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 Form Locator 3 (Patient Control Number) of the 837 Institutional/UB-04 Claim Form 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 Form Locator 3 of the 837 Institutional/UB-04 Claim Form 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 new adjusted bill (Type of Bill 117) is submitted on a new claim form. (See your applicable 837

Institutional/UB-04Billing Guide from the PA PROMIS*e*™ Provider Handbook for the 837 Institutional/UB-04 Claim Form.)

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 PROMIS*e*™ Internet site at promise.dpw.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.

DHS's goal is to pay all proper, correctly completed 837 Institutional/UB-04 Claims within 30 days of the date received. Therefore, unresolved or outstanding bills more than 30-days old could be considered your "accounts receivable". If your submitted file is growing at a fast rate or bills are not being resolved in the 25-35 day time period, you should contact the appropriate Provider Inquiry Unit at DHS.

8.6 Example of RA Statement for Inpatient Acute Care Hospitals PA PROMISe™

PA PROMISe™
Remittance Advice

Commonwealth of Pennsylvania
Department of Public Welfare

PROVIDER Provider ID	Service Location	Type	Processing Date	Page
100002457	0001	01	04/14/2004	2

RID 0854987411 Recipient Name Joseph Smith
Patient Account Number 857521

ICN	LINE NUMBER	QTY	Begin Date Of Service	End Date Of Service	PROCEDURE CODE (MODIFIER, DRUG ID, DRUG CODE)	AMOUNT BILLED	AMOUNT PAID	STATUS	EXPLANATION CODES OR COMMENTS
1004070890123	1	1	02272004	03012004	0110	$ 5,426.45	$ 3035.49	P	9001

COPAY: $ 0.00 PATIENT STATUS: 01 DRG: 090 GA DEDUCTIBLE: $ 0.00
DATE OF CLAIM FORM: 03/05/2004 CLAIM TOTAL BILLED: $ 3,045.49

RID 5475214710 Recipient Name Mary Zucker
Patient Account Number 9587412452

ICN	LINE NUMBER	QTY	Begin Date Of Service	End Date Of Service	PROCEDURE CODE (MODIFIER, DRUG ID, DRUG CODE)	AMOUNT BILLED	AMOUNT PAID	STATUS	EXPLANATION CODES OR COMMENTS
1004070890124	1	1		03012004	0110	$ 7,421.63	$ 0.00	D	204, 1012

COPAY: $ 0.00 PATIENT STATUS: 01 DRG: 036 GA DEDUCTIBLE: $ 0.00
DATE OF CLAIM FORM: 03/05/2004 CLAIM TOTAL BILLED: $ 7,421.63

Happy Valley Hospital
596 Sugar Run Road
Yourtown, PA 15000

RA Number 43/06191

8.7 Example of RA Statement for Outpatient Hospitals

PA PROMISe™
Remittance Advice

Commonwealth of Pennsylvania
Department of Public Welfare

PROVIDER Provider ID	Service Location	Type	Processing Date	Page
100002457	0001	01	04/14/2004	2

RID 0854987411 Recipient Name Joseph Smith
Patient Account Number 857521

ICN	LINE NUMBER	QTY	Begin Date Of Service	End Date Of Service	PROCEDURE CODE (MODIFIER, DRUG ID, DRUG CODE)	AMOUNT BILLED	AMOUNT PAID	STATUS	EXPLANATION CODES OR COMMENTS
1004070890123	1	1	03012004	03012004	70010 TC	$ 125.00	$ 39.00	P	9001

COPAY: $0.00 PATIENT STATUS: 01 DRG: 000 GA DEDUCTIBLE: $ 0.00
DATE OF CLAIM FORM: 03/05/2004 CLAIM TOTAL BILLED: $ 125.00

RID 5475214710 Recipient Name Mary Zucker
Patient Account Number 9587412452

ICN	LINE NUMBER	QTY	Begin Date Of Service	End Date Of Service	PROCEDURE CODE (MODIFIER, DRUG ID, DRUG CODE)	AMOUNT BILLED	AMOUNT PAID	STATUS	EXPLANATION CODES OR COMMENTS
1004070890124	1	1	03012004	03012004	80074	$ 175.00	$ 0.00	D	204, 1012

COPAY: $0.00 PATIENT STATUS: 01 DRG: 000 GA DEDUCTIBLE: $ 0.00
DATE OF CLAIM FORM: 03/05/2004 CLAIM TOTAL BILLED: $ 175.00

Happy Valley Hospital
596 Sugar Run Road
Yourtown, PA 15000

RA Number 43/06191

8.8 Example of RA Statement for Nursing Facilities/Intermediate Care Facilities

PA PROMISe™
Remittance Advice

Commonwealth of Pennsylvania
Department of Public Welfare

PROVIDER Provider ID	Service Locati n	Type	Processing Date	Page
100003333	0001	03	04/14/2004	2

RID 0854987411 Recipient Name Joseph Smith
Patient Account Number 857521

ICN	LINE NUMBER	QTY	Begin Date Of Service	End Date Of Service	PROCEDURE CODE (MODIFIER, DRUG ID, DRUG CODE)	AMOUNT BILLED	AMOUNT PAID	STATUS	EXPLANATION CODES OR COMMENTS
1004070890123	1	30	02012004	02292004	0100	$ 2, 800.00	$ 2, 800.00	P	9001

COPAY PATIENT STATUS: 30
DATE OF CLAIM FORM: 03/05/2004 CLAIM TOTAL BILLED: $ 2, 800.00

RID 5475214710 Recipient Name Mary Zucker
Patient Account Number 9587412452

ICN	LINE NUMBER	QTY	Begin Date Of Service	End Date Of Service	PROCEDURE CODE (MODIFIER, DRUG ID, DRUG CODE)	AMOUNT BILLED	AMOUNT PAID	STATUS	EXPLANATION CODES OR COMMENTS
1004070890124	1	30	02012004	02292004	0100	$ 3, 200.00	$ 0.00	D	204, 1012

COPAY PATIENT STATUS: 30
DATE OF CLAIM FORM: 03/05/2004 CLAIM TOTAL BILLED: $ 3,200.00

ABC Nursing Facility
1050 Maple Drive
Yourtown, PA 15000

RA Number 43/06191

8.9 Example of RA Statement for Inpatient Rehabilitation Hospitals/Units and Inpatient Psychiatric Hospitals/Units

PA PROMISe™
Remittance Advice

Commonwealth of Pennsylvania
Department of Public Welfare

PROVIDER Provide ID	Service Location	Type	Processing Date	Page
100004444	0001	01	04/14/2004	2

RID 0854987411 Recipient Name Joseph Smith
Patient Account Number 857521

ICN	LINE NUMBER	QTY	Begin Date Of Service	End Date Of Service	PROCEDURE CODE (MODIFIER, DRUG ID, DRUG CODE)	AMOUNT BILLED	AMOUNT PAID	STATUS	EXPLANATION CODES OR COMMENTS
1004070890123	1	30	02012004	02292004	0110	$ 1, 800.00	$ 1, 800.00	P	9001

COPAY: $ 0.00 PATIENT STATUS: 30
DATE OF CLAIM FORM: 03/05/2004 CLAIM TOTAL BILLED: $ 1,800.00

RID 5475214710 Recipient Name Mary Zucker
Patient Account Number 9587412452

ICN	LINE NUMBER	QTY	Begin Date Of Service	End Date Of Service	PROCEDURE CODE (MODIFIER, DRUG ID, DRUG CODE)	AMOUNT BILLED	AMOUNT PAID	STATUS	EXPLANATION CODES OR COMMENTS
1004070890124	1	30	02012004	02292004	0110	$ 3, 800.00	$ 0.00	D	204, 1012

COPAY: $0.00 PATIENT STATUS: 30
DATE OF CLAIM FORM: 03/05/2004 CLAIM TOTAL BILLED: $ 3,800.00

ABC Nursing Facility
1050 Maple Drive
Yourtown, PA 15000

RA Number 43/06191

8.10 Example of RA Statement for JCAHO Residential Treatment Facilities

PA PROMISe™
Remittance Advice

Commonwealth of Pennsylvania
Department of Public Welfare

PROVIDER Provider ID	Servi e Location	Type	Processing Date	Page
10000777	0001	03	04/14/2004	2

RID 0854987411 Recipient Name Joseph Smith
Patient Account Number 857521

ICN	LINE NUMBER	QTY	Begin Date Of Service	End Date Of Service	PROCEDURE CODE (MODIFIER, DRUG ID, DRUG CODE)	AMOUNT BILLED	AMOUNT PAID	STATUS	EXPLANATION CODES OR COMMENTS
1004070890123	1	30	02012004	02292004	0110	$ 5,400.00	$ 3, 750.00	P	9001

COPAY PATIENT STATUS: 30
DATE OF CLAIM FORM: 03/05/2004 CLAIM TOTAL BILLED: $ 5,400.00

RID 5475214710 Recipient Name Mary Zucker
Patient Account Number 9587412452

ICN	LINE NUMBER	QTY	Begin Date Of Service	End Date Of Service	PROCEDURE CODE (MODIFIER, DRUG ID, DRUG CODE)	AMOUNT BILLED	AMOUNT PAID	STATUS	EXPLANATION CODES OR COMMENTS
1004070890124	1	30	02012004	02292004	0110	$ 4,675.00	$ 0.00	D	204, 1012

COPAY PATIENT STATUS: 30
DATE OF CLAIM FORM: 03/05/2004 CLAIM TOTAL BILLED: $ 4,675.00

ABC Nursing Facility
1050 Maple Drive
Yourtown, PA 15000

RA Number 43/06191

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 three 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 DXC Technology, DHS's claims processing contractor, prior to submitting their first claim. To register, please go to https://promise.dpw.state.pa.us/eprom/_ProviderCertification/softwareCertificationForm.aspx 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 PROMISe™ 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 DXC Technology. 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 DXC Technology 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 a DXC Technology 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 a DXC Technology HIPAA clearinghouse ID that grants access to the DXC Technology 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 a DXC Technology HIPAA clearinghouse ID that grants access to the DXC Technology 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 a DXC Technology HIPAA clearinghouse ID that grants access to the DXC Technology 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 DXC Technology 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 DXC Technology 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

10Provider Preventable Conditions (PPCs)

This section is for:

- Acute care general hospitals paid under the prospective payment system;
- Inpatient rehabilitation and psychiatric hospitals and excluded rehabilitation and psychiatric units of acute care general hospitals paid under the prospective per diem system;
- Nursing facilities, including private, county and state operated nursing facilities paid under the prospective per diem system;
- Intermediate care facilities for the intellectually disabled (ICF/ID) or other related conditions (ICF/ORC) paid under the prospective per diem system;
- Ambulatory surgical centers and hospital based short procedure units 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/MRs', 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 PROMIS*e*™ 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