pennsylvania
DEPARTMENT OF HUMAN SERVICES

Process for 180- Day and 365- Day Timely Filing Edits: Exception and Special Handling Requests

ODP Announcement 21-046

AUDIENCE:

Direct Service Providers that render and bill for the Consolidated, Person/Family Directed Support (P/FDS), Community Living and Adult Autism Waiver (AAW) funded services and Administrative Entities (AEs)

PURPOSE:

This Office of Developmental Programs Communication is intended to instruct providers how to proceed when a claim denial is received for Error Status Codes (ESC) 545 and 512. The short descriptions for these ESC's are "Claim Past Filing Limit" and "Claim Past 365 Day Filing Limit."

Please note: The release of this communication will obsolete Informational Memo 037-17.

DISCUSSION:

Medical Assistance (MA) Regulation, 55 Pa. Code § 1101.68(b)(1) established criteria for submitting invoices for services rendered to MA recipients. Please click on the hyperlink below to view the regulation:

http://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/055/chapter1101/s1101.68.html&d=reduce

When Under 55 Pa. Code Chapter 1101.68(b)(1), all providers of MA services are required to submit original invoices no later than 180-days from the date of service

(DOS). With the implementation of the Prospective Payment System (PPS), instituted by ODP effective July 1, 2009, 55 Pa. Code Chapter 1101.68(b)(1) is applicable to providers that render waiver-funded services and are paid through the Pennsylvania (PA) Treasury.

Every ODP Waiver provider enrolled in the Provider Reimbursement and Operations Management Information System in electronic format (PROMISe™) system is required to sign a "Provider Agreement for Outpatient Providers" and a waiver provider agreement. By signing these agreements, the provider agrees to "comply with all applicable State and Federal laws, regulations, and policies which pertain to participation in the Pennsylvania Medical Assistance Program." Timely filing of an original claim within a maximum 180-day period is one such regulation that must be followed.

EXCEPTIONS AND SPECIAL HANDLING

Exceptions: 55 Pa. Code Chapter 1101.68 (c) defines the circumstances under which an exception to the timely-filing rules may be granted. There are two reasons where ODP has the authority to issue such exceptions:

1. *(MA) Eligibility determination was requested within 60 days of the date of service and the Department has received an invoice exception request from the provider within 60 days of receipt of the eligibility determination*
2. *Payment from a third party was requested within 60 days of the date of service and the Department has received an invoice exception request from the provider within 60 days of receipt of the statement from the third party*

However, ODP recognizes there are certain instances that may not fall within this federal authority, but timely billings are delayed due to circumstances beyond a provider's control. For these situations, ODP will review requests on a case-by-case basis under its special handling process.

Special Handling: This is an internal ODP process to review the details of specific cases to determine the reason for a delay in ODP's business processes. The review is executed by regional ODP staff, and their determination is forwarded to ODP's Claim Resolution for finalization. This process is in place primarily to reduce the number of exception requests for reasons outside of the limited criteria provided under 55 Pa. Code Chapter 1101.68 (c).

Exception requests must be denied unless this criterion is met. Special Handling, when approved, results in payments of claims with state funds only.

****Provider billing errors are specifically prohibited to be used as reasoning for issuing both exceptions and special handling.*

ODP 180-DAY EXCEPTION/SPECIAL HANDLING PROCESS

ODP direct service providers should do the following when a claim denies for ESC 545:

1. If the claim that set ESC 545 is a **resubmission** of a previously submitted claim that was billed within the 180-day claim submission time limit, then resubmit the claim and enter the original Internal Control Number (ICN) from the initial claim into the "Original ICN" field. By doing this, the provider will bypass the 180-day timely filing edit and be given a maximum of 365 calendar days from the DOS to correct the claim. Federal regulations allow up to 365 calendar days from the DOS for resubmission of a rejected original claim or claim adjustment.

   The Department is not obligated to pay providers for services rendered that are not authorized on the Individual Supports Plan (ISP). Providers who engage in this practice are risking non-payment. **ODP strongly discourages this practice;** however, it is recognized that this situation may occur in rare instances when technical issues prevent the service from being authorized on the individual's ISP in a timely manner. If this situation applies to you, ensure that the approval of the service by the AE is otherwise documented and submit

a claim for the service. The claim will deny after processing because the service submitted on the claim will not be found on the individual's ISP.

The purpose of submitting the claim before the service has been authorized on the ISP is to meet the timely-filing requirement and obtain an ICN number. The ICN number for the original denied claim should be entered on the claim that is resubmitted after the service is authorized on the individual's ISP. Please note that the original claim must include the correct procedure code, Recipient Identification Number (RID), and 13-digit MPI and service location code that will eventually appear on the individual's ISP at a future date. If followed exactly as stated, this process will give the provider up to 365 calendar days from the DOS to correct the issue and resubmit the claim.

2. If the claim that set ESC 545 or 512 is an **original claim**, please review the criteria above and determine if the situation falls within the two reasons where exceptions can be granted; if so, email ODP Claims Resolution at: **ra-odpclaimsres@pa.gov**

3. If the claim that set ESC 545 or 512 is an **original claim** and does not meet the criteria for an exception and is not a billing error, e-mail your regional ODP office and request they review the situation for special handling

   Current special handling points of contact (POC) for Consolidated, Person/Family Directed Support and Community Living Waivers:

   - Western Region – Michele O'Toole **micotoole@pa.gov**
   - Central Region - Denise Sloand **dsloand@pa.gov**
   - Northeast Region – Bob Conklin **rconklin@pa.gov**
   - Southeast Region – Shelley Zaslow **rzaslow@pa.gov**

   Current special handling POC for Adult Autism Waiver:

- **Amber Bennet**, **c-ambennet@pa.gov**

For the ODP Claims Resolution Section (*exceptions*) or regional ODP offices (*special handling*) to expedite a resolution, **ALL** of the following information **MUST** be included in the e-mail:

- ***Exceptions:*** Please enter "ESC545" in the subject line of the e-mail. Please ensure there are no spaces between "ESC" and "545"
    - In the body of the e-mail include the Internal Control Number (ICN) that denied for ESC 545/512. If more than one ICN denied for ESC 545/512 for the same individual, you are permitted to list all the ICNs in one e-mail as long as all the ICNs apply to the same individual
    - It is critical that the reason(s) why the claim was not submitted within the180-day timeframe is included in the e-mail. Describe, where applicable, the efforts made to resolve the issue that delayed billing the service or services and what efforts have been made to prevent the same issue from reoccurring. Include any supporting documentation. Include the POC's phone number, including area code, and e-mail address. The phone number and e-mail address should be for the provider's POC specifically dedicated to this 180-day exception request.
- ***Special Handling:*** Please enter "SPECIAL HANDLING REQUEST" in the subject line of the e-mail.
    - Attach the completed form for Special Handling requests

After the ODP Claims Resolution Section/Regional ODP office reviews the e-mail and claim

information, a final determination will be made to approve or deny the exception/special handling request. ODP will communicate the determination, via e- mail, to the provider's POC. It is recommended that these requests are tracked by your organization as part of your financial management strategy.

PLEASE NOTE: All Base claims and all claims that contain services ineligible for Waiver funding are not subject to the timely filing regulations or the edits (ESC 545 or 512).

Providers should consult with the applicable county regarding local policies.

SPECIAL NOTES AND CLARIFICATIONS FOR BILLING

1. ODP providers work with two main systems for billing: PROMISe™ and HCSIS (Home and Community Services Information System). PROMISe™ is the billing system, and HCSIS is the authorization system. The timely-filing requirement applies to PROMISe™ and awaiting an authorization in HCSIS does not equate to an inability to bill. The requirement to bill within 180 days from the DOS still applies. As explained on the second page of this document, meeting the 180-day billing requirement allows for adjustments up to 365 days from DOS. Not billing within 180 days, while awaiting HCSIS authorization, is considered a provider billing error and exceptions or special handlings cannot be issued with that as the sole reasoning.
2. Per 55 Pa. Code § 1101.68(b)(2), *departmental receipt of a claim is evidenced by appearance of the claim on a remittance advice (RA)*; Moreover, 55 Pa. Code § 1101.68(b)(4) states a claim not appearing on an RA within 45 days from submission should be resubmitted by the provider.
3. MA and Waiver eligibility should be checked by providers before billing. Eligibility can also be checked if a claim denies, stating lack of recipient eligibility. This can be done using the Eligibility Verification System (EVS) via the PROMISe™ Provider Portal, Provider Electronic Solutions Software, or a provider's own certified software.
4. DO NOT adjust claims in to delete or add a detail line. There is a nightly interface between

PROMISe™ and HCSIS that requires adjustments match the original claim exactly. If not, there is a high probability that utilized units will be out of sync between the two systems.

5. Voids, processed because of a private audit, do not qualify for exceptions or special handling to resubmit.
6. Reconcile your billing weekly, using RA's, to prevent discovery of all discrepancies at the end of the fiscal year when there may not be sufficient time to recoup denied claims.