1150 Administrative Waiver (Program Exception)

An 1150 Administrative Waiver (Program Exception) may be approved for one the following reasons:

- A service or item was provided; however, the recipient requires the service or item in excess of the established limits.
    - For example, the Medical Assistance (MA) has fee schedule limits for catheters. However, there may be a medical reason why an MA recipient requires more than the established limit. In order for an MA recipient to receive the catheters in excess of the limit, a request for an 1150 Administrative Waiver (Program Exception) must be initiated by the prescribing practitioner.
- Noncompensable services and/or items (non-fee schedule items).
    - For example, an MA recipient may have a medical need for a wheelchair that is not on the MA Program Fee Schedule. Consequently, the wheelchair may be requested by the prescribing practitioner via the 1150 Administrative Waiver.

An 1150 Administrative Waiver request must be submitted on the MA 97 (Outpatient Services Authorization Request). The MA 97 is available on the OMAP website at http://www.dpw.state.pa.us/omap/provinf/maforms/omapmaforms. Detailed instructions regarding the proper completion of the MA 97 are included with the form.

Long Term Care (LTC) facilities should refer to MA Bulletins 35-02-04 or 36-02-04 (Exceptional Durable Medical Equipment - DME), issued April 4, 2002, effective November 1, 1999, for instructions on submitting requests for exceptional payments relating to specially adapted wheelchairs, beds, and ventilator services.

Approval of Services or Items via the 1150 Administrative Waiver Process

If a service or item is approved via the 1150 Administrative Waiver, providers are instructed to submit the claim as documented in the 'Status Section' per the Department of Public Welfare Notice of Decision (also referred to as a Program Exception (PE) Notice). The 'Status Section' of the Notice of Decision contains the services or items that were approved via the 1150 Administrative Waiver (Program Exception) request.

Please note that claims may deny if the claim is not submitted per the 'Status Section' as per the Notice of Decision.

With the implementation of national procedure codes, the Department has determined the need to enhance claims processing for services and/or items approved through the Program Exception process. As a result, two new error status codes (ESCs) are being implemented to ensure appropriate adjudication of claims for services/items not otherwise covered on the MA Program Fee Schedule.

The following error status codes (otherwise known as edits) have been implemented in the Provider Reimbursement and Operations Management Information System (PROMIS*e*™):

- ESC 3055 (Amount Billed Must be Equal to or Less Than the Authorized Amount) – This edit will post on an individual claim line when the amount billed is more than the amount authorized for the service or item on the Program Exception Notice.
    - The amount billed should reflect the amount approved on the Program Exception Notice, unless the actual cost of providing the service or item was less than the amount approved on the Program Exception Notice of Decision. If the actual cost to provide the service or item was less than the authorized amount on the notice, the billed amount on the claim line should reflect the actual cost.

- ESC 5081 (Manual Review of Program Exception) – When local procedure codes were cross-walked to national procedure codes, there were numerous instances where several local procedure codes cross-walked to a single national procedure code. As a result, the Department may authorize the same procedure code more than once on a given Notice of Decision. To ensure that claims adjudicate correctly in a situation where the same procedure code must be authorized one or more times on the same Notice of Decision, claims will be suspended on ESC 5081 for manual review. This allows for the claims to be paid where the service/item may have denied for duplicate services.

Examples

The example below is for items not compensable on the MA Program Fee Schedule where a Program Exception was approved by Medical Assistance.

A sample Notice of Decision is provided below to instruct providers on the completion of each claim line.

STATUS SECTION

Requested Services Frequency/Duration	Quantity Description	Status	Service(s) Approved Other Than As Requested Frequency/Duration	**Quantity** Description **Rate**	**Billing Code** **Modifiers**	Authorization Period	Reason Codes
HEAVY DUTY WHEELCHAIR	1 CHAIR	APPROVED OTHER THAN REQUESTED		**1** CHAIR **$1500.00**	**K0006** **NU SC**	06/09/2006 – 12/06/2006	9999
WHEELCHAIR COMPONENT OR ACCESSORY, NOT OTHERWISE SPECIFIED	1	APPROVED OTHER THAN REQUESTED		1 ACCESSORY $238.00	K0108 NU SC	06/09/2006 – 12/06/2006	9999
WHEELCHAIR COMPONENT OR ACCESSORY, NOT OTHERWISE SPECIFIED	1	APPROVED OTHER THAN REQUESTED		1 ACCESSORY $378.00	K0108 NU SC	06/09/2006 – 12/06/2006	9999

The procedure code and/or procedure code modifier combination for the approved item can be located in the 'Status Section' of the notice, sixth column, entitled 'Billing Code'. Directly below the 'Billing Code' is a column entitled 'Modifiers', which will contain the modifier or modifiers associated with the approved procedure code.

When a non-fee schedule service or item is approved, DPW must authorize an amount for payment because the service or item is not on the MA Program Fee Schedule. The authorized amount can be located in the 'Status Section' of the notice, fifth column, entitled 'Rate'.

The quantity approved can be located in the 'Status Section' of the notice, fifth column, entitled 'Quantity'.

Using the sample notice above, if submitting a claim on the CMS-1500, the approved procedure code and modifiers would be entered in Block 24D as noted on the following page.

The billed amount would be placed in Block 24F. Using the example notice above, the billed amount would be $1500.00 or the actual cost of providing the item, if less than $1500.00 as noted on the following page.

Claim Submission Instructions for Services Approved via the 1150 Administrative Waiver

If the billed amount on the claim line is more than the amount authorized on the claim, Edit 3055 will post on the claim line and subsequently cause the claim line to deny. Please note that if more than one unit is approved in conjunction with a single service or item, the billed amount must not exceed the authorized amount multiplied by the quantity approved.

Each claim line should reflect each authorized line contained on the Notice of Decision. Please see the example below.

STATUS SECTION

Requested Services	Quantity	Status	Service(s) Approved Other Than As Requested	Quantity			
Frequency/Duration	Description		Frequency/Duration	Description Rate	Billing Code Modifiers	Authorization Period	Reason Codes
HEAVY DUTY WHEELCHAIR	1 CHAIR	APPROVED OTHER THAN REQUESTED		**1** CHAIR **$1500.00**	**K0006** NU SC	06/09/2006 – 12/06/2006	9999
WHEELCHAIR COMPONENT OR ACCESSORY, NOT OTHERWISE SPECIFIED	1	APPROVED OTHER THAN REQUESTED		1 ACCESSORY $238.00	K0108 NU SC	06/09/2006 – 12/06/2006	9999
WHEELCHAIR COMPONENT OR ACCESSORY, NOT OTHERWISE SPECIFIED	1	APPROVED OTHER THAN REQUESTED		1 ACCESSORY $378.00	K0108 NU SC	06/09/2006 – 12/06/2006	9999

CMS-1500 (Paper Claims)

If completing the CMS-1500, the claim lines should be completed as noted below.

24A	24B	24C	24D			24E	24F	24G	24H
Dates of Service From To mm/dd/yy mm/dd/yy	Place of Service	EMG	PROCEDURES, SERVICES, OR SUPPLIES (EXPLAIN UNUSUAL CIRCUMSTANCES)			Diagnosis Code	$CHARGES	Days or Units	EPSDT Family Plan
07/18/2006	12		**K0006**	**NU**	**SC**	1	**$1500.00**	**1**	
07/18/2006	12		**K0108**	**NU**	**SC**	1	**$ 238.00**	**1**	
07/18/2006	12		**K0108**	**NU**	**SC**	1	**$ 378.00**	**1**	

Please note that when the actual cost to provide the item is less than the amount authorized, the billed amount should reflect the actual cost of providing the service or item.

Reminder – The date of service must reflect the actual date the service was provided or the item was dispensed. The place of service must reflect where the service was provided or where the item was dispensed.

When the claim is processed in PROMIS*e*™, claim line three (#3) will post ESC 5081 so that the authorization can be reviewed to determine if payment if due for the item.

Claim Submission Instructions for Services Approved via the 1150 Administrative Waiver

Professional Internet Claims

When completing Professional Internet claims, each service line (claim line) of the Professional Internet claim would be completed based on the approved notice received from MA. Please see the sample notice below.

Sample Notice of Decision:

STATUS SECTION

Requested Services	Quantity	Status	Service(s) Approved Other Than As Requested	Quantity			
Frequency/Duration	Description		Frequency/Duration	Description Rate	Billing Code Modifiers	Authorization Period	Reason Codes
HEAVY DUTY WHEELCHAIR	1 CHAIR	APPROVED OTHER THAN REQUESTED		**1** CHAIR **$1500.00**	**K0006** NU SC	06/09/2006 – 12/06/2006	9999
WHEELCHAIR COMPONENT OR ACCESSORY, NOT OTHERWISE SPECIFIED	1	APPROVED OTHER THAN REQUESTED		1 ACCESSORY $238.00	K0108 NU SC	06/09/2006 – 12/06/2006	9999
WHEELCHAIR COMPONENT OR ACCESSORY, NOT OTHERWISE SPECIFIED	1	APPROVED OTHER THAN REQUESTED		1 ACCESSORY $378.00	K0108 NU SC	06/09/2006 – 12/06/2006	9999

The following three pages show an example of the proper completion of the service lines (claims lines) on a Professional Internet claim based on the same Notice of Decision above.

Claim Submission Instructions for Services Approved via the 1150 Administrative Waiver

Using the sample notice on page 4, the first service line (claim line) on a Professional Internet claim would be completed as follows:

From DOS:	07/15/2006 (MM/DD/YYYY)
To DOS:	07/06/2006 (MM/DD/YYYY)
Place of Service:	12 - Home
Procedure:	K0006
Modifier 1:	NU
Modifier 2:	SC
Modifier 3:	
Modifier 4:	
Diagnosis Pointer:	1 (1:2:4)
CLIA Number:	
Comment:	
Basis of Measurement:	Unit (Professional Service)
Units	1.00
Billed Amount	1500.00
Emergency?	No
Family Planning?	No
EPSDT?	No
Contract Type	
Contract Code	
Contract Version	

The following page provides an example of how the second claim line would be completed based on the notice.

Claim Submission Instructions for Services Approved via the 1150 Administrative Waiver

The second service line (claim line) would be completed as follows base on the sample notice on page 4.

From DOS:	07/15/2006 (MM/DD/YYYY)
To DOS:	07/06/2006 (MM/DD/YYYY)
Place of Service:	12 - Home
Procedure:	K0108
Modifier 1:	NU
Modifier 2:	SC
Modifier 3:	
Modifier 4:	
Diagnosis Pointer:	1 (1:2:4)
CLIA Number:	
Comment:	
Basis of Measurement:	Unit (Professional Service)
Units	1.00
Billed Amount	238.00
Emergency?	No
Family Planning?	No
EPSDT?	No
Contract Type	
Contract Code	
Contract Version	

The following page provides an example of how the third claim line would be completed based on the sample notice on page 4.

Claim Submission Instructions for Services Approved via the 1150 Administrative Waiver

The third service line (claim line) would be completed as follows base on the sample notice on page 4.

From DOS:	07/15/2006 (MM/DD/YYYY)
To DOS:	07/15/2006 (MM/DD/YYYY)
Place of Service:	12 - Home
Procedure:	K0108
Modifier 1:	NU
Modifier 2:	SC
Modifier 3:	
Modifier 4:	
Diagnosis Pointer:	1 (1:2:4)
CLIA Number:	
Comment:	
Basis of Measurement:	Unit (Professional Service)
Units	1.00
Billed Amount	378.00
Emergency?	No
Family Planning?	No
EPSDT?	No
Contract Type	
Contract Code	
Contract Version	

Page 8 recaps the completion of the three service lines on a Professional Internet claim using the sample notice on page 4.

Claim Submission Instructions for Services Approved via the 1150 Administrative Waiver

Service Line #1 must contain the first item approved (Billing Code/Modifiers), authorized unit(s) (Quantity), and authorized amount (Rate) contained in the 'Status Section' of the notice.

Service Line #2 must contain the second item approved (Billing Code/Modifiers), authorized unit(s) (Quantity), and the authorized amount (Rate) contained in the 'Status Section' of the notice.

Service Line #3 must contain the third item approved (Billing Code/Modifiers), authorized unit(s) (Quantity), and the authorized amount (Rate) contained in the Status Section of the notice.

Additional Information for Internet Claim Submission – If more than one service line must be entered on an individual Internet claim, click on the blue 'Add' button.

The following example is for a service approved in excess of the established MA Fee Schedule limits.

Below is a sample of the 'Status Section' of the Program Exception notice, which must be used when completing a claim for claim submission.

STATUS SECTION

Requested Services	Quantity		Service(s) Approved Other Than As Requested	Quantity			
Frequency/Duration	Description	Status	Frequency/Duration	Description Rate	Billing Code Modifiers	Authorization Period	Reason Codes
Home Health Visits	7 HOME HEALTH VISITS	APPROVED		**7** HOME HEALTH VISITS	**G0154** U8 SC	01/09/2006– 06/09/2006	9999

The sample notice indicates that seven additional home health visits were approved in excess of the MA Fee Schedule limits. The procedure code and modifiers approved for the seven visits is G0154, Modifiers U8 and SC. For the purpose of this example, the visits were provided on 03/21/2006, 03/22/2006, 03/23/2006, 03/25/2006, 03/27/2006, 03/28/2006, and 03/31/2006. Multiple claims will be submitted for the various dates of services.

If billing on a CMS-1500, Block 24A would contain the first date where consecutive services were provided (From) and the last date where consecutive services were provided (To). Block 24B must contain the place of service and Block 24D must contain the procedure code and modifier(s) from the Notice of Decision. The service is being provided in excess of the MA Fee Schedule limits. As a result, a fee is not assigned on the Notice of Decision. Therefore, Block 24F must contain the provider's usual and customary charge to the self-paying public.

Because three visits were provided on three consecutive dates of service, Block 24F would contain the provider's usual and customary charge multiplied by three (e.g., the usual and customary charge is $100.00 and three visits were provided in the dates indicated in Block 24A.). The amount indicated in Block 24F is the result of multiplying the usual and customary charge by the number of units reported in Block 24G (for this example, $300.00).

Individual claim for dates of service 03/21/2006 through 03/23/2006 – Because the first three visits were provided on consecutive days (i.e., 03/21, 03/22, and 03/23/2006) a single claim line may be used to bill for dates of service 03/21/2006 through 03/23/2006.

Claim Submission Instructions for Services Approved via the 1150 Administrative Waiver

Example:

24A	24B	24C	24D			24E	24F	24G	24H
Dates of Service From To mm/dd/yy mm/dd/yy	Place of Service	EMG	PROCEDURES, SERVICES, OR SUPPLIES (EXPLAIN UNUSUAL CIRCUMSTANCES)			Diagnosis Code	$CHARGES	Days or Units	EPSDT Family Plan
03/21/2006 03/23/2006	12		**G0154**	**U8**	**SC**	1	**$300.00**	**3**	

The remaining visits would be billed as follows if separate claims will be used to bill the home health visits.

For date of service 03/25/2006, the claim line would appear as follows:

24A	24B	24C	24D			24E	24F	24G	24H
Dates of Service From To mm/dd/yy mm/dd/yy	Place of Service	EMG	PROCEDURES, SERVICES, OR SUPPLIES (EXPLAIN UNUSUAL CIRCUMSTANCES)			Diagnosis Code	$CHARGES	Days or Units	EPSDT Family Plan
03/25/2006	12		**G0154**	**U8**	**SC**	1	**$100.00**	**1**	

For dates of service 03/27/2006 and 03/28/2006, the claim line would appear as follows:

24A	24B	24C	24D			24E	24F	24G	24H
Dates of Service From To mm/dd/yy mm/dd/yy	Place of Service	EMG	PROCEDURES, SERVICES, OR SUPPLIES (EXPLAIN UNUSUAL CIRCUMSTANCES)			Diagnosis Code	$CHARGES	Days or Units	EPSDT Family Plan
03/27/2006 03/28/2006	12		**G0154**	**U8**	**SC**	1	**$200.00**	**2**	

For date of service 03/31/2006, the claim line would appear as follows:

24A	24B	24C	24D			24E	24F	24G	24H
Dates of Service From To mm/dd/yy mm/dd/yy	Place of Service	EMG	PROCEDURES, SERVICES, OR SUPPLIES (EXPLAIN UNUSUAL CIRCUMSTANCES)			Diagnosis Code	$CHARGES	Days or Units	EPSDT Family Plan
03/21/2006 03/23/2006	12		**G0154**	**U8**	**SC**	1	**$300.00**	**3**	

Below is an example of how the claim must be completed if using a single claim to submit dates of service 03/21/2006, 03/22/2006, 03/23/2006, 03/25/2006, 03/27/2006, 03/28/2006, and 03/31/2006.

24A	24B	24C	24D			24E	24F	24G	24H
Dates of Service From To mm/dd/yy mm/dd/yy	Place of Service	EMG	PROCEDURES, SERVICES, OR SUPPLIES (EXPLAIN UNUSUAL CIRCUMSTANCES)			Diagnosis Code	$CHARGES	Days or Units	EPSDT Family Plan
03/21/2006 03/23/2006	12		**G0154**	**U8**	**SC**	1	**$300.00**	**3**	
03/25/2006	12		**G0154**	**U8**	**SC**	1	**$100.00**	**1**	
03/27/2006 03/28/206	12		**G0154**	**U8**	**SC**	1	**$200.00**	**2**	

Please note that services must be provided consecutively in order to submit a claim using different dates in the ‘from’ and ‘to’ fields. The number of units reported on the claim must equal the number of days indicated in the date span entered in the ‘from’ and ‘to’ fields on the claim.

Claim Submission Instructions for Services Approved via the 1150 Administrative Waiver

For home health providers, there may be an instance where two home health visits are provided on the same date of service. If indicating a date span in the 'from' and 'to' fields of the claim when services were provided consecutively, the number of units may equal or exceed the dates indicated in the 'from' and 'to' fields on the claim.

For example, seven visits may have initially been approved beyond the established limits. However, within the original approval time frame, an additional visit is requested and an additional visit is approved that is subsequently provided on that same date of service as one if the initial seven visits approved.

Below is an example of a notice, which updates the original example, based on an additional visit being approved within the same time frame.

STATUS SECTION

Requested Services	Quantity		Service(s) Approved Other Than As Requested	Quantity				
Frequency/Duration	Description	Status	Frequency/Duration	Description Rate	Billing Code Modifiers	Authorization Period	Reason Codes
Home Health Visits	8 HOME HEALTH VISITS	APPROVED		**8** HOME HEALTH VISITS	**G0154** U8 SC	01/09/2006– 06/09/2006	9999

If the initial seven visits were submitted and paid, a separate claim may be submitted for the additional visit or an adjustment can be submitted to the initial paid claim.

For example, if the additional visit was provided on 03/25/2006, an adjustment may be submitted to the original claim. If date of service 03/25/2006 was submitted on an individual claim, completed Block 22 as follows:

- In Block 19, include 'AT99" and paper clip and 8 and ½ by 11 sheet of paper, including the recipients name and recipient number, the provider number, and the reason you are adjusting the claim.
- In the second portion of Block 22, enter the letters 'ADJ' followed by the ICN that reflects payment for date of service 03/25/2006.

Blocks 24F and 24G would be modified as follows when adjusting the claim to receive payment for the additional visit that was provided:

24A	24B	24C	24D			24E	24F	24G	24H
Dates of Service From mm/dd/yy To mm/dd/yy	Place of Service	EMG	PROCEDURES, SERVICES, OR SUPPLIES (EXPLAIN UNUSUAL CIRCUMSTANCES)			Diagnosis Code	$CHARGES	Days or Units	EPSDT Family Plan
03/25/2006	12		**G0154**	**U8**	**SC**	1	**$200.00**	**2**	

Block 24F would reflect the provider's usual and customary charge to the self paying public multiplied by two, because two visits were subsequently provided (in this example, Block 24F would contain $200.00 to account for that fact that the adjustment is to reflect that two visits, not one were provided on 03/25/2006).

Block 24G would reflect 2 units to reflect that two visits were provided on 03/25/2006 and the initial claim only accounted for one of the two visits provided.

When submitting adjustment via the Internet, an attachment is not necessary. Please use Frequency Code 7 and enter the ICN of the paid claim you wish to adjust in the Original Claim # field.