Protocol for Gross Adjustments for Providers of Waiver Services
Cash Flow Concerns

The Department of Public Welfare (DPW) understands provider concerns that the transition to a prospective cost based system may result in cash flow issues for some providers. During this transition period, DPW is willing to work with providers who experience a cash flow issue, and in some cases, provide a gross adjustment to providers. While DPW is willing to work with providers in these instances, providers must first show a good faith effort toward attempting to use the new payment system prior to receiving any gross adjustment. At present approximately 93 percent of practice bills submitted by providers are approvable as "clean claims".

The Department, through its Office of Developmental Programs (ODP), will consider a request for a gross adjustment when a provider encounters a significant cash flow issue that impacts its ability to operate that is related to billing issues, particularly if that issue can impact its ability to pay staff salaries or otherwise compromises the health and safety of Medicaid recipients.

Action	Expected Completion Date
1. A provider experiencing cash flow problems submits an Emergency Funding Request Form to the appropriate ODP regional office.	As soon as the problem is discovered
2. The ODP regional office reviews the request and determines if the problem is: a. related to a billing issue; b. impacts the provider's ability to pay staff salaries or vendors; or c. otherwise affects the health and safety of waiver participants; or d. an unusual circumstance that for other reasons requires intervention. If the billing issue can be resolved quickly at the regional level, regional office will work with the provider to resolve the issue. Situations which cannot be quickly resolved at the regional level will be sent to the ODP Central Office for resolution.	Within 2 business days
3. ODP Central Office reviews the issue to determine whether it meets the criteria for a gross adjustment. ODP will also provide a detailed explanation of any denial. If it determines that the request meets the criteria for a gross adjustment, ODP will send a request for a gross adjustment to the Comptroller's Office and to the Office of Medical Assistance Programs (OMAP).	Within 5 business days
4. OMAP approves and issues remittance advice (RA). Both the credit and the debit for this gross adjustment will be entered into PROMISe and reflected on the RA. The debit and credit will be entered for the provider service location code so when the billing issue is resolved the receivable is properly offset.	Within between 5 and 10 business days
5. Payment is made.	Usually within 8 business days from the issuance of the RA.

6. Payment made through gross adjustment is offset through PROMISe against the paid claim after resolution of the billing issues which caused the cash flow issue and future billings by the provider.	Within 30 days of payment of the claim absent agreement for a different time period.