	OLTL FAQs - Service Coordination	
	Question	**Answer**
	CMI/LOCA	
1	Why do the IEB and AAA do a CMI when the SC will be doing a CMI when they go out to develop the ISP? Is a full CMI needed at the time of reassessment?	Certain sections of the CMI are prepopulated from the LOCA by the AAA and the IEB completes certain sections of the CMI at the time of enrollment. The SC is responsible to complete the unfinished sections of the CMI at the initial service plan development meeting, and is completed by the SC at the time of annual reassessment.
2	When should a new LOCA be completed if the SC feels that the current LOCA is no longer valid?	A new LOCA can be requested at any time the SC feels there has been a change in condition that would result in a change to the participant's level of care determination.
3	Who would send the closure/NFI notice if the participant is no longer NFCE?	If a new LOCA is completed and the participant is determined to be NFI, the SC would need to send the PA 1768 to the CAO. The CAO would issue the eligibility notice.
	ISP Development	
4	If a participant refuses to sign the ISP or create a back-up plan, can the SC deny waiver services or does the initial plan need to be submitted to OLTL for rejection?	If the participant refuses to sign the ISP, the SC should inform them that refusal to sign might delay or prevent services from starting. The SC should still submit the initial plan to OLTL for review and approval.
5	If a participant refuses to create a back-up plan, can they accept the risk of not having a back-up plan?	No. The participant must have a back-up plan in place. The SC must assist the participant develop an appropriate back-up plan.
6	What is considered the ISP start date? The date of the LOCA, the date of the 162, the date the ISP is developed, or the date the ISP is approved? What would be the annual reassessment date?	According to 55 Pa Code § 52.25 (i), the start date of the initial ISP is the date the ISP is approved by OLTL. The annual reassessment date is to be done within one year of the completed LOCA.
7	When does the Aging Office provide the Provider Choice Form? Is it when the LOCA is done or when they go out to do the initial visit and CMI?	The provider choice form is reviewed and completed when the SC does the initial visit and develops the initial ISP with the participant.
	Service Delivery	
8	Does the SC have to wait for the paper file to come from the IEB before they can go out and meet with the participant?	The IEB is required to send the participant materials within 3 business days. The SC should wait to get the complete information from the IEB so there is no duplication of effort or work.
9	Can PAS be provided when someone is in a senior center as long as hands-on care is needed?	Yes. PAS may be provided when someone is in a senior center as long as there is a need.
10	How long does a provider have to start services? For example, a participant chooses a PAS agency on 6/1 and has still not received a PAS worker by 6/30. What time frame is the PAS agency held to?	OLTL does not have a policy on timeframes for direct service providers. It is the SC's responsibility to communicate to direct service providers of the participant's choice regarding start dates.
11	Is there an annual limit for institutional respite in the Aging Waiver?	The only limits for respite in accordance with the Aging Waiver are as follows: Individuals are authorized for up to 14 consecutive days in an institutional facility. However, this may be increased up to 29 consecutive days, based on need and with the prior approval of the State Medicaid Agency program office.
12	How does an SC locally approve a DME < $500 or an EMOD < $6000? The SCs reported that when they enter the DME or EMOD in HCSIS, the Critical Revision is still coming to OLTL to be reviewed.	For billing purposes a critical revision must be completed and sent to OLTL per normal procedures in HCSIS. OLTL completes expedited approvals of these requests and reviews the information retrospectively.
13	Can a participant's POA also be the PAS worker?	No. This is not allowable according to appendix C:2 of the waiver.
14	Can a participant's Mother be the PAS worker?	Yes. This is allowable under the waiver as long as the mother is not the POA, Legal Guardian, and meets the provider qualifications as outlined in the waiver.
15	Can an SC supervisor offer temporary respite care?	Yes, respite is considered a temporary service. Temporary is defined as 120 days or less.
16	Can 24/7 care be provided in the home?	Approval of 24/7 care is based on careful review of the participant's identified assessed needs accompanied by a justification for the request in the ISP. The SC must also document any alternatives that have been explored including Third Party Resources (TPR), discussions with the participant and family about alternatives, the result of the discussion, and justification for the request.
17	Does an agency have to provide services on a holiday?	Yes. If services are needed on a holiday, the agency is responsible for providing the service.
18	If the direct care provider listed on the plan does not have staff to provide service when services have been authorized, do they have to give 30 day's notice?	In this instance, the provider never provided services, therefore, there is no requirement to provide a 30 day notice.

19	If an agency attendant is ill, whose responsibility is it to staff?	The agency is responsible for providing a replacement in the event a regular agency worker is ill.
20	If an applicant is in the process of applying for VA benefits, can the waiver services be utilized until VA benefits start?	Yes, waiver services may be utilized until VA benefits start. The SC must document what steps are being taken to obtain VA benefits and where they are in the process in order for the service plan to be approved.
21	Are Home Modifications paid for upfront?	Home Modifications are handled the same as other waiver services. The service is provided and the provider is then reimbursed.
22	Can waiver be used to pay for warranties on home mods or just repairs?	The waiver does not pay for warranties, but does pay for repairs.
23	How is a Home Modification in HCSIS billed when it is split between two fiscal years?	It is the responsibility of the SC to plan accordingly for Home Modifications as the end of the fiscal year approaches. Home Modifications are to be billed only after completion.
24	What is the process of converting Options to Aging for PPL?	For participant-employers transitioning from Options to the Aging Waiver, the SC should take the following steps: 1) Enter the referral in the PPL Web Portal, 2) Request an 'Existing Employer Identification Number (EIN) Tool Kit' and a 'Referral Form for Options Transfers' from the PPL regional enrollment manager, and 3) Follow the steps outlined in the tool kit and complete and submit the referral form to PPL.
	Service Coordination Billing	
25	How does an SC bill for service coordination provided after the date of death?	The date of service cannot be after the date of death. These types of activities are considered non-productive time and are a component of the rate for Service Coordination, which is currently under review with the SC stakeholder workgroup.
26	How does an SC bill for entering an incident report into EIM for hospitalization? Can an SC bill while the individual is hospitalized? Does the SC adjust the billing date so it is for a date when the participant was not in the hospital?	According to Medicaid rules, the SC cannot bill at the same time a participant is in the hospital and this would be considered duplicative billing. These types of activities are considered non-productive time and are a component of the rate for Service Coordination which is currently under review with the SC stakeholder workgroup.
27	Once a 162 is received to terminate waiver services, how long should the providers (SC, PAS, etc.) continue to provide service? Do they need to continue to provide for 30 days? What does the SC do to assist the participant if they are no longer being paid for SC?	If a participant is no longer financially eligible for services the provider will not be able to bill or get paid for any service rendered after the date of termination. The service delivery date must not exceed the termination date identified on the PA 162.
28	Can SC's bill for service planning when someone is leaving the hospital, nursing facility, or rehab facility? Changes to ISP and CMI are usually needed for these situations.	These activities are not billable when provided on a date prior to discharge from a facility. This issue is being addressed with the SC rate review with the SC stakeholder workgroup.
29	How does the SC bill for closing out services? Is the time spent closing the case billable? Ex. Contacting providers, fax termination orders, documentation, completing PA 1768 and sending to CAO.	These types of activities are considered non-productive time and are a component of the rate for Service Coordination which is currently under review with the SC stakeholder workgroup.
	Documentation	
30	Where should ICD 9 codes be entered? Do ICD 9 codes need entered for each service?	The ICD 9 code should be documented in the special instructions in SAMS, and in the comment section of the diagnosis screen in HCSIS.
31	Do SC's need to document in the 3rd person in their service notes?	No. This is not an OLTL requirement.
32	How do we enter dates of when the note is entered? Should AAA's change the auto-filled date in SAMS to be the same as the date the service was provided as opposed to the date when it is being documented in the system.	To clarify, the note date can be different from the date of service. If a notation of what occurred during the provision of service absolutely cannot be entered on the same date the service is rendered, then the Service Coordinator MUST be clear that the services listed were rendered on a date prior to the service note entry. Both dates must be clear.
33	Are QMETs looking at the date the note was put in? Should a SAMS journal date be changed when entering the comment to match the date of service?	Yes, QMETs look at both the date the note was entered and the date of service. The dates should be within a reasonable timeframe. No, a SAMS journal date should not be changed when entering the comment to match the date of service.
34	Is OLTL requiring an SC to enter a service note within 24 hours of activity? Does QMET have a time frame for when SC notes should be entered after a contact with the participant?	No. This is not an OLTL requirement. There is no timeframe requirement for entering a service note after contact with a participant but should be within a reasonable timeframe.
35	Where does an SC enter "strengths" in SAMS so they are pulled into the ISP custom report?	For the ISP custom report in SAMS, strengths are pulled from the "care plan worksheet". Any Risk management issues in the "care plan worksheet" that have a need indicator status as "met" will show on the custom report as "participant strengths".
36	What is the expected specificity of frequency and duration on the ISP?	Unless specifically needed or requested by a participant for certain days and hours, the ISP and the service authorization form should reflect how many days per week and how many hours per day, (3 x per week for 2 hours) and the participant can work out exact details with the provider agency.
37	When there is a change, do you have to complete a new CMI in SAMS or can you complete an Addendum and incorporate those changes at the Annual?	The CMI must be completed whenever there is a change in 2 or more functional areas contained within the CMI. For example a change in cognition in addition to a change in availability of informal supports will result in the completion of a new CMI. For changes that do not meet the criteria listed here, the SC may complete an Addendum and incorporate those changes at the annual reassessment.

38	Will the ISP signature page be updated to include the new Participant information materials from bulletin #51-13-04?	Yes. OLTL plans to update this form in the near future.
39	When the ISP is updated for a critical revision, do all of the forms on the ISP signature page need to be completed again?	No, this would depend on the type of change that occurred for the critical revision in HCSIS. If the change was a reduction or termination of a service, or addition, the SC would need to complete the ISP signature page and the appeal form when appropriate.
40	What if the participant cannot sign the signature page?	SCs should document that the participant verbally agreed. The participant may also make an X on the signature line and enter documentation in the service notes or journal entry to justify.
41	Does an SC need to have every denied Third Party Resource service denial in the participant's file, or would the provider agency keep the denial on file?	Yes. The SC is required to have copies of any Third Party Resource denials in the participant's file to ensure that Waiver is the payer of last resort. This is something that the QMET's monitor when reviewing participant files.
42	Does the SC obtain a script for therapy services?	Yes. The SC is required to obtain a script for Occupational, Speech, and Physical therapies.
	Terminating Services	
43	Does the participant need to give 30 days notice to terminate a direct care provider?	No. This is not a requirement.
44	Does the provider need to give 30 days notice if they no longer want to serve a participant?	Yes. In accordance with the MA provider agreement, the provider must give the participant 30 days notice before terminating services.
	Hearings and Appeals	
45	If the SC determines that PAS-consumer model would not be appropriate for a participant, is the denial of PAS-consumer model appealable?	Yes. The participant has the right to appeal a denial or termination of the participant-directed model of service. This information can be found in Appendix E of the current OLTL waiver documents.
	Critical Incidents	
46	Are direct service providers required to submit in EIM?	Yes. According to the Critical Incident Management Policy issued on October 14, 2011, providers are required to submit incidents in EIM.
47	How do AAAs report critical incidents? RA account or in SAMS?	The AAA reports critical incidents through the RA account.
	Policy	
48	Are there programs for children	EPSDT (Early and Periodic Screening Diagnosis and Treatment) is available to children until age 21. EPSDT covers medically necessary PAS and nursing services, does not cover respite or home modifications. SCs are encouraged to contact EPSDT through the local County Assistance Office (CAO) or Managed Care Organization when an applicant is between the age of 18-21 to determine what services are being covered under EPSDT, these services would not be duplicated under the waiver.
49	Are SC's required to check employees, and vendors that are part of OHCDS, including some volunteers utilized. Does that also include organizations which are approved MA providers?	Service Coordination Entities (SCEs) are not required to check providers, or the provider's employees, who are approved by the Department and enrolled in the Medicaid program. If the SCE is providing the allowable services through the Organized Health Care Delivery System (OHCDS), the SCE is responsible for reviewing the LEIE, EPLS and Medicheck lists to ensure that the vendor – or in the case of individuals, that individual – is not on the list.
50	If a participant's POA seeks employment at an agency and is hired for agency PAS services, can this person service the participant?	No. This is not an allowable practice under the waiver.