| # | Question | Answer |
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| | **FINAL OLTL FAQs - 55 Pa. Code Chapter 52 - 6/17/2013** | |
| | **Enrollment - Provider and Consumer** | |
| 1 | The regulations state that services can't start unless there is an OLTL approved service plan in place. Does this apply when there is a delay in approval by OLTL because of technical/IT problems or the Commonwealth is behind in reviews? | No. If the delay is due solely to occasional technical difficulties or backlogs in review of service plans by OLTL, services to consumers must continue while these difficulties are resolved. However, payment will NOT be made for services rendered to someone who is not enrolled in a waiver or who does not have initial approval of their service plan. |
| 2 | Are the following approved OLTL forms still to be used:<br>a.) PA Office of Long-Term Living Criminal History Background Check<br>b.)Participant Verification of Acceptance of Responsibility<br>c.)OLTL Provider Choice Protocol<br>d.)OLTL-BIS Service Provider Choice Form<br>e.) Freedom of Choice Form<br>f.) Selection of AC Control Option | Out of the list of forms in question, the following forms are to be used:<br>c. Provider Choice Protocol is to be followed<br>d. OLTL-BIS Service Provider Choice Form<br>e. Freedom of Choice Form<br>The remaining forms are obsolete. |
| 3 | Is the CMI completed by the enrollment agency or the service coordination agency? Is there a checklist of information and/or forms that need to be sent to the SCE by the IEB? Is the referral to a SCE still part of enrollment? | 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. Yes, the checklist is the LOCA, physician certification, CMI, Freedom of Choice Form and the PA 162. Yes, the referral to a SCE is part of enrollment. |
| 4 | How does the AAA bill for a successful enrollment when the consumer chooses the LIFE program and there is no successful enrollment into the Aging Waiver? | There would be no payment. Successful enrollment pertains to Aging Waiver activities. |
| 4A | How is "successful" enrollment defined? | A successful enrollment is defined as a referral to the Aging Waiver in which the AAA completes all necessary steps to submit the application for enrollment. Necessary steps include facilitating the process of obtaining a physician certification form, completion of a LOCA and CMI, and MA eligibility. The applicant must be found eligible, both clinically and financially for the waiver. |
| 4B | a.) If an Aging Waiver participant goes into the nursing facility for more than 30 days and must be closed from the waiver, are we paid for their enrollment when they are discharged from the nursing facility?<br>b.) Is there a limit on how often this can happen?<br>c.) What is the procedure now? Must this consumer complete a new PA 600 or do we continue to send the PA 1768?<br>d.) What part will be care enrollment?<br>e.) Can we resume prior services when the consumer comes home or will they have to wait on the CAO approval? | a.) Please refer to the Maintaining Waiver Eligibility While in an Institution bulletin (05-12-02, 51-12-02, 52-12-02, 55-12-02, 59-12-02) issued January 24, 2013. The timeframe was extended to 180 days.<br>b.) Payment for a new enrollment is permitted only once in a calendar year.<br>c.) There is no need to complete a new PA600 unless there is a change in the person's financial situation.<br>d.) None, if the participant is in the facility for less than 180 days.<br>e.) Prior services can resume - unless the participant's needs have changed. |
| 4C | Can you please clarify, when a participant transfers from Options to Waiver what start date should we be utilizing to be reimbursed for both enrollment and service coordination. | This scenario is no different than a regular enrollment - the same procedures for enrollment should be used. The start date is the date that OLTL approves the ISP. |
| 5 | What constitutes "enrollment paperwork"? What if anything will be sent to the SC provider via hardcopy/mail? (outside of SAMS for Aging Waiver participants) | Enrollment paperwork consists of a copy of the PA 162, the physician certification, and the Freedom of Choice form. For the Aging Waiver, the LOCA and CMI are located in SAMS for the receiving SCE. |
| 5A | The AAA will do the enrollment for the Aging Waiver. The SC training refers to an Enrollment form to be sent to the SCE. Is that form available? | There is no separate form titled "Enrollment Form"; send the PA 162, physician certification, and freedom of choice form. |
| 6 | If an agency needs to make a request to the Department of Health (DOH) to move the Home Care license from one agency to another, will OLTL cite them if they have documentation in their file that they requested the moving of the license but haven't yet had a response from DOH? OR, will OLTL not allow them to provide service until DOH either moves this license or issues a new one? | OLTL will not cite an agency in this scenario as long as the request is in the file and there is reasonableness in the length of time from the request to the review. There should also be documentation of requests to DOH for the transfer if lengthy periods have elapsed between the original request and the review. |
| 7 | Is the Conflict Free Service Coordination Choice Form the only enrollment requirement that has to be completed by the AAAs? Are there any other enrollment requirements if the agency has only had the administrative care management program through a contract? | The Conflict Free Service Coordination Choice Form is for any agency, including Area Agencies on Aging (AAAs), that desires to become or are currently a Service Coordination Entity (SCE). Please contact the Bureau of Provider Support (BPS) at 1-800-932-0939 for any additional paper requirements. |
| 8 | What process will be utilized by service coordination agencies to indicate what population should be served? Will there be requirements to serve waiver "populations"? | Entities should contact the Bureau of Provider Support (BPS) at 1-800-932-0939 for instructions and requirements on enrollment. |
| 9 | If a county has only one home delivered meal provider serving Aging Waiver participants, and the provider is the parent agency, how can that provider comply with the conflict free regulation? | As an Organized Health Care Delivery System (OHCDS) provider, the agency is able to maintain the home delivered meal service. |

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| 9A | How does and agency find out if it is still an Organized Healthcare Delivery System Provider to provide Meals or Home Mods for our Aging Waiver Consumers? | Contact the Bureau of Provider Support (BPS) at 1-800-932-0939 for any questions related to provider status. |
| 10 | Where can the rules and regulations be found for Procedural Code W1793, Personal Assistance Services (Agency Model) and the requirements that are required to hire employees, maintain cases, etc.? | Providers should refer to the applicable waiver for requirements for agency model of services. The waivers can be found at: **http://www.portal.state.pa.us/portal/server.pt?open=514&objID=733116&mode=2**. Any further question should be directed to the Bureau of Provider Support (BPS) at 1-800-932-0939. In addition, requirements can be found in the PA Department of Health (DOH) Home Care Regulations. |
| 11 | For AAAs who wish to enroll as service coordination entities, what process occurs to indicate the region they wish to serve? | AAAs should contact the Bureau of Provider Support (BPS) at 1-800-932-0939 for instructions on enrollment. |
| 12 | Is the two step tuberculosis (TB) immunization required upon hire and the one step TB immunization to be done annually? | TB immunization requirements are in the PA Department of Health (DOH) Home Care regulations. Please refer to them or contact your County Health Department for additional information. |
| 13 | How will the data reporting changes be handled: HCSIS for AAAs and SAMS for the under 60 waiver providers? | Instructions and training will be provided to those agencies as they enroll to provide services to new specific populations. |
| 14 | In regard to the enrollment rate, reimbursement is for "successful" enrollments only. Did the rate methodology take into account staff time that it takes attempting to enroll a consumer who, subsequently, is determined to not be eligible for the Aging Waiver? | For updated enrollment rate for AAAs please refer to **http://www.pabulletin.com/secure/data/vol43/43-4/146.html,** and the Billing Instructions Bulletin **(05-13-02, 51-13-02, 54-13-02, 55-13-02, 59-13-02)** issued on February 7, 2013. The Billing Instructions Bulletin may be found at the following link: **http://www.portal.state.pa.us/portal/server.pt/community/bulletins/19451**. |
| 15 | Where can we find the crosswalk OLTL BPS Provider Specialty Code to the Aging Waiver procedure codes? If OLTL certifies a provider as a Type 05 Home Health Provider using Specialty Code 050 Home Health Agency:<br>(a) Should we be entering that provider into SAMS Admin for every Aging Waiver procedure code for each skilled care service?<br>(b) Must they be separately approved for W1793 PAS Agency Model?<br>(c) We enter DPW Specialty Code 362 as Provider Service W1793 in SAMS Admin. Does Specialty Code 361 also become W1793? | The crosswalk can be found with the Billing Instructions Bulletin referenced above.<br>a.) Yes.<br>b.) Yes, AAAs are to enter the provider into the admin tables in SAMS based on the approved information received from OLTL.<br>c.)OLTL – not AAAs – is responsible for assigning provider type specialty codes in PROMISe and SAMS. AAAs should not assign or add any provider codes or provider specialty codes. |
| 16 | Where would I find the paperwork that goes with the Act 150 program? We also are in need of information on how we work with HCSIS for these under 60 consumers. | The Act 150 program utilizes the same policies, procedures and forms as the Attendant Care Waiver. Contact BPS at 1-800-932-0939 for new provider training and HCSIS access. |
| 17 | If a current Aging Waiver participant informs the SC entity that they are planning to relocate to another county, what would be the process to transfer them to the receiving county, i.e. enrollment and choice of service coordination entity serving that county? | There is no new enrollment needed. It is the SC entity's responsibility to provide the relocating participant with an SC entity list for the new county, to provide choice of providers to the participant and to coordinate the transfer with the participant's new service coordinator. |
| 18 | In cases where service coordination is being done by both counties to coordinate a cross county transition how should these billing dates occur? | A transfer date should be agreed upon by both entities. Any service coordination performed before the transfer date is billed to the old location; any service coordination performed after the transfer date is billed to the new location. |
| 18A | When we are dealing with waiver transfers from one county to another, can we have some clarification and training across the AAAs and CAOs regarding how the PA 1768s are being completed? | Service coordination agencies should simply use the "Change of County Residence" block on the PA 1768 form. The current SC must send the PA 1768 form to the CAO and to the new SC entity. |
| 18B | When should the enrolling agencies start offering choice of SCEs and when will an updated freedom of choice form be available to reflect that Aging Waiver participants now have a choice? | The enrolling agency should provide choice upon completion of enrollment. An updated choice form is forthcoming. |
| 19 | Prior to June 30, we had been using one of the grant funded home modification contractors through Home Modification Construction Officers (HMCOs) to evaluate for home modifications and obtain estimates for home modifications. HMCOs would then provide the home modification through the contractor. Do you have any suggestions for how we can obtain these home modifications moving forward? | There have been no changes to this process. |
| 20 | How does separation of enrollment and SC for "conflict free" SC affect NHT? | Service Coordination Entities are permitted to continue as an OLTL recognized Nursing Home Transition partner. |
| 21 | To enroll as a PAS provider for waiver, do you have to provide all three services of personal care, personal assistance, and home support? | Personal Care and Home Support are no longer discrete services in the Aging Waiver, but have been incorporated into the Personal Assistance service definition. If an agency enrolls to provide Personal Assistance Services, they are expected to provide all components of the service definition as outlined in the participant's service plan. |

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| | **FINAL OLTL FAQs - 55 Pa. Code Chapter 52 - 6/17/2013** | |
| **#** | **Question** | **Answer** |
| | **Conflict Free Service Coordination** | |
| 1 | In regards to conflict free service coordination, should agencies send a notification of eligibility to consumers for the services they decide not to provide? | 55 PA Code Chapter 52 §52.61 outlines what actions must be taken by providers who plan to cease providing a service. The provisions of that section do not require that a notification of eligibility form be sent. |
| 2 | Can a provider split and start new corporations, one for service coordination and one for direct services? | Providers are required to follow 55 PA Code Chapter 52, including § 52.28 which addresses the requirements providers must meet to ensure that the agency is conflict free. |
| | **Qualifications for Service Coordination** | |
| 1 | If staff does not meet the service coordinator qualifications, should their employment be terminated? | Under 55 PA Code, the Home and Community-Based Services (HCBS) regulation does not provide for grandfathering of service coordinators. However, for employees hired prior to the regulation being in place, OLTL will review requests by agency directors on a case-by-case basis, and OLTL will work with them to bring their staff into compliance. Please send written requests to: RA-HCBS-REG@pa.gov. |
| 2 | What are DPW's plans for training the new service coordination agencies, AAAs and others? | Ongoing SC training began in March 2012 and new provider training is scheduled quarterly on an ongoing basis. A schedule of new provider training dates can be requested from the Bureau of Provider Support at 1-800-932-0939 . There are also several resources on the Long Term Living Training Institute's website at http://www.ltltrainingpa.org |
| 3 | Is a licensed RN that meets the training and experience requirements, recognized as meeting the requirements for supervision of service coordination? | Anyone who meets the requirements for service coordination supervisor may be hired in this supervisory position. |
| 4 | Is it possible for a staff member who has been entering service orders for many years, who does not have the requisite college credits, to have an exemption from the qualifications? Nothing else is being done other than entering them into the computer – it is purely data entry. | No. Data entry by anyone other than the SC may not be billed for under Service Coordination. Only if the service coordinator enters data is it considered to be a component of service coordination. |
| | **Service Coordination** | |
| 1 | Are RN's required and have they ever been required? Does the RN need to review and sign off on the LOCAs and CMIs once Service Coordination is implemented July 1st? How is that to be implemented? | There has been no change in policy on these matters. RNs are required to sign Level of Care Assessments. Only in limited cases where a participant has complex medical needs, or if they request it, must an RN sign the CMI (see Aging Waiver, Appendix D, at **http://www.portal.state.pa.us/portal/server.pt?open=514&objID=733693&mode=2**). |
| 1A | Does a homecare agency need to have a nurse to do the supervisory visit every 90 days? | The OLTL waivers do not stipulate that Personal Assistance Services agencies must have a nurse conduct a supervisory visit every 90 days. However, please check the Department of Health licensing requirements and Medicare requirements for your agency. |
| 2 | Can the service coordination entity (SCE) provide FMS for COMMCARE consumers under the new HCBS regulation? Does 55 Pa. Code Chapter 52 supersede the COMMCARE Waiver standards? | No. Effective January 1, 2013 an SCE may not provide FMS for COMMCARE consumers or those in any other OLTL waivers.<br>Yes, 55 PA Code Chapter 52 supersedes the COMMCARE waiver all standards. |
| 3 | If an RN home visit is not a component of service coordination, does this mean that the RN does not have to visit the consumer during the year unless it is documented that a visit is required and justification is provided to implement it as a formal support? | An RN does not have to visit a consumer during the year. Ongoing skilled nursing care must be provided as a distinct waiver service if there is a documented need. |
| 3A | If it is documented that an RN must visit the consumer, how do we receive reimbursement for this? Is there an “enhanced” SC rate to allow for the additional cost? | RN home visits are services that, if based on the documented assessed need, would be added to the service plan as a discrete service. There is no enhanced SC rate. |
| 4 | Do we still enter a service delivery of Assessment, LOCA (Annual Recertification) since the time to do the LOCA will now be a billable service under Service Coordination? If we do not enter the Assessment, does this affect reports being run for compliance purposes? | Conducting the LOCA is NOT a billable service under service coordination. It is a separate function paid for by Title XIX. There is no change in how LOCAs are documented in SAMS. |
| 5 | When we help the consumer complete their annual recertifications for DPW to determine their continued financial eligibility, is that billable for service coordination? Why is conducting Medicaid financial eligibility determinations or redeterminations considered as non-billable; particularly the redeterminations? | Assisting in collection of participant-required information, including assisting the participant with the MA application, contacting the CAO, assisting with the appeals process if necessary, etc., is billable for service coordination.<br>Financial eligibility determination or redetermination can only be conducted by the CAO and therefore cannot be billed under Service Coordination. |

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| 6 | (a) If consumers continue to refuse to have personal care (PC) tasks completed, do AAAs terminate them from the waiver?<br>(b) If so, is termination appealable?<br>(c) Do they need to give advance notice? | (a) Yes. Waiver services cannot be provided if an individual refuses the minimum services that are requisite for enrollment in a waiver. In such a case, the service coordinator may choose to pursue other funding mechanisms to support the individual.<br>(b) Yes.<br>(c) Yes. |
| 7 | Can PAS Agency aides transport consumers to medical and non-medical visits without the same restrictions placed on transportation by personal care aides? | When PAS is provided through an agency, the agency makes the determination whether they will allow their employees to provide transportation to participants. When the participant is the employer of the PAS worker, the PAS worker can provide transportation for the participant. However, the PAS worker cannot be paid for both hours worked and mileage. |
| 8 | What is the process for requesting approval of additional service coordination hours? | **See page 4** of the Billing Instructions Bulletin **(05-13-02, 51-13-02, 54-13-02, 55-13-02, 59-13-02)**, issued on February 7, 2013 which contains information on the process: The Billing Instructions Bulletin may be found at the following link: **http://www.portal.state.pa.us/portal/server.pt/community/bulletins/19451**. |
| 8A | As long as you stay under 144 units a year, can you exceed 12 units per month? | Yes. The 144 units is a yearly, flexible limitation. Service Coordinators may see increased and decreased service coordination needs from month to month depending on the needs of each participant. |
| 8B | Are there recommendations on how to provide service coordination within the suggested cap? | Service coordination is provided based on the assessed needs of each individual waiver participant. For more detailed information and guidance on how to request additional units please see the Billing Instructions Bulletin **(05-13-02, 51-13-02, 54-13-02, 55-13-02, 59-13-02)** |
| 8C | Will the cap be reviewed over time and changed if it is found that the hours exceed the recommended cap? | OLTL monitors utilization of all services and looks for trends across agencies as well as across the overall program. Determination of where increases or decreases are made is dependent on analysis of utilization. Also, additional units may be requested when needed in accordance with the Billing Instructions Bulletin. |
| 8D | We have been submitting Service Plan Review Requests for additional Service Coordination to OLTL. This is not a situation where we have utilized 75% of our allocated units. These requests are due to prorating. What will future entries look like? | According to the Billing Instructions Bulletin **(05-13-02, 51-13-02, 54-13-02, 55-13-02, 59-13-02)** requests to increase SC units should not be submitted to OLTL until 75% of the original authorized units have been used. When developing initial Individual Service Plans for participants, Aging waiver Service Coordinators should **not** be prorating, as ISPs in SAMS are developed for the 12 month plan period.<br>HCSIS users are only to prorate units because entries are based on effective start date to the end of the fiscal year. (which may not total 12 months) |
| 8E | Will the process for requesting additional SC units be different for individuals with Protective Services? | If, due to the involvement of PS, additional service coordination units are needed immediately because the originally requested units have been depleted, additional units may be provided and requested after the fact. SCs must document the usage of all SC units. |
| 8F | Will HCSIS allow us to decrease units after the end of the month? | In HCSIS, Service Coordination units are allocated on an annual basis. It is, therefore, unnecessary to adjust units each month. |
| 9 | If we put the service coordinator as the sub provider, the only way to enter a service delivery is to enter that particular service coordinator. Also, if we enter daily service deliveries, will there be a report which we can run so that we are able to bill? | AAAs should enter Service Allocations and Service Orders in SAMS, not service deliveries. The Service Order will upload to HCSIS. The AAA will bill PROMISe for services rendered. PROMISe will interface with HCSIS to ensure that the number of units billed do not exceed the number of Units authorized in the Service Units. The Service Orders will always show the correct amount of units delivered. Reference: Service Coordination Module and Webinar. |
| 10 | If two SCs visit a consumer at the same time due to safety concerns, can only one of the SCs bill? | Yes, only one can bill for service coordination. |
| 11 | Since Service Coordination cannot be billed until OLTL approves the start of the ISP, this places the AAA at a great disadvantage for timely billing. What is being done to address this so that the AAAs can bill for Service Coordination in a timely manner? | OLTL is working with a small workgroup of AAAs to develop a way to address this issue. |
| 12 | Since eligibility for all waiver programs is determined by Nursing Facility Clinically Eligible status, how does OLTL/BIS determine medical needs? Is a request made to have a nurse assess the client to determine medical needs which require ongoing medical management? | OLTL/BPO reviews the LOCA, CMI and service plan to determine the needs of the individual. OLTL has a physician and RNs available to review the information if there are questions or requests regarding medical needs. |
| 13 | Whose responsibility is it to recruit providers for services? In one county a behavioral health provider has stopped doing business because the rates were insufficient to meet the costs of doing business. This service is not available to consumers. | Medicaid is a free-market system; providers decide to participate based upon the established rates and potential volume of business. Service Coordinators should notify OLTL when a service is unavailable to participants due to a lack of providers of the service. |
| 14 | How are AAAs notified as to who provides Service Coordination in their planning service areas? How are AAAs notified when there are new Service Coordination agencies since offering a participant a choice of providers is part of the enrollment process? | The Bureau of Provider Supports will send a letter to a AAA when another service coordination agency has been enrolled to provide Aging Waiver service coordination in the same service area. |

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| # | Question | Answer |
| 15 | The Service Coordination training manual states that a AAA sends a written communication to consumers when OLTL approves a service. Is this the ISP or another form? Do we create our own form? | Every participant to be provided services must receive a copy of their approved service plan, as stated in the ISP Bulletin (issued October 20, 2010) at: **http://www.portal.state.pa.us/portal/server.pt/community/bulletins/19451**. |
| 15A | The AAAs have two separate forms that are sent relative to notification of adverse action and the right to appeal. Is there a standard form to use statewide? | OLTL is developing a standardized form and process across all OLTL waivers for informing participants of adverse actions. The standardized form and training is forthcoming. |
| 16 | Do monthly contacts need to be scheduled in SAMS under Activities as they were required prior to the change from care management to service coordination? | Yes. Continue to schedule monthly contacts and place them in the same location as before. |
| 17 | Are AAAs required to have the Provider's attendant logs (bathing, grooming, etc) in our files from our Waiver Providers? | No. The attendant logs are not required to be kept; however, the SC is responsible for monitoring the participant's service plan. |
| 18 | Is the nurse required to review the CMI when notified the consumer has a wound? What if the CMI was already reviewed by the RN because the consumer met one of the other criteria for a nurse review? | If the consumer does not require a new CMI, then an RN review is not required. A registered nurse must be either on staff with the Service Coordination agency or be available under contract as a nursing consultant to the Service Coordination agency for instances where RN consultation may be necessary or requested. |
| 19 | Should there be a diagnosis code in the special instructions section in the service plan for service coordination? | Yes, the diagnosis code should be entered in the special instructions as best practice. Since SCs are responsible for providing direct service providers with ICD-9 codes, OLTL expects AAAs to document ICD-9 codes in SAMS. For HCSIS users, the ICD-9 code is documented on the Diagnosis Screen, in the comments section. |
| 20 | My agency provides service coordination for the Independence Waiver, and we will soon start to provide service coordination for Aging Waiver participants. We do the annual recertification for the Independence Waiver – do we perform the annual recertification for Aging participants as well? | The AAA in the participant's county of residence is responsible for recertifications for Aging Waiver participants using the LOCA. |
| 20A | Where can we find the list of service coordination agencies in our area? How would I find out what waiver programs these providers are service coordinators for? | A list is provided in the Services and Supports Directory in Compass. OLTL will send a letter to the AAA when additional SCEs are enrolled in their area and those agencies will be added to SAMS. The Services and Supports Directory (SSD) lists all SC agencies. The link is located at: https://www.compass.state.pa.us/compass.web/EPProviderSearch/Pgm/EPWEL.aspx?prg=LTH |
| 20B | Are we able to adjust the list to only show the agencies that serve our county or do we have to give to consumers as is? | Consumers must be shown all agencies approved in their county. An agency can offer its own county list, but it will not be generated by OLTL. |
| 21 | What is the date we should be using for the Annual Recertification date for the Waiver? | Continue to use the date of the LOCA or the MA 51 for the OBRA Waiver. |
| 22 | Who completes the Annual Recertification for the Under 60 Waivers and the LIFE program? | The SCE is responsible for completion of the annual reevaluation of the level of care for under 60 waivers. The LIFE provider completes the *LIFE Participant Annual Recertification Form* for the LIFE program. |
| 23 | What do we do if we need quick approval for additional SC units due to unexpected consumer needs, what process should we use to get the approval in a timely manner? Will those units be approved? | Please see Billing Instructions Bulletin (05-13-02, 51-13-02, 54-13-02, 55-13-02, 59-13-02) issued on February 7, 2013 that has detailed instructions for requesting additional SC units. |
| 24 | Is there a standardized form stating service coordinators notify participants that an RN is available? | This information will be included in the standard informational packets begin put together by OLTL for participants. |
| 25 | If there is a change of service coordinators with the AAAs, do the service plan and service orders have to be updated with the new sub provider? | Since the service coordinator must create/update the service order the last day of each month to reflect the actual number of delivered units, it would be the time to make the SC change. The service order item must be deleted in order to recreate the service order to include the correct SC. The entire service order can be deleted and recreated with the new SC. If the change occurs in the middle of the month, two service orders are required but the dates cannot overlap. |
| | **Rates** | |
| 1 | What is the process to request a rate increase for the consumers who are part of the state program? | Participants using the participant-directed model of service should contact the F/EA vendor, PPL, for information on adjustment of direct care worker wages. Their number is1-877-908-1750. In the agency model of service, rates are now standardized and there are no negotiated rates for waiver or Act 150 services. |
| 2 | Is there an update to the April 20, 2012 letter which included rate amendments that could be effective as soon as June 1? | Please see Billing Instructions Bulletin **(05-13-02, 51-13-02, 54-13-02, 55-13-02, 59-13-02)** issued on February 7, 2013 that reviewed the rate-setting methodology, fee schedule rates, and vendor goods and services for the Medical Assistance Aging, Attendant Care, COMMCARE, Independence and OBRA Waivers as well as the Act 150 Program. |
| 3 | What are the exact rates? What is the exact date when they will take effect for each waiver. | Please see the Billing Instructions Bulletin **(05-13-02, 51-13-02, 54-13-02, 55-13-02, 59-13-02)** issued on February 7, 2013. |

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| 4 | Do the rates take into consideration overhead costs? | Overhead or indirect costs are included as a component of the OLTL HCBS market-based rates. Included in indirect costs are administrative expenses such as management, office supplies and equipment, recruitment, information technology, human resources, billing, finance, accounting, legal, and other indirect costs necessary for program operations. |
| 5 | The travel between consumers for 1 or 2 hour visits in counties with rural areas cannot be accomplished with the proposed rate. "We are required by Labor & Industry to pay travel time." | OLTL's market-based rates factored in the cost of travel and non-productive time. |
| 6 | There appears to be regional disparities in the rates. Were the different needs of urban counties and those of rural counties considered in formulating the new rates? | Yes, in order to determine the regional groupings for OLTL HCBS rates, county specific wage information and population densities were obtained and utilized to evaluate the characteristic of each county looking for commonalities in geographic market cost variances. |
| 7 | Were increasing transportation issues and rising costs factored into the rates? | Both non-client time for travel and travel costs were utilized when setting the rates. |
| 8 | The new fee is lower than the service coordination currently reimbursed in PA's Mental Health (MH) system. What would indicate that the rates should be different? | The rates were developed based on a consistent definition for service coordination for all OLTL waivers. DPW's MH system has a number of targeted case management services, and each has a corresponding fee. OLTL has reviewed the MH definitions and none appear to be consistent with OLTL's service coordination definition. |
| 9 | We will have to begin to stop providing services on evenings, weekends and holidays. Are we allowed to do that? | No. As a provision of the provider agreement, OLTL waivers and the Home and Community-Based Services regulation, providers MUST provide services in the type, scope, amount, duration and frequency as indicated in the service plan and must assure for the health and safety of waiver participants. If a service plan indicates a need for services in the evening, weekend or holiday the provider MUST provide these services. |
| 10 | How was what is now considered to be non-billable time that is spent by care managers working with Aging Waiver consumers included in the rate methodology? | The market-based rate-setting methodology that was used to set the service coordination rate includes a non-client time component. |
| 11 | Are there any plans to increase the Home Delivered Meals vendor service rate? Do we have to request a rate increase? Is there a cap for the PERS rate for the installation and the monthly monitoring? Where do we find what providers can be paid for PERS? | Please refer to Attachment A of the Billing Instructions Bulletin **(05-13-02, 51-13-02, 54-13-02, 55-13-02, 59-13-02) which** contains the new procedure codes and rates. A vendor service means that the Department will pay an Organized Health Care Delivery System or provider for the actual cost of a vendor good or service listed in the rate notice **(http://www.pabulletin.com/secure/data/vol42/42-23/1058.html)** when rendered to an enrolled waiver participant. The payment may not exceed the amount for similar vendor goods or services charged to the general public. See 55 PA Code § 52.51. |
| | **Billing** | |
| 1 | Should providers begin billing using the new procedure codes and rates beginning June 1, 2012, or will these billings be rejected until all the information is in the Social Assistance Management System (SAMS) for all the counties? | The new rates were effective on June 1, 2012, and loaded into SAMS on June 4, 2012, except for enrollment for the Aging Waiver and service coordination services. Please refer to the Billing Instruction Bulletin **(05-12-01, 51-12-01, 54-12-01, 55-12-01, 5912-01)** issued on February 7, 2013 for further information on enrollment and service coordination. |
| 2 | Does nursing home transition fall into the definition of "community transition"? Is nursing home transition a "service" that AAAs would have to choose to eliminate in order to provide service coordination? | Service Coordination Entities are permitted to continue as an OLTL recognized Nursing Home Transition partner. |
| 3 | What happens under the new regulations when a PCA shows up at the participant's home and the participant does not want services? Is this still billable since the PCA had to travel to the home? | No, if the service is not provided, a provider many not bill. |
| 4 | Is the intent to eliminate respite in the nursing home? | No. Nursing facility respite care is still allowed in the Aging Waiver. The nursing facility will bill PROMISe. |
| 5 | Will enrollment be a separate contract for the AAAs? | Enrollment will be included in the AAA Title XIX Medicaid Waiver Grant Agreement. AAAs will bill PROMISe for successful enrollments rather than receive the funding through their monthly allocation. |
| 6 | Do Aging Waiver Providers need to supply gloves to their direct care workers when they provide consumers with personal assistance such as toileting? Can providers bill the state for the gloves? | Providers are required to supply gloves to direct care workers. *See,* Occupational Safety and Health Standards, 29 CFR § 1910.1030(d)(3).<br>In terms of billing the state, no, providers cannot bill --- these costs are a component of the rate. |
| 7 | What services are billable and not billable? | Please refer to the Billing Instructions Bulletin **(05-13-02, 51-13-02, 54-13-02, 55-13-02, 59-13-02)** issued on February 7, 2013, specifically the procedure section. |

| # | FINAL OLTL FAQs - 55 Pa. Code Chapter 52 - 6/17/2013 | |
|---|---|---|
| **#** | **Question** | **Answer** |
| 8 | May smaller amounts of time for one consumer be accumulated to get one 15 minute billable unit? If so, what documentation is required? | No. Please refer to the Billing Instructions Bulletin **(05-13-02, 51-13-02, 54-13-02, 55-13-02, 59-13-02)** issued on February 7, 2013. |
| 8A | Can the activities for setting up services for a new participant, that are completed in a consecutive time period, be considered billable time if done consecutively and is directly related to that one participant? (e.g. 30 minutes to coordinate services) | Yes. Since these were billable activities conducted in a consecutive time period, this can be billed as 2 billable 15-minute units of service coordination. The actual beginning and ending times for work activities related to a participant need to be documented. For example, *"10:03am-10:33am: Made calls on behalf of Mary to find a PAS provider for her. Those calls included agency A, B, and C."* |
| 8B | Regarding the number of minutes being converted into billable units, why is 7.5-29.99 all considered 1 unit in your matrix? | In this example, 7.5-29.99 is considered two billable units. To further clarify, 7.5-22.49 minutes is considered one unit. Please refer to the Billing Instructions Bulletin **(05-13-02, 51-13-02, 54-13-02, 55-13-02, 59-13-02)** issued on February 7, 2013. |
| 9 | Where can we find information about the waivers, including service definitions and provider requirements? | Waiver information, including service definitions and provider requirements for all OLTL waivers can be found at: **http://www.portal.state.pa.us/portal/server.pt?open=514&objID=733116&mode=2**. |
| 10 | When does a consumer's "participant" status begin, allowing billing for the participant as an Aging Waiver consumer? | A consumer's "participant" status begins upon receipt of the PA 162 by the AAA. Billing for services should not occur until after OLTL approves the service plan. |
| 10A | Does the above answer just apply to direct services (such as PAS, PERS, etc.) or does it also apply to billing for service coordination and enrollment? | No billing is permitted to occur until there is an MA recipient number for an individual. It applies to service coordination and enrollment as well. The services must be on the plan and authorized in order to bill. |
| 11 | Are the following services billable: Adult Day In Home Services, Ambulance Services, Medical Transportation, Music Therapy and Recreational Services? | No, none of these services are approved services in OLTL waivers and are not billable. |
| 11A | We are no longer able to add S5185 (medication set-up by pharmacy) to our service plans. We have many consumers who use this service. What are we to do with our consumers who are currently using this service? | As of June 1, 2012, S5185 - Medication Set-up by Pharmacist is no longer a covered service in the waiver. Neither the waiver nor MA fee for service covers medication set up as a separate billable activity. Please reassess for an appropriate service to meet the need. |
| 11A1 | How does above answer affect the PDA waiver covering Philips Medication Dispensing Service? Is there anything happening to make this Philips Medication Dispensing Service allowable in the under 60 waivers? | The pharmacy exclusion will not affect the Medication Dispensing Service. It is still covered under Telerate Dispensing and Monitoring. No, this service is currently not approved for the under-60 waivers. |
| 11B | Are interpreter Services billable? | No. Interpreter Services are not billable. Your Medicaid provider agreement and the waivers require providers to provide oral and written assistance to Limited English Proficient (LEP) persons to aid them to access and use services. Compliance with this provision is included as a component of the service rate. |
| 12 | Since our case aides and clerical staff perform some of the face-to-face visits, phone calls and SAMS functions, is case aide/clerical time billable? | No. Case aide/clerical time is not billable as service coordination. Clerical and administrative support is included as a component of the service coordination rate. |
| 13 | Would an RN home visit be billed at a separate rate? Would an RN paper review be billed at a separate rate which would reflect her/his advanced expertise? | RN paper reviews are a component of SC and is included in the rate. AAAs should not bill SC for time spent by the RN. |
| 14 | When an RN is required to sign off the CMI, how do we bill for that event? Is it allowed to be Service Coordination and can it be entered by the RN even though they do not meet the Service Coordinator requirement or can the Service Coordinator enter the review time for the RN? | The RN is a component of Service Coordination and is included in the rate. The AAA shouldn't be billing SC for time spent by the RN. |
| 15 | During a hospital admission, consumers are considered suspended. We know service providers will not and should not be able to bill during this time. Service Coordinators could be assisting with the discharge planning etc. Is this billable time or will service coordination also be suspended and activities will not be billable during this time? | Service coordination will be suspended and activities will not be billable during that time. Any services provided on the date of discharge are billable as service coordination. |
| 16 | If an Aging Waiver consumer passes away, are the activities done by the SC after the date of death billable? Can we bill if we use a date prior to date of death to be in compliance? | No, 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. |
| 17 | When we bill for service coordination, are we permitted to bill for supervision? Is Supervisor sign off of the CMI a billable SC activity? | No. Supervisory activities are non-billable and are built into the rate. |
| 18 | How does the AAA bill for the successful enrollment once the PA 162 is received, but the consumer departs from the program (i.e. passes away, enters a Nursing Facility, voluntarily withdraws) prior to receiving OLTL approval for the care plan? | The enrollment service must be authorized before billing can occur. Once this occurs and the AAA has the 162, they can bill PROMISe. Date of service cannot occur after the date of death. |
| 19 | We have formed a new non-profit organization and are unsure what tax return is needed to satisfy 55 Pa. Code 52.11(a)(3)(i). We don't have an "owner" so do we have to send in the entire board's information? | No. For new non-profit organizations ONLY, the Office of Long-Term Living is not requiring the submission of tax return under 55 Pa. Code 52.11(a)(3)(i). |

| | FINAL OLTL FAQs - 55 Pa. Code Chapter 52 - 6/17/2013 | |
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| **#** | **Question** | **Answer** |
| 20 | In your example of a 30-minute home visit, is there some other place that topics discussed need to be recorded? | The only requirement is that billable and non-billable units are documented in Journal Entries in SAMS and the Service Notes in HCSIS. |
| 21 | What if a consumer switches counties - can the new agency bill for the W0009? | No. A new enrollment is not needed. |
| 22 | Can a supervisor bill for a billable activity when he/she is covering service coordination duties for a service coordinator? | If a service coordination supervisor is qualified as a service coordinator, they can perform service coordinator duties at the service coordination rate. |
| 23 | Are we required to enter a journal entry for every billable activity? | Yes. Activities that are not documented and billed may be disallowed as the result of a monitoring/audit. |
| 24 | Initial SC activities can take 2-4 hours. When the ISP is approved by OLTL it takes the service coordinator an additional 1-2 hours to authorize services (contacting the provider, contacting the participant, updating the service plan, generating service orders, etc.). Because the participant is care managed by Options we are not able to bill for these activities. Is there a possibility we will be able to bill for the service coordination Aging Waiver provided? | This is not an allowable practice. If a person is receiving services through another funding source, waiver funds cannot be used retroactively. OLTL is working with AAAs to explore possible ways that this activity may be covered. |
| 25 | How do we bill RN services under the new billing codes? | If a waiver participant requires nursing services, this service should be included on the participant's service plan. Home Health – Nursing is a discrete service that is available in many of OLTL's waivers. Please refer to the Billing Instructions Bulletin **(05-13-02, 51-13-02, 54-13-02, 55-13-02, 59-13-02)** issued on February 7, 2013 for further information on billing codes. |
| 26 | For AAAs, what are the services we can bill for under enrollment services? | Enrollment consists of the following:<br>• Assist in securing the Physician's Script<br>• Assist in securing financial eligibility determination<br>• Internally coordinate completion of the LOCA (does not include actual performance of the LOCA)<br>• Ensure that the participant's CMI has been pre-populated from the LOCA<br>• Provide participant with choice of service coordination agencies<br>• Send 1768 form to CAO<br>• Upon receipt of PA 162 from CAO, submit corresponding enrollment paperwork to chosen SC agency to begin service plan development<br>• Enter information into SAMS for enrollment<br>Enrollment ends |
| 27 | Can you tell me if file auditing (reviewing files for accuracy and completeness) is billable or non-billable? | Those activities are considered to be supervisory activities and are, therefore, non-billable. Supervisory activities are already built into the SC rate. |
| 28 | We recently learned AAAs receive their assessment allocation based on the total number of assessments completed x $226. The RNs cannot bill for reviewing the Aging Waiver LOCAs &/or CMI's. The Aging Waiver annual reassessment requires an RN signature for the LOCA's. How does that get paid, from the $226? | The assessment allocation for LOCA's and reassessments are set by the Department of Aging (PDA) for each AAA. This allocation is reconciled to actual costs but at a cap of $226 per assessment/ reassessment. The AAA's report all costs incurred to perform this function including the RN as required. |
| 29 | If we have an NHT contact due for a Waiver participant, can we count that also for one of the contact visits for Aging Waiver? Would it be billable under SC since we are already reimbursed under NHT. | Yes, you can count it as a contact visit. But, no, you cannot bill both NHT and SC. |
| 30 | Is it mandatory to have times listed in every single service note that is being entered as billable time? | Yes. SCs are required to list specific times. |