

## Technical Questions Re: IP Cover Sheets and PARs Final

1. **Should we be checking “yes” on the IP cover sheet for individuals actually paying PETI or all of those that are PETI-assessable (300%ers)?**

Response

The case manager should mark the “yes” checkbox for any client that is PETI-assessable (300%ers) regardless of PETI payments. This does not include consumers which qualify for Medicaid through 1634 c, 1619 b, or the Pickle Amendment.

2. **When we complete an amended Comprehensive IP Cover Sheet for amended services, how soon can a Service Agency bill for services?**

Response

Generally the mail is processed by the date it arrives in our office. All mail received by the 15<sup>th</sup> of the month will be reviewed and processed for that month. If the CCB marks the “HIGH PRIORITY” box on the Amended IP Cover Sheet, DDD will pull these IP Cover Sheets out of our mail and process them before processing any other submissions. However, since this is a new process, it is impossible for us to determine the specific time frames in which these will be processed. With the amount of information that we have, it would be reasonable to assume that the CCB or Service Agency could bill for the services that have been added/changed one week after the information was sent on to DDD. Please keep in mind that with all of the pending changes, this is an approximation that may depend on the volume of changes DDD is receiving.

3. **What is the timeframe for amending the PAR?**

Response

Due to the fact that all service changes must be made in the PAR, the CMA should submit PAR changes to DDD as soon as they are aware of the change.

4. **When completing IP Cover Sheets and calculating units, should we base our figures off the IP cycle or the fiscal year?**

Response

The numbers of units for each service that are indicated on the IP Cover Sheet are the number of units for the IP period.

**5. Please define Line Staff, Senior Therapist and Lead Therapist under the Behavioral Service under the Behavioral Services category?**

Response

Line Staff: Behavioral Line Staff are additional staff, who are working under the direction of the senior or lead therapist, that are brought into the residential and day program locations to specifically carry out the behavioral plan only. These activities are time limited and targeted to the behavioral plan. This does not include residential or day program staff that are doing follow-up to the behavioral therapy identified in the plan in the course of their regular day or residential program activities. Does not require credentialing but must be trained regarding behavioral plan implementation and interventions.

Senior Therapist: Requires a Master's degree; or a Bachelors degree with one year of experience.

Lead Therapist: Requires a doctoral degree - these are not the people who carry out the day to day plan for an individual, but rather the people who develop the plan and do oversight. (See instructions on group sessions above.)

**6. Does line staff include regular residential staff that are implementing behavioral ISSPs?**

Response

No, Behavioral Line Staff are additional staff, working under the direction of the senior or lead therapist that are brought into the residential and day program locations to specifically carry out the behavioral plan only. The activities administered by the behavioral line staff are time limited and targeted to the behavioral plan. This does not include residential or day program staff that are doing follow-up to the behavioral therapy identified in the plan in the course of their regular day or residential program activities.

**7. Is Program Manager time billable under the Behavioral Services category? (i.e. the time that the program manager spends developing a behavioral plan and training direct care staff)**

Response

No, a program manager's time is not billable. The behavioral plan is to be developed by the Lead or Senior therapist not a program manager. If a program manager participates in discussions with the therapist their time would not be billed under behavioral services.

- 8. When aligning the BUS dates with the IP dates, which IP Cover Sheet should be used?**

Response

If the BUS assessment is being completed at the time of the annual IP, the Annual IP Cover Sheet should be used to indicate both dates. If the Bus assessment is being completed prior to the IP, the Amended IP Cover Sheet would be used to inform DDD of the BUS certification dates.

- 9. How can we amend an SLS/CES PAR when we have not yet submitted the units to DDD? (i.e. SLS IP has certification dates of 12/1/05 – 11/30/06 and the CMA needs to add hours of day program services to the PAR, but the old IP Cover Sheet did not indicate service hours)**

Response

In this example, a “new” IP cover sheet has not yet been submitted (i.e.: the annual IP is not due until 12/01/06), so the CMA is not required to submit an amended IP cover sheet to DDD if there is a change to the IP. Please Note: It is important to maintain clear and complete documentation of any changes to the IP in the client master record. Per instructions given, as of July 1, 2006 the CMA is required to submit the “new” IP cover sheet for all new enrollments and annual redeterminations. This new version includes the number of units allotted in the plan. If the new version of the IP cover sheet has already been submitted and a change to the IP occurs then an amended IP cover sheet must be sent in indicating the change in units.

- 10. How are GPS tracking devices billed? In Comp? In SLS? In CES?**

Response

If a GPS tracking device were **allowable and approved** they would be billed under Assistive Technology for both waivers.

**11. What is included in Disposable Supplies? What is included in Specialized Medical Equipment?**

Response

Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control or communicate with the environment in which they live.

This service also includes items:

1) Necessary for life support

2) Ancillary supplies

3) Maintenance and equipment necessary to the proper functioning of such items

4) Durable and non-durable medical equipment not available under The Medicaid State plan.

Some disposables that are included in the Medicaid State Plan have a cap such as attends and gloves, so if these items are needed above the cap they may be billed through the Waiver under Disposable Supplies.

Please note all supplies and equipment through the Medicaid State Plan must be prior authorized Information about what is available through the Medicaid State Plan is available on the Internet at:

<http://www.chcpf.state.co.us/HCPF/refmat/MRB/MRBNewpg.asp>

**12. Dentists vary in the way they bill for services. Some dentists lump everything together under treatment and some bill separately for diagnostic. Is it the responsibility of the CMA to ask the dentist to break this out?**

Response

If the service is a benefit covered under the Medicaid State Plan, the Medicaid enrolled dentist will directly bill Medicaid. The CMA is only responsible for breaking this out for billing purposes that involve services covered under the Waiver. In those situations, the CMA should notify the dentist office in the beginning that they will need the bill broken down.

**13. How is sedation for Dental billed?**

Response

When the Medicaid enrolled dentist prescribes hospitalization and general anesthesia for the individual in order to receive dental procedures, the medical portion of the bill may be billed and reimbursed through the Medicaid State Plan as long as it meets the criteria set forth in Medicaid Rule 8.190.

The dental portion of the bill should be billed through the Medicaid State Plan if it meets the requirements set forth in Medicaid Rule 8.201. Otherwise it will be billed through the Waiver, according to the Waiver definition.

**14. Are Professional therapies such as music, Massage or Hippo-Therapy billable under the SLS and CES Waivers?**

Response

Professional services such as Music, Massage, or Hippo-Therapy can be funded under the category of "Professional Services" as long as the provider is licensed in that profession, and the intervention is related to an identified behavioral need. **The service must be an identified need by a licensed Medicaid State Plan therapist/physician and that therapist/physician has identified a goal for the treatment and is willing to monitor the progress of that goal.** The identified "Professional Service" cannot be available through the Medicaid State plan or third party source if it is paid for by Medicaid SLS.

Please Note: There is no "Professional Services" category in the Comp Waiver.

**15. When a therapist provides training to the child/adult and/or the family on how to properly use assistive technology, how is this billed?**

Response

Under the definition provided in the approved waiver, operating medical, assistive or adaptive equipment is covered under personal assistance services, even when a therapist is providing the training to the child/adult and/or the family. This is not included in the \$10,000 cap for Environmental Engineering.

- 16. For SLS, in cases where Recreation Center passes, punch passes, etc. are recommended by a licensed professional, I understand that this would be billed under Day Habilitation (T2021), Community Access, part b. as they are supplies/resources for participation in activities and functions in the community. Is this correct?**

Response

No, that is not correct. At the present time there are no "item" billing categories available under SLS. DDD will be discussing this issue with HCPF in the very near future to see if these issues can be resolved. .The only mechanism currently available under SLS is to include these types of individual costs into an overall rate for a paid community support staff, who would then pay for the item as part of the support they would be providing.

- 17. Regarding recommendations for alternative therapies, assistive technology, etc. for both CES and SLS, I am of the understanding that SLS and CES cannot fund an OT, SLP, or PT for this service, and that an approved provider should bill it through Medicaid. Can we use a recommendation/prescription from the individual's physician? In cases where we can obtain a recommendation from a therapist at the child's school, is this OK or do we need one of the above for justification for alternative therapies or assistive technology?**

Response

The statement is correct that PT, OT, and SLP are not reimbursable under either the SLS or CES waiver and must be obtained through the Medicaid State Plan or EPSDT. If an alternative therapy or assistive device is prescribed then this must come from an approved Medicaid State Plan therapist/physician. For alternative therapy, the Medicaid State Plan therapist/physician is required to identify goals and monitor them.

- 18. Are billings for SLS and CES switching over to Units, retroactive to July 1, 06? Can SLS/CES providers (PASA's and Independent Contractors, public providers such as dentists, etc.) still use their own billing formats they have historically used, as long as the billing reflects Units, and is tallied daily (as it has been)? It is up to the Provider billing MMIS to bill in units?**

Response

There has been no change to how CES is being billed. Effective July 1, 2006, SLS changed from a bundled monthly payment method to billing for each service being provided. The provider can determine the manner in which they request billing information from the entity providing the service. It is up to the billing provider to ensure that they have appropriate documentation to support the units that are billed. In the examples of dentists, they usually send a bill with a total dollar amount. Dental services under the waiver are billed by procedure code as 1 unit equals \$1, so there should be no change in how that information is provided.

- 19. Do any of these changes affect State SLS? Is State SLS billed on a fee for service basis or on a 1/12th billing?**

Response

State SLS is still paid out on 1/12th billings and has all the same reporting requirements.

- 20. Are PRN meds not covered by the person's Medicaid state plan included in disposable supplies or equipment under specialized medical?**

Response

No, these are the responsibility of the client out of their personal needs funds. The only things required to be paid for by residential are the over the counter drug list in the personal needs manual.

**21. How are hearing aids and audiology exams billed?**

Response

Audiology Exams may be billed through the Medicaid State Plan. Specifics on this service can be found in the Specialty Billing Information Manual. It is available on-line at:  
[http://www.chcpf.state.co.us/ACS/Provider\\_Services/Billing\\_Manuals/Billing\\_Manuals.asp](http://www.chcpf.state.co.us/ACS/Provider_Services/Billing_Manuals/Billing_Manuals.asp)

Hearing Aids are covered through the Medicaid State Plan for clients under the age of twenty-one. In the SLS waiver hearing aids are covered under Environmental Engineering (Assistive Technology). In the Comp Waiver hearing aids are billed under Specialized Medical Equipment.

**22. Can the new IP Cover Sheet that is sent in be electronically signed?**

Response

Until further notice, DDD requires an original signature by the case manager on all IP Cover Sheets.

**23. How is transportation defined and billed under SLS? Under Comprehensive Services?**

Response

Claims are paid for an approved benefit delivered by a qualified Medicaid provider to an eligible client for a specific unit of service that is identified by a procedure code. There is a distinct difference between the Comprehensive Services and SLS waivers in regards to transportation. Individuals enrolled in the Comprehensive Services waiver must receive residential services. As part of that service the residential program is responsible to provide for the transportation needs of the individual except, for transportation to and from day program services (day program under the Comprehensive waiver is defined as specialized day habilitation, community accessibility and supported employment services.) In contrast, the consumer in the SLS Waiver requires additional transportation supports by virtue of not being in a residential setting (i.e.: grocery shopping).

The Comprehensive Services waiver definition for transportation states: "Service offered in order to enable individuals served on the waiver to gain access to waiver day program services and activities specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR

440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized.”

Transportation in the Comprehensive Services waiver is billed using a daily rate set forth in the Comp interim rates and the established tier. It can be billed each day that transportation is provided to and from day program Services. Any other transportation will be provided through the residential rate.

The SLS waiver definition for transportation is defined as, “Service offered in order to enable waiver recipients to gain access to waiver and other community services and resources, required by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services offered under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the recipient's plan of care. Whenever possible, family, neighbors, friends, or community agencies, which can provide this service without charge, will be utilized. In no case will family members be reimbursed for the provision of transportation services under the waiver.”

Transportation provided under the SLS waiver is currently billed based on the cost to provide transportation for that day. At this time there are no billing codes in the SLS waiver that allow for item billing. The CMA will need to project the annual cost of transportation for the year and divide by the number of days that the consumer will be utilizing it for services identified in the plan. This will be the daily amount that will be billed. For example, the annual bus pass cost \$365. The person’s plan identifies that they need a bus pass to get to and from day program as well as for grocery shopping. The consumer attends day program 12 times per month and goes grocery shopping 5 times per month. The daily rate for transportation would be \$1.79.

**24. Community safety risk was omitted from the new IP Cover Sheet. Should this still be tracked?**

Response

Yes, this data still needs to be included in the CCMS Core Data.

**25. If a consumer does not utilize as many units as planned in a given month, do those units carry over to the next month?**

Response

The units indicated in the PAR record are for the entire plan year and are not specified by month. Obviously there will be some services that do not carry over because the individual would not derive any benefit from receiving more in the next month.

**26. Can provider agencies bill for provider attendance at IPs and IDTs?**

Response

No, provider agencies are not allowed to bill direct service categories for attendance at IPs or IDTs. Attending meetings to discuss and identify the services to be provided would be considered part of the cost of doing business. Those indirect cost, are built into the reimbursement rate for a claimed benefit delivered to a client..

**27. When billing residential services, how is a “day” defined?**

Response

Being “in residence” refers to the individual:

- Ø Being in the physical location of the residence (e.g. licensed group home, host home, their own apartment, etc.) for any portion of the day.
- Ø Being physically with your residential provider outside of the home and receiving services identified in the Plan Of Care that are allowable under the waiver definition of residential services. This is not allowable if the individual is staying with a relative as defined in C.R.S. 27-10.5-102.

**28. How are we to do our billing in SLS and CES? Do we have to start billing in quarter unit increments or can we continue to bill in hourly increments until all of the IP’s have changed to reflect the correct units?**

Response

Providers will bill units based on the procedure code unit designation. American Medical Association (AMA) and Center's for Medicare and Medicaid Services (CMS) set the unit designation for each procedure code. The only procedure code that has an hourly unit designation is SLS - Pre-Vocational services. Most codes that have a time unit designation are 15 minutes.

**29. Can we bill everything the way we have in the past and just compute the totals into the unit increments, for now?**

Response

No. CCBs and provider agencies, which are directly billing, must bill the appropriate units with cost.

**30. Do we need to change all IP's right now to reflect units?**

Response

No, the CMA only needs to change the IPs that were due July 1 to current date because all IPs should already contain amount, scope and duration. DDD has run the necessary reports to identify the persons who need corrected IP Cover Sheets and sent those out to the CCBs. To clarify, the IP does not necessarily need to indicate "units", as long as the amount, scope and duration indicated in the IP matches the number of units in the IP and PAR.

**31. Is there a cap on Vision Services?**

Response

There is no cap on vision services as long as the services fall within the Waiver definition. The Waiver definition states: "These services are provided only when the services are not available through the Medicaid State Plan due to not meeting the need for medical necessity as defined in Health Care Policy and Financing rules at 8.011.11 or available through a third party resource. Vision services are provided by a licensed Optometrist or physician and include eye exams and diagnosis, glasses, contacts, and other medically necessary methods used to improve specific dysfunctions of the vision systems. Lasik and other similar types of procedures are only prior approved and allowable when the procedure is necessary due to documented specific behavioral complexities (i.e. constant destruction of eye glasses) associated with the client that make other more traditional remedies impractical."

**32. In projecting the number of units for the year, do we need to amend the IP if the person leaves (i.e.: vacation, hospitalization, etc) for 30 days?**

Response

The expectation is that at least planned leaves (i.e. vacations) would have been included in the calculations for the IP. However if there were unexpected or unanticipated leaves, DDD would not expect the IP to be amended.

- 33. Since the interim PARs were only created through June 30, 2007 do we need our IP certification periods to end at that time as well?**

Response

No, the IP will still have a year certification period. For persons with IP end dates between 9/1/06 and 6/30/07, the CMA will be meeting during this period to conduct the annual IP meeting and submitting a new IP Cover Sheet to reflect the dates and units discussed in the IP meeting. For persons with IP end dates that fall between 7/1/07 and 8/31/07, the CMA will be submitting a new IP Cover Sheet to update the PAR.

- 34. How do we convert units from Interim PAR end date to IP date when amending an IP? For example, the Interim PARs sent in are effective until 6/30/07; however, an amended staffing held today has an IP End Date of 1/31/07. How are the units on the Amended IP Coversheet to be figured - by Interim PAR date (6/30/07) or by IP End Date (1/31/07)? If the IP End Date is used, all of the figures are dramatically reduced. For example, for transportation the Interim PAR shows 221 units (for 10 months). If you are amending the IP today to add 1 extra unit of transportation per week and you calculate using the IP End Date (30 weeks), you get 185, which shows a PAR decrease even though you are actually increasing the service (so no actual number is entered in the "Additional Units Needed..." column on IPCS). Please clarify.**

Response

Since the CMA is amending the Interim PAR data, the units should reflect the amended amount through 6/30/07 that matches the Interim PAR. When the CMA holds the IP for the 2/1/07 start date and submits the new IP Cover Sheet, DDD Medicaid Operations staff will inactivate the Interim PAR and create a new PAR with the service information entered on the IP Cover Sheet.

- 35. If the provider is changing, but not the number of units/hours in the IP, is an amended IP cover sheet required?**

Response

Only if there is a change in the Residential Location Code. The amended IP cover sheet has a box in which to indicate this. Otherwise, if it is any other provider change an amended IP cover sheet is not required.